

**ADOLESCENT SUICIDE TASK FORCE**  
**REPORT and RECOMMENDATIONS**

**THE GOVERNOR'S OFFICE FOR CHILDREN**

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## THE ADOLESCENT SUICIDE TASK FORCE

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## EXECUTIVE SUMMARY

## EXECUTIVE SUMMARY

by Eric Benjamin, M.D.

The first question I asked the members of the Adolescent Suicide Task Force upon becoming chairman was, "Must one have a psychiatric disorder in order to experience a suicidal episode?" A suicidal episode is defined as an occurrence of suicidal ideation, threats, attempts, completion or any combination of these factors. After much research and debate, the members concluded that, indeed, almost all suicidal individuals have a psychiatric disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised (DSM-III-R).

We found that those at risk for suicide had depressive disorders, or other mood disorders, impulse control disorders such as Attention Deficit Hyperactivity Disorder (ADHD), and frequently a family history of suicide or previous suicidal episodes. In addition, substance abuse or alcoholism further enhanced the risk. The access to a lethal method, particularly firearms, increased the likelihood of a completed suicide.

Not all young people with these psychiatric disorders commit suicide. Psychiatrically disordered children and adolescents are at greater risk if they are from disrupted families with lower levels of education, low economic status, or if they are raised in environments where they are chronically exposed to abuse, violence or criminal activity.

Therefore our recommendations follow from these well-researched findings:

1. Those children whose biological parents or relatives have a family history of previous suicidal episodes must be screened and monitored as part of their early health care. This is a genetically at-risk population of children who are vulnerable to suicidal behavior. These children must have universal access to mental health care from the time behavioral problems are first noted (i.e., in school, by parents, by a pediatrician, etc.). Timely treatment of this population will serve to prevent the morbidity and mortality that is associated with suicidal episodes.
2. Children and youth with depressive disorders and other mood disorders, impulse control disorders (ADHD) and drug or alcohol problems must also have universal access to mental health services. Again, a family history for these disorders increases the risk that these children will have similar problems through inheritance.
3. The availability of firearms to children and youth predisposes this vulnerable population to a greater rate of suicide completion. Thus, there should be stringent control of the availability of firearms to children and adolescents. When there is a family history of suicidal episodes or the psychiatric disorders described above, specific safeguards should be in place if firearms are to be present in the home.

We strongly urge legislators and the general public to understand that suicide and homicide are two indicators of the status of mental health of our children and adolescents. Both of these behaviors are the outcomes of psychiatrically disturbed youth having access to lethal means where there are few social supports or treatments in place. Indeed, homicidal or aggressive behavior is the outward display of poor impulse control and mood disorders, often in combination with alcohol and drug problems, learning disorders or other psychiatric disorders. Identification of this at-risk population as described above, with early treatment, will prevent the morbidity and mortality for both the individual and society. This will be reflected not only in lives saved, but in monetary savings as well.

As we approach the twenty-first century, *Prevention* should become the treatment approach for these psychiatrically disordered children as early as possible in life. Thus, a three-year-old exhibiting impulse control problems in a chaotic home environment where homicidal or suicidal behavior has occurred in the parents or relatives requires immediate access to long-term mental health care. The price tag of identifying and treating this child, when compared to the cost of paying for his habilitation as an adult is minimal, particularly when one considers that he may contribute to society in a productive manner if treated.

The Adolescent Suicide Task Force has explored various programs, both at school and in the community, including school-based prevention programs and crisis hotlines to identify children and adolescents at risk. We have also detailed paradigms to be implemented to help in this task. Ultimately, the funding of the programs designed to triage and initiate treatment of these youths, at school and in the community, and the funding of the mental health care delivery system to assess and maintain treatment will provide the means to prevent suicide, homicide, and other aggressive behavioral disorders in children, adolescents and adults. The return on this investment will be a safer, healthier world at less cost to society.



## **INTRODUCTION AND BACKGROUND**

## INTRODUCTION

The Adolescent Suicide Task Force, organized in November, 1991, is an outgrowth of the State Select Commission on Adolescent Suicide that was originally convened in September, 1988. This Commission produced a Prevention Program Guide and submitted a Report of its activities to the Governor in September, 1989. This Report recommended increased funding for behavioral health services and coordination among state agencies to reduce fragmentation and maximize resources.

In spite of these efforts, the problem of suicide among teenagers and young adults in Arizona has remained serious. When Marti Lavis assumed the Directorship of the Governor's Office for Children in April, 1991, several members of the State Select Commission asked her to organize a group to study the problem and develop new strategies for decreasing suicides among Arizona's most important resource, its youth.

Dr. Eric Benjamin, Medical Director of Child and Adolescent Psychiatry at Phoenix Children's Hospital, was named Chair in March, 1992, and has provided able leadership since that time. Under his direction, the Task Force conducted a review of the substantial literature that exists on the subject of teen suicide and divided into three subcommittees to study specific aspects of the issue. These subcommittees included:

- Psychiatric Diagnoses and Risk Factors
- School-based Prevention Programs
- Hotlines, Crisis Intervention and other Community Programs

The following report is the result of two years' work on the part of the Task Force and its subcommittees. Although the Task Force has experienced many challenges during this period, it has continued to work toward a greater understanding of the problem and identification of realistic strategies to improve outcomes.

But recommendations, no matter how well researched or articulated, are empty words without the will to translate them into reality. The ultimate success of the Task Force will depend upon its message being heard and addressed across the state in homes, schools, mental health centers and among those who set priorities and make decisions at the state level.

Teen suicide cannot be seen in isolation. Often the culmination of failed hopes, nonexistent opportunities and unmet mental health needs, it is exacerbated by the conditions facing young people today. These include poverty, broken families, substance abuse and rapidly escalating violence. It is critical that we as a state begin to address these primary issues if the condition of our children and youth is ever to improve.

## BACKGROUND

### DEFINITIONS AND RISK FACTORS

**Suicidal Ideation** - Persistent thoughts or ideas about killing oneself.

**Suicidal Threat** - Involves thoughts about killing oneself as well as overt expression of these thoughts.

**Suicide Attempt** - A self-inflicted act with the intent to cause injury.

**Suicidal Episode** - An occurrence of suicidal ideation, threats, attempts, completion or any combination of these factors.

**Psychiatric Disorders** - Conditions described in the *Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised)*.

**Adolescence** - The period of physical and psychological development from the onset of puberty to maturity. Exact age markers cannot be assigned to this transition because individuals enter and leave it at different ages. Usually, however, adolescence takes place between the ages of 10 and 24. Within this transitional period, there are several developmental tasks to be completed:

- Transition from dependence on family to independence.
- Development of identity and sense of social responsibility.
- Development of mature personal relationships including sexual relationships.
- Identification of career goals and acquisition of skills necessary for economic independence.

**Risk Factors Associated with Adolescent Suicidal Episodes** - See the second section of this report for a more complete description of these factors.

- Previous suicide attempts.
- Suicidal ideation.
- Family history of suicidal episodes.
- Psychiatric disorders.
- Depression and hopelessness.
- Poor impulse control.
- Substance abuse and/or alcoholism
- Stressful life events and humiliating experiences.
- Disturbed interpersonal relationships.
- Gender identity issues.
- Accessibility of firearms.
- Prominent display of suicide in the media.

## ADOLESCENT SUICIDE IN ARIZONA

Throughout the decade of the 1980s and the early 1990s, the suicide rate in Arizona has been among the highest in the nation. This is true for persons of all ages as well as for adolescents. From 1985 through 1989, Arizona's rate of suicide for persons of all ages ranked among the five worst while its average rate for persons between 15 - 24 ranked eighth (Mrela, 1991). Mrela stated that, "The 1991 Arizona suicide rate was 50.9 percent higher than the national rate, and 58.1 percent higher than the year 2000 national health objective of 10.5 suicides/100,000 population." (1991, p. 4) Table 1 provides comparisons of suicide rates and numbers over a ten year period for three age groups.

**TABLE 1**  
**NUMBER OF SUICIDES AND SUICIDE RATES 1982 - 1992**

YEAR	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
<b>AGES UNDER 15</b>											
NUMBER	2	5	6	2	8	7	5	3	4	6	10
AZ RATE	0.9	2.2	2.6	0.9	3.4	2.9	2	1.1	1.6	2.3	3.7
U.S. RATE	1.1	1.1	1.3	1.6	1.5	1.3	1.4	1.4	N/A	N/A	N/A
<b>AGES 15-19</b>											
NUMBER	36	34	28	41	37	52	47	48	42	49	34
AZ RATE	15.1	14.5	12	17.3	15	20.9	18.5	18.7	16.1	18.3	12.4
U.S. RATE	8.7	8.7	9	10	N/A	10.3	11.3	N/A	N/A	N/A	N/A
<b>AGES 20-24</b>											
NUMBER	71	57	64	65	67	68	59	59	74	62	57
AZ RATE	25.4	20.8	23.2	23.7	24.4	25.1	29.2	21.8	26.4	21.6	19.3
U.S. RATE	15.3	14.8	15.6	16.3	N/A						
<b>ARIZONA TOTALS - AGES 24 AND UNDER</b>											
NUMBER	109	96	98	108	112	127	111	110	120	117	101

Other states with high rates of suicide are, with few exceptions, Rocky Mountain States (Centers for Disease Control and Prevention, 1993). Figure 1 shows the states with the highest and lowest suicide rates for individuals between 10 and 24 years of ages for the years 1987 and 1988. Although there has been considerable speculation about the cluster of high rates in the West, a definitive answer does not appear to be available. Possible explanations include isolation, transient populations and higher rates among Native Americans. Although each of these has merit, none seems to hold true for all the states involved.

In Arizona, the theory of transiency is not consistent with other trends. Teenagers in urban environments, where transiency is greatest, were not killing themselves with the same frequency as rural youths. From 1980 to 1989, the increase in teen suicide rates was 3.4 times greater for rural teens (Gersten & Mrela, 1990). In 1991, the counties with the highest suicide rates for persons 15 - 24 were rural counties with the highest rates of all seen in Apache, Cochise, Pinal and Yavapai (Mrela, 1993).

The suicide rate for individuals 15 through 19 years of age has increased steadily between 1981 and 1991 while the rate for persons 20 - 24 has declined slightly (Mrela, 1993). Figure 2 illustrates the trend toward increasing rates among teenagers.

Although the number of suicide attempts is believed to be much greater among females, the number of completions is considerably higher among males. In 1991, There were 40 deaths by suicide among males 15-19 years of age and 9 among females in the same age group. In the young adult age group, 20 - 24, a similar difference was evident. In 1991, there were 52 males who killed themselves and 10 females (Mrela, 1993).

The highest suicide rates for Arizona youth are among white males and Native American males. The rate for Native Americans teens of both sexes was especially high in 1990 (40.2 deaths per 100,000 population). This rate was more than twice the rate for white teenagers (18.7) and almost nine times the rate for hispanics (4.6) (Mrela, 1992).

According to the American Association of Suicidology (1993), the most common method of suicide is use of firearms. Nationally, 61.1% of the suicides for persons of all ages in 1990 were the result of firearms. The second most common method in 1990 was hanging, strangulation or suffocation which accounted for 14.4% of all suicides. This was followed by ingestion of solid or liquid poisons which accounted for 10.2% of all deaths by suicide.

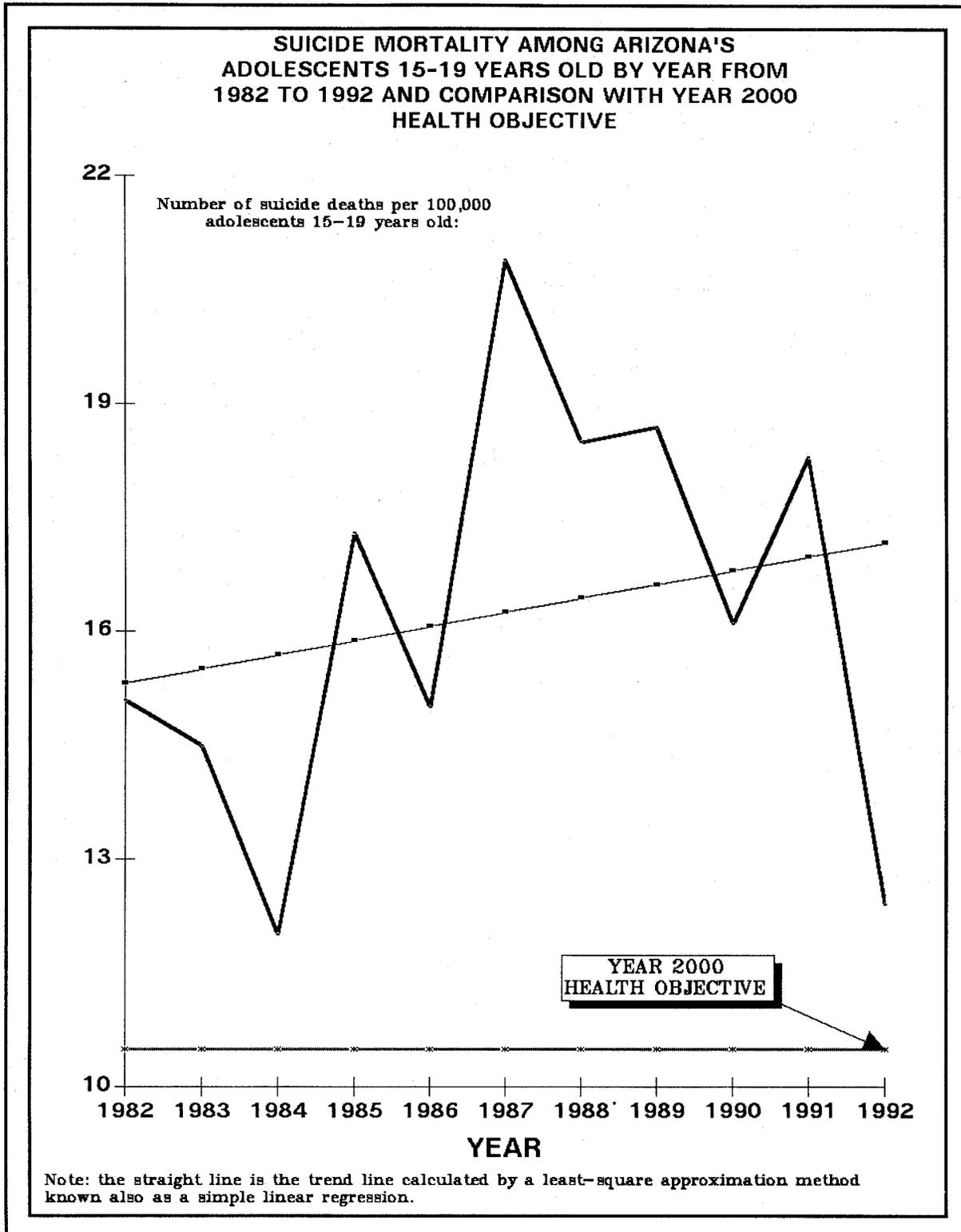
A somewhat different mix of methods is observed in attempted suicide. Most common is the overdose of medication, often in combination with other substances. Attempts also involve jumping from high places, use of cutting instruments such as knives and razors as well as hanging, gassing and traffic accidents.

In Arizona, firearms accounted for 67.6 % of all suicides from 1989 to 1991. Most of the increase in suicides among young people can be accounted for by use of firearms.

It seems likely that actual attempts and completions are significantly more numerous than reported figures indicate. Many suicidal episodes and actual attempts are never reported. Also, it is frequently difficult to determine whether certain fatalities are planned or accidental, especially those involving motor vehicles. For this reason, the Task Force has chosen to emphasize suicidal episodes rather than completions.



FIGURE 2



Source: Mrela, C. K. (1994). Arizona Department of Health Services

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**PSYCHIATRIC DIAGNOSES AND RISK FACTORS  
SUBCOMMITTEE**

**REPORT and RECOMMENDATIONS**

## ADOLESCENT SUICIDE RISK AND PREVENTION

Dramatic demographic and social changes occurring during the latter half of the twentieth century in the United States have contributed to social and personal disorganization. Demographic changes include urbanization, population mobility and increasing numbers of poor, uneducated, unemployed and disadvantaged members of society. Social factors include the decline in religious/moral values, prevalence of divorce and the startling increase in the number of single-parent families. Earlier initiation of sexual activity, increased unintentional pregnancies, sexually transmitted diseases, child abuse, domestic violence, increased criminal activity all tend to exacerbate the situation. Stigmatization surrounding gender identity conflicts is an additional factor.

These societal stressors appear to be associated with feelings of anger, alienation and hopelessness among vulnerable individuals, including adolescents. When associated with psychiatric illness, especially depression, individuals may experience loss of self-esteem, decreased coping skills and a loss of hope. Trigger factors such as the use of alcohol or drugs, the availability of a lethal method (particularly firearms) and the occurrence of stressful life events may increase the likelihood of a suicidal episode.

### **Risk Factors for Adolescent Suicidal Episodes:**

#### **Previous suicide attempts:**

Between 6% and 13% of adolescents have reported that they attempted suicide at least once in their lives (Dubow, Kausch, Blum & Reed, 1989; Gallup Organization, 1991; Meehan, Lamb, Saltzman & O'Carroll, 1992; Shaffer, Garland, Vieland, Underwood & Busner, 1991). The vast majority of suicide attempters do not seek or receive medical or mental health care (Smith & Crawford, 1988).

#### **Family history of suicide:**

Garfinkel, Froese and Hood (1991) found that the rate of suicide in the families of adolescent suicide attempters was seven times greater than the rate in families of medical patients. Suicidal adolescents are more likely than other adolescents to know someone who has either attempted or committed suicide (Sprito, et al., 1989).

When students who attempted suicide after a close school friend completed suicide (contagion effect), studies indicated that there was a significant history of psychiatric illness in these children's families.

#### **Psychiatric disorders including depression and hopelessness:**

The most prevalent psychiatric disorders among completed adolescent suicides appear to be mood disorders, conduct disorder and substance abuse (Brent et al., 1988; Shaffer, 1988). Psychological difficulties are also indicated by the fact that the majority of adolescents who commit suicide experienced long-standing problems in school, with their families and possibly with the law.

Kazdin, French, Unis, Esveldt-Dawson and Sherick (1983) found that children who had made a suicide attempt reported more depression and hopelessness than did children who were suicide ideators. Hopelessness with depression may be a stronger predictor of suicidal behavior than depression alone.

**Suicidal ideation:**

Smith and Crawford (1981) indicated that 62.6% of a midwestern high school sample reported some suicidal ideation of behavior. Another study reported a lifetime prevalence of suicidal ideation of 54% among college students (Meehan et al., 1992).

**Poor impulse control:**

It is characterized by a general lack of responsible, rational behavior and can be included within such disorders as intermittent explosive disorder, many of the disruptive behavior disorders (ADHD) and affective disorders such as bipolar disorder. When impulsivity is combined with other risk factors such as depression and use of substances, the risk of a suicidal episode is greatly increased.

**Substance abuse and /or alcoholism:**

Drug and alcohol abuse is a significant factor for suicidal behavior, both as it affects cognitive, social, affective familial and behavioral functioning, and as an immediate precipitant to suicide due to decreased inhibitions (Shaffer, 1988). Brent et al. (1988) found that at least one-third of adolescents who commit suicide are intoxicated at the time of death and many more may be under the influence of drugs.

**Stressful life events, humiliating experiences and interpersonal relationships:**

Hendlin (1987) reported that adolescent suicide attempters experienced more family turmoil (such as parental separations, changes in caretakers and living situations) as well as increased social instability in the year before the suicide attempt than did nonsuicidal adolescents and a normal sample of adolescents.

Completed suicide is often immediately precipitated by a shameful or humiliating experience such as an arrest, a perceived failure at school or work or a rejection or interpersonal conflict with a romantic partner or parent (Brent et al., 1988; Shaffer, 1974, 1988; Shaffer et al., 1988). The experience of sexual or physical assault appears to be a particularly significant risk factor for girls.

Hoberman and Garfinkel (1988) found that the most common precipitant of suicide in their sample of 229 youth suicides was an argument with a boyfriend or girlfriend or a parent (19%), followed by school problems (14%). Brent et al. (1988) reported that an interpersonal conflict was a precipitant in more than 70% of the suicides they studied. Additionally, when a person has poor impulse control, they experience increased difficulties in resolving interpersonal conflicts due to deficits in problem solving skills (Rotheram-Borus, Trautman, Depkins & Shrout, 1990).

**Gender identity issues:**

Gay youth are two to three times more likely to attempt suicide than other young people (Larkin Street, 1984). While there is nothing inherently self-destructive in homosexual feelings and relationships, suicide attempts by gay and lesbian youth are likely to involve conflicts around sexual orientation because of the overwhelming pressures they face in coming out at an early age (Bell and Weinberg, 1978). The Los Angeles Suicide Prevention Center found that the strongest causative indicators of suicidal behavior among gay youth were awareness of their sexual orientation, depression and suicidal feelings, all before the age of 14 (Los Angeles Suicide Prevention Center, 1986).

### **Accessibility of firearms:**

The rate of suicide by firearms has increased three times faster than the rates of all other methods for 15-19 year olds since 1950 (Boyd & Moscicki, 1986). Brent et al. (1988) reported that there was greater availability of firearms in homes of adolescents who completed suicide than in homes of adolescents who had made suicide attempts.

### **Increased pressure to perform:**

Elkind (1981) attributed the dramatic increase in adolescent suicide to increased pressure on children to achieve and to be responsible at an early age.

### **Prominent display of suicide in the media:**

Several studies have confirmed that suicide rates increase following television or newspaper coverage of suicide, and that teenagers appear to be particularly susceptible to this effect (Gould & Shaffer, 1986; Phillips & Carstenson, 1988). Fictional stories about suicide have also been found to be associated with an increase in suicidal behavior (Gould & Shaffer, 1986). It is not clear how or whether the manner in which the information is presented influences the effect.

Factors that tend to mitigate these trends include the presence of a stable home and community environment, individual protective factors, positive school experiences and primary prevention programming in social and educational settings.

The objective of secondary prevention is to identify adolescents at risk and ensure that they receive appropriate, timely mental health care. Friends of teenagers who have attempted suicide are clearly among those at risk and intervention programs can identify them and prevent a contagion effect.

Comprehensive mental health care for those at risk should be readily available, affordable and accessible regardless of geographic location and economic status. Professionals in settings in which identification is likely (e.g. the schools, medical care facilities, youth centers and crisis intervention centers/hotlines), should be well informed regarding the risk factors and the protocol for making mental health referrals. Additional training at various levels will be required to achieve this. The mental health care system includes qualified professionals such as counselors, nurses, primary care physicians and pediatricians, social workers, psychologists and psychiatrists.

Tertiary prevention involves controlling events after a suicidal episode. This includes obtaining care for the adolescent and/or providing support to the family, friends and others impacted by a suicidal episode. Tertiary prevention also includes decreasing media coverage and glamorization of suicide.

The risk and prevention factors associated with adolescent suicidal episodes are now becoming much more clearly defined. Finding the resources to implement a continuum of care remains challenging.

## Conclusions

- Suicidal behavior is an outcome of psychiatric disorders in combination with exacerbating circumstances.
- The most common psychiatric disorders associated with suicide are depression, impulse control disorders and substance abuse.
- Suicidal behavior is most common among youth where there is a family history of psychiatric disorders and suicide.
- Prevention of suicide among adolescents lies in the earliest possible identification of psychiatric disorders and initiation of appropriate treatment.
- Many violent and/or homicidal acts are a result of psychiatric disorders turned outward into aggressive acts of violence.
- Stigmatization surrounding gender identity issues is strongly associated with suicidal behavior.
- The use of firearms is strongly associated with completed suicides.
- There is a serious lack of available, accessible and timely services as well as inadequate coordination among the agencies that encounter and intervene in the lives of young people at risk.

## Recommendations

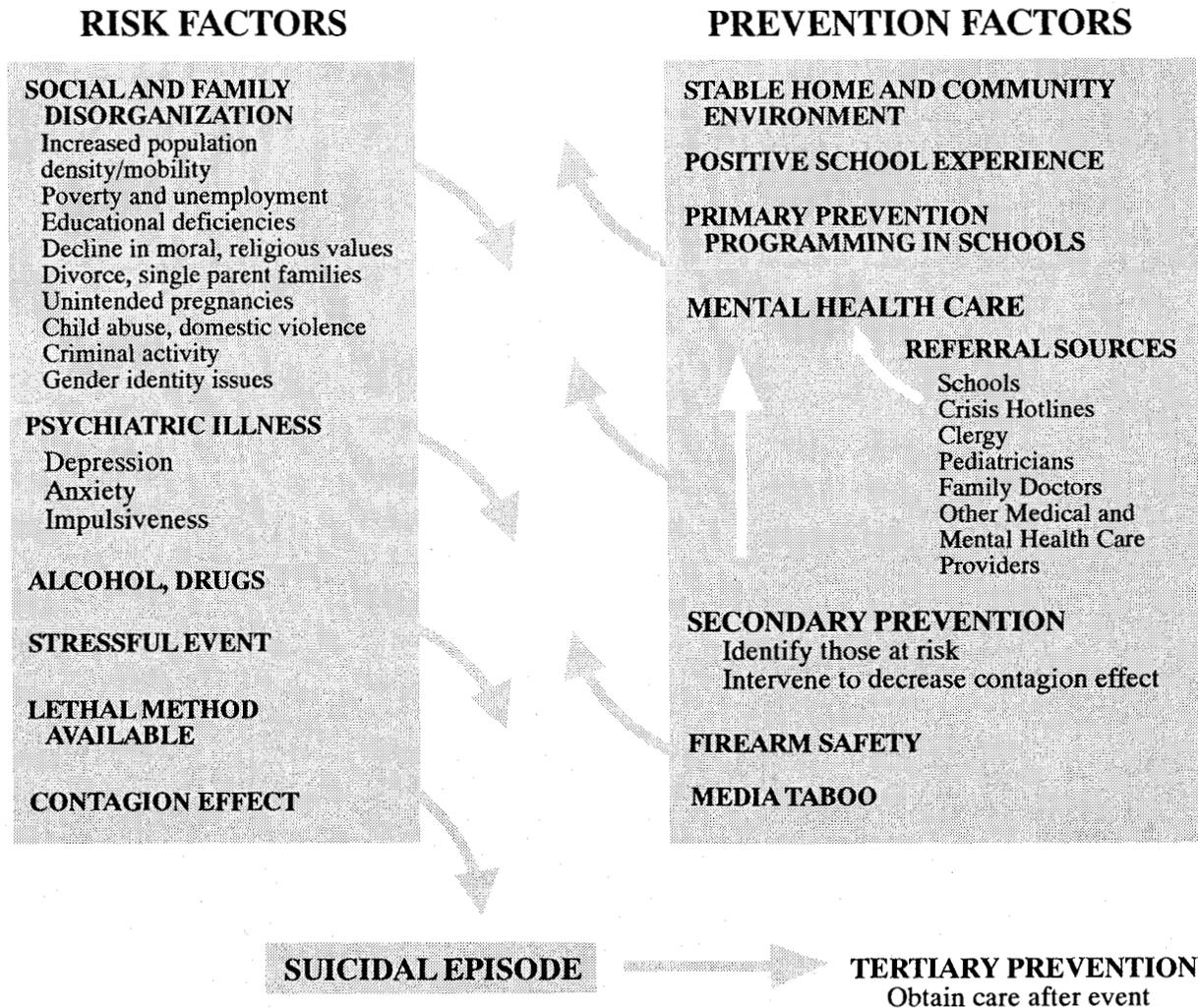
- Early, systematic identification and treatment are essential for children and youth at risk for suicidal episodes.
- Children and youth must have universal access to mental health care.
- Appropriate training for professionals should be developed and required.
- Existing services should be coordinated and consolidated with the addition of a centralized information line and data collection and tracking system.
- Serious efforts to control access to firearms among children and youth should be initiated.
- Arizona's Child Fatality Review Team should be strongly encouraged to review adolescent suicidal episodes and develop prevention and early intervention strategies.

## SUPPORTING MATERIALS

The following flow chart visually represents factors that tend to increase or decrease the risk of suicidal episodes. A suicidal episode is defined as an occurrence of suicidal ideation, threats, attempts or completion or any combination of these factors (Pfeffer et al., 1991).

In addition, a hypothetical case study has been included to illustrate a possible scenario. Problems included are those that are likely to be encountered within the various systems that frequently interact with children and youth at risk. Points of contact with these systems are also highlighted with suggested interventions.

### ADOLESCENT SUICIDE RISK AND PREVENTION



## CASE STUDY

### AN ADOLESCENT SUICIDE ATTEMPTER

A fourteen year old white male was brought to the emergency room by police following a suspicious single car accident. He had borrowed his mother's car, run off the road, hit a tree and was treated for a concussion and minor injuries. He was under the influence of alcohol at the time of the accident. He was upset about his mother's nagging him about not going to school. He also appeared despondent and depressed. He was admitted for a 72 hour evaluation and the Regional Behavioral Health Authority (RBHA) was asked to assess his behavioral health needs.

This 14 year old male had been to the emergency room on various occasions for injuries sustained during one prior auto accident and numerous fights. His mother indicated that drugs or alcohol were involved on all occasions. The mother, a 30 year old single white female living in an urban area, was mildly mentally retarded and could not remember the exact times or locations of the previous hospitalizations. She worked part-time cleaning houses. There was a 11 year old sister. The mother was not married but both children had the same father. She reported that neither she nor the father had completed high school. Both families, apparently, had some history of depression and suicidal episodes. The father was presently incarcerated in the state prison for child molestation of his daughter and another neighborhood girl. Child Protective Services (CPS) was involved at the time of the disclosure of molestation and the daughter had been briefly placed in foster care. She was returned to her mother when the father was arrested and removed from the home.

The mother had communication difficulties but believed her son had become increasingly depressed over the past six months and she suspected that he was involved with a local gang. She stated that her son is also mildly mentally retarded and is in special education classes at the public school. Additionally, the boy had suffered from grand mal seizures since he was three years old. They have been partially controlled by medication which he takes irregularly. The family receives medical care through AHCCCS.

The boy has always done poorly in school but recently his attendance has been very irregular. The principal discussed this with the mother on several occasions. She stated that she cannot control her son and can't force him to go to school. He has been spending more and more time with friends and recently his mother found a gun in his room. The police have been called for various neighborhood incidents of fighting and, at one point, he threatened to kill his mother and his sister with a knife. Charges were not pressed.

The young man stated that he hates school because others make fun of him because he is slow and weird and the only place where he feels accepted is among his gang who are school dropouts. His sister indicated to the emergency room staff that she has been worried about her brother for some time. He once told her when he was drunk that he felt like dying.

### SYSTEMS ISSUES

In the previous case study there are various points at which interventions could have occurred to assist the youth and his family but did not or were not sufficient to ensure timely and appropriate services.

This youth was identified at age three as having neurological problems manifested through grand mal seizures and poor fine motor coordination. Although he received medication for this condition, no known referrals were provided at this time for neuropsychiatric or developmental disability (DD) assessment. His mild mental retardation was not discovered until he was in second grade when he was referred for behavior problems and testing.

Testing provided through the school resulted in a recommendation for placement in special education, however, he was not placed until he was in 5th grade. By this time, his achievement had further declined and his behavior problems had worsened. Because his medication was not effectively monitored, he continued to experience seizures at school.

The special education teacher noticed signs of depression which she discussed with the mother. The teacher suggested sources for assistance but the mother did not pursue them. The boy's acting out behavior increased over the years as his achievement declined. By the time he reached the junior high school level, his attendance was poor and school staff suspected gang involvement. Several incidents involving the police resulted in brief detentions but no follow up behavioral health services.

The most recent incident led to emergency room treatment and the 72 hour evaluation through the local Regional Behavioral Health Authority (RBHA). The evaluation revealed severe depression with conduct disorder. Although the boy admitted to suicidal thoughts, he was not deemed actively suicidal at discharge. A treatment plan was developed by the RBHA which included in-home therapy and medication monitoring. Although he was placed on antidepressants, he did not take them regularly, refused to attend the in-home therapy sessions, ran away on several occasions and had several additional skirmishes with police.

Since this treatment was not successful, a staffing was held by the RBHA to address future planning. Results of the staffing included recommendations for services through Developmental Disabilities in cooperation with the RBHA for a therapeutic group home placement. This recommendation was the result of escalating concerns about the boy's deteriorating mental and physical condition and increased risk for suicide.

The RBHA and the Department of Developmental Disabilities disagreed over the child's primary diagnosis which affected placement decisions and funding responsibilities. Additionally, in the most recent school individual education plan (IEP), the school district recommended residential treatment since they considered the child to be uncontrollable in his current setting. DDD considered the need for intensive residential service to be totally related to behavioral health issues rather than seizures or retardation.

The RBHA believed that a DD group home with wrap around behavioral health services was the most appropriate intervention clinically and most cost effective since costs would be shared.

The Behavioral Health Services Medical Director was contacted by the school district due to Hodges v. Bishop mandates and the child was placed in residential treatment.

The RBHA appealed this decision for clinical reasons. In addition, the full burden of funding was their responsibility until the child became eligible for Title XIX behavioral health services.

## POINTS OF INTERVENTION

In an ideal system, interventions would occur at the earliest point and comprehensive, preventive services would be provided. The following list illustrates points of possible entry and treatment or services that could have been accessed.

### CRITICAL POINT

The mother was a teenager when her child was born. She could have been identified as high risk during her pregnancy or at the birth of her child. Her developmental delay could have been discovered at this time.

A pediatrician discovered the boy's seizure disorder when he was three years old.

The boy entered school at age 5 or 6. Mental deficiencies and continuing medical problems might have been discovered.

In second grade problems were identified and recommendations were made for a special education placement. Placement did not occur until 3 years later.

The special education teacher noticed that the boy seemed depressed and suggested that the mother seek counseling. The mother did not follow through.

The boy was involved in various minor skirmishes with the police and briefly detained.

The boy was brought to the emergency room on several occasions for minor injuries sustained in fights.

### POSSIBLE INTERVENTION

Services for high-risk mothers such as Healthy Families could have been provided.

If the developmental delay was discovered, the mother may have been eligible for services through Developmental Disabilities.

Referrals for neurological and developmental assessments would have been appropriate. If results indicated the need, referrals to DDD or Behavioral Health Services could have been made.

Appropriate remedial strategies or referrals could have been initiated by the school nurse or other staff upon initial screening.

Special education services could have been implemented immediately.

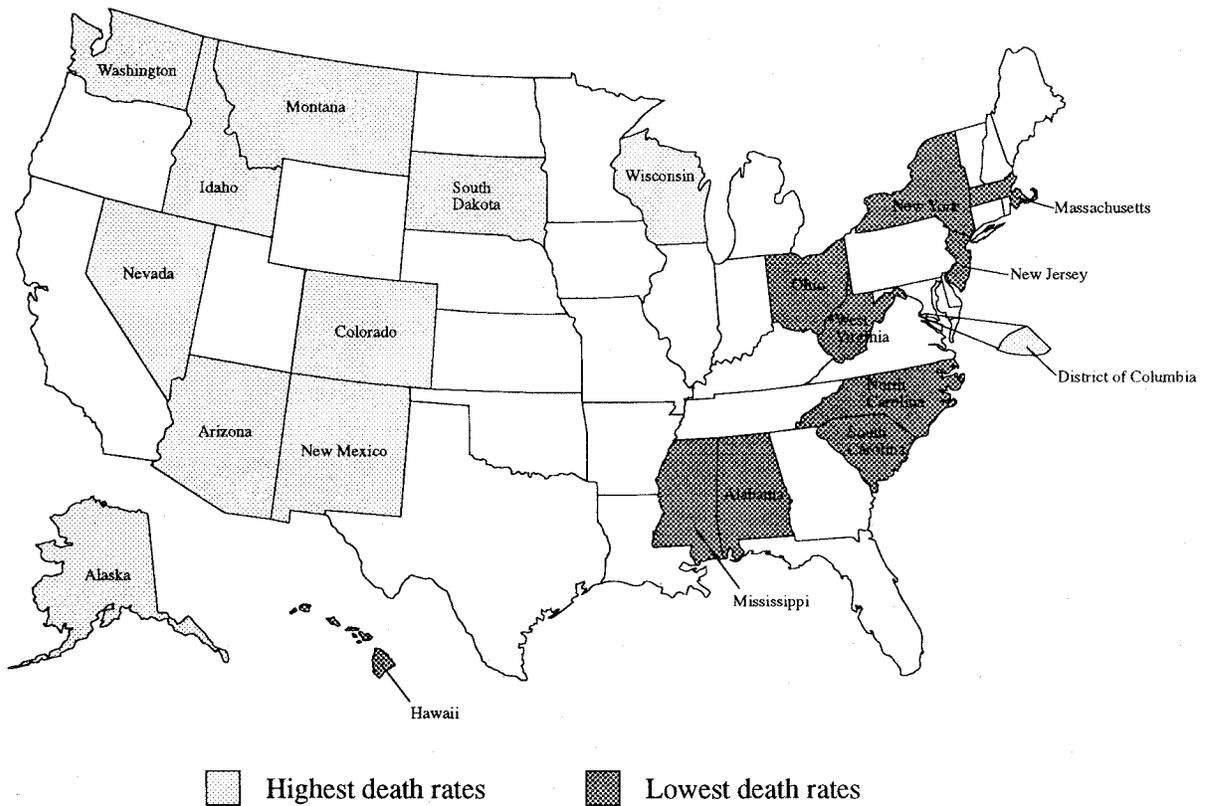
When the mother did not follow the teacher's suggestions, the teacher could have discussed the case with the school psychologist. Teacher or psychologist could have met with the mother and suggested other available resources.

These incidents could have resulted in juvenile court intervention and court ordered treatment could have occurred at this time.

Emergency room staff should have made referrals to have the youth evaluated.

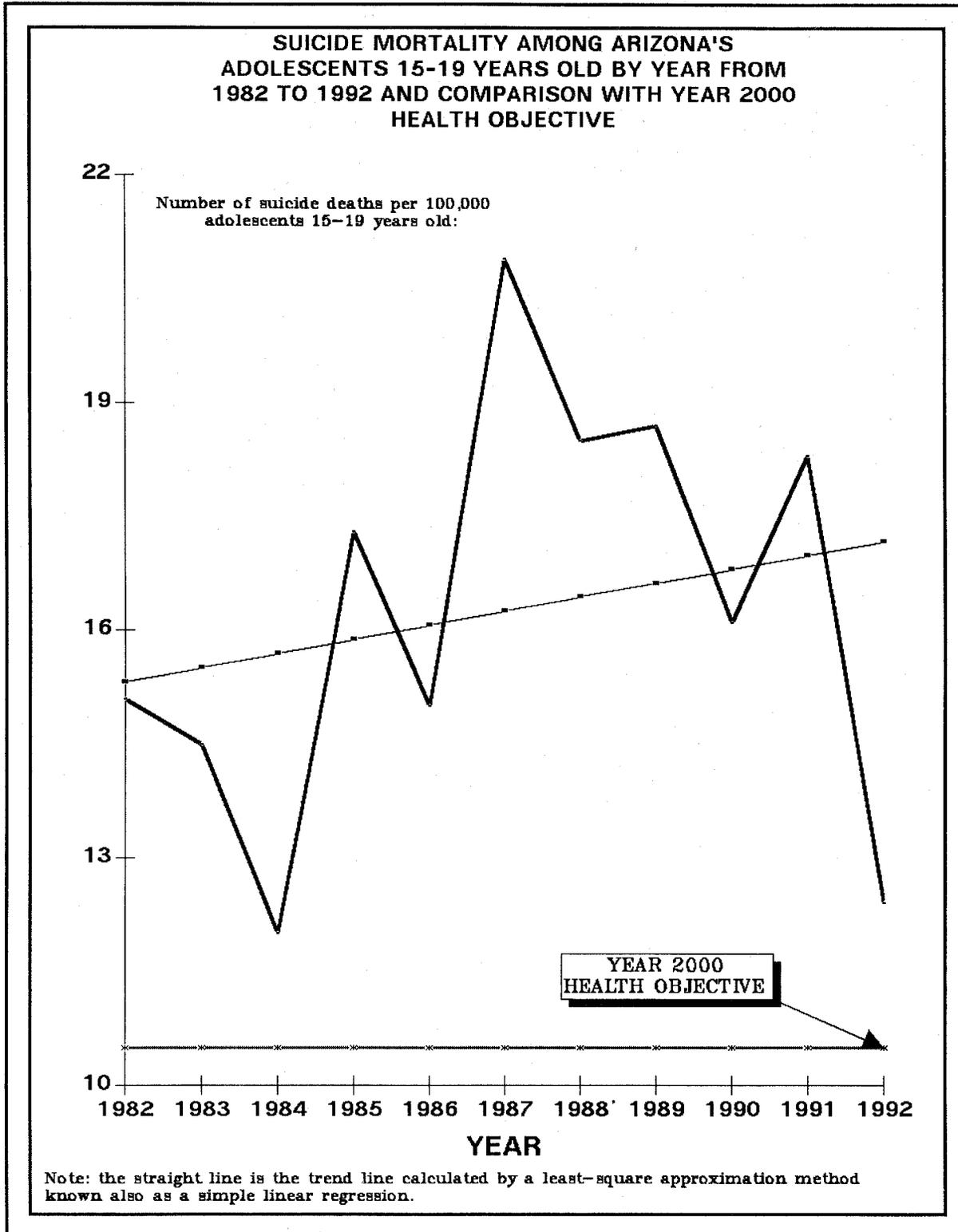
FIGURE 1

STATES WITH THE HIGHEST AND LOWEST RATES OF SUICIDE  
for  
PERSONS 10 - 24 YEARS OF AGE, 1987 - 1988



Source: Centers for Disease Control and Prevention. (1993). *Mortality Trends, Causes of Death and Related Risk Behaviors among U. S. Adolescents.* p. 33.

FIGURE 2



Source: Mrela, C. K. (1994). Arizona Department of Health Services

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**PSYCHIATRIC DIAGNOSES AND RISK FACTORS  
SUBCOMMITTEE**

**REPORT and RECOMMENDATIONS**

## ADOLESCENT SUICIDE RISK AND PREVENTION

Dramatic demographic and social changes occurring during the latter half of the twentieth century in the United States have contributed to social and personal disorganization. Demographic changes include urbanization, population mobility and increasing numbers of poor, uneducated, unemployed and disadvantaged members of society. Social factors include the decline in religious/moral values, prevalence of divorce and the startling increase in the number of single-parent families. Earlier initiation of sexual activity, increased unintentional pregnancies, sexually transmitted diseases, child abuse, domestic violence, increased criminal activity all tend to exacerbate the situation. Stigmatization surrounding gender identity conflicts is an additional factor.

These societal stressors appear to be associated with feelings of anger, alienation and hopelessness among vulnerable individuals, including adolescents. When associated with psychiatric illness, especially depression, individuals may experience loss of self-esteem, decreased coping skills and a loss of hope. Trigger factors such as the use of alcohol or drugs, the availability of a lethal method (particularly firearms) and the occurrence of stressful life events may increase the likelihood of a suicidal episode.

### **Risk Factors for Adolescent Suicidal Episodes:**

#### **Previous suicide attempts:**

Between 6% and 13% of adolescents have reported that they attempted suicide at least once in their lives (Dubow, Kausch, Blum & Reed, 1989; Gallup Organization, 1991; Meehan, Lamb, Saltzman & O'Carroll, 1992; Shaffer, Garland, Vieland, Underwood & Busner, 1991). The vast majority of suicide attempters do not seek or receive medical or mental health care (Smith & Crawford, 1988).

#### **Family history of suicide:**

Garfinkel, Froese and Hood (1991) found that the rate of suicide in the families of adolescent suicide attempters was seven times greater than the rate in families of medical patients. Suicidal adolescents are more likely than other adolescents to know someone who has either attempted or committed suicide (Sprito, et al., 1989).

When students who attempted suicide after a close school friend completed suicide (contagion effect), studies indicated that there was a significant history of psychiatric illness in these children's families.

#### **Psychiatric disorders including depression and hopelessness:**

The most prevalent psychiatric disorders among completed adolescent suicides appear to be mood disorders, conduct disorder and substance abuse (Brent et al., 1988; Shaffer, 1988). Psychological difficulties are also indicated by the fact that the majority of adolescents who commit suicide experienced long-standing problems in school, with their families and possibly with the law.

Kazdin, French, Unis, Esveldt-Dawson and Sherick (1983) found that children who had made a suicide attempt reported more depression and hopelessness than did children who were suicide ideators. Hopelessness with depression may be a stronger predictor of suicidal behavior than depression alone.

**Suicidal ideation:**

Smith and Crawford (1981) indicated that 62.6% of a midwestern high school sample reported some suicidal ideation of behavior. Another study reported a lifetime prevalence of suicidal ideation of 54% among college students (Meehan et al., 1992).

**Poor impulse control:**

It is characterized by a general lack of responsible, rational behavior and can be included within such disorders as intermittent explosive disorder, many of the disruptive behavior disorders (ADHD) and affective disorders such as bipolar disorder. When impulsivity is combined with other risk factors such as depression and use of substances, the risk of a suicidal episode is greatly increased.

**Substance abuse and /or alcoholism:**

Drug and alcohol abuse is a significant factor for suicidal behavior, both as it affects cognitive, social, affective familial and behavioral functioning, and as an immediate precipitant to suicide due to decreased inhibitions (Shaffer, 1988). Brent et al. (1988) found that at least one-third of adolescents who commit suicide are intoxicated at the time of death and many more may be under the influence of drugs.

**Stressful life events, humiliating experiences and interpersonal relationships:**

Hendlin (1987) reported that adolescent suicide attempters experienced more family turmoil (such as parental separations, changes in caretakers and living situations) as well as increased social instability in the year before the suicide attempt than did nonsuicidal adolescents and a normal sample of adolescents.

Completed suicide is often immediately precipitated by a shameful or humiliating experience such as an arrest, a perceived failure at school or work or a rejection or interpersonal conflict with a romantic partner or parent (Brent et al., 1988; Shaffer, 1974, 1988; Shaffer et al., 1988). The experience of sexual or physical assault appears to be a particularly significant risk factor for girls.

Hoberman and Garfinkel (1988) found that the most common precipitant of suicide in their sample of 229 youth suicides was an argument with a boyfriend or girlfriend or a parent (19%), followed by school problems (14%). Brent et al. (1988) reported that an interpersonal conflict was a precipitant in more than 70% of the suicides they studied. Additionally, when a person has poor impulse control, they experience increased difficulties in resolving interpersonal conflicts due to deficits in problem solving skills (Rotheram-Borus, Trautman, Depkins & Shrout, 1990).

**Gender identity issues:**

Gay youth are two to three times more likely to attempt suicide than other young people (Larkin Street, 1984). While there is nothing inherently self-destructive in homosexual feelings and relationships, suicide attempts by gay and lesbian youth are likely to involve conflicts around sexual orientation because of the overwhelming pressures they face in coming out at an early age (Bell and Weinberg, 1978). The Los Angeles Suicide Prevention Center found that the strongest causative indicators of suicidal behavior among gay youth were awareness of their sexual orientation, depression and suicidal feelings, all before the age of 14 (Los Angeles Suicide Prevention Center, 1986).

**Accessibility of firearms:**

The rate of suicide by firearms has increased three times faster than the rates of all other methods for 15-19 year olds since 1950 (Boyd & Moscicki, 1986). Brent et al. (1988) reported that there was greater availability of firearms in homes of adolescents who completed suicide than in homes of adolescents who had made suicide attempts.

**Increased pressure to perform:**

Elkind (1981) attributed the dramatic increase in adolescent suicide to increased pressure on children to achieve and to be responsible at an early age.

**Prominent display of suicide in the media:**

Several studies have confirmed that suicide rates increase following television or newspaper coverage of suicide, and that teenagers appear to be particularly susceptible to this effect (Gould & Shaffer, 1986; Phillips & Carstenson, 1988). Fictional stories about suicide have also been found to be associated with an increase in suicidal behavior (Gould & Shaffer, 1986). It is not clear how or whether the manner in which the information is presented influences the effect.

Factors that tend to mitigate these trends include the presence of a stable home and community environment, individual protective factors, positive school experiences and primary prevention programming in social and educational settings.

The objective of secondary prevention is to identify adolescents at risk and ensure that they receive appropriate, timely mental health care. Friends of teenagers who have attempted suicide are clearly among those at risk and intervention programs can identify them and prevent a contagion effect.

Comprehensive mental health care for those at risk should be readily available, affordable and accessible regardless of geographic location and economic status. Professionals in settings in which identification is likely (e.g. the schools, medical care facilities, youth centers and crisis intervention centers/hotlines), should be well informed regarding the risk factors and the protocol for making mental health referrals. Additional training at various levels will be required to achieve this. The mental health care system includes qualified professionals such as counselors, nurses, primary care physicians and pediatricians, social workers, psychologists and psychiatrists.

Tertiary prevention involves controlling events after a suicidal episode. This includes obtaining care for the adolescent and/or providing support to the family, friends and others impacted by a suicidal episode. Tertiary prevention also includes decreasing media coverage and glamorization of suicide.

The risk and prevention factors associated with adolescent suicidal episodes are now becoming much more clearly defined. Finding the resources to implement a continuum of care remains challenging.

## Conclusions

- Suicidal behavior is an outcome of psychiatric disorders in combination with exacerbating circumstances.
- The most common psychiatric disorders associated with suicide are depression, impulse control disorders and substance abuse.
- Suicidal behavior is most common among youth where there is a family history of psychiatric disorders and suicide.
- Prevention of suicide among adolescents lies in the earliest possible identification of psychiatric disorders and initiation of appropriate treatment.
- Many violent and/or homicidal acts are a result of psychiatric disorders turned outward into aggressive acts of violence.
- Stigmatization surrounding gender identity issues is strongly associated with suicidal behavior.
- The use of firearms is strongly associated with completed suicides.
- There is a serious lack of available, accessible and timely services as well as inadequate coordination among the agencies that encounter and intervene in the lives of young people at risk.

## Recommendations

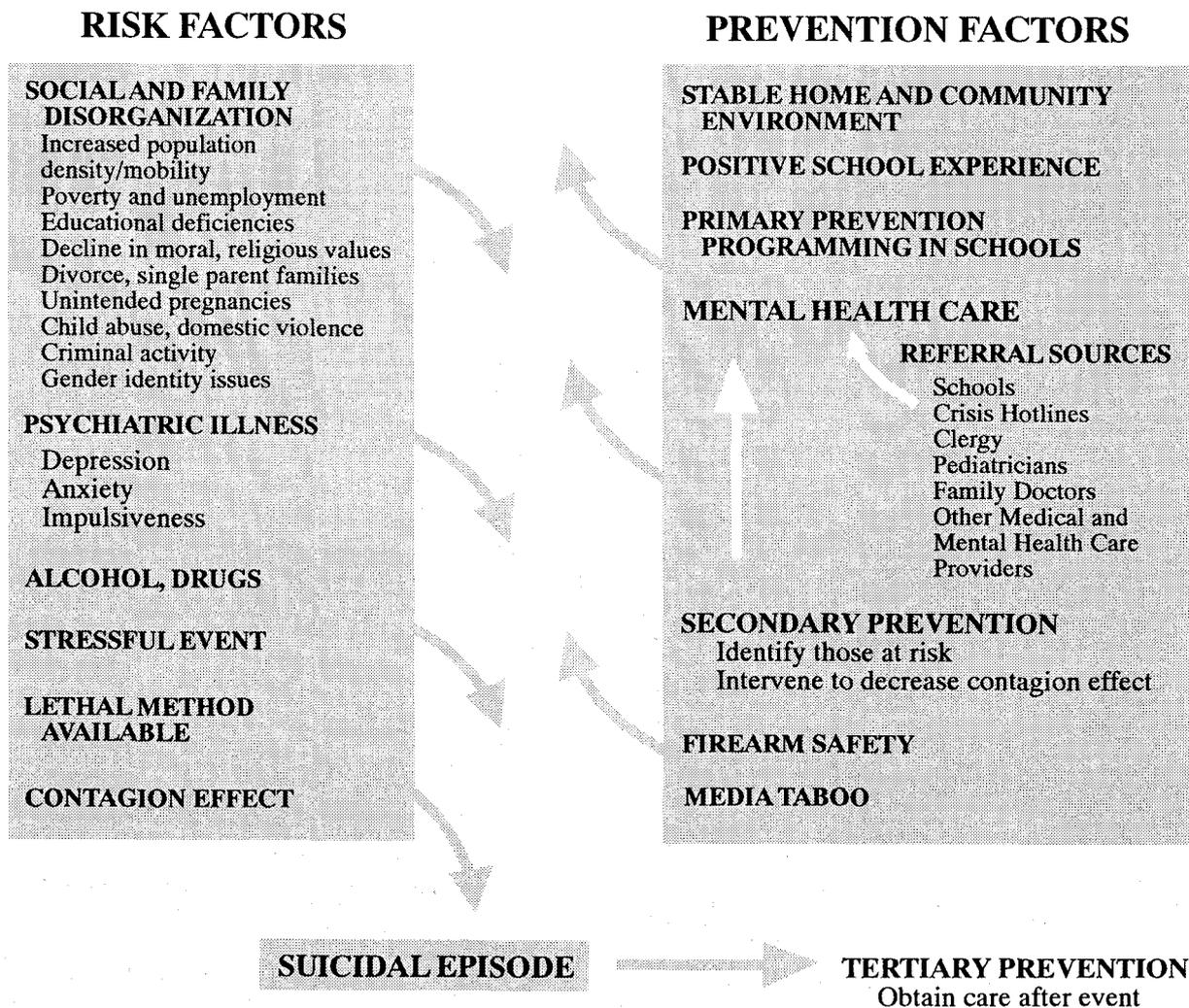
- Early, systematic identification and treatment are essential for children and youth at risk for suicidal episodes.
- Children and youth must have universal access to mental health care.
- Appropriate training for professionals should be developed and required.
- Existing services should be coordinated and consolidated with the addition of a centralized information line and data collection and tracking system.
- Serious efforts to control access to firearms among children and youth should be initiated.
- Arizona's Child Fatality Review Team should be strongly encouraged to review adolescent suicidal episodes and develop prevention and early intervention strategies.

## SUPPORTING MATERIALS

The following flow chart visually represents factors that tend to increase or decrease the risk of suicidal episodes. A suicidal episode is defined as an occurrence of suicidal ideation, threats, attempts or completion or any combination of these factors (Pfeffer et al., 1991).

In addition, a hypothetical case study has been included to illustrate a possible scenario. Problems included are those that are likely to be encountered within the various systems that frequently interact with children and youth at risk. Points of contact with these systems are also highlighted with suggested interventions.

### ADOLESCENT SUICIDE RISK AND PREVENTION



## CASE STUDY

### AN ADOLESCENT SUICIDE ATTEMPTER

A fourteen year old white male was brought to the emergency room by police following a suspicious single car accident. He had borrowed his mother's car, run off the road, hit a tree and was treated for a concussion and minor injuries. He was under the influence of alcohol at the time of the accident. He was upset about his mother's nagging him about not going to school. He also appeared despondent and depressed. He was admitted for a 72 hour evaluation and the Regional Behavioral Health Authority (RBHA) was asked to assess his behavioral health needs.

This 14 year old male had been to the emergency room on various occasions for injuries sustained during one prior auto accident and numerous fights. His mother indicated that drugs or alcohol were involved on all occasions. The mother, a 30 year old single white female living in an urban area, was mildly mentally retarded and could not remember the exact times or locations of the previous hospitalizations. She worked part-time cleaning houses. There was a 11 year old sister. The mother was not married but both children had the same father. She reported that neither she nor the father had completed high school. Both families, apparently, had some history of depression and suicidal episodes. The father was presently incarcerated in the state prison for child molestation of his daughter and another neighborhood girl. Child Protective Services (CPS) was involved at the time of the disclosure of molestation and the daughter had been briefly placed in foster care. She was returned to her mother when the father was arrested and removed from the home.

The mother had communication difficulties but believed her son had become increasingly depressed over the past six months and she suspected that he was involved with a local gang. She stated that her son is also mildly mentally retarded and is in special education classes at the public school. Additionally, the boy had suffered from grand mal seizures since he was three years old. They have been partially controlled by medication which he takes irregularly. The family receives medical care through AHCCCS.

The boy has always done poorly in school but recently his attendance has been very irregular. The principal discussed this with the mother on several occasions. She stated that she cannot control her son and can't force him to go to school. He has been spending more and more time with friends and recently his mother found a gun in his room. The police have been called for various neighborhood incidents of fighting and, at one point, he threatened to kill his mother and his sister with a knife. Charges were not pressed.

The young man stated that he hates school because others make fun of him because he is slow and weird and the only place where he feels accepted is among his gang who are school dropouts. His sister indicated to the emergency room staff that she has been worried about her brother for some time. He once told her when he was drunk that he felt like dying.

### SYSTEMS ISSUES

In the previous case study there are various points at which interventions could have occurred to assist the youth and his family but did not or were not sufficient to ensure timely and appropriate services.

This youth was identified at age three as having neurological problems manifested through grand mal seizures and poor fine motor coordination. Although he received medication for this condition, no known referrals were provided at this time for neuropsychiatric or developmental disability (DD) assessment. His mild mental retardation was not discovered until he was in second grade when he was referred for behavior problems and testing.

Testing provided through the school resulted in a recommendation for placement in special education, however, he was not placed until he was in 5th grade. By this time, his achievement had further declined and his behavior problems had worsened. Because his medication was not effectively monitored, he continued to experience seizures at school.

The special education teacher noticed signs of depression which she discussed with the mother. The teacher suggested sources for assistance but the mother did not pursue them. The boy's acting out behavior increased over the years as his achievement declined. By the time he reached the junior high school level, his attendance was poor and school staff suspected gang involvement. Several incidents involving the police resulted in brief detentions but no follow up behavioral health services.

The most recent incident led to emergency room treatment and the 72 hour evaluation through the local Regional Behavioral Health Authority (RBHA). The evaluation revealed severe depression with conduct disorder. Although the boy admitted to suicidal thoughts, he was not deemed actively suicidal at discharge. A treatment plan was developed by the RBHA which included in-home therapy and medication monitoring. Although he was placed on antidepressants, he did not take them regularly, refused to attend the in-home therapy sessions, ran away on several occasions and had several additional skirmishes with police.

Since this treatment was not successful, a staffing was held by the RBHA to address future planning. Results of the staffing included recommendations for services through Developmental Disabilities in cooperation with the RBHA for a therapeutic group home placement. This recommendation was the result of escalating concerns about the boy's deteriorating mental and physical condition and increased risk for suicide.

The RBHA and the Department of Developmental Disabilities disagreed over the child's primary diagnosis which affected placement decisions and funding responsibilities. Additionally, in the most recent school individual education plan (IEP), the school district recommended residential treatment since they considered the child to be uncontrollable in his current setting. DDD considered the need for intensive residential service to be totally related to behavioral health issues rather than seizures or retardation.

The RBHA believed that a DD group home with wrap around behavioral health services was the most appropriate intervention clinically and most cost effective since costs would be shared.

The Behavioral Health Services Medical Director was contacted by the school district due to Hodges v. Bishop mandates and the child was placed in residential treatment.

The RBHA appealed this decision for clinical reasons. In addition, the full burden of funding was their responsibility until the child became eligible for Title XIX behavioral health services.

## POINTS OF INTERVENTION

In an ideal system, interventions would occur at the earliest point and comprehensive, preventive services would be provided. The following list illustrates points of possible entry and treatment or services that could have been accessed.

### CRITICAL POINT

The mother was a teenager when her child was born. She could have been identified as high risk during her pregnancy or at the birth of her child. Her developmental delay could have been discovered at this time.

A pediatrician discovered the boy's seizure disorder when he was three years old.

The boy entered school at age 5 or 6. Mental deficiencies and continuing medical problems might have been discovered.

In second grade problems were identified and recommendations were made for a special education placement. Placement did not occur until 3 years later.

The special education teacher noticed that the boy seemed depressed and suggested that the mother seek counseling. The mother did not follow through.

The boy was involved in various minor skirmishes with the police and briefly detained.

The boy was brought to the emergency room on several occasions for minor injuries sustained in fights.

### POSSIBLE INTERVENTION

Services for high-risk mothers such as Healthy Families could have been provided.

If the developmental delay was discovered, the mother may have been eligible for services through Developmental Disabilities.

Referrals for neurological and developmental assessments would have been appropriate. If results indicated the need, referrals to DDD or Behavioral Health Services could have been made.

Appropriate remedial strategies or referrals could have been initiated by the school nurse or other staff upon initial screening.

Special education services could have been implemented immediately.

When the mother did not follow the teacher's suggestions, the teacher could have discussed the case with the school psychologist. Teacher or psychologist could have met with the mother and suggested other available resources.

These incidents could have resulted in juvenile court intervention and court ordered treatment could have occurred at this time.

Emergency room staff should have made referrals to have the youth evaluated.

## **Policies and Procedures**

Every school district is required by law (A.R.S. 15-345) to have written chemical abuse (alcohol and other drug use) policy and procedures. It is highly recommended that such policy and procedures be broad and comprehensive to include identifying and assisting students or staff who are not only at risk for chemical abuse but might also be at risk for suicidal behavior.

## **Technical Assistance, Training for School Districts, and the Development and Dissemination of Prevention Curriculum**

Arizona is fortunate to have available a wide variety of resources for technical assistance and training regarding prevention. One of those resources is the Arizona Prevention Resource Center (APRC) which is Arizona's central source for prevention information and materials. In addition to providing materials for special target and high risk populations, the APRC can provide a network of trainers, educators, and consultants, entitled "PeopleLinks," to provide effective training and technical assistance to schools in developing, implementing, and evaluating their comprehensive school/community prevention efforts. The Arizona Prevention Resource Center is a cooperative effort of four state agencies: the Governor's Office of Drug Policy, the Arizona Department of Education, the Arizona Department of Health Services, and Arizona State University, College of Extended Education. It is recommended that school districts take advantage of these excellent services.

## **CONCLUSIONS AND RECOMMENDATIONS**

- Comprehensive programs that include primary, secondary and tertiary activities should be in place in all schools in Arizona.
- An integrated prevention curriculum should emphasize protective factors, resilience, positive health and well-being.
- Preservice training should be provided in all teacher education programs in the state.
- All classroom teachers should be provided with adequate inservice training in the development and use of integrated prevention curriculum.
- A multidisciplinary child study team (CST) or crisis response team (CRT) should be established in each school to implement assessment, intervention and referral procedures. This team should collaborate with local mental health agencies.
- Each school should establish guidelines for dealing with death or traumatic events in the school or community. An inservice training for all faculty and staff should include training in the policies and procedures for managing a crisis or traumatic event.
- The chemical abuse policy and procedures that are required by law (ARS 15-345) should be broad and comprehensive to include identifying and assisting students or staff who are not only at risk for chemical abuse but might be at risk for suicidal behavior.
- Support groups should be provided for students that have been identified as at-risk for self-defeating behaviors.

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**COMMUNITY BASED PROGRAMS SUBCOMMITTEE**

**REPORT and RECOMMENDATIONS**



## COMMUNITY BASED PROGRAMS SUBCOMMITTEE REPORT

Assisting suicidal youth or teenagers in need of behavioral health services is not an easy task. Traditional community-based counseling services are generally not utilized by the teenage population. This approach tends to be geared toward the adult population and does not effectively address the adolescent in crisis. In general, adolescents rarely seek help from a mental health professional. According to Offer et al. (1991), the majority of distressed adolescents would be willing to go to a school-based clinic, prefer to talk to friends and parents regarding emotional problems, and find the help from both friends and parents beneficial. While nondisturbed adolescents prefer to turn to their parents for help, disturbed adolescents usually turn to friends.

For those adolescents who did seek help from a behavioral health professional, Earls (1989) indicated that only one quarter of adolescents in treatment reported their suicidal thoughts or attempts to the clinic they attended. Of those adolescents who did report, it was done at either a school-based and/or neighborhood-based clinic. Thus, utilizing new modalities to reach teenagers in a nonthreatening manner becomes a key component in effectively addressing the behavioral health needs of this population. If teenagers will not come to a traditional behavioral health setting, moving these services to a nontraditional setting is vital. Locating such services in youth centers then becomes a viable option.

Location, however, is not the only barrier to accessing services. Adolescents seeking services face many other obstacles within the existing behavioral health system. Reducing the barriers or guiding teens through them is therefore necessary to ensure that youth receive help.

Also, training for those who are likely to come into contact with suicidal youth is vital. Rotheram-Borus (1989) suggested that those individuals who work with youth (teachers, recreation leaders, staff at runaway shelters, ministers, etc.) should be able to identify and intervene with suicidal youth. Consequently, gatekeeper training on basic behavioral health issues as well as suicide assessment is necessary.

Another key component in reaching this population can be provided in two ways: utilizing a hotline and peer counselor/helpers. Shaffer et al. (1988) suggested that hotlines and crisis services can be beneficial with the adolescent population if the service is an identifiable service by teens in the community, a 24-hour service, and advertised in the presence of the target group. Staffing a hotline with "teen volunteers" can be helpful in reaching adolescents. Utilizing teens in suicide prevention and intervention can be an important tool. Brent et. al (1988) reported that of those adolescents who completed suicide, 83 percent had made a statement of their intent within the week of the suicide. One-half had reported their intent to a friend or sibling only. Enlisting the help of friends and siblings can improve the mechanism by which at risk youth are identified and referred for treatment. Training natural and peer helpers can be an effective technique in identifying these young people. Caplan (1989) suggested using natural helpers as a supportive network. Training for these helpers in school and community settings is important.

Finally, after adolescents have sought help, it is important that they feel the services are relevant to teen issues. Nelson et. al. (1988) stated that adolescents desire more relevancy in services provided. Programs need to be geared toward the life experiences that youth find to be most meaningful.

This study recommended the availability of counseling and educational programs as well as a supportive environment in the community for youth in crisis. Youth stressed the importance of informal counseling and support. All groups surveyed reported the need to befriend and talk to young people, to provide support in a loving way, and family support as key elements in an intervention program. "Educational programs and intervention designs to prevent youth suicide should address attitudes about communication and identify barriers to open communication among adolescents themselves and their adult caregivers." (Nelson, 1988, p. 41)

## RECOMMENDATIONS

- One 24-hour statewide behavioral health hotline should be established for referral, information and advocacy and should include a peer counseling component.
- Comprehensive, coordinated "gatekeeper" training should be available, especially regarding adolescent depression, alcohol/drug assessment, suicide assessment and referrals.
- The availability of counseling, educational and meaningful recreational programs conducted in a supportive community environment for youth in crisis should be increased. A team approach coordinated at one site (one-stop shopping) is desirable.
- Parental education regarding the significant danger of suicidal ideation, gestures and attempts should be available. Parents should be provided with basic information on warning signs, risk factors as well as information on how to access behavioral health services. This report may serve to partially satisfy this need.

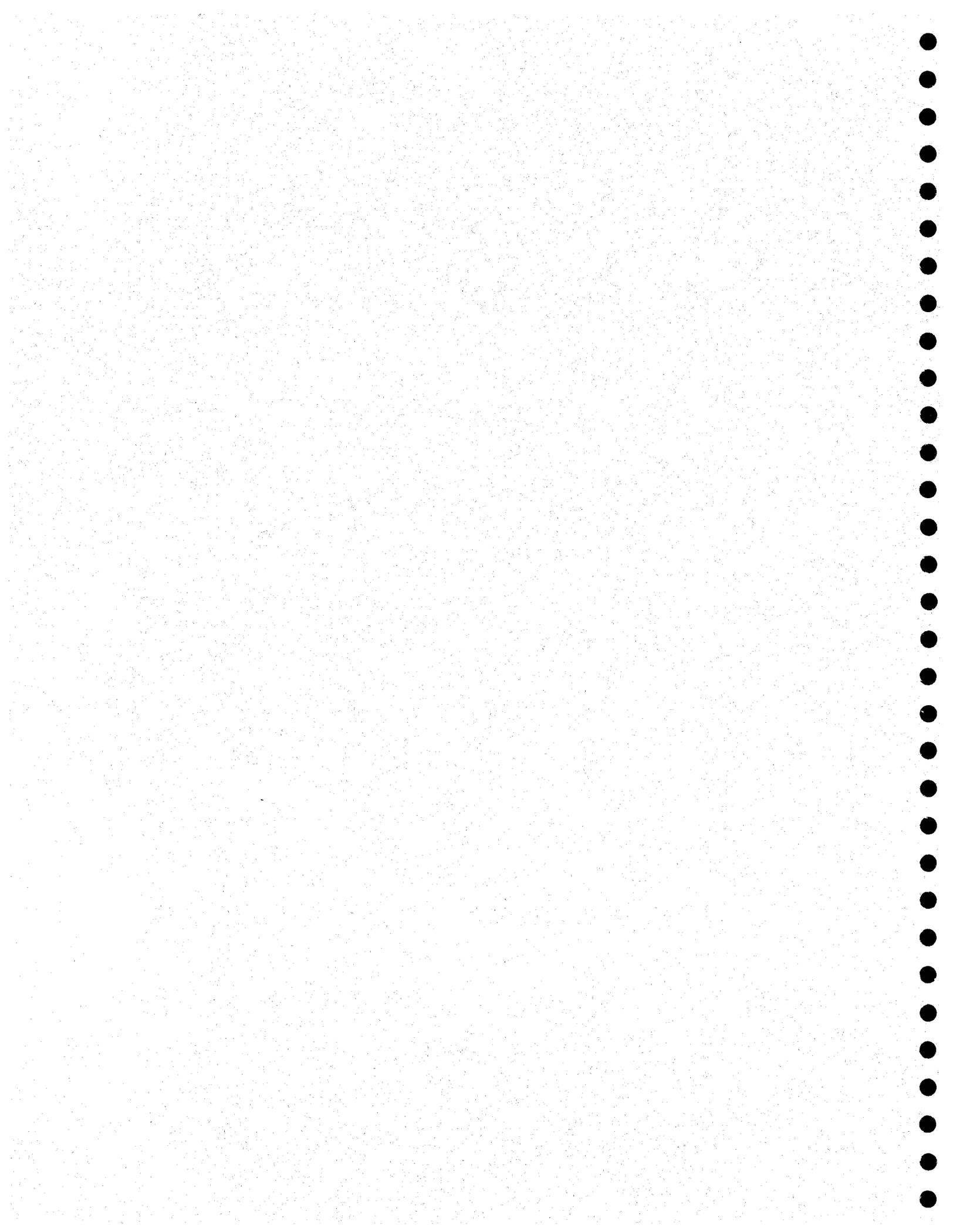
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**APPENDIX A**

**INTERVENTION PROCEDURES**

**Suicide Crisis Response**



## Sample

### INTERVENTION PROCEDURES Suicide Crisis Response

#### Flagstaff Unified School District

A Crisis Response Team (CRT) will be established in each school in order to implement referral, assessment, intervention or postvention procedures in situations related to suicidal risk or suicide

#### General Responsibilities of Crisis Response Team members:

1. Help faculty and staff understand symptoms and signals of potential suicidal behavior and understand referral procedures.
2. Compile and keep current a confidential list of "at-risk" students; review and revise list at periodic intervals.

#### Referral Response:

Only those members of the CRT who are trained as mental health professionals (Counselors, school psychologists) and who have received suicide assessment/intervention training may assess risk factors in order that appropriate procedures may be followed.

#### Referral Procedures:

1. A referral is made by a teacher, parent, staff member, friend, etc.
2. A member of the CRT qualified to make an assessment of risk factors will contact the student.
3. The meeting with the student should result in a determination of whether the case appears to be low risk, medium risk, or high risk. When there is a question on the part of the CRT member or the supervisor of counseling and psychological services will occur.

The following procedures should be followed depending upon the judgment made as to level of risk:

#### LOW RISK

- Low Risk is characterized by communication of a double message; for example, a student may say he/she has no suicidal thoughts, but his/her behavior contradicts this. At least some low level objective data that suicide is a consideration ( such as journal entries). The student may be mildly upset or mildly depressed; however, the depression is generally not chronic. The student is undergoing or has recently gone through some crisis. There is a basic support available to the student.
- With any low-risk threat, contact the parent(s)/legal guardian(s). The CRT member should call the parent(s)/legal guardian(s) and inform them of the concerns and what is going on with their child.
- There is probably no need for the parent(s)/legal guardian(s) to come to school to pick up the student(though parents(s)/legal guardian(s) may wish to do so).
- The CRT member will supply a list of outside referral sources. In addition to outside referrals, the student may participate in an assistance program on campus.
- The student's name is added to the list of at risk students maintained by the CRT.

## MEDIUM RISK

- Medium Risk is characterized by having a suicide plan which is not highly lethal; the means to complete suicide plan are not immediately available; chronic depression is a factor, but the student hasn't acted on it; implementing a suicide plan is not as imminent as with "high suicide risk"; the student has an escalating preoccupation with suicide; the student expresses ambivalence regarding suicide; the student may reach out for help.
- The principal of the school is notified of the potential risk.
- The parent(s)/legal guardian(s) is notified of the risk involved. The student is required to stay with CRT member or other designated school personnel until the parent arrived to have a conference and to transport the student home and/or to treatment.
- The CRT member will make a referral for outside professional assistance, supplying referral sources. In addition to outside assistance, a student may participate in a student assistance program on campus.
- Follow-up is required. An appointment time and date will be set for the CRT member or a designated person to see the student again. Additional follow-up may involve the school's contacting the student's therapist, psychologist or psychiatrist directly. Help may be enlisted from the student's teacher to monitor the situation.
- Feedback about the disposition of the case is provided to the referral source.
- The student's name is added to the list of at-risk students maintained by the CRT.

## HIGH RISK

- High Risk is characterized by the student having a suicide plan which is immediate and highly lethal; is in imminent danger of self-harm; previous suicide attempts; appearance of suffering from acute depression, a history of suicide/suicide attempts among family or friends and feelings of helplessness and hopelessness or stated intent to die.
- The principal of the school is notified of the potential risk for a student suicide.
- The parent(s)/legal guardian(s) is notified of the risk involved. The student is required to stay with the CRT member or other school personnel until the parent(s)/legal guardian(s) arrives to have a conference and to transport the student to a treatment source.
- The CRT member will supply a list of possible outside referral sources and assist the parent in obtaining immediate intervention. If the parent(s)/legal guardian(s) refuses to take the student for outside professional help despite the school's effort to facilitate this, a report should immediately be made to Child Protective Services. The student may also participate in a student assistance program on campus.
- When there is reason to believe the student is in immediate danger, the proper/or appropriate law enforcement agency should be notified of the situation so that the student may receive appropriate outside assessment and treatment. This may be done without the permission of parent(s)/legal guardian(s), if they cannot be reached, under the following regulations (Title 34-99.36):
  - A. An educational agency or institution may disclose personally identifiable information from the education records of a student to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individual.
  - B. The factors to be taken into account in determining whether personally identifiable information from the education records of a student may be disclosed under this section shall include the following:
    1. The seriousness of the threat to the health or safety of the student or other individuals,
    2. The need for the information to meet the emergency,
    3. Whether the parties to whom the information is disclosed are in a position to deal with the emergency and
    4. The extent to which time is of the essence in dealing with the emergency.
- School personnel should never transport a student to a hospital or other care facility. The police or parent(s)/legal guardian(s) are responsible for transporting.
- Follow-up is required. The CRT member or designated person will set an appointment date and time to see the student again when the student returns to school. Monitoring will occur to

determine if the student is receiving follow-up outside help. If this is not occurring, the parent will be contacted again to be urged to obtain these services. Faculty help in monitoring the situation will be solicited. Follow-up may involve the CRT member or designated person contacting the student's therapist, psychologist or psychiatrist directly.

- Feedback about the disposition of the case is provided to the referral source, strong support and praise for referring are recommended. Students who refer and/or intervene should be assured that they have done the right thing in order for the person to receive help.
- The student's name is added to the list of at-risk students maintained by the CRT.

### **Response to Off-Campus Attempts:**

A CRT member will:

1. Call the parent(s)/legal guardian(s) to verify the situation and determine probable absence time.
2. Contact the student's teachers and request assignments, if appropriate.
3. Monitor the student's friend, and/or follow-up on other students who may be perceived to be risks.
4. Work with the parent(s)/legal guardian(s) and/or other professionals involved with the student to share relevant information.
5. Upon the student's return, determine whether outside counseling is being provided and by whom. Periodic contact and support should be provided by a CRT member or designated person.

### **Response to Suicide:**

1. An administrator calls to verify and obtain appropriate details. The same administrator notified the district office.
2. The supervisor of counseling and psychological services will initiate a phone tree to notify district members and request assistance as appropriate
3. Contact all administrators, counselors, the student's teachers, school psychologist and nurse to inform them of the incident and request their presence at a faculty meeting.
4. Depending on time factors, a telephone tree is strongly suggested to notify faculty of the suicide and request their presence at a faculty meeting.
5. Hold a faculty meeting to discuss procedures for the day and relay the facts about the suicide. The following guidelines are suggested for teachers:
  - a. If there is likely to be a strong widespread response by many students, a designated periods early in the day as possible should be encouraged for classroom discussion rather than repeating discussions all day long.
  - b. Students should be allowed to talk about the suicide and their feelings. Students who may appear to be having significant problems should be escorted to a CRT member or counselor. Another student who appears to be emotionally in control may do the escorting.
  - c. Class sessions through the remainder of the day should follow a relatively normal routine, but with added flexibility. Attention spans are likely to be shorter, students may still initiate questions or discussion related to the suicide, and some students may show or demonstrate emotional upset to the degree that a referral to the guidance department is in order.
  - d. In addition to allowing students to process feelings, teachers, particularly in the period designated for discussion, may wish to share the following ideas with their students:
    - While it is extremely regrettable that a young person has chose suicide, students should think about the positive in their own lives and take care of themselves.
    - Referrals to the counseling department should be an option for students feeling particularly troubled.

- Help students understand that no single factor causes a suicide. There is always more than one problem, usually of an ongoing nature.
  - No one person can be responsible for the suicide death of another and that even highly trained professionals cannot always predict it.
  - If a friend threatens suicide, teachers should be sure that the friend is referred to a professional helper. Students should know it's okay to break a confidence if it means it might save a life.
6. If a staff meeting is not possible, disseminate information about the suicide to all teachers and inform them of what procedures to follow.
  7. Call the district supervisor of counseling and psychological services, inform of the incident, and, if needed, request the support of a district team to come to the building to work with school personnel and students.
  8. Contact the victim's parent(s)/legal guardian(s) to offer assistance and determine additional action.
  9. Continue with a normal school schedule, excusing students to attend the services.
  10. Designate one school staff member to be the media spokesperson. Ask all other staff to refer any media contacts to the designated spokesperson. Statements to the media should be limited so as not to "dramatize" the occurrence, which could increase chances of "imitations". Statements expressing regret and that the school has a plan to offer intervention and support are probably sufficient. No personal statements about the victim or his/her family should be given.
  11. Students who are possibly at risk for imitating the event should be contacted to assess how they are doing.
  12. Provide an opportunity through individual contacts or small groups for the victim's circle of friends to discuss their feelings.
  13. Adult support groups should be made available by the counseling department as appropriate as soon as possible after the occurrence. Meetings such as these help to dispel feelings of helplessness and frustration.
  14. Teachers should be made aware of symptoms/signals and should be encouraged to refer students who may be in need of help.

### **In Case of an Attempted or Completed On-Campus Suicide:**

1. Notify an administrator immediately.
2. Notify district office and all CRT members immediately.
3. If an attempt, the nurse and an administrator will determine if the situation requires immediate medical attention. If so:
  - a. The administrator will immediately notify the police and call for an ambulance.
  - b. The parent(s)/guardian(s) should be notified immediately.
  - c. Have all CRT members available to deal with other students involved. Try to keep students and faculty members away from the immediate crisis area. Isolate any witnesses and/or friends with help from team members.
  - d. Notify the district office and supervisor of counseling and psychological services for immediate assistance.
  - e. Refer all requests from the media to the district office. Make no comment. Do not release information until after the crisis is over.

Arizona Department of Education, Comprehensive Health Unit (1991). *Model Policy and Procedures for School District Alcohol and Other Drug Prevention Programs*, pp. 23-28.