RING THE ALARM

THE CRISIS OF BLACK YOUTH SUICIDE IN AMERICA

A REPORT TO CONGRESS FROM THE CONGRESSIONAL BLACK CAUCUS

EMERGENCY TASKFORCE ON BLACK YOUTH SUICIDE AND MENTAL HEALTH

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This report would not exist without the efforts of the Working Group empowered by the Emergency Taskfore. Their dedication and willingness to lend both time and expertise have powered the Taskforce's work. Special thanks to the NYU McSilver Institute for their invaluable contributions in producing this report.

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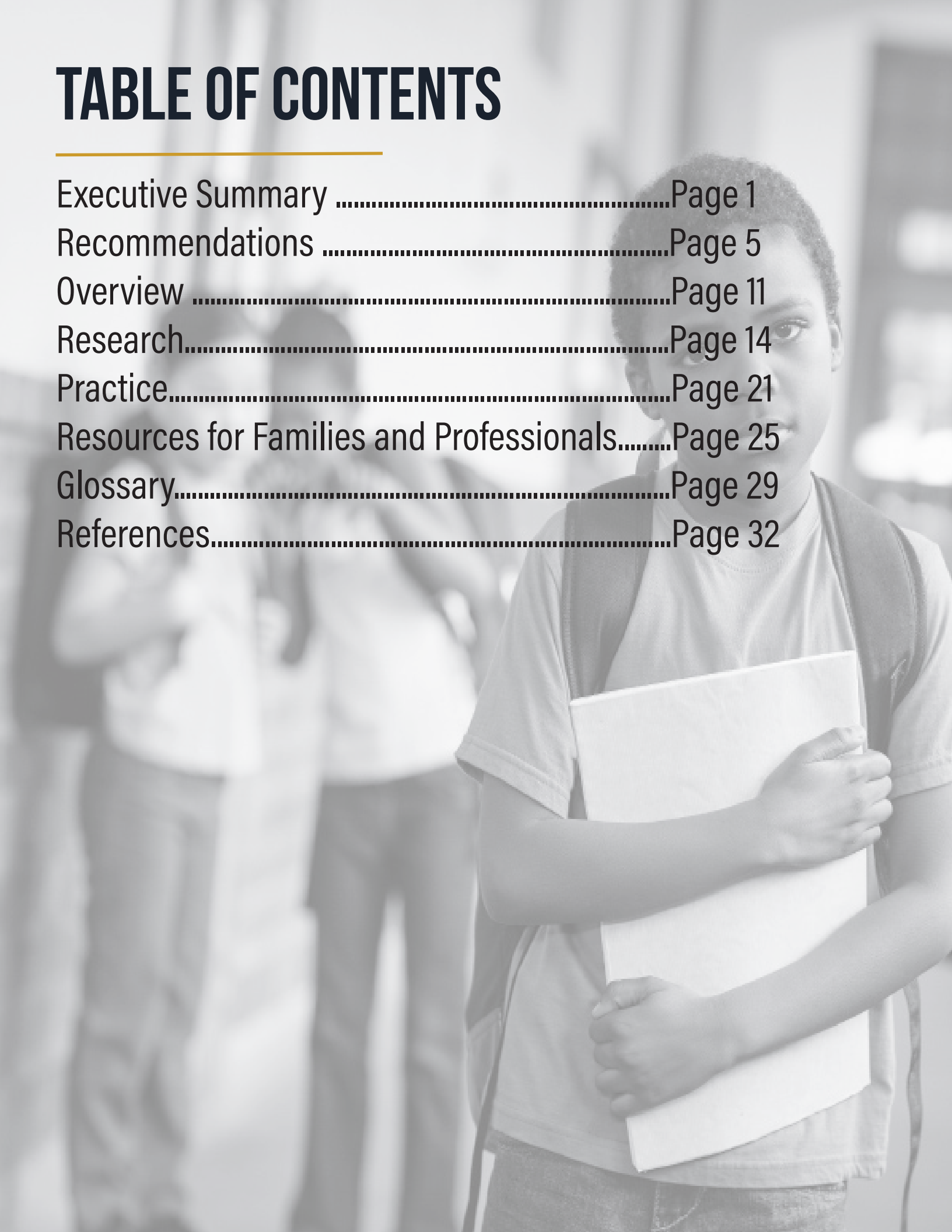

EXECUTIVE SUMMARY

INTRODUCTION

Over the last several years, data has emerged indicating an alarming increase in the suicide rates for Black children and teenagers over the past generation. While research has also shown climbing rates for youth from other racial and ethnic groups, this trend in Black youth runs counter to historical data showing lower rates of suicide among Black Americans. It challenges the public perception that Black youth simply do not commit suicide. Additional research about suicidal behaviors has raised questions about whether the path from suicidal thoughts to attempts is well understood in Black youth, and whether we have the knowledge and tools to intervene before the worst happens.

A GROWING CRISIS

In youth ages 10 to 19 years, suicide is the second leading cause of death, and in 2017, over 3,000 youth died by suicide in this age group. Over the past decade, increases in the suicide death rate for Black youth have seen the rate rising from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017. Black youth under 13 years are twice as likely to die by suicide and when comparing by sex, Black males, 5 to 11 years, are more likely to die by suicide compared to their White peers. Finally, the suicide death rate among Black youth has been found to be increasing faster than any other racial/ethnic group.

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When examining suicidal ideation and behavior results have been mixed. Nonetheless, a new study using the Youth Risk Behavior Survey (a national school survey of adolescent health behaviors developed by the Centers for Disease Control and Prevention) paints a further alarming picture for Black high-school aged youth. That study's findings indicated that suicide attempts rose by 73% between 1991-2017 for Black adolescents (boy and girls), while injury by attempt rose by 122% for Black adolescent boys during that time period. This would suggest that Black males are engaging in more lethal means when attempting suicide. Although Black youth have historically not been considered at high risk for suicide or suicidal behaviors, current trends suggest the contrary.[1]

THE CHALLENGE AHEAD

The narrowing racial gap in suicide rates tells us that this emergent issue among Black youth warrants attention now. A cadre of Black researchers from across the United States has been ringing the alarm to raise awareness about this disturbing trend.

Yet, very few research dollars have been committed by entities such as the National Institutes of Health (NIH), National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to investigate into what is happening; specifically, for evidence-based interventions relating to mental health and suicide risk; and studies about risk factors, protective factors, mental health utilization and engagement, as they pertain to Black youth. Black scientists—those most closely connected to this population—are 10 percentage points less likely than White scientists to be awarded NIH research funding; and a recent study by NIH scientists concluded that research topics proposed by Black scientists are less likely to be funded than those proposed by White researchers.

Despite a growing body of research on Black youth suicide and mental health, news coverage of suicide trends among

1 *To see the reference information for the aforementioned research, please see the full report.*

American youth too often fails to mention specific developments related to Black youth suicide, which urgently need addressing.

THE FIRST STEPS TOWARD ACTION

These are among the reasons that on December 6, 2018, U.S. Representative Bonnie Watson Coleman (D, NJ —12th District), who has been a long-standing advocate of the mental health needs of the Black community, convened a congressional hearing that included some of the country's leading Black researchers and practitioners to discuss mental health solutions for the increasing rates of suicide among Black youth. An outcome of that hearing was a recommendation for the Congressional Black Caucus to establish a taskforce to further examine Black youth suicide and devise solutions, with regard to both legislation and other interventions.

On April 30, 2019, the Congressional Black Caucus (CBC) established the Emergency Taskforce on Black Youth Suicide and Mental Health (the Taskforce), with Rep. Watson Coleman as the chair. Upon its creation, the Taskforce empowered a Working Group of experts composed of the country's leading Black academic, research and practicing experts.

The Taskforce and the Working Group were charged with identifying causes and solutions for Black youth suicide and mental health needs; developing and producing a report by the end of 2019; and describing the latest research, as well as practices and policy recommendations.

As part of the fact-gathering process, the CBC and the Taskforce held a number of hearings on Black youth suicide, including ones that focused on the impact of social media and the role of the faith community. They also held a hearing to ascertain Black youths' perspectives on the issue of suicide and mental health. Taraji P. Henson, founder of the Boris L. Henson Foundation (which focuses on mental health), testified about mental health stigma and the barriers Black people face in accessing treatment during a special hearing on June 7, 2019.

THE PATH FORWARD

The intention of this report is to raise awareness; provide an overview on the existing body of research; identify gaps in research, policy and practice; highlight best practices for practitioners; and create a resource document for all who come into contact with Black youth in healthcare, schools and other settings.

