Evaluation of

IMMINENT DANGER

for Suicide

A TRAINING MANUAL

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I. ADOLESCENT SUICIDE: BASIC FACTS

Monique, 15 years old, is referred to a runaway shelter by a social worker at Planned Parenthood. Monique has been sleeping in Central Park for the last four nights after having left home following a fight with her stepfather. She knocks meekly on the door of the runaway shelter, her shoulders droop and her face remains blank. Without stating any greeting, she hands the counselor a referral card. She gives short, one word answers to the intake worker regarding her background, her current feelings, and indicates no future plans. She discloses to the caseworker that she has tried to kill herself twice in the last four days — once with twenty diet pills which she had in her purse, and once by jumping in front of an oncoming car. She refuses to disclose information regarding her family.

What do you do as the intake worker? Is Monique seriously suicidal? Should she see a psychiatrist? Is she trying to hide her past and avoid the obvious ways to get help? Do you admit her to the shelter? How can you tell if she is suicidal? These are the kinds of problems confronted by staff in community agencies on a daily basis. This manual is aimed at providing guidelines to administrators and staff members in community agencies regarding decisions about suicidal risk.

Teenage suicide has increased threefold over the last ten years and has become an issue of major concern to parents and community leaders. Therapists, teachers, and child care staff have struggled with the needs of teenagers who are thinking about suicide or who make attempts to hurt themselves. However, due to the lack of empirical knowledge regarding suicide, it is difficult to address the issue in a meaningful way. Research into the causes of youth suicide, efforts to identify adolescents at risk for suicide, and the development of interventions for these teenagers are all relatively recent. Much of what is known about teenage suicide comes from research and clinical work with adults. While this is important and helpful, those working with teenagers know that youth are emotionally and developmentally different from adults. Teenagers are confronted with problems and life challenges that are specific to adolescence. Before outlining the essential components of a suicide prevention approach and intervention techniques, it is important to discuss what we do know about teenage suicide and about runaway and homeless youth.

To effectively and skillfully intervene with runaways at risk for suicide, it is essential for child care staff and caseworkers to become well informed about this issue.

While relatively few teenagers kill themselves, suicide attempts are far more common among adolescents.

A. Demographics

1. Adolescent suicide is a relatively rare event. Although adolescents account for approximately 10% of the population, they commit only 6.1% of the suicides (National Center for Health Statistics, 1979). However, over the last ten years, there has been a disturbing increase in adolescent suicide, particularly among older, adolescent males for whom the rate has increased three-fold (Shaffer, Bacon, Fisher, & Garland, 1987).

2. While relatively few teenagers kill themselves, suicide attempts are far more common among adolescents. It is difficult to estimate the actual number of suicide attempts because follow-up studies are few, and there is no systematic reporting of suicide attempts. In fact, doctors often try to help families by not reporting drug overdoses and wrist slashings as suicide attempts. However, this leads epidemiologists to underestimate the actual number of suicide attempts. Conservative estimates are that the attempt rate is 40 times the number of completed suicides for boys and 100 times the completed suicide rate for adolescent girls (Shaffer, Bacon, Fisher, & Garland, 1987).

Teenagers, whose lives are disrupted by running away or by being thrown away, face many hurdles in the effort to become stable, hopeful adults.

3. Females are more likely to attempt suicide than males, but male rates of completed suicide are much higher at every age. There are two possible reasons for this phenomenon. First, although girls are more likely to be depressed, they are less severely depressed than boys, and do not as often have histories of school problems and behavior difficulties (such as fighting or delinquency) which researchers have found to be linked with completed suicide. Second, when attempting suicide, females tend to use less lethal methods (e.g., drug overdoses instead of shooting themselves with guns or hanging).

4. White teenagers of either sex have been found more likely to commit suicide than Black and Hispanic teenagers. Native Americans commit suicide most often. These findings may relate to different means of coping with problems and stress or may reflect the way that suicide is reported and understood.

5. Youth who have made suicide attempts are at high risk for repeated attempts. Fisher and Shaffer found that almost half of completed child and adolescent suicides had previously threatened, discussed, or attempted suicide (1984). In addition, other studies show that half of the teenagers hospitalized after a suicide attempt will repeat the attempt.

6. Adolescents who attempt suicide have been found to be experiencing major problems in their personal lives and within their families. These include:

a. Family conflict: There is often conflict between the parents, as well as between the child and his/her parents. Teenage attempters are likely to view their parents as hostile, indifferent, having extremely high expectations, and as highly controlling. The parents of suicide attempters have often been found to have psychiatric problems.

b. Poor school achievement: Adolescents who attempt suicide tend to have more social and academic problems than peers.

c. Poor peer relationships: Many teenage attempters have been found to have inadequate peer relationships and experience extreme social isolation.

d. Drugs and alcohol abuse: Not only do suicide attempters abuse drugs and alcohol, their parents are also often abusers.

e. Physical illness or medical concerns: Attempters report higher rates of medical illness than other youth. Also, pregnancy or the fear of pregnancy is often the impetus for girls' suicide attempts.

7. Suicide attempts have been related to the following psychological states: feelings of depression and anger; antisocial behavior such as fighting and committing crimes; and preoccupation with death.

8. Adolescents who attempt suicide often have poor communication skills.

B. Description of Runaways

Professionals and nonprofessionals working with runaway and homeless youth are aware of the multiple problems confronted by these youth. There are differences among runaways found in rural, suburban, and urban areas and differences in the environmental resources available to youth in various states and cities. However, all who work with these teenagers feel that the act of running away is an indication of serious unmet needs and unresolved conflicts. Teenagers, whose lives are disrupted by running away or by being thrown away, face many hurdles in the effort to become stable, hopeful adults.

In many areas of the country, repeat runaways and youth who are homeless are more common than those runaway youth who can easily return to family environments. Obviously, there is reason to consider this group of teenagers at high risk for suicide attempts: they come from situations which they may view as hopeless, and face lives on the streets or in institutional settings that appear overwhelming. Both the clinical experience of those who work with runaways, and current research shows that runaways are a population at high risk for attempting suicide. A good summary of the characteristics of runaway and homeless youth is provided by Shaffer and Caton (1984) who conducted an

epidemiological survey of all youth admitted to shelters in New York City for a two week period in 1983:

1. Past suicidal behavior: *Thirty-three percent* of runaway girls and 16% of boys had made suicide attempts and an additional *28%* had actively thought about suicidal behavior. Evidence from our own suicide prevention project with runaway shelters in New York City, conducted between 1985–1987, has found that 23% of the runaways were currently feeling suicidal and 30% had made previous attempts (Rotheram-Borus, & Bradley, 1987).

2. Family conflict: Although conflicts between parents, or between parents and children, are often related to suicide attempts, these conflicts have also precipitated youths leaving home (81%). The high rates of physical (24%) and sexual abuse (37%) among runaways further supports concern about serious family problems that may relate to runaway and/or suicidal behavior. In addition, high percentages of criminality and alcohol/drug abuse were found among the parents of runaways: 36% of the fathers and 13% of the mothers had spent time in jail; and 46% of the parents suffered from alcoholism. Forty-seven percent of runaways come from large families and have more than four siblings.

3. School problems: As with suicide attempters, runaways have been shown to experience many academic and social difficulties in school. Fifty-five percent of the runaways served in NYC shelters had repeated a grade in school and 43% scored below average on the WRA reading test. Fifty percent had been expelled or suspended from school due to fighting (more than 50% of the boys and 25% of the girls) or drug use (again, more than 50% of the boys and 25% of the girls). Moreover, 28% of the boys and 12% of the girls admitted to stealing.

4. Social isolation: Researchers and service workers have found many runaways to be socially isolated and lacking in supportive peer relationships (42%).

5. Drug and alcohol abuse: There is a high rate of drug and alcohol abuse in the runaway population, a characteristic which is also found frequently among suicide attempters: 8% were found to be dealing drugs; 71% used marijuana; 28% used cocaine; and 7% of the boys and 3% of the girls used heroine.

6. Sexual behavior: Over 85% of runaways are sexually active: 10% of the boys and 13% of the girls have children of their own; 21% of the girls had undergone abortions; 25% of the girls had been raped; and 34% of the girls were pregnant. While teenage pregnancy has long been acknowledged as a risk factor for suicide, now a youth's sexual behavior creates the additional risk of premature death by AIDS and sexually transmitted diseases. The risk for suicidal behavior increases by over 800% for persons identified with HIV positive antibody status (e.g., those likely to develop AIDS).

7. Coping with instability: Instability is reflected in the high percentages of repeat runaways and/or runaways who have previously been placed in foster care: fifty percent have run away more than once; 10% have run away more than five times; and more than 50% of the runaways had previously lived in foster homes.

In addition to this clinical and research evidence, it is clear that many of the indicators of risk for running away are the same as those for suicide. This reciprocal relationship can be understood when we view both suicidal and runaway behaviors as faulty coping strategies aimed at dealing with stressful situations, which have both internal and environmental causes. As runaways struggle for solutions to their problems at home, with peers, or in school, more than 14% of boys and 44% of girls become depressed, 27% of boys and 18% of girls engage in antisocial behavior, and 45% of boys and 37% of girls are both antisocial and depressed. Suicide becomes seen as a way out.

Thirty percent of runaways have attempted to commit suicide.

II. A SUICIDE PREVENTION MODEL

A. Theoretical Base

To meet intervention requirements in individual, institutional, and community-based organizations, we have relied on several areas of theory in developing our procedures. Organizational theory and systems theory underlie interorganizational protocols and networking. Significant research findings in child psychiatry provide grounding for choosing specific statistically-based risk factors to predict suicidal behavior. The basis for the evaluation procedure used to determine imminent danger for suicide, however, is formed out of social learning theory which emphasizes individual characteristics and coping skills. Because social learning theory is believed to be particularly effective in the treatment of suicide attempters, as well as in suicide evaluation, the following section will review its major concepts.

Intervention activities attempt to teach youth effective means to implement skills in stressful situations.

Social learning theory (Bandura, 1969, 1978) assumes that there are characteristics of the individual, those with whom the person is interacting, the environmental context, and the match among these factors which determine any act. It assumes that persons generally try to maximize the rewards they receive for themselves and from others. All acts are understandable as responsive to the rewards from oneself and other people and/or characteristics of the environment. In contrast to early research, social learning theorists emphasize that our thinking skills allow us to learn more efficiently as we imitate others and observe others' successes and failures. It also provides an explanation for how someone may receive considerable punishment for an undesirable behavior and yet continue to act the same. For example, if an aggressive boy has learned to value himself as macho for his aggressive acts, this behavior may not be modifiable by the teachers' or the parents' rewards for non-aggressive behavior.

In recent years, social learning theorists have placed strong emphasis on one's desire to feel efficacious. By efficacious, we mean to feel competent in one's actions, thoughts, and feelings. Personal efficacy allows persons to shape their environment and to effect others. Most of one's actions are oriented towards maintaining personal efficacy (pleasing oneself and others).

1. Personal skills and attributes: People feel efficacious when they possess skills which allow them to effectively satisfy their needs. These skills are shaped by one's background and history (e.g., those factors which are statistical indicators of suicide risk). For adolescents these factors include a history of school, family, and behavior problems; depressed and angry feelings; suicidal behavior by other family members; and past suicidal behavior.

Social learning theorists have identified a series of coping skills — some affective, some behavioral, and others cognitive. The affective skills include the ability to identify, label, and to assess the intensity of one's feelings, as well as the ability to control one's emotional reactions. Behavioral skills focus on verbal and nonverbal behaviors. Among verbal behaviors are the assertive skills necessary to make clear requests and refusals, and to be able to respond to criticism. Nonverbal behaviors include the ability to express oneself through eye contact, facial expressiveness, voice tone, voice latency, gestures, personal space, and mannerisms. Cognitive skills include the ability to self-reward; to see positive events as internally activated, stable across time, and applicable to many areas of one's life; to see negative events as caused by external circumstances, specific to one area of one's life, and changing across time; interpersonal problem solving ability (to clarify goals, generate alternatives, evaluate the means, ends, and consequences of a behavior, and to re-evaluate after implementation of an alternative); and talking to oneself in a

manner to minimize problems rather than emphasize difficulties. If a youth is able to exhibit these skills, the counselor can confidently determine that there is not immediate risk of suicide.

Intervention activities attempt to teach youth effective means to implement skills in stressful situations, minimizing the probability that youth will be overwhelmed and become suicidal. Youth may become suicidal because they have been rewarded or encouraged for it in the past.

2. Environmental context: The environment dramatically affects the probability of suicidal behavior. If parents and youth are getting along well, there are no financial problems, and the youth has good friends, the probability of suicide is low. However, suicide risk is likely to be much higher in a context where the youth is homeless, has no friends, is alienated from family, and has no money. The individual's particular situation affects the probability of risk of suicide.

The interaction between the person and the situation also effects risk assessment. If a youth is different from others in his or her environment, the probability of suicide risk increases.

External conflict or internal, negative attributions can emerge if one is different from others in one's environment. For example, a youth experiencing learning problems, whose family and community are highly academically competitive, may be at increased risk. Similarly, a homosexual teenager living in a conservative and religiously dogmatic community may also experience negatives in his social environment, increasing his risk for suicide.

When the characteristics of youth match those of his/her environment the probability of risk is reduced. A mismatch between the youth and the environment increases the chances of risk for suicide.

3. Systems: The procedures outlined in this manual are based on the theoretical perspective outlined above. The procedures we selected to assess current suicidality are based on tasks which are incompatible with suicide and are predicated on the skills we believe youth need in order to cope effectively. However, social learning theory emphasizes the importance of others in the environment (e.g., counselors and peers in the community agency) and the environmental context (agency protocols, and a network of services available as resources). Therefore, four components are addressed in this manual: staff feelings and skills, youth's background and skills, agency protocols, and network of services.

B. Assumptions Underlying the Evaluation Procedure

The strategy used in the suicide prevention procedure is pragmatic. The assessments are brief and are oriented toward problem solving. They have been developed particularly for use in runaway programs working with adolescents in crisis. The suicide screening procedure has been used by shelter staff of various skill levels and is geared to both professionals with vast clinical experience and to those paraprofessionals who are just beginning to work with youth. It is intended to provide critical information about potentially suicidal teenagers, information which will assist staff in making immediate clinical decisions and in developing long-range treatment plans.

Several key concepts guided the development of the procedure. The first relates to the idea of adolescent suicide risk. It has proven extremely difficult to develop an effective evaluation for suicide risk partly because definitions of risk have been too broad and also because actual attempts, while on the increase, are still relatively rare among the general adolescent population. The use of statistically- based risk factors (e.g., depression or substance abuse) to predict suicidal behavior is of limited value. Any strategy based on known risk factors will overpredict the number of teenagers who are likely to make suicide attempts. Most of the studies that have been conducted to date are with adults; therefore many of the risk factors that have been identified (e.g., retirement status) are inappropriate for

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prediction with teenagers. Likewise, psychological profiles and psychometric assessments have problems of overprediction and are not easily administered in community settings. Finally, these assessments do not consider environmental variables or the interaction of the person and the situation. For example, a runaway might be highly likely to become suicidal if her boyfriend breaks up with her, but will not be suicidal in other situations.

1. Constraints: Due to these limitations we adopted a model for prediction of imminent danger of suicide instead of using statistical risk factors alone. Our procedures focus on an assessment which determines which adolescents are in an *immediate, suicide-related crisis*. Imminent danger has three criteria:

a. It is a time limited concept, no one can predict suicide beyond a three day period.

b. The situations which are likely to elicit suicide are specified.

c. The emotional state of the person is assessed.

2. Therapeutic considerations: The Imminent Danger Assessment (IDA) is a clinical evaluation that relies on the interaction between staff and the youth in order to determine if there is an emergency situation or if non-emergency intervention can be provided for a specific runaway adolescent. IDA is a performance-based screening procedure which has the following value assumptions and therapeutic biases:

a. Evaluations are interventions that should provide therapeutic *benefits* as well as serve as an assessment.

b. Youth respond to *clear, concrete,* and *specific requests* and *plans*.

c. All evaluations/interventions must be *supportive* in nature.

d. The evaluator is a *model* for youths.

e. Exercising *personal power* is important for all participants (youth and staff) in an intervention.

Suicidal behavior results from an individual's lack of coping skills, as well as from stress created by difficult or overwhelming situations.

Suicidal behavior is viewed as having both psychological roots and environmental precipitants. Suicidal behavior results from an individual's lack of coping skills, as well as from stress created by difficult or overwhelming situations. The therapeutic approach reflected in this manual emerges from a *cognitive-behavioral model* of treatment that emphasizes teaching skills, and new ways of perceiving life situations. This approach recognizes the need to help runaway teenagers and, when possible, their families to stabilize chaotic circumstances. Finally, it views assessments and short-term counseling as viable modalities for having a major impact on adolescents.

C. Networking

No community-based project can be effective without the availability of a range of services for the adolescents who participate. Staff must feel supported by available alternative treatment strategies, or they may ignore certain issues due to lack of identifiable solutions. Having identified the needs of individual youth, it is essential to have resources in place that can address these needs, resources to which staff have quick and regular access. Of course, the specific nature of networks will vary depending on geographic location, available agencies, and transportation, as well as the staffing and resources of the runaway program itself. Nevertheless, there are several essential resources that all programs should consider in the development of a workable network for the care of runaways at high risk for suicide:

1. Teenagers who feel suicidal or appear to be at risk for suicide will vary in the seriousness of their current episode. Workers must evaluate each suicidal teen independently, while remembering patterns typifying high-risk adolescents. Intervention plans must be individually tailored to unique needs. It is almost as important to avoid the trauma of unnecessary hospitalization as it is essential in specific situations to use the option of hospitalization. With youth who are in crisis, it is easy for staff to overreact

to expressions of depression and suicidal thoughts. Preventing such overreactions and tailoring appropriate individualized, clinical responses are major challenges for administrators in community agencies.

2. Although runaway youth vary in their needs, staff, when in doubt, should always act conservatively in suicide situations. Since death through suicide is an unacceptable outcome, it is better to make sure that staff make conservative estimates of risk for youth who are in crisis. Therefore, if there is any concern about the safety of a particular youth, one should obtain second opinions or psychiatric consultation.

3. A prevention program should include both identification of runaways who are at risk for suicide and subsequent strategies for decreasing this risk. Thus, it is important to screen all youth who come for shelter to identify those who have made previous attempts or who have suicidal thoughts. At times, those who fall in high risk categories may not initially volunteer information about their feelings or experience. After identifying youth who are at risk, individually-tailored interventions can be made depending on the specific needs of the adolescent.

4. The following types of resources are recommended as part of any suicide prevention network:

a. Psychiatric hospital: For youth who are an imminent danger to themselves, the structure and services of a hospital are essential as well as legally and therapeutically necessary. Although it is anticipated that few of the runaways who are screened will need this level of care, (current data suggest 1.6%, Rotheram-Borus, & Bradley, 1987), it is critical to develop a working arrangement with a local facility that can provide rapid and continuous emergency back-up.

b. Outpatient clinic or youth counseling program: Many teenagers who are screened for suicide risk have major psychiatric problems and need help to resolve them. Counseling or therapy is often needed for youth to develop coping skills, to improve self-esteem and to solve problems. A crucial component of any suicide prevention network is a community mental health agency. Although the crisis intervention offered by shelters can make a major difference for runaways, one must remember that many teenagers, particularly those expressing suicidal or self-destructive feelings, may be in need of ongoing long-term treatment or other support services.

c. A resource for emergency psychiatric evaluation: When suicide screening is done routinely by shelter staff, there are instances in which it is somewhat unclear as to whether a youth is in immediate danger and/or is appropriate for the runaway shelter. These situations are not common, but as youth present complex situations and feelings, it is at times essential that an evaluation be made by a psychiatrist who is specially trained in assessing mental status. In some communities this service can only be provided through a local hospital emergency room. However, in other communities a local youth center or counseling program may provide this service, while in still others, a local psychiatrist may agree to be available for emergency consultations. Where such arrangements have been made, evaluating psychiatrists can offer needed assistance in determining the needs of suicidal youth and can, when necessary, facilitate hospitalization.

It is almost as important to avoid the trauma of unnecessary hospitalization as it is essential in specific situations to use the option of hospitalization.

D. Agency Protocols

Due to the varying size, staffing and resources of runaway programs there will be variations in the specific ways in which suicide prevention strategies are implemented. Intake policies, residential plans, and supervision models should be considered carefully in implementing the prevention project. Several essential program considerations relating to the identification of youth at risk for suicide are presented below:

1. The need for a program protocol regarding suicidal youth: The responsibility that agency staff feel in

Protocols provide clear guidelines for staff regarding supervision, consultations, and referral procedures.

assessing suicide risk is always burdensome. However, while staff always bear a certain amount of responsibility for their evaluations of adolescents, it is crucial that the shelter develop a clear protocol for triaging youth who are suicidal. Such protocols provide clear guidelines for staff regarding supervision, consultations, and referral procedures. This shifts the burden of responsibility from the individual staff member to the program. Protocols should be written and included in orientation of all new staff.

2. Inclusion of senior administrative staff is needed in the implementation of any suicide screening. An agency protocol must be established by agency directors in collaboration with staff. Training must include administrative staff because suicide presents a potential crisis situation with substantial liability to the community agency.

3. Any suicide screening should be done within the context of normal agency intake, orientation and welcoming processes. Because runaways have many needs and often complex life situations, the more that is known about history and future options, the better will be the plan for services related to suicidal feelings or risk. In addition, if suicide screening becomes a routine part of intake, staff become more familiar, comfortable, and competent in evaluating risk. In developing our current project, it was evident that suicide attempts frequently occur while runaways are in the shelter, with over nine suicide attempts in two shelters over a three month period (Rotheram, Bradley, & Obolensky, in press).

4. The effort to engage youth and to establish trust (an effort that can be begin during intake) should precede suicide screening. In order for an individual teenager to perceive the suicide screening as supportive, the youth must have already begun to perceive staff as genuinely interested in helping him/her. Therefore, evaluations need to be implemented after the youth has been engaged.

5. It is essential to follow up on referrals and treatment plans to ensure that these at-risk youth receive needed services. Given that runaway youth will typically have three to five risk factors placing them at risk for suicide, the agency must have systematic referral and intervention services available to help stabilize youth and to reduce risk. These services necessitate adequate treatment planning.

E. Staff Training

Staff training has four key components, each of which is critical for implementing an effective prevention strategy:

1. An exploration of staff feelings about suicidal behavior and responses to suicide-related situations.

2. A review of current agency practices for evaluating and triaging youth, an understanding of resources in a community network, experience in referring youth, and protocols for coping with suicidal youth in emergency situations.

3. An examination of recent findings and current knowledge about suicide risk factors.

4. An intensive training program about specific screening procedures.

The following sections of this manual, Parts III-VI, contain a detailed review of the above four components, in addition to exercises and suggested discussion topics that can be used in an agency training program.

III. TRAINING: STAFF FEELINGS ABOUT SUICIDE

A. Overview

Before attempting to increase staff skills in working with adolescents who may be at risk for suicidal behavior, it is critical to explore staff members' feelings about suicide, as well as their personal responses to situations involving the expression of suicidal feelings. Each of us has known a friend or client who has talked of suicide. The subject of death is charged emotionally, especially death by suicide. Confronting a potentially suicidal individual, in both work and personal situations, can elicit feelings of hopelessness, helplessness, fear, anxiety, depression and thoughts about one's own death. These are normal reactions. The trainer does not attempt to eliminate these feelings but, instead, he aims to help staff acknowledge them in order to sensitize them to biases which might affect their evaluations.

It is only when a clinical staff member has difficulty acknowledging the presence of his/her own feelings regarding suicide and death, that he will encounter problems in assessment and, more importantly, in being therapeutically helpful to the adolescent in crisis. For example, one worker may become highly anxious when talking to a suicidal youth and try to solve many years of problems and major emotional distress with a "pep talk" or a lecture. A second worker may become so depressed in talking to a suicidal youth that she has difficulty developing a plan of action.

Therefore, to increase staff effectiveness, a staff trainer's first goal is to increase staff members' awareness regarding these feelings. A youth's discussion of suicidal feelings can be a catalyst for helpfulness or a cause for staff frustration, withdrawal, or over-identification. Staff trainers must encourage clinical workers to express their feelings about suicide, and must offer support for worker's awareness of their own feelings.

These issues are considered by having staff review their own personal values and experience with suicide. Although details of staff members' personal lives are not necessarily relevant to work situations, it is important for anyone offering therapeutic services to become aware of the influence of personal experience in client-related situations. Thus, a discussion of experience and understanding of suicide is critical. For instance, if a staff member has had a family member or close friend make a suicide attempt, the emotional intensity of this experience may cause him or her to avoid or overinvest in client situations where the issue emerges. Insight and sharing of this experience is important to the extent that it helps the staff to become more attuned to feelings that may adversely effect the youth she/he wishes to serve.

Second, it is important to encourage staff members to review their own activities and feelings from interviews or suicide-related incidents with previous clients. In this manner, staff can evaluate their own work, identifying strengths. skills, and weaknesses. We plan at least a two-hour session for covering this initial training area with the following curriculum:

Confronting a potentially suicidal individual can elicit feelings of hopelessness, helplessness, fear, anxiety, depression and thoughts about one's own death. These are normal reactions.

B. Session 1

1. Exercise I: Positive feelings and personal strengths

a. Objective:

1. To identify personal strengths of staff members to create a positive training environment (e.g., a cohesive supportive staff group).

2. To give the trainer initial information about the staff.

b. Activity:

Each staff person is asked to disclose to the group two personal qualities or assets that make him/herself a good counselor (e.g.,caring, honest, ability to talk straight). Staff persons are also encouraged to give compliments and disclose positive attributes that they have observed of each other, especially from observations of staff encounters with youth in crisis. The trainer asks: "What two qualities do you most like about yourself in your work with youth?" The trainer's role is to encourage the staff to interact with each other. If staff have a difficult time and cannot generate compliments, the trainer should be quick to model how to give compliments and disclose positive attributes of staff members.

c. Discussion and follow-up:

As this is meant to be a beginning exercise, there is no need to follow it up with a lengthy discussion. A brief review of the various strengths of individuals and the group will suffice. However, encouraging group members to appreciate and to concretely acknowledge their strengths, will help create an environment in which honest questions, feedback and self-awareness will be possible. In addition, the strengths of the staff can be used later to encourage sharing and growth, and to discourage self-doubt or harsh self-criticism.

Staff persons are encouraged to give compliments and disclose positive attributes that they have observed of each other.

2. Exercise II: Staff feelings regarding death

a. Objective:

To help staff be aware of their own feelings regarding suicide.

b. Activity:

1. Each staff member spends five minutes remembering a specific adolescent whom they have encountered who was feeling suicidal or a young person for whom the staff member was concerned about potential suicide risk. They are asked to close their eyes and try to recall the adolescent's situation, current crisis, history, family, school, runaway problems, the way the adolescent expressed him/herself, and the feelings that were present. The counselor tries to remember the day of the week, time of the interview, clothes worn by the youth, and as many other details that can trigger the emotional intensity of the moment. If some staff members have difficulty recalling an appropriate teenager, suggest that they pick someone who appeared depressed, someone encountered at work or in their personal lives and imagine that this youth has died. What does the counselor feel? What does the supervisor's report say?

c. Discussion:

A brief discussion focuses on the following questions.

