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NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH AND HUMAN SERVICES

UNDERSTANDING THE IMPACT OF SUICIDE IN RURAL AMERICA

POLICY BRIEF AND RECOMMENDATIONS

DECEMBER 2017

EDITORIAL NOTE

During its September 2017 meeting in Boise, Idaho, the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as “the Committee”) discussed the impact of suicide in rural communities along with prevention strategies at the state and federal level. Specifically, on the first day, the Committee heard about suicide epidemiology as well as federal and Idaho-specific efforts geared towards funding and programming. On the second day, the subcommittee, tasked with this topic, gathered in Emmett, Idaho and heard from local behavioral health providers and practitioners, first responders, school-based counselors, faith-based leaders, and other key community stakeholders.

ACKNOWLEDGEMENTS

The Committee would like to acknowledge and give thanks to all whose participation helped make the meeting in Boise, the site visit in Emmett, and this policy brief possible.

The Committee benefited greatly from the knowledge and expertise of Dr. Holly Hedegaard (Centers for Disease Control and Prevention) and Dr. Richard McKeon (Substance Abuse and Mental Health Services Administration) – both of whom presented at the meeting. Additionally, the Committee expresses their gratitude to Kim Kane (Idaho Department of Health and Welfare), Jeni Griffin (Suicide Prevention Action Network of Idaho), Dotti Owens (Ada County Coroner), Dr. J. Robert Polk (Saint Alphonsus Health System, former, now retired) all of whom provided a multi-faceted perspective rural suicide within the Idahoan context.

The Committee would like to thank each of the community panelists who shared their experiences and insights during the site visit. These individuals include Steve Kunka (Chief of Police for the City of Emmett); Janelle Schneider (Chief Juvenile Probation Officer for Gem County); John Buck (Coroner for Gem County); Melisa Blackwell (Suicide Prevention Action Network of Idaho); Sarah Ludovic and Tim Heinze (Valley Family Health Care); Camille Evans and Scott Conklin (Valor Health Hospital); Dr. Ryan J. Hulbert (Psychologist for EPIC Psychological Services); Joy Husmann (Community Liaison for Intermountain Hospital); Matthew Macy and Stephanie Smith (Emmett School District); and Dr. Andrew Sapp and Ryan Hale (Cherry Gulch and Novitas Academy).

The Committee is also grateful to Pastor Lance Zagaris and First Baptist Church for their generosity and hospitality they provided in accommodating the subcommittee’s site visit to Emmett.

Special thanks goes to the Committee host, Mary Sheridan and for her leadership in helping coordinate and bring together key community panelists. Additionally, special thanks to Kathleen Belanger, who served as subcommittee chair for this issue and the other members of this subcommittee, which included: Barbara Fabre, Constance Greer, Octavio Martinez, Jr., Benjamin Taylor, Donald Warne, and Peggy Wheeler.

Finally, the Committee would like to acknowledge the work of Alfred Delena in putting together this policy brief.

NOTES ON TERMINOLOGY

Defining Key Terms The Centers for Disease Control and Prevention (CDC) provides the following definitions for *suicide*, *suicide attempt*, and *suicidal ideation*. While the justification for providing concrete definitions is meant primarily for researchers to collect and disseminate suicide-related data, having a shared language creates consistency and a common understanding among individuals involved in this work (e.g., researchers, educators, practitioners, and policy makers).^a

- *Suicide*: Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.
- *Suicide attempt*: A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior; might not result in injury.
- *Suicidal ideation*: Think about, considering, or planning suicide.

Words Matter When addressing suicide, it is important to be mindful of the language that one uses as certain words and phrases have the potential to isolate people and/or unintentionally contribute to existing misconceptions of suicide. Below are some words and phrases to avoid along with alternatives to use in lieu of.

- For language that can be interpreted as suicide being a desirable outcome OR suicide being synonymous with a crime or sin, refrain from saying “successful/unsuccessful suicide,” or “commit/committed suicide”. Instead, use phrases such as “took their own life,” “ended their own life,” or “died by suicide.”
- For language that can be perceived as glamorizing a suicide attempt, avoid “failed suicide,” and instead, say “made an attempt on their life,” “suicide attempt,” or “non-fatal attempt.”
- For language that sensationalizes suicide rates, use words such as “higher,” “increasing,” or “concerning” in place of “epidemic,” “outbreak,” or “skyrocketing.”

^a For more information about suicide terminology, refer to pp. 21-23 in Crosby, Alex. E., LaVonne Ortega, and Cindi Melanson. “Self-directed violence surveillance: Uniform definitions and recommended data elements, version 1.0.” Centers for Disease Control and Prevention, 2011. Retrieved from <https://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf>.

RECOMMENDATIONS

Research and Evaluation

1. The Committee recommends that the Secretary require the Department of Health and Human Services (HHS) to conduct a national comprehensive evaluation that assesses existing state and Tribal efforts to reduce rural suicide rates and that identifies successful evidence-based, rural-specific strategies that can be implemented within states and Tribal communities.
2. The Committee recommends the Secretary require the Agency for Health Research and Quality and the National Institutes of Mental Health to conduct research on the use of Community Health Workers to determine if these efforts can reduce suicide risk and increase referrals for at-risk individuals. The study should also look at cost- and clinical-effectiveness of these efforts and broadly disseminate findings.

Outreach, Promotion, and Awareness

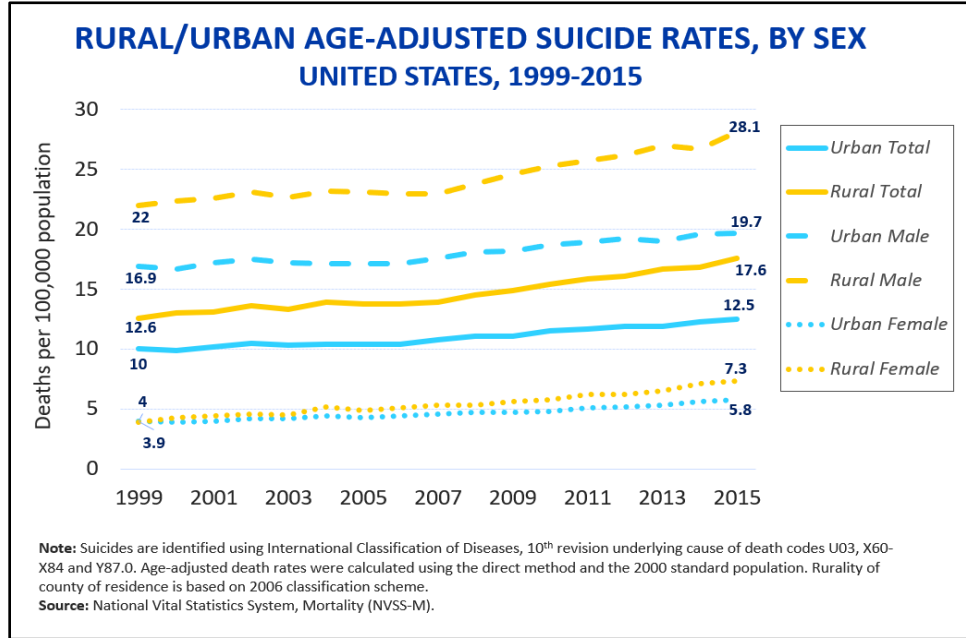
3. The Committee recommends Health Resources and Services Administration to expand and increase the promotion of the Rural Health Care Services Outreach, Network and Quality Improvement grant programs through HHS partners to inform rural communities on the opportunity to incorporate suicide prevention activities and increase access to mental health services using grant funds.
4. The Committee recommends HHS Agencies and Offices to promote the broader use of the PHQ-9, a clinically validated depression screening and monitoring instrument, in rural health facilities and to educate providers on how to bill for services.
5. The Committee recommends Substance Abuse and Mental Health Services Administration to integrate rural-specific research and considerations for prevention into the National Strategy for Suicide Prevention if it is revised and updated so as to reflect existing rural suicide trends and disparities.

INTRODUCTION

Suicide continues to be a deeply concerning public health challenge that affects all individuals that are involved – family, friends, colleagues, and community members. In 2015, an American took their own life roughly every 12 minutes,¹ making suicide the 10th leading cause of mortality in the United States.² Compared to the age-adjusted suicide rate in 1999 (10.5 deaths per 100,000), the suicide rate rose to approximately 13.3 deaths per 100,000 by 2015.³

Although suicide affects both rural and urban residents, rural populations face persistent and widening increases in suicide compared to their urbanized counterparts.⁴ Mortality data from the National Vital Statistics System (NVSS) show a significant increase from 2000 through 2015 in the national age-adjusted rate of suicide.⁵ Moreover, researchers from CDC observed a rural-urban disparity that continued to widen over time and diverged even further around 2007-2008.^{4, 6} Data

indicates that the rate of suicide among nonmetropolitan (rural) counties was consistently higher compared to medium/small and large metropolitan (urban) counties;⁶ however, this discrepancy can be traced back well before 2000.⁷ Previous research has documented this divergence,⁸ highlighting the fact



that as counties become less urbanized, the prevalence of suicide becomes increasingly higher.⁹ In fact, in 2015, rural counties had an age-adjusted suicide rate of 17.7 deaths per 100,000 compared to 12.5 deaths per 100,000 among urban counties.¹⁰ Consistent with previous findings,¹¹ NVSS (2015) data has shown that age-adjusted suicide rates were higher among males than females for both rural and urban areas. In 2015 alone, male suicide rates based on urbanization began to diverge around early adolescence (10-14) and remained relatively separate throughout the lifespan.¹⁰ Similarly, rural and urban female suicide rates deviated from each other during adolescence; however, they began to slowly converge around age 24, only to diverge and widen throughout the lifespan until around ages 60-65 when the trend gap closes.¹⁰ (See **Appendix A** for graphs displaying male and female suicide trends by age in 2015. See **Appendix B** for a further breakdown of male/female differences based on level of urbanization.) In addition to sex differences, NVSS data show that among rural counties, about 60 percent of all suicide deaths were attributable to firearm, 24 percent to suffocation/hanging, 12 percent to poisoning, and

SUICIDE IN INDIAN COUNTRY

Amongst other health disparities,¹² Native communities face disproportionately high rural suicide rates⁶ and mental health challenges.¹³ In 2015, suicide rates were highest among non-Hispanic American Indian/Alaska Natives (19.9 per 100,000)² and particularly among young Native people, ages 15-24 (34.1 per 100,000),¹⁰ compared to their racial counterparts. Though, it is important to note that reported suicides for young Native people is likely to be underrepresented as overall deaths for this group have historically been poorly documented.¹⁴

American Indian/Alaska Natives (AI/AN) represent roughly 2 percent of the total U.S. population¹⁵ with more than half (54 percent) residing within rural or small-town areas and 68 percent living on or near Tribal designated areas (e.g., reservations).¹⁶

5 percent to “other” means.¹⁰ By comparison, for urban counties, 47 percent of all suicide deaths were attributable to firearm, 28 percent to suffocation/hanging, 16 percent to poisoning and 9 percent to “other” means.¹⁰

While the direct *causes* of suicide remain uncertain, the coalescence of various biological, psychological, social, and cultural factors can *increase* an individual’s risk and susceptibility. Risk factors include previous suicide attempt(s),

history of mental illness, hopelessness, lack of social support, intense stressful events, exposure to another person's suicide, barriers to health care, access to lethal means, and stigma.^b Moreover, rural populations face additional significant obstacles related to the *accessibility*, *availability*, and *acceptability* of mental health care services.^{17, 18} Some of these rural-specific factors – health professional workforce shortages, stigma associated with seeking and receiving treatment, and issues with accessing care – may explain, in part, the widening gap between rural and urban suicide rates.

Accessibility, Availability, and Acceptability of Rural Mental Health Care

The lack of social integration^c (i.e., social isolation) is a well-documented risk factor¹⁹ that also plays a role in explaining rural-urban differences. Specifically, because of their geographic isolation, rural residents have difficulty accessing health care. In addition to having slightly higher uninsured rates, compared to urban areas,²⁰ a commonly identified barrier among rural communities has been the lack of transportation (public or private) to services. While a 2004 study found that 60 percent of all rural counties had some form of public transit services, it was often limited.²¹ Only 32 percent of those rural counties had full access while 28 percent had limited services, leaving the other 40 percent without any options for public transportation.²¹ Without transportation, accessing health care services may increase delayed or missed appointments or disrupt ongoing treatment for a chronic illness.^d This, combined with an inability to pay for health care, creates further challenges and may serve only to increase isolation.

Geography also poses challenges for the recruitment and retention of rural mental health professionals. A 2016 WWAMI Rural Health Research Center data brief highlighted the disparity in the allocation of behavioral health providers based on urbanization levels. Specifically, among rural counties:

- Sixty-five percent had no psychiatrists (compared to 27 percent of metropolitan counties),
- Forty-seven percent of these counties were without psychologists (versus 19 percent),
- Twenty-seven percent were without social workers (contrasted with 9 percent),
- Eighty-one percent were without psychiatric nurse practitioners (compared to 42 percent), and
- Eighteen percent were without counselors (versus 6 percent).²²

With the lack of mental health professionals, accessing care and treatment for individuals with mental health challenges becomes limited. In fact, individuals in urban areas who died by suicide were more likely than their rural counterparts to have had a psychiatric diagnosis and received proper mental health care.²³ However, it is important to point out that because of stigma, individuals often do not seek the services they need or if they do, they do not fully engage in the treatment,²⁴ which is especially significant among rural areas. Smaller population densities lead to

^b For more information about suicide risk (and protective) factors, refer to CDC at <https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html> and the American Foundation for Suicide Prevention at <https://afsp.org/about-suicide/risk-factors-and-warning-signs/>.

^c Social integration refers to the level of connectedness an individual feels to a group or community in society.

^d For more information about transportation issues among rural populations, refer to <https://www.ruralhealthinfo.org/topics/transportation>.

an increase in mental health stigma because of decreased anonymity, which, stem, in part, from a prominent trait typically identified among rural settings known as “rugged individualism.”^e

FEDERAL RESOURCES

The Department of Health and Human Services’ (HHS) Agencies and Offices, specifically the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Service (IHS), and the Health Resources and Services Administration (HRSA) have federal programs^f that either directly address suicide prevention or more broadly target mental health-related efforts. HHS also funds a range of clinical and health services research through CDC, the National Institutes of Health/Mental Health (NIH/NIMH) and the Agency for Health Research and Quality (AHRQ) that potentially can include issues related to suicide. (See **Appendix C** for an analysis of HHS’ collective impact on suicide prevention programming and research.^g)

SAMHSA Programs^h

SAMHSA administers funding through state block grants, discretionary grants, contracts, and cooperative agreements that address a range of behavioral health and substance abuse issues. Specifically, SAMHSA’s Suicide Prevention Branch manages programs that target suicide prevention and crisis intervention efforts. These actions are spearheaded through several funding mechanisms, namely, the Garrett Lee Smith Memorial Act, the National Strategy for Suicide Prevention, the National Suicide Prevention Lifeline, and two Native-specific programs.

Enacted in 2004 and reauthorized in 2015,ⁱ the Garrett Lee Smith (GLS) Memorial Act (Public Law 108-355) permits SAMHSA to oversee two youth-focused prevention programs and a resource center.

- The *GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program* provides states and Tribes with funding to design and apply suicide prevention and early intervention approaches in collaboration with youth-serving organizations. To date, 180 grants have been awarded to 50 states, the District of Columbia, 47 Tribes/Tribal organizations, and 2 U.S. territories. Evaluations conducted by SAMHSA have shown counties that implemented GLS youth suicide prevention activities had lower rates²⁵ and fewer attempts²⁶ when compared to matched counties that did not.

^e Rugged individualism refers to the belief that existing problems and challenges are handled by the individual or within one’s own family and not to be vocalized outwardly; a “suck-it-up” or “pull-yourself-by-the-boot-straps” mentality.

^f **Programs**, in the context of federal resources refers to established grant funding mechanisms. Notably, this is different from the on-the-ground suicide prevention and intervention practices, which are also referred to as “programs”.

^g HRSA and AHRQ programs were not included in this higher-level analysis because HRSA programs do not specifically target suicide-related activities and although AHRQ does fund various suicide-related projects, funding information for these efforts were not provided. Importantly, because **Appendix C** serves as a first attempt at displaying a collective federal impact on suicide-related activities, all HHS agencies were not accounted for, only primary agencies. The current table was constructed from various sources, including Congressional budget justifications and funding information graciously provided to the Committee by CDC and NIMH. Future efforts should consider compiling funding information from all HHS agencies to provide an accurate picture of suicide prevention activities at the federal level.

^h SAMHSA’s detailed 2018 Justification of Estimates for Appropriations Committee provides further information about SAMHSA-specific programming. For specific suicide-related activities, refer to *pp. 54-62 & 82-84*. Accessed at <https://www.samhsa.gov/sites/default/files/samhsa-fy-2018-congressional-justification.pdf>.

ⁱ Garrett Lee Smith Memorial Act Reauthorization of 2015: <https://www.congress.gov/bill/114th-congress/house-bill/938/text>.

- The *GLS Campus Suicide Prevention Program* has allowed higher education institutions to offer training and awareness through campus-, Tribal-, and state-sponsored activities.^j
- The *Suicide Prevention Resource Center (SPRC)*, a project of the Education Development Center (EDC), offers a wide range of resources and technical assistance support to SAMHSA grantees, organizations, Tribes, and states for the development of and implementation of suicide prevention practices and/or policies.^k

SAMHSA also manages grants for the *National Strategy for Suicide Prevention (NSSP)* and the *National Suicide Prevention Lifeline*. Originally issued in 2001 by the Office of the Surgeon General and updated in 2012, NSSP guides national comprehensive suicide prevention efforts with the goal of reducing overall deaths.²⁷ NSSP grants offer states funding to address its outlined strategic goals and objectives, specifically among working-aged adults (ages 25-64). In 2017, Zero Suicide grants were awarded for the first time by SAMHSA to strengthen suicide prevention efforts within health care systems. In addition, the Suicide Lifeline (1-800-273-8255) services 24/7 crisis intervention and emotional support to individuals in distress while also linking those individuals with local resources through a network of 164 certified crisis centers located across the country.^l Importantly, in collaboration with the Department of Veterans Affairs (VA), the Veterans Crisis Line (VCL) was set-up to provide support to veterans, active service members, and their families.^m In the same year (2007), the *Joshua Omvig Veterans Suicide Prevention Act of 2007* (Public Law 110-110) was also signed into law.ⁿ

Lastly, SAMHSA funds two programs that explicitly center on Native populations. First, the *Tribal Training and Technical Assistance Center (Tribal TTAC)* provides Indian Nations with resources to implement prevention strategies to reduce mental health and substance use challenges. Tribal TTAC offers assistance, training, and education to grantees.

SUICIDE PREVENTION AMONG U.S. VETERANS

With the passage of the Joshua Omvig Veterans Suicide Prevention Act, a comprehensive effort for veterans was formally established. Specifically, the Act permits the provision of health assessments, the designation of prevention counselors at medical facilities, and the inclusion of research for best practices and sexual trauma.ⁿ Additionally, the Act authorizes 24-hour mental health care, a toll-free 24-hour hotline staffed by trained personnel, and outreach and education for veterans and their families, with a specific focus on those who served in Operation Iraqi Freedom and Operation Enduring Freedom.ⁿ

In 2014, despite representing 8.5 percent of the U.S. population, on average, 20 veterans died by suicide each day, which attributed to 18 percent (7,403 deaths) of all suicides.²⁸ Of those deaths, only six were in VA health care. Moreover, data from the U.S. Census Bureau's American Community Survey show that from 2011 to 2014, an estimated 24.1 percent (5 million) U.S. veterans (ages 18 and over) resided in rural-designated parts of the country.²⁹

^j As of April 2017, 1,280,249 individuals have participated in 34,562 training events or educational seminars hosted by recipients of both the GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program and the GLS Campus Suicide Prevention Program.

^k SPRC has dedicated resources for rural areas. For more information, refer to <http://www.sprc.org/settings/rural-areas>.

^l According to SAMHSA's Suicide Prevention Branch Chief, Dr. Richard McKeon, an estimated 2 million calls were answered through the Lifeline in 2017.

^m The VCL is linked to the Suicide Lifeline – after dialing 1-800-273-8255, callers can reach the VCL by pressing 1. For more information about either the VCL or the Suicide Lifeline, refer to <https://www.veteranscrisisline.net> or <https://suicidepreventionlifeline.org>, respectively.

ⁿ Joshua Omvig Veterans Suicide Prevention Act of 2007: <https://www.congress.gov/bill/110th-congress/house-bill/327>.

Secondly, the *Tribal Behavioral Health Grants (TBHG)* awards five-year contracts to Indian Nations to fund the development and implementation of promising community-based projects that address suicide, trauma, and substance abuse while also promoting the mental health and resilience of high risk AI/AN youth. As of FY 2017, SAMHSA has supported 113 TBHG grantees.

IHS Programs^o

Within HHS, IHS is the principal agency charged with improving the holistic well-being of federally recognized AI/AN populations by increasing access to effective, culturally appropriate health care and human services. Through the *Mental Health/Social Services (MH/SS)* program, IHS oversees community- and prevention-based service activities that target a wide range of issues. In addition to suicide prevention, MH/SS programming also includes trauma-informed care, the integration of behavioral health with primary care, and telebehavioral health and workforce development. As part of its suicide prevention portfolio, in FY 2015, IHS collaborated with SAMHSA to introduce the Zero Suicide Initiative as a way to extend its reach into Indian Country. Developed by the EDC's SPRC, Zero Suicide is a comprehensive approach geared towards improving care and outcomes for at-risk individuals within health systems.^p Since its launch, IHS has supported the AI/AN Zero Suicide Training Academy. It has also provided funds to the EDC to offer specialized technical assistance to IHS health facilities that are implementing Zero Suicide into their health systems.

In addition to MH/SS, IHS also manages the *Substance Abuse and Suicide Prevention (SASP)* program, formerly known as the Methamphetamine and Suicide Prevention Initiative (MSPI). Initially a demonstration project that began in September 2009, MSPI was later renamed SASP, making it an official IHS funded program after its successful six-year pilot trial.^q SASP awards grant funding to support projects that address at least one of four purpose areas, with Suicide Prevention, Intervention, and Postvention (Purpose Area 2) being one of the four. The current SASP cohort is in its third year of a five-year grant cycle that began in September 2015 and will end in September 2020. In Year 1 of the program, SASP projects under Purpose Area 2 have reported the frequent utilization of several practice-based strategies such as the Question, Persuade, Refer suicide prevention training and Mental Health First Aid. Prior to its name change, MSPI supported 130 IHS, Tribal, and Urban Indian health pilot projects. Currently, IHS funds 175 projects.^r

HRSA Programs

HRSA administers grant programs with the goal of providing and increasing access to quality health care services for geographically, economically, and/or medically underserved populations nationwide. HRSA oversees multiple programs focused on primary care, maternal and child health,

^o IHS's detailed 2018 Justification of Estimates for Appropriations Committee provides further information about IHS-specific programs. For specific suicide-related activities, see pp. *CJ-85 – CJ-90 & CJ-93 – CJ-94*. Retrieved from https://www.ihs.gov/budgetformulation/includes/themes/responsive2017/display_objects/documents/FY2018CongressionalJustification.pdf.

^p Information about the Zero Suicide approach is available at <http://zerosuicide.sprc.org/>.

^q A letter from IHS's Principal Deputy Director to Tribal leaders informing the name change and program achievements. Retrieved from

https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/DTLL_SASP_040116.pdf.

^r For more information about IHS funded projects, refer to <https://www.ihs.gov/mspi/aboutmspi/>.

HIV/AIDS, health professions, and rural health. Although HRSA programs do not explicitly target suicide prevention efforts, opportunities that include improving broader mental health challenges can be addressed through the work of the Community Health Centers, rural health programs, and the recruitment, training, and placement of mental health professionals in underserved and rural areas.

HRSA-funded Community Health Centers offer mental health services that can help address the reduction of suicide. Similarly, HRSA's National Health Service Corps and NURSE Corps recruits and places mental health clinicians and practitioners in underserved and rural areas. In addition, the Rural Health Outreach authority programs, administered through the Federal Office of Rural Health Policy (FORHP), can support rural pilot programs focused on suicide reduction and treatment for those at risk. Additionally, in partnership with SAMHSA, HRSA co-funds a training and technical assistance portal, the Center for Integrated Health Solutions, which supports the management of resources for integrating primary care and behavioral health services.^s

RECOMMENDATIONS

Although suicide prevention can be traced back to as early as the 1950s,^t addressing rural suicide through federal programs seems take a more general approach. Given the scale and scope of the issue, overall, the Committee urges HHS Agencies and Offices to focus more explicitly on emphasizing and including the rural dimensions of suicide into their programs, research, and outreach to address existing knowledge gaps and strengthen the evidence base.

RESEARCH AND EVALUATION

National Rural-specific Suicide Prevention Analysis

To the Committee's knowledge, SAMHSA's National Registry on Evidence-based Programs and Practices (NREPP) serves as the primary online database of existing, evaluated mental health and substance use interventions. According to the registry, to date, there are 24 evidence-based programs for suicide prevention – of those, 12 interventions can be and have been implemented in rural as well as urban settings.^u While the Committee recognizes and commends NREPP for being a significant national resource, additional research is needed to examine and evaluate rural-specific best practices, which can further contribute to NREPP's efforts in building an evidence base. Moreover, as emphasized in their 2017 MMWR Surveillance Summary about the topic, researchers from the CDC highlighted “the need for [the] development and evaluation of suicide prevention efforts [that are] specific to rural communities.”⁶

^s For more information about the Center for Integrated Health Solutions, refer to <https://www.integration.samhsa.gov>.

^t For a brief history of suicide prevention efforts, refer to pp. 94-95 in Office of the Surgeon General (U.S. Department of Health and Human Services and the National Action Alliance for Suicide Prevention). “2012 National Strategy for Suicide Prevention: Goals and objectives for action.” U.S. Department of Health and Human Services, 2012. Retrieved from <https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf>.

^u To date, there are 454 (and growing) substance abuse and mental health interventions. Substance Abuse and Mental Health Services Administration. National Registry of Evidence-based Programs and Practices, 2017. Accessed at <http://nrepp.samhsa.gov/AdvancedSearch.aspx>.

In addition, robust, evidence-based practices that center on Native populations, specifically for young Native people and rural Tribal communities,^v are also essential, given their higher rates. In a review of existing strategies in Indian Country, Gary and McCullagh (2014) conclude, “Although there are several different suicide prevention programs that are being utilized across AI/AN communities, very few have been adequately empirically evaluated and, thus, it is difficult to make more than preliminary interpretations of the result of these programs.”³⁰

Recommendation 1: Considering the persisting and widening suicide disparities between rural and urban counties, the Committee recommends that the Secretary require HHS to conduct a national comprehensive evaluation that assesses existing state and Tribal efforts to reduce rural suicide rates and that identifies successful evidence-based, rural-specific strategies that can be implemented in states and Tribal communities. The Committee believes that a targeted evaluation of current rural-specific strategies, followed up with recommendations for further research to strengthen the rural evidence base is needed as part of developing an ongoing, sustainable effort.

OUTREACH AND AWARENESS FOR SUICIDE PREVENTION STRATEGIES

During their site visit to Emmett, Idaho, the Committee repeatedly heard from local stakeholders about the importance of and need for implementing NREPP-identified programs such as Sources of Strength (SOS) and the Applied Suicide Intervention Skills Training (ASIST).^w

Although this is beyond the Secretary’s purview, the Committee emphasizes the need for having some outreach and awareness mechanisms in place that link rural communities with the use of NREPP-identified strategies. Programs such as SOS and the American Indian Life Skills (AILS)^w curriculum can provide strength-based approaches, especially since both SOS and AILS have rural and Native origins. Moreover, the Committee also acknowledges CDC’s work in developing and disseminating their technical package on best practices for suicide prevention, which serves as an important resource for rural populations.³¹

Ultimately, the Committee believes outreach and awareness will help with the implementation of prevention programs, which benefits rural populations and will further strengthen the rural evidence base.

Utilization of Community Health Workers

With workforce shortages, increased stigma, and barriers to accessing care, community health workers (CHWs) are a potential area for improving rural mental health care and reducing suicide risk, attempts, and deaths. The widely used definition of a CHW is “...a frontline public health worker who is a trusted member of and has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.”^x Although CHWs face various challenges, vis-à-vis

^v In their analysis, researchers from CDC reported, “When comparing rates by race/ethnicity across urbanization levels, suicide rates are highest for non-Hispanic whites in metropolitan counties and for non-Hispanic American Indian/Alaska Natives in nonmetropolitan/rural counties” (7). Refer to Ivey-Stephenson, Asha Z., et al. “Suicide trends among and within urbanization levels by sex, race/ethnicity, age group, and mechanism of death – United States, 2001-2015.” *MMWR Surveillance Summaries*, 66.18 (2017): 1-16. Retrieved from <https://www.cdc.gov/mmwr/volumes/66/ss/ss6618a1.htm>.

^w For more information about SOS, ASIST, and AILS, refer to NREPP at <https://nrepp.samhsa.gov/AllPrograms.aspx>.

^x Definition of a CHW provided by the American Public Health Association. Refer to <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities>.

restricted professional recognition, difficulty sustaining financing mechanisms, and limited best practices,³² CHWs have been shown to improve people’s health, reduce health care costs, and address the social determinants of health.³³ Importantly, the National Rural Health Association reported that “CHWs can play an important role in the transition to value and care support in rural settings with work in the community to support chronic disease management, insurance enrollment, and prevention.”³⁴

THE POTENTIAL IMPACT OF CHWs ON REDUCING SUICIDE RATES

In a rural setting where resources are already limited, CHWs trained in mental health would fill critical roles within health systems, law enforcement, and educational environments. In the context of suicide prevention, CHWs specialized in mental health care, serve as bridges for providing essential, additional services beyond traditional health facilities. Specifically, CHWs have the potential to assist in hospitals with screening and assessment and follow-up after a suicide hospitalization discharge, provide on-the-ground support with local law enforcement, and/or offer mental health services and administer suicide prevention programming within school settings. These challenges and potential solutions were identified by community stakeholders during the subcommittee’s site visit.

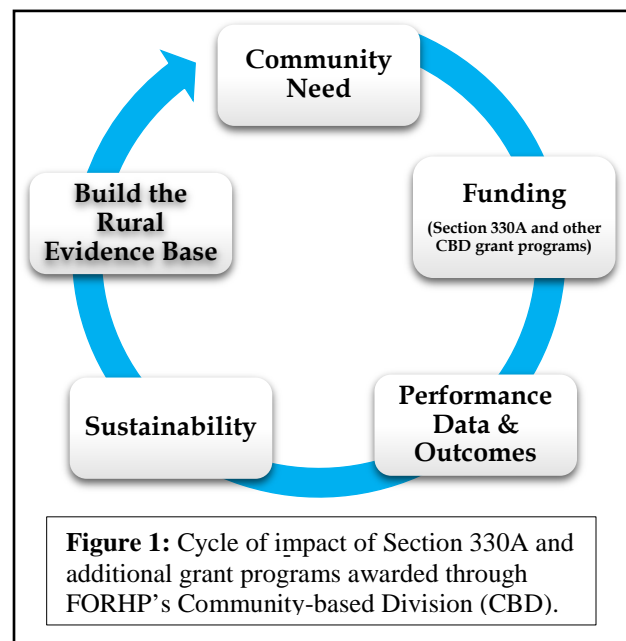
Recommendation 2: Based on the growing body of literature on the benefits and contributions CHWs provide to the health care system, especially in rural areas, the CHW model poses as a promising prevention and intervention strategy for reducing suicide attempts and deaths. However, research and evaluation is needed to better quantify impact and identify successful strategies. Therefore, the Committee recommends the Secretary require the AHRQ and NIMH to conduct research on the use of CHWs to determine if these efforts can

reduce suicide risk and increase referrals for at-risk individuals. The study should look at cost- and clinical-effectiveness of these efforts and broadly disseminate findings.

OUTREACH AND AWARENESS

Rural Health Funding

The Rural Health Care Services Outreach, Network and Quality Improvement grant programs are key investments by FORHP in improving rural community health. Funded out of Section 330A of the Public Health Service Act (42 U.S.C. 254c), these grants aim to improve care coordination, the integration of services, access to care, and overall quality improvement. The Outreach, Network, and Quality Improvement authority permits competition for grant funding strictly for and among rural communities – as larger metropolitan communities tend to have greater resources. Additionally, these grants are “among the only non-categorical grants within HHS [that] allow the grantees to determine the best way to meet local need. This flexibility in



funding reflects the unique nature of health care challenges in rural communities and need to allow communities to determine the best approach to addressing need.”^y

Due in part to this flexibility and because these grants are specifically tailored to meet the needs of rural populations, the Committee believes that future applicants should be made aware of funding implications. As identified earlier, community stakeholders expressed the importance of and need for implementing evidence-based programs. They also voiced limited funding as an obstacle to incorporating these efforts. Thus, greater awareness of Section 330A grant funding can help to maneuver over this barrier as funds can be used to include suicide prevention.

Recommendation 3: To better leverage federal resources from HRSA, SAMHSA, and other HHS agencies, the Committee believes broader awareness and promotion from the Department about grant funding and existing suicide prevention strategies is important for developing a comprehensive, sustainable effort to reduce risk, attempts, and deaths. Therefore, the Committee recommends HRSA to expand and increase the promotion of the Rural Health Care Services Outreach, Network and Quality Improvement grant programs through HHS partners to inform rural communities about the opportunity to incorporate suicide prevention activities and increase access to mental health services using grant funds.

Promotion of the PHQ-9 Instrument

Although suicide risk screening and assessment^z are important upstream prevention strategies,³⁵ there has been less empirical evidence documenting and supporting their effectiveness.³⁶ Nevertheless, in agreement with the Zero Suicide^{aa} approach, the Committee believes that universal screening and assessment should be implemented within health systems as health facilities are key places for intervention. Data from a 2015 study published in the *Journal of Medical Care* showed that between 2009 and 2011, approximately 22,400 individuals made a non-fatal attempt. Of those individuals, more than a quarter (38 percent) of patients made a visit to a health care facility within a week prior to attempting suicide. Researchers further noted that more than half (64 percent) and 95 percent of patients had visited a health care facility within a month and within a year of attempting suicide, respectively.³⁷

As such, the Committee encourages the use of clinically validated instruments such as the PHQ-9³⁸ to help facilitate this process. While the PHQ-9 is meant for the screening of depression severity, item 9 does screen for the presence of suicidal ideation: “Over the past 2 weeks, how often have you had thoughts that you would be better off dead or of hurting yourself in some way?”^{bb} To date, two existing studies – one conducted among 84,418 outpatients (2007-2011)³⁹ and the other conducted among 447,245 Veterans Health Administration patients (2009-2010)⁴⁰ – demonstrated positive associations between responses to item 9 (i.e., higher scores for suicidal

^y To read more about the Rural Health Care Services Outreach, Network, and Quality Improvement Grants, refer to pp. 259-263 of HRSA-FORHP’s FY 2018 Justification of Estimates for Appropriations Committees at <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-2018.pdf>.

^z Whereas *screening* refers to a standardized procedure to identify individuals who may be at risk, *assessment* is a robust evaluation completed by a clinician to confirm assumed risk, calculate any direct danger to the patient, and develop a treatment plan.

^{aa} “Systemically identify and assess suicide risk among people receiving care” is one of the seven foundational elements to the Zero Suicide approach. For more information about Zero Suicide, refer to <http://zerosuicide.sprc.org/>.

^{bb} For more information about the PHQ-9 and how to score, refer to http://www.cgaimh.org/pdf/tool_phq9.pdf.

ideation) and a significant risk for attempting or dying by suicide. Billing for services using the PHQ-9 in primary care or behavioral health settings can be achieved through the application of CPT Code 96127, a code that is appropriate for brief behavioral or emotional assessment reimbursement.^{cc} These assessments may include any standardized screening instruments that will provide both scoring and further documentation to the health care provider.

Recommendation 4: Because the health care setting (primary care or behavioral health) is an ideal environment for intervention and prevention, the Committee recommends HHS Agencies and Offices to promote the broader use of the PHQ-9 in rural hospitals and clinics and to educate providers on how to bill for services.

Inclusion of “Rural” in the National Strategy

As previously noted, the 2012 National Strategy for Suicide Prevention serves to guide America’s suicide prevention efforts as it aims to reduce the suicide rate by 10 percent.⁴¹ However, research on rural suicide trends and considerations for prevention are not included in the 2012 National Strategy. The inclusion and implications of suicide in rural America is paramount as a majority of states, including Idaho, have adopted or included the strategic goals and objectives into their state prevention plans to align with the National Strategy.^{dd}

Recommendation 5: Considering the higher prevalence of suicide among rural populations, the Committee recommends SAMHSA to integrate rural-specific research and considerations for prevention into the National Strategy for Suicide Prevention if it is revised and updated to reflect existing rural suicide trends and disparities.

IDAHO SUICIDE PREVENTION EFFORTS

With the release of the 2001 National Strategy, the Idaho Suicide Prevention Plan (ISPP) was developed in 2003 to guide local, regional, and statewide prevention initiatives.^{ee} The year previous (2002), the Suicide Prevention Action Network (SPAN) of Idaho was created as a 501(c)(3) to formally develop, plan and execute activities across the state. Comprised of dedicated volunteers and a part-time executive director, SPAN Idaho aims to reduce suicide through “statewide advocacy, collaboration, and education in best practices.”^{ff}

Following these two major milestones, in 2006, then-Governor Dirk Kempthorne established the Idaho Council on Suicide Prevention, which was commissioned, in part, to oversee the implementation of the ISPP. Ten years later, the Idaho Suicide Prevention Program (SPP) was instituted to further implement strategies in alignment with the ISPP. Housed within the Division of Public Health at the Idaho Department of Health and Welfare, SPP “provides funding for upstream youth education, funding for the Idaho Suicide Prevention Hotline, and conducts a public awareness campaign.”^{gg} While much work in the field of suicide prevention remains, through the combined grassroots efforts and institutional reform, Idaho serves as an example of elevating public awareness and inspiring action for preventing suicide.

^{cc} For more information about CPT Code 96127, refer to <https://mentegram.com/blog/cpt-code-96127-answers-to-the-frequently-asked-questions-about-billing-this-code/>.

^{dd} For more information on each state’s suicide prevention and strategic plans, refer to <http://www.sprc.org/states>.

^{ee} Since 2003, ISPP was revised in 2011. Suicide Prevention. Idaho suicide prevention plan: An action guide. Idaho Council of Suicide Prevention, 2011. Retrieve from <https://gov.idaho.gov/HealthCare/PDF/SuicidePreventionPlan.pdf>.

^{ff} For more information about SPAN Idaho, see <http://www.spanidaho.org>.

^{gg} For more information about SPP, see <http://healthandwelfare.idaho.gov/Families/SuicidePreventionProgram/tabid/486/Default.aspx>.

CONCLUSION

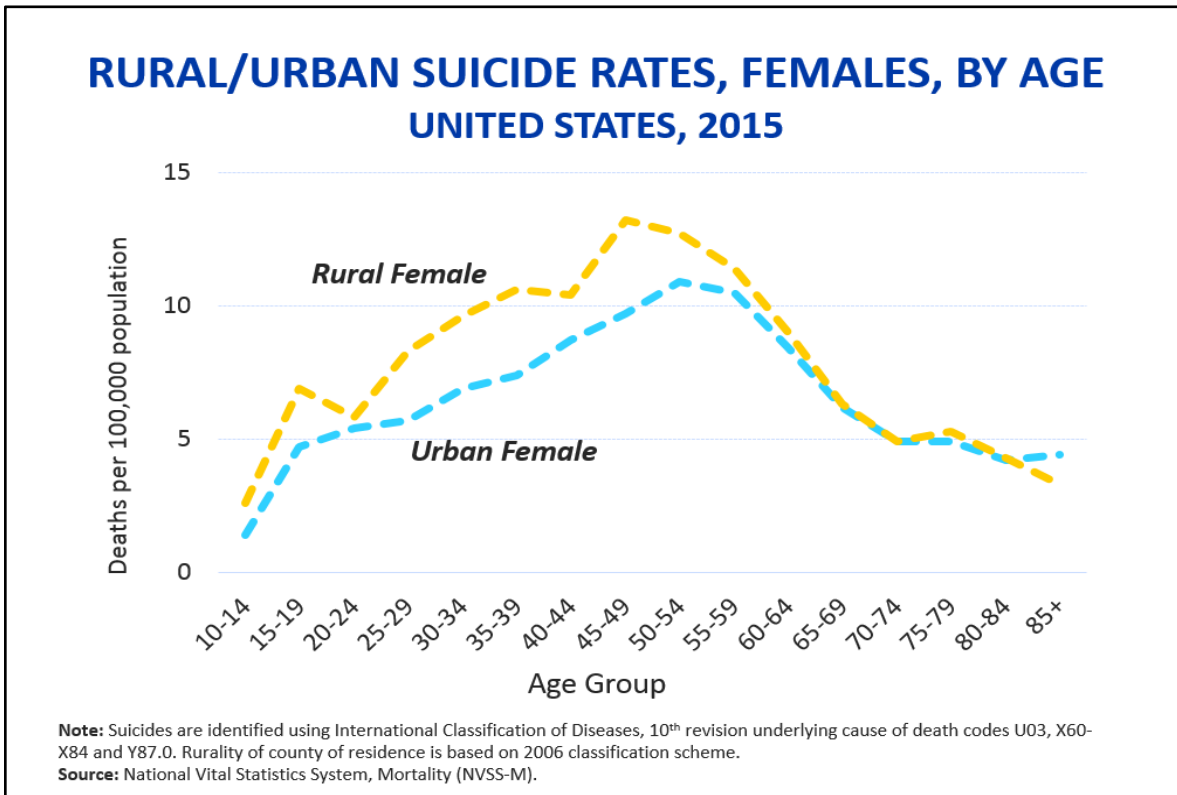
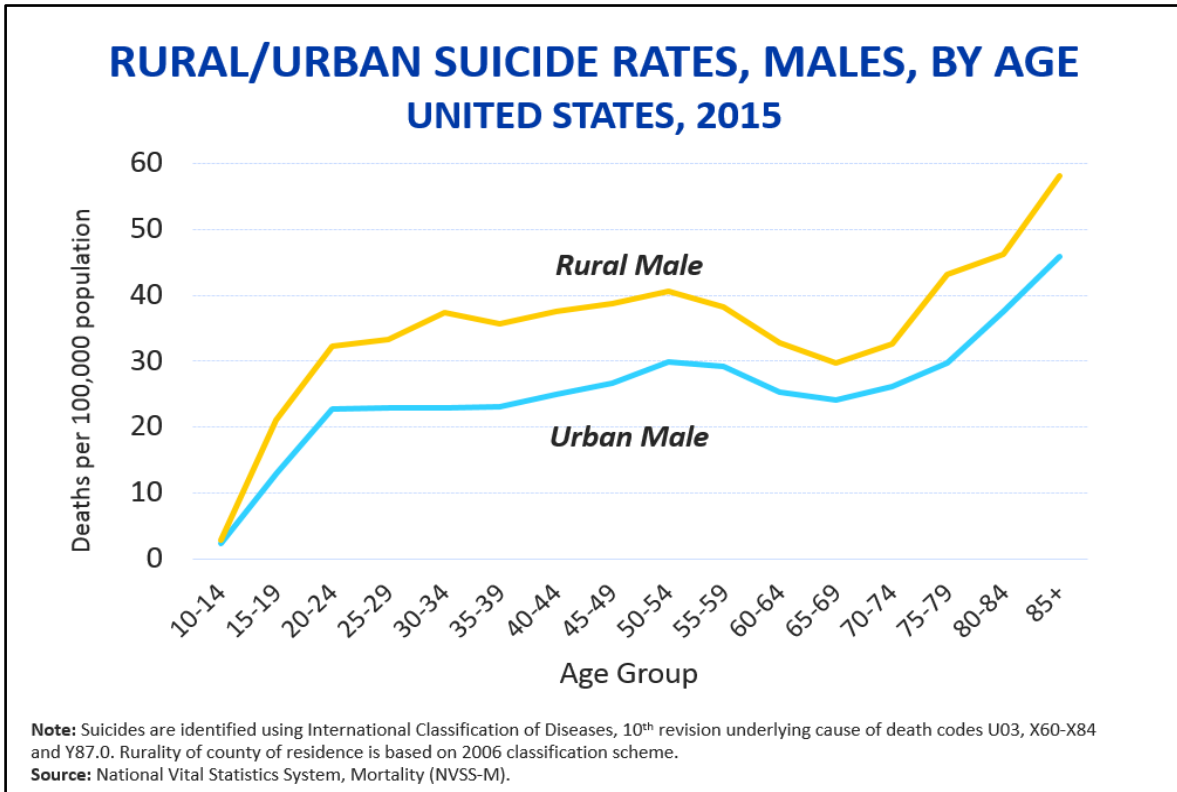
In summary, this policy brief discusses national trends based on level of urbanization and highlights federal resources. It also establishes a set of recommendations that provide insights on how the HHS can better inform policy as it relates to reducing overall rates and deaths in rural America. Importantly, this brief contributes to the broader, ongoing HHS prioritization of and conversation about how to best address and improve the mental health of all Americans.

Given that suicide is influenced by the interplay of multiple risk factors (biological and environmental), multifaceted strategies are needed to develop and sustain ongoing comprehensive efforts. Suicide prevention that utilizes evidence-based programs and practices that inform policies can lessen the impact of suicide. Although rural populations face a confluence of numerous challenges that can negatively affect mental health, individuals residing in rural communities have a share responsibility in reducing attitudes and conditions that give way to harmful environments, which can increase a person's vulnerability to suicide. Ultimately, family, friends, colleagues, health care and social service providers, educators, law enforcement, justice system personnel, public policy makers, and government officials can create avenues for individuals to thrive. Suicide prevention is, therefore, a collective endeavor and not simply an issue that is restricted to the health care industry.

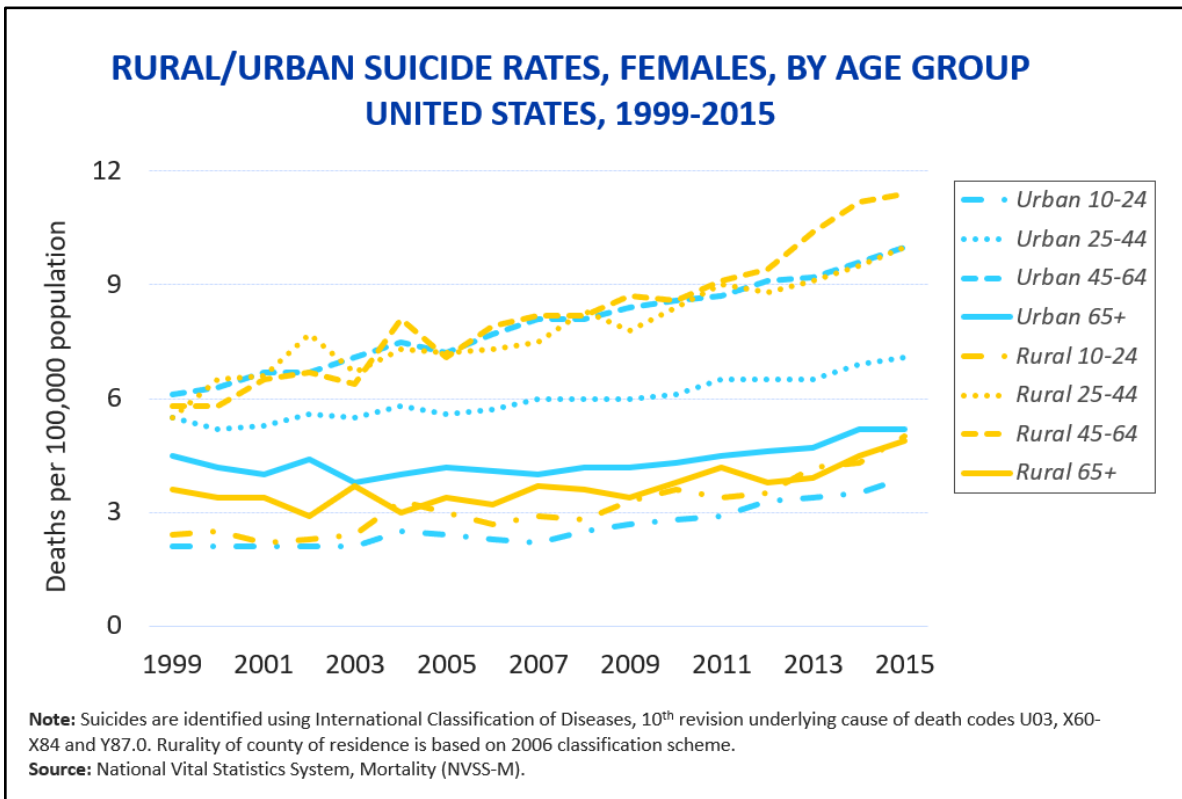
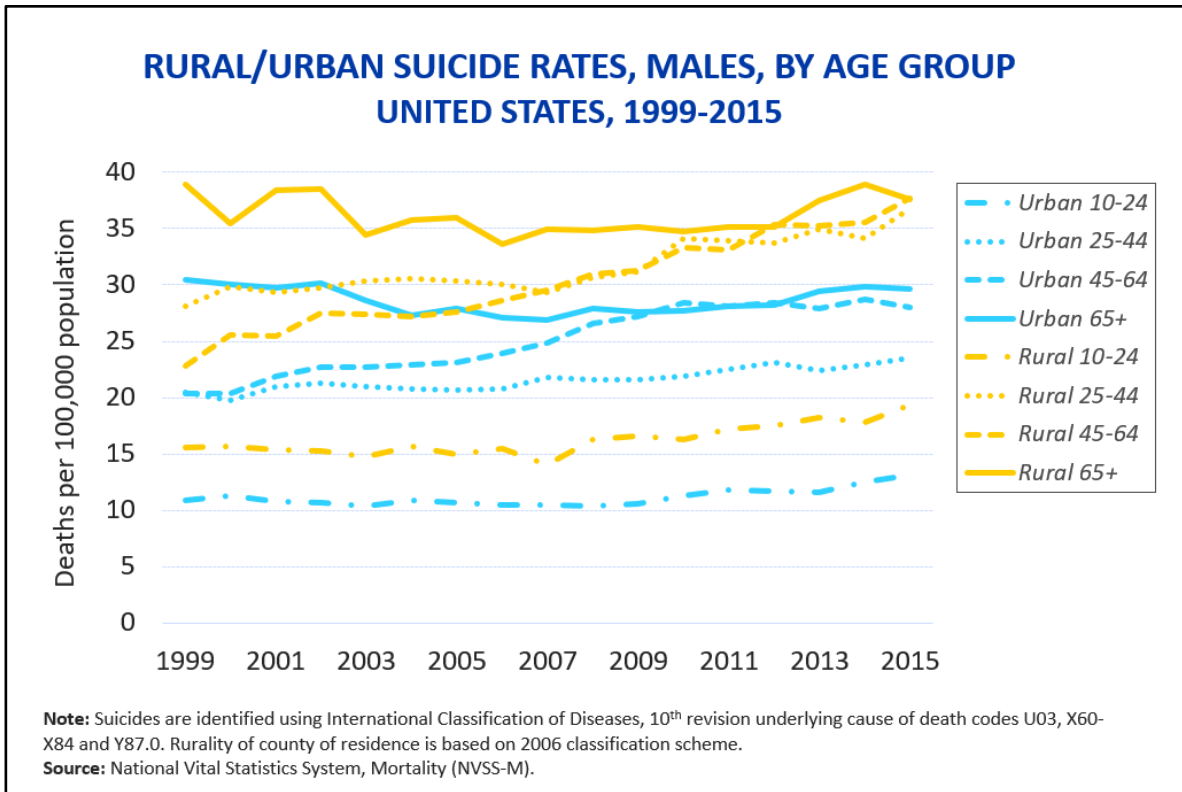
APPENDICES

- A. Suicide Rates for Males and Females in 2015 by Age**
- B. Male/Female Suicide Rates by Urbanization Level Across the Lifespan**
- C. HHS' Collective Suicide Prevention Impact**

Appendix A: 2015 Suicide Rates for Males and Females by Age



Appendix B: Male/Female Suicide Rates by Urbanization Levels across the Lifespan



Appendix C: HHS' Collective Suicide Prevention Impact

Agency	Program/Project Name	Funding History		
		FY 2016 Final	FY 2017 Annualized CR	FY 2018 Estimated
SAMHSA	Suicide Prevention	\$60,032,000	\$59,940,000	\$59,940,000
	<i>National Strategy for Suicide Prevention</i>	\$2,000,000	\$1,996,000	\$1,996,000
	<i>Suicide Lifeline (1-800-273-TALK)</i>	\$7,198,000	\$7,184,000	\$7,184,000
	<i>Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program</i>	\$35,427,000	\$35,382,000	\$35,382,000
	<i>Garrett Lee Smith Campus Suicide Prevention Program</i>	\$6,488,000	\$6,476,000	\$6,476,000
	<i>Garrett Lee Smith Suicide Prevention Resource Center</i>	\$5,988,000	\$5,977,000	\$5,977,000
	<i>Tribal Training and Technical Assistance Center</i>	\$2,931,000	\$2,925,000	\$2,925,000
	Tribal Behavioral Health Grants	\$15,000,000	\$14,971,000	\$14,971,000
	Projected Total Dollars Spent	<u>\$75,032,000</u>	<u>\$74,911,000</u>	<u>\$74,911,000</u>
IHS	Mental Health/Social Services (MH/SS)*	\$82,100,000	\$81,944,000	\$82,654,000
	Substance Abuse and Suicide Prevention (SASP)	\$15,475,000	\$15,475,000	\$15,475,000
	Generation Indigenous (Gen-I)	\$10,000,000	\$10,000,000	\$10,000,000
	Projected Total Dollars Spent	<u>\$107,575,000</u>	<u>\$107,419,000</u>	<u>\$108,129,000</u>
NIH	Suicide Research	\$41,041,913	\$43,319,800	\$33,641,800
	Suicide Prevention Research	\$27,488,875	\$29,014,500	\$22,532,400
	Projected Total Dollars Spent	<u>\$68,530,788</u>	<u>\$72,334,300</u>	<u>\$56,174,200</u>
CDC	<i>National Electronic Injury Surveillance System – All Injury Program</i>	\$51,959	\$51,959	\$51,959
	<i>Evaluating Innovative and Promising Strategies to Prevent Suicide Among Middle-Aged Men</i>	\$695,960	\$658,370	\$658,370
	<i>Injury Control Research Centers – Suicide-related projects**</i>	\$1,600,000	\$1,600,000	\$1,600,000
	<i>State of Suicide – Environmental Scan of Suicide Prevention Among States and Tribes</i>	\$299,942	\$276,341	\$277,129
	<i>Non-Fatal Suicide Attempts Project</i>	--	\$29,990	\$29,990
	<i>Building Capacity Among Governors to Address Suicide in Suicide Belt States</i>	--	\$150,000	--
	<i>Veteran Informed Plan for Suicide Prevention</i>	--	\$150,000	--
	Projected Total Dollars Spent	<u>\$2,647,861</u>	<u>\$2,916,660</u>	<u>\$2,617,448</u>

* Provided funding for MH/SS displays the total amount; specific numbers for suicide-related funding were not available as MH/SS funds multiple services, not just suicide.

** These projects are part of larger funded initiatives; the funding amount is estimated based on a percentage of suicide-related work.

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