Examining Opportunities for Improving Suicide Care Among Black Youths

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Abstract

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Background: In recent years, there has been a spike in rates of suicide among Black youths, and there's an urgent need for this matter to be addressed. Black youths are a very vulnerable group in the United States due to racism but many lack the resources that are needed to get the appropriate mental health support that they need. This could be due to various factors that are seen across different levels of the socio-ecological model including individual, interpersonal, and organizational. Additionally, systematic racism particularly within healthcare systems needs to be addressed along with addressing implicit/explicit bias, and the lack of racial diversity within the workforce. Evaluating potential racial disparities in suicide risk identification practices among Black youths in one large regional healthcare system can help shed light on this issue.

Methods: Black and White youths aged 13-17 were examined for this study. Both groups were compared in all aspects of the study including SI screening, SI reporting, and risk assessment, Additionally, both groups were analyzed at the population and visit-based level. De-identified electronic health records and data obtained via Epic from Kaiser Permanente Washington were used. The data included patient sociodemographic information

such as race, and gender, along with responses from the PHQ-9, and the C-SSRS. PHQ-9 responses were analyzed for SI screening, and SI reporting and C-SSRS responses were analyzed for risk assessment.

Analysis: The analysis examined the proportion of Black youths enrolled within Kaiser Permanente Washington. The proportion of Black youth enrollees from 2017-2023 who answered the PHQ-9, reported relatively frequent thoughts about self-harm (PHQ-9 score 2 or 3) and answered the C-SSRS after reporting a 2 or 3 on the PHQ-9 were examined. Also, all findings were compared to the White youths enrolled in KPWA in the same time period.

Results: There was a total of 6005 Black youths, about 7.1% of the study population, compared to 36807 White youths, about 43.8% of the study population. At the population level, the proportions of Black youths who completed the PHQ-9 were lower than White youths. However, at the visit level, the proportions of Black youths who completed the PHQ-9 were similar to White youths. Similarly, there were no differences between the proportion of Black youths as compared to White youths reporting relatively frequent thoughts about self-harm at the visit level. Moreover, among Black youths reporting relatively frequent thoughts about self-harm, rates of suicide risk assessment with the C-SSRS were similar to White youths at the visit level.

Conclusion: This study highlights the need for improvements surrounding suicide care among Black youths. With the increasing rates of suicide among these vulnerable, healthcare systems must look to investigate ways to improve the mental health of Black youths and to create a safe space for them and their families. Based on the literature review, the socio-ecological model is useful for understanding ways to improve suicide care among Black youths. Finding ways to strengthen well-visit adherence among Black youths and their families, increasing the diversity of the workforce, and providing training to healthcare providers on implicit/explicit bias can all be beneficial in decreasing racial disparities when looking at SI screenings among youths.

Introduction:

The increasing rates of suicide among Black youths is an urgent public health crisis that warrants attention and actionable prevention research. Suicide is the second leading cause of death among all youths aged 10-17 [1]. However, between 2007 and 2020, the suicide rate among Black youths ages 10-17 increased by 144%; from 1.54 per 100,000 in 2007 to 3.77 per 100,000 in 2020 [2]. This suicide rate is increasing faster among Black youths than all other racial and ethnic groups in the U.S. [3].

Complex societal factors likely contribute to increasing rates of suicide among Black youths, including systemic racism. The socio-ecological model helps conceptualize the contributing factors at the individual, interpersonal, and organizational levels [4]. At the individual level, Black youths may lack the self-efficacy (belief in their ability) to get the mental health care that they need due to internalized stigma [5]. Internalized stigma has been associated with several negative outcomes, including increased depressive symptoms, social avoidance, decreased self-esteem, and decreased persistence in accessing mental health services and other types of support [6]. At the interpersonal level, fear of stigma attached to mental health issues may prevent youths from sharing their mental health struggles with family members or friends. Additionally, Previous studies show that it is prevalent among Black youths who have passed away by suicide to have had a romantic relationship crisis or a family-related crisis before they attempted suicide [7]. At the organizational level, provider bias in healthcare may prevent Black youths experiencing mental health issues from accessing the care they need. Along with this, disparities are evident when looking at rates of well-visit adherence among Black and White youths with Black youths coming in less [8]. Additionally, a lack of diversity among healthcare workers can result in Black patients not feeling satisfied with their healthcare provider, thus leading to them being less receptive to care [8]. Additional information is included in the Literature Review (see Appendix A).

Recent Findings:

Several recent studies have examined mental health care disparities among Black youths. For example, Douglas and colleagues [9] analyzed mental health service utilization during the COVID-19 pandemic between Match 1st, 2020, and September 1st, 2022, by conducting a comprehensive literature search with narrative methods. They found that overall, Black youths utilized mental health services less during the COVID-19 pandemic in comparison to White youths [9]. In a study conducted by Vance and colleagues [10] to explore service use disparities among suicidal Black youths in a suicide prevention care coordination intervention, it was seen that while Black and White youths were both likely to engage in individual therapy and non-mental health services, utilization rates for mental health and medication management services were lower for Black youths compared to White youths. Additionally, Black youths were less likely than Whites to receive medication management [10].

While these studies have helped us understand mental health-related care disparities among Black youths, research specific to suicide care disparities is uncommon. To our knowledge, no studies to date have examined screening for suicidality among Black youths. This is important because identifying Black youths at risk of suicide is the first crucial step in engagement in risk mitigation and evidence-based treatment [11].

Therefore, the goal of this study was to evaluate potential racial disparities in suicide risk identification practices among Black youths in one large regional healthcare system. Specifically, we analyzed the rates of suicidal ideation (SI) screening, SI reporting, and risk assessment among Black youths (ages 13-17) and compared those rates to White youths (ages 13-17) in primary care and mental health specialty settings. We hypothesized that Black youths would be less likely to be screened than their White peers during healthcare visits. Findings from this study will inform efforts in healthcare systems nationwide to address increasing rates of suicide among Black youths.

Methods

Data Source

The study utilized de-identified data from the electronic health record (EHR), insurance claims, and the health system enrollment database from Kaiser Permanente Washington (KPWA), a large, regional, healthcare system serving approximately 700,000 patients in urban, suburban, and rural communities across Washington. During the study, there were 25-30 primary care clinics and 7 mental health clinics with populations ranging from 4%-57% Black, Indigenous, and patients of color, including Hispanic/Latinx patients (for additional information see Appendix B). Data utilized included patient sociodemographic information, patient responses to the Patient Health Questionnaire (PHQ-9), and the Columbia-Suicide Severity Rating Scale (C-SSRS) (detailed below).

Study Population

The current study included patients aged 13–17 years old enrolled at KPWA from 1/1/2017–12/31/2023. Patients less than 13 years old or older than 17 were excluded from this analysis which focused specifically on youths.

Measures

Primary outcome measures included the use of the PHQ-9 and C-SSRS to identify suicide risk. The PHQ-9 is a commonly used nine-item depression symptom severity measure. The ninth question asks about "thoughts you'd be better off dead or hurting yourself" in the prior two weeks with response options ranging from "0" (not at all) to "3" (nearly every day) [12]. The PHQ-9 has been validated for use among youths and administered in various ways across KPWA clinics during the study, including as a pre-visit electronic questionnaire in the waiting room, on paper, on a tablet, or verbally by the provider in person or on the phone. [13]. Mental health specialty providers are encouraged to assess depression severity among all patients aged 13 before visits.

Primary care providers began screening for depression using the PHQ-9 during adolescent preventive care visits (i.e. Well-Visits) in April 2022. The C-SSRS was designed to help providers assess the risk of suicide [14]. At KPWA, when youths indicate having relatively frequent thoughts about self-harm (PHQ-9 score 2 or 3) providers are prompted in the EHR to complete a C-SSRS with patients (either verbally or on paper).

Sociodemographic Characteristics

Sociodemographic characteristics known to be associated with suicide among youths were extracted from EHR and the health system enrollment database from KPWA. These include race/ethnicity (Black or African American and White), and age (13-17) which were both self-reported.

Analysis

Descriptive statistical analyses examined demographic characteristics of all KPWA youth enrollees (age 13-17) from 2017-2023, and among youths who received primary care or mental health specialty care during the study period. Primary analyses examined the proportion of Black youth enrollees (as compared to White youths) who: 1) answered the PHQ-9, 2) reported relatively frequent thoughts about self-harm (PHQ-9 score 2 or 3), and 3) answered the C-SSRS after reporting a 2 or 3 on the PHQ-9.

Results

Study population

During the study period, 84,138 youths ages 13-17 were enrolled patients at KPWA, including 6005 Black youths, representing 7.1% of all enrolled youths (see Table 1). Among all Black youth enrollees during the study period, 4153 (69%) had one or more primary care visit(s) during the study period and 799 (13%) had one or more mental health specialty visit(s).

Main Outcomes

Among all enrolled Black and White youths during the study period, the proportions of Black youths who completed the PHQ-9 were lower than White youths (Figure 1). However, among Black youths who had a primary care or mental health specialty visit, the proportions of Black youths who completed the PHQ-9 were similar to White youths (Figure 2). Similarly, there wasn't much of a difference between the proportion of Black youths as compared to White youths reporting relatively frequent thoughts about self-harm at primary care or mental health specialty visits (Figure 3). Moreover, among Black youths reporting relatively frequent thoughts about self-harm, rates of suicide risk assessment with the C-SSRS were similar to White youths at primary care and mental health specialty visits (Figure 4).

Discussion

This study evaluated disparities in suicide risk identification practices among Black youths in a large healthcare system in Washington State. Contrary to our hypothesis that Black youths would be less likely to be screened for suicidal ideation during healthcare visits, this analysis showed similar proportions of Black and White youths being screened during mental health and primary care visits. Rates of suicidal ideation reporting and suicide risk assessment were also similar among Black and White youths. However, this analysis also indicated disparity at the population level among Black youths that persisted across the observation period. Specifically, among healthcare system enrollees, irrespective of care utilization, lower proportions of Black youths were screened for suicidal ideation. Together these screening patterns indicate a lower proportion of Black youths, as compared to White youths, utilized healthcare in settings like primary care and mental health where screening for suicidal ideation was occurring. Notably, screening rates were similarly low (25%) for Black and White youths during primary care visits across the observation period. Screening rates in mental health specialty were

highest at the beginning of the observation period, suddenly dropping below 50% at the beginning of 2020, likely due to the COVID-19 pandemic, and slowly rising again to above 50% (but not to pre-pandemic levels). Furthermore, though confidence intervals overlap, suicidal ideation reporting rates appear to peak among Black youths in 2020.

The socio-ecological model is useful for understanding how results from this study align with prior research. Findings indicating healthcare utilization patterns are lower overall among Black youths as compared to White youths are consistent with prior research evidence demonstrating macro-level factors, such as social, economic, and political factors, create lifelong health inequities characterized by poverty, adversity, and distress which could interfere with families of color attending their well-visits [15]. At the individual level, mental health and suicide are largely stigmatized within the Black community [16] which could prevent an individual and/or their families from seeking care. At the organizational level, the lack of racial diversity among healthcare providers, and experiences with discrimination may discourage Black families from scheduling regular preventive care visits [17]. The increase in suicidal ideation reporting rates among Black youths in 2020 is consistent with other research demonstrating higher rates of depression and anxiety among all ages of Black people in the United States after the footage of George Floyd's murder was circulated on social media [18] which demonstrates how racism operating at the societal level negatively impacts mental health for large populations of people.

The clinical implication of this study highlights how healthcare systems may address suicide risk identification disparities among Black youths. For example, at the population level health care systems may consider targeted outreach to Black families to encourage them to schedule preventive and mental health care visits. Similarly, healthcare systems may consider how to better support Black families during their healthcare visits.

A study done by Casanova-Perez [19] and colleagues found that individuals from marginalized communities, including Black and LGBTQ+ patients, did not feel comfortable going back to their providers after they were treated poorly, and therefore, self-medicated or delayed treatment until their conditions worsened to seek medical attention. This highlights the potential value of training focused on cultural humility and anti-racism, as prior research indicates this may effectively increase providers' bias awareness (implicit and explicit) [20]. Along with this, recruiting and retaining a more racially diverse workforce could improve options for Black youths and families in receiving healthcare from a provider that they feel comfortable and safe with.

This descriptive analysis relied on data from one large regional healthcare system, which had implemented workflows supporting the identification of suicide risk. Therefore, the lack of evidence of screening disparities among Black youths receiving primary and mental health care may not be generalizable to other systems. Similarly, the population receiving care from this system may not be generalizable to other healthcare systems, particularly those that provide care to higher proportions of uninsured people and those eligible for Medicaid. Additionally, while this descriptive statistical analysis helps us understand that focusing on care utilization may be a possible target for addressing lower suicide screening rates among Black youths, additional research will be needed to understand how to address this disparity. For example, semi-structured interviews or focus groups with Black youths and parents may help understand how to offer and engage Black youths in preventive care. Specifically, future work should qualitatively evaluate upstream barriers preventing Black youths from utilizing mental healthcare and ways to address them. Community engagement may also be useful for investigating how to increase cultural humility among healthcare providers and enhance health equity efforts.

Conclusion:

This study analyzed patterns of suicide risk identification disparities among Black youths as a mechanism for improving suicide prevention within a large healthcare system. Findings support efforts to increase rates of suicide risk identification in primary care visits among Black youths and in parallel focus on increasing care utilization among Black youths. While these analyses were limited to one regional healthcare system, the findings inform national efforts to address increasing rates of suicide among Black youths. This study is essential because it sheds light on a crisis that's occurring among a vulnerable group in the United States. Black youths must get the resources that they need so that suicide attempts can be prevented and reduced.

Table 1. Sociodemographic characteristics of youth with eligible visits* between January 1, 2017 – December 31, 2023

	Visits		People (LAST visit in study period)**		Total Enrollees
Question	Primary care	Mental Health Specialty	Primary Care	Mental Health Specialty	(last enrollment period in study period)
TOTAL N (number individuals with eligible visits)	**253384**	**96900**	**76938**	**16034**	**84138**
	N (%)	**N (%)**	**N (%)**	**N (%)**	**N (%)**
Demographics					
AGE					
13-14	95472 (37.0%)	32800 (33.9%)	12144 (24.5%)	2904 (25.8%)	17604 (20.9%)
15-17	162912 (63.1%)	64100 (66.2%)	37351 (75.5%)	8340 (74.2%)	66534 (79.1%)
RACE/ETHNICITY					
White	149030 (57.7%)	63048 (65.1%)	26684 (53.9%)	6844 (60.9%)	36807 (43.8%)
Black or African American	21284 (8.2%)	6007 (6.2%)	4153 (8.4%)	799 (7.1%)	6005 (7.1%)
Hispanic / Latino	23862 (9.2%)	8640 (8.9%)	4379 (8.9%)	1041 (9.3%)	6064 (7.2%)
Asian	36093 (14.0%)	9167 (9.5%)	7184 (14.5%)	1066 (9.5%)	9672 (11.5%)
Native Hawaiian/Other Pacific Islander	5467 (2.1%)	1850 (1.3%)	1120 (2.3%)	171 (1.5%)	1643 (2.0%)
American Indian/Alaskan Native	4425 (1.7%)	1303 (1.3%)	752 (1.5%)	203 (1.8%)	1135 (1.4%)
Other	4610 (1.8%)	1360 (1.4%)	934 (1.9%)	185 (1.6%)	1275 (1.5%)
Unknown	13613 (5.3%)	5511 (5.7%)	4289 (8.7%)	936 (8.3%)	21537 (25.6%)
SEX					
Female	144495 (55.9%)	63821 (65.9%)	25123 (50.8%)	6727 (59.8%)	41090 (48.4%)
Male	113872 (43.1%)	33070 (34.1%)	24370 (49.2%)	4516 (40.2%)	43046 (51.2%)

Unknown/Missing	17 (<0.01%)	9 (0.01%)	2 (<0.01%)	1 (0.01%)	2 (<0.01%)
GENDER IDENTITY					
Cis Male	11734 (4.5%)	4010 (4.1%)	1565 (3.2%)	401 (3.6%)	1947 (2.3%)
Cis Female	17299 (6.7%)	6318 (6.5%)	2228 (4.5%)	624 (5.6%)	2922 (3.5%)
Transgender: Male to Female	1376 (0.5%)	1083 (1.1%)	132 (0.3 %)	88 (0.8%)	166 (0.2%)
Transgender: Female to Male	4339 (1.7%)	4353 (4.5%)	299 (0.6%)	243 (2.2%)	340 (0.4%)
Other	6200 (2.4%)	6119 (6.3%)	688 (0.9%)	458 (2.9%)	720 (0.9%)
Do not wish to disclose	381 (0.2%)	321 (0.3%)	32 (<0.1 %)	15 (0.1%)	35 (<0.1%)
Unknown/Missing	217055 (84.0%)	74696 (77.1%)	44629 (90.2%)	9466 (84.2%)	78008 (92.7%)
SEXUAL ORIENTATION					
Heterosexual	3099 (1.2%)	1069 (1.1%)	438 (0.9%)	120 (1.1%)	638 (0.8%)
Gay or Lesbian	1172 (0.5%)	711 (0.7%)	117 (0.2%)	55 (0.5%)	155 (0.2%)
Bisexual	1904 (0.7%)	1568 (1.6%)	216 (0.4 %)	120 (1.1%)	292 (0.4%)
Other	1964 (0.8%)	2000 (2.1%)	186 (0.4%)	122 (1.1%)	209 (0.2%)
Unsure	1420 (0.6%)	1338 (1.4%)	120 (0.2%)	83 (0.5%)	115 (0.1%)
Do not wish to disclose	1123 (0.4%)	1182 (1.2%)	81 (0.2%)	52 (0.5%)	103 (0.1%)
Unknown/Missing	247702 (95.9%)	89032 (91.9%)	48347 (97.8%)	10700 (95.1%)	82611 (98.2%)
Economic and Education†					
	PC	MH	PC	MH	
Median household income <$40K (KP)	14627(5.7%)	5348 (5.5%)	2975 (6.0%)	661 (5.9%)	5067 (6.0%)
>=$40K (KP)	243689 (94.3%)	91522 (94.5%)	46520 (94.0%)	10583 (94.1%)	79071 (94.0%)
Missing income					
Neighborhood <25% college-educated (KP)	88719 (34.3%)	32450 (33.5%)	17598 (35.6%)	3908 (34.8%)	31128 (37.0%)
>=25% college-educated	169648 (65.6%)	64435 (66.5%)	31897 (64.4%)	7336 (65.2%)	53010 (63.0%)
Missing education					

Less than 75% of neighborhood above 200% poverty level	33455 (13.0%)	11785 (12.2%)	6596 (13.3%)	1391 (12.4%)	11639 (13.8%)
75% or more of neighborhood above 200% poverty level	224909 (87.1%)	85096 (87.8%)	42899 (86.7%)	9853 (87.6%)	72499 (86.2%)
missing					
Insurance					
Medicaid/Medicare/State Subsidized	41074 (15.9%)	12244 (12.6%)	7218 (14.6%)	1345 (12.0%)	12019 (14.3%)
Private Pay	22484 (8.7%)	6111 (6.3%)	4930 (10.0%)	810 (7.2%)	8437 (10.0%)
Self-Funded					
Commercial	194822 (75.4%)	78545 (81.2%)	37346 (75.5%)	9089 (80.8%)	63622 (75.6%)
Other					60 (0.1%)
Enrolled with health plan at least 1 year prior to index visit***	239519 (92.7%)	91413 (94.3%)	45034 (91.0%)	10513 (93.5%)	68266 (81.1%)

*Age at time of first visit in the study period
† Economic and education data are census based

Figure 1. *SI screening at the population level, comparing Black and White youths (January 1, 2017 – December 31, 2023).*

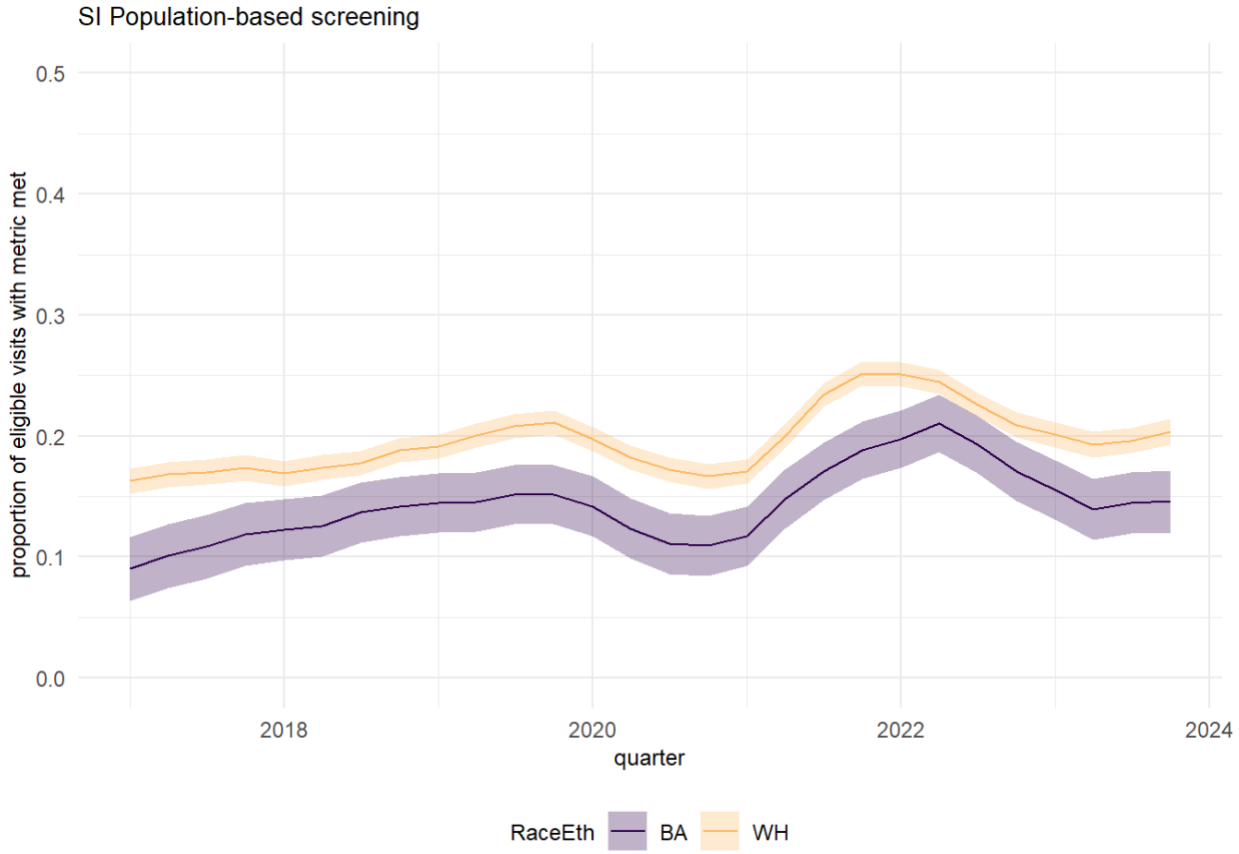


Figure 2. *SI screening in Mental Health Specialty and Primary Care, comparing Black and White youths (January 1, 2017 – December 31, 2023).*

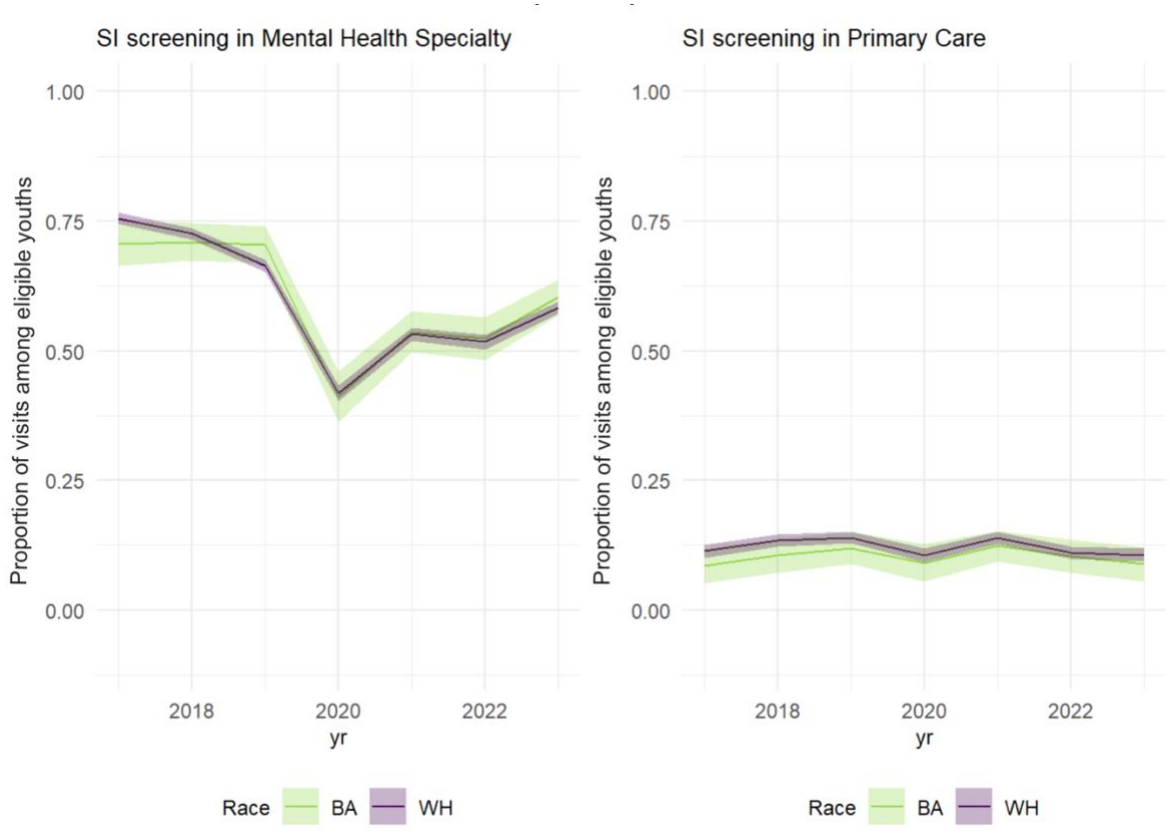


Figure 3. *SI reporting in Mental Health Specialty and Primary Care, comparing Black and White youths (January 1, 2017 – December 31, 2023).*

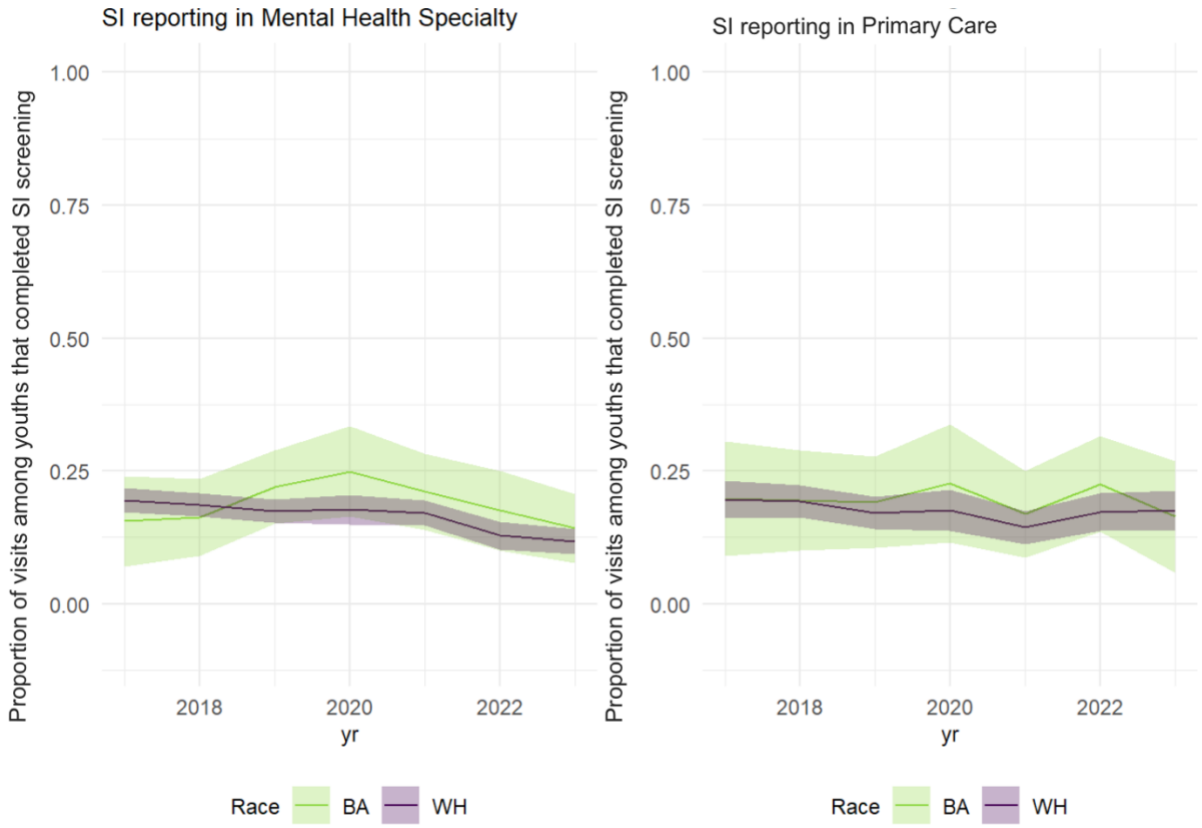
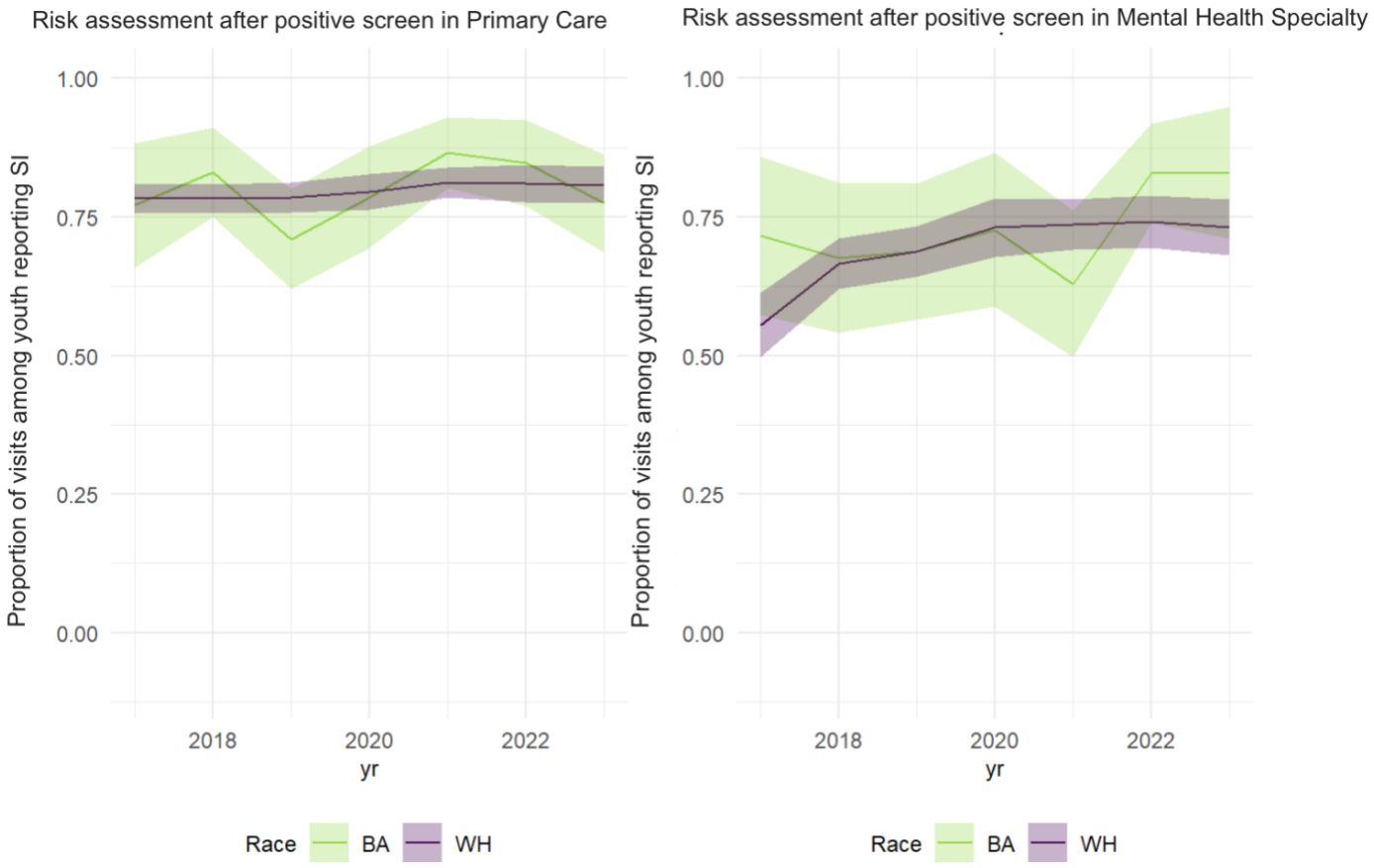


Figure 4. S*uicide risk assessment (via C-SSRS) among Black and White youths reporting thoughts about self-harm (January 1, 2017 – December 31, 2023)*



Appendix A: Literature Review

Socio-ecological Model:

The socio-ecological framework is a multilevel conceptualization of health that includes individual, interpersonal, organizational, environmental, and public policy factors. The socio-ecological framework emphasizes multiple levels of influence and supports the idea that behaviors both affect and are affected by various contexts [4]. Although all elements of the socioecological framework are equally important, due to the smaller scope of the present study, the environmental and public policy levels will not be discussed.

Individual:

At the individual level, Black adolescents with mental health problems are less likely than non-Black adolescents with mental health problems to receive treatment [22]. This may be due to various factors, such as negative perceptions of services and providers, and self-stigma associated with experiencing mental health problems [22]. One factor that may contribute to this problem is internalized stigma. Internalized stigma refers to the shame and expectation of discrimination that prevents people from talking about their experiences and stops them from seeking help [23]. Internalized stigma has been associated with several negative outcomes, including increased depressive symptoms, social avoidance, decreased self-esteem, and decreased persistence in accessing mental health services and other types of support [6]. The internalized stigma that Black youths may be experiencing could be connected to the fear of being rejected and/or shamed if they share that they are experiencing poor mental health with their peers and family [24]. The fears some adolescents may have about being seen in a negative light by family and friends could contribute to a general negative feeling toward mental health and help-seeking, thus preventing them from seeking the help that they need [24].

Interpersonal:

At the interpersonal level, other people in an individual's life may contribute to their suicidal thoughts and behaviors. Previous studies [25] show that it is prevalent among Black youths who have passed away by suicide to have had a romantic relationship crisis or a family-related crisis before they attempted suicide. In a 2021 national study conducted by the Youth Risk Behavior Surveillance [26], it was revealed that 9.7% of Black youths experienced some form of interpersonal violence, including dating violence. A Black youth witnessing these instances, especially at home, may contribute to depressive symptoms and suicidal ideation. A 2020 study conducted by the U.S. Department of Health and Human Services [27] reported that 42% of Black youths who died by suicide, had a family-related crisis 2 weeks beforehand, compared to White youths (37%). 39% of Black youths who died by suicide also experienced family relationship problems beforehand, compared to White youths (37%) [27]. In a New York Times piece [28] that interviewed survivors of suicide, some of the interviewees who had attempted suicide shared that they had a family-related conflict right before attempting suicide. Interviewees described a range of interpersonal conflicts that preceded their suicide attempt, including arguments and sexual assault; these conflicts, no matter the severity, made the person feel as though their only option to end the pain they were experiencing was to die by suicide.

Stigma is an important factor when looking at the high rates of suicide among Black youths, especially in the context of interpersonal relationships [16]. For example, Cooper-Patrick and colleagues [29] discovered that Black patients voiced more concern about stigma than their white counterparts. They noted that seeking help for mental health problems was not "culturally acceptable" among family and peers. Additionally, Thompson and colleagues [30] found that not only do African Americans consider stigma a barrier to seeking professional treatment for mental health concerns but also that they may hold more stigmatizing attitudes toward mental illness than other racial and ethnic groups. More research needs to be done regarding the correlation between

the increase in suicide rates among Black youths and stigma. However, it is still a factor that healthcare systems should be mindful of when looking at suicide care among Black youths.

Organizational:

At the organizational level, disparities are evident when looking at rates of well-visit adherence among Black and White youths. In a cross-sectional study conducted by Abdus and Selden [31], they compared rates of well visit adherence during the years 2007-2008 and 2016-2017 among ages 0-18. They found that adherence grew unevenly across race and ethnicity. Adherence among Black non-Hispanic children increased by only 5.6 percentage points (95% CI, 0.3%-11.0%) vs 15.3 percentage points (95% CI, 10.9%-19.7%) among White non-Hispanic children, widening the Black-White adherence disparity among non-Hispanic children [31]. Previous studies [15] have noted that macro-level factors such as social, economic, and political factors create lifelong health inequities characterized by poverty, adversity, and distress which could interfere with families of color attending their well visits.

In addition to the lack of well-visit adherence among Black youths, the lack of a racially diverse workforce is a factor that heavily contributes to the disparities of well visits adherence. In a study conducted by Saha and colleagues, it was discovered that Black patients who had a healthcare provider who was also Black were more likely to be satisfied with their provider and go in for care, in comparison to Black patients who did not have a Black provider [8]. Increasing the number of minority healthcare providers can help better address the unique needs of Black youths, along with improving health outcomes including reducing the rates of suicide among this group.

Additionally, implicit bias among providers is a common issue across the United States that contributes to structural inequities within the healthcare system which prevents Black youths from getting the mental health support they need [32,33]. Whether it's explicit or implicit, it can cause a lot of harm to anyone's mental health. Research in clinical settings has shown that Black youths receive less counseling during well-child visits [34]

and have lower rates of treatment for mental health-related issues [35]. Burgess and colleagues [36] noted that the racial stereotypes healthcare providers hold influence the interpretation of patient behaviors and symptoms and, thus, clinical decisions. It was also noted that application of these stereotypes is unconscious; and that providers have fewer effective interactions with their minority patients compared to their white patients [36]. Stereotypes (and prejudices) are transmitted and learned through culture and therefore, can shape how medical professionals evaluate and interact with patients of color [37]. Also, circumstances inherent to pediatric clinical care today, such as heavy workload, fatigue, and uncertainty, create an environment of cognitive stress that increases the risk of bias and errors in medical decision-making [38]. In connection to implicit bias, it has been documented that there's a higher likelihood of Black youths with psychiatric disorders being referred to juvenile systems while White youths are referred to treatment-oriented interventions [39]. When Black youths do seek help for mental health, they are less likely to receive evidence-based treatments, follow-up care, and referrals to specialized mental health treatment [39]. These are all important for healthcare systems to keep in mind when investigating ways to better care for suicidal Black youths.

Appendix B: Additional information about Kaiser Permanente Washington (KPWA)

KPWA provides comprehensive medical and psychiatric specialty care to a defined population of about 700,000 members who are enrolled through employer-sponsored or individual insurance plans or capitated Medicaid or Medicare programs. KPWA maintains a robust electronic health record database that captures members' demographic, enrollment, and clinical/diagnostic information, prescription dispensing data, internal service utilization, external health care claims data and mortality data. Electronic health records data are organized into a research virtual data warehouse and mortality data is updated regularly via linkage to state death data and National Death Index data. Members are representative of their respective regional populations in terms of age, sex, race, and ethnicity.

KPWA is one of eight Kaiser Permanente regional healthcare systems that together serve 12.5 million members as one of the nation's largest not-for-profit healthcare organizations and share suicide prevention practices during quarterly meetings organized by the Care Management Institute.

KPWA is currently the only region that implements systematic population-based suicide risk assessment and safety planning in primary care as part of an integrated mental health initiative. KPWA also leads the NIMH-funded MHRN, a consortium of research centers affiliated with 14 large health systems across the U.S.

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