



Suicide in Montana

Facts, Figures, and Formulas for Prevention

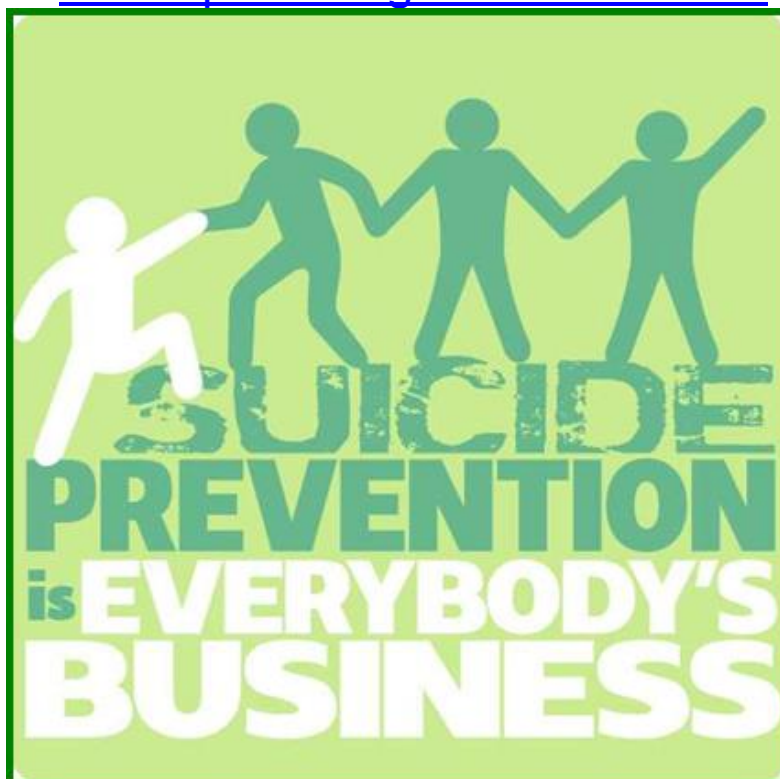
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“Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.”

**Kay Redfield Jamison, Ph.D.
Professor of Psychiatry
Johns Hopkins University**

“Night Falls Fast: understanding suicide”, pg. 24

Suicide Fact Sheet

Source: Center for Disease Control – WISQARS website, <http://www.cdc.gov/injury/wisqars/index.html>, (December, 2015), 2014 National Vital Statistics Reports (January, 2016)

- ❖ For the first time, suicide has surpassed car accidents as the No. 1 cause of injury-related death in the United States. There has been a 28% increase in the number of suicides in the United States since 2001. (CDC, 2015)
- ❖ In 2014 there were **42,773 suicides in the U.S.** (117 suicides per day; 1 suicide every 12 minutes). This translates to an annual **suicide rate of 13.4 per 100,000.**
- ❖ Suicide is the tenth leading cause of death.
- ❖ Males complete suicide at a rate four times that of females. However, females attempt suicide three times more often than males.
- ❖ Firearms remain the most commonly used suicide method, accounting for 50% of all completed suicides.
- ❖ Up to 45% of individuals who die by suicide visit their primary care provider within a month of their death, with 20% of those having visited their primary care provider within 24 hours of their death
- ❖ Those suffering from chronic pain are 3 times the risk of suicide.

Suicide among Children

- ❖ In 2014, **428 children ages 5 to 14 completed suicide in the U.S. (increase from 395 in 2013)**
- ❖ Suicide rates for those between the **ages of 5-14 increased 60%** between 1981 and 2010.

Suicide among the Young

- ❖ Suicide is the 2nd leading cause of death among young (15-24) Americans; only accidents and homicides occur more frequently. In **2014, there were 5,079 suicides by people 15-24 years old** (increase from 4,878 in 2013)
- ❖ Youth (ages 15-24) suicide rates increased more than 200% from the 1950's to the mid 1990's. The rates dropped in the 1990's but went up again in the early 2000's.
- ❖ Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- ❖ Within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- ❖ *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- ❖ The biggest factor associated with adolescent suicidal ideations is parental disconnect (not feeling validated or accepted by their parents)

Suicide in our LGBT youth

Source: The Trevor Project (www.thetrevorproject.org)

- ❖ LGB youth are **4 times** more likely, and questioning youth are 3 times more likely, to attempt suicide as their straight peers.
- ❖ Nearly **half** of young transgender people have seriously thought about taking their lives, and one quarter report having made a suicide attempt.
- ❖ LGB youth who come from **highly rejecting families are 8.4 times** as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.
- ❖ Each episode of LGBT victimization, such as physical or verbal harassment or abuse, **increases the likelihood of self-harming behavior by 2.5 times** on average.