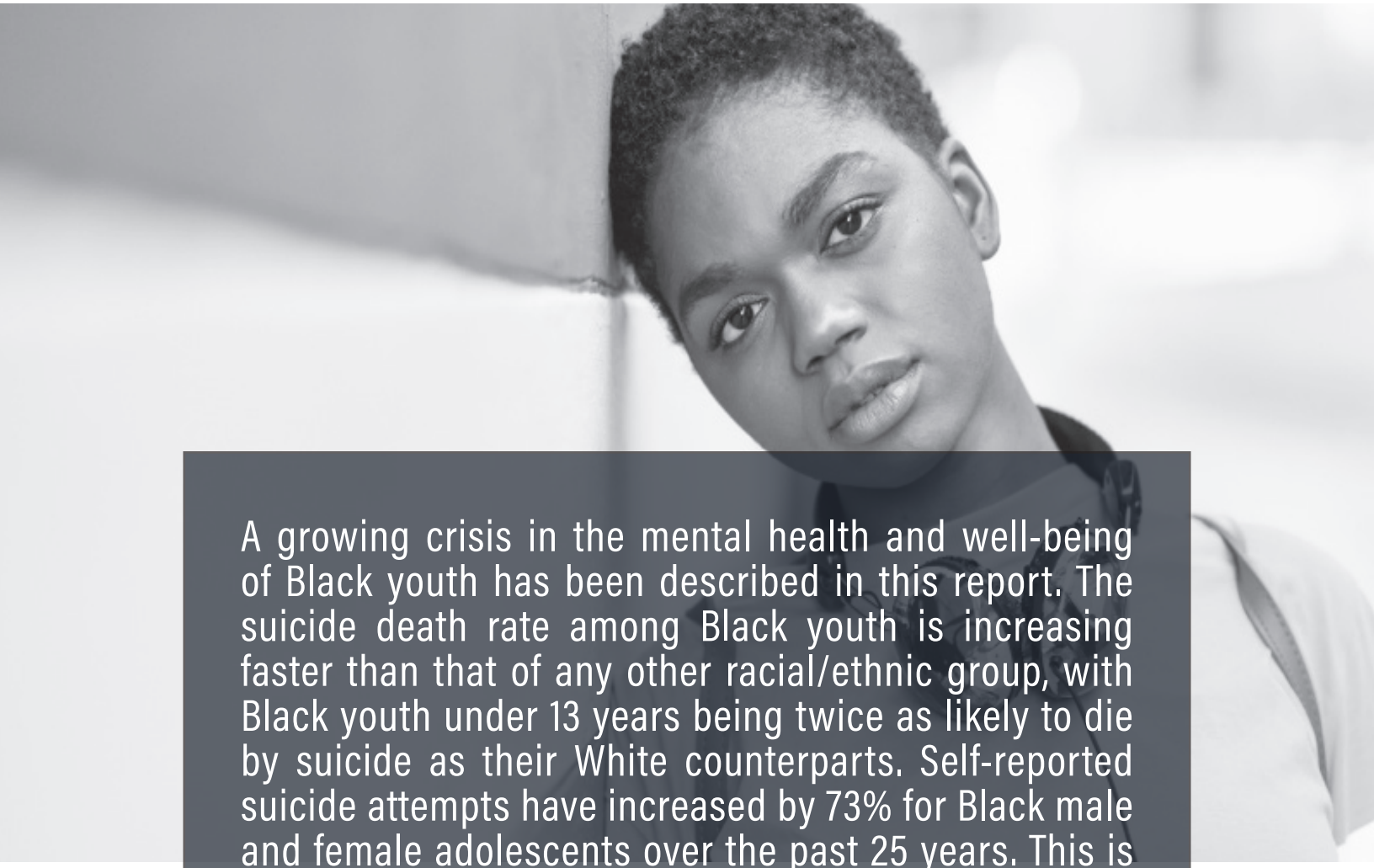
The work of this Taskforce, in partnership with the CBC, will be ongoing and will include legislation; demonstration projects; regional roundtables; trainings; and engagement of policy makers on the federal, state and local levels. Most importantly, the Taskforce would like for this report to serve as a vital resource for the parents and caregivers of Black youth.

This report is dedicated to the families of Black youth, and to the children who have called our attention to this urgent matter. We know that suicide is a difficult topic to discuss; and while there are some very technical aspects to what is contained in this report, we have included the glossary in recognition that this report must be as accessible to everyone.

There is much work to be done within schools, the allied mental health professions, health institutions, funders and government entities to provide the necessary investment and training to properly address the mental wellness needs of Black youth. We must reverse the trends for suicide and ensure that more Black children and teens are received and engaged in mental health care.

Let this report serve as an urgent call to action for all Americans.

RECOMMENDATIONS



A growing crisis in the mental health and well-being of Black youth has been described in this report. The suicide death rate among Black youth is increasing faster than that of any other racial/ethnic group, with Black youth under 13 years being twice as likely to die by suicide as their White counterparts. Self-reported suicide attempts have increased by 73% for Black male and female adolescents over the past 25 years. This is while self-reported suicidal thoughts and plans have decreased, pointing to a need to examine why they may be going straight to attempts.

Meanwhile, Black adolescents are significantly less likely to receive care for depression—a major risk factor for suicide—with pervasive structural inequities, social determinants of health, stigma and mistrust of healthcare providers creating daunting barriers to treatment.

Knowing the depth and scope of the crisis facing our Black youth, we are making the following policy, practice and research recommendations for addressing their needs relating to suicide and mental health.

Our overarching goals for these recommendations are to:

1. Increase the amount of research into topics relating to Black youth mental health and suicide through National Institutes of Health (NIH) and National Institute of Mental Health (NIMH) funding.

2. Increase funding and resources for Black researchers who are focused on these topics.

3. Demonstrate and promote evidence-based interventions and best practices for clinicians, school personnel, teachers, parents and others who interact with Black youth.

4. Amplify the work of the Taskforce and its Working Group through strategic collaboration, outreach and technical assistance to state and local governments, as well as through public-private partnerships.

Our specific recommendations come under the following categories:

- NIH/NIMH Funding and Attention
- Demonstration Projects
- Promoting Best Practices
- Community Engagement and Awareness
- National Website and Repository for Data on Suicidal Behavior
- Engagement of State and Local Governments
- Ongoing Work of the Task Force

NIH/NIMH FUNDING AND ATTENTION

Research findings by this body point to an urgent need for more research relating to Black youth suicide and mental health. Yet, Black scientists—those most closely connected to this population—are 10 percentage points less likely than White scientists to be awarded NIH research funding. A recent study by NIH scientists underscores the problem, concluding that research topics proposed by Black scientists are less likely to be funded than those proposed by White researchers; with community or population-level research, health disparities research and patient-focused interventions—proposed with greater frequency by Black scientists—garnering among the lowest grant award rates.

In light of the funding gap, we recommend that the dearth of NIH- and NIMH-funded research relating to Black youth mental health and suicide be addressed through federal legislation and engagement of those agencies. Research areas of focus should include, but not be limited to:

1. Risk and protective factors for suicidal behaviors among Black youth
2. Mental health motivation, utilization and engagement among Black youth with an emphasis on examining motivation for mental health treatment

3. Risk and protective factors, as well as mental health utilization and engagement, among Black LGBTQ+/SGL youth.
4. Practical, systemic and cultural barriers to treatment
5. The effectiveness of depression screenings by professionals across health care professions and institutions for helping to identify Black youth at risk for suicide
6. The effect of social media usage on Black youth
7. Evidence-based interventions relating to mental health and suicide risk; in particular, those that are age-appropriate, and culturally and linguistically relevant for Black youth

In addition, this body recommends the following:

- That the CBC, together with the Taskforce, shall convene a roundtable with NIH and NIMH to discuss funding, interventions and evidence-based practices and a road map for identifying the best ones.
- That the CBC, together with the Taskforce, shall convene hearings on the issue of the dearth of research funding relating to Black youth mental health and suicidal behavior, and how to increase that funding.
- Engagement of NIH and NIMH about funding to address the dearth of evidence-based approaches to the treatment of depression or suicide prevention that are tested in large enough samples of Blacks to help establish an evidence base for this population.
- That federal funding be provided to demonstrate evidence-based interventions that show the effect of placing social workers and other mental health professionals in schools, proportionate to the number of students in each school.

DEMONSTRATION PROJECTS

A primary objective of this Taskforce is to ensure that we continue to advance best practices that are guided by the research led by experts, researchers and clinicians working with Black youth. Demonstration projects will provide opportunities to test, assess and advance such best or promising practices. We recommend funding and demonstrating evidence-based interventions targeting Black youth suicidal behaviors and depression, in schools and other settings, through government, public-private partnerships and in collaboration with faith-based organizations.

Let this report serve as an urgent call to action for all Americans.

