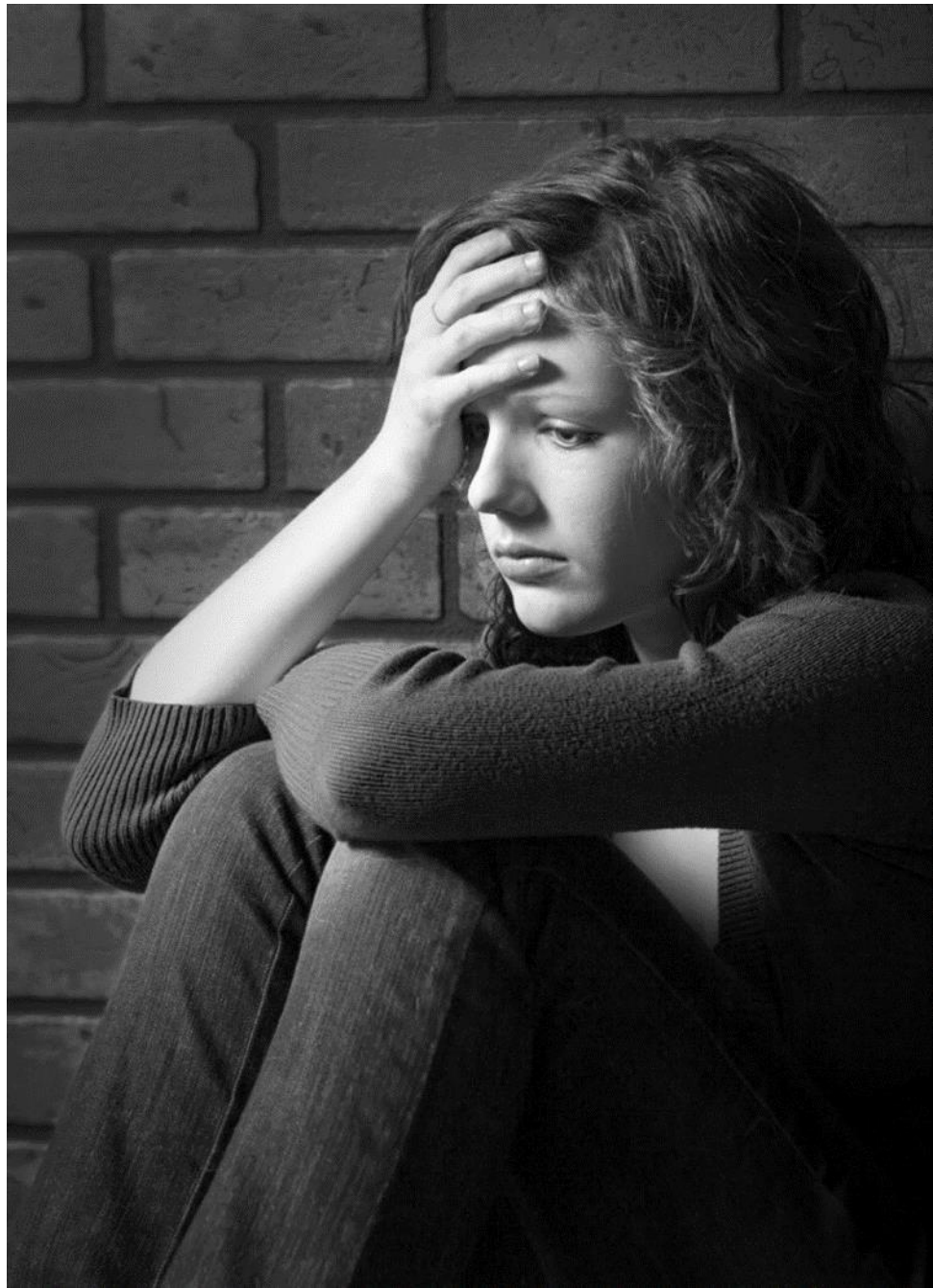
Montana Suicide Prevention Program



MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

March, 2022

Suicide Fact Sheet

Data Source: CDC (1/22), Montana DPHHS (3/22)

- In 2020 there were **45,979** suicides in the U.S. (**126** suicides per day; 1 suicide every **11** minutes). This translates to an annual suicide rate of **14 per 100,000**.
- Males complete suicide at a rate **four times** that of females. However, females attempt suicide **three times** more often than males.
- Firearms remain the most commonly used suicide method, accounting for nearly **50%** of all completed suicides.

