Introducing the Rural Suicide Prevention Toolkit – 12/11/19

Kristine Sande: Hello everyone. I'm Kristine Sande, the Program Director for the Rural Health Information Hub. I'd like to welcome you to today's webinar on Rural Suicide Prevention. I'll quickly run through some housekeeping items before we begin.

We hope to have time for your questions at the end of the webinar. If you have questions for our presenters, please submit them 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've provided a PDF copy of the presentation on the RHIhub website, accessible through the URL on your screen, and we will also send the link via the chat function.

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And now it is my pleasure to introduce our speakers for today's webinar. Dr. Carrie Henning-Smith is the Deputy Director of the University of Minnesota Rural Research Center and is an Assistant Professor in the division of Health Policy & Management at the University of Minnesota School of Public Health.

Dr. Henning-Smith has led multiple research projects at the Rural Health Research Center, with a wide range of topics, including the social determinants of health, access to quality of care, and aging in long-term care. She has also led the development of multiple RHIhub toolkits, with the most recent focus on rural suicide prevention. She was a 2017 Rural Health fellow with the National Rural Health Association and serves as the current Editorial Board Chair for the Journal of Rural Health. She received her MPH and MSW from the University of Michigan and her PhD in Health Services Research Policy & Administration from the University of Minnesota.

Scott LoMurray is the Deputy Director of the evidence based Upstream Production Program, Sources of Strength. Scott has helped developed Sources into one of the most rigorously evaluated and widely disseminated best practice prevention programs in the country. Scott has partnered on research initiatives with the University of Rochester on the National Institute of Mental Health funded National Peer Leadership Study, with Stanford University researching prevention impacts in communities that have experienced suicide contagion, and most recently with the Centers for Disease Control and Prevention and the Colorado Department of Public Health and Environment on the effect of shared risk and protective factor approach on sexual violence outcomes.

Scott has a graduate degree with an MBA in Social Enterprise. He is a foster parent, a frequent trainer, speaker and Upstream prevention evangelist. He lives in Lakewood, Colorado with his wonderful wife and three exceedingly adorable children.

Catherine Barber is a Senior Researcher at the Harvard School of Public Health's Injury Research Center, where she led the effort to design and test the pilot for the CDC's National Violent Death Reporting System. She is the founding director of Means Matter, a project to disseminate research and interventions aimed at reducing a suicidal person's access to highly lethal suicide methods. She is the recipient of the American Foundation for Suicide Prevention's Allies in Action Lifetime Achievement Award.

Adam Swanson provides consultation support to state governments, tribal nations, and university systems as the Senior Prevention Specialist at the Suicide Prevention Research Center, which is operated by the education development center. Adam is a member of the National

Suicide Prevention Lifelines Consumer Survivor Advisory Committee and a 2018 Lambda Literary fellow. Adam previously worked at the National Council for Behavioral Health, Mental Health America, and the United States Senate. He holds a Masters of Public Policy from George Mason University, and is an alumni of George Washington University's LGBT Health Policy and Practice Graduate Certificate program.

And with that, I will turn it over to our first speaker, Dr. Carrie Henning-Smith.

Carrie Henning-Smith: Thank you, Kristine. I am delighted to be here today to talk about the Rural Suicide Prevention Toolkit. I hope that this leaves all of you with good information that you can go and use and apply in your own rural communities. And I know that the speakers that you'll hear from after me will give you some really tremendous examples.

So the Rural Suicide Prevention Toolkit went live earlier this year, and it's available free of charge at the Rural Health Information Hub website. The toolkit itself was funded by the Federal Office of Rural Health Policy, and I want to thank my collaborators at the NORC Walsh Center for Rural Health Analysis, and my collaborators at the University of Minnesota Rural Health Research Center. I also want to thank the National Organization of State Offices of Rural Health and the National Rural Health Association for their supports.

The Rural Suicide Prevention Toolkit and all of the other evidence based toolkits that are housed on RHIhub are funded through the outreach authority of section 330A of the Public Health Service Act. And the Outreach Authority Grantees seek to expand rural healthcare access, coordinate resources, and improve quality of health in rural areas. The goal of this toolkit and of all of the other toolkits on RHIhub is multi part. It's first to identify evidence based and promising community health programs in rural communities, to study the experiences of these programs, including facilitators of their success, what makes it work for them, and to disseminate lessons learned through the evidence based toolkits.

If you haven't yet had a chance to check out these toolkits on RHIhub, I strongly encourage you to do that. I think you'll find them to be a wealth of information. Not only on suicide prevention, but on a range of other critical health topics. But today we are talking about suicide in rural communities, and why are we talking about that? Rates of suicide and suicide attempts are increasing across the country, and rural communities have higher rates of suicide and suicide attempts than urban areas do. Suicide doesn't impact all people equally. We see that people who face the highest risk of dying by suicide include men and middle aged adults, although certainly people of all ages and genders are vulnerable.

Suicide is also more common in counties with lower social cohesion, more gun shops, and more veterans, among other risk factors. And there are various and complicated challenges to preventing suicide in rural areas that are unique and different from the challenges faced in preventing suicide in urban areas. These include the fact that rural areas have fewer healthcare facilities. In rural areas, many of them, the majority of them, face mental healthcare workforce shortages. Rural areas have limitations and constraints around transportation and infrastructure, including access to broadband internet and other technologies. Many rural areas face financial constraints, including lower insurance rates and chronic economic stressors. Rural areas have higher rates of gun ownership, and guns are the most lethal means of suicide. And rural areas face increased mortality and poorer health outcomes for most other causes of death.

