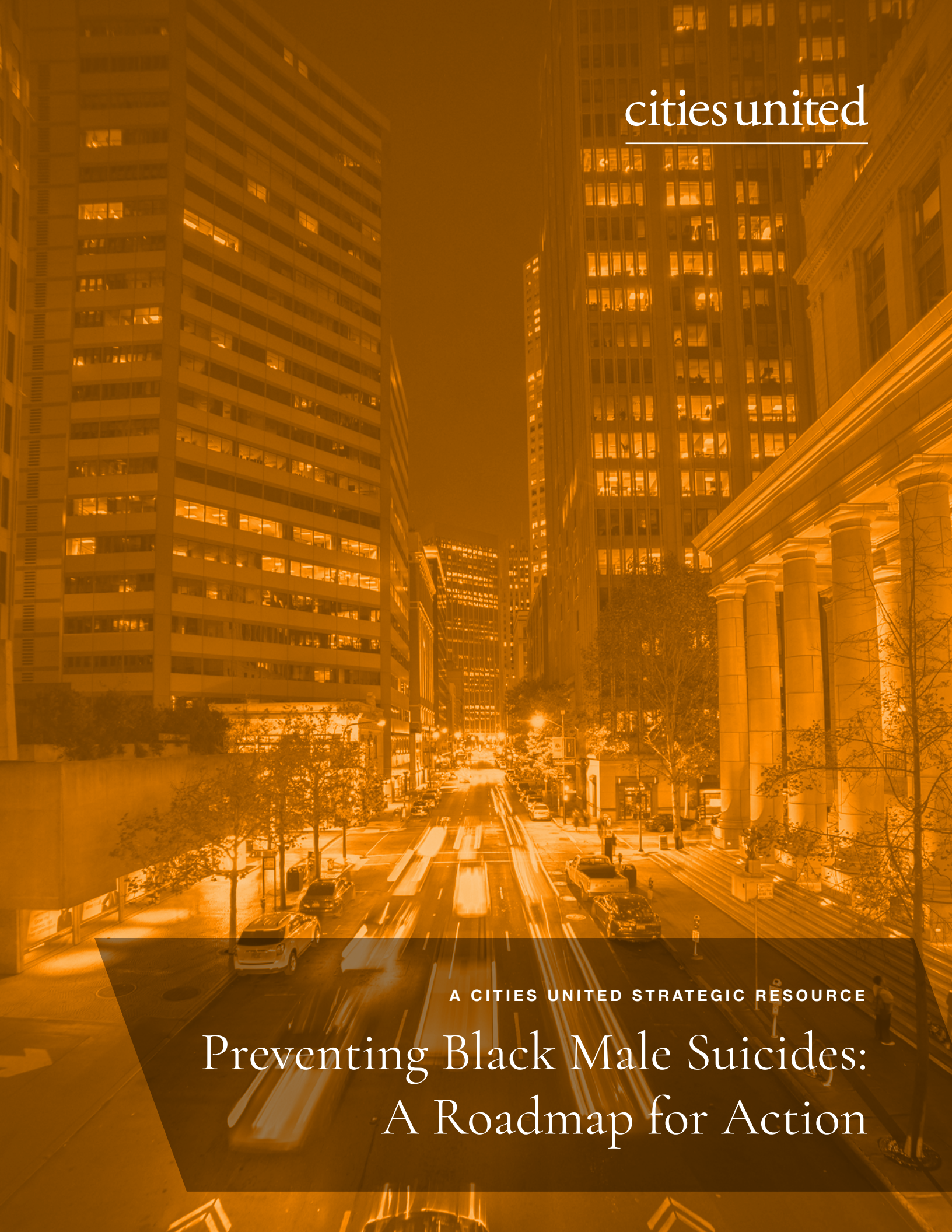


cities united

A CITIES UNITED STRATEGIC RESOURCE

Preventing Black Male Suicides: A Roadmap for Action

Every young Black man and boy deserves to live in communities where they feel safe and are free from harm. They deserve to grow up in healthy environments that are nurturing and affirming. They deserve to live lives that are full of hope, with endless possibilities. This is our vision for young Black men and boys, and their families – for all of them to be able to live in communities that are safe, healthy, and hopeful.

Over the past 10 years, we have continued to hear from our partners about the need for resources and tools that will help them address the most pressing issues that hold far too many young Black men and boys back from living out our vision. From community violence and homicides; police-involved shootings and in-custody deaths; suicides, and child abuse and neglect – all of these forms of violence have a direct and indirect impact on young Black men and boys – lessening their chances to be safe, live healthy lives or see any hope for the future. In response, Cities United has developed a series of strategic resources to equip mayors, city and community leaders, and young leaders – with the tools they need to address these tough challenges, and prevent them from happening in the first place

This is the third strategic resource in the series and it will focus on suicide prevention, providing a roadmap that city leaders can use to address this pressing issue. We are focusing on suicide because it is a growing crisis among Black children and youth, that demands urgent attention from local leaders including mayors, schools, healthcare systems, and community-based organizations. There is a need to spotlight this issue at the local level, deploy effective solutions for identifying young people at risk, and get them the help that they need.

It is critical for local leaders to identify the prevalence and patterns of young Black male suicide in their cities and counties and to launch prevention strategies targeting the most crucial areas of risk. The following report surveys the existing suicide literature to help local leaders understand the prevalence of suicide among young Black males, current suicide trends, major risk areas, protective factors, and evidence-based interventions for reversing the rise in suicides among Black boys.

In this resource guide, we share a framework for local action – that identifies integral front-line components of a prevention system organized around universal screening and detection, timely referral to evidence-based services, and timely intervention to prevent future suicidal behavior. The framework provides actions steps that key stakeholders can implement to keep young Black men and boys from suicidal behaviors.

The recommendations outlined in this resource are based on emerging best practices and effective responses we have identified through research – they are rooted in community transformation and healing.

We recognize that every city and community faces unique realities particular to its size, geography, demographics, and access to resources. We intend for this resource to serve as a guide that can be utilized by any of our partner cities given its unique context.

We hope that this resource, along with the others, can serve as one of the many important tools in your work. Our vision aims to make sure young Black men and boys, and their families live in communities that are safe, healthy, and hopeful.

In Partnership,

Anthony Smith, Executive Director

Executive summary

Suicide among Black children and youth is a growing crisis that demands urgent attention from local leaders including mayors, schools, healthcare systems and community-based organizations. There is a need both to spotlight this issue at the local level and to deploy effective solutions for identifying young people at risk and getting them the help that they need.

A Growing Crisis of Suicide Among Young Black Children, Particularly Boys

- Suicide among young children is a growing problem in the U.S. today with rates among Black children younger than 12 doubling in the past two decades and rates for Black boys ages 12-14 increasing by 80% between 1999 and 2014. The increase in suicide rates among Black children ages 5 to 17 has remained persistent through today.
- Across 17 states in the U.S., between 2003 and 2012, Black children were found to comprise roughly 12% of suicide victims among adolescents, but fully 37% of suicide victims under the age of 12.
- Among Black children and youth, Black males tend to comprise a large majority of suicide victims. They are typically 3-6 times more likely to die by suicide than Black females are and comprised as much as 80% of Black suicide victims in 2014.
- Although the research base on risk factors for children younger than 12 is quite limited, there are insights that point to the importance of key factors including:
    - previous suicide attempts
    - a diagnosis of ADHD
    - experiencing abuse or neglect
    - out-of-home placement
    - family disruption
    - a family member who has a history of psychopathology or suicidal behavior or experiences mental illness or substance abuse
- Young children who die by suicide are also much less likely (33%) to have shown signs of depression or dysthymia (mild long-term depression) than adolescents (66%) who do so.

A Persistent Crisis Among Black Male Youth

- Among Black males ages 15-24, rates of suicide deaths declined by 17% between 1999 and 2014. For Black youth between the ages of 15 and 17, recent evidence has shown an uptick of suicides for this group.
- While suicide rates among Black male adolescents and young adults are generally lower than those among White males and show a decline in recent years, the problem of misclassification of suicide deaths for Black youth and children may obscure actual rates and trends.
- The evidence base on suicide risk factors for adolescents and young adults is quite extensive, and studies tend to find that risk factors operate similarly for Black and White youth. Key risk factors identified in the literature include:
    - prior suicide attempt
    - suicidal ideation
    - depression and anxiety
    - childhood trauma and abuse
    - foster care placement
    - lack of family support
    - exposure to violence
    - risk-taking behavior
    - early alcohol abuse
    - racial discrimination
    - social isolation
- Although less extensively researched than risk factors, a set of protective factors have been identified in the literature. Key protective factors include:
    - cohesive and supportive family
    - intrinsic religious or spiritual factors like a belief in a higher power (not church membership or religious importance)
    - relationships, including perceived social support, dense school networks, attachment to school, and connections with supportive peers
    - high self-esteem, emotional wellbeing, sense of hope and academic achievement
    - longer duration of time spent living in one residence and living in the same community more than five years

A Framework for Local Action

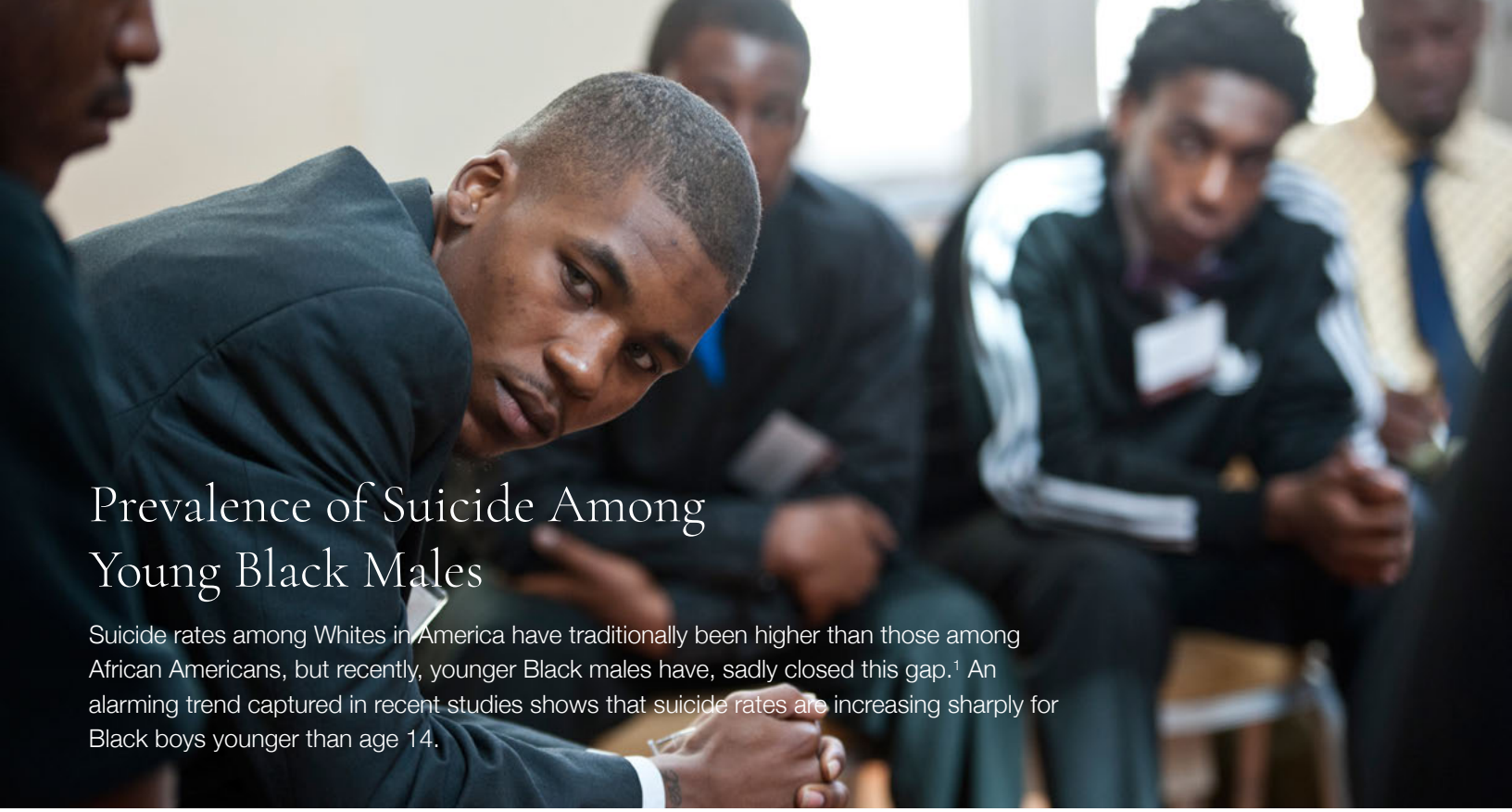
- Schools, primary care settings, and emergency departments are integral front-line components of a prevention system organized around universal screening and detection, timely referral to evidence-based services, and timely intervention to prevent future suicidal behavior.
- Cities and community-based organizations have a critical role to play in [or by] developing a better understanding of the local suicide problem, convening key stakeholders, and helping organize a systemwide response.
- **School-based prevention:** Relatively few Black adolescents seek professional help with thoughts of suicide and only around 50% who have attempted suicide have ever been diagnosed with a psychiatric disorder at the time of their attempt. The limited contact that suicidal young Black males have with professional mental health services means that schools are likely the most important front line for suicide prevention for this population. Schools should adopt a framework for suicide prevention modeled on "Multi-tiered Systems of Support" (MTSS) that include:
    - **Tier 1:** A universal screening and education tier involving such screen tools as Columbia TeenScreen and education programs like the Good Behavior Game and Signs of Suicide.
    - **Tier 2:** Additional layers of risk assessment and more intensive programming for those with elevated risk that might include programs like Reconnecting Youth (RY) and Coping and Support Training (CAST).
    - **Tier 3:** The provision of therapeutic interventions with demonstrated efficacy for adolescents that are currently experiencing suicidal behavior like Dialectical Behavior Therapy (DBT) or Cognitive Behavioral Therapy (CBT).
- **Primary Care Prevention:** The passage of the Affordable Care Act has significantly expanded the scope of primary care for supporting socio-emotional health and wellbeing for children and adolescents. Programs are required that: educate providers; use tools like The Behavioral Health Screen—Primary Care to screen for suicide risk; manage symptoms of depression; and assess and manage suicide risk over time. The Pennsylvania Youth Suicide Prevention in Primary Care (YSP-PC) model is one such exemplar model.
- **Emergency Room Prevention:** Emergency departments are a third critical site for suicide detection and prevention where universal screening is essential for ensuring timely intervention. Screening tools like Ask Suicide-Screening Questionnaire (ASQ) combined with intervention programs like The Youth-Nominated Support Team—Version II (YST) and Multisystemic Therapy (MST) are promising approaches for suicidal youth in emergency care.

