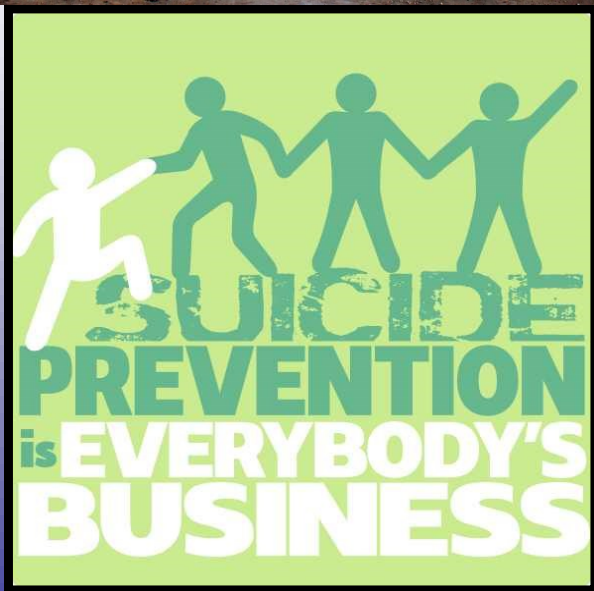


Montana Strategic Suicide Prevention Plan 2017





CRISIS TEXT LINE |

Text MT to 741-741
A free, 24/7 text line
for people in crisis.



**YOU
 ARE
 NEVER
 ALONE**



The compilation of the Montana Strategic Suicide Prevention Plan was coordinated by Karl Rosston, LCSW. Comments concerning the contents of this plan should be directed to:

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SUICIDE PREVENTION IN MONTANA:

The Process of Making a Cultural Shift in Thinking

Introduction

Suicide persists as a major public health problem in Montana. There are many individuals and organizations working to address this issue. The individuals and agencies currently addressing suicide often do so from their own unique perspective and in many cases without collaboration with other entities. Until 2000, there had been no statewide, strategic effort to link these many assets and to build a stronger network of resources to address suicide as a major statewide public health priority.

In the spring of 2000, the Montana Department of Public Health and Human Services invited a group of private organizations, concerned citizens and government officials to begin the development of a statewide plan for suicide prevention. With consultation from international experts in suicide prevention, the Montana Suicide Prevention Steering Committee began work that led to the development of this statewide strategic plan. This document is a continuation of the initial planning effort, which originally outlined a 5-year strategic direction and an action plan.

The current plan is the seventh revision. Accomplishments and ongoing challenges are delineated. Strategic directions for prevention, intervention, postvention and coordination among providers are expanded, along with special attention to groups within Montana's population with the highest risk of suicide. The plan also aligns with the 2012 National Strategy for Suicide Prevention by identifying the national goals and objectives and identifying specific Montana objectives for each of the national goals.

This version of the Montana State Suicide Prevention includes the findings of the Montana Suicide Mortality Review Team along with recommendations.

Progress

Since 2007, there have been significant accomplishments made toward addressing the issue of suicide in the state of Montana. Some of the primary suicide prevention accomplishments made over the past nine years include:

- Signs of Suicide (SOS) School-Based Program provided to middle and high schools around the state.
- Training in depression screening and suicide risk assessment has been provided to primary care providers around the state. The Suicide Prevention Toolkit for Rural Primary Care Providers is also available at no cost at www.dphhs.mt.gov/amdd/suicide.
- Suicide Prevention Toolkit for Senior Living Communities is available to long term care, assisted living, and nursing facilities at www.dphhs.mt.gov/amdd/suicide.
- Mental Health First Aid and Question, Persuade, Refer (QPR) are part of the core curriculum at the Montana Law Enforcement Academy.
- Stabilized the State Suicide Prevention Lifeline. The Lifeline consists of two regional call centers with additional phones, computers, updated data bases, and ensures that there are full-time, trained professionals available 24/7.
- Partnered with the National Crisis Text Line to provide crisis services to Montanans by texting "MT" to 741 741.
- Through collaboration with the Governor's Office, provided suicide prevention training and EAP resources to more than 1,100 state employees.
- Suicide prevention postcards sent out to over 100,000 veterans and 4,000 licensed cosmetologists.
- Core competency training for therapists working with suicidal clients for therapists from around the state.
- "After a Suicide" distributed to all funeral homes in the state.
- Statewide webinars to all VAs on the treatment of suicidal and PTSD veterans.
- Over 20,000 gunlocks with suicide prevention tags distributed to counties and tribal entities.
- Over 7,000 people in communities and reservations trained in ASIST (Applied Suicide Intervention Skills Training).
- Since 2014, grief resources sent to every family who lost a loved one to suicide.
- Provide yearly training to senior care givers through the Senior and Long Term Care Division.
- Over 20,000 people trained in QPR (Question, Persuade, Refer) around the state and on tribal lands, including over 3,000 teachers and school personnel.
- Member of the Attorney General's task force to reduce prescription drug abuse.
- Provided suicide prevention training to 120 county judges.

Progress continued

- Presentations at the University of Montana, Montana State University, Salish Kootenai College, Rocky Mountain College, Montana Tech, Montana State Billings, Stone Child College, University of Montana Western, Chief Dull Knife College, Carroll College, Fort Peck Community College, Aaniiih Nakoda College, Missoula College, Little Big Horn College, College of Great Falls, and Helena College of the University of Montana in suicide prevention to students and faculty.
- Community grants for suicide prevention trainings and interventions provided for numerous counties including Missoula, Ravalli, Flathead, Gallatin, Cascade, Lewis & Clark, Sanders, Custer, Yellowstone, and District II (which encompasses 11 counties in Eastern Montana).
- Suicide prevention training and risk assessment has been provided to hospitals in Billings, Butte, Bozeman, Dillon, Glasgow, Ennis, Great Falls, Kalispell, Miles City, and Missoula. In addition, a suicide prevention webinar for physicians and emergency room staff was held for 27 Montana hospitals.
- Co-sponsor of numerous conferences which has trained people to provide QPR, provide survivor support services, and brought in nationally recognized experts in suicide prevention.
- Mental Health First Aid provided to communities around the state.
- Over 7,000 “Quick Reference” guides for suicide prevention distributed to chemical dependency facilities and made available to chemical dependency counselors and others around the state.
- Over 20,000 “Parents as Partners: a suicide prevention guide for parents” booklets sent out to school districts around the state and made available to agencies working with families.
- Collaborative effort with the Dept. of Revenue, Liquor Control, on providing training to bartenders and liquor distributors. Over 100,000 drink coasters being distributed to Montana bars.
- State wide media campaigns on Charter Communication, Montana Broadcaster’s Association, Northern Broadcasting Association, Facebook, and Cha Cha. The Facebook ad focused not only on young people in Montana but also Montana Veterans.
- Suicide prevention training to detention officers in county jails and juvenile facilities, and providing anti-suicide blankets and clothing to all county jails and correctional facilities.
- Implementing a standardized suicide screening instrument for all county jails around the state.
- Suicide prevention training for juvenile parole officers and detention officers around the state.
- Co-sponsor of the Military Appreciation games at the University of Montana and Montana State University, where fans received self-rating depression scales with resources.
- The annual enrollment survey (July, 2016) by the Office of the Commissioner of Securities and Insurance found that approximately 92.6 percent of Montanans had health coverage as of May 2016, an uninsured rate of about 7.4 percent. That’s down from 20 percent in 2013. The uninsured rate dropped to 16.9 percent in 2014 and in 2015, it was at 15 percent.
- **Creation of the Nations first suicide mortality review team (see next page)**

What is the Suicide Mortality Review Team (SMR Team)

The Montana Suicide Mortality Review Team Act was passed during the 2013 Legislative session through the approval of House Bill 583. The SMR team is a statewide effort to identify factors associated with suicide in an effort to develop prevention strategies. The suicide mortality review team is composed of mental health, social service, law enforcement, coroners, and other experts to review de-identified suicide deaths. The purpose of the review team is to determine if a suicide was preventable and the factors associated with the suicide. The prevention of suicide is a community responsibility. The suicidal death of a person can be viewed as a sentinel event that is a measure of a community's overall social and economic well-being and health. The SMR team process identifies critical community strengths and needs to understand the unique social, health and economic issues associated with suicide. The goal of the SMR team program is to reduce the inequalities that impact the number of deaths through local community and state collaboration.

The Operating Principles of Suicide Mortality Review

- Suicide is a community responsibility.
- Suicide is a sentinel event that should urge communities to identify other people at risk.
- A suicide review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent suicide and to keep people healthy, safe and protected.

The Purpose

Through a comprehensive and multidisciplinary review of suicides, we will better understand how and why people die by suicide and use our findings to take action to prevent other suicides and improve the health and safety of Montanans.

The Objectives

The objectives of the SMR process are multifaceted and will meet the needs of many different agencies, ranging from the investigation of deaths to their prevention.

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every suicide.
2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.
3. Improve agency responses in the investigation of suicides.
4. Improve agency response to protect survivors of the deceased.
5. Identify specific barriers and system issues involved in suicides.
6. Identify significant risk factors and trends in suicides.
7. Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in suicide prevention.
8. Increase public awareness and advocacy for the issues pertaining to suicide prevention.

The findings of the Suicide Mortality Review Team and recommendations will be outlined later in this report. The findings cover the review of 555 suicides that occurred in Montana from January 1, 2014 until March 1, 2016.

Challenges

Though we have made progress since the initiation of the inaugural Suicide Prevention Plan, Montanans are still faced with many challenges. Montana's suicide rate remains among the highest in the nation. Over the past ten years, suicide is the second leading cause of death for children, adolescents and young adults in our state and the rate of suicide is high throughout the life span. We have identified many areas where improvements can be made.

Lack of statewide coordination

- Systems collaboration between tribal entities, counties and state government, especially for adolescent and young adult populations are insufficient.
- Coordination between community levels and state systems is insufficient. Local communities may not know about initiatives in other parts of the state or in state government. State government agencies are often not aware of prevention efforts related to suicide in other agencies.
- Development of suicide prevention strategies often occurs without the involvement of youth in the planning process.
- Screening for mental illness and suicide does not consistently occur in public schools, juvenile justice systems, or other child-serving agencies. Screening is inconsistent in the medical community and symptoms of depression are often missed by medical professionals.

Montana demographics and geography

- Montana is a large frontier state with many isolated communities.
- There is a generational culture of acceptance of suicide as a viable option to resolve feelings of hopelessness and when one feels they are a burden to others.
- Ongoing stigma towards seeking mental health services and concerns of maintaining confidentiality in small communities inhibit individuals from seeking needed treatment.
- Montana has a high availability of lethal means, especially firearms, that increase the lethality of impulsive suicidal behaviors .
- Montana has high rates of alcohol consumption, underage drinking, and binge drinking, along with other drug addictions; including the current devastating epidemic of methamphetamine use.

Challenges continued

- The farm and ranch economic crisis and the difficulty in attracting industry to provide a stable employment market in Montana are ongoing stressors.
- An analysis of National Violent Death Reporting System (NVDRS) data revealed that suicide rates are higher among people who live at high altitudes than those living at lower elevations.

Lack of mental health providers and treatment facilities

- There is a shortage of inpatient mental health treatment facilities and crisis stabilization beds.
- The funding/reimbursement for outpatient services throughout the state is considered inadequate by many providers.
- There is insufficient integration of traditional and culturally specific interventions, especially among our American Indian population.
- Montana has a severe shortage of psychiatrists, especially child and adolescent psychiatrists.
- Montana has a shortage of psychiatric mental health nurse practitioners.
- Montana does not recognize Licensed Marriage and Family Therapists (LMFT) as a separate professional license. This further reduces mental health resources in the state. There are only two states in the nation that do not recognize LMFT's, Montana and West Virginia.
- There is a shortage of physicians capable of providing appropriate psychiatric medication treatments.

Suicide – A Public Health Issue that isn’t going away

United States

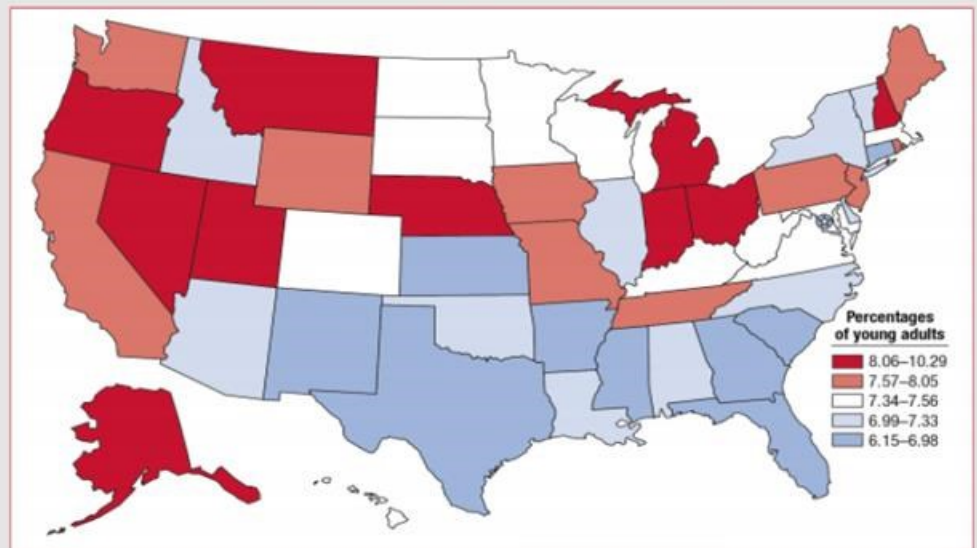
Since 2000, the rate of suicide has increased 28% in the United States. Increases in the rates of suicide among certain age, gender, and ethnic groups have changed. Suicide rates among adolescents and youth in some areas of the nation have increased dramatically. However, in 2014, suicide rates remain the highest among white males over the age of 45. Differences are also occurring in some racial groups with the rates of suicide among young African American males showing significant increases.

Approximately 1,069,325 people a year in the United States attempt suicide. Suicide has a devastating and, often lasting, impact on those that have lost a loved one as a result of suicide. While suicide rates in the U.S. place it near the mean for industrialized nations, the rates within the U.S. are highly variable by region and state. The intermountain western states have the highest rates of suicide as a region and Montana ranks persistently at the top of the rate chart annually. The following information was taken from the 2014 National Vital Statistics Report (2015) and the Center for Disease Control-WISQARS (2016). 2014 is the most recent national numbers available.

In the United States for 2014:

- Suicide was the 10th leading cause of death for all ages, 2nd for young people.
- Suicides accounted for 1.6% of all deaths in the U.S.
- 42,773 suicides occurred in the U.S. This is the equivalent of 117 suicides per day; one suicide every 12 minutes or a crude rate of 13.4 suicides per 100,000 people.
- In the United States, Whites have the highest rate of suicide (15.4) followed by Native Americans (10.8).
- Middle aged people (45-64 years) have the highest rate of suicide (19.5), followed by the elderly (16.6) and the young (11.6).

Figure 1. Serious thoughts of suicide in the past year among young adults aged 18 to 25, by state: annual averages, 2013-2014



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 and 2014.

2014, United States **Suicide Injury Deaths and Rates per 100,000** **All Races, Both Sexes, All Ages**

Number of Deaths	Population	Crude Rate	Age-Adjusted Rate**
42,773	318,857,056	13.41	12.93

Compared to 29,350 suicides and a crude rate of 10.43 in 2000, a rate increase of 28%

Suicide among the Young (ages 15-24)

- In 2014, 5,079 youth between 15 and 24 completed suicide in the US.
- Suicide is the 2nd leading cause of death for 15 to 24 year olds.
- Male youth die by suicide over four times more frequently than female youth.
- Native American/Alaska Native youth (15-24) have the highest rate with 16.74 per 100,000. White youth are next highest with 12.60 per 100,000.
- In the US, the majority of youth who died by suicide used firearms (45%). Suffocation was the second most commonly used method (40%).

According to the 2015 National Youth Risk Behavior Survey;

- During the 12 months before the survey, 14.6% of students nationwide had made a plan about how they would attempt suicide .
- 8.6% of all high school students had attempted suicide one or more times during the 12 months before the survey.

Nonfatal Suicidal Thoughts and Behavior

- There were 1,069,325 suicide attempts in the US in 2014. This translates to one attempt every 30 seconds. There are three females attempts for every male attempt.
- Among young adults ages 15 to 24 years old, there is one suicide for every 100-200 attempts.
- Among the general population, there is one suicide for every 25 attempts.
- Among adults ages 65 years and older, there is one suicide for every four suicide attempts.

Racial and Ethnic Disparities

<u>Gender (US for 2014)</u>	<u>Number</u>	<u>Rate</u>	<u>Percent of Total</u>
All Races	42,773	13.4	#
White	38,675	15.4	90.4%
Black	2,421	5.5	5.6%
American Indian/Alaska Native	489	10.8	1.2%
Asian/Pacific Islander	1,188	6.1	2.8%

<u>Suicide Method (US for 2014)</u>	<u>Number</u>	<u>Rate</u>	<u>Percent of Total</u>
All Means	42,773	13.4	#
Firearm	21,334	6.7	49.9%
Suffocation/Hanging	11,407	3.6	26.7%
Poisoning	6,808	2.1	15.9%
Cut/Pierce	740	0.2	1.7%
All Other Means	2,484	0.78	5.8%

Suicide among the Elderly (US for 2014)

- There were 7,693 suicides of people over age 65 for a rate of 16.6 per 100,000. That equates out to 21 elderly suicides every day in the United States.
- The highest rate of suicide is among White males over the age of 85 (1,024 suicides for a rate of 54.39)
- Males over 65 have a rate of suicide 6.2 times higher than females over 65 (31.39 compared to 5.04)
- A White male over the age of 65 has a rate of suicide 2.6 times higher than a American Indian male over the age of 65 (34.68 compared to 13.38)

Source: CDC WISQARS website (http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html). Obtained June, 2016)

Rates of suicide per 100,000 population, by sex, and ranked overall by Standard Occupation Classification (SOC) group — 17 states, 2012*

SOC code	Occupational group	Overall	Male	Female
45	Farming, fishing, and forestry	84.5	90.5	— [†]
47	Construction and extraction	53.3	52.5	—
49	Installation, maintenance, and repair	47.9	47.5	—
51	Production	34.5	39.5	10.8
17	Architecture and engineering	32.2	36.3	—
33	Protective service	30.5	34.1	14.1
27	Arts, design, entertainment, sports, and media	24.3	32.9	12.4
15	Computer and mathematical	23.3	32.8	12.5
53	Transportation and material moving	22.3	30.2	4.8
11	Management	20.3	27.4	8.4
23	Legal	18.8	24.2	13.9
29	Healthcare practitioners and technical	17.4	31.6	13.3
19	Life, physical, and social science	16.7	23.7	—
13	Business and financial operations	15.9	20.4	10.3
31	Health care support	14.6	32.9	11.8
21	Community and social service	13.6	18.6	8.9
41	Sales and related	13.4	21.0	5.3
37	Building and grounds cleaning and maintenance	13.3	16.5	4.5
35	Food preparation and serving related	12.8	19.3	7.7
39	Personal care and service	8.0	17.2	4.9
43	Office and administrative support	7.9	15.2	5.3
25	Education, training, and library	7.5	15.1	4.7
Total		20.3	39.2	12.4

* Rates were calculated using data from the U.S. Census Current Population Survey March supplement.

† Rates were not calculated where the decedents were fewer than 20 because those estimates might be unreliable.

Source: McIntosh WL, Spies E, Stone DM, Lokey CN, Trudeau AT, Bartholow B. Suicide Rates by Occupational Group — 17 States, 2012. MMWR Morb Mortal Wkly Rep 2016;65:641–645. DOI: <http://dx.doi.org/10.15585/mmwr.mm6525a1>.

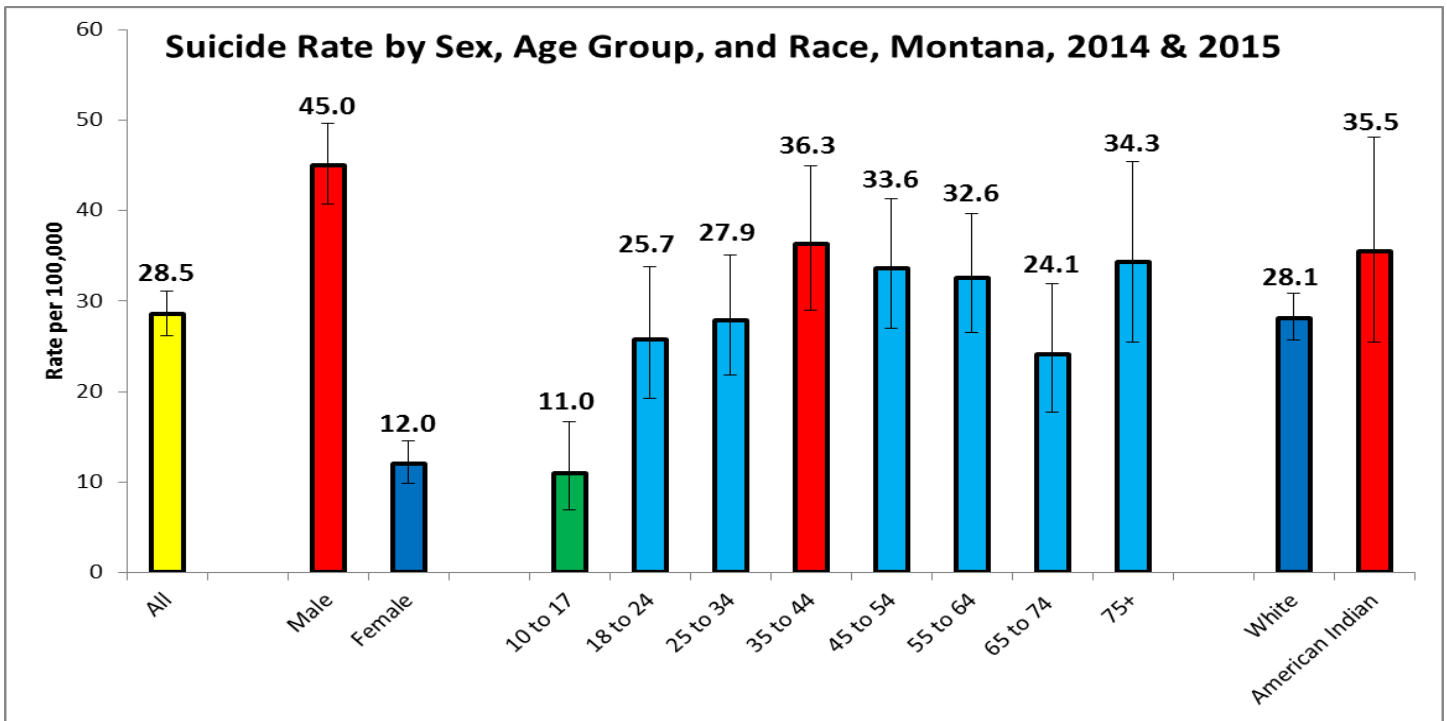
Suicide in Montana: The Findings of the Montana Suicide Mortality Review Team

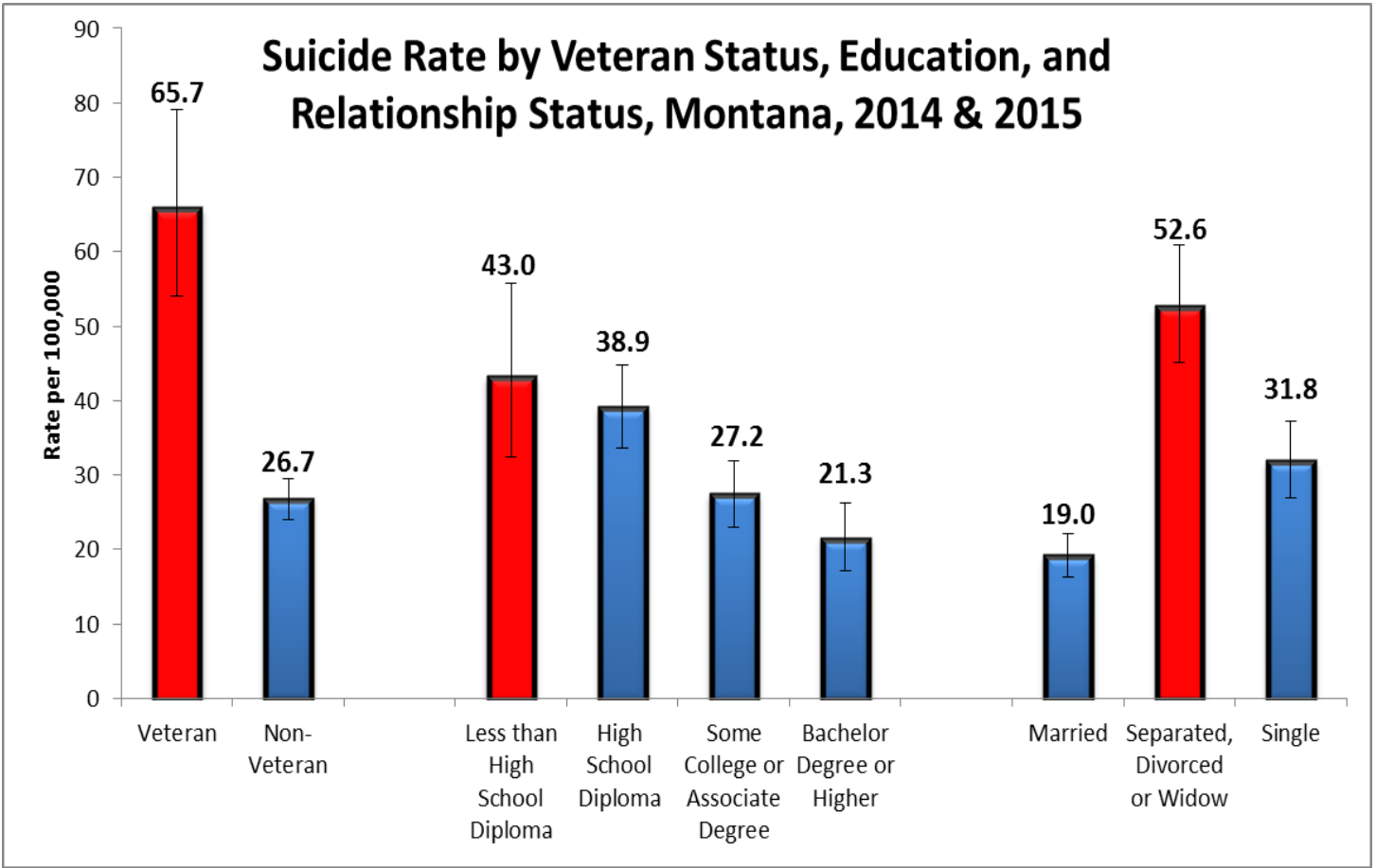
Over the following pages are the findings and recommendations of the Montana Suicide Mortality Review Team and is based on the review of 555 suicides that occurred in Montana between January 1, 2014 and March 1, 2016. The first set of charts represent all suicides in Montana. This is followed by data specific to youth suicides. Later in the plan, charts will be provided that are specific to American Indian suicides and suicides by our veterans.

Suicide continues to be a major public health issue in the state. Montana has been at or near the top in the nation for the rate of suicide for nearly four decades. In the past ten years (2005-2014), the crude rate of suicide in Montana is 22.33 per 100,000 people (the national rate during that period is 12.22 per 100,000). Between 2005 and 2014, a total of 2,199 Montana residents have died by suicide for an average of 220 people per year.

For all age groups for data collected for the year 2014, Montana had the highest rate of suicide in the United States (American Association of Suicidology, Dec., 2015). Montana has been in the top five for nearly 40 years.

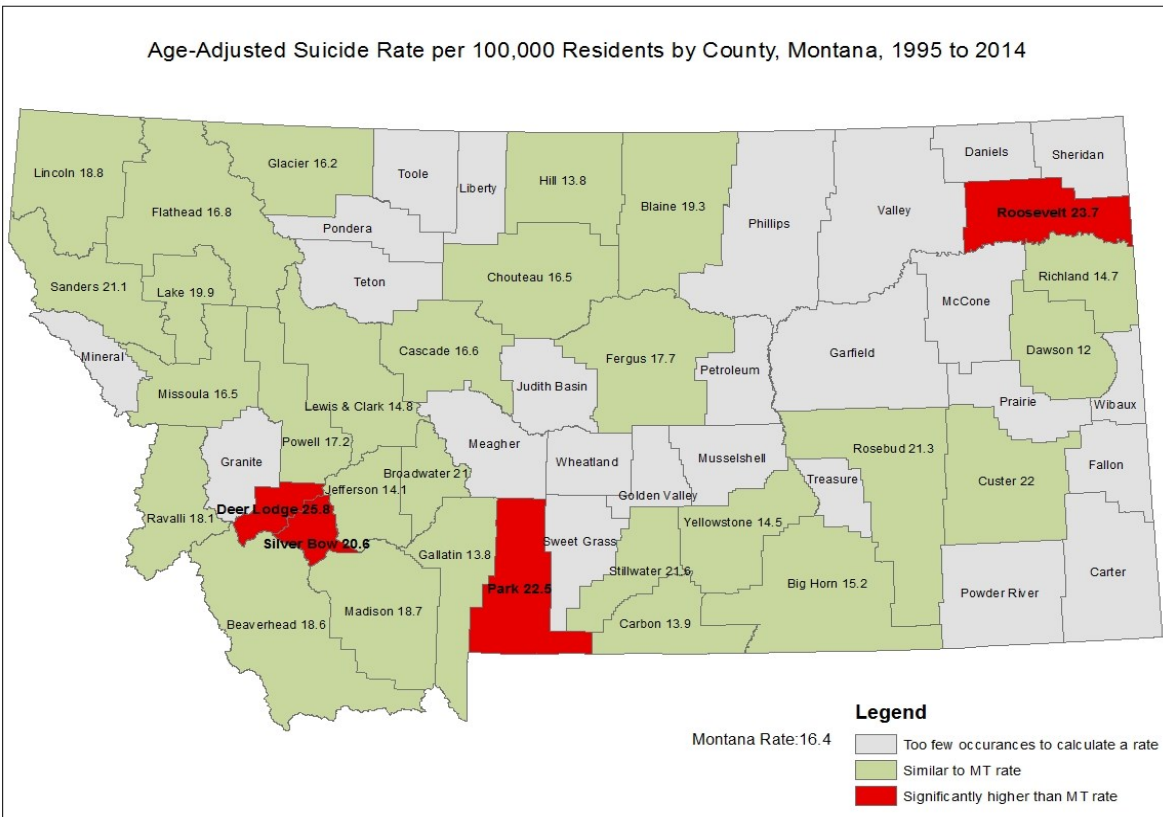
- In Montana, between 2005 and 2014, suicide was the number two cause of death for children ages 10-14, adolescents ages 15-24, and adults ages 25-44, behind only unintentional injuries (CDC, 2016)
- Access to lethal means (firearms), alcohol, a sense of being a burden, social isolation, altitude, undiagnosed and untreated mental illness, lack of resiliency and coping skills, and a societal stigma against depression, all contribute to the long-term, cultural issue of suicide in Montana.
- In 2015, 29.3% of high school students in Montana reported they felt so sad or hopeless almost every day for two weeks or more that they stopped doing some of their usual activities (Montana YRBS, 2015).
- For 2014 and 2015, the highest rate of suicide in Montana is among American Indians (35.5 per 100,000) followed by Whites (28.1 per 100,000).
- Over the last 10 years, firearms (63%), suffocation (19%), and poisoning (12%) are the most common means of suicide in Montana.





Suicide in Montana Counties

The suicide rate in Montana's counties varies from year to year due to small populations in the rural counties that greatly influence the rate of suicide with even one death by suicide. Based on analysis of county rates



between 2005-2014, only four counties were found to have a suicide rate statistically higher than the Montana rate during that period of time. For information on the rate of suicide in other Montana counties over the last 20 years (1995-2014), please see the proceeding page.

Age Adjusted Suicide Rates (per 100,000), Montana Residents, 1995-2014

DATA PROVIDED BY OFFICE OF EPIDEMIOLOGY AND SCIENTIFIC SUPPORT, MT DPHHS

County	Deaths	Population*	Age-Adjusted Rate	County	Deaths	Population	Age-Adjusted Rate
Montana	3,183	15,401,557	16.4				
Beaverhead	37	153,333	18.6	McCone	†	30,347	‡
Big Horn	35	186,417	15.2	Meagher	10	31,764	‡
Blaine	24	102,200	19.3	Mineral	17	67,184	‡
Broadwater	21	80,271	21.0	Missoula	349	1,705,929	16.5
Carbon	30	162,921	13.9	Musselshell	19	75,012	‡
Carter	5	21,470	‡	Park	76	261,288	22.5
Cascade	272	1,312,915	16.6	Petroleum	†	8,138	‡
Choteau	20	92,634	16.5	Phillips	10	71,862	‡
Custer	52	192,715	22.0	Pondera	14	99,991	‡
Daniels	5	31,787	‡	Powder River	5	29,944	‡
Dawson	22	150,345	12.0	Powell	28	120,849	17.2
Deer Lodge	49	159,925	25.8	Prairie	†	20,360	‡
Fallon	6	47,071	‡	Ravalli	145	622,190	18.1
Fergus	41	195,333	17.7	Richland	28	158,284	14.7
Flathead	284	1,340,633	16.8	Roosevelt	48	158,102	23.7
Gallatin	221	1,312,113	13.8	Rosebud	37	142,102	21.3
Garfield	†	20,682	‡	Sanders	50	181,745	21.1
Glacier	38	197,815	16.2	Sheridan	16	63,991	‡
Golden Valley	†	15,539	‡	Silver Bow	145	566,349	20.6
Granite	14	49,903	‡	Stillwater	35	139,094	21.6
Hill	46	259,764	13.8	Sweet Grass	14	57,926	‡
Jefferson	32	171,635	14.1	Teton	18	100,342	‡
Judith Basin	8	35,732	‡	Toole	15	85,187	‡
Lake	109	438,257	19.9	Treasure	†	12,993	‡
Lewis & Clark	182	964,355	14.8	Valley	18	124,105	‡
Liberty	†	37,452	‡	Wheatland	6	35,292	‡
Lincoln	79	318,460	18.8	Wibaux	†	17,424	‡
Madison	29	122,752	18.7	Yellowstone	405	2,239,334	14.5

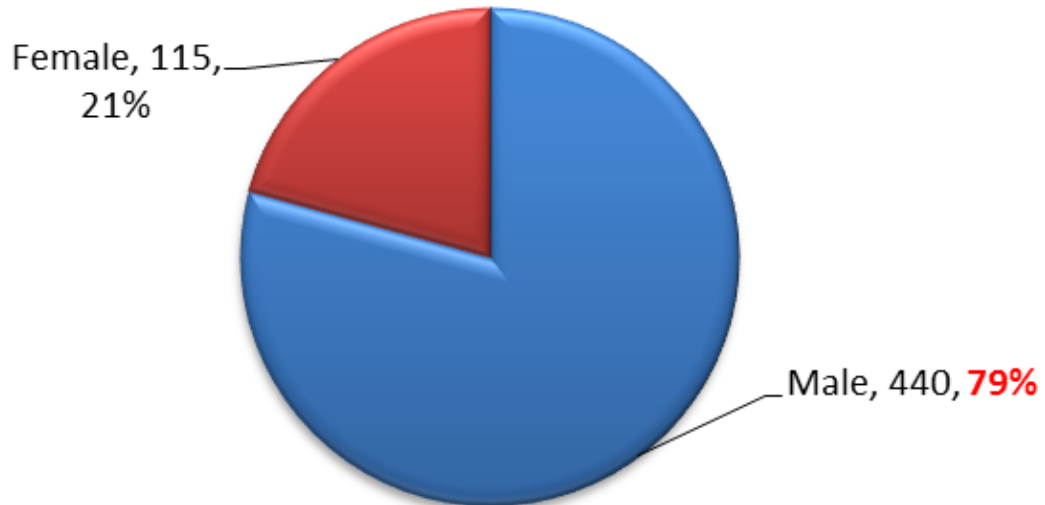
***POPULATION TOTALS ARE CUMULATIVE FOR EACH YEAR OVER THE PAST 20 YEARS**

National Center for Health Statistics. Bridged-race intercensal estimates of the July 1, 1990-July 1, 1999; July 1, 2000-July 1, 2009. Postcensal estimates of the resident population of the United States for July 1, 2010-July 1, 2014. United States resident population by year, county, single-year of age, sex, bridged race, and Hispanic origin, prepared by the U.S. Census Bureau with support from the National Cancer Institute. Available on the Internet at: <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm> as of April 24, 2004; Oct 26, 2012; June 30, 2015

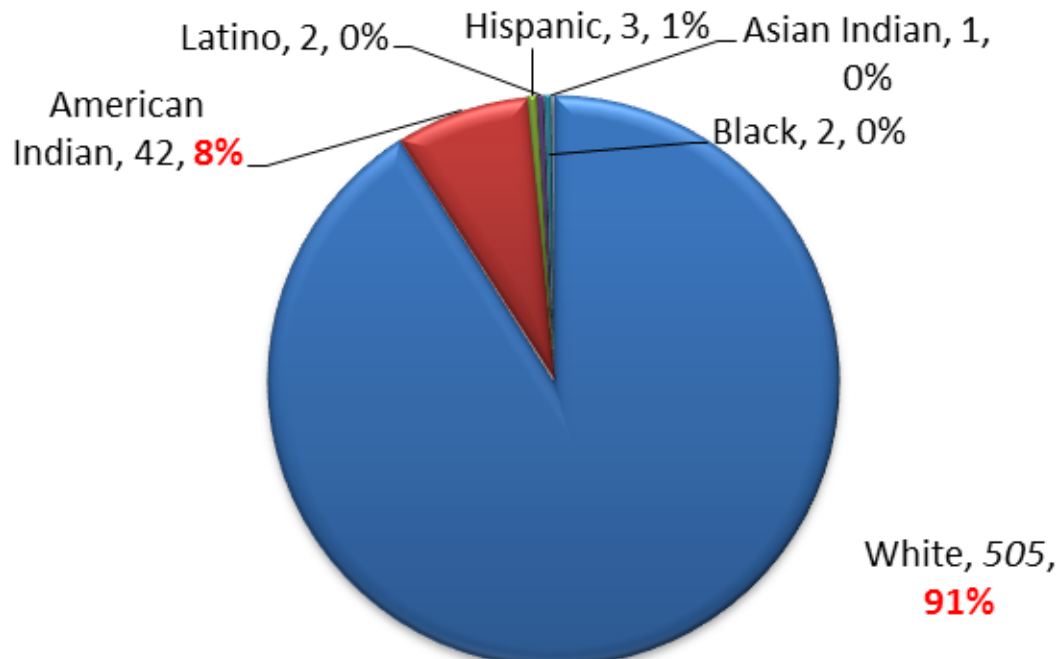
† Fewer than five events;

‡ Rates are not calculated for fewer than 20 events; Data do not meet standards of precision or reliability.