PROMOTING BEST AND PROMISING PRACTICES

One remedy for closing the racial gap in mental health services that is described in the Research section of this report is to examine best and promising practices for addressing the needs of Black youth. Therefore, this body recommends the following:

1. Establish online and regional training academies for school-based personnel and mental health providers on how to recognize signs of depression, suicidal behaviors and other mental health problems.
2. Fund the development of a model curriculum for administrators, teachers, other school personnel, parents and community-based organizations and around mental health and suicide, leveraging the expertise of the Working Group of the Taskforce. Such a curriculum would include training in anti-bias, anti-oppressive and gender equity practices.
3. Developing culturally-effective guidelines for national suicide and mental health hotlines and organizations relating to Black youth, leveraging the expertise of the Working Group of the Taskforce.
4. Identify and promote best and promising practices for increasing the pipeline of social workers and other mental health providers to address the dearth of school-based personnel who can address the mental health needs of Black students, with the goal of placing a proportionate number of social workers and other mental health providers in each school relative to the student body population.
5. Develop a certification program for medical personnel, clinicians, school personnel and others who interact with Black youth in an educational or healthcare setting, to ensure they are trained to address the mental health needs of Black youth.
6. Develop a screening tool for use by providers across healthcare professionals and institutions relating to suicidal thoughts, ideation and self-harm, as well as a protocol on how to treat and connect Black youth to care.
7. Identify and implement highly universalized models, such as Mental Health First Aid and Zero Suicide.

COMMUNITY ENGAGEMENT AND AWARENESS

The research, practices and recommendations described in this report will only be effective if lawmakers, policy makers, school and medical personnel who interact with Black youth, parents, media, members of the faith community, other stakeholders and members of the general public are aware of them. Toward that end we recommend establishing and funding an awareness campaign about Black youth suicidal behaviors and engage the following populations:

- Youth
- LGBTQ+/SGL Youth
- Clergy
- Parents
- Elected Officials
- Fraternal and Civic Organizations

NATIONAL WEBSITE AND REPOSITORY FOR DATA ON SUICIDAL BEHAVIOR

It is imperative that the nation collects better data on Black youth suicidal behaviors and makes that information available to researchers and the public through an online repository. Such a repository should include the following relevant document types:

- Fact sheets
- Research
- Reports
- Legislation
- A searchable database of experts by region
- Best and promising practices
- A glossary of terms

ENGAGEMENT OF STATE AND LOCAL GOVERNMENTS

It requires more than federal action to address the mental health needs of Black youth and the rising rates of suicidal behavior in this population. Research, education and evidence-based solutions must occur at the local government level, connecting with communities and families. Toward that end, we make the following recommendations:

1. Amplify the work of the Taskforce at the state and local level, by engaging state and city legislative bodies.
2. Establish taskforces on Black Youth Suicide and Mental Health at the local government level.
3. Provide technical assistance and support to local taskforces through legislation.

ONGOING WORK FROM THE CBC

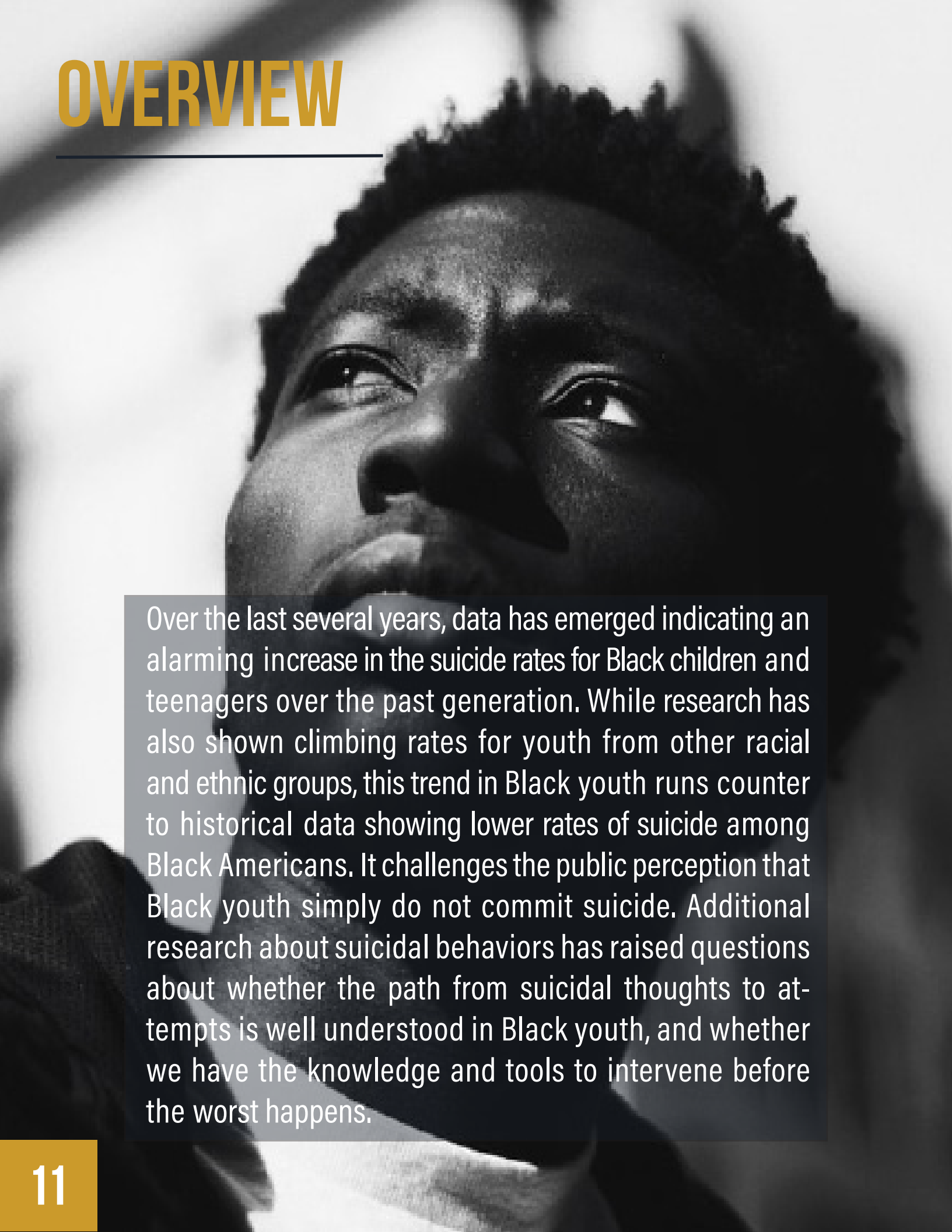
The growing crisis in Black youth suicide and mental health will not abate with the issuance of this report or actions to carry out its recommendations. We urge the following steps to ensure that the work continues, with far-reaching impact.

1. Provide oversight in order to continue the critical work begun by the taskforce
2. Establish an annual convening and/or conference on Black Youth Suicide and Mental Health under the auspices of the CBC
3. Garner resources and support for the pursuit of public-private partnerships through legislation
4. Propose and introduce legislation with the goal of addressing Black youth suicide and mental health trends 1

The information contained in this report sets out a blueprint for action and for saving precious, young lives. Following the aforementioned recommendations will prove that we, as a nation, are no longer willing to lose any Black youth to suicide.

1 To see the reference information for research cited in this section, please see citations 109 and 110 in the Reference section of the full report.

OVERVIEW



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- Identify gaps in research, policy and practice
- Highlight best practices for practitioners
- Create a resource document for all who come into contact with Black youth in health care, schools and other settings.

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SUICIDE AND SUICIDAL BEHAVIOR AMONG BLACK YOUTH

This section shares the most recent prevalence rates regarding suicide (completed suicide or suicide death) and suicidal behaviors (thinking about, planning or attempting suicide), with a particular focus on the rates of suicide and engagement in suicidal behaviors among Black youth. With great intention, we distinguish suicide from suicide behaviors in terms of rates. What you will see below is that prevalence rates are concerning for Black youth, both in terms of suicide and engagement in suicidal behaviors.

In youth ages 10-19, suicide was the second leading cause of death and in 2017: over 3,000 youth died by suicide in this age group. The Black youth suicide rate rose from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017. Black youth under 13 years are two times more likely to die by suicide and when comparing by sex, Black males, 5 to 11 years, are more likely to die by suicide compared to their White peers. [1-3] Finally, the suicide death rate among Black youth has been found to be increasing faster than any other racial/ethnic group.[4]

Results have been mixed when examining suicidal thoughts and behavior. Nonetheless, a new study using the Youth Risk Behavior Survey (a national school survey of adolescent health behaviors developed by the Centers for Disease Control and Prevention) paints a further alarming picture for Black high-school aged youth. That study's findings indicated that suicide attempts rose by 73% between 1991-2017 for Black adolescents (boy and girls), while injury by attempt rose by 122% for adolescent Black boys during that time period.[5] This would suggest that Black males are engaging in more lethal means when attempting suicide. Although Black youth have historically not been considered at high risk for suicide or suicidal behaviors, current trends suggest the contrary.

