

# **Working in Rural and Frontier Communities**

**December 13, 2006  
9:45 a.m. – 12:30 p.m.**

**Technical Assistance Meeting  
State/Tribal/Adolescents at Risk Suicide Prevention Grantees  
Bethesda, MD**

# **Working in Rural and Frontier Communities**

## **Presenters:**

**Ann Kirkwood, Idaho State University  
John Gale, Maine Rural Health Research Center  
Neal Horen, National TA Center for Children's Mental Health,  
Georgetown University  
Joyce Sebian, National TA Center for Children's Mental Health,  
Georgetown University**

**Moderator:  
Anara Guard, SPRC**

## Learning Objectives:

Participants will:

- Increase awareness and understanding of Rural and Frontier cultures and identity.
- Learn about key federal, national, and state activities in rural behavioral health and identify strategic leveraging opportunities with their grant programs.
- Identify opportunities and challenges for planning and implementing suicide prevention programs in rural and frontier communities such as: workforce development, changing demographics, aging populations, substance abuse, lack of behavioral health services, transportation etc.
- Discuss the importance of system development and sustainability planning.
- Share ideas, exchange knowledge, and develop networks to promote the successful implementation of suicide prevention programs that build upon the unique characteristics of each rural and frontier community.

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## Session outline

- **Welcome: Anara Guard**
- **Behavioral Health and Suicide Prevention in Rural and Frontier Areas:**  
*Joyce Sebian*
- **Grantee perspective and experience: Idaho:** *Ann Kirkwood.*
- **Public Health Approach to Understanding Rural Mental Health Delivery Systems:** *John Gale*
- Working in Rural and Frontier Communities: **Systems of care and State strategies and work underway:** *Neal Horen*
- **Rural and Frontier America- Culture - Facilitated discussion:** *Ann Kirkwood and John Gale*
- **Focused Discussion and interactive work** including networking around priorities and identification of strategies for further consideration.
- **Wrap up**

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Advancing Suicide Prevention: July/August 2006  
**Lessons from Rural America**

- “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.”

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Advancing Suicide Prevention: July/August 2006  
**Lessons from Rural America**

- “Yet the tight-knit nature of rural relationships may (also) 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.”

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

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## Behavioral Health in Rural and Frontier America

- **60 million** = # of Americans living in Rural and frontier areas
- **2<sup>nd</sup> leading cause of death** = rank of suicide as a cause of death in states with primarily rural populations, especially in states in the rural mountain west and Alaska.
- **4<sup>th</sup> most often identified health priority** = Importance of Mental health and mental disorders among state and local rural health leaders.
- **1,253**= the # of smaller rural counties with populations of 2,500 to 20,000 – nearly ¾'s of which lack a psychiatrist. 95% lack a child psychiatrist.
- **84/100,000** = rate for suicide in Nome County, Alaska – the highest rate of any county in the US.
- **Stigma** = more of an issue in rural areas than in urban areas i.e., “Where do you park your car?”
- **Underreporting** = lack of accuracy of surveillance data

*from Advancing Suicide Prevention: July/August 2006*

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## Behavioral Health in Rural and Frontier America

- The face of rural America is changing – rapid increases of new immigrant populations in rural and small towns in all regions of the country. *Carsey Institute 2006*
- Increasing complexity and richness of rural and frontier communities as well as introducing significant challenges
- Potential benefits – bringing new life to fading communities
- Culture matters. Community strengths not just pathologies
- Soaring suicide rates among Native Americans – 2.5 x the national average for Indian youth ages 15- 24.
- Farm population is experiencing high suicide rates- seasonally influenced (Gunderson et. Al. (1993)
- Rural occupations, such as farming, appear to be a risk factor in rural suicide (42-58 per 100,000).

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# **New Freedom Commission on Mental Health**

## **Achieving the Promise:**

### **Transforming Mental Health Care in America**

#### **Subcommittee on Rural Issues:**

We must address:

- **Accessibility,**
- **Availability, and**
- **Accessibility** (Larson, Beeson, & Mohatt, 1993; Mohatt, 2000)

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## **Federal Action Agenda**

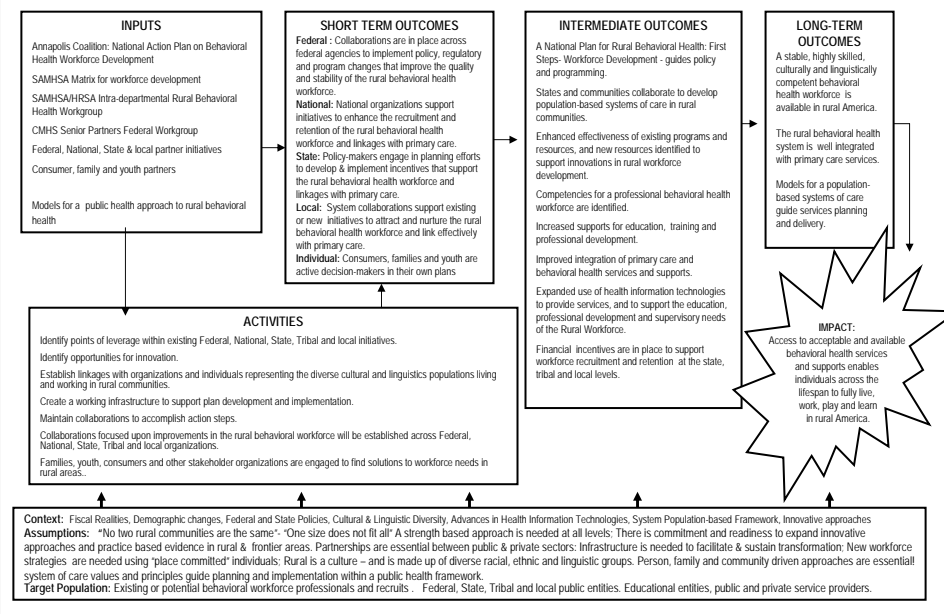
- **Development of a National Plan for Rural Mental Health**
  - **Highlights**
    - Web portal for SAMHSA Children's grant programs working in Rural areas
    - Integration of Primary Care and Mental Health
    - HRSA and SAMHSA collaborations – Rural Action Center and Suicide Prevention
    - Removing barriers to financing rural behavioral health care services
    - Collaboration across TA Centers
    - Targeting research funds through HRSA/NIMH to Rural
    - Partnerships with NASMHPD on workforce, rural, other
    - Partnerships with National organizations

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## Building a National Plan for Rural Behavioral Health: First Steps – Workforce Development

**Mission:** To develop a stable, highly skilled, culturally and linguistically competent behavioral health workforce.

**Vision:** To improve the availability, accessibility and acceptability of behavioral health services and supports in rural America.



## Contact information

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