



Suicide: Losing Lives in Montana

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INTRODUCTION

Suicide is a tragic subject. It is difficult to even discuss and unimaginably hard for those who have lost someone to suicide. It is, however, a topic that we cannot ignore because of its devastating impact on communities and families. Suicide remains a pervasive problem in Montana, despite the progress being made in our understanding of suicide and suicide prevention, especially among our youth.

That young people in our state take their own lives at over twice the national rate is alarming and compels us to investigate and dig deeper into the data related to the issue, to better understand why and how, in order to prevent the tragic loss of life. In addition to an examination of suicide-related data, this issue brief explores evidence-based prevention programs and prevention policies.

Suicide in the U.S. and in Montana

In 2013, more than 41,000 people died from suicide in the U.S. In that same year, 243 Montanans committed suicide, for a rate of 23.9 suicide deaths per 100,000 people – the highest suicide rate in the nation. Other states with high rates include Alaska and Wyoming (23.3 and 22.1, respectively), while the District of Columbia had the nation’s lowest suicide rate, at 5.9 per 100,000. Other states with low rates include New Jersey and Massachusetts (both at 8.5) and New York (8.6). Unfortunately, Montana’s high rate for 2013 is not a one-off occurrence; each year for the past 30 years, Montana has had the tragic distinction of having one of the five highest suicide rates in the U.S.

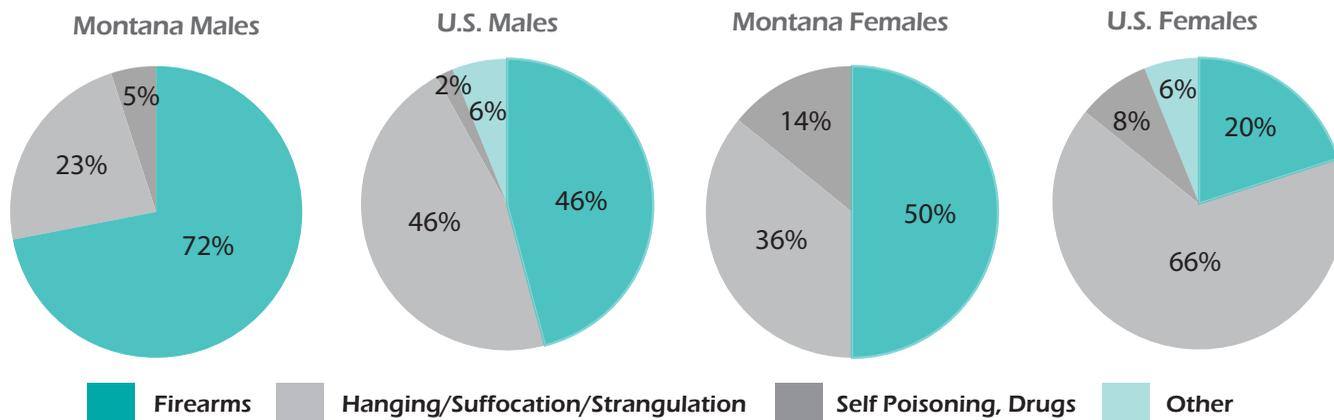
Suicide affects all age groups; however, the remainder of this issue brief will focus primarily on data pertaining to suicide in Montana’s child population ages 10-17. In 2013, the national suicide rate for children ages 10-17 was 10.5, while in Montana it was 23.0 – more than twice as high.

Suicide by Means and by Gender

Firearms are the most frequently used means by which people die by suicide. In the U.S. during the period 2009-2013, 51 percent of all suicides and 39 percent of youth suicides were completed by firearms. In 2013 alone, over 21,000 suicide deaths in the U.S. resulted from self-inflicted gunshot wounds. Hanging/strangulation/suffocation is the next most frequent means of suicide, followed by drug overdoses, jumping from tall structures, and gas inhalation (Figure 1).

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Figure 1
Means by Gender and Area, Ages 10-17, 2009-2013



Suicide means differ based on age, sex, and area of residence, reflecting variation in both degree of access and general mindset. Youth and adults differ in their access to means. In older populations, drug overdoses are far more common than in the 10-17 age group, and in Montana, suicide by firearms is far more common than in the rest of the U.S. In fact, whereas hanging is the most frequent means of suicide for female youth outside Montana, it is a distant second to firearms for female youth in Montana, who choose firearms 2.5 times more often than the national average.

