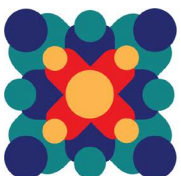


# ***Suicide in U.S. Black and African American Communities***



**African American Behavioral Health**  
**CENTER OF EXCELLENCE**

**NATIONAL COUNCIL**  
*for Mental Wellbeing*

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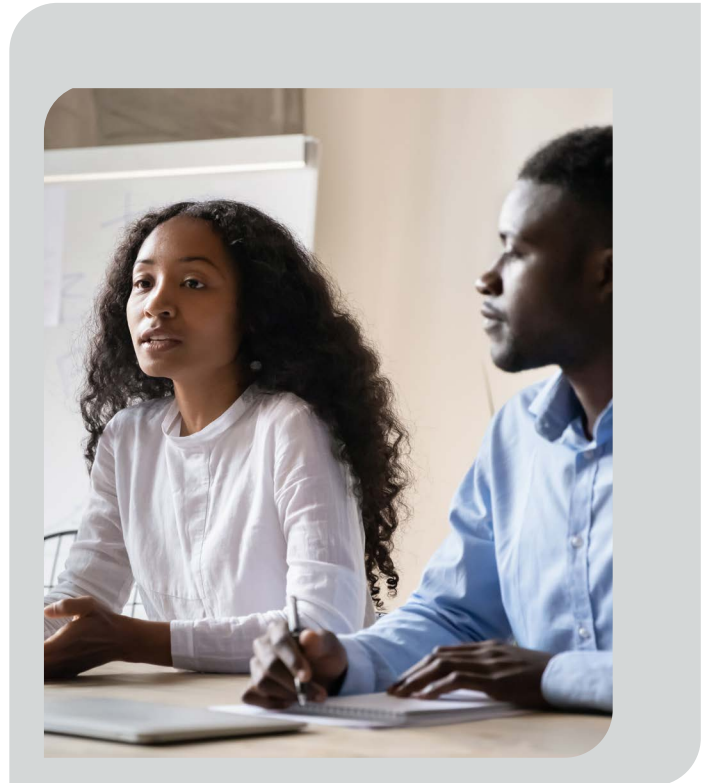
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# A Word from the National Council

The [National Council for Mental Wellbeing](#) is one of the leading voices ensuring access to high quality mental health and substance use services for all. We recognize that eliminating disparities and promoting health equity is central to achieving this goal. To that end, we partnered with the newly established [African American Behavioral Health Center of Excellence](#) (AABH CoE) at Morehouse School of Medicine, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is tasked with providing training and technical assistance to organizations and practitioners to address the needs of African Americans.

As one of the AABH CoE's national partners, the National Council has compiled this fact sheet with information, resources and potential solutions to better address suicide among Black and African American (B/AA) communities.



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# The Prevalence of Suicide in U.S. Black and African American Communities

## HISTORICAL BACKGROUND

B/AA communities have generally been cautious about seeking mental health treatment, as past acts of dehumanization and oppression in America have led to systemic racism and fueled distrust of formal systems within the community (Curry, 2022). B/AA adults are the **least likely** of any racial or ethnic group to seek mental health treatment. Tamecia Curry, Ph.D., suggests that there is an expectation among B/AA communities that the family should serve as the primary “safety net” in addressing mental health needs. Subjecting a vulnerable family member to mental health treatment could be seen as rejection of the family member and ultimately bring “shame and guilt to the family name.”

