April 15, 2021

National Institute of Mental Health
Office for Disparities Research and Workforce Diversity
Office of Rural Mental Health Research

Submitted electronically at: https://rfi.grants.nih.gov/?s=60008a6b534d000034005162

Re: NOT-MH-21-190 (Improving the Mental Health of Rural People)

On behalf of the American Psychological Association (APA), the leading scientific and professional organization representing psychology in the United States, with more than 122,000 researchers, educators, clinicians, consultants, and students as its members and affiliates, I am pleased to provide our comments in response to this Request for Information (RFI). The recommendations come from various divisions, boards, and committees across the organization whose psychologist members have expertise in rural mental health, integrated care, aging, and health equity for underserved populations.

To achieve health equity for rural and frontier populations, APA recommends taking a population health approach that also recognizes the cultural and geographic diversity of rural and frontier populations, including African Americans, Native American/American Indian, Latinx, Hispanic, veterans, women, farmers, LGBTQ populations, ranchers, migrants, individuals with disabilities and those living in resource-limited areas with declining population density. While the prevalence of mental health disorders is similar to populations in urban settings, rural and frontier communities face unique barriers to care that have been classified broadly in terms of accessibility, availability, acceptability, affordability and stigma, and a robust research agenda should seek to address each of these barriers (Juntunen, 2017).

Access to psychologists in rural and frontier communities is of particular concern to APA, which has documented these workforce shortages. Of the 734 U.S. counties that were entirely rural, the vast majority (93.6%) had no records of licensed psychologists (APA, 2016), about 2.4% had one to four licensed psychologists, and 4.0% had five or more licensed psychologists. Research is needed on specific effective and innovative recruitment strategies for rural mental health providers, including a focus on cultural competence in rural populations.

The expansion of integrated care and telemental health holds promise for improving access to mental and behavioral health care and improving outcomes, but more research is needed to determine the essential components of integrated health care teams and ensure that workforce shortages do not undermine the ability to implement evidence-based interventions in these communities. Research is also needed to increase the availability of evidence-based behavioral health assessment, evaluation, prevention, and treatment within medical practices (in addition to primary care) in rural settings, including barriers to access.

Recognizing the Diversity of, and within, Rural and Frontier Populations

Historically, research takes an urban-centered approach that has not focused on the unique needs of rural and frontier populations when developing or conducting research and implementing interventions. APA supports the greater recognition of the need to develop research programs that recognize the tremendous diversity of, and within, rural and frontier communities. To achieve health equity, community-based participatory research should include

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community engagement strategies that take into consideration these diverse cultures to increase the participation of rural communities in research and diversify the research workforce. As much of the research on rural health disparities examines disparities between rural and urban communities, additional research could focus on disparities within rural communities. Growing diversity increases the difficulty of fully understanding the psychological characteristics and needs of rural citizens. Culturally competent providers must also recognize the culture inherent in the geographic and social locations of rural citizens and be open to both the challenges and opportunities to supporting rural psychological health and well-being. (Juntunen 2017)

In addition to the complexity of rurality itself, it is important to note that other vulnerable populations, including elders and people living in poverty, are over-represented in rural communities. Rural areas also include culturally diverse populations, although this is not consistently recognized. Racial and ethnic minorities in rural areas may live in even more isolated communities (such as American Indian reservation and tribal lands) and often are overlooked in diversity conversations, but that is also changing as rural demographics reflect more ethnic and racial diversity (Lichter, 2012). Some tribes do not recognize traditional diagnoses like major depressive disorder. American Indians and Alaska Natives have a much higher reported rate of distress (13%) in comparison to the general population (9%) (Stewart, 2018, p. 57).

Refugees and undocumented immigrants are a group which face a number of mental health issues such as PTSD and attachment issues (relevant to family separation both at the border and in general). When traveling to the United States, they face a number of traumatic events like abuse or torture, leading to social adjustment issues. These are very unique problems, which need to be treated with culturally competent care. There are also language and cultural barriers which need to be taken into account. Similar to Native Americans and Alaskan Natives, this group have different cultural understandings of what we would consider a diagnosis (Stewart, 2018, p. 61).

Considering that much of the research on empirically supported treatments is conducted with urban populations, little is generalizable to rural residents’ who often face unique challenges that may act as barriers to care, treatment engagement and retention, and treatment outcomes. Research is needed to more explicitly identify clinical and professional methods and strategies that engage and retain rural patients in behavioral health treatment.

