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Montana Suicide Prevention Consortium

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Abstract

The purpose of this study was to identify risk factors for suicide and to implement strategies to increase awareness and use of suicide prevention resources among youth in an Eastern Montana community. In Spring 2012 and Winter 2013, attitudinal surveys were administered to high school students in Miles City, Montana to evaluate the impact of a community-based media project on youth attitudes towards and awareness of suicide prevention resources. The project involved a youth theatre production, youth photography workshop, art exhibit, and social media website designed to highlight suicide prevention resources and enable young people to discuss emotions related to suicide and depression. Surveys were administered online at baseline (May 2012), with follow-up in January 2013, to approximately 225 (n = 224 at pre-test, n = 217 at post-test) high school youth in Miles City. Questions were designed to assess the impact of the project on awareness, attitudes, and behavioral intentions towards suicide prevention resources. Variables probed on students' self-reported risk for depression and suicide, awareness of online and local suicide prevention resources, and willingness to engage with such resources and/or communicate with peers, family members or mentors about suicide and depression. A comparison between pre-test and post-test showed high levels of campaign awareness, prompted and unprompted recall, and access of online resources. This evaluation involved interdisciplinary research by professors in psychology, communication, and sociology at Montana State University Billings. The quantitative data reported was supplemented with qualitative research to identify cultural and personal reports on campaign effectiveness and areas for improvement. These results were used to design and implement a similar community-based media project in a larger, more urban community, with a more diverse population. The goal is to develop a self-sustainable curriculum that can be used by communities to administer similar community-based media projects for suicide prevention.

Introduction – Background

Suicide has ravaged eastern Montana, an area known for its sparse population, extreme climate range, and “cowboy up” mentality and culture. In 2005, Montana had the highest suicide rate in the U.S. Montana has ranked the top five in the nation over the past 30 years. The rate of suicide in the U.S. is 11.2 per 100,000 people, according to the most recent statistics by the Centers for Disease Control and Prevention taken in 2006 (Xu et al., 2010). In 2006, Montana ranked the second highest – just behind Wyoming – with 20 suicides

per 100,000 people. There were 189 reported suicides statewide that year, according to the U.S. Centers for Diseases Control (CDC) (CDC, 2010).

Factors exacerbating the distressingly high suicide rate include a lack of mental health awareness, an inadequate availability of mental health services, widespread use of firearms, and social isolation. While people living in Eastern states experience high stress – congested cities, high crime, and high cost of living – the suicide rates are much lower than rates in Montana. People in the Eastern U.S. are more likely

to seek help on mental health issues. The bottom five states – with suicide rates far below the national average – include Rhode Island, Connecticut, Massachusetts, New York, and New Jersey. Washington, D.C., actually had the lowest suicide rate at 5.1 per 100,000 people, the CDC reported. The CDC reports that 66 percent of the suicides in Montana in 2006 involved a firearm (Xu et al. 2010). The average nationally is about 50 percent for firearms used in completed suicides. The U.S. “Mountain States” all share similar qualities that make them ripe for high suicide rates: these states are often socially isolated,

have a lack of public services to help with depression and thoughts of suicide, and there is often easy access to firearms. Statistics in Montana show that more than 80 percent of the suicides are done by men (Montana Department of Public Health and Human Services, 2010). It's this tough-guy attitude that makes men in Montana unable to admit they need help, experts say (Emeigh 2010).

In order to attenuate the isolation and deficiency of knowledge in the eastern portion of Montana - the nation's fourth-largest state geographically - an increase in suicide awareness and mental health awareness is needed. In the spring of 2000, the Montana Department of Public Health and Human Services (MDPHHS) invited a group of private organizations, concerned citizens, and government officials to begin the development of a statewide plan for suicide prevention (MDPHHS, 2010). Yet, no previous intervention included community-based media projects, which have a proven track record in tackling other sensitive public health issues around the nation. Jepson et al. (2010) reviewed 103 public health interventions and found small to moderate effects across a range of behaviors in studies published between 1995 and 2008. Interventions that were most effective included physician advice or individual counseling and workplace- and school-based activities. Mass media campaigns and legislative interventions also showed small to moderate effects in changing health behaviors.

Examples of success with similar community-based media approaches also exist in the realm of suicide. A community-based intervention for suicide prevention that focused on improving awareness and care for depression performed by the Nuremberg Alliance Against Depression (NAAD) in Europe was found to be effective in reducing suicidal behavior (MetaConnects, 2012). A CD-Rom designed for suicide prevention administered to local leaders in an Inuit community in Northern Canada effectively increasing suicide knowledge

and counseling skills, and willingness to use the computer-based video for future training (Haggarty et al., 2012; Substance Abuse and Mental Health Services Administration, 2010).

While not all interventions reviewed by Jepson et al. (2010) involved the extensive community-based involvement described in this study, a few studies have shown positive health outcomes in response to similar approaches. An evidence-based, community participatory process was used to develop Healthy Foods North (HFN), a culturally appropriate nutrition and physical activity intervention program that effectively reduced the risk of chronic disease and improve dietary adequacy amongst Inuit/Inuvialuit in Nunavut and the Northwest Territories in Canada (Sharma et al., 2010). A culturally adapted behavioral intervention designed to lower blood pressure delivered to Latino communities in North Carolina achieved favorable physiological, diet, and exercise outcomes. After 6 weeks of group motivational interviewing sessions, systolic blood pressure decreased an average of 10.49/10.6 mmHg, weight decreased 1.59/3.2 lbs, Body Mass Index decreased 0.39/0.5, and physical activity increased 40 minutes per week (Rocha-Goldberg et al., 2010).

The Global Health Equity Foundation, an international public health non-profit organization dedicated to closing the gaps in health disparities, launched the first community-based media effort in Miles City in 2012. This project used a three-pronged approach to increasing awareness and access of Montana's suicide prevention resources: 1) A community-based media intervention to promote awareness and use of suicide prevention; 2) A qualitative study of the barriers to public health models for suicide prevention and to identify modifications to improve community interventions; and 3) A quantitative survey to identify the social support factors related to suicide ideation among youth.

In order to address the complexity of suicide and treatment, it is imperative to assess the complexity through a variety of research and intervention strategies. Preliminary results from a pilot intervention using community-based media projects to increase youth suicide awareness and access of prevention resources showed promising results. Yet the community was racially homogenous (93 percent Caucasian) and did not yield significant data on minority youth. Due to the high rates of suicide among American Indian communities in Montana, we are therefore eager to replicate the pilot on a slightly larger scale, in the more diverse community of Billings, Montana. Community-based media interventions have a proven track record in tackling sensitive public health issues around the U.S. (Jepson et al., 2010).

Pilot Study

In Spring 2012 and Winter 2013, attitudinal surveys were administered to high school students in Miles City, Montana to evaluate the impact of a community-based media project on youth attitudes towards and awareness of suicide prevention resources. The project involved a youth theater production, youth photography workshop, art exhibit, a social media page, and a project website designed to highlight suicide prevention resources and enable young people to discuss emotions related to suicide and depression. Surveys were administered online at baseline (May 2012), with a follow-up in January 2013, to approximately 225 (n = 224 at pre-test; n = 217 at post-test) high school students in Miles City. Questions were designed to assess the impact of the project on awareness, attitudes, and behavioral intentions towards suicide prevention resources. Variables probed on students' self-reported risk for depression and suicide, awareness of online and local suicide prevention resources, and willingness to engage with such resources and/or communicate with peers, family members or mentors about suicide and depression. The intervention

took place June – September 2012. This evaluation involved interdisciplinary research by professors in psychology, communication, and sociology at Montana State University Billings (MSUB). The quantitative data reported was supplemented with qualitative research to identify cultural and personal reports on campaign effectiveness and areas for improvement.

Methods

Questionnaire

An online questionnaire was administered to Miles City High School students ages 14-18 (who have participant assent and parental consent) to assess self-reported history of depression and suicidal thoughts, awareness of suicide prevention resources, awareness of interpersonal resources for suicide prevention, willingness to access resources, and willingness to engage in interpersonal communication about suicide or depression. After the first round of data collection was completed, a 3-month community-based media intervention was administered to self-selected Miles City youth to raise awareness and self-efficacy around suicide and suicide prevention resources. After the intervention, a second round of data collection was conducted, asking similar questions, alongside exposure questions to assess reach of the intervention. The procedure for the second survey was identical to the first.

Measures

Variables for the survey included Likert scales to assess self-reported experience with suicide and depression; self-reported awareness of online and community-based suicide prevention resources; self-reported self-efficacy to access online and/or community-based resources; and self-reported self-efficacy to communicate interpersonally about suicide and depression.

Questions probed on students' self-reported risk for depression and suicide, awareness of online and local suicide prevention resources, and willingness to engage with such resources and/or communicate with peers, family members or mentors about suicide and depression. A measure of stress was given to understand the quantity and quality of life stressors that each individual is experiencing. Second, a measure of depression and suicidal ideation were given to understand each adolescents' individual risk level for psychopathology. Finally, a measure for social support was given to assess each individual's quantity and quality of support persons available. With the combination of these measures, a multiple regression analysis was conducted to determine whether or not social support buffers the effects of stress upon depressive and suicidal ideation symptoms.

Sample

Due to the small size of the community of Miles City, and the opportunity to access all teenagers currently attending high school, the sample will include all current students (est. 400) enrolled in Miles City High School (est. ages 14-18), who have both parental consent and participant assent to take part in the study. The justification for inclusion is to gain better insight into the factors related to the high risk of suicide among young people state-wide, specifically in rural communities in Eastern Montana, in order to identify effective strategies for suicide prevention among youth. "Seniors," students in their final year of high school, were excluded from the pre-test in order to ensure the same students would be around for the follow-up. Hence, 224 students (Freshmen, Sophomores, and Juniors)¹

¹ All terms for U.S. High School students. Freshman are students in grade 9, usually 14-15 years old; Sophomores, students in grade 10, usually 15-16 years old; Juniors, students in grade 11, usually 16-17 years; Seniors, students in grade 12, usually 17-18 years old

were surveyed at pre-test, in spring 2012, and 217 students (Sophomores, Juniors, and Seniors) were surveyed 9 months later, in winter 2013, after the intervention.

Analysis

Descriptive frequencies on all constructs were compared at baseline and post-test to assess changes in attitudes and behavioral attentions before and after the campaign. In addition, bivariate analysis assessed for relationships between campaign exposure and all descriptive variables. Demographic variables collected were controlled to assess campaign affects beyond pre-existing variations within the sample.

In-Depth Qualitative Interviews

Due to the desire to incorporate qualitative findings into the survey and intervention design, in-depth interviews were conducted with key stakeholders to study the issue of youth suicide and depression from a qualitative standpoint. This part of the combined project was designed to explore attitudes among youth in a Montana community toward various treatment/intervention options for depression and/or suicidal ideation. Among adult populations research indicates that social stigma attached to mental illness, the lack of availability of services, and the cultural pervasiveness of the medical model of mental illness shape treatment preferences and behaviors. While the data explore differences across lines of race, class, and gender, little research has been conducted among adolescent populations, despite recognition of the prevalence of depression in teen populations.

This qualitative study consisted of in-depth interviews with 15-20 adolescents focusing on the following primary issues: a) attitudes toward help-seeking behaviors, b) barriers to help-seeking behaviors, c) knowledge about treatment options, d) preferences for particular treatment options, and e) reasons for stated treatment preferences. Interviews

were conducted in the spring/summer 2012, with independent coding and data analysis occurring in fall 2012. The findings from this project have the potential to assist in the development of effective public health campaign messages, to inform local and state organizations about the availability of mental health services in the community, and to add to the body of data in the literature on patient attitudes and their relationship to treatment efficacy.

Results

Survey Results

Demographics In both samples:

- 95% (n = 200) described themselves as White or Caucasian;
- 1.9% American Indian or Alaska Native;
- 1.9% Hispanic, 0.9% African American;
- and 0.5% Asian or Pacific Islander.

The age distribution was fairly even. At baseline

- 39% (n = 7) were 17 or older;
- 34% (n = 75) were 16;
- 21% (n = 46) were 15;
- and 7% (n = 15) were 14.

The age break for post-test was slightly younger:

- 22% (n = 47) age 17;
- 33% (n = 77) age 16;
- 25% (n = 53) age 15;
- 20% (n = 42) age 14;
- and 0.5% (n = 1) age 13.

There were slightly more females (61%) than males (39%) in both surveys.

Suicide Exposure

Responses obtained from both surveys showed consistently high levels of suicide and depression, although exposure to suicide and suicidal thoughts was slightly lower in the post-test survey (possibly explained by the younger age of participants):

- 81% (n = 182) at baseline and 74% (n = 160) at post-test said they knew someone who had committed suicide;
- 12% (n = 27) at pre-test and 10% (n = 22) at post-test said they were currently being treated for depression.
- 22% (n = 49) at pre-test and 19% (n = 41) at post-test said they had sought help for depression in the past;
- 14% (n = 32) at pre-test and 12% (n = 27) at post-test reported having had suicidal thoughts in the past.
- 18% (n = 41) at pre-test and 13% (n = 29) at post-test admitted they had considered killing themselves in the past year.
- Five percent (n = 11) at pre-test and 4% (n = 9) at post-test said they had actually attempted suicide.

Interpersonal Communication

Most, 67% (n = 151) at pre-test and 71% (n = 153) at post-test said they would feel comfortable talking to someone if they felt suicidal or depressed. The most likely person respondents said they would talk to were (in descending order): parent/family members, friends, teacher/school counselors, health care providers, social workers, or church leaders. Most students (86%, n = 192 at pre-test; 79%, n = 187 at post-test) said they would “very likely” or “likely” tell someone else if a friend approached them about wanting to commit suicide. The most likely people a student would tell were

a family member/parent or a teacher/school counselor.

Campaign Exposure

Post-test results showed high levels of campaign awareness, prompted and unprompted recall, and access of online resources: 66% (n = 144) of students at post-test had heard of a suicide prevention media project in Miles City; 36% (n = 76) could correctly identify the campaign name (without prompting) as Let’s Talk or Let’s Talk Miles City (Table 1 - next page).

Table 1 displays the three items that were used to measure campaign awareness.

- A majority, 66%, reported having heard of a suicide prevention campaign.
- 35.2 % of respondents claimed to know the name of the campaign, and
- 55% said that they had specifically heard of the “Let’s Talk” campaign.

Interestingly, there were no negative responses to this question which, with 44.9% of the data missing, indicates that many respondents preferred not to answer the question. Overall it appears that awareness of the campaign was very high:

- 40% (n = 60) of respondents reported that the campaign had increased their awareness of suicide prevention resources.
- 62% (n = 224) said they would go to the Internet for information on suicide or depression.
- 32% (n = 139) said they knew of specific resources to visit about suicide and depression online.

Prevention Resources

Many (49%, n = 105), although not most, students reported using the Internet to access health information over the past

Table 1 [q 1,2,3) - AWARENESS

Item	NO		YES	
	Frequency	Percent	Frequency	Percent
Have you heard of a suicide prevention campaign?	71	32.9	144	66.7
Do you know the campaign name?	138	63.9	76	35.2
Have you heard of the “let’s talk” campaign?	0	0	119	55.1

Notes: Discrepancies are due to missing data.

Table 2 [12.1-12.6] - SELF-EFFICACY (SELF)

If I were suicidal I would feel comfortable talking to	Pre-test			Post-test		
	N	Mean	SD	N	Mean	SD
Parent/family member	215	3.26	1.44	161	3.37	1.39
Friend	222	3.72	1.31	160	3.83	1.20
Teacher/school counselor	215	2.80	1.43	161	3.07	1.70
Church leader	211	2.71	1.51	159	2.93	1.40
Doctor/nurse/healthcare provider	211	2.76	1.41	161	2.93	1.23
Social worker	209	2.22	1.28	158	2.54	1.18

year. Nutrition, followed by substance abuse and depression, were the most likely topics a teenager had searched. Most (48%, n = 102) said they would use the Internet to find information about suicide or depression. Only 18% (n = 39) said they knew of a suicide prevention organization online.

Differences Between Groups

ANOVA comparison of means showed few significant differences between the pre- and post-test groups.

- A slight increase occurred in the likelihood that respondents knew someone who had committed

suicide (pre-test mean = 1.19, SD = .396; post-test mean = 1.25, SD =.446; p ≤ .10).

- Students were more likely to consider a teacher or school counselor a trustworthy source to communicate with about a suicidal thought or friend (pre-test mean = 2.80, SD = 1.43; post-test mean = 3.06, SD = 1.1; p ≤ .05).
- Students were more likely to consider a social worker to be a trustworthy source to communicate with about a suicidal thought or friend (pre-test mean = 2.65, SD = 1.49; post-test mean = 2.96, SD = 1.4; p ≤ .05).

- A significant increase occurred in the percentage who said they would feel comfortable talking to someone else if a friend confided in them about suicidal thoughts or intentions (pre-test mean = 1.56, SD = 1.39; post-test mean = 1.96, SD = 1.02; p ≤ .01).
- A strongly significant increase occurred in the number of students who knew of a suicide prevention resource online (pre-test mean = 1.55, SD = 0.5; post-test mean = 1.81, SD = 0.4; p ≤ .001).

Outcome Variables. Two outcome variables of interest (self-efficacy and response efficacy) were associated with campaign exposure. Table 2 through Table 5 examine mean scores for five point Likert scaled items ranging from 1 to 5, with the higher number indicating greater agreement or affirmation for the item.

Table 2 compares the pre- and post-test means and standard deviations of 6 items used to measure self-efficacy (the confidence in one’s own ability to achieve goals and accomplish tasks). The mean of each item was higher in the post-test than in the pre-test, suggesting that that campaign may have had a positive influence on the self-efficacy of respondents. Those answering the survey indicated that if they were depressed or suicidal they would be most comfortable talking to a friend (=3.83) or a parent or family member (=3.37). Health care professionals (=2.93) and social workers (=2.54) were the least desirable confidants. But even in these cases the mean level of self-efficacy rose after campaign exposure.

Table 3 - SELF-EFFICACY (OTHERS) 14.1-14.5

If someone talked to me about being suicidal I would feel comfortable talking to	Pre-test			Post-test		
	N	Mean	SD	N	Mean	SD
Parent/family member	218	3.72	1.37	182	3.90	1.28
Friend	212	3.56	1.39	174	3.50	1.30
Teacher/school counselor	217	3.63	1.41	185	3.94	1.21
Church leader	207	3.10	1.55	178	2.23	1.46
Doctor/nurse/healthcare provider	207	2.99	1.46	175	3.15	1.37
Social worker	204	2.65	1.49	173	2.95	1.38

Table 3 examines the pre- and post-test means and standard deviations of six additional items also used to measure self-efficacy (the confidence in one's own ability to achieve goals and accomplish tasks). Rather than measuring self-efficacy in response to one's own thoughts about suicide, these items explored (as in Table 2) this response in relation to the knowledge of someone else considering suicide. The means of four of the items were higher in the post-test than in the pre-test. Teacher/school counselor and social worker were higher in the pre-test. Those answering the survey indicated that if someone talked to them about wanting to commit suicide they would be most comfortable speaking with a teacher/school counselor (=3.94) followed by a parent/family member (=3.90). The lowest scores in the post test were Church leader (=2.23) and social worker (=2.29). Once again campaign exposure appears to have increased self-efficacy among respondents.

Table 4 - RESPONSE EFFICACY 15.1-15.5

Item	Pre-test			Post-test		
	N	Mean	SD	N	Mean	SD
The following individuals can help young people deal with depression and/or suicide						
Parent/friend	219	4.00	.99	214	4.15	.86
Teacher/school counselor	222	3.59	.98	216	3.75	.93
Church leader	219	3.58	1.013	213	3.57	1.10
Doctor/nurse/healthcare provider	219	3.69	1.04	212	3.69	1.00
Social worker	218	3.34	.97	212	3.27	1.05

Table 4 examines the pre- and post-test means and standard deviations of five items used to measure response efficacy (extent to which a response effectively addresses a threat) by asking respondents to rate how helpful various people or occupational groups would be in assisting young people with depression and/or suicide. Higher post-test means were found with two items (parent/friend and teacher/school counselor), while two items had lower post-test means (church leader, social worker) and one was the same (doctor/nurse/healthcare provider). In the post-test response efficacy was greatest for parent/friend (=4.15) and teacher/school counselor (=3.75), indicating that respondents believed these categories were the most able to help young people dealing with depression or suicidal thoughts.

Table 5 - RESPONSE EFFICACY 17.1-17.5

Item	Pre-test			Post-test		
	N	Mean	SD	N	Mean	SD
Information About Nutrition	222	3.30	1.93	214	2.97	1.38
Information About Pregnancy	220	2.46	1.22	210	2.19	1.24
Information About Substance Abuse	220	2.43	1.17	209	2.33	1.26
Information About Eating Disorders	218	2.44	1.17	210	2.14	1.18
Information About Depression/Suicide	216	2.39	1.19	211	2.23	1.22

Table 5 examines the pre- and post-test means and standard deviations of five items used as a general measure of self-efficacy as it relates to the willingness and ability of respondents to access the Internet for health-related information. Interestingly, the means of all five items were lower in the post-test than they were in the pre-test. Moreover, the means for both categories were low, indicating that the Internet is used infrequently as a means of accessing information about health-related issues. This is notable considering that the Internet is the primary way that young people gain information.

Interview Results

Qualitative results indicated students had a strong desire to learn more about how to peer counsel their friends and get help independently of adults. More attention will therefore be placed on peer-to-peer communication in the upcoming intervention. No changes were observed in the number who reported using the Internet for suicide or depression.

Preliminary results from this study also suggest that the medicalization of depression and suicidal ideation among teens might actually *prevent* help-seeking behavior. Among high school students ranging from age 14 to 18, interview data reveal reluctance among respondents to label depression as illness. Subjects much preferred to conceptualize depression and thoughts of suicide as within the range of “normal” behavior for adolescents. In addition, they expressed a reluctance to seek help from professionals (either physicians or therapists) because, if friends and family learned of their help-seeking, they worried that they would be seen as different, strange, or abnormal. Subjects reported that they would prefer to confide in friends and if they did seek out an adult, they preferred to couch the interaction as “talking about normal problems.” In contrast to data on adults, the teens emphatically rejected medication as a treatment option, on the grounds that it would make it seem like they were “sick.” These findings suggest that schools, family, peers, and mental health practitioners might have more success in encouraging teens to seek help for thoughts of suicide by de-

medicalizing depression and normalizing mental health interventions. This might alleviate the fear among teens that they will be seen as “outsiders” if they acknowledge feeling depressed.

Conclusions and Implications

The findings of this project have the potential to inform future suicide prevention campaigns including the benefits of social support for adolescents in similar areas. Such interventions could include family, friends, schools, communities, and social networking sites to implement the intervention. In addition, the potential findings from this study may generalize to other parts of Montana, which could be beneficial for many of our communities. Results may be disseminated via academic conferences and journals.

Future research will analyze effects of the intervention on such outcome variables of interest as self-efficacy, response-efficacy, awareness of suicide prevention resources, and self-reported access of health-related Internet web sites. Campaign exposure will be treated as an independent variable, allowing for a comparison of means from pre-test to post-test for each of the outcome variables listed above, controlling for campaign exposure.

Preliminary results show significant increases in students’ self-efficacy (self-reported confidence for specific behaviors). Students exposed to the campaign were more willing to talk to an adult (family member, teacher, social worker, health professional, pastor) about suicide and depression. As noted in the results presented here, students gained confidence in the use of social workers and high school counselors for communicating about these sensitive topics.

The interdisciplinary approach to understanding the relationship between youth suicide and available prevention resources will hopefully enrich our understanding of how, when, and why students access or fail to access the help

available, and which kind of prevention resources would be more useful to them and why. Specifically, pilot qualitative data indicated potential differences in gender preferences and barriers to accessing school counselors and psychologists.

Some basic logistical recommendations may be implemented by school administrations to increase the use of counselors by both genders. Similarly, pilot results showing a preference among adolescents for handling suicidal complaints among themselves may require more formal instruction and resources for youth disseminated by trained youth leaders/educators. The early results on this creative approach to prevention are promising. Clearly, more information is needed about how to reach under-served populations and how to implement this creative approach on a larger scale. It is our hope that an integration of data from the disciplines of sociology, communication, and psychology will not only shed further light on how to engage youth populations around suicide prevention, but will deliver a highly useful approach that can be replicated in other communities.

The results described here are currently being used to implement a new intervention with a more diverse audience in a larger city in south-central Montana, Billings. The Billings intervention will also involve a youth theater production, youth photography workshop, art exhibit, and project website designed to highlight suicide prevention resources and enable young people to discuss emotions related to suicide and depression. It will be administered to high school youth in Billings by students and professionals from Montana State University Billings and the Global Health Equity Foundation, in conjunction with key stakeholders from Billings.

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*Sarah Mosdal
took part in the
photography
workshop sponsored
by GHEF
for local teens
in 2012*

*Teenage actors pose
for a group portrait
before performing
in vignettes
related to the
subject of
suicide prevention
and awareness*



GHEF's Community Based Media Projects - Let's Talk Billings

Let's Talk Billings is a Community Based Media Project in Billings, Montana designed to help people become comfortable communicating with each other about suicide and depression and expressing their own feelings, or listening to the feelings of others. Through media workshops, trainings, and performances, GHEF teaches teens to spread the message that talking about your feelings and seeking help for depression or suicidal thoughts is healthy and important.

Montana has ranked among the top five U.S. states with the highest suicide rates for over three decades. Among Montana's youth aged 14-25 and Native American populations, the suicide rates are even higher than state rate. A sparse population, extreme climate range, and "cowboy up" mentality and culture – which discourages discussing personal issues or feelings – are all drivers of the high rate of suicide in this state. In response to this crisis, GHEF created an awareness campaign called Let's Talk, and ran its first pilot project in Eastern Montana's Miles City.

After a successful campaign in Miles City, GHEF initiated Let's Talk Billings in Billings in Fall 2013 in collaboration with Montana State University Billings and with outside support from the National Institute of General Medical Sciences of the National Institutes of Health. Local organizations, local leaders, individual school administrators, and the press enthusiastically welcomed the project to Billings as a pro-active approach to a hard-felt public health challenge.

Let's Talk Billings engaged three teen groups, including a Native American teen group, to develop and write original stories and performances pieces that would generate community conversation about depression and suicide. They learned how to lead audience participation and share available support service information. They translated their works into stage performances for the public and have performed at least once a month since January 2014 bringing important a positive mental health message to Billings and its surroundings.

Successful Performances and Recognition:

- **August 2013** The Billings Gazette editorial team called *Let's Talk Billings* "an innovative, youth suicide prevention project," "a concrete step that transcends lip service" and a "significant starting point" for addressing youth suicide
- **January 2014** The Billings Gazette features *Let's Talk Billings* several times in the lead up to the first performance, including articles about the Native American teen group, the three teen-original plays, and the performance premier.
- **February 2014** *Let's Talk Billings* is invited to perform among professional performers at the Billings Fringe Festival at NOVA Center for the Performing Arts.
- **April 2014** Yellowstone Valley Woman Magazine writes a full-feature on *Let's Talk Billings* "Shining the Spotlight on Teen Suicide and Depression".
- **April 15, 2014** *Let's Talk Billings* and *Let's Talk Miles City* teens performed together in a "Mash Up" for County Custer High School students; bringing their message to a high-risk population
- **May 13, 2014** The Eastern Service Area Authority (ESAA) invited *Let's Talk Billings* to perform at its annual congress for healthcare and government representatives. ESAA works with the Department of Public Health and Human Services to assist in the management of public mental health care.
- **May 14, 2014** Montana State University Billings celebrates the teens involved in *Let's Talk Billings* and high-profile mental health advocate Dr. Donald Harr shows his support for the project
- **May 14, 2014** Let's Talk Billings holds Lodge Grass Performance, with special guests Dr. Donald Harr, Professor Adrian Heidenreich, and Anna Decrane.

Monitoring and Evaluation

A team at Montana State University Billings, directed by Dr. Sarah Keller, is monitoring and evaluating the impact of this approach on suicide ideation and willingness to seek help by the teens involved in the project and teens exposed to the project through their school or attending the public performances.