

# **YOUTH SUICIDE**

**National Program Inspection**



**OFFICE OF INSPECTOR GENERAL**  
**OFFICE OF ANALYSIS AND INSPECTIONS**

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### This Report

Entitled "Youth Suicide," this inspection was conducted to collect information to supplement the work of the HHS Task Force on Youth Suicide.

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YOUTH SUICIDE

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## INTRODUCTION

Public attention is focusing on the tragedy of suicide among the nation's youth. According to data from the National Center for Health Statistics, the suicide rate among 15- to 24-year-olds increased 129% from 1960 to 1983 (i.e., from 5.2 to 11.9 suicides per 100,000 youth). During 1983, 28,295 Americans took their own lives. Of these, 5,050 were 5 to 24 years old. This averages 14 a day. Every 100 minutes, another young person kills himself. The actual number of deaths may be two times higher than the reported incidence because (a) there is no common definition of suicide among medical examiners/coroners, (b) the social stigma attached to suicide encourages underreporting and (c) some suicides are masked, such as car accidents.

In recognition of the effect youth suicide has on society as a whole, President Reagan, pursuant to Senate Joint Resolution 53, proclaimed June 1985 as Youth Suicide Prevention Month. As part of the federal government's response to the call for action on this problem, the Department of Health and Human Services (DHHS) cosponsored a National Conference on Youth Suicide during June, and established a high-level HHS Task Force on Youth Suicide. The Task Force includes senior officials from the National Institute of Mental Health, National Institute of Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, Centers for Disease Control, and the Office of Human Development Services' (OHDS) Administration for Children, Youth and Families.

The Task Force's mandate is to "assess and consolidate information which currently exists and to recommend or initiate activities which will attack--'head on'--the youth suicide dilemma" and to generate research on the factors which place young people at risk of suicide. It sponsored three national conferences on (1) Risk Factors, (2) Prevention and Intervention and (3) Strategies for the Future between May and November 1986. The Task Force will culminate its work with a series of reports and final recommendations which will be presented to the Secretary in January 1987.

The Office of Inspector General (OIG) was asked to conduct a qualitative national program inspection of youth suicide which would supplement the work undertaken by the Task Force. The 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 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 the inspection are reflected in two reports. The enclosed report, entitled Youth Suicide, reflects findings based on 348 interviews, including many of the nationally known and recognized experts in the field of suicide research and prevention. 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 services agencies (most of whom were funded by DHHS), OIG staff interviewed 178 persons. In all, we talked to persons in 183 communities.

Under separate cover is a companion report, entitled Inventory of State Initiatives in Addressing Youth Suicide. It reflects findings based on telephone interviews with 283 officials from 5 program areas in each of the 50 states, including (a) education, (b) mental health, (c) maternal and child health, (d) drug and alcohol abuse, and (e) children's services.

## MAJOR FINDINGS

1. Youth at risk of suicide come from various walks of life and personal experiences. They come from dysfunctional families, as well as loving, supportive families. Health, educational and social service agencies describe increasing trends, however, in (a) the number of very young (aged 10 and under) attempters, (b) suicide ideation among youth of all ages, (c) multiple forms of self-destructive behavior and (d) a sense of futility among youth.
2. Suicide is viewed as the ultimate form of self-destructive behavior. It is a symptom and should not be dealt with in isolation from other self-destructive behaviors or from social, health and educational problems facing young people.
3. Community response to youth suicide ranges from fear, denial and resistance to widespread support for suicide prevention.
4. Public education is helpful to demystify and prevent suicides. Anyone who lives or works with youth should learn to recognize the signs of risk and where to go for help. News and entertainment media need to avoid sensationalizing or glamorizing youth suicide.
5. Educational, health and social service providers rely primarily on subjective approaches to detect youth at risk. Once detected, however, suicidal youth generally are screened out and referred to mental health providers. At issue are both legal liability and lack of staff expertise among non-mental health providers. As agencies become more knowledgeable and sophisticated in detecting suicidal youth, potential exists for more agencies to screen out suicidal youth from participation in their programs.
6. Among HHS grantees, runaway programs have the greatest focus on youth suicide. Most community and migrant health centers and family planning programs are involved minimally. Many grantees expressed a need for more training and information on youth suicide.
7. Many youth who kill themselves never enter the service system and those who do often drop out prior to completing treatment. This is due, in part, to the stigma associated with mental health problems and suicide.
8. More than half the study respondents cited family problems as contributing factors to suicidal risk. Family support is key to (a) getting youth into treatment, (b) assuring they do not drop out of treatment and (c) effecting a successful outcome.
9. Lack of financial resources or private insurance limits access to mental health treatment.

10. The most significant gaps in the service system include (a) too few inpatient psychiatric adolescent beds, particularly for public pay patients who, if admitted, are discharged prematurely, (b) limited subacute and alternative living arrangements, including residential treatment, day treatment, group homes and foster care, (c) limited out-patient treatment in community mental health centers where demand is greater than supply, and (d) scarce crisis intervention programs and hotlines with a special focus for youth.
11. Suicide prevention must be community based. School programs are key and should be developed in coordination with existing community resources, including mental health and crisis intervention programs. Networking is crucial to keeping youth from falling through the cracks.

#### RECOMMENDATIONS

1. Recognizing the public's need for accurate information, the Department of Health and Human Services should assume a leadership role in educating the public to the seriousness of youth suicide. Public education should not focus solely on youth suicide, but should address related problems, such as the extent of self-destructive behavior among the nation's youth and removing the stigma associated with mental health treatment.
2. The Department should assure that grantees serving youth receive adequate training and technical assistance on issues related to suicide and other self-destructive behaviors and their prevention.
3. The Department should continue to fund research on youth suicide, including evaluation of the effectiveness of prevention models and education programs.
4. The Department should identify a coordinator for youth suicide-related initiatives.



## SUICIDAL YOUTH: AN OVERVIEW

Youth suicide is considered to be a serious problem by most of the service providers sampled in this study. Many cautioned against viewing suicide in isolation from other types of self-destructive behavior and other social and health problems facing young people. Suicide is a symptom, not a disease or illness like alcoholism or schizophrenia. They emphasized that the reported incidence of completed suicides underestimates the magnitude of the problem. As a mental health provider noted, "The numbers are not that significant, but the devastation caused by a completion outweighs all other problems." A number of problems, including substance abuse, physical and sexual abuse and teen pregnancies, are viewed to be more significant than youth suicide among discrete service populations.

A few trends surfaced among respondents' descriptions of youth at risk of suicide. The most frequently mentioned were (a) an increase in younger attempters (ages 5 to 10), (b) an increase in ideation and open discussion among all youth, (c) an increase in seriously disturbed youth (including chronically mentally ill), (d) an increase in multiple forms of self-destructive behavior and (e) an increasing sense of futility among youth which leads them to live only for the moment. As one community mental health provider summarized, "They're sicker and younger when they first come to us."

In describing the characteristics of youth at risk of suicide, half the respondents cited family problems, conflicts or dysfunction as a contributing factor. More than a third mentioned that the suicidal youth they see are the victims of physical and/or sexual abuse, and 17% said family and/or youth abuse of alcohol or drugs were key factors. Other characteristics of youth at risk included learning difficulties, depression, isolation, loneliness, low self esteem, poor self image, poor impulse controls, poor coping skills, inability to communicate, perceived futility in the present, lack of hope for the future, need for instant gratification, and unrealistic perceptions of death.