Expanded Use of Tele-Mental Health and Its Impact on Rural Communities

To counter disparities in mental health care there has been a growing momentum to introduce technologies to deliver mental health care remotely. Telemental health enables effective care management, expands access to services, and promotes the integration of primary and mental healthcare services. The Veterans Affairs Health Administration has been a leading health care system in delivering these types of services with great success (Caver et al., 2020). More recently, due to the global pandemic, telemental health expansion across other health care systems has also shown great promise in offering adequate and timely mental health care (Patel et al., 2020). These technologies have been found acceptable to older adult communities (Choi et al., 2020).

Despite the advantages of telehealth for care services, several barriers exist. For example, critical issues remain with coverage and reimbursement, licensure, broadband access and adequacy, privacy and policy barriers. There are also concerns related to shortages in the community-based geriatric healthcare workforce shortage in delivering care and using these technologies.

Research on the effectiveness of different modalities of telehealth care delivery in rural communities is needed. While video-based telehealth and telespsychiatry services provide clinicians the opportunity to observe important, non-verbal cues that may have clinical relevance (Lindsay et al., 2021), many rural and frontier residents lack adequate broadband infrastructure to support the delivery of video-based services (Graves et al., 2020; FCC, 2020).
Prioritizing the effectiveness of other telehealth delivery models to increase access to behavioral health care is warranted given this geographic digital divide.

Research addressing the impact of audio-only telehealth services on mental health treatment access in rural and remote regions is needed. The pandemic has demonstrated significant access related opportunities through audio-only services that have uniquely met rural patients’ needs. Rural individuals are more likely to face internet service and technology-based barriers to telehealth services. Audio-only services that rely on phone access is typically more reliable and available in rural areas when compared to internet-based video telehealth services. APA recommends that NIMH invest in research to test multiple tele-mental health delivery systems (e.g., telephone, versus videoconference, or hybrid formats) to address optimal care in rural settings, including for older adults.

Examining Essential Components of Integrated Care Models
Most rural residents receive mental health services in primary care settings, making integrated care models and studies of tele-mental health critical areas of research. Studies have demonstrated the effectiveness of integrated care, though the roles of team members, including psychologists as psychiatric consultants is a potential area for further research. APA recommends NIMH expand health services research in telepsychiatry and integrated care models, including collaborative care models.

The research base in support of integrated care models as effective solutions to overcoming barriers to mental health care is robust. However, guidance on how these models translate to rural integrated primary care (IPC) settings is limited. Clinicians working in rural IPC face unique clinical challenges that require flexibility and creativity in the IPC model including: balancing diverse and simultaneous professional roles, striving to meet access to care goals, navigating complicated and competing ethical dilemmas, and often trying to manage more complex and long-term caseloads than is typical for IPC practice because of a dearth of community mental health services to refer to in the surrounding rural area. Guidance for IPC clinicians in rural communities is needed (Selby-Nelson, Bradley, J., Hoover-Thompson, & Schiefer, 2018).

NIMH should seek to identify the core components of the models for improving patient outcomes for a range of mental health conditions for rural populations and ensure inclusion of psychologists in research in telepsychiatry and integrated care models, including collaborative care models.

Collaborative Care has been defined by the American Psychiatric Association as care for mental health disorders that is provided by a Primary Care Provider (PCP) for a patient by having a Behavioral Health Care Manager (BHCM) who will screen and monitor the patient, the PCP provides medication treatment, the BHCM either providing psychotherapy and having a Psychiatric Consultant (PC), prescribing provider, provide consultation. The model cited is always that of the AIMS center from the University of Washington Medical Center. In this model, psychologists are defined as “A behavioral health care manager is a behavioral health professional, typically a counselor, clinical social worker, psychologist or psychiatric nurse, who performs all of the care management tasks including offering psychotherapy when that is part of the treatment plan.”

The essential staff in this model are the Primary Care Physician, the Psychiatric Consultant, and the Behavioral Health Care Manager. The model requires two behavioral health clinicians, the BHCM and a PC. The essential tasks of the team is to provide patient-centered, evidence based, population based, accountable care that relies on repeated measurement, described as treatment to target.

Evidence has demonstrated support for integrated care models, including collaborative care models for treatment of depression and anxiety (Archer, 2012). However, Archer et al.’s (2012) paper has a distinctly different definition of collaborative care. They define collaborative care much more simply, with 4 elements:
1. Multi-professional approach with a Primary Care Provider providing medical care, one other health professional (nurse, psychologist, psychiatrist, paraprofessional) providing mental health care. (1 PCP & 1 MH)

2. Structured management plan, with access to evidence based psychotherapy and/or pharmacological treatment & patient education.

3. Scheduled patient follow ups.

4. Enhanced interprofessional communication.

Thus, using the definition from Archer et al. (2012), successful collaborative care models can be implemented without a prescribing provider serving as the consultant. This review showed that collaborative care resulted in improvement in depression and anxiety in short and medium term, but did not demonstrate long-term results, indicating a need for additional research into long-term effectiveness. It also showed that CC resulted in better medication adherence, but it did not specifically ask which elements of treatment (patient education, psychotherapy, medication) were related to improvement.

A meta-analysis that specifically asked the question of what works in collaborative care identified psychological treatment as the core essential element for patient improvement. (Coventry, 2014). Under the same model definition of collaborative care, including a PCP and a mental health provider, enhanced communication, structured management plan and scheduled follow up. Their conclusions were: “Trials of collaborative care that included psychological treatment, with or without anti-depressant medication, appeared to improve depression more than those without psychological treatment. Trials that used systematic methods to identify patients with depression and also trials that included patients with a chronic physical condition reported improved use of anti-depressant medication”. Medication did not have a main effect, it only had an impact as part of a multi treatment program. (Coventry, 2014).

A recent paper on collaborative care widely cited by the American Psychiatric Association on a ‘replication’, showed great outcome improvement in depression, blood pressure and diabetes measures. However, it appears that the main treatment differences were that the CC group had more in person visits, more phone calls. All patients were offered counseling through care managers who had some basic training in cognitive interventions. With regards to anti-depressants, 17.3% of the CC group were prescribed antidepressants and 5.6% of the control group. Thus, the vast majority did not receive anti-depressant medication. (Ali et al., 2020)

This collaborative care study appears to support the Coventry et al. (2014) conclusion that psychotherapy was the essential component.

Currently, we have Collaborative Care CPT billing codes that require a prescribing provider to serve as the PC and a second behavioral health provider who serves as the BHCM on the teams. The fundamental underlying documents that were used to create these codes, the Cochrane Review of 2012, clearly states that Collaborative Care requires a PCP and a mental health consultant; it does not specify a psychiatrist or prescribing provider. The essential elements cited are offering structured management, follow up and enhanced communication between providers. The follow up studies by that same team of investigators specifically cites psychotherapy as the active ingredient that is needed. Based on these studies the National Health Service in the UK has been on a 10-year program to provide psychotherapy. However here in the U.S., these studies have been used to support a pharmacologically based model.

We believe that psychologists should be able to serve as the PC in the collaborative care model. If psychotherapy is essential it does not follow that a prescribing provider must serve as the required consultant in order to bill under
collaborative care codes; rather, a doctoral level psychologist should be permitted to serve in this role. Psychologists are experts in psychological treatments and allowing them to serve as the PC allows them to practice at the top of their scope and makes the best use of their expertise. In addition, there are populations for whom there are few if any pharmacological psychiatric treatments that have been shown to be effective, those under the age of five and over the age of 80. For those vulnerable populations it is essential that within collaborative care the PC be allowed to be a skilled psychologist rather than prescriber.

APA recommends an investment in research on the Collaborative Care Model to determine if there are differences in clinical outcomes between a prescribing clinician serving as the PC versus a psychologist serving as the PC.

Additional research on the effectiveness of collaborative care telehealth models—specifically pediatric mental health care access programs (PMHCA)—is also needed. Effectiveness data supporting PMHCAs comes exclusively from nonrandomized trials, states with large metropolitan and low rurality levels (i.e., Massachusetts, Oregon, Maryland), and mostly are descriptive in nature focusing on program usage and provider satisfaction (Bettencourt et al., 2020; Academic Pediatrics). Given the emphases and substantial resources being summoned by federal funders such as HRSA for PMHCAs, research on their generalized effectiveness (i.e., on other outcomes, such as from provider knowledge/skill to practice and population-based impacts) is needed urgently to inform allocation of scarce resources and specialist mental health provider availability. Research that studies their effectiveness is critically needed at this time due to likely expansion and implementation of PMHCAs nationally to improve access to care.

