

Suicide Prevention for Racine County Juvenile Detention
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A Seminar Paper

Presented to

The Graduate Faculty

University of Wisconsin-Platteville

In Partial Fulfillment of the

Requirement for the Degree

Masters of Science

in

Education

Adult Education

Approved by (Type instructor name here)

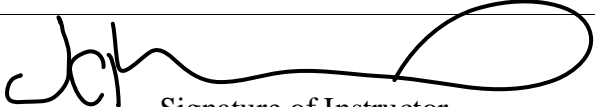
JaTawn Pinson	5/14/2018
 Signature of Instructor	Date Approved

TABLE OF CONTENTS

	PAGE
TITLE PAGE.....	1
ABSTRACT	2
CHAPTER	
I. INTRODUCTION.....	3
Background	
Statement of the Problem	
Purpose of the Study	
Significance of the Study	
Delimitations of Research	
Method of Approach	
II. REVIEW OF LITERATURE	9
III. CONCLUSIONS AND RECOMMENDATIONS.....	22
IV. REFERENCES	24

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2018

Abstract

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Juvenile detention centers are seeing more juveniles with mental health disorders. Without the proper policies and procedures to deal with mental health and suicide the suicide rate will increase. This study will provide a comprehensive review on the best practices for suicide prevention. The literature suggests the need to address mental health and suicide.

Introduction

The American Foundation of Suicide Prevention (2016) reports the following statistics about suicide in the United States:

- Each year in the US 44,965 Americans die by suicide.
- Suicide costs the United States \$69 Billion annually.
- The annual age-adjusted suicide rate is 13.42 per 100,000 individuals.
- Men die by suicide 3.53x more often than women.
- On average, there are 123 suicides per day. White males accounted for 7 of 10 suicides in 2016. Firearms account for 51% of all suicides in 2016.
- The rate of suicide is highest in middle age white men in particular

Mirroring these national statistics, according to The American Foundation for Suicide Prevention (2017) suicide is the 10th leading cause of death in Wisconsin. In fact, the Wisconsin Department of Public Instruction (2017) reports that more than three times as many people die by suicide in Wisconsin annually than by homicide. In 2017 there were 877 suicides; which on average is one person dying of suicide every 10 hours in Wisconsin (American Foundation for Suicide Prevention, 2016). Of these deaths 13.15% are juveniles. The popularity of social media brings about a new way of bullying that on a larger platform. Cyber bullying is the cause of 10% suicides among the youth. Schools, churches and other organizations are attempting to help with

this epidemic.

Locally in Racine County, the Racine Unified School District has partnered with Racine Area School Community Alliance (RASCA) to provide critical information about suicide to students, parents and the rest of the community throughout the county in early 2016. RASCA mission is to affect positive change in the lives of young people throughout the Racine community, through supporting positive decision making, and greater parent and community awareness of key topics that affect all students to help with this issue. (Racine Unified School District). Whereas school districts, churches and other community organization are able to address juvenile suicide, there is a gap in being able to effectively address issue in youth corrections.

Youth involved in the juvenile justice and child welfare systems have a high prevalence of many risk factors for suicide (U. S. Department of Health and Human Services [HHS], 2012). Many youth in confinement have experienced physical, sexual, and emotional abuse; substance abuse; and mental disorders prior to incarceration, often resulting in self-injurious behavior (HHS, 2012).

Statement of the Problem

Each year, approximately 157,000 youth aged to 10 to 24 receive medical care for self-inflicted injuries at emergency departments across the United States (CDC, 2012). In 2004, the U.S. Justice Department's Office of Juvenile Justice and Delinquency Prevention released the National Center on Institutions and Alternatives' national survey on juvenile suicide in

confinement (Hayes, 2004), the first study of its kind. Although the number of reported suicides appears low, many juvenile justice clinicians believe the problem is underreported (Penn, Esposito, Schaeffer, Fritz, & Spirito, 2003). In addition, the placement of youth adjudicated as adults raise concern as to what effect the adult correctional environment may have on this problem.) The purpose of Juvenile Corrections is to protect the community from youths that have committed a serious offense. Offenders placed in corrections custody are from varying backgrounds, including offenders with mental health diagnosis. Mental health is link to suicide 90% of those who died from suicide have diagnosable mental disorders. Youth with mental health disorders continue to enter and remain in juvenile detention, corrections, and adult jails and prisons. Some of these youth are mildly disturbed; others have a serious mental illness. Their ability to function in a facility can be compromised by:

- Severe attention and concentration problems.
- Serious mood disorders.
- Histories of repeated trauma.
- Unusual and bizarre thinking.
- Self-destructive behavior.
- Low intellectual functioning.

- Issues related to alcohol or other drug use.
- Aggression and violence.

Youth in custody with mental health disorders are a mixed group. Within the same week, staff may work with youth who have ADHD and struggle with rigid rules and stimulating living units, youth who hear voices, those who smear their feces on walls, and those who try to take their own lives (Boesky, 2014)

The fact that the minimum qualifications for a youth worker is having a high school diploma, which means many of the workers that have the day to day contact with the offenders do not have the background to deal with mental health. The Racine Juvenile Detention Center is no different. In 2017, they had their first suicide death, but numerous attempts or suicidal ideations happen daily. High turnover, low pay and lack of experience makes dealing with suicide and mental health a challenge.

Significance of the Study

Although 79% of suicide victims die in facilities that had a written suicide prevention policy at the time of the suicide, only 10% among detention centers were in facilities that had comprehensive programming at that time. Detention facilities lack adequate suicide prevention curriculum, suggesting lack of commitment to such training. The staggering statistics of suicide not only impact individual families but also has a huge impact on the state. Suicide cost Wisconsin \$939,359,000 of combined lifetime medical and work loss cost (American Foundation for

Suicide Prevention, 2017). In addition to helping reduce the cost in the State budget, proper intervention, policies and strategies for the Racine County Juvenile Detention Center will aid in proper treatment and positive outcomes in curbing the number of suicide and suicide attempts in the facility.

Purpose of the Study

This purpose of this study is to identify resources, best practices and programs that will address suicide, suicide attempts and the mental health issues of youths housed in the Racine County Youth Detention Center.

The study will examine research policies, procedures and best practice applied when dealing with suicide attempts and suicidal ideations. Thus, providing aid to the Racine County Detention Juvenile Center personnel and families properly advocate for help with young ones and to reduce the number of suicides in juvenile facilities. And provide resources need to develop sound and comprehensive suicide prevention program and policies that will provide early identification and intervention for at-risk and suicidal youth.

Delimitations

There is a vast amount to research on youth suicides and mental health. However, there is limited amount on youth correctional facilities. This study only focuses on juveniles who are

in Racine county juvenile detention center.

Method of Approach

The author researched stats from educational periodicals on the number of suicides in the United States, Wisconsin, Racine County Juvenile Detention Center, corrections facilities, and other juvenile correction programs. Special focus will be given to studies that highlight interventions for youth correctional facilities, programs and policies.

Chapter Two: Review of Literature

Connection between Suicide and Mental Illness

Mental Illness exists frequently throughout the United States. About one in five adults suffer from a diagnosable mental illness (disorder) in a given year (SAVE, 2018).

The vast majority of people who experience a mental illness do not die by suicide. However, of those who die from suicide, more than 90 percent have a diagnosable mental disorder. People who die by suicide are frequently experiencing undiagnosed, undertreated, or untreated depression (SAMSHA, 2018).

Overall Population

- An estimated 2-15 % of persons who have been diagnosed with major depression die by suicide. Suicide risk is highest in depressed individuals who feel hopeless about the future, those who have just been discharged from the hospital, those who have a family history of suicide and those who have made a suicide attempt in the past.
- An estimated 3-20% of persons who have been diagnosed with bipolar disorder die by suicide. Hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals.
- An estimated 6-15% of persons diagnosed with schizophrenia die by suicide. Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Between 75 and 95% of these individuals are male (SAMSHA, 2018).

