THE MEDIA AND MENTAL HEALTH:

MEDIA FAMILIARITY WITH NATIONWIDE

STANDARDS FOR REDUCING MENTAL ILLNESS AND SUICIDE

by

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B.S., Kansas State University, 1975

A THESIS

submitted in partial fulfillment of the requirements for the degree

MASTER OF SCIENCE

A, Q. Miller School of Journalism and Mass Communications
College of Arts and Sciences

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2013

Approved by:

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Abstract

Mental illness and suicide present vexing challenges for journalists who seek to elevate public understanding of public health issues and remedies. Using the theoretical frameworks of media agenda setting and issue framing, content analysis was used to examine a nationwide sample of newspapers stories for evidence of media familiarity with prevailing norms for community mental health care and suicide prevention. Stories examined showed little evidence of such expertise, leaving questions about the ability of journalists — and their readers — to differentiate between standard and substandard mental health care systems. Long-term change in public policy about mental illness and suicide prevention will likely depend on the ability of special interests to capture and keep media attention as well as media management decisions to assign mental health coverage to general assignment reporters or place it in the hands of journalists with specialized training.

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Dedication

Knowing is not enough; we must apply.
Willing is not enough; we must do.
— Goethe

It is said that science protects us against the mistakes of daily inquiry, which is to say that it protects us from ourselves. Independent, objective inquiry demands that our questions begin with what exists, not what we wish existed. Smart science, like smart journalism, cannot determine what should be without first understanding what is and how it came to pass.

For their leadership and instruction, I am grateful to the members of my faculty advisory committee at Kansas State University: William Adams, Ph.D., Joye Gordon, Ph.D.; Louise Benjamin, Ph.D., as well as Gloria Freeland, journalism assistant professor and ex-officio committee member. The support of my students and fellow graduate students was more than I expected; the support of my family was more than I deserved.

Lastly, this project would not have been possible, or necessary, without those whose research on mental illness and suicide has preceded mine, whose questions have inspired mine. Research does not always produce solutions; many questions yield no answers, only more questions. Together, however, questions and research have the power to replace fear and ignorance with understanding and knowledge.

— dvc

Chapter 1: Introduction and Background

Mental illness and suicide are inextricable components of a global health threat. They dwarf the frequency and severity of diseases that generate far more risk perception by the public and the news media. Mental illnesses account for nearly 1 million deaths and an estimated 10 million attempted suicides each year (Centers for Disease Control [CDC], 2012).

In the United States, an estimated 54 million people — 1 in 5 — suffer a treatable mental illness (U.S. Department of Health and Human Services, 2012). Each year, local coroners checkmark the box labeled "suicide" on more than 35,000 death certificates. If there existed a similar system to track attempted suicides, HHS surveys suggest the tally would easily top 500,000 annually (President's Commission, 2003). The Centers for Disease Control estimates that mental illnesses affect nearly one in five children and cost $247 billion yearly in medical bills, special education and juvenile justice (Centers for Disease Control and Prevention [CDC], 2013). Nationwide, according to the CDC, suicide is the second leading cause of death (after accidents) among children ages 12 to 17.

During the past 20 years, the tangle of variables that lead to mental illness and suicide has been repeatedly unraveled to shape and refine a set of standardized policy measures that must be in place before communities and their school systems can achieve long-lasting reductions in the number of youth suicides as well as the number of those suffering various types of mental illness that often lead to suicide. A great deal is known about such standards and how they came to pass. The same cannot be said regarding news media standards for covering this difficult issue. The purpose of this study is not to analyze the health care standards or the scholarly work that led to their establishment. Rather, the purpose of this study is to more fully understand the news

media's ability to evaluate existing mental health care through the lens of what is supposed to exist.

Mental illness drew scant attention from the American public and news media until events in the 1980s made it a story impossible to ignore. A sharp increase in youth suicide rates created headlines about a phenomenon that heretofore had been closely tracked only in obscure quarters of public health epidemiology and the emerging disciplines of behavioral science and adolescent psychiatry (Grob, 2011). By the late eighties, diagnostic and mortality findings had seeped from the medical community into the general population. Nationwide curiosity morphed into nationwide alarm after a series of suicide "clusters" that left grieving loved ones holding suicide notes that spoke of deep-seated resentments and cultural alienation. The most famous of these was the March 1987 cluster of teen suicide sin Bergenfield, N.J. The incidence of such tragedies — or at least the public nature of such tragedies — launched renewed zeal for new knowledge that might explain, if not predict or prevent, localized suicide clusters. What journalists and lay bystanders once stereotyped as "copycat suicides" eventually matured into scholarly acceptance of "suicide contagion theory" (Gould, 1990; Shaffer, 1994). Contagion theory ignited a stampede of research that continues today, most of it focused on the relationship — assuming one exists — between suicide and the mass media. By the late 1990s, contagion theory had worked its way, and its warnings, deep into the heart of scholarly thought about how journalists write about suicide, and how they ought to write about it. Warnings about the risk of too much coverage also became standard language in the official "crisis response" and "crisis communications" protocols adopted by American school systems (Brock & Lazarus, 2012, Chapter 11).

The media and mental illness

Applying traditional news standards to a once-taboo topic proved vexing to American news media. Most print and broadcast media have longstanding policies, only occasionally put in writing, stipulating that suicides are covered only when they involve public officials/celebrities or when they occur in public places (Tatum, Canetto, & Slater, 2010). Such editorial judgment reflects traditional social concerns about media intrusion into the private lives of the privately mourning. Digging into the deceased's history or searching for explanations can unwittingly inflict public embarrassment upon the grieving and exacerbate their suffering (Jamison, 1999). While media thinking about the bounds of privacy would eventually be rethought in the wake of school massacres and public shootings yet to come, the media coverage continued to reflect the general public sentiment that mental illness and suicide involve the private problems of private families (Ruggiero, 2007).

The mass media's first investigation into public attitudes about mental illness was not the work of a newspaper or television station but, rather, a freelance journalist. Ten years after the Bergenfield suicide cluster, Donna Gaines visited the New Jersey community to reassemble the lives and events that ended with a tragedy that had generated short-term shock but little long-term analysis. Gaines' best-seller, *Teenage Wasteland: Suburbia's Dead End Kids* presented the Bergenfield suicides not as a local story or isolated tragedy but as one page in a story of teenaged depression and despair being played out across America's middle-class (Gaines, 1998, Chapter 7). Suburban adolescents, seething with resentment and defiance, were isolating themselves from those who might have been in a position to intervene. Eventually, isolation led to depression, and depression to hopelessness. Whatever the specific symptoms, Gaines concluded, the Bergenfield teens died from a malady that had gone undiagnosed but not unnoticed. Those who saw warning

signs told Gaines they didn't know what the signs meant or where to find help. They recalled an abiding fear in the community that the quality of life was being threatened by the growing number of "alternative" youth whose music, clothing and lifestyle had taken on a "defiant" and "alternative" posture (Gaines, 1998, p. 195-196).

Wasteland was heralded as a warning shot for communities, especially the middle-class and its school systems. The message: Learn the warning signs of mental illness and find out where to get help. *Wasteland's* message would later prove prescient but the book's first release in 1991 did little to catapult youth depression or mental illness in general onto the public and media priority lists. Most communities had already established an agenda that targeted juvenile violence, drinking and drug abuse. In his highly acclaimed, *The Road to Whatever,* author-sociologist-criminologist Elliott Currie dubbed the 1990s the "juvenile crackdown decade," notable for its tough-love discipline and "zero tolerance" policies in schools and courtrooms (Currie, 2005). Congress opened the government's wallet for schools and communities willing to launch substance abuse campaigns. The national assumption, Currie wrote, was that drugs and drinking caused teenage depression and suicidal thoughts. Few had considered reversing the equation. Was it possible that depression and suicidal thoughts drove people to medicate themselves with alcohol and drugs?

Lacking knowledge of mental illness and its origins, communities also lacked a rationale for interventions other than those aimed at substance abuse. As the nineties came to a close, mental health researchers were about to receive the first promising reports of successfully tested programs and strategies for early detection of mental illness and suicidal ideation (Shaffer & Craft, 1999; Gould, Greenberg, Velting, & Shaffer, 2003). The newly developed interventions, however, presumed that communities would welcome recommendations from outside experts

rather than try to re-invent the wheels of mental health research. This presumption had not considered the magnitude to which political and cultural pressure affected the decisions of locally elected school boards. What scholars and scientists considered a grave public health issue, some considered a breach of cherished values regarding family privacy and the inviolate nature of parenthood. School board meetings across the nation were standing-room-only when the agenda included proposals for early detection of depression and other mental illnesses (UCLA Center for Mental Health in Schools, 2005). To this day, according to the National Association of School Psychologists, many school systems readily take part in "awareness" campaigns that advise troubled students where to turn for help but resist proposals to require formal suicide prevention training for teachers and counselors (Poland, 2010).

Mass communications research has repeatedly concluded that information and awareness do not always produce response and action (Lippmann, 1922). As the 1990s neared an end, the nation's highest-ranking health official announced that it was time to take action.

Mental illness officially declared a major public health issue

In March 1999 the U.S. Surgeon General issued the nation's first official pronouncement that mental illness was a major public health problem and suicide its "avoidable outcome" (Satcher, 1999). Mental health research, the Surgeon General said, had undergone "a scientific revolution" that had already begun generating "safe and effective" diagnostic tools to intercept and treat the disease. The major obstacle to scientific progress, the Surgeon General said, were persistent cultural myths that stigmatized suicide as the inevitable fate of star-crossed misfits under the malignant pull of an evil presence too dangerous to confront. The Surgeon General's message would be repeated over the next decade in three additional consensus reports, each one

presenting the increasingly detailed ingredients of community mental health care as identified by an increasingly wider circle of scholars and clinicians. (National Strategy, 2001; President's Commission, 2003; National Strategy, 2012). Each national report expanded the inventory of evidence-based models for early detection of mental illnesses and reducing suicide among high-risk populations. Each report expanded the knowledge base of remedies for early interception of mental illness and suicidal thought. In 2003, *The President's New Freedom Commission on Mental Health* stitched the accumulated body of knowledge and remedies into a step-by-step map for community intervention.

The 2003 report also offered the authors' accumulated frustration. It described the nation's mental health care system as, "a system that manages symptoms and accepts long-term disability … a patchwork relic — the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families and our communities." The time had passed, the report stated, for "yet another piecemeal approach to mental health reform and suicide prevention. " The authors concluded that only a "fundamental transformation" would ensure that the mentally ill and suicidal "receive the same quality of care available to other Americans" (Office of the President, 2003, Executive Summary).

Chapter 2: Literature Review

This project is not an attempt to evaluate the quality of mental health care in the United States or the progress achieved in reducing the incidence of suicide. Rather, this investigation looks solely at published coverage of mental health issues in search of evidence that journalists possess sufficient training to sort out the difference between communities that have adopted national standards for mental health care and communities that have not. Any analysis of media proficiency on an issue commands that one first establish the relevant base of knowledge that may signal media proficiency. Accordingly, the Literature Review's first priority was to identify and assemble primary source documents that offer the most complete body of knowledge about prevailing standards for community mental health care and suicide prevention initiatives. Secondly, this review combed relevant libraries and databases for other examples of research into media coverage of mental illness and/or suicide. Thirdly, this review identifies the mass communications theories most pertinent to this investigation. Lastly, this review presents a set of necessary research questions that emerge from the review of scientific literature.

Identification of national norms and consensus reports

The nation's prevailing standards for community mental health care and suicide prevention are found in a series of four nationwide research expeditions that began in late 1999 and most recently culminated in the autumn of 2012. All four contained detailed roadmaps for community mental health response, step-by-step instructions that were published with the intent of providing communities a "template" and discouraging communities from turning to homemade or locally designed methodologies.

Following are the four landmark studies that contain the prevailing standards and policies for community mental health care and suicide prevention:

The 1999 U.S. Surgeon General's "Call To Action" reports

The 1999 Surgeon General's report reflected an emerging scholarly concern that American communities had been given responsibility for local mental health care without concomitant standards and protocols for the design and delivery of such care. The Surgeon General David Satcher's 1999 "Call to Action" report was actually a matched pair of twin statements about the threat of mental illness and suicide. The documents represented the federal government's first official declaration that mental illness and suicide were to be treated as a public health issues with no less national urgency than that applied to other health issues. Surgeon General David Satcher called his report a "blueprint" and "framework" based on "evidence-based and highly prioritized recommendations by leading experts." The terms "blueprint" and "framework" and "strategy" would find their way into the three national consensus reports that followed the Surgeon General's. Satcher said that mental illness and suicide required the same intervention models and methodologies used to combat other health issues: define the problem, identify causes and protective factors, develop and test intervention techniques, and, implement the consensus strategies. Satcher challenged the nation to "chart a course" for "constructive public health policy, measurable overall objectives, and ways to monitor and evaluate progress toward these objectives." His repeated use of the language of institutionalized public health practices caught the attention of many, including the National Alliance on Mental Illness, the nation's largest advocacy organization for the mentally ill. NAMI hailed the Surgeon General report as the first step in "codifying the consensus best practices of what is currently scientifically known" regarding suicide prevention and mental illness. U.S. Secretary of Health and Human Services Donna E. Shalala referred to the Surgeon General recommendations as

"seminal reports" that "provide us an opportunity to dispel the myths and stigma surrounding mental illness" and advance the argument that "mental health is fundamental health."

