Court Involved Youth and Suicide: 10 Ways We Often Get It Wrong
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Teens involved in the juvenile justice system are at higher risk to die by suicide. Discussed in this keynote address was which youth are most likely to kill themselves and the latest research on which individuals are most likely to move from thinking about suicide to making a suicide attempt. Also discussed were ways that suicidal youth involved in the justice system are not identified as at risk, ways that workers can use language and tools to help reduce youths' suicidality, and potential liability issues for workers when a youth commits suicide.

The dynamics of teen suicide are incredibly complex, making research expensive. In addition, research on risk factors predicts group behavior, not the behavior of a single individual. Standardized assessments that predict an individual's risk have not changed significantly for many years, however the work done by Dr. Boesky and others does provide insight into ways that a worker might more readily identify a suicide risk and respond in a more effective manner. Standardized suicide screenings can be helpful but lack the "conversation" that might prove most helpful in determining the youth's mindset and lead to development of a safety plan that includes finding solutions to the emotional pain that is causing the youth to consider suicide. Focus on talking with the teen about finding ways to reduce the pain; let them know that we want them to live.

The premise that "living becomes too much to bear" is often a fundamental factor in teen suicide attempts. Teens don't typically want to die—in fact most have at least some fear of dying—but want relief or escape from pain. Stressors that make life seem unbearable for teens that develop a suicide ideation include being bullied, social isolation, sleep issues, depression or bi-polar, substance abuse, and aggressiveness. A youth that is assaulted in a detention or juvenile facility setting might attempt suicide out of "impulsive aggression" as a response to being hurt.

A youth that has depression/bi-polar, substance abuse issues, *and* aggression issues is at significant risk, as are youth with sleep disorders. Likewise, an LGTBI youth who has been bullied and/or rejected—both common factors for that population—is at significant risk. It should be noted that teenagers that commit mass murders with school shootings *expect* to be killed. In addition to killing others they are committing suicide.

A sense of not belonging, real or perceived isolation or connection with others, and the sense of being a burden, thinking that others "would be better off without me", are common thoughts and beliefs of teens with suicide ideations. When the youth begins to lose his or her fear associated with dying, when scary things like guns and hanging become less scary, a suicide attempt might occur. Workers can help the teen counter the suicide ideation by providing protective factors, including:

- Hope and encouragement that things will get better; developing a therapeutic, caring relationship with the youth.

- Helping the youth identify *one thing* that if changed would help them to want to live.
- Talking with the youth to identify reasons to continue living; what and/or who would you miss if you were to die?
- Educate parents.
- Religion can be a protective factor however it can also be a risk, especially for LGTBI youth that have largely been condemned or rejected by mainstream religions.
- Keep youth involved in activities and with others.

Apart from the priority of keeping youths safe, workers need to know that they might have legal liability when a youth commits suicide in a facility. Liability in generalized, lawman's terms, can be measured as a response to the question, "What would a reasonable person have done (to prevent the suicide)?" Workers are advised to do what's best to keep the youth safe and to document all activities that they take to keep youth safe. It was also suggested that workers and employers seek out opportunities to receive training on suicide. College-educated workers, on average, have taken only eight hours of suicide prevention training in college and/or in workplace settings.

Dr. Boesky cited ways that we often "get it wrong" when assessing teens and responding to suicide risk:

- Workers might not recognize mood disorders. They may see that the youth has poor grades, is a drug user, has been bullied, and is irritable. If these symptoms are observed, professional evaluation is needed. Underneath the youth is likely to be intensely angry and sad and might have a suicide ideation.
- Workers cannot be totally reliant on a youth's self-report. Teens in the juvenile justice system have likely taken these self-report type assessments before and know how to skew the answers to mask issues. Also, workers might be looking at a suicide screening as a "once and done" event.
- Non-suicidal injury, such as cutting, might not be considered as a suicide ideation however these behaviors warrant further examination to determine the youth's intent when engaging in self-harm. There could be a co-occurring risk. The intent of self-injury can be escape from emotional pain. The intent of suicide is usually to escape from a life that is too painful to bear, which is closely related.
- Latino teens now are the highest risk group for suicide due to cultural competency and parental tradition factors.
- A break-up with a significant other when there are additional underlying risk factors can result in a suicide ideation.
- Bullying, including cyber-bullying, and resultant isolation and lack of supportive relationships with a peer group are significant warning signs.
- Sex offenders saddled with the life-long requirement to register and the resultant social labeling.
- Victims of sexual trafficking enter a facility with so many issues, such as substance abuse, truancy, and disorders, that suicide risk might be overlooked.
- Access to a lethal means to commit suicide, including car wrecks. Guns are the number one method of committing suicide when a teen has access to a usable firearm. Hanging is

the number one method, about 90% of the time, for teens that commit suicide in a facility setting.

- Workers do not have enough training on how to conduct suicide assessments, and can treat assessments as a checklist, instead of having a conversation about the answers provided in the assessment. Parents do not have enough education on suicide, and how staying connected with their teens in a supportive relationship is one key to prevention.
- Waiting too long to make referrals.

Note: A summary of a training session only provides general information on the topic as it was presented. A summary of the presentation cannot provide all the detailed information presented. Due to the seriousness of the session topic, teen suicide, it is strongly recommended that juvenile justice workers and others that work with teen populations educate themselves on this topic by participating in trainings, seminars, and/or other professional development activities that are designed to address teen suicide prevention.