Introduction

Suicide is a significant and growing national problem. It is the second-ranked cause of death (following accidents) in the U.S. among young people ages 10-24 and accounts for 17.3% of deaths in this age group.1 In 2006, over 8% of high school students interviewed nationally had attempted suicide during the previous year.2 There is growing evidence that the number of deaths by suicide may indeed be increasing for Black males, particularly those younger than 12 years old. There is an urgent need for local leaders to identify the prevalence and patterns of young Black male suicide in their cities and counties and to launch prevention strategies targeting the most critical areas of risk. The following report surveys the existing suicide literature to help local leaders understand the prevalence of suicide among young Black males, current suicide trends, major risk and protective factors, and evidence-based interventions for reversing the rise in suicides among Black boys.

Methods

The research scan conducted for this report involved a scan of the peer-reviewed research literature using multiple academic databases. The scan involved a search for meta-analyses, systematic reviews, and individual empirical studies related to the prevalence, patterns, risk and protective factors, and interventions for preventing suicides and deaths among children, adolescents, and young adults. Studies that specifically addressed risk factors, protective factors, and interventions to prevent suicide among Black males were identified and prioritized for inclusion in this report. All research scans were conducted between May 1, 2018 - March 1, 2019 and October 1, 2021 - November 15, 2021.



Prevalence of Suicide Among Young Black Males

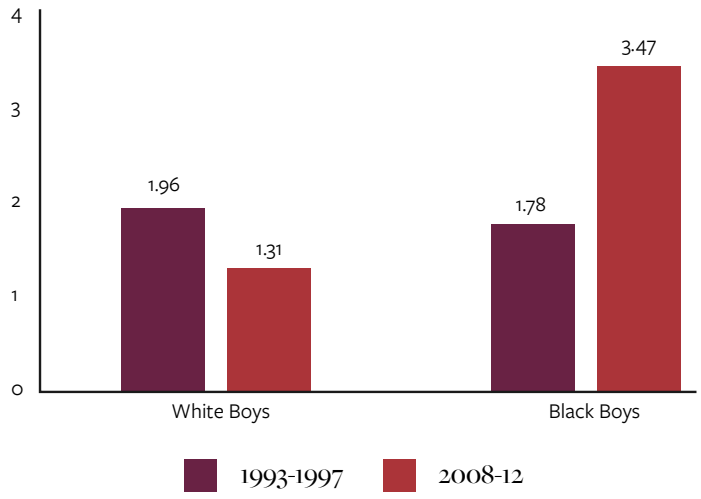
Suicide rates among Whites in America have traditionally been higher than those among African Americans, but recently, younger Black males have, sadly closed this gap.[1] An alarming trend captured in recent studies shows that suicide rates are increasing sharply for Black boys younger than age 14.

Suicide rates have nearly doubled among young Black children ages 5-11, especially boys, while decreasing among young White children

The suicide rate for Black children ages 5-11, though small compared to the rate among other age groups, rose 87%, from 1.36 per million (1993-1997) to 2.54 per million (2008-2012). For White children, rates for this same period showed a decline of 32% from 1.14 to 0.77 per million.[2] Analysis of differences based on sex and race showed that only the differences between Black and White boys were statistically significant (White: 1.96 to 1.31 per million; Black: 1.78 to 3.47), as shown in Figure 1. There were also regional differences reported by the CDC, with the largest increase in the suicide rate (214%) occurring for Black males who lived in the South. The most recent data available as of December 2021 showed that between 2010 and 2019, the rate of suicide deaths among Black children younger than 12 increased 95%, effectively doubling.[3]

FIGURE 1

Suicide Rates per Million for Black and White Boys ages 5-11 (1993-7 to 2008-12)



Suicide rates have increased by 80% among Black boys ages 10-14

The suicide rates for Black boys ages 10-14 have also spiked. Between 1999 and 2014, suicide rates for pre-adolescent and early adolescent Black boys increased by 80% while rates for White boys in the same age range increased by 50%.[4] More recent data on suicide deaths for Black children ages 5-14 shows that this trend of increasing suicide rates continued through at least 2017.[5]

Figure 2: Suicide Rates per 100,000 for Black and White Boys ages 10-14 (1999 to 2014)

FIGURE 2

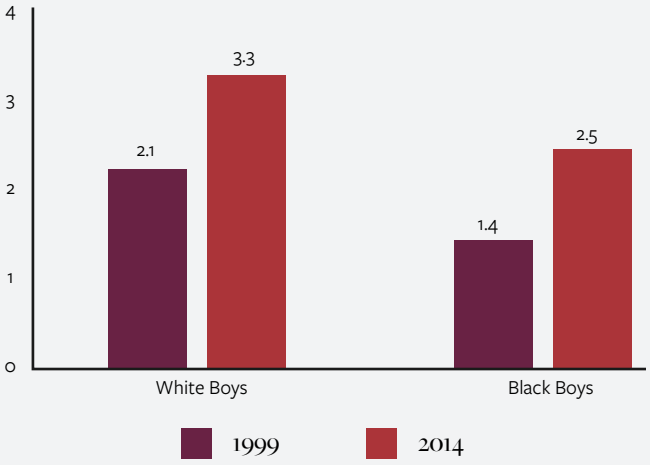
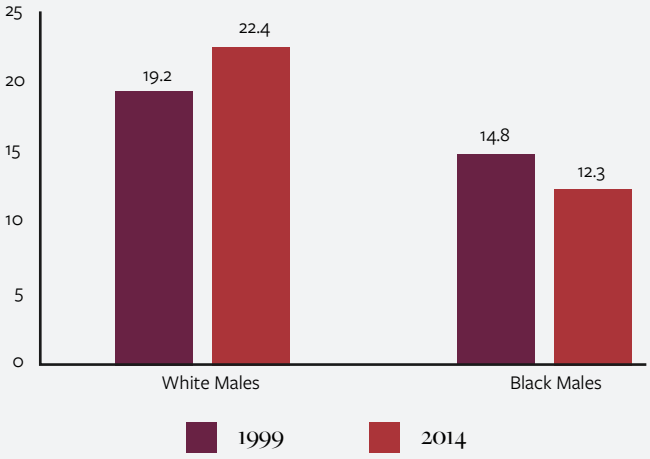


FIGURE 3



Suicide rates have decreased somewhat for Black males ages 15-24

Rates of suicide deaths declined by 17% for Black males in late adolescence and early adulthood between 1999 and 2014. However, rates of suicide among adolescents are generally 50 times higher than suicide rates among children younger than 12.[6] In contrast to older youth, for Black youth between the ages of 15 and 17, recent evidence has shown an increase in their number of suicides.[7]

Figure 3: Suicide Rates per 100,000 for Black and White Males ages 15-24 (1999 to 2014)

Although females attempt suicide twice as often as males roughly three to six times as many males actually die from suicide.[8] In 2014, males accounted for 80% of Black deaths from suicide.[9] This extreme difference in death rates indicates something fundamentally different about the methods and motivations of suicide attempts between young males and females.

The Problem of Misclassification of Black Suicides

There are reasons to believe that suicide rates among Blacks are higher than reported, and only a few studies have explored the reasons for this underestimation.[10] That Whites have historically died by suicide at higher estimated rates than Blacks, despite Blacks having higher numbers and levels of risk factors, is a paradox that could be explained by what is described as "misclassification bias." Researchers have found that medical and legal authorities are more likely to misclassify Black suicides than they are to misclassify White suicides, leading to a potential undercount of actual suicide prevalence among Blacks.[11] A recent national study examining suicide deaths among children and youth ages 10-19 found that Black children were significantly more likely than White children to receive a manner-of-death classification of "undetermined intent." No such statistically significant difference was found between White and American Indian/Alaska Native, Latino or Asian/Pacific Islander children.[12]

Risk Factors for Suicide Among Black Males

While it is understood that multiple triggers, causes, and risk factors interact in instances of suicidal behavior, the importance of or influence of one factor over another is unknow. Furthermore, in longitudinal studies, the diagnostic accuracy of risk factors identified in the research is only slightly better than chance as a predictor of who will engage in suicidal behavior.[13]

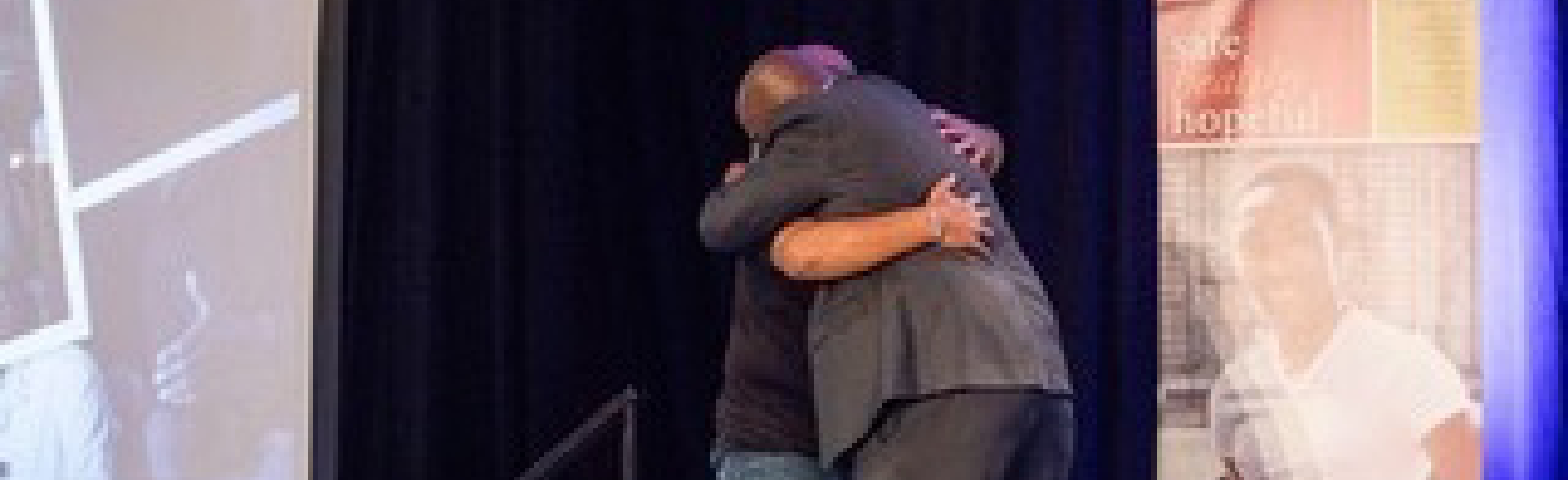
Recent trends in suicide among Black males show that age matters in assessing suicide risk. Adolescents and young adults have higher overall risks for suicide compared to young children. However, young children have shown a sharp rise in suicide rates in recent years. Therefore, assessing suicide risk factors for young Black males should occur based on the stage of the life during which they occur. The section that follows compares the research literature on suicide risk factors for Black male children ages 5-11 and Black male adolescents and young adults ages 12-25.

Suicide Risk Factors for Young Children ages 5 to 11

The research literature on the epidemiology of suicide among young children is quite limited, because most suicide studies have excluded children younger than 10. Most findings regarding the precipitating circumstances or risks for suicide are derived almost exclusively from studies of adolescents and young adults.[14] Historically, child development practitioners believed that young children could not engage in suicidal thinking and behavior because they were too young to grasp the concept and finality of death. However, that belief has begun to change as a small but growing body of scientific literature indicates that children as young as preschool age can experience distress or despair significant enough for them to attempt to harm themselves or express a wish to die.[15] Significant findings from this literature help to identify an emerging set of risk factors that may help guide prevention efforts for this population.

In a study examining suicide deaths for 17 U.S. states between 2003 and 2012, researchers found that the precipitating factors for suicide differed for young children under age 12 and adolescents ages 14 to 17.[16] In particular, nearly two out of every five young children who died by suicide (37%) were Black, compared to roughly one in eight adolescents (12%). Young children were more likely to:

- die by hanging/suffocation than adolescents (81% vs. 64%)
- have **family conflict or friction that preceded suicide** (60% vs. 46%)
- die by suicide at home (98% vs. 88%)
- have **ADHD** (59% vs. 29%)



Importantly, in this study, researchers found **suicide among young children to be much less likely to be associated with depression or dysthymia than among adolescents (33% vs. 66%).**

The longitudinal Preschool Depression Study conducted in Washington state with children ages 3 to 7 found that suicidal ideation (thinking about suicide), was more common among boys and was highly associated with mental or behavioral disorders of the mother. Children who showed patterns of suicidal ideation were more than three times more likely to continue reporting suicidal ideation later in childhood even after controlling for demographic factors, psychiatric disorders (e.g., ADHD or oppositional defiant/conduct disorder) and later school-age psychiatric disorders.[17] Among the central conclusions of the study are that young children show remarkable persistence in psychological disorders from preschool years to middle childhood predisposing them to continued risk in suicidality as they age.[18]

Another study, in which researchers looked specifically at Black children under age 12 who were admitted to a psychiatric hospital in Southern California for suicidal ideation and/or attempting suicide, found a small set of critical risk factors evident in that population. Almost half of the 92 Black children who participated in the study had a history of out-of-home placement, more than half had a family member with a mental illness, 1/3 had a family member who engaged in substance abuse, and nearly half had experienced abuse or neglect.[19]

A review of risk factors across the few studies of suicidal behavior among young children that exist identified additional factors potentially crucial to prevention efforts: [20]

- **Previous suicide attempts:** young children that have attempted suicide are six times more likely to attempt suicide in adolescence
- **Presence of psychiatric disorders and psychopathology:** children displaying mood disorders (e.g., depression, anxiety), disruptive/conduct disorders, schizophrenia, and bipolar disorder are at elevated risk of engaging in suicidal behavior with greater severity of disorder symptoms being a stronger predictor of suicide risk
- **Preoccupation with death:** children who dream about, fear, or worry about death are at higher risk of suicidal behavior
- **Family history of psychopathology and suicidal behavior:** young children of adults that have attempted or died from suicide are at significantly elevated risk of attempting suicide themselves
- **Family disruption or maltreatment:** children whose parents divorce or separate, who are neglected or abused, or who were initially unwanted by their parents have been shown to be at increased risk of suicidal behavior.

Suicide Risk Factors for Adolescents and Young Adults ages 12-25

Adolescents and young adults exhibit much higher rates of suicidal thoughts and behavior than younger children. The lifetime prevalence of suicidal ideation, plans and attempts for a national sample of American adolescents was estimated to be 12.1%, 4.0% and 4.1% respectively.[21] Looking at Black adolescents specifically, a national study estimated their lifetime prevalence of suicidal ideation and attempts to be 7.5% and 2.7% respectively. According to this study, roughly half of Black adolescents that reported a suicide attempt had never met the criteria for a DSM-IV disorder by the time of their attempt.[22] Thus, relying on clinical criteria alone to screen for suicide risk among Black adolescents is liable to miss a substantial portion of those at risk.

Fortunately, there is a large body of research that examines multiple risk factors for suicide among adolescents and young adults. This section of the report will focus where possible on research studies that study Black adolescents and young adults, with a particular emphasis on studies that distinguish risk factors by gender.

Do Suicide Risk Factors for Adolescents and Young Adults Vary by Race?

While the literature is small, nationally representative studies have not found suicide risk factors to consistently differ by race.[23] The findings of one nationally representative longitudinal study on risk factors associated with suicidal behavior in young adults show that risk factors appear to be similar by race or ethnicity except for substance abuse, which seems to be a stronger suicide risk factor for Blacks.[24] The findings of one local longitudinal study show that suicide attempts among Black adolescents are less likely to be preceded by suicidal ideation than those of White adolescents.[25] Broadly speaking, the research literature does not point to any consistent differences in risk factors between Black and White adolescents and young adults, although, exposure to commonly identified risk factors might vary considerably.

Major Risk Factors for Adolescent and Young Adult Suicide

- Prior Suicide Attempt
- Suicidal Ideation
- Depression and Anxiety
- Child Trauma and Abuse
- Foster Care Placement
- Exposure to violence
- Lack of Family Support
- Risk-taking behaviors
- Early Alcohol Abuse
- Racial Discrimination
- Social Isolation

Major Risk Factors for Adolescent and Young Adult Suicide

The following risk factors were identified in the literature review as being among the consistent predictors of suicidal behaviors, particularly suicide attempts.

Prior Suicide Attempt: Suicide attempts are far more common than suicide deaths, and they are among the most reliable predictors of suicides. While nearly 70% of all youth suicide deaths had no previous suicide attempt, a prior suicide attempt increases the odds of dying from suicide in the future by almost 23 times.[26] Suicide survivors can be interviewed about their other risk factors and motivations, and the data collected can provide a rich source of information to help with suicide prevention efforts. In one study, 51 adolescents between the ages of 12 and 18 who had already made a suicide attempt were compared to 124 control patients who had not attempted suicide. A regression analysis of risk factors was used to rank multiple factors, and the strongest of these included insomnia, substance abuse, neglect, thoughts of suicide, failure at school, and the threat of separation from a parent.[27]

Suicidal Ideation: While thinking about suicide virtually always precedes a suicide attempt, it is not yet clear how thoughts of suicide can be quantified into risk assessments. In a study of 977 Black adolescents ages 11-18, researchers concluded that traumatic stress and suicidal thoughts predicted continued suicidal thoughts. These future ideations were correlated with the severity of the stress and the frequency of prior suicidal thoughts, and they became stronger with age.[28] This study showed that, like suicide attempts, suicidal thoughts could be a strong predictors of future suicides.

In another study, researchers followed a diverse sample of 506 high-school adolescents in New York City for up to 6 years and found that even after controlling for the presence of mood, anxiety, substance use disorders, and prior history of suicide attempts, there was a correlation between future suicide attempts and thinking about suicide often, seriously, and/or for a long time. Finally, a study focused specifically on 581 Black adolescents, followed longitudinally from ages 11 through 19, **showed that suicidal ideation peaked in the 7th grade and declined steadily in subsequent grades.**[29] An increasing trajectory of suicidal ideation was shown to predict subsequent suicide attempts, with the frequency and duration of suicidal ideation being most strongly associated with higher odds of future suicide attempts.[30]

Depression and Anxiety: Mental disorders are consistently among the strongest predictors of suicide attempts and deaths in young people.[31] While not all those who attempt suicide are depressed (nor are all depressed people at risk for suicide), a great deal of literature supports depression's connection to suicide attempts.[32] There is also ample circumstantial evidence of a link between depression and suicide, in that many adolescents who are hospitalized for self-harm as well as those who have died by suicide have been depressed.[33] In an assessment of risk factors among Black adolescents, Lyon and colleagues found that 81.6% of suicide attempters were depressed, while only 36.8% of the control group—who had not attempted suicide—were depressed.[34] Another study showed that symptoms of depression and substance abuse were the strongest predictors of suicidal behavior. Both factors are likely to be associated with suicidal behavior across race and sex.[35]

Depression is commonly associated with other psychological problems such as low self-esteem and anxiety.[36] The interacting psychologies of depression, low self-esteem, and anxiety were examined in a study of 176 Black High School students (61 males) that found that depression contributed to hopelessness and suicidal behaviors.[37] And a meta-analysis of the interactions among depression, anxiety, and suicide, conducted by Kanwar and colleagues, concluded that suicide rates are higher for patients suffering from any anxiety disorder except obsessive-compulsive disorder (OCD).[38]

Child Trauma and Abuse: Trauma is significantly associated with suicide attempts across racial groups; however, traumatic stress tends to be higher among lower-income children, and particularly among Black children.[39] A recently conducted meta-analysis was conducted to determine how different traumas influenced suicide attempts.[40] Sexual, physical, and emotional abuse, as well as physical neglect, were associated with increased probabilities of suicide attempts, while emotional neglect and divorce did not.

Another meta-analysis of 28 published articles concerning suicide in young people ages 10-25 found that there was a dose-dependent association between adversity and both thoughts of suicide and suicide attempts, with sexual abuse being among the most consistent triggers.[41]

Foster Care Placement: The reasons for placing children under the care of the state are varied, but most of them are traumatic for the child. Youth in group homes are seven times more likely to think about suicide, while children in foster care are three times more likely to consider suicide.[42] Evans found the prevalence of suicidal thoughts to be 24.7% in young people under the care of the state (including those at home with a parent or parents), compared to 11.4% in the control group.[43] Almost 4% of children ages 9-11 attempt suicide after being placed in foster care following abuse.[44]

Exposure to violence: Black and Latino youth living in high poverty urban environments witness or experience violence far more frequently than their suburban counterparts, and this is another kind of childhood trauma that is likely to increase suicidal behaviors.[45] Exposure to violence can include assault victimization; the murder of a friend or family member; witnessing violent acts such as stabbings, shootings, or beatings; and personal involvement in violence, including physical fights. These experiences are correlated with and contribute to other suicide predictors, including depression, anxiety, substance abuse, and violent behavior.[46] The more violence an adolescent is exposed to, the more vulnerable they are to suicide.[47] Moreover, national studies show that Black youth, particularly males, are at much higher risk of exposure to violence during adolescence and young adulthood than their White counterparts.[48] Black adolescents and young adults are 1.4 times as likely as Whites to be victims of violent crime, and Black males, in particular, are 19 times as likely as White males to experience nonfatal firearm victimization.[49] In addition, between 2004 and 2011, 21% of Black children experienced confirmed maltreatment by age 18, compared to 10.7%, 13%, 14.5% and 3.8% for White, Latino, American Indian, and Asian Pacific Islander children, respectively.[50]

A meta-analysis of 29 studies covering the population ages 12-26 found that different forms of violence had varying influence on suicide attempts, ranked (as odds ratios, smallest to greatest): community violence (1.48), dating violence (1.65), child maltreatment (2.25), and bullying (2.39).[51]

Lack of Family Support: Family support has long been considered an important protective factor against suicide. Lack of support from family is thus an important risk factor for suicide attempts.[52] While family support is strongly protective against suicide, evidence suggests that family structure is not central to this effect.[53] A recent study failed to find significantly reduced suicidality in two-parent homes for Black youth.[54] Instead, they found that family bonds and feelings of support, regardless of family structure, was protective. Furthermore, a nationally representative population study found that “child-reported family conflict” was one of the strongest predictors of suicidality.[55] In comparing psychiatrically hospitalized Black and White adolescent suicide attempters, interpersonal orientation and feedback and support from others was important to Black adolescents and differentiated single suicide attempters from multiple attempters.[56] For their White counterparts, only relative levels of suicide ideation were associated with the number of suicide attempts.

Risk-taking behaviors: Risk-taking behaviors were associated with suicide attempts in a study of 336 Black urban youth ages 12-16.[57] The study evaluated a common asset assessment questionnaire called the "Profiles in Student Life." Of 53 items on the questionnaire, 15 were found to differ between suicide attempters and non-attempters, and of these, 11 measured risk-taking behaviors. Violence, depression, and delinquent behaviors were associated with suicidal behaviors among these adolescents. The study's authors recommend that school personnel, parents, law enforcement, and community services should be aware of this suite of interacting behaviors that are associated with risk-taking.

Early Alcohol Abuse: A survey of Black adolescents ages 11-18 years was designed to assess suicide risk related to alcohol use.[58] Alcohol use was significantly associated with thoughts of suicide and suicidal attempts, but differences were noted based on age and frequency, with frequent alcohol use among younger adolescents having the greatest effects on suicidal attempts.

Racial Discrimination: The direct effects of discrimination, as well as the indirect effects of thinking about discrimination, can cause depression and its associated risk for suicide.[59] Blacks face greater discrimination than any other group, and perceptions of racism can be passed down from parents to children.[60] The experience of discrimination in mothers resulted in a 3.19 % increase in suicidality in Black male adolescents.[61] This effect was not significant in young women, suggesting different modes transmission of discrimination between boys and girls. A longitudinal study of Black youth (mean age 10.6) found that two years after they were first interviewed, racial discrimination had a direct effect on increasing thoughts of death.[62]

Social Isolation: Durkheim's classic work on suicide, Suicide: A study in Sociology, studied France in the 19th century and found that suicide was related to disconnectedness and that it varied "inversely with the degree of integration of the social groups of which the individual forms a part." Individual involvement in groups and institutions tends to strengthen compliance with social norms and provides meaning and purpose to life.[63] Measures of integration can be subdivided into structural (involvement in institutional collectives), and psychological (subjective feelings of connectedness), and both are important when explaining suicide.[64] A longitudinal study examining the density of the social networks of 1,819 Blacks found that after four years, controlling for demographics and depressive symptoms, individuals with less dense social networks were three times more likely to think about and/or plan a suicide.[65]

Protective Factors against Suicide for Black Males

While risk factors for suicidal behavior among adolescents and young adults are studied quite extensively, protective factors are explored far less commonly in the research literature, especially with respect to suicidal behavior among Black adolescents and young adults. A recent systematic review of 26 studies drawn from the suicide literature identified a limited number of factors that demonstrated an apparent protective effect for the risk of suicidal thoughts and behaviors among adolescents.[66] No such review of protective factors for young children could be identified.

Major Protective Factors Against Adolescent African American Suicidality

1. **Cohesive and Supportive Family:** Based on 13 studies, being connected to a cohesive and supportive family and a nurturing relationship with parents were found to be among the strongest protective factors against suicidality among Black adolescents. Familial factors not found to be protective include family structure, parental involvement, supervision/monitoring, parental social capital, and parental education.[67]

2. **Intrinsic religious or spiritual factors:** In seven studies, intrinsic religiosity, connections with a higher power, and a sense of spirituality were shown to be protective against suicidal behavior. However, church membership, the importance of religion to a person, and the frequency of prayer were not found to be protective against suicidality for Black adolescents. Specifically for urban Black adolescents, no religious-based factors were protective against suicidality.[68]

3. **Relational/Social Factors:** Drawing on 12 studies, several relational/social factors were found to be protective against Black adolescent suicidality, including perceived social support, dense school networks, attachment to school, and connections with supportive peers. Favorable school climate has also been shown to be protective. Factors not found to be protective included being popular and extracurricular activities.[69]

4. **Personal Factors:** Personal protective factors identified across 14 studies included higher self-esteem, emotional well-being, academic achievement, GPA, sense of hope, and adaptive attributional styles. School engagement was not found to be protective.[70]

5. **Socioecological Factors:** Drawing on seven studies, longer duration of time spent living in one residence and living in the same community for more than five years were protective against suicidality.[71]

Cohesive and supportive family

INTRINSIC RELIGIOUS OR SPIRITUAL FACTORS

RELATIONAL/SOCIAL FACTORS
E.G. SUPPORTIVE PEERS, ATTACHMENT TO SCHOOL

PERSONAL FACTORS
E.G. HIGH SELF-ESTEEM, ACADEMIC ACHIEVEMENT

SOCIOECOLOGICAL FACTORS
E.G. LIVING IN THE SAME COMMUNITY MORE THAN FIVE YEARS

Preventing Black Male Suicides: A Roadmap for Action

Preventing suicidal thoughts and behaviors among Black males is an urgent need that requires comprehensive, multi-model approaches operating across multiple prevention venues. The existing literature identifies three critical prevention sites that should form the basis of a comprehensive local strategy for suicide prevention for young Black males: schools, primary care settings, and emergency departments. In each context, prevention approaches should be organized around universal screening and detection, timely referral to evidence-based services, and timely intervention to prevent future suicidal behavior.

Cities and Community-Based Organizations

Cities and community-based organizations have a critical role to play to help better understand the local suicide problem, convene key stakeholders, and help organize a systemwide response:

1. **Understanding the Suicide Problem:** City leaders have an important role to play in gathering and interpreting data on potential suicide deaths for Black boys, adolescents, and young adults. Because Black males are more likely to have suicide deaths misclassified as having some other causes, interrogating the accuracy of publicly gathered data reported by coroners is a crucial first step. Efforts to make sense of suicide prevalence data should involve community-based organizations, especially service providers, to help identify what might be local drivers of suicide risk (e.g. child maltreatment).
2. **Convene Key Stakeholders:** City leaders can serve as essential conveners for bringing together other local leaders—including those from county departments, health systems, school systems, child welfare systems and community based organizations (CBOs) —to make sense of suicide data for young Black males and develop strategic priorities for addressing the problem where it exists.
3. **Help Organize a Systemwide Response:** In addition to convening key stakeholders, city leaders and community-based organizations can work multiple system stakeholders to create an integrated systemwide response to suicide risk by establishing efficient and consistent referral and treatment networks.

School-Based Prevention

A growing body of research indicates that most adolescents contemplating suicide or self-harm do not seek any health services. A systematic review of the existing literature found that across 17 studies, less than half of young people ages 26 and under sought professional help when thinking about or attempting suicide.[72] A majority sought informal help through their social networks of support. Blacks, whose communities are often underserved by mental health treatment providers, are even less likely than other groups to seek professional help with suicidal thoughts and behavior.[73] Black adolescents are only 65% as likely to use health services when thinking about or attempting suicide as White adolescents.[74] Furthermore, only 50% of Black adolescents who have attempted suicide had ever been diagnosed with a psychiatric disorder at the time of their attempt.[75] Even when help from others is sought, Black students may be less likely to discuss suicidal thoughts.[76] They may face elevated levels of stigma and embarrassment in seeking help and discussing their mental health.[77] The limited contact that suicidal young Black males have with professional mental health services means that schools are on the front line for suicide prevention for this population.

A recently completed meta-analysis reviewing school-based suicide prevention programs evaluated using randomized controlled trials found that, while few methodologically rigorous studies have been conducted in school settings, school-based suicide prevention programs appear effective at reducing subsequent self-harm in treated groups.[78] The evidence base, however, is profoundly limited concerning interventions that are shown to reduce suicide deaths. Two school-based programs—The Good Behavior Game and Signs of Suicide—have been shown to reduce suicide attempts, but not suicide deaths.[79] One study, a cultural adaptation of the Adolescent Coping with Stress Class, tested with 758 Black youth in grades 9-11 found a significant reduction in suicide risk, but not suicide deaths. The evaluation, however, did not include a control group so the program should only be considered promising.[80]

While there is a dearth of school-based programs are proven to reduce suicide deaths, especially among Black males, schools serve a potentially critical role in screening for suicide risk among student populations. A group of researchers suggests that schools adopt a framework for suicide prevention modeled on "Multi-tiered Systems of Support" (MTSS) as described in the school literature.[81] MTSS differentiates screening and services into three tiers:

1. **Primary (Tier 1):** Tier 1 programs target all students within the school population through universal screening and education about suicide.

    - **Staff Training:** This tier requires training school staff and students to be able to identify suicide risk in students, especially in middle school, when suicidal ideation peaks in children. So-called "gatekeeper" training programs teach staff and students to recognize warning signs and help-seeking behaviors that should trigger supportive intervention. Examples of gatekeeper training programs for school personnel include Applied Suicide Intervention Skills Training (ASIST) (https://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist) and Question, Persuade, Refer (QPR) (https://qprinstitute.com/).
    - **Student Education:** Tier 1 also includes programs for students that include awareness activities, curricula, and skill-building activities. One of the most researched universal prevention programs is Signs of Suicide (https://www.sprc.org/resources-programs/sos-signs-suicide), which educates students on how to respond to signs of suicide among themselves or their peers. For young children, The Good Behavior Game is a promising solution for reducing suicide attempts.[82]
    - **Universal Screening:** Signs of Suicide includes an optional screening component. Columbia TeenScreen, a suicide screening tool specifically tested with African American adolescents was implemented at 13 middle and high schools in Washington, DC.[83]

2. **Secondary (Tier 2):** Tier 2 programs identify and support students at elevated risk for suicide as established through universal screening. For these students, additional risk assessment and timely referral to mental health services, preferably within school environments, is critical. Tier 2 programs for youth at elevated risk include Reconnecting Youth (RY) (https://www.sprc.org/resources-programs/reconnecting-youth-peer-group-approach-building-life-skills) and Coping and Support Training (CAST) (https://www.sprc.org/resources-programs/cast-coping-support-training). In addition to suicidal behavior, these programs target youth at risk of school failure or dropout.

3. **Tertiary (Tier 3):** Tier 3 programs target high-risk students who are showing current or prior suicidal behavior. For students demonstrating imminent suicidal risk, the timely application of therapeutic interventions in a health setting is essential. Therapeutic interventions with demonstrated efficacy for reducing self-harm in adolescents include dialectical behavior therapy (DBT) (https://www.sprc.org/resources-programs/dialectical-behavior-therapy), cognitive-behavioral therapy (CBT) (https://www.sprc.org/resources-programs/cognitive-therapy-suicide-prevention) , and mentalization-based therapy (MBT).[84] These therapeutic modalities could be implemented in schools, a community-based setting, a health services clinic.

Primary Care Prevention

Primary care is increasingly becoming a critical prevention setting for suicide in children and adolescents.[85] By some estimates, about half of those who die by suicide visit their primary care provider within one month of doing so.[86] The passage of the Affordable Care Act has significantly expanded the scope of primary care for supporting socio-emotional health and wellbeing for children and adolescents.[87] Psychologists, moreover, should play a more significant role in primary care settings to help with screening and implementing preventative, therapeutic services. A recent review of the suicide interventions in primary care identified four major components to extant program models:[88]

1. Educating providers
2. Screening for suicide risk
3. Managing symptoms of depression
4. Assessing and managing suicide risk

The Pennsylvania Youth Suicide Prevention in Primary Care (YSP-PC) model is one promising program model that targets adolescents and incorporates both provider education and screening for suicide risk. YSP-PC is a multi-component program that provides suicide training for primary care practitioners and referral clinicians as well as a screening system for identifying suicide risk. The screening tool—The Behavioral Health Screen-Primary Care—is a web-based tool that contains a 55-item, comprehensive health assessment that takes about 10 minutes to complete. The program model has yet to be evaluated using a randomized controlled trial, but the model offers a promising framework for coordinating adolescent suicide prevention care in primary settings.[89]

Emergency Department Prevention

Emergency departments are the third critical site for suicide risk detection and prevention. Universal screening for suicide risk in emergency departments is essential for ensuring timely intervention for a population that has been shown to have an elevated risk for suicide. A recent study found that the administration of the Ask Suicide-Screening questionnaire (ASQ) in emergency departments to a sample of 10- to 12-year-old patients resulted in a positive screen rate for suicide of 29.1%. More than half (54%) of patients presenting with psychiatric chief complaints screened positive for suicide risk, while 7.1% of patients presenting with a medical chief complaint. A similar study that administered the ASQ to a sample of 970 pediatric patients found that 53% of the patients who screened positive for suicide risk did not present to the emergency department with a suicide-related complaint. Furthermore, the patients that fell into this group were more likely to be male, African American, and have externalizing behavior diagnoses (e.g. "acting out," aggression, fighting).[90] The ASQ screening tool was able to predict 43% of return visits to the emergency department with suicide-related presenting complaints within six months of the screening visit.

Evidence-based emergency department interventions for adolescents at risk of suicide are quite limited. Two interventions have demonstrated some effectiveness in reducing suicide deaths and suicide attempts. The first, The Youth-Nominated Support Team—Version II (YST), is a "psychoeducational, social support intervention" for adolescents who had suicidal ideation or attempts after psychiatric hospitalization. In the program, adolescents nominate "caring adults" who meet with YST intervention specialists to learn about the adolescents' psychological wellbeing and treatment plan and to learn how they can provide support. Caring adults have regular contact with the youth and program staff for three months. An initial randomized controlled trial found that YST resulted in a reduction in the severity of suicidal thoughts at a 6-week follow-up. At a 12-month follow-up, YST was associated with a mortality rate in the treatment group 50% lower than in the control group.[91] While this study is small, these results are promising and suggest that a social support approach might be an important adjunct to therapeutic interventions for adolescents.

The second intervention with demonstrated effectiveness for reducing suicide attempts specifically for Black male adolescents is called Multisystemic Therapy (MST). A study of MST administered to youth ages 10-17 who were hospitalized in the emergency psychiatric unit of a medical center due to suicide-related presenting complaints found a significant reduction in suicide attempts and ideation. The study sample, 65% male and 65% Black, showed a 27% reduction in suicide attempts for the treatment group at the 1-year follow-up. Suicidal ideation was also reduced by 41% after one year.[92]

For young children ages 5 to 11, there are virtually no evidence-based treatments for their suicidal risk. A 2016 review could find only one such treatment involving only 11 children in a feasibility study that did not provide outcome evidence.[93] Given the rise in suicidal deaths for young Black boys, developing new treatments or adapting existing ones for this population is of the greatest urgency.

Conclusion

The longstanding problem of adolescent and young adult Black male suicide appears from trend line data to be improving, but the problem of misclassification may obscure actual patterns, calling for greater attention to this issue. The problem of suicide among children younger than 12 has emerged as a crisis in the past two decades and requires an urgent spotlight, given that young Black boys comprise a disproportionately large share of these deaths. While we have some evidence regarding the potential suicide risk factors for young children, we don't have evidence-based interventions to turn to. For adolescents and young adults, we have a robust evidence base of potential risk factors, but a relatively limited set of preventative interventions with demonstrated efficacy. Utilizing those interventions that show promise in reducing suicidal risk among adolescent Black males, local leaders have a critical role to play in building a detection and prevention system across schools, primary care offices, and emergency departments that can help young Black males in moments of crisis weather the storm.

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