Since there are such differences in age groups and geographical patterns in terms of chosen suicide means, suicide prevention has to be approached differently for different populations, especially when it comes to means restrictions. Limiting access to prescription drugs will have less of an impact on suicide rates in Montana youth than in the adult U.S. population.

There are additional gender-based differences in suicide rates as well, but youth in Montana exhibit less of a difference than in the rest of the U.S. For many years, suicide rates in the U.S. have been almost 3 times higher among male youth than among female youth (72 percent and 28 percent, respectively). In Montana, the male youth suicide rate is not quite twice that of female youth (61 percent and 39 percent, respectively). The overall trend nationally, for all age groups, shows that males choose means of suicide that are more likely to result in immediate death, with firearms or hanging/strangulation/suffocation

being most frequently used (46 percent each of completed suicides). By contrast, only 20 percent of suicides among female youth are completed using firearms, while 46 percent of female suicides were completed by hanging. Hanging/strangulation/suffocation, unlike firearms, does not necessarily result in immediate death, leaving a greater chance of discovery and, thus, survival – hence, the national female suicide rate is much lower.

In Montana, by contrast, and particularly for youth, females tend to choose firearms over hanging as a means of suicide, thus increasing the odds of a completed suicide and increasing the female youth suicide rate.

WHAT TO DO IF YOU BELIEVE SOMEONE IS AT RISK FOR SUICIDE:

- Ask them if they are thinking about killing themselves;
- Call the Suicide Prevention Lifeline at 1-800-273-TALK (8255);
- Take them to an emergency room or seek help from a medical or mental health professional;
 - Remove any objects that could be used in a suicide attempt; and
 - If possible, do not leave them alone.

American Indian Youth

In 2014, the American Psychological Association's Committee on Rural Health issued a report addressing suicide in rural areas and American Indian populations. Today's young American Indians are coping with historical trauma in addition to the deep levels of poverty, substance abuse, and violence in their communities. They are also dealing with feeling disconnected from their respective cultures, which is exacerbated by the loss of native language. In a culture that is in part defined by loss, one consequence is that American Indian suicide rates are much higher than White rates. In Montana, for youth ages 10-17, the suicide rate for American Indians is almost four times that of Whites.

Suicide Perceptions and Related Behaviors

Some national- and state-level public health surveys include questions about suicide and suicide-related behaviors, and data resulting from responses to these questions help us understand prevailing trends in opinions about suicide, as well as the issue of suicide itself. Two such

surveys are the *National Survey on Drug Use and Health* and the *Youth Risk Behavior Survey*.

Youth Risk Behavior Survey (YRBS)

YRBS is a federally mandated survey administered by states. In Montana, the Office of Public Instruction samples students in grades 9 through 12 in schools across the state in odd-numbered years. The 2013 survey included five questions on suicide-related behavior (Table 1). The YRBS data is especially instructive as it allows for side-by-side comparisons between state and national high school populations and behaviors.

A trend analysis of YRBS data from 1991 through 2013 indicates that despite a long-term decrease among the whole student population in three of the five behaviors related to suicide (seriously considering attempting suicide; making a suicide plan; attempting suicide), recent short-term trends suggest an increase in the number of youth who have seriously considered attempting suicide, or have made a suicide plan.

Table 1
Montana High School Students' Responses to
Youth Risk Behavior Surveillance Survey (YRBS), 2013

	U.S. Students	MT Students	Male MT Students	Female MT Students	American Indian MT Students
Q 31. Students who felt so sad or hopeless for two weeks or more that they stopped doing some usual activities	30%	26%	18%	35%	31%
Q 32. Students who seriously considered attempting suicide	17%	17%	13%	21%	23%
Q 33. Students who made a plan about how to attempt suicide	14%	14%	11%	16%	19%
Q 34. Students who attempted suicide	8%	8%	6%	9%	16%
Q 35. Students whose suicide attempt caused them to need treatment by doctor or nurse	3%	3%	3%	3%	5%

Sources: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services and Montana Office of Public Instruction.

ADDITIONAL FACTORS

Suicide and Substance Abuse

Alcohol abuse affects the likelihood of attempting or completing suicide. In a study of all deaths associated with alcohol intoxication (but unrelated to motor vehicle crashes), over 20 percent were suicides. Alcohol abuse that is both recent and severe puts a person at higher risk, and co-occurring alcohol and drug use appear to increase the incidence of attempted or completed suicide even further. Other substances shown to put individuals at higher risk include opiates, cocaine, and sedatives.

The link between alcohol and suicide-related behaviors is of particular concern, as Montana has the highest rate of underage alcohol and drug abuse or misuse in the U.S. YRBS data on alcohol abuse among Montana youth show that 37 percent of high school students have had at least one drink of alcohol on one or more days during the past 30 days. For 12th graders only, the rate is 48 percent. Almost 25 percent of Montana students reported having five or more drinks at one time, compared to the national average of 20 percent. Twenty percent of Montana 12th graders reported illegal prescription drug use, compared to the national average of 18 percent. In addition, substance abuse measures are significantly higher for American Indian students.

Suicide and Family History

Individuals with a family history of completed suicides are at a higher risk of attempting suicide themselves, even in the absence of mental illness.

Suicide and Rural Youth

Suicide rates are higher in rural than in urban areas; thus, youth in Montana are inherently more likely to be at risk. Rural residents face problems related to stigma and lack of anonymity in seeking help, and many rural communities lack mental health services, making primary care doctors de-facto mental health professionals. According to a 2002 study by the *American Journal of Psychiatry*, approximately 50 percent of those who die by suicide contacted their primary care physicians in the month preceding the suicide. In rural areas this number is even higher, prompting the U.S. Surgeon General's Office and the National Action Alliance for Suicide Prevention to include training of primary health care providers as one of their recommendations in the *2012 National Strategy for Suicide Prevention*.



Bullying and Suicide

As a risk factor associated with suicidal behavior, bullying has come under increasing scrutiny for its link to suicide. In 2008, a meta-analysis of 37 scholarly articles determined that both the youth who is being bullied, and the one doing the bullying, are at higher risk of dying by suicide.

The most common reason for bullying is a teen's appearance, which is central to a teen's self-esteem and self-expression. Second-most common is a teen's actual or perceived gender expression. At a time when adolescents are struggling with their sexual orientation, they often face the added burden of being bullied by their peers.

Cyberbullying

Over the past decade there has been a seismic shift in how youth communicate with each other, with an exponential growth in the use of email, texting, instant messaging, and various social media platforms. As a result, the anonymity and ease offered by such virtual means of communication makes cyberbullying easier to perpetrate than face-to-face harassment.

Sexual Orientation

Nationally, youth who self-identify as having same-sex orientation are 2 to 3 times more likely to die by suicide than their “straight” peers. Forty-eight percent of gay and lesbian youth said their suicidal thoughts were related to their sexual orientation, due in large part to gay and lesbian youth being more likely to be bullied. Perceived or real lack of acceptance of their sexual orientation and identity by family and/or friends is also a factor in suicidal thoughts.

Twenty-six percent of Montana high school students reported that they are bullied at school, a rate considerably higher than the national 20 percent. For American Indian students, rates of bullying are similar nationally and in Montana (20 percent and 21 percent, respectively). Eighteen percent of Montana students, and 15 percent of American Indian students in Montana, report being subjected to cyberbullying as well.

Joiner’s Comprehensive Theory on Suicide

Current suicide research builds on the work of Thomas Joiner, Ph.D., who introduced the Interpersonal Psychological Theory of Suicidal Behavior in 2005. The conditions of Joiner’s theory have been identified as predictors of suicide across cultures, demographic groups, and time periods. The theory has withstood a number of empirical studies and stands today as the most recognized, comprehensive theory on suicide. Joiner’s theory states that three conditions must be present for an individual to attempt to kill himself or herself.

Perceived Burdensomeness: “I am a burden”

Individuals who attempt suicide feel that their death is worth more than their life to their family, friends, neighborhood, or community. The perception of being a burden can be associated with conditions such as family discord, academic problems, or functional handicap.

Low Belonging/Social Alienation: “I am alone”

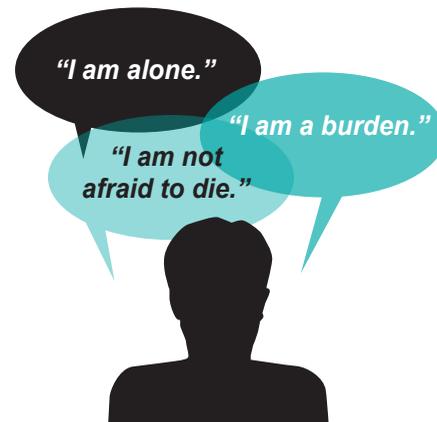
The need to feel connected, to feel some social belonging, is a basic human motivation. When individuals feel a lack of connection with their families or other social groups, they feel like they do not belong, or are not attached to something important. Feeling like an “outsider” is often associated with teenagers, minorities, and socially-stigmatized groups.

Acquired Ability to Enact Lethal Self-Injury:

“I am not afraid to die”

Humans are born with an instinct for self-preservation and survival. Experiences such as suicide attempts in others or being continuously exposed to, or participating in, violent acts can desensitize an individual to injury or death, and suppresses the instinct of self-preservation. By acquiring the ability to inflict injury or self-injury, a person is also acquiring an ability to attempt suicide.

Before someone dies from suicide (or has a near-fatal attempt) they are thinking...



INTERVENTION AND PREVENTION

Suicide is preventable. Most people who are contemplating suicide do not really want to die, but are rather seeking an end to intense mental and/or physical pain. Most have a mental illness, and intervention can save lives.

Intervention by Individuals

While suicide is a public health issue and large-scale prevention efforts need to be systems-based, we as individuals all have the responsibility to intervene if we even suspect that someone we know may be contemplating

Suicide Warning Signs and Risk Factors

What you may hear:	What you may see:	What may be present in an individual's life:
Wanting to die or to commit suicide;	Looking for suicide means such as searching online or obtaining a gun;	Family history of suicide; or history of previous suicide attempts;
Feeling hopeless or having no reason to live;	Increased consumption of alcohol and/or drugs;	History of depression or other mental illness;
Feeling trapped or in unbearable pain;	Anxious, agitated, or reckless behavior;	Stressful life event or loss;
Feelings of being isolated;	Sleeping too little or too much;	Easy access to lethal means;
Being a burden to others; and	Withdrawing; and	Exposure to the suicidal behavior of others;
Seeking revenge.	Displaying extreme mood swings, including rage and aggression.	History of bullying or being bullied;
		Incarceration; and
		Struggling with sexual orientation

suicide. It is our duty as family, as friends, as co-workers and acquaintances, to speak up and voice our concern – saving a life is worth a moment of awkwardness.

Prevention Programs

Programs that build resilience in adolescents have shown to be effective in lowering their risk of suicide. Such programs are generally divided into two categories: 1) Programs targeted specifically at youth themselves; and 2) Programs targeted at gatekeepers – mostly adults who regularly interact with youth, such as educators, parents, or other community members.

Successful Prevention Programs: Youth Focus

- **Coping and Support Training (CAST)** is a high school-based suicide prevention program for youth 14 to 19 years old. CAST delivers life-skills training and social support in small groups of 6-8 students.
- **Linking Education and Awareness of Depression and Suicide (LEADS)** is a curriculum for high school students designed to increase knowledge of depression and suicide; modify perceptions of depression and suicide; increase knowledge of suicide prevention resources; and encourage help-seeking behaviors.
- **Reconnecting Youth** is a classroom-based intervention that establishes peer groups to build life skills. Designed for students ages 14-19, the program teaches skills to build resiliency against risk factors, and to address early

signs of substance abuse and emotional distress.

- **Signs of Suicide (SOS)** is a school-based curriculum and screening program that seeks to prevent suicide attempts; increase knowledge about suicide and depression; develop healthy attitudes toward suicide and depression; and increase help-seeking behavior among youth. Students are screened for depression and suicide risk and referred for professional help as needed.

Successful Prevention Programs: Gatekeeper Focus

- **Question, Persuade, and Refer (QPR)** is a 1- to 2-hour program that educates parents, friends, neighbors, teachers, coaches, caseworkers, police officers, and other gatekeepers to recognize someone at risk of suicide. QPR teaches these gatekeepers to (1) Question the individual's desire or intent regarding suicide; (2) Persuade the person to seek and accept help; and (3) Refer the person to appropriate resources. QPR is being implemented in high schools, middle schools, and alternative schools across Montana.
- **Emergency Department Means Restriction Education** is aimed at the adult caregivers of youth ages 6 to 19 who have been seen in emergency rooms and who have been determined to be at risk of suicide. The program's focus is to reduce access to lethal means and, as a consequence, reduce the incidence of suicide attempts and completions.

- **Applied Suicide Intervention Skills Training (ASIST)** is a standardized workshop designed for members of all gatekeeping groups. The emphasis is on teaching suicide first-aid to help at-risk individuals stay safe and seek further help as needed. ASIST is being implemented in Montana.

Successful Prevention Programs: Focus on American Indian Youth

Many mainstream suicide prevention programs are not suitable for American Indian youth due to the differences in cultural backgrounds and traditions. However, more and more traditional approaches are being used to help young people on and off the Reservations, with a higher degree of acceptance and success among American Indian communities

- **Sources of Strength** is a program aimed at youth, gatekeepers, and community members. This inclusive program works to build protective factors to reduce the likelihood that at-risk high school students will become suicidal. Student peer leaders are trained and connected with adult advisors at school or in the community. Young leaders work with their peers to influence coping mechanisms and negative behaviors. Sources of Strength has been applied in Indian Country with some success and has been implemented in Montana high schools and middle schools.
- **Model Adolescent Suicide Prevention Program** is a public health-oriented suicidal behavior prevention and intervention program originally developed for an American Indian tribe in rural New Mexico. The goals of the program are to reduce the incidence of adolescent suicides and suicide attempts through community education about suicide and related behavioral issues, such as child abuse and neglect, family violence, trauma, and alcohol and substance abuse.

- **American Indian Life Skills Development/Zuni Life Skills Development** is a school-based program delivered by teachers that includes lesson plans covering topics such as building self-esteem; identifying emotions and stress; increasing communication and problem-solving skills; recognizing and eliminating self-destructive behavior; learning about suicide; role-playing around suicide prevention; and setting personal and community goals. This program is currently being implemented by the Northern Cheyenne and the Chippewa Cree tribes in Montana.

Prevention Programs and Rural Youth

Rural communities often have limited access to mental health services, and rural residents may have little experience with suicide or knowledge of youth suicide risk and protective factors. The most important suicide-prevention strategy for people of all ages living in rural communities is improving access to clinical care services. Training gatekeepers, such as teachers, law enforcement, court systems, and faith community leaders in rural areas has also been identified as an effective suicide prevention strategy.

Montana Suicide Prevention Objectives

The Montana Department of Public Health & Human Services (DPHHS), through its Prevention Resource Center and Addictive & Mental Disorders Division, is working to reduce the incidence of suicide in the state. The Department recognizes that Montana faces a long list of challenges.

Strategic Directions for Suicide Prevention

1. Healthy and empowered individuals, families, and communities;
2. Clinical and community preventive services;
3. Treatment and support services; and
4. Surveillance, research, and evaluation.

Source: 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, U.S. Surgeon General's Office and the National Action Alliance for Suicide Prevention.

There is a lack of coordination between state, local, and tribal entities, which in turn exacerbates issues brought about by the sheer size of the state, with its numerous isolated communities and seemingly chronic shortage of mental health providers and treatment facilities. In the 2015 Montana Strategic Suicide Prevention Plan, DPHHS provides Montana-specific objectives for each of the goals within the National Strategic Directions for Suicide Prevention (see www.sprc.org/states/montana).

SUICIDE IN THE MEDIA

Language and words affect how an issue is perceived and understood. In order to change popular views on suicide it is necessary to shift the current conversation on the subject, from focusing on the individual to focusing on suicide as a public health issue. Ongoing community dialogues around smoking, seat belt use, or marijuana use illustrate how exchanging ideas, opening channels of communication, and insuring a flow of information can change societal attitudes.

News Media

It is especially important to consider how the media responds to and reports on suicide, as the media contributes significantly to how the public dialogue about suicide is framed. Such coverage is often sensationalized and problem-focused, and the language used can be very influential. Phrases like “committed suicide,” or “successful” or “failed” suicide attempts are counter-productive; “committed” is a word more associated with sin or crime, while “successful” or “failed” are value-laden, indicating favorable or inadequate results. The recommendation is to describe the death of someone by suicide as “died by suicide,” “completed suicide,” or “killed himself/herself.”

Stories that include lurid details about the methods used in suicides, or continuous and repetitive coverage of a prominent person dying by suicide both convey messaging that can increase the likelihood of someone committing suicide. Likewise, covering suicide as though it is a common occurrence normalizes it; instead, suicide should be treated as a tragic and uncommon event.

Social Media and the Internet

Information about suicide abounds, and online sources are rife with opinions both for and against suicide. One

study found that using 12 suicide-related terms in an online search engine yielded in over 240 websites, of which over half were pro-suicide. Such pro-suicide sites provide detailed information on how to obtain the means to kill oneself, as well as the “support” to do it. The same was observed for online message boards and forums.

However, websites, social media, and the like can and do positively affect individuals who are feeling isolated and hopeless. People who are experiencing suicidal thoughts can share stories, access crisis help lines, and learn about suicide prevention programs, and family members and friends can educate themselves on how to help an individual who is struggling.

POLICY SOLUTIONS

In addition to direct prevention efforts, policy solutions are important tools in the work to reduce suicide.

Existing Policies

The Garrett Lee Smith Memorial Act (GLSMA) is considered landmark legislation directed specifically at suicide prevention. Passed by Congress and signed into law in 2004, the GLSMA provides grants to states, tribes, territories, and institutions of higher education to implement youth and college suicide prevention efforts. More than 300 grants have been awarded since the Act’s inception, including grants to the Northern Cheyenne and Chippewa Cree tribes in Montana for implementation of the American Indian Life Skills Development Program.

Two other federal laws reflect efforts to remove the means of suicide from the hands of youth by restricting the carrying of firearms in and around the nation’s schools. Homicides and suicides by firearms have been reduced since these laws were enacted:

- The Gun-Free School Zones Act of 1990 prohibits anyone from knowingly carrying a firearm in a school zone.
- The Gun-Free Schools Act of 1994 requires school districts to adopt a gun-free position in exchange for federal funds.

The *National Violent Death Reporting System* (NVDRS) currently allows for 32 states to voluntarily participate in a program designed to improve and ensure the timely,

accurate collection of data. Montana currently does not participate in the NVDRS.

Montana's Suicide Prevention Resource Center was created in 2007 in response to Montana Senate Bill 478, which required the Montana Department of Public Health & Human Services to create a suicide prevention program. The bill appropriated an annual budget of \$400,000.

Montana's Child Access Prevention Law prohibits anyone who has charge of a child under the age of 14 from allowing that child to carry or use a firearm in public. The exception is if the child is accompanied by a legal guardian or parent, or by someone who has "charge or custody" of the minor, and is being supervised by a qualified firearms safety instructor. A violation constitutes a misdemeanor.

School-Based Laws

Suicide prevention laws at the school-district level generally focus on one of three facets: 1) suicide prevention training for school personnel; 2) having district-wide policies and procedures in place specific to suicide prevention, intervention, and postvention; or 3) educating students on suicide prevention.

Montana currently has no state law requiring school districts to have a policy or school program on suicide prevention, or suicide prevention programs for students; however, the state encourages schools to provide suicide prevention training to their personnel. At the time of publication, a bill requiring schools to provide such training has passed in the state House and is awaiting a hearing in the Montana Senate.

Additionally, Montana law states that no one may knowingly carry a firearm in a school building, although the trustees of a school district can grant individuals permission to do so. If a student brings a firearm to school, school authorities are required to suspend the student for no less than a year. Again, school trustees have some leeway to change the expulsion on a case by case basis.

Recommendations for Additional Policies

Most suicide prevention advocates recommend the following approaches as additional federal-level policy solutions.

Reducing Substance Abuse

Abuse of legal or illegal substances has been shown to be a causal determinant of suicidal behaviors, thus policies designed to reduce such abuse will also impact suicide rates. Research by numerous health economists shows that policies raising alcohol taxes and restricting availability of alcohol can impact underage youth's alcohol use and abuse.

Mental Health Parity

Because of the close link between suicide and mental illness, policies that increase access to care and health insurance coverage for people with mental illness will help reduce suicide rates. Providing access to affordable mental health treatment is imperative to suicide prevention efforts.

Restricted Access to Lethal Means

The effort to restrict access to lethal means is considered increasingly important in suicide prevention. These efforts focus on the specific means by which people kill themselves; such as jumping from heights, or using firearms and prescription drugs. Without the means to commit suicide directly at hand, at-risk individuals get the time to think and to reconsider their actions.



Erecting Nets and Barriers at Jumping Sites

A very specific way to prevent and reduce suicide by jumping is to erect nets and barriers at bridges and other such sites chosen by individuals as a means to commit suicide. Studies show that suicides decrease after barriers or nets are installed.

Child Access Prevention Laws

Twenty-eight states and the District of Columbia have a Child Access Law. These laws vary in degree of severity, from ones that impose criminal liability if a child accesses a negligently-stored firearm, to ones that prohibit someone from providing a firearm to a minor.

Additional Montana Efforts to Prevent Suicide

Montana has achieved much through the efforts of its Suicide Prevention Resource Center. Additionally, in 2013 the Montana Legislature required the creation of a temporary Montana Suicide Review Team. This team, appointed by the governor in 2014, is charged with analyzing suicides that occurred during 2014, as well as those occurring in past years where records are available. A preliminary report issued in December 2014 covered the first seven months of that year, during which time 155 suicides occurred in the state. Most of the data confirmed the trends and results already noted: males die by suicide more frequently than females; firearms are the number one means people use to kill themselves; and American Indian suicides constitute a disproportionately large share of the total number of suicides in the state.

CONCLUSION

No written report can by itself change suicide numbers or the devastating repercussions of a suicide. However, Montana KIDS COUNT hopes to encourage a more open dialogue on the issue. By highlighting the data associated with suicide we can better understand the issue and find direction in how to address it. By neutralizing the stigma of suicide, we can normalize the conversation, making it more inclusive and productive. We can all contribute to reducing the number of youth suicides in the state by talking about it, by educating ourselves, and by getting involved.

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What can you do?

If you are a member of STATE or TRIBAL GOVERNMENT, you can:

- Sponsor trainings and disseminate information on means restriction to mental health providers, professional associations, and patients and their families.
- Analyze and identify strategies to increase the efficiency of state-based processes for certifying, amending, and reporting vital records related to suicide deaths.
- Improve data linkages across agencies and organizations, including hospitals, police departments, psychiatric and other medical institutions, to better capture information on suicide attempts.

If you are an EMPLOYER, you can:

- Ensure that mental health services are included as a benefit in health plans and encourage employees to use these services as needed.
- Train employees and supervisors to recognize coworkers in distress and respond appropriately.

If you are a HEALTH PROFESSIONAL, you can:

- Screen for mental health needs, including suicidal thoughts and behaviors, and make referrals to treatment and community resources as needed.
- Develop and implement protocols to ensure immediate and continuous follow-up after discharge from an Emergency Department or inpatient unit.
- Educate family members and significant others about appropriate steps they can take to support individuals at suicide risk during treatment and/or after discharge from an Emergency Department or inpatient unit.
- Routinely document suicide-related information (e.g., alcohol use, drug use, description of intent) in emergency department charts.

If you represent a SCHOOL or COLLEGE, you can:

- Integrate information about the responsible depiction of suicide and suicide-related behaviors into the curricula of schools of journalism, film, and other communications disciplines.
- Ensure that students at risk of suicide have access to mental health and counseling services and are encouraged to use those services.
- Train relevant school staff to recognize students at potential risk of suicide and refer to appropriate services.

If you are a COMMUNITY or FAMILY MEMBER, you can:

- Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk.
- Store household firearms locked and unloaded, with ammunition locked separately.
- Dispose of unwanted medications, particularly those that are toxic or abuse-prone.
- Learn when to contact treatment providers or emergency services for loved ones who are at risk for suicide.

Montana KIDS COUNT

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