Suicide Risk Prevention:
An Analysis of Minnesota's Black Community

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Executive Summary

In recent years, rising suicide rates for Minnesota's Black community has captured the attention of the Minnesota Department of Health (MDH). Comparing aggregated suicide rates from 2005 through 2009 to 2010 through 2014, Black suicides increased by 18%.[1] The purpose of this project is to understand suicide within the Black community by examining underlying risk factors, awareness of the issue and prevention resources, and readiness to address the problem.

Risk Factors

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

Suicide Risk and Protective Factors

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

Community Awareness Findings

Based on the Community Readiness Assessment (CRA) interviews with community leaders about suicide and suicide prevention resources, the Black community is in the first stage of readiness, No Awareness. This signifies the community is not aware of or does not consider suicide to be a problem.

Prevention Recommendations

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

- Contextualize suicide within the awareness campaign by addressing the role of mental health in violent crime and suicide.

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

Problem Statement

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

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

The purpose of this research is to investigate suicide awareness and resources for prevention within the Black community and to determine what education and resources can be provided based on each community's needs in accordance with the State Suicide Prevention Plan.

This project will address three research questions:

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

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

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

Methodology

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

Literature Review

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

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

A lack of research on suicide risk factors and intervention techniques within the Black community exists. Most literature focuses on White middle-aged males and Native Americans, the populations with the highest rates of suicide within the U.S. The available literature on suicide prevention for the Black community is outdated and primarily addresses risk factors and prevention techniques for African American youth under the age of 18 years.

General Population Suicide Risk Factors

Researchers identify four categories of suicide risk factors within the population: psychiatric/psychological factors, demographic characteristics, environmental factors, and beliefs.[4,5] The four categories are interrelated as they all impact one another. For example, the

World Health Organization found a number of social conditions[ii] are major contributors to mental health issues including: socioeconomic status, individual behaviors, and other environmental factors.[6] Having risky environmental factors can lead to greater psychological risk factors, though positive environmental factors can also be a protective factor against psychological problems.

People affected by specific psychiatric disorders are at a higher risk of suicide.[7] In fact, nine out of ten people who die by suicide have been diagnosed with a mental illness.[8] Psychiatric disorders that are associated with suicide include: depressive disorders, bipolar disorder, schizophrenia, anorexia, borderline personality disorder, posttraumatic stress disorder (PTSD), adult antisocial personality disorder, panic disorder, and drug and/or alcohol abuse or dependence.[9]

Psychological risk factors can be associated with an individual's psychiatric disorders, with their environmental factors, or both.[10,11] Joiner, Brown, & Wingate define psychological suicide risk factors as hopelessness, social isolation, and ineffectiveness. Hopelessness refers to an individual's belief in poor future outcomes.[12] Social isolation is defined as an absence of interpersonal relationships.[13] Ineffectiveness is an individual's perception that they are unable to effect outcomes in their life and therefore they are a burden to their family or society.[14] Psychological risk factors also include impulse control problems and strong emotional sensitivity.[15]

Suicide risk factors differ greatly across demographic characteristics such as age, gender, race, education, household and socioeconomic status.[16, 17] Young adolescents attempt suicide more frequently than adults, but adults ages 45 to 64 years have the highest rate of suicide due to using more lethal means.[18, 19] Similarly, women attempt suicide more frequently than men, but the suicide rate for men is four times that of women because they use more lethal means.[20, 21, 22] Suicide rates are highest among Native Americans/Native Alaskans and White Americans, and are lowest amongst other minority groups.[23] Single people have higher rates of suicide compared to married people.[24]

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

The main environmental suicide risk factors are adverse life events and a lack of mental health care treatment.[25, 26, 27, 28, 29, 30] An environmental event is defined as "a[n] event that changes the person's social or personal environment that is external and not internal or psychological."[31] The most traumatic and psychologically harmful events occur during childhood and significantly increase the risk of an individual dying by suicide.[32] The most common adverse life events in children include: sexual abuse and molestation, physical abuse and neglect, family dysfunction and environmental violence, and separation from a close parent.[33] Adult adverse life events are usually considered stressors and include: severe national economic downturns, prolonged job loss for low-educated individuals, divorce, and legal problems.[34, 35] Populations living in rural areas have a higher rate of suicide than populations living in urban areas.[36] Access to health care has been linked to reduced suicide ideation and deaths.[37] However, people who die by suicide are more likely to have seen their primary care doctor, or have visited the emergency room, but the risk of suicide was not detected or treated.[38,39] Access to mental health care is limited and often cost is a barrier.[40] Overall, the effect of health care access on suicide is difficult to measure as many individuals choose not to seek medical or mental health treatment due to their beliefs.[41]

African American Suicide Risk Factors

Despite robust research of suicide risk factors for the general population, there is a lack of suicide risk factor research for the African American community. Researchers agree that psychiatric and psychological risk factors are present within the African American population; however, there is conflicting evidence about the impact of these factors compared to the White American population. Black men who are victims of suicide are less likely to have documented psychiatric disorders compared to White men.[42] Black men are not necessarily less likely to experience psychiatric disorders, but they have a greater proportion of unmet mental health care needs than White men, which may lead to differences in reporting psychiatric disorders.[43] Psychiatric disorders can manifest as violent and impulsive behaviors, which can lead to suicidal tendencies.[44]

Additionally, researchers have found substance use risk factors, particularly those related to alcohol and illicit drugs, tend to be higher for Blacks than Whites.[45, 46] Given the higher rate of substance use, some substance use-related deaths might obscure cases that would otherwise be classified as suicide. Rockett and Thomas suggest some deaths categorized as resulting from

injury of undetermined intent and unintentional poisoning and drowning may also be misclassified suicides.[47]

There are many demographic characteristics that heighten the risk of suicide within the African American community compared to the overall population. On average, African American men die of suicide ten to twenty years earlier, between their late teens to early thirties, compared to White American men who typically die from suicide between the ages of 40 to 60 years.[48] African American men have a higher rate of suicide compared to African American women, but have a lower rate than White American men.[49] African American men who kill themselves are more likely to be single and less educated.[50] Also, those who experience homelessness are at higher risk for suicide.[51] Past criminal conviction is a suicide risk factor for African American men, as well as the overall population, but African American men have higher rates of criminal conviction compared to the overall population.[52]

There are many environmental factors that increase the risk of suicide for African American men. Those men who have experienced violence, physical, sexual, or emotional traumas are at a higher risk of dying by suicide.[53] Individuals who have poor interpersonal family relationships are more likely to die from suicide.[54] The loss of a loved one can also increase the risk for suicide either in short-term or the long-term.[55] Contact with law enforcement is also an environmental risk factor for African Americans even though it may not lead to a criminal conviction. African American unmet mental health care needs are related to multiple environmental factors including socioeconomic status, insurance type, and geographic location.[56]

Some African American cultural beliefs prevent treatment of psychiatric or psychological conditions that are associated with suicide.[57, 58] Compared to White Americans, Black Americans report that antidepressant drug therapy is a less valid mental health treatment option.[59] African Americans also report psychotherapy to be a less acceptable treatment option compared to the White American population.[60] Among African Americans who perceived a need for mental health care, they were significantly less likely to receive care compared to White Americans.[61]

Historical Trauma & Protective Factors

Often touched upon within literature is the argument that the burdens of historical trauma experienced by the African American community have elevated the community's level of stress.

While historical trauma is considered an environmental risk factor, the weight of the risk factor is deserving of a separate section. Systemic racism and discrimination, both of which are remnants of slavery and other African American abuses, are related to depression in African Americans and contribute to the trauma African Americans still experience today.[62] Modern deindustrialization in urban areas has reduced economic and social opportunities for African Americans, which has increased feelings of hopelessness, depression, and suicide within the community.[63] Goldston et al. unearth historical abuses of Blacks by caregiving institutions that date back to the pre-Civil War era. The authors hypothesize that distrust of mental health facilities by the Black community is historically rooted in these abuses by caregiving institutions.[64]

Springing from these forms of historical trauma is the commonly held African American cultural belief that Blacks will endure and overcome suffering, often times referred to as "resiliency", as many generations have before them.[65] The literature demonstrates the stigma surrounding mental health and suicide within the Black community is perpetuated by a notion of abuses of African Americans within the health care setting. The resiliency and stigma act as both risk and protective factors. Since the Civil Rights movement, institutional racism and discrimination have exerted pressure on Blacks to adopt "White" behaviors, which causes internal stress and conflict about holding on to Black cultural identity and experiences, further contributing to the trauma.[66] Based on a history marred with oppression and suffering, the African American community has come to understand a life in which pain is innate and borne; perseverance offers the only escape from the trials of life. This trauma has created a culture of resiliency within the African American community that has enabled a stigma to form around mental health and suicide.[67, 68]

Additionally, mental health care needs may be undiagnosed for African Americans because they are significantly more likely to express anxiety and other underlying mental health needs as physical suffering. According to Snowden's study, African Americans seeking mental health care indicated somatic complaints such as "headaches, 'weaks and dizzies,' pounding heart, hot flashes, and chills" significantly more often than Whites using mental health services.[69]

The stigma associated with suicide and mental health within the Black community may result in misreporting of suicides as a homicide or accidental death.[70] In fact, Rockett, Samora, and Coben

suggest that the African American suicide rate, which is nearly half that of Whites, is paradoxical. Based on the aforementioned socioeconomic risk factors, Blacks appear to be at a higher risk of suicide than Whites, yet the rate of suicide is much lower.[71]

Walker et al. found that African American stigmatization of suicide is inherently religious and attributable to the fact that Blacks are more likely than Whites to believe God is responsible for one's life rather than the individual or state. This finding aligns with other literature that identifies religion as one of the protective factors against suicide for African Americans.[72, 73, 74] The other identifiable protective factors noted throughout this literature include the family, Black social and fraternal organizations, and Black culture. The notion of Black culture as a protective factor circles back to the historical trauma endured by African Americans that instilled a deep-seated value of perseverance through suffering.

African American Intervention Techniques

To date, there is little published literature on suicide prevention or intervention strategies specific to African Americans. Available literature encourages the implementation of mental health programs and screenings in churches, schools, and community organizations, rather than through government agencies.[75, 76, 77, 78, 79] Joe and Kaplan suggest that instead of direct service provision, public funding should be used to raise awareness of programs and reduce the stigma associated with mental illness.

Goldston et al. suggest involving the church in prevention strategies and using a gatekeeper model that involves church members under the age of 35 years acting as a point of first contact for those struggling with unmet mental health needs. Under the gatekeeper methodology, non-professionals are trained to detect risk factors for mental health crises, connect individuals with the proper resources, and act as mentors to younger individuals within the community.[80] Gatekeeper programs have been instituted in churches and schools with high levels of success in the short-term, though long-term effectiveness has yet to be measured.

Findings

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

Quantitative – Public

Suicide rates for Black males were compared to the general male population for Minnesota and the U.S. A difference-in-difference test was run to measure the disparity between the suicide rates for the community compared to the same population in the U.S. as a whole.

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

General Findings

Within Minnesota, Black males have a higher suicide rate of 11.8 per 100,000 individuals compared to the Black female suicide rate of 3.1 suicides per 100,000 individuals (Table 1).[81] Both Black Minnesota males and females have significantly lower rates of suicide than Minnesota's overall male (19.1 suicides per 100,000) and female suicide rates (5.2 suicides per 100,000).[82] Consistent with the Minnesota findings, U.S. Black males have a higher suicide rate compared to U.S. Black females (9.4 male suicides per 100,000 and 1.9 female suicides per 100,000).

There are stark disparities when comparing Black suicide rates by gender in Minnesota to the U.S. Minnesota Black male suicide rates are 26% higher than U.S. Black male suicide rates.[83] Minnesota Black female suicide rates are 63% higher than the U.S. Black female suicide rates.[84] Minnesota male and female Blacks have significantly higher suicide rate than U.S. male and female Blacks.

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

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

Source: Centers for Disease Control and Prevention, National Center for Health Statistics (CDC)[85]
Definitions:
* denotes a 95% or greater significant suicide rate difference between the Black population by gender to the total population by gender within a geography (MN or US).
** Measures the percentage point difference between the Black age-adjusted suicide rate in Minnesota compared to the U.S. age-adjusted suicide rate within gender. The difference is statistically significant at the 95% level.
*** Age-adjusted rate means that the population age distribution is set at the 2000 U.S. Standard population to allow for a more accurate comparison of rates across populations with different age structures.

Risk Factor Findings

The goal of this quantitative research is to understand if Minnesota Black males have different levels of known suicide risk factors than their total comparison population. The quantitative variables in Table 2 compare selected suicide risk factors including psychiatric/psychological factors, demographic characteristics, and environmental characteristics, by race and geography.[86, 87]

From a psychiatric/psychological risk perspective, Minnesota Black males had few differences in mental health indicators compared to Minnesota's total male population (Table 2). The only significant difference is Minnesota Black males have a higher rate of bipolar disorder compared to the total U.S. Black male population. Within the U.S., Black males are significantly less likely to report being a current heavy drinker than the U.S. total male population. Overall, there are

minimal differences in Black psychiatric/psychological suicide risk factors across race and geography.

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

Based on the limited publicly available data on environmental suicide risk factors, there does not appear to be heightened suicide risk factors for either Minnesota Black males or Black males in the U.S. People living in rural areas face a higher risk of suicide than people living in urban areas.[88] Both Black males in Minnesota and the U.S. are significantly more likely to live in metro areas than the total population suggesting a lower suicide risk.

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

Table 2: Selected Suicide Risk Factors by Geography, Black Males to the Total Male Population, 2010-2014 Aggregated Estimates (See Appendix 1 for all variables)

CATEGORIZED SUICIDE RISK FACTORS	MINNESOTA		UNITED STATES		Difference (MN & US)**
	Black Males	Total Male Population	Black Males	Total Male Population	Black Males
PSYCHIATRIC/PSYCHOLOGICAL					
% Ever told had bipolar[1]	2%*	1%	1%*	2%	1.0**
% Ever told had schizophrenia[1]	1.5%	0.7%	1.4%	0.8%	0.1
% Current heavy drinker[1]	6.6%	8.1%	7.3%*	8.6%	-0.7
DEMOGRAPHIC					
Income					
Median Per Capita Income[2]	$ 36,612	$ 51,625	$ 37,570	$ 48,745	$ (958)
% Below poverty level[1]	31.8%*	13.7%	26.7%*	14.8%	8.4**
% Unemployment[2]	12.5%*	5.2%	10.8%*	6.5%	1.7**
Education[3]					
% < High School	43.7%*	30.0%	39.9%*	33.9%	3.8**
% High school/GED completed	26.3%	27.6%	31.8%*	28.6%	-5.5**
Marital Status[3]					
% Married, spouse present	19.8%*	41.0%	22.5%*	37.8%	-2.7**
% Never married	66.7%*	47.8%	62.1%*	48.8%	4.6**
Geography[3]					
% Not in Metro Area	7.6%*	30.4%	17.4%*	25.5%	-9.8**
% In Metro Area – Central	40.3%*	14.6%	43.4%*	24.0%	-3.1**
% In Metro Area – Outside Central	52.1%*	54.9%	39.2%*	50.4%	12.9**
Health Insurance[4]					
% Medicaid/CHIP	41.0%*	12.3%	25.6%*	14.6%	15.4**
% Uninsured	10.7%*	5.9%	13.5%*	11.6%	-2.7**
Health[1]					
% Reported poor mental health status	2.2%	1.5%	1.5%	1.7%	0.7**

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

Quantitative – Office of Vital Records

To gain a greater understanding of the suicide trends in recent years, the numbers of suicides for Black males within Minnesota were analyzed using Minnesota Office of Vital Records data for 2013 to 2015. The 2015 data is only preliminary data due to privacy restrictions so exact numbers and percentages are not available. For the Black population, the Office of Vital Records specifically pulled data on native-born males which was not possible using CDC Wonder.

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

Qualitative – Community Readiness Assessment & Theme Analysis

The Community Readiness Assessment (CRA) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) was adapted to meet the need of the community for interviewing community leaders. The tool was edited to fit each community based upon literature review findings and the recommendations of community liaisons (See Appendix 2 for the community readiness assessment instrument). The tool was then used to conduct eight interviews with community leaders.

A snowball sampling method was used; MDH identified community liaisons that in turn gave the team names of appropriate interviewees. The community interviews followed the purposeful sampling model laid out in the CRA. Interviews were conducted with African American community leaders from the following sectors: health, social services, mental health and treatment services, schools, city government, law enforcement, clergy, and the community at large.

These interviews were analyzed according to the six dimensions of the CRA tool: existing community efforts, community knowledge about prevention, leadership, community climate,

knowledge about the problem, and resources for prevention. The community received one score for each of the six dimensions that was calculated by averaging the individual interviewee scores for the given dimension. The six community dimension scores were averaged to create the final CRA score for the community (See Table 3). The scoring was based on a scale of one to nine, with each number representing a unique stage of awareness (See Appendix 3 for the full scoring details). Additionally, a theme analysis was completed for the interviews to identify the frequency and intensity at which themes came up throughout the interviews.

Interview Analysis

In the interviews with Black community leaders, several common themes and subthemes arose from the conversations (See Appendix 4 for code book). The five major themes were a lack of community awareness of suicide and suicide prevention resources, African American culture, suicide risk factors, access barriers for mental health and suicide prevention services, and assets for suicide prevention programs. Within each of these broader themes were subthemes that provided additional content and context for suicide awareness and prevention within the community.

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

Overwhelmingly, the most common subtheme within the African American culture theme was the stigmatization of mental health by the community. Most community leaders mentioned a large portion of the stigma is generated by a history of trauma within the community, including

intergenerational, systemic, and historical trauma. The trauma endured by the community has perpetuated a sense of African American resiliency. As several community members mentioned mental health and suicide are considered "White people problems" – it is believed the Black community should be resilient to them. More than half of the community leaders stated that as a result of this belief, Black males internalize problems rather than seeking help. If individuals do turn to someone for help, the church is likely a first point of contact. It is noteworthy that a few community leaders stated mental health and suicide are becoming less stigmatized among younger community members because it is talked about increasingly.

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

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

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

about suicide and suicide prevention if community-specific education was provided, which should include facts, data, stories, and culturally specific information.

The interviews for the African American population were also assessed using SAMHSA's Community Readiness Assessment scoring guidelines for suicide prevention. The community scored 1.55 overall out of nine, indicating the community is at the first stage, No Awareness (See Appendix 5). All six dimensions for the community scored in the first stage of No Awareness, suggesting "suicide prevention is not generally recognized by the community or leaders as a problem."[89] Given a majority of community leaders stated the community has more pressing concerns than suicide, the No Awareness stage seems appropriate.

Qualitative – National Violent Death Reporting System

To understand the suicide risk factors for the target population, information on individuals who were victims of suicide was extracted from the National Violent Death Reporting System (NVDRS).[90] This data source provided narratives describing the details of an individual's suicide, including location, life stressors, known diagnoses, and a toxicology report. The information in these narratives came from Medical Examiner and/or Law Enforcement reports. Due to the limited number of up-to-date abstractions, this source gave a supplemental qualitative insight into the already abstracted suicides of 2015. These data were used to analyze the conditions under which the suicides occurred and link them back to recurring themes and risk factors.

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

Each individual experienced one or more major life stressors within two weeks prior to death, although most of the incidents took place within a few days of the suicide. Reported stressors

include family or partner disputes, substance abuse, and financial problems. All victims had a high school degree or a GED equivalent, some had a Bachelor's degree.

Discussion

The discussion centers around assessing suicide risk factors across both the literature review, quantitative (public), and qualitative methods (interviews and NVDRS) in order to understand the strength of risk factors (Appendix 6). The corroboration of suicide risk factors across all four data sources suggests strong validity of risk factor within the population. Many risk factors could not be identified quantitatively due to the inherent limitations of measuring psychological symptoms and beliefs. Risk factors that cannot be measured quantitatively were considered strong suicide risk factors if corroborated across the literature and qualitative methods. There were few risk factors found in the literature that could not be corroborated either by quantitative or quantitative methods.

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

Many psychological risk factors, such as previous suicide attempts, and feelings of hopelessness, were only identified through the literature review and qualitative methods. Similarly, the belief risk factors of stigma of mental illness, distrust in mental and health care treatment, and

historical trauma were only found within the literature review and qualitative methods. Only two risk factors, homelessness and somatization of symptoms were identified in the literature review, but were not corroborated by either the quantitative or qualitative methods. Many suicide risk factors can only be measured qualitatively and thus could still be identified as strong suicide risk factors despite lack of quantitative evidence.

Limitations

There are several quantitative and qualitative limitations in this paper. The publicly available federal survey data used to determine suicide risk factors for the Black community are not truly representative of the community. The federal survey data does not distinguish between U.S.-born Blacks and non-U.S.-born Blacks; therefore, we were unable to isolate risk factors for the target population of U.S.-born Blacks.

Several qualitative methods used have notable limitations. Although the snowball sampling method was most suitable for identifying community leaders, there is some concern about selection and information bias based on using this approach. The CRA interview protocol used to analyze the Black community often asked interviewees about topics they could not address based on their position. For example, many interviewees had difficulty speaking about the viewpoints of their political leaders and funding for suicide prevention resources within their community. The scoring of the CRA was problematic as many of the scoring criteria were not directly related to the interview section or defined scores were not representative of the interviews responses. This limitation was offset by the qualitative theme analysis that provides a more accurate representation of the community's beliefs of suicide.

Data limitations also exist in NVDRS. The data reviewed in NVDRS was not complete with all suicide cases in 2015, therefore, the information from this source should be further analyzed once fully abstracted. Another limitation associated with NVDRS was the source of information for the narratives. In many cases, both the Medical Examiner (ME) and Law Enforcement (LE) provided reports on an individual, but some cases only had a report from one of these sources. This limits the amount of information available for compiling a narrative for each case.

Recommendations

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

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

Through our research, it is evident that several of these concerns are risk factors for both suicide and violent criminal activity, suggesting what some community leaders described as one "toxic path" with two possible outcomes. MDH should address the role of mental health in violent criminal activity and suicide within the awareness campaign. Additionally, MDH could contextualize suicide by framing it within a more familiar realm, such as deaths by homicide, for the same population. For example, the gap between the number of homicides and suicides continues to narrow – in 2014, there were 32 Black male homicides and 22 Black male suicides in Minnesota.[91] By contextualizing suicide for the community, MDH is more likely to establish suicide as a problem, build trust, generate awareness, and establish an effective suicide prevention program, which would coincide with State Suicide Plan Objective 2.6.

Second, we recommend MDH develop relationships that build community trust in order to secure buy-in for suicide prevention interventions. One way to build community trust is to train existing community leaders and organizations to discuss suicide and prevention efforts with community members. Trusted community partners suggested by the interviewees include Turning Point, Northpoint, Kente Circle, Empower, Kofi Services at Wilder, Cultural Wellness Center, Tubman Center, Stairstep Foundation (Alfred Babington-Johnson), 180 degrees, Washburn Center for Children, Hennepin County Medical Center, and African American

psychologists and psychiatrists such as Thad Wilderson and Dr. BraVada Garrett-Akinsanya. Other stakeholders MDH should consider engaging with include the NAACP, Black Lives Matter, Urban League, and the African American Leadership Council (Appendix 7).

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

Third, we recommend MDH use culturally competent and reflective suicide awareness, prevention and treatment services. The community articulated mixed opinions on what determines culturally reflective and competent care. Some recommended a greater need for male practitioners and people of color to make the providers more reflective of the individuals seeking services and more culturally knowledgeable of the individual's background. Still, other interviewees focused on providers engaging clients on their cultural wants and needs, without making assumptions based on race. Based on the mixed opinions of culturally competent care, we recommend MDH engage a community partner in providing instruction on culturally competent care. Two specific culturally competent issues the community recommends providers acknowledge are historical trauma that stems from slavery, intergenerational poverty, abuse, and recognizing the community's feeling that mental and medical health providers have been punitive or are untrustworthy. Culturally competent care coincides with State Suicide Plan Objective 1.1.

Finally, based on the statistical and qualitative analysis, we recommend MDH create a suicide prevention awareness campaign within the Black Twin Cities Metro community. The community recommended increasing awareness of suicide prevention resources by: creating public service announcements and commercials for advertising on KMOJ radio station, billboards, and buses; increasing communication from National Alliance for Mental Illness; discussing emotional health and historical trauma in Black newspapers (Spokesman-Recorder, Insight Newspaper,

etc.) and mainstream news; using social media to spread the message to young Black men; and providing suicide prevention resources to health care providers within existing social service organizations that serve the Black community. Suicide awareness within the Black community is low partly due to the fact that individuals and agencies do not know how to access suicide services. The community recommends increasing access to services by making clear which community providers can assist with mental health and specifically suicide prevention. Increased advertising of how to access the suicide hotline, including the hours of operation and the privacy rules, will also help build awareness. Increasing awareness and access coincides with the State Suicide Plan Objective 1.2.

Conclusion

Through the interviews with Black community leaders, it is evident that awareness for suicide prevention and resources is low. Additionally, the community lacks the proper resources such as funding, providers, space, and culturally competent services to address the rising suicide rates. Nevertheless, with an appropriate approach, Black community leaders stated the community would support efforts to address suicide prevention strategies.

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

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

Appendices

Appendix 1: Suicide Risk Factors, All

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

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

(Appendix 1 Continued)

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

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

Appendix 2: Community Readiness Assessment Instrument

Community Readiness Assessment Script & Questions

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

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

Dimension A. Existing Community Efforts

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

Dimension B. Community Knowledge about Prevention

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

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

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

Dimension C. Leadership

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

Dimension D. Community Climate

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

Dimension E. Knowledge about the Problem

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

Dimension F. Resources for Prevention Efforts

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

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

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

Appendix 3: CRA Scoring Guidelines

Scoring Community Readiness Interviews (From SAMHSA Manual)

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

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

Anchored Ratings

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

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

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

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

	modifying support accordingly.

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

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

	effectiveness of local programs.

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

Appendix 4: Community Readiness Assessment Themes

Community Awareness

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

Risk Factors

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

Cultural Themes

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

Cultural Themes (Cont.)

- Mental health/suicide is not a Black person problem
- Role of the mother
- Resiliency of African Americans
- Suicide is glamorized

Barriers

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

Prevention

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

Appendix 5: Community Readiness Assessment Scoring

Community Readiness Assessment Scoring

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

Appendix 6: Risk Factors by Data Source

Suicide Risk Factors Summary Across Methods

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

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

Appendix 7: Community Partners

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

Suggested Community Partners

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

Suggested Stakeholders

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

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