NATIONAL CFRP

Center for Fatality Review & Prevention

November 2023

Equity in Fatality Review: Child and Youth Suicide

National Center Guidance Report

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Equity in Fatality Review: Child and Youth Suicide

Introduction

Families and communities are devastated when a young person dies by suicide. Between 2005-2020 suicide was the second leading cause of death among children and youth ages 5-17 in the United States (U.S.).[1] Certain groups of children and youth are more at risk for dying by suicide and experiencing suicidal despair, including young people of color, LGBTQ+ youth, young people with disabilities, and those living in rural communities.

It is critical that we continuously seek to better understand the inequities that are driving these differences.

The goal of this brief is to highlight disparities in suicide and suicidality alongside the associated social determinants, or conditions in which people are born, grow, live, learn, play, and age.

This understanding directs how Child Death Review (CDR) teams approach the reviews of suicide deaths and our subsequent prevention efforts to reduce suicidal despair and keep our children and youth alive and healthy. The second half of this brief includes a variety of strategies to incorporate equity into your suicide death review process, as well as example prevention recommendations that consider equity.

Health Equity and Disparities

For purposes of this brief, **health equity** is the state in which everyone has a fair and just opportunity to attain their highest level of health.[2] **Disparities** are preventable differences in health outcomes experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment.[3] Measuring disparities helps measure our progress toward achieving equity.[4] In this brief, data from the National Fatality Review-Case Reporting System (NFR-CRS) (URL: https://bit.ly/370ec8M) are shared for children and youth ages 5-17 years old who died by suicide, where possible. Data from the NFR-CRS are not population-based and cannot be used to calculate rates or trends over time. Supplemental data from additional sources are highlighted when data from the NFR-CRS are limited.[5]

Race and Ethnicity

This section covers how historical trauma, racism, and barriers to resources perpetuate disparities in poor mental health and suicidality among young people of color.

Historical Trauma

Historical trauma is the "cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants."[6] Research illustrates how historical trauma through racist experiences of colonialism, genocide, slavery, and oppression flows across generations to impact the health of American Indian or Alaska Native (AI/AN), Native Hawaiian or Pacific Islander (NH/PI), and African American populations.[7]

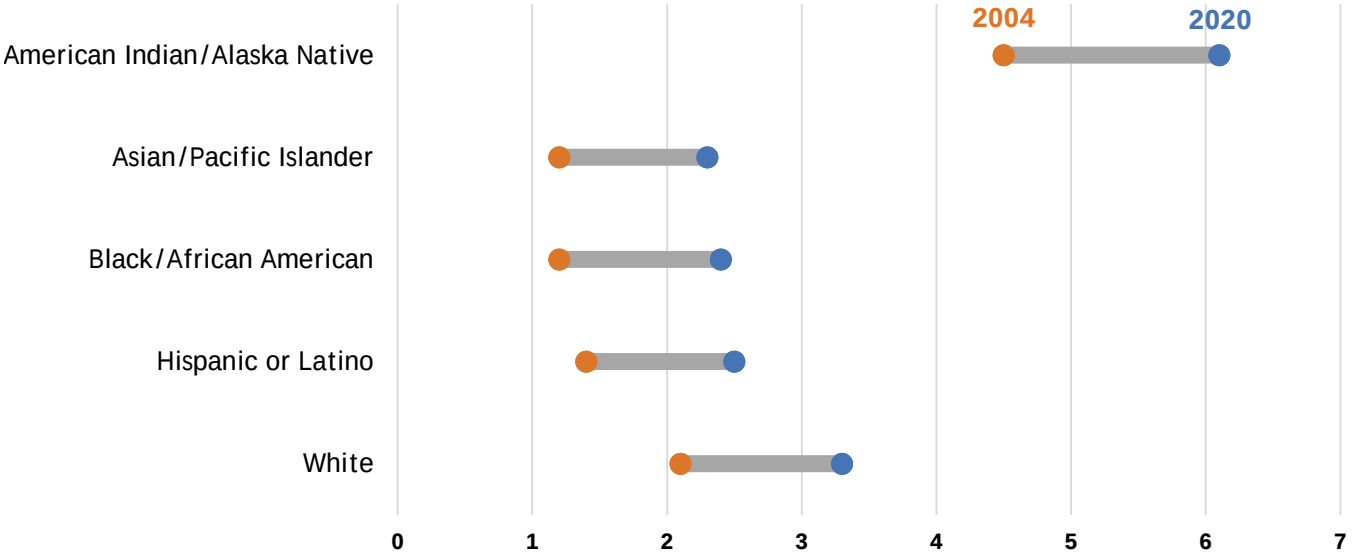
The increased likelihood of suicide deaths among AI/AN populations may stem from the historical loss of population, land, language, and tradition that was endured by these indigenous communities.[8] Their historical trauma originates in colonization, the brutal and forcible removal of AI/AN people from their lands in the U.S. and Canada, and results in population decline and subjugation of Indigenous peoples. Following colonization, AI/AN children were forcibly removed from their families and taken to boarding schools that were designed to strip them of their culture. Attendance at these schools was mandatory, and AI/AN children were forbidden to practice their culture. Paralleling AI/AN experiences, NH/PI populations endured colonization by the U.S. and historical trauma that includes the overthrow of the Hawaiian monarchy and contamination of their lands and people by U.S. military nuclear testing. For African Americans, the violence and cruelty of the African slave trade is the root of historical trauma.[9] Captured and enslaved people endured inhumane conditions and cruelty both during transit and after arrival in North America. Millions died during the passage.

INTERSECTING SYSTEMS

Be mindful of how intersecting systems of oppression produce differential effects for youth based on the combination of identities they hold. See the section on **intersectionality**.

The effects of these historical traumas rooted in racist ideologies continue to impact communities of color to this day. The legacy of colonization, oppression, and slavery accrues across generations, leading to substantial socioeconomic and health disparities, including poor mental health and increased suicidality.[10,11]

Figure 1. *American Indian/Alaska Native Children and Youth Ages 5-17 Years Old Have the Highest Suicide Rate and Experienced the Greatest Change in Rate Between 2004 and 2020**



* The change in rate for AI/AN children and youth between 2004 and 2020 was not statistically significant.

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2004-2020 on CDC WONDER Online Database.

Racism

In addition to historical traumas rooted in racism, research has found that ongoing experiences of racism and racial discrimination are associated with increased suicidality among young people of color. Racism is defined as racial prejudice or bias used along with social or institutional power to advance or oppress people.[12] Racism works to denigrate and invalidate racial and ethnically minoritized people at multiple levels, including individual and systemic levels.

- **Individual racism occurs within and between individuals, and includes a person's racist beliefs, attitudes, and actions such as racial slurs or acts of violence.**
- **Systemic racism is built into and across systems in society, working independently from the actions of individuals. Even if individual and interpersonal racism were eradicated, racial and ethnic disparities would remain unchanged due to the persistence of systemic racism.[13]**

Systemic racism is reinforced and supported by multiple social systems (e.g., housing, labor, education, criminal justice, health care) and has created barriers to accessing resources that are vital to a young person's health and well-being, such as a home, safe neighborhood, and quality school.[14] Living in a society whose policies and practices are rooted in racism creates cycles of violence and trauma for minoritized racial and ethnic groups, increasing mental health concerns. Black children ages 5–12 have nearly twice the rate of suicide as white children, and the prevalence of suicidal ideation and attempts have increased significantly among Black youth over time.[15] In addition, racist depictions of AI/AN culture have been linked with lower self-esteem, community worth, and decreased academic achievement among AI/AN youth. The continued presence of racialized stereotypes in schools and communities, such as AI mascots, are psychologically detrimental to AI students.[16]

In another example, research found that Black and Hispanic young people exposed to police brutality were more likely to have trouble in school and develop mental health challenges.[17] A particular concern is the direct exposure to murders of unarmed Black men, which has been associated with negative mental health outcomes in the Black community.[18] Perceived racism has been shown to have a direct effect on experiences of suicidality among Black youth.[19] In addition, the high prevalence of online racism through social media and the widespread posting about hate crimes and of racial violence videos has been shown to significantly predict suicidality among young people of color.[20]

WITNESSING VIOLENCE

10% of Black youth who died by suicide in 2020 and were included in the NFR-CRS had experienced the life stressor of witnessing violence being perpetrated against others in their school or community, compared to 6% of all suicide deaths.[21]

Racial Residential Segregation and Neighborhood Poverty

One prominent example of systemic racism is racial residential segregation. Discriminatory policies and practices, such as redlining, systematically denied communities of color equal access to well-resourced and opportunity-rich neighborhoods.

Neighborhoods that people of color were segregated to experienced disinvestment, leaving them with concentrated poverty, failing schools, physical and environmental stressors, and limited access to health services, housing, and nutritious foods.[22]

Figure 2. *Families With a White Householder in the U.S. Are More Likely to Live Above the Federal Poverty Level*

Race/Ethnicity of Householder	% Living Above Poverty Level
American Indian/Alaska Native	81.8%
Asian	92.5%
Black or African American	81.9%
Hispanic or Latino	84.9%
Multiracial	87.1%
Native Hawaiian/Pacific Islander	86.5%
White	93.7%

Data Source: U.S. Census Bureau; 2021 American Community Survey 1-Year Estimates, Poverty Status in the Past 12 Months of Families, Table S1702. Retrieved from the U.S. Census Bureau (URL: https://bit.ly/3MhSRZT).

Where people live matters, and many people of color in the U.S. are still more likely to live in segregated neighborhoods with high poverty rates. Recent research found that more than 80% of major metropolitan areas in the U.S. were more racially segregated in 2019 than they were in 1990.[23] Census data show that in 2021, families with a white householder in the U.S. are more likely to live above the federal poverty level when compared to householders of color. Learn more about how poverty is measured in the U.S. through the U.S. Census Bureau (URL: https://bit.ly/40bSS7h).

Research has found a link between poverty concentration and increased rates of child and youth suicide.[24] When young people of color who live in high poverty, segregated areas have mental health concerns, they likely have limited access to needed resources, services, and treatment options, such as school counselors.[25]

MENTAL HEALTH TREATMENT

10% of AI/AN young people who died by suicide from 2004 through 2020 and were included in the NFR-CRS had known issues that prevented them from receiving mental health services, compared to 5% of all suicide deaths.[26]

Barriers to Seeking Help and Accessing Care

As described above, minoritized racial and ethnic groups experience increased mental health challenges, possibly due to experiencing a variety of systemic inequities. However, for some groups, the cost of seeking help when mental health challenges arise is insurmountable. Some families, especially low-income families who may be uninsured or underinsured, cannot afford mental health care. People who are undocumented may fear the risk of deportation if they engage in mental health care.[27] AI/AN, NH/PI, Asian, and Black communities who have experienced historical and ongoing oppression may also have a cultural mistrust of health care settings with predominantly white providers. And finally, people whose mental health is significantly affected by factors such as racism, discrimination, and historical trauma may not feel comfortable discussing these topics with mental health providers, leading to them possibly not seeking care at all.[28]

There is also ongoing stigma related to seeking help for mental health concerns, which is generally higher among communities of color.[29] Some may feel pressure to "be strong" and not seek help due to normative beliefs that mental illness is a "white man's issue."[30] Hispanic youth may especially feel pressure to keep concerns around mental health within their families, not seeking help from friends or professionals.[31] Overall, young people of color may not feel like they can seek treatment due to the high stigma around mental health held by their family or other important adults in their life.

Even when treatment is accessible to youth of color, there are inequities impacting the effectiveness of that treatment. Black youth who seek treatment may have limited benefits if they live in a community with prevalent racism.[32] People who experience language and cultural barriers with their mental health provider may not receive effective treatment and providers who carry bias about their clients may not deliver effective treatment. Although it is known that patients benefit from having a provider that matches their racial and ethnic identity, a large majority of people receiving degrees to provide mental health care identify as white.[33]

Lack of Culturally Relevant Prevention Strategies

For many years, research on suicide has centered a white perspective by not prioritizing study designs that involve participants of color and undervaluing research papers that do discuss race.[34,35] Since research findings spur the development and implementation of suicide prevention initiatives, many current strategies are not effective for youth of color. For example, ample research conducted with a white centric lens has identified mental health problems and history of suicide attempts as risk factors for dying by suicide. However, new studies suggest that these factors are significantly less likely to precede suicide deaths among Black youth.[36] The Congressional Black Caucus took notice of the rising rates of suicidality among Black youth, accompanied by a lack of culturally relevant prevention strategies. In the 2019 report "Ring the Alarm: The Crisis of Black Youth Suicide in America," the Caucus calls to fund more Black scientists and mobilize a research agenda focused on preventing Black youth suicide.[37]

Applying These Concepts to Fatality Review

Key Tools to Incorporate During Suicide Death Reviews:

- ☐ Refer to the National Center's existing guidance documents:
  - Improving Racial Equity in Fatality Review (URL: https://bit.ly/3tSF8Ch)
  - Improving the Coordination of Fatality Review Programs with American Indian and Alaska Native Communities (URL: https://bit.ly/4767RCi)

- ☐ Provide team members with training and education on racial equity and implicit biases. For example, use this resource on implicit bias compiled by Racial Equity Tools (URL: https://bit.ly/40782ed).

- ☐ Develop shared terminology. If team members are hesitant to discuss racism because they are unfamiliar with the terms, provide education and resources. For example: Anti-Racism Toolkit (Georgetown University) (URL: https://bit.ly/407ghad).

- ☐ Discuss race and ethnicity in a respectful, non-stigmatizing way. Misunderstanding often leads to prejudice against people of color. The language we use can help break the stigma and show empathy to people. Frame the conversation such that systems of oppression (e.g., racism) are the risk factors, not the young person's identity. Recognizing prejudice and discrimination and becoming educated on these topics will allow the team to better and more effectively discuss prevention.
  - Talking About Disparities (FrameWorks Institute) (URL: https://bit.ly/4097d4u)
  - Bias-Free Language (American Psychological Association) (URL: https://bit.ly/46WeyH2)

Supplemental Data Sources to Consider:

- ☐ Consider neighborhood and community context. Use resources that aren't specific to the child but inform us about the community more broadly, including about healthcare and education access, economic stability, and poverty. Example data sources include:

  - PeriStats (March of Dimes) (URL: https://bit.ly/3yNNpbe)
  - City Health Dashboard (NYU Langone Health) (URL: https://bit.ly/3Q3byS0)
  - PLACES (CDC) (URL: https://bit.ly/3s4ZlVa)
  - Kids Count Data Center (The Annie E. Casey Foundation) (URL: https://bit.ly/3s2UHXN)

Example Equitable Prevention Recommendations:

- ☐ Support policies, training, and workforce development to ensure that school staff and health care professionals are knowledgeable about the unique needs of young people of color and that they reflect the populations they serve. For example: Adapting a Zero Suicide Approach to Native Communities (Suicide Prevention Resource Center) (URL: https://bit.ly/3FweVfx).

- ☐ Strengthen economic supports, including through household financial security and housing stabilization policies.

- ☐ Develop and evaluate anti-oppressive, culturally relevant prevention strategies.

- ☐ Education for community members, school staff, and clinicians on the prevention of suicide and youth risk behaviors. For example: Guidance for Culturally Adapting Gatekeeper Trainings (Suicide Prevention Resource Center) (URL: https://bit.ly/3s2VPdZ).

- ☐ Engage people with lived experience in all aspects of suicide prevention.

Sexual Orientation and Gender Identity

This section covers how heterosexism and transphobia perpetuate disparities in poor mental health and suicidality among LGBTQ+ youth. Here are a few definitions:

1

Sex Assigned at Birth:

The sex that the medical community labels a person at birth based on observable medical factors (e.g., appearance of genitals). Most people are assigned male or female, and this is what is put on their birth certificate. When someone does not fit the typical definitions of female or male, they may be described as intersex.

2

Gender Identity:

A person's innate, deeply felt sense of identifying as a man, as a woman, or gender-nonbinary, regardless of the sex assigned at birth. Gender identity is distinct from sexual orientation. The term "cisgender" means someone's gender identity is the same as their sex assigned at birth. "Transgender" refers to a gender identity that is different from the sex assigned at birth.

3

Sexual Orientation:

A person's physical or emotional attraction to people of the same, neither, both, and/or opposite gender. "Heterosexual," "bisexual," "gay," and "lesbian" are all sexual orientations. Sexual orientation is distinct from gender identity.

4

LGBTQ+:

An umbrella term that collectively refers to people who are lesbian, gay, bisexual, transgender, queer, and questioning. The '+' represents those who are part of the community, but for whom LGBTQ does not accurately capture or reflect their identity (e.g., intersex, asexual, pansexual, agender, bigender, and genderqueer).

Heterosexism and Transphobia

It is well-researched that LGBTQ+ children and youth experience increased suicidal ideation and suicide attempts when compared to their heterosexual and cisgender peers.[38] For example, 48.1% of LGB high school students in the U.S. in 2021 reported seriously considering attempting suicide, compared to 15.0% of heterosexual students.[39] However, it is also well-documented that these disparities are substantially reduced for LGBTQ+ children and youth who live in supportive and affirming communities.[40]

LGBTQ+ youth are systematically impacted by the stigma that stems from heterosexism and transphobia in families, schools, communities, and policies. These systems of oppression are upheld by a society that privileges being heterosexual and cisgender as normative, while other sexual orientations and gender identities are devalued and discriminated against. This structural stigma constrains LGBTQ+ children and youth, placing them at the margins, and making them more likely to experience poor health and wellbeing.[41]

- **47% of young people with a gender identity other than cisgender (e.g., transgender, non-binary, other) who died by suicide in 2020 and were included in the NFR-CRS had experienced stress related to their gender identity.**
- **53% of young people with a sexual orientation other than heterosexual (e.g., gay, lesbian, bisexual, questioning, other) who died by suicide in 2020 and were included in the NFR-CRS had experienced stress related to their sexual orientation.[42]**

A few ways that heterosexism and transphobia manifest in society and impact mental health among LGBTQ+ young people are detailed below.

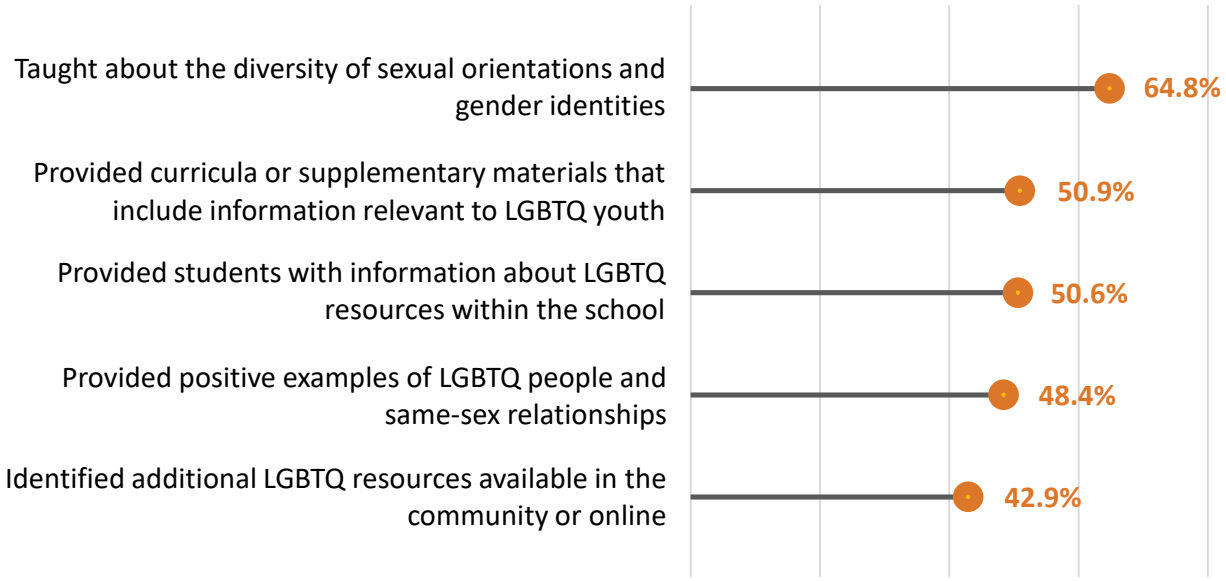
Non-inclusive School Curricula

Research has shown that schools with LGBTQ+ inclusive education, including receiving information about sexual orientation, learning about LGBTQ+ history, and discussions of LGBTQ+ current events, increases the likelihood of students thinking their school was a safer place. LGBTQ+ inclusive sex education is specifically associated with reduced suicidal ideation, increased mental health, and lower experiences of bullying among LGBTQ+ youth.[43] However, data from the 2020 School Health Profiles show that young people in secondary schools do not always receive this education.

INTERSECTING SYSTEMS

Be mindful of how intersecting systems of oppression produce differential effects for youth based on the combination of identities they hold. See the section on intersectionality.

Figure 3. *Secondary Schools in the U.S. Do Not Always Practice LGBTQ Inclusive Sexual Health Education*



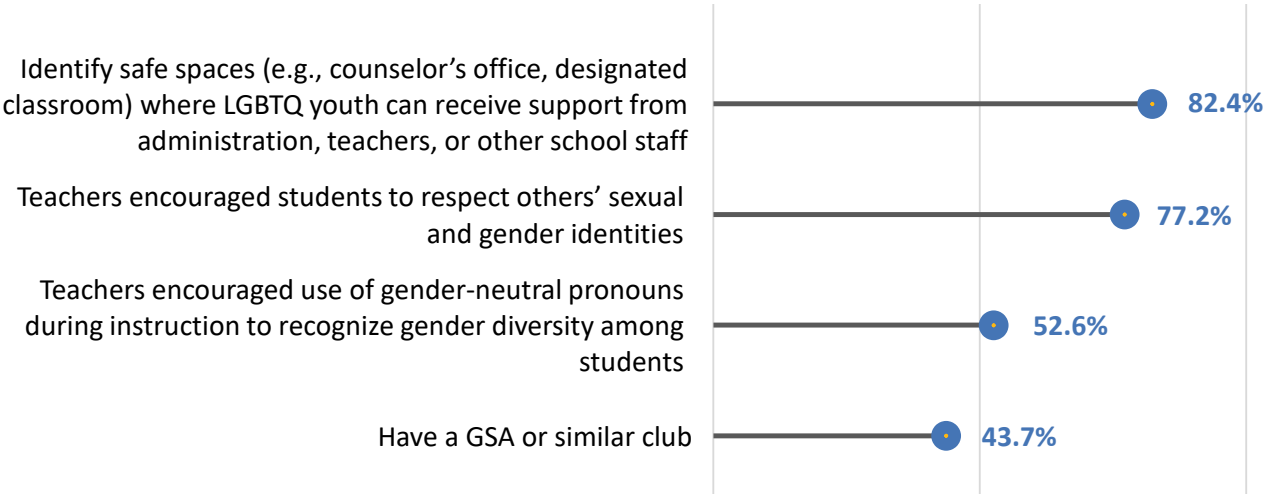
Data Source: Centers for Disease Control and Prevention. School Health Profiles 2020: Characteristics of Health Programs Among Secondary Schools.

Limited Access to Safe and Affirming Spaces

Support and acceptance of young people by their family, peers, colleagues, and communities are an essential foundation to ensure all young people thrive. LGBTQ+- affirming practices such as the use of chosen names and pronouns and access to preferred restrooms, locker rooms, and safe spaces can help to create supportive environments and reduce suicidality. For example, research shows that the risk of suicidal behavior by transgender youth reduces for every additional context (e.g., at home, school, work, or with friends) in which their chosen name is used.[44]

Research also shows that access to Gay Straight Alliances (GSAs) create a positive climate for all students and have positive effects on student health and wellness, including reduced suicidality.[45] GSAs, also referred to as Gender & Sexuality Alliances, are student-run organizations that unite LGBTQ+ and allied students to build community and organize around issues impacting them in their schools and communities. In addition to being a safe place for LGBTQ+ youth, GSAs have become clubs that advocate for broader social change, including racial, gender, and educational justice. Overall, data from the 2020 School Health Profiles show that secondary schools have room to improve when it comes to providing access to safe, affirming spaces for LGBTQ+ youth.

Figure 4. *Secondary Schools in the U.S. Do Not Always Have Inclusive Practices or Access to Safe, Affirming Spaces for LGBTQ Youth*



Data Source: Centers for Disease Control and Prevention. School Health Profiles 2020: Characteristics of Health Programs Among Secondary Schools.

Limited Access to LGBTQ+-Informed and Affirming Health Care

Providing health care that is informed, affirming, and inclusive is critical to improve health outcomes among LGBTQ+ youth. However, LGBTQ+ young people frequently encounter discriminatory, stigmatizing, or disrespectful interactions with health care providers and often have difficulty finding providers knowledgeable about the unique challenges facing them, and therefore are not adept in addressing their specific health needs.[46] Health care providers and staff receive little to no training specific to LGBTQ+ patients, and many providers report not feeling equipped to provide quality care to LGBTQ+ people due to this lack of education and resources.[47,48]

Lack of LGBTQ+-Informed Prevention Strategies

Although disparities in suicidality persist for LGBTQ+ youth, most evidence-based suicide prevention programs are universal, available for a broad population of youth. Universal interventions do not adequately address the unique experiences of LGBTQ+ youth, such as coming out and the stigma stemming from heterosexism and transphobia. To close disparities, programs must be designed for LGBTQ+ young people and evaluated for their effectiveness at reducing suicidality in this unique population.[49]

Applying These Concepts to Fatality Review

Key Tools to Incorporate During Suicide Death Reviews:

- ☐ Develop shared terminology. If team members are hesitant to discuss sexual orientation and gender identity because they are unfamiliar with the terms, provide education and resources.

    - Sexual Orientation, Gender Identity, Mental Health, and Suicide Resources (The Trevor Project) (URL: https://bit.ly/3s5gvBU)

- ☐ Discuss sexual orientation and gender identity in a respectful, non-stigmatizing way. Misunderstanding often leads to prejudice against LGBTQ+ people. The language we use can help break the stigma and show empathy to people. Frame the conversation such that systems of oppression (e.g., heterosexism, transphobia) are the risk factors, not the young person's identity. Recognizing prejudice and discrimination and becoming educated on these topics will allow the team to better and more effectively discuss prevention.

    - GLAAD Media Reference Guide – 11th Edition (GLAAD) (URL: https://bit.ly/3S7o4mm)
    - Bias-Free Language (American Psychological Association) (URL: https://bit.ly/46WeyH2)

Supplemental Data Sources to Consider:

- ☐ Although mortality data systems face challenges in collecting data about sexual orientation and gender identity, there are other data sources that can provide information about the experiences of LGBTQ+ youth. Example data sources include:

    - Youth Risk Behavior Survey Explorer (CDC) (URL: https://bit.ly/40i9F8T)
    - U.S. National Survey on the Mental Health of LGBTQ Young People (The Trevor Project) (URL: https://bit.ly/3FwXBac)
    - School Climate Survey (GLSEN) (URL: https://bit.ly/49a6Vyw)
    - School Health Profiles (CDC) (URL: https://bit.ly/45Tt1Ta)

Example Equitable Prevention Recommendations:

- ☐ Improve data collection and data quality to aid prevention. Provide education and training to death scene investigators on best practices for collecting information on sexual orientation and gender identity.

    - LGBT Mortality (URL: https://bit.ly/47njepB)
    - Learning Community on Safe and Effective LGBTQ+ Data Collection (National SOGIE Center) (URL: https://bit.ly/473Wwm5)

- ☐ Support policies, training, and workforce development to ensure that school staff and health care professionals are knowledgeable about the unique needs of young people and that they reflect the populations they serve.

    - Resources for Workforce Development (National SOGIE Center) (URL: https://bit.ly/409bncK)

- ☐ Support the development of Gender and Sexuality Alliances (GSAs)

- ☐ LGBTQ+ inclusive school curricula, comprehensive sex education, anti-harassment policies, and anti-bullying policies.

- ☐ Name, pronoun, and bathroom affirmation for gender diverse youth.

- ☐ Educational opportunities around suicide, equity, and LGBTQ+ affirmation for adults, young people, families, and community members. For example: AFFIRM Caregiver (URL: https://bit.ly/3MdD7a8), AFFIRM Youth (URL: https://bit.ly/40s20oD), and Journey Ahead (URL: https://bit.ly/49lEGNo)

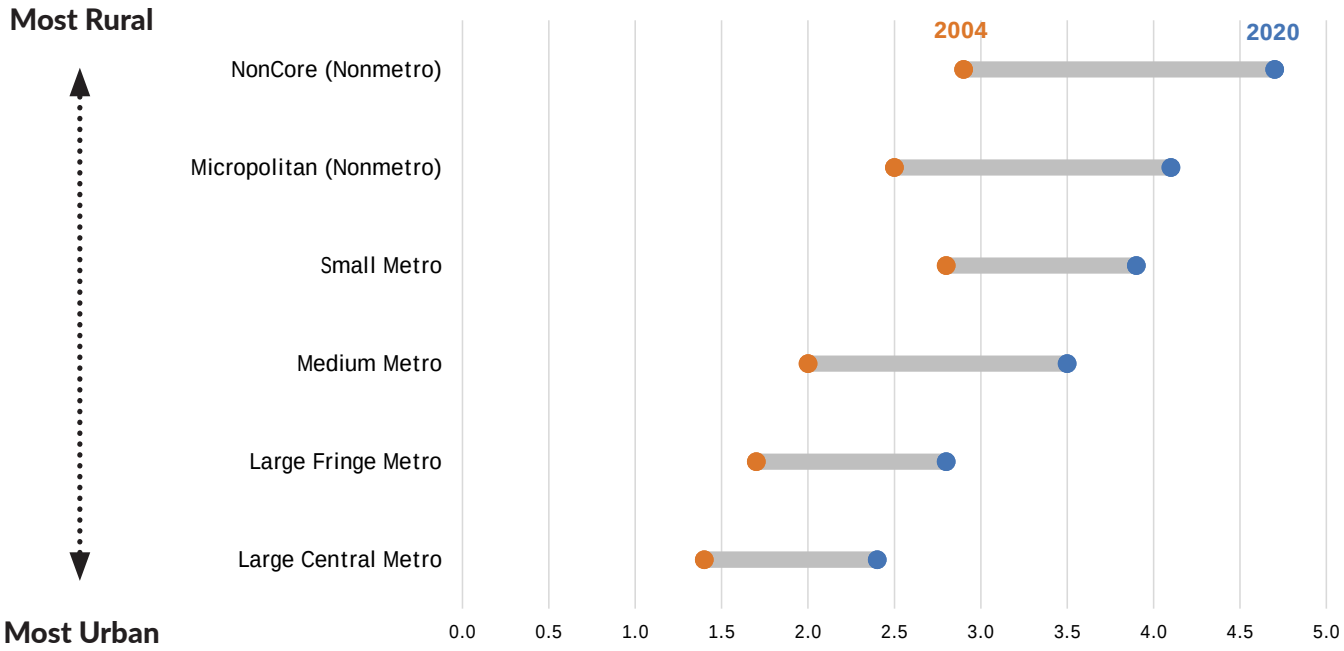
Geography

This section covers how isolation, limited access to care, stigma, and increased access to firearms perpetuate disparities in poor mental health and suicidality among rural communities.

Geographic and Social Isolation

Rural counties usually encompass large geographic areas, which results in broad expanses of land with small population sizes. Living in a rural area can be isolating, where many residents are self-reliant for survival. This can decrease a person's sense of connectedness and support, which is an important protective factor for several forms of injury and violence, including suicide.[50] With less face-to-face contact and connection with support networks, people living in rural areas may experience greater feelings of loneliness, depression, and suicidality.

Figure 5. *Children and Youth Ages 5-17 Years Old Living in the Most Rural Areas Have the Highest Suicide Rate and Experienced the Greatest Change in Rate Between 2004 and 2020**



* The change in rate for each urbanization category between 2004 and 2020 was statistically significant.

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2004-2020 on CDC WONDER Online Database.

Limited Access to Mental and Behavioral Health Care

Possible explanations for geographic disparities include limited availability and accessibility of mental and behavioral health services, which when available may help prevent outcomes such as suicide.[51,52,53] Nationally, access to care has been a long-standing problem for rural communities, which is mostly owed to shortages in qualified clinicians and long travel times to any health care facility. At the end of 2022 in the U.S., there were about 1,200 geographic areas federally designated as having a shortage of mental health care professionals, and about 87% of those were at least partially rural.[54] Instead, primary care physicians are often called on for mental health care, even though these physicians report feeling unprepared to treat mental illness.[55,56]

Increased Stigma Associated with Mental Health Challenges and Seeking Help

Coupled with isolation and lack of health services, the increased stigma in rural communities related to seeking help and mental health helps explain geographic disparities in suicide.[57] Even when services might be available, many people living in rural areas report not wanting to seek help because of the stigma and lack of anonymity when accessing services in a rural setting. When distressed, many people living in rural areas may attempt to help themselves alone or seek informal support from family and faith communities rather than mental health professionals. This sense of independence may foster a sense of shame about mental illness, which can ultimately run deep and across generations within families.

INTERSECTING SYSTEMS

Be mindful of how intersecting systems of oppression produce differential effects for youth based on the combination of identities they hold. See the section on **intersectionality**.

Increased Access to Firearms as a Lethal Means

USE OF FIREARMS AS MEANS OF SUICIDE

Among suicide deaths included in the NFR-CRS, firearms were the means used in 49% when the incident occurred in a rural or frontier area, compared to 35% in urban or suburban areas.[58]

Rural and frontier communities have greater access to firearms as a lethal means because rural residents may have firearms in their homes, and use them for protection, hunting, agricultural needs, and recreation.[59,60] Rural families may also have more firearms in the home, with 75% of rural firearm owners having more than one firearm, compared with 48% of urban firearm owners.[61] Living in a home with firearms that are stored unlocked and loaded increases the risk of suicide and having more firearms in the home is a potential barrier to safety with more weapons to store securely. Research shows that restricting access to lethal means such as firearms is effective in preventing suicide.[62] This is especially the case in contexts where the method is popular, highly lethal, and widely available.

Applying These Concepts to Fatality Review

Key Tools to Incorporate During Suicide Death Reviews:

- ☐ Discuss firearms in a respectful, non-judgmental manner that emphasizes autonomy and options. Conversations about firearms can be difficult, especially in rural areas, but should not be avoided.
    - Normalize the conversation by discussing the risk of firearms without stigma. This is the same manner we address other risks, like not wearing a seat belt for people who have cars, not locking up medications for people with prescriptions in the home, not putting a baby gate at the top of stairs and a fence around a swimming pool. Team coordinators should emphasize that it is not about taking firearms away from people, but rather about reducing risks and discussing how to be responsible and safe with potential hazards in the home.
    - Focus on firearm safety rather than ownership. We all want our families to be safe, no one wants a firearm to be used to injure a child. Discuss firearm access as a risk factor.

Supplemental Data Sources to Consider:

- ☐ Consider community context in rural areas. Use resources that aren't specific to the child but inform us about the community more broadly. Example data sources include:
    - HRSA Map Tool (HRSA) (URL: https://bit.ly/3Sf30dF)
    - Health Workforce Shortage Areas (HRSA) (URL: https://bit.ly/45H6NmZ)
    - Rural Data Explorer (Rural Health Information Hub) (URL: https://bit.ly/3tRkl2k)
    - Kids Count Data Center (The Annie E. Casey Foundation) (URL: https://bit.ly/3s2UHXN)

Example Equitable Prevention Recommendations:

- ☐ Support policies that expand access to broadband internet for increased connectedness to social networks and health care.

- ☐ Support policies to improve behavioral health care by increasing telehealth services, especially in rural areas.

- ☐ Support lethal means restriction and safety by empowering communities to implement proven approaches.

Children and Youth with Disabilities

This section covers how ableism perpetuates disparities in poor mental health and suicidality among young people with disabilities.

The UN Convention on the Rights of Persons with Disabilities identifies people with disabilities as individuals who have long-term physical, mental, intellectual, or sensory impairments which, when combined with negative attitudes or environmental barriers, prevents them from taking a full and active role in society.[63] This broad definition of disability is used for purposes of this report.

Ableism

Youth with disabilities are systematically impacted by the stigma, prejudice, and discrimination that stems from ableism in communities, systems, and policies. Ableism is a set of beliefs or practices that devalue and discriminate against people with disabilities. Compared with their non-disabled peers, youth with disabilities report lower levels of happiness and higher rates of suicidal ideation, bullying, and harassment.[64] There is emerging evidence that this poor wellbeing is not inherent to the presence of a disability or chronic condition, but rather is linked to the stigma and inequitable access to resources that is perpetuated by ableism in society.[65]

PRIOR DISABILITY OR CHRONIC ILLNESS

25% of young people who died by suicide from 2004 through 2020 and were included in the NFR-CRS had a known prior disability or chronic illness. Among these, 54% were mental health or substance use related, 40% were cognitive/intellectual, 17% were physical/orthopedic, and 2% were sensory.[66]

A few ways that ableism manifests in society and impacts mental health among young people with disabilities are detailed below.

Barriers to Quality Health Care

Although health care is critical to all youth, like LGBTQ+ young people, youth with disabilities lack access to care specific to their needs. Even finding general health care may be difficult, as providers hesitate to take on routine care for people with disabilities, mistakenly believing that a specialist is always necessary.[67] Plus, disability-specific care can be cost-prohibitive and especially difficult to access for families living in rural communities.

INTERSECTING SYSTEMS

Be mindful of how intersecting systems of oppression produce differential effects for youth based on the combination of identities they hold. See the section on **intersectionality**.

Inaccessible Transportation and Public Buildings

Accessibility of the built environment is crucial to ensuring that people with disabilities can fully participate in society. However, many places fail to meet the built environment standards set by the Americans with Disabilities Act. An inaccessible built environment prevents people with mobility limitations from being able to participate in health services, education, employment, and social activities. Barriers can include poor vehicle design; lack of accessible ramps, curbs, crosswalks, and sidewalks; the absence of elevators; and non-existent or inaccessible signage and wayfinding.

Isolation and Limited Social Supports

Youth with disabilities have shared that participating in social activities, being with and having the support of friends and family, and feeling valued and capable are vital to their personal wellbeing.[68] Unfortunately, many of these young people tend to have difficulty acquiring and maintaining relationships with peers. This may be due in part to individual level factors that negatively impact social problem-solving or emotional regulation. However, larger community and societal factors, including stigma and poor accommodations, compounds social exclusion. There is limited availability of accessible social activities for youth with disabilities to help foster peer relationships and connectedness. Plus, where there may be access, staff who lead activities often lack the training and understanding to meaningfully engage youth with disabilities, leaving these young people further isolated.[69]

EXPERIENCING ISOLATION

33% of young people with a known disability or chronic illness who died by suicide in 2020 and were included in the NFR-CRS experienced isolation as a life stressor, compared to 19% of non-disabled children and youth.[70]

Lack of Resources

The cost of raising a child with a disability increases a family's risk of falling below the federal poverty level, and it can be difficult to regain financial security. There are additional demands on household income for medical care and disability related expenses. Research has also shown that limited access to skilled child care for children with disabilities forces caregivers to leave their employment, possibly reducing family income.[71] Spending prolonged periods of time in poverty has been linked to stress, anxiety, and feelings of unhappiness in young people with disabilities.[72]

Applying These Concepts to Fatality Review

Key Tools to Incorporate During Suicide Death Reviews:

- ☐ Discuss mental health and disability in a respectful, non-stigmatizing way. Misunderstanding often leads to prejudice against people with mental health challenges, addictions, and/or disabilities. The language we use can help break the stigma and show empathy to people. Frame the conversation such that systems of oppression (e.g., ableism) are the risk factors, not the young person's identity or social status. Recognizing prejudice and discrimination and becoming educated on these topics will allow the team to better and more effectively discuss prevention.

    - Dos and Don'ts When Talking About Mental Health (On Our Sleeves) (URL: https://bit.ly/46BCb7P)
    - Use Person-First Language to Reduce Stigma (Mental Health First Aid) (URL: https://bit.ly/40eV4v4)
    - Communicating With and About People with Disabilities (CDC) (URL: https://bit.ly/40ds5Yz)
    - Get Started Tools (National Center on Disability in Public Health) (URL: https://bit.ly/3QanwcI)

Supplemental Data Sources to Consider:

- ☐ Use resources that aren't specific to the child but inform us about youth with disabilities more broadly. Example data sources include:

    - Students with Disabilities (National Center for Education Statistics) (URL: https://bit.ly/3FA30xn)
    - Data and Statistics on Disability and Health (CDC) (URL: https://bit.ly/45JEZyA)
    - Kids Count Data Center (The Annie E. Casey Foundation) (URL: https://bit.ly/3s2UHXN)

Example Equitable Prevention Recommendations:

- ☐ Support policies to improve health care access by increasing telehealth services, especially in rural areas.
- ☐ Strengthen economic supports, including through household financial security and housing stabilization policies.
- ☐ Find more prevention resources for People with Physical Health Problems or Disabilities (Suicide Prevention Resource Center) (URL: https://bit.ly/3MigFNo).

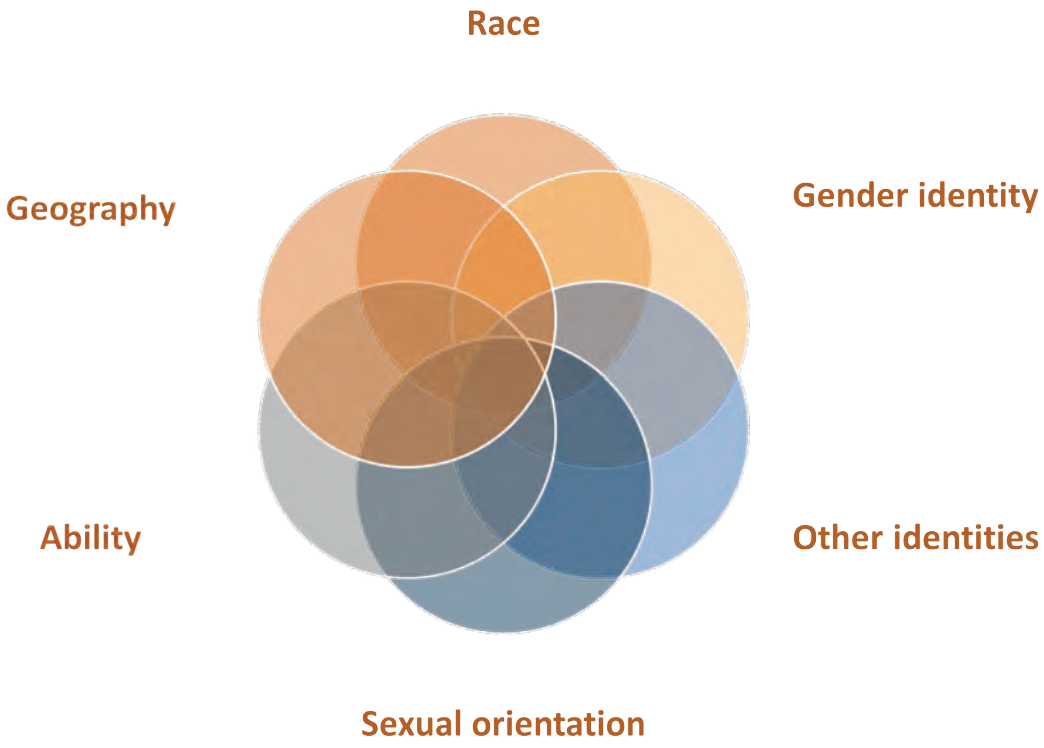
Intersectionality

Intersectionality is a framework developed by Kimberlé Crenshaw that illustrates the ways social systems of oppression (e.g., racism, classism, heterosexism, cisgenderism, ableism) intersect and shape the lives of people with multiple identities and social statuses.[73,74]

Children and youth who identify with multiple stigmatized and minoritized identities are among the most impacted by suicide, as different inequities overlap and create a compounding effect. For example, emerging evidence shows that LGBTQ+ youth with disabilities are at a higher risk of experiencing suicidal ideation compared to both heterosexual youth without disabilities and LGBTQ+ youth without disabilities.[75] In another example, young people with disabilities that live in rural areas are less likely to receive medical care due to the compounding effects of cost, unavailability of care, and geographical challenges like limited broadband access and transportation, amplifying risk of suicide.[76]

Since suicide is a complex and multifaceted problem, intersectionality is crucial in understanding suicide risk, and should always be considered during the review and prevention discussion.

Figure 6. *Intersectionality Is Crucial in Understanding Suicide Risk, and Should Always Be Considered During the Review and Prevention Discussion*



The COVID-19 Pandemic: Impact on Existing Inequities and Disparities

The lives of children and youth were changed profoundly during the COVID-19 pandemic. A global impact was felt among young people due to the socio-economic consequences of the pandemic. Many families lost sources of income, causing households to fall below the poverty line. Although effective at slowing the transmission of COVID-19, mitigation measures associated with the pandemic (e.g., stay-at-home orders, remote schooling) sometimes did more harm than good for youth. Many young people reported poorer mental and physical health and feeling more socially isolated, risk factors for suicide. On top of the universal impact of COVID-19 on young people that will likely last long past the end of the pandemic, we must consider how the pandemic exacerbated inequities experienced by specific communities and the subsequent impact on disparities in suicide deaths.[77]

Emerging research found excess suicide mortality among non-Hispanic AI/AN, non-Hispanic Black, and non-Hispanic Asian/Pacific Islander (A/PI) youth during the first year of the COVID-19 pandemic.[78] The cause of this excess mortality is complex. However, several existing inequities that perpetuated disparities in suicide were made worse during the pandemic. For example:

- In AI/AN communities, the pandemic limited the ability to gather for spiritual ceremonies, which is a critical aspect of their culture that is normally protective against suicide.[79] AI/AN communities also experience stigma and structural barriers to accessing mental health services, inequities that were made worse by the pandemic.[80]

- For Black youth, COVID-19-related disruptions to mental health services exacerbated the fact that they were already less likely to seek help for depression and suicidal ideation compared to other youth.[81] Coinciding with the pandemic, Black youth had increased exposure to racial violence, including following the murder of George Floyd, which is associated with adverse effects on mental health.[82,83,84]

- For A/PI youth, the mental health impact of COVID-19-related discrimination and heightened xenophobia may have contributed to higher-than-expected suicide deaths. Physical assaults and bullying of A/PI youth increased significantly in 2020.[85]

COVID-19 PANDEMIC

CDR teams determined that the COVID-19 pandemic indirectly contributed to 39% of suicide deaths among AI/AN youth and 27% of suicide deaths among Asian youth that occurred in 2020 and were included in the NFR-CRS, compared to 19% of all suicide deaths.[86]

The inequities faced by LGBTQ+ youth were also exacerbated by the pandemic. Stay-at home measures and prolonged remote schooling confined LGBTQ+ youth to their homes.[87] Many of these young people are unable to live as their authentic selves at home because they have not shared their sexual and gender identities or because they were not met with support and acceptance from their family.[88] Being confined to an unsafe, not affirming home during the pandemic worsened mental health and suicidality among LGBTQ+ youth. The closing of schools was particularly impactful for LGBTQ+ youth, as many rely on school-based mental health services, social and community supports and resources like GSAs, and relationships with trusted and supportive school staff.

Finally, inequities and barriers faced by youth with disabilities were magnified during the COVID-19 pandemic. For example, the rapid transition to remote learning was challenging for everyone involved, but accommodating students with disabilities was especially difficult and unclear. Many services and educational accommodations that are tailored to each individual student with a disability could not be easily or quickly replicated in a remote, virtual teaching environment. In addition, the pandemic even further limited access to health care and personal care for youth with disabilities. Many critical health care services accessed by youth with disabilities are classified as nonemergent, and therefore were delayed during the pandemic.[89]

COVID-19 PANDEMIC

CDR teams determined that the COVID-19 pandemic indirectly contributed to 30% of suicide deaths among youth with a prior disability or chronic illness that occurred in 2020 and were included in the NFR-CRS, compared to 19% of all suicide deaths.[90]

The pandemic amplified many entrenched inequities, as demonstrated by the communities most impacted. Ongoing waves of the pandemic and post-pandemic recovery will require special attention to these communities, re-fostering safe environments and removing barriers to quality health care and needed resources.

Additional Tools to Incorporate Equity During Suicide Death Reviews

By approaching the fatality review process with an equity lens, local teams are likely to improve data quality and identify prevention recommendations that prioritize addressing the root causes of deaths and reduce disparities. In addition to the tools provided throughout this report, teams may also consider utilizing the following tools and strategies.

Refer to the National Center's existing guidance documents:

- ☐ Suicide Prevention Best Practices (URL: https://bit.ly/3MiB9pf)
- ☐ Suicide Prevention Recommendations Based on Child Death Review (URL: https://bit.ly/3Qx8y1S)
- ☐ Health Equity: Diversity, Equity, and Inclusion Assessment Guide for Multidisciplinary Teams (URL: https://bit.ly/3MEPuwv)
    - Facilitator's Manual (URL: https://bit.ly/495S4oB) for the Health Equity: Diversity, Equity, and Inclusion Assessment Guide for Multidisciplinary Teams
- ☐ Findings Guidance (URL: https://bit.ly/3QahTLO)
- ☐ Life Stressors Guidance (URL: https://bit.ly/3tQb62k)
- ☐ Training module: Using Health Equity in Fatality Review (URL: https://bit.ly/3s8QYb3)

Utilize education and resources from the Suicide Prevention Resource Center (URL: https://bit.ly/3s6kQoq), including the Best Practices Registry (URL: https://bit.ly/4099YTx).

Provide team members with training and education on equity and implicit biases.

- ☐ Example online courses:
    - Roots of Health Inequity (National Association of County and City Health Officials) (URL: https://bit.ly/3QxBkzo)
    - Unconscious Bias: Understanding Bias to Unleash Potential (FranklinCovey) (URL: https://bit.ly/3SkOq4x)
- ☐ Example educational resources:
    - Implicit Bias Resource Guide (National Institute for Children's Health Quality) (URL: https://bit.ly/3Qx4PBv)
    - Project Implicit (Harvard University) (URL: https://bit.ly/3Qwb1JM)

- ☐ Example educational videos:
    - Implicit Bias: Concepts Unwrapped (McCombs School of Business) (URL: https://bit.ly/479SwRb)
    - Implicit Bias: How it Effects Us and How We Push Through (TEDx Talk by Melanie Funchess) (URL: https://bit.ly/46FRIU6)

Develop co-created community agreements.

- ☐ Engaging your team in a collective process to identify group norms, shared values, or commitments helps to establish a solid foundation for team members to understand and agree about how to participate in the CDR process.
- ☐ Establishing and being held accountable to a community agreement of making the meeting a safe space for learning about how oppression impacts child deaths is one way to help foster psychological safety within the team.
- ☐ Having agreements in place is helpful, for example, when a team member acts in contradiction to the agreed-upon values, such as by shaming caregivers or making a racist remark, the coordinator or other team members can refer back to the group agreements as a way to keep the review focused on prevention and remind the group of how they have agreed to be present during the meetings.
- ☐ Example resources:
    - Co-creating community agreements in meetings (Drawing Change) (URL: https://bit.ly/45NUhSW)
    - Developing community agreements (National Equity Project) (URL: https://bit.ly/3tLX9m3)

Use best practices for communicating about suicide.

- ☐ Words Matter: Suicide Language Guide (CAMH) (URL: https://bit.ly/3Mj9pAF)
- ☐ Language Matters: Talking About Suicide (Texas HHS) (URL: https://bit.ly/45Kkguw)

Take 5-10 minutes after each case review meeting to acknowledge implicit bias and assumptions that may have shown up in the review.

- ☐ Encourage team members to check in with their internal selves and recognize what may have come up.
- ☐ Allow space for those who would like to share their biases with other team members during the end of the case review.

Additional Example Equitable Prevention Recommendations

When developing recommendations in Section L of the NFR-CRS (URL: https://bit.ly/370ec8M) and prioritizing recommendations for implementation, it is critical to consider equity and the populations systemically impacted by inequities. In addition to the example recommendations provided throughout the report, the examples below are not exhaustive and are meant to inspire conversation. Carefully consider what may be relevant in your state or jurisdiction.

For additional examples and up-to-date resources, visit:

- Suicide Prevention Resource Center's Best Practice Registry (URL: https://bit.ly/4099YTx) and Culturally Competent Approaches (URL: https://bit.ly/3sc3B56)
- National SOGIE Center (URL: https://bit.ly/496Ij9P) and the Center of Excellence on LGBTQ+ Behavioral Health Equity (URL: https://bit.ly/40iEtXe)
- National Strategy for Suicide Prevention (URL: https://bit.ly/3tTz7oY) and the Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention (URL: https://bit.ly/408ehhT)
- National Institute of Mental Health (URL: https://bit.ly/3QaCnUz)

Improve data collection and data quality to aide prevention. Examples include:

☐ Develop and implement a process to collect family/survivor or key informant interviews.

- Conducting interviews with the surviving members of a young person's family centers equity and justice in child death review by providing powerful personal stories and key details of the family and young person's experiences.

☐ Encourage schools and communities to participate in data collection through state-wide instruments (e.g., Youth Risk Behavior Surveillance System (URL: https://bit.ly/3QuivNs), School Health Profiles (URL: https://bit.ly/45Ljn4O)) to inform systemic change.

Create safe, supportive environments for young people, being mindful of how intersecting systems of oppression produce differential effects for youth based on the combination of identities they hold. Examples include:

- ☐ Support policies, training, and workforce development to ensure that school staff and health care professionals are knowledgeable about the unique needs of young people and that they reflect the populations they serve. Examples include:
  - Workforce Education (URL: https://bit.ly/3MgE7u9) and Action (George Washington University) (URL: https://bit.ly/3ScPeIs)
  - Clinical Workforce Training Guidelines (National Action Alliance for Suicide Prevention) (URL: https://bit.ly/3Qe27iH)
- ☐ Support policies that expand access to inclusive and informed mental health services.
- ☐ Increase collaboration between youth-serving community organizations to better support young people of color who identify as LGBTQ+.
- ☐ Support inclusive, peer-led suicide prevention programs that promote connectedness to trusted peers and adults in school and community.

Education and training. Examples include:

- ☐ Increase understanding of the protective factors associated with promoting resilience and improved health and wellbeing.
- ☐ Education for community members, school staff, and clinicians on the prevention of suicide and youth risk behaviors. Examples include:
  - Mental Health First Aid (National Council for Mental Wellbeing) (URL: https://bit.ly/3tNUSXs)
  - Question. Persuade. Refer. (QPR Institute) (URL: https://bit.ly/49mSIOX)

Conclusion: Achieving Health Equity

We can move towards achieving health equity by comprehensively incorporating equity into the child death review process and developing equity-centered prevention recommendations. Measuring the change in health disparities as described above is one way we can measure our progress toward achieving health equity. Each of us has a role and must work together to prevent suicide through evidence-based programming, connection, and being trusted adults. The steps you take to support a young person can be lifesaving.

Need help now? If you or someone you know needs support now, call or text 988 or chat 988Lifeline.org. 988 connects you with a trained crisis counselor who can help. Help and hope are available 24 hours a day, 365 days of the year.

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