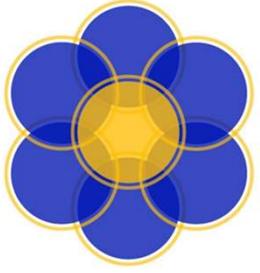


How Where We Live Shapes Suicide Risks and Support in America



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Introduction

Dr. Anne Kelly and Ms. Janet Schnell analyzed data from 297 counties to understand how structural and resource conditions shape suicide risk and the availability of postvention supports. We use those national results to highlight where need is highest and support is thinnest. After summarizing the national patterns, we move into a closer look at seven Indiana counties tied to military installations: Martin, Monroe, Knox, Vigo, LaPorte, Allen, and Marion.

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Learning Outcomes

- Explain how things like income, education, and where people live affect the chances of suicide and the help needed after a suicide in different U.S. counties.
- Describe ways to study how many suicides happen in each county, how access to health care is not easy, and the signs/symptoms of depression that people in the area are struggling with.
- Identify the differences in the help people get after a suicide death, depending on where they live in the United States and Urban vs. Rural communities.

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Learning Outcomes

- Discuss what is learned can help each community make better plans to prevent suicide and help people after a suicide death.
- Use information from research to help communities work together and respond better to suicide risks.

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2023 Suicide in the US

Over **49,000** people died by suicide in 2023

1 death every **11** minutes

Many adults think about suicide or attempt suicide

12.8 million Seriously thought about suicide

3.7 million Made a plan for suicide

1.5 million Attempted suicide

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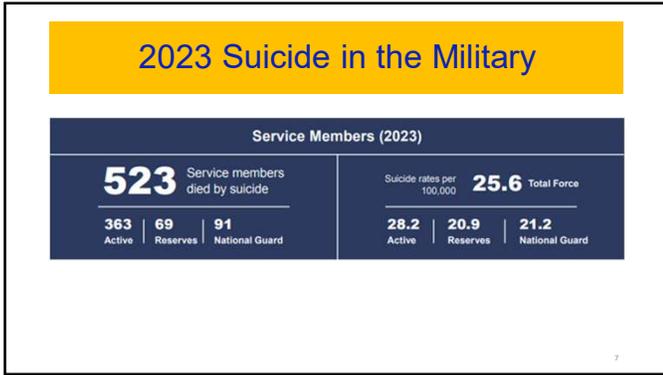
2023 Suicide in Indiana

The suicide rate in Indiana has increased by **42.9%** over the past 20 years.

Age-adjusted deaths per 100,000 people

Source: Centers for Disease Control and Prevention -> USAFacts

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Why This Study Matters

- Suicide risk is not evenly distributed across America.
- Access to care is not evenly distributed either.
- Where we live shapes both risk and recovery.
- This study examines structural patterns across U.S. counties.

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What We Studied

- 297 U.S. counties.
- All include or border military installations.
- Mix of rural and urban counties.
- Nationwide geographic representation.



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The Core Question

- How do community conditions shape:
 - Suicide burden
 - Mental health distress
 - Access to care
 - Support after a suicide death

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Key Terms

- Suicide rate: Deaths per 100,000 residents.
- Distress: Depression, PTSD, suicidal thoughts.
- Access: Ease of getting care (providers, EDs, broadband).
- Postvention: Structured support after a suicide death.

IT'S OK TO TALK ABOUT SUICIDE!

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Composite Distress and Access Indices

- Composite Distress Index is a standardized score combining:
 - Depression
 - PTSD
 - Suicide ideation
 - Suicide mortality
- Access Index is a standardized score combining:
 - Emergency department availability
 - Preventable hospital stays
 - Self-reported poor health

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How We Compared Counties Fairly

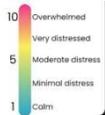
- Used rates (per 100,000) instead of raw counts
- Standardized values (z-scores)
- Groups counties into quintiles (five equal groups)
 - Q1: lowest overall need
 - Q5: Highest overall need

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What "Need" Means in This Study

- Need: Distress plus Access Barriers
- High Need (Q5)
 - High Composite Distress
 - Weak Access Index
 - Greater structural vulnerability



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Rural vs. Urban: Two Distinct Structural Patterns

- Rural Counties
 - Higher suicide rates per 100,000
 - Fewer providers per capita
 - Fewer emergency departments per capita
 - Longer travel times
 - Limited broadband and transit
- Urban Counties
 - Lower rates per 100,000
 - Larger total number of deaths
 - More providers but greater demand
 - Systems under strain