RISK & PROTECTIVE FACTORS FOR SUICIDE AMONG BLACK YOUTH

Risk Factors

Risk factors are characteristics that increase the likelihood that youth develop a problem behavior, are not static, and can change over time.[6] Key risk factors for suicide thoughts and behaviors for youth in general include the presence of a psychiatric disorder (e.g., depression, anxiety), sex (with females being more likely to attempt suicide and males being more likely to die from suicide), LGBTQ+/SGL identity, prior suicide attempts, being a victim of bullying and bullying others, socioeconomic factors, impaired family functioning, exposure to suicide (including a family member or celebrity) and access to lethal means.[7-13]

The relationship between risk factors for suicide and suicidal behaviors is complex. For example, research suggests children and adolescents who have been bullied are more likely to report experiencing suicidal thoughts and/or have made a suicide attempt, but it is unclear if there is a direct causal relationship between bullying and suicidal behaviors.[7,14] Additionally, emerging areas of research, such as media and technology use, are evaluating other potential risk factors for youth suicide and suicidal behavior. For instance, research suggests adolescents who spend more time "on screens" (i.e., on the computer, tablets and/or smart phones) and who engage in high levels of social media use have higher levels of depressive symptoms and suicide related outcomes.[15]

The few studies that have examined suicide risk in Black adolescents suggest that depression, delinquent behavior,

poor familial support and, in some cases, substance abuse are risk factors for suicide thoughts, attempts and/or deaths.[16-19] To date, there are limited studies examining the role of bullying, social media, LBGTQ+/SGL identity and other risk factors and their impact on suicide related behaviors in Black youth. One recent study conducted an online survey of Black and Latinx adolescents and found exposure to online racial traumatic events (e.g., seeing images or videos of others from their racial/ethnic group being beaten) was associated with greater depression and post-traumatic stress symptoms which both have been associated with suicide risk.[20]

While the risk factors for suicide may be similar across racial groups, it is not always clear if the mechanisms for suicidal behavior function differently among racial groups. For example, Dr. Sean Joe and colleagues (2009) found female sex, older age and the presence of a mental health disorder were risk factors for suicide in an ethnically diverse sample of Black adolescents, but Black adolescent suicide attempters were less likely to have a diagnosed mental health disorder.

LGBTQ+/SGL Identity

Research completed among sexual minority youth (SMY) also found that Black and Latinx identities were associated with increased risk of suicide, but this elevated risk was not explained by mood or substance use disorders suggesting that Black SMY were at elevated risk for suicide attempts, even in the absence of traditional markers of depression.[21] These findings may point to the need to examine alternative explanations for increased suicide risk that may be specific to the experiences of Black LGBT+/SGL youth, such as discrimination. In a recent survey of 1,678 Black LGBTQ+/SGL youth, 67% have been verbally insulted because of their LGBTQ+/SGL identity; 30% have been physically threatened because of their LGBTQ+/SGL identity; and 90% have experienced racial discrimination.[22] Mueller, James, Abrutyn and Levin found, however, that White and Latinx LGBI youth were significantly more likely to be bullied than their White heterosexual peers while no significant differences in the rates of bullying were found between Black LGB youth and their White heterosexual peers.[23] Yet, Mueller et al., also found that Black LGB youth were more likely than their White heterosexual counterparts to report suicidal thoughts.[23] Thus, more research is needed specifically related to suicide risk factors among Black LGBTQ+/SGL youth. Black LGBTQ+/SGL youth have multiple identities which may increase their experiences of stress and isolation from both the Black and the LGBTQ+/SGL communities.[24,25]

Role of Trauma

Another risk factor for suicide that commonly affects Black youth is exposure to trauma. Black youth are not all the same and have diverse experiences; however, there are numerous traumatic experiences that Black youth can have including exposure to racism, discrimination, neighborhood violence, economic insecurity, abuse, grief and other adverse childhood experiences. Trauma is disproportionately experienced in Black communities when compared with other communities, and traumas experienced are more likely to be severe. Research has long established the association of traumatic events and suicidal behavior in

youth.[26-28] When examining trauma and suicidal behaviors in Black youth, this relationship remains. Research has found that Black adolescents who reported a history of trauma and adversity (e.g., physical abuse) were five times more likely to attempt suicide than those adolescents without a history.[29] Other research has also found that these traumatic experiences have lasting effects in adulthood, with the number of childhood traumatic experiences increasing the likelihood of suicidal behaviors in adulthood.[30]

Protective Factors

Protective factors are characteristics that help youth adapt to different levels of hardship.[31] Even fewer studies have looked at protective factors in Black children and adolescents that buffer against suicidal thoughts and attempts. One way to describe protective factors against suicide for Black youth is to categorize them into five areas: 1) strong familial support/relationships; 2) religious and spiritual engagement; 3) community/social support; 4) personal factors (e.g., positive self-esteem, emotional well-being, strong academic performance); and 5) factors such as stable family housing, income and employment. What many of these factors have in common is they promote a sense of connectedness and "mattering" (i.e., being acknowledged by others, having a sense that others are concerned about your well-being) in children or adolescents who may otherwise be at risk for suicide.[32] For example, several researchers have argued that higher levels of religious involvement reduce suicide risk because religious institutions provide important community support to individuals, as well as that cultural/religious prohibitions against suicide may actually serve as a buffer against suicide for Blacks.[33-36]

Despite the recent increase in suicidal behaviors in Black children and adolescents, there is a lack of research on both risk and protective factors associated with suicidal thoughts and attempts in this population. In particular, it has been noted a lack of data on protective factors for suicidal risk among LGBTQ+/SGL individuals.[37] As the field moves forward in establishing more research to understand Black youth risk for suicide, it is critical not to assume that all Black youth are the same. Research should further explore intersectionality of risks such as sex, gender identity, developmental stage, socioeconomic status, religious affiliation, sexuality, ethnicity and living in an urban or rural setting.

MENTAL HEALTH UTILIZATION AND ENGAGEMENT AMONG BLACK YOUTH

As noted by the American Psychological Association, "Health disparities are caused by a complex interaction of multiple factors including individual, genetic and environmental risk factors.[38] Pervasive structural inequities and social determinants of health are believed to be the primary cause.[39,40] Rates of engagement and completion in treatments for depression are lower for Black adolescents (compared to Whites) due to negative perceptions of services and providers and reluctance to acknowledge symptoms.[41,42]

Structural barriers such as racism and poverty can negatively impact access to and pursuit of mental health care.[43] The impact of chronic stressors such as ongoing de facto segregation, crime, economic disadvantage and discrimination puts children, as well as the adults in their lives and communities at an increased risk for mental health issues.[44,45] Racial disparities in treatment exist in the youth, as well as the adult population, with Black youth less likely than Whites to receive outpatient treatment even when other variables are accounted for.[46]

Black youth may express their depression symptoms differently than White youth, including through externalizing behaviors (e.g. behavioral and conduct problems).[47] Black youth dealing with these problems are more likely to be referred to inpatient services than Whites46 or are often pushed into the juvenile justice system where access to adequate treatment is even less available.[48] This is exemplified by the commonly referred to "school to prison pipeline," or the disproportionate disciplinary sanctions and referrals faced by Black youth in schools.[49] As school settings are often a point of treatment referrals,[50] discriminatory

practices or unconscious biases on the part of practitioners and school officials can have—potentially compounding—deleterious effects on Black youth.

Nationally, about half of adolescents with depressive disorders never receive mental health treatment for depression.[51] Data from the National Comorbidity Survey – Adolescent Supplement indicate that compared to their White counterparts, Black adolescents are significantly less likely to receive care for depression.[51,52] Youth and caregiver mistrust of mental health professionals can delay or prevent care.[53] In addition to the weight of historical abuse and misconduct by the general medical community,[54] perceived cultural competence among mental and behavioral health providers can also impact whether care is sought or if an individual continues treatment.[55] These concerns are warranted. Blacks on average also receive poorer quality of care compared to Whites when they pursue mental health treatment.[56] Black youth are also significantly less likely than Whites to receive outpatient treatment even after a suicide attempt.[57] Additionally, assessment tools may lack nuance in culture-specific expressions of depression symptoms, resulting in under- or misdiagnosis in youth that do present for treatment.[47] For many Black adolescents, exiting treatment early is the norm, and poor engagement is a key influence on termination.

