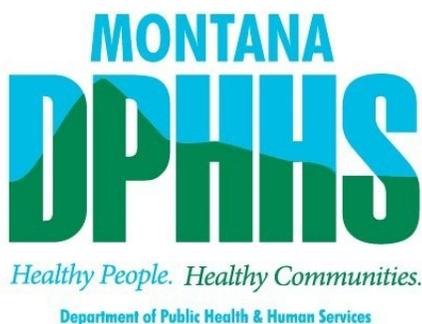




Montana Strategic Suicide Prevention Plan—2013



Updated August, 2012



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

**Karl Rosston, LCSW
Suicide Prevention Coordinator
Montana Department of Public Health and Human Services
555 Fuller Avenue
Helena, Montana 59620-2905
(406) 444-3349
krosston@mt.gov**

A special thank you to Bruce Schwartz, Carol Ballew, and Cody Curtis with the Montana Office of Epidemiology and Scientific Support for all of their assistance and support in obtaining much of the data that is available in this report.

Table of Contents

Suicide Prevention in Montana: The Process of Making a Cultural Shift in Thinking.....	5
Progress & Challenges.....	6
Suicide—The Magnitude of the Problem	
United States.....	9
Montana.....	11
Risk and Protective Factors associated with Suicide.....	20
Opportunities for Prevention Activities.....	24
Other Populations in Montana with a high risk of Suicide....	27
Vision, Mission, Goals and Objectives.....	47
The Environment for Suicide Prevention in Montana.....	49
References.....	51

SUICIDE PREVENTION IN MONTANA:

The Process of Making a Cultural Shift in Thinking

Introduction

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

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

The current plan is the fifth revision. Accomplishments and ongoing challenges are delineated. Strategic directions for prevention, intervention, postvention and coordination among providers are expanded, along with special attention to groups within Montana's population with the highest risk of suicide.

Progress

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

- Signs of Suicide (SOS) kits provided for 150 schools around the state.
- Suicide Prevention Toolkit for Rural Primary Care Providers for 120 medical clinics and now available at no cost at www.prc.mt.gov/suicideprevention.
- Suicide Prevention Toolkit for Senior Living Communities. Sent out to all licensed long term care, assisted living, and nursing facilities and available at no cost on www.prc.mt.gov/suicideprevention.
- Crisis Intervention Training for over 600 law enforcement officers and first responders. A basic mental health course has also been added to the core curriculum at the Montana Law Enforcement Academy.
- Stabilized the State Suicide Prevention Lifeline. The Lifeline consists of two regional call centers with additional phones, computers, updated data bases, and ensured that there are full-time, trained professionals available 24/7.
- Suicide prevention postcards sent out to over 4,000 licensed cosmetologists.
- Core competency training for therapists working with suicidal clients for 105 therapists from around the state.
- Suicide assessment software sent to all licensed psychiatrists in the state.
- “After a Suicide” distributed to all funeral homes in the state.
- Statewide webinars to all VAs on the treatment of suicidal and PTSD veterans.
- Over 7,000 gunlocks with suicide prevention tags distributed to sixteen counties and seven tribal entities.
- Over 1,500 people in communities and reservations trained in ASIST (Applied Suicide Intervention Skills Training).
- Trained 200 CSCT school staff from around the state.
- Collaborated with Missoula and Ravalli County to implement the Yellow Ribbon Program in all of the county high schools.
- Trained over 200 licensed senior care givers through the Senior and Long Term Care Division.
- Filmed five episodes of “Aging Horizons” on the Big Sky Channel concerning suicide prevention in the elderly and two episodes of the “Dunwell Report” concerning suicide prevention in Montana.
- Over 12,000 people trained in QPR (Question, Persuade, Refer) around the state and on tribal lands.
- Semester presentations at Western Montana College, Carroll College, and Helena College of the University of Montana in suicide prevention to nursing and education students. Also presented to counseling students at the University of Montana.
- Member of the Attorney General’s task force to reduce prescription drug abuse.
- Suicide prevention trainings and interventions funded for numerous counties including Missoula, Ravalli, Flathead, Gallatin, Cascade, Lewis & Clark, Sanders, Custer, and District II (which encompasses 11 counties in Eastern Montana)

- Suicide prevention webinar for physicians and emergency room staff to 27 Montana hospitals.
- Trained all Key Clubs in Montana as they focused on suicide prevention in the 2012 academic year..
- Over 2,000 “Quick Reference” guides for suicide prevention distributed to chemical dependency facilities and made available to chemical dependency counselors and others around the state.
- Over 7,000 “Parents as Partners: a suicide prevention guide for parents” booklets sent out to school districts around the state and made available to agencies working with families.
- Collaborative effort with the Dept. of Revenue, Liquor Control, on providing training to bartenders and liquor distributors. Over 100,000 Drink coasters being distributed to Montana bars.
- State-wide media campaigns on Optimum Communication, Montana Broadcaster’s Association, Northern Broadcasting Association, Facebook, and Cha Cha. The Facebook ad focused not only young people in Montana but also Montana Veterans. Also appeared twice as the guest on “Voices of Montana” to promote suicide prevention resources around Montana.
- Suicide awareness postcards to Veterans (over 102,000) in the state.
- Suicide prevention training to detention officers in county jails and juvenile facilities, and providing anti-suicide blankets and clothing to all county jails and correctional facilities.
- Suicide prevention training for juvenile parole officers and detention officers around the state.

Challenges

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

Lack of statewide coordination

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

Montana demographics and geography

- Montana is a large frontier state with many isolated communities.

Challenges (continued)

- There is a generational culture of acceptance of suicide as a viable option to resolve feelings of hopelessness and when one feels they are a burden to others.
- Ongoing stigma towards seeking mental health services and concerns of maintaining confidentiality in small communities inhibit individuals from seeking needed treatment.
- According to the Census Bureau, in 2010, 17% of the population or 161,500 Montanans, lacked health insurance coverage including more than 23,000 children (www.statehealthfacts.org)
- Montana has a high availability of lethal means, especially firearms, that increase the lethality of impulsive suicidal behaviors .
- Montana has high rates of alcoholism, underage drinking, and binge drinking, along with other drug addictions; including the current devastating epidemic of Methamphetamine use.
- The farm and ranch economic crisis and the difficulty in attracting industry to provide a stable employment market in Montana are ongoing stressors.
- An analysis of National Violent Death Reporting System (NVDRS) data revealed that suicide rates are higher among people who live at high altitudes than those living at lower elevations.

Lack of mental health providers and treatment facilities

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

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

United States

Over the last ten years, the rate of suicide has been slowly increasing 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. At the other end of the age spectrum, suicide rates remain the highest among white males over the age of 65. Differences are also occurring in some racial groups with the rates of suicide among young African American males showing significant increases.

Approximately 922,725 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 National Vital Statistics Report (2012) and the Center for Disease Control-WISQARS (2012).

In the United States for 2009:

- Suicide was the 10th leading cause of death for all ages.
- Suicides accounted for 1.5% of all deaths in the U.S.
- Nearly 37,000 suicides occurred in the U.S. This is the equivalent of 101 suicides per day; one suicide every 14 minutes or a crude rate of 12 suicides per 100,000 people.
- The National Violent Death Reporting System examined toxicology tests of those who committed suicide in 13 states: 33.3% tested positive for alcohol; 16.4% for opiates; 9.4% for cocaine; 7.7% for marijuana; and 3.9% for amphetamines.

**2009, 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
36,909	307,006,550	12.02	11.77

Suicide among the Young

- In 2009, 4,371 youth between 15 and 24 completed suicide in the US
- Suicide is the 3rd 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 have the highest rate with 17.4 per 100,000. White youth are next highest with 7.5 per 100,000
- The majority of youth who died by suicide used firearms (45%). Suffocation was the second most commonly used method (40%).

According to the 2011 National Youth Risk Behavior Survey;

- 15.8% of all high school students had seriously considered attempting suicide during the 12 months before the survey.
- 7.8% 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 922,725 suicide attempts in the US in 2009. This translates to one attempt every 34 seconds. There are 3 female 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

- Between 1999 and 2009, suicide is the second leading cause of death for American Indians/Alaska Natives ages 10- to 34-years,
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 (15.92 per 100,000) are 1.7 times higher than the national average for that age group (9.27 per 100,000).
- Nationally in 2009, White males had the highest rate of suicide at 21.56 per 100,000, followed by American Indians/Alaska Natives (17.87), Non-white males (9.2), Asian/Pacific Islanders (8.85), Black males (8.58), Hispanics (8.52) and White females (5.6)

<u>Suicide Method (US for 2009)</u>	<u>Number</u>	<u>Rate</u>	<u>Percent of Total</u>
Firearm	18,735	6.1	50.8%
Suffocation/Hanging	9,000	2.9	24.4%
Poisoning	6,398	2.1	17.3%
Cut/Pierce	669	0.2	1.8%
Drowning	389	0.1	1.1%

Suicide among the Elderly (US for 2009)

- There were 5,858 suicides of people over age 65 for a rate of 14.8 per 100,000. That equates out to 16 elderly suicides every day in the United States.
- The highest rate of suicide is among White males over the age of 85 (736 suicides for a rate of 45.60)
- Males over 65 have a rate of suicide 7.3 times higher than females over 65 (29.5 compared to 4.01)
- A White male over the age of 65 has a rate of suicide 4.4 times higher than a American Indian male over the age of 65 (31.95 compared to 7.18)

Source: CDC WISQARS website (http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html). Obtained Aug., 2012)



Montana

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 over three decades. In the past ten years, the crude rate of suicide in Montana is 20.92 per 100,000 people (the national average is 12 per 100,000). Between 2002 and 2011, 1,992 Montana residents have completed suicide for an average of 199 people per year.

