AMERICAN PSYCHOLOGICAL ASSOCIATION

FEATURE

Reducing rural suicide

Psychologists are finding innovative ways to reach out to people in isolated communities.

By Rebecca A. Clay
April 2014, Vol 45, No. 4
Print version: page 36

All's not well down on the farm. Or up in the mountains. Or in the farthest reaches of Alaska. According to the U.S. Centers for Disease Control and Prevention (CDC), people in the nation's rural areas are at higher risk of suicide than their urban counterparts.

"Suicide rates tend to be high in rural areas in part because there is greater access to firearms, high rates of drug and alcohol use and few health-care providers and emergency medical facilities," says Julie Goldstein Grumet, PhD, director of prevention and practice at the Suicide Prevention Resource Center in Washington, D.C. "It's a lethal triad."

Now, Goldstein Grumet and other psychologists are finding innovative ways to keep rural residents from killing themselves. They're integrating mental health care into primary care as a way to fight the stigma about mental health problems and help-seeking that's prevalent in rural areas. They're equipping veterans with webcams and Skype-like software so that even the most far-flung can get mental health treatment. And they're focusing on rural populations at especially high risk, including American Indians and Alaska Natives.

Overcoming stigma

The 60 million people who live in rural America — 20 percent of the U.S. population — have limited access to psychologists and other mental health professionals, says K. Bryant Smalley, PhD, PsyD, director of the Center of Excellence for Rural and Minority Health at Georgia Southern University. The vast majority of Mental Health Professional Shortage Areas are rural, he points out.

But simply working to ensure there are enough psychologists and other mental health professionals to go around isn't enough, says Smalley, co-editor of the 2012 book "Rural Mental Health: Issues, Policies, and Best Practices."

"There are more barriers to psychological treatment in rural areas than can easily be put into words," says Smalley, citing stigma, long distances and transportation problems, lack of insurance coverage and nonexistent privacy as just a few examples. "Increasing access by recruiting additional providers is a key component, but only one aspect of a large, systemic challenge with improving overall utilization of psychological treatment in rural areas."

Fortunately, says Smalley, the situation is starting to improve.

"Innovations such as telehealth treatment provision and community-based interventions to decrease mental health stigma hold much promise in helping to address the suicide disparity in rural areas," he says. "Overall, the increased focus on developing culturally tailored interventions and programs that take into account the sociocultural realities of rural living will help significantly advance rural suicide prevention research."

The trend toward integrating psychological care into primary care is one effective way to overcome stigma in rural communities, says Jameson K. Hirsch, PhD, a member of APA's Committee on Rural Health and an associate professor of psychology at East Tennessee State University.

"In rural areas, there's stigma not only against mental health and treatment-seeking but against any external interferences," says Hirsch, adding that members of rural communities may adhere to principles of honor and "rugged individualism" — the belief that problems should be handled on one's own or within one's family. In southern Appalachia, in particular, he says, people can often be resistant to change and outside intervention.

But, says Hirsch, people in rural areas still go to their primary-care providers, which is where they bring up depression, anxiety and other mental health concerns that can contribute to suicide risk. That makes such settings important catchment sites for identifying and preventing suicide, says Hirsch. And that's why he's developing brief interventions that could help rural primary-care providers reduce suicide risk.

"About 50 percent or more of people who die by suicide contact their primary-care physicians in the month before the suicide," says Hirsch, citing a 2002 study in the *American Journal of Psychiatry* (http://ajp.psychiatryonline.org/article.aspx?articleid=175577) . That number is even higher in rural areas, he says.

Addressing historical trauma

Other psychologists are finding ways to treat populations that are at even higher risk than the rest of rural America.

American Indians are one group at especially high risk. According to the CDC, American Indians and Alaska Natives ages 15 to 34 have a suicide rate two-and-a-half times higher than the national average for adolescents and young adults, for example.

Historical trauma is a major factor, says Jacque Gray, PhD, past president of the Society of Indian Psychologists and another member of APA's Committee on Rural Health.

"The loss of land, culture, identity, all those things have really taken a toll and haven't been grieved," says Gray, associate director of the Center for Rural Health at the University of North Dakota.

The history of removing American Indian children from their parents and placing them in far-away boarding schools also contributes to suicide, says Gray. "That whole generation didn't learn how to parent," she says. "What they learned was how they were treated in boarding schools, so substance abuse, sexual abuse, child abuse, physical abuse, emotional abuse have just repeated generation after generation."

Add to all that poverty, lack of insurance and provider and resource shortages so severe that clinics are forced to turn away suicidal clients. And many suicide prevention efforts aren't well-suited to American Indians, says Gray.

What often happens is that people try to apply practices that work in other contexts to Indian country, says Gray. "It doesn't work," she says.

Fortunately, she says, practitioners in Indian country have developed promising practices. One is using traditional cultural ceremonies, such as sweat lodges, purifications, rites of passage, dancing and storytelling. These traditions can help individuals build a stronger sense of both individual and cultural identity and connect them to their communities — sources of strength that can help reduce suicide risk, says Gray.

Another promising practice is to broaden the focus beyond the individual at risk of suicide. One suicide hotline in Indian country gets entire families involved in phone calls, for example. Staff will also go out to communities rather than expecting individuals and families to come to them, a trip that can be more than 100 miles. Also important is training native psychologists, the mission of Gray's own Health Resources and Services Administration-funded Seven Generations Center of Excellence in Native Behavioral Health.

Bringing care to vets

Rural veterans are another group at heightened risk of suicide.

Forty-four percent of vets returning from Iraq and Afghanistan come home to rural ZIP codes, says psychologist Mark F. Ward, PhD, director of the Oregon Rural Mental Health Team at the Portland Veterans Affairs Medical Center in Portland, Ore.

But while the VA has 160-odd medical centers and about 1,000 community-based outpatient clinics, many vets must still travel long distances to get care. Most VA clinics have very small mental health teams if they offer any mental health services at all; community-based mental health centers may not have the expertise to treat post-traumatic stress disorder, military sexual trauma and other suicide risk factors common among vets. Plus, the stigma about mental health disorders and treatment is especially strong in the military.

"We often see them two years after they're back, when they've lost their jobs, their [spouses] have kicked them out and now they're in real trouble," says Ward. "We're trying to head off all those problems."

To achieve that goal, Ward and colleagues established the Oregon Rural Mental Health Team in 2009 to provide high-quality mental health services to even the most isolated veterans in the state. The solution? Technology.

Mental health providers based in Portland connect with veterans in the VA's community-based outpatient clinics, using webcams and videoconferencing units that work like Skype but with heightened security. Because many vets live far from clinics, the team can also mail webcams to veterans for use in their own homes — the first time the VA has granted such permission, says Ward, adding that the team will soon start providing tablets and notebooks to veterans who lack access to high-speed Internet but do have cellular coverage.

As a result, the state's rural veterans can now receive medication evaluation and management, individual and group psychotherapy, couples counseling and other services no matter where they are. And, says Ward, nobody has to know they're seeking help because it can happen in their own living rooms.

"A variety of mental health services can now be piped into rural, isolated communities to provide care to vets who would have never received care without it," says Ward, adding that there are practical as well as psychological ramifications. "In 2013, we saved veterans 826,290 miles — the equivalent of three-and-a-half trips to the moon — and an estimated $161,126 worth of gas."

Preventing access to lethal means

In addition to focusing on what's going on in suicidal clients' heads, psychologists must also focus on what's going on in their environments, say Hirsch and others.

Take firearms, for example. While firearms are a common suicide method across the country, says Hirsch, the rate of suicide by firearms is much higher in rural areas.

"Rural individuals often grow up around guns and have them in their homes," he says, explaining that rural residents often keep guns for hunting and agricultural needs, recreation or simply because there's a culture of guns in their areas. "There have not been any efforts or studies to examine acceptable ways of means restriction in these communities, many of which have a pro-firearm stance as well as some mistrust of external interference." Hirsch and Kelly Cucrowicz, PhD, an associate professor of psychology at Texas Tech, are hoping to answer that question in proposed research.

In the meantime, the Suicide Prevention Resource Center offers a course called "Counseling on Access to Lethal Means" (CALM). Available online (http://training.sprc.org/course/description.php#course3) , the free, self-paced course teaches those who already have training and experience in mental health counseling why restricting access to guns and other methods must be part of a comprehensive approach. It also offers guidance on how to ask clients about their access to lethal means and how to work with both clients and families to reduce that access, including concrete tips such as keeping only non-lethal quantities of medications in the home and storing guns with trusted individuals, firearm storage facilities or the police department.

"People in the suicide prevention world understand that you need to ask if someone has access to guns, but they need to know what to do next when someone says, 'Yes,'" says Goldstein Grumet.

Rebecca A. Clay is a journalist in Washington, D.C.

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http://www.apa.org/monitor/2014/04/rural-suicide.aspx