Fishing Without a Pole: Experiences and Insights of Adults Working to Prevent Youth Suicide in a Low-Income, High-Rate State

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FISHING WITHOUT A POLE: EXPERIENCES AND INSIGHTS OF ADULTS WORKING TO PREVENT YOUTH SUICIDE IN A LOW-INCOME, HIGH-RISK STATE

by

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DISSERTATION

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Education Educational Leadership

The University of New Mexico Albuquerque, New Mexico

December, 2020
Dedication

This dissertation is dedicated to the living: those who survived suicide attempts and those who have experienced the loss of a loved one to suicide. It is dedicated to those who live with mental health issues and to those who love them. It is dedicated to those selfless preventionists who battle stigma and work tirelessly to keep our youth safe and healthy. Lastly, this is dedicated to the two strongest women in my life: my Wife, who has supported me in all I do, loved me through every moment, and loaned me courage whenever I ran low; and my Mother, who is an endless wellspring of love, compassion, and reassurance. Both women inspire me, daily, to be better, love harder, and give my all. My admiration, respect, and love go out to those who give up their peace and comfort to help others.
Acknowledgements

I would like to thank the distinguished members of my committee: Dr. Thomas Chávez, Dr. Jennifer Gomez-Chávez, Dr. Eliseo (Cheo) Torres, and Dr. Sheri Williams. I want to thank my participants for their prevention work, for their willingness to be a part of this study, for their frankness, bravery, endurance, sacrifices, and the hope they give me and so many others. It is with deep gratitude that I thank my Chair, Dr. Alicia F. Chávez; she guided me, with abundant patience and timely encouragement, on a very long journey. I could not have completed this research without her direction, persistence, and support.
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ABSTRACT

This study explores the underrepresented perspective of suicide preventionists in the state of New Mexico, their experiences and insights surrounding the prevention of youth suicide. I present these in narrative form; the primary method of investigation was purposeful, individual interviews with an initial and follow-up interviews. Preventionists in New Mexico face the enormous task of reducing historically high youth suicide rates when compared with the rest of the nation; additionally, New Mexico is a rural state that exhibits a complex mix of risk and resiliency factors. I invited participants to discuss their experiences, share barriers to their work, offer success stories, and speculate on the future of youth suicide prevention in New Mexico. Through this study I opened a candid dialogue with youth suicide preventionists concerning their vital work; the findings lend to more effective protocols for youth suicide prevention. Participant experiences and wisdom serve as an invaluable resource, from which other preventionists can benefit and learn. Additionally, those who make policy making and funding decisions can benefit from knowing the barriers these preventionists face and can directly address removal of
those obstacles. Finally, the COVID-19 pandemic struck during this study, so impacts were explored.

*Keywords:* suicide, New Mexico, narrative inquiry, mental health, behavioral health, public health, wellness, underserved populations, at risk, prevention, preventionist, southwest, school, student, youth, adolescent, education, pandemic, 2019-nCoV, 2019 novel coronavirus, corona virus, COVID-19, rural, frontier
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Chapter 1: An Underrepresented Essential Perspective

Every individual has a unique response to suicide. *Selfish, relief, painless, thoughtless, honorable, cowardly, peace.* These are just some of the words used by news media, neighbors, the entertainment industry, family, and on social media to describe suicide. The topic can be awkward to discuss, with reactions varying widely from anger and condemnation to glorification, sadness, outrage, dismissal, and more (Lester, 2005). Further, the problem of suicide has been with us for a very long time:

In 1910, at a conference in Vienna attended by Sigmund Freud, participants expressed concern about the perceived excess of youth suicides. In 1989, the Surgeon General’s report focused on the problem of suicide in the United States, conveying conclusions similar to those reached at the Vienna conference – not enough is known about suicide and its causes, and more research is needed in order to comprehensively address the issue. (State of New Mexico, 2008, p. 4)

With suicide rates on the rise (World Health Organization, 2014), innovative investigation of suicide prevention is necessary. As someone who has worked for over twenty years on the prevention of youth suicide in New Mexico, I needed to know why rates continue to increase, and I wanted others in education to know, too. We already have a broad and deep body of literature that addresses why and how individuals become suicidal, but the statistics speak loud and clear, and undoubtedly we must delve further and from different directions (State of New Mexico, 2008; World Health Organization, 2014). Spearheading a new direction, I studied an underrepresented perspective: the experiences and insights of the adults who work to prevent youth suicide. Their perspectives add a valuable facet to our current understanding of youth suicide and its
prevention. I examined the experiences and insights of preventionists to understand their achievements, barriers, and outlook on youth suicide prevention in New Mexico because I found no evidence in the literature representing this perspective.

At the state, national, and global levels, youth suicide prevention is conceptualized in ways that focus almost entirely on the experiences of the suicidal individual (Gould, Greenberg, Velting, & Shaffer, 2003; Joiner, 2005; Lathrop, 2013; Mann et al., 2005; New Mexico Public Education Department, 2013; World Health Organization, 2014). My interest and focus for this study specifically targeted the professionals doing the prevention work: preventionists. The group of individual participants is made up of non-profit volunteers, educators, mental health professionals, medical professionals, community members, and others.

**An Incomplete Protocol.**

According to the literature, mental health professionals report feeling underprepared, untrained, and lacking in resources when it comes to youth suicide prevention (Feldman & Freedenthal, 2006; Singer & Slovak, 2011; Valente & Saunders, 2004). A 2013 study in New Mexico found that, among respondents, 44.2 percent of school nurses reported their own knowledge of lesbian, gay, bisexual, transgender, or questioning (LGBTQ) student “risk for suicide and depression” as being “low” or “none” (Mahdi, Jevertson, Schrader, Nelson, & Ramos, 2014). This is particularly noteworthy, as LGBTQ populations have proven to be at significantly high-risk for suicide (Mahdi et al., 2014). In 2011, a groundbreaking study was done to explore school social workers in the Midwest and youth suicide; although it was found that the large majority of these social workers felt confident working with suicidal students, only 57 percent of social workers
and 40 percent of school psychologists were prepared in their graduate school to work with suicidal students (Singer & Slovak, 2011). When it comes to volunteers working in the prevention of youth suicide, Whiting states: “the nature and boundaries of (their) role, and therefore of their necessary training, are not easily defined” (1998); the variability in training, confidence, and experience among volunteers who are not mental health professionals is an unknown that is explored in this study; the findings generated useful recommendations for change, as well as highlights of what is working well.

As a school counselor in the state of New Mexico for nearly 20 years, I am a member of the group of paid and volunteer professionals I studied. I hold a poignant interest in the mental health of youth in New Mexico and struggle to understand why their youth suicide rates continue to be among the highest in the nation.

Every year, I anticipate the release of our state reports on health and wellness with a heavy heart. Since I began my career as a school counselor, our youth suicide rate has far outstripped the national average. We consistently report youth suicide rates that are approximately double the national average:

**Table 1: New Mexico Rank Among States, by Year, with National Averages**

2005-2017, crude rates per 100,000, all races, both sexes, ages 5 to 18 years old Suicide, all mechanisms

<table>
<thead>
<tr>
<th>Year</th>
<th>New Mexico crude rate per 100,000</th>
<th>United States* crude rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>6.33</td>
<td>2.41</td>
</tr>
<tr>
<td>2006</td>
<td>6.07</td>
<td>2.15</td>
</tr>
<tr>
<td>2007</td>
<td>6.30</td>
<td>2.13</td>
</tr>
<tr>
<td>2008</td>
<td>7.28</td>
<td>2.47</td>
</tr>
<tr>
<td>2009</td>
<td>4.49</td>
<td>2.67</td>
</tr>
<tr>
<td>2010</td>
<td>5.19</td>
<td>2.53</td>
</tr>
<tr>
<td>2011</td>
<td>5.97</td>
<td>2.70</td>
</tr>
<tr>
<td>2012</td>
<td>4.75</td>
<td>2.85</td>
</tr>
<tr>
<td>2013</td>
<td>4.78</td>
<td>2.90</td>
</tr>
<tr>
<td>2014</td>
<td>4.33</td>
<td>3.37</td>
</tr>
<tr>
<td>2015</td>
<td>5.91</td>
<td>3.28</td>
</tr>
<tr>
<td>2016</td>
<td>4.88</td>
<td>3.45</td>
</tr>
<tr>
<td>2017</td>
<td>10.32</td>
<td>3.96</td>
</tr>
</tbody>
</table>

Intellectually, I wanted answers that could guide how I do my job; personally, I needed to know what was happening for others who work to reduce youth suicide in New Mexico. A personal desire to know, an intellectual interest to understand, and a passion for saving the lives of youth, are what drove me to study preventionists.

**What is a Youth Suicide Preventionist?**

For the purposes of this study, the term “preventionist” was used to describe adults who work (both paid and unpaid) to reduce youth suicide in New Mexico. Those adults include people who work for non-profit organizations, governmental agencies, and other organizations or institutions (such as schools); their prevention services may be paid or unpaid, funded publicly or privately. In addition to mental health professionals, many others engage in youth suicide prevention work: educators, health educators, public health workers, medical professionals, policy makers, epidemiologists, religious and spiritual leaders and laypeople, and more. To accurately and broadly represent suicide
preventionists in New Mexico, I did not exclude participants from this study on the basis of their job title or affiliation. Further, preventionist activities are defined as anything embodied in the World Health Organization’s “areas of strategic action” for suicide prevention (World Health Organization, 2014, pp. 68-69), including:

- Conduct evaluation and research
- Engage key stakeholders
- Change attitudes and beliefs
- Reduce access to means
- Conduct surveillance and improve data quality
- Engage the media
- Mobilize the health system and train health workers
- Raise awareness
- Develop and implement a comprehensive prevention strategy

**Theoretical and Conceptual Framework.**

I theorized the experiences and insights of preventionists are the key to both identifying and understanding what hinders the reduction of youth suicide because, so far, it appears everything we know about reducing youth suicide has yet to yield a lasting decrease in historically high youth suicide rates in New Mexico. Despite identification of risk factors, resiliency factors, and protective factors, New Mexico rates remain comparatively high (Sullivan, Annest, Simon, Luo, & Dahlberg, 2015; United States Department of Health and Human Services Office of the Surgeon General, 2012; World Health Organization, 2014). In New Mexico, and elsewhere, what is it that we are missing as we fight to reduce suicide rates? I believe preventionists hold valuable
information and experience that better inform this fight. Based on an initial review of the literature, suicide rates in New Mexico and the United States continue to climb despite efforts to reduce them (Substance Abuse and Mental Health Services Administration, 2014; World Health Organization, 2014); so, I proposed that barriers that hinder suicide prevention do exist. More pointedly, those barriers impact youth suicide prevention in New Mexico, and until those barriers are identified and understood, they cannot be addressed. I proposed that the experiences and insights of preventionists could be a highly effective tool in doing so.

**Summary of the Study**

I conducted a narrative, multi-interview study with preventionists from high-risk, low-income areas of the state. As an individual investigator, with limited material resources and time, I strove for insights that could contribute to a rich narrative, exploring and articulating meaning of the experiences of preventionists in New Mexico. Specifically, this study targeted people who work to prevent suicide in children of 18 years old and younger (children defined, for the purposes of this study, as aged five years to eighteen years old to encompass the typical school-going ages).

**Statement of the Problem**

Although the United States is considered a “high income” (World Health Organization, 2014, p. 88) nation, the site of this study (New Mexico) is an economically disadvantaged state (New Mexico Department of Health, 2013a, 2013b). New Mexico claims a uniquely diverse ethnic and cultural make-up in a largely rural setting (Peshkin, 1997; Roberts, 2001). Additionally, as a high-risk state (see Table 1: New Mexico Rank Among States, by Year, with National Averages
New Mexico is ideal for foundational research on youth suicide prevention and, more specifically, preventionists.

I posited our public education system does not have a complete protocol for youth suicide prevention, in that schools are not given specific guidance nor mandates to reduce youth suicide deaths (New Mexico Public Education Department, 2013). Current research gives us models to conceptualize suicide (Beautrais, Gibb, Fergusson, Horwood, & Larkin, 2009; Joiner, 2005; Novins, Beals, Roberts, & Manson, 1999; Swanson & Colman, 2013; Wissow, Walkup, Barlow, Reid, & Kane, 2001), factors for determining suicide risk, and procedures to protect from suicide (Center for Mental Health Services; Centers for Disease Control and Prevention, 2004; Gould et al., 2003; Hatzenbuehler, Birkett, Van Wagenen, & Meyer, 2014; Hirsch, 2006; Mann et al., 2005; Paskus, 2014; Koukel, S., & Jacobs, B., 2013; Sharaf, Thompson, & Walsh, 2009; Walsh & Eggert, 2007; World Health Organization, 2014), but what about the valuable experiences and insights adults who are working to prevent suicide among our youth have to offer? Do they have suggestions for a more complete protocol? There are innumerable opportunities to prevent youth suicide, yet rates remain relatively high in New Mexico. Despite all our knowledge about suicide, I was unable to locate literature and research depicting the experiences of individuals who work to reduce youth suicide. Preventionists are on the front line, working with youth, communities, families, and other groups. Research on suicidal individuals is abundant, therefore, examining the public health issue of suicide prevention from the perspective of those doing the work can give us a more complete picture of prevention. As a comparison, consider teachers, students, and education. If we only study students, their behavior, and factors contributing to their achievement without
learning about the experiences of teachers, we have an incomplete understanding of education.

Focusing this study on youth suicide preventionists is an effective and efficient strategy in reducing suicide in general, because evidence suggests the suicidal behavior of young people could be reduced using prevention programs in their schools and that a large majority of youth are subject to compulsory attendance laws that place them in school systems (Joe & Bryant, 2007; Kalafat & Ryerson, 1999; Sandoval & Brock, 1996; Substance Abuse and Mental Health Services Administration, 2012; Zenere & Lazarus, 2009). Further, early intervention with youth builds resiliency and skills that prevent suicide later in life among adults. Schools provide a venue to deliver suicide prevention in ways that are particularly promising for some of the most at-risk populations (Hatzenbuehler et al., 2014). By exploring the experiences and insights of preventionists, I sought an understanding of the barriers they may face and their successes; their experiences and insights add valuable information to discourse on public policy making, funding, and prevention work.

My curiosity, and deep concern, drove me to consider what might be thwarting current prevention efforts. There are precious few studies on youth suicide in New Mexico; I found no studies that consider the state’s youth population as a whole, nor barriers to prevention (Chino & Fullerton-Gleason, 2006; May et al., 2002; Singh & Lathrop, 2008; Styka, White, Zumwalt, & Lathrop, 2010; Vorenberg, 2006). Why do lower suicide rates elude New Mexico? I believe my questions about youth suicide prevention are best answered by preventionists; they work directly with people and have the unique perspective of being members of the communities they wish to impact through
their work. Analyzing suicide rates, risk factors, protective factors, and state demographics cannot give us the valuable information that preventionists provide about their work and involvement. I learned a lot from their experiences and insights, gained knowledge about so many factors that influence their prevention work, and listened to impassioned recommendations for change.

**Purpose of the Study**

This qualitative study contributes to the literature regarding youth suicide prevention, particularly in providing a deep understanding, with narrative and quotations, of the experiences and insights of the research participants involved. Greater understanding can serve as a catalyst for state-wide dialogue about prevention and funding and encourage new perspectives on program delivery, health and education policy, and collaboration in New Mexico. I aim to enhance the general literature on youth suicide prevention, particularly in the state of New Mexico, while providing an account of engagement in a deep, innovative investigation of the first-hand experiences of preventionists, their perceptions, and the meaning they make of this important work.

**Research Questions**

The following research questions guided this qualitative study:

1. What are the experiences and insights of professionals/volunteers working to prevent youth suicide in New Mexico from their perspective?

   a. How do these participants conceptualize prevention and decipher the relatively high rates of suicide among New Mexican youth?
b. What are the success stories of preventionists, and what contributes to positive outcomes in their work?

c. What are the challenges and barriers to preventing youth (aged five years to 18 years old) suicide in New Mexico?

d. What would help preventionists? What, or who, do preventionists identify as helpful to their continued work in suicide prevention?

Participant stories gave me a rich multi-layered and multi-perspective understanding of suicide prevention through the narratives of preventionists. I asked interview participants open-ended questions to explore their experiences and insights from their perspective with their prevention work in New Mexico. I also presented state and national suicide rate data to each participant to elicit their reactions, recommendations, and understandings of differences in rates.

**Significance of the Study**

The information gleaned by this study helps fill a void. Without an understanding of prevention at its most base level of work, discourse is simply speculation. I sought to enhance the literature on suicide prevention, in the state of New Mexico, while representing the personal experiences and insights of preventionists, the wisdom they carry from those, and the effects they see in their important work. This qualitative study is only the beginning of the discussion about what is happening among youth suicide preventionists in New Mexico and it sought to raise awareness of lived experiences. Ultimately, the enormous task of reducing youth suicide in New Mexico will always reside with those who do the daily work: families, faith communities, friend groups, community organizations, educational institutions, volunteers, paid professionals, and the
like; I pursued an understanding of that work and their experiences. This research breaks new ground because, to date, I am unable to find any studies or reports of the experiences of preventionists in New Mexico.

The intended professional audiences for this study are those interested in suicide prevention, intervention, postvention, public health, mental health, state-level policy makers, and professionals in education. This study contributes to the development of theory and research on youth suicide prevention; this is significant in the field of education policy because it makes known information that can be used to guide statewide prevention strategies and legislation that could save the lives of youth in New Mexico. Additionally, this study can assist mental health professionals and professionals in education as they consider approaches to youth suicide prevention. Because New Mexico is a low population state with a markedly unique and diverse ethnic make-up, and relatively low socio-economic status overall (New Mexico Department of Health, 2013a, 2013b; Roberts, 2001), research of this nature is limited. This research adds to the knowledge of state-level policy makers, school boards, and anyone who works with youth in the state of New Mexico.

Limitation and Delimitations of the Study

This study is limited in that the number of participants offers a limited variety of perspectives. Additionally, interview time with each participant was limited by travel, resources, and my timeline to complete the study, and that limits what participants were able to convey, remember, and share. Culture could play a role in limiting what participants were willing or able to share with me; this could have been out of respect for, or protection of, a particular population or group (i.e. a tribal leader choosing to keep
EXPERIENCES AND INSIGHTS IN NEW MEXICO

some stories private out of respect for their tribal members). Also, even using the snowball method, I may not have identified someone who has important or impactful information.

**The Importance of Terminology**

To engage in narrative discourse regarding suicide, it was vital that I utilized appropriate and respectful verbiage. I looked to the Centers for Disease Control and Prevention (CDC) to learn and avoid inappropriate suicide nomenclature and “unacceptable terms;” the CDC defines terms and provides suggestions about better ways of expressing meaning (Crosby, Ortega, Melanson, & National Center for Injury Prevention and Control (U.S.). Division of Violence Prevention., 2011). As in any field, the vocabulary of suicidology has evolved over time and continues to do so; modern themes in that evolution include removal of value-laden terminology, standardization of all terminology to aid in comparative data analysis, and an effort to encompass all facets of suicide (i.e. financial impact, social burden, injury, mental health, etc.) rather than simply focusing solely on a death by suicide (Crosby et al., 2011). I made every effort to use the most respectful and judgement-free terminology in this study by familiarizing myself with the CDC list of terms and continually consulting it as I interviewed, analyzed, and wrote. The CDC definition of suicide is used in this study: “death caused by self-directed injurious behavior with any intent to die as a result of the behavior” (Crosby et al., 2011). Other key terms and unacceptable terms pertinent to this study are as follows (Crosby et al., 2011):

**Table 2: Key Terms and Unacceptable Terms for Suicide Discourse**

<table>
<thead>
<tr>
<th>Key Terms</th>
<th>Unacceptable Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>Completed suicide</td>
</tr>
</tbody>
</table>
For the purposes of this investigation, the word “barriers” is defined as anything identified through the literature review, interviews, interview feedback, document review, or qualitative data analyses that slow, thwart, hinder, or extinguish youth suicide prevention efforts by individuals, organizations, governmental bodies, or institutions. The terms “youth” and “school age children,” for the purposes of this study, refers to individuals aged five through 18 years old unless otherwise noted. Though the majority of youth fall within that age range, I acknowledge there are those who do not, so I did not exclude any discourse regarding other ages during data collection.

**Summary**

The remainder of this manuscript includes a literature review, research design, appendices of data collection instruments, findings, and recommendations, as well as a list of references. Do our preventionists know why New Mexico reports suicide rates that are regularly well-above that of other states? Why is there such disproportion among states in a nation classified as having a “high income” economy (World Bank, 2013)? I expected preventionists in New Mexico would have some knowledge of working with low-income populations as well as with other populations at higher risk for suicide (i.e. lesbian, gay, bisexual, and transgender youth). The primary task of this study is to gain an understanding of what suicide preventionists in the state encounter as they do their work. With that knowledge, I made “analytic sense” of what is hindering their work (Charmaz,
2006, p. 3). That valuable knowledge can be applied to make prevention efforts more effective and, subsequently, save lives. From my participants, the preventionists, I learned useful and compelling information that gave me a deeper understanding of what can be focused upon in New Mexico. Through my own lens as a preventionist, in the following pages, I bring forward a new narrative for understanding suicide prevention (Charmaz, 2017). Even more valuable, participants gave rich insight into what they know works and what should be duplicated across the state, within and between communities. They also gave insight into what strengths can be engaged within communities, with individuals, and with particular identity populations. Preventionists are the people doing the work, and their experiences give us a wealth of information about prevention in New Mexico.
Chapter 2: Review of the Literature

Background

Regardless of how suicide is conceptualized, prevention is an important focus, and preventionists, especially in schools, are an important part of prevention. Prevention efforts are greater than ever in our national history, and a focus on prevention has become a central focus issue (Substance Abuse and Mental Health Services Administration, 2017). After decades of study, the conversation has turned to understanding the barriers to suicide prevention, refining strategies, and identifying challenges (Substance Abuse and Mental Health Services Administration, 2017).

Theorists pose numerous explanations for suicide: Robert Burton blamed suicide on “black bile” in the 1600’s (Burton, 2001), thwarted masturbation was a cause cited in the 1930’s (Murray, 1938); a more recent theory suggests “perceived burdensomeness and failed belongingness” (Joiner, 2005), while “exposure to trauma” is an oft cited explanation (Linehan, 1993). In any instance, death by suicide is tragic; its impacts are varied and can be far-reaching. The stigmatization of mental illness and suicidal ideation are prevalent in the United States and serve to increase the isolation and hopelessness of individuals struggling with mental health issues (Joiner, 2005; World Health Organization, 2014). Regardless of our diverse reactions to and opinions about suicide, prevention is an important focus (Centers for Disease Control and Prevention, 2004; United States Department of Health and Human Services, 1998; United States Department of Health and Human Services Office of the Surgeon General, 2012; United States Public Health Service, 1999; White & Morris, 2010; World Health Organization, 2014).
In pursuit of an understanding of preventionists, it is important to note that death by suicide is a limiting view of suicide which excludes attempts, behaviors, and ideation. Prevention does not only address death by suicide, but also addresses things like depression, anxiety, mental health stigma, self-injurious behaviors, and other related topics. Suicide reporting is not 100% accurate, as not all suicides are ruled suicide for lack of evidence (i.e. single car accidents, shooting accidents, overdose without letter, death by cop) (Crosby et al., 2011; Gambill, 2014; Substance Abuse and Mental Health Services Administration, 2012; United States Department of Health and Human Services Office of the Surgeon General, 2012; World Health Organization, 2014). Further, federal and state data collection and reporting of health and mortality data has been inconsistent over time; this is due to changing report parameters, evolving terminology and definitions, shifting public sentiment, and even technological issues in data collection (Crosby et al., 2011).

According to the World Health Organization (WHO), there is a suicide death every 40 seconds across the globe; that same report describes suicide as a “health imperative” which is “preventable” (World Health Organization, 2014). For the year 2012, the United States ranked 53rd for suicide rates among the 172 countries represented in the 2014 WHO study (pp. 80-87). In the United States, nearly one million deaths by suicide were reported to the Centers for Disease Control and Prevention (CDC) between 1981 and 2011 (Centers for Disease Control and Prevention, 2014a; Centers for Disease Control and Prevention, 2014b).

Notably, over a decade of data show suicide rates in the United States increased over time by 24.2%; it grew from 9.8 suicides per 100,000 people in the year 2000, to
12.1 suicides per 100,000 people in the year 2012 (World Health Organization, 2014). From the year 1999 to the year 2018 overall, suicide was the tenth leading cause of death in the United States for ages one to 85 years (Centers for Disease Control and Prevention). Moreover, suicide was the third leading cause of death overall for youth aged ten to 14 years old and youth aged 15 to 19 years old from 1999 to 2018 (retrieved from the CDC WISQARS™ database on 9/1/2020); for youth aged five to 18 years old, suicide was the second leading cause of death for the same time period (retrieved from the CDC WISQARS™ database on 9/1/2020).

The data show suicide as a prominent cause of death, worldwide; WHO researchers tell us there may be as many as 20 suicide attempts for each suicide death, which means there is a suicide death somewhere in the world every 40 seconds and a suicide attempt somewhere in the world every other second (World Health Organization, 2014). This means preventing suicide is a vast task, done by innumerable people; discussing the problem is only half of the story, with prevention being the other half.

**Suicide and its Prevalence and Persistence**

What impacts suicide rates? Federal resources have led to extraordinary collaboration among governmental agencies, non-governmental agencies, and institutions (United States Department of Health and Human Services Office of the Surgeon General, 2012); one may reasonably expect this would have a noticeable effect on the nation’s suicide rates. Prominent national studies and reports have generated common risk factors that have direct impact on suicide rates (National Action Alliance for Suicide Prevention, 2015; United States Department of Health and Human Services Office of the Surgeon General, 2012). Having causal factors clearly identified, one could anticipate a reduction
in suicides; in fact, the 2014 WHO report shows the national suicide rate continues to increase (World Health Organization, 2014); New Mexico suicide rates show a similar increase (New Mexico Department of Health, 2013b). If preventionists now know an abundance about the causes of suicide, why are we not seeing a decrease in rates? What are we missing?

What are preventionists doing in New Mexico? The literature is scarce when it comes to understanding the perspectives of suicide preventionists (May et al., 2002; Tsosie, 2011; United States Department of Health and Human Services, 1998; Wissow et al., 2001). Further, I was unable to find evidence of research in New Mexico that investigates the experiences of preventionists nor anything outside a few studies that targeted specific populations.

Despite a national trend toward the coordinated school health model, which is embraced by the New Mexico Public Education Department (New Mexico Public Education Department, 2013), there is no coordinated state-wide program to reduce youth suicide. To be effective, “suicide prevention efforts require a broad multi-sectoral approach that addresses the various population and risk groups and contexts throughout the life course,” and preventionists are those tasked with this work (World Health Organization, 2014, p. 30).

**Prevention and Outcomes of Prevention**

Through preventionists, essential departments within federal government and large non-profit organizations and faith communities are devoting enormous resources to disseminate the latest research-based prevention data and programs: the United States Department of Health and Human Services (DHHS) teamed with the Substance Abuse
and Mental Health Services Administration (SAMHSA) to publish the cost-free “Preventing suicide: A toolkit for high schools” (Substance Abuse and Mental Health Services Administration, 2012). The toolkit can be downloaded at no cost; it contains a plethora of information and resources that are meant for schools that wish to implement a suicide prevention program. Another example is the National Institute on Mental Health (NIMH); it published a comprehensive brochure to address common questions about suicide (Substance Abuse and Mental Health Services Administration, 2012), as well as a flyer that addresses youth and suicide (National Institute of Mental Health). Additionally, the United States Department of Veterans Affairs (VA) launched the “Veterans Crisis Line” campaign, which includes a toll-free crisis line, an online chat platform, texting responses, videos, prevention materials, and resources (Veterans Crisis Line, 2019). The American Foundation for Suicide Prevention hosts a website with an impressive offering of print and digital resources that address prevention (American Foundation for Suicide Prevention). Lastly, the Centers for Disease Control and Prevention (CDC) regularly adds to its offering of data and resource publications focusing on awareness and prevention (Centers for Disease Control and Prevention, 2014).

The previous examples are just a few of the various nation-wide efforts to increase awareness and make research-based prevention programs and resources available on a large scale. Additionally, innumerable agencies and organizations publish their own versions of suicide risk factors, warning signs, protective or resiliency factors, and resources for immediate help.

Looking back, on the heels of the 1996 WHO report on suicide, United States Surgeon General David Satcher was moved to publish the first federal report on suicide
The first of its kind, the Surgeon General’s report was a sparse 19 pages that aimed at introducing “an initial blueprint for reducing suicide and the associated toll that mental and substance abuse disorders take in the United States” (United States Public Health Service, 1999). The document was a marriage of what was known about suicide in America at the time and what needed to be studied; additionally, contributors provided a clear plan for collecting data and moving forward with a national plan to reduce suicide (United States Public Health Service, 1999). The contributors issued “15 key recommendations” they “categorized as Awareness, Intervention, and Methodology, or AIM” (United States Public Health Service, 1999, p. 6).


1. Promote awareness that suicide is a public health problem that is preventable
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services
4. Develop and implement suicide prevention programs
5. Promote efforts to reduce access to legal means and methods of self-harm
6. Implement training for recognition of at-risk behavior and delivery of effective treatment

7. Develop and promote effective clinical professional practices

8. Increase access to and community linkages with local health and substance abuse services

9. Improve reporting and portrayals of suicide behavior, mental illness, and substance abuse in the entertainment and news media

10. Promote and support research on suicide and suicide prevention

11. Improve and expand surveillance systems

The publication embraces a “public health approach to suicide prevention,” and although action-oriented, it lacks specifications for empirical measurement (United States Department of Health and Human Services, 2001, p. 29). In the year 2012, U.S. Surgeon General Regina M. Benjamin issued a 183-page revision that organized Satcher’s goals and objectives into “four interconnected strategic directions,” which served as a replacement structure for the previous “AIM” categories (United States Department of Health and Human Services, 2001; United States Department of Health and Human Services Office of the Surgeon General, 2012, p. 24):
Figure 1: Goals and Objectives for Action

(United States Department of Health and Human Services Office of the Surgeon General, 2012)

Another tool for preventionists, the 2012 revision emphasized a flexible approach to prevention that is “adapted to the distinctive needs of each group,” and can be used in a variety of settings (United States Department of Health and Human Services Office of the Surgeon General, 2012, p. 24). The graphic representation of the new model is intended to convey its “interrelated and interactive” nature (United States Department of Health and Human Services Office of the Surgeon General, 2012). A major revision is
evidenced, markedly, in the 17 added objectives and the extensive work done to produce a “crosswalk of goals and objectives from 2001 to 2012” (United States Department of Health and Human Services Office of the Surgeon General, 2012). The entire report is clearly a refinement of previous work, with an emphasis on integrating new data and information; unfortunately, suicide rates continue to increase (World Health Organization, 2014).

More recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a revised set of strategies, using data from preventionists, to produce the following goals that serve as guidelines for prevention work (Substance Abuse and Mental Health Services Administration, 2017):

1. Integrate and coordinate suicide prevention activities across multiple sectors and settings
2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors
3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery
4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide
5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors
6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk
7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors

8. Promote suicide prevention as a core component of health care services

9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors

10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides

11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action

12. Promote and support research on suicide prevention

13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings

Based on analysis of information gathered during the process of revising the goals, the following four recommendations were made to address needs identified by preventionists: 1) establish state, tribal, and community infrastructure for suicide prevention; 2) create a blueprint for effective community action that complements the guidance provided for health care by the Zero Suicide initiative; 3) promote comprehensive state and community suicide prevention efforts; 4) ensure regular and coordinated monitoring of National Strategy implementation (Substance Abuse and Mental Health Services Administration, 2017). Lastly, the plan generally classifies two realms of prevention: community and clinical.
Suicide and its Prevention in New Mexico.

In New Mexico, one of the high rate states, the suicide rate historically hovers between double and triple that of the national average (see Table 1: New Mexico Rank Among States, by Year, with National Averages.

Despite historically high youth suicide rates, research on prevention in New Mexico is limited and typically involves relatively small ethnic groups and implications that are not necessarily generalizable for informing statewide changes and initiatives.

Suicide research in the state is sparse and targets smaller Native American populations; though that research is inarguably important, examining the issue from a statewide perspective also provides valuable insight and helps begin to fill a gap in the literature. With a diverse population, New Mexico is mainly rural and impoverished (New Mexico Department of Health, 2013b; Peshkin, 1997; Roberts, 2001). Fifteen years after suicide prevention was spotlighted as a national imperative, (United States Public Health Service, 1999), New Mexico continues to lag behind, showing virtually no progress in lowering suicide rates; “developing a statewide suicide prevention plan,” the award of a 3-year grant from SAMHSA “to implement and evaluate youth suicide prevention programs,” and the establishment of two non-profit organizations dedicated to “address public health and community concern about suicide and attempted suicide” are notable ways the state addresses the alarming suicide rate (New Mexico Department of Health, 2013b). The absence of rich research on youth suicide prevention in New Mexico makes it especially important to gather insights from preventionists.

In 1999, the same year that U.S. Surgeon General Satcher’s report on suicide came out, the New Mexico Department of Health published “Hope for the heart: New
Mexico youth suicide prevention plan;” specifically, the plan was created to address the 400 percent increase in the suicide rate for youth aged 15 to 24 between the year 1950 and the year 1996 in New Mexico (Krider, Schnell, Larson-Bright, & Mares, 1999). According to the 163-page publication, it was meant to remain a living document that would be updated and amended over the course of the following five to ten years to reflect completed work, tasks, and action; I was unable to locate any follow-up documents that reflected a phase two or evidence of implementation, nor amendment and update. Here are the seven strategies identified in the plan (Krider et al., 1999, p. viii):

1. Develop a statewide youth suicide prevention coordinating committee
2. Develop and implement youth suicide surveillance, assessment, and evaluation protocols
3. Develop and provide a youth suicide prevention tool-kit for community members
4. Offer youth suicide prevention training
5. Promote a statewide public education campaign
6. Establish a statewide toll-free youth hotline
7. Build community resource capacity

Despite a follow-up publication to the “Hope for the heart” plan, there are some noticeable similarities between it and a 2005 publication. The New Mexico Department of Health Secretary Michelle Lujan Grisham led Governor Richardson’s Task Force on Youth Suicide Prevention in generating a 15-page recommendations document, which included the following “recommendations and multi-year action steps” that were to span three years of implementation (New Mexico Department of Health, 2005):
• Working with statewide and local suicide coalitions, the Behavioral Health Collaborative and the contractor designated as the statewide entity, implement a statewide campaign that targets communities, families, and youth to eliminate the stigma associated with suicidal behaviors and efforts to find help, and address survivor bereavement, mental illness, and substance abuse

• Deliver a suicide prevention program through the Public Education Department for kindergarten through 12th grade students as part of a comprehensive health education program

• Through the New Mexico Behavioral Health reorganization, increase and maintain suicide prevention and intervention strategies throughout the behavioral health systems, emphasizing local/community-oriented strategies

• Identify available bioterrorism funding in the Department of Health to create a safe school environment that is conducive to learning by providing suicide prevention and intervention and post-suicide intervention training for K – 12 school personnel, school-based health center personnel, youth-oriented community organizations, and first responders

• Develop child and adolescent behavioral health care workforce, including identifying barriers to licensing, simplifying licensing processes and developing the means to actively recruit professionals, as directed in Governor’s Executive Order 2004 – 062
• Implement a suicide surveillance system for New Mexico that enhances current data collection activities and collaborative data analysis

• Expand behavioral health screening and referral to treatment services in schools, primary care, youth community organizations, juvenile justice settings, and in the community

• Support and fund a statewide crisis line that integrates suicide prevention information and referral services that are directly accessible to youth, families, and communities. The crisis line would not charge callers who make calls by cell phone. Provisions could be made to make free cell phones available through schools or other organizations to children without landline phones

• Support and fund statewide and local coalitions implementing suicide prevention activities and programs

• Jumpstart the Statewide Entity to recruit, train and maintain professional satisfaction of quality community-based child and adolescent trained mental health/substance abuse providers, especially in rural areas

More recently, suicide prevention was included in the New Mexico 2020-2022 State Health Improvement Plan (SHIP), which led to the convening of “a work session with representatives from a wide variety of groups who (were) asked to participate in reviewing, refining, and fleshing out a state-wide Strategic Plan for Suicide Prevention” (New Mexico Department of Health, 2018a). The SHIP recognizes “suicide and suicide-related behaviors” as “a significant public health concern in New Mexico,” and that “New Mexico youth report high rates of persistent sadness or hopelessness, suicidal
ideation, and suicide attempts” (New Mexico Department of Health, 2018a, p. 17).

Within the SHIP, statewide goals and strategies for suicide prevention are:

1. Statewide goal: Develop a statewide suicide prevention plan
   a. Strategy 1: Convene stakeholders and develop a statewide plan based on evidence of effectiveness

2. Statewide goal: Increase the number of suicide gatekeepers
   a. Strategy 1: Increase the number of suicide gatekeeper trainings
   b. Strategy 2: Pass the suicide gatekeeper legislation

3. Statewide goal: Increase secondary prevention of suicide through emergency departments
   a. Strategy 1: Implement pilot program in Santa Fe County
   b. Strategy 2: Expand programs throughout New Mexico, once pilot program is fully implemented

This Strategic Plan includes “a plan for increasing the number of individuals in communities who receive suicide gatekeeper training, particularly school personnel, and implementing programs in emergency departments across the state to enhance preventative care provided to patients who present with suicide attempts and ideation” (New Mexico Department of Health, 2018a, pg. 18). Progress of these endeavors is reported quarterly, and the work is ongoing (New Mexico Department of Health, 2020b).

Lastly, state “Child Death Review Legislation” established a “child fatality review team” (CFR) for suicide in 1998; the CFR panel for suicide is a “retrospective case review of death in the . . . child population . . . by a multidisciplinary team of
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experts” whose purpose “is to reduce future rates of such deaths by identification of prevention factors, risk reduction factors and/or systems failure factors and the dissemination of such information to policy makers, providers, communities and to the public” ("Maternal, fetal, infant and child death review," 1998). As of 2020, the most recent annual report from the CFR was published in May 2015 (Office of Injury Prevention, 2015). That report identified the following:

Key findings

1. There were 52 suicides of New Mexico children in 2011-2013.
2. The suicide rate was highest among American Indian children and among males.
3. Suffocation was the leading mechanism of suicide among American Indian children and accounted for 56% of suicides in this population.
4. Suffocation (67%) and firearms (29%) were the leading mechanisms of suicide among Hispanic children. Together they accounted for 96% of the suicides in this group.
5. Of the 40 suicides reviewed, 20% (n=8) had previously discussed suicide or threatened to commit suicide.

Recommendations

1. The NM Public Education Department should promulgate a regulation requiring a standardized orientation day for all mid-high and high school students to include information and sources of help and support at each school, to help prevent suicide, and develop a teacher refresher module on school-based resources for student counseling and
assistance. In addition, School Safety Plans should include information on how to appropriately respond to the suicide of a student or staff member.

2. The Human Services Department, the Behavioral Health Collaborative, and private insurance companies should increase the availability of behavioral health screening and treatment services for adolescents by increasing compensation to providers offering these services.

3. The NM Board of Social Worker Examiners should require completion of two hours of education in suicide prevention for NM licensure.

(Office of Injury Prevention, 2015)

**Using School Systems for Suicide Prevention.**

The public education system is an ideal platform for reducing youth suicide through the implementation of statewide, multi-faceted, and developmentally appropriate suicide prevention programs (Joe & Bryant, 2007; Kalafat & Ryerson, 1999; Sandoval, London, & Rey, 1994; Substance Abuse and Mental Health Services Administration, 2012). Preventionists are integral in prevention designs and implementation. For more than a decade, the topic of suicide prevention has appeared in the New Mexico Public Education Department’s (PED) guidance for School Safety Plans (New Mexico Public Education Department, 2008, 2013). These Plans require every brick and mortar school in the state to include a suicide prevention component to their school safety plan; by mandate, schools update the plans every year and submit them to the PED for review.
every three years. Schools who do not provide a plan that sufficiently addresses all components are flagged by the PED and their district is sent a letter of non-compliance, with instructions to revise and resubmit for approval ("School district wellness policy," 2006). Additionally, the state of New Mexico’s Office of School and Adolescent Health suicide prevention activities includes the following:

- Students in New Mexico have access to behavioral health services at the 52 school-based health centers including access to preventionists.

- Teachers in New Mexico have access to a free, one-hour, on-line interactive gatekeeper training simulation designed to prepare high school and middle school teachers and staff to recognize the common indicators of psychological distress and how to approach an at-risk student and refer to the appropriate school support services.

- A statewide Youth Suicide Hotline network was developed in 2006 to offer resources for those in crisis. Receiving approximately 17,000 calls annually, the statewide network reaches youth in crisis and provides bilingual services.

- A federally funded SAMHSA Garrett Lee Smith Youth Suicide Prevention grant was awarded in August of 2012 for statewide suicide prevention initiatives.

- The Office of School Health, in collaboration with the New Mexico Suicide Prevention Coalition and New Mexico Suicide Intervention Project provide trainings on suicide prevention and intervention throughout the state.
Across states, suicide rates for school aged children (aged five years to 18 years) vary widely; for example, 2010 data show rates as high as 12.26 suicides per 100,000 people in South Dakota to a low of 1.51 suicides per 100,000 people in New York state (Table 1: New Mexico Rank Among States, by Year, with National Averages).

Our “knowledge about suicidal behavior has increased greatly in recent decades” (World Health Organization, 2014), yet New Mexico reports ominously higher suicide rates than other states (Table 1: New Mexico Rank Among States, by Year, with National Averages). In addition to economic factors, Native American populations and sexual minorities are at higher risk for suicide (Curtin, 2016; Wissow et al., 2001).

The site of this study, the state of New Mexico, “has, over the past two decades, consistently reported suicide rates that are at least 50% higher than the U.S. rate” (New Mexico Department of Health, 2018). According to the literature, we have identified suicide prevention knowledge but, despite that, New Mexico’s school-aged children continue to die by suicide at comparatively higher rates than their peers in most other states; with rare exception, the rates have increased each year, for the past 30 years. This information begs the question: what is hindering suicide prevention efforts in New Mexico from having an observable impact on the suicide rate of school-aged children? Our preventionists are key in understanding youth suicide prevention.

**Preventionists**

How do the immense influences of suicide and its contexts impact the job of the preventionist? Scholars in the field of suicidology theorize that each suicide has a direct, significant impact on six to 15 people (Schneider, Grebner, Schnabel, & Georgi, 2011;
Research supports the idea that media coverage of suicide can actually increase suicide rates (Edwards-Stewart, Kinn, June, & Fullerton, 2011; Pirkis, Blood, Beautrais, Burgess, & Skehan, 2006; Sudak & Sudak, 2005). Ironically, there is also evidence the media can play a role in decreasing suicide rates (Romer, Jamieson, & Jamieson, 2006). Online, anyone can learn the most effective suicide methods, converse about suicidal ideation, view graphic video or pictures exhorting suicide, or obtain anonymous, immediate help and support (Westerlund, 2013). What other influences, barriers, and systems impact the preventionist?

When I reviewed the following most recent reports that relate to health and mental health for youth in New Mexico, I found no mention of how preventionists should be trained, information on the experiences of the preventionists doing the fieldwork to reduce youth suicide, nor best practices for those preventionists:

1. The status of health and mental health in New Mexico (New Mexico Department of Health, 2013)
2. The New Mexico department of health fiscal year strategic plan (New Mexico Department of Health, 2014)
3. Health equity in New Mexico: A report on racial and ethnic health disparities (New Mexico Department of Health, 2013a)
4. Planning for safe school in New Mexico (New Mexico Public Education Department, 2013)

I also searched all the available databases within the Elton Bryson Stephens Company data service (EBSCOhost) for the University of New Mexico Health Sciences Library and utilized keywords (applied to all search fields and the full texts) to determine
a body of literature pertinent to this study. After an exhaustive search of the literature, targeting suicide preventionists in New Mexico, I found nothing beyond the short list above. I also was not able to locate any requirements for the licensing of educators nor mental health providers, as relates to suicide prevention training. Reviewing the literature, I discovered this study adds to both the breadth and depth of our understanding of youth suicide in New Mexico by sharing the experiences of the preventionists. Ultimately, a better understanding can lead to changes that reduce youth suicide.

**Types and Training.**

According to the literature, the training of preventionists falls into two general categories: clinical or community. Clinical training refers to medical and behavioral health settings, typically with licensed clinicians (such as therapists, counselors, psychologists, psychiatrists), and centers on the provision of treatment (i.e. psychotherapy, medication, behavioral modification). Clinical training is formal, taking place through educational systems, and is typically completed in certification or degree programs at colleges and universities. Community training is broadly classified as gatekeeper training, which involves training laypeople, or non-mental health professionals, in how to recognize warning signs and how to respond to help someone who may be suicidal.

The literature demonstrates no direct causal link with any particular prevention methods, but rather, suggests reducing risk factors and increasing protective or resilience factors directly has the most impact. This sort of work is upstream from gatekeeper training and clinical treatment, in that it addresses the reasons people become hopeless and then suicidal. This leaves us with so many questions about prevention work, such as:
where and when should prevention begin? Who is best situated to impact mental health and prevention efforts?

**How This Study Contributes to Existing Literature.**

There is a vast literature about suicide and suicide prevention: the mechanisms, history, risks factors, protective factors, effective prevention programs and curricula (Gould et al., 2003; United States Department of Health and Human Services Office of the Surgeon General, 2012; World Health Organization, 2014). Yet, New Mexico suicide rates remain high, and I could find no literature exploring the people who are tasked with doing the prevention work, the influence of their prevention activities on suicide, or their insights, experiences, and suggestions. This study provides a beginning to an understanding in those areas.

This investigation focused on how the work of preventionists is impacted by policy, funding, culture, religion, spirituality, resources, and what we have yet to consider. There is a broad base of literature that tells us about the warning signs of suicide, the protective factors, and rate of incidence; what we lack is the perspectives of people who attempt to synthesize that information in their work. Preventionists who serve youth (aged five to 18 years old) will be targeted, since schools are clearly in a prime position to identify and implement changes that can reach the majority of that age group. The participating preventionists work with schools in various capacities: as volunteers, paid professionals (i.e. educators, nurses, therapists, juvenile justice, public health, and spiritual leadership), and community partners such as non-profit organizations. Interview participants included suicide preventionists in the state, known to me through previously established professional relationships (Miles & Huberman, 1994), and then the snowball
method was employed to acquire additional participants with a rich knowledge of the topic (Creswell, 2007; Seidman, 2006).

Based on a review of the literature, suicide rates in New Mexico and the United States continue to climb despite efforts to reduce them (Substance Abuse and Mental Health Services Administration, 2014; World Health Organization, 2014). Interviews addressed what, specifically, barriers impact the reduction of New Mexico suicide rates; identifying those barriers is the first step in addressing them.
Chapter 3: Research Design

Summary of the Study

Through this qualitative investigation, I explored the experiences and insights of preventionists, from their perspective, as they conduct youth suicide prevention work. A main goal in this study was to reveal barriers that hinder suicide prevention, as well as presenting the solutions and recommendations of my participants. Stories, meaning making, and suggestions from individual interviews with preventionists are incorporated into a rich narrative that can help us conceptualize their roles, knowledge, suggestions, and experiences, as well as understand their successes and barriers. Specifically, I explored what participants perceived is and is not working as they attempt to overcome factors that put the youth of New Mexico at high-risk for suicide. Certain questions come to mind when considering the high suicide rates: Are we doing enough? Do our programs work? Is funding sufficient? Is there public and community buy-in? Do New Mexicans believe youth suicide is preventable? What are we missing? My interviews with preventionist participants helped me answer many questions.

Through this study, I was able to produce a narrative of the experiences and insights of youth suicide preventionists in the state of New Mexico. I conducted a qualitative, narrative study in which my methods included individual interviews and follow-up interviews over the course of 12 months. My research design focused on understanding the experiences and insights of the participants from their own perspective.

Using open-ended questions to explore their perspectives, I gathered preventionist stories, insights, suggestions, and meaning making, in order to compose a rich, multi-layered and multi-perspective understanding of suicide prevention. In second-round
interviews, I presented the most recent state and national suicide rate data to each participant to elicit their reactions, recommendations, and understandings of differences in rates. Due to the vastly unknown impacts of the COVID-19 pandemic, I asked participants to address and interweave the impact of the pandemic on their work and youth suicide prevention, as well as mental health.

**Mode of Inquiry: Qualitative**

The two principal methods of research are categorized as qualitative or quantitative; they can be used in combination or independently. I chose to explore the stories of my participants through qualitative study because I wanted to know about the experiences of adults who work to prevent youth suicide in New Mexico, and “stories are a way of knowing” (Seidman, 2006, p. 7). A qualitative mode of inquiry is the logical choice to begin exploring stories (Creswell, 2007; Denzin & Lincoln, 2005), because I want to make meaning from their stories while showing connections between them and comparing “select details of their experience” in their interviews (Seidman, 2006, p. 7).

**Qualitative Methodology - Narrative**

Narrative research best fit this study since I wanted to describe the experiences of participants through their own experiences and insights and in their own words (Creswell, 2007). Using multiple interviews to compose unique narratives, I gained a deeper understanding of these preventionists. Using a narrative approach, to relay the rich stories and experiences of my participants, helped minimize the boundaries of a more prescribed delivery of the information and accommodated deep, nuanced information that was previously unknown to me (Wertz et al., 2011). In essence, narrative research allowed participants to establish their own limitations and boundaries, rather than me as the
researcher constraining them and their stories. Narratives are stories told by the participants and curated by the researcher.

**Positionality: Researcher’s Orientation to the Literature and the Study**

I was an observer-participant, as well as researcher in this study. I am a white, 45-year-old, lesbian, graduate student at a university in the southwestern United States. I was able to contribute my own experiences to this study and found that gaining access to preventionists was made easier as a currently practicing preventionist in New Mexico. Participants were asked questions that may have been emotional for them, or they may have felt apprehensive, and I believe my status as a preventionist was an asset in accessing the full depth of their experiences. As a researcher who is a preventionist, I was in a unique position to compose evocative interview questions as well as develop needed real-time wordrewording of questions for clarification. I am also experienced in probing more deeply for stories, following lines of thought, and asking for clarification whenever it is needed; given the focus of the research, these skills were highly relevant to gathering participant stories.

My own experience with survivors and their reactions has been, literally, lifelong; my Mother’s sibling died by suicide many years before my birth. My Mother openly discussed mental health stigma, shortages in mental health resources and providers, as well as the circumstances of my family member’s suicide. Growing up with these conversations, I believe I was much more aware of suicide and mental illness than my peers. My Mother made sure I was able to talk about these issues, and that has inevitably produced a different sort of worldview in me than if I had not had those conversations. My lens is that of an insider, when it comes to suicide and its impact. Additionally, I
never heard critical or condemnatory words about suicide in my childhood and early adult life. This life experience is helpful to my research, in that it promotes a more neutral approach that is less likely to stigmatize mental health and helps me come from a less judgmental perspective than someone who was raised to view suicide in a negative or value-laden manner.

As a professional school counselor, I have experienced the loss of several students to suicide. Those experiences heightened my desire to reduce suicide and assisted me in understanding the preventionists in my study. During my 20-year career as a school counselor in New Mexico, I worked with countless students who displayed some level of suicidal ideation. Currently, I work as the statewide youth suicide prevention coordinator for a department of health. My personal experiences with suicide, depression, and suicidal ideation include my close family members and friends. The lifelong impact of the suicide of my Mother’s sibling is always present for me and continues to influence my life. My Mother’s open and inviting attitude toward discussions about suicide and depression continue to impact my values, interests, and advocacy. Carrying this openness into my research helped ease discussion during my interviews with other preventionists; my professional experiences as a counselor made me aware of the stigma that is often associated with mental health issues and helps me have easy and open discussions about them. Collectively, my personal and professional experiences increase both my sensitivity to and passion for suicide prevention, and made it easy to quickly establish rapport with my participants.

To minimize my own biases, I journaled after every interview to reflect on the process and content as well as my own reactions and thoughts; this helped me remain
cognizant of how I impacted this research and how I interpreted participant stories. I endeavored to make meaning using quotes, examples, and stories so that readers can understand through the voices and experiences of participants.

My personal and professional experiences with youth suicide prevention in New Mexico enhanced the interview process and aided in making meaning of the chasm between youth suicide rates and youth suicide prevention efforts in the state. Considering my own lenses through which I investigated, my personal experiences and my interpretation of the interviews colored the findings. Using my listening skills, developed over my 20 years as a school counselor and 15 years as a crisis interventionist, I strove to remain as neutral as possible and remain open to new ideas and theories.

At the foundation of this study resides a personal and professional understanding that youth suicide is preventable; I choose to hold this belief. Further, I plainly believe youth suicide should be prevented. Lastly, I reject the notion that suicide should be viewed as another facet of “survival of the fittest” (Spencer, 1898, p. 444) or “natural selection” mechanisms (Darwin, 1860, p. 60).

Site of the Study

“More than half a million New Mexicans—over one-quarter of the state’s population—live in poverty,” in “the fifth largest U.S. state in terms of land area . . .” but with a relatively small population as “the 36th most populous state” (New Mexico Department of Health, 2013b, pg. 6). The state’s “population distribution by race and ethnicity is strikingly different from that of the United States overall, with smaller proportions of persons who are Black and Asian, and larger proportions of person who are American Indian and Hispanic . . . while White, non-Hispanic persons comprised a
EXPERIENCES AND INSIGHTS IN NEW MEXICO

minority (41.4%) . . . in 2012” (New Mexico Department of Health, 2013b, pg. 6). As an economically disadvantaged, ethnically diverse, and mainly rural state, (New Mexico Department of Health, 2013a; New Mexico Department of Health 2013b; Peshkin, 1997; Roberts, 2001), to date, New Mexico has yet to publish a statewide strategic plan for suicide prevention. The few suicide studies in the state have not addressed obstacles to reducing the youth suicide rate (Chino & Fullerton-Gleason, 2006; Lathrop, 2013; May et al., 2002; Styka et al., 2010; Vorenberg, 2006). A lack of information and the high suicide rates alone make the state of New Mexico worthy of study and exploration. Moreover, the state’s long history of several decades of comparatively high suicide rates adds to the timeliness of this study; the need for insight is urgent.

Summary of Methods

To gather storied narratives from preventionists, I used a series of three semi-structured interviews with each participant so that there was time for reflection, for me to review what I learned in between interviews, add and hone questions, identify themes, incorporate topics from previous interviews, and improve my collection of information with each subsequent interview (Seidman, 2006; Weiss, 1994). Using my 20 years of experience as a counselor, I also reviewed my own interview notes, my interviewing journal, and the recordings of the interviews, in order maximize my understanding and add process notes to my data. This allowed me to notate voice inflection, tone, cadence, speed, and other elements not captured in the textual transcripts of each interview and added meaning beyond their spoken words.

Nature of the study
I conducted initial interviews in person, via telephone, and over virtual meeting platforms (Zoom© and Microsoft® Teams), with preventionists I know, and then utilized the snowball method for adding more participants. Every interview was one-on-one, with follow-up via email and telephone to solicit additional thoughts for each interview. Prior to the COVID-19 pandemic, all interviews were conducted face-to-face; due to public health orders addressing the pandemic (Kunkel, 2020), all interviews conducted after March 16, 2020, were completed using either telephone or virtual meeting platforms that were agreed upon by the researcher and each individual participant. Interviews varied in length from approximately two hours to 45 minutes. Semi-structured interviews were used, with a written set of questions to begin the conversation and provoke thought, with the unstructured portion being more directed by the participant and what topics were most important to them, rather than the interviewer (Wertz et al., 2011). I added the topic of the COVID-19 pandemic’s impact on mental health and suicide prevention to all interviews, after March 16, 2020, in order to capture that aspect of participant work and experiences.

**Semi-Structured Interviews**

I began the first-round interviews with a structured approach, starting with a set of pre-determined questions (see Appendix A: Interview Questions). Every interview was concluded with the final questions: Is there anything you’d like to add that I haven’t asked you about? Or anything that is important to you that I include? In the second-round interviews, I presented the themes I identified from first-round interviews, then asked the participant for their feedback and thoughts on each theme. For the third, and final, round of interviews I presented themes from second-round interviews and asked for input; I also
asked participants to provide their ideas, wishes, and hopes for changes that would
decrease youth suicide in New Mexico. For all interviews, I used probes, rewording,
summarizing, and reflection help participants feel more comfortable and to increase my
understanding of their stories and meaning making.

A total of seven individuals were interviewed, three times each over the course of
12 months, including (Seidman, 2006) a follow-up invitation via telephone and email
after each interview to clarify and ask for additional stories to illustrate key aspects; this
gave participants an opportunity to add anything they may have thought of after their
interviews. Using less structure for each interview round allowed for a progressively
more conversational approach with each round which resulted in a more natural approach
“where the unknown is more easily accessible and participants are not held to the
interviewer’s limiting views or biased structure” (Creswell, 2007).

Since I believe every person has a unique experience in the world, I explored
multiple truths in the constructivist tradition (Patton, 2001). Using this approach, I crafted
open questions to allow for unexpected responses (Marshall & Rossman, 2006). I used
follow-up questions to clarify and deepen my own understanding of each participant’s
experiences. Using open-ended questions, I discovered attitudes, information, and stories
that I would not have heard if I utilized only closed-ended questions (Denzin & Lincoln,
2005). Conducting a second interview with each participant helped me explore facets I
discovered through my review of the first interview content, and it gave me the
opportunity to seek clarification and deeper understanding. Second interviews also gave
participants the opportunity to add to, complete, or expand their information from the
first interview. I asked clarifying questions and elicited additional stories as follow-up
from the first interview. Lastly, the third interview allowed time to discuss themes from the previous two interviews, covering de-identified information from all participants, which helped compare and contrast participant experiences and better understand their stories and perspectives.

Once themes were identified and presented back to participants, it was clear when we had reached the point of “saturation of information,” signaled by multiple returns and mentions of similar topics (Douglas, 1976; Glaser & Strauss, 1967; Lincoln & Guba, 1985; Rubin & Rubin, 1995; Weiss, 1994). I worked to minimize the effect my own experiences had on this research by using open-ended questions to explore the experience of others, rather than applying a set of closed ended questions that would be crafted through my own lens of personal experience (Creswell, 2007). In addition, I asked probing questions to gain deeper understandings and regularly asked participants to share examples and narratives describing various aspects of their experiences. In this way, I developed a rich description of narratives of preventionists’ experiences and remained as authentic as possible to what they shared with me. As a member of the group I studied, I also used my own experiences to stimulate ideas and create questions during discussion.

Participants and Sampling

The study focused on preventionists who work directly on reducing youth suicide in the state of New Mexico. Interview participants were recruited using a snowball method (Bertaux, 1981; Charmaz, 2008a; Creswell, 2007; Seidman, 2006), starting with preventionists known to me through my own suicide prevention work. As I selected participants from the names given to me by the initial participants, I worked to reduce the chances of personal or economic agendas affecting interview content by balancing views
from both private or non-profit and governmental or public settings. I began with three key individuals, then used a snowball method to determine subsequent participants, largely based on the fervency of initial recommendations and the suggested participants particular experience with cultural groups, ethnic groups, and other factors in representing the vast diversity of Peoples in New Mexico.

Interviews were conducted only with participants of legal majority age (Annas, 1992; Reynolds, 1979). Seeking participants active in suicide prevention, both paid professionals and unpaid volunteers, served to increase the likelihood of obtaining current and pertinent information about effective prevention strategies and barriers. At the beginning of every interview, and the end of the final interview, I asked each participant to provide a first name or chosen pseudonym to be used in this study; I asked multiple times in order to give participants the chance to change their minds about whether or not they were identifiable. This was an extra precaution so that participants could consider the cumulation of the information they provided and then decide if they wanted to be identifiable; this extra measure was an effort to protect participants from possible negative impacts of sharing their authentic experiences and opinions.

To represent the views of the many cultural groups of New Mexico, I intentionally sought interview participants who could speak from personal and professional experience and provide multiple lived, cultural perspectives (Peshkin, 1997). I was fortunate to have sampled participants in the following generations, by age group: twenties, thirties, forties, fifties, and sixties. Below is a table of participant characteristics, I was able to include through my snowball sampling method, that add breadth to the body of perceptions gathered.
Table 3: Seven Participant Sampling Grid

<table>
<thead>
<tr>
<th>Participants (n = 7)</th>
<th>Self-reported participant demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported participant experience with:</td>
<td>Cisgender man</td>
</tr>
<tr>
<td>Rural areas</td>
<td>x</td>
</tr>
<tr>
<td>Suburban areas</td>
<td>x</td>
</tr>
<tr>
<td>Urban areas</td>
<td>x</td>
</tr>
<tr>
<td>Community work</td>
<td>x</td>
</tr>
<tr>
<td>Government work</td>
<td>x</td>
</tr>
<tr>
<td>Clinical settings</td>
<td>x</td>
</tr>
<tr>
<td>Northwest public health region of New Mexico</td>
<td></td>
</tr>
<tr>
<td>Northeast public health region of New Mexico</td>
<td></td>
</tr>
<tr>
<td>Metro public health region of New Mexico</td>
<td></td>
</tr>
<tr>
<td>Southwest public health region of New Mexico</td>
<td></td>
</tr>
<tr>
<td>Southeast public health region of New Mexico</td>
<td></td>
</tr>
<tr>
<td>Hispanics</td>
<td>x</td>
</tr>
</tbody>
</table>
### Research Process/Protocol

To keep my research findings true to participant perspectives, I: a) invited participants to take their own notes, if they wished, during each interview and asked them to share their notes with me at the end so I could include any additional thoughts they offered during the interview; b) contacted all participants via telephone and email (for those who were willing to provide me with a telephone number and email address) for follow-up to add to or expand on their interviews; and c) followed-up with participants during their interviews whenever I needed to clarify their meaning. To help maintain confidentiality, I was the only researcher involved in this study. For all documentation, note-taking, and labelling, I used the first names or pseudonyms that participants chose; I

<table>
<thead>
<tr>
<th>Native Americans</th>
<th>x</th>
<th>x</th>
<th>x</th>
<th>x</th>
<th>x</th>
<th>x</th>
<th>x</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGBTQ</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Poverty</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Elementary schools</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Middle schools</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>High schools</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Faith or spiritual communities</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Special education</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Formal preparation</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Informal preparation</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Paid work</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Volunteer work</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
maintained use of the chosen pseudonyms in my findings, except for those who chose and provided written permission to use their first names. Finally, I destroyed all recordings after transcribing so that voices cannot be matched with transcripts or any narrative used in the dissertation or other publications. With informed consent and written permission, I recorded the audio of each interview and wrote process notes. Additionally, I composed research notes immediately after every interview. I reviewed transcripts and identified themes and illustrative quotes, continually, so that I could present them to my next interviewee.

**Data Analysis**

After completing first interviews with all participants, I used a professional transcribing service that met the requirements of the University of New Mexico Institutional Review Board. Using those transcripts, the original recordings, and my own interview notes, I assigned meaning to their stories by identifying themes (Creswell, 2007). To increase the accuracy of data collection and analysis, I present themes from within and across interviews to participants in each subsequent interview and encouraged them to recapitulate their meaning for me to better understand their messages. As noted in the Semi-Structured Interviews section, as well as other sections, I used a variety of processes throughout interviews to identify and process emerging themes with participants, as well. Employing qualitative research, and using three interviews with each participant, allowed me to do this kind of emergent and deep exploration and analysis of data collected during my study.

After every interview, I notated each transcript with process notes and content summary notes, then added in my own notes that I took during the interview. Although I
invited them to take notes and share them with me, none of my participants provided any interview notes. Between each of the round one interviews I followed this notating process so that I could share deidentified topics and recurring themes with each subsequent round one interviewee. After round one interviews were complete, I analyzed all transcripts, with summary and process notes, to identify both recurring themes and topics and those that were outliers. When I began the second round of interviews, I presented the themes and outliers from round one to each participant and asked for their feedback, insights, and to compare their experiences to the deidentified data I collected from other participants. At each interview, I presented both the deidentified data as a collection and that which I collected from the individual I was interviewing. I repeated this between and after each individual interview and each completed round of the total of 21 interviews. I used this constructivist approach to make meaning of the three interviews I conducted with each of the seven participants (Charmaz, 2017), while presenting that data in a narrative to represent the voices of research participants.

Quality and Rigor of the Research Design and Study

Ethics, Compliance (Institutional Review Board)

To address interview participant concerns regarding anonymity, all participants were asked to choose their own first name or a pseudonym to be used in this report of the findings of this study. I also replaced specific job titles, agency names, organization names, locations, and any other identifying information with a general description of their functions (i.e. a non-profit organization that works with youth) or broad geographical references (i.e. changing a town name to be descriptive, such as a medium sized town in northwestern New Mexico).
The participation consent form included the option for interviewees to stop the interview at any time, drop out of the study at any time, or decline to answer any question; I reiterated these options, verbally, at the beginning of every interview. De-identification and multiple opportunities help address both imminent and perceived safety and confidentiality issues (Creswell, 2007; Seidman, 2006). I obtained written and verbal consent to record audio for each interview; reviewing recordings permitted me to produce two layers of analysis, while allowing me to focus on the interviews as they unfolded (Denzin & Lincoln, 2005; Patton, 2001; Strauss & Corbin, 1990). I also utilized recordings to reflect upon and improve my interview style and listening skills (Seidman, 2006).

To help reduce researcher bias, I solicited participant feedback during and after each interview. I did not observe, nor was I alerted to, participants incurring any negative consequences due to interviewing, but there is always the possibility for discomfort in discussing the topic of youth suicide and negative experiences in prevention work. I provided participants appropriate referral information, so they could easily locate services, should they experience negative effects after interviews. All participants were given the contact information for both national and state hotlines for suicide prevention and crisis intervention, in case they wished to speak with a professional in mental health. I negotiated mutually safe, private, and convenient interview venues (both in-person and virtual), time, and date with each participant for each interview. Chosen venues and virtual platforms lent to clear recordings and met both our requirements and preferences for privacy and comfort. I provided opportunities before, during, and after each interview for participants to express concerns and ask questions, so as to reduce stress and anxiety.
I rigorously adhered to all ethical guidelines, policies, and procedures set forth by the University of New Mexico Institutional Review Board (IRB), as well as my professional organization: the American School Counselor Association. I obtained IRB approval for this research before commencing, used all required consent forms, followed all protocols, and completed all mandatory training.

I disclosed a brief synopsis of my own personal and professional experiences with suicide and youth suicide prevention work, as well as losses I experienced when my students have died by suicide. Those disclosures were made for transparency purposes and in hopes of promoting trust and communication. It is important to me, and for the accuracy of this study, that participants understood instances in my personal life and career which influence my motivation for this investigation. I began with minimal disclosure and shared more when I determined it would put the participant at ease or stimulate the conversation.

This investigation and data collection were limited by time, funding, and travel; I needed to complete this research before my program of study expired, funded my own travel, and had to take leave from work for some travel and research. The number of individuals working on youth suicide prevention in New Mexico far exceeds the amount of time I had for interviews and travel. Travel to interviews was limited by funding and depended upon recommendations from the snowball sampling method. This investigation was not externally funded, and there are too many possible participants to interview everyone given my own limitations of funding and time.
Chapter 4: Research Findings

I know what kids go through and if we can get kids when they’re younger and teach them healthy coping skills and how to speak up when something is wrong, that getting services is OK, we can hopefully prevent this in the long run. I’ve never experienced having money (for this work) but we’ve been able to go out and educate on this, whereas in my last job we were very cookie cutter – you do this, you do this, you do this. Any extra money? Nope. Any extra education I wanted to do for myself, I did it by myself. Any extra phone calls or conversations you had with your youth; you got no extra pay for it. I really think a lot of it goes back to funding and the monies we have for it (suicide prevention), unfortunately. People don’t want to die. There is a point in time where they just feel helpless . . . Maybe those conversations (about funding) happen, but they don’t trickle down to the boots on the ground and to the schools and the teen centers or the boys and girls centers (Teresa).

In this chapter, the experiences of seven adults (pseudonyms - Adrien, Brenda, Elsie, Jeanne, Joseph, Leigh, and Teresa) working to prevent youth suicide in New Mexico are discussed; their experiences and wisdom are organized by the following themes and topics, from individual interviews:

Table 4: Themes and Topics from Individual Interviews

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Assets and solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stigma at all levels</td>
<td>○ Strengths of New Mexico</td>
</tr>
<tr>
<td>• Awareness, social climate, and education</td>
<td>○ Statewide mandates</td>
</tr>
<tr>
<td>• Communication, sharing, and collaborating</td>
<td>○ Urgency to act</td>
</tr>
<tr>
<td>• 2019 novel coronavirus/2019-nCoV (COVID-19) pandemic</td>
<td></td>
</tr>
<tr>
<td>Distribution and permanency of resources and funding</td>
<td></td>
</tr>
</tbody>
</table>

I embarked on this research prepared to delve deeply into contextual factors that influence their work and their experiences with various groups of youth; what I found, was that participants had little to say about those factors. Even when I asked specifically about what they found works or does not work as well with particular types of youth, particular groups, cultures, and even geographic regions, they described their work as both unique and highly individualized in instances of one-on-one intervention, and correspondingly tailored to every type of group they worked with. Elsie talked about the importance of knowing “where they’re coming from and what they’ve experienced,” in terms of working successfully with youth who may be suicidal. The importance of that approach was echoed, again and again, throughout the study. Every participant was, or had been, engaged in suicide prevention with groups of which they were a member and groups of which they had to make an effort to learn more about because they lacked the lived experiences of that group. I found it striking that participants, in every round of interviews, focused almost entirely on factors that are typically more outside the reach of youth, such as state-level policymaking, stigma surrounding mental health, curriculum and systems mandates, and more. Inferring, it is clear participants are battling through systems and constructs in order to reach youth. Some came from the juvenile justice system, others have experience in education and public health, while one serves as clergy,
and another co-founded a non-profit organization that serves the transgender community. At the time of this study, one participant was a court-appointed special advocate, another a nurse, and another was a girl’s soccer coach. This assorted group of preventionists was chocked full of suicide prevention trainers, and even had experience with every age group. Some made sure I included in my notes that they firmly believed adult suicide prevention was a major factor in preventing youth suicide. I interviewed a total of seven participants who all reported working with diverse populations of youth; notably, they all reported working with primarily low-income and at-risk communities. What contributes to successful youth suicide prevention? They said:

**Table 5: Themes of Successful Youth Suicide Prevention**

<table>
<thead>
<tr>
<th>Interpersonal</th>
<th>Techniques or styles</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Starting young</td>
<td>Continuity within and</td>
</tr>
<tr>
<td>Perspective</td>
<td>Collaboration</td>
<td>between services</td>
</tr>
<tr>
<td>Listening</td>
<td>Sharing information</td>
<td>Social climate</td>
</tr>
<tr>
<td>Being nonjudgmental</td>
<td></td>
<td>Sense of safety</td>
</tr>
<tr>
<td>Compassion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These preventionists varied their approaches and techniques, depending primarily on the following factors that they identified in their work and training environments and communities: culture, social climate/environment, level of mental health stigma, religion, and the level of social or geographical isolation. This wisdom came from seven participants who varied in experience in the field of youth suicide prevention from one
year to over 20 years. They held, and had held, a mix of paid and volunteer positions in the field; as a group, they represented work experience in every one of the state’s five public health regions, with the Navajo nation, and spanned the private, public, and non-profit sectors. Leigh said that she has engaged in suicide prevention work, whether formally or informally, her entire adult life. When I asked her to describe her work and history, she chuckled and said “I’ve been doing this stuff (suicide prevention) since I was in high school! It’s not something you get paid for, right? But, you do it because it’s people’s lives we’re talking about here.” I found that the participants were humbly dismissive of the length of their service as preventionists, often minimized their contributions to suicide prevention, and persistently steered their interviews to talk about the plight of others who are suffering.

One might wonder how and why these preventionists continue such taxing work. I found that every participant shared a personal connection to suicide prevention work, whether it was the loss of a loved one or their own struggles with depression, suicide attempts, or other mental health issues. Every one of them was invested at a personal level, and that seems to be what gives them such strong purpose and determination to continue the work. Participants answered, without hesitation, when asked what led to their involvement in youth suicide prevention:

Adrien had personal experiences and was driven by data:

I mean, it's just almost unthinkable when you look at the statistics, so for me it was really just being a trans activist. I have personal familial experience with suicide, too.
Brenda had a direct connection to seeing a need and providing what her community needs: “I see the effects that it has on families, school communities, and the community at large.”

Elsie gave personal and professional reasons:

I had an experience that really affected me profoundly, where there was a cluster of suicides in one of the small communities that I worked with and I was assigned to be part of a response team and spent almost two months there, every day. That work had had a really profound effect on me, and in fact I ended up at the end of that period of time being hospitalized for stress related chest pain. And, you know that just made me realize that I didn't want to be in working in postvention or intervention, but that I really wanted to focus more on suicide prevention.

Jeanne, discussing her service on the New Mexico Child Fatality Review (Office of Injury Prevention, 2015) suicide panel:

Since I started to go it’s like it made me more aware and, like, this is a problem. I have a concern for how to help kids and what to do and signs and symptoms of my own kids coming home telling me: Mom so-and-so said something at school today and they said not to say anything. And you know those kinds of things keeps me focused on what’s the right thing to do and how to help those kids because I see that stuff every day between work and home and coaching.

Joseph shared his very personal experience:

I was very suicidal as a kid growing up and when I got to a place when I wasn’t, I just wanted to understand that. And I know that nobody just arrives there like there’s so much turmoil and struggle before you even get to that place and I know
that first hand and I understand that first hand. When I recognize that in other
people, I literally devoted my life to helping people so I want to be a part of that
solution because I understand that personally. But I also understand that it’s
something we can do things about. This is a very avoidable thing.

Leigh, with familial and professional ties:

I grew up in a family that had experienced a suicide loss my Mom had a sibling
that died from suicide and my Gramma found ‘em so that really profoundly
impacted my Mom’s family in different ways. You could definitely see the
imprint that it left on my Mom’s entire family and my Mom. I think in a lot of
ways it shaped how she raised me and the things she said to me. I was really
fortunate. My mom doesn’t have a college education or anything like that but she
was somebody who always told me that if I felt sad or I need to talk to somebody
she was there for me and that if I didn’t want to talk to her she would find me
someone that I did want to talk to. Just the way she raised me really impacted how
I approach suicide prevention and life. So, I mean that’s how I grew up and then I
just took a natural interest in psychology and counseling and went in that
direction, so went to college for that and you know suicide prevention is just a
huge part of mental health.

Teresa, like other participants in this study, was impacted by a suicide loss:

My friend killed himself; he died by suicide. And, ever since that, it has been
kinda like my driving force saying: you know what? this needs to be something
that’s talked about and educated on because it happens to people.
To my surprise, participants identified overwhelmingly similar factors impeding their work; even with prompting to dig deeper into their stories, there was always a return to societal, political, and logistical factors that hinder their work and the work of their colleagues. It was as if the impacts of things like trauma and poverty of New Mexico’s youth was an integrated and accepted part of life and the larger problems, or areas of focus, were more along the lines of direct suicide prevention building resilience and addressing mental health issues. This may be because the participants all work in fields where they meet youth where they are and specialize in helping with the effects of those traumas, rather than working to prevent those traumas. This view contrasts with engaging in what some in the field refer to as “upstream” work in prevention, where the common general causes of suicidality (hopelessness, helplessness, and isolation) are addressed directly.

One participant, Adrien, is heavily involved in improving the quality of life for transgender youth; his non-profit organization helps provide transgender youth with needle exchange, housing, food, social and emotional supports, job placement, and much more. Providing those types of supports and services helps address, directly, the risk factors for “diseases of despair,” such as suicide (New Mexico Department of Health, 2020d, pg. 15). Adrien is passionate about helping transgender youth, and gave a relatable, compassionate summary of what is at stake and what he thinks needs to be done:

All you had to do was hold on another two years and your whole life was gonna change and you didn't even know it. It feels like a tragedy. I really think that there's a lot of reasons that people don't want to continue to struggle through life.
But with young people it's such a waste, you know? Because there's no telling what could've happened. You know it's like so many other things we talk about in New Mexico where lots of people are doing lots of work and they don't even know who each other is, or that this is happening. And if we joined up we could make a bigger impact; because they have the support because they could reach out and make relationships and have somebody care about them and have things that they needed provided; people's own accounts of it are the most powerful thing that we have. I don't know all the kind of nuances of (suicide), but I think so much of it really is about not feeling loved and cared for and the power of that; You know, for them to feel that it was really their own. I think this makes a big difference. It's really about connection; Don't be inhibited because the cost could be so high and all you have to do is just ask questions. Everyone can do something; everyone can do something, and you don't have to be a special person; it doesn't feel like a crisis to us in the same way cuz it always has been at a total crisis level.

Adrien describes himself as not formally trained in suicide prevention, is not a clinician, yet articulated New Mexico’s suicide prevention situation so eloquently, which really reinforces the role that everyone can play in suicide prevention:

I've started comparing it in conversations. Well, how much time do you spend on something else, right? You know how much time do you spend on taking blood borne pathogen and asthma response classes? How many people die from asthma at school? You talk to them about how to stay safe or how to cross the street or how to ride; you know they have those bike rodeos. So, if you tell me you spent X
number of minutes with the bike rodeo to teach kids how to ride their bikes safely and to wear a helmet and how to obey the laws, you know how to walk their bike across the crosswalk because we're trying to keep them safe. So, so if that's worth minutes, this (suicide prevention) is so much more, and how many kids do you know (who died by suicide)? And there are kids that die riding their bikes of course, but we know that that number is way higher for suicide. So, if you're gonna spend minutes on teaching them how to ride their bike the right way, which is super important, why won't they spend minutes on suicide prevention? I think many, many people feel that it's not preventable, they don't understand how preventable it is.

In contrast to the interview elements that I found surprising, I also heard confirmation of many of my own twenty years of experiences in the field of youth suicide prevention. Hearing about so much frustration, exhaustion, and even the sharpness of sarcasm and humor borne of long hours, gut-wrenching stories, and raw conversations with youth who feel immeasurably hopeless and helpless, was so very familiar to me. Often, I heard something close to despair when participants talked about communication, funding, stigma, and the need for urgency. They were tired, so tired, and still convinced by their successes that they could and do make a difference in youth suicide prevention. This mixture of exhaustion and hope profoundly impacted me, as a researcher and as a youth suicide preventionist.

In the first round of interviews I posed over thirty pre-determined questions, and in the second round presented a collection of themes from first round answers; this made for rich conversation and often a more detailed continuation of topics that interested
them; in particular, some strong beliefs and attitudes came through about topics from the first round. In the second round, after introducing communication as a theme from round one, Leigh vehemently stated that the “lack of communication is the trademark of mental health work in New Mexico!” and then “New Mexico’s high suicide rates are so chronic, they’re normalized.” Another change was from the first to second rounds with nearly all participants recommending some sort of statewide suicide prevention mandate to more specific, targeted mandates that gave a glimpse into participant experiences with education systems and their thoughts on solutions:

“There should be mandated standards in every grade.”

“Have suicide prevention as part of the curriculum.”

“Law is the first step towards implementation.”

“We need a framework that can be tailored to different communities and schools; that would be valuable.”

Using a research design that included multiple interviews and careful probing, to explore the initial themes, was helpful to gain both depth and breadth in my findings. To their credit, participants were willing to be open, share, and engage in deep conversations during their interviews. As participants had more opportunity to speak on the issues, they were increasingly more specific about their ideas on fixing problems that impeded youth suicide prevention. Their ideas, suggestions, and recommendations are included in each of the following sections.


This study began before the COVID-19 pandemic, and data collection concluded while it persisted. Considering the rarity of pandemics, and the presumably significant
impacts on daily life and mental health, I was compelled to capture its impact on the work of participating preventionists. Since connection and belonging are oft cited by preventionists as key to well-being and good mental health, I assumed they would have insights and experiences with the impact of a pandemic that resulted in multiple, evolving, public health orders in New Mexico that included stay-at-home orders. To reduce the spread of the virus, New Mexicans were subject to public health orders that limited their in-person interaction with others, closed in-person schooling, and halted or reduced social gatherings. I asked participants open-ended questions to explore their own perceptions of the impacts. I was careful to avoid the assumption that all impacts would be negative or detrimental.

If they’re not safe at home or don't feel supported at home, are they gonna be OK?

It's an additional burden for them, a bad thing, I think. Also, there’re probably other students who are unsafe at home or who are feeling just really isolated, as well and so and those are not likely to be the ones who speak up in class and say hey, I'm not doing so well, right? (Elsie)

Elsie put words to what every participating preventionist alluded to, or spoke directly about, when I asked for their impressions of the impact of the COVID-19 pandemic on youth mental health and suicidality. Without exception, impressions were grim, worried, and they were uncertain about the full scope of the impacts the pandemic has, and will have, on New Mexico’s youth. Focusing on preventionist experiences, Jeanne had a supervisor’s perspective and spoke of her own staff who provide a system of supports for youth:
We've put some things in place, not like a protocol, but we've really encouraged supervisors and line staff and everyone in between to check in more frequently with each other. Not just the day-to-day work, but really just how people are doing themselves, steer away from work-related questions and just ask how people are feeling, how people are doing, and let him talk about whatever they want to talk about . . . reminded people to give each other a little bit of grace. Instead of counting minutes per day they’re working, or not working, really focus instead on what they're doing and how they're doing. It's really been a challenge in some ways and it's made people feel more isolated than they normally would or feel less supportive than they normally would . . . you know the same is very true for the kids that we provide service to as well and their families, their whole extended families. Kids that are not necessarily in a system like the juvenile justice system, but kids that are in mainstream schools, you know they go there for their academics and but they also go there for their social skills and their socializing. Not having that is going to expose some kids that perhaps thrived in that atmosphere that no longer have it.

Jeanne expressed some important thoughts on the multi-faceted impacts of the pandemic. For one, isolation, fear, anxiety, and other reactions to the circumstances of the pandemic are impacting people differently, and that is something we need to take into account. For supervisors like Jeanne, the need for vigilance in monitoring how people are adapting to isolation and major changes in their social interactions, both for youth and those who support them, has become a focus. She alluded to the role caregivers and supportive adults can play in creative facilitation of socializing for youth in a safe space.
Teresa’s concept of needing to “give each other a little bit of grace” struck me as something that we should continue, even after the pandemic has resolved. By grace, I believe Teresa was speaking to unconditional, positive regard, which is a familiar concept to many mental health professionals. I think this concept aligns so well with suicide prevention work, as it means helping others without expectation of payment or reward.

Jeanne also talked about her own family and the impact the pandemic has had on her children, as well as a productive way to think about the changes in the number of child abuse cases being reported:

With my own kids, I see them not having sports and the outlet that provided every day, some stress relief with some exercise. We've had to come up with some creative ways to get it done on our own without the social interaction, but then we're lucky that we can do that. A lot of families don't have that. As far as like our protective services used and kids that are involved in the child welfare system, you know there's a theory that child abuse numbers are way, way down. But is that because they're not in school, which is where most of the referrals come from? Where teachers were paying attention to how kids look and feel, how they're doing, and kids open up to teachers, now not having that ability to do that outside of a zoom meeting at school. You know, maybe that's why it's down. We just need to pay more attention, not to just what the numbers say, but why they say what they say.

Numbers and rates could be misleading, especially when related social structures have undergone such profound changes. Rates and statistics associated with the safety and wellness of youth can be particularly misleading when there is a big change in
reporting environs. Before the pandemic and public health orders, consider how many trained adults interacted with youth each day at school. The quality, length, and nature of those interactions, in many ways, were very different than those that take place over virtual meeting platforms. For example, nonverbal behaviors and communication is substantially less apparent in the virtual environment. It is much more difficult to detect changes in mood; consider all the information that is lost between seeing a youth’s face, posture, personal grooming, and overall appearance in person versus via a virtual platform that shows them from shoulders up and in a small square on a computer screen.

The pandemic has resulted in a drastic drop in the number of child abuse reports in New Mexico. Children are spending nearly all of their time at home, and with less interaction with other adults, especially teachers, it is harder for youth to report abuse or for adults outside the home to notice the signs ("The impact of COVID-19 on children’s well-being in New Mexico," 2020). At the time of these findings, no new statistics or rates were publicly available to illuminate the pandemic’s impact on New Mexico youth suicide rates. That lack of up-to-date data makes it difficult to surmise what is happening and how preventionists can adapt their work to the pandemic environment. There is clear evidence that schools provide an ideal system for delivering mental health and prevention initiatives (Hatzenbuehler et al., 2014); in light of this pandemic, we are finding out how crucial the school’s role is in identifying youth who need services or intervention and, we do not yet have a clear picture of the impact on youth safety. To conclude, Jeanne has a positive take on a positive impact from the COVID-19 pandemic:

I’ve seen people come together even in the pandemic, where maybe there wasn’t, or they didn't feel like there was, an opportunity to before. The pandemic has
certainly opened a lot of eyes to different things, but the way people have come together with the Native American communities and the more impoverished communities in the rural areas. I mean, it's just it's been kind of cool to see. It sucks that it had to be a pandemic that open eyes, but it's been kind of cool to see. So, whether it's suicide, or substance abuse, or teen pregnancy or whatever it is, it just seems like we have the right communities to get it going. I just don't know that they all realize. Um, that it's not insurmountable that it's tough work and it's going to take a long time to make a dent, but it's not insurmountable.

**Strengths of New Mexico**

The pandemic revealed some real strengths and drive to overcome and adapt, as illustrated in Jeanne’s previous comments. In an impoverished state, with few professional resources available, it is important to take a strengths-based approach so that the cultural and familial riches of the state are employed. This can lend to adoption of suicide prevention ideas and approaches in a very personal and localized manner, leveraging local wisdom and bonds within groups that already exist. Exploring further, I found each participant had much to say about specific qualities and assets they observe in their suicide prevention work.

Some community members that you just know they genuine . . . I found that pretty much across the board that there are people that really can be tapped, who may not feel like they have the knowledge they need or the skills that they need, or even the time that they need to do (suicide prevention) . . . that's the thing I think . . . has really been obvious to me . . .
Elsie sees, even in small communities, there are people who would be very effective in preventing suicide but they do not feel prepared, or maybe even think it is work that should or can only fall to mental health professionals. As a preventionist, it is intriguing that she has routinely noticed community members who could work with her but hold themselves back. She was uncertain if this was more self-imposed out of perception and maybe even a type of stigma, or if it was a more external force keeping them from becoming involved.

Diversity across and within communities, pride and protectiveness in groups, rich cultures, strong bonds, authenticity, and family; those are the words used by participants to describe the strengths of New Mexico. During interviews, I asked all participants what they had experienced during their work, in terms of strengths that could relate to preventing youth suicide, and there was hesitation with every answer. Jeanne began with “wow, that’s a tough one!” and Leigh started by saying “OK, that’s a hard question”. The hesitation played out as what I can only explain as a resistance to essentializing groups; given the nature of their personal and professional commitments to helping others, I interpreted this as a reluctance to perpetuate stereotypes – which can be seen as a type of stigma, and something they are devoted to eliminating. The hesitation makes sense, through the lens of de-stigmatization. Upon further questioning, participants had further trouble with this question; I am confident their reactions to this question were also influenced by recent shifts in national awareness of ethnic, racial, and cultural discrimination and inequities, as well as hate and extremism (Labode, Moten, & Wolde-Michael, 2020). Eventually, with encouragement, they related having seen the following
strengths in the people of New Mexico, which they believe could prove helpful in reducing youth suicide:

**Pride in Diversity, Cultural Heritage, Identity**

I feel like people from here. Have here being New Mexico have a sense of pride about it and are very loyal to it, so I feel like there's a genuine work, a genuine value. That people hold in helping their own community . . . (Jeanne).

Teresa put it this way, and thinks we can leverage cultures as a resource to enhance suicide prevention:

I really do like people here (southern New Mexico) and think they're very loving and I feel like our diversity really does play to our culture and I feel like that in itself could be our key factor to help end youth suicide, because we do have a diverse number of cultures and people who live here so we have resources at our fingertips. We just I think we're struggling to reach out to those resources.

Joseph said:

The goal, other places, is to assimilate and you cannot hold on to that identity or culture. Where here (New Mexico), people are proud to be Native, proud to be Hispanic, proud to be a 4th generation rancher or something, and I think you can use that. We're a little more rural state that is more separated; there's less for people to assimilate into, so people stay closer to their cultures, and that's a good thing.

Discussing this strength of cultural identity, and maintaining that, Joseph talked about his experiences in New Mexico and compared them with other states in which he has lived. He highlights how large distances between communities helps them hold on to their cultural values, traditions, ways of learning and teaching, and ways of coping and
making meaning of their experiences. This perspective was also emphasized in a *New Mexico Voices for Children* report:

> . . . unlike many tribes across the U.S. who were displaced from ancestral lands, most of the state’s tribes and pueblos have largely maintained or regained this important connection. Having a tangible tie to tradition and the land has a positive impact on community well-being . . . (Hollis, 2012)

Adrien also suggested using “cultural traditions to protect the kids . . . because they (youth) will do better than if they are forced to be assimilated into White western communities or schools.” He further advised, particularly with our Native communities:

> . . . (the) U.S. government or state government need to invest in outcomes instead of trying to control them . . . not putting deliverables or expectations on them . . . as much as just saying like here, we want to make an investment in a protective strategy that has been shown to be effective and you all are the ones who should figure out how to do it and what that means . . .

Adrien showed a deep respect for Native communities and their sovereignty; he brings up that the resources, knowledge, and strategies that work often come directly from a community – that they know themselves best.

The preventionists, themselves, are a strength that can be applied as a strength, in that they know so much about the communities, groups, and individuals with whom they work. They hold wisdom and knowledge, beyond formulaic tactics, clinical techniques, and formal approaches, that is immensely valuable to New Mexico communities. These preventionists are key in building unique systems of support and prevention that work for and with New Mexicans, based on their prevention experiences. Combining their
knowledge, they are ideal, invested partners for developing useful and effective strategies and engaging entire communities.

**Resilience and Survival**

“In a lot of ways, I feel like resilience is something I’ve seen in New Mexico . . . the fact that people work so hard to survive, that is a strength . . .” (Leigh). Illustrating resilience and survival, Adrien talked about families engaging in prevention and intervention, coming together to help each other, in the context of drug use and overdose:

More grandmas, right? One of the interesting things in syringe exchange that we’ve found is that it’s a lot of time those family members (helping) . . .

Grandma’s not using but grandson is and she wants the Narcan so she could save his life, you know maybe she feels embarrassed or ashamed . . . maybe she doesn’t want the neighbors judging . . . but she’s not going to let him die over it.

To engage and utilize that resilience and survival that is present in New Mexico families, he would love to see every family member get trained in suicide prevention so that “whoever you tell about this (signs of suicide) has some skills.” Adrien believes family members and social supports can provide the same lifesaving measures for suicide that Narcan does for drug overdose. What he exemplified was the ability and willingness of families to do the work themselves and provide that frontline response and intervention; he would like to see this spread to suicide prevention.

**Relationships, Families, Trust, Bonds**

I think that the loyalty that people tend to have that are from here (New Mexico) and they have lived here and have seen New Mexico change through the years, I think that that is a huge bonus to us and I think people come together . . . (Jeanne)
Born and raised in New Mexico, Jeanne has a personal and professional perspective. She speaks to the connection that people have, or investment, that comes from living in the state for many years. Specifically, she mentions seeing changes over time and how that helps people come together; she sees the familiarity as a bond that can be helpful in youth suicide prevention.

So, you know relationship building is super important in New Mexico. When I go to towns that I've worked in, it's like a homecoming. Practically, when I see people, even that I worked with many, many years ago. It's like I never left when I see them, and that's really helpful in the work that I do (Leigh).

Leigh went on to say that having become familiar with a town, school, or community makes her work much easier; she feels that having built trust and relationships lends to people accepting new information, such as when she teaches about the warning signs and risk factors for suicide, and more likely to implement suicide prevention programs, curriculum, and policies and procedures. Her experience has been that prevention efforts have a better chance of being adopted, and result in quicker implementation, when delivered by someone the community recognizes and trusts.

Taking this topic further with her, I asked if she knew of any suicide prevention training, programs, or curriculum that utilized that familiarity and trust as a formal component; we came to the conclusion, together, that neither of us was aware of any such incorporation into formal or evidence-based approaches, techniques, or programs. This was an interesting topic to explore with her, since trust, familiarity, relationships, or some sort of “in” was mention by the majority of interviewees when they talked about successes. Elsie said:
s... schools in particular, since that's my most experience, there are loving, caring, deeply committed people who are grounded in their communities... they genuinely love and deeply care about the students... I do think that genuine commitment to students, and I'm thinking largely of school nurses and teachers and counselors and social workers and some community members, that just you know they just genuine.

The preventionists I interviewed spoke fondly of the closeness and connectedness of New Mexicans, and all referenced wanting to incorporate that into suicide prevention initiatives: “Since family, extended family, and even just that family feeling, is a strong thing in New Mexico and I think of using that to like personalize mental health and suicide prevention” (Adrien). This personalization, knowing and connecting with communities, was a theme within the theme. This rang true for me, in my experiences as a preventionist, and reminded me of encountering former colleagues at a statewide conference. I recall presenting on a mental health issue, at the professional conference, and seeing several familiar faces in the audience. There were handshakes, hugs, and waves before the presentation began. Those same people approached me, individually and from different communities around the state, and said things like “do you think we should use this model?” and “give me your opinion; should we use this at our school?” and “you know us, so tell me if this will work for us.” The relationships I built, the trust I earned, were just as important to them as the material and empirical evidence I presented in the formal session. This makes for a compelling argument to include relationship-building into prevention models and curricula; it also lends to the idea that suicide prevention is a community effort, since people appear to trust and believe those
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preventionist whom they already know. Taking it even further, a way to connect preventionists with one another could build a strong network to improve suicide prevention; implementing a way for preventionists to build relationships with one another could exponentially increase their impact, wellness, and longevity. Along with the many strengths preventionists identify, New Mexico also exhibits a variety of types of stigma surrounding suicide.”

**Stigma at All Levels**

Elsie cited people’s beliefs, echoing other participant experiences with stigma, as a barrier and is certain there are different norms that vary by community, especially as they relate to religion or faith; she also mentioned trying to adapt services during the pandemic:

There are regional differences and sort of community norms, attitudes, also influenced by the church. I also think at schools and with principals we don't want to rock the boat. You care about their kids, and really just hafta rock the boat . . . you know, one of the hardest things is parents who aren't supportive of their kids, right? . . . it’s a really hard thing 'cause we have a number of schools who have adapted GSAs (genders and sexualities alliances) to be online, which is phenomenal, but there are still students who can't connect that way because they are in a home where it's unsafe, right? So, those folks are super at risk and so trying to figure out creative ways to reach them is a challenge.

Trying to provide support to youth in the LGBTQ community, Elsie describes layering of barriers, in attitudes and then access (internet), then even safety at home to provide an environment where youth feel safe logging on to support groups. As with
many of the barriers identified, they are complex and multilayered. Crossing over one hurdle seems to reveal the next. Throughout, stigma permeates; Leigh said:

\[ \ldots \text{well there are a lot (of barriers), I can tell you that. Some of the things I said before like politics and funding and society (laughter); those are definitely barriers. I really feel like compared to other places I’ve been and lived and worked, there is a lot of stigma here in our state.} \]

Leigh, Elsie, Jeanne, Teresa, and Brenda all shared experiences with stigma and said the hesitancy of communities, families, and even faith communities were a big barrier to their work. In fact, they all related the process of engaging in suicide prevention nearly always began with a great, time-consuming effort to convince local stakeholders and decision-makers to permit suicide prevention activities and discourse in their areas of oversight or control.

Joseph talked about his role as a youth pastor:

\[ \ldots \text{spending a lot of time with these kids so you can see when things change and something shifts within them. Being able to ask that question (about suicide) \ldots knowing best practices and still being faith-informed I’m just grateful that I have that opportunity to be in those situations.} \]

It was moving to hear someone talk about feeling so fortunate to be in what many would consider a scary or difficult position with a youth. He also talked about “indirect intervention” in the form of training every educator in his rural school district in an evidence-based course that teachers about mental health and substance-use issues; he took joy in that accomplishment and classified it as a success. As a preventionist, what
Adrien talked about was a purposeful and direct act of de-stigmatizing mental health and suicide discourse.

The participants related different types of stigma that they have observed and experienced: stigma around mental health issues, self-stigma, stigma around suicide death and suicidal behaviors and language, and stigma around seeking or needing help with mental health and wellness. Joseph proclaimed stigma “the biggest hurdle,” and Adrien shared a wish for “fast-forwarding 40 years to the future where this (stigma) won’t be a problem.” Elsie agreed that stigma was a huge factor in suicide prevention work, but saw some progress, saying “people are more willing to talk about suicide than they were in the past.” Even with universal agreement among participants that mental health stigma is a clear and present obstacle, there were some interesting distinctions about how that is experienced. “Self-stigma corresponds to the negative self-perceptions and demoralization that occur when societal stigma regarding mental health and counseling is internalized and applied to the self” (Lannin, Vogel, Brenner, Abraham, & Heath, 2016, p. 351); that research uncovered social stigma around suicide death, attempts, and even thoughts and behaviors. Their study suggested that external types of stigma are seen as impacting policy-making, whether or not school administrators choose to address suicide and mental health issues with their students and staff, and even how funding is dispersed at all levels of state and local government. Echoing what the Lannin, et al study found, during one of my interviews Teresa emotionally asked “suicide prevention? What suicide prevention?” Her frustration was evident with her experiences seeing youth suicide “ignored” due to stigma among decision makers and policy makers. It is unclear if that
particular stigma among policy makers is due to cultural influences, personal experiences, or lack of awareness about youth suicide and prevention.

Brenda and Elsie both described self-stigma that acts like a type of filter for youth, in that it involves their own perceptions of themselves and can prevent them from disclosing suicide warning signs like depression, hopelessness, or feeling helpless. Self-stigma is a function of social stigma. Brenda, a seasoned school counselor, described working with suicidal youth who feared being seen as different or being ostracized for needing mental health assistance in the school setting. She related a frustration with school site-level decisions and even district-level decisions that increase stigma after a suicide death:

I think one of the barriers that I face personally is people’s mindsets and their personal beliefs about suicide. Also . . . if a student dies by suicide and the parents say “don’t talk about it” but then it’s on social media and then the school acts like they don’t know how they died or they say “we can’t tell you,” then there’s that stigma all over again and the kids look at us like we’re idiots or that maybe we are cowards because we’re not gonna talk about it.

Brenda’s example points to a need for us to constantly assess how students process this type of tragedy and adjust accordingly. It is reasonable to expect that each generation of students may understand suicide, and tragedies, differently, and we need to be prepared to evolve to meet their needs so that we can keep them safe and healthy.

In Teresa’s experiences, she has interacted with adult caretakers, families, and guardians involved with foster care and child protective services who do not want to acknowledge that their youth needed help with suicidal thoughts or behaviors. She is very
cognizant of the role of stigma in suicide prevention, has encountered many instances of families worrying how they will be seen by others if their youth is suicidal, but is still hopeful for a larger trend towards change.

I think it is just now becoming an “oh crap this is something we need to deal with, type of thing” and I think it has always been an issue . . . but I don’t think anybody’s been ready to deal with it or even know how to educate on it. Even when my friend died by suicide there was no conversation at home about it and you know it’s a very taboo subject, and you don’t see the news talking about it or you know for support go here. You don’t see it coming from the state (of New Mexico) down, from a mental health perspective. So, I think it’s been very lax and very taboo, and I’m hoping and I see the change, because people unfortunately -- kids are dying, and that’s what’s shocking teachers, educators, superintendents, the state into thinking “oh crap! we need to do something about this.” It’s sad it has to come to that, but I wanna believe we’re getting to that point.

Joseph talked about leading change from inside out, by public state agencies and institutions adopting and internalizing suicide prevention policies and practices before pushing out training, interventions, and policies to the public. He believes the public agencies and systems that support people in the state should set the tone and decrease stigma by making a public commitment to suicide prevention. He cites other movements, or campaigns, that were started from the top down and from inside those agencies:

At some point in history, all of the public departments were told that they need to figure out how to not be sexist anymore. They weren't allowed to be racist
anymore, it was part of policy. And yeah, you'd have to figure that out internally what that was going to look like in your department directly . . . so, you know, we did that successfully on paper. There's definitely health inequities across, you know, race, ethnicity, gender. But we've created policy saying that that's not legal, and it's important to each department to use that lens, and we're not really there with suicide. All the agencies, what is their particular policy or take or commitment to suicide prevention and mental health? So, they need to really address it internally first.

According to these preventionists, stigma is widespread, showing up among professionals, elected officials, in families, woven into cultures and communities. Upon analysis, stigma seems just as borderless and pervasive as suicide itself. To combat stigma, to confront it and change it, these preventionist talked about more universal awareness; they talked about change from inside agencies, change at all the same levels we find stigma. This is a fine example of the concept of meeting people where they are, in terms of building change. A formulaic awareness campaign that addresses the general public may not reach all the levels at which preventionists find stigma; they propose a multi-layered approach that could appeal to every type of person in every type of group, community, or agency.

**Awareness, Social Climate, and Education as Barriers**

When I asked the research participants about what hinders their work, every one of them spoke of an overall, general lack of awareness in communities, schools, agencies, and institutions. That awareness was in relation to what people know about mental health, suicide, and preventing suicide. Relating their experiences in their respective work and
volunteer environments, they told me about ongoing surprise and frustration that community leaders seemed to have little knowledge about suicide, especially in comparison to other health and safety issues in the lives of youth. From our conversations, it seems there is no definable limit to who or where that knowledge certainly does or does not permeate. Every research participant gave examples of encountering either an environment, group, or individual that they spent time convincing and educating on suicide prevention, its merits and their opinions of its simplicity. Leigh described direct and indirect types of success as she navigates barriers and works to get youth to understand she is there to help them:

... sometimes they just need to talk to somebody and understand there are other options, that somebody cares. I guess for me, seeing the relief. A lot of the time when I have talked to a student who is suicidal, and I ask them about it they seem very relieved and I think that relief is a victory because it’s opening a door to conversation and communication. Suddenly they no longer feel alone and that’s what I would like to think that I’ve been able to provide, in many instances over the years. Honestly, when I see another student that’s actually noticed the warning signs and spoken up on behalf of their friend the kids call it ratting them out (laughter), but I really admire those young people. It’s really scary for them to potentially lose a friend from suicide but they may be terrified to lose their friend because they spoke up... I think that takes a lot of courage and so you know those I think are really in my opinion some of the biggest success stories as well. If I can get other young people and just people in general to notice when somebody is struggling that much and actually take action to try and help them
and try to prevent suicide, I think those are really the things that stand out to me the most.

Brenda was ardent about trying to get school leaders and administrators to prioritize youth suicide prevention, and touched on how funding is not the singular solution: “I could have all the money in the world but if people are still baulking at the idea of using class and instruction time to talk about suicide prevention, that’s not gonna help me.”

Her statement, above, cuts to the center of a problem she has identified during her years as a school counselor: making room in school schedules to teach suicide awareness, help-seeking behaviors, problem solving, and other skills that promote resilience and suicide prevention. She went on to say, “I need to be in an environment that allows me to be persuasive and to have my voice valued and my expertise valued.” Clearly, she did not feel her professional voice was heard. Her frustration, during this part of our conversation, was intense. She had a creative thought about needing a figure or a movement to normalize the discussion around suicide prevention so that it is easier for everyone to talk about:

I feel like that there’s only a small group of people who are trying to make it known that it is a problem and that we have some issues, but I just really feel like people don’t like to talk about it. There is a huge stigma around and that if you talk about these feelings or these feelings that are happening to you there’s something wrong with you, you’re broken, your family’s broken. So, it’s just it needs more work and it needs more focus and support and attention. Maybe we need someone like what’s her name? Greta Thunberg! She’s all for climate
control and change. We need someone like her to hold people accountable for preventing suicide and then they can be on the cover of Time magazine.

During the second round of interviews, I presented themes from the first round of interviews with participants; that generated a new discussion that seemed to take aim at leaders and administrators at all levels, throughout systems across the state. There was a shared experienced described by all that valuable time and effort were used in convincing decision-makers to take notice of youth suicide and to act upon that knowledge. This theme nearly overshadowed the more general, societal stigma that was oft referred to in the very first set of interviews. According to Brenda, “many, many people feel that it’s not preventable. They don’t understand how preventable it is.” Above, Brenda really emphasized the presence of awareness and stigma in the community, among youth, families, educators, policy and decision makers. In my experience, it is often assumed that adults know what is best and make fact-based decisions, especially involving youth and their safety. In reality, society as a whole harbors complex and historical layers of stigma that act as barriers to suicide prevention.

As an example, a school counselor like Brenda may want to implement a suicide prevention curriculum. To accomplish that, she may encounter pushback from her school administrator who, because of stigma, does not believe the topic should be discussed at school. Teachers may believe the topic is either irrelevant or inappropriate; parents and guardians may think it is taboo to talk about suicide, and youth may hesitate to engage in the curriculum for fear of being seen as different or “broken” like Brenda described. There are multiple points of debate along the path to Brenda’s attempts to implement a suicide prevention curriculum at her school. There are endless reasons as to why school
personnel and school communities may resist suicide prevention activities. School leaders can be fearful of the proverbial can of worms: opening up the topic may result in a tidal wave of suicide-related referrals and may overwhelm school supports. My experiences, working in public education, showed me that school personnel are concerned about the safety and well-being of their students; I posit those same school personnel feel unprepared to discuss suicide and suicide prevention, so some naturally will avoid it. Furthermore, school personnel are human beings and have all sorts of different experiences with both suicide and suicide prevention. Some find the topic of suicide emotionally charged and do not feel safe, themselves, addressing the topic in their work setting. Further, it has been my experience, working extensively in crisis intervention and recovery after tragedies, that when school leaders have not formally acknowledged the problem of youth suicide, their employees fear reprisal for bringing up such a serious and, apparently, contentious topic without a directive from leadership. A recommendation Brenda made to help remedy this situation within schools was a statewide mandate for teaching suicide prevention-related standards at every grade level. This type of mandate would smooth the road to providing vital information to youth and give preventionists a precedence for implementing a program.

Encountering adults with a lack of awareness of risk factors, warning signs, as well as protective factors and ways to prevent suicide, were universal themes among participants. I heard multiple stories about community leaders, district and school administrators, and state policy makers that do not seem to understand or are unaware of the problem of suicide, nor how to combat it. Participants strongly expressed professional fatigue and frustration caused by the time and energy they spent trying to convince
people like school principals, school district leaders, elected officials, and others to look at the statistics related to youth suicide and to allow preventionists to follow proven methods for suicide prevention. Elsie went so far as to say how happy she was “to be working with an organization that is actually studying best practices, prevention, evidence-based strategies, including policy implementation.”

“This is a very avoidable thing. It’s not like getting struck with a terminal illness” (Joseph). As Joseph’s comment illustrates, sometimes, there is a chasm between how preventionists see the problem of suicide and how others see it. Time after time, interviewees described instances when they wanted to share warnings signs of suicide and what to do when someone exhibits those signs, like the lists below (New Mexico Department of Health, 2020a), with youth and adults who support youth, but were denied access, time, and venue to do so.

**Table 6: Warning Signs and What to do if Someone May be Suicidal**

<table>
<thead>
<tr>
<th>Warning sign of suicide</th>
<th>What to do if someone exhibits warning signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Talking about wanting to die</td>
<td>o Do not leave the person alone</td>
</tr>
<tr>
<td>• Looking for a way to kill oneself</td>
<td>o Remove any firearms, alcohol, drugs,</td>
</tr>
<tr>
<td>• Talking about feeling hopeless or having no purpose</td>
<td>or sharp objects that could be used in a</td>
</tr>
<tr>
<td>• Talking about feeling trapped or in unbearable pain</td>
<td>suicide attempt</td>
</tr>
<tr>
<td>• Talking about being a burden to others</td>
<td>o Call the New Mexico Crisis and Access Line at 1-855-NMCRISIS (662-7474), the Agora Crisis Center at 1-505-277-3013 or the U.S. National</td>
</tr>
</tbody>
</table>
• Increasing the use of alcohol or drugs
• Acting anxious, agitated or recklessly
• Sleeping too little or too much
• Withdrawing or feeling isolated
• Showing rage or talking about seeking revenge
• Displaying extreme mood swings

Suicide Prevention Lifeline at 1-800-273-TALK (8255)

○ Take the person to an emergency room or seek help from a medical or mental health professional

Communication, Training, and Collaborating

*Google*(™) only goes so far. You know? Because Google is endless; it’s a black hole. And I feel, sometimes, that’s what people go to is Google because it’s readily available.

Teresa gave insight into the predicament that a lack of communication, training, and collaborating within the state, within and among communities, creates for preventionists. Unavailable or ineffective methods and modes of communication across regions and groups was also described by Leigh as “working in silos.” In my own experiences as a preventionist, that breaking down of siloed work happens through communication and collaboration which, in turn, results in the sharing of resource pools, ideas, solutions, and can even improve the morale and longevity of professionals and laypeople, alike. Exploring communication and disconnectedness, Jeanne began jokingly and then quickly turned very serious:

Well, at the risk of offending everyone that I am connected to now, based on my experiences, it (suicide prevention) seems like something that is nonexistent . . .
unless you are in the middle of it like we are, not enough people even know about
the things that are going on and what they can help and what they can do to help.

It’s not non-existent but it’s not enough. It’s not everywhere that should be.

This idea of a platform for preventionists to communicate would empower them
in coordinating their efforts and, presumably, result in a greater impact on suicide rates. If
preventionists had a reliable and easily navigable venue for sharing ideas, it could reduce
the workload of developing and implementing new programs, services, training,
awareness campaigns, and curricula. Without knowledge of their colleagues’ work,
preventionists miss out on the ingenuity of and helpful research done by their
counterparts. Elsie said she was excited that, in her part of the state, there was an
increased interest in suicide prevention training, but that she does not “have a really good
sense of what’s going on, not so much aware of what’s going on in other places (in New
Mexico).” Not having that venue or method for collaboration and communication, she
said she “would guess that it’s (suicide prevention) really scattered and variable,” when it
comes to suicide prevention training across the state. Unique to the suicide preventionists
I interviewed, they come from different professions, regions, and communities. Their
own backgrounds are as varied as the youth with whom they work. It has been my
experience, as a mental health professional in New Mexico, that topic-based
collaboratives and communication platforms are often hosted by professional
organizations or publicly funded organizations and state agencies. It may be that linking
preventionists together proves difficult because of their diversity as a group. Ultimately,
preventionists want to enlist every community member in preventing suicide; so,
collaboration and communication would need to scale to accommodate that endeavor.
Jeanne, with liveliness, described a systemic change that she helped introduce and implement, using collaboration within her agency:

My region has like a third of the whole state. Working with my counterparts in the north and south, and then my counterpart in facilities because we are divided into field or facility. We issued this challenge and it became competitive and a sort of ‘we are better than you are’ taunting and it totally worked, and everybody got on board. As a result of that, we had nearly all of our JJ (juvenile justice) field people involved and facility members in training of suicide awareness. QPR (Question Persuade Refer).

Her novel approach, instigating a competition, was just what Jeanne’s staff needed to drive them to completing a suicide prevention training that she knew was important to their work. This is a great example of knowing one’s audience and playing to the strengths of their particular professional culture. It is a wonderful example of a supervisor identifying internal assets, in this case, competitiveness, and leveraging them to reduce youth suicide.

The very first eight or nine days from when we rolled it out here and, specifically, this office in (a metropolitan county) just that first week alone I had three different probation officers come in and say, ‘oh my God that training was perfect!’ And I was like what? What happened? They each gave real examples of a client saying or doing something that prompted them take exactly what they learned from the QPR (Question Persuade Refer) training and applied it. You know, who knows if that was the number one thing that saved those kids; for the probation officers, they felt like it (suicide awareness training) was a factor and so
it was 100% worth it. I think it’s hard across the state, especially when it (suicide) slaps them in the face but now they feel confident and they know what to do. Before they knew maybe they had to do something but now they know what to do and that they need to add asking, so now they know they can, and they did get those kids to the right people to help them. All of those kids are still with us. It (intervening) sounded like a really bad thing at first because it proved that we have no protocol.

The urgency of suicide prevention training and intervention was made immediately evident, in Jeanne’s experience with her staff. Later in her interview, she talked about how we find youth at risk of suicide more when we are taught to look for and she was thrilled that her staff were increasing their identification of youth at risk for suicide.

They didn’t know what to do if somebody said ‘I want to die or I have no friends,’ which is crazy because, like CYFD (New Mexico Children, Youth and Families Department), we work with all these high-risk kids of every socioeconomic status, LGBTQ (lesbian gay bisexual transgender and queer or questioning), all racial and ethnic groups, and without it (new protocol) we have nothing that would help us know what to do or direct us on what we should do when something like that happens. Now we do.

Jeanne’s examples of systemic communication, training, and standardized procedures and policies show what can be done to produce a workforce that is filled with suicide preventionists. Collaborating, at every level, within her organization, resulted in a high awareness, an alertness, and a perceived license to act when field and facilities staff
thought a youth may be suicidal. Jeanne illustrated how sharing information, sharing responsibilities, collaborating to identify and intervene, may have saved lives.

Teresa brought up an unplanned postvention support, which happened during a planned suicide prevention training. As other preventionists expressed, Teresa was honored to be in a position to help; according to her, that in itself was a reward for her involvement and work.

I found out through the middle of a training that there’s a been a suicide . . . I kind of power through it but it turns into this “we’re here for you let’s build a community let’s be a support.” That was in one of the rural communities in the southwest. Someone’s relative had died by suicide and then a community member died by suicide a few days later. We didn’t know till halfway through our training. It turned into this way to uplift them . . . and at the end of it being able to talk with them and them tell us “thank you for this, we really appreciated it. If this (suicide prevention training) wouldn’t have happened, we wouldn’t have been this open about this” and “what tips do you have for us like at the funeral? What should we do?” . . . And having those people there saying that has been so impactful for me

Joseph discussed networking as a means of communication:

It’s been a fight to even get the few tools we have to deal with this (suicide) as a community. The only way I was able to get those tools was networking regionally. That’s the reason I spend so much outside my community, for my community.

In contrast to some of Joseph’s success with networking, Teresa had a different perspective on the method, and made some suggestions about how it could work better:
So, I always think it’s important to stick to a region, have regional meetings, and have representatives from regions come to a state meeting and then roll it back out to disseminate information. The problem with that is, though, if people that go to those meetings then they have to bring stuff back to the community . . . we see that people go to these awesome conferences with all this information and they don’t bring it back; they don’t share any of it. I don’t know if other states are doing it better than us. I don’t know why we can’t be just like wow you’re doing a great job can we just collaborate? Yes, we’re New Mexico, yes, we’re super poor but what does a conversation hurt?

Her desire to know more about what others are doing, and what works, was prominent, as it was with most participants. Time and again, I heard this desire to know what was going on in other communities, to know about resources and curriculum, to know who else is doing this work. Exasperated, Teresa summed it up with an example:

We’re all doing great work but there’s no collaboration together and I think there should be. What if we turned that into like our youth suicide prevention taskforce? You know you have these people who went to a training and want to do good and are doing work, but do we know what we’re doing? No! Because there’s no communication and collaboration!

A mechanism or platform for organized and facilitated sharing of best-practices, barriers, and successes would enable broader and more effective reach in suicide prevention work. To accommodate pandemic health orders, but also to help preventionists who are in rural areas, this type of gathering or meeting could be done monthly over a virtual meeting platform or on a shared conference call. This concept
goes beyond directory information, calling for a place or platform to freely and quickly communicate and collaborate. Collaboration is seen as a way to reduce the work load and take advantage of the cumulative effect of combining efforts. Leigh captured the silo situation, saying:

You know it's like so many other things we talk about in New Mexico where lots of people are doing lots of work and they don't even know who one another is, or that this is happening. And if we joined up, we could make a bigger impact.

Brenda added, feeling conflicted: “Everyone is doing their own thing, and nothing is happening. There’s no positive changes. Everything and nothing is happening to prevent youth suicide.” Working independently, alone, in silos, negatively impacts youth suicide prevention because resources and information, successes and solutions, are not shared. Sharing information reduces the workload, celebrates and promotes innovation. Sharing, communicating, collaborating, can accelerate and expand the impact of preventionist work on suicide rates. Sharing information is crucial to successful prevention, especially in “one of the poorest states in the Nation, with more than half of the population either covered by public health insurance or uninsured” (U.S. Department of Health and Human Services, 2019, p. 2) that also has “provider shortages and limited availability of behavioral health services” (U.S. Department of Health and Human Services, 2019, p. 23).

**Urgency to Act**

*I mean, I felt really good about it. We’ve literally had people tell us that they didn’t die because of us; I mean just like very straightforward. We’ve had people of every age say that, you know, because they have the support because they could*
reach out and make relationships and have somebody care about them and have things that they needed provided. Because of the resource center they didn't die.

It's like your ultimate work, right? I mean, that's yeah, what more can you say?

Adrien poignantly talked about saving lives, and how this is possible because of his organization’s work with transgender people; they make youth feel safe and supported. During all interviews, it was made clear to me how urgent the participants felt suicide prevention was, and they conveyed a longing for action on a situation they consider to be an emergency for in New Mexico.

These preventionists all described different moments in time when they became aware of the suicide rates in New Mexico. Teresa gave what I thought was the best summary of how people react when they realize the extent of the suicide problem in New Mexico: “Oh crap!” Adrien, Brenda, and Leigh all asked some version of: “how can you not act when you see the numbers?” Some, like Leigh, see the state as nearing a tipping point:

Things are changing; they’ve changed. But you know I honestly think we are kind of gaining some ground on stigma, because you used to never hear anyone even say the word suicide. Now, you see stories on the news, you see it in pop culture – I mean, not always in the right light – but it’s (suicide) become this thing that we talk about happening instead of pretending it doesn’t even happen. You know, the teens I’ve worked with are so actually happy that an adult is willing to talk with them with this huge thing that has impacted their lives. Seriously, there are so many teens that have lost someone to suicide. So, ya, I’d say we are gaining ground at least on being able to talk about it.
Like other interviewees, Leigh attributed some action and movement toward prioritizing suicide prevention as a direct result of the number of youths dying from suicide. I also found a sadness to the discourse on deaths being the motivating factor for change. Jeanne spoke her truth:

. . . it’s just the reality that it just feels like every single time the public school system loses another kid (to suicide) I want to look at them and go - now you get it? Now is it a problem? And it feels like they’re starting to think OK, now it’s a problem.

Brenda, working in school settings, expressed frustration over a lack urgency to address suicide with the same vigor other issues are addressed in education:

. . . this (suicide prevention) is my priority . . . I feel like it should be just as important to everyone else and it’s not. That’s why I say it’s only a small group of us who are saying please help these kids, do what you can so that they stay alive!

I see, and now I understand, that it’s not easy to get people to care about what you care about.

This recurring theme of prioritizing other issues over youth suicide prevention speaks to every other theme; if it was prioritized according to the data and death rates, it makes sense that we would see increased and equitable funding, statewide mandates to address systemic suicide prevention and building awareness, shifts in stigma through public health campaigns and social norms, and maybe even the intentional identification and usage of community strengths to reduce suicide deaths. Jeanne provides a great summary of the urgency of preventionists:
I hear about (suicides) through my social connections and personal connections but why aren’t we blasting it? E. coli is everywhere so we blast it everywhere, and now we have coronavirus blasting everywhere. Why don’t we blast about suicide prevention everywhere? What about teen suicide and youth suicide? Because people don’t know. It just seems like it has not reached the awareness that it should’ve; it hasn’t reached, I want to say, panic but people are not panicking about it yet because maybe it hasn’t reached their community or their neighborhood or their family. When it does, they’re like OH! And all of a sudden there’s this one person carrying this huge giant task on their shoulders and advocating.

Leigh was exasperated, saying: “it’s like people here just ignore the fact that it’s one of the top killers of our youth and that is so bizarre, and it’s really hard to stay calm sometimes about that.”

In a way, my findings are at odds; these preventionists described what they see as some progress in conversations about suicide (or, reducing stigma and increasing awareness) and a building wave of suicide prevention (or urgency to act), but they also attested to the continually high suicide rates. The contrast can be resolved by another theme: communication, training, collaboration. In discussing what they see, hear, and experience, these participants also provide their own solutions by identifying the need to work together and share knowledge.

Statewide Mandates

Every participant who disclosed experience working in school settings brought up content standards in public education; in one form or another. Brenda said “it’s not as
prevalent as read and writing . . . but mental health is also important.” Despite the very real situation that “testing requirements have increased . . . more is piled on that leaves less and less room for thing like mental health,” Leigh believes it is vital that schools “teach students how to problem solve and talk to them about their wellness and their own mental health . . .” Leigh also noted that “since there are no requirements on these things” then that sends the message “they are obviously less important.”

Participants called for every grade level to be taught skills and knowledge that would improve mental health through coping skills, promote wellness, and increase resilience. They talked about problem solving, help seeking behaviors, protective factors, and reducing risk factors (American Foundation for Suicide Prevention). Leigh stated: “we teach them so many important things at school and then there is this huge void where there should be the skill set for interpersonal relationships and safety and mental health.” Participating preventionists called for the types of standards that would require the above so that public school education would include teaching that decreases stigma by normalizing conversations about mental health.

Research participants continually voiced the desire for continuity across the state, in and among communities, in prioritizing suicide prevention and awareness as well as professional roles being on the same page in their efforts and approaches. Teresa held that her rural communities are not asking for strict mandates, but . . . maybe a framework that we could be given and then tweak it to make it ours and make it work for our part of the state, because what works in the minds of policy-makers in Santa Fe is not what works for us in southern New Mexico.
Jeanne is another preventionist who wants to see change from within government and public entities:

I want to see that it (suicide prevention) is embedded in everyone's policy, whether you're at Walmart as a manager or you’re at a state agency, law enforcement, et cetera. I wish that every agency sort of had their own resident experts on suicide intervention and prevention.

**Preventionist Well-Being**

Woven throughout these interviews was a reluctance to discuss the personal impact of the work, yet when they did share, it is clear that many aspects of this work challenge their wellbeing. Leigh said: “we really are kind of on our own a lot of the time and it’s frustrating and it’s very tiring and exhausting and I have seen colleagues leave the profession because of that and that’s always hard.” Their focus, in answering my questions and discussing their work, seemed to be concentrated directly on the youth they serve. Even when we discussed their experiences with specific suicide losses, participants immediately turned our conversations to how those losses compounded the urgency and difficulty of preventing more suicides. I was brought to a quiet halt in the last of the third and final round interviews by Elsie; speaking from the heart, she conveyed the substantial impact of working to prevent youth suicide:

One friend that I had who completed suicide was somebody that I was working with on suicide prevention and who was just this like dear friend and colleague. And you know we talked about a lot of things and we were getting ready to go do a training. He had an important job and was also a huge advocate for young people and equity and all kinds of things that are really important . . . I knew that
he had had some issues with depression in the past, but I don't know if I really
don't know if I wasn't paying attention or if he just really was extremely good at
hiding it, or didn't want me to know. But yeah, it was a total shock when he
completed suicide. And so, I bring that up only really because it also reminded me
of the stress that people who do this work all the time . . . and so I have some
concern around that, too. I mean, the heaviness of people who carry vicarious
trauma and all kinds of stuff. You know that happens when you work with
troubled young folks. I worry about that too, I mean, it's kind of something in my
brain about how we support take care of ourselves, but how we support each other
in the work.

More in her tone and hesitations, her thoughtfulness, than in her specific words,
she allowed me to feel that heaviness that youth suicide preventionists carry. The
vicarious trauma she referred to can also be called secondary traumatic stress and is
sometimes referred to as compassion fatigue or burnout (Hydon, Wong, Langley, Stein,
& Kataoka, 2015). Joseph echoed the weight of loss, stress, and the emotional load
associated with suicide prevention work:

When I first moved here (a rural county in New Mexico) it (suicide) was one
about every few months and as a pastor you experience it in a different way
because there’s only five of us that do funerals, so you know it’s going to be one
of the five of you. On top of that, some pastors won’t do funerals for people who
commit suicide. So, you get to see a different side of it (suicide); you see the pain
and the families, you see how the community addresses it . . . and every few
months somebody was committing suicide, I’m like why isn’t everybody freaking
out? This is like an emergency and it’s not getting better. We’re one of the worst (counties) in the state; out of the thirty-three counties, we haven’t left the top ten in the last thirty years -- it’s crazy! We’re like five times the national rate of suicide; when you say something like that to a local, it just kind of doesn’t mean anything. They just kind of don’t want to deal with it... the number thing; you can look at it and say it’s only twelve (suicides), but twelve out of thirty-five hundred (3,500) people is a lot. I just think people have a really hard time in visualizing and understanding the weight of that rate and how heavy it is. But also, like I said, there’s the proximity. To acknowledge it is to never get a break from looking at it because it is something that will consistently happen a couple times a year.

Multiple times, Joseph makes interesting reference to how he has experienced smaller communities coping with suicide death. This coping mechanism of denial, or acting like something has not happened, is what he has witnessed in his rural county. It sounds like, to survive the grief and loss, his community tries to move forward and put the loss behind them. Admittedly, having lived and worked in rural and frontier New Mexico myself, I have seen this same sort of coping. It begs the questions: is this the best way for a close-knit community to cope? Do the consequences of this type of coping lead to more suicide deaths? The wellbeing of preventionists can easily be discussed along with what resources they have available with which to do their work. They often spoke about how funding and resources directly impact their successes and the barriers they encounter.

**Distribution and Permanency of Resources and Funding**
The reality is, we’re in a situation where that whole proverb of give a man a fish and teach him to fish et cetera. It’s like that’s great, but we don’t have a fishing pole and it’s like if we don’t have a fishing pole, we’re wasting our time here. Just sitting there looking at the fish, no pole (Joseph).

Joseph gives a stunning metaphor, albeit disheartening, based on his experiences working with people at different economic levels and in different regions of the state. He works for a non-profit organization that promotes and contributes to health and wellness. He strongly believes that funding is often assigned to causes and locations where the monies impact greater numbers rather than going towards lowering rates. Without commensurate funding, communities and preventionists are left with “no pole.” This type of funding allocation can lead to broader health inequities, bigger gaps in mental health infrastructure, and even perpetuates provider shortages; additionally, access to mental health and prevention grants is reduced because they often require a degree of fiscal matching and provision of facilities. Leigh talked about “the fact that people work so hard to survive, and that is a strength” that comes from living in poverty and in a high-risk state. She described some of the smaller communities she has worked in as “being in survival mode;” she explained that as using what one had to do the best for their community and “just making it work, no matter what you have or don’t have.” Joseph talked about how those valuable resources are meted out:

So, if it just comes down to balancing an equation, then that’s how crazy oversights like the most vulnerable people getting the least help happens. The specific problem you’re supposed to solve (suicide), the most vulnerable people
are being left out. Because, it just doesn’t seem like that funding always follows the need unless it’s beneficial to your numbers.

Not only did participants feel funding was not always allocated in an equitable manner, they were puzzled by how some services, programs, and personnel are being distributed throughout the state. Teresa and I discussed the example of some state-funded services and programs being available in some counties, but not in others; specifically, we discussed the wraparound service model, “a process by which a supportive team is formed to work together to develop, monitor, and update the support plan until success is achieved” (Hunter, Elswick, & Casey, 2018). We both agreed the service model is highly effective and is needed in every county, but it is not. Teresa said “I think that (wraparound services) is definitely beneficial but, I don’t know, it kind of baffles me. How can different places have different services? If we know it works, why can’t we have it somewhere else? It seems odd.” During her interview, Brenda added: “It just doesn’t seem like the funding always follows the need . . . I feel like suicide prevention is this abstract word that has no teeth. No support. No funding.”

Another funding topic was a lack of permanency of funding for suicide prevention. Participants unanimously expressed experience with continuously revolving grant funding. They described youth suicide prevention efforts in New Mexico as driven by grant funding and constantly rotating pilot programs that end with grant cycles. There was pronounced frustration with seeing successful programs and services end when grants complete. It is clear that temporary funding directs youth suicide prevention work in the state and yet I was unable to locate public records to show a dollar amount of permanent and public monies that are committed to youth suicide prevention in New
Mexico. From my professional experience, I do know that there is permanent funding assigned to fund a full-time position for a suicide prevention coordinator in the New Mexico Department of Health’s Office of Injury Prevention, Epidemiology and Response Division; likewise, there is permanent funding assigned to fund a full-time position for a youth suicide prevention coordinator in the New Mexico Department of Health’s Office of School and Adolescent Health. Public reports and documentation show that these positions are funded by their respective bureaus’ budgets and their work is not shown separately and specifically notated in public budget tables for their departments.

Not only does the data tell a story, Joseph provided an example of how those risk factors play out in his community.

The reality is, if somebody is in crisis they have to go to a hospital that is over an hour away if an ambulance is available to get to them . . . an example: my family member was visiting and had a terrible medical event; it took almost an hour for them to even get to our house then they had to drive over an hour to get to the hospital. Imagine how much worse their condition was in the midst of that . . . bringing it back to suicide, our first responders aren’t even trained . . . one of the capacities of my work is just trying to get training to our first responders because they don’t understand the first thing about mental health. There’s nobody either giving them money to learn or demanding that they must learn.

We see frontier and rural communities often lack the resources to address medical and behavioral health needs, and that can be compounded when New Mexicans living in those communities may lack the personal resources (insurance, transportation, or the knowledge of how to navigate care systems, etc.) necessary to access providers outside
their area. As Joseph said, even when there is a provider in a rural area, they are often so overwhelmed with meeting the needs of their community that they are not able to address prevention or integrate mental health into their practices. It sounds as if, when resources are strained medical services are prioritized over behavioral health services even when we know they are inseparably connected. Without blaming, Joseph pointed out that essentially the area’s first responders are not trained in mental health but are expected to respond to those calls. In small communities, there are not enough people to have the many specialists that more populated areas have. Having worked in rural and frontier communities myself, I can attest to the phenomena of many hats: the smaller the town, the more hats one wears. That means, when resources are few, we find ourselves needing to be versatile and adept at many things so that we can support the community in as many ways as possible and needs are met.

The COVID-19 pandemic has intensified factors that can contribute to suicide risk, and further strained public funding for the safety and wellness of youth, as noted by a nonpartisan, statewide advocacy organization (New Mexico Voices for Children):

Before the COVID-19 pandemic reached New Mexico, the state had just begun to make critical investments in our families and children after a decade of stingy spending had driven us to last in the nation for child well-being. COVID-19 is threatening this progress and has quickly exacerbated existing disparities along racial and economic lines, with people of color and families earning low-incomes disproportionately impacted (New Mexico Voices for Children, 2020, p. 1).

In relation to funding, Brenda told me:
there is no funding... when you’re grasping at things that are free then nothing gets done. It’s like this cyclic pattern: there’s no money, therefore I don’t know what to do, therefore it’s not important to me.

She makes a strong point: funding lends legitimacy to a movement, such as preventing suicide, decreasing stigma, or raising awareness. Funding also assigns a value, a social value, to an issue; permanent funding demonstrates commitment to an issue and publicly acknowledges a problem while giving some hope for a solution.

**Summary**

Driven by suicide rates, personal experiences, and a sense of professional responsibility, I was struck by how upfront and conversational participants all were about why they do this work. One of the most fulfilling parts of these interviews was when we discussed success stories. With a huge smile, Teresa talked about inspiring others and her contagious passion for the work. She described a training success:

I’d like to say when I see that other people are as excited about it as I am. For example, we did a train-the-trainer in (a large city) for QPR (Question Persuade Refer) and I met a counselor from a local school district there and I followed up with her a few days ago and she was like ‘I’ve trained all my teachers, all my counselors, and all my nurses’ and she hasn’t even been trained for like a full month. So that just makes me so happy, because I’m one person and if someone else can feel as passionate about this as I do then that means I’m doing what I should be doing.

In the next chapter, I will present a discussion of my research findings in a larger context that encompasses education, policy-making, and funding. Further, I will provide
an update of the most pertinent literature and discuss the implications for today and for the future.
Chapter 5: Discussion and Recommendations

Since I began this study, based on a review of the literature, there have been some palpable shifts in the climate, funding, and awareness of suicide prevention in New Mexico. The state was awarded a suicide prevention grant from the Substance Abuse and Mental Health Services Administration, providing over a quarter of a million dollars each year for five years. This is New Mexico’s third such grant award (2009, 2012, 2019). As helpful as those monies are for the state, it is another example of the temporary funding that participants identified as troublesome for permanently decreasing the youth suicide rate. In 2019, the state established a suicide prevention coalition, which is working to draft a statewide strategic plan for suicide prevention.

On August 14, 2019, a “Federal Communications Commission (FCC) staff report to Congress in 2019 proposed establishing 988 as an easy to remember there-digit code for the National Suicide Prevention Lifeline” (Federal Communications Commission, 2020, p. 1). This was a significant move by the federal government to improve access to resources, for anyone who may be in crisis. The FCC “adopted rules to establish 988 as the new, nationwide, 3-digit phone number” and the new rules “require all phone service providers to direct all 988 calls to the existing National Suicide Prevention Lifeline by July 16, 2022” (Federal Communications Commission, 2020, p. 1). “The Lifeline was established in 2005 by the Substance Abuse and Mental Health Services Administration (SAMHSA);” there are two crisis centers in New Mexico that are members of the Lifeline network and, in the last six months of 2019, there were 7,693 callers from New Mexico (Federal Communications Commission, 2020). The FCC expectation is that implementation of the 988 number will significantly increase calls to the Lifeline.
For New Mexico, this could help connect people from remote areas of the state to the help they need.

Additionally, a pandemic struck with significant impact on the United States and New Mexico (Kunkel, 2020; New Mexico Voices for Children, 2020) which prompted me to capture participant experiences and insights surrounding how that has impacted their suicide prevention work. Throughout the study, taking in all that participants had to say, it became apparent to me the landscape of suicide prevention is constantly changing and shifting, even outside a pandemic; it is not stagnant. This was a surprise to me, as the suicide rates for the state could be described as stagnant. Despite the increasing suicide rates throughout the country and in New Mexico, I found the preventionists to be full of innovative ideas and, unexpectedly, hope. Being shocked by their enduring hope revealed my own bias, my exhaustion from this work, and spoke to some of my own experiences of frustration and feeling overwhelmed in my suicide prevention work over the past twenty years in New Mexico. Admittedly, their stories and anecdotes helped me recognize the hope and perseverance I carry with me, even if it may be a bit buried. For this, I am joyous. This also highlighted the importance of communication, collaboration, and sharing in making prevention work impactful, while improving the longevity of preventionists. Next, I will discuss the research study sub-questions and then explain the recommendations I am making, based on my findings:

- Changes, that result in lowering youth suicide rates, can be made in the form of mandates at the state and local levels.

- Preventionists can be connected through a statewide communications platform, especially utilizing the virtual environment to increase accessibility for rural and
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frontier communities, in order to multiply their impact on youth suicide prevention by sharing data, successful approaches, programs and techniques, and decreasing the isolation that research participants shared as part of their experiences.

- Funding and the distribution of resources for youth suicide prevention, at state and local levels, needs to be made in a transparent and data-driven manner.
- A strengths-based approach should be employed in this low-income, high-risk state to encourage wide participation and utilization of community assets, as well as to leverage cultural, familial, and community strengths for youth suicide prevention.

Exploring Research Questions

The driving question of my research was “what are the experiences and insights of adults working to prevent youth suicide in New Mexico?” I found that, despite their wide variety of experiences and settings, there were more common threads and themes than there were differences. As revealed in my findings, there were a number of shared experiences and insights among participants:

- Stigma at all levels
- Awareness, social climate, and education as barriers
- Communication, sharing, and collaborating
- Urgency to act
- Statewide mandates
- Distribution and permanency of resources and funding
• Impressions of the 2019 novel coronavirus/2019-nCoV (COVID-19) pandemic

• Strengths of New Mexico

I found myself nodding in agreement throughout the interviews and feeling a real connection to their experiences and insights. Using my lens, as a preventionist, I was able to relate to their stories, meaning, and perceptions. Undoubtedly, I have deep personal and professional interest in the data I collected; as always happens when I speak with fellow preventionists, I learned a lot and was inspired by their thoughtful approaches to the work, as well as their innovation. I found myself pulled, wanting to share resources and ideas that I had learned from each interview with the next participant. This spoke to the theme of needing a platform for preventionists to connect, collaborate, and share.

When I was able to share deidentified information in the course of an interview, preventionists were extremely interested; they sat forward, immediately began asking questions, and were more engaged than during any other topics we discussed. Their thirst for connection with the other preventionists and the work of others, networking, reinforcement, and even validation of their own work, was stunning.

Sub Question 1 – How do participants think about prevention?

The preventionists in my study seemed to take the high suicide rates as matter-of-fact and all expressed easy agreement that common risk factors were high and protective factors were low in New Mexico. “Risk factors are characteristics of a person or (their) environment that increase the likelihood that (they) will die by suicide (i.e. suicide risk)” (Suicide Prevention Resource Center, 2019). Those factors typically include:

Table 7: Risk Factors and Protective Factors for Suicide
<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prior suicide attempt(s)</td>
<td>○ Effective behavioral health care</td>
</tr>
<tr>
<td>• Misuse and abuse of alcohol or other drugs</td>
<td>○ Connectedness to individuals, family, community, and social institutions</td>
</tr>
<tr>
<td>• Mental disorders, particularly depression and other mood disorders</td>
<td>○ Life skills (including problem solving skills and coping skills, ability to adapt to change)</td>
</tr>
<tr>
<td>• Access to lethal means</td>
<td>○ Self-esteem and a sense of purpose or meaning in life</td>
</tr>
<tr>
<td>• Knowing someone who died by suicide, particularly a family member</td>
<td>○ Cultural, religious, or personal beliefs that discourage suicide</td>
</tr>
<tr>
<td>• Social isolation</td>
<td>○ Lack of access to behavioral health care</td>
</tr>
<tr>
<td>• Chronic disease and disability</td>
<td></td>
</tr>
<tr>
<td>• Lack of access to behavioral health care</td>
<td></td>
</tr>
</tbody>
</table>

Both lists are interesting; nearly every risk factor could be considered prominent in New Mexico. Prior suicide attempts: according to the premiere youth survey in New Mexico (the YRRS), 9.9% of high school (grades 9 through 12) students surveyed reported they “made a suicide attempt (during the past 12 months)” ("New Mexico youth risk and resiliency survey," 2020). This data is telling, especially when one considers the question is only capturing the past twelve months for the respondents. Misuse and abuse of alcohol or other drugs: of high school students surveyed, 20.7% reported having their
first drink of alcohol before age thirteen (compared to the national average of 15.5%); 15.7% first used marijuana before age thirteen (compared to 6.8% nationally); 9.4% had ever used cocaine, 3.4% had ever used heroin and 4.1% had ever used methamphetamines (compared to national averages of 4.8%, 1.7%, and 2.5%, respectively) (New Mexico Department of Health, 2020c). Mental disorders, depression and other mood disorders: according to the 2017 YRRS, an astounding 35.8% of respondents reported having “persistent feelings of sadness of hopelessness for at least two weeks in a row during the past twelve months,” while access to lethal means is high when “half of all New Mexican households report gun ownership, compared to about 29 percent nationally” and the state has the “seventh highest gun ownership rate in the country” (Pachelli, 2019, pg. 1). With one of the highest suicide rates in the country (New Mexico Department of Health, 2018b), knowing someone who has died by suicide is a commonality. Social isolation, for many, is a part of life in this large state with an unevenly distributed and small population; New Mexico largely considered a rural and frontier state (New Mexico Department of Health, 2018b). Although chronic disease is on par with national averages, chronic diseases "account for five out of the six leading causes of death in New Mexico” (New Mexico Department of Health, 2018b). Finally, lack of access to behavioral health care is a major issue for New Mexicans; not only is there a shortage of providers in thirty-two of New Mexico’s thirty-three counties (New Mexico Department of Health, 2018b), in 2018 a full 5% of youth under age 18 years old were not covered by any health insurance (The Annie E. Casey Foundation, 2020). The data tells the story of a population of youth in crisis and, presumably, at great risk for suicide.
Remarkably, many of the protective factors listed by the Suicide Prevention Resource Center were actually listed by participants as being strengths they see in New Mexico: pride in diversity, cultural heritage, identity can be likened to self-esteem and a sense of purpose or meaning in life, as well as cultural, religious, or personal beliefs that discourage suicide; resilience and survival can be equated to life skills; relationships, families, trust, bonds can be associated with connectedness.

I postulate those strengths enumerated by the preventionists are, in fact, found throughout New Mexico but are under-utilized, specifically, for preventing suicide. Could it be that New Mexico communities hold more protective factors than we know and we have not yet employed them as tools to prevent youth suicide? Joseph and Adrien both talked about the strong faith in communities within the state and were interested in seeing them engaged in suicide prevention. It could be that New Mexico has the tools, like Joseph’s metaphorical “fishing pole,” but is not using them.

Compared to other interview topics, conceptualizing prevention, this question stimulated the least amount of discussion, but brought on some of the most zealous expression. When I asked how they describe suicide prevention in New Mexico, that generated the most sarcasm, laughter, and joking of all other topics we covered. I interpreted these reactions as their ways of coping with the stress and frustration the question evoked. Many laughed, and several took a deep breath before answering. Leigh laughed, and said:

OK, that’s a tough one. I think there are a lot of people I have met that are doing really hard work and rally amazing things and just doing the best they can and scraping together... it’s a huge state and it feels disconnected most of the time to
me and I have felt that way for my whole career that people are just working so hard but it’s almost like we are alone a lot of the time.

Echoing that perception, Elsie stated:

You know it's like so many other things we talk about in New Mexico, where lots of people are doing lots of work and they don't even know who each other is, or that this (suicide prevention) is happening; and, if we joined up, we could make a bigger impact.

**Sub Question 2 – What are the success stories?**

Teamwork was never mentioned, specifically, but was represented in how preventionists smiled and spoke fondly of their work done with other preventionists. The overwhelming consensus, though never directly spoken, was that working with others on common goals had always been better, less draining, and more impactful, not to mention more enjoyable. As for examples of successes, participants had no shortage of stories that were visibly central to their own evaluation of their efficacy, as well as motivation for continuing their work. The success stories, connecting with youth and saving lives, is the fuel that keeps them going. Like Elsie recounted, every success story involved helping youth to connect and find hope, and sometimes that was a hotline, sometimes a support group, sometimes someone to listen, or safety, or making it through the worst day: “if I can help someone who is suicidal get through the crisis and reengage, then that feels super important.”

**Sub Question 3 – What are the challenges and barriers?**

This question resulted in the bulk of my interview content; the preventionists were full of examples and ideas for change. Barriers to their work seemed to be something they
had discussed a lot, and preventionists in this study were at no loss for stories and 
opinions on how to remove those barriers. A common thread, in these particular 
discussions, was that the preventionists identified barriers that need intervention from 
others, in order to be removed, such as a school leader changing or implementing a policy 
that would allow them to do their work. It was not a matter of feeling powerless, but 
more that the preventionists do not normally have the oversight or authority to change the 
things they need to change for improving youth suicide prevention.

Brenda’s account of barriers in the school setting resonated the prominence of 
stigma and need for increasing awareness. She described instances in which a student 
died by suicide and their peers were talking about, posting on social media, and Brenda 
was specifically told by her school administrator that she could not talk about suicide 
with those students. She expressed deep concern, obvious frustration, and said she felt 
defeated in providing the care those suicide loss survivors needed. Brenda believes that 
refusing to acknowledge a youth suicide has occurred further stigmatizes mental health 
and suicide, creating an unsafe and unhealthy school environment for youth and adults.

Many of these barriers, exposed by participants, beg intervention at managerial, 
policy-making, or legislative levels by leaders who need to be convinced or moved to act. 
This adds to the responsibilities of the preventionist, necessitating they provide direct 
service, prevention, intervention, postvention, networking, evaluation, advocacy, and 
policy development, in addition to teaching to raise awareness among decision-makers; 
that is a tall order. Participants talked about systems, policies, social norms, as barriers. I 
found they held a wide variety of experience, when it comes to changing those types of 
things. Some had experience with writing policy and even advocating for legislation at
the local and state levels, while others had no such experience. It may be that developing advocacy skills, policy writing skills could serve these preventionists well. The question is: how many roles are wrapped up in the title “preventionist?”

Sub Question 4 – What would help preventionists?

What, or who, do preventionists identify as helpful to their continued work in suicide prevention? Adrien brought up how working together with faith and spiritual communities can be a real asset in suicide prevention, and that healing relationships can be a powerful tool; he thinks “there is an untapped power in faith traditions.” His thoughts on this speak to how preventionists who work within a community are well-situated to learn about a community’s strengths and identify what already exists in communities that could be used for impactful suicide prevention, rather than bringing in methods and principles from outside the community. Brenda commented on seeing change in the Catholic church in New Mexico, which she described as being a major influencer in the communities she works in: “the last funeral I went to was a suicide and I was shocked because the priest didn’t shame them (the family) and it made me feel really happy . . . I don’t know, maybe it’s changing.” Brenda’s experience is a great example of a shift in stigma, but also shows the opportunity in faith communities to work on suicide prevention from within.

To further elicit what helps preventionists, I asked preventionists about what they would like to change or see happen in New Mexico. They talked about funding, equity, collaboration, stigma, entire movements to change public perceptions of mental health. Joseph firmly declared: “It’s equity. It comes down to equity. To expect more from somebody you’re giving less, that has the most need, that’s just stupid. It’s stupid.” If he
could see his community get the same resources and support as others, and to see 
communities with more need receive more assistance, he knows it would help. Brenda 
wants to see “classrooms a little more friendly . . . more caring.” Leigh was concrete, 
with a suggestion for schools that embraces the notions of trust and the benefits that come 
with community bonds:

I would love for teachers and school staff to just have fewer students so that they 
can interact and build relationships better, rather than it being like a factory 
turning out students from one grade level to the next . . . if they had smaller 
classes they could really get to know their students, their habits, and just they 
would notice changes in them more quickly and they would also have more time 
to teach them the skills that they need to stay healthy and to stay safe.

This is the type of systemic issue that was shared by all participants in their desires to see 
suicide prevention policy written at the state level. The type of help they want is in 
changing society, people’s attitudes, and reducing stigma.

When I asked preventionists about a personal quality or skill they would like to 
develop, in order to better prevent youth suicide, they had a wide variety of answers; 
every answer had to do with improving advocacy in some way. They said things like 
“communicate better” and “become more patient” or “put a face to the problem (youth 
suicide),” while more than one wished for money to spend on prevention efforts and 
 improving the quality of services, support and life for youth.

**Meaning of Findings in a Larger Educational Context**

Preventing youth suicide cannot be done only by mental health professionals, just 
like the responsibility for teaching bicycle safety cannot only be solely assigned to traffic
safety professionals. There are not enough preventionists; by that, I mean, simply, people working within a variety of professional, community, and familial roles to prevent youth suicide. The literature, and the findings of this study, support that effective, impactful suicide prevention requires large-scale contributions by communities, families, groups, schools, institutions, organizations, faith and spiritual communities, leaders, educators, and anyone who cares about youth. New Mexico holds rich resources and strengths that can be purposed for preventing suicide among youth; this requires communication, coordination, and sharing. The education system in New Mexico can and should adopt and implement permanent, youth suicide prevention initiatives and weave effective practices throughout the roles of various professionals and throughout the school day and year. Schools are often focal points in New Mexico towns, cities, and villages; they provide information, resources, entertainment, connection, and guidance to their communities. The preventionists in this study interact with religious organizations and faith communities, schools, youth-serving organizations, emergency responders, families, and youth, directly. Their wisdom about what can and should be done to prevent youth suicide can be a guiding light for a coordinated, statewide effort.

Implications and Recommendations for Practice

The following sections put forth recommendations for changes, based on the findings of this study. There is enormous value in listening to the people doing the prevention work, and I strove to capture the essence of their wisdom here. I suggest the following recommendations, based on the findings of this study.

Change by Mandate
The legislature has the responsibility to understand the needs of these agencies and organizations, to fund appropriate programs and to foster a spirit of cooperation among all those involved in protecting and educating our children and their families. But the legislature alone is not enough. All branches of government must work together for this common cause. We need a family’s cabinet initiative that monitors family needs and builds upon family strengths to provide workable solutions for public agencies, nonprofit organizations and private enterprises . . . State agencies and nonprofit organizations would benefit from a unified, upgraded data analytics and reporting system that would provide evidence-based data and innovations, while allowing communication among stakeholders. Coordinating the missions of the many fine organizations and public agencies in New Mexico is crucial to providing a healthy environment . . .

(Campos, 2018)

Participants echoed the feeling that central authority and mandates would serve as a platform to decrease stigma, prioritize suicide prevention, and publicly normalize help-seeking and suicide prevention work, increase awareness of the issues contributing to suicide. Further, these types of mandates or policy can be composed in a way that embraces the strengths that preventionists see in New Mexico.

**Connecting Preventionists to Multiply Impact**

Development of a permanently maintained, easily accessible, statewide communication platform aimed toward resourcing New Mexicans in suicide prevention, to help “make people talk to each other” (interview with Teresa), could have enormous impact on youth suicide rates. Participants in my study often discussed the isolation and
need for consultation with others doing similar work. Often, this discussion turned to the use of online platforms that were easily accessible throughout the large, rural state. There was consensus that someone who was employed by the state and worked throughout the state would manage an online platform. Presumably, this type of platform would include a type of forum where questions could be posed to users, as well as a searchable database where users could find resources. To accommodate the very real impact of poverty, trauma and historical trauma, and the high-risk present in the state, resources would need to target those issues. An evaluation component would be invaluable, to assess use of the online platform, as well as the resources and collaboration within.

**Funding**

In light of the passion, vehemence, and even anger with which study participants addressed the topic of funding, it calls for further consideration. A plan for funding localities for their youth suicide prevention programs and activities is essential. Especially high-risk and impoverished communities, and those that are small and have little infrastructure, need to be infused with monies to target suicide prevention and the promotion of mental health wellness. Vital to this stimulus, communities need to have voice in how those monies are used. According to what I learned from participants and, indeed, in my own experience, prevention dollars are typically assigned without a transparent accounting of determining factors. It may even prove useful to ask community leaders to design a funding formula that they agree is fair, transparent, and based on need.

**Taking a Strengths Based Approach**
In reflecting on success and community strengths, Elsie described her connectedness to the communities in which she works like this: “I have learned just how important it is to be visible as an advocate, plus an ally . . . even if young people don’t feel like they can engage with us then at least we are our in the community.” She was part of the community in which she worked to prevent youth suicide. This embedded, group membership perspective could, perhaps, be utilized in building locally pertinent training, professional development, methods of communicating suicide prevention messages and promoting mental health wellness, writing local policy, and in engaging community members as partners to develop an abundance of localized strategies that are both impactful and embraced. An example would be taking a community approach to these mandates, in the same way that emergency plans are created in communities and by communities to help during a crisis. This would assure that suicide prevention was done using the strong community bonds that are a strength in New Mexico, and that local wisdom, knowledge, traditions, and relationships are incorporated into suicide prevention plans.

**Implications for Future Research**

This study provided a rich platform from which to draw ideas for future research. It is a foundational study, exploring the perspectives of a group that has not been studied in New Mexico: adults working to prevent youth suicide. As a foundational study, it reveals several topics for future study that could enrich suicide prevention discourse and, ultimately, reduce youth suicide.

**What was Missing**
Missing from the data collected was any mention by preventionist on changes that youth need to make. For example, they talked about how we, as supportive adults, need to eliminate stigma and provide better supports; they did not say that youth need to be the ones to eliminate, or even decrease, stigma nor did they suggest youth need to become more resilient. This indicates the problems with the world we have built for youth and the systems of support we provide them.

Furthermore, the literature surveyed, and the data collected in this study made no mention of relying on other states or national resources; this is compelling, as the majority of evidence-based youth suicide prevention curriculum is developed outside New Mexico. So now what? We need to quantify the needs and resources or assets New Mexico holds, in order to move forward with enhanced suicide prevention.

Also absent from the data collected: participating preventionists never indicated a lack of understanding as to how or why youth suicide happens, especially within the specific contexts in which they worked. Though Singh and Lathrop posited, in their study of youth suicide in New Mexico, “with a solid understanding of the circumstances, it may be possible to predict, and hopefully prevent, future cases of child and adolescent death” (Singh & Lathrop, 2008), that idea was not shared by participants. They indicated deep, personal, and professional understandings of why youth become suicidal and how they carry out their suicides. Participants never indicated they wanted or needed to know more about the circumstances of youth suicide and, in fact, were more focused on discussing how the systems that care for youth can change or improve to support them; they identified those systems as: state government, schools, the professional mental health provider workforce, families, and communities in general, especially when it involves
decreasing stigma. Narrative studies in each of the areas described above could set a foundation upon which to construct quantitative surveys that help policymakers provide the assistance that communities could best utilize for suicide prevention.

**Identify Systems Failures**

“Conventional wisdom advises that a strategy will never have an impact if it sits around collecting dust on a shelf” (Substance Abuse and Mental Health Services Administration, 2017, p. 40). What is preventing us from adopting and implementing, not only the highly researched and evidence-based methods of preventing suicide but also, the recommendations that the state of New Mexico has painstakingly investigated and put forth through government reports and documents? Further, it would be illuminating to uncover why New Mexico legislation that targets suicide prevention has failed in the past. Like an onion, is the state’s failure to legislate youth suicide prevention a mechanism of the stigma at all levels that the research participants revealed? It is possible that mental health and suicide stigma permeate the state’s law-making bodies.

Participants related experiencing stigma in families, schools, local authorities and state agencies. In order to determine how to best assist lawmakers in combatting youth suicide, I propose an exploratory study such as a… to determine the levels of stigma and experiences with both mental health and suicide within our body of lawmakers. This could inform next steps in writing and passing legislation that would address youth suicide.

**Measuring Impacts and Aligning Prevention Work**

Are prevention efforts making an impact on youth suicide rates? Would suicide rates be higher if the prevention work was not being done? How are other states
measuring their prevention work, especially those with large rural populations and those with a diversity of populations? It would benefit New Mexico to identify a way to evaluate suicide prevention work in the state and compare and contrast those findings with national studies and what has been found in other states. Research participants all expressed a desire to know about what others in their field are doing, what works in New Mexico, and how they can collaborate and share. Although it was not addressed in this study, the impacts and perceptions of New Mexican youth would illuminate the work of preventionists. A large-scale, statewide, survey of New Mexico youth to determine their perceptions and ideas about youth suicide prevention would be priceless, as communities craft their prevention plans and programs. A convenient and effective survey that is already administered, the YRRS ("New Mexico youth risk and resiliency survey," 2020), could be updated to administer additional questions that directly asked youth about their experiences with and ideas surrounding suicide prevention and what particular strengths might be engaged within specific communities and populations toward suicide prevention.

**What is the Impact on Rural Communities?**

How does suicide and suicide prevention impact smaller communities differently than more populated areas? Joseph felt both a deep frustration and sorrow about watching his small, rural community cope with suicide death by ignoring or stifling their grief. In his prevention work and, indeed, his work as clergy, a study examining this type of survival or coping mechanism and the impact it has on youth. This type of study could explore the complexities and differences in coping with grief from suicide deaths in different types of New Mexican communities. I posit there are unknown ways of coping, in those communities, that may provide positive and negative results. Furthermore, a
broader comparison study of regions, cultures, and other groups across New Mexico could reveal important wisdom about historical trauma, individual versus communal coping mechanisms, survival and mental health, and would give us insight into unknown ways of coping and the preservation of self, family, culture, and community. These suggested studies could help us answer question, such as: how can we assist smaller communities with high suicide rates? Are some rural communities better at coping with grief due to suicide? If they are, how might we learn from them? How do various cultures facilitate the wellbeing of youth within their cultural norms, ceremonies, family life, educational systems, and traditions.

**Health Equity**

A study of health indicators, as well as a comprehensive audit of public funding assigned to improve health and wellness in the state, would be useful to enhance the conversation on reducing youth suicide. In part, this suggestion is based on my research findings that according to participants, the distribution of resources and funding is not transparent. Risk factors for suicide are abundant in New Mexico. A survey of New Mexicans to determine what equity looks and feels like to them would inform next steps. I suggest that there may be vast differences between health equity reporting and what New Mexicans have to say about their own experiences. This is based on this study’s participants relating their experiences that are difficult to quantify. A good example is when Teresa discussed training a community group in suicide prevention and wound up providing so much more, in the way of grief resources. I would venture to guess that those community members felt they had been heard and that Teresa helped meet their needs; this particular scenario is something that does not fit into a health indicator or
health equity report category and cannot be measured. I am interested in how and when communities feel heard and that their needs have been met, as well as learning about their unmet needs.

**Helping Preventionists**

Study of longevity, retention, stress, and coping of preventionists as well as the short and long-term impact of the work would be helpful since those who experience suicide loss are more at risk. A specific study that inventories the impact of strain on those who work in rural and frontier areas when they constantly are without the resources they need or the people they refer cannot access providers is critical in New Mexico? A qualitative exploration of the impacts on resilience, coping, and help-seeking behavior would be valuable so that we can show as much care for our preventionists as they do our youth. Further, a more quantitative study that measures the outcomes for communities, families, and individuals who experience long-term provider shortages would give valuable and actionable ideas that could improve their quality of life. Additionally, an area of inquiry could seek to discover longitudinal changes that are caused by perpetually unmet needs and the longing for services. With these shortages in mental health providers and not having other necessary resources, it would be wise to explore how low-income, rural communities have responded to fill those needs in their own innovative ways. As with many non-urban areas, people without resources are often gifted problem solvers, visionaries, and work very hard to help their own communities and families. For decades, I was fortunate to witness this sort of creativity in solving problems when I visited my Grandmother. She was a sharecropper in the deep south, growing up and into young adulthood. She never failed to amaze me with her ingenuity; I saw her repair a leaky roof,
unclog sink drains, remove trees, perform insect and pest control, and repair fences, all with nothing more than a set of well-worn kitchen tools.

I am curious, too, how the distance to inpatient and outpatient mental health services impacts: 1) recovery 2) future help-seeking behaviors 3) treatment compliance 4) efficacy of treatments 5) rapport between mental health professionals and their consumers and 6) mental health consumer perceptions of support systems. More pointedly, I propose research revealing the nuances of how mental health consumers feel about being treated by someone who is not a member of their community, including a study of being treated by someone outside their culture. Lastly, how have rural and frontier communities overcome to meet the needs of their most vulnerable? What are the strengths and adaptations that are particular to those communities? I suggest an explorative study to uncover how those communities respond within.

Evaluation

Evaluation; a study to reveal ways of knowing when prevention work is successful and effective would help guide the general public, educators, families, providers, policy makers, and preventionists in their efforts. It would also guide policy makers in writing public policy that can reduce suicide. Finding out what successful suicide prevention looks like, sounds like, and feels like in New Mexico could also help connect prevention work, funding, policy making, and awareness campaigns. Prevention efforts need to include communication that is shared, linked, and accessible to everyone, including youth. I believe applying a method for assessing the impact of youth suicide prevention work would encourage more impactful work, increase involvement, raise awareness, increase permanent funding, and increase initiatives. A supportive study
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would generate multiple perspectives, including knowledge, attitudes, and perspectives of entire communities, people groups, families, individuals, and professionals working in prevention. The stories of my participants, when discussing how they know when they have been successful in their work, focused almost entirely on stories of working with individuals. They would benefit greatly from a study that theorized systemic approaches and measurements. Through a grounded theory study, a model for systemic youth suicide prevention could be built for New Mexico.

**Provider Shortages**

The participants in this study identified the professional mental health care provider shortage as a major barrier to reducing suicide especially in rural, low-income areas and among high-risk populations; state reports confirm that New Mexico has experienced a provider shortage for several years, now (U.S. Department of Health and Human Services, 2019; New Mexico Department of Health, 2018b; Krider et al., 1999; New Mexico Department of Health, 2013a). In addition to having too few providers to access (U.S. Department of Health and Human Services, 2019), preventionists thought that many of the New Mexicans they work with face barriers of poverty, transportation, and stigma, as they weigh their treatment choices. Preventionists held that language is a barrier for some, while immigration status is for others. In a geographically large state, what are the long-term effects of a long-term provider shortage? Does this perpetuate other barriers like stigma? As a matter of health equity, in a poor state, rural and frontier communities must be given voice.

**Bring People Together**
Every bit of work that can be done, every suggestion, every barrier, every success, it can all be done by bringing more people together. Participants demonstrated this in relating that everyone of their successes involved teamwork and unity in their communities. People, meaning anyone and everyone. New Mexico has strengths, tools, professionals, caring and invested people who want the best for their families, faith communities and spiritual groups, schools, departments, institutions. Leveraging the assets of New Mexico will take collaboration, communication, and coordination, just like the preventionists described. If New Mexico can come together, work together, and join efforts, it can save the lives of its youth. Everything New Mexico needs is already in New Mexico. An invaluable study would reveal what community resources are already present, which could be focused on suicide prevention. What outside support do communities need? Inevitably, communities may have some common needs to develop their own strategies and mobilize their strengths; identifying the catalysts needed to activate local strengths, assets, and connections is key to beginning impactful, local suicide prevention.

**Conclusion**

After exploring preventionist experiences, hearing their insights, and surveying the literature, I am convinced that we have more knowledge of how to prevent suicide than I realized. Considering what participating preventionists had to say, that vast knowledge has not reached the general public, families, first responders, educators, faith and spiritual leaders, and youth. Instead, mainly because of stigma, that critical knowledge sits on virtual shelves that are only frequented by mental health professionals and others who chose their paths in prevention work.
This qualitative study provides insight into preventionists experience in their work: isolation, rewards, frustration, relationships; it demonstrates how important bonds and community are in this work. It is fascinating to me, even provocative, that the protective factors for suicide are mirrored in the strengths and assets that were identified by the participants. To save youth from suicide, we must continue this discussion; we must renew our work with a focus on the inherent strengths of New Mexico, while connecting with its communities and peoples. I learned, from my participants, there is plenty of work to do and so many ideas to move forward. Only after intense review of the data collected did I see that the stigma I heard about from participants was really addressing the topic of mental health and suicide prevention, but not necessarily people themselves; viewing communities as not having resources or professional mental health providers is operating under a deficit model when, in fact, we need to explore and research from a strengths perspective so that we can find solutions. Impoverished, rural communities can determine their own needs and we need to determine a mechanism to meet those needs rather than make assumptions. From everything I learned from this study, I posit that applying outside measures, making assumptions, and excluding local communities from suicide prevention plans may be a fundamental error and could even be the biggest barrier to effective suicide prevention.

If we can stimulate communities with resources that they have asked for, so they can identify their own traditions and ways of teaching and learning to address suicide prevention, we may find long-lasting success in reducing suicide rates. Asking communities, families, and groups what help they desire to pass along wisdom and skills, in the same ways they do other important knowledge, can open a door to sustained
prevention. Can we, through study, determine how communities already communicate about any other life-saving wisdom and ask for their help in creating a way to do that with suicide prevention? I expect that study would reveal stunning, useful data.

Research participant Joseph talked about fishing without a pole and, indeed, that could be a fitting metaphor for trying to prevent youth suicide in New Mexico. On the other hand, maybe we have all the fishing poles we need in the form of the strengths that were identified. Further, maybe it is that we simply need hooks on those poles, and, perhaps, we need to acknowledge that there are more ways to fish than just with poles. Each community has its own ways that can be engaged, once we learn from them and partner with them. I look forward to finding ways to help all New Mexicans catch youth before they reach the precipice of suicide; it can be done.
Appendix A: Interview Questions

Interview #1 Questions

• How long have you worked in youth suicide prevention and in what capacities?
• Describe your work.
• Are you paid or volunteer, or both?
• In what areas of New Mexico have you worked?
• Tell me about the populations you have worked with (age groups, ethnic, cultural, military, socio-economic status, rural/urban, genders and sexualities, etc.)?
• What led you to become involved with youth suicide prevention?
• How do you describe youth suicide prevention in New Mexico?
• What are some success stories, accomplishments, or achievements you have experienced while doing youth suicide prevention work?
• In your opinion, how do you know when your work has been successful?
• What do you think contributes to successful suicide prevention for youth?
• How, if at all, does this differentiate with different populations of students (i.e. genders, sexuality, ethnicity, personality types, etc.)?
• What do you see and hear when you know you have made a positive impact on youth suicide prevention?
• What do you think makes some techniques more effective than others?
  o What kinds of techniques have you engaged that have not seemed effective?
  o Why do you think they were not effective and what would improve them?
What do you think is different about preventing youth suicide as opposed to preventing adult suicide?

- How has your work evolved over time as you gain more experience and/or training?
- How has funding impacted how you work?
- What have been some memorable events or changes that impacted your work (i.e. societal, funding, politics, social climate)?
- How has access to youth changed?
- Describe some of the ways you work with students, school staff, and the school community.
- If you could add one way that teachers and other school professionals could work more effectively or differently to prevent youth suicide, what would it be?
- If you could add one thing that parents/extended families could do to prevent youth suicide, what would it be?
- Describe the process you go through, your protocol.
- How does this vary, and how do you determine when variation is needed?
- What personal strengths do you bring to your work as a suicide preventionist?
- How have you developed and applied your own personal strengths over time?
- If you could develop an additional strength in your work, what would it be?
- What characteristics about New Mexico influence the specific ways you work to be effective?
- What suggestions would you offer other suicide preventionists who work in New Mexico?
• What specific resources do you draw on in your service area?
  
  o Services, people, nature, Tribe?
  
  o What resources do you wish you had access to that you do not?
  
  o If you could add one additional resource, what would it be?

• What are barriers to your work?

• How would you describe your role in youth suicide prevention?

• How do you engage communities/adults/youth in prevention? Can you provide examples?

• What outside factors impact your prevention work?

• If you could remove any one barrier to your work, what would it be?

• Is there anything you’d like to add that I haven’t asked you about? Or anything that is important to you that I include?
Interview #2 Questions

- Deliver themes from previous interviews and ask for comment.
- Follow-up on any questions that were not addressed in previous interviews.
- What have you reflected on or thought of since our last discussion?
- How has the COVID-19 pandemic impacted your youth suicide prevention work?
- What other observations do you have on how the COVID-19 pandemic has impacted factors that influence youth suicide prevention, youth, and others doing this work?

Interview #3 Questions

- Deliver themes from previous interviews and ask for comment.
- Follow-up on any questions that were not addressed in previous interviews.
- What have you reflected on or thought of since our last discussion?
- What are your recommendations for youth suicide prevention work in New Mexico?
- What would you like to see change?
- What strengths do you see in New Mexico, our communities, our people, that may or may not be particular to the state?
Appendix B: Parameters of Report from Web-based Injury Statistics Query and Reporting System (WISQARS™)

Report retrieved from https://webappa.cdc.gov/cgi-bin/broker.exe

1. Intent or manner of the injury? Suicide
2. Cause or mechanism of the injury? All injury
3. Select specific options
   - Census Region/State: United States
   - Years of Report: 1999 to 2016
   - Metro / Non-metro Indicator: None Selected
   - Hispanic Origin: All
   - Race: All Races
   - Output Options: Standard Output
   - Sex: Both Sexes
4. Advanced Options
   - Select age groups: Custom Age Range <one to 18
   - Compare injury rates using age-adjusting: No Age-Adjusting Requested
   - Select output groups: 1. Year 2. State
Appendix C: Letter of Invitation to Participate in Interviews

Dear — (Adult Working in Youth Suicide Prevention)

My name is Victoria Waugh-Reed, and I am a doctoral candidate in the College of Education of the Department of Educational Leadership at the University of New Mexico. I am pursuing my dissertation topic: “An Exploration of the Experiences of Youth Suicide Preventionists in New Mexico.” I will be conducting one-on-one interviews, with adults throughout the state, to explore the experiences of and gain insights from preventionists. I would really appreciate your participation and can offer more information if you are willing.

Thank you for your consideration and for the important work you do.

Sincerely,

Victoria Waugh-Reed
reed42@unm.edu
IRB #630857-3 Approved 10-28-2019
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