



INTEGRATED SERVICES COMMITTEE REPORT AND RECOMMENDATIONS:

YOUTH SUICIDE PREVENTION AND INTERVENTION

Background:

In December 2003 the CSN Executive Committee asked the Integrated Services Committee (ISC) to discuss youth suicide and make recommendations about prevention and intervention policies and procedures. To that end the ISC began a series of discussions with the various community groups and agencies that address youth suicide with four objectives:

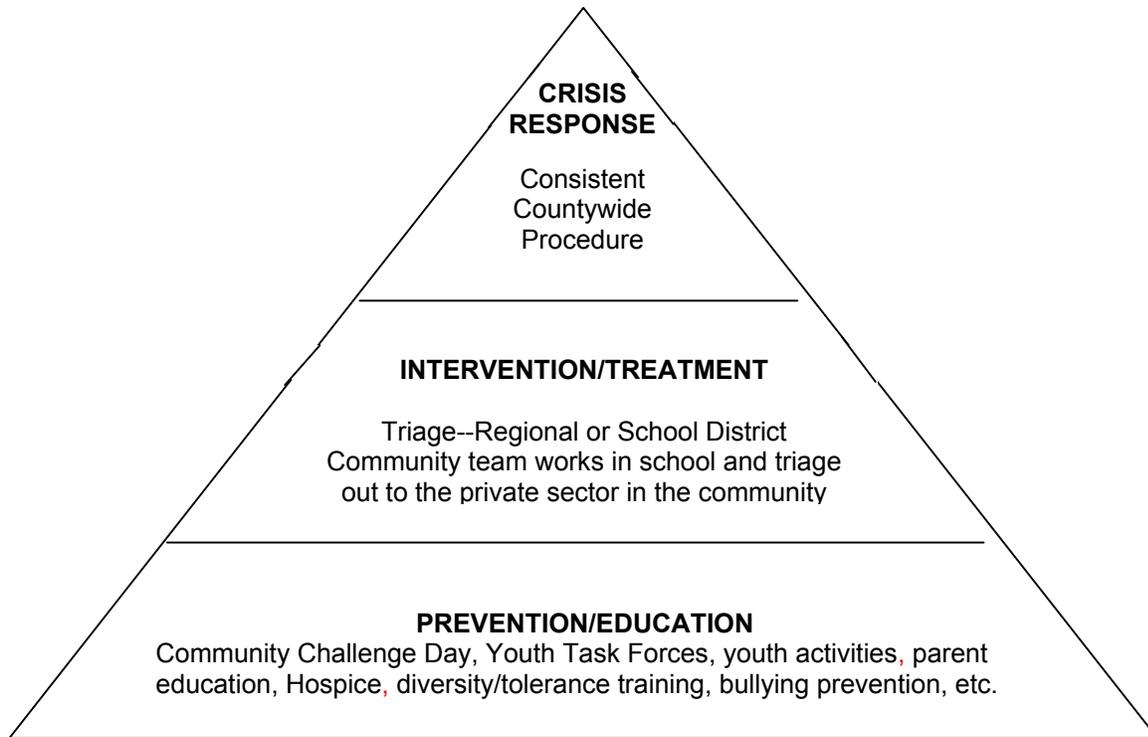
- To inventory the programs and services that are currently in place
- To identify gaps in services
- To recommend strategies to establish and maintain comprehensive youth suicide prevention and intervention services in San Luis Obispo County and
- To share the information gathered with service providers county-wide

It is difficult to ascertain the number of youth suicides that occur in our county – or any locale - each year. Death certificates rarely list suicide as the cause of death except in the most obvious cases. Teenagers and young adults often engage in risky behavior and a resulting death could be an accident or a suicide, depending on the state of mind. Professionals who work with young people note that suicides often occur in “clusters” – that is, if there is one it is not uncommon for others to occur. In the school year 2003-2004 there were three recognized youth suicides in San Luis Obispo County.

In FY 2003-2004 the SLO County Mental Health served 324 youth in Adolescent Crisis Intervention. Two hundred eighty seven (287) were seen by the Mobile Crisis unit and 37 in CMH clinics. Almost half of these youth (172) were seen because of a suicide gesture (68) or suicide ideation (104). In addition, 17 were seen for depression and 17 for agitation/anger/aggression (a common way for young males to express depression). Problem resolution involved 97 involuntary hospitalizations (5150 holds), 10 voluntary hospitalizations, 23 referrals to a private psychiatrist and 51 referrals to a private therapist in addition to 111 referrals to CMH clinics and other County services. These numbers do not reflect the crisis telephone calls to CMH clinics, which are estimated to at least equal the number of face-to-face contacts noted above. Counts of these calls will be available starting FY 04-05.