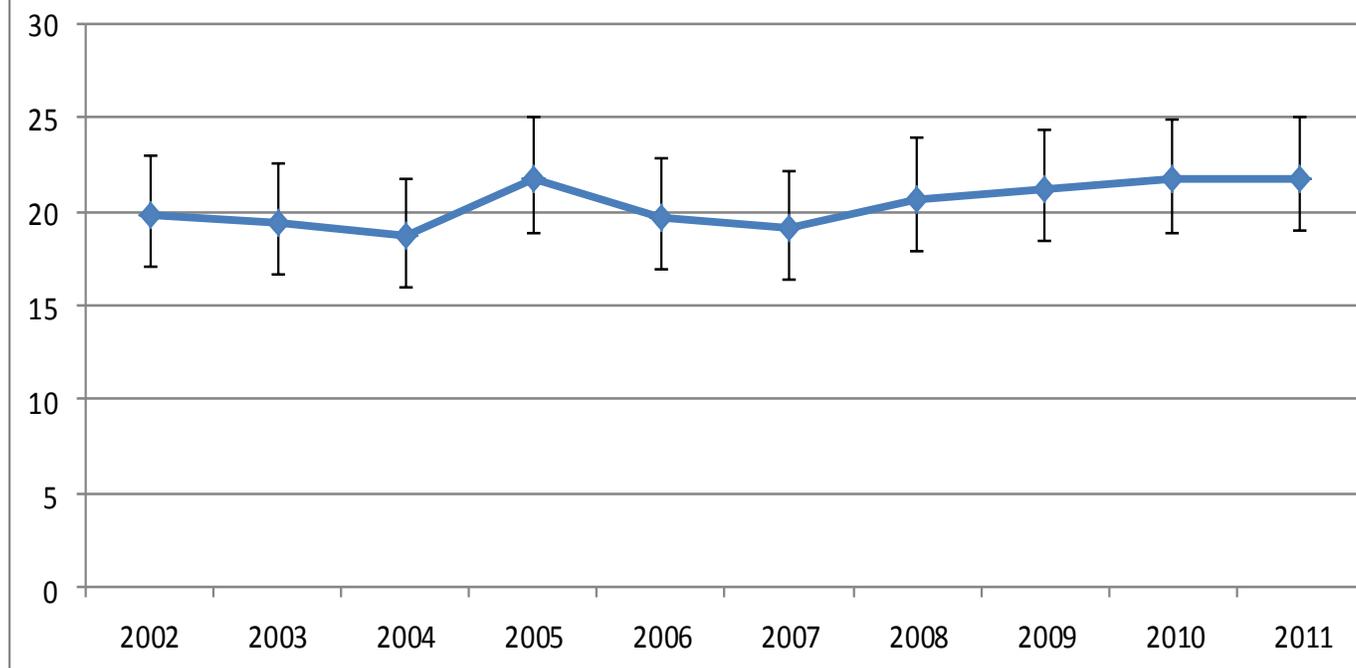
For all age groups for data collected for the year 2009, **Montana has the highest rate of suicide in the United States** (American Association of Suicidology, Jan. 2012). Montana has been in the **top five** for the past **thirty five years**.

- In Montana, between 1999 and 2009, suicide was the number **two** cause of death for children **ages 10-14**, adolescents **ages 15-24**, and adults **ages 25-34**, behind only unintentional injuries (CDC, 2012)
- **Alcohol and drug impairment**, a sense of **hopelessness**, underlying **mental illness**, and a **so-cietal stigma against depression**, all contribute to the high rate of youth suicide in Montana.
- In 2011, **25.2% 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, 2011).
- The highest rate of suicide in Montana is among **American Indians** (27.2 per 100,000) followed by Caucasians (22.2 per 100,000).

Montana Suicide (ICD-10: X60-X84, Y87.0) Counts and Rates, 2002-2011

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number Of Suicides	182	179	173	205	188	192	203	218	227	225
Population	909,722	916,620	925,711	934,656	946,059	957,123	967,717	974,163	990,958	998,199
Crude Rate (When More Than 20 Events)	20	19.5	18.7	21.9	19.9	20.1	21	22.4	22.9	22.5
Age Adjusted Rate (When More Than 20 Events)	19.8	19.4	18.7	21.7	19.7	19.1	20.7	21.2	21.7	21.8

Age Adjusted Suicide Rates (With Confidence Bars)
Montana Residents, 2002-2011
Montana Office Of Vital Statistics



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 completed suicide. Due to the small population numbers for 2010-2011, only seven counties and one cluster of eleven counties in Eastern Montana are available (see below). All other counties had less than 20 suicides for the period 2010-2011; rates based on less than 20 numbers are statistically unreliable. However, for information on the rate of suicide in other Montana counties over the last 15 years (1997-2011), please see the preceding page.

Montana County (ICD-10: X60-X84, Y87.0) Suicide Counts and Rates, 2010-2011 Aggregate
Montana Office of Vital Statistics (8/12)

County	CASCADE	FLATHEAD	GALLATIN	LEWIS & CLARK	MISSOULA	*District II	RAVALLI	YELLOWSTONE	MONTANA
Number Of Suicides	39	38	34	26	51	27	29	61	452
Population	163,346	182,172	180,993	127,922	219,581	102,768	80,793	298,519	1,989,157
Crude Rate	23.9	20.9	18.8	20.3	23.2	26.3	35.9	20.4	22.7
Age Adjusted Rate	24.1	19.1	17	18.8	21.2	29.7	33.6	20.3	21.7

*District II consists of Phillips, Valley, Daniels, Sheridan, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux counties

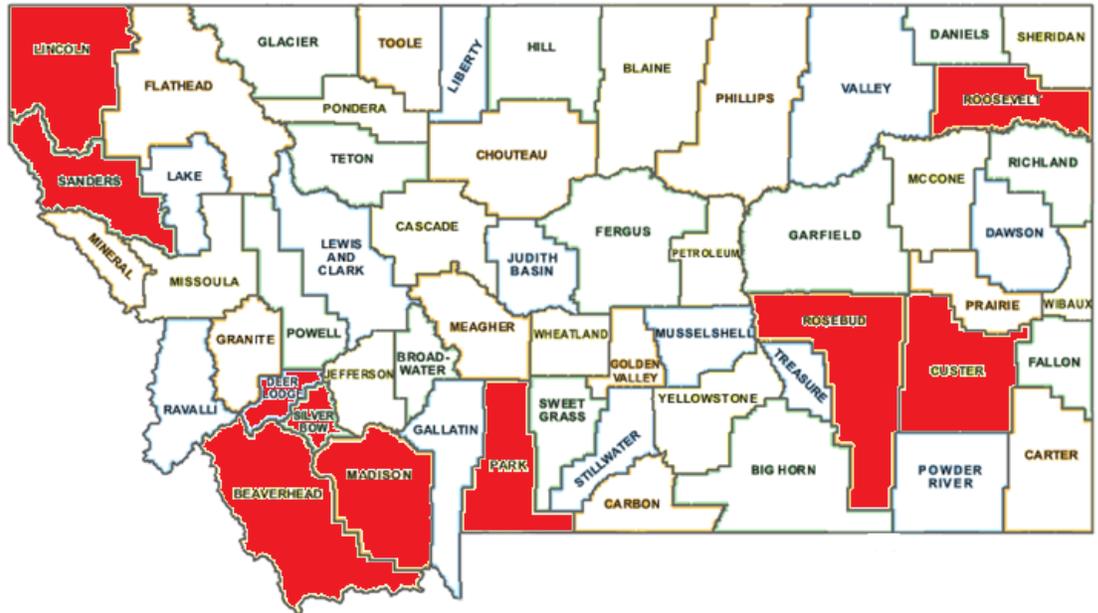
National Center for Health Statistics. Bridged-race intercensal estimates of the July 1, 1990-July 1, 1999; Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2010; July 1, 2010-July 1 2011 United States resident population by year, county, single-year of age, 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; May 31, 2012; July 18, 2012

*All other counties had less than 20 suicides for the period 2010-2011; rates based on less than 20 numbers are statistically unreliable

FREQUENCY AND RATE OF SUICIDE BY COUNTY OF RESIDENCE

MONTANA RESIDENTS, 1997 - 2011

Montana counties with the highest rate of suicide between 1997 and 2011



County	Suicides	Population*	Crude Rate
BEAVERHEAD	29	135,458	21.4
BIG HORN	26	191,937	13.5
BLAINE	20	100,489	19.9
BROADWATER	16		
CARBON	22	144,985	15.2
CARTER	<5		
CASCADE	224	1,216,092	18.4
CHOUTEAU	13		
CUSTER	45	171,987	26.2
DANIELS	<5		
DAWSON	19		
DEER LODGE	40	137,661	29.1
FALLON	6		
FERGUS	33	173,821	19
FLATHEAD	230	1,222,514	18.8
GALLATIN	179	1,171,236	15.3
GARFIELD	<5		
GLACIER	33	199,749	16.5
GOLDEN VALLEY	<5		
GRANITE	10		
HILL	38	247,398	15.4
JEFFERSON	24	158,531	15.1
JUDITH BASIN	8		
LAKE	83	410,940	20.2
LEWIS & CLARK	141	875,249	16.1
LIBERTY	<5		
LINCOLN	64	281,890	22.7
MCCONE	<5		

County	Suicides	Population*	Crude Rate
MADISON	25	106,453	23.5
MEAGHER	<5		
MINERAL	11		
MISSOULA	263	1,522,942	17.3
MUSSELSHELL	15		
PARK	56	235,902	23.7
PETROLEUM	<5		
PHILLIPS	9		
PONDERA	13		
POWDER RIVER	<5		
POWELL	17		
PRAIRIE	0		
RAVALLI	113	573,021	19.7
RICHLAND	19		
ROOSEVELT	35	156,486	22.4
ROSEBUD	30	139,580	21.5
SANDERS	41	160,221	25.6
SHERIDAN	12		
SILVER BOW	105	505,049	20.8
STILLWATER	23	126,697	18.2
SWEET GRASS	13		
TETON	11		
TOOLE	13		
TREASURE	<5		
VALLEY	13		
WHEATLAND	6		
WIBAUX	0		
YELLOWSTONE	310	2,044,162	15.2

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

*The population is the total number of people who lived in the county for each year between 1997 and 2011.

Gender

Montana is consistent with the rest of the U.S. in that suicide deaths vary by gender with males at greater risk than females. For 2010-2011, Montana males were more than three times more likely than females to complete suicide. There were 350 completed suicides by males in Montana and 102 completed suicides by females. More females choose *reversible* means such as poison; more males choose *irreversible* means such as fire arms. **Figure 1** shows the percentage of completed suicides by gender for 2010-2011.