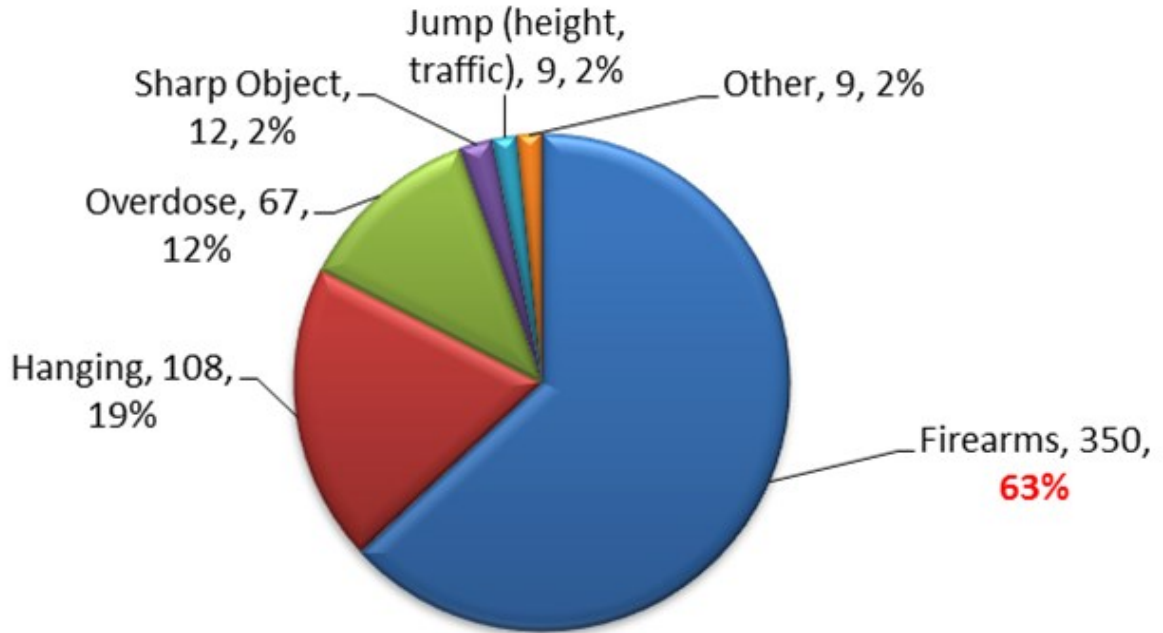
Montana Suicides by Gender (1/1/14-3/1/16)



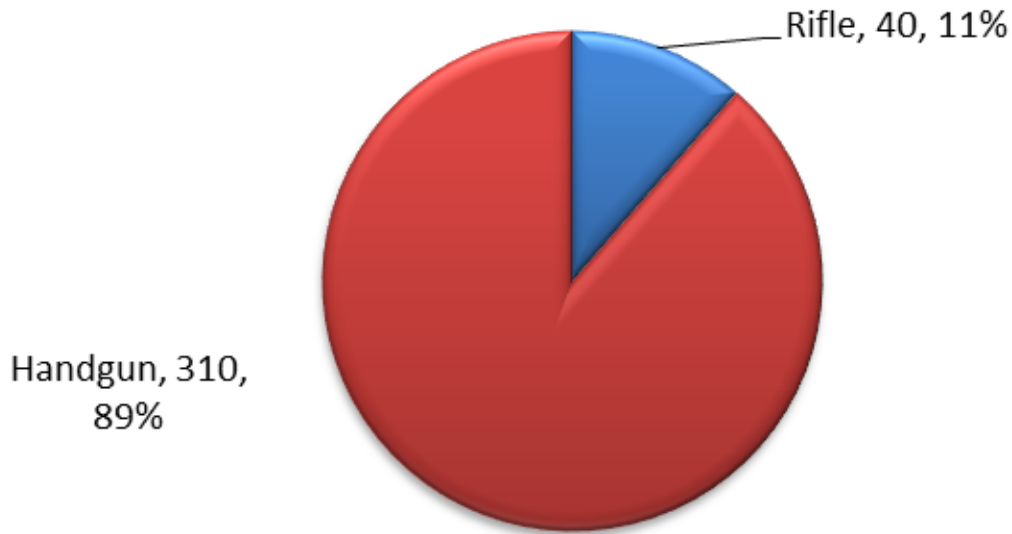
Montana Suicides by Ethnicity (1/1/14-3/1/16)



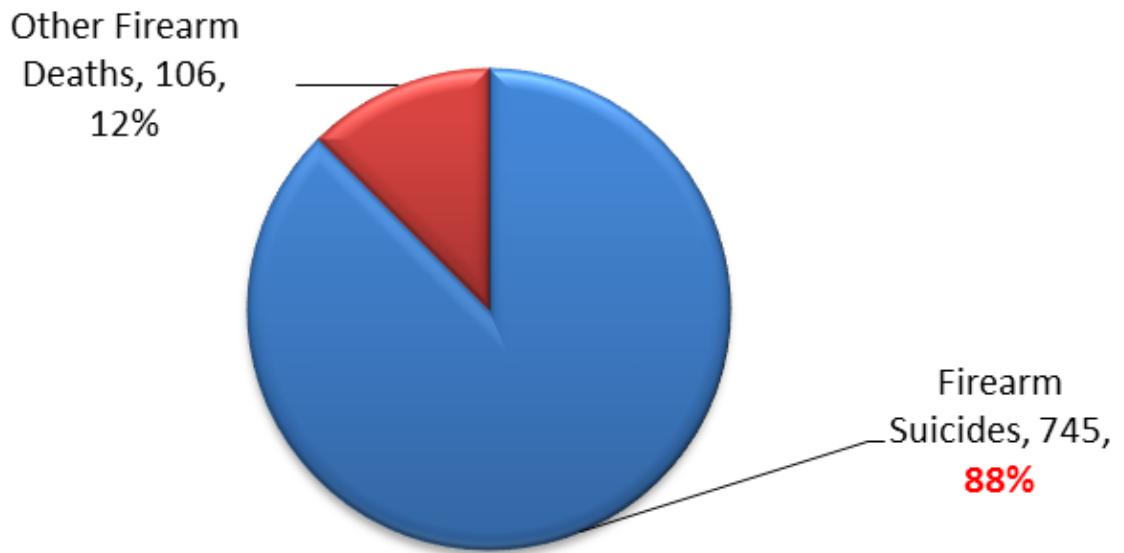
Montana Suicides by Means (1/1/14-3/1/16)



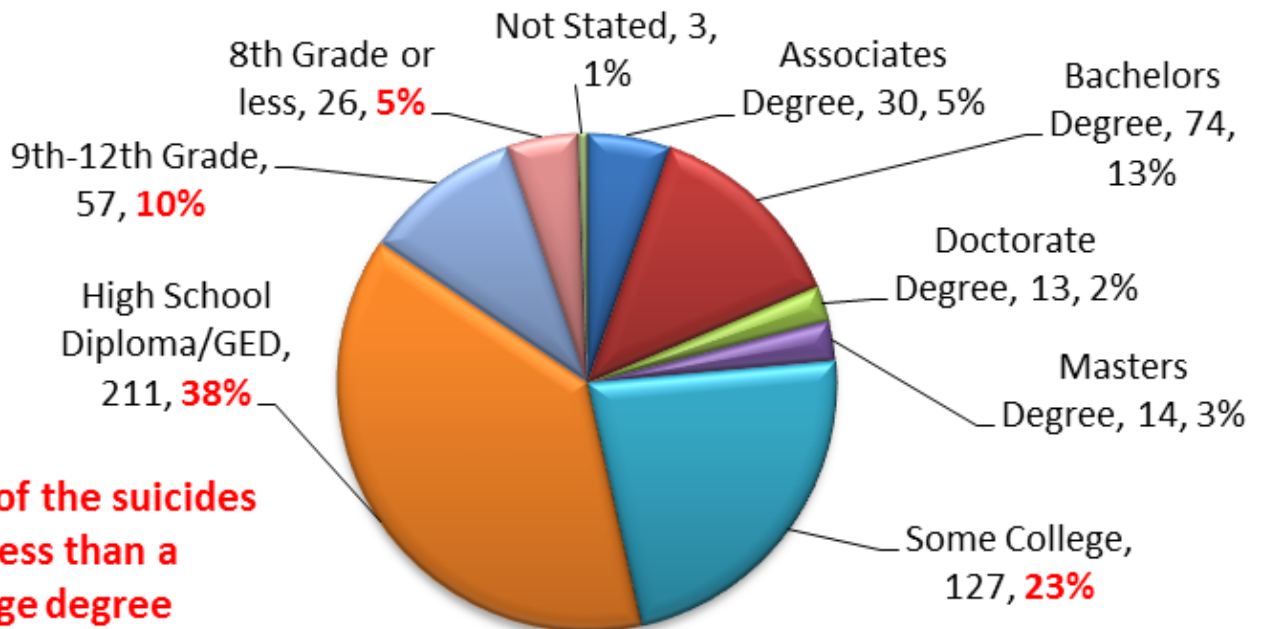
Montana Suicides by Type of Firearm (1/1/14 - 3/1/16)



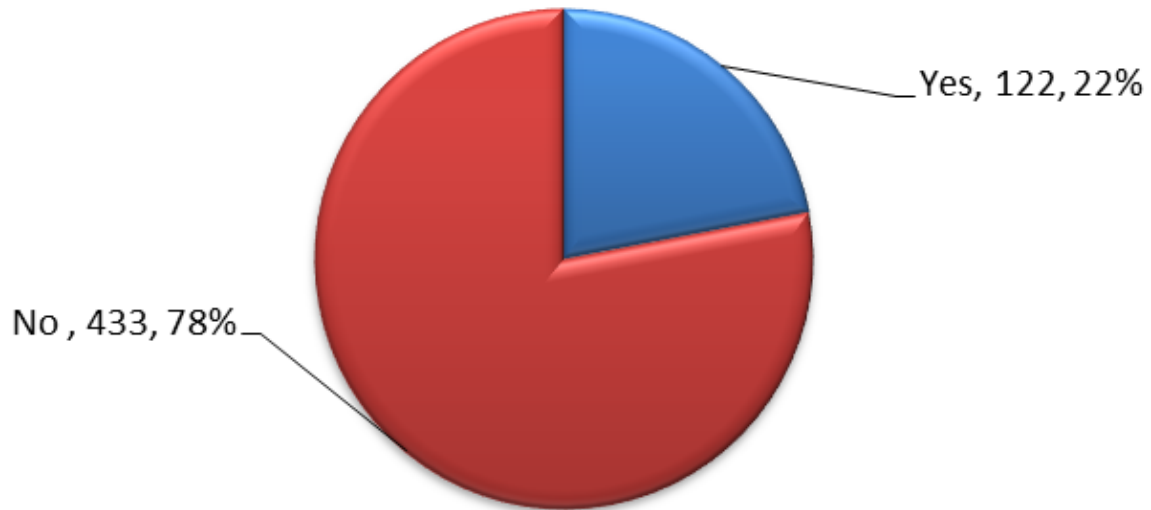
Firearm Deaths in Montana 2010-2014



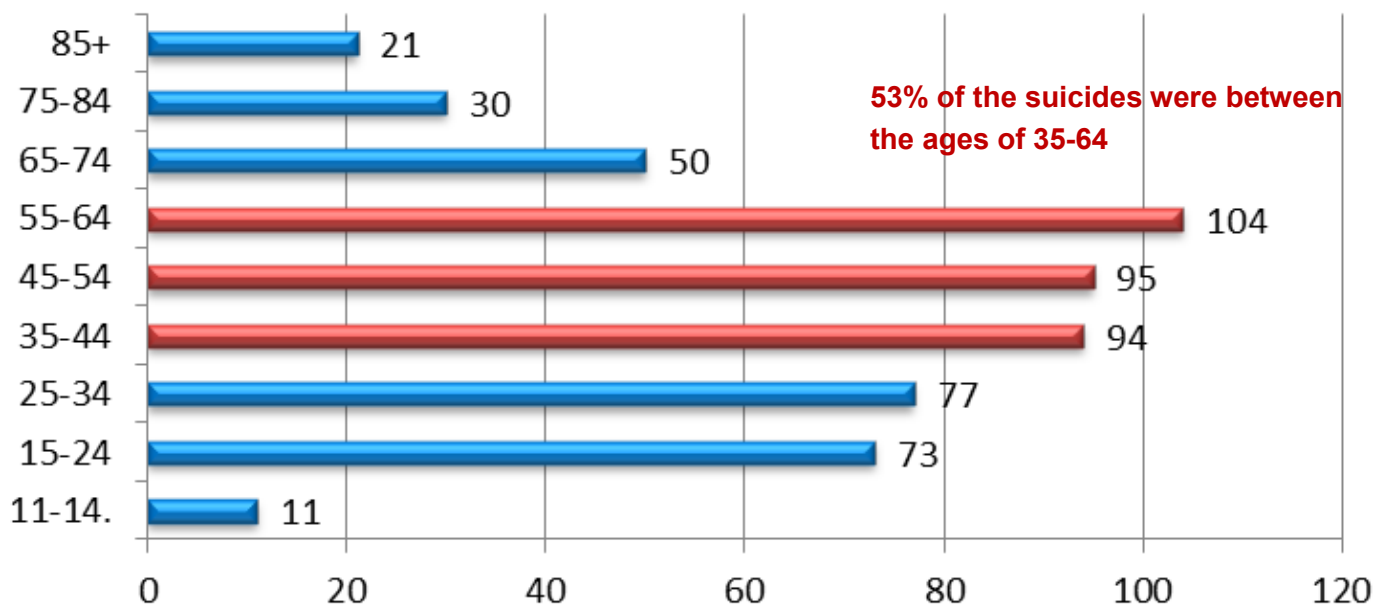
Montana Suicides by Education (1/1/14 - 3/1/16)



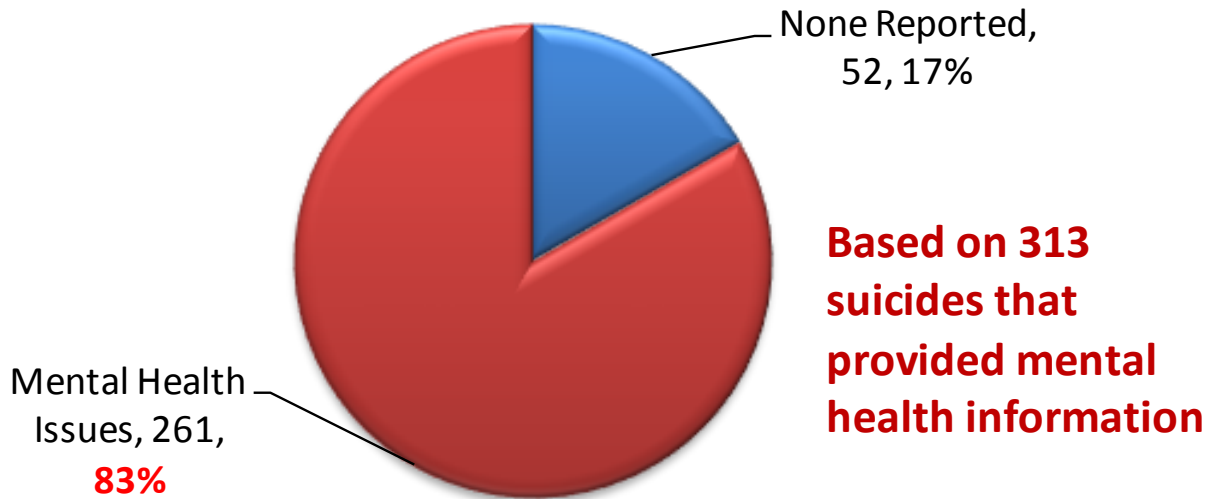
Montana Suicides who were Veterans (1/1/14 - 3/1/16)



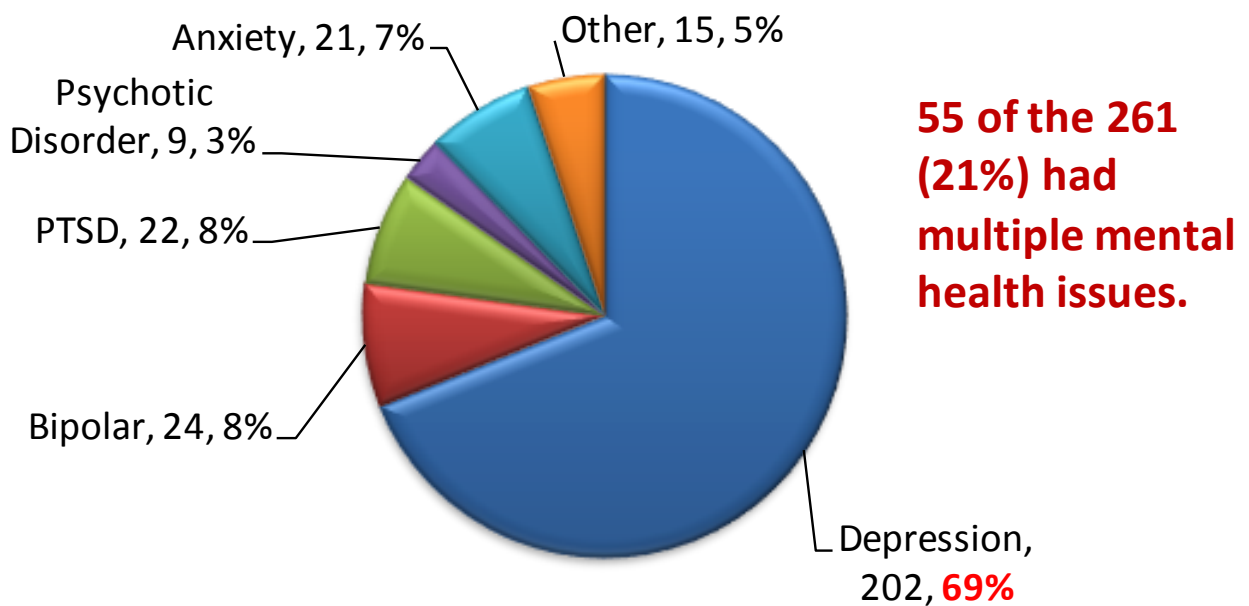
Montana Suicides by Age Range (1/1/14 - 3/1/16)



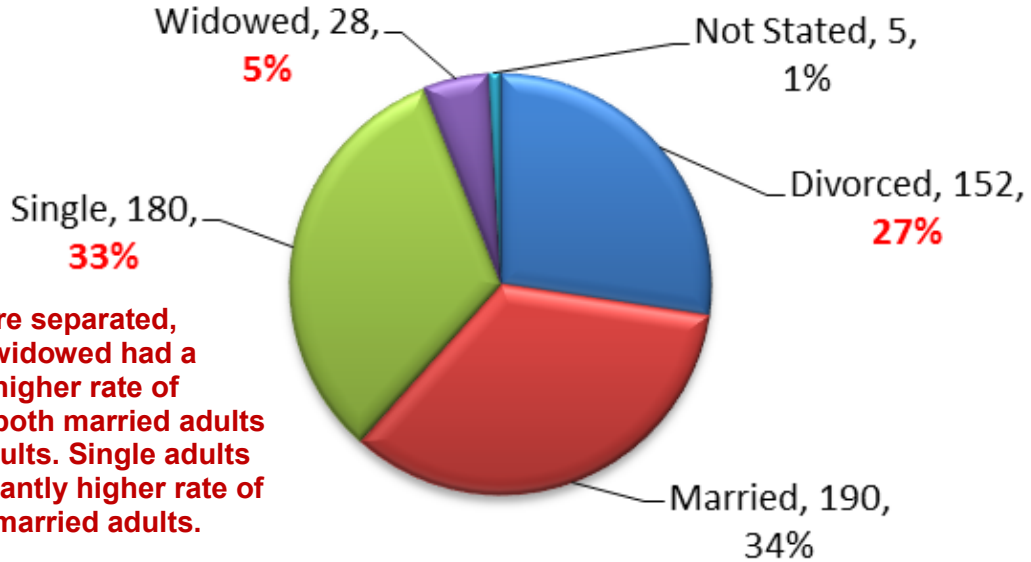
Montana Suicides with Identified Mental Health Issues



Montana Suicides By Type of Mental Health Disorder

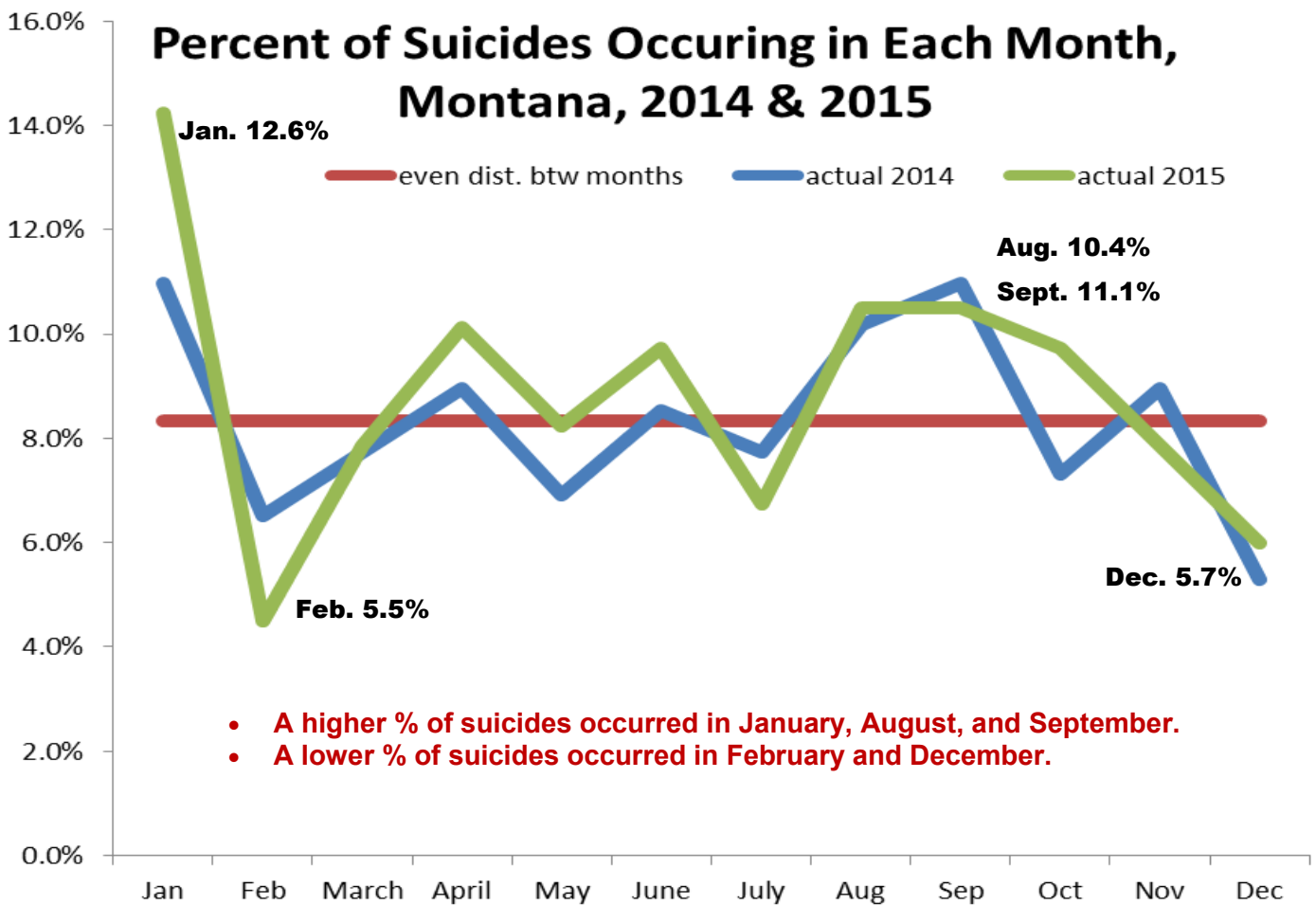


Montana Suicides by Relationship Status (1/1/14 - 3/1/16)



Adults who are separated, divorced, or widowed had a significantly higher rate of suicide than both married adults and single adults. Single adults had a significantly higher rate of suicide than married adults.

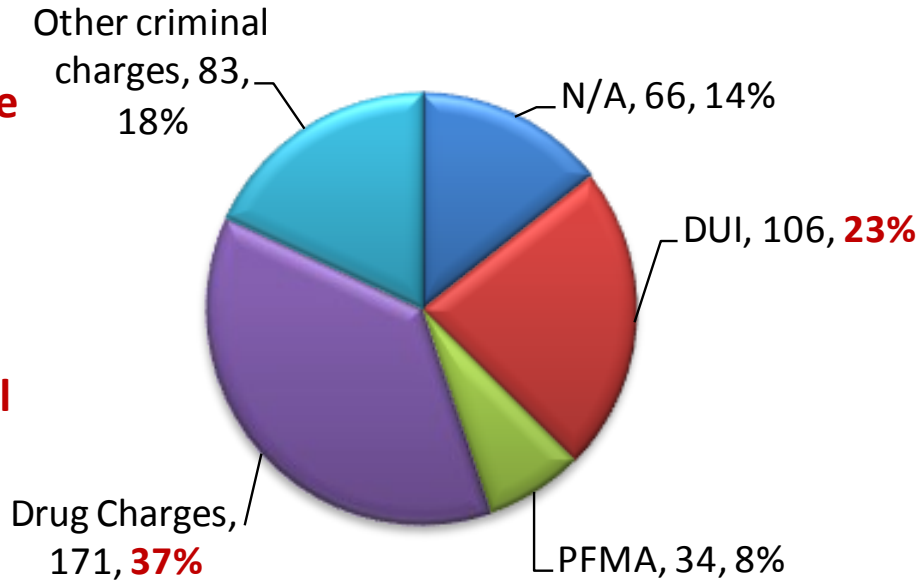
Percent of Suicides Occuring in Each Month, Montana, 2014 & 2015



- A higher % of suicides occurred in January, August, and September.
- A lower % of suicides occurred in February and December.

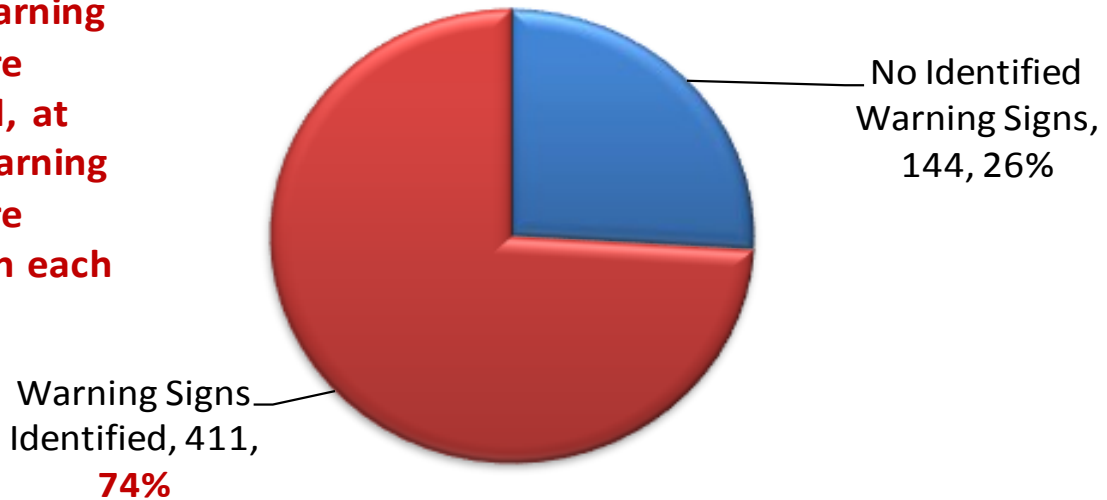
Montana Suicides based on Criminal History (1/1/14 - 3/1/16)

Based on 460 records where criminal charges were identified. Of these, 86% had a criminal record.

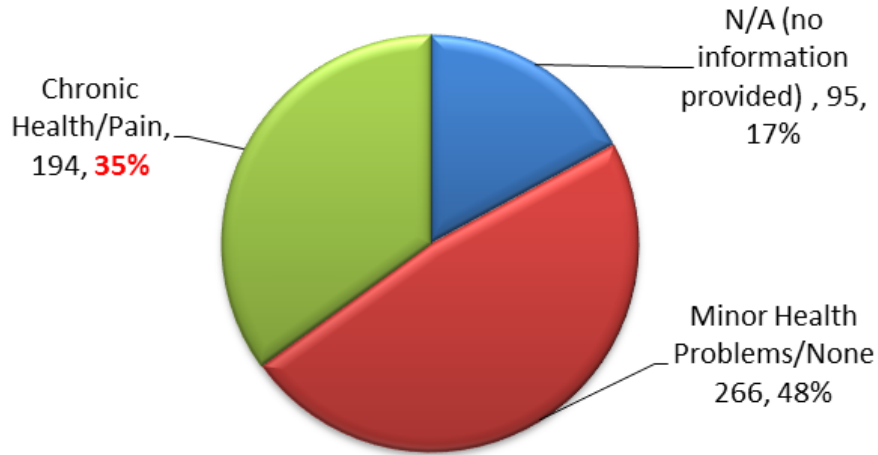


Montana Suicides with identified Warning Signs

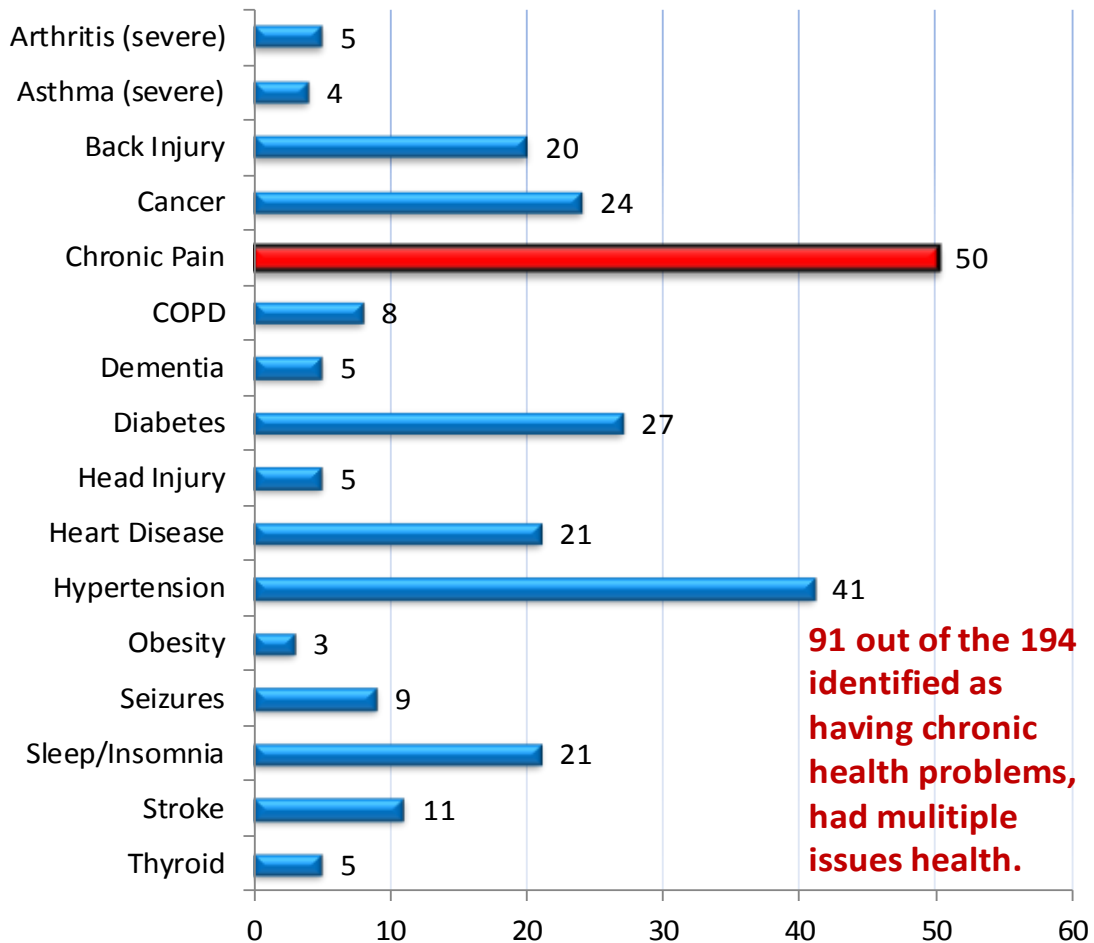
In the 74% of the suicides where warning signs were identified, at least 3 warning signs were present in each suicide.



