FULL REPORT

Preventing Suicide

Working With Youth Who Are Justice Involved

Prepared by the
Youth in Contact With the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

September 2013

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Contents

EXECUTIVE SUMMARY

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Introduction

This summary describes the background of and resources produced by the Youth in Contact with the Juvenile Justice System Task Force (http://actionallianceforsuicideprevention.org/task-force/juvenilejustice) of the National Action Alliance for Suicide Prevention (http://actionallianceforsuicideprevention.org) (Action Alliance). The task force was established in June 2011 to focus attention on the needs of youth in the juvenile justice system, particularly in the areas of suicide-related awareness and education, suicide research, suicide prevention programming and training, and collaboration between the juvenile justice and mental health systems.

Youth in Contact with the Juvenile Justice System Task Force

The task force produced resources, organized by workgroup name and described in greater detail below, to provide findings, recommendations, and practical tools for juvenile justice and mental health system administrators and staff:

1: Public Awareness and Education

- *Need to Know: A Fact Sheet Series on Juvenile Suicide*
  - *Juvenile Court Judges and Staff*
  - *Juvenile Detention and Secure Care Staff*
  - *Juvenile Probation Staff*

2: Suicide Research

- *Suicidal Ideation and Behavior among Youth in the Juvenile Justice System: A Review of the Literature*
- *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification and Risk Reduction among Juvenile Justice Youth*

3: Suicide Prevention Programming and Training

- *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*

4: Mental Health and Juvenile Justice Systems Collaboration

- *Preventing Juvenile Suicide through Improved Collaboration: Strategies for Mental Health and Juvenile Justice Agencies (and summary)*

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. Supporting the work of the Action Alliance are time-limited task forces working collaboratively to achieve specific NSSP objectives.

The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs (OJJDP), U.S. Department of Juvenile Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice (NCMHJJ), Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task with input and review by the task force's co-leads and the Action Alliance's Secretariat staff (David Litts, OD, Executive Secretary; Katie Deal, MPH, Deputy Secretary; Jason H. Padgett, MPA, MSM, Task Force Liaison; Emily Barocas, Director of Communications; and Liliya Melnyk, Communications Coordinator).

Public Awareness and Education Workgroup

Workgroup Members and Staff

- Deborah Stone, ScD, MSW, MPH (*workgroup lead*) – Behavioral Scientist, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- Christy Lentz, MSW – Senior Policy Associate, National Association of State Mental Health Program Directors (NASMHPD)
- Roy Praschil – Director of Operations, NASMHPD
- Steffie Rapp, LCSW-C – Program Manager, OJJDP
- Kathleen Skowyra – Associate Director, NCMHJJ

This group developed the *Need to Know: A Fact Sheet Series on Juvenile Suicides* (http://actionallianceforsuicideprevention.org/JJFactSheets) to promote awareness among individuals who work with youth involved with the juvenile justice system. It is important that these service providers – i.e., juvenile court judges and staff, juvenile detention and secure care staff, and juvenile probation staff – recognize that there is an increased risk for suicide ideation and suicidal behaviors among youth in contact with the juvenile justice system and that suicide for this target population is preventable. Each fact sheet includes: data on the prevalence of suicide among youth in the general population and in the juvenile justice system, factors that may increase and decrease the risk of suicide among system-involved youth, signs that immediate help for suicide risk is necessary, practical steps that staff can take to prevent suicide, and practical steps that systems (i.e., juvenile courts, detention and secure care facilities, and probation departments) can take to prevent suicide.

Suicide Research Workgroup

Workgroup Members and Staff

- Denise Juliano-Bult, MSW (*workgroup lead*) – Chief, Systems Research Programs and Disparities in Mental Health Research Programs, National Institutes of Health
- Laurie Garduque, PhD – Director, Justice Reform, John D. and Catherine T. MacArthur Foundation
- Thomas Grisso, PhD – Director, National Youth Screening Assessment Project, University of Massachusetts Medical Center
- Karen Stern, PhD – Social Science Analyst, National Institutes of Justice
- Barbara Tatem-Kelley, MA, MEd – Program Manager, OJJDP
- Linda A. Teplin, PhD – Vice Chair of Research, Director, Health Disparities and Public Policy, Northwestern University, Feinberg School of Medicine (Northwestern)

Additional Contributors

Karen M. Abram, PhD, Kathleen P. McCoy, PhD, and Marquita L. Stokes, MA – Northwestern

This group collected and reviewed current research on suicide and its prevention among juvenile justice-involved youth to identify gaps, to make recommendations for future research, and to develop a white paper documenting its findings. These efforts produced two documents:

- *Suicidal Ideation and Behavior among Youth in the Juvenile Justice System: A Review of the Literature* (http://actionallianceforsuicideprevention.org/system/files/JJ-5-R1-Literature-Review.pdf) summarizes the relevant, peer-reviewed literature on suicide in the juvenile justice system. It explores the prevalence of recent and past suicidal ideation and suicide attempts among justice-involved youth; gender and ethnic differences; and variables associated with suicidal ideation and attempt.
- *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth* (http://actionallianceforsuicideprevention.org/system/files/JJ-6-R2-Screening-Assessment.pdf) examines the juvenile justice system's responsibilities in preventing suicide, the contexts in which screening and assessment instruments are used, current standards for instruments used in mental health and juvenile justice settings, and specific instruments that are available.

Suicide Prevention Programming and Training Workgroup

This group developed a guide for implementing accepted guidelines for juvenile suicide prevention at each critical intervention point within the juvenile justice processing continuum: referral/arrest, courts, probation, detention and secure/non-secure care facilities, and aftercare. The guide, *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System* (http://actionallianceforsuicideprevention.org/system/files/JJ-7-P1-ProtocolGuidelines.pdf), describes eight critical components of a sound juvenile suicide prevention program: (1) training, (2) identification, referral, and evaluation, (3) communication, (4) housing (safe environment), (5) levels of observation, follow-up, and treatment planning, (6) intervention (emergency response), (7) reporting and notification, and (8) critical incident stress debriefing and mortality-morbidity review.

Workgroup Members and Staff

- Ned Loughran, MA (*workgroup lead*) – Executive Director, Council on Juvenile Correctional Administrators
- Karen Abram, PhD – Associate Professor, Health Disparities Program, Northwestern
- Donald Belau, PhD – Psychologist, Geneva Youth Residential Treatment Center
- Lindsay Hayes, MS – Project Director, Jail Suicide Prevention and Liability Reduction, National Center for Institutions and Alternatives
- Shawn Marsh, PhD – Chief Program Officer, National Council of Juvenile and Family Court Judges
- Kara McDonagh, MSW – Program Manager, OJJDP
- Nicholas Read, MA – Research Analyst, Human and Social Development, American Institutes for Research (AIR)

Mental Health and Juvenile Justice Systems Collaboration Workgroup

This group developed recommendations for improving the level and quality of collaboration between the juvenile justice and mental health systems for suicide prevention. Members compiled recommendations for promoting collaboration between mental health and juvenile justice agencies, which they then tailored to promoting suicide prevention supports and services for youth in the juvenile justice system. This information was organized into:

- ***Overarching Priorities*** — This group recommends that mental health and juvenile justice agencies at the state and local levels pursue ten overarching collaborative priorities to inform joint policy and budgeting decisions associated with suicide prevention for youth involved in juvenile justice.
- ***Strategies*** — A master set of twelve strategies is offered to facilitate achievement of the overarching priorities. Specific strategies are applied to each overarching priority.

Workgroup Members and Staff

- Eric Trupin, PhD (*workgroup lead*) – Director, Division of Public Behavioral Health and Justice Policy, University of Washington
- David DeVoursney, MPP – Program Analyst, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Simon Gonsoulin, Med – Principal Research Analyst, AIR
- Carl Wicklund – Executive Director, American Probation and Parole Association
- James Wright, MS, LCPC – Public Health Advisor, SAMHSA

The priorities and strategies are presented in *Preventing Juvenile Suicide through Improved Collaboration: Strategies for Mental Health and Juvenile Justice Agencies* (http://actionallianceforsuicideprevention.org/system/files/JJ-9-C2-CollaborationFullVersion.pdf), which also includes a matrix that graphically represents the strategies. The workgroup also developed an environmental scan tool as an appendix to the report to help jurisdictions assess strengths, weaknesses, opportunities, and threats across the ten overarching priorities, thereby lending direction to the process of building collaboration between agencies. A summary (http://actionallianceforsuicideprevention.org/system/files/JJ-8-C1-CollaborationSummaryVersion.pdf) of the recommendations presented in *Preventing Juvenile Suicide through Improved Collaboration* is also available.

Major Findings

Major findings from the four workgroups are summarized below. Each finding is followed by a number that cross-references the work of the corresponding workgroup (listed above).

- Youth suicide is a significant, yet preventable, public health problem.
  - Suicide is the second leading cause of death among youth ages 10–18.
  - About one in thirteen high-school students attempted suicide in the past year. (1)
- Youth involved with the juvenile justice system have increased risk of suicide.
  - Risk factors for suicide are much more prevalent among youth involved with the juvenile justice system than youth who are not involved with the juvenile justice system.
  - Youth in juvenile justice residential facilities have nearly three times the rate of suicide compared with their peers in the general population. (1)
- There are risk factors that may increase the risk of suicide among youth. Such factors include: mental health or substance abuse disorders; suicide or other death of friend or family member; and social isolation, relationship problems, or separation from family. (1)
- There are protective factors that may decrease the risk of suicide among youth. Such factors include: cultural or religious beliefs that discourage suicide; connectedness and support; suicide-resistant housing; and collaborative communication between systems. (1)
- There are steps that juvenile justice personnel can take to prevent suicide, such as ensuring access to effective mental health and substance abuse services, understanding the risk and protective factors related to suicide, and knowing the warning signs that may lead to suicide. (1)
- Juvenile justice systems can do more to help prevent suicide by providing suicide prevention training; ensuring that a standardized suicide risk screening is provided; and creating an emergency response protocol. (1)
- Much of the research reviewed relied on data collected 10–30 years ago. Furthermore, findings varied widely: from 21.9 suicides per 100,000 youth to 57 suicides per 100,000 youth. New research studies must be conducted to determine a current and reliable rate of suicide prevalence among youth involved in the juvenile justice system. (2)
- It is clear that suicidal ideation and behavior are quite prevalent among justice-involved youth: up to one-third of juvenile justice-involved youth report having experienced suicidal ideation in the past year and up to 36.7 percent have attempted suicide over their lifetimes. However, information on number of attempts, preparatory acts, method of attempts, etc. remains scant, which hinders the development of research-based suicide prevention programming. (2)
- Risk factors associated with suicide among youth in contact with juvenile justice system need to be explicitly identified. While juvenile justice youth with a history of depression or sexual abuse were found to be at increased risk of suicidal ideation and behavior, other factors proven to impact suicide in the general population – e.g., lack of social support, family history of suicide – have not been sufficiently researched for youth in juvenile justice. (2)
- Little has been done to date to empirically test the effectiveness of preventive interventions and programs in reducing suicide risk among justice-involved youth. This needs to change, beginning with the implementation of randomized clinical control trials of currently existing programs. Adaptability of successful preventive interventions used in other high-risk populations to juvenile justice youth should also be studied. (2)
- Juvenile justice providers should implement currently available tools for both detecting and intervening with individuals at risk for suicide.
  - Screening tools should be administered to every youth entering the juvenile justice system.
  - Assessment tools, which provide a more refined evaluation of suicide risk and identify individualized clinical and social circumstances, should be used in reducing suicide risk.(2)

- Many of the screening and assessment tools have not been validated for juvenile justice populations. This calls for increased empirical testing on related factors, such as the validity of standard cut-off points in screening tools for justice-involved youth. (2)
- Suicide prevention programs should include strategies at all points of youth contact within the juvenile justice system: referral/arrest, courts, probation, detention and secure/non-secure care facilities, and aftercare. (3)
- While some variation will exist, all eight critical components of a comprehensive juvenile suicide prevent program should be incorporated at each point of contact. These components include: training; identification, referral, and evaluation; communication; housing; levels of observation, follow-up, and treatment planning; intervention; reporting and notification; and critical incident stress debriefing and mortality-morbidity review. (3)
- In recognition of the higher rate of suicidal ideation and behavior among justice-involved youth, thoughtfully planned collaboration across all levels of government and jurisdictions is strongly urged. The collaboration of two systems in particular – mental health and juvenile justice – will greatly enhance the provision of appropriate services to this vulnerable population. Overarching priorities and specific strategies exist to facilitate greater collaboration. (4)

The National Action Alliance for Suicide Prevention is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) (http://actionallianceforsuicideprevention.org/NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance envisions a nation free from the tragic experience of suicide. For electronic copies of this paper or for additional information about the Action Alliance and its task forces, please visit http://www.actionallianceforsuicideprevention.org.

FACT SHEET

Need to Know: A Fact Sheet Series on Juvenile Suicide

Juvenile Court Judges and Staff

Prepared by the
Youth in Contact With the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

September 2013

National Action Alliance for Suicide Prevention
The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

Need to Know:
A Fact Sheet Series on Juvenile Suicide

Juvenile Court Judges and Staff

What You Need to Know about Juvenile Suicide

About this Fact Sheet

Need to Know: A Fact Sheet Series on Juvenile Suicide was developed by the Youth in Contact with the Juvenile Justice System Task Force of the National Action Alliance for Suicide Prevention. The task force's Public Awareness and Education Workgroup developed this series to raise awareness among individuals who work with youth involved with the juvenile justice system.

- **Youth suicide is a significant, yet *preventable*, public health problem.**
  - Suicide is the second leading cause of death among youth ages 10–18.[1]
  - About one in thirteen high-school students attempted suicide in the past year.[2]
  - Nearly 88,000 youth ages 10–18 were treated in emergency rooms for self-harm injuries in 2011.[3,4]
  - Males are more likely to die by suicide[1] and females are more likely to attempt suicide.[4]
  - Certain populations (e.g., American Indian/Alaskan Native and sexual minority youth) have increased rates of suicide.[5,6]
- **Youth involved with the juvenile justice system have *increased* risk of suicide.**
  - Suicide is the leading cause of death for youth in confinement.[7]
  - Youth in residential facilities have nearly three times the suicide rate of peers in the general population.[8]
  - Risk factors for suicide are often more prevalent among youth in the juvenile justice system.[9]
  - Studies report that over half of juveniles had current suicidal ideation[10] and one-third had a history of suicidal behavior.[11]
- **Factors that may *increase* the risk of suicide among all youth include:**[11,12,13,14]
  - Mental illness and/or substance use disorder
  - History of suicide attempts, self-harm behavior, and/or death by suicide in the family
  - Social isolation, relationship problems, or separation from family
  - Impulsive, aggressive, or reckless behavior
  - History of bullying or being bullied
  - Access to lethal means
  - History of trauma or child maltreatment
- **Factors that may *increase* suicide risk among youth in the justice system include:**[15,16,17,18]
  - History of mental illness and/or substance use disorder
  - Involvement in special education
  - Legal/disciplinary problems
  - Prior disciplinary action
  - Prior offenses
  - Referral to juvenile court
  - Being placed on room confinement

- **Signs that *immediate* help for suicide risk is needed include:**[10,11,12,13]
  - Perceived crisis (e.g., transition within the juvenile justice system)
  - Unusual or sudden changes in personality, behavior, or mood
  - Talking about wanting to die or kill oneself
  - Withdrawal from friends, family, or usual activities
  - Expressions of hopelessness or feeling trapped
  - Actively securing access to lethal means
- **Protective factors that may *decrease* suicide risk among youth in the justice system include:**[18,19,20]
  - Easy access to effective mental health and substance abuse treatment services
  - Problem-solving and conflict-resolution skills
  - Cultural or religious beliefs that discourage suicide
  - Connectedness and support from family and community
  - A positive school experience
  - Lack of access to lethal means
  - Suicide-resistant housing
  - Collaborative communication between juvenile justice and mental health systems

What You Can Do to Prevent Juvenile Suicide

- **Demonstrate your belief that suicide *can be* prevented.**[15]
- **Learn the protective factors, risk factors, and warning signs related to suicide.**[15]
- **Implement and evaluate comprehensive suicide prevention policies, programs, and practices that address risk and protective factors on multiple levels.**
- **Take any written, spoken, or other communication of suicide seriously. If you think someone is at risk:**
  - Do not be afraid to ask if someone is considering suicide. This *will not* cause suicide.
  - Be direct. Ask:
    - Are you thinking about killing yourself?
    - Are you considering taking your own life?
    - Do you ever feel like things would be better if you were dead?
  - Listen and do not judge anyone who you think might be thinking of suicide.
  - Avoid acting shocked if a youth says he or she is considering suicide.
  - Do not be sworn to secrecy or make promises that you won't tell anyone.
  - Communicate any suspicion that a youth is thinking about suicide to a mental health professional or supervisor *immediately*.
  - Stay with the youth. Do *not* leave a suicidal youth alone while you go get help.

What Courts Can Do about Juvenile Suicide

- **Incorporate suicide prevention training into standard training for all judges, clerks, and staff.**
- **Ensure that a standardized suicide risk screening using a valid and reliable tool is provided to all youth at probation and detention intake, and that suicide risk assessment by qualified mental health professionals occurs as necessary on an ongoing basis.**
- **Establish a protocol to convene judicially led stakeholder meetings on a regular basis to help improve communication and planning around suicide prevention.**
- **Establish a protocol for physical safety in all interview rooms and holding cells.**
- **Create an emergency response protocol that addresses youth suicides, suicide attempts, or other suicide-related crises on court grounds.**
- **Establish policy requirements for multi-disciplinary participation (including juvenile court staff) in the review and report of incidents involving youth suicides, suicide attempts, or suicide threats.**[13]
- **Access additional resources for more information.**
  - Centers for Disease Control and Prevention
    - http://www.cdc.gov/ViolencePrevention/suicide
  - National Center on Institutions and Alternatives, Inc.
    - http://www.ncianet.org/services/suicide-prevention-in-custody
  - National Council of Juvenile and Family Court Judges
    - http://www.ncjfcj.org
  - National Suicide Prevention Lifeline
    - http://www.suicidepreventionlifeline.org; (800) 273-TALK (8255)
  - Office of Juvenile Justice and Delinquency Prevention
    - http://www.ojjdp.gov
  - Substance Abuse and Mental Health Services Administration
    - http://www.samhsa.gov/prevention/suicide.aspx
  - Suicide Prevention Resource Center
    - http://www.sprc.org

Need to Know:
A Fact Sheet Series on Juvenile Suicide

Juvenile Court Judges and Staff

About This Fact Sheet

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- **you need to know** about juvenile suicide
- **you can do** to prevent juvenile suicide
- **systems can do** to prevent juvenile suicide

This fact sheet is tailored to juvenile court judges and staff; companion pieces are tailored to juvenile probation staff and to juvenile detention and secure care staff.

The Public Awareness and Education Workgroup included the following members and staff:

- Deborah Stone, ScD, MSW, MPH (*workgroup lead*) – Behavioral Scientist, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- Christy Lentz, MSW – Senior Policy Associate, National Association of State Mental Health Program Directors
- Roy Praschil – Director of Operations, National Association of State Mental Health Program Directors
- Steffie Rapp, LCSW-C – Program Manager, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice
- Kathleen Skowyra – Associate Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

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Action Alliance

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The Action Alliance established the Youth in Contact with the Juvenile Justice System Task Force to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration.

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[2] Centers for Disease Control and Prevention. *1991–2011 High school youth risk behavior survey data*. Accessed August 2012. Retrieved from http://apps.nccd.cdc.gov/youthonline

[3] The term "self-harm" includes suicide attempts and non-suicidal self-injuries.

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FACT SHEET

Need to Know: A Fact Sheet Series on Juvenile Suicide

Juvenile Detention and Secure Care Staff

Prepared by the
Youth in Contact With the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

September 2013

National Action Alliance for Suicide Prevention
The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

Need to Know:
A Fact Sheet Series on Juvenile Suicide

Juvenile Detention and Secure Care Staff

What You Need to Know about Juvenile Suicide

- **Youth suicide is a significant, yet preventable, public health problem.**
  - Suicide is the second leading cause of death among youth ages 10–18.[1]
  - About one in thirteen high-school students attempted suicide in the past year.[2]
  - Nearly 88,000 youth ages 10–18 were treated in emergency rooms for self-harm injuries in 2011.[3,4]
  - Males are more likely to die by suicide[1] and females are more likely to attempt suicide.[4]
  - Certain populations (e.g., American Indian/Alaskan Native and sexual minority youth) have increased rates of suicide.[5,6]

About this Fact Sheet

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- **Youth involved with the juvenile justice system have *increased* risk of suicide.**
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  - Youth in residential facilities have nearly three times the suicide rate of peers in the general population.[8]
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  - Studies report that over half of juveniles had current suicidal ideation[10] and one-third had a history of suicidal behavior.[11]
- **Factors that may *increase* the risk of suicide among all youth include:**[11,12,13,14]
  - Mental illness and/or substance use disorder
  - History of suicide attempts, self-harm behavior, and/or death by suicide in the family
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  - Impulsive, aggressive, or reckless behavior
  - History of bullying or being bullied
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  - History of trauma or child maltreatment
- **Factors that may *increase* suicide risk among youth in the justice system include:**[15,16, 17,18]
  - History of mental illness and/or substance use disorder
  - Involvement in special education
  - Legal/disciplinary problems
  - Prior disciplinary action
  - Prior offenses
  - Referral to juvenile court
  - Being placed on room confinement

- **Signs that *immediate* help for suicide risk is needed include:**[10,11,12,13]
  - Perceived crisis (e.g., transition within the juvenile justice system)
  - Unusual or sudden changes in personality, behavior, or mood
  - Talking about wanting to die or kill oneself
  - Withdrawal from friends, family, or usual activities
  - Expressions of hopelessness or feeling trapped
  - Actively securing access to lethal means
- **Protective factors that may *decrease* suicide risk among youth in the justice system include:**[18,19,20]
  - Easy access to effective mental health and substance abuse treatment services
  - Problem-solving and conflict-resolution skills
  - Cultural or religious beliefs that discourage suicide
  - Connectedness and support from family and community
  - A positive school experience
  - Lack of access to lethal means
  - Suicide-resistant housing
  - Collaborative communication between juvenile justice and mental health systems

What You Can Do to Prevent Juvenile Suicide

- **Demonstrate your belief that suicide *can be* prevented.**[15]
- **Learn the protective factors, risk factors, and warning signs related to suicide.**[15]
- **Implement and evaluate comprehensive suicide prevention policies, programs, and practices that address risk and protective factors on multiple levels.**
- **Take any written, spoken, or other communication of suicide seriously. If you think someone is at risk:**
  - Do not be afraid to ask if someone is considering suicide. This *will not* cause suicide.
  - Be direct. Ask:
    - Are you thinking about killing yourself?
    - Are you considering taking your own life?
    - Do you ever feel like things would be better if you were dead?
  - Listen and do not judge anyone who you think might be thinking of suicide.
  - Avoid acting shocked if a youth says he or she is considering suicide.
  - Do not be sworn to secrecy or make promises that you won't tell anyone.
  - Communicate any suspicion that a youth is thinking about suicide to a mental health professional or supervisor *immediately*.
  - Stay with the youth. Do *not* leave a suicidal youth alone while you go get help.

