Memorandum

Date   OCT - 6 1986

         /s/ Bryan B. Mitchell

From   Richard P. Kusserow
         Inspector General

Subject OIG Final Report: "Assessment and Documentation of Youth at
         Risk of Suicide," P-09-86-00101

To   Jean K. Elder, Ph.D.
         Acting Assistant Secretary
            for Human Development Services

Attached for your information is our final inspection report
entitled "Assessment and Documentation of Youth at Risk of
Suicide." This is the third in a series of three reports
reflecting the findings of a national program inspection on
youth suicide conducted at the request of the Secretary's
Task Force on Youth Suicide. The other two reports, entitled
"Youth Suicide" and "Inventory of State Initiatives In
Addressing Youth Suicide," have been sent previously under
separate memorandum.

Our major findings are:

o Few respondents use formal tools to screen for risk of
   suicide. Although many respondents were very receptive to
   the idea that HHS develop a screening tool, some were
   skeptical that the Department could develop an effective
   tool.

o A screening tool would be most useful to service providers
   who do not have a specific mental health focus or do not
   routinely work with clients at risk of suicide. Training
   in the use of such a tool is essential.

o With the exception of hotlines and a few school districts,
   service providers do not maintain statistics on youth
   suicide.

o Information on individual clients can usually be shared
   with a signed release. Sharing of aggregate data is
   generally not a problem.

If you have any questions, please have your staff contact
Ta Zitans at 472-5340.

Attachment

cc: Dodie Livingston
     Administration for Children, Youth
        and Families

ASSESSMENT AND DOCUMENTATION
OF YOUTH AT RISK OF SUICIDE

INTRODUCTION

The Office of Inspector General (OIG) was asked to conduct a qualitative national program inspection of youth suicide which would supplement the work of the Department of Health and Human Services (DHHS) Task Force on Youth Suicide. The primary focus of the inspection was to (a) assess the extent to which HHS-funded programs are involved in efforts to prevent youth suicide, (b) review how states and selected communities are responding to the problems associated with youth suicide and (c) identify barriers and gaps which hinder delivery of services to suicidal youth and/or their families. The results of this inspection are reflected in two reports, entitled <u>Youth Suicide</u> and <u>Inventory of State Initiatives in Addressing Youth Suicide</u>.

In addition, this special report has been prepared for Mark Rosenberg, M.D., Chief of the Violence Epidemiology Branch, Centers for Disease Control (CDC). During his review of the original inspection design, Dr. Rosenberg indicated that querying respondents on three issues would be helpful in his work at CDC. Thus, the OIG inspection team asked respondents the following three questions:

1a. If HHS developed a screening tool to identify youth at risk of committing suicide, would it be helpful to you? (Explain yes or no.)

 b. If yes, would you actually use it? (Explain)

2. What kinds of records or documentation do you maintain on youth at risk of suicide (e.g., clinical/client records; aggregate statistics/analysis)?

3. Do you share this information with any other agencies or practitioners? Why or why not?

This report reflects responses to these questions. Our findings are based on 348 interviews. Of this total, 170 in-person interviews were conducted through visits to 10 communities in 9 states. In a telephone survey of randomly selected community service agencies (most of whom were funded by HHS), OIG staff interviewed an additional 178 persons. In all, we talked to persons in 183 communities throughout all 50 states.

MAJOR FINDINGS

1. Almost all mental health professionals and many other service providers report that they look for indications of suicide risk. Their approach is often informal and subjective, however, with reliance on clinical experience and judgment to detect warning signs. A few use formal tools to screen for risk of suicide.

2. Although 42% of the respondents report that they would use a screening tool developed by the Department and another 42% report they might use such a tool, several respondents are skeptical that the Department could develop an effective tool. HHS grantees do not want the Department to require mandatory use of a screening tool.

3. A screening tool is seen as being of greatest value to service providers who work with youth, but do not routinely encounter youth at risk of suicide. Mental health professionals and staff working with hotlines and crisis intervention programs express less interest in using a tool to screen individual clients, but perceive its utility to help with training and community education. School officials are skeptical that they would be allowed to use a screening tool due to policies on privacy and requirements for parental permission.

4. It is important that anyone using a screening tool receive adequate training on (a) how to use it, (b) appropriate demeanor, attitudes and interviewing approaches and (c) what to do if risk of suicide is detected.

5. With the exception of hotlines, service providers do not keep statistics related to suicides.

6. Most agencies share information on clients selectively, as long as clients have signed release forms. Many have policies allowing them to share information without a release if the client is judged to be at risk of harming himself or others. Release forms are not an issue when sharing aggregate data.

