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IN PRACTICE

Youth Suicide and Self-Harm: What Advocates Need to Know

by Lisa Pilnik

- Suicide is the third most common cause of death for youth age 15-19.¹
- In a national survey of youth risk behaviors, 17% of students said they had seriously considered suicide in the past year, 13% had formed a plan to commit suicide, and 8% had made one or more suicide attempts.²
- In a statewide study of high school students in Massachusetts, almost one in five reported having cut, burned or otherwise intentionally hurt themselves.³
- According to two-year findings from four states and two counties as part of the U.S. Centers for Disease Control and Prevention's National Violent Death Reporting System, in 41% of cases, investigators learned that before their completed suicide the youth had previously attempted to take their own lives and/or told someone else that they were considering suicide.⁴
- In over a third of cases, reports found youth had experienced a crisis (e.g., broke up with a girlfriend or boyfriend, argued with a parent) on the day of the suicide.⁵
- A 2006 study found adolescents who had been in foster care at some point in their lives were almost four times as likely as other adolescents to have attempted suicide and more than twice as likely to have thought seriously about killing themselves in the previous 12 months.⁶

Youth in foster care may experience many risk factors for suicide, but a caring advocate can connect them to supports that allow them to thrive despite the difficulties they've had to overcome. For teens in immediate crisis, an attentive attorney may be able to identify warning signs and ensure that they receive the mental health care they need.

Suicide Risk Factors

Risk factors, warning signs, and protective factors are variables that

Note: This article alternates the male and female pronouns, although females are more likely to attempt suicide and males are more likely to complete suicide.

influence the probability that a person will take her own life.⁷ Warning signs indicate that a person is more likely to kill herself in the near future, while risk factors relate to longer-term outcomes.⁸ (See Sidebar "Suicide Red Flags" p. 54 for more information about warning signs and suggested responses.) Suicide protective factors are qualities or experiences that decrease the likelihood that someone will kill herself. There is no formula or combination of factors that can tell us who will become a suicide victim,

explains Effie Malley, MPA, Senior Prevention Specialist with the SAMSHA-funded Suicide Prevention Resource Center. Having a greater number of or more severe risk factors *increases the likelihood* of suicide. However, having a greater number of or stronger protective factors *decreases the likelihood* of suicide. Risk factors are also compounding, says Malley, meaning that having multiple risk factors can make each one have more of an impact than it would alone.

These factors need to be looked at in the context of each young person and her life (because two adolescents with the same risk factors may be impacted differently by them), together with the warning signs. A mental health professional may also need to evaluate and assist the teen.

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Suicide Red Flags

The American Association of Suicidology convened an expert working group that reviewed existing resources and developed the following suicide warning signs and responses:

Warning Signs for Suicide and Corresponding Actions*

Call 9-1-1 or seek immediate help from a mental health provider when you hear, say or see any of these behaviors.

- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person Seek help by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral should you witness, hear, or see anyone exhibiting any one or more of these behaviors
- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family, and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

*Source: American Association of Suicidology

If a young person you represent is in an acute crisis, you can also follow these guidelines from the American Foundation for Suicide Prevention:

- Take him to a psychiatric hospital or emergency room.
- Stay with him until he gets help.
- Remove any lethal means (firearms, drugs or sharp objects) from his vicinity.
- Understand that he may need to be hospitalized until the crisis is over.
- Call 911 or the National Suicide Prevention Lifeline at 1-800-273-TALK if you cannot do any of the above.**

** Source: American Foundation for Suicide Prevention. "When You Fear Someone May Take Their Own Life." Available at www.afsp.org/index.cfm?fuseaction=home.viewpage&page_id=F2F25092-7E90-9BD4-C4658F1D2B5D19A0 (last accessed May 21, 2008).

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Advocates should pay close attention to the risk factors and protective factors the youth on their caseload have, and work to decrease risk factors and increase protective factors (see "How to Help Troubled Youth," next page). They should also watch for warning signs and take appropriate action (see "Suicide Red Flags" for specifics).

Risk factors for suicide that may

apply to youth in care include:

- mental illness (e.g., depression, anxiety),
- alcohol or other drug dependence,
- previous suicide attempts,
- exposure to others who have completed suicides or a family history of suicide (having a classmate, friend, or family member, or someone they know

and identify with die by suicide has a greater impact on youth than on adults),

- tendency towards aggression or impulsiveness,
- past abuse or other trauma (e.g., physical, sexual, or emotional abuse),
- loss of an important relationship (e.g., loss of contact with a mentor, breakup of a friendship, fear or anticipation of a loss),
- access to pills, guns or other means of self-harm such as having nonprescription or prescription drugs or firearms and bullets in the home,
- certain physical illnesses (e.g., diseases that cause chronic pain, facial disfigurement, treatments that are frequent and invasive like dialysis),⁹
- stressful life events, such as getting into trouble with the police, or fear of being punished,
- inadequate or neglectful parenting,¹⁰ and
- having a mentally ill and/or substance abusing parent.¹¹

Many or most youth in foster care will have one or more of these risk factors. Remember, having them does not mean that a young person *will* take his own life. It simply means that he is at greater risk and needs both careful assessment and a reliable support system. Fortunately, protective factors may be more influential than risk factors and are an area where advocates may be able to have a greater impact. Although you can't change a family history of suicide or undo the loss of a key relationship, you can connect a youth to an effective treatment program or a supportive care provider.¹² One national study of adolescents found those with three protective factors had a 70% to 85% lower risk of suicide attempt, whether or not they had risk factors.¹³

Risk and protective factors are dynamic, meaning they are always

changing, says Malley. As a foster youth switches schools, foster families, and experience other changes, their risk and protective factors change. Having one close, caring adult in a foster youth's life can be a key protective factor for these young people, suggests Malley, and the impact of having that kind of relationship may be even greater once the adolescent has aged out of care and has fewer other supports. Good peer relationships also benefit foster youth, Malley adds. Other protective factors for youth include:

- effective mental and physical health care and substance abuse treatment
- consistent and supportive relationships with health care providers
- problem-solving and conflict resolution skills¹⁴
- support from and connections to family and community (e.g., one study found that “adolescents who reported that they discussed problems with friends or family members, were in good emotional health, or had a sense of connectedness with family were much less likely to have attempted suicide.”¹⁵)
- a feeling of control over one's own destiny
- spiritual faith
- a positive school experience
- an adaptable temperament¹⁶

How to Help Troubled Youth

“You don't need to be a mental health professional to have an impact,” says Peggy West, Ph.D., M.S.W., a senior advisor to the SAMSHA-funded Suicide Prevention Resource Center. Use the tips below to identify and help suicidal youth, to reduce suicide risk factors and increase suicide protective factors for youth.

Meet In Person. You'll get many more cues when you see a teen face-to-face, Dr. West explains. Changes in behavior, cut marks or bandages on a young person's wrists, or the smell of

Promising Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) funds national suicide prevention work, such as the Suicide Prevention Resource Center (www.sprc.org) and the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org), as well as efforts by 38 states and tribal organizations.

Several grantees are currently trying to get their local child welfare agencies to include suicide prevention information in their foster parent training curriculum. Two state programs supported by SAMHSA include:

Youth Education and Support (Y.E.S.) Project works to decrease suicide and suicidal behavior among youth in foster care in Massachusetts. The project provides training to foster parents, kinship caregivers, and Department of Social Services caseworkers on suicidal behavior and how to identify and respond to warning signs.

Project Connect addresses the higher risk of suicide among youth involved with the juvenile justice system in New York. This project provides probation officers training on mental health issues faced by adolescents, appropriate treatments, and strategies to work effectively with families and mental health providers.

For more information about SAMHSA-funded suicide prevention programs, visit www.sprc.org/grantees/index.asp.

alcohol are causes for concern that you wouldn't pick up over the phone. Youth who are withdrawn and noncommunicative, the ones you just can't get to talk, and who won't make eye contact are probably internalizing the bad things that have happened to them, says Dr. West. These adolescents may not necessarily be suicidal, but they should be evaluated by a mental health professional.

Ask Direct Questions. If you are concerned about suicide don't be afraid to ask if your client is considering suicide, or if she has made a plan or taken any steps towards suicide. Asking doesn't increase the risk that a young person will attempt suicide, explains Dr. West. Avoid asking in a way that is abrupt or intrusive, however, as you could disrupt your rapport with the youth and make it less likely that he will share his mental health concerns.¹⁷

Try asking open-ended and non-threatening questions until the adolescent is more comfortable (e.g., “How

are things going at home”).¹⁸ Being able to talk through their problems will reduce the risk. If a youngster admits she has been thinking about suicide and has made a plan or taken steps (e.g., stored up pills or obtained a weapon), she is at high risk, says Dr. West, and needs to be supervised until help is secured. She needs an immediate mental health assessment and further mental health services.

For a teen who has thought about suicide but has not taken any steps, ask more questions:

- Has the young person thought about and rejected the idea?
- Were the suicidal thoughts recent or a long time ago?
- How seriously has the youth considered suicide?
- Are the problems in her life getting worse or better?

If any of these answers raise concerns, you can have the teen see a mental health professional or you can get more guidance on how severe the

risk is and how to react (see “Call for Help,” next page). It’s also important to keep in frequent contact, and make sure other adults check in regularly.

Listen, Listen, Listen. Being direct, asking questions, and most importantly listening to young people shows you care. This is one of the best ways you can support them in difficult times. Also, explain to your client that he can come to you with problems, even if they are things he’s already discussed with his caseworker. Children often don’t understand the roles of different adults well enough to know who they should tell what, explains Dr. West, and may assume that if they tell one adult something, all the adults in their life will have that information.

Share Your Knowledge. Having a greater number of risk factors or warning signs is cause for more serious concern, but you may not be in a position to see all of your client’s behaviors. Tell other adults who have more regular contact or longer relationships (e.g., caseworkers, treatment providers, foster parents) when you observe something troublesome, and ask them if they’ve noticed changes in the teen or other risk factors or warning signs. All advocates should ask youth for permission before sharing concerns with others, but a child’s attorney *cannot* disclose this information unless the client has given permission or disclosure is otherwise permitted by your state’s ethics rules (e.g., if a client has diminished capacity). Even if an exception to the confidentiality restrictions applies, you will need to balance the benefit of alerting others to watch for warning signs and provide help and services with the harm that disclosure may do to your relationship with your client and her willingness to trust and confide in you.

Watch for Warning Signs in Younger Clients. Michael Pines, Ph.D., clinical psychologist, consultant, and co-chair of the Los Angeles County Child and

Two Advocates, Two Stories

A tragic loss

Tonya came into care at age 14 because of sexual abuse by her mother’s boyfriend. Many of her family members did not believe she’d been abused, and those who did were not stable enough to care for her. At age 16 she was living with a therapeutic foster parent, and varied between stable and difficult times, often running away from her foster home.

Laura, Tonya’s guardian ad litem (GAL), advocated for a new caseworker because the current caseworker wasn’t meeting Tonya’s needs and securing necessary services. The replacement caseworker was male, which was difficult for Tonya because of her past. At a family support meeting, during which Tonya was confronted about some of her behaviors, Tonya got a knife, threatened to hurt herself, and locked herself in a room. The police were called and an ambulance came, but Tonya ultimately remained in the home. Laura also learned during this meeting that Tonya had previously been hospitalized for a sexually transmitted disease, and the hospital staff had concerns about her mental health. Laura felt that Tonya should be hospitalized, but the rest of the team disagreed. Laura deferred to them because she thought they saw Tonya more often and therefore knew her better.

After that incident, Tonya’s behavior deteriorated; she ran away more, skipped school, and began meeting with people from a phone chat line. Laura wanted Tonya to be placed in a residential treatment facility (RTF) but the case manager said no beds were available. Laura later learned he was only looking at facilities his agency contracted with, but Tonya could have been placed elsewhere. While Laura was trying to have Tonya moved to an RTF, the foster mother reported that Tonya had run away. In fact, Tonya had taken her own life in her bedroom at the foster home, and was not discovered for several days.

Looking back, Laura sees several places where systemic problems kept Tonya from getting the help she needed:

- The case manager was new and not receiving much direction or supervision.
- The agency had a financial incentive to keep her in the community.
- GALs and attorneys were often “out of the loop.” As a result, Laura did

Adolescent Suicide Review Team, says that although the majority of the 20-30 youth suicides his team reviews each year are by high school students, his team sees one or two 9- or 10-year-old suicide victim(s) each year. The American Association of Suicidology also reports there were 283 suicide victims age 10-14 in 2004.¹⁹ Connecting at-risk youth to appropriate support at younger ages can also make sure they enter adolescence with as many protective factors as possible.

Request Regular Mental and Physical Health Check-ups. The Ameri-

can Academy of Child and Adolescent Psychiatry recommends all children and teens be screened for mental health issues and drug use within 60 days of entering foster care (or sooner if the child’s need is greater).²⁰ Youth should be reassessed at least once a year.²¹ Since youth may change medical providers when they change homes, they don’t always receive necessary follow-up. A new assessment can catch problems that were not adequately dealt with, even if they were previously identified. Facilitating regular physical and mental health assessments for young people is also a way to make sure they get necessary

not receive vital information that would have allowed her to best focus her advocacy for her client.

- The hospital's concerns about Tonya's mental health were not acted on (Laura believes the hospital informed the caseworker but he was too inexperienced and did not receive enough supervision to address them accurately).

A crisis averted

Dena Johnson represented Joanna for several years. During that time Joanna had bounced among several foster homes, but she was currently living with her grandmother. One day, during a routine planning meeting, Dena noticed that Joanna seemed jumpy and unlike her usual self. Dena asked the group to take a break so she could speak to her client privately.

When asked what was wrong, Joanna talked about a number of problems, including conflicts with other students at her school and a recent argument with her grandmother. Dena remembered once hearing that if you were concerned that someone was thinking of harming herself, you should ask about it directly, so she asked Joanna if she was considering hurting herself. Joanna confessed that the night before she had looked through her grandmother's medicine cabinet for prescription drugs she could take. Dena was not sure if Joanna was telling the truth, but she asked Joanna if she wanted Dena's help, and if it was okay to talk to her caseworker about what Joanna had told her.

Joanna agreed, and the caseworker called a mental health hotline. The hotline staff did a phone screening and discovered other risky behaviors and sent her to a local facility for an in-person evaluation. Joanna was then referred to an inpatient facility. Dena accompanied Joanna and the caseworker to the facility to be supportive, but when they arrived, the facility did not want to admit Joanna without her mother's signature. Since her mother was not available, Dena had to convince the facility that under state law Joanna had the legal authority to authorize her own treatment under the state's minor consent law.

As a result of the advocacy by her attorney and caseworker, Dena received the mental health care she needed.

Note: All names and identifying details have been changed.

care early enough to prevent bad outcomes, explains Dr. West. Advocates can also ensure foster youth keep the same health providers whenever possible, even if caregivers or placements change.

Call for Help. The National Suicide Prevention Lifeline—1-800-273-TALK (8255)—isn't just for individuals considering suicide, it is also a resource for those who want to help someone in crisis. You can get advice if you are concerned about a client, or obtain referrals to local mental health or other services. They can also help with

other crises, such as homelessness, substance abuse, violence and loneliness.

Ask About Lethal Means. Find out whether foster homes, group homes, and residential treatment facilities have firearms or potentially lethal drugs, and how accessible they are to teens. Although firearms are decreasing as a means of youth suicide (as the category hanging/suffocation are rising), they are still the most common method, according to some studies.²² Research has shown that youth often know where firearms are hidden and/or how to get into locked cabinets to reach

them. Visit www.meansmatter.org for research and practical information about the link between suicide and lethal means.

Help Change the System. Taking time to share information with other attorneys can help identify larger issues. Are there agencies that never seem to find residential treatment beds for their children? Are caseworkers unable to meet court orders for mental health needs because of a lack of local providers? Systemic barriers can reduce access to suicide protective factors (such as effective mental and physical health care), which could increase youth suicide. By working with other professionals (informally or through your local bar association or children's advocacy organization) you can create policy changes that will lead to better outcomes in your cases.

State and local child death review teams analyze all youth deaths (including suicide) and offer prevention recommendations based on the trends they identify. For example, a state team may see multiple cases in which several students in a school took their lives after a classmate's suicide (known as a cluster suicide). They may use this information to suggest that the state provide support programs to friends of suicide victims. Find your state's team at www.childdeathreview.org/state.htm.

You can also advocate for your jurisdiction to require foster parents to lock up medications and weapons, if such a rule is not already in place. Be aware, however, that in some states only the state legislature, not an administrative agency, can regulate firearms.

Also, most states hold trainings on mental health and suicide prevention for people who work with high-risk children. Advocate for foster parents and children's attorneys to be included in these trainings and for suicide to be discussed in your jurisdiction's foster parent certification programs. To learn about current suicide prevention efforts in your state, visit www.sprc.org/stateinformation/index.asp.

Take Deliberate Injuries Seriously. Many adolescents harm themselves in varied ways, including cutting, burning, scratching or biting their skin, pulling out hair, banging their heads, or giving themselves bruises, brands, abrasions or other marks.²³ Some behaviors are a statement of identity or a result of peer pressure, but they may also be a cry for attention, an expression of desperation or hopelessness, or a result of suicidal thoughts.²⁴ No matter what the cause, intentional self-harm should be addressed with youth, and evaluated by a mental health professional.²⁵

Promote Connections. Transitions, such as the end of a relationship, a move, or changing or leaving school, are risk factors for youth that Dr. Pines says he sees in more than half of the suicide cases he reviews. Youth in foster care are more vulnerable because it's difficult to form lasting attachments when they move so much. Try to minimize the number of transitions youth make, and when changes do happen, lessen their impact as much as possible (e.g., by ensuring a child stays in the same school, and goes to the same physical and mental health care providers).

Remember, continuous relationships with caring adults are an important protective factor for at-risk teens. Find out who the important adults in your clients' lives are and help them stay connected. Let a teen call an out-of-state aunt from your office if long distance charges are an issue. Encourage caregivers to allow youth to maintain afterschool jobs despite placement changes if there are mentors there. Work with caseworkers and foster parents to match a child with a Big Brother or Big Sister. In court, advocate for visitation and other contact with important adults, even if they aren't blood relatives. The more reliable, nurturing adults a child or teen has to go to in difficult times, the better off they are.

Research Relevant Law and Push

for Services. Know your jurisdiction's rules for who can consent to mental health care for youth in foster care. Keep copies of relevant statutes easily accessible in case you need to convince a treatment facility to make an emergency admission. Also, when a possibly suicidal teen needs inpatient treatment, push agency workers to find a bed immediately. Make it clear that they need to look beyond the usual providers if those spots are full and find a safe place for the young person to receive care. If there are no mental health beds available, the American Foundation for Suicide Prevention recommends that the adolescent be brought to an emergency room or psychiatric hospital.²⁶ Also review your jurisdiction's ethics rules to determine how confidentiality issues apply in situations where there is potential danger to your client and/or you have concerns about your client's mental capacity. It's always preferable to get your client's consent to tell other service providers what she's confided about suicidal thoughts or attempts, even if sharing the information is allowed under the ethics rules.

Trust Your Instincts. If your opinion differs from the foster parents' or caseworker's, speak to a supervisor or a mental health professional, advises Dr. Pines and make sure your client can contact you directly if she needs you. Also make sure she has the number of another trusted adult or a crisis hotline in case you are not reachable.

Show You Care. Spending time and being willing to talk and listen shows children you value them. Take time to explain your role, the roles of others involved in the case, and what might happen in the courtroom. As discussed above, a sense of control over one's life and feeling connected to and having close relationships with others are protective factors. A 13-year-old who has been involved in the child welfare system since she was 8 may still misunderstand basic things,

because they were only explained when she first came to the court's attention and she was too young to understand them, says Dr. West. She also advises that advocates listen to questions, don't just anticipate, because children often have questions that are different than you'd think they have. Many children and teens believe that their situation is due in part to their "being bad" or not trying hard enough. It's important for advocates to make clear that involvement in an abuse or neglect case is in no way the child's fault.

Address Your Own Stress. Working with youth in crisis on a daily basis can take its toll on child advocates. Although most legal professionals work incredibly hard on behalf of their clients, sometimes bad outcomes cannot be prevented, and you have to make peace with that. Use stress reduction methods to combat daily frustrations. If you are in crisis or considering harming yourself, contact your local lawyers assistance program (a partial list is available at www.abanet.org/legalservices/colap/lapdirectory.html, and you can also ask your local bar organization) or call 1-800-273-TALK (8255).

As you work with adolescents in the child welfare system, you are in a position to identify youth who may be at immediate risk for suicide and connect them to help. You can also advocate for all youth you represent to have as many of the suicide protective factors as possible to decrease their risk of an attempted or completed suicide now or later in life. For young people who are at risk for suicide, or who have attempted suicide, you can help them receive necessary services.

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Suicide and Self-Harm Among Sexual Minority Youth

Sexual minority youth often feel isolated and sad, putting them at risk of self-harm. Studies show teens who identify as gay, lesbian or bisexual are more likely to have suicidal thoughts, and to have attempted suicide. Other factors that may put sexual minority youth at risk for suicide or other self-harm, are:

- nonconformity with traditional gender roles;
- fears or rejection related to coming out (particularly young children),
- harassment or other victimization related to sexual identity, and
- stressors such as lack of family or community support.

Protective factors may help counter these risks, including:

- support from families, communities and schools (e.g., parental acceptance, school antibullying programs);
- intellectual, athletic or artistic abilities that increase self-esteem;
- participation in social networks such as a chapter of Gay-Straight Alliance, Project 10, or Parents, Families and Friends of Lesbians and Gays;
- positive portrayals of sexual minorities in the media; and
- coping mechanisms.

Adults working with these youth must be supportive, nonjudgmental, and sensitive to their identities and needs. (For advocacy tips, see *CLP's* "Opening Doors" series.)

Resource: The Trevor Helpline, a 24-hour confidential suicide prevention hotline for gay and questioning youth. Call 866-4-U-TREVOR, or visit www.thetrevorproject.org/helpline.aspx.

Sources: "Suicide Risk and Prevention for Lesbian, Gay, Bisexual and Transgender Youth" (forthcoming article from the Suicide Prevention Resource Center by Effie Malley); *The Trevor Project Helpline Training Manual*, 2008.

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