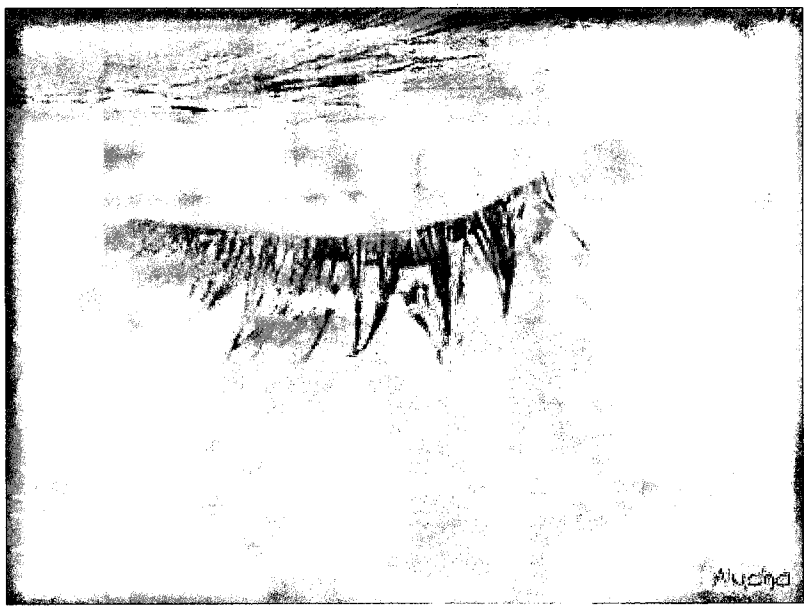
State-Tribal Relations IC
April 4, 2012
Fort Peck Reservation
EXHIBIT 5

Suicide Among American Indian Youth

Facts, Figures, and Formulas for Prevention

Karl Rosston, LCSW
Suicide Prevention Coordinator
406-444-3349
krosston@mt.gov
www.prc.mt.gov/suicideprevention



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

Kay Redfield Jamison, Ph.D.
Professor of Psychiatry
Johns Hopkins University
"Night Falls Fast: understanding suicide", pg. 24

Youth Suicide Fact Sheet

Source: Center for Disease Control, October 24, 2011

- In 2008, suicide ranked as the **third leading** cause of death for young people (ages 15-24); only accidents and homicides occurred more frequently.
- In 2008, **36,035 people** completed suicide. Of these, **4,298 were completed by people between the ages of 15 and 24. (3% increase from 2007)**
- Suicide rates, for 15-24 year olds, have more than **doubled since the 1950's**, and remained largely stable at these higher levels between the late 1970's and the mid 1990's. There was a 29% decline between 1994 and 2003, but then an **8% increase in 2003-2004.**
- In the past 60 years, the suicide rate has **quadrupled for males 15 to 24 years old**, and has **doubled for females of the same age** (CDC, 2002).
- For every completed suicide by youth, it is estimated that **100 to 200 attempts** are made.
- Each day, there are approximately **11 youth suicides.**
- Every **2 hours**, a person under the age of 25 completes suicide.
- **Firearms** remain the most commonly used suicide method among youth, accounting for **50% of all completed suicides.**

Suicide Among Children

- In 2008, **222 children ages 5 to 14 completed suicide in the U.S. (up from 184 in 2007)**
- Suicide rates for those between the **ages of 10-14 increased 51%** between 1981 and 2004.

Other factors

- Research has shown that most adolescent suicides occur **after school hours** and **in the teen's home.**
- Within a typical high school classroom, it is likely that **three** students (one boy and two girls) have made a suicide attempt in the past year.
- The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills, while the profile of the typical suicide completer is a male who dies from a gunshot wound.
- *Most* adolescent suicide attempts are precipitated by **interpersonal conflicts**. The intent of the behavior appears to be to **effect change in the behaviors or attitudes of others.**
- Repeat attempters (those making more than one nonfatal attempt) generally use their behavior as a means of coping with stress and tend to exhibit more chronic symptom logy, poorer coping histories, and a higher presence of suicidal and substance abuse behaviors in their family histories.