Discussion and recommendations:

The Integrated Services Committee considered information in three areas: *crisis response*, *intervention and treatment*, including after-care (individual, school and community services after a suicide has taken place) and *prevention*, including education and promising practices. The inter-relationship and relative intensity of these areas are depicted in the following diagram.



Within each area the Committee inventoried current resources and practices and developed recommendations. In summary, the Committee found that

- There is not a common response to youth suicide
- School suicide prevention programs are not consistently present.
- School staff and other service providers may not be informed that a child has attempted suicide
- Screening and follow-up care are inconsistent
- Community resources and coordination are inconsistent
- In general there is a lack of awareness of the issues surrounding youth suicide.

The Committee recommends that:

- appropriate local training be developed
 - for community gatekeepers
 - to strengthen peer support programs
- school districts develop policies and practices to insure on-going training (such as ASIST, taught through the County Office of Education)

- all service providers for children and families understand emergency response protocols (police, recreation leaders, sports coaches, etc.)
- community based resources be developed to connect with school districts for student, family and school staff support.
- an annual training and planning cycle be established
- there should be a coordinated interagency effort to increase public awareness

I. Crisis response

County Mental Health is the primary responder. If the child is at school and exhibiting symptoms or signs (see Appendix C) school staff should first call the Mental Health clinic in the region the child is in or the Managed Care number (1-800-838-1381) to triage the appropriate intervention. (A list of clinic contact numbers can be found in Appendix A). Intervention may include a Mental Health staff site visit, taking the youth to the local clinic or deploying the Mobile Crisis Unit (MCU) to work with the teacher, parents and youth. **School staff should call the appropriate clinic as soon as a crisis is sensed.** It may take some time for the Crisis Team to arrive. The MCU consists of one full time person, on call, with one back-up person. If the MCU can't provide intervention and/or arrive in a timely manner the person at the scene with the most knowledge should call 9-1-1 in the case of imminent danger.

Mental Health is mandated to serve persons who are Medi-cal eligible, 3632 eligible with an active IEP, Healthy Families eligible with a designated SED (Seriously Emotionally Disturbed) diagnosis or indigent. **In emergency situations the above criteria are waived and Mental Health responds as needed.**

Recommendations:

- All youth service providers, each school district and emergency responders will have a standardized protocol in place and train all staff regularly. The County Office of Education offers an excellent two-day "Train the Trainers" program each year.
- Develop community-based assessment, crisis intervention and after-care teams comprised of both agency and private provider volunteers.
Action: Drug & Alcohol Services staff developed and sent out a community therapist survey to assess interest in participation on a community-based team. Twenty responses were received from all regions of the county.
Next steps:
 - Develop training for providers and responders
 - Develop regional community resource teams to partner with school districts for prevention, after-care and debriefing (based on existing disaster response teams)
- CMH staff will encourage parents to sign a release of information allowing coordination with school and other follow-up services.
- Develop monthly or quarterly reports of crisis team response for the purpose of local prevention and intervention planning

- Develop handouts for students and families that include the Hotline and other relevant phone numbers
- Train designated staff in all law enforcement jurisdictions about suicide response and youth issues.

II. Intervention and treatment

“After-care” or “postvention” consists of strategies designed to help prevent or contain suicide clusters and to help youth, families and friends and school staff effectively cope with feelings of loss and grief.

Community Mental Health and school district confidentiality laws inhibit counselors at school from assisting with follow-up services. The counselors may have no way of knowing that a child has attempted suicide unless the youth or friend reveals the information. If parents won't sign a release of information Mental Health can't collaborate with the school or other service provider for appropriate after-care.

Recommendations:

- Research the ability to include suicide risk and/or attempt information as part of the multi-disciplinary team (MDT) court order to foster better-coordinated services.
- Train school line staff and youth service providers to watch for students exhibiting warning signs, offer to screen all students at risk and follow up with high- and medium risk youth.

III. Prevention, education and promising practices

Schools are, of course, where most kids spend their days and are often the place where the child is best understood. As a result much of the burden for identification and referral falls on school staff. Although there are ten school districts in the county there is a vast disparity between tiny districts, such as San Miguel and Pleasant Valley, that govern a single elementary school, and districts like Lucia Mar, stretching from Shell Beach to Nipomo and encompassing all levels from kindergarten to high school. All have dedicated and concerned staff, but some have more resources than others for non-academic prevention programs.

Community-based Youth Task Forces or Coalitions have been developed in almost every area of the County. These citizens' groups play a major role in providing healthy, constructive activities and safe places for kids. They provide positive role models and caring adult relationships and form the first line of defense against youth suicide. But again we see that the more rural, isolated areas often have fewer resources upon which to draw – whether human or financial.

Recommendations:

Schools/Colleges

- Require In-service trainings about suicide prevention and signs of depression for all school staff at the beginning and mid point of the year
- Use informational e-mails to school and agency staff, with bold eye-catching one-liners to share information.
- Offer bullying prevention training and diversity/tolerance training to students and responders (include sexual identity information).
- Increase community awareness about the correlation between substance abuse, risky behaviors and suicide.
- School principals/administration should take the lead in bringing information and training to their schools
- Ways to keep students/parents informed:
 - Displays at school
 - Training/education at the PTA
 - Train kids to outreach to other kids
 - Let kids know they are loved and cared for
 - Wrap training/education into Youth Coalition/Asset Development activities
 - Provide Hospice training/education about the grieving process before a crisis develops
- Encourage school poetry projects for student expression
- Seek assistance from retired professionals in school district areas
- Develop a training program, presented by professionals, that will provide a consistent message throughout the county
- Schools and communities should develop team building for students, parents, staff, service providers and others.
- Provide resource information and phone numbers on the back of student ASB card
- Add to Cal Poly curriculum for teachers
- Develop and distribute student resource cards with appropriate crisis-intervention contact numbers. Encourage students to make face-to-face contact with a helping person if possible.

Community

- Develop public forums and/or discussion groups to explore youth suicide. What are the commonalities in our area?
- Participate in activities such as Community Challenge Day, designed to unite members of the school and community and empower them to carry the themes of the program back to the school population. Themes include building self-esteem and self-confidence in students, shifting dangerous peer pressure to positive peer pressure, and making teasing, bullying, and all forms of violence unacceptable.
- Explore the possibility of a community-based resource person at school to keep track of trainings, etc. and to coordinate and mobilize in times of crisis
- Utilize the County Office of Education's ASIST training.
- Utilize Hospice and other community trainings and support groups
- Develop trainings for Youth Task Forces and Coalitions.

Health, Behavioral Health, education, law enforcement, Probation and Child Welfare Services professionals

- Develop and present a program similar to Mandated Reporter Training focused on suicide's warning signals and the policies/procedures to follow
- Establish a countywide model/curriculum for suicide/crisis response and education
- Focus efforts to catch kids that fall between the insurance/services gap
- Develop and support a community-based intervention network
- Tie in with new employee orientations

Promising practices

Promising practices from the Centers for Disease Control (1992; see Appendix G for the full Executive Summary):

School Gatekeeper Training: program directed at school staff (teachers, counselors, coaches, etc.) to help them identify students at risk of suicide and refer students for help. Teaches staff how to respond to school crisis.

Community Gatekeeper Training: provides training to community members such as clergy, police, merchants, and recreation staff. Designed to help these people identify youths at risk of suicide and refer them for help.

General Suicide Education: school-based programs provide students with facts about suicide, alert them to suicide warning signs, and provide them with information to seek help for self or others. Often incorporates a variety of self-esteem or social competency development activities.

Screening Programs: involve administration of an instrument to identify high-risk youth to provide more thorough assessment and treatment for a smaller, targeted population

Peer Support Programs: conducted in either school or non-school settings. Designed to foster peer relationships, competency development, and social skills as a method to prevent suicide among high-risk youth.

Crisis Centers and Hotlines: provide emergency counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Some offer a "drop-in" crisis center and referral to traditional mental health services

Means Restriction: activities designed to restrict access to firearms, drugs, and other common means of committing suicide.

Intervention After a Suicide: strategies designed in part to help prevent or contain suicide clusters and to help youth effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is one of several goals of interventions made with friends and relatives of a suicide victim so called "postvention" efforts.

CDC Summary: no single program demonstrates any great success, but a combination of the various types of programs is effective. Evaluation is needed.

Next Steps:

- Develop a countywide training schedule and curriculum and encourage the adoption of organizational policies to provide training at least annually
- Identify a lead person at each organization to provide the training
- Include youth suicide information and resources with the school's annual parent notice
- Have school plans readily available for staff and parents
- Educate parents about symptoms of depression and risk factors for and warning signs of suicide. (See Appendices B and C)
- Establish a community model for parents' involvement in their children's lives, crisis management and effective parenting and provide parent education
- Promote and publicize support resources, parent access to parent education classes
- The CSN should work with other community groups to deliver community based trainings and conferences
- The CSN should widely distribute and publicize this report, emphasizing the findings
- Integrated Services Committee will report back to the CSN Council as a focus topic training.

APPENDICES

APPENDIX A: ACCESS TO EMERGENCY MENTAL HEALTH SERVICES

A. Weekday Emergency Coverage

1. Countywide Services

- a. San Luis Obispo Clinic.....(805) 781-4700
There is a full time emergency worker on duty at this clinic Monday through Friday.

- b. SLO Youth Services Clinic(805) 781-4179
There is a clinician assigned to provide emergency services at the clinic during normal business hours Monday through Friday.

- c. Paso Robles Clinic(805) 237-3170
There is a clinician assigned to provide emergency coverage at the clinic during normal business hours Monday through Friday.

- d. Atascadero Clinic(805) 461-6060
There is a clinician assigned to provide emergency coverage at the clinic during normal business hours Monday through Friday.

- e. South County Clinic.....(805) 473-7060
There is a clinician assigned to provide emergency coverage at the clinic during normal business hours Monday through Friday.

B. Lunchtime Coverage

When a clinic is closed for lunch, the calls are automatically forwarded to the SLO Clinic receptionist who will forward it to the appropriate clinician for assistance.

C. Lunch-time and After Hours Coverage

During lunch time, after 5PM and on weekends and holidays emergency services from SLO County Mental Health are accessed by calling the 24 hour phone line at **1-800-838-1381**. After hours, this number will ring at the inpatient hospital unit. The unit staff are trained to screen emergency calls and will provide referrals to appropriate services or they will activate the county Mobile Crisis Team if appropriate.

APPENDIX B: WARNING SIGNS OF DEPRESSION

From the American Academy of Child & Adolescent Psychiatry

Not only adults become depressed. Children and teenagers also may have depression, which is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way to feel better. Children and adolescents who cause trouble at home or at school may also be suffering from depression.

Early diagnosis and treatment are essential for depressed children. Depression is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. Treatment may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a qualified mental health professional, who can diagnose and treat depression in children and teenagers.

APPENDIX C: WARNING SIGNS AND RISK FACTORS FOR SUICIDE

Taken separately, these warning signs and risk factors are often seen as common characteristics of adolescence and are considered to be just part of the growing up process that our youth and teens endure. However, when one or more of the warning signs are coupled with one or more of the risk factors, the combination drastically increases the risk of suicide.

Warning Signs

- **Makes suicidal comments**
- **Abrupt changes in personality**
- **Giving away possessions**
- **Previous suicide attempt**
- **Change in sleeping or eating habits - significant weight changes**
- **Perfectionism**
- **Depression or hopelessness**
- **Lack of self esteem**
- **Loss of enthusiasm, energy or motivation**
- **Loss of interest in favorite activities**
- **Extreme or extended boredom**
- **Inability to tolerate frustration**
- **Restlessness - unable to concentrate**
- **Withdrawal (from people, close friends, family and activities)**
- **Unwillingness or inability to communicate**
- **Unusual sadness**
- **Rebellious, hostile, reckless or self destructive behavior**
- **Neglect of personal appearance**
- **Use of drugs and/or alcohol (self medication)**
- **Promiscuity**
- **Themes of death or hopelessness in conversation, schoolwork or artwork**

Risk Factors

- Problems at school or with the law
- Tendency towards anger and impulsiveness
- Recently experienced a significant loss: a romance, the death of a loved one, divorce
- Unexpected pregnancy
- Loss of self esteem - humiliation
- Stressful family life - unrealistic parental pressure
- Physical, emotional or sexual abuse
- Parents who are depressed or substance abusers
- Family history of suicide
- Stress due to new situations - beginning a new school or relocating to a new community
- Loss of security - fear of authority, peers or group
- Teens who are gifted
- Teens with learning disabilities
- Failing - in school, an important test or an athletic goal
- A serious injury or illness
- Remorse at causing another persons pain - physically or emotionally
- Sexual orientation or identity confusion

Warning Signs and Risk Factors from the
Yellow Ribbon Suicide Prevention Program of Los Angeles
www.yrla.net

APPENDIX D: GENERAL INFORMATION ABOUT YOUTH SUICIDE

The chart below shows San Luis Obispo County's youth demographics in relation to California's suicide statistics for 2000 (as reported by the Department of Health Services).

Ethnicity/Age	San Luis Obispo County age-specific population in 2000			California Total Number of Suicides in 2000			CA rates (per 100,000 population)		
	Total	Male	Female	Total	M	F	Total	M	F
All, ages 5-14	29,933	15,486	14,447	24	16	8	0.4	0.6*	0.3*
All, ages 15-24	42,599	23,633	18,966	327	268	59	7.1	11.2	2.7
Asian/other, 5-14 ¹	579	283	296	2	1	1	0.3*	0.3*	0.3**
Asian/other, 15-24 ¹	2,119	1,257	862	32	24	8	5.3	7.8	2.7*
Black, 5-14	392	194	198	2	2	0	0.5*	1.0*	0.0**
Black, 15-24	863	673	190	25	20	5	7.0	10.6	3.0*
Hispanic, 5-14	7,617	3,924	3,693	6	1	5	0.3*	0.1*	0.4*
Hispanic, 15-24	9,049	5,350	3,699	109	87	22	6.8	10.5	2.8
White, 5-14	21,345	11,085	10,260	14	12	2	0.6*	1.1*	0.2*
White, 15-24	30,568	16,353	14,215	161	137	24	7.9	12.9	2.4

*unreliable, relative standard error is greater than or equal to 23 percent

** standard error indeterminate, death rate based on no (zero) deaths

¹ SLO population is for Asian only; CA population is for Asian/other

More information:

- Nationally suicide is currently the third leading cause of death for young people between 15 and 24. In the western states (including California) suicide is the **second** leading cause of death in this age group.
- In 2000 13.6% of all suicides were committed by persons under the age of 25.
- The male/female ratio of completed suicides in 2000:
 - 3.7 to 1 among 10-14 year olds
 - 5 to 1 among 15-19 year olds
 - 6.2 to 1 among 20-24 year olds

- The Yellow Ribbon Suicide Prevention Program of Los Angeles estimates that there are conservatively 100 attempts per completed suicide.
- A 1989 Report to the (US Department of Health and Human Services) Secretary's Task Force on Youth Suicide estimated that gay and lesbian youth are two to three times more likely to commit suicide than other youths, and 30 percent of all completed youth suicides are related to the issue of sexual identity.
- In 2000 in California there were a total of 351 recorded suicides for people ages 5-24. Twenty-four are listed for ages 5-14 and 327 for ages 15-24. (Suicide is apparently not considered below age 5, although anecdotally individual cases are known.)
- The American Association of Suicidology (AAS) estimates that approximately 12 young people between the ages of 15-24 die every day by suicide, and that within every 2 hours and 2.5 minutes a person under the age of 25 completes suicide.
- AAS also notes that nationally within a typical high school classroom it is likely that three students (one boy and two girls) have made a suicide attempt in the past year. (This is likely to be higher in the west.)
- The Centers for Disease Control estimate that more than 20% of young people have seriously considered suicide, with 10th grade girls exhibiting at 30% rate.
- Most adolescent suicides occur in the afternoon or early evening in the teen's home.
- CDC data on youth suicide behaviors, risk factors and prevention show:
 - studies of youth 10-14 years show that suffocation (mostly hangings) has replaced firearms as the most common method of suicide. In 2001 suffocation suicides in this age group occurred nearly twice as often as firearms suicides, the most frequently used method before 1997.
 - One in 20 high school students reported both suicide attempts and involvement in physical fights in the past year. Students who reported attempting suicide in the past 12 months were nearly four times as likely to report involvement in physical fights.
 - Of the lethal acts of school violence carried out by students between July 1, 1994 and June 30, 1999, more than 20 percent were suicides. One in four suicide victims injured or killed someone else before their suicide.
 - Hispanic youth are the fastest growing segment of the US population and account for one fourth of all Hispanic suicide deaths.
- AAS estimates that the lives of (conservatively) at least 6 people related to or connected to individuals who attempt or complete suicide are impacted.

APPENDIX E: ARTICLE FROM *JOIN TOGETHER ONLINE*: TAKE ACTION AGAINST SUBSTANCE ABUSE AND GUN VIOLENCE

www.jointogether.org

Youth Suicides: A Public Health Crisis

5/11/2004

By Patrick Cliff
Columbia News Service

When a person commits suicide, friends and family are left to mourn and wonder why a life was ended so early, what caused it all? The questions can seem even more unanswerable when the victim is a teenager.

"It's very hard for most of us to believe that a young person would take their life," said Laurie Flynn, director of [TeenScreen](#), a national suicide prevention program.

Suicide is the fourth-leading cause of death among children aged 7-17, according to a new study by the [Centers for Disease Control and Prevention](#) and the Department of Justice. Between 1981 and 1998 -- the period of the study -- 20,775 people in that age group committed suicide, compared with 24,000 who died of cancer. Suicide has long been considered a single and inevitably tragic incident. But experts are starting to view suicide as a broad public health issue, rather than as an individual struggle.

Even though youth suicide has become a public health crisis, "the money has lagged behind the research," according to Dr. Lanny Berman, director of the [American Association of Suicidology](#), an advocacy group in Washington. That could change soon, though. In March, Sen. Chris Dodd (D-Conn.) introduced legislation that would provide up to \$30 million annually to suicide-prevention programs.

The CDC study also detailed the growing role of guns in both youth suicide and homicides. During the study period, youth suicides increased by 44 percent, with gun-related suicides making up 80 percent of that increase. At the same time, the number of youths who committed murder with a firearm tripled, even as the total number of murders remained constant. This shows, according to the CDC's Dr. Alex Crosby, that suicide is linked to other social ills, like gun violence.

Now that public-health officials have come to understand that the suicide is not just an isolated mental-health issue, they are faced with the challenge of slowing the decades-long rise in youth suicide. In 2001, the U.S. surgeon general released the [National Strategy for Suicide Prevention \(NSSP\)](#), which provided public-health officials with new approaches to addressing the problem. Since then, the Department of Health and Human Services subsequently established an

affiliated resource center for the public-health community. One of the main goals of the project is to open discussion among a broad range of academic and medical disciplines. "Mental health, social services, education can all play a role," Crosby said. "This is a societal problem, not just one field."

The NSSP recommends that suicide-prevention programs be implemented as widely as possible. One preventative approach is screening youths who seem particularly vulnerable to suicide. For example, TeenScreen created a survey -- developed at Columbia University in 1991 -- designed for middle- and high-school students that takes only 10 minutes to complete.

In 1991, 2,000 students took the TeenScreen survey. An analysis of the results showed that only 31 percent of those with major depression, 26 percent of those who considered suicide, and 50 percent of those who had attempted to kill themselves were in treatment. (Emphasis added.) Suicide "almost never occurs unless there is a mental disorder present," said Flynn, director of the TeenScreen group at Columbia

About 13,000 students will take the TeenScreen survey in 26 states this year. For the first time since the early 1950s, some data indicate that youth suicide is slowing, says Crosby, and public-health officials are beginning to think they've made inroads. "For a long time, we didn't know much" about suicide, Flynn said. "There was a sense that you can't predict it and can't do anything to stop it."

Each year between 1994 and 2001, fewer families have had to try and answer questions left behind by a suicide. Through increased screening and care for at-risk teens, public-health professionals hope to keep youth suicides on the decline.

"There is still a stigma," Crosby said. "But it really can be prevented."

APPENDIX F: RESOURCES

- Centers for Disease Control, National Center for Injury Prevention and Control: www.cdc.gov/ncipc/factsheets/suifacts.htm
- Suicide Awareness Voices of Education website: www.save.org
- Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov
- American Association of Suicidology: www.suicidology.org or 1-202-237-2280
- American Foundation for Suicide Prevention: www.afsp.org
- National Institute of Mental Health (NIMH): www.nimh.nih.gov
- National Strategy for Suicide Prevention: www.mentalhealth.org/suicideprevention/
- National Suicide Prevention Strategy: www.sg.gov/library/calltoaction/
- National Youth Violence Prevention Resource Center: www.safeyouth.org
- Reporting on Suicide: Recommendations for the Media: www.afsp.org/education/newrecommendations.htm
- Suicide Prevention Advocacy Network (SPAN): www.spanusa.org
- Screening for Mental Health / SOS High School: www.mentalhealthscreening.org/sos_highschool
NOTE: the County Office of Education has this program available for preview or loan. Contact Christine Enyart at 782-7284.
- Columbia University Teen Screen Program: www.teenscreen.org
- Yellow Ribbon Suicide Prevention Program of Los Angeles: www.yrla.net
- Parents, Family and Friends of Lesbians and Gays (PFLAG): www.pflag.org
- Teaching Tolerance: www.tolerance.org
- Gay, Lesbian and Straight Education Network: www.glsen.org
- Mental Health in Schools Training and Technical Assistance Center: www.smhp.psych.ucla.edu

APPENDIX G: YOUTH SUICIDE PREVENTION PROGRAMS: A RESOURCE GUIDE

**U.S Department of Health and Human Services,
Public Health Service, Centers for Disease Control,
National Center for Injury Prevention and Control**

Prepared by:

Patrick W. O'Carroll, M.D.,M.P.H.
James C. Hersey, Ph.D.
Mary Odell-Butler, Ph.D.

James A. Mercy, Ph.D.
Casey Boudreau, M.S.

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Executive Summary/Background and Approach

Given the continued high rates of suicide among adolescents and young adults (15-24 years of age), it is more urgent than ever that we apply our limited resources for prevention in the most effective manner possible. To that end, we developed this resource guide to describe the rationale and evidence for the effectiveness of various youth suicide prevention strategies and to identify model programs that incorporate these different strategies. The guide is for use by persons who are interested in developing or augmenting suicide prevention programs in their own communities. Because the diagnosis and treatment of mental disorders is so widely accepted as a cornerstone of suicide prevention, we excluded from this guide programs that provide mental health services in traditional health service delivery settings. We did include, however, programs that were designed to increase referral to existing mental health services.

We developed this resource guide through networking. Initially, 40 experts in youth suicide prevention around the country were asked to identify exemplary youth suicide prevention programs. Representatives from these programs were then contacted and asked to describe their activities and to identify other programs that they considered exemplary. The list was supplemented by contacting program representatives who participated in the 1990 national meeting of the American Association of Suicidology (AAS) and by soliciting program identification through Newslink, the newsletter of AAS. The resulting list of programs is not meant to represent all exemplary youth suicide prevention programs, but it does characterize the diversity of existing programs and can serve as a resource guide for those interested in learning about the types of prevention activities in the field.

For this guide, we delineated eight different suicide prevention strategies, most of which were incorporated in some combination into the programs we reviewed. These were:

- **School Gatekeeper Training.** This type of program is directed at school staff (teachers, counselors, coaches, etc.) to help them identify students at risk of suicide and refer such students for help. These programs also teach staff how to respond in cases of a tragic death or other crisis in the school.
- **Community Gatekeeper Training.** This type of gatekeeper program provides training to community members such as clergy, police, merchants, and recreation staff. This training is designed to help these people identify youths at risk of suicide and refer them for help.
- **General Suicide Education.** These school-based programs provide students with facts about suicide, alert them to suicide warning signs, and provide them with information about how to seek help for themselves or for others. These programs often incorporate a variety of self-esteem or social competency development activities.
- **Screening Programs.** Screening involves administration of an instrument to identify high-risk youth in order to provide more thorough assessment and treatment for a smaller, targeted population.
- **Peer Support Programs.** These programs, which can be conducted in either school or non-school settings, are designed to foster peer relationships, competency development, and social skills as a method to prevent suicide among high-risk youth.
- **Crisis Centers and Hotlines.** These programs primarily provide emergency counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Some programs offer a "drop-in" crisis center and referral to traditional mental health services.
- **Means Restriction.** This prevention strategy consists of activities designed to restrict access to firearms, drugs, and other common means of committing suicide.
- **Intervention After a Suicide.** Strategies have been developed to cope with the crisis sometimes caused by one or more youth suicides in a community. They are designed in part to help prevent or contain suicide clusters and to help youth effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is but one of several goals of intervention made with friends and relatives of a suicide victim- so-called "postvention" efforts.

Findings

Overall, we noted that:

- Despite many differences, the various prevention strategies incorporated into current youth suicide prevention programs have **two common themes**. As noted above, we delineated eight different strategies for youth suicide prevention that were generally incorporated in some combination into the programs we reviewed. Despite their obvious differences, these

eight strategies may be considered to constitute just two conceptual categories: (1) strategies to enhance the recognition of suicidal youth and their referral to existing mental health resources, and (2) strategies designed to directly address known or suspected risk factors for youth suicide.

- **Strategies to enhance recognition and referral.** This category includes active strategies to identify and refer suicidal youth (general screening programs, targeted screening in the context of an apparent suicide cluster) as well as passive strategies to increase referrals (training school and community gatekeepers, general education about youth suicide, establishing crisis centers and hotlines). Some of the passive strategies are designed to lower barriers to self-referral for those with suicidal feelings; others are designed to increase referrals by persons who recognize suicidal tendencies in someone they know.
- **Strategies to address known or suspected risk factors.** This category includes interventions designed to promote self-esteem and build competency in stress management (general suicide education, peer support programs); to develop support networks for youths who have attempted suicide or who are otherwise thought to be at high risk (peer support programs); and to provide crisis counseling or otherwise address the proximal stress events that increase the risk of suicide among susceptible youths (crisis centers and hotlines, interventions to minimize contagion in the context of suicide clusters). Although means restriction may be critically important in reducing the risk of youth suicide, none of the programs we reviewed placed a major emphasis on this prevention strategy.
- **Most programs focus on teenagers** with little emphasis given to suicide among young adults. With a few important exceptions, most programs designed to reduce youth suicide were developed with high school-aged youth in mind. This may be due to the fact that adolescents in high school are easier to reach than young adults 20-24 years of age. But it may also be due to a failure to appreciate that **the suicide rate is generally twice as high among persons 20-24 years of age as among adolescents 15-19 years of age.** More prevention efforts need to be targeted toward young adults at high risk of suicide.
- **Current programs are sometimes inadequately linked with existing community mental health resources.** Some programs, notably the Pennsylvania Student Assistance Program, have deliberately worked to develop very close ties with community mental health resources. In a substantial number of other programs, however, linkages with existing mental health resources have been somewhat tenuous. We believe that strengthening these ties would substantially enhance suicide prevention efforts.
- **Some strategies are applied very infrequently--despite great apparent potential for success--whereas others are very commonly applied.** In particular, despite evidence that restricting access to lethal means of suicide (e.g., firearms and lethal dosages of drugs) may prevent some youths from completing suicide, none of the youth suicide prevention programs we reviewed incorporated this strategy as a major focus of their efforts. Parents should be educated in suicide warning signs and encouraged to restrict their teens' access to lethal suicide means. Other promising strategies, such as peer support programs for

previous suicide attempters or high-risk youth, might also be more widely incorporated into current suicide prevention programs, but great care should be taken to ensure that there are no adverse consequences from involving peers in such activities.

- **Certain potentially effective programs targeted at high-risk youth are not thought of as "youth suicide prevention" programs.** Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs. Few of the programs we reviewed had any formal ties with such programs.
 - **There is very little evaluation research in this area--**indeed, there is very little data collected that would facilitate such research. The tremendous dearth of evaluation research stands as the single greatest obstacle to improving current efforts to prevent youth suicide. In the final analysis, despite many years of experience and hard work, all we can say--and scientifically defend--is that every one of the eight strategies described herein, as currently implemented, may or may not prevent youth suicide. Clearly, this is an unsatisfactory state of affairs. We urgently need to evaluate existing suicide prevention programs wherever possible and to incorporate the potential for evaluation into all/new prevention programs. Moreover, whenever possible, the outcome measure for such evaluations should be changes in suicidal behavior. After all, it is the level of suicidal behavior--not attitudes toward suicide or knowledge of warning signs--that we are ultimately working to change. When measuring a program's effect on the level of suicidal behavior is not feasible, the outcomes measured should be those that are closely associated with actual suicidal behavior. In this regard, it is worth noting that any health intervention may have unforeseen negative consequences; suicide prevention efforts are no exception. This is another, even more important reason why evaluation must be built into every youth suicide prevention program. Regardless of the prevention strategy employed, we must be vigilant to ensure that efforts to prevent suicide do not result in untoward consequences.
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Recommendations

Although we do not have sufficient information to recommend one suicide prevention strategy over another at this stage, the following recommendations seem prudent:

- **Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources on the community.** As noted, many of the strategies are designed to increase referrals of at-risk youth--this approach can be successful only to the extent that there are appropriate, trained counselors to whom referrals can be made.
- **Avoid reliance on one prevention strategy.** Most of the programs we reviewed already incorporate several if not all of the eight strategies we described. However, certain strategies tend to predominate, despite limited evidence of their effectiveness.

- **Incorporate promising but underused strategies into current programs where possible.** The restriction of lethal means by which to commit suicide may be the most important candidate strategy here. Peer support groups for those who have felt suicidal or have attempted suicide also appear promising.
- **Expand suicide prevention efforts for young adults 20-24 years of age,** among whom the suicide rate is twice as high as for adolescents.
- **Incorporate evaluation efforts into all new and existing suicide prevention programs,** preferably based on outcome measures such as the incidence of suicidal behavior, or measures closely associated with such incidence. Be aware that suicide prevention efforts, like all health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to identify such consequences, should they occur.

Like many prevention programs, the suicide prevention programs described in this resource guide are evolving. They are subject to changes in staff, funding, and program emphasis. Hence, readers should contact programs directly to obtain current information on their activities.