Also at high risk are individuals who suffer from depression at the same time as another mental illness. Specifically, the presence of substance abuse, anxiety disorders, schizophrenia and bipolar disorder put those with depression at greater risk for suicide.

People with personality disorders are approximately three times more likely to die by suicide than those without. Between 25 and 50% of these individuals also have a substance abuse disorder (SAMSA, 2018).

Incarcerated Population

Mental illness among today's inmates is also pervasive, with 64 percent of jail inmates, 54 percent of state prisoners and 45 percent of federal prisoners reporting mental health concerns, the report found. Substance abuse is also rampant and often co-occurring (American Psychological Association, 2018).

Incarcerated Youth Population

Estimates reveal that approximately 50 to 75 percent of the 2 million youth encountering the juvenile justice system meet criteria for a mental health disorder. Approximately 40 to 80 percent of incarcerated juveniles have at least one diagnosable mental health disorder (Underwood, L. A., & Washington, A. 2016).

According to the National Center on Institutions and Alternatives (2009) the prevalence of mental disorders among confined youth has been studied in several states.

A California study found that 32 percent of confined male juveniles met the criteria stress disorder and that these youths experienced increased levels of distress, anxiety, and depression while exhibiting lower levels of restraint, impulse control, and suppression of aggression (Steiner, Garcia, and Matthews, 1997). Another report by the Coalition for Juvenile Justice raised great concern about the number of mental health disorders among incarcerated youth (50 – 75 %). It is estimated that one out of every five

youth who are incarcerated has a “serious emotional disturbance.” The report states that: In one study 73 percent of youth in juvenile facilities reported mental health problems and 57 percent of those youth had previously received mental health treatment. Fifty-five percent of youth in the juvenile justice system have symptoms associated with clinical depression, 50 percent have Conduct Disorders, and up to 45 percent have Attention Deficit/Hyperactivity Disorder. One to six percent of incarcerated youth have Schizophrenia or other psychotic disorders. Up to 19 percent of youth involved in the juvenile justice system may be suicidal. At least half of the youth who have a mental illness have a co-occurring substance abuse disorder. It is believed that many of these youths use illegal substances to self-medicate for untreated mental health issues. The further report that Many youths have a dual diagnosis.

In Mississippi, a study found that at least 66 percent of confined youth met the *Diagnostic and Statistical Manual* (DSM-IV) criteria for a mental disorder, with more than half the youth suffering from multiple disorders including conduct disorder and substance abuse (Robertson and Husain, 2001).

In Maryland, some 57 percent of confined youth self-reported a prior mental health history (Shelton, 2000). In Virginia, more than 60 percent of youth admitted to the state’s juvenile reception and diagnostic center were identified with a mental health treatment need (McGarvey and Waite, 2000).

In Georgia, 61 percent of confined youth were found to have mental health disorders (Marsteller et al., 1997). In comparing rates of mental disorder for juveniles in confinement with rates for youth in the general population, the Georgia researchers found

substantially higher rates for juveniles in confinement (61 percent versus 22 percent for any disorder, 30 percent versus 11 percent for anxiety disorders, and 13 percent versus 4 percent for depression).

In Texas, researchers found that detention center youth had a high prevalence of psychiatric disorders, usually undiagnosed, and that comorbidity was common (Domalanta et al., 2003). Preliminary data from an ongoing longitudinal analysis of mental disorders among 1,830 youth confined in a county juvenile detention center in Illinois suggest that two-thirds of the youth have one or more alcohol, drug, or mental disorders, thus projecting that more than 670,000 youth processed into the juvenile justice system throughout the country each year would meet the diagnostic criteria for one or more alcohol, drug, or mental disorders (Teplin et al., 2002).

Additionally, *The Juvenile Suicide in Confinement: National Study* (2009) reports that based off the following two comprehensive reviews of the literature (Otto et al., 1992; Edens and Otto, 1997), youth in confinement have been estimated to experience the following rates of mental disorders:

- Conduct disorders (50–90 percent).
- Attention deficit disorders (up to 46 percent).
- Anxiety disorders (6–41 percent).
- Substance abuse or dependence (25–50 percent).
- Affective disorders (32–78 percent).

- Psychotic disorder (1–6 percent).
- Co-occurring mental health and substance abuse disorders (more than 50 percent).

Thus, significant rates of mental disorders, particularly conduct disorder, have been consistently reported for youth in confinement. Because DSM-IV criteria for conduct disorder include “aggressive conduct that causes or threatens physical harm to other people or animals, non-aggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rule” (American Psychiatric Association, 2000:94), the high rates of this disorder among incarcerated youth are not surprising. In conclusion, two facts appear undisputed—a high percentage of youth in the juvenile justice system have a diagnosable mental disorder, and these juveniles have higher rates of mental disorders than youth in the general population (Cocozza and Skowyra, 2000).

Youth Detentions across the United States and how they deal with Mental Health and Suicide.

To effectively treat mental health issues and suicide a detention center should have an effective screening and assessment processes, as well as varied effective treatment options. The screening should include:

1. Written policies and procedures covering all reasonably predictable aspects of a suicide prevention program (as listed below);
2. Training of staff on suicide prevention issues in general and, specifically, on the facility’s suicide prevention policies and procedures, including any skills necessary to implement the policies and procedures; and

3. Documentation of all actions associated with suicide prevention efforts;
4. Ongoing review of incidents, such as suicide attempts and suicides, and implementation of necessary changes based on such review; and
5. Ongoing supervision of personnel to ensure maximum compliance with policies and training (Drapkin, 2018).

In examining other youth detention centers and how they deal with mental health and suicide. Clark County Juvenile Court, in its own report completed in 2000, found that a small number of youth (20%) accounted for the majority of bed days used in Detention. The report revealed that these “high-end users” of Detention were very likely to be afflicted with mental and behavioral health disorders and often were diagnosed with co-occurring drug and alcohol dependence. Clark County Juvenile Justice Center has thoroughly detailed mental health, suicide prevention policies, and practices regarding mental health issues with youth in the Detention Facility. Listed below are some procedures that stood out:

- **Assessments-** All youth entering the Clark County Juvenile Detention Facility will be assessed by Detention Officers or their equivalent via the Mental Health–Detention Assessment Tool Drug and Alcohol Assessments will be completed upon request. Youth in custody who display symptoms associated with suicide or express a desire to commit suicide will receive a First Level Suicide Evaluation.
- **Crisis Services-** Youth who report that they are an imminent risk to harm them self or who are required by statute to be evaluated will be referred to the on-site psychologist or the County Designated Mental Health Professional.

The County Designated Mental Health Professional may assist to identify the level of risk the youth presents for self-harm and at what Suicide Watch Level (I, II, III, and IV) the youth should be placed. The County Designated Mental Health Professional may also recommend a treatment plan to address the youth's safety needs. Additionally, the department psychologist will monitor all youth on suicide watch. The staff psychologist will review and adjust all suicide watch levels.

- **Mental Health Triage-** Youth that are in crisis or experiencing issues related to mental health problems will be referred to the Detention facility's on – site mental health treatment program and other service providers that are specified.
- **Discharge of Youth Receiving Services-** Parents of youth who were on Suicide Watch Level 1, 2, or 3, while in Detention, will be notified via letter at discharge of their child's potential need of additional services. Each letter will contain information regarding the location of where such services can be accessed.
- **Training-** Juvenile Detention Officers will receive training on a yearly basis to increase professional competence and to insure they are able to meet the needs of a diverse Detention population. The pursuit of Detention Officers becoming trainers in a particular discipline will be emphasized. Staff will be encouraged to pursue additional training to better address detained youths' mental health needs. To include extensive coursework in Behavior Management. Suicide Prevention Training will be provided by Staff psychologists, a two hour annual training on depression, suicidal ideation, signs and symptoms of a youth that may have suicidal ideation, and how to respond to a youth exhibiting these behaviors. The

distribution and review of the Suicide Prevention Policy and Plan also occurs during these yearly meetings (Clark County, 2009).

Another facility examined was the Pima County Juvenile Detention Center in Tucson, Arizona policies and procedures for dealing with mental health and suicide. Their policy for suicide prevention and intervention also include watch levels. Here are some of the procedures that stood out:

- **Suicide Precaution-** If at any time, information is received from anyone (e.g. Probation Officer, youth, parents, law enforcement, etc.) that a youth in Detention may present a threat to self, (youth who is currently demonstrating suicidal thoughts or self-injurious behaviors) will be placed on a Crisis Watch.
- **Intervention-** the Health Services Professional will assess the youth within ten (10) minutes of the request.
- **Treatment-** If the youth has criminal allegations of such a serious nature that may require Detention; but is in need of medical and/or mental health intervention the referring agent shall be asked to transport the youth to a local community hospital for evaluation or treatment. If the referring agent refuses to take the youth to a local facility for treatment, the following actions should be taken:
 1. The referring agent's superior is to be immediately notified of the situation and asked to follow the established protocol of complying with our request.
 2. The youth may be diverted to a hospital for further evaluation and/or treatment

3. Transportation Staff or Detention Officers will transport the youth for evaluation and/or treatment (Pima County Juvenile Court Center, 2010).

Racine County Juvenile Detention Center

The Racine County Juvenile Detention Center up until recently partnered with Behavioral Health Services Mental Health Mobile Response unit when there was a suicide issue. Recent changes with policies and another company has allowed the detention center to have a Mental Health Professional on site 48 hours a week. The Mental Health Professional has a 24 hour window to evaluate a juvenile on suicide watch.

The intake process consists of a very basic screening for suicide risk as part of the routine intake health screening of each new Juvenile. Detention Center staff members shall work cooperatively with the healthcare staff to minimize the risk of Juvenile suicides. The healthcare staff will conduct follow-up screening of Juveniles for suicide risk, and may provide suggestions for proper care and supervision of Juveniles who appear to be suicide risks (Racine County Juvenile Detention Center, 2018).

If a Juvenile suicide attempt is discovered, proper intervention procedures shall be followed to try to ensure health and safety of the Juvenile involved as well as facility security.

- **Suicide Prevention-** At any time a juvenile expresses any suicidal ideation or suicide attempt you immediately place them on suicide precautions.
Complete the suicide risk screening tool
- **Intervention-** Forward a copy of the screening tool to the detention mental health email group, and follow up with a phone call they will be evaluated by a qualified mental health professional within 24 hours

- **Crisis Situation-** If a Juvenile appears to be undergoing a severe emotional crisis in which a suicide attempt seems imminent, officer or supervisor should seek help from the mental health staff (This should be done as soon as possible, but at least within 12 hours if possible).
- **Treatment-** They will stay on suicide precautions until released by the qualified mental health professional.
- **Training-** There will be annual Juvenile Detention Center staff training regarding suicide prevention and identification of the risk factors which will be documented by the training office (Racine County Juvenile Detention Center).

All actions by officers and other Detention Center staff members regarding suicide prevention shall be fully documented. A Juvenile who has been classified on suicide watch status may only be removed from such status by the recommendation of the healthcare mental health staff. All Juvenile suicides and designated suicide attempts shall be reported to the state Office of Detention Facilities staff, in accordance with provisions of Administrative Code under DOC 346. The training is done annually for staff about suicide prevention and documented (RCJD, 2018).

Chapter Three: Conclusion and Recommendations

Suicide prevention within a juvenile detention center must be a collaboration amongst all staff and made a priority. According to the national correctional standards and practices (as reported in Hayes, 2014) , all juvenile facilities, regardless of size and type, should have a detailed written suicide prevention policy that addresses each of the following critical components (Council of Juvenile Correctional Administrators, 2003; Hayes, 1999, 2000; National Commission on Correctional Health Care, 1999, 2004; Roush, 1996):

