



## Briefing on Interventions for High Risk Populations

### Identifying Populations Disproportionately Affected by Suicide

A "high risk population" is a group that is disproportionately affected by suicide. While suicidal thoughts and behaviors are more common in certain populations, suicide risk is not inherently tied to identifying as part of that population. While this briefing will focus on risk, it is also valuable to consider how protective factors (e.g. faith and community connectedness) can be stronger in certain groups as well.

High risk can be defined in several ways:

- Large numbers of suicide deaths or attempts
- Higher rates of deaths or attempts (e.g. white males-deaths, Latina females-attempts); rates are calculated as a proportion of a particular group, so higher rates indicate a disproportionate impact from what might be expected if suicide were evenly distributed in a population group
- those that have high percentages of suicidality as a percentage of the population (such as transgender individuals)
- Upward trends in numbers or rates within a population group; surveillance and regular review of data can detect trends

Sources:

- [National Action Alliance Framework for Successful Messaging](#)
- Suicide Prevention Resource Center: [Risk and Protective Factors](#)

### Sources of data to identify populations disproportionately affected by suicide

Mortality (deaths that were confirmed to be suicide) and Morbidity (non-fatal, intentional self-injuries) data originates from Coroner/Medical Examiner reports, and hospitals and Emergency Department databases. It can be obtained locally through relationships and agreements or retrieved from the California Department of Public Health's [EpiCenter](#) web site and [County Health Status Profiles Reports](#). Nationally the CDC compiles similar information for states and counties and can be retrieved from the [WISQARS](#) and [WONDER](#) databases. WONDER includes a broader range of public health data whereas WISQARS is focused on fatal and nonfatal injuries.

Note that Morbidity data is not the same as "suicide attempt data"; not all intentional self-injuries are suicide attempts, and not all suicide attempts lead to medical treatment. Mortality and Morbidity data are both externally verifiable, whereas other data sources rely on self-reporting and are not externally verifiable.

While mortality and morbidity data are primary sources, it is equally important to look at data on circumstances surrounding suicide in order to inform prevention strategies. CDC data was used to inform the [June 8th, 2018 Morbidity and Mortality Weekly Report](#) that found suicide rates increasing in most states. This report also found that the majority of people who died by suicide did not have known mental health conditions, but that other problems often contribute to suicide, such as relationship problems, substance use, physical health challenges, and stress related to employment, finances or housing.

Co-morbidity data includes factors such as behavioral health or health conditions that are related to the suicidal behavior. It can also provide information about risk and protective factors (factors are more correlated with suicide - risk factors- or less correlated with suicide - protective factors- when large numbers of cases are studied across populations).

A primary source of co-morbidity data is the [California Electronic Violent Death Reporting System](#), which is modeled on [CDC's National Violent Death Reporting System](#) and provides detailed information on violent deaths, including homicides and suicides. The system links data from vital statistics death files, supplementary homicide reports from the California Department of Justice, and coroners' investigations. Currently the following counties participate: Alameda, Kern, Los Angeles, Monterey, Riverside, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Shasta, Solano, Stanislaus, and Yolo.

Co-morbidity and Risk and Protective Factor data can also be found from surveys. Survey results are based on self-reports, and so are not externally verifiable, but can be informative. National surveys that report data on the state level include the [Behavioral Risk Factor Surveillance System](#) (adults), [Youth Risk Behavioral Surveillance System](#) (high school students), and [National Survey on Drug Use and Health](#) (ages 12 and over). Within California, the [California Health Interview Survey](#) conducts separate survey modules for children, teens, and adults; currently only the adult and teen modules contains questions about suicide. The [California School Climate, Health, and Learning Surveys](#) (includes the California Healthy Kids Survey, California School Staff Survey, and California School Parent Survey).

Additional sources of data include measures of help seeking such as call volume to hotlines and warm lines, and service usage. Qualitative data can be compiled from Suicide Death Review Teams, psychological autopsies, and community needs assessments that includes strengths and gaps analysis. The CDC [WISQARS](#) website also compiles cost of injury and leading causes of death data.

