NACRHHS Policy Brief on Understanding the Impact of Suicide in Rural America – 4/24/18

Kristine Sande: Good afternoon everyone, I'm Kristine Sande and I'm the program director for the Rural Health Information Hub. I'd like to welcome you to today's webinar, featuring the National Advisory Committee on Rural Health and Human Services policy brief on understanding the impact of suicide in rural America. We are very happy to have folks from the National Advisory Committee with us today for this webinar. And I'm going to quickly run through some housekeeping items before we begin.

We do hope to have time for your questions at the end of today's webinar. If you have questions for our presenters, we ask that you submit those at the end of the webinar using the Q & A section that will appear on the lower right hand corner of the screen following the presentations. We have provided a pdf copy the presentations on the RHIhub website, and that's accessible through the URL that's on your screen right now. If you experience any technical difficulties during today's webinar please call web-x support at 866-229-3239.

Now it is my pleasure to introduce our first speaker for today, that will be the honorable Ronnie Musgrove. He has served as the chair of the National Advisory Committee on Rural Health and Human Services since 2010. He is also the former governor of Mississippi, having served from 2000 to 2004, and as the Lieutenant Governor prior to that. Governor Musgrove has dedicated his life to serving the people of Mississippi. For more than two decades he has taken a leading role in the State to improve education, and expand economic development. Governor Musgrove will provide some background information on the committee, introduce two additional speakers and set the stage for why the committee chose the important topic of rural suicide to focus on. With that, I'll turn it over to you Governor Musgrove.

Ronnie Musgrove: Thank you Kristine. I would also like to take this opportunity our audience to today's webinar on understanding the impact of suicide in rural America of the National Advisory Committee on Rural Health and Human Services. We will cover National, Rural, Urban suicide trends, provide the committee's findings and review the topic specific recommendations. But first, here's some background on the committee. Tasked with advising the secretary of the US department of Health and Human Services or as we know HHS, the National Advisory Committee on Rural Health and Human Services is a federally chartered independent citizen’s panel that is comprised of 21 members. The members’ expertise touches upon various issues in the delivery, financing, research, development and administration of Health and Human Services in rural areas. The committee was chartered in 1987 to, as referenced earlier, advise the secretary of HHS on ways to address health care challenges in rural America. The committee's chart was later expanded to include Human Services several years later. The committee convenes twice a year to examine important issues that affect the health and wellbeing of rural Americans. At the September 2017 meeting in and near Boise, Idaho, in addition to examining the rural suicide, the committee also looked at modernizing rural health clinic provisions. To read about both topics, as well as other rural health and human service related issues, be sure to visit the link below.

In the month following the meeting, the committee sent both policy briefs with topic specific recommendations to the secretary of HHS. These recommendations provide insights on how the department and its programs can better address these issues.

Today we will hear from two additional speakers. First Dr. Holly Hedegaard, is an Epidemiologist at the Centers for Disease Control and Preventions National Center for Health Statistics, or

NCHS. Prior to her work at NCHS Dr. Hedegaard worked in the Colorado State Health department managing the injury epidemiology program, the Colorado trauma registry and the Colorado emergency medical services information system, which is a mouthful. She was the principle investigator of the CDC funded Colorado violent death reporting system, collecting and analyzing data from death certificates on all suicides and homicides occurring in the State. Since 2012 Dr. Hedegaard has been with NCHS. Dr. Hedegaard presented to the committee on the first day of the meeting. She will talk about rural/urban differences in the US.

She will be followed by Kathleen Belanger who is professor emeritus at Stephen F. Austin State University School of social work. In addition to her work with the committee, Kathleen is a member of the Rural Policy Research Institutes Human Services Panel. Her experience, research and numerous publications address a number of areas related to rural human services. In particular, these issues include racial disproportionality in child welfare, building sustainable programs in and with communities. Addressing foster and adoptive parent recruitment and retention challenges, and building evidence and practice. Kathleen served as subcommittee chair for this topic. She will discuss federal efforts that will address suicide prevention. She will also provide information about the committee's visit in Emmitt, Idaho, and highlight the recommendations provided in the policy brief.

Before we dive in, to ensure that everyone is on the same page, we have provided the following definitions for suicide, suicide attempt, and suicide ideation. These definitions were provided by the CDC. We highlight them here because it is important to have a common language to develop a shared understanding of the topic.

Additionally, because suicide is an important and sensitive topic, we want to note that when addressing this issue, it is important to be mindful of the language that we use. For language to reporting suicide death, refrain from saying successful, unsuccessful suicide, or commit, committed suicide. Instead, use phrases such as took his, her, their own life. Ended his, her, their own life, or died by suicide. For language that touches upon a suicide attempt, avoid using the phrase failed suicide. Instead, use made an attempt on his, her or their life, or nonfatal attempt. For language to describe suicide rates, in place of epidemic, outbreak, or skyrocketing, use words such as higher, increasing or concerning.

Why suicide? To begin with, more than 44 thousand suicide deaths in 2015 alone. Suicide was the tenth leading cause of mortality in the US and the second leading cause of death among young and young adults. And while suicide does affect both rural and urban areas, it seems that rural counties in the nation face persistent and widening increases in the disparity of suicide rates. You will hear more about these difference between rural and urban suicide trends for Dr. Hedegaard. At our spring meeting last year, members of the committee collectively expressed a deep concern about this trend. Moreover we chose to meet in Idaho to understand what prevention efforts were taking place across the state to address their higher rates. Kathleen will provide more information about Idaho later in the webinar. In hindsight, given the overlap between the increasing rates of suicide and the opioid epidemic, both of which have impacted rural communities, we see the significance of examining rural suicide as it is an issue that needs to be addressed.

On the note of the opioid epidemic, the Kaiser family foundation have reported that opioid overdose deaths seem to be connected to suicide deaths. According to the article snapshot on this slide, anywhere between 25 and 45 percent of deaths by overdose may be actual suicides. I bring this relationship up because for me, it is very personal. Our daughter and her husband while pregnant unbeknown to us, were continuing a drug ... I want to say epidemic, but a drug use that had lingered for some time. Upon the birth of her child, obviously it was detected in the child's blood system. We have had a two and half year old grandson from the day that he

walked, or was carried out of the hospital. It has been an ongoing up and down battle with our daughter with her constant need for rehabilitation and not being successful on rehabilitation. Her husband, about a year and half ago died of a drug overdose.

So for us, it's like so many other Americans. We've had this happen to us up close and personal. It is a very difficult situation to go through. It's difficult to figure out all of the measures and what goes into what people are thinking. But it is certainly caused me to listen much more closely and try to be more proactive in what it is we need to do when it comes to dealing with opioid use and opioid abuse, and the consequence of deaths and or suicides as results from that use. So I appreciate the opportunity to participate today to be a part of what the work that the committee has done, and I hope that you all are able to learn and take away some things from two outstanding speakers today. So at this time I will pass the baton to Dr. Hedegaard who will provide data from the CDC on rural/urban suicide trends. Dr. Hedegaard.

Holly Hedegaard: Well hello, and thank you for this opportunity to discuss some of the national trends on rural suicides. As Governor Musgrove mentioned, suicide is now the tenth leading cause of death. This is a graph that shows the leading causes of death by different age groups, and overall suicide is number 10. But you can see that for some of the younger age groups from 10 to 34, suicide is the second leading cause of death, and for ages 35 to 54, suicide is the fourth leading cause of death. So in this presentation what I want to do is talk a little bit about the data that we used in the analysis and how we classify counties by rural and urban status. And then show you some of the changes over time in terms of the suicide trends, and geographic trends in terms of where suicide rates are highest. And then focus really on the rural and urban disparities in terms of suicide rates.

So the data I'm going to show you comes from the National Vital Statistics System Mortality Data, and this is a data set that is actually compiled from information from death certificates that are captured at the state level. So most suicides are investigated by coroners or medical examiners, and they do a rather thorough investigation. Determine the cause and manner of death, write that down on the death certificate and submit that to the state vital registrar. And components of the information on the death certificates are then sent forward to create our national vital statistics system. That data set includes information on all US residents, it includes information such as the demographic characteristics of the person who died, the cause of death, geographic information and other variables.

Additionally, the National Center for Health Statistics has created a classification system for grouping counties and designating them as rural or urban. And so, overall it's generally based on the population in that county, or whether or not there's a central core with large population. We have six major groups, and the six groups here are grouped into two smaller groups. So the four groups that are in blue are what we call metro or urban, and then the two groups that are shown here in yellow are what we group together to call nonmetro, or rural. And of course as you go from large central to noncore, you're going from a largest population to the smallest population.

So let's look at the suicide rates by these rural/urban classification. So this graph shows what's been happening with regard to rural/urban suicide rates from 1999-2016. That yellow line shows what the rate looks like for rural, and the blue line shows you what the rate looks like for the urban counties. And what we can see is over this entire time period the rates have always been higher for rural than for urban. But what we're seeing is an acceleration in the rates among the rural. So if you look at the left side of the figure where we see the rates back in 1999, there was a difference between urban and rural, but it was only about a 20 percent difference or so. And then now as we look in 2016 the rate now in the rural area is up to 17.9, in the urban area at 12.6. so now it's about 42 percent higher in the rural areas compared to the urban areas. And

this rapid increase in what's going on in suicide rates in the rural area has happened starting in about 2007.

This graph looks at each of those individual county groupings. So going from that large central to large fringe metro, medium metro, small metro, to micropolitan and noncore. So if you look across from left to right, you're going from more urban to more rural. And this is showing what those suicide rates looked like in 1999 and then in 2016. And over all you can see that in 1999 there was a difference between urban and rural, but it wasn't nearly as spread out as it is in 2016. So in 1999 the most urban area, the rate was 9.6, the most rural area it was 13.1. but in 2016 the difference is now 10.7 for the most metro area, the most urban area, and 19.0 for the most rural area. So the spread is much greater than it was previously.

So this shows you a little bit in terms of how the trends have looked over time, but I wanna now focus a little bit on how things look from a geographic standpoint across the US. So one of the things that we've done at the National Center for Health Statistics is try to do some modeling that looks at county level suicide rates. And then generate maps to sort of see which areas of the country have the highest suicide rates. So rather than looking just at the state level, we really wanted to get more granular, get down to the level of the individual counties. In creating these models we factor in a lot of different characteristics about the county in terms of diagnosis for mental illness, the poverty level, race/ethnicity breakdown of the counties. A variety of different factors that go in to sort of stabilize the rate and give us a better look at what the rate is at the county level. We generated maps for every year between 2005 and 2015 so that we could see how those patterns might have changed over time. And I'm only going to show you three maps. One at 2005, one at 2010, and one at 2015, so you can see how the patterns have been changing in recent years.

So here's the first map that looks at the county level rates in 2005. And in this graph those counties that are in blue have lower suicide rates, whereas those counties that are in red have higher suicide rates. And as you might expect from other studies and from other results, a lot of the counties with the higher rates are over in the western part of the US. But there are a few areas in Oklahoma and in the middle part of the country here that have higher rates in 2005.

If we move to 2010, you can see that there are fewer areas that are now in blue, and more areas that are in the darker orange moving to the red color. And then this last figure is from 2015 where again, you see a lot less in terms of the counties that are in blue, a lot more counties that are in the darker orange and darker red colors. So again, indicating that the suicide rates are going up in particular counties, not just in the western US, but we also see some areas again in Oklahoma and in the Appalachian region where the suicide rates have increased over time.

In the same study, we were also able to look at which counties showed more than a 30 percent increase in their suicide rates from 2005 to 2015 by rural and urban classification. So again, these are the six different rural and urban classifications that I have mentioned previously, and this shows the percent of those counties in each of those groups that had a suicide rate that increased by 30 percent or more. And so, if we look at the large central metro, you'll see roughly about 10 percent of the counties with that designation had an increase of 30 percent or more in its suicide rate between 2005 and 2015. But if you move over to the right and you look at the light yellow bar, the noncore, this is the most rural counties and almost half of the most rural counties showed at least a 30 percent increase in their model base suicide rates between 2005 and 2015. So again, highlighting that the issue of increasing suicide rates in rural areas is really prominent.

So now having looked at some of the trends over time, as well as some of the geographic areas that have been most affected by suicide, what I want to do now is turn to the characteristics of

the people who are involved in these suicides. So this first figure now looks at the urban and rural suicide rates by male and female. Okay so there are four lines here. The yellow solid line is the change in rates for rural males between 1999 and 2006. The blue solid line is for urban males, the yellow dotted line is rural female, and the blue dotted line is for urban females. So rural males have always had the highest suicide rates, and that disparity between rural and urban male has increased in most recent years, starting in about 2007.

For females the rates were actually pretty similar up until again, about 2007/2008. And in the most recent years we've seen a widening in terms of a higher rate for rural females than for urban females. This is looking at just rural suicide rates for males, but by age group because there is a couple interesting patterns that are going on here. So if we look at rural suicide among males by age group, back in 1999 there was a clear difference among the rates for different age groups. And the rates were highest among men aged 65 and older. But again, what we're seeing over time is that there's almost this convergence in terms of several of the age groups. So by 2016 the rate is fairly similar for men aged 25 to 44, 45 to 64, and 65 and older, with a rate between 35 and 40 per hundred thousand.

For rural males aged 10 to 24, the rate stayed fairly stable again till about 2007/2008. And now we've seen an increase, so that in 2016 it's close to 20 per hundred thousand for that particular age group. This is a comparison of rural males and urban males in terms of age groups. And here I wanted to show you that the patterns for rural males and urban males by age is similar. The rural males are always higher but in terms of what particular age groups where there might be a peak, is fairly similar between rural males and urban males. Where there's sort of a peak around the 50 to 59 age group, then it sort of drops down a little bit, and then increases with age, so that by age 85 is where you see the highest rates for both rural males and urban males.

I'm going to turn now to the patterns for females, and again, focusing just on rural females. So these are rural suicide rates for females by age group. Again, to just show you that there's a little bit of difference when it comes to females compared to males. And for females what we see is the highest rates, actually the rates were fairly similar for the 25 to 44 and 45 to 64 age groups until the most recent years where all of a sudden now the rates are much higher for the 45 to 64 year olds compared to the 25 to 44 year olds. And then rates are lower for ages 10-24 and 65 and older. But for every single age group from 1999 through 2016 there has been an increase in the rates.

This figure is showing sort of a comparison of rural females to urban females, rates by age group. And this pattern is a little bit different than what we saw for the males. So for females the rates are higher in the 50 to 54 year old age group, but what's interesting is that for urban and rural females, rates are fairly similar for the youngest age groups, about 10 to around 24. And also for the older age group, so from about 60 and older the rates are similar between urban and rural. So it's mostly in the 25 to 59 age range where the rates are much higher for rural females than for urban females.

This graph is looking at rural and urban suicide rates by race ethnicity. So as we can see, for both urban and rural populations, the rates are highest among the American Indian, Alaskan Native group. And the only group for which the urban and rural suicide rates are not statistically different is for the non-Hispanic black population. But for all the other race ethnicity groups rates are higher for the rural population compared to the urban population.

And finally, this figure is looking at rural and urban suicides by the means of suicide. So I'm showing you the results for suicide by drug overdose or poisoning, by firearm, by suffocation or hanging, and by other methods. And again, it's sort of comparing the urban to the rural. For both urban and rural firearm contributed the most to the total percent of suicide, but a much

higher percent, close to 60 percent in the rural areas compared to around 47 to 48 percent in the urban areas.

So just to summarize, we've seen increasing disparity between urban and rural suicide rates over time. And those suicide rates have been highest for rural males. In terms of the age patterns for rural and urban males, the age patterns are very similar but the rural rates have been higher for all age groups. In terms of females, again, similar age patterns for rural and urban females, but the rural rates are higher for ages 25 to 59. Among race ethnicity groups the rates are highest for rural American Indians, Alaska Natives. And then compared to urban suicides a higher percent of rural suicides involve use of a firearm.

So I believe we're going to hold questions till the end, or you can write your questions in the chat box. But this is my contact information in case you have additional questions or you want to contact me about other analysis you might be interested in. And with that, I will now turn this over to Dr. Belanger who is going to tell us about suicide prevention, which is a positive thing.

Kathleen Belanger: Thanks so much Dr. Hedegaard for providing the helpful graphs and statistics, the maps. I'm Kathleen Belanger and welcome everyone. I'm honored to present on behalf of the committee our findings and recommendations. But before we cover those areas I'm going to first begin my providing some information on key federal agencies within Health and Human Services, and highlight some of the work they do regarding suicide prevention programming. It's always helpful to know where the money's coming from. These key agencies within HHS include SAMHSA, the Substance abuse and Mental Health Services Administration. Indian Health Service IHS, and several others including the Health Resources and Services Administration, HRSA, The National Institute of Health, NIH, and the Centers for Disease Control or CDC. Okay, so within HHS. SAMHSA is the primary agency that oversees grant programs that address a range of behavioral, health and substance abuse issues. But related to suicide prevention SAMHSA manages several programs. As you can see the Garett Lee Smith memorial ACT programs, and those are the first three bullets. The National Strategy for Suicide prevention which is the next one. The National Suicide prevention lifeline, and two native specific programs, the last two.

So the Garett Lee Smith memorial ACT was enacted in 2004 and reauthorized in 2015. SAMHSA administers funds for the GLS state Tribal Youth Suicide Prevention and early intervention grant program. The GLS Campus Suicide Prevention Program and the Suicide Prevention Resource Center as you can see on those bullets.

The first two GLS programs provide funding to help grantees develop and implement approaches to prevent suicide among youth and young people. And the SPRC offers a wide range of resources to help SAMHSA grantees in developing and implementing these approaches.

Next SAMHSA oversees grants for the National Strategy for Suicide prevention, and the National Suicide prevention lifeline. Originally released in 2001, and updated in 2012, the National Strategy guides comprehensive suicide prevention efforts for the nation. And you can see the number for the lifeline there, and that provides 24/7 crisis intervention and emotional support to individuals while also linking them to the local resources through a network of 164 certified crisis centers, which is very important. So according to SAMHSA suicide prevention branch chief Dr. Richard McKean an estimated 2 million calls were answered through the lifeline in 2017. So SAMHSA also provides funding for two native specific programs which you can see there. The Tribal Training and Technical Assistance Center provides tribal communities with resources to implement suicide prevention strategies, and SAMHSA awards five year contracts to Indian Nations through the tribal behavioral health grant. The funding for these grants is used to design and apply promising community based projects that address suicide, trauma and substance abuse.

So on this slide you can see the other funding mechanisms. IHS serves as the departments lead agency tasked with improving the holistic well-being of federally recognized American Indian and Alaska's Native population. So as you can see here IHS manages two key suicide prevention programs. First the Mental Health Social Services program MHSS supports funding to target a wide range of community and prevention based activities that include suicide prevention, trauma informed care, primary care, and behavioral health integration. And then also telebehavioral health and work force development.

So also as part of IHS's suicide prevention portfolio in fiscal year 2015 IHS partnered with SAMHSA to introduce the zero suicide initiative as a way to extend its reach into Indian Country. This initiative, zero suicide is a comprehensive approach geared towards improving care and outcomes for at risk individuals and health systems. Second, IHS manages funding for the Substance abuse and Suicide Prevention (SASP) Program, and it used to be referred to as the Methamphetamine and Suicide Prevention Initiative or MSPI, but SASP awards grants to support projects that address at least one of four purpose areas. Suicide prevention, intervention, and postventions is one of those four purpose areas. Of course there are other agencies within the departments such as HRSA, NIH, MINH, and CDC that administer programs and funding that touch upon prevention efforts. For example while HRSA's programs do not explicitly focus on suicide prevention, opportunities that include improving broader mental health challenges can be addressed through the work of the community health centers, the rural health programs and the recruitment training and placement of mental health professionals in underserved and rural areas.

So here you can see a table that sums up the identified HHS agencies and their programs. And it's a first attempt to explain the collective federal impact on suicide related activities. It doesn't account for all HHS agencies as I said before. The table was constructed from various sources including the individual agencies congressional budget justification and funding information that was provided to the committee by MINH and CDC. So in the future we might consider complying funding information from all HHS and Federal agencies to provide an accurate picture of all the suicide prevention activities at the Federal level.

So I'm going to discuss the take aways from Idaho. And while I do that I want to say how warmly we were welcomed in Idaho and how impressed the whole committee was with the passion, the dedication, the knowledge of the people working so hard in Idaho. And we were so grateful for everything that they shared with us.

So this is what we learned during our gathering in September of 2017. So as Governor Musgrove mentioned earlier, the committee decided to meet in Idaho partly because of its high suicide rate. As you can see on the slide, according to the American Foundation for Suicide prevention, in 2016 Idaho had the seventh highest suicide age adjusted rate with 21.32 deaths per 100 thousand. And as you saw on the maps provided by Dr. Hedegaard, the mountain west region has consistently reported the highest rates of suicide in the country. So that's why we decided to meet in Idaho. And we were interested in understanding the efforts at the local and state levels that were being made to address the trend.

So here's a look at Idaho's prevention efforts. As the committee learned the state of Idaho has several suicide prevention activities. So you can see in 2001, the National Strategy for Suicide Prevention was released, and in Idaho in 2001, the first suicide prevention conference was initiated. Then in 2002 the Suicide Prevention Action Network or SPAN of Idaho was created to develop and implement prevention activities state wide. And you can see in that small bullet underneath that from 2002 to 20017 SPAN Idaho expanded to nine different regional chapters and conferences every year, and survivor support and training. Then in 2003 Idaho's suicide prevention plan, the ISPP, was developed. You can see there are conferences across the state.

We do want to mention that in 2003 Jenny Griffin lost her son to suicide and then she went on to chair the SPAN, Idaho SPAN, it's a 501c3. And the organization has also leadership and supported many volunteers, including regional chapter leadership. And it's a wonderful organization. We had the privilege of hearing from them, their efforts, and all that they do.

So we already talked about from 2001 to 2003, then in 2006 Governor Dirk Kempthorne established the Idaho council for suicide prevention. And in part it oversees the implementation of the Idaho suicide prevention plan. A prevention hotline was set up in 2012 and the prevention coalition was formed in 2014. And something to note here is that in 2006 the Idaho Suicide Prevention Program was instituted. And the prevention program is housed within the division of public health at the Idaho Department of Health and Welfare. And it's tasked with providing funding for upstream youth education and the prevention hotline, and also for conducting public awareness campaigns. And in addition, that same year the Idaho legislature allocated nearly 1 million dollars for suicide prevention activities. So before we play this following video here, this is one of four public service announcements that the Idaho Suicide Prevention Program developed as part of their Rock your Role public awareness campaign. The campaign involved with development and wide dissemination materials emphasizing the important role that everyone, family, friends, colleagues, and community members, that everyone played in serving as crucial gatekeepers in preventing suicide. So we'll now play the following PSA developed by the Idaho Department of Health and Welfare.

Video: Jim.

Hey Pete, how you doing?

That's the day Jim saved my life. I tried ending it all once before.

Morning fellas

Jim wasn't going to let it happen again.

Hi Jim. Where's my best tipper?

When I stopped showing up, Jim showed up at my door. He didn't let me brush him off. And he took me to the hospital in town to get me help.

Everyone has a role in preventing suicide. Know the warning signs and rock your role. If someone you know is in crisis or emotional distress, call the Idaho Suicide Prevention Hotline at 208-398-HELP.

Kathleen Belanger: That was very impressive, but also the discussions that individuals had and the scenarios they presented to us, the examples they presented of how everybody can help by all the families and friends and colleagues, they were very impressive. So in part of our meeting on the second day the committee assembled into two sub committees, one for each topic. And they travel and visit nearby rural communities to get that community level understanding of the issues and hear from community stake holders. So for this topic the subcommittee visited Emmett Idaho, and we were graciously hosted by Pastor Lance Zagaris at First Baptist Church, and we heard from the people affiliated with law enforcement, the justice system, primary and behavioral health care, schools, faith based institutions. And so these conversations along with the background materials that we were given on day one, and presenters like Dr. Hedegaard, all helped to form the committee's policy recommendation which are here.

So the committee made five specific policy recommendations, and believe me that was difficult to do, but we did. The five recommendations emphasize the need for HHS agencies and offices to focus their efforts on including and underscoring the rural dimensions of suicide in HHS program, research and outreach to address existing knowledge gaps and strengthen the evidence base. So basically we were looking at efforts to look at the rural dimensions of suicide and include the research we need to strengthen the evidence base and to promote awareness. So here's our first recommendation. According to the 2017 CDC, MMWR surveillance summary on the topic, researchers emphasize the need for the development and evaluation of suicide prevention efforts that are specific to rural communities. And as we also heard from Dr. Hedegaard's presentation, given the disparities and the persistent and growing rural/urban suicide trends, the great over representation of rural people. The first recommendation provides the national rural specific suicide prevention analysis be conducted. So we're talking rural here. The analysis must include tribal population. So as noted in policy brief, native communities face disproportionally high suicide rates and mental health challenges. And as you also saw in Dr. Hedegaard's slides, in 2015 suicide rates were highest among non-Hispanic, American Indian, Alaska Natives, and particularly among young native people ages 15 to 24. So that is included in recommendation one.

The committee believes that a targeted evaluation of current rural specific strategies, followed up with further recommendations of action is needed as part of developing an ongoing comprehensive effort. So we want to know what strategies work and we really need to have an evaluation of those. And then during the site visit, we heard from multiple stakeholders about the importance and the need for implementing evidence based programs. Such as sources of strength, and the applied suicide intervention skills training.

While 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 evidence based programs. You may have all the evidence based programs out there but if you can't get them into your community, if you can't afford them, it doesn't do that much good in rural America.

So recommendation two centers on utilization of community health workers, or CHWs. And these are the front line public health workers. And we know they're trusted community workers, they're recognized by the National Rural Health Association, that's pulling in an important role in communities for value based care. And the CHW model poses that the promising strategy or reducing risks, attempts, deaths, that we need the research to quantify and evaluate their impact and identify successful strategies. So what works with this and what doesn't work. And what are the benefits. So the committee believes the utilization of CHWs for suicide prevention and intervention should be evaluated and that cost and clinical effectiveness of these efforts should also be investigated.

Recommendation three it touches on the awareness of rural health funding. So under section 330a of the public health service act, the rural health care services outreach, network and quality improvement grant programs are key investments by the Federal Office of Rural Health Policy in helping to elevate rural community health. And the authority permits competition between grant funding strictly for and among rural communities. This is very important. So because these are fairly flexible funds, the grants allow the awardees the chance to determine how best to use the funding to address their community specific challenges and needs. So 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, along with existing suicide prevention strategy is important to developing a comprehensive and sustainable approach.

Lastly, as mentioned earlier, community stakeholders during the site visit voiced limited funding as an obstacle to incorporating prevention efforts. So greater awareness of section 330a grant funding can help overcome this barrier and funds can be used to include suicide prevention.

So recommendation four discusses the promotion of a screening and assessment tool. So in the health care setting, both primary care and behavioral health, it's an ideal place for prevention and intervention. A 2015 study found that between 2000 and 2011 about 22,400 people made a non-fatal attempt. Of those, 38 percent of the patients in the study made a visit to a health care facility within a week of their suicide attempt. And they also found that 64 percent and 95 percent of patients had visited a health care facility within a month, 64 percent. And 95 percent within a year of attempting suicide. So given the important role that health setting plays, the committee encourages screening for suicide using a clinically validated instrument such as PHQ9. Although that instrument is meant for screening depression, item 9 does screen for the presence of suicidal ideation. It asks, over the past two weeks how often have you had thoughts that you would be better off dead or of hurting yourself in some way. So with broader promotion of the PHQ9 in rural health facilities, the committee recommends the department helps educate providers also on how to bill for the services, which is very important.

Finally our fifth recommendation addresses the gaps in the National Strategy for Suicide Prevention. So as we talked about earlier, the 2012 National Strategy Guide is the nation's suicide prevention effort. But the research on rural specific suicide trends and considerations for prevention, weren't included, the inclusion and implications of rural suicide is critical at the majority of states, including Idaho, have adopted or included strategic goals and objectives into their state prevention plan. So if the national strategy is updated, the committee recommends that SAMHSA integrate rural specific research and considerations for prevention to reflect existing trends and disparity.

So here is a ... here is a list of resources and these are links to these resources. And each of them is hyperlinked okay. And then for more information about the committee you can visit that web page there and you can find a lot of information including all of the publications. So we covered most of the content, very quickly I might add, of the policy brief today. But if you'd like to read more and browse through the committee's previous work, including just recent work that will be posted soon in the next couple of months, please visit the publications page on the committee's website. I'm here as a bit of a preview. The committee met last week in and near Saratoga Springs, New York, and the two topics that we discussed were rural health insurance, market challenges, and assessing and mitigating the effects of adverse childhood experiences among rural American. And with that I'll turn it back over to Kristine Sande.

Kristine Sande: Thank you so much for those great presentations. At this point we will open the webinar up for questions. You should see the Q & A box on the lower right hand corner of your screen where you can enter your questions. As you enter those questions, we do ask that you select the option to send the question to all panelists, just so your question doesn't get missed. I do have one question here to start. Dr. Belanger, when discussing recommendations for you mentioned a statistic about how of those who had made a suicide attempt, 38 percent had seen a health care provider in the week prior to the attempt, what is the source of that statistic?

Kathleen Belanger: Let's see, I don't have it written down but I know we can actually provide it to you. I just have a terrible memory on this. We can get that back to you. I'm so sorry not to have it right here. Somebody else might have that statistic too and be able to speak to it.

Kristine Sande: Alright. We can find that answer and get it back to the person who asked that question. So that was hard to find those things on the spot. So here's another question. What has been the reception within HSS to the recommendations of the advisory committee?

Kathleen Belanger: I'm going to ask Paul Moore. He staffs this committee to answer that question.

Paul Moore: Kristine can you read the question again please.

Kristine Sande: Sure. What has been the reception within HSS to the recommendations of the advisory committee?

Paul Moore: Excellent question. We've looked back over a number of years, the committee, and I know that ... I don't know the exact percentage but I know it's somewhere near half. Recommendations that we can go back and look at where we see that later on a change was made or a regulation was implemented or a program or something. Now it's impossible to go back and say the very reason for that is because the committee recommended it, but we have found out they make that correlation of almost half of the recommendations.

Kristine Sande: Great, thanks for that Paul. Alright, the next question is, according to the research, what role does alcohol play in suicide attempts? Do we have any idea what percent of suicides were committed while the victim was under the influence of alcohol?

Paul Moore: Kristine this is Paul again. While I don't have an exact percentage on that, it just occurred to me that much of this information and the previous questioner query may be in the footnotes as part of the brief itself. So let me invite the listeners to go to our website and you can just google NACRHSS, go to publications and the brief will be there and I think some of this... If we cited it in the brief it will have a footnote.

Kristine Sande: Thanks.

Holly Hedegaard: Kristine, this is Holly Hedegaard and I just wanted to comment about the alcohol question as well. I don't know the actual number but there is a data system that's been established for the Centers for Disease Control called the National Violent Death Reporting System. It's a data system that looks at homicides and suicides and captures in depth information, and one of the pieces of information they capture is whether or not the person was intoxicated with alcohol at the time of death. And like I said, I don't know the numbers right off hand but whoever asked this question, if you search for reports coming from the National Violent Deaths Reporting System, the NVDRS, I'm sure you will run across articles that comment about the percent of people who die by suicide who were under the influence of alcohol at the time of death. So I hope that helps.

Kristine Sande: Thank you, and another place you can go for information if you have questions like that, that you'd like somebody to help you with is the RHIhub. We do have folks who will answer your email or call if you want to send the question and they can help you find that. And…yes

Kathleen Belanger: I just wanted to add I know the person who asked about where the source of the statistic I quoted. I apologize but you should never apologize for asking for facts, and I do think that it is included at the back. It looks like it's from Ahmedani "Racial/ethnic differences in healthcare visits made prior to suicide attempt across the United States." So I believe that's where your source of that stat came from.

Kristine Sande: Great, thanks for that. So another question is, have folks considered addressing the historical and intergenerational trauma for those American Indian and Alaska Native groups that are affected so much by suicide? Any thoughts or comments?

Kathleen Belanger: Yeah this is Kathleen. Our committee did discuss the intergenerational trauma. It's very difficult to determine what to do, and so that's part of the reason that we focused our recommendations

on detecting and trying to provide help to communities to form relationships to reach out. And also to support them and to look at evidence based strategies. I don't know that we heard any evidence based strategy to deal with historical and intergenerational trauma other than ... so that's part of the reason for our research and particularly the tribal communities to help them to find out what does work. I know it doesn't answer your question, but we discussed it quite a bit.

Kristine Sande: Also related to Native American and Alaska Native population, this person says that in working with that population they've noticed that it's difficult to get individuals to admit suicide ideation. So how do the reports and the statistics compensate for that taboo about speaking about suicide? Maybe they don't. You want to have thoughts on that? That's a tough thing to compensate for I think.

Kathleen Belanger: I don't have an answer.

Kristine Sande: Okay. I think the answer to that is that it's very difficult, so I'm not sure that it's really been compensated for. So I think at this point, it is after 2 o'clock here central time, so I think we will take this opportunity to wrap up the webinar. On behalf of the Rural Health Information Hub I'd like to take another opportunity to thank our speakers for the great information and insights that they've shared today. I'd also like to thank our participants for joining us. A survey will automatically open at the end of the webinar. We encourage you to complete the survey to provide us with your feedback that we can use in hosting future webinars. The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of todays will be made available on the RHIhub website, and we'll send that to you by email as well in the near future so that you can listen again and share that with your colleagues. Thanks so much for joining us and have a great day.