High Risk Populations, Social Determinants of Health, and Comorbid Conditions

A review of rural health concerns reveals that there are higher levels of depression, substance abuse, domestic violence, incest, child abuse, higher rates of suicide in rural communities when compared to urban communities (Smalley, Yancey, Warren, Naufel, Ryan, & Pugh, 2010). One study of practitioners serving the Appalachian region discovered high rates of comorbid substance use, with 83% of practitioners endorsing “frequent” interaction with clients with substance abuse and 92.8% stating they “frequently” worked with individuals living in impoverished settings (Hastings & Cohn, 2013).

Citizens of rural communities are also more likely to live in poverty than those in metropolitan regions, particularly in the southern region of the United States (USDA, 2013). In 2012, 17.7% of people living in non-metropolitan areas were poor, compared to 14.5% of the metropolitan US population. 10% of rural populations are farmers, and many who live on farms must work non-farm jobs to survive. Evidenced-based recommendations for how to design and deliver mental health services in a way that meets patients where they are (in the context of poverty) is recommended. Campbell and Selby-Nelson (2020) highlight the importance of class competence care and offer recommendations for translating clinical services to meet the needs of individuals living in poverty.

Older Adults

One in five of the rural population in the US are over the age of 65 (Smith & Trevelyan, 2019). Commonly known, rural living presents challenges and inequities in the area of health care and mental health. Prevalence estimates suggest that among rural populations close to 20% will have a mental health disorder (Wang et al., 2005). In the context of rural living, older adults will experience significant mental health disparities for two major reasons: 1) Rural residents of all ages face inadequate mental health care in rural areas (Lawrence & McCulloch, 2001) and 2) Rural older adults face having poor mental health care because of their age.
The double impacts (or double jeopardy) of insufficient mental health care access and support are further compounded by additional intersecting identities that have been historically disenfranchised (e.g., statuses related to race/ethnicity, disability, and age) (Carpenter-Song, Snell-Rood, 2017; James et al., 2017; Smith & Trevelyan, 2019; & Suarez-Balcazar et al., 2018). Given the current vulnerabilities older adults in rural settings face, there are unique and important opportunities for research to improve the well-being of rural populations, and of older adults in this setting in particular.

**Children and Adolescents**

Additional research in rural areas, particularly those with large communities of color, is needed sorely, including the examination of infant and early childhood mental health treatment. Despite some extant meta-analytic data on treatment effectiveness with largely Caucasian, higher SES samples, several widely-known treatments with youth in this age range (e.g., Parent-Child Interaction Therapy (PCIT)) have been examined rarely within rural, disadvantaged, and communities of color. It is crucial to potentially test for the effectiveness of these types of early mental health interventions in rural areas.

Studies examining effectiveness with novel telehealth modalities, earlier age ranges (e.g., toddler), or involving PCIT-related prevention/intervention programs with other allied health providers that provide early intervention supports (e.g., speech-language, OT, PT providers) would be critically needed to ensure that we know the extent that efficacy is generalized in other areas, communities, populations, and potentially delivered by non-specialists along the continuum of care. These treatments often have prevention/early intervention adaptations that need to be studied to ensure prevention effects are present. Additional interventions that fall in this same area include Child-Parent Psychotherapy, Circle of Security, and Child-Adult Relationship Enhancement.

Children and adolescents that identify as members of the LGBTQ+ community in rural areas are at an increased risk of mental health disparities. Research exploring specific issues facing rural members of this population is needed, as are recommendations for how clinicians can provide culturally competent and tailored interventions to meet the unique needs of this typically isolated and under-supported population, particularly in rural communities where less resources are available.

We also need to understand how various social determinants of health, Adverse Childhood Experiences (ACEs), and multiple levels of analysis (biology, physiological arousal, cognitive processing) influence risk for early mental health problems in children under the age of 7. Additional research among highly vulnerable youth, specifically those with early vulnerabilities seen in children with Neonatal Intensive Care Unit (NICU) histories who are at high risk for mental health problems, is crucially needed. This is especially critical in areas where NICU stays due to factors such as prematurity and low birth weight are highest in the population (e.g., Rural South, Mississippi, Delta Region) and intersect with longstanding structural, racial, and social determinant barriers that may intersect with risk.

**Farmers and Agricultural Workers**

While most rural residents are employed in education, health care and social assistance, 10% of rural populations work in the farming and agriculture industries (U.S. Census Bureau, 2016). In addition to an occupation that can be isolating, physically taxing, and where so many factors are beyond an individual's control, these trends are contributing to reports of increased stress levels among farmers. In 2015, suicide rates among farmers were more than twice the rate of the general population (CDC, 2018). Unique stressors from volatile economic and financial risks and changing environmental conditions due to climate change have led to a growing incidence of devastating natural disasters, and calls for more focus on farmer wellness and stress assistance.
Coordination with Community Organizations to Reduce Stigma

While there are many economic, transportation, cultural and workforce shortage issues that impact the accessibility of mental health treatment, the most commonly reported barrier to treatment was the personal belief that "I should not need help." (Brenes et al. 2015). Other commonly reported barriers included practical barriers (cost, not knowing where to go, distance), mistrust of mental health providers, not thinking treatment would help, stigma, and not wanting to talk with a stranger about private matters.

There are some avenues to obtaining help and support that are seen as less stigmatizing, for example though the use of a primary care physician or clergy member (Andren, McKibbin, Wykes, Lee, Carrico & Bourassa, 2013). Additionally, addressing attitudes about mental health through education (Robinson et al., 2012) and targeting perceptions (Deen, Bridges, McGahn, & Andrews, 2012) could reduce stigma and increase likelihood of rural individuals seeking services.

Schools are important settings for accessing mental health professionals, yet rural students are less likely to have access to school-based mental health services (Shelton et al., 2021). School-based mental health service is an ever-evolving and growing service that effectively meets the needs of rural and underserved children and adolescents. There are a number of successful school-based programs that have been established and tested by psychologists (see Espelage & Poteat, 2012), but relatively few have been specifically implemented or tested in rural schools. In many rural areas, the school bus is the most reliable form of transportation, making school-based settings the optimal setting to access children and families in need. This service presents diverse opportunities for screening, prevention, and treatment of some of our most at-risk rural individuals and families. APA recommends behavioral health services in schools to address rural-urban disparities in access to mental health care. Expanding research partnerships with schools and school-based health centers could demonstrate effectiveness in school-based interventions for children and adolescent mental health.

The utilization of faith-based leaders who are trained to deliver counseling services is also a recommended strategy to increase access to care in rural areas (Kano et al, 2016). NIMH should examine prevention and education efforts that can be implemented through rural institutions, including schools, churches, public health nurses, county offices, local police forces, and county agents of the US Department of Agriculture.

Adopting Consistent Methodology to Define Rurality and Leveraging Datasets

With different government agencies defining rurality based on variant factors, research would benefit by using consistent terminology. The United States Department of Agriculture relies on a population density approach, which includes a continuum for rural as well as frontier communities. The Office of Management and Budget used a system based on counties, under which 17 percent of the population lives in rural areas spread across about 80 percent of the country’s land mass. About two-thirds of the nation’s approximately 3,100 counties and county equivalents are rural, including about 450 geographically remote and isolated “frontier” counties. (NASEM, 2018).

With the current revision of how to define rural populations being undertaken by the Office of Rural Health Policy at the Health Resources and Services Administration, NIMH’s research programs should seek a consistent approach to better align research questions with FORHP’s desire to accurately identify areas that are rural in character using a data-driven methodology that relies on existing geographic identifiers and utilizes standard, national level data sources (HRSA, 2021).

Research involving the triangulation of multiple existing data that include rural-urban differences and population-level (hospital records, claims datasets, population-based surveys) would be a very ideal and low-cost way to isolate
the needs of rural and frontier populations. Specifically, NIMH should leverage existing dataset and sources for secondary data analysis that may include aspects of rural and minority mental health. Several population-based surveys (NCHS, NHIS) and linkage with other federally funded data sources could be leveraged.

Research programs and projects that include rural emersion experiences for researchers early in the preparation phases of research design may promote insight and awareness into the nuances of rural life and practice. Such preparatory efforts launched before research design might lead to more culturally competent research designs that yield research results and implications that are more relevant and applicable to rural practice and life (Shelton, 2021).

**Research to Inform Rural Suicide Prevention Strategies**

Research is needed to better understand the contributors to regional differences in suicide mortality across the United States. Rural areas are highly diverse with respect to their landscapes, demographic composition, and socioeconomic conditions. Studies are needed to identify risk and protective factors for mental health outcomes within different types of rural communities and across the rural-urban continuum.

For rural populations, firearms and poisoning are the most common means of suicide, and those populations are at higher risk for suicide via firearms and pesticide ingestion because of greater familiarity and accessibility. Classification as a military veteran also confers risk; for example, in a study of over five million veterans in the United States, rural veterans were at 20% greater risk for suicide than urban veterans (McCarthy et al., 2012). Research reviewing the effectiveness of lethal means safety interventions has shown that restricting access to handguns, pesticides or other lethal means for patients with suicidal ideation or training clinicians to recommend lethal means restriction can reduce rates of suicide by these means (Stewart, 2018, p. 159).

Particularly striking are the suicide rates among adolescents and young adults in these communities. Suicide rates in 2014 for American Indian/Alaskan Native individuals between the age of 15 to 24 years old was 39.7 per 100,000, compared with the overall U.S. rate of 9.9 per 100,000. This rate is more than 3 and a half times the suicide rate for males of all races in the same age group. The suicide rate for AI/AN females in the same age group was lower than males at 20.2 per 100,000. However, this rate was still nearly six times the rate for females of all races. (SAMHSA, 2017).

As part of the coordinating role, the NIMH Office of Rural Mental Health Research should collaborate with other departments that are building networks to reach high risk rural populations, including veterans, farmer, ranchers and the agricultural community. The Department of Veterans’ Affairs, the Department of Agriculture, the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Indian Health Service and others. Farmers, agricultural and migrant workers face unique stressors. The CDC results on deaths by suicide per capita (by occupation) reveal that these stressors can have tragic effects. Farmers, agricultural workers and their families likely would benefit from stress assistance programs tailored to the specific needs of this population, including such elements as a stress hotline and prescription drug abuse education for farmers, ranchers and agricultural workers.

**Additional Research Recommendations**

Below are potential research initiatives that can be of help to individuals living in rural areas and needing mental health support:

1) Testing resiliency models to promote individual, family, and community mental health.
2) Research is needed to develop and/or disseminate interventions that reduce stigma and promote wellness and access to behavioral health care in BIPOC, LGBTQ+, and other marginalized groups in rural and frontier communities.

3) Addressing mental health care equity and diversity among older adult rural populations.

4) Training community health workers to deliver and disseminate evidence-based treatments among older adults.

5) Developing peer coaching mental health interventions to deliver mental health support and reduce stigma in accessing mental health care.

6) Integration and dissemination of geriatric assessments in the delivery of telehealth care to improve mental health, and substance use referrals.

7) Designing caregiving coaching/skill-based interventions to improve mental health outcomes for older adults.

8) Research to better understand some of the rural cultural factors that facilitate or create barriers to engaging in behavioral research aimed at reducing health and healthcare disparities and in improving health care services and health outcomes.

9) With the COVID-19 pandemic impacting schools and teachers (including early childcare educators), who are clear targets for mental health intervention for youth, it is important to provide and understand ways these individuals can be supported to enhance the mental health functioning of youth. Existing and novel universal interventions/prevention approaches are clearly needing study such as Child Adult Relationship Enhancement and Teacher Child Interaction Training. These and related programs are poorly disseminated and have very little to no evidence for their delivery via telehealth or in communities of color or in rural areas.

10) Research that would increase the use of effective, evidence-based interventions for enhancing self-management and health outcomes in chronic health conditions (e.g., pediatric cancer, cystic fibrosis, diabetes), as well as effective screening and referral procedures for mental/behavioral and developmental problems arising from these healthcare conditions and their treatment.

11) Strategies to empower and encourage the research community to conduct innovative research that helps identify service delivery modalities and interventions that are well-suited for rural settings.

12) Specific research to understand factors that increase risk of suicidal completion, including access to lethal means and the effectiveness of lethal means restrictions for rural populations.

13) Additional research on digital therapeutics, including treatment-adjunctive smartphone applications and software programs to deliver evidence-based and validated mental health interventions, to these populations.

Thank you again for the opportunity to share our ideas. APA would welcome an opportunity to work with NIMH to further develop and implement these recommendations. If you have any questions or would like to further discuss any of these recommendations, from APA please contact myself (MPrinstein@apa.org) or Deputy Chief of Scientific Affairs Pat Kobor (pkobor@apa.org).

Sincerely,

Mitch Prinstein, PhD
Chief Science Officer
American Psychological Association
References:


