

Advancing Suicide Prevention

July/August 2005
Volume I Issue 2

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Suicide in Rural Areas

Lost in Rural America

The challenges, the
progress, the hope

Tragedy in Indian Country

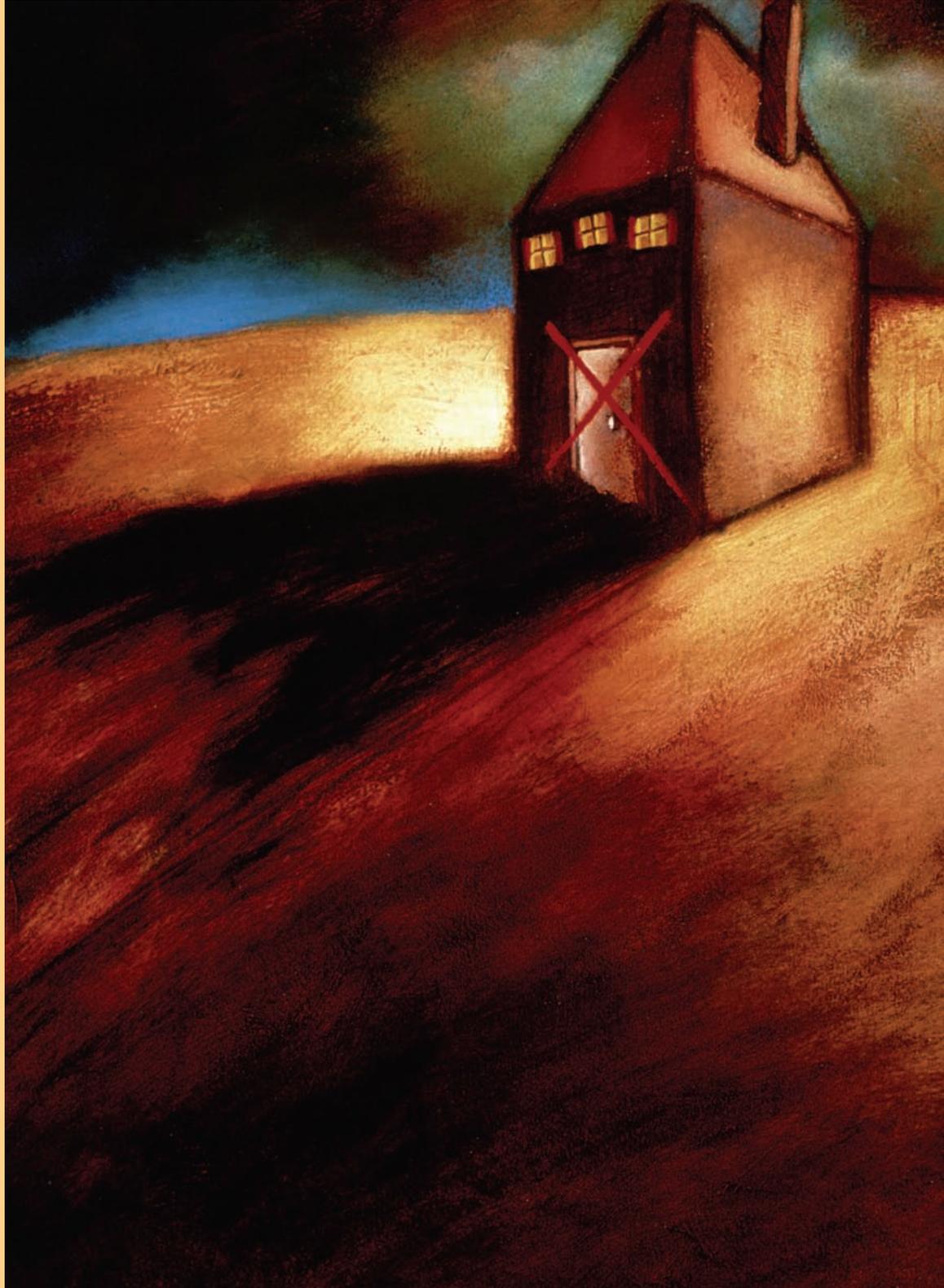
Soaring suicide among
Native Americans

Fatal Connection

Firearms and
completed suicide

also inside:

- Farmer-psychologist
sows hope
- Cultural competency
- States and counties
with highest rates
for suicide





Which helping hand will prevent a suicide?

THEY ALL MIGHT.

In the United States, someone dies by suicide every 17 minutes. In many cases, these deaths are preventable.

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As a nation, fully implementing the National Strategy for Suicide Prevention and establishing mental health parity could help save lives.

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Copy Editor
Ann Bernard

Editorial Offices

629 North 8th Street, Suite 203
Sheboygan, Wisconsin 53081-4502
Phone 920-457-4033
Fax 920-457-4011
advancingsp.com

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POSTMASTER: See page 31

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Message from the Editorial Advisory Board

Prevention lessons to learn from rural America

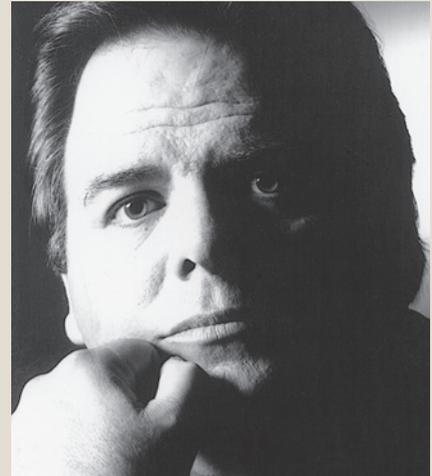
Suicide rates in rural and remote frontier regions are significantly higher than in urban areas. Moreover, the impact of suicide is much greater in rural America because of its tightknit, integrated nature.

In urban or suburban America, when a suicide occurs, we may read about it in the newspaper. There is sadness for family members and puzzlement about how someone may come to take their life. Yet it's rare that we know the individual personally.

But in rural America a suicide reverberates through small communities where it's likely we know the victim well. We know them from the towns in which they live, the schools they attend. We interact with them at the gas station and in the grocery store.

So when this person takes their life we can't distance ourselves. It touches us in a deeply personal way. We question how someone we know can do this. Often we are surprised by their suicide, and so we question our ability to judge others. We question our sense of social codes in our communities, whether we see things the way the person did who died by suicide.

There's a very real difference here. The same event has much greater impact on a rural community and is more likely to ripple out and affect others, young and old. Like the hub on a wheel, when a person at the hub completes suicide, it radiates outward and can precipitate risk for self-harm among other vulnerable individuals in the community.



Perhaps we all can learn how to better reduce suicide by respecting our differences and looking to lessons that may emerge from the life experiences of others.

Yet the tightknit nature of rural relationships may offer great hope for reducing suicide. In these relationships early indicators for risk may be more easily detected. Resources and the means to extend them may be more easily identifiable. And effective interventions may be more easily implemented. This can be harder to do in urban areas.

Those of us who live in urban and suburban America often think it's up to us to teach lessons to our rural counterparts. But maybe it's our rural counterparts who have lessons to teach us. Perhaps we all can learn how to better reduce suicide by respecting our differences and looking to examples that emerge from the life experiences of others.