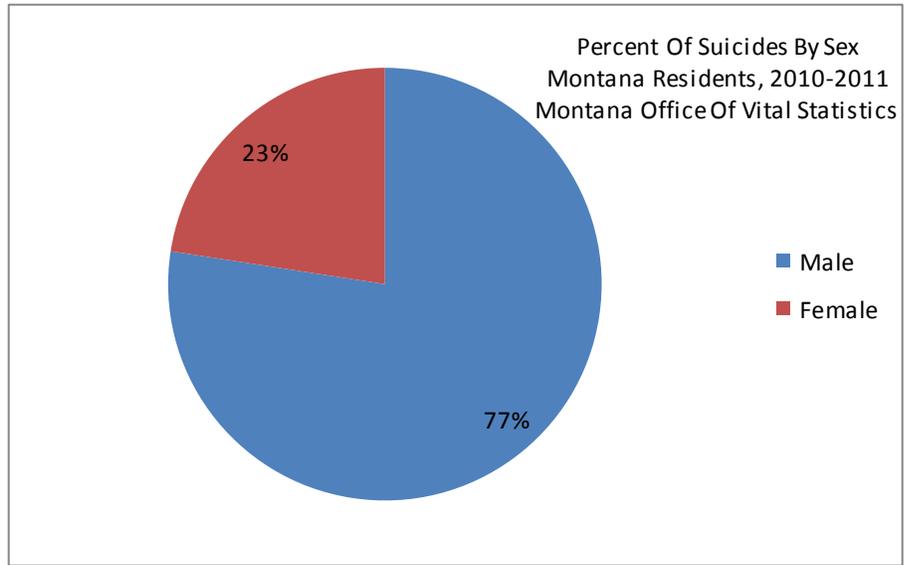


Figure 1

Race

Suicide in Montana also varies by race. The small population of American Indians residents in Montana results in highly variable rates by year. A small increase in the actual numbers of deaths can have, what appears to be, a catastrophic impact on the rate for that year. For 2010-2011, there were 38 suicides by American Indians, compared to 410 by Whites. However, Whites constitute 90% of the population while American Indians only constitute approximately 6.4%. Taking into account this rate variability due to small populations, American Indians in Montana have the highest rate of suicide in the state. **Figure 2** documents the rates by race for the years 2010-2011 (Montana Vital Statistics, 2012).

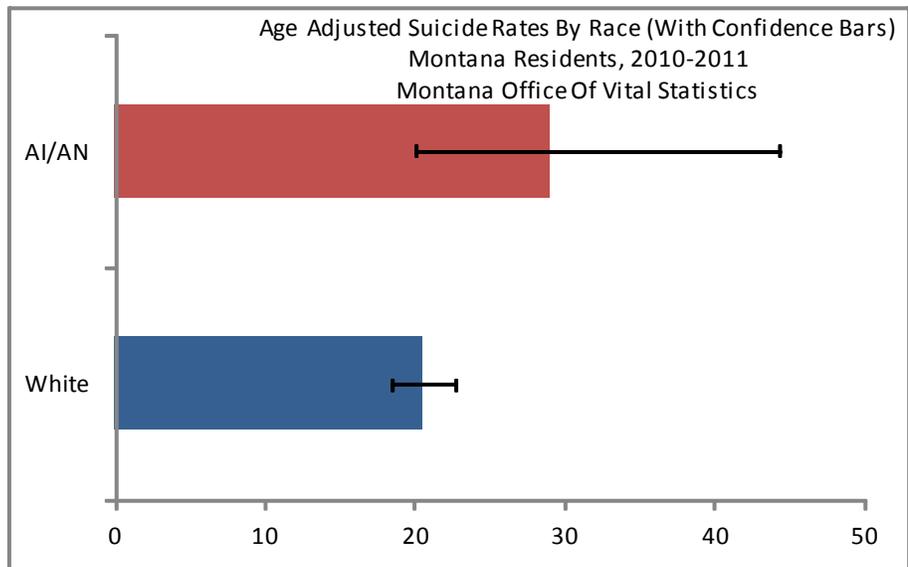


Figure 2

<u>Montana Suicides by Race, 2010-1011</u>			
	White	AI/AN	Other
Number Of Suicides	410	38	<20
Population	1,817,300	139,460	32,397
Crude Rate (When More Than 20 Events)	22.2	27.2	#
Age Adjusted Rate (When More Than 20 Events)	20.6	29	#

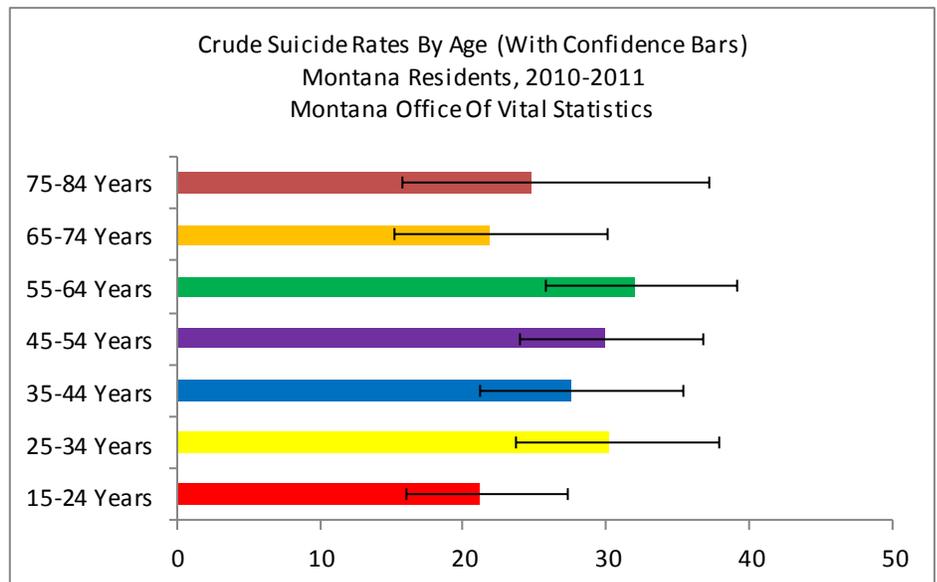
While **Figure 2** does not break down the American Indian population into the various subdivisions of nations, tribes, bands and clans, for any given time period there is a high degree of variability among these classifications, just as there is similar variability among the Caucasian population when stratified by counties, cities and towns.

Specific risk factors for American Indian communities contribute to the suicide rates for this population. These include high unemployment rates, substance abuse, alienation and varying cultural views on suicide. A major issue among the American Indian communities is the separation taking place between generations. Traditionally, the youth have looked towards the tribal elders for guidance and identity. However, in recent generations, there has been a breakdown in this guidance. Subsequently, American Indian youth appear more hopeless and unsure of their place in their culture. This may contribute to the high number of suicides among American Indian youth.

Age

When all ages are combined, suicide is ranked the 9th leading cause of death for Montanans. However, when those rankings are examined by age group, the risk of suicide for Montanans over the past two years is a prominent public health issue from adolescents through the life span.

For 2010-2011, there were 57 suicides by Montanans ages 15 to 24, 75 suicides between the ages 25 to 34, 62 between the ages 35 to 44, 88 for ages 45 to 54, 91 for ages 55 to 64, 36 for ages 65 to 74, and 23 for ages 75 to 84 and 15 for ages 85 and over (Montana Office of Vital Statistics, 2012). For all of these age groups, the rate of suicide was near or double the national rate. **Figure 3** documents the rate of suicide for different age ranges in Montana for 2010-2011.



Montana Suicide Rates by Age Group, 2010-2011

Age Groups	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Number Of Suicides	57	75	62	88	91	36	23	15
Population	270,303	248,150	224,537	294,568	284,722	165,464	92,658	40,955
Crude Rate (When More Than 20 Events)	21.1	30.2	27.6	29.9	32	21.8	24.8	#
Age Adjusted Rate (When More Than 20 Events)	27.3	37.9	35.4	36.8	39.2	30.1	37.2	#

Lethal Means

A number of means are used in the act of suicide in Montana. Of these, firearms is the most common means of completing suicide accounting for 291 of the 452 suicides for 2010-2011, followed by suffocation (76) and poisoning (69). Other means include: drowning, cutting/piercing, jumping from heights, fire/burn, and motor vehicle

Figure 4 verifies the preponderance of firearms in Montana suicides.

	Number by Means	%
Total Suicides	452	100
Firearm	291	64.4
Suffocation	76	16.8
Poisoning	69	15.3
Other Methods	8	1.8
Cut or pierce	4	0.9
Drown	4	0.9

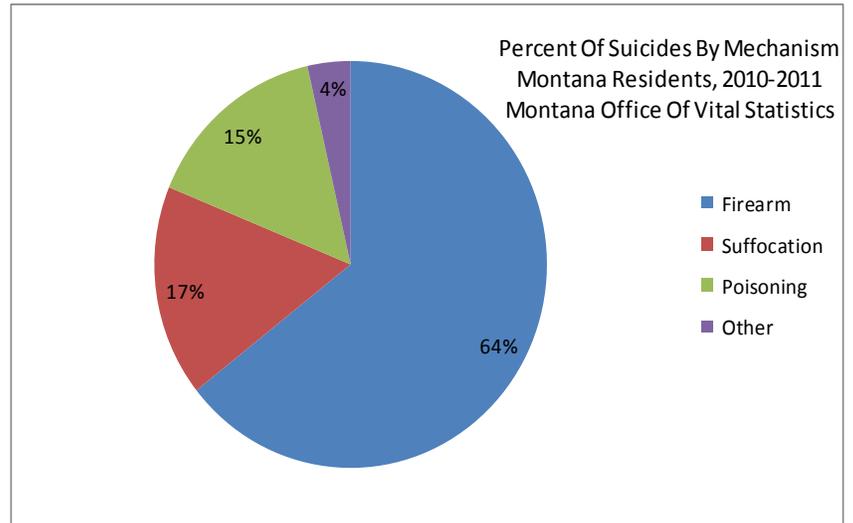


Figure 4

Alcohol and Suicide

Alcohol has long been known to play a role in suicides, but there have been little data regarding which victims use it and how often until recently. In 2006, the National Violent Death Reporting System conducted a 16 state study (MMWR, 2009) concerning alcohol and suicide and found that among suicide decedents, 33.3% tested positive for alcohol. Out of those, 56.3% had been legally drunk, with a blood alcohol content at or above the federal standard of 0.08, or 8 milligrams of alcohol per 100 milliliters of blood (see table 6). This is especially relevant in Montana,

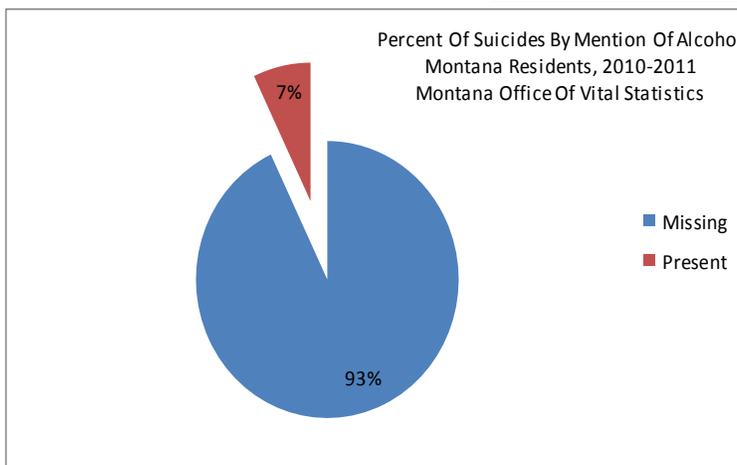
TABLE 6. Number* and percentage of suicide victims tested for alcohol and drugs whose results were positive, by toxicology variable — National Violent Death Reporting System, 16 states,† 2006

Toxicology variable	Tested		Positive	
	No.	%	No.	%
Blood alcohol concentration (BAC) [§]	6,234	72.5	2,073	33.3
BAC ≤ 0.08 mg/dL			744	35.9
BAC >0.08 mg/dL			1,167	56.3
Alcohol-positive, level unknown			162	7.8
Amphetamine	3,767	43.8	149	4.0
Antidepressant	3,541	41.2	952	26.9
Cocaine	4,260	49.5	438	10.3
Marijuana	3,085	35.9	249	8.1
Opiate	4,287	49.9	820	19.1
Other drug(s)	3,801	44.2	1,837	48.3

* N = 8,599.

† Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin.

§ BAC of >0.08 mg/dL used as standard for intoxication. Other substances indicated if any results were positive; levels for these substances are not measured



where the state has often been near the top in the nation in alcohol-related deaths, underage drinking, and binge drinking. However, it is very difficult to determine the role of alcohol in Montana suicides since alcohol use is not a required item on the Montana death certificate. We must rely on the medical certifier to provide that information, therefore we cannot be sure we detected the cases that actually occurred. Of the information that we did receive, about 7% of the suicides in Montana were found to involve alcohol in 2010-2011.

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 2011 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>):

- During the 12 months before the survey, 25.3% of students statewide had felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities.
- Statewide, 15.2% of students had seriously considered attempting suicide during the 12 months before the survey.
- During the 12 months before the survey, 12.3% of students statewide had made a plan about how they would attempt suicide.
- Statewide, 6.5% of students had attempted suicide one or more times during the 12 months before the survey. **(Lowest rate in 20 years)**
- During the 12 months before the survey, 2.4% of students statewide had made a suicide attempt that resulted in an injury, poisoning, or an overdose that had to be treated by a doctor or nurse.

The news is even worse for Montana American Indian students on or near a reservation:

- During the 12 months before the survey, 30.9% of American Indian students had felt so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities.
- 21.2% of American Indian students had seriously considered attempting suicide during the 12 months before the survey.
- During the 12 months before the survey, 15.1% of American Indian students had made a plan about how they would attempt suicide.
- 11.9% of American Indian students had attempted suicide one or more times during the 12 months before the survey.
- During the 12 months before the survey, 5.2% of students statewide had made a suicide attempt that resulted in an injury, poisoning, or an overdose that had to be treated by a doctor or nurse.

Montana High School Survey - YRBS Results

Survey Year

Trend Report

1999 2001 2003 2005 2007 2009 2011

Injury and Violence	1999	2001	2003	2005	2007	2009	2011
Percentage of students who felt so sad and hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	25.9	26.6	26.4	25.6	25.8	27.3	25.3
Percentage of students who seriously considered attempting suicide during the past 12 months	18.6	19.4	18.9	17.5	15.1	17.4	15.2
Percentage of students who made a plan about how they would attempt suicide during the past 12 months	15.6	16.3	14.8	14.6	13.2	13.4	12.3
Percentage of students who actually attempted suicide one or more times during the past 12 months	6.7	10.4	9.7	10.3	7.9	7.7	6.5
Percentage of students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.	2.5	3.7	3	3.1	2.7	2.8	2.4

**10 Leading Causes of Death, Montana
1999 - 2009, All Races, Both Sexes**

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 205	Unintentional Injury 67	Unintentional Injury 59	Unintentional Injury 61	Unintentional Injury 882	Unintentional Injury 642	Unintentional Injury 770	Malignant Neoplasms 1,560	Malignant Neoplasms 3,405	Heart Disease 17,415	Heart Disease 21,181
2	SIDS 124	Congenital Anomalies 20	Malignant Neoplasms 22	Suicide 28	Suicide 293	Suicide 318	Malignant Neoplasms 384	Heart Disease 1,157	Heart Disease 2,174	Malignant Neoplasms 15,327	Malignant Neoplasms —
3	Short Gestation 67	Homicide 14	Homicide 10	Malignant Neoplasms 13	Homicide 78	Malignant Neoplasms 99	Suicide 383	Unintentional Injury 841	Unintentional Injury 581	Chronic Low. Respiratory Disease 5,742	Chronic Low. Respiratory Disease 6,460
4	Maternal Pregnancy Comp. 42	Malignant Neoplasms 13	Congenital Anomalies —	Homicide —	Malignant Neoplasms 73	Heart Disease 64	Heart Disease 320	Suicide 389	Chronic Low. Respiratory Disease 547	Cerebro-vascular 5,265	Unintentional Injury 5,908
5	Placenta Cord Membranes 34	Heart Disease 10	Influenza & Pneumonia —	Congenital Anomalies —	Heart Disease 22	Homicide 64	Liver Disease 167	Liver Disease 356	Diabetes Mellitus 344	Alzheimer's Disease 2,703	Cerebro-vascular 5,809
6	Unintentional Injury 31	Influenza & Pneumonia —	Heart Disease —	Heart Disease —	Diabetes Mellitus —	Liver Disease 32	Diabetes Mellitus 64	Diabetes Mellitus 187	Liver Disease 324	Diabetes Mellitus 2,049	Alzheimer's Disease 2,724
7	Neonatal Hemorrhage 23	Five Tied —	Six Tied —	Influenza & Pneumonia —	Congenital Anomalies —	Diabetes Mellitus 25	Homicide 63	Cerebro-vascular 154	Cerebro-vascular 314	Influenza & Pneumonia 1,980	Diabetes Mellitus 2,682
8	Circulatory System Disease 18	Five Tied —	Six Tied —	Diabetes Mellitus —	Nephritis —	Congenital Anomalies 15	Cerebro-vascular 55	Chronic Low. Respiratory Disease 141	Suicide 268	Unintentional Injury 1,953	Influenza & Pneumonia 2,232
9	Three Tied 12	Five Tied —	Six Tied —	Six Tied —	Three Tied —	Cerebro-vascular 12	Septicemia 32	Viral Hepatitis 79	Influenza & Pneumonia 104	Nephritis 1,154	Suicide 2,047
10	Three Tied 12	Five Tied —	Six Tied —	Six Tied —	Three Tied —	Complicated Pregnancy 11	Influenza & Pneumonia 31	Influenza & Pneumonia 77	Septicemia 90	Parkinson's Disease 757	Nephritis 1,281

Source: http://www.cdc.gov/injury/wisqars/leading_causes_death.html. Obtained August 16, 2012

What is Suicide Costing the State of Montana?

- Total cost estimates are additive both within the state and across states to the U.S. total.
- * Cost estimates based on 20 or fewer deaths may be unstable. Interpret with caution.
- Note: For injury-related deaths, lifetime medical costs refer to the medical costs associated with the fatal injury event.
- Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
- Data Source: NCHS Vital Statistics System for numbers of deaths. NEISS All Injury Program operated by the U.S. Consumer Product Safety. Obtained August 3, 2012 from <http://www.cdc.gov/injury/wisqars/fatal.html>
- Commission (CPSC) for numbers of nonfatal injuries. Pacific Institute for Research and Evaluation (PIRE), Calverton, MD for unit cost estimates.

**Fatal Injuries, Both
Sexes, All Ages,
Montana, 2005
Intent: Suicide
Mechanism: All
Number of Deaths and
Estimated Average and
Total Lifetime Costs**
Classified by Mechanism and Intent
Costs Expressed in 2005 U.S. Prices

Deaths and Type of Cost			Intent Suicide
Mechanism	Deaths	--	206
	Medical Cost	Average	\$2,446
		Total	\$504,000
All Mechanisms	Work Loss Cost	Average	\$1,091,392
		Total	\$224,827,000
	Combined Cost	Average	\$1,093,837
Total		\$225,331,000	

Risk and Protective Factors associated with Suicide

Risk Factors

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

Biopsychosocial Risk Factors

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

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

Environmental Risk Factors

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

Socio-cultural Risk Factors

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

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

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

Family Risk Factors

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

Environmental Risk Factors

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

Behavioral Risk Factors

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

Personal Risk Factors

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

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

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

Protective Factors

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

According to the National Strategy of Suicide Prevention (2001), protective factors for all ages include:

- Effective and appropriate clinical care for mental, physical and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts, including American Indians practice of non-separation of culture, spirituality, and/or religion

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

Protective Factors for the Young

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

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

Protective Factors for the Elderly

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

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

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

Opportunities for Prevention Activities

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

Youth – Ages 10 - 24

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

Possible prevention measures for this group include:

- Implementation of the “Good Behavior Game” in 1st and 2nd grade. Studies have suggested that the skills taught in this game may delay or prevent onset of suicidal ideations and attempts in early adulthood (Wilcox et al., 2008).
- Implementation of evidenced-based school curriculums, such as Signs of Suicide (SOS), Teen Screen, Yellow Ribbon Program, Safe Talk, or the American Indian Life Skills Development, into Montana schools.
- Distribution of suicide prevention toolkits for rural primary care providers. The purpose of the toolkits is to provide physicians, nurses, and health care staff with screening tools and state-wide resources to manage suicidal patients.
- Increase in awareness and access to counseling services provided at state colleges and universities.
- Home visitation to high risk young families by public health or school personnel.
- Therapeutic Foster Care for high needs youth to provide a safe environment in which “wrap around” services could be provided.
- Inclusive, drug free, violence free, after school activity programs that run between 3pm – 8pm; offering a wide array of activities including the arts, volunteer opportunities and sports which will appeal to youths of varied backgrounds. These programs provide adult supervision by both qualified staff and volunteers and provide a forum for community resiliency and mentoring.

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

Older Adults – Ages 25 - 64

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

- Addressing the significant stigma associated with admitting to having depression or a mental illness. This could be achieved through a public awareness campaign addressing the myths and stereotypes associated with having a mental illness and beginning to challenge the culture of acceptance around suicide.
- Continued implementation of evidenced-based gatekeeping programs such as QPR and ASIST in communities to increase recognition of warning signs of suicide and to intervene with appropriate assistance.
- As the primary first responders, increase the number of law enforcement personnel and correctional officers around the state trained in Crisis Intervention Training (CIT).
- Having physicians receive gatekeeper training and subsequently assessing all patients for depression (universal screening) and suicide risk factors and making appropriate and timely referrals for mental health services.
- Due to the correlation between smoking and suicidal behavior (see section later in report on suicide and smoking), focus smoking cessation campaigns towards this age group.

- Crisis lines - recently, two large SAMHSA-funded studies found that telephone crisis services, like those in the Lifeline network, can provide an effective mental health and suicide prevention service for callers (Kalafat et al., 2007; Gould et al., 2007). A study of 1,085 suicidal and 1,617 non-suicidal crisis callers to 8 crisis lines found that callers showed significant reductions on all measures of emotional distress, hopelessness and suicidality by the end of the call, as well as at follow-up 2 to 3 weeks later.
- Development of lay provider crisis intervention teams, creating more hospital beds designated for mental health, and suicide stigma reduction campaigns would increase intervention possibilities for suicidal individuals.
- As in the younger group, increase in awareness and access to counseling services provided at state colleges and universities.

Senior Caucasian Males, Over Age 65

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

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

This group has one of the highest rates of suicide in the United States and Montana:

- In the US in 2009, 5,870 people over the age of 65 died by suicide for a rate of 14.83 per 100,000 people.
- The rate of suicide for women typically declines after age 60. 84% of elderly suicides are by men. Elderly men are more than 5 times the risk of suicide than elderly woman.
- 73% of elderly people who completed suicide saw their primary care physician within a month of their suicide. Nearly half of those saw their primary care physician within 2 weeks of their suicide.
- Between 2000 and 2009, there were 324 suicides for Montanans over the age of 65. This equates to an approximate rate of 25.51 per 100,000.

Other Populations in Montana with a high risk of Suicide

Suicide Among American Indians

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 :

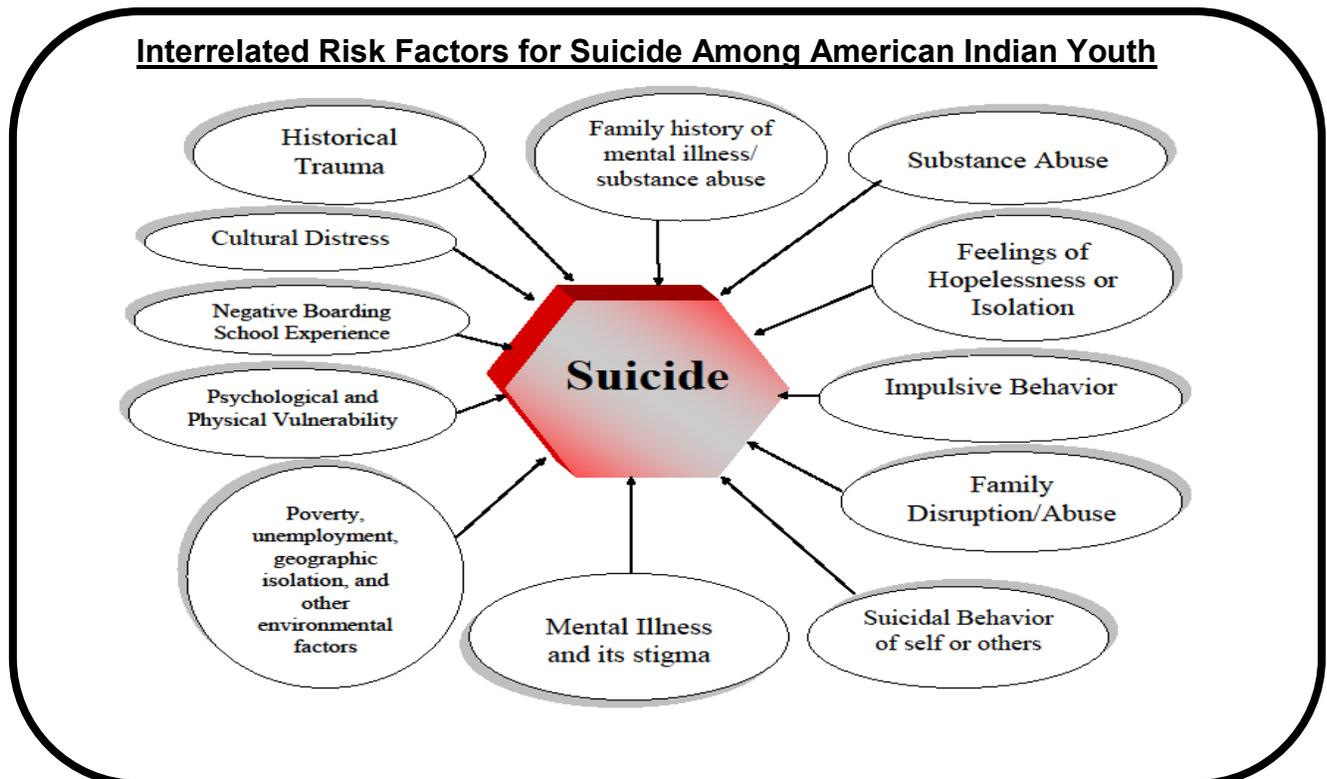
- 13.5% of the deaths of 10-14 year olds (7.2% for all races)
- 26.5% of the deaths of 15-19 year olds
- 15.9% of the deaths of 20-24 year olds; and
- 14.7% of the deaths of 25-34

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

Youth Statistics

- 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.
- For American Indian students in urban settings, 18.9% had attempted suicide one or more times in the twelve months before the survey.
- From 2000 to 2009, American Indian/Alaska Native males in the 15 to 24 year old age group had the highest suicide rate, 30.99 per 100,000, compared to white (17.33 per 100,000), black (11.71 per 100,000), and Asian/Pacific Islander (9.51 per 100,000) males of the same age.



Interrelated Risk Factors for Suicide Among American Indian Youth

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

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

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

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

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

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

What is important to understand is that although most young American Indians did not experience the historical trauma that their ancestors did, generational changes to the family system were caused that effect how families function. It is estimated that it took 7 generations for the historical trauma to get to where it is today and will take 7 generations to fix it.

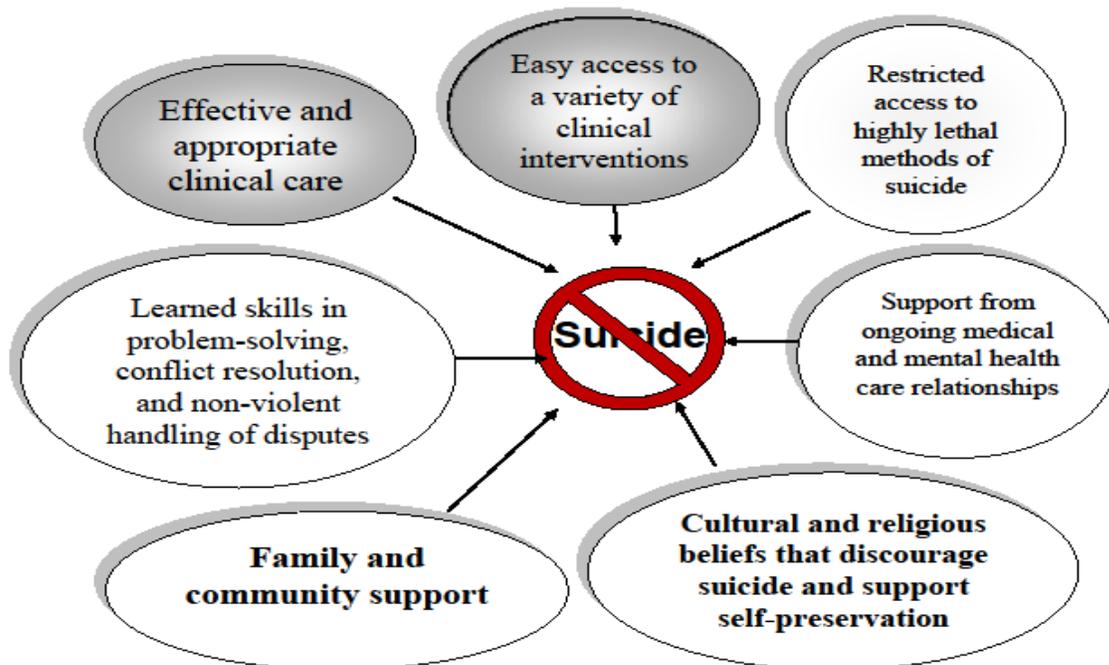
Historical trauma may also have an effect on the help-seeking behavior of American Indian youth. They may believe these services represent the "white man's" system and culture or that the professional will not understand Native ways. Not only do a majority of American Indians use traditional healing,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

Mental Health Considerations

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

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

Ethnic and Cultural Considerations

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

Strengths and Protective Factors

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

What can be done at the Community Level?

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

Canadian First Nations Elder

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

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

Suicide among Montana's Veterans

Another special population in Montana that is at high risk of suicide is Montana's military veterans. Between 2002 and 2011, there were 460 suicides by Montana veterans of all ages (Office of Vital Statistics, Montana DPHHS, August, 2012), which gives Montana veterans a estimated rate of 53 per 100,000. Montana has more than 100,000 veterans or nearly one person in every 10. Montana had the highest recruitment in the nation per capita into the U.S. Army in 2004 and 2005. Montana has more than 700 Army National Guard Soldiers between the ages of 18 and 24 who have been deployed to date for both CONUS (Continental United States) and OCONUS (Outside the Continental United States) missions in support of OIF (Operation Iraqi Freedom) and OEF (Operation Enduring Freedom). Suicide is not only a major concern in Montana but at a national level as well. Of the 36,000 suicides each year in America, about 20 percent are committed by veterans. The VA estimates the suicide rate for young veteran men between the ages of 18-29 is around 56 per 100,000. In the US, a veteran dies by suicide every 80 minutes, about 18 a day, or 6,500 suicides a year. (Losing the Battle: The Challenge of Military Suicide, 2011) Suicide attempts by Iraq and Afghanistan veterans remain a key area of concern. In 2009 there were 1,621 suicide attempts by men and 247 by women who served in Iraq or Afghanistan, with 94 men and four women dying.

Troubling new data show there's an average of 950 suicide attempts each month by veterans who are receiving some type of treatment from the Veterans Affairs Department (Army Times, April 26, 2010). Seven percent of the attempts are successful, and 11 percent of those who don't succeed on the first attempt try again within nine months. Of even greater concern, veterans who did not access VA health demonstrated an even higher rate of completed suicide than their peers who were enrolled in treatment from the VA (USA Today, 1/11/2010). That's a change from 2005. A key part of the new data shows the suicide rate is lower for veterans aged 18 to 29 who are using VA health care services than those who are not. That leads VA officials to believe that about 250 lives have been saved each year as a result of VA treatment. Access to care appears to be a key factor. Once a veteran is inside the VA care program, screening programs are in place to identify those with problems, and special efforts are made to track those considered at high risk, such as monitoring whether they are keeping appointments.

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

Suicide Signs Unique to Vets

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

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

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

In this VA treatment population, male veterans were more likely to complete suicide than female veterans. Suicide rates were 89.5 per 100,000 for depressed veteran men and 28.9 per 100,000 for veteran women.

However, the differential in rates between men and women (3:1) was smaller than has been observed in the general population (4:1).

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



Veterans Suicide Prevention Hotline

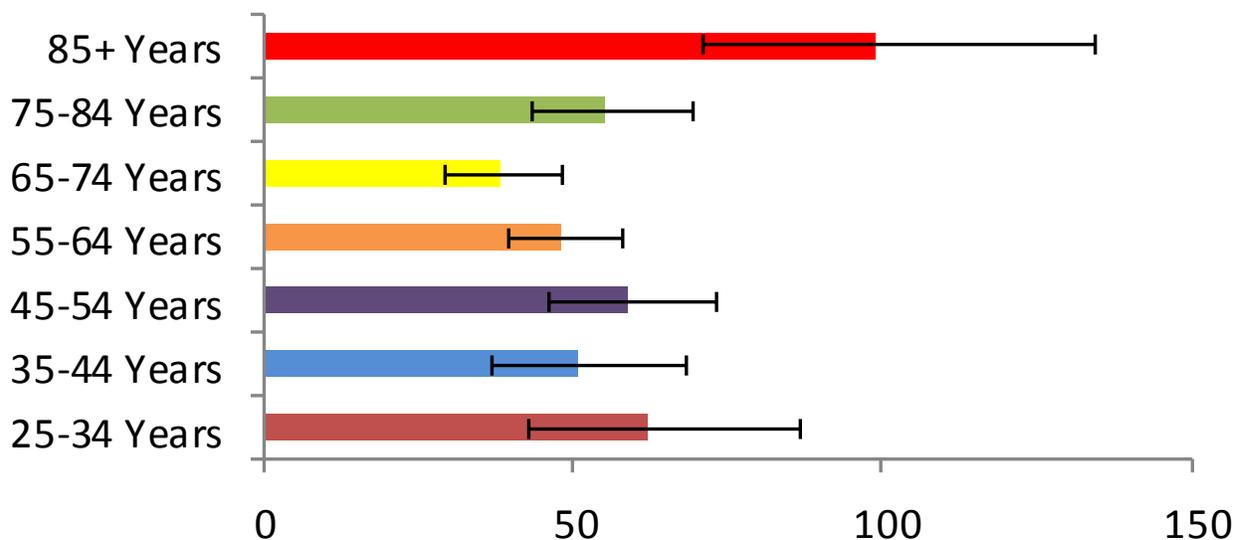
1-800-273-TALK, Veterans Press 1

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

Suicide among Montana Veterans, 2002-2011

Age Groups	25-34	35-44	45-54	55-64	65-74	75-84	85+
Number Of Suicides	34	45	76	109	68	75	41
Population	54,721	88,491	129,579	226,914	179,268	135,921	41,449
Crude Rate (When More Than 20 Events)	62.1	50.9	58.7	48.0	37.9	55.2	98.9
Age Adjusted Rate	86.8	68.0	73.4	57.9	48.1	69.2	134.2

Crude Suicide Rates By Age (With Confidence Bars)
 Montana Male Veterans, 2002-2011
 Montana Office Of Vital Statistics



About the Montana VA Mental Health Care System

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

Services Offered

Mental health services provided include treatments for:

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

Confidentiality

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



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

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

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

At the 18-month mark, each service member completes another, identical PDHRA online to identify if any reintegration issues have surfaced. A MTNG staff member will call any service member whose assessment is flagged, and if a condition is identified, they will be referred to counseling. At the two-year mark and on an annual basis thereafter, all service members must again have a Periodic Health Assessment and talk to both a physician and behavioral health provider. Senator Max Baucus of Montana recently proposed S. 711, the Post Deployment Health Assessment Act of 2009, which would make the PDHRA a mandated national program.

Suicide among those with Serious Mental Illness (SMI)

According to Mental Health America (Mark, et al., 2007), 12.46% of Montana's adult population has serious psychological distress and approximately 9% of Montana adolescents and adults have major depressive episodes. Individuals with serious mental illness (SMI) constitute 6-8% of the U.S. population, but account for several times that proportion of the 36,000 suicides that occur each year in the country (Litts et al. 2008). For people with virtually every category of SMI, suicide is a leading cause of death, with lifetime risks ranging from 4-8%. Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors. Still, a large majority of those with SMI neither attempt nor die by suicide and predicting those who will presents a significant challenge.

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

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

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

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

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

The following mental disorders present a high risk of suicide:

Mood Disorders

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

Schizophrenia

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

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

Anxiety Disorders

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

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

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

Substance Use Disorders

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

Increased Risk of Suicide among Suicide Survivors

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

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

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

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

Other resources for survivors can be found at the Suicide Prevention Resource Center's library for survivors at <http://library.sprc.org/browse.php?catid=11> . A survivor handbook is also available on the Montana Suicide Prevention website at www.prc.mt.gov/suicideprevention

Suicide in Prisons and Jails

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

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

The most common means of suicide by inmates is by hanging, which can result in death in five or six minutes. Severe brain damage from hanging can occur in as little as four minutes. Inmates have died after hanging themselves from clothing hooks, shower knobs, cell doors, sinks, ventilation grates, windows, and smoke detectors. According to the Montana Office of Vital Statistics (2012), local Coroners reported 21 suicides in Montana's State Prison, federal detention centers, or county jails between 2003 and 2011. Hanging was the means in all but one of the cases. Four of the suicides occurred in the Montana State Prison, 16 occurred in county jails or detention centers, and one occurred in a federal detention center. **BECAUSE THERE IS NOT AN RELIABLE MEANS OF COLLECTING THIS DATA, WE KNOW THESE NUMBERS**

Suicide Prevention in Montana's Correctional Facilities

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

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

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

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

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

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

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

ARE NOT ACCURATE, WITH THE ACTUAL NUMBER OF JAIL SUICIDES ESTIMATED TO BE NEARLY DOUBLE WHAT IS KNOWN TO VITAL STATISTICS.

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

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

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

Demographics of a Jail Suicide

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

Demographics of the Inmate

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

History of Mental Illness or Substance Abuse

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

Time Demographics

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

Means

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

Characteristics of the jail facility

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

Juvenile Suicide in Confinement

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

Demographics of the Inmate

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

History of Mental Illness or Substance Abuse

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

Means

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

Time Demographics

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

Characteristics of the jail facility

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

Suicide and Sexual Orientation

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

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

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

The primary protective factors include:

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

There is little research concerning how much of a factor this is in Montana, however nationally, studies have shown that youth with same-sex orientation are 2-3 times more likely than their same-sex peers to attempt suicide (Russel, S.T. & Joyner, K., 2001, Centre for Suicide Prevention, 2003). Approximately 15% of youth who reported suicide attempts also reported same-sex attraction or relationships. These youth also presented as higher risk for alcohol abuse and depression. In Montana, the number of gay and lesbians is difficult to determine. However, according to a report from the Williams Institute (Gates, 2006), as of 2005, there were 1,600 same-sex couples in Montana, up from 1,200 in 2000. This number is considered to be significantly lower than the actual number, especially since this number does not include youth. This study indicated that there were a similar number of same-sex male couples (806) as there were same-sex female couples (853). The report estimated that 2.6% of Montana's population was gay, lesbian, or bisexual. Based on the Montana's 2011 estimated population (US Bureau of the Census, www.census.gov), this equates that the gay, lesbian, or bisexual adult population in Montana is just under 26,000.

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

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

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

Suicide and Smoking

According to the Center for Disease Control (Sustaining State Programs for Tobacco Control: Data Highlights 2010), 18.5% (138,000) of Montana adults smoke and 12.2% (11,000) of Montana youth (ages 12-17) smoke. An average of 1,400 Montanans die each year from smoking-attributable causes and it is projected that another 18,000 youth will die from smoking. There have been a number of studies that indicate a correlation between smoking and increased risk of suicide. Hemenway, et al (1993) found a strong correlation between suicide and smoking in nurses. In their study, women who smoked 1 through 24 cigarettes per day had twice the likelihood of committing suicide as those who had never smoked. Women who smoked more than 25 cigarettes per day had four times the likelihood of suicide in the succeeding 2 years as those who had never smoked. In another study published in the American Journal of Public Health (Miller, M. et al., 2000), compared with never smokers, heavy smokers were at increased risk for suicide. The risk of suicide increased with the number of cigarettes smoked daily. Current smokers of 15 or more cigarettes per day had more than 4 times the risk of suicide compared with never smokers. The suicide

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

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

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

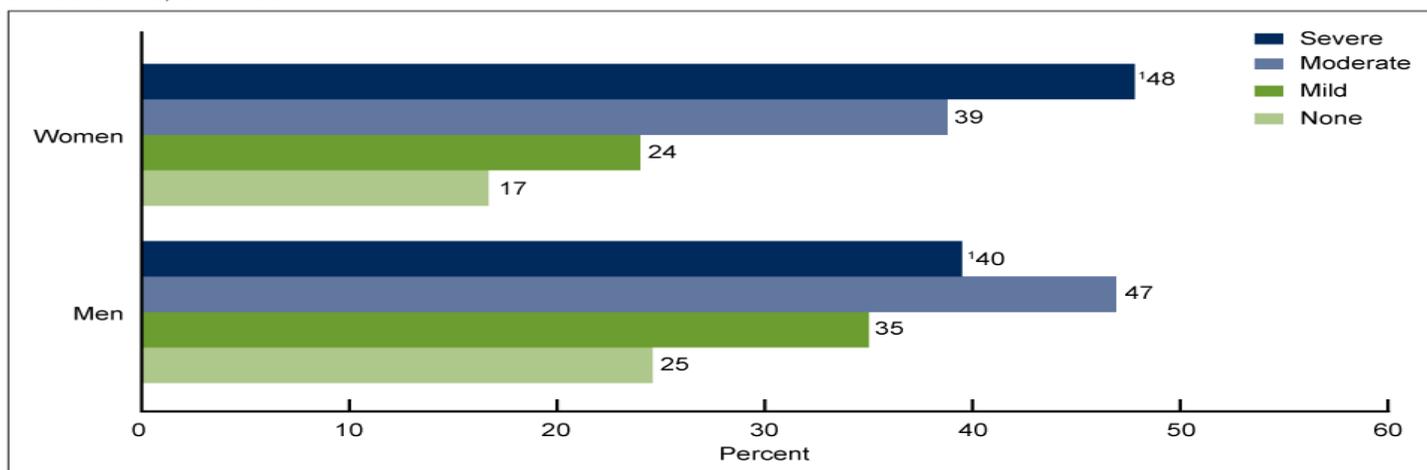
The proportion of adults who were current smokers tended to increase with an increase in depression severity. Even persons with mild depressive symptoms below the threshold for the diagnosis of depression were more likely to be smokers than people with no depressive symptoms. Adults with depression were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

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

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

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

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



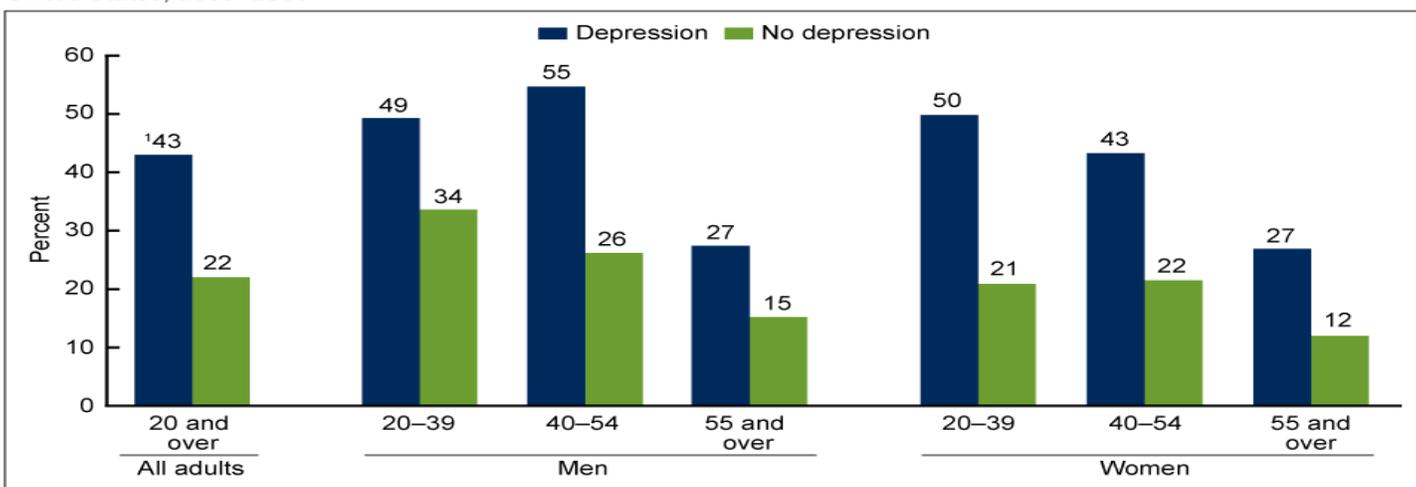
¹Statistically significant trend.

NOTES: Moderate or severe indicate depression, while mild indicates mild depressive symptoms. Access data table for Figure 2 at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig02.xls or ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig02.csv.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Surveys, 2005–2008.

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

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



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

NOTE: Access data table for Figure 1 at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig01.xls or ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/db034/fig01.csv.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Surveys, 2005–2008.

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

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

The Vision

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

The Mission

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

The Goals and Measurable Objectives

Although Montana has had one of the highest rates of suicide in the nation for decades, it has only been in the last couple of years that an investment in preventing this public health issue has been made. In the past few years there has been legislation to address the issue of suicide along with significant efforts at the state, local, and tribal levels. However, change does not occur over night and with the issue of suicide, we are talking about changing a culture, and that takes time. Montana is also a large frontier state and many local efforts go unnoticed and collaboration is often difficult.

To accomplish our mission and move towards the realization of our vision there are several key goals which we want to focus on in the next five years. Interventions to accomplish these goals and objectives can be found throughout this report, but specifically have been identified in the **Opportunities for Prevention Activities** section. [Below are the original measurable objectives identified in the 2008 state plan along with the progress achieved and updated objectives for the 2013 state plan.](#)

Reduce the incidence of completed suicide in Montana.

Measurable Objective: By 2013, Montana will be out of the national top 5 for rate of suicide as evidenced by final data for the *National Vital Statistics Reports*. This would equate to preventing approximately 30 suicides in a given year in Montana.

Progress: None. We continue to have the highest suicide rate in the country.

Change in Objective: Continue with goal and look at 2018 to achieve goal.

Measurable Objective: By 2013, the Youth Risk Behavior Survey will demonstrate a 10% decrease in the number of youth reporting attempting suicide (compared to the 2009 survey).

Progress: Marginal. According to the 2011 YRBS, 6.5% of students had attempted suicide one or more times during the 12 months before the survey. This is the lowest percentage in more than 20 years. However, it is too soon to determine if this is a trend until we see the 2013 results.

Change in Objective: Continue. Monitor 2013 and 2015 YRBS data to see if percentage decrease continues.

Measurable Objective: By 2013, the Behavior Risk Surveillance System will demonstrate a 10% decrease in the number of adults reporting attempting suicide.

Progress: None. In 2010, an estimated 3,600 to 5,500 (11.5%, 95% CI 3.6-11.7) non-institutionalized adult population actually attempted suicide one or more times in the prior year. This percentage was lower than in 2009 (19.0%, 95% CI 11.4-29.8), but it was not significantly different statistically (Montana Behavioral Risk Factor Surveillance System 2009 and 2010 data sets)

Change in Objective: Continue with goal and look at 2018 to achieve goal

To dedicate sufficient personnel and fiscal resources to address the issue of suicide prevention activities in a structured and long-term manner,

Measurable Objective: DPHHS will continue to allocate \$400,000 a year toward supporting suicide prevention in the state.

Progress: Marginal. Recent budget cuts have resulted in a 5% cut to the suicide prevention budget.

Change in Objective: Continue to fund prevention activities around the state.

Measurable Objective: DPHHS will identify and apply for future suicide prevention grants.

Progress: Marginal. DPHHS has received nearly \$250,000 dollars in grants through Bresnan Communication, the Montana Mental Health Settlement Trust Grant, and the Federal Rural Flex Veterans Grant.

Change in Objective: Continue to seek funding for prevention activities around the state.

To increase public awareness and concern around the issue of suicide as a leading cause of death and significant public health problem in Montana,

Measurable Objective: By 2011, implement a media campaign targeting 75% of Montana's population.

Progress: Good. Through media campaigns with the Optimum Communication, Northern Broadcasting, Montana Broadcasters Association, Learfield Sports Management, and Facebook, it is estimated that 80% of Montana's population has been exposed to the Montana Suicide Prevention program.

Change in Objective: Continue with goal to increase exposure to all Montana residents.

Measurable Objective: By 2011, educate all policy makers with research-based information about suicide in Montana.

Progress: Good. Before each legislative session, an updated version of this plan is provided to all legislators.

Change in Objective: Continue to provide policy makers with the most up to date information available concerning suicide prevention in Montana.

Measurable Objective: By 2013, provide gatekeeper (QPR, ASIST) curriculum to 50% of Montana's American Indian population on reservations as measured by Planting Seeds of Hope.

Progress: Good. According to Planting Seeds of Hope, more than 33% of Montana's American Indian population on reservations (almost 3,500 people) has received suicide prevention training since 2009.

Change in Objective: Continue with goal and look at 2018 to achieve goal

Measurable Objective: By 2013, provide gatekeeper curriculum to 10% of Montana's population.

Progress: Marginal. As of August, 2012, approximately 24,000 people have received gatekeeper training in Montana over the past 5 years.

Change in Objective: Reduce percentage to 5% and look at 2018 to achieve goal

Measurable Objective: By 2013, provide Crisis Intervention Training to 40% of all law enforcement and correctional officers.

Progress: Marginal. More than 600 officers (approximately 20%) have been trained. However, the basic mental health course and suicide prevention course have been expanded at the Montana Law Enforcement Academy and is now part of the core curriculum. An additional 1,100 officers have received either the mental health training or the suicide prevention training.

Change in Objective: By 2013, 50% of all law enforcement and correctional officers will receive either Crisis Intervention Training, mental health training, or suicide prevention training..

Increase evidenced-based suicide prevention curriculum being implemented in Montana's high schools.

Measurable Objective: By 2013, 50% of Montana's high schools (87 out of 175) will have an evidenced-based suicide prevention curriculum implemented.

Progress: Good. As of August, 2012, 90 high schools and 60 middle and alternative schools have received the suicide prevention programs (SOS, QPR, Yellow Ribbon).

Change in Objective: Continue with goal to reach as many students as possible.

Measurable Objective: By 2013, 50% of Montana's high school students will have been exposed to an evidenced-based suicide prevention curriculum in their high schools.

Progress: Unknown due to inability to collect accurate data.

Change in Objective: Discontinue due to difficulty in collecting data (number of students). Focus on increasing the number of schools with prevention programs (above objective)

To work together in a collaborative, coordinated manner at the local, regional, tribal and state levels to best implement strategies and practices for suicide prevention.

Measurable Objective: The State Suicide Prevention Coordinator will meet with local prevention specialists in all corners of the state on an annual basis to identify accomplishments, barriers, and collaborate on prevention efforts.

Progress: Good. More than 50 different communities have received direct services through the Suicide Prevention program and representatives from all 56 counties have received training in suicide prevention.

Change in Objective: Continue to be a resource to every community in the state.

The Environment for Suicide Prevention in Montana

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

Perceptions that create barriers

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

Prevention

- Address the stigma associated with mental illness and asking for help
- Increase awareness of youth suicide prevention and focus on social/coping skill development at the elementary and middle school level
- Develop community provider networks
- Increase training for law enforcement agencies and hospital personnel
- Conduct gatekeeper (QPR, ASIST) trainings
- Provide screening programs (Teen Screen)
- Implement evidenced-based curriculum into Montana's schools (SOS, QPR, etc).
- Continue with an aggressive media campaign that increases awareness of warning signs, how to intervene, and resources.

Mo

nta

Intervention

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

Postvention

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

Coordination

- Improve communication and community linkages with mental health and substance abuse service systems serving youth and young adults.
- Demonstrate collaboration

References

1. American Association of Suicidology. (2012). *Suicide in the U.S.A.* Retrieved August 2, 2012, from <http://www.suicidology.org/associations/1045/files/SurvivorsFactSheet.pdf>
2. American Psychiatric Association. (2000). *Psychiatric services in jails and prisons* (2nd ed.). Washington, DC: Author.
3. Army Times (April 26, 2010), "18 veterans commit suicide each day". Retrieved on July 21, 2010 from http://www.armytimes.com/news/2010/04/military_veterans_suicide_042210w/
4. Beautrais, A. L. (2002). A case control study of suicide and attempted suicide in older adults. *Suicide & Life-Threatening Behavior*, 32(1), 1-9.
5. Bender, E. (2003). Study Identifies Suicide Risk Factors In Native-American Youth. *Psychiatric News*. American Psychiatric Association. 38(11). P.28.
6. Bolton, J. M., Cox, B. J., Afifi, T. O., Enns, M. W., Bienvenu, O. J., & Sareen, J. (2007). Anxiety disorders and risk for suicide attempts: Findings from the Baltimore Epidemiologic Catchment area follow-up study. *Depression & Anxiety*, Published online May 31, 2007. Retrieved April 28, 2008, from <http://dx.doi.org/10.1002/da.20314>.
7. Bureau of Justice Statistics. (August, 2005). *Suicide and Homicide in State Prisons and Local Jails*. Washington, DC: U.S. Department of Justice.
8. Bureau of Justice Statistics. (July, 2010). *Special Report: Mortality in Local Jails, 2000-2007*. Washington, DC: US Department of Justice.
9. CBS News (November 13, 2007). *Suicide Epidemic Among Veterans*. Retrieved May 22, 2008 from: http://www.cbsnews.com/stories/2007/11/13/cbsnews_investigates/main3496471.shtml
10. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (Cited August, 2012). National Center for Injury Prevention and Control, CDC (producer). Available from URL: www.cdc.gov/ncipc/wisqars/default.htm
11. Center for Disease Control and Prevention (2010). *Web-based Suicide Facts at a Glance (2007)*. Retrieved on July 6, 2010 from : <http://www.cdc.gov/ncipc/dvp/Suicide/SuicideDataSheet.pdf>
12. Centre for Suicide Prevention. (December, 2003). *Suicide Among Gay, Lesbian, Bisexual or Transgender Youth*. Retrieved on May 3, 2008 from: <http://www.suicideinfo.ca/csp/assets/alert53.pdf>
13. Children's Safety Network Economics & Data Analysis Resource Center, at Pacific Institute for Research and Evaluation, Calverton, MD, 2008. Incidence based on the National Center for Health Statistics Multiple Cause-of-Death File, 1999-2002. The costs were adapted using state-specific price adjusters.

14. Conwell, Y, Duberstein, PR, & Caine, ED (2002), Risk factors for suicide in later life. *Biological Psychiatry*. 1;52(3);193-204.
15. Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. The National Academies Press, Washington D.C. Retrieved April 28, 2008, from http://www.nap.edu/catalog.php?record_id=10398.
16. Gould, M. S., Kalafat, J., Harris-Munfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 340-354.
17. Grossman, D.C., Mueller, B.A., Riedy, C., Dowd, M.D., Villaveces, A., Prodzinski, J., Nakagawara, J., Howard, J., Thiersch, N., & Harruff, R., (2005). Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries. *Journal of the American Medical Association*. 293(6), 707-714.
18. Hawton, K., Sutton, L., Haw, C., Sinclair, J., & Deeks, J. J. (2005). Schizophrenia and suicide: Systematic review of risk factors. *British Journal of Psychiatry*, 187(1), 9-20.
19. Hemenway, D., Solnick, S., & Graham, C. (1993). Smoking and Suicide among Nurses. *American Journal of Public Health*. 83(2). 249-251.
20. Kaiser Family Foundation. (2012). *Health Insurance Coverage of the total population, states (2012)*. Retrieved August 10, 2012 from: www.statehealthfacts.org.
21. Kalafat, J., Gould, M. S., Harris-Munfakh, J. L., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Non-suicidal crisis callers. *Suicide & Life-Threatening Behavior*, 37(3), 322-339.
22. Pratt LA, Brody DJ. Depression and smoking in the U.S. household population aged 20 and over, 2005-2008. NCHS data brief, no 34. Hyattsville, MD: National Center for Health Statistics. 2010.
23. Litts, D. A., Radke, A. Q., & Silverman, M. M. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. National Association of State Mental Health Program Directors/Suicide Prevention Resource Center.
24. Luoma, J.B., Martin, C.A., & Pearson J.L., (2002). Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. *Am J Psychiatry*, 159:909-916, June 2002.

25. Maine Youth Suicide Prevention Program (2006). Maine Department of Health and Human Services. Retrieved May 1, 2008 from <http://maine.gov/suicide/about/riskprot.htm>
26. Mann, JJ. (1998). The neurobiology of suicide. *Nature Medicine*. 4:25-30.
27. Mark, T., Shern, D., Bagalman, J.E., & Cao, Z. (December, 2007). Ranking America's Mental Health: An Analysis of Depression Across the States. Alexandria, VA. Mental Health America.
28. Miller, M., Hemenway, D., & Rimum, E. (2000). Cigarettes and Suicide: A Prospective Study of 50,000 Men. *American Journal of Public Health*. 90(5), 768-773.
29. Montana Strategic Suicide Prevention Plan Work Group. Meeting held in Helena, Montana on March 24, 2008.
30. Montana Tobacco Prevention Advisory Board (2012). Montana Tobacco Use Prevention Plan. Montana Department of Public Health and Human Services.
31. Montana Youth Risk Behavior Survey (2009), Montana Office of Public Instruction.
32. Montana Youth Risk Behavior Survey (2011), Montana Office of Public Instruction.
33. National Center for Posttraumatic Stress Disorder (2007), National Center for PTSD Fact Sheet: PTSD and Suicide. United States Department of Veteran Affairs. Retrieved April 28, 2008 from http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_suicide.html
34. National strategy for suicide prevention: Goals and objectives for action. Rockville, MD: US Dept. of Health and Human Services, Public Health Service, 2001.
35. Highlights section and Detailed Tables for the NVSR (2012 January). Deaths: Final Data for 2009, *National Vital Statistics Report*, 60(3). Obtained August, 2012;
36. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (2006). *The OAS Report: Suicidal Thoughts, suicide attempts, major depressive episode & substance use among adults*. Retrieved April 28, 2008, from <http://www.oas.samhsa.gov/2k6/suicide/suicide.pdf>
37. Office of Epidemiology and Scientific Support (Office of Vital Statistics), Montana Department of Public Health and Human Services. (August, 2012).
38. Seattle Times (July 5, 2010). Local veteran's suicide reflects troubling trend. Retrieved July 9, 2010 from http://seattletimes.nwsourc.com/html/localnews/2012287375_orrh06m.html.
39. Gates, GJ (2006). *Same-sex Couples and Gay, Lesbian, Bisexual Populations: New Estimates from the American Community Survey*. The Williams Institute.

40. Riala, K., Viilo, K., Hakko, H., Räsänen, P. & the STUDY-70 research group. Heavy daily smoking among under 18-year-old psychiatric inpatients is associated with increased risk for suicide attempts (2007). *European Psychiatry*. [22\(4\)](#), 219-222.
41. Russel, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91, 1276-1281.
42. Sher, L. (2005). Alcohol consumption and suicide. *QJM*, 99(1), 57-61.
43. Suicide Prevention Resource Center (2008). *Montana Suicide Prevention Fact Sheet*. Retrieved on April 12, 2008 from: http://www.sprc.org/stateinformation/PDF/statedatasheets/mt_datasheet.pdf
44. Suicide Prevention Resource Center (2007). Suicide Among American Indians/Alaska Natives. Retrieved May 1, 2008 from <http://www.sprc.org/library/ai.an.facts.pdf>
45. Suicide Prevention Resource Center (October, 2007). , *What Corrections Professionals Can Do to Prevent Suicide*. Retrieved April 13, 2008 from: http://www.sprc.org/featured_resources/customized/pdf/corrections.pdf
46. Sustaining State Programs for Tobacco Control: Data Highlights 2010 (2012). Center for Disease Control. U.S. Department of Health and Human Services.
47. USA Today, January 11, 2010, "Suicide rate of veterans increases", Retrieved on July 21, 2010 from http://www.usatoday.com/news/military/2010-01-11-veterans-suicide_N.htm.
48. U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report
Obtained August 6, 2012.
49. U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC: Department of Health and Human Services.
50. Wilcox, H.C, Sheppard, K., Hendricks, B., Jeanne, M, Poduska, N.S., Ialongo, W.W., & Anthony, J.C. (June, 2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence*, 95(1), S60-S73.
51. Zivin, K., Myra Kim, H., McCarthy, J., Austin, K., Hoggatt, K., Walters, H., & Valenstein, M. (December, 2007), *Suicide Mortality Among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics*, *American Journal of Public Health*, Vol. 97, No. 12, 2193-2198

52. Betz, M. E., Valley, M. A., Lowenstein, S. R., Hedegaard, H., Thomas, D., Stallones, L., & Honigman, B. (2011). Elevated suicide rates at high altitude: Sociodemographic and health issues may be to blame. *Suicide and Life-Threatening Behavior*, 41 (5), 562-573.
53. Surveillance for Violent Deaths-National Violent Death Reporting System, 16 States, 2006. *MMWR*, March 20, 2009, 58(SS01):1-44.
54. Juvenile Suicide in Confinement: A National Survey (February 2009), Office of Juvenile Justice and Delinquency Prevention Report , Lindsay M. Hayes, National Center on Institutions and Alternatives.
55. Data are provided by Dr. Joanne Oreskovich, MT BRFSS Director, MTDPHHS, Source: Montana Behavioral Risk Factor Surveillance System 2009 and 2010 data sets, available at www.brfss.mt.gov.
56. 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.
57. National Study of Jail Suicides: 20 years later (April, 2010). U.S. Dept. of Justice, National Institute of Corrections.
58. Juvenile Suicide in Confinement: A National Survey (February 2009), Office of Juvenile Justice and Delinquency Prevention Report , Lindsay M. Hayes, National Center on Institutions and Alternatives.

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)

