PREVENTING YOUTH SUICIDE IN RURAL AMERICA:

Recommendations to States

APRIL 2008

Prepared by the Rural Youth Suicide Prevention Workgroup
Convened by the Suicide Prevention Resource Center (SPRC), Education Development Center (EDC)
and the State & Territorial Injury Prevention Directors Association (STIPDA)

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Introduction

Between 1994 and 2004, youth suicide rates in the United States declined 23 percent — from a high of 9.36 suicides per 100,000 youth to 7.17 in 2004.[1] These declines are encouraging, but for the families and friends left behind in suicide's wake, trends and statistics matter less than the irrevocable, singular loss of one life — a child, a sister or brother, a best friend. The grief from suicide is shadowed by what-ifs. Loved ones (also referred to as survivors) are haunted by a sense that somehow, this outcome could have been prevented. Sometimes, shame commingles with grief — a vestige of cultural and religious stigma and reproach that surrounds suicide.

Even after two decades of decreasing rates, suicide remains the third leading cause of death among youth between the ages of 10 and 24.

Even after two decades of decreasing rates, suicide remains the third leading cause of death among youth between the ages of 10 and 24.[2] Moreover, the declines are not evenly distributed. In 15 states, youth suicide rates remain as high as or even higher than the 20-year peak of 9.36 suicides per 100,000.[3] Western and mountain states consistently have higher suicide rates than the rest of the country, and all of the states with the highest suicide rates have many counties that would meet most definitions of "rural" — that is, with very low population density and residents living in relatively small communities, separated by vast landscapes.

Small rural communities may be better prepared to launch prevention efforts because their social and economic infrastructures are well integrated and community members are linked to one another in ways that may be less common in urban areas. However, these same strengths can turn into barriers when small communities lack the resources, access to care, and privacy or anonymity that larger communities may offer.

This report presents recommendations that approach youth suicide prevention through the lens of America's rural communities, so that both the strengths and limitations of rural settings can be taken into account to design and implement more effective prevention strategies.

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[1] CDC. Suicide Trends Among Youths and Young Adults Aged 10-24 Years -- United States, 1990-2004. *MMWR* 2007;56(35):905-908.

[2] Ibid.

[3] CDC. National Center for Health Statistics (http://www.cdc.gov/nchs/Default.htm)

The Rural Youth Suicide Prevention Workgroup

During the summer of 2007, the Suicide Prevention Resource Center (a project funded by the Substance Abuse and Mental Health Services Administration—SAMHSA) partnered with the State and Territorial Injury Prevention Directors Association (STIPDA) to convene a Rural Youth Suicide Prevention Workgroup. The Workgroup's members represent a variety of disciplines, federal and state agencies, national associations, and five states with rural populations. (A full list of Workgroup members is provided in Appendix A.)

During a series of teleconferences, Workgroup members explored ways that state-level agencies — especially injury prevention and control, mental/behavioral health, and substance abuse prevention agencies — could address suicide prevention for rural youth more effectively.

About This Report

Following a brief discussion of the rural context for youth suicide prevention, this report presents the Workgroup's discussions and recommendations to state-level agencies in seven key areas:

- Promoting Help-Seeking Behaviors,
- Data and Surveillance,
- Services,
- Screening and Identification,
- Gatekeeper Training,
- Bereavement, and
- Survivor Issues.

The recommendations were generated to offer states and local communities a resource that describes a rural perspective on prevention and early interventions. Not all of the recommendations will be appropriate for every state or rural community, but it is the Workgroup members' hope that those living and working in rural communities will work with state and other agencies to craft effective suicide prevention efforts that fit the geography, demographics, and social and political contexts of rural communities.

A Public Health Approach: Risk and Protective Factors, Prevention, Data, and Partnerships

The Workgroup's recommendations in each of these areas reflect a commitment to promoting a multifaceted and comprehensive public health

approach to prevent suicide, as described by the Surgeon General's Call to Action to Prevent Suicide in 1999.[4]

Historically, communities have relied almost exclusively on clinical approaches to suicide prevention. However, emerging evidence suggests that clinical care and crisis intervention should be complemented by many other approaches: primary prevention, early intervention, research, public health surveillance, health promotion, media, training and education. Indeed, suicide prevention can be integrated into the work of educators, healthcare providers, social service providers, juvenile justice workers, public safety workers, emergency room workers, faith community members, business owners, social service workers, youth service volunteers, and individuals.

Each of these can address the factors that place people at risk for suicide or, conversely, buffer or protect them from suicide risk. A family history of suicide (and how it is understood and discussed), underlying mental or substance abuse disorders, access to lethal methods and feelings of isolation, hopelessness, or loss are all considered risk factors. Access to various types of support — especially clinical care and interventions, and family and community support — can protect people from suicide, as can problem-solving skills and some cultural and religious beliefs that discourage suicide. Understanding how these might vary in rural settings is an important aspect of effective prevention.

Clinical care and crisis intervention should be complemented by many other approaches: primary prevention, early intervention, research, public health surveillance, health promotion, media, training and education.

Another way of thinking about this is that many community-based activities are protective and can be considered suicide prevention. For instance, skill-building programs, sports activities, social activities, and youth programs may develop leadership skills that enhance and support a youth's emerging ability to choose healthy activities and behaviors. Assuring that youth at risk are included rather than excluded from these activities may be an important first step in resource development. In a multifaceted, comprehensive approach, each discipline and sector should identify and integrate appropriate prevention activities into their practice.

A great deal of skill and knowledge about how to reduce discriminatory attitudes, change public perceptions, and encourage help-seeking have been accumulated as our nation has successfully reduced morbidity and mortality

[4] U.S. Public Health Service. 1999. *The Surgeon General's call to action to prevent suicide.* Washington, DC: Author.

due to health problems such as AIDS, lung cancer, and motor vehicle crashes. The movements to reduce these problems used public health surveillance data to identify populations with the highest incidence rates, then identified risk and protective factors (behavior, beliefs, knowledge, public policy, etc.) on individual, community, and societal levels, developed interventions that would affect those factors, tested the results of those activities, and disseminated the results broadly.

As we have seen in past and ongoing health promotion initiatives, champions and leaders in numerous fields can work together in coalition and partnerships to advance a single goal that could not have been achieved by a single method or approach. The recommendations in this report include activities across sectors and disciplines, they address downstream efforts that intervene with those in acute crisis as well as turning to look upstream to define and incorporate practices in primary prevention and early intervention.

A public health approach recognizes that no single agency or intervention alone can make a dent in suicide rates; partnerships and simultaneous efforts on multiple fronts are required. For this reason, the Workgroup's recommendations are geared to an audience of the state-level agencies with the most direct responsibility for supporting and implementing the recommendations in each area, but with the recognition that many other stakeholders at local, state and federal levels will be involved. In addition, the Workgroup's members hope that this set of recommendations will encourage simultaneous progress in each of the seven topic areas since they share significant overlap. In fact, success in one area (such as increased screening and identification or gatekeeper training) often depends on success in another (a network of services to which youth can be referred).

The Rural Context for Suicide Prevention

The United States has a long history of romanticizing and idealizing its rural spaces. Many Americans can vividly and effortlessly summon up an idyllic rural scene of fields and farmhouses — and of close-knit, supportive communities. Of course, the modern rural landscape is (and perhaps always was) far more complicated and encompasses much more variation and contradiction.[5] Two useful lenses through which rural communities can be viewed are their economic and social infrastructures. Both offer insights about the differences between urban and rural areas, as well as the variation

[5] Ohio University and the Rural Clearinghouse at Kansas State University. 1993. Rural Communities: Legacy and Change. [Instructional video series, available at: http://www.learner.org/resources/series7.html]

within rural areas. And both types of infrastructure must be engaged to support youth suicide prevention in rural areas.

The social infrastructure in rural areas includes institutions — churches, schools, and employment-based networks — as well as informal social networks. Common features of rural culture include a strong sense of place, residents knowing one another and one another's families (often for generations), and a strong sense of loyalty to one another and to the community — especially during times of crisis. These social and place-centered ties can be wellsprings of support, but they also can be limiting if they impinge on an individual's privacy, force conformity with community norms, or lead to a sense of isolation.

Remoteness is another way to classify rural communities. Those that are located over 50 miles from a neighboring community have a lot in common with one another, tending to be relatively homogeneous, isolated, and even insular. However, many modern rural communities are in close proximity to larger urban centers. Instead of being relatively remote and isolated, residents of these communities may live in a place that feels and looks rural, but their work and social connections may have a more urban flavor. This, in turn, may make it more difficult for residents of "near-urban" rural communities to foster the social ties that can be supportive in more remote communities.

In many rural communities, economic factors and sparse population density have created shortages of health professionals — especially mental health professionals.

On the economic front, rural communities also differ in the degree to which they are experiencing a steady decline (along with a population exodus, especially of their young people) or, in contrast, an economic boom. While an economic boom can infuse a community with new resources and development, jobs for young people, and an influx of new residents, it also can present significant challenges. For example, economic growth can alienate those who resist change and can introduce new residents who do not necessarily share a culture that has been passed down through generations. Long-standing social networks may be overwhelmed by change and suddenly fail to provide the connectivity that is needed to maintain the character of a place and its people.

Of course, on the opposite end of the economic spectrum, extreme poverty, unemployment, and an exodus of youth can drain the vitality from communities. In many rural communities, economic factors and sparse population density have created shortages of health professionals — especially mental health professionals. In 1997, fewer than 80% of non-metropolitan U.S. counties had any mental health professional serving their population; 76% of all designated Mental Health Professional Shortage

Areas were rural counties.[6] (A Health Professional Shortage Area, or HPSA, is a federal designation in which the ratio of citizens of a service area to primary care physicians is greater than 3,500:1. For mental health professionals, the formula is 9,000:1 for core mental health professionals and 30,000:1 for psychiatrists.)

Suicide is a statistically rare event. But because of the close-knit social infrastructure common in rural communities, a suicide death can impact everyone who lives there. Communities may not have experience in dealing with the trauma of a suicide death or may have very limited experience with suicide. This lack of experience or the tendency to suppress knowledge about suicidal behavior can lull community members into believing that "we don't have these problems." The need to work to prevent suicide may not surface until a death occurs.

In some ways, the strengths inherent in rural communities can contribute to an understanding that the whole community has a part to play in prevention and intervention. Unlike in urban areas, the burden of helping is more often shared. In rural United States, people believe that churches, schools, emergency response, families, and natural helpers all share responsibility for community and individual well-being. This knowledge and the practice of working together for the common good are fertile ground for building prevention practices. For example, new networks of "gatekeepers" or "natural helpers" can build upon existing networks. Suicide prevention activities can be absorbed into existing social and educational structures, reinforcing social norms that support prevention (and countering those that create barriers).

For state agencies and coalitions seeking to prevent youth suicide in rural areas, it is important to take these economic and social variables into account and to understand their current status in each rural community.

Promoting Help-Seeking Behaviors

Key Issues

In many religions and cultures, suicide is perceived as a mysterious, sinful or shameful act. As a result, the topic and act of suicide often are surrounded by stigma — that is, by a deep and pervasive sense of disgrace and reproach. The Workgroup members note that negative attitudes about suicide have an element that may be protective, in that such beliefs may, in some situations, prevent people who might otherwise take their lives from doing so. However, a general and widespread discomfort with discussing

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[6] Hartley D, Bird DC, Dempsey P. Rural mental health and substance abuse. In: Ricketts TC, ed. *Rural Health in the United States*. New York, NY: Oxford University Press Inc. 1999:159-178.

suicide and broader mental health issues certainly undermines help-seeking behaviors as well as the ability to collect accurate information about suicide ideation, attempts, and fatalities. Similarly, discriminatory attitudes can affect the families of those who attempt or die by suicide by preventing them from seeking the formal or informal support they need.

Negative attitudes also permeate two underlying conditions closely linked to suicide: mental illness and substance abuse. Even though both can be treated, they are still viewed by many as predominantly moral failings or character weaknesses — a view reflected in a continued lack of equal insurance coverage for these health issues compared to those for treating physical ailments.

In rural areas, negative attitudes towards help-seeking may be more keenly felt. In part, this can stem from a lack of privacy, the absence of alternative perspectives, or social isolation for youth who are ostracized, experience isolation and oppression because of their physical or emotional state, family or life circumstance, minority status, or other characteristics (e.g., overweight youth, youth with juvenile justice or foster care involvement, sexual minority youth).

The Workgroup's members join numerous other national and international groups in viewing attitudes about suicide, mental illness, and substance abuse as key barriers to help-seeking and to suicide prevention in general — attitudes that affect everything from data collection to screening to service provision.

Workgroup Recommendations: Promoting Help-Seeking Behaviors

- State injury prevention and behavioral/mental health agencies should seek opportunities to **work with leaders and decision-makers in schools, healthcare, public and private employers, faith communities, and other sectors to raise awareness of suicide prevention, risk factors, and interventions; debunk myths; and erode barriers that inhibit help-seeking behavior.** The U.S. Air Force's successful suicide prevention model that enlisted the help of Commanding Officers to change attitudes and support help-seeking behaviors throughout the organization is one model for this approach[7].

- **State-level campaigns to promote help-seeking behavior should go beyond general awareness to address specific objectives** —

[7] Knox KL, Litts DA, Talcott GW, Feig JC, Caine ED.
Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. *BMJ*. 2003 Dec 13;327(7428):1376-81.

such as raising awareness of telephone support systems (including phone-based case management), hotline services, and Web resources (especially important in rural areas where access to services may be more difficult). These campaigns and messages should be directed to specific target audiences (e.g., decision-makers in organizations or legislatures, clergy, schoolteachers).

- State injury prevention and mental/behavioral health agencies should **consider innovative ways of using and promoting technology as potential resources** — e.g., the use of telemedicine and/or Web-based support groups. These resources may be especially crucial for people who are isolated from services in rural areas and/or face additional discrimination, risks and barriers to seeking help (e.g., sexual minority youth, Native American youth).

Data and Surveillance: Understanding the Contours of the Problem

Key Issues

Data sources for public health suicide surveillance include death certificates, hospital discharge data, emergency department data, medical examiner/coroner data, and child death review data. Some states also include questions in their Youth Risk Behavior Survey that provide important self-reported information on self-directed violence and other conditions that increase the risk of self-harming behavior among youth. A wide variety of factors influence the quality of data from these sources.

There is no consistently applied standard definition for self-harming behavior in use among medical examiners, coroners, and clinicians working in primary care facilities. This affects the completeness, reliability and validity of data available from hospitals, medical examiners/coroners, and vital statistics offices. In the face of vague and/or varying definitions (or, in some cases, no definitions), many factors affect how a case is defined. They include personal and professional bias, community and family pressure, and societal attitudes and myths about suicide. Any of these can lead to a reluctance or inability to identify cases.

Epidemiologists and researchers working with data sets to develop analysis and interpretation for use in prevention and policy development are challenged to describe the limitations of data sets. Analysis of data between and among counties and states is also complicated by the fact that suicide is epidemiologically a rare event. The limitations mentioned above and the small numbers of cases identified in rural areas create surveillance, analysis, and interpretation challenges.

On the national level, hospital discharge data are coded using the International Classification of Diseases Clinical Modification Manual, 9th Revision (ICD-9-CM), which includes codes to specify both the nature of the injury (e.g., skull fracture) and the mechanism or external cause of the injury (e.g., gunshot, motor vehicle crash, poison). Currently, hospitals routinely code injuries according to the nature of the injury, but the external cause code is not consistently or uniformly included in the hospital discharge databases. Limited progress has been made in improving external cause coding since 1990. When injury cases lack external cause of injury coding, the utility of these data for planners and policy makers is undermined.[8]

Workgroup Recommendations: Data and Surveillance

A number of national, state and local activities could improve the usefulness of data from--and for--rural areas.

- State-level data quality assurance programs should **develop and implement education for clinicians, hospital records coders, and hospital administrators that promotes the importance of external cause coding of medical records** as a way to improve the completeness, specificity and accuracy of external cause of injury codes found in hospital records. Education should include the importance of these data for use in public health injury surveillance that informs policy, guides prevention efforts, contributes to research, and evaluates program outcomes.

- The Uniform Hospital Discharge Data Set (UHDDS) and uniform billing (UB) procedures that drive the submission of data to statewide hospital discharge databases do not currently require the submission of external cause codes. If these systems and billing procedures required external cause of injury coding, suicide attempt data set coding completion would be improved at the hospital level. **A unified federal approach to implementing mandated external-cause of injury coding (e-coding) of hospital data should be promoted under the aegis of the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) and the National Center for Injury Prevention and Control (NCIPC).**

- State health department epidemiologists should **develop methods for aggregating death and hospitalization data from rural areas** that makes meaningful data available on intentional self-harm in rural areas.

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[8] Suicide Prevention Action Network USA (SPAN USA). 2006. *Strategies to Improve Non-fatal Suicide Attempt Surveillance: Recommendations from an Expert Roundtable.* SPAN USA, Washington DC. http://www.stipda.org/associations/5805/files/SPANsurveillance06.pdf

- STIPDA, the Centers for Disease Control and Prevention (CDC)/National Center for Injury Prevention and Control (NCIPC), National Violent Death Reporting System (NVDRS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Association of Medical Examiners (NAME) should **jointly develop a training module for coroners and medical examiners that improves the case identification of suicide, such that it guides suicide investigations and case variable documentation** (as has been done for SIDS)**.** This training should incorporate education that increases understanding and awareness of suicide and promotes incorporation of referrals for bereavement support. At the state level, injury surveillance programs and suicide prevention partners (suicide prevention advocates and mental/behavioral health agencies) can partner with state and local medical examiner/coroner professionals and state professional associations to assess training needs that would improve case identification, investigation and documentation of case variables.

- State mental/behavioral health and injury prevention stakeholders should **work with epidemiologists and others collecting and analyzing rural suicide data to guide the interpretation and communication of findings** based on these data.

- State injury and violence prevention programs should take steps to **make suicide morbidity, mortality, and risk factor data — including data on suicides among rural youth — more readily available to partners, policy makers and the public,** ideally via a Web-based query system. Data on suicide morbidity, mortality, and risk behaviors — including data specific to rural youth — should be made available annually in a report format to raise awareness and stimulate prevention activities where they are most needed.

Clinical Care Services: Increasing Access for Rural Youth

Key Issues

A number of factors limit the scope and supply of behavioral health and other screening, prevention and treatment services available to rural youth and their families. These include workforce shortages, primary care that does not incorporate mental/behavioral health, few referral options for more specialized care or treatment, lack of insurance coverage and lack of training and specific skills among providers. In making the recommendations below, the Workgroup recognizes that some of these barriers are beyond the purview of state agencies — and that they have

been the subject of decades of similar efforts to increase the supply and availability of health and mental health services for rural populations.

Workgroup Recommendations: Clinical Care Services

Since primary care is the *de facto* mental health system in many rural areas, this venue is a crucial one. Recommendations to improve access to mental/behavioral health via primary health care include:

- **Inventory.** As a first step, state agencies should inventory the specific competencies needed for primary care and mid-level professionals to serve as alternatives to mental health professionals in mental health professional shortage areas and provide targeted outreach and training to meet these needs.

- **Training.** Based on the inventory above, state agencies should make training available to rural primary care providers on mental health and substance abuse screening and treatment, particularly identifying risk factors for suicide.

    - State agencies should expand training for mid-level providers in primary care (public health nurses, physician's assistants, nurse practitioners, nurse midwives) and Master's level practitioners (counselors, social workers) on identifying risk factors for suicide, managing suicidal patients, and appropriate referrals.

    - State agencies should use technology to expand access to training for professionals in rural areas — including videoconferences, Webinars, and other online training delivery mechanisms.

- **Expanded Workforce and Access.** State agencies should expand access to consultations with mental health professionals (using technology, as appropriate) for primary care and mid-level providers.

    - State agencies should play a stronger role in identifying and promoting incentives for mental health professionals to work in rural areas, such as loan forgiveness, pay differentials, and others.

    - State agencies and professional associations should expand and strengthen partnerships with paraprofessionals — such as county extension workers — who could be trained to serve as behavioral health outreach teams or workers in rural areas to create a broader response network.

    - State agencies should identify and work to overcome barriers to certain mid-level practitioners (such as physician assistants and

nurse practitioners) to providing prescription medication in areas of acute need.

- State agencies and professional associations should reach out to non-medical professionals (such as spiritual leaders) who are likely to interact in a counseling capacity with rural people at risk. Training, support, and access to consultations with mental health professionals all could strengthen the ability of non-medical professionals to respond more effectively to those who approach them for help and guidance.

- **Promoting Resources and Referrals.** State agencies should increase the capacity of state-level crisis centers to make referrals to rural professionals by ensuring that state-level crisis centers are more knowledgeable about the availability of services at local levels to serve local needs.
  - State agencies should promote awareness of evidence-based state and national resources (such as the National Suicide Prevention Lifeline[9]) that are especially crucial when services are not immediately available.

- **System of Care.** State agencies should model a seamless collaboration between mental health and public health agencies at the state and local levels to define and support a system of care in which mental health is part and parcel of health care, and rural residents have access to a true medical home and continuum of services. Agencies should enlist the support of other local partners and stakeholders (e.g., local elected officials, medical societies, primary care providers, school health clinics, insurers, partner agencies, advocates) in promoting this vision of comprehensive care.
  - State agencies should work with state partners and advocacy groups to promote parity (i.e., equal coverage) for mental/behavioral health care within public and private health insurance coverage and to close loopholes and sustain parity where such legislation already has been enacted.
  - State injury prevention and mental/behavioral health agencies should seek ways to collaborate with federally funded maternal and child health programs. In all 50 states, these programs have performance measures related to adolescent suicide prevention.

[9] 1-800-273-TALK is available 24 hours a day; calls are routed to the nearest crisis center.

Screening and Identifying Rural Youth at Risk for Suicide

Key Issues

Screening is typically a two-step process in which an instrument or tool is used to gauge whether an individual shows some of the risk factors for suicide, followed by appropriate referral if one or more risk factors are present.

The Workgroup's concerns about screening and identifying rural youth at risk for suicide centered not on the tools or programs themselves, but rather on the use of screening and identification as a stand-alone tool, without links to services. **Links to referrals and services must be in place before any screening program — targeted or universal — is launched.**

The Workgroup's members noted that a number of screening tools are available that can be matched to different goals. In some cases, a program may want to choose tools to meet universal screening goals (such as Columbia University's Teen Screen program), while in other cases (e.g., a screening program used in detention facilities) a more targeted tool that identifies those at highest risk would be more appropriate. Before any tool is selected and implemented, an appropriate match should be considered between the screening tool and overall goals.

Tools and programs also should be selected for a particular purpose and setting. For example, some tools do not have a diagnostic component; rather, they initiate a caring conversation among peers or trusted adults. Others do incorporate some diagnostic capacity, with implications for the training of those involved as well as the services that must be in place.

Workgroup members note the importance of peers in youth culture; peers are often the first (and sometimes the only) people in a suicidal youth's life to know about the extent of his or her problems or ideation. In addition, Workgroup members note that many youth-serving organizations miss opportunities to reach out to young people at risk for suicide, such as those in jail, in trouble for substance abuse, or experiencing the aftermath of a fight. More routine opportunities include sports physicals and church programs, as well as greater use of technology, which plays such an intense and influential role in the lives of many youth.

Workgroup members also note the importance of cultural context in understanding how youth (and adults) respond to screening and identification efforts. Many young people are justifiably concerned about being labeled in a negative way that will follow them throughout their school years if their help-seeking behavior or mental health or other

problems become widely known. In any setting, confidentiality safeguards are a crucial element of any screening and identification program.

Workgroup Recommendations: Screening and Identification

Screening to identify people who are at risk for suicide should never be a stand-alone strategy; screening must be connected to services and support.

State injury prevention and behavioral/mental health agencies, in conjunction with national groups, can help rural (and other) programs connect screening to services by:

- Making it easier for rural (and other) programs to select appropriate screening tools. This might include **identifying screening tools that have been evaluated and shown to be effective for the population with whom they would be used (e.g., different age groups or settings) and making a list or set of tools and criteria widely available.**

- Encouraging programs to **review a number of screening tools and options from this list in order to carefully select the one most appropriate for a particular setting and population** — e.g., by making such a review a requirement of grant funding.

- Convening partners at state and local levels to **ensure that needed services, referral procedures, and follow-up are in place before screening begins.**

- Establishing an expectation that **screening programs will be evaluated not only on the basis of how many youth are screened, but rather on how many of those screened and identified as at-risk were connected to short- and/or long-term services.**

- Working with other state agencies and professional associations to identify screening and referral protocols appropriate to the mission and context of different organizations and to **align protocols across agencies to ensure that rural youth who are screened by one agency or program do not fall through the cracks** due to the protocols of another agency or program.

- Working with professional associations to **fund, support, and/or deliver ongoing training in both screening and referral for adults likely to interact with rural youth:**

    - Pediatricians and other physicians (e.g., those who conduct sports physicals)

- Faith community leaders
- Teachers and school personnel, including at community colleges
- First responders
- Juvenile justice/detention personnel
- Child welfare/foster care personnel

Considering the relative merits of "passive" vs. "active" permission for school-based screening. (Active permission requires parents to permit their children to be screened, while passive permission assumes parental permission but allows them to opt out if they object.)

- Working with federal health counterparts and researchers to **rigorously evaluate screening and identification programs that have not yet been evaluated**, and **including rural settings in any large-scale evaluations** of these programs.

Training Gatekeepers

Key Issues

Many adults and youth are likely to encounter a suicidal person at some point in their professional or personal lives, but lack the skills, comfort level, and training to recognize warning signs or respond effectively. In rural areas where discrimination against help-seeking behaviors may be heightened and access to services limited, a community-wide cadre of trained "gatekeepers" may make a difference.

Workgroup Recommendations: Gatekeeper Training

- Gatekeeper training represents a significant opportunity for state injury prevention, mental/behavioral health, education departments **and many others** to **work collaboratively to identify gaps in training and ways to address those gaps, including specific gatekeeper training plans for school systems.**

- Prior to selecting and delivering one or more gatekeeper training curricula, state injury prevention and mental/behavioral health programs should **assist communities in assessing their need, demand, and preferences for curricula and priority audiences** who would participate.

- State injury prevention and mental/behavioral health agencies should **promote and fund training programs that have undergone**

evaluation or have other evidence of being a best practice. (To find evidence-based programs and best practices, visit SPRC's Best Practices Registry at www.sprc.org.)

- State programs should **seek secure state funding to support and expand** ongoing gatekeeper training.

- At the same time, more rigorous outcome evaluations are needed. State agencies should work with researchers and federal agencies to **prioritize and design more rigorous evaluations of gatekeeper training programs that include their implementation in rural settings** and that provide incentives for rural communities to participate**.**

- **Priority audiences for gatekeeper training** include rural youth themselves and adults who are most likely to interact with them, including

    - primary care providers
    - teachers and school personnel
    - law enforcement personnel
    - juvenile justice/detention personnel
    - judges and court staff
    - faith community leaders
    - military personnel (e.g., Commanding Officers, chaplains, family support teams).

- States should **fund and offer gatekeeper training following a train-the-trainer model** (incorporated into many existing curricula) to expand access to training and ensure sustainability and via various delivery mechanisms (including videoconferencing, online courses, and Webinars) to reach more remote areas and audiences.

- In every community or neighborhood, **some adults enjoy particular rapport with youth** and can be identified by asking youth themselves. **This group of adults, no matter what their professional affiliation or background, also would be an ideal priority audience for gatekeeper training in rural areas.**

- Gatekeepers need to be continually updated on resources for suicidal persons in their communities. State injury prevention and mental/ behavioral health agencies should have **updated listings of "helplines," mental health services (public and private), faith-**

based assistance, etc. to help gatekeepers refer people to appropriate services.

Strengthening Support During Bereavement

Key Issues

Family members and friends who mourn a loved one's death by suicide go through a different and uniquely painful grieving process. In small rural communities, people are more likely to know one another — which can be a source of support or, in some cases, can complicate the grieving process even more.

Workgroup Recommendations: Bereavement

- State injury and mental/behavioral health agencies can help families and friends through the difficult and unique bereavement period following a suicide by **maintaining an up-to-date list of bereavement resources available statewide, including support groups, counseling, and Web-based resources.** This inventory of resources must be kept up-to-date; maintenance of an accurate inventory should be a specific and periodic reporting responsibility of a state agency.

- National groups involved in suicide prevention should **make suicide bereavement-specific support and resources available via the Web**, which has particular potential for people in rural communities who may lack access to face-to-face counseling or support groups.

- State injury prevention and mental/behavioral health agencies can work with suicide prevention coalitions and other partners to **expand bereavement support that is available locally — such as support for specific groups (e.g., siblings) or connections to survivors or other bereaved families willing to share their experiences and assistance** (e.g., the American Foundation for Suicide Prevention's Survivor Outreach Program).

Supporting Young Rural Suicide Attempt Survivors

Key Issues

Surviving a suicide attempt can be a risk factor in and of itself: up to half of those who survive a suicide attempt make another attempt. Youth who

have survived a suicide attempt may experience additional shame and isolation from friends and relatives, instead of support.

Workgroup Recommendations: Survivorship

- State injury prevention and mental health agencies should **develop and promote Web-based resources for peers and other support for rural youth who have survived suicide attempts**.

- State injury prevention and mental health agencies should **develop a set of materials and/or resources that first responders, law enforcement, spiritual leaders and others can offer to survivors and their families**.

- Few data are available on whether survivors receive follow-up services at all, or in a timely way. State mental/behavioral health and medical care systems should **track suicide survivors over time to determine how many are receiving follow-up services and the types of services they receive.**

Conclusion

Rural communities bring unique strengths and challenges to the important task of youth suicide prevention, yet the unique features of America's rural places are not always taken into account as broader prevention efforts are planned and deployed. The Rural Youth Suicide Prevention Workgroup members hope that the recommendations presented in this report will prompt the state agencies most directly charged with these efforts — public health agencies and substance abuse and mental/behavioral health agencies — to incorporate rural youth suicide prevention into their ongoing efforts.

The Workgroup members anticipate many benefits from attention to these recommendations, including fostering closer collaboration between these entities that share so many common goals, and highlighting the important role that primary prevention and a public health approach can play. Of course, the ultimate goal is to help youth and the adults who care for them gain the awareness, tools and services they need to bring rural suicide rates down over time.

We believe that implementing these recommendations, in whole or in part, will help move states with rural areas and populations towards this goal.

Web Sites and Other Resources

Suicide Prevention Resource Center (SPRC) www.sprc.org
SPRC's Web site provides a range of information from suicide prevention and mental health news to strategic tools for developing suicide prevention programs. The site includes pages for each state and territory, news and events, an online library, a Training Institute, and the Best Practices Registry for suicide prevention. SPRC is supported by SAMHSA.

State and Territorial Injury Prevention Directors Association (STIPDA) www.stipda.org
STIPDA is a national non-profit 501(c)3 organization of professionals committed to strengthening the ability of state, territorial and local health departments to reduce death and disability associated with injury and violence. STIPDA is the only national nonprofit organization comprised of public health injury professionals representing all US states and territories. The organization's Web site offers links to training resources, publications, and surveillance information.

National Suicide Prevention Lifeline 1 (800) 273-TALK 1Hwww.suicidepreventionlifeline.org
A 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis or concerned about someone who may be at risk.. Callers are routed to the closest possible crisis center in their area. The call is free and confidential. Para obtener asistencia en español durante las 24 horas, llame al **1-888-628-9454**.

National Registry of Evidence-based Programs and Practices http://nrepp.samhsa.gov/
This Web site provides a searchable database of interventions for the prevention and treatment of mental and substance use disorders.

Rural Web Portal: Healthy Children and Families https://learn.aero.und.edu/pages.asp?PageID=101055
The Rural Portal: Healthy Children and Families provides technical assistance resources to rural and frontier communities working to transform systems for children's behavioral health in rural and frontier areas. An outcome of the National Plan for Rural Behavioral Health, this activity is funded by SAMHSA's Center for Mental Health Services.

Rural Assistance Center 2Hwww.raconline.org/info_guides/suicide
A resource for a wide variety of information on health and human services in rural areas, including an information guide specific to suicide prevention. Staff are available to answer specific questions and to respond to requests for information.

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control
www.cdc.gov/ncipc/dvp/Suicide/youthsuicide.htm
The CDC's Web site features data, program information, and links to other organizations working on preventing suicide in general and youth suicide in particular.

National Strategy for Suicide Prevention www.mentalhealth.org/suicideprevention or http://www.surgeongeneral.gov/library
The National Strategy for Suicide Prevention goals and objectives for action fulfill a key recommendation of the 1999 Surgeon General's Call to Action to Prevent Suicide. Copies of both reports are available at the Web sites listed above.

WISQARS www.cdc.gov/ncipc/wisqars/default.htm
The Web-based Injury Statistics Query and Reporting System (pronounced "whiskers") is a national, interactive database of injury-related morbidity and mortality data useful for research and for making informed public health decisions.

The American Foundation for Suicide Prevention (AFSP) www.afsp.org
AFSP is a non-profit organization dedicated to understanding and preventing suicide through research and education, and to reaching out to people with mood disorders and those impacted by suicide. Its Web site offers information on research, education, survivorship, advocacy, and special topics such as helping the media cover suicide-related stories appropriately.

Suicide Prevention Action Network USA (SPAN USA) www.spanusa.org
SPAN USA is the nation's only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors (those who have lost a loved one to suicide) and others to advance public policies that help prevent suicide. The organization was created to raise awareness, build political will, and call for action with regard to creating, advancing, implementing and evaluating a national strategy to address suicide.

SAMHSA's Resource Center to Address Discrimination and Stigma Associated with Mental Illness (ADS Center)
3Hwww.adscenter.org
SAMHSA's ADS Center counters the stigma and discrimination associated with mental illness by gathering information and research and providing technical assistance and support, including Webcasts and information on how to develop a stigma reduction initiative.

Appendix A: Rural Youth Suicide Prevention Workgroup Members

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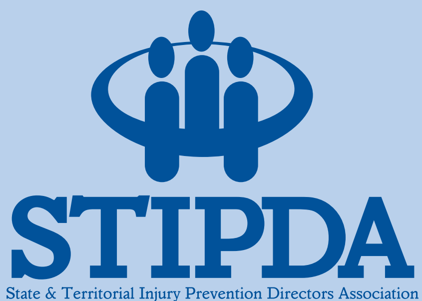

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