Suicide and Primary Care

- Up to **45%** of individuals who die by suicide visit their primary care provider for presenting physical health problems within **a month** of their death, with **20%** of those having visited their primary care provider within **24 hours** of their death

- Elders who complete suicide:
  - **73%** have contact with primary care physician within a **month** of their suicide, with **nearly half** visiting in the preceding week.

- There is a strong correlation between chronic pain and suicide
  - **20-30%** of those who die by suicide have issues of chronic illness or pain.
  - A person with chronic pain is **3 times** the risk of suicide

Suicide among Children

- In 2020, **581** children ages 10 to 14 completed suicide in the U.S. (Youngest – an 8 year old)

- Suicide rates for those between the ages of 5-14 **increased 60%** between 1981 and 2010.

Suicide among the Young

- Suicide is the **2nd leading cause of death** among young (15-24) Americans; only accidents occur more frequently. In 2020, there were **6,062** suicides by people 15-24 years old.

- Youth (ages 15-24) suicide rates increased more than **200%** from the 1950's to the mid 1990's. The rates dropped in the 1990's but went up again in the early 2000's.

Suicide among our Veterans

- In 2019, an average of **17** Veterans died from suicide each day. One every 84 minutes. The rate of suicide for Veterans in 2019 was 31.6 per 100,000
- Veterans accounted for **18%** of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the US population.
- Approximately **66%** of all Veteran deaths from suicide were the result of **firearms**.
- Approximately **65%** of all Veterans who died from suicide were aged **50 years or older**.
- After adjusting for differences in age and gender, risk for suicide was **21% higher among Veterans when compared to U.S. civilian adults**.

Source: 2021 National Veteran Suicide Prevention Annual Report. Office of Mental Health and Suicide Prevention, September , 2021

Suicide among the Elderly

- In 2019, **9,137** Americans over the age of 65 died by suicide for a rate of **17** per 100,000 people

- The rate of suicide for women typically stabilizes after age 64 (after peaking in middle adulthood, ages 50-54) .

- 85% of elderly suicides were male; the rate of male suicides in late life was **7 times** greater than for female suicides.

