An Evaluation of the Circumstances Surrounding Youth in Crisis

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Executive Summary

Harbor City Youth Services (HCYS) has been asked to redesign its response to adolescents in crisis. The original proposal recommends a broad public-information campaign using radio, television, print, and some digital media. Awareness remains important, but crisis communication cannot be treated mainly as advertising. Young people need immediate, confidential, developmentally appropriate routes into care; parents and schools need guidance; and the organization must be able to respond safely when outreach succeeds. A responsible campaign therefore combines evidence-based communications with clinical triage, referral partnerships, safeguarding, privacy, accessibility, and evaluation. The plan below identifies priority audiences, message principles, channels, workflows, budget priorities, and measures for an integrated youth-crisis initiative. (World Health Organization, 2024; Office of the Surgeon General, 2021)

Defining “Youth in Crisis”

A youth crisis may involve suicidal thoughts, self-harm, acute anxiety, severe depression, psychosis, abuse, family violence, homelessness, substance use, trafficking, grief, school exclusion, or another situation in which ordinary coping and support are insufficient. Not every distressed adolescent is in immediate danger, and not every crisis has a psychiatric cause. The communication system should distinguish emergency danger from urgent but non-life-threatening needs and from preventive support.

The original proposal uses the age range twelve to twenty-four. Developmentally, a twelve-year-old and a twenty-four-year-old differ substantially in legal status, dependence, school setting, communication habits, and care pathways. HCYS should create at least two audience tracks: adolescents aged twelve to seventeen and young adults aged eighteen to twenty-four. Materials can overlap, but consent, confidentiality, safeguarding, and referral procedures require different handling.

Situation Analysis

Before launching media, HCYS should map available services, opening hours, language capacity, disability access, transport, eligibility, insurance requirements, and emergency response. A campaign that generates demand without available appointments can increase frustration and risk. The

organization should establish written agreements with crisis lines, hospitals, schools, youth shelters, primary-care practices, mental-health providers, substance-use services, child-protection agencies, and community organizations.

Local data should guide the campaign. Useful sources include youth surveys, emergency-department visits, school referrals, crisis-line contacts, homelessness data, overdose trends, and focus groups. Data should be disaggregated carefully by age, gender, race and ethnicity, disability, geography, and school status without exposing small groups or reinforcing stereotypes.

Campaign Objectives

1. Increase recognition of urgent warning signs among youth, peers, caregivers, educators, and community members.
2. Increase use of appropriate crisis and early-support services.
3. Reduce stigma and misinformation without normalizing or sensationalizing self-harm.
4. Improve coordination among schools, healthcare, emergency services, and community organizations.
5. Measure whether outreach reaches underserved young people and produces safe follow-through.

Priority Audiences

Young People

Youth-facing messages should be direct, nonjudgmental, and action oriented. They should acknowledge fear about confidentiality, cost, immigration, family reaction, or being dismissed. The primary action should be easy to remember: call, text, chat, or visit a clearly named source.

Peers

Friends are often the first to notice changes. Peer materials should teach them to listen, ask directly about safety where appropriate, involve a trusted adult, and use emergency services when danger is immediate. Peers must not be made responsible for providing therapy or keeping life-threatening secrets.

Parents and Caregivers

Caregivers need guidance on warning signs, calm conversation, reducing access to lethal means, arranging assessment, and responding without punishment. Materials should also explain

confidentiality so parents understand why a clinician may speak privately with an adolescent.

Schools and Youth-Serving Professionals

Teachers, counselors, coaches, youth workers, faith leaders, and employers need role-specific protocols. They should know whom to call, what to document, when to stay with a young person, and how to follow up after referral.

Message Principles

Messages should communicate hope and the availability of help. They should avoid romanticizing crisis, portraying suicide as inevitable, or presenting a single event as the cause of a death. Detailed descriptions of methods should never be used in public materials. The Action Alliance's recommendations for safe messaging emphasize avoiding sensationalism, using nonstigmatizing language, and including appropriate help resources. (National Action Alliance for Suicide Prevention, 2025)

Language should not promise total confidentiality. A better statement is: "Your privacy matters. We explain what stays private and when we must act to keep someone safe." This is honest and supports trust.

Core Message Framework

Every piece of communication should answer four questions:

1. What might be happening? Examples of distress and crisis warning signs.
2. What can I do now? One simple action.
3. What will happen when I contact HCYS? A clear description of response and privacy.
4. What if there is immediate danger? Emergency instructions appropriate to the jurisdiction.

Materials should be tested with young people before release. Comprehension and emotional effect matter more than whether adults consider the design attractive.

Digital Hub

The campaign needs one authoritative, mobile-first website or landing hub. It should load quickly, use plain language, and include click-to-call, text, and chat options; service hours; what to expect; emergency guidance; privacy information; language options; accessibility; and separate pages for youth, peers, and caregivers.

