

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

Reducing Suicides in the Black Community Will Require a Community-Informed Approach

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A recent CDC report highlights a 29.4% increase in suicide rates among Black youth (aged 10–24) from 2018–2023, contrasting with national declines. Addressing this crisis requires moving beyond “one-size-fits-all” models toward relational, community-based care that prioritizes trust, cultural nuance, lived experience, and the social drivers of health affecting Black communities.

A recent Centers for Disease Control and Prevention (CDC) report revealed a concerning trend regarding suicide and the Black community. According to the report, “Differences in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2018–2023,” we are seeing alarming trends regarding suicide among Black youth (aged 10–24).¹ Although overall suicide rates remained stable from 2018–2023, rates and changes in rates over time differed by race and ethnicity and age group. According to the report, between 2018 and 2023, the suicide rate for Black youth aged 10–24 increased by 29.4%. This increase occurred while the overall US suicide rate for the same age group (10–24) declined by 7.0%. Suicide rates for White youth (aged 10–24) decreased by 14.8% during the same period.

The report highlights that the rising rates among Black populations are “particularly concerning” because they represent a continuation of upward trends noted in earlier surveillance periods.¹ We could attribute this cause to several factors, including trauma, racism, poverty, and social media. While we do not have a definitive cause, we have a definitive trend. The report notes among its conclusions that, “There is no single cause of suicide.”¹ It does conclude, however, that “community-based approaches such as strengthening economic supports, increasing connectedness, and health care-based strategies can save lives.”¹

One of the constant themes one hears in suicide prevention work is the importance of human connection. We consistently reference the importance of community and the role of community in upstream care. This is particularly relevant when speaking about youth mental health, as youth rely on family, school systems, justice systems, health care systems, social services, and other systems to ensure that they thrive. To effectively reach Black youth with the resources necessary to end suicide, we must reach Black communities.

Access is essential to effective community-based mental health care. If we are to successfully reach and connect with Black youth via Black communities, we must approach access differently. Access is not just about having physical proximity to traditional resources. Having reliable access to behavioral health services means that people and their communities can receive support through various resources that are practical and relatable to their lived experience. Expanding the reach of existing resources is not always conducive to improving equitable access within a community if folks are not truly willing or able to utilize the services being provided. Perhaps we have been “feeding people things that they cannot digest.” If we want to reach Black youth, we need to think differently about what access looks like instead of fostering a one-size-fits-all approach.

According to the National Alliance on Mental Illness (NAMI), while roughly 21% of Black adults report mental health concerns, only about one in three (roughly 39%) receive care.² At the same time, they are less likely to initiate treatment and more likely to terminate treatment prematurely. Similarly for Black youth, studies show that while Black youth face high risks for depression and anxiety, they are less likely to seek help compared to White youth. In some instances, only 40% of Black youth with major depression receive treatment.³

When we plan access strategies, we should be mindful that people who are in a state of crisis will seek familiarity and safety. When we feel broken, afraid, alone, and vulnerable, what we need and seek most is connection, community, and understanding. The challenge for many Black and Brown communities is that resources have not been built “by them,” nor were they created to account for the nuances of race, culture, and ethnicity. In other words, communities cannot “see” themselves in the resources and are reluctant to utilize the resources themselves, let alone introduce those resources to their children. It is important to ask ourselves, “When someone is feeling vulnerable, are they going to be willing to access this resource, or are they going to perceive it as something that was designed for someone else but co-located in their community?”

How Do We Get There From Here?

Communities are looking for a meaningful partner to work alongside them and help them achieve their goals. What collaborations look like from our perspectives (as providers, state and federal agencies, and clinical entities) may often diverge from what collaboration looks like at the community level. In mental health care, we come from a very transactional space, while communities are much more relational and need to feel a sense of connection. This requires relationship-building strategies.

One strategy is to leverage the expertise of providers of color and people with lived experience, as well as providers with expertise in serving specific groups: rural, BIPOC (Black, Indigenous, and People of Color), aging populations, LGBTQ+, and others. This often means looking at people who do not have access to government grants or contracts. It might not be the highest-ranking person within a given organization that can provide the expertise you need. For relationship building, you can also find people and entities who have already built trust within communities and have expertise in how to reach different pockets of those groups. Many communities and non-government entities form partnerships and build through and by relationships, not just grants and contracts (consider alliances with faith-based organizations).

We should also focus on justice-involved populations and reevaluate how individuals who are seeking addiction treatment enter services. Court-ordered and legally enforced treatment should not be our go-to strategy. We need to think about what re-entering citizens need, including youth leaving detention facilities, how to support their social determinants of health, and how to address trauma from incarceration. How we treat these youth (and adults) reflects on how we can engage with the rest of the community—these are people’s family members—sons, daughters, brothers, and sisters.

Other relationship-building strategies include:

- Incorporating the voices of lived experience into mitigation strategies.
- Creating and following a strategy of partnering with the community.
- Seeking to understand what meaningful collaboration looks like from the community’s perspective, not just from the state or agency’s perspective.
- Being intentional about reviewing all treatment models and reflecting on how they might not account for the realities of social drivers of health.

Our treatment options need to account for the realities and social drivers of health in the Black community if we are to reach Black youth. We must consider the role of economic status, trauma history, systemic racism, legal barriers, and generational challenges. We cannot train providers to simply meet people where they are today—they need to also understand “what’s in the ground” and the histories of where the Black community is coming from. Black youth, like all individuals, want to feel seen and heard. If we are to reduce the rising rate of suicide among Black youth, it will take more than slogans and brochures. It will take collaboration and a trusted relationship with the Black community.

Disclosure of interests

The author has no conflicts of interest to disclose.

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