1. How does an adolescent act when he/she feels depressed, or angry? How do they talk and act?

2. Does he or she want help? Is the youth reluctant to talk about his/her feelings?

3. How does it feel for you to "tune in" to this suicidal teen?

3. Exercise III: Roleplay high risk situations

a. Objective:

To enable staff members to experientially rediscover interview situations with adolescents at risk for suicide and to begin to analyze their own responses to these situations as well as those of teenagers with whom they work.

b. Activity:

Remembering the specific teenager who was imagined above, the staff member roleplays an interview with this adolescent. Participants are broken into dyads with each pair doing two brief roleplays. First, one staff member plays the part of a teenager with another playing the part of a staff member conducting an intake interview. Roles are subsequently reversed. The instructions should be given as follows:

"Let's try a brief roleplay (give any necessary encouragement and support).

First pick a partner.(Pause) Now one of you will be a teenager. Use the youth who you recalled in the previous activity. The other person is a counselor interviewing this youth. Let's start the roleplay at a point in the interview at which the counselor becomes concerned about possible depression or suicide. We assume that the current situation and basic history have been discussed, and that you are both feeling comfortable. *You* choose how to begin the interview. The counselor should explore the issue of suicide and suicide risk, to find out what you can about this issue. We will roleplay for about three minutes and then reverse roles with the other person becoming the counselor."

c. Discussion:

The discussion of this activity should include feedback and input from all staff who wish to participate. It should take three basic directions. First, the trainer reviews *what happened during the roleplays*? Key questions to be addressed are:

1. How many asked directly about suicide? How many did not?

2. How many were able to determine the seriousness of the risk? How?

3. How many explored past suicide attempts?

4. How many discussed possible methods?

5. What was most important to you as counselors in this part of the interview?

d. Trainer goals:

1. To encourage differences of opinion and differences in approach.

2. To facilitate staff to share concerns and questions.

3. To support staff for disclosing personal feelings about suicide which may influence their effectiveness with youth.

The discussion is structured so that staff initially identify the behaviors each liked during the roleplay. After identifying strengths, each staff member is asked to identify one goal for improving their skills. For example, "I like my tone of voice. I conveyed caring. Next time, I would like to look the youth in the eye when I talk to him." After identifying one's own goals, the supervisor delivers feedback. Again, feedback should be structured first by listing the staff members strengths (e.g. "You were firm in your requests,") and then by setting goals for staff (e.g. "Next time I would like to see you . . .").

e. Review role play:

Second, staff are asked to address the question,"How did you feel as teenagers?" Try to elicit a full range of responses typifying youth who may be depressed, angry, crying, friendly, or with flat affect and explore the different attitudes and approaches of counselors. The key questions to review are:

1. If you did not ask directly about suicide, what stopped you? How comfortable were you during the roleplay? What made individual "youth" feel positively or negatively about being asked about suicide?

2. What behaviors by staff made you feel comfortable? Which behaviors were most helpful?

3. What behaviors were not helpful? Try to elicit specific verbal and nonverbal patterns.

f. Role Reversal:

Third, "How did you, the staff, feel as interviewers?" Try to elicit different responses by using information shared during the first two discussions. There should be variation in the responses of staff to suicidal situations. Key questions are:

1. How did you feel interviewing this youth? (helpful, hopeless, knowledgeable, anxious, relaxed, self-assured?)

2. What was most difficult for you in this situation? Being direct/staying with his or her feelings? Not rushing to solutions (by giving advice)? Feelings emerging from your own life? Something else?

After identifying strengths, staff members are asked to identify one goal for improving their skills.

Every suicidal act needs to be responded to as a serious threat.

3. How does this brief roleplay compare to real situations? How differently do you feel with actual teens?

4. How were you able to use your skills to help youth during this interview?

g. Trainer's role:

The trainer's job is to restrain from judgment and criticism of staff during this exercise. A supportive training atmosphere will allow staff to address emotionally charged issues more easily. Senior staff members with good clinical skills are encouraged to lead in disclosing their own feelings and experiences.

We routinely make a rule in training groups that all feedback must be delivered in the following manner:

1. a positive, complimentary statement

2. a specific behavior which appears inappropriate or lacking

3. a specific request for a behavioral change stated in positive manner.

This reinforcement is extremely useful in training groups. First, when feeling negative, many staff are shy about expressing concerns. In order to muster energy for delivering negative feedback, they tend to generalize the negative, i.e., believe everything about the other person is bad, rotten, and no good. People hearing negative information have the same tendency — to believe that everything about them is awful, terrible and unchangeable. The initial positive statement reminds both the deliverer and receiver of feedback that the negative information is specific and focused. The second step defines the specific negative behavior. The third step outlines the positive change requested. Rather than stating, "I don't like the way you look away from that adolescent you are interviewing," a staff member would state, "I would like you to look youth in the eye when you interview them."

4. Exercise IV: Cohesion building and review

a. Objectives:

1. To bring closure to the initial phase of training responses.

2. To recognize common struggles, feelings, concerns and to share support among co-staff.

b. Activity:

Make a summary list of the group's issues and concerns that emerge during the initial phase of training. The following questions should be used to compile lists:

1. What are common feelings shared by staff confronting suicidal teenagers?

2. What do suicidal teenagers appear to need from counselors?

3. What questions emerged which might need further discussion or which might be answered by the training?

c. Discussion:

In our experience, staff members often describe feelings of frustration and hopelessness in working with suicidal adolescents. Many express concerns about being responsible for the safety of individual youth and become overwhelmed with the responsibility for triaging suicidal youth. Suicidal behavior is often felt to be manipulative, a means of getting needs met. Acts labeled, "manipulative" are not taken as seriously as others.

Every suicidal act needs to be responded to as a serious threat. Adolescents and children are poor at predicting the consequences of their behavior. Youth who ingest four diet pills expect to die, just as strongly as youth who ingest 50 methadone tablets. A "manipulative" act is defined as one where the adolescent is rewarded for the act, i.e., there appears to be a positive reward for acting in a suicidal manner. Manipulation is directed to the intention of the adolescent: it focuses on the consequences of the interaction between the adolescent and the staff or parents responding. The possibility of encouraging further suicidal behavior needs to be addressed by staff and counselors. In response to adolescent's disclosure of suicidal feelings and intent, the staff member has three goals:

1. To separate and to differentiate the youth's feelings from their behaviors. Expression of depressed, angry, or hopeless feelings is encouraged by staff.

2. To encourage expression and discussion of feelings.

3. To discourage youth from engaging in suicidal acts by having the staff express personal discomfort and anxiety with suicidal behavior (not by giving excessive attention, and not by modifying pre-established standards of behavior).

Some staff are hesitant to ask youth directly about suicide. We feel it is crucial for staff to ask this question directly and to encourage youth to further discuss relevant feelings.

IV. REVIEW OF AGENCY REFERRAL & TRIAGE PRACTICES

A. Overview

Administrators, supervisors, and staff in community agencies need to review past crises with suicidal youth.

It is crucial that the problems of suicide prevention be viewed as an organization's problem, rather than that of individual staff members. To shift the responsibility from the individual staff member to the agency, specific triage procedures and written protocols should be outlined. The administrators, supervisors and staff in community agencies need to review past crises with suicidal youth in the context of discussing current protocols regarding suicide and suicidal risk among the youth served. Staff, as a group, identify problem areas by reviewing recent cases. Staff members need to be encouraged to be honest in assessing the cases. It is also important for staff and administrators to acknowledge successful strategies employed in previous suicide-related situations. Furthermore, a specific agency may have to adopt aspects of the model to meet the requirements of its population, organizational structure or staffing patterns.

B. Evaluation of Strengths and Weaknesses

1. Exercise V: Identify organizational strengths

a. Objective:

1. To have staff identify strengths and weaknesses in the organization's ability to evaluate, triage, and treat youth at risk for suicidal behaviors.

2. To develop protocols for evaluation, triage, and treatment.

3. To network with other agencies in order to provide necessary services.

b. Activity:

1. Review with staff several recent emergency situations involving suicide risk. Conduct a psychological autopsy of the crisis. Outline in a step-by-step fashion what actions were taken, by whom, on the basis of what information. Discuss how the perspective of each staff member who participated in the decision making was slightly different, and specifically diagram the lines of authority within the organization, the community resources or alternative agencies available for assistance, and the concerns of staff involved. List responses to the following questions:

1. What concerns can best be answered administratively through an agency protocol?

2. What issues can best be addressed by clinical training or the use of a consistent screening procedure?

3. What are the primary problems that the staff confronts in dealing with youth who are potentially suicidal or in suicide-related emergencies?

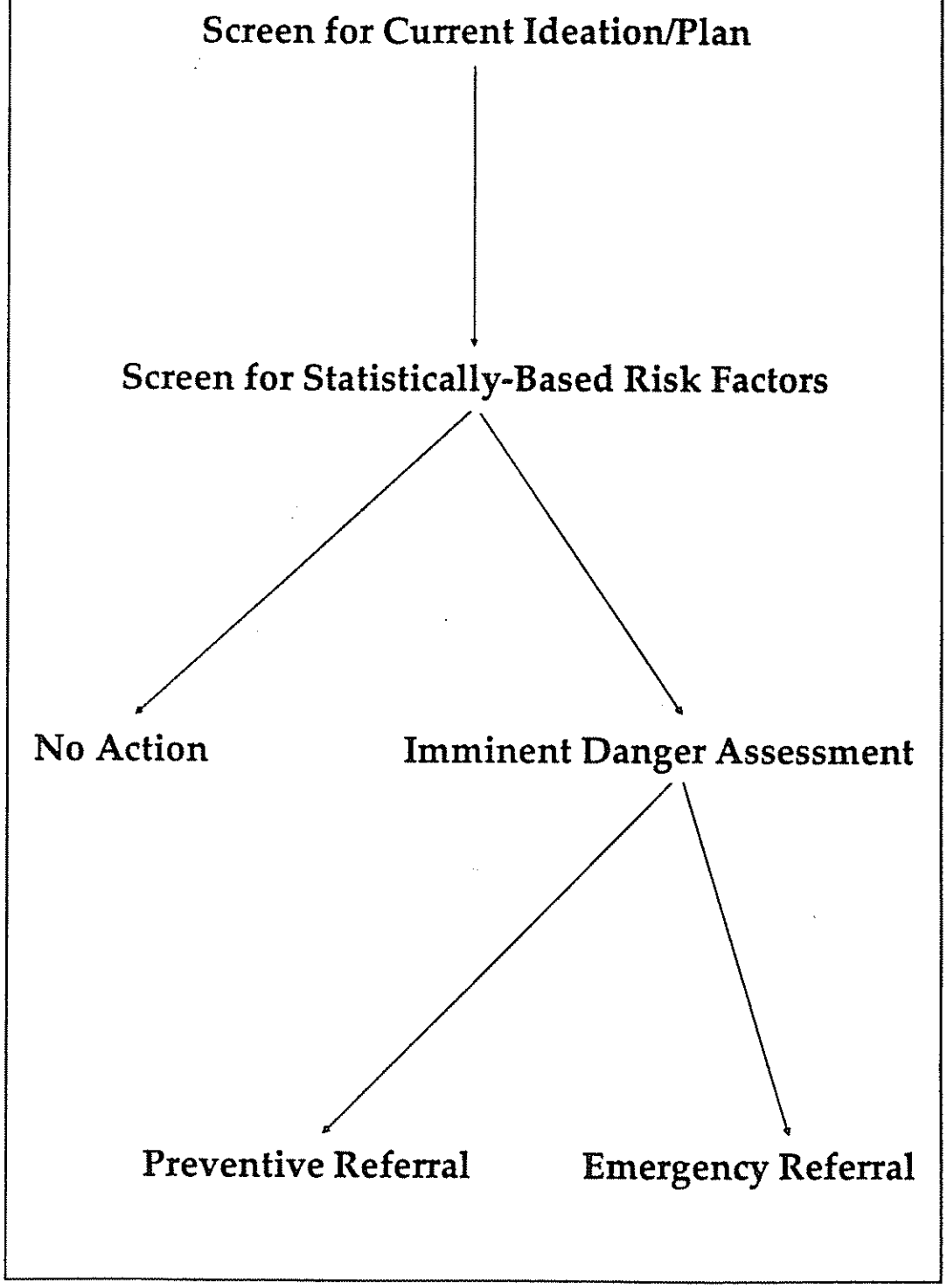
c. Discussion:

These lists of issues and concerns guide the review of agency protocols and resources. The clinical concerns raised can form a basis for developing future training agendas.

The remaining portion of this manual (parts V & VI) will cover specific screening procedures for evaluating suicide risk and several exercises recommended for staff training. First, a general discussion of the screening procedures and key concepts will be outlined. Next the evaluation instrument will be described in detail, beginning with the *assessment of risk-related factors*, followed by the *assessment of imminent danger*. Finally, we present the staff training exercises which are critical for all agency trainers or administrators who seek to implement this procedure.

FIGURE 1

Simplified Flow Chart of Triage Process



V. SCREENING PROCEDURE

A. Overview

To evaluate whether a runaway is at risk for suicidal behavior, it is critical to be informed about those background and behavioral characteristics that researchers have found to be associated with suicide attempters and completers. These statistically-based risk factors should serve as a guideline in the preliminary stage of evaluation, and are useful in determining which youth are at greater risk for suicide compared to other youth their age.

The use of risk factors does not assist in assessing whether the youth is in imminent danger of attempting suicide and which situations may precipitate an attempt.

The handout, presented in Appendix A, briefly outlines strategies for evaluating risk for suicide and contains a list of those statistically-based risk factors associated with suicide attempters and completers. A supplementary bibliography appears at the end of the handout for further reference.

While a youth with many of these behaviors and/or background factors is at high risk for suicide, it is important to reiterate the limitations of statistically-based risk factors in predicting suicide attempts. First, while current research on suicide is focusing increasingly on the adolescent population, our knowledge of risk factors is founded primarily on past studies of the adult population. Second, suicide is a relatively rare event: the use of statistical risk factors will automatically overpredict the number of youth at high risk for suicide. Finally, these risk factors do not take into account that a youth's potential for attempting suicide will vary, depending on the specific stressful situations being experienced, the youth's current state of mind, the potential resources available for support, and the youth's coping skills. For example, an evaluation based solely on statistical risk factors cannot address the fact that an adolescent might feel highly suicidal in the presence of his/her sexually abusive father, but not suicidal with peers or in school. Suicides are usually instigated by specific, immediate precipitators and transitory emotional states; risk factors will, at best, help determine which youth are at highest risk for making an attempt at some point in their lives.

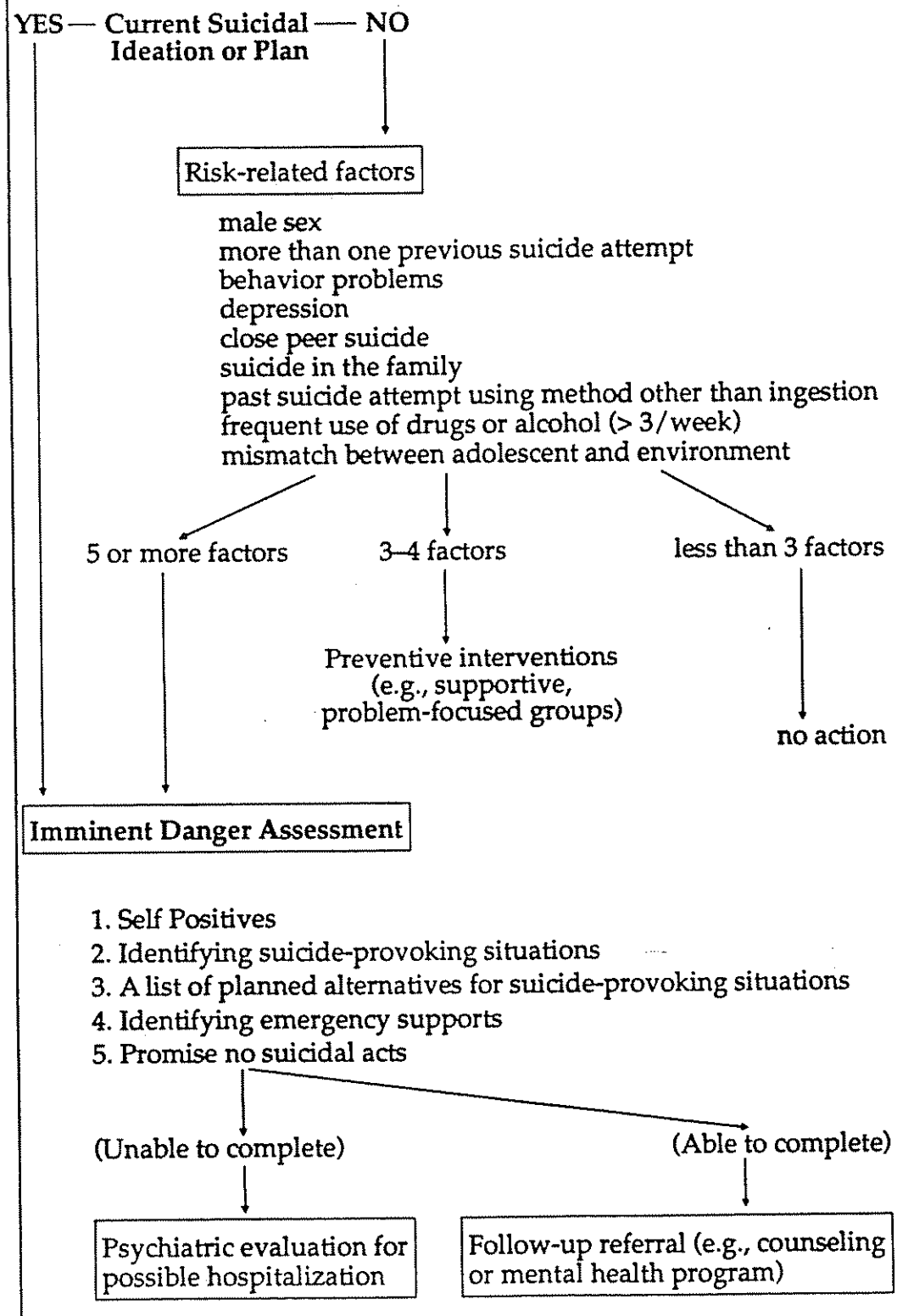
The use of risk factors does not assist in assessing whether the youth is in imminent danger of attempting suicide and which situations may precipitate an attempt. Yet, in our experience, runaway shelters are especially concerned about understanding these immediate issues in order to develop individually-tailored crisis treatment plans and referrals. With this in mind, we recommend a procedure based on the assessment of both current coping skills and statistically-based risk factors for the evaluation of immediate suicide risk.

The assessment is composed of two stages. Stage one, Screening for Risk Related Factors, averages 10 to 15 minutes in length. It aims to identify youth who may be at high risk for suicide attempts and is based on direct questions about suicide, as well as an evaluation of risk factors commonly associated with suicide. Stage two, the Imminent Danger Assessment (IDA), takes an additional twenty minutes, and is done with those adolescents determined to be at high risk for suicidal behavior in order to determine whether an immediate crisis exists. The flow charts presented in Figure 1 and Figure 2 illustrate the suicide assessment procedure.

The first criterion used for determining risk is the presence of current suicidal feelings, ideation, and/or a plan to commit suicide. If an adolescent has any current suicidal feelings, it is necessary to assess the youth's ability to cope in a manner incompatible with suicide. If a youth does not have current suicidal feelings, or a plan, then statistically-based risk factors are evaluated to determine whether there is a need for a further assessment of imminent danger for suicide, or to decide on an appropriate treatment plan. Youths

FIGURE 2

Flow Chart of Screening Procedures for Suicide Assessment Procedure



who score positively on five or more of the statistically-based risk-related factors should receive an imminent danger assessment. Those who score positively on three or four factors should be viewed as at moderate risk and be referred to problem-focused groups or individual counseling. Adolescents who have less than three risk factors are generally considered at low risk for suicidal behavior, and no specific action is recommended.

All runaways who express current suicidal feelings and/or who have five or more statistically-based risk factors should receive the Imminent Danger Assessment (IDA).

All runaways who express current suicidal feelings and/or who have five or more statistically-based risk factors should receive the Imminent Danger Assessment (IDA). The IDA consists of five tasks to determine whether an adolescent is in immediate danger of making a suicidal gesture. Youth who cannot complete these tasks are in need of emergency psychiatric evaluation or hospitalization. Those who can complete the tasks should be referred for mental health services, but may not be in need of emergency evaluations. Staff who work in runaway shelters can use the IDA to determine the appropriateness of shelter services for specific youth and to begin therapeutically engaging these runaways to improve their ability to cope with suicidal feelings.

The form which you will use to complete this evaluation is presented in sections throughout the remainder of the manual and once again, in its complete form, in Appendix B. It is recommended that each section of the screen be reviewed separately with staff during a scheduled training session.

B. Screening For Risk-Related Factors: Stage 1

The first section of the screen (questions 1–3) covers a time period of the past two weeks and attempts to determine the intensity of current emotional states, current suicidal ideation, recent attempts, and current plans. Two non-threatening questions about a client's current feelings of anger and depression are presented first to allow the interviewer to gain a general sense of the youth's current emotional state, and to provide the interviewer a means of leading the client gradually into the more sensitive area of suicide.

1. Intensity of current emotional state — Anger:

FIGURE 3
(Question 1)

1. A. How often in the last week have you been angry?
(If not at all, skip to question 2)

1 Not at all
2 Occasionally, 1 to 2 times
3 Sometimes, 3 to 4 times
4 Frequently, 5 or more times

1. B. When people get angry sometimes they are just a little annoyed or irritated, and other times they are furious. In the last week, what was the most angry that you felt?

no anger — most angry possible

1 2 3 4 5 6 7

2. Intensity of current emotional state — Depression:

FIGURE 4
(Question 2)

2. A. How often in the last week have you felt sad, depressed, or down in the dumps?
(If not at all, skip to question 3)

1 Not at all
2 Occasionally, 1 or 2 times
3 Sometimes, 3 or 4 times
4 Frequently, 5 or more times in past week

2. B. What was the most depressed you felt in the last week?

not depressed at all — most depressed possible

1 2 3 4 5 6 7

3. Current suicidal feelings/ideation: Question 3 directly asks about current suicidal ideation during the past week. Thinking about suicide two or three times during the past week indicates immediate risk and the need for an IDA assessment.

FIGURE 5
(Question 3)

3. A. Have you thought about hurting yourself or killing yourself in the last week? **(If not at all, skip to question 4)**

0 No, not at all
1 Thought about it once
2 Thought about two (2) or three (3) times
3 Thought about it every day
4 Thought about it so much that I could not think of anything else

3. B. In the last week, have you made any plans to hurt or kill yourself?

0 No, not at all
1 Made plans, but did not actually try to hurt or kill myself
2 Actually tried to hurt or kill myself

3. C. Do you want to die now?

0 No, not at all
1 Maybe
2 Yes

In reviewing this section of the screen with staff, it is recommended the trainer make sure that the shelter worker is comfortable being direct in asking about suicide.

4. Past suicide attempts: This includes the history of suicide attempts, the seriousness of any attempts, the precipitating events, and the coping skills of the adolescent.

Question 4, items A, B, and C, explores suicidal feelings which have occurred during the youth's lifetime, finding out about the teenager's experiences of these feelings and how he/she has coped with them in the past. Information gathered from these questions may prove critical in developing appropriate treatment plans.

FIGURE 6
(Question 4, Part s A–C)

4. A. Have you ever seriously thought about killing yourself? By seriously, I mean every day for a week, or more.
(If not, skip to question 4C)

0 No, not at all
1 Yes

If yes, enter the number of times _____

4. B. If yes, when was the last time you thought about hurting yourself?

1 Less than a week ago
2 1 week–1 month
3 1–6 months
4 6 months–1 year
5 1–3 years
6 more than 3 years ago

4. C. Have you ever hurt yourself or tried to kill yourself?
(If not at all, skip to question 5)

0 No, not at all
1 Yes

If yes, enter the number of times _____

The remaining items from question 4, shown on page 22, focus on previous suicide attempts. If a teen has no previous attempts and answers "no" to 4C, the interviewer should skip to the next section of the screen. However, if a teen has made any past attempts, it is crucial to explore the number of attempts (4C), the timing of the attempt (4D), the method used in the attempt (4E), precipitating factors (4J), whether drugs or alcohol were being used during this period (4G) and psychiatric and/or treatment services being provided to the youth because of previous attempts (4F, H and I).

Risk factors used in determining the degree of risk are drawn from questions about previous attempts and method of previous attempts. The other questions in this section will help interviewers determine the seriousness of attempts and of emotional troubles as well as the degree to which past precipitating factors may exist, or be likely to exist, at the current time. In developing treatment plans for individual youth.

A youth who has made several suicide attempts is at higher risk for suicide than one who has no past suicide attempts. When we examined responses of 741 runaways on these questions, we found that the best predictor of future suicidality

Risk factors used in determining the degree of risk are drawn from questions about previous attempts and method of previous attempts.

If a boy appears seriously depressed, this is a far more important indicator of potential suicidality than for a girl.

FIGURE 7
(Question 4, Parts D–K)

4. D. When was the last time you tried to hurt yourself?

1 Less than a week ago
2 1 week–1 month ago
3 1–6 months ago
4 6 months–1 year ago
5 1–3 years ago
6 more than 3 years ago

4. E. How did you try to kill yourself the last time you tried?

1 Taking pills, drinking chemicals
2 Cutting wrist
3 Hanging
4 Carbon monoxide
5 Jumping
6 Gun
7 Other

4. F. Have you ever been hospitalized for trying to kill yourself?

0 No, not at all
1 Yes

If yes, enter the number of times _____

4. G. Did you use drugs or alcohol within 2 days of trying to kill yourself?

0 No, not at all
1 Yes

If yes, enter the number of times _____

4. H. Have you ever received counseling or therapy for trying to kill yourself?

0 No, not at all
1 Yes

If yes, enter the number of times _____

4. I. How long did you receive services?

Enter length of treatment in months ___

4. J. Did any of these things happen to you during the three days before you tried to kill yourself?

- ❑ argument
- ❑ told "I wish you were dead"
- ❑ trouble at home
- ❑ humiliation
- ❑ trouble at school
- ❑ trouble with police
- ❑ assaulted
- ❑ disappointed
- ❑ pregnancy
- ❑ sexual abuse
- ❑ other _____

4. K. Thinking of your most serious attempt, the attempt when you came closest to dying, were you along at the moment you tried to kill yourself; that is, were you alone when you (refer to method(s) above).

0 Alone
1 Not alone

was a past attempt. Therefore, making plans about how to cope in suicide-eliciting situations would be critical for those with past attempts. Past attempts is considered an additional risk factor.

Ingesting pills is the most common method of attempting suicide. Therefore, if a youth attempted suicide in the past using a different method, it is also considered an additional risk factor. Guns, hanging, and reckless behavior (e.g., driving through the woods at night alone with no lights) are the most lethal methods of past attempts.

In more than half of all completed adolescent suicides, drugs and/or alcohol have been ingested prior to the attempt. These substances serve to disinhibit risk behaviors. Therefore, a youth who feels suicidal who is also using dangerous substances is a greater risk.

Inquiring regarding the specific precipitants and past treatment experiences helps primarily in setting treatment goals and plans. If an imminent danger assessment is conducted, there precipitants give the worker clues regarding future situations which are likely to precipitate suicidal behavior.

FIGURE 8
(Question 5)

5. A. Have any of your parents, brothers, sisters, grandparents, aunts, or uncles, relatives or close friends killed themselves or tried to kill themselves?
(If no, skip to question 6)
0 Yes
1 No

5. B. How many members of your family have attempted suicide?

Enter the number of family members __

5. C. When was the most recent suicide attempt by a family member?
1 during the last 3 months
2 from 3 months to a year ago
3 from 1 to 2 years ago
4 more than 2 years ago

5. D. How many have died by suicide?

Enter the number _____

Relationship to teen _____

5. E. Have many of your close friends attempted suicide?
(If none, skip to question 6)

Enter the number _____

5. F. When was the most recent suicide attempt by a person your own age?
1 during the last 3 months
2 from 3 months to a year ago
3 from 1 to 2 years ago
4 more than 2 years ago

5. G. How many of your friends, other than relatives, have died by suicide?

Enter the number _____

Behavior problems such as truancy, vandalism, delinquency and fighting have been highly associated with completed suicides.

5. Family background: As many runaways have both friends and family who have made attempts, it is important to note that although these are both explored in question 5, they are counted as two separate risk factors. Risk increases if youth have had close peers and/or close family members who make attempts. The nature of the increased risk may vary, depending both on the youth's relationship to the person and the length of time which has passed since the attempt.

6. Depression: Question six explores depression during the past two weeks. Although depression can be ongoing or transitory, it is the current feelings of a youth that will determine risk for suicidal behavior. Depression in teens is often reflected in changes in behavior (e.g., changes in eating and sleeping habits) as well as crying, sadness, and feelings of distraction. As it is common for adolescents to feel depressed, the goal of this section is to identify depressed feelings that are particularly intense or unusual. Adolescent girls are more frequently depressed than boys, particularly in relation to hormonal changes at menstruation. *If a boy appears seriously depressed, this is a far more important indicator of potential suicidality than for a girl.*

Together these twelve items form a depression scale. To meet the criteria for depression a youth would need to answer six items indicating depression. Notice that items D, H, and K are framed positively and, thus, scores of 0 (not ever) or 1 (occasionally) should be considered indications of depression. The last item (L) asks about weight change. Significant loss or gain of weight may be a sign of depression and thus recent fluctuation of weight should be viewed as positive indication of depression. All other items in question six are framed negatively, so that a score of 3 (frequently) on any of these items would be indications of depression. In other words, the youth would need to score on a *total of six items* in any of the following combinations:

A *SCORE OF* 3 on any of items *(A),(B),(C),(E),(F),(G),(I),or (J)*

and/or

A *SCORE OF 0 OR 1* on any of items *(D), (H), or (K)*

and/or

A *WEIGHT GAIN/LOSS OF AT LEAST 5 POUNDS* on item *(L)*.

FIGURE 9
(Question 6)

6. Answer how often you have experienced each of the following during the last week.

	5–7 days	3–4days	1–2days	< 1 day
6. A. How often in the last week have you been bothered by things that do not usually bother you?	3	2	1	0
6. B. How often have you felt lonely?	3	2	1	0
6. C. How often have you felt fearful?	3	2	1	0
6. D. How often have you felt hopeful about the future?	3	2	1	0
6. E. How often has your sleep been restless in the last week?	3	2	1	0
6. F. Because of your mood, how often have your eating habits changed during the past week?	3	2	1	0
6. G. How often have you had trouble speaking your mind to others?	3	2	1	0
6. H. How often have you enjoyed yourself in the last week?	3	2	1	0
6. I. How often have you felt your life was a failure?	3	2	1	0
6. J. How often have you felt you could not "get going"?	3	2	1	0
6. K. How often have you been happy?	3	2	1	0
6. L. How much weight have you gained or lost in the last week?				

Lbs. gained _____

Lost _____

Teenagers' suicidal feelings are related to their perceptions of the world and self and to insufficient problem-solving skills in crisis.

While we have provided a straightforward scale for assessing depression, workers should be encouraged to use their clinical judgment in this evaluation. Workers should be attuned to youth's affect, signaled through their nonverbal behavior, expression and demeanor. We recommend being cautious, that is, leaning towards a positive finding when in doubt.

7. Conduct Disorder: Question seven explores behavior problems. As indicated in the review of current research findings (Appendix A), behavior problems such as truancy, vandalism, delinquency and fighting have been highly associated with completed suicides.

The behavior assessment consists of two parts. First, questions 7 A,B,C, and D explore general history of behavior problems. There is no scaling for these questions. Rather, they are recommended for use in determining whether there is any pattern of behavior problems. Items E–O use a scale (with a time frame of two months) to evaluate whether problematic behaviors currently exist. Fighting, stealing, vandalism, and truancy are explored, as are drug and alcohol use. A

FIGURE 10
(Question 7)

Enter the number of times each of the following has ever happened to you.

7. A. been arrested _____ times

7. B. run away _____ times

7. C. used a weapon in a fight _____ times

7. D. been kicked out of school _____ times

Circle how often in the LAST TWO MONTHS you have:

	5 or more	3–4	1–2	Not at all
7. E. missed school	3	2	1	0
7. F. destroyed property	3	2	1	0
7. G. joined with members of a gang to cause trouble	3	2	1	0
7. H. teased or fought with younger children	3	2	1	0
7. I. got into a physical fight with others	3	2	1	0
7. J. drank alcohol	3	2	1	0
7. K. used drugs	3	2	1	0
7. L. got in trouble at home (if you are a runaway, before you left home)	3	2	1	0
7. M. lied	3	2	1	0
7. N. stole	3	2	1	0
7. O. set fires	3	2	1	0

To use this procedure effectively, staff must engage the youth, becoming both teacher and role model.

score of (3) or greater on four or more of the eleven items is an indication that behavior problems should be considered a risk factor. In addition, a score of (4) on either 6J or 6k indicates substance abuse as a positive risk factor.

8. *The Summary Scoring Sheet* (see page 26) should be included with every screening instrument. The checklist outlines decision rules to facilitate the suicide assessment process. Evaluators can rate youth on specific factors and quickly arrive at a score which will indicate whether an adolescent is at high, moderate or low risk.

C. Imminent Danger Assessment: Stage 2

1. Overview: The IDA takes approximately twenty minutes to administer and is straightforward and relatively easy to implement. It is an active, behaviorally focused clinical interview, which determines if a high-risk adolescent is in immediate danger of making a suicide attempt. Staff attempt to elicit five behaviors from the youth which are incompatible with suicidal actions; that is, five behaviors which a youth in imminent danger of a making suicide attempt would most likely be unable to accomplish.

One premise underlying the evaluation strategy is that teenagers' suicidal feelings are related to their perceptions of the world and self and to insufficient problem-solving skills in crisis. By initiating a therapeutic relationship between interviewer and high-risk youth, the IDA encourages the development of effective problem-solving skills.

SUICIDE RISK SUMMARY SCORING

POTENTIAL IMMINENT DANGER is based on meeting either criteria 1 or 2:

1. Current ideation or plan to attempt suicide	Question 3.A. with a 3 or 4 Question 3.B. with a 1 or 2
2. The youth reports 5 or more of the following risk factors:	
A previous suicide attempt	Question 4.C
More than one suicide attempt	Question 4.C
A past suicide attempt using a method other than ingesting drugs	Question 4.E.
Suicide behavior by family	Question 5.A.
Suicidal behavior by a friend	Question 5.E
Depression	Question 6, answering a (3) on A,B,C,E,F,G,H, or I (including a weight gain/loss of 5 lbs.) or a (0) or (1) on D,H, or K for a total of six items
Behavior problems	Question 7, answering positive on A to D or a 2 or 3 on E–O for a total of 6 items
Frequent use of drugs and alcohol	Question 7.J. or 7.K. answering a 2 or 3
Being a boy and scoring depressed	

Training staff to respond in a supportive and empathetic manner, with a clear understanding of concrete adaptive behaviors is critical. To use this procedure effectively, staff must engage the youth, becoming both teacher and role model. The interviewer can have an impact on high-risk youth by modeling positive behavior and by encouraging the development of alternative non-suicidal responses to stressful life situations. Implementation of the IDA should answer the question most often asked by shelter staff when working with depressed and suicidal youth, "What should we do with this particular runaway?" As indicated in the flowchart (Figure 2), youth who can not demonstrate the five non-suicidal behaviors are to be considered in imminent danger of making a suicide attempt, and should be referred to emergency psychiatric services in order to assure their safety. Other youth may be at high risk but are not exhibiting the need for emergency psychiatric intervention based on the assessment. These youth can be offered needed shelter and support, and subsequently can be referred for mental health services. The five clinical activities which comprise the IDA are:

a. self-positives and compliments

b. identifying suicide-provoking situations

c. making plans for ways to avoid suicide-provoking situations

d. identifying supports

e. commitment for no suicidal acts

Space is provided for documenting the youth's responses to the IDA in the screening form (see Appendix A). Unlike the preceding sections of the screen, this form allows for open ended answers. It can be used to show that an evaluation was completed and to demonstrate that an appropriate treatment plan was developed.

In addition, this form, when included in client's charts, can be used by staff in the agency to provide ongoing care while a youth is in the shelter or community agency. The documentation helps alert staff to events which might serve as precipitants to a suicide attempt and to behaviors which would indicate a possible suicide related emergency. For example, if a girl indicates that breaking up with her boyfriend is a possible precipitant to suicidal feelings, the IDA form can make staff aware that if this were to occur, intervention with this girl would be essential. The five tasks listed in the IDA as incompatible with imminent danger for suicide attempts, and the summary are presented in detail below:

2. Tasks incompatible with suicide

a. Self-positives

Adolescents who are in immediate danger of making a suicidal gesture feel hopeless and negative, perceiving nothing positive about themselves or their environment. They can not accept or give themselves compliments, even with help from an interviewer. The capacity to identify positive characteristics or circumstances, however small, is thus a non-suicidal behavior, an indication of hopefulness, and a good starting place for helping adolescents start to develop improved coping skills. In addition, this activity establishes a therapeutic bond, helping develop trust between youth and the worker. The evaluator will usually have to help elicit self-positives by modeling for the adolescent how to give and receive compliments and by encouraging the youth to share something they like about themselves. Self-positives can be general or specific, about one's personality or one's clothes, about one's boyfriend or a math test, even about the interview process itself.

We recommend spending several minutes helping the adolescent exchange and elicit compliments. Taking this time will benefit the youth and further strengthen the therapeutic relationship, allowing for smooth movement into the second activity. A interviewer might ask the following questions.

- "Tell me, what are the things that you like about yourself?"
- "What are the things going on in your life that make you feel good?"
- "How about your boyfriend? Do you feel good about him?"
- "You said you do well in math. That's great!You're good in math."
- "I love your blouse (t-shirt, shoes). Do you like your eyes or your blouse better?
- "You really have good taste in clothes. Which do you like, your clothes or the way you carry yourself?"
- "I'm finding it really nice to talk to you today. You are so honest, thoughtful."

It is important to note in these sample statements that the worker serves as a role

The capacity to identify positive characteristics or circumstances, however small, is thus a non-suicidal behavior, an indication of hopefulness.

1. SELF-POSITIVES:

Try to elicit at least three positive self-compliments. Compliments can include statements about physical appearance, peers, family, personality characteristics, school, relationships with the interviewer or others in the youth's life.

If the youth has difficulty identifying these, compliment the youth and ask the youth to choose between two positive features. For example, "I like your eyes. What do you like better — your eyes or your hair?"

"What do you like best about yourself? What happened to you today that made you feel good?"

They should be encouraged, as much as possible, to recognize their own contributions to positive circumstances and to credit themselves with compliments.

model, helping to elicit self- compliments. Also note that self-positives can range from feeling good about talking to the interviewer, to shoes, school, or personality,general and/or specific events.

Examples of self-positive statements from youth are:

- "Sometimes my boyfriend makes me feel really good."
- "Yeah, school is pretty good. I am a good student."
- "I take care of myself, you know, exercise so I'll look good. I like my body."
- "Yes, I picked these shoes...I guess I sometimes have good taste."
- "I like my sense of humor when I feel good."
- "I guess I feel comfortable talking to you. Maybe I am easy to talk to."
- "I guess I have nice eyes. People say I do, yeah, I like them."
- "When I listen to certain music I feel real good. I guess that is something I like and, yeah, I like that about myself."

Note that youth should be encouraged to say positive things about *any* aspect of their lives. They should be encouraged, as much as possible, to recognize their own contributions to positive circumstances and to credit themselves with compliments. If the adolescent is able to give more than one compliment, it is helpful for the therapist to repeat back the entire list of compliments, reinforcing the idea that there are many good aspects in the runaway's life.

A sample dialogue might be:

① "There is nothing good about me."

② "Which do you like, your jeans or your eyes? I think your eyes look caring. I like your eyes."

① "I don't like my eyes, I like my hair."

② "Good, you like your hair. It is a nice color." What else do you like? I feel good that you came here today."

① "Well, you are okay. Talking to you is okay."

② "I enjoy talking to you also. Okay, now you like you hair and you like talking to me. There are two good things. What is a third thing good in your life? It doesn't have to be large. Today I noticed it was a bright day. What was good for you?"

① "I had a good meal last night."

② "Great, you had a good meal. Well you like your hair and you like talking to me and you had a good meal. The world is not all negative, there are at least three good things in less than one day. Thanks."

Section 1 of the IDA form is straightforward in documenting the self-positives elicited from the adolescent:

b. Identifying suicide-provoking situations (*Feeling Thermometer*):

The second activity focuses on an adolescent's ability to identify suicide-provoking situations by assessing his or her own capacity for awareness of feeling states. We want to determine whether the high-risk teenager can describe how she/he feels in various situations, and whether he/she can develop a set of feeling "signals" that can be triggered in suicide-precipitating circumstances.