The site should not require an account before displaying essential help. Analytics should be privacy preserving. Health-related search behavior should not be sold, reused for commercial targeting, or combined with unnecessary identifiers.

Search Advertising

Search advertising can reach people already seeking help. Keywords may involve panic, depression, self-harm, family crisis, youth shelter, counseling, or crisis support. Ads should lead directly to the relevant page, not to a generic home page.

Negative keywords and location controls can reduce irrelevant traffic. Search-query review must be handled carefully because queries may contain highly sensitive information. Access should be limited and data retained only as necessary.

Social Media

Short video and social content can reach youth where they spend time, but paid microtargeting based on inferred mental-health vulnerability is ethically unacceptable. HCYS can use age-appropriate contextual or broad geographic targeting and partner with trusted local youth organizations.

Comments and direct messages require moderation and escalation protocols. A social-media account should not invite crisis disclosures if it is not monitored continuously. Automated replies must state response times and direct emergencies to immediate resources.

Peer-Led Communication

Young people can advise on language, visuals, placement, and credibility. Peer ambassadors may distribute information and encourage help seeking, but they need training, supervision, boundaries, and support. Their role is not to assess clinical risk.

Paid youth advisory participation is preferable to token consultation. HCYS should include diverse youth, including those with lived experience, while protecting them from pressure to disclose personal histories publicly.

Schools

Schools can display discreet posters and cards, include resources in student portals, and train staff. A campaign should not consist only of an assembly, because large one-time events may not create safe disclosure or follow-up. Training and referral capacity must exist before awareness activities.

School materials should explain how to access help without public identification. QR codes can be useful but should be accompanied by readable phone and text information for students without private device access.

Radio and Television

Local radio and television remain useful for caregiver awareness, community legitimacy, and broad reach. The original proposal recommends celebrity voice-overs. Local trust may be stronger when messages feature youth advocates, clinicians, parents, or community leaders who understand the service.

Broadcast spots should be concentrated around a clear campaign period and repeated enough to be remembered. A short message cannot explain every issue, so it should direct people to one action and a reliable hub.

Print and Outdoor Media

Transit, pharmacy, library, clinic, school, shelter, sports, and community-center placements can reach people who are not searching online. Designs should not rely on small print or a QR code alone. Cards small enough to take privately may be more useful than a dramatic billboard.

Materials need translations and accessible formats based on local need. Images should represent the community without implying that crisis belongs only to one demographic group.

Community Partnerships

Partnerships extend credibility and access. HCYS should work with youth centers, libraries, faith communities, cultural organizations, LGBTQ+ groups, disability organizations, shelters, Indigenous or tribal organizations where relevant, immigrant services, and healthcare providers.

Partners need current referral information and named contacts. A logo on a poster is not a partnership. The relationship should include training, feedback, data-sharing rules, and joint problem solving.

Crisis Intake Workflow

HCYS should establish one intake workflow across phone, text, chat, and referrals. Staff confirm immediate safety, location where needed, preferred language, consent, and the reason for contact. They use a standardized but flexible risk assessment and involve emergency services only when

necessary.

Every contact receives a documented disposition: emergency intervention, same-day clinical assessment, urgent appointment, routine referral, practical support, information, or follow-up. The system should avoid forcing youth to repeat traumatic information to several people.

Clinical and Safeguarding Capacity

Communication staff need protocols for suicide risk, abuse, trafficking, intoxication, psychosis, homelessness, and medical emergency. Clinical supervision should be available. Mandatory-reporting and duty-to-protect requirements vary, so staff need jurisdiction-specific training.

Safeguarding should not become automatic police involvement. The response must consider the young person's risk, age, family safety, disability, race, immigration concerns, and available crisis alternatives. Partnership with mobile crisis teams can reduce unnecessary emergency-department or law-enforcement use.

Lethal-Means Safety

When suicide risk is present, clinicians and caregivers can work collaboratively to reduce access to firearms, medications, or other lethal means. Messaging should frame this as temporary safety during a crisis, not accusation. Secure storage and medication management can create time for the crisis to pass and care to begin.

Public materials should not describe methods in detail. Training for caregivers can provide practical, evidence-informed safety steps privately.

Follow-Up

Connection to care is not complete when a referral is handed over. HCYS should obtain consent to follow up, confirm whether the service was reached, and help resolve barriers such as transportation, cost, wait lists, language, or caregiver involvement.

Brief caring contacts after a crisis can communicate continuity and provide another opportunity to identify worsening risk. Follow-up frequency should reflect need and service capacity.

Privacy

HCYS should collect the minimum information necessary for safety, care, operations, and evaluation. Access should be role based, and sensitive records encrypted. Communication platforms and vendors

must be assessed for health-data privacy and security.

Marketing lists should never be created from crisis contacts without explicit, separate permission. Someone who asked for immediate help should not later receive fundraising or promotional messages unexpectedly.

Accessibility

The digital hub should support screen readers, captions, keyboard navigation, high contrast, text resizing, and understandable reading level. Phone, text, and video options can support different communication needs. Interpretation and relay services should be planned rather than improvised.

Physical referral locations need accessibility. A campaign that tells disabled youth to seek help at inaccessible facilities creates false access.

Media Relations

Journalists may ask HCYS to comment on a local death or crisis trend. The organization should have trained spokespeople and safe-reporting guidance. Statements should avoid speculation, identify help resources, protect privacy, and emphasize that suicide is complex and preventable.

HCYS should not use a family's tragedy as campaign content without informed permission and careful consideration of harm. Lived experience can be powerful but should never be extracted for publicity.

Budget Strategy

The budget should prioritize service readiness before media reach. A reasonable allocation might include:

- 30% for intake staffing, clinical supervision, and extended response capacity;
- 20% for website, text/chat infrastructure, accessibility, and cybersecurity;
- 15% for school and partner training;
- 15% for paid digital and search campaigns;
- 10% for broadcast, print, and outdoor testing;
- 10% for research, youth advisory work, evaluation, and contingency.

If service capacity is already fully funded elsewhere, more can be assigned to reach. HCYS should not spend the majority on media while leaving calls unanswered.

Implementation Phases

Phase 1: Readiness

Map services, create protocols, train staff, build the digital hub, and test intake.

Phase 2: Limited Pilot

Launch in selected schools or neighborhoods, monitor demand and safety, and correct problems.

Phase 3: Community Launch

Expand channels with coordinated partner activity and media coverage.

Phase 4: Optimization

Adjust audience, messages, staffing, and referral agreements according to outcomes.

Evaluation Framework

Reach measures include impressions, frequency, website visits, completed video views, and distribution. These are process indicators, not proof of benefit.

Action measures include calls, texts, chats, referrals, appointments scheduled, appointments completed, and repeat contact. Safety measures include response time, abandoned contacts, emergency escalations, safeguarding actions, and adverse incidents.

Equity measures examine whether groups facing the highest barriers receive and complete support. Outcome measures may include distress, connection to care, school reengagement, housing stabilization, or other program-specific goals. Suicide mortality alone is too rare and influenced by too many factors to serve as the only campaign measure.

Research Design

A pilot can compare baseline and post-launch service use while examining matched areas or staggered rollout where feasible. Surveys can assess message recognition, knowledge, stigma, and help-seeking intention. Qualitative interviews reveal why young people did or did not contact the service.

Evaluation should look for unintended effects, including distress from content, overwhelming demand, privacy concerns, or inequitable emergency escalation. Youth advisers should participate in interpreting findings.

Risk Register

Major risks include:

- Demand exceeding response capacity;
- Unsafe or sensational messaging;
- Unmonitored social-media disclosures;
- Data breach;
- Inaccurate referral information;
- Partner inconsistency;
- Disproportionate law-enforcement response;
- Failure to reach youth outside school or online systems.

Each risk needs an owner, prevention action, trigger, and response plan.

Recommended Campaign Concept

A simple theme could be: “You do not have to handle this alone.” Supporting messages would differ by audience:

- Youth: “Tell us what is happening. We will listen and explain the next step.”
- Peers: “You can care without carrying this alone. Bring in help.”
- Caregivers: “Ask directly, listen calmly, and act when safety is at risk.”
- Professionals: “Recognize, respond, connect, and follow up.”

Every version includes the same phone, text, and web contact and clear emergency direction.

Conclusion

HCYS should move from a media-centered proposal to an integrated youth-crisis response. Radio, television, print, search, social media, schools, and community partners can increase awareness, but communication is ethical only when services are ready to respond. The plan requires age-specific messages, safe suicide communication, confidential intake, clinical supervision, safeguarding, follow-up, privacy, accessibility, and evaluation.

The campaign’s success is not the number of advertisements seen. It is whether young people in distress recognize the message, reach a trustworthy service, receive appropriate help, and remain

connected through the next stage of care. (American Academy of Pediatrics, American Foundation for Suicide Prevention, & National Institute of Mental Health, 2022; Substance Abuse and Mental Health Services Administration, 2023)

Works Cited

American Academy of Pediatrics, American Foundation for Suicide Prevention, and National Institute of Mental Health. *Youth Suicide Prevention Blueprint*. 2022.

National Action Alliance for Suicide Prevention. *Framework for Successful Messaging*. 2025.

Office of the Surgeon General. *Protecting Youth Mental Health*. 2021.

Substance Abuse and Mental Health Services Administration. *National Guidelines for Child and Youth Behavioral Health Crisis Care*. 2023.

World Health Organization. “Adolescent and Young Adult Health.” 2024.