Suicide among our Veterans

Source: Source: Kemp & Bossarte, R, Suicide Data Report, 2012 (2013), Department of Veteran Affairs

- ❖ The VA estimates the suicide rate for young veteran men between the ages 18-29 is around 56 per 100,000 (compared to 20 for non-vet males 18-29)
- ❖ In the US, a veteran dies by suicide every 65 minutes, 22 a day, or over 8,000 suicides a year.
- ❖ The suicide rate for the Army is 20 per 100,000, compared to 12 for the nation.
- ❖ Between 2004 and 2013, there were 566 suicides by Montana veterans of all ages (Office of Epidemiology and Scientific Support, Montana DPHHS, August, 2014), which gives Montana veterans an estimated rate of 54 per 100,000

Suicide among College Students

- ❖ It is estimated that there are more than **1,100 suicides on college campuses per year**.
- ❖ **1 in 12** college students has made a suicide plan (**2nd leading cause of death**)
- ❖ In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
 - **9.5% of students had seriously contemplated suicide.**
 - An estimated **24,000 suicide attempts** occur annually among US college students age 18-24 (JAMA).

Source: American Association of Suicidology webpage. <http://www.suicidology.org/web/guest/stats-and-tools/statistics> , May 24, 2010, Journal of the American Medical Association (2006), Vol. 296, No. 5

Suicide among the Elderly

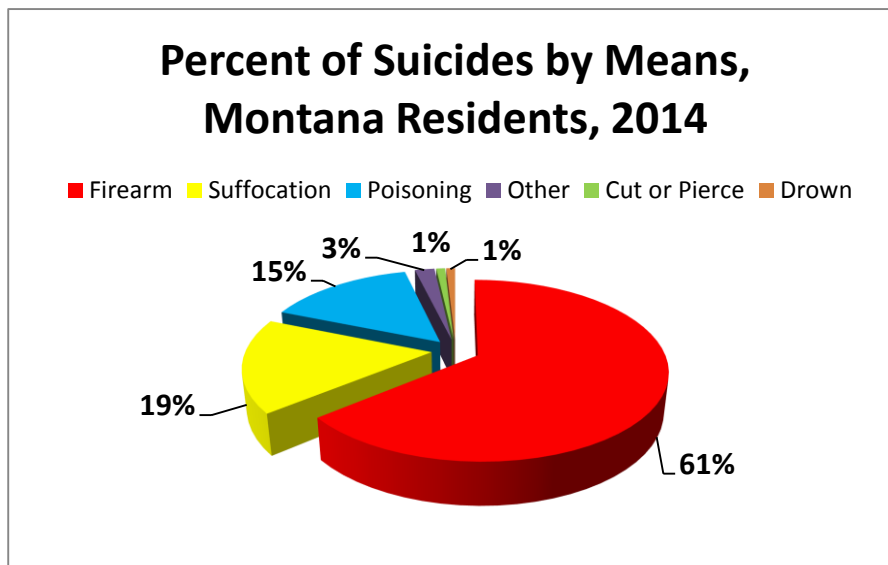
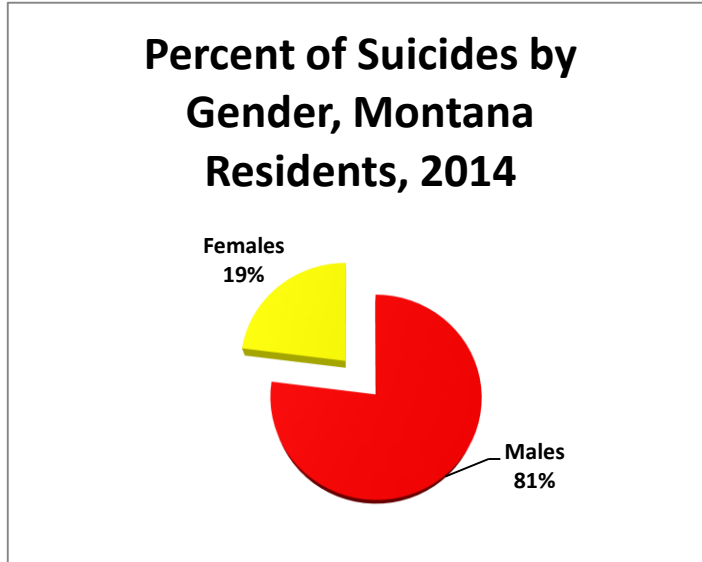
- ❖ In 2014, 7,693 Americans over the age of 65 died by suicide for a rate of 16.6 per 100,000
- ❖ The rate of suicide for women typically stabilizes after age 64 (after peaking in middle adulthood)
- ❖ 85% of elderly suicides were male; the rate of male suicides in late life was 7 times greater than for female suicides.
- ❖ White men over the age of 85, who are labeled “old-old”, were at the greatest risk of all age-gender-race groups. In 2014, the suicide rate for these men was 54.4 per 100,000.
- ❖ Elders who complete suicide:
 - 73% have contact with primary care physician within a month of their suicide. Nearly half of those people visited with their primary care physician within **two weeks** of their suicide.

Suicide in Montana

Data Source: 2014 National Vital Statistics Reports (January, 2016), Montana Office of Epidemiology and Scientific Support (January, 2016), Montana Youth Risk Behavior Survey (July, 2015)

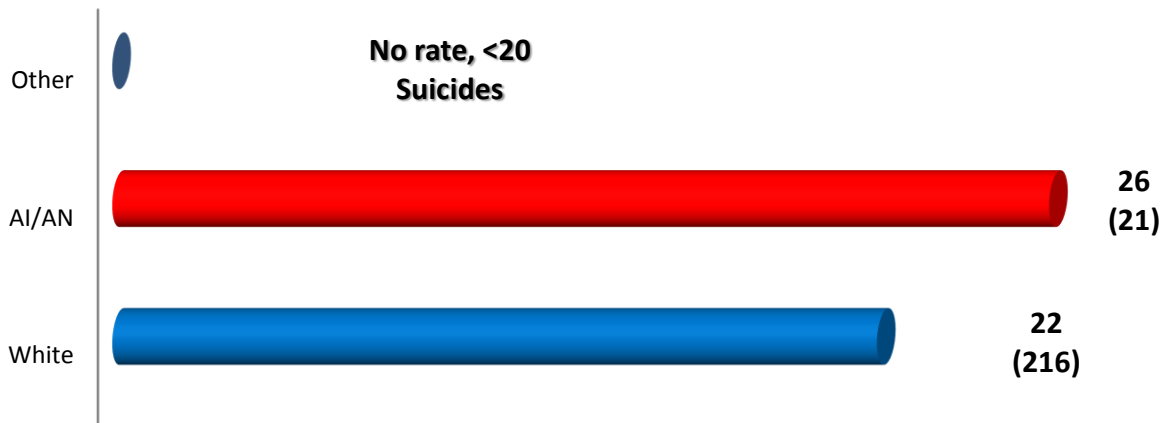
- ❖ For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past thirty years. **[In a report for 2014 in the National Vital Statistics Report, Montana has the highest rate of suicide in the nation](#)** (251 suicides for a crude rate of 24.5)
- ❖ In Montana, the highest rate of suicide is among American Indians (28 per 100,000) although they only constitute 6% of the state’s population. Caucasians are second at 24 per 100,000.
- ❖ Firearms (59%), suffocation (19%), and poisoning (16%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.

- ❖ In Montana in 2014 there were 11 youth suicides (ages 11-17). This is double the national rate for the same age group. [Over the ten years 65% of the youth suicides were completed by firearms.](#)
- ❖ According to the 2015 Youth Risk Behavior Survey, during the 12 months before the survey, 8.9% of all Montanan students in grades 9 through 12 had made a suicide attempt and 11.6% of 7th and 8th graders. For American Indian students, 15.6% had attempted suicide one or more times in the twelve months before the survey.
- ❖ Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- ❖ Over the past ten years suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-44.
- ❖ Studies show that for every completed suicide, there are 6 survivors. Given there are approximately 220-230 suicides in Montana every year, that means there are about 1,400 new survivors every year in Montana. [A survivor of suicide is 3x the risk of completing suicide themselves.](#)

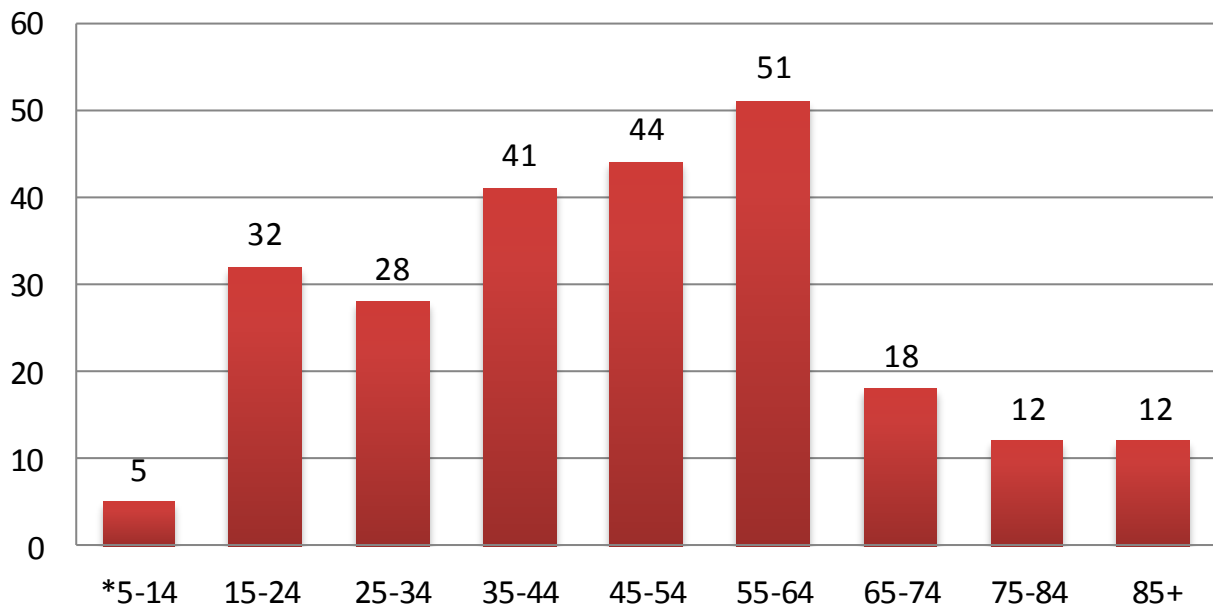


Crude Suicide Rates by Ethnicity, Montana Residents, 2014

■ White ■ AI/AN ■ Other



Suicides by Age Group (2014)

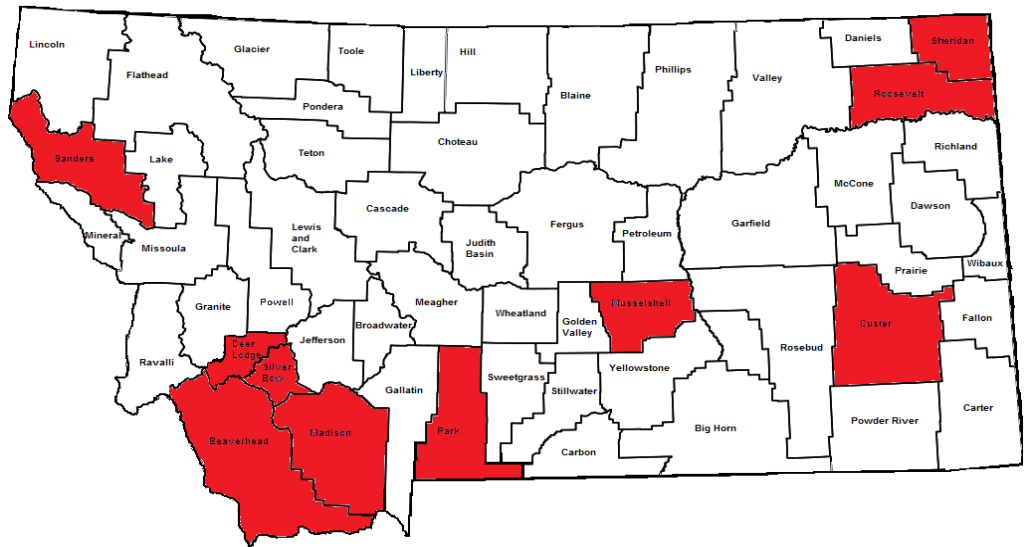


Frequency and Rate of Suicide by County of Residence, Montana Residents, 1994-2013

Montana counties with the highest rate of suicide between 1994 and 2013

Data is only provided for counties that had 20 or more suicides. Numbers below 20 are statistically unreliable, especially when we presenting 15 years of data. Counties with fewer than 5 suicides are only identified with a <5 indication.

The population is the total number of people who lived in the county for each year between 1994 and 2013.



County	Suicides	Population	Rate
BEAVERHEAD	47	182,684	25.7
BIG HORN	43	253,231	17
BLAINE	30	135,060	22.2
BROADWATER	24	95,732	25.1
CARBON	30	194,180	15.4
CARTER	<5	25,944	-
CASCADE	343	1,617,743	21.2
CHOUTEAU	21	116,478	18
CUSTER	65	234,408	27.7
DANIELS	<5	38,017	-
DAWSON	31	180,777	17.1
DEER LODGE	54	189,121	28.6
FALLON	7	57,603	-
FERGUS	46	235,906	19.5
FLATHEAD	331	1,622,072	20.2
GALLATIN	250	1,534,987	16.3
GARFIELD	<5	25,500	-
GLACIER	46	264,776	17.4
GOLDEN VALLEY	<5	19,343	-
GRANITE	18	58,625	-
HILL	56	329,605	17
JEFFERSON	39	208,669	18.7
JUDITH BASIN	8	43,690	-
LAKE	123	542,939	22.7
LEWIS & CLARK	229	1,169,129	19.6
LIBERTY	<5	45,228	-
LINCOLN	91	381,654	23.8
MCCONE	8	37,453	-

County	Suicides	Population	Rate
MADISON	37	142,857	25.9
MEAGHER	7	38,159	-
MINERAL	17	79,594	-
MISSOULA	394	2,017,420	19.5
MUSSELSHELL	24	89,446	26.8
PARK	89	313,209	28.4
PETROLEUM	<5	9,987	-
PHILLIPS	15	89,514	-
PONDERA	18	125,637	-
POWDER RIVER	<5	36,692	-
POWELL	36	140,984	25.5
PRAIRIE	<5	23,719	-
RAVALLI	170	747,641	22.7
RICHLAND	27	195,486	13.8
ROOSEVELT	56	211,648	26.5
ROSEBUD	45	189,019	23.8
SANDERS	59	214,799	27.5
SHERIDAN	23	76,699	30
SILVER BOW	189	684,671	27.6
STILLWATER	33	168,426	19.6
SWEET GRASS	15	71,209	-
TETON	19	124,815	-
TOOLE	19	103,545	-
TREASURE	<5	15,901	-
VALLEY	27	152,626	17.7
WHEATLAND	8	43,998	-
WIBAUX	<5	20,974	-
YELLOWSTONE	509	2,734,418	18.6

Social Factors Associated With Suicide

Suicidal behavior is associated with a wide variety of social factors, but correlates most highly with:

- Social Isolation (isolation from peers or social relationships that are troubled)
- Social Disorganization (society lacks the regulatory constraints necessary to control the behavior of its members.)
- Downward Social Mobility (socioeconomic)
- Rural Residency

Approximately 90% of those who complete suicide suffer from mental illness.

- The most frequent diagnosis is Major Depression
- The 2nd most frequent diagnosis is Alcoholism

REMEMBER: Depression is Treatable!

Depression is one of the most treatable of all psychiatric disorders in young people.

- ❖ 86% treatment success rate with a combination of antidepressants and therapy*
- ❖ Only 40-70% with either by themselves.

* Source: The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct 2007; VOL 64(10).

Rebound Effect – This is a very important effect to watch for. People do not recover overnight unless there is a very important reason. People tend to come out of wanting to commit suicide slowly. Some times people who have decided to kill themselves may appear quite happy. This is because they have finally made up their minds and see an end to their pain and anguish. They aren't really happy. They are simply relieved of their burden or stress or pain. Also, sometimes people who are severely depressed and contemplating suicide don't have enough energy to carry it out. But, as the disease begins to "lift" they may regain some of their energy but will still have feelings of hopelessness.

You can't tell the difference by looking at them. Studies of people who have been institutionalized for depression who later killed themselves all indicate that the period of greatest suicidal risk is not when the people are in the depths of depression, but during the first 90 days after the depression begins to lift.

Warning Signs of Suicide

Here's an Easy-to-Remember Mnemonic for the Warning Signs of Suicide: **IS PATH WARM?**

I deation	Expressed or communicated ideation threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or talking or writing about death, dying or suicide, when these actions are out of the ordinary.
S ubstance Abuse	Increased alcohol or drug use
P urposelessness	No reason for living; no sense of purpose in life, start giving things away because there's no purpose in keeping anything, no reason to maintain their hygiene
A nxiety	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
T rapped	Feeling trapped (like there's no way out and things will never get better)
H opelessness	Hopelessness, no future orientation
W ithdrawal	Withdrawal from friends, isolating from family and society
A nger	Rage, uncontrolled anger, seeking revenge, irritable
R ecklessness	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
M ood Change	Dramatic mood changes, flat affect, depressed mood, acting out of character

VERY IMPORTANT - All suicidal ideations are serious and every precaution needs to be taken, even if you believe the action is purely to gain attention. NEVER PUT A PERSON IN THE POSITION OF NEEDING TO PROVE THAT THEY ARE SERIOUS. Suicidal ideations are a cry for help. **DON'T AVOID THE TOPIC, TALK ABOUT THE FEELINGS AND DON'T BE AFRAID TO MENTION THE WORD "SUICIDE."** Most people will respond honestly. Many people are hesitant to bring up the subject of suicide for fear that they will be planting the idea in the mind of the person. This is a serious mistake! If the person is suicidal, asking them might lead to a conversation that could prevent the suicide.

Assessing the Degree of Risk – Mental health professionals should be used whenever possible, but once you suspect potential suicide, the best procedure is to approach the person in a **warm, accepting, non-judgmental manner** and ask a question similar to:

“Have you had thoughts of killing yourself?” or “Are you suicidal?”

Be careful with how you word your questions. Avoid asking questions that start with “why...”. This elicits a defensive response and may cause the youth to close down. For example, don't ask a youth, “Why would you want to do something like that?” Instead ask, “**How would you harm yourself?**” This will let you quickly know if the youth has a **suicide plan**.

If the youth does have a **suicide plan**, remember the four factors that help you determine the seriousness of the risk.

- **Specificity** – How specific are the details of the plan of attack. The greater the amount of detail, the higher the risk.
- **Lethality** – What is the level of lethality of the proposed method of self-attack? The higher the lethality, the higher the risk.
- **Availability** – What is the availability of the proposed method? The more readily available the proposed method is the higher the risk.
- **Proximity** – What is the proximity of helping resources? The greater the distance the youth is from those you could help him, the higher the risk.

Four factors to use to assess the current level of risk (given an attempt)
The strongest behavioral warning is an attempted suicide.

- **Dangerousness** – The greater the dangerousness of the attempt, the higher the current level of risk. *e.g. Did the youth take five pills or twenty five?*
- **Intent** – Did the youth believe that taking five pills was going to actually kill him? **DON'T JUST LOOK AT THE BEHAVIOR, LOOK AT THE INTENT BEHIND THE BEHAVIOR.**
- **Rescue** – Did the youth tell anyone that they made the attempt? Did the youth leave any signs (notes, give away possessions), or just acted normally?
- **Timing** – The more recent the attempt, the higher the current level of risk.

Talking with a Suicidal Person

(Source: The Mayo Clinic, <http://www.mayoclinic.org/diseases-conditions/suicide/in-depth/suicide/art-20044707>)

Start by asking questions

The first step is to find out whether the person is in danger of acting on suicidal feelings. Be sensitive, but ask direct questions, such as:

- How are you coping with what's been happening in your life?
- Do you ever feel like just giving up?
- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Are you thinking about suicide?
- Have you thought about how you would do it?
- Do you know when you would do it?
- Do you have the means to do it?

Asking about suicidal thoughts or feelings won't push someone into doing something self-destructive. In fact, offering an opportunity to talk about feelings may reduce the risk of acting on suicidal feelings.

Look for warning signs

You can't always tell when a loved one or friend is considering suicide. But here are some common signs:

- Talking about suicide — for example, making statements such as "I'm going to kill myself," "I wish I were dead" or "I wish I hadn't been born"
- Getting the means to commit suicide, such as buying a gun or stockpiling pills
- Withdrawing from social contact and wanting to be left alone
- Having mood swings, such as being emotionally high one day and deeply discouraged the next
- Being preoccupied with death, dying or violence
- Feeling trapped or hopeless about a situation
- Increasing use of alcohol or drugs
- Changing normal routine, including eating or sleeping patterns
- Doing risky or self-destructive things, such as using drugs or driving recklessly
- Giving away belongings or getting affairs in order when there is no other logical explanation for why this is being done
- Saying goodbye to people as if they won't be seen again
- Developing personality changes or being severely anxious or agitated, particularly when experiencing some of the warning signs listed above

Get emergency help, if needed

If you believe someone is in danger of committing suicide or has made a suicide attempt:

- Don't leave the person alone.
- Call 911 or your local emergency number right away. Or, if you think you can do so safely, take the person to the nearest hospital emergency room yourself.
- Try to find out if he or she is under the influence of alcohol or drugs or may have taken an overdose.
- Tell a family member or friend right away what's going on.

If a friend or family member talks or behaves in a way that makes you believe he or she might commit suicide, don't try to handle the situation without help — get help from a trained professional as quickly as possible. The person may need to be hospitalized until the suicidal crisis has passed.

Offer support

If a friend or loved one is thinking about suicide, he or she needs professional help, even if suicide isn't an immediate danger. Here's what you can do.

- **Encourage the person to seek treatment.** Someone who is suicidal or has severe depression may not have the energy or motivation to find help. If your friend or loved one doesn't want to consult a doctor or mental health provider, suggest finding help from a support group, crisis center, faith community, teacher or other trusted person. You can help by offering support and advice — but remember that it's not your job to become a substitute for a mental health provider.
- **Offer to help the person take steps to get assistance and support.** For example, you can research treatment options, make phone calls and review insurance benefit information, or even offer to go with the person to an appointment.
- **Encourage the person to communicate with you.** Someone who's suicidal may be tempted to bottle up feelings because he or she feels ashamed, guilty or embarrassed. Be supportive and understanding, and express your opinions without placing blame. Listen attentively and avoid interrupting.
- **Be respectful and acknowledge the person's feelings.** Don't try to talk the person out of his or her feelings or express shock. Remember, even though someone who's suicidal isn't thinking logically, the emotions are real. Not respecting how the person feels can shut down communication.

- **Don't be patronizing or judgmental.** For example, don't tell someone, "things could be worse" or "you have everything to live for." Instead, ask questions such as, "What's causing you to feel so bad?" "What would make you feel better?" or "How can I help?"
- **Never promise to keep someone's suicidal feelings a secret.** Be understanding, but explain that you may not be able to keep such a promise if you think the person's life is in danger. At that point, you have to get help.
- **Offer reassurance that things will get better.** When someone is suicidal, it seems as if nothing will make things better. Reassure the person that these feelings are temporary, and that with appropriate treatment, he or she will feel better about life again.
- **Encourage the person to avoid alcohol and drug use.** Using drugs or alcohol may seem to ease the painful feelings, but ultimately it makes things worse — it can lead to reckless behavior or feeling more depressed. If the person can't quit on his or her own, offer to help find treatment.
- **Remove potentially dangerous items from the person's home, if possible.** If you can, make sure the person doesn't have items around that could be used to commit suicide — such as knives, razors, guns or drugs. If the person takes a medication that could be used for overdose, encourage him or her to have someone safeguard it and give it as prescribed.

Take all signs of suicidal behavior seriously

If someone you know says he or she is thinking of suicide or is behaving in a way that makes you think the person may be suicidal, don't play it down or ignore the situation. Many people who commit suicide have expressed the intention at some point. You may worry that you're overreacting, but the safety of your friend or loved one is most important. Don't worry about straining your relationship when someone's life is at stake.

You're not responsible for preventing someone from taking his or her own life — but your intervention may help the person see that other options are available to stay safe and get treatment.

Suicide Prevention Resources (trainings and programs)

- ❖ **QPR**- A two hour gatekeeper training that provides anybody the ability to recognize the warning signs, how to intervene, and who to refer the person to.
- ❖ **ASIST** - A two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers are taught to recognize the warning signs and to intervene with appropriate assistance.
- ❖ **SOS: Signs of Suicide** - School-based program which combines a curriculum that aims to raise awareness of suicide and reduce stigma of depression. There is also a brief screening for depression and other factors associated with suicidal behavior.
- ❖ **Parents as Partners** – A 9 page booklet that helps parents recognize the symptoms of depression and the warning signs of suicide in their children and how to intervene.
- ❖ **Crisis Intervention Training** - CIT came out of the Memphis Police Dept. and is a training for law enforcement officers to help them manage mental health issues when they respond to a call.
- ❖ **PAX Good Behavior Game** - The PAX Good Behavior Game is an environmental intervention used in the classroom with young children to create an environment that is conducive to learning. The intervention is designed to reduce off-task behavior; increase attentiveness; and decrease aggressive and disruptive behavior and shy and withdrawn behavior. The intervention also aims to improve academic success, as well as mental health and substance use outcomes later in life.
- ❖ **Mental Health First Aid**- Mental Health First Aid is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises or are in the early stages of one or more chronic mental health problems.

For additional information about these programs or other evidenced-based practices, go to http://www.sprc.org/featured_resources/bpr//ebpp.asp or <http://www.nrepp.samhsa.gov/>

Other Available Suicide Prevention Resources

(go to www.dphhs.mt.gov/amdd/Suicide to download these programs)

- ❖ **Suicide Prevention Toolkit for Rural Primary Care Physicians** – Assessment and intervention material for physicians in rural communities.
- ❖ **Suicide Prevention Toolkit for Senior Living Communities** – Assessment and intervention material for assisted living programs and nursing home.

Additional Suicide Prevention Resources

- ❖ **Montana Suicide Prevention Website at www.prc.mt.gov/suicideprevention**
- ❖ In the event of an immediate crisis, **Call 911**, law enforcement, or take the person to the **nearest hospital emergency room or clinic**.
- ❖ **Montana Suicide Prevention Lifeline 800-273-TALK (8255)**
Provides immediate assistance to individuals and Veterans in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider
www.suicidepreventionlifeline.org
- ❖ **American Association of Suicidology (202) 237-2280**
Call for written material on suicide and suicide prevention or visit www.suicidology.org
- ❖ **American Foundation for Suicide Prevention (888) 333-AFSP (2377)**
For more information on suicide prevention, call toll free or visit www.afsp.org
- ❖ **National Alliance for the Mentally Ill (800) 950-NAMI (6264)**
Call Help Line for local support group and/or additional materials on depression, or visit www.nami.org
- ❖ **Suicide Prevention Resource Center (SPRC) 877-GET-SPRC (438-7772)**
Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. Includes materials for students, parents, school staff, and others. Includes state suicide data on state pages www.sprc.org.
- ❖ **The Trevor Project (www.thetrevorproject.org)**. Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24.

Depression is Treatable Suicide is Preventable

If you are in crisis and want help,
call the Montana Suicide
Prevention Lifeline, 24/7, at

1-800-273-TALK

(1-800-273-8255)

Or visit www.dphhs.mt.gov/amdd/Suicide



It's OK to get help

Hope is always within reach.

Suicide is never the only option.

Montana Suicide Prevention Lifeline

800-273-TALK (8255)

www.dphhs.mt.gov/amdd/suicide