On the other hand, some high achievers and perfectionists are also considered to be at risk of suicide. These youth impose rigidly high expectations on themselves or perceive pressures from their parents and peers to succeed academically or socially. Their sense of self worth is contingent upon achievement, and they cannot accept what they perceive or define as failure. As one crisis worker explained, "I associate suicide with indomitable spirit. A young person says, 'If I can't succeed my way, I'll die my way.' The touchstone of suicide is not intent to die, but to use suicide as the solution to life's problems. The goal is not death. The method is death to end the pain they're in."

Two specific target groups of youth were singled out by many respondents as being particularly vulnerable to suicide--refugees from war-torn countries and youth in farm crises. Refugees have suffered loss of families killed in their homelands, may feel guilty for surviving when others died, and have never completed the grieving process. The farm crisis reportedly has resulted in adult suicides which, in turn, have trickled down to youth who are becoming increasingly despondent about their families' losses.

## GENERAL COMMUNITY INVOLVEMENT AND PUBLIC AWARENESS

### COMMUNITY RESPONSE

Study respondents were asked to characterize their communities' response to the problem of youth suicide. Although three basic themes surfaced, a caveat is necessary. In some categories of service agencies, there was a parallel between the respondent's assessment of his community's concern and his own agency's involvement with youth at risk. This was most apparent among community health centers, many of whom do not come in contact with suicidal youth. The three emerging themes were:

- ° Approximately 21% of those who answered the question said youth suicide is not an issue in their communities, primarily because none has occurred. As a social worker in a youth agency said, "Out of sight, out of mind. It only hits home when it's someone you know." Most people don't personalize it. When it occurs, it happens to someone else.
- ° Another 19% said denial, fear and resistance characterize their communities. In some cases, there's "utter denial that young people take their own lives." Some are driven by fear and conclude that "if you don't recognize it, it will go away." In some cases the resistance is exacerbating the problem among surviving youth. A runaway shelter administrator noted, "There have been several suicides among high school students with no discussion allowed in the schools and no media coverage for the community at large. Kids aren't allowed to mourn, and the result is negative."
- ° Approximately 37% said their communities are very concerned about the problem, are eager to learn and respond, and have cooperated in marshalling support. As an example, in one small midwestern farm community, there was a six-week general education night course for adults held at the local school. Parents and other adults learned what signs to look for, what to do when they detected a suicidal person, and what to do about the stresses in their families. Others pointed out, "It's an issue that cannot be ignored. Nobody finds a child's death acceptable--we must do something."

Other responses were quite varied. In some areas, other youth issues--primarily teen pregnancy and substance abuse--are perceived to be of such import that the problem of suicide diminishes in comparison. In some communities, cyclical patterns were described: first, outrage and hysteria occur immediately after a suicide; then, individuals and agencies scurry to intervene and educate; and finally, concern "dries out" until another death occurs. Some mental health professionals particularly distinguish between community response to youth suicide and the mental health problems among children which, if unrecognized and untended, will create future personal and

societal problems. They believe their communities are very uninformed about mental health problems of youth.

## PUBLIC AWARENESS

The consensus among study respondents was that public awareness is necessary to demystify and prevent suicides. Generally, public education has a positive effect when people (a) understand that suicide can happen to someone they know and (b) are taught what to do and where to go for help when they detect a friend, peer, colleague or loved one who is at risk. In other words, education leads to better decision making. A few respondents expressed fear, however, that public awareness can have a mixed impact and may increase the incidence among youth. "It may bring suicide on more quickly among persons who eventually would destroy themselves," said a family planning practitioner. A community health practitioner cautioned, "You need to educate the public to save lives, but you'll lose some, too. It's a dilemma."

A major concern among many respondents is the role of both the news and entertainment media. The power of the media is phenomenal, whether it is positive or negative. Respondents believe children and adolescents to be particularly vulnerable to media influence and point to problems when the media sensationalize, glamorize or romanticize a death. Movies, TV and music particularly give kids erroneous messages about death and dying. To the contrary, as one school official noted, "Kids need to realize there's no Easter Sunday for mortals." A hotline director summarized the belief expressed by many respondents, "Don't underestimate the influence of the media. Kids get the idea they can have everything--every sexual, travel, cosmetic and drug experience. It distorts the way they perceive life and themselves."

Some respondents expressed gratitude that their local media are responsive and responsible in their coverage of suicides. Some others, however, were appalled and angry over media insensitivity and irresponsibility. In one school when two completions and one serious attempt occurred, the local news media sensationalized each story "bigger and bigger. They tried to talk to kids when we said they couldn't. When we wouldn't allow them on campus, they followed kids home and queried them when their parents weren't present. We had a memorial service in the school gym for one student whose family asked the press not to attend. It was like war, trying to keep reporters and cameramen out. One snuck in with a camera under his coat."

In summary, many study respondents call for responsible public education in order to reduce the social taboos which hinder (a) a person from expressing suicidal feelings and (b) family, friends, teachers and service providers from receiving the message. In particular, it helps young people learn that it's "o.k. to tell" when a friend is in danger. As a school psychologist teaches students, "It's better to lose a friendship than a friend."

## THE COMMUNITY SERVICE SYSTEM

The description of the service system which follows is based on discussions with 305 providers who served over 1.6 million youth. They represent social, mental health, health, educational, juvenile justice and other service areas which touch on the lives of young people. Table 1 reflects the number of youth served by the study respondents who were able to provide data on their clientele.

TABLE 1			
CLIENTS SERVED BY COMMUNITY RESPONDENTS			
Provider/Program (N = 261)	Total Number Clients Served	Total Number Youth Served	Percent Youth Served
<u>UNDUPLICATED COUNTS:</u>			
Community Mental Health Centers (N = 62)	261,012	95,173	36.5
Other Mental Health Providers (N = 33)	27,661	15,672	56.7
Community/Migrant Health Centers (N = 33)	383,209	180,956	47.2
Child/Teen Health Clinics (N = 4)	15,950	15,950	100.0
Family Planning (N = 18)	414,087	210,446	50.8
Runaway & Homeless Programs (N = 71)	111,870	93,924	84.0
Multi-Service Youth Agencies (N = 8)	28,240	27,970	99.0
Schools (N = 12)	860,740	860,740	100.0
Juvenile Justice (N = 4)	<u>61,140</u>	<u>61,140</u>	<u>100.0</u>
<b>TOTALS</b>	<b>2,163,909</b>	<b>1,591,971</b>	<b>73.6</b>
<u>DUPLICATED COUNTS:</u>			
Crisis Programs/Hotlines (N = 16)	631,607	293,580	46.5

## HHS GRANTEEES

Three categories of HHS-funded grantees were surveyed during the study to assess the extent to which they are involved in efforts to prevent youth suicide. These grantees were (a) runaway and homeless youth programs funded by the Office of Human Development Services (OHDS), (b) family planning agencies funded by the Public Health Service (PHS) and (c) community health centers and migrant health centers, also funded by PHS.

Runaway and Homeless Youth Programs. Most of the runaway and homeless programs sampled both on-site and by telephone focused on young people ages 18 and under. A few, particularly large programs, also served parents and other adults through their crisis intervention, emergency shelter and counseling programs. The runaway and homeless programs provided a broad range of services, including emergency shelter, individual, family and group counseling, legal representation for youth in custody hearings, case advocacy, medical and dental care, drop-in services (primarily food and clothing for street people), recreation programs, hotlines and community education.

Most runaway and homeless program respondents in the sample believed that the youth they serve are at risk of suicide. On average, they report that about 39% of their clients have considered suicide and 12% are at serious risk of killing themselves. (See Tables 2 and 3 on pages 13 and 14.) A few dissenters pointed out, however, that runaways, homeless youth and street kids have a strong survival instinct.

Several shelters admitted to screening out youth at risk of suicide, primarily because of the liability they would incur if a client completed suicide while in their care. Those who do accept youth at risk take great precautions to not leave the youth alone, but rather to supervise them 24 hours a day. Such "suicide watches" require an intense one-on-one monitoring capability among the shelter staff.

Family Planning. Most of the family planning grantees sampled by telephone in this study had little or no involvement in youth suicide issues. The exceptions (19% of the sample) were primarily comprehensive health centers, multi-service agencies or local health departments that incorporated a family planning program. One of these had a separate suicide counseling program to which youth at risk were referred. Another agency had a psychiatrist and a mental health counselor on staff to help detect and treat those at risk. Other suicide-related services included: (a) school and community outreach, including presentations on subjects such as depression, grief management, self-esteem and decision making, (b) peer advocate training, (c) sex abuse therapy for two- to six-year-olds, and (d) basic counseling. Otherwise, the grantees noted that they would refer any client they believe to be at risk to mental health providers. Several family planning respondents decried their inability to

identify or assess risk of suicide, especially given their lack of training and limited staff and funding which prescribe their service priorities. Overall, they estimated that less than 5% of their young clients have considered suicide and less than 1% are at serious risk (see Tables 2 and 3).

Community Health Centers (CHCs) and Migrant Health Centers.

These health clinics (sampled by telephone) serve low income people in underserved rural or inner city areas. A third said they had special pediatric staff to serve children and youth. More than a third provide mental health services, although they are available only to adults in some instances. An additional 8% with no mental health services indicated the availability of educational and/or social services. A few work with the schools in their communities.

The tone of these interviews was significantly different from other types of study respondents. Seventy percent said they had virtually no involvement with the issue of youth suicide. A typical comment was, "We're a medical facility, and people come to us for medical problems only."

Approximately 25% of the clinics had occasionally been involved with the issue of youth suicide. Three clinics are actively involved in screening kids for risk factors, including suicide. Noted a staff member at one of these clinics: "A lot of kids at risk of suicide also need medical care. There's a real tie." Overall, the community and migrant health centers estimated that over a third of the youth they serve have had some suicidal ideation and that 8% are seriously at risk. (See Tables 2 and 3.)

**MENTAL HEALTH SERVICES**

The availability of mental health services varies significantly among communities. Ideally, communities offer a broad range of services, varying in intensity, which collectively comprise a "continuum of care." Such a system theoretically enables clients to move from one component of the service system to another as their treatment needs change. In the course of this study, we contacted over 100 mental health providers--a wide array in communities selected for on-site field work plus an additional sample of community mental health centers and National Health Service Corps psychiatrists by telephone. Nearly all the providers indicated at least some involvement with youth at risk of suicide. They represented the following components of the mental health service system:

Community Mental Health Centers (CMHCs). These agencies, funded primarily from public sources and sliding fees, are often located in low income and underserved areas. Some are staffed to provide outpatient counseling, while others offer a comprehensive range of services, including hotlines, emergency/crisis intervention, day treatment, community education and residential treatment.

Over a third of the sample had specialized staff to work with children and youth, primarily up to the age of 18. Most categorize youth over 18 as adults.

Sixty percent of the sample said they work with schools on mental health issues. Some participate on crisis teams that respond to school suicides. Many work with other community sectors, providing speakers, sponsoring workshops and conferences, promoting networking and developing coalitions around suicide issues.

Sixty percent frequently or routinely treat suicidal youth. Another 30% occasionally do. Ten percent indicated they rarely ever treat youth at risk of suicide. On average, CMHCs estimate that 38% of the youth they serve evidence some suicidal ideation and that more than half are at serious risk of suicide (see Tables 2 and 3).

Other Outpatient Mental Health Clinics. A few other outpatient mental health clinics, primarily attached to major medical or psychiatric facilities, were visited during on-site fieldwork. All reported involvement with suicidal youth.

Therapists in Private Practice. Several private therapists were contacted during on-site fieldwork. Most have been involved in counseling suicidal youth and reflect concerns similar to therapists employed in CMHCs and other outpatient mental health clinics. The biggest difference is that their caseloads consist primarily of private pay clients.

Day Treatment Programs. At a more intense level, a few communities offer adolescent day treatment programs, which are sometimes used as an alternative to hospitalization. They provide a highly structured, therapeutic environment during the day, but participants reside elsewhere--often with their families, in foster care or group homes. Many clients have been discharged from psychiatric hospitals.

These youth attend school on site and participate in recreational and other structured social activities. Some receive vocational training. There is a strong emphasis on counseling and therapy, as well as on strengthening problem solving and practical daily living skills. Where feasible, the rest of the family is involved in the treatment plan. Participants commonly stay in day treatment for months or even years. The threat of suicide is reported to be "an ever present risk" among youth in these programs.

Group Homes and Residential Treatment Facilities. Some communities also have group homes and residential treatment facilities which provide an even higher level of structure and intensity. Of those visited, some focused on drug and alcohol treatment while others were primarily psychiatric facilities. Participants reside on site with varying degrees of supervision



and independence. Indicated one program director: "If a kid can't make it here, then he has to be hospitalized. We're the last stop before inpatient treatment or the first step back into society upon discharge from the hospital." Substantively, the programs visited were similar to the day treatment programs, offering on-site educational, vocational, recreational and therapeutic components with a strong focus on problem solving and practical skill development. Stays ranged from a few months to a few years. Residential facilities are actively and routinely involved with youth considered to be at risk of suicide.

Inpatient Psychiatric Hospitals. At the most intense level are the acute, inpatient psychiatric facilities. OIG staff visited a dozen such facilities. Eight had special units for adolescents. Youth who are acutely at risk of suicide are admitted to inpatient facilities most frequently for a few days of crisis stabilization, but sometimes for more extended periods. In addition to intense psychotherapy and crisis management, these facilities emphasize educational, recreational, coping and practical skills.

Emergency Services. Communities vary dramatically in their approach to suicidal emergencies. In most larger communities, there was some focal point for trying to stabilize a crisis situation and/or determine whether voluntary or involuntary commitment to a hospital is warranted. Sometimes this function was performed by hospital emergency room staff or by community mental health center staff. Other communities have specialized mobile crisis units which are available 24 hours a day and can go to the person in crisis to conduct an evaluation. One city visited had a specialized mobile crisis team that focuses specifically on children and youth.