“

*“Anything that is perceived as mental health-related is taboo in the Black community. To further complicate things, ‘getting help’ is seen as a weakness so folks press on even when they are struggling. Doing so is part of a cultural legacy of survival in the face of brutal circumstances.”*

– **Rheeda Walker, Ph.D., Professor of Psychology and Director of the University of Houston’s Culture, Risk and Resilience Lab.**



Rheeda Walker, Professor of Psychology

## CURRENT STATE OF AFFAIRS AND THE IMPACT OF COVID-19

Suicide death rates among B/AA people increased by **43%** between 2010 and 2020 – the largest percentage increase of any group (Saunders and Panchal, 2022). Due to the disproportionate impact of the COVID-19 pandemic, the suicide mortality among B/AA communities appeared to double between March and May 2020 while the suicide mortality for White residents went down by nearly **50%** (Bray, Daneshvari and Radhakrishnan, 2020). Additionally:

- Suicide was the second leading cause of death among B/AA people ages 15 to 24 in 2019 (Hoskin, 2022).
- B/AA women, grades 9-12, were **60%** more likely to attempt suicide in 2019, as compared to non-Hispanic White women the same age (Mental and Behavioral Health – African Americans, 2021).
- B/AA living below the poverty level are **twice as likely** to report serious psychological distress compared to those over twice the poverty level (Mental and Behavioral Health – African Americans, 2021).
- As in the overall U.S. population, the suicide death rate for men is more than **three times** the rate for women in B/AA populations (Mental and Behavioral Health – African Americans, 2021).

## THE ROLE OF STIGMA

[Mental Health First Aid](#) (MHFA) describes stigma as fear and misunderstanding involving negative attitudes (prejudice) and negative behaviors (discrimination). For example, if someone commits a crime and is said to have a mental illness, it may reinforce the belief that individuals with mental health or substance use challenges are violent and feed into the idea that mental health challenges are a sign of weakness and should be kept hidden from others. In the United States, there is still a great deal of stigma associated with mental health and substance use disorders, which disproportionately affects B/AA communities (Morin, 2020).

Patrice Harris, M.D., Everyday Health’s chief health and medical editor and the first Black woman to be elected president of the American Medical Association, reflects in a recent article that, “we create and present these images for people to feel that they have to live up to,” including the persona of the “strong Black woman” that promotes expectations of B/AA women to show tireless strength and prioritize others’ needs before their own (Hoskin, 2022). This, in turn, discourages them from practicing self-care or showing vulnerability to loved ones and ultimately seeking treatment when needed.

- Lack of representation among mental health professionals (Hoskin, 2022) and in research studies (Morin, 2020) also contributes to stigma and makes it difficult for B/AA people to find culturally competent mental health care, which should meet a patient’s cultural, social and language-related needs. In fact, only **2%** of psychiatrists and **4%** of psychologists in the United States are Black or African American (Hoskin, 2022).

