OCT - 6 1986

/s/ Bryan B. Mitchell
Richard P. Kusserow
Inspector General

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

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

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

Our major findings are:

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

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

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

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

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

Attachment

cc: Dodie Livingston
Administration for Children, Youth and Families
ASSESSMENT AND DOCUMENTATION
OF YOUTH AT RISK OF SUICIDE

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Aaron Beck Depression Inventory (mentioned most frequently)
- Taylor Johnson Temperament Scale
- Zung Test
- Screen developed by Dan Leterri, currently at the National Institute on Alcohol Abuse and Alcoholism
- Screen developed by Tom Barrett, psychologist involved with the Suicide Prevention Allied Regional Effort (SPARE) and Cherry Creek School District in Colorado
- Screen developed by Elinor Bar, Suicide Prevention Center, Pueblo, Colorado
- Screen used by the Los Angeles Suicide Prevention Center
- Screen developed by Mary Jane Rotheram, Columbia University

OHDS has funded grantees to work with runaway and homeless youth programs to identify and prevent youth from committing suicide. Different approaches are being tried, including the development of screening tools. Several runaway programs in New York City are currently screening all clients for risk of suicide, using the screen developed by Dr. Rotheram, listed above. This tool, designed for paraprofessionals and service agency staff with little or no mental health background, identifies risk, assesses the immediacy of the problem...
and helps workers begin to structure an intervention strategy. Staff using the screen participate in a short formal training program with a follow-up session after they have screened a few clients. Participating runaway programs are universally supportive of this initiative.
II. INTEREST IN HHS DEVELOPMENT OF A SCREENING TOOL

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

<table>
<thead>
<tr>
<th>Respondents</th>
<th>N</th>
<th>Yes</th>
<th>Maybe</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Agencies</td>
<td>85</td>
<td>62%</td>
<td>31%</td>
<td>7%</td>
</tr>
<tr>
<td>Health Providers</td>
<td>56</td>
<td>54%</td>
<td>34%</td>
<td>13%</td>
</tr>
<tr>
<td>Hotlines/Crisis Programs</td>
<td>20</td>
<td>25%</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td>Mental Health Providers</td>
<td>94</td>
<td>23%</td>
<td>57%</td>
<td>19%</td>
</tr>
<tr>
<td>Schools</td>
<td>13</td>
<td>15%</td>
<td>46%</td>
<td>38%</td>
</tr>
<tr>
<td>All Respondents</td>
<td>268</td>
<td>42%</td>
<td>42%</td>
<td>16%</td>
</tr>
</tbody>
</table>

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

* We always welcome something new, but I don't think it would help too much. If you've been in this field awhile, you sense when there's a problem.*
"I might use it, knowing it is not going to give me the whole answer. I wouldn't use it in lieu of my clinical knowledge, but as a supplement."

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

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

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

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

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

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

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

"I can't imagine you could come up with something we don't already know. It's the subtleties that drive us crazy. Suicide is a very difficult outcome to predict."
Other respondents questioned the value of using screens to predict youth at risk of suicide, noting in particular that screens which have worked well with adults have had less utility when applied to teens. Respondents stressed that the effectiveness of screens is dependent upon accurate self-reporting, frequently a problem among adolescents. Some mental health practitioners noted that their initial impressions often change after they have had a few sessions with a client and that a screen only measures a client's behavior and attitude at a given time. "These are volatile kids and circumstances can change quickly," noted one researcher. There were some suggestions that HHS should put resources into identifying and evaluating existing tools, as opposed to "reinventing the wheel."

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

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

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

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

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

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

Training. "If you're going to use a tool, you can't just give it to people and expect it to work," noted one researcher. Several respondents stressed that it is essential to train anyone screening for problems as sensitive as suicide risk in (1) how to use the screen, (2) appropriate demeanor, attitudes and approaches to asking questions in nonthreatening ways and (3) what to do if risk of suicide is detected. It is important that screeners address their own feelings about suicide, since this is an issue that
makes many people nervous and uncomfortable. Furthermore, screens do not work well if users believe there are no constructive treatment options available. Noted one clinician, "If someone doesn't know what to do or where to go, he won't identify a kid at risk. There is a tendency to deny the problem if nothing can be done about it." It was reported that the benefits of using a tool often extend beyond a diagnostic value by stimulating staff interest in and demand for more training on issues related to suicide. Training should be ongoing because users become complacent when they use the same tool repeatedly. It was suggested that revising the format occasionally helps resolve this dilemma.

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

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

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

**Cultural Sensitivity.** There was considerable concern that a tool be sensitive to various ethnic and socioeconomic groups. Many respondents said they would review any tool the Department developed to determine whether it could be adapted to their particular client groups.
III. MAINTAINING RECORDS AND STATISTICS ON YOUTH SUICIDE AND SHARING INFORMATION

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

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

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