#### CRISIS INTERVENTION/HOTLINES

The crisis intervention programs contacted ranged from hotlines serving solely latch-key grade school children to comprehensive crisis care for all ages. The latter multi-purpose organizations included such services as phone hotlines, therapeutic treatment, drop-in group counseling, day care referral, community outreach, chemical dependency detoxification, suicide prevention training, grief counseling and survivors' support, research, and psychological autopsies. Their focus also ranged from specific target groups such as teenagers to all ages, from suicide-specific to general crises. Some hotlines are manned 24 hours a day, others for the few hours children are home alone after school. Some serve specific local communities, others are national in scope. Despite their range of size, structure, services and targets, they had some commonalities. Most rely on volunteers to staff their crisis phone lines and require these volunteers to complete intensive training after which the selected volunteers formally commit to contribute specific amounts of time. Those with suicidal focus or expertise are sought after in their communities as resources to train adults

and youth on suicide prevention. Some also provide intervention teams to assist school officials when suicides occur among the student body. On average, they estimate that 34% of the youth they serve evidence suicidal ideation and 9% are at serious risk of suicide. (See Tables 2 and 3.)

Some hotlines advocate reflective listening with a guarantee of anonymity to help the caller work through a crisis and reach his own decision. Others aggressively trace calls when they believe the caller to be at or near suicide and call the police or other emergency response units to intervene. The latter is impossible, however, through the national lines.

Beyond basic funding, a great challenge facing most crisis programs is maintaining the reservoir of experienced, trained volunteers. Other major concerns include:

- outreach--getting kids to call, to use the crisis services,
- determining lethality (i.e., the seriousness of suicidal intent) in youth, since most assessment tools are geared to adults,
- getting kids to treatment. "Once we intervene, the system falls apart or the caller doesn't follow through," noted a director.

In one community, local hospitals were converting excess beds to adolescent care and marketing them as suicide prevention services. They use a crisis line approach, but then won't talk to callers unless they're interested in hospitalization.

## SCHOOLS

Public and Private Schools. Public and private school respondents in the study varied from officials of the second largest school district in the nation serving 585,000 students in kindergarten through 12th grade to an alternate grammar and high school program serving 65 depressed youth and juvenile delinquents ages 5 to 21, whom the public schools could no longer serve.

The most comprehensive intervention and prevention efforts were in place in districts and schools where visible and frequently multiple suicides among the student body had sparked peer, parental, school and community concern and response. Among the school initiatives, OIG staff saw models for:

- screening elementary school children to determine risk,
- crisis intervention teams in the schools who respond to emergencies,
- student curricula for in-class prevention awareness,
- afterschool hotlines,
- peer counseling,
- in-service training, written manuals and resource guides for faculty and staff,

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- peer counseling,
- in-service training, written manuals and resource guides for faculty and staff,

- ° periodic or ongoing workshops, seminars and conferences, and
- ° protocols for action in the event of a suicide crisis.

Admittedly, some districts are cautiously addressing suicide, given the myriad demands upon schools, limited funding for special initiatives, liability concerns, and community and/or parental pressures to focus only on academic services.

Peer Programs. An interview was conducted with the architects of a peer program which has been adopted by over 150 schools in several states. The program is based on the premise that "natural helpers" (those to whom students are likely to turn in a crisis) exist in every peer group in a school. The concept is to identify those kids and give them intensive training so they can do an even better job of what they would be doing anyway-- identifying and supporting peers with problems. Selection of these "natural helpers" is accomplished through an "anonymous" survey of all students. The program stresses that the role of a "natural helper" is to identify and support a peer with a problem, not to be a counselor. Even with intensive training, one of the biggest challenges has been to persuade the "natural helpers" to "share the secret" with an adult when they suspect or are told of a pending suicide attempt.

Many schools, therapists and other service providers were enthusiastic about the role peers can play in the identification of youth at risk of suicide. Some schools have resisted implementing peer programs because of a concern with liability.

#### JUVENILE JUSTICE FACILITIES

A few juvenile justice facilities were visited during the on-site fieldwork. All expressed considerable concern and involvement with the potential for suicide among the youth detained in their care and stressed that they place a strong emphasis on minimizing the opportunity for suicide in their facilities. They estimate that 68% of their population have some suicidal ideation and more than a third are at serious risk of suicide. (See Tables 2 and 3.) One facility reported that because they are not considered to be a treatment facility, they are precluded from conducting a psychological evaluation until a child has been in residence for at least two weeks.

#### POLICE

Since suicide is not considered to be a crime in the communities visited by OIG staff, the police generally were not actively involved in suicide issues. A few basic exceptions existed. In half of the cities, police investigate suicide attempts, looking especially for indications of physical, sexual or substance abuse of attempters under age 18. In a third of the cities, the police investigate deaths for the medical examiners' offices. In one community, a youth counselor was assigned to the police department to intervene in crises, including working with

attempters or youth at risk of suicide. Finally, one officer noted that the police investigate persons who aid attempters since assisting a suicide is a crime. In some communities, mobile crisis teams are dispatched through the police department and in others police trace calls and run interception when they receive direct calls from suicidal youth or are asked by crisis hotlines to trace and intervene. Commonly, when the police encounter suicidal youth, they refer them to mental health agencies for evaluation.

#### MEDICAL EXAMINERS

The role and philosophy of medical examiners visited varies greatly. Two had no protocol or official criteria for determining suicide, noting that deaths are deemed to be accidents unless hard evidence of suicide exists. In one city, the medical examiners' staff did no on-site (scene of death) investigations, relying on the police or morticians to transport the bodies for examination. Only one medical examiner had an extensive suicide protocol used by investigative staff to define not only the cause and manner of death but also what led up to the death. Basically, these investigators do a psychological autopsy. The other examiners' offices noted that they do routine autopsies to determine the type of death--i.e., accident, natural cause, homicide, suicide.

In two communities, the issue of age is key in suicide determinations. In one state, deaths of children aged ten and under cannot be considered suicides. In a large urban county in another state, the medical examiner said, "We're cautious about determining suicide," and said he would not consider any death of a youngster aged 14 or under as a suicide. He explained that the age criterion differed from county to county depending on each medical examiner's policies. Yet in another large urban area, the youngest documented suicide was a seven-year-old boy who left a note of intent and shot himself. Some medical examiners admitted feeling, and sometimes succumbing to, pressure from families to determine deaths as accidents or natural causes because of the associated stigma.

#### SURVIVOR'S GROUPS

The need for grief counseling is being recognized in many communities. Whether it is provided through special survivor's organizations, churches, mental health centers or crisis intervention programs, these grief counseling groups help family members, friends, colleagues and classmates to survive the pain, anger, guilt and other emotions associated with a suicide. Most counsel with loving support toward a goal of preventing family or friends from also taking their own lives in their anguish.

