Dying in the Shadows: Suicide Among the Homeless

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According to the 2017 Annual Homeless Assessment Report to Congress, conducted by the U.S. Department of Housing and Urban Development (HUD), nearly 554,000 individuals, or 17 per 10,000 people, are homeless within the U.S. on any particular night (HUD, 2017). Homeless individuals represent some of society's most marginalized and unsupported populations. One particularly alarming outcome amongst those experiencing homelessness is the prevalence of suicides. Suicide rates among homeless populations are estimated at nine times that of the US general population (112.5 suicide deaths per 100,000 versus the U.S. national average of 12.5 per 100,000; Centers for Disease Control and Prevention [CDC], 2014; Peate, 2013). Unfortunately, little is known—much less being done—about alleviating this risk because empirical knowledge and evidence-based prevention efforts regarding suicide in these marginalized populations are lacking, particularly among diverse ethnic minority and LGBTQ individuals.

Among those experiencing homelessness, transitional age youth (TAY) ages 18-24, LGBTQ individuals, and ethnic minorities represent groups of elevated need. For example, in the midst of growing rates of homelessness among TAY, sexual minorities become homeless at rates that are nearly double that of heterosexual peers, often due to social and family conflict (Cochran, Stewart, Ginzler, & Cauce, 2002). Among homeless TAY, sexual minorities are over eight times more likely to attempt suicide than their heterosexual counterparts (LAFYS, 2014). Further, suicide rates and risk factors vary across cultural groups – among youth, those identifying as Latino or African American demonstrate particularly elevated risk (CDC, 2015; Chu, Goldblum, Floyd, & Bongar, 2010). Moreover, individuals with multiple minority identities (e.g., ethnic and LGBTQ) have higher suicide rates than those with single minority status (Hughes, Matthews, Razzano, & Aranda, 2002). Yet, while homelessness is increasingly reaching individuals at particularly high risk for suicide, the environment remains absent of a response.

Inadequate Prevention Services

Despite the fairly recent increase in commitment to suicide prevention efforts

nationally, strategies focused on identifying clear and definitive approaches to preventing suicide amongst the homeless have remained largely overlooked. A number of interventions and screening tools have demonstrated effectiveness in reducing suicide in the general population (van der Feltz-Cornelis et al., 2011), and some have demonstrated efficacy among specific populations such as veterans, elderly adults in primary care, Native Americans or Alaskan Natives, and youth in high schools (Suicide Prevention Resource Center, n.d.). However, few of these programs have been tested with the homeless, and no program broadly targeting culturally diverse homeless individuals at risk for suicide exists under the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (SAMHSA, 2015).

A crucial part of managing risk for suicidal patients is restricting an individual's access to lethal means. Having the means to complete suicide greatly increases the risk of fatal results (Brent & Bridge, 2003; McNeil, 2009). Yet, despite this knowledge, there is a paucity of research examining standards of care for restricting access to these lethal means amongst the homeless. Current lethal means restriction approaches primarily focus on firearms, the most common method of suicide among Caucasian males and the leading cause of completed suicide in the United States, which accounts for 51% of completed suicide attempts (Bryan, Stone, & Rudd, 2011; CDC, 2012). Unfortunately, these efforts predominantly benefit individuals utilizing typical means, which may fail to address the needs of marginalized and/or minority populations.

When examining the chosen means of suicide among groups other than Caucasian males, one sees tremendous variability. Rather than firearms, hanging among Asian American individuals and drug overdose among LGBTQ youth, for example, are the most common methods of suicide (D'Augelli & Hershberger, 1993; Shiang et al., 1997). These methods, hanging and intentional overdose, are also used more commonly than firearms by those experiencing homelessness (Barak, Cohen, & Aizenberg, 2004). As the accessibility of means greatly influences the acceptability of a particular suicide method within cultural and geographic groups (Ajdacic-Gross et al., 2008), easily accessible means should be assessed among diverse homeless populations to appropriately tailor means-restriction interventions to the cultural sanctions of the population.

Lack of Cultural Competence

Compounding the problem of a lack of best practice efforts and programs designed and tested specifically for the homeless is a dearth of clear guidelines for *culturally competent* suicide prevention efforts (American Psychiatric Association, 2003; Granello, 2010). With ethnic minority and LGBTQ individuals overrepresented in homeless populations compared to the general U.S. population (Durso & Gates, 2012), it is imperative that any suicide prevention practice incorporates cultural competency.

In recent years, cultural competence has emerged as a focus in suicide risk and prevention (Leong & Leach, 2010), as different cultural groups experience culturally variant suicide risk factors (Chu et al., 2010). For example, though psychiatric disorders such as depression, schizophrenia,

and bipolar disorder are present among 90% of suicidal individuals in the general population, approximately half of suicidal Asian Americans exhibit a non-psychiatric subtype of suicide marked by cultural, medical, and functional factors rather than mental health symptoms (Chu, Chi, Chen, & Leino, 2014) – a finding suggesting that mental illness may be a poor indicator for suicide prevention strategies among some ethnic minorities. Additionally, research shows that LGBTQ individuals often turn to community supports in the face of rejection from family members, making high family rejection and alienation from one's social community particularly important suicide risk factors for LGBTQ populations (D'Augelli, 2002; McBee-Strayer & Rogers, 2002; Ryan, Huebner, Diaz, & Sanchez, 2009). Understanding social isolation from a supportive LGBTQ community may be a better indicator of suicide risk than social isolation from family for an LGBTQ client struggling with the coming out process.

Suicide prevention practices also typically target the dominant culture and neglect minority populations. Homeless agency gatekeepers often apply existing prevention strategies such as QPR (question, persuade, and refer; QPR Institute, n.d.) for the management of suicide risk. However, interventions such as QPR do not address cultural differences in early warning signs, expressions of distress, communication differences, and help-seeking preferences that are often found across minority groups. On the flip side, several culturally sensitive efforts exist, but suicide prevention targeting homeless populations have largely been neglected within such efforts (Christensen & Garces, 2006).

Ultimately, we are currently failing to reduce lives lost during a time when individuals are facing acute and extremely challenging cultural stressors. As a result, there is a clear need for primary prevention suicide efforts targeted at a culturally diverse homeless population. If, as President Carter noted, *the measure of a society is found in how they treat their weakest and most helpless citizens*, we undoubtedly have room to grow.

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