### Reaching Populations Disproportionately Impacted by Suicide

A comprehensive approach to suicide prevention includes a broad range of prevention, early intervention, treatment and postvention strategies that take into account the developmental trajectory of the suicidal crisis path. Targeting strategies for populations disproportionately

affected by suicide applies this framework to a subset of the general population that is more likely to experience risk factors for suicide. The framework includes:

#### Examples of Settings

- Workplaces
- Courts, jails, prisons
- Primary care, hospitals, ERs
- Aging services, senior living communities
- Social services, housing assistance programs
- Schools, universities
- Substance abuse programs
- Religious/faith organizations

#### Examples of Strategies to Impact Change

- Campaigns, education, and policies that help reduce stigma around suicide, mental health challenges, and help-seeking; reducing access to lethal means
- Promoting connectedness and reducing isolation through community programs
- Suicide prevention training for key gatekeepers in settings where people with risk factors are more likely to be present
- Suicide prevention and crisis plans within key settings
- Integrated mental health services and supports where people are already going for other types of help
- Outreach and education in non-traditional settings to reach higher risk populations, and their helpers, with positive messaging and information about resources

#### Sources:

- Caine ED (2020). Building the foundation for comprehensive suicide prevention – based on intention and planning in a social–ecological context. *Epidemiology and Psychiatric Sciences* 29, e69, 1–3. <https://doi.org/10.1017/S2045796019000659>
- University of Rochester Center for the Study & Prevention of Suicide, Washington, DC: Scientific Consensus Conference, June 11-12, 2003. 12p. ([http://www.sprc.org/sites/default/files/resource-program/SPRC\\_MiMYReportFinal\\_0.pdf](http://www.sprc.org/sites/default/files/resource-program/SPRC_MiMYReportFinal_0.pdf))
- CDC, [Preventing Suicide: A Technical Package of Policies, Programs, and Practices](#)

### Men in Middle Age and Older

Although men in middle age (35-64 years of age) comprise 19 percent of the population, they account for 40 percent of suicide deaths in the U.S. From 1993-2013, 78% of the 73,705 Californians that died by suicide were male. The majority were White (70%), followed by Hispanic (17%) and Asian/Pacific Islander (8%). The rate and number of suicides among adults aged 35-64 has been increasing nationally. In California, one-third of men who die by suicide

are between the ages of 45-64, and men account for 40% of hospitalizations or Emergency Department treatment due to self-inflicted injuries.

Sources:

- California Department of Public Health, [EpiCenter](#)
- Centers for Disease Control, "[Suicide among adults aged 35-64 years—United States, 1999-2010.](#)" MMWR, May 3, 2013

There are challenges with reaching men as a group. They are dispersed throughout communities; no agency or system is dedicated to promoting men's mental health; and signs of distress may be concealed or misinterpreted. However, given the highly disproportionate impact of suicide on men, making progress toward any goal of reducing suicide requires a substantial focus on men. Strategies require engaging new, non-traditional partners (workplaces, local businesses, gun shops, firing ranges) as well as more traditional ones (primary care, hospitals/emergency departments).

National initiatives such as [Men's Mental Health Month](#) and [Movember](#) are helping to raise awareness about health issues impacting men. In California the [Captain Awesome](#) campaign in Shasta County is specifically designed to reach men with positive and inspiring messaging about mental health. Captain Awesome was initially inspired by [Man Therapy](#), a highly successful campaign in Colorado that is focused on working aged men (25-54 years old).

Captain Awesome campaign ads feature real men from the community who have volunteered to share their photos along with their personal story of recovery and resiliency in the face of life challenges. The ads drive people to the campaign web site, which includes information about mental health conditions, maintaining mental health, and local resources. Shasta County Health & Human Services, which developed the campaign, has also convened a Men's Advisory Group to review draft materials and provide input about messaging and images to ensure cultural competence and strong appeal to the target population.