TABLE 2

## ESTIMATE OF SUICIDAL IDEATION AMONG RESPONDENTS' YOUTH CLIENTS

Provider/Program (N = 179)	Total Number Youth Served	Number Who Considered Suicide	Percent Who Considered Suicide
<u>UNDUPLICATED COUNTS:</u>			
Community Mental Health Centers (N = 41)	61,971	23,819	38.4
Other Mental Health Providers (N = 27)	13,421	6,655	49.6
Community/Migrant Health Centers (N = 19)	86,203	30,311	35.2
Child/Teen Health Clinics (N = 1)	2,500	500	20.0
Family Planning (N = 7)	122,175	5,462	4.5
Runaway & Homeless Programs (N = 58)	76,655	29,489	38.5
Multi-Service Youth Agencies (N = 4)	11,370	3,173	27.9
Schools (N = 6)	146,920	1,109	0.8
Juvenile Justice (N = 3)	<u>11,090</u>	<u>7,514</u>	<u>67.8</u>
<b>TOTALS</b>	532,305	108,032	20.3
<u>DUPLICATED COUNTS:</u>			
Crisis Programs/Hotlines (N = 13)	61,548	21,081	34.3

TABLE 3

## RESPONDENTS' ESTIMATE OF YOUTH CLIENTS AT SERIOUS RISK OF SUICIDE

Provider/Program (N = 183)	Total Number Youth Served	Number Youth At Risk	Percent Youth At Risk
<u>UNDUPLICATED COUNTS:</u>			
Community Mental Health Centers (N = 46)	65,183	14,666	22.5
Other Mental Health Providers (N = 26)	6,527	2,268	34.7
Community/Migrant Health Centers (N = 20)	86,527	6,710	7.8
Child/Teen Health Clinics (N = 2)	10,500	255	2.4
Family Planning (N = 8)	122,195	222	0.2
Runaway & Homeless Programs (N = 54)	75,779	9,318	12.3
Multi-Service Youth Agencies (N = 4)	14,570	4,368	30.0
Schools (N = 9)	150,635	920	0.6
Juvenile Justice (N = 3)	<u>11,090</u>	<u>3,917</u>	<u>35.3</u>
TOTALS	543,006	42,644	7.9
<u>DUPLICATED COUNTS:</u>			
Crisis Programs/Hotlines (N = 11)	54,039	5,191	9.6

## IDENTIFICATION OF YOUTH AT RISK OF SUICIDE

### DETECTION AND ACTION

School officials and service providers were asked to describe how they detect youth at risk of suicide among their service population. Mental health providers (both inpatient and out-patient) all had some type of screening approach to identify suicide risk. These approaches varied from (a) reliance on their clinical expertise and training to identify warning signs (including body language) to (b) patient self-reporting at intake to (c) routine mental health status examinations and structured interviews to (d) formal clinical assessments. Mental health professionals note that by the time a client is referred to them, someone in the social, health or educational service system or a family member or friend has identified a mental health problem. Thus, the practitioners often are alert to any warnings or signs of suicidal risk. Some youth are particularly difficult to identify. For example, one inpatient psychiatric practitioner said, "The ones who scare us are those who can't verbalize, but give clues through drawings or gestures."

Among non-mental health respondents, approximately half rely on subjective or informal approaches to detecting youth at risk. This ranges from observation of behavior and open-ended discussions to "how do you feel about yourself" questions during the intake process. Approximately ten percent apply what they describe as a full suicide assessment. OIG staff did not evaluate these tools. A few programs, including runaway shelters, currently are testing screening tools developed by OHDS-funded grantees. In addition to detection, such tools are designed to help workers begin to structure intervention approaches.

A few respondents admitted to doing nothing to detect youth at risk of suicide. Most prominent among those "no detection" respondents were 45% of the community and migrant health centers, 19% of the schools and 22% of the crisis programs/hotlines.

Agencies were asked if an HHS-developed screening tool would be helpful to them. Of the 271 who responded to the question, 41% said it would be helpful and they would actually use it, and 16% said they would not use such a tool. Most of the latter respondents are satisfied with the tools they currently are using or testing. The exceptions are the schools who face special constraints. Most schools are not allowed to do such assessments without parental permission. Others are precluded by time and resource limitations. For example, in some districts, school counselors and psychologists must focus on special education students since their funding is derived primarily from P.L. 94-142, the Education for the Handicapped Act. The remaining 43% qualified their answers, noting that they might modify their current approaches by adopting portions of any new tools developed by HHS or others.



Actions taken subsequent to detection also vary widely. Most non-mental health providers refer at-risk youth to hospitals, CMHCs or private therapists for further evaluation, intervention and treatment. It should be noted that some school districts are precluded by law from referring students to private practitioners or anyone not tax-supported. Hotlines specifically mentioned the need to talk a caller through the immediate crisis before making referrals. Some hotlines trace calls or try in some way to identify the caller and seek police or paramedic intervention when a caller is in a highly lethal situation. Some organizations, including schools, family planning and runaway shelters have in-house staff who counsel clients. Approximately 20% of the runaway and homeless programs have a triage protocol. Acutely suicidal youth are screened out and taken to inpatient psychiatric facilities or to outpatient facilities, depending on availability. Two factors provide the primary impetus to screen out acutely suicidal youth: (a) a recognition that mental health professionals may be better able to intervene and save the client's life and (b) the threat of legal/financial liability if the youth dies while still a program client. Less acute youth are monitored closely (via 24-hour suicide watches) and counseled. Many agencies "contract" with the youth who remain under their care. In essence, the youth is asked to agree to a "no suicide pact," to promise he will not commit suicide for a specific period of time.

#### TRAINING

In approximately 15% of the service agencies, staff and volunteers have not received any training on suicide issues. In approximately half the agencies, staff receive some kind of in-service training that touches on suicide--these range from an hour's presentation to week-long intensive sessions on detection and intervention. Another 13% have sent their staff to suicide workshops, and 17% said their staff had received mental health and/or suicide-specific training prior to being hired.

#### FACTORS CONTRIBUTING TO SUCCESSFUL TREATMENT AND PREVENTION

Study respondents were asked to describe what works for them in addressing the problems of youth at risk of suicide. The consensus was that youth at risk need professional help and that, if possible, the family should be involved in the treatment plan. As a medical practitioner emphasized, "We can't treat suicide. We have to treat what caused the child to consider this as an option." This ties into the next most common response--to provide a supportive environment. Families are an integral part of a support system. Where parental involvement is not possible, other players (e.g., teachers, counselors, peers, friends) in the support system become even more important. Also emphasized was the need to develop caring, trusting, honest relationships, preferably one-on-one. This is especially important in developing positive therapeutic relationships. Kids need to be able to talk about their feelings and their problems. This can

occur more easily when someone listens and cares in a nonthreatening, nonjudgmental way.

Other frequent suggestions were to (a) teach youth better daily living skills--how to cope with problems, make wiser decisions, (b) contract during the immediacy of crisis by establishing a no-suicide pact, (c) provide peer advocacy through the schools, (d) provide strong case management once a child is in the system to assure he doesn't drop through the cracks, (e) assure continuity of care and (f) sanitize the environment by removing the lethal items--e.g., guns and pills--which can be used easily upon impulse. As one researcher pointed out, "Often whether kids die or not depends on how well stocked their medicine cabinet is. Completers die because the means are readily available."

## WHY AREN'T KIDS BEING SERVED?

### BARRIERS TO SERVING YOUTH AT RISK OF SUICIDE

Several major barriers to serving youth at risk of suicide were identified consistently by all types of respondents:

Accessing the service system. Significant numbers of youth who kill themselves never enter the service system at all. Some typical comments:

- ° "There is a certain segment of suicidal youth who do not give any signs, but who are incredibly lethal. We can impact those who are ambivalent, but not those who are beyond ambivalence." (CMHC therapist)
- ° "The ones in therapy aren't killing themselves. It's those beyond our reach we must worry about." (psychiatrist)

A county medical examiner's study of 25 youth suicides (age 19 and under) found that 72% had not received any services. Indeed, the overwhelming majority of service agencies interviewed by OIG staff were unaware of any completed suicides within the past year among their clients. (See Table 4 on page 25.) Mental health professionals are not in a position to initially screen youth who might be suicidal. They are dependent on parents, school personnel, pediatricians, clergy and other "front-line" workers to detect that something is amiss and that professional help is needed. Over half the mental health providers indicated that one of their biggest challenges is getting kids into treatment.