So that's a gloomy picture, and I want to leave everyone with hope and a promise that there is something that can be done about this. That's the whole goal of this toolkit, and that's what the other speakers will be sharing today too. This is what the Rural Suicide Prevention Toolkit looks like on RHIhub. If you haven't had a chance to see it yet, you can see the URL, really tiny on the

top of the screen there, and this is what the cover page of the toolkit looks like. All of the toolkits on RHIhub are formatted in a similar way. So if you've used one before, this will look familiar to you. If you haven't used one before, I think you'll find it to be really intuitive to navigate.

To put these toolkits together, we follow a standard method. We first review the Federal Office of Rural Health policy grantees to see what grantees are doing work in this area. And we also broaden, and we look in the literature, both the academic literature and the gray literature, to see who else is doing really good work in this area, what is the evidence for preventing suicide in rural places, and what are some promising models.

Once we've identified some of those, we conduct interviews on the telephone with programs who are addressing rural suicide prevention and with experts in the field. And then we develop this toolkit that has resources about evidence based and promising models for suicide prevention, how to implement, fund, sustain and evaluate programs, and successful examples that are operating in rural communities today. And there again is the URL, in slightly bigger font, so that you can easily navigate to the toolkit.

As I said, all of the toolkits are organized in a standardized way. This is what the organization of the toolkit looks like. It's organized into seven distinct modules. And I'm going to show you just a little bit on the program models, Module Two here. We identified multiple ways that rural communities can begin to address suicide prevention. There's not necessarily one right or wrong place to start. There are many options here.

Among those options, rural suicide prevention can use these various program models. Public education and awareness campaigns, school based programming, crisis lines or hotlines, harm reduction, ways to lessen harms and reduce risks, screening tools, both in clinical settings and in other settings, fostering community connectedness and addressing social isolation, and conducting specific suicide prevention trainings. You'll be hearing examples of some, but not all of these today. But the toolkit contains more detail on each of these models.

And if you're in the rural community, and you're thinking that this is something that you'd like to do, you'd like to create a program that's going to address rural suicide prevention, there are several pieces that need to be in place before you implement that program. First, you want to ensure that all relevant stakeholders are at the table. You want to consider the target population. Who is it that you are most concerned about reaching, and how do you best reach them? Make sure that they have a voice in the process. Develop a plan from the outset for implementation, evaluation, and sustainability. And disseminate the results. Please please share your results from the program so that others might learn from them. RHIhub is a wonderful place to disseminate your results, and you'll see a lot of program examples throughout the website there.

Important to keep in mind as you are thinking about rural suicide prevention. Suicide seems like a personal tragedy. It is, indeed, a personal tragedy. But beyond being an individual and a family crisis, it has wide reaching community and societal implications. And everyone can have a role in suicide prevention. When considering prevention, it's important to be clear about where, who, and with whom you will intervene. And there is hope. I want to leave you with that, most importantly today. Promising models and programs do exist. There are things that we can do here. And you'll hear about those from our other presenters today.

So with that, I want to thank you for your time and for tuning in, and I want to pass it on to Scott LoMurray, who's going to share a wonderful example from Sources of Strength.

Scott LoMurray: Yeah, so my name is Scott LoMurray, and I am the Executive Director of Sources of Strength. And Sources of Strength was actually started by my dad, so you are listening to the voice of nepotism here. We've got a bit of an atypical father-son business. He'd been the Director of the Police Youth Bureau in North Dakota for about 16 years. And as a part of that position, he was involved in a lot of crisis response work and a lot of intervention work. And part of that job, over about a three-year span of time, he ended up going to over 30 funerals of teenagers. And some of those were drunk driving accidents, and some of those were accidental drug overdoses. And quite a few of those were suicide deaths. And he came away from that experience with this really profound sense that we could do more to get in front of this issue. That everything we were doing felt very crisis driven and reactive. And he has a really strong sense that we could do more to get ahead of it.

And that was kind of the genesis around the development of thinking about Sources of Strength. And there's kind of this common parable that we tell in the mental health space, and public health space, that I'm sure many of you are familiar with, about this woman that lived along the waterfall. You know, situated along this river right near a waterfall. And every day she takes a walk on the water's edge. And one day she's taking a walk and she hears this shout. And she looks and she sees somebody caught up in the current, about to go over the waterfall. And so she dives into action, swims out there, pulls them to safety, gets them to shore and does CPR and ends up saving their life. It's this really heroic thing. And the next day she's walking along the water's edge again and she hears another shout, and she looks, and she sees somebody else caught up in the current. Dives in there, pulls them to safety. As she pulls them to shore, she hears another shout.

And they start to realize, man, there's all these people caught up in the current, about to go over the waterfall. And so they get organized. And they train lifeguards. And they build watchtowers. And they train the whole community in CPR. And they're able to save a lot of lives. But unfortunately, they're not able to save everybody. And one day the woman starts walking upstream, and the people say, "Where are you going? We need you here? It's all hands on deck right now." And she says, "Well, I'm going to see if I can keep some people from falling in the river."

And that's what we mean when we talk about upstream prevention. But the truth is, most of the time when we use the word "suicide prevention," what we're typically talking about is actually suicide intervention. It's identifying people who are already in crisis, who are already at risk, and trying to kind of intervene in that crisis moment, in that waterfall moment in their lives. And trying to get them to the proper mental health referral. And that is incredibly important work. Please don't hear me saying that that isn't what we should be doing. We absolutely need to be doing that kind of work.