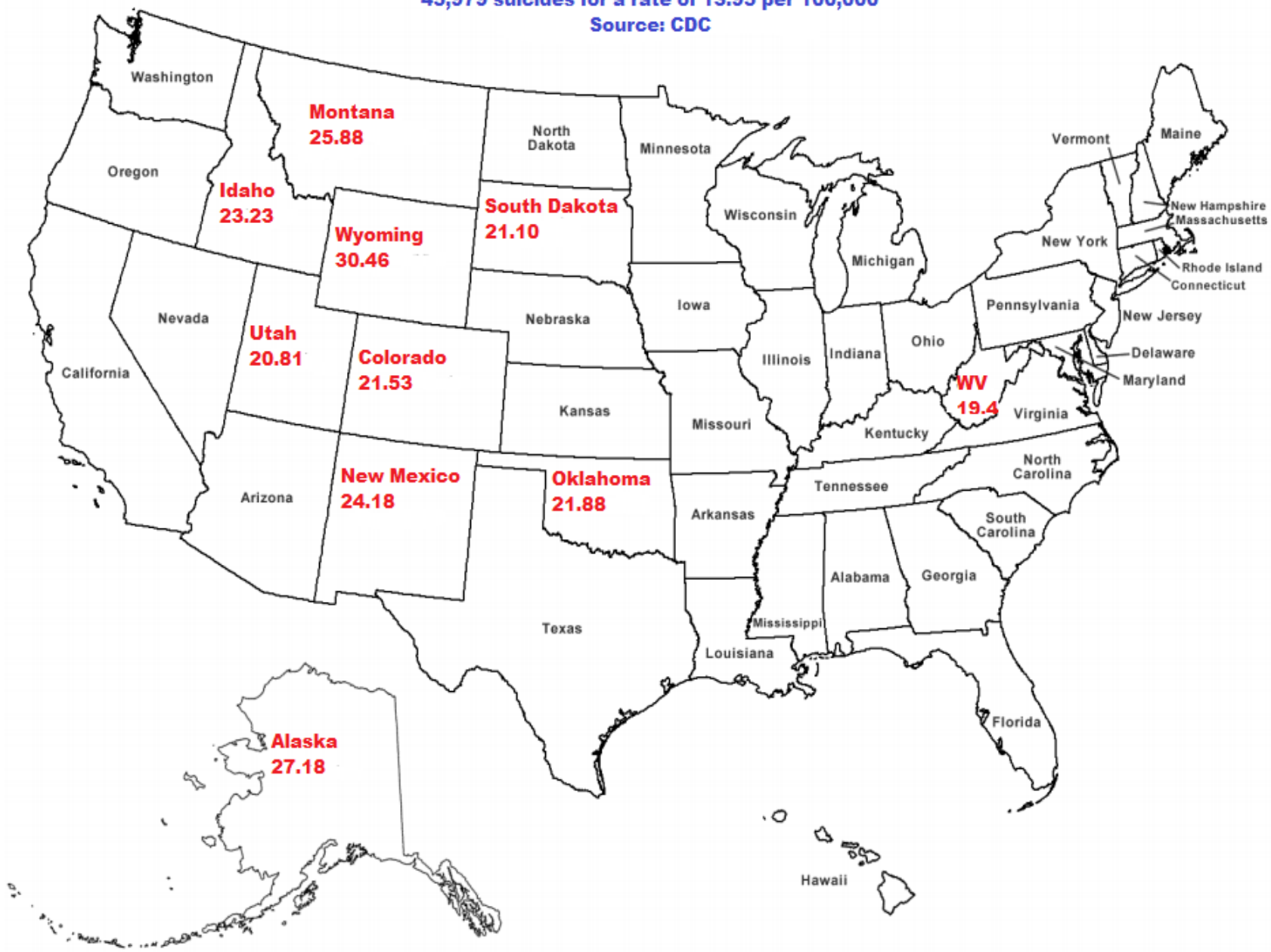
Suicide in Montana

Data Source: CDC (3/22)), Montana DPHHS (1/22)

- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past forty years.

- According to the most recent numbers released by the National Vital Statistics Report for **2020**, **Montana has the 3rd highest rate of suicide in the United States (300 suicides for a rate of 25.9).**

2020 US Suicide Rates
45,979 suicides for a rate of 13.95 per 100,000
Source: CDC



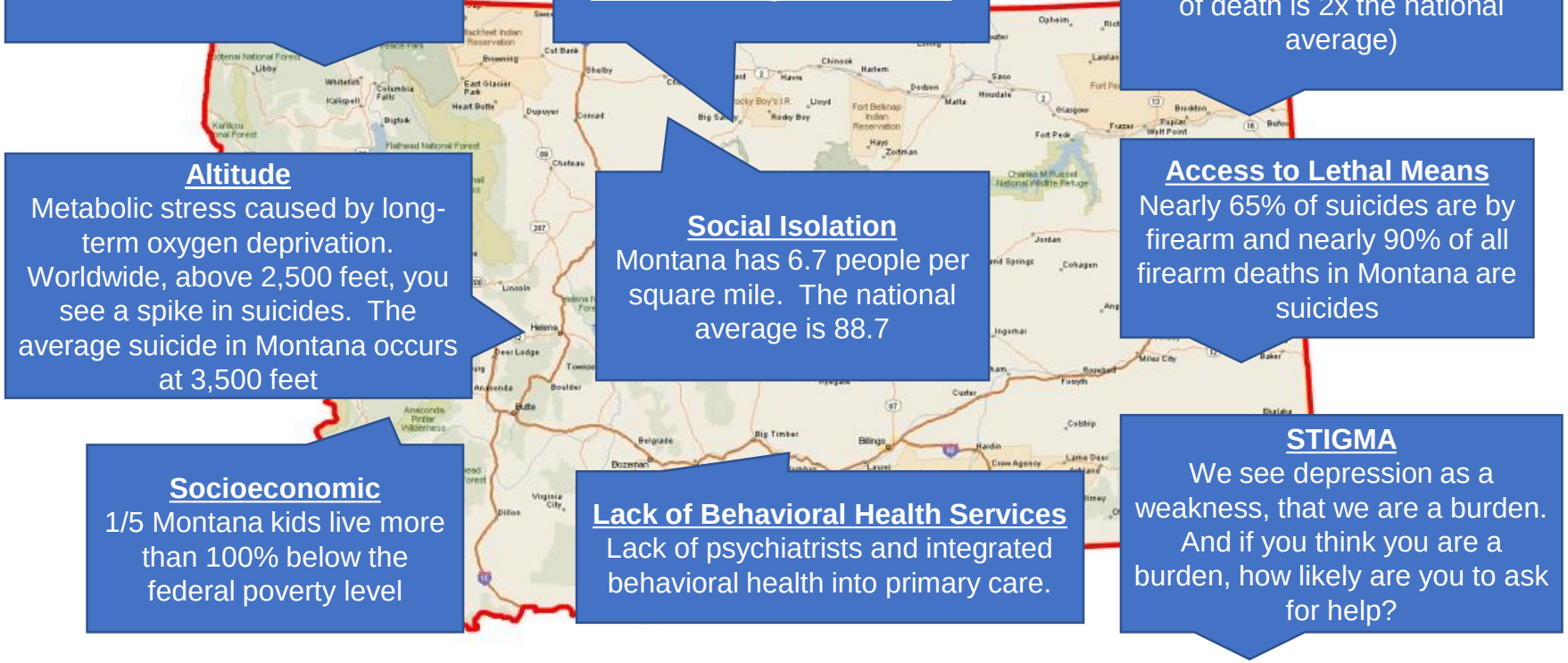
Why does Montana have such a high rate of suicide?

It's not one factor, but rather multiple factors all occurring at the same time.
It is a cultural issue.

Vitamin D Deficiency (correlated with increased risk of depression)

High concentration of Veterans, American Indians, and middle age White men

Alcohol as a coping strategy (alcohol in the blood at the time of death is 2x the national average)



Altitude
Metabolic stress caused by long-term oxygen deprivation. Worldwide, above 2,500 feet, you see a spike in suicides. The average suicide in Montana occurs at 3,500 feet

Social Isolation
Montana has 6.7 people per square mile. The national average is 88.7

Access to Lethal Means
Nearly 65% of suicides are by firearm and nearly 90% of all firearm deaths in Montana are suicides

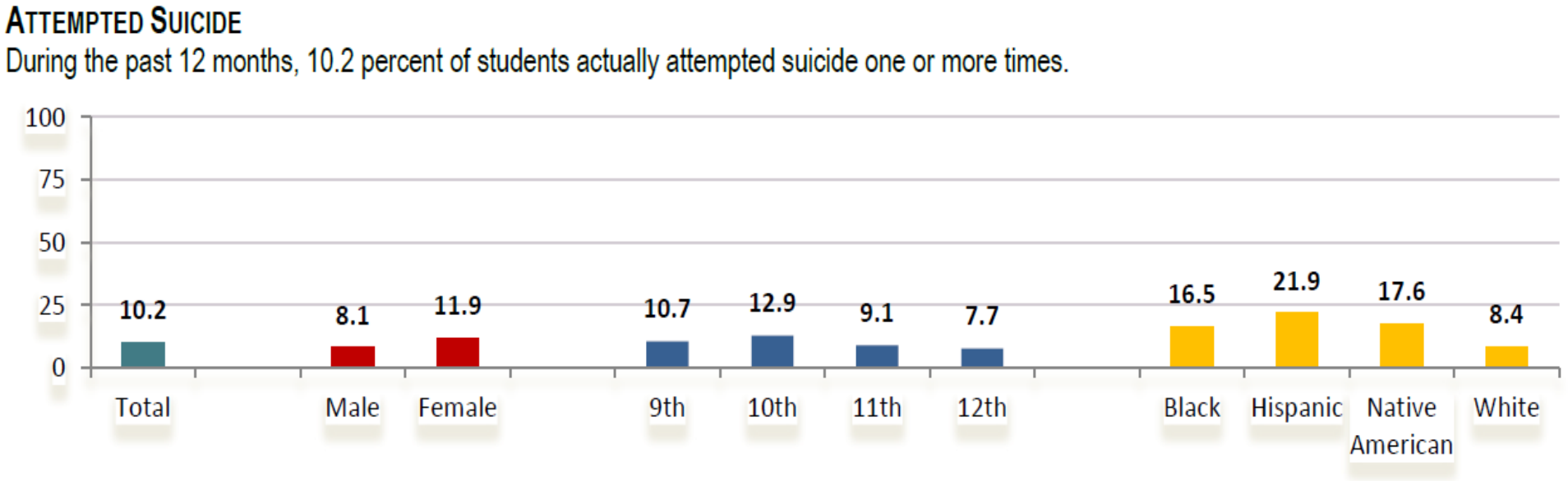
Socioeconomic
1/5 Montana kids live more than 100% below the federal poverty level

Lack of Behavioral Health Services
Lack of psychiatrists and integrated behavioral health into primary care.

STIGMA
We see depression as a weakness, that we are a burden. And if you think you are a burden, how likely are you to ask for help?

2021 YRBS Data - Suicide

During the past 12 months, 10.2% of Montana high school students attempted suicide one or more times



13.5% of 7th-8th graders have attempted suicide in the past 12 months

2020 Youth Suicide Data

Age (Years)	Sex	NCHS 'BRIDGED RACE	County of Residence	Underlying Cause of Death (COD) - Label Added by NCHS
11	FEMALE	ASIAN/ PACIFIC ISLANDER	MISSOULA	Intentional self-harm by hanging, strangulation and suffocation
13	MALE	WHITE	LEWIS & CLARK	Intentional self-harm by handgun discharge
15	MALE	WHITE	PARK	Intentional self-harm by handgun discharge
15	MALE	WHITE	BEAVERHEAD	Intentional self-harm by hanging, strangulation and suffocation
15	FEMALE	AMERICAN INDIAN	YELLOWSTONE	Intentional self-harm by rifle, shotgun and larger firearm discharge
16	MALE	WHITE	YELLOWSTONE	Intentional self-harm by handgun discharge
16	MALE	AMERICAN INDIAN	ROOSEVELT	Intentional self-harm by other and unspecified firearm discharge
16	MALE	WHITE	LEWIS & CLARK	Intentional self-harm by handgun discharge
16	FEMALE	WHITE	DEER LODGE	Intentional self-harm by other and unspecified firearm discharge
17	MALE	WHITE	FLATHEAD	Intentional self-harm by hanging, strangulation and suffocation
17	MALE	WHITE	LEWIS & CLARK	Intentional self-poisoning by and exposure to antiepileptic,
18	MALE	AMERICAN INDIAN	BLAINE	Intentional self-harm by hanging, strangulation and suffocation
18	MALE	WHITE	LEWIS & CLARK	Intentional self-harm by rifle, shotgun and larger firearm discharge

N=13

White-9 (69%), AI-3 (23%), Asian-1

Male-10 (77%), Female-2

Firearm-8 (62%), Hanging-4 (31%), Overdose-1

L&C-4 *

Yellowstone-2

2021 Youth Suicide Data

Age (Years)	Sex	NCHS 'BRIDGED RACE	County of Residence	Underlying Cause of Death (COD) - Label Added by NCHS
11	FEMALE	AMERICAN INDIAN	GLACIER	Intentional self-harm by hanging, strangulation and suffocation
12	MALE	WHITE	YELLOWSTONE	Intentional self-harm by hanging, strangulation and suffocation
12	MALE	WHITE	GALLATIN	Intentional self-harm by other and unspecified firearm discharge
13	MALE	WHITE	LEWIS & CLARK	Intentional self-harm by other and unspecified firearm discharge
14	MALE	AMERICAN INDIAN	CASCADE	Intentional self-harm by other and unspecified firearm discharge
14	MALE	WHITE	FALLON	Intentional self-harm by other and unspecified firearm discharge
15	MALE	WHITE	PARK	Intentional self-harm by other and unspecified firearm discharge
15	MALE	WHITE	LINCOLN	Intentional self-harm by other and unspecified firearm discharge
15	FEMALE	WHITE	LEWIS & CLARK	Intentional self-harm by hanging, strangulation and suffocation
15	MALE	WHITE	FLATHEAD	Intentional self-harm by other and unspecified firearm discharge
16	MALE	WHITE	LAKE	Intentional self-harm by handgun discharge
16	MALE	WHITE	LEWIS & CLARK	Intentional self-harm by handgun discharge
17	MALE	WHITE	SANDERS	Intentional self-harm by other and unspecified firearm discharge
17	MALE	AMERICAN INDIAN	ROOSEVELT	Intentional self-harm by hanging, strangulation and suffocation
17	MALE	ASIAN/ PACIFIC ISLANDER	CASCADE	Intentional self-harm by jumping or lying before moving object
17	MALE	WHITE	YELLOWSTONE	Intentional self-harm by handgun discharge
17	FEMALE	WHITE	FLATHEAD	Intentional self-harm by other and unspecified firearm discharge
17	FEMALE	WHITE	SANDERS	Intentional self-harm by hanging, strangulation and suffocation
17	MALE	AMERICAN INDIAN	LINCOLN	Intentional self-harm by hanging, strangulation and suffocation
17	FEMALE	WHITE	FLATHEAD	Intentional self-harm by hanging, strangulation and suffocation
17	MALE	WHITE	FLATