What is the state of Rural America?

Karen B. Francis, Ph.D.
Principal Researcher
American Institutes for Research (AIR)
Washington, D.C.
• The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
A View of Rural America

Alaska

“lower 48”

Adapted from WICHI Mental Health Program
Definition of Rural

- Rural definitions can be based on administrative, land-use, or economic concepts, exhibiting considerable variation in socio-economic characteristics and well-being of the measured population. (Cromartie, Bucgoltz, 2008)
“Rural America” is a simple term describing a complex place

Rural America’s complexity is reflected in:
- The varying definitions of “rural.”
- Rural demographic trends.
- The varying opportunities and challenges in rural communities.
- The need for place-specific policies and programs.
Changing Demographics of Rural America

Description of trends:

- Increasing out-migration of young adults for education and employment.
- In-migration of ethnic minorities for jobs in construction, manufacturing, agriculture, and meat packing.
- Growing numbers of retirees moving to rural areas.

Source: https://wrdc.usu.edu/files-ou/publications/pub___3471631.pdf
Four Rural Americas

- Amenity-Rich
- Declining Resource-Dependent
- Chronically Poor
- Transitioning areas with amenities (Amenity Transition)
Amenity-Rich Rural Places

- High population growth
- Natural amenities
- High education levels, income, and employment
- Impact of sprawl on the natural environment, and the changing character of their communities

(Carsey Institute, 2011)
Declining Resource-Dependent Rural Places

• Past strong resource-extractive industries

• Stagnant economic conditions

• Population decline

• Education and employment rates remain relatively high and poverty rates relatively low

(Carsey Institute, 2011)
Chronically Poor Rural Places

• Persistent poverty

• High unemployment

• Long-term underinvestment

• Attracting few newcomers and are losing many young adults who are essential to healthy civic and economic life

Appalachia (Kentucky)
Amenity Transition Rural Places

• Mix of amenity-rich and declining resource-dependent places

• Decline in their more traditional industries but have been able to attract some newcomers

• Modest to low population growth and relatively high employment and education levels
Gains and Persistent Disparities in Rural Communities

Institutional
Social
Cultural
Highlighting Rural Disparities

- Inadequate access to care.
- Limited availability of skilled care providers.
- Inadequate transportation to service delivery points.
- Poverty/low incomes.
- Less access to private health insurance benefits (mental health care).
Implications for RBH Policy and Programming

- **Availability** – does it exist?
- **Accessibility** – ease and convenience to obtain and use services
- **Affordability** – cost?
- **Appropriateness** – effectiveness and quality of services
- **Acceptability** – is it congruent with the world view, cultural beliefs and values?

Adapted from Jackson, 2008 - NCCC
Karen B. Francis, Ph.D
Principal Researcher
American Institutes for Research (AIR)
1000 Thomas Jefferson Street, N.W.
Washington, D.C. 20007
(202) 403-5164
kfrancis@air.org
Comprehensive School Mental Health

- What is it?
- Why grow it?
- Current Status of the Field
- Elements of School Mental Health Quality
- Elements of School Mental Health Sustainability
- Shaping your System
WHAT IS COMPREHENSIVE SCHOOL MENTAL HEALTH?
What School Mental Health is NOT
MTSS School-Community Partnerships

Kathy Short, 2016, Intl J. of Mental Health Promotion
WHY GROW SCHOOL MENTAL HEALTH?
Reflection Question

If you could pick one quality or skill that all young people would possess by the time they graduate from high school, what would it be?

Roger Weissberg, CASEL
CASEL Core Competencies

Roger Weissberg, CASEL

- Self-Management: Managing emotions and behaviors to achieve one's goals
- Self-Awareness: Recognizing one's emotions and values as well as one's strengths and challenges
- Social Awareness: Showing understanding and empathy for others
- Responsible Decision-Making: Making ethical, constructive choices about personal and social behavior
- Relationship Skills: Forming positive relationships, working in teams, dealing effectively with conflict
Median Age of Onset: Mental Illness

- Birth
- Mid-teens
- Age 20
- Age 40
- Age 60
- Age 80

- Autism Spectrum Disorders
- Phobias & Separation Anxiety
- ADHD
- Opposition Defiant Disorder
- Conduct Disorder
- Intermittent Explosive Disorder
- Psychosis
- Major Depression
- Substance Abuse
- Mid-20s

Source: WHO World Mental Health surveys as reported in Kessler et al. (2007)
Advantages of Mental Health in the School Setting

• Greater **access** to all youth → mental health promotion/prevention

• **Less time lost** from school and work

• Greater **generalizability** of interventions to child’s context

• **Less threatening** environment
  • Students are in their own social context

• Clinical **efficiency and productivity**

• Outreach to youth with **internalizing** problems

• **Cost effective**

• Greater potential to impact the learning environment and **educational outcomes**

Sharon Hoover, 2018

• Findings from 36 primary research, review, and meta-analysis articles

• 2000-2017

• Benefits of school behavioral health clinical interventions and targeted interventions on a range of academic outcomes for adolescents.

In the aftermath of the Surgeon General’s warning that “the nation is facing a public crisis in mental health care for infants, children, and adolescents,” the prevalence of mental health disorders among children and adolescents and the unmet need for treatment have received increased attention. Mental health problems are common among children and experience a mental health disorder annually, and an estimated 40% of adolescents meet lifetime diagnostic criteria for major mental health disorders. These mental health conditions have wide ranging effects, interfering with students’ functioning in school, at home, with their friends, and in their communities, and potentially affecting their successful attainment.

Sharon Hoover, 2018
SAFE SECURE SCHOOLS
Two Visions

March 2018 Congressional Briefing: School Violence, Safety, and Well-Being: A Comprehensive Approach

http://www.npscoalition.org/school-violence
Two Visions About What Our Schools and Society Should Be

• One vision believes that the path for lasting safety comes from welcoming, caring, and supportive schools
  – focuses on school climate, social emotional learning, and community— in addition to great academics.
  – also advocates for humane social supports, community linkages to resources for those students struggling with mental health, family and societal obstacles.
Alternative Vision of School Safety

- Another vision is a restrictive and punitive reaction to the mass shootings in schools that aims to protect students from mass shootings
  - based on tools and ideas that originate in law enforcement,
  - prison architecture and security measures
  - military strategies
Comprehensive Reviews Covering Hundreds of International Studies, and Large-scale Epidemiological Studies Show:

- Schools with positive school climate and integrated SEL foci have significantly reduced
  - Isolation
  - Verbal bullying
  - Physical bullying
  - Sexual harassment/ assault
  - Cyberbullying
  - Negative relationships between students and between students and teachers

- And have decreased student/ teacher reports of:
  - Weapons use, being threatened by a weapon, and seeing or knowing about a weapon on school grounds
MENTAL HEALTH IS ESSENTIAL TO SAFE SECURE SCHOOLS

Sharon Hoover, 2018
What’s happening on the front lines of school mental health?
APPROACHES FOR ALL

Sharon Hoover, 2018
UNIVERSAL Mental Health/Safe Supportive (SS) Strategies

- Promote supportive positive school culture and climate
- Staff wellness
- Social Emotional Learning (SEL)
- Create trauma-responsive school policies
- Training/coaching on crisis/trauma and ways to interact with students exposed to trauma
- Mental health literacy for school staff and students
Why Wellness for School Staff?

THE MODERN SCHOOLTEACHER

DISHEVELED HAIR FROM GETTING UP AT 5:00 AFTER GETTING TO BED AT 1:16

MONEY FOR CLASSROOM SUPPLIES (OUT OF HER OWN POCKET)

SHOES FOR TRAFFIC DUTY, PLAYGROUND DUTY, CAFETERIA DUTY AND THAT REALLY FAST BRAT

PRANK FROM STUDENT (FUTURE CARTOONIST)

LESSON PLANS, PAPERS TO GRADE AND GRADE BOOKS TO UPDATE BY TOMORROW

NOTE FROM PARENT SAYING TEACHERS GET PAID TOO MUCH

Sharon Hoover, 2018
But seriously, why wellness for school staff?

Teachers are stressed!
- Large class size, Behavioral challenges in students,
  Inadequate resources & poor physical space, Bureaucracy,
  Workload & Paperwork, High responsibility for others,
  Perceived inadequate recognition or advancement, Gap
  between pre-service training expectations and actual work experiences

Teachers are leaving the profession in alarming numbers!
- 10% of teachers leave after 1 year
- 17% of teachers leave within 5 years
- In urban districts, up to 70% of teachers leave within first year

Teacher Stress Impacts Students

- Teachers who are stressed demonstrate greater negative interactions with students:
  - Sarcasm
  - Aggression
  - Responding negatively to mistakes

- *Classrooms led by a teacher who reported feeling overwhelmed (high burnout) had students with much higher cortisol levels*

  *Oberle & Schonert-Reichl (2016)*
Promising School Staff Wellness Programs

- Mindfulness-Based Stress Reduction (MBSR)
  - Reductions in psychological symptoms and burnout, improvements in observer-rated classroom organization and increase in self-compassion (Flook et al, 2013)
  - Improvement in: self-regulation, self-compassion, mindfulness and sleep quality (Frank et al, 2015)
Community Approach to Learning Mindfully (CALM)

- Improvements in:
  - Mindfulness
  - Emotional functioning
  - Positive affect
  - Distress tolerance
  - Efficacy in classroom management
  - Physical symptoms
  - Blood pressure
  - Cortisol


Cultivating Awareness and Resilience in Education (CARE)

- Improvements in well-being, efficacy, burnout, mindfulness
  (Jennings et al, 2013)

Sharon Hoover, 2018

Createforeducation.org
Social and Emotional Learning (SEL)

Students in the Social Emotional Learning (SEL) programs demonstrated:

- Improved Social-emotional skills
- Improved attitudes towards self, school, and others
- Reduced conduct problems and emotional distress

- **Improved Academic performance**
  - Average gains on achievement test scores of 11 to 17 percentile points.

www.casel.org

Building and mobilizing one of the most important movements in decades.
Social and Emotional Learning.
PSYCHOLOGICAL FIRST AID:
Listen Protect Connect/Model and Teach

https://traumaawareschools.org/pfa
Copyright M. Schreiber, R.H. Gurwitch, & M. Wong, 2006
Adapted, M. Wong, 2012

Sharon Hoover, 2018
Mental Health Literacy

- Understand **how to obtain and maintain good mental health**
- Understand and identify mental disorders and their treatments
- Decrease stigma
- Enhance **help-seeking efficacy**: know where to go; know when to go; know what to expect when you get there; know how to increase likelihood of “best available care” (skills and tools)

*Kutcher and Wei; 2014; Kutcher, Bagnell and Wei; 2015; Kutcher, Wei and Coniglio, 2016.*

Sharon Hoover, 2018
APPROACHES FOR SOME
TARGETED Mental Health/Safe Supportive Strategies

– School staff training on identifying, approaches, referring students experiencing psychological distress

– Mental health screening

– Support for transitions

– Provide additional check-in support (e.g., mood ratings beginning and end of day)

– Interventions for students with mild impairment – SSET, STRONG

Sharon Hoover, 2018
Youth Mental Health First Aid

- 8 hour in person public education training program
- Teaches participants the risk factors and warning signs of a variety of mental health challenges common among adolescents (ages 12-18)
- Teaches participants a 5-step action plan:
  - Assess for risk of suicide or harm
  - Listen nonjudgmentally
  - Give reassurance and information
  - Encourage appropriate professional help
  - Encourage self-help and other support strategies
- Adult version- SAMHSA NREPP Evidence-based program

Sharon Hoover, 2018
TEACHER TRAINING: At-Risk Suite for K-12 Educators

www.kognito.com

- Online 24/7; 50 – 60 minutes
- Virtual role-play conversations with at-risk “emotionally active” student avatars
- Created in collaboration with school and mental health experts and educators
- Deliberate practice and personalized feedback
- Listed: SPRC/AFSP Best Practice Registry
- Listed: National Registry of Evidence-Based Programs and Practices (HS only)
- Effectiveness demonstrated in national empirical studies (HS only)
- Widespread adoption – over 100,000 teachers in Texas, NY, Arizona, Ohio (HS only)

Sharon Hoover, 2018

© 2013 Kognito Interactive. All Rights Reserved.
Welcome to the Support for Students Exposed to Trauma Program!

You now have access to the free online training and resources.

The Support for Students Exposed to Trauma (SSET) team is here to help you at every stage of implementation, from preparation and training to ongoing support as you lead groups. That’s why in addition to the online training, we’ve created several areas where you can interact with the developers of the SSET Program as well as other educators like you.

- **Ask an Expert** Submit questions directly to the developers of the SSET Program
- **Discussion Board** Connect with other educators running SSET groups
- **Collaborative Workspace** Share files with other group leaders

Be sure to visit our **Resource Center**, a comprehensive library of implementation tools that allows you to:

- watch video Quick Tips with lesson-by-lesson instructions and advice for leading groups,
- access screening tools and suggested measures,
- download the program manual,
- read pre-training background information on trauma,
- check out helpful links, and more!

Whether you’ve led student support groups in the past or are planning to run a group for the first time, rest assured that we’re here for you every step of the way!
Supporting Transition Resilience of Newcomer Groups

Sharon Hoover, 2018
Ontario Launch!

- 10-week, school-based group intervention for newcomer students

- Pilot (Spring 2018) in four schools in the Peel District School Board and four in the Toronto Catholic District School Board
SELECT Mental Health Strategies

– Refer for evaluation and appropriate treatment

– School and/or Community Based services

– Special education accommodations

– Ensure good communication between families, community, and school personnel

– Evidence-based interventions – e.g., CBITS/Bounce Back, TF-CBT

Sharon Hoover, 2018
CBITS developed to help children in schools cope with trauma

- Begun in 1998
- Collaboration with Los Angeles Unified School District, University of California, Los Angeles
• **Statewide Learning Collaborative**
  - 2-day training
  - Bi-weekly consultation
  - Audio fidelity monitoring/feedback
  - Data tracker

• **350 students**
  - 70 groups
  - 23 clinicians

• **90.3% completion rate**

Successes

• Increasing emphasis on:
  – Multi-tiered Systems of Support (RtI, PBIS-SMH/ISF, etc)
  – Evidence-based (research-supported) Practice (EBP)
  – Consideration of cultural context in development, implementation, and evaluation of EBP
  – Meaningful partnership with families
  – School-community partnerships
  – Workforce training for mental health providers and educators
  – Outcomes

• Pockets of funding to support school mental health
  – Increased federal investments
  – Creative funding streams at local/state levels
Challenges

• Limited, variable funding
• Limited system integration (Mental Health-Education)
• Poor practice selection
• Gaps in training, particularly related to working schools, engaging families, evidence-based practice
  “C.O.W. Therapy” – Crisis of the Week
• Poor implementation support
• Limited control/accountability of providers and services provided
• Lack of good data metrics and infrastructure
We need **STANDARDS**, **PROCESSES**, and **STRATEGIES** for integrating mental health into education.
School Health Services
NATIONAL QUALITY INITIATIVE

Accountability • Excellence • Sustainability

an initiative of the School-Based Health Alliance and the Center for School Mental Health
Elements of School Mental Health Quality

☑ Teaming
☑ Needs Assessment / Resource Mapping
☑ Screening
☑ Evidence-Based Services and Supports
☑ Evidence-Based Implementation
☑ Data-Driven Decision Making
Elements of School Mental Health Sustainability

✓ Funding and Resources
✓ Resource Utilization
✓ Quality
✓ Documentation and Reporting Impact
✓ Marketing and Promotion
SHAPE your school mental health system

- A Resource to Support Quality Improvement and Sustainability
Join Us!

When you click Join Now and answer a few questions, your school mental health system will be counted in the National School Mental Health Census and will receive a Blue Star SHAPE Recognition.

Also, we will use your name and e-mail address to update you on SHAPE System news and resources. Anyone (district/school leader, educator, health/mental health provider, parent, student, etc.) from a school system can join us!

Join Now

Schools and school districts can use SHAPE to:

- Be counted in the National School Mental Health Census
- Achieve SHAPE recognition to increase opportunities for federal, state, and local grant funding
- Access free, targeted resources to help advance your school mental health quality and sustainability
- Advance a data-driven mental health team process for your school or district

Register to Improve Your School Mental Health System

Free Custom Reports
Strategic Team Planning
Free Resources
Be Counted
Schools and School Districts Can Use SHAPE To:

Document your service array and multi-tiered services and supports

www.theshapesystem.com
Schools and School Districts Can Use SHAPE To:

Advance a data-driven mental health team process for the school or district

- Strategic Team Planning
- Free Custom Reports

www.theshapesystem.com
Schools and School Districts Can Use SHAPE To:

Access targeted resources to help advance your school mental health quality and sustainability.
SHAPE - Trauma-Responsive Schools (TRS)
- Developed by the NCTSN, i Treatment and Services Adaptation Center for Resiliency, Hope and Wellness in Schools (www.traumaawareschools.org) and the CSMH

Domains:
- **School-wide Safety** (e.g., predictable routines, physical safety)
- **School-wide Programming** (e.g., restorative justice, culturally responsive teaching)
- **Staff Trauma Knowledge** (e.g., school/classroom impact of trauma, neurological impact)
- **Staff Trauma Skills** (e.g., trauma-informed communication, de-escalation)
- **Early Intervention Activities** (e.g., trauma screening, early intervention evidence-based trauma practices)
- **Targeted Intervention Activities** (e.g., School-based Trauma Treatments, Referrals)
- **Staff Wellness/Burnout/Secondary Traumatic Stress** (e.g., Staff Assessment, Staff Supports)

*All items are on a 6-point Likert scale reflecting degree of implementation*
### Files to be Processed

There are currently no files that need to be processed.

#### Search:

<table>
<thead>
<tr>
<th>Instrument Name</th>
<th>Purpose</th>
<th>Target Symptoms</th>
<th>Reporter (Age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Impairment Scale (BIS)</td>
<td>Screening/Initial Assessment</td>
<td>Academic Engagement Social Skills</td>
<td>Parent</td>
</tr>
<tr>
<td>Center for Epidemiological Studies Depression Scale for Children (CES-DC)</td>
<td>Screening/Initial Assessment</td>
<td>Depression</td>
<td>Student/Self-Report</td>
</tr>
<tr>
<td>Child and Adolescent Disruptive Behavior Inventory (CADI)</td>
<td>Screening/Initial Assessment</td>
<td>Hyperactivity Oppositional Behavior</td>
<td>Parent</td>
</tr>
<tr>
<td>Eating Attitudes Test-26 (EAT-26)</td>
<td>Screening/Initial Assessment</td>
<td>Disordered Eating</td>
<td>Student/Self-Report</td>
</tr>
<tr>
<td>Pediatric Symptom Checklist (PSC-35 or PSC-17)</td>
<td>Screening/Initial Assessment</td>
<td>Anxiety</td>
<td>Student/Self-Report (11-18)</td>
</tr>
<tr>
<td></td>
<td>Progress Monitoring</td>
<td>Depression, Global Functioning,</td>
<td>Parent (4-16)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hyperactivity, Inattention,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oppositional Behavior</td>
<td></td>
</tr>
</tbody>
</table>
It's messy work
Find good partners, and invest (in the relationships)
Thank you!

Sharon A. Hoover, Ph.D.
shoover@som.umaryland.edu
443-801-3254

@drsharonhoover

Center for School Mental Health
http://csmh.umaryland.edu
Email: csmh@psych.umaryland.edu
Phone: (410) 706-0980

@CtrSchoolMH
Special Considerations for School Mental Health in Rural Communities

Kurt Michael, Ph.D.
Professor of Psychology
Appalachian State University

SAMHSA Meeting
Rockville, MD
May 17, 2018
US vs. State vs. Western NC Suicide Rates

Graph showing the trend of suicide rates from 2000 to 2014 for the US, NC, and Western NC.
Demonstrated Regional Need

• Rural areas experience higher rates of …
  – Depression and suicide
  – Alcohol and opiate addiction, particularly among adolescents/young adults

• Limited access to MH providers in rural NC
  – 22% of NC counties have no practicing psychologist
  – Several counties have virtually zero access

(Fontanella et al., 2015; Kessler et al., 2005; Kochanek et al., 2016; Mohatt et al., 2005; Probst et al., 2005; SAMHSA, 2012; Zhang et al., 2008)
Helping educators to educate by:

- Providing access to high quality, supervised mental health services to children and families regardless of their ability to pay
- Training a steady stream of qualified school mental health professionals who join the regional workforce
- Conducting research that informs effective school mental health practices
ASC Service Definitions across Tiers

• Surveillance, consultation, education (teachers, administrators)
• Assessment & referral
• Outpatient psychotherapy (14 sessions of CBT or DBT, 35-40 min/session)
• Crisis intervention; Prevention of Escalating Adolescent Crisis Events (PEACE)
  – Collaborative Assessment and Management of Suicidality (CAMS)
  – Counseling on Access to Lethal Means (CALM)
• Postvention
• Evaluation
• Continuous Quality Improvement (CQI)
Select ASC Outcomes

- Clinically significant **reductions in psychological symptoms** for 65-70% served (Albright et al., 2013)
- Clinically significant **improvements in mood symptoms** using modular CBT (Michael, George et al., 2016)
- Modest changes in **academic variables**: attendance, discipline referrals, GPA (Michael et al., 2013)
- Identification and treatment of **suicidal ideation/intent** (Michael, Jameson et al., 2015; Sale et al., 2014)
- Rapid reduction in **psychological distress** (Kirk et al., revise & resubmit)
- Revision of **suicide prevention protocol** (Capps et al., under review)
- In 2017, published the inaugural **Handbook of Rural School Mental Health**, which included 73 authors from across the U.S., Canada, & Australia
Regional Base Rates; Local Results

Adolescent Suicide Attempts Requiring Medical Attention

- National Average: 2.4%
- Western North Carolina: 6%

Post-Treatment Results 2012-2014

- Recovered: 49%
- Improved: 21%
- Unchanged: 25%
- Deteriorated: 5%

70% of students who started in a clinical range were significantly improved by the end of treatment.
Implementation challenges led to innovation

• Address public health problem of suicide via the schools
• Systematize procedures to expeditiously and consistently intervene
• School-wide, community-based intervention
• Non-technical jargon
Prevention of Escalating Adolescent Crisis Events (PEACE)

• School Safety Paradigm
• Easy to understand algorithm assessing evidence-based risk and protective factors that is implemented across disciplines
• 4 levels of risk:
  • Green, Yellow, Orange, Red
• Each level is associated with a set of behaviorally anchored action steps, consultative & supervision elements, notification requirements, safety planning, documentation, and follow-up procedures
PEACE Descriptive Data

- Last 5 years, plus YTD
- 223 students; 325 crisis events
Counseling on Access to Lethal Means (CALM; Elaine Frank, Cathy Barber)
Philosophical Underpinnings

- Public health approach
- Focuses on the “how” of suicide
- Prevention via safety planning & risk reduction
- Acknowledges gap in the empirical literature regarding our capacity to predict attempts
Duration of Suicidal Crises ("Ideation to Action")

Deisenhammer et al., 2009

Time Between 1st Thought of Suicide and Attempt

![Bar chart showing the duration of suicidal crises from ideation to action with the percentage of attempters for different time intervals.](chart.png)
Self-Harm Case Fatality Rates

CDC WISQARS

Firearms
- 85-90% fatal
- 10-15% nonfatal, treated in hospital ER

Cutting or Poisoning
- 1-2% fatal
- 98% nonfatal, treated in hospital ER
Israeli Defense Force (IDF): An International Example of Means Restriction
## Variation in State Suicide Rates (Miller et al., 2013)

<table>
<thead>
<tr>
<th></th>
<th>High Gun States*</th>
<th>Low Gun States**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>31.5 million</td>
<td>31.3 million</td>
</tr>
<tr>
<td>% household with firearms 2004</td>
<td>50%</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Suicides 2008-2009

<table>
<thead>
<tr>
<th></th>
<th>High Gun States*</th>
<th>Low Gun States**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearm suicides</td>
<td>7,492</td>
<td>1,697</td>
</tr>
<tr>
<td>Non-firearm suicides</td>
<td>4,397</td>
<td>4,341</td>
</tr>
<tr>
<td>Total suicides</td>
<td>11,889</td>
<td>6,038</td>
</tr>
</tbody>
</table>

**Suicide attempts (est.) 2008-2009**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High Gun States*</td>
<td>246,000</td>
</tr>
<tr>
<td>Low Gun States**</td>
<td>303,400</td>
</tr>
</tbody>
</table>

* LA, UT, OK, iA, TN, KY, AL, MS, ID, ND, WV, AR, AK, SD, MO, WY
** HI, NJ, MA, RI, CT, NY
Regional Firearm Deaths (CDC Wonder, 1999-2014)

78% of NW NC firearm deaths are suicides

Unintentional, Homicide, Suicide
Clinical & Prevention Goals

• Create barriers to death by suicide
  – Time
  – Distance
  – Future prevention
  – Resolution of key drivers to suicidal ideation
Providers Asking about Gun Access (Miller et al., 2013)

% Reporting they almost always ask

- Pt suicidal in past mo., not now: 16%
- Suicidal today, no plan: 22%
- Suicidal today, non-gun plan: 21%
- Suicidal today, gun plan: 64%