African American Youth Suicide: Report to Congress

U.S. Department of Health & Human Services
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Contents

Abbreviations

ACE	Adverse Childhood Experience
ACF	Administration for Children and Families
AHRQ	Agency for Healthcare Research and Quality
CBC	Congressional Black Caucus
CDC	Centers for Disease Control and Prevention
HHS	U.S. Department of Health & Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IOM	Institute of Medicine (now National Academy of Medicine)
NIH	National Institutes of Health
NRC	National Research Council
NVDRS	National Violent Death Reporting System
SAMHSA	Substance Abuse and Mental Health Services Administration
YRBSS	Youth Risk Behavior Surveillance System

Executive Summary

Congress requested the Department of Health and Human Services (HHS) to submit a report examining reasons for why Black children aged 5 to 12 are dying by suicide at nearly twice the rate of their White counterparts. To supplement the limited research that investigated reasons for higher suicide rates in Black children compared to White children, we analyzed National Violent Death Reporting System (NVDRS) data between 2014–2017, to examine the risk and precipitating factors in 274 non-Hispanic Black children and 1992 non-Hispanic White children aged 10 to 17, who died by suicide. Compared to their White peers, Black youth had higher rates of experiencing a crisis in the two weeks prior to their death by suicide, had a family relationship problem, argument or conflict and a history of suicide attempts. In contrast, Black youth had lower rates of a current known mental health problem, current depressed mood, a history of suicidal thoughts or plans, and either a past or current treatment for mental illness compared to White youth. Lower rates of current or past mental health problems despite higher rates of past suicide attempts suggests that Black youth have limited access to and/or utilization of mental health services. Early detection and mitigation of modifiable risk factors for suicide, including identification and treatment of mental health issues, interpersonal problem-solving skills training, and family-based interventions that improve interactions are critical components of evidence-based suicide prevention interventions in Black children and youth. Prevention of the downstream outcome of death by suicide in Black children and youth cannot be achieved without actively addressing the upstream risk factors such as healthcare disparities, and social determinants of health including racism.

Introduction

This report responds to the following language from H. Rept. 116-62, which was incorporated by reference in the explanatory statement accompanying the FY2020 Further Consolidated Appropriations Act (P.L. 116-94):

> *African American Children and Suicide.—The Committee is concerned that the suicide rate among children aged 10 to 17 increased by 70 percent between 2006 and 2016. The Committee is also concerned that African American children aged 5 to 12 are dying by suicide at nearly twice the rate of their white counterparts. Accordingly, the Committee directs the Office of the Surgeon General to submit a report on this pressing public health issue, within 90 days of enactment of this Act, including an examination of factors that may be causing this disparity as well as evidence-based interventions. The Surgeon General should collaborate with the CDC, SAMHSA, ACF, the National Institute of Minority Health and Health Disparities, the National Institutes of Mental Health, and the National Institute of Child Health and Human Development, as appropriate.*

This report builds on and augments the excellent, recent publication by the Congressional Black Caucus (CBC) Emergency Taskforce on Black Youth Suicide and Mental Health, "*Ring the Alarm: The Crisis of Black Suicide in America."* Consistent with the CBC report, the present report uses the term *Black* to include not only "African Americans but also individuals from the continent of Africa, the Caribbean, and other parts of the world with African ancestry who are living in the United States" (CBC, 2019, p. 29). We concur with the findings and recommendations of the CBC report and have highlighted additional aspects to augment the risk factors and treatment sections.

The Office of the Assistant Secretary for Health with the Office of the Assistant Secretary for Planning and Evaluation convened relevant HHS subject matter experts on youth suicide to respond to this Congressional request and build on the recent CBC report. Subject matter experts from the National Institutes of Health (specifically, the *Eunice Kennedy Shriver* National Institute of Child Health and Development [NICHD]) contributed to the epidemiology section (also see Appendix A), the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration contributed to the risk factors and precipitating factors section (Appendix B), the National Institute of Mental Health contributed to the evidence-based treatment section (Appendix C), and all relevant agencies contributed to a compilation of HHS Youth Suicide Prevention Initiatives (Appendix C). The National Institute on Minority Health and Health Disparities (NIMHD), Administration for Children and Families (ACF), HHS Office of Minority Health (OMH) and Agency for Healthcare Research and Quality (AHRQ) provided input and review.

Youth Suicide Demographics and Epidemiology

NICHD analyzed death data for children aged 10 to 17, between 1999 to 2018, and found that suicide rates for non-Hispanic Black children increased by 87% while the suicide rates of death by for all children increased by 76% (Table 1, Figure 1). The racial and ethnic disparities in youth suicide, specifically Black, American Indian/Alaskan Native Non-Hispanic and Asian/ Pacific Islander Non-Hispanic youth are illustrated below. Additional research (Bridge et al., 2018) confirmed that the suicide rate (2001 -2015) in Black children aged 5 to 11 was twice the rate of White children.

Table 1: Rates of Death by Suicide and Proportion of Overall Deaths Due to Suicide in 1999 and 2018, U.S. Children Aged 10 to 17

	Suicides per 100,000		% Increase in Suicide Rate	% of Overall Deaths Due to Suicide	
Race/Ethnicity of children aged 10 to 17	1999	2018	1999 to 2018	1999	2018
All Children	3.1	5.5	76%	9%	23%
Black, non-Hispanic	**2.1**	**3.9**	**87%**	**5%**	**11%**
White, non-Hispanic	3.5	6.5	85%	11%	29%
Hispanic	2.3	3.8	63%	8%	20%
Asian and Pacific Islander, non-Hispanic	2.0	4.8	140%	9%	32%
American Indian/Alaska Native, non-Hispanic	7.8	18.3	133%	17%	40%

*Source: National Vital Statistics System

Figure 1: Crude Suicide Rates by Race/Ethnicity, 1999 – 2018, U.S. Children Aged 10 to 17
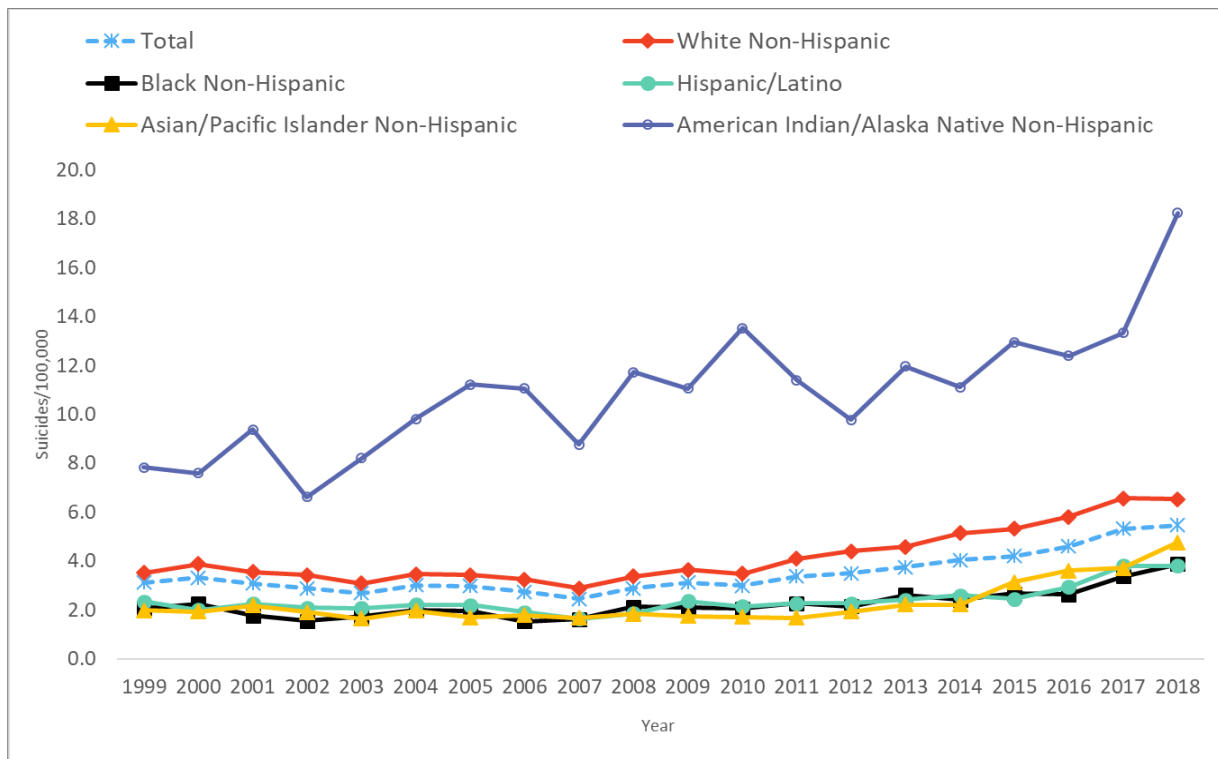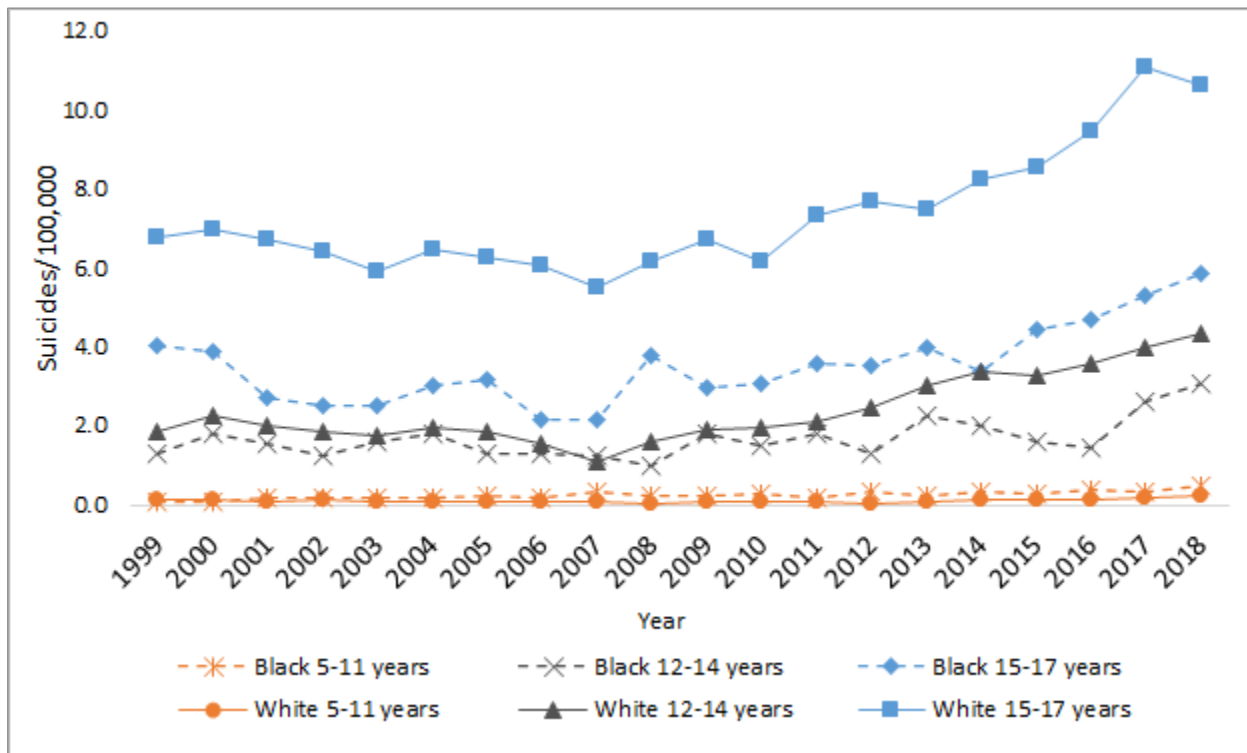

*Source: National Vital Statistics System

Misclassification of the cause of death in children and youth introduces errors in the calculation of the rate of death by suicide. Suicides are more likely to be misclassified among youth than among adult populations (Crepeau-Hobson, 2010), and Riddell, Harper, Cerda, and Kaufman (2018) note that suicides (and homicides) may be misclassified as deaths due to unintentional injury (accidents). Rockett et al. (2010) speculate that suicide misclassification "might explain much of the African American-White suicide rate gap," a hypothesis supported by our analyses of mortality data, which show that rates of death due to unintentional injury among younger Black children were, on average, 1.6 times greater than rates among non-Hispanic White children between 1999 and 2018. De Leo (2015) states, "Despite the clear need for reliable mortality data related to it, suicide possibly remains one of the most under-

reported causes of death worldwide (it is rarely over-enumerated)." Mohler and Earls (2001) argue one factor leading to underestimates of suicide is that coroners' decisions may be affected by factors "such as insurance benefits and religious or social stigmas of suicide" and that some apparent increases in suicide rates are actually due to decreasing misclassification.

For a detailed discussion of data issues affecting the collection, classification, the scientific limitations of analyzing suicide rates in children aged 5 to 12, and calculation of the rate of suicide in Black children and youth, please refer to Appendix A, Table A-3 and Table A–4. Additional information on demographic and epidemiological factors are provided in Appendix A.

Figure 2: Suicide Rates Among Black & White Youth (all ethnicities) by Age—United States, 1999-2018

Source: National Vital Statistics System

Risk Factors Associated with Higher Suicide Rates among Black Compared to White Youth

The CBC report comprehensively reviewed several factors that increase the risk of death by suicide in Black children. Findings from research published since the CBC report and results of new analysis conducted for the purposes of this report are included below.

Lee and Wong (2020) used NVDRS data to examine racial, ethnic and gender differences in risk factors in youth aged 10 to 18 prior to their death by suicide. Interpersonal problems were the most prevalent risk factor for death by suicide across White, Black, Native American, Asian American, and Latinx youth with the exception of White female decedents who had the highest rates of current mental health problems. White youth had the highest rates of current mental health problems and treatment at the time of death compared to other racial/ethnic groups. Black decedents were less likely to have a previous history of suicide attempt compared to their White counterparts.

However, a CDC study that analyzed Youth Risk Behavior Surveillance System (YRBSS) data found that Black youth had higher rates of suicide attempts compared to White youth, while White youth had higher rates of suicidal ideation compared to Black youth (CDC, 2018).

Compared to early adolescents (aged 12-14) who died by suicide, children (aged 5-11) who died by suicide were more commonly male, black, more likely to have relationship problems with family members and friends, had higher rates of attention deficit hyperactivity disorder and died by hanging/strangulation/suffocation at home (Sheftall et al 2016). Lack of significant differences in precipitating circumstances, suicide related circumstances, including history of suicide attempts, and mental health characteristics between 32 Black children aged 5-11 years compared to 55 non-black children were most likely due to small samples sizes from NVDRS data from only 17 states (Sheftall et al 2016).

Additional risk factors for suicide in Black youth are social determinants of health including lower socioeconomic status, lower educational achievement, unemployment, living in high poverty neighborhoods and homelessness (WHO, 2014). Gattis and colleagues (2016) examined the prevalence of depression and suicidality in Black youth experiencing homelessness and found high prevalence rates of depressive symptoms and suicidality. Tobler and colleagues (2013) examined data from over 2,400 minority youth and found that youth who had experienced racial/ethnic discrimination were at greater risk for depression and more likely to report suicidal thoughts.

Liu et al (2020) assessed the relationship between adverse childhood experiences (ACEs) and health outcomes in 30,668 Black (10.4%), Latinx (12.3%), and White youth (77.3%) aged 12 to 17, using data from the 2011-2012 National Survey of Children's Health. ACEs included any of the following: (a) financial hardship, (b) parental divorce/separation, (c) parental death, (d) parental imprisonment, (e) witness to domestic violence, (f) victim or witness of neighborhood violence, (g) lived with mentally ill/suicidal person, (h) lived with someone with alcohol/drug problem, and/or (i) treated unfairly because of race/ethnicity. Greater levels of adversity correlated with worse health status while access to protective factors in school, family and community was associated with better health. Compared to Black youth, White youth had consistently fewer ACEs, more protective factors and better health.

 Since very few studies study directly compared risk factors and precipitating factors in Black and White youth who died by suicide, for this report, the CDC team analyzed risk and precipitating factors in youth decedents who died by suicide between 2014–2017, using the NVDRS data from 35 states. Death certificates, police reports and coroner/medical examiner reports of NVDRS data of children who died by suicide were reviewed and analyzed to respond to the current Congressional request.

There are several important considerations when examining suicide among younger children aged 5 to 12. First is the risk of misclassifying cause of death, since determining suicidal intent in younger children can be difficult (Crepeau, 2010). Second, some medical examiners/coroners may be reluctant to name the cause of death in children, especially those aged younger than 10, as suicide. Third, the misclassifications likely change over time, introducing errors when combining cases over multiple years. Finally, the issue of unstable and unreliable rates due to low sample sizes and missing data in NVDRS are especially important when evaluating circumstances associated with suicides. In one study of suicide circumstances among elementary school-aged children using NVDRS, approximately 13% of the decedents were missing information regarding the circumstances prior to the death by suicide (Sheftall et al., 2016). Therefore, to preserve the scientific integrity of this analysis, the circumstances preceding death were evaluated only in children and youth aged 10 to 17.

Circumstances preceding death by suicide in Black versus White youth are presented below, while comparison between Black youth and youth from all other races are presented in Appendix B. The stressors and precipitating factors that occurred prior to the death listed below are not mutually exclusive.

Table 2. Circumstances preceding suicide among non-Hispanic Black and White children aged 10 to 17 —United States, 2014–2017*,*

	Non-Hispanic White (n=1,992)	Non-Hispanic Black (n=274)
Crisis in preceding or upcoming 2 weeks	37%	42%
Family relationship problem	31%	39%
Current mental health problem	50%	37%
Ever treated for mental health problem	45%	33%
History of suicidal thoughts or plans	36%	27%
Argument or conflict	21%	27%
Person left a suicide note	42%	26%
Other suicide circumstance	22%	26%
School problem	27%	25%
Current treatment for mental illness	36%	24%
History of suicide attempts	21%	23%
Current depressed mood	34%	22%
Disclosed intent to commit suicide	24%	19%
Intimate partner problem	22%	16%
Other relationship problem (besides family)	9%	7%
Other death of friend or family member	5%	5%
Victim had history of abuse/neglect as a child	5%	5%
Other substance abuse problem	10%	4%
Recent criminal legal problem	5%	4%
Suicide of friend or family member in past 5 years	5%	4%
Physical health problem	3%	3%
Previous perpetrator of violence in the past month	1%	2%
Physical fight between 2 people	1%	2%
Other legal problems	1%	1%
Caretaker abuse/neglect led to death	1%	1%
Eviction or loss of home	1%	1%
Alcohol dependence	3%	1%
Financial problem	1%	1%
Previous victim of violence in the past month	1%	1%
Anniversary of traumatic event	1%	0%
Job problem	1%	0%
Exposure to disaster	0%	0%
Victim had other addiction (e.g., gambling, sexual)	1%	0%
Other undetermined circumstance	0%	0%

* Analysis uses data from National Violent Death Reporting System (NVDRS) accessed via WISQARS (Web-based Injury Statistics Query and Reporting System), available at https://www.cdc.gov/ncipc/wisqars/nvdrs/DataElements-ReportOptions.htm.
**A decedent can have more than one circumstance.

Taken together, a higher proportion Black youth who died by suicide experienced the following stressors prior to death by suicide compared to their White peers (Table 2):

- Crisis in the preceding two weeks
- Having a family relationship problem
- Argument or conflict
- History of suicide attempts
- Other suicide circumstances:
  - Event where a crisis is related to a death AND not routinely captured by any of the existing NVDRS circumstances. This might include factors like housing instability, history of non-suicidal self-injury/self-harm, or history of traumatic brain injury.

In contrast, a lesser proportion of Black youth had:

- A current, known mental health problem or a current known mental disorder
- Current depressed mood
- A history of suicidal thoughts or plans, although a marginally higher proportion of Black youth suicide decedents had a history of suicide attempts
- Either a past or current treatment for mental illness.

Previous research by the CDC found that non-Hispanic White decedents had higher rates of mental health diagnosis and mental health treatment compared to racial/ethnic minority youth. However, Black youth had higher rates of suicide attempts compared to White youth and also when compared to all youth (CDC, 2018).

As highlighted in the CBC report, Black youth are also less likely to receive care in diverse sectors, such as school-based services and child welfare (Lyon et al., 2013; Locke et al., 2017). Increases in the number of mental health visits per Federally Qualified Health Center (FQHC) patient corresponded with fewer outpatient psychiatric Emergency Department (ED) visits among Black youth, relative to White youth, suggesting poor follow-up with outpatient mental health after a psychiatric emergency (Bruckner et al., 2020)). Increased social risk factors and untreated and undertreated mental health conditions among minority youth also contribute to costly and disproportionate rates of mental health severity, burden, and persistence among minority adults (Butler & Rodgers, 2019).

Taken together, the lower rates of known current or past mental health problems or diagnoses in Black youth, despite higher rates of past suicide attempts and interpersonal/family problems, support the likelihood that Black children and youth have limited access to and/or utilization of mental health screening and treatment services (Office of the Surgeon General, 2001). It is unlikely that Black youth are less likely to develop mental health issues. Early detection and mitigation of mental health issues and other risk factors for suicide while simultaneously bolstering protective factors are key components of evidence-based suicide prevention interventions in Black youth (Office of the Surgeon General, 2001). Our results also highlight the need for interpersonal problem-solving skills training, improving emotional skills, family-based interventions, addressing healthcare disparities and social determinants of health, especially for Black youth.

Additional descriptions of risk and precipitating factors and protective factors are listed in Appendix B.

Descriptive analysis of suicide mechanism using the National Vital Statistic System: Data from the National Vital Statistics System (NVSS) from 2000 to 2018 were analyzed to examine mechanism of suicide by race and ethnicity (Figure 3). Among racial/ethnic minority children aged 10 to 17, most deaths were by hanging, suffocation, or strangulation, followed by firearms. However, among White children of the same aged, the order was reversed, with suicide via firearm being most common, followed by suffocation. The implications of the mode of death for suicide prevention are discussed in the next section.

Figure 3: Mechanism of suicide by race and ethnicity among children aged 10 to 17—United States, 2000–2018
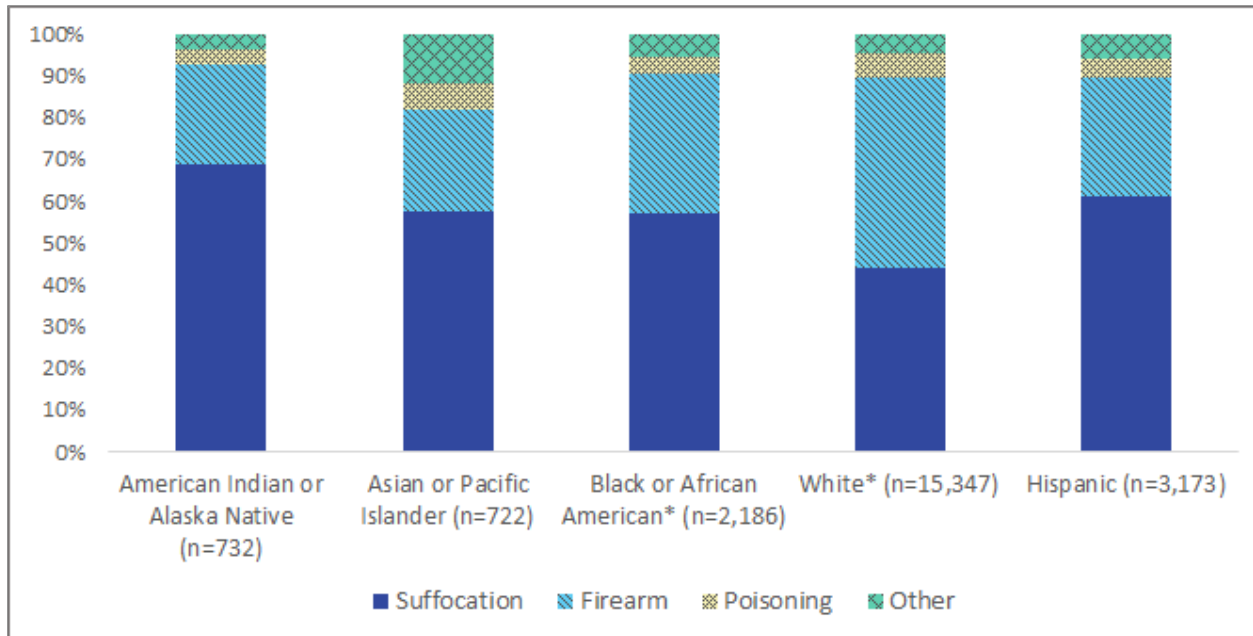

*Non-Hispanic
Note: Suffocation includes deaths by hanging.
Source: NVSS

Suicide mechanism among Black children fluctuated over time (Figure 4), with no consistent pattern. In 2000 and 2002, half of suicide deaths resulted from firearm use. In the years since, the leading mechanism has been suffocation, ranging from 48% in 2016 to 70% in 2010 and 2013. In 2018, 51% of Black youth suicides were from suffocation.

Figure 4: Mechanism of suicide among non-Hispanic Black children aged 10 to 17, by year—United States, 2000–2018
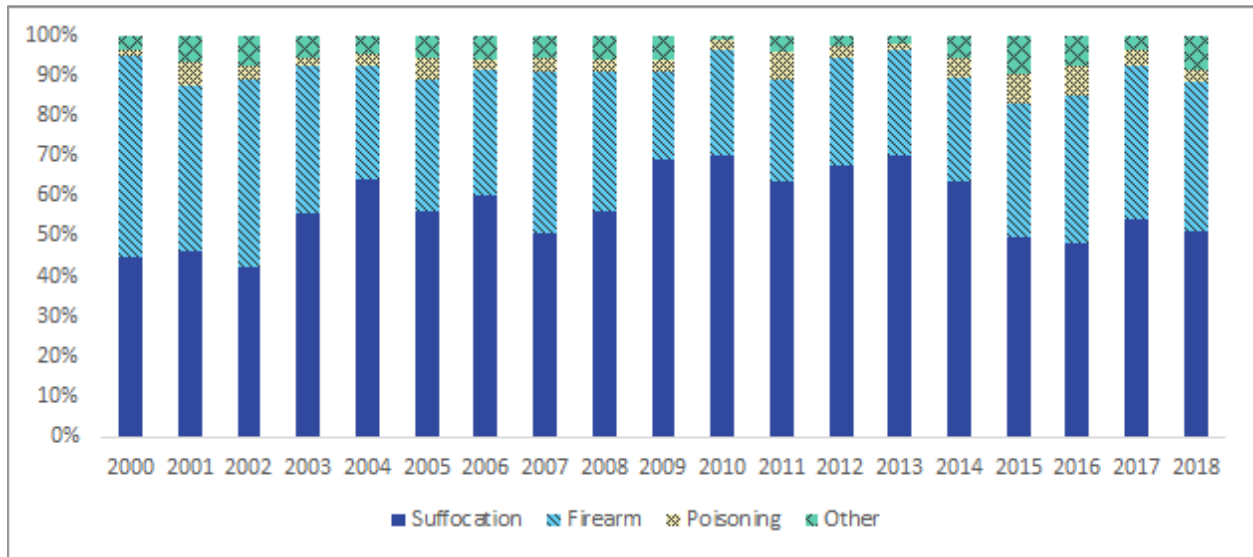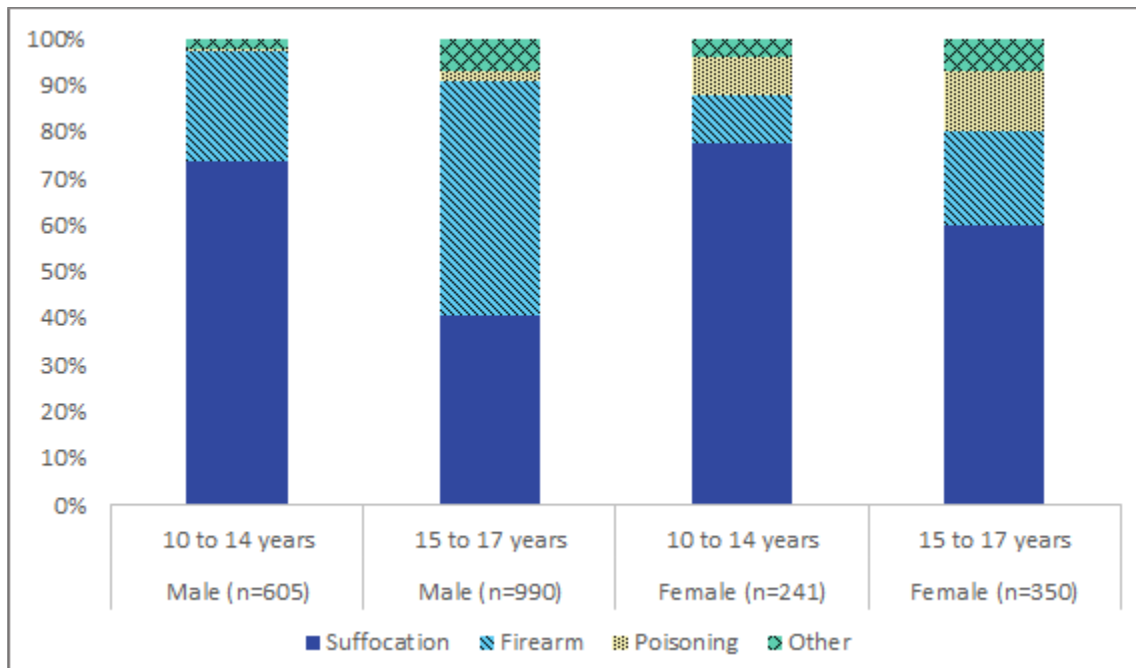

Note: Suffocation includes deaths by hanging.
Source: NVSS

Among Black youth, mechanism differed by sex and age (Figure 5). Half of Black males aged 15 to 17 utilized firearms. In contrast, firearms were utilized by only a quarter of Black males aged 10 to 14, and fewer than one in five Black females.

Figure 5 Mechanism of suicide among non-Hispanic Black children aged 10 to 17, by age and sex—United States, 2000–2018

Note: Suffocation includes deaths by hanging
Source: NVSS

Evidence-Based Interventions to Prevent Youth Suicide Ideation and Behavior

This section uses the U.S. National Strategy for Suicide Prevention's (NSSP; HHS 2012) comprehensive, public health framework that includes opportunities for intervention in healthcare settings and the community. Supporting this National Strategy, the CDC developed a suicide prevention technical package that aims to identify community strategies to strengthen economic supports; strengthen access and delivery of suicide care; create protective environments; promote connectedness; teach coping and problem-solving skills; identify and support people at risk; and lessen harms and prevent future risk (Stone et al., 2017). Consistent with the NSSP and the CDC technical package, this report describes a variety of evidence-based interventions and in-progress studies of interventions. Interventions described in this section are not intended to summarize systematic reviews of the broader youth suicide prevention literature (e.g., Calear et al., 2016; Robinson et al., 2018). Rather, the intent is to highlight evidence-based interventions to prevent suicide among Black youth. Some of the interventions described have been developed specifically for at-risk Black youth. Other interventions highlighted may not focus on any particular race or ethnicity; however, they are included because of their accessibility to Black youth at risk, and/or the targets of risk that they address (e.g., coping skills to mitigate stressors).

Approaches to Suicide Prevention: The Social Ecological Model

Principles of suicide prevention include identifying youth at risk for death by suicide, mitigating risk factors and bolstering protective factors. As described in other sections of this report, the social ecological model (Bronfenbrenner, 1977) provides a multi-dimensional suicide prevention framework at the individual, relationship, community, and societal levels. The Institute of Medicine (IOM) model (Institute of Medicine Committee on Prevention of Mental Disorders, 1994) outlines a complementary approach that also consider levels of risk in developing suicide prevention efforts.

Figure 6 Behavioral Health Continuum of Care Model
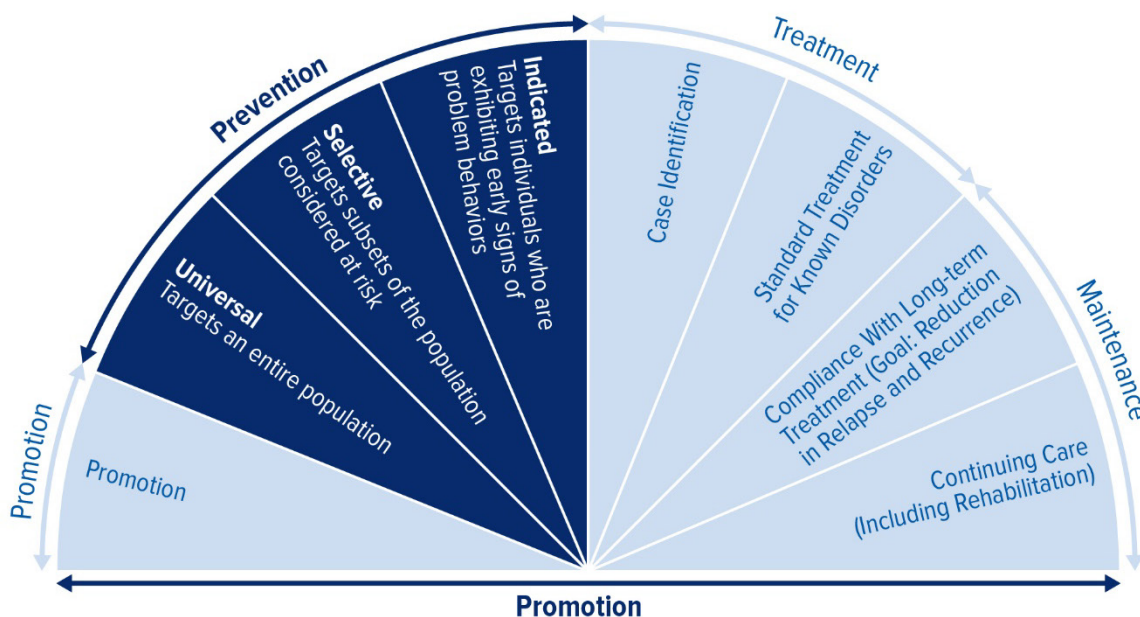
Source: SAMHSA (2015, Exhibit 1.1-2), which adapted the figure from IOM (2009, p. 67) and IOM (1994, p. 23).

The broad category of prevention is sub-divided into universal, selective, and indicated approaches depending on the level of risk. Universal approaches are available to an entire target population regardless of risk. Selective approaches target youth known to be at elevated risk for suicide compared to the general population such as those with mental disorders, those experiencing family discord, or child abuse and neglect. Indicated approaches are for individuals with identified risk factors for suicide (e.g., more severe mental disorders or for a youth seen in an emergency room for severe suicidal ideation or after a suicide attempt).

Described below are a variety of youth suicide prevention interventions that can be offered in numerous settings (e.g., Universal screening can occur primary care settings or in schools).

Screening Youth for Suicide Risk Factors

Adequate detection of current ideation and history of attempts through screening, combined with appropriate intervention and follow-up, can help prevent deaths by suicide. Although there are few tested screening and intervention efforts for youth aged 10 and younger (Ayer et al., 2020), an example of a screening measure being used in practice with children as young as 10 is the Ask Suicide-Screening Questions (ASQ; Horowitz et al., 2012). DeVlylder and colleagues (2019) examined the benefits of ASQ suicide screening of those presenting with mental health problems, compared to universal ASQ screening in urban pediatric ED (study included 68% Black youth). Over half of patients aged 8 to 18 in this urban ED who screened positive on the universal ASQ screen did not report suicidal ideation or behavior as their presenting problem (i.e. would not have been known be at risk for suicide unless screened), and were more likely to be male, and Black. This finding illustrates the importance of universal screening of youth to identify suicide risk, particularly among Black male youth. However, more research is needed on how racial and ethnic minorities respond to suicide screening questions especially because of adolescent denial of suicidal thoughts reported in the Philadelphia cohort study (which included 31% Black youth). Jones et al. (2019) found rates of both parental unawareness and adolescent denial of adolescent's suicidal thoughts were higher among racial/ethnic minority families (many of whom were Black).

Gardner and colleagues (2010) examined the feasibility of a brief computerized suicide screening (Patient Health Care Question for Adolescents; PHQ-A) for over 1,500 youth aged nine to 20 across nine urban primary care clinics associated with Nationwide Children's Hospital. Fourteen percent of the youth screened positive; of these, the majority received mental health care. Triage of youth who screened positive was facilitated by the availability of on-call suicide prevention specialists comprised primarily of social workers, and referrals went to emergency care or outpatient mental health. However, while Black youth reported suicide ideation at comparable levels to non-Black youth, they were less likely to be referred to mental health specialty services. In addition to their research in EDs described above, Horowitz and colleagues (Brahmbhatt et al., 2019) have developed youth suicide screening procedures and workflows in medical/surgical units.

Screening for suicide risk in school-based health centers that can address mental health needs is an important opportunity for suicide prevention, as more than one in three adolescents have the school as their primary access to mental health care, with 42% of these youth on public insurance (Ali et al., 2018).

Interventions to Mitigate Risk Factors and/or Enhance Protective Factors

Treatment of Mental Disorders

As described in the previous sections, mental disorders are a major risk factor for suicide among Black youth. Therefore, treating mental disorders can effectively reduce suicide risk. Evidence-based psychotherapies such as cognitive behavioral therapy (e.g., Spirito et al., 2012) and others (e.g., see review by Glenn et al., 2019), as well as some psychotropic medications for common conditions such as mood and anxiety disorders (e.g., Maalouf & Brent, 2012) have been found effective in youth with mental disorders and suicide risk. In addition, an NIH study found that youth with borderline personality characteristics who received Dialectical Behavior Therapy skills training were at lower risk for a repeated suicide attempt (McCauley et al., 2018).

Collaborative Care programs provide team-based care for mental health conditions in which primary care providers, care managers, and mental health specialists work together to evaluate, treat, and monitor progress (Asarnow et al., 2015). Collaborative Care programs use patient registries (to avoid missing high risk patients) and measurement-based care to monitor patient outcomes and adjust treatment approaches efficiently. These programs have been effective in treating mental disorders among youth seen in pediatric settings, including Black youth, as well as reducing suicidal ideation (e.g., Unützer et al., 2006).

Many effective suicide prevention interventions, including those related to treatment, involve the mental healthcare system. However, when we examine access and service utilization patterns among Black youth and families in this context, we find that Black youth underutilize mental health services compared to other racial/ethnic groups. Not only are Black adolescents less likely to receive outpatient mental health care, but they also have less contact with the mental health treatment system prior to a crisis compared to White adolescents (Snowden et al., 2009). NVDRS data show that Black youth are less likely to disclose suicidal intent to an adult, which may reflect less use of mental health services. Indeed, a California-based study (Snowden et al., 2008) found that Black youth were over-represented in psychiatric emergency care (e.g. hospital stabilization, and community crisis services), indicating that limited service utilization may contribute to problems that escalate before mental health care is received.

School-Based Approaches

A number of early, universal, school-based prevention programs have been shown to reduce risks related to youth suicide through the prevention of mental and substance use disorders (National Institute on Drug Abuse, 2003). The Good Behavior Game (GBG; Barrish et al., 1969) is a classroom management approach found to reduce aggressive, disruptive classroom behavior (e.g., Ialongo et al., 2001). Teachers use a game format with teams and rewards to improve student on-task behaviors during instructional times. The GBG has been reported to have long term benefits, reducing the incidence of behavioral outcomes such as alcohol abuse and other drug dependence, smoking, antisocial personality disorder, and violent and criminal behaviors. Wilcox and colleagues (Wilcox et al., 2008) examined GBG effects on several Baltimore first grade cohorts (~70% Black) on outcomes at aged 19 to 21, finding a lower incidence of suicidality through childhood, adolescence, and into young adulthood compared to youth not exposed to the program. Youth who received GBG in elementary school reported one-half the lifetime rates of suicide ideation and attempts compared with their matched controls.

Other interventions can target school climate and peer norms to reduce known risk factors. The Sources of Strength program trains middle and high school students, identified as key opinion leaders' to disseminate school-wide healthy norms, encourage integration with competent peers, share and encourage practices for coping, and to increase youth–adult connections with ongoing adult mentoring (Wyman et al., 2010). In a trial across 18 high schools across Georgia, New York, and North Dakota, training improved the peer leaders' adaptive norms regarding suicide (i.e., that suicide is not a normal response to distress), their connectedness to adults, and their school engagement, with the largest gains for those entering with the least adaptive norms. Trained peer leaders in larger schools were more likely to refer a suicidal friend to an adult. Among students, this intervention increased perceptions of adult support for suicidal youths and the acceptability of seeking help. Perceptions of adult support increased in students with a history of suicide ideation. Network analyses from a larger NIH supported Sources of Strength trial of 38 schools has illustrated how youth with suicide ideation and attempt history have lower peer network integration and cohesion (Wyman et al., 2019), suggesting that expanding youths' supportive social engagement network is a potent target for interventions.

Robinson et al. (2015) have culturally adapted a school-based cognitive-behavioral intervention to reduce stress/anxiety and suicide ideation, and enhance coping skills among 9th grade Black youth, and are now testing this program with social workers, on a larger scale in Chicago (Robinson, 2019).

Family-Based Approaches

Proximal risk factors for adolescent suicidal behavior are often preceded by family dysfunction, including poor family problem solving, family conflict, and poor support from parents (Wagner et al., 2003). Thus, family-based interventions that improve parent interactions and provide supportive and structured youth contexts have the potential to alter at risk trajectories. A universal family--based intervention that addressed age--appropriate parent monitoring and communication of expectations of adolescent behavior, and ways of dealing with discrimination for rural Black teens, the Strong African American Families–Teen (SAAF–T) program, resulted in reduced rates of conduct problems, substance use problems, and depressive symptom frequencies compared to adolescents in the control condition (Brody et al., 2012). The Family Check-up (FCU) Program is another intervention that augments parenting skills, using a brief intervention based on motivational interviewing techniques designed to enhance family engagement and trigger the behavior change process. FCU involves assessment, observations, and when appropriate, links families to existing intervention services that support family management practices. Several trials of FCU found reductions in suicide risk (Connell et al., 2019; Connell et al., 2016), mediated by improvements in children's inhibitory control. NIH is currently funding a study (Connell, 2020) that aggregates data across three trials of the Family Check-Up (FCU) to include 2322 families (25% Black); one trial was conducted with families of children who were age 2; and two trials focused on youth age 11. All three trials examine long-term outcomes in late adolescence and early adulthood.

Reducing Access to Lethal Means

Consistent with NSSP and the World Health Organization (WHO) suicide prevention recommendations (WHO, 2014), reducing access to lethal means may be one of the most rapid and effective approaches to reducing suicide deaths. Youth typically live in contexts where adults control access to lethal means, and efforts to reduce access to lethal means among adults may also have benefits for suicide risk reductions among youth. As an example of an indicated intervention, Zatzick and colleagues (2014) demonstrated that collaborative, stepped care; including one motivational interview targeting substance use, risky behavior and weapon carrying; delivered to youth admitted to a trauma center significantly reduced the

likelihood of carrying a weapon 12-months after their injury . These findings highlight opportunities in healthcare settings to address means safety, and a need for developmentally appropriate suicide prevention efforts to reduce risk, as lethal methods used seem to differ between younger and older youth. To address this, NIH has recently started building infrastructure to improve research on firearm safety for youth (Cunningham, 2017).

Special Populations

Some interventions are tailored to specific subpopulations of youth at higher risk, including sexual and gender minority youth, those who are justice-involved, in foster care, and experiencing homelessness. NIH is funding research that examines delivery of the Safety Planning Intervention to juvenile justice-involved youth. This study also addresses high-risk transitional periods, using "Sequential Intercept Model Mapping" to inform "points of interception" that provide opportunities for screening and intervention delivery (Spirito & Kemp, 2019). Interventions recommended to improve outcomes among justice-involved youth, who may be at higher risk for suicide upon entry into the justice system, include those that address systemwide transition points (Heilbrun et al., 2017) such as diversion from the justice system or emergency crisis care and alternatives to detention, as well as interventions that address trauma and emotional dysregulation (e.g, Smith et al., 2012). Additionally, juvenile justice systems that use community-based supervision have the potential to lessen further mental health problems and offer more opportunities for family-based interventions (Heilbrun et al., 2012). Proponents of community-based supervision programs argue that this approach is cost saving while at the same time improving rehabilitative benefits for youth. (e.g. National Juvenile Justice Network, 2014). Community-based programs have provided family interventions with justice-involved youth (aged 12 to 17) that have been found effective in reducing re-arrests. As an example, multidimensional Treatment Foster Care (MTFC) has been found to reduce delinquency among girls in juvenile justice through two-year follow-up, as well as reduce depressive symptoms and suicidal ideation (Kerr et al., 2014).

Youth in foster care have elevated rates of suicide death, attempts, and ideation. In 2014, Black youth comprised nearly one in four children in the foster care system (Child Welfare Information Gateway, 2016). An NIH study is examining incidence of suicide across and within four public child-serving systems (Medicaid, child welfare, juvenile justice, and behavioral health) in Ohio in order to identify high risk periods for suicide among youth (2.2 million youth aged 10 to 24) in publicly-funded sectors; and aims to develop and validate a risk prediction algorithm to estimate individual risk for suicide in this population (Bridge, 2019).

A cohort study found youth experiencing homelessness to be at high risk for suicidal behavior (Yoder et al., 2010) due to multiple risk factors including substance use; childhood physical and sexual abuse; family rejection due to sexual minority status; victimization and other traumatic experiences while homeless; and, mental health problems that include depression, hopelessness, and limited distress tolerance, impulse control, social support, and problem solving. An NIH supported pilot study by Lynn and associates (Lynn et al., 2014) tested a family strengthening intervention compared to a health information intervention among families in a homeless shelter (youth were aged 11 to 14; 47% Black) and found that the strengthening program significantly decreased youth suicidal ideation.

Research by Durso and Gates (2012) indicates that LGBT youth are overrepresented among homeless youth, largely due to family rejection of their sexual orientation and gender identity. Additionally, youth that identify multiple levels of racial, ethnic, and sexual and gender minority statuses, described as intersectional youth, may show complex patterns for suicide risk (e.g., Bostwick et al., 2014). A current NIH synthesis study across many preventive intervention trials is examining intervention effects for

sexual minority youth, as well as intersectional youth (Brown, 2020). Interventions that increase family acceptance of sexual/gender minority youth, especially among families with conservative religious views (e.g., SPRC, 2014), has been an effective approach to reducing homelessness and suicide risk (Ryan et al., 2010).

HHS Youth Suicide Prevention Initiatives

HHS supports numerous programs specifically focused on preventing death by suicide in children and youth. Select HHS activities, including those focusing on Black youth are described in Appendix C.

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APPENDIX A

Demographics and Epidemiology: Supplemental Information

Data issues affecting the collection and analysis of suicide data

Because suicide among children, especially younger children, is rare, minor classification errors in race/ethnicity and cause of death can introduce major errors in estimates of suicide rates. Heron (2019) and Curtin and Hedegaard (2019) note that mortality estimates for non-Hispanic American Indians/Alaska Natives, non-Hispanic Asian/Pacific Islanders, and Hispanic populations may be underestimated because of misclassification of individuals in these groups to other race and ethnicity groups. Curtin and Hedegaard (2019) note "The specific extent and direction of misclassification of suicide deaths is unknown; however, the number of suicide deaths for these race and ethnicity groups may also be underestimated."

Also See Report to the Secretary's Task Force on Youth Suicide (1989).

Leading Causes of Death by Race, Children Aged 10 to 17

Table A-1: 1999 Leading Causes of Death Among U.S. Youths Aged 10 to 17

1999 Leading Causes of Death	All Youths Aged 10 to 17	White Non-Hispanic	Black Non-Hispanic	Hispanic or Latinx	Asian or Pacific Islander Non-Hispanic	American Indian or Alaska Native Non-Hispanic
Leading Cause	Accidents	Accidents	Accidents	Accidents	Accidents	Accidents
2nd Leading Cause	Homicides	Suicides	Homicides	Homicides	Cancer	Suicides
3rd Leading Cause	Suicides	Cancer	Cancer	Cancer	Homicides	Homicides
4th Leading Cause	Cancer	Homicides	Heart Problems	Suicides	Suicides	Heart Problems
5th Leading Cause	Health Problems	Heart Problems	Suicides	Heart Problems	Heart Problems	Cancer

Source: National Vital Statistics System
Note: The full name of the "Accidents" category is "Accidents (unintentional injuries)."

Table A-2: 2018 Leading Causes of Death Among U.S. Youths Aged 10 to 17

2018 Leading Causes of Death	All Youths Aged 10 to 17	White Non-Hispanic	Black Non-Hispanic	Hispanic or Latinx	Asian or Pacific Islander Non-Hispanic	American Indian or Alaska Native Non-Hispanic
Leading Cause	Accidents	Accidents	**Homicides**	Accidents	**Suicides**	**Suicides**
2nd Leading Cause	**Suicides**	**Suicides**	Accidents	**Suicides**	Accidents	Accidents
3rd Leading Cause	**Homicides**	Cancer	**Suicides**	Cancer	Cancer	**Homicides**
4th Leading Cause	Cancer	**Homicides**	Cancer	**Homicides**	**Homicides**	Cancer
5th Leading Cause	Congenital Abnormalities	Congenital Abnormalities	Heart Problems	Congenital Abnormalities	Congenital Abnormalities	Influenza or Pneumonia

Source: National Vital Statistics System
Note: The full name of the "Accidents" category is "Accidents (unintentional injuries)."

Details of Race Categories

Subsection 1: The other racial/ethnic groups are non-Hispanic Whites, Hispanics, non-Hispanic Asian/Pacific Islanders, and non-Hispanic American Indians/Alaska Natives. The racial/ethnic categorizations used differ between Sub-sections 1 and 2. In sub-section 1, Hispanic children are classified as a separate category that includes Hispanics of all races, so the Black and White categories, as well as the other racial/ethnic categories, exclude Hispanic children.

Subsection 2: All Black children (both Hispanic and non-Hispanic) are compared with all White children (both Hispanic and non-Hispanic); The age and racial groupings in Section 2 were used to be responsive to the request from Congress and to parallel the groupings used in peer-reviewed literature cited in the Congressional Black Caucus's Report "Ring the Alarm: The Crisis of Black Youth Suicide in America" (Watson Coleman, 2019).

Selection of Age Ranges and Age Grouping and Effects on Statistical Reliability

The Committee expressed concerns about children aged 10 to 17 and Black children aged 5 to 12. In order to produce scientifically defensible analysis for the five and older group, we extended the age range to 5 to 14. As noted by the National Center for Health Statistics (2004) and in the CDC Wonder dataset documentation (Centers for Disease Control and Prevention, 2020), estimates of death rates for groups in which the number of deaths is less than 20 are not considered statistically reliable. We chose age 14 as the upper limit because that is the youngest age at which the number of suicides for Black children and White children is at 20 or higher for each year. See Table A-3.

Restricting analysis to age ranges for which there are at least 20 deaths from suicide in each age group in each year between 1999 and 2018 limits our ability to compare our results with the Bridge et al. (2018) analysis of the relative risks of suicide for Black and White children. Bridge and colleagues compared suicide rates between 2001 and 2015 for children aged 5 to 17 using nine age categories, combining aged 5 to 9 in a single category and using single years of age thereafter. As Table A-4 illustrates, for the nine age groups used by Bridge and colleagues, there was no age group for which there were 20 or more

deaths from suicide for Black youth in every year between 1999 and 2018. Suicide was particularly rare among children aged 5 to 9. Between 1999 and 2018, the total annual number of Black children aged 5 to 9 whose deaths were reported as suicide ranged from 0 to 4 per year, averaging 1.8. This is consistent with the findings of Bridge et al. (2018) whose data showed an annual average of 1.7 suicides among Black youth.

Table A-3. Number of Suicides per Year for Children Aged 5 to 17, 1999 to 2018

Cells with fewer than 20 cases are indicated with yellow shading.

| Ages 5 to 9	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	2	7	7	4	6	2	2	3	4	7	6	7	5	5	9	3	4	7	5	9
Black children	0	0	2	1	1	1	1	0	2	2	2	0	3	2	4	2	2	4	3	4
Ages5 to 11	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	31	45	34	42	30	32	37	26	33	24	34	34	33	30	38	49	46	53	59	84
Black children	4	5	10	8	9	9	12	9	15	9	12	12	8	16	11	15	15	19	16	25
Ages 5 to 12	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	63	88	73	85	68	69	76	56	58	49	82	70	75	76	102	117	102	121	136	185
Black children	13	11	21	14	16	17	22	14	18	19	21	18	19	22	22	28	26	26	29	42
Ages 5 to 13	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	118	182	157	161	136	157	141	113	107	113	157	148	153	158	219	249	220	242	285	349
Black children	19	27	28	23	30	33	27	27	32	25	30	26	32	36	39	39	36	31	50	61
Ages 5 to 14	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	244	307	279	264	250	285	272	219	184	222	265	274	287	311	395	428	413	443	522	605
Black children	29	40	40	35	43	49	41	35	42	30	47	43	43	42	55	55	47	44	66	87
Ages 12 to 14	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	213	262	245	222	220	253	235	193	151	198	231	240	254	281	357	379	367	390	463	521
Black children	25	35	30	27	34	40	29	26	27	21	35	31	35	26	44	40	32	25	50	62
Ages 15 to 17	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All children	760	782	748	710	668	744	747	721	654	763	793	735	842	859	854	916	986	1,092	1,256	1,229
Black children	72	73	52	47	50	60	67	48	48	85	66	64	76	68	80	67	88	91	105	110

Source: National Vital Statistics System

Table A-4. Number of Suicides, 1999 to 2018, Black Children Aged 5 to 17

Cells with fewer than 20 cases are indicated with yellow shading

| Age	Mean	Minimum	Maximum	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
5 to 9	1.8	0	4	0	0	2	1	1	1	1	0	2	2	2	0	3	2	4	2	2	4	3	4
10	3.8	1	10	1	3		2	2	4	3	1	6	2	6	4	2	5		4	5	3	5	10
11	6.8	2	12	3	2	8	5	6	4	8	8	7	5	4	8	3	9	7	9	8	12	8	11
12	9.0	3	17	9	6	11	6	7	8	10	5	3	10	9	6	11	6	11	13	11	7	13	17
13	11.7	5	21	6	16	7	9	14	16	5	13	14	6	9	8	13	14	17	11	10	5	21	19
14	13.1	5	26	10	13	12	12	13	16	14	8	10	5	17	17	11	6	16	16	11	13	16	26
15	18.6	5	36	14	24	6	5	6	18	21	17	11	25	23	11	19	21	21	16	19	33	26	36
16	22.1	13	42	22	20	15	15	20	14	16	13	14	27	22	21	31	16	23	25	36	22	42	28
17	30.2	18	46	36	29	31	27	24	28	30	18	23	33	21	32	26	31	36	26	33	36	37	46

Source: National Vital Statistics System

Figure A-4: Crude Suicide Rates by Race/Ethnicity, 1999 – 2018, U.S. Children Aged 10 to 17
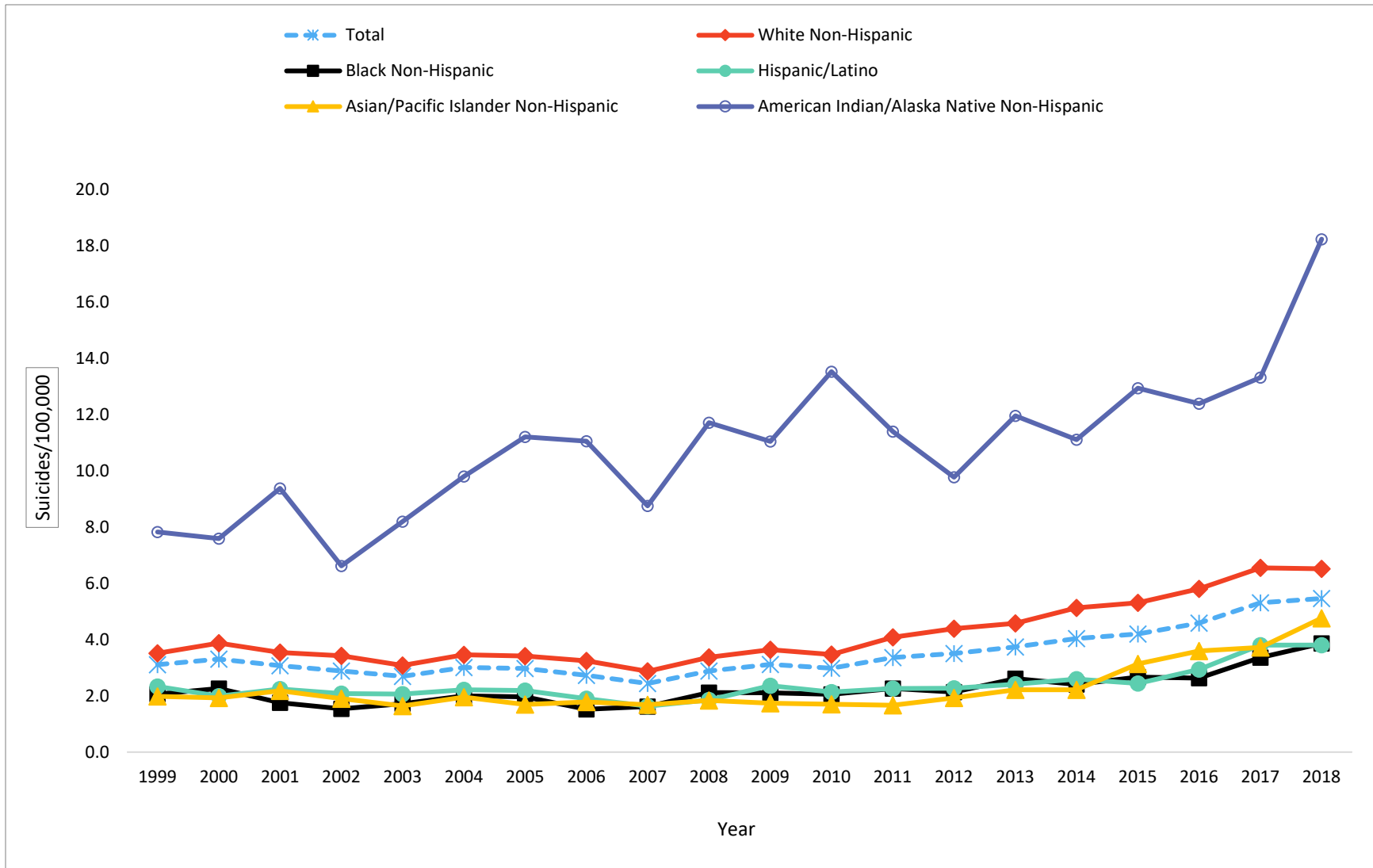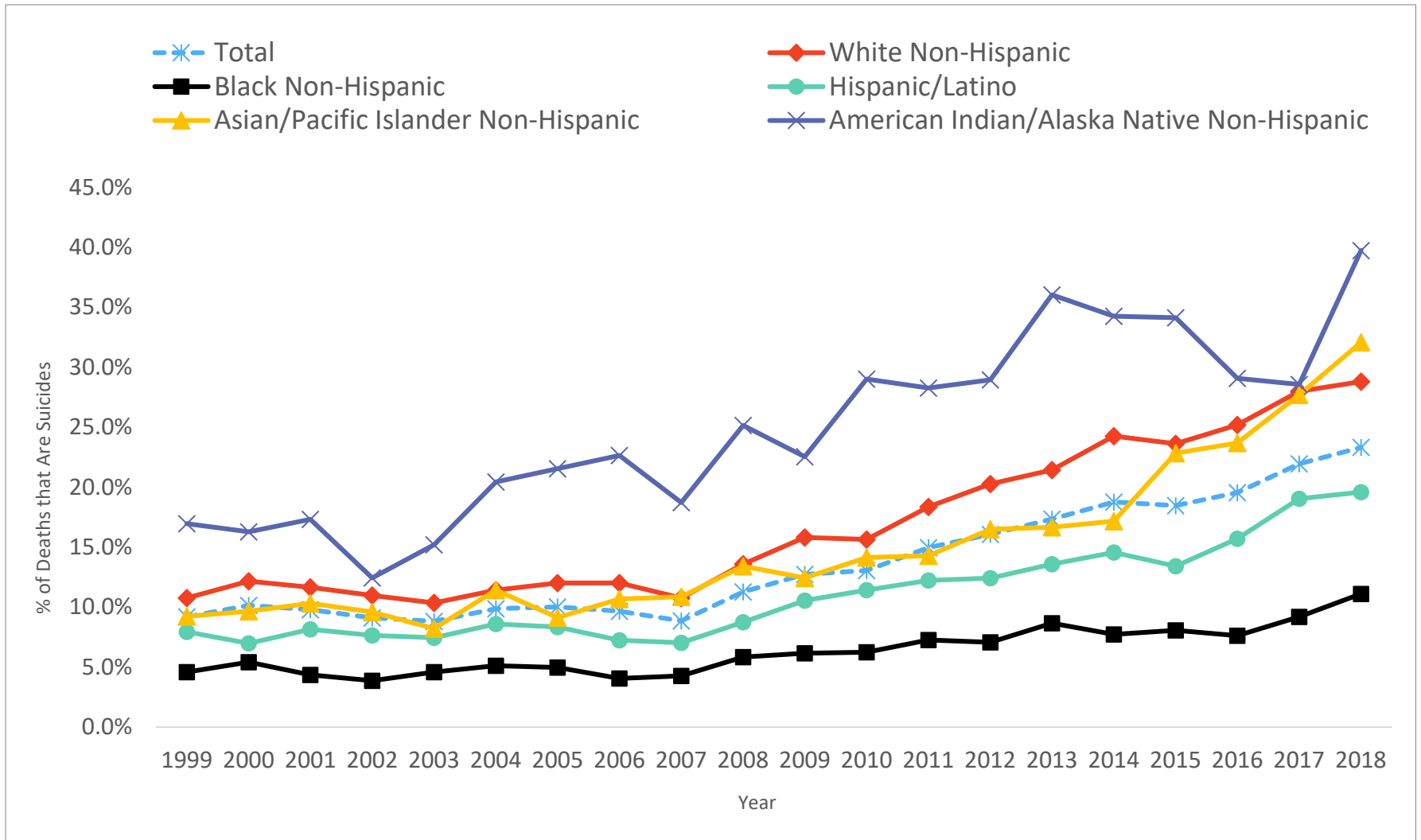

Source: National Vital Statistics System

Figure A-5: Crude Death Rates by Race/Ethnicity, 1999 – 2018, U.S. Children Aged 10 – 17
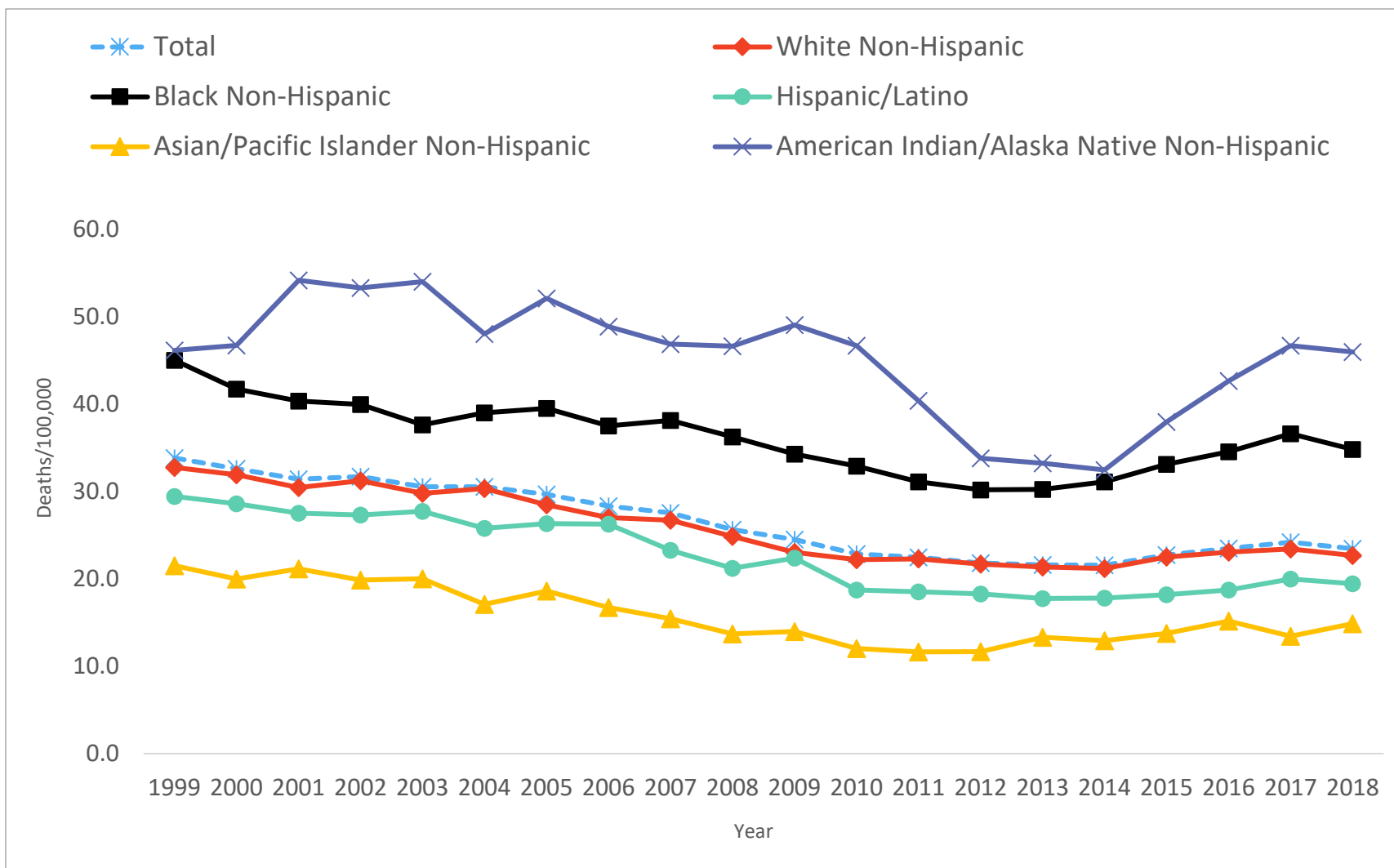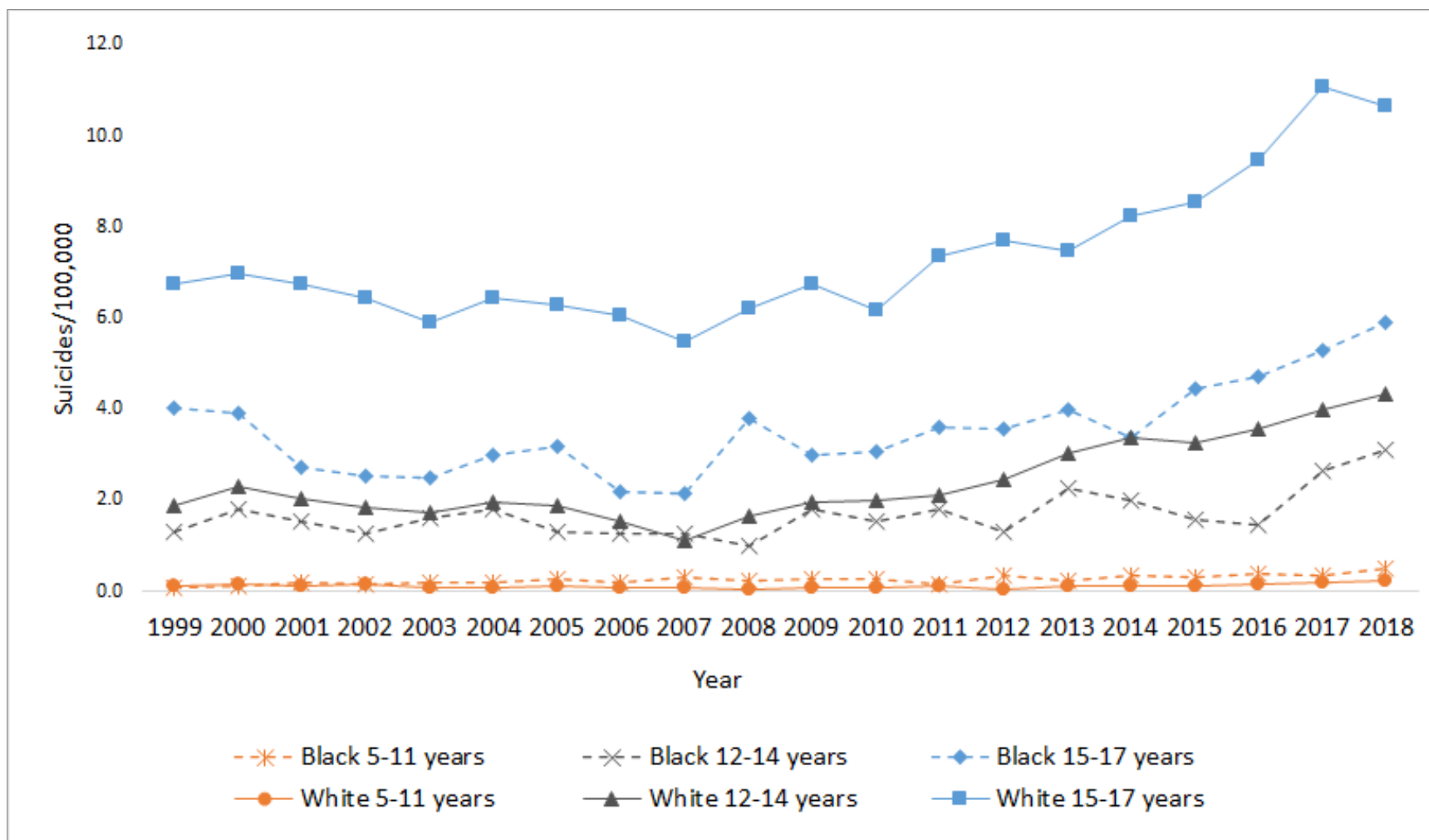

Source: National Vital Statistics System

Figure A-6: Suicide as Percentage of All Deaths, 1999 – 2018, U.S. Children Aged 10 to 17, by Race/Ethnicity
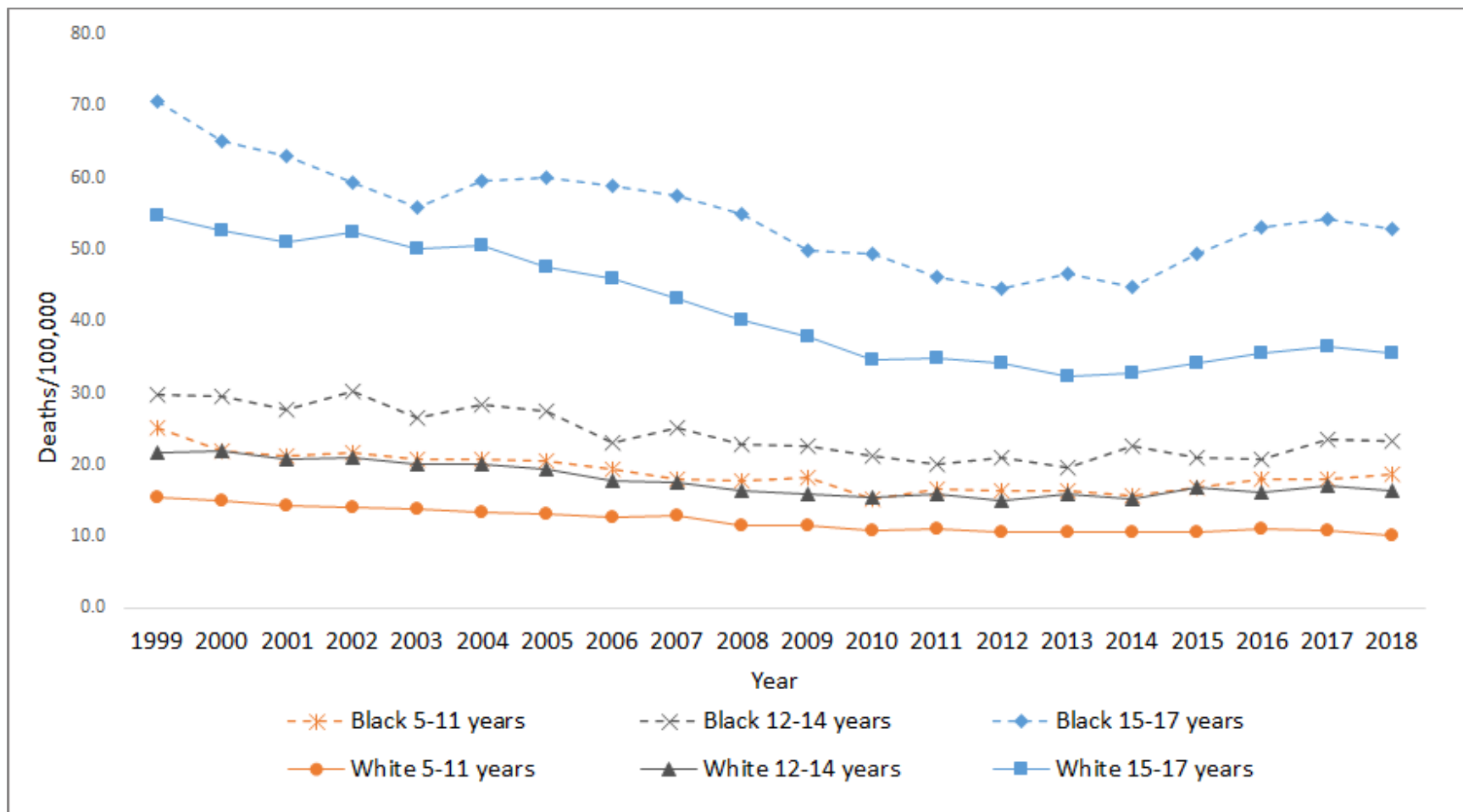

Source: National Vital Statistics System

Figure A-7: Suicide Rates Among Black & White Youth (all ethnicities) by Age, 1999-2018 United States

Source: National Vital Statistics System

Figure A-8. All-cause Mortality Among Black & White U.S. Youth (all ethnicities) by Age, 1999-2018


Source: National Vital Statistics System

APPENDIX B

Protective Factors, Risk Factors, and Precipitating Circumstances

Deaths due to suicide and nonfatal suicidal behavior are influenced by many factors. Frequently, several risk factors intersect to increase a person's risk for suicide while simultaneously interacting with protective factors that mitigate vulnerability. This section addresses protective factors, risk factors, and precipitating circumstances, defined as follows:

- *Protective factor:* A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes (NRC and IOM, 2009).
- *Risk factor:* A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes (NRC and IOM, 2009).
- *Precipitating Circumstances:* The key events or characteristics of the situation immediately preceding a completed suicide (CDC, 2019). Note that precipitating circumstances and risk factors are not mutually exclusive concepts.

The four-level social-ecological model delineates the numerous domains involved in risk and protective factors in order to inform prevention strategies at the appropriate level. Starting from micro-to macro levels, the first level identifies biological and personal history factors, the second level examines relationships, the third level explores community settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and the fourth level looks at the broad societal factors.

Figure B-1. The Social-Ecological model
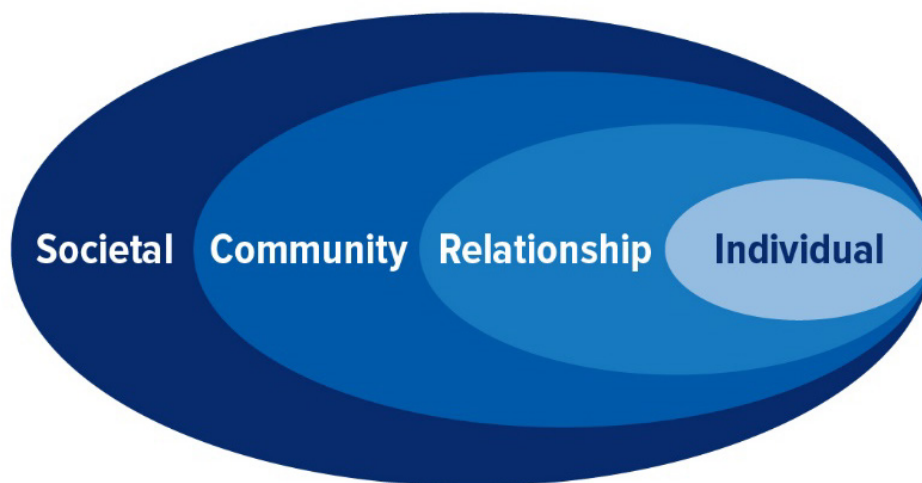
Source: Bronfenbrenner, 1977.

Protective Factors

Protective factors have been the subject of comparatively little research, relative to risk factors. The protective factors that have been identified include resiliency and coping skills at the individual level; connectedness to family, school, a caring adult, or positive peer at the relationship level; awareness about mental health, stability of norms, and spirituality at the community level; and a strong social network and social support at the societal level (Gould, 2003; McLean et al., 2008; National Youth Suicide Prevention Strategy, 1999).

Protective factors for Black youth that have been identified include a strong sense of ethnic identity; connectedness to individuals, family, community, and social institutions; problem-solving skills; nonfamilial social support (e.g., clergy), collaborative religious coping; and informal support (Crosby et al., 2018; Joe et al., 2006; Goldston et al., 2008; Griffin-Fennell et al., 2006; Harris et al., 2000; Utsey et al., 2007; Willis et al., 2003; Willis et al., 2002).

Risk Factors

For all youth: Societal factors include lack of resources for social services, economic determinants (such as poverty), lack of employment, poor living and housing conditions, inappropriate media reporting of suicide, accessibility of lethal means to suicide, lack of healthcare accessibility, and stigma against help-seeking. The community-level factors include rurality, social isolation, and school and work problems. Relationship factors include child maltreatment, bullying, parental history of suicide and/or psychiatric disorders, and parental loss (e.g., divorce, death). Individual factors include socio-demographic characteristics; stressful life events, including adverse childhood experiences; mental disorders; substance misuse; chronic physical illness; previous history of suicide attempts; poor coping strategies; and sexual orientation and identity (Bridge, 2006; Cash, 2009; Gould, 2003; Shain, 2016).

Unfortunately, few studies that have tried to quantify the relative contribution of each of the factors to overall suicide risk, such as through estimating a population attributable risk percent (PAR%). One review proposed the following as estimates: low socio-economic status (49.8%); parental separation or divorce (37.5%); affective disorders (57.1%); previous suicidal behavior (46.9%); previous psychiatric history and treatment (64%); interpersonal losses or conflicts (23.1%); and legal or disciplinary crises (20.2%) (National Youth Suicide Prevention Strategy, 1999). These PAR% estimates suggest that no one factor accounts for all the risk of suicide and that economic factors account for almost as much as affective disorders.

National Violent Death Reporting System (NVDRS):

https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html

NVDRS defines a suicide death as a death resulting from the use of force against oneself when a preponderance of the evidence indicates that the use of force was intentional. NVDRS links information about the "who, when, where, and how" for violent deaths including suicide, and provides insights about "why" they occurred. To do this, NVDRS collects and pools data from death certificates, coroner/medical examiner reports, law enforcement reports, and toxicology reports. (Blair, 2015). Thirty-five states (Alaska, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Iowa, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Maryland, Maine, Michigan, Minnesota, North Carolina, New Hampshire, New Jersey, New Mexico, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia) and the District

of Columbia contributed data for one or more years during this time frame. The content reported on the coroner/medical examiner and law enforcement reports were reviewed and entered into the NVDRS by trained abstractors to determine the circumstances (i.e., events that immediately preceded and may have contributed to the youth's death by suicide).

Population studied:

There were 274 non-Hispanic black children aged 10 to 17 with circumstance data (about 87% of the total) captured in NVDRS during 2014–2017.

Precipitating Circumstances

As noted in the definitions above, precipitating circumstances are events or situations that occurred within 2 weeks prior to the youth's death by suicide and are not mutually exclusive with risk factors.
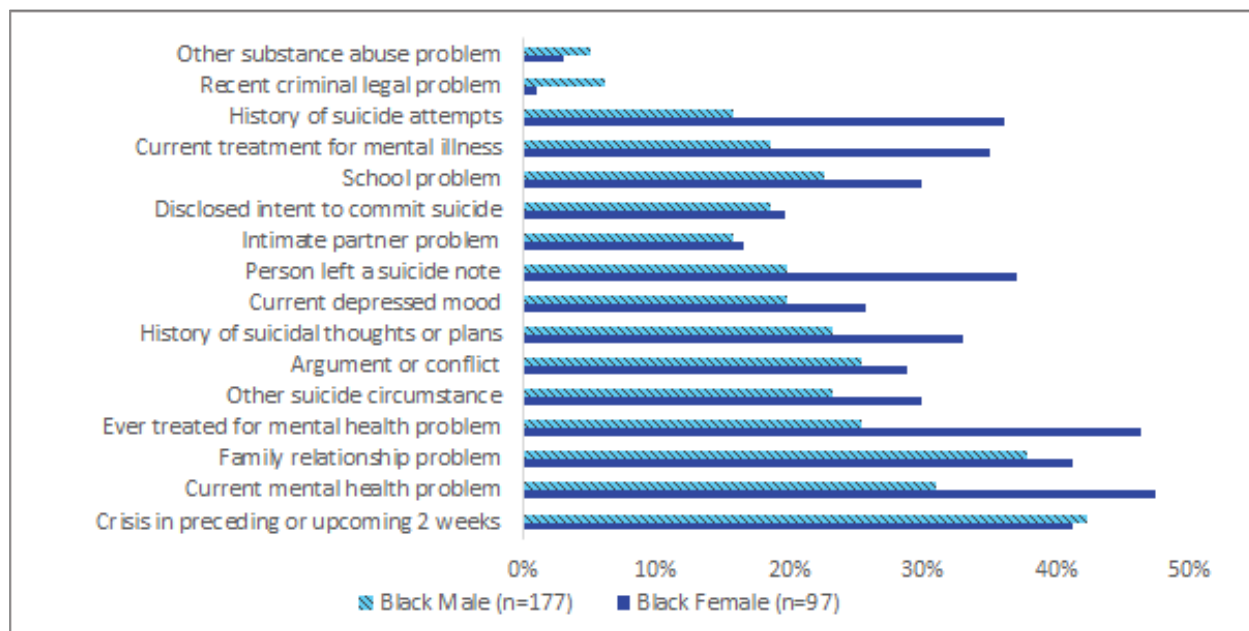
Figure B-2. Circumstances* preceding suicide among children aged 10 to 17, by race—United States, 2014–2017
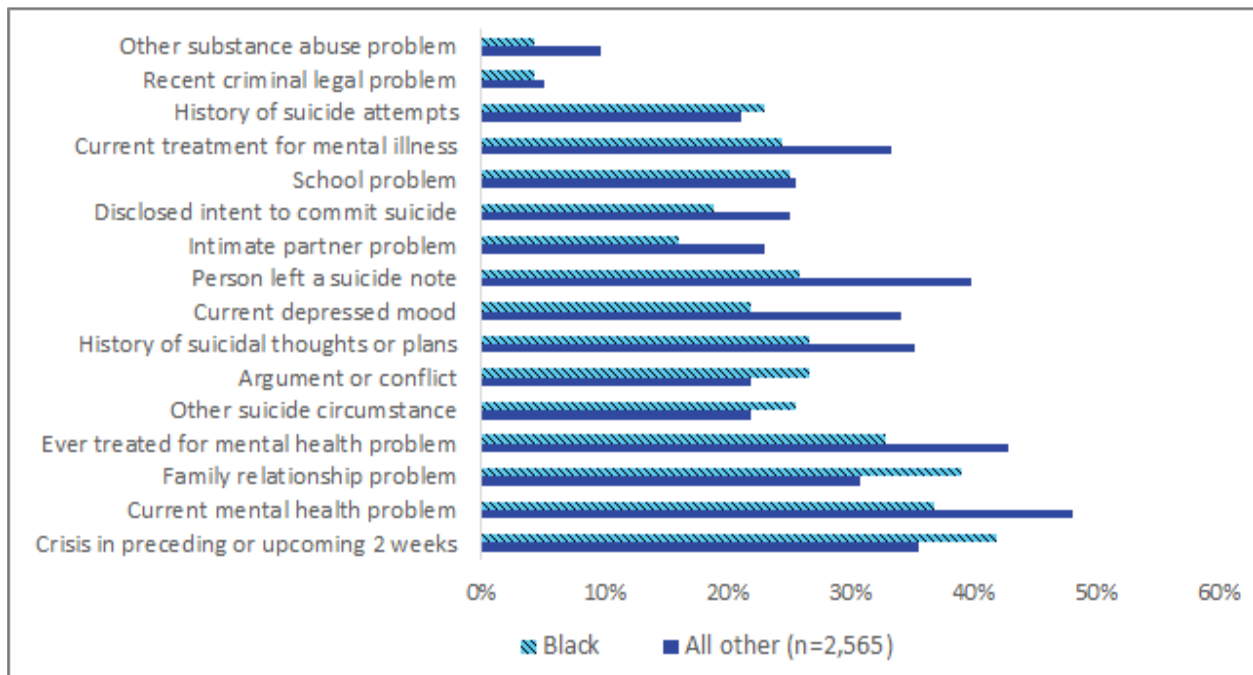
*Decedent can have multiple circumstances; therefore, circumstances sum to greater than 100%.
Source: NVDRS

Figure B-3. Circumstances* preceding death by suicide among Black children aged 10 to 17, by sex—United States, 2014–2017

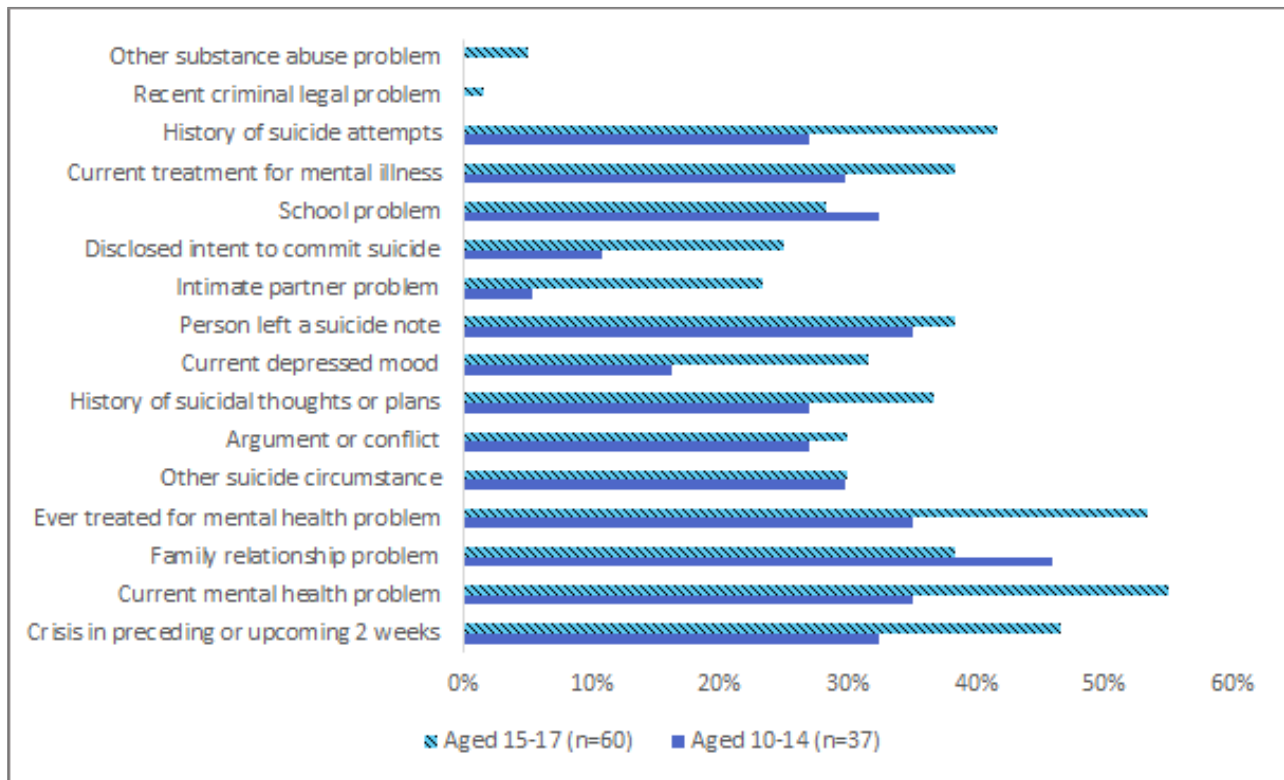*Decedent can have multiple circumstances; therefore, circumstances sum to greater than 100%.
Source: NVDRS

Among Black youth, there was a notable difference between males and females (Figure B-3). Nearly every circumstance measured was identified more often among Black female decedents compared to males. The discrepancy was particularly notable with regard to having a current mental health problem (47% vs. 31%), ever being treated for a mental health problem (46% vs. 25%), leaving a suicide note (37% vs. 20%), and having a history of suicide attempts (36% vs. 16%), all of which were cited more frequently for female suicide decedents compared to males.

For age-related differences, in Black females aged 10 to 17, there were a few differences by age group (Figure B-4). Having a current mental health problem (55%), ever having been treated for a mental health problem (53%), and having a crisis in the preceding or upcoming two weeks (47%) were identified in approximately half of female decedents aged 15 to 17. Although less commonly reported, 12% of female decedents aged 15 to 17 were known to have been abused or neglected as a child. Among female decedents aged 10 to 14, having a family relationship problem (46%), a current mental health problem (35%), or a school problem (32%) were most frequently noted.

There were fewer differences by age group among Black males (Figure B-5). Among males aged 15 to 17, no precipitating factors were noted in more than 40% of decedents. Among males aged 10 to 14, having a family relationship problem was noted in over half (57%) of decedents. In contrast, a family relationship problem was identified in only 27% of male decedents aged 15 to 17. Also commonly reported among males aged 10 to 14 was a school problem (31%). From this analysis of surveillance data from NVDRS we are able to quantify some of the contributing factors to suicide among Black youth. Similar to other populations, these findings from NVDRS indicate a complex interaction of multiple relationship, mental health, interpersonal, and life stressors that precede suicides among Black youth.

Figure B-4. Circumstances* preceding suicide among Black females, by age—United States, 2014–2017

*Decedent can have multiple circumstances; therefore, circumstances sum to greater than 100%.
Source: NVDRS

Figure B-5. Circumstances* preceding suicide among Black males, by age—United States, 2014–2017
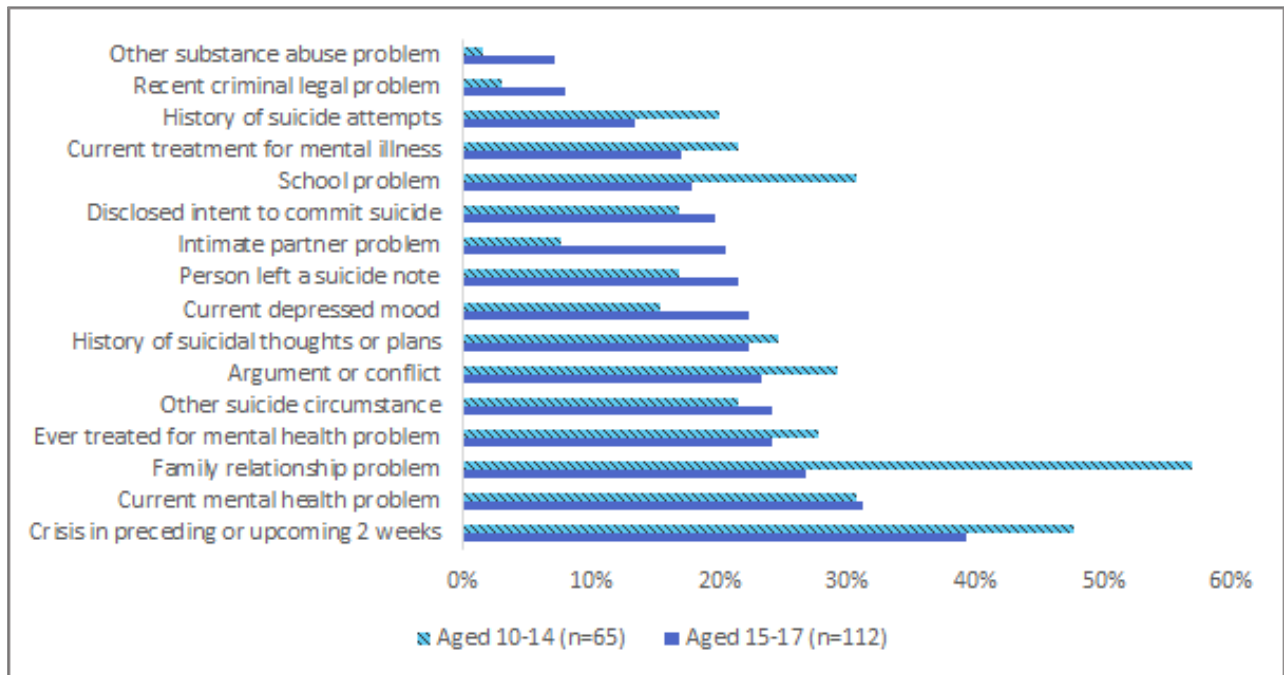
*Decedent can have multiple circumstances; therefore, circumstances sum to greater than 100%.
Source: NVDRS

Crosby and Jack (2018) examined the factors associated with suicide death among young Black males aged 10 to 34 in 18 states between 2003-2014 using NVDRS data. Although this study did not include a comparison group, interpersonal problems and life stressors, especially experiencing some type of recent crisis, and mental health issues were the most common precipitating factor among every age group. Depression/dysthymia was the most common mental health diagnosis among 15-19 (60.2%) and 20-34 (50.9%) year old decedents whereas Attention Deficit/Attention Deficit Hyperactivity Disorder was the most common diagnosis for 10-14-year-old decedents (57.1%) and almost twice more common than depression/dysthymia (28.6%) in this age group. Problems at school (41%) and non-intimate/non-family relationships (31.0%) were the most commonly identified precipitating circumstance among 10-14-year-old suicide deaths. Among young adult decedents, more than a quarter of 15-19-year olds (25.2%) and 41.7% of 20-34-year olds were noted to have intimate partner problems. Young Black adolescents aged 10 to 14 were less likely to have disclosed their suicidal intent to an adult than older adolescents or young adults, underlining the urgent need for multidisciplinary and multilevel interventions to prevent suicide.

APPENDIX C

HHS Youth Suicide Prevention Initiatives

The U.S. Department of Health and Human Services (HHS) supports a number of programs and efforts focused on youth suicide prevention. Select HHS activities, including those focusing on Black youth are listed below.

HHS

National Strategy for Suicide Prevention

The 2012 National Strategy for Suicide Prevention (the National Strategy) is the result of a joint effort by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance). The National Strategy is a call to action that is intended to guide suicide prevention actions in the United States over the next decade. It outlines four strategic directions with 13 goals and 60 objectives that are meant to work together in a synergistic way to prevent suicide in the nation. As a common theme across the four strategic directions, the National Strategy asserts that suicide prevention efforts should address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities. The Substance Abuse and Mental Health Services Administration (SAMHSA) funds the Suicide Prevention Resource Center (SPRC), which is devoted to advancing the implementation of the National Strategy and supports the Action Alliance. More details on the SPRC are in the SAMHSA section below.

Administration for Children and Families (ACF)

Mental Health First Aid

The Office of Refugee Resettlement's Division of Refugee Health (DRH) coordinates Mental Health First Aid (MHFA) trainings for refugee communities and staff serving refugee/torture survivors nationwide. MHFA is an evidence-based 8-hour curriculum that includes education about mental health issues (e.g., depression, anxiety, and suicide ideation) and teaches participants the skills to respond to someone who may be having a mental health crisis. DRH provides the training in the context of the refugee experience. ORR also funded the training of refugee leaders, including from African communities, to be certified MHFA instructors.

Though not routinely offered as part of DRH's efforts, DRH has also helped coordinate a Youth Mental Health First Aid (YMHFA) training; this course aims to give adults who work with youth the skills they need to reach out and provide initial support to adolescents (aged 12 to 18) who may be developing a mental health or substance use problem and help connect them to appropriate care. Studies of MHFA and YMHFA have found promising and significant effect size in changes in knowledge, skills and behaviors among participants (Morgan, 2018; Noltemeyer, 2020; Aakre, 2016). Additional information about MHFA is available at https://www.mentalhealthfirstaid.org/.

Agency for Healthcare Research and Quality (AHRQ)

Healthcare Cost and Utilization Project (HCUP)

A previous Healthcare Cost and Utilization Project (HCUP) Statistical Brief focused on adult utilization related to suicidal ideation and self-harm can be found at: Emergency Department Visits Related to Suicidal Ideation, 2006-2013 (PDF file, 238 KB; HTML). For additional information on HCUP, please see: www.hcup-us.ahrq.gov.

[Outcome Measure Harmonization and Data Infrastructure for Patient Centered Outcomes Research in Depression](#)
This project announced in December 2019 is building data infrastructure to capture information on depression treatment response, remission and worsening, and will include capturing information from the question on suicidal thoughts from the PHQ-9. Part of the goal of this project is to help physicians track patient status over time. This project will include youth aged 18 and up.

[Depression in Children: Systematic Review](#)
This review examines the effectiveness of treatments for depression in children. It looks for any studies that find an effect on suicide and suicidal ideation.

Centers for Disease Control and Prevention (CDC)

[National Violent Death Reporting System (NVDRS)](#)
The NVDRS links information about the "who, when, where, and how" from data on violent deaths and provides insights about "why" they occurred. It is a state-based surveillance system that covers all types of violent deaths – including homicides and suicides – in all settings for all age groups. NVDRS captures suicide data for youth (CDC reports on this data starting from age 10) and race/ethnicity (reported in 5 groups: Non-Hispanic White, Non-Hispanic Black, Asian/Pacific Islander, American Indian/Alaska Native, and Hispanic/Latino). NVDRS began collecting data on violent deaths from six states in 2002, followed by progressive additions to the system over several years. In 2018, NVDRS was expanded to include data collection from all 50 states, Puerto Rico, and the District of Columbia. This expansion brings NVDRS closer to the goal of providing a complete picture of violent deaths across the nation. See the "Risk and Protective Factors, Precipitating Circumstances, and Mechanisms Related to Youth Suicide" section of this report for additional analysis of NVDRS data on Black youth. More information is available at: https://www.cdc.gov/violenceprevention/pdf/NVDRS-factsheet508.pdf

[Preventing Suicide: A Technical Package of Policy, Programs and Practices](#)

Technical package presenting a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide. Strategies include: a) strengthen economic supports; b) strengthen access and delivery of suicide care; c) create protective environments; d) promote connectedness; e) teach coping and problem-solving skills; f) identify and support people at risk; and g) lessen harms and prevent future risks. The package includes programs with a focus on children and youth, for instance:
- *Emergency Department Counseling on Access to Lethal Means (ED CALM)* trained psychiatric emergency clinicians in a large children's hospital to provide lethal means counseling and safe storage boxes to parents of patients under age 18 receiving care for suicidal behavior
- *Sources of Strength* is a program found to can improve school norms and beliefs about suicide that are created and disseminated by student peers in high school
- *Youth Aware of Mental Health Program* is a program developed for teenagers aged 14 to 16 that uses interactive dialogue and role-playing to teach adolescents about the risk and protective factors associated with suicide (including knowledge about depression and anxiety) and enhances their problem-solving skills for dealing with adverse life events, stress, school and other problems.

- *Good Behavior Game* is a classroom-based program for elementary school children aged 6 to 10. The program uses a team-based behavior management strategy that promotes good behavior by setting clear expectations for good behavior and consequences for maladaptive behavior.
- *Incredible Years* is a comprehensive group training program for parents, teachers and children designed to reduce conduct and substance use problems (two important suicide risk factors in youth) by improving protective factors such as responsive and positive parent-teacher-child interactions and relationships, emotional self-regulation and social competence (all protective factors for suicide).
- *Strengthening Families 10–14* is a program that involves sessions for parents, youth, and families with the goal of improving parents' skills for disciplining, managing emotions and conflict, and communicating with their children; promoting youths' interpersonal and problem-solving skills; and creating family activities to build cohesion and positive parent-child interactions.
- *Attachment-Based Family Therapy* is a program for adolescents aged 12 to 18 and is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety.

Health Resources and Services Administration (HRSA)

Children's Safety Network (CSN)
Among other activities, CSN facilitates Child Safety Learning Collaboratives on several topics, including Suicide/Self Harm Prevention (SSHP). These cyber teams are a network of peers that:
- Share lessons-learned, conquer challenges, and implement and spread evidence-driven strategies and programs to prevent childhood injuries and achieve state and national performance measures;
- Participate in ongoing trainings, personalized coaching, and technical assistance from nationally-renowned content experts to support and guide their program improvement efforts; and
- Build the capacity to establish a child safety system of improvement in their state/jurisdiction.

States participating in the SSHP cyber team: Indiana, Louisiana, South Carolina, Tennessee, Texas, Vermont, and Wyoming. States select evidence-based strategies, called a change package, to implement to address suicide and self-harm:
- Zero Suicide (SC, WY)
- Evidence-based gatekeeper training (IN, LA, TN, TX, WY)
- Valid and reliable screening (LA, TX, VT)
- Evidence-based parenting/caregiving programs that include resources on adverse childhood experiences (IN, SC)
- Evidence-based, multi-component suicide and self-harm prevention programs (LA, SC, TX, WY)

Critical Crossroads Care Pathway Toolkit
With the rising number of children seeking care for a mental health crisis presenting to the emergency department, hospitals in rural areas bear an excessive burden responding to such crises, given their limited mental health services. The toolkit aims to improve identification, management, and continuity of care of children and adolescents who present to the emergency department in a mental health crisis. This toolkit was developed in partnership between HRSA's Maternal and Child Health Bureau Emergency Medical Services for Children (EMSC) Program and the Federal Office of Rural Health Policy. Other federal agencies that contributed to the development of the toolkit include several operating divisions of HHS, the Department of Transportation, and the Department of Justice.

[Delta States Rural Development Network Grant Program](#)
The Delta Program supports and encouraged the development of integrated health care networks to address unmet local health care needs and prevalent health disparities in rural Delta communities. Two currently funded projects related to youth suicide prevention are:

- County of Mississippi Health Department (Charleston, MO) – The organization implements diabetes prevention programs within service areas to address chronic disease counseling and education for patients. They also coordinate behavioral/mental health referrals within their network partners that include a community mental health center and a Federally Qualified Health Center. Participants aged 12 and above are assessed for clinical depression and then referred to services with a documented follow-up plan working toward the Primary Care Behavioral Health model. Patients are also presented with wraparound services such as referrals to housing, food banks, and prescription drug assistance services.
- Southern Illinois University (Carbondale, IL) – The organization is implementing the Coordinated Approach to Child Health (CATCH) curriculum into their local schools within the service area. Through this integration they have also formed wellness committees at the middle and high schools to create a referral protocol for connecting at-risk youth to appropriate mental health services. They are also improving communication throughout the schools and community, including parents to raise awareness and increase capacity of parents/guardians to talk with their children regarding health behaviors.

[Randomized Control Trial (RCT) of Universal vs. Targeted School Screening for Adolescent Major Depressive Disorder](#) – The SHIELD Trial
The primary goal of the study is to compare the effectiveness of universal versus targeted adolescent major depressive disorder (MDD) screening in a school setting. This study addresses the US Preventive Services Task Force call for large, high-quality randomized clinical trials to better understand the effects of MDD screening and quantify the proportion of adolescents with screen-detected MDD successfully referred and treated.The long-term goal is to improve adolescent mental health and reduce the sequelae of MDD (e.g. suicide, academic failure). One of the aims of the study is to examine the effectiveness among racial/ethnic minority students, specifically urban non-Hispanic Black and Hispanic students (Sekhar, 2019). The schools included in the RCT are using a targeted screening approach, by which only students for whom there are observable behaviors related to the referral concern were referred for screening and assessment. The project is in progress and will end in December 2022.

[National Center for Fatality Review and Prevention](#)
The National Center for Fatality Review and Prevention provides technical assistance and training to 1,350 Child Death Review (CDR) teams nationally. The Center hosts the Case Reporting System for CDR teams to enter their death review data. Of the 217,030 cases in the system, 10,608 (4.9 percent) were suicides. The Center's Data Dissemination Committee reviews requests for data for research purposes. The Center collaborates with the Substance Abuse and Mental Health Services Administration (SAMHSA) and others to update the Case Reporting Form questions related to suicide; develop a guidance for local teams; and host a webinar on reviewing suicides.

[Pediatric Mental Health Care Access (PMHCA) Program](#)

PMCHA promotes behavioral health integration into pediatric primary care using telehealth. Statewide or regional networks of pediatric mental health teams provide tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions including those associated with a higher risk of suicide. The overarching goal of the program is to use telehealth modalities to provide timely detection, assessment, treatment, and referral of children and adolescents with behavioral health conditions, using evidence-based practices and methods in web-based education and training sessions. PMHCA awardees have identified suicide assessment as a training topic and have addressed suicidal ideation during teleconsultation, as well as providing referral options to specialty care for evaluation and treatment.

[Rural Health Care Services Outreach Program](#)

The Outreach Program is a community-based grant program aimed towards promoting rural health care services by enhancing health care delivery in rural communities. Two currently funded projects related to youth suicide prevention are:

- Regional Health Care Clinic (Sedalia, MO) – The West Central Missouri Zero Suicide Coalition is implementing a suicide prevention and intervention program using the Zero Suicide model and toolkit in conjunction with other evidence-based practices. The primary goals of the project are to improve screening and assessment in the school and primary care settings to identify individuals at risk for suicide so that early intervention and treatment can lead to improved outcomes, and to build workforce capacity competencies in suicide prevention in the West-Central Missouri region through awareness, training and education.
- Health Communities Coalition (HCC) of Lyon & Storey Counties (Dayton, NV) – HCC is implementing a comprehensive patient-centered health system throughout Lyon County, Nevada that begins with prevention and has wellness as an outcome. One of the evidence-based models that HCC is using is the Signs of Suicide program for middle and high school students.

[Rural Health Network Development Program (RHND)](#)

The purpose of the RHND program is to support integrated rural health care networks that have combined the functions of the entities participating in the network, including skilled and experienced staff and a high functioning network board, in order to address the health care needs of the targeted rural community. Two currently funded projects related to youth suicide prevention are:

- Tri-County Health Network (Telluride, CO) – This project seeks to improve community health and wellbeing by increasing accesses to trauma-informed care and behavioral health promotion services. They have implemented Family-to-Family and Safe-Talk programs to help residents develop skills to better cope with and overcome a mental health crisis for themselves or a loved one. They have also trained healthcare providers and community members using the evidence-based, Mental Health First Aid program.
- Southeast Alaska Regional Health Consortium (Juneau, AK) – This project increases access to prevention activities for youth by developing an evidence-based, peer-driven leadership program to support youth in adversity and build community resiliency related to suicide, alcohol and substance abuse, and domestic violence.

[Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program](#)

The purpose of the Screening and Treatment for Maternal Depression and Related Behavioral Disorders program is to establish, improve, or maintain programs that expand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum women for maternal depression and related behavioral health disorders, including in rural and medically underserved areas. The program's

overarching goal is to improve the mental health and well-being of pregnant and postpartum women and, thereby, their infants' social and emotional development, through increased access to affordable, culturally and linguistically appropriate treatment and recovery support services.

HHS Office of Minority Health

[National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)](#)
The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. The Think Cultural Health website offers resources to support education and implementation of CLAS, including the *Cultural Competency for Behavioral Health Professionals* e-learning program. The e-learning program is accredited for licensed alcohol and drug counselors, nurses, psychologists, psychiatrists and social workers.

Indian Health Service (IHS)

IHS programs focus on the American Indian population, but are included in this Report to provide broader context for HHS suicide prevention efforts.

[Indian Health Manual, Chapter 34 "Suicide Prevention and Care"](#)
The IHS national policy establishes standards of care for the care and treatment of American Indians and Alaska Natives (AI/ANs) at risk for suicide. The policy is located at: [https://www.ihs.gov/ihm/pc/part-3/p3c34/.](https://www.ihs.gov/ihm/pc/part-3/p3c34/)

[Zero Suicide Initiative (ZSI) Program](#)
A nationally coordinated grant and award program that funds tribes and IHS federal facilities to implement a culturally tailored Zero Suicide model within tribal communities and federal facilities. The ZSI focuses on all aged within the AI/AN population. The program operates on a three-year funding cycle from November 15, 2017, to October 31, 2020. The program provides eight awards to three federal sites and five tribes totaling $3.2 million dollars. More information on the ZSI is located at: https://www.ihs.gov/zerosuicide/

[Substance Abuse and Suicide Prevention (SASP) Program](#)
A nationally-coordinated program that funds tribes, urban Indian organizations, and IHS federal facilities to provide substance abuse and suicide prevention and intervention resources that are culturally appropriate to AI/AN communities. The program operates on a five-year funding cycle from September 30, 2015, to September 29, 2020.

The SASP program has four purpose areas: 1) Community Needs Assessment and Strategic Planning; 2) Suicide Prevention, Intervention, and Postvention; 3) Methamphetamine Prevention, Treatment, and Aftercare; and, 4) Generation Indigenous (Gen-I) Initiative Support for Native Youth. In both fiscal year (FY) 2016 and FY 2017, the IHS received additional funding totaling $16.5 million to expand Purpose Area 4: Gen-I Initiative Support. The Gen-I Initiative focuses on youth up to and including age 24.

The IHS awarded a total of $27.9 million to 175 projects. All funded projects are in the final year of the current funding cycle, which is scheduled to end on September 29, 2020. More information on the SASP is located at https://www.ihs.gov/mspi/.

Ask Suicide Screening Questions Quality Improvement Pilot (ASQ QIP)
A three-year project to initiate universal suicide risk screening within IHS Emergency Department pilot sites to address health disparities, develop competencies related to suicide risk, and increase integration of behavioral health screening into the IHS health care system in order to identify AI/ANs at risk for suicide. The ASQ QIP is a partnership between the IHS and National Institutes of Health, National Institute on Mental Health scheduled for completion on September 30, 2021. The ASQ QIP focuses on all aged within the AI/AN population.

Community Crisis Response
The IHS provides technical assistance and consultation to federal and tribal partners to address suicide-related crises within tribal communities and federal facilities. Since March 2017, the IHS has provided one-on-one consultation, technical assistance, resources management, and deployment requests for tribes across the twelve IHS Areas to address suicide crisis and clusters. More information on community crisis response located at https://www.ihs.gov/suicideprevention/communityguidelines/.

Telebehavioral Health Center of Excellence (TBHCE)
The TBHCE programs and hosts suicide prevention webinar training sessions for all aged within the AI/AN population. All trainings are archived at https://www.ihs.gov/teleeducation/webinar-archives/.

National Institutes of Health (NIH)

National Death Index Linkage Access for NIH-Supported Investigators
Beginning January 1, 2020, through an agreement between the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS), NIH reimburses the NCHS National Death Index (NDI) for the costs of NIH-supported investigators to link their research databases with the NDI for the research aims supported by the NIH.

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) Consortium for Research on Pediatric Trauma and Injury Prevention
This program funds a project titled "Building Research Capacity for Firearm Safety Among Children" which aims to brings together a multidisciplinary team of researchers and community stakeholder groups (e.g., gun advocates, gun safety trainers, veterans, family groups) across the U.S. to inform and catalyze the science **of** childhood firearm injury prevention by addressing both the gaps **in** research and human resources. The project is funded for a total of $936,449 from September 5, 2017 to August 31, 2022.

NIH Health Care Systems Research Collaboratory - Demonstration Projects for Pragmatic Clinical Trials
This program funds a project titled "A Pragmatic Trial of Parent-focused Prevention in Pediatric Primary Care**" which** will use a parental guidance and education program within pediatric primary care for adolescents that is aimed at making good choices, and assess prevention of substance use, depression, anxiety, and anti-social behavior. The project is funded for a total of $1,540,949 from May 15, 2018 to May 31, 2023.

National Institute of Mental Health (NIMH) Programs

NIMH funds a range of research grants to examine risk/precipitating/contributing factors for suicide, data linkaged, effective prevention and early intervention approaches. Selected programs are below:

- Addressing Suicide Research Gaps: Aggregating and Mining Existing Data Sets for Secondary Analyses: This program funds a project titled "Identifying periods of high risk and predictors of suicide for youth in public child serving systems" which aims 1) to quantify the incidence of suicide across and within four public child-serving systems in Ohio; 2) to identify high risk periods for suicide among youth in publicly funded sectors; and 3) to develop and validate a risk prediction algorithm to estimate individual risk for suicide in this population. The project is funded for a total of $415,015 from August 17, 2018 to May 31, 2022.
- Clinical Trials to Test the Effectiveness of Treatment, Preventive, and Services Interventions: This program funds a project titled "Preventing Suicide in African American Adolescents" which aims to test the effectiveness of a culturally-adapted, school-based suicide prevention intervention (the Adolescent Coping With Stress Course), delivered by indigenous Rush University social workers for low-resourced, urban, African American 9th grade students. The project is funded for a total of $1,235,922 from September 1, 2019 to June 30, 2024.
- Collaborative Hubs to Reduce the Burden of Suicide among American Indian and Alaska Native Youth (U19): This program is co-funded by NIMH and the National Institute on Minority Health and Health Disparities (NIMHD) and supports research focused on reducing the burden of suicide and promoting resilience among AI/AN youth,). In 2017, this program funded three collaborative research hubs (total $2,628,546) through May 2022 to increase the reach of and research base on effective, culturally relevant, preventive interventions that have the potential to increase resilience and reduce suicide in rural and urban indigenous communities.
- Pilot Effectiveness Trials for Treatment, Preventive and Services Interventions
  - Integrated Electronic and Care Manager Support Intervention for Caregivers of Adolescents with Suicide Attempts aims to develop, refine, and preliminarily test an integrated electronic and care support manager services intervention for caregivers of adolescents who have made a recent suicide attempt. This intervention may provide needed information and supports to parents, increase their parenting self-efficacy, increase their ability to follow safety plans in the home, reduce their emotional distress, and help parents access needed services in the community. The project is funded for a total of $247,275 from April 1, 2018 to February 28, 2021.
  - School-based depression prevention for adolescents with ADHD aims to develop and test a modified behavioral activation prevention program [Behaviorally Enhancing Adolescents' Mood in Schools (BEAM-S)] that incorporates modules to directly target reward responsivity (RR) and emotion regulation (ER) to mediate the association between ADHD and depression. The project also plans to examine effect on suicide ideation. A pilot program in Baltimore will involve school youth of whom 90% are Black. The project is funded for a total of $222,406 from August 7, 2018 to June 30, 2021.
  - Engaging Black youth in depression and suicide prevention treatment within urban schools: a preliminary study aims to examine the effectiveness of the Making Connections Intervention, a theoretically-driven 1-2 session intervention designed to improve engagement, perceived relevance, and treatment satisfaction among depressed, Black adolescents. The project also aims to identify key mediators of both engagement and response to treatment for depression. The project is funded for a total of $226,967 from March 1, 2019 to December 30, 2021.

- [Pilot Studies to Detect and Prevent Suicide Behavior, Ideation and Self-Harm in Youth in Contact with the Juvenile Justice System](#): This funding opportunity aims to support research to test the effectiveness of combined strategies to both detect and intervene to reduce the risk of suicide behavior, suicide ideation, and non-suicidal self-harm (NSSI) by youth in contact with the juvenile justice system. An estimated $1.3 million total is available for this funding opportunity, which expires in January 2021.
- [Secondary Data Analysis to Examine Long-Term and/or Potential Cross-Over Effects of Prevention Interventions: What are the Benefits for Preventing Mental Health Disorders?](#)
  - [Long-term effects of the Family Check-Up on depression and suicide across trials and development](#)" aims to aggregate data across three trials (to include 2322 families, 25% of whom are Black) of the Family Check- Up, an empirically-supported prevention program designed to reduce behavior problems and substance use, to examine long-term collateral effects on depression and suicidal ideation/attempts. The project is funded for a total of $367,699 from December 2, 2019 to October 31, 2022.
- [Netting prevention intervention butterfly effects: An integrative data analysis investigating the long-term and cross-over effects of randomized, school-based prevention programs on adult mental health](#) aims to aggregate data from existing prevention intervention trials with longitudinal follow-up (combined sample is 75% Black) to allow for novel secondary data analyses which will enhance understanding of intervention impacts on 1) suicidal behaviors, 2) depression and anxiety symptoms and diagnoses, and 3) psychosis symptoms. The project is funded for a total of $789,627 from February 1, 2020 to November 30, 2022.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The following SAMHSA programs and efforts have a connection to suicide prevention for Black youth:

[Faith.Hope.Life (National Action Alliance for Suicide Prevention)](#)
Faith.Hope.Life. campaign*,* developed by the National Action Alliance for Suicide Prevention's [Faith Communities Task Force](#), is an opportunity for every faith community in the United States, regardless of creed, to support suicide prevention. The [Faith.Hope.Life website](#) houses various resources for faith leaders and places of worship to become equipped to address the issue of suicide prevention such as sample prayers, religious text that has been used to address mental health, and competencies for faith leaders who want to know more about suicide prevention. During the weekend of May 15-17, 2020, the National Action Alliance for Suicide Prevention's (Action Alliance) Faith.Hope.Life. campaign will invite faith communities across the nation to come together to pray for those whose lives have been touched by suicide.

[Historically Black Colleges and Universities Center of Excellence in Behavioral Health](#)
This program recruits students at Historically Black Colleges and Universities (HBCUs) to careers in the behavioral health field to address mental and substance use disorders, and provides training that can lead to careers in the behavioral health field, and/or prepares students to obtain advanced degrees in the behavioral health field. The HBCU-CFE activities emphasize education, awareness, and preparation for careers in mental and substance use disorder treatment, including addressing opioid use disorder treatment; serious mental illness (SMI) (including First Episode Psychosis (FEP); and suicide prevention.

[Mental Health Technology Transfer Center Network](#)

The Mental Health Technology Transfer Center (MHTTC) Network is a collaborative network that supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. The MHTTCs work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals. The Region 3 MHTTC has been active in engaging providers in the region on the increase in Black youth suicide rates. In March 2020, the Region 3 MHTTC will host a webinar called: "*Dying to Ask for Help: Suicide Trends and Treatment Disparities among U.S. Adolescents*" hosted by Dr. Michael Lindsey, Chair of the CBC Task Force on Black Youth Suicide.

[Minority Fellowship Program](#)

The Minority Fellowship Program (MFP) is a grant initiative that awards funding to organizations to support the development of behavioral health practitioners. The MFP aims to increase the presence, knowledge, and skill base of practitioners available to serve racial and ethnic minority populations. By increasing the number of culturally competent professionals in the workforce, the program seeks to reduce health disparities and improve behavioral healthcare outcomes for underserved, minority communities.

The program also seeks to encourage more racial and ethnic minorities to join the behavioral health workforce. Racial and ethnic minorities make up more than 28% of the nation's population, yet less than 20% of America's behavioral health workforce consists of racial or ethnic minorities. The relative scarcity of professionals who are from culturally and linguistically diverse backgrounds constitutes a workforce issue that contributes to the current disparities in quality of care and access to behavioral health treatment.

Pathways to Behavioral Health Equity

SAMHSA's Office of Behavioral Health Equity hosted an in-person expert panel, a virtual roundtable, and a stakeholder call between 2016 and 2018 to address the emerging Black youth suicide trends, based on earlier research papers examining the suicide rate among children. Meeting participants included researchers, mental health practitioners, community leaders, federal partners, and other stakeholders. Discussion topics included early childhood development and mental health approaches, engagement and partnerships, data and research resources and gaps, access to services, emerging promising/best practices, prevention and early intervention. In 2018, the Office of Behavioral Health Equity at SAMHSA conducted a webinar of the rising rates of Black youth suicide (https://www.youtube.com/watch?v=ZeAg8epnz98&t=9s).

[Suicide Prevention Resource Center (SPRC)](#)

The Suicide Prevention Resource Center (SPRC) is the only federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention.
SPRC advances suicide prevention infrastructure and capacity building through:

- Consultation, training, and resources to enhance suicide prevention efforts in [states](#), [Native settings](#), [colleges and universities](#), [health systems and other settings](#), and organizations that serve populations at risk for suicide.
- Staffing, administrative, and logistical support to the Secretariat of the [National Action Alliance for Suicide Prevention](#) (Action Alliance), the public-private partnership dedicated to advancing the [National Strategy for Suicide Prevention](#).
- Support for [Zero Suicide](#), an initiative based on the foundational belief that suicide deaths for individuals under care within health and behavioral health systems are preventable. The initiative provides information, resources, and tools for safer suicide care.

The SPRC houses an extensive library of suicide prevention resources. The resources created by the SPRC are free and available for download.

Other SAMHSA Programs

There are also a number of SAMHSA programs addressing youth suicide prevention in general:
- Campus Suicide Prevention Program: This program advances a comprehensive approach to preventing suicide in institutions of higher education. The intent is to assist colleges and universities—including tribal colleges and universities—to build a foundation to prevent suicide. It also enhances services for students with mental and substance use disorders that put them at risk for suicide and suicide attempts.
- Circles of Care (COC) Program: Through this program, tribes receive support to increase the capacity and effectiveness of mental health systems serving their communities. COC grantees focus on reducing the gap between the need for mental health services; the availability and coordination of mental health, substance use, and co-occurring disorders; and, the impact of historical trauma.
- Garrett Lee Smith State/Tribal Youth Suicide Prevention Program: The focus of this program is on implementation of statewide or tribal youth suicide prevention and early intervention strategies. Grants support public/private collaboration among youth-serving institutions, schools, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child/youth supporting organizations.
- Grants to Implement Zero Suicide in Health Systems: The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. The purpose of this program is to implement suicide prevention and intervention programs for individuals who are aged 25 or older. This program is designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for such individuals who are at risk for suicide. Recipients will implement the Zero Suicide model throughout their health system.
- Linking Actions for Unmet Needs in Children's Health (Project LAUNCH) Program: This program promotes wellness of young children from birth to age 8 by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Project LAUNCH drives the development of networks that coordinate key child-serving systems and integrate behavioral and physical health services. The intent is for children to thrive in safe, supportive environments and enter school ready to learn and able to succeed.
- National Child Traumatic Stress Initiative: The purpose of this program is to provide and increase access to effective trauma-focused treatment and services systems in communities for children and adolescents, and their families who experience traumatic events throughout the nation.
- National Suicide Prevention Lifeline: The National Suicide Prevention Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week.
- Preventing Suicide: A Toolkit for High Schools: This toolkit assists high schools and school districts in designing and implementing strategies to prevent suicide and promote behavioral health. Will be updated by the end of 2020.
- Systems of Care (SOC) Program: The SOC program is intended to improve behavioral health outcomes for children and youth with serious emotional disturbances and their families. The program supports the availability and provision of mental health and related recovery support services along with systemic changes in policy, financing, services and supports, training and

workforce development, and other areas that are necessary for expanding and sustaining the system of care approach.

- Tribal Behavioral Health Grant (TBHG/Native Connections): The purpose of this program is to prevent and reduce suicidal behavior and substance use, reduce the impact of trauma, and promote mental health among American Indian/Alaska Native young people up to and including age 24.

Future Initiatives

HHS has several planned efforts focused on suicide prevention.

AHRQ

Healthcare Cost and Utilization Project (HCUP)

Data from the vast collection of billing data on inpatient hospitalizations and emergency department visits through the Healthcare Cost and Utilization Project (HCUP) will be used to produce an HCUP Statistical Brief that examines hospital utilization related to suicidal ideation and self-harm.

Systematic Evidence Reviews on the Benefits and Harms of Screening for Suicide Risk

To support the USPSTF in updating its current recommendation statements on *Screening for Suicide Risk in Adolescents, Adults and Older Adults*, *Screening for Depression in Adults* and *Screening for Depression in Children and Adolescents* , AHRQ is in the early staged of commissioning 2 systematic evidence reviews on the benefits and harms of screening for suicide risk; one review will focus on screening in adults and the other will focus on screening in children and adolescents. Each of these reviews will be part of a larger review that also looks at the benefits and harms of screening for depression and anxiety in each population as well. The literature search will include minority youth and/or Black youth, aged up to (and including) 18.

CDC

ACEs & Suicide Microsimulation Model

This project supports the development of a microsimulation model that models the relationship between ACEs and suicide. This project includes data on youth between 7th and 12th grade and also includes data on Black youth. The CDC Division of Injury Prevention is funding this project from 9/2020-8/2025.

Comprehensive Suicide Prevention Notice of Funding Opportunity (CDC-RFA-CE19-1906)

This Notice of Funding Opportunity (NOFO) supports implementation and evaluation of a comprehensive public health approach to suicide prevention. Such an approach includes strong leadership as the convener of multi-sectoral partnerships; prioritizes data to identify vulnerable populations and to better characterize risk (e.g., relationship, job/financial, mental health problems) and protective factors (e.g. connectedness, hope, resilience) impacting suicide; leveraged current prevention practices and fills gaps by selecting multiple and complementary strategies with the best available evidence using CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices; rigorously evaluates the overall approach and individual activities; feeds data back into the system for quality improvement and sustainability; and effectively communicates results. The purpose of this NOFO is to implement and evaluate this approach to suicide prevention, with attention to vulnerable populations (e.g., veterans, tribal populations, rural communities, LGBTQ, homeless, other) that account for a significant proportion of the suicide burden and have suicide rates greater than the general

population in a jurisdiction(s) (e.g., state, city/county, tribe). Key outcomes include a 10% reduction in suicide morbidity and mortality in the jurisdiction(s). CDC anticipates funding projects from 9/2020-8/2025 for a total of $7m annually.

Zero Suicide Initiative Program
The IHS is forecasting the publication of a Notice of Funding Opportunity (NOFO) for a new Zero Suicide Initiative grant funding cycle. The anticipated publication in the Federal Register is spring 2020, with a likely start date for funding on, or after September 30, 2020.

Substance Abuse and Suicide Prevention (SASP) Program
The IHS is forecasting the publication of a NOFO for a new Suicide Prevention, Intervention and Postvention grant funding cycle. To further integrate the emphasis on youth prevention, Gen-I goals will be incorporated into the goals of the new NOFO, rather than a separate announcement. The anticipated publication in the Federal Register is spring 2020, with a likely start date for funding on, or after September 30, 2020.

Notice of Special Interest (NOSI) in Research on Risk and Prevention of Black Youth Suicide
The purpose of this NOSI, issued by NIMH, the National Institute on Minority Health and Health Disparities and the NIH Office of Disease Prevention, is to encourage research focused on Black child and adolescent suicide. Appropriate topics include, but are not limited to, studies on epidemiology, etiology and trajectories; intervention and services research; preventive interventions; treatment interventions; services interventions; and multiple domains and levels of influence to understand and address health disparities. The first available due date is August 25, 2020 and the expiration date is July 31, 2022.

Faith.Hope.Life (National Action Alliance for Suicide Prevention)
The Faith.Hope.Life Campaign is currently developing resources for youth ministries to support and be prepared for youth who experience suicidal ideation. The Youth Ministry Workgroup is also creating resources specifically for faith communities to recognize the specific risk factors for Black children.