Suicide in Montana

Data Source: Center for Disease Control, October 24, 2011

- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past thirty years. **In a report for 2008 data released by the American Association of Suicidology in October , 2011, Montana has the 4th highest rate of suicide in the nation**.
- Suicide has ranked as the 7th or 8th leading cause of death for Montanans for more than two decades. Gender differences are similar with national statistics, with males at greater risk.
- Since 2000, the gap between the rate of suicide among American Indians and Caucasians has widened with the rate for Caucasians remaining relatively steady at 13.06 per 100,000, while the rate of suicide for American Indian youth has grown to 17.96 per 100,000 (2000-2007, ages 10-24, both genders)
- According to the 2011 Youth Risk Behavior Survey, during the 12 months before the survey, **6.5% of all Montanan students in grades 9 through 12 had made a suicide attempt.** For **American Indian students on reservations, 16.2% had attempted suicide one or more times in the twelve months** before the survey. (the lowest % since 1997)
- But...

  The percentage of 7th and 8th graders who attempted suicide in the past 12 months jumped from 6.1% (2009) to 10.8% (2011).
- Could it be correlated to bullying?

  The percentage of 7th and 8th graders who reported being bullied on school property in the past 12 months jumped from 38% (2009) to over 50% (2011)
- Firearms (64%), poison (18%), and suffocation (14%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.
- Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- Over the past seven years (2000-2006), suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-34.

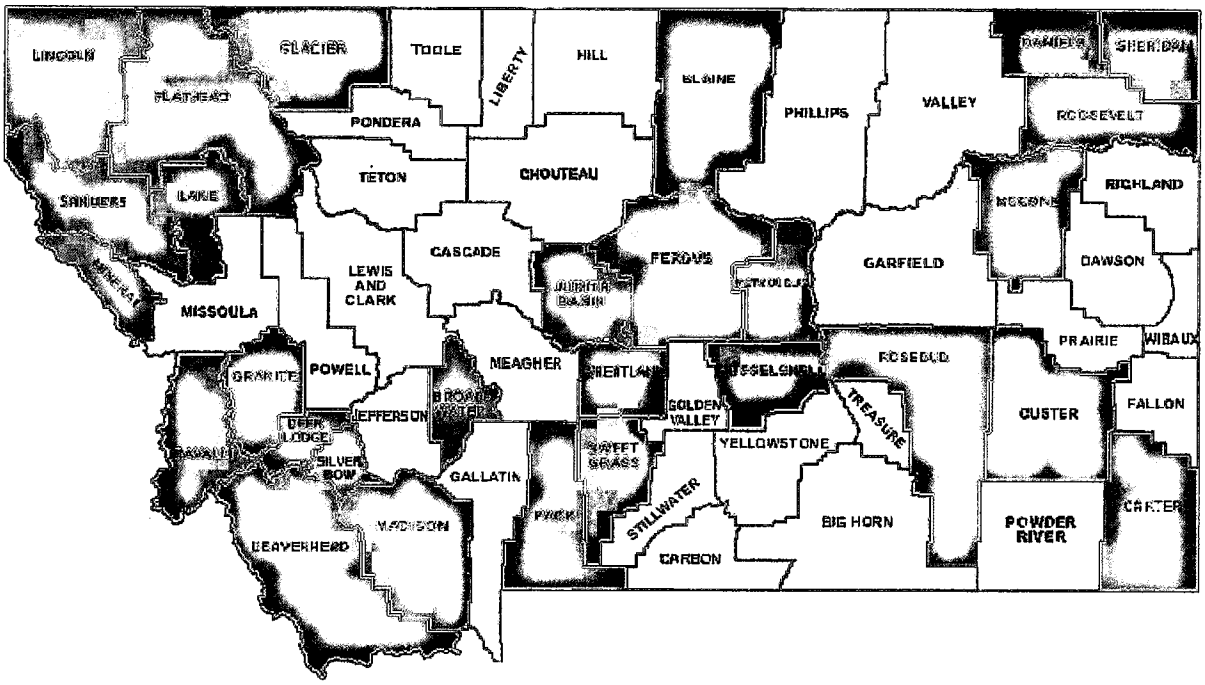
*"I think of stabbing myself with a knife. When Mom yells at me, I think she does not love me. I worry a lot about my family. Mom is always depressed and sometimes she says she will die soon. My brother becomes very angry, often for no reason. He tried to kill himself last year and had to go to the hospital. Mom was in the hospital once also. I worry a lot about my family. I worry that if **something happens to them, no one will take care of me. I feel sad about this."***