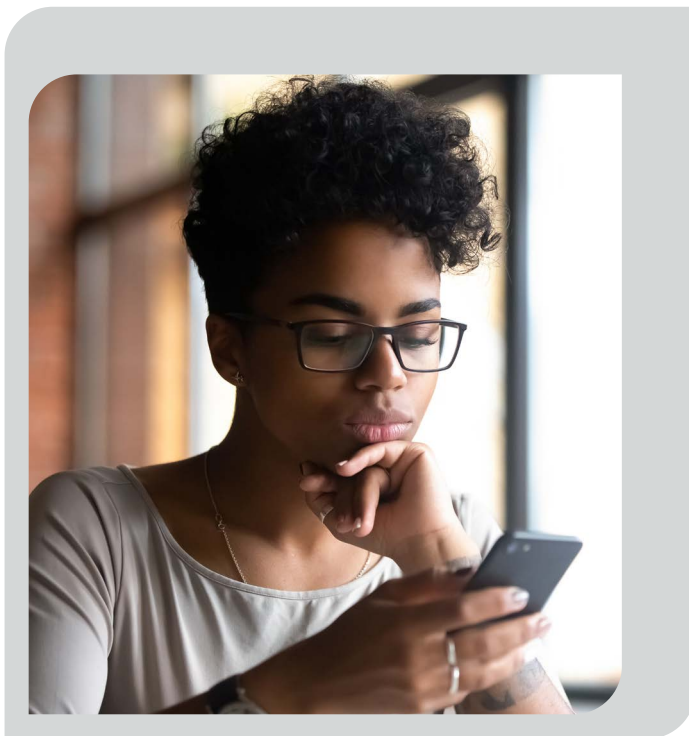


## SUICIDE AMONG BLACK AND AFRICAN AMERICAN YOUTH

Suicide remains the second leading cause of death among all adolescents (Suicide, 2022), and research shows that B/AA children under the age of 13 die by suicide at nearly **double** the rate of White children (Pattani, 2021). This trend is not a new one; according to a report from the Congressional Black Caucus, suicide attempts rose by **73%** between 1991 and 2017 for B/AA adolescents, and injury by attempt rose by **122%** (Ring the Alarm, 2021). Additionally, suicide deaths among B/AA teenagers and young adults have increased more than **45%** between 2012 and 2019 (Pattani, 2021).

The Centers for Disease Control and Prevention's (CDC) High School Youth Risk Behavior Survey (2019) found that of the B/AA youth in the U.S. in 2019:

- **32%** reported feeling sad or hopeless.
- **17%** seriously considered suicide.
- **15%** made a suicide plan.
- **12%** attempted suicide.
- **3%** were injured and had to be treated by a doctor or nurse due to a suicide attempt.



Social media has a unique impact on youth and is one of the many factors contributing to increased suicidality among B/AA people. Cyberbullying via social media, for example, is a common experience among B/AA youth, which is associated with increased suicidal ideation (Hoskin, 2022). According to Tao and Fisher (2022), **79%** of adolescents of color reported experiencing individual racial discrimination on social media, and reports were significantly higher among B/AA youth. The experiences reported include having rude things said about them related to their race or ethnic group, being shown racist images, having jokes made about them because of their race or ethnic group and having people say things that were untrue about people in their race or ethnic group. Social media can also cause young people to experience extreme pressure to create a picture-perfect image of their lives and compete with their peers' appearance, which can negatively affect their sense of self-worth, identity and belonging (Hoskin, 2022).

The rising number of suicides among B/AA people is likely multifactorial (Hoskin, 2022), and additional research is needed to pinpoint exactly what's driving these rates. We will explore a few of the many potential contributing factors.



## LACK OF ACCESS TO MENTAL HEALTH SERVICES

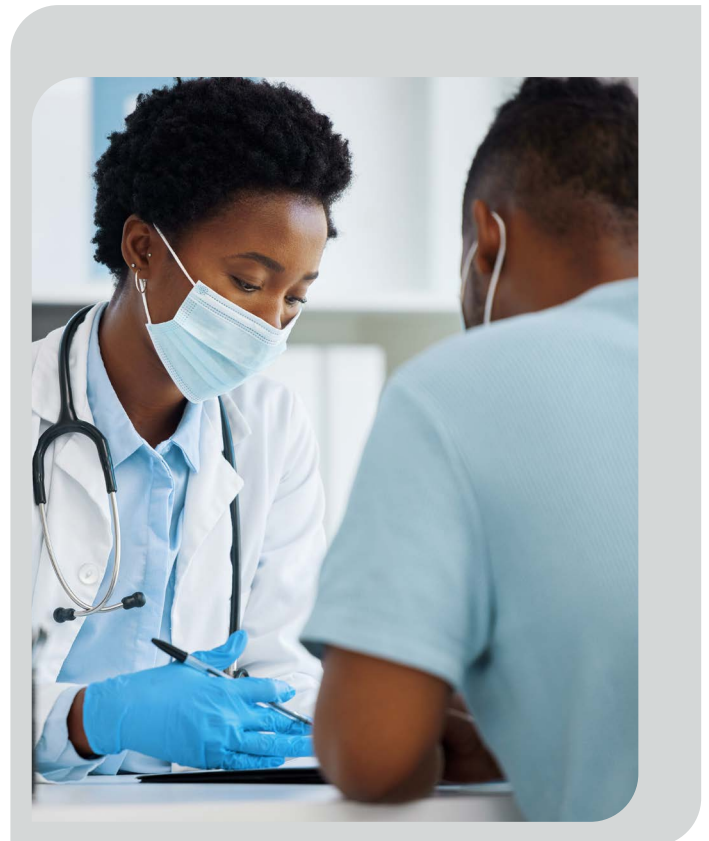
Untreated mental illness is another cause contributing to increased suicide rates among B/AA people.

7X

*While B/AA people have the same risk of mental illness as White people, they are over seven times as likely to live in neighborhoods with high rates of poverty and little to no access to mental health care (Hoskin, 2022).*

Additionally, **nearly a quarter** of B/AA individuals are uninsured, and they are more likely to seek treatment for mental health-related concerns from emergency or primary care practitioners, which may indicate they are waiting for an issue to become a crisis before seeking help. This is concerning, as we know from the Mental Health First Aid (MHFA) program that the sooner a person experiencing a mental health challenge receives support, the more likely they are to recover. We also know that emergency and primary care practitioners are not as well-equipped to treat mental health challenges as mental health and substance use professionals.

Lack of access to and utilization of mental health care may be exacerbated by other factors like structural racism (Hoskin, 2022), which pervades public policies, institutions, housing, education and the justice system, to name a few. Structural racism can even be found within the mental health care field. For example, mental health care providers may hold racist or discriminatory views, whether subconscious or not, that lead them to characterize a mental health issue that requires help as “disruptive behavior.”



## DISCRIMINATION, VIOLENCE AND TRAUMA

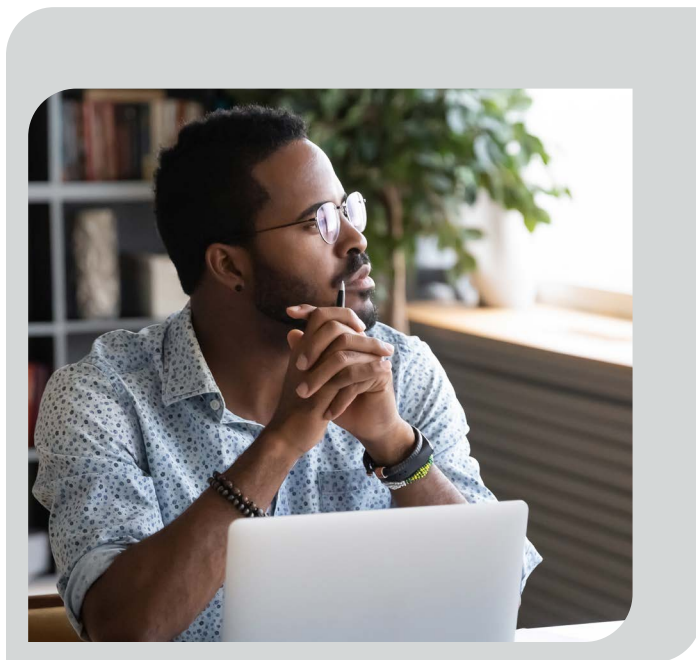
Discrimination is a universal risk factor for suicidal ideation among B/AA youth and is even predicative of the deterioration of the mental health of B/AA people decades later (Assari, Lankarani and Caldwell, 2017).



*“If experiences with racism and discrimination are increasing at a faster rate than we are increasing protective factors, then that might be related to the reported increase in suicidality among B/AA youth.”*

**– Kate Keenan, Ph.D., Clinical Psychologist at the University of Chicago**

B/AA individuals have a higher risk of being targeted, profiled and arrested for minor offenses and the rate of incarceration of B/AA people is **six times** that of White people (Homelessness and Racial Disparities, 2020). While this disparity is nothing new, the murder of George Floyd in 2020, which sparked nationwide protests surrounding racial inequities, has acted as a tipping point for increased anxiety and depression for many B/AA people (Hoskin, 2022).



B/AA people have faced increased exposure in recent years to racialized violence and trauma (Curry, 2022), whether directly or indirectly, such as church shootings, footage of riots and lootings, police brutality, divisive political rhetoric and more (Black and African American Communities and Mental Health, n.d.), which increases susceptibility to suicidal behaviors. We also know that exposure to violence and cumulative trauma can negatively affect a child’s development psychologically, emotionally and physically (Children Exposed to Violence, 2016). Children who are exposed to violence are more likely to use drugs or alcohol, experience school-related difficulties, develop depression or other mental health challenges, behave aggressively and engage in criminal activities as adults than those who aren’t exposed to violence.



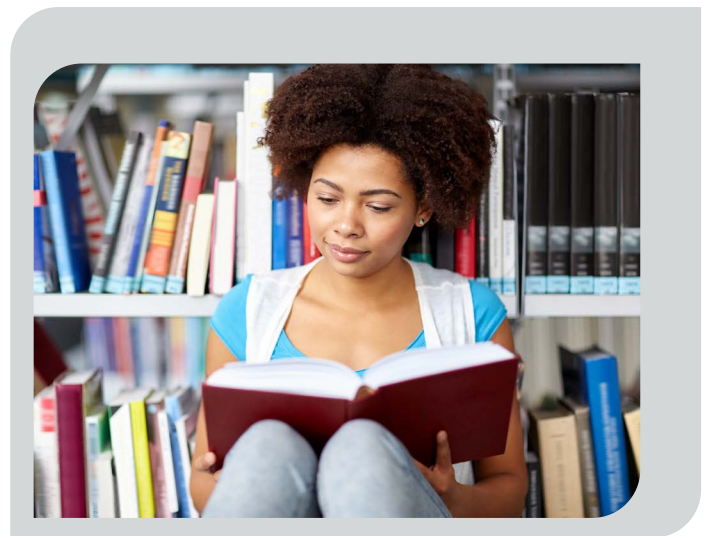


## GENDER IDENTITY AND SEXUALITY

B/AA women have higher mental health risks associated with social pressure and increased responsibilities in a postmodern society, as they often find themselves assuming a central role of support to those occupying their personal and professional circles (Curry, 2022). Women are the heads of household in roughly **30%** of B/AA homes, compared to only **9%** of White homes (Black and African American Communities and Mental Health, 2022). Managing these demands while taking on increased home, work and communal responsibilities has led to increased rates of depression, post-traumatic stress disorder (PTSD) and suicide.

Caron (2021) found that the effects of this can be seen as early as childhood. There was a reported **182%** increase in deaths by suicide from 2001 to 2017 among B/AA women under the age of 18. Between 2003 and 2017, over 1,800 B/AA children died by suicide, and while most of the deaths were among boys, the suicide rate of girls increased an average of **6.6%** each year — more than twice the increase for boys.

Race also plays a role in how young B/AA women are treated in school settings, which can have long-lasting impacts on attitudes toward mental health. By 10th grade, White children are nearly **twice as likely** to receive a diagnosis for attention deficit hyperactivity disorder (ADHD) as B/AA children (Sibonney, 2021). Furthermore, B/AA girls are **six times as likely** to be suspended from schools as White girls for negative behaviors associated with ADHD such as “talking back in class,” and often remain undiagnosed because their symptoms are mischaracterized. This is a cause for concern for our country’s B/AA girls, as ADHD can lead to increased rates of anxiety and depression, risky behavior, drug use, self-harm and suicide attempts, especially when left untreated.



LGBTQ+ B/AA youth are at higher risk of suicide compared to LGBTQ+ youth overall (Black LGBTQ Youth Mental Health, 2020):

- B/AA transgender and non-binary youth reported **double** the rate of seriously considering and attempting suicide in the past year compared to their cisgender peers.
- B/AA LGBTQ+ youth are significantly less likely to receive professional care than LGBTQ+ youth overall despite having similar rates of mental health disparities.
- Only half of B/AA LGBTQ+ youth who seriously considered suicide received psychological or emotional counseling compared to three out of five LGBTQ+ youth overall.
- Among a B/AA LGBTQ+ sample, **66%** reported depressed mood, **35%** reported seriously considering suicide and **19%** reported a suicide attempt in the past year.



## IDEAS AND SOLUTIONS

Suicide among B/AA communities is a complex issue that requires a multi-pronged approach to address effectively.

The three main reasons people seek professional mental health treatment are a self-identified recognition of a need for professional help, a referral from a primary care provider and support from family and friends in the early stages of help-seeking (Curry, 2022). However, as previously discussed, B/AA individuals continually underutilize mental health services and suicide rates tend to peak during adolescence and young adulthood (Mental and Behavioral Health - African Americans, 2021).

The following recommendations are not exhaustive and focus on how mental health issues are viewed and discussed in Black communities, combatting potential bias among mental health providers and addressing mental health stigma among B/AA people.



### **Expand access to evidence-based, culturally competent mental health-related awareness and education trainings like MHFA.**

Through educational approaches, individuals have reported gaining a greater understanding of how poor mental health can be negatively impactful and an increase in knowledge regarding mental illnesses (Curry, 2022).

[Peer-reviewed studies](#) from around the world show that individuals trained in MHFA:

- Expand their knowledge of signs, symptoms and risk factors of mental health and substance use challenges and crises.
- Can identify appropriate types of professionals and self-help resources for individuals with a mental health or substance use challenge.
- Have increased confidence in and likelihood to help an individual in distress.
- Show increased mental wellness themselves.



### **Offer increased community-based care.**

Family support, peer support and community connectedness have been shown to help protect B/AA adolescents from suicidal behavior (Cards SPEAK, n.d.). Findings from The Trevor Project also support the use of community-derived prevention programs involving respected community and church leaders; parents, grandparents and other family members; and B/AA individuals themselves (Black LGBTQ Youth Mental Health, 2020).



### **Increase funding for B/AA scientist-led research.**

B/AA scientists, which are the most closely connected to this population, are **10%** less likely than White scientists to be awarded National Institutes of Health (NIH) research funding (Ring the Alarm, 20219).



### **Place an emphasis on integrated systems and holistic approaches to wellbeing.**

Research has shown that participating in organized religious practices is linked to lower suicide risk in African Americans (Cards SPEAK, n.d.). Furthermore, among B/AA individuals living with psychiatric disorders, religiosity has been found to delay the age of onset of and decrease the number of psychiatric disorders.

Curry (2022) describes holistic approaches to mental health services, which treat the entire person as opposed to individual aspects of their wellbeing, as involving mental health professionals helping to connect the mind, body and spirit for balance and healing. They found that cultivating collaborative partnerships with physicians, emergency rooms, schools, religious leaders and community care centers can lead to increased referral and retention rates as individuals are able to more easily access resources related to mental health treatment.



### **Expand treatment availability and support, particularly for young B/AA people.**

Potential strategies include offering after-hours or weekend appointments to accommodate patients with busy work and school schedules, providing appointment reminders and collaborating with outside agencies like transportation services to mitigate accessibility concerns (Curry, 2022).



### **Increase recruitment efforts for providers from diverse racial and ethnic backgrounds.**

The shortage of psychiatrists and counselors of color has severe implications for all B/AA individuals needing treatment. A 2019 SAMHSA survey found nearly 5 million, or **16%**, of Black Americans reported having a mental illness. However, only one in three Black adults who needs mental health care receives it (O'Malley, 2021). Because of the scarcity of mental health professionals of color, it can be difficult for Black Americans to find a practitioner they feel comfortable enough with to share race-related trauma. A 2016 study from the Journal of Black Psychology also found that African American therapists and their patients often had relationships marked by a “distinct sense of solidarity ... as evidenced by having a better understanding of the context of Black clients’ lives” (O'Malley, 2021).

Potential strategies for improvement include utilization of pipeline programs that reach students at all stages of their academic careers to support recruitment and retention of racial and ethnic minorities into the health care workforce. Such pipeline programs have been shown to double the likelihood of diverse students attending graduate school, the majority in the health professions (Bliss, Wood, Martineau, Hawes, Lopez & Rodríguez, 2020). Another study spanning 2008-2018 in which undergraduate students were exposed to health disparities research and clinical skills over a period of seven weeks found that **92%** of participants went on to pursue a career or further studies within a health profession, and **46%** of graduates were accepted or matriculated in medical school by the end of 2018 (Stewart, Brown, Wrensford & Hurley, 2020).



### **Engage with federal, state and local governments to affect policy change.**

Curry (2022) recommends more closely monitoring the application of ethical standards relating to the Council on Social Work Education’s (CSWE) code of ethics, increasing health care policy advocacy efforts and ensuring that there is consistency among the application of ethical guidelines for diverse populations. Another study suggests that research, education and evidence-based solutions must occur at the local government level to connect with communities and families (Ring the Alarm, 2019).



### **Provide conflict resolution skills and coping mechanisms, which could be particularly beneficial for young B/AA women.**

A recent study by The New York Times found that about **9%** of young B/AA women who died by suicide experienced a relationship crisis before the suicide and nearly **20%** had an argument within 24 hours of their death (Caron, 2021).

# 988

## IF YOU ARE IN CRISIS OR ARE HAVING SUICIDAL THOUGHTS, CONTACT SOMEONE IMMEDIATELY!

988 is the new, easy to remember three-digit dialing code connecting people to the [988 Suicide & Crisis Lifeline](#) (formerly known as the National Suicide Prevention Lifeline), where free and confidential support from trained crisis counselors is available 24/7 nationwide for anyone experiencing a mental health or substance use crisis or any other emotional distress.

### THREE WAYS TO ACCESS CARE:



**Call 988**



**Text 988**



**Chat**  
**[988lifeline.org/chat](https://988lifeline.org/chat)**

- **Fewer than 2%** of Lifeline calls require connection to emergency services like the 911 system. Activation only occurs when the imminent risk to someone's life can't be reduced during the Lifeline call.
- The pre-existing Lifeline number, 800-273-8255 (TALK), will continue to function indefinitely. If a life-threatening crisis is underway (such as a suicide attempt in progress), call 911.
- Numerous studies have shown that most 988 Suicide & Crisis Lifeline callers feel significantly less depressed, less suicidal, less overwhelmed and more hopeful after speaking to a Lifeline crisis counselor.
- Almost **98%** of people who call, chat or text the 988 Suicide & Crisis Lifeline get the crisis support they need and do not require additional services in that moment.

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# Appendix A: Additional Data

## SUICIDE DEATH RATES BY DEMOGRAPHICS AND LOCATION, 2010 TO 2020

Race/Ethnicity	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
White	15.0	16.8	12.0
Black	5.4	7.7	43.0
Hispanic or Latino	5.9	7.5	27.0
Asian or Pacific Islander	6.2	6.8	10.0
American Indian or Alaska Native	16.9	23.9	41.0
Age	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
12-17	3.9	6.3	62.0
18-25	12.8	17.0	33.0
26-44	15.0	17.8	19.0
45-64	18.6	17.4	-6.0
65+	14.9	16.4	10.0
Sex	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
Male	19.8	22.0	11.0
Female	5.0	5.5	10.0
Rurality	2010 Suicide Death Rate/100,000 population	2020 Suicide Death Rate/100,000 population	Percent Change from 2010 to 2020
Nonmetro	15.5	19.1	23.0
Metro	11.5	12.6	10.0

NOTE: Analysis of CDC WONDER underlying cause of death data, 2010 to 2020. Suicide deaths were identified using ICD-10 113 Cause List, Intentional self-harm (U03, X60-X84, Y87.0). Rates are age-adjusted for all demographics except age groups. Changes in suicide death rates between 2010 and 2020 are statistically different. Suicide death rates in 2020 were statistically different for race/ethnicity groups (relative to White), age groups (relative to 12-17), sex (relative to male), and rurality (relative to metro). Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data were insufficient to allow for analysis of other racial groups. SOURCE: KFF analysis of CDC WONDER, 2010 to 2020

Source [KFF.org](https://www.kff.org)