But we were really filled with the sense that that's not a comprehensive model for what prevention can look like. And really asking ourselves, what does it look like to move upstream? How do we keep people from falling in the river in the first place? How do we help people get back out of the water while it's still relatively tranquil, before it's this full blown kind of crisis event in somebody's lives? How do we increase help seeking and connectedness, and belonging, and protective factors, and healthy coping strategies and resilience, and all of these things that we know to be protective?

And that's really the primary mission of Sources of Strength, is looking at, what does it look like to move upstream and do those things. And we've been really fortunate to see outcomes in those areas around increasing help seeking, and connection, and protective factors, and coping, and resiliency. But what we've learned in that process is that that also makes us more effective in our intervention work. That if we are shifting the culture around help seeking, that asking for

health is kind of courage and bravery and not a sign of weakness. Getting help for a friend, you're being a good friend, not a snitch. That if you get an adult involved, they could be helpful, not just complicate things. When that kind of culture change is happening, we're able to get to people that are struggling much sooner and much further upstream. And we're actually getting more people that are in the water to our attention, because we are shifting those help seeking norms and breaking down those codes of secrecy and silence that can be really prevalent in our society, especially in middle schools and high schools.

And then we also learn that we have an impact in the realm of post-vention. That if there is a loss, if there is a tragedy, if there is some sort of trauma that hits a community, we know that that leaves people feeling more vulnerable and at heightened risk. And what we've learned is that not only can we help utilize our peer team to kind of be our eyes and our ears and look out for people that might be struggling, but we can also really utilize them to help the school or the community lean into their strength and move through that trauma, move through that tragedy in a way that's healing. In a way that's helpful.

And that trauma, that might be a suicide death, or it might be a car accident, or a beloved teacher that died of cancer, these things that hit us in life. And these ups and downs that can kind of increase some risk and some vulnerability. But that really being able to utilize that kind of process to help in the recovery and the resilience process. So that was really the primary driver on the development, the genesis of Sources of Strength was asking, how do we get upstream in our prevention efforts.

And then the other thing was we were trying to really bridge some of the gaps that we were seeing in prevention space. And so one of those gaps that we were seeing is that, a lot of things were really risk focused. And so the primary strategy was to come in, and they would talk about risk factors and warning signs, and try to educate people around these things. And in our experience, when we went around and we talked to groups of young people and we asked them, "Hey what are the risk factors and warning signs for suicide?" Pretty much everywhere we went, they could just fire off those answers. But when we asked them, "How does somebody who's suicidal get better? How does somebody who's addicted to drugs or alcohol, how do they recover? How does somebody who's been abused, or harassed, or raped, how do they get through that?"

And it was really crickets. And we started to realize, man, there's just not a lot of dialogue happening around, "what does recovery look like? What does resiliency look like? What does it look like to meet the adversity and the difficulty and the ups and downs that life will throw our way with strength look like?" And so, while we do still talk about risk factors and warning signs, we spend about 90% of our time talking about strength and protective factors, and resiliency, and all of these things that really help us navigate and get through those difficult times in life and really focusing on talking about those, and developing those, and cultivating those in our lives and in our community.

And then we thought, a lot of programming, I think the prevention field in general, and sometimes the suicide prevention field in particular, can sometimes get stuck in this sad shock trauma paradigm, especially around the messaging. So it can be a lot of shocking statistics, a lot of sad imagery, a lot of traumatic death stories. And what we were finding with some of student that themselves were feeling suicidal themselves, you know, and hopeless, they were seeing that sad image, hearing that shocking statistic, hearing that traumatic story, and they were saying, "Yeah. That's me." And it was reinforcing a sense of inevitability and hopelessness, and could actually contribute to causing harm. And obviously the last thing we want to do is cause harm. And we really want to be able to help people.

And sometimes even with the use of statistics, while they may be accurate statistics, they could be a bit misleading. And what we were seeing contributing to maybe a false normalization effect. Making suicide seem more common than it truly was. When the truth is, the vast, vast, vast majority of people that struggle with feeling suicidal do not go on to die by suicide. That recovery and resiliency are the true norm, but that's often not what's communicated when we just throw out statistics about suicide rates or attempt rates or things like that, that can actually kind of be normalizing it.

And so actually trying to normalize recovery. Trying to normalize strength. Trying to normalize help seeking, and hope, and the possibility. So that a student that is feeling that way can hear these stories of hope and of connection and of recovery and say, "Yeah, that could be me." And really creating a counter narrative in the way that we're talking about some of these issues.

And then the last thing we were seeing was that a lot of the work that was being done was really adult driven, and we're doing teen suicide prevention without any teenagers. And we felt pretty strongly that, if we're going to move the needle into high school, we have to have high school students involved. And so bringing in that peer component.

And so really quickly, the model is we come in and we work with supportive, caring, connected, positive adult advisors. We've joked that we've had caring, connected, cynical, pessimistic adult advisors and it doesn't work as well. Because what we're really trying to do here is get a public health culture change initiative off the ground. And using teenagers, that's not easy and it doesn't happen overnight. And actually that positivity is really important to be able to work through those growing pains. But we partner students and adults together. We really feel like one without the other lacks prevention power. And that by combining the two together that we have more impact.

So training a group of supportive adult advisors, a group of diverse peer leaders, representative of the student body. Really interactive, engaging trainings. But then that team, the power of the program isn't in the training. It's not a one shot assembly style model. The power in the program is in that team continuing to work and meet together over the duration of the year, over multiple years, working on strategic messaging, public health campaigns that are engaging the broader population into interacting with their strengths, interacting with their protective factors, developing their own help seeking pathways and healthy coping strategies to really create this kind of public health positive culture change initiative in communities.

And then we use that with this idea of social network theory. And I won't go too into the weeds into some of these social network slides here, but, suffice it to say we all exist inside these social networks. And you all have your own social network. Your friends, and your family, and your barista, and the people that you do life with. And we understand intuitively that things can spread through a network. We think about this when we think about a disease process. If I had some terrible contagious disease, y'all would be thankful I'm on the phone today and not in person. Because if we were together, you and your friend and your family and your barista would all be at great risk of catching it. Even though I've never met a single one of those people. We understand that things can spread through a network.

And what we've learned is that attitudes and behaviors and beliefs can spread through networks in remarkably similar ways. We've seen this with a lot of negative things like binge drinking and smoking behavior, and even obesity and things like that. But what keeps me doing this job every day is we've learned that positive things can spread through a network in the same way. Things like resiliency, and hope, and connection, and protective factors, and healthy copying, and healthy help seeking. These kinds of things can spread through a network. And so we're not training students to be junior psychologists and counselors, to pull up a couch outside of their

locker and start admitting patients, and fix all of their friends' problems. Rather, we're training them to be these agents of social change. That they can really become the Patient Zero of an epidemic of health, of a contagion of strength within their school and within their community. And then also equipping them to be connectors to help. They're not the source of that help only, but they're a part of that process and they can connect people that are struggling to help.

And so really taking that sort of social network approach to what we're doing. And again, for time's sake I won't get too into the weeds on some of the social network data, but this is a slide from our NIMH study that we've been doing, where we're really analyzing these social networks to try to figure out how do these messages and these norms and things spread through networks? Who are the most effective peer leaders? What are the most effective text messaging? What helps and hinders these kinds of approaches in communities?

And so a lot of really fascinating insight, and really fortunate to have worked with a lot of different researchers and entities to establish an evidence base. Again, I'll skip through this for time's sake. But Sources of Strength is an evidence based best practice program, shown impact on both our peer leaders and also the school population level. And this initial study that was published in the American Journal of Public Health is the first study to show that you could use peer leaders to change population level health norms associated with reducing suicide risk.

And really thankful to have been able to participate in a lot of ongoing research. That we really have a commitment to an evidence base, a commitment to research. That we feel like we never have a finished product or program. It's constantly improving based upon what we're learning in the field and what we're leaning through our evidence and our research partnerships. And the one that I just wanted to touch on real quick here is this partnership with the CDC and the Colorado Department of Public Health & Environment and several research partners.

To really evaluate this idea of the shared risk and protective factor framework, which is essentially this idea that it's not just the risk factors for suicide are over here, and then the risk factors for substance abuse are over there, and violence is over there. We understand that these things have shared risk factors. They also have shared protective factors. So if we do our job well and we move upstream, and we increase these protective factors, and resiliency, and healthy coping, and connection, and help seeking, and all of these things, that we're going to have an impact on suicide. But we can also see an impact on substance abuse, on violence, on truancy, on grade point average. It's a lot easier to focus on your signs when you're not constantly in crisis. That at its core, at its heart it's a wellness model. Ultimately our goal isn't just to keep people alive, it's to help people really live healthy lives. And it's that idea that a rising tide lifts all boats. That we can actually move upstream, and focus on health, focus on connection, focus on wellness, and have these protective benefits further downstream.

And so this is the Sources of Strength wheel. And I'll kind of end on this slide. These eight different protective factors that we spend a lot of our time talking about. In public health and in mental health and in community work, we tend to spend a lot of time talking about the leading causes of death. And that's understandable, and that's important. But I think we also need to spend more time talking about the leading causes of life. And what are the things that help us navigate the ups and downs in life, and how do we tap into that individually and collectively to create strength and resiliency in our communities.

So I'll leave it there and I'll pass it off to Cathy, and then certainly we'll be hanging around at the end to answer questions. And if you want to learn more about Sources of Strength, you can certainly find out more on our website at SourcesofStrength.org. So, I'll stop and I'll pass it off to Cathy.

Catherine Barber: Hi. I'm Cathy Barber. Thanks for having me on this webinar. I really appreciate it. Ten years ago, most suicide prevention groups weren't talking about guns, and most gun groups weren't talking about suicide. Even though gun owners and their families die by suicide at higher rates than non-gun owners. And it's not because they're more likely to have a mental illness, or to think about suicide, or to attempt suicide, it's that they're more likely to die should they attempt because their attempts are more likely than non-owners to involve a gun. And so it's a modifiable risk factor. And yet the movement was stuck, kind of paralyzed. Suicide prevention groups couldn't think outside the gun control box and said, "Hey, guns are too controversial an issue for us to touch." And for gun groups, suicide just wasn't on their radar.

And yet, here's a modifiable risk factor. So how do we reach gun owners at risk of suicide? Do we do it with anti-gun agenda? By saying, "Guns are bad and you shouldn't have them." Well I'd say no. I'd say that's sort of like sending an anti-gay group to do a suicide prevention campaign in the gay and lesbian community. If you don't trust the messenger, you don't trust the message. And you're likely to get the message wrong. And what I've learned over the past ten years is that, when approached as part of the solution rather than vilified as part of the problem, most gun owners, most gun owner groups are eager to help and will really offer creative practical assistance.

And what's the message? Well let's say that a person is revealing that they or someone they love is at risk for suicide. And whoever they're speaking with, whether it's a friend or clinician or a hotline worker or the defense attorney who's handling the person's third DUI, I wanted it to occur to that person, in addition to other helpful things like saying, "I care," and "Let's see if we can get you some help," is to say, "Hey, is there somewhere you can store your guns for now, until things get back on track?"

And I think firearm instructors, opinion leaders in the gun owning community like firearm instructors and gun shop owners and people who write for Gun and Ammo type magazines, they're great messengers for this message. Because when you think about what are the kind of values that groups like this typically have? It's really strong values around a safety culture, around firearm responsibility, around protecting the family and neighbors looking out for one another. And those are values that dovetail really well with suicide prevention. And expanding gun groups' focus from preventing accidental gun deaths, which number about 500 a year, to preventing suicides, firearm suicides, which number about 23,000, is really a natural fit.

And when it comes to this work, we're really pushing on an open door. This work had its birthplace back in 2009 in New Hampshire with the Gun Shop Project, and it's really spread since then all around the country with different iterations. And so let me give you a couple of examples. Starting in New Hampshire with The Gun Shop Project, which, that began back in 2009 when a small group of us gun retailers and suicide prevention folks, under the banner of the New Hampshire Firearms Safety Coalition, began meeting together to figure out whether there was a role that gun shops could play in preventing suicide. And what we did was we created materials aimed at day to day customers. Posters to let customers know that if they're worried that a loved one is at risk for suicide, that they can offer to hold on to their guns, which is generally fine under New Hampshire law. Or in other ways, put time and distance in between them and their guns and call up a hotline to learn about other ways to help.

We also created brochures that situate suicide awareness as a basic tenant of firearm safety. So the 10 usual commandments of firearm safety, you know, things like, "Be aware of your target and what's beyond." We added an 11th, which is, "Keep household guns from those at risk for suicide until they've recovered." After we sent out the materials, coalition members made unannounced visits to all of the shops in the state and nearly half were displaying at least one of the materials, which is really great uptake for a topic like suicide prevention.

Another example is in Utah. There, 85% of firearm deaths are suicides. Suicides far outnumber homicides, and suicides have been rising. So a Republican legislator had contacted me in 2014 looking for ideas on how to stem the tide. And he was worried I'd only recommend gun control legislation. And instead I talked about the approach we were taking in New Hampshire and elsewhere to create gun owner friendly materials. And applying sort of a, "Friends Don't Let Friends Drive Drunk," approach to the issue of guns and suicide.

So the legislature really embraced this approach and put the state mental health agency in charge. And so Kim Myers put together a committee to advise on this work, and it includes a lot of the players you would expect, but also some you might not expect, like firearm instructors and some people from the Utah Shooting Sports Council, which is the state's largest gun lobbying group. The Shooting Sports Council folks were convinced by the data that they needed to expand their mission to protecting gun owners from suicide.

I had pitched the idea of creating a firearm safety module for use in courses that are required of people who are seeking a Utah concealed firearm permit. And I suggested that the module be voluntary. And the head of this shooting sports council looked down, and kind of frowned at the data, and looked up and said, "You know, if the data were any different I'd agree with you, but I think it needs to be mandatory." And so we worked together on creating the module, which is now available. We also surveyed over 1,000 firearm instructors. And after showing them a draft of the module, we asked if they'd be interested in teaching it. And two thirds said yes. Only nine percent said no. Which is pretty incredible, given what a new topic this is for most of them. And we're currently evaluating the impact of the course.

So a couple of years later, a Democrat, which is a rare bird in the Utah legislature, introduced budget language to fund a study for guns and suicide in the state. And a proposal like that would normally be dead in the water. But in this case because of the trust that had built up on this issue, Clark Aposhian, the head of the state gun lobby testified in support. So we got involved in doing the study and what we did was link together two years' worth of data on people who had died by suicide with other data sources to learn about potential opportunities for prevention.

So I want to spend these last couple of minutes highlighting some findings and how they've sparked prevention work in the state. So, how many suicide decedents could pass a background check for legal firearm possession on the day that they took their life? Well the answer was nine out of 10, in fact, 92% for people who used guns in their suicides. And that's because the bar for legal firearm ownership is really quite low, unless you've been convicted of a felony or a domestic violence misdemeanor, of have been involuntarily hospitalized. So this really underlines the important role of friends and family and clinicians and gatekeepers in persuading those at risk to store guns away from home or inaccessibly until they've recovered.

Within six months of release of the report, the legislature had established a two-million-dollar public private matching fund to conduct a social norms change campaign promoting safer firearms storage and suicide awareness. One of the largest donors is the Shooting Sports Council, along with Intermountain Healthcare and the Church of Jesus Christ of the Latter Day Saints, the Mormon Church there.

This PSA, this is a 30 second PSA. We weren't able to load it up, so let me just walk you through it. The guy's shooting at the range, he sits down his gun and turns to the camera and says, "Last year, I was at my worst, suffering from depression. A couple of my friends stopped by the house and said they were worried about me. Said they'd feel a lot better if they could hold on to my guns. I think those guys saved my life." And then he turns back to shooting.

Building on what Adam was saying about, you don't want to be messaging around suicide and death. This is one of the best PSAs I've seen on suicide prevention because it's such a great example of resilience and recovery. It doesn't wait for the person in distress to disclose suicidal thoughts or to ask for help, but it shows a nice, bro way to show support and to truly increase safety by offering to hold on to a person's guns when they're in trouble.

Okay, how many men who took their lives with a gun had a concealed firearm permit? Turns out it was one in four. Suicide prevention lethal means safety had just been added to the concealed firearm permit classes. But now, as a result of the report, it was also added to the application process and the renewal process. When you go to apply, when you go to renew, you view the materials on suicide prevention and safe storage.

What percent of rural youths' gun suicides are by rifle or shotgun as opposed to handgun? Over 62%. And the state now provides cable locks to gun shops to accompany all sales of rifles and shotguns. Most guns used in suicide among adult and even some of those hunting guns used by kids are owned by the suicide decedent themselves. So the messaging that we promote around gun safety can't just be, "Be sure all guns are locked." Obviously we need to be aware of who has the key or the combination. So when a household member is struggling with a mental health or a substance abuse problem, or is in serious pain over a life crisis, the message needs to be to store guns away from home or to take other steps like changing the combination and keeping it from the person at risk, most often who is the gun owner, until they recover.

And that's the approach that the state is taking and training its mental health workforce in a free online training called CALM Utah, or Counseling on Access to Lethal Means. Which is produced by Intermountain Healthcare for the Utah version and was produced with Means Matter and with Aline Frank of CALM. Thirty years ago, no one had heard the phrase, "Designated Driver," or, "Friends Don't Let Friends Drive Drunk." And now, really everyone has. And by 2025, I'd like us to set a goal that for clinicians and gatekeepers, discussing gun access, reducing access to guns, is second nature. It's just, of course I would bring that up. It's not only second nature but it's comfortable for both the clinician and the client.

And also for the gun owning community that every class, or website, or brochure that covers firearm safety mentions keeping guns from those at risk of suicide until they've recovered. That the spaghetti dinner at the sportsman club or articles in gun magazines or in hunting newsletters, that from time to time they cover this concept. Because really the more that the gun owning community is having these conversations outside the clinicians' office, the easier it's going to be to have these conversations inside the office.

So I invite you to visit the gun owner pages on that MeansMatter.org for training materials, or contact me if there are things that I've mentioned that aren't on there. And also for the national version of CALM Online, visit the SPRC's website. And speaking of SPRC, up next now is Adam Swanson.

Adam Swanson: Thank you Cathy, and I want to thank the Rural Health Information Hub for having me as a guest presenter at today's webinar. As Cathy mentioned, I work at the Suicide Prevention Resource Center as a Senior Prevention Specialist. I am also a member of the National Suicide Prevention Lifelines Consumer Survivor Advisory Committee. I need to put a disclaimer in here that SPRC is a federally funded technical assistance center funded by HHS, Health and Human Services, and the Substance Abuse and Mental Health Services Administration. The views, opinion and content that I share today do not necessarily reflect the perspectives of those institutions.

So with that, I'm briefly just going to provide an overview of SPRC as a resource center, and then I'm really going to try to get into some of the nuts and bolts of SPRC's model for effective suicide

prevention. We'll get into this, but there are three parts to that approach, and I think for this audience, really thinking about the comprehensive approach element is going to be important, but I hope that we have time to touch on each part of the effective prevention model. And then finally, I'll highlight some ways that you can further explore the effective prevention model unique to your situation, your context, your organization and your positioning, wherever you are in the country.

I hope you most of you on the call are familiar with SPRC, but we have been funded since 2002 by SAMHSA. We are operated by a global nonprofit called The Education Development Center. We provide consultation and support for suicide prevention, federal grantees, state leadership, tribal nations, college campuses, and health and education systems. We also provide secretariat support for The National Action Alliance for Suicide Prevention. Our website includes a library of programs with evidence of effectiveness. We have a weekly Spark newsletter that I encourage folks, if you're not already receiving that newsletter to sign up as it includes regular information on the latest news, research and resources related suicide prevention.

Our website also includes guidance on how to really champion effective prevention model, as well as online, self-paced learning modules, toolkits, fact sheets and guides. So I really encourage folk to think of SPRC as one of the central one stop shops for all things suicide prevention related. That can definitely compliment all of the resources that have presented on today's webinar.

So this is a basic graphic that really explains through images the effective prevention model. So effective suicide prevention really is based on the idea that no one single approach is going to reduce the rate of suicide. So we can have various situations in particular contexts that prevent suicide deaths, and that is fantastic. But from a comprehensive systemic approach, we know that it takes multiple systems working in tandem to really lower a community's rate of suicide. Which brings us to the effective prevention model.

So effective suicide prevention should help you understand the suicide problem in your community or setting. It should help you set clear goals and prioritize actions that are most likely to make a difference using a strategic planning approach. And in that middle key, using guided principles or keys to success are how you're going to make sure that you have a robust and effective program. And we'll get into some of the details about how to do this.

And finally the comprehensive approach to effective prevention is really combining multiple efforts to make sure they're working in sync to help catalyze change rather than relying on standalone programs. And the comprehensive approach is really where I want to focus some of my remarks today. Another way to think about the effective prevention model is to think about it as a process, having guiding principles and specific strategies. So let's really start to talk about some of these strategies, which I think my colleagues on today's webinar have done a great job explaining. But, suicide prevention efforts are most likely to be effective when they combine multiple strategies that work in sync to create change rather than relying on standalone programs. So this comprehensive approach includes multiple research based effective and evidence based interventions that really focus on key risk and protective factors.

So this is really taking a lifespan approach, thinking about risk and protective factors, and thinking upstream. Kind of as Scott mentioned earlier. It's comprehensive in that the comprehensive approach relies on multiple strategies working in sync with one another. That's why this graphic kind of illustrates the comprehensive approach in being puzzle pieces, that when they're combined together, that's when we really know we have a comprehensive approach. And this approach can be applied to an organizational setting, it can be applied to a community, it can be applied to a county, to a state government.

That's one of the things I really value about the comprehensive approach in how we think about suicide prevention. It provides a nice framework to localize it for your community. One thing is, it doesn't mean we just do something in each box here. We really want to focus on creating a collaborative effort across a community. So engaging in comprehensive efforts that engage multiple stakeholder groups so that everyone is doing their part. So this is really the menu of options. And I wanted to share some examples of what type of activities we would talk about in a comprehensive approach.

These are just a few of the elements that I thought might compliment some of the other remarks that were being made during today's webinar. But, identifying folks at risk. So, insuring that you have screening and assessments in place in situations where they would be most appropriate. So, primary care settings or behavioral health settings. Thinking about gatekeeper training. The Means Matter project is a great example of really making sure that education and gatekeeper training is being done in a place where risk and protective factors are paramount. Increasing help seeking.

So all of these can really be specified to a rural community through a strategic planning process. Thinking we're looking at the data, and asking ourselves, okay, if we know deaths are occurring in these ways, what are the mechanisms in our community to perhaps have an effect on those deaths? Reducing access to lethal means. Really thinking about Dr. Barber's remarks, Cathy Barber's remarks on environmental change and using data to inform specific initiatives. Or even training health providers how to have conversations about lethal means. Again, putting in a plug for the CALM lethal means training. Providing immediate and long-term post-vention. So thinking, in our community, if a death does occur, what are the proper institutional protocols and plans that need to be in place?

So this could be an organizational approach to post-vention, but it could also be a county based approach. So really thinking, what is the unique setup of my community and how am I implementing strategies that are going to affect the largest number of people possible? So all of this leads back to this overarching process guiding principles and strategies. So when we're using a comprehensive approach, are we really thinking about a strategic planning to that comprehensive, right? Thinking about the problem in our community in its context. Choosing long-term goals based on that context. Identifying key risk and protective factors based on our community and where we're at, what type of factors are in play.

A comprehensive approach to suicide prevention in rural Utah might look very different than it does in the upper peninsula of Michigan. So really taking the time to think strategically about the context of your community. In addition, keys to success, we know that each one of these elements can really contribute to building a very effective suicide prevention strategy. So engaging people with lived experience, ensuring that you're bringing other partners into the fray, using safe and effective messaging. Again, back to Cathy's remarks, kind of really thinking about culturally competent approaches and trying to engage as many evidence based strategies as possible.

So ultimately, when all of these different elements are working together, that's when we really start to see effective suicide prevention occur in communities. And I don't have time to get into all of this today, but on the right here you see a report from the National Action Alliance about transforming communities which really outlines various strategies and how to implement those strategies that communities can use. I think all of these resources are very complementary to the Rural Health Information Hub's new Suicide Prevention Toolkit.

But each one of these different programs that I have listed on the slide, the United States Air Force Academy, the Lifespan Program, Zero Suicide. All of these different approaches have used

a comprehensive approach to champion prevention efforts, and as a result have seen a net reduction in the number of suicides that have occurred within those settings. So we know that when we think strategically through a comprehensive approach, we can really have an effect on the rate of suicide.

There are resources that were included on the website advertising this webinar. I just put a link in the chat. I developed a one pager that really highlights some rural health specific resources on SPRC's website, but I wanted to point out that on our website if you hover at the top of the page over the effective prevention tab, you'll see that all the elements of effective prevention are highlighted here. So comprehensive approach, strategic planning and keys for success. Each one of those tabs then has resources specific to those considerations. So if you are leading a community effort, or an organizational effort, you really want to think specifically about, "What do we need to be doing within our setting?" I very much encourage you to use this navigation tool to think and to help guide some of the resources that you identify.

I just want to say thank you for your time and for allowing me to speak on today's webinar, and I'll hand it back over to our host to lead the Q & A.

Kristine Sande: Thank you. Thanks for all those great presentations. They were very informative. So at this time, we will open the webinar up for questions. So you should see a Q & A box that should have just popped up on the lower right hand corner of your screen. And that's where you can enter your questions. We are about at the end of our hour, but if our presenters can stay on to answer a few questions, that would be great. As we wait for questions, I would just mention that there are lots of other resources available on the Rural Health Information Hub website to help with this topic as well. Under our Models in Innovation section, you can find suicide and suicide prevention models as well as mental health models. And in our topic guides, you can find a topic guide on mental health as well as a new topic guide on farmer's mental health and suicide prevention. So those are resources that I hope you'll also check out.

A question here is, "Is there a page that gives people ideas of words to start conversation, or helps you with how to have those conversations with people who might be considering suicide?"

Scott LoMurray: This is Scott. I would be curious to see if maybe Adam or Catherine had recommendations for a page. I think if you Google that, you'll find plenty of results. I know there are resources both on the American Foundation for Suicide Prevention, AFSP, and the Suicide Prevention Resource Center. There's some helpful tools. The lifeline can also be a resource that you can call and utilize too, not only if you yourself are in crisis but if you have somebody that you're worried about and you're wanting someone to maybe give you some suggestions or some tips or some resources. So those are all, a couple things that come to mind. The other panelists may have more specific links that they can share.

And then I think it's just important to note that it's okay to have that conversation and to ask that questions. And there's been a lot of research to indicate that that's not going to plant the idea in somebody's head, and that often that question is met with relief for somebody that's been struggling that someone has finally noticed. And then I think just having that conversation in a way that is caring and is empathetic and that the goal isn't to try to fix everything right away, but to really listen, to understand, and then also the importance of bringing in other people to help. That you don't have to do that alone.

But being able to have kind of that caring, empathetic conversation and then bringing in some of those additional resources or professionals, should someone indicate that they are feeling suicidal to help kind of navigate what those resources look like in your community.

Adam Swanson:	Yeah, just to add on to that comment. This is Adam. I would say The Lifeline is always my go to resource if you don't have 1-800-273-TALK saved in your phone as a contact, I think I would recommend everyone on this call get their cell phones out now and save that as a contact. Because The Lifeline can be helpful not only to a person in crisis, but a person supporting someone in crisis. So if you find yourself worried about someone, you can call The Lifeline and say, "I find myself very worried about this person and I don't feel comfortable navigating this scenario. Can you help give me some pointers about how I might want to do that?"
	So I definitely think The Lifeline can be a resource. I also think yes, there has to be some delicacy, but I also think not being afraid of the conversation. Suicide is a part of American culture whether we want it to be or not, and being able to have conversations openly about them is one of the key steps to prevention. So I definitely encourage folks to log on to The Lifeline's website. I put a link in the Q & A box here to some of the guidance that The Lifeline provides around how to have these conversations in a personal manner.
	But I definitely encourage folks to save The Lifeline and make that a resource. Not only for yourself, but for others who you might come across within your daily lives who might be experiencing a crisis that The Lifeline can be a valuable resource.
Kristine Sande:	Thank you. Another question is, "What are the best strategies to involve rural, non-mental health professionals in suicide prevention?" So folks who might not feel that it's not their job, or it's not their role? Anyone want to weigh in on that?
Catherine Barber:	I think one great way, and especially is relevant to middle aged white men, is involving people in the gun owning community who are kind of opinion leaders to do this sort of work. Not as suicide prevention work per se, but as part of their work to promote firearm safety. When we're doing suicide prevention work, I think sometimes we can inadvertently cause a little harm by spreading sort of a doom and gloom, "Suicide is an increasing problem," and it almost normalizes suicide. But using the gun owning community to situate suicide awareness just as a very normal part of gun safety, that, okay, people generally are fine, but when you hit a period in your life where you're struggling with a depression, generally people will be able to recover from it. But in the meantime until they have, the safest approach, one way to increase safety is to make the guns inaccessible.
	Folks like that, firearm instructors or people who run sportsmen clubs or shooting ranges, are way outside the mental health treatment box and can reach people in really different ways than people who are just kind of mired in the mental health treatment paradigm.
Adam Swanson:	Yeah. And I would just add to that, you know, in terms of the question around ways to involve professionals that feel like it's not their job or not their role, is sometimes I think, even inviting the question around not, "Do I have a role," but, "What is my role? " And that what we're not asking that role to be, to be a mental health provider and to council suicidal individuals, but to be a caring member of this community. Sometimes I think even just broadening the conversation, and as I was talking about the leading causes of life, finding that itch and scratching it. What are the areas that they work in? Are they able to support in other ways in terms of being a protective factor, or increasing connectedness, or increasing a sense of belonging in the community? And I think inviting people into how are they a part of that protective factor framework, and then including in that, and here's how to ask w, here's if you have concern what the process looks like and how to get somebody else involved in that.
	But I think that we need to broaden the conversation for people where suicide prevention is not only suicide intervention, but it's also how are we knitting together a community of connection and of strength, where people see each other, and know each other, and help each other. And

that getting help for a friend or a neighbor is not being a snitch, it's being a really good friend and neighbor. And I think that's also the work of suicide prevention. In helping cast that vision for people.

Catherine Barber: I think some other good sources of assistance are people like divorce attorneys or defense attorneys or people working in, like social workers. People who are part of the DUI chain. The people who you are forced to go to if you're going through a divorce and custody issues are involved, and they're given their training on how to deal with children in divorce. That's a really vulnerable time for suicide risk. People who are part of that process, who are dealing with you when you're at your lowest, I think, are good people to involve in spreading the message about not only the gun safety message but also the message that sometimes people can become so distressed in these situations when they're arrested, when they're going through a divorce that they might consider suicide. If that does occur for you, we want you to reach out for help and we want you to know that it will very likely be short lived and that you can get through it. And we want to be sure that you do get through it.

Kristine Sande: Thank you. That's great information. I'll just comment on one other question, and then I think it might be time to wrap up. The question is, "How do we find financial resources to plan a strategy, such as a planning grant?" The Rural Health Information Hub website, in our funding section, might be a good place to start. You can also call our information specialists or email them to get assistance with finding financial resources like that. The Federal Office of Rural Health Policy does offer some non-categorical community based grants that might be a good option for doing that planning.

With that, I will bring the webinar to a close. Thank you all for being with us today and for staying longer than our scheduled hour, for those of you who are still with us. Thank you so much to our speakers. This information is very valuable for rural communities, and thank you so much for taking the time to share it with us today.

A survey will automatically open at the end of today's webinar, and we encourage you to complete that survey to provide us with feedback that we can use for 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 today's webinar will be made available on the RHIhub website and sent to you by email in the near future so that you can listen again or share this presentation with your colleagues. Thank you again for joining us and have a great day.