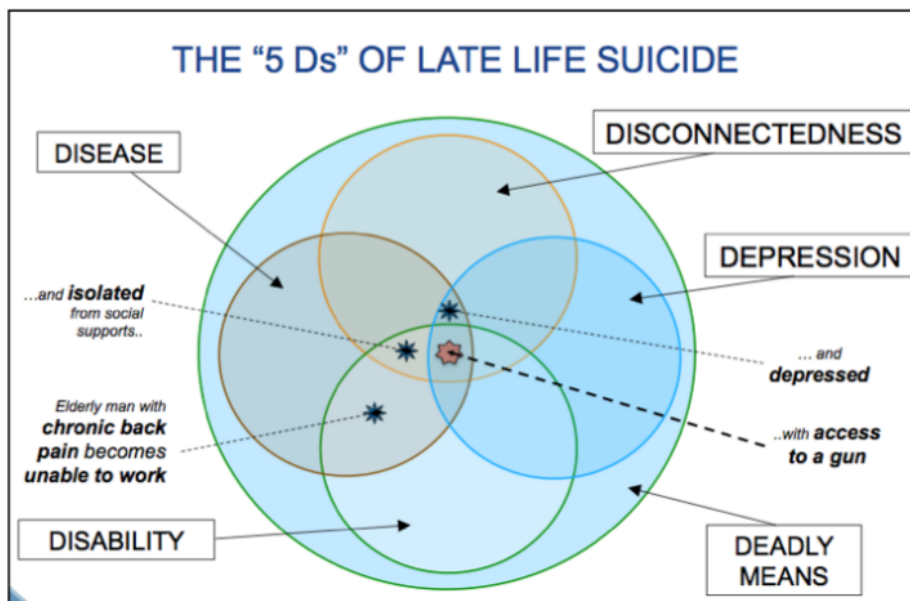
- Find resources and materials to support suicide prevention among men in the [Know the Signs 2017 Suicide Prevention Week Toolkit with a focus on Men in the Middle Years](#) and the [Each Mind Matters collection of resources to address men's mental health concerns](#)

## Older Adults

Data consistently shows that suicide rates are highest among middle aged and older adults. Suicide rates are particularly high among older men, with men ages 85 and older having the highest rate of any population group. Higher frailty among older adults means that suicide attempts are more likely to result in death than attempts among younger people. Older adults often plan more carefully and use more lethal means, such as firearms.

Although numerous cultures around the world and some cultural groups within the United States revere older adults for their experience and wisdom, many Americans—even older Americans—tend to regard the aging process negatively, and there is a substantial focus on and value for youth and youthfulness. These attitudes contribute to misconceptions that depression and even suicidal thinking are inevitable parts of aging. These attitudes can become barriers to recognizing warning signs and seeking help for conditions that are treatable. The gerontological literature suggests that for many, well-being, satisfaction in relationships, frequency of positive emotions, all improve with age.

The graphic below depicts the complex interplay between risk factors that are more commonly seen in older adults.



Source: Adapted from Conwell, Y. (2013). Suicide and Suicide Prevention in Later Life. *Focus* 11(1), 39–47. Reprinted with permission from FOCUS, (Copyright ©2013). American Psychiatric Association. All Rights Reserved.

A public health approach to preventing suicide among older adults includes strategies to promote protective factors across the population along with identification of opportunities to intervene (such as primary care) and interventions to address and treat sources of risk.

- Shift cultural norms around aging
- Reduce stigma and encourage help-seeking
- Reduce isolation and increase connection and purpose
- Improve screening and early identification of behavioral health conditions and suicidal ideation into services often utilized by older adults (e.g. primary care)
- Link and integrate primary care, aging services, and behavioral health support to weave a community safety net

Sources:

- [Suicide Prevention Resource Center: Older Adults](#)
- Conwell Y, K Van Orden, and ED Caine. Suicide in Older Adults. *Psychiatr Clin North Am.* 2011 June; 34(2): 451–468. doi:10.1016/j.psc.2011.02.002

California is fortunate to have the [Friendship Line](#), the only accredited crisis line in the country for people aged 60 years and older. Based in San Francisco but with a much broader reach, the service is free and available 24 hours per day. The Friendship Line offers crisis intervention as well as a warm line for emotional support. In addition, the Friendship Line offers:

- Elder abuse reporting
- Well-being checks
- Grief support through assistance and reassurance
- Information and referrals for isolated older adults, and adults living with disabilities
- Referrals for these services can be made by calling the business line or through an online form.

In 2019 Santa Clara County launched a campaign designed to reach older adults. Ads are placed in a variety of media outlets that drive people to the hotline and [campaign web site](#), which includes information about warning signs, how to help and resources specific for older adults. Tabling and outreach in community settings frequented by older adults are also used to get the word out about the campaign. The Santa Clara County Suicide Prevention Oversight Committee monitors call volume and web site traffic to determine if the goals are being met.

- Find resources and materials to support older adult suicide prevention in the [Know the Signs 2016 Suicide Prevention Week Toolkit with a focus on Older Adults](#) and the [Each Mind Matters collection of resources to support older adult mental health](#)
- [Know the Signs older adult brochure](#)
- [Know the Signs older adult billboard](#)

Isolation is a primary risk factor in older adult suicide. Community-based programs that reduce isolation, increase purpose and connection, and offer linkages to support and treatment can reduce risk and promote protective factors.

[Meals on Wheels](#) provides free or low-cost meals to older adults in their homes. Meals on Wheels volunteers provide connection for isolated older adults, and volunteers are in a great position to recognize problems early and connect people to services and supports then they are trained to do so.

In-home visitor programs provide homebound seniors with weekly “social visits” by screened and trained volunteers. In addition to emotional support and companionship, volunteers can provide information about resources and are also in a position to recognize and respond to suicide risk.

- [Seniors First](#) Friendly Visitors Program in Placer County

- San Mateo County [Volunteer Visitors](#) Program
- Southern CA Council on Aging [Friendly Visitor](#) Program

Inter-generational programs bring older adults and young people together for shared activities. Activities can range from reading to children, to cooking, gardening, arts & crafts, games, or exercise. Studies have shown that older adults who participated in intergenerational programs increased several measures of wellness, such as a sense of meaningfulness, ability to manage their challenges, and reduction in symptoms of depression.

- [Time Out @ UCLA](#) brings college students together with older adults for a range of activities and is offered free of charge to participants.
- [Generations United](#) is a national network of organizations that promote wellness across the lifespan, especially through intergenerational connection & collaboration, and has programs in many communities as well as models that can be implemented.

Up to 45% of individuals who die by suicide have visited their primary care physician within a month of their death; additional research suggests that up to 67% of those who attempt suicide receive medical attention as a result of their attempt. Given these statistics, primary care has a lot of potential to help prevent suicides. Many older adults frequent primary care providers and settings, and often have long-standing relationships with their primary care providers, so programs in the primary care setting are key to reach and support this population. Healthcare professionals are more likely to recognize and respond to older adult depression and suicide risk if they have the tools for screening and referral.

The [Suicide Prevention Toolkit for Primary Care Practices](#) includes the information and tools necessary for physicians as well as others in the primary care setting to enhance their ability to connect at-risk adults to needed services and supports. The Toolkit includes screening tools as well as resources to develop an office protocol around what to do to support a high-risk patient.

Based on this toolkit, [Know the Signs](#) developed the [Suicide Prevention in Primary Care Settings Training Resource Guide](#) that includes a brief one-hour presentation and all the materials necessary to conduct the presentation in a primary care setting. This guide is a great resource for you as you work to develop partnerships for suicide prevention with primary care providers in your area.

The [Older Adult Hopelessness Screening Program](#) was developed by Tulare County Health and Human Services Agency, to assess levels of hopelessness in older adults and provide early intervention services to reduce suicide risk, improve quality of care, and prevent the onset of serious mental illness. It is a universal screening program, meaning all adults 55+ receiving primary health care services are screened for hopelessness and suicidal intent. Based on the results of the screening, participants are offered ongoing support, case management, short-

term intervention, and warm linkages to local services that can help improve social, physical, environmental, emotional, and financial wellness.

The [Program to Encourage Active, Rewarding Lives \(PEARLS\)](#) is an evidence-based program for older adults with depression or dysthymia, to reduce symptoms of depression and suicidal ideation and improve quality of life. PEARLS was created in partnership between the University of Washington and the Seattle/King County Area Agency on Aging. The program uses behavioral techniques to enhance problem-solving, participation in social and physical activities, and identification of and involvement in pleasurable activities of interest to each client. The program is delivered in 6 to 8 sessions by a trained health or social service professional in the client's home or other community-based setting. An evaluation of the PEARLS program found that individuals who received the PEARLS Program were more likely than those who did not receive PEARLS to have a significant reduction in depressive symptoms and greater health-related quality-of-life improvements. The evaluation also found a trend toward lower hospitalization rates.

- The [PEARLS Toolkit](#) includes detailed guidance for implementing the program. The toolkit can be downloaded and used at no cost, however users are encouraged to invest in a [training](#) before implementing a program.

### Military Veterans and Their Families

Military veterans are more likely to experience certain risk factors than the general population. The course of their duties often involves frequent and lengthy deployments, sometimes to hostile environments (though deployment to combat does not necessarily increase risk). They are often exposed to extreme stress, not just during deployments but also including physical/sexual assault while in the service (not limited to women). Service-related injuries can exacerbate challenges that elevate risk. Finally, veterans typically have ready access to and familiarity with firearms which can increase lethality of a suicide attempt. Suicide prevention strategies that focus on veterans should also include services and supports for their families, who often experience stress and hardship related to the challenges the veteran is experiencing as well as deployments. The [CaSCHLS](#) survey (formerly known as the *CA Healthy Kids Survey*), shows higher levels of self-reported suicide ideation among youth who have parents serving in the military.

#### Sources

- [\*Understanding the Military and Veteran Culture\*](#). David Weiner, Retired Chief of Police, Long Beach Veteran Affairs and currently CEO of Secure Measures, LLC
- [\*Los Angeles Suicide Prevention Summit 2019: PowerPoint Presentations and Recordings\*](#)

The [Mayor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families](#) is a partnership between SAMHSA and the Department of Veterans Affairs to encourage states and communities to implement targeted suicide prevention practices for



service members, veterans and their families using a public health approach. The Challenge engages leadership across agencies to implement action plans modeled on the CDC's [Preventing Suicide: A Technical Package of Policies, Programs and Practices](#). This approach serves as model that can also be used for other higher risk populations.



## First Responders

There is no consistent data source for tracking suicide deaths or suicide attempts among first responders (therefore a suicide rate is difficult to calculate). However, various reports and studies have shown that first responders are more likely to die by suicide than in the line of duty. Other studies have shown that suicide ideation and attempts rates for first responders are higher than general population. Very few studies examine EMTs (Emergency Medical Technicians) or individuals who serve as dispatchers.

Specific risk factors for first responders include:

- Long term physiological strain may have a significant harmful impact on health, leading to the high rates of stress-related illness known to exist in the profession<sup>1</sup>
- Experiences may lower one's fear of death, creating conditions under which suicidality emerges<sup>2</sup>
- Shift-work may cause sleep disturbances and disruptions in familial social support which are risk factors for suicide.<sup>2</sup>
- Often have access to highly lethal suicide means<sup>2</sup>
- First responder groups are overwhelmingly comprised of white males, the same demographic group that is also disproportionately affected by suicide<sup>2</sup>

## Sources

- SAMHSA Disaster Technical Assistance Center, Supplemental Research Bulletin. [First Responders: Behavioral Health Concerns, Emergency Response, and Trauma](https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf). May 2018. <https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf>
- Waters J.A., Ussery W. Police stress: history, contributing factors, symptoms and interventions. *Policing: An International Journal of Police Strategies and Management*. 2007; 30(2):169–88. <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=241457>
- Stanley I.H., M.A. Hom, T.E. Joiner, A Systematic Review of Suicidal Thoughts and Behaviors Among Police Officers, Firefighters, EMTs, and Paramedics. *Clinical Psychology Review*, Volume 44, March 2016, Pages 25-44.

## EMM Resources for First Responders:

- <https://emmresourcecenter.org/resources/suicide-prevention-resources-first-responders>
- Webinar recording: <https://register.gotowebinar.com/recording/5191262088772409857>

## Individuals with Substance Abuse Disorders

Alcohol and drug use disorders are second only to depression and other mood disorders as the most frequent risk factors associated with suicidal behavior. Individuals with a diagnosable substance use disorder are almost 6 times more likely to report a lifetime suicide attempt than those without a substance use disorder. Among male veterans, suicide rates among males with a substance abuse disorder are 2 to 3 times higher than among males who do not have a substance abuse disorder. Among women veterans, a substance use disorder increases the risk of suicide by 6.5 times.

## Sources

- Center for Disease Control: Suicides Due to Alcohol and/or Drug Overdose (Accessed: 11/25/19) <https://stacks.cdc.gov/view/cdc/11981/>
- Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1999;56:617-626
- Ilgen MA, Bohnert AS, Ignacio RV, et al. Psychiatric diagnoses and risk of suicide in veterans. *Arch Gen Psychiatry*. 2010;67:1152-1158

Because alcohol and other drug treatment providers are in regular contact with patients at risk for relapse and suicide, they are an important resource for early detection and prevention of suicidal behavior. Individuals entering into substance abuse treatment often feel overwhelmed by emotions that they have been medicating with substance use. The resurgence of these underlying symptoms can pose as an increased risk for suicidal thoughts and behaviors.

SAMHSA has several resources that are useful in substance abuse treatment and other settings to help identify suicide risk and intervene:

[TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#) provides a comprehensive and thorough treatment improvement protocol. The document highlights benefits for implementing suicidal interventions that stretch across the treatment milieu, staff, and overall program.

The [SAFE-T card](#) references a five step evaluation and triage process suitable for clinicians to use in their practice settings.

Lastly, SAMHSA's Suicide Prevention Resource Center has an abundance of information on resources, programs, trainings and much more.

- For more information, view the [Substance Abuse and Suicide Prevention Know the Signs webinar recording](#)

## Homeless Individuals

"Homeless" includes individuals who are unsheltered and living on the streets as well as those who are at imminent risk of losing housing, living in unstable or unsuitable housing, or in temporary housing or shelters. It also includes those fleeing or attempting to flee domestic violence and without alternative resources for housing. People falling within any of these categories of homelessness are undergoing intense physical, emotional, social, economic and cultural stressors. These stressors can increase suicide risk.

Some sources have reported that suicide rates among homeless populations are estimated at 9 times that of the U.S. general population, and that more than half of homeless individuals have had thoughts of suicide. Among those experiencing homelessness, transitional age youth (ages 18-24), LGBTQ individuals, and ethnic minorities have elevated risk.

According to SAMHSA, over one quarter of those who are sheltered and homeless, and nearly 35% of those who are unsheltered and homeless have a severe mental illness. Among those who are chronically homeless, one third have mental health conditions and about half have co-occurring substance abuse problems. The majority have experienced lifetime mental health and substance abuse problems. This population is also primarily male and middle aged (35-44 years old), and disproportionately consists of people of color, particularly African Americans and Latinos.

There is a significant relationship between incarceration and homelessness: 15.3% of inmates have been homeless within a year of incarceration, and 20% of those incarcerated who also have a mental illness were homeless. Finally, about 45% of homeless veterans also have a mental illness, and 70% have a substance abuse problem. Finally, a substantial portion of the

homeless population are also veterans who tend to be single males, older than their non-veteran peers, and more likely to have a disability.

Young people experiencing homelessness often struggle with self-esteem, which puts them at risk for substance use, suicide, and other negative outcomes. Youth with multiple minority identities (e.g. ethnic and LGNTB) have higher suicide rates than those with single minority status. According to data from the [CaISCHLS](#) survey, 28 percent of youth who identify as homeless report having considered suicide in the previous year, compared to 16 percent of youth who live at home with one or more parent/guardian.

Homeless transitional age youth (TAY) ages 18-24, LGBTQ individuals, and ethnic minorities represent groups of elevated need. TAY who are also sexual minorities become homeless at twice the rate of heterosexual peers, often due to social and family conflict. It is estimated that gay, lesbian, bisexual, and transgender homeless adolescents are more than 8 times more likely to attempt suicide than heterosexual peers.

The homeless population is a distinct cultural group with specific challenges and needs compared to populations with stable housing, with implications for access to services and supports. Many people experiencing homelessness may also have history of trauma, legal problems, and chronic health conditions. While counseling can make a life and death difference for a stably housed person, an individual without the resources to meet their most basic needs is likely to require a different level of support to address their risk that must include efforts to secure housing, food, and medical care.

Suicide prevention strategies such as gatekeeper training, screening, interventions to support those thinking about suicide, and reducing access to lethal means, have demonstrated effectiveness in general, but these strategies have not been tested in populations of homeless individuals. While they are likely to be helpful, their intent is to weather immediate crisis and connect those at risk to behavioral health services and supports. With individuals experiencing homelessness, this must include immediate assistance with meeting basic housing and health care needs.

#### Sources:

- SAMHSA, July 2011. Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the U.S. Retrieved from: [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/homelessness\\_programs\\_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf)
- National Health Care for the Homeless Council, May 2018. Suicide and Homelessness: Data trends in suicide and mental health among homeless populations. Retrieved from <https://nhchc.org/wp-content/uploads/2019/08/suicide-fact-sheet.pdf>
- National Alliance to End Homelessness, Washington, D.C. Retrieved from <https://endhomelessness.org>

- Lilly, K. 2014. Fighting to Live: Self-Esteem and Homeless Youth. SAMHSA publication retrieved from <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/self-esteem-homeless-youth>
- Holleran, L., Poon G. Dying in the Shadows: Suicide Among the Homeless. *Harvard Public Health Review*. Fall 2018; 20. Retrieved from <http://harvardpublichealthreview.org/lori/>

## Youth in Foster Care

Foster care can refer to placement with relatives, unrelated foster parents, or settings such as group homes, residential care facilities, emergency shelters, and supervised independent living. In addition to the stress of separation from parents, caregivers, and natural supports, youth in foster care may experience multiple placements and frequent moves, feelings of loss and shame, disruption of normal routines and challenges in developing and establishing social support networks. In some cases, abuse or neglect in their foster placement occurs, multiplying the trauma some foster youth experience.

Youth in foster care are more likely to have mental health and substance abuse disorders than those who have never been in foster care. Youth in foster care are about 2.5 times more likely to have seriously considered suicide and almost 4 times more likely to have attempted suicide than other youth. 39 percent of youth living in a foster home reported having considered suicide in the previous 12 months ([CalSCHLS](#)).

Adverse Childhood Experiences (ACEs) including abuse (physical, emotional, and sexual) or neglect; parental death, incarceration, or substance abuse; and family suicidality can increase the risk of suicide ideation and attempts by 1.4 to 2.7 times, and this risk carries into adulthood. The negative impacts of ACEs are cumulative, meaning the greater the number of adverse experiences, the higher the risk. By definition, every child in foster care has experienced at least one ACE, and studies have shown that they are far more likely to have experienced at last 4 ACEs.

In California a larger percentage of black children are in foster care compared to other racial/ethnic groups. A large-scale study of youth in the foster care system in LA county found that a disproportionate percentage identified as lesbian, gay, bisexual, transgender or questioning, and the majority of LGBTQ youth in foster care were also youth of color. Within this group, LBGTO youth had a higher than average number of placements, were more likely to be living in a group home, and reported more negative experiences with the child welfare system.

A significant portion of youth leaving foster care continue to struggle with education, housing, employment, behavioral health, and criminal justice involvement for years after exiting the system. There is some evidence that outcomes can be improved when foster care was extended from 18 to 21 years of age to increase the amount of time young people have to learn skills they need for self-sufficiency.

Strategies for preventing suicide among youth in foster care and transitioning from foster care include:

- Educating and training foster parents and foster caregivers about the warning signs of suicide and how to help/intervene; planning for safety including reducing access to lethal means (including firearms, medications, and alcohol) in the home or group setting; and trauma.
- Helping foster care agencies and group home settings have crisis and postvention plans to support youth at risk as well as their peers
- Ensuring foster youth and young adults leaving foster care have access to and continuity of behavioral health care, as well as other supports to promote crucial life skills

Sources:

- Thompson, MP, JB Kingree, & D. Lamis. (2019) Associations of adverse childhood experiences and suicidal behaviors in adulthood in a U.S. nationally representative sample. *Child: Care, Health and Development*, Vol.45(1): 121-128).
- [Children's Bureau](#), US Dept. of Health & Human Services
- Suicide Prevention Resource Center, [Foster Care Providers: Helping Youth At Risk of Suicide](#)
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- Courtney, ME, Dworsky, A & Pollack, H, (2007). [When Should the State Cease Parenting? Evidence from the Midwest Study](#). Chicago: Chapin Hall at the University of Chicago.
- [Foster Care in California](#), Public Policy Institute
- [Youth Law Center](#)
- [Preventing Suicidal Behavior Among Youth in Foster Care](#), [National Center for the Prevention of Youth Suicide](#)

## Incarcerated Adults

Risk factors for suicide include mental health conditions as well as legal or criminal justice problems. Ongoing stressors related to these risk factors are multiplied when an individual is incarcerated. Risk among jail inmates is even higher, in part due to the "shock of confinement" as they are suddenly removed from their job, family, housing and sense of normalcy.

A significant proportion of incarcerated adults have struggled with mental health problems, and many continue to have mental health challenges behind bars. One in seven federal inmates and 1 in 4 jail inmates report serious psychological distress within the past 30 days, compared to 1 in 19 for the general population. More than one third of prisoners, and nearly half of jail inmates reported that they had been diagnosed with a mental health condition in the past.

Within corrections systems, much of the suicide prevention focus is on physical barriers to suicide, and many rules and regulations limit the availability of potentially lethal objects and materials. Once an individual is deemed at immediate risk, typically the next step is seclusion and continuous observation. While these measures can be useful, they further isolate vulnerable individuals and also may in themselves have limited effectiveness.

The National Institute of Corrections developed the following recommendations to enhance suicide prevention among incarcerated adults:

- Enhanced screening earlier in the process of booking and admission as well as at other potentially higher risk points, such as leading up to a court hearing
- more opportunities for interaction between inmates and medical or corrections staff that offer opportunities for screening or recognizing suicide risk
- improving suicide prevention for corrections staff, including interactive live training rather than relying on infrequent training scheduled for convenience, webinars or watching videos.

#### Sources

- [Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates](#), June 2017. Bureau of Justice Statistics
- National Inst. of Corrections, [Suicide in Corrections](#)
- [Suicide Prevention in Correctional Facilities: Reflections and Next Steps](#)

### Corrections Officers

Similarly to their colleagues in law enforcement and other first responder professions, Corrections Officers are at elevated risk of job-related mental health problems, physical health problems, and suicide. Many Corrections Officers are regularly exposed to violent incidents and may often feel unsafe at work.

This has myriad health and mental health impacts. Correctional officers have a high incidence of serious stress-related physical illnesses such as high blood pressure and heart disease compared to the general population. Over one quarter report often or sometimes feeling down, depressed or hopeless. 1 in 3 have experienced at least one symptom of post-traumatic stress disorder. As a point of comparison, about 1 in 7 combat veterans are diagnosed with PTSD. As many as ten percent have considered suicide, and this rate may be even higher among retired Corrections Officers.

Recommended strategies for suicide prevention among Corrections Officers include:

- Establishing Employee Assistance Programs that include counseling, assessments and referrals Improving staffing levels to reduce the risk of burn-out, stress and unsafe conditions
- Improving training in recognizing and responding to mental health problems and suicide risk among peers and managers/supervisors
- Peer support/"buddy system" strategies to help colleagues support one another

EMM Suicide Prevention Week toolkits on [Workplace Suicide Prevention](#) and [Suicide Prevention for First Responders](#) also share a range of strategies and resources that can be implemented in the corrections environment.

Sources:

- Officer Health and Wellness: [Results from the California Correctional Officer Survey](#). University of California, Berkeley, November 2017.
- Buble, C. Nov. 27, 2019. [Federal Correctional Officer Suicides Sound Alarms at Bureau of Prisons](#). *Gov. Exec.*
- Frost, N.A. and C.E., Monteiro. [Correctional Officer Suicide and Officer Wellbeing](#). Northeastern University College of Social Sciences and Humanities.

## Youth in the Juvenile Justice System

According to a report from the National Action Alliance for Suicide Prevention, suicide is the leading cause of death among incarcerated youth, with a rate nearly three times as high as among non-incarcerated peers. Studies cited in this report indicated that over half of incarcerated youth had current suicidal ideation and one third have a history of suicidal behavior. In general risk factors for suicide are more prevalent among incarcerated youth.

This report also listed twelve strategies to promote suicide prevention through the partnership of mental health and juvenile justice agencies, including:

- Increased collaboration and partnership between the mental health and juvenile justice systems including training, data collection, information sharing and improvement of barriers and gaps to effective care
- Screening and risk assessment followed by immediate provision of mental health services
- Diverting youth at risk to more appropriate treatment settings
- Trauma-informed and culturally appropriate
- Increased family involvement at all levels

Source: Youth in Contact with the Juvenile Justice System Task Force. (2013). [Preventing juvenile suicide through improved collaboration: Strategies for mental health and juvenile justice agencies](#).



## Additional Considerations

The majority of suicide deaths occur among working age adults, so implementing suicide prevention strategies in workplace settings is an important way to reach and support this population. See the [EMM Collection: Suicide Prevention in the Workplace](#) for resources to support this work.

The time after discharge from psychiatric inpatient care is a critical period for preventing suicides. The suicide death rate is 300% higher in the first week and 200% higher in the first month than that of the general population. Bridging the transition from inpatient to outpatient care can help prevent high risk people from falling through the cracks. The National Action Alliance for Suicide Prevention, "[Best Practices in Care Transitions for Individuals with Suicide Risk](#)" includes recommendations for inpatient providers as well as outpatient providers to provide continuity of care between inpatient and community-based settings.

Survivors of Suicide Loss are also at elevated risk of suicide due to the complicated grief after a suicide death. Postvention is prevention - implementing community plans for response after a suicide death can enhance timely and effective support and healing in the community. [After Rural Suicide: A Guide for Coordinated Community Response](#) outlines the key elements of community postvention and offers tools, resources and tips for creating a community postvention plan. Ongoing support for loss survivors can mitigate this risk. [Pathways to Purpose and Hope: A Guide to Creating a Sustainable Bereavement Support Program for Families and Friends After a Suicide Death](#) can help loss survivors build ongoing loss support programs. TO learn more, listen to the [Pathways to Purpose and Hope webinar recording](#).