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Suicide Prevention in Rural Communities: Perspectives From a Community of Practice

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Developing effective suicide prevention approaches for rural settings is critical for reducing rates nationwide. Although suicide is a public health problem that affects everyone, suicide rates are generally higher in rural areas (Hirsch, 2006). From October 2013 to April 2014, the Suicide Prevention Resource Center (SPRC) convened a Community of Practice (CoP), an interactive peer learning group of 26 organizations including state suicide prevention coordinators and federal Garrett Lee Smith youth suicide prevention grantees, to discuss challenges and strategies of rural suicide prevention work. They agreed that rural areas have limited mental health providers, barriers in accessing available providers, and stigma around talking about and seeking mental health treatment. In a series of virtual meetings, they shared experiences and strategies in 5 areas: improving access to treatment, addressing crisis response, using data to plan and evaluate prevention efforts, working cross culturally, and environmental changes. Drawing on these CoP discussions and prior research on effective approaches, SPRC developed 5 recommendations for rural suicide prevention: (a) train primary care professionals to screen for suicide risk, (b) use incentives to encourage mental health professionals to work in rural areas, (c) strengthen crisis centers' capacity to link to local resources, (d) establish crisis response protocols for the local community, and (e) target suicide prevention programming to community or population needs by collaborating with state partners to access local data on suicide deaths, attempts, and risk and protective factors.

Keywords: rural, suicide, mental health, Community of Practice, prevention

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Suicide is a major public health problem that affects communities throughout the United States, whether in urban cities, towns, or rural localities. It is the 10th leading cause of death among all Americans, the second leading cause of death among 25- to 34-year-olds, and the third leading cause of death among 15- to 24-year-olds (Centers for Disease Control and Prevention, 2014). Suicide rates tend to be higher in rural areas relative to the rest of the nation, in part because of insufficient mental health providers and resources (Singh & Siahpush, 2002, Office of Rural Health Policy, 2005). While the social infrastructure in rural communities includes protective factors such as strong community connections, close networks, and a strong sense of belonging, these factors can also contribute to a lack of privacy, which, in turn, may discourage help-seeking (Rural Youth Suicide Prevention Workgroup, 2008). Nonetheless, the strong sense of community and loyalty to others in rural areas, particularly during crises, can offer the opportunity to weave comprehensive suicide prevention programs into the already existing social and educational structures in the community (Rural Youth Suicide Prevention Workgroup, 2008).

In spite of the high need in rural communities, successful strategies for addressing suicide

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in rural areas are still emerging. To enhance the rural suicide prevention efforts of federally funded suicide prevention grantees, the Suicide Prevention Resource Center (SPRC) created a Community of Practice (CoP) in 2013–2014. This group brought together Garrett Lee Smith Memorial (GLS) Act[1] youth suicide prevention grantees, as well as state suicide prevention coordinators currently addressing or wishing to address rural suicide prevention.

SPRC is the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. Funded by Substance Abuse and Mental Health Services Administration, SPRC provides support, training, and resource materials to increase knowledge, build capacity, and promote collaboration for effective suicide prevention programs. SPRC serves state, tribal, and campus GLS grantees, as well as state and community suicide prevention organizations and coalitions, health care providers, and national partners.

As part of its work with grantees and states, SPRC facilitates one CoP each year. CoPs—interactive peer learning groups—utilize collaboration to build knowledge in specific practice areas. Wenger (2006), researcher and codeveloper of the concept of COP, describes them as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (para. 3). CoPs are especially useful for topics where best practices are still emerging as well as where practitioners may feel isolated, such as suicide prevention in rural settings.

Many prevention practitioners wish to exchange ideas and practices with peers on a frequent basis, sharing strategies on effectively reaching particular high-risk populations, working across diverse sectors, and other key topics. For groups who are not colocated in the same geographic area, this desire to connect with others who are doing similar work to "pick each other's brains" can often only be served via e-mail lists, infrequent conferences, or sporadic one-on-one personal connections, none of which offer a consistent group format. CoPs not only convene a consistent group of peers interested in a particular topic, but also allow for multiple points of view, incorporate diverse experiences and expertise, and, over time, generate a more in-depth exploration of a topic than can be accomplished by a one-time event or dialogue.

SPRC's 7-month-long Rural Suicide Prevention CoP (October 2013 to April 2014) brought together 26 diverse member sites across five time zones. SPRC organizers used Web technology and drew on community organizing techniques and adult learning principles to facilitate learning and information-sharing across this group about best practices in addressing suicide prevention in rural communities. Members were recruited from current and former federal GLS youth suicide prevention grantees, as well as from SPRC's state suicide prevention contacts seeking to work in rural areas of their state. CoP participants, as shown in Table 1, included organizations that self-identified as serving one or more rural (nonurban or nonurbanized) area, and all were working or seeking to work in rural areas of their community. According to the U.S. Census Bureau (2014), "To qualify as an urban area, the territory identified according to criteria must encompass at least 2,500 people, at least 1,500 of whom reside outside institutional group quarters" (para. 2). Any area or territory not fitting that definition is considered "rural" (U.S. Census Bureau, 2014). SPRC did not point to a specific definition for participants but allowed them to self-select based on interest in rural suicide prevention. The CoP met virtually once a month for an hour and half through teleconference and Webinar platform.

CoP members prioritized five key suicide prevention-related topic areas for their discussions: (a) improving access to treatment, (b) crisis response, (c) using data to plan and evaluate prevention efforts, (d) working cross culturally, and (e) environmental changes. Each topic was discussed by the group in the monthly meetings, which were cofacilitated by an SPRC staff member and a volunteer CoP member. The majority of the meetings did not have a formal presenter, but instead relied on a peer-based discussion format to share experiences, challenges, and strategies.

[1] The Garrett Lee Smith Memorial Act was ratified and signed into law in 2004, and grantees have been funded by Substance Abuse and Mental Health Services Administration since 2005. As of this writing, grants have been funded for 3 years to implement best practice suicide prevention programs among youth ages 10–24 years.

Table 1
Rural Suicide Prevention Community of Practice Participants

Participant type	Number	Locations[a]
State Garrett Lee Smith grantees	10	DE, HI, IN, KS, KY MN, NV, WI, WV, VA
Tribal Garrett Lee Smith grantees	6	AK, CA (2), MT, OK, SD
Campus Garrett Lee Smith grantees	5	CO, KY, MS, NY, ND
State suicide prevention coordinators	5	MD, PA, SD, UT, WY

[a] Organizations' locations are listed by state using U.S. Postal Code abbreviations.

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Key Challenges and Strategies in Rural Suicide Prevention

The CoP meetings focused on discussing key challenges and strategies in rural suicide prevention: lack of mental health resources and staff, responding to a crisis, accessing data to plan and evaluate prevention efforts, working cross-culturally, and environmental changes for prevention.

Access to Mental Health Care

Rural counties comprise 87% of the designated mental health professional shortage areas in the United States (Bird, Dempsey, & Hartley, 2001). Members of the CoP repeatedly shared that the absence of trained mental health professionals in the areas they serve is a major barrier to their prevention efforts, and some noted that those mental health professionals who are available have not been trained in assessing and managing suicide risk. Because rural areas are sparsely populated, individuals often have to travel long distances to access mental health treatment services (regardless of level of clinician training), and these services often include long wait times to schedule an initial appointment. Prevention programs often promote information on referral services and how to seek help, but if there are few clinicians readily available in the area, this can impair the effectiveness of the program.

In addition to these physical barriers to treatment, CoP participants also noted that rural communities often attach significant stigma to mental health services and seeking help for suicidal thoughts, a challenge that has been documented in the literature (Hoyt, Conger, Valde, & Weihs, 1997). Therefore, in addition to improving access to treatment, prevention practitioners also need to address negative attitudes attached to suicide and mental health services, so people in need feel comfortable getting help.

The CoP participants outlined a number of creative strategies to address the shortage of providers in their area. A few campus GLS grantees make use of graduate or psychology students who need practicum hours, inviting them to fulfill this requirement in their counseling centers on rural campuses. One member's local community mental health center recruits providers via a student loan repayment program available in exchange for working in their community for a set number of years. This program is funded through internal and federal government funding; the National Health Service Corps, Indian Health Services, and some individual states offer similar programs. CoP members also were interested in "telehealth," the use of electronic and telecommunications technologies (videoconferencing and the Internet) to support long-distance clinical health care (Health Resources and Services Administration, 2014). One member set up "telemental" health units in schools, so that students can receive counseling from a mental health professional via video technology without leaving the school health center.

The members of the CoP also discussed strategies to overcome the stigma around help-seeking and mental health services. Awareness presentations and "gatekeeper trainings"—workshops that teach how to recognize suicide warning signs and how and where to refer people to help—have made some progress toward normalizing help-seeking and improving people's confidence in helping others. Other CoP members have conducted awareness campaigns to reduce the stigma around help-seeking.

Because people living in rural areas most often visit their primary care physician and may

disclose feelings of depression or other mental health concerns in that setting (Clay, 2014), SPRC and the Western Interstate Commission for Higher Education (WICHE) developed the *Suicide Prevention Toolkit for Rural Primary Care*, which includes tools, information, and resources to implement suicide prevention practices and overcome barriers to treating suicidal patients in the primary care setting. Some members reported higher levels of willingness to seek care in their communities when the mental health program was colocated with a school-based health center or community health clinic, and some have intentionally offered services in this way. For instance, the telemental health example noted earlier is located within the school health center, so that it is not obvious that students are accessing mental health versus other health services. This parallels the national movement toward integration of primary care and behavioral health services, one of the advantages of which is higher levels of acceptance of mental health care when it is located in the same place as physical health services (Brunelle & Porter, 2013).

Responding to a Crisis

Crisis hotlines. Crisis centers or hotlines are often the first resource people turn to in a suicidal crisis. Because the function of a crisis center is to help someone in an emergency, crisis centers generally do not offer long term treatment. Crisis phone lines (or text lines) can be even more critical in rural settings, which may have limited resources. Two of the CoP participants were affiliated with crisis centers, and one of them shared their experience piloting extended follow-up programs for people at high risk of suicide, which can fill any gaps until the person is connected to longer term behavioral health care. Another program has created a text messaging crisis service to connect youth with trained counselors, using a more culturally competent medium for youth than traditional hotlines. The availability of text crisis lines have increased (in a variety of settings) because the number of texts teens are sending is on the rise, and talking on a phone is on the decline (Lenhart, 2012), However, one tribal site noted that there were no cell towers in their community, which would make both calling and texting difficult. Because only a limited number of crisis centers may exist in states with large rural areas, the center to which the caller is routed can be hundreds of miles away, and sometimes even in another state. To make sure that counselors answering crisis calls know of local resources, one site had their local coalitions create resource packets to distribute to the crisis centers in their state.

Transportation to emergency and inpatient treatment. In light of the fact that psychiatric hospitals and emergency rooms are often many miles from rural communities (participants from some sites said these services were 4–6 hr away from their local community), transportation can be a significant barrier to effective and timely crisis response. It may fall to family or local law enforcement to transport a person in crisis to needed emergency treatment, but that relies on access to a car or other law enforcement infrastructure to ensure prompt transportation to a hospital. Two tribal participants shared that access to a car on their reservations is rare, and, although they have local bus transportation around the reservation, it is unreliable and only runs during the day. Another participant noted that many Alaska Native villages are only accessible by small airplane, and inclement weather can hinder flight paths to their area.

Some CoP members have had success in obtaining transportation support from volunteers who work with the local crisis center and law enforcement. However, one participant noted that there may be liability issues involved when volunteers transport children or minors. Another member site is working with the National Guard to access helicopters for transportation. One participant set up mobile crisis response teams that are sent to schools to help individuals at risk. These teams follow a suicide risk assessment protocol to determine what further services were needed (e.g., link to a mental health professional, or send to a hospital). One of the campus participants shared that their local community mental health center will conduct an evaluation, but will rarely decide to hospitalize someone, and that the campus had no other crisis care or stabilization options. As a result, they have trained all of their clinicians on campus in assessing and managing suicide risk.

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Accessing and Using Data to Inform Prevention Activities

The public health approach to suicide prevention uses five basic steps to identify strategies that are most likely to produce significant and sustained reductions in suicide and suicidal behaviors. The five steps are to (1) define the problem using data and surveillance, (2) identify the causes (risk and protective factors), (3) develop and test interventions, (4) implement interventions, and (5) evaluate interventions (Suicide Prevention Resource Center, 2014). CoP members identified several key challenges in the first step of collecting accurate and complete data in rural areas. As a result of widespread stigma, coroners may fail to rule a death as a suicide to spare family feelings or otherwise protect the family. One of the crisis center participants in the CoP noted that it is difficult to garner support for local data collection from state partners because there is a lack of state resources. Gathering certain kinds of data from youth requires parental consent, which also can be a barrier.

In spite of these obstacles, CoP participants were able to identify a number of strategies to obtain data on suicide in their local communities. Some sites have worked with their local crisis hotline to identify changes in crisis call volume, requested Youth Risk Behavior Surveillance System data for the local school district, participated in the Healthy Minds Study on their campus, or worked with their state to obtain local National Violent Death Reporting System data. The group also pointed to the importance of process data many sites are collecting, such as number of participants in gatekeeper trainings, community exposure to campaign messages, and attendance at events.

Programs used the local data they were able to access to inform their prevention activities. For example, one State Office of Suicide Prevention collected information on gun-related suicide deaths from their state's Child Fatality Review Boards and used the information to build a partnership with the local firearms coalition. One member's State Board of Education collected data from school personnel for a bullying initiative. The results showed a lack of knowledge by school personnel on how to address bullying in schools. Because both those who bully and those who are bullied are at higher risk for suicide (Kim & Leventhal, 2008), the state identified a suicide prevention gatekeeper training and implemented it in local schools.

Data also were used by CoP members to demonstrate successes and make the case for continued state or local support for suicide prevention efforts. One participant conducted a small study in its local schools to help count instances of intervention with suicidal students. The results showed many interventions and referrals to the school counseling center, with no deaths or attempts having occurred in the school district. These data were presented to the school board as a way to document the need for continuing to support school counseling services. Sites that did not have access to outcome or surveillance data used process data to evaluate program activities' successful uptake in the community and to inform any needed adjustments to ensure the goals and objectives of the program were being met. These measures included numbers of lay supporters trained, numbers of people in the general public exposed to campaign messages, and numbers of community members who attended events.

Working Cross-Culturally and Environmental Change

In the discussions of these two final topics, the CoP used a different format for its discussions than the challenges/strategies approach. In addressing cross-cultural work, the focus was on how to work with different cultural groups and how to make programs more culturally sensitive for the local context. Participants in this session described strategies ranging from learning more about their target audience's history and culture, to making connections and establishing relationships with respected leaders of that community. This meeting included a discussion led by one member on historical trauma with American Indian and Alaska Native communities.

During the meeting about environmental changes, SPRC invited outside speakers from the Western Interstate Commission for Higher Education and from Rural Solutions in Colorado to give presentations. One important environmental strategy discussed at this meeting related to high firearm suicide rates in rural areas (Clay, 2014). Objective 6.2 in the Na-

tional Strategy for Suicide Prevention is “Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership” (U.S. Department of Health and Human Services, Office of the Surgeon General, and National Action Alliance for Suicide Prevention, 2012, p. 44). Participants agreed that this can be a sensitive topic, and shared the need to find ways to work with gun shop owners and to frame the issue around gun safety. Several participants voiced interest in getting gun shop owners involved in suicide prevention, citing the popularity of the Gun Shop Project by the New Hampshire Firearm Safety Coalition (“Preventing Another Newtown,” 2013). Drawing on state data around where suicide decedents had purchased firearms, this project educated gun shop and firing range owners about how to avoid selling or renting a firearm to someone who might be suicidal, and also encouraged gun stores and firing ranges to display and distribute suicide prevention materials.

Evaluation of Community of Practice

SPRC conducted a pre- and postassessment with participants. The preassessment was completed after the first meeting. Postassessment results showed a 21% increase in knowledge of relevant subject matter and an 85% overall satisfaction rate with the CoP. The most successful aspect of the CoP reported was the opportunity to share and interact with their peers. The preassessment included an opportunity to identify goals members wanted to achieve over the 7 months. One participant’s goal was to “gain knowledge regarding rural culture attitudes, needs, and resources. Increase ideas on what strategies might be helpful to engage those in rural settings in suicide prevention.” Another member identified, “At the end of the CoP, I will have usable strategies to implement in my rural communities.” At postassessment, almost all members (80%) reported that the CoP was successful at helping them achieve their individual goals. Following the CoP, the majority of members also reported that they have already shared what they learned with others and/or have started to implement different ideas, interventions, and strategies.

Summary and Recommendations

Based on the detailed discussions of the CoP and the extant research on suicide prevention in rural areas, SPRC developed five key recommendations for rural suicide prevention. The first three recommendations are consistent with recommendations made by the State and Territorial Injury Prevention Directors Association (now Safe States Alliance) Rural Youth Suicide Prevention Workgroup, in collaboration with SPRC in 2008 (Rural Youth Suicide Prevention Workgroup, 2008), although the last two are new recommendations generated through the CoP. (a) Train primary care professionals to screen for suicide risk and connect them to referral resources. (b) Use federal, state or local resources to incentivize mental health professionals to work in rural areas. (c) Strengthen capacity of crisis centers to link to appropriate local resources. (d) Establish protocols on crisis response for the local community, including protocols and alternatives for transportation to hospitals and emergency services or alternate assessment procedures. (e) Target suicide prevention programming to community or population needs by collaborating with state epidemiologists, universities, and crisis centers to access local data on suicide deaths, attempts, and risk and protective factors.

Conclusions

The 7-month CoP raised many important issues and challenges around rural suicide prevention, while also offering new and innovative strategies to address them. The group agreed that access to effective treatment, responding to a crisis, and collecting and using data for program planning were key challenges in rural settings. Although the barriers are significant, the CoP offered a number of strategies for improving each of these areas, while also addressing critical cultural competence and environmental considerations. Additional dialogue and research are needed to continue to deepen our understanding of what works for rural suicide prevention.

Beyond the specific information yielded by the CoP, the collaboration has demonstrated the value of the CoP process for identifying and sharing experiences with respect to priority issues and needs in suicide prevention in rural

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communities. In an era of dwindling resources and fewer face-to-face trainings, facilitating virtual peer connections and knowledge-sharing via new technologies provides a valuable format for advancing capacity to implement health programming in areas of emerging knowledge. The CoP postassessment showed an increase in knowledge and high agreement that the CoP met individuals' goals. In addition, although the formal CoP meetings have ended, half of the members voluntarily decided to continue meeting informally to further discuss suicide prevention challenges and strategies in rural areas. Clearly, CoPs can be an important part of continuing to build innovative approaches to promote health that meet the unique needs and constraints in rural settings.

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