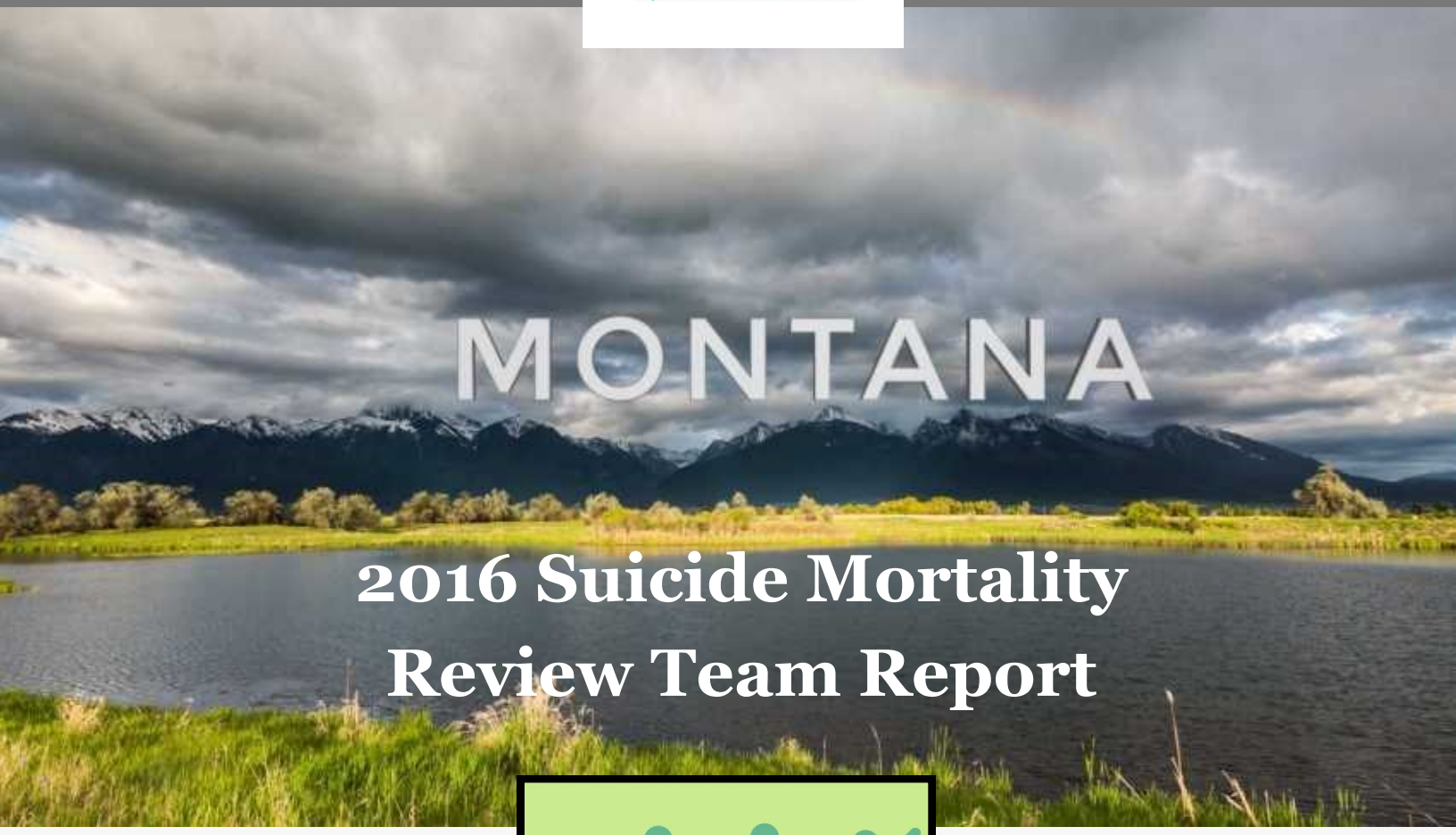
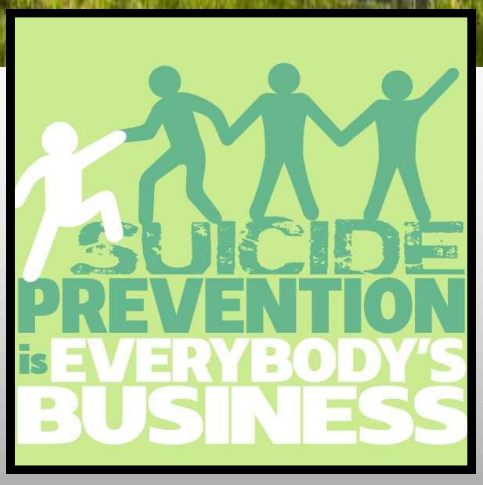


2016 Suicide Mortality Review Team Report



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.

Table of Contents

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).

2014, United States
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**
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 3 females attempts for every male attempt.
- Among young adults ages 15 to 24 years old, there is 1 suicide for every 100-200 attempts.
- Among the general population, there is 1 suicide for every 25 attempts.
- Among adults ages 65 years and older, there is 1 suicide for every 4 suicide attempts.

Racial and Ethnic Disparities

Gender (US for 2014)	Number	Rate	Percent of Total
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%

Suicide Method (US for 2014)	Number	Rate	Percent of Total
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)

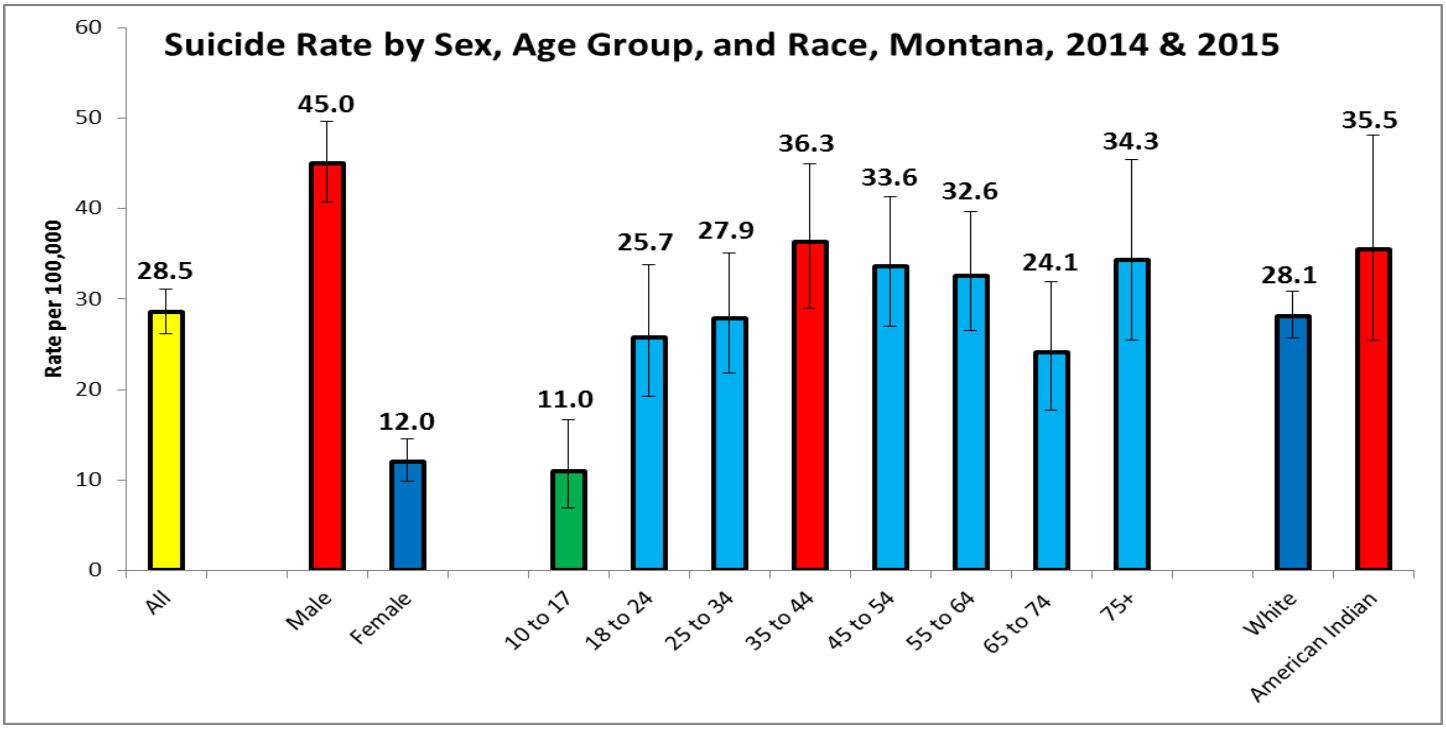
Suicide in Montana: The Findings of the Montana Suicide Mortality Review Team

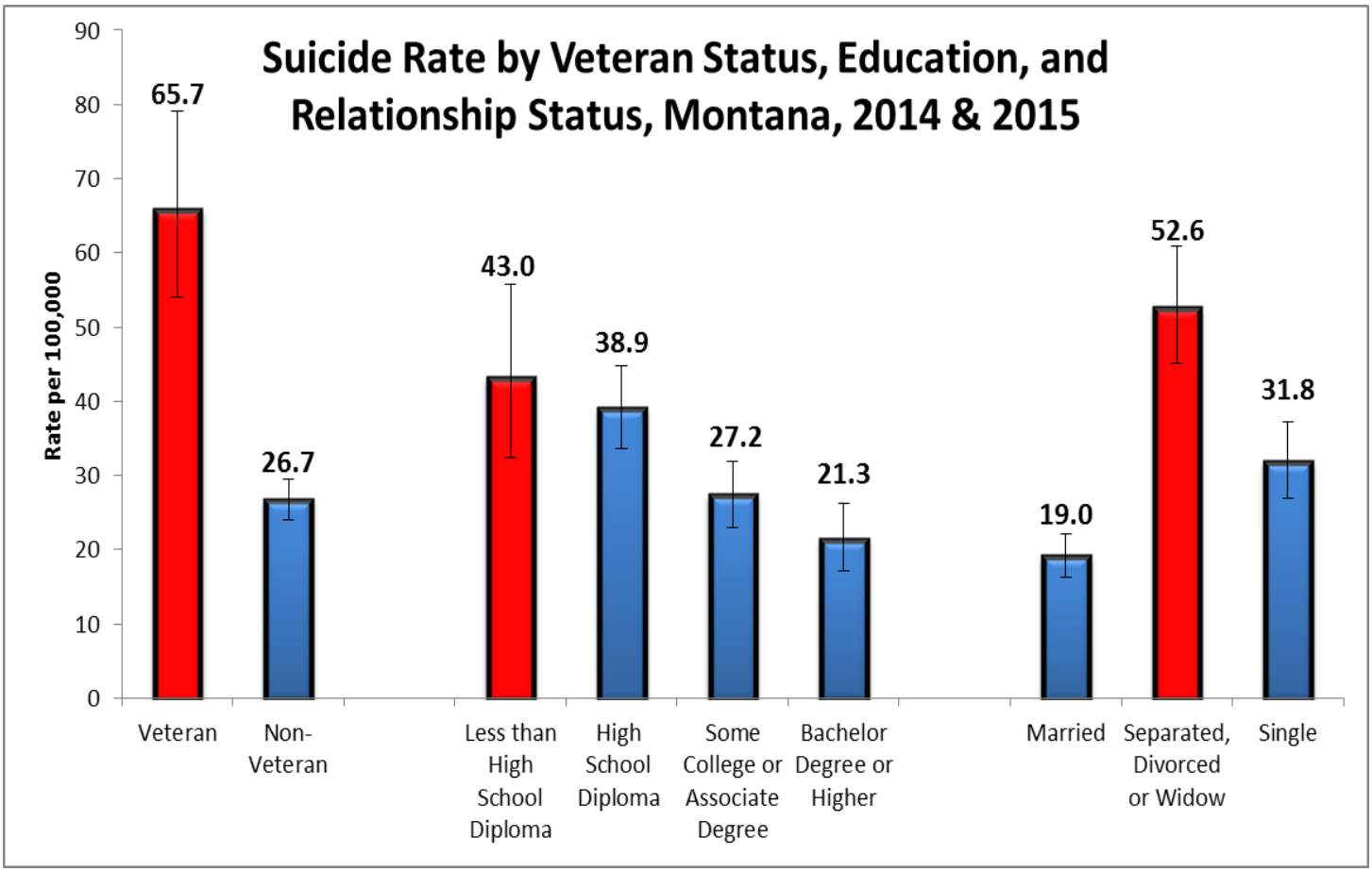
Over the following pages are the findings of the Montana Suicide Mortality Review Team and is based on the review of 555 suicides that occurred in Montana between January 1, 2014 and March 1, 2016. The first set of charts represent all suicides in Montana. This is followed by data specific to youth suicides,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

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, 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**.

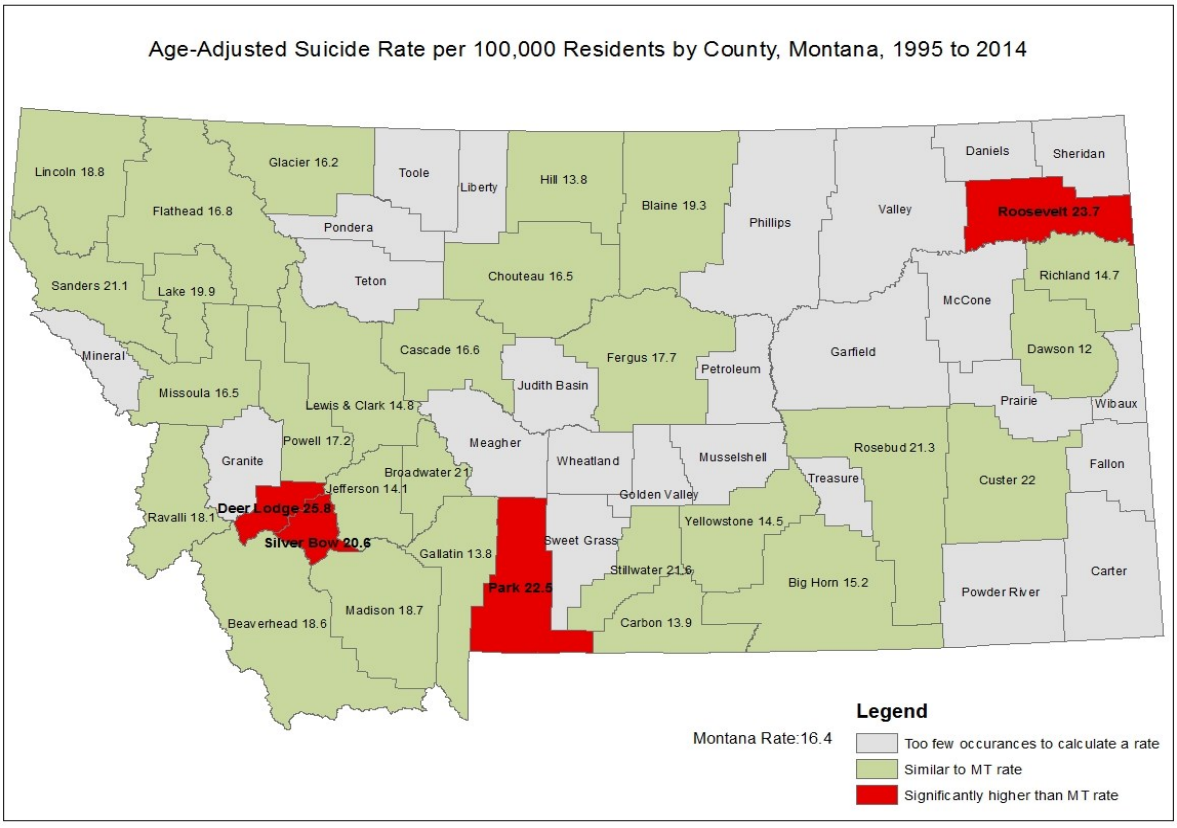
- In Montana, between 2005 and 2014, suicide was the number **two** cause of death for children **ages 10-14**, adolescents **ages 15-24,** and adults **ages 25-44**, behind only unintentional injuries (CDC, 2016)
- Access to lethal means (**firearms**), **alcohol**, a sense of **being a burden**, **social 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 **Caucasians** (28.1 per 100,000).





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

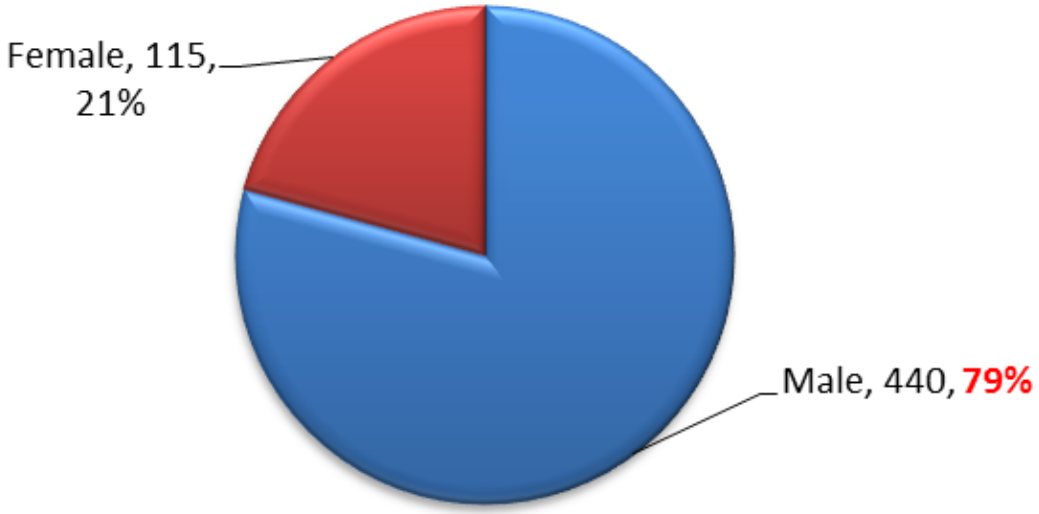
County	Deaths	Population	Age-Adjusted Rate	County	Deaths	Population	Age-Adjusted Rate
Montana	3,183	15,401,557	16.4				
Beaverhead	37	153,333	18.6	McCone	†	30,347	‡
Big Horn	35	186,417	15.2	Meagher	10	31,764	‡
Blaine	24	102,200	19.3	Mineral	17	67,184	‡
Broadwater	21	80,271	21.0	Missoula	349	1,705,929	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

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; June30, 2015

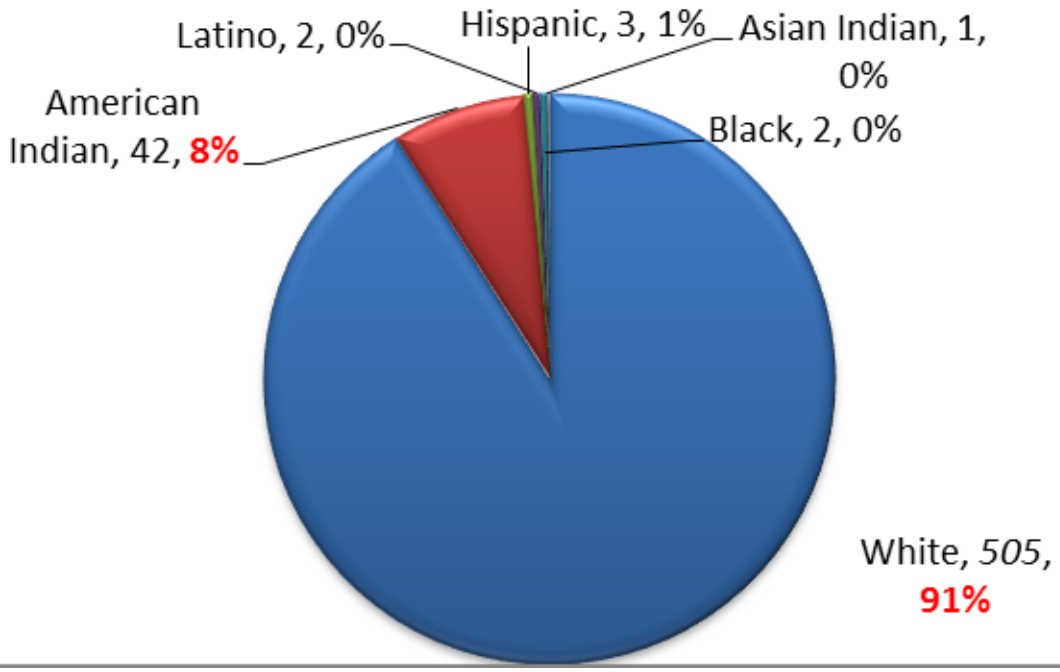
† Fewer than five events;

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

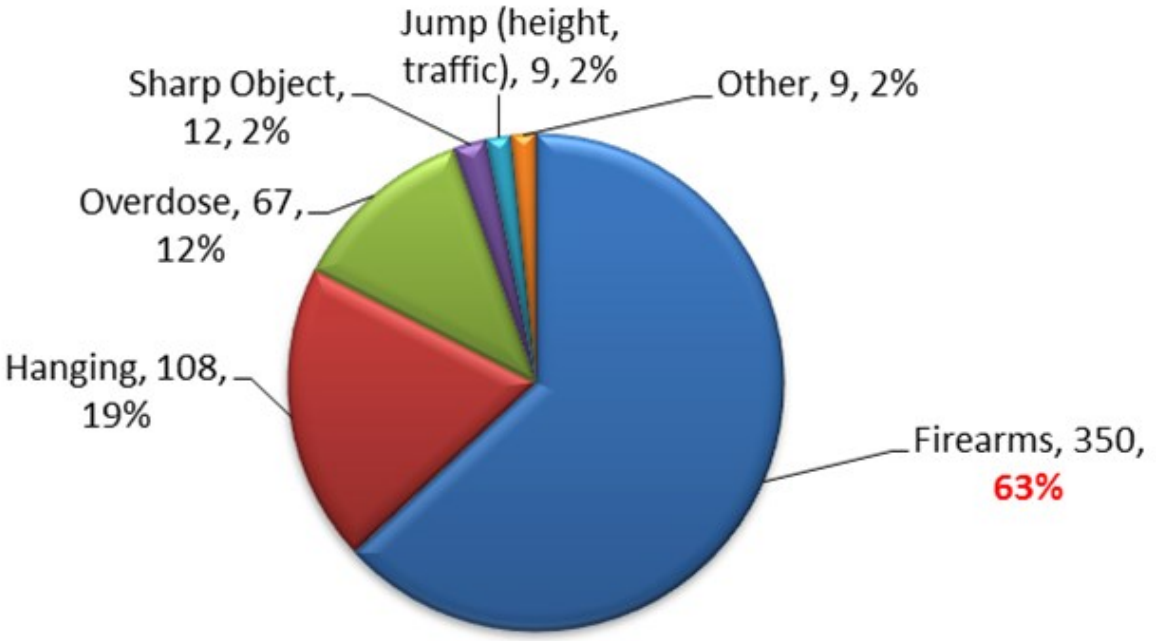
Montana Suicides by Gender
(1/1/14-3/1/16)



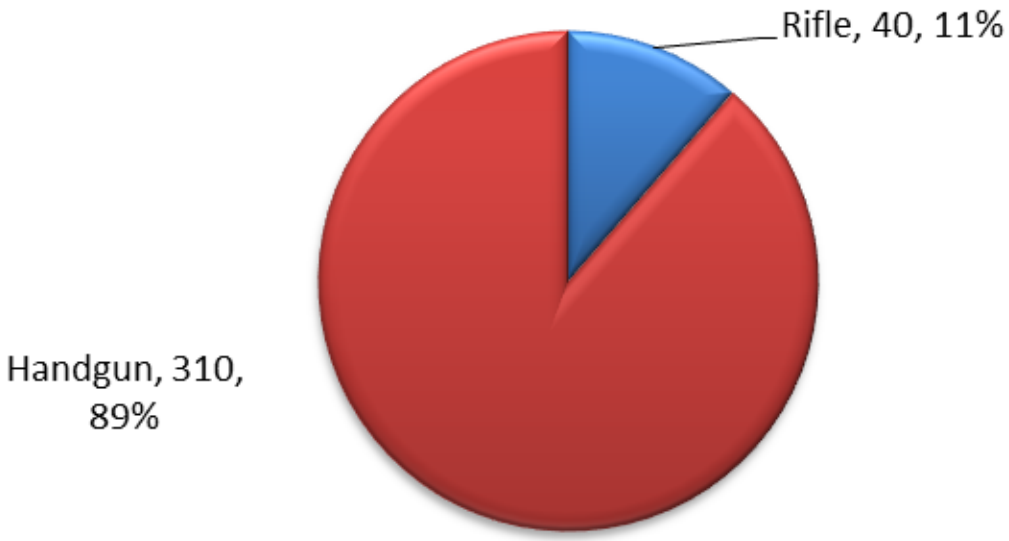
Montana Suicides by Ethnicity
(1/1/14-3/1/16)



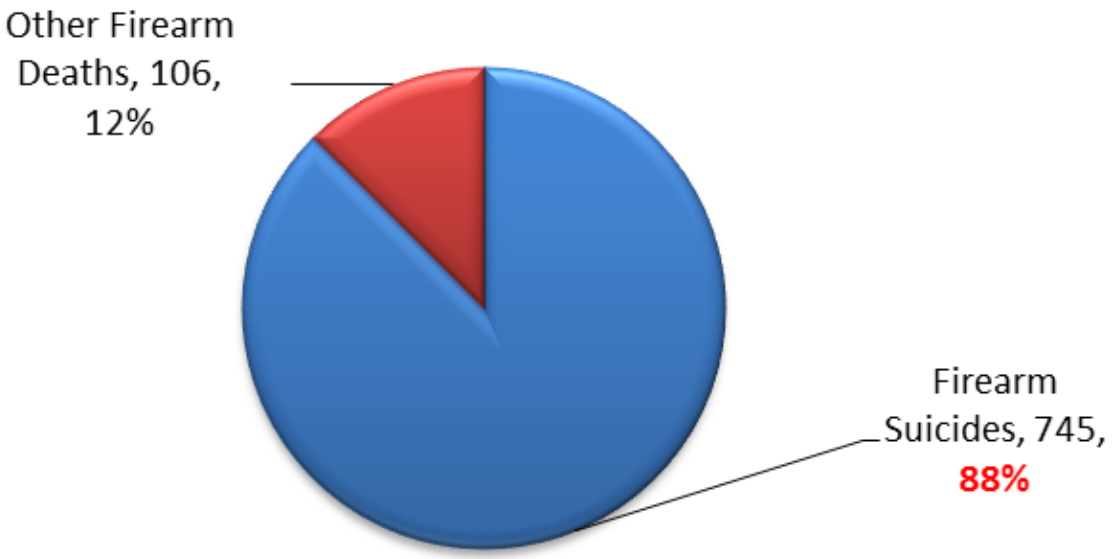
Montana Suicides by Means (1/1/14-3/1/16)



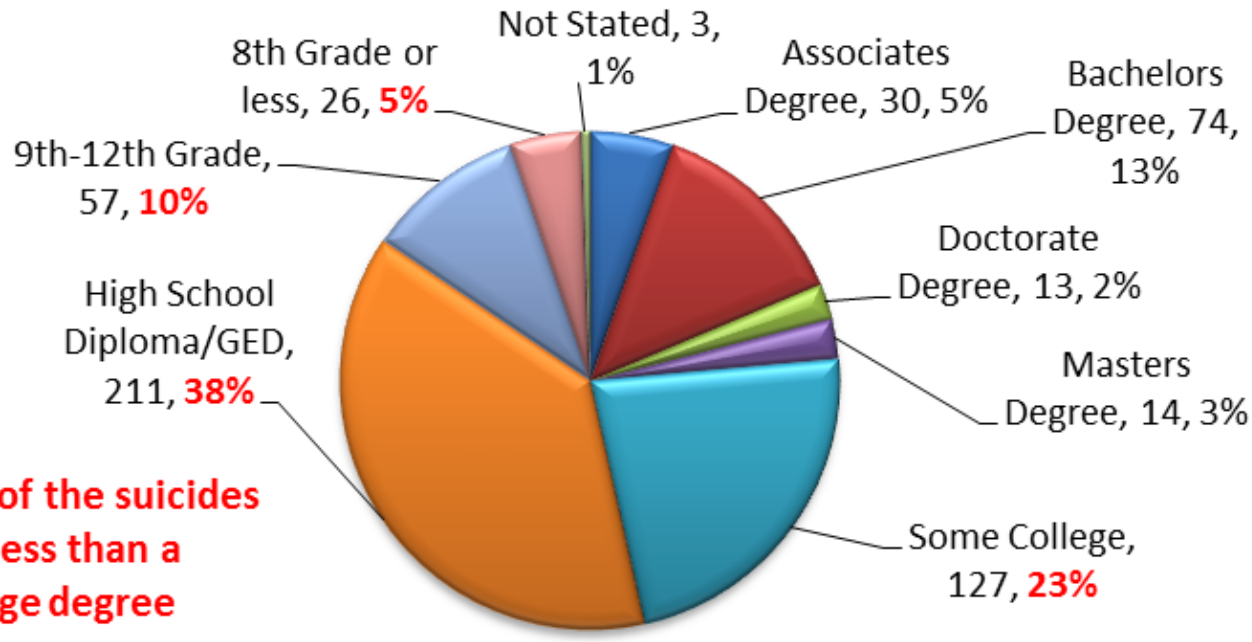
Montana Suicides by Type of Firearm (1/1/14 - 3/1/16)



Firearm Deaths in Montana 2010-2014

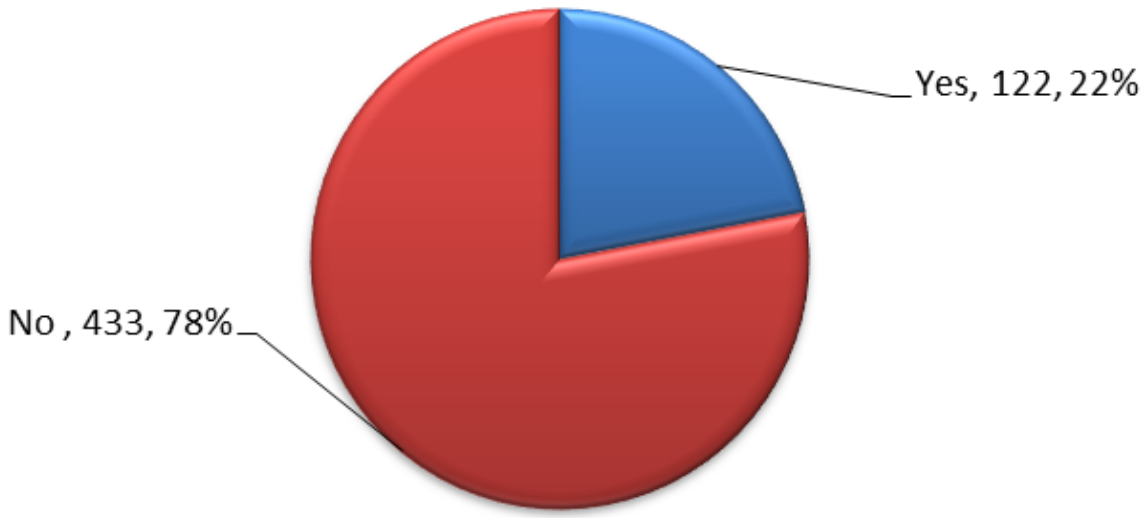


Montana Suicides by Education (1/1/14 - 3/1/16)

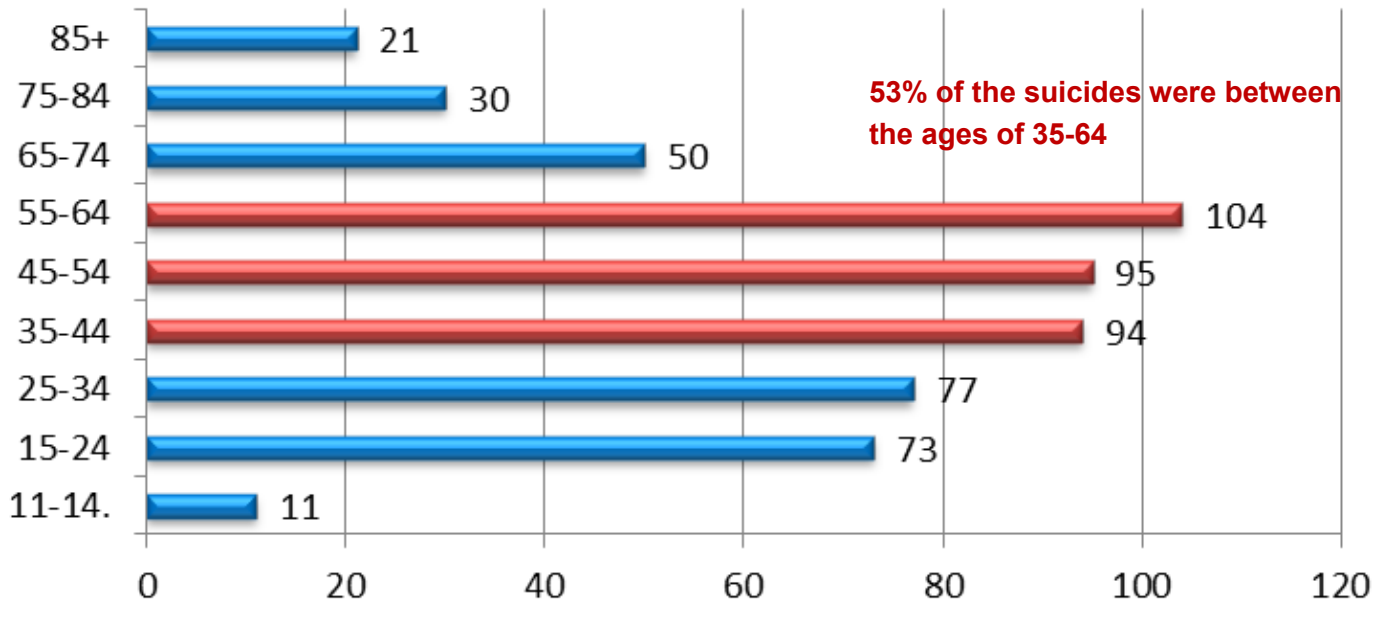


76% of the suicides had less than a college degree

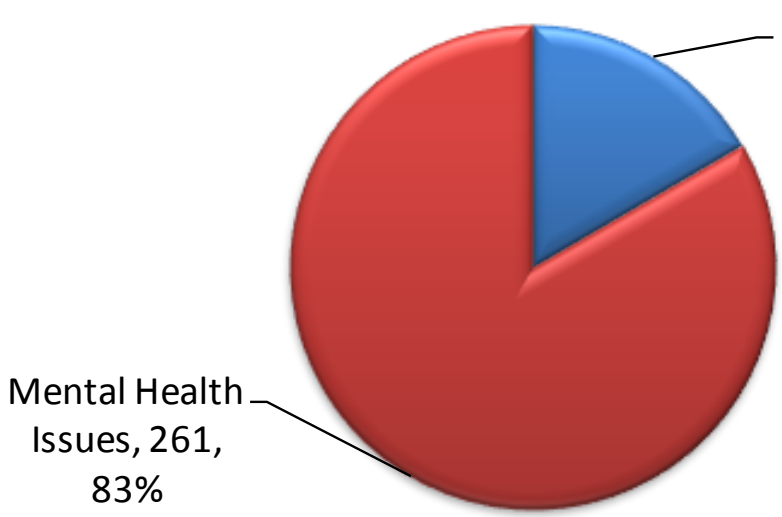
Montana Suicides who were Veterans
(1/1/14 - 3/1/16)



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

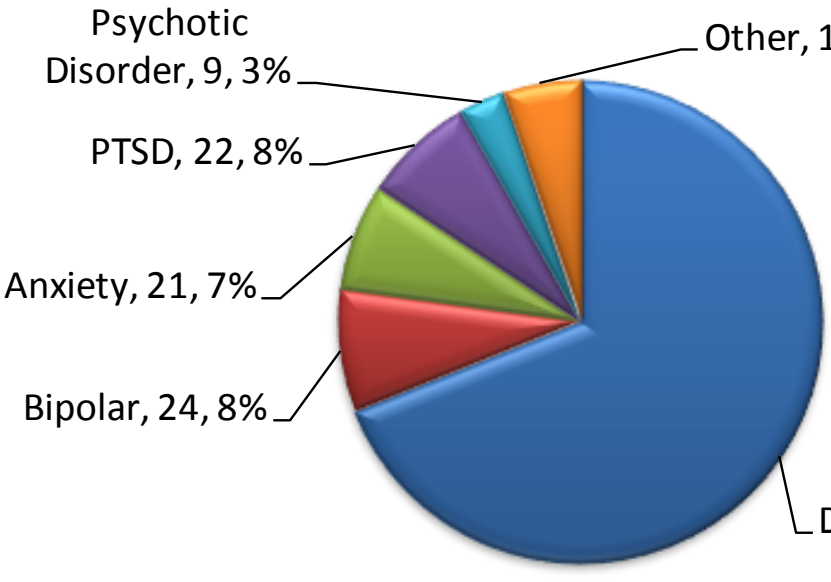


Montana Suicides with Identified Mental Health Issues



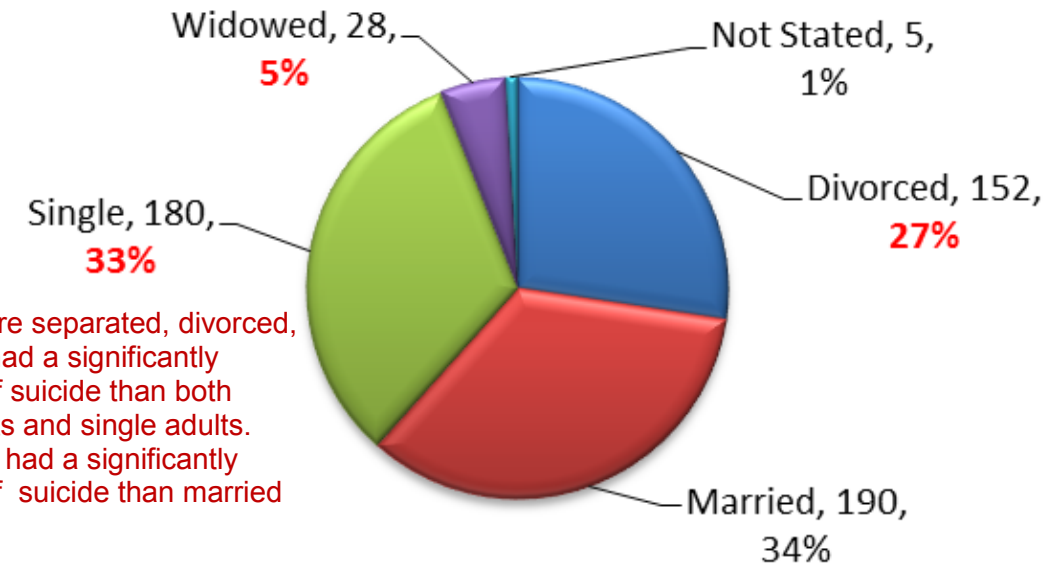
Based on 313 suicides that provided mental health information

Montana Suicides By Type of Mental Health Disorder

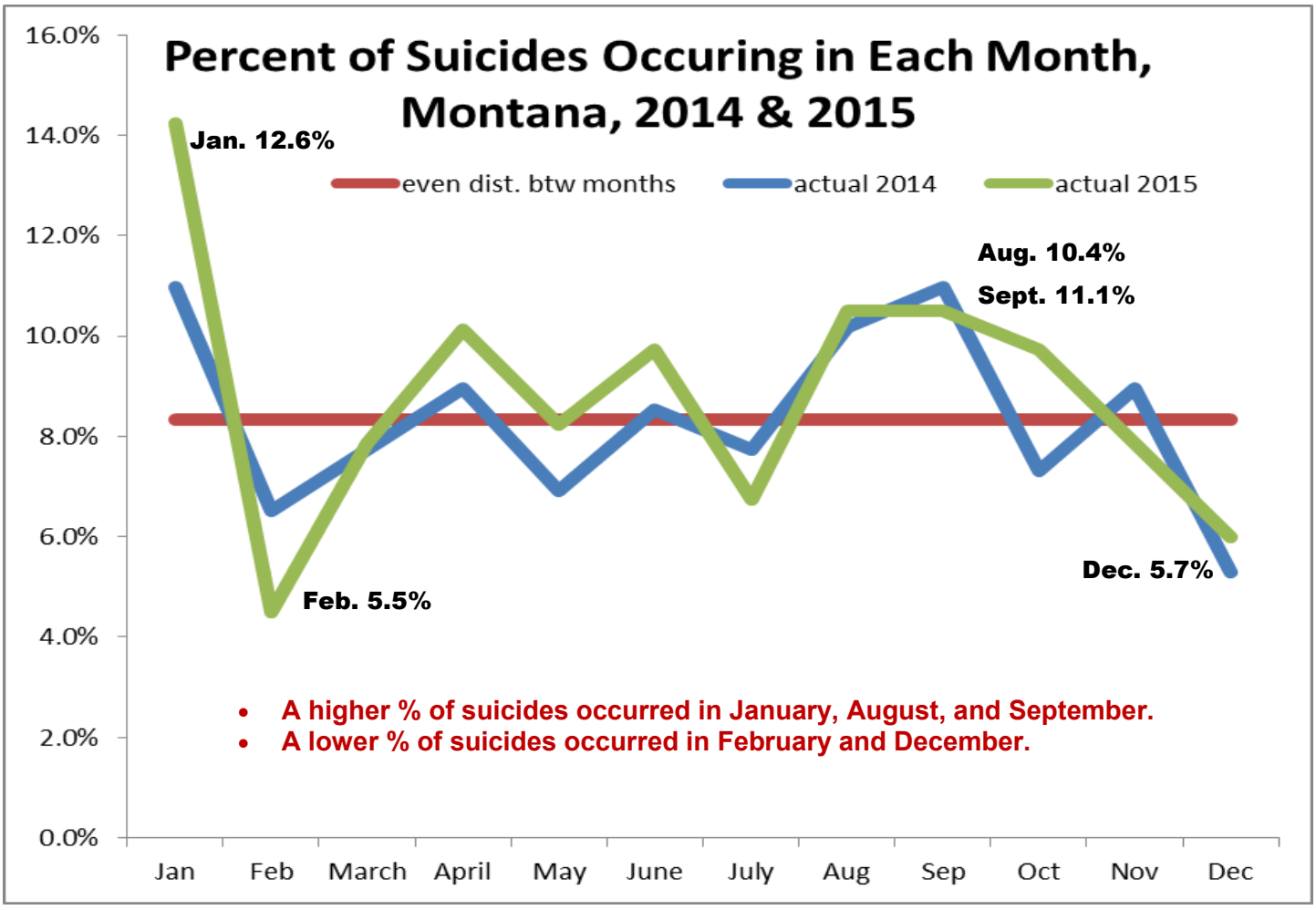


55 of the 261 (21%) had mulitple mental health issues.

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.

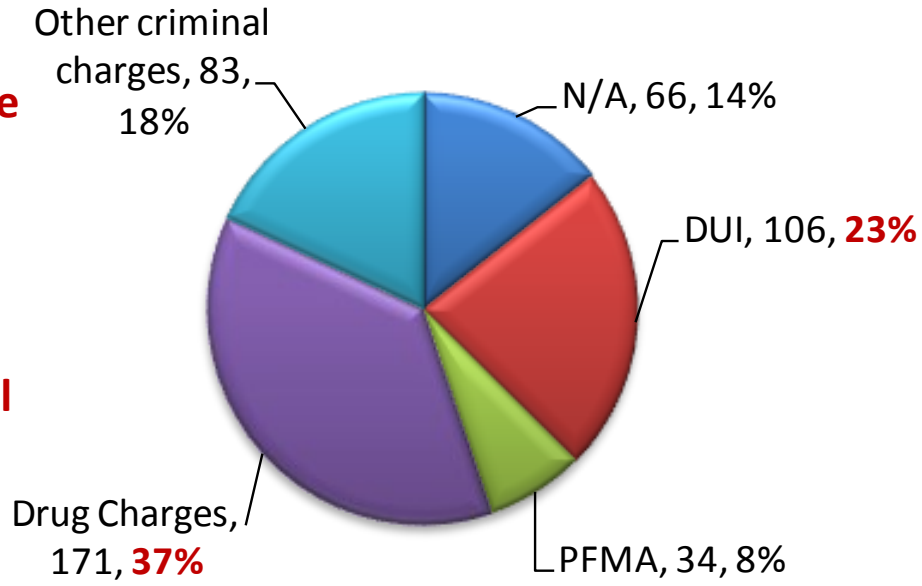


- A higher % of suicides occurred in January, August, and September.
- A lower % of suicides occurred in February and December.

Montana Suicides based on Criminal History

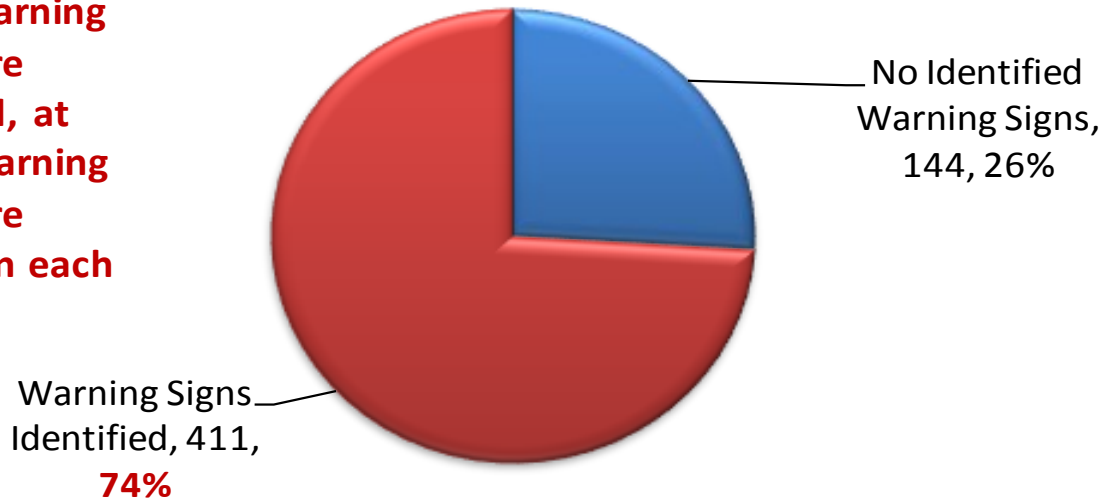
(1/1/14 - 3/1/16)

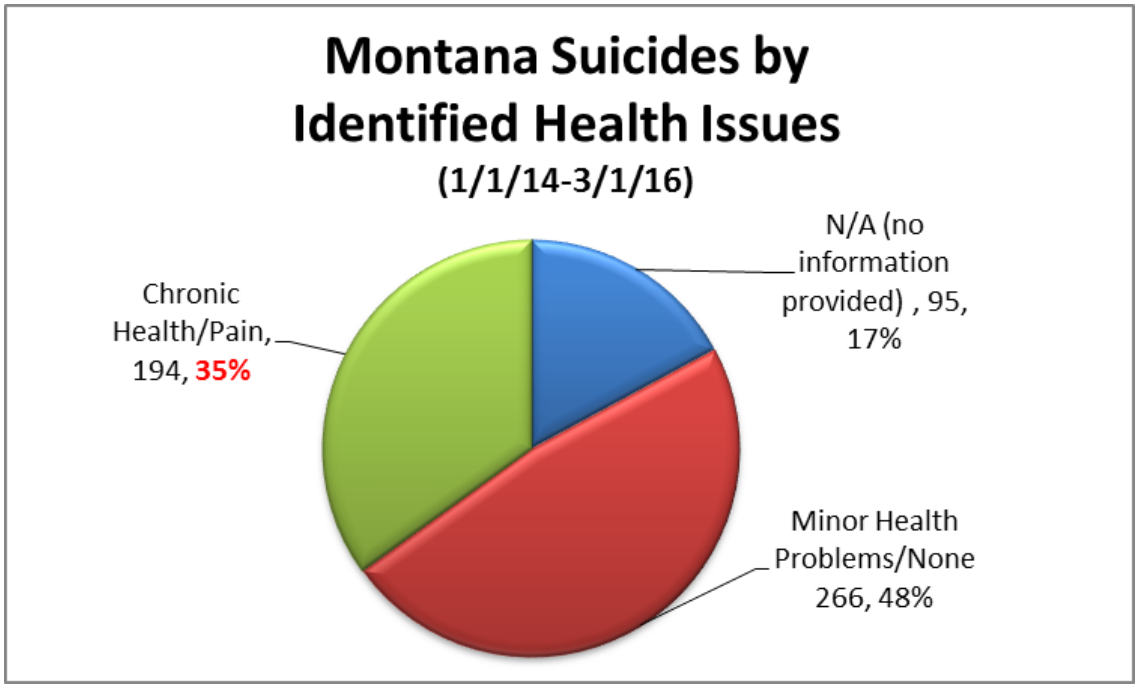
Based on 460 records where criminal charges were identified. Of these, 86% had a criminal record.

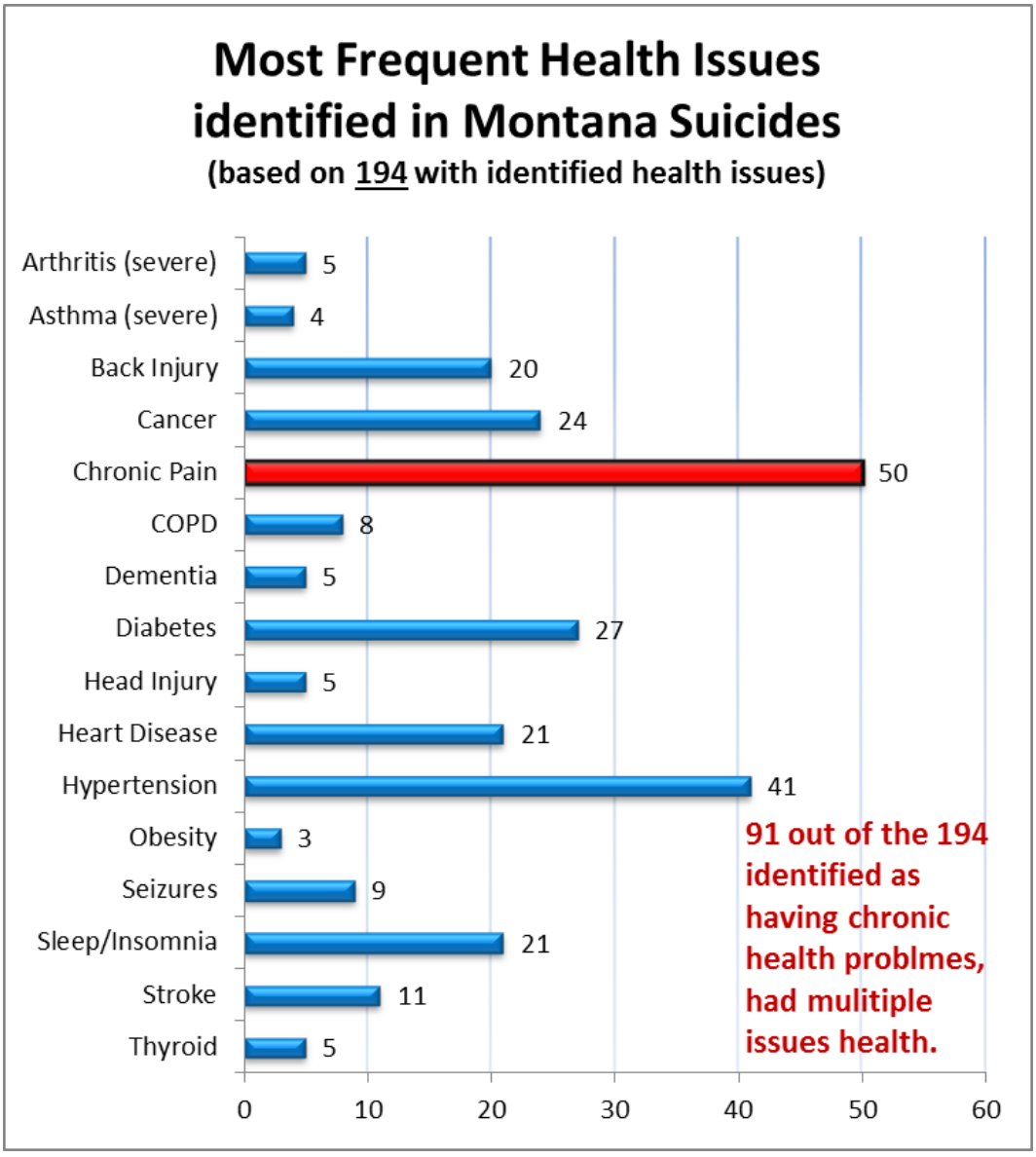


Montana Suicides with identified Warning Signs

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

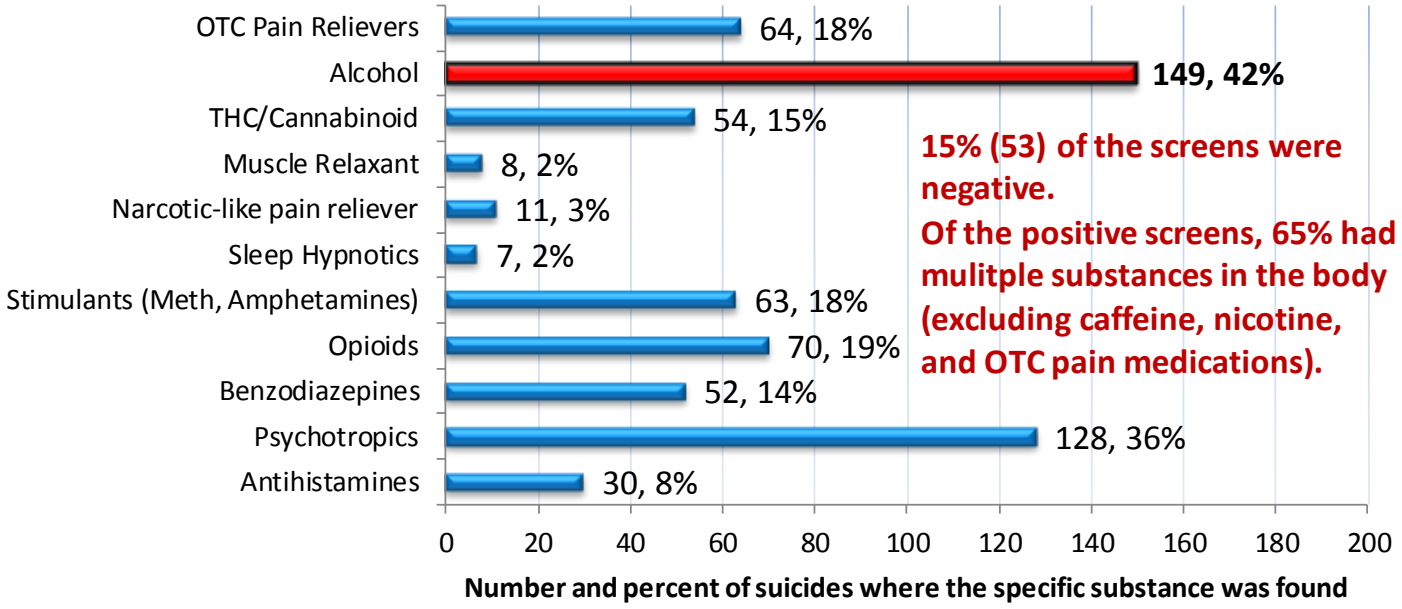



Montana Suicides by Identified Health Issues
(1/1/14-3/1/16)
N/A (no information provided) , 95, 17%
Chronic Health/Pain, 194, 35%
Minor Health Problems/None 266, 48%


Most Frequent Health Issues identified in Montana Suicides
(based on 194 with identified health issues)
Arthritis (severe) 5
Asthma (severe) 4
Back Injury 20
Cancer 24
Chronic Pain 50
COPD 8
Dementia 5
Diabetes 27
Head Injury 5
Heart Disease 21
Hypertension 41
Obesity 3
Seizures 9
Sleep/Insomnia 21
Stroke 11
Thyroid 5
0 10 20 30 40 50 60
91 out of the 194 identified as having chronic health problmes, had mulitiple issues health.

Montana Suicides based on Toxicology Reports

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

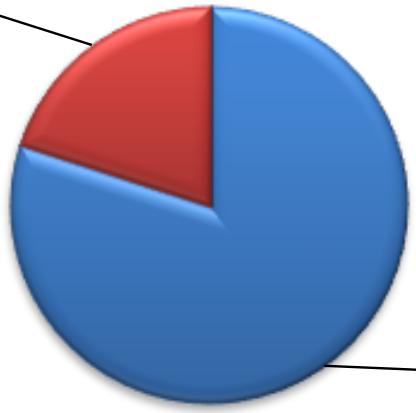


15% (53) of the screens were negative.

Of the positive screens, 65% had mulitple substances in the body (excluding caffeine, nicotine, and OTC pain medications).

Montana Suicides that received Publically Funded Mental Health Services

Approved to receive public mental health services, 111, 20%



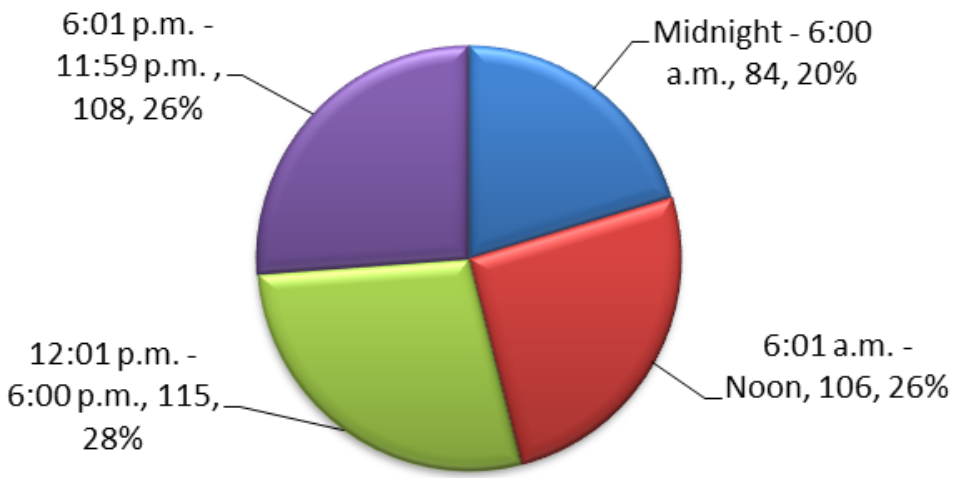
Did not receive public mental health services, 444, 80%

Of the 74 that received serivces, on average, each had been seen 9 times for services since 2013.

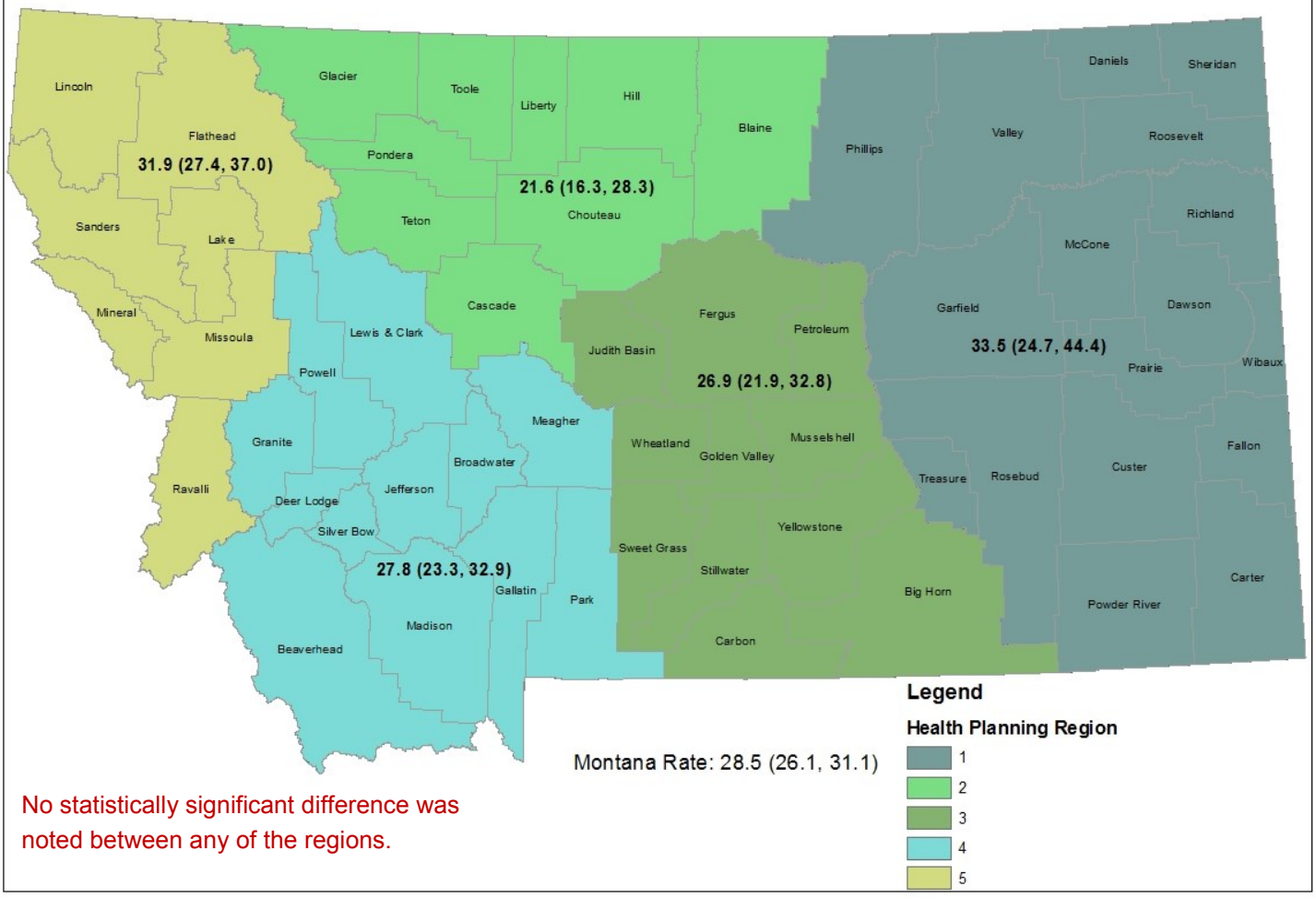
Of the 111 approved for services, 67% (74) received services in mental health, chemical dependency or with primary care since 2013.

Montana Suicides by Time of Death

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

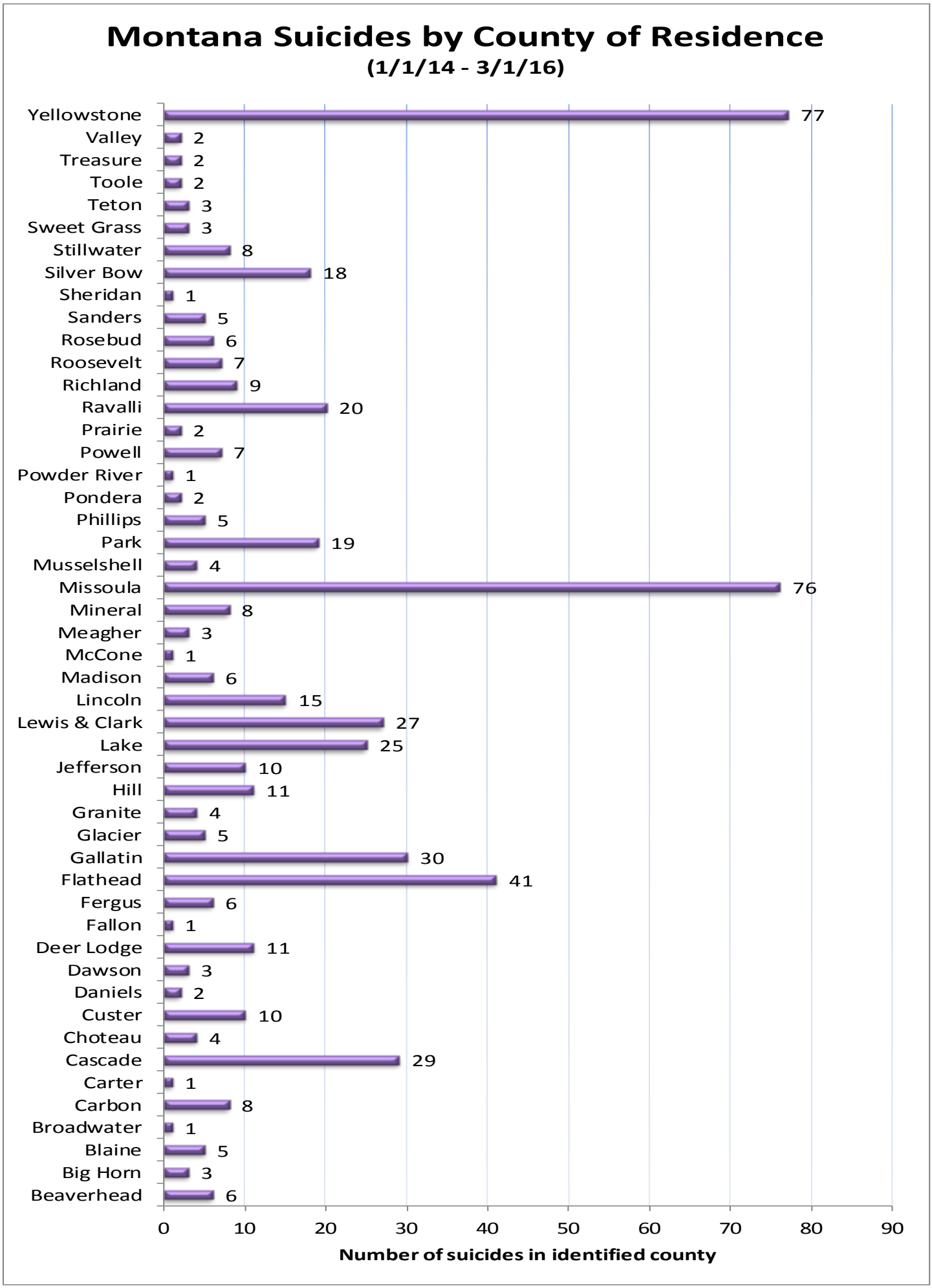


Suicide Rate per 100,000 Residents by Health Planning Region, Montana, 2014 & 2015



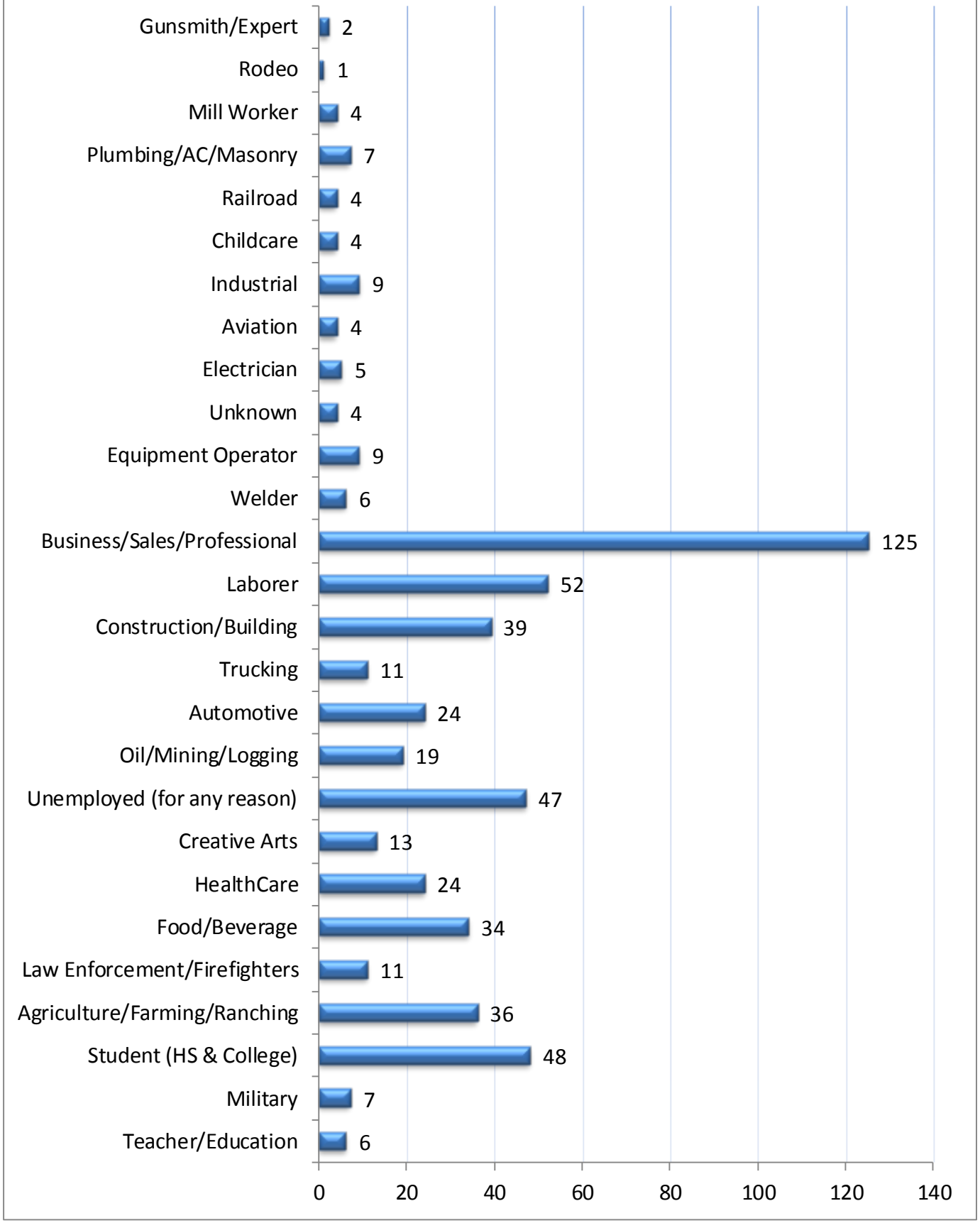
Montana Rate: 28.5 (26.1, 31.1)

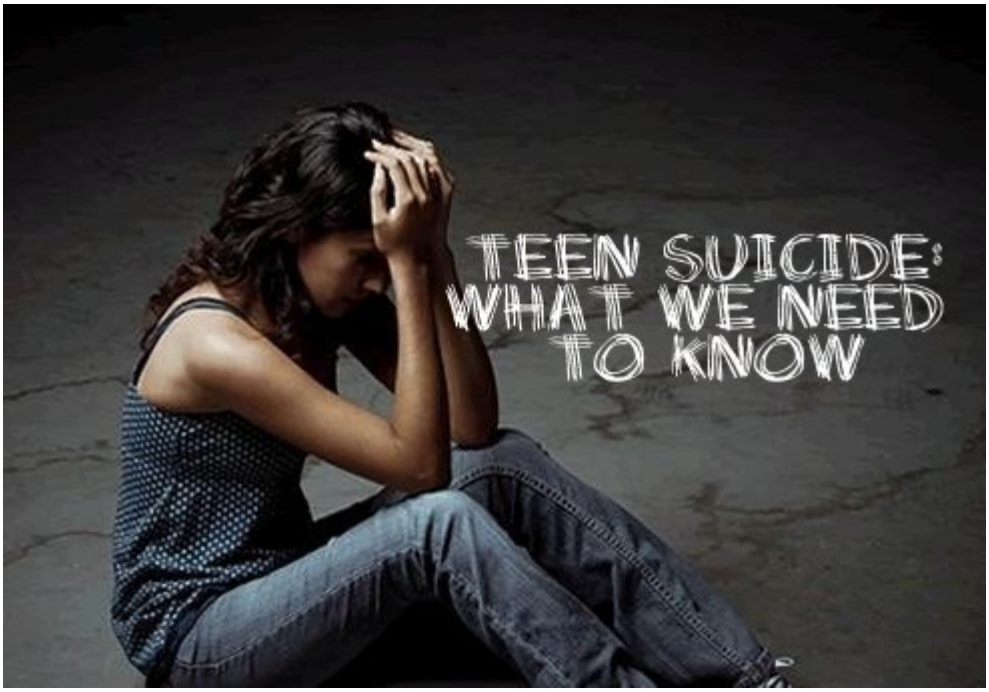
No statistically significant difference was noted between any of the regions.


Montana Suicides by County of Residence
(1/1/14 - 3/1/16)
Yellowstone 77
Valley 2
Treasure 2
Toole 2
Teton 3
Sweet Grass 3
Stillwater 8
Silver Bow 18
Sheridan 1
Sanders 5
Rosebud 6
Roosevelt 7
Richland 9
Ravalli 20
Prairie 2
Powell 7
Powder River 1
Pondera 2
Phillips 5
Park 19
Musselshell 4
Missoula 76
Mineral 8
Meagher 3
McCone 1
Madison 6
Lincoln 15
Lewis & Clark 27
Lake 25
Jefferson 10
Hill 11
Granite 4
Glacier 5
Gallatin 30
Flathead 41
Fergus 6
Fallon 1
Deer Lodge 11
Dawson 3
Daniels 2
Custer 10
Choteau 4
Cascade 29
Carter 1
Carbon 8
Broadwater 1
Blaine 5
Big Horn 3
Beaverhead 6
0 10 20 30 40 50 60 70 80 90
Number of suicides in identified county

Montana Suicides by Occupation

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





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 on the following pages are 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

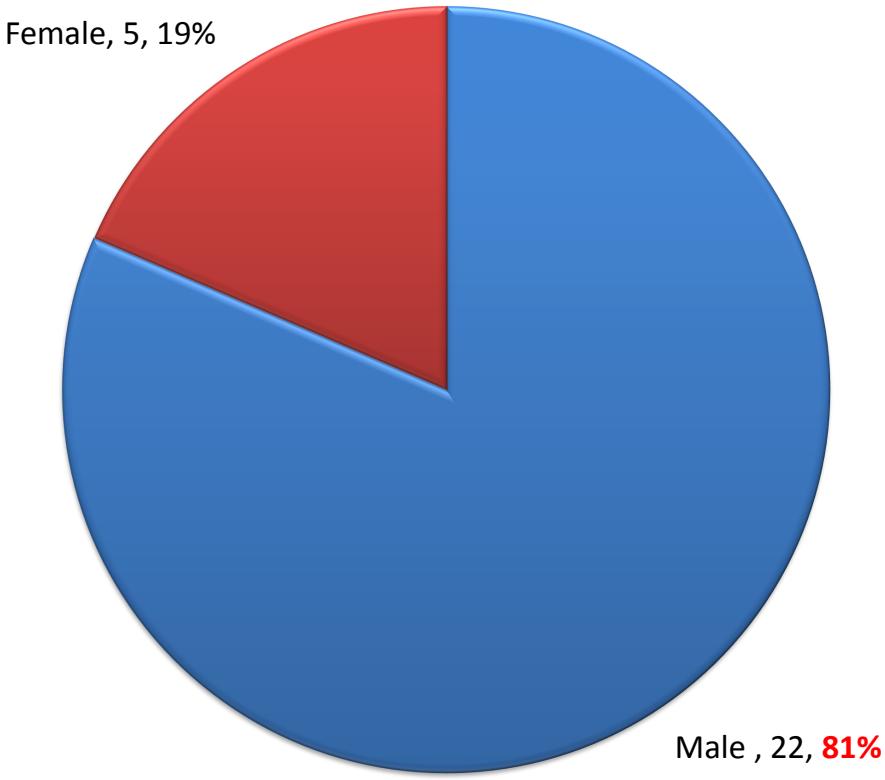
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Females, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0,*U03

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

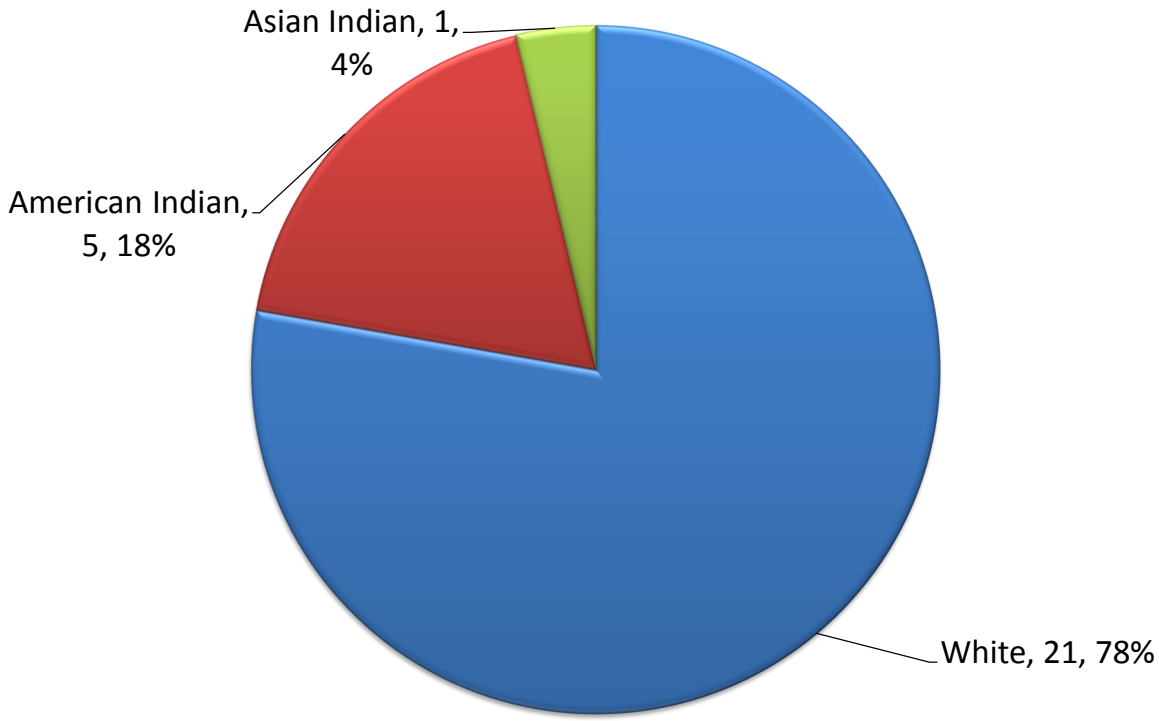
Number of Deaths	Population***	Crude Rate
13*	44,908	28.95*

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



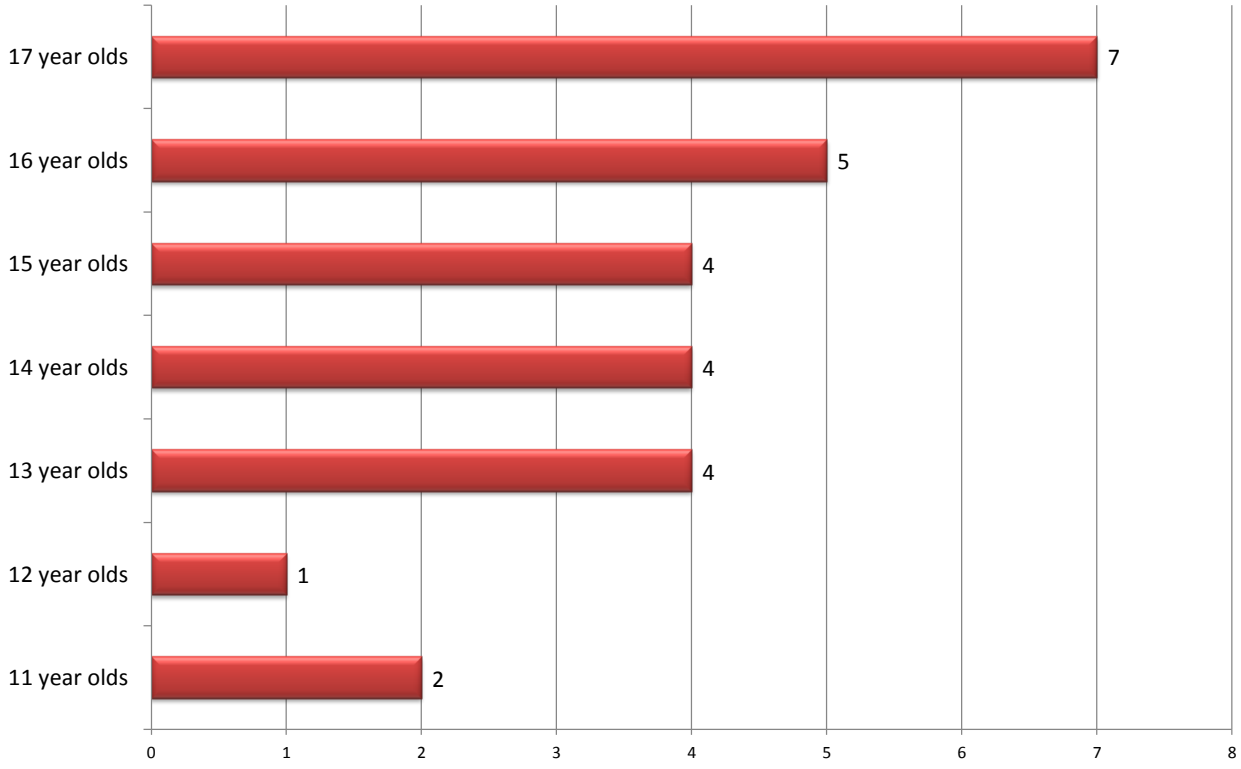
Youth Suicides (11-17) by Race

(January 1, 2014-March 1, 2016)

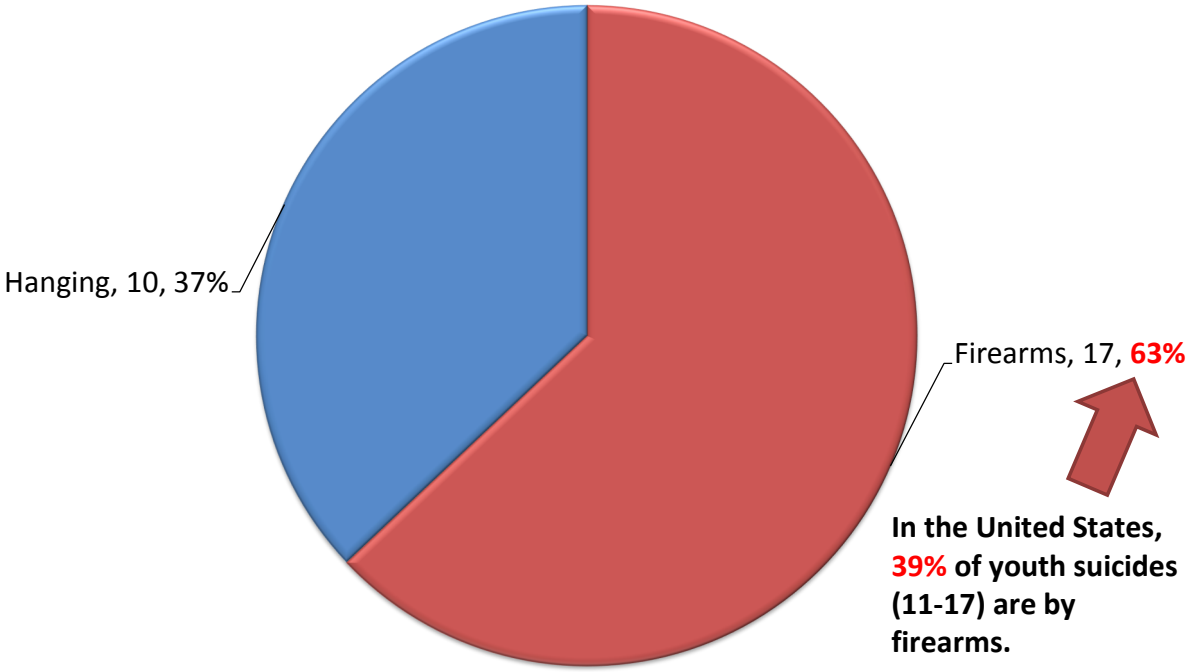


Youth Suicides (11-17) by Age

(January 1, 2014-March 1, 2016)

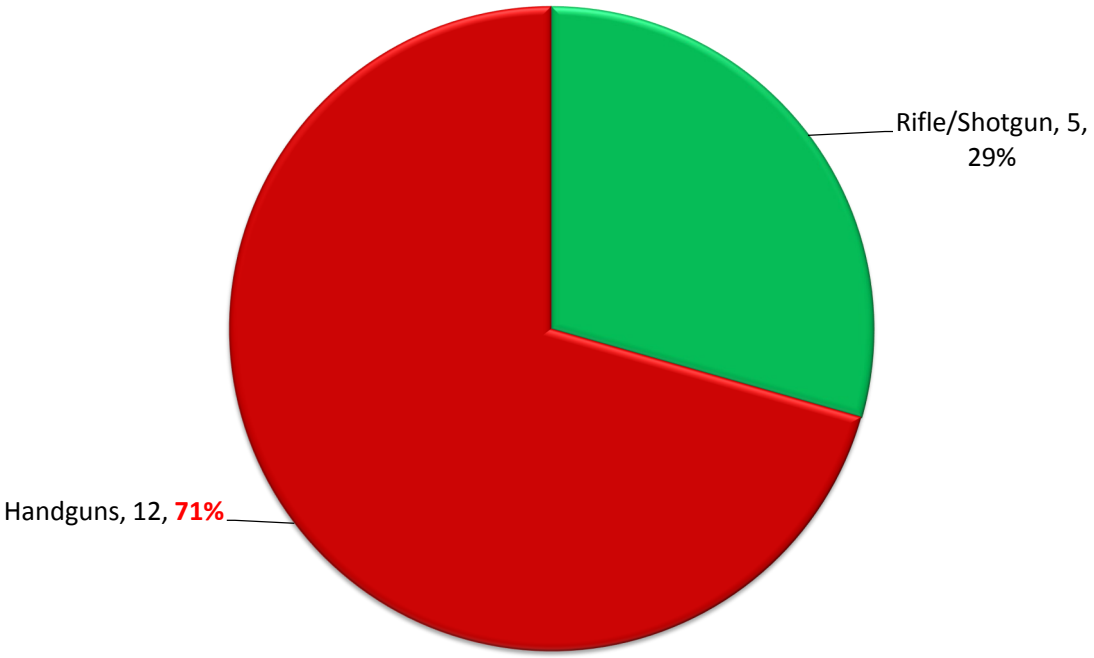


Youth Suicides (11-17) by Means
(January 1, 2014-March 1, 2016)

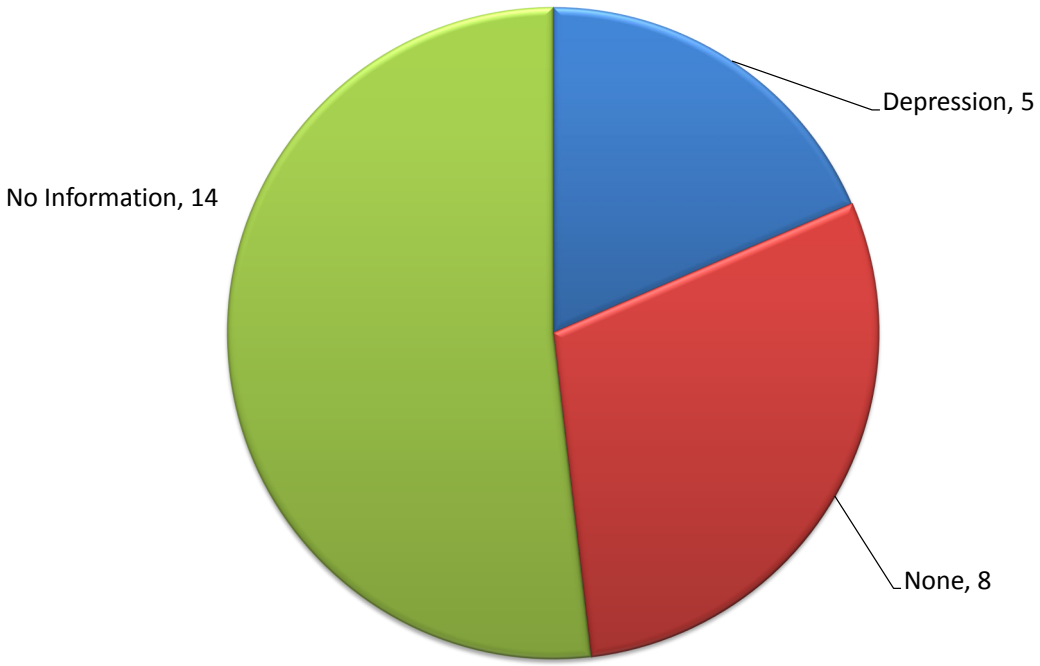


In the United States, 39% of youth suicides (11-17) are by firearms.

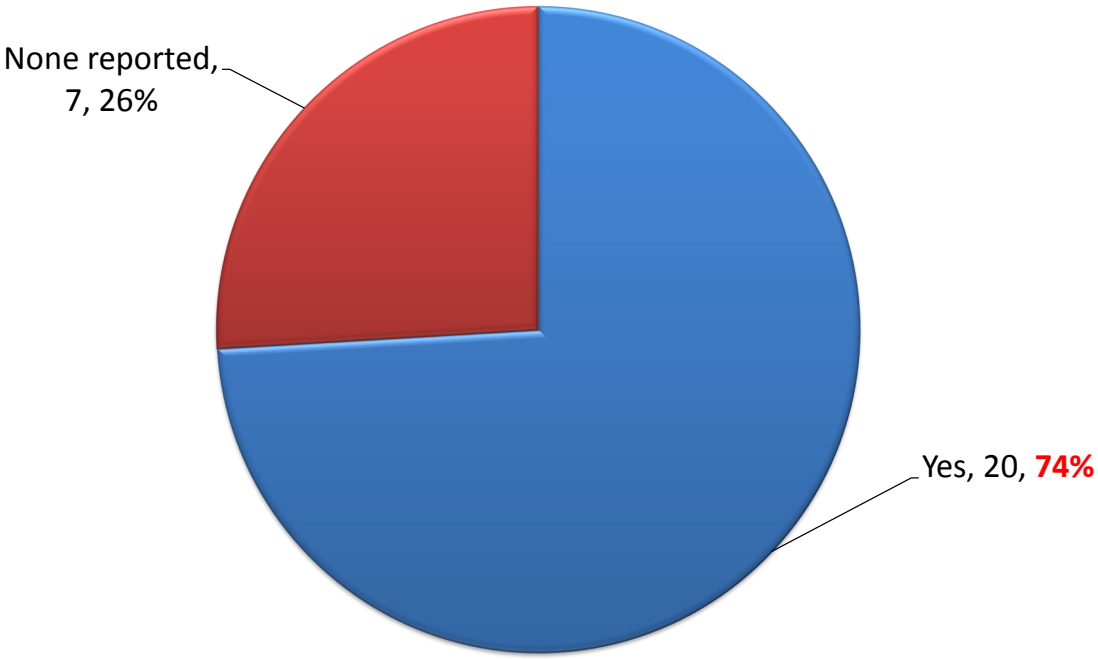
Youth Suicides (11-17) by Type of Firearm
(January 1, 2014-March 1, 2016)



Youth Suicides (11-17) with Identified Mental Health Issues
(January 1, 2014-March 1, 2016)

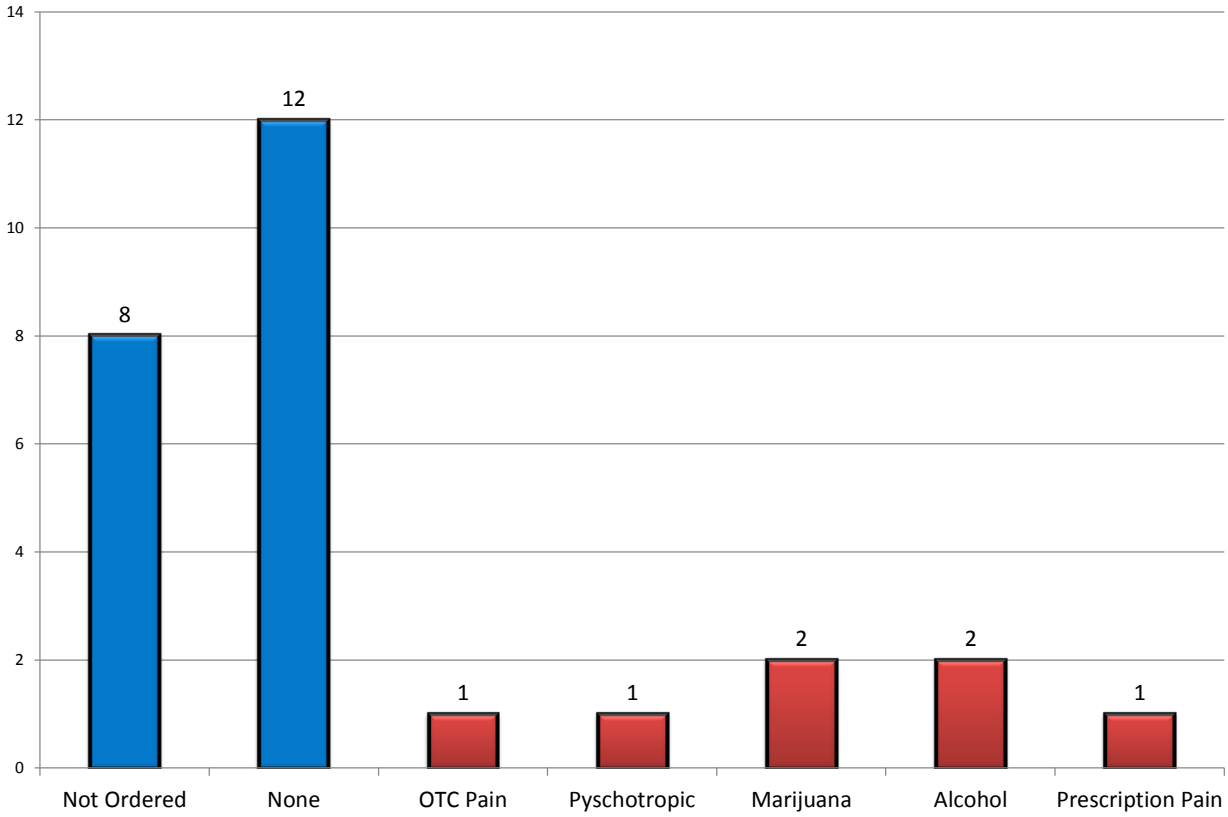


Youth Suicides (11-17) with identified Warning Signs
(January 1, 2014-March 1, 2016)



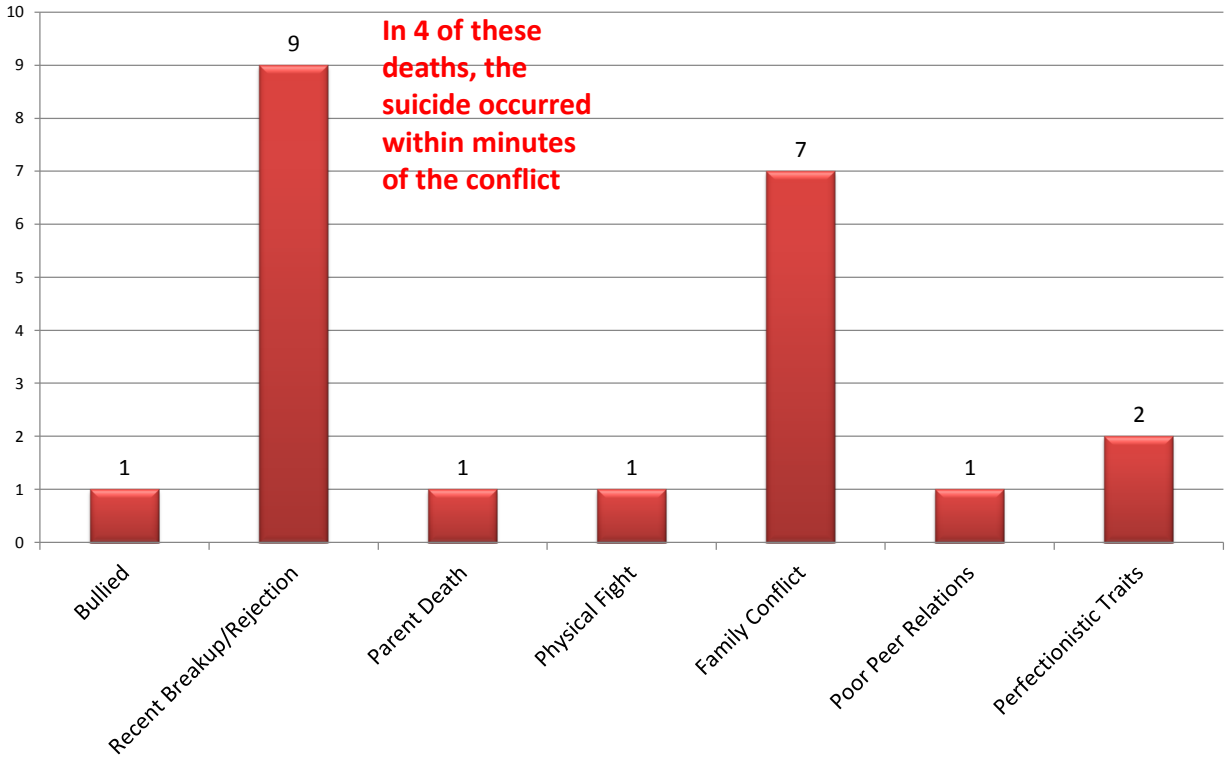
Toxicology Findings on Youth Suicides

(January 1, 2014-March 1, 2016)

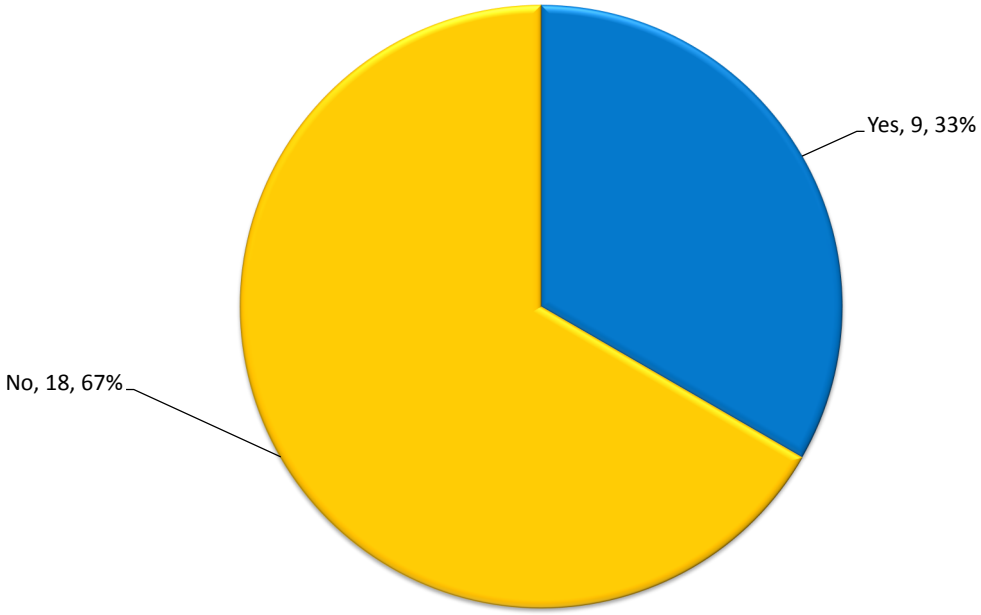


Youth Suicides (11-17) with known Relational Conflicts

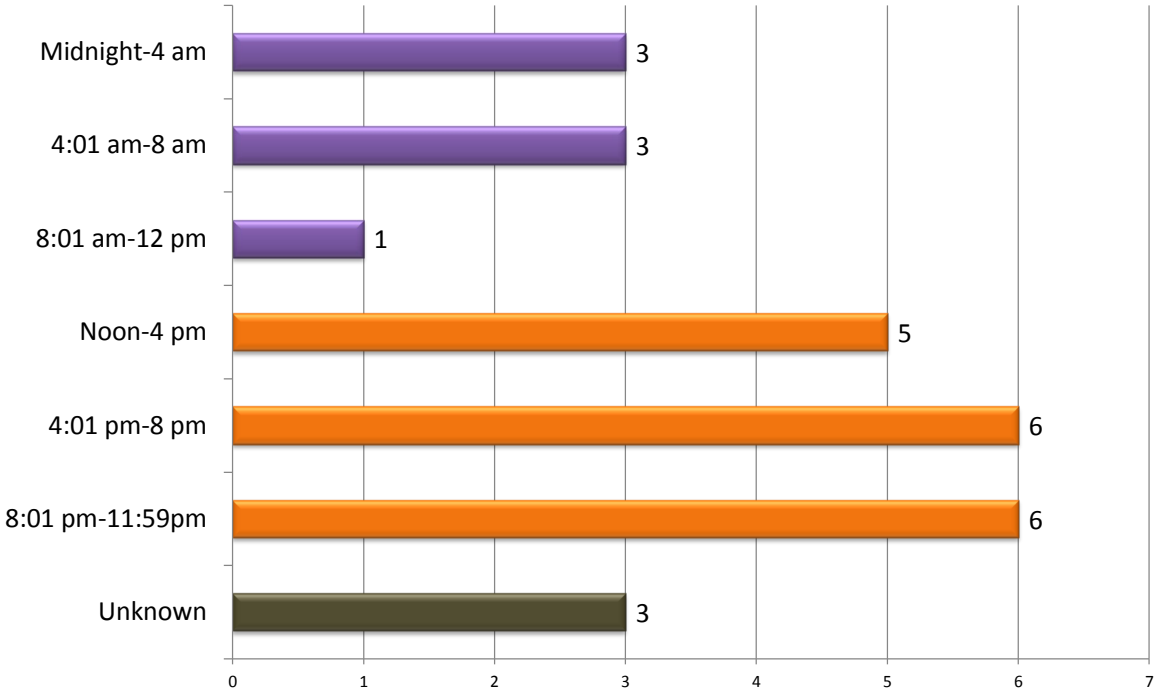
(January 1, 2014-March 1, 2016)



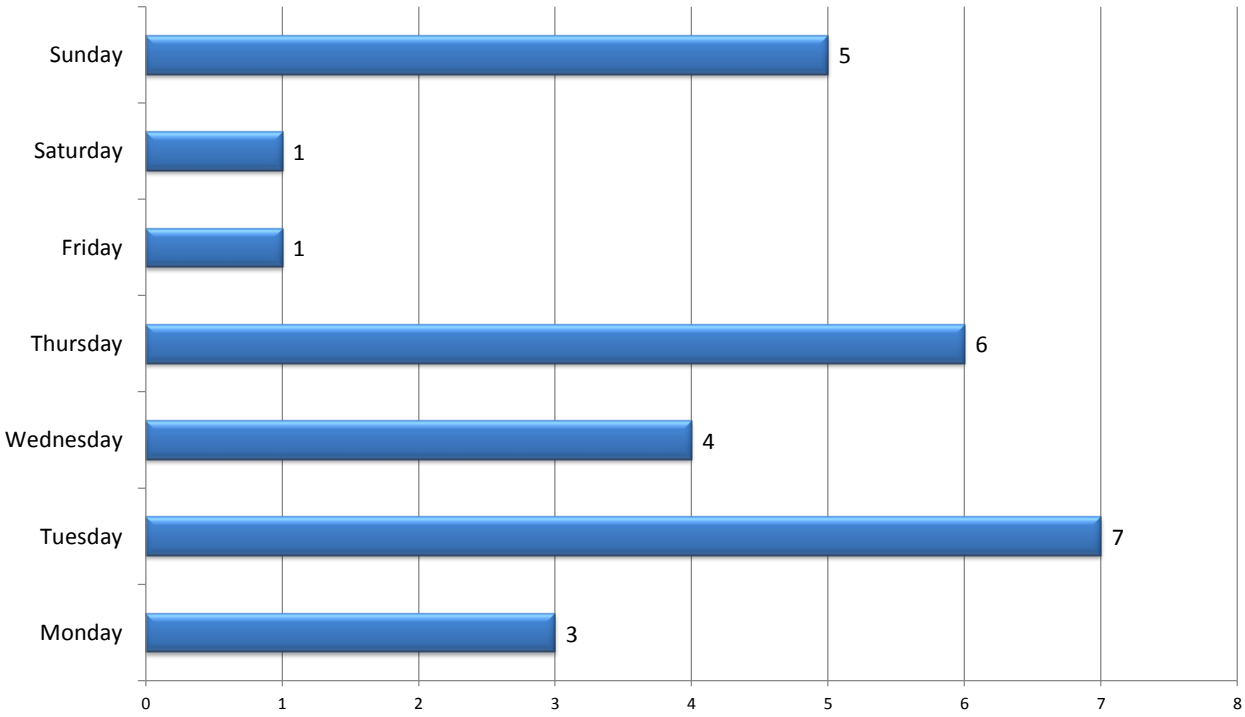
Youth Suicides (11-17)
where a note was left
(January 1, 2014-March 1, 2016)



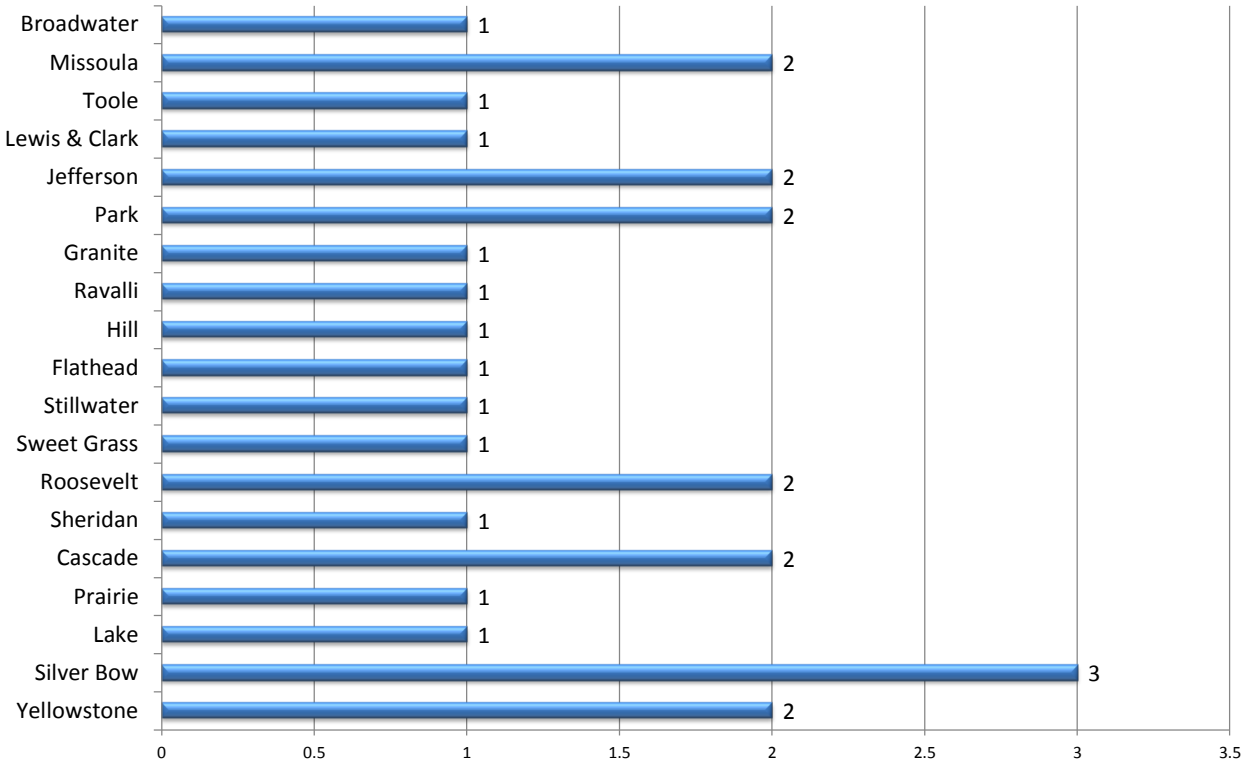
Youth Suicides (11-17) by Time of Day
(January 1, 2014-March 1, 2016)



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)

Suicide Among American Indians

Based on **42** identified suicides between January 1, 2014 and March 1, 2016

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 27.3/100,00 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, 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 among American Indians by Race

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

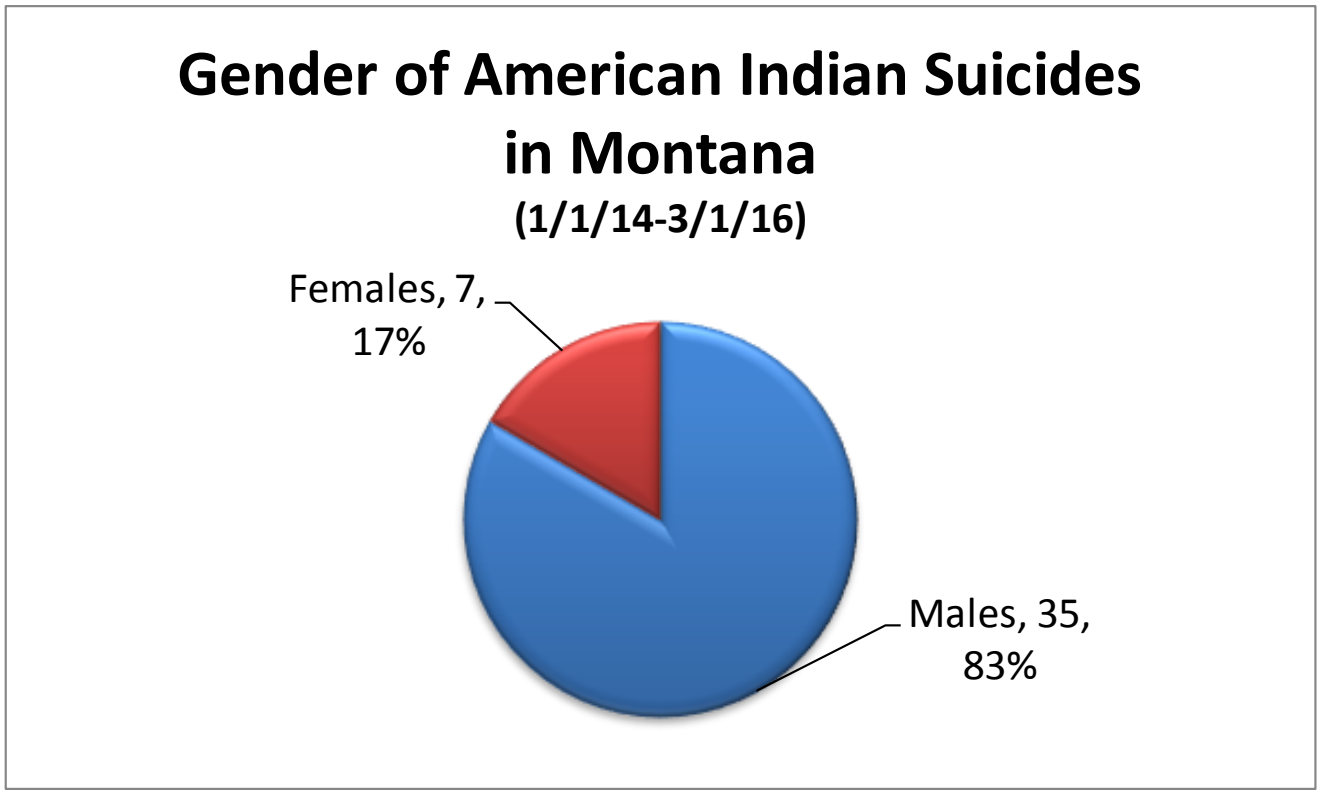
Suicides among American Indians by Gender

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



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

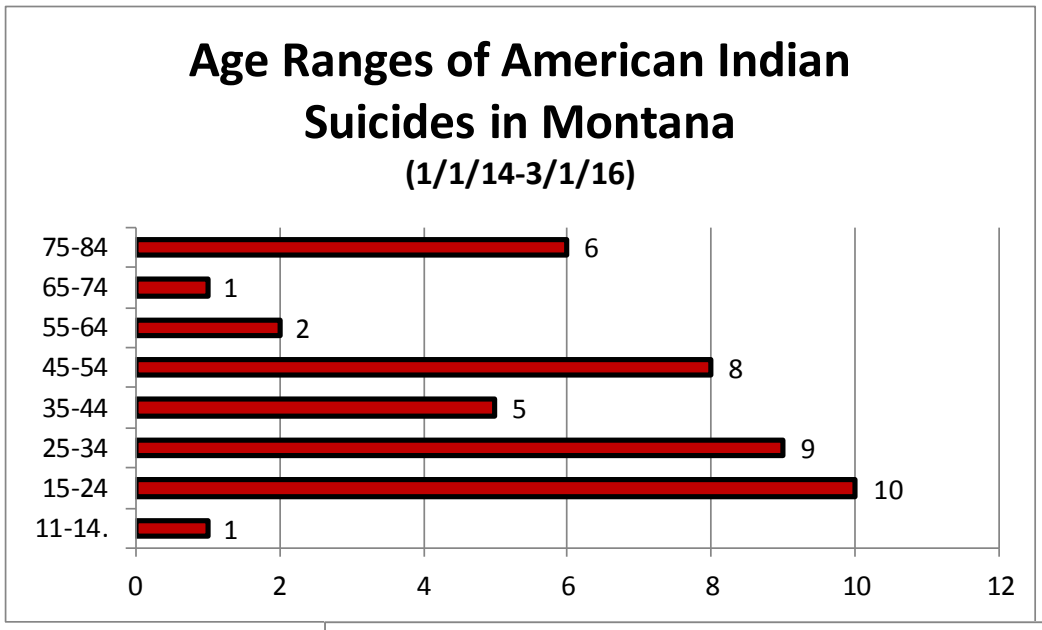
Number of Deaths	Population***	Crude Rate
48,186	601,605,595	8.01

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

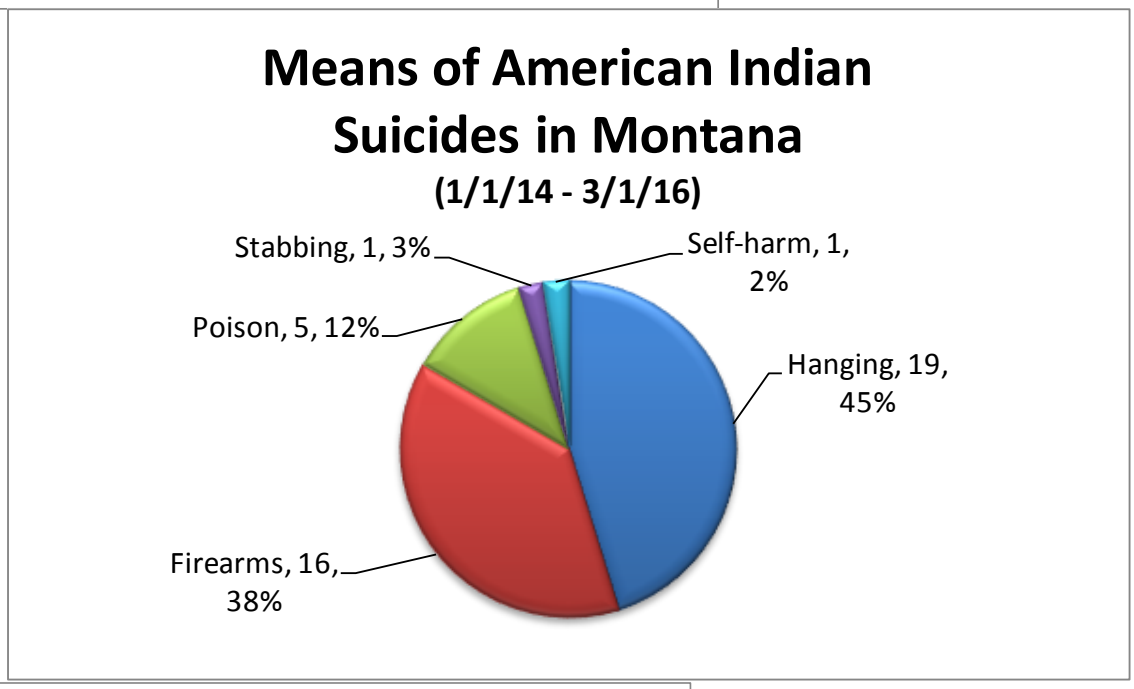
Number of Deaths	Population***	Crude Rate
246	1,654,999	14.86

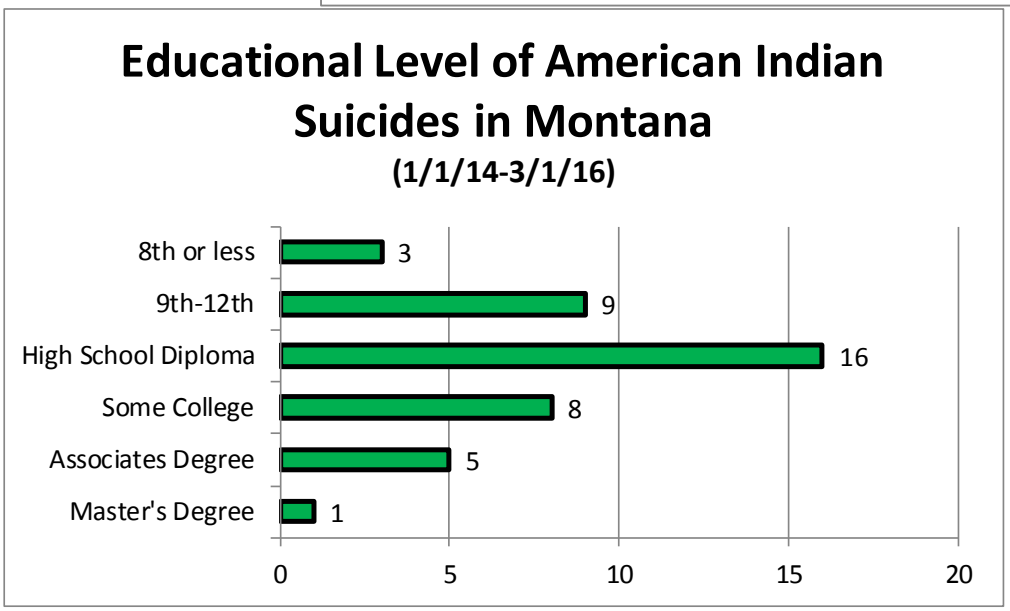
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
Am Indian/AK Native, Both Sexes, Ages 11 to 24
ICD-10 Codes: X60-X84, Y87.0,*U03

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



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.

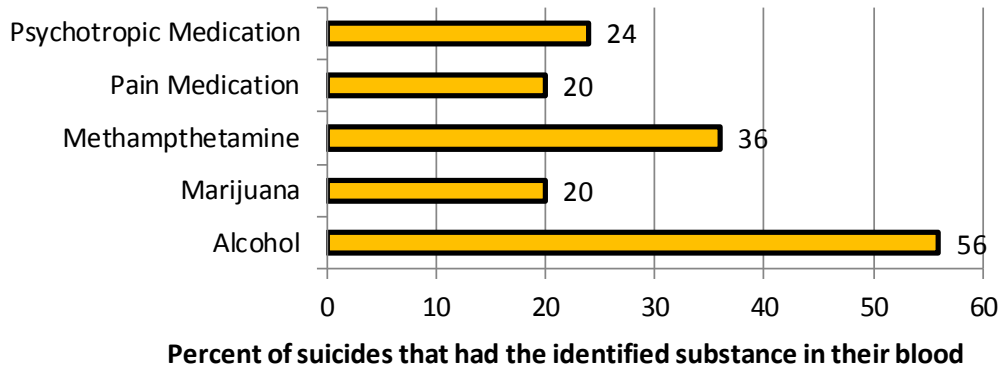




67% of the American Indian suicides had a high school diploma or less

Toxicology reports of American Indian Suicides for 2014-2015

(% based on 25 received toxicology reports)

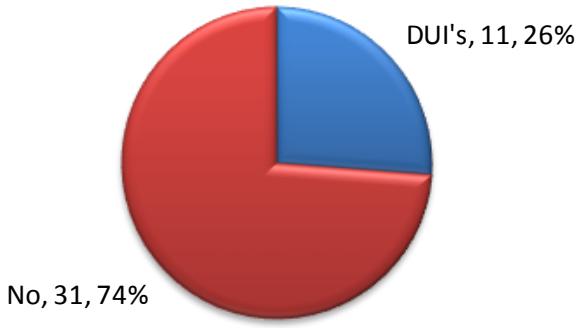


Percent of suicides that had the identified substance in their blood

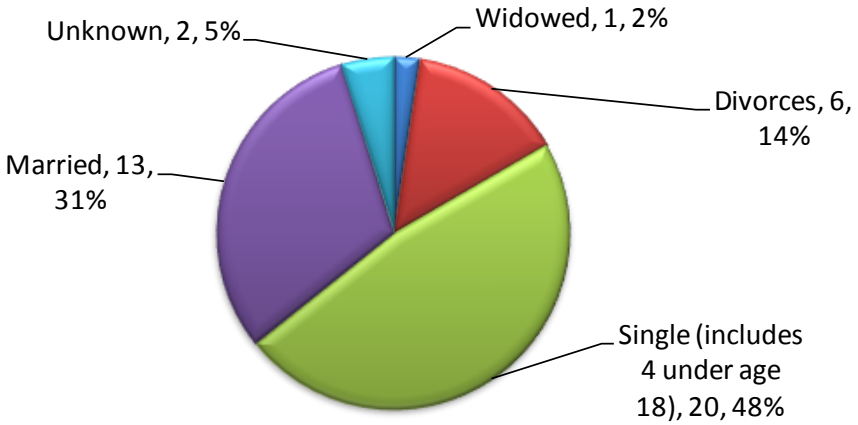
This is based on a small number of toxicology reports and only represents a percentage of those reports received. In 17 of the 25 toxicology reports, multiple substances were found (excluding caffeine, nicotine, and OTC medications.)

American Indian Suicides that had a History of DUI's

(2014-2015)



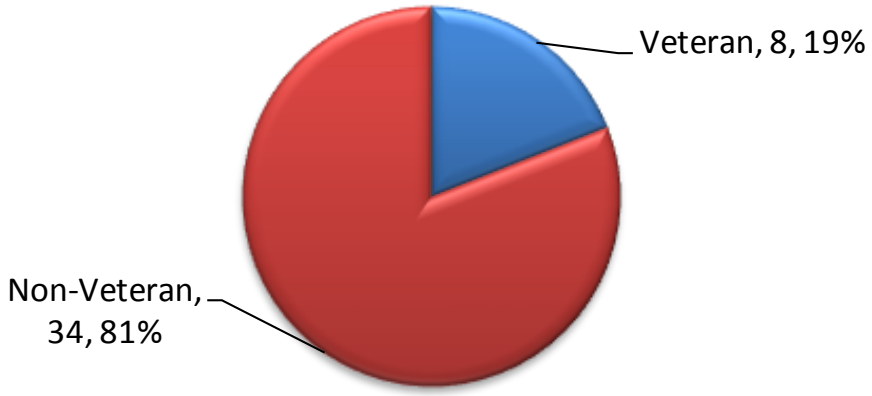
American Indian Suicides by Relationship Status



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

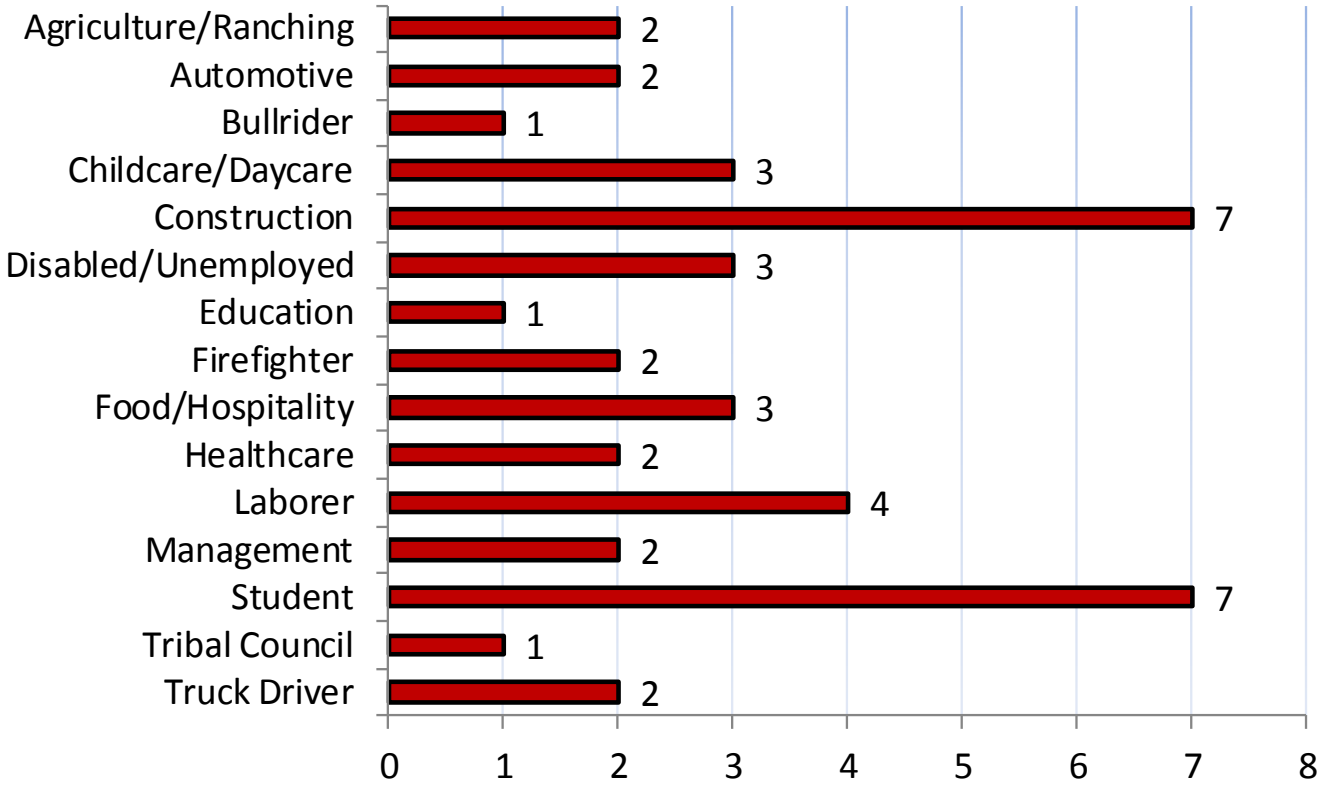
American Indian Suicides that were Veterans

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



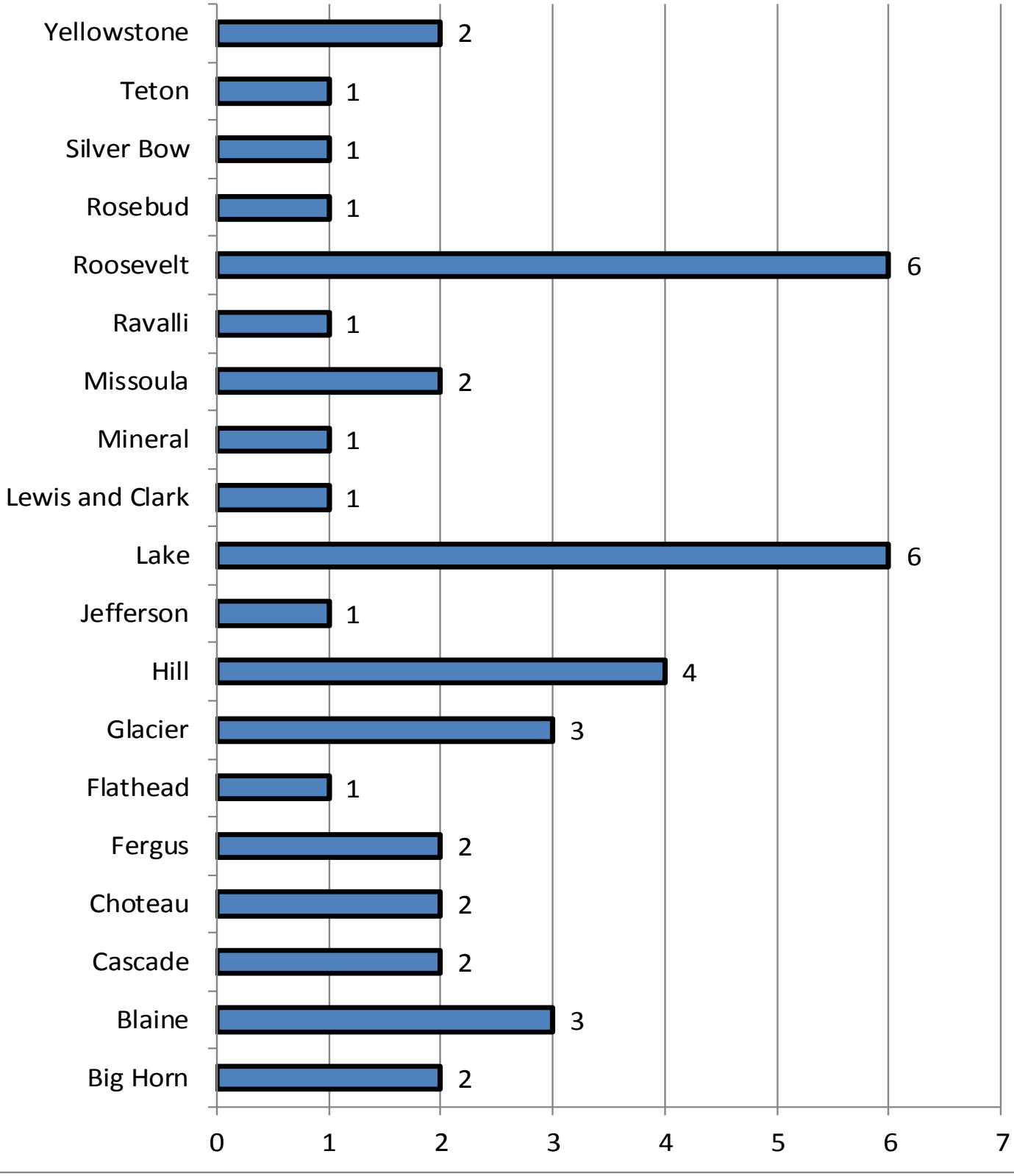
American Indian Suicides by Occupation

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



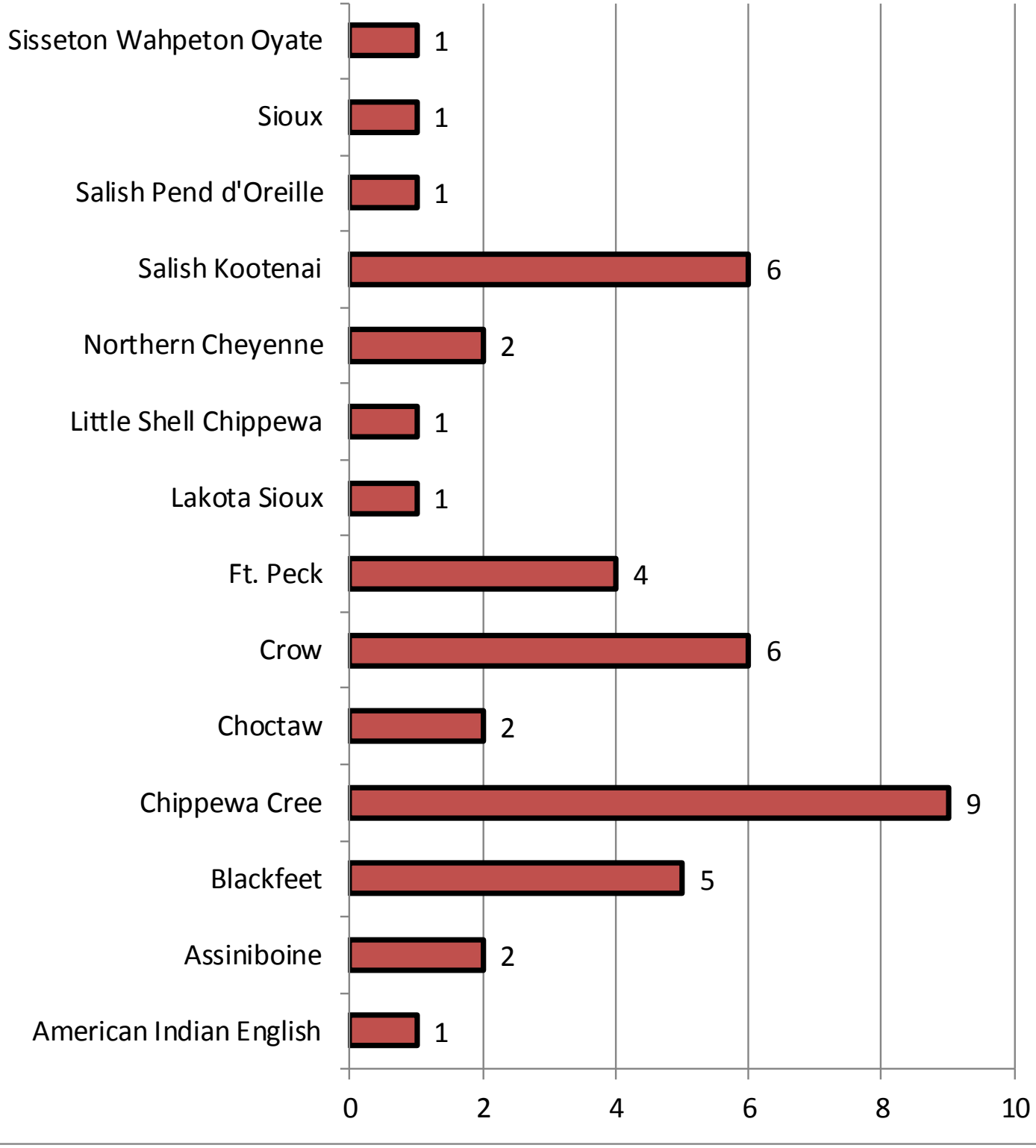
County of Residence of American Indian Suicides in Montana

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



Tribes of American Indian Suicides in Montana

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



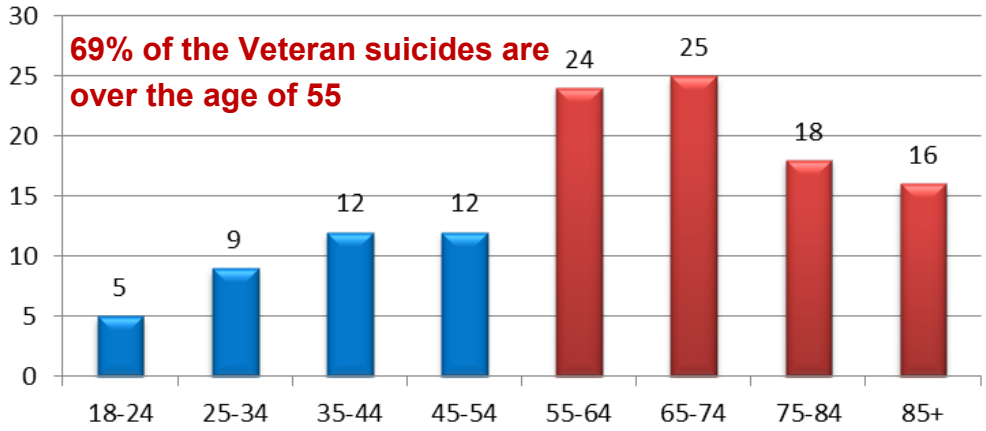
Statistics concerning Veteran Suicides in Montana.

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.

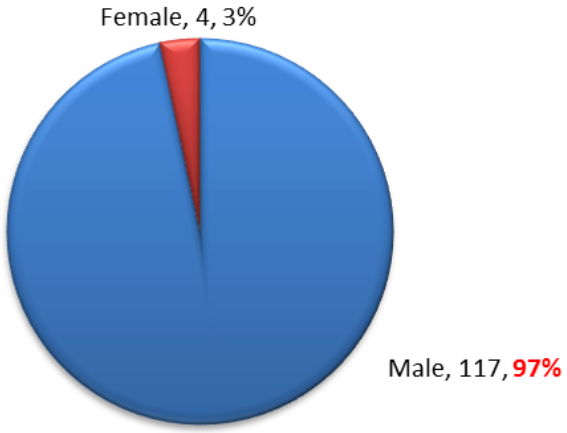
The information is based on death certificates identifying that the deceased was in the armed services. Additional information was obtained from coroner reports, supplemental questionnaires, health records, and information obtained from families.

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 .

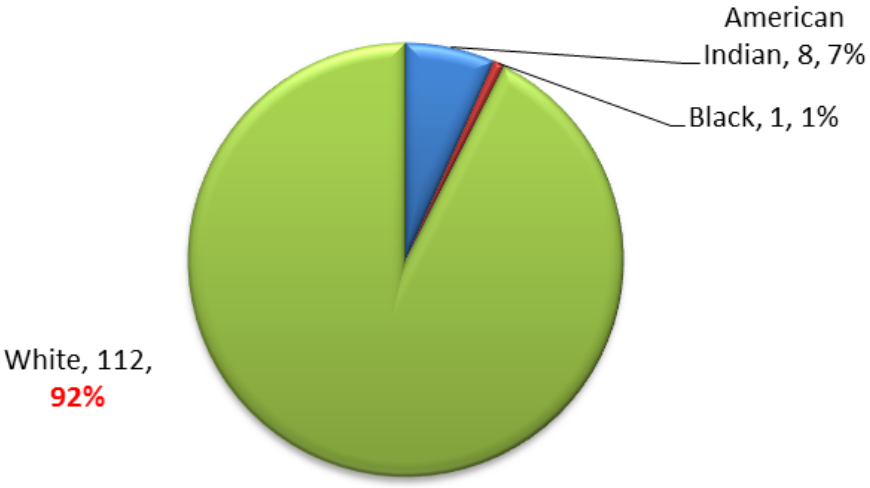
Montana Veteran Suicides by Age Range

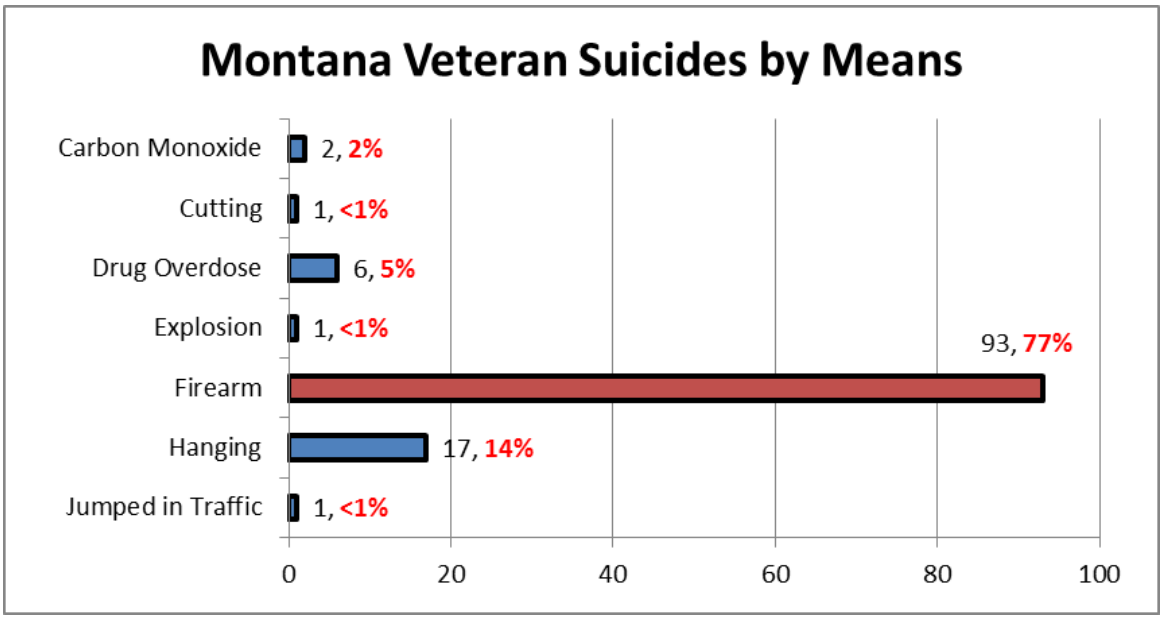


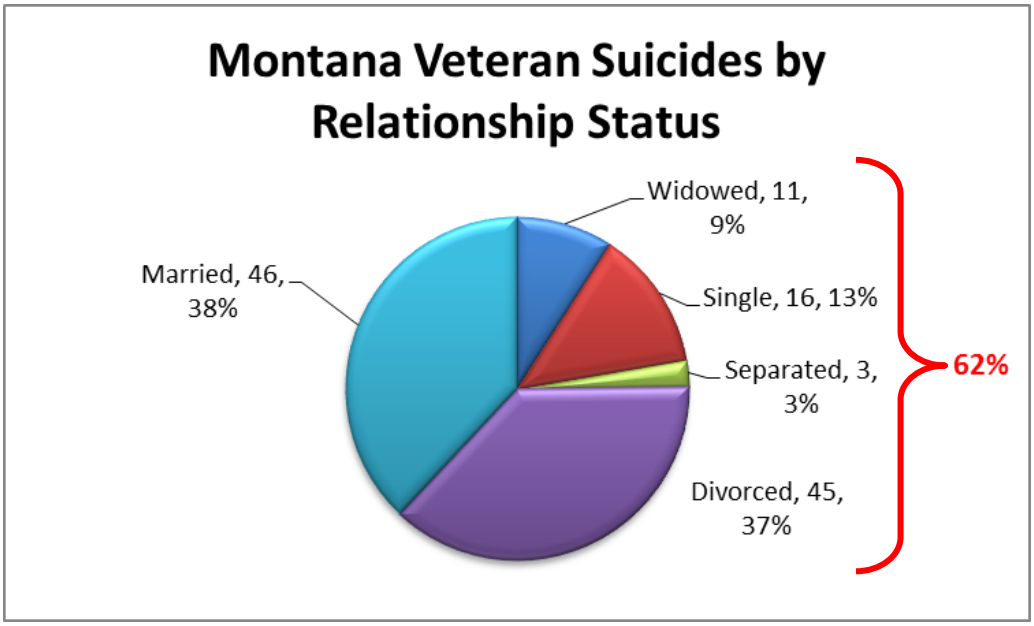
Montana Veteran Suicides by Gender

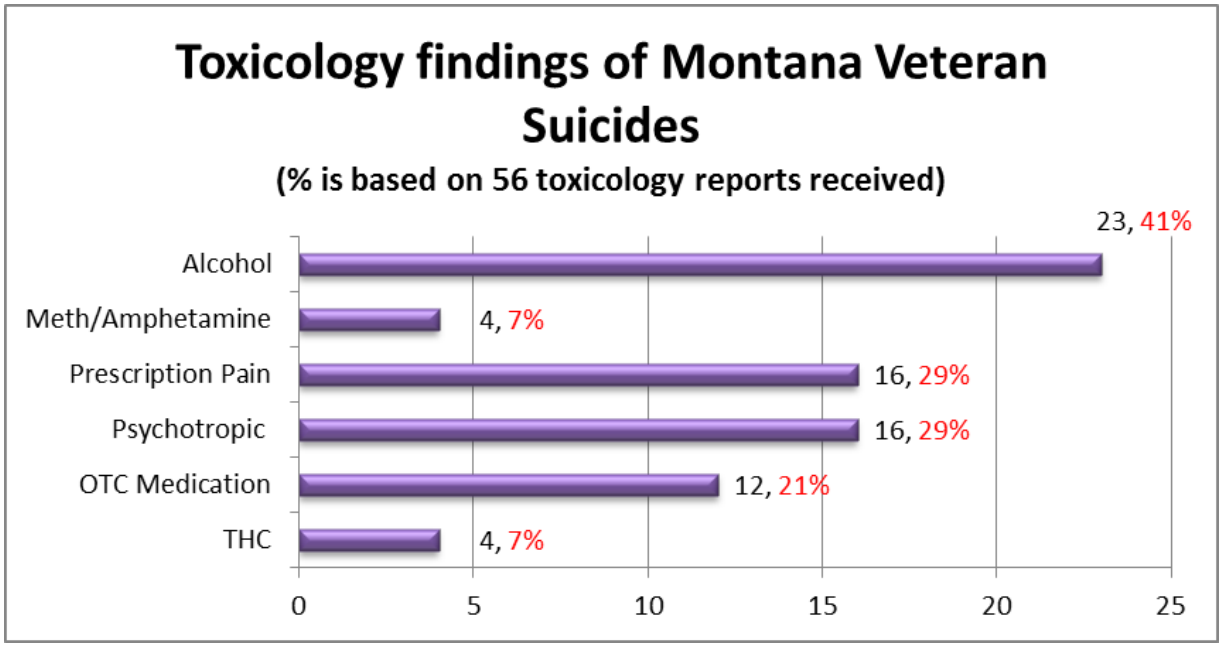


Montana Veteran Suicides by Race



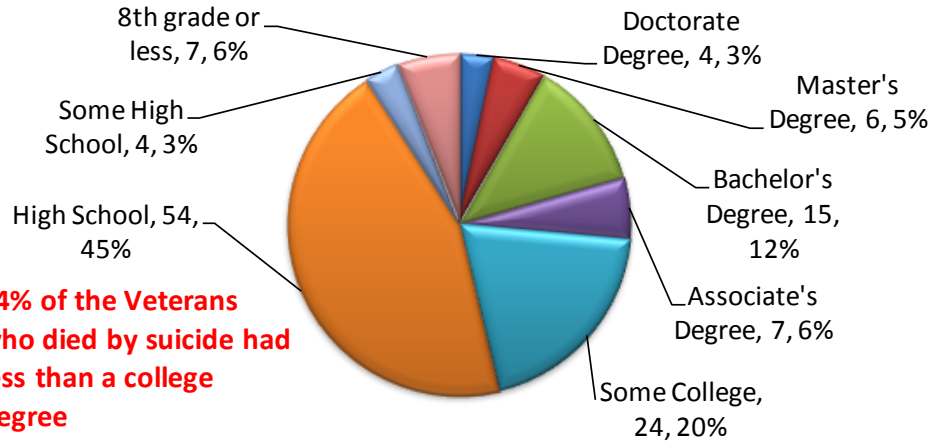

Montana Veteran Suicides by Means
Carbon Monoxide
2, 2%
Cutting
1, <1%
Drug Overdose
6, 5%
Explosion
1, <1%
Firearm
93, 77%
Hanging
17, 14%
Jumped in Traffic
1, <1%
0
20
40
60
80
100


Montana Veteran Suicides by Relationship Status
Widowed, 11, 9%
Married, 46, 38%
Single, 16, 13%
Separated, 3, 3%
Divorced, 45, 37%
62%


Toxicology findings of Montana Veteran Suicides
(% is based on 56 toxicology reports received)
Alcohol
23, 41%
Meth/Amphetamine
4, 7%
Prescription Pain
16, 29%
Psychotropic
16, 29%
OTC Medication
12, 21%
THC
4, 7%
0
5
10
15
20
25

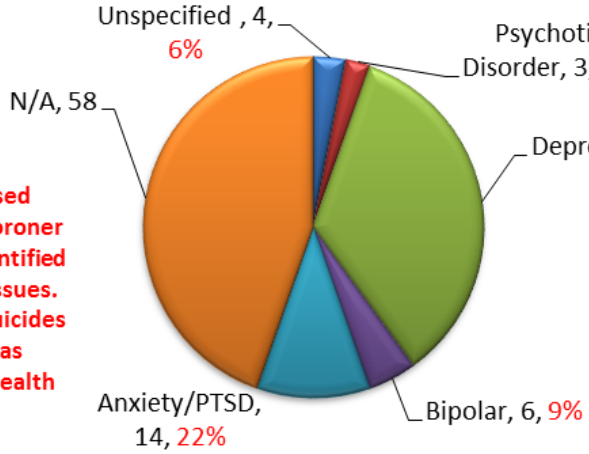
Montana Veteran Suicides with Chronic Pain/Health Issues

Montana Veteran Suicides by Education Level



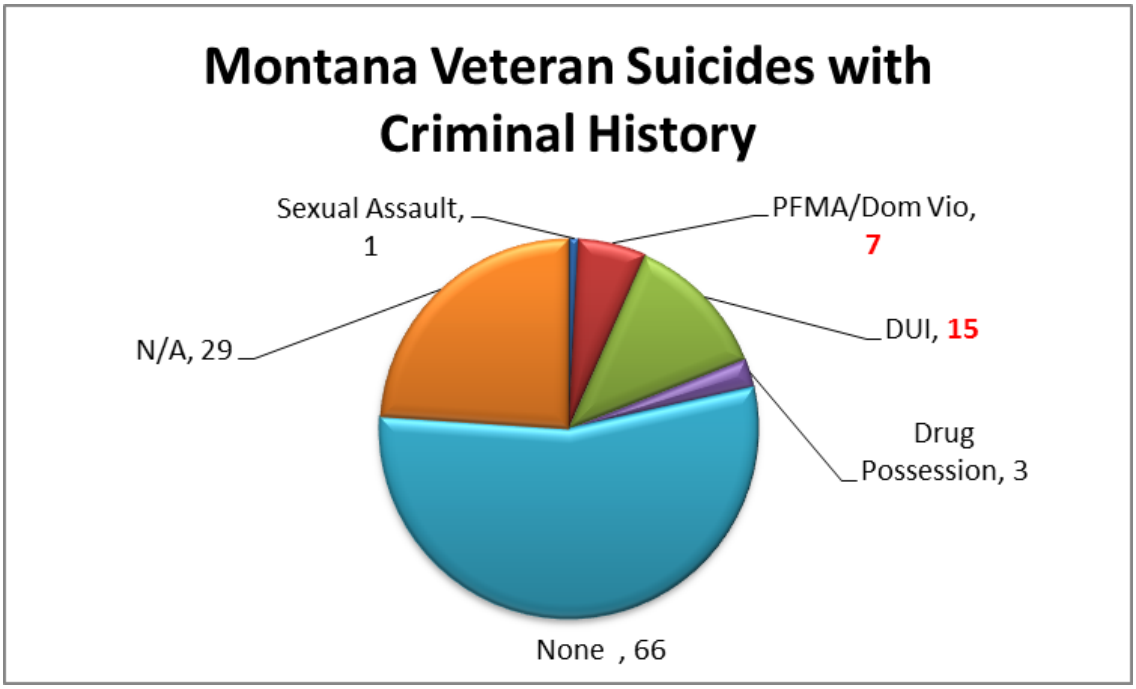
74% of the Veterans who died by suicide had less than a college degree

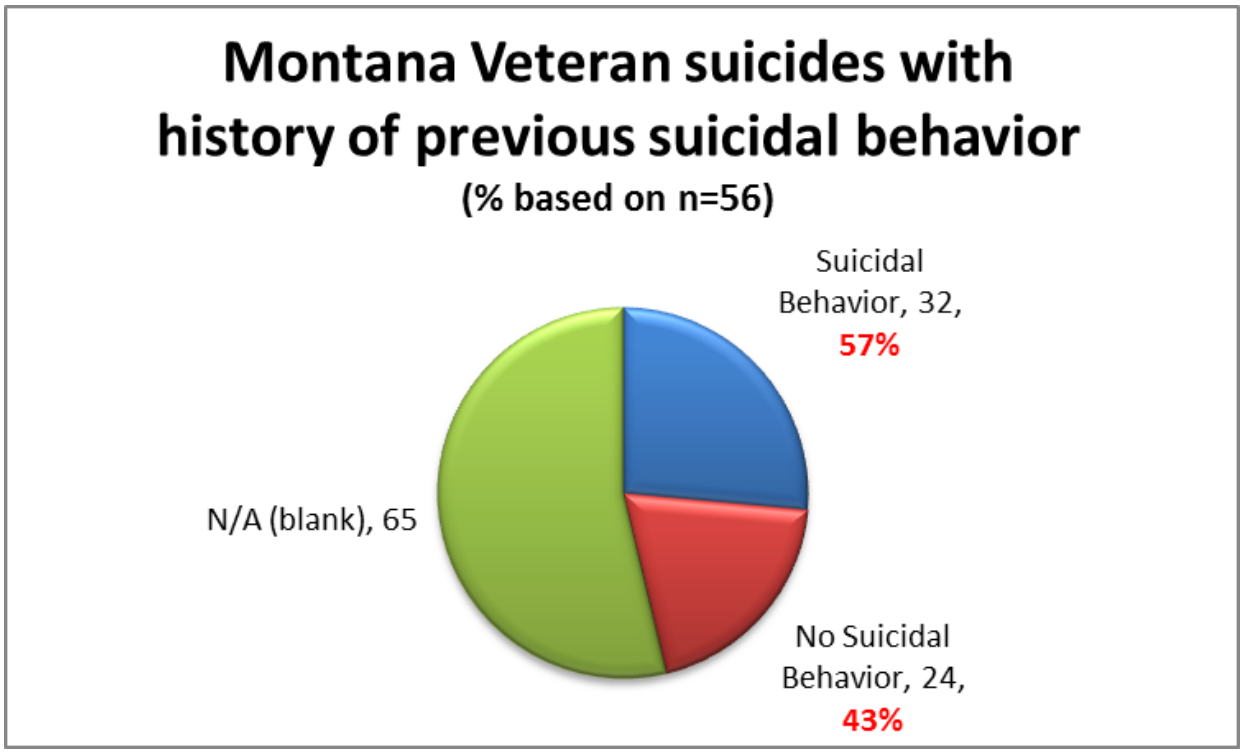
Montana Veteran Suicides with identified Mental Health Issues



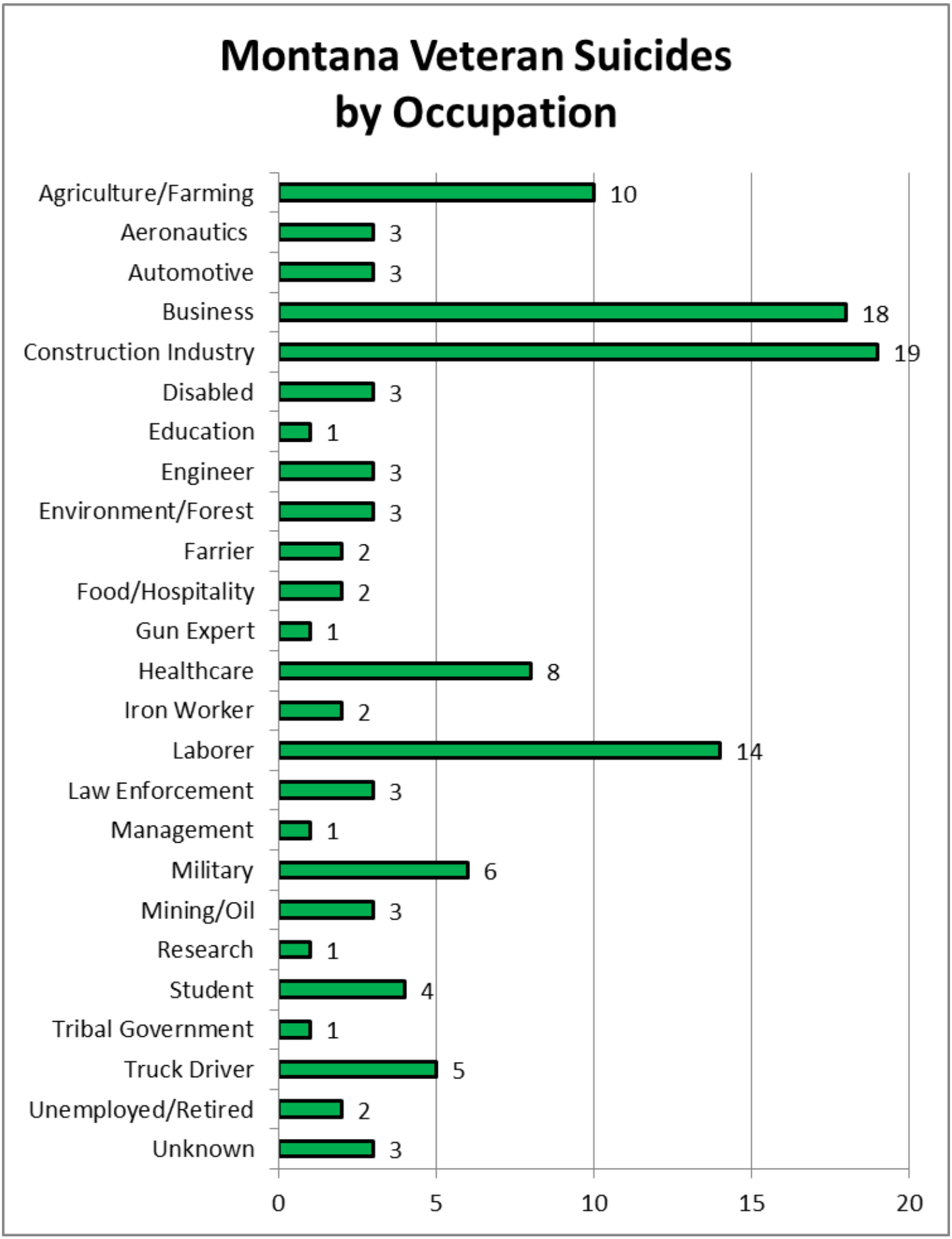
Percentages based only on those coroner reports that identified mental health issues. 63/121 of the suicides were identified as having mental health issues .

19% (12/63) had more than one diagnosis

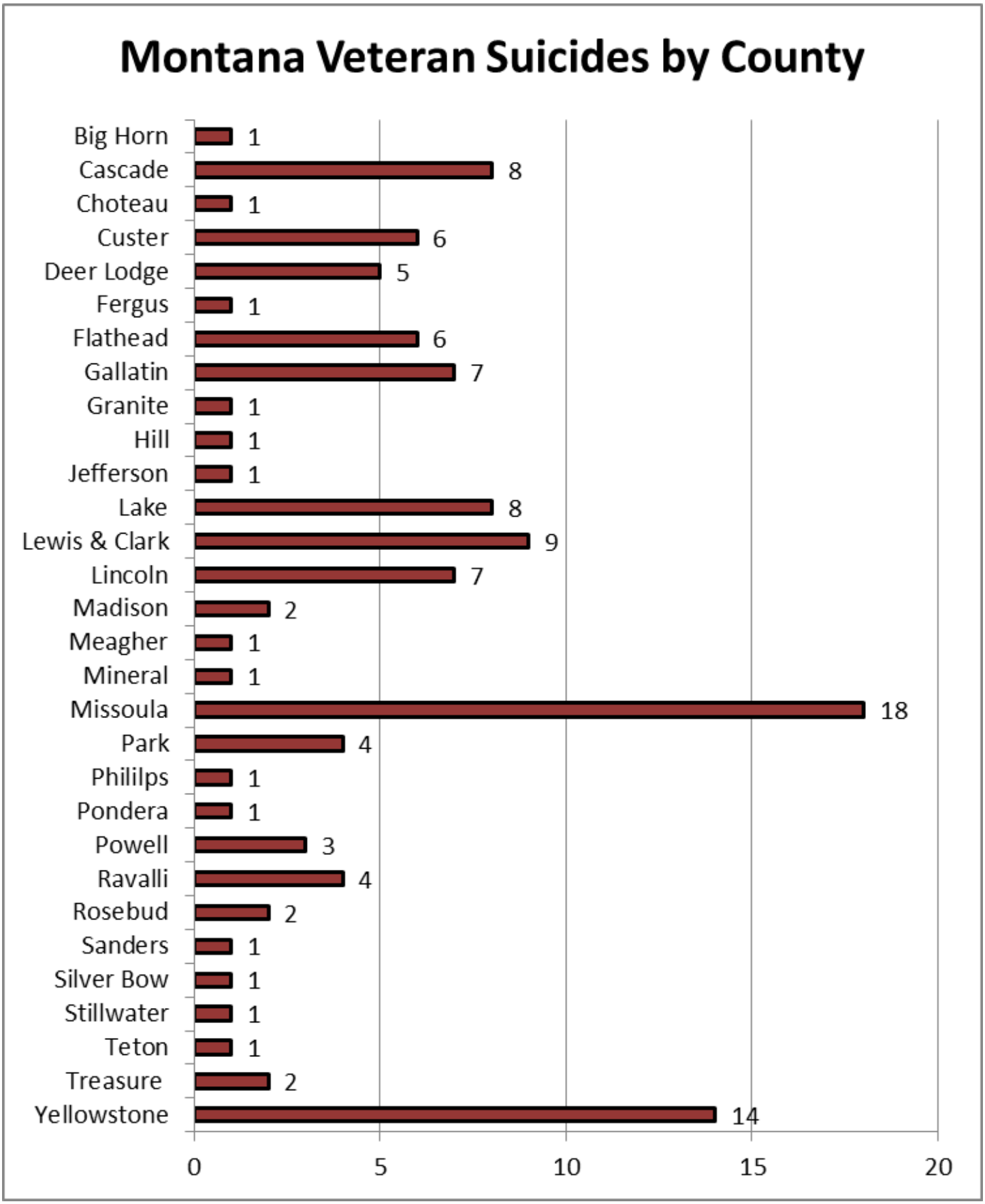

Montana Veteran Suicides with Criminal History
Sexual Assault, 1
PFMA/Dom Vio, 7
DUI, 15
Drug Possession, 3
None , 66
N/A, 29


Montana Veteran suicides with history of previous suicidal behavior
(% based on n=56)
Suicidal Behavior, 32, 57%
No Suicidal Behavior, 24, 43%
N/A (blank), 65

Montana Veteran Suicides by Occupation



Montana Veteran Suicides by County



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 figety 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-SSCS Suicidal Ideation Severity	48 hr	Month	Lifetime (Worst)
1) **Wish to be dead** *Have you wished you were dead or wished you could go to sleep and not wake up?*			
2) **Current suicidal thoughts** *Have you actually had any thoughts of killing yourself?*			
3) **Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*			
4) **Suicidal Intent without Specific Plan** *Have you had these thoughts and had some intention of acting on them?*			
5) **Intent with Plan** *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*			
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* 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.	48 hr	3 Months	Lifetime

Current and Past Psychiatric Dx:
- □ Mood Disorder
- □ Psychotic disorder
- □ Alcohol/substance abuse disorders
- □ PTSD
- □ ADHD
- □ TBI
- □ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
- □ Conduct problems (antisocial behavior, aggression, impulsivity)
- □ Recent onset

Presenting Symptoms:
- □ Anhedonia
- □ Impulsivity
- □ Hopelessness or despair
- □ Anxiety and/or panic
- □ Insomnia
- □ Command hallucinations
- □ Psychosis

Family History:
- □ Suicide
- □ Suicidal behavior
- □ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:
- □ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
- □ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- □ Sexual/physical abuse
- □ Substance intoxication or withdrawal
- □ Pending incarceration or homelessness
- □ Legal problems
- □ Inadequate social supports
- □ Social isolation
- □ Perceived burden on others

Change in treatment:
- □ Recent inpatient discharge
- □ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
- □ Hopeless or dissatisfied with provider or treatment
- □ Non-compliant or not receiving treatment

□ **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 concerning primary care providers 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 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.


SUICIDE
PREVENTION
CRISIS TEXT LINE
Text MT to 741-741
A free, 24/7 text line
for people in crisis.
NATIONAL
SUICIDE
PREVENTION
LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org