This is not a problem unique to mental health providers. Youth have a general reputation for reluctance to enter any traditional service system. Many of the health clinics' staff indicated their difficulties in getting youth, especially adolescents, in their doors for medical treatment. "Kids won't come in and they're very hostile when they do," noted a physician at an adolescent health clinic. "Unless they need a sports physical, they're acutely ill by the time we see them," said a community health center physician.

There is, however, a particular stigma associated with mental health services. Young people fear being labeled "crazy" and are terrified that their peers will find out they are in therapy. Respondents stressed that young people should be told what to expect before they enter the mental health service system. Furthermore, suicide is still a taboo subject for many people. Convincing minorities to enter the treatment system is seen as a particularly difficult challenge.

Parents are often seen as contributing to the problem. Over a third of the mental health providers and a fourth of the runaway programs saw parental resistance and denial as a major barrier to

- Subacute programs and alternative living arrangements. Another major gap in the mental health service system is the need for an array of subacute facilities, other therapeutic programs and alternative living arrangements, such as residential treatment facilities, day treatment programs, group homes and foster care. Respondents stress the need for follow-up of care. Noted one hospital-based psychiatrist, "We can bring them in from the ledge, but without continuity of care, they'll be right back out there in a different presentation, but just as suicidal."

Many hospitalized youth cannot be discharged successfully from a psychiatric facility without an intermediate stop in an after-care program. A range of therapeutic options with varying levels of service intensity and supervision are needed. These programs also serve a key role as alternatives to inpatient treatment. Because so many hospitalized youth cannot realistically return home to a stable family environment, alternative living arrangements are critical. There is also a need for respite care for parents and foster families. These latter programs are nonexistent or rare in most communities.

- Outpatient therapy. Although available in most communities, community mental health centers are plagued with chronic staff shortages and long waiting lists. Frequently they can accept only the most severe cases. Noted one health clinic physician, "Even following a crisis, there's a six to eight week waiting period for CMHC counseling." A CMHC clinician said, "We are forced, due to lack of resources, to wait until a patient is imminently suicidal before we can intervene and treat." Some CMHCs do not have specialized staff to work with youth, and several identified the need for more family therapy. Although the services of private therapists are available in many communities, fees are often prohibitively high for many families.

- Emergency mobile crisis response teams. Communities without this type of service stress the need for crisis teams, available on a 24-hour basis, that can go to a youth in a suicidal crisis for stabilization and evaluation. Even where available, it sometimes takes too long for the crisis unit to respond.

- o Hotlines. Although many communities have at least one hotline, sometimes it is difficult to get through--a critical problem for a person in imminent danger. A hotline director admitted, "If teens are put on hold more than sixty seconds, they're lost. We never hear from them again." There are few bilingual hotlines. Those without special outreach to youth find that few adolescents use their services.

° Mental health continuum of care

- Inpatient psychiatric beds and special units for adolescents. The most frequently mentioned gap in the service system is the lack of inpatient psychiatric beds for youth (reported by more than half of the community mental health centers, more than a quarter of the runaway programs, community health centers and other therapists, and numerous other respondents as well).

In many communities, there are no specialized adolescent psychiatric units. Youth are placed in adult psychiatric wards or general purpose hospital beds, neither of which is regarded as a satisfactory alternative. Even in communities that have adolescent psychiatric units, access is extremely limited for other than private pay patients. One runaway shelter reported that they had experienced three serious suicide attempts from three different youth in a two-month period. In each case, there was no inpatient bed available, and they eventually had to send these youth back home to await placement. Noted an official at a juvenile justice institution, "If parents can afford it or have insurance, we can sometimes transfer a severely disturbed kid to a psychiatric hospital, but otherwise it's the juvenile prison."

Staff at many of the inpatient psychiatric facilities agree that demand outweighs supply:

- "They're turned away unless they're dripping blood. We can only accept the most extreme cases."  
-- "By the time we can treat them, we can't reach them."

In some cases, the only way for a child without insurance to be admitted as an inpatient is for the parents to negate custody and declare the youth a ward of the court.

Inpatient staff report tremendous pressure to discharge public pay patients as soon as possible. Over a third said they cannot keep public pay patients long enough. "We're allowed to keep them two weeks when they need to stay three to six months," noted a psychiatrist. After-care facilities such as residential and day treatment programs complain that youth are frequently discharged to them in highly unstable conditions. Noted one director, "The hospital stays are briefer and briefer, so there's more recycling all the time. We get them back here when they're not even close to being stabilized."

Others require large co-payments and have annual or lifetime limits on what they will pay. Health maintenance organizations were singled out by several respondents as providing inadequate mental health coverage for their members.

#### Legal barriers.

- Commitment laws. Laws regarding the voluntary and involuntary commitment of youth to inpatient facilities vary among jurisdictions. It is difficult in most, however, to commit an acutely suicidal youth without his consent.
- Concern over liability. Fear of liability keeps many service providers from serving potentially suicidal youth. One state is rewriting regulations for its drug and alcohol inpatient treatment facilities, requiring that youth at risk of suicide be screened out of treatment. There were reports of increased insurance costs associated with crisis intervention. One telephone hotline reported a 900% increase in insurance rates during this past year.
- Parental consent. In many jurisdictions, youth cannot receive services without the signature of a parent or guardian.

#### Other Barriers.

- Transportation. This is particularly a problem in rural areas and communities without adequate public transportation.
- Staff fear and burnout. Suicidal youth are a difficult, highly stressful group to serve. The threat of suicide raises anxiety at every level. Providers express fear that "even if I can detect a potential suicide, I can't keep it from happening." Noted staff from a runaway shelter, "Our fear of dealing with high risk kids blocks us from effectively serving them."
- Cultural/societal attitudes toward self-destructive behavior. Several respondents expressed concern over the promotion of self-destructive behavior at rock concerts, through music videos and in movies. Said a therapist, "I'm fighting a whole culture that's condoning self-destructive behavior through MTV, rock concerts, Rambo fantasies and a general punk lifestyle."

#### **GAPS IN SERVING YOUTH AT RISK OF SUICIDE**

Many respondents stressed that the service system in general is stretched to capacity and that most communities need more services for youth, particularly the poor. The need for additional staff and funding was one of the most frequently mentioned issues, regardless of the type of provider. Other major gaps include:

the treatment of high risk youth. Many parents feel threatened and are extremely defensive to the possibility that they might be part of the problem. It is also a challenge to convince them of the seriousness of a suicidal threat and to enlist their cooperation. Noted one school official, "A fourth grader told a counselor how he was going to commit suicide. When we told his parents--an attorney and a health professional--their reaction was, 'he doesn't even know what that means.'"