10 year old girl as quoted in "Night Falls Fast"

Suicide in Montana's Counties

(**Source:** Montana DPHHS, 2012 Montana Vital Statistics)

Red (dark) counties - At or above the 90th percentile in suicide nationally



2001-2010 Rate of Suicide for Montana Counties

Rate is per 100,000 people

County	# of Suicides	Crude Rate	County	# of Suicides	Crude Rate
BEAVERHEAD	24	26.9	MCCONE	4	22.9
BIG HORN	20	15.6	MEAGHER	3	15.7
BLAINE	14	21.2	MINERAL	10	25.7
BROADWATER	12	26.0	MISSOULA	200	19.3
CARBON	16	16.4	MUSSELSHELL	10	22.4
CARTER	3	23.8	PARK	47	29.8
CASCADE	169	20.7	PETROLEUM	1	21.4
CHOUTEAU	11	20.3	PHILLIPS	7	17
CUSTER	37	32.8	PONDERA	11	18.2
DANIELS	4	22.3	POWDER RIVER	3	17.2
DAWSON	16	18.5	POWELL	14	20
DEER LODGE	31	34.5	PRAIRIE	0	0
FALLON	4	14.8	RAVALLI	89	22.7
FERGUS	28	24.6	RICHLAND	17	18.5
FLATHEAD	179	21.4	ROOSEVELT	30	29.1
GALLATIN	144	17.6	ROSEBUD	24	26.1
GARFIELD	2	16.6	SANDERS	30	27.8
GLACIER	29	21.7	SHERIDAN	8	22.9
GOLDEN VALLEY	1	9.5	SILVER BOW	88	26.6
GRANITE	6	20.7	STILLWATER	16	18.8
HILL	31	19	SWEET GRASS	10	27.4
JEFFERSON	18	16.6	TETON	8	12.9
JUDITH BASIN	7	32.8	TOOLE	10	19.4
LAKE	60	21.6	TREASURE	1	14.1
LEWIS & CLARK	107	18.1	VALLEY	9	12.7
LIBERTY	1	5.1	WHEATLAND	5	24.1
LINCOLN	49	26.2	WIBAUX	0	0
MADISON	19	26.5	YELLOWSTONE	242	17.6

2001-2010 Montana Suicide Rate- 20.2 (1,941) **2000-2007 US Suicide Rate-11.05 (226,735)**

Suicide Among American Indian Youth and Young People

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.

- Suicide is the second leading cause of death for American Indians for all ages.
- Suicide was the reported cause of :
  - 13.5% of the deaths of 10-14 year olds (7.2% for all races)
  - 26.5% of the deaths of 15-19 year olds
  - 15.9% of the deaths of 20-24 year olds; and
  - 14.7% of the deaths of 25-34
- Suicide rates were highest for American Indian male youth and young adults. The rate of suicide for American Indian males was:
  - More than 2 ½ times higher than the average rate for 15-19 year olds (32.2% vs 12.6%)
  - Nearly 1 ½ times higher than the average rate for 20-24 year olds (29.1% vs 20.8%); and
  - More than 1 ½ times higher than the average rate for 25-34 year olds (31.1% vs 20.4%)
- Young people ages 15-24 make up 40% of all suicides in Indian Country

Montana compared to the United States in American Indian Suicides

Center for Disease Control. WISQARS Injury Mortality Report. http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