Lastly, the Surgeon General called upon communities to address a barrier that continues to frustrate health experts to this day — the lack of current local data regarding the victims of mental illness and suicide. Such data, Satcher said, is essential in order to define the health problem from community to community. Community success, he added, "requires data collection as a means to continue evaluating the effectiveness of an intervention."

2001 National Strategy on Suicide Prevention

The 2001 report confirmed and expanded upon the 1999 Surgeon General's conclusions. While the Surgeon General reports addressed mental illness in general as well as suicide, the 2012 report focused specifically on suicide — defining the problem and presenting prescriptive remedies for saving lives. It opened with a clarion call for "the public health approach to suicide prevention." Recommendations ranged from the sweeping (inpatient and outpatient psychiatric care at all community hospitals) to the highly narrow (restricting public access to guns, the most common means of suicide. The report also endorsed the theory, advanced in a mounting volume of new research, that suicide prevention required the official cooperation of the nation's news media. The reported stated that, "Once individuals in the media have a clear understanding of the implications of the ways in which suicide and other issues are depicted, many can see the value in modifying their approaches (National Strategy, 2001, p. 107).The report also echoed the Surgeon General's finding that the campaign against suicide was plagued by a lack of "surveillance" systems that would quantify suicide incidence data at the local level:

Surveillance systems are key to health planning. They are used to track trends in rates, to

identify new problems, to provide evidence to support activities and initiatives, to identify

risk and protective factors, to target high-risk populations for interventions, and to assess the

impact of prevention efforts.(National Strategy, 2001, p. 30)

To address the surveillance problem and the need for more detailed incident data at the

community level, the report called for:

•Increasing the number of hospitals (including emergency departments) that collect uniform

and reliable data on suicidal behavior by coding external cause of injuries, utilizing the

categories included in the International Classification of Diseases.

•Implementation of a national violent death reporting system that includes suicides and

collects information not currently available from death certificates.

•Increasing the number of states that produce annual reports on suicide and suicide attempts,

integrating data from multiple State data management systems.

•Increasing the number of nationally representative surveys that include questions on suicidal

behavior (National Strategy, 2001, pp. 30-31).

The 2001 document also reaffirmed the Surgeon General's recommendation to replace

outdated or untested prevention methodologies with newer, evidence-based practices. As an

example of unacceptable techniques, the 2001 report cited California's experience with school-

based suicide prevention. The 1987 California legislature passed a law mandating that all school

districts install formalized suicide intervention and prevention training for staff as well as

students. The law stipulated that the style and content of such training was to be established by

the state Department of Education (California State Department of Education School Climate

Unit, 1986). The DOE developed a five-day set of one-hour suicide prevention classes, with all teaching and lesson plans provided by the DOE. Two years after the law took effect, the state DOE dispatched auditors to determine school compliance. The findings of the compliance team are chronicled in a report conducted later by the University of California (Sandoval, London, & Rey). The auditing methods included mailed questionnaires sent to school administrators, followed up by on-site visits by DOE auditors. Response to the mailed questionnaires found that 62% of the state's high schools had complied with the law. The figure was later reduced to 40% after the field auditors discovered wide discrepancies between the schools' answers to the mailed questionnaire and the evidence provided during the audit visits. Among the schools that had indicated compliance in the mailed survey, 30% were teaching suicide prevention with videotape about substance abuse. Fifty-six percent of the schools were found to be using suicide prevention materials "that make little, if any, mention of suicide." (Sandoval et al., 1994, p. 600). The schools found not in compliance offered a variety of reasons for not using the suicide prevention materials stipulated by the DOE. Thirty-three percent pointed to teacher reluctance, 28% blamed time constraints, and 15% did not identify an obstacle.

The call for standardization of intervention methodologies was accompanied by a call for standardization of the language of suicide. Citing the findings of recent research on suicide contagion, the 2001 National Strategy offered a set of guidelines for media coverage of suicide,). The guidelines stated that, "The way suicide is reported can either CAUSE suicides or PREVENT suicide" (National Strategy, 2001, p. 108). Following are excerpts from the 2001 report's media guidelines:

- Sensitive articles about suicide can help REDUCE this stigma; but please be
    EXTREMELY careful about how you talk about it and how you cover stories

about suicide.

- Minimize coverage of suicides. Keep the stories relatively brief and do not run too many stories. But it is important to run stories!

- ALWAYS provide suicide prevention information with suicide stories. This is CRITICAL.

- Always provide the national suicide hotline numbers, which are 1-800-SUICIDE and 1-800-273-TALK. Consider providing local suicide hotline numbers, too.

- Emphasize that suicide can be prevented if people get help.

- Emphasize the number one cause for suicide: The number one cause for suicide is untreated depression.

- Do not hesitate to talk about suicide in stories. But ALWAYS do so in a way that provides help, hope, and resources for the suicidal and suicide survivors.

- Do not begin a television newscast with a suicide story.

- Do not place suicide stories on the cover of newspapers or magazines.

- Do not sensationalize suicides.

- Do not romanticize suicides.

- Never portray suicides as heroic.

•Never say that a suicide "ended pain" or "ended suffering." Suicide CAUSES

excruciating pain for suicide survivors.

•Be careful about describing the methods used. Do not go into great detail about

the methods, and do not show detailed pictures of the locations where the

suicides occurred.

•Do not say suicides occur because of one event. (Suicides rarely occur because

of one event.)

•Be careful with the wordings of headlines. Be careful with all of the words that

are used in the story.

•DO NOT say "committed suicide." Say, "died by suicide." People commit

crimes. Suicide is not a crime.

•Also, do not use the term "successful suicide." Instead say, "died by suicide." It is

extremely insensitive and entirely inaccurate to label a suicide as "successful."

•Do not use the word 'epidemic' in suicide stories. If suicide rates are rising, use the

word "rising." If they are falling, use the word "falling" (National Strategy, 2001,

pp. 109-110).

The 2001 report, including the California experience with school-based programs, led to

similar investigations around the nation that reached similar conclusions about the nature and

effectiveness of suicide prevention practices among U.S. schools (Lester, 1990; Shaffer et al., 1990,

p. 112-113). Many schools, for example, offered prevention programs but only during after-school

hours. Early scholarly research had concluded that school-based programs were ineffective unless incorporated into the school day with other mandatory curricula (Streiner & Adam, 1987, p. 331; Brock & Lazarus, 2012, Chapter 14). Some research argued that uninformed prevention practices could backfire and *create* suicidal thoughts among students (Shaffer & Craft, 1999).

Authors of the 2001 report summarized their findings as a "comprehensive and integrated approach to suicide prevention to be implemented across the country." The report delivered the first set of verified methods for reducing suicide through community-based and school-based practices. It also expanded the ring of community institutions — including local news media — that must work together in partnership in order to achieve long-lasting reduction in suicide deaths. The document also fueled an explosion of research into suicide contagion and the risks created by those who ignored the emerging standards and took suicide prevention — and suicide news coverage — into their own hands (Gould, Jamieson, & Romer, 2003; Gould et al., 2003).

2003 President's New Freedom Commission on Mental Health

As the 2001 report focused on suicide prevention, the 2003 commission focused on general mental health reform. The two reports were twin offspring of the1999 Surgeon Genera's "call to action." The authors of both documents applied "public health" intervention methodology to the menace of suicide and mental illness.

The 2003 Commission listed 19 formal recommendations organized under six proposed national goals for mental health, all of which echoed the calls for uniformity and standardization that resonated through its predecessor reports of 1999 and 2001. However, the 2003 authors engaged the more colorful language of frustration and impatience. It described the quality of mental health care in America as "fragmented, disconnected and

often inadequate, frustrating the opportunity for recovery." It characterized existing community mental health programs as "a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families and our communities." The authors stated, "The time has long passed for yet another piecemeal approach." The report demanded a "fundamental transformation" of the nation's approach to mental health care. It defined "fundamental transformation" as one that would "ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges." The authors said that the current system "simply manages symptoms and accepts long-term disability." Building upon the mandate of the 1999 Surgeon General report, the commission declared that its proposals "can improve the lives of millions of our fellow citizens now living with mental illnesses. The benefits will be felt across America in families, communities, schools and workplaces."

The commission report departed from the 1999 and 2003 reports by painting a picture of the future rather a picture of the past. The language was not that of "change" so much as the language of starting over, from scratch. The commission framed its recommendations as the vision of the future rather the detritus of the past. Its recommendations included increased public education regarding mental health, greater involvement of patients and families in care decisions, creating individualized care plans, increasing support for employment and affordable housing, early screening and treatment, and greater use of evidence-based practices. The commission also recommended that the prevailing "fragmentation of services for people with mental illness be replaced with one that coordinates all the needs — physical and emotional — of mentally ill persons. Throughout the report the authors avoided the voice

of the status quo or the perspective of governmental institutions. Instead, recommendations were presented as if they were taken from the mouths of the mentally ill and their families (now collectively referred to as "consumers).

Following are excerpts from the text of the 2003 commission report. The authors described a future in which all communities will:

- Give consumers control over their own care.

- Identify and assist consumers needing employment or income supports.

- Help consumers receive better help finding employment when necessary.

- Help consumers find affordable housing.

- Ensure that essential mental health services are available in correctional facilities.

- Abandon the use of seclusion or restraints to manage the seriously mentally ill.

- Establish more community-based treatment facilities for children who currently are sent to psychiatric treatment centers a significant distance from their parents and families.

- Design a delivery system for the mentally ill in rural or remote areas.

- Adopt a community policy that local schools should play a larger role in mental health care for children.

- Educate families and school officials about the benefits of early detection and screening tactics that intercept emotional disorders at an early age.

- Develop an alliance with local businesses willing to address the employment

crisis among mentally ill persons.

• Identify and eliminate health care disparities for minorities (2003 Commission, 2003, p. 38-39).

As did the 1999 and 2001 reports, the 2003 commission established "collaboration" and "partnerships" as litmus tests for transformed communities. In using such themes, all three reports drew heavily on current consensus that mental illness was a complex malady involving multiple co-occurring disorders that required the care and cooperation of multiple community services. The existing system, the 2003 report stated, shuttles patients to overlapping health care providers, from treatment to treatment, with each provider knowing little about what the others have done.

The 2003 commission demanded a more complex, multidimensional approach that rested on the success of partnerships between local institutions that frequently interact with the depressed or mentally ill — schools, health care providers, government agencies, law enforcement, employers — institutions that often had little history of collaboration. All three reports gradually intensified the pressure toward nationally standardized health care models delivered through community networks. All three reports drew heavily upon modern understanding of mental illness as a tangle of multiple, co-occurring disorders rather than a single identifiable malady. Accordingly, it was deemed that treatment and support systems had to be similarly complex, a collaboration and cross-collaboration of many moving parts of the community.

A major difference between the 2003 report and the three earlier reports was its lukewarm reception among certain consumer groups who questioned the impartiality of a

report sponsored by the Bush administration. The 2003 commission endorsed the merits of psychotropic medication as an important component of comprehensive mental health care, a finding that brought accusations that the commission report had been influenced by the pharmaceutical industry. Other mental health consumers and activists supported the commission recommendations as codification of state-of-the-art practices.

The 2012 National Strategy for Suicide Prevention

The 2012 report was, officially, an update of the 2001 National Strategy on Suicide Prevention. Its primary significance to this research project is its comprehensive indexing of current research and methodologies, much of which was still in development at the time of the original 2001 suicide prevention report. The report reaffirms the recommendations in the earlier reports that communities combat combatting suicide using the public-health principle — an elaborate web of community resources that collaborate seamlessly to address the mosaic of treatment challenges presented by mental illness and suicidal behavior. The 2012 report also repeated the concerns of the earlier reports regarding the risk of suicide contagion and the need to enlist the news media as an ally for the purpose of carefully managing the public flow of information that might create suicidal thoughts among local youth.

The 2012 report sorted the existing body of suicide prevention research into four general findings, each one identifying the specific needs required for long-term change. They were:

- The need for streamlined public services that make it easier for the mentally ill and their loves ones to retake control over their lives.

- The need to insert suicide prevention strategies more deeply into the community health

care establishment to more fully coordinate the treatment needs of the mentally ill.

• The active participation of civic leaders willing to shift community resources and

priorities in order to expand the number of mental health treatment facilities.

• The significance of real-time surveillance systems in order to track local suicide

incidence, target new areas of research and aid in the evaluation of new remedies.

Within those four categories, the 2012 report listed 10 new objectives being added to the 2001 strategy for suicide prevention. Those included:

• Establish effective, sustainable, and collaborative suicide prevention programming at

the state/territorial, tribal and local levels.

• Reach policymakers with dedicated communication efforts.

• Promote effective programs and practices that increase protection from suicide risk.

• Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

• Provide training to mental health and substance abuse providers on the recognition,

assessment and management of at-risk behavior and the delivery of effective clinical

care for people.

• Promote the adoption of "zero suicides" as an aspirational goal by health care and

community support systems that provide services and support to defined patient

populations.

• Develop and implement protocols for delivering services for individuals with suicide

risk in the most collaborative, responsive and least restrictive settings.

• Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

• Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

• Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs(U.S. Department of Health and Human Services, 2012, p. 92).

The 2012 report cited the U.S. military as a model for community-based suicide intervention. Pressured by Congress and the public to reduce the number of suicides among deployed troops, the Pentagon ordered the Army to implement a modern suicide prevention and intervention system that used the same principles of *SOS: Signs of Suicide*. A July 2010 Pentagon report praised the early results from the Army experiment. (U.S. Department of the Army, 2010). Initial success was attributed to a dynamic not present in the civilian population, namely, a chain of command with little tolerance for those who fail to carry out orders. Each Army suicide was carefully examined to track the rise and fall of the soldier's military experience. Had the solder sought help and, if so, was proper help provided? Commanding officers who failed to provide timely care and treatment were held responsible, military-style. The Army's mandate to reduce military suicides reflected modern scientific consensus about suicide as a preventable tragedy. Its methodology, however, ran counter to cultural sensibilities about suicide as a blameless act for which others are not responsible. In military parlance, those who fail to prevent a preventable outcome must be held accountable. A *New*

York Times story ("Pentagon Report Places Blame for Suicides") offered this statement from

Gen. Peter W. Chiarelli, Army vice chief of staff: "There are instances where a leader's lack

of soldier accountability resulted in suicide victims not being found until they had been dead

for three or four weeks" (Bumiller, 2010, p. 7A).

The significance of the four national reports

All four studies were presented to the nation as more than just the findings of scholarly

inquiry. They were presented as standards and policy measures to be implemented by American

communities, communities that would now have a master blueprint for the implementation of

evidence-based interventions. Communities would not have to reinvent the wheel of mental

health reform because they would have a set of instruction manuals that were greater than the

sum of their parts.   Most significantly, although the first and fourth reports were separated by a

dozen years, all four reports shared a list of common findings.

In regards to care for the mentally ill, the four reports shared the following findings:

•Communities should eliminate disparities between health care services provided for the

mentally ill and those available to the rest of the population. Such parity should

include the availability of inpatient and outpatient hospital services.

•Schools should implement early mental health screening, assessment and referral for all

children.

•Local health care providers should use current electronic technology to bette rcoordinate

the primary care services received by the mentally ill and the treatment provided by

psychiatrist, psychologists, social workers, etc. The 2003 President's Commission

stated that there exists a "chasm" between the treatment the mentally ill are given by

family physicians and the specialty treatment they receive from psychiatrists and
psychologists.

•Communities and schools should install incident-gathering systems that provide real-
time information about suicide incidence and the needs of the mentally ill. All of the
reports lamented the substantial time gap between the occurrence of local suicides
and the availability of information about the deaths. The 2012 National Strategy
report notes that such real-time monitoring is critical to guard against local clusters or
outbreaks of suicide.

•Community fundraisers and civic leadership organizations should extend their charitable
work to include the creation of integrated/transitional housing for the recovering
mentally ill. The 2003 President's Commission found that most American
communities "lack decent, safe, affordable and integrated housing, which is one of
the most significant barriers to full participation in community life."

•All communities should dispatch independent investigations into the quality of care
provided to the imprisoned mentally ill. Three of the four reports noted that the rate of
serious mental illness among those in correctional facilities is nearly four times that
of the general population.

In regards to suicide prevention, the four national studies shared numerous
common findings, calling for:

•School-based suicide prevention programs that focused on behavioral change and
coping strategies in the general school population. Combined with skill training and
social support for at-risk students such programs have beneficial effects on short-term

suicidal behavior.

- •Restriction of access to lethal means (e.g., firearms and pharmacological agents) may reduce the rate of cause-specific suicide in the general population, but its effect on the overall suicide rate was unclear.

- •Psychosocial and pharmacological treatments, such as problem-solving therapy, provision of a card for emergency contact, and cognitive behavioral therapy were promising in reducing rates of repeated self- harm among suicide attempters.

- •The Suicide Prevention Resource Center's vast best-practices registry, which, along with the U.S. Department of Health and Human Services, has identified evidence-based programs — especially for schools— since 2002. Among the most popular program is *Signs of Suicide*, a school prevention program developed by private behavioral therapy consultants in Boston. The company provides a set OF *SOS* instructional materials for teachers and students at schools of any size, with permission to make unlimited copies, plus an instructional DVD. The cost per school: $400.

The above four seminal documents contain, collectively, the standards by which scholars measure the quality of community-based mental health care and suicide prevention. A reading of all four reports provides a clear picture of the mental health care and suicide prevention technology that had existed prior to the year 2000 and what experts believe should because of the reports. The 2012 national strategy report, for example, identifies best practices of the Suicide Prevention Resource Center (SPRC) as the nation's primary library of evidence-based suicide prevention programs for

schools. SPRC's "best practices registry," in turn, offers an index of more than 200 evidence-based

programs and short courses available to schools. Those include *SOS: Signs of Suicide*, a structured

two-day program that was among the first programs in the nation to receive endorsement in major

scholarly journals (Shaffer & Craft, 1999). The *SOS staff* offers its program and materials to schools

for a one-time fee of $400, regardless of school size or frequency of use. The four national reports

also cited the National Association of School Psychologists, publisher of *Best Practices in School*

Crisis Prevention and Intervention, a textbook that sets out the professional protocols for responding

to school tragedies such as a school shooting incident or a student suicide (Brock & Lazarus, 2012).

The NASP also manages a nationwide network of crisis management experts who can be summoned

to the scene of any school crisis anywhere in the country to brief local officials on the proper steps to

take, and decisions to make, in the aftermath of tragedy.

The mass media and mental illness: Existing research

The review of literature reveals a large volume of existing content analysis of media

coverage of mental health issues. Virtually the entire body of such research, however, has

focused on the narrow issue of suicide contagion. Suicide contagion theory holds that localized

clusters of suicide can be caused by reckless publicity — usually in the news media. Such

research has engaged the framework of traditional media impact theory to demonstrate a cause-

effect relationship between media coverage of suicide and actual suicides (Gould, Wallenstein, &

Kleinman, 1990; Gould, Jamieson, & Romer, 2003; Perry, 2010). The professed goal of such

research has been to influence how the media write about suicide — how the media should not

write about suicide.   The pre-eminent authority on suicide contagion is Madelyn Gould, a

Columbia University professor who specializes in the clinical epidemiology of psychiatric

disorders. Dr. Gould's name is a standard citation in most published materials about suicide prevention.

Most contagion theory research traces the birth of suicide contagion to a spike in suicides immediately following the Aug. 6, 1962 death of Hollywood starlet Marilyn Monroe. Monroe's death, and sensational media reports calling it a suicide, reportedly produced a substantial number of suicides across the nation in the month following Monroe's death. Researchers claim to have documented 300 "additional" suicides during the 30-day period after Monroe's death. This was interpreted as a 12% increase over the number of expected suicides during that time of year based on historical patterns. The research on Monroe's death stopped short of claiming that media publicity *caused* the additional suicides; the research simply documented the suicides and the date of occurrence. Nonetheless, the Monroe publicity elevated suicide contagion from nascent, untested theory to official fodder for news media speculation. By the late 1980s, journalists found it impossible to ignore reported "epidemics" of teen suicide. Among the first, and most dramatic, episodes of media intrigue was *Teenage Wasteland*, freelance journalist Donna Gaines' investigation into the 1987 suicide clusters in Bergenfield, N.J. Another was *Final Exit, a* 1992 best-seller that sought public acceptance of human euthanasia and assisted suicide for the long-suffering and terminally ill. The book took awareness to another level by including detailed instructions on self-asphyxiation, which the author identified as the least painful means of suicide. Stack's research cites data from coroner and law enforcement sources indicating that suicides in New York City rose from eight to 33 in the year following the book's release. A copy of *Final Exit* reportedly was found at the scene of 10 of the suicide scenes. By the late 1980s, scientific intrigue about contagion had itself become contagious. A 2003 meta-

analysis documented 42 suicide contagion research studies between 1991 and 2002 (Stack, 2003, p. 1).

Subsequent contagion investigations added to the list of media guidelines, fueling the enthusiasm for reducing suicides by changing how the media write about suicide. Suicide research applies media impact theory in reverse. Media impact theory tests the ability of the media to alter public policy. Thus, suicide contagion research tests the ability of public policymakers (mental health specialists) to alter media coverage. Columbia University's Madelyn Gould is among the suicide scholars who present suicide contagion not as a theory but as epidemiological doctrine. Gould uses the term "media contagion" to describe a cause-effect relationship between media coverage and suicide. In a 2003 review of recent contagion research, Gould states that, "There is ample evidence from the literature on suicide clusters and the impact of the media to support the contention that suicide is contagious (Gould et al., 2003, p. 1269). She adds that suicide contagion can be viewed within the theoretical framework "of behavioral contagion … in which the same behavior spreads quickly and spontaneously through a group." Gould also cites social learning theory as another paradigm through which suicide contagion may be understood, adding that, "most human behavior is learned observationally through modeling (Bandura, 1977)." Gould then advocates for the "preventive effects of appropriate reporting of suicide in the news media." Her 2003 journal article cites other research studies that "have identified a decrease in suicides following the implementation of media guidelines." The 2003 journal article concludes that:

> The substantial evidence that vulnerable youth are susceptible to the influence of reporters and portrayals of suicide in the mass media underscores the importance of educating media

professionals about the potential for suicide imitation and ways to avert it. (Gould et al., 2003, p. 1276-1277)

The article concludes with a four-page set of recommendations that encourage the media to write about suicide as long as such coverage avoids sensationalism that might cause contagion. As an example, the guidelines state that, "the use in headlines of the word 'suicide' or referring to the cause of death as self-inflicted increases the likelihood of contagion" (Gould et al., 2003, p. 1279).

Gould cites numerous other content analysis projects, including a 2000 examination of suicide-related articles in ten major U.S. daily newspapers, including the Chicago *Tribune*, the *Dallas Morning News*, the *Los Angeles Times*, *USA Today*, *The New York Times*, and the *Washington* Post. The content analysis findings revealed that "the opportunity for suicide contagion from stories in major newspapers is quite high" (Gould et al., 2003, p. 1274).

During the first decade of the new century, contagion theory had won sufficient acceptance in scholarly communities that it became the basis for organized communications seeking media acceptance of specific guidelines covering stories about suicide. If media coverage causes suicide, then researchers were compelled to design ways to change media coverage of suicide. Among the media recommendations typical of suicide contagion studies:

- Avoid reporting the location of a suicide, the method of death, or the contents of suicide notes

- Use appropriate wording when referring to suicide, such as "died by suicide" or "completed suicide." Do not use expressions such as, "successful suicide attempt."

- Avoid terms such as "epidemic" or "skyrocketing" numbers

•Avoid reports suggesting that suicide was preceded by a single event, such as a recent

job loss or firing

•Seek advice from suicide prevention experts instead of quoting or interviewing police or

first responders about the causes of suicide

The zeal for such content analysis has been worldwide — all of it devoted to

documenting or disproving "media contagion" theory. Among these was a 1997 quantitative and

qualitative analysis of media reports in the Swiss print media (Frey, Michel, & Valach, 1997).

Quantitative aspects included the length and positioning of the article, presence or absence of a

picture, size of headline, and frequency of reporting. Qualitative aspects included contents of the

report, whether articles might serve as a model, and presence of prevention or treatment

resources. A coding and scoring scheme was devised to generate an "imitation risk score" for

each newspaper article. Approximately 400 newspapers and magazines were examined. During

an eight-month period, the Swiss team found 151 articles about suicide in 79 different

publications. The headline in 47% of the stories was considered to be "sensational." In 13% of

the articles, the headline was judged as "romanticizing the event" or "glorifying" the deceased.

The research team found "inappropriate" pictures in 20% of the articles. Overall, 44% of the

articles in the research sample were deemed highly dangerous for their potential to cause

contagion. The Swiss researchers presented their findings at a national press conference as a

means to launch guidelines for suicide reporting

The most recent attempt to alter media polices was a campaign by the California Mental

Health Services Authority (California Mental Health Services Authority, 2012). The agency

engaged a team of private education analysts to examine more than 200 news reports involving

suicide. The report found a "slight reduction" in what it called "sensational language" in suicide stories. However, the authors of the study said there was insufficient evidence to claim any cause-effect relationship between actual media content and campaigns urging media compliance with the reporting guidelines. The authors concluded that the media's overall handling of suicide was "largely unchanged."

The apparent null or default position of such media-directed research is that, lacking familiarity with mental health issues and suicide in specific, professional journalists will be receptive to protocols supplied by experts outside the journalism profession. A reading of such studies reflects no intent at censorship or information control but, rather, an assumption that the media's lack of knowledge about suicide mirrors that of the general public and, hence, journalists writing about the subject require expert assistance.

Dissenting Voices

The literature turns up numerous researchers who have criticized the methodology underlying contagion theory (Etzersdorfer & Sonneck, 1998, p. 2). These critics argue that there exists little documentation of media-induced suicides and only conjecture esimates about the ratio of contagion-related deaths to all reported suicides. Furthermore, critics point out that conclusions of media-induced contagion are reached inferentially, with media coverage accepted as the default explanation reached without consideration of other plausible variables (Stack, 2003) — a flawed *modus tollens* reasoning reminiscent of Bandura's early theories about media-induced violence among children. The observation of white swans yields no conclusion about the existence of black swans (Joiner, 1999). Others have expressed concern that the relentless pursuit of contagion research has diverted attention from the need for broader research into the media's

ability to coverage suicide and mental illness (Pavesi & DiFiorino, 1990). Lastly, experts in

school-based suicide prevent voice concern that dire warnings about contagion can create anxiety

among school administrators, and school attorneys, that official enthusiasm for suicide

prevention initiatives is dampened by official concerns about liability and lawsuits (Poland,

2010, p. 9-10).

Gould, considered the world's leading authority on media contagion, acknowledges the

doubts about contagion theory while presenting swift rebuttal:

In contrast to this ample body of literature supportive of the hypothesis that suicides

dramatized in the media encourage imitation, a few studies have not reported an

association between media reporting and subsequent suicides (Berman, 1988; Phillips &

Paight, 1987) or found an association only among adolescent, not adult, suicides (Kessler,

Downey, Stipp, & Milavsky, 1989). A highly publicized recent study by Mercy et al.

(2001) found that exposure to media accounts of suicidal behavior and exposure to the

suicidal behavior in friends or acquaintances were associated with a lower risk of youth

suicide attempts compared to persons who had not recently attempted suicide. However,

the interpretability of the findings is limited because (a) the media exposure measure was

an aggregate of different types of media stories; (b) attempters may have had less

exposure to media generally (e.g., read fewer books, fewer news- papers, etc.); (c)

attempters had significantly more proximal stressors, possibly overshadowing their

recollection of media exposure; (d) the timing of exposure was a 30-day interval, in

contrast to most other studies, which examined a shorter interval following the exposure;

and (e) nearly half of the sample was between 25 to 34 years of age, a group not

particularly sensitive to imitation.

Another finding by Mercy et al. (2001) — no effect of parental suicide — also was inconsistent with the prevailing research literature. In contrast with this finding, a recent study (Cutler, Glaeser, & Norberg, 2001) using data from ADD Health, a nationally representative stratified random sample of U.S. high school students, found that teenagers who knew friends or family members who had attempted suicide were about 3 times more likely to attempt suicide than teens who did not know someone who had attempted suicide. There was support for the causality of the association because in an examination of two waves of data, teenagers who had not already made a suicide attempt in the first wave were more likely to attempt suicide by the second wave if they had a friend or relative attempt suicide. Stack's (2000) review of the literature indicates that methodological differences among studies examining the impact of the media are strong predictors of differences in the findings. A summary of interactive factors that may moderate the impact of media stories, including characteristics of the stories, individual reader/viewer attributes, and social context of the stories, is presented by Gould (2001). (Gould et al., 2003, p. 1272)

Critics argue that contagion theory has reached the level of mental health doctrine, a scholarly status beyond what is justified by its core methodology (Etzersdorfer & Sonneck, 1998). Such research contends that contagion theory fails to consider events and variables other than media coverage, relying instead upon a formula of "If P, then Q." Nor, say the critics, does contagion theory take into account suicide clusters that occur without being preceded by media publicity. Lastly, critics express concern that suicide contagion theory is widely presented to the public and the news media as a consensus theory when, in fact, the available literature presents it

as a theory contested and debated. A team of Australian researchers recently conducted a systematic literature review aimed at critically evaluating the evidence concerning the effectiveness of contagion-based media guidelines for reporting on suicide. The authors found "significant variability" in media reception to such reporting guidelines, adding that, "journalist awareness, use, and opinion of guidelines is generally low. "In his meta-analysis of 42 contagion studies, Stack argues that suicide contagion theory rests on wobbly knees. He states that, "Most of the evidence to date for a copycat suicide effect is very indirect and not fully satisfactory. The associations are drawn between the presence of a suicide story and a rise in the suicide rate. It typically is not known to what extend the people committing suicide are even aware of the suicide story"(Stack, 2003, p. 239). Lastly, very recent research suggests that the widespread use of electronic social media among young people renders news media coverage irrelevant as a contagion trigger (Swanson, 2013). Contagion theory holds that reckless reporting about suicide can trigger additional suicides with a given community. However, modern social media outpaces the news media in its ability to saturate a community with information — information that may be balanced and accurate or false and grossly sensationalized. Swanson's research argues that social media allow uninformed gossip to quickly reach those most vulnerable to "contagiousness," namely, severely depressed adolescents who receive word about the suicide of a friend or relative (Swanson, 2013, p. 8).

Other than contagion research, this literature review unearthed no other content analysis regarding media coverage of mental illness and/or suicide. The media guidelines developed by contagion research focuses on what the media should *not* do in writing about suicide. Contagion-generated research does not address the "why" and "how" and "who's to blame" considerations that typically create the framework for independent media coverage. A recent commentary by

Andrew Beaujon, a Poynter Institute media analyst, offers an example of how the media prefer to frame such stories — and the frustration among journalists when no framework exists:

> How can we explain shootings if we don't report on mental illness? It is easy to find out an individual state's gun laws. It's far harder to assess a state's approach to mental health issues. Responsibility for that failure lands heavily on the collective shoulders of the U.S. news media . . . We might not be able to answer why someone would gun down kindergarteners but couldn't we help our audience figure out what society is doing for the mentally ill? (Beaujon, 2012, p.1)

Media framing: A research framework

Social scientists have long sought to examine, explain and predict the interaction between media content and public attitudes (Lippmann, 1922; McCombs, 1972). Early theory, for instance, contemplated the relationship between violent media content and violent behavior in the population (Bandura, Ross, &Ross, 1963). Later media theoriest reshaped and redefined our understanding of when and how the media's influence is most apparent and significant. Historically, media impact theory held that if the media devote time and space to the economy or gas prices, these issues will also rise to the top of the public agenda. Conversely, if the media devote scant attention to global climate change or youth suicide, each will hold a lower station on the public dance card, if they join the dance at all. Over time, media impact theory was shaped and modified by fresh research suggesting that the media did not influence how people think so much as what people think about (Cohen, 1963). The co-founders of agenda setting theory (McCombs, 1972;Lippmann, 1922) created plausible explanations for the *ability* of the news to influence the number and variety of issues that shape public policy — the issues that are added to and removed from

the public's agenda. By elevating certain issues over others, the media have the ability to influencehow voters think, behave and vote, which is to say the media have the ability to alter how policies and policy makers are viewed by the public (Krosnick & Kinder, 1990).

Additional research led to the thinking that certain media influence certain people on certain issues (Lang and Lang, 1966). The nature of the relationship between media coverage and public policy eventually evolved into multi-purpose apparatus of specialized tools suitable to a wide variety of media-public interactions, such as presidential elections, advertising, and health care (McCombs and Shaw, 1972). The new utensils of media impact theory required new names that more accurately described their purpose. The modern toolbox of media impact theories became known as "agenda setting" or "agenda building." Among most useful devices for understanding media impact is a precision-alignment device known as "framing." Tankard defined a story's frame as "the central organizing idea for news content that supplies a context and suggests what the issue is through the use of selection, emphasis, exclusion and elaboration" (Severin & Tankard, 2001, p. 110-111). Framing theory offers the best available perch from which to witness, if not fully explain, the influence of the news media on public understanding of mental illness and suicide as public health threats. Media framing can be a conscious manipulation caused by media bias. The frame also may be indirectly determined by the quality and completeness of information provided to the media or the quality and completeness of journalistic research (Zucker, 1978; McCombs, 1994; Terkildsen & Schnell, 1997).

Those who engage agenda setting and framing theory must contend with the risk of misperceived correlations (Classsen, 2013). Does media framing determine the public agenda setting, or vice-versa? What forces might produce a news media agenda that gives diminished significance to a health risk that health experts consider a major crisis? The trajectory of media

framing can be more clearly witnessed through the lens of yet another agenda setting offspring — issue obtrusiveness. The ability of media framing to influence the public agenda is more likely with issues unfamiliar to the public (Zucker, 1978; Severin & Tankard, 2001). Unfamiliar issues are unobtrusive issues, that is, issues that do not impact one's everyday life, even if it only seems that way. Many people are unconcerned about global climate changes, for example, which may leave them uninformed on the topic and, thus, more likely to be influenced by the mass media. High gas prices, on the other hand, are an obtrusive issue, one that affects everyday life. The typical consumer may read news stories about the explanation for high gas prices but his personal interest or agitation exists regardless of how much newsworthiness the media attach to the issue (Wanta, 1997; Wimmer, 2009). Similarly, those with responsibility for providing and managing local public services will be more sensitive to media coverage of health issues than will the average person. Policymakers have much at stake in the media framing of public issues, which motivates them to actively seek, attend and process media messages. (Yanovitkzky, 2002). The reputation and careers of public officials can be altered not only by the media's characterization of issues but also by the information used by journalists — or provided to them — for evaluating the performance of public officials (McCombs, 1994; Zucker, 1978).

The news media, of course, can choose whether or not to let their coverage agenda be influenced by pressure groups and special interests. Journalists can decline to engage in "reactive" coverage and, instead, use their own shovels to unearth heretofore-ignored issues. Such independent behavior is in line with the journalism profession's vow to remain separate and apart from outside influence, functioning as an independent influence on public policy ("SPJ Code," 2013).Editors and reporters engage in agenda building and issue framing with every decision made about which issues are within reach of available manpower. The choices are

rarely between covering and not covering, but, rather, between informed, in-depth stories (sometimes known as "thematic") and that which is merely anecdotal and episodic in nature (Krosnick & Kinder, 1990). Such decisions by the news media are made under the same restraints of familiarity and unfamiliarity —obtrusiveness and unobtrusiveness — that affect the public agenda (Terkildsen & Schnell, 1997). Familiar issues and familiar sources can shape the media's framing of mental health and suicide as public health issues. Conversely, how the media frames mental health and suicide prevention can alter the media's familiarity — or its perceived familiarity with such issues.

This interaction— between media framing of mental health stories and the media's familiarity with mental health issues — has not gone unnoticed in journalism circles. In March 2013, the Associated Press offered some journalistic guidance on coverage of mental health by announcing what it called a "long-overdue" addition to the *AP Stylebook* — the glossary of grammatical standards conventions for print journalists — regarding stories about mental illness and suicide. In explaining the new guidelines, a senior Associated Press official stated that, "It is the right time to address how journalists handle questions of mental illness in coverage. This isn't only a question of which words one uses to describe a person's illness. There are important journalistic questions, too" (Carroll, 2013, p.1). At this writing, the new standards were available online in draft form and were expected in print editions by summer 2013.

The new AP guidelines for reporters and editors include:

• Do not describe an individual as mentally ill unless it is clearly pertinent to a story and the diagnosis is properly sourced.

• When used, identify the source for the diagnosis. Seek firsthand knowledge; ask how the source knows. Don't rely on hearsay or speculate on a diagnosis. Specify the time

frame for the diagnosis and ask about treatment. A person's condition can change over time, so a diagnosis of mental illness might not apply anymore. Avoid anonymous sources. On-the-record sources can be family members, mental health professionals, medical authorities, law enforcement officials and court records. Be sure they have accurate information to make the diagnosis. Provide examples of symptoms.

•Mental illness is a general condition. Specific disorders are types of mental illness and should be used whenever possible: *He was diagnosed with schizophrenia, according to court documents. She was diagnosed with anorexia, according to her parents. He was treated for depression.*

•Do not use derogatory terms, *such as insane, crazy/crazed, nuts or deranged*, unless they are part of a quotation that is essential to the story.

•Do not assume that mental illness is a factor in a violent crime, and verify statements to that effect. A past history of mental illness is not necessarily a reliable indicator. Studies have shown that the vast majority of people with mental illness are not violent, and experts say most people who are violent do not suffer from mental illness.

•Avoid unsubstantiated statements by witnesses or first responders attributing violence to mental illness. A first responder often is quoted as saying, without direct knowledge, that a crime was committed by a person with a "history of mental illness." Such comments should always be attributed to someone who has knowledge of the person's history and can authoritatively speak to its relevance to the incident.

•Avoid descriptions that connote pity, such as *afflicted with, suffers from or victim of*. Rather, *he has obsessive-compulsive disorder*.

•Double-check specific symptoms and diagnoses. Avoid interpreting behavior common to many people as symptoms of mental illness. Sadness, anger, exuberance and the occasional desire to be alone are normal emotions experienced by people who have mental illness as well as those who don't.

•Wherever possible, rely on people with mental illness to talk about their own diagnoses

•Avoid using mental health terms to describe non-health issues. Don't say that an awards show, for example, was schizophrenic.

•Use the term *mental* or *psychiatric hospital*, not *asylum* (Carrroll, 2013, p. 2-3).

It is important to note that the *AP Stylebook* is news journalism's pocket dictionary, a professional guide to language that is both proper and accurate. It does not contain recommendations on which issues the media should cover or how to structure long-term investigation of mental health and suicide issues. Itzhak Yanovitsky, Rutgers University health communications scholar, suggests that the media's ability to shape public policy often is underestimated by research that focuses on short-term behavior and short-term results (Yanovitzky, 2002).   In yet one more demonstration of the flexibility of modern agenda setting theory, Yanovitsky sought to chart a timeline between initial media attention and eventual social change. Put another way, Yanovitsky's findings demonstrated the difference between social movements that gain mere "attention" and those that bring about permanent policy change Long-term change, he concluded, requires long-term media "attention" to a particular issue.

Those forces patient enough to develop media trust and credibility over a long period of time are most likely to shape the media's eventual framing of the issues involved.

Yanovitsky charted the history of America's grassroots campaign against drunk driving from the late 1970s to the 1990s. Alongside the timeline of events he graphed the trajectory of *media attention* to the issue. The time difference between media attention and final action, he concluded, represented the news media's learning curve — the time required for consumer safety activists to reach dominance as the media's primary source of trusted information. Though research into drunk driving as a public health issue had begun a decade earlier, it had received little media coverage until the beginning of the 1980s and the emergency of consumer advocates such as Ralph Nader and Mothers Against Drunk Driving. By the end of the 1980s, passenger cars had lost their reputation as the ticket to entertainment and the good life. Consumer groups successfully redescribed the automobile as a deadly, killing machine. Despite the auto industry's efforts to reverse this framing, the consumer activists had carried the day. By winning the race for media attention and credibility, the consumerists were able to shape the media's framing of the health and safety issues involved. Shouts of protest from automakers became helpless whimpers once the news media accepted drunk driving and dangerous cars as two pictures requiring a single frame, refusing to let the industry distance themselves from the carnage caused by drunk drivers media enabling consumer activists to referee the line between available information and existing information. Attention *drawn*, Yanovitsky argues, is short-lived and produces short-term results. Attention *captured* produces long-term change. The Naderites' influence over public policy, Yanovitsky argues, began long before it was noticed: nearly 20 years worth of grassroots lobbying, media briefings, expert testimony, and Ralph Nader press conferences. Short-term results included the nation's first laws mandating seat belts and air bags.

As news media attention began shifting to other issues during 1990s, Yanovitsky notes, public officials and policy makers had been conditioned to consider the ultimate prize: fundamental, permanent reduction in human suffering. Such change included not only the redesign of passenger vehicles but also the redesign of auto advertising that now touted safety over speed. From 1970 to 1990, auto fatalities dropped from 52,000 to 42,000. The 2011 death toll was 32,300 — the lowest in 62 years. The biographies of countless automakers and politicians contained documented credit for the regulatory and engineering changes that so dramatically reduced the loss of life from car accidents. Less documented, Yanovitsky argues, was the contribution of those who understood the potential for an informed news media to make such change possible.

In reviewing the ability of special interests to control media framing, Yanovitsky is careful to distinguish "public attention" from public "awareness." He defines public attention as the end result of sustained attention to a clearly visible problem for which there are clearly visible solutions. He defines "awareness" as the end result of public attention to a dimly understood problem for which there are no apparent solutions:

> The impact of media attention on policy is a function of the extent to which media framing of public problems serves policymakers' interests or the special interests they represent. If media frames of problems put policy makers in uncomfortable positions, they are likely to respond more slowly to a problem by sticking to organizational and institutional routines (e.g., convening a panel or a committee to study the issue). (Yanovitsky, p. 445)

Yanovitsky's findings about the arc of auto safety reform in the late 1900s — the long span of media attention required to produce long-term policy change — offers yet another example of how traditional media impact theory has been molded and modeled over time to meet the needs of specialized research.

Literature Review: A Summary

For the media and anyone else trying to understand the public health issues presented by mental illness and suicide, the sources identified in this review provide an evaluative tool greater than the sum of its parts. The seminal reports of the past two decades have been consistently presented by their authors not as a series of disparate findings but rather, as a vision for the future — a bundled set of standards for reducing mental illness and suicide. One need not agree with the vision in order to acknowledge that the vision exists.

While available research offers a detailed blueprint for addressing mental illness, no similar blueprint addresses the needs of journalists trying to cover such a complex public health issue. Existing research about the media and mental illness focuses solely on suicide contagion. Such research has triggered repeated attempts at advising the news media about the dangers of writing about suicide. These research projects can be viewed as a blueprint for what *not* to write and how *not* to cover mental illness and suicide. Such cautionary warnings, however, do not offer guidance on how journalists *ought* to address mental illness and suicide — within what framework journalists should address the problem and its solutions. The literature review for this project uncovered no attempts at synthesizing the history, facts, consensus documents, and expert sources into a checklist or litmus tests that journalists might use to assess the nation's progress, or lack of progress, against mental illness and suicide. Nor did the inspection of existing literature produce any research

regarding those community agencies and institutions considered accountable for the quality

of mental health care and suicide prevention systems. Absent such research, a conclusion

was made that the news media possess no standard guidelines or litmus tests for sorting out

what currently exists and what should exist in community health care and suicide

prevention.   This does not imply that the news media lack the ability to make such

distinctions but, rather, that there is no coherent presentation of the criteria needed to make

such distinctions.

This finding makes a compelling argument for six research questions, the answers to

which will address the overall question regarding the news media's familiarity.

Research Questions

RQ1: *Does media coverage of mental health and/or suicide make any reference to any of the*
four national consensus reports that have established the criteria for community mental health
reform and suicide prevention?

Many scholars and scholarly institutions have investigated mental illness, its symptoms

and treatments. However, only a limited number of research projects have produced

widespread agreement on the standards and baseline requirements for community-based

systems and interventions. The most frequently acknowledged source documents for

such standards are the 1999 Surgeon General's Call To Action, the 2001 National

Strategy on Suicide Prevention, the 2003 President's New Freedom Commission on

Mental Health and, the 2012 National Strategy for Suicide Prevention.

RQ2: *Do journalists reporting on mental health or suicide seek out the recognized primary sources of information regarding general community-based interventions?*

> Though there exist many sources of scholarly and clinical standards for treating mental illness or suicidality, the most commonly cited blueprint for community-wide action are found in the materials developed for schools. Because local quality of life is often considered synonymous with quality of local schools, great efficacy inures to the recommendations of school boards and school administrators. The literature abounds with agreement regarding the importance of making schools a central figure, if not the starting point, in community initiatives regarding mental health and suicide prevention (Mowbray & Holter, 2002, Chapter 3; Avery, 2013, p. 17-20).

RQ3: *Do journalists writing about mental illness and suicide among young persons seek out the primary source of standards developed for schools and universities?*

> There is unanimity in the literature that the intervention of choice for all public health issues involves the trinity of early screening, early detection, and early treatment. A wide body of research confirms that most mental illnesses and suicidal thought can be traced to symptoms that were present, but not diagnosed, as early as third or fourth grade. The literature is consistent in the recommendation that communities implement one unified approach to mental health intervention rather than attempt public cooperation with multiple systems. The four nationwide consensus reports present the goals and objectives of mental health care reform. The most widely endorsed set of actual tactics, however, are found in the "best practices" textbooks published by the National Association of School Psychologists.

RQ4: *Does media coverage of mental health and/or suicide cite the need for community*

surveillance/tracking as frequently cited in the nationwide studies?

> The mental health source documents and research reports were unanimous in their
>
> demand for better data at the community level regarding the local incidence of suicide
>
> and the local population of persons needing mental health treatment.

RQ5: *Do media reports about suicide mention "contagion" or "suicide contagion" (sometimes*

referred to as "copycat suicide") as a health threat created by media coverage of suicide?

> This data point addresses media familiarity with an issue that can significantly impact
>
> community response to the threat of suicide. Fourteen years after the U.S. Surgeon
>
> General's report declaring suicide a major public health issue (Satcher, 1999), neither
>
> the U.S. Public Health Service (www.usphs.gov) nor the National Association of
>
> Community Health Centers (www.nachc.com)nor the National Council for Community
>
> Behavioral Healthcare Services (www.thenationalcouncil.org) recognizes suicide
>
> tracking or contagion monitoring as an obligation of local public health agencies.
>
> Nonetheless, suicide contagion theory has played a fundamental role in public
>
> understanding of suicide. It also has driven the bulk of scholarly research regarding
>
> media coverage. The review of contagion literature revealed no consensus formula for
>
> identifying suicide contagion or declaring a state of contagion. Neither the U.S. Public
>
> Health Service nor the Department of Health and Human Services tracks local suicide
>
> outbreaks; neither agency establishes public health norms for the definition of contagion.
>
> Most of what is known about contagion, and how to recognize it, is found in Gould's
>
> work and that of Dr. Scott Poland of the National Association of School Psychologists.
>
> A review of the research on suicide contagion finds consensus on the theory of

contagion and its threat to public health. The research contains no officially endorsed

methodology for identifying contagion or declaring a condition of contagion. Gould's

most recent research (Gould et al., 2010) defines suicide contagion as:

1.a localized outbreak of suicide greater than historical norms

2. in a single community

3. during any three-month period

An example: Community USA has never had more than two youth suicides in any given month

over the past 20 years, with "youth" defined as ages 15-24. During mid-August, administrators at

the Community USA School District discover that eight students have died by suicide in the first

two weeks of August. If school officials were to seek the counsel of Dr. Gould or Dr. Poland,

both experts would declare that a state of suicide contagion exists in Community USA and

prescribe a specific set of school and community intervention steps. The literature review yielded

no clarity on the definition of "community" for the purposes of computing gathering contagion

data.

"Suicide contagion" is an academic expression used by mental health scholars; no such

term or mortality classification is found in the nation's uniform reporting systems for crime,

mortality, and injury (Centers for Disease Control [CDC], 2012). The tracking or report of

suicide contagion, or apparent contagion, is not included among the standard reporting

obligations of state and local health agencies charged with tracking public health threats and

communicable disease. A close examination of contagion research literature suggests there are

two ways in which U.S. communities may be alerted to a current or past outbreak of suicide

matching the scholarly criteria for contagion. Such notice can be delivered by:

•local health, school, or law enforcement officials who believe the community's

suicide incidence has suddenly increased. Such community declarations rarely use

the technical term "contagion" but, rather, draw public and media attention to

what officials believe to be a current spike in suicides.

•state mortality data reports that document past community history of suicide

incidence. Suicide is accepted as the cause of death based solely on entries made

on death certificates by local coroners or medical examiners. Death certificates

are submitted to a state health agency that tracks mortality and injury data. All

such data is later compiled into annual "vital statistics" reports that are subsequent

released to the media and posted online. Such vital statistics summaries report

mortality incident only at the county and state level. The time lag between a

coroner-confirmed suicide and the inclusion of that suicide in a state vital

statistics report is typically 12 to 18 months. Thus, most outbreaks of suicide

contagion are not known or report in real time but, rather, are identified much

later by researchers who search state mortality reports for indications of recent

"contagion" outbreaks. Unless communities install their own suicide surveillance

systems, the gathering and release of community-level suicide incident data is left

to the discretion of local officials.

RQ6: *In stories that discuss suicide contagion theory, do the media seek out recognized national experts on this topic or do the media rely upon explanations from persons of unknown expertise?*

As with RQ5, this data point addresses the media's familiarity with a significant mental health issue that frequently arises in public reports about mental illness and suicide. Educating the public and media about suicide contagion requires considerable scholarly expertise. Misinterpretations and misunderstandings about contagion can result in community policies and decisions not intended or substantiated by contagion research (Poland, Lieberman, & Cowan, 2006, p. 2). Epidemiological science addresses communicable disease — mumps, measles, and influenza. "Contagious" is the lay expression for the behavior of communicable disease. Suicide contagion theory involves an inversion of epidemiological language. Suicide is not a disease; it is an action. The suicidal act is the fatal outcome of an untreated disease. The National Institute of Mental Health estimates that 90% or more of all suicide victims died after prolonged affliction with one or more co-occurring mental illnesses as listed in the national DSM-IV psychiatric diagnostic manual ("NIMH," 2013, p. 1). Mental illnesses can be inherited but it is not contagious. Relying on traditional principles of behavior theory, suicide contagion holds that information about the suicides of others can compel other suicidal persons to do likewise. Suicide scholars can help the media and public distinguish the "contagiousness" of suicide from the contagiousness of familiar communicable disease. Explanations offered by non-experts can lead to misinterpretations by the general public as well as public officials (Bertolote, 2004, p. 149). Whether accurately or inaccurately interpreted, warnings about suicide contagion are today deeply established in the public health and public education fields as well as the rapidly emerging field of crisis communication and crisis management (Joiner, 2005, p. 60). The news media regularly receive recommendations and warnings from suicide experts about how to cover suicide

without triggering contagion. A casual review of media reports on youth suicide turns up numerous reports of emotionally charged standoffs involving school administrators' interpretation of contagion theory and the clamor of grieving students seeking to preserve the memory of a fallen classmate (Mach, 2012).*Appendix B.*

Chapter 3: Methodology

Content analysis methodology is well suited for an examination of media coverage. It allows both qualitative and quantitative techniques to measure authorship, authenticity, meaning, and audience impact (Lombard, Snyder-Dutch, & Bracken, 2002, p. 587). Content analysis of a large body of information can lead to reliable conclusions about the impact of media coverage on public policy. In the case of mental health coverage, content analysis is particularly useful tool for analyzing media coverage of complicated issues that has vexed society for many generations.

To examine media familiarity of mental illness and suicide, a coding sheet was constructed by converting six research questions into 19 specific text strings or textual "data points." Each of the 19 points represents a specific piece of information drawn from the literature and deemed essential for a comparison between the quality of mental health care and suicide interventions that exist today and the systems that should exist according to national standards. Sixteen of the 19 data points indicated journalist familiarity with a primary source document (i.e., one of the four nationwide reports) or a primary source individual — experts considered the nation's leading scholars on mental health and suicide. Two data points indicated familiarity with the issue of suicide contagion. One data point represented familiarity with the surveillance data required for community intervention, as noted in the national consensus reports.

For example, one data point sought evidence of familiarity with the 2012 National Strategy for Suicide Prevention and its recommendations. Coders searched each newspaper article for any specific mention of the 2012 report.   Finding such a reference, the coder checked the "Yes" box next to 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION on the code sheet. Finding no such reference, the coder checked the "No" box.

Data points for each research question were drawn from the major source documents found in the review of literature. Care was taken to identify the most significant community recommendations/standards found in all four of the national consensus reports. Though the consensus reports spanned a period of nearly 13 years (1999, 2001, 2003, 2012) a number of significant recommendations were common to all four reports. In addition, suicide contagion theory played a central role in the nation's history of mental health research as well as history of research into media coverage of mental health. Accordingly, references to contagion theory were deemed essential to any measurement of media familiarity. Lastly, the names of three leading scholars were added to the code sheet in order to measure media familiarity with experts considered credible sources for media interviews. There are literally scores of mental health and suicide experts around the globe, who could potentially provide current and consistent information about national standards on such issues. The three individuals listed on the code sheet were chosen based on (a) the frequency with which their names appeared in the literature search, (b) the frequency with which their names have previously appeared in media coverage dating back to the early 1990s. Although media samples were only drawn from the past two years, a much longer time is typically required for any individual or expert to build a reputation as a reliable and available source for the news media. As assumption was made that mental health experts sought out by journalists during the 2000 -2012 period would likely include experts utilized by journalists prior to that time period.

In constructing the research question data points, great care was taken to heed the body of instructional and scholarly literature regarding intercodal reliability in research that relies upon content analysis. Common cautions found in such readings include the important of creating text strings or "data points" that are sufficiently specific so as to reduce or eliminate ambiguity or

coder misinterpretation. Achieving such interpretive convergence among coders requires that all

coders receive clear and consistent instruction (Hruschka, Schwartz, St. John, Jenkins, & Carey,

2004, p. 320-323). Drawing upon the literature, a set of data points was constructed to provide

answers to the Research Questions. That is, the code sheet raters searched each newspaper article

for any mention of these data points.

Content analysis coding instrument

Following are the data points established for each Research Question:

Research Question #1

Does the sample mention any of the four (4) national consensus reports that have

established the criteria for community mental health reform and suicide prevention?

- The 1999 U.S. Surgeon General's Call To Action [Yes/No]

- The 2001 National Strategy on Suicide Prevention [Yes/No]

- The 2003 New Freedom Commission on Mental Health [Yes/No]

- The 2012 National Strategy on Suicide Prevention [Yes/No]

Research Question #2

Does the sample mention or quote any of the organizations and experts considered

primary sources of information about the essential components of community mental health

reform and suicide prevention?

- The National Association of School Psychologists (NASP). For nearly two decades the

    NASP's "best practice" textbooks have been considered the gold standard for crisis

    intervention and postvention involving schools and students. [Yes/No]

•The Suicide Prevention Resource Center. SPRC is the world's largest publisher and repository for evidence-based community programs designed to reduce suicide and suicide attempts. [Yes/No]

•Scott Poland, Ed.D., Nova Southeastern University, Fort Lauderdale, Fla. [Yes/No]

•Stephen E. Brock, Ph.D., California State University, Sacramento, Calif. [Yes/No]

Poland and Brock are the nation's leading experts, academicians, and crisis management consultants for school-based mental health care and suicide prevention. The two are credited as the founding co-authors of the NASP's "best practice" textbooks series, which is required study for school psychologists and counselors as well as school administrators. The two are widely published and quoted on such issues as school crisis response, youth violence, suicide intervention, self-injury, school safety, threat assessment, parenting, and the delivery of psychological services in schools. The two have lectured and written extensively on these subjects and appeared on all major television network news programs. They have presented thousands of workshops in every state and numerous foreign countries. Poland is a founding member of the National Emergency Assistance Team for the National Association of School Psychologists and serves as the Prevention Director for the American Association of Suicidology. Poland also has led multiple national crisis teams following numerous school shootings and suicides and has assisted schools and communities after major terrorism acts. Both are past presidents of the National Association of School Psychologists.

Research Question #3

Does the sample mention or cite any of the following as sources or experts regarding school-based mental health issues?

•The Suicide Prevention Resource Center [Yes/No]

•The National Association of School Psychologists [Yes/No]

•Scott Poland, Ed.D., Nova Southeastern University, Fort Lauderdale, Fla. [Yes/No]

•Stephen E. Brock, Ph.D., California [Yes/No]

It is not by chance that the data points for RQ3 are identical to those for RQ2. The goals and objectives of community-based intervention and school-based interventions are often similar and frequently identical (2003 Commission, 2003, p. 64-65). Community-based prevention efforts typically begin with, and intersect with, prevention programs launched in local school systems. The names and organizations in these four data points are readily available, primary sources for journalists who write about mental illness and suicide from the perspective of schools, the general community, or both.

Research Question #4

Does the sample mention the need for, or significance of, local incidence data as a prerequisite for community intervention systems? [Yes/No]

The importance of a local surveillance system is mentioned in many source documents about community-based mental health reform. It is specifically cited in the U.S. Surgeon General's Call To Action (1999); The National Strategy on Suicide Prevention (2001); and, The President's New Freedom Commission on Mental Health (2003)

Research Question #5

Does the media sample mention "contagion" or the risk of "copycat" suicides?

[Yes/No]

The recent avalanche of research into media coverage of suicide requires journalistic familiarity with suicide contagion theory — what contagion is and what it is not. The theory holds that too much publicity or coverage about suicide can trigger localized outbreaks or clusters of suicide. Concerns about contagion, in turn, have weighed heavily on deliberations among school administrators and school attorneys about the dangers of classroom instruction regarding suicide prevention (Lester, 1990, p. 40-42; Poland, Lieberman, & Cowan, 2006)).

This Research Question searches for textual evidence that stories about suicide reflect an understanding of contagion theory, what it is and what it is not.

Research Question #6

What sources are cited in media coverage about the risks of suicide contagion?

•Local sources only   [Yes/No]

•Scott Poland, Ph.D. (national expert)   [Yes/No]

•Madelyn Gould, Ph.D., Columbia University (national expert)

• Others identified as scholarly experts   [Yes/No]

There are many medical and scientific experts that can provide information about suicide contagion. Dr. Gould and Dr. Poland are the experts most frequently cited in contagion research reports as well as news media reports. Dr. Gould is considered the nation's leading scholar and researcher on contagion theory; Dr. Poland is the leading national expert on how contagion concerns should shape the community/school response to suicide among local youth. There also is considerable consensus in the national source documents that contagion theory is sufficiently

complex, and widely misinterpreted, that media explanations by national experts may be significantly different from the explanations and definitions offered by a local school principal or minister (Tatum, Canetto, & Slater, 2010, p. 390-392).

Sample search criteria

The media sample for this content analysis was taken from the LexisNexis database of mental health-related stories published in both large newspapers and small newspapers over a two-year period, 2010-2012. Samples were pulled randomly from five LexisNexis content categories: mental illness, mental health, suicide, teen suicide, and suicide prevention. The LexisNexis sorts print media stories into "major" or "small town" newspapers, based upon audited circulation data published in the annual Editor & Publisher Year Book.

Searching both large and small newspapers for stories in the five subject categories (mental illness, mental health, suicide, teen suicide, suicide prevention) produced a total population of more than 6,300 possible print media articles, as shown in Table 3.1.

Table 3.1

Population of Qualified Media Samples

	Major newspapers	Small Newspapers
Mental health	999	323
Mental illness	1,000	157
Suicide	1,009	180
Teen suicide	2,808	25
Suicide prevention	120	21
Total qualifying samples	**5,936**	**706**

From the total qualifying population of 6,642 print media articles, 200 were randomly selected for coding using the19 data points generated by the six research questions. A coding sheet was constructed to sort the 200-story sample according to newspaper size as well as type of story. Story type was broken into three groupings:

- Episodic — "Hard news" stories, which are generally given immediate but superficial attention and typically do not involve in-depth or investigative reporting. Examples would include stories that report recent statistical trends in mental illness or suicide, or the declaration of a local "awareness week."

- Thematic — In-depth feature stories or investigative stories that typically require lengthy preparation by the author. Examples might include a feature story, or series of stories, examining the overall quality of mental health care in a community. Such stories typically seek out mental health scholars and experts to address "why" and "how" questions about trends in mental illness or suicide.

- Editorial Commentary — Commentaries, typically found on newspaper editorial and "op-ed" pages. These may by unsigned institutional editorials that represent an official viewpoint of the newspaper's management or bylined commentaries that represent the opinion of an identified editorial writer or columnist.

Raters indicated little difficulty in coding articles by story type. All were student journalists. All were tutored by the author to understand the distinction between "hard news" (episodic), in-depth or investigative reporting (thematic), and editorial commentary. Additionally all news articles from LexisNexis lists the article's word count as well as its headline, which gives the user a rough indication of the story type when choosing random samples. For example,

an article of 1,000 or more words is more likely to be a thematic story than an article of 400 words or less.

The training of coders (student journalists) involved an in-depth review of media story types in order to ensure that all coders had the same understanding of the three story types (see Appendices B, C and D for examples of samples used). A St. Louis story about funding for local mental health services and a Topeka story about a murder-suicide were used as examples of episodic coverage. A *New York Times* magazine article about suicide and a Cincinnati story about how teenagers can save the lives of suicidal friends were used as examples of thematic or in-depth coverage. A commentary from a Lawrence, Mass., newspaper was among the examples used to demonstrate editorial samples.

The RQ data points along with the search criteria for newspaper size and story type led to the design of a one-page coding instrument (Appendix A). Each code sheet contained the coder's name and date, the newspaper name, the story headline, and Yes/No checkboxes to indicate whether the article was pulled from the LexisNexis list of "major" newspapers or the LexisNexis list of "small town" papers. The coder's initials also were recorded directly onto each newspaper sample for later reference if needed. Before proceeding to coding the targeted sample of stories, the conducing instrumented was tested for coding reliability and agreement.

Testing the coding instrument

SPSS Statistics was the software was used to measure intracodal and intercodal agreement. Such analysis affirms (or rejects) a necessary measure of reliability and agreement in how each rater applies and interprets the code sheet criteria. All coding criteria (data points) in agreement are divided by the total number of criteria. The resulting figure is a range from 0 to

1.00, with the larger values indicating better reliability. Generally, an agreement of .70 is considered acceptable; .80 is considered very good.

Coding tests were conducted using a set of news articles taken from both large and small newspapers. Intercodal testing was conducted using a group of volunteers (Kansas State University journalism students). Two teams of five raters each were given samples to code. In one test, all 10 coders were given the same article to code. In the second test, Team 1 members coded one article while Team 2 members coded a different article. The project author also coded the same articles given to the two teams. All tests, by the coding teams and the project author, produced an intercodal agreement of .9 or higher across all Research Questions. The code sheet and search criteria were then used to create a research sample of 200 newspaper articles. All 200 code sheets were gathered and the results entered into an SPSS Statistics file. The SPSS file was formatted according to the data variables and field headings of the coding instrument. All coding data was entered by the author and then re-checked by a member of the volunteer coding team.

Description of the coded sample

The code sheet, along with the search criteria regarding newspaper size and story content, produced a sample of 200 newspaper stories with the following characteristics:

Table 3.2

Composition of Coded Media Sample by Circulation Size

	Frequency	Percent	Cumulative Percent
Small Town Papers	108	54.0	54.0
Major Papers	92	46.0	46.0
	200	100.0	100.0

Table 3.3

Composition of Coded Sample by Type of Story

	Frequency	Percent
Thematic	75	37.5
Episodic	82	41.0
Editorial	43	21.5
Total	200	100.0

The sampling approach used for this project made it possible to obtain data to address the overall research question regarding the media's familiarity with the national standards and protocols for reducing mental illness and suicide. This research project, as stated in the title, had a single purpose defined as the sum of two parts (1) media familiarity/knowledge, and (2) mental illness/suicide.   It is possible to find evidence of such media familiarity in a lengthy investigative article, a brief piece of episodic reporting, or an editorial commentary. Additionally, the five LexisNexis content categories (mental health, mental illness, suicide, teen suicide, suicide prevention) span the spectrum of language and terminology common to most stories about mental illness or suicide prevention. It is possible that the five LexisNexis content categories chosen for this study do not include every newspaper article containing the words "suicide" or "mental illness." Some stories may focus on other issues while making only technical or passing reference to mental illness or suicide. This content analysis vetted print media coverage that focused directly on the actions of suicidal or mentally persons as well as the overall public health

challenges presented by mental illness and suicide. Lastly, the balanced distribution of major

newspapers and small newspapers allowed for the fact that learned, enterprising news reporting

takes place at newspapers large and small. Numerous Pulitzer Prizes have been awarded to

newspapers and journalists whose paid subscription base would be considered "small" by

LexisNexis and other newspaper databases.

Chapter 4: Results

This chapter examines the results from the six original research questions.

Research Question #1

Does media coverage of mental health and/or suicide make any reference to any of the four national consensus reports that have established the criteria for community mental health reform and suicide prevention?

- 1999 U.S. Surgeon General's Call To Action

- 2001 National Strategy on Suicide Prevention

- 2003 President's New Freedom Commission on Mental Health

- 2012 National Strategy for Suicide Prevention

This does not mean that the author of the sampled stories failed to consult credentialed experts regarding community-based intervention. It simply means there is no textual evidence in the sample to indicate author familiarity with these major source documents.

Table RQ1.1

1999 Surgeon General's Call To Action

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	2	1.0	1.0	1.0
No	198	99.0	99.0	100.0
Total	200	100.0	100.0	

Table RQ1.2

2001 National Strategy on Suicide Prevention

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	1	.5	.5	.5
No	199	99.5	99.5	100.0
Total	200	100.0	100.0	

Table RQ1.3

2003 President's New Freedom Commisson on Mental Health

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Table RQ1.4

2012 National Strategy for Suicide Prevention

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	4	2.0	2.0	2.0
No	196	98.0	98.0	100.0
	200	100.0	100.0	

Research Question #2

Do journalists reporting on mental health or suicide seek out the recognized primary

sources of information regarding general community-based interventions?

- •National Association of School Psychologists (NASP)

- •Suicide Prevention Resource Center

- •Scott Poland, Ed.D., Nova Southeastern University

- •Stephen E. Brock, Ph.D., California State University.

As with RQ1, only a handful of the media samples made reference to the primary sources listed as criteria or data points. Sampled stories that mentioned community or school-based intervention tended to rely upon statements by local community officials or other mental health experts identified independently by the author of the story. Story text did not compare the statements of those persons with the protocols outlined in the best-practiced standards.

Table RQ2.1

National Association of School Psychologists

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	3	1.5	1.5	1.5
No	197	98.5	98.5	100.0
	200	100.0	100.0	

Table RQ2.2

Suicide Prevention Resource Center

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	3	1.5	1.5	1.5
No	197	98.5	98.5	100.0
	200	100.0	100.0	

Table RQ2.3

Scott Poland, Ph.D.

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Table RQ2.4

Stephen Brock, Ph.D.

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Research Question #3

Do journalists writing about mental illness and suicide among young persons seek out the primary source of standards developed for schools and universities?

- National Association of School Psychologists (NASP)

- Suicide Prevention Resource Center

- Scott Poland, Ed.D., Nova Southeastern University

- Stephen E. Brock, Ph.D., California State University

As with RQ1 and RQ2, only a few of the media samples cited or referenced the major sources of school-based intervention. This finding is of interest because school-based mental health intervention typically requires the involvement of certified school psychologists. It would be rare to find an elementary or secondary school whose psychologists were not certified by, and members of, the National Association of School Psychologists (NASP). The NASP for decades has been the sole developer and publisher of best-practice standards in school crisis management, suicide prevention, and mental health screening.

The likely explanation for this is that schools and school districts employ a wide range of educators, administrators, and counselors who present themselves to the media as qualified experts on such issues as at-risk children, suicidal children, crisis management after a suicide, etc. Rather than used nationally standardized protocols, most American schools develop their own procedures for suicide prevention or postvention (the clinical term for crisis response or post-tragedy intervention). Only journalists with advanced knowledge and expertise on these

subjects would find reason to question whether a school's established policies comply with, or conflict with, national best-practice guidelines. For many reporters and many stories, information and comments provided by local school personnel would be considered sufficient research.

Table RQ3.1

National Association of School Psychologists

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	3	1.5	1.5	1.5
No	197	98.5	98.5	100.0
	200	100.0	100.0	

Table RQ3.2

Suicide Prevention Resource Center

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	4	2.0	2.0	2.0
No	196	98.0	98.0	100.0
	200	100.0	100.0	

Table RQ3.3

Scott Poland

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Table RQ3.4

Stephen Brock

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Research Question #4

Does media coverage of mental health and/or suicide cite the need for community surveillance/tracking as frequently cited in the nationwide studies?

Twenty-six news stories contained text that cited the lack of local suicide death statistics and/or mental illness incidence in community populations. The stories were evenly balanced between large and small newspapers. There was no significance difference in the circulation size of newspapers where such stories appeared (see Table RQ4.2).

It is perhaps of little surprise that this research question was addressed more than another other of the six research questions. Statistics and numbers are the bread and butter of news journalism. Statistics and statistical trends are routinely presented as useful and newsworthy regardless of context or completeness. Most suicide statistics published by the news media represent national or statewide incidence, which have little relevance to suicide trends in a specific city or county. Stories that mentioned the lack of local suicide data did so with little discussion about the significance or need for collecting such information.

The suicide tracking system in Washington County, Oklahoma, was among the few local surveillance systems identified in the news sample search. The system was established after a series of media reports that the community suicide rate was twice the national average. In a July 1, 2012 article in the *Bartlesville Examiner-Enterprise*, a spokesman for the county health department called the local data "staggering" and vowed that a real-time suicide surveillance system would be up and running within the week. "With the data," the spokesman said, " we will be able to look for trends. Hopefully, we might be able to save lives."

Table RQ4.1

Need for surveillance data

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	26	13.0	13.0	13.0
No	174	87.0	87.0	100.0
	200	100.0	100.0	

Table RQ4.2

Cross-tab: Need for data according to newspaper size

	Data Needed Yes	Data Needed No	Total
Small papers	12	96	108
Large papers	14	78	92
	26	174	200

Research Question #5

Do media reports about suicide mention "contagion" or "suicide contagion"

(sometimes mentioned in discussions of "copycat" suicides) as a potential health threat

created by media coverage of suicide?

The few mentions of contagion are somewhat surprising given that more than half of

the sample population consisted of sources about suicide or suicide prevention. On the other

hand, suicide contagion research has consistently found a lack of knowledge about

contagion among the news media. Thus, it is unlikely a journalist will ask or write about

contagion unless the topic is specifically raised by a news source.

Table RQ5.1

Mention of suicide contagion or copycat effect

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	4	2.0	2.0	2.0
No	196	98.0	98.0	100.0
	200	100.0	100.0	

Research Question #6

In stories that discuss suicide contagion theory, do the media seek out recognized national experts on this topic or do the media rely upon explanations from persons of unknown expertise?

The frequency result for RQ6 is unsurprising, given that only four media samples addressed the issue of contagion. Of the four samples that referenced contagion, none quoted or referenced Dr. Gould or Dr. Poland, the nation's two leading experts on the subject. The authors of the four stories turned to other suicide experts for information about contagion.

Table RQ6.1

RQ6 Madelyn Gould/national expert

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Table RQ6.2

RQ6 Scott Poland/national expert

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	0	0	0	0.0
No	200	100.0	100.0	100.0

Table RQ6.3

RQ6 Other national experts on contagion

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	2	1.0	1.0	1.0
No	198	99.0	99.0	100.0
	200	100.0	100.0	

Table 6.4

RQ6 Local non-expert sources

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	2	1.0	1.0	1.0
No	198	99.0	99.0	100.0
	200	100.0	100.0	

Chapter 5: Discussion and Conclusions

This project yielded no evidence of media familiarity with nationally accepted norms regarding community mental health care. More specifically, content analysis of 200 media samples found only random reference to the accepted tenets of modern community mental health care as found in primary source documents. A small number of samples (<14%) mentioned the lack of local data needed to measure the severity and frequency of suicide. The text of such stories offered no indication as to whether local data was unavailable or simply not pursued by the story author. Nor did such articles mention the significance of such data as a critical component of local suicide reduction efforts, which was among he unanimous findings common to all four of the national consensus studies. In addition, the media sample presented virtually no mention of the four major national reports (RQ1) or the stature of these documents as scientific standards, principles, norms, tenets, benchmarks or litmus tests.

While many of the samples dealt with suicide, only four mentioned suicide/media contagion. This finding is surprising given the considerable volume of existing research intended to educate journalists about the risks of media-induced suicide clusters. On the other hand, the scare references to contagion offers perhaps further evidence of the failure of research-based campaigns designed to change how the news media reports and depicts suicide deaths. Contagion research, its successes and failures, represents this study's primary point of departure from existing research. While there exists legitimate concern about community publicity that romanticizes suicide or glorifies its victims, there is reasonable concern that suicide contagion theory has been given attention far beyond its usefulness, or significance, as a vehicle for expanding media understanding of mental illness and suicide. Suicide contagion, a contested explanation for a small percentage of all suicides, leaves unaddressed the broader and more problematic question addressed by this research investigation: What is the news

media's level of familiarity with nationwide norms for community mental health care and suicide reduction systems? Put in other words: Does the media's current mental health acumen enable it to distinguish communities using evidence-based systems from communities using unproven methods — thereby enabling media consumers to make the same distinctions.

Despite this study's limitations, a number of conclusions are possible about the content analysis results. It is possible, for example, that the coding instrument was overly restrictive or exclusionary in the selection of criteria used to measure media familiarity. This would explain the small number of samples, across all research questions, containing any mention of the criteria data points. The study could be repeated with different sets of criteria, and various criteria combinations. However, there may be implicit defects in the assumption that media competence — on any issue — can be justly evaluated by content analysis alone. The demands of time and urgency require journalists to summarize and condense their research methods and findings. The demands of such work leave journalists fiercely protective of their right to choose sources and facts as they see fit.

Eschewing "episodic" stories would be a reasonable correction to the methodology used in this analysis. Coverage of hard news and breaking stories, by definition, does not offer time or space for complex journalistic investigation. A sample comprised solely of thematic or in-depth stories might generate a population of media samples more commensurate with the goals of this research. Media expertise is best revealed by stories that demand expertise. Narrowing the search to thematic stories published by the nation's 20 or 30 largest newspapers might provide the best gauge of media expertise, by examining the expertise of media outlets most capable of applying expert resources.

Other possible explanations for the findings of this investigation:

• While there are many trade and specialty health-relation publications, few journalists in the print media specialize in health care, let alone mental health coverage. This may change in the coming years as journalists — print, broadcast, and Internet —re-examine their understanding of the issues underlying the nation's recent series of horrific mass shootings. Some in the profession argue that the media's future — and its relevance — rests with the ability of the nation's journalism schools to produce fewer generalists and more specialists — reporters with advanced expertise in health, science, the law, the environment, and technology, and (USC/Annenberg, 2011).

• This investigation employed textual analysis criteria regarding the sources and source documents utilized in mental health coverage. News stories, unlike academic dissertations, do not use footnote and bibliographic documentation. Journalists present readers with thumbnail sketches, of a story, with sources and citations randomly cited. The most in-depth treatment of major issues is found in the nation's top tier of major newspapers, magazines, and broadcast media. A case could be made that useful content analysis of media expertise should start with those media most equipped to provide highly informed, specialized reporting.

• The nation's long and conflicted battle against mental illness notwithstanding, it may be premature to form judgments about the mass media's ability to explain such a complex issue using existing journalism methodologies. Recent national tragedies have dramatically increased media attention on the connection between psychopathic violence and the failure of community mental health care. Yanovitkzky research indicates that the media's track record on other social issues demonstrates the long passage of time required for social reformers to fully influence media coverage, and for media coverage,

in turn, to impact long-term public policy. Those pursuing social change, Yanovitkzky

says, must first pursue the media's attention, patiently and fastidiously convincing the

media to frame the issue in a manner that compels policymakers to respond.

•More than two decades of contagion research may have backfired. Rather than expand

media understanding of mental illness and encourage more meaningful reporting of

suicide and its causes, the ceaseless warnings about media-induced suicide clusters may

have had a chilling effect on the media's willingness to vigorously pursue suicide as a

public health issue. There is palpable irony in the notion that scientific research designed

to reduce suicide may actually have interfered with suicide prevention efforts by stifling

public discussion or community intervention. A casual Internet search produces countless

examples of bitter debate between students and school administrators regarding the

proper response to student suicides. Among the source of such controversies is the

refusal to permit public or permanent memorials (tree markers, yearbook pages, etc.) for

students who die by suicide (see Appendix B). The ban on such memorials is standard

text in school crisis management procedures, which typically cite the risk of suicide

contagion as the basis for bifurcated crisis response procedures — one set of protocols

for suicides and a separate set of protocols for all other student tragedies.

Future Research

This investigation was a first attempt to measure media competence in the coverage of

mental illness and suicide. The measurement criteria (the RQ data points) were taken from

defensible but admittedly subjective conclusions regarding primary sources of information that

ought to inform and direct media coverage regarding standards for treating the mentally ill and

preventing suicide. Applying the principle that framing swings both directions — from media to

public and back again — the possibilities are many for future research into media coverage of

mental health and suicide. Future research might replicate the methodology using other criteria

suitable for content analysis. Such research would then be repeated with yet other criteria until

the accumulated findings are sufficient to warrant broad conclusions about media competence.

Such research, however, would remain vulnerable to arguments about media economics and

structure. Media coverage of major issues is frequently the work of news generalists who face

the daily challenge of educating readers about complex issues on behalf of an industry with a

limited history of personnel specialization. Only at the largest of the large American newspapers

does one find highly trained journalists with full-time responsibility for a singular topic. Where

such specialists are found, the assignment boundaries are broadly drawn — the courts, crime,

science, education, technology, health, etc.   This author's Internet searches provided no data on

the number of media outlets whose mental health coverage is provided by full-time mental health

specialists. Replication of this investigation using other textual criteria would expand knowledge

and understanding of the media's performance in coverage of major public health issues. Lack

of specialization notwithstanding, community journalists know how to obtain facts about a local

arson fire or a contaminated water supply. Often, the journalist's toil is rendered effortless by

media-savvy organizations that engage professional communicators charged with installing

information management protocols to meet the information needs of local media and local

residents. The timely release of such information serves the publishing needs of the media and

the risk-protection needs of local residents. It would be difficult to find an American community

not served by such public health alert systems — be it for a measles outbreak among local

schoolchildren, reports of food poisoning at a popular eatery, or the imminent threat of tornadoes

and hail storms.   It also would be difficult to find an American community whose public alert

systems involved outbreaks of suicide or the needs of the gravely mentally ill. In most communities, such information exists but is not available; all too often, local news media never ask why.

More meaningful research would take a page from Yanovitsky's "attention" research and clearly identify those persons, sources, agencies, institutions with the greatest motive to influence media framing of mental health problems and available solutions. Such research would avoid national experts and generalized findings about the quality of mental health care nationwide. Rather, qualitative and quantitative inquiry would focus on the situs of mental health care delivery as mandated by existing public policy: American communities.   A small number of communities would be sorted into two groups, using search criteria drawn from prevailing standards for evidence-based interventions. The two community groups would be labeled "mental health success" and "mental health failure." A methodology would be constructed to search for relationships between media coverage and mental health success, between media coverage and mental health failure. Media coverage content analysis, focus group research, and attitude surveys would be designed with the singular focus of identifying those community forces that most frequently influence — or attempt to influence — local media reporting about mental illness and suicide. Particularly attention would be given to community forces that control the universe of information available to the local media about mental illness and suicide. Such a list would include community mental health care providers, local medical examiners, local legislators, school administrators, and local mental health activists. The greatest challenge of such research would be the difficulty of identifying a sufficiently complete list of individuals and agencies with a significant stake in the local media's framing of "success" and "failure." Needless to say, those with the greatest motivation to influence media framing

will include those most likely to be held accountable for success and failure — generating a list of individuals potentially too numerous to manage with traditional focus-group techniques. In accordance with Yanovitsky's theory about the length of time required to win and retain media attention, identification of accountable parties would consider each individual's tenure and history as a local influence on mental health care policy. The research findings and cross-tabulations would look for relationships between: (a) media framing and mental health success; (b) media attention/credibility accorded to specific community officials and long-term media framing of mental health issues; (c) media framing and media attention paid to non-community sources.

Media messages, media attention

A more precise understanding of mental health coverage may result from research that reaches beyond mere identification of what exists in order to focus attention on what should exist. Ample precedence for such an approach is found in the extensive history of scholarly research into suicide contagion, the theory that localized suicide clusters can be directly traced to reckless local media coverage. Prior to the late 1990s, contagion research was couched in largely empirical terms, with the stated purpose of describing media coverage before and after local suicides. More recent contagion research involves the testing of various strategies designed to *change* media coverage of suicide. The media's predictable indifference to such research efforts can be understood by the apparent pointlessness of asking journalists to exercise restraint in covering tragedies (imitative suicides) that rarely occur and cannot be documented until long after media interest has ceased. Rather than focus on coverage to be avoided, more useful research would attempt to identify current impediments to meaningful coverage of mental health and suicide.   Such research would require a blend of media content analysis and media focus

groups to determine the types of information that would stimulate media understanding of the problems and solutions regarding mental illness and suicide. For example, what impact would community-based surveillance data have on media attention to mental illness and suicide? How would local media react to real-time reports on the number of mentally ill persons in the community, the number of suicides by age group, or the number of persons requiring inpatient mental health treatment v. the community's supply of inpatient hospital beds? Communities and states currently wage campaigns to prevent all kinds of accidents and diseases that afflict far fewer people than do mental illness and suicide. Yavinsky's chronicle of the nation's auto safety movement suggest that the media coverage of mental health issues might be dramatically enhanced by a long-term campaign that delivers singular, coherent messages about the lack of meaningful mental health and suicide data. As noted in Yavinsky's analysis of the auto safety movement, it is worthwhile to consider the merit of content-analysis research that narrows the mental health message to *lack of data*. Such research would force journalists to consider "why" questions rather than accept "what exists" explanations. One can only imagine the sparkling repartee among journalists participating in a focus group discussion about the likelihood of saving countless mental health victims in if no one is counting them.

Lastly, the literature review indicates that American schools have long been urged to take a leading role in the battle against mental illness and suicide. Until their college years, many young people spend more time at school than they do at home, or so it is claimed. What, then is the obligation of schools to identify and protect children presenting signs of depression, suicidal thought, or various behavioral disorders? What community forces most directly influence the decision by school administrators to install evidence-based systems for early detection and screening of troubled students? Here, too, it would be worthwhile to use a methodology that

seeks similarities and differences between communities considered a "success" in reducing suicide and those that have failed to take action. The Suicide Prevention and Resource Center maintains a registry of evidence-based suicide prevention programs, which can be used to identify schools that have implemented such initiatives and those that have not. Criteria would be established to evaluate the history of local media attention to mental illness and suicide in "success" communities as well as "failure" communities. Where correlations are found between media coverage and mental health "success," focus group research and media interviews would be conducted to identify what community or national forces have historically influenced local media attention to mental illness and/or suicide.

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Appendix A— Code Sheet

Mental Health Stories/Code Sheet

Rater Name & Initial				
Publication Name				
Publication city/state				
Publication Date				
Story Headline				
Circulation Size				
Large				
Small				

Story Type	Yes	No		
Thematic coverage				
Episodic coverage				
Editorial commentary				

Choose ONLY ONE story types

Thematic = Feature story. A piece that goes into the overall issues of mental health, mental illness, suicide....addressing problems and solutions

Episodic = A straightforward hard news story. A report about an actual suicide death. A story about some agency cutting funds for the mental health department

Editorial -- An article clearluy labeled as an opinion or commentary. An individual's opinion or the newspaper's official editorial opinion.

RQ1 National Reports & Standards	Yes	No		
1999 US Surgeon General Call to Action				
2001 National Strategy on Suicide Prevention				
2003 President's Commisson on Mental Health Reform				
2012 National Strategy for Suicide Prevention				

RQ2 GENERAL COMMUNITY Action	Yes	No		
Nat'l Assn School Psychologts (NASP)				
Suicide Prev Resource Center (SPRC)				
Scott Poland				
Stephen Brock				

RQ3 SCHOOL-based response to mental health and suicide prevention	Yes	No		
Nat'l Assn School Psychologts (NASP)				
Suicide Preven Resource Center (SPRC)				
Scott Poland				
Stephen Brock				

RQ4 Citation of LOCAL data; NEED for local data	Yes	No		
Does story identify LOCAL mental illness/suicide data; the need for such DATA				

RQ5 Text addressing SUICIDE CONTAGION	Yes	No		
Does story discuss the threat of copycat suicides or suicide contagion?				
If RQ5 is "No" then all RQ6 = NO				

RQ6 Suicide Contagion SOURCES cited	Yes	No		
Local sources only				
National sources/experts				
Madelyn Gould				
Scott Poland				

Appendix B — Episodic story samples

St. Louis Post-Dispatch

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$7 million more in mental health funding could go to St. Louis County children

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14 hours ago · By Nancy Cambria nancy.cambria@post-dispatch.com 314-340-8238

The St. Louis County Children's Fund hopes to award an additional $7 million in grants next year and will revamp some of its strategies after the release Wednesday of a $250,000 needs assessment.

The assessment found that bullying, substance abuse, and disruptive and disrespectful behavior still pervade St. Louis County public and private schools despite numerous school-based programs supported by the Fund. More than 10 percen of children surveyed said they had seriously contemplated suicide.

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Victims Identified In Topeka Double Murder-Sui

Sunday, April 14, 2013

Police say three people whose bodies were found inside a Topeka home died in an apparent double murder-suicide.

Police said Saturday in a news release that "there is no threat to the publi

Police identified the victims as 36-year-old Shawna Solis, 40-year-old Antwan Muhammad and 37-year-old Howard Givens.

Police didn't say who was suspected of pulling the trigger. The shooting w reported around 9:15 p.m. Friday. The officers who rushed to the home found three gunshot victims, and police said all three were pronounced dead at the scene.

Appendix C — Thematic story samples

NEWS ANALYSIS
Suicide, With No Warning

By ELISABETH ROSENTHAL
Published: March 8, 2013

TO his large, loving family and many friends, Kerry Lewiecki was an optimist and problem-solver, with a big laugh and impressive hugs. Early in the summer of 2010, he graduated from the University of Oregon with dual degrees in law and conflict resolution; invitations went out for his August wedding to his longtime girlfriend.

Then, just a few weeks later, within the span of a few hours, he bought a gun and shot and killed himself, at age 27. His father, Mike, a doctor in Albuquerque, who still chokes up when he recalls that

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Teen suicide on the rise - how can you prevent it?

Posted: Nov 16, 2010 12:43 PM CST
Updated: Nov 23, 2010 6:29 AM CST
By Trina Edwards - email

By Tricia Macke – bio | email

CINCINNATI, OH (FOX19) - There is a growing trend in the United States that we don't like to talk about, b we don't talk about it, we can't do anything to stop it.

Jay Triggs had the world at his fingertips. He was 19 years old, and graduated from Turpin High School in 2007. He was a college student, a popular kid, had girlfriends, a stud on the football field and an 'A' student He was someone everyone wanted to be around.

"He was a good kid, he was easy to talk to, fun to watch, playing, whatever he got involved in playing he pu his all into it," said his mother, Elisia Triggs.

Elisia didn't see the warning signs. After searching for a reason why Jay would kill himself, Elisia looked to hindsight as 20/20. He did get upset easily and lost his temper quickly.

But Elisia never thought her son would commit suicide until the morning of Sept. 19, 2009 and a text messa

Appendix D — Editorial commentary sample

Eagle-Tribune

Lannan Mazda
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March 26, 2013

Editorial: Set rules now on mental health parity

The Eagle-Tribune

Nearly five years ago, Congress passed the mental health parity law that requires coverage for mental health treatment be equal to that for medical and surgical care.

Almost immediately, insurance and employer groups fought against the specifics of implementation just as hard as they fought for 10 years against the law itself.

Consequently, the Obama administration has slowed down any progress on regulations to a snail's pace. And even with new studies and re-emerging news reports of the inadequacy of coverage for those with mental illness, the White House says it still needs yet another year to finalize the rules.

This is scandalous.

Appendix E — Suicide memorial controversy
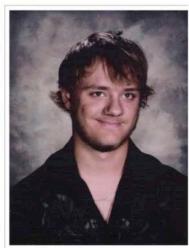
15
Oct
2012
:33pm, EDT

High school: No yearbook memorial for student who committed suicide

By Andrew Mach, NBC News, Staff Writer, NBC News

Officials at a high school in Minnesota are drawing the ire of more than a hundred of its students and parents for refusing to memorialize in its yearbook a student who committed suicide.

Kyle Kenyan would have been a senior this year at Menagha Public School in Menagha, Minn., but he committed suicide on Jan. 8. When word got out that school staff wouldn't memorialize the teen in this year's yearbook due out in May 2013, classmates started a petition to appeal their decision.

Even though this year's senior class has less than 50 students, about 100 students throughout the rest of his school have signed the petition to get a memorial page in their yearbook, something his mother, Peggy Haynes, would also like to see

right to right," Kyle's mother, Peggy Haynes, told NBC News. "My main concern is the kids, and I want to stand up for the injustice that goes to Kyle's classmates, the class of 2013."

But Menahga Public Schools Superintendent Mary Klamm said the school district's policy on the issue is clear and firm.

"Long before Kyle's death, we made the decision not to include memorials in our K-12 yearbook while we were updating our crisis manual," Klamm told NBC News.

During that process, we took a lot of time to decide how to properly respond to the death of a student or faculty member, and we were recommended not to memorialize suicide because of the possibility of copycats. That's our biggest fear."

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