

## Chapter 5: Order and Safety

This chapter covers three important dimensions of order and safety within juvenile facilities. Section A is about security—that is, preventing escapes, preventing the introduction of contraband, and providing a safe environment for confined juveniles. Section B discusses the control of suicidal behavior. Section C concerns sanitation, fire and life safety issues, and provision of emergency power.

### A. Security

Section A examines three assessment criteria: whether the facility has three or more counts per day; whether risk-based classification is used to make housing assignments; and whether facilities meet minimum supervision staff ratios. It describes the elements considered in facility classification practices and the decisions that are based on classification results. The section also describes supervision staff turnover rates. Section A also describes other facility security practices and procedures, such as perimeter fences or walls, locked doors, and perimeter checks. It examines the relationship between conformance to assessment criteria and two outcome measures: injury rates (both juvenile-on-juvenile and juvenile-on-staff) and escape rates (both attempted and successful). Finally, it examines relationships between other variables (such as supervision staff ratios and turnover rates) and these outcome measures.

Effective security should limit the number of successful escapes and walkaways, protect juveniles from harming each other, and provide a stable environment for programming and other services. Facilities achieve security by a mixture of staff surveillance, hardware (such as locked doors), physical plant controls (such as perimeter fences), resident classification procedures, and resident counts. The particular mix of security strategies used in any facility depends on the administrative philosophy, the characteristics of the physical plant, available staff, financial resources, and the type of youth in custody.

National standards express a preference for relying on staff rather than on hardware to provide security<sup>1</sup> and in general require facilities to adopt the least restrictive security alternative consistent with safety and restriction of escapes.<sup>2</sup> This reflects a general concern for normalization—that is, for minimizing institutionalization in the juvenile correctional environment.<sup>3</sup> Security processes, equipment, and procedures conflict with the ideal of a normalized environment for youth. The principle of the least restrictive alternative attempts to balance the conflict between security and normalization—that juveniles will be "restricted only to the degree necessary to carry out the purpose of the court's order."

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<sup>1</sup> For example, the Institute of Judicial Administration/American Bar Association (IJA/ABA) Standards, *Architecture of Facilities* Volume, Standard 2.4, p. 25, states, "Secure settings should provide security measures which (a) instill a sense of well-being in facility residents; and (b) rely on increased staff coverage rather than building plant."

<sup>2</sup> National standards advocate the "least restrictive alternative" as a guiding principle for juvenile corrections. IJA/ABA Corrections Administration, Standard 1.2B, p. 46; see also ACA, Standards for Juvenile Detention Facilities, Introduction, p. xv; NAC Standard 3.152 "Juveniles...should not be detained in a secure facility unless (e) there is no less restrictive alternative that will reduce the risk of flight, or of serious harm to property or to the physical safety of the juvenile or others," p. 297.

<sup>3</sup> IJA/ABA Standards, *Architecture of Facilities* Volume, Standard 2.1: "Facilities for the juvenile justice system should be designed with the objective of creating environments which will encourage normalization," pp. 22–23.

This section explores differences in security among juvenile correctional facilities. We organize the discussion of security around conformance to three assessment criteria involving: (a) the number of daily facility-wide counts, (b) classification and separation of juveniles, and (c) supervision staffing levels.

**Counts.** Counts are a basic control procedure in correctional settings, ensuring that proper numbers of juveniles are in each location or unit and within the facility perimeter. Counts notify administrators of missing youth, which could indicate an attempted escape or an injury. The ACA recommends counts of all juveniles at least once per shift.<sup>4</sup> A count is defined as a major institutional tally of all youth in custody in which the results are gathered in one central location. In small facilities, a single individual might do a formal institutional count. In larger facilities, counts typically are conducted at each unit, and results are phoned to a central administrative post. Facilities conform with the assessment criteria if they conduct three or more counts per day. However, many institutions conduct informal counts throughout the day: during meals, before and after movements between buildings, and at random times during the evening. These informal counts on the unit level are not included in our conformance measure.

**Classification and separation.** Classification and separation are two interrelated procedures used to manage correctional facility populations. These processes provide the foundation on which both adult and juvenile facilities effectively control a wide variety of offenders, including the most troublesome and disruptive. By making it possible to separate disruptive from nondisruptive residents, effective classification protects the personal safety of both juveniles and facility staff. Classification also can be used to place juveniles in the "least restrictive alternative," with no more surveillance or control than necessary.

Administrators in detention centers are faced with a wide range of offenders, and they must have adequate classification policies and separation areas at their disposal. Often classification is difficult, for little information is available about recently admitted youth. Classification must be completed quickly (during admission or shortly thereafter), for the length of stay is often short.

Classification reoccurs if a youth is committed to a postdispositional facility. Some large systems have separate reception centers which perform classification to determine the proper facility placement for juveniles. In States without separate reception centers, classification is usually performed in separate orientation units at training schools.

There are two major factors involved in the issue of juvenile classification. The first is the importance of classifying on the basis of useful criteria. For example, separation of adults from juveniles is a well-established principle, codified in the Juvenile Justice and Delinquency Prevention Act. The Supreme Court has ruled that separation of violent offenders from nonviolent offenders is mandatory to assure the personal safety of inmates (*Smith v. Wade*). Other factors considered in separating different

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<sup>4</sup> ACA, *Standards for Juvenile Detention Centers*, Standard 8189, "There should be at least one juvenile count per shift, and a count at night lockup," p. 52.

juvenile residents include offense history, maturity and age level, gender,<sup>5</sup> medical status, and gang membership.<sup>6</sup>

The second requirement of a good classification and separation system is that facility resources are available to implement classification policies. Classification screening criteria and procedures are not effective if incoming juveniles are placed in the first available open bed no matter where it is located.

A facility conforms to our assessment criteria if it (a) had a written classification plan or procedure; (b) classified juveniles using at least one of four dimensions of risk: escape risk, danger to self, danger to others, or offense history; and (c) used classification results to make decisions about housing.<sup>7</sup>

**Supervision staff.** National standards prefer security based on staff rather than hardware.<sup>8</sup> Practitioners and site visitors report that administrators and staff perceive that declining staff ratios can lead to numerous facility difficulties: increased assaults on staff and youth, greater use of punitive sanctions and lockdown by staff, and increased gang activity.

Researchers have tried to determine the effect of understaffing on the facility's safety level and disciplinary techniques. Carbone and Lynch (1981) found that a decrease in the staff-to-juvenile ratio led to greater reliance on punitive measures and harsher disciplinary actions. Declining staffing ratios also lead to increased pressure on staff: more overtime, more staff burnout and turnover, greater recruitment difficulties, and increased training needs and costs.

Staff charged with primary responsibility for maintaining order and security are given a variety of titles: youth supervision staff, group care workers, youth care workers, youth counselors, and security staff. Recognized national standards say only that training schools should have "sufficient" supervision

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<sup>5</sup> Site visits documented that separation by gender is often an administrative challenge, particularly in small- and medium-sized facilities. Where sleeping rooms are single and lockable, little difficulty is presented since separation is accomplished by room. In some facilities with dormitory housing, the need for gender separation puts crowding pressures on units housing males (particularly older and more mature males), while open beds exist in female units. In other facilities, there may be only one female unit where females of all ages and offense types are mixed together.

<sup>6</sup> In some areas of the country, youth gangs present a management problem in juvenile facilities. During site visits, administrators offered different solutions to classification by gang membership. While it is standard practice not to allow leaders and members of the same gang to live together, some facilities separate rival gang members into different units, while others place them in the same living units, striking a numerical balance to maintain safety and attempting to establish an understanding between the different factions.

<sup>7</sup> ACA standards relating to classification mandate that a facility have a written classification plan which considers the level of risk and type of housing required (see Appendix A for details).

<sup>8</sup> IJA/ABA, *Architecture of Facilities*, Standard 2.4; see also NAC Standard 4.21 *Training Schools* (Discussion), "It should be emphasized, however, that in high security units, as well as in training schools themselves, intensive staffing should be preferred over physical barriers and mechanical devices as the way for providing for the safety of the community, residents, and staff," p. 378.

staff.<sup>9</sup> However, the discussion section of ACA standards for detention centers defines specific supervision staffing ratios: 1 staff member to 8 youth during daytime shifts, and 1 to 16 at night.<sup>10</sup> For comparison purposes, this was used to develop assessment criteria for all facility types.

Security staffing ratios are computed using data from the 1991 CIC census. Because security staff must provide coverage 24 hours a day, 7 days a week, facilities use shifts to rotate coverage. While most use three shifts per day, others use other patterns, such as 24-hour days on duty followed by 2 days off or other methods of coverage. Whatever method is used, facilities need more staff than are on duty at any one time to provide coverage for time off. When other factors such as vacation time, sick time, disability leave, training time, and other types of leaves are considered, the number of staff necessary to fill a 24-hour position multiplies. Due to these coverage needs, the ratio of staff to juveniles is not determined merely by dividing the number of staff by the number of youth. It is estimated that 5.2 persons are required to cover one security staff position 24 hours a day, 7 days a week.<sup>11</sup> Thus, the ratio is calculated by taking the total number of security staff positions, dividing by 5.2, and dividing that figure by the number of juveniles in custody.

The CIC census does not break staffing numbers down by shift, so an average ratio was computed based on two daytime shifts staffed at a 1:8 ratio and one evening shift staffed at a 1:16 ratio. This produces an average staffing ratio of 1 staff member to 10.6 juveniles, which is the level defined for our assessment criteria.

Table 5A-1 shows the percentage of juveniles in facilities that conform to each of these three assessment criteria. Relatively few juveniles are in facilities other than ranches that do not undertake three or more counts per day. Juveniles in training schools and especially ranches are often in facilities that do not meet our criteria for classification. Substandard security staffing ratios are widespread.

The remainder of this section is divided into three parts. First, we review conformance with each of the three assessment criteria in more detail. Following this, we discuss a number of other security features and practices. Finally, we examine the incidence of escapes and juvenile violence and discuss the extent to which conformance with assessment criteria or other practices appear to affect them.

### **Further Discussion of Assessment Criteria**

**Counts.** As shown in Table 5A-1, below, 81 percent of juveniles are in facilities that conform to the count criterion. All four facility types include some facilities where there are no formal counts; overall, 12 percent of confined juveniles are held in facilities that do not conduct any formal counts (data not shown). Juveniles in ranches are far more likely to be in facilities that do not conform to the count criteria, and in facilities that never conduct formal counts. Rather than conducting formal institutional counts, these less-secure facilities rely on frequent, informal head counts to ensure that juveniles have not escaped.

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<sup>9</sup> ACA, *Standards for Juvenile Training Schools*, Standard 9173, "There is sufficient staff to ensure the appropriate supervision of juveniles at all times," p. 47.

<sup>10</sup> ACA *Standards for Juvenile Detention Centers*, Standard 8186 (Discussion), p. 51.

<sup>11</sup> The number 5.2 is derived from extended communication with practitioners and accrediting agencies, including personal communication with Lloyd Mixdorf, Director of Juvenile Justice Projects, American Correctional Association.

**Table 5A-1**

**Percent of Juveniles in Facilities That Conform to Security Assessment Criteria,  
by Facility Type\***

<b>Percent of Juveniles in Facilities that</b>	<b>Detention Centers</b>	<b>Reception Centers</b>	<b>Training Schools</b>	<b>Ranches</b>	<b>Total</b>
	<b>N=19,579 -19,957</b>	<b>N=2,348 -2,618</b>	<b>N=33,616 -34,624</b>	<b>N=5,741 -7,096</b>	<b>N=61,285 -64,236</b>
<b>Conform to count criteria<sup>a</sup></b>	<b>86%</b>	<b>96%</b>	<b>81%</b>	<b>63%</b>	<b>81%</b>
<b>Conform to classification criteria<sup>b</sup></b>	<b>77%</b>	<b>70%</b>	<b>59%</b>	<b>28%</b>	<b>62%</b>
<b>Conform to supervision staff ratio criteria<sup>c</sup></b>	<b>52%</b>	<b>19%</b>	<b>31%</b>	<b>16%</b>	<b>36%</b>
Percent of juveniles in facilities that conform to all criteria	32%	14%	16%	2%	20%
Conform to two criteria	51%	66%	50%	26%	49%
Conform to one criterion	16%	19%	26%	58%	25%
Conform to none of the criteria	1%	1%	8%	14%	6%

Source: CIC Census and Mail Survey, 1991

<sup>a</sup> For information on the percent of facilities that conform, see Appendix E, Table E-14.

<sup>b</sup> For information on the percent of facilities that conform, see Appendix E, Table E-15.

<sup>c</sup> For information on the percent of facilities that conform, see Appendix E, Table E-16.

\*Note: Throughout the report, the number of juveniles on whom the tables are based vary due to missing responses to individual questions. (No attempt was made to adjust for nonresponse.)

Conformance with the formal count criterion varies by size, as well as by facility type. Overall, juveniles in larger facilities are more likely to be confined in facilities that conform to the formal count criteria (data not shown). Regardless of facility type, facilities with 20 or fewer juveniles are least likely to conform to this criteria, and facilities with more than 150 juveniles are most likely to conform.

**Classification.** Sixty-two percent of confined youth are housed in facilities that conform to the classification criterion. Ranches have the lowest rate of juveniles in facilities which conform (28 percent),

again reflecting the less-secure nature of those programs. Predictably, the highest rates of conformance occur in detention centers and reception centers—facilities whose mission is secure, short-term detention.

Larger facilities are more likely to conform than smaller facilities. One site visitor observed that proper classification and separation procedures could make even a very large facility seem small, by using the living unit as the architectural and organizational focal point of the facility, thereby breaking down the population into smaller and more manageable groups.

The conformance criterion for classification reflected in Table 5A-1 is based on the combination of a classification plan, classification based on risk, and the use of classification in assigning housing. Classification is carried out for other purposes as well.

The criteria most commonly used to classify juveniles are shown in Table 5A-2. Although 48 percent of juveniles are in facilities that do not meet our classification assessment criterion, only 21 percent are in facilities with no form of classification. Three of the risk factors involved in our assessment criteria (escape, danger to staff, and danger to others) are commonly used in classification. Other frequently used factors include special needs (for example, physical or emotional disabilities), age, and gender.

**Table 5A-2**  
**Percent of Juveniles in Facilities**  
**That Use Recommended and Other Factors to Classify Juveniles,**  
**by Facility Type**

Classification Factors:	Detention Centers N=19,957	Reception Centers N=2,618	Training Schools N=34,624	Ranches N=7,037	Total N=64,236
No Classification	16%	14%	22%	38%	21%
Risk of escape	74%	81%	63%	45%	65%
Danger to self	78%	80%	64%	50%	68%
Danger to others	78%	84%	69%	51%	71%
Special needs	72%	80%	70%	58%	70%
Age	75%	76%	57%	55%	63%
Gender	73%	69%	31%	36%	46%
Other factors	21%	7%	14%	10%	15%

Source: Mail Survey, 1991

Facilities use classification for other purposes than housing. As shown in Table 5A-3, for example, outside of reception centers, classification is more often used for programming decisions than for custody-level decisions.

**Table 5A-3**

**Percent of Juveniles in Facilities That Use Classification for Custody Level and Programming, by Facility Type**

Types of Decisions	Detention Centers N=15,347	Reception Centers N=1,834	Training Schools N=20,549	Ranches N=2,002	Total N=39,733
Custody level	57%	62%	66%	51%	62%
Programming	58%	58%	94%	80%	78%

Source: Mail Survey, 1991

Accurate classification may be especially difficult in detention centers. Detention centers often have minimal information about newly admitted juveniles. Short average durations of stay cause rapid turnover of detention center populations and do not allow time to obtain information about juveniles that is as detailed as that of reception centers. Single-occupancy sleeping rooms may reduce the dangers to juveniles associated with inaccurate classification. Thus, ACA standards require that in detention centers no more than 20 percent of the population should be housed in multiple-occupancy rooms.

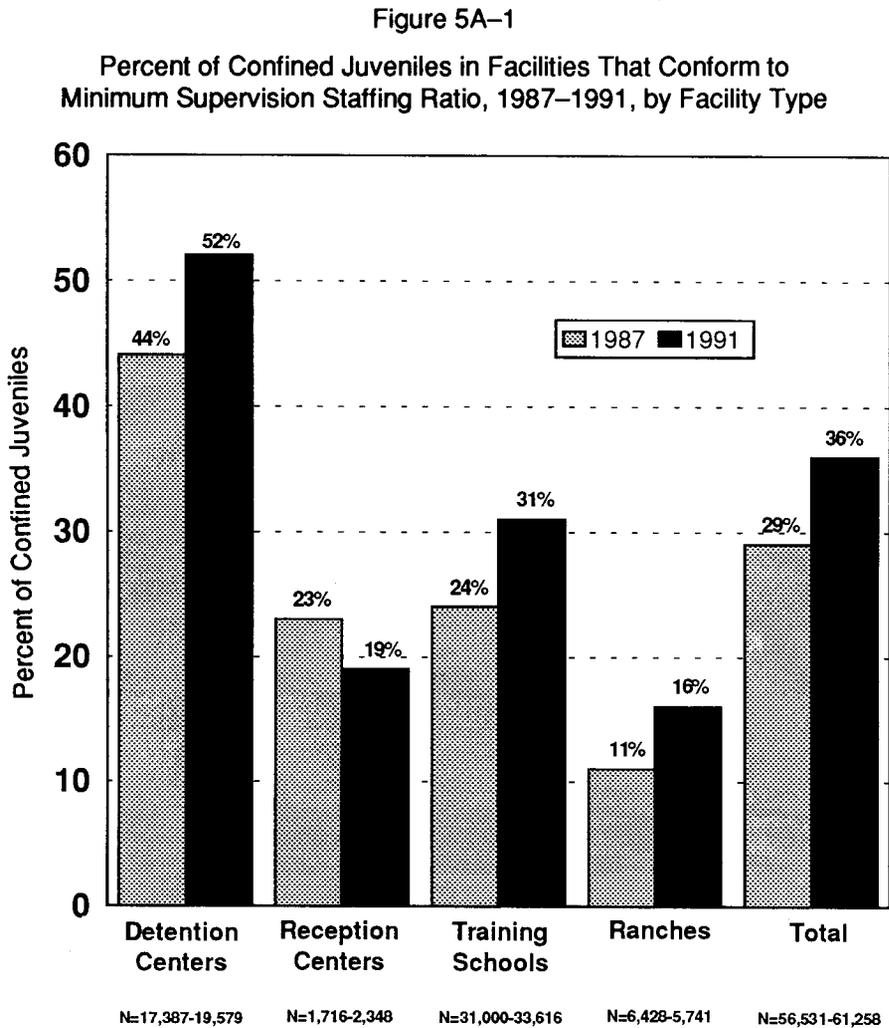
Forty-two percent of juveniles in detention centers are confined in facilities in which more than 20 percent of the population sleep in multiple-occupancy rooms. Altogether, almost one-fourth of the juveniles confined in detention centers sleep in multiple-occupancy rooms. Smaller detention centers are less likely to have more than 20 percent of their population in multiple-occupancy rooms than are larger detention centers. Twenty-three percent of all juveniles in detention centers, however, are in facilities that house 60 percent or more of their population in multiple-occupancy sleeping rooms, and 5 percent of all juveniles in detention centers are in facilities that house their entire populations in multiple-occupancy sleeping rooms (data not shown).

**Staffing.** As shown in Table 5A-1, above, only 36 percent of juveniles are held in facilities which conform to the security staff ratio criteria. Fifty-two percent of juveniles in detention centers are held in conforming facilities, compared to 31 percent in training schools, 19 percent in reception centers, and 16 percent in ranches.

National standards are not unanimous in what constitutes adequate supervision staffing ratios. NAC sets a less rigorous standard for training schools than ACA: calling for 1 staff member for every 10 juveniles during waking hours and 1 for every 20 juveniles during sleeping hours for an average

staffing ratio of 1:12.<sup>12</sup> However, even with this relaxed standard, conformance rates are low. Only 54 percent of juveniles are held in facilities which meet the NAC standard of 1:12. Seventy-five percent of youth held in detention centers meet the NAC standard. As with the previous supervision staff criteria, other facility types, especially ranches and reception centers, have much lower conformance rates (data not shown).

Conformance to the staffing ratio criterion improved between 1987 and 1991 for all facilities but reception centers (Figure 5A-1). From 1987 to 1991, the percentage of juveniles in facilities conforming



Source: CIC Census, 1987, 1991

<sup>12</sup> NAC, Standard for Training Schools, *Staff Size*, Standard 4.2121: "e. One (1) youth-care worker on duty per 10 juveniles during waking hours; f. One (1) youth-care worker on duty per 20 juveniles during normal sleeping periods," p. 384.

with supervision staffing ratio criteria increased by 8 percentage points for detention centers, by 7 percentage points in training schools, and by 5 percentage points for ranches, but fell by 4 points for reception centers.<sup>13</sup>

We also examined turnover rates for supervision staff (Table 5A-4). We estimated turnover rates by dividing the number of supervision staff who had left their positions within the last year by the total number of supervision staff.<sup>14</sup>

**Table 5A-4**  
**Supervision Staff Turnover Rates in Juvenile Facilities,**  
**by Facility Type**

	Detention Centers N=18,492	Reception Centers N=2,326	Training Schools N=32,268	Ranches N=5,758	Total N=58,844
Turnover rate for average confined juvenile	14%	12%	18%	18%	16%
% juveniles in facilities with zero turnover rate, prior 12 months	24%	31%	13%	33%	19%
Range of turnover rates	0-83%	0-50%	0-90%	0-86%	0-90%

Source: CIC Census and Mail Survey, 1991

<sup>13</sup> Recent events, however, may have reversed this pattern of general improvement in supervision staff ratios since 1987. The results reported for 1991 in Table 5A-12 and in the assessment criteria reported in Table 5A-1 are based on data reported on the CIC census and reflect both facility populations and staffing levels on February 15, 1991. During the subsequent site visits (conducted between September 1991 and January 1992) we found that several jurisdictions had suffered staffing reductions since February linked to State revenue shortfalls. One State juvenile justice agency declined to participate in site visits because their funding had just been cut by 35 percent, and they were engaged in emergency planning to close selected facilities and pare staffing levels. In July 1992 we learned that additional jurisdictions had their funding cut after the site visits concluded and that some which had sustained earlier funding cuts had later experienced a second round of even deeper cuts.

<sup>14</sup>This included those who left for any reason, including leaving the employment of the facility and agency, as well as those who transferred to different positions within the facility or agency. We included the latter because positions left vacant must, nonetheless, be filled and new staff trained.

On average, juveniles were confined in facilities with an annual supervision staff turnover rate of 16 percent (about one out of every six staff members). Average turnover rates were somewhat higher in training schools and ranches than in detention and reception centers.

There is a very wide range in supervision staff turnover rates. Almost one-fifth of confined juveniles are in facilities that had no turnover in 1990. On the other hand, a few facilities had very high turnover rates. In detention centers, for example, 5 percent of juveniles are confined in facilities whose turnover rates were 50 percent or higher. The highest reported turnover rate in a detention center was 83 percent. In training schools, 5 percent of the juveniles are held in facilities with turnover rates of 43 percent or higher, and the highest reported turnover rate was 90 percent. In ranches, 4 percent of the juveniles are held in facilities with turnover rates of 67 percent or higher, and the highest turnover rate was 86 percent.

We also examined the relationship between supervision staff turnover rates and conformance to the assessment criterion on supervision staffing ratios. As expected, we found that detention centers and training schools that conform to the staffing ratio criterion have lower turnover rates (significant at the .05 level). In ranches, conforming facilities have lower turnover rates, but the difference is not statistically significant. Unexpectedly, conforming reception centers actually have higher turnover rates (significant at the .05 level).

### **Other Security Practices and Procedures**

Facilities may adopt a number of other practices or features to maintain internal and external security. As noted above, recognized national standards prefer to provide security and control by relying on staffing levels and staffing activity, rather than relying on hardware and facility design. Nonetheless, security hardware—fences, walls, locks, and surveillance equipment—is an important and growing feature of secure juvenile facilities.

**Facility Hardware Features.** Juvenile detention and correctional facilities typically do not have the elaborate security hardware that often characterizes adult jails and prisons. Their investment in such equipment is nonetheless substantial, particularly in larger facilities and in urban areas. Table 5A-5 shows that 47 percent of juveniles are housed in facilities with a perimeter wall or fence. There is a substantial difference in the use of perimeter walls between facilities that hold juveniles before assessment (detention and reception centers) and those that hold them after assessment (training schools and ranches). Reception centers (77 percent) and detention centers (62 percent) hold a greater relative percentage of youth behind fences than do training schools (44 percent) and ranches (13 percent).

**Table 5A-5**

**Percent of Juveniles in Facilities With Selected Security Features,  
by Facility Type**

Security Features:	Detention Centers N=19,963- 20,073	Reception Centers N=2,618	Training Schools N=34,643- 35,102	Ranches N=6,860- 7,180	Total N=64,084- 64,874
Perimeter wall or fence:	62%	77%	44%	13%	47%
12 feet or more	52%	68%	31%	7%	37%
Barbed wire	19%	67%	29%	3%	25%
Climb resistant mesh	31%	69%	33%	5%	31%
Surveillance Cameras:	82%	76%	44%	26%	55%
At entrances and exits	72%	66%	24%	8%	39%
In living units	61%	70%	34%	19%	42%
In program areas	41%	36%	22%	2%	26%
In recreation areas	50%	61%	10%	3%	24%

Source: Mail Survey, 1991

Fifty-five percent of juveniles are held in facilities that utilize surveillance cameras. Although the percentage of juveniles held in facilities with video equipment is similar across facility types, when cameras are installed, detention and reception centers use them in a greater number of areas. Observation towers, a widely recognized symbol of both maximum- and medium-security adult prisons, are only located in four training schools and one detention center, housing 1 percent of confined juveniles.

Practitioners on our advisory panel suggested that juvenile facilities have been using more security hardware in recent years. To test this observation, we compared data collected from the 1987 CIC census with comparable data collected as part of this project's 1991 mail survey (Table 5A-6).

**Table 5A-6**

**Percent of Juveniles Confined in Facilities  
With Walls and Surveillance Cameras,  
by Facility Type,  
1987 and 1991**

		Percent of Juveniles in Facilities With Walls*	Percent of Juveniles in Public Facilities With Surveillance Cameras
Detention Centers	1987 N=16,146-16,543	54%	62%
	1991 N=19,664-20,858	62%	82%
Reception Centers	1987 N=1,437-1,829	57%	57%
	1991 N=2,317-2,696	81%	86%
Training Schools	1987 N=26,076-32,804	38%	39%
	1991 N=27,374-34,755	44%	50%
Ranches	1987 N=4,516-10,687	11%	6%
	1991 N=3,663-7,407	13%	36%
Total	1987 N=48,175-61,863	38%	47%
	1991 N=53,018-65,015	47%	62%

Source: 1991 Mail Survey and 1987 CIC Census

\* Data on surveillance cameras were not collected from private facilities on the 1987 CIC Census.

The use of walls or fences and video surveillance equipment increased in all types of facilities between 1987 and 1991. Use of video surveillance equipment has increased more than use of walls or fences.

**Locks and Doors.** Locks on sleeping rooms and living units function as both perimeter and internal security. Keeping juveniles locked in their sleeping rooms and units not only prevents escape but also maintains classification and separation schemes, protecting youth from one another. As shown in Table 5A-7, facilities vary greatly in their use of locked doors. Overall, 64 percent of juveniles are locked inside their sleeping rooms during the night. Of the four facility types, detention centers are much more likely to lock juveniles in their sleeping rooms at night (96 percent); juveniles in ranches are the least likely to be locked in their sleeping rooms at night (10 percent). Thirty-four percent of juveniles either have no doors on their sleeping rooms, no locks on their doors, or doors to their sleeping rooms are never locked. The percentage of juveniles whose rooms are never locked ranges widely by facility type—from 2 percent of youth in detention centers to 86 percent of the ranch population—consistent with their differing missions and security levels.

**Table 5A-7**

**Percent of Juveniles in Facilities That Lock Doors to Sleeping Rooms and Living Units, by Facility Type**

	Detention Centers	Reception Centers	Training Schools	Ranches	Total
Lock doors to sleeping rooms	N=20,058	N=2,618	N=33,183	N=7,180	N=63,039
Never	2%	26%	43%	86%	34%
During day	2%	0%	3%	4%	3%
Only at night	47%	45%	31%	4%	34%
24 hours/day	49%	30%	23%	6%	30%
Lock doors to living units	N=19,930	N=2,618	N=34,618	N=7,157	N=64,324
Never	7%	3%	22%	65%	21%
During day	1%	0%	4%	7%	3%
Only at night	3%	13%	22%	22%	16%
24 Hours/day	89%	83%	52%	6%	60%

Source: Mail Survey, 1991

A similar pattern holds for the locking living unit doors. Over one-half of juveniles in ranches do not have their doors to living units locked, compared to only 7 percent of juveniles in detention centers. At the other extreme, 89 percent of juveniles in detention centers have their living unit doors locked 24 hours a day, compared to 6 percent of juveniles in ranches.

**Perimeter Checks.** In addition to hardware, staff procedures are an important element of perimeter security. We already have dealt with counts as part of our assessment criteria. Facility perimeter checks by staff are used to monitor the stability of perimeter barriers to ensure that juveniles are not attempting to escape and that there are no attempts by the community to compromise perimeter boundaries. Perimeter checks are a common security precaution, conducted in facilities housing 83 percent of juveniles (Table 5A-8). In some locations, staff use perimeter checks not only to keep residents in but also to keep nonresidents out. On site visits, more than one detention center reported instances in which gang affiliates broke into the facility to assist an escape. In other cases, friends or gang affiliates of confined youth tossed drugs onto facility grounds to be retrieved by confined juveniles.

**Table 5A-8**

**Percent of Juveniles in Facilities With Perimeter Checks,  
by Facility Type**

	Detention Centers N=19,962	Reception Centers N=2,618	Training Schools N=34,871	Ranches N=7,042	Total N=64,493
Percent of juveniles in facilities reporting perimeter checks	87%	91%	84%	60%	83%

Source: Mail Survey, 1991

Ninety-one percent of juveniles in reception centers, 87 percent of those in detention centers, and 84 percent of those in training schools are in facilities that conduct perimeter checks. Ranches show a much lower rate of perimeter check usage, reflecting the less secure nature of those facilities. Overall, there was little change in the use of perimeter checks between 1987 and 1991 in public facilities, probably because perimeter checks already were highly prevalent in 1987 (Table 5A-9).

**Table 5A-9**

**Percent of Juveniles in Public Facilities Performing Perimeter Checks,  
by Facility Type, 1987 and 1991**

Year	Detention Centers N=16,146- 19,582	Reception Centers N=1,437- 2,317	Training Schools N=26,076- 27,235	Ranches N=3,663- 4,516	Total N=48,175- 52,797
1987	85%	96%	88%	80%	87%
1991	88%	92%	89%	82%	88%

Source: Mail Survey and CIC Census, 1991

## Escapes and Injury

We collected information on attempted and actual escapes and on injuries inflicted by juveniles on other juveniles and staff. Examination of this information shows the importance of security conditions.

**Escapes.** For each facility, we calculated rates of escapes and attempted escapes by dividing the reported number of escapes and attempted escapes during the last 30 days by the facility's population on the date of the survey. Table 5A-10 displays average rates of unsuccessful attempted escapes and successful escapes by facility type. On average, about 2.5 of every 100 confined juveniles attempted to escape or successfully escaped in the 30 days before the mail survey. Staff foiled about one of every two escape attempts. Ranches have the highest rate of both attempted and actual escapes, followed by training schools. These rates are substantially lower for detention centers and reception centers, which are generally more secure facilities.

**Table 5A-10**

**Attempted and Successful Escape Rates per 100 Juveniles  
and Totals Over Last 30 Days, by Facility Type**

	Detention Centers N=19,852- 19,938	Reception Centers N=2,598	Training Schools N=34,276- 34,419	Ranches N=6,968- 7,152	Total N=63,779- 64,021
Unsuccessful attempted escape rate per 100 juveniles	.82	.63	1.39	1.94	1.24
Total attempted escapes <sup>a</sup>	169	16	478	150	814
Escape rate per 100 juveniles	.54	.68	1.33	2.83	1.22
Total successful escapes	108	18	454	226	806

Source: Mail Survey, 1991

<sup>a</sup> Excludes successful escapes.

Many facilities rely on fences or walls to prevent escape. Table 5A-11 shows, by facility type, how escape rates are affected by the presence of a wall or fence. Both attempted and successful escape rates are markedly lower in facilities with fences or walls. However, only training schools demonstrate a significant difference in attempted and successful escapes in facilities that are equipped with a wall or fence. In the regression analysis of escape rates in Chapter 8, no association is found between the escape

rate and having a wall or fence. We can neither conclusively assert a deterrent effect nor conclude that there is no deterrent effect.

Table 5A-12 shows how attempted and actual escape rates are affected by conformance to the count criterion, which requires three or more counts daily. Conformance to the count criterion is associated with lower rates of escape and attempted escapes in all facility types. Differences are significant only for attempted escapes in training schools and ranches. As with fences or walls, the regression analysis of Chapter 8 yields a large negative estimated effect for counts but also a large standard error, so the result is inconclusive.

The regressions presented in Chapter 8 indicate that facilities with 24-hour-a-day locked living units have significantly lower escape rates. As expected, the tradeoff between normalization and prison-like practices that offer greater security is higher escape rates.

**Table 5A-11**

**Attempted and Successful Escape Rates Over Last 30 Days,  
by Presence of Wall or Fence and by Facility Type<sup>a</sup>**

	Detention Centers		Training Schools		Ranches	
	No Wall or Fence N=7,407 -7,535	Wall or Fence N=12,402 -12,444	No Wall or Fence N=19,242 -19,280	Wall or Fence N=15,034 -15,140	No Wall or Fence N=6,015 -6,199	Wall or Fence N=953
Unsuccessful attempted escape rate per 100 juveniles	1.33	.51	2.10	.49*	2.11	.87
Escape rate per 100 juveniles	.87	.34	2.20	.21*	3.07	1.31

Source: Mail Survey, 1991

\*  $p \leq .05$

<sup>a</sup> There were too few reception centers for meaningful analysis.

**Table 5A-12**

**Attempted and Successful Escape Rates Over Last 30 Days,  
by Conformance to the Count Criteria  
(Conformance means three or more counts per day)<sup>a</sup>**

	Detention Centers		Training Schools		Ranches	
	Non Conform N=2,814 -2,831	Conform N=16,861 -16,963	Non Conform N=6,041 -6,122	Conform N=26,849 -26,911	Non Conform N=2,434 -2,606	Conform N=4,450 -4,462
Attempted escape rate per 100 juveniles	1.06	.78	2.45	1.10*	3.71	.89*
Escape rate per 100 juveniles	.74	.51	2.03	1.16	3.90	2.23

Source: Mail Survey, 1991

\*  $p \leq .05$

<sup>a</sup> There were too few reception centers for meaningful analysis.

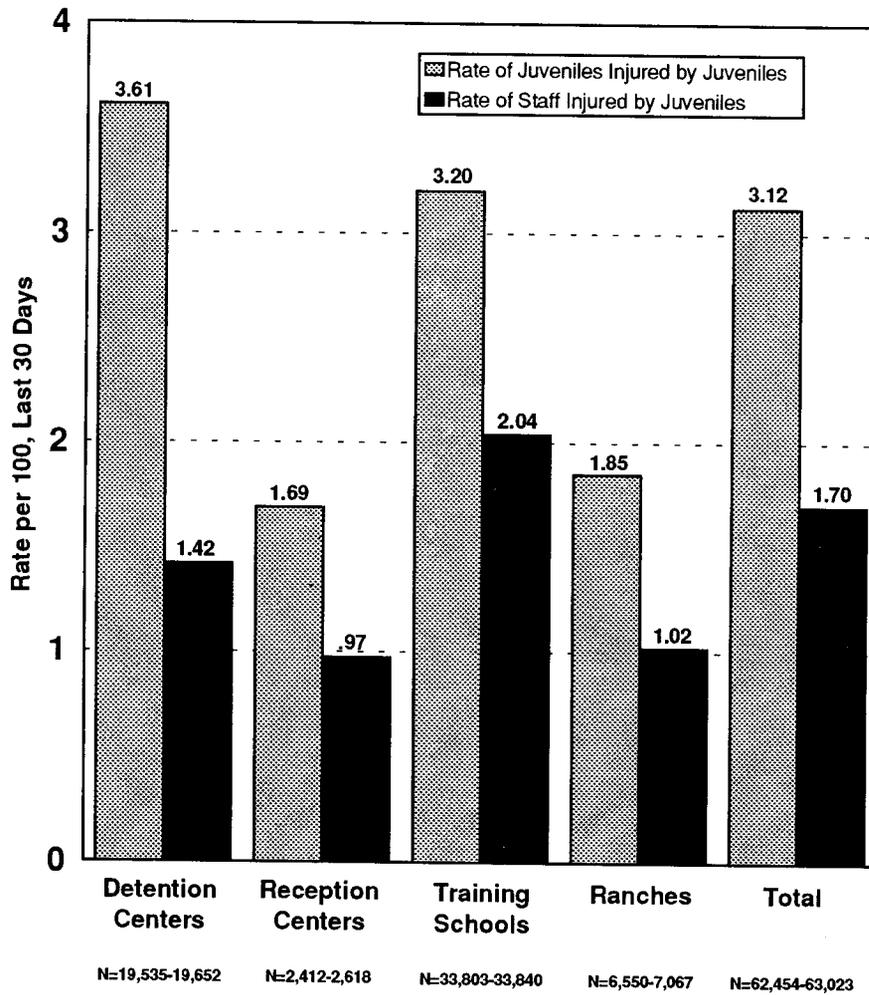
**Injury rates.** We also measured the success of internal security by examining injury rates within facilities. The mail survey asked facilities to report the number of injuries to juveniles and staff during the previous 30 days.<sup>15</sup> The number of injuries was broken down into three categories: juveniles injured by staff, juveniles injured by other juveniles, and staff injured by juveniles. Injuries to juveniles by staff are examined in Chapter 7, Section B, "Limits on Staff Discretion." Figure 5A-2 shows rates of injuries sustained during a 30-day period in the two remaining categories.

Nearly 2,000 confined juveniles and 651 staff were injured in the 30 days before the mail survey. On average, about 3 percent of juveniles were injured by other juveniles in the previous month. About 1.7 percent of staff were injured by juveniles in the same period.

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<sup>15</sup> We have no indication of the seriousness of these injuries based on mail survey data, but site visitors observed juveniles with cuts, bruises, and scrapes, which were said to be the result of fights. In addition, we have no data on the level of unreported injuries. While serious injuries are likely to be reported, those involving minor cuts or bruises may be reported less frequently. Staff cannot report what they do not observe. During interviews several juveniles indicated that staff observed only a small percentage of the fights that occurred between juveniles. One juvenile reported he had been in 20 fights during his 5 months of confinement and that training school staff had observed only 3 of them. If staff ratios were to decline, it seems likely that the percentage of fights observed by staff would diminish.

Figure 5A-2  
Average Juvenile and Staff Injury Rates,  
Last 30 Days, by Facility Type



Source: Mail Survey, 1991

Violence affects many aspects of staffing inside facilities, making it harder for correctional facilities to recruit and retain quality staff. It also increases the need for replacement and coverage staff to replace injured workers. Facility expenses may increase due to workman's compensation costs, insurance payments, and staff lawsuits. Violence also increases the need to provide emergency medical care outside juvenile facilities (Table 4B-8).

Thirty-six percent of confined juveniles were held in facilities that reported no incidents of juvenile injuries caused by other juveniles in the last 30 days. Fifty-four percent of confined juveniles were housed in facilities which reported that no staff were injured by juveniles in the last 30 days. On the other hand, a small number of facilities had extremely high injury rates. For example, about 10 percent of juveniles were in facilities that had juvenile-on-juvenile injury rates of 8 per 100 juveniles or higher. One percent of juveniles were in facilities that had rates over 25 per 100. The highest reported

juvenile-on-juvenile injury rate was 59.26 per 100 juveniles per month. Likewise, the situation in a small number of facilities also appeared to be especially dangerous for staff. About 10 percent of juveniles were in facilities where the juvenile-on-staff injury rate was 4.88 or higher per month. About 1 percent of juveniles were in facilities in which the juvenile-on-staff injury rate was 16.7 per 100 staff members or higher. The highest reported juvenile-on-staff injury rate was 66.7 per 100 staff members per month.

Rates of injuries to staff at the hands of juveniles are highest in detention centers followed by training schools. For juveniles injured by juveniles, the injury rate was highest for juveniles in training schools, followed by detention centers. Interestingly, the regression analyses of Chapter 8 did not find any substantial or significant reduction in juvenile injuries associated with either classification or staffing ratios. The most important factor was the percentage of juveniles housed in dormitory sleeping rooms with 11 or more juveniles. Having a wall surrounding the facility was also associated with a significantly higher rate of juvenile injuries by other juveniles. Injuries to staff were significantly higher in facilities with crowded conditions. Again, although staffing ratios were not associated with the rate of staff injuries, turnover was. Higher supervision staff turnover was associated with more injuries to (presumably less experienced) staff.

**Juveniles' Feelings of Safety.** Personal safety is extremely important to youth in custody. When asked to rank how important personal safety was to them on a scale of 1 to 5, with 1 being "extremely important" and 2 being "very important," juveniles ranked safety as 1.5 ( $\pm .2$ ). Most juveniles were satisfied with their level of personal safety. When asked to rank how well the facility did in providing for their personal safety on a scale of 1 to 5, with 2 being "very good" and 3 being "satisfactory," juveniles rated safety as 2.3 ( $\pm .1$ ).

During interviews, juveniles also were asked if they felt safe in the facility. Across all facilities, 20 percent ( $\pm 4$  percent) of confined youth said they did not feel safe inside the facility. Of those that did not feel safe, 69 percent ( $\pm 10$  percent) stated that they feared other juveniles who were confined with them. Only 10 percent of juveniles in ranches did not feel safe, compared to over one-fourth of those in training schools.

As site visitors found in conversations with juveniles, however, juveniles' perceptions of safety are relative to their outside environment. After indicating to a visitor that he felt safe, one youth explained that the only worry he had in a facility was getting punched in the face or hit over the head with a chair, whereas at home he feared getting shot. Realizing there is essentially no danger of being shot inside a facility, he felt perfectly safe.

### **Summary Regarding Security**

Larger facilities give more emphasis to tight security and control. On the measures of both the classification and counts criteria, larger facilities are more likely to conform. Conformance to security staffing ratios is extremely low, especially in large facilities. Larger facilities are more likely to try to achieve security by use of hardware.

Escapes or runaways are a problem in many facilities, particularly those with minimum security features. Ranches, the facility type with the lowest level of security, had the greatest rate of escapes and attempted escapes. Perimeter walls or fences are significantly associated with reduced rates of attempted and actual escapes in training schools. Training schools and ranches which conformed to the count criteria of three or more per day also had significantly fewer attempted escapes.

Injuries are a serious problem in juvenile facilities. In the 30 days before the mail survey, roughly 3 percent of the confined juvenile population was injured by other juveniles and about 1.7 percent of staff were injured by juveniles. However, patterns of injuries are highly variable. Over one-third of confined juveniles are in facilities that reported no juvenile-on-juvenile injuries in the last 30 days. Over one-half of confined juveniles are in facilities that reported no juvenile-on-staff injuries in the last 30 days. On the other hand, a small number of facilities report very high rates of juvenile-on-juvenile and juvenile-on-staff injuries.

Supervision staff turnover rates are associated with increases in the rates of juveniles injured by staff. We cannot establish causality from our analysis; that is, we cannot say whether high injury rates lead to increased turnover rates, whether high turnover rates lead to increased injury rates, or whether both injury and turnover rates respond to some other factor or factors.

Turnover rates are highly variable—zero in some facilities and extraordinarily high in others. Practitioners suggest that some level of staff turnover is desirable and can revitalize staff and provide more opportunities for professional growth and development. At some point, however, turnover reaches a threshold where the negative outcomes described above outweigh the benefits. Our data cannot identify a threshold below which turnover rates are not associated with these outcomes.

Based on the site visits, it appears that turnover rates vary with a host of factors, including salaries, quality of preservice and in-service training, working conditions at the facility—including staff safety—and characteristics of the local job market, to name a few. The factors that affect turnover probably vary from facility to facility.

The majority of juveniles in custody report that they feel safe, yet their feeling of safety may be more relative than absolute. Some practitioners suggest that many youth may be safer from serious injury in juvenile facilities than in their home neighborhoods, due to the facilities' structured environment and the relative absence of weapons. During site visits, administrators of facilities with low violence rates expressed concern that juveniles would come to view their facilities as a haven from which to escape community violence. Others, however, saw their ability to protect juveniles as an important requisite to changing their behavior.

In any case, as discussed further in Chapter 8, analysis of escape rates and juvenile and staff injuries suggest that classification as currently practiced or simple increases in the number of staff may not be the keys to increased security. Examination of conditions of confinement showed that almost 40 percent of juveniles are in facilities that either do not classify juveniles or do not use the results in assigning housing. Almost two-thirds of confined juveniles are in facilities with apparently inadequate numbers of security staff, as judged by national standards. On the other hand, analysis of escape rates and rates of juvenile and staff injury do not show any substantial relationship between classification or staffing levels and escape or injury. We were also unable to find evidence that building fences reduces escape rates.

### **Recommendations Regarding Security**

Indeed, although we were able to identify some juveniles characteristics and facility conditions, such as crowding, that affected injuries or escapes, there is substantial and unexplained variation across facilities in both escapes and injury.

*We recommend that juvenile justice agencies conduct more detailed comparative studies of facilities with low- and high-escape and injury rates to identify policies and practices that can*

*materially improve security and safety. These studies should pay special attention to the procedures used to classify juveniles and the ways in which classification is used.*

*We recommend that agencies operating juvenile confinement facilities examine supervision staff turnover rates, identify the causes for turnover, and develop strategies to manage turnover rates. In addition, facilities should attempt to offset the effects of high turnover rates with increased training.*

## **B. Controlling Suicidal Behavior**

Section B uses four assessment criteria: whether facilities have written suicide prevention plans; whether juveniles are screened at admission for suicide risk; whether staff are trained in suicide prevention; and whether suicidal juveniles are monitored in person at least four times per hour. The chapter describes the content of written suicide prevention plans and the hours of suicide prevention training provided to staff. It examines suicidal behavior rates and describes relationships between those rates and conformance to assessment criteria, and between those rates and other variables, such as staff ratios, turnover rates, and housing patterns.

Control of suicidal behavior is treated here as a separate focus of conditions of confinement rather than as a subsection of general health care services, a topic addressed in another section of this report. Unlike most other health care issues, suicidal individuals present a problem of immediate life-and-death importance. The issues are complex. Some juveniles who threaten or engage in suicidal behavior are genuinely suicidal. Others may threaten or engage in feigned suicidal behavior in order to manipulate staff. Some of the latter, nonetheless, may carry their act too far and become "accidental" suicide victims. Hence, staff must define its role in controlling suicidal behavior in broad terms. Nonmedical staff must be trained to spot suicidal behaviors or tendencies and must be trained and empowered to take prompt preventive action.

Both ACA and the National Commission on Correctional Health Care Standards (NCCHC) have four similar standards that address suicide prevention with juvenile inmates. Both organizations recommend:

- A written suicide prevention plan.
- Screening of admissions for suicide risk.
- Staff training in suicide prevention.
- Monitoring of suicidal individuals.<sup>16</sup>

We developed assessment criteria patterned after each of these four standards.

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<sup>16</sup> The standards for screening, staff training, and monitoring are three of nine topics that NCCHC recommends for inclusion in the written suicide prevention plan. We did not evaluate facility implementation of the other six procedures recommended by the Commission.

**Written plan.** Developing a suicide prevention plan is expected to encourage facilities to develop and coordinate services for suicidal youth. Having a written plan may help to assure that staff know how to respond to suicidal juveniles. Both ACA and NCCHC recommend that every juvenile corrections facility have a written plan for identifying and responding to suicidal individuals. ACA also recommends that the plan be reviewed and approved by a qualified medical or mental health professional. Facilities conformed to our assessment criteria if they had a written suicide prevention plan, regardless of the plan's content.

**Admission screening.** ACA recommends that the written suicide prevention plan include specific procedures for screening at time of admission to identify suicidal youth. Similarly, NCCHC recommends that a facility's initial health screening form include observation and interview items related to each juvenile's potential suicide risk. A number of State and Federal appellate courts have also held that children should receive psychological screening by trained staff at admission to any juvenile institution or soon thereafter. The mail survey questionnaire asked whether facilities included identification of potential suicide risks as part of their health screening. If they do, they are classified as conforming with the suicide screening assessment criteria.

**Staff training.** ACA recommends that all staff responsible for juvenile supervision be trained in the implementation of the written suicide prevention program. NCCHC recommends that all staff who work with juveniles be trained to recognize verbal and behavioral cues that indicate potential suicidal tendencies. Courts have also held that children in institutions should receive psychological services from trained staff, particularly if the residents have already attempted suicide. Facilities conformed to our assessment criteria if both during the first year that employees are hired and during each subsequent year of employment they conduct any staff training in suicide prevention.

**Frequent monitoring.** Both ACA and NCCHC recommend that written suicide prevention plans cover procedures for monitoring juveniles identified as suicide risks. NCCHC standards call for close supervision, which is interpreted in the medical profession as constant supervision, 60 minutes per hour. At the time we began this study, ACA had no specific standard on monitoring suicidal youth. Our assessment criteria requires suicidal youth be monitored by direct visual means at least once every 4 minutes. We selected 4 minutes because brain damage can begin to occur after 4 minutes in a hanging, the most common form of attempted suicide in juvenile facilities.

Table 5B-1 shows the percentage of juveniles in facilities that conform to these criteria. Conformance rates are lower for monitoring, admissions screening, and staff training than for planning. Fifty percent of juveniles are in facilities that monitor suicide risks at least every 4 minutes; 89 percent are in facilities with written suicide prevention plans; 75 percent are in facilities where staff are trained in suicide prevention; and 72 percent are in facilities that screen juveniles for suicide risk at admission. Conformance rates for the suicide plan and admissions screening standards are markedly lower in ranches than in other types of facilities. Because 85 percent of total admissions to confinement are to detention centers, however, the percentage of total admissions screened is higher than indicated by the population-based rates of Table 5B-1.

Only 25 percent of confined juveniles are in facilities that conform to all four suicide prevention assessment criteria. Thirty-three percent of juveniles in detention centers are in facilities that conform to all four, compared to 21 percent in training schools, 18 percent in reception centers, and 18 percent in ranches.

**Table 5B-1**

**Percent of Juveniles in Facilities That Are in Conformance  
With Suicide Prevention Standards,  
by Type of Facility and for All Facilities**

<b>Assessment Criteria</b>	<b>Detention Centers N=17,213- 20,074<sup>a</sup></b>	<b>Reception Centers N=1,672- 2,618<sup>a</sup></b>	<b>Training Schools N=28,160- 35,087<sup>a</sup></b>	<b>Ranches N=6,317- 7,180<sup>a</sup></b>	<b>Total N=53,362- 64,905<sup>a</sup></b>
<b>Written suicide prevention plan<sup>b</sup></b>	<b>97%</b>	<b>100%</b>	<b>89%</b>	<b>66%</b>	<b>89%</b>
<b>Suicide screening at admission<sup>c</sup></b>	<b>89%</b>	<b>62%</b>	<b>67%</b>	<b>49%</b>	<b>72%</b>
<b>Staff trained in suicide prevention<sup>d</sup></b>	<b>78%</b>	<b>86%</b>	<b>73%</b>	<b>73%</b>	<b>75%</b>
<b>Suicide risks monitored at least every 4 minutes<sup>e</sup></b>	<b>47%</b>	<b>36%</b>	<b>50%</b>	<b>62%</b>	<b>50%</b>
Percent of juveniles in facilities that:					
Conform to all four criteria	33%	18%	21%	18%	25%
Conform to three criteria	38%	18%	43%	32%	39%
Conform to two criteria	25%	64%	26%	30%	28%
Conform to fewer than two criteria	4%	0%	10%	20%	8%

Source: Mail Survey, 1991

<sup>a</sup> Sample size varies depending on number of completed responses.

<sup>b</sup> For information on the percent of facilities that conform, see Appendix E, Table E-21.

<sup>c</sup> For information on the percent of facilities that conform, see Appendix E, Table E-21.

<sup>d</sup> For information on the percent of facilities that conform, see Appendix E, Table E-21.

<sup>e</sup> For information on the percent of facilities that conform, see Appendix E, Table E-21.

One-fourth of juveniles were confined in institutions without staff training in suicide prevention. Facilities that do train staff in suicide prevention provide an average of 5.9 hours of training for first-year employees and 6.45 hours of training each subsequent year (Table 5B-2). However, this average obscures a wide variation in the number of training hours. For example, while 5.9 hours of training is the average for all facilities during the first year after hire, 33 percent of facilities provide only 1 or 2 hours of training while 30 percent provide 8 or more hours of training (Table 5B-3). Similarly, while 6.4 is the average number of training hours in subsequent years of employment, 21 percent of facilities provide no training, 38 percent provide only 1 or 2 hours, and 25 percent of facilities provide 8 or more hours of followup training.

Site visitors inspected facilities' suicide prevention plans and recorded which nine elements recommended by NCCHC were covered by the facilities' suicide prevention plan.<sup>17</sup>

**Table 5B-2**

**Average Number of Hours of Staff Training Provided  
During the First Year and Each Following Year of Employment  
for Facilities With Suicide Prevention Training, by Facility Type**

Average Hours of Staff Training in Suicide Prevention	Detention Centers N=16,341-19,613	Reception Centers N=2,384-2,618	Training Schools N=27,065-32,268	Ranches N=5,540-6,032	Total N=51,330-60,531
First year of hire	7.0	3.8	5.4	5.6	5.9
Each following year of employment	6.9	9.4	6.1	5.6	6.4

Source: Mail Survey, 1991

<sup>17</sup> We did not judge whether the content of each element was consistent with NCCHC recommendations.

**Table 5B-3**

**Percent of Facilities With Suicide Prevention Training,  
by Number of Hours of Training During  
the First Year and Each Following Year of Employment and  
by Facility Type and for All Facilities**

	Detention Centers	Reception Centers	Training Schools	Ranches	Total
<b>First year of hire</b>					
No training	2%	0%	8%	16%	7%
1-2 hours	22%	36%	40%	30%	33%
3-7 hours	25%	52%	33%	24%	30%
8 hours	34%	10%	5%	21%	16%
Over 8 hours	16%	2%	14%	9%	14%
<b>Each following year of employment</b>					
No training	19%	9%	23%	23%	21%
1-2 hours	29%	35%	44%	34%	38%
3-7 hours	19%	12%	14%	24%	17%
8 hours	18%	10%	2%	10%	8%
Over 8 hours	15%	34%	17%	9%	17%

Source: Mail Survey, 1991

We estimate that between 62 and 73 percent of confined juveniles are housed in facilities nationwide that include seven of the nine elements (Table 5B-4). However, two elements—housing and training—are included considerably less often. In fact, we estimate that just 42 percent of juveniles are held in facilities in which training is an element in suicide prevention plans.

CIC census reports 10 suicides in juvenile facilities for 1990—5 in detention centers, 4 in training schools, and 1 on a ranch, camp, or farm. There were no reported suicides in reception centers. Two suicides occurred in one facility—a training school; no more than one suicide was reported in any other facility. While the number of suicides may seem small, the figure is believed to be correct.<sup>18</sup>

<sup>18</sup> Personal communication from Earl Dunlap, Executive Director of the National Juvenile Detention Association.

**Table 5B-4**

**Estimated Percent of Juveniles in Facilities  
With Specific Elements in Suicide Prevention Plans**

	%	CI
Identification	63%	± 10%
Training	42%	± 10%
Assessment	67%	± 10%
Monitoring	70%	± 9%
Housing	56%	± 10%
Referral	62%	± 10%
Communication	63%	± 10%
Reporting	73%	± 9%
Notification	68%	± 9%

Source: Site Visit Protocol, 1991

It is difficult to compare data on suicide rates for confined juveniles with that of children in the general population. Anecdotal evidence suggests that confined juveniles are more likely to attempt suicide shortly after they are admitted to facilities. We do not, however, have solid information about the duration between admission to facilities and completed suicides. Because suicides seemed linked to the period immediately following admission, it may be most appropriate to compute suicide rates using admissions as the denominator. Unfortunately, different States collect and report admissions data in different ways.<sup>19</sup>

The mail survey requested information about suicidal behavior in juvenile facilities during the 30-day period before respondents answered the questionnaire. In addition to obvious efforts by juveniles to kill themselves, we asked respondents to include suicide "gestures" and acts of self-mutilation in their

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<sup>19</sup> In order to develop reliable estimates of suicide rates in juvenile confinement facilities, we need better and more consistent data on admissions and on the duration of time between admission and suicide. Even if we could solve these reporting problems, the rates of such rare events are likely to vary so widely from year to year as to be of little use. Hence, it may be more instructive to focus on rates of suicidal behavior rather than rates of completed suicides.

tally of suicidal behavior.<sup>20</sup> The responses suggest that there is considerable suicidal behavior in juvenile facilities.

In 939 facilities, 970 juveniles attempted suicide, made a suicide gesture, or mutilated themselves in the previous 30 days. During this 30-day period, these 970 juveniles committed 1,487 acts of suicidal behavior, for an average of 1.4 suicide-related incidents per suicidal juvenile.

In terms of rates, an average of 1.56 juveniles out of every 100 were involved in suicidal behavior during the previous 30-day period. There was an average of 2.4 incidents involving suicidal behavior for every 100 juveniles in each facility during the previous 30-day period (Figure 5B-1). Both the individual rate and the incident rate were markedly higher in detention centers than in other types of facilities and markedly lower in ranches.<sup>21</sup> This suggests that lower conformance levels in ranches may partly reflect a lower incidence of suicidal behavior. Tables 5B-5 and 5B-6 compare the individual and incident rates in institutions that do and do not conform with the two suicide prevention assessment criteria and indicates where the relationship is statistically significant.

Detention centers that conduct suicide screenings and train staff in suicide prevention have lower rates of suicidal behavior incidents. However, the reverse seems to be true in training schools. The rate of juveniles' suicidal behavior is higher in facilities that conform to the two criteria. One possible explanation is that these facilities conduct suicide screening and train staff because they have more suicidal juveniles. It is, of course, possible that staff in conforming facilities are more sensitive to suicidal behavior (particularly gestures and self-mutilations) and, hence, report it more frequently.

In regression analyses of suicidal behavior, presented in Chapter 8, we found positive associations with staff turnover, crowding, and the percentage of juveniles in single rooms. The finding regarding staff turnover suggests that less experienced staff are, in fact, less effective in dealing with potential suicidal behavior. The finding regarding the percentage of juveniles in single rooms is also not unreasonable. Single rooms isolate juveniles from social contact and offer opportunities for unobserved, self-destructive behavior. This suggests that the common failure of facilities to include policies dealing with housing in their suicide prevention plans (Table 5B-4, above) is a serious shortcoming.

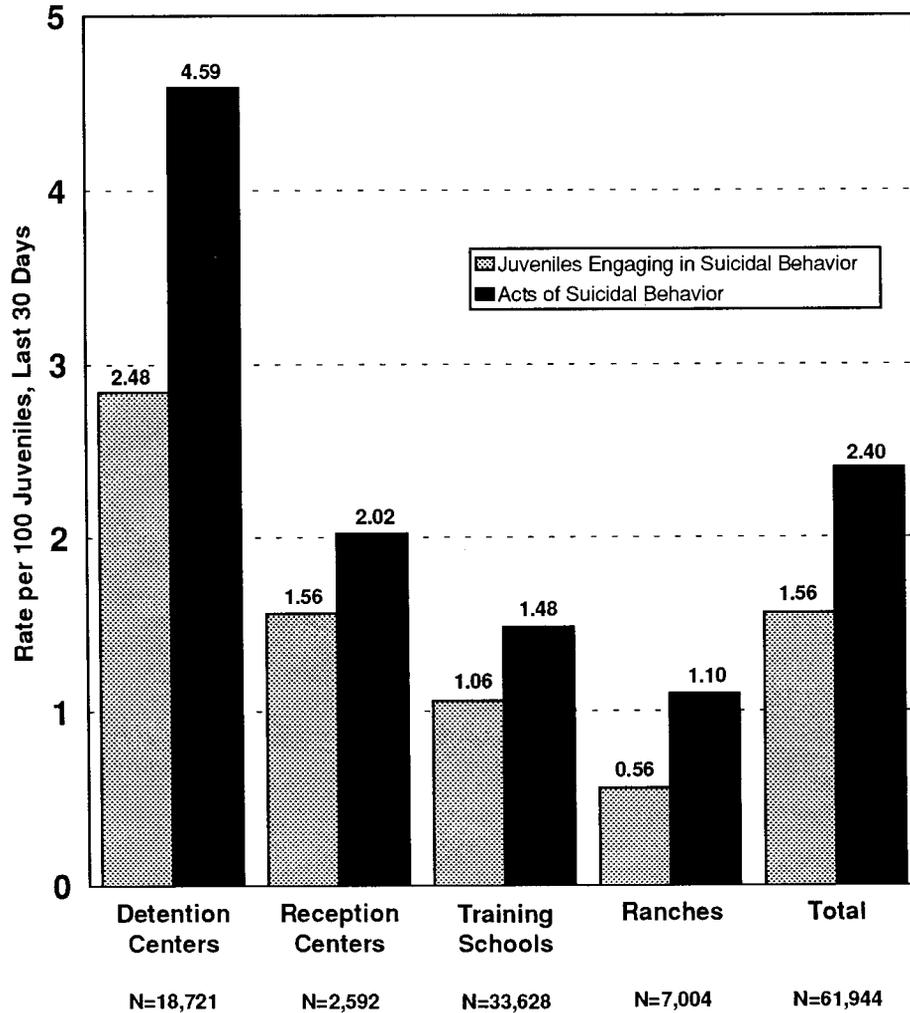
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<sup>20</sup> Because we anticipated that some staff would classify gestures and self-mutilating acts as suicidal behavior, we decided to ensure comparability among staff responses by asking all respondents to include these incidents in their counts. Actual suicides, however, have been excluded from the tabulations on suicide attempts.

<sup>21</sup> The higher rate in detention centers is in part driven by the higher turnover rate, because juveniles are more likely to engage in suicidal behavior when they are first admitted. When the suicidal behavior rate was regressed on facility characteristics, controlling for average length of stay, we found that the rate was significantly higher in detention centers compared to training schools (see Chapter 8).

Figure 5B-1

Rates of Suicidal Behavior\* and Acts of Suicidal Behavior per 100 Juveniles, Last 30 Days, by Facility Type



Source: Mail Survey, 1991

\* Includes suicide attempts, suicidal gestures, and acts of self-mutilation

**Table 5B-5**

**Individual and Incident Suicide Rates,  
by Facility Type and by Conformance to Suicide Screening Criterion**

	Detention Centers		Reception Centers		Training Schools		Ranches	
	Suicide Screenings?		Suicide Screenings?		Suicide Screenings?		Suicide Screenings?	
	No N=1,792	Yes N=16,859	No N=994	Yes N=1,598	No N=11,239	Yes N=22,136	No N=3,499	Yes N=3,469
Juveniles engaged in suicidal behavior, rate per 100 juveniles	4.3	2.7	1.6	1.5	.7*	1.3	.7	.5
Acts of suicidal behavior, rate per 100 juveniles	11.8*	3.8	2.1	2.0	1.0	1.7	1.8	.5

Source: Mail Survey, 1991  
\* p ≤ .05

**Table 5B-6**

**Individual and Incident Suicide Rates,  
by Facility Type and by Conformance to Staff Training in Suicide Prevention Criterion**

	Detention Centers		Reception Centers		Training Schools		Ranches	
	Staff Trained?		Staff Trained?		Staff Trained?		Staff Trained?	
	No N=3,760	Yes N=12,386	No N=235	Yes N=1,411	No N=7,910	Yes N=20,588	No N=1,738	Yes N=4,571
Juveniles engaged in suicidal behavior, rate per 100 juveniles	2.9	2.8	7.0	1.6	.9*	1.2	.3	.6
Acts of suicidal behavior, rate per 100 juveniles	7.7*	3.6	7.0	2.4	1.2	1.7	.3	1.4

Source: Mail Survey, 1991  
\* p ≤ .05

Finally, the measure of crowding which indicates that the facility is over design capacity is also associated with higher rates of suicidal behavior. If a facility is operating beyond its capacity, the flow of juveniles may overwhelm the available resources, translating into less attention to juveniles during the admission process and during their confinement.

This interpretation is consistent with our other findings in the regression analysis of suicidal behavior. Significant reductions in the rate of suicidal behavior are associated with conformance to the staffing ratio, suicide screening, and staff training criteria. Having adequate numbers of staff, screening juveniles at the time of admission, and training staff to be aware of the danger signs of suicidal behavior all reduce the incidence of such behavior.

### **Summary Regarding Controlling Suicidal Behavior**

Conformance to suicide standards varies. Ten juveniles in confinement killed themselves in 1990. Rates of suicidal behavior (which includes attempted suicides, suicide gestures, and self-mutilations) are high in juvenile facilities. We also note that suicidal behavior rates are highly variable. Almost 44 percent of confined juveniles are in facilities that had no incidents of suicidal behavior in the 30 days before the mail survey, and hence, had rates of zero. The average rate for suicidal behavior was 2.4 per 100 juveniles per month. Ten percent of the juveniles were in facilities with rates of 5 or more.

Almost all juveniles are in facilities where suicide risks are monitored by direct visual observation at least four times per hour. Most juveniles are in facilities that have written suicide prevention plans. However, only about three-fourths of juveniles are in facilities where staff are trained in suicide prevention—and in these facilities levels of training for new and veteran staff vary substantially. Only 72 percent of confined juveniles are in facilities that screen for suicide risk at admission. Suicide screening is frequent (89 percent) in detention centers, but much less common (49 percent) in ranches.

We analyzed differences in the rates of suicidal behavior across agencies. Such regressions must be interpreted with caution. For example, although a policy of frequent monitoring of suicidal juveniles showed no material relationship to rates of suicidal behavior, it could be vital to preventing successful suicides. Even so, analysis of suicidal behavior yielded two suggestive findings.

We found that suicide screening at admission and staff suicide training were associated with lower rates of suicidal behavior, suggesting that staff were at least somewhat successful in identifying suicide risks. We also found that suicidal behavior was more frequent in facilities in which a large number of juveniles are in single rooms. Examination of suicide prevention plans collected during the site visits, however, indicated that only 56 percent of the plans included any restriction of housing decisions for suicide risks.

### **Recommendations Regarding Controlling Suicidal Behavior**

*We recommend that all juveniles be screened for risk of suicidal behavior immediately upon their admission to confinement facilities.*

*We recommend that suicidal juveniles be constantly monitored by staff. This means that suicidal youth should not be isolated or placed in a room by themselves. When suicidal juveniles are housed in single rooms, staff should be with them continuously. A mental health professional should assess suicidal youth as quickly as possible and, if they deem it necessary, the youth should be transferred to a medical or mental health facility that is staffed and equipped to deal with suicidal youth.*

*We also recommend that agencies study the causes of high supervision staff turnover rates, develop strategies to reduce high turnover rates, and soften the effects of turnover by increased training.*

## **C. Inspections and Emergency Preparedness**

Section C includes four assessment criteria: whether facilities have (1) annual sanitation inspections, (2) annual fire or life safety inspections, (3) quarterly fire drills, and (4) access to emergency power. The section describes site visitors' ratings of maintenance and cleanliness as well as descriptions of site visitors' observations of fire and life safety problems.

Juvenile institutions are responsible for maintaining a safe and healthy environment for residents and staff. The literature on conditions of confinement acknowledges this responsibility but does not present substantive findings. However, both nationally recognized standards and the courts have identified a number of sanitation and fire and life safety conditions that juvenile facilities should meet.<sup>22</sup> In this section, we discuss assessment criteria relating to sanitation, fire and life safety, and emergency power.

### **Annual Sanitation Inspection**

Although sanitary conditions are essential for institutional health and safety, nationally recognized sanitation standards tend to be procedural rather than substantive. ACA requires facility administrators to comply with applicable Federal, State, and local sanitation and health codes, as evidenced by annual sanitation inspections.<sup>23</sup> Our assessment criteria parallel this standard. To conform, a facility must have had a sanitation inspection by authorized government officials within the past year.

### **Annual Fire/Life Safety Inspection**

ACA standards for fire safety require annual fire/life safety inspections and quarterly fire drills. Our assessment criteria also parallels this standard. To conform, facilities must have had a fire/life safety inspection by authorized government officials within the last year and at least four fire drills each year.

### **Access to Emergency Power Source**

Locks and ventilation systems in many facilities are electrically activated. In the event of an electrical outage, ventilation would be inoperative and locks would have to be manually operated, which is time consuming. ACA standards require that facilities have access to an alternative power source in an emergency. To conform to our assessment criteria, facilities must have their own emergency generator, access to emergency power within 30 minutes, or obtain emergency power through another arrangement.

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<sup>22</sup> Courts have mandated that facilities clean cells, rooms, and bathrooms on a regular basis; exterminate insects and rodents; and comply with all local and State health and sanitation codes. Minimum standards in case law for fire safety require two exits from a facility, clearly marked and equipped with lights, smoke alarms, fire extinguishers, air packs, and a specific evacuation plan (Soler, pp. 2-49 to 2-52).

<sup>23</sup> Generally, major components of an annual sanitation inspection include assessing the overall cleanliness, maintenance, and upkeep of the facility; inspecting all plumbing equipment, including toilets, baths, showers, sinks, and laundry facilities; assessing waste disposal procedures for all liquid and solid waste; and ensuring trash disposal receptacles are clean, undamaged, and securely covered.

Table 5C-1 shows the percentage of confined juveniles in facilities that conform to each of these four criteria, as well as the percentage of juveniles in facilities that conform to all four.

**Table 5C-1**

**Percent of Juveniles in Facilities That Conform to Inspections and  
Emergency Preparedness Assessment Criteria**

<b>Assessment Criteria</b>	<b>Detention Centers N=18,439- 20,031</b>	<b>Reception Centers N=1,849- 2,595</b>	<b>Training Schools N=28,544- 34,984</b>	<b>Ranches N=5,860- 7,009</b>	<b>Total N=54,692- 64,619</b>
<b>Annual sanitation inspection<sup>a</sup></b>	<b>94%</b>	<b>96%</b>	<b>86%</b>	<b>90%</b>	<b>89%</b>
<b>Fire/life safety inspection<sup>b</sup></b>	<b>95%</b>	<b>99%</b>	<b>86%</b>	<b>98%</b>	<b>91%</b>
<b>Quarterly fire drills<sup>c</sup></b>	<b>91%</b>	<b>98%</b>	<b>92%</b>	<b>96%</b>	<b>93%</b>
<b>Access to emergency power<sup>d</sup></b>	<b>89%</b>	<b>78%</b>	<b>82%</b>	<b>60%</b>	<b>82%</b>
Percent of juveniles in facilities that:					
Conform to all four criteria	75%	74%	63%	53%	67%
Conform to three criteria	19%	21%	23%	34%	23%
Conform to fewer than three criteria	6%	5%	14%	13%	10%

Source: Mail Survey, 1991

<sup>a</sup> For information on percent of facilities in conformance, see Appendix E, Table E-22.

<sup>b</sup> For information on percent of facilities in conformance, see Appendix E, Table E-23.

<sup>c</sup> For information on percent of facilities in conformance, see Appendix E, Table E-24.

<sup>d</sup> For information on percent of facilities in conformance, see Appendix E, Table E-25.

Eighty-nine percent of confined juveniles are housed in facilities that have had sanitation inspections within the past year. Ninety-one percent of juveniles are in facilities that receive annual fire/life safety inspections, and 93 percent are held in facilities that conduct quarterly fire drills. Eighty-two percent of

all confined juveniles are housed in facilities that have access to an emergency power source. A significantly smaller percentage of residents of ranches are in facilities with access to an emergency power source. Ranches are more likely to operate in an open setting that does not rely on electrical locks and mechanical ventilation systems. Just 66 percent of confined juveniles are in facilities that conform to all four criteria.

### Conditions of Confinement Related to Inspections and Emergency Preparedness

While there are high levels of conformance to the individual assessment criteria, observations during our site visits suggest that conditions in facilities are sometimes problematic.

**Sanitation.** Juveniles in institutions with annual sanitation inspections will usually, but not always, be in facilities that are inspected for pests, food service, and water purity (Table 5C-2).

**Table 5C-2**  
**Percent of Juveniles in Facilities**  
**That Hold Three Particular Inspections Annually,**  
**by Facility Type**

	Detention Centers N=19,009 -19,196	Reception Centers N=2,547 -2,575	Training Schools N=29,498 -31,681	Ranches N=6,218 -6,427	Total N=57,620 -59,517
Pest	92%	96%	83%	83%	87%
Food services	95%	88%	87%	93%	90%
Water purity	62%	46%	72%	76%	68%

Source: Mail Survey, 1991

Site visitors rated facilities on three measures of sanitation: maintenance, cleanliness, and odor. Additionally, they looked for signs of vermin. There are too few nonconforming facilities to allow a meaningful comparison of site visitor ratings for conforming and nonconforming facilities. We can, however, present data for all visited facilities and all visited conforming facilities (Table 5C-3).

Site visitors provided separate ratings for sleeping rooms, common-use areas, isolation rooms, bathrooms, and kitchen areas. In Table 5C-3, we show the distribution of facility ratings based on the average rating across all areas observed in each facility. Most juveniles are housed in clean, well-maintained, odor-free facilities. Juveniles in the site visit sample were usually in facilities where the maintenance is between excellent and adequate, with only minor deterioration or disrepair evident. Most juveniles were in facilities rated as moderately to extremely clean and that were either odor-free or had some noticeable odor due to cleaning agents. We estimate that 12 percent of juveniles are housed in facilities with noticeable signs of rats, mice, or roaches.

**Table 5C-3**

**Site Visitor Ratings of  
Maintenance, Cleanliness, and Odor**

	All Facilities		Conforming Facilities	
	Percent	95 % Confidence Interval	Percent	95 % Confidence Interval
<u>Maintenance</u> Percent of juveniles in facilities with average rating of:				
1 = Excellent	23%	± 8%	21%	± 10%
2 = Good	44%	± 10%	46%	± 12%
3 = Adequate	24%	± 9%	27%	± 11%
4 = Poor	7%	± 5%	3%	± 4%
5 = Very poor	2%	± 3%	2%	± 4%
<u>Cleanliness</u> Percent of juveniles in facilities with average rating of:				
1 = Extremely clean	27%	± 9%	24%	± 10%
2 = Moderately clean	64%	± 10%	69%	± 11%
3 = Moderately unclean	8%	± 5%	4%	± 5%
4 = Extremely unclean	2%	± 3%	3%	± 4%
<u>Odor</u> Percent of juveniles in facilities with average rating of:				
1 = Odor-free	76%	± 9%	75%	± 10%
2 = Antiseptic odor	18%	± 8%	21%	± 10%
3 = Slight unpleasant odor	5%	± 4%	3%	± 4%
4 = Medium unpleasant odor	1%	± 2%	1%	± 3%
5 = Strong unpleasant odor	0%		(a)	
<u>Vermin</u> Percent of juveniles in facilities with noticeable signs of vermin	12%	± 7%	12%	± 8%

Source: Site Visit Protocol, 1991

(a) No facilities.

As expected, exceptions did exist, and we found that sanitation inspections did not guarantee that these poor conditions were not present. In one detention center, site visitors observed graffiti and falling plaster in sleeping rooms, loose windows in isolation rooms, and flooded toilets in bathrooms. On campus, site visitors saw broken windows and two empty buildings which had been condemned. Although visual inspection suggested otherwise, the majority of facilities where site visitors observed poor maintenance were in conformance with the sanitation standard and had undergone sanitation inspections within the past year.

**Fire and Life Safety.** Although conformance to the two individual fire and life safety assessment criteria is high, site visit data suggests substantial deficiencies, especially in detention centers. More than one-half of the 30 detention centers visited had at least 1 unmarked fire exit in a sleeping area. Nearly two-thirds of detention centers, and approximately one-fourth of the other facility types, did not have fire escape routes posted in at least one of the three living units that site visitors randomly observed. In 8 percent ( $\pm 5$  percent) of the facilities visited, fire exits were blocked by furniture or other objects.

At one training school, a site visitor observed that there was only one exit from a sleeping area. When the visitor asked how juveniles would escape if fire blocked the one exit, staff said residents had been instructed to "kick out" a full-length plexiglass window at the opposite end of the corridor.<sup>24</sup>

Site visitors examined fire and life safety inspection reports and noted whether deficiencies were discovered and whether corrections had been made. Where corrections had not been made, visitors asked why.

We estimate that 63 percent ( $\pm 10$  percent) of confined juveniles are in facilities that have fire or life safety deficiencies identified during annual inspections. It appears that most identified deficiencies are corrected within a few months. The two reasons cited most often for not correcting deficiencies are lack of funds and the minimal nature of some identified deficiencies.

**Emergency Power.** The need for emergency power is less pressing for juveniles in facilities that do not have electrically operated door locks or mechanical ventilation. Twenty-one percent ( $\pm 9$  percent) of juveniles are housed in facilities with mechanical ventilation systems and no emergency power. Eight percent are in institutions that have electrically operated door locks but lack an emergency power source (data not shown).

### **Summary Regarding Inspection and Emergency Preparedness**

Sixty-six percent of confined juveniles are in facilities that conform to all four emergency preparedness and inspection criteria. Conformance to individual criteria is considerably higher. However, these criteria address potentially life-threatening conditions and any conformance level less than 100 percent is cause for concern.

Our assessment criteria address only the existence and frequency of State or local inspections. They do not assess the content of State or local standards, which are the basis of inspections. The rigor of inspections may vary from State to State, along with enforcement procedures applied when unacceptable conditions are found. Site visits confirmed that certain easily observed fire and life safety deficiencies are commonplace. Unmarked fire exits in sleeping areas were found in more than one-half

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<sup>24</sup> The window appeared to be firmly glazed, and the plexiglass appeared to be about one-quarter inch thick. The cottage itself was secure and locked at night.

of the detention centers. Nearly two-thirds of the 30 detention centers we visited and one-fourth of reception centers, training schools, and ranches did not post fire escape routes in all observed living units. Site visitors observed blocked fire exits in sleeping areas or living units at 8 percent of the facilities visited.

Nationally recognized standards for juvenile facilities prohibit the common fire and life safety violations we observed during site visits. In many cases, facility administrators told us that existing State laws or regulations did not require marked fire exits in juveniles' living units, even though marked fire exits usually were required in public areas of the facility and in other public buildings in the jurisdiction. Other violations, such as failure to post fire escape routes, may be corrected by more careful internal housekeeping, more frequent inspections, and more vigorous enforcement of existing regulations.

### **Recommendations Regarding Inspection and Emergency Preparedness**

*We recommend that appropriate State and local agencies increase the frequency of inspections for fire and life safety violations in juvenile confinement facilities and exercise available enforcement authority more vigorously to correct violations. We recommend that State laws or regulations governing fire and life safety in juvenile facilities should be as rigorous as those that apply to schools, hospitals, or other public buildings.*