Parents often react negatively to the mental health stigma or are apathetic toward their children's welfare. Noted a therapist, "We have had parents whose kids have attempted suicide refuse treatment, because they didn't want their kids to be labeled crazy." A psychiatrist who heads a clinic specifically for suicidal youth said that "of the 40% who refuse treatment, usually it's the whole family, not just the kid, who isn't interested."

An equally big problem is that many youth who enter treatment don't stay long enough. A clinic which specializes in depressed and suicidal youth found that 80% of their patients do not complete the necessary treatment. Young people are notorious for not keeping appointments. Many won't come voluntarily, so without strong family support the likelihood of dropping out of therapy is considerable, especially after the immediate crisis has been stabilized.

The dilemma of getting and keeping youth in treatment was summarized by a therapist, "Unfortunately, many kids at risk of suicide never get identified or by the time we get to them it's too late. But an even greater tragedy is that many who are identified refuse treatment or drop out before we've had a chance to do much good."

Respondents also express frustration that once treated, youth are forced to return to the same unhealthy environment that contributed to the crisis in the first place. Noted one psychiatrist, "It is very frustrating to discharge them back to the same hopeless environment--no job, a screwed-up family and a bleak future. So many have so few options."

Lack of resources. Mental health therapy is expensive. Outpatient therapy commonly ranges from \$50 to \$100 an hour, and inpatient treatment without private insurance coverage is prohibitive for all but the wealthiest of families. For families with limited resources and no insurance, there are few treatment options available. For outpatient services, these families will most likely be steered to community mental health agencies, which charge for services on a sliding fee scale. For some families, even a sliding fee is prohibitive.

Available insurance is often inadequate. Many policies place limitations on mental health services. For example, some do not cover the services of clinicians who are not medical doctors.

- Services in rural areas. Rural communities face a special challenge because the nearest mental health services are often miles away. Noted one community health clinician, "In places like this, you're lucky to have even one mental health professional in the whole community."
- School programs. One of the most common themes was the need for school programs which include a focus on faculty, staff, parents and students. Components need to include staff training, a student curriculum and a well-defined protocol outlining steps to take in the event of a suicide emergency. There were reports of resistance from some school board members and administrators, partly out of a fear that any effort would encourage suicide, or a denial that this is a problem in their student populations.
- Community education and awareness. There is a need for extensive training and education on youth suicide throughout communities. Anyone who comes into regular contact with youth, the so-called "gate-keepers," should be made aware of the potential for suicide among young people, know the warning signs to look for, and where to go for help. This includes parents, school personnel, hospital emergency room staffs, pediatricians and primary care physicians, child protective services staff, foster parents, clergy, coaches, the whole array of youth service agencies, and the police, as well as youth themselves. The importance of developing peer programs was frequently stressed.

There is also a need for better training of mental health professionals, to work with both youth and suicidal persons of any age. A number of mental health professionals said they wished they had better diagnostic tools, particularly to predict the potential lethality of suicidal risk. A few stressed that standardized diagnostic tests don't work well on youth.

- Networking. Respondents said that service agencies need to join together in cooperatively preventing youth suicide, rather than working in isolation. Many mentioned turf problems, which are exacerbated by the fact that so many agencies are competing for the same limited dollars. Some typical comments:

- "Too many people claim ownership of different parts of the same kid." (CMHC therapist)
- "Each service agency is very isolated from the others. They don't know what's happening in the other parts of their clients' lives. It's very important to mesh service systems." (psychiatrist affiliated with a university)
- "Because suicide is a symptom of children with serious, often multiple problems, networking is very important."



Suicide can be the ultimate effect of falling through the cracks and being treated by a compartmentalized service system." (therapist)

° Services to pre-teens and older youth. Many respondents stressed the need to focus more on older youth, particularly those 17 and older, as well as pre-teens. Several mental health providers said that they have had patients as young as five or six who evidenced obvious suicidal symptoms. Respondents also stressed the need for early intervention. Identifying and treating young children at risk prevents problems from escalating into even more serious dimensions as these children move into adolescence.

## FEDERAL ROLE

More than half the respondents said they would like to see HHS involved in educating the public about youth suicide. They support the federal government assuming a leadership role in recognizing the seriousness of the problem and serving as a catalyst to encourage communities to develop their own initiatives. Most stressed that the thrust of a public education campaign should not focus solely on youth suicide, but should address related problems such as removing the stigma associated with seeking mental health treatment and the extent of all self-destructive behavior among today's youth. Of the HHS-funded grantees contacted in this study, over a third of the runaway programs and over a quarter of the family planning programs and community/migrant health centers said they would like more training and information on this issue.

There is a particular interest in having the Department develop and disseminate materials on youth suicide or support a clearinghouse for materials developed elsewhere. There was great concern that communities not "reinvent the wheel" as they develop their own initiatives. A significant number of materials, including curricula, have been developed, but there is no central repository where interested parties can go to see what is available.

Other suggestions which surfaced frequently:

- ° HHS should support youth suicide research. Evaluating what works in preventing suicides is especially needed.
- ° HHS should establish national policies in support of youth and the family. Many respondents echoed the theme that "our children are our future." There is a great deal of concern about the disintegration of American families.
- ° HHS should provide demonstration funding for suicide prevention programs as well as stabilized funding for mental health and youth services in general.

## STATE AND LOCAL ROLE

Respondents believe that youth suicide issues need to be addressed primarily at the community level through grass roots involvement. There is a need for a collaborative, community-based approach to this problem. Respondents especially stressed the need for public education, community awareness and the involvement of the schools. They also called for private sector involvement, particularly for businesses to educate their own employees about mental health and youth suicide issues and to support financially local service agencies.

## COMMUNITY RESPONSE TO YOUTH SUICIDE: A SUMMARY

Nobody really knows what prevents youth suicide. There is clearly a need for more research in this area. We have attempted to summarize, however, what the study respondents collectively see as key elements to addressing the problem of youth suicide. No community had all of these elements in place, but many are striving toward these as goals. This, then, is what a model service system and community approach would include:

° A full continuum of mental health services, including:

- Inpatient psychiatric facilities, preferably with special units for adolescents.
- A range of subacute programs for youth with varying levels of service intensity and supervision, including residential treatment facilities, day treatment programs and therapeutic group homes. These are needed as "after-care" programs for youth discharged from inpatient facilities, as well as for alternatives to hospitalization.
- Outpatient counseling, preferably by therapists who specialize in treating youth and who involve the entire family in treatment.
- A mobile emergency crisis response team which can go to the youth, responding quickly in the event of a suicidal crisis.
- Improved access to mental health services for those with no insurance and limited private resources.
- Special training on youth suicide for mental health professionals.

° Programs in the schools, including:

- Training for teachers, nurses, counselors, administrators and other school personnel in the identification of youth at risk of suicide and other self-destructive behaviors.
- Training parents similarly, plus emphasizing the need to rid the home of guns, medicines and other potentially lethal weapons, and stressing the importance of seeking professional help for high risk children.
- A curriculum for students, which focuses not only on suicide issues, but also other self-destructive behavior and youth problems, with a strong emphasis on developing good coping and decision making skills, positive mental health attitudes and "life management" skills.

- Development of peer advocacy programs, with emphasis on peer identification, referral and support of youth with problems, rather than peer counseling.
- A well-defined step-by-step protocol to use in the event of a suicide or an attempt, to avoid contagion among students.
- A clearly defined referral system to use when at-risk youth are identified.
- An evaluation component to determine which initiatives are helping to prevent suicide.
- Utilizing existing community resources, such as crisis intervention centers, community mental health centers and private therapists, in the development of school-based strategies and initiatives.