1999-2007 Suicide Injury Deaths and Rates per 100,000 American Indian/AK Native

Both Sexes, All Ages	United States	10.93
	Montana	19.63
Both Sexes, Ages 15-24	United States	19.32 (981)
	Montana	28.69 (31)
Females, All Ages	United States	4.46
	Montana	9.63
Males, All Ages	United States	17.49
	Montana	31.64
Females, Ages 15-24	United States	8.18 (202)
	Montana	13.40 (7)
Males, Ages 15-24	United States	29.85 (779)
	Montana	42.99 (24)

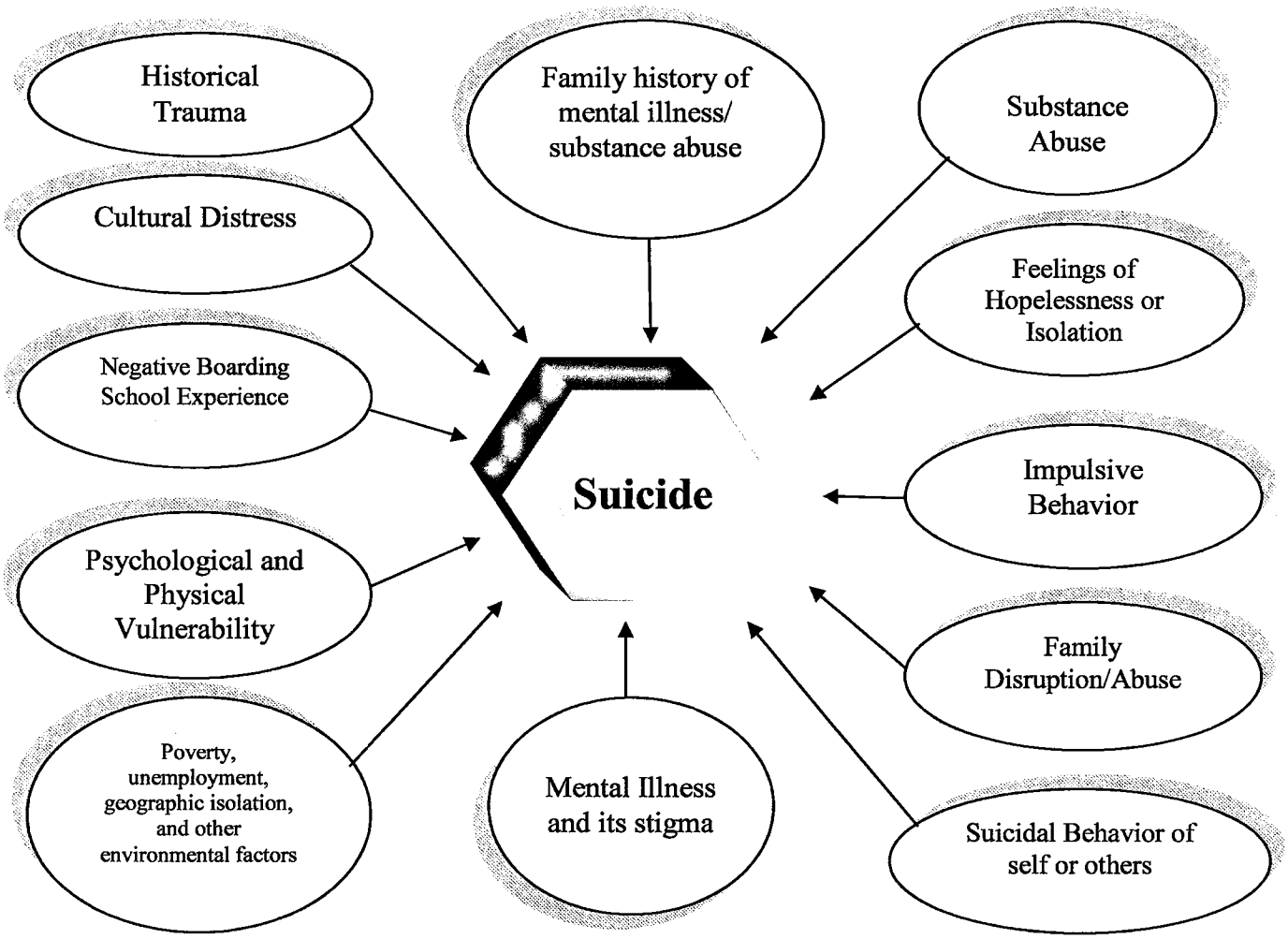
American Indian, Montana Resident, Suicide Rates, 2001-2010

Montana DPHHS, Office of Vital Statistics, Feb, 2012.

Primary County	Tribe	All ages	15-24	25-34	35-44	
Big Horn	Crow	19.1 (13)	40.8	30.1	20.9	
Blaine	Ft. Belknap	36.3 (10)	32.5	**83.7**	53.7	
Glacier	Blackfeet	25.9 (21)	38.5	78.4	37.3	
Hill	Rocky Boy	24.8 (8)	44.4	44.3	24.3	56.1 (55-64)
Lake	CSKT	29.2 (20)	48.6	47.7	48.2	75.8 (55-64)
Roosevelt	Ft. Peck	37.4 (25)	**82.6**	56.1	68.2	
Rosebud	North. Cheyenne	31 (10)	63.9	55.9	26.9	
Montana	**All Montana AI**	**25.2**	**41**	**44.8**	**41.2**	

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 above, 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 7 generations for the historical trauma to get to where it is today and will take 7 generations to fix it.

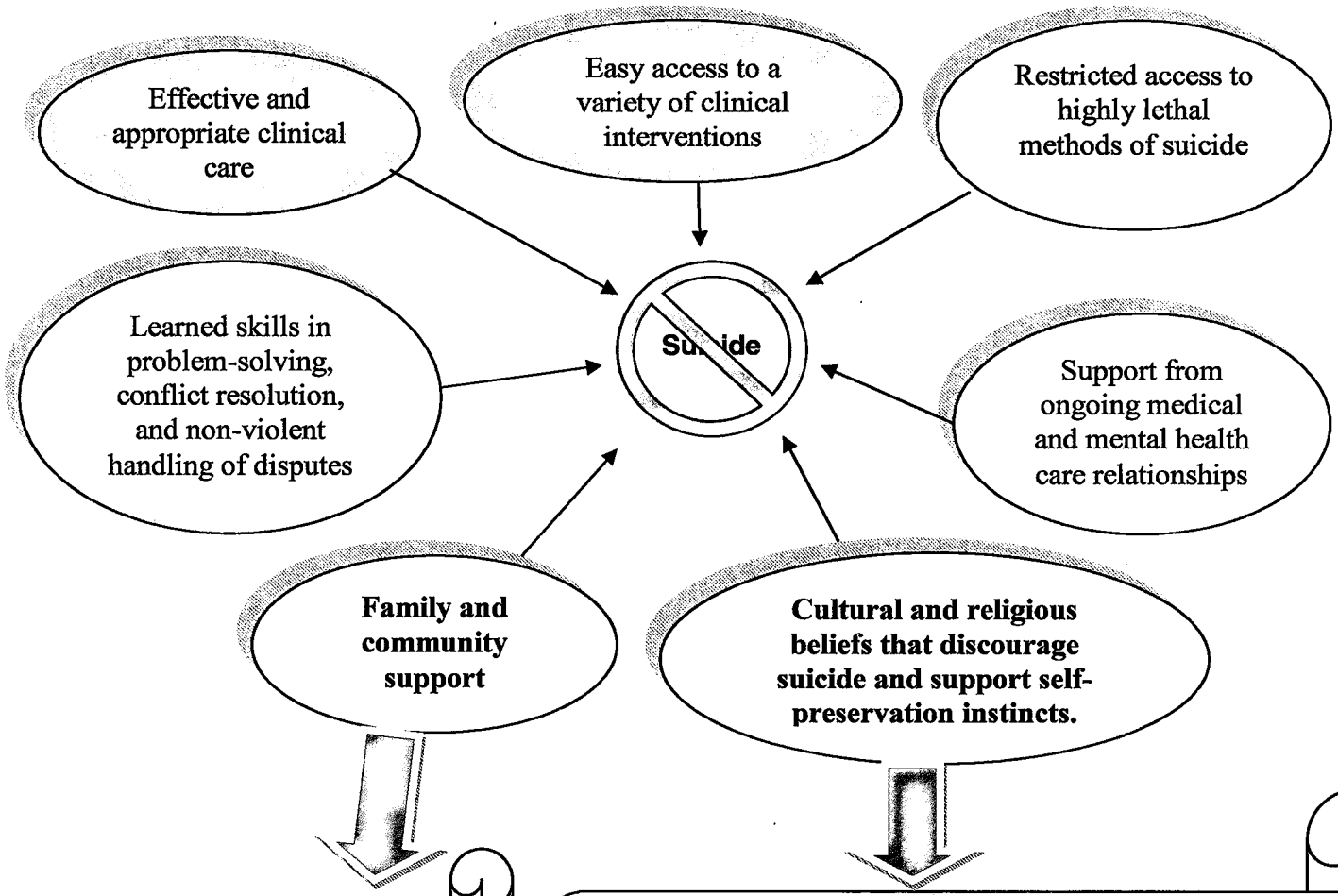
Historical trauma may also have an effect on the help-seeking behavior of American Indian youth. They may believe these services represent the "white man's" system and culture or that the professional will not understand Native ways. Not only do a majority of American Indians use traditional healing, 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 6 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.