Adolescents who make suicide attempts often describe having little or no feelings (being numb) as they make the suicidal gesture. Their awareness of their feeling state is limited and the self-destructive act is an impulsive, often detached action. The capacity to identify, through emotional and physical feelings, situations when one is likely to make an attempt gives an adolescent the capability of developing a more thoughtful response to those situations. In addition, this activity supports a general awareness of feelings. Although teens need to know when they are most upset, they also need to develop awareness of when they feel slightly upset, fairly good, and particularly happy.

High-risk youth are reminded of the *transitory nature of negative, hopeless feelings* and of *their own ability to monitor and adjust how they are feeling.*

We teach awareness of feeling states to runaway adolescents using the *Feeling Thermometer*. It consists of asking the teenager to view their emotions as a

thermometer and identify situations in which they are the hottest (most upset — either depressed or angry), the coolest (most relaxed, feeling good), warm (upset, but not terribly) and cool (feeling Okay). Teenagers should be encouraged to describe what happens emotionally and physically under each condition. One adolescent may describe anger, violent feelings, loss of control, sweating, and shaking when most upset. A second may withdraw, start to feel nothing, feel edgy, runaway, or cry. It is important to help individual adolescents, especially those at high risk, to learn to be attuned to their feelings. This capacity is evidence of skills that run counter to those of suicide attempters.

The *Feeling Thermometer* activity must be done with energy and creativity. A visual aid is helpful to most staff as teenagers readily understand the concept when shown a drawing. This can be a sketched thermometer or scale which some agencies have created for their staff. They will also need encouragement and support in trying to describe what happens to them emotionally and physically in various situations.

Staff find it helpful to share the experience of other young people with their client, or even to give examples of their own feeling states. However, while we think it is useful and creates a positive environment to explore *both* upsetting and calming experience with youth, it is crucial to focus extensively on what happens to them and how they feel in upsetting, *suicide-provoking situations*. By helping an adolescent become aware of signs of distress, one is increasing the possibility that the adolescent will recognize the situation and be able to attempt to leave it as soon as possible. Clearly, the ability to develop alternative plans in suicide-provoking situations depends largely on a youth's being able instantly to recognize these situations as they occur.

When asking about times when the youth felt upset and those in which the youth felt calm, it is important to be very specific and concrete. The worker will want to ask about four or five different situations, one with a feeling thermometer of 0, one at 20, 40, 60, 80, and 100. For each situation, the youth tries to remember where they were, the time of day, the feelings inside their body, and their actions. A completed feeling thermometer with associated interpersonal problem situations is shown here.

The results of this activity are recorded in part 2 of the Imminent Danger Assessment form:

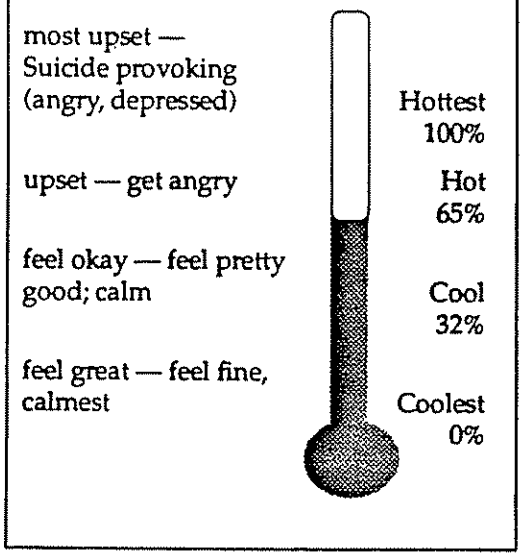
C. Plans for ways to cope with suicide-provoking situations:

Adolescents who have been able to identify suicide-provoking situations and to describe their own feeling states can generally begin to develop strategies for coping with these situations. Although this

High-risk youth are reminded of the transitory nature of negative, hopeless feelings and of their own ability to monitor and adjust how they are feeling.

Feeling Thermometer	Situation	Bodily reaction
100	Thrown out of my home for stealing	Could not breathe, hands were sweaty
90	Girlfriend broke up with me	Angry, red face, yelling, shaking
60	Bought a new radio; it was broken	Frowning, nervous, stomach tight, moving feet back and forth
40	Came home late, parents unhappy	Lick my lips more
20	Got a B on a test; thought I had failed	Calm, smiling
05	Reading a book in bed	No tension, smiling

Feeling Thermometer



activity may appear obvious, many teenagers who make suicide attempts act impulsively and become unable to generate alternatives in highly stressful situations. In choosing a suicide attempt as their response, they have ignored options which at the time of heightened excitement did not appear available to them. As part of the IDA, runaways are assisted in developing clear, simple, concrete plans for avoiding situations in which an attempt might be provoked.

The capacity of a young person to make plans for coping with stressful situations forms a critical part in determining whether or not he/she is in immediate danger. What will they do if confronted with that most upsetting situation again? What can they do? What are the options? Will they be able to avoid the situation in the future?

The circumstances which provoke a suicide attempt vary greatly among individuals. One runaway may make attempts after a visit from an abusive father. Another may feel suicidal after receiving a C in Social Studies class. During the Imminent Danger Assessment, staff should assist in generating a list of alternative actions, constantly encouraging the youth to take the lead in this search for better choices. The alternatives considered

Clearly, the bility to develop lternative plans n suicide- rovoking ituations epends largely n a youth's eing able nstantly to ecognize these ituations as hey occur.

2. FEELING THERMOMETER AND IDENTIFYING RISK SITUATIONS:

Describe a FEELING THERMOMETER to each youth (see the training manual). Ask youth to identify situations of great discomfort (a thermometer of 100) and those in which the youth feels very comfortable (a thermometer of 0). Identify at least five situations of varying discomfort. Ask specifically about the last three situations in which the youth felt suicidal and the behaviors associated with suicidal feelings.

	FEELING THERMOMETER (0–100)	SITUATION	BEHAVIORAL RESPONSE
A.			
B.			
C.			
D.			
E.			
		SUICIDAL SITUATIONS	BEHAVIORAL RESPONSE
F.			
G.			
H.			

should be *realistic, accessible,* and as *safe and supportive* as possible. One is not attempting to resolve the situation that exists, but rather to help the client simply avoid it and the feeling state it creates. The ability of a runaway at high risk for suicide to be attuned to precipitating situations and to seek alternative actions when confronted with them is another positive indication that he/she is not in immediate danger for suicide.

The alternatives generated can be used by adolescents as part of self-instructional "cues" which they can rehearse and remember quickly when necessary. Some adolescents find it helpful to write down alternative plans and instructions so that they are always armed with a written plan. For example, one girl felt suicidal when her father (who had separated from her mother) would come to the family home and attempt to enter forcibly. She found great relief from carrying an instruction sheet with her which outlined five steps she would follow if this situation arose. The card read:

1. stay quiet and act as if no one is home;
2. call to him through the closed door and tell him I will meet him downstairs;
3. go to the fire escape and climb in the neighbor's window.
4. go to the neighbor's house, by the fire escape and call the police;
5. go to the fire escape and scream for help.

The plan of a 14-year old who is provoked into suicidal thoughts by a poor school grade would be entirely different. It might read:

1. talk to my best friend about grades and school
2. approach a trusted teacher to talk about my grades
3. go to the library, relax, imagine my last report card and anticipate the next good report card
4. call home; talk to my mother about school

In this situation it may be the young person's globalization of a negative experience such as a poor grade which makes him feel suicidal. His plan includes four steps in which he will be helped to remember that this poor grade is not a reflection of his overall school work, potential, or experience of the world.

In developing alternative plans as part of the IDA, it should be remembered that this assessment procedure is meant to be brief and that it is the youth's ability to perform these tasks that is being assessed. Plans should be kept simple and short-term, particularly as the concern of shelter staff is primarily for immediate safety and safety during a shelter stay. Yet, this process of developing alternatives in suicide- provoking situations can form a major part of a treatment approach, as this assessment attempts to introduce a high-risk youth to basic problem-solving concepts.

One is not attempting to resolve the situation that exists, but rather to help the client cope with it and the feeling state it creates.

3. PLAN OF ACTION:

Make a plan with the youth about how the youth will cope in each situation which elicits suicidal thoughts.

SITUATION PLAN

F. _____

_____

G. _____

_____

H. _____

4. SUPPORT PERSONS:

Identify three resource persons to help the youth cope with suicidal feelings. "Who are the three people you will call if you are feeling suicidal? Which adult or counselor do you feel comfortable calling?"

_____

_____

_____

A plan of action in each situation which elicits suicidal thoughts is recorded in section 3 of the Imminent Danger Assessment form:

d. Identification of emergency supports:

Adolescents who make suicide attempts generally feel socially isolated at the time of the attempt and cannot identify someone to call for help. After having established specific plans for the avoidance of suicide-provoking situations, it is important to help adolescents at high risk think of who they can talk to if they begin to feel suicidal. This activity is closely related to the previous one. A preventive plan should always include the availability of family, peers, or professional support persons. We recommend identifying a minimum of three people to whom an adolescent can turn if they begin to feel suicidal. Although any friend or family member can be a support person, staff must remember the instability of runaway youth and the relative unpredictability of a suicidal crisis. For this reason, at least one of the support persons should be a shelter staff member who can be immediately accessible. The evaluator often can help to establish himself in this role and/or can facilitate the identification of other people at the shelter who can be available if needed.

Support persons available to the youth are recorded in section four of the Imminent Danger Assessment form:

e. Commitment for no suicidal acts:

If a high-risk youth has been able to deliver self-positives, to identify feeling states, especially those which are suicide-provoking, and to develop alternatives for avoiding suicide-provoking situations, he or she can now be asked to make a time limited commitment for no suicidal acts. Essentially this is a contract made between staff and youth in which the client agrees to make no suicide attempts during a specified period, and to seek supports and alternative solutions should a highly stressful situation arise. The contracting phase of this assessment has been used effectively in shelters that provide short-term residence in order to help assure that attempts will not be made during a youth's brief stay at the shelter.

Although commitments or contracts can vary, it is recommended that, as part of this assessment, they be kept extremely short, no longer than a few days. This is recommended because of the unstable situations of runaways, the volatile nature of many of their family, peer, and legal circumstances, and the extreme emotional shifts which may occur during a youth's stay in a shelter. It is easy to re-contract after a few days, even daily, depending on a worker's concerns about a specific youth. Adolescents when asked for a *clear, realistic, short-term commitment*, usually will not lie or give false promises regarding suicidal acts. Rather, if they can not make this commitment, they will avoid it and refuse to form a contract. Certainly, as all suicidal adolescents have some level of ambivalence, being honest about their capabilities and fears may be one way of ensuring necessary intervention. Youth who can make a commitment to no suicide attempts for even a brief period of time generally do not appear in need of emergency intervention and/or referral, and are indicating this to the staff. Youth who make and keep commitments should be supported in their effort at

This process of developing alternatives in suicide-provoking situations can form a major part of a treatment approach.

5. PROMISE:

Elicit a promise for no suicidal behavior for a specified period.

"Please write me a promise that you will not try to kill yourself within the next two weeks. Also, I want you to promise me that if you feel suicidal you will talk to me (not leave a message) and/or another counselor about your feelings, before you try to kill yourself."

self-awareness and control, a skill which can form a part of successful treatment.

We recommend that these commitments be made into brief written contracts. This is especially important if youth have expressed current suicidal feelings or recent attempts. Contracts should include a clear statement agreeing not to make any attempts as well as an indication of specific steps which the young person will take should they begin to have suicidal feelings. These steps will parallel the alternatives already established during the assessment but should also include the names of shelter staff who will be contacted if suicidal feelings arise. The more clear and specific the contract, the more effective it will be as a preventive intervention.

In section five of the IDA form, the interviewer documents the establishment of a contract for no suicidal behavior.

The IDA form ends with a summary section which should be used to describe briefly specific situations and behaviors of a youth which may indicate that he/she is feeling suicidal. These comments will have emerged from the IDA, and can be used by supervisors, directors, or other staff to quickly review the results of the assessment.

Contracts should include a clear statement agreeing not to make any attempts, as well as an indication of specific steps which the young person will take should they begin to have suicidal feelings.

SUMMARY

What are the warning signs or the situations which are likely to lead this youth to feel suicidal, based on the FEELING THERMOMETER and the situations described above?

SITUATIONS LIKELY TO ELICIT SUICIDE (e.g., boyfriend breaks up with youth):

BEHAVIORS WHICH THIS YOUTH IS LIKELY TO SHOW WHEN FEELING SUICIDAL:

VI. STAFF TRAINING: ASSESSMENT OF RISK

A. Session 2

1. Exercise VI:

a. Objective:

To help staff become acquainted with the screening instrument.

b. Activity

The trainer or a selected senior staff member assumes the role of a troubled adolescent, one who staff feel may be at risk for suicide. Two senior staff members roleplay an interview with a disturbed youth. One plays the role of an adolescent who may exhibit one of these following patterns:

1. A 14-year old boy has been thrown out of the family home for chronic lying and stealing. The boy is arrogant and denies that he has any problems. His father is an alcoholic. His mother treats him like a baby and is over-indulgent. He is the oldest of three children. He has wrecked four cars by driving through the woods with the lights of the car turned off.

2. A 13-year old girl presents with a shy and timid manner and will not disclose her name. She has been frightened away from home. She was given three failing marks on her report card and does not want to live. She cries throughout the interview.

3. A 16-year old girl has five knife slashes on her arm. She uses marijuana daily and engages in prostitution when she needs money. Her boyfriend threw her out of their apartment. She wants to die.

A second senior staff person plays the worker role and administers the suicide screen (sections 1–7 and summary) in front of the group. This worker-client dyad stops after each question in order to elicit feedback, comments, and suggestions from the observers. We recommended repeating this public roleplay several times using different staff to play various types of runaway adolescents such as young, extremely "together", angry, withdrawn, male and female adolescents. Each may respond differently to the screening process and roleplays involving a range of adolescents will help staff members solidify their skills and increase their comfort with the instrument. It should be noted that this instrument has been completed with nearly 1000 runaways and that the staff who used the screen reported minimal difficulties with it.

c. Discussion and follow-up:

The discussion focuses on both the staff's and client's experience of the evaluation procedure (sections 1-7 and summary). In addition, staff become comfortable and begin to integrate the screen into their individual interview style. The trainer raises the following issues:

1. How did the youth respond to questions in each risk-related area?

2. What were the verbal and nonverbal behaviors that signaled the youth's reaction?

3. How does the interviewer administer the screen?

a. What is he or she doing that is helpful?

b. What is he or she doing that is not helpful?

4. How do different types of adolescents vary in their response to the screen? Are there modifications in the inquiry style that could facilitate honest responses?

After the individual roleplays are completed, the staff member scores the screen to determine if individuals were at high, moderate, or low risk. This portion of

We recommended repeating this public role-play several times using different staff to play various types of runaway adolescents such as young, extremely "together", angry, withdrawn, male and female adolescents.

he screen is not general ssessment tool nd is not xpected to rovide a full ssessment of inaway youth.

the screen is aimed at discovering high risk youth who should receive an Imminent Danger Assessment. The screen is not a general assessment tool and is not expected to provide a full assessment of runaway youth.

d. Trainer needs to review:

1. Did the screen identify high risk adolescents?

2. Did the screen identify youth at moderate risk?

2. Exercise VII: Risk Evaluation interviewing

a. Objective:

To strengthen interviewing skills.

b. Activity:

Staff is divided into dyads with one staff member role-playing a troubled youth, and the second staff member administering the screen (sections 1-7 and summary) to assess the degree of risk. Staff members then change roles and repeat the exercise.

c. Discussion:

Individual staff may begin to feel more comfortable with the instrument. While roleplays are quite helpful in practicing the screening, interviews with youth will help staff members efficient with the screen.

3. Exercise VIII: IDA, Eliciting self-positives

a. Objective:

1. To introduce the concept of self-positives.

2. To create cohesion in the training group. This exercise follows an explanation of self-positives and its application as part of assessment of imminent danger.

b. Activity:

The trainer reminds the group of compliments that staff made during Exercise I and asks each participant for two additional self-positives. The group members are encouraged to support the compliments shared by other individuals.

c. Discussion:

The group discusses how they feel about complimenting themselves and explore the value of encouraging self-compliments with runaway youth. Key questions to stimulate discussion are:

1. How do you feel when complimenting yourself, especially when supported by others?

2. What two things have you done to have a good day today?

3. Can young people give themselves compliments?

4. Which young people cannot? Why can't they?

4. Exercise IX: IDA, Feeling Thermometer training

a. Objective:

To introduce the concept of feeling states and the Feeling Thermometer. This exercise follows an explanation of feeling states and identification of suicide-provoking situations and their importance as part of the assessment of imminent danger.

b. Activity:

The trainer requests a volunteer to share a situation in which he/she gets most upset and then to describe what happens physically and emotionally under those circumstances. Other volunteers are requested to share and describe their "hottest" situations. There is often great laughter during these discussions as staff members recall anxiety-provoking situations. After the group has discussed upsetting situations, individuals are asked to describe happy situations, and those which create moderately upset and moderately happy feelings. In this activity, it is important that the trainer focus on specific descriptions of feeling states, especially emphasizing the physical changes which accompany various feeling states. These might include, for example, sweating, turning red, difficulty in breathing, or tightening muscles. In addition, it is critical for the trainer to ask for specific numbers on the thermometer in order to help staff clearly understand

the importance of fully differentiating feeling states when assessing youth.

c. Discussion:

The group discusses the importance of recognizing feeling states and signals of distress in their own lives, and then explores the value of encouraging youth to become aware of their feeling states. Several points need to be emphasized with the feeling thermometer:

1. Every person has their *own* thermometer. My temperature may be 30 in the situation which makes you feel 80 or vice versa.

2. Feelings are often mislabeled, particularly anxiety and excitement. Assisting youth to clarify which feelings they have is *very* important.

3. No one feels *0* all the time; nor does anyone feel *100*; nor do they flip from *0* to *100*. When teens report these feelings, they are missing the bodily cues which tell them they are getting upset. Practice will increase awareness of feelings.

4. Staff can use the feeling thermometer among themselves, making it easy to transfer the concept to teens.

5. Exercise X: IDA, Problem-solving high risk situations

a. Objective:

To help staff become acquainted with the IDA and to generate issues for discussion, as well as identify areas of difficulty or concern for individual staff members. This exercise should follow a thorough presentation and discussion of all parts of the Imminent Danger Assessment.

b. Activity:

The trainer or a senior staff member plays the role of a specific adolescent, one who appears at high risk for suicide. A volunteer from the training group begins an Imminent Danger Assessment with this "youth" by attempting to elicit self-positives. After a brief roleplay, the group members are asked for feedback and to make suggestions to the interviewer. A second volunteer is asked to do self-positives with the "youth". After a few staff members have practiced the self-positives part of the assessment, volunteers are chosen to roleplay the section on feeling thermometer and identification of suicide-provoking situations. After each brief roleplay, feedback is given and discussion encouraged. This group activity should be repeated with each part of the IDA. The success of this activity depends on the trust and openness of the group, the willingness of individuals to roleplay, and especially the creation of a supportive, sharing atmosphere by the trainer.

c. Discussion:

As the Imminent Danger Assessment is a clinical evaluation, its accuracy and success depend largely on the skills of the evaluator. While the assessment activities are straightforward and easily learned, nevertheless, shelter staff members must practice and become comfortable with them. This exercise gives staff members an opportunity to practice each part of the assessment, to observe and learn from others, and to discuss techniques and approaches that make the assessment a positive and valuable experience for interviewer and youth.

Key questions to be discussed after *each* roleplay are:

1. How did the interviewer present the activity?

   a. What did he or she do that was helpful?

   b. What did he or she do that was not helpful?

   c. What one change should he or she make in their next interview?

2. How did the youth respond to the activity?

3. What did one learn about the youth's immediate risk for suicide from this activity?

In addition, a summary discussion should follow this exercise to focus on the staff's experience in administering the IDA and to identify any anticipated strengths or problems in implementing it in the agency. Comments should be explored briefly and

As the Imminent Danger Assessment is a clinical evaluation, its accuracy and success depend largely on the skills of the evaluator.

viewed as areas on which to focus the next activity. Key questions in the summary discussion are:

1. How did the Imminent Danger Assessment work as an evaluation of immediate suicide risk?

2. What aspects of this assessment do staff find most difficult or problematic?

3. How do you anticipate clients responding to this activity?

6. Exercise XI: IDA, A complete evaluation

a. Objective:

To continue to give staff an opportunity to practice the Imminent Danger Assessment and to continue to identify issues.

b. Activity:

Staff members are broken into dyads. One staff member assumes the role of a suicidal youth modeled after a youth from the worker's own clinical experience, if possible. The second staff member administers the Imminent Danger Assessment. The dyad members then change roles and repeat the exercise.

c. Discussion:

Having role-played the assessment imitating a youth with whom they are familiar, individual staff may begin to feel more comfortable with this assessment. This exercise may also generate additional concerns and raise issues for future discussion. The members of the dyads should offer each other feedback and a group discussion should follow the activity. The key questions for this discussion are the same as those used in Exercise X.

7. Exercise XII: Risk evaluation training

a. Objective:

This exercise is a summary and review of both parts of the suicide screening procedure and an attempt to discuss with staff its implementation at the shelter.

b. Activity:

The trainer should review with staff the screening procedures and elicit questions about the procedure, particularly seeking to develop a list of future training needs and concerns about integrating the screening procedure into current agency practices and protocols. This review session should be used to create three lists:

1. A list of steps to be taken to implement the program, including a timetable, if possible. What issues need to be addressed administratively? What further skills are needed?

2. A list of future training needs regarding teenage suicide or related topics.

3. A list of issues related to the specific screening procedure that should be reviewed after all staff have had a chance to use it in clinical situations with runaway youth.

B. Follow-Up To Training

We recommend a staff meeting be convened at least one month after the initial training or at a time when all staff members have used the screening procedure several times. At this time, staff can share their experiences using the screen and give each other ideas and suggestions. Agency protocols and resources can also be reviewed. The lists of issues generated during the previous training exercise should be used to help focus the problem identification and problem-solving activities that should form the major content of this follow-up meeting.

We recommend a staff meeting be convened at least one month after the initial training or at a time when all staff members have used the screening procedure several times.

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Appendix A

A. Research-Based Strategies for Evaluating Risk

1. *Matching the social demographics of completed suicides:* Researchers conduct psychological autopsies on youth who have completed suicides and identify predictors common to many youth. Risk factors in adults are: male sex, living alone, unemployment, frequent use of drug and alcohol, past suicide attempts, a family history of suicide, and completed suicide by a friend.

2. *Psychometric measures:* Using psychological test batteries, researchers attempt to find profiles that might predict suicide. MMPI profiles have been used extensively with adults, yielding descriptions of suicide attempters who are high on denial and depression.

3. *Specific risk groups:* Persons with previous suicide attempts, pregnant teenagers, runaways, and youth chronically abusing drug and alcohol have high rates of attempted and completed suicide.

4. *Psychological profiles:* Clinical researchers look for psychological features that are commonly found among suicide attempters. A suicidal act signals that an adolescent perceives a severe problem in his/her life and has an ineffective style of coping with that problem. He/she is likely to have significant social and/or psychiatric maladjustment.

a. precipitating factors:

1. *associated physical illness:* Adolescent suicide attempters report 30% to 50% higher rates of current medical illness than do peers. Pregnancy or fear of pregnancy is often associated with girls' suicide attempts.

2. *drug and alcohol abuse in self or family:* At least 37% of suicide attempters abuse drugs and attempts are common among abusers. Further 30% to 40% of the families of adolescent suicide attempters show alcohol abuse.

3. *poor school achievement:* Adolescents who attempt suicide have more social problems at school and more academic problems.

4. *poor peer relations:* Suicide attempters appear to have inadequate peer relationships and increased social isolation.

5. *family psychiatric illness:* Rates of psychiatric disturbance have been reported as high as 50% in the parents of suicide attempters.

6. *family conflict:* Adolescent suicide attempters come from families where there is more conflict between the parents and frequent parent-child conflict. Adolescent suicide attempters are likely to perceive their parents as hostile, indifferent, and having extremely high expectations. Researchers have noted that adolescents' descriptions of their parents as withdrawn and unresponsive to the adolescents'crises are consistent with the observations of clinicians treating these youth.

7. *life stress* : Adolescent and adult suicide attempters have been found to be experiencing high levels of stress in their personal lives and within their families.

B. How do Adolescent Suicide Attempters Cope?

1. *Depression and anger:* Not all suicide attempters are depressed. In fact only about 30%–40% appear to be depressed. More frequently (45%) youth appear to have a history of behavior problems (e.g., conduct disorder). Among adults, suicidal behavior is related more to hopelessness than to depression. Many attempters have been found to lack interpersonal assertiveness and to be ineffective in communicating their needs to others. Attempters appear resentful and angry without a socially acceptable method of resolving their feelings.

2. *Unrealistic expectations:* The pattern of thinking associated with suicide attempters/completers is characterized by the perception that negatives events are their own fault, unending, and spanning across all areas of their life. In contrast, positive events are perceived of as atypical, chance events which will not last.

3. *Few pleasant events and negative ways of perceiving themselves and others:* The number of problems in the lives of attempters and non-attempters is the same; however, the attempters perceive their lives as more negative and do not engage socially with others as often. Suicidal adolescents often perceive a lack of control over their environment that *leads to feelings* of hopelessness.

4. *Interpersonal problem solving:* Suicide attempters have been unable to find alternative solutions to problems, and become locked into rigid thought patterns which do not provide helpful alternatives. Impulsivity or acting without planning and without evaluating consequences has consistently been related to suicidal behavior.

C. Summary of Risk Factors

1. *Current suicidal ideation:* Any youth expressing thoughts of suicide more than three times in the last week is at high risk. Suicidal ideation and plans should always be taken seriously and responded to immediately, regardless of perceived manipulative intent.

2. *Recent suicide attempt:* Any youth who has made a recent attempt (within the last 6 months) is at high risk for attempting suicide again. In situations where a youth makes a repeat attempt, it is often the case that the crisis which precipitated the original attempt was left unresolved. Without a resolution to underlying causes, the youth's suicidal feelings may remain present or re-emerge when the youth is under stress.

3. *One or more previous suicide attempts:* Suicide attempters are likely to make future attempts.

4. *Approximately 90% of suicide attempters ingest drugs to try to kill themselves:* Methods other than ingestion such as jumping from high places, hanging, or use of a gun are much more likely to be lethal. If an adolescent has used such a method in the past he/she may do so again and, therefore, has an increased chance of completing the attempt.

5. *Depression.*

6. *Antisocial behavior:* (fighting, delinquency, truancy)

7. *Close peer suicide:* There is strong evidence suggesting that adolescents can be influenced by the suicide attempt or completion of someone close to them. This contagion effect can occur among groups of youth and is referred to in the research literature as "suicide clustering."

8. *Suicide in family:* The suicide of a family member also increases the risk for adolescents.

9. *Frequent use of drugs and/or alcohol.*

10. *Male sex:* Males, while making fewer attempts overall than females, have a much higher rate of completion. Thus, a male who expresses suicidal feelings, or is otherwise determined to be at high risk, is at greater risk for actually killing himself than a female.

11. *Mismatch between a youth and his/her environment:* Because suicide attempts relate to transitory, emotional states and to environmental stress, a youth whose environment creates obvious stress is at increased risk. For example, both a 13-year old without a family, living on the streets, and a young person of limited learning skills who is in an extremely competitive family and academic environment, have environments that frustrate their needs and place them at increased risk.

D. Selected Reading About Adolescent Suicide

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Sudak, H. S., Ford, A. B., & Rushforth, N. (Eds.). (1984). *Suicide in the young.* London: John Wright — PSG Inc.

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2 Matching the Social Demographics of Completed Suicide

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3 Psychometric Measures

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Clopton, V. R., Post, R. D., & Larde, J. (1984). Identification of suicide attempters by means of MMPI profiles, *Journal of Clinical Psychology, 31*(6), 868–871.

4 Specific Risk Groups

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5 Psychological Profiles

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Shaffer, D. (1985). Research: Studies and Issues. A paper presented at the National Conference on Youth Suicide, Washington, DC.

Toolan, J. M. (1975). Suicide in children and adolescents. *American Journal of Psychotherapy, 29,* 339–344.

6 Poor Peer Relations

Cohen-Sandler, R., Berman, R., & King, R. A. (1982). A follow-up study of hospitalized suicidal children. *Journal of American Academy of Child Psychiatry, 21*(4), 398–403.

Shaffer, D. (1974). Suicide in childhood and early adolescence. *Journal of Child Psychology and Psychiatry, 15,* 275–291.

7 Family Conflict

Facy, F., Choquet, M., & Lechevallier, Y. (1979). Reserache d'une typologie des adolescents suicidants. *Social Psychiatry, 14,* 75–84.

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8 Family Psychiatric Illness

Garfinkel, B., Froese, A., & Hood, J. (1982). Suicide attempts in children and adolescents. *American Journal of Psychiatry, 139,* 1257–1261.

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Life Stress

9 Life Stress

Paykel, E., Prusof, & Myers, S. (1975). Suicide attempts and recent life events. *Archives of General Psychiatry, 32,* 321–333.

10 Depression and Anger

Cohen-Sandler, R., Berman, R., King, R. A. (1982). Life stress and symptomatology: Determinants of suicidal behavior in children. *Journal of American Academy of Child Psychiatry, 20*(2), 178–186.

Mattson, A., Seese, L. R., Hawkins, J. W. (1969). Suicidal behavior as a child psychiatric emergency. *Archives of General Psychiatry, 20,* 100–109.

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Hawton, K., O'Grady, J., Osborn, M., & Cole, D. (1982). Adolescents who take overdoses: Their characteristics, problems and contacts with helping agencies. *British Journal of Psychiatry, 140,* 118–123.

12 Drug and Alcohol Abuse

Frederick, C., Resnik, & Wittlin, B. (1973). Self- destructive aspects of hard core addiction. *Archives of General Psychiatry, 28,* 579–585.

Klitzner, M., & Blasinsky, M. (in press). Substance abuse and suicide. In M. Rotheram-Borus, J. Bradley, & N. Obolensky (Eds.), *A plan for living: Evaluating and treating suicidal teens in community settings.* Tulsa, OK: University of Oklahoma Press.

13 Poor School Achievement

Barter, J., Swaback, D., & Todd. (1968). Adolescent suicide attempts: A follow-up study of hospitalized. *Archives of General Psychiatry, 19,* 523–527.

14 Skill Deficits

a. Pleasant Events:

Gotlib, I. H. (1982). Self-reinforcement & depression in interpersonal interaction: The role of performance level. *Journal of Abnormal Psychology, 91*(1), 3–13.

Seligman, M. Abramson, C., Semmel, A., & Von Baeyer, C. (1974). Depressive attributional style. *Journal of Abnormal Psychology, 88*, 243–247.

b. Interpersonal Problem Solving:

Gotlib, I. H., & Asarnow, R. F. (1979. February). Interpersonal and impersonal problem-solving skills in mildly and clinically depressed university students. *Journal of Consulting and Clinical Psychology, 47*(1), 86–95.

Gotlib, I. H. (1982). Self-reinforcement & depression in interpersonal interaction: The role of performance level. *Journal of Abnormal Psychology, 91*(1), 3–13.

Rotheram-Borus, M.J., Trautman, P.D., Dopkins, S., and Shrout, P.D. (1988). Deficits in pleasant activities and cognitive style. Annual meeting of the American academy of child psychiatry.

Appendix B

EVALUATION OF SUICIDE RISK AMONG ADOLESCENTS

Screener: Mark the teen's response on the lines on the left. On any answer: Not applicable — 8; Cannot remember — 9

— 1. A. How often in the last week have you been angry?
(If not at all, skip to question 2)
1 Not at all
2 Occasionally, 1 to 2 times
3 Sometimes, 3 to 4 times
4 Frequently, 5 or more times

— 1. B. When people get angry sometimes they are just a little annoyed or irritated, and other times they are furious. In the last week, what was the most angry that you felt?
no anger 1 2 3 4 5 6 7 most angry possible

— 2. A. How often in the last week have you felt sad, depressed, or down in the dumps?
(If not at all, skip to question 3)
1 Not at all
2 Occasionally, 1 or 2 times
3 Sometimes, 3 or 4 times
4 Frequently, 5 or more times in past week

— 2. B. What was the most depressed you felt in the last week?
not depressed at all 1 2 3 4 5 6 7 most depressed possible

— 3. A. Have you thought about hurting yourself or killing yourself in the last week?
(If not at all, skip to question 4)
0 No, not at all
1 Thought about it once
2 Thought about two (2) or three (3) times
3 Thought about it every day
4 Thought about it so much that I could not think of anything else

— 3. B. In the last week, have you made any plans to hurt or kill yourself?
0 No, not at all
1 Made plans, but did not actually try to hurt or kill myself
2 Actually tried to hurt or kill myself

— 3. C. Do you want to die now?
0 No, not at all
1 Maybe
2 Yes

— 4. A. Have you ever seriously thought about killing yourself? By seriously, I mean every day for a week, or more. **(If not skip to question 4C)**
0 No, not at all
1 Yes

If yes, enter the number of times _____

— 4. B. If yes, when was the last time you thought about hurting yourself?

1 Less than a week ago
2 1 week–1 month
3 1–6 months
4 6 months–1 year
5 1–3 years
6 more than 3 years ago

— 4. C. Have you ever hurt yourself or tried to kill yourself?
(If not at all, skip to question 5)

0 No, not at all
1 Yes

If yes, enter the number of times _____

— 4. D. When was the last time you tried to hurt yourself?

1 Less than a week ago
2 1 week–1 month ago
3 1–6 months ago
4 6 months–1 year ago
5 1–3 years ago
6 more than 3 years ago

— 4. E. How did you try to kill yourself the last time you tried?

1 Taking pills, drinking chemicals
2 Cutting wrist
3 Hanging
4 Carbon monoxide
5 Jumping
6 Gun
7 Other

— 4. F. Have you ever been hospitalized for trying to kill yourself?

0 No, not at all
1 Yes

If yes, enter the number of times _____

— 4. G. Did you use drugs or alcohol within 2 days of trying to kill yourself?

0 No, not at all
1 Yes

If yes, enter the number of times _____

— 4. H. Have you ever received counseling or therapy for trying to kill yourself?

0 No, not at all
1 Yes

If yes, enter the number of times _____

— 4. I. How long did you receive services?

Enter length of treatment in months _____

— 4. J. Did any of these things happen to you during the three days before you tried to kill yourself?

- ❑ argument
- ❑ trouble at home
- ❑ trouble at school
- ❑ assaulted
- ❑ pregnancy
- ❑ other _____
- ❑ told "I wish you were dead"
- ❑ humiliation
- ❑ trouble with police
- ❑ disappointed
- ❑ sexual abuse

— 4. K. Thinking of your most serious attempt, the attempt when you came closest to dying, were you along at the moment you tried to kill yourself; that is, were you alone when you (refer to method(s) above).

0 Alone
1 Not alone

— 5. A. Have any of your parents, brothers, sisters, grandparents, aunts, or uncles, relatives or close friends killed themselves or tried to kill themselves?
(If no, skip to question 6)

0 Yes
1 No

— 5. B. How many members of your family have attempted suicide?

Enter the number of family members _____

— 5. C. When was the most recent suicide attempt by a family member?

1 during the last 3 months
2 from 3 months to a year ago
3 from 1 to 2 years ago
4 more than 2 years ago

— 5. D. How many have died by suicide?

Enter the number _____

Relationship to teen _____

— 5. E. Have many of your close friends attempted suicide?
(If none, skip to question 6)

Enter the number _____

— 5. F. When was the most recent suicide attempt by a person your own age?

1 during the last 3 months
2 from 3 months to a year ago
3 from 1 to 2 years ago
4 more than 2 years ago

— 5. G. How many of your friends, other than relatives, have died by suicide?

Enter the number _____

— 6. Answer how often you have experienced each of the following during the last week.

	5–7 days	3–4days	1–2days	< 1 day
— 6. A. How often in the last week have you been bothered by things that do not usually bother you?	3	2	1	0
— 6. B. How often have you felt lonely?	3	2	1	0
— 6. C. How often have you felt fearful?	3	2	1	0
— 6. D. How often have you felt hopeful about the future?	3	2	1	0
— 6. E. How often has your sleep been restless in the last week?	3	2	1	0
— 6. F. Because of your mood, how often have your eating habits changed during the past week?	3	2	1	0
— 6. G. How often have you had trouble speaking your mind to others?	3	2	1	0
— 6. H. How often have you enjoyed yourself in the last week?	3	2	1	0
— 6. I. How often have you felt your life was a failure?	3	2	1	0
— 6. J. How often have you felt you could not "get going"?	3	2	1	0
— 6. K. How often have you been happy?	3	2	1	0

— 6. L. How much weight have you gained or lost in the last week? Lbs. gained _____

Lost _____

— 7. Enter the number of times each of the following has ever happened to you.

— 7. A. been arrested _____ times

— 7. B. run away _____ times

— 7. C. used a weapon in a fight _____ times

— 7. D. been kicked out of school _____ times

Circle how often in the LAST TWO MONTHS you have:

		5 or more	3–4	1–2	Not at all
__	7. E. missed school	3	2	1	0
__	7. F. destroyed property	3	2	1	0
__	7. G. joined with members of a gang to cause trouble	3	2	1	0
__	7. H. teased or fought with younger children	3	2	1	0
__	7. I. got into a physical fight with others	3	2	1	0
__	7. J. drank alcohol	3	2	1	0
__	7. K. used drugs	3	2	1	0
__	7. L. got in trouble at home (if you are a runaway, before you left home)	3	2	1	0
__	7. M. lied	3	2	1	0
__	7. N. stole	3	2	1	0
—	7. O. set fires	3	2	1	0

Suicide Risk Summary Scoring

POTENTIAL IMMINENT DANGER is based on meeting either of criteria 1 or 2:

1. Current ideation or plan to attempt suicide	Question 3.A. with a 3 or 4 Question 3.B. with a 1 or 2

2. The youth reports 5 or more of the following risk factors:

A previous suicide attempt	Question 4.C
More than one suicide attempt	Question 4.C
A past suicide attempt using a method other than ingesting drugs	Question 4.E.
Suicide behavior by family	Question 5.A.
Suicidal behavior by a friend	Question 5.E
Depression	Question 6, answering a (3) on A,B,C,E,F,G,H, or I (including a weight gain/loss of 5 lbs.) or a (0) or (1) on D,H, or K for a total of six items
Behavior problems	Question 7, answering positive on A to D or a 2 or 3 on E–O for a total of 6 items
Frequent use of drugs and alcohol	Question 7.J. or 7.K. answering a 2 or 3
Being a boy and scoring depressed	

1. SELF-POSITIVES:

Try to elicit at least three positive self-compliments. Compliments can include statements about physical appearance, peers, family, personality characteristics, school, relationships with the interviewer or others in the youth's life.

If the youth has difficulty identifying these, compliment the youth and ask the youth to choose between two positive features. For example, "I like your eyes. What do you like better — your eyes or your hair?"

"What do you like best about yourself? What happened to you today that made you feel good?"

_____

_____

_____

2. FEELING THERMOMETER AND IDENTIFYING RISK SITUATIONS:

Describe a FEELING THERMOMETER to each youth (see the training manual). Ask youth to identify situations of great discomfort (a thermometer of 100) and those in which the youth feels very comfortable (a thermometer of 0). Identify at least five situations of varying discomfort. Ask specifically about the last three situations in which the youth felt suicidal and the behaviors associated with suicidal feelings.

	FEELING THERMOMETER (0–100)	SITUATION	BEHAVIORAL RESPONSE
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____
		SUICIDAL SITUATIONS	BEHAVIORAL RESPONSE
F.	_____	_____	_____
G.	_____	_____	_____
H.	_____	_____	_____

3. PLAN OF ACTION:

Make a plan with the youth about how the youth will cope in each situation which elicits suicidal thoughts.

SITUATION	PLAN
F.	_____
G.	_____
H.	_____

4. SUPPORT PERSONS:

Identify three resource persons to help the youth cope with suicidal feelings. "Who are the three people you will call if you are feeling suicidal? Which adult or counselor do you feel comfortable calling?"

5. PROMISE:

Elicit a promise for no suicidal behavior for a specified period.

"Please write me a promise that you will not try to kill yourself within the next two weeks. Also, I want you to promise me that if you feel suicidal you will talk to me (not leave a message) and/or another counselor about your feelings, before you try to kill yourself."

Summary

What are the warning signs or the situations which are likely to lead this youth to feel suicidal, based on the FEELING THERMOMETER and the situations described above?

SITUATIONS LIKELY TO ELICIT SUICIDE (e.g., boyfriend breaks up with youth):

BEHAVIORS WHICH THIS YOUTH IS LIKELY TO SHOW WHEN FEELING SUICIDAL: