Youth Suicide Prevention Programs: a Resource Guide

The Centers for Disease Control (CDC) published "Youth Suicide Prevention Programs: A Resource Guide" in September 1992. The guide was designed to assist those who are interested in developing or in augmenting youth suicide prevention programs. The following article is an adaptation of the executive summary of the guide.

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A free copy of the guide may be obtained by sending a name and address to "Youth Suicide Prevention Programs: A Resource Guide," CDC, National Center for Injury Prevention and Control, MS K60, 4770 Buford Hwy. NE, Atlanta, GA 30341-3724.

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Given the continued high rates of suicide among adolescents and young adults (15-24 years of age), it is more urgent than ever that we apply our limited resources for prevention in the most effective manner possible. To that end, we developed this resource guide to describe the rationale and evidence for the effectiveness of various youth suicide prevention strategies and to identify model programs that incorporate these different strategies.

The guide is for use by persons who are interested in developing or augmenting suicide prevention programs in their own communities. Because the diagnosis and treatment of mental disorders is so widely accepted as a cornerstone of suicide prevention, we excluded from this guide programs that provide mental health services in traditional health service delivery settings. We did include, however, programs that were designed to increase referral to existing mental health services.

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

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

- **School gatekeeper training.** This type of program is directed at school staff (such as teachers, counselors, and coaches) to help them identify students at risk of suicide and refer such students for help. These programs also teach staff how to respond in cases of a tragic death or other crisis in the school.
- **Community gatekeeper training.** This type of gatekeeper program provides training to community members, such as clergy, police, merchants, and recreation staff. This training is designed to help these people identify youths at risk of suicide and refer them for help.
- **General suicide education.** These school-based programs provide students with facts about suicide, alert them to suicide warning signs, and provide them with information about how to seek help for themselves or for others. These programs often incorporate a variety of self-esteem or social competency development activities.
- **Screening programs.** Screening involves administration of an instrument to identify high-risk youth

in order to provide more thorough assessment and treatment for a smaller, targeted population.

- **Peer support programs.** These programs, which can be conducted in either school or nonschool settings, are designed to foster peer relationships, competency development, and social skills as a method to prevent suicide among high-risk youth.
- **Crisis centers and hotlines.** These programs primarily provide emergency counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Some programs offer a "drop-in" crisis center and referral to traditional mental health services.
- **Means restriction.** This prevention strategy consists of activities designed to restrict access to firearms, drugs, and other common means of committing suicide.
- **Intervention after a suicide.** Strategies have been developed to cope with the crisis sometimes caused by one or more youth suicides in a community. They are designed in part to help prevent or contain suicide clusters and to help youth effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is but one of several goals of interventions made with friends and relatives of a suicide victim—so-called "postvention" efforts.

Findings

Overall, we noted that

Despite many differences, the various prevention strategies incorporated into current youth suicide prevention programs have two common themes. As noted, we delineated eight different strategies for youth suicide prevention that were generally incorporated in some combination into the programs we reviewed. Despite their obvious differences, these eight strategies may be considered to constitute just two conceptual categories: (*a*) strategies to enhance the recognition of suicidal youth and their referral to existing mental health resources, and (*b*) strategies designed to directly address known or suspected risk factors for youth suicide.

Strategies to enhance recognition and referral. This category includes active strategies to identify and refer suicidal youth (general screening programs, targeted screening in the context of an apparent suicide cluster) as well as passive strategies to increase referrals (such as training for school and community gatekeepers, general education about youth suicide, and establishing crisis centers and hotlines). Some of the passive strategies are designed to lower barriers to self-referral for those with suicidal feelings; others are designed to increase referrals by persons who recognize suicidal tendencies in someone they know.

Strategies to address known or suspected risk factors. This category includes interventions designed to promote self-esteem and build competency in stress management (general suicide education and peer support programs), to develop support networks for youths who have attempted suicide or who are otherwise thought to be at high risk (peer support programs), and to provide crisis counseling or otherwise address the proximal stress events that increase the risk of suicide among susceptible youths (crisis centers and hotlines and interventions to minimize contagion in the context of suicide clusters). Although means restriction may be critically important in reducing the risk of youth suicide, none of the programs we reviewed placed a major emphasis on this prevention strategy.

Most programs focus on teenagers, with little emphasis given to suicide prevention among young adults. With a few important exceptions, most programs designed to reduce youth suicide were developed with high school-aged youth in mind. This may be due to the fact that adolescents in high school are easier to reach than young adults 20–24 years of age. But it may also be due to a failure to appreciate that the suicide rate is generally twice as high among persons 20–24 years of age as among adolescents 15–19 years of age. More prevention efforts need to be targeted toward young adults at high risk of suicide.

Current programs are sometimes inadequately linked with existing community mental health resources. Some programs, notably the Pennsylvania Student Assistance Program, have deliberately worked to develop very close ties with community mental health resources. In a substantial number of other programs, however, linkages with existing mental health resources have been somewhat tenuous. We believe that strengthening these ties would substantially enhance suicide prevention efforts.

Some strategies are applied very infrequently—despite great apparent potential for success—whereas others are very commonly applied. In particular, despite evidence that restricting access to lethal means of suicide (that is, firearms and lethal dosages of drugs) may prevent some youths from

completing suicide, none of the youth suicide prevention programs we reviewed incorporated this strategy as a major focus of their efforts. Parents should be educated in suicide warning signs and encouraged to restrict their teens' access to lethal suicide means. Other promising strategies, such as peer support programs for previous suicide attempters or high-risk youth, might also be more widely incorporated into current suicide prevention programs, but great care should be taken to ensure that there are no adverse consequences from involving peers in such activities.

Certain potentially effective programs targeted at high-risk youth are not thought of as "youth suicide prevention" programs. Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs. Few of the programs we reviewed had any formal ties with such programs.

There is very little evaluation research in this area—indeed, there is very little data collected that would facilitate such research. The tremendous dearth of evaluation research stands as the single greatest obstacle to improving current efforts to prevent youth suicide. In the final analysis, despite many years of experience and hard work, all we can say, and scientifically defend, is that every one of the eight strategies described in the guide, as currently implemented, may or may not prevent youth suicide.

Clearly, this is an unsatisfactory state of affairs. We urgently need to evaluate existing suicide prevention programs wherever possible and to incorporate the potential for evaluation into all new prevention programs. Moreover, whenever possible, the outcome measure for such evaluations should be changes in suicidal behavior. After all, it is the level of suicidal behavior, not attitudes toward suicide or knowledge of warning signs, that we are ultimately working to change. When measuring a program's effect on the level of suicidal behavior is not feasible, the outcomes measured should be those that are closely associated with actual suicidal behavior.

In this regard, it is worth noting that any health intervention may have unforeseen negative consequences; suicide prevention efforts are no exception. This is another, even more important reason why evaluation must be built into every youth suicide prevention program. Regardless of the prevention strategy employed, we must be vigilant to ensure that efforts to prevent suicide do not result in untoward consequences.

Recommendations

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

Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources in the community. As noted, many of the strategies are designed to increase referrals of at-risk youth. This approach can be successful only to the extent that there are appropriate, trained counselors to whom referrals can be made.

Avoid reliance on one prevention strategy. Most of the programs we reviewed already incorporate several, if not all, of the eight strategies we described. However certain strategies tend to predominate, despite limited evidence of their effectiveness.

Incorporate promising but underused strategies into current programs where possible. The restriction of lethal means by which to commit suicide may be the most important candidate strategy here. Peer support groups for those who have felt suicidal or have attempted suicide also appear promising.

Expand suicide prevention efforts for young adults, those 20–24 years of age. The suicide rate for this age group is twice as high as for adolescents.

Incorporate evaluation efforts into all new and existing suicide prevention programs. Evaluation should preferably be based on outcome measures, such as the incidence of suicidal behavior, or measures closely associated with such incidence. Be aware that suicide prevention efforts, like all health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to identify such consequences, should they occur.

Like many prevention programs, the suicide prevention programs described in this resource guide are programs that are evolving. They are subject to changes in staffing, funding, and program emphasis. Hence, readers need to communicate directly with the individual programs to obtain current information on program activities.