EQUITY AND SUICIDE PREVENTION

The Colorado Office of Suicide Prevention, in collaboration with partners across the state and country, works to prevent all Coloradans from feeling suicidal, from attempting suicide, and from dying by suicide and to support Coloradans who have been impacted by suicide, including suicide loss. Experiences of suicide exist on a continuum. The majority of people who experience suicidal despair do not go on to attempt or die by suicide. Effective and authentic suicide prevention must support everyone impacted by suicide.

Suicide impacts people of all ages, from all geographic regions of Colorado, and from all demographics. In Colorado and nationally, adult men ages 25-64 die by suicide at the highest rates. Older adults (ages 65 and older) die by suicide more often than youth (ages 10-18). Hispanic/Latina/o/x residents make up 21.7% of the population, Black/African Americans make up about 4% of the population, and about 10% of Coloradans are immigrants. Rural communities in Colorado are also disparately impacted, with higher and more variable population based suicide rates occuring off the Front Range.

What is equity?

Equity assures that everyone has a fair opportunity and the resources they need, regardless of who they are or where they come from, in order to have the opportunity to thrive. Achieving equity requires eliminating barriers like poverty, repairing injustices in systems such as education, health, criminal justice and transportation, and centering lived experiences. Black, Indigenous, and People of Color are more likely to experience socioeconomic disparities such as exclusion from health, educational, social and economic resources.[1] Equity is not the same as equality. Equality assures everyone is treated the same regardless of the starting point or context.

More broadly, equity means **people have what they need**. Different people and communities have different needs. Some people experiencing suicidal despair may need temporary safe respite from an unsafe situation, some may need an evidence-based intervention (for example: working with a provider who uses the Collaborative Assessment and Management of Suicidality approach), and some may need access to food and sleep.

[1] Black/African American. (n.d.). Retrieved March 29, 2021, from www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

Why does equity matter in suicide prevention?

Nationally, Black, Indigenous, and People of Color are less likely to have access to mental health services, less likely to use mental health services, and more likely to receive low-quality mental health care[2]. Economic and racial segregation impact access to education, employment, and health care. In the United States, injustice and segregation are associated with lasting mental health impacts.[3] For example, Black people are less likely to seek mental health service due to experiences of discrimination and unfair treatment within systems.[4] In 2018, American Indian / Alaska Native adults reported the highest rate for past-year suicidal thoughts, followed by white and Black adults.[5] That same year, American Indian / Alaska Native adults reported the highest rates of past-year suicide attempts, followed by Black and Hispanic adults.[6] Suicidal despair, attempts and deaths by suicide impact all races, ethnicities, cultures, and communities making it imperative that suicide prevention efforts support all populations.

Centering equity is crucial to address disparities and reduce suicidal despair, attempts, and fatalities.

What are some disparities impacting Colorado communities that are linked to increased suicidal despair, attempts, and fatalities?

Food Insecurity:

According to the Colorado Blueprint to End Hunger, hunger is common and widespread in Colorado. 1 in 10 Coloradans struggle with hunger (which is defined as not always having enough money to buy food); 1 in 6 Colorado kids may not know when or where they will get their next meal; and 1 in 10 Colorado seniors struggle with having enough food.[7] Disparities impact hungry Coloradans: 10% of white students indicated they went hungry in the past 30 days, whereas 19.5% of Black / African American students said they went hungry in the past 30 days.[8] Research shows that food-insufficient adolescents are 5 times more likely to attempt suicide.[9] Acknowledging that ending hunger is a suicide prevention strategy, Colorado's Suicide Prevention Commission endorses the overall vision and five major goals of the Colorado Blueprint to End Hunger.

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[2] Breunlin, E. (2020, January 30). Most Colorado public school teachers are white, but almost half of their students are not. Can the state close the gap? Retrieved February 22, 2021, from coloradosun.com/2020/01/30/colorado-lawmakers-want-to-increase-teacher-diversity/

[3] Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old Issues, New Directions. *Du Bois review: social science research on race, 8*(1), 115–132. doi.org/10.1017/S1742058X11000130

[4] Polanco-Roman, L., Anglin, D. M., Miranda, R., & Jeglic, E. L. (2019). Racial/Ethnic Discrimination and Suicidal Ideation in Emerging Adults: The Role of Traumatic Stress and Depressive Symptoms Varies by Gender not Race/Ethnicity. *Journal of youth and adolescence, 48*(10), 2023–2037. doi.org/10.1007/s10964-019-01097-w

[5] Racial and Ethnic Disparities. (n.d.). Retrieved January 04, 2021, from https://sprc.org/scope/racial-ethnic-disparities

[6] Racial and Ethnic Disparities. (n.d.). Retrieved January 04, 2021, from https://sprc.org/scope/racial-ethnic-disparities

[7] Colorado Blueprint to End Hunger (2018). www.endhungerco.org/

[8] Healthy Kids Colorado Survey, 2019.

[9] Alaimo, Katherine. et al. (2002). Family food insufficiency, but not low family income, is positively associated with dysthymia and suicide symptoms in adolescents. *The Journal of Nutrition, 132*(4). Retrieved from: academic.oup.com/jn/article/132/4/719/4687337

Veterans:

Nationally, the annual suicide rate among Veterans has ranged from 1.5 to 2.1 times higher than non-Veteran adults (which has increased since 2005),[10] and the national suicide rate among female Veterans is twice that of non-Veteran adult females.[11] Minority veterans face even greater mental health disparities[12] and suicide rates[13] compared to non-minority veterans and non-veteran minorities. Although Colorado Veterans comprise about 7% of the state population,[14] it is estimated that they represent 9% of the homeless population[15] and at least 19% of Colorado suicide fatalities. As highlighted by the lived experience of an LGBTQ+ Veteran and current Veteran Affairs Peer Support Specialist, understanding Colorado Veteran demographics, and the challenges unique to each veteran, helps guide equitable suicide prevention efforts to ensure that prevention strategies can support all veterans:

> *"During the 'Don't Ask, Don't Tell' timeframe, it was very isolating being in a situation where one has to really depend on fellow servicemembers for your very life, yet I never fully could be myself. Even among those whom we value as family, hampered by the trauma of losing family over our identities, insecurity and shame keep us unable to trust or connect. Even now, within the VA system and among Veterans, fears of rejection over my identity keep me hesitant. It's really hard to move past that and many of us still haven't."*

Black, Indigenous, and Youth of Color (Colorado middle and high school students):

According to the 2019 Healthy Kids Colorado Survey, approximately 45% of Colorado youth attending public high schools identify as non-white. Table 1 highlights three indicators related to mental health and/or suicidal despair which are indicative of disparities that impact non-white students in Colorado.

[10] www.mentalhealth.va.gov/docs/FINAL_VA_OMHSP_Suicide_Prevention_Fact_Sheet_508.pdf
[11] www.va.gov/PREVENTS/suicide-data.asp
[12] Office of Health Equity. (2020). Mental health disparities among LGBT Veterans. www.va.gov/HOMELESS/nchav/resources/docs/veteran-populations/lgbt/LGBT_Veterans_Disparities_Fact_Sheet-508.pdf
[13] Office of Mental Health and Suicide Prevention. (2020). 2020 National Veteran Suicide Prevention Annual Report. www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf. See also (2020) Evaluation of suicide mortality among sexual minority US Veterans from 2000 to 2017 doi.org/10.1001/jamanetworkopen.2020.31357
[14] www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Colorado.pdf
[15] Veterans. (n.d.). Retrieved March 29, 2021, from www.coloradocoalition.org/veterans

Table 1. Mental Health Indicators as Reported by Students on the Healthy Kids Colorado Survey (2019)*

2019 Healthy Kids Colorado Survey Results			
Race/Ethnicity	Percentages of students who reported, in the past 12 months:		
	making at least one suicide attempt.	feeling sad or hopeless.**	having at least one trusted adult to ask for help with serious problems.
Native Hawaiian or other Pacific Islander, non-Hispanic	15.8%	41.7%	66.3%
American Indian or Alaska Native, non-Hispanic	15.8%	37.4%	66.9%
Multiple Race or Hispanic Other Race	11.1%	40.0%	69.7%
Hispanic only or Hispanic White	9.4%	38.0%	68.4%
Black or African-American, non-Hispanic	8.6%	31.7%	66.6%
Asian, non-Hispanic	6.6%	29.5%	68.6%
White, non-Hispanic	6.1%	32.5%	76.5%

** cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data*

*** Complete indicator reads: "feeling so sad or hopeless they stopped doing usual activities almost every day for 2+ consecutive weeks."*

Lesbian, Gay, and Bisexual Youth of Color:

For youth who identify as Lesbian, Gay, or Bisexual (LGB), there are additional disparities impacting LGB youth of color.[16] For youth who are white and LGB, 70.2% report having access to a trusted adult, whereas 66.8% of youth who are Hispanic and LGB and 51.8% of youth who are Black and LGB report access to a trusted adult. By comparison, 88.2% of youth who are white and heterosexual report having access to a trusted adult. Having access to a trusted adult is protective against suicide, and youth suicide prevention efforts must consider how to support youth who do not have access to a trusted adult.

Older Adults:

Colorado's aging population is fast-growing, which means that the number of adults over age 65 is rapidly increasing. Older adults are at increased risk of suicide due to unique and specific health conditions and cultural factors. Suicide attempts by older adults are more likely to result in death due to the methods used in the attempt. From 2013-2017 in Colorado, older adults had a suicide rate of 22.6 per 100,000, slightly under of the working-age adults ages 25-39 years (23.6 per 100,000) and ages 40-64 years (27.0 per 100,000).[17] When

[16] Healthy Kids Colorado Survey, 2017 and 2019.

[17] Jamison, E., Michelson, D., Bol, K. (2020). Older Adult Suicide in Colorado, 2013-2017, Colorado Violent Death Reporting System. *HealthWatch 111,* 1-8. drive.google.com/file/d/1xsTa0chg7e5rnlBXwaD3l-5bEC1bXaxs/view

compared across both age *and* sex, older adult males had the highest suicide rate across all groups at 40.5 per 100,000. Non-Hispanic white older adults had the highest suicide rate compared to all other racial and ethnic groups, at 25.5 per 100,000, followed by Asian or Pacific Islander older adults at 10.4 per 100,000. Despite this high rate of suicide among older adults, there is a lack of suicide-specific resources for this age group. Identifying these gaps is crucial to expanding supports and resources for this highly impacted population.

Why are we centering racism when there are other forms of discrimination that cause inequities?

Suicide and racism are intertwined public health crisises. Racism is a fundamental issue that results in poor physical and mental health.[18] Perceived racial discrimination is both directly and indirectly associated with suicide ideation.[19] Calling attention to racism and health disparities allows us to address systems that impact other forms of oppression. Racism has historically been at the center of many injustices and inequities in our society, including redlining, segregation, eugenics, etc., all of which contribute to disparities that Black, Indigenous, and People of Color continue to experience, including higher rates of poverty, homelessness, and negative physical health outcomes. By centering anti-racist efforts, suicide prevention can begin to address all intersecting forms of injustice.

The Office of Suicide Prevention recognizes that racism is a public health crisis. We are committed to pursuing equity and anti-racism using an intersectional lens.

How does intersectionality drive comprehensive suicide prevention?

In the disparities impacting Coloradans, including those that contribute to suicidal despair, intersectionality compounds the injustices people face. In 1989, Dr. Kimberlé Crenshaw introduced the concept of intersectionality which demonstrated how race and gender intersect in ways that can increase or decrease discrimination.[20] In its more general form, intersectionality refers to the overlap and relationship of different social identities in how we experience the world. These overlaps (or intersections) include gender, race, ethnicity, sexual orientation, language, education, citizenship, religion, and more. For example, a young queer Latina teenager in rural Colorado likely has different needs than a white male attorney in his 50s in the Denver metro area.

[18] Devakumar, D., Selvarajah, S., Shannon, G., Muraya, K., Lasoye, S., Corona, S. Achiume, E. T. (2020). Racism, the public health crisis we can no longer ignore. *The Lancet, 395*(10242). doi:10.1016/s0140-6736(20)31371-4
[19] Walker, R. L., Salami, T. K., Carter, S. E., & Flowers, K. (2014). Perceived racism and suicide ideation: Mediating role of depression but moderating role of religiosity among African American adults. *Suicide and Life-Threatening Behavior, 44*(5), 548-559. doi:10.1111/sltb.12089
[20] Crenshaw, K. (2018). Demarginalizing the intersection of race and Sex: A Black feminist critique of Antidiscrimination Doctrine, feminist theory, and Antiracist Politics [1989]. *Feminist Legal Theory*, 57-80. doi:10.4324/9780429500480-5

Why do we need a comprehensive approach to suicide prevention?

Solutions to complex public health problems, like suicide, are often most successful when government, businesses, health services, nonprofit organizations and individual citizens coordinate their efforts. This way, partners can channel their resources to the same goals, avoid duplicating efforts, and enhance each other's work to produce lasting change. Comprehensive suicide prevention requires equitable opportunities for health, such as employment, housing, and education.[21] Many community-level factors contribute to suicide among those with and without mental health conditions. According to the Centers for Disease Control (CDC), more than half of people (54%) who died by suicide did not have a known mental health condition.

In Colorado, community-level, interpersonal, and substance-related factors that contributed to suicide fatalities 2017-2019 include:[22]

- Contributing intimate partner problem (38%).
- Contributing physical health problem (34%).
- Problem with alcohol (29%).
- Contributing job problem (21%).
- Contributing financial problem (19%).
- Problem with a substance other than alcohol (19%).
- Family relationship problem (18%).
- Contributing criminal legal problem (16%).

The Office of Suicide Prevention supports a comprehensive community-based public health approach to suicide prevention. In order to create communities that foster connection, a public health approach that supports individuals and their communities is key to suicide prevention. Because suicide is complex and is not just a mental health problem, the role of public health is to create communities worth living in.

A comprehensive approach must include upstream prevention, intervention supports, and postvention.

[21] Behavioral health equity. (n.d.). Retrieved April 05, 2021, from www.samhsa.gov/behavioral-health-equity
[22] Suicides in Colorado: Circumstances, Toxicology, and Injury Location. Colorado Violent Death Reporting System.

Upstream Prevention: Strategy or approach that seeks to prevent the onset of suicidal thinking/behavior, also called upstream prevention

Examples of upstream prevention: infusing protective strategies such as increasing access to household financial stability and food security programs to elevate the overall wellness of a community and spread of positive social norms.

Intervention Supports: Strategy or approach to identify and support those currently experiencing suicidal despair.
Examples of intervention: gatekeeper training; focused efforts within priority populations, industries or occupations; crisis response; and connection to culturally responsive care.

Postvention: Support for individuals and communities affected in the aftermath of a suicide attempt, crisis or death.
Examples of postvention: safe reporting and messaging about suicide by the media as well as by/within affected organizations, caring follow up contacts after a suicide attempt or mental health crisis, Colorado Follow Up Project, community-level response after a loss.

Colorado has identified six priority areas for the comprehensive model:

Suicide prevention needs to be a comprehensive and community-based effort. The Office's work strives to address through models that vary based on community needs. Our work will continue until all Coloradans have the opportunity to lead healthy lives, in a way that celebrates intersectional identities including, but not limited to, race, ethnicity, ancestry, gender identity and/or expression, sexual orientation, education level, age, language, religion, ability, family and marital status, and geographic location.

To read more about how the Office will be putting equity into action, please review the VIP-MHP Action Plan v. 2.