Spero M. Manson, PhD
Professor of Psychiatry and Head
American Indian and Alaska Native Programs
University of Colorado

Powerful insights driving suicide prevention forward™



Congratulations on your first issue of *Advancing Suicide Prevention*. I applaud your efforts to bring the issue of suicide to

the forefront. Florida has been very active in our commitment to reduce our suicide rate. In 2000, Governor Jeb Bush met with grass-roots organizations and recognized suicide as an increasing problem in the state of Florida. He made the issue a priority and directed the Office of Drug Control to handle the initiative and coordinate all of the efforts throughout the state. Florida has been a leader in the fight to reduce suicide. In March 2005, the Office of Drug Control released Florida's statewide plan entitled the Florida Suicide Prevention Strategy. Its aim is to reduce the suicide rate in Florida by one-third by 2010. I am confident that with our collaborative efforts we will accomplish this goal. It is my hope that as we continue in this vital work, many more lives will be saved due to our combined efforts.

Bruce D. Grant
Chief of Staff
On behalf of James R. McDonough
Director, Office of Drug Control
State of Florida

Thank you for sending us the premier copy of your new journal, *Advancing Suicide Prevention*. We applaud your innovative efforts

to advance the field by fostering exchange of views from diverse perspectives and for diverse audiences. Magazines like this fill a much-needed gap by emphasizing evidence-based practice and a public health approach, while providing a stimulating forum for suicide prevention leaders and visionaries to present their views. I particularly appreciate your inviting me to share my views on key issues facing suicide prevention and mental health system transformation. Thank you for your commitment to advancing suicide prevention. I look forward to future issues of your publication and continuing to work with you toward improving the lives of Americans with mental health needs.

A. Kathryn Power, MEd
Director
Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration (SAMHSA)
U.S. Department of Health and
Human Services
Washington, D.C.

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When Rosalynn Carter began working on mental health care issues more than 30 years ago, few people even spoke the words “mental health.” Mental health meant only mental illness, and mental illnesses were shrouded in such shame and stigma that many people avoided and neglected the issue.

Public attitudes toward mental illnesses have shifted as knowledge of the brain and mental disorders has grown, but despite advances, stigma and ignorance remain.

The Carter Center’s Mental Health Program facilitates the efforts of mental health leaders and national organizations, promotes awareness, and addresses public policy issues. Visit us online at www.cartercenter.org to learn more about our powerful programs that support mental health and help overcome barriers to treatment.



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A Tragedy of Enormous Proportions

Recent suicides among Native American youths have sparked hearings before the U.S. Senate on how to address this tragedy of enormous proportions.



Photo courtesy of U.S. Senate



PAGE 9 Teenagers from Standing Rock Reservation in North Dakota testify before the U.S. Senate Committee on Indian Affairs about an epidemic of youth suicide in Indian Country.

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The link between guns and suicide is explored by Catherine Barber with the Harvard Injury Control Research Center.

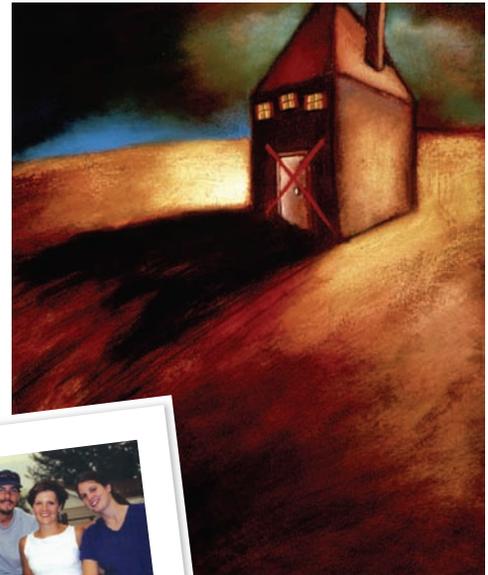


Photo by Pat Kendall

PAGE 16 Lack of mental health services in rural areas can mean life or death for vulnerable individuals.

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Lost in Rural America

Over 60 million people living in rural, remote and frontier regions face daunting challenges in accessing mental health care. These are reflected rural suicide rates that consistently surpass those of urban America.

Preventing suicide. It's *everyone's business.*

Suicide affects each and every one of us.

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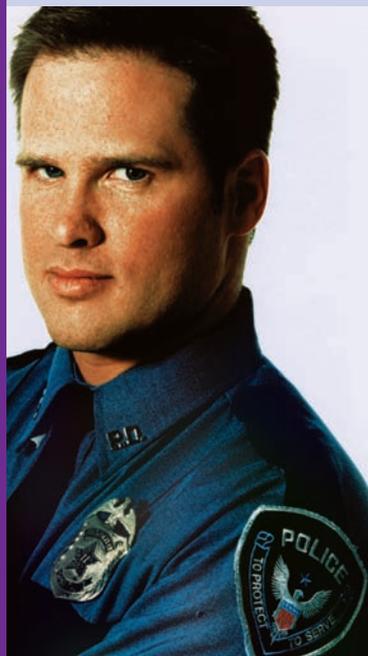
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* 2002 data, Centers for Disease Control and Prevention

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What life can we make for our children?

Photo by Noble Photography, Harlan, Iowa



PAGE 10 Mike Rosmann brings help and hope to agricultural populations.

“A tragedy of enormous proportions”

A breakdown of the Native American family is growing worse, say experts, fueled in part by a high prevalence of depression, anxiety, substance abuse, violence and suicide on isolated rural reservations nationwide.

“We have a bona fide, full-scale crisis on many reservations, particularly with young children, but also the elderly and others who are not getting the care they need because we do not have a system that works, and it is not

funded properly,” said U.S. Senator Byron L. Dorgan (R-ND) at an April 13 oversight hearing on the status of Indian health care before the U.S. Senate Committee on Indian Affairs.

The recent and tragic spate of suicides on the Standing Rock Reservation in North Dakota stands as a testament to this crisis that experts say has been

building for decades and is made worse by inadequate mental health and other services for tribal populations.

The tragedy at Standing Rock unfolded in December 2004 and January 2005 when five young people – three teenagers and two 25-year-olds – took their lives. Moreover, 30 other young people on the reservation threatened or attempted suicide during that same brief time span.



The suicide rate for American Indian and Alaskan Native youths ages 15 – 24 is 250 percent higher than the national average. Suicide is the second leading cause of death for this population. Injuries and violence account for 75 percent of all deaths among Native Americans ages 1 – 19, according to the Centers for Disease Control and Prevention and the 2000 United States Census.

Twila (Summers) Rough Surface has felt firsthand the aftermath of tragic and premature deaths at Standing Rock. Her sister’s son died in a car accident on January 7. A friend who was to be a pallbearer at his funeral took his own life on the day of her nephew’s burial. Less than a month later, Rough Surface’s niece, a sister of the accident victim, took her life on February 2. Best friend of the young car accident victim, despondent over his death, killed himself on April 7.

How does Rough Surface help her sister cope with the loss of two children in less than a month’s time?

“My sister was overwhelmed by the deaths and also tried to take her own life ... she thought the only way to make the hurt go away was to take her own life so she would not feel the hurt and pain,” Rough Surface testified at a June 15 Senate hearing in Washington. →

isolation

lack of hope

**potential
for suicide**

discontinuity

**lack of
belief in future**

Still reeling from the Standing Rock epidemic, Native Americans were again assailed in March when troubled teen Jeffrey Weise, 16, went on a shooting rampage on the impoverished Red Lake reservation in northern

Minnesota. Weise, who killed nine people before taking his own life, was, like many of his Native American peers, the victim of a broken home. Weise's father had died by suicide, and with his mother in a nursing home, the youngster was staying with his grandmother on the reservation.

Standing Rock and Red Lake aren't the only recent suicide tragedies in Indian Country. The impoverished

Cheyenne River Reservation in North Central South Dakota, home to 6249 American Indians – 45 percent under age 18 – lost a staggering 17 teens to suicide from 2002 – 2003 with an average of five attempts per week. Among those who died were a group of young men who made a suicide pact with one another. They drew numbers and died by self-inflicted hanging when their number “came up.” And in spring 2004 a rash of four suicides occurred at the tribal school on the Crow Creek Sioux Reservation in South Dakota.

“There's an epidemic in Indian Country. This is a problem that needs attention,” says Lynn Cutler, a senior advisor on policy in the area of public law and Indian issues. Ms. Cutler, now employed by a Chicago law firm, served in the Clinton White House as deputy assistant to the President for Intergovernmental Affairs and was senior advisor to the White House Chief of Staff on Indian Country issues.



Disproportionately high rates of poverty, unemployment, substance abuse and suicide have plagued Native Americans for decades. On some reservations unemployment is as high as 75 percent, and average life expectancy of men is under 57 years. American Indians, which number 4.1 million, have the highest rate of suicide among all ethnic groups in the U.S., with youth at greatest risk.

Senate messages

This year's tragedies at Standing Rock and Red Lake seized attention of federal officials, who convened in Washington this spring to address the tragic impact of suicide and violence in Indian Country. Those meetings included three hearings – April 13, May 2 and June 15 – before the U.S. Senate Committee on Indian Affairs. Some excerpts from June 15:

“Quite honestly, I would rather not be here today ... but the reality of the situation is that we need help. Our children need your help.”

Julie Garreau, director of the Cheyenne River Youth Project, who claims the effort has been a success only because the tribe took matters into its own hands

“It's a four-month waiting list. Two people are not enough.”

Dr. R. Dale Walker, a member of the Cherokee Nation and director of the One Sky Center at Oregon Health and Sciences University, in reference to scant mental health services available on some Indian reservations

She recalls President Clinton's address in July 1999 to the community at Pine Ridge Indian Reservation in South Dakota where he cited the 75 percent unemployment rate as "appalling."

Equally appalling, adds Cutler, is the average life expectancy of men at Pine Ridge – just 56.5 years. This is the lowest of anywhere in the United States, according to a December 1997 study by the Harvard School of Public Health. This places it on par with life expectancy for Sub-Saharan Africa and lower than any nation in the Western Hemisphere except for Haiti.

"We have to acknowledge the problem and apply some pressure to deal with it," says Cutler of the abysmal life expectancy, unemployment and suicide rates among Native Americans. "It's America's dirty little secret." **A**

Michelle Fast Horse, a senior at Standing Rock Community School, testifies before a May 2 hearing of the U.S. Senate Committee on Indian Affairs. She, like many others on her reservation, have lost friends to suicide. Convened by Senator Byron Dorgan, the Senate hearing is the first ever held to address teen suicide.



Photo courtesy of United States Senate

"I don't know how you can draw any other conclusion other than it has something to do with the history of Native Americans and their exploitation and placement in American society, which leads to greater despair."

Senator John McCain (R-AZ), chairman of the U.S. Senate Committee on Indian Affairs, noting that historical mistreatment of Native peoples is partly to blame for high suicide rates



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SOWING HOPE

Psychologist-farmer Mike Rosmann toils to prevent suicide in agricultural communities

Psychologist and farmer is a rare combination of occupations, yet Mike Rosmann lays claim to both. A fourth-generation farmer and former seminarian, Rosmann still lives on the western Iowa land he farmed for 20 years. As a practicing clinical psychologist Rosmann is a steadfast mental health advocate for farmers who are coping with loss of land – and loss of their very way of life.

Do you still farm these days?

I still manage and live on a farm. But since 1998 I devote my time to the agricultural population. In 2000 I sold my cattle. That was the part I disliked the most; they were good cows. I still miss them a little bit. But you have to make choices.

Were there pivotal events in your life that inspired you to focus your career on the psychological needs of farmers?

There are always events one sees around us. I guess I perceived mental health as a need even as a high school student.

One of the families in my community had a terrible tragedy. It was 1963, and the father was investing with the Board of Trade and losing money. On an August evening he poisoned his infant child and wife with cyanide gas pellets. Then he shot himself. His 20-year-old daughter came home and found the family. She tried to resuscitate her mother and she, too, died from cyanide poisoning. Then a second daughter, an 18-year-old, walked in on the scene and tried to resuscitate her sister. She died as well. One of the remaining children was a 17-year-old daughter, a classmate of mine.

What factors might provoke these awful tragedies in farm families?

For farm families there is potential to lose the farm. It means loss of land. Loss of face. The sense of “I am a failure because I’m not making it on the farm.” Farmers think when you plant things, they grow; they see cause and effect. When they don’t succeed, they feel they’ve let down their forbearers.

Farming is a culture unto itself, isn’t it?

Absolutely. Farmers believe that “if our hearts aren’t into it, we don’t find meaning.” For farm people who do this as their life’s work, it becomes a calling. A necessity to help the larger

community of people everywhere – we all have to eat. It becomes a sacred act. A calling, similar to a priest or health care provider or teacher.

Farmers are vulnerable to a whole different set of stressors, yes?

Ag is such a risky population – and a health disparity group. Farm people have loss of control over factors that affect their livelihood – economically. There’s not much control over market prices or policies that govern them. They can’t control the weather – if it rains or not.

Can that loss of control spur thoughts of suicide?

There’s a sense of losing control of your own destiny. Loss of the farm is just too much stress. Substance abuse may enter the picture. You drink alcohol to relax, to sleep, to not think.

And forced sale of the farm can place farmers at risk for suicide?

It happened during the hoof-and-mouth disease epidemic in Britain. Many farm people died by suicide. The government came in and destroyed their herds. Suicide among British farmers was about ten times the norm over a six-month period. Livestock are harder to part with. Sure, people can put pride →

Sowing Hope *(continued)*

in the tractor they got to work for years – they repaired the valves, kept it running, painted it. But there's more input on an emotional level with cattle and sheep. You know all the animals by name, their behavior, where they are in the pecking order, who's a kicker. I felt terrible letting my prized animals go. I still have dreams about it.

This period of the sale seems precarious for farmers and their mental health. They're most vulnerable for suicide in the days leading up to the sale. About four years ago I saw a man who was being forced out of the family farm. He had to take his cows out of the herd, haul them to auction. When I went out to see him that day, I found him crying in his machine shed. He told me: "I gave this my all. I missed everything. I haven't spent enough time getting to know my daughters." His oldest daughter was finishing high school at the time.

How hard is it to get these folks to see a psychologist?

It's a hurdle for them to get services. They seem to be

bargaining as to whether this is something they have to do – if it's a good thing or a sign of weakness. I tell them it's a sign of strength when they reach out to manage their behavioral health more effectively. It makes them more economically viable.

What do you think needs to happen to better protect agricultural communities from suicide?

We need to put money into interventions where the suicide rate is the highest. When a wife calls and says, "My husband is drinking too much and won't talk to me," the sheriff treats it as a law enforcement call, not a mental health call. It would be great if a mental health professional and an advocate – two people – could go along. I'm thinking of a terrible tragic death just yesterday, nearby in western Iowa. A soldier who died in Iraq is being buried today, and yesterday his 19-year-old brother was struck and killed by a truck. So this community has lost two brothers. Here's a family that is at significant risk. The loss is overwhelming. A



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RECENT RELEVANT RESEARCH

Doubtful treatment

Despite about 50 percent more suicides than homicides every year in the U.S., the study of suicide is still in its infancy. Little is known about trends in suicidal ideation, plans, gestures or attempts – or about their treatment. Yet such data are needed to guide and evaluate policies that can advance suicide prevention. To see if treatment enacted in the 1990s has reduced suicide-related behaviors, researchers in the Department of Health Care Policy at Harvard Medical School analyzed suicide trend data, studying data from the 1990 – 1992 National Comorbidity Survey, and compared it with data generated in a similar survey a decade later. Their findings? Despite a dramatic increase in treatment, no significant decrease occurred in suicidal thoughts, plans, gestures or attempts during the 1990s. The upshot? Steadfast efforts that increase outreach to untreated individuals with suicidal ideation – and before they attempt to take their life – are vital to reducing suicide.

Trends in Suicide Ideation, Plans, Gestures and Attempts in the United States, 1990-1992 to 2001-2003. R. C. Kessler, P. Berglund, G. Borges, M. Nock, P. S. Wang. *JAMA*. 2005 May 25;293(20):2487-95.



Helpers helping others

A remarkable and documented downward trend in suicidal acts is reported in this important study, which evaluates 15 years of a suicidal-behavior prevention program among youths living on an American Indian reservation. Data from this community-based program, which focused primarily on 10 – 19-year-olds, show a substantial drop in suicidal gestures and attempts, with total number of



self-destructive acts declining by 73 percent. This key research supports the effectiveness of using “natural helpers” or volunteers within a community to act as trusted laypersons and engage in peer training, personal and program advocacy, referral of those at risk and consultation with professionals to help decrease suicidal acts among at-risk individuals.

Outcome Evaluation of a Public Health Approach to Suicide Prevention in an American Indian Tribal Nation. P. A. May, P. Serna, L. Hurt, L. DeBruyn. *Am J of Public Health*. 2005 Jul;95(7):1238-44.

PROGRAM COMPONENTS: Elements of this noteworthy program that contribute to a significant downward trend in suicidal acts include: 1) surveillance through constant data and information gathering; 2) screening/clinical interventions with extensive outreach in both conventional (health clinics, schools, social welfare settings) and unconventional settings (outdoor venues, community functions); 3) school-based prevention programs on topics including general life-skills development; 4) community education for adults and youths on general topics such as parenting and specific topics such as the nature of self-destructive behaviors; and 5) neighborhood volunteers of various ages as “natural helpers.”



Veterans at Risk

Thousands of veterans returning from Iraq and Afghanistan with PTSD, or post-traumatic stress disorder, mean that support systems back home – crisis interventionists, clinicians, primary care doctors – need to look for signs that may place these former soldiers at risk for suicide. In this study male military combat veterans who completed a VA residential rehabilitation program for PTSD were analyzed to consider how to best predict high-risk behaviors after release from inpatient treatment. These behaviors include violence, substance abuse, and suicide attempts and completion. Results suggest that *most recent* high-risk behaviors, not patient history, appear to be more predictive of risky behaviors post-discharge. All the more reason for health care and social service gatekeepers who interact with veterans to be vigilant when inquiring about PTSD and recent risky behaviors veterans are engaging in, as these may suggest potential for suicide.

Predicting High-Risk Behaviors in Veterans With Posttraumatic Stress Disorder, T.L. Hartl, C. Rosen, K. Drescher, T. T. Lee, F. Gusman. *J Nerv Ment Dis* 2005 Jul;193(7):464-472.

ON A RELATED NOTE: In June Congress voted to add nearly \$2.5 billion to the budget for the U.S. Department of Veterans Affairs after the VA noted it had underestimated the cost of veterans’ health care by as much as \$2.7 billion through 2006. About 103,000 veterans from Afghanistan and Iraq will have used VA medical care by the end of September – four times what the agency budgeted for 2005.



INSIGHT

In plane sight

If today is like any other in America, 86 people will die by suicide. Sixty-nine of them will be male, and 17 will be female. Eleven of these will be teens and young adults ages 15 – 24. And 15 of them will be age 65 and over. “These 86 deaths are the equivalent



of a passenger airplane falling out of the sky every day, 365 days a year, and killing everyone onboard,” says Karen Marshall, who

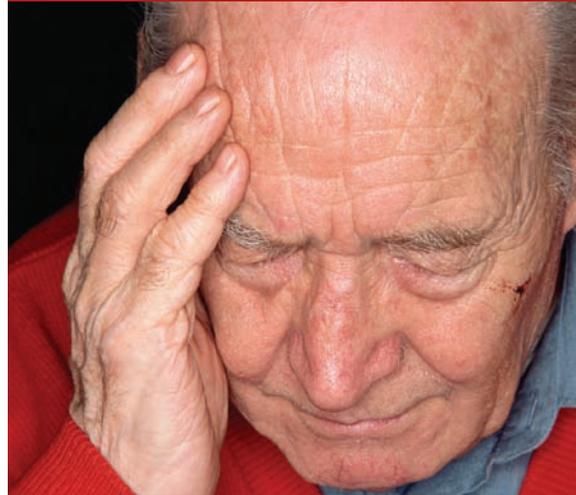
lost her father to suicide when she was a teen and her paternal uncle 17 years later. “You can only imagine how our country would react to that. They’d be demanding action; they’d want to know why. We’re not seeing that level of outrage – not even an acknowledgement of the magnitude of this problem.” Marshall is founder and director of the Stop Suicide Alliance, a national nonprofit organization that partners with employers and communities to bring effective depression awareness and suicide prevention programs to those at risk. Contact her at stopsuicideinfo@aol.com.

OPINION

Come together

What needs to happen to move the field of suicide prevention forward? Bob Gebbia thinks more togetherness is in order. “The whole notion of bringing together two very different, but interdependent, constituencies – survivor (of suicide loss) and professional. These two groups bring such expertise and passion. But bringing them together is what will really change this field,” says Gebbia, executive director of the American Foundation for Suicide Prevention. He advocates for more inclusion of researchers in survivor initiatives and survivors in professional forums as well – such as a recent college-focused suicide prevention symposium at Columbia that included survivors. “This cross education is very important. I think our field will be stronger for it.”

Old age and depression.



They don't have to go together.

The elderly have the highest rate of suicide in our country – nearly 50 percent greater than the national rate of 11.0 per 100,000 people. The Cornell Institute of Geriatric Psychiatry is responding, breaking new ground in understanding geriatric psychiatric disorders, educating and training future behavioral healthcare professionals, and providing specialized care to older adults.

The Institute of Geriatric Psychiatry at Weill Medical College of Cornell University is a leader in the study of geriatric depression, spearheading groundbreaking research that will further our understanding of the mind, our treatment of mental illness – and our ability to prevent suicide.

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TREND

Culture shock

Calling for cultural competency when considering how to prevent suicide

They are among a growing cadre of researcher-advocates calling for more “cultural competency” when treating patients who have mental illness or are suicidal.

Sherry Molock, Luis Zayas and Teresa LaFromboise all took part in a workshop last September on “Pragmatic Considerations of Culture in Preventing Suicide,” cosponsored

by the National Institute of Mental Health and Indian Health Service, among others. And Drs. Molock, Zayas and LaFromboise warn that there is danger in ignoring the effects of culture, ethnicity, tradition, religious beliefs, social class and national origin on mental health and mental illness.

“Does culture matter? If we thought culture mattered, we wouldn’t have these same discussions over and over again. Some of us just think culture is politically correct,” said

Molock, a clinical psychologist, ordained minister and mental health researcher. She spoke out during closing discussions at a workshop this June in Washington,

challenging attendees to put talk into action and better address culture in suicide prevention research, clinical practice and programs.

Molock has put forth a model for suicide prevention that incorporates religious beliefs and traditions of the African-American church. Familial focus among Hispanics is at the center of Zayas’s culturally centered model for suicide prevention. And LaFromboise’s model includes tribal values and rituals in the American Indian community (see page 22 for more).

Their models are only the beginning, as research on the role of culture in suicide risk and protection is in its infancy. This was recently spotlighted by *The Washington Post* in a high-profile three-part series published June 26 – 28, noting that patient diversity and culture are broadly downplayed in research, diagnosis, treatment and outcome of mental disorders.

This lack of cultural sensitivity has real implications for rural and ethnic populations, and Molock thinks that has to change for suicide prevention efforts to progress.

“Are we going to make partnerships with communities or aren’t we? Are we going to think about strengths of communities, not just their pathologies?”



Sherry Molock, PhD



This Alaskan Native family in traditional attire demonstrates the rich diversity of Americans. This diversity must be acknowledged, honored and addressed with culturally sensitive programs if suicide prevention efforts among these and other populations are to be successful.

Photo courtesy of Indian Health Service, U.S. Department of Health and Human Services

Lost

IN RURAL AMERICA

For all the seeming peace of pastoral country life, those who reside in rural and remote areas face daunting challenges summed up by one word: loss.

Patricia Kendall has learned firsthand about rural life and loss. Pat was just 24 when she left urban San Diego in

1974 to resettle with her husband and children in the wide-open spaces of Montana.

Her only son was that same age when he, too, left family and friends behind.

Joshua Kendall died by suicide in 2000, leaving a wife and two young daughters.

Five years later Pat can't help but consider the impact of growing up in Montana on her son. Today – in all-too-clear hindsight – she knows one thing for sure: by relocating to so rural an area, she lost access to critical health care specialists and social services for her at-risk son – a child that at the time of her move was not yet born.

“It never even occurred to us,” says Pat as she recalls the family’s considerations about moving – none of them health care-related. “We knew our kids would need to get vaccinations. They’d get colds. They’d have their tonsils removed. But they weren’t going to get depression and kill themselves. At that point in our lives, this was never a concern. We didn’t consider it, even subconsciously.”

When Josh entered middle school and began acting out, Pat and her family practice physician attributed his behavior to adolescence. When Josh’s problems escalated in his late teens and early adulthood, Pat found out firsthand the loss that can come with rural living. Josh died on September 18, 2000, after attempting suicide ten days prior.

“The resources were so minimal. The services weren’t there,” adds Pat. “Yet nobody warned us of that.” →



Josh Kendall, 24, poses with his sisters in August 2000. Five weeks later Josh died by his own hand. His mom Pat wonders if lack of access to competent mental health treatment in their rural Montana town contributed to her son’s struggles – and ultimately his self-inflicted death.

Photo courtesy of Pat Kendall

By the numbers

60 million

Americans living in rural and frontier areas

4th

Most often identified health priority among state and local rural health leaders is mental health and mental disorders

1,253

Number of smaller rural counties with populations of 2,500 to 20,000 – nearly three-fourths of which lack a psychiatrist

84/100,000

Rate for suicide in Nome County, Alaska – the highest rate of any county in the U.S.





In stark contrast to the wide-open vistas surrounding them, many residents of rural America are trapped by poverty, limited opportunities, sparse mental health services and the stigma in seeking them out. For those most vulnerable, suicide can appear to be the only way out.

Mental health research suggests that loss is a risk for suicide attempt and completion.

Sudden loss, such as that brought about by the diagnosis of a terminal illness or threat of incarceration, can increase risk for suicide in vulnerable individuals. So can loss sustained over time, such as from a farm that is failing.

Then it makes sense that those living in rural and remote regions, while embracing quiet country life, also shoulder bleak aspects of sparse rural living, many loss-related, that can impact mental well-being. The numbers tell the story.

Suicide is the second leading cause of death in states with primarily rural populations, especially in states in the rural mountain west and Alaska.

Suicide rates in rural areas consistently surpass those of urban areas in America. From 1970 to 1997, the incidence of suicide among **males in rural areas was 37 percent higher than urban areas** – 27 per 100,000 versus 17 per 100,000.

Suicide rates for **Native Americans range from 1.5 to over 3 times the national average** for other groups. Youths are disproportionately affected with a rate 2.5 times higher than the national average for Indian youths ages 15 – 24.

Nearly three-fourths of rural counties in America lack a psychiatrist, and 95 percent lack a child psychiatrist.

Among small counties with less than 2500 population, **one-third have no health professional** able to address mental health needs.

“The services just aren’t there. In urban areas you might have a caseworker assisting a suicidal person. In rural areas sometimes the best ‘mental health’ services you get are from a police officer or school counselor,” says Christian Hanna, MPH, who works in rural and agricultural health and safety at the Marshfield Clinic Research Foundation in Marshfield, Wis. Hanna works with states nationwide to boost suicide prevention efforts. “Rural populations are underserved for mental health; there are gross inequities for distribution of mental health services.”

Sparse services, stigma are contributors

Since the 1950s rural suicide rates have outpaced those in urban areas. But, in recent years, this gap is widening as suicide rates decline in some urban areas, but increase in rural America.

“Rural has a lot of significant disparities. Over 90 percent of psychiatrists practice in urban and suburban areas,” notes Dennis Mohatt of the gross shortage of skilled professionals in rural America to treat those with mental illnesses and suicidal behaviors. Mohatt is director of the mental health program at WICHE, the Western Interstate Commission for Higher Education.

When mental health specialists are available, they don’t often last long in rural areas.

“It’s a matter of economics, of social choice and more modest insurance. There’s a depressed insurance marketplace for professionals to draw on,” adds Mohatt of inadequate insurance coverage for mental health in rural



America. “The economics of it are you don’t make any money.”

Poverty, geographical isolation and cultural differences can further remove rural populations from services they need. When people do seek care, oftentimes their symptoms are more serious and their illnesses have progressed, thus requiring more intensive and expensive treatment.

Moreover, some rural residents raised in stoic and self-reliant cultures resist seeking mental health treatment – no matter how despondent they are.

“There’s a stigma. These are strong, independent people who think they don’t really need help from anyone else,” continues Hanna with the Marshfield Clinic.

Lack of confidentiality and anonymity in close-knit communities doesn’t help when someone is struggling with mental illness or thoughts of suicide.

Barriers

To mental health care in rural areas

Availability

Accessibility

Acceptability

“Stigma is more of an issue in rural, more traditional areas than in more urban areas,” says Lloyd Potter, PhD, director of the federally funded Suicide Prevention Resource Center. “If you park your car in front of a psychotherapist’s office in a small town, people are going to know.”

Stigma may also affect reporting of cause of death by

coroners in rural areas. In these close communities, coroners may bow to wishes of grieving families who ask that their loved one’s death be listed as accidental or undetermined, not as suicide. Hanna estimates that up to half of suicides go unreported as such. This underreporting leads to lack of accurate surveillance for suicide.

The changing face of rural America also stresses its residents.

“Thirty years ago, you sat in the same desk at school that your parents did,” Hanna says. “Today towns of 600 are becoming towns of 1200. That rapid growth affects the stability of small towns. There are disjointed or no services as new people move into town.”

Easy access to lethal means is also a factor in high rates of self-inflicted death in rural areas (see companion story on page 25).

“A child could do something, and a mile away neighbors wouldn’t hear the gunshot,” Hanna adds. →

Loss of supports and services in rural America

Loss of support networks for those who leave family and friends behind when migrating from urban to rural areas.

Loss of convenience of nearby schools, stores and other services.

Loss of family farms and all they represent – the land, livelihood, way of life and commitment to carry forward what past generations have built and sustained.

Loss of adequate health services – a pediatric audiologist for a deaf child, a trained oncologist for a mother with cancer, a geriatric psychiatrist for a depressed parent.

Loss of cultural identity particularly in Native Americans – with the resultant high rates of unemployment, alcoholism, violence and suicide.

Loss of local control and way of life brought about by the influx of wealthy urban dwellers to traditionally rural communities.

Loss of political voice and influence as numbers of farmers and ranchers dwindle.

Loss of educational and cultural opportunities that urban areas offer.





Stopping the surge

What needs to happen to boost mental health and curb suicide rates in rural America? Recent landmark reports including the 2003 *Achieving the Promise: Transforming Mental Health Care in America* (the final report from the President’s New Freedom Commission on Mental Health) call for the following:

- ▶ Early identification, screening, diagnosis, treatment and recovery services that are delivered by competent professionals and accessed close to home.
- ▶ Parity of access to mental health emergency response.
- ▶ Improved strategies to build the number of trained professionals and alternate providers of mental health services who are competent to work in rural communities.
- ▶ A “rural impact statement” of all behavioral health rules, policies and initiatives within the Department of Health and Human Services, required by the Secretary of HHS.
- ▶ A single definition of what constitutes “rural” that can then be applied consistently across all HHS programs.
- ▶ Insurance purchasing pools available to rural individuals and small businesses, to enhance access to more affordable health insurance options.

- ▶ Broad public education programs – including those delivered in school settings – to increase rural residents’ understanding of mental illness, warning signs and risk factors for suicide and how to respond appropriately when someone is suicidal.

Federal policymakers have responded in part with the formation of an Office of Rural Mental Health Research in the National Institute of Mental Health. This is joined by an Office of Rural Health Policy within the Health Resources and Services Administration.

In May the Substance Abuse and Mental Health Services Administration appointed Susan G. Keys, PhD, to be the point person overseeing rural mental health within SAMHSA’s Center for Mental Health Services (CMHS). Keys is branch chief, Prevention Initiatives and Priority Programs Development Branch. “My work falls within the larger initiative of mental health transformation,” says Keys, referring to transformation of delivery of mental health services called for by the President’s New Freedom Commission. “Suicide prevention plays a role within this larger picture.” →



Farmers and ranchers are at greater risk for suicide than other populations. Stressors including reliance on weather conditions, fluctuating crop prices and social isolation – when combined with easy access to guns and other lethal means – all contribute to high suicide rates among agricultural workers.

Danger zones

Settings where populations at high risk for suicide can be found and where outreach can be effective include:

- Farm credit offices
- Unemployment offices
- Juvenile detention facilities
- Home health care settings
- Youth and women’s shelters
- DWI court

Emotional states most associated with suicidality:

- Hopelessness
- Loss of self-worth
- Perceived loss of desired level of functioning
- Depression

SOURCE: Research on the Reduction and Prevention of Suicidality: PA-MH-03-120, National Institutes of Health, U.S. Dept. of Health and Human Services

Rural America

A Patchwork of Diversity

The face of rural America is changing. Farmers and ranchers, hunters, American Indians and Alaskan Natives, lumbermen and miners all are part of the rural landscape. Yet together they are a decreasing minority as other ethnic/racial groups grow in rural presence.

Together these diverse populations paint a complex, rich portrait of rural and frontier America, yet one with significant challenges for suicide prevention. These include barriers of language, culture, economy, environment, ideology and tradition. Prevention programs that are culturally competent – that is, recognize, honor and address distinct cultures and all their diversities – are critical to combating suicide in rural America.





Promising programs

Programs that consider culture and geographic barriers are among those that show promise for rural populations.

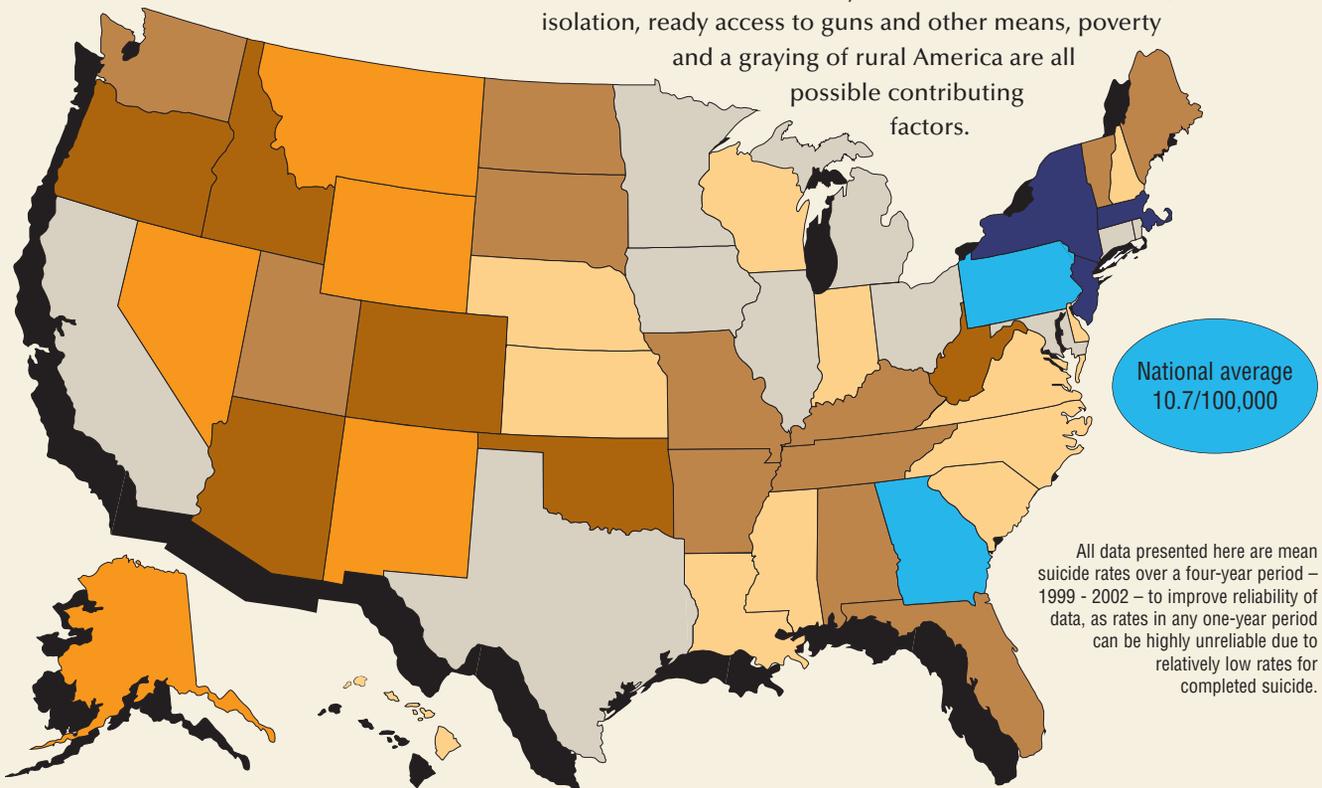
CULTURAL BARRIERS: A community-based participatory intervention among the Zuni Pueblo in New Mexico targets specific skills to reduce risk for suicide in vulnerable ethnic populations. These skills include increasing knowledge about suicide prevention; managing depression, stress and anger; improving communication; increasing goal setting; and boosting ability to refer a friend for help when he or she is suicidal. This model, the work of Teresa LaFromboise, PhD, shows how research based on white youths can be culturally

tailored for ethnic minority youths through community-based participatory research. LaFromboise worked collaboratively with American Indian school administrators and teachers to gain their input and incorporate critical Zuni values into the curriculum. This collaboration appears to enhance the retention and sustainability of this intervention.

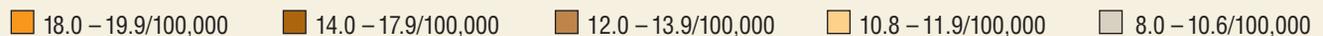
GEOGRAPHIC BARRIERS: To address geographic isolation and distances that can impede suicidal individuals from getting help, telemedicine shows promise. By using videoconferencing, the Internet and other technologies, telemental health services can connect remote patients with skilled providers for real-time access to intervention expertise not typically available locally.

Suicide Rates State by State

Rural America, including Alaska, the mountain states and other sparsely populated areas, consistently has the highest rates of suicide in our country. Lack of health care services, isolation, ready access to guns and other means, poverty and a graying of rural America are all possible contributing factors.



Thanks to John L. McIntosh, PhD, Department of Psychology, Indiana University South Bend for assistance with data gathering and interpretation



“The concept behind telemedicine has been used in Alaska for years,” says Susan Soule, a retired 18-year veteran of state government who now trains and consults on community-based suicide prevention programs. Soule notes that village health aids employed by the Indian Health Service communicate via short-wave radio with physicians at IHS hospitals in regional hubs. “Telemedicine is just a logical extension of this, not a break with the past,” she adds. A

County Suicide Watch

Which counties in the United States have the highest rates of suicide? Here are the top six*, all well above the national rate of 10.7 suicides per 100,000 people (mean rate over four-year period 1999 – 2002).

| | | |
|------------------|------------------|---------------------|
| Alaska | Nome | 84.1/100,000 |
| Tennessee | De Kalb | 42.8/100,000 |
| Texas | Freestone | 31.9/100,000 |
| Arizona | Yavapi | 27.5/100,000 |
| Georgia | White | 25.5/100,000 |
| Ohio | Adams | 20.9/100,000 |

* These are data reported by the CDC as reliable because they are rates based on more than 20 deaths. Note that other states – many of them rural, western and mountain – have counties with rates comparable to above; but these are deemed unreliable because total number of completed suicides is 20 or below.

■ 6.0 – 7.9/100,000

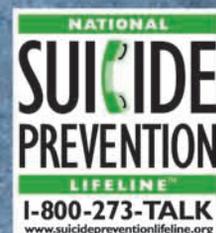
No matter where you are, help is only a phone call away.

Many communities lack mental health care resources. For people in crisis, that can be a major obstacle to getting the help they need.

Through the National Suicide Prevention Lifeline (1-800-273-TALK), a trained crisis worker is always just a phone call away. With more than 100 crisis centers participating in the network, callers are linked to the crisis center closest to them.

The federally funded Lifeline puts a valuable resource in your hands to help people in distress 24 hours a day, no matter where they live.

To learn more about how the Lifeline can serve your community, call the administrative offices at 1-866-350-5465 or visit www.suicidepreventionlifeline.org.





LEARNING MORE

National Association for Rural Mental Health (NARMH)
narmh.org

HRSA Office of Rural Health Policy
ruralhealth.hrsa.gov

National Rural Health Association
nrharural.org

Critical Illness and Trauma Foundation
citmt.org

Rural Assistance Center
raonline.org

Marshfield Clinic
marshfieldclinic.org

Frontier Mental Health Services Resource Network
wiche.edu/MentalHealth/Frontier

AgriWellness
argiwellness.org

NIMH Office of Rural Mental Health Research
www.nimh.nih.gov/ormhr

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Indian Health Service
www.ihs.gov

Southwest Rural Health Research Center
srphmain.tamu.edu/centers/srhc/default.htm

APA Resource Center for Rural Behavioral Health
apa.org/rural

Rural Health Policy Research Institute (RUPRI)
rupri.org

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Fatal *connection*

The link between guns and suicide

By Catherine W. Barber, MPA
Harvard Injury Control Research Center

Where there are more guns, there are more suicides, the National Research Council (NRC) concluded in a report on firearm policy released last winter. Areas with higher household gun ownership rates have higher suicide rates, even when controlling for things also associated with suicide,

Not all suicide victims have a sustained desire to die. For some, their impulse is short-lived, and what weapon they reach for during that impulse determines whether they live or die.

like divorce rates and unemployment. In 2002, 31,655 Americans took their lives, 17,108 of them with firearms.

Gun prevalence is not the only predictor of suicide rates. Cultural factors also play a key role. China, for example, has fewer guns and higher

suicide rates than the U.S. But within the United States, the link, the National Research Council concluded, is clear.

What is less clear is *why* that link exists.

Gun ownership and suicide are both high in rural areas. Is it “rural-ness,” not guns, that accounts for the high suicide rates? Perhaps people are more depressed in rural areas and more likely to attempt suicide or to die from their actions. Drs. Matthew Miller, Deb Azrael, and David Hemenway of

the Harvard School of Public Health explored these hypotheses and found no evidence for each.

Using data from population surveys, hospital discharges and death certificates, they found rural dwellers were about as likely as urban dwellers to report depressive symptoms or suicidal thoughts. And they were about as likely to *attempt* suicide. The proportion dying from a given weapon type was also about the same. An attempter hospitalized with an overdose in rural Maine, for example, was about as likely to die as one hospitalized with an overdose in suburban Boston. The primary difference was that people in rural areas were more likely to attempt with a firearm. Firearm attempts almost always end in death, and firearm attempts are more likely in gun-dense areas.

But why should that affect the overall suicide rate? After all, if you really want to die, a rope or an overdose will do the job. But here’s the key question: Do all suicide victims really want to die? Do all have a long-term, sustained desire that, if thwarted today, will persist until they find the weapon that works tomorrow?

We can’t ask suicide victims. But we can ask victims who nearly died from their attempts. The Centers for Disease Control and Prevention conducted a study among just such people, ages 15 – 34, and asked how much time →

Minority communities are impacted by suicide.

Cultural barriers can isolate minorities, impeding their integration into surrounding communities and preventing access to critical services.

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Fatal Connection (continued)

elapsed between the time they decided to commit suicide and the time they took action. For nearly a quarter, the answer was less than five minutes. Other studies have followed victims of nearly lethal attempts and found that ten to 20 years later, 90 percent or more had not gone on to commit suicide.

This, then, is one of the most important lessons in the newly burgeoning field of suicide prevention. Not all suicide victims have a sustained desire to die. For some, their impulse is short-lived, and what weapon they reach for during that impulse determines whether they live or die. If the weapon is immediately available, immediately lethal and irreversible, the result will be death.

Imagine a 16-year-old boy who storms out of the living room after a furious argument with his mother over the failing report card he brought home that day. If he reaches into the hall closet, takes out a loaded rifle, and pulls the trigger, a young life is tragically lost. But if there is no gun, in the ten minutes it takes him to find a rope and rig up a noose, his rage may have passed. Or in the 15 minutes it takes him to burst enough pills from their blister packs and start feeling their effect, he might change his mind. Or in the 20 minutes it takes for the garage to fill with car exhaust, a family member might find him and call 911.

If guns disappeared from the nation's homes or were always stored locked and inaccessible to more vulnerable household members, would our suicide problem disappear? No. But research suggests that the numbers would go down and many of the lives saved would be those whose impulses were most fleeting. For some, the best form of suicide prevention can be as simple as putting time or distance between the impulse to die and the weapon at hand. **A**

Catherine Barber is codirector of the National Violent Injury Statistics System at the Harvard Injury Control Research Center within the Harvard School of Public Health. She can be reached at cbarber@hsph.harvard.edu. For the National Research Council report cited here, see *Firearms and Violence: What do We Know?* National Academies Press, Washington, D.C. 2004 <http://books.nap.edu/catalog/10881.html>.

Adolescent **Maltreatment** - **Alcohol** and Teens Athlete **Alcohol and Drug Use** - Community-based **Prevention Models** - **Dating Violence** - **Depression Domestic Violence** and Youth - **Drunk Driving Countermeasures** - **Eating Disorders** - **Gambling Grief and Bereavement** - **Harm Reduction** - **Help Seeking Behaviors** - **Homeless Youth** - **Inhalant Abuse** - **Involving and Engaging Youth** in After-School Programs - Juvenile **Bullying** - Juvenile **Delinquency** - Juvenile **Sex Offenders** - **Lesbian, Gay, and Bisexual Students** - **Mentoring** - **Outreach to Hispanic Students & Their Families** - **Positive Youth Development** - **Post-Traumatic Stress Disorder Pregnancy Prevention** - **Resiliency** - **School Based Alcohol and Drug Use Prevention Models** - School and **Gun Violence** - School **Dropout Prevention Self-Injury** - **Suicide Prevention** - **Tattooing and Body Piercing** - **Teen Fathers** - **Teen Mothers Teenage Tobacco Use** - Youth **Gang Violence**

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- Ken Tullis, MD, founder of Suicide Anonymous,
author and attempt survivor
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authors and attempt survivors

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New FDA warning

The FDA has issued a second public health advisory suggesting an increased risk of suicidal thinking and behavior in adults taking anti-depressants. Data on adults will be analyzed in similar fashion to the FDA evaluation of risk of suicidal behavior in children taking anti-depressants. It may take up to a year to hear the final word from the FDA on this issue. For more see fda.gov.

National Suicide Prevention Week

American Association of
Suicidology (AAS)

Annual observance promoting awareness
and advocacy about suicide prevention.

September 4 – 10
suicidology.org



10th Anniversary National Awareness Event Suicide Prevention Action Network (SPAN USA)

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advocacy training and visits to Capitol
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suicide prevention.

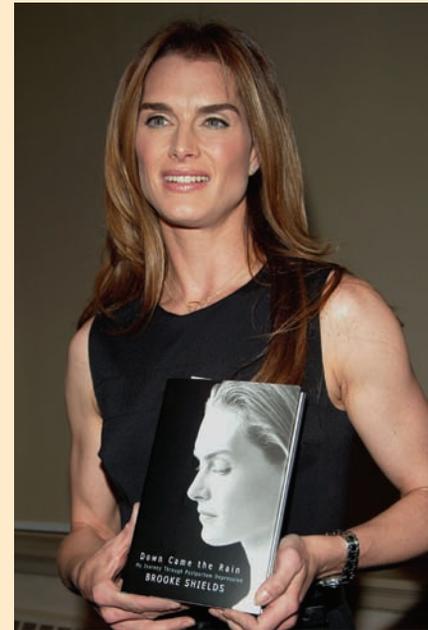
September 8 – 10
Arlington, Virginia
spanusa.org



World Suicide Prevention Day International Association for Suicide Prevention (IASP)

September 10
med.uio.no/iasp/wspd/menu.html

Actress **Brooke Shields** poses for photos at a book signing on May 9 in New York. Her new book has sparked a firestorm of attention on postpartum depression and use of antidepressants as part of a treatment plan.



© 2005 Getty Images Used with permission

Last word?

The debate may be just beginning on use of antidepressants to treat postpartum depression. Especially if you consider the so-called “war of words” launched this summer between actors Brooke Shields and Tom Cruise, sparked by Shields’ new book, *Down Came the Rain*, from Hyperion, which chronicles her journey through postpartum depression. Her comments were fired back at Cruise after his public and controversial criticism of

Shields’ use of drugs as part of her treatment plan after the 2003 birth of daughter Rowan Francis. In a June 25 appearance on NBC *Today*, Cruise was dismissive of psychiatry and claimed “no such thing as a chemical imbalance” in the brain. In days after the interview the American Psychiatric Association called Cruise’s comments “irresponsible.” Stay tuned.

CALENDAR

Depression and Bipolar Support Alliance 2005 Conference

September 10
Whippany, New Jersey
dbsalliance.org



Scaling the Summit: Suicidal Behavior in Diverse Cultures

International Association for Suicide Prevention (IASP)

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September 13 – 16

Durban, South Africa
med.uio.no/iasp/



National Depression Screening Day (NDSD)

Screening for Mental Health, Inc.

National outreach, education and screening event during National Mental Illness Awareness Week.

October 6

mentalhealthscreening.org

CASP Annual Conference Canadian Association for Suicide Prevention

October 17 – 19
Ottawa, Ontario

[thesupportnetwork.com/
CASP/conferences.html](http://thesupportnetwork.com/CASP/conferences.html)



First National Conference for Survivors of Suicide Attempts and Health Care Professionals

OASSIS (Organization for Attempters and Survivors of Suicide in Interfaith Services)

October 19 – 21

Memphis
oassis.org



LivingWorks Applied Suicide Intervention Skills Training (ASIST) for Trainers

LivingWorks Education

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October 24 – 28

Denver
livingworks.net

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October 26 – 28

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prevent.unc.edu



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American Foundation
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October 28 – 29

Kansas City
afsp.org

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Overview

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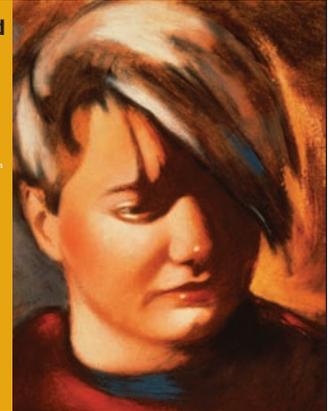
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Volume 1 Number 3

Youths and Suicide

The crisis of suicide among youth populations
Issues that impede treatment of children and teens

The role of schools
Colleges, high schools, elementary schools and promising programs

Substance abuse as an indicator
How to recognize a crisis



COMING IN SEPTEMBER

YOUTHS AND SUICIDE

Teens and young adults have some of the highest rates of suicide in our country. Don't miss this special issue that examines the crisis of suicide among youth populations, issues that impede treatment of children and teens and an update on use of antidepressant medications in youngsters.

also in this issue:

■ The Role of Schools

Promising school-based programs

■ Substance Abuse as an Indicator

How to recognize a crisis



Far too many Native youngsters live in homes broken by poverty, substance abuse, domestic violence, incarceration and suicide. Communities in Indian Country, scarred by centuries of historical trauma and oppression, bear a disproportionate burden of these dire ills. Intervening to halt this self-destructive cycle is vital if we are to meet the challenge put forth by the great Lakota leader Sitting Bull:

“Let us put our minds together and **see what life we can make for our children.**”

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Since 1977 the National Association for Rural Mental Health has worked cooperatively to improve delivery of mental health and substance abuse services in rural, remote and frontier regions. We promote the needs and concerns unique to rural

mental health, develop educational materials and sponsor an annual conference where rural mental health professionals can share knowledge and resources. To learn more about NARMH, visit us online at www.narmh.org.



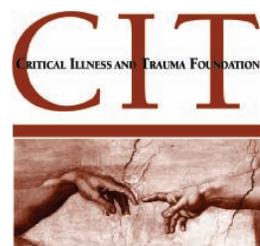
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Bozeman, MT 59715
Phone: 406.585.2659
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Managers of REMSTTAC, the Rural Emergency Medical Services and Trauma Technical Assistance Center, an initiative funded by the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services