What Detention and Secure Care Facilities Can Do to Prevent Juvenile Suicide

- **Develop, implement, and maintain a comprehensive written suicide prevention program that includes the following eight critical components:**[13]
  - Routine suicide prevention training for all staff
  - Standardized intake screening for suicide risk using a valid and reliable tool for all youth, with suicide risk assessment by a qualified mental health professional administered as necessary
  - Protocols that provide shared information about suicide risk
    - Among the arresting/transporting officer, family members, and facility staff
    - Between facility staff members
    - Between facility staff and youth
  - Varying levels of supervision[21]
    - Close observation for youth with suicidal ideation or behavior
    - Constant observation for youth who are talking about or displaying suicidal behavior
      Closed-circuit television does ***not* substitute for observation.
  - Safe physical environment
  - Emergency response protocol in the case of suicides or suicide attempts
  - Notification system for suicides or suicide attempts through the chain of command
  - Critical incident stress debriefing protocol (for all staff and youth) and a death review
- **Access additional resources for more information.**
  - Centers for Disease Control and Prevention
    - http://www.cdc.gov/ViolencePrevention/suicide
  - National Center on Institutions and Alternatives, Inc.
    - http://www.ncianet.org/services/suicide-prevention-in-custody
  - National Suicide Prevention Lifeline
    - http://www.suicidepreventionlifeline.org; (800) 273-TALK (8255)
  - Office of Juvenile Justice and Delinquency Prevention
    - http://www.ojjdp.gov
  - Substance Abuse and Mental Health Services Administration
    - http://www.samhsa.gov/prevention/suicide.aspx
  - Suicide Prevention Resource Center
    - http://www.sprc.org

About This Fact Sheet

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- **you need to know** about juvenile suicide
- **you can do** to prevent juvenile suicide
- **systems can do** to prevent juvenile suicide

This fact sheet is tailored to juvenile detention and secure care staff; companion pieces are tailored to juvenile probation staff and to juvenile court judges and staff.

The Public Awareness and Education Workgroup included the following members and staff:

- Deborah Stone, ScD, MSW, MPH (*workgroup lead*) – Behavioral Scientist, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- Christy Lentz, MSW – Senior Policy Associate, National Association of State Mental Health Program Directors
- Roy Praschil – Director of Operations, National Association of State Mental Health Program Directors
- Steffie Rapp, LCSW-C – Program Manager, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice
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Action Alliance

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The Action Alliance established the Youth in Contact with the Juvenile Justice System Task Force to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration.

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[9] National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice Task Force – Suicide Research Workgroup. (2013). *Suicidal ideation and behavior among youth in the juvenile justice system: A review of the literature.* Washington, DC: Author.

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The National Action Alliance for Suicide Prevention is the public-private partnership advancing the *National Strategy for Suicide Prevention* (NSSP) (http://actionallianceforsuicideprevention.org/NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance envisions a nation free from the tragic experience of suicide. For electronic copies of this paper or for additional information about the Action Alliance and its task forces, please visit http://www.actionallianceforsuicideprevention.org.

FACT SHEET

Need to Know: A Fact Sheet Series on Juvenile Suicide

Juvenile Probation Staff

Prepared by the
Youth in Contact With the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

September 2013

National Action Alliance for Suicide Prevention
The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

Need to Know:
A Fact Sheet Series on Juvenile Suicide

Juvenile Probation Staff

What You Need to Know about Juvenile Suicide

Youth suicide is a significant, yet *preventable*, public health problem.

- Suicide is the second leading cause of death among youth ages 10–18.[1]
- About one in thirteen high-school students attempted suicide in the past year.[2]
- Nearly 88,000 youth ages 10–18 were treated in emergency rooms for self-harm injuries in 2011.[3,4]
- Males are more likely to die by suicide[1] and females are more likely to attempt suicide.[4]
- Certain populations (e.g., American Indian/Alaskan Native and sexual minority youth) have increased rates of suicide.[5,6]

About this Fact Sheet

Need to Know: A Fact Sheet Series on Juvenile Suicide was developed by the Youth in Contact with the Juvenile Justice System Task Force of the National Action Alliance for Suicide Prevention. The task force's Public Awareness and Education Workgroup developed this series to raise awareness among individuals who work with youth involved with the juvenile justice system.

Youth involved with the juvenile justice system have *increased* risk of suicide.

- Suicide is the leading cause of death for youth in confinement.[7]
- Youth in residential facilities have nearly three times the suicide rate of peers in the general population.[8]
- Risk factors for suicide are often more prevalent among youth in the juvenile justice system.[9]
- Studies report that over half of juveniles had current suicidal ideation[10] and one-third had a history of suicidal behavior.[11]

Factors that may *increase* the risk of suicide among all youth include:[11,12,13,14]

- Mental illness and/or substance use disorder
- History of suicide attempts, self-harm behavior, and/or death by suicide in the family
- Social isolation, relationship problems, or separation from family
- Impulsive, aggressive, or reckless behavior
- History of bullying or being bullied
- Access to lethal means
- History of trauma or child maltreatment

Factors that may *increase* suicide risk among youth in the justice system include:[15,16,17,18]

- History of mental illness and/or substance use disorder
- Involvement in special education
- Legal/disciplinary problems
- Prior disciplinary action
- Prior offenses
- Referral to juvenile court
- Being placed on room confinement

- **Signs that *immediate* help for suicide risk is needed include:**[10,11,12,13]
  - Perceived crisis (e.g., transition within the juvenile justice system)
  - Unusual or sudden changes in personality, behavior, or mood
  - Talking about wanting to die or kill oneself
  - Withdrawal from friends, family, or usual activities
  - Expressions of hopelessness or feeling trapped
  - Actively securing access to lethal means
- **Protective factors that may *decrease* suicide risk among youth in the justice system include:**[18,19,20]
  - Easy access to effective mental health and substance abuse treatment services
  - Problem-solving and conflict-resolution skills
  - Cultural or religious beliefs that discourage suicide
  - Connectedness and support from family and community
  - A positive school experience
  - Lack of access to lethal means
  - Suicide-resistant housing
  - Collaborative communication between juvenile justice and mental health systems

What You Can Do to Prevent Juvenile Suicide

- **Demonstrate your belief that suicide *can be* prevented.**[15]
- **Learn the protective factors, risk factors, and warning signs related to suicide.**[15]
- **Implement and evaluate comprehensive suicide prevention policies, programs, and practices that address risk and protective factors on multiple levels.**
- **Take any written, spoken, or other communication of suicide seriously. If you think someone is at risk:**
  - Do not be afraid to ask if someone is considering suicide. This *will not* cause suicide.
  - Be direct. Ask:
    - Are you thinking about killing yourself?
    - Are you considering taking your own life?
    - Do you ever feel like things would be better if you were dead?
  - Listen and do not judge anyone who you think might be thinking of suicide.
  - Avoid acting shocked if a youth says he or she is considering suicide.
  - Do not be sworn to secrecy or make promises that you won't tell anyone.
  - Communicate any suspicion that a youth is thinking about suicide to a mental health professional or supervisor *immediately*.
  - Stay with the youth. Do *not* leave a suicidal youth alone while you go get help.

What Probation Departments Can Do to Prevent Juvenile Suicide

- **Develop, implement, and maintain a comprehensive suicide prevention program that includes the following critical components:**[13]
  - Routine suicide prevention training for all probation staff
  - Standardized intake screening for suicide risk using a valid and reliable tool for all youth, with suicide risk assessment by a qualified mental health professional administered as necessary
  - Protocol to share information between probation staff and detention/facility staff about a youth's suicide warning signs and risk/protective factors
  - Protocol for physical safety in probation offices and other spaces where youth meet officers and other staff
  - Protocol for responding to a suicide, suicide attempt, or suicide-related crises in emergency response plans
  - Memoranda of understanding and agreements with mental health providers for emergency referral and treatment
  - Reporting requirements for all incidents of suicide, suicide attempts, or suicide-related crises
- **Access additional resources for more information.**
  - American Probation and Parole Association
    - http://www.appa-net.org
  - Centers for Disease Control and Prevention
    - http://www.cdc.gov/ViolencePrevention/suicide
  - National Center on Institutions and Alternatives, Inc.
    - http://www.ncianet.org/services/suicide-prevention-in-custody
  - National Suicide Prevention Lifeline
    - http://www.suicidepreventionlifeline.org; (800) 273-TALK (8255)
  - Office of Juvenile Justice and Delinquency Prevention
    - http://www.ojjdp.gov
  - Substance Abuse and Mental Health Services Administration
    - http://www.samhsa.gov/prevention/suicide.aspx
  - Suicide Prevention Resource Center
    - http://www.sprc.org

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- **you need to know** about juvenile suicide
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- **systems can do** to prevent juvenile suicide

This fact sheet is tailored to juvenile probation staff; companion pieces are tailored to juvenile court judges and staff and to juvenile detention and secure care staff.

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The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration.

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Suicidal Ideation and Behavior among Youth in the Juvenile Justice System: A Review of the Literature

Prepared by the
Youth in Contact with the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

September 2013

Suggested Citation: National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force. (2013). *Suicidal ideation and behavior among youth in the juvenile justice system: A review of the literature.* Washington, DC: Author.

Introduction

Despite significant concern over suicidal ideation and behavior among youth involved with the juvenile justice system, no systematic review of the literature on suicidal ideation and behavior among this population exists. In response, this paper was developed by the Youth in Contact with the Juvenile Justice System Task Force (http://actionalliancefor suicideprevention.org/task-force/juvenilejustice) of the National Action Alliance for Suicide Prevention (Action Alliance) (http://www.actionallianceforsuicide prevention.org/) to: a) provide a comprehensive review of the available research, b) assess what we know and identify existing gaps, and c) offer a series of recommendations for future research. This review explores the prevalence of recent and past suicidal ideation and suicide attempts among justice-involved youth; gender and ethnic differences; and variables associated with suicidal ideation and attempt.

Suicidal Ideation and Behavior among Youth in the Juvenile Justice System

Many youth today are at risk for suicide. Suicide is the second leading cause of death among individuals aged 10–18 (Centers for Disease Control and Prevention (CDC) 2012). Approximately seven of 100,000 adolescents aged 15–19 die by suicide each year. Suicides are associated with previous suicidal ideation and attempts (Brent et al. 1988; Kessler, Borges, & Walters 1999; Lewinsohn, Rohde, & Seeley 1996; Lewinsohn, Rohde, & Seeley 1994; Shaffer et al. 1996). A recent review estimated that 19.8–24.0 percent of youth have experienced suicidal ideation, and 3.1–8.8 percent have attempted suicide in their lifetime (Nock et al. 2008). The most recent study of youth aged 15–19, the 2011 Youth Risk Behavior Survey, estimated that 15.8 percent of youth seriously contemplated suicide, and 7.8 percent made at least one attempt in the past year (CDC National Center for Injury Prevention and Control (NCIPC) 2012). Rates of suicidal ideation and behavior vary according to gender and race/ethnicity. Adolescent females have higher rates of suicidal ideation and behavior than males (Beautrais 2002; Cannetto & Sakinofsky 1998; CDC NCIPC 2012; D'Eramo et al. 2004; Greenhill & Waslick 1997).

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was established to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Juvenile Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task.

Suicide Research Workgroup Members and Staff

- Denise Juliano-Bult, MSW (*workgroup lead*) – Chief, Systems Research Programs and Disparities in Mental Health Research Programs, National Institutes of Health
- Laurie Garduque, PhD – Director, Justice Reform, John D. and Catherine T. MacArthur Foundation
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- Karen Stern, PhD – Social Science Analyst, National Institutes of Justice
- Barbara Tatem-Kelley, MA, Med – Program Manager, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice
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Non-Hispanic whites have higher rates than African Americans and Hispanics (CDC NCIPC 2012; Harris et al. 2006; Kessler, Borges, & Walters 1999; Miller & Eckert 2009).

Suicides are more common among youth in the juvenile justice system than in the general population (Gray et al. 2002; Hayes 2009). In the first published national survey of completed suicide among incarcerated juveniles, the suicide rate was estimated at 57 per 100,000 in detention facilities, 4.6 times higher than youth in the general population (Memory 1989). More recently, the rate is reported to be 21.9 per 100,000 young people in juvenile justice facilities, approximately three times higher than peers in the general population (Gallagher & Dobrin 2006).

Risk factors for suicidal ideation and behavior are far more common among youth in the juvenile justice system than in the general population (Brown et al. 1999; Dube et al. 2001). For example, more than two-thirds of detained youth have a psychiatric disorder and/or a substance use disorder (Teplin et al. 2002; Wasserman et al. 2002). More than three-quarters of detained females and more than two-thirds of detained males have a history of physical abuse (King et al. 2011).[1] Because of these and other risk factors, youth in the juvenile justice system are at great risk for suicide.

Methods

To accomplish the goals of this paper, it was first necessary to identify criteria for inclusion of research studies, define key terminology, and establish a procedure for data extraction.

Criteria for Inclusion

For this review, MEDLINE/PubMed, PsycINFO, and PsycARTICLES databases for epidemiologic studies were searched using the following words: "suicidal ideation and juvenile justice," "suicide attempts and juvenile justice," "suicidal behavior and juvenile justice," "suicide and juvenile justice," "suicide and youth incarceration," and "suicidality and juvenile justice." Only publications written in English and published between 1990 and 2012 were considered. Reference lists from these publications were then manually searched for relevant studies, i.e., those that examined either suicidal ideation or behavior. Studies were excluded if they: (1) provided only case reports or commentaries; (2) did not use well-validated screening measures; (3) reported scale means instead of prevalence rates; (4) were not conducted in the United States; or (5) assessed only non-suicidal self-injury (e.g., cutting), where a person does not intend to die. For studies with multiple publications examining the same sample (e.g., Esposito & Clum 1999; Esposito & Clum 2002), only the most recent publication was included.

Definitions of Terms

Terminology for the literature search and in this paper was adopted from the CDC (Crosby, Ortega, & Melanson, 2011). "Suicidal ideation" is defined as thoughts of engaging in behavior intended to end one's life. "Suicidal behavior" refers to nonfatal, self-directed potentially injurious behavior with any intent to die as a result of the behavior. A "suicide attempt" may or may not result in injury. In the juvenile justice system, "suicidal behavior" and "suicide attempts" are often used interchangeably.

[1] Additional risk factors are available within the task force's *Need to Know: A Fact Sheet Series on Juvenile Suicide* (http://actionallianceforsuicideprevention.org/JJFactSheets)

Extraction of Data

Two reviewers independently identified relevant studies, extracted data, and assessed the quality of the study, resolving disagreement by consensus. In addition to obtaining information on suicidal ideation and behavior, the following information was reviewed and extracted: (1) sample characteristics (size, location, and demographic features); (2) measures of risk for suicide; and (3) assessment of risk factors for suicide.

Findings from the First National Survey of Juvenile Suicide in Confinement

The first national survey on juvenile suicide in confinement (Hayes, 2009) identified 110 juvenile suicides occurring between 1995 and 1999 and analyzed the 79 of those cases for which complete data were available. Findings from the survey include the extent and distribution of juvenile suicides; provide descriptive data on the characteristics of victims, incidents, and juvenile facilities; and, most importantly, highlight critical gaps in current knowledge and programming, suggesting areas for future research to develop evidence-based prevention strategies. The resulting recommendations are as follows:

- Possible precipitating factors for suicide were identified in only slightly more than one-third of the cases. Improved reporting in this area is critically important to informing the development of effective suicide prevention strategies.
- Approximately half of juveniles who committed suicide were under room confinement at the time of their deaths, and the majority of those died during waking hours. In addition, the timing of suicides was evenly distributed over the length of confinement, with the same number of deaths occurring in the first few days as occurred over many months of confinement. These findings should inform the structure and timing of prevention programming to be tested for maximum impact in improving outcomes.
- Suicide prevention strategies were uneven across the facilities examined, underscoring the need for improved resources to support relevant programming and training in juvenile justice settings. It is critical that the strategies employed have been developed and tested for effectiveness specifically in juvenile justice populations.

Source: Hayes, L. M. (2009). Juvenile Suicide in Confinement—Findings from the First National Survey. *Suicide and Life-Threatening Behavior*, *39*: 353–363. doi: 10.1521/suli.2009.39.4.353

Results

A total of 27 studies that examined recent or lifetime suicidal ideation and behavior among youth involved in the juvenile justice system were discovered. Based on the aforementioned exclusion criteria, 11 studies were omitted: eight did not use well-validated screening measures (Abrantes, Hoffmann, & Anton 2005; Battle, Battle, & Tolley 1993; Corcoran & Graham 2002; Evans et al. 1996; Freedenthal et al. 2007; Penn et al. 2003; Rohde, Seeley, & Mace 1997; Voisin et al. 2007) and three reported scale means, not prevalence rates (Butler, Loney, & Kistner 2007; Sanislow et al. 2003; Timmons-Mitchell et al. 1997).

This paper reviews the remaining 16 studies (see Appendix A). Most of these studies examined history of both suicidal ideation and attempts via self-report (Abram et al. 2008; Archer et al. 2004; Chavira et al. 2010; Esposito & Clum 2002; Morris et al. 1995; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Wasserman & McReynolds 2006). Of note, recent attempts may or may not have occurred in a correctional setting. Overall, sample sizes ranged from 51 (Kempton & Forehand 1992) to 70,423 (Vincent et al. 2008). Studies sampled youth at various points of contact within the juvenile justice system: post-arrest (Nolen et al. 2008), pre-adjudicated intake to detention (Abram et al. 2008; Archer et al. 2004; Cauffman 2004; Chapman & Ford 2008), in detention (Esposito & Clum 2002; Goldstein et al. 2003; Kempton & Forehand 1992; Morris et al. 1995; Rohde, Mace, & Seeley 1997; Shelton 2000), post-adjudication (e.g., probation intake, juvenile court supervision) (Mallett et al. 2012; Wasserman & McReynolds 2006), and combined points of contact: intake, detention, and secure post-adjudicated corrections (Vincent et al. 2008; Wasserman et al. 2010). In the 11 studies that reported the age of participants, the mean age was approximately 15 years. Racial/ethnic minorities comprised between 17 percent (Rohde, Mace, & Seeley 1997) to 84 percent (Abram et al. 2008). Overall, most studies examined only males or included a relatively small proportion of females. One study included only females (Goldstein et al. 2003) and another included only males (Kempton & Forehand 1992).

Suicidal Ideation and Behavior

Findings from the available research on the prevalence rates of suicidal ideation and suicide attempts of youth in contact with the juvenile justice system are reviewed below. (Details of the reviewed studies are provided in Appendix A.) For the purposes of this review, "recent" is defined as occurring within the past 6 months. Methodological differences in sampling and measurement are also noted, including the racial/ethnic composition, number of females, and the point of contact in the system from which the sample was obtained (e.g., CDC NCIPC 2012; Wasserman et al. 2010).

Suicidal Ideation

Prevalence rates of suicidal ideation within recent months, during the past year, and over the youth's lifetime were gathered from the studies included in this review.

Recent Suicidal Ideation

As noted in Appendix A, prevalence rates of recent suicidal ideation in juvenile justice youth ranged from 3 percent to 52 percent (Abram et al. 2008; Archer et al. 2004; Cauffman 2004; Esposito & Clum 2002; Goldstein et al. 2003; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Vincent et al. 2008; Wasserman & McReynolds 2006). Differing assessment tools, as well as demographic differences within samples, may contribute to the varying prevalence rates. Esposito and Clum (2002), who reported the highest rate of 52 percent, used a measure designed specifically to assess suicidal ideation: The Modified Scale for Suicidal Ideation. The other studies assessed suicidal ideation using a diagnostic or screening tool (e.g., Massachusetts Youth Screening Instrument-Second Edition (MAYSI-2), Diagnostic Interview Schedule for Children (DISC)). Because Esposito and Clum used a suicide-specific assessment tool, its findings may not be comparable to those of studies using a diagnostic or screening tool. Archer and colleagues (2004) used a screening battery, which included the MAYSI-2 and an unstructured interview; however, they did not specify which tool was used to assess current suicidal ideation. Thus, it is unclear whether a standardized screening tool was used. Goldstein and colleagues: a) did not specify a definitive assessment period and b) analyzed suicidal ideation in an all-female sample (2003). Rohde, Mace, & Seeley (1997) studied only 60 participants, most of whom were non-Hispanic white (83 percent).

In sum, methodological differences may contribute to inconsistencies across studies and bias estimates of suicidal ideation. Given the limitations of the literature, the best estimates of recent suicidal ideation among youth in juvenile justice settings ranges from 8 percent to 21 percent (Abram et al. 2008; Cauffman 2004; Nolen et al. 2008; Vincent et al. 2008; Wasserman & McReynolds 2006).

Past-Year Suicidal Ideation

Prevalence rates of past-year suicidal ideation ranged from 10.0 percent to 29.2 percent (Chapman & Ford 2008; Chavira et al. 2010; Morris et al. 1995; Shelton 2000). All studies except Chapman and Ford (2008) assessed suicidal ideation using a diagnostic screening tool (e.g., MAYSI-2, DISC). Chapman and Ford used the Suicidal Ideation Questionnaire (SIQ). The SIQ uses clinical cut-off scores to classify juveniles into "suicidal ideation risk" and "no-risk" groups; this may result in estimates that are more conservative. If the study by Chapman and Ford is excluded, the best estimate of suicidal ideation in the past year is 19.0–29.2 percent.

Lifetime Suicidal Ideation

Only two studies (Archer et al. 2004; Rohde, Mace, & Seeley 1997) reported lifetime prevalence rates of suicidal ideation. There are substantial methodological differences between them. Rohde and colleagues reported a lifetime rate of 35 percent; however, their sample of 60 detainees limits the study's ability to estimate reliable rates. Archer and colleagues included over 700 youth detainees; they reported a rate of 13.9 percent. In sum, a definitive estimate of lifetime suicidal ideation is not yet available.

Suicidal Behavior

Prevalence rates of suicide attempts within recent months, during the past year, and over the youth's lifetime were also noted in this review.

Recent Suicide Attempts

Prevalence rates of recent suicide attempts range from 1.4 percent to 8.5 percent (Abram et al. 2008; Esposito & Clum 2002; Nolen et al. 2008; Wasserman & McReynolds 2006; Wasserman et al. 2010). Esposito and Clum (2002) reported the highest prevalence of suicide attempts and used a sample that was primarily non-Hispanic white. The remaining studies, which included a larger proportion of minority youth, reported lower rates, ranging from 1.4 percent to 3.0 percent.

Past-Year Suicide Attempts

Studies that examined suicide attempts in the past year had methodological limitations. Esposito and Clum (2002) used a sample that was primarily non-Hispanic white. They reported that 9.5 percent of their sample had attempted suicide in the past year. Morris and colleagues (1995) found that 15.5 percent of their sample reported an attempt in the past year. This study's rate may be higher because the sample includes youth in both short-term and long-term detention facilities. Deeper involvement in the juvenile justice system (i.e., long-term detention) is associated with increased suicide attempts (Wasserman et al. 2010). Due to these methodological differences, a definitive estimate of the prevalence rate of past-year suicide attempts is not available.

Lifetime Suicide Attempts

As noted in Appendix A, rates of lifetime suicide attempts range from 10.0 percent to 36.7 percent (Abram et al. 2008; Archer et al. 2004; Chavira et al. 2010; Esposito & Clum 2002; Kempton & Forehand 1992; Mallett et al. 2012; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Wasserman & McReynolds 2006; Wasserman et al. 2010). Studies with smaller samples sizes ($n \leq 60$) reported lifetime rates above 30 percent (Kempton & Forehand 1992; Rohde, Mace, & Seeley 1997). Studies with larger sample sizes reported lower rates, ranging between 11.0 percent and 15.5 percent (Abram et al. 2008; Archer et al. 2004; Chavira et al. 2010; Esposito & Clum 2002; Mallett et al. 2012; Nolen et al. 2008; Wasserman & McReynolds 2006; Wasserman et al. 2010).

Gender and Ethnic Disparities in Suicidal Ideation and Behavior

The examination of the 16 studies included in this review also focused on the impact of gender and ethnicity on rates of suicidal ideation and behavior.

Recent Suicidal Ideation

Gender and racial/ethnic differences in recent suicidal ideation varied across studies (see Appendix A). Most studies (Abram et al. 2008; Cauffman 2004; Vincent et al. 2008) found that females had higher rates of recent suicidal ideation than males. Esposito and Clum (2002), however, did not find any significant differences between males and females. Findings also varied in terms of racial/ethnic differences. Two studies found that non-Hispanic whites had higher prevalence rates than African Americans and Hispanics (Cauffman 2004; Vincent et al. 2008). Abram and colleagues (2008) found that racial differences varied by gender. Among males, non-Hispanic whites had higher rates of recent suicidal ideation than African Americans. Among females, Hispanics had higher rates of ideation than African Americans. Esposito and Clum (2002) did not find any significant racial/ethnic differences. Differences in sampling composition and measurement may account for the varying findings. The sample studied by Esposito and Clum, for example, was mostly white; they also used a measure designed specifically to assess suicidal ideation.

Past-Year Suicidal Ideation

One study examined racial/ethnic and gender differences in past-year rates of suicidal ideation (Morris et al. 1995). Females had higher prevalence rates than males. Non-Hispanic whites had higher prevalence rates than African Americans and Hispanics. Notably, this study included juveniles in short-term and long-term facilities; however, the researchers did not examine if rates differed by facility. Deeper involvement in the juvenile justice system is associated with higher rates of suicidal behavior specifically (Wasserman et al. 2010); therefore, including juveniles in long-term facilities may have skewed the findings for ideation. Neither study (Archer et al. 2004; Rohde, Mace, & Seeley 1997) examined racial/ethnic or gender differences in lifetime suicidal ideation rates.

Recent Suicide Attempts

Findings for past-month suicide attempts were consistent across studies (Wasserman & McReynolds 2006; Wasserman et al. 2010). Females had higher prevalence rates than males. In addition, non-Hispanic whites had higher prevalence rates than Hispanics and African Americans.

Past-Year Suicide Attempts

Similar to rates of recent suicide attempts, prevalence rates for past-year suicide attempts were higher for females than for males (Morris et al. 1995). In addition, non-Hispanic whites, American Indians, and individuals classified as “other” minority had higher prevalence rates than Hispanics and African Americans (Morris et al. 1995).

Lifetime Suicide Attempts

Findings related to gender differences in lifetime suicide attempts were similar to findings regarding recent and past-year suicide attempts. Females had higher lifetime prevalence rates of previous suicide attempts than males (Abram et al. 2008; Esposito & Clum 2002; Morris et al. 1995; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Wasserman & McReynolds 2006).

Racial/ethnic differences in prevalence rates varied slightly across studies. Two studies (Morris et al. 1995; Wasserman & McReynolds 2006) found that non-Hispanic whites had higher prevalence rates than Hispanics and African Americans. Nolen and colleagues (2008) found that non-Hispanic whites and Hispanics had higher lifetime prevalence rates of suicide attempts than African Americans. Abram and colleagues (2008) examined racial/ethnic differences separately for males and females. Among females, non-Hispanic whites and Hispanics had higher prevalence rates of suicide attempts than African Americans. Among males, non-Hispanic whites had higher prevalence rates than both Hispanics and African Americans. Esposito and Clum (2002) and Rohde, Mace, and Seeley (1997) did not find any differences among racial/ethnic groups. Differences in sampling composition may account for the inconsistent findings for racial/ethnic differences. Studies that found no racial/ethnic differences had small samples that were predominantly non-Hispanic white.

Variables Associated With Suicidal Ideation and Behavior

The reviewed studies also explored variables associated with increased risk of suicidal ideation and behavior. Psychopathology was the most commonly studied variable (Abram et al. 2008; Chavira et al. 2010; Goldstein et al. 2003; Kempton & Forehand 1992; Mallett et al. 2012; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Wasserman & McReynolds 2006). Depression significantly increased the risk for both suicidal ideation and behavior in all studies. Substance use (Chapman & Ford 2008; Morris et al. 1995) or substance use disorder (Chavira et al. 2010; Kempton & Forehand 1992; Mallett et al. 2012; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Wasserman & McReynolds 2006) were also studied; findings were inconsistent. Both substance use and substance use disorder were associated with an increased risk for suicidal ideation and behavior (Chapman & Ford 2008; Mallett et al. 2012; Morris et al. 1995; Nolen et al. 2008; Rohde, Mace, & Seeley 1997; Wasserman & McReynolds 2006). Other studies (Chavira et al. 2010; Kempton & Forehand 1992), however, did not find a significant association. Kempton and Forehand's (1992) sample did not include females. Chavira and colleagues (2010) did not separately examine rates of suicidal ideation and attempt. Findings are inconclusive because of these methodological differences.

Traumatic experiences were significantly associated with suicidal ideation and behavior (Chapman & Ford 2008; Chavira et al. 2010; Esposito & Clum 2002; Morris et al. 1995). Sexual abuse history was consistently associated with suicidal ideation and behavior (Chavira et al. 2010; Esposito & Clum 2002; Morris et al. 1995). Only Chavira and colleagues found a significant association between physical abuse history and suicidal ideation and behavior; however, it did not emerge as an independent predictor. Differing definitions of physical abuse may account for this inconsistency. Esposito and Clum (2002) used a measure that only counted physical abuse if the following criteria were met: "physical marks, breaks to the skin, bruises, or injury that warranted medical treatment regardless of whether it was received." Chavira and colleagues (2010), however, used the Child Trauma Questionnaire, which uses less stringent criteria (e.g., does not require that the abuse warrant medical treatment). While there seems to be a strong relationship between suicidal ideation and behavior and sexual abuse history, the relationship is less clear for physical abuse.

Discussion

The literature review reveals that suicidal ideation and behavior are extremely prevalent in juvenile justice youth. Rates varied widely because of methodological differences across studies; nonetheless, rates within the observed ranges are cause for concern. For example, 8–21 percent of juvenile justice-involved youth experience past-six-month suicidal ideation; 19–29 percent report suicidal ideation in the past year. In addition, 1.4–3.0 percent have attempted suicide in the past month and 9.5 percent to 15 percent have attempted suicide in the past year. Finally, between 10.0 percent and 36.7 percent report having attempted suicide in their lifetime.

Even the lowest prevalence rates in the ranges found for suicidal ideation and behavior among youth in the juvenile justice system are higher than those among youth in the general population. For example, the Youth Risk Behavior Surveillance System (YRBSS) study, conducted by the CDC's National Center for Injury Prevention and Control (2012), found that 15.8 percent of youth attending high schools reported suicidal ideation in the past year; the rates in juvenile justice populations seem to fall between 19 percent and 29 percent. Between 11 percent and 15.5 percent of youth in the juvenile justice system reported suicide attempts in their lifetime, compared with 3 percent and 8.8 percent in the general population (Nock et al. 2008). Consistent with the general population (Beautrais 2002; Cannetto & Sakinofsky 1998; D'Eramo et al. 2004; Greenhill & Waslick 1997), prevalence rates of suicidal ideation and behavior were higher among females in the juvenile justice system than males. Most studies found non-Hispanic whites to have higher rates when compared with African Americans and Hispanics (CDC NCIPC 2012).

Prevalence rates, however, varied considerably among studies for four reasons.

- First, demographic characteristics of the samples varied substantially. The percentage of females included in studies ranged from 12 percent (n = 1,801) to 36 percent (n = 1,829). Because there are significant gender differences in rates of suicidal ideation and behavior, the gender composition of the samples may affect overall rates. Similarly, racial/ethnic composition of samples differed across studies. The percentage of African Americans included in each sample ranged from 15 percent (n = 232) to 74 percent (n = 704).
- Second, the point in the juvenile justice process at which samples were obtained (e.g., intake, detention, juvenile assessment center) varied across studies. Stressors may vary depending on the point of contact of juvenile justice system involvement (World Health Organization 2007). Deeper involvement in the juvenile justice system has been correlated with an increase in suicidal ideation and behavior (Wasserman et al. 2010).
- Third, studies used different assessment tools, including screening, diagnostic, and suicide-specific assessments.
- Fourth, studies were conducted at different juvenile justice centers. Juvenile justice centers have different procedures and services, which may affect the risk for suicide.

Several variables were consistently associated with suicidal ideation and behavior. Youth with a history of depression or sexual abuse were found to be at increased risk. These findings are comparable to the general population (Fergusson & Woodward 2002; Polusny & Follette 1995; Shaffer et al. 1996; Weissman et al. 1999). Findings were inconsistent regarding the impact of physical abuse. Differing definitions of physical abuse may account for this inconsistency. Substance use and disorder were also explored as risk factors; findings were inconsistent across studies. Differences in sampling may account for these disparate findings. Most studies that found an association between suicidal ideation and behaviors and substance use had larger samples. Studies with smaller sample sizes may not have detected the relationship between suicidal ideation and substance use due to lack of statistical power.

Recommendations for Future Research

Based on the findings of this review, the following strategies for future research are recommended.

1. **Determine the incidence of suicide among juvenile justice youth**

   Few studies have determined the incidence of suicide in juvenile justice-involved youth (Gallagher & Dobrin 2006; Memory 1989). The most widely cited study used data collected in 1978–1979 (Memory 1989). A more recent study (Gallagher & Dobrin 2006) used data collected in 2002. Rates varied widely between these two studies (21.9 per 100,000 – 57 per 100,000). New research studies should be conducted to reliably determine a more current rate of suicide among youth involved in the juvenile justice system. One opportunity may be to further explore data from the National Violent Death Reporting System (NVDRS) which does have the ability to capture information on involvement in the juvenile justice system, and further educate local jurisdictions within participating states to submit this information to NVDRS.

2. **Incorporate variables on suicidal ideation and attempts in studies of juvenile justice populations**

   Although many studies examine incarcerated youth populations (e.g., detention, residential placement), few focus on the prevalence and consequences of suicidal ideation and attempts. Future epidemiologic surveys of juvenile justice-involved youth should address suicidal ideation and behaviors (e.g., number of attempts, preparatory acts, methods of attempt, etc.). This strategy would garner important information on the prevalence of suicidal ideation and behaviors, related outcomes, and demographic and environmental differences.

3. **Further examine mutable risk and protective factors in order to develop effective preventive interventions**

   Psychopathology, alcohol use, and traumatic experiences (e.g., sexual and/or physical abuse) are the most commonly studied risk factors for suicidality in juvenile justice; however, very little research has focused on the development and testing of preventive interventions in this population. Establishing the effectiveness of such interventions may be expedited by targeting variables relevant to suicidality and prevention in the general population, including social support, family history of suicide, problem-solving skills, housing structures, parent-child relationships, and access to and use of mental health services (Beautrais 2000; Beautrais, 2003; Brent 1995; Borowsky, 1999; Evans, Hawton, & Rodham 2004; Wasserman, 2003). In addition, factors unique to individuals in juvenile justice, such as type of crime committed or length of previous incarceration(s), may be important for personalizing interventions for certain subpopulations (Hayes, 2009). Better understanding of the contributions of specific risk and protective factors can inform intervention strategies at individual, staff, clinician, and organizational levels. Future research must provide the empirical basis to develop effective and informed intervention programs.

4. **Sample youth at different points of contact in the juvenile justice system**

   Stressors on youth involved with the juvenile justice system vary, depending on the point of contact, whether arrest, intake, detention, or post-adjudication (Wasserman et al. 2010; World Health Organization 2007). Individuals who are more deeply involved with the justice system may be at greater risk. Future studies must identify when individuals may be most vulnerable to suicide.

5. **Evaluate the effectiveness of preventive interventions**

   A number of preventive interventions have been developed, such as Question, Persuade, Refer (QPR) (http://www.qprinstitute.com/); Applied Suicide Intervention Skills Training (ASIST) (http://www.livingworks.net/programs/asist/); the Chester County (Pennsylvania) Juvenile Detention Center Program (http://www.paspi.org/Chester_County.php); safeTALK (http://www.livingworks.net/programs/safetalk/); and Shield of Care (http://www.tn.gov/mental/recovery/shieldcare.shtml). However, little has been done to empirically test the effectiveness of these interventions in reducing risk among justice-involved youth. This is an important area for future research.

   The first step in this process is to implement randomized clinical control trials to assess the effectiveness of currently existing programs. Secondly, studies should examine the effectiveness of recent guidelines designed to reduce suicide issued by the National Commission of Correctional Health Care (2009). The third step of the process is to encourage study of the adaptability of successful preventive interventions used in other high-risk populations to juvenile justice youth. Modifications may be needed. Finally, future studies should identify institutional and operational characteristics that create safer detention centers.

6. **Further evaluate screening tools and procedures to detect suicidal ideation and behavior in the juvenile justice system**

   The critical nature of identifying suicidal ideation and behavior among youth in the juvenile justice system demands careful evaluation of the tools and procedures used to perform this on-going activity. Although there are many tools available to screen for suicide risk, few have been validated for juvenile justice populations. Researchers must also determine the most effective way to administer them. Currently, there are no standardized procedures for the use of suicide screens within juvenile justice settings. Some detention centers use a qualified mental health professional to screen for suicide; others do not (Hayes 2009). Finally, standard cut-off points should be empirically tested. To date, no studies have investigated whether clinical cut-offs based on general populations are valid for youth in the juvenile justice system.

The Youth in Contact with the Juvenile Justice System Task Force sets forth these six recommendations in response to the gaps it discovered during its review of the research on suicide among youth involved in the juvenile justice system. Each year, more than 1.9 million youth are arrested (Puzzanchera & Adams 2011). On an average day, approximately 71,000 youth are in custody in detention centers (Office of Juvenile Justice and Delinquency Prevention 2011). Based on findings of this review, between 13,500 and 20,600 detainees may have considered suicide in the past year and 11,000 delinquent youth may have attempted suicide in the past year. With proper screening and intervention, these estimates can be lessened and the risk of suicide among this vulnerable population can be minimized. Collaboration between juvenile justice professionals and researchers is strongly recommended to increase the safety, and improve the mental health, of delinquent youth.

Appendix A

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth Sampled at Post-Arrest (n = 1)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %[2]	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N[3]	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior[4]	Did study explore variables associated with suicidal ideation and behavior?
Nolen et al./2008	n=1,012 (Juvenile Assessment Center Site: Orange County, FL	B=54 W=31 H=15	x=15	24.5	*V-DISC*	X	X			• Ideation (PM): 8% • Attempt (PM): 1.4% • Attempt (LT): 10% • Attempts (LT): Females > Males • Attempts (LT): nHW and H > B	YES: age; living situation; arrest charge; prior juvenile justice experiences; psychopathology (only associated with lifetime suicide attempts)

[2] AA indicates Asian American (or Pacific Islander); AI, American Indian (or Native American); B, African American; H, Hispanic; MR, mixed race; nHW, non-Hispanic white; O, other.
[3] Small female sample defined by proportion of females < 20 percent of overall sample.
[4] PM indicates past month; PY, past year; P2W, past 2 weeks; LT, lifetime.

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth Sampled at Intake to Detention (n = 4)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %2	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N3	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior4	Did study explore variables associated with suicidal ideation and behavior?
Chapman & Ford /2008	n=405 Site: Connecticut	B=39 W=36 H=24	x=14	31	*Suicidal Ideation Questionnaire* (SIQ)	X				• Ideation (PY): 10% scored positive for suicide risk	YES: trauma; alcohol and drug used
Abram et el./2008	n=1,829 Site: Cook County Juvenile Temporary Detention Center/ Chicago, IL	B=55 H=29 W=16 O=0.2	x=15	35.9	*DISC 2.3*	X	X			• Ideation (P6M): 10%; 4% thought about death a lot • Attempt (P6M): 3% • Attempt (LT): 11% • Ideation (P6M): Females > Males • Ideation (P6M): Females: H > B • Ideation (P6M): Males: nHW > B • Attempts (P6M, LT): Females > Males • Attempts (LT): Females: nHW, H > B • Attempts (LT): Males: nHW > H, B	YES: psychopathology (recent attempts only)
Archer et al./20044	n=704 Sites: Hampton & Newport News, VA	B=74 W=25 H=1	x=16	22	*MAYSI-2* Questions on intake interview	X	X			• Ideation ("current")[5]: 3.0% • Ideation ("past history"): 13.9% • Attempts ("past history"): 12.4%	NO
Cauffman/ 2004	n=18,607 Sites: 15 detention centers/ PA	B= 44 W=44 H= 10 O= 5	x=15	18	*MAYSI-2*	X		X		• Ideation (recent): 21% • 18% males and 33% females scored above clinical cut-off on suicidal ideation scale • Ideation (recent): nHW > H > B	NO

[5] Archer et al. (2004) specified rates as either "current" or having a "past history of." Specific classification of PM, PY, LT was not provided.

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth Sampled in Detention (n = 6)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %2	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N3	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior4	Did study explore variables associated with suicidal ideation and behavior?
Goldstein et al. /2003	n=232 Sites: 2 detention centers/MA	W=58 B= 15 H=18 AA=2.5 O=6	12–14, 27% 15–18, 73%	100	*MAYSI* *Millon Adolescent Clinical Inventory* (MACI)	X			X	• Ideation (recent)[6]: 36.2% (on at least one measure of ideation)	YES: anxiety, depressed mood, internalizing and externalizing behavior problems
Esposito & Clum/2002[7]	n=200 Sites: 3 detention centers/unspecified location	W=65 B= 27 O=7	x=15.7	29.5	*Modified Scale for Suicidal Ideation* (MSSI) *Scale for Suicidal Behavior* (SSB)	X	X		X	• Ideation (P2W): 52 % • Attempts (PM): 8.5% • Attempts (PY): 9.5% • Attempts (LT): 15.5% • Attempts: Females > Males • Ideation and attempts: No significant racial/ethnic differences	YES: child physical abuse, sexual abuse (ideation and attempts), social support & problem-solving (moderate relationship among both ideation and behaviors under high abuse related stress)
Shelton/ 2000	n=350 Site: Maryland Department of Juvenile Justice	B=57 W=26 O=17	range: 12–20 82% (15–17)	19	*Child Health and Illness Profile: Adolescent Edition* (CHIP-AE)	X		X		• Ideation (PY): 19%	NO

[6] Goldstein et al. (2003) did not specify a timeframe for suicide assessment (current, past two weeks, past month, past few months), but based on the measures used, it is assumed to be "recent" (i.e., up to 6 months).

[7] Esposito & Clum (1999) was not included due to using the same sample of detainees as Esposito & Clum (2002), which replicated the current suicidal ideation prevalence rate of 52 percent.

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth Sampled in Detention (n = 6) (continued)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %2	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N3	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior4	Did study explore variables associated with suicidal ideation and behavior?
Morris et al./1995	n=1,801 Sites: 39 detention centers and prisons in U.S.	B=46 W=27 H=19 AI=8 AA=2 O=4	x=15	12	*United States Centers of Disease Control Youth Risk Behavior Surveillance System* (YRBSS)	X	X	X		• Ideation (PY): 21.8% seriously considered suicide • Attempts (PY): 15.5% • Ideation and attempts: Females > Males • Ideation and attempts: nHW > AI & O > H, AA, B	YES: age, substance use, sexual abuse, sexually transmitted disease history (attempts only), gang membership (attempts only)
Rohde, Mace, & Seeley/1997	n=60[8]	W=83 H=7 AI=5 B=1.7 AA =1.7 O=1.7	x=14.9	27	*Schedule for Affective Disorders and Schizophrenia for School-Aged Children* (K-SADS)	X	X		X	• Ideation (P2W): 18% • Ideation (LT): 35% • Attempts (LT): 36.7% • Ideation and attempts: Females > Males • Ideation and attempts: No significant racial/ethnic differences • Suicidal intent: low = 11% of attempters, medium = 48% of attempters, high = 42% of attempters	YES: substance use, psychopathology (only attempts)
Kempton & Forehand/ 1992	n=51[7] Site: Youth Detention Center in Georgia (juvenile prison)	B=71 W=29	range: 11–18	0	*DISC*		X	X		• Attempts (LT): 31% • Attempts (LT): nHW 3.5x > B	YES: substance use, psychopathology

[8] n ≤ 60

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth Sampled Post-Adjudication (n = 2)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %2	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N3	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior4	Did study explore variables associated with suicidal ideation and behavior?
Mallett et al./2012	n=433 (juvenile court supervision) Sites: 1 urban and 1 rural county in U.S. Midwest state	W=35.8 O=64.2	x=15.2	30	*Juvenile Court Case Records*		X			• Attempts (LT): 12.2%	YES: psychopathology, child welfare involvement, mental health service utilization; juvenile court involvement and disposition
Wasserman & McReynolds/ 2006	n=991 (probation intake) Sites: 8 counties in TX	H=51.5 B=28.5 W=19.9	x=14.7	20	*DISC-IV*	X	X			• Ideation (PM): 12.7% • Attempts (PM): 2.9% • Attempts (LT): 13.2% • Attempts (PM & LT): Females > Males • Attempts (PM): nHW > H & B • Attempts (LT): no significant ethnic differences	YES: major depressive disorder, substance use disorder (only recent and lifetime attempts)

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth Sampled at Different Points of Contact in the Juvenile Justice System (n = 2)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %2	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N3	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior4	Did study explore variables associated with suicidal ideation and behavior?
Wasserman et al./2010	n=9,819 (intake, detention, secure post adjudica-tion) Sites: 57 juvenile justice sites	W=41 B=35 H=19 AI=3 O=2	x=16	23.5	*Voice-DISC* (V-DISC)		X		X	• Attempts (PM): 2.4% • Attempts (LT): 14.4% • Attempts (PM & LT): Females > Males • Attempts (LT): nHW > H or B • Intake: 1.9% (PM); 10.8% (LT) • Detention: 3.7% (PM); 17.7% (LT) • Adjudicated: 2.5% (PM); 16.3% (LT)	NO
Vincent et al./2008[9]	n=70,423 (intake, detention, secure correction) Sites: 19 U.S. states	W=39 B=34 H=24 A=1 O=3	12–14, 29% 15–17, 71%	22	*Massachusetts Youth Screening Instrument* (MAYSI-2)[10]	X			X	• Ideation (recent): 18% • 15% males and 29% females above the caution cutoff on the SI subscale • Ideation (recent): nHW = 22%; H = 17%; B = 15%	NO

[9] Archival/retrospective studies (Vincent et al., 2008; Archer et al., 2004).

[10] MAYSI/MAYSI-2 assesses suicidal ideation "within past few months." Therefore, behavior assessed with these measures will be classified as "recent."

Studies of Prevalence of Suicide Ideation and Behavior among Youth in the Juvenile Justice System—Studies of Youth in the Juvenile Justice System, Undefined (n = 1)

Author	Sample: Size/Type	Sample: Race/ Ethnicity, %2	Sample: Age	Sample: Female, %	Suicide Measures	Suicide Variable: Ideation	Suicide Variable: Attempts	Study Limitation: Small Female N3	Study Limitation: Race/Eth. not rep.	Results for Suicidal Ideation & Behavior4	Did study explore variables associated with suicidal ideation and behavior?
Chavira et al./2010	n=300 (actively involved in juvenile justice) Site: San Diego County , CA	W=33 H=30 B=21 AA=8 MR=7	range: 11–18	32	*Diagnostic Interview Schedule for Children* (DISC-IV)	X	X		X	• Ideation (PY): 29.2% of active juvenile justice youth thought of death and dying • Attempts (LT): 14%	YES[11]: age, special education, psychopathology, smoking, lack of social support by mother and father, physical/sexual abuse

[11] Chavira et al. (2010) assessed for suicide risk predictors using "suicidal behavior" as a dependent variable which signifies a "yes" response to both: 1) thinking about death or talking about suicide in the past year and 2) having at least one lifetime suicide attempt.

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Screening and Assessment for Suicide Prevention:

Tools and Procedures for Risk Identification among Juvenile Justice Youth

Prepared by the
Youth in Contact with the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

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Introduction

Identifying suicide risk among young people is a critical component of the comprehensive approach that the juvenile justice system must adopt to prevent suicide. Ideally, this identification is done with research-based screening and assessment instruments. To select effective instruments, it is necessary to be aware of the juvenile justice system's responsibilities in preventing suicide, the contexts in which screening and assessment instruments are used, current standards for screening instruments and assessment tools used in mental health and juvenile justice settings, and specific instruments that are available to advance suicide prevention efforts. These facets of suicide prevention are explored in this paper, which was developed by the Youth in Contact with the Juvenile Justice System Task Force (http://actionallianceforsuicideprevention.org/task-force/juvenilejustice) of the National Action Alliance for Suicide Prevention (Action Alliance) (http://actionallianceforsuicideprevention.org). The paper was prepared by members of the task force's Suicide Research Workgroup, which was charged with identifying gaps in literature and in research on suicide and its prevention among juvenile justice-involved youth.

Measuring Suicide Risk

The juvenile justice system has two general responsibilities for suicide prevention. The first responsibility is to assure the safety of young people while they are in the system's custody. This responsibility begins as soon as the youth comes under the system's jurisdiction and authority regardless of the point of contact. Prevention of in-custody suicide involves detection and assessment of the suicide risk in the immediate or short-term future. This typically occurs at first points of contact, such as during the intake probation interview or soon after a youth's admission to a juvenile pre-trial detention center or a juvenile correctional intake unit, and is aided by the use of formal screening instruments.

The system's second responsibility is to facilitate rehabilitation and treatment that will prevent further delinquency and promote positive youth development.

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was established to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Juvenile Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task.

Suicide Research Workgroup Members and Staff

- Denise Juliano-Bult, MSW (*workgroup lead*) – Chief, Systems Research Programs and Disparities in Mental Health Research Programs, National Institutes of Health
- Laurie Garduque, PhD – Director, Justice Reform, John D. and Catherine T. MacArthur Foundation
- Thomas Grisso, PhD – Director, National Youth Screening Assessment Project, University of Massachusetts Medical Center
- Karen Stern, PhD – Social Science Analyst, National Institutes of Justice
- Barbara Tatem-Kelley, MA, Med – Program Manager, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice
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This long-range and therapeutic responsibility implies an obligation far beyond the mere identification of suicide risk. The juvenile justice system must employ treatment methods that will reduce the presence of that risk as it relates to the youth's development. To that end, instruments are necessary for developing a suicide risk-reduction plan. Such plans require a dynamic understanding of the clinical characteristics of the youth as an individual, as well as environmental and social circumstances that contribute to both near-term and long-term risk of suicide for that particular youth.

Screening and Assessment Procedures

To fulfill their suicide-prevention objectives, juvenile justice programs must employ two types of evaluation: "screening" and "assessment" (Grisso, Vincent, & Seagrave 2005; U.S. Department of Health and Human Services 2009).

Screening should be administered to every youth at a particular point of contact with the juvenile justice system, such as admission to a juvenile pre-trial detention center. To be feasible in this context, the administration and scoring of the screening tool must not take more than 10–15 minutes. Additionally, the tool cannot depend on administrators with specialized clinical training because the juvenile justice system cannot employ mental health professionals at all stages of its custodial process.

Because of these restrictions, the tools that work best for screening have modest objectives. In a sense, they serve as "triage" by screening out young people who are highly unlikely to be at risk for suicide and screening in a small set of young people who may be at moderate or high risk. The "screened-in" group then needs follow-up – i.e., additional standardized interview questions or consultation by a qualified mental health professional – in order to identify the seriousness of the suicide risk. Tools used in screening, therefore, tend not to provide individualized information about the nature or causes of a youth's suicidal condition; they merely classify and alert to potential risk.

In contrast, assessment involves identification of more individualized needs of a youth and is often used for intervention. Suicide risk assessment, therefore, seeks information about why a youth is suicidal, focusing on the clinical and social circumstances that must be considered in constructing a plan for intervention. Typically, assessment requires more time and expertise than is feasible for routine use with every youth entering the juvenile justice system.

Almost all instruments that are useful for suicide screening focus on suicide risk alone. They sacrifice individualized information about youth in exchange for the high degree of structure, brevity, and simplicity that is necessary for non-clinical juvenile justice staff to serve every youth. In contrast, tools of assessment usually gather information helpful for assessing suicide risk and that can be also be used to guide interventions to reduce suicide risk. Although the length and complexity of administration precludes administration to every youth entering the juvenile justice system, these tools verify suicide risk with greater precision and provide individualized information vital to planning intervention and treatment.

Current Standards for Instrument Selection

Today's consensus is on the use of "evidence-based" methods for assessing the behavioral health needs of youth (American Psychological Association 2008), meaning that the instruments have undergone scientific study that demonstrates their reliability and validity with a particular population in a particular service setting. There should be evidence that the instruments measure what they are supposed to

measure. Using instruments about which little or nothing is known concerning validity is potentially wasteful of resources and may result in poor suicide risk identification and risk-reduction planning.

The use of evidence-based instruments to identify suicide risk is especially important within juvenile justice settings. Often, the personnel who will be using the method are not mental health professionals trained to perform clinical evaluations. They are probation officers, juvenile detention personnel, or juvenile corrections officers who manage youth and the processing of cases, but are not trained to make clinical judgments about the mental status of young people. The most effective tools in these circumstances have substantial structure, provide clear guidance, and use score-based rules for decision-making.

The most useful screening and assessment tools share a number of characteristics:

- They are structured or semi-structured, involving a set of questions or procedures that are employed in the same way when administered to each youth.
- Their accompanying manuals offer clear and explicit descriptions of the conditions under which the instrument should be used, the specific procedures for administration to the youth, the scoring or rating procedures, and the interpretation of the results.
- The tools provide norms that allow comparison of a youth's results to groups of young people (e.g., by age, gender, and/or race/ethnicity) in settings and circumstances similar to the one in which the youth is being screened.
- Research has demonstrated that the instruments perform reliably. (i.e., the results will be similar no matter who administers the tool or performs the scoring or rating).
- More than one research study has shown that the results are related to behaviors or events that the instrument was intended to identify (e.g., in research situations, young people scoring higher on a suicide risk tool were observed in other ways to actually have higher risk of suicidal thoughts or behaviors).

Instruments that were designed for use with youth in juvenile justice settings will have advantages over tools developed for use with young people in community mental health settings, since the former will have taken into account the background and training of the people who will likely administer the screening. Moreover, norms that describe how young people have scored in general clinical settings might not be appropriate for describing results obtained in juvenile justice settings.

Regardless of the tool selected to evaluate adolescents' suicide-risk status, perfection cannot be expected. There are a number of challenges that impede validation of suicide risk instruments for use with juvenile justice populations, including (Grisso 2004):

- *The developmental nature of adolescence:* "Adolescence" is not a uniform stage of development. It covers, approximately, the age span from 10 to 18, and young people early in this age range are very different developmentally – in behavior, emotions, and capacities – from those in late adolescence. Different factors may contribute to suicide risk or risk-reduction at different ages or developmental stages of adolescence. Thus, instruments with a single set of items might not operate equally well for youth across the full spectrum of adolescence.

- *The course of adolescents' mental status*: Clinical conditions of adolescents are less often fixed or stable, so that young people's mental status varies more than that of adults across short periods of time. This means that accurate estimates of suicide risk among adolescents are limited to a shorter future time span.

- *The standard for determining validity*: Validating a suicide risk tool's ability to "predict suicide" is difficult because suicides are rare; most youth who are at risk do not actually die by suicide. Even suicide attempts offer a limited comparison event to establish validity because an instrument's warning cannot ethically be ignored to determine accuracy of the instrument. Typically, validation of suicide risk instruments must use indirect comparisons, such as whether young people with histories of suicide attempts score higher on the instrument or whether consistent implementation of the tool in juvenile justice settings reduces suicide attempts compared to those that occurred prior to implementation.

Reviews have identified more than 50 screening and assessment tools for suicide risk relevant for adolescents (e.g., Goldston 2000). A number of these tools have been developed for use in research, rather than in practice. Other tools may have been promising, but were never validated beyond the test developers' initial studies. Many have not been studied for use in juvenile justice settings or examined for their value with delinquent youth. Selecting tools for suicide prevention with youth in juvenile justice settings, therefore, can be difficult for juvenile justice personnel who are not familiar with the research history of the tools.

Screening and Assessment Tools

The tools described in the next two sections are among the most frequently used suicide risk or risk-reduction tools currently employed in juvenile justice settings. They are presented in two categories: screening tools and assessment tools. The focus of this presentation is not on recommending the "best" tool, but on demonstrating how different tools may be "best" for different purposes and juvenile justice contexts.

Screening Tools

A limited number of tools are appropriate for screening every youth entering a juvenile justice facility. The purpose of these tools is to identify potential suicide risk, leading merely to additional attention (e.g., clinical consultation or suicide precautions), not to diagnoses, treatment, or long-range risk-reduction plans.

Four of the tools are described here: two that focus entirely on suicide risk and two that contain a suicide risk indicator along with indicators of other behavioral health problems. Each of the tools has its unique benefits and limits, but they do share certain features that qualify them as screening tools appropriate for use in juvenile justice settings:

- They can be managed by non-mental health professionals with minimal in-service training on administration and scoring.

- They require less than 15–20 minutes to administer and score.

- They have been developed for use with adolescents and have been used (or specifically designed) for screening in juvenile justice settings.

Suicidal Ideation Questionnaire (SIQ)

http://www4.parinc.com/Products/Product.aspx?ProductID=SIQ

The SIQ was developed for use with high school-aged youth, and a slightly different version (the SIQ –JR) is available for ages 12–14 (Reynolds 1987, 1988; Reynolds & Mazza 1999). The questionnaires are presented as paper-and-pencil tasks or by computer-assisted administration. There are 30 items (questions) in the SIQ and 15 in the SIQ-JR, all focusing on suicidal ideation. Youth are asked how often they experience the thoughts described in the question, selecting from six responses that range from "never" to "almost every day." Norms are available indicating the scores that should raise concern about suicide risk.

The SIQ has been studied with a wide range of youth in varied clinical and non-clinical situations, as well as with different cultural backgrounds. Substantial research on the SIQ has demonstrated its good psychometric properties, as well as its ability to identify youth who have histories of suicide attempts or who may make future suicide attempts. The SIQ has been used in juvenile justice settings, although research on its use in those settings is somewhat limited. Administration requires purchase of a manual and forms for scoring. An answer sheet is required for each administration, creating a per-case cost of about one to two dollars.

Suicidal Behaviors Questionnaire-Revised (SBQ-R)

http://www.glaje.com/Scales/Suicidal_Beh_Quest_pre_assessment.pdf

The 14-item SBQ-R (Linehan 1996) and the 4-item SBQ-R (Osman et al. 2001) were originally developed for use with adults, but subsequently have been studied and used with adolescents. On the more-frequently used SBQ-R, youth check any of five responses to whether they have experienced thoughts about killing themselves, whether they have told anyone before about it, and how likely they believe it is that they will attempt suicide someday. The SBQ-R's brevity makes it the quickest screening method available for suicide risk assessment. Validation research has been favorable (identifying youth who were at risk according to other predictors), but use in juvenile justice settings – and SBQ-R research in those settings – has been limited. The SBQ-R's greatest value lies in its validation with adolescents in general, its simplicity and ease of administration, and its absence of cost for materials because it is in the public domain.

Massachusetts Youth Screening Instrument-Second Version (MAYSI-2)

http://www.nysap.us/MAYSI2.html

The MAYSI-2 (Grisso & Barnum 2000, 2006; Grisso et al. 2001) was developed specifically to screen for potential behavioral and mental health symptoms at admission to juvenile justice settings. It consists of 52 items about thoughts and feelings. Youth respond either "yes" or "no" based on current or recent applicability of the items. The items contribute to seven scales describing symptom conditions (e.g., Angry-Irritable, Depressed-Anxious). The instrument is administered in paper-and-pencil form or by computer, which allows the youth to see, hear, and respond to the items in English or Spanish. The computer software version (MAYSIWARE) provides for automatic scoring, reports, and database storage.

The Suicide Ideation scale within the MAYSI-2 has five brief questions referring to current or recent feelings (e.g., "Have you wished you were dead?"). A validated cut-off score on the scale alerts staff to the need for follow-up (e.g., suicide precautions, clinical attention). Norms are based on a sample of over 70,000 youth in juvenile justice settings nationwide. A substantial body of research, all of it within juvenile justice populations and settings, has demonstrated the instrument's good psychometric properties (see bibliography at http://www.nysap.us). Five

studies have examined the MAYSI-2 Suicide Ideation scale in juvenile justice settings and have demonstrated strong relations between its scores and past suicide attempts, other measures of current suicidal thoughts, and suicide indicators in the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV)*. The MAYSI-2 is used statewide in probation, detention, or juvenile corrections programs in over 40 states. Users have access to an on-call MAYSI-2 technical assistance center. A juvenile justice facility that intends to use the tool is required to purchase a manual and to register with the MAYSI-2 center, and registered users have no further per-case cost for use of the MAYSI-2 for routine intake screening.

Global Appraisal of Individual Needs – Short Screener (GAIN-SS)

http://www.gaincc.org/gainss

The GAIN-SS (Dennis, Chan & Funk 2006; Dennis et al. 2008) is a screening companion to a more comprehensive tool called the Global Appraisal of Individual Needs (GAIN) (Dennis et al. 2006). The GAIN is widely used as a structured way to identify the behavioral and mental health service needs of youth. The GAIN requires up to two hours to administer and the GAIN-SS was designed to "screen out" individuals who might not need the more extensive GAIN evaluation.

The GAIN-SS has four scales: Internalizing Disorder, Externalizing Disorder, Substance Use Disorder, and Crime/Violence. Each scale has five questions, which are posed to the youth in an interview (not paper-and-pencil). There is no suicide scale, but the Internalizing cluster inquires about depressed mood and includes one item on suicide ideation. Thus, the Internalizing component of the GAIN-SS acts as a suicide risk screen within the context of the GAIN assessment system.

The GAIN-SS is in the public domain, and therefore has no per-case cost. It is used in some states' juvenile justice systems because of state and federal government regulations that require GAIN assessment for access to community behavioral health services. Unfortunately, there is no research evidence to address the ability of the GAIN-SS Internalizing Scale to identify suicide risk among community-based or juvenile justice youth.

In summary, it is clear that each screening tool has its unique values and limits. There may be no "best" tool for use across all juvenile justice settings, financial circumstances, and demands for brevity and validity. As noted earlier, all of the screening tools are limited to a "triage" function that identifies the potential for suicide risk. A high score itself does not prescribe any specific action, other than the need for basic suicide precaution (e.g., "suicide watch") and a more individualized consultation or assessment with a qualified mental health professional to determine the seriousness of the potential risk.

Assessment Tools

As described earlier, suicide assessment tools serve not only to provide a more refined evaluation of suicide risk (during intake and in an ongoing fashion), but also to identify individualized clinical and social circumstances that need to be considered when planning for future risk-reduction. To gain this benefit, risk assessment tools typically require more time than is feasible for routine use with every youth entering the juvenile justice system. Moreover, these tools typically require moderate to substantial clinical training for proper administration and proper use of the results in developing risk-reduction plans.

Five assessment tools are described below. Three of them represent a class of structured interview tools aimed at psychiatric diagnoses, the fourth facilitates diagnoses without the need for clinical training, and

the fifth is a psychometric tool that assesses a range of symptoms and personality styles. All share the following features:

- They attend to suicide risk.
- They provide psychiatric diagnostic information with which to interpret behavioral and mental health symptoms that may be related to the suicide risk.
- They are highly structured, thus minimizing error that would be associated with general, unguided clinical interviews.
- They typically require some clinical training on the part of the user in order to employ the results to achieve risk-reduction potential.

Child and Adolescent Psychiatric Assessment (CAPA), http://devepi.duhs.duke.edu/capa.html Diagnostic Interview Schedule for Children (DISC-IV) http://www.ncbi.nlm.nih.gov/pubmed/10638065, and Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) http://www.ncbi.nlm.nih.gov/pubmed/9204677

The CAPA (Angold & Costello 2000), DISC (Shaffer et al. 2000), and K-SADS (Kaufman et al. 1997) are all interview schedules. They pose questions about symptoms and behaviors in a highly structured, sequentially controlled way, leading to probable psychiatric diagnoses as defined specifically in the *DSM-IV*. All of these tools include questions that ask about past suicide attempts and current suicidal thoughts.

When used in juvenile justice settings by clinical psychologists or psychiatrists who are trained in their use, these tools require careful attention to the wording and sequence of the interview questions. To some extent, they allow for exploration of a youth's answers in order to gain a more individualized understanding. All three of the tools require between one and two hours to administer.

The three tools differ in certain formal respects, such as diagnoses for different time frames. The DISC-IV and K-SADS provide diagnoses for the recent past, the past year, and lifetime, while the CAPA focuses on the past three months and current diagnosis. In addition, the K-SADS allows for interviews of both the youth and parents (although this would not necessarily be feasible in juvenile corrections settings, where access to parents is sometimes limited).

All of these tools have been extensively researched. The results have been sufficiently good that these tools often are used as the defining criterion for psychiatric disorders in major research studies that examine causes and treatment outcomes for adolescents with behavioral and mental health problems. Nevertheless, there has been insufficient research specifically on the tools' utility in juvenile justice settings.

Voice-Diagnostic Schedule for Children-IV (Voice-DISC) http://promotementalhealth.org/voicedisc.htm

The Voice-DISC (Wasserman et al. 2002) is based on the Diagnostic Interview Schedule for Children (DISC) and provides one or more tentative psychiatric diagnoses based on *DSM-IV*

criteria. In contrast to the DISC, however, the Voice-DISC interview is software that offers computer-assisted administration. The "Voice" in its title refers to the fact that youth respond on-screen to the DISC questions they hear through earphones.

The interview includes a series of questions about suicide ideation and past suicidal thoughts and attempts, providing an indicator of suicide risk. Answers are automatically scored to arrive at one or more tentative psychiatric diagnoses, as well as the level of suicide risk. Responses to individual or diagnostic groups of items for a youth – such as the cluster of suicide history and suicide ideation items in the DISC interview – can be accessed by the clinician who reviews the results.

The Voice-DISC was developed specifically for use in juvenile justice detention and corrections programs, and it is used in a significant number of states' juvenile justice programs. The tool can be administered by non-clinical staff trained in its operation and then reviewed and interpreted by a facility's trained clinical staff. The tool has been substantially validated specifically in juvenile justice settings with delinquent youth, and technical assistance is available from a center that supports the Voice-DISC.

Millon Adolescent Clinical Inventory (MACI)

http://www.millon.net/instruments/MACI.htm

The MACI (Millon 1993) offers a paper-and-pencil or computer-assisted approach to assessing a wide range of youth characteristics. The 97 items of the test, which requires 20–30 minutes to complete, are answered true or false by youth. Their answers contribute to 12 "personality scales" (e.g., Introversive, Egotistic), eight "expressed concerns" (e.g., Peer Insecurity, Family Discord), and seven "clinical scales" (e.g., Impulsive, Depressive). One of the clinical scales is "Suicidal Tendency," thus providing a suicide risk indicator. High scores on this scale can be examined along with youth's scores on other clinical, personality, and expressed-concern scales, allowing clinicians to formulate individualized interpretations of factors related to youth's suicidal feelings. Substantial research with the MACI has been performed on juveniles in custody, although further research is needed to assure the value of its Suicidal Tendency scale specifically. Nevertheless, the MACI was designed and developed in part for use in juvenile justice settings and can be used with confidence for assessment of delinquent youth.

In summary, the assessment tools described above provide a range of options to meet the diverse needs of juvenile justice settings. Each tool, in its own way, offers not only assessment of suicide risk, but also some information about youths' diagnostic and personality features with which to fashion treatment planning. Unfortunately, the tools lack capability in this area in two ways:

- First, they tend not to provide a picture of the environmental and situational circumstances that might increase or decrease suicide risk for individual youth. The focus of the tools is on frequency and seriousness of past suicide attempts and on clinical characteristics of youth that might increase those risks. But, the tools do not have assessment features that identify the specific social stressors and social contexts surrounding a youth's past suicide attempts – information that could be important in helping reduce future attempts.

- Second, none of the tools provides specific strategies for combining the information they generate into a treatment plan for reducing the youth's suicide risk.

These two shortcomings are targets for future research to improve suicide assessment of young people for the purpose of creating individualized treatment plans for reducing suicide risk.

Implementation of Suicide Risk Screening and Assessment

Selecting the proper suicide screening or assessment tool is important for successful suicide prevention in juvenile justice settings. Yet, the best tool will function no better than the manner in which it is implemented. There is substantial evidence that good screening and assessment tools fail if inadequate attention is given to their proper administration in a juvenile justice setting (Grisso, Vincent, & Seagrave 2005; Proctor et al. 2009).

Implementation of suicide screening and assessment tools is based on three activities. First, personnel in the juvenile justice program must develop clear and explicit policies concerning how, when, and by whom the tools will be administered. Policies should include clear identification of the scores or results on a screening or assessment tool that will require a team response. The response itself should also be part of institutional policy.

Second, staff training is critical for properly implementing suicide screening and assessment tools. All staff members need to be trained in the purpose for implementing the tools, the meaning of their results, and the team actions that the responses will require. Training is also needed for those who will be administering the tools. When non-clinical staff will be responsible for administering suicide screening tools, training must include not only "didactic" exposure, but also actual practice administrations under the supervision of a trainer skilled in the specific tool being used. Administration of the tool must adhere closely to the specific conditions described in the tool's manual; otherwise, the results will have been obtained in a manner that nullifies the tool's reliability and validity, no matter how well it performed during the research to develop it.

Finally, periodic monitoring for quality of administration and use of suicide risk tools is essential. Across time, a juvenile justice setting's practices and procedures tend to "drift" away from the standard described in the tool's manual. Occasional monitoring and re-training is usually necessary to avoid this.

Conclusion

Use of standardized suicide screening by trained staff and assessment tools by qualified mental health providers helps the juvenile justice system identify and plan for the longer-term care and healthy development of youth at risk of suicide. It is strongly recommend that juvenile justice programs become aware of and consistently use tools and procedures for risk identification among youth involved with the juvenile justice system. Screening and assessment should also be part of a comprehensive suicide prevention program that is supported by training; identification, referral, and evaluation; communication; housing (safe environment); levels of observation, follow-up, and treatment planning; intervention (emergency response); reporting and notification; and critical incident stress debriefing and mortality-morbidity review. More information about a comprehensive program is available via the *Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System* (http://actionallianceforsuicideprevention.org/system/files/JJ-7-P1-ProtocolGuidelines.pdf), also developed by this task force.

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Guide to Developing and Revising Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System

Prepared by the
Youth in Contact with the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

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Contents

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Introduction

Youth who come into contact with the juvenile justice system, especially those in residential facilities, have higher rates of suicide than their non-system-involved peers (Gallagher & Dobrin 2006). Suicide prevention efforts by this system should begin at the initial point of entry and be coordinated to protect youth at every step along the way. This guide, developed by the Youth in Contact with the Juvenile Justice System Task Force (http://actionallianceforsuicideprevention.org/task-force/juvenilejustice) of the National Action Alliance for Suicide Prevention (Action Alliance) (http://actionallianceforsuicideprevention.org), discusses suicide prevention practice components across the following points of contact:

- Referral/Arrest
- Courts
- Probation
- Detention and Secure/Non-Secure Care Facilities
- Aftercare

The task force's Suicide Prevention Programming and Training Workgroup was charged with developing a guide for implementing accepted suicide prevention guidelines at each point of contact. To do so, the group turned to *Suicide Prevention in Juvenile Correction and Detention Facilities* (Hayes, 1999), which was produced by the Council of Juvenile Correctional Administrators (CJCA) with support from the Office of Juvenile Justice and Delinquency Prevention. This report addresses performance-based standards for juvenile correction and detention facilities and describes a comprehensive suicide prevention program for juvenile facilities that involves the following components:

- Training
- Identification; Referral; Evaluation
- Communication
- Housing (Safe Environment)
- Levels of Observation; Follow-Up; Treatment Planning
- Intervention (Emergency Response)
- Reporting and Notification
- Mortality-Morbidity Review

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was established to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Juvenile Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task.

Suicide Prevention Programming and Training Workgroup Members and Staff

- Ned Loughran, MA (*workgroup lead*) – Executive Director, Council on Juvenile Correctional Administrators
- Karen Abram, PhD – Associate Professor, Health Disparities Program, Northwestern University, Feinberg School of Medicine
- Donald Belau, PhD – Psychologist, Geneva Youth Residential Treatment Center
- Lindsay Hayes, MS – Project Director, Jail Suicide Prevention and Liability Reduction, National Center for Institutions and Alternatives
- Shawn Marsh, PhD – Chief Program Officer, National Council of Juvenile and Family Court Judges
- Kara McDonagh, MSW – Program Manager, Office of Juvenile Justice and Delinquency Prevention
- Nicholas Read, MA – Research Analyst, Human and Social Development, American Institutes for Research

For this document, the workgroup tailored and extended these original key components to points of contact beyond detention and secure/non-secure care facilities.

Because of the intense level of daily interaction, it may be argued that suicide prevention lies primarily in the domain of detention and other secure/non-secure settings. However, suicide prevention must be a priority for providers at *all* points of contact within the system. Correspondingly, this guide builds on a foundation established for detention and other secure/non-secure care settings to address the other points of contact: referral/arrest, courts, probation, and aftercare.

Suicide Prevention in Juvenile Correctional Facilities (http://www.sprc.org/training-institute/juvenile-correctional-curriculum) is a two-hour curriculum to help state juvenile correctional administrators and facility, training, and mental health directors develop and implement comprehensive suicide prevention policies. This course was developed by the Suicide Prevention Resource Center (SPRC), in partnership with CJCA, for all states, Puerto Rico, and major metropolitan counties. SPRC and CJCA also developed a two-part webinar series (housed on the same website as the course) titled *Suicide Prevention in Juvenile Detention and Correctional Facilities*, in partnership with the National Center on Institutions and Alternatives, to complement the course.

Component 1: Training

In considering the breadth of the juvenile justice processing continuum, it is not difficult to overlook that the "system" is composed of individuals, with varying levels of education, experience, and responsibilities. These providers, at every level of contact, must be equipped with the skills necessary to properly address the needs of youth, particularly those youth at risk of suicide.

Detention and Secure/Non-Secure Care Facilities

The essential component to any suicide prevention program is properly trained direct care staff, members of which form the backbone of any juvenile detention and secure/non-secure care facility (including training schools and residential treatment). As suicides often occur during late afternoon/early evening or on weekends – generally outside the purview of program staff and when direct care staff are often the only personnel available – these staff members form the front-line defense against suicide and must therefore be trained to thwart these incidents.

All direct care, medical, and mental health personnel, as well as any staff who has regular contact with youth, should receive eight hours of initial suicide prevention training, followed by two hours of refresher training each year. The initial training should include:

- administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts
- why the environments of juvenile facilities are conducive to suicidal behavior
- potential predisposing risk and protective factors related to suicide
- high-risk suicide periods
- juvenile suicide research
- warning signs of suicide
- identification of suicidal youth despite the denial of risk
- components of the facility's suicide prevention policy
- liability issues associated with juvenile suicide

The two-hour annual refresher training should include:

- administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts
- review of predisposing risk and protective factors related to suicide
- warning signs of suicide
- identification of suicidal youth despite the denial of risk
- review of any changes to the facility's suicide prevention policy
- general discussion of any recent suicides and/or suicide attempts in the facility

To ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff. All staff should be trained in the use of emergency equipment located in each housing unit. In addition, all staff who have routine contact with youth should receive standard first-aid and cardiopulmonary resuscitation (CPR) training.

Referral/Arrest

Local jurisdictions should embrace and train law enforcement officers in the Crisis Intervention Team concept, a nationally-recognized program known as the "Memphis Model" of pre-arrest jail diversion for individuals in a mental illness crisis. This program provides law enforcement-based crisis intervention training for helping individuals, including youth, with mental illness. By preventing more youth with mental health needs from penetrating deeper into the system, the overall likelihood of suicide by youth within the system at large is decreased.

Courts

Judges, prosecutors, public defenders, and allied juvenile court professionals should be trained to (1) understand that justice-involved youth are at higher risk for suicide, (2) understand risk and protective factors for suicidal behavior in justice-involved youth, and (3) recognize and respond to warning signs of suicide in justice-involved youth, particularly at key decision points (e.g., detention, disposition). Court hearings are a rare occasion for juvenile justice stakeholders and youth and families to be in mutual contact, and a shared understanding and appreciation of suicide dynamics are critical for coordinated case processing and maintained well-being of system-involved youth.

Brief (i.e., one-hour) training in suicide awareness should be incorporated into training that is standard for new court personnel (and those new to juvenile cases). Training should also be incorporated into annual conferences of the National Legal Aid and Defender Association or similar organizations via continuing legal education requirements for public defenders.

Probation

All probation staff should be required to complete an initial two-hour suicide prevention training workshop, followed by an annual one-hour refresher course. The workshops should include discussion of topics detailed in the Detention and Secure/Non-Secure Care Facilities section above.

Aftercare

The range of people with whom youth will interact greatly increases following release from a secure setting. Probation/parole officers; parents and other caregivers; teachers, schools administrators, counselors, and other school staff; community-based mental health providers; and peers all become critical partners in preventing suicide during the aftercare process. Suicide prevention training for these individuals will vary in formality and intensity, but all recipients must understand the trauma experienced by youth leaving secure care, the risk of suicide among these youth, and how to prevent it.

Additional training on CPR and other basic life-saving measures should be offered or required to prepare critical partners to respond to an actual suicide and/or self-harm attempt.

Probation and parole officers, school-based mental health and security staff, and community-based mental health providers should all formally receive at least basic-level training on suicide awareness and prevention. Although similar to training offered to detention and secure/non-secure care facility staff, training provided to those associated with aftercare should emphasize warning signs of suicide visible during short and/or sporadic periods of interaction since the time they spend with youth is not constant.

Available Training Resources

There are a variety of suicide prevention training programs available to schools and communities. The Suicide Prevention Resource Center, in collaboration with the American Foundation for Suicide Prevention (AFSP), maintains the SPRC/AFSP Best Practices Registry for Suicide Prevention (BPR) (http://www.sprc.org/bpr/section-iii-adherence-standards) that lists programs, practices, policies, protocols, and informational materials whose content has been reviewed according to current program development standards and recommendations. The programs and materials featured on the registry are designed for use in schools, communities, campuses and other settings. Similarly, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) maintains the National Registry of Evidence-based Programs and Practices (NREPP) (http://www.nrepp.samhsa.gov/), which is an online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.

In February 2013, the first suicide prevention training for juvenile justice direct care staff was accepted to the BPR (http://www.sprc.org/bpr/section-III/shield-care-system-focused-approach-protecting-juvenile-justice-youth-suicide). Developed by the Tennessee Department of Mental Health and Substance Abuse Services, *Shield of Care* teaches suicide prevention strategies and emphasizes a system-focused model of prevention. Specifically, it: 1) emphasizes that policy, connectedness to youth, and communication between staff are essential system-level elements of prevention; 2) teaches steps of effective suicide intervention and 3) provides opportunities for staff to reflect on internal policies for prevention, discuss strategies for overcoming potential barriers, and plan how to take action in their specific setting. *Shield of Care* materials are available for free download at http://tn.gov/mental/recovery/shieldcare.shtml

Schools seeking to train staff may benefit from a document developed by the Prevention Division of the American Association of Suicidology. This document, entitled *Guidelines for School Based Suicide Prevention Programs* (http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf) *(1999),* provides practical recommendations for the safe and effective implementation of school-based suicide prevention programs. Topics addressed in *Guidelines*, which could be incorporated into community- and home-based trainings as well, include:

- the conceptual basis for prevention programs
- requirements for effective suicide prevention programs and their implementation
- components of comprehensive school-based suicide prevention programs
- institutionalization and sustainability of suicide prevention programs

For parents, other caregivers, siblings, and peers, more informal training may be most appropriate. Training should still focus on the youth's trauma exposure and signs of potential suicidal behavior, but also include skill building in being a caring, observant caregiver and friend. Creating and maintaining a comfortable environment of caring individuals within a home and neighborhood is very important for a youth returning from secure care.

Component 2: Identification, Referral, and Evaluation

There is little disagreement about the value of screening and assessment in preventing suicide. Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death, and that many individuals with a history of one or more suicide attempts are at a greater risk for suicide than those who have never made an attempt. Identification of youth at risk of suicide, then, is paramount to suicide prevention efforts. (The Suicide Research Workgroup of the Youth in Contact with the Juvenile Justice System Task Force addresses risk identification in its paper, *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth* (http://actionallianceforsuicideprevention.org/system/files/JJ-6-R2-Screening-Assessment.pdf). Also, the BPR and NREPP include potential screening instruments to consider. To render identification meaningful, however, it must be followed by appropriate referral and evaluation.

Detention and Secure/Non-Secure Care Facilities

Intake screening and continuous assessment of all juveniles is critical to a facility's suicide prevention efforts. Screening and assessment should not be viewed as a single event, but as an ongoing process. Youth can become suicidal at any point during confinement, including the initial admission into the facility; after adjudication and upon return to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; during confinement in isolation, segregation, and/or "time-out"; and following a prolonged stay in the facility.

Intake screening for suicide risk may be contained within the medical screening form or presented as a separate form. Inquiry during the screening process should determine the following:

- Was the youth a medical, mental health, or suicide risk during any prior contact and/or confinement within this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates the youth is a medical, mental health, or suicide risk now?
- Has the youth ever considered suicide?
- Has the youth ever attempted suicide?
- Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety? Has the youth recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend of the youth ever attempted, or died by, suicide?
- Does the youth feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Is the youth thinking of hurting and/or killing him/herself?

Although verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on a youth's denial of suicidal intent and/or history of mental illness, particularly when behavior or previous confinement in the facility suggests otherwise. For such cases, the screening process must include referral procedures to qualified mental health and/or medical personnel for a more thorough and complete assessment.

As noted earlier, the risk of suicide is ever-present, so vigilance must continue after the intake screening process. Should any staff hear a youth verbalize a desire or intent to kill his/herself, observe a youth engaging in any self-harm, or otherwise believe a youth is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the youth is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

Finally, given the strong association between juvenile suicide and room confinement, any youth assigned to room confinement or any form of isolation/segregation should receive a written assessment for suicide risk by medical or mental health staff upon admission to the placement.

Referral/Arrest

Brief intake screening for suicide risk should be conducted while a youth is being held post-arrest by law enforcement agencies and prior to entry into a juvenile detention facility.

Courts

Juvenile court judges should ensure, to the extent feasible given system variances, that a valid and reliable screening instrument is used at critical points of contact (e.g., intake to juvenile detention).

Probation

Each probation department (and its officers) should be required to complete for each youth a validated trauma exposure/depression screening instrument that also addresses suicide risk.

Aftercare

Screening and assessment for suicide risk should be a vital component of the aftercare process and involve all of the critical partners noted above.

- Formal screening and assessment for suicidal ideation and/or behavior should be a part of continued probation/parole interaction, from the first meeting with a youth and repeated throughout supervision.
- Screening and assessment should be a part of school mental health services, with referral from correctional/detention placement, family members and other caregivers, school personnel, and/or community-based providers.
- Community primary and mental health care providers should provide screening and assessment services for youth exiting secure care.
- Screening should be conducted by parents and other caregivers from the time the youth returns home and continued indefinitely. Training for parents and caregivers can be provided by the secure care facility staff and/or by school-based and community mental health providers and should focus on screening procedures and practices most appropriate for the home setting.

Component 3: Communication

Certain behavioral signs exhibited by juveniles may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. Most suicides can be prevented by providers who establish trust and rapport with youth, gather pertinent information, and take action. Poor communication between and among direct care, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, courts, probation, and family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts, and boundary issues.

Detention and Secure/Non-Secure Care Facilities

There are essentially three layers of communication necessary for preventing juvenile suicides during detention and in secure/non-secure facilities: (1) between the arresting/transporting officer and direct care staff; (2) between and among facility staff (including direct care, medical, and mental health personnel); and (3) between facility staff and the juveniles.

Suicide prevention in the juvenile justice system begins at the point of arrest. What juveniles say and how they behave during arrest, transport to the facility, and at intake are crucial in detecting risk of suicidal behavior. Direct care staff members rely on arresting/transporting officers to brief them on any pertinent information regarding the youth's well-being. It is also critically important for direct care staff to maintain open lines of communication with family members of the youth, who often have pertinent information regarding the mental health status of the youth.

The second layer of communication – among direct care personnel and other professional staff in the facility – directly influences the effectiveness of suicide prevention once youth are in the facility. Because youth can display warning signs at any point during confinement, direct care staff must maintain awareness, share information, and make appropriate referrals to qualified mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate direct care staff is properly informed of the status of each youth placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all youth on suicide precautions. Multidisciplinary team meetings (to include direct care, medical, and mental health personnel) should occur on a regular basis to discuss the status of youth on suicide precautions. Finally, authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

To communicate with youth at risk of suicide (i.e., the third layer of communication), facility staff must hone skills such as: active sympathetic listening; staying with the youth if they suspect immediate danger; and maintaining contact through conversation, eye contact, and body language to show that they care. Direct care staff should trust their own judgment and observation of risk behavior and avoid being misled by others (e.g. mental health staff, other youth) into ignoring signs of suicidal behavior.

Referral/Arrest

The scene of arrest is often the most volatile and emotional time for the youth. Arresting and/or transporting officers should pay close attention to youth during this time. Suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers, such as family members and friends. Additionally, youth acting aggressively can be a warning sign of being impulsive. Communication of any intent is another warning sign.

The arresting/referring officer should communicate any concerns revealed during the brief intake screening process to the transport officer and detention facility intake staff. In addition, the arresting/referring officer should speak with family members about any concerns before transporting the youth to a detention facility, as well as speak with the youth using Crisis Intervention Team (CIT) training techniques about any suicidal ideas/thoughts or plans.

Courts

Judicially-led stakeholder meetings, held on a regular basis as part of quality enhancement efforts, can assist in improving communication and planning around suicide prevention.

Probation

Probation departments should establish a protocol for the sharing of results from any screening pertinent to suicide risk with the youth's parents/guardians and/or placement settings.

Aftercare

Regular, formalized communication between all agencies and individuals involved in the lives of youth leaving secure care is essential to providing a wraparound approach to suicide prevention during aftercare.

- The primary communication should always be between individuals caring for youth and the youth themselves. This communication should be friendly, supportive, and positive, helping youth overcome past trauma and feel connected to people who care about them.
- Communication between detention/secure care facility staff and probation/parole officers is critical for sharing previous screening and assessment results, past suicide attempts and self-injurious behavior, and any necessary treatment needs.
- Facility staff should communicate with parents and other caregivers to discuss the youth's time within the facility, any relevant screening and assessment results, and warning signs to heed.
- Parents and caregivers should likewise communicate with school- and community-based mental health providers to maintain open dialogue on the home behavior of youth and treatments they are receiving.
- Facility-based mental health staff should communicate with school- and community-based providers so that all are aware of each other and, to the extent possible, be able to communicate with each other about the youth they serve (if only in generalities).

Overall, memoranda of understanding/agreement should be established to create safe and effective information-sharing agreements between agencies, parents/caregivers, schools, and community providers. Youth and family privacy rights must be maintained, and agencies should work with family members to ensure relevant information is shared in an appropriate manner.

Component 4: Housing (Safe Environment)

Providing a safe environment for youth who are at risk for suicide may be the most observable, physical component of a comprehensive suicide prevention program. Special care must be paid to ensuring that opportunities for suicide or self-harm are minimized throughout the juvenile justice-processing continuum.

Detention and Secure/Non-Secure Care Facilities

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

All rooms or cells designated to house suicidal youth should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility.

- Rooms or cells should not contain any live electrical switches or outlets; bunks with open bottoms; or any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging.
- Rooms or cells should contain tamper-proof light fixtures, smoke detectors, and ceiling/wall air vents that are protrusion-free.
- Each room or cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior.

Finally, each housing unit in the facility should contain various emergency equipment, including a first-aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Direct care staff should ensure that such equipment is in working order on a daily basis.

Referral/Arrest

Should a youth be held temporarily (including overnight) in a police department lockup or any other temporary facility, the place of confinement should be as safe and suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility (see details above). When a youth is transported to and from facilities and court proceedings, the vehicle should provide a similarly safe environment.

Courts

Juvenile court judges and administrators must remain mindful that system involvement is inherently stressful for youth. Court facilities – including holding cells and interview rooms – must be inspected and modified to ensure the physical safety of all youth (see general recommendations for ensuring a safe environment above).

Probation

Probation departments should inform and train parents and guardians as to the risk factors, protective factors, and warning signs associated with suicidal behaviors. Guidelines for means-restriction activities and descriptions of community resources (e.g., mental health resources, support groups, school-based resources, youth/recreation centers, churches, etc.) should also be provided. As a component of aftercare, probation is further discussed below.

Aftercare

The *home* will represent a major portion of a youth's post-release environment. It is an environment that is extremely difficult for the justice system to affect, though probation and parole officers can play a part by checking to make sure the home environment is as safe and supportive as possible. Parents and caregivers will need training on how to make the home safe and supportive for their children and be vigilant in watching for signs of possible suicidal and self-injurious behavior. A youth's time in isolation within the home should be limited and/or supervised to any extent possible, utilizing friends, family members, and other care providers whenever possible. After-school time is a particularly important time to make sure the youth is supervised and supported (especially in the absence of parents or caregivers).

Assuming they are still of school age, youth exiting secure care will likely spend much time in the *school building*. Compared to homes, most schools are more controlled, but they typically are not as controlled as the facility from which youth were discharged. All school staff should be aware of the risk for suicide

and self-harm in youth exiting secure care and be prepared to maintain a safe and supportive environment for such youth. Any school discipline policies that result in the isolation of youth should be discouraged. Minimally, such policies must take into account the potential for suicide attempts and self-harm and be monitored appropriately.

Youth's post-release life will likely also include time spent in *general community locations* (e.g., playgrounds, "Boys and Girls Clubs", etc.). While the hope is that these settings are safe and supportive, they nonetheless represent spaces in which youth could engage in suicidal or self-injurious behavior. The presence of caring and aware staff or other adults may act as a deterrent for such behavior. Additionally, the extent to which a youth's presence in such places is voluntary (rather than mandatory) might also decrease the likelihood of suicidal or self-injurious behavior. At the very least, all formal community center staff should have a basic awareness of suicide risk for youth exiting secure care and maintain a safe, supportive environment for such youth.

Similarly, *probation and parole offices* should be welcoming environments so as not to re-traumatize youth through continued system involvement. Though suicides within the confines of the office are less likely, youth's experience at the office may residually impact how they feel when they are not with their probation or parole officer. The more these experiences are viewed as positive and supportive, the less likely re-traumatization will occur.

Finally, *mental and medical service provider offices* are much like those of probation/parole officers and should be safe, supportive, and positive places for youth. It may be further traumatizing or stigmatizing to youth to have to report to these facilities for "treatment," so providers should be aware of this and work to mitigate the effects.

Component 5: Levels of Observation, Follow-Up, and Treatment Planning

Supervision of youth involved in the juvenile justice system ranges from constantly observing youth in secure care who are actively suicidal to determining the appropriate level of supervision necessary for youth in aftercare. In all cases, supervision is one aspect of the overall support that youth, particularly those at risk of suicide, need as they progress through the juvenile justice system.

Detention and Secure/Non-Secure Care Facilities

The promptness of response to suicide attempts in juvenile facilities is often driven by the level of supervision afforded the youth. Two levels of supervision are generally recommended for suicidal juveniles.

- **Close observation** is reserved for youth who are not actively suicidal but who express suicidal ideation (i.e., expressing a wish to die without a specific threat or plan) and/or have a recent history of self-destructive behavior. In addition, youth who deny suicidal ideation or do not threaten suicide but who demonstrate other concerning behavior (through actions, current circumstances, or recent history), indicating the potential for self-injury, should be placed under close observation. Staff should observe such youth in a protrusion-free room at staggered intervals not to exceed every ten minutes (e.g., five minutes, ten minutes, seven minutes).

- **Constant observation** is reserved for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior. Staff should observe such youth on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every five minutes.

Other aids (e.g., closed-circuit television, roommates) can be used as a supplement to, but never as a substitute for, these observation levels. In addition, because the overwhelming majority of juvenile suicides are by hanging and death by hanging occurs in only a few minutes, observation under these levels will be safe only if the room or cell is suicide-resistant.

In addition to direct observation, mental health staff should assess and interact with suicidal youth on a daily basis. The daily assessment should focus on current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., "What are your current feelings and thoughts?" "Have your feelings and thoughts changed over the past 24 hours?" "What are some of the things you have done or can do to change these thought and feelings?").