I. CURRENT USE OF SCREENING TOOLS

Almost all mental health professionals and many other service providers interviewed during this study report that they look for indications of suicide risk among their clients. Their screening approach is often informal and subjective with a heavy reliance on clinical experience and judgment to detect warning signs. Respondents also rely on patient self-reporting during the intake process, as well as routine mental health status examinations and structured interviews. A few use formal tools to screen for risk of suicide. Some respondents have developed their own tools for use within their agencies.

The OIG inspection team did not systematically inventory or evaluate the various screening tools currently in use. However, the following tools were identified by some respondents:

- Aaron Beck Depression Inventory (mentioned most frequently)

- Taylor Johnson Temperament Scale

- Zung Test

- Screen developed by Dan Leterri, currently at the National Institute on Alcohol Abuse and Alcoholism

- Screen developed by Tom Barrett, psychologist involved with the Suicide Prevention Allied Regional Effort (SPARE) and Cherry Creek School District in Colorado

- Screen developed by Elinor Ham, Suicide Prevention Center, Pueblo, Colorado

- Screen used by the Los Angeles Suicide Prevention Center

- Screen developed by Mary Jane Rotheram, Columbia University

OHDS has funded grantees to work with runaway and homeless youth programs to identify and prevent youth from committing suicide. Different approaches are being tried, including the development of screening tools. Several runaway programs in New York City are currently screening all clients for risk of suicide, using the screen developed by Dr. Rotheram, listed above. This tool, designed for paraprofessionals and service agency staff with little or no mental health background, identifies risk, assesses the immediacy of the problem

and helps workers begin to structure an intervention strategy. Staff using the screen participate in a short formal training program with a follow-up session after they have screened a few clients. Participating runaway programs are universally supportive of this initiative.

II. INTEREST IN HHS DEVELOPMENT OF A SCREENING TOOL

Reaction was generally positive to a possible HHS
initiative to develop a screening tool which would
identify youth at risk of suicide. Forty-two percent of
the respondents who answered the question indicated they
would welcome and use such a tool, while an additional
42% said they might find such a tool useful under
certain circumstances. By far, the most enthusiastic
response came from service providers without a specific
mental health or suicide prevention focus. As the
following table indicates, the highest interest in
acquiring a new screening tool was among (1) community
service providers such as runaway programs, juvenile
justice agencies and multi-service youth agencies and
(2) health providers such as community and migrant
health centers, family planning programs and adolescent
health clinics. "We would welcome anything that would
help us," was a common response.

INTEREST IN A NEW SCREENING TOOL				
Respondents	N	Yes	Maybe	No
Community Agencies	85	62%	31%	7%
Health Providers	56	54%	34%	13%
Hotlines/Crisis Programs	20	25%	40%	35%
Mental Health Providers	94	23%	57%	19%
Schools	13	15%	46%	38%
All Respondents	268	42%	42%	16%

As the above table indicates, respondents who are more
routinely confronted with suicidal youth (mental health
professionals, crisis intervention programs and hotlines)
were less interested in a new screening tool. Most
indicated they are comfortable with their current methods
and procedures of identifying high risk youth. Many
emphasized that a tool would never take the place of
clinical intuition and judgment. Typical were the
comments of two mental health professionals:

° We always welcome something new, but I don't think it
would help too much. If you've been in this field
awhile, you sense when there's a problem."

5

°   "I might use it, knowing it is not going to give me
    the whole answer. I wouldn't use it in lieu of my
    clinical knowledge, but as a supplement."

Several mental health and crisis intervention
professionals who expressed an interest in a screening
tool indicated it would be useful in their efforts to
educate and train people in their communities, as opposed
to its utility in clinical diagnostic work with
individual clients. Some typical comments:

°   "It would have value in elevating an awareness among
    nonprofessionals--the lay public. Clinicians are
    very familiar with the classic signs, but there is a
    definite need in the schools and in the community at
    large."

°   "I can rely on my gut feeling because I've been in
    the business for 18 years, but to train others I need
    a tool."

°   "It would be good for front line service providers.
    Once we can get kids into a clinical setting, we're
    comfortable we can sense suicide as a problem, but so
    many suicidal kids never get that far."

School officials also expressed less interest in a tool.
Many emphasized that school policies preclude staff from
administering any type of individual assessment or survey
without administrative or school board approval or
parental permission. Noted one official, "Schools have
strict laws on privacy and questionnaires. I would have
a concern about objections from parents." School
officials also questioned whether they would have time to
administer a screening tool, given heavy workload
demands.

Despite general support for the concept of developing a
screening tool, there was considerable ambivalence and
some skepticism that the Department could produce a tool
that would be a better predictor than is already
available. Several respondents indicated they would want
to evaluate any tool HHS might develop and compare it
with their own screens before judging its utility. Some
typical comments:

°   "Lots of people are trying to develop an effective
    screen that works with kids, but so far nobody's been
    able to come up with one."

