Suicide Risk Prevention:
An Analysis of the Minnesota Black and Lao Populations

MPP Capstone Project

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Executive Summary

In recent years, rising suicide rates for Minnesota's Black and Lao communities have captured the attention of the Minnesota Department of Health (MDH). Comparing aggregated suicide rates from 2005 through 2009 to 2010 through 2014, Black suicides increased by 18% while Asian suicides increased significantly by 71%.[1] After working with the Lao community it was determined that the community would be better served by looking at the many stressors that may lead to suicide, referred to as overwhelming stress. The purpose of this project is to understand suicide within the Black community and overwhelming stress in the Lao community by examining underlying risk factors, awareness of the issue and prevention resources, and readiness to address the problem.

Risk Factors

The authors used a mixed methods approach to evaluate suicide and overwhelming stress risk and protective factors for each community. Other populations may also share many of the following factors; however, the Black and Lao communities were found to have heightened risk or protection.

Black Community Suicide Risk and Protective Factors

- Psychiatric/psychological disorders that serve as risk factors include trauma (physical, sexual, and emotional), bipolar disorder, posttraumatic stress disorder, and historical trauma.
- Demographic characteristics that serve as risk factors include low socioeconomic status, low education level, high unemployment, and homelessness.
- Environmental risk factors include limited access to health care (low insurance rates, low access to mental health care providers), criminal record, major adverse life events such as divorce, job loss, or the death of a close family member, and domestic partnership issues.
- A belief within the African American community that serves as a risk factor is distrust in the mental health care system.
- Factors that serve to protect individuals from suicide include a resilient community attitude and strong religious beliefs.

Lao Community Overwhelming Stress Risk and Protective Factors

- Psychiatric/psychological disorders that serve as risk factors include psychological symptoms displayed physically, not mentally (somatization), substance abuse, gambling, and mental health disorders.
- Demographic risk factors include low socioeconomic status, low education level, high unemployment, and limited English proficiency.
- Lao beliefs that serve as risk factors include a culture that values privacy, a stigma against asking for help, and a stigma around mental health.
- Environmental risk factors are limited access to health care (insurance, mental health care providers), major adverse life events, familial problems, and immigrant or refugee status.

- Protective factors against overwhelming stress include strong religious communities, strong familial connectedness, and strong community leaders seeking to address challenges.

Community Awareness Findings

Based on the Community Readiness Assessment (CRA) interviews with community leaders about suicide and suicide prevention resources, the Black community is in the first stage of readiness, No Awareness. This signifies the community is not aware of or does not consider suicide to be a problem. Due to culturally appropriate changes made to the tool, the Lao community's stage of readiness, Denial/Resistance, measures the community's ability to prevent and respond to "overwhelming stress." Though the community is starting to comprehend the issue of overwhelming stress, they tend to ignore or avoid dealing with the problem.

Prevention Recommendations

The following are suggested recommendations that align with the Minnesota State Suicide Prevention Plan for reducing Black and Lao suicides based on the CRA scores and a theme analysis of the qualitative interviews:

Black Community

- Create awareness of the issue of suicide and prevention services by implementing a public awareness campaign.
- Build community trust by training trusted community leaders and organizations to talk about suicide and prevention services.
- Contextualize suicide within the awareness campaign by addressing the role of mental health in violent crime and suicide.
- Implement culturally competent suicide awareness and treatment by providing funding for a community member to become a mental health professional.

Lao Community

- Create a culturally appropriate awareness campaign to address the stigma associated with receiving help, particularly mental health services.
- Provide mental health and social service resources in both English and Lao and distribute these resources more widely within the community.
- Develop funding and assistance for at least one community member to become a mental health professional in the community.
- Increase connections between the Lao Assistance Center and other institutions in the Lao community to bring resources to more community members.

Problem Statement

In 2015, the Minnesota Department of Health (MDH) instituted a five-year, comprehensive State Suicide Prevention Plan to address rising suicide rates within the state.[2] By 2020, MDH hopes to reduce suicide within Minnesota by 10%.[3] In order to achieve this goal, MDH is seeking to provide culturally appropriate education and resources to the many diverse communities within the state.

Two communities, the Black[i] and Lao[ii], specifically caught the attention of MDH staff. The Black community was identified by MDH as having a rising burden of suicide. As is typical for most populations, males had a higher rate of suicide than females. However, unlike other populations, a large number of African American male suicide victims were between the ages of 25 and 34 years – this is 10 to 20 years younger than other population average ages. Therefore, the first target population for this report is the Black native-born males age 25-34 years old.

In 2015, the Lao Assistance Center (LAC) approached MDH seeking help to better understand and identify the causes of the increasing number of suicides within their community. LAC reported eight suicides from 2010 through early 2015. Upon examining suicides within the Lao community, MDH found discrepancies between the suicides reported by the community and state death records. MDH identified five suicides between 2010 through 2015, of which only one matched those reported by LAC.[4] Despite concern over suicide deaths, it was determined by Lao community leaders, MDH, and the researchers that it was more culturally appropriate to focus on the overwhelming stressors Lao people face that could lead to suicide, rather than suicide specifically. As a result, the second target population for this report is the Minnesota Lao community in its entirety and the scope of the study is the overwhelming stress within the community.

The purpose of this research is to investigate suicide awareness and resources for prevention within the Black community, and the awareness and resources to prevent, and respond to, overwhelming stress in the Lao community, and to determine what education and resources can

[i] Throughout this paper, Black and African American will be used interchangeably.
[ii] Throughout this paper, Lao and Laotian will also be used interchangeably.

be provided based on each community's needs in accordance with the State Suicide Prevention Plan.

This project will address three research questions:

1. What are the unique underlying suicide risk factors for the Black and Lao communities? Which risk factors are shared between the two communities?
2. What is each community's current knowledge of and engagement with resources for suicide prevention?
3. Based on the identified risk factors, how can suicide be prevented in these two communities?

This report aims first to identify risk and protective factors for the Black and Lao communities and second to evaluate community readiness and resources for suicide prevention plans within each community. As a result, the team will recommend culturally appropriate methods for reducing Black and Lao suicides and stressors in the Lao community that align with the State Suicide Prevention Plan.

Methodology

A mixed methods research approach was used to complete this report including a literature review, quantitative statistical analysis, and qualitative analysis. To increase clarity, the specific methodology for each data source is included at the beginning of each section.

Literature Review

A literature review on suicide risk factors and interventions for the United States total population, as well as U.S. Black and Lao populations, was conducted to understand current knowledge of suicide. Both Black and Lao populations were found to have similar to or heightened suicide risk factors compared to the total population, along with some notable differences. The information from the literature review helped to identify variables to study in the quantitative and qualitative analyses. Few suicide interventions were found for either the Black or Lao communities and thus could not be used to inform suicide recommendations in this paper.

The literature review was conducted using academic peer-reviewed articles and grey literature compiled from a number of online databases, including: JStor, PsychInfo, Academic Search Premier, Web of Science, PubMed, Annual Reviews, and Google Scholar. Keywords such as suicide, suicide risk factors, suicide prevention, Black, African American, Lao, and Asian American were used to narrow the relevant literature. Additional sources were gleaned from the reference lists of the most pertinent articles.

A lack of research on suicide risk factors and intervention techniques for both of these communities exists. Most literature focuses on White middle-aged males and Native Americans, the populations with the highest rates of suicide within the U.S. The available literature on suicide prevention for the Black community is outdated and primarily addresses risk factors and prevention techniques for African American youth under the age of 18 years. There is little literature on Lao suicides specifically, and Asian American/Pacific Islander (AA/PI) populations in general. Furthermore, the mental health research for this population was generally conducted over 20 years old and focused on recently arrived refugees.

General Population Suicide Risk Factors

Researchers identify four categories of suicide risk factors within the population: psychiatric/psychological factors, demographic characteristics, environmental factors, and beliefs.[5,6] The four categories are interrelated as they all impact one another. For example, the World Health Organization found a number of social conditions[iii] are major contributors to mental health issues including: socioeconomic status, individual behaviors, and other environmental factors.[7] Having risky environmental factors can lead to greater psychological risk factors, though positive environmental factors can also be a protective factor against psychological problems.

People affected by specific psychiatric disorders are at a higher risk of suicide.[8] In fact, nine out of ten people who die by suicide have been diagnosed with a mental illness.[9] Psychiatric disorders that are associated with suicide include: depressive disorders, bipolar disorder,

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[iii] Within this paper, social conditions and environment are used interchangeable to describe factors within communities that affect individuals.

schizophrenia, anorexia, borderline personality disorder, posttraumatic stress disorder (PTSD), adult antisocial personality disorder, panic disorder, and drug and/or alcohol abuse or dependence.[10]

Psychological risk factors can be associated with an individual's psychiatric disorders, with their environmental factors, or both.[11,12] Joiner, Brown, & Wingate define psychological suicide risk factors as hopelessness, social isolation, and ineffectiveness. Hopelessness refers to an individual's belief in poor future outcomes.[13] Social isolation is defined as an absence of interpersonal relationships.[14] Ineffectiveness is an individual's perception that they are unable to effect outcomes in their life and therefore they are a burden to their family or society.[15] Psychological risk factors also include impulse control problems and strong emotional sensitivity.[16]

Suicide risk differs greatly across demographic characteristics such as age, gender, race, education, household and socioeconomic status.[17, 18] Young adolescents attempt suicide more frequently than adults, but adults ages 45 to 64 years have the highest rate of suicide due to using more lethal means.[19, 20] Similarly, women attempt suicide more frequently than men, but the suicide rate for men is four times that of women because they use more lethal means.[21, 22, 23] Suicide rates are highest among Native Americans/Native Alaskans and White Americans, and are lowest amongst other minority groups.[24] Single people have higher rates of suicide compared to married people.[25]

The main environmental suicide risk factors are adverse life events and a lack of mental health care treatment.[26, 27, 28, 29, 30, 31] An environmental event is defined as "a[n] event that changes the person's social or personal environment that is external and not internal or psychological."[32] The most traumatic and psychologically harmful events occur during childhood and significantly increase the risk of an individual dying by suicide.[33] The most common adverse life events in children include: sexual abuse and molestation, physical abuse and neglect, family dysfunction and environmental violence, and separation from a close parent.[34] Adult adverse life events are usually considered stressors and include: severe national economic downturns, prolonged job loss for low-educated individuals, divorce, and legal problems.[35, 36] Populations living in rural areas have a higher rate of suicide than populations living in urban areas.[37] Access to health care

has been linked to reduced suicide ideation and deaths.[38] However, people who die by suicide are more likely to have seen their primary care doctor, or have visited the emergency room, but the risk of suicide was not detected or treated.[39,40] Access to mental health care is limited and often cost is a barrier.[41] Overall, the effect of health care access on suicide is difficult to measure as many individuals choose not to seek medical or mental health treatment due to their beliefs.[42]

African American Suicide Risk Factors

Despite robust research of suicide risk factors for the general population, there is a lack of suicide risk factor research for the African American community. Researchers agree that psychiatric and psychological risk factors are present within the African American population; however, there is conflicting evidence about the impact of these factors compared to the White American populations. Black men who are victims of suicide are less likely to have documented psychiatric disorders compared to White men.[43] Black men are not necessarily less likely to experience psychiatric disorders, but they have a greater proportion of unmet mental health care needs than White men, which may lead to differences in reporting psychiatric disorders.[44] Psychiatric disorders can manifest as violent and impulsive behaviors, which can lead to suicidal tendencies.[45]

Additionally, researchers have found substance use risk factors, particularly those related to alcohol and illicit drugs, tend to be higher for Blacks than Whites.[46, 47] Given the higher rate of substance use, some substance use-related deaths might obscure cases that would otherwise be classified as suicide. Rockett and Thomas suggest some deaths categorized as resulting from injury of undetermined intent and unintentional poisoning and drowning may also be misclassified suicides.[48]

There are many demographic characteristics that heighten the risk of suicide within the African American community compared to the overall population. On average, African American men die of suicide ten to twenty years earlier, between their late teens to early thirties, compared to White American men who typically die from suicide between the ages of 40 to 60 years.[49] African American men have a higher rate of suicide compared to African American women, but have a lower rate than White American men.[50] African American men who kill themselves are more likely to be single and less educated.[51] Also, those who experience homelessness are at

higher risk for suicide.[52] Past criminal conviction is a suicide risk factor for African American men, as well as the overall population, but African American men have higher rates of criminal conviction compared to the overall population.[53]

There are many environmental factors that increase the risk of suicide for African American men. Those men who have experienced violence, physical, sexual, or emotional traumas are at a higher risk of dying by suicide.[54] Individuals who have poor interpersonal family relationships are more likely to die from suicide.[55] The loss of a loved one can also increase the risk for suicide either in short-term or the long-term.[56] Contact with law enforcement is also an environmental risk factor for African Americans even though it may not lead to a criminal conviction. African American unmet mental health care needs are related to multiple environmental factors including socioeconomic status, insurance type, and geographic location.[57]

Some African American cultural beliefs prevent treatment of psychiatric or psychological conditions that are associated with suicide.[58, 59] Compared to White Americans, Black Americans report that antidepressant drug therapy is a less valid mental health treatment option.[60] African Americans also report psychotherapy to be a less acceptable treatment option compared to the White American population.[61] Among African Americans who perceived a need for mental health care, they were significantly less likely to receive care compared to White Americans.[62]

Historical Trauma & Protective Factors

Often touched upon within literature is the argument that the burdens of historical trauma experienced by the African American community have elevated the community's level of stress. While historical trauma is considered an environmental risk factor, the weight of the risk factor is deserving of a separate section. Systemic racism and discrimination, both of which are remnants of slavery and other African American abuses are related to depression in African Americans and contribute to the trauma African Americans still experience today.[63] Modern deindustrialization in urban areas has reduced economic and social opportunities for African Americans, which has increased feelings of hopelessness, depression, and suicide within the community.[64] Goldston et al. unearth historical abuses of Blacks by caregiving institutions that date back to the pre-Civil War era. The authors hypothesize that distrust of mental health facilities by the Black community is historically rooted in these abuses by caregiving institutions.[65]

Springing from these forms of historical trauma is the commonly held African American cultural belief that Blacks will endure and overcome suffering, often times referred to as "resiliency", as many generations have before them.[66] The literature demonstrates the stigma surrounding mental health and suicide within the Black community is perpetuated by a notion of abuses of African Americans within the health care setting. The resiliency and stigma act as both risk and protective factors. Since the Civil Rights movement, institutional racism and discrimination have exerted pressure on Blacks to adopt "White" behaviors, which causes internal stress and conflict about holding on to Black cultural identity and experiences, further contributing to the trauma.[67] Based on a history marred with oppression and suffering, the African American community has come to understand a life in which pain is innate and borne; perseverance offers the only escape from the trials of life. This trauma has created a culture of resiliency within the African American community that has enabled a stigma to form around mental health and suicide.[68, 69]

Additionally, mental health care needs may be undiagnosed for African Americans because they are significantly more likely to express anxiety and other underlying mental health needs as physical suffering. According to Snowden's study, African Americans seeking mental health care indicated somatic complaints such as "headaches, 'weaks and dizzies,' pounding heart, hot flashes, and chills" significantly more often than Whites using mental health services.[70]

The stigma associated with suicide and mental health within the Black community may result in misreporting of suicides as a homicide or accidental death.[71] In fact, Rockett, Samora, and Coben suggest that the African American suicide rate, which is nearly half that of Whites, is paradoxical. Based on the aforementioned socioeconomic risk factors, Blacks appear to be at a higher risk of suicide than Whites, yet the rate of suicide is much lower.[72]

Walker et al. found that African American stigmatization of suicide is inherently religious and attributable to the fact that Blacks are more likely than Whites to believe God is responsible for one's life rather than the individual or state. This finding aligns with other literature that identifies religion as one of the protective factors against suicide for African Americans.[73, 74, 75] The other identifiable protective factors noted throughout this literature include the family, Black social and fraternal organizations, and Black culture. The notion of Black culture as a protective

factor circles back to the historical trauma endured by African Americans that instilled a deep-seated value of perseverance through suffering.

African American Intervention Technique

To date, there is little published literature on suicide prevention or intervention strategies specific to African Americans. Available literature encourages the implementation of mental health programs and screenings in churches, schools, and community organizations, rather than through government agencies.[76, 77, 78, 79, 80] Joe and Kaplan suggest that instead of direct service provision, public funding should be used to raise awareness of programs and reduce the stigma associated with mental illness.

Goldston et al. suggest involving the church in prevention strategies and using a gatekeeper model that involves church members under the age of 35 years acting as a point of first contact for those struggling with unmet mental health needs. Under the gatekeeper methodology, non-professionals are trained to detect risk factors for mental health crises, connect individuals with the proper resources, and act as mentors to younger individuals within the community.[81] Gatekeeper programs have been instituted in churches and schools with high levels of success in the short-term, though long-term effectiveness has yet to be measured.

Lao Population Overview

Due to little understanding of the Lao population among the general public, it is necessary to explain the population prior to addressing literature findings. Minnesota has the third largest Lao population in the United States.[82] From 2000 to 2010, the population grew about 20% in Minnesota. The Center for American Progress reported that as of April 2015, there were slightly less than a quarter-million documented Lao individuals in the U.S. In 2015, there were approximately 12,100 Lao in Minnesota, comprising 0.2% of the total Minnesota population.[83] Of all Lao Minnesotans, approximately 60% are foreign-born.[84]

In 2006, the population of Laos was approximately 5.9 million.[85] Of the population only 52.5% identify as ethnic Lao while only nine percent of the population in Laos is Hmong.[86] It is likely the immigration of individuals from Southeast Asia to the U.S. results in ethnic identity confusion and concerns, especially in Minnesota where there are large Lao and Hmong

populations. In 2010, the Hmong population was the largest Asian population in Minnesota (27% of total Asian population) and the Lao population was just less than five percent of the total Asian population.[87] Many Hmong people are from Laos, but are quite different than the Lao people, who are the focus of this study.[88] The two groups have different cultures, languages, and beliefs.

Lao Suicide Risk Factors

Little current literature exists on mental health prevalence in the Lao community, though there are a number of studies from around 1990. A Minnesota study found Laotians have a higher incidence of PTSD, anxiety, somatoform disorders, and schizophrenia compared to Southeast Asian refugees of other cultural groups.[89] However, compared to the other groups, Laotian refugees had lower incidence of major depressive episodes. Multiple studies corroborate that Southeast Asians are greatly affected by PTSD and other affective disorders.[90, 91] Despite elevated rates of mental illness, research suggests current treatments are ineffective with Lao refugees.[92] Additionally, Lao individuals show high rates of problem gambling behaviors.[93]

Lao and AA/PI face a number of demographic risk factors, one of the greatest being many members of the community are immigrants compared to the overall U.S. population. A great deal of research has documented the negative effects of acculturation, assimilation, and other common stressors on immigrants. Specific immigrant stressors include: culture shock, gender role disparities, discrimination and racism, and trauma related to country of origin experiences.[94] For the Asian American population, and specifically Lao population, family connectedness and relations play a key role in one's sense of belonging; these connections can often be stressed during the assimilation process.[95, 96] Feeling a "loss of identity," and an inability to communicate in their native tongue, can also have negative effects on immigrants.[97]

Geographically, immigrants are more likely to live in inner city neighborhoods with higher crime.[98] These unsafe neighborhoods lead to less social cohesion among refugees, a large protective factor for immigrants.[99] Additionally refugees have lower levels of education and job skills leading to higher unemployment.[100]

Despite these many risk factors for immigrants, Beiser and Hou hypothesize that being a native-born Asian American may also be a risk factor.[101] Research suggests that all Asian American

individuals are viewed as foreign-born, despite the fact they may be native born.[102] As a result, race prevents Asian Americans from being able to fully assimilate. However, those who were born in America may be distressed by the fact that they will always be assumed to be foreigners, not native-born Americans.[103]

Socioeconomic status is a heightened risk factor and plays a significant role in the overall well-being of Asian Americans.[104] The Lao population is economically disadvantaged compared to other Asian populations in Minnesota and the overall Minnesota population.[105] The Lao poverty rate is nearly double that of Minnesota's overall population.[106] Unemployment is another risk factor for the Lao population. Laotians face much higher unemployment rates compared to other Minnesota Asians and U.S. citizens.[107] High Laotian unemployment levels could be connected to low levels of education compared to Minnesotan education averages.[108]

The Lao population faces heightened environmental risk factors, including language barriers, along with health access and outcomes disparities compared to the overall population. In 2014, it was reported that 41% of Laotian households in the U.S. had limited English proficiency.[109] The U.S. Lao population had a higher health insurance coverage rate than other foreign-born populations from 2008 to 2010.[110] However, there is a largely publicized concern that many immigrants are forgoing care due to the access barriers, such as lack of health insurance knowledge, lack of interpreters for limited English speakers, and costs.[111, 112] Asian Americans use a variety of mental health services, but less frequently than White Americans.[113]

There are a number of beliefs that act as risk factors for Asian populations. Since many Southeast Asian cultures do not believe in the separation of body and mind, individuals may first report mental health symptoms as physical distress.[114] This somatization of psychological symptoms may prevent individuals from receiving the mental health care necessary to treat psychological disorders.[115] Furthermore, many immigrants mistrust Western medicine and prefer to continue to use traditional medicine. One study found that it took about three generations before new Asian immigrants fully trusted the American health care system.[116] Some choose not to access the health and mental health care systems because they do not believe Western health care providers understand their culture.[117] Refugees report behaviors from health practitioners that unintentionally insulted or frightened them.[118] Finally, due to cultural beliefs about

respecting authority, these individuals may be hesitant to raise concerns about a diagnosis or treatment to a therapist out of respect and deference.[119]

Another cultural risk factor is the stigma that is often associated with mental illness in Asian cultures.[120] Due to this stigma, Asian Americans are half as likely to mention mental health problems to a relative or friend and six times less likely to talk to a psychiatrist or mental health professional than the population as a whole.[121]

Lao Suicide Interventions

This literature review found no mental health treatments specific to Lao or Asian American populations. There are, however, recommendations for methods that are more effective for providing services to Asian American clients. Sue et al. found that Asian American clients who received treatment from an ethnically matched therapist were in treatment for longer and were less likely to drop out.[122] This ethnic match was especially important for clients who were less acculturated to the U.S. society.

Unfortunately, there is a dearth of Asian American providers. The latest statistics show that there are approximately 70 Asian American mental health professionals for every 100,000 Asian Americans.[123] The ratio is about two times higher for Whites.[124] Translating advertisements into a variety of Asian and Pacific Island languages increases the likelihood of an Asian American seeking services.[125]

Findings

Suicide risk factor and awareness findings were constructed and synthesized below using four types of data including quantitative public data, quantitative Minnesota vital statistics records, qualitative interview theme analyses, and Community Readiness Assessment (CRA) scoring.

Quantitative – Public

Suicide rates for Black males and AA/PI populations were compared to the general population for Minnesota and the U.S. A difference-in-difference test was run to measure the disparity between the suicide rates for these specific communities in Minnesota compared to the same population in the U.S. as a whole.

To understand each group's suicide risk factors, publicly available federal survey data was utilized to understand whether the target populations have different levels of risk factors compared to the total population in Minnesota and the U.S. The suicide risk factors identified in the literature review were analyzed for the two populations. The quantitative findings were constructed from publicly available data from the Census Bureau, utilizing the Minnesota Population Center's Integrated Public User Microdata Series (IPUMS), and the State of Minnesota. For public data analysis, Black males in Minnesota were compared to all males in the state. Additionally, the disparities between the Minnesota populations were compared to the disparities in the national populations using a difference-in-difference test. In the Lao population, all Lao/Asian Americans were compared to the overall state population. Similarly, the state disparities were compared to the national disparities for the same populations. For analysis, data was aggregated from 2010 to 2014 because the populations were quite small, and doing so provided greater statistical power. For both groups, suicide statistics were assembled by geography, race, and gender and were tested at the 95% significance level.

Black Suicide Findings

Within Minnesota, Black males have a higher suicide rate of 11.8 per 100,000 individuals compared to the Black female suicide rate of 3.1 suicides per 100,000 individuals (Table 1).[126] Both Black Minnesota males and females have significantly lower rates of suicide than Minnesota's overall male (19.1 suicides per 100,000) and female suicide rates (5.2 suicides per 100,000).[127] Consistent with the Minnesota findings, U.S. Black males have a higher suicide rate compared to U.S. Black females (9.4 male suicides per 100,000 and 1.9 female suicides per 100,000).

There are stark disparities when comparing Black suicide rates by gender in Minnesota to the U.S. Minnesota Black male suicide rates are 26% higher than U.S. Black male suicide rates.[128] Minnesota Black female suicide rates are 63% higher than the U.S. Black female suicide rates.[129] Minnesota male and female Blacks have significantly higher suicide rate than U.S. male and female Blacks.

Table 1: Suicide Disparities by Geography, Race, and Gender, 2010 – 2014 Aggregated Estimates

	Minnesota				United States				Difference (MN & US)**	
	Black		Total		Black		Total		Black	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
Suicide Count	92	23	2,600	709	9,328	2,188	158,228	44,176	-	-
Age-Adjusted Rate* (per 100,000)**	11.8*	3.1*	19.1	5.2	9.4*	1.9*	20.24	5.36	2.4**	1.2**

Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC)[130]
Definitions:
* denotes a 95% or greater significant suicide rate difference between the Black population by gender to the total population by gender within a geography (MN or US).
** Measures the percentage point difference between the Black age-adjusted suicide rate in Minnesota compared to the U.S. age-adjusted suicide rate within gender. The difference is statistically significant at the 95% level.
*** Age-adjusted rate means that the population age distribution is set at the 2000 U.S. Standard population to allow for a more accurate comparison of rates across populations (Blacks and Asians in this instance) with different age structures.

Asian Suicide Findings

Minnesota Asian males have a higher rate of suicide, 12.5 per 100,000 compared to Minnesota Asian females suicide rate of 5.0 per 100,000 (Table 2). Minnesota Asian males have a significantly lower rate of suicide than Minnesota's overall male suicide rate whereas female Asians have similar suicide rates to the to the overall Minnesota female population.[131] Both U.S. Asian males and females have a significantly lower suicide rate compared to the total U.S. male and female suicide rates.

Stark differences exist when comparing the Asian suicide rates by gender in Minnesota to the U.S. rates. Minnesota Asian male suicide rates are 268% higher than U.S. Asian male suicide rates.[132] Minnesota Asian female suicide rates are 45% lower than the U.S. Asian female suicide rates.[133]

Table 2: Suicide Disparity Statistics by Geography, Race, and Gender, 2010 – 2014 Aggregated Estimates

	Minnesota				United States				Difference (MN & US)**	
	Asian		Total		Asian		Total		Asian	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*

Suicide Count	72	27	2,600	709	1,631	3,934	158,228	44,176	-	-
Age-Adjusted Rate (per 100,000) ***	12.5*	5.0	19.1	5.2	3.4*	9.1*	20.2	5.4	9.1**	-4.1**

Source: CDC[134]
Definitions:
* denotes a 95% or greater significant suicide rate difference between the Asian population within gender to the total population by gender within a geography (MN or US).
** Measures the percentage point difference between the Asian age-adjusted suicide rate in Minnesota compared to the U.S. Asian age –adjusted rate within gender. The difference is statistically significant at the 95% level.
*** Age-adjusted rate means that the population age distribution is set at the 2000 U.S. Standard population to allow for a more accurate comparison of rates across populations (Blacks and Asians in this instance) with different age structures.

Risk Factor Findings

The goal of this quantitative research is to understand if Minnesota Black males and Minnesota Asians have different levels of known suicide risk factors than their total comparison population. The quantitative variables in Tables 3 and 4 compare selected suicide risk factors including psychiatric/psychological factors, demographic characteristics, and environmental characteristics, by race and geography.[135, 136]

From a psychiatric/psychological risk perspective, Minnesota Black males had few differences in mental health indicators compared to Minnesota's total population (Table 3). The only significant difference is Minnesota Black males have a higher rate of bipolar disorder compared to the total U.S. Black male population. Within the U.S., Black males are significantly less likely to report being a current heavy drinker than the U.S. total male population. Overall, there are minimal differences in Black psychiatric/psychological suicide risk factors across race and geography.

Both Minnesota and U.S. Black males have many more demographic suicide risk factors than the total male population; however, Minnesota Black males face heightened risks compared to U.S. Black males. Black Minnesota males are significantly economically disadvantaged as a higher proportion fall below the Federal Poverty Level and are more likely to be unemployed compared to the overall U.S. male and U.S. Black male population. Minnesota and U.S. Black males are significantly more likely to have lower educational attainment than the total population;

however, Minnesota Black males face a significant education disparity compared to U.S. Black males. Although both Minnesota and U.S. Black men are more likely to be single, Minnesota Black males are significantly more likely to be single than U.S. Black males. Both Minnesota and U.S. black males have higher demographic suicide risk factors compared to U.S. total males, but Minnesota Black men have greater suicide risk disparities compared to U.S. Black men.

Based on the limited publicly available data on environmental suicide risk factors, there does not appear to be heightened suicide risk factors for either Minnesota Black males or Black males in the U.S. People living in rural areas face a higher risk of suicide than people living in urban areas.[137] Both Black males in Minnesota and the U.S. are significantly more likely to live in metro areas than the total population suggesting a lower suicide risk.

Minnesota and U.S. Black males face disparities in access to health care compared to the overall population. Minnesota Black males are significantly more likely to be insured by Medicaid compared to Minnesota males, total U.S. males, and Black U.S. males. Minnesota and U.S. Black males have a higher proportion of uninsured compared to U.S. males. However, Minnesota Black males are have a lower proportion of uninsured than U.S. Black males. Black males in both Minnesota and the U.S. are significantly more likely not to be able to afford medical care compared to the total male populations. Minnesota Black males report a significantly higher rate of poor mental health status compared to U.S. Black males; however, overall proportions of poor mental health status are low. Health care access is greater for Minnesota Black males compared to U.S. Black males.

Table 3: Selected Suicide Risk Factors by Geography, Black Males to the Total Male Population, 2010-2014 Aggregated Estimates (See Appendix 1 for all variables)

CATEGORIZED SUICIDE RISK FACTORS	**MINNESOTA**		**UNITED STATES**		**Difference (MN & US)[**]**
	Black Males	Total Male Population	Black Males	Total Male Population	Black Males
PSYCHIATRIC/PSYCHOLOGICAL					
% Ever told had bipolar[1]	2%*	1%	1%*	2%	1.0**
% Ever told had schizophrenia[1]	1.5%	0.7%	1.4%	0.8%	0.1
% Current heavy drinker[1]	6.6%	8.1%	7.3%*	8.6%	-0.7
DEMOGRAPHIC					
Income					
Median Per Capita Income[2]	$ 36,612	$ 51,625	$ 37,570	$ 48,745	$ (958)
% Below poverty level[1]	31.8%*	13.7%	26.7%*	14.8%	8.4**

% Unemployment[2]	12.5%*	5.2%	10.8%*	6.5%	1.7**
Education[3]					
% < High School	43.7%*	30.0%	39.9%*	33.9%	3.8**
% High school/GED completed	26.3%	27.6%	31.8%*	28.6%	-5.5**
Marital Status[3]					
% Married, spouse present	19.8%*	41.0%	22.5%*	37.8%	-2.7**
% Never married	66.7%*	47.8%	62.1%*	48.8%	4.6**
Geography[3]					
% Not in Metro Area	7.6%*	30.4%	17.4%*	25.5%	-9.8**
% In Metro Area – Central	40.3%*	14.6%	43.4%*	24.0%	-3.1**
% In Metro Area – Outside Central	52.1%*	54.9%	39.2%*	50.4%	12.9**
Health Insurance[4]					
% Medicaid/CHIP	41.0%*	12.3%	25.6%*	14.6%	15.4**
% Uninsured	10.7%*	5.9%	13.5%*	11.6%	-2.7**
Health[1]					
% Reported poor mental health status	2.2%	1.5%	1.5%	1.7%	0.7**

Definitions: * denotes a 95% or greater significant suicide rate difference between the Black population within gender to the total population by gender within a geography (MN or US).
** Measures the percentage point difference between the Black age-adjusted suicide rate in Minnesota compared to the U.S Black age-adjusted rate within gender. The difference is statistically significant at the 95% level.
Sources:
[1] Minnesota Population Center and State Health Access Data Assistance Center, Integrated Health Interview Series: Version 6.12. Minneapolis: University of Minnesota, 2015. Estimates aggregated between 2010 – 2014. Minnesota estimates are based on the North Central/Midwest region. Retrieved from http://www.ihis.us.
[2] U.S. Census Bureau. American Fact Finder. American Community Survey 2014 1 year estimates of full time workers. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.
[3] Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek. Integrated Public Use Microdata Series: Version 6.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2015. Data from American Community Survey, 5 year estimates 2010 – 2014.
[4] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

Lao Suicide Risk Factor Findings

Significant differences were found between the psychiatric/psychological risk factors within Minnesota and U.S. Asians (Table 4). Asians residing in Minnesota had significantly lower reports of depression and heavy drinking compared to the Minnesota total population. Within the U.S., Asians have significantly lower psychiatric risk factors than the total U.S. population. Overall, there were few disparities between Minnesota Asian's psychiatric risk factors compared to Asians in the U.S.

Based on the findings in the literature review, many demographic variables play a role in the risk factors associated with suicide for the Asian populations. Economically, Minnesota Asians are significantly more likely to have lower median incomes, fall under the Federal Poverty Line, and be unemployed compared to both Minnesota overall population and total U.S. Asian populations.

Minnesota Asians have significantly higher proportions of individuals with less than a high school degree compared to the state average. At the national level, the estimated difference between educational attainment among Asians and the total population is much smaller than at the state-level, but there is still a significant difference between the two. Additionally, more Asians within Minnesota have resided in the U.S. for less than five years than the Minnesota total population, which likely contributes to the difference in educational attainment.

From an environmental risk factor standpoint, levels of access to medical care of Minnesota Asians and the total population are very different. Though the Asian population in Minnesota has a significantly a lower proportion of uninsured individuals, the number of Minnesota Asians with no standard source of primary care is significantly higher than that of the total Minnesota population -- 18.7% compared to 10.6%. Similarly, U.S. Asians are significantly less likely to have a primary source of care than the total U.S. population.

Table 4: Selected Suicide Risk Factors by Geography, Asians to the Total Population, 2010-2014 Aggregated Estimates (See appendix 2 for all variables)

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
	Asian	Total Population	Asian	Total Population	Asian
PSYCHIATRIC/PSYCHOLOGICAL[6]					
% Ever told had bipolar disorder[2]	-	0.7 %	0.3%*	0.6%	-0.3**
% Ever told had schizophrenia[2]	-	0.2 %	0.0%*	0.2%	0.0
% Current heavy drinker[2]	0.4 %*	1.8 %	0.7%*	1.8%	-0.3

(Table 4 Continued)

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
	Asian	Total Population	Asian	Total Population	Asian
DEMOGRAPHIC					
Income					
Median Per Capita Income[2]	$25,425	$33,277	$32,404	$30,815	$ -6,979
% Below poverty level[1]	20.2 %*	14.8 %	16.9%	15.8%	3.3**
% Unemployment[3]	5.5 %*	4.5 %	5.2%*	5.8%	0.3**
Education[3]					
% < High School	44.1 %*	30.1%	32.7%*	34%	11.4**
% High school/GED completed	12.9 %*	20.2%	13.2%	21.7%	-0.3
Marital Status[3]					
% Never married	54.4 %*	44.9%	44.4%*	45.7%	10.0**
Immigration					
0 to 5 Years	21.5 %*	19.6%	19.8%*	15.2%	1.7**
ENVIRONMENTAL					
Health Insurance[4]					
% Uninsured	6.0 %*	15.4%	10.3%*	11.6%	-4.3**

Access to Care[1]					
% No Usual Source of Primary Care	18.7 %*	10.6%	16.7%*	11.8%	2.0
% Couldn't afford medical care needs	3.5 %*	5.7%	4.5%*	6.2%	-1.0
% Couldn't afford mental health care needs	3.5 %*	5.7%	1.3%*	2.2%	2.2**

Notes: * represents Asians are significantly different compared to the total population within the geography at the 95% confidence interval or greater.
**Measures the percentage point difference between the Asian age-adjusted suicide rate in Minnesota compared to the U.S within gender. The difference is statistically significant at the 95% level.
Sources
[1] Minnesota Population Center and State Health Access Data Assistance Center, Integrated Health Interview Series: Version 6.12. Minneapolis: University of Minnesota, 2015. Estimates aggregated between 2010 - 2014. Minnesota estimates are based on the North Central/Midwest region. Retrieved from http://www.ihis.us.
[2] U.S. Census Bureau. American Fact Finder. American Community Survey 2014 1-year estimates of full time workers. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.
[3] Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek. Integrated Public Use Microdata Series: Version 6.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2015. Data from American Community Survey, 5 year estimates 2010 - 2014.
[4] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

Quantitative – Office of Vital Records

To gain a greater understanding of the suicide trends in recent years, the numbers of suicides for Black males within Minnesota were analyzed using Minnesota Office of Vital Records data for 2013 to 2015. The 2015 data is only preliminary data due to privacy restrictions so exact numbers and percentages are not available. For the Black population, the Office of Vital Records specifically pulled data on native-born males which was not possible using CDC Wonder. As the Office of Vital Records provides information to CDC Wonder, it was not necessary to also look at Asian data, as it is the same data from our public quantitative research.

From 2013 to 2015, there were a total of 40 reported suicides by Minnesota Black males with 40% of the victims in the 25 to 34 year age group. In 2013, there were 12 suicides by Black males, 25% were in the 25 to 34 year age group. In 2014, there were 16 suicides by Black males, half were in 25 to 34 year age group. In 2015, preliminary data shows that the number of suicides among Minnesota Black males decreased but the 25 - 34 age group still had the highest reported number of suicides. Though the numbers of suicides have fluctuated, each year the 25 - 34 age group has had the greatest proportion of suicides among the Minnesota Black male population.

Qualitative – Theme Analysis & CRA

The Community Readiness Assessment (CRA) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) was adapted to meet the needs of each community

for interviewing community leaders. The tool was edited to fit each community based upon literature review findings and the recommendations of community liaisons (See Appendix 3 for the Black community instrument). For the Lao population, wording in the CRA was used to measure “overwhelming stress” in the community, instead of suicide (See Appendix 4 for the Lao instrument, including the definition of overwhelming stress). The community leader felt the stigma around suicide within the Lao community would render interviewees unresponsive to the researchers.

The tools were then used to conduct interviews with community members and leaders in each of the communities. Eight interviews were conducted with Black community leaders and six interviews were completed in the Lao community. In the Lao community, three were group interviews, each with three individuals, and three were individual interviews. The Lao community liaison recommended group interviews to create a more comfortable, less intimidating atmosphere for participants. Respondent answers were not associated with names or individual identities, but rather with a number to preserve respondent anonymity.

A snowball sampling method was used for each of the communities; MDH identified community liaisons that in turn gave the team names of appropriate interviewees. The Black community interviews followed the purposeful sampling model laid out in the CRA. Interviews were conducted with African American community leaders from the following sectors: health, social services, mental health and treatment services, schools, city government, law enforcement, clergy, and the community at large. The Lao community did not follow the same purposeful sample laid out in the CRA due to a lack of active community members in many of the sectors. The Lao interviewees were identified by the snowball method based on recommendations from the Lao community liaison and other interviewees. There were several individuals from the health and social services sectors, one from city government, and a number from the community at large.

These interviews were analyzed according to the six dimensions of the CRA tool: existing community efforts, community knowledge about prevention, leadership, community climate, knowledge about the problem, and resources for prevention. The community received one score for each of the six dimensions that was calculated by averaging the individual interviewee scores

for the given dimension. The six community dimension scores were averaged to create the final CRA score for the community (See Table 5). The scoring was based on a scale of one to nine, with each number representing a unique stage of awareness (See Appendix 5 for the full scoring details). Additionally, a theme analysis was completed for the interviews to identify the frequency and intensity at which themes came up throughout the interviews.

African American Interview Analysis

In the interviews with Black community leaders, several common themes and subthemes arose from the conversations (See Appendix 6 for code book). The five major themes were a lack of community awareness of suicide and suicide prevention resources, African American culture, suicide risk factors, access barriers for mental health and suicide prevention services, and assets for suicide prevention programs. Within each of these broader themes were subthemes that provided additional content and context for suicide awareness and prevention within the community.

Within the community awareness and suicide prevention theme, a majority of interviewees indicated the community was either unaware or did not consider suicide an issue within the community. However, several community leaders articulated that the community would support suicide prevention if the community was aware of the problem. Largely, the lack of awareness stemmed from the fact that the community was more concerned with meeting basic needs such as providing food, finding affordable housing, getting an education, and reducing crime. More than half of community leaders noted that members of the community are more aware of the issue of suicide when someone they personally know is lost to suicide. Nevertheless, most community leaders agreed that though the community had some information on suicide and suicide prevention services, community members neglect to connect this information to themselves or those around them.

Overwhelmingly, the most common subtheme within the African American culture theme was the stigmatization of mental health by the community. Most community leaders mentioned a large portion of the stigma is generated by a history of trauma within the community, including intergenerational, systemic, and historical trauma. The trauma endured by the community has perpetuated a sense of African American resiliency. As several community members mentioned

mental health and suicide are considered “White people problems” – it is believed the Black community should be resilient to them. More than half of the community leaders stated that as a result of this belief, Black males internalize problems rather than seeking help. If individuals do turn to someone for help, the church is likely a first point of contact. It is noteworthy that a few community leaders stated mental health and suicide are becoming less stigmatized among younger community members because it is talked about increasingly.

More than half of community leaders suggested that contact with the legal system, such as a criminal history, confrontations with law enforcement, or even a contentious custody battle, may increase a person’s risk of suicide. Several community leaders noted that substance abuse, homelessness, poverty, and interpersonal or gang violence tended to be predictors of suicide within the community.

Within the barriers to resources theme, nearly all community leaders stated that there was a lack of suicide specific services, and those providers offering resources failed to advertise the suicide specific services within the community. Most community leaders believed that community members lacked trust in the mental health and healthcare system. More than half of community leaders noted mental health and suicide prevention services are not culturally competent or reflective of the community, which is necessary to build trust.

When discussing the essential attributes for suicide prevention efforts, more than half of community leaders believed that before a suicide prevention program began, trust would need to be built between the community and the organization providing resources. Almost all of the community leaders believed this would require spreading the message through a key group of leaders who were already involved within the community. Additionally, the prevention programs would need to be culturally competent and staffed with providers who were community members. Several community leaders suggested a campaign that involved the media or social media to create suicide awareness. Community leaders emphasized the need for community involvement in the planning stages, which includes power to shape how funding is allocated. Finally, community leaders believed community members would be most receptive to messages about suicide and suicide prevention if community-specific education was provided, which should include facts, data, stories, and culturally specific information.

The interviews for the African American population were also assessed using SAMHSA's Community Readiness Assessment scoring guidelines for suicide prevention (See Appendix 7). The community scored 1.55 overall out of nine, indicating the community is at the first stage, No Awareness. All six dimensions for the community scored in the first stage of No Awareness, suggesting "suicide prevention is not generally recognized by the community or leaders as a problem."[138] Given a majority of community leaders stated the community has more pressing concerns than suicide, the No Awareness stage seems appropriate.

Lao Interview Analysis

Within the Lao interviews there were five main themes that were present: stigma, stressors, systemic barriers, symptoms and strengths (referred to as the 5 S's) (See Appendix 8). These themes represent the various cultural, environmental, and behavioral factors that impact the Lao community and individual levels of stress. The 5 S's are all interrelated and each may impact the others depending on the scenario and individual.

Stigma was the most common theme. In the Lao culture, seeking help for a problem is stigmatized. There is a belief that Lao people should not talk about their problems with those outside their immediate family and friends - in some cases individuals will not even discuss problems with those closest to them. It is expected that issues remain private and one cannot disclose troubles they are facing without a sense of judgment by others in the community. Additionally, there is a stigma associated with mental health; there is actually no proper translation of these terms from Lao to English. The closest translation has a connotation of possession by demonic forces. Therefore, asking for help or assistance shows a sign of weakness or "possession". One interviewee described overwhelming stress as a "way of life", it was expected that everyone would face major difficulties in life.

The second major theme was stressors. The events that largely cause financial stress begin with low educational attainment and a lack of English proficiency among Lao individuals. Since many jobs require English proficiency and a high school diploma, many Laotians are unable to attain adequate employment. This leads to financial problems that cause great stress. One result of financial stress that was discussed frequently is an inability to maintain stable housing. An additional, non-financial stressor that was frequently discussed was a generation gap that exists

between younger and older members of the Lao community. As younger individuals become more acculturated they eschew traditions of their elders causing a rift. Additionally, the younger Laotians are pressured by their parents and elders to succeed, but many find they do not have role models and supports to know how to attain success.

The third theme was the systemic barriers associated with learning about, accessing, and receiving help. Given the societal stigma of asking for help, many community members do not feel safe when approaching doctors, especially those of different cultural backgrounds and understandings. Since there are no local Lao providers for mental or physical health needs, many people forego care. Another key systemic barrier is language. In many interviews, a frequent anecdote was individuals were given a Hmong translator rather than Lao at a local doctor's office. As a result, individuals felt their cultural identity was threatened and they lost hope in receiving the necessary help they needed. These language barriers also include a lack of printed material in Lao.

Additionally, several interviewees said that the larger community does not know or understand the Lao people are distinct from Hmong people. Another aspect to the systemic barriers is the generational gap related to assimilation. Many interviewees discussed the stressors between the younger populations and the older populations. The younger, native-born individuals are assimilating to the Western culture at a faster rate than the seniors. Thus, the cultural beliefs of the younger populations are not as strong as among the seniors and due to this, the stigmatized nature of seeking help is not as heavily valued in comparison to their senior counterparts. In the Lao culture, family influences the actions of the younger populations creating additional stressors for the younger populations when wanting to seek help, but facing discouragement to do so by family.

The fourth theme was symptoms of overwhelming stress. Since so many individuals face large stressors, and often do not receive the help they need, they resort to coping strategies, often in the form of destructive behaviors. The behaviors that were most frequently discussed were problem gambling, alcohol abuse, and substance abuse. Interviewees also noted financial stresses often lead to marital problems and divorce. According to interviewees, any help that does exist in the communities focuses on these symptoms, but never gets to the deeper causes of stress.

The final theme was the strengths, or protective factors, of the Lao community. The role of religious communities was mentioned in every interview. Temples and churches were mentioned as one place that individuals would go to seek help for problems. It was noted that older community members were more likely to be connected to a place of worship than younger individuals. Other strengths of the Lao community include a belief that there is a strong reliance upon family in the Lao community. There is also strong core of leaders within the Lao community that is seeking to address the issues the community faces.

The interviews in the Lao community were also assessed using the CRA scoring guide, as used for the Black community (Appendix 9). Due to the changes made to the tool, the scores are not a suicide prevention readiness score, they measure the community's ability to prevent and respond to "overwhelming stress". Overall, the Lao interviews scored a 2.95, putting the community in the second state, Denial/Resistance, but on the cusp of stage three, Vague Awareness.

Qualitative – NVDRS

To understand the suicide risk factors for the target populations, information on individuals who were victims of suicide was extracted from the National Violent Death Reporting System (NVDRS).[139] This data source provided narratives describing the details of an individual's suicide, including location, life stressors, known diagnoses, and a toxicology report. The information in these narratives came from Medical Examiner and/or Law Enforcement reports. Due to the limited number of up-to-date abstractions, this source gave a supplemental qualitative insight into the already abstracted suicides of 2015. These data were used to analyze the conditions under which the suicides occurred and link them back to recurring themes and risk factors.

Black

There were a total of nine suicides by Black, native-born, adult males in Minnesota in 2015 with abstracted narratives available in NVDRS. Ages of the decedents ranged from 22 to 59 years with the average age being 35.1 years. The two most common causes of death were gunshot wounds to the head and intentional hanging. Four of the victims had previous diagnoses of depression and four had a reported history of suicidal thoughts or attempts. Five victims had some substance in their toxicology report including alcohol, opiates, stimulants and/or other

drugs. Substance use was the most common risk factor. In four of the cases, the victims had some involvement in criminal activity and/or had been recently in custody.

Each individual experienced one or more major life stressors within two weeks prior to death, although most of the incidents took place within a few days of the suicide. Reported stressors include family or partner disputes, substance abuse, and financial problems. All victims had a high school degree or a GED equivalent, some had a Bachelor's degree.

Lao

In 2015, there were two cases of suicide by individuals born in Laos, but living in Minnesota with abstracted narratives available in NVDRS. The average age was 65.5 years. Both individuals had an education level less than or equal to eighth grade and neither spoke English. Only one had a history of suicidal thoughts or attempts and diagnoses. Both had major life stressors that contributed to the suicide—one suffered from chronic pain, the other faced a current family dispute. Both suicides were by hanging; however, one of the victims had high quantities of painkillers in his system. Both deaths occurred in the current place of residence.

Asian

Not including the Lao suicides mentioned above, there were six suicides by individuals identified as Asian. Due to data limitations it is not known if these individuals were of Lao descent. The average age of the six individuals was 27.5 years, with a range from 20 to 51 years. Of the six cases, one is not formally categorized as a suicide, but it is thought to be a suicide as the individual had repeated attempts in the past. Four of the individuals had a history of suicidal attempts, thoughts, or plans. Many of the major stressors were related to mental health conditions. None of the cases mentioned financial concerns. Three of the individuals were at some point admitted to a psychiatric ward within the past year of their lives.

Discussion

The discussion centers around assessing suicide risk factors across both the literature review, quantitative (public), and qualitative methods (interviews and NVDRS) in order to understand the strength of risk factors (Appendices 10 and 11). The corroboration of suicide risk factors across all four data sources suggests strong validity of risk factor within the population. Many

risk factors could not be identified quantitatively due to the inherent limitations of measuring psychological symptoms and beliefs. Risk factors that cannot be measured quantitatively were considered strong suicide risk factors if corroborated across the literature and qualitative methods. There were few risk factors found in the literature that could not be corroborated either by quantitative or quantitative methods. The discussion also draws out suicide risk factor similarities and differences between the Black and Lao communities.

Several suicide risk factors were identified across multiple data methods for the Black community. The only suicide risk factor found in all four methods was low socioeconomic status suggesting this demographic characteristic is a strong risk factor for suicide within the Black community. Substance abuse and mental health disorders were found across three methods. Mental health disorders as risk factors were described differently across methods. The literature review and NVDRS data both found a psychiatric diagnosis to be less prevalent among Black male victims of suicide compared to population at large. The quantitative data, however, unearthed a heightened risk factor for bipolar within Minnesota Black males. Demographic factors including low education and high unemployment risk factors were identified across three data sources. Almost all environmental risk factors were corroborated across three data methods including dysfunctional families, criminal records, trauma, and limited access to mental health services and insurance. Similar suicide risk factor findings across the literature, quantitative, and qualitative data sources suggest strong evidence of these heightened risk factors within the Black community compared to the total population.

Many psychological risk factors, such as previous suicide attempts, and feelings of hopelessness, were only identified through the literature review and qualitative methods. Similarly, the belief risk factors of stigma of mental illness, distrust in mental and health care treatment, and historical trauma were only found within the literature review and qualitative methods. Only two risk factors, homelessness and somatization of symptoms were identified in the literature review, but were not corroborated by either the quantitative or qualitative methods. Many suicide risk factors can only be measured qualitatively and thus could still be identified as strong suicide risk factors despite lack of quantitative evidence.

Few risk factors exist that were corroborated among all four data collection points in the Lao community. This is partly due to limits in the available quantitative data. There were only two factors that were found in all data sources. One was a lack of education among the Lao community and the second was being a first generation immigrant. Low socioeconomic status was found in three of the four data sources along with mental health disorders and family problems.

There were several concepts that were not corroborated across data sources. One concept that was not reinforced across methods was trauma. Trauma was found in previous literature as a risk factor in the Lao community, but this was not corroborated within quantitative or qualitative methods. Somatization, having mental distress manifest as physical symptoms, was also only found in the literature review. One place there appears to be contradiction between sources is access to care. Quantitative data found a lower rate of uninsurance among Lao people than the general population, but lack of access was brought up in interviews and the literature review. One possible explanation is that these sources of data were reporting on a lack of access to appropriate services.

Both the Black and Lao communities face some similar suicide risk factors. The main risk factor shared by both populations is a major life stressor happening two weeks prior to the suicide. Both communities are plagued with low socioeconomic status, high unemployment, and low educational attainment. Additionally, a lack of health care access, particularly mental health, is a common risk factor. Family strife is also an extremely significant variable within both communities. Finally, both groups have a stigma against seeking and receiving mental health care and tend to distrust health and mental health care systems. These similar suicide risk factors illustrate that Black and Lao populations have heightened risk factors compared to the total population.

Both communities have a historical risk factor, though they are quite different from each other. For the Black population the historical trauma the community has suffered leads to an increase in suicide risk currently. Similarly, the immigrant status of many in the Lao community puts those individuals at higher suicide risk. These concepts both represent historical difficulties that have current suicide risk factor implications.

There are several suicide risk factors that differ across the Black and Lao populations. The Black population is at higher risk of substance abuse, mental health disorders, and suicidal ideation or attempt than the Lao population. The differences between demographics of these two populations means that Blacks are more likely to be male, young, and single. These demographic characteristics are heightened risk factors for suicide compared to the Lao and overall populations. Finally, criminal activity and involvement with the legal system appear to be a greater risk factor for the Black population than the Lao and overall populations.

Limitations

There are several quantitative and qualitative limitations in this paper. The publicly available federal survey data used to determine suicide risk factors for the Black and Lao community are not truly representative of these two communities. The federal survey data does not distinguish between U.S.-born Blacks and non-U.S.-born Blacks; therefore, we were unable to isolate risk factors for the target population of U.S.-born Blacks. Federal survey data does not define Lao as a population and thus "other Asian" race was used as the most representative category, despite encompassing other races beyond Lao. "Other Asian" is used differently across surveys, but most often it is defined as not including the following ethnicities: Chinese, Filipino, and Asian Indian.[140] Suicide statistics reported from the Centers of Disease Control and Prevention only categorize "Asians" as a race and do not delineate further. Thus, the Asian suicide statistics in this report encompass all individuals defined as Asians instead of the Lao target population.

Several qualitative methods used have notable limitations. Although the snowball sampling method was most suitable for identifying community leaders, there is some concern about selection and information bias based on using this approach. The CRA interview protocol used to analyze the Black community often asked interviewees about topics they could not address based on their position. For example, many interviewees had difficulty speaking about the viewpoints of their political leaders and funding for suicide prevention resources within their community. Within the Lao community, the CRA is representative of "overwhelming stress" which could be tied to mental health, but is difficult to generalize specifically to suicide. The scoring of the CRA was problematic as many of the scoring criteria were not directly related to the interview section or defined scores were not representative of the interviews responses. This limitation was offset

by the qualitative theme analysis that provides a more accurate representation of the community's beliefs of suicide.

Data limitations also exist in NVDRS, as there are issues with reporting of ethnicity. In NVDRS it is possible to see birth location, but ethnicity is not given. Given that many of the Minnesota Lao were born in the U.S., it is not possible to distinguish ethnicities of U.S.-born Lao in the NVDRS reports. As a result, a cross-comparison of data from the two sources was not beneficial to the project. The data reviewed in NVDRS was not complete with all suicide cases in 2015, therefore, the information from this source should be further analyzed once fully abstracted. Another limitation associated with NVDRS was the source of information for the narratives. In many cases, both the Medical Examiner (ME) and Law Enforcement (LE) provided reports on an individual, but some cases only had a report from one of these sources. This limits the amount of information available for compiling a narrative for each case.

Recommendations

Suicide prevention recommendations for both the Black and Lao populations are provided below based on the synthesis and analysis of the quantitative and qualitative findings. These recommendations are mostly influenced by the community leader interviewees' perspectives and adapted to fit within Minnesota's State Suicide Prevention Plan. The authors highly recommend MDH use these suggested recommendations to engage with each community further.

Black Recommendations

First, the issue of suicide must be contextualized within the broader array of problems facing the community. While some community leaders interviewed recognized that suicide was a problem for the community, a majority of interviewees stated the community is operating based on Maslow's hierarchy of needs – basic needs such as personal safety from violence, high crime rates, institutional and systemic racism, economic stability, trauma, and education must be addressed before issues deemed less pressing by the community can be considered.

Through our research, it is evident that several of these concerns are risk factors for both suicide and violent criminal activity, suggesting what some community leaders described as one "toxic path" with two possible outcomes. MDH should address the role of mental health in violent

criminal activity and suicide within the awareness campaign. Additionally, MDH could contextualize suicide by framing it within a more familiar realm, such as deaths by homicide, for the same population. For example, the gap between the number of homicides and suicides continues to narrow – in 2014, there were 32 Black male homicides and 22 Black male suicides in Minnesota.[141] By contextualizing suicide for the community, MDH is more likely to establish suicide as a problem, build trust, generate awareness, and establish an effective suicide prevention program, which would coincide with State Suicide Plan Objective 2.6.

Second, we recommend MDH develop relationships that build community trust in order to secure buy-in for suicide prevention interventions. One way to build community trust is to train existing community leaders and organizations to discuss suicide and prevention efforts with community members. Trusted community partners suggested by the interviewees include Turning Point, Northpoint, Kente Circle, Empower, Kofi Services at Wilder, Cultural Wellness Center, Tubman Center, Stairstep Foundation (Alfred Babington-Johnson), 180 degrees, Washburn Center for Children, HCMC, and African American psychologists and psychiatrists such as Thad Wilderson and Dr. BraVada Garrett-Akinsanya. Other stakeholders MDH should consider engaging with include the NAACP, Black Lives Matter, Urban League, and the African American Leadership Council (Appendix 12).

Community leaders stressed that the high frequency of one-time events or funding for issues deemed important by community outsiders created distrust within the community that will need to be overcome for effective suicide prevention. By training community leaders, MDH is generating deeper awareness of the issue, reducing the stigma associated with mental health and suicide, and fostering trust in suicide prevention services. Building working relationships with the community leaders and organizations will ensure a long-term approach to suicide prevention, which coincides with State Suicide Plan Objective 1.1 Task 4.

Third, we recommend MDH use culturally competent and reflective suicide awareness, prevention and treatment services. The community articulated mixed opinions on what determines culturally reflective and competent care. Some recommended a greater need for male practitioners and people of color to make the providers more reflective of the individuals seeking services and more culturally knowledgeable of the individual’s background. Still, other

interviewees focused on providers engaging clients on their cultural wants and needs, without making assumptions based on race. Based on the mixed opinions of culturally competent care, we recommend MDH engage a community partner in providing instruction on culturally competent care. Two specific culturally competent issues the community recommends providers acknowledge are historical trauma that stems from slavery, intergenerational poverty, abuse, and recognizing the community's feeling that mental and medical health providers have been punitive or are untrustworthy. Culturally competent care coincides with State Suicide Plan Objective 1.1.

Finally, based on the statistical and qualitative analysis, we recommend MDH create a suicide prevention awareness campaign within the Black Twin Cities Metro community. The community recommended increasing awareness of suicide prevention resources by: creating public service announcements and commercials for advertising on KMOJ radio station, billboards, and buses; increasing communication from National Alliance for Mental Illness; discussing emotional health and historical trauma in Black newspapers (Spokesman-Recorder, Insight Newspaper, etc.) and mainstream news; using social media to spread the message to young Black men; and providing suicide prevention resources to health care providers within existing social service organizations that serve the Black community. Suicide awareness within the Black community is low partly due to the fact that individuals and agencies do not know how to access suicide services. The community recommends increasing access to services by making clear which community providers can assist with mental health and specifically suicide prevention. Increased advertising of how to access the suicide hotline, including the hours of operation and the privacy rules, will also help build awareness. Increasing awareness and access coincides with the State Suicide Plan Objective 1.2.

Lao Recommendations

Recommendations for the Lao community are not specifically related to suicide, as interviews were not focused on suicide, but rather on "overwhelming stress". For this reason the recommendations are broader. It is believed, however, that improving these related areas will reduce the number of suicides in the Lao community.

Before the problems associated with overwhelming stress and suicide are addressed in the Lao community, members will need to be willing to come forward and admit they are in need of help. Therefore, a culturally appropriate awareness campaign is necessary to help reduce this stigma and resistance to receiving help. The exact language and means of messaging would be decided through community input, but there are several things that are clear from interviews. First, materials would need to be in English and Lao. Many people talked about how most information is not available in Lao, which limits how many people in the community have access to information. Second, materials would need to be available in several places like the LAC, temples, and neighborhoods predominantly comprised of Lao individuals. Interviewees frequently explained that the Lao people were private and did not share their problems with others. Since privacy is so culturally ingrained, this campaign will have to be very tactful and sensitive to the community and culture. This campaign would meet Objective 1.4 in the State Suicide Prevention Plan.

Another frequent theme from the interviews and the literature review is many community members would be more comfortable seeking help from a mental health provider who is Lao and speaks Lao. Interviewees were unaware of any Lao mental health provider in the area. Additionally, interviewees explained that community members do not know where to go for help, and there are no Lao-specific services available.

It is recommended that funding and support be established to assist a Lao community member to become a mental health professional. Ideally, this community member would receive a Master's of Social Work (MSW) and become a Licensed Independent Clinical Social Worker so they would also have an understanding of other services available. Training a Lao community member as a Marriage and Family Therapist or Licensed Psychologist - Clinical Counselor would also help to address some of the mental health needs within the community.

There are currently some funding sources that could help with this. The Diversity Social Work Advancement Program provides funding and professional support to individuals from underserved communities who are training as MSWs. Furthermore various loan forgiveness programs exist for those who work in underserved communities. It is likely, however, that there is a lack of information in the community about these programs. Though these programs do

exist, it would be beneficial to supplement these funds with Lao specific funds. This task would improve the community's capacities for wellness, meeting Objective 2.5.

Though having Lao social workers or mental health professionals would help, there are still challenges. First, this person would need an accessible, yet private office space. One community member reported that the Lao Assistance Center used to have a social worker, but with no private place to hold sessions, community members were uncomfortable seeking services. Additionally, due to the stigma of mental health in the community there was a great deal of animosity toward the social worker, which the interviewee believed might have contributed to her leaving. Several interviewees stated it might be difficult to find an individual interested in going into mental health in the Lao community because the stigma around mental health extends to those working in the field.

A third recommendation is to increase awareness of the Lao people among the general population and elected leaders. Many interviewees said they do not believe the Minnesota population at large knows that the Lao people are different from Hmong. This lack of knowledge has caused many Lao people to receive Hmong interpreters at the doctor's office and other locations. In addition, improving disaggregation of data to make more Lao-specific data available would allow better interventions to be enacted. For example, NVDRS only captures individuals as Lao if they were born in Laos, this should be changed to reflect the growing number of American-born Lao individuals.

One of the main risk factors brought up in interviews was a lack of jobs in the Lao community. This was largely tied to a lack of education among Lao community members. In order to improve the job prospects in the Lao community the fourth recommendation is to ensure better education for those in the Lao community, including children and adolescents in traditional schools, and adults. Adult education will need to include both English classes and job training. Many interviewees also explained that having financial problems was a major source of conflict and stress in the community. Improving education, and thus financial opportunity, for Lao community members meets the goal of "Health in All Policies"[142] in the suicide prevention plan.

Finally, it would be beneficial to increase the connections between the Lao Assistance Center and other community resources including temples, churches, the Southeast Asian Diaspora

Project, and the various Lao Associations for various groups incuding women, seniors and youth. This includes both resources within and outside the Lao community. Most interviewees brought up the crucial role that the temple has in the Lao community, especially in the older population. The temple is one place where people are willing to seek help, if monks were willing and able to refer individuals to LAC, or other service providers, it would be very beneficial. Additionally, monks at the temples could benefit from “gatekeeper” training which would teach them the signs of high suicide risk. Being that some people will go to the temple for help it is important that the monks encourage help-seeking behaviors.

Conclusion

Through the interviews with Black and Lao community leaders, it is evident that awareness for suicide prevention and resources is low. Additionally, each community lacks the proper resources such as funding, providers, space, and culturally competent services to address the rising suicide rates. Nevertheless, with an appropriate approach, both Black and Lao community leaders stated the community would support efforts to address suicide or overwhelming stress prevention strategies. The risk factors for the two communities greatly vary and will require two separate intervention strategies.

Despite the differences in risk factors, there are two common threads MDH will need to address: stigma and cultural context. Within both communities, cultural stigmas around mental health and suicide play an important role in preventing individuals from seeking out resources during times of duress. The Black and Lao communities must also prioritize basic individual needs, such as education, jobs, and economic stability before addressing a community problem, such as suicide or overwhelming stress.

Based on the literature review, interviews, and quantitative analysis, it is apparent that there is both a great need for awareness of rising suicide rates and resources for suicide prevention within the Black and Lao communities, as well as stigmas and contextual factors that prevent discussion of suicide. The suicide prevention methods MDH selects must be designed to recognize the stigmas and cultural context of each unique community to ensure long-term effectiveness while simultaneously working to increase awareness of the rising burden of suicide and resources for prevention.

Appendices

Appendix 1: Black Suicide Risk Factors, All

Suicide Risk Factors by Geography, Black Males to the Total Male Population, 2010-2014 Aggregated Estimates

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
	Black Males	Total Male Population	Black Males	Total Male Population	Black Males
PSYCHIATRIC/PSYCHOLOGICAL					
% Ever told had depression[1]	26.1%	24.3%	22.1%	23.6%	4.0
% Ever told had bipolar[1]	2%*	1%	1%*	2%	1.0**
% Ever told had schizophrenia[1]	1.5%	0.7%	1.4%	0.8%	0.1
% Current heavy drinker[1]	6.6%	8.1%	7.3%*	8.6%	-0.7
DEMOGRAPHIC					
Income					
Median Per Capita Income[2]	$36,612	$51,625	$37,570	$48,745	$(958)
% Below poverty level[1]	31.8%*	13.7%	26.7%*	14.8%	8.4**
% Unemployment[2]	12.5%*	5.2%	10.8%*	6.5%	1.7**
Education[3]					
% < High School	43.7%*	30.0%	39.9%*	33.9%	3.8**
% High school/GED completed	26.3%	27.6%	31.8%*	28.6%	-5.5**
% Some college	18.1%*	19.9%	18.1%*	17.6%	0.0**
% Bachelor's	7.8%*	15.1%	6.9%*	12.5%	0.9**
% Post-grad	4.1%*	7.3%	3.3%*	4.0%	0.8**
Age[3]					
0-19	37.7%*	27.30%	32.1%*	27.4%	5.6**
20-24	8.3%*	6.70%	8.9%*	7.4%	-0.6
25-34	16.9%*	14.0%	14.2%*	13.8%	2.7**
35-44	14.5%*	12.70%	13.2%*	13.1%	1.3**
45-54	11.7%*	14.70%	13.6%*	14.1%	-1.9**
55-59	4.7%*	6.90%	5.7%*	6.5%	-1.0**
60-64	2.6%*	5.70%	4.5%*	5.6%	-1.9**
65-74	2.2%*	7.0%	5.0%*	7.3%	-2.8**
75-84	0.9%*	3.70%	2.2%*	3.7%	-1.3**
85+	0.3%*	1.40%	0.6%*	12.0%	-0.3**
Gender[3]					
% Male	51.6%*	49.7%	47.7%*	49.2%	1.9**
% Female	48.4%*	50.3%	52.3%*	50.8%	-1.9**
Marital Status[3]					
% Married, spouse present	19.8%*	41.0%	22.5%*	37.8%	-2.7**
% Married, spouse absent	3.7%*	1.4%	2.7%*	2.2%	1.0**
% Widowed	0.7%*	1.8%	2.0%*	2.0%	-1.3**
% Divorced	7.20%	7.2%	7.9%*	7.7%	-0.7
% Separated	1.9%*	0.8%	2.8%*	1.5%	-0.9
% Never married	66.7%*	47.8%	62.1%*	48.8%	4.6**

(Appendix 1 Continued)

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
ENVIRONMENTAL					
Geography[3]					
% Not in Metro Area	7.6%*	30.4%	17.4%*	25.5%	-9.8**
% In Metro Area - Central	40.3%*	14.6%	43.4%*	24.0%	-3.1**
% In Metro Area - Outside Central	52.1%*	54.9%	39.2%*	50.4%	12.9**
Health Insurance[4]					
% Employer	38.6%*	59.1%	43.6%*	51.2%	-5.0**
% Individual	3.0%*	7.4%	4.1%*	6.4%	-1.1**
% Medicaid/CHIP	41.0%*	12.3%	25.6%*	14.6%	15.4**
% Medicare	6.8%*	15.3%	13.3%*	16.2%	-6.6**
% Uninsured	10.7%*	5.9%	13.5%*	11.6%	-2.7**
Access to Care[1]					
% No Usual Source of Primary Care	15.9%	13.9%	15.1%	15.0%	0.8**
% Couldn't afford medical care needs	7.3%*	5.2%	7.2%*	5.6%	0.1
% Couldn't afford mental health care needs	2.1%	1.7%	2.0%	1.7%	0.1
Health[1]					
% Reported poor health status	2.1%	2.0%	2.5%*	2.2%	-0.4
% Reported poor mental health status	2.2%	1.5%	1.5%	1.7%	0.7**

Definitions:
* denotes a 95% or greater significant suicide rate difference between the Black population within gender to the total population by gender within a geography (MN or US).
** Measures the percentage point difference between the Black age-adjusted suicide rate in Minnesota compared to the U.S within gender. The difference is statistically significant at the 95% level.
Sources:
[1]Minnesota Population Center and State Health Access Data Assistance Center, Integrated Health Interview Series: Version 6.12. Minneapolis: University of Minnesota, 2015. Estimates aggregated between 2010 - 2014. Minnesota estimates are based on the North Central/Midwest region. Retrieved from http://www.ihis.us.
[2] U.S. Census Bureau. American Fact Finder. American Community Survey 2014 1 year estimates of full time workers. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.
[3] Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek. Integrated Public Use Microdata Series: Version 6.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2015. Data from American Community Survey, 5 year estimates 2010 - 2014.
[4] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

Appendix 2: Asian Suicide Risk Factors, All

Suicide Risk Factors by Geography, Asians to the Total Population, 2010-2014 Aggregated Estimates

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
	Asian	Total Population	Asian	Total Population	Asian
PSYCHIATRIC/PSYCHOLOGICAL[5]					
% Ever told had depression[1]	5.2 %*	10.4 %	5%*	9.4%	0.2
% Ever told had bipolar[1]	-	0.7 %	0.3%*	0.6%	-0.3**
% Ever told had schizophrenia[1]	-	0.2 %	0%*	0.2%	0.0
% Current heavy drinker[1]	0.4 %*	1.8 %	0.7%*	1.8%	-0.3
DEMOGRAPHIC					
Income					
Median Per Capita Income[2]	$25,425	$33,277	$32,404	$30,815	$ -6,979
% Below poverty level[1]	20.2 %*	14.8 %	16.9%	15.8%	3.3**
% Unemployment[3]	5.5 %*	4.5 %	5.2%*	5.8%	0.3**
Education[3]					
% < High School	44.1 %*	30.1%	32.7%*	34%	11.4**
% High school/GED completed	12.9 %*	20.2%	13.2%	21.7%	-0.3
% Some college	18.2 %*	26.5%	19.4%*	23.9%	-1.2**
% Bachelor's	14.7 %*	15.9%	21.6%*	13.0%	-6.9**
% Post-grad	10.1 %*	7.4%	13.0%*	7.4%	-2.9**
Age[3]					
0-19	34.5%*	26.9%	25.7%*	26.7%	8.8**
20-24	9.4 %*	6.7%	7.4%*	7.2%	2.0
25-34	20.8 %*	13.9%	17.9%*	13.7%	2.9**
35-44	16.2 %*	12.8%	17.4%*	13.2%	-1.2
45-54	9.6 %*	14.9%	13.2%*	14.3%	-3.6**
55-59	3.1 %*	7.0%	5.5%*	6.7%	-2.4**
60-64	2.5 %*	5.8%	4.6%*	5.8%	-2.1**
65-74	2.9 %*	7.4%	5.8%*	7.8%	-2.9**
75-84	0.9 %*	4.3%	2.3%*	4.3%	-1.4**
85+	0.1 %*	0.3%	0.1%	0.3%	0.0
Gender[3]					
% Male	48.6 %	49.7%	48.0%	49.2%	0.6
% Female	51.4 %	50.3%	52.0%	50.8%	-0.6
Marital Status[3]					
% Married, spouse present	35.5 %*	40.6%	43.2%*	36.9%	-7.7**
% Married, spouse absent	2.8 %*	1.4%	3.8%*	2.0%	-1.0*
% Widowed	2.1 %*	4.2%	3.3%*	4.8%	-1.2**
% Divorced	3.5 %*	7.9%	4.1%*	8.8%	-0.6**
% Separated	1.7 %*	0.9%	1.1%*	1.8%	0.6**
% Never married	54.4 %*	44.9%	44.4%*	45.7%	10.0**

(Appendix 2 Continued)

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
DEMOGRAPHIC (Continued)					
Immigration					
0 to 5 Years	21.5 %*	19.6%	19.8%*	15.2%	1.70**
6 to 10 Years	15.1 %*	18.9%	14.6%	14.5%	0.50
11 to 15 Years	9.4 %*	18%	13.7%*	15.5%	-4.30**
16 to 20 Years	12.1 %	12.8%	11.9%	11.8%	0.20
21+ Years	42.0 %*	30.7%	40%*	43%	2.00**
% Not a Citizen	24.7 %*	4%	27.2%*	7.1%	-2.50**
ENVIRONMENTAL					
Geography[3]					
% Not in Metro Area	5.6 %*	30.0%	5.6%*	25.1%	0.0
% In Metro Area - Central	32.4 %*	14.5%	31.3%*	24.3%	1.1
% In Metro Area - Outside Central	62.1 %*	55.6%	63.2%*	50.6%	-1.1
Health Insurance[4]					
% Employer	65.2 %	63.0%	59.1%*	56.3%	6.1**
% Individual	11.0 %*	16.9%	15.1%*	12.9%	-4.2**
% Medicaid/CHIP	23.5 %*	16.3%	16.1%*	19.1%	7.4**
% Medicare	5.36 %*	15.4%	11.1%*	16.2%	-5.7**
% Uninsured	6.04 %*	15.4%	10.3%*	11.6%	-4.3**
Access to Care[1]					
% No Usual Source of Primary Care	18.7 %*	10.6%	16.7%*	11.8%	2.0
% Couldn't afford medical care needs	3.5 %*	5.7%	4.5%*	6.2%	-1.0
% Couldn't afford mental health care needs	3.5 %*	5.7%	1.3%*	2.2%	2.2**
Health[1]					
% Reported poor health status	1.70 %	2.2%	1.8%*	2.4%	-0.1
% Reported poor mental health status	-	1.6%	0.7%*	1.8%	-**

Notes: * represents Asians are significantly different compared to the total population within the geography at the 95% confidence interval or greater.

[1] Minnesota Population Center and State Health Access Data Assistance Center, Integrated Health Interview Series: Version 6.12. Minneapolis: University of Minnesota, 2015. Estimates aggregated between 2010 - 2014. Minnesota estimates are based on the North Central/Midwest region. Retrieved from http://www.ihis.us.

[2] U.S. Census Bureau. American Fact Finder. American Community Survey 2014 1 year estimates of full time workers. Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

[3] Steven Ruggles, Katie Genadek, Ronald Goeken, Josiah Grover, and Matthew Sobek. Integrated Public Use Microdata Series: Version 6.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2015. Data from American Community Survey, 5 year estimates 2010 - 2014.

[4] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

[5] All data reported from year 1999 forward; no data available for 2010-2014

Appendix 3: Black CRA Instrument

Black Community Readiness Assessment Script & Questions

"Hello, my name is Jenna Larson and this is Carrie Suplick Benton. We are student researchers from the Humphrey School of Public Affairs. We are assisting the Center for Health Promotion at the Minnesota Department of Health (MDH) with conducting community readiness assessments in your community to ask questions about suicide prevention. The Center promotes, encourages, and supports healthy and safe communities, and works to build capacity for individual, community and system change to improve health and prevent injury, suicide, and chronic disease.

I'm contacting key people and organizations in your community that represent a wide range of community-based organizations and community members. The purpose of this interview is to learn how ready your community is to address suicide prevention. Each interview will last about 30 to 60 minutes, is voluntary, and individual names will not be associated with interviews. These questions will cover six dimensions, which include: existing community efforts, community knowledge about prevention, leadership, community climate, knowledge about the problem, and resources for prevention efforts. Is it okay that Carrie takes notes during our interview? Do you have any questions for us? Great, let's get started."

Dimension A. Existing Community Efforts

1. On a scale from 1 to 10, how much of a concern is suicide in your community? (With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.
2. What suicide prevention programs or services are available in your community?
3. How long have these programs or services been available?
4. What suicide prevention programs or services are being planned for your community?
5. What mental health treatment efforts or services are available in your community?
6. How long have these services been available?
7. What mental health treatment efforts or services are being planned for your community?
8. Generally, do people in the community use these services? Are there plans to expand additional services or efforts? Please explain.
9. Can you describe efforts to involve the community, including youth and elders, in the planning of prevention programs or mental health services?

Dimension B. Community Knowledge about Prevention

10. Based on your knowledge, what does the community know about efforts for suicide prevention and the treatment of mental illness? Include information such as the name of programs, the services provided, how to access services, who they serve (such as youth,

adults, males, females), whether they treat both mental health problems and alcoholism, etc.

11. On a scale from 1 to 10, how aware is the general community of these prevention and treatment efforts? (With 1 being “not at all” and 10 being “a great deal”). Please explain your rating.
12. What are the strengths of the available prevention programs and treatment services?
13. What are the limitations of the available prevention programs and treatment services?

Dimension C. Leadership

14. On a scale from 1 to 10, how concerned are your elected leaders with providing suicide prevention and mental health services for community members? (With 1 being “not at all” and 10 being “a great concern”). Please explain your rating.
15. On a scale from 1 to 10, how concerned are your informal or influential leaders with providing suicide prevention and mental health services for community members? (With 1 being “not at all” and 10 being “a great concern”). Please explain your rating.
16. How are these leaders (elected or informal) involved in efforts regarding suicide prevention in your community? In other words, what are they doing?
17. Would the leadership (elected or informal) support additional efforts to address suicide prevention planning in your community? Please explain.

Dimension D. Community Climate

18. How would you describe your community?
19. What are the community’s feelings about suicide prevention?
20. How does the community support the prevention and treatment efforts?
21. What are the primary obstacles to obtaining or adding more suicide prevention programs or mental health treatment services in your community?

Dimension E. Knowledge about the Problem

22. How knowledgeable are community members about the issue of suicide? Please explain.
23. In your community, what types of information are available about suicide prevention?
24. Is local data on suicide prevention available in your community? If so, from where?

Dimension F. Resources for Prevention Efforts

25. Who would a person turn to first for help if he or she was thinking about suicide?
26. What are the community’s feelings about getting involved in suicide prevention efforts (e.g., talking to a person thinking about suicide, volunteering time, financial donations, providing space)?
27. Please describe any prevention plans or grants to address the issue of suicide in your community.
28. Do you know if any of these prevention activities or grants are being evaluated?

29. These are all of the questions we have for you today, do you have anything else to add?

"Thank you for taking the time to do this interview. Your information will be used to help our community build a prevention plan to address and prevent mental and substance use disorders, suicide, and to promote mental health. It will be based on the information from this and other interviews, and an assessment of our community strengths and needs. Your time and your commitment to our community are greatly appreciated."

Appendix 4: Lao CRA Instrument

Lao Community Readiness Assessment Script & Questions

"Hello, my name is Steven Lutes and this is Kendal Orgera. We are here on behalf of the Minnesota Department of Health and The University of Minnesota Humphrey School of Public Affairs. We are conducting interviews in the Lao community to ask questions about overwhelming stress in the Lao community.

You have been asked to be here because you are key people in the Lao community that represent a wide range of community-based organizations and community members. The purpose of this interview is to learn how ready the Lao community is to address overwhelming stress. Throughout this interview I will ask questions about "overwhelming stress." By this I am talking about the challenges people face that are so big they do not know what to do and feel like they cannot change the situation. All people face hard, stressful challenges in life. We are talking about people who feel their challenges are so big they do not think they can overcome them and sometimes think life is not worth living.

In addition, we will use the term "services" throughout this session. For that term we mean the programs and resources available to the community for stress and mental health support. Your information will be used to help your community build a plan to address and prevent people from facing overwhelming stress in an effort to prevent mental and substance use disorders, suicide, and to promote mental health. It will be based on the information from this and other interviews, and an assessment of your community strengths and needs. Your time and your commitment to our community is greatly appreciated.

This interview is scheduled to last two hours, is voluntary, and individual names will not be associated with interviews. You are not required to answer every question. These questions will cover six dimensions, which include: existing community efforts, community knowledge about prevention, leadership, community climate, knowledge about the problem, and resources for prevention efforts. Do you have any questions?"

Dimension A. Existing community efforts

1. On a scale from 1 to 10, how much of a concern is overwhelming stress in our community? (With 1 being "not at all" and 10 being "a great concern"). Please explain your rating.
2. What programs or services are available to people facing overwhelming stress to help them deal with stressors and associated mental health needs in the Lao community?
   If the following information is not given we will ask a follow up question about it:
   a. Name of programs
   b. Services provided
   c. How to access services
   d. Who they serve (such as youth, adults, males, females)

    e. Whether they treat both mental health problems and something else (gambling, substance abuse, etc.

3. Do these services help people in a crisis or do they help them before they get to a crisis point?
4. How aware of these services do you think the Lao community is?
5. How long have these programs or services been available?
6. Where are they available?
7. Are they accessible to most people?
8. Generally, do people in the community use these services? Please explain.
9. What programs or services that are currently are not available would be helpful for the Lao community?
10. How is the community involved in the planning the programs that exist or are in the process of being developed?

Dimension B. Community knowledge about prevention

11. Based on your knowledge, what does the Lao community know about these services?
12. What is good about these services that do exist? (try to categorize life stressor services and mental health services)
13. What are the limitations of the available services?

Dimension C. Leadership

14. Are elected leaders concerned about people in the Lao community who are struggling with overwhelming stress?
15. Are Lao community leaders concerned about people who are struggling with overwhelming stress?
16. What are elected and community leaders doing to help those in your community who are struggling with overwhelming stress?
17. Would the elected and community leaders support more help for people in your community struggling with overwhelming stress? Why or why not?

Dimension D. Community Climate

18. How would you describe your community? (Probing questions may be needed?)
19. What are your community's feelings about preventing overwhelming stress?
20. What are your community's feelings about helping those who face overwhelming stress?
21. What are the primary obstacles to obtaining or adding more supports for those facing overwhelming stress in the community?

Dimension E. Knowledge about the problem

22. How knowledgeable are community members about the issue of overwhelming stress? Please explain.

23. How common is it for people in the Lao community to experience overwhelming stress?
24. Why are these people experiencing overwhelming stress?
25. What things in life make a person more likely to face overwhelming stress?
26. In your community, what types of information are available about help for people who feel overwhelmed by stress?
27. Do you have concerns that the overwhelming stress may lead some members of your community to hurt themselves or think about ending their life?

Dimension F. Resources available

28. Who would a person turn to first for help if he or she was facing overwhelming stress?
29. What are the community's feelings about preventing overwhelming stress or supporting those who are experiencing overwhelming stress (e.g., talking to a person about their stressors, volunteering time, financial donations)?
30. Please describe any prevention plans or grants to address the issue of overwhelming stress in your community.
31. These are all the questions we have for you today, do you have anything else to add?

"Thank you for taking the time to do this interview."

Appendix 5: CRA Scoring Guidelines

Scoring Community Readiness Interviews (From SAMHSA Manual)

Scoring is an easy step-by-step process that gives you the readiness stages for each of the six dimensions. The following pages provide the process for scoring. There is a scoring worksheet on page 26 and anchored rating scales starting on pages 28. Ideally, two people should participate in the scoring process in order to ensure valid results on this type of qualitative data. Here are step-by-step instructions:

- Working independently, both scorers should read through each interview in its entirety before scoring any of the dimensions in order to get a general feeling and impression from the interview. Although questions are arranged in the interview to pertain to specific dimensions, other interview sections may have some responses that will help provide richer information and insights that may be helpful in scoring other dimensions.
- Again, working independently, the scorers should read the anchored rating scale for the dimension being scored. Always start with the first anchored rating statement. Go through each dimension separately and highlight or underline statements that refer to the anchored rating statements. If the community exceeds the first statement, proceed to the next statement. In order to receive a score at a certain stage, all previous levels must have been met up to and including the statement which the scorer believes best reflects what is stated in the interview. In other words, a community cannot be at stage 7 and not have achieved what is reflected in the statements for stages 1 through 6.
- On the scoring sheet on page 26, each scorer puts his or her independent scores in the table labeled INDIVIDUAL SCORES using the scores for each dimension of each of the interviews. The table provides spaces for the eight key respondent interview.
- When the independent scoring is complete, the two scorers then meet to discuss the scores. The goal is to reach consensus on the scores by discussing items or statements that might have been missed by one scorer and which may affect the combined or final score assigned. Remember: Different people can have slightly different impressions, and it is important to seek explanation for the decisions made. Once consensus is reached, fill in the table labeled COMBINED SCORES on one of the scoring sheets. Add across each row to yield a total for each dimension.

Anchored Ratings

Dimension A. Existing community efforts	
Rating	**Meaning**
1	No awareness of the need for efforts to address SUICIDE PREVENTION.
2	No efforts addressing SUICIDE PREVENTION.
3	A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
4	Some community members have met and have begun a discussion of developing community efforts.
5	Efforts (programs or activities) are being planned.

6	Efforts (programs or activities) have been implemented.
7	Efforts (programs or activities) have been running for at least 4 years or more.
8	Several different programs, activities and policies are in place, covering different age groups, and reaching a wide range of people. New efforts are being developed based on evaluation data.
9	Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

Dimension B. Community knowledge of the efforts	
Rating	**Meaning**
1	Community has no knowledge of the need for efforts addressing SUICIDE PREVENTION.
2	Community has no knowledge about efforts addressing SUICIDE PREVENTION.
3	A few members of the community have heard about efforts, but the extent of their knowledge is limited.
4	Some members of the community know about local efforts.
5	Members of the community have basic knowledge about local efforts (e.g., purpose).
6	An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
7	There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.
8	There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.
9	Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.

Dimension C. Leadership (includes appointed leaders and influential community members)	
Rating	**Meaning**
1	Leadership has no recognition of the SUICIDE issue.
2	Leadership believes that SUICIDE is not a concern in their community.
3	Leaders recognize the need to do something regarding SUICIDE PREVENTION.
4	Leaders are trying to get something started.
5	Leaders are part of a committee or group that addresses SUICIDE PREVENTION.
6	Leaders are active and supportive of the implementation of efforts.
7	Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.
8	Leaders are supportive of expanding and improving efforts through active participation in the expansion or improvement.
9	Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

Dimension D. Community climate	
Rating	**Meaning**
1	The prevailing attitude is that SUICIDE is not considered, is unnoticed, or overlooked within the community, “It’s just not our concern.”
2	The prevailing attitude is, “There’s nothing we can do,” or “Only ‘those’ people do that,” or “Only ‘those people’ have that.”
3	Community climate is neutral, disinterested, or believes that SUICIDE does not affect the community as a whole.
4	The attitude in the community is now beginning to reflect interest in SUICIDE PREVENTION, “We have to do something, but we don’t know what to do.”
5	The attitude in the community is, “We are concerned about this.” and community members are beginning to reflect modest support for efforts.
6	The attitude in the community is, “This is our responsibility.” and is now beginning to reflect modest involvement in efforts.
7	The majority of the community generally supports programs, activities, or policies, “We have taken responsibility.”
8	Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high, “We need to keep up on this issue and make sure what we are doing is effective.”
9	All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

Dimension E. Community knowledge about the issue	
Rating	**Meaning**
1	SUICIDE is not viewed as an issue that we need to know about.
2	No knowledge about SUICIDE.
3	A few in the community have basic knowledge of SUICIDE, and recognize that some people here may be affected by the issue.
4	Some community members have basic knowledge and recognize that SUICIDE occurs locally, but information and/or access to information is lacking.
5	Some community members have basic knowledge of SUICIDE, including signs and symptoms. General information on SUICIDE PREVENTION is available.
6	A majority of community members have basic knowledge of SUICIDE and SUICIDE PREVENTION, including the signs, symptoms, and behaviors. There are local data available.
7	Community members have knowledge of, and access to, detailed information about local prevalence.
8	Community members have knowledge about prevalence, causes, risk factors, and related health concerns.

9	Community members have detailed information about SUICIDE and SUICIDE PREVENTION and related health concerns, as well as information about the effectiveness of local programs.

Dimension F. Resources related to the issue (people, money, time, space)	
Rating	**Meaning**
1	There is no awareness of the need for resources to deal with SUICIDE PREVENTION.
2	There are no resources available for dealing with SUICIDE PREVENTION.
3	The community is not sure what it would take, or where the resources would come from, to initiate efforts.
4	The community has individuals, organizations, and/or space available that could be used as resources.
5	Some members of the community are looking into the available resources.
6	Resources have been obtained and/or allocated for SUICIDE PREVENTION.
7	A considerable part of support of ongoing efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.
8	Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for further efforts.
9	There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

*NOTE – For the Lao community SUICIDE PREVENTION is replaced with preventing overwhelming stress.

Appendix 6: Black Community Readiness Assessment Themes

Community Awareness
- Unaware/don't consider suicide is a problem
- Unaware of suicide prevention resources
- Community would support prevention efforts
- Aware when personally lost someone to suicide
- Aware suicide is a problem
- Community has info, doesn't personally connect it
- Community has other concerns/priorities
- Mental health and suicide becoming less stigmatized
- Concerned if/when aware of suicide problem

Risk Factors
- Homelessness
- Hopelessness
- Substance abuse
- Family problems
- Contact with legal system/crime
- Interpersonal violence
- Poverty
- Lack of education
- Unemployment

Cultural Themes
- Lack of male role models
- Stigma of mental health
- Role of the church
- Engaging in self-sabotaging behaviors
- Historical/intergenerational trauma
- Use mental health services because of system referral
- Focus on symptoms, not problem of suicide
- Internalize problems
- Males can't be vulnerable

Cultural Themes (Cont.)
- Mental health/suicide is not a Black person problem
- Role of the mother
- Resiliency of African Americans
- Suicide is glamorized

Barriers
- No advertisements of services
- Lack of African American male providers
- Access to care
- Cost
- General lack of providers/services
- Data on suicide and resources unavailable/out of date
- Lack of suicide specific services
- Not culturally competent/reflective
- Lack of trust
- Hours of operation
- Fear of being put on medication

Prevention
- Community involvement necessary in prevention efforts
- Need a key group of leaders already involved in community
- Provide community-specific suicide education (facts, stories, general info)
- Communicate plans with community
- Provide culturally competent/reflective services
- News/media campaign
- Build relationships/trust with community
- Number of service providers increasing
- Funding and allowing community the power to shape how spending
- Engage youth in activities, make them feel equal to peers
- Accessibility of services important

Appendix 7: Black CRA Scoring

Black Community Readiness Assessment Scoring

	Int. 1	Int. 2	Int. 3	Int. 4	Int. 5	Int. 6	Int. 7	Int. 8	Dimension Total
Dimension A: Community Efforts	1	1	2	1	1	3	1.5	1	1.44
Dimension B: Community Knowledge of Efforts	2	1	2.5	1	1	3	3	1	1.81
Dimension C: Leadership	1	1	1	2.5	1	2	1.5	1	1.38
Dimension D: Community Climate	1.5	3	1.5	2	1	1.5	1	1	1.56
Dimension E: Community Knowledge about the Issue	2	1.5	2	1.5	1	3	2	1	1.75
Dimension F: Resources for Prevention	2	1	1	1	1	2	2	1	1.38
								Final Score:	**1.55**

Appendix 8: Lao Community Readiness Assessment Themes

Community Awareness
- Unaware/do not consider stress a problem
- Leaders not aware of Lao community specifically
- Aware suicide is a problem
- Do not know where to go for resources/help

Risk Factors
- Lack of employment
- Alcohol abuse
- Drug abuse
- Smoking
- Family problems
- Financial Problems
- Poverty
- Lonely
- Gambling
- Lack of Education
- Housing
- Health Issues

Cultural Themes
- Stigma of mental health
- Role of the religion
- Don't talk about problems
- Shame in seeking help
- Internalize problems
- Generation gap
- Family Reliance

Barriers
- No services
- Lack of Lao providers
- Access to care
- Not culturally competent
- Cost
- Language

Prevention
- Need a key group of leaders already involved in community
- Better info
- Communicate plans with community
- Provide culturally competent services
- News/media campaign
- Build relationships/trust with community
- Broader service

Appendix 9: Lao CRA Scoring

Lao Community Readiness Assessment Scoring

	Int. 1	Int. 2	Int. 3	Int. 4	Int. 5	Int. 6	Int. 7	Int. 8	Dimension Total
Dimension A: Community Efforts	2.75	3.75	3	4	2.75	2	3.04	2.75	3.75
Dimension B: Community Knowledge of Efforts	3	3.5	2	3.5	2	2	2.67	3	3.5
Dimension C: Leadership	3	4	3	3.75	3.75	4	3.58	3	4
Dimension D: Community Climate	1	2	2	4	2	2	2.17	1	2
Dimension E: Community Knowledge about the Issue	4	4.5	3	3.75	3	3	3.54	4	4.5
Dimension F: Resources for Prevention	2	2.75	2	3.5	2.5	3.5	2.71	2	2.75
								Final Score:	**2.95**

Appendix 10: Black Risk Factors by Data Source

Black Suicide Risk Factors Summary Across Methods

Category	Literature Review	Public Data	NVDRS Data	Interviews
Psychiatric/ Psychological				
Somatization of symptoms	X	N/A		
Previous ideation or attempt	X	N/A	X	
Hopelessness	X	N/A		X
Substance use	X		X	X
Mental health disorder	X	X*	X	
Historical trauma	X	N/A		X
Demographic				
SES	X	X	X	X
Single	X	X		
Low education	X	X		X
Age	X	X		
Unemployment	X	X		X
Sex (male)	X	X	X	
Environmental				
Dysfunctional families (divorce/spouse/other)	X	N/A	X	X
Criminal record	X	N/A	X	X
Homelessness	X	N/A		
Trauma (physical, sexual, emotional, violence)	X	N/A	X	X
Major life stressor	X	N/A	X	
Limited access to mental health/insurance	X	X		X
Beliefs				
Stigma of mental illness	X	N/A		X
Distrust in mental health care/treatment	X	N/A		X

X indicates the variable was observed.
N/A indicates the variable is not measurable for the data collection method.
*The data only bipolar was significant.

Appendix 11: Lao Risk Factors by Data Source

Lao Suicide Risk Factors Summary Across Methods

Category	Literature Review	Public Data	NVDRS Data	Interviews
Psychiatric/ Psychological				
Somatization of symptoms	X	N/A		
Limited access to mental health and/or insurance	X			X
Mental health disorder	X		X	X
Gambling	X			X
Alcohol abuse				X
Drug abuse				X
Demographic				
SES	X	X		X
Low education	X	X	X	X
Unemployment	X			X
Limited English skills	X	X		X
Generation gap in expectations				X
No stable housing				X
Environmental				
Trauma - (physical, sexual, emotional, violence)	X			
Family problems	X		X	X
First-generation American	X	X	X	X
Lack of access to care	X			X
Lack of Lao, or culturally competent, therapists	X			X
Beliefs				
Respect for authority	X	N/A		
Stigma of mental illness	X	N/A		X
Distrust in mental health care/treatment	X	N/A		X
Lao culture is private				X
Stigma against asking for help				X

X indicates the variable was observed.
N/A indicates the variable is not measurable for the data collection method.

Appendix 12: Black Community Partners

Throughout our interviews with the Black community leaders, it was recommended that MDH engage with the following community partners and stakeholders when proceeding with raising awareness for suicide and suicide prevention resources.

Suggested Community Partners

1) Turning Point
2) Northpoint
3) Kente Circle
4) Empower
5) Kalfi at Wilder
6) Cultural Wellness Center
7) Tubman Center
8) Stairstep Foundation (Alfred Babington-Johnson)
9) 180 degrees
10) Washburn Center for Children
11) HCMC
12) African American psychologists, psychiatrists, etc.
    a) Thad Wilderson
    b) Dr. BraVada Garrett-Akinsanya

Suggested Stakeholders

1) NAACP
2) Black Lives Matter
3) Urban League
4) African American Leadership Council

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