An individualized treatment plan (to include follow-up services) should be developed for each youth on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the youth, but medical and direct care personnel. The treatment plan should describe warning signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the youth and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal youth, all youth discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is no nationally acceptable schedule for follow-up, an assessment schedule following discharge from suicide precautions to consider is: 24 hours, 72 hours, one week, and then once a month until release.

Referral/Arrest

Should youth be held temporarily (including overnight) in a police department lockup or any other temporary facility, they should be placed on either close or constant observation, as described above.

Courts

Consistent with the recommendations presented for detention and secure/non-secure care facilities above, juvenile court administrators should develop and maintain policies and procedures for supervising youth while in court facilities to ensure their safety and the safety of the public.

Probation

For a comprehensive approach to providing support to youth preparing to transition to life in the community, probation departments should integrate mental health services into their other services. A "coach" or mentor should be identified as a key player in the crisis response plan.

Aftercare

In supervising youth during the aftercare period, a balance must be struck between keeping youth safe (preventing suicidal behavior) and over-supervising them (possibly re-traumatizing them). Justice system-involvement is in itself traumatizing, and continued involvement with probation and parole officers may contribute to juveniles' suicidal ideations or activity. Interaction with aftercare providers must be as supportive and positive as it is supervisory.

Parents and other caregivers will play a vital role in watching over, observing, and supporting their youth returning from secure care. It is important that all caregivers be equipped with the skills to do so

without being too overprotective and suffocating. Independence is important to youth and lack thereof could negatively impact their self-perceptions or otherwise contribute to suicidal thoughts and behaviors.

Parents and caregivers will need support from other family members, their child's peers, the school, and community partners to support and protect their child in the proper way and to the appropriate extent. The friends of a juvenile youth are often surprisingly effective in spreading protection and support, as they are typically regarded as allies who care about the youth, rather than authority figures looking to supervise or manage the youth.

Finally, teachers, school administration staff, and school mental health providers should all play a role in the supervision and support of youth during aftercare. Working together is essential to ensure that the school experience for the youth is positive and not too restrictive and/or overprotective. Receiving extra attention from school personnel may be stigmatizing to the youth and so must be mitigated appropriately.

Component 6: Intervention (Emergency Response)

As noted numerous times throughout this paper, a suicide attempt can occur at any of point of contact within the juvenile justice-processing continuum. It is therefore vital that providers from all points of contact be prepared to intervene with an emergency response. The degree and promptness of intervention, coupled with the efficiency of communication among relevant staff, often foretell whether the victim will survive a suicide attempt. Although not all suicide attempts require emergency medical intervention, *all* suicide attempts and other clear displays of intent should result in immediate intervention and assessment by qualified mental health staff.

Detention and Secure/Non-Secure Care Facilities

National correctional standards and practices, such as those published by the Council of Juvenile Correctional Administrators, the National Commission on Correctional Health Care, and the American Correctional Association, generally acknowledge that a facility's policy regarding intervention should be threefold:

1) All staff members who come into routine contact with juveniles should be trained in standard first-aid procedures and CPR.

2) Any staff member who discovers a youth engaging in a suicide attempt should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits staff from entering a room or cell without back-up support, the first responding staff member should, at a minimum, make the proper notification for back-up support and medical personnel, secure the area outside the room or cell, and retrieve the housing unit's emergency response bag (first-aid kit, pocket mask or face shield, Ambu-bag, and rescue tool).

3) Direct care staff should never presume that the victim is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Referral/Arrest

All staff who work in a police department lockup or any other temporary facility that houses youth should be trained in standard first-aid procedures and CPR. Facilities should follow the emergency response procedures described earlier.

Courts

Protocols for responding to a suicide or an attempted suicide on court grounds should be part of a court's emergency response plan. These protocols should include emergency-response procedures described earlier.

Probation

Probation departments should train staff on recognizing and responding to acute-risk situations, as well as chronic-risk situations, within both initial and annual training programs.

Aftercare

All agencies and individuals involved with youth exiting secure care should be versed in the statistics of suicide completion and suicide attempts by youth exiting secure care. Providers should recognize the vital role they play in preventing future suicides and be trained to act upon that responsibility. This preparation should include not only working knowledge of the practical steps to fully interrupt the act and protect the youth, but also awareness of the trauma that the situation may cause.

Component 7: Reporting and Notification

To facilitate more effective suicide prevention efforts in the future, documentation of suicide attempts and suicides must be completed. While the steps of this process are agency-specific, it can be generally stated that this component involves a) reporting to officials through the chain of command and b) notification of the family of the victim.

Detention and Secure/Non-Secure Care Facilities

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

Referral/Arrest

In the event of a suicide attempt or a suicide in a police department lockup or any other temporary facility, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family, as well as appropriate outside authorities, should be immediately notified.

Courts

Juvenile court judges and administrators should participate in reporting data on major incidents involving suicide attempts and suicides by youth who are under court jurisdiction (from petition to disposition).

Probation

Probation departments should develop a central collection point for medically serious suicide attempts and suicides at state and national levels which can be evaluated to address acute- and chronic-risk patterns.

Aftercare

All agencies and individuals involved with youth exiting secure care should be trained on how to communicate any suicide or self-injury attempts or completion to the appropriate entities in the appropriate manner. To maintain awareness and promote vigilance, this information should be shared with relevant "stakeholders" to the degree confidentiality laws allow.

Component 8: Mortality-Morbidity Review

Suicide among youth involved with the juvenile justice system is devastating personally and professionally to providers and personally and socially to other youth. Debriefing and review should follow every completed suicide to not only address the extreme stress associated with the incident, but also to identify necessary revisions to policies and protocols.

Detention and Secure/Non-Secure Care Facilities

Juvenile suicide impacts both providers and youth. Direct care staff members who are involved, even indirectly, with a juvenile suicide may display misplaced guilt (e.g. "What if I had made my room check earlier?"). They may also feel ostracized by fellow personnel and administration officials. Youth in the facility can be equally traumatized by such critical events, which may lead to suicide contagion, especially with already vulnerable youth.

When crises occur in which staff and youth are affected by a traumatic event, they should be offered immediate assistance. Every suicide attempt, fatal or non-fatal, should be followed by active crisis management, including efforts to provide comfort and support to those who are affected by the event and to identify those in significant distress and provide them with individualized support or treatment. Assessment of factors leading to the suicide should seek to identify opportunities to improve policies and protocols.

In addition to this immediate attention to staff and youth in the facility, a multidisciplinary mortality-morbidity review process should be initiated for every completed suicide, as well as every serious suicide attempt (i.e., requiring medical treatment and/or hospitalization). Minimally, the review should include direct care, medical, and mental health staff. If resources permit, clinical review through a psychological autopsy is also recommended. Ideally, the mortality-morbidity review should be coordinated by an outside agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of:

- the circumstances surrounding the incident
- facility procedures relevant to the incident
- all relevant training received by involved staff
- pertinent medical and mental health services/reports involving the victim
- possible precipitating factors leading to the suicide or serious suicide attempt
- recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures

Referral/Arrest

All appropriate follow-up procedures should be followed, including the mortality-morbidity review described above.

Courts

Juvenile court judges and administrators should review major incidents of serious suicide attempts and suicides involving youth who are under court jurisdiction (from petition to disposition).

Probation

When youth are identified as engaging in suicidal behaviors, probation departments should conduct an immediate review of possible risk factors. If a crisis response plan was in place, its utilization should be assessed. If a response plan was not in place, reasons for its absence should be identified and discussed.

Aftercare

Ongoing support to all agencies and individuals involved with youth exiting secure care should be provided, especially in circumstances when suicides or self-injury take place within the "jurisdiction" or community. Any trauma experienced by aftercare providers due to such events should be addressed and appropriate backup support for youth should be available in the event that the usual personnel are unable to fulfill roles or obligations.

Conclusion

Due to the risk of suicide at all points of contact with the juvenile justice system, it is imperative that suicide prevention efforts begin at the time of arrest and continue throughout aftercare. The providers with whom youth will interact during this continuum of services are many and varied, but they must all share the goal of suicide prevention. This goal can be achieved by all providers through a comprehensive suicide prevention program involving the eight components described within this document:

- Training
- Identification; Referral; Evaluation
- Communication
- Housing (Safe Environment)
- Levels of Observation; Follow-Up; Treatment Planning
- Intervention (Emergency Response)
- Reporting and Notification
- Mortality-Morbidity Review

While each of these components should be tailored for the specific responsibilities and needs of the respective provider – i.e., staff of detention and secure/non-secure care facilities, referring/arresting officers, courts, parole and probation officers, and the many providers of aftercare – the shared goal of suicide prevention results in much useful overlap conducive to implementing consistent policy.

It should be further noted that, much like the providers of services, the components themselves are interrelated. For example, while the screening and assessment process provides an opportunity to identify suicide risk in juveniles, it can only be successful if the necessary training of staff is in place and communication throughout the facility or program regularly occurs. Simply stated, a multidisciplinary approach is *the* approach to suicide prevention for youth in contact with the juvenile justice system.

Appendix: Terms and Definitions

Close observation

Deliberate focus on a youth in a detention or secure/non-secure care facility who is not actively suicidal but meets one or more of the following: (1) has expressed suicidal ideation, (2) has a recent history of self-destructive behavior, (3) has denied suicidal ideation or threatened suicide but demonstrates other concerning behavior (through actions, current circumstances, or recent history), indicating potential for self-injury. Staff should observe such youth in a protrusion-free room at staggered intervals not to exceed every 10 minutes (e.g., five minutes, 10 minutes, seven minutes).

Constant observation

More intensive than close observation, constant observation is reserved for youth who are actively suicidal, either forming a specific plan or engaging in suicidal behavior. Staff should observe such youth on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every five minutes.

Continuous assessment

Intake screening and additional follow-up assessment of all juveniles that is critical to a facility's suicide prevention efforts. Assessment should not be viewed as a single event, but as an ongoing process. Youth can become suicidal at any point during confinement, including the initial admission into the facility; after adjudication and upon return to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; during confinement in isolation, segregation, and/or "time-out"; and following a prolonged stay in the facility.

Crisis Intervention Team (CIT)

A nationally-recognized program known also as the "Memphis Model" of pre-arrest jail diversion for individuals in a mental illness crisis. This program provides law enforcement-based crisis intervention training for helping individuals, including youth, with mental illness.

Denial of risk

When individuals who are suicidal misrepresent their condition by denying risk factors or attempting to refute what might appear to an observer as a suicide warning sign. Although verbal responses during the intake screening and subsequent screenings are critical for assessing suicide risk, staff should not exclusively rely on a youth's denial of risk, particularly when behavior or previous confinement in the facility suggests otherwise. For such cases, the screening process must include referral procedures to mental health and/or medical personnel for a more thorough assessment.

High-risk suicide periods

Times in which the likelihood of a suicide attempt is greater than normal, whether due simply to time of day or the day of the week, or due to a recent suicide attempt in the facility. Because suicides often occur during late afternoon/early evening hours or on weekends – generally outside the purview of program staff – direct care staff must be trained to thwart these incidents. Direct care staff members are often the only personnel available 24 hours/day; thus, they form the front line of defense in preventing suicides.

Intake screening

Inquiry done with the youth upon intake at a facility or confinement that covers the following questions: (1) Was the youth a medical, mental health, or suicide risk during any prior contact and/or confinement within this facility, (2) Does the arresting and/or transporting officer have any information (e.g. from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates that the youth is a medical, mental health, or suicide risk now, (3) Has the youth ever considered suicide?, (4) Has the youth ever attempted suicide?, (5) Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety, (6) Is the youth now being treated (or ever been treated) for mental health or emotional problems, such as depression or anxiety?, (7) Has the youth recently experienced a significant loss (relationship, death of family member/close friend, job, etc.), (8) Has a family member/close friend of the youth ever attempted, or died by, suicide, (9) Does the youth feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness?) and (10) Is the youth thinking of hurting and/or killing him/herself? See *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth* for more information: http://actionallianceforsuicideprevention.org/ system/files/JJ-6-R2-Screening-Assessment.pdf.

Mock drills

Rehearsals aimed at increasing the efficiency of an emergency response to a suicide attempt. By incorporating mock drills into both the initial and refresher trainings for all staff, the likelihood that staff members understand how to best respond in the event of a suicide attempt will improve. Mock drills should allow all staff who have routine contact with youth to rehearse what to do in an event where standard first-aid and CPR are required of them.

Protective factors

Characteristics that decrease the likelihood that an individual will consider, attempt, or die by suicide. Examples include effective mental health care; connectedness to individuals, family, community, and social institutions; problem-solving skills, and contacts with caregivers.

Risk factors

Characteristics that increase the likelihood that an individual will consider, attempt, or die by suicide. Examples include prior suicide attempts, substance abuse, mental health disorders, history of trauma, previous system involvement, and access to lethal means (e.g., hanging).

Self-injury

Bodily harm inflicted upon oneself. One commonly seen form of self-injury is the cutting of one's skin. Although self-injury has the potential the result in death, it is often done to produce a numbing effect, rather than to result in death.

Shield of Care

An 8-hour curriculum developed by the Tennessee Department of Mental Health that teaches juvenile justice staff strategies to prevent suicide in their correctional facility environment. It is the first suicide prevention training for juvenile justice direct care staff that has been accepted into the BPR. It: (1) emphasizes that policy, connectedness to youth, and communication between staff are essential system-level elements of suicide prevention; (2) teaches staff specific steps of effective suicide intervention, and (3) provides opportunities for staff to reflect on internal policies

for prevention, discuss strategies for overcoming potential barriers, and plan how to take action in their setting.

Suicidal ideation

Persistent thoughts of, or wishes for, one's own death, without a specific threat or plan. Screening and assessment for suicidal ideation at all stages of contact with the juvenile justice system is a fundamental component of a suicide prevention-informed juvenile justice system.

Suicide contagion

When one suicide provides a model to follow for others who are suicidal. In detention and secure/non-secure care facilities, youth can be traumatized by critical events, including the suicide of another youth, which may lead to suicide contagion, especially among already vulnerable youth.

Suicide precautions

The management of youth identified as being at risk for suicide, to include, but not be limited to, provisions for safe housing, levels of observation, assessment/treatment by qualified mental health professionals, treatment planning, and follow-up treatment.

Suicide prevention training

Initial: An 8-hour training on suicide prevention that should be completed by all direct care, medical, mental health personnel, and any other staff who have regular contact with youth. Staff who have not yet received suicide prevention training should receive education about their role in creating a suicide prevention-informed juvenile justice system. This training should cover: (1) administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, (2) why the environments of juvenile facilities are conducive to suicidal behavior, (3) potential predisposing risk and protective factors related to suicide, (4) high-risk suicide periods, (5) juvenile suicide research, (6) warning signs of suicide, (7) identification of suicidal youth despite the denial of risk, (8) components of the facility's suicide prevention policy, and (9) liability issues associated with juvenile suicide. This training program should be followed each year with a 2-hour suicide prevention refresher training (described below).

Refresher: An annual 2-hour training to remind staff about what they learned during the initial, more in-depth suicide prevention training program. The refresher training covers topics including (1) administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, (2) a review of predisposing risk and protective factors related to suicide, (3) warning signs of suicide, (4) identification of suicidal youth despite the denial of risk, (5) review of any changes to the facility's suicide prevention policy, and (6) general discussion of any recent suicides and/or suicide attempts in the facility.

Treatment plan

A description of the signs and symptoms of suicide; circumstances under which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions that youth and staff will take if suicidal ideation reoccurs

Warning signs

Indications that an individual is at immediate risk of a suicide attempt. Warning signs include threatening to hurt or kill oneself, seeking a means to kill oneself, expressing feelings of hopelessness, increasing alcohol or drug use, and dramatic mood changes.

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Preventing Juvenile Suicide through Improved Collaboration: Strategies for Mental Health and Juvenile Justice Agencies

Summary of Recommendations

Prepared by the
Youth in Contact with the Juvenile Justice System Task Force
of the National Action Alliance for Suicide Prevention

September 2013

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Introduction

Up to 70 percent of youth in the juvenile justice system have mental health disorders, which severely impact one or more life functions for a significant percentage of these youth (Skowyra & Cocozza, 2007). Due to the multiple traumatic events that these youth have experienced and the sense of hopelessness and isolation that ensues from the experience of confinement, suicide risk for these youth dramatically increases. The following factors need to be addressed by all systems coming in contact with justice-involved youth:

- Suicide is the leading cause of death for youth in confinement (Bureau of Justice Statistics, 2005).
- Youth in residential facilities have nearly three times the suicide rate of peers in the general population (Gallagher & Dobrin, 2006).
- Risk factors for suicide are often more prevalent among youth in this system. (National Action Alliance for Suicide Prevention, 2013).
- Studies report that over half of confined youth had current suicidal ideation (Esposito & Clum, 2001), and one-third also had a history of suicidal behavior (Parent et al., 1994).

The gravity of this situation requires urgent action in order that systems and practitioners in juvenile justice, law enforcement, mental health, substance abuse, child welfare and education work collaboratively to successfully prevent suicide (Skowyra & Cocozza, 2007). This report, developed by the Youth in Contact with the Juvenile Justice System Task Force (http://actionallianceforsuicideprevention.org/task-force/juvenilejustice) of the National Action Alliance for Suicide Prevention (Action Alliance) (http://www.actionallianceforsuicideprevention.org), provides recommendations for achieving such collaboration. The task force's Mental Health and Juvenile Justice Systems Collaboration Workgroup was charged with identifying priorities and strategies to help these agencies improve collaboration, ultimately resulting in more effective suicide prevention programming. The workgroup compiled recommendations, tailored for suicide prevention supports and services for youth involved in the juvenile justice system, in two categories:

- ***Overarching Priorities***: The workgroup recommends that state and local mental health and juvenile justice agencies pursue ten overarching collaborative priorities to inform joint policy

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was established to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Juvenile Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task.

Mental Health and Juvenile Justice Systems Collaboration Workgroup Members and Staff

- Eric Trupin, PhD (*workgroup lead*) – Director, Division of Public Behavioral Health and Justice Policy, University of Washington
- David DeVoursney, MPP – Program Analyst, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Simon Gonsoulin, Med – Principal Research Analyst, American Institutes for Research
- Carl Wicklund – Executive Director, American Probation and Parole Association
- James Wright, MS, LCPC – Public Health Advisor, SAMHSA

and budgeting decisions associated with suicide prevention for youth involved in juvenile justice.

- ***Strategies***: A set of twelve strategies was developed to facilitate achievement of the overarching priorities. Specific strategies that apply to each overarching priority are listed by number after the discussion of the respective overarching priority in the full version of the Collaboration document. As a visual organizer, a matrix graphically represents the alignment of the strategies and priorities.

The workgroup also developed an environmental scan tool (Appendix A in the full document) to help jurisdictions assess strengths, weaknesses, opportunities, and threats across the ten overarching priorities, thereby lending direction to the process of building collaboration between agencies.

Overarching Priorities to Improve Collaboration

The following priorities are recommended to mental health and juvenile justice agencies seeking to collaboratively improve outcomes for youth involved in juvenile justice who may be at risk for suicide. For specific strategies to achieve these priorities, refer to the matrix on pages 7–8 of this executive summary and to the full report.

Overarching Priority A

State mental health and juvenile justice agencies should establish effective data collection and information-sharing for the purposes of 1) law, policy, and program development related to youth at risk for suicidal behavior; 2) individual case-planning and decision-making; and 3) program evaluation and performance measurement addressing suicide prevention.

In an effort to improve service delivery and to develop and promote effective laws, policies, and programs, state mental health and juvenile justice agencies should establish parameters for collecting and sharing data that have specific utility for all parties involved in partnerships. Data should be collected for development and evaluation of laws, policies, and programs and for individual case-planning and decision-making. An additional goal of data collection, including aggregate data and case-level specific data, should be for future evaluation or program improvement. Procedures to guarantee proper handling and usage of shared information should be outlined in memoranda of understanding and/or use agreements.

Overarching Priority B

All states should establish policies related to collaboration on issues facing youth who are involved with dual jurisdictions, particularly those youth who are at risk for suicidal behaviors.

States should engage in comprehensive planning and collaboration, including cross-system training, to reduce the risk of suicide among youth involved in the juvenile justice system. This work should involve the variety of systems (e.g. juvenile justice, mental health, education, social services) that interact with youth and will likely include creation of state laws, written policies, and executive orders. States should not only address data and information-sharing, decision-making, and policy and program improvement, but also consider barriers. Strategies for overcoming those barriers should be detailed in written memoranda of agreement or understanding.

Overarching Priority C

Juvenile justice and mental health agencies should work together to ensure that youth who are at risk of suicide always receive evidence-based services in the least restrictive settings possible.

Difficulties for youth at risk for suicidal behavior can be exacerbated by placement in restrictive environments where contact with family and other community caregivers is limited, which only fuels feelings of isolation, hopelessness, and helplessness. Less restrictive, community-based alternatives with access to interventions that have demonstrated success in reducing offending behaviors should be prioritized for the majority of juvenile offenders.

Overarching Priority D

Juvenile justice and mental health agencies should collaboratively provide mental health services that respond to the gender, ethnicity, and sexual orientation of youth who are at risk of suicide.

Mental health services should be provided to increase the quality and range of treatment, rehabilitation, and support for people with mental illness, their families, and communities. This is particularly true for individuals demonstrating suicidal ideation or emotional crisis. Collaborative efforts should focus on providing appropriate and respectful services to each individual, regardless of gender, ethnicity, and sexual orientation.

Overarching Priority E

All systems should work collaboratively to provide close follow-up and sufficient support to youth who are re-entering the community from secure care, especially youth who have a history of suicidal ideation and behaviors.

Youth transitioning from secure care to their home-based community need transition plans that address all potential areas of concern (e.g., education, physical health, mental health, job skills, substance abuse, peer/family relationships, and risk of suicide). Effective transition plans encompass a meshing of comprehensive services and supportive policies provided through a collaboration of all involved systems committed to working together to foster better outcomes for youth and their families. Communication among agencies ensures that delays or oversights will not prevent youth from successfully re-entering their community.

Overarching Priority F

Juvenile justice and mental health agencies should work in tandem to establish and provide developmentally appropriate services to youth who are at risk of suicide.

All providers involved in juvenile justice should have a working knowledge of the most current scientific findings on the adolescent brain and emotional development. Because youth will be of different ages and in different developmental, emotional, and psychological stages, interactions, treatments, and interventions must be tailored accordingly. Communication and cognitive approaches with youth must be appropriate to not only chronological age, but also to emotional and psychological age. Accounting for developmental stages is also critical when evaluating for suicidal ideation and emotional crisis. When possible, all communication should be articulated to youth in both written and oral forms.

Overarching Priority G

Youth-serving agencies should establish collaborative agreements and practices to better provide services for youth who are at risk of suicide.

To reduce fragmentation and duplication of services and to improve program efficiency and outcomes for youth involved in one or more systems, child-serving agencies should establish collaborative agreements and practices. All agencies involved must commit to overcoming barriers (e.g., philosophical, structural, language/communication, staff resistance) that often prevent effective alignment of services.

Overarching Priority H

Collaboratively developed services and strategies for youth who are at risk of suicide should be evaluated regularly.

Evaluation is a key component in the development and management of any program, and is particularly useful for the collaborative efforts of juvenile justice and mental health agencies. Program managers from both agencies must work together to evaluate operations, practices, accomplishments, and results.

Overarching Priority I

Juvenile justice and mental health cooperative agreements should inform courts of existing mental health supports and services to avoid placing youth in the juvenile justice system solely to access mental health services.

Courts need to work closely with public behavioral health, chemical dependency, child welfare, and public education systems to identify accessible interventions that do not require youth to be placed either under the care of the juvenile court or remanded to secure detention in order to access mental health interventions.

Overarching Priority J

State Medicaid and juvenile justice agencies should formally establish a collaborative relationship to better provide services to youth who are at risk of suicide.

Youth served by the Medicaid and juvenile justice systems make up a significant percentage of system-involved youth. To more effectively administer benefit packages to this population, Medicaid officials must be informed about the needs of youth in the juvenile justice system. Likewise, juvenile justice staff must be informed of Medicaid policy so that they can coordinate with funded services, support enrollment of youth exiting juvenile justice placements, and fill gaps in coverage for youth who are at risk of suicide. Prescribed and common data collection across the State Medicaid and juvenile justice agencies is recommended to improve service delivery to youth involved in the juvenile justice system.

Overview of Strategies

To achieve the overarching priorities, the Mental Health and Juvenile Justice Systems Collaboration Workgroup recommends the following strategies for mental health and juvenile justice agencies seeking to collaborate on suicide prevention goals. The full report presents these strategies in more detail and cross-references applicable strategies to each overarching priority.

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system.

Strategy 2: Use valid screening and risk assessment instruments that identify risk for suicide and immediately provide necessary mental health services.

Strategy 3: Implement interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.

Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.

Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Strategy 6: Explore, at a state-wide level, more effective data collection and information-sharing processes.

Strategy 7: Implement, at the state level, innovative funding strategies (e.g., blended funding, pooling, decategorization, coordinating, and devolving) to collaboratively serve dual-jurisdiction youth who exhibit risk for suicidal behaviors.

Strategy 8: Explore, at the state level, barriers to effective collaboration and develop strategies for overcoming those barriers, recognizing the opportunities offered by memoranda of understanding and agreement.

Strategy 9: Improve state data collection strategies by identifying that data most pertinent to Medicaid and juvenile justice agencies serving youth.

Strategy 10: Facilitate collaboration through shared staff members, regularly held joint meetings, ad hoc meetings, shared workgroups, interagency agreements, memoranda of understanding, and data sharing.

Strategy 11: Educate juvenile justice staff on Medicaid policy and its application to youth involved in juvenile justice through tailored workshops provided by the State Medicaid agency.

Strategy 12: Conduct general training on Medicaid to all child-serving agencies.

Matrix of the Overarching Priorities and Strategies

Strategies	Priority A: Effective data collection & info-sharing	Priority B: Policies related to collaboration	Priority C: Least restrictive, evidence-based services	Priority D: Sensitivity to gender, ethnic & sexual orientation	Priority E: Follow-up & system linkages for youth re-entry	Priority F: Develop-mentally appropriate services	Priority G: Collaboration of child-serving agencies	Priority H: Regular evaluation of services	Priority I: Access to mental health services	Priority J: Formal relationship between Medicaid & JJ
Strategy 1: Form an interagency task force	√	√	√	√	√	√	√	√	√	√
Strategy 2: Use valid screening & risk assessment instruments	√		√	√		√	√		√	
Strategy 3: Use evidence-based interventions	√		√	√	√	√	√	√	√	√
Strategy 4: Divert suicidal youth to treatment	√	√	√	√		√	√		√	
Strategy 5: Provide care that is sensitive to culture, trauma, and gender	√		√	√	√	√	√			√
Strategy 6: Explore decision points, agreements, and practices	√	√			√		√	√		√

Matrix of the Overarching Priorities and Strategies (continued)

Strategies	Priority A: Effective data collection & info-sharing	Priority B: Policies related to collaboration	Priority C: Least restrictive, evidence-based services	Priority D: Sensitivity to gender, ethnic & sexual orientation	Priority E: Follow-up & system linkages for youth re-entry	Priority F: Develop-mentally appropriate services	Priority G: Collaboration of child-serving agencies	Priority H: Regular evaluation of services	Priority I: Access to mental health services	Priority J: Formal relationship between Medicaid & JJ
Strategy 7: Implement innovative funding strategies	√	√			√		√			
Strategy 8: Address barriers to effective collaboration	√	√			√		√			
Strategy 9: Improve data collection strategies of Medicaid & JJ	√				√		√			√
Strategy 10: Facilitate collaboration through joint meetings, etc.					√		√			√
Strategy 11: Educate JJ staff on Medicaid policy and its application					√		√			√
Strategy 12: Conduct training on Medicaid for child-serving agencies					√		√			√

Conclusion

In recognition of the higher rate of suicide and suicidal behaviors among youth involved in the juvenile justice system who have mental health disorders, substance abuse disorders, and other relevant risk factors for suicide (e.g., a history of child sexual and physical abuse and other forms of trauma), it is urgent that all youth-serving systems effectively collaborate across all levels of government. The collaboration will likely save the lives of vulnerable youth by creating opportunities to intervene prior to the youth engaging in suicidal behaviors and greatly enhance the provision of appropriate and effective supports and services. Implementing the strategies recommended in this paper will enable systems and practitioners to reduce the risk of youth suicide while achieving the collaborations necessary for sustained positive suicide prevention strategies.

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September 2013

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Introduction

Up to 70 percent of youth in the juvenile justice system have mental health disorders, which severely impact one or more life functions for a significant percentage of these youth (Skowyra & Cocozza, 2007). Due to the multiple traumatic events that these youth have experienced and the sense of hopelessness and isolation that ensues from the experience of confinement, suicide risk for these youth dramatically increases. The following factors need to be addressed by all systems coming in contact with justice-involved youth:

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- Studies report that over half of confined youth had current suicidal ideation (Esposito & Clum, 2001), and one-third also had a history of suicidal behavior (Parent et al., 1994).

The gravity of this situation requires urgent action in order that systems and practitioners in juvenile justice, law enforcement, mental health, substance abuse, child welfare and education work collaboratively to successfully prevent suicide (Skowyra & Cocozza, 2007). This report, developed by the Youth in Contact with the Juvenile Justice System Task Force (http://actionallianceforsuicideprevention.org/task-force/juvenilejustice) of the National Action Alliance for Suicide Prevention (Action Alliance) (http://www.actionallianceforsuicideprevention.org), provides recommendations for achieving such collaboration. The task force's Mental Health and Juvenile Justice Systems Collaboration Workgroup was charged with identifying priorities and strategies to help these agencies improve collaboration, ultimately resulting in more effective suicide prevention programming. The workgroup compiled recommendations, tailored for suicide prevention supports and services for youth involved in the juvenile justice system, in two categories:

- ***Overarching Priorities***: The workgroup recommends that state and local mental health and juvenile justice agencies pursue ten overarching collaborative priorities to inform joint policy and budgeting decisions associated with suicide prevention for youth involved in juvenile justice.

Background

Envisioning a nation free from the tragic experience of suicide, the Action Alliance was launched in 2010 by U.S. Department of Health and Human Services Secretary Kathleen Sebelius and former U.S. Department of Defense Secretary Robert Gates. This public-private partnership advances the *National Strategy for Suicide Prevention* (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. The Action Alliance's Youth in Contact with the Juvenile Justice System Task Force was established to focus attention on the needs of youth in the juvenile justice system. The task force was co-led by:

- Melodee Hanes, JD – Acting Administrator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Juvenile Justice
- Joseph J. Cocozza, PhD – Director, National Center for Mental Health and Juvenile Justice, Policy Research Associates

The task force comprised four workgroups: Public Awareness and Education; Suicide Research; Suicide Prevention Programming and Training; and Mental Health and Juvenile Justice Systems Collaboration. Each workgroup developed products specific to its respective task.

Mental Health and Juvenile Justice Systems Collaboration Workgroup Members and Staff

- Eric Trupin, PhD (*workgroup lead*) – Director, Division of Public Behavioral Health and Justice Policy, University of Washington
- David DeVoursney, MPP – Program Analyst, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Simon Gonsoulin, Med – Principal Research Analyst, American Institutes for Research
- Carl Wicklund – Executive Director, American Probation and Parole Association
- James Wright, MS, LCPC – Public Health Advisor, SAMHSA

- ***Strategies***: A set of twelve strategies was developed to facilitate achievement of the overarching priorities. Specific strategies that apply to each overarching priority are listed by number after the discussion of the respective overarching priority. As a visual organizer, a matrix graphically represents the alignment of the strategies and priorities.

The workgroup also developed an environmental scan tool (Appendix A) to help jurisdictions assess strengths, weaknesses, opportunities, and threats across the ten overarching priorities, thereby lending direction to the process of building collaboration between agencies. A summary of the priorities and strategies is listed below.

Overarching Priorities

Overarching Priority A: State mental health and juvenile justice agencies should establish effective data collection and information-sharing for the purposes of 1) law, policy, and program development related to youth at risk for suicidal behavior; 2) individual case-planning and decision-making; and 3) program evaluation and performance measurement addressing suicide prevention.

Overarching Priority B: All states should establish policies related to collaboration on issues facing youth who are involved with dual jurisdictions, particularly those youth who are at risk for suicidal behaviors.

Overarching Priority C: Juvenile justice and mental health agencies should work together to ensure that youth who are at risk of suicide always receive evidence-based services in the least restrictive settings as possible.

Overarching Priority D: Juvenile justice and mental health agencies should collaboratively provide mental health services that respond to the gender, ethnicity, and sexual orientation of youth who are at risk of suicide.

Overarching Priority E: All systems should work collaboratively to provide close follow-up and sufficient support to youth who are re-entering the community from secure care, especially youth who have a history of suicidal ideation and behaviors.

Overarching Priority F: Juvenile justice and mental health agencies should work in tandem to establish and provide developmentally appropriate services to youth who are at risk of suicide.

Overarching Priority G: Youth-serving agencies should establish collaborative agreements and practices to better provide services for youth who are at risk of suicide.

Overarching Priority H: Collaboratively developed services and strategies for youth who are at risk of suicide should be evaluated regularly.

Overarching Priority I: Juvenile justice and mental health cooperative agreements should inform courts of existing mental health supports and services to avoid placing youth in the juvenile justice system solely to access mental health services.

Overarching Priority J: State Medicaid and juvenile justice agencies should formally establish a collaborative relationship to better provide services to youth who are at risk of suicide.

Overview of Strategies

To achieve the overarching priorities, the workgroup recommends the following strategies for mental health and juvenile justice agencies seeking to collaborate on suicide prevention goals:

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system.

Strategy 2: Use valid screening and risk assessment instruments that identify risk for suicide and immediately provide necessary mental health services.

Strategy 3: Implement interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.

Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.

Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Strategy 6: Explore, at a state-wide level, more effective data collection and information-sharing processes.

Strategy 7: Implement, at the state level, innovative funding strategies (e.g., blended funding, pooling, decategorization, coordinating, and devolving) to collaboratively serve dual-jurisdiction youth who exhibit risk for suicidal behaviors.

Strategy 8: Explore, at a state-wide level, barriers to effective collaboration and develop strategies for overcoming those barriers, recognizing the opportunities offered by memoranda of understanding and agreement.

Strategy 9: Improve state data collection strategies by identifying that data most pertinent to Medicaid and juvenile justice agencies serving youth.

Strategy 10: Facilitate collaboration through shared staff members, regularly held joint meetings, ad hoc meetings, shared workgroups, interagency agreements, memoranda of understanding, and data sharing.

Strategy 11: Educate juvenile justice staff on Medicaid policy and its application to youth involved in juvenile justice through tailored workshops provided by the State Medicaid agency.

Strategy 12: Conduct general training on Medicaid to all child-serving agencies.

Overarching Priorities to Improve Collaboration

The following priorities are recommended to mental health and juvenile justice agencies seeking to collaboratively improve outcomes for youth involved in juvenile justice who may be at risk of suicide. Utilize the environmental scan tool (Appendix A) as you address these priorities.

Overarching Priority A

State mental health and juvenile justice agencies should establish effective data collection and information-sharing for the purposes of 1) law, policy, and program development related to youth at risk for suicidal behavior; 2) individual case-planning and decision-making; and 3) program evaluation and performance measurement addressing suicide prevention.

Discussion

In an effort to improve service delivery and to develop and promote effective laws, policies, and programs, state mental health and juvenile justice agencies should establish parameters for collecting and sharing data that have specific utility for all parties involved in partnerships. Data should be collected for development and evaluation of laws, policies, and programs and for individual case-planning and decision-making. Determining an efficient means for collecting data, such as electronic case management systems or consistent formats, will facilitate the process and make transfer of data from one agency to the other easier and more accurate. Other components of the process should include pilot tests, quality checks of accumulated data, uniform data sources, data back-up, and attention to privacy, confidentiality, and security.

Information-sharing among agencies must start with the premise that information needs to be shared. Information-sharing is critically important in that it:

- saves all practitioners time
- encourages a more coordinated, coherent, and comprehensive approach to supports and services for youth
- can be cost-effective or at least cost-neutral
- helps to establish a set of data or metrics for program evaluation and future decision-making

All parties should collaboratively participate in determining the types of information that should be shared. The Models for Change Information Sharing Tool Kit (http://modelsforchange.net/publications/282) (Rosado et al., 2008) provides guidance to jurisdictions seeking to improve their information- and data-sharing practices in the handling of juveniles and reach the ultimate goal of improving the outcomes for those youths. Additionally, successful information-sharing requires privacy policies with stakeholders, which are based on the results of a privacy impact assessment. (Searching the Internet for “privacy impact assessment” will yield many samples.) Procedures to guarantee proper handling and use of shared information should be outlined in memoranda of understanding and/or use agreements. Such memoranda should include release-of-information forms.

Agencies may choose to use open, automated information solutions (e.g., National Information Exchange Model, Global Reference Architecture, Global Federated Identification and Privilege Management). Regardless of automation, information security must be established. Effective ways to protect shared information are outlined in the U.S. Department of Justice’s Office of Justice Program’s Global Information Sharing Toolkit (http://www.it.ojp.gov/gist) (2012).

Strategies That Relate to Overarching Priority A

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.

Strategy 2: Use valid screening and risk assessment instruments that are administered by qualified staff to identify risk for suicidal behavior through every stage of youth's involvement with the juvenile justice system and immediately provide necessary mental health services.

Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.

Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.

Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Strategy 6: Explore, at the state-wide level, more effective data collection and information-sharing processes by:

- Identifying goals for information-sharing
- Identifying key decision points that may require the sharing of information and map out the desired flow of information from one point to the next
- Developing protections for the information that is to be shared
- Developing protocols for the utilization of information-sharing agreements, practitioner's guides, authorization-to-release forms, and other pertinent tools
- Compiling questions that need to be answered to improve law, policy, and program development and to determine whether desired outcomes are being met
- Refining existing databases, and developing any additional, databases necessary to support improved law, policy, and programming
- Establishing each agency's responsibility and accountability for data collection
- Establishing quality control for data collection
- Establishing safeguards against the potential for undesired publication of individual case information in the data collection process

Strategy 7: Implement, at the state level, innovative funding strategies to collaboratively serve dual-jurisdiction youth who exhibit risk for suicidal behaviors, such as:

- Blending – conducting a review and analysis of jurisdictions/programs' funding sources and revenue streams to better align funding
- Pooling – combining funds from several agencies, jurisdictions, or programs into a single funding stream
- Decategorizing – removing narrow eligibility requirements or other rules that may restrict how groups can spend funding (thereby making funding streams less categorical)
- Coordinating – aligning categorical funding from a number of jurisdictions, agencies, or funding streams to support agreed-upon initiatives; this is often referred to as "braided funding" in reference to separate funding streams being wrapped together to support programs of unified services
- Devolving – delegating authority for the allocation of funds from higher to lower levels, such as from state agencies to community-based organizations or agencies

Strategy 8: Explore, at the state level, barriers to effective collaboration (e.g., funding, confidentiality requirements, philosophical differences) and develop strategies (such as memoranda of understanding and agreement) for overcoming those barriers.
Strategy 9: Improve state data collection strategies by identifying that data most pertinent to Medicaid and juvenile justice agencies serving youth.

Overarching Priority B

All states should establish policies related to collaboration on issues facing youth who are involved with dual jurisdictions, particularly those youth who are at risk for suicidal behaviors.

Discussion

States should engage in comprehensive planning and collaboration, including cross-system training, to reduce the risk of suicide among youth involved in the juvenile justice system. Following appropriate screening and assessment by a qualified mental health professional, youth identified as at risk of suicide should be immediately connected to a setting where treatment is provided. This treatment should be tailored to the unique needs of the youth and involve all necessary systems to support positive outcomes.

Policy work should involve the variety of systems (e.g. juvenile justice, mental health, education, social services) that interact with youth and will likely include creation of state laws, written policies, and executive orders. States should not only address data and information-sharing, decision-making, and policy and program improvement, but also consider barriers. Strategies for overcoming those barriers should be detailed in written memoranda of agreement or understanding. For example, any fiscal barriers to collaboration should be addressed.

Strategies That Relate to Overarching Priority B

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.
Strategy 6: Explore, at the state-wide level, more effective data collection and information-sharing processes by:

- Identifying goals for information-sharing
- Identifying key decision points that may require the sharing of information and map out the desired flow of information from one point to the next
- Developing protections for the information that is to be shared
- Developing protocols for the utilization of information-sharing agreements, practitioner's guides, authorization-to-release forms, and other pertinent tools
- Compiling questions that need to be answered to improve law, policy, and program development and to determine whether desired outcomes are being met
- Refining existing databases, and developing any additional, databases necessary to support improved law, policy, and programming
- Establishing each agency's responsibility and accountability for data collection
- Establishing quality control for data collection
- Establishing safeguards against the potential for undesired publication of individual case information in the data collection process

Strategy 7: Implement, at the state level, innovative funding strategies to collaboratively serve dual-jurisdiction youth who exhibit risk for suicidal behaviors, such as:

- Blending – conducting a review and analysis of jurisdictions/programs' funding sources and revenue streams to better align funding
- Pooling – combining funds from several agencies, jurisdictions, or programs into a single funding stream
- Decategorizing – removing narrow eligibility requirements or other rules that may restrict how groups can spend funding (thereby making funding streams less categorical)
- Coordinating – aligning categorical funding from a number of jurisdictions, agencies, or funding streams to support agreed-upon initiatives; this is often referred to as "braided funding" in reference to separate funding streams being wrapped together to support programs of unified services
- Devolving – delegating authority for the allocation of funds from higher to lower levels, such as from state agencies to community-based organizations or agencies.

Strategy 8: Explore, at the state level, barriers to effective collaboration (e.g., funding, confidentiality requirements, philosophical differences) and develop strategies (such as memoranda of understanding and agreement) for overcoming those barriers.

Overarching Priority C

Juvenile justice and mental health agencies should work together to ensure that youth who are at risk of suicide always receive evidence-based services in the least restrictive settings possible.

Discussion

Difficulties for youth at risk for suicidal behavior can be exacerbated by placement in restrictive environments where contact with family and other community caregivers is limited, which only fuels feelings of isolation, hopelessness, and helplessness. Less restrictive, community-based alternatives with access to interventions that have demonstrated success in reducing offending behaviors should be prioritized for the majority of juvenile offenders. Intensive evidence-based treatments, such as Functional Family Therapy (FFT) (http://www.ojjdp.gov/mpg/Functional%20Family%20Therapy-MPGProgramDetail-29.aspx) and Multi-Systemic Therapy (MST) for Juvenile Offenders (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=254), have consistently demonstrated both improved outcomes related to future crime as well as decreased risk for suicide and self-harm (Trupin 2007).

In all settings, youth involved in juvenile justice must be screened for suicide risk at in-take and as needed on an ongoing basis. When a need for intervention is identified, it is essential that evidenced-based interventions are provided to youth and their families to prevent suicide ideation, attempts, and deaths. For more information on this, see *Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth* (http://actionallianceforsuicideprevention.org/system/files/JJ-6-R2-Screening-Assessment.pdf).

Strategies That Relate to Overarching Priority C

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.

Strategy 2: Use valid screening and risk assessment instruments that are administered by qualified staff to identify risk for suicidal behavior through every stage of youth's involvement with the juvenile justice system and immediately provide necessary mental health services.
Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.
Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Overarching Priority D

Juvenile justice and mental health agencies should collaboratively provide mental health services that respond to the gender, ethnicity, and sexual orientation of youth who are at risk of suicide.

Discussion

Mental health services should be provided that are evidence based and culturally competent. These services should emphasize family and caregiver involvement. Emphasis should be placed on youth learning and utilizing skills that help them tolerate distress and learn to regulate their emotions. This is particularly true for individuals demonstrating suicidal ideation or emotional crisis. Collaborative efforts should focus on providing effective supports and services to each individual, with sensitivity to gender, ethnicity, or sexual orientation. Services that engender an enhancement sense of maturity of thought and emotions are to be considered a protective factor against suicide risk (Kaslow, et al, 2002).

Consistent and sustained commitment to collaboration by system leaders will lead to better educated and empowered parents and caregivers, more engaged and fairly treated youth, and juvenile justice, law enforcement, and other child-serving-system staff who are better trained in effective interventions to suicide.

Strategies That Relate to Overarching Priority D

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 2: Use valid screening and risk assessment instruments that are administered by qualified staff to identify risk for suicidal behavior through every stage of youth's involvement with the juvenile justice system and immediately provide identified emergency mental health services.
Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.
Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Overarching Priority E

All systems should work collaboratively to provide close follow-up and sufficient support to youth who are re-entering the community from secure care, especially youth with a history of suicidal ideation and behavior.

Discussion

Youth transitioning from secure care to their home-based communities need transition plans that address all potential areas of concern (e.g., education, physical health, mental health, job skills, substance abuse, peer/family relationships, and risk of suicide). Effective transition plans encompass a meshing of comprehensive services and supportive policies provided by all involved systems collaborating to foster better outcomes for youth and their families. Intra-agency communication avoids delays or oversights that could keep youth from successfully re-entering their communities, e.g.:

- Home-based schools should receive records and other anecdotal information about the youth's educational needs and progress prior to re-enrollment in the home-based school.
- For youth placed on medication as part of mental health treatment while confined, an appointment at a community mental health agency must be established and the youth must be provided with enough medication for the period between release and the initial appointment.
- Effective communication and collaboration allow youth with substance abuse disorders to be referred to substance abuse counseling services prior to leaving the secure facility, which can facilitate better outcomes upon re-entry into the community.

Representatives of all involved agencies should meet with all significant parties, including family members, to map out strategies for the youth's successful re-entry. This pre-release step, combined with close follow-up with all of the same parties once the youth has re-entered the community, will establish an environment of mutual trust in which youth and families are viewed as key decision makers.

Strategies That Relate to Overarching Priority E

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.

Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.

Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Strategy 6: Explore, at the state-wide level, more effective data collection and information-sharing processes by:

- Identifying goals for information-sharing
- Identifying key decision points that may require the sharing of information and map out the desired flow of information from one point to the next
- Developing protections for the information that is to be shared
- Developing protocols for the utilization of information-sharing agreements, practitioner's guides, authorization-to-release forms, and other pertinent tools
- Compiling questions that need to be answered to improve law, policy, and program development and to determine whether desired outcomes are being met
- Refining existing databases, and developing any additional, databases necessary to support improved law, policy, and programming
- Establishing each agency's responsibility and accountability for data collection
- Establishing quality control for data collection
- Establishing safeguards against the potential for undesired publication of individual case information in the data collection process

Strategy 7: Implement, at the state level, innovative funding strategies to collaboratively serve dual-jurisdiction youth who exhibit risk for suicidal behaviors, such as:

- Blending – conducting a review and analysis of jurisdictions/programs' funding sources and revenue streams to better align funding
- Pooling – combining funds from several agencies, jurisdictions, or programs into a single funding stream
- Decategorizing – removing narrow eligibility requirements or other rules that may restrict how groups can spend funding (thereby making funding streams less categorical)
- Coordinating – aligning categorical funding from a number of jurisdictions, agencies, or funding streams to support agreed-upon initiatives; this is often referred to as "braided funding" in reference to separate funding streams being wrapped together to support programs of unified services
- Devolving – delegating authority for the allocation of funds from higher to lower levels, such as from state agencies to community-based organizations or agencies

Strategy 8: Explore, at the state level, barriers to effective collaboration (e.g., funding, confidentiality requirements, philosophical differences) and develop strategies (such as memoranda of understanding and agreement) for overcoming those barriers.
Strategy 9: Improve state data collection strategies by identifying that data most pertinent to Medicaid and juvenile justice agencies serving youth.
Strategy 10: Facilitate collaboration through shared staff members, regularly held joint meetings, ad hoc meetings, shared workgroups, interagency agreements, memoranda of understanding, and data sharing.
Strategy 11: Educate juvenile justice staff on Medicaid policy and its application to youth involved in juvenile justice through tailored workshops provided by the state Medicaid agency.
Strategy 12: Conduct general training on Medicaid to all child-serving agencies.

Overarching Priority F

Juvenile justice and mental health agencies should work in tandem to establish and provide developmentally appropriate services to youth who are at risk of suicide.

Discussion

All providers involved in juvenile justice should have a working knowledge of the most current scientific findings on the adolescent brain and emotional development. Because youth will be of different ages and in different developmental, emotional, and psychological stages, providers must tailor interactions, interventions, and treatments accordingly. Communication and cognitive approaches with youth must be appropriate to not only chronological age, but also to emotional and psychological age. Among adolescents of the same chronological age, those who are psychologically younger will have different developmental needs than those who are psychologically older. Accounting for developmental stages is also critical when assessing risk and intervening in an emotional crisis. When possible, all communication should be articulated to youth in both written and oral forms.

Strategies That Relate to Overarching Priority F

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 2: Use valid screening and risk assessment instruments that are administered by qualified staff to identify risk for suicidal behavior through every stage of youth's involvement with the juvenile justice system and immediately provide necessary mental health services.

Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.
Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.

Overarching Priority G

Youth-serving agencies should establish collaborative agreements and practices to better provide services for youth who are at risk of suicide.

Discussion

To reduce fragmentation and duplication of services and to improve program efficiency and outcomes for youth involved in one or more systems, child-serving agencies should establish collaborative agreements and practices. While not inclusive, this list may include agencies dedicated to mental health, juvenile justice, child welfare, substance abuse, education, law enforcement, and labor. All agencies involved must commit to overcoming barriers (e.g., philosophical, structural, language/communication, staff resistance) that often prevent effective alignment of services.

Agencies seeking to collaborate with one another to better meet the needs of youth and their families will also benefit from establishing memoranda of understanding for sharing information, cross-training staff, adopting common screening tools, and aligning practices. By sharing responsibility, resources, and decision-making, collaborating agencies can provide wraparound services that facilitate the successful transition of youth back into the community.

Strategies That Relate to Overarching Priority G

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 2: Use valid screening and risk assessment instruments that are administered by qualified staff to identify risk for suicidal behavior through every stage of youth's involvement with the juvenile justice system and immediately provide necessary mental health services.
Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.
Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.
Strategy 6: Explore, at the state-wide level, more effective data collection and information-sharing processes by:

- Identifying goals for information-sharing
- Identifying key decision points that may require the sharing of information and map out the desired flow of information from one point to the next
- Developing protections for the information that is to be shared
- Developing protocols for the utilization of information-sharing agreements, practitioner's guides, authorization-to-release forms, and other pertinent tools

- Compiling questions that need to be answered to improve law, policy, and program development and to determine whether desired outcomes are being met
- Refining existing databases, and developing any additional, databases necessary to support improved law, policy, and programming
- Establishing each agency's responsibility and accountability for data collection
- Establishing quality control for data collection
- Establishing safeguards against the potential for undesired publication of individual case information in the data collection process

Strategy 7: Implement, at the state level, innovative funding strategies to collaboratively serve dual-jurisdiction youth who exhibit risk for suicidal behaviors, such as:

- Blending – conducting a review and analysis of jurisdictions/programs' funding sources and revenue streams to better align funding
- Pooling – combining funds from several agencies, jurisdictions, or programs into a single funding stream
- Decategorizing – removing narrow eligibility requirements or other rules that may restrict how groups can spend funding (thereby making funding streams less categorical)
- Coordinating – aligning categorical funding from a number of jurisdictions, agencies, or funding streams to support agreed-upon initiatives; this is often referred to as "braided funding" in reference to separate funding streams being wrapped together to support programs of unified services
- Devolving – delegating authority for the allocation of funds from higher to lower levels, such as from state agencies to community-based organizations or agencies

Strategy 8: Explore, at the state level, barriers to effective collaboration (e.g., funding, confidentiality requirements, philosophical differences) and develop strategies (such as memoranda of understanding and agreement) for overcoming those barriers.

Strategy 9: Improve state data collection strategies by identifying that data most pertinent to Medicaid and juvenile justice agencies serving youth.

Strategy 10: Facilitate collaboration through shared staff members, regularly held joint meetings, ad hoc meetings, shared workgroups, interagency agreements, memoranda of understanding, and data sharing.

Strategy 11: Educate juvenile justice staff on Medicaid policy and its application to youth involved in juvenile justice through tailored workshops provided by the state Medicaid agency.

Strategy 12: Conduct general training on Medicaid to all child-serving agencies.

Overarching Priority H

Collaboratively developed services and strategies for youth who are at risk of suicide should be evaluated regularly.

Discussion

Evaluation is a key component in the development and management of any program and is particularly useful for the collaborative efforts of juvenile justice and mental health agencies. Program managers from both agencies must work together to evaluate operations, practices, accomplishments, and results. While there are many evaluation models used in the field with both practitioners and evaluators, it is suggested by this work group that whichever the model is used, it should include the following steps:

1) Define the problem or practice to be evaluated
2) Implement evidence-based or evidence-informed practices
3) Develop a logic model
4) Identify the necessary measures

5) Collect and analyze the data
6) Report the findings
7) Reassess the logic model

Strategies That Relate to Overarching Priority H

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 6: Explore, at the state-wide level, more effective data collection and information-sharing processes by:

- Identifying goals for information-sharing
- Identifying key decision points that may require the sharing of information and map out the desired flow of information from one point to the next
- Developing protections for the information that is to be shared
- Developing protocols for the utilization of information-sharing agreements, practitioner's guides, authorization-to-release forms, and other pertinent tools
- Compiling questions that need to be answered to improve law, policy, and program development and to determine whether desired outcomes are being met
- Refining existing databases, and developing any additional, databases necessary to support improved law, policy, and programming
- Establishing each agency's responsibility and accountability for data collection
- Establishing quality control for data collection
- Establishing safeguards against the potential for undesired publication of individual case information in the data collection process

Overarching Priority I

Juvenile justice and mental health cooperative agreements should inform courts of existing mental health supports and services so to avoid placing youth in the juvenile justice system solely to access mental health services.

Discussion

Between 60–70 percent of youth involved in the juvenile justice system manifest a co-occurring behavioral health disorder (mental health and substance abuse) for which the youth would benefit from an evidence-based treatment intervention (National Council on Disability, 2002). The practice of placing a youth in a juvenile justice setting in order to access these services requires policy and legislative monitoring. Courts need to work closely with public behavioral health, chemical dependency, child welfare, and public education systems to identify accessible interventions that do not require youth to be placed either under the care of the juvenile court or remanded to secure detention in order to access mental health interventions. Court administrators, judges, prosecuting attorneys, and the defense bar need to create facilitated and prioritized access outside of the system for youth needing interventions.

Strategies That Relate to Overarching Priority I

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-

systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 2: Use valid screening and risk assessment instruments that are administered by qualified staff to identify risk for suicidal behavior through every stage of youth's involvement with the juvenile justice system and immediately provide necessary mental health services.
Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 4: Immediately divert youth with increased risk of suicide to a setting where appropriate treatment is available.

Overarching Priority J

State Medicaid and juvenile justice agencies should formally establish a collaborative relationship to better provide services to youth who are at risk of suicide.

Discussion

Youth served by the Medicaid and juvenile justice systems make up a significant percentage of system-involved youth. To more effectively design and administer benefit packages for this population, Medicaid officials must be informed about the needs of youth in juvenile justice. Likewise, juvenile justice staff must be informed of Medicaid policy so that they can coordinate with funded services, support enrollment of youth exiting juvenile justice, and fill gaps in coverage for youth at risk of suicide.

Building a shared understanding of the number of youth involved in juvenile justice who are enrolled in Medicaid, of the amount of money spent on youth involved in juvenile justice, and of the most frequent diagnoses that are related to suicide risk in this population will empower state governments to improve suicide prevention efforts. To that end, prescribed and common data collection across state Medicaid and juvenile justice agencies is recommended. Specific data-related issues that should be considered include: shared goals for use of data, data and privacy protections, protocols for the management and sharing of data, priority questions which data could be used to answer, and database management.

Strategies That Relate to Overarching Priority J

Strategy 1: Form an interagency task force (to include justice, education, mental health, social services, and other agencies/systems), with active family and community involvement, that promotes cross-systems training on helping youth cope with the juvenile justice system, with an emphasis on strategies to reduce the risk of suicide.
Strategy 3: Ensure that youth are being served with interventions that have evidence supporting their effectiveness with youth at risk for suicidal behaviors.
Strategy 5: Provide access to evidence-based mental health care that is culturally sensitive, trauma-sensitive, and gender-specific and that encourages family involvement.
Strategy 6: Explore, at the state-wide level, more effective data collection and information-sharing processes by:

- Identifying goals for information-sharing
- Identifying key decision points that may require the sharing of information and map out the desired flow of information from one point to the next
- Developing protections for the information that is to be shared
- Developing protocols for the utilization of information-sharing agreements, practitioner's guides, authorization-to-release forms, and other pertinent tools
- Compiling questions that need to be answered to improve law, policy, and program development and to determine whether desired outcomes are being met

- Refining existing databases, and developing any additional, databases necessary to support improved law, policy, and programming
- Establishing each agency's responsibility and accountability for data collection
- Establishing quality control for data collection
- Establishing safeguards against the potential for undesired publication of individual case information in the data collection process

Strategy 9: Improve state data collection strategies by identifying that data most pertinent to Medicaid and juvenile justice agencies serving youth.

Strategy 10: Facilitate collaboration through shared staff members, regularly held joint meetings, ad hoc meetings, shared workgroups, interagency agreements, memoranda of understanding, and data sharing.

Strategy 11: Educate juvenile justice staff on Medicaid policy and its application to youth involved in juvenile justice through tailored workshops provided by the state Medicaid agency.

Strategy 12: Conduct general training on Medicaid to all child-serving agencies.

Matrix of the Overarching Priorities and Strategies

Strategies	Priority A: Effective data collection & info-sharing	Priority B: Policies related to collaboration	Priority C: Least restrictive, evidence-based services	Priority D: Sensitivity to gender, ethnic & sexual orientation	Priority E: Follow-up & system linkages for youth re-entry	Priority F: Develop-mentally appropriate services	Priority G: Collaboration of child-serving agencies	Priority H: Regular evaluation of services	Priority I: Access to mental health services	Priority J: Formal relationship between Medicaid & JJ
Strategy 1: Form an interagency task force	√	√	√	√	√	√	√	√	√	√
Strategy 2: Use valid screening & risk assessment instruments	√		√	√		√	√		√	
Strategy 3: Use evidence-based interventions	√		√	√	√	√	√	√	√	√
Strategy 4: Divert suicidal youth to treatment	√	√	√	√		√	√		√	
Strategy 5: Provide care that is sensitive to culture, trauma, and gender	√		√	√	√	√	√			√
Strategy 6: Explore decision points, agreements, and practices	√	√			√		√	√		√

Matrix of the Overarching Priorities and Strategies (continued)

Strategies	Priority A: Effective data collection & info-sharing	Priority B: Policies related to collaboration	Priority C: Least restrictive, evidence-based services	Priority D: Sensitivity to gender, ethnic & sexual orientation	Priority E: Follow-up & system linkages for youth re-entry	Priority F: Develop-mentally appropriate services	Priority G: Collaboration of child-serving agencies	Priority H: Regular evaluation of services	Priority I: Access to mental health services	Priority J: Formal relationship between Medicaid & JJ
Strategy 7: Implement innovative funding strategies	√	√			√		√			
Strategy 8: Address barriers to effective collaboration	√	√			√		√			
Strategy 9: Improve data collection strategies of Medicaid & JJ	√				√		√			√
Strategy 10: Facilitate collaboration through joint meetings, etc.					√		√			√
Strategy 11: Educate JJ staff on Medicaid policy and its application					√		√			√
Strategy 12: Conduct training on Medicaid for child-serving agencies					√		√			√

Conclusion

In recognition of the higher rate of suicide and suicidal behaviors among youth involved in the juvenile justice system who have mental health disorders, substance abuse disorders, and other relevant risk factors for suicide (e.g., a history of child sexual and physical abuse and other forms of trauma), it is urgent that all youth-serving systems effectively collaborate across all levels of government. This collaboration will likely save the lives of vulnerable youth by creating opportunities to intervene prior to the youth engaging in suicidal behavior and greatly enhance the provision of appropriate and effective supports and services. Implementing the strategies recommended in this paper will enable systems and practitioners to reduce the risk of youth suicide while achieving the collaborations necessary for sustained positive suicide prevention strategies.

Appendix A: Environmental Scanning Tool

The following tool is designed to assist jurisdictions seeking to collaborate on efforts to prevent suicide among youth involved in the juvenile justice system. With this tool, jurisdictions can assess strengths, weaknesses, opportunities, and threats across the ten overarching priorities (A-J). More commonly known as a SWOT framework, this assessment of relevant information within and outside of an organization makes obvious the internal and external factors that, in this case, impact collaborative efforts to prevent suicide among youth involved with juvenile justice. Gathering and studying this information will result in specific action steps and indicators to achieve greater collaboration.

Strengths and Opportunities

Strengths are internal qualities of an agency that will be beneficial in addressing the priority in question. For example, a strength under Priority A might be: "Data-sharing agreements already exist across the state behavioral health, juvenile corrections, and juvenile probation agencies." Building on this strength might be expressed thusly: "These agreements can be amended to emphasize suicide prevention."

Opportunities, on the other hand, are situations external to an agency that may be helpful in a given priority. For example, an opportunity under Priority C might be: "The state behavioral health system has set up a network of centers to support the implementation of evidence-based community behavioral health services." The resulting action step associated with this opportunity might be: "Our agency will engage these centers, facilitating access to a network of community-based providers that can connect youth living in community settings who may be at risk of suicide to evidence-based behavioral health services."

Weaknesses and Threats

Weaknesses are qualities internal to an agency that may make it more difficult to address the priority in question. In Priority H, for example, a weakness might be, "The staff devoted to evaluation within the Department of Juvenile Justice has recently been reduced, which will prohibit additional resources for evaluating suicide prevention efforts."

Threats are situations outside of an agency that may make it more difficult to address the priority in question. A threat in Priority F might be, "Many of the youth involved in the juvenile justice system come from rural areas that lack behavioral health services. The lack of behavioral health providers in these areas who have expertise in working with children and youth is especially problematic."

Action Steps

Action steps are specific activities that advance progress on a given priority. Actions steps to further Priority J, for example, might include:

1) Identify a representative from the state Medicaid agency to participate in juvenile justice system-efforts related to behavioral health and suicide prevention
2) Identify a representative from the state juvenile justice agency to participate in Medicaid service planning efforts related to behavioral health and suicide prevention
3) Ensure that youth exiting the justice system have the necessary resources to enroll in Medicaid and Children's Health Insurance Program (CHIP)

Indicators and Benchmarks

A mechanism for assessing progress toward suicide prevention will greatly enhance collaborative efforts. Depending on the availability of data, this assessment may take a variety of forms. Indicators can track outcomes (e.g., percent of justice-involved youth reporting suicidal ideation 60 days after returning to the community) or process measures (percent of justice-involved youth identified as at-risk for suicide who have received services from a community behavioral health care provider within two weeks of community re-entry). Benchmarks can also be used at a more basic level to track efforts, such as representatives from juvenile justice, mental health, substance abuse, and Medicaid agencies all participating in quarterly planning meetings.

Overarching Priority A

Mental health and juvenile justice agencies at the state, local, and tribal levels should establish effective data collection and information-sharing for the purposes of 1) law, policy, and program development related to youth at risk for suicidal behavior; 2) individual case planning and decision-making; and 3) program evaluation and performance measurement addressing suicide prevention.

1) How does the juvenile justice system work with mental health and other related partners to share information? How do these systems currently coordinate data collection and share data?

2) What are the strengths of current data-collection and information-sharing efforts? What are current opportunities?

3) What are the weaknesses of current data-collection and information-sharing efforts? What are current threats?

4) What action steps can be taken to develop or strengthen data collection and information-sharing across partners?

5) What indicators or benchmarks can be used to assess data collection and information-sharing?

Overarching Priority B

All states should establish policies related to collaboration on issues facing youth who are involved with dual jurisdictions, particularly those youth who are at risk for suicidal behaviors.

1) Does the juvenile justice agency have formal policies related to collaboration with partners (e.g., mental health, broader medical care, substance abuse treatment, schools, and law enforcement)?

2) What are the strengths of current collaboration policies? What are current opportunities?

3) What are the weaknesses of current collaboration policies? What are current threats?

4) What action steps can be taken to develop or strengthen collaboration policies related to suicide prevention for youth involved in juvenile justice?

5) What indicators or benchmarks can be used to assess collaboration policies?

Overarching Priority C

Juvenile justice and mental health agencies should work together to ensure that youth who are at risk of suicide always receive evidence-based services in the least restrictive settings as possible.

1) How does the juvenile justice system work with mental health and other partners to promote care in the least restrictive settings possible, using evidence-based services?

2) What are the strengths of current efforts to ensure delivery of evidence-based services in the least restrictive settings possible? What are current opportunities?

3) What are the weaknesses of current efforts to ensure delivery of evidence-based services in the least restrictive settings possible? What are current threats?

4) What action steps can be taken to ensure the use of evidence-based services in the least restrictive settings possible?

5) What indicators or benchmarks can be used to ensure the use of evidence-based services in the least restrictive settings possible?

Overarching Priority D

Juvenile justice and mental health agencies should collaboratively provide mental health services that respond to gender, ethnicity, and sexual orientation to youth who are at risk of suicide.

1) How does the juvenile justice system work with partners to promote services that are responsive to gender ethnicity, and sexual orientation?

2) What are the strengths of current efforts to use services that are responsive to gender, ethnicity, and sexual orientation? What are current opportunities?

3) What are the weaknesses of current efforts to ensure the services that are responsive to gender, ethnicity, and sexual orientation? What are current threats?

4) What action steps can be taken to develop or strengthen efforts to ensure services that are responsive to gender, ethnicity, and sexual orientation?

5) What indicators or benchmarks can be used to assess efforts to ensure services that are responsive to gender, ethnicity, and sexual orientation?

Overarching Priority E

All systems should work collaboratively to provide close follow-up and sufficient support to youth who are re-entering the community from secure care, especially youth who have a history of suicidal behaviors.

1) How does the juvenile justice system work with mental health providers, schools, community organizations, families, and other partners to ensure follow-up care for youth re-entering the community who are at risk of suicide?

2) What are the strengths of current follow-up care for youth who are at risk of suicide? What are current opportunities?

3) What are the weaknesses of current follow-up care for youth who are at risk of suicide? What are current threats?

4) What action steps can be taken to develop or strengthen follow-up care for youth who are at risk of suicide?

5) What indicators or benchmarks can be used to assess follow-up care for youth who are at risk of suicide?

Overarching Priority F

Juvenile justice and mental health agencies should work in tandem to establish and provide developmentally appropriate services to youth who are at risk of suicide.

1) How does the juvenile justice system work with partners to promote the use of developmentally appropriate services?

2) What are the strengths of current efforts to ensure developmentally appropriate services? What are current opportunities?

3) What are the weaknesses of current efforts to ensure developmentally appropriate services? What are current threats?

4) What action steps can be taken to develop or strengthen efforts to ensure developmentally appropriate services?

5) What indicators or benchmarks can be used to assess efforts to ensure developmentally appropriate services?

Overarching Priority G

Youth-serving agencies should establish collaborative agreements and practices to better provide services for youth who are at risk for suicide.

1) Does the juvenile justice agency have collaborative agreements and practices related to collaboration with partners (e.g. mental health, broader medical care, substance abuse treatment, schools, law enforcement) in response to youth at risk for suicide?

2) What are the strengths of current collaborative agreements and practices? What are current opportunities?

3) What are the weaknesses of current collaborative agreements and practices? What are current threats?

4) What action steps can be taken to develop or strengthen collaborative agreements and practices related to suicide prevention for juvenile justice-involved youth?

5) What indicators or benchmarks can be used to assess the effectiveness of collaborative agreements and practices?

Overarching Priority H

Collaboratively developed services and strategies for youth who are at risk of suicide should be evaluated regularly.

1) How does the juvenile justice system work with partners to evaluate collaborative efforts to prevent suicide among youth involved with juvenile justice?

2) What are the strengths of current evaluation efforts? What are current opportunities?

3) What are the weaknesses of current evaluation efforts? What are current threats?

4) What action steps can be taken to develop or strengthen evaluation efforts across partners?

5) What indicators or benchmarks can be used to assess evaluation efforts?

Overarching Priority I

Juvenile justice and mental health cooperative agreements should inform courts of existing mental health supports and services so to avoid placing youth in the juvenile justice system solely to access mental health services.

1) Are youth currently placed in the juvenile justice system so that they can receive behavioral health services? If so, are any steps being taken to ensure that this does not continue to happen?

2) What are the strengths of current efforts to reduce these types of inappropriate placements? What are current opportunities?

3) What are the weaknesses of current efforts to reduce these types of inappropriate placements? What are current threats?

4) What action steps can be taken to reduce these types of inappropriate placements?

5) What indicators or benchmarks can be used to assess efforts to reduce these types of inappropriate placements?

Overarching Priority J

State Medicaid and juvenile justice agencies should formally establish a collaborative relationship to better provide services to youth who are at risk of suicide.

1) How does the juvenile justice system at state, local, and tribal levels currently work with Medicaid?

2) What are the strengths of current work with Medicaid? What are current opportunities?

3) What are the weaknesses of current work with Medicaid? What are current threats?

4) What action steps can be taken to develop or strengthen work with Medicaid?

5) What indicators or benchmarks can be used to assess efforts to establish a collaborative relationship between state Medicaid and juvenile justice agencies?

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