°   "I can't imagine you could come up with something we
    don't already know. It's the subtleties that drive
    us crazy. Suicide is a very difficult outcome to
    predict."

6

Other respondents questioned the value of using screens to predict youth at risk of suicide, noting in particular that screens which have worked well with adults have had less utility when applied to teens. Respondents stressed that the effectiveness of screens is dependent upon accurate self-reporting, frequently a problem among adolescents. Some mental health practitioners noted that their initial impressions often change after they have had a few sessions with a client and that a screen only measures a client's behavior and attitude at a given time. "These are volatile kids and circumstances can change quickly," noted one researcher. There were some suggestions that HHS should put resources into identifying and evaluating existing tools, as opposed to "reinventing the wheel."

Respondents also stressed that no tool will identify all high risk youth. "We can add one more tool to the arsenal, but we'll never catch them all," noted a school official. Other typical comments included:

o   "Most tools don't measure nonverbal clues. A screen would be useless if it told us that most or all the kids have some risk factors. We already know that. The challenge is figuring out who is going to go ahead and do it."

o   "Suicide is very hard to predict. I am concerned that any tool HHS developed would be too general and simplistic to be of much value. We could end up registering lots of false positives, while others would be missed. This could foster a false complacence."

o   "Beware of absolute tools. Experience has shown us there's no clear-cut scale to really determine risk."

o   When a person is in crisis, he doesn't want someone interrogating him. He becomes frightened and will hang up."

If HHS proceeds with the development of a screening tool, respondents suggested that the following be considered:

Training. "If you're going to use a tool, you can't just give it to people and expect it to work," noted one researcher. Several respondents stressed that it is essential to train anyone screening for problems as sensitive as suicide risk in (1) how to use the screen, (2) appropriate demeanor, attitudes and approaches to asking questions in nonthreatening ways and (3) what to do if risk of suicide is detected. It is important that screeners address their own feelings about suicide, since this is an issue that

7

makes many people nervous and uncomfortable. Furthermore, screens do not work well if users believe there are no constructive treatment options available. Noted one clinician, "If someone doesn't know what to do or where to go, he won't identify a kid at risk. There is a tendency to deny the problem if nothing can be done about it." It was reported that the benefits of using a tool often extend beyond a diagnostic value by stimulating staff interest in and demand for more training on issues related to suicide. Training should be ongoing because users become complacent when they use the same tool repeatedly. It was suggested that revising the format occasionally helps resolve this dilemma.

Length and Complexity. Many respondents said they would use a tool only if it were simple and did not take too long to administer. Some said they would be willing to incorporate a few questions into their current intake forms.

Content. A tool should go beyond diagnosis of risk. There should also be components which assess the lethality and immediacy of risk, as well as helping the interviewer decide what to do when a high risk youth is identified.

Voluntary Screening. HHS grantees emphasized they would oppose any mandatory requirement to screen clients for risk of suicide. Noted one state official, "Please don't tie dollars to it or restrict us by mandating your tool over something that might better meet our needs." A family planning grantee said they would willingly use a screen "if we had the luxury of an optimal program, but not under the reality of our current budget situation."

Cultural Sensitivity. There was considerable concern that a tool be sensitive to various ethnic and socioeconomic groups. Many respondents said they would review any tool the Department developed to determine whether it could be adapted to their particular client groups.

III. MAINTAINING RECORDS AND STATISTICS ON YOUTH SUICIDE AND SHARING INFORMATION

Almost all the service providers keep individual case files on clients. This is true of virtually all the health and mental health service providers and most of the runaway programs and other youth service agencies. Any information related to risk of suicide is documented in the case file. Almost all the service providers report that they selectively share relevant information on a client with parents and other service providers, but only if the client signs a release. Many indicated, however, that they make exceptions to this policy if a client is judged to be in imminent danger of harming himself or others, which would include risk of suicide. Obtaining a release from individual clients is not seen as a problem. Often clients are informed of agency policies with regard to confidentiality when they begin receiving services.

Many agencies report that they maintain statistics, but do not systematically collect data with regard to suicide ideation, gestures, attempts or completions. Some indicated they could manually tabulate this information, but the process would take considerable time. Several respondents said that they had the capability to collect this type of information, but nobody has ever made such a request. Sharing aggregate information is generally not a problem.

The exceptions are the hotlines. Most hotlines keep a record of each telephone call received and can report in the aggregate the number of calls in which suicide was the primary presenting problem. Most do not record the nature of the call by an age category, however, so it would be difficult to determine how many calls were from youth. Furthermore, the hotlines emphasize that their report of suicide calls is very conservative, because the presenting problem is often something else and suicide is an underlying issue.

9