Montana Suicides by Identified Health Issues (1/1/14-3/1/16)

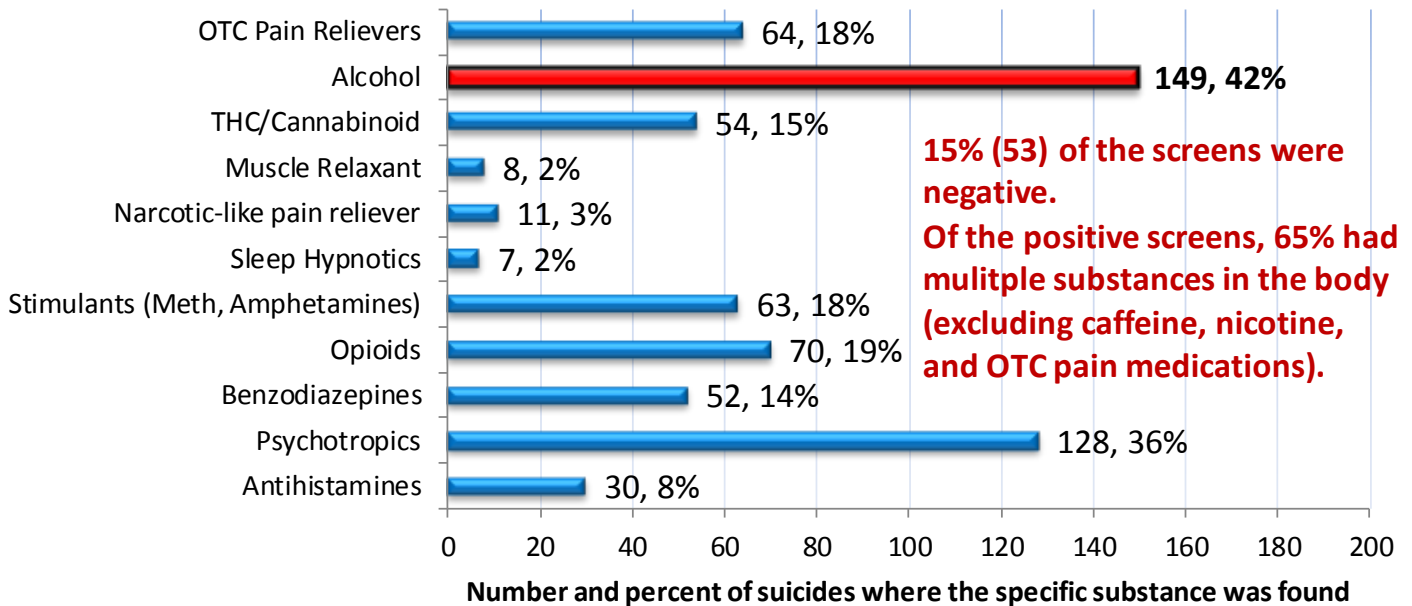


Most Frequent Health Issues identified in Montana Suicides (based on 194 with identified health issues)

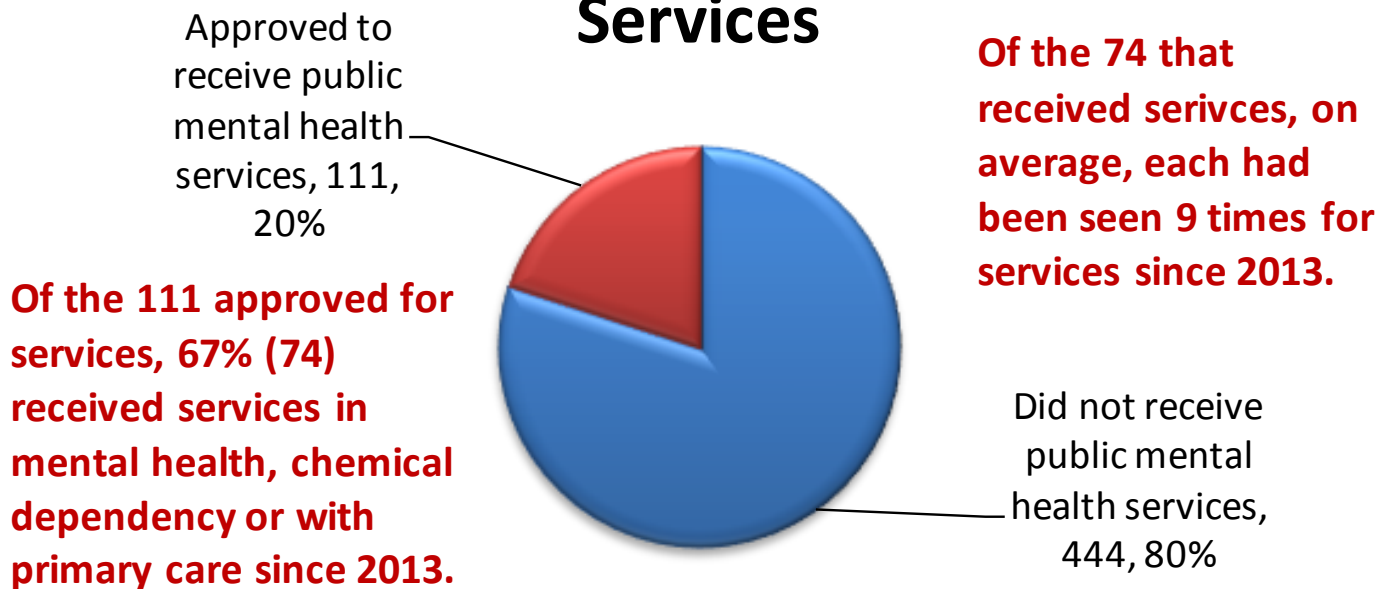


Montana Suicides based on Toxicology Reports

(based on 359 toxicology reports, between 1/1/14 and 3/1/16)

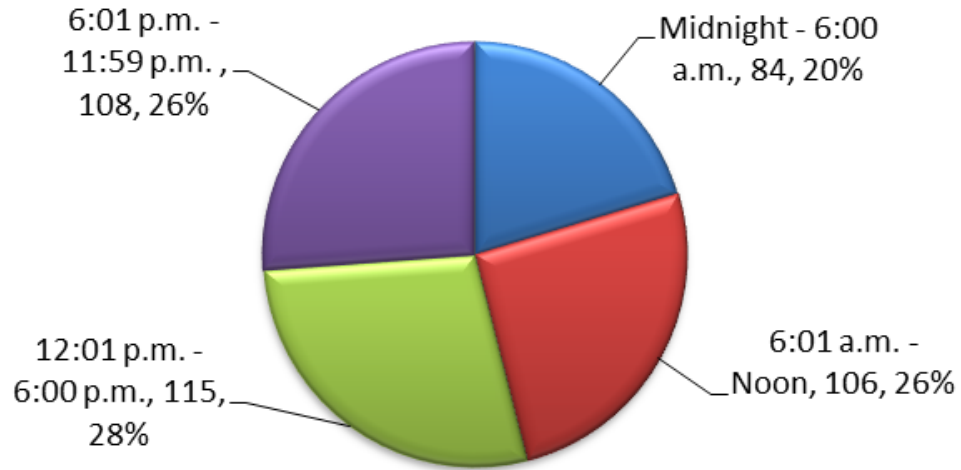


Montana Suicides that received Publically Funded Mental Health Services

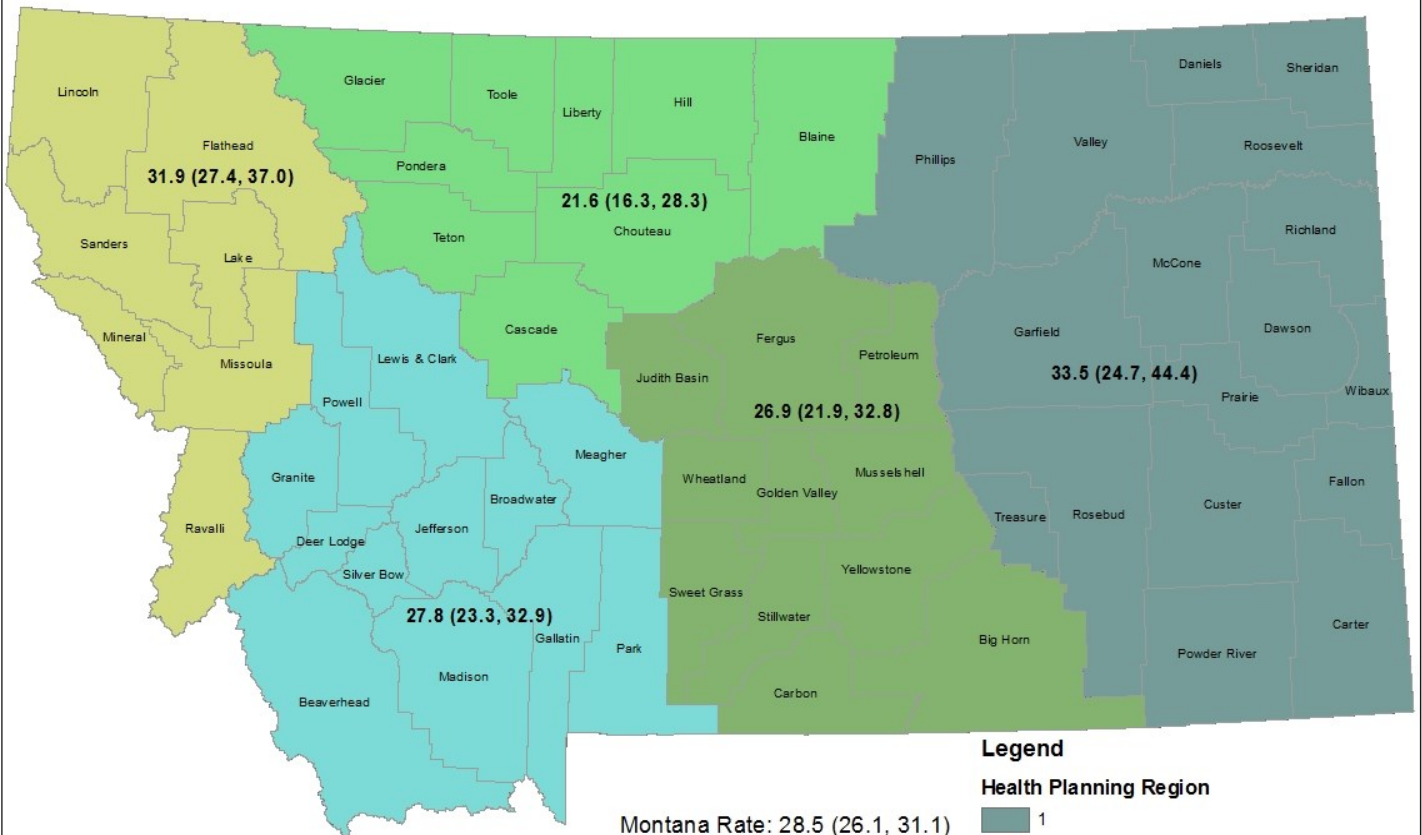


Montana Suicides by Time of Death

(Based on 413 deaths, time of death unknown in 142 of the deaths)

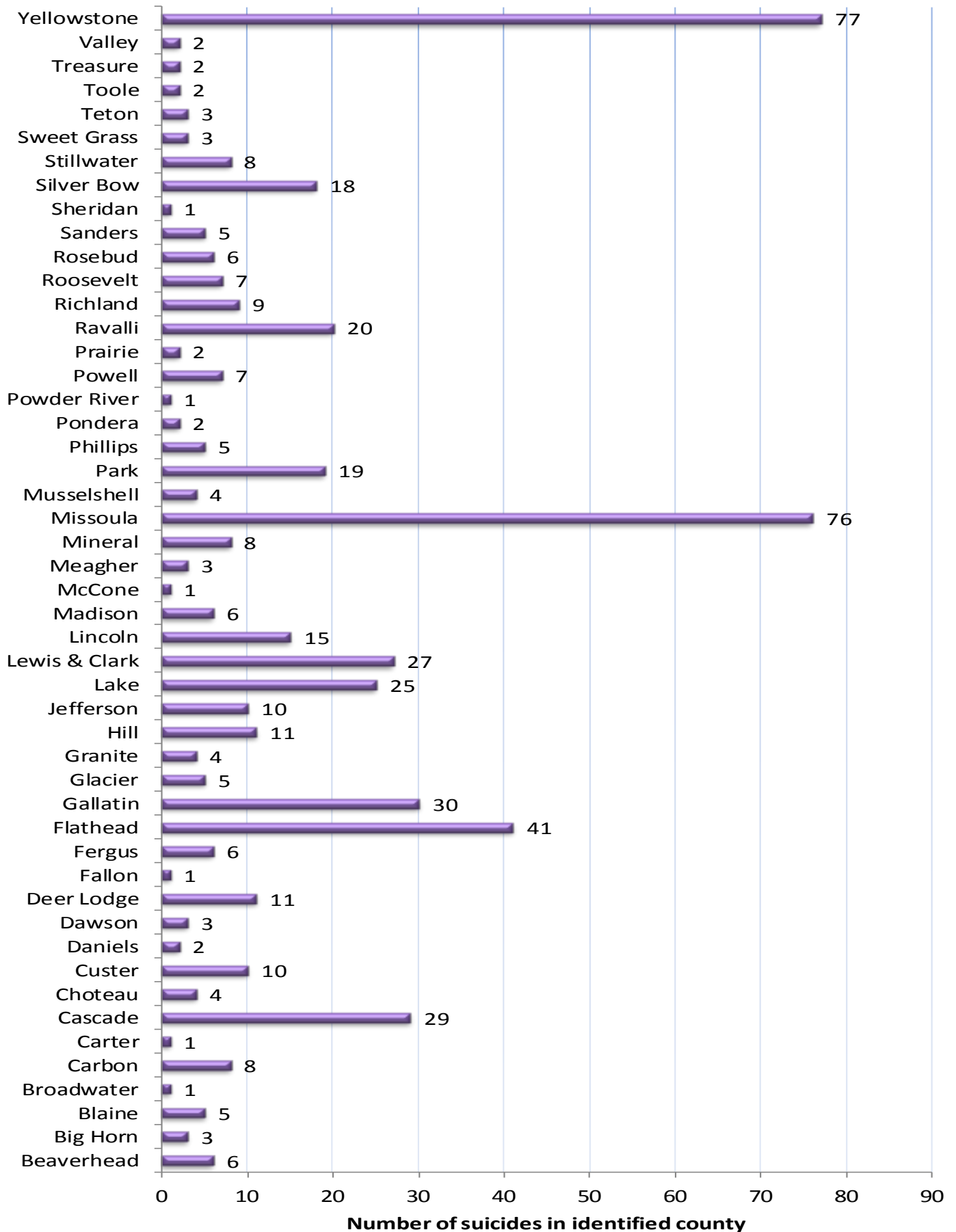


Suicide Rate per 100,000 Residents by Health Planning Region, Montana, 2014 & 2015



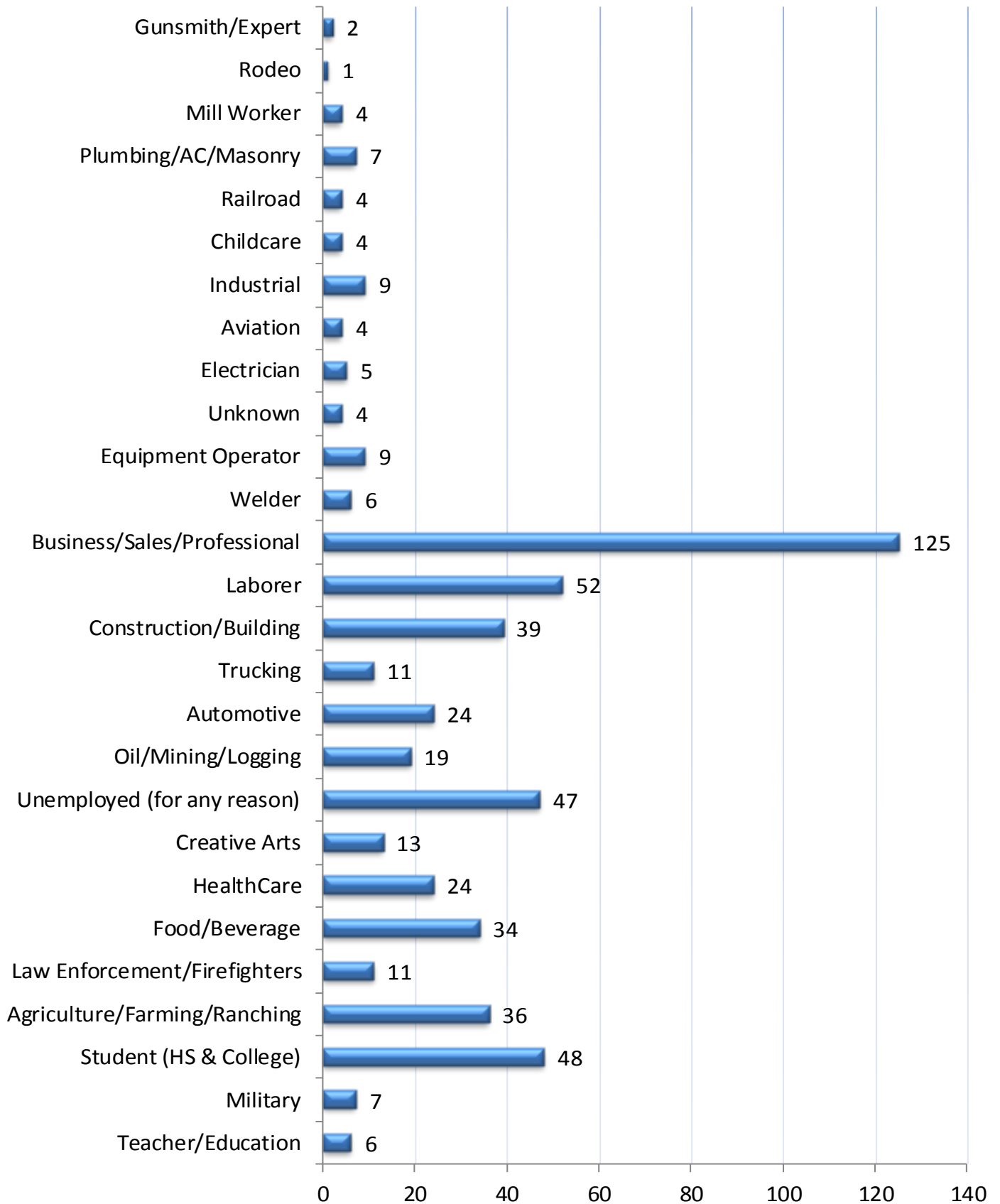
No statistically significant difference was noted between any of the regions.

Montana Suicides by County of Residence (1/1/14 - 3/1/16)



Montana Suicides by Occupation

(1/1/14 - 3/1/16)



Recommendations of the Montana Suicide Mortality Review Team (Released July, 2016)

Policy Level Interventions

- ◆ **Depression Screening** – It is recommended that Montana Medicaid write policy that requires universal screening for depression for all patients, 12 and older, and require reporting of its use by all organizations that bill Montana Medicaid.
 - Examples of a depression screen would be the PHQ-9 (right) and the PHQ-A (adolescent). The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. The PHQ-9 incorporates depression diagnostic criteria with other leading major depressive symptoms into a self-report tool. The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which reflect improvement or worsening of depression in response to treatment.

- ◆ **Safety Planning Intervention** – It is recommended that Montana Medicaid write policy that requires the use of this intervention as part of any patient who has been positively screened for depression. The purpose of the Safety Planning Intervention is to provide people who are experiencing suicidal ideation with a specific set of concrete strategies to use in order to decrease the risk of suicidal behavior. The safety plan includes coping strategies that may be used and individuals or agencies that may be contacted during a crisis. The Safety Planning Intervention is a collaborative effort between a treatment provider and a patient and takes about 30 minutes to complete. The basic steps of a safety plan include (a) recognizing the warning signs of an impending suicidal crisis; (b) using your own coping strategies; (c) contacting others in order to distract from suicidal thoughts; (d) contacting family members or friends who may help to resolve the crisis; (e) contacting mental health professionals or agencies; and (f) reducing the availability of means to complete suicide (Stanley & Brown, 2012).

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use “-” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	_____
Somewhat difficult	_____
Very difficult	_____
Extremely difficult	_____

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SAMPLE SAFETY PLAN	
Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Place _____ 4. Place _____
Step 4: People whom I can ask for help:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Name _____ Phone _____
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Local Urgent Care Services Urgent Care Services Address _____ Urgent Care Services Phone _____
4.	Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
Step 6: Making the environment safe:	
1.	_____
2.	_____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

The one thing that is most important to me and worth living for is:

◆ **Columbia Suicide Severity Rating Scale (C-SSRS)** – It is recommended that Montana Medicaid write policy that requires the use of this intervention as part of any patient who has been positively screened for moderate to severe depression. The C-SSRS is used extensively across primary care, clinical practice, surveillance, research, and institutional settings. It is available in over 100 country-specific languages, and is part of a national and international public health initiative involving the assessment of suicidality, including general medical and psychiatric emergency departments, hospital systems, managed care organizations, behavioral health organizations, medical homes, community mental health agencies, primary care, clergy, hospices, schools, college campuses, US Army, National Guard, VAs, Navy and Air Force settings, frontline responders (police, fire department, EMTs), substance abuse treatment centers, prisons, jails, juvenile justice systems, and judges to reduce unnecessary hospitalizations. The C-SSRS has been administered several million times and has exhibited excellent feasibility (Posner et al, 2011, Mundt et al, 2013) – no mental health training is required to administer it.

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up

Step 1: Identify Risk Factors			
C-SSRS Suicidal Ideation Severity	48 hr	Month	Lifetime (Worst)
1) Wish to be dead <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>			
2) Current suicidal thoughts <i>Have you actually had any thoughts of killing yourself?</i>			
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) <i>Have you been thinking about how you might kill yourself?</i>			
4) Suicidal Intent without Specific Plan <i>Have you had these thoughts and had some intention of acting on them?</i>			
5) Intent with Plan <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>			
C-SSRS Suicidal Behavior: <i>"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"</i>	48 hr	3 Months	Lifetime
Examples: collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.			
Current and Past Psychiatric Dx: <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Alcohol/substance abuse disorders <input type="checkbox"/> PTSD <input type="checkbox"/> ADHD <input type="checkbox"/> TBI <input type="checkbox"/> Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic) <input type="checkbox"/> Conduct problems (antisocial behavior, aggression, impulsivity) <input type="checkbox"/> Recent onset Presenting Symptoms: <input type="checkbox"/> Anhedonia <input type="checkbox"/> Impulsivity <input type="checkbox"/> Hopelessness or despair <input type="checkbox"/> Anxiety and/or panic <input type="checkbox"/> Insomnia <input type="checkbox"/> Command hallucinations <input type="checkbox"/> Psychosis	Family History: <input type="checkbox"/> Suicide <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Axis I psychiatric diagnoses requiring hospitalization Precipitants/Stressors: <input type="checkbox"/> Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated) <input type="checkbox"/> Chronic physical pain or other acute medical problem (e.g. CNS disorders) <input type="checkbox"/> Sexual/physical abuse <input type="checkbox"/> Substance intoxication or withdrawal <input type="checkbox"/> Pending incarceration or homelessness <input type="checkbox"/> Legal problems <input type="checkbox"/> Inadequate social supports <input type="checkbox"/> Social isolation <input type="checkbox"/> Perceived burden on others Change in treatment: <input type="checkbox"/> Recent inpatient discharge <input type="checkbox"/> Change in provider or treatment (i.e., medications, psychotherapy, milieu) <input type="checkbox"/> Hopeless or dissatisfied with provider or treatment <input type="checkbox"/> Non-compliant or not receiving treatment		
<input type="checkbox"/> Access to lethal methods: Ask specifically about presence or absence of a firearm in the home or workplace or ease of accessing			

◆ **Conferences on Suicide Prevention** – Montana Department of Public Health and Human Services to continue to utilize existing budgets to support the education of communities, educators and professionals in basic interventions which are “best practices” in suicide prevention.

State Legislature Interventions

- The Montana Suicide Mortality Review team recommends mandatory suicide prevention training and suicide risk assessment training for primary care providers, to include physicians (those who have contact with patients), nurses, chiropractors, naturopaths, and behavioral health providers. This is based on research that indicates that nationally, 45% of the people who die by suicide saw their primary care providers within a month of their death, and 20% of those people saw their primary care provider within 24 hours of their death. 73% of those of the age of 65 who died by suicide, saw their primary care provider within a month of their death. Other recommendations for primary care include;
 - ◆ Enhance availability of tele-psychiatry
 - ◆ State financial support in the development of Integrated Behavioral Health to support primary care in providing mental health care and best practices in Perfect Depression Care.

- School Prevention and Interventions** – The Montana Suicide Mortality Review Team recommends a multi-level approach for all elementary and secondary students, utilizing programs that have been identified as evidence-based interventions according to SAMHSA’s National Registry of Evidence Based Programs and Practices (NREPP).

 - At the elementary school level, resiliency and coping skills training is recommended for all 1st and 2nd grade students utilizing the PAX Good Behavior Game. For tribal schools, the Indigenous version of the PAX Good Behavior Game is recommended.
 - At the middle school level, Question, Persuade, Refer (QPR) gatekeeper training for all education staff that includes teachers, support staff, bus drivers, custodians, and food service personnel is recommended. For all school counselors, Applied Suicide Intervention Skills Training (ASIST) is recommended. For all middle schools, the Signs of Suicide (SOS) School-based program for middle schools is recommended. Finally, based on the national recommendations made by the U.S. Prevention Task Force, it is recommended that all middle school students be screened for depression and that all schools develop district-wide crisis response protocols to respond to those students identified as being at higher risk.
 - At the high school level, Question, Persuade, Refer (QPR) gatekeeper training for all education staff that includes teachers, support staff, bus drivers, custodians, and food service personnel is recommended. For all school counselors, Applied Suicide Intervention Skills Training (ASIST) is recommended. For all middle schools, the Signs of Suicide (SOS) School-based program for middle schools is recommended. For high schools, we also encourage the piloting of other promising practices, such as the Youth Aware of Mental Health program (YAM). Based on the national recommendations made by the U.S. Prevention Task Force, it is also recommended that all high school students be screened for depression and that all schools develop district-wide crisis response protocols to respond to those students identified as being at higher risk.
- Standardize State Coroners** – Recommend standardized training, standardized reporting and regular auditing of training and reporting due to a lack of adherence to standards and vast discrepancies between coroners in the reporting of suicide deaths in Montana.
- Crisis Response** – Continued support to phone and text-message crisis lines; enhance community coordination from crisis lines; support community specific crisis response protocols (Fort Peck Crisis Response Protocol); continued support of crisis response teams (CRT) and crisis homes; and continued support of Crisis Intervention Training (CIT) for law enforcement.



Federal Level Interventions

- ♦ **Drug Courts** – Drug courts are problem-solving courts that operate under a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities work together to help non-violent offenders find restoration in recovery and become productive citizens. Treatment success rate as high as 75%.
- ♦ **Veteran Courts** – The first veteran’s court opened in Buffalo, N.Y. in 2008. The veteran’s court model is based on drug treatment and/or mental health treatment courts. Substance abuse or mental health treatment is offered as an alternative to incarceration. Treatment success rate as high as 98%.
- ♦ **Native American Cultural Engagement** – change policy surrounding providing financial support of cultural practices (i.e., horsemanship, sweats, and feasts) that are relevant to suicide prevention efforts.

Suicide Research in Montana

- ♦ Perfect Depression Care – consider a follow-up study in a large (relatively-contained) Montana medical system (e.g., Billings Clinic)
- ♦ Ongoing pilot study at Montana State University with Youth Aware of Mental Health (YAM)

Top 6 recommendations for 2017 state legislative action from the Montana Suicide Mortality Review Team (MSMRT)

1. Renew the MSMRT and approve coordinated data sharing with American Indian Nations and the Montana University System and update the statute to include obtaining data from hospital systems on numbers and types of suicide attempts (important to have balanced leadership outside of government – in suicide prevention; findings will ensure better interventions, better results and better expenditure of tax dollars).
2. PAX Good Behavior Game in every 1st or 2nd grade classroom (\$55 return of investment for every dollar spent on this program.; reduces youth suicide; increases the amount of time a teacher spends teaching instead of managing behavior problems; reduces teacher burnout) .
3. Mandatory training of primary care in suicide prevention and suicide risk assessment.
4. Addition of an American Indian Suicide Prevention Coordinator (enhance longer-lasting relationship building and dedicated technical assistance that is culturally sensitive and meaningful).
5. A “Declaration of Firearm Safe Storage Standards for Children” (88% of all firearm deaths in Montana are suicides. Firearms are the means in 63% of youth suicides in Montana. Handguns constitute 89% of the firearm-related suicides in Montana).
6. Mandatory depression screening for all school children ages 11-17 (depression is the highest risk factor for youth suicide) and development of school district mental health crisis response protocols.



Montana Youth Suicides

Ages 11-17

(Data compiled through the Montana Suicide Mortality Review Team
and the CDC's WISQARS)

Based on **27** identified suicides between
January 1, 2014-March 1, 2016

The information presented in the following slides is based on death certificates identifying that the deceased was between the ages of 11 and 17. Additional information was obtained from coroner reports, supplemental questionnaires, health records, and information obtained from families.

DUE TO THE SMALL SAMPLE SIZE, NO INFERENCES SHOULD BE MADE CONCERNING THE DATA PRESENTED. THIS IS ONLY MEANT TO GIVE NUMBERS AND PERCENTAGES CONCERNING YOUTH SUICIDES IN MONTANA.

Youth Suicides (11-17) United States compared to Montana

2005 - 2014, **United States**
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
10,609	295,866,475	3.59

2005 - 2014, **Montana**
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
80	899,318	8.90

Youth Suicides (11-17) United States compared to Montana for Firearm Suicides

2005 - 2014, **United States**
Suicide **Firearm** Deaths and Rates per 100,000
All Races, Both Sexes, Ages 11 to 17
ICD-10 Codes: X72-X74

Number of Deaths	Population***	Crude Rate
4,162	295,866,475	1.41

2005 - 2014, **Montana**
Suicide **Firearm** Deaths and Rates per 100,000
All Races, Both Sexes, Ages 11 to 17
ICD-10 Codes: X72-X74

Number of Deaths	Population***	Crude Rate
50	899,318	5.56

Youth Suicides (11-17) Males compared to Females in Montana

2005 - 2014, **Montana**
Suicide Injury Deaths and Rates per 100,000
All Races, **Females**, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
29	436,553	6.64

2005 - 2014, **Montana**
Suicide Injury Deaths and Rates per 100,000
All Races, **Males**, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
51	462,765	11.02

Youth Suicides (11-17) Males compared to Females in Montana

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Females, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
29	436,553	6.64

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Males, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
51	462,765	11.02

Youth Suicides (11-17) Montana by Ethnicity

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Both Sexes, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
55	788,356	6.98

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
24	91,752	26.16

Youth Suicides (11-17) Montana Males by Ethnicity

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Males, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
39	406,131	9.60

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Males, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
11*	46,844	23.48*

Youth Suicides (11-17) Montana Females by Ethnicity

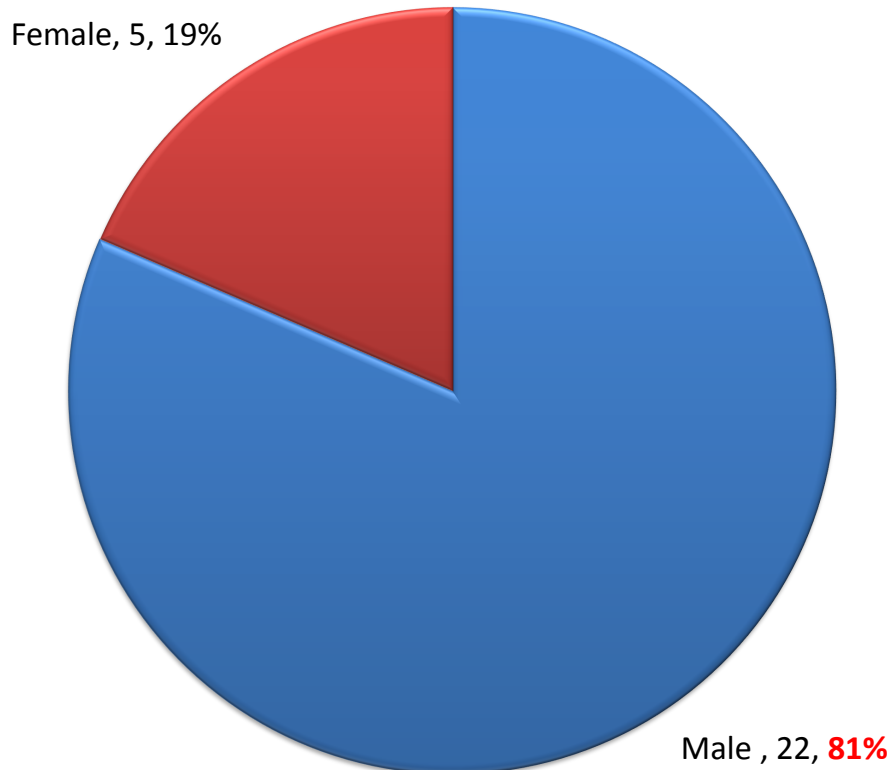
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Females, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0, *U03

Number of Deaths	Population***	Crude Rate
16*	382,225	4.19

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Females, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0, *U03

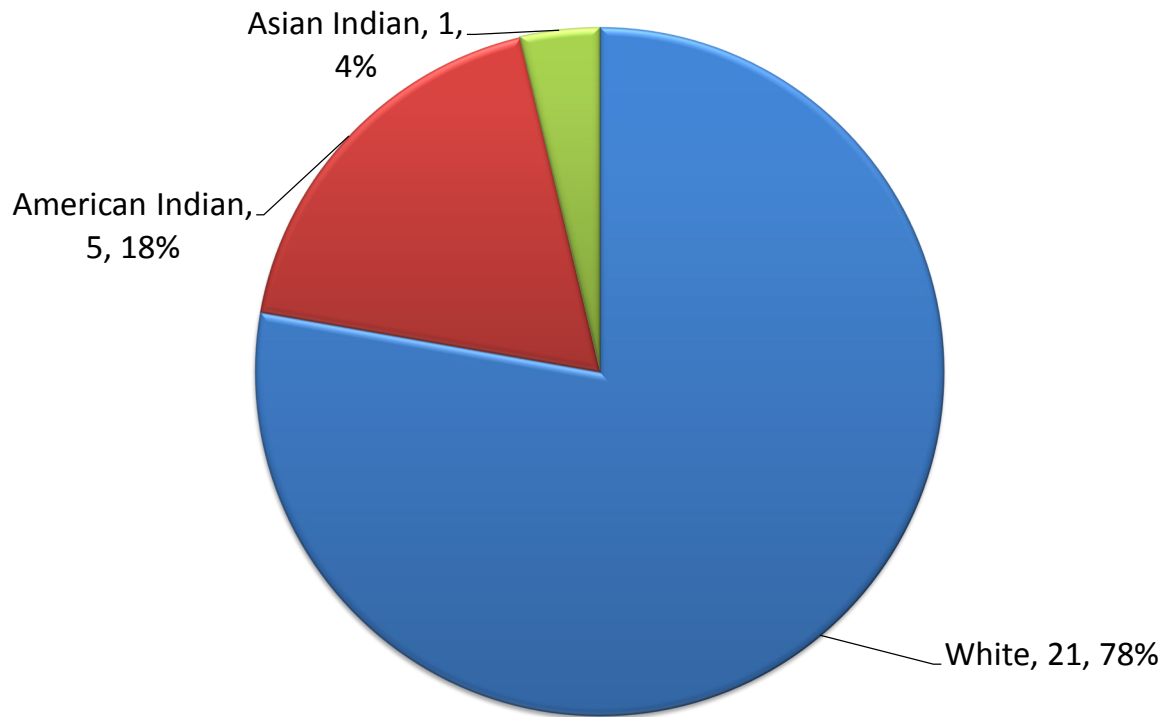
Number of Deaths	Population***	Crude Rate
13*	44,908	28.95*

Youth Suicide (11-17) by Gender (January 1, 2014-March 1, 2016)



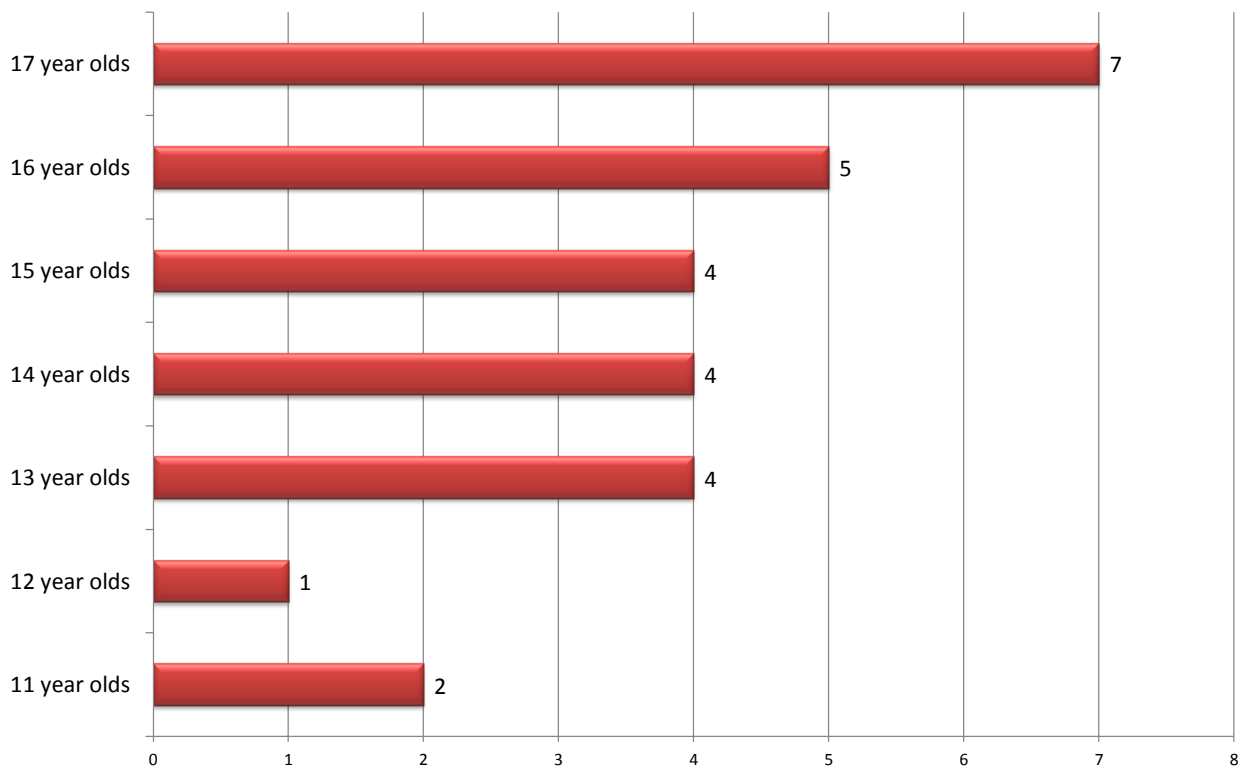
Youth Suicides (11-17) by Race

(January 1, 2014-March 1, 2016)

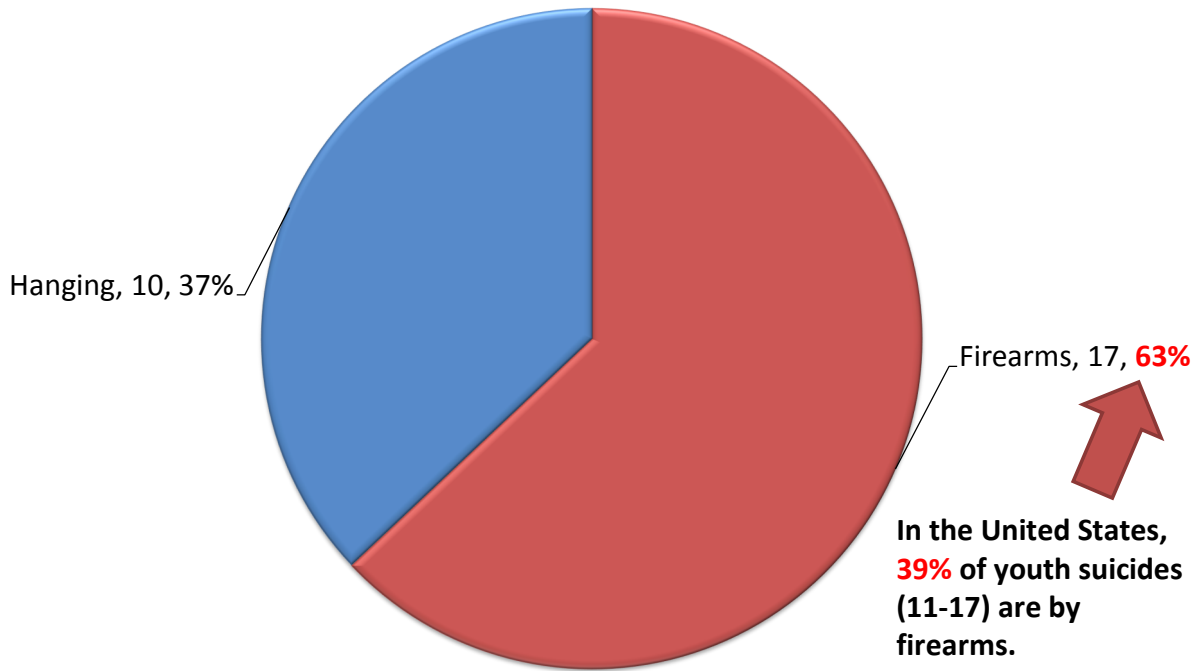


Youth Suicides (11-17) by Age

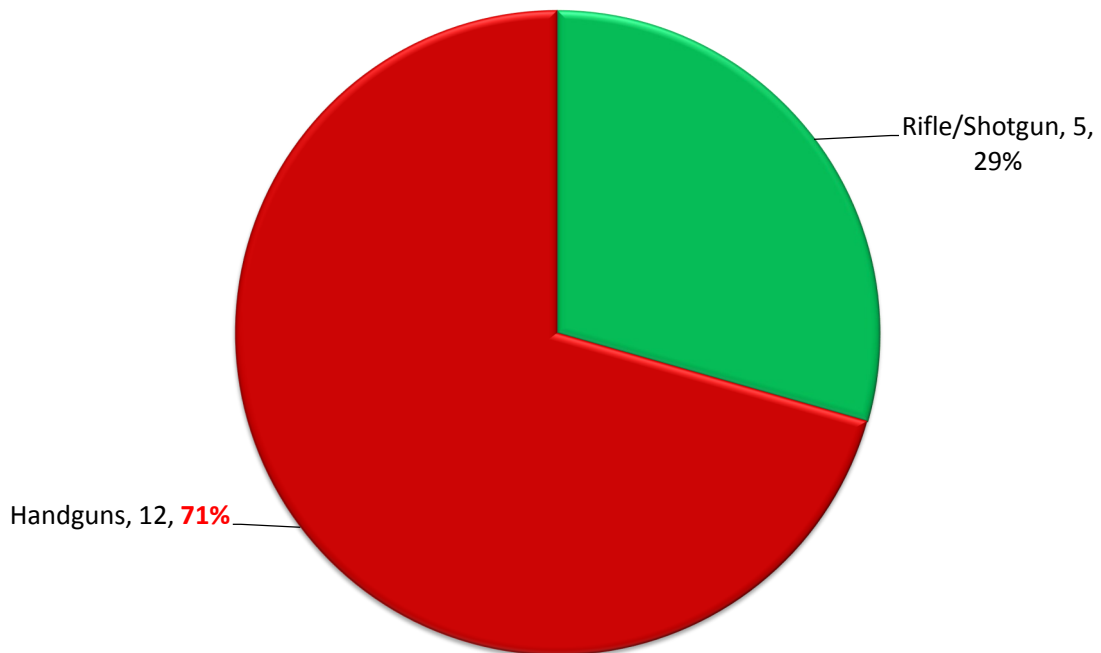
(January 1, 2014-March 1, 2016)



Youth Suicides (11-17) by Means (January 1, 2014-March 1, 2016)

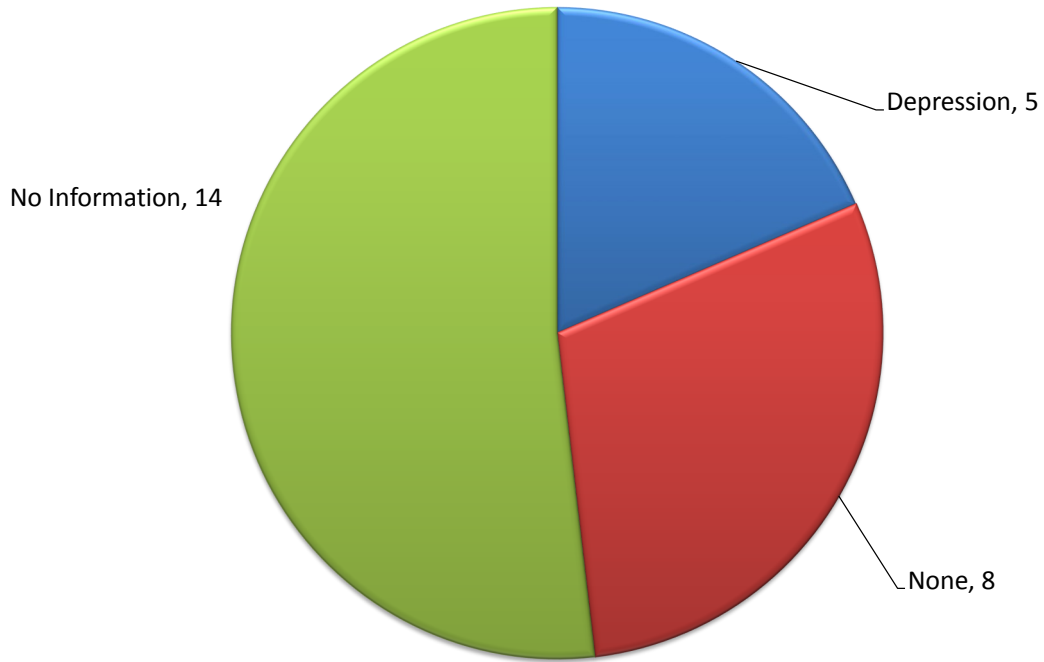


Youth Suicides (11-17) by Type of Firearm (January 1, 2014-March 1, 2016)



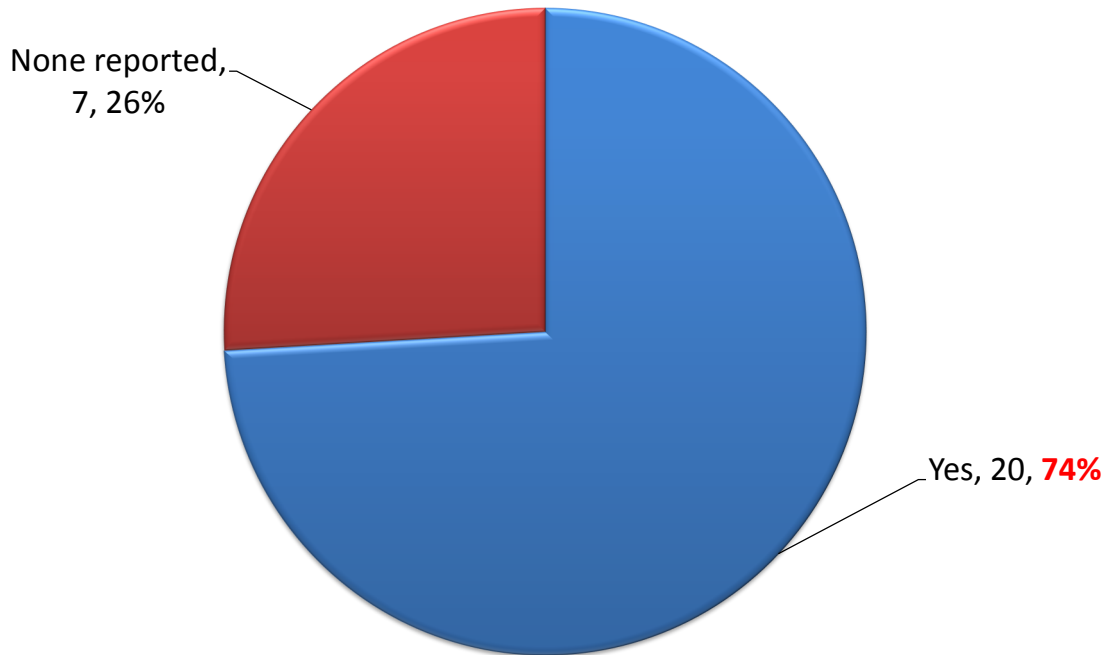
Youth Suicides (11-17) with Identified Mental Health Issues

(January 1, 2014-March 1, 2016)

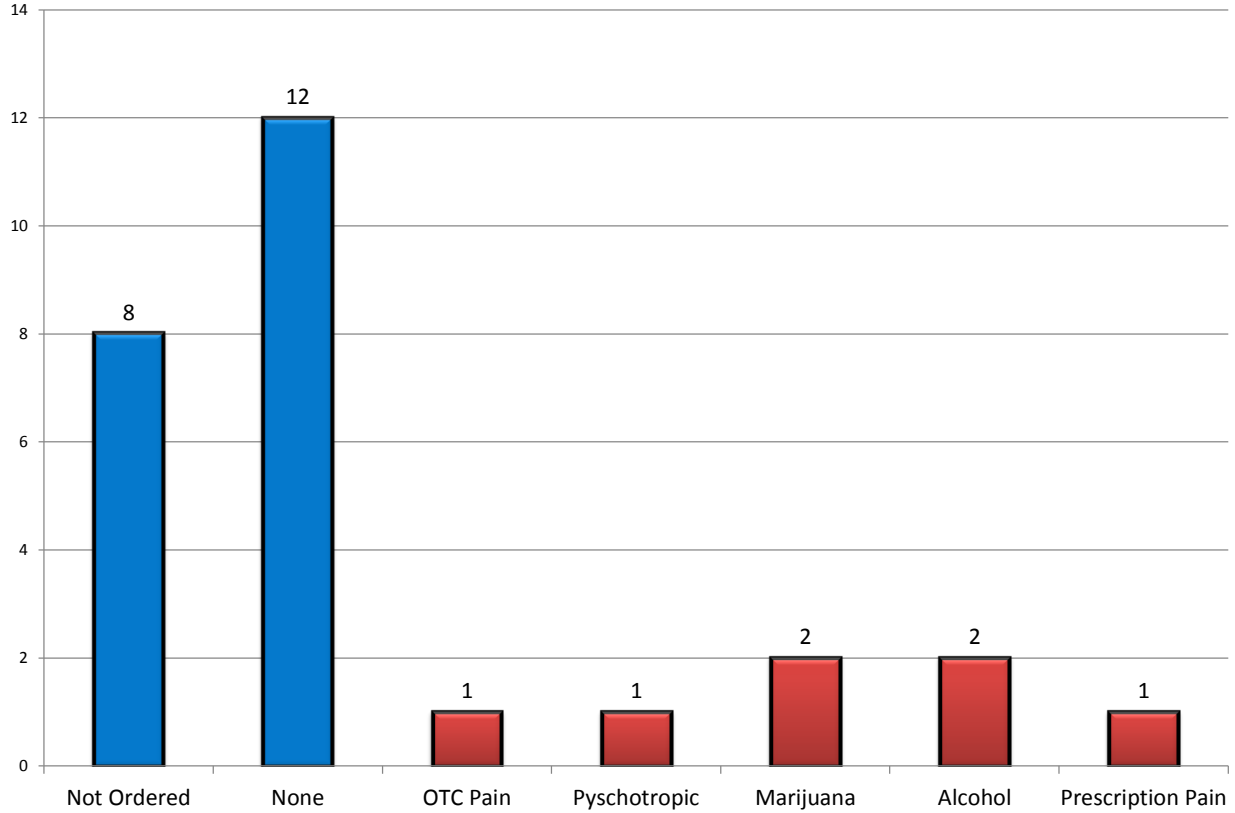


Youth Suicides (11-17) with Identified Warning Signs

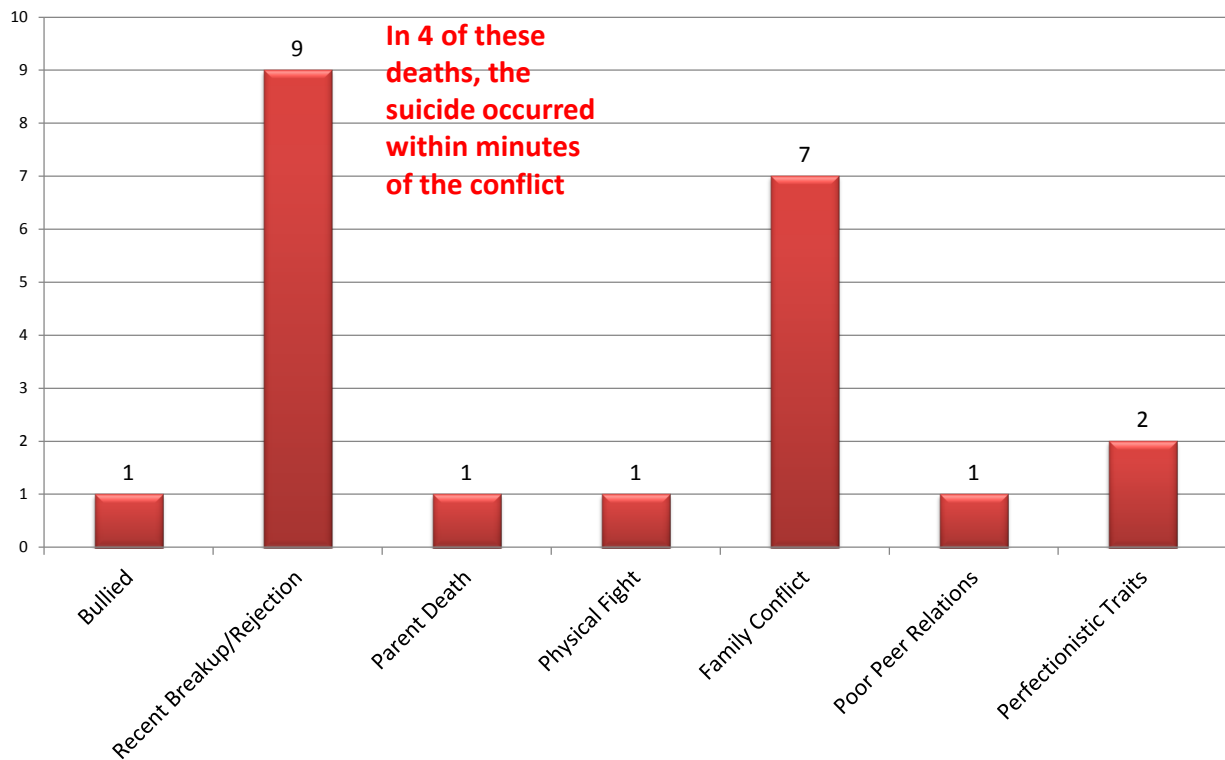
(January 1, 2014-March 1, 2016)



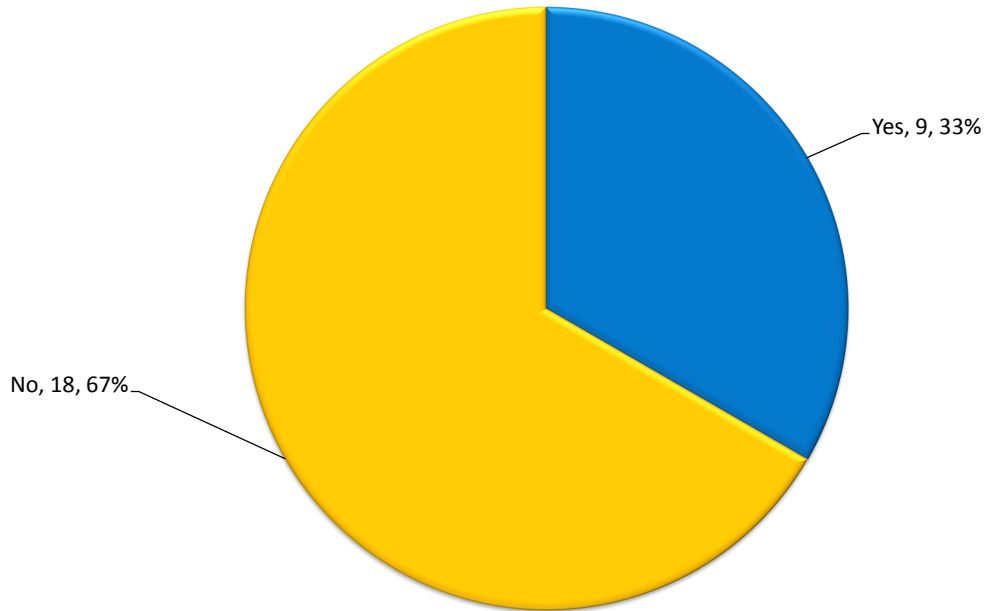
Toxicology Findings on Youth Suicides (January 1, 2014-March 1, 2016)



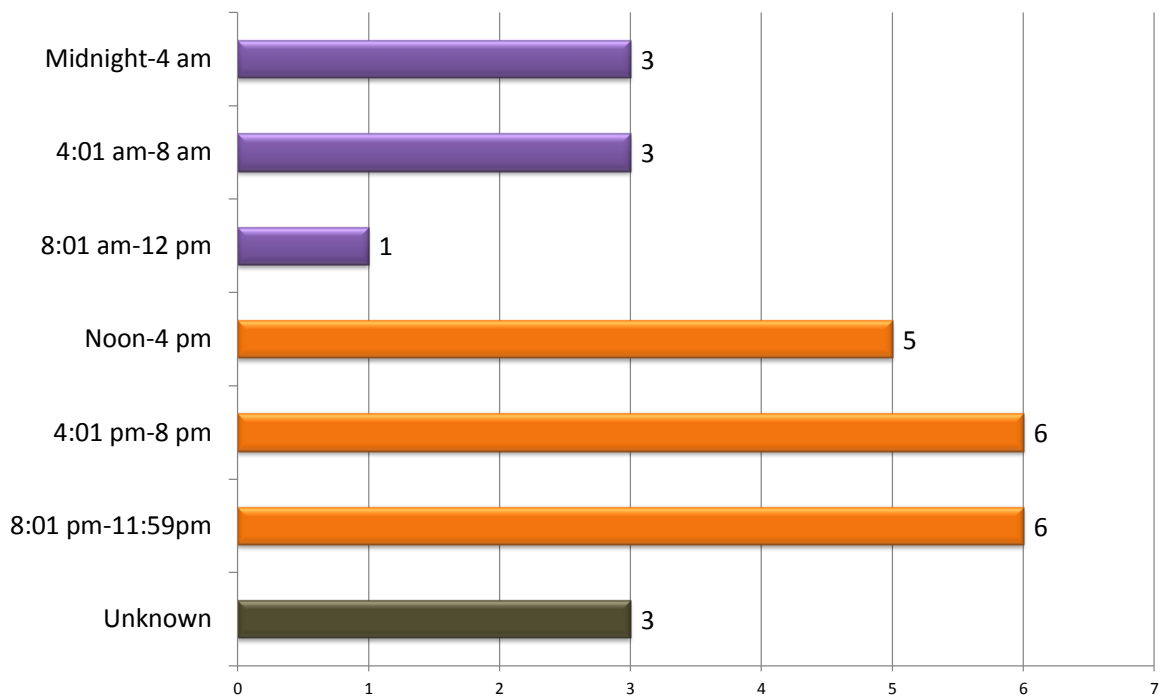
Youth Suicides (11-17) with Known Relational Conflicts (January 1, 2014-March 1, 2016)



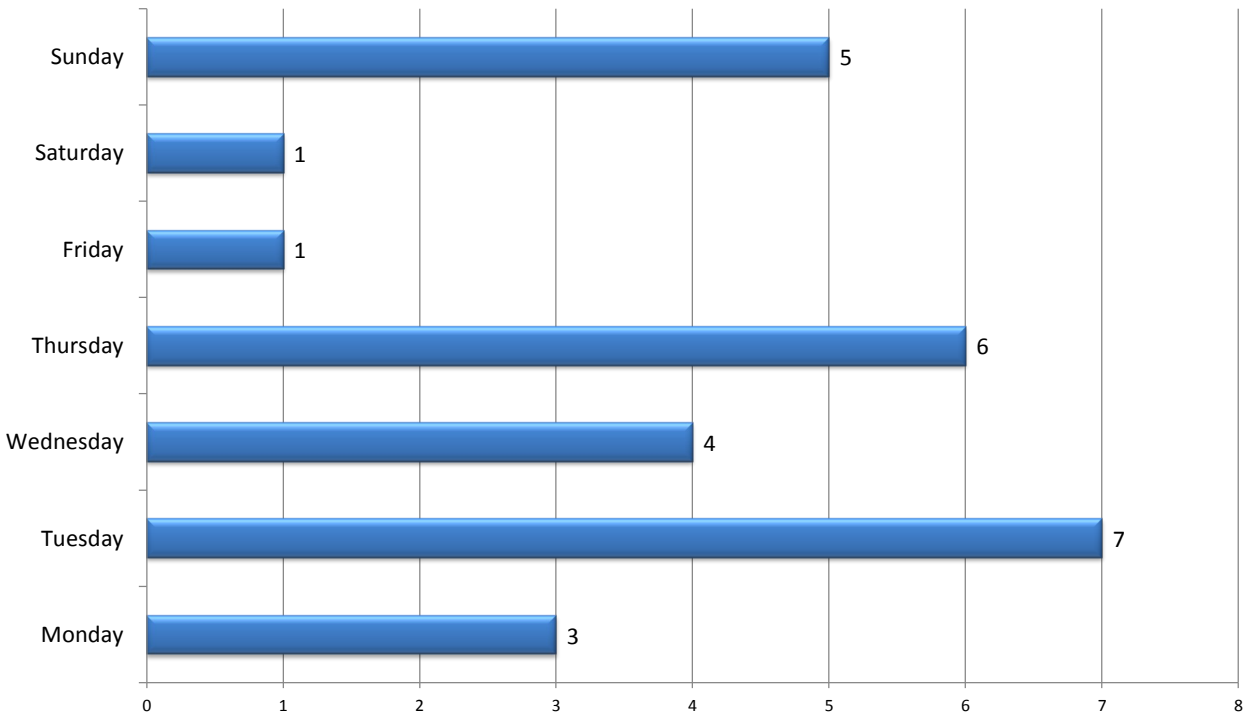
**Youth Suicides (11-17)
Where A Note Was Left
(January 1, 2014-March 1, 2016)**



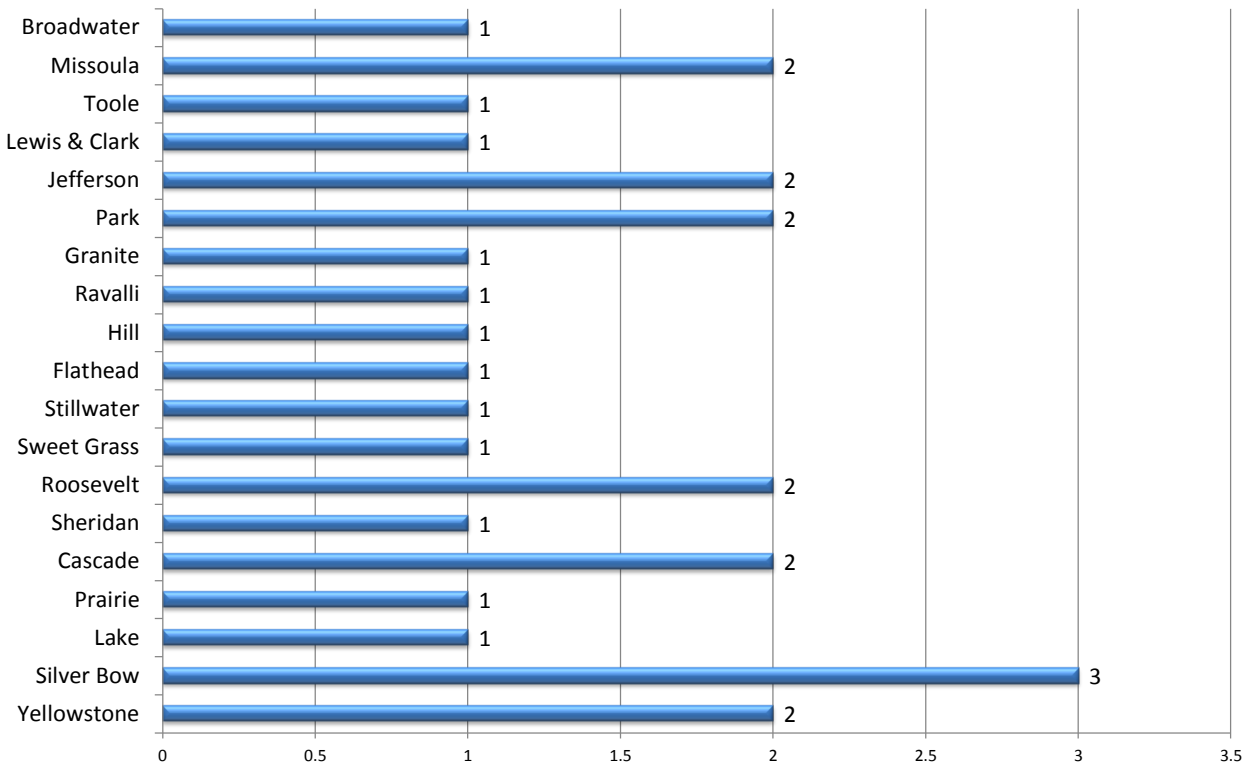
**Youth Suicides (11-17) by Time of Day
(January 1, 2014-March 1, 2016)**



Youth Suicides (11-17) by Day of the Week (January 1, 2014-March 1, 2016)



Youth Suicides (11-17) by County of Residence (January 1, 2014-March 1, 2016)



Montana Youth Risk Behavior Survey – Montana Youth and Suicide

The Montana Youth Risk Behavior Survey is administered by the Montana Office of Public Instruction every two years to 7th and 8th grade students and to high school students. The purpose of the survey is to help monitor the prevalence of behaviors that not only influence youth health, but also put youth at risk for the most significant health and social problems that can occur during adolescence. For the purpose of this report, the 2015 survey is referenced with the focus on depression and suicidal behavior (for complete results and data, go to <http://opi.mt.gov/Reports&Data/YRBS.html>):

2015 Montana Youth Risk Behavior Survey Results Comparative Tables

Table (left to right): High School ~ Grades 7-8 ~ American Indian Students on Reservations (AI-R) American Indian Students in Urban Schools (AI-U) ~ Nonpublic Accredited Schools (NPA) Alternative Schools (ALT) ~ Students with Disabilities (SWD)

Injury and Violence Percentage of students who:	High School	Grades 7-8	AI-R	AI-U	NPA	ALT	SWD
Felt sad or hopeless for 2 or more weeks in a row that they stopped doing some usual activities during the past 12 months	29.3	26.1	37.5	41.1	25.1	53.5	42.9
Seriously considered attempting suicide during the past 12 months	18.8	17.1	24.0	30.3	15.2	36.6	31.4
Made a plan about how they would attempt suicide during the past 12 months	15.5	14.2	20.9	25.3	12.5	33.5	24.2
Attempted suicide during the past 12 months	8.9	11.6	19.3	19.8	10.9	25.8	20.0
Had a suicide attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or a nurse during the past 12 months	3.1	3.3	6.5	6.5	3.9	8.0	8.4

2015 Youth Risk Behavior Survey Results

Montana – 10-year Trend Analysis Report

Injury and Violence Percentage of students who:	2005	2007	2009	2011	2013	2015	10-year Trend	Change from 2013-2015
Felt sad or hopeless for 2 or more weeks in a row that they stopped doing some usual activities during the past 12 months	25.6	25.8	27.3	25.2	26.4	29.3	Increased	Increased
Seriously considered attempting suicide during the past 12 months	17.5	15.1	17.4	15.2	16.8	18.8	No change	Increased
Made a plan about how they would attempt suicide during the past 12 months	14.6	13.2	13.4	12.3	13.6	15.5	No change	Increased
Attempted suicide during the past 12 months	10.3	7.9	7.7	6.5	7.9	8.9	No change	No change
Had a suicide attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or a nurse during the past 12 months	3.1	2.7	2.8	2.4	2.6	3.1	No change	No change

2015 Montana Youth Risk Behavior Survey

Suicide Report

For the purpose of this report, youth that are classified as having attempted suicide are those Montana youth in 2015 that reported attempting suicide one or more times during the 12 months prior to taking the YRBS. Forty-five separate risk behaviors were queried for association with the attempted suicide question.

Health Risk Behavior - percentage of students	Students Who Attempted Suicide	Students Who Did Not Attempt Suicide
Never or rarely wore a seat belt when riding in a car driven by someone else	18.4% (13.7-23.1)	8.1% (6.8-9.4)
Never or rarely wore a seat belt when driving	13.9% (10.0-17.8)	6.9% (5.5-8.2)
Rode with a driver who had been drinking during the past 30 days	43.0% (37.3-48.7)	20.8% (19.0-22.6)
Drove when drinking alcohol during the past 30 days	26.6% (17.6-35.6)	9.0% (7.4-10.7)
Texted or e-mailed while driving a car or other vehicle during the past 30 days	57.5% (49.5-65.4)	54.6% (51.2-58.0)
Talked on a cell phone while driving during the past 30 days	57.4% (49.5-65.3)	58.3% (55.3-61.4)
Carried a weapon such as a gun, knife, or club during the past 30 days	39.9% (34.8-45.0)	24.4% (22.5-26.3)
Did not go to school because they felt unsafe at school or on their way to or from school during the past 30 days	19.9% (15.1-24.7)	3.4% (2.7-4.2)
Were threatened or injured with a weapon on school property during the past 12 months	19.9% (14.9-25.0)	3.7% (2.9-4.5)
Ever physically forced to have sexual intercourse when they did not want to	31.6% (26.7-36.6)	6.1% (5.3-7.0)
Were bullied on school property during the past 12 months	54.5% (49.9-59.2)	22.6% (20.7-24.6)
Were electronically bullied (e-mail, chat rooms, instant messaging, websites, or texting) during the past 12 months	49.4% (43.6-55.3)	15.8% (14.4-17.3)
Were the victim of teasing, name calling, or bullying because someone thought they were gay, lesbian, or bisexual during the past 12 months	36.2% (30.7-41.7)	12.6% (11.4-13.9)
Felt sad or hopeless almost every day for 2 or more weeks in a row during the past 12 months	79.3% (74.6-84.1)	24.8% (23.1-26.5)
Seriously considered attempting suicide during the past 12 months	85.4% (81.3-89.4)	12.7% (11.4-14.0)
Ever tried cigarette smoking	64.2% (57.1-71.2)	35.8% (32.4-39.2)
Smoked a cigarette during the past 30 days	34.7% (27.9-41.5)	10.7% (9.1-12.3)
Used smokeless tobacco (chewing tobacco, snuff, or dip) during the past 30 days	19.5% (14.5-24.6)	10.9% (9.7-12.1)
Smoked cigars, cigarillos, or little cigars during the past 30 days	21.4% (16.6-26.3)	11.2% (9.9-12.5)
Ever used electronic vapor products (e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens such as blu, NJOY, or Starbuzz)	70.2% (65.0-75.5)	48.9% (46.5-51.3)
Used electronic vapor products during the past 30 days	51.4% (44.1-58.7)	27.1% (25.1-29.1)

2015 Montana Youth Risk Behavior Survey

Suicide Report

For the purpose of this report, youth that are classified as having attempted suicide are those Montana youth in 2015 that reported attempting suicide one or more times during the 12 months prior to taking the YRBS. Forty-five separate risk behaviors were queried for association with the attempted suicide question.

Health Risk Behavior by percentage of students	Students Who Attempted Suicide	Students Who Did Not Attempt Suicide
Ever had a drink of alcohol in their lifetime	84.9% (79.9-89.9)	68.7% (66.7-70.6)
Had a drink of alcohol during the past 30 days	57.3% (50.0-64.6)	32.1% (29.9-34.3)
Had 5 or more drinks of alcohol within a couple hours during the past 30 days	38.4% (34.7-45.2)	19.1% (17.5-20.6)
Ever used marijuana in their lifetime	66.3% (59.0-73.6)	34.3% (30.7-38.0)
Used marijuana during the past 30 days	42.4% (35.6-49.3)	17.0% (14.8-19.2)
Ever used methamphetamines in their lifetime	11.7% (7.1-16.3)	1.9% (1.3-2.5)
Ever used ecstasy in their lifetime	17.8% (13.1-22.6)	4.6% (3.7-5.5)
Ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax)	41.1% (35.0-47.2)	12.7% (11.3-14.1)
Ever had sexual intercourse in their lifetime	71.3% (65.0-77.5)	41.3% (38.2-44.5)
Had sexual intercourse with four or more persons during their life	29.2% (23.2-35.1)	11.8% (10.1-13.5)
Had sexual intercourse during the past 3 months	57.6% (50.9-64.3)	29.7% (27.2-32.3)
Drank alcohol or used drugs before last sexual intercourse	31.1% (23.3-38.8)	17.3% (15.0-19.6)
Did not eat fruit or drink 100% fruit juice during the past 7 days	8.5% (5.3-11.8)	4.5% (3.6-5.3)
Did not eat green salad, potatoes, carrots, or other vegetables during the past 7 days	10.5% (4.0-17.1)	4.3% (3.5-5.2)
Drank a can, bottle, or glass of soda or pop daily during the past 7 days	30.0% (25.2-34.8)	17.0% (15.6-18.5)
Did not drink milk during the past 7 days	20.3% (16.3-24.2)	15.1% (13.7-16.4)
Did not eat breakfast during the past 7 days	22.7% (17.9-27.6)	11.5% (10.4-12.5)
Were physically active at least 60 minutes per day on 5 or more of the past 7 days	44.7% (38.2-51.1)	55.1% (53.3-57.0)
Watched 3 or more hours of TV on an average school day	30.2% (24.3-36.1)	21.1% (19.2-23.0)
Played video or computer games 3 or more hours per day on an average school day	42.2% (36.6-47.8)	34.1% (32.4-35.9)
Played on at least one sports team during the past 12 months	52.1% (44.7-59.5)	63.2% (61.3-65.2)
Had 8 or more hours of sleep on an average school night	20.3% (16.0-24.6)	33.4% (31.7-35.1)
Made mostly A's or B's in school during the past 12 months	60.5% (54.4-66.7)	77.2% (75.1-79.4)
Received help from a resource teacher, speech therapist, or other special education teacher during the past 12 months	25.1% (20.7-29.4)	10.9% (9.6-12.2)

10 Leading Causes of Death, Montana 2014, All Races, Both Sexes

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 16	Unintentional Injury ---	Unintentional Injury ---	Unintentional Injury ---	Unintentional Injury 56	Unintentional Injury 55	Unintentional Injury 60	Malignant Neoplasms 105	Malignant Neoplasms 380	Heart Disease 1,584	Malignant Neoplasms 2,066
2	Short Gestation 10	Homicide ---	Perinatal Period ---	Suicide ---	Suicide 32	Suicide 31	Suicide 43	Heart Disease 82	Heart Disease 261	Malignant Neoplasms 1,532	Heart Disease 1,957
3	Maternal Pregnancy Comp. ---	Influenza & Pneumonia ---	---	Malignant Neoplasms ---	Malignant Neoplasms ---	Malignant Neoplasms 12	Malignant Neoplasms 32	Unintentional Injury 73	Chronic Low. Respiratory Disease 79	Chronic Low. Respiratory Disease 572	Chronic Low. Respiratory Disease 668
4	SIDS ---	---	---	Benign Neoplasms ---	Heart Disease ---	Heart Disease ---	Heart Disease 22	Suicide 45	Unintentional Injury 65	Cerebrovascular 420	Unintentional Injury 581
5	Placenta Cord Membranes ---	---	---	Septicemia ---	Homicide ---	Homicide ---	Liver Disease 13	Liver Disease 34	Suicide 52	Unintentional Injury 253	Cerebrovascular 480
6	Circulatory System Disease ---	---	---	Whooping Cough ---	Benign Neoplasms ---	Cerebrovascular ---	Diabetes Mellitus ---	Diabetes Mellitus 20	Liver Disease 51	Alzheimer's Disease 251	Alzheimer's Disease 253
7	Pulmonary Hemorrhage ---	---	---	---	Chronic Low. Respiratory Disease ---	Congenital Anomalies ---	Homicide ---	Chronic Low. Respiratory Disease 15	Cerebrovascular 40	Diabetes Mellitus 184	Suicide 251
8	Respiratory Distress ---	---	---	---	Complicated Pregnancy ---	Liver Disease ---	Cerebrovascular ---	Cerebrovascular 12	Diabetes Mellitus 40	Influenza & Pneumonia 156	Diabetes Mellitus 250
9	Unintentional Injury ---	---	---	---	Diabetes Mellitus ---	Four Tied ---	Nephritis ---	Homicide ---	Septicemia 17	Nephritis 104	Influenza & Pneumonia 179
10	Four Tied ---	---	---	---	---	Four Tied ---	Two Tied ---	Influenza & Pneumonia ---	Viral Hepatitis 13	Parkinson's Disease 79	Liver Disease 150

WISQARS Note: For leading cause categories in this State-level chart, counts of less than 10 deaths have been suppressed (---).

Suicide is in green

What is Suicide Costing the State of Montana?

Fatal Injuries, Both Sexes, All Ages , Montana, 2010

Intent: Suicide

Mechanism: All

Number of Deaths and Estimated Average and Total Lifetime Costs

Classified by Mechanism and Intent

Costs Expressed in 2010 U.S. Prices

Mechanism	Deaths and Type of Cost		Intent	
			Suicide	Total
Mechanism	Deaths	--	227	227
	Medical Cost	Average	\$2,449*	\$2,449*
		Total	\$556,000*	\$556,000*
	All Mechanisms	Work Loss Cost	Average	\$1,113,764
Total			\$252,825,000	\$252,825,000
Combined Cost		Average	\$1,116,213	\$1,116,213
		Total	\$253,380,000	\$253,380,000
Total	Deaths	--	227	227
	Medical Cost	Average	\$2,449*	\$2,449*
		Total	\$556,000*	\$556,000*
	Work Loss Cost	Average	\$1,113,764	\$1,113,764
Total		\$252,825,000	\$252,825,000	
Combined Cost	Average	\$1,116,213	\$1,116,213	
	Total	\$253,380,000	\$253,380,000	

Injury Classification Scheme: Mechanism by Intent of Injury.

Reports for All Ages include those of unknown age.

Total cost estimates are additive both within the state and across states to the U.S. total.

*** Cost estimates based on 20 or fewer deaths are considered unstable. Estimates based on more than 20 deaths may also be unstable due to high relative variability of case-level costs. Interpret unstable estimates with caution.**

Note: For injury-related deaths, lifetime medical costs refer to the medical costs associated with the fatal injury event.

Produced by: National Center for Injury Prevention and Control, CDC

Data Source: NCHS Vital Statistics System for numbers of deaths. NEISS All Injury Program operated by the U.S. Consumer Product Safety

Commission (CPSC) for numbers of nonfatal injuries. Pacific Institute for Research and Evaluation (PIRE), Calverton, MD for unit cost estimates.

Risk and Protective Factors associated with Suicide

Risk Factors

Risk factors are long standing conditions, stressful events, or situations that may increase the likelihood of a suicide attempt or death. The following lists are representative of information found in suicide literature. While no list is all-inclusive, those included below serve to summarize an enormous amount of information.

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Risk factors do not cause suicide, but when many factors are present, these may increase an individual's vulnerability. The following risk factors for all ages are identified in the National Strategy of Suicide Prevention (2001):

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

When the risk factors for specific age groups are explored, some differences are evident. The following are the risk factors identified for youth and the elderly:

Risk Factors for the Young (The risk factors were taken from the Maine Youth Suicide Prevention Program, 2006, created through the Maine Department of Health and Human Services and by the Montana Strategic Suicide Prevention Plan Work Group, 2008)

Family Risk Factors

- Family history of suicide (especially a parent)
- Changes in family structure through death, divorce, re-marriage, etc.
- Family involvement in alcoholism
- Lack of strong bonding/attachment within the family, withdrawal of support
- Unrealistic parental expectations
- Violent, destructive parent-child interactions
- Inconsistent, unpredictable parental behavior
- Depressed, suicidal parents
- Physical, emotional, or sexual abuse

Environmental Risk Factors

- Access to lethal means
- Frequent mobility
- Religious conflicts
- Social isolation/alienation or turmoil
- Exposure to a suicide of a peer
- Anniversary of someone else's suicide
- Incarceration/loss of freedom
- High levels of stress; pressure to succeed
- Over-exposure to violence in mass media

Behavioral Risk Factors

- One or more prior suicide attempt(s)
- Alcohol/drug abuse
- Aggression/rage/defiance
- Running away
- School failure, truancy
- Fascination with death, violence, Satanism

Personal Risk Factors

- Mental illness/psychiatric conditions such as Depression, Bipolar, Conduct and Anxiety disorders
- Poor impulse control
- Confusion/conflict about sexual identity
- Loss of significant relationships
- Compulsive, extreme perfectionism
- Lack skills to manage decision-making, conflict, anger, problem solving, distress, etc.
- Loss (or perceived loss) of identity, status
- Feeling powerless, hopeless, helpless
- Victim of sexual abuse
- Pregnancy or fear of pregnancy
- Fear of humiliation

Risk Factors for the Elderly (taken from Luoma et al, 2002, and the Montana Strategic Suicide Prevention Plan Work Group)

- Male
- Age (the older the age, the greater the risk)
- Bereavement (loss of a loved one)
- Physical illness, uncontrollable pain or the fear of a prolonged illness;
- Perceived poor health
- Social isolation and loneliness
- Undiagnosed depression
- Neurobiological factors: age-related effects on central serotonergic function are associated with a predisposition to impulsive and aggressive acts along with greater risk of depression (Mann, JJ., 1998)
- Major changes in social roles (e.g. retirement, transition to assisted living)
- Contrary to popular opinion, only a fraction (2-4%) of suicide victims have been diagnosed with a terminal illness at the time of their death.
- Financial insecurity (Montana Strategic Suicide Prevention Plan Work Group)

Protective Factors

Some individuals and communities are more resistant to suicide than others. Little is known about these protective factors. However they might include genetic and neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. As with prevention and intervention activities, when programs to enhance protective factors are introduced, they must build on individual and community assets. They must also be culturally appropriate. As an example protective factors enhancement in any one of Montana's American Indian communities must capitalize on the native customs and spiritual beliefs of that nation, tribe or band.

According to the National Strategy of Suicide Prevention (2012), protective factors for all ages include:

- Availability of physical and mental health care
- Restrictions on lethal means of suicide
- Safe and supportive school and community environments
- Sources of continued care after psychiatric hospitalization
- Connectedness to individuals, family, community, and social institutions.
- Supportive relationships with health care providers.
- Coping and problem solving skills
- Reasons for living (e.g., children in the home)
- Moral objections to suicide

When we explored the protective factors for specific age groups, we found some differences. The following are the protective factors identified for youth and the elderly:

Protective Factors for the Young

(The protective factors were taken from the Maine Youth Suicide Prevention Program (2006) created through the Maine Department of Health and Human Services.)

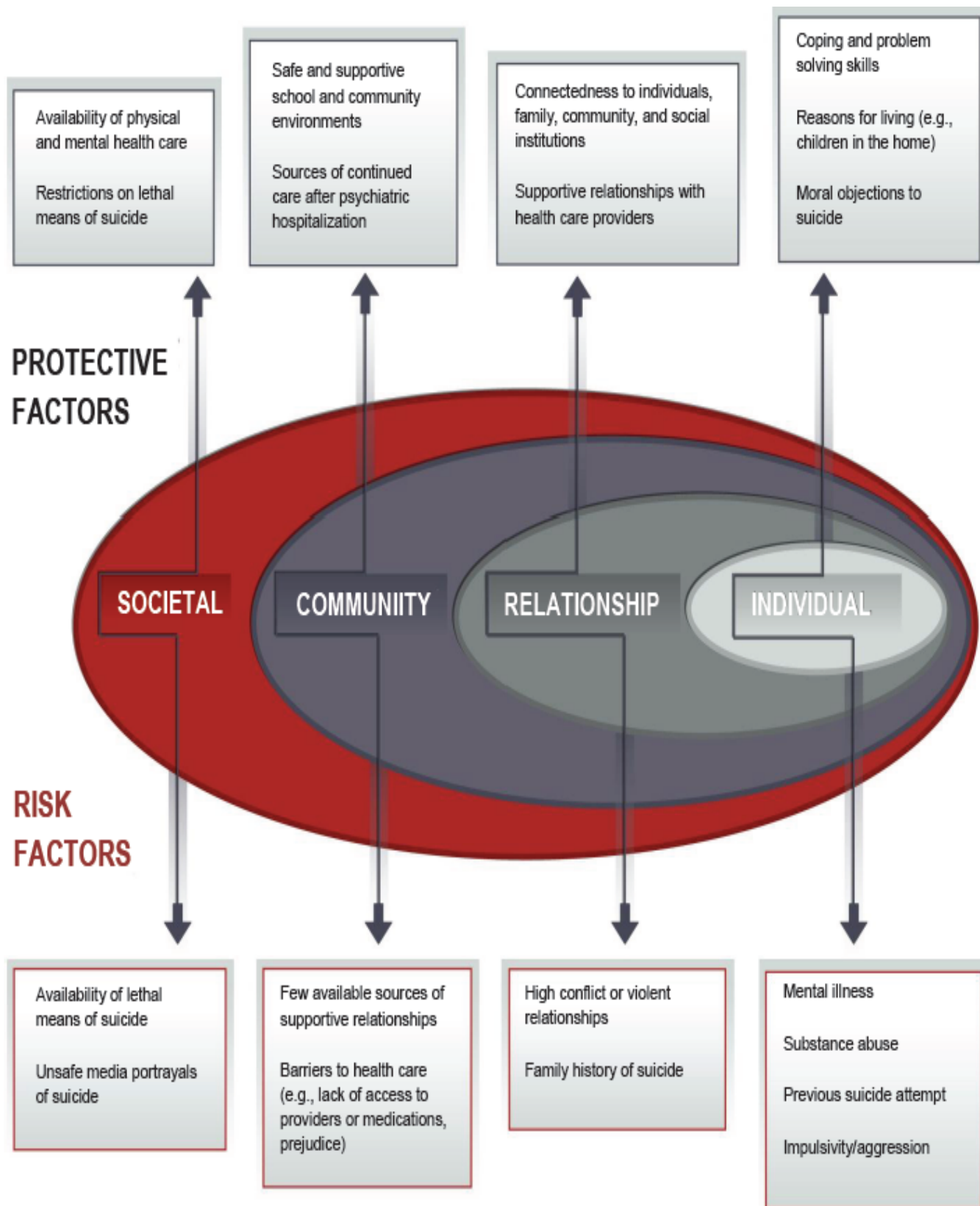
- Dominant attitudes, values, and norms prohibiting suicide, including strong beliefs about the meaning and value of life
- Life skills (i.e., decision-making, problem-solving, anger management, conflict management, and social skills)
- Good health, access to health care
- Best friends, supportive significant others
- Religious/spiritual beliefs
- A healthy fear of risky behavior, pain
- Hope for the future
- Sobriety
- Medical compliance
- Good impulse control
- Strong sense of self-worth
- A sense of personal control
- Strong interpersonal bonds, particularly with family members and other caring adults
- Opportunities to participate in and contribute to school and/or community projects/activities
- A reasonably safe, stable environment
- Difficult access to lethal means
- Responsibilities/duties to others
- Pets

Protective Factors for the Elderly

(taken from Luoma et al, 2002, and the Montana Strategic Suicide Prevention Plan Work Group, 2008)

- Female
- Established Social Support Network
- Positive health
- Social activity
- Cultural and religious beliefs
- Coping or problem-solving skills
- Genetic or neurobiological makeup
- Restricted access to lethal means
- Adequate access to healthcare for mental health and pain management
- Higher life satisfaction
- Experience and wisdom (Montana Strategic Suicide Prevention Plan Work Group)
- Pets (Montana Strategic Suicide Prevention Plan Work Group)

Later in the plan when the discussion focuses on other populations in Montana with a high risk of suicide, specific risk and protective factors for those populations will be identified.



Taken from the 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION. A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention.

Opportunities for Prevention Activities

The variations in suicide rates by age groups and gender provide a wide array of opportunities for prevention and intervention activities. Prevention strategies can cover a wide variety of target groups (e.g., population at large, those who have ever thought of suicide as an option, those who have made previous attempts at suicide, and those in immediate crisis who are contemplating suicide as well as those who have experienced the death of a family member or close friend). Such activities can also range from a broad focus such as addressing risk and protective factors to a more narrow focus such as preventing imminent self-harm or death. Although the data on effectiveness of various programs and interventions is limited, certain strategies are beginning to emerge as more effective than others. Clearly, a singularly focused intervention strategy such as a crisis line or gatekeeper training program will not have a lasting impact in isolation. Each program needs to be tightly integrated and interlinked with other strategies to reach the broadest possible range of persons at risk. Various prevention activities have been identified for young people, older adults, and senior Caucasian males.

Youth – Ages 10 - 24

Although males are more at risk of dying from suicide, females make more attempts. Among the leading causes of hospital admission for women in this age group are poison-related suicide attempts, however, there has been a significant increase in suffocation/hanging in young females in the past decade.

Possible prevention measures for this group include:

- Implementation of the PAX Good Behavior Game in 1st and 2nd grade. Studies have suggested that the skills taught in this game may delay or prevent onset of suicidal ideations and attempts in early adulthood (SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)).
- Implementation of evidenced-based school curriculums, such as Signs of Suicide (SOS), Question Persuade Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), Safe Talk, or the American Indian Life Skills Development, into Montana schools. Also, pilot promising programs such as Youth Aware of Mental Health (YAM) (Wasserman, D, 2010)
- Distribution of suicide prevention toolkits for rural primary care providers. The purpose of the toolkits is to provide physicians, nurses, and health care staff with screening tools and state-wide resources to better manage suicidal patients.
- Increase in awareness and access to counseling services provided at state colleges and universities.
- Home visitation to high risk young families by public health or school personnel.
- Therapeutic Foster Care for high needs youth to provide a safe environment in which "wrap around" services could be provided.
- Inclusive, drug free, violence free, after school activity programs that run between 3pm – 8pm; offering a wide array of activities including the arts, volunteer opportunities and sports which will appeal to youths of varied backgrounds. These programs provide adult supervision by both qualified staff and volunteers and provide a forum for community resiliency and mentoring.
- Marketing of the National Crisis Text Line as a crisis resource (text "mt" to 741 741)

- School-based mentoring programs for at-risk youth as well as students transitioning to high school, provided by older students and/or adults .
- Mandatory screening for depression, starting at age 12. This is based on the recommendations of the US Prevention Task Force (2016) (<http://www.uspreventiveservicestaskforce.org/Page/Name/home>)
- Increased firearm safety measures. Based on their research, Grossman and his colleagues made the following summary: “storing household guns as locked, unloaded, or separate from the ammunition is associated with significant reductions in the risk of unintentional and self-inflicted firearm injuries and deaths among adolescents and children. Programs and policies designed to reduce accessibility of guns to youth, by keeping households guns locked and unloaded, deserve further attention as one avenue toward the prevention of firearm injuries in this population” (Grossman, et al, 2005).
- Reducing illegal drugs (methamphetamine, marijuana, etc.), alcohol and lethal prescription drugs would decrease the impact of this risk factor for suicide.
- Suicide prevention resources available on the Montana Suicide Prevention website at **www.dphhs.mt.gov/amdd/suicide**
- Enhance protective factors and provide coping skills for youth in all arenas of life.
- There is a correlation between smoking and suicidal behavior in people of all ages (see section later in report on suicide and smoking). *European Psychiatry* (2007) reported after adjusting for psychiatric diagnoses, an over twofold risk for suicide attempts was found among adolescents who smoked over 15 cigarettes a day. Additionally, if an adolescent also smoked the first cigarette immediately after waking up the risk was over threefold.

Older Adults – Ages 25 - 64

This group represents the biggest actual number of suicides in Montana; most suicides in this group are male and completed with use of a gun. Interventions for this group could include:

- Addressing the significant stigma associated with admitting to having depression or a mental illness. This could be achieved through a public awareness campaign addressing the myths and stereotypes associated with having a mental illness and beginning to challenge the culture of acceptance around suicide.
- Continued implementation of evidenced-based gatekeeping programs such as QPR and ASIST in communities to increase recognition of warning signs of suicide and to intervene with appropriate assistance.
- As the primary first responders, increase the number of law enforcement personnel and correctional officers around the state trained in Crisis Intervention Training (CIT).
- Having physicians receive gatekeeper training and subsequently assessing all patients for depression (universal screening) and suicide risk factors and making appropriate and timely referrals for mental health services.
- Due to the correlation between smoking and suicidal behavior (see section later in report on suicide and smoking), focus smoking cessation campaigns towards this age group.
- Crisis lines - recently, two large SAMHSA-funded studies found that telephone crisis services, like those in the Lifeline network, can provide an effective mental health and suicide prevention service for callers (Kalafat et al., 2007; Gould et al., 2007). A study of 1,085 suicidal and 1,617 non-suicidal crisis callers to 8 crisis lines found that callers showed significant reductions on all measures of emotional distress, hopelessness and suicidality by the end of the call, as well as at follow-up 2 to 3 weeks later.

- Development of lay provider crisis intervention teams, creating more hospital beds designated for mental health, and suicide stigma reduction campaigns would increase intervention possibilities for suicidal individuals.
- As in the younger group, increase in awareness and access to counseling services provided at state colleges and universities.

Senior Caucasian Males, Over Age 65

Rural isolation, lack of access to mental health resources and access to lethal means are major risk factors with this age group. Prevention efforts for this population should focus on:

- The development of calling trees set up among senior volunteer groups to reduce isolation.
- Providing gatekeeper interventions (ASIST, QPR) among caregivers and volunteer groups.
- The medical community serving this population could be trained in gatekeeper strategies and begin to universally screen patients for depression, mental illness and or drug/alcohol abuse.
- Senior suicide is related to severe illness and chronic pain. Improved pain management and increased resiliency among this group could reduce suicide.
- Exploration of implementing an evidenced-based intervention such as the Prevention of Suicide in Primary Elderly: Collaborative Trial (PROSPECT), into community programs.

The elderly have one of the highest rates of suicide in the United States and Montana:

- **In the US in 2014, 7,693 people over the age of 65 died by suicide for a rate of 16.6 per 100,000 people.**
- **The rate of suicide for women typically declines after age 60. 85% of elderly suicides are by men. Elderly men are more than 7 times the risk of suicide than elderly woman.**
- **73% of elderly people who completed suicide saw their primary care physician within a month of their suicide. Nearly half of those saw their primary care physician within 2 weeks of their suicide.**
- **Between 2005 and 2014, there were 363 suicides for Montanans over the age of 65. This equates to an approximate rate of 24.62 per 100,000.**

Other Populations in Montana with a High Risk of Suicide



Suicide Among American Indians

Although nationally, Caucasians have the highest rate of suicide (15.4/100,000), with American Indians/Alaskan Natives being second (10.8/100,000), the rates are quite different when we talk about Montana, especially among American Indian youth. Over the past 10 years, Montana is averaging approximately 19 American Indian suicides a year, for a rate of 27.3/100,000 compared to 200 suicides for Caucasians in Montana over the same period of time for a rate of 22.11/100,000. This rate is largely due to the difference in population size. American Indians only constitute approximately 6% of Montana's population, compared to 90% Caucasian.

Over the next few pages, the data concerning American Indian suicides in Montana is presented. Initially, comparing Montana American Indians to those nationally. This is based on numbers collected by the Center for Disease Control. This will be followed by the statistics collected by the Montana Suicide Mortality Review Team concerning American Indian suicides from January 1, 2014 through March 1, 2016. This will be followed by known risk and protective factors, along with recommendations to be made at the community level.

DUE TO THE SMALL SAMPLE SIZE, NO INFERENCES SHOULD BE MADE CONCERNING THE DATA PRESENTED. THIS IS ONLY MEANT TO GIVE NUMBERS AND PERCENTAGES CONCERNING AMERICAN INDIAN SUICIDES IN MONTANA .

Suicides among American Indians, US vs MT

(Based on the CDC's WISQARS)

Content source: Centers for Disease Control and Prevention, [National Center for Injury Prevention and Control](http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html), WISQARS Fatal Injury Data. Obtained June 15, 2016 from http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html

2005 - 2014, United States
Suicide Injury Deaths and Rates per 100,000
 Am Indian/AK Native, Both Sexes, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
4,440	41,165,530	10.79	10.63

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
 Am Indian/AK Native, Both Sexes, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
188	689,001	27.29	28.16

Suicides by Race in Montana

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
2,199	9,848,579	22.33	21.70

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Both Sexes, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
1,990	9,001,143	22.11	21.07

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
188	689,001	27.29	28.16

Suicides among American Indians by Gender

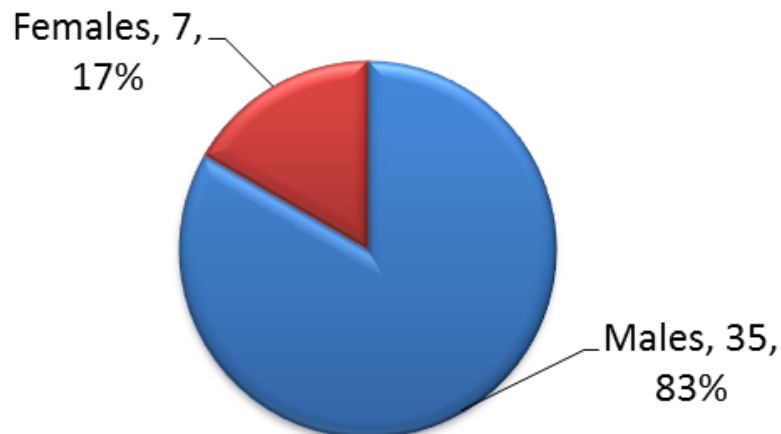
2005 - 2014, Montana
 Suicide Injury Deaths and Rates per 100,000
 Am Indian/AK Native, **Females**, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
50	347,454	14.39	14.17

2005 - 2014, Montana
 Suicide Injury Deaths and Rates per 100,000
 Am Indian/AK Native, **Males**, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate	Age-Adjusted Rate**
138	341,547	40.40	43.28

Gender of American Indian Suicides in Montana (1/1/14-3/1/16)



Suicide among American Indians, ages 11-24

2005 - 2014, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 11 to 24
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
48,186	601,605,595	8.01

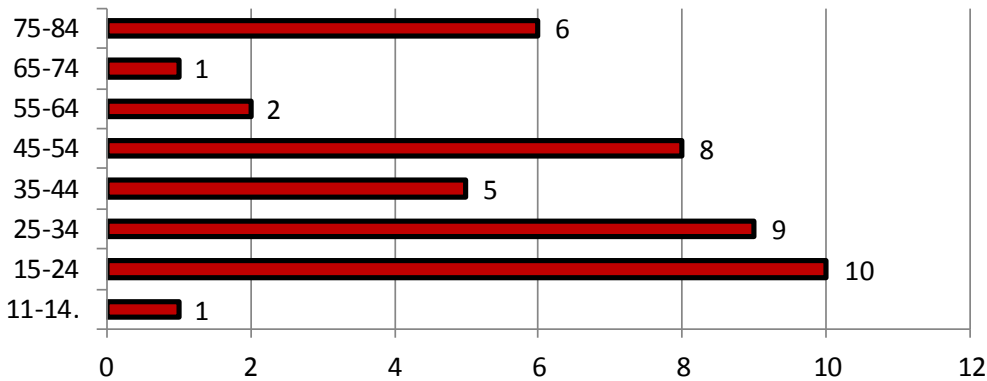
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Both Sexes, Ages 11 to 24
 ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Population***	Crude Rate
246	1,654,999	14.86

2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, Ages 11 to 24
 ICD-10 Codes: X60-X84, Y87.0,*U03

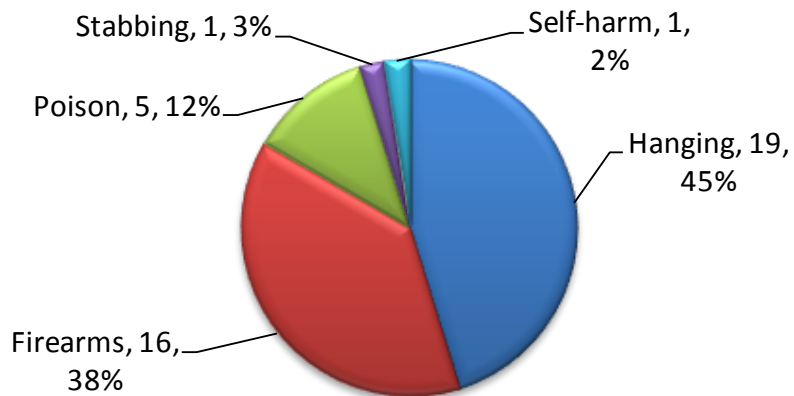
Number of Deaths	Population***	Crude Rate
76	177,489	42.82

Age Ranges of American Indian Suicides in Montana (1/1/14-3/1/16)

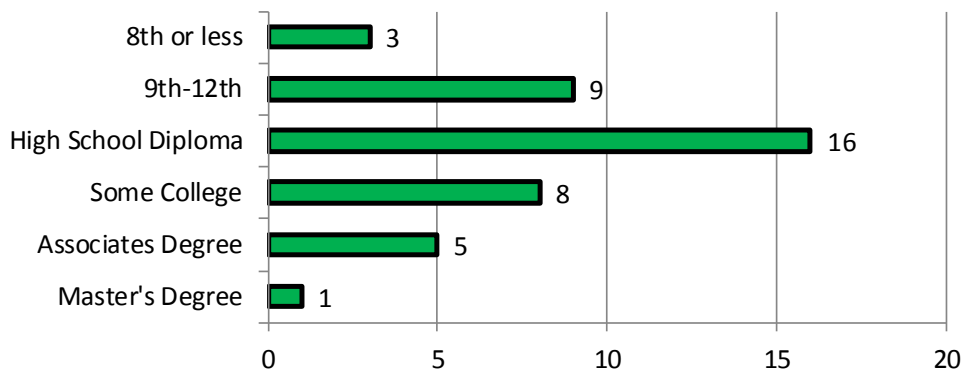


Unlike national and Montana percentages where firearms are the most common means of suicide, among Montana's American Indians, hanging was the most prominent means used.

Means of American Indian Suicides in Montana (1/1/14 - 3/1/16)

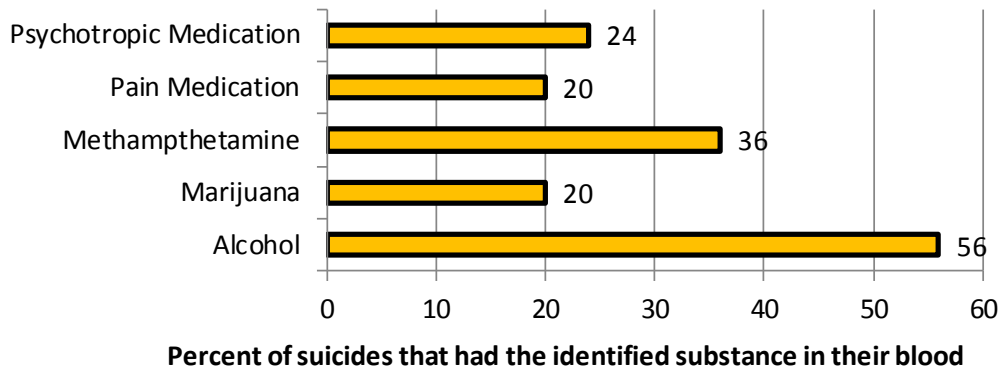


Educational Level of American Indian Suicides in Montana (1/1/14-3/1/16)



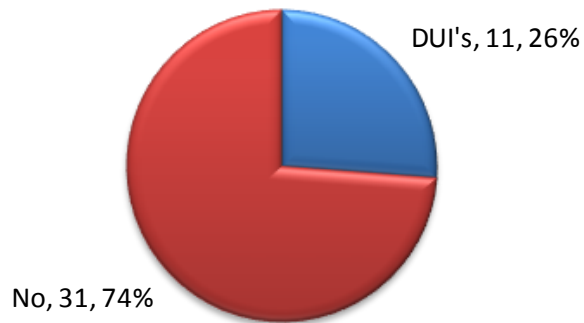
67% of the American Indian suicides had a high school diploma or less.

Toxicology reports of American Indian Suicides for 2014-2015 (% based on 25 received toxicology reports)

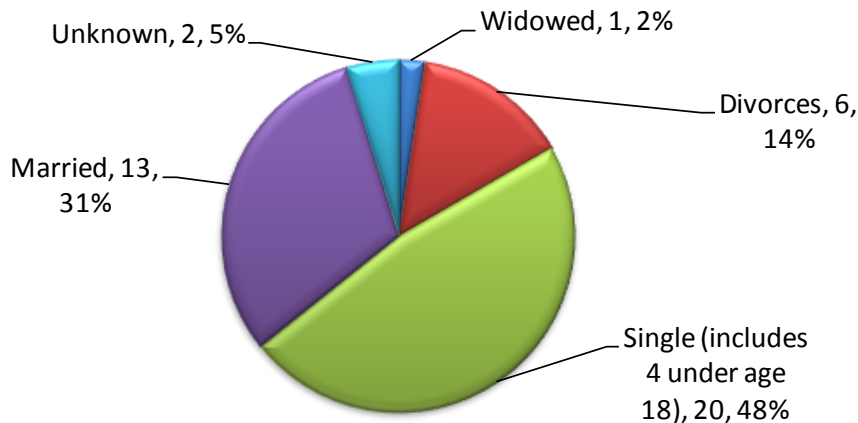


This is based on a small number of toxicology reports and only represents a percentage of those reports received. In 17 of the 25 toxicology reports, multiple substances were found (excluding caffeine, nicotine, and OTC medications.)

American Indian Suicides that had a History of DUI's (2014-2015)

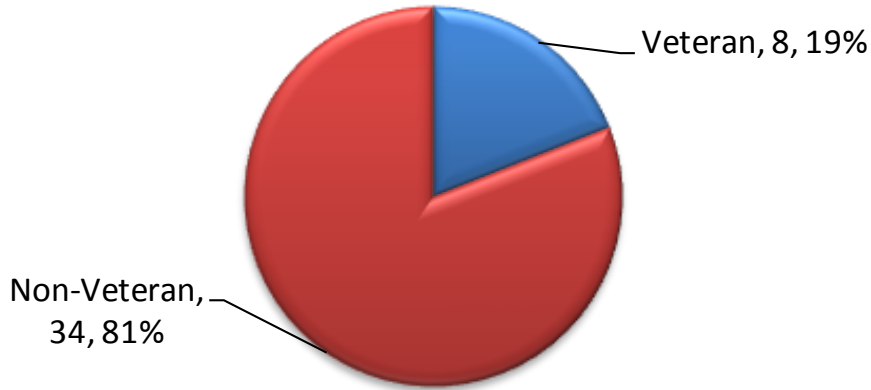


American Indian Suicides by Relationship Status

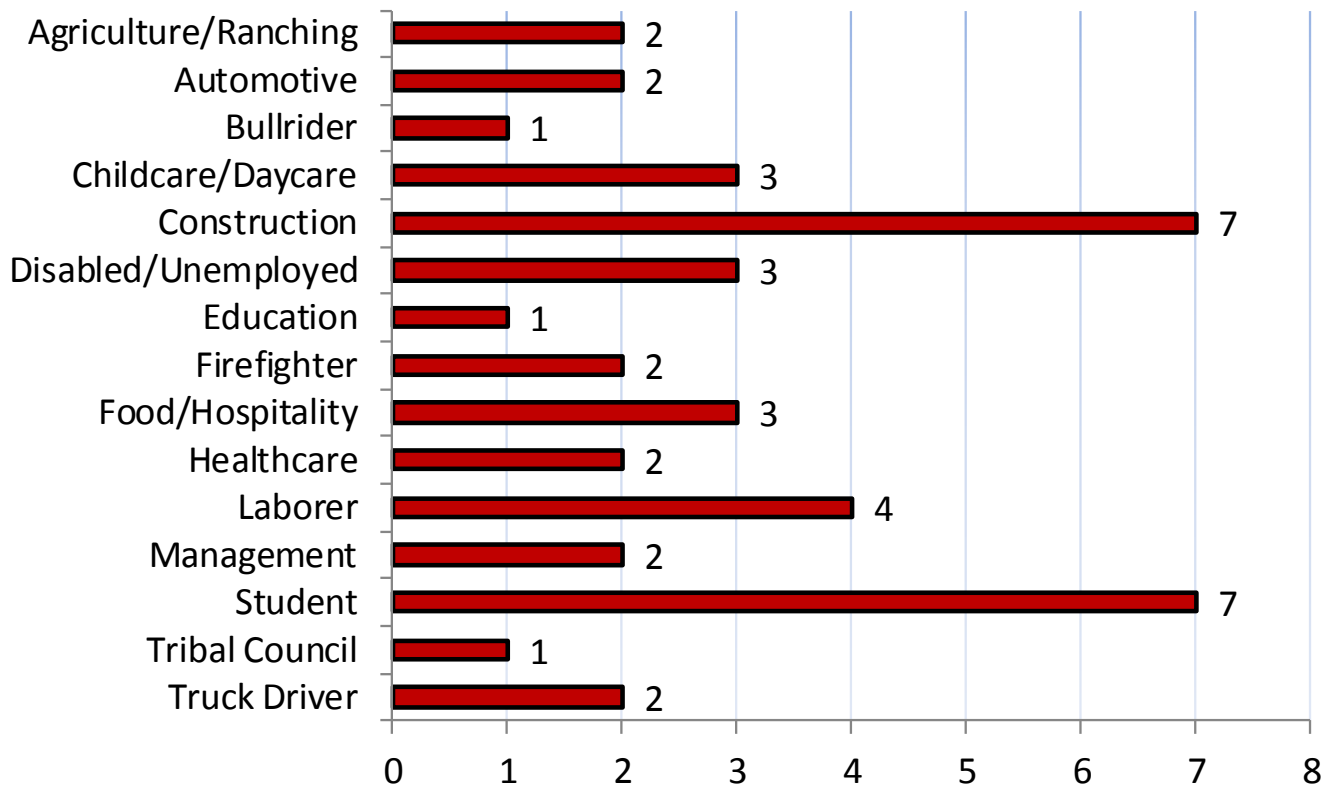


64% of American Indian suicides were either divorced, widowed, or single.

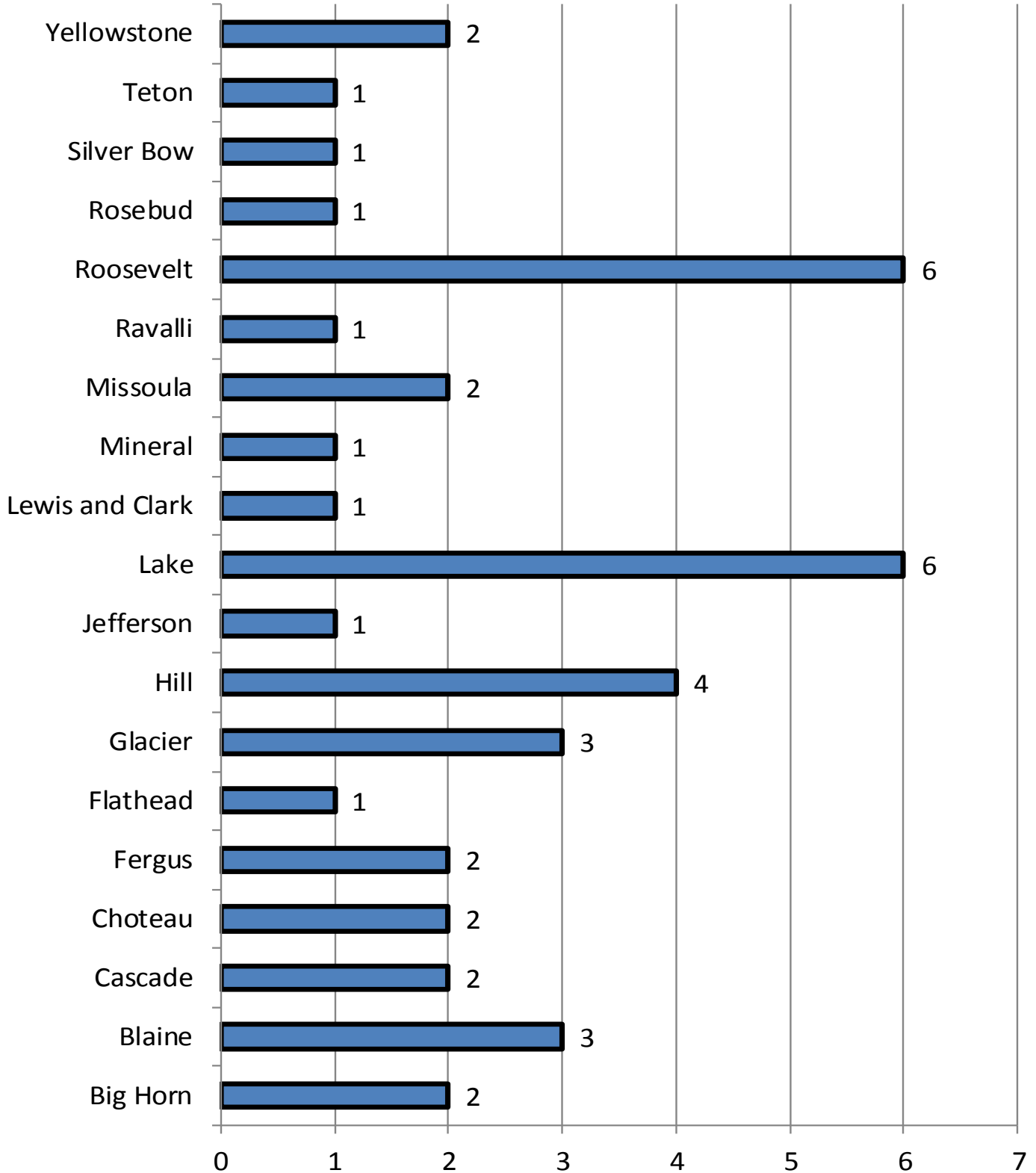
American Indian Suicides that were Veterans (1/1/14 - 3/1/16)



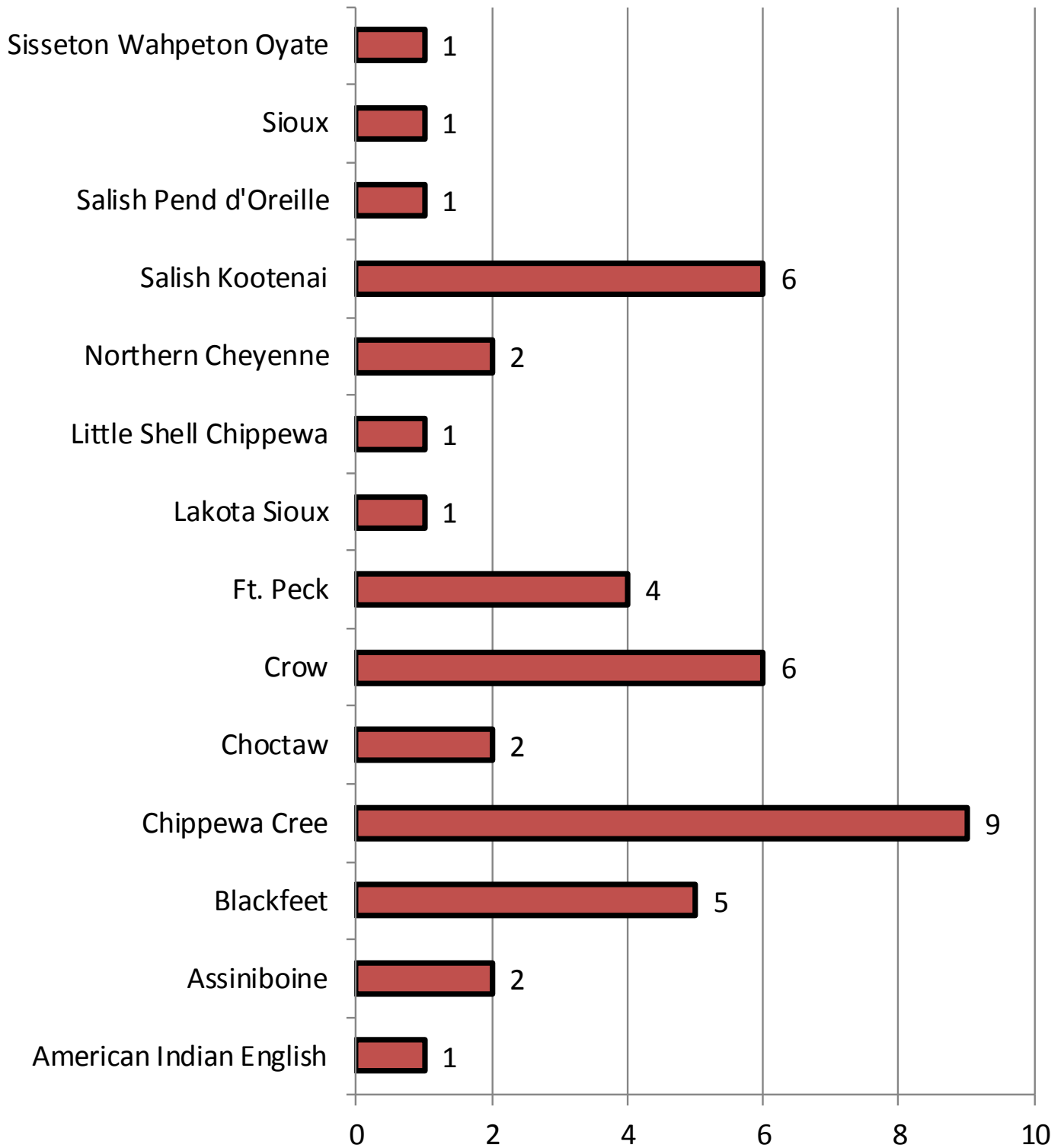
American Indian Suicides by Occupation (1/1/14-3/1/16)



County of Residence of American Indian Suicides in Montana (1/1/14 - 3/1/16)



Tribes of American Indian Suicides in Montana (1/1/14 - 3/1/16)



Interrelated Risk Factors for Suicide Among American Indian Youth

Adapted from Walker, D., Walker, P.S., & Bigelow, D (2006). *Native Adolescent Suicide Cofactors; Prevention and Treatment Best Practices*.

Risk factors can be divided into those that a community can change and those that it cannot change to reduce a person's risk of suicide. **Some changeable risk factors include; substance abuse, exposure to bullying and violence, and development of resiliency and problem-solving skills.**

Factors that cannot be changed include age, gender, and genetics. **While a community cannot change any of these factors, its members can be aware of the increased risk for suicide that these factors present.**

As taken from "*To Live To See the Great Day That Dawns*"*, within the American Indian community, the group with the highest risk for completing suicide is males between the ages of 15 and 24. The reasons why more males than females complete suicide are complex, but some possibilities include;

- Social pressure and family demands placed on males at an early age. Males may feel burdened by the expectations that they will be strong protectors and providers.
- The traditional role of males of any ethnic group is associated with greater risk-taking behaviors.
- Young males also appear more reluctant than young females to seek help. Whether this lack of help-seeking behaviors is the result of stigma, shame, conditioning, attitudes, or not wishing to appear weak, the outcome is the same – young males do not receive needed assistance.

As indicated before, historical trauma is also a risk factor for suicide. Historical trauma includes forced relocations, the removal of children who were sent to boarding schools, the prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices. Today's American Indian youth are experiencing a new type of historical trauma in the form of poverty, substance abuse, violence, loss of language and disconnect from their culture.

What is important to understand is that although most young American Indians did not experience the historical trauma that their ancestors did, generational changes to the family system were caused that effect how families function. It is estimated that it took seven generations for the historical trauma to get to where it is today and will take seven generations to fix it.

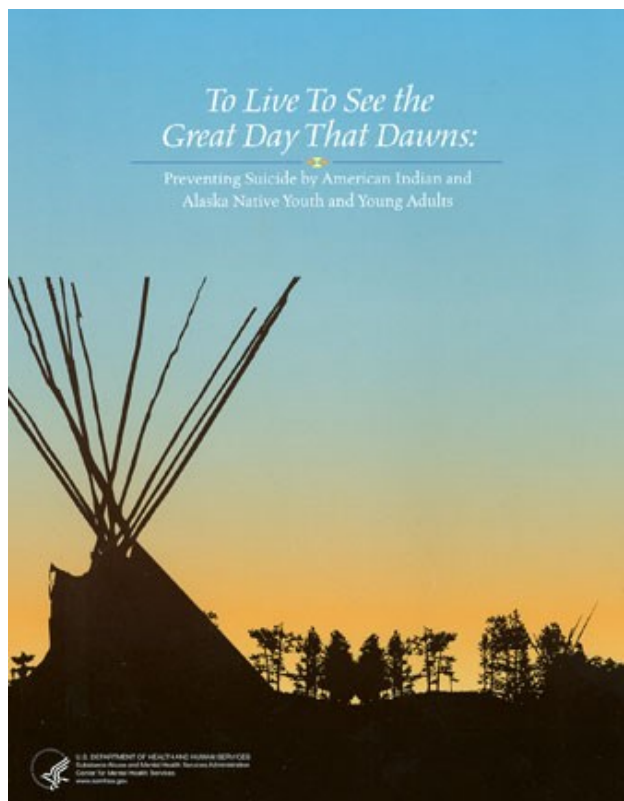
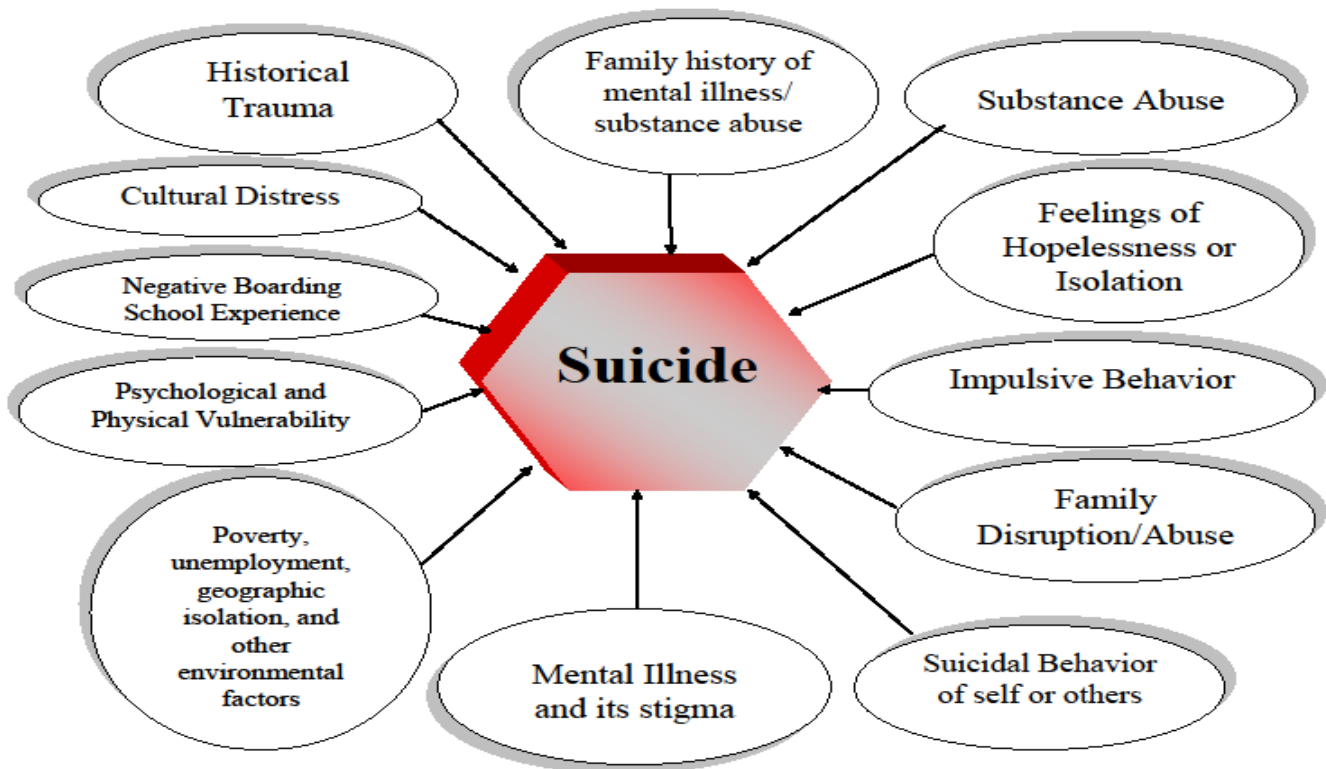
Historical trauma may also have an effect on the help-seeking behavior of American Indian youth. They may believe these services represent the "white man's" system and culture or that the professional will not understand Native ways. Not only do a majority of American Indians use traditional healing, they rate their healer's advice more than 60% higher than their physician's advice.

It is also important to remember the survivors of suicide. Research has indicated that for every suicide, there are six direct survivors. This is even more prominent in the American Indian community, where the direct survivors may be 25 or even the entire community. What is vital to know is that a survivor of suicide is three times the risk of completing suicide themselves.

*U.S. Department of Health and Human Service. *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. DHHS Publication SMA (10)-4480, CMHS-NSPL-0196, Printed 2010. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2010.

Interrelated Risk Factors for Suicide Among American Indian Youth

*U.S. Department of Health and Human Service. *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. DHHS Publication SMA (10)-4480, CMHS-NSPL-0196, Printed 2010. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2010.



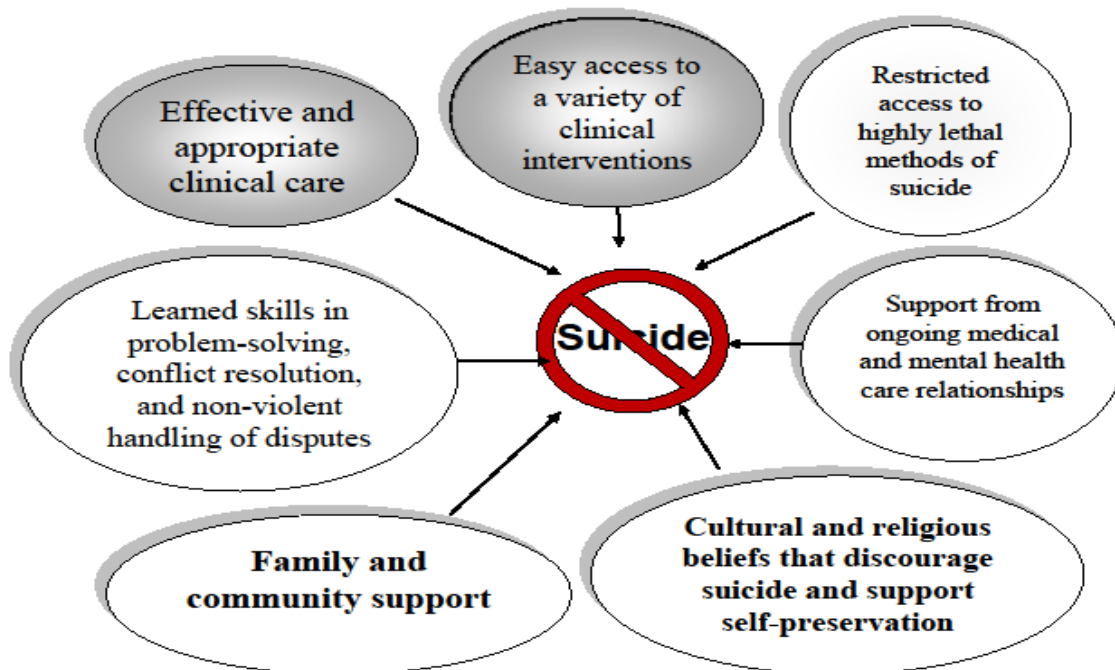
To Live To See the Great Day That Dawns

Lays the groundwork for community-based suicide prevention and mental health promotion plans for American Indian and Alaska Native youth and young adults. Addresses risks, protective factors, and awareness, and describes prevention models for action.

Available free to download at the SAMHSA website (www.samhsa.org) or off the Montana Suicide Prevention website at www.dphhs.mt.gov/amdd/suicide

Protective Factors for Suicide Among American Indians

Although the reduction of risk factors is essential to any suicide prevention plan, research has indicated that adding protective factors is equally or more effective than decreasing risk factors in reducing suicide risk among American Indian youth. Common protective factors that have been found to prevent suicide include:



The most significant protective factors against suicide attempts among American Indian youth are the opportunity to discuss problems with family or friends, feelings connected to their family, and positive emotional health.

When a suicide has occurred, the possibility of suicide contagion is decreased by a healing process that involves the role of Elders and youth in decision-making, the presence of adult role models, and the use of traditional healing practices.

Native communities that succeed in taking steps to preserve their heritage culture and work to control their destinies are more successful in insulating their youth against the risk of suicide. Tribal influence over education, police and fire service, health delivery along with use of indigenous language and strong spiritual beliefs are protective and promote survival.

Addressing the issue of Historical Trauma and Community Readiness

as taken from “*To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults.*” (2010)

“Eduardo Duran, director of health and wellness for the United Auburn Indian Community of Northern California, provides community interventions and consultations around the issue of historical trauma. He contends that an AI/AN community’s seeming inability to address current issues of violence, including suicide, sometimes can be traced to the internalization of the violence perpetrated on Native people for generations.

In his book, *Healing the Soul Wound: Counseling with American Indians and Other Native Peoples*, Duran describes how important it is for a community to engage in a healing process that reflects its own history of trauma rather than generic Native American trauma. He writes,

Preparation for community healing is critical. It is important that the community’s specific traumas be delineated first in order for the intervention to be relevant. It is useful to speak in general of the historical trauma and no one would fault the attempt at healing with this approach. However, I have found that communities, like individuals, have their own set of traumas that result in particular symptoms that need to be dealt with very specifically.

It is through this process of healing that Duran feels community members begin to release the burden of shame and guilt and to recognize the historical path that has led them to the present day. The emphasis is on the process of healing and restoring balance. Identification of historical trauma is viewed as the beginning rather than the end of a journey.

The Aboriginal Healing Foundation (AHF) has identified four phases to community healing that provide some insight into this journey. AHF is a Canadian initiative developed to address the impact of residential schools on First Nations communities. Its principle focus is on achieving community well-being by addressing personal and intergenerational trauma, which it believes will help end cycles of abuse and violence and build strength and resiliency within the survivors and the community. “

The Aboriginal Healing Foundations Four Phases of Community Healing.*

The four phases of Community Healing include the following.

Phase 1: The Journey Begins

Gathering of a core group of people, who begin to address their own healing needs

Phase 2: Gathering Momentum

Increasing of healing activity, with recognition of root causes of addiction, abuse, and violence through community-wide awareness workshops

Phase 3: Hitting the Wall

Building healing capacity by providing training and employment, with a focus on community development

Phase 4: From Healing to Transformation

Shifting from fixing problems to transforming systems

* From Lane, P., Bopp, M., Bopp, J., & Norris, J. (2002). *Mapping the Healing Journey: The Final Report of a National Research Project on Healing in Canadian Aboriginal Communities*. (Four Directions International, unpublished research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General)

Mental Health Considerations

- When compared with other racial and ethnic groups, American Indian/Alaska Native youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse, and depression.
- Mental health services are not easily accessible to American Indians and Alaska Natives, due to:
 - ◆ lack of funding,
 - ◆ culturally inappropriate services,
 - ◆ mental health professional shortages and high turnover.

For these reasons, American Indians tend to underutilize mental health services and discontinue therapy.

Ethnic and Cultural Considerations

- According to the U.S. Commission on Civil Rights, American Indians continue to experience higher rates of poverty, poor educational achievement, substandard housing, and disease.
- Elements of acculturation - mission and boarding schools, weakening parental influence, separation from tribal elders, and dislocation from native lands - undermine tribal unity and have removed many safeguards against suicide that American Indian culture might ordinarily provide.
- There are very few evidence-based programs that are adapted for American Indian and Alaska Native cultures.

Strengths and Protective Factors

- The most significant protective factors against suicide attempts among American Indian/Alaska Native youth are:
 - ◆ discussion of problems with family or friends,
 - ◆ connectedness to family,
 - ◆ emotional health.
- Culturally sensitive programs that strengthen family ties, including addressing substance abuse, could protect against suicide among American Indian adolescents.
- A study of American Indians living on reservations found that tribal spiritual orientation was a strong protective factor. Individuals with a strong tribal spiritual orientation were half as likely to report a suicide attempt in their lifetimes (SPRC, 2007).
- School-based strategies: For American Indian and Alaska Native communities in particular, the lack of behavioral health access and geographic isolation can be addressed more effectively by forming integrated care models that center suicide prevention/intervention activities around the schools. School-based behavioral health care is a promising solution to these issues. Whenever possible, the best approach to school-based suicide prevention activities is teamwork that includes teachers, school health personnel, school psychologists and school social workers, working in close cooperation with behavioral health, community agencies, and families. School-based strategies include:
 - ◆ Suicide awareness curriculum (such as American Indian Life Skills Development, Native HOPE, SOS: Signs of Suicide)
 - ◆ Staff and faculty training (gatekeeper training such as QPR or ASIST)
 - ◆ Resiliency Training (PAX Indigenous Good Behavior Game)
 - ◆ On-site prevention and behavioral health programs/ services
 - ◆ Create a Crisis Intervention Team
 - ◆ Identify local crisis beds
 - ◆ Postvention

What can be done at the Community Level?

“Silence is dangerous when we pretend the problem is not there... communication is a healer to break the silence”

Canadian First Nations Elder

This cannot be done with a cookie cutter approach. Each community is individual and must look within their own culture and traditions for the strength and wisdom to change. With this in mind, here are some themes for American Indian communities to consider in assessing their readiness to change.

- Determine the community readiness to change. Ask the community Elders how community members have traditionally come together to address issues and what are the stories that have motivated members to address issues in the past. Many of the stories told by the Elders hold the values of what once was and the vision of what ought to be and can be for a Tribe or Village. Thus, when a community views the behavior of its young and finds it at odds with the values of these stories, the seeds of change are planted.
- Underlying all of the barriers to the suicide conversation is language. The concept of suicide as “honorable” needs to be acknowledged within its historical context and then reassessed and confronted as it applies to the lives of today’s youth and young people. Individual American Indian communities will know best how to address the suicide conversation within the context of their own collective experience.
 - ◆ The pain experienced by those who have lost loved ones to suicide is another barrier to having an open and public conversation about suicide. With this barrier in mind, it is appropriate that the person wishing to hold a suicide conversation within the community should first ask permission to bring up the topic.
 - ◆ It may also be appropriate to ask for forgiveness for causing painful feelings when the conversation is over. Time must also be available for those who wish to speak about the loved ones who died by suicide, as it may be the first time anyone has asked them to share their stories.
 - ◆ In attempting to open up a suicide conversation with a family who has lost someone to suicide, it is polite to inquire first as to what would be helpful or if they would like to talk about their loved one or about their grief. In any event, ask permission before beginning.
- American Indian community prevention plans need to include community-based ceremonies and traditions to begin the healing of the collective grief. This may be accomplished through ceremonies such as the Wiping of the Tears or a Gathering of Native Americans. To ensure that everyone who attends these gatherings is given support during the conversation, counselors or traditional healers may need to be present.
- When a suicide has occurred, the possibility of suicide contagion is decreased by a healing process that involves the role of Elders and youth in decision-making, the presence of adult role models, and the use of traditional healing practices.
- Native communities that succeed in taking steps to preserve their heritage culture and work to control their destinies are more successful in insulating their youth against the risk of suicide. Tribal influence over education, police and fire service, health delivery along with use of indigenous language and strong spiritual beliefs are protective and promote survival.

Suicide among Montana's Veterans

Another special population in Montana that is at high risk of suicide is Montana's military veterans. **Between 2005 and 2014, there were 556 suicides by Montana veterans of all ages (Office of Epidemiology and Scientific Support, Montana DPHHS, June, 2016), which gives Montana veterans a estimated rate of 54 per 100,000.** Montana has more than 97,000 veterans or nearly one person in every 10. Montana had the highest recruitment in the nation per capita into the U.S. Army in 2004 and 2005. Montana has more than 700 Army National Guard Soldiers between the ages of 18 and 24 who have been deployed to date for both CONUS (Continental United States) and OCONUS (Outside the Continental United States) missions in support of OIF (Operation Iraqi Freedom) and OEF (Operation Enduring Freedom). Suicide is not only a major concern in Montana but at a national level as well.

In 2014, an average of 20 Veterans died from suicide each day (Thompson, C, VA Suicide Prevention Program: Facts about Veteran Suicide (2016)). 6 of the 20 were users of VA services. In 2014, Veterans accounted for 18% of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the US population. In 2010, Veterans accounted for 22% of all deaths from suicide and 9.7% of the population. Approximately 66% of all Veteran deaths from suicide were the result of firearm injuries. There is continued evidence of high burden of suicide among middle-aged and older adult Veterans. In 2014, approximately 65% of all Veterans who died from suicide were aged 50 years or older. After adjusting for differences in age and gender, risk for suicide was 21% higher among Veterans when compared to U.S. civilian adults. After adjusting for differences in age, risk for suicide was 18% higher among male Veterans when compared to U.S. civilian adult males. After adjusting for differences in age, risk for suicide was 2.4 times higher among female Veterans when compared to U.S. civilian adult females.

In 2014, among all U.S. adult deaths from suicide, 18% were identified as Veterans of U.S. military Service (Thompson, C, VA Suicide Prevention Program: Facts about Veteran Suicide (2016)). In 2014, the rate of suicide among U.S. civilian adults was 15.2 per 100,000, while the rate of suicide among all Veterans was 35.3 per 100,000. Other findings include:

- Since 2001, the age-adjusted rate of suicide among U.S. civilian adults has increased by 23.0%, while the age-adjusted rate of suicide among U.S. Veterans has increased by 32.2%.
- In 2014, the rate of suicide among U.S. civilian adult males was 26.2 per 100,000, while the rate of suicide among U.S. Veteran males was 37.0 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. civilian adult males has increased by 0.3%, while the age-adjusted rate of suicide among U.S. Veteran males has increased by 30.5%.
- Since 2001, the age-adjusted rate of suicide among U.S. civilian adult females has increased by 39.7%, while the age-adjusted rate of suicide among U.S. Veteran females has increased by 85.2%.

Suicide Signs Unique to Vets

Experts on suicide prevention say for veterans there are some particular signs to watch for.


- Calling old friends, particularly military friends, to say goodbye
- Cleaning a weapon that they may have as a souvenir
- Visits to graveyards
- Obsessed with news coverage of the war, the military channel
- Wearing their uniform or part of their uniform, boots, etc
- Talking about how honorable it is to be a soldier
- Sleeping more (sometimes the decision to commit suicide brings a sense of peace of mind, and they sleep more to withdraw)
- Becoming overprotective of children
- Standing guard of the house, perhaps while every one is asleep staying up to "watch over" the house, obsessively locking doors, windows
- If they are on medication, stopping medication and/or hoarding medication
- Accumulating alcohol -- not necessarily hard alcohol, could be wine
- Spending spree, buying gifts for family members and friends "to remember by".
- Defensive speech "you wouldn't understand," etc.
- Stop making eye contact or speaking with others.

Predictors of suicide among veterans in depression treatment differs in several ways from those observed in the general US population. Typically, people in the general population who die by suicide are older, male, and white, and have depression and medical or substance abuse issues. In the AJPH study, researchers found that depressed veterans who had substance abuse problems or a psychiatric hospitalization in the year prior to their index depression diagnosis had higher suicide rates.

However, when they divided depressed veterans into three age groups: 18 to 44 years, 45 to 64 years, and 65 years or older, they found that the younger veterans were at the highest risk for suicide. Differences in rates among **depressed** veterans of different age groups were striking; 18-44 year-olds completing suicide at a rate of 95.0 suicides per 100,000, compared with 77.9 per 100,000 for the middle age group, and 90.1 per 100,000 for the oldest age group.

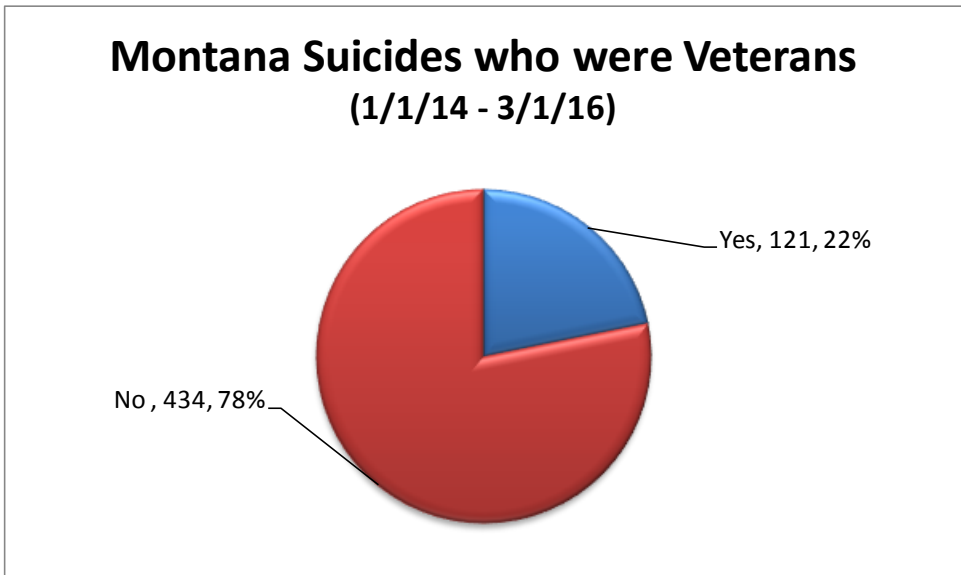
In this VA treatment population, male veterans were more likely to complete suicide than female veterans. Suicide rates were 89.5 per 100,000 for depressed veteran men and 28.9 per 100,000 for veteran women. However, the differential in rates between men and women (3:1) was smaller than has been observed in the general population (4:1).

Surprisingly, the initial findings revealed a lower suicide rate among depressed veterans who also had a diagnosis of post-traumatic stress disorder (PTSD) compared to depressed veterans without this disorder. Depressed veterans with a concurrent diagnosis of PTSD had a suicide rate of 68.2 per 100,000, compared to a rate of 90.7 per 100,000 for depressed veterans who did not also have a PTSD diagnosis. Concurrent PTSD was more closely associated with lower suicide rates among older veterans rather than among younger veterans. This study did not reveal a reason for this lower suicide rate, but the hypothesis was that it may be due to the high level of attention paid to PTSD treatment in the VA system, and the greater likelihood that patients with both depression and PTSD will receive psychotherapy and more intensive visits. In general, individuals with depression and PTSD diagnoses have higher levels of VA mental health services use than individuals with depression without PTSD.

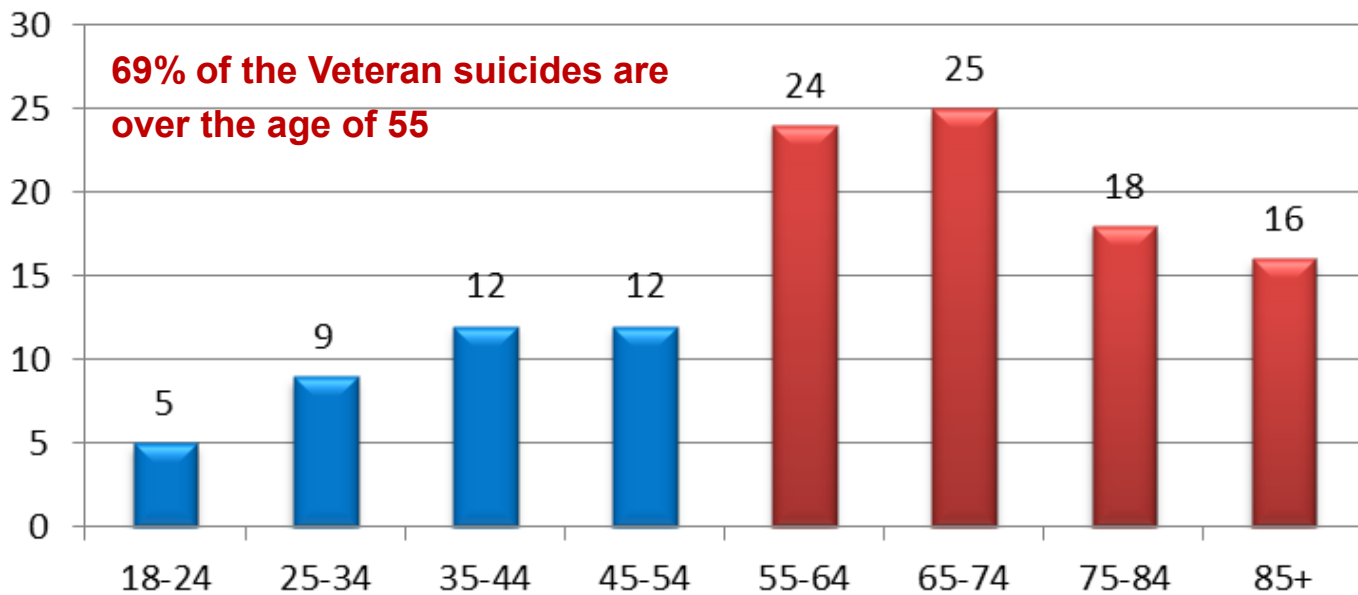


Veterans Suicide Prevention Hotline
1-800-273-TALK, Veterans Press 1

The Department of Veterans Affairs' (VA) [Veterans Health Administration \(VHA\)](#) has founded a national suicide prevention hotline to ensure veterans in emotional crisis have free, 24/7 access to trained counselors. To operate the Veterans Hotline, the VA partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline. Veterans can call the Lifeline number, 1-800-273-TALK (8255), and press "1" to be routed to the Veterans Suicide Prevention Hotline.



Montana Veteran Suicides by Age Range



About the Montana VA Mental Health Care System

Mental health services in VA Montana Healthcare System provide consultation, evaluation, and treatment for a variety of issues that can impact emotional well-being.

Services Offered

Mental health services provided include treatments for:

- depression, sadness, grief
- anxiety, worry, nervousness
- addictive behaviors
- relationship problems
- stress from medical problems and/or pain
- post-traumatic stress disorder (PTSD)
- emotional problems, such as managing anger
- vocational issues
- troublesome thoughts or ideas
- confused thinking
- aggressive or self-harming behaviors
- memory problems
- Outreach to homeless veterans.

Confidentiality

Mental health services are confidential. We will not talk to anyone about information you share unless you give written consent. Under federal law, a few exceptions to this rule exist. If you have questions, please ask your mental health consultant.



The Montana National Guard's Post Deployment Health Reassessment (PDHRA)

In March of 2007, Specialist Christopher Dana, an OIF veteran and member of the Montana National Guard (MTNG) died by suicide. This incident spurred the MTNG Adjutant General, Major General Randall D. Mosley, to create a Post-Deployment Health Reassessment (PDHRA) Task Force to review the DoD-mandated PDHRA process. The Task Force was composed of members representing a wide variety of service member interests, including the VA, mental health counselors, Veterans Service Organizations (VSOs), and the Montana state legislature. The Task Force concluded that the MTNG was supporting all standards set forth by DoD for the PDHRA, but that several significant deficiencies existed in caring for returned service members. From June 2007 until the summer of 2008, the MTNG developed a campaign plan and strategies to implement the Task Force's recommendations, from expanding the PDHRA program to setting up a crisis response team.

The centerpiece of the MTNG's reintegration program is the Post Deployment Health Reassessment (PDHRA) program. While this program bears the same acronym as the standard health screening assessment completed by all service members, the program goes far beyond its namesake. The PDHRA program begins where the standard YRRP ends: at the 90-day mark. Beyond 90 days post-deployment, a behavioral health provider attends every MTNG drill weekend. Every service member deploying or redeployed has to talk to this health provider. At six-month intervals for two years following the conclusion of the YRRP, each service member must undergo a health screening with both a physician and a behavioral health specialist.

At the 18-month mark, each service member completes another, identical PDHRA online to identify if any reintegration issues have surfaced. A MTNG staff member will call any service member whose assessment is flagged, and if a condition is identified, they will be referred to counseling. At the two-year mark and on an annual basis thereafter, all service members must again have a Periodic Health Assessment and talk to both a physician and behavioral health provider.

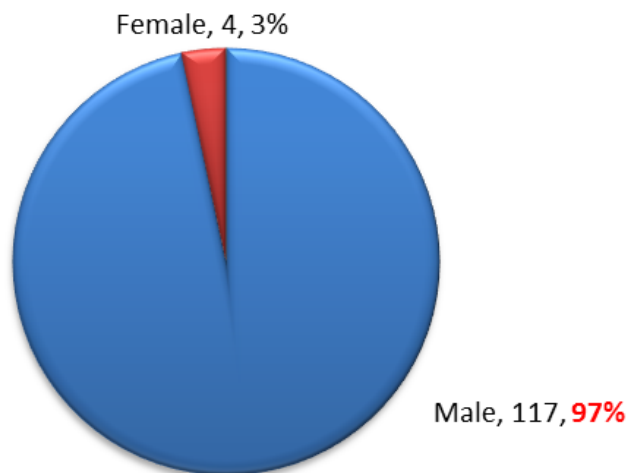
Statistics concerning veteran suicides in Montana.

The following information was obtained by the Montana Suicide Mortality Review Team and includes 121 veteran suicides that occurred in Montana between January 1, 2014 and March 1, 2016.

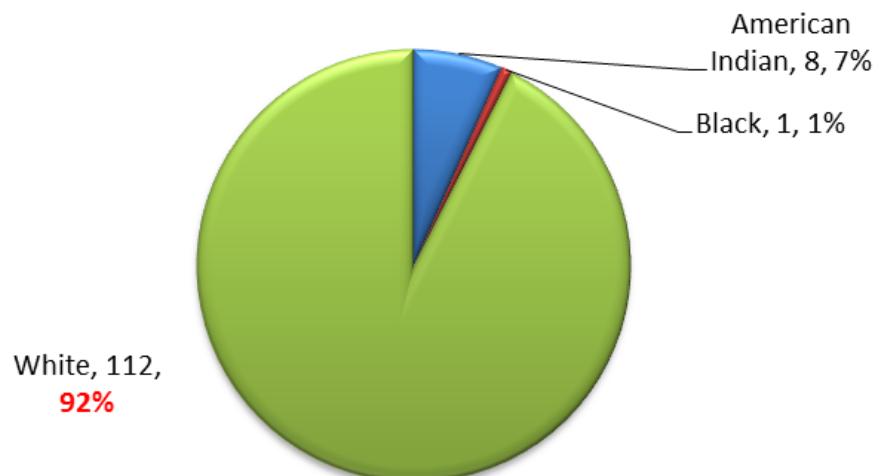
The information is based on death certificates identifying that the deceased was in the armed services. Additional information was obtained from coroner reports, supplemental questionnaires, health records, and information obtained from families.

DUE TO THE SMALL SAMPLE SIZE, NO INFERENCES SHOULD BE MADE CONCERNING THE DATA PRESENTED. THIS IS ONLY MEANT TO GIVE NUMBERS AND PERCENTAGES CONCERNING VETERAN SUICIDES IN MONTANA .

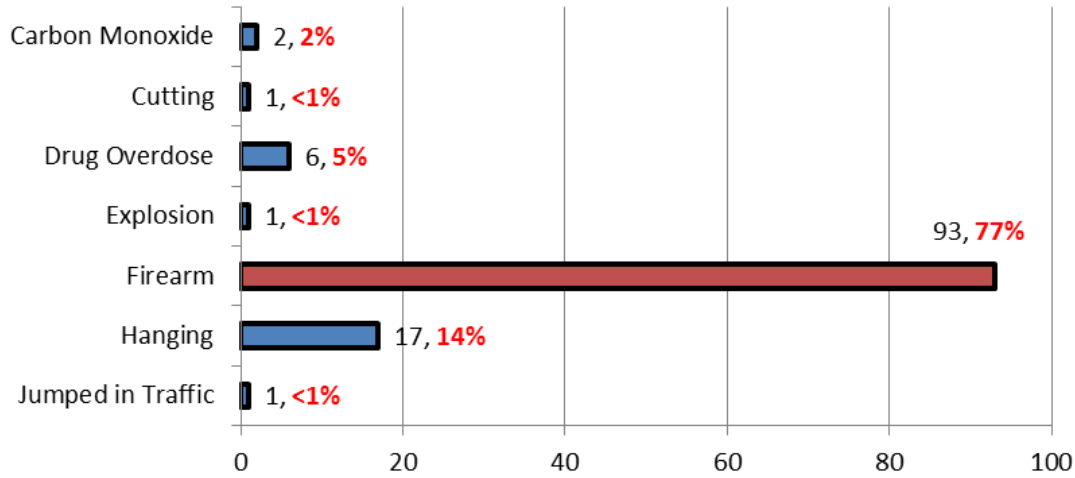
Montana Veteran Suicides by Gender



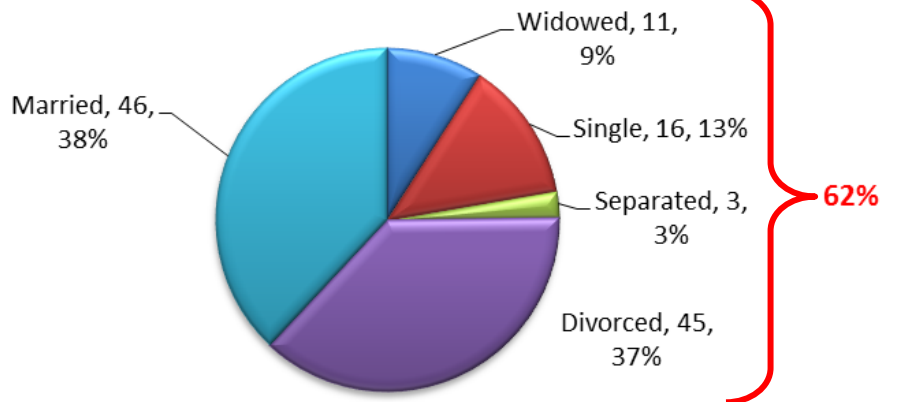
Montana Veteran Suicides by Race



Montana Veteran Suicides by Means

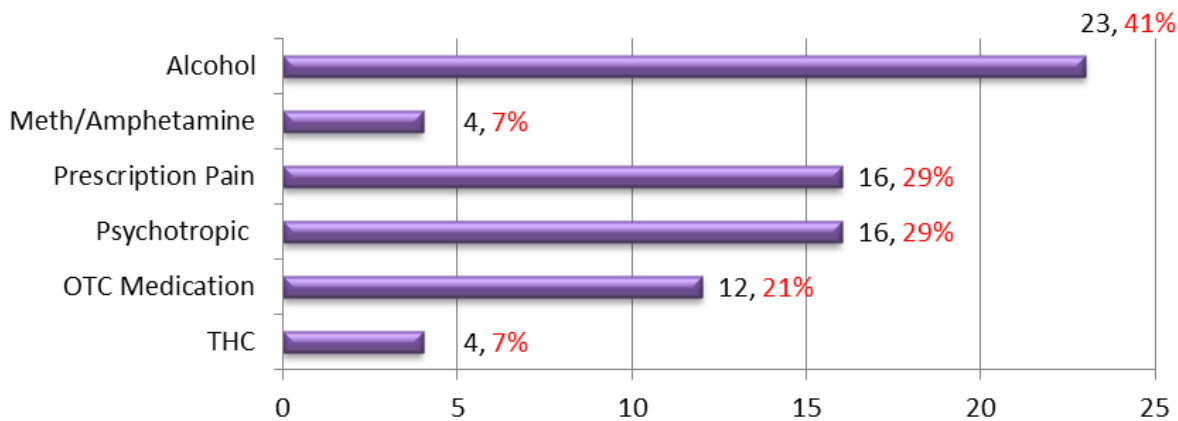


Montana Veteran Suicides by Relationship Status



Toxicology findings of Montana Veteran Suicides

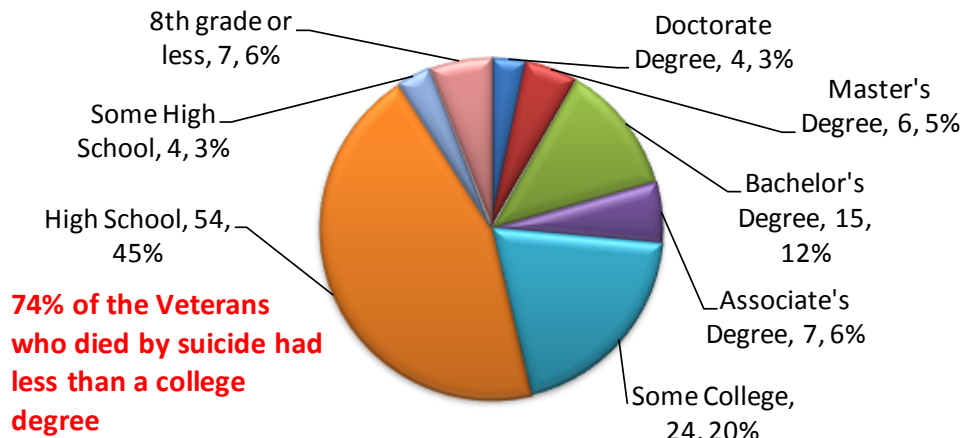
(% is based on 56 toxicology reports received)



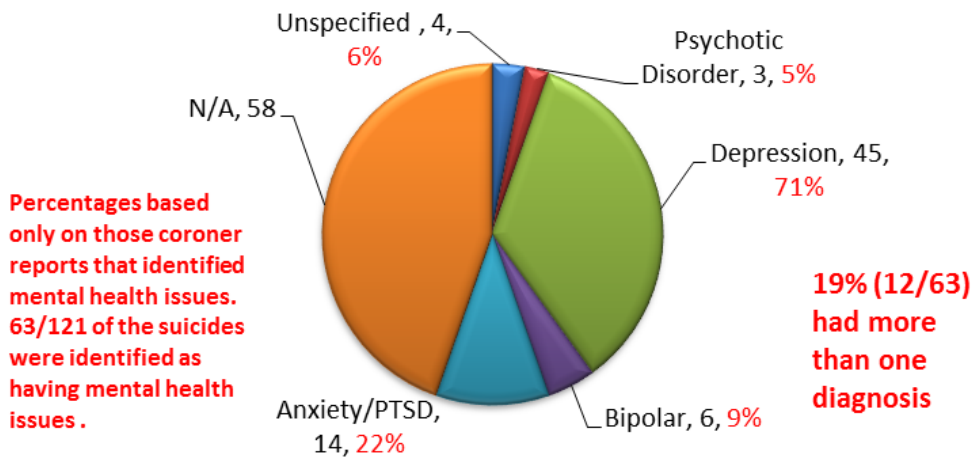
Montana Veteran Suicides with Chronic Pain/Health Issues



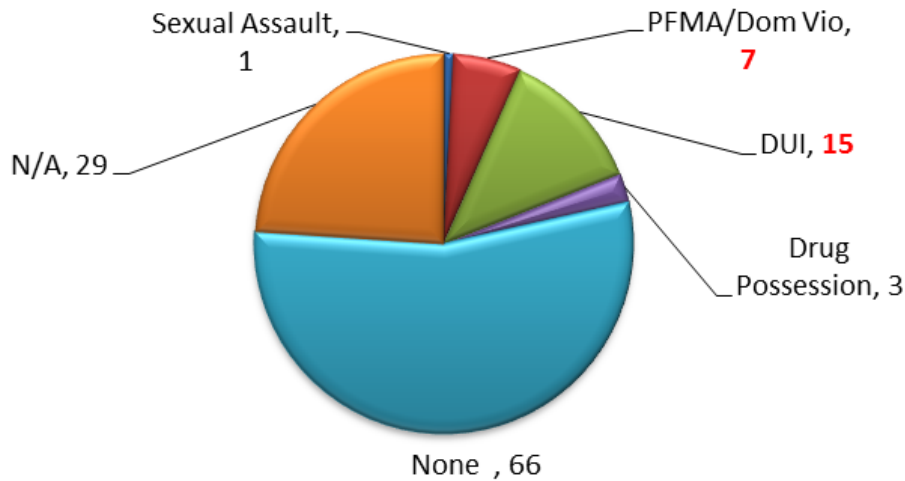
Montana Veteran Suicides by Education Level



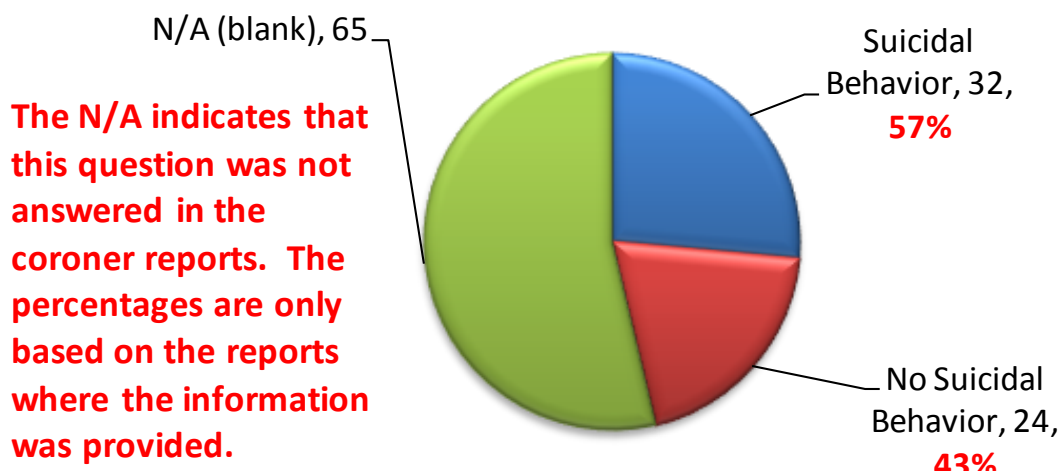
Montana Veteran Suicides with identified Mental Health Issues



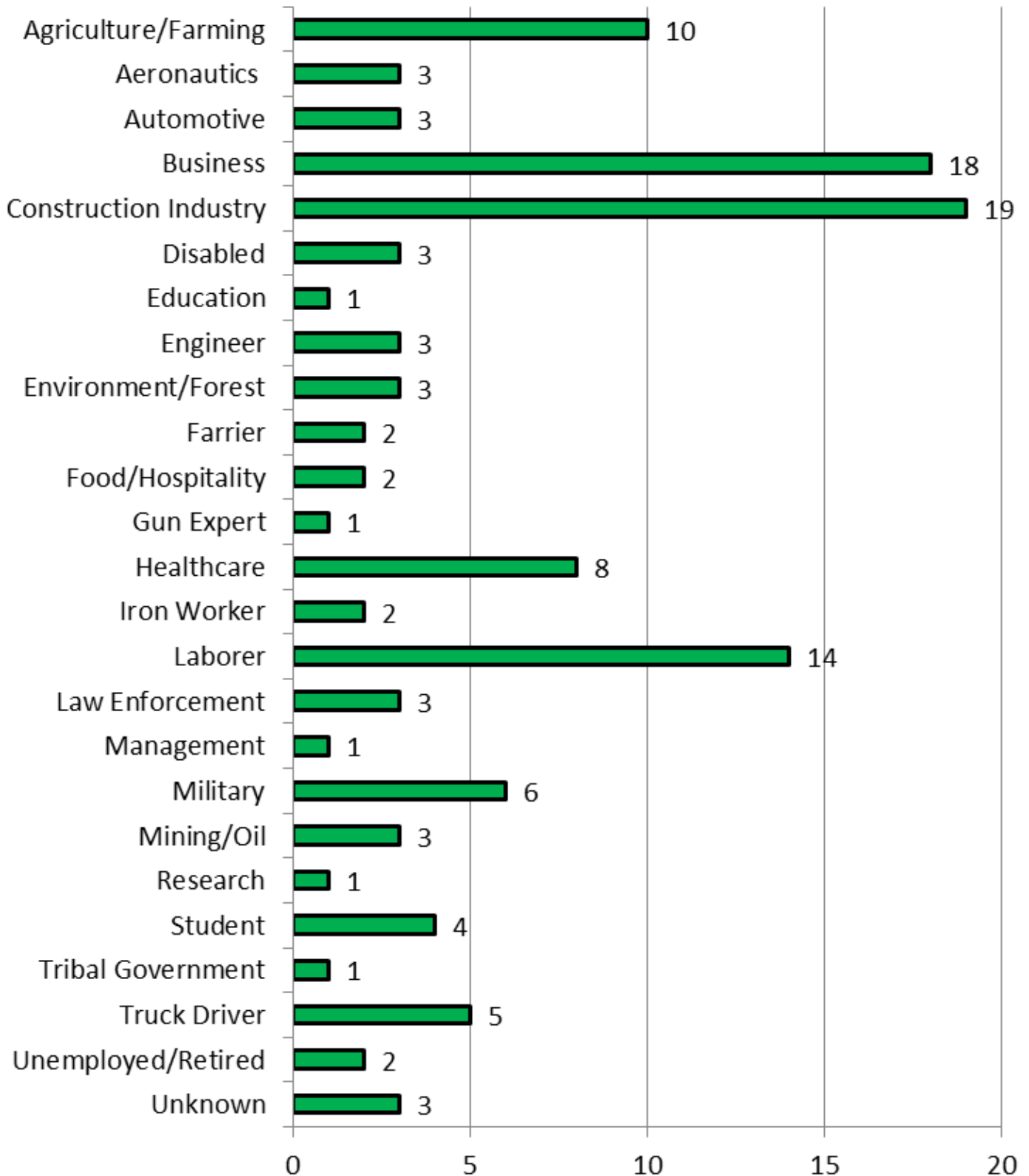
Montana Veteran Suicides with Criminal History



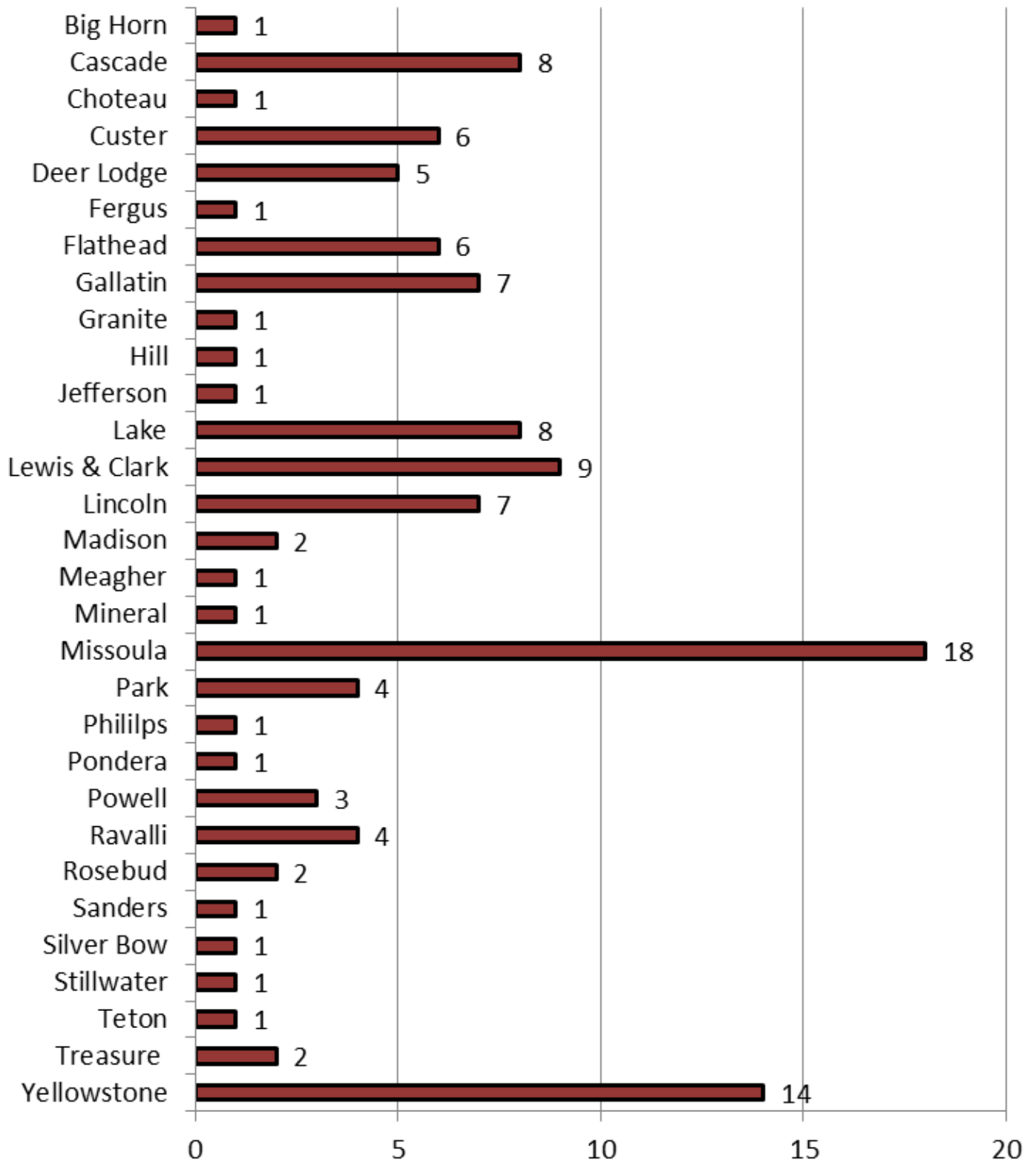
Montana Veteran suicides with history of previous suicidal behavior (% based on n=56)



Montana Veteran Suicides by Occupation



Montana Veteran Suicides by County



Suicide among those with Serious Mental Illness (SMI)

According to Mental Health America (Mark, et al., 2007), 12.46% of Montana's adult population has serious psychological distress and approximately 9% of Montana adolescents and adults have major depressive episodes. Individuals with serious mental illness (SMI) constitute 6-8% of the U.S. population, but account for several times that proportion of the more than 42,000 suicides that occur each year in the country (Litts et al. 2008). For people with virtually every category of SMI, suicide is a leading cause of death, with lifetime risks ranging from 4-8%. Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors. Still, a large majority of those with SMI neither attempt nor die by suicide and predicting those who will presents a significant challenge.

There are multiple risk factors, often acting together, that greatly influence the extent to which suicide attempts and completions occur. A highly common risk factor combination is a mood disorder co-occurring with a substance use disorder. This combination when associated with a host of additional risk factors or triggers, such as a major stressful event, binge use of substances, certain personality features (e.g., impulsivity), or a recent discharge from a hospital, greatly increase the risk of suicide. Some of the triggering factors may be generic to anyone with a psychiatric disorder, while others may be fairly unique to specific disorders.

Additionally, there are several mental illness-related symptoms that act as acute risk factors. These include:

- severe hopelessness
- impulsivity
- unrest, instability
- agitation, panic, anxiety
- relational conflict
- aggression, violence
- alcohol/substance abuse
- insomnia

The most common risk factors that apply across many psychiatric disorders include:

- prior suicide attempt
- intimate partner conflict
- social isolation
- family history of suicide, mental disorder or substance abuse
- family violence, including physical or sexual abuse
- firearms in the home
- legal charges or financial problems
- incarceration
- exposure to the suicidal behavior of others, such as family members, peers, or media figures
- physical illness and functional impairment, especially in older people

The following mental disorders present a high risk of suicide:

Mood Disorders

Across all psychiatric disorders, mood disorders, which include major depressive disorder and bipolar disorder, appear to carry the highest risk of suicide and suicide attempts. For patients ever hospitalized for a mood disorder, the lifetime risk is 4%, but for those ever hospitalized for suicidality, the lifetime risk is close to 9%. According to the Office of Applied Studies (2006), among adults aged 18 or older who experienced a major depressive episode in the past year, 56.3 % thought, during their worst or most recent episode, that it would be better if they were dead, 40.3 % thought about committing suicide, 14.5 % made a suicide plan, and 10.4 % made a suicide attempt. The survey also found that suicide attempts are far more likely in depressed adults who report binge alcohol or illicit drug use than by their counterparts who do not abuse substances. Suicide attempts were responsible for nearly 38,000 emergency room visits in 2004 by depressed adults using or abusing drugs. Later-life is a period of particular vulnerability in relation to mood disorders. A startling 74% of all attempts or completions among people older than age 55 were attributable to mood disorders (Beautrais, 2002). Prevention efforts should focus on assessment of suicidality on any patient experiencing a mood disorder by those in the medical and mental health professions.

Schizophrenia

According to Litts et al (2008), suicide is the leading cause of early mortality in people with schizophrenia. A person with schizophrenia has a lifetime risk of suicide of nearly 6%. The first ten years after diagnosis is a period of higher risk, suggesting that suicide prevention efforts should be focused on newly diagnosed people. An analysis of the suicide risk factors for people with schizophrenia found elevated risk was related less to the core psychotic symptoms of the disorder and more to the following (Hawton et al., 2005):

- affective symptoms (worthlessness, hopelessness, agitation or motor restlessness)
- awareness that the illness is affecting mental functioning
- living alone or not living with family
- recent loss events
- previous suicide attempts
- previous depressive disorders
- drug misuse
- fear of mental disintegration
- poor adherence to treatment

Anxiety Disorders

In the past, the risk of suicidal behavior from anxiety disorders was not seen as serious enough to warrant national attention. More recently, however, studies have found that any type of anxiety disorder has independent risk factors for suicide attempts. This suggests that anxiety does not have to be co-morbid with other disorders to be a suicidal risk. The onset of an anxiety disorder of any kind doubles the risk of suicide attempts. Some anxiety disorders, for example, simple phobia, are unlikely to meet the Federal definition of an SMI. But others, such as PTSD, frequently meet the criteria, yet research often aggregates them under the mantle of “anxiety disorders.” That categorization tends to diminish the perception of their severity and the associated suicidal risk. The two anxiety disorders most frequently associated with suicide completion are panic disorder and PTSD. According to the National Center for Post Traumatic Stress Disorder (2007), there is a large body of research indicating a correlation between PTSD and suicide. There is evidence that traumatic events such as sexual abuse, combat trauma, rape, and domestic violence generally increase a person’s suicide risk. Considerable debate exists, however, about the reason for this increase. Whereas some studies suggest that suicide risk is higher due to the symptoms of PTSD, others claim that suicide risk is higher in these individuals because of related psychiatric conditions. Some studies that point to PTSD as the cause of suicide suggest that high levels of intrusive memories can predict the relative risk of suicide. High levels of arousal symptoms and low levels of avoidance have also been shown to predict suicide risk. In contrast, other researchers have found that conditions that co-occur with PTSD, such as depression, may be more predictive of suicide. Furthermore, some cognitive styles of coping, such as using suppression to deal with stress, may be additionally predictive of suicide risk in individuals with PTSD. Given the high rate of PTSD in veterans, considerable research has examined the relation between PTSD and suicide in this population. Multiple factors contribute to suicide risk in veterans. Some of the most common factors are listed below:

- male gender
- alcohol abuse
- family history of suicide
- older age
- poor social-environmental support (exemplified by homelessness and unmarried status)
- possession of firearms
- the presence of medical and psychiatric conditions (including combat-related PTSD) associated with suicide

Currently there is debate about the exact influence of combat-related trauma on suicide risk. For those veterans who have PTSD as a result of combat trauma, however, it appears that the highest relative suicide risk is in veterans who were wounded multiple times or hospitalized for a wound. This suggests that the intensity of the combat trauma, and the number of times it occurred, may influence suicide risk in veterans with PTSD. Other research on veterans with combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt. Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war. These thoughts can often overpower the emotional coping capacities of veterans.

Substance Use Disorders

Substance Use Disorders such as alcohol intoxication, by itself, does not constitute a psychiatric disorder, much less an SMI, but its role in suicidal behavior is profound. Acting as a disinhibitor, alcohol is involved in up to 64% of suicide attempts or completions, many of them associated with the combination of impulsivity, anger, and relationship losses (Goldsmith et al., 2002). The findings from several autopsy studies reveal that 33% of all individuals who die by suicide are intoxicated at the time of death (MMWR, 2009). Alcoholism is associated with higher rates of suicide attempts, as well. One urban study showed those with alcoholism had five times the number of attempts as those with other psychiatric diagnoses. Comorbidity appears to play an important role in suicidal behaviors. Four million Americans have a substance use disorder plus an SMI. In fact, studies show that major depression existed at the time of death in 45 to >70% of suicides involving a history of alcoholism (Sher, 2005). Prevention efforts with this population would include a greater awareness of the signs of suicide and the correlation between substance abuse and suicide in chemical dependency treatment providers.

Increased Risk of Suicide among Suicide Survivors

The risk of suicide in survivors is an area in need of further research. According to the American Association of Suicidology (2012), there are six survivors for every completed suicide. Based on this figure, there are approximately 5 million survivors in the U.S. in the last 25 years or 1 out of every 65 Americans. Six new survivors are added to the cohort every 14.2 minutes. For survivors experiencing complicated grief associated with the death of a loved one by suicide the risk for suicidal ideation or attempts is elevated. According to Litts et al. (2008) stigmatizing reactions add to a survivor's burdens, often intensifying their social isolation and secrecy while impeding their access to accurate information that could help them recover, or in some cases, become involved as advocates for suicide prevention. Suicide survivors frequently report unique problems and challenges following the death of their loved one. These include:

- A prolonged and intense search for the reason for the suicide
- Feelings of being rejected by the deceased
- A distorted sense of responsibility for the death and the ability to have prevented the suicide
- Feelings of being blamed, by others or themselves, for causing the problems that led to the suicide
- Elevated levels of anger, family dysfunction, and feelings of social stigmatization.

Furthermore, survivors of a suicide have a high likelihood of not seeking out formal or informal support or mental health treatment. Those that seek these forms of help may be thwarted by difficulty locating resources or by their own overwhelming grief. Large numbers of adult survivors find that they improve their ability to cope with the many and complex facets of being a suicide survivor by participating in formal support groups with others who have experienced loss through suicide. Children who survive the suicide of a parent or guardian frequently struggle with guilt and feelings of abandonment. Adults who were traumatized as children by the suicidal behaviors of caretakers observe that using secrecy to protect the child-survivor may cause additional complications and misperceptions. Children need to know that the death was not their fault and that their continued care is certain. Honest, age-appropriate communication with the child is critical (AAS, 2007).

Intervention for this population should include increased awareness of the survivor's own suicidality and access to local support groups.

Other resources for survivors can be found at the Suicide Prevention Resource Center's library for survivors at <http://library.sprc.org/browse.php?catid=11> .

A survivor handbook is also available on the Montana Suicide Prevention website at www.dphhs.mt.gov/amdd/suicide

Suicide in Prisons and Jails

According to the Bureau of Justice Statistics (July, 2010), while suicide has been the leading cause of death in local jails since the 1980's, it has declined over time. The suicide rate among jail inmates was 129 per 100,000 inmates in 1983, but 10 years later the rate had declined by more than half to 54 per 100,000 inmates. From 2000 to 2007, the suicide rate declined by about a quarter, from 49 to 36 suicide deaths per 100,000 jail inmates. The suicide mortality rate in small jails (42 per 100,000) was 2.6 times that in state prisons (16 per 100,000). The lower rate of suicide in large jails may reflect the capacity of these jails to provide a variety of suicide prevention measures. According to data, over half (54%) of jails holding fewer than 50 inmates provided staff training in suicide prevention, compared to 91% of the largest jails. Fewer than half (41%) of the smallest jails provided inmate counseling or psychiatric services, while such services were provided by over 90% of the largest facilities. Overall, the availability of various suicide prevention measures increased with facility size.

Violent offenders (80 per 100,000) and public-order offenders (68 per 100,000) were the most likely to commit suicide. Specifically, offenders serving time for homicide, rape, and kidnapping (200, 197, and 195 per 100,000, respectively) had the highest suicide rates. Violent offenders also had the highest rates of cancer and homicide mortality. Property and drug offenders (106 per 100,000) had the lowest overall mortality rates. Drug offenders had the lowest mortality rates from suicide (22 per 100,000) and homicide (1 per 100,000).

The most common means of suicide by inmates is by hanging, which can result in death in five or six minutes. Severe brain damage from hanging can occur in as little as four minutes. Inmates have died after hanging themselves from clothing hooks, shower knobs, cell doors, sinks, ventilation grates, windows, and smoke detectors. **According to the Montana Office of Epidemiology and Scientific Support (2016), Montana's county detention centers average three suicides a year, over the past 10 years. There was a period between 2011 and 2013 where the average was five suicides per year, but this has returned to the average of three in the past two years.**

Prisons and jails contain large numbers of people with the types of

Suicide Prevention in Montana's Correctional Facilities

Correctional facilities should have written policies and procedures for both preventing suicides and responding to attempts that may occur. All staff at the facilities should be trained on when and how to implement these plans. At a minimum, suicide prevention plans should include protocols for the following:

Assessing suicide risk and imminent suicide risk. While a formal intake suicide risk and mental health assessment is an essential part of this process, an inmate's risk status can change dramatically over time. Thus, staff need to be trained to recognize and respond to changes in an inmate's mental condition.

Effective communication about suicide risk. Knowledge about an inmate's risk status and history can be lost as he or she is transferred between units or facilities (or as shifts change). Formal procedures for communicating knowledge about suicide risk of particular inmates will help staff maintain and target their vigilance. Information that needs to "follow" the prisoner includes the following:

- ◆ suicide threats by the inmate
- ◆ behaviors that indicate he or she may be depressed
- ◆ a history of psychiatric care and medication
- ◆ whether the inmate is in protective custody.

Use of isolation cells. While it is often appropriate for prisoners to be placed in isolation cells, this placement can raise the risk of suicide. If an inmate thought to be at risk of suicide requires isolation, attention must be paid to appropriate observation of the inmate as well as ensuring that all isolation cells are suicide-resistant – that is, minimize the presence of items that could be used for self-harm, such as bed sheets and projections from walls or furniture that could be used as anchors for a hanging.

Training for staff, including training in recognizing and responding to suicide risk, and training in first aid (including CPR) as well as the need to begin procedures such as CPR immediately.

Availability of appropriate first aid safety equipment, including latex gloves, resuscitation breathing masks, defibrillators, and tools for opening jammed cell doors and cutting down a hanging inmate.

mental illnesses associated with elevated risk of suicide. According to the Bureau of Justice Statistics (2005) half of prison and jail inmates have mental health problems. Approximately three-quarters of inmates with mental health problems have a co-occurring substance abuse disorder. Substantial numbers of inmates have major depressive disorders (29.7% of those in local jails, 23.5% of those in state prisons, and 16% of those in Federal prisons). Another Bureau of Justice Statistics (2005) study found that about 10% of those incarcerated in Federal or state prisons or local jails had reported at least one overnight stay in a mental institution prior to their arrest. An American Psychiatric Association review (2000) of the research literature concluded that 20% of prison and jail inmates are in need of psychiatric care and 5% are “actively psychotic”.

The following intervention guidelines were taken from the Suicide Prevention Resource Center document, “*What Corrections Professionals Can Do to Prevent Suicide*” published in October, 2007. The guidelines identify the most effective way to prevent suicides in correctional facilities involves recognizing and responding to the warning signs that an inmate may be at imminent risk of trying to harm him or herself. These warning signs include the following:

- **Verbal warnings.** People who are considering killing themselves often talk about their plans. Staff should pay attention to similar thoughts or statements expressed in letters, poems, or other writings that may come to their attention.
- **Depression.** Although most people suffering from clinical depression do not kill themselves, a significant proportion of people who die by suicide are clinically depressed.
- **Psychosis.** Any signs of psychosis, such as talking to oneself, claiming to hear voices, or suffering hallucinations, should also be taken as a sign that the prisoner may be at risk. Staff should be especially alert if prisoners have stopped taking anti-psychotic or anti-depressive medication.
- **Reaction to incarceration.** [Many suicides in jails occur during the first 2 weeks of detention.](#) Many occur when an inmate is under the effect of alcohol or drugs. Young adults arrested for nonviolent offenses – such as alcohol or drugs - are often at elevated risk of suicide. They can be afraid of jail, embarrassed by their situation, and afraid of reaction of their family and friends to their arrest.
- **Current precipitating events.** In addition to arrest and detention, there are other events that can precipitate a suicide attempt, including receiving bad news from home, conflict with other inmates, legal setbacks, withdrawal from drugs, and the tension caused by court hearings or sentencing , or sexual coercion. [80% of inmates who committed suicide attended a court hearing within 2 days of their death.](#)
- **Recognizing and Responding to the Warning Signs** -Correctional personnel should not be afraid to ask an inmate if he or she has considered suicide or other self-destructive acts. Asking someone if he or she has thought about suicide will NOT increase the risk of suicide. Correctional staff may want to be very direct and simply ask the question “*Are you thinking about killing yourself?*” It is very possible that an honest answer will not be forthcoming, given the tension that can exist between inmates and correctional staff and the unwillingness of prisoners to “open up” about issues that they may consider to be signs of weakness. Any suspicion that a prisoner may be actively at risk of suicide should be communicated to a mental health professional. Any suspicion that a prisoner may be in imminent danger should be reported. Reports of such suspicions by inmates’ families or other inmates should also be taken seriously. Some prisoners use the threat of suicide (or a “feigned” suicide attempt) to manipulate the system and, for example, delay a court date or obtain a transfer to another unit or facility. It is extremely difficult to tell whether an inmate is feigning suicide risk. Thus, all suicide threats must be taken seriously.

Demographics of a Jail Suicide

Source: National Study of Jail Suicides: 20 years later (April, 2010). U.S. Dept. of Justice, National Institute of Corrections

Demographics of the Inmate

- ◆ 67% were white
- ◆ 93% were male
- ◆ Average age was 35
- ◆ 43% were held on a violent charge
 - Highest rate was among those charged with homicide, kidnapping, and rape.
 - Lowest rate was among Drug Offenses

History of Mental Illness or Substance Abuse

- ◆ 47% had a history of substance abuse
- ◆ 20% were intoxicated at the time of death
- ◆ 38% had a history of mental illness
- ◆ 34% had a history of suicidal behavior

Time Demographics

- ◆ Deaths were evenly distributed throughout the year.
- ◆ 32% occurred between 3 p.m. and 9 p.m.
- ◆ 23% occurred within the first 24 hours, 27% between 2 and 14 days, and 20% between 1 and 4 months.
- ◆ 80% of inmates who committed suicide attended a court hearing within 2 days of their death

Means

- ◆ 93% of victims used hanging
- ◆ 66% used bedding as the instrument (followed by 11% by clothing and 3% by shoelace)
- ◆ 30% used a bed or bunk as the anchoring device.
- ◆ 31% were found dead more than an hour after the last observation
 - * Death by hanging can occur in five or six minutes.
 - * Severe brain damage from hanging can occur in as little as four minutes.

Characteristics of the jail facility

- ◆ 93% had a protocol for suicide watch but only 2% had option for constant observation (87% used 15-minute observation) Intoxicated or history of substance abuse.
- ◆ 73% provided intake screening for suicide but only 27% verified the victim's risk during prior confinement and only 31% verified whether the arresting officer believed the victim was a suicide risk.
- ◆ 62% provided suicide prevention training but only 37% provided annual updates.

Juvenile Suicide in Confinement

Juvenile Suicide in Confinement: A National Survey (February 2009), Office of Juvenile Justice and Delinquency Prevention Report , Lindsay M. Hayes, National Center on Institutions and Alternatives

Demographics of the Inmate

- ◆ Almost 70% (68.4 percent) of victims were Caucasian.
- ◆ Almost 80% (79.7 percent) of victims were male.
- ◆ Average (mean) age of victims was 15.7, with more than 70% of victims ages 15–17.
- ◆ A sizable number (38.0 percent) of victims were living with one parent at time of confinement.
- ◆ Almost 70% (69.6 percent) of victims were confined for nonviolent offenses. (different from adult population)
- ◆ All detention center suicides occurred within the first 4 months of confinement, with more than 40 percent occurring within the first 72 hours.

History of Mental Illness or Substance Abuse

- ◆ Nearly 75% (73.4 percent) of victims had a history of substance abuse,
- ◆ 19.0 percent had a history of medical problems,
- ◆ 44.3 percent had a history of emotional abuse,
- ◆ 34.2 percent had a history of physical abuse,
- ◆ 27.8 percent had a history of sexual abuse.
- ◆ Nearly 66% (65.8 percent) of victims had a history of mental illness (with 65.3 percent of these victims suffering from depression at the time of death); 53.5 percent of victims were taking psychotropic medications.
- ◆ Nearly 70% (69.6 percent) of victims had a history of suicidal behavior, with suicide attempt(s) the most frequent type of suicidal behavior (45.5 percent), followed by suicidal ideation/threat (30.9 percent) and suicidal gesture (23.6 percent).

Means

- ◆ Almost all (98.7%) the suicides were by hanging; 71.8% of these victims used their bedding (e.g., sheet, blanket) as the instrument. A variety of anchoring devices were used in the hangings, including door hinge/knob (20.5 percent), air vent (19.2%), bedframe (19.2%), and window frame (14.1%).
- ◆ None of the victims were under the influence of alcohol or drugs at the time of the suicide.
- ◆ Almost 75% (74.7 percent) of victims were assigned to single-occupancy rooms.

Time Demographics

- ◆ Approximately 60% of victims were found more than 15 minutes after the last observation of the youth. Slightly more than 15 percent of victims were found more than 1 hour after last being seen alive.
- ◆ About half (50.6%) the victims were on room confinement status at the time of death
- ◆ A large majority (85%) of victims who died by suicide while on room confinement status died during waking hours (6 a.m. to 9 p.m.)

Characteristics of the jail facility

- ◆ Only 37.9% of the suicides took place in facilities that provided annual suicide prevention training to its direct care staff.
- ◆ Although a large majority (78.5%) of victims died in facilities that maintained a written suicide prevention policy at time of suicide, only 20.3% of victims were in facilities that had all seven suicide prevention components (written policy, intake screening, training, CPR certification,

Suicide and Sexual Orientation

Another population that presents a significant risk of suicide is gay and lesbian youth. According to the Center for Suicide Prevention (2003), 42% of gay and lesbian youth studied had thoughts of suicide at some time. 25% had thoughts of suicide in the past year, and 48% said thoughts of suicide were related to their sexual orientation.

According to the Centre for Suicide Prevention (2003), there are risk factors and protective factors for gay and lesbian youth. The primary risk factors include:

- Previous suicide attempt
- Suicidal behavior among friends
- Mental illness (depression, anxiety)
- Substance abuse
- Family dysfunction (parental alcoholism, domestic violence, divorce)
- Identity conflict or identity confusion
- Interrupted social ties or lack personal support networks (including rejection by family)
- Social inequity (limited social and legal protection, hostile school or work environment, physical and verbal victimization, harassment and persecution)

The primary protective factors include:

- Having a strong support system (family, peers, school, mental health services)
- Ability to maintain sense of confidence and self-esteem

There is little research concerning how much of a factor this is in Montana, however nationally, studies have shown that youth with same-sex orientation are 2-3 times more likely than their same-sex peers to attempt suicide (Russel, S.T. & Joyner, K., 2001, Centre for Suicide Prevention, 2003). Approximately 15% of youth who reported suicide attempts also reported same-sex attraction or relationships. These youth also presented as higher risk for alcohol abuse and depression.

In Montana, the number of gay and lesbians is difficult to determine. However, according to a report from the Williams Institute (Gates, 2006), as of 2005, there were 1,600 same-sex couples in Montana, up from 1,200 in 2000. This number is considered to be significantly lower than the actual number, especially since this number does not include youth. The report estimated that 2.6% of Montana's population was gay, lesbian, or bisexual. Based on the Montana's 2015 estimated population (US Bureau of the Census, www.census.gov), this equates that the gay, lesbian, or bisexual adult population in Montana is just under 27,000.

Suicide prevention and intervention efforts should consider the role that victimization plays in the everyday lives of all youths and its potential effects on suicidality. As identified above, among primary youth suicide risk factors, high levels of depression and alcohol abuse are reported by same-sex orientation. It has been suggested that for gay and lesbian youths who are concealing their sexual identities, alcohol may be used to numb the related anxiety and depression. Research and prevention efforts with this population should also focus on depression and substance abuse as precursors to suicidality (Russel, S.T. & Joyner, K., 2001).

Support of gay and lesbian youth in schools can be achieved through:

- Developing and enforcing school policy to support and protect gay and lesbian youth from verbal and physical harassment.
- Educating school staff on issues related to sexuality
- Providing appropriate referrals for gay and lesbian youth with mental health problems
- Developing support groups for gay and lesbian youth.

Additional resources for working with the LGBT population are available at www.dphhs.mt.gov/amdd/suicide

Suicide and Smoking

A paper released in July of 2014, published online in the journal *Nicotine & Tobacco*, finds state public health interventions, such as cigarette excise taxes and indoor smoking bans, could also reduce rates of suicide by as much as 15 percent. According to the report, smokers have 2 to 4 times higher risk for suicide than non-smokers. Studies suggest that people who smoke are more likely to have psychiatric disorders or abuse other substances such as drugs or alcohol. Some research even argues that smoking changes neural pathways related to the pleasure centers of the brain that are activated as a result of addiction, which can severely impact mental health. The study, led by Washington University School of Medicine in St. Louis, analyzed data from the National Center for Health Statistics, representing all 50 states. The researchers concluded that each dollar increase in cigarette taxes could reduce suicide risk by as much as 10 percent. From 1990 to 2004 those states that adopted strict tobacco control policies saw a decrease in suicide rates as well. In that same time period, states with lower excise taxes on cigarettes and fewer laws on smoking in public spaces saw a 6 percent increase in suicide.

Other studies have also linked smoking to increased risk of suicide. According to the Center for Disease Control (Sustaining State Programs for Tobacco Control: Data Highlights 2010), 18.5% (138,000) of Montana adults smoke and 12.2% (11,000) of Montana youth (ages 12-17) smoke. An average of 1,400 Montanans die each year from smoking-attributable causes and it is projected that another 18,000 youth will die from smoking. There have been a number of studies that indicate a correlation between smoking and increased risk of suicide. Hemenway, et al (1993) found a strong correlation between suicide and smoking in nurses. In their study, women who smoked 1 through 24 cigarettes per day had twice the likelihood of committing suicide as those who had never smoked. Women who smoked more than 25 cigarettes per day had four times the likelihood of suicide in the succeeding 2 years as those who had never smoked. In

another study published in the *American Journal of Public Health* (Miller, M. et al., 2000), compared with never smokers, heavy smokers were at increased risk for suicide. The risk of suicide increased with the number of cigarettes smoked daily. Current smokers of 15 or more cigarettes per day had more than 4 times the risk of suicide

According to the Miller study (2000), the rate of suicide increased with the number of cigarettes smoked daily (The number indicates the crude incidence of suicide per 100,000 people.)

Never Smoked	12 per 100,000 people
Former Smoker	18
Current Smoker, 1-14 cigarettes a day	32
Current Smoker, >15 cigarettes a day	55

compared with never smokers. The suicide risk among former smokers was intermediate between the risks among never and current smokers. Another more study (Pratt & Brody, 2010) found a correlation between smoking and depression. In the study, the authors summarized, "Persons with depression were more likely to be current smokers than persons without depression. Almost one-half of adults under age 55 with current depression were current smokers, while less than one-quarter of people in this age group without depression were smokers.

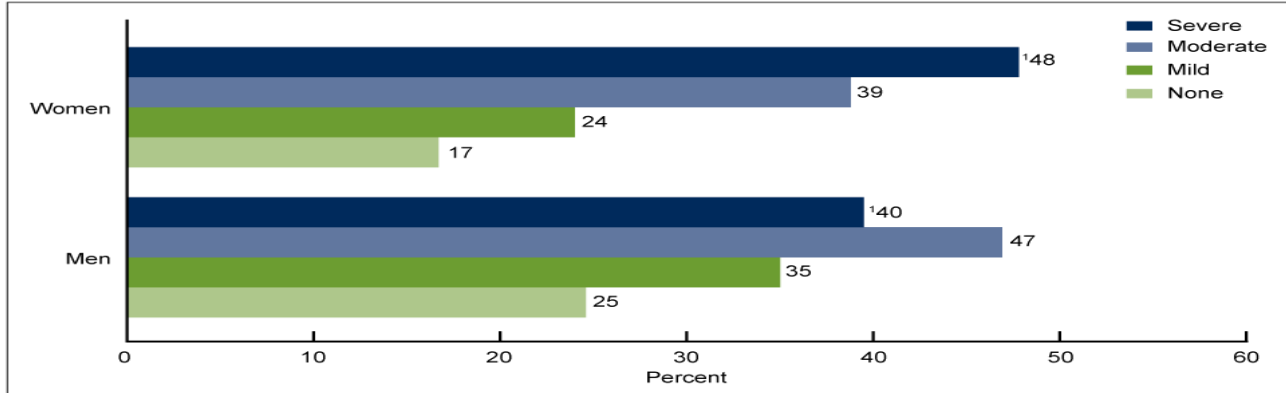
The proportion of adults who were current smokers tended to increase with an increase in depression severity. Even persons with mild depressive symptoms below the threshold for the diagnosis of depression were more likely to be smokers than people with no depressive symptoms. Adults with depression were more likely to smoke over a pack a day and smoke their first cigarette within 5 minutes of waking up than were adults without depression. Both of these are indicators of heavy smoking. Heavy smoking is highly correlated with inability to quit.

Those with depression had a higher rate of smoking initiation (ever smoking) as well as a lower quit rate. They were also heavier smokers than persons without depression. Individuals with other mental illnesses have similar smoking patterns. Studies have shown that persons with depression and other mental illnesses smoke a disproportionate share of all the cigarettes consumed in the United States.”

Interventions for the problem of smoking should model the prevention recommendations made by the Montana Tobacco Prevention Advisory Board in their 2004 publication of the Montana Tobacco Use Prevention Plan (<http://tobaccofree.mt.gov/>)

Adults with depression were more likely to be current cigarette smokers than those without depression.

Figure 2. Percentage of adults aged 20 and over who were current smokers, by sex and depression severity: United States, 2005–2008

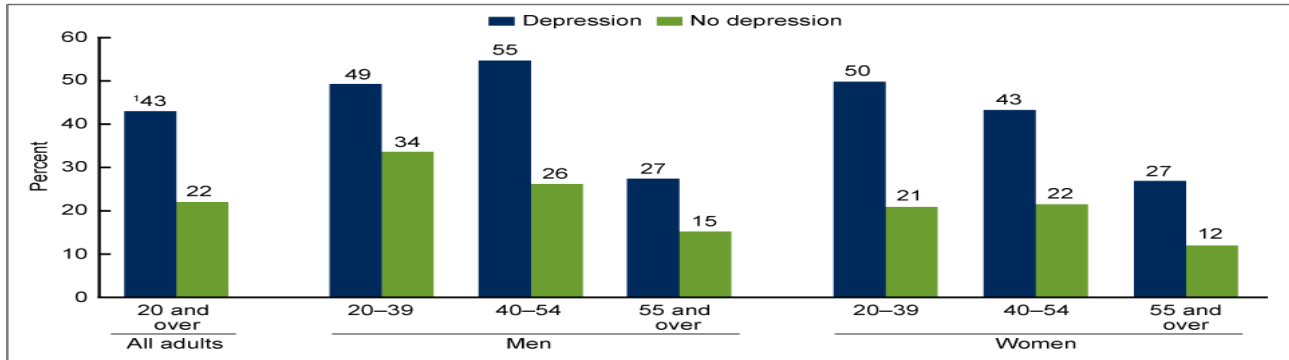


¹Statistically significant trend.

NOTES: Moderate or severe indicate depression, while mild indicates mild depressive symptoms. Access data table for Figure 2 at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig02.xls or ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig02.csv. SOURCE: CDC/NCHS, National Health and Nutrition Examination Surveys, 2005–2008.

The percentage of adults who were current smokers increased as depression severity increased.

Figure 1. Percentage of adults aged 20 and over who were current smokers, by age, sex, and depression status: United States, 2005–2008



¹All comparisons between depression and no depression are significant ($p < 0.05$).

NOTE: Access data table for Figure 1 at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig01.xls or ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig01.csv. SOURCE: CDC/NCHS, National Health and Nutrition Examination Surveys, 2005–2008.

Four possible explanations for the smoking–suicide connection were proposed:

- depression is a common antecedent of suicide and a condition that leads to smoking as a form of self-medication;
- smoking alters brain chemistry, leading to depression, which increases the risk of suicide;
- smoking leads to malignant disease, such as cancer, which increases the risk of suicide; and
- smoking is associated with other characteristics that predispose individuals to suicide, such as low self-esteem (not because smoking physiologically exacerbates low self-esteem, but because in our culture they tend to occur together).

Montana Strategic Suicide Prevention Plan—2017

The Vision

We value human life. We encourage all people and organizations in Montana to deal openly, collaboratively, and with sensitivity for all cultures to minimize suicide. We are working to create an environment where everyone will have access to qualified resources for help when they are in need.

The Mission

There will be a sustained reduction in the incidence, prevalence and rate of suicide and non-lethal suicidal behavior in Montana.

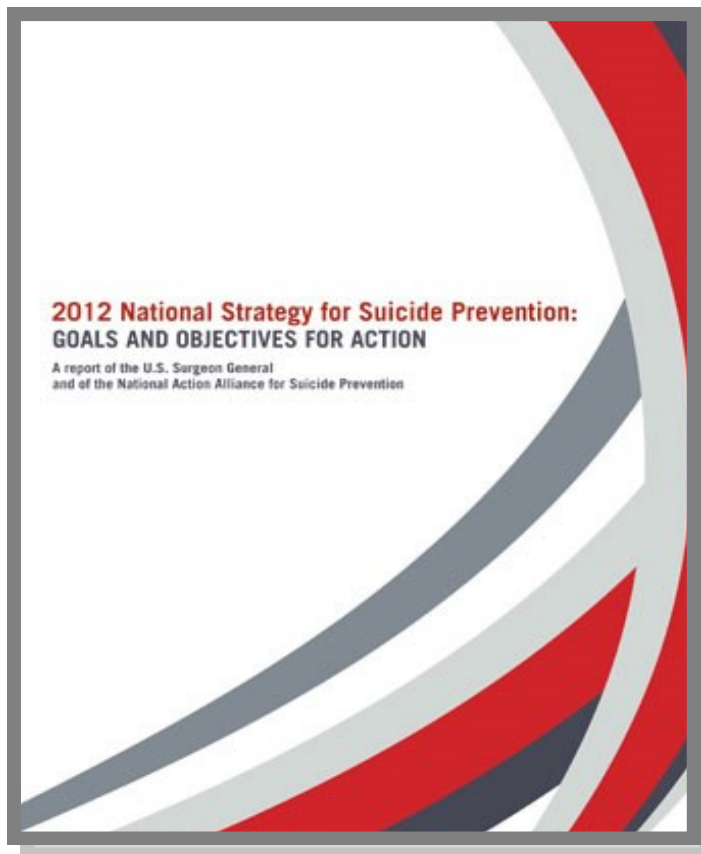
The Goals and Measurable Objectives

Although Montana has had one of the highest rates of suicide in the nation for decades, it has only been in the last decade that an investment in preventing this public health issue has been made. In the past few years there has been legislation to address the issue of suicide along with significant efforts at the state, local, and tribal levels. In Montana, suicide is part of our culture, and has been for nearly a century. To address this issue, it is going to take a cultural shift in thinking, and that takes time.

To accomplish our mission and move towards the realization of our vision there are several key goals which we want to focus on in next decade. Interventions to accomplish these goals and objectives can be found throughout this report, but specifically have been identified in the **Opportunities for Prevention Activities** section. On the following pages are objectives specific to Montana that align with the revised **2012 National Strategy for Suicide Prevention**. You will notice in the national strategy there are *4 strategic directions with 13 goals* that have been identified. Under each goal, a number of objectives are listed. **Although all the objectives are listed in the coming pages, not all will be specifically addressed as part of the Montana plan. This is not to say that these objectives are not valued, but in an effort to ensure that we set realistic expectations, we are only identifying one Montana specific objective under each goal for the purpose of this report. However, other objectives may be addressed as we continue to focus on meeting our vision and mission statement.**

Goals and Objectives

In an effort to ensure that Montana aligns with the revised National Strategy for Suicide Prevention (2012), the Montana State Strategic Suicide Prevention Plan will identify at least one specific Montana objective for each goal identified in the national plan. National goals and objectives are in black. **Specific Montana objectives are in blue.**



Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Objective 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state/territorial, tribal, and local levels.

Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance suicide prevention.

Objective 1.4: Develop and sustain public-private partnerships to advance suicide prevention.

Objective 1.5: Integrate suicide prevention into all relevant health care reform efforts.

Montana Objective: Integrate suicide prevention gatekeeper training and prevention tools into law enforcement, health care, primary and secondary education, tribal, and community levels.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Objective 2.2: Reach policymakers with dedicated communication efforts.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Objective 2.4: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

Montana Objective: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care through public awareness campaigns, social media, and community presentations.

GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Objective 3.2: Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.

Objective 3.3: Promote the understanding that recovery from mental and substance use disorders is possible for all.

Montana Objective: Reduce stigma, promote the understanding that recovery from mental and substance use disorders is possible, and promote protective factors from suicide risk through implementation of evidence-based practices .

GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of suicide and other related behaviors.

Objective 4.3: Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.

Objective 4.4: Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

Montana Objective: Encourage media resources and institutes of public education to utilize known SAMHSA resources on the reporting and responding of suicides in communities.

Strategic Direction 2: Clinical and Community Preventive Services

GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local suicide prevention programming.

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

Montana Objective: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors through the use of evidence-based programs available through the DPHHS.

GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Objective 6.1: Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.

Objective 6.2: Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Objective 6.3: Develop and implement new safety technologies to reduce access to lethal means.

Montana Objective: Encourage and promote the safe storage and protection of firearms from high risk populations through the use of gunlocks and other gun safety measures.

GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.

Objective 7.2: 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 with suicide risk.

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 7.5: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Montana Objective: Provide training on suicide prevention to community groups, mental health/chemical dependency providers, law enforcement, health care providers and school educators.

Strategic Direction 3: Treatment and Support Services

GOAL 8. Promote suicide prevention as a core component of health care services.

Objective 8.1: 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.

Objective 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Objective 8.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Objective 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

Objective 8.5: Encourage health care delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

Objective 8.6: Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer support programs.

Objective 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

Objective 8.8: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge.

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

Montana Objective: Encourage health care providers to universally screen for depression starting at age 12 through the life span and utilize nationally recognized suicide risk assessment tools (C-SSRS)

GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.

Objective 9.2: Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.

Objective 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Objective 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

Objective 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.

Objective 9.6: 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.

Objective 9.7: Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

Montana Objective: Implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk through training in core competencies and access to national protocols.

GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1: Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.

Objective 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Objective 10.3: Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.

Objective 10.4: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

Objective 10.5: Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Montana Objective: Provide appropriate resources to individuals affected by a suicide attempt or bereaved by suicide, including survivor support.

Strategic Direction 4: Surveillance, Research, and Evaluation

GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 11.1: Improve the timeliness of reporting vital records data.

Objective 11.2: Improve the usefulness and quality of suicide-related data.

Objective 11.3: Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

Objective 11.4: Increase the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

Montana Objective: Improve the timeliness, usefulness, and quality of suicide-related data through collaboration between the DPHHS and local coroners and health care professionals.

GOAL 12. Promote and support research on suicide prevention.

Objective 12.1: Develop a national suicide prevention research agenda with comprehensive input from multiple stakeholders.

Objective 12.2: Disseminate the national suicide prevention research agenda.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

Objective 12.4: Develop and support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

Montana Objective: Through the Montana Suicide Mortality Review Team, review all suicides that occur in the state and identify factors and correlated interventions that could be implemented.

GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 13.1: Evaluate the effectiveness of suicide prevention interventions.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions.

Objective 13.3: Examine how suicide prevention efforts are implemented in different states/territories, tribes, and communities to identify the types of delivery structures that may be most efficient and effective.

Objective 13.4: Evaluate the impact and effectiveness of the National Strategy for Suicide Prevention in reducing suicide morbidity and mortality.

Montana Objective: Evaluate the effectiveness of suicide prevention interventions through monitoring of trend data, vital statistics, and number of people trained in suicide prevention.

The Environment for Suicide Prevention in Montana

DPHHS has identified factors that could impact the implementation of this plan. These factors include: assets that could have a positive and supportive impact on the implementation of the plan; barriers and challenges to carrying out the plan; and finally, near term opportunities that could be leveraged to aid in the successful implementation of the plan.

Perceptions that create barriers

- To date there has been a lack of community awareness and acceptance of the problem.
- The debate continues in some groups about whether suicide is an individual or community problem. It is, for some, easier to tackle the “individual” problem (acute care or after the fact intervention) and more difficult to take on the “community problem” (primary prevention and encouraging protective factors).
- There is a lack of cultural awareness and sensitivity by suicide prevention staff and in prevention materials and programs.
- In many communities, there is insufficient expertise and capacity and often they must rely on expertise from outside of the local community to guide plans and activities. This lack of local capacity may result in the purchase of commercial products and programs that are without proven efficacy.
- The actual *number* of suicides within a given community is low; therefore, the problem is easy to ignore or dismiss.
- Sustaining interest in suicide prevention activities is difficult after a crisis situation or a completed suicide fades into the distant past.
- Changes in leadership often means changes in public health agendas and priorities.

Montana’s Unique Characteristics

- Much of Montana epitomizes geographical isolation, accentuated by the harsh winter climate. According to the 2010 US Census, Montana has 6.8 people per square mile. The US average is 87.4
- Since the arrival of the earliest white settlers, there has been an ingrained social culture that has accepted suicide as a part of life in Montana.
- Montana’s rate of suicide has proven resistant to improvement from previous prevention efforts.
- There is a lack of availability and access to mental health services in many areas in the state, in part due to the state’s remoteness.
- There is a prevalent and proud “western” culture and attitude among the Caucasian majority in Montana - ‘we can take care of ourselves.’ This is especially true when it comes to asking for help for depression or anxiety. We see asking for help as a weakness and we are being a burden to our families.
- Frequently, there is access to firearms that are not properly stored. Research indicates that a home with a firearm is 20 times the risk of having a suicide.
- There is a lack of transportation services for some people that inhibits their ability to seek or receive help.
- There is a lack of communication infrastructure (phones, cellular service, and Internet access) in some areas, including American Indian reservations, frontier and rural areas.
- Montana ranks high in alcohol and substance abuse when compared to other states in the U.S. Montana is near the top in the nation in alcohol related deaths, underage drinking, binge drinking, and consumption per capita.

Strategic Directions Toward Reducing Suicide in Montana

Due to the diversity of the State and the cultural barriers that exist, DPHHS considers the most important direction to focus resources and attention is promoting public awareness and implementation of programs specific to communities and/or the state. These programs are to be evidenced-based whenever possible and begin the process of changing the culture for future generations. **This will be a slow change.** There is a culture of suicide in Montana that has been evident for generations. It is going to take a cultural shift in thinking that starts with our young people, giving them the tools and skills necessary to cope when they reach the high-risk ages between their mid 20's through their 50's.

Below outlines the prevention, intervention, postvention, and coordination that is recommended throughout the state to decrease the incidence of suicide.

Prevention

- Address the stigma associated with mental illness and asking for help.
- Increase awareness of youth suicide prevention and focus on coping/resiliency skill development at the elementary and middle school level.
- Develop community provider networks.
- Increase training for law enforcement agencies and health care professionals.
- Conduct gatekeeper (QPR, ASIST) trainings.
- Provide depression screening programs in schools and health care.
- Implement evidenced-based curriculum into Montana's schools (SOS, QPR, Mental Health First Aid).
- Continue with an aggressive media campaign that increases awareness of warning signs, how to intervene, and resources.
- Pilot promising interventions and programs (YAM)

Intervention

- Increase access to mental health and substance abuse services including smoking cessation programs.
- Develop and implement clinical screening programs and standard screening tools with appropriate referral and follow-up.
- Increase the number and ability to access crisis stabilization beds.

Postvention

- Reduce access to lethal means with affected circles of suicide survivors
- Improve services for survivors
- Provide support and resources to families of persons at high risk or who have attempted
- Improve media reporting of suicides based on nationally recognized standards.

Coordination

- Improve communication and community linkages with mental health and substance abuse service systems serving youth and young adults.
- Demonstrate collaboration between state, local, and tribal communities.

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