Suicide and Homelessness

Data Trends in Suicide and Mental Health Among Homeless Populations

National Health Care for the Homeless Council
Fact Sheet | May 2018

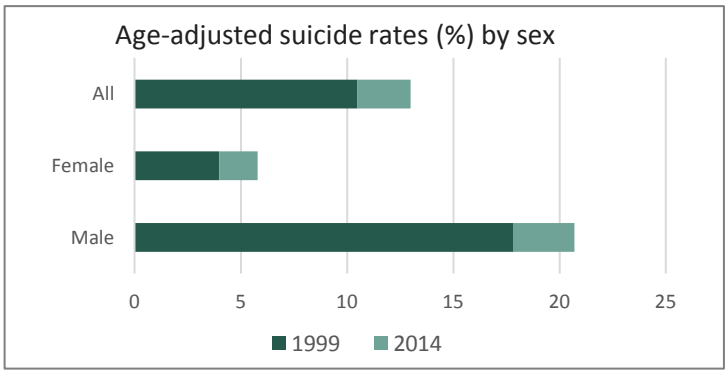
Purpose

This fact sheet was developed by the National Health Care for the Homeless (HCH) Council as part of a series related to emerging issues in the HCH field. To determine areas of interest, the Council met with the HCH Clinician's Network Steering Committee and together, prioritized those topics that the clinicians identified the need of a renewed framework and public awareness as they relate to homelessness. Of those, suicidality and the disparities among homeless populations was among the most reported.

Background

According to the Centers for Disease Control (CDC), suicide is the tenth leading cause of death overall and has been climbing, as shown by the increase in suicide rates highlighted in Figure 1.[1,2] Nearly 45,000 people died by suicide in the United States in 2016. Among ages 35-54, suicide is the fourth leading cause of death, and among ages 10-34, suicide tragically ranks as the second leading cause of death. Three percent of those who died by suicide suffered from Severe Prolonged Mental Illness (SPMI), and of those three percent, 78 percent of deaths by suicide were among those suffering with bipolar disorder.[3]

Figure 1. Age-adjusted suicide rates by sex: United States



Common Risk Factors of Suicide

Despite these high and growing numbers, there continues to be a relatively large gap in knowledge on the issue.[4] According to the Interpersonal Theory of Suicide, the desire to attempt or commit suicide is caused by the simultaneous presence of "thwarted belongingness," "perceived burdensomeness," and a general hopelessness about these states. While there is no single cause of suicide, recent literature has identified a number of potential risk factors, as shown in Table 1.[4,5,6]

Table 1. Suicide risk factors

Risk Factors:
Depression and Mental Illness
Anxiety and Stress
Family Conflict
Isolation and Loneliness
Domestic or Sexual Abuse
Unemployment
Alcohol or Drug Use
Previous Suicide Attempts
Adverse Childhood Experiences (ACEs)

All of these, if impacting children at a young age, can be categorized as Adverse Childhood Experiences (ACEs), which include neglect, abuse, or household dysfunction. An ACE score of 7 or more increases the risk of suicide in adolescents by 51 times, and by 30 times in adults.[7] It is important to note that some definitions of traumatic events may be more inclusive than others. For example, additional types of trauma and violence listed by the Substance Abuse and Mental Health Services Administration (SAMHSA) include serious accidents or medical procedures, community violence, school violence, bullying, natural disasters, historical trauma, forced displacement and system-induced trauma.[8] While suicide prevention efforts typically take place at the individual or family/relationship levels, experts in the field suggest a

comprehensive effort across education, business, and health care fields to reduce exposure to adverse experiences and ultimately reduce suicidal behaviors and the risk factors that contribute to them.[9]

Increased Risk Among Homeless Populations

In comparison to the general population, a 2012 study found suicide rates to be 10 times higher for a homeless cohort, and other research has indicated a higher suicide rate among people experiencing homelessness than the general population.[10] In fact, more than half of people experiencing homelessness have had thoughts of suicide or have attempted suicide.[11]

According to a 2017 study, more than 40 percent of homeless teens struggle with depression, which is 12 percentage points higher than their housed peers. School-age children and youth who are homeless are three times more likely to attempt suicide than students who live at home with a parent or guardian (20 percent versus six percent housed).[12] Additionally, research has found that LGBTQ youth experiencing homelessness are twice as likely to commit suicide compared to heterosexual youth who are homeless, according to the National Coalition for the Homeless.

Research has shown that individuals experiencing homelessness have greater morbidity and mortality rates than the general population and experience more co-morbidities than their housed counterparts.[13] When compared to non-homeless populations, individuals experiencing homelessness face a multitude of complex health and social issues that are often integrated with past, present, and daily trauma that impact these individuals' prioritization and decision-making efforts.

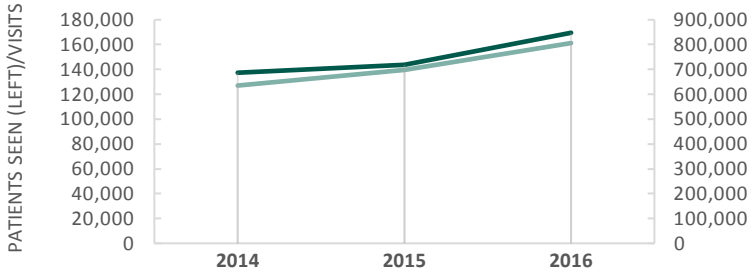
Mental Health and Utilization Trends Among HCH Programs

According to the HRSA Uniform Data System (UDS), in 2016, 161,229 patients were seen by mental health staff over 847,612 visits in health centers receiving 330(h) funding.[14] These visits included patients seen by psychiatrists, licensed clinical psychologists, licensed clinical social workers, licensed mental health providers, and other mental health staff.

As shown in Figure 2, this is a 15 percent increase from 139,777 patients seen by mental health staff in 2015, and a 27 percent increase in patients seen by mental health staff in 2014.[15,16] This represents an 18 percent increase in visits, up from 719,635 in 2015, and a 23 percent increase in visits since 2014. It should be noted that 330(h)-funded programs increased from 268 in 2014 to 295 in 2015 (or by 10 percent); however, there was not an increase in funded programs from 2015 to 2016.

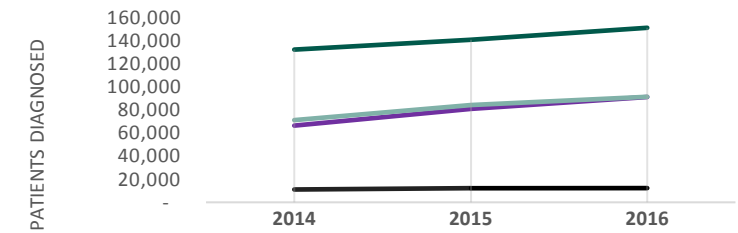
Similarly, the number of patients diagnosed with mental health conditions has increased each year, with a steady increase in patients diagnosed with "depression and other mood disorders" since 2014, and nearly

Figure 2. 330(h) Mental health service utilization since 2014



	2014	2015	2016
Patients	127,027	139,777	161,229
Visits	686,792	719,635	847,612

Figure 3. 330(h) Mental health diagnosis since 2014



	2014	2015	2016
Depression	132,192	140,976	151,078
Anxiety/PTSD	66,397	80,802	91,159
ADD	11,096	12,246	12,302
Other	71,157	84,321	91,346

identical trends in increased diagnoses of "anxiety including PTSD" and "other mental disorders, excluding drug or alcohol abuse." Meanwhile, diagnosis of "attention deficit and disruptive behavior disorders," though rising slightly, has remained comparatively level (Figure 3).

The UDS does not provide patient-level detail of encounters, therefore, utilization and diagnosis of mental conditions are not direct indicators of suicide trends. As a proxy, the demonstrated increased diagnoses and utilization of mental health services in HCH programs indicates an increasingly at-risk population.

Suicide and Circumstance Among People Experiencing Homelessness

While there is a dearth of national-level data that accounts for death by suicide specific to homeless populations, the CDC's National Violent Death Reporting System (NVDRS) offers a state-based surveillance system that pools and links detailed information – from death certificates, police reports, coroner or medical examiner records, and crime laboratories – into a useable, anonymous database. Table 2 shows participating state data from 2014[†]—the most recent year publicly available—grouped by circumstances and demographics, compared to the general population.[17]

Figure 4. States participating in NVDRS

2014 SUICIDE COUNTS	General Population		Homeless Population	
Gender	Death Counts	Percentage	Death Counts	Percentage
All	14,156	100	106	100
Male	10875	76.8	92	86.7
Female	3281	23.2	14	13.3
Place of Injury	Death Counts	Percentage	Death Counts	Percentage
Transport area: public highway, street or road	309	2.18	14	13.21
Transport area: other, including inside motor vehicle	901	6.36	24	22.64
Natural area/countryside	621	4.39	16	15.09
House, apartment, including driveway, porch, yard	10,849	76.64	23	21.7
Military Status	Death Counts	Percentage	Death Counts	Percentage
Current/former military	2,357	16.65	17	16.04
Circumstance	Death Counts	Percentage	Death Counts	Percentage
Eviction or loss of home	451	3.53	27	27.27
Other relationship problem	269	2.1	6	6.06
Other Substance Problem	2,046	16	34	34.34
Financial problem	1,275	9.97	21	21.21
Alcohol Dependence	2,325	18.18	25	25.25
Current treatment for mental illness	3,689	28.84	21	21.21
Current Depressed Mood	4,750	37.14	30	30.3
Current Mental Health Problem	6,193	48.42	42	42.42
Ever Treated for Mental Problem	4,698	36.73	37	37.37
Crisis in past 2 weeks	4,329	33.85	34	34.34

Table 2. Suicide Counts by Homeless Status and Circumstance

[†] The 18 participating states in the 2014 NVDRS include Alaska, Colorado, Georgia, Kentucky, Massachusetts, Maryland, Michigan, North Carolina, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin.

Causes and Considerations

During a workshop at the 2017 National Health Care for the Homeless Council annual conference, one health center serving homeless populations reported that when screening for suicide attempts, they found 33 percent of their patients have attempted suicide. This percentage is unfortunately in accordance with findings from other research focused on suicide and homelessness.

As discussed in the National Health Care for the Homeless Council's publication on the value provided by HCH programs, many individuals that are unhoused have health conditions that are often intertwined with behavioral health issues. In fact, 68 percent of homeless individuals reported that they had experienced psychological distress in the past month.[18] These health issues are exacerbated by exposure to the elements, heightened risk of violence through physical and sexual abuse, and a fragmented health system with restrictions on how and to whom care is delivered, which can lead to hopelessness, distrust, misuse of emergency services, and self-treatment.[18]

Given the conditions above that already increase the likelihood of suicide in the general population, these compounding factors place those experiencing homelessness at an explicitly higher risk..

Resources

If you or someone you know is having suicidal thoughts, you can call the National Suicide Prevention Lifeline (1-800-273-8255) at any time of day or night, or you can use the online Lifeline Crisis Chat. Both are free and confidential, and will connect you to a trained counselor.

Below are additional resources for more information and support:

- Preventing Suicide: A Technical Package of Policy, Programs, and Practices. CDC. https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf
- National Violent Death Reporting System: A powerful tool for prevention. https://www.cdc.gov/violenceprevention/pdf/nvdrs_overview-a.pdf
- Behavior Management Systems. http://www.bmscares.org/services/major-mental-illness-adults
- National Institute of Mental Health: Statistics – Suicide. https://www.nimh.nih.gov/health/statistics/suicide/index.shtml
- Understanding Suicide: Fact Sheet
- Uniform Definitions for Self-Directed Violence
- Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence
- The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools
- Recommendations for Media Reporting on Suicide
- Preventing Suicide: A Global Imperative
- Suicide Prevention Resource Center

Suggested Citation for this Fact Sheet: National Health Care for the Homeless Council. (December 2017.) Suicide and Homelessness: Data trends in suicide and mental health among homeless populations (Author: Brett Poe, Research Associate) Available at: http://www.nhchc.org/suicide

This project is supported by the Health Resources and Services Administrators (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS09746, National Training and Technical Assistance Cooperative Agreement, for this budget year's total cooperative agreement award of $1,625,741.00, and 0% of this total NCA project financed with nonfederal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

References

1. NCHS, National Vital Statistics, Mortality.
2. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online].(2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html.
3. Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. https://www.cdc.gov/injury/wisqars/fatal_injury_reports.html
4. Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E. (2010). The interpersonal theory of suicide. Psychological Review, 117(2), 575–600.
5. Kyoung Hag Lee, Jung Sim Jun, Yi Jin Kim, Soonhee Roh, Sung Seek Moon, Ngoyi Bukonda & Lisa Hines (2017): Mental Health, Substance Abuse, and Suicide Among Homeless Adults, Journal of Evidence-Informed Social Work, DOI:10.1080/23761407.2017.1316221
6. Bolton, J. M., & Robinson, J. (2010). Population-attributable fractions of axis I and axis II mental disorders for suicide attempts: Findings from a representative sample of the adult, noninstitutionalized U.S. population. American Journal of Public Health, 100(12), 2473–2480. doi:10.2105/AJPH.2010.192252
7. Dube SR, Anda RF, Felitti FJ et al. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the Adverse Childhood Experiences Study. JAMA, 2001; 286:3089-3095.
8. Substance Abuse and Mental Health Services Administration. "Types of Trauma and Violence." Samhsa.gov. September 03, 2014. https://www.samhsa.gov/trauma-violence/types
9. Ports, K. A., Merrick, M. T., Stone, D. M., Wilkins, N. J., Reed, J., Ebin, J., & Ford, D. C. (2017). Adverse childhood experiences and suicide risk: Toward comprehensive prevention. American Journal of Preventive Medicine. http://dx.doi.org/10.1016/j.amepre.2017.03.015
10. Patterson, A. A., & Holden, R. R. (2012). Psychache and suicide ideation among men who are homeless: A test of Shneidmans model. Suicide & Life-Threatening Behavior, 42(2), 147.
11. Coohey, C., Easton, S. D., Kong, J., & Bockenstedt, J. K. W. (2015). Sources of psychological pain and suicidal thoughts among homeless adults. Suicide and Life-Threatening Behavior, 45(3), 271–280.
12. Centers for Disease Control and Prevention. 2015 New York City Youth Risk Behavior Survey Data. Available at: www.cdc.gov/yrbs.
13. Lebrun-Harris LA, Baggett TP, Jenkins DM, et al. Health Status and Health Care Experiences among Homeless Patients in Federally Supported Health Centers: Findings from the 2009 Patient Survey. Health Services Research. 2012/11/07 2012;48(3):992-1017.
14. Uniform Data System Report. 2016 Health Center Data: National Health Care for the Homeless Program Grantee Data. 2016.
15. Uniform Data System Report. 2015 Health Center Data: National Health Care for the Homeless Program Grantee Data. 2015.
16. Uniform Data System Report. 2014 Health Center Data: National Health Care for the Homeless Program Grantee Data. 2014.
17. National Violent Death Reporting System (NVDRS) for Number of Deaths, Bureau of Census for Population Estimates. Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
18. Lin W-C, Bharel M, Zhang J, O'Connell E, Clark RE. Frequent Emergency Department Visits and Hospitalizations Among Homeless People With Medicaid: Implications for Medicaid Expansion. American Journal of Public Health. 2015/11 2015;105(S5):S716-S722.