° A community-wide collaborative approach to addressing youth suicide, including:

- Group homes, foster homes and other alternative living arrangements for youth who cannot live at home.
- Training programs for agencies and individuals who work with youth, including emergency room personnel, pediatricians, primary care physicians, child protective service workers, foster parents, youth agencies, coaches, clergy, juvenile justice programs and police.
- A responsible media which has adopted voluntary guidelines in the coverage of youth suicides.
- Improved networking and cooperation among agencies and individuals who serve youth.
- Greater attention to suicide among older youth and pre-teens.

## STUDY METHODOLOGY

During this study, OIG staff interviewed a total of 631 people, as defined by the following categories:

## STUDY RESPONDENTS

Community Mental Health Centers	66
Other Mental Health Providers	38
Community and Migrant Health Centers	38
Children's and Teen Health Clinics	5
Family Planning Programs	26
Runaway and Homeless Youth Programs	72
Multi-Service Youth Agencies	9
Crisis Intervention Programs and Hotlines	27
Schools	20
Juvenile Justice	4
Survivor/Grief Counseling Groups	3
Local Government	10
Police	9
Medical Examiner's Offices	7
Experts, Researchers, Academicians	14
State Programs (a minimum in each state of education, mental health, children's services, substance abuse, and maternal and child health programs)	283
	<hr/>
TOTAL	631

Interviews were held in person and by telephone. Of the total, 170 in-person interviews were conducted through staff visits to ten communities in nine states. On-site fieldwork was conducted in February and March 1986 in:

Phoenix, Arizona	Chicago, Illinois
Los Angeles, California	Central New Jersey
San Francisco, California	New York City, New York
Denver, Colorado	Fairfax County, Virginia
Jacksonville, Florida	Seattle, Washington

Selection of these sites was based on the following criteria:

- geographic spread
- a mix of large and small populous states
- a mix of cities and larger urban areas
- states with a high rate and/or high incidence of suicide
- presence of innovative state, local government and private sector efforts
- a mix of communities with recognized suicide prevention programs and communities without such recognized efforts.

Community contacts included:

- Schools (K-12)
- Police
- Juvenile justice programs
- Health and mental health providers (both inpatient and outpatient)
- Child welfare agencies
- Medical examiners/coroners
- Hotlines/crisis intervention centers
- Drug and alcohol programs
- Youth shelters/runaway and homeless youth programs
- Survivor groups
- Youth/peer groups
- State and local governments
- Researchers/academicians/experts

Also during February and March, OIG staff interviewed by telephone 178 persons representing community service agencies funded by HHS, either directly or indirectly. These respondents were selected at random from nationwide lists of (a) direct grantees and (b) service providers funded under block grants to states. Four categories of respondents were selected from OHDS and PHS grantee lists:

- family planning programs
- runaway and homeless youth programs
- community and migrant health centers
- National Health Service Corps psychiatric sites

Sites belonging to the fifth category--community mental health centers--were selected from the National Directory of CMHCs (June 1985) prepared by the National Council of Community Mental Health Centers, because mental health programs are funded through HHS block grants to the states, and comprehensive lists of state grantees were unavailable.

A total of 183 local communities were represented in interviews conducted on-site and by telephone. (See Appendix B, which lists the specific communities represented in the on-site fieldwork and random telephone surveys.)

During April, 283 state respondents were interviewed by telephone in an effort to inventory state initiatives which address youth suicide issues. The findings from this inventory are published under separate cover. The following five agencies were contacted in each state. Generically, these core state agencies were defined as:

- education/public instruction
- mental health
- drug and alcohol abuse
- maternal and child health
- children's services (foster care, child abuse and neglect, and children's protective services)

In some states, knowledgeable representatives from governor's and lieutenant governor's offices, legislatures and planning agencies were contacted.

In summary, OIG staff contacted representatives of state and local, public and private sectors in all 50 states, Puerto Rico and the Virgin Islands.

MONTANA

- Billings

NEBRASKA

- Lincoln
- Omaha

NEVADA

- Las Vegas
- Reno

NEW HAMPSHIRE

- Manchester

NEW JERSEY

- Atlantic City
- Belle Mead
- Belleville
- Bridgewater
- Cape May
- Dumont
- Dunellen
- Edison
- Glassboro
- Hackensack
- Newark
- Piscataway
- Somerville
- South Orange
- Trenton

NEW MEXICO

- Albuquerque
- Portales

NEW YORK

- Albany
- Astoria
- Bronx
- Brooklyn
- Goshen
- Jamaica
- Manhattan
- Norwich
- Rochester
- Rockaway Beach
- Rome
- Staten Island
- White Plains
- Woodstock

NORTH CAROLINA

- Charlotte
- Durham

NORTH DAKOTA

- Bismarck
- Grand Forks

OHIO

- Cleveland
- Columbus
- Toledo
- Youngstown

OKLAHOMA

- Alva
- Ardmore
- McAlester

OREGON

- Portland
- Woodburn

PENNSYLVANIA

- Doylestown
- State College

PUERTO RICO

- Ponce

RHODE ISLAND

- Providence

SOUTH CAROLINA

- Charleston

SOUTH DAKOTA

- Sioux Falls
- Sisseton

TENNESSEE

- Knoxville
- Nashville
- Wartburg

TEXAS

- Austin
- Dallas
- Houston
- Plainview

UTAH

- Ogden

VERMONT

- Montpelier

VIRGINIA

- Arlington
- Fairfax
- Falls Church
- McLean
- New Canton
- Reston
- Richmond
- Springfield

VIRGIN ISLANDS

- St. Thomas

WASHINGTON

- Bellevue
- Issaquah
- Kirkland
- Seattle
- Spokane
- Tacoma
- Toppenish

WEST VIRGINIA

- Charleston
- Fairmont

WISCONSIN

- Milwaukee
- Racine

WYOMING

- Rock Springs



QUESTIONS ASKED BY YOUTH ABOUT SUICIDE

A church-affiliated organization of 200 youth meet once a week in study groups of 20 to discuss issues of major concern. Each year, suicide has been identified as a topic to be addressed. Following are examples of issues and questions raised by one study group in preparation for discussion of this topic:

How do you recognize the symptoms of suicide?

I would like to know about what causes people to turn to suicide. This will make us more aware of the situations around us.

How do you deal with people who have tried and failed?

What sort of problems are bad enough to end it all?

How to make yourself better without dying?

What does it feel like to lose a person you love because that person kills himself?

What can be done to prevent it? The thought has sometimes entered my mind.

Is teenage drinking and driving actually suicide?

Teach us how to cope with these situations.

Explain other ways out besides suicide.

What is the death rate for teen suicide?

How do you deal with a friend who is talking about suicide?

How to deal with a death of someone close to you and how they would feel if you committed suicide.

Are people who commit suicide very depressed and do it as a quick thought or do these people think it out?

If someone calls and tells you they're going to kill themselves, what do you tell them? Do you just listen or try to give advice?

I think there should be a course in high school on suicide.

Problems that teens have and how to cope.

You say that suicide doesn't solve your problems, but doesn't it? Everything is over...dead.