- **Training.** All facility, medical, and mental health staff should receive 8 hours of initial suicide prevention training, followed by a minimum of 2 hours of annual refresher training. Training should provide information about predisposing factors, high-risk periods, warning signs and symptoms, identifying suicidal behavior despite the denial of risk, and components of the facility's suicide prevention policy.
- **Identification/screening.** Intake screening for suicide risk should take place immediately upon confinement and prior to housing assignment and include inquiry regarding current and past suicidal behavior, earlier mental health treatment, recent significant loss, suicidal behavior by a family member or close friend, suicide risk during prior contact with or confinement in agency, and arresting or transporting officers' opinion whether youth is currently at risk. The policy should include procedures for referral to mental health personnel for further assessment.¹⁹
- **Communication.** At a minimum, facility procedures should enhance communication among facility staff (including medical and mental health personnel) and the arresting/transporting officer(s), family members, and suicidal youth.

- **Housing.** Excessive and unjustified isolation should be avoided. Whenever possible, suicidal youth should be housed in the general population, mental health unit, or infirmary, in close proximity to staff. Youth should be housed in suicide-resistant, protrusion-free rooms. Removal of clothing (excluding belts and shoelaces) and use of restraints should be avoided when possible, and should only be used for short periods of time when the youth is engaging in self-destructive behavior.
- **Levels of supervision.** Two levels are normally recommended for suicidal youth:
 - Close observation—reserved for youth who are not actively suicidal, but express suicidal ideation and/or have recent histories of self-destructive behavior and are now viewed as potentially suicidal—requires supervision at staggered intervals not to exceed every 15 minutes. In addition, a youth who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed on close observation.
 - Constant observation—reserved for youth who are actively suicidal (threatening/engaging in the act)—requires supervision on a continuous, uninterrupted basis.

In addition, an intermediate level of supervision can be used with observation at staggered intervals not to exceed every 5 minutes. Other supervision aides (e.g., closed-circuit television, companions or watchers) can be used as a supplement to, but not as a substitute for, these observation levels.

- **Intervention.** A facility's policy regarding intervention should be threefold:
 - All staff should be trained in standard first aid and cardiopulmonary resuscitation (CPR).
 - Any staff member who discovers a youth attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures.
 - Staff should never presume that the youth is dead, but rather initiate and continue appropriate life-saving measures until relieved by medical personnel.

All housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material).

- **Reporting.** In the event of an attempted or completed suicide, all appropriate facility officials should be notified through the chain of command. All staff who came in contact with the victim before the incident (or in responding to the incident) should submit a statement as to their full knowledge of the youth and the incident.
- **Follow-up/mortality review.** All staff (and youth) involved in the incident should be offered critical incident stress debriefing. If resources permit, a psychological autopsy is recommended. Every completed suicide and serious suicide attempt (i.e., requiring hospitalization) should be examined by a review process. Ideally, the review should be coordinated by an outside agency or facility to ensure impartiality. The mortality review, separate and apart from other formal investigations that may be required to determine the cause of death, should be multidisciplinary (i.e., involve correctional, mental health, and medical personnel) and include a critical inquiry of the following:
 - 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.
- Recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

Youth involved in the juvenile justice and child welfare systems have a high prevalence of many risk factors for suicide (U. S. Department of Health and Human Services [HHS], 2012). Many youth in confinement have experienced physical, sexual, and emotional abuse; substance abuse; and mental disorders prior to incarceration, often resulting in self-injurious behavior (HHS, 2012). Detention and confinement facilities should maintain comprehensive suicide prevention policies and programming that attempt to circumvent suicide attempts (Hayes, 2010).

To increase the effectiveness of suicide prevention Racine County Juvenile Detention Center must acknowledge that mental health is growing within the incarcerated population. Juveniles need to be appropriately assessed and diagnosed so that the proper treatment and services can be provided. Racine County Juvenile Detention Center should consider revising their Suicide Watch policies to include watch levels ranging from 1 to 5, having an on duty psychologist as well as Mental Health Professionals who respond to juveniles in an hour or less even in crisis situations while on duty. The Detention center should offer information and services during discharge to parents for juveniles who attempted suicide while in the facility. Finally, annual staff training needs to include training on mental health needs of youth.

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