Suicide Prevention and Student Mental Health Task Force Report to the Board of Regents

September 15, 2016

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Executive Summary

In the spring of 2015, at the request of the Commissioner of Higher Education and the Montana Board of Regents, the Suicide Prevention and Student Mental Health Task Force was formed to assess student mental health services and suicide prevention efforts throughout the Montana University System and develop best practices and make recommendations for improvement.

A 24 member task force was developed, consisting of a diverse group of experts from throughout the Montana University System and community colleges which included: practitioners, faculty, staff, students and administrators. The diverse membership provided various lenses to view the issues and possible solutions.

The task force developed three objectives:

- Develop and host a statewide summit on suicide prevention
- Conduct assessments of current practices and policies and recommend changes and improvements
- Develop best practices and common training approaches that can be shared and followed by campuses

The task force established five workgroups to accomplish the objectives:

Early Intervention Efforts, Primary Care, Screenings and Assessment Tools
Develop expectations for primary care providers in the Montana University System to identify, intervene and/or refer patients who may be suicidal. The work group will identify and disseminate a toolkit that can used to meet the expectations.

Common Training, Awareness, Education and Collaboration
Develop recommendations on standards for the campuses in the MUS, to look at both short-term and long-term goals for implementation, and enhancing collaboration across the MUS.

Suicide Prevention Summit Planning
Host a statewide summit on suicide prevention during academic year 2015-16. (Planning, logistics, develop various tracks and themes)

Means Restrictions
Review our current policies to ensure safe storage and monitoring of items that could be used for suicide.

Data
Review and analyze national survey data related to suicide prevention and student mental health programs, utilization and funding. Survey and analyze Montana University System and community college data and develop comparisons to peer groups.

Findings
The Task Force administered two surveys to campuses. The first survey was used to develop an inventory of suicide prevention training programs provided to faculty, staff and students and the second survey detailed the mental health services provided by campuses. Analysis of the services provided by campuses and comparable national data is detailed in the report from the Data Work Group entitled "Montana University System: Student Mental Health Resources – 2016." The analysis indicated significant findings including:

- On campus student mental health counseling services are not provided on all of the MUS and community college campuses.
- Campuses provide significant services to students for mental health needs, but there is not one model used by all campuses to provide student mental health services
- Campuses have seen a significant increase (16% over the last five years) in utilization of services.
- Campuses do not have adequate staffing or resources to address the need for services.
- Campuses are not meeting national standards for staffing of 1 counselor per 1000-1500 students, the MUS is at 1 counselor per 1800 students.
- Montana has the highest suicide rate in the nation.

Recommendations

The work group recommendations have been incorporated into the Task Force Recommendations which are listed below. Each work group's recommendations and recommended best practices are detailed in this report for background purposes in establishing the Task Force recommendations.

Recommendation 1: Each MUS campus should have a licensed mental health clinician on staff or have readily available through contract services (counselor, social worker, psychologist, mental health nurse practitioner, mental health physician assistant, or psychiatrist) with new funding provided for campuses that do not currently have licensed clinicians on staff to assist with accurate diagnosis, effective treatment, and appropriate follow-up.

Recommendation 2: The MUS and campuses should establish guidelines to ensure appropriate individuals and groups are receiving evidence-based suicide prevention training.

Recommendation 3: The MUS and campuses should develop a formal process by which staff across campuses can consult with each other about programming and services.

Recommendation 4: MUS campuses that provide medical care on campus should adhere to the recommendations outlined in the United States Preventive Services Task Force (USPSTF) report on depression screening.

Recommendation 5: MUS campuses should complete the depression screening survey to establish baseline practices, obstacles to implementation, needed resources, and later complete a follow up survey to measure outcomes.

Recommendation 6: The MUS should provide necessary resources, including compulsory ongoing training for mental health professionals and the formation of a depression screening consortium to encourage implementation and overcome obstacles.

Recommendation 7: Conduct assessments of campus environments to assess the access to lethal means to attempt suicide; create services/policies to help reduce access to lethal means; review policies and practices related to prescription drugs, access to heights and firearms.

Recommendation 8: Review programs and policies that could enhance student safety and implement a system-wide protocol and tracking system for suicide attempts and completions.

Recommendation 9: Increase partnerships with other mental health and suicide prevention stakeholders, increasing communication between all involved, developing efficiencies and best practices and sharing resources to combat student mental health issues and suicide from a holistic approach.

Recommendation 10: The MUS should explore funding/resource availability and determine funding sources to increase mental health services to students.

Recommendation 11: The MUS should host a biennial summit on student mental health and suicide prevention.

Conclusion

Significant efforts are conducted on campuses throughout the Montana University System to address student mental health needs, including suicide prevention. Campus stakeholders are interested in providing additional services and developing best practices and collaborative approaches but are limited due to resources and need additional funding in order to increase services. The Office of the Commissioner of Higher Education should lead the system-wide efforts and provide guidance, structure and leadership in development and expansion of additional programming and services.

SUICIDE PREVENTION SUMMIT RECAP

- First ever system-wide Suicide Prevention Summit held February 1-2, 2016
- Hosted by MSU-Bozeman
- Cornerstone to our Suicide Prevention and Student Mental Health Initiative
- Over 300 attendees from the MUS, community colleges, tribal colleges, private colleges, community
- Four different tracks available to attendees:
  - Clinicians
  - Students
  - Faculty
  - Administrators/Student Affairs
- National expert keynote speakers
  - Utilization of campus mental health services by students is increasing
  - Campuses from throughout the country are feeling the strain on resources, including Montana
  - Montana has the highest suicide rate in the nation and has been in the top five for 40 years
- Members of MUS staff and Suicide Prevention and Student Mental Health Task Force held breakouts which were specific to the charge of the task force and their work group
- Solicited input from a broader scope of experts and others

300+ participants at the Summit, and 112 participants who participated in the evaluation (38% response rate). A few findings from the evaluation:

- The Summit seemed to be a major success in benefitting those who attended. For example:
  - 83% of survey takers agreed or strongly agreed that the Summit enhanced their skills.
  - 93% of survey takers agreed or strongly agreed that the Summit will benefit their work.
  - 89% of survey takers agreed or strongly agreed that they would recommend this Summit to a colleague.
  - 93% of survey takers shared information from the Summit with others.

- Many comments were made on the helpfulness of resiliency training and QPR training. For those tracks that did not include the training, comments were made to please include for next year.
  - Perhaps because many summit-attendees learned more about the prevalence and depth of issue during the Summit (as seen in survey comments), comments were also made on further engagement of this issue – many want to know more about how to incorporate suicide prevention in their offices and classrooms

- Some of the community members who attended made comments on perhaps needing a track for non-MUS employees, or at least a workshop on how to help MSU (or other community) students. Much of the focus was on university tools and tips.

MUS Suicide Prevention and Student Mental Health Task Force
Depression Screening in Primary Care Workgroup Recommendations to OCHE

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Work Group Charge: Develop expectations for primary care providers in the Montana University System to identify, intervene and/or refer patients who may be depressed and/or suicidal. The work group will identify and disseminate a toolkit that can be used to meet the expectations.

National and State recommendations: The US Preventive Services Task Force[1] (USPSTF) and Montana's suicide prevention strategic plan[2] recommend screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Recommendation 1: MUS schools that provide medical care on campus should adhere to the recommendations outlined in the USPSTF report on depression screening.

Major depression is the psychiatric diagnosis most commonly associated with suicide, with about 25 times the risk found in the general population.[3] Depression, bipolar disorder and PTSD are the primary diagnoses of students who stop attending college because of a mental health related reasons (within the past five years).[4] Almost half of individuals who die by suicide have visited their primary care physician within a month of their death and about two thirds of those who attempt suicide receive medical attention as a result of their attempt.[5] Primary care has enormous potential to prevent suicides and connect people to needed specialty care — especially when they collaborate or formally partner with behavioral healthcare providers.

We recommend that primary care settings prioritize implementing universal screening for depression as soon as possible and no later than 2020. Medical providers should be trained in depression screening, suicide risk assessment, interview skills for suicide inquiry, mental status assessment, safety planning

[1] Albert L. Siu, MD, MSPH; and the US Preventive Services Task Force (2016). Screening for Depression in Adults, US Preventive Services Task Force Recommendation Statement, JAMA; 315(4):380-387. Last accessed on 4/5/16 at: http://jama.jamanetwork.com/article.aspx?articleid=2484345&utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=a_rticlePDF&utm_content=jama.2015.18392

[2] Montana Suicide Prevention Strategic Plan (2015). Last accessed on 4/5/16 at: http://www.sprc.org/sites/sprc.org/files/State%20Suicide%20Plan-2015_0.pdf

[3] American Association of Suicidology (2014). Depression and Suicide Risk; 1. Last accessed on 4/5/16 at: http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2011/DepressionSuicide2014.pdf

[4] Gruttadaro, Darcy; Crudo, Dana; and the National Alliance on Mental Illness (2012). College Students Speak: A Survey Report on Mental Health; 8. Last accessed on 4/5/16 at: https://www.nami.org/collegesurvey

[5] Reed, Jerry PhD, MSW (2016). eSolutions Newsletter - Primary Care: A Crucial Setting for Suicide Prevention. Last accessed on 4/5/16 at: http://www.integration.samhsa.gov/about-us/esolutions-newsletter/suicide-prevention-in-primary-care

that includes lethal means counseling, documentation, caring contact (follow up), and treatment planning.

Some schools do not provide medical care on campus. Those that contract for such services with community providers should establish a memorandum of understanding that the providers adhere to these recommendations.

Recommendation 2: Each campus should have a licensed mental health clinician (counselor, social worker, psychologist, mental health nurse practitioner, mental health physician assistant, or psychiatrist) on staff or readily available to assist with accurate diagnosis, effective treatment, and appropriate follow-up.

Depending on screening methods employed, when university campuses systematically screen for depression and suicidality, from 11.0% to 20% of patients are likely to screen positive.[6] The 2015 American College Health Association Summary reported that 14.6% of all college students experienced depression in the preceding 12 months[7]. In a 2011 survey of students attending four different North American student health services for any reason, the frequency of depression was 25.5%, and suicidal ideation was experienced by 10-13% of students in the preceding 2 weeks.[8] Consequently, it is essential to have adequate follow-up personnel and resources available. Many medical settings use a collaborative care team of multidisciplinary (specialty) providers to provide the best standard of care to patients with specific problems.

To address follow-up with students who display suicide ideation or clinical depression, we recommend having at least one licensed mental health clinician on staff to: 1) directly provide mental health services, or 2) provide assessment and referral to off-campus partners, including coordination of resources and development of an off-campus referral network. Campuses that cannot hire licensed clinicians should employ one or more behavioral health specialists, who can screen, assess and refer to community resources. These campuses should establish a contract for mental health services with a licensed provider in their communities.

Recommendation 3: MUS schools should complete the Task Force's survey to establish baseline practices, obstacles to implementation, needed resources, and later complete a follow up survey to measure outcomes.

Without adequate tracking systems in place, it is impossible to know the extent of student problems with depression and/or suicide ideation. All MUS schools need baseline and ongoing data collection to

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[6] Farabaugh, A., Nyer, M., Holt, D., Baer, L., Petrie, S., DiPierro, M., . . . Mischoulon, D. (2015). Screening for suicide risk in the college population. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 33*(1), 78-94. And Center for Collegiate Mental Health. (2015, January). 2014 Annual Report (Publication No. STA 15-30).

[7] American College Health Association. ACHA-NCHA Assessment II: Reference Group Executive Summary Fall 2015. Hanover, MD: ACHA; 2016. Last accessed on 03/29/16 at: http://www.acha-ncha.org/docs/NCHA-II%20FALL%202015%20REFERENCE%20GROUP%20EXECUTIVE%20SUMMARY.pdf

[8] Mackenzie S, Wiegel JR, Mundt M, Brown D, Saewyc E, Heiligenstein E, Harahan B, Fleming M. Depression and suicide ideation among students accessing campus health care. Am J Orthopsychiatry. 2011 Jan;81(1):101-7. doi:10.1111/j.1939-0025.2010.01077.x. PubMed PMID: 21219281; PubMed Central PMCID:PMC3057910.

help campus medical and mental health providers to address student problems with depression and suicide ideation more efficiently.

Recommendation 4: MUS should provide necessary resources to accomplish these goals, including compulsory ongoing training for mental health professionals and the formation of a depression screening consortium to encourage implementation and overcome obstacles.

It is widely recognized that all mental health professionals should receive training in suicide assessment and intervention during their graduate education. Unfortunately, it is also widely recognized that programs in psychiatry, psychology, counseling, and social work generally do not have adequate suicide training content. Consequently, formal and ongoing training and resources in program evaluation and suicide assessment/intervention should be provided to medical, mental health, and administrative personnel.

The follow training resources are available through the Montana Department of Public Health and Human Services (DPHHS):

- Suicide Prevention Toolkit for Rural Primary Care: http://www.sprc.org/for-providers/primary-care-tool-kit
- "Caring for Patients with Suicide Risk: Building a Foundation for Assessment, Screening, and Treatment": a four hour training seminar for medical providers, which can be modified based on setting and experience of the providers.

A large, multicenter project for universal depression screening in primary care student health centers (The National College Depression Partnership) was developed on 42 colleges and universities from 2006-2014 and screened over 300,000 students.[9] Although the partnership is no longer actively funded, MSU-Bozeman participated in the program and will be able to provide some guidance to other campuses beginning universal depression screening.

[9] National College Depression Partnership 2016; last accessed on 03/29/16 at: http://collegehealthqi.nyu.edu/ncdp/

MUS Suicide Prevention and Student Mental Health Task Force
Common Training Workgroup Recommendations to OCHE

Members: Betsy Asserson - MSU – Chair, Nathan Johnson – MSUN, Jessie Dufner – MCC, Jacque Boyd – Helena College, Brian Kassar – MSU, Tammy Steckler – Helena College, Karl Rosston – DPHHS – Technical Advisor, Carlin Hale – FVCC, Elfriede Neber – Great Falls College – MSU; Brenda York - MSU

The Jed Foundation, Suicide Prevention Resource Center, and Campus Program recommend the implementation of gatekeeper training programs on college campuses. Gatekeeper programs train students, faculty, and staff to identify students at risk and refer them to appropriate resources for help. Gatekeeper training is one component of a larger comprehensive approach to suicide prevention and mental health.

Common Training Workgroup Charge:
Develop recommendations on standards for the campuses in the MUS, to look at both short-term and long-term goals for implementation, and enhancing collaboration across the MUS.

The Common Training Workgroup has worked collaboratively to develop the following recommendations to OCHE.

Recommendation 1: Each campus should have a licensed clinician (counselor, social worker, or psychologist) on staffwith new funding provided for campuses that do not currently have licensed clinicians on staff.

The International Association of Counseling Services (IACS) maintains standards for University and College Counseling Services. Their recommended ratio for on-campus, licensed staff to students is 1:1000 or 1:1500. Given the high need for mental health services and suicide prevention programming on MUS campuses, we recommend having a licensed clinician on staff to either: 1). Provide mental health services, or 2). Provide assessment and referral to off-campus partners, including coordination of resources and development of an off-campus referral network. Additionally, the licensed clinician or other appropriately trained professional (i.e. Public Health) could lead outreach and prevention efforts related to suicide prevention, wellness education, and substance use prevention/education.

Recommendation 2: MUS campuses have established guidelines to ensure that appropriate individuals and groupsare receiving evidence-based suicide prevention training.

We recognize that each MUS campus has a unique culture and varying student needs. Therefore, we suggest that each campus provide evidence-based suicide prevention training, examples of which can be found at http://www.sprc.org/bpr/section-i-evidence-based-programs. The following groups on campuses are recommended to be targeted for suicide prevention training. The list is not exhaustive, but is intended to guide campuses on where to focus their gatekeeper training efforts.

1. Students
   Students often seek each other out for support and assistance during a crisis. Training a wide variety of students in gatekeeper training helps to ensure that students are adequately trained to refer a fellow student to appropriate services.

   Student groups to target include:
   - Student Government Leaders
   - Residence Life Student Staff (RAs and front desk workers)
   - Greek life leadership
   - Student Athletes
   - Special Populations (LGBT, veterans, American Indian, International students)
   - Transfer Students

2. Faculty & Staff
   Faculty and staff interact with students and others in the community on a regular basis. They are often the ones to notice a change in behavior, emotional distress, or mental health issues. Empowering faculty and staff to have the skills and training to refer students and others at risk to the appropriate resources is critical for enhancing help-seeking on campuses and creating a culture of care.

   Faculty and staff groups and events to target include:
   - New Faculty Orientation
   - Department Meetings
   - Deans
   - University Administration
   - Athletics Departments
   - Student Affairs Staff (including registrar, financial aid, and others with frequent student contact)
   - Auxiliary and Facilities Staff who may supervise students (ie. custodial staff or food service staff)

3. Parents and Families
   Parents and families are also key partners in an effective comprehensive approach to suicide prevention. It is recommended that resources are provided to parents and families related to mental health services and how to identify if their student may be struggling with a mental health issue.

Recommendation 3: Develop a formal process by which staff across campuses in the MUS can consult with each other about programming and services.

Many MUS campuses are already doing excellent work on suicide prevention. We recommend further discussion to determine possible ways to enhance cross-communication and sharing of information/resources. Possible ideas include: a suicide prevention listserv for MUS campus employees, a webpage on the OCHE website to share resources, formalized conference calls each academic year to bring together interdisciplinary employees working on suicide prevention, and/or a biennial summit on mental health.

References:

1. International Association of Counseling Services, Inc.: Standards for University and College Counseling Services. Retrieved from http://0201.nccdn.net/1_2/000/000/0ce/fa4/IACS-STANDARDS-updated-9-24-2015.pdf.
2. Jed Foundation: Comprehensive Approach. Retrieved from https://www.jedfoundation.org/professionals/comprehensive-approach.
3. Jed Foundation & Clinton Health Matters Campus Program. (2015). Retrieved from http://www.thecampusprogram.org/framework-for-success.
4. Suicide Prevention Resource Center: Suicide Prevention Basics. Retrieved from http://www.sprc.org/basics/about-suicide-prevention.

MUS Suicide Prevention and Student Mental Health Task Force
Reduced Access to Lethal Means Workgroup Recommendations to OCHE

Rationale:

Lethal Means Reduction involves removing or reducing access to potential means for suicide. The Jed Foundation *(1)* and Suicide Prevention Resource Center *(2)* recommend that Lethal Means Reduction be included as one component of a comprehensive plan for suicide prevention at colleges and universities, and is part of the National Strategy for Suicide Prevention *(9).* Common lethal means for college student suicides include firearms, jumping from high places, poisoning, suffocation, drowning, and hanging *(3).* Lethal means counseling, reduced access, and environmental changes can reduce suicide risk *(10).*

Impulsivity & Suicide:

Research indicates that as many as two-thirds of those who reported suicide attempts didn't plan their attempt ahead of time *(4, 5).* Also, the time between decision and action was short: a quarter of those made an attempt 5 minutes after making the decision; half of those within 20 minutes, and three-quarters within an hour *(3).* When means aren't available in this brief window, a suicide attempt or fatality can be drastically reduced.

Firearms

Firearms are highly lethal because the effects are immediate and irreversible with little opportunity to back out or be saved once the trigger is pulled *(2).* Gun safety and Lethal Means Reduction can be helpful in preventing suicide: States with gun safety regulations (waiting period, open carry regulations, background checks, and locking) had lower suicide rates compared to states that didn't, and states who repealed their safety regulations saw an increase in suicide *(11)*. In Montana between 2010 and 2014, 88% of firearm deaths were suicides *(6).* It is recommended that access to firearms be restricted during times of a mental health or suicidal crisis until the crisis has passed *(2, 10).*

Lethal Means Reduction Reduces Suicide

A common misconception is that people who are suicidal will find a way to kill themselves even without a gun or their chosen means. However, studies show that if a person's preferred suicide method is unavailable, it is unlikely they will switch to a different one *(7),* and that even if an alternate method is used, it is likely to be less lethal *(8).* Lethal Means Reduction is effective in the following ways *(2, 3, 10):*

-Reducing immediate access to means in times of crisis or impulsive decision making
-Delaying time between thought and action
-Reducing fatality when less lethal means are chosen
-Increasing likelihood of intervention by others

Clinical Recommendations:

These recommendations are intended to provide resources to MUS campuses to initiate conversations regarding Reducing Access to Lethal Means. They are not intended as blanket mandates for campuses, recognizing that the culture, environment, needs, and resources vary widely across campuses in the MUS System. Additionally, there is

not the expectation that each recommendation be adopted as written here on every campus, given varying needs and resources. Many contributing factors and limitations may prevent the enactment of these recommendations, such as staff resources, funding, and existing campus policies/procedures. While it is not possible to prevent every suicide, means restriction is one part of a comprehensive approach to suicide prevention, and efforts made in this area are not the only strategies that are effective. Additional strategies include providing crisis intervention, referral and access to mental health services, gatekeeper training, wellness/prevention education, postvention interventions, etc. The following is a summary of various options for Means Reduction retrieved from The Harvard School of Public Health: https://www.hsph.harvard.edu/means-matter/recommendations/colleges.

1. Consider conducting a campus assessment regarding suicide attempts/completions, potential access to lethal means, and explore opportunities to create services/polices to help restrict access to means.

-Form a work group or task force of counselors, health clinicians, campus police/security, faculty, administration, students, and campus/community partners.

-The Harvard Means Matter website (meansmatter.org) or Jed Campus Program can be helpful resources.

Potential options for reducing access/enhancing safety may include:

-Limiting access to heights (rooftops, windows, balconies, ledges, bridges).

-Restricting access to heights with locks or alarm doors.

-Providing crisis numbers or emergency phones near rooftop exits or other high places.

-Considering the installation of break-away closet rods or limiting other implements for hanging.

- Tracking, monitoring, and controlling access to toxic substances found in laboratories, pharmacies, and other departments that are accessible to students, staff, and faculty.

2. For campuses that have a Student Health Center and/or Pharmacy (or community partners), review policies and practices regarding prescription drugs to examine options for:

-Limiting the quantity/dosage of medications with potential for harm/abuse.

-Publicizing local take-back services for unused medications with potential for harm/abuse.

-How to limit access to potentially lethal medication for an individual during times of crisis/suicidal thinking.

3. Examine potential access to firearms and review potential polices/procedures. Areas to consider include:

-Campus policies regarding gun possession and storage on campus

-Consideration of a centralized storage facility staffed by trained professional staff or university security/police

-Training in recognition of distress/signs of suicide for those storing/releasing firearms

-How to limit access to firearms for an individual during times of crisis/suicidal thinking

4. Review/explore potential programs or policies that could enhance student safety:

-Widely publicize crisis resources

-Examine guidelines for medical amnesty

-Utilize a campus care team or Behavioral Intervention Team

-Provide opportunities for education/reduction of high-risk drug and alcohol use among students
-Ensure health/counseling clinicians are trained in the assessment of risk and access to means: CALM is a free, online training module provided by the SPRC at: http://training.sprc.org/

Footnotes

1. Jed Foundation & Clinton Health Matters Campus Program. (2015). Retrieved from http://www.thecampusprogram.org/framework-for-success.

2. Suicide Prevention Resource Center: Counseling on Access to Lethal Means. Retrieved from http://training.sprc.org/.

3. Harvard T.H. Chan School of Public Health. (2015). Means Matter. Retrieved from http://www.hsph.harvard.edu/means-matter.

4. Kessler, R. C., Berglund, P., Borges, G., Nock, M., & Wang, P. S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990- 1992 to 2001-2003. *JAMA*, 293(20), 2487–2495.

5. Drum, D. J., Brownson, C., Denmark, A. B., & Smith, S. E. (2009). New data on the nature of suicidal crises in college students: Shifting the paradigm. *Professional Psychology: Research and Practice*, 40(3), 213–222.

6. The Montana Department of Public Health & Human Services, Montana Suicide Mortality Review Team, June, 2016.

7. Daigle, M. S. (2005). Suicide prevention through means restriction: Assessing the risk of substitution. A critical review and synthesis. *Accident Analysis and Prevention*, 37(4), 625–632.

8. Vyrostek, S., Annest, J., & Ryan, G. W. (2004). Surveillance for fatal and nonfatal injuries—United States, 2001. *Morbidity and Mortality Weekly Report*, 53(SS07), 1–57.

9. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012. www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf.

10. Barber, C.W.; Miller, M.J. (2014). Reducing a Suicidal Person's Access to Lethal Means of Suicide: A Research Agenda. *American Journal of Preventive Medicine*, 47(3S2), S264–S272.

11. Anestis, M.D.; Anestis, J.C. (2015). Suicide Rates and State Laws Regulating Access and Exposure to Handguns. *American Journal of Public Health*, 105(10): 2049-2058.

Provided by The Means Restriction workgroup for OCHE. Members include: ***Brian Kassar, Psy.D.,*** *MSU Bozeman;* ***Karl Rosston, LCSW,*** *Montana DPHHS;* ***Jerry Girard,*** *LCPC, UM-Western;* ***Matt Caires, Ed.D.,*** *MSU Bozeman;* ***Elizabeth Stearns-Sims, MS.Ed,*** *UM-Helena College;* ***Jamie Smith Eastwood,*** *UM-Helena College.*

Suicide Prevention and Student Mental Health Task Force Members

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