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Suicide Rates by Rurality

- Across all quintiles:
 - Rural suicide rates are consistently higher
 - Rural rates average 25-30% higher than urban
 - The rural-urban gap never reverses



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Distress and Access Move in Opposite Directions

- From Q1 → Q5:
 - Composite Distress increases sharply
 - Access Index increases (weaker care access)
 - Emergency departments per capita decline
 - Firearm Fatality rates increase
- Reminders:
 - Higher Distress = more burden
 - Higher Access Index = weaker access

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Emergency Capacity Differences

- Across quintiles:
 - Emergency departments per capita drop significantly
 - Full-time facilities decline
 - Rural transport times increase



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Firearm Fatalities Increase with Suicide Burden

- Firearm fatality rates rise across quintiles
 - Firearm fatality rate = deaths per 100,000 residents
- Firearms are highly lethal
- Strong statistical relationship with suicide burden

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Economic and Infrastructure Signals

- Higher-suicide counties show:
 - Lower median income
 - Higher food insecurity
 - Higher uninsured rates
 - Reduced public transportation
 - Slightly lower broadband coverage



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Structural Pattern Summary

- Across 297 counties:
 - Suicide burden clusters with structural barriers.
 - Rural counties show deeper access gaps.
 - Urban counties show broader population impact.
 - Emergency capacity declines in high-need areas.
 - Postvention capacity remains uneven.

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National Patterns: Where Risk Rises and Support Weakens

- Suicide burden rises where access declines.
- Rural and urban vulnerabilities differ.
- Emergency and infrastructure gaps matter.
- Postvention capacity remains uneven.



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Indiana Installation Counties

- Seven Indiana counties:
 - Vigo
 - Monroe
 - Marion
 - LaPorte
 - Allen
 - Knox
 - Martin
- All contain military installations.
- These counties reflect broader national patterns.

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**Vigo County (Urban) | Very High Need
Terre Haute (National Guard)**

- Population: 106,166
- Suicide Rate: 19 (high in this set)
- Distress: Highest tier (very elevated composite distress)
- Access: Worst access / highest barriers
- Postvention: Resources present, but burden plus barriers



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**Monroe County (Urban) | Very High Need
Bloomington (Naval Support)**

- Population: 104,702
- Suicide Rate: 13
- Distress: High across multiple indicators (depression, PTSD, suicidal thoughts)
- Access: Weaker access (high barrier score)
- Postvention: AFSP support present

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**Marion County (Urban) | High Need
Indianapolis (Camp Atterbury)**

- Population: 981,628 (largest in group)
- Suicide Rate: 15
- Distress: Elevated
- Access: Worst access / highest barriers
- Postvention: Resources present, but scale challenges coverage



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**LaPorte County (Urban) | High Need
Michigan City (Coast Guard)**

- Population: 111,348
- Suicide Rate: 18 (high)
- Distress: Elevated (Q4 distress tier)
- Access: Worst access / highest barriers
- Postvention: AFSP support present but likely thin

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**Allen County (Urban) | High Need
Fort Wayne (Air National Guard)**

- Population: 399,295
- Suicide Rate: 13
- Distress: Moderately elevated
- Access: Meaningful barriers (thin or uneven coverage)
- Postvention: Partial coverage



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**Knox County (Rural) | High Need
Vincennes (National Guard)**

- Population: 35,872
- Suicide Rate: 16
- Distress: Elevated, especially PTSD
- Access: Rural barriers amplify need
- Postvention: Resources present but reach are likely limited

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**Martin County (Rural) | Very Low Need*
Shoals (Crane Naval Base)**

- Population: 9,864
- Suicide Rate: 10
- Distress: Lowest tier in this group
- Access: Rural, but overall low measured need
- Postvention: Lower need for additional postvention resources



*This may underestimate the true need, as some data were missing, which is common in rural counties.

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Rural vs. Urban Postvention Differences

- Rural
 - Absolute scarcity
 - Few trained providers nearby
 - Long travel Distances
- Urban
 - More providers
 - Larger population demand
 - Support stretched by scale

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Postvention Capacity

- Many counties have zero bereavement-trained clinicians.
- Many have no survivor support groups.
- Telehealth access varies.
- Postvention capacity does not consistently align with burden.

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Conclusion and Q&A

- Summary of key points
- Importance of integrating RFA into national suicide prevention efforts
- Open floor for questions and discussion

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