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.

Suicide Among The Young

Facts, Figures, and Formulas for Prevention

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

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

REMEMBER: *Depression is Treatable!*

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

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

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

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

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

Factors involved in adolescent suicidal ideations

- Lack of parental connectedness is the most important variable (defined as a lack of parental support, poor communication, and not feeling understood or accepted.) 86% of parents of kids who died by suicide reported not knowing their child was suicidal
- Depression by the youth
- Suicidal behavior by the parents
- Family violence

Traits that are highly associated with suicide are:

- Immaturity
- Ego Centricity
- Dependency
- Hostility
- Anxiety
- Low Tolerance for Frustration
- Impulsivity

A few things to remember concerning the method of the ***attempted*** suicides.

- 70-90% of attempted suicides involve drug overdose.
- Both sexes prefer overdose, but males tend toward violent means (guns, autos)
- In recent years, there has been an increase in wrist cutting. However, this is rarely the sole cause of death in completed suicides.
- Wrist cutting is a common method of self-mutilation seen in people suffering from personality disorders, especially borderline personality disorder. After the attempt many of these youth describe a feeling of relief from cutting on themselves whereas a depressed individual often will express a sense of disappointment or failure.

Some of the demographics associated with the youth who attempts suicide

- Females make more attempts (about 3:1)
- Males succeed more often (about 5:1)
- Average age is 16
- History of previous out of home placements
- Committed criminal offenses, including violence
- Previous suicide attempts

THIS INFORMATION IS GIVEN AS A MEANS OF HELPING PEOPLE BETTER UNDERSTAND THE SUICIDAL YOUTH, NOT AS A MEANS OF TREATING THE YOUTH THEMSELVES. ALWAYS REFER THE YOUTH FOR PROFESSIONAL HELP. IT IS BETTER TO BE SAFE THEN SORRY.

Warning signs that people should be aware of concerning adolescent suicide:

- Abrupt change in personality
- Giving away prized possessions
- Previous suicide attempts
- Increase in drug or alcohol use
- Eating disturbance, either weight gain or loss
- Sleep disturbance, either too much or too little
- Inability to tolerate frustration
- Withdrawal and rebelliousness
- Isolating on the unit and choosing to spend time alone.
- Unwillingness or inability to communicate
- Sexual promiscuity
- Decline in personal hygiene
- Uncharacteristic theft or vandalism
- Flat affect or depressed mood
- Exaggerated or extended apathy
- Complaints of being bored
- Carelessness or increase in accidents
- Unusually long grief reaction (varies with different youth)
- Overall sense of sadness and hopelessness
- Increase in hostility
- Decrease in academic performance
- Difficulty concentrating
- Recent family disruption
- Recent history of running away
- Abrupt end to a romance

The key is that the youth is **acting out of character** and is exhibiting many of these cues. The only way to know if a youth is acting out of character is if you know the youth. If you work with kids, spend the time on developing a **RELATIONSHIP WITH THE YOUTH**.

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

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

"Have you had thoughts of killing yourself?" or "Are you suicidal?"

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

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

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

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

- **Dangerousness** – The greater the dangerousness of the attempt, the higher the current level of risk. *e.g. Did the youth take five pills or twenty five?*
- **Intent** – Did the youth believe that taking five pills was going to actually kill him?
- **Rescue** – Did the youth tell anyone that they made the attempt? Did the youth leave any signs (notes, give away possessions), or just acted normally?
- **Timing** – The more recent the attempt, the higher the current level of risk.

Talking with the Suicidal Adolescent using QPR

QPR is not therapy, it is a way of offering hope.

Question, Persuade, Refer

Do	Don't
• Voice concern • Ask if they have a plan • Tell someone else	• Leave the person alone • Be sworn to secrecy • Act shocked • Challenge or dare • Argue or debate

QPR

Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent (ask the question at least twice)
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; phone numbers, counselor's name and any other information that might help

QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

How NOT to ask the suicide question

- "You're not thinking of killing yourself, are you?"
- "You wouldn't do anything stupid would you?"
- "Suicide is a dumb idea. Surely you're not thinking about suicide?"
- Never start with "why". It elicits a defensive response.

PERSUADE

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention.
- Encourage them to talk about their reasons for dying without challenging them or telling them they "shouldn't feel that way." Validate their experience.
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

Then Ask:

- "I don't want you to kill yourself, I want to help"
- "Will you go with me to get help?"
- "Will you let me get you some help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help (therapist, emergency room, pastor, police).
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help and get others involved.

HELP REDUCE THE MEANS OF ATTEMPTING SUICIDE BY REMOVING OR LOCKING UP ALL FIREARMS AND MEDICATIONS.

Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies. www.sprc.org.

Depression is Treatable, Suicide is Preventable

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

1-800-273-TALK (8255)

www.prc.mt.gov/suicideprevention

QPR Training Exit Survey

Location of training: _____ Date of training: _____

Please take the 50 seconds that it requires to complete this short survey. It provides us with valuable data to improve future trainings. Thank you.

Which item is **not** a warning sign of suicide?

- ☐ Ideation
- ☐ Substance abuse
- ☐ Purposelessness
- ☐ Anxiety
- ☐ Trapped
- ☐ Hopelessness
- ☐ Smiling
- ☐ Withdrawal
- ☐ Anger
- ☐ Recklessness
- ☐ Mood change

Which item is **not** part of how to intervene with a suicidal person

☐ Question ☐ Persuade ☐ Secret ☐ Refer

Which item is **not** a suicide prevention resource in our state.

- ☐ 1-800-273-TALK
- ☐ SOS for schools
- ☐ Toolkit for physicians
- ☐ Toolkit for senior living comm.
- ☐ Teen Screen
- ☐ Ignoring the warning signs
- ☐ ASIST
- ☐ QPR
- ☐ Crisis Intervention Training

On a scale of 1-10, please rate how effective this training was in increasing your awareness of the warning signs of suicide and how to intervene.

(not effective) 1 2 3 4 5 6 7 8 9 10 (very effective)

On a scale of 1-10, please rate the facilitator's knowledge of the subject matter and ability to present the material in a manner in which you can apply what you learned.

(not effective) 1 2 3 4 5 6 7 8 9 10 (very effective)

How can we improve this training?

_____

_____

Thank you for your feedback