Black adolescents, particularly males, seek professional help as a last resort for mental health treatment, and negative social and familial networks (e.g. family and friends) play a pivotal role in their help-seeking behaviors.[58] Black youth may also not identify their experiences as depression, instead viewing their symptoms as "a mild experience of somatic [physical] complaints and changes in general behavior [that] makes it much less likely that a youth or his or her family might seek depression treatment of their own volition."[59]

When experiencing emotional or psychological problems, Black adolescents discuss their problems almost exclusively with their family and receive messages consistent with not talking to "outsiders" about their mental health problems.[60] Black youth also report reaching out in indirect or nonverbal ways to get their caregivers to query them on their well-being.[53] Peers and friends also influence Black adolescents' help-seeking behaviors: for example, they fear friends would tease and make fun of them about mental health treatment and hesitate to tell them.[2,60] Mental health help-seeking among Black adolescents, therefore, may be more stigmatizing and social networks are not likely to be supportive.[2,60,61]

Treatment integrity is defined as delivery of an intervention as intended.[62,63] It is informed by engagement and influences

clinical outcomes. Treatment integrity is a critically important, but rarely addressed, element in evidence-based mental health treatments and in the treatment engagement literature.[64,65] Empirical research has demonstrated that poor integrity is linked to worse outcomes, while strong integrity can help optimize treatment effects.[66,67] Despite the importance of treatment integrity, it has received surprisingly little attention in treatment research, with only 3.5% of clinical trials adequately evaluating integrity.[62] Most integrity research has focused on adult treatment,[68,69] with few studies targeting child and adolescent treatment.[67,70,71] Neglect of the potential influence of child and caregiver engagement on treatment integrity is an important shortcoming.[72] Empirical evidence suggests that when clients demonstrate a high degree of engagement in treatment, therapists may be more responsive in intervention delivery, and the therapist-client alliance also improves.[73,74] Treatment will not be effective if implemented poorly, and even an evidence-supported intervention can experience implementation failure.[75] Indeed, research suggests that when evidence-based treatments (EBTs) are delivered in community settings they have lower alliance, adherence and competence compared to when the same EBT is delivered in research contexts.[74,76,77] One reason for these differences may be differences in treatment motivation and expectations across settings.[74]

Motivation for treatment is a severely understudied aspect of mental health disparities for Black youth. Underutilization of available and relevant mental health services can be due to practical, systemic and cultural barriers. For instance, oft-cited practical barriers to care include limited community resources, difficulties in physically accessing available services and associated costs and insurance limitations.[72,78-80] However, as indicated previously, the greater barriers to care are less socioeconomic and more psychosocial. Systemic obstacles like provider bias and underrepresentation of multicultural providers and perspectives in treatment abound;[81,82] and once in care, Blacks and other people of color receive less information about treatment, are more likely to be given inappropriate treatment referrals and recommendations for their presenting problems and are misdiagnosed when they have the same presenting symptoms as Whites.[38,83] The impact of these intractable issues often contributes to cultural mistrust of the system as individuals seeking care can feel that their complaints and symptoms are ignored or dismissed by professionals unfamiliar with their experiences.[84,85]

Cultural mistrust of professional health care systems and providers and general stigma towards mental health issues, overall, are well-established impediments to service utilization by Black youth and families which reinforces the need for cultural competence and the use of evidence-based engagement strategies, to better facilitate rapport between clinicians and clients of color.[24,43,50,72,86] Scholars have established racial similarities in depression prevalence but also that significant disparities exist in the use of traditional mental health treatments across Black, White and Latinx youth, noting both statistics and anecdotal evidence.57,87-90 Among Blacks, treatment underutilization has been attributed to resistance toward labeling their problems as those requiring mental health care and financial barriers including insurance type and ability to pay.[91,92]

In light of these facts, it is therefore important to examine best practices for closing this service gap and to determine how to address the needs of Black youth. Mental health treatment engagement is an emergent area of study that historically focused on reducing structural barriers for impoverished families,[68,93] but in recent years has emerged as an area of study to address the needs of socioeconomically diverse people of color, including Blacks.[94,95]

Recent research supports the importance of treatment engagement research by suggesting that while psychosocial barriers are not unique to Blacks, they are manifested in culturally nuanced ways.[50,77,96] For example, Blacks are reported to have significantly more stigmatized attitudes toward depression treatment, reliance on non-clinical faith-based supports and concerns about the lack of cultural relevance of treatments.[43,92] In contrast, Whites are more likely to view depression as a medical disorder that is treatable through therapy and medication.[97] So, while socioeconomic and structural barriers are clearly important, they may not fully account for the differences in depression perceptions, suicide prevention outcomes and service use that negatively impact Black youth.

INTERVENTIONS

Screening

According to the US Preventive Services Task Force (USPSTF), there is not currently sufficient empirical evidence to recommend universal screening for suicide risk of adolescents.[98] Specifically, the task force did not find improved health outcomes for the general population of youth who were screened for suicide risk nor adequate research supporting the benefits of screening. However, there is sparse research in this area, thus more data is needed to justify that screening for suicide risk will result in more youth being identified and appropriately treated. This finding causes a dilemma as suicidal thoughts are often missed in youth.

In a recent large-scale study, it was found that half of the caregivers were unaware that their child had thoughts about suicide, and rates of both parental unawareness and adolescent denial of suicidal thoughts were higher among racial minority families (most of whom were Black).[99] Parental unawareness and adolescent denial of suicidal thoughts may prevent these youth from receiving the mental health services they need. Furthermore, a recent study suggested that for Black youth, suicidal thoughts and plans have trended downward (1991-2017), while suicide attempts have increased for Black adolescents and injury by attempt have increased for Black adolescent males.[5] These findings suggest that great caution should be given to factors associated with suicide attempts among Black adolescents as they may actually engage in a suicide attempt without thinking about or planning it.

Nonetheless, related to suicide risk, the U.S. Preventive Services Task Force found sufficient evidence to recommend screening for depression in adolescents ages 12-18 years in primary care settings100 which was followed in 2018 by the American Academy of Pediatrics recommending universal screening for patients ages 12 and older annually with a self-report measure.101 Several self-report depression measures for children and adolescents have items screening for suicidal thoughts. Thus, suicidal thoughts and risk may be assessed with depression screening and would be particularly important to assess with youth presenting with significant depression symptoms.[102] Meanwhile, the matter of suicide attempts among Black youth remains a gravely important concern.

Interventions for Suicide Risk

Recently, another study by Sean Joe et al. examined the current state of interventions or treatments for Black adolescent males at risk of suicide.[103] Although this article focuses on males, it sought to identify treatment and interventions studies for Blacks in general. This study revealed a dearth of research in this area, a general lack of scientific investment in randomized controlled trials for this population and a failure to document the effect of any interventions over time. Overall, the body of research on suicidal behavior is woefully underdeveloped, thus not sufficient to guide comprehensive practice protocols for what works when treating Black youth at risk for suicide.

Only two treatments demonstrating effects for young, Black males were available from the data. There were effects for Multisystemic Therapy (MST) for reducing the risk for suicidal thoughts and attempts. Attachment-Based Family Therapy (ABFT) was important for use as a component of clinical practice for Black youth being treated for suicidal thoughts. The benefits of these treatments are estimated to last, at best, one year according to the studies for MST and ABFT. Until more conclusive evidence exists, particularly demonstrating sustained benefits over time, alternative strategies are needed in order to find appropriate interventions or prevention strategies for Black youth at risk for suicide.

Interventions for Mental Health Disorders

In a recent review and update of the evidence base of psychosocial interventions of racial/ethnic minority youth in studies published between 2007-2018, few interventions were shown to be effective with Black youth.[104] MST for behavioral problems (not suicide) was the only therapy that was well-established for Black youth. Two interventions that are probably effective for Black youth which are peer resilient treatment for traumatic stress and cognitive behavioral treatment (CBT) for disruptive behaviors. The authors noted that every intervention meeting both the well-established or probably effective criteria was culturally adaptive or tailored to meet the needs of the youth and families. Pina and colleagues indicated that there were no randomized clinical trials for racial/ethnic diverse youth with Bipolar Disorder.[104] This recent review clearly indicates that there are significant gaps and evidence in research of treatment for mental health problems, including suicide (and associated suicidal behaviors) among Black youth.

Despite the limited research on the efficacy of interventions for Black youth, other psychosocial interventions have shown to be well-established in efficacy for youth mental health conditions. For example, CBT (both individual and group) and interpersonal psychotherapy (IPT) are currently well-established depression interventions for adolescents in the general population.[105] The evidence base for children with depression has been mixed, and there is currently no treatment that is well-established in efficacy.[105] Furthermore, CBT and IPT have not been sufficiently tested with Black youth with depression.104 For anxiety, CBT individually, with parents, and with medication and behavioral therapy (such as exposure and modeling, and psychoeducation) have a strong evidence base for treatment of youth anxiety disorders.[106] Similar to depression, there is insufficient evidence with these anxiety treatments for Black youth, specifically.[104]

Overall in the treatment research, there are areas of missed opportunities to gather this necessary information. Polo and colleagues (2019) reviewed randomized clinical trials in depression and found that more than half of trials with children did not report on race/ethnicity. Additionally, they identified that although Blacks have increasingly been included in clinical trials, only approximately 9% of the samples in youth depression trials were Black. Another gap in the research is that when studies have a sufficient number of Blacks in their trials, they did not conduct further analysis to examine treatment outcomes across race/ethnic groups. These limitations found in the depression treatment literature are representative of the treatment research in general. In fact, as of 2019 there is no established evidence-based approach to the treatment of depression or suicide prevention tested in large enough samples of Blacks to help establish an evidence base for this population (https://www.apa.org/depression-guideline).

Another way to increase the knowledge base is through practice research which examines how interventions or services are provided within service systems and evaluates how to improve their delivery.[107] Currently, clinicians, providers and service organizations are treating Black youth with suicidal behaviors. Efforts to systematically examine these practices, develop and test culturally appropriate interventions and service models and add to the research evidence would be beneficial to the field.

FUNDING DISPARITY

This lack of evidence pertaining to Black youth mental health and suicide can be explained in large part by the documented disparities that exist in funding for Black investigators. A recent report examining NIH R01 applications from 2011-2015 confirmed that Black investigators were half as likely to receive NIH funding than White investigators.[108] Disparities existed at all levels including submission rates, grants being discussed in the review meeting and impact score received. Additionally, Black applicants were more likely to propose research topics such as health disparities, adolescents, psychosocial, risk, community and socioeconomic factors, which were less likely to be funded. These research topics significantly overlap with the research presented in this report.

BACKGROUND

Suicide among Black youth is a steadily growing problem in the United States. It remains a complex issue to tackle, requiring prevention efforts, interventions and partners in various sectors. Practices that focus specifically on suicide prevention among Black youth remain scarce, with many programs happening at the local level in silos.

There has been a heightened awareness of the mental health needs of Black youth within the community. There have been increases in community programs, mentoring opportunities and initiatives to teach coping skills to Black youth. Many prevention strategies and interventions exist for youth. Most of them have been tested in majority White populations, therefore, their effectiveness with youth of color is limited.

Practice undertaken to prevent suicide among Black youth and respond to their mental health needs and well-being must account for and incorporate the following components in line with the Research section of this report:

- Upstream (social-environmental) factors
- Risk factors and protective factors regarding suicide risk
- Treatment considerations for Black youth
- Interventions for mental health disorders and suicide risk
- Looking toward the future.

Taking an Upstream Approach

Undertaking an upstream approach and keeping Black youth out of harm's way is essential to establishing a social environment in this nation in which Black children and youth find themselves in family, community and society in which at least one caring adult shows them unconditional love and values and affirms them in their identity as Black children. This overarching, core tenet requires that Black youth are embraced along with any and all accompanying intersectional identities and characteristics they possess including gender, sexual orientation, gender identity, national origin, immigration status and ability.

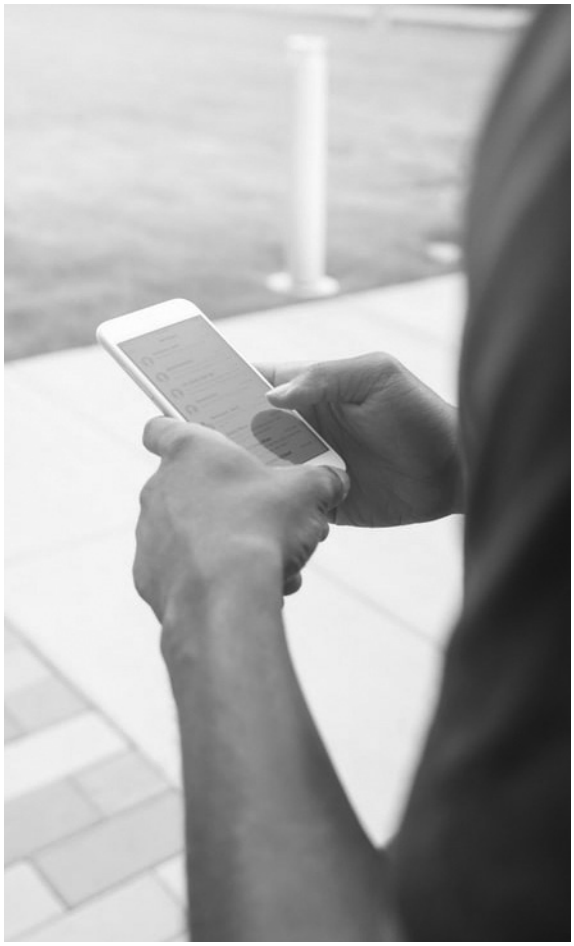
Risk Factors and Protective Factors Regarding Suicide Risk

Being at risk does not necessarily mean that a Black child will have suicidal behaviors, because a variety of protective conditions and support systems can intervene. Key risk factors for suicide in youth in general include: 1) the presence of a psychiatric disorder, 2) gender (with females being more likely to attempt suicide and males being more likely to die from suicide), 3) prior attempts, 4) being a victim of bullying and bullying others, 5) socioeconomic factors, 6) family functioning, 7) exposure to suicide and 8) access to means. The few studies that have examined suicide risk specifically in Black adolescents suggest that 9) depression, 10)

delinquent behavior, 11) poor family support, and, in some cases, 12) substance abuse, are risk factors for suicidal thoughts, attempts and/or completions.

These risk factors dictate that Black youth with presence of symptoms of a psychiatric disorder and/or current or previous suicide attempts as in 1), 2), 3) and 9) in the previous paragraph, need to receive a mental health evaluation and treatment if deemed necessary. It is well known that Black youth are less likely to receive mental health services than their White counterparts. Practice must, therefore, involve social and emotional learning among students, educators and families, and education about mental health conditions to reduce cultural stigma and remove barriers so that when symptoms of mental health conditions arise, there will be sufficient awareness of the importance of seeking mental health care. This awareness will increase the likelihood that Black youth in need will engage in mental health services and be supported by peers and family, thereby reducing the risk of suicide.

Bullying and Cyberbullying



There is a higher risk of suicidal ideas and suicide attempts among youth who are victims of bullying as in 4) above. Youth who are at risk for being bullied include youth with disabilities, learning differences, sexual/gender identity differences, or cultural differences. A protective factor that can be undertaken in practice is to encourage youth to speak to a family member or other caring adult about the bullying they are experiencing to initiate measures to stop it. Stopbullying.gov is a website that provides information about bullying for youth, families and educators and how to prevent and respond to it. Teens who spend more time on social media are more likely to experience cyberbullying and have higher levels of depressive symptoms and suicide related outcomes. The link between high levels of social media use, depression and cyberbullying suggests that exposure to social media and screen time should be limited as a preventive and protective approach by families; and that counselors should encourage such measures.

LGBTQ+/SGL Discrimination

LGBTQ+/SGL youth are at higher risk of psychological distress and suicide attempts. They may experience rejection from their families when they disclose their sexual orientation or gender identity. Furthermore, they may be subject to conversion therapy, a practice that is harmful and ineffective, yet is still used in many states. It is crucial for this practice to be discontinued and for sexual orientation-affirming and gender-affirming care to be provided in a practice that emphasizes the value of the youth and supports them in their sexual orientation and gender expression.

Suicide Vulnerability

For Black youth who have been exposed to suicide, which is a risk factor for suicide, one important practice is to deploy counselors to help them process the suicide of a peer due to the risk of "copycat" (contagion effect) suicidal behavior. Mental Health First Aid is an approach which is helpful to apply in these instances.

Protective Factors

Black youth face a variety of stressors and behavioral challenges, such as adverse socioeconomic factors, strain associated with racism and discrimination, difficulties in family functioning, delinquent behavior, poor family support and substance use. These can put them at increased risk for suicide thoughts and attempts. To address these risks, practice must include the application of protective factors including strong family support and relationships, religious involvement, personal factors including positive self-esteem, emotional well-being and strong academic performance and social determinants such as stable family housing, income and employment.

Contact sustained over time with gatekeepers such as school social workers and other school personnel, pediatricians and other primary care health practitioners, faith community leaders, athletic coaches and after-school or community center personnel provide channels through which protective factors can be conveyed. Many of these avenues provide the opportunity for appropriate practice to assess the mental health needs of Black youth through screening, counseling and taking the time to express concern and listen to what is going on in their lives.

Communicating with a caring posture with Black youth in these situations increases the likelihood of connecting them with the services that they may need, mental health or otherwise.

Addressing Trauma and Cultivating Resiliency

The work of the late psychiatrist Dr. Carl Bell is particularly relevant here in addressing trauma and cultivating resilience among Black youth. He advocated for the reestablishment of a sense of community by bringing together churches, schools and families to create networks — networks capable of organizing resources and establishing programs that provide support, safety and security. Practice that creates a sense of community also reinforces cultural identity which supports cultural grounding and self-esteem. Dr. Bell also advocated for the provision of models, tools, skills and techniques to facilitate implementation of concepts such as mentoring, multi-family groups and manualized family interventions

TREATMENT CONSIDERATIONS FOR BLACK YOUTH

Black youth are more likely than White youth to have limited access to mental health services due to practical, systemic and cultural barriers; disproportionately low engagement in and completion of treatment; and receipt of poorer quality of care. There is a lack of cultural relevance of empirically-supported approaches, as well as an absence of an established evidence-based approach to the treatment of depression or suicide prevention tested in studies with a sufficiently-sized sample of Blacks to establish an evidence base for this population. One reason for this is the documented disparity in funding levels of Black researchers pursuing support for large-scale research trials.

The fact that Black adolescents with depression may express symptoms differently than White youth dictates that practice must acknowledge these differences in order to identify and treat depression in Black youth appropriately so as not to vilify their behavior as emblematic of bad conduct. It is common for the mental health symptoms of Black youth to be misunderstood, leading them to be suspended from school or punished and sent into the juvenile justice system, where they are even less likely to receive adequate mental health treatment.

Practice must reverse the discriminatory practices and unconscious bias that collude to send children with trauma and unmet mental health needs into the school-to-prison pipeline. It is imperative to have mental health professionals in schools to increase the likelihood that the mental health needs of Black youth are recognized and treated rather than being misunderstood as bad conduct.

Given the stigma of mental health concerns and help-seeking among Black youth, it is critical that peer support be used as a mechanism to help young people get connected with the help they need. Project Rise at University of Virginia is a model program that has had success in peers supporting Black students and other youth of color with mental health concerns in the university setting.

INTERVENTIONS FOR BEHAVIORAL HEALTH DISORDERS AND SUICIDE RISK

Psychosocial interventions shown to be effective or probably effective in the treatment of Black youth are multisystemic therapy (MST) for disruptive behaviors; peer resilient treatment for traumatic stress; and cognitive behavioral treatment (CBT) for disruptive behaviors. The latter two approaches were culturally tailored to meet the needs of Black youth and their families. Individual and group CBT and individual Interpersonal Psychotherapy (IPT) are well-established depression interventions for adolescents in general. These interventions have been tested in diverse samples of young people, yet there is currently insufficient evidence in Black youth, specifically.

Suicidal ideas are often overlooked in youth, especially in families of color where parental unawareness and adolescent denial of suicidal ideas are higher. This underscores the importance of the U.S. Preventive Services Task Force (USPSTF) recommendation to screen for depression in adolescents ages 12–18 in primary care settings. The American Academy of Pediatrics endorses this approach and recommends the use of a self-report tool which includes items that screen for suicidal ideas and risk. Assessing youth presenting with significant depression symptoms with depression screening is an important strategy.

LOOKING TOWARD THE FUTURE

The concept of the "village" is embodied in a recent conference workshop involving leaders of Black -focused and Black -led, mental health-focused organizations who presented a panel called It Takes a Village, at the Boris Lawrence Henson Foundation's Conference, Can We Talk? This program was centered on mental health in the Black community in June 2019 and included the interactive session, It Takes a Village, in which the audience contributed to the conceptualization and development of a village concept to promote the mental health and wellness of the Black community. The mental health and wellness of Black youth are central to this work. This "village" concept has become a driving force in the establishment of a national environment in which the lives, and mental health and wellness of Black youth and families, are valued and placed at a high priority.

RESOURCES FOR FAMILIES AND PROFESSIONALS

NATIONAL HOTLINES
FOR IMMEDIATE SUPPORT

The National Suicide Prevention Lifeline
(800) 273-8255
available 24/7

The Crisis Text Line
text TALK to 741-741
available 24/7

The Steve Fund
text STEVE to 741741

ORGANIZATIONS FOR MENTAL HEALTH AND SUICIDE PREVENTION

National Alliance on Mental Illness (NAMI) — nami.org
the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

National Organization for People of Color Against Suicide (NOPCAS) — nopcas.org
Provides training on recognizing the signs when someone is in a suicidal crisis.

The Society for the Prevention of Teen Suicide — sptsusa.org
Encourages public awareness through educational training programs.

Suicide Prevention Resource Center (SPRC) — sprc.org
Federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention, including an extensive library of suicide prevention resources.

The Trevor Project Lifeline — thetrevorproject.org
Offers around the clock crisis intervention and suicide prevention lifeline for gay, bisexual, transgender, and questioning young people, from ages 13 to 24.

FINDING MENTAL HEALTH CARE

Therapy for Black Men — therapyforblackmen.org
Web site and directory for men of color seeking support from mental health guidance or professionals.

Therapy for Black Girls — therapyforblackgirls.com
Web site and directory for women of color seeking support from mental health guidance or professionals.

Black Mental Health Alliance for Education and Consultation — (410) 338-2642
Mental health referrals and resources.

MENTAL HEALTH PROVIDER ASSOCIATIONS WITH SEARCHABLE DATABASES

National Directory of Black Psychiatrists of America: Black Mental Health Alliance — blackmentalhealth.com/black-psychiatrists
Develops, promotes and sponsors trusted culturally-relevant educational forums, trainings and referral services that support the health and well-being of Black people and other vulnerable communities.

The National Queer and Trans Therapist of Color Network — nqttcn.com
A community of care, resource sharing, connection, and learning for queer and trans black, indigenous and people of color providing and seeking mental health resources.

HELP FOR CHILD AND TEEN SURVIVORS OF SUICIDE LOSS

The Dougy Center — dougy.org
Resources for children, teens, young adults and their families grieving a death.

The National Alliance for Grieving Children — nationalallianceforgrievingchildren.org
raises awareness about the needs of children and teens who are grieving a death and provides education and resources for anyone who supports them

BOOKS

Mind Matters: A Resource Guide to Psychiatry for Black Communities by Global Health Psychiatry, LLC et al
Black Mental Health: Patients, Providers & Systems by Ezra E.H. Griffith, et al
The Impact of Racism on Child & Adolescent Health by the American Academy of Pediatrics
Black Suicide by Alton Kirk, PhD

ADDITIONAL ORGANIZATIONS AND PROGRAMS

Mentoring Opportunities from 100 Black Men of America — 100blackmen.org/four-for-the-future/
Mentoring for youth through local chapters of 100 Black Men of America

Aban Aya Youth Project — youth.gov/content/aban-aya
A program developed specifically for African American youth to reduce and prevent five problem behaviors: violence, provoking behavior, substance use, school delinquency and risky sexual activity.

CLAS Standards from the U.S. Department of Health and Human Services — ThinkCulturalHealth.hhs.gov
Culturally and linguistically appropriate services (CLAS) is a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity.

Emotional Emancipation Circles (Community Healing Network and the Association of Black Psychologists) — communityhealingnet.org/emotional-emancipation-circle/
Emotional Emancipation Circles (EECs) are evidence-informed, psychologically sound, culturally grounded, and community-defined self-help support groups designed to help heal the trauma caused by anti-Black racism.

Faith.Hope.Life (National Action Alliance for Suicide Prevention) — theactionalliance.org/faith-hope-life
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.

The Good Behavior Game (GBG) — air.org/topic/education/good-behavior-game
A classroom-based program for elementary school children aged 6–10. 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.

Mentoring Brothers in Action (Big Brothers Big Sisters of America) — bbbs.org/african-american/
"Mentoring Brothers in Action" is a partnership between Big Brothers Big Sisters and the nation's three largest African American fraternities: Alpha Phi Alpha, Kappa Alpha Psi, and Omega Psi Phi, to engage more African American men in fraternal, social, faith-based, and professional organizations to get involved in one-to-one mentoring to change the odds for African American boys.

National Child Traumatic Stress Network (NCTSN) — www.nctsn.org/
Created by Congress in 2000 as part of the Children's Health Act to raise the standard of care and increase access to services for children and families who experience or witness traumatic events. This unique network of frontline providers, family members, researchers, and national partners is committed to changing the course of children's lives by improving their care and moving scientific gains quickly into practice across the U.S.

The National Center for the Prevention of Youth Suicide (NCPYS) — preventyouthsuicide.org/
A program of the American Association of Suicidology (AAS) working to change how schools and communities address the issue of suicide among young people, by ensuring student involvement, engaging young adults, disseminating warning signs, and more.

SHE's Mentally Prepared (Black Girls Smile Inc.) — blackgirlssmile.org/programs
An interactive mental health literacy program that aids in educating youth on mental health, illness and wellness.

Soul Shop: Ministering to Ministering to Suicidal Desperation — soulshopmovement.org
A suicide prevention training program operating in the Wake Forest, North Carolina area that includes a daylong training session specially designed to train church leaders, clergy, program staff, lay ministers, office staff and faith-based therapists to detect the signs of young people that are contemplating suicide and possibly save their lives.

Sources of Strength — sourcesofstrength.org/discover
A best practice youth suicide prevention project designed to harness the power of peer social networks to change unhealthy norms and culture, ultimately preventing suicide, bullying, and substance abuse.

The Youth Aware of Mental Health Program (YAM) — www.ncbi.nlm.nih.gov/pmc/articles/PMC5805239/
A school-based program developed for teenagers aged 14–16 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

Strengthening Families (SF) — www.ncbi.nlm.nih.gov/pubmed/12033699
Strengthening Families 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.

"Widening the Lens": Exploring the Role of Social Justice in Suicide Prevention: A Racial Equity Toolkit — mass-preventssuicide.org/wp-content/uploads/2019/09/WideningTheLensToolkit.pdf
Designed as a guide to enable organizations to begin to have conversations around incorporating social justice and racial equity into suicide prevention and mental health.

Youth Mental Health First Aid — mentalhealthfirstaid.org/about/
Designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis.

GLOSSARY

Access to lethal means – for the purposes of this report, having firearms, medication or other potentially lethal means readily available, which can make a person more vulnerable to completing suicide.

Adolescent – in this report, we are referring to youth between the ages of 10-18. This age range falls within the World Health Organization (WHO) definition of youth between ages 10-24.

Adverse Childhood Experiences (ACEs) – as described by the Centers for Disease Control and Prevention (CDC), these are potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability and bonding, such as: growing up in a household with substance misuse, mental health problems, or instability due to parental separation; or incarceration of a parent, sibling or other member of the household.[114]

Attachment-Based Family Therapy (ABFT) – a treatment for individuals aged 12-18 who are at risk for suicide and is designed to treat depression, eliminate thoughts of suicide and reduce anxiety.

Black – a person with known African ancestry or lineage. This report when referring to Black people, does not only include 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.

Cognitive Behavioral Therapy (CBT) – a therapy that suggests an individual's thoughts, behaviors and feelings are intimately linked and affect one another. The goal of CBT is to control and change thinking, actions and feelings through collection and use of observable data (asking the individual about their thoughts and behavior). Homework assignments and peer group reflections help in this process. CBT focuses on the present and is not focused on going back and reviewing adverse childhood experiences. The key is reframing your thinking that is causing emotional pain.

Depression (clinical) – in this report we refer to depression as clinical, meaning a mood disorder in which feelings of sadness, anger, loss or frustration interfere with daily life for a period of two weeks or more.

Depressive Symptoms or Symptoms of Depression – as described by the American Academy of Clinical Psychology, individuals with symptoms of depression may experience the following:

Mood – anxiety, apathy, general discontent, guilt, hopelessness, loss of interest or pleasure in activities, mood swings or sadness.

Behavioral – agitation, excessive crying, irritability, restlessness, or social isolation.

Sleep – early awakening, excess sleepiness, insomnia, or restless sleep

Whole body – excessive hunger, fatigue, or loss of appetite

Cognitive – lack of concentration, slowness in activity, or thoughts of suicide

Weight – weight gain or weight loss[115]

Direct Causal Relationship – a direct link between the cause and the effect of a phenomenon. In this report, for example, we are referring to whether or not bullying directly causes suicide.

Empirical Research – scientific research that gathers information through observation or experimentation. This information is recorded and analyzed in order to

establish facts and evidence.

Engagement – attending actual mental health treatment sessions with the motivation to both participate in sessions and complete the full course of treatment.

Evidenced-based interventions – interventions that have been proven to be effective through empirical research.

Externalizing behaviors – behaviors that are focused outward, rather than inward. In this report, we distinguish depressive symptoms among Black youth as being externalizing – meaning acting out either through disruptive conduct, violent gestures, inappropriate verbalization, fighting, yelling, and expressing anger.

Interpersonal Psychotherapy (IPT) – examines how an individual's personal life impacts depression and helps them learn communication skills to effectively address their relationships with others. The goal of IPT is to improve the quality of a person's interpersonal relationships and social functioning to help reduce their distress.

Intersectionality (of risk) - a term that describes overlapping or intersecting social identities and related systems. For example, the onset of mental disorders or suicidal thoughts due to age or stages of development, gender, gender identity, sexuality, race, living in urban areas and socioeconomic status. Two or three of these factors can overlap or intersect.

Interventions – a set of procedures or strategies designed to support the reduction of mental health symptoms related to depression, anxiety, trauma or any other mental health challenge.

Latinx – a gender-neutral word that is used instead of the gendered terms Latino or Latina to refer to people of Latin American cultural or racial identity in the United States. The (-x) suffix replaces the masculine (-o) and feminine (-a) ending of nouns and adjectives in Spanish. The plural of Latinx is Latinxs.

LGBTQ+/SGL – Lesbian, Gay, Bisexual, Transgender, Queer, and others in the gender- and sexually-expansive community/Same Gender Loving (the last term coined specifically for African Americans)

Mental Health First Aid – an extensive training program for groups to learn how to recognize the signs of mental distress or if someone is in crisis; and offer short-term comfort to someone until professional assistance or support from a family member or peer arrives.

Multisystemic Therapy (MST) – an intense, family-focused and community-based treatment program for court-involved youth with serious criminal offenses and who are possibly abusing substances. It is also a therapy strategy to teach their families how to foster their success in recovery.

Outpatient Treatment – treatment for a person who is not hospitalized overnight and visits a hospital, clinic or associated facility for diagnosis and ongoing therapy during the day, while staying at home.

Post-traumatic stress116 – in this report, we refer to having symptoms of post-traumatic stress disorder, which develops in some people who have experienced a shocking or dangerous event that can be defined as trauma. According to the National Institute of Mental Health, some of the symptoms are:

> *Cognitive and Mood Symptoms*: trouble remembering key features of the traumatic event; negative thoughts about oneself or the world; distorted feelings like guilt or blame; loss of interest in enjoyable activities
>
> *Arousal and Reactivity Symptoms*: being easily startled; feeling tense or "on edge"; having difficulty sleeping; having angry outbursts
>
> *Avoidance symptoms*: staying away from places, events, or objects that are reminders of the traumatic experience; avoiding thoughts or feelings related to the traumatic event; re-experiencing symptoms; flashbacks that cause reliving the trauma over and over, including physical symptoms like a racing heart or sweating; bad dreams; frightening thoughts

Prevalence — as defined by the National Institute of Mental Health: the proportion of a population who have a specific characteristic in a given time period. For example, the population of people in a given area that experience

depression. [117]

Protective Factors – are conditions or attributes (for example; skills, resources, strengths, support systems or coping strategies) that help individuals deal more effectively with stressors and that can lessen or eliminate risk factors.

Rates of suicide – are measured in terms of deaths per 100,000 inhabitants (total). Can be presented by race, age, and gender.

Resilience – how one copes with adversity, barriers or limited resources.

Risk factors – conditions that increases a person's chances of developing a disorder. In this report, we refer to risk factors for a mental health disorder or thoughts of suicide. For example, feelings of hopelessness or impulsive or aggressive tendencies can be risk factors for suicide thoughts, suicide behavior, or death by suicide.

Sexual Minority Youth (SMY) – refers to youth who identify as lesbian, gay, bisexual, asexual, transgender, two-spirit, queer, intersex, non-binary, same-gender loving; as well as individuals who do not self-identify with any of the previously mentioned groups. LGBTQ+/SGL individuals are among those who belong to sexual minorities.

Social and emotional learning – the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relations.

Social Networks – a network of social interactions and personal relationships.

Suicide – a death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt – a non-fatal and potentially injurious behavior that an individual carries out with any intent to die. Injury may or may not result from a suicide attempt.

Suicide Behaviors – acts or preparation for making a suicide attempt up until the point that the potential for harm has begun. This can include thinking about suicide or expressing the desire verbally, such as buying a gun, collecting pills or other actions; or preparing for death by writing a suicide note, giving things away or taking other preparatory actions.

Suicide Contagion – as described by the CDC, this is a process by which exposure to suicide or suicide behaviors of one or more people influences others to commit or attempt suicide. This effect appears to be strongest among adolescents and those who are already vulnerable to suicide. Media coverage of suicide has been associated the contagion effect, as well.118

Suicide Risk – an indicator of how much a person may be prone to take their own life. Clinical professionals evaluate a patient's risk of suicide on a rating scale ranging from no risk to low risk to moderate risk to high risk, and where high risk might be imminent risk or in the danger zone.

Zero Suicide – an initiative focused on safer suicide care within health and behavioral health care systems. The framework is meant to prevent suicidal individuals from falling through the cracks in health care systems.

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