EVIDENCE-BASED RESOURCE GUIDE SERIES

Suicide Prevention Strategies for Underserved Youth

Suicide Prevention Strategies for Underserved Youth

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Abstract

Suicide is a leading cause of preventable death in the United States. In 2022, suicide was the second-leading cause of death for youth ages 10–14 and the third-leading cause of death for youth ages 15–24. Underserved youth ages 10–24 are especially at risk for suicidal behavior, with the most affected groups being American Indian/Alaska Native; Black/African American; Hispanic or Latino; and lesbian, gay, bisexual, transgender, queer or questioning, and intersex youth, and youth with intersecting identities. Although youth suicide is a serious public health crisis, there is limited evidence addressing this public health concern across underserved communities.

This evidence-based guide provides strategies and insights specific to these at-risk groups to support interventions and help prevent suicides. It highlights existing research, discusses barriers that hinder access to prevention and intervention services for youth, and offers guidance on selecting, implementing, and evaluating evidence-based prevention programs. The guide also highlights programs that are making strides in addressing suicidal thoughts and behaviors in young people from underserved communities.

MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Suicide Prevention Strategies for Underserved Youth*.

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Laboratory developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policy makers, and others with the information and tools to incorporate evidence-based practices (EBPs) into their communities or clinical settings. As part of the series, this guide aims to inform community leaders, behavioral health practitioners, and other stakeholders about EBPs for underserved youth and the process of selecting, implementing, and evaluating such programs.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. Each guide recognizes that substance use disorders and mental illness are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health practitioners and community stakeholders must address health equity as a strategy for improving individual and population health.

The inclusion of evidence-based, practice-based, and adapted EBPs are essential to mitigating behavioral health disparities. This guide provides an overview of research on youth suicide prevention and offers guidance on identifying, implementing, and evaluating EBPs for traditionally underserved youth.

I encourage you to use this guide to ensure that all youth benefit from culturally appropriate and clinically effective care.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

FOREWORD

Evidence-Based Resource Guide Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices (EBPs) and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health conditions or substance use disorders. SAMHSA designs these guides for practitioners, administrators, community leaders, health professionals, educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provide input for each guide in this series. The panels include accomplished researchers, educators, service providers, community members with lived experience, community administrators, and federal and state policy makers. Panelists give input based on their lived expertise, knowledge of healthcare systems, implementation strategies, EBPs, provision of services, and policies that foster change.

A priority topic for SAMHSA is ensuring that suicide prevention services and interventions reach underserved youth. However, the evidence base for these services and interventions in these populations is limited. Potential implementers—schools, community organizations, tribal governments, and others—face many challenges in identifying and implementing effective programs. This guide reviews these challenges, interventions that have been shown to be effective, and EBPs for general populations that might be adapted for underserved groups.

Implementing new programs and practices requires a comprehensive, multipronged approach. This guide is one piece of an overall approach to implement and sustain change. Readers are encouraged to review the SAMHSA website for additional tools and technical assistance opportunities.

The Substance Abuse and Mental Health Services Administration defines behavioral health equity as the right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable healthcare services and support.

Advancing behavioral health equity means working to ensure that every individual has the opportunity to be as healthy as possible. In conjunction with access to quality services, this involves addressing social determinants of health—such as employment and housing stability, insurance status, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes.

Content of the Guide

This guide contains a foreword and five chapters. Each chapter is intended to be brief and accessible for community providers, behavioral health stakeholders, organizational leaders, school administrators, and others invested in preventing suicide among underserved youth populations.

FW Evidence-Based Resource Guide Overview

Introduction to the series.

1 Issue Brief

Provides an overview of suicide among underserved youth and the barriers they face in accessing culturally responsive prevention and intervention services.

9 What Research Tells Us

Summarizes research about youth suicide prevention programs.

15 Guidance for Selecting and Implementing Evidence-Based Programs

Provides guidance for identifying and implementing evidence-based practices to prevent suicide among underserved youth.

24 Examples of Evidence-Based Youth Suicide Interventions

Reviews specific examples of suicide prevention programs focused on underserved youth.

33 Guidance and Resources for Evaluation

Offers guidance and resources for evaluating and sustaining future evidence-based suicide prevention programs.

FOCUS OF THE GUIDE

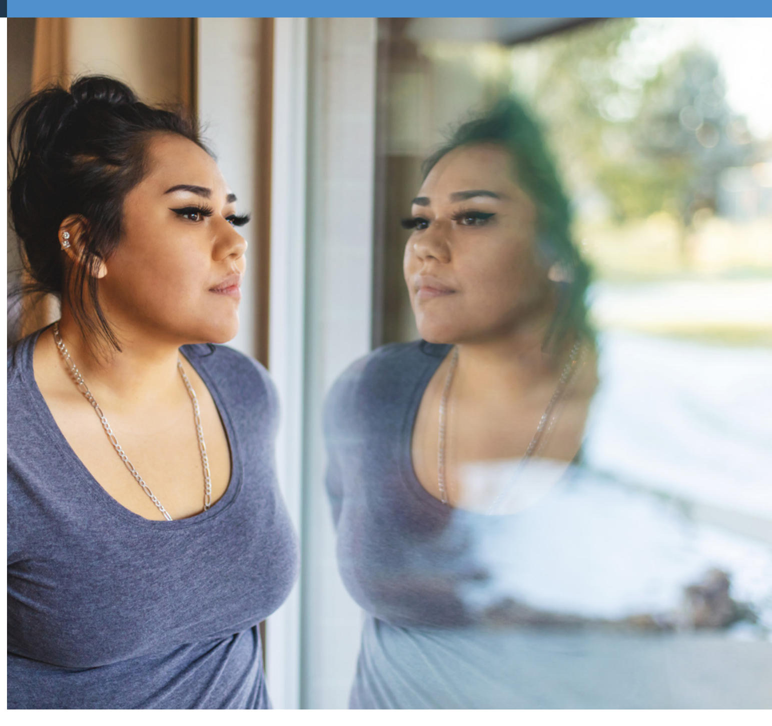
Tailoring care, programs, and services to the cultural, social, gender, and other demographic contexts of youth leads to better health outcomes and helps prevent suicides.

This guide describes various evidence-based practices to prevent suicide and their cultural adaptations for underserved youth. It explores the barriers these youth face when in need of mental health or crisis services, how to address these barriers, the information necessary to select a program, considerations for implementation, model programs, and evaluation information.

The publication is intended to be broad and provide information for practitioners, schools, and communities on preventing suicide, advancing mental health, and mitigating risks for the population of focus.

CHAPTER

1



Issue Brief

Suicide is a leading cause of preventable death in the United States. In 2022, suicide was the second-leading cause of death for youth ages 10–14 and the third-leading cause of death for youth ages 15–24.[1] Between 2007 and 2021, suicide rates for youth ages 10–24 increased by 62 percent (from 6.8 to 11.0 per 100,000).[2] Additionally, barriers remain to accessing mental health services. For example, in 2022, only 56.8 percent of youth ages 12–17 with a past-year major depressive episode—a risk factor for suicidality among youth, received mental health treatment in the past year.[3]

American Indian/Alaska Native (AI/AN), Black/African American, Hispanic or Latino, and lesbian, gay, bisexual, transgender, queer or questioning, intersex, and other sexual and gender minority (LGBTQI+) youth have a higher risk of suicide due to racism, discrimination, and a host of other factors. Although suicide among youth from diverse racial and ethnic backgrounds[4-6] or the LGBTQI+ community has not been well studied,[6] research on these populations is increasing.[7-9] This evidence-based guide provides strategies and insights to prevent suicide and suicidal behavior in underserved youth populations ages 10–24 and to mitigate disparities in research and treatment of underserved youth.

This chapter reviews data on suicide trends and disparities related to underserved youth and, when available, data on youth with intersectional identities (e.g., Black/African American and transgender) and those whose identities include two or more of the LGBTQI+ groups (e.g., transgender and bisexual).

The Substance Abuse and Mental Health Services Administration's (SAMHSA) comprehensive approach to addressing the behavioral health needs of LGBTQI+ individuals builds on the Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals. However, not all research presented in this guide included each sexual or gender minority; therefore, the acronyms used in the guide reflect the specific population(s) studied in the cited research.

Suicide Rates Among Underserved Youth

Many intersecting socio-ecological challenges can hinder access to treatment, including inadequate insurance coverage, stigma, cultural and linguistic barriers in patient-provider interactions, systemic racism, and implicit biases. These barriers contribute to systemic inequities within the U.S. healthcare system, resulting in prolonged wait times, diminished quality of care, limited community-based treatment resources, and pervasive mistrust and avoidance of healthcare institutions among underserved populations.

American Indian/Alaska Native Youth

The Centers for Disease Control and Prevention (CDC) report that the suicide rate for AI/AN youth was nearly three times higher than for non-Hispanic White youth from 2018 to 2021.[10] Suicide rates for this population increased by 16.7 percent (from 31.1 to 36.3 per 100,000) between 2018 and 2021. Of note, suicides in this population may be underreported due to the potential for racial misclassification on death certificates. A 2021 study using data from 1999 to 2017 found that AI/AN youth also experience a loss of a parent to overdose at a higher rate than any other demographic, which further increases the likelihood of adverse behavioral health outcomes.[11] AI/AN high school-aged male individuals reported attempted suicide at higher rates than their White counterparts.[12]

Black/African American Youth

Rates of suicide for Black/African American youth ages 10–24 increased by 36.6 percent (from 8.2 to 11.2 per 100,000) between 2018 and 2021.[10] In 2021, Black/African American high school students in grades 9–12 reported suicide attempts at higher rates than their White counterparts.[12] Additionally, Black/African American male high school students were more likely to report attempted suicides that required medical treatment than White male high school students.[12] Racial discrimination and historical mistrust of healthcare systems also contribute to Black/African American youth's reluctance to engage with mental health services, particularly for serious mental illness.[13-15] Black/African American youth are less likely to receive a follow-up appointment within one week of being discharged from psychiatric care, compared with their White counterparts.[16]

Hispanic or Latino Youth

Given the diversity of ancestry and countries of origin, Hispanic or Latino ethnic identification remains challenging in the U.S. racial classification system, especially for those who are multiracial.[17-19] Identity and classification may present challenges for tailored suicide prevention approaches. Hispanics and Latinos are the second-largest ethnic group, following non-Hispanic Whites, in the United States.[20] The rate of suicide in Hispanic or Latino children younger than age 12 increased by 92.3 percent from 2010 to 2019.[21] Between 2018 and 2021, the suicide rate increased by about 8 percent (from 7.3 to 7.9 per 100,000) for Hispanic or

Latino youth ages 10–24.[10] In 2021, Hispanic or Latino high school students in grades 8–12 reported higher rates of attempted suicide requiring medical treatment, compared with their White counterparts.[12]

LGBTQI+ Youth

Youth who identify as nonheterosexual or transgender are at higher risk for suicidal ideation and suicide attempt, compared with peers who are heterosexual or cisgender.[22,23] National data from 2023 shows that 25.9 percent of transgender students and 25.8 percent of questioning students in grades 9–12 had a past-year suicide attempt relative to 24 percent of cisgender females and 12.1 percent of cisgender males.[24] Additionally, 10.3 percent of transgender and 3.7 percent of questioning high school students had a past-year suicide attempt requiring medical treatment compared with 1 percent of cisgender male and 2.6 percent of cisgender female youth.[24] Anti-LGBTQ+ politics and state laws have also adversely affected LGBTQ+ youth and their mental health.[24] According to a survey conducted in 2023, 90 percent of young LGBTQ+ people reported feeling negatively impacted by recent anti-LGBTQ+ politics.[25]

Intersectionality

Youth who have multiple marginalized social identities (for example, both a racial or ethnic minority and a sexual or gender minority, or a disability and racial or ethnic minority) may experience compounded forms of oppression that can exacerbate their challenges in accessing mental health services.[26-28] Racism, sexism,

homophobia, and other types of oppression create structural barriers and inequities that can intensify feelings of alienation, hopelessness, and despair and make youth with intersectional identities especially vulnerable to suicidal thoughts and behaviors.[29]

The Trevor Project's 2024 national survey of LGBTQ+ youth ages 13–24 included intersectional analysis.[25] Among LGBTQ+ youth, it found that 48 percent of AI/AN respondents, 41 percent of Black/African American respondents, and 40 percent of Hispanic or Latino respondents considered suicide, compared with 37 percent of White respondents. Additionally, 24 percent of AI/AN respondents, 14 percent of Black/African American respondents, and 13 percent of Hispanic or Latino respondents reported attempting suicide in the past year, compared with 10 percent of White respondents. There are few studies on AI/AN Two-Spirit youth suicide; however, one study that reviewed 20 years of data in British Columbia showed Two-Spirit adolescents had an elevated risk of suicidality.[30]

Disability intersects with other aspects of identity, especially for those who hold multiple marginalized identities.[31] Several studies have highlighted the intersectionality of disability and sexual or gender minority, racial or ethnic minority and mental health disparities. Disability and sexual minority status were found to be associated with increased rates of suicidality and peer victimization in a national sample of American youth.[32] Youth with disabilities who were also sexual minorities were more likely to report suicidality than youth who did not share both identities.[33] Additionally, those with disabilities who are also members of marginalized racial and ethnic groups experience racism, ableism, and their intersections.[34]

Children and youth with intellectual disabilities are a vulnerable and marginalized population who may be at risk for developing suicidal thoughts and behaviors and death by suicide. This population has 2.8 to 4.5 times the risk of psychiatric comorbidities, compared with their peers in the general population.[35] These studies underscore the critical need for targeted interventions and culturally responsive mental health services to address the unique challenges and elevated risk of suicide among underserved youth with disabilities.

Risk and Protective Factors

Risk and protective factors for suicide among youth exist at the individual, interpersonal, community, and societal levels, and these levels often overlap. Risk and protective factors are cumulative and influence a person across the lifespan.[36] The cumulative effect of risk factors can increase the odds of developing mental health conditions and substance use disorders. The cumulative effect of protective factors can mitigate this risk.[36-38] Theorists have conceptualized risk and resilience among the youth populations discussed in this guide, notably the integrative risk and resilience model and minority stress theory.[38-40] How individuals process their experiences can be described as externalizing (e.g., fighting, breaking rules, defiance) or internalizing (e.g., depression, anxiety, social isolation) problems.[41] Some factors may have roots in early childhood experiences.

> The public health field must invest in a great deal more research about the unique characteristics of underserved youth to further build resiliency, mitigate risk factors, and save lives. The National Institute of Mental Health funds research on this topic, including several grants on suicide prevention for Black/African American youth.

Risk Factors

The following factors have been associated with a higher risk of suicide in youth across populations:

- **Adverse childhood experiences (ACEs):** ACEs are potentially traumatic events that occur in childhood and are associated with health outcomes throughout the life course, including suicidality. They are disproportionately prevalent in underserved populations, who may experience higher levels of toxic (i.e., prolonged or chronic) stress.[42,43] The Intersectional Nature of ACEs Framework links individual experiences to broader high-risk environmental (e.g., political, geographical, economic, social) factors and intergenerational risk factors, especially for historically excluded populations.[43] Children and families from historically marginalized backgrounds are more likely to be exposed to multiple adverse experiences, including systemic inequity and intergenerational adversity, which amplify the effects of toxic stress on their long-term well-being.[43]
- **Lack of parent or caregiver support:** In adolescents, a lack of authoritative parenting (nurturing, supportive parenting that includes firmly setting limits and consequences that are well explained to children) significantly increases risk of suicidal ideation, making a suicide plan, and suicide attempt.[44]
- **Parental incarceration:** Parental incarceration has profound implications for youth mental health, including heightened risks of suicidal ideation and behavior.[45,46]
- **Community-level risk:** Exposure to violence in the community is a risk factor for suicidal thoughts.[47]
- **School environments:** Bullying and peer victimization is associated with suicide risk. For example, a multilevel study in California found that high schools with higher rates of peer victimization (e.g., threats of harm, social isolation, harassment) were associated with increased suicidality, compared with high schools that had lower rates of peer victimization.[48]
- **Social determinants of health (SDOH):** Suicide is often referred to as one of the deaths of despair, a collective term capturing preventable deaths from substance use or self-harm.[49] Underlying causes of such despair may be associated with certain SDOH[50]—nonbiological factors in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[51] SDOH can be affected by historical, collective trauma (i.e., multigenerational trauma experienced by a specific cultural, racial, or ethnic group),[52] as well as discrimination and racism—interpersonal, systemic, and structural.[53]
- **Social media and social networks:** The widespread use of mobile technology and social networks can have both negative and positive effects on suicidal behavior among adolescents.[54] For example, it has exposed youth to risks, such as online self-harm[55] and cyberbullying,[56] which are associated with depression and suicidal thoughts that may persist over time.
- **Substance use:** Substance use is associated with suicidality among youth.[57,58] The ready availability and increased potency of harmful substances have increased the risks for youth who may use substances or even be exposed to other highly potent substances, such as illicitly manufactured fentanyl, accidentally due to adulteration of the illicit drug supply.[59] One study found that students, particularly girls, who used e-cigarettes, cannabis, or both concurrently were at significantly increased odds of suicidal thoughts and behaviors, compared with female students who were not using substances.[60]
- **Access to lethal means:** Safely storing firearms and medications can mitigate suicide risk. Suicide attempts with firearms are much more lethal than those using other means, with mortality rates as high as 90 percent.[61,62] Suicide attempts can often occur impulsively during moments of crisis.[63,64] Keeping firearms in the home significantly increases the risk of death by suicide in youth.[65] A 2023 study found that youth with access to firearms had 1.52 times higher odds of suicidal ideation and 1.61 times higher odds of a previous suicide attempt, compared with youth without firearm access.[66] In addition to locking up firearms, restricting access to prescription medications and household poisons are also crucial strategies to reduce access to lethal means.[67]

Rurality and Suicide

Youth who live in rural, frontier, and remote locations face additional difficulties accessing services. For instance, rural AI/AN individuals had the highest suicide rates between 2000 and 2020.[68] Remote AI/AN youth may live in areas inaccessible by road, with care being hours away.[69] Compared with urban residence, rural residence increases the risk for firearm-related suicide among youth, especially young men, with research finding that gun ownership and youth access are more common in rural areas than in urban ones.[70-73]

Protective Factors

Protective factors buffer risk of suicide, promote resilience, and can reduce the likelihood that someone will harm themselves or take their own life.[63] Protective factors have historically been less well studied than risk factors,[74-76] and they include having a positive sense of social connectedness, feeling safe and accepted, and having a positive sense of racial, ethnic, and gender identity.[77-79] Protective factors include the ability to cope with stressors, the availability and accessibility of physical and mental healthcare services, and social connectedness.

Impact of Risk and Protective Factors on Underserved Youth

Different cultural contexts, ethnic backgrounds, and life experiences may influence the risk of suicidal ideation and suicide.[80] Multilevel risk and protective factors are associated with suicidal thoughts and behaviors in underserved youth.

American Indian/Alaska Native Youth

Risks. AI/AN youth have the highest suicide rate among all racial and ethnic groups.[81] They also are at elevated risk for suicide clusters—suicides or suicide attempts that occur close together in time and/or place and are beyond what would be expected to occur by chance alone. This fact underscores the need to identify and better understand risk and protective factors.[82] AI/AN male youth ages 10–24 have the highest rate of suicide deaths by firearm (23.4 per 100,000), compared with male youth counterparts from other groups.[83] In AI/AN male youth, suicide deaths by firearm increased 67 percent between 2019 and 2020. A recent study found that the ongoing opioid overdose epidemic in AI/AN communities is having a "syndemic" effect on the concurrent suicide epidemic, in that the two epidemics are amplifying each other. As such, a syndemic approach to suicide prevention and intervention should be considered in these communities.[84]

Protective factors. A 3-year study of six talking circles (safe spaces for discussion, problem solving, and decision making) helped identify barriers to suicide prevention and possible protective factors for AI/AN youth.[85] Normalization of suicide, stigma, and historical trauma emerged as risk factors for suicide. Tribal elders, adults, and youth identified a need for intergenerational and cultural connectedness to bolster resilience and develop successful suicide prevention strategies. In another study, having positive relationships with adults in the home, but not with those outside the home, was found to be protective against suicide.[86]

Climate Change and Youth

The mental and emotional states related to climate change have been described as climate anxiety, eco-grief, climate grief,[87] and solastalgia (environmentally induced distress).[88] Increasingly, youth are concerned about the effects of climate change (e.g., natural disasters, extreme weather events, rising sea levels, forced migration, disrupted food supplies). In a 2021 global survey of youth ages 16–25, more than 45 percent reported that climate change negatively impacted their daily functioning.[89] The adverse effects of climate change on youth mental health can also influence suicidal thoughts and behaviors.[90] Climate change is especially distressful for AI/AN youth with strong cultural affinities to the land and interdependence on the environment.[87] Additionally, there are often race-based disparities in forced migration and displacement following natural disasters.[91] For more information, see the *Supplemental Research Bulletin: Climate Change and Behavioral Health*, *The Dialogue: Impacts of a Warming Planet*, and Mental Health and Our Changing Climate: Children and Youth Report 2023.

Black/African American Youth

Risks. The rate of suicide among African American youth ages 10–19 increased by 54 percent between 2018 and 2022 and is increasing at a higher rate than any other racial group.[92] Black/African American youth in early and late adolescence are at greater risk of attempting suicide without thoughts or plans, compared with White youth.[56] A significant association has been observed between experiencing racism and suicidality,[93] even after controlling for sociodemographic characteristics.[94] Data from the National Violent Death Reporting System show that between 2003 and 2017, 1,810 Black/African American children and adolescents, ages 5–17, died by suicide.[93] Some precipitating circumstances leading to suicide among Black/African American children ages 5–17 include interpersonal issues, problems at school, being diagnosed with a mental disorder, and alcohol or other substance use.[87] There was a significant increase in the firearm suicide rate among Black/African American young adults ages 18–25 between 2013 and 2019, including an 84.5 percent increase in the firearm suicide rate among young Black/African American men and a 76.9 percent increase among young Black/African American women.[95] These data suggest that access to lethal means, such as firearms, is a risk factor for Black/African American young adults.

Protective factors. Possible protective factors to buffer suicidal ideation and suicide attempts among Black/African American youth include having a strong racial and ethnic identity, a sense of purpose,[80] and high levels of positive parenting.[96] One study that used data from SAMHSA's National Survey on Drug Use and Health from 2014 to 2018 analyzed feelings of worthlessness, parent relationships, and suicide among African American youth.[97] Researchers found that building self-esteem among Black/African American youth and encouraging positive familial relations can help prevent suicide in this group.[97] Similarly, a strong, positive sense of ethnic identity, racial socialization, racial pride, and racial and ethnic connectedness have been found to promote resiliency and protect against suicidality in this group.[5] This positive sense of identity is also associated with higher self-esteem, fewer mental health problems, and better academic adjustment, even in the face of systemic and structural racism.[80]Additionally, religiosity—personal beliefs, awareness of faith, and feeling connected to a spiritual community—has the potential to act as a protective shield against youth suicide in the Black/African American community.[5] However, religiosity can be also associated with the discouragement of seeking formal mental health services[98] and cultural stigma associated with discussing mental health challenges.[99]

Hispanic or Latino Youth

Risks. Suicide is the second-leading cause of death among Hispanic or Latino youth ages 15–19 and the third-leading cause of death among those ages 10–14.[100]

Although interpersonal issues have been shown to be a significant precursor to death by suicide across all groups, Hispanic or Latino youth had higher rates of intimate partner relationship issues contributing to suicide deaths than other groups.[39]

Even though a minority of Hispanic or Latino youth are immigrants or children of immigrants, a family member's immigration can affect mental health. Latino immigrant youth (mean age, 12.8 years) with a family member detained or deported in the prior year had higher risks of suicidal ideation, alcohol use, depression, and risk-taking behaviors than nonimmigrant peers.[101] Mexican American children in mixed-immigration status homes where one parent is an undocumented immigrant have higher internalizing and externalizing behaviors than Mexican children whose mothers are U.S. citizens.[102] Socio-ecological factors stemming from immigration policies, such as deportation and immigration raids, have been associated with lower health service utilization,[103] hypervigilance, chronic stress, and poor mental health among undocumented immigrants.[104]

Microaggressions

Microaggressions are subtle forms of "everyday discrimination" that can come in the form of body language, gestures, or subtle insults.[105] These acts can have psychological effects, such as depression and suicidal thoughts, in underserved populations, including AI/AN, Black/African American, Hispanic or Latino, and LGBTQI+ individuals.[105-107] One study measured racial microaggressions across six dimensions in college-age African American youth and found that environmental, verbal, and behavioral microaggressions were associated with higher perceptions of being a burden to others and suicidal ideation.[108]

Protective factors. Positive relationships with an adult family member or unrelated adult are protective against suicide for Hispanic or Latino youth.[86,109,110] In one study, having the support of caring adults reduced the probability of suicide attempts by as much as 50 percent.[8] A general sense of school connectedness (feeling supported by adults and peers in learning and as an individual), has also shown to be protective.[111] Other protective factors include a strong sense of ethnic identity.[8] *Familismo*, or familism, involves a sense of family cohesion and loyalty and is a central value to Hispanic or Latino families. Familism may have protective effects for suicidal ideation and decrease suicidal thoughts and behaviors among Hispanic or Latino youth, whereas family conflict and peer conflict may predict increased suicidal thoughts and behaviors.[110]

LGBTQI+ Youth

Risks. Lesbian, gay, or bisexual youth are at greater risk for suicidal ideation and making a suicide attempt than their heterosexual counterparts.[112] According to CDC, high school students in 2021 who identified as lesbian, gay, or bisexual attempted suicide at a rate five times higher than heterosexual students.[81] One factor that may account in part for this difference is the variable effect, by age, on suicide risk of "outness," or the degree to which a person is open about their LGBTQ+ identity. In one study, being more open or "out" was associated with greater suicidal ideation among 12- to 17-year-olds, but not among 18- to 24-year-olds.[113] Other significant risk factors for suicidal behaviors include misuse of prescription pain medication, illicit drug use, a history of sexual assault, being bullied, depression, and cigarette smoking.[112] Youth Risk Behavior Surveillance System data show that youth who identify as "questioning/not sure" and drank alcohol were seven times more likely to have attempted suicide than those who did not drink alcohol—triple the rate seen for any other sexual identity.[114]

Protective factors. Supportive schools and communities that enable youth to feel safe at school, valued in their community, and comfortable seeking help[121,122] are associated with decreased risk of suicide attempts across several groups of high school students.[7] Past-year suicide attempts are significantly lower among questioning and heterosexual girls in communities with more LGBTQI+-supportive resources, than in less supportive communities, indicating that supportive resources may benefit all adolescents, regardless of sexual orientation.[7] Moreover, the risk of suicide attempts among gay, bisexual, and questioning boys in schools with a gender-neutral bathroom (a marker of overall support from the school community) was approximately one-half of that among their cohorts without access to such a bathroom.[7] Acceptance by parents, cisgender heterosexual friends, and other peers is associated with lower odds of past-year suicide attempt for LGBTQ youth.[123] One study found that mental health risks (e.g., depression, suicidal ideation, suicidal behavior) lessen when transgender youth choose their own gender-affirming name and feel able to use that name in multiple contexts.[124] Other possible protective factors include having a sense of parent-family connectedness and a sense of pride.[125]

The Impacts of the COVID-19 Shutdown

The COVID-19 pandemic took a toll on mental health and well-being across all age groups, especially among youth.[115]

Between March 27, 2020, and July 14, 2020, when many schools were closed and engaged in virtual learning, anxiety and depression symptoms increased among adolescents.[116] The shutdown contributed to social isolation, lost classroom time, the inability to participate in sports and other extracurricular activities, and missed opportunities to be around peers and gain new experiences. These life disruptions led to increased rate of depression and poor academic performance among youth.[117,118]

Even though the age-adjusted suicide rate in the United States decreased from 2019 to 2020, it increased by about 4 percent for youth during this time period, with an estimated 212 excess deaths over pre-pandemic levels.[119] Several subgroups experienced larger increases in the suicide rate, including youth ages 5–12 and 18–24, AI/AN youth, Black/African American youth, and youth who used firearms. During the first 10 months after the pandemic was declared in March 2020, 5,568 children and youth (ages 5–24) died by suicide, most (2,843) by firearms. The end of the COVID-19 lockdown was associated with some improvement in suicide rates. Provisional estimates indicate that between 2021 and 2022, the suicide rate declined by 18 percent in the 10–14 age group and by 9 percent in the 15–24 age group.[120]

CHAPTER

2

What Research Tells Us

This chapter describes research on the unique barriers that contribute to suicidal thoughts and behaviors among underserved youth. Suicide prevention efforts begin with addressing barriers faced by youth, their families, and their communities. These efforts must enhance protective factors and mitigate risks across various environments, such as schools, religious and community settings, hospitals, and emergency departments.

Medicaid and CHIP

Many Americans cannot afford private insurance but are not eligible for Medicaid or the Children's Health Insurance Program (CHIP), depending on the rules of their state. There remain disparities among youth under Medicaid and CHIP, especially among Hispanic or Latino children who are twice as likely and American Indian/Alaska Native children who are three times more likely to be uninsured compared to White children.[127]

In states without Medicaid expansion, Medicaid eligibility often requires lower household income than in expanded-Medicaid states, leaving many families without access to affordable health insurance options. This coverage gap can result in significant barriers to healthcare access.

Barriers To Healthcare Access

Numerous issues affect the ability to obtain mental health services, including lack of insurance, high cost, inadequate transportation, language, and limited or nonexistent community treatment options. When an underserved community lacks equitable access to health care, its level of mental health may suffer.[126]

Some other general barriers to accessing mental health services may include:

- **Affordability:** More than 4 percent of children younger than 18 (3 million children) remained uninsured as of 2022, while 43.7 percent had public coverage and 54.3 percent had private coverage.[128] Even if patients have coverage, mental health professionals who accept insurance may have long waitlists or cannot accept new patients. Families with lower incomes often struggle to afford basic needs like food and shelter and may not be able to cover the cost of mental health services.[129] Free, low-cost, or sliding scale fee services are critical for such families.[130,131]

- **Transportation:** Transportation barriers (e.g., unreliable transportation, cost, lack of access to a private vehicle, lack of technology to secure rides, limited public transportation)[132] can impede access to and participation in vital health services for youth. Public transportation in urban areas may be disjointed, requiring the use of multiple types of transportation (e.g., subway, bus, trolley).[132] Rural, frontier, and remote youth may lack transportation to access services that are often a great distance from their home.[133] Inadequate transportation can lead to youth missing scheduled appointments, delaying interventions, or going without care altogether—all of which can contribute to poorer health outcomes.[134]
- **Shortage of qualified mental health professionals:** At least 169 million people in the United States (more than half of the population) live in a mental health professional shortage area,[135] and the American Academy of Child and Adolescent Psychiatry noted that 72 percent of U.S. counties do not have practicing psychiatrists for children and adolescents.[136] Underserved groups also lack available providers who offer culturally and linguistically appropriate care.[137] Lack of available, accessible, and appropriate providers creates long waitlists and delays care for youth in need of services.
- **Parent or caregiver support:** When parents or caregivers do not support youth seeking mental health services, access to these services is further delayed. Lack of parental support can stem from various factors, including stigma around mental health issues, cultural beliefs, or misconceptions about psychotherapy and psychotropic medications.[138,139] These attitudes undermine the importance of mental health services and discourage youth from seeking help due to fear of judgment or backlash from their primary caregivers.

Barriers To Accessing Telehealth

The dramatic increase in the availability and use of telehealth during the COVID-19 pandemic demonstrated how this technology could help alleviate disparities and expand access to providers. Between February and April 2020, daily telehealth visits rose by 70 percent.[140] Mental health providers, in particular, embraced virtual visits during the pandemic, and many have maintained that mode of treatment as a permanent option.[141] However, underserved populations may face numerous barriers to telehealth, including:[126]

- Low digital literacy
- Lack of access to technology (e.g., smartphone, computer)
- No or unreliable internet service
- Language barriers
- Limited space for privacy (see the section on Stigma, page 14).

Strategies To Support Telehealth

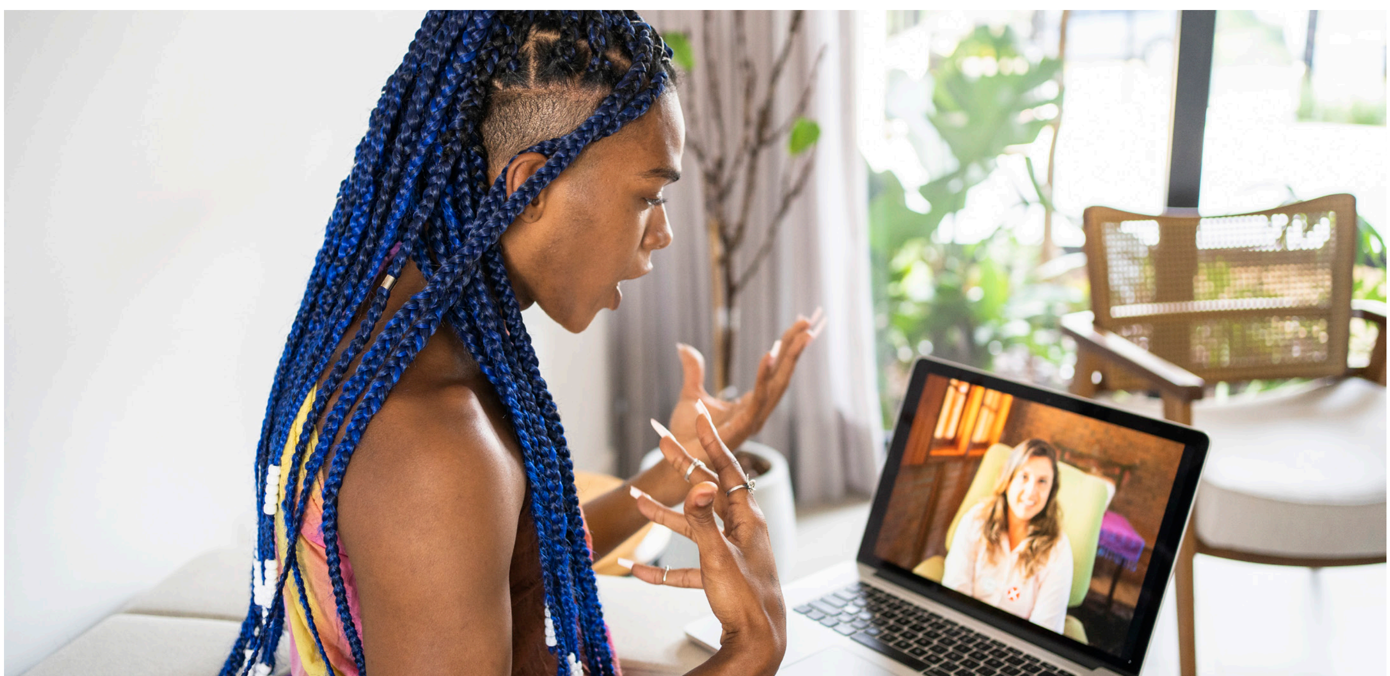
To address barriers related to telehealth, the American Academy of Pediatrics recommends the following practical ideas to support people from rural and underserved communities:

- Determine what technology a family can access and their level of comfort with using devices
- Assess available options in the community (e.g., laptops issued by schools for in-home use)
- Identify community spaces (e.g., libraries) to access technology
- Offer classes to help patients prepare for telehealth visits

Source: American Academy of Pediatrics, (2021). Minimizing Telehealth Technology Barriers in Rural and Underserved Communities

Access Barriers Among Specific Underserved Populations

AI/AN youth are more likely to be uninsured than White youth (9 percent versus 4 percent) and almost twice as likely to be covered by public insurance (44 percent versus 23 percent).[142] Members of federally recognized tribes are constitutionally entitled to services provided by the Indian Health Service (IHS).[143,144] For AI/AN people who do not have coverage with IHS and lack public or private medical insurance, it is even more difficult to access a full range of healthcare services. Additionally, AI/AN youth who live in rural or remote locations may face difficulties accessing mental health services.[69]



Black/African American youth and their caregivers face numerous barriers, including systemic issues, to accessing mental health services for suicide prevention. These barriers are particularly notable due to the intersections of mental health services with other social institutions, such as child welfare and the juvenile justice system. For example, a study using data from 11 emergency departments in a New England healthcare system from 2013 to 2020 revealed that Black/African American youth were more likely than White youth to be subjected to physical restraint while in crisis.[145] This inequitable treatment contributes to mistrust of healthcare systems and is a barrier to accessing care when a Black/African American youth may be experiencing crisis.

Socioeconomic challenges in the mental health system continue to disproportionately affect utilization by Black/African American families. The inability to afford care and lack of coverage for mental health services contribute significantly to the disparities observed in mental health outcomes, including suicide, for Black/African American youth.[146] Together, these access barriers create an increased risk of crisis situations for Black/African American youth.

Hispanic or Latino youth may face barriers to mental health services related to language, lack of health insurance, discrimination, mental health stigma, and fear of deportation (for those with undocumented status or from mixed-status households).[147] Hispanic or Latino caregivers identified lack of recreation opportunities (often due to violence in public spaces), family communication limitations, lack of mental health education and support, discriminatory school environments, limited ability to help with schoolwork, fear of immigration enforcement, and lack of health insurance and bilingual providers as barriers to suicide prevention among the youth.[148]

LGBTQI+ youth encounter numerous barriers to care and are more likely to live in poverty or experience homelessness or housing instability compared to their non-LGBTQI+ peers.[149] Many LGBTQI+ youth face familial exclusion and mistreatment due to their identity, with 16 percent of youth reporting that they ran away from home (55 percent due to mistreatment) and 14 percent reported being kicked out of their home or abandoned. Racial and ethnic minority LGBTQI+ youth experience homelessness or housing instability at much higher rates than their White peers. Housing instability and homelessness have been associated with higher suicidality rates. Additionally, many states have enacted laws banning or restricting gender-affirming care, which restricts providers and creates barriers for these youth. More details on barriers to gender-affirming care can be found in the section, Cultural Responsiveness of Mental Health Service Providers as Access Barriers on page 12.

Racism and Implicit Bias in Healthcare Settings

Racism, a social determinant of health, is one of the most prominent systemic barriers in accessing mental health services.[150] Structural racism, deeply ingrained in societal structures and institutions, plays a pivotal role in shaping health outcomes and perpetuating race-based health inequities.[146,151,152] Structural racism serves as a primary and potent driver of health outcomes, contributing to race-based mental health inequities,[153] which are evident across various health indicators, including access to care, quality of care received, and health outcomes.[154] In addition, cognitive biases—conscious and deliberate (explicit) or unconscious and unintentional (implicit)—have far-reaching consequences. These biases intrinsically affect patients' health outcomes, the patient-clinician communication dynamic, clinical decision making, and institutionalized practices.[155] Recognizing and addressing the impact of structural racism on mental health disparities among underserved youth is imperative for promoting equity and preventing suicidal behavior.

> The healthcare field has made positive strides in suicide prevention, but racial/ethnic differences remain underexplored.[156] The U.S. Surgeon General has recommended recruiting program staff from the communities being served as a strategy to promote equity in mental health.[157]

Cultural Responsiveness of Mental Health Service Providers as Access Barriers

A systemic barrier to providing equitable mental health services for underserved youth is the lack of culturally responsive services within mental health systems, which can lead to feelings of alienation and mistrust toward mental health services and hinder young people's willingness to seek help when needed.[148] Many youth, particularly those from marginalized racial and ethnic backgrounds, often find it challenging to access care that aligns with their cultural beliefs, practices, and linguistic preferences.[146,148,158]

Some LGBTQI+ youth may need gender-affirming care to help them live authentically and comfortably in alignment with their gender identity.[159-161] A growing number of states have adopted or are adopting policies that prevent the provision of gender-affirming care.[162]

As of April 2024, there were 120,200 transgender youth ages 13–17 living in states that have banned gender-affirming care and 160,100 youth living in states with pending legislation.[162]

The limited availability of racially diverse and gender-affirming mental health practitioners exacerbates these systemic barriers.[163-165] The underrepresentation of mental health professionals who reflect the identities of the underserved youth population limits the availability of providers who understand the unique challenges faced by different racial and gender identity groups.[166] It can also contribute to feelings of isolation and invalidation among marginalized youth seeking support. Addressing these systemic barriers requires comprehensive efforts to promote equity and inclusivity within mental health care systems, including increasing practitioner diversity, implementing culturally responsive practices, and ensuring affordable and accessible services for all youth.[150,157]

American Indian/Alaska Native Youth

AI/AN youth face significant barriers when seeking mental health care, including a pervasive distrust of the healthcare system. This mistrust is rooted in the historical trauma and systemic injustices experienced by Indigenous communities.[144] Intergenerational trauma, the passing through generations of trauma from centuries of colonization, forced assimilation policies, and cultural

genocide has profoundly affected the mental health and well-being of AI/AN youth.[167,168] It has also contributed to a collective distrust of institutions, including government agencies and healthcare providers.[144,169]

Furthermore, like members of other underserved communities, AI/AN youth frequently encounter discrimination and bias within healthcare settings, compounding their mistrust of the system.[170] Studies have documented instances of racial stereotyping, cultural insensitivity, and unequal treatment experienced by Indigenous people when accessing mental health services.[170,171] Experiences of discrimination undermine the therapeutic relationship between AI/AN youth and healthcare providers, leading to feelings of alienation and reluctance to seek care.[172] Addressing the structural causes of mistrust, including historical trauma, systemic injustices, and discrimination, helps build culturally responsive and equitable healthcare systems that meet the needs of AI/AN youth and foster trust and engagement with healthcare services.

Black/African American Youth

Structural racism in mental health support has dire and multifaceted consequences for Black/African American youth.[173,174] It can exacerbate the youth's mental health symptoms, such as depression and anxiety, and influence interpersonal experiences in healthcare settings. Racism can also contribute to poor patient-provider communication, misdiagnosis or lack of diagnosis for a mental health condition, or ruptures in continuity of care. A longitudinal study found an association between perceived racism and suicidal ideation and death by suicide.[175]

The negative impact of structural racism goes beyond individual interactions between patients and providers. It has historically perpetuated disparities in access, treatment, and outcomes for Black/African Americans, leading to a deep-seated cultural mistrust. This mistrust stems from a legacy of discriminatory practices in healthcare delivery, reinforcing skepticism toward medical institutions and hindering engagement with healthcare services.[176,177] A systematic review of the literature[178] on the dynamics of help-seeking behaviors among Black/African American youth, including facilitators and barriers to accessing mental health services, revealed that cultural distrust is a pervasive obstacle hindering treatment engagement for Black/African American adolescents. The consequences of mental health disparities in Black/African American youth include higher attrition rates,[179] deferred care,[176] and lack of post-discharge follow-up care.[16,180]

Hispanic or Latino Youth

Discrimination, structural racism, and immigration concerns can lead to mistrust of the healthcare system and impede access to mental health services.[146] Moreover, there remains a lack of culturally responsive services, including a lack of bilingual mental health providers.[181] Language and cultural provider concordance are barriers to accessing mental health services. Communication challenges between monolingual providers, even when using an interpreter, can affect the quality of mental health services.[182] Perceived helpfulness of mental health service providers may also influence a Hispanic or Latino youth's decision to seek formal mental health services. For example, a study among Hispanic or Latino and Asian adolescents found that participants had differing ratings of perceived helpfulness of mental health providers and services.[138] Another study on experiences with mental health service providers among 13 to 20-year-old Latinas with depressive symptoms found that participants reported that therapy and treatment approaches were unhelpful.[183] The reasons for the participants' dissatisfaction

included provider mistrust, negative experiences during hospitalization, having to switch providers, and financial constraints.

Transgenerational trauma and mistrust in systems of care have been noted by mental health service providers who serve Hispanic or Latino children and families.[184] Cultural responsiveness for serving Hispanic or Latino individuals requires an understanding of the role of the family in treatment, the level of acculturation, culturally specific nuances, and the role of traditional healing or "*curanderismo*."[185,186] Collaboration between mental health service providers and traditional healers has been recommended as a strategy to bridge cultures with some Hispanic or Latino populations.[185-188]

Although undocumented youth and those from mixed-status households represent a minority of Hispanic or Latino youth, fear of detection may be a barrier to accessing mental health services for these youth.[189] Immigrant and refugee youth experience long-term trauma derived from the migration process that includes trauma before migration, "in journey," and during resettlement.[190] Mental health service providers may not understand well these systemic issues and traumatic experiences.

LGBTQI+ Youth

A 2023 survey of LGBTQ+ youth ages 13–24 indicated that 84 percent of them wanted mental health services, yet 50 percent of them were unable to access these services.[25] These youth faced significant barriers of prejudice and discrimination[191] and often feared being misunderstood by healthcare professionals.[192] Some LGBTQ+ youth fear being "outed" by mental health service providers, which is more often the case in the South (23 percent), the Midwest (22 percent), and the West (22 percent).[193] These fears are not unfounded—many mental health professionals lack the training to understand and address the unique challenges that LGBTQ+ youth face, and the treatment they offer may be non-affirming and lack cultural responsiveness.[194,195]

Stigma

Stigma poses a significant barrier for underserved youth seeking mental health services, exacerbating their vulnerability to suicide risk. For example, a study of more than 150,000 college students found perceived stigma to be associated with increased odds of suicidal

ideation, planning, and attempt, with higher odds of a suicide attempt in the past year among Black and Asian International students relative to White students.[196] Perceived societal stigma surrounding mental illness often leads to feelings of shame, embarrassment, and fear of judgment, ultimately deterring youth from seeking help when they need it most.[197] Self-stigma can be influenced by cultural beliefs involving internalized negative stereotypes about mental health and the belief that seeking treatment is a sign of weakness or failure.[138] Another factor associated with stigma is fear of disclosure.[197] Many youth may not want others to find out that they are receiving or seeking treatment for mental illness, even when they know that those around them would be supportive. It is imperative to recognize and address the detrimental impact of stigma to guarantee equitable access to mental health services, particularly for underserved youth.

Stigma can be learned from a number of sources, including families.[198] For example, immigrants from cultures that stigmatize symptoms of mental illness may have parents or other family members who view seeking treatment for mental health conditions as embarrassing or as a sign of weakness.[199] For instance, Hispanic or Latino youth may be reluctant to seek help for their mental health conditions, as there is a strong cultural emphasis on family honor.[138]

CHAPTER

3

Guidance for Selecting and Implementing Evidence-Based Programs

This chapter provides information to help schools and other organizations select and implement evidence-based programs that address suicidal thoughts and behaviors among underserved youth. The chapter:

- Reviews potential settings for prevention and intervention programs
- Describes some programs designed for underserved youth and available research results for these programs (i.e., offers guidance for selecting a program)
- Suggests resources for program implementation (i.e., provides background information for implementation)

Evidence is often limited for the programs that this chapter describes. For example, the groups studied may be small in number or often there is no control group, for either practical or ethical reasons. Pre- and post-intervention questionnaires vary in the types of information that they gather, making it difficult to compare the overall effectiveness of programs. Populations served may not stay in one location long enough for effective study, especially those who are unhoused or in foster care. Since suicide is relatively rare, it is difficult to assess suicide prevention programs, except when applied over a long period of time, because other factors might confound and obscure results.

Nonetheless, all the programs presented in this chapter have had some measurable impact. Some programs are directed at specific underserved groups; others may need adaptation for specific groups. Not all evidence-based programs are suited to cultural adaptation. Many communities are developing strategies to meet the unique needs of the people they serve.[200]

To explore program or curriculum adaptation, the 2022 SAMHSA publication *Adapting Evidence-Based Practices for Under-Resourced Populations* provides examples of research on adapted evidence-based practices for mental conditions and problematic substance use for clients with a range of demographic characteristics.

Settings for Prevention and Intervention Programs

Elementary School

The incidence of suicide in elementary-age children remains low, so developing evidence-based preventive programs would be difficult. However, this is a

crucial developmental stage to implement upstream interventions. Elementary schools can take measures to protect their students from suicidal thoughts and behaviors and create an environment where they feel safe discussing frightening feelings. An important starting point is training adults on what to look for and how to respond, according to the Pacific Southwest Mental Health Technology Transfer Network, which has developed a detailed suicide awareness guide for elementary educators. This guide dispels myths, describes current research, and reviews how race, ethnicity, sexual orientation, and gender identity may play into young students' experiences with suicidal thoughts and behaviors. Although formal assessments should be conducted by trained mental health professionals, elementary educators and staff are often able to sense when a student is struggling and make an appropriate referral.

Mental health awareness training is available for educators and school personnel.

The Good Behavior Game (GBG) is a classroom management strategy that can be used in elementary-aged youth as an upstream intervention. Although not specifically intended as a suicide prevention program, GBG has shown long-term improvements in reducing suicidal thoughts and attempts. Decades of research, including a randomized controlled trial within predominately Black/African American classrooms in Baltimore, MD, have informed the evidence of the effectiveness of GBG. Additional information about GBG can be found in the Blueprints evidence-based registry.

Middle School and High School

Middle and high schools play important roles in students' mental health due to the amount of time children spend at school, the centrality of peer relationships in this age group, and the influence of teachers and other adults. School staff are sometimes able to identify suicidal thoughts and behaviors, particularly if they have been trained to do so. The evidence cited below suggests that focused mental health education programs and student-initiated mental health clubs can reduce stigma and enable students to recognize when they or their peers should seek help.

Curriculum-Based Programs

SOS Signs of Suicide for middle and high school students teaches young people to recognize warning signs in themselves and others, while teaching them the best ways to seek help. SOS Signs of Suicide also engages school faculty to recognize suicide risk and how to take action. This intervention has been rigorously evaluated[201,202] and has been shown to be effective in diverse populations, ages, and genders in reducing suicide attempts (self-reported) and increasing student knowledge of suicidal thoughts and behaviors. An evaluation study with diverse students found a decrease in self-reported suicide attempts, an increase in knowledge, and favorable help-seeking or help-offering behaviors.[203] Implementation and training materials are available.

The Building Assets, Reducing Risks (BARR) model focuses on building on students' strengths and identifying resources to help them to thrive. Although BARR has no explicit goal of suicide prevention and has not been evaluated on that basis, it uses eight interlocking strategies to foster strong peer relationships, family involvement, and development of emotional awareness, all of which can play a role in suicide prevention. A controlled study of more than 21,000 students in 66 schools across 12 states showed a variety of statistically significant effects, including improved academic performance and engagement.[204]

Building Resilience for Healthy Kids (Healthy Kids) is a multi-phased, six-session, 1:1 health coaching program for middle school students designed to improve resilience, self-efficacy, and grit.[205] A single-arm study conducted in an urban school with a sample of 252 students who had completed pre- and post-intervention surveys found that the program significantly increased resilience scores for all races and ethnicities, with more marked benefits among African American, Asian, American Indian/Alaska Native (AI/AN), and Native Hawaiian/Pacific Islander students, and students of more than one race.[206] The program is under review in a clinical trial.

Teen Connection Project® (TCP®) is an interactive program for high school students that focuses on changing peer environments and strengthening relationships to improve overall mental health and build

resilience. TCP® is a 12-session program conducted in small groups that facilitates discussions of values and feelings and encourages participants to talk about their lives. A controlled trial of 610 students in 4 urban districts, mostly from racial/ethnic minority groups, showed significantly increased quality of peer relationships immediately after program completion.[207] At 4 months after program completion, participants showed greater academic engagement and lower depressive symptoms.

Peer Support Groups

Bring Change 2 Mind (BC2M) is a mental health awareness club focusing on schools with a high enrollment of historically underserved groups.[208] As of 2023, it had chapters in 480 high schools and 16 middle schools and a student membership of 14,000.[208] The club's objectives are to facilitate youth engagement in conversations about mental health, encourage help-seeking behaviors, identify resources, reduce stigma, encourage youth to lead advocacy efforts at the school and governmental levels, and to increase the number of mental health service providers by encouraging youth to pursue careers in the field. A peer-reviewed evaluation of the program at three underserved high schools with predominantly Latino enrollment showed a statistically significant reduction in stigma and increases in positive views, peer support, and help-seeking among club members.[209]

Youth Aware of Mental Health (YAM), used worldwide, is an evidence- and school-based program for 13- to 15-year-old students to learn about mental health. This 5-hour curriculum over 4 weeks includes lectures and role play to help students learn about risk and protective factors associated with suicide and improve coping skills and resilience in dealing with depression, anxiety, stress, and adverse life events. A clinical trial among 11,110 students in Europe showed significant reductions in new suicide attempts and suicidal ideation in the YAM group compared to the control group over a 1-year period.[210] The program has not been studied systematically in the United States, although a feasibility study found that it was well accepted by students and parents.[211] Program developers stress the importance of adapting the curriculum to fit each group's culture and needs.

Sources of Strength is a peer-led, evidence-based suicide prevention program for secondary schools (students ages 12–17). The program trains students to be peer leaders and connects them with adult advisors, both at school and in the community.[212] Sources of Strength has been implemented in a variety of settings, including tribal communities, cultural community centers, and LGBTQ+ centers. The role of the peer leaders is to model positive behaviors (such as help-seeking, healthy coping, and identifying trusted adults) and to change peer group norms surrounding problem behaviors (such as self-harm, drug use, and unhealthy sexual practices). This process builds protective influences and is intended to reduce the likelihood that vulnerable youth will become suicidal. The organization also launched a program for elementary schools (grades K–6) in 2020. Sources of Strength has been rigorously evaluated, including in several randomized controlled trials.[212] A study that analyzed three cluster randomized trials showed promise in reducing suicide mortality.[213]

School-Based Health Centers

School-based health centers (SBHCs) provide physical and mental health and wellness services to students and serve many students who do not otherwise have routine access to health care. One study showed strong evidence that SBHCs reduce depressive and suicidal symptoms and are particularly effective for sexual minority youth.[214] In a study of more than 13,000 Oregon 11th-graders from 137 schools, sexual minority youth in schools with an SBHC showed relative reductions in the likelihood of depressive episodes (30 percent), suicidal ideation (34 percent), and suicide attempts (43 percent).

Extracurricular/Out-of-School Activities

Participation in sports and other extracurricular activities is associated with greater self-esteem and reduced odds of self-harm and other mental health problems.[215] This effect has been noted across multiple racial and ethnic categories, as well as with LGBTQI+ youth.[216]

College/University

Active Minds is a network of student-led groups in middle and high schools, universities, and communities that create supportive cultures and promote mental health, advocacy, and community-building. Its mission calls out the extra risk associated with being a member of a marginalized group. A survey of more than 1,100 students across 12 California college campuses showed that increased familiarity with Active Minds was associated with increases in perceived knowledge, decreases in perceived stigma around mental conditions over time, and a range of helping behaviors.[217]

Suicide Prevention for College Student (SPCS) Gatekeepers Program trains college students to recognize suicidal behaviors in their peers. In a study of 876 undergraduate and graduate students at 3 colleges in the north-central, south-central, and southeastern regions of the United States over 3 years, participants demonstrated significant gains in suicide knowledge and suicide prevention self-efficacy and reductions in stigmatizing beliefs about people with suicidal thoughts.[218] Almost half of the participants who completed the 12-week follow-up survey reported putting their skills to use since the training. Another 45 percent reported that following their training, they had provided support to at least one person experiencing a mental health concern.

Early Individual and Family Treatment

Repairing and strengthening family relationships has been shown to be effective for youth exhibiting suicidal thoughts and behaviors. Three approaches are described below.

Attachment-Based Family Therapy (ABFT) is a mental health program, consisting of five treatment tasks, to treat depression and suicidality in youth by promoting secure relationships. In a randomized controlled trial of suicidal youth ages 12 to 17, 70 percent of whom were Black/African American, the youth treated with ABFT had greater reductions in suicidal ideation than youth with treatment as usual.[219]

Family Check-Up® (FCU) is a brief, home-based, parent-led, strengths-based intervention designed to support positive parenting practices and promote well-being for families with children ages 2–17.[220]

FCU consists of three sessions to establish a shared perspective and build rapport and mutual trust between the provider and the family, and understand the parents' concerns and goals; assess family interactions, including child behavior; and collect information from significant people in the child's life. The third session involves tailored feedback, when the provider reviews assessment results and discusses follow-up services with the family.[221] Follow-up services typically focus on relationships, positive behavior support, and setting healthy boundaries. They may also include Everyday Parenting, a parenting program that is typically delivered by the FCU provider. There are many published studies on FCU, which is rated as a well-supported practice in the Title IV-E Prevention Services Clearinghouse.[220] Implementation and training materials for FCU are also available.

The Family-as-Host (FAH) Model is a framework for culturally responsive practices for mental health service engagement of Black youth of African descent and their families.[222] The model is rooted in a person- and family-centered approach to practice. It emphasizes cultural humility, sensitivity, and responsiveness, which are essential for effective treatment engagement of families from culturally diverse backgrounds. FAH positions Black youth and their families as "primary initiators" who act as "Host," and service providers as "facilitators" who play the role of "Guest." The model's six steps span the entirety of the care engagement

continuum: problem identification and help seeking, intake process, assessment, intervention, acceptance of recommendations, and outcome. Providers work within family cultural contexts, while leveraging the family's strengths and cultural assets, which promotes the mental health well-being of youth and families.[222] Evidence to support the model's effectiveness is limited, as FAH is an emerging practice.

Technology-Based Interventions

Technology can play a role in suicide prevention by connecting those in crisis to a clinician or trained hotline responder or by automating some of the assessment and intervention elements traditionally provided by mental health professionals. These emerging practices do not yet have a strong evidence base.

The National Suicide Prevention Lifeline transitioned to the 988 Suicide & Crisis Lifeline for the public to call, chat, or text during an emotional crisis. Between July 2022 and May 2024, 988 received 10.8 million calls, chats, and texts.[223] The nation's first adaptation for AI/AN populations, Washington State's Native and Strong Lifeline,[224] offers a culturally tailored help option (accessed by pressing "4" within the main 988 service, if dialed from a Washington state area code) based on Native wisdom and lived experiences. LGBTQI+ youth can access an LGBTQI+ trained crisis counselor by texting PRIDE to 988 or by pressing "3" when calling 988.

Mental health phone apps and online treatment modules have proliferated, including those designed for suicide prevention. In April 2024, the U.S. Food and Drug Administration approved an app for major depressive disorder,[225] on a prescription basis, for adults ages 22 and older, who are also taking antidepressant medication under clinical supervision.

An emerging body of evidence supports other online interventions. The BRAVE multimedia intervention for AI/AN youth ages 15–24 is the first mobile intervention to be studied in a national randomized controlled trial.[226]

For more information, see the SAMHSA *Advisory* on Digital Therapeutics for Management and Treatment in Behavioral Health.

Targeted Programs and Approaches for Underserved Groups

Interventions that have shown promise for suicide prevention among underserved groups are discussed below. Although suicide prevention is not an explicit goal for some interventions, they do have goals consistent with that aim, such as improving overall mental health or family relationships, reducing substance use, or decreasing depression. Suicide prevention programs are covered in depth in Chapter 4.

American Indian/Alaska Native Youth

Among AI/AN youth, there is strong evidence for a protective effect from a strong connection to heritage, culture, and tradition. Several tribes have been active in developing programs and curricula, and prevention and intervention for AI/AN youth have been studied in more depth than for some other traditionally underserved groups. Additional information is provided in the Indian Health Service webpage on Youth and Suicide Prevention.

American Indian Life Skills (AILS) is a school-based program to reduce AI/AN adolescent suicidal behaviors that was collaboratively developed with Pueblo of Zuni community members in New Mexico and has been used since 1990.[9,227] It is typically delivered over 30 sessions during the school year or as an after-school program, with students participating in lessons three times per week.[9] The curriculum emphasizes social–cognitive skills training, including information on suicide, recognizing and eliminating self-destructive behavior, and suicide intervention training. The curriculum incorporates domains of well-being that are specific to tribal groups, including helping one another, group belonging, and spiritual belief systems and practices. There is limited evidence that shows a reduction in depressive symptoms and suicidal thoughts and behaviors.

Elders' Resilience Curriculum (*Nohwi nalze dayúwéh bee goldoh dolee*), developed by the White Mountain Apache Tribe, addresses youth suicide and strengthens the ties between youth and elders. Tribal elders teach a curriculum through monthly visits to reservation schools, designed to connect students to various aspects

of Apache tradition and culture. A pilot phase starting in 2015 reached more than 1,000 students.[228] The preliminary evidence from the pilot study indicated good acceptance, but further study is needed to gauge efficacy. This intervention completed a clinical trial in 2024.

Culture Forward is a strengths- and culture-based tool to protect Native youth from suicide that was developed with input from various communities and organizations. Culture Forward contains a variety of evidence-based interventions to prevent AI/AN suicide. The program is centered around five core themes that focus on the importance of community, connection, traditional knowledge, self-determination, and youth leadership to reclaim the community's autonomy and well-being.[229] Culture Forward is a tribally driven, practice-based suicide prevention program; as such, the program is still building the evidence to support its effectiveness.

Culture Camps aim to revitalize and connect Indigenous youth to their culture to promote mental health and resilience. A pilot investigation of such an intervention was carried out among 111 Alaska Native youth, ages 13–18, over a 5-day culture camp in two remote regions of Alaska. Pre- and post-intervention surveys revealed increased positive mood and sense of belongingness and an enhanced perceived ability to manage potential life stressors.[230]

Qungasvik (Toolbox) is a multilevel, strength-based intervention to reduce and prevent suicide and alcohol misuse disorder in 12- to 18-year-old Yup'ik Alaska Native youth.[231] (See Chapter 4 for detailed information.)

Black/African American Youth

Strong African American Families (SAAF) supports African American youth ages 10–14 and their families; SAAF-T supports adolescents ages 14–16.[232] The seven-session intervention helps preteens transition into their teen years and emphasizes topics critical for the adolescent, caregivers, and family unit. Youth participants in the program had delayed sexual behavior or were less likely to initiate substance use, and adolescents experienced fewer behavioral issues.

Adapted Coping with Stress Course (A-CWS) was adapted using stakeholder input from curriculum originally used with predominantly White adolescents. A-CWS is aimed at enhancing African American adolescents' skills at coping with individual and contextual stressors, such as personal and systemic racism and community violence, which are known suicide risk factors.[233] (See Chapter 4 for detailed information.)

The YBMen Project is an educational and social support program for young Black/African American men ages 18–30. It uses private social media groups (e.g., Facebook, Instagram) to provide mental health education and social support with information and prompts from social media and popular culture (e.g., YouTube videos, photos, lyrics, current headlines). The body of research on this intervention highlights the impacts of gender and race on Black/African American boys and men. Although the program is not specifically intended for suicide prevention, a 2020 study showed a significant decrease in depressive symptoms among participants.[234]

Hispanic or Latino Youth

Life is Precious™ is a community-based program that helps Latina adolescents and their families address risk factors.[235] In one study, participants ages 11–18 were assessed every 4 months for trauma exposure, depressive symptoms, family cohesion, and suicidal ideation.[235] In this same study of 107 participants who were members of this high-risk population, there were no suicide attempts and no one died by suicide. The study found a reduction in suicidal ideation, anger, depression, and posttraumatic stress. A follow-up study tracking 31 participants over a year found modest improvements in measures of depression and suicidal ideation.[236]

LGBTQI+ Youth

Proud & Empowered is a high school program for LGBTQI+ students that addresses minority stressors via a 10-session, small-group intervention that includes education, discussion, and role playing. It covers such issues as stress and coping; safety in relationships; LGBTQI+ community and history; issues related to race, ethnicity, and social justice; and peer relationships. Research conducted among a small sample showed reduced anxiety in the test group.[237]

Family Acceptance Project® helps ethnically, racially, and religiously diverse families learn to support their LGBTQ children, to decrease rejection and health risks, and to increase support and well-being for LGBTQ young people. Family Acceptance Project® is based on research showing the centrality of family relationships in LGBTQ children's mental health. Additionally, the project provides multilingual educational materials and training for agencies, families, providers, and religious leaders.

Student-initiated genders and sexualities alliances (GSAs) and welcoming school policies have been shown to increase feelings of acceptance and reduce risk of suicidal thoughts and behaviors for LGBTQI+ students.[238] A 2020 study of more than 1,000 racially diverse LGBTQ students ages 15–21 found that GSAs and supportive school policies can strengthen social support (highest levels reported by Black/African American youth) and reduce bullying, creating a supportive school climate for LGBTQ+ youth.[238] The GSA Network is one resource for starting a GSA chapter.

Youth in Difficult Transitions

Youth Experiencing Homelessness

Cognitive Therapy for Suicidal Patients (CT-SP) is a version of cognitive–behavioral therapy (CBT) focused on the irrational beliefs associated with suicidal ideation.[239] The treatment consists of ten 50-minute sessions either weekly or biweekly, with an option of nine additional maintenance sessions. A study recruited 150 youth experiencing suicidal ideation and homelessness, ages 18–24, from a drop-in center and assigned them to either CT-SP or usual treatment. Although all participants showed a decline in suicidal ideation over time, the decline was faster in the group assigned to CT-SP.

Youth Involved With the Justice System

e-Connect is a digital clinical decision support system (CDSS) for youth involved with the juvenile probation system. It screens for suicidal risk and helps probation officers identify youth with suicidal thoughts and behaviors and rapidly refer and link them to appropriate services.[240] This multisystem approach to suicide prevention is the first digital CDSS for probation officers to prevent suicide in justice-involved youth. A recent study showed that probation officers were 5 times more likely to identify youth with suicidal thoughts and behaviors and 11 times more likely to refer youth to behavioral health services, compared to care-as-usual. e-Connect is undergoing a 3-year clinical trial to scale up the intervention with 3,629 participants ages 10 years and older.

Preventing Reattempt: Caring Contacts

Earlier suicide attempt is a major risk factor for subsequent attempts. Any suicide prevention program should incorporate extra measures to address participants who have attempted suicide, including regular contact and connections with care resources.

One evidence-based intervention is Caring Contacts, a program in which people who have made a suicide attempt receive periodic letters or text messages from a behavioral health practitioner, creating a connection and showing someone cares. First proposed in 1976 by psychiatrist Jerome Motto, the intervention has been shown to reduce suicidal ideation and reattempts even years later,[241,242] and it has been adapted for AI/AN communities.[243]

The University of Washington is studying whether computer algorithms can study a patient's text messages and identify indicators of risk and other important information to help behavioral health practitioners with the nature and timing of their responses. This approach would allow one behavioral health practitioner to extend effective contacts to many more suicidal patients.

Implementation Resources

Many of the interventions described above have information on their websites on how to implement them. Some additional resources are listed below.

Tools for Clinicians

- **Youth ASQ Toolkit:** This widely used short questionnaire, the Ask Suicide-Screening Questions (ASQ) screening tool, is adapted for youth and for various settings.
- ***A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children:*** This SAMHSA guide assists medical, mental health, and other community providers who serve youth to provide care and guidance to caregivers and families of LGBT children.
- **Columbia-Suicide Severity Rating Scale (C-SSRS):** This screening tool assesses suicidal ideation and behavior and can be adapted to a variety of settings and populations, including children with cognitive impairment.
- **The Reiss Scale:** This mental health screening tool for youth ages 4–21 with an intellectual disability takes approximately 15 minutes to administer.

Resources for Schools

- ***After a Suicide: A Toolkit for Schools:*** This guide offers administrators and staff the appropriate resources to support middle and high school communities after the loss of a student to suicide. The resource also contains guidance on managing memorial efforts, communication regarding suicide death, and mitigating the risk of suicide contagion.
- ***Preventing Suicide: A Toolkit for High Schools:*** This SAMHSA toolkit is intended for education professionals to increase their ability to promote behavioral health and prevent suicide in high school students.
- **Suicide: Blueprint for Youth Suicide Prevention:** This resource provides pediatric health clinicians guidance on suicide prevention strategies for youth.

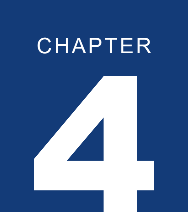
- **National Center on Safe Supportive Learning Environments:** The center provides a collection of culturally and linguistically competent resources about promoting safe and supportive learning environments on a variety of school climate topics.
- ***Toolkit for Mental Health Promotion and Suicide Prevention:*** Topics covered in this toolkit include promoting youth mental wellness, recognizing and responding to mental health crises, and supporting school communities after a suicide loss.
- ***North Carolina School Suicide Prevention Toolkit:*** This resource prepares school staff to identify students with suicidal ideation and behaviors, take action to ensure safety, refer students to professional care, and follow up to ensure receipt of wraparound services.
- **National Association of School Psychologists:** This organization offers detailed guidance about programs, including legal, ethical, and technological considerations.

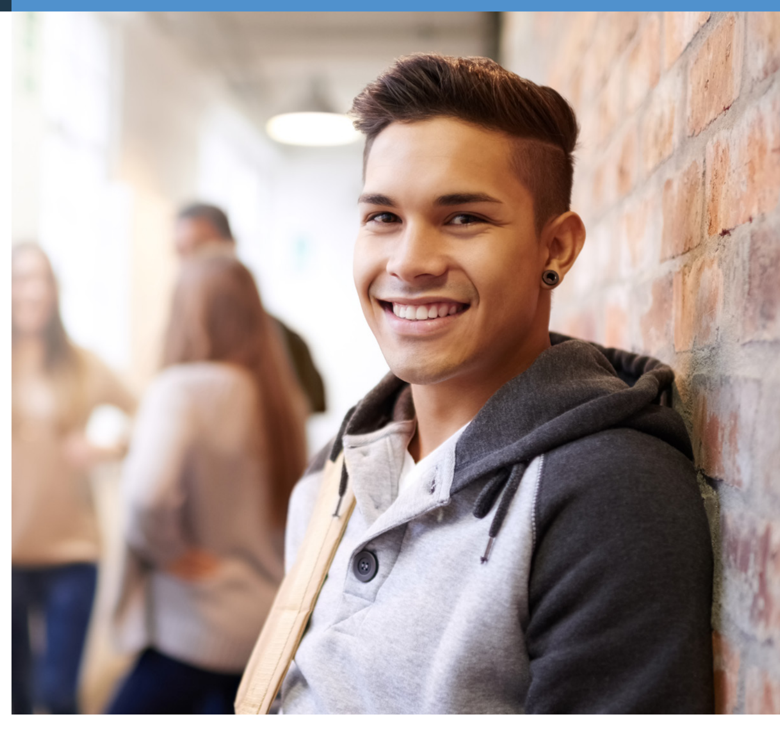
Peer Support Groups and Programs

- **Hope Squad** is a peer-to-peer program that aims to "reduce youth suicide risk through education, training, community partnerships, and cultural change."[244] Hope Squad curricula are available for elementary, middle, and high school students.[245] Listed as a best practice by the Suicide Prevention Resource Center, Hope Squads are in more than 1,600 schools across the United States and Canada.
- **Unité** is a peer-driven organization that promotes mental health and provides information for many groups in several languages.
- **The Yellow Tulip Project** focuses on school-based, peer-led mental health promotion.
- **The Trevor Project** supports LGBTQ+ youth through information, research, access to trained counselors, chat and text hotlines, and TrevorSpace—a safe online community for youth to interact.

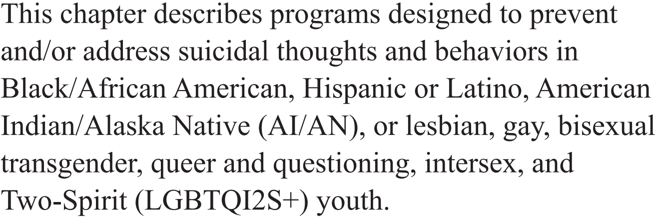
Additional Resources

- **The AAKOMA Project** is a resource for youth and young adults of color and their families that focuses on empowerment, inclusive mental health services, and facilitating systemic change.
- **We R Native** is a digital resource for AI/AN youth that promotes holistic health, social connectedness, and community involvement. Youth can also text (available 24/7) to be connected to counseling or support.
- **Rainbow Youth Project USA** connects LGBTQIA+ youth to free suicide prevention and mental health services.
- **Black Girls Smile** is an organization dedicated to the mental well-being of Black girls and women, led by Black women.
- **The National Network to Eliminate Disparities in Behavioral Health's NNED Share** has a variety of innovative and culturally tailored interventions.
- **The Act, Support, and Protect (ASAP) Center** trains organizations, health, and mental health professionals in trauma-informed treatments for youth. ASAP focuses on treating and preventing suicidal behavior, self-harm, depression, and substance use.
- **Black Mental Wellness** provides resources and fact sheets on a range of mental health concerns from a Black perspective.
- **Safe Reporting Guidelines for Media** offers guidance for media on how to cover suicide-related deaths, including safe reporting practices to protect vulnerable youth and respect surviving families.





Examples of Evidence-Based Youth Suicide Interventions



This chapter describes programs designed to prevent and/or address suicidal thoughts and behaviors in Black/African American, Hispanic or Latino, American Indian/Alaska Native (AI/AN), or lesbian, gay, bisexual, transgender, queer and questioning, intersex, and Two-Spirit (LGBTQI2S+) youth.

The programs included in this chapter were identified through a review of the literature and consultation with experts. Programs met the following inclusion criteria:

- **Evidence of effectiveness:** Demonstrated success in improving outcomes in mental well-being or lower risk of suicide, as evidenced by suicide severity rating scales, aggregate self-reported outcomes, or peer-reviewed research among populations they are intended to serve.
- **Adaptability:** Can be adapted to reach youth in underserved communities, considering cultural, socioeconomic, and geographic factors.
- **Cultural responsiveness:** Provides culturally and linguistically appropriate services.
- **Implementation:** Point of contact can detail how the program was implemented.
- **Credibility:** The program or organization, as well as the research that supports program outcomes, are evidence based or have been rigorously evaluated.

Qungasvik (“Toolbox”): For Alaska Native Communities

Qungasvik is a community-initiated, strengths-based suicide and alcohol use prevention intervention that focuses on enhancing protective factors among adolescents ages 12–18 in rural Alaska Native communities.[246] The intervention was developed in collaboration with Yup’ik communities in southwest Alaska. Outcomes show an increase in reflective processes to promote “reasons for sobriety” and “reasons for life.” This intervention promotes protective factors in youth, empowers the development of Elder leadership, and fosters intergenerational relationships.[231,247] It can best be described as “culture as intervention.”[248]

Program Overview

Qungasvik consists of 19 (J. Allen, researcher, 2024, personal communication) intervention modules that draw upon Yup’ik cultural traditions and practices to promote positive health behaviors and protective factors.[247,249] The intervention manual provides outlines of the modules, which are described as teachings and conducted at the individual, family, or community level through one or more 1- to 3-hour sessions. Each module promotes protective factors at the individual, family, and community levels.[247]

Qungasvik is defined through four characteristics[231,247]:

- Local control by the community
- Culturally grounded model of change
- Culturally grounded theory-driven implementation
- Culturally grounded approach to knowledge development

Outcomes and Other Benefits

Much of the research on Qungasvik focused on the development of this community-initiated, community-driven intervention.[247,249,250] The program has served more than 1,000 youth in small, rural, Native communities in southwest Alaska for more than 20 years (J. Allen, researcher, 2024, personal communication).

A 2021 study of Alaska Native youth, ages 12–18, used a set of measures in the Yup’ik language grounded in Yup’ik theory of change.[250] Researchers culturally and linguistically adapted and combined instruments to measure a variety of protective factors related to “reason for life.” This study centered on adapted instruments to measure “reason for life” protective factors in a culturally grounded manner to better understand risk and resilience from a culturally specific lens.

In a study among Yup’ik youth ages 12–17, one community received high-intensity Qungasvik and the other received a low-intensity intervention.[248] This study used adapted measures for “reason for life” and reflective processes to better understand the dose response and found that higher intensity (more sessions) had a greater effect on youth protective factors for suicide. A longitudinal study found that a dose-dependent relationship associated Qungasvik with greater “reason for life” and reflective processes as protective factors for preventing suicide and alcohol misuse.[231] These studies provide evidence of cultural traditions and practices as resources for suicide and alcohol use prevention.

Cultural Sensitivity and Adaptations

Qungasvik was initiated and developed by Yup’ik communities, with help from researchers.[249] However, it can be culturally tailored to other communities, settings, traditions, and world views through a community-based participatory process. The adaptive process also fosters community ownership.[247] The intervention manual provides a process for community adaptation.[248] Fidelity is measured through adherence to the core functions.

Accessibility

The associated costs of implementation will vary according to setting and individual programmatic needs. For example, the cost is $4,000 per youth participant in remote, off-the-road system communities in Alaska. A no-cost preview of the curriculum is available online.

For More Information

http://www.qungasvik.org/home or email admin@qungasvik.org

Adaptations of the Coping with Stress Course: For Black/African American Youth

There are two adaptations of the Coping with Stress Course (CWS) for Black/African American adolescents, Adapted-Coping with Stress (A-CWS) and Resilient In spite of Stressful Events (RISE). CWS is an evidence-based intervention that draws on cognitive–behavioral therapy (CBT).[251]

A-CWS is a stress-reduction intervention that has been culturally adapted for Black/African American adolescents living in low-resourced urban environments. The adaptation process was guided by the theoretical framework of Bernal and colleagues[252] and was informed by focus groups of 20 Black/African American students in grade 9.[253] The A-CWS curriculum was modified to include culturally relevant multimedia and names[254] and environmentally relevant and culturally specific elements.[253]

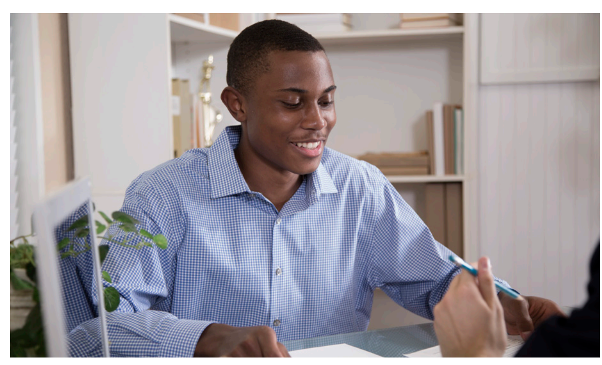
RISE was developed through a community-based participatory process conducted over 6 years with predominantly low-income, urban, Black community members and youth.[255] RISE adapted CWS using "surface" (e.g., changes in graphics, language/dialect, proper names, and cultural references) and "deep" (core values, cultural norms, social, historical, and environmental influences, world view) structural adaptations.

Black/African American adolescents in urban environments are subjected to chronic stress attributed to socioenvironmental factors that are associated with increased risk of suicidal thoughts and behaviors.[253,256,257] Given these environmental susceptibilities and the structural effects of racism on chronic stress, the A-CWS and RISE programs are well suited as culturally grounded interventions to enhance coping and stress-reduction skills in urban Black/African American adolescents.

Program Overview

A-CWS follows these core components:

- Groups of 8–10 adolescents participate in 45-minute sessions, delivered weekly or bi-weekly.
- Review of the previous week's group topic and home activity, group discussion of the week's topic, group activities focused on behavior, and the week's home activity assignment. In the final session, students receive a Certificate of Completion.[254]



Note on Available Interventions for Black/African American Youth

Despite urgent calls to action to address suicide in Black/African American youth in *Ring the Alarm: The Crisis of Black Youth Suicide in America* and *Still Ringing the Alarm: An Enduring Call to Action for Black Youth Suicide Prevention*, there is limited evidence on suicide prevention for this population. These publications recommended that funding and research be directed toward evaluation of community-based suicide prevention programs and that Black/African American voices be centered in these efforts.

As a result of these recent calls for Black/African American youth suicide prevention, many programs and interventions for this group are still in a pilot phase and not yet scaled to provide large-scale implementation guidance, a criteria for this report. There has been a shortage of culturally grounded and community-led research and evaluation frameworks that specifically address the unique experiences and needs of Black/African American youth in the context of suicide prevention. Traditional federal and non-federal research funding and priorities may not have focused adequately on community-based and culturally responsive interventions, leading to a gap in the formal evaluation of these programs. Indeed, a number of suicide prevention efforts are related to screening and identification, rather than providing culturally responsive resources to reduce suicidal thoughts and behaviors. A significant gap remains in formal evaluation or research to support the effectiveness of these programs. The featured interventions are examples of promising, culturally grounded suicide prevention interventions for Black/African American youth that are continuing to scale up for widespread implementation.

- A licensed clinical psychologist or master's-level clinicians facilitate sessions. They have been trained in facilitation, engagement, and use of validated instruments to measure suicidality at postintervention. Facilitators should monitor participants' emotional status and have an established referral process to an onsite provider for crisis intervention, if needed, throughout the program.[233]
- A-CWS can be delivered in school settings.[254]

RISE consists of the following core components:

- Groups of 8–12 adolescents participate in 1 hour and 45-minute sessions, delivered weekly over 9 weeks.
- RISE follows specific goals for each session. Upon completion, youth are referred to other youth development programs and provided a tour of local universities.
- Facilitation is delivered by diverse graduate students (co-leaders) and undergraduate students (program assistants) and supervised by a licensed psychologist. Facilitators receive training on the intervention. The ratio of program assistants to students is 2:1.
- RISE is delivered in an after-school program setting.[255]

Outcomes and Other Benefits

A-CWS has been tested for acceptability and feasibility among ninth graders, who responded positively to the length, duration, content, and facilitation of the sessions.[233] A-CWS has shown promise in reducing anxiety and improving mediators of depressive symptoms.[254]

A randomized controlled trial (RCT) with urban Black/African American students in grades 9–11 in a low-resourced Midwestern city produced several significant effects in the intervention group compared with the control group, including reduced anxiety at the posttest and improvements to mediators of depression (e.g., self-efficacy, adaptive coping, positive thinking).[254] In another study with the same group, 682 students completed a survey on suicide risk, with almost half of the students indicating an elevated risk of suicidality.[253] Longitudinal trials in which 410 students from 4 high schools were given 6- and 12-month postintervention assessments suggested that participants who had elevated levels of suicidal ideation at the baseline screening showed greater effects of A-CWS treatment at 12 months postintervention, and that students who had attended 12 or more A-CWS sessions were more likely to maintain positive social support coping skills than the control group.[258,259]

In a pilot trial, RISE demonstrated a high rate of acceptability among adolescents, who had fewer externalizing (e.g., aggression, defiance) behaviors, as rated by their caregivers.[255,260] There is currently a manuscript in preparation about an RTC on RISE among students from 17 high schools who attended the RISE after-school program.[260] The outcome measures for this study are self-reporting coping self-efficacy and control beliefs.

Cultural Sensitivity and Adaptations

As noted, A-CWS and RISE were adapted for urban Black/African American high-school aged adolescents from the CWS curriculum by using an adaptation theoretical framework, input from adolescents and community members, and rigorous studies. CWS has undergone further adaptation in recent years, revising the content from surface structure to deep structure adaptations.[255] These culturally grounded adaptations of the original CWS intervention address the specific socioenvironmental stressors, including racism and exposure to community and police violence, that Black/African American adolescents who live in urban environments experience in their daily lives.

Accessibility

Currently, there is limited information about accessing materials for A-CWS or RISE.

For More Information

A-CWS: Dr. LaVome Robinson, lrobinso@depaul.edu; RISE: Dr. Angela Clarke, aclarke@wcupa.edu

Familias Unidas: For Hispanic or Latino Families

Familias Unidas was developed by research faculty at the University of Miami, Department of Public Health Sciences, through community-based participatory research.[261] This family-based intervention can reduce health risk behaviors in Hispanic or Latino youth ages 12–16 by focusing on multilevel risk and protective factors. While the initial focus of Familias Unidas was to prevent substance use and risky sexual behavior, the intervention has been broadly applied to reducing other behavioral problems among youth. The intervention empowers parents and caregivers to communicate effectively with their youth, practice positive parenting skills, and improve family functioning.[262]

Program Overview

A key component of Familias Unidas is the involvement of the parent(s) or caregiver(s) in group sessions guided by trained facilitators. The intervention typically takes place in person but has been adapted for delivery through the internet.[263] Familias Unidas is underpinned by ecodevelopmental theory, which informs its multilevel intervention to enhance protective factors and decrease risk factors at the adolescent, peer, school, parent or caregiver, family support network, and cultural levels of influence.[261]

Familias Unidas has been tested in multiple randomized trials over the past two decades.[263-275] Familias Unidas is listed as a promising or well-supported program on several evidence-based practice registries and clearinghouses.[276,277] In addition, it has evidence that improvements in family functioning and communication are associated with a crossover effect of reduced internalizing behaviors for adolescents with an increased risk of suicidal thoughts and behaviors and other internalizing symptoms.[272]

Familias Unidas has the following components, essential to implementing with fidelity.[262,278,279]

- **Parent or caregiver sessions:** At least 1 parent or caregiver from a family attends 2-hour group sessions with 12 to 15 parents or caregivers. Group sessions focus on fostering parental involvement in their adolescent's life, increasing parental protective factors, and building positive parenting skills.
- **Family sessions:** Family sessions include the adolescent and their parent(s) or caregiver(s). These facilitated sessions focus on application of the skills from the group sessions and are intended to increase self-efficacy and improve family functioning.
- **Duration:** Parent or caregiver sessions are delivered across 12 weeks.
- **Facilitation:** All sessions are led by a bilingual (Spanish and English) facilitator and co-facilitator. Facilitators must have a bachelor's degree or higher. They can become certified by completing a 24-hour training.
- **Delivery setting:** Schools and community-based organizations deliver the program.

Outcomes and Other Benefits

This intervention has been studied for more than two decades in the United States and, more recently, Latin American countries. Research on Familias Unidas has shown a variety of outcomes that include the program's influence on family functioning,[266,271,273,280] decrease in risky behavior,[271] and internalizing symptoms (e.g., depression, anxiety).[268] Internet-based adaptations of Familias Unidas have been implemented in novel settings, such as primary care.[266,274]

Cultural Sensitivity and Adaptations

Familias Unidas has been implemented with Spanish-speaking Hispanic or Latino families of diverse origins and backgrounds, including Afro-Latino families from Cuban, Honduran, Nicaraguan, Dominican Republic, and other backgrounds.[277] Familias Unidas has also been adapted for Hispanic or Latino sexual minority adolescents, who reduced risky sexual behaviors.[275,281] The intervention is primarily conducted within community-based and school-based settings; however, there have been adaptations into primary care settings.

Accessibility

Training is available for facilitators to become certified in delivering the intervention, as well as a train-the-trainer to deliver facilitator instruction.[262,278,279] Familias Unidas training generally takes 3 to 4 days.[262] Additionally, formal support provides guidance, supervision, troubleshooting, and fidelity assessments. An implementation manual is available.

Fidelity measures, developed by the founders of Familias Unidas, rate the core components of the program. The facilitator training provides information on how to measure fidelity.

For More Information

https://www.sonhs.miami.edu/research/familias-unidas/index.html

AFFIRM Youth: For LGBTQ+ Youth

The AFFIRM Youth program adapted CBT techniques to the unique needs of LGBTQ+ youth ages 12–25 to reduce psychological distress and aid in developing self-awareness and identity, the ability to distinguish between thoughts and feelings, and the capacity to build and utilize effective coping skills.[282] This intervention was developed through community-based participatory research with culturally diverse LGBTQ+ youth.[283] AFFIRM has been implemented across the United States and Canada and is being adapted for implementation in Hong Kong, the Netherlands, Hungary, and Mexico.[284] AFFIRM is rooted in affirmative and trauma-informed practice and the minority stress framework.[200]

In addition to AFFIRM Youth, the developers have created programs for LGBTQ+ adults (AFFIRM Adult) and for parents and other caregivers of LGBTQ+ youth (AFFIRM Caregiver).

Program Overview

The goals of AFFIRM Youth include reducing mental health symptoms of anxiety and depression, reducing the impact of LGBTQ+-specific stressors (e.g., homophobia, transphobia, gender dysphoria, discrimination), and increasing healthy coping skills.[282]

AFFIRM Youth includes the following components[282]:

- Eight modules of tailored CBT curriculum rooted in an understanding of the stressors specific to LGBTQ+ youth and focused on building effective coping skills through a range of strategies, such as identifying thoughts and feelings, cognitive restructuring, grounding and emotional regulation, behavioral activation, cultivating self-compassion, fostering hope, developing safe identity-affirming social networks, and mobilizing resilience.
- Sequential 90-minute modules co-facilitated via closed group format.
- Sessions are led by trained and certified mental health professionals.
- AFFIRM can be delivered in person or online in a variety of settings, including schools, community-based organizations, medical or behavioral health settings, residential care/treatment, or child welfare agencies.

A manual, workbooks, and evaluation tools are available to support fidelity in implementation.

Outcomes and Other Benefits

AFFIRM is listed in the Suicide Prevention Resource Center's best practices registry. Evidence from several research articles supports this practice,[285-291] which has gained international recognition. As of 2024, AFFIRM Youth is the only scored LGBTQ+ youth intervention (with a score of 3–promising intervention) in the California Evidence-Based Clearinghouse for Child Welfare.

Research on AFFIRM includes randomized controlled trials and longitudinal studies with LGBTQ+ youth ages 14–24 and have demonstrated the following outcomes:

- Reduced depression symptoms, per the Beck Depression Inventory (BDI-II)[285,286,289,290]
- Improved stress appraisal, as measured by the Stress Appraisal Measure-Adolescents[286,290]
- Increased coping skills, as measured by the Brief Coping Orientation to Problems Experienced Inventory (COPE)[287,289]
- Increased hope, as measured by the Hope Scale (HS)[290]

Cultural Sensitivity and Adaptations

The creators of the AFFIRM program recognized a lack of behavioral therapies focused on the unique needs and experiences of LGBTQ+ youth, which can include minority stress, discrimination, and bullying.[200,292] Studies of CBT-based programs for the general population typically do not separately track depression or anxiety outcomes for LGBTQ+ youth. AFFIRM's developers used community-based research to enhance the standard CBT tenets with additional context, strategies, examples, and modules that address the experiences and specific stressors of LGBTQ+ youth.

AFFIRM interventions are designed to be implemented flexibly and with diverse LGBTQ+ youth across a range of settings, including school, clinic, and community, with positive outcomes for both online and in-person delivery. They serve youth with a range of different sexual and gender minority identities, as well as other intersecting identities (e.g., rural, racial/ethnic minority, religious minority, lived experience in foster care). The curriculum is available in English, Chinese, Dutch, Spanish, and Hungarian.[293]

In response to the COVID-19 pandemic, developers adapted AFFIRM into a virtual format,[289,294] which was tailored to a context that exacerbated existing stressors (e.g., hostile family environments, loneliness, isolation) and eliminated access to critical in-person services. The need and benefit of virtual interventions have persisted after the pandemic for many LGBTQ+ populations. Program developers also created an adapted intervention for foster and biological parents called AFFIRM Caregiver, which demonstrated improvements in affirmative attitudes, behaviors, and caregiving in foster parents of LGBTQ+ youth.[295]

Accessibility

AFFIRM is typically facilitated by experienced mental health clinicians who are trained in the model.[293] The developers provide a 3-day virtual training for facilitators (5.5 hours a day), which can be adapted to the schedule of the organization.[296] AFFIRM facilitator trainings are small (capped at 18 participants), a combination of didactic and experiential learning, and participatory. As part of the training, facilitators receive a facilitator manual, a participant workbook, an implementation guide, materials associated with fidelity checking and supervision, an evaluation guide for data collection, and templates for marketing the groups to potential clients in the community. Coaching and supervision are available at a cost to providers and may improve organizations' ability to deliver AFFIRM effectively and with fidelity.

Developers noted that many organizations seek and successfully access funding from local, state, and national sources to underwrite the costs of AFFIRM trainings. The developers also noted that leadership support (e.g., executive director, clinical director, supervisor) is a key ingredient for successful implementation, and an organization must be fully committed to supporting LGBTQ+ youth.

For More Information

www.affirmativeresearch.net; https://www.projectyouthaffirm.org

Important Considerations

Many of the programs highlighted in Chapters 3 and 4 incorporated lessons learned through the implementation and evaluation process. Most of these programs mention the importance of workforce diversity and community-initiated interventions that are culturally congruent and responsive to community needs. The interventions in this publication largely echo what has been described as "culture is prevention."[297] There is vast diversity within and among underserved populations, so adaptations for one group may not be appropriate for another group without specific adaptations to meet their unique needs, language, and cultural contexts.

For example, colonization and structural racism contribute to elevated suicidality in AI/AN youth.[298] Culturally grounded interventions offer connection to cultural values and practices as a means to empower and inspire youth, especially when the focus is on collaboration, sharing power, and collectivism.[299] Culturally specific interventions, such as Qungasvik, may not be easily adaptable to other communities.[247] Therefore, it is important to empower AI/AN communities to take the lead in developing culturally specific interventions. Researchers can help by assisting with development and evaluation tools, as well as providing resources for AI/AN communities to engage in advocacy efforts.

Implementation research suggests that LGBTQI+ youth respond well to an affirmative and trauma-informed approach to suicide prevention.[300] A few challenges that were identified through the implementation process for AFFIRM include:

- System readiness: difficulty identifying the target population due to lack of sexual orientation, gender identity, and gender expression data
- Adequate staffing: sufficient staff to respond to crises and provide support after the intervention period
- Building a network of trusted adults: AFFIRM staff often became the only trusted adults in the youth's social network, but they cannot always be available to meet youth's needs.

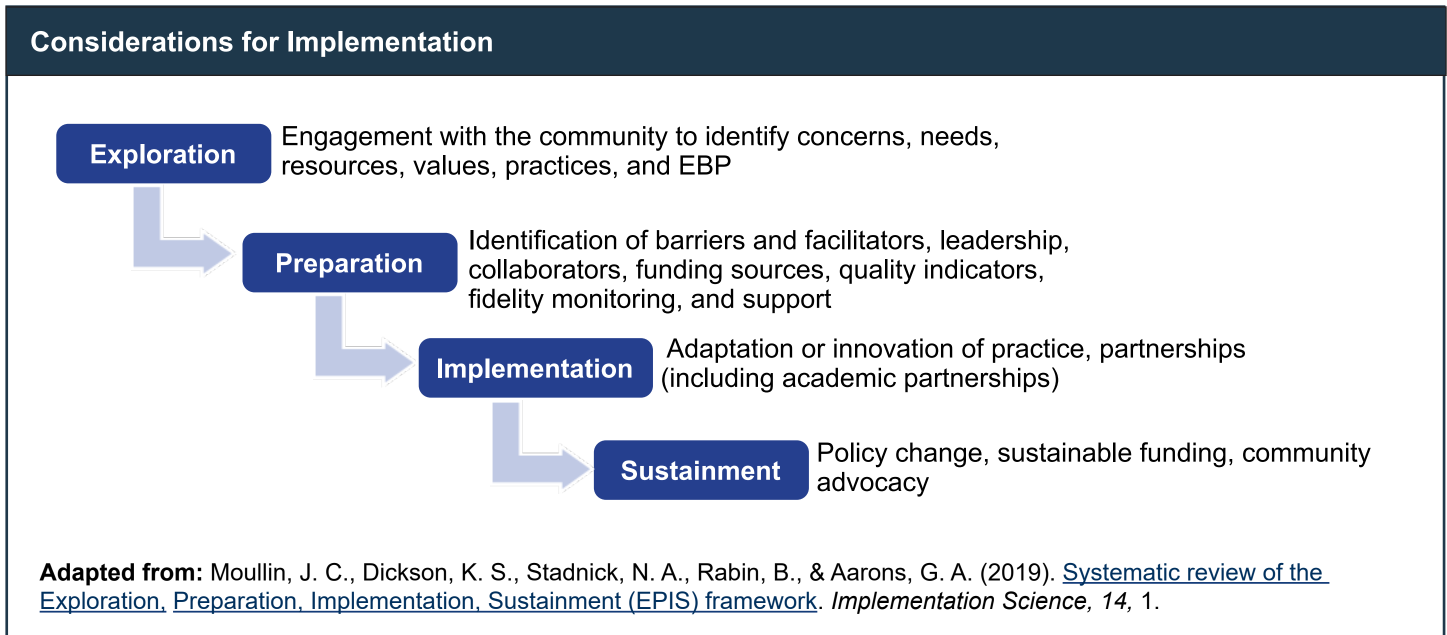
Other interventions have been successful in their adaptations to a variety of cultural contexts. For example, the Sources of Strength framework was well suited to Native Hawaiian beliefs about wellness, and the focus on strengths and connectedness worked well for cultures built on collectivism and collaborative solutions.[301]

It has been suggested that the prevention field must be diversified so that underserved communities are represented as researchers, clinicians, and in community-based implementation. Representation and cultural responsiveness are amenable to uptake of interventions.

Many interventions mentioned in this publication arose from community-based participatory research, participatory action research, community-driven research, or another participatory framework for conducting research *with* communities, rather than *about* communities. In other cases, interventions emerged from communities and later (if at all) connected with academic researchers to evaluate the effectiveness of the intervention. Additionally, suicide prevention efforts in underserved communities must be sustainable so communities are not harmed when grant funding ends.[302]

The considerations shown below are derived from the Exploration, Preparation, Implementation, Sustainment framework[303] and the literature about implementation of several of the suicide prevention interventions noted in this guide.

Considerations for Implementation



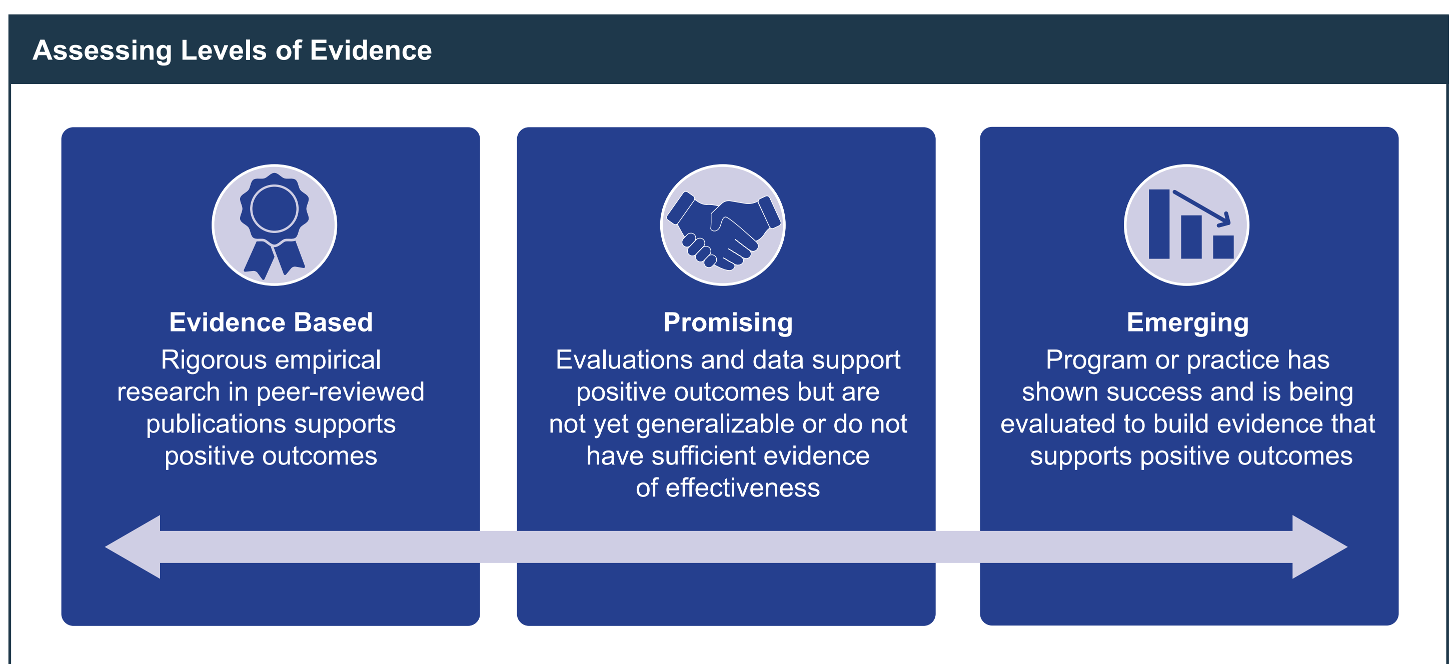
Adapted from: Moullin, J. C., Dickson, K. S., Stadnick, N. A., Rabin, B., & Aarons, G. A. (2019). Systematic review of the Exploration, Preparation, Implementation, Sustainment (EPIS) framework. *Implementation Science, 14,* 1.

Choosing and implementing an evidence-based practice (EBP) requires several steps:

- Issues of concern and community strengths can be identified through an environmental scan.
- Participatory processes, including participatory research methods and engagement with the population of interest, will generate interest, identify common goals, and engender strong partnership and collaboration.
- Implementers search registries and clearinghouses to identify an appropriate EBP.
- If needed, implementers seek sources of funding.

In some instances, funding is tied to the level of evidence for an intervention. The graphic below briefly describes characteristics of common terms.

Assessing Levels of Evidence



CHAPTER

5

Guidance and Resources for Evaluation

Evaluation can show how well a program has been implemented, identify which aspects have been successful, and point the way to improvement. Evaluation data can be helpful in making program adjustments, justifying program continuation, and securing funding by providing evidence of program effectiveness. Stakeholders can use information gathered via evaluation to encourage implementation interventions in other settings or communities.

If an evaluation is carefully planned from the outset of the program and conducted with sufficient rigor, it can be published and included in the evidence base for a program, helping to fill knowledge gaps in the wider body of research.

Evaluating outcomes for youth suicide prevention programs can be challenging, especially when they are directed to underserved groups. Measuring the primary quantitative outcome—reduction in suicidal thoughts and behaviors—can be extremely difficult if the sponsoring organization does not track program participants over the long term, as most cannot. Gathering qualitative data has its own challenges because participants may be reluctant to share their thoughts and feelings. Disclosing suicidal thoughts is potentially sensitive and traumatic by its nature, and participants may be especially reticent due to negative experiences with organizations and authorities (see Chapter 2). Program sponsors may need to acquire such information indirectly, perhaps by asking about other topics, such as reactions to the program or future life plans.

This chapter provides an overview of possible approaches to evaluate implementation and results of programs intended to prevent suicidal thoughts and behaviors among youth in underserved groups. It includes information on implementing a continuous quality improvement (CQI) process and specific evaluation resources, as well as suggestions for funding sources for formal research.

Culturally Responsive and Equitable Evaluation

Evaluating programs for underserved groups requires insight and sensitivity regarding the culture and language of the group, particularly if the program sponsor or evaluator is not part of the group themselves. Accessibility (including language access) need to be considered early in the evaluation process. The following resources may be helpful:

- Expanding the Bench Initiative: This resource promotes culturally responsible and equitable evaluation processes by helping evaluators share power, diversify the evaluation team, and foster a participatory process.

- The Equitable Evaluation Initiative helps programs explore how to evaluate programs equitably to shift practice across multiple systems (e.g., philanthropy, foundations, public sector, nonprofits). The initiative is grounded in three principles:
  - The core responsibility of evaluative work should serve equity.
  - Evaluative work should be culturally valid and oriented toward participant ownership.
  - Evaluative work should address historical and structural conditions that have affected what the organization is addressing, systemic drivers of inequity, and how cultural context intersects with structural conditions and change.

Strategies To Practice Equitable Evaluation	
Evaluation Step	**Guiding Questions**
Building the Evaluation Team	• Are proposed team members representative of the lived experiences of the target population (culturally, linguistically, racially, gender, sexuality, ability, backgrounds, lived experience, etc.)? • What types of training or capacity building is needed for evaluation team members? • Are stakeholders from the populations served included in the evaluation process? • Do the stakeholders have an active voice and meaningful engagement in the evaluation process? • Are members of the evaluation team compensated appropriately, compared to other staff at the organization?
Purpose and Audience	• Has the program defined equity? Equity should be defined prior to engaging in the evaluation process. • Is multilevel (individual, community, systemic) equity specifically referenced as the purpose of the evaluation? • Has the target population been identified as an audience for the evaluation results? Will the evaluation be written and disseminated with these groups in mind?
Questions	• Are stakeholders from the target populations involved in identifying and prioritizing evaluation questions? • Do the questions consider those with the highest burden and disadvantage? • Do the questions consider whether groups experience or use services differently?
Indicators and Outcomes	• Do outcomes include strengths of the population served? • Are the outcomes culturally relevant and meaningful to the population served? • Do indicators provide enough information to identify disparities? • Do indicators provide enough information to show meaningful change/progress?
Data Collection, Analysis, and Reporting	• Is there transparency about the use of data? • Are all stakeholders involved in data collection? How? • Are data collection tools culturally and linguistically relevant and appropriate? • Are stakeholders actively engaged in reviewing and analyzing data and making recommendations? • Does the organization appropriately and equitably share the results with a variety of audiences?
Adapted from: Youth Development Executives of King County. (n.d.). Equitable evaluation guiding questions.	

Types of Evaluations

Given the variety of settings and populations for programs described in this guide, they might use many different approaches for evaluating their efforts. However, there are three broad categories of program evaluation:

- **Formative:** conducted before an intervention is implemented to determine its feasibility
- **Process:** conducted during implementation to assess correctness of program implementation
- **Outcome:** conducted to measure the effects of the program by collecting information from participants at the conclusion of the program and/or from follow-up.

Types of Data

Evaluations can use a qualitative, quantitative, or mixed-methods approach. These two types are complementary; each provides insight into whether and how the intervention is achieving the intended objectives.

Qualitative data usually take the form of free-text information, for example, from interviews, focus groups, clinical observations and notes, and open-ended polling or survey questions.

Quantitative data can be processed by mathematical or statistical analysis. Quantitative data includes demographic data, numeric test results, close-ended survey questions and polling responses (multiple choice, true/false, etc.), utilization data, and claims data.

A mixed-methods evaluation uses qualitative and quantitative data for a comprehensive analysis.

Preparing To Collect Data

The following steps can help program staff prepare to collect and analyze data.

Determine Purpose of Data Collection

Determine whether the purpose of the data collection is evaluation or research. Qualitative and quantitative evaluation and research enable administrators and clinicians to learn from participants and obtain the perspectives of those with lived experiences. Both evaluation and research can also involve collecting

data from staff who deliver the intervention to obtain their perspectives on facilitators and challenges to implementation.

While program evaluation supports program improvement, research systematically follows study protocols to develop generalizable knowledge. Depending on the type of organization sponsoring the program, research may require protocol and procedure approval by an Institutional Review Board (IRB) to adhere to human subject research protections. Most program evaluations and quality improvement projects

Continuous Quality Improvement

CQI is a systematic process for assessing program implementation and short-term outcomes and identifying and implementing improvements to achieve better outcomes. Conducted by program staff, CQI helps measure practice fidelity—the degree to which a program adheres to its intended structure and meets its goals. As its name suggests, it creates a continuous cycle of evaluation and improvement.

CQI does not replace other qualitative or quantitative measures of program effectiveness, long-term process evaluation, or research. It supplements these with quick assessments of program performance, timely identification of problems and potential solutions, and implementation of small improvements to enhance quality. CQI is usually conducted by and among those who manage and execute a program.

For more information, visit the Institute for Healthcare Improvement.

do not require IRB approval, but if IRBs play any role in the sponsoring organization, administrators and researchers should seek review during evaluation design to ensure they are following appropriate data collection procedures.

Determine Outcomes of Interest

An outcome is the change that a program plans to accomplish through the implementation of an intervention. Evaluations exist across a continuum, from tracking staff activities, the number of participants receiving an intervention, and program attrition rates, to conducting satisfaction surveys and comparing mental health outcomes following program participation.

Identify Who Will Collect Data

No matter the type of research or evaluation, collecting and analyzing data takes time, skill, and resources. Program sponsors must identify team members with the skills to conduct evaluation activities and secure funding for evaluation trainings, data collection, analyses, and reporting. For some initiatives, the ideal evaluator may not be part of the organization or program; in this case, an outside party can provide an unbiased approach to data collection and analysis. Program sponsors may want to explore collaborations with academic researchers or public health practitioners, who are trained in data collection and have appropriate analytical skill sets.

Possible Process and Outcome Measures

The table on page 37 lists potential measures, illustrative indicators, and data sources that can be used to evaluate interventions like those described in Chapters 3 and 4. Programs will have widely varying needs, goals, and access to data, depending on their setting and the population they serve, and most of these measures will not apply universally.

Regardless of the measure being used, it is important to establish a baseline so that changes can be measured. The same instrument—whether a standardized screening questionnaire, a one-on-one interview, or some other method—should be used before the start of the program and then during and after the intervention to track participants' experiences. Quantitative data, such as enrollment, engagement, and retention, can also be tracked.

Process and Outcomes Measures		
Illustrative Measure	**Illustrative Indicators**	**Illustrative Data Sources**
Process Measures		
Engagement	• Increased participant engagement • Increase in number of participants • Increased rate of participants bringing peers into program	• Qualitative interviews • Participant self-reports • Intake/administrative data
Retention	• Attendance at program activities* • Participant completion of program	• Attendance/administrative data • Adverse events/hospitalizations*
Satisfaction	• Increased access to care • Increased acceptability of care • Increased self-efficacy • Improved therapeutic relationship	• Qualitative interviews • Structured scales and assessments (e.g., Client Satisfaction Questionnaire, Satisfaction With Therapy and Therapist Scale)
Short-Term and Intermediate Outcome Measures		
Reduction in suicidal thoughts or behaviors and reductions in non-suicidal self-injury	• Reduced or absence of suicidal ideation and self-harm • Reduced emergency department visits and hospitalizations	• Client self-reports • Structured scales and assessments (e.g., Columbia Suicide Severity Risk Scale) • Electronic health record data
Long-Term Individual Outcome Measures		
Reduction in mental health conditions and co-occurring substance use disorders	• Decrease in leaving school or work for mental health reasons • Decrease in crisis interventions	• Client self-reports • Student records and administrative data (for school settings) • Hospital and medical facility administrative data
Population-Level Effects		
Reduction in mental health concerns	• Reduced prevalence of mental health concerns • Reduced rate of suicide and attempted suicide • Reduced rates of hospitalization and medical leave related to mental health	• Large-scale national surveys (e.g., the Youth Risk Behavior Surveillance System (YRBSS), the National Survey of Children's Health (NSCH) or the National Longitudinal Study of Adolescent to Adult Health (Add Health)) • Student records and administrative data • Hospital and medical facility administrative data
Improvements in community mental health knowledge	• Increased communitywide mental health knowledge, knowledge of resources, and likelihood of intervention with at-risk students/peers	• Staff, participant, and community surveys

*Participant safety should be monitored during any program or study, including absences from scheduled activities and adverse events that contribute to absences. Follow-up should occur with participants who drop out to determine whether they are experiencing a mental health issue that should be addressed.

Adapted from: Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Prevention and treatment of anxiety, depression, and suicidal thoughts and behaviors among college students*. SAMHSA Publication No. PEP21-06-05-002. Rockville, MD: National Mental Health and Substance Use Policy Laboratory.

Research: Building the Evidence Base

If a program serves a large enough population and its sponsor has staff interested in doing research, its evaluation activities can be conducted with the intent to publish the results and expand the evidence base. Possible sources of support for such efforts follow below:

- The Centers for Disease Control and Prevention's (CDC) Injury Center awards states, tribes, territories, non-governmental organizations, and university research programs with funding for surveillance, evaluation, implementation, and capacity building for evidence-based suicide prevention programs.
- American Foundation for Suicide Prevention funds various types of research, usually over multiple years. Grant amounts vary from $50,000 to $500,000 per year, depending on the type and scope of project and the career level of the researchers. Grant deadlines vary. Several grantees in 2023 studied interventions for underserved and/or minority populations.
- Harvard University's Center for Suicide Research and Prevention offers grants and fellowships to expand and diversify the suicide prevention research community. The 2024 grant year focuses on equity/disparity, implementation science, and ethics/algorithmic bias.
- The National Institute of Mental Health Practice-Based Suicide Prevention Research Centers conduct transdisciplinary research not well-suited to standard research project grant mechanisms. The intent is to develop practices for rapid adoption. One of the initiative's interest areas is groups who experience differential risk or disparities in mental health services, including Black/African American youth, sexual and gender minorities, publicly insured youth and adults, and people involved with the justice system.

Resources

This section includes resources to support program evaluation and quality improvement. Organizations may consider partnering with academic institutions or local program evaluation experts for external evaluation services or building internal evaluation capacity.

Evaluating Programs

- A Framework for Program Evaluation from CDC's Program Performance and Evaluation Office summarizes essential elements of program evaluation.
- The Community Toolbox from Center for Community Health and Development at the University of Kansas includes a step-by-step guide to developing an evaluation of a community program, specific tools, and examples.
- RAND Suicide Prevention Program Evaluation Toolkit helps program staff overcome challenges to evaluating and planning improvements to their programs.

Evaluating Client-Level Outcomes and Population-Level Prevalence

- HealthMeasures includes PROMIS® and the National Institutes of Health Toolbox®, free comprehensive sets of neurobehavioral measurements that assess a range of symptoms and risk and resilience factors.
- The Suicide Prevention Resource Center offers online courses on how to find and use sources of data on suicide and how to use the data to inform community partners and policy makers. The Center's directory of state-specific resources includes contact information for state suicide prevention directors and suicide prevention strategic plans.
- CDC's Youth Risk Behavior Surveillance System, a national survey, measures prevalence of risk behaviors, including suicidal ideation and suicide attempt among students in grades 9–12.

- CDC's WISQARS™ (Web-based Injury Statistics Query and Reporting System) is an interactive, online database that provides fatal and nonfatal injury, including self-harm and suicide, and cost of injury data from a variety of trusted sources.
- SAMHSA's National Survey on Drug Use and Health (NSDUH) provides national survey data on substance use, mental health concerns, and suicidal thoughts and behaviors.

Evaluating Program Sustainability

The Center for Public Health Systems Science at Washington University in St. Louis developed a Program Sustainability Assessment Tool and a Clinical Sustainability Assessment Tool to measure progress toward sustaining new implementation efforts.

Quality Improvement and Continuous Performance Monitoring

- The Institute for Healthcare Improvement's Quality Improvement Essentials Toolkit has tools and templates to launch a quality improvement project and manage performance improvement.
- The NIATx model of process improvement, developed by the University of Wisconsin, is available for behavioral health settings to improve access to and retention in treatment.
- The Zero Suicide Institute Toolkit is intended to assist health and behavioral healthcare organizations in developing a data-driven, quality improvement approach to suicide care.

Evaluating Mental Health Programs

Based on its experience evaluating prevention and early intervention programs implemented by the California Mental Health Services Authority, RAND developed a guide to evaluation approaches, including key steps, evaluation designs, and data collection methods.

Evaluating Programs in American Indian/Alaska Native Communities

The Administration for Children and Families' A Roadmap for Collaborative and Effective Evaluation in Tribal Communities centers American Indian/Alaska Native values and priorities, knowledge of which can enhance trust between tribal programs and their evaluation partners and other stakeholders. Even though this resource was initially created for stakeholders of the welfare system, it has widespread relevance to suicide prevention.

Cultural Competence Resources

- The American Evaluation Association's Public Statement on Cultural Competence in Evaluation affirms the importance of cultural competence in evaluation and provides a guide to the essential practices for cultural competence.
- The Foundation Review's Raising the Bar– Integrating Cultural Competence and Equity: Equitable Evaluation presents a framework for building equitable evaluation capacity.
- CDC provides Practical Strategies for Culturally Competent Evaluation.
- The Great Plains Tribal Epidemiology Center has created an Indigenous Evaluation Toolkit.
- A Language Justice Framework for Culturally Responsive and Equitable Evaluation provides a framework centered on language justice and access.
- SAMHSA's Treatment Improvement Protocol, Improving Cultural Competence, includes guidance for conducting culturally responsive evaluation.

SAMHSA Training and Technical Assistance for Underserved Communities

- The Tribal Training and Technical Assistance Center provides guidance to tribal communities to support wellness.
- The African American Behavioral Health Center of Excellence provides resources on behavioral health equity for Black/African American people.
- The Hispanic/Latino Behavioral Health Center of Excellence is a resource for serving the Hispanic or Latino community.
- The Center of Excellence on LGBTQ+ Behavioral Health Equity provides guidance on enhancing culturally responsive care for this population.

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APPENDIX 1: Glossary

LGBTQI+: Lesbian, gay, bisexual, transgender, queer, intersex, those who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual. LGBTQI+ is used interchangeably with "sexual and/or gender minority" and persons of "diverse sexual orientation and/or gender identity" (or similar language) throughout this guide.

Cisgender: Describes a person whose current gender identity matches the sex they were assigned at birth.

Cultural adaptation: The systematic modification of an evidence-based practice's protocol and/or content to incorporate language, culture, and context that is compatible with a client's cultural patterns, meanings, and values.

Cultural competence: A set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in cross-cultural situations.

Cultural responsiveness: A set of behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in cross-cultural situations. It involves honoring and respecting the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services.

Equity: Resources are distributed based on the unique needs of the specific audience. Equity recognizes that some individuals or communities will need different or greater access compared to other individuals or communities. (This is different from equality which is giving everyone the same resources.)

Evidence-based practices: Interventions guided by the best research evidence with practice-based expertise, cultural competence, and the values of the people receiving the services, which promote individual-level or population-level outcomes.

Fidelity: The extent to which an intervention is delivered as conceived and planned.

Hispanic or Latino: Hispanic refers to individuals with ancestry from a Spanish-speaking country. Latino refers to individuals of Latin American descent, including Spanish-speaking islands in the Caribbean. Latino is used to describe male-identifying individuals, Latina for female-identifying individuals, and Latinx or Latine are commonly used gender-neutral terms.[185] In this publication, Hispanic or Latino is used to simplify both identifiers.

Protective factors: Factors that directly decrease the likelihood of substance use and behavioral health problems or reduce the impact of risk factors on behavioral health problems.

Risk factors: Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems.

Social determinants of health (SDOH): Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.

Systemic barrier: A policy, practice, or behavior that, as part of an organizational or community structure, perpetuate disadvantage for a group or community (e.g., language access, complicated written material, insurance, transportation, racism and bias, etc.).

Systemic racism: A form of racism and unfair treatment that have been embedded within systems (e.g., education, politics, religion, family, economy, housing, etc.).[53]

Trauma-informed care/approach: A program, organization, or system that recognizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist retraumatization.

Two-Spirit: Two Spirit refers to someone who is Native and expresses their gender identity or spiritual identity in indigenous, non-Western ways. This term can only be applied to a person who is Native. A Two Spirit person has specific traditional roles and responsibilities within their tribe. Not all Native LGBTQ people identify as Two Spirit. LGBTQI2S+ includes Two-Spirit people.

Underserved: Describes populations and geographic communities that have been systematically denied the opportunity to participate fully in aspects of economic, social, and civic life.

APPENDIX 2: Acknowledgments

This guide incorporates the thoughtful input of SAMHSA staff and the Technical Expert Panel on Suicide Prevention Strategies for Underserved Youth. A series of guide development meetings and one expert panel meeting were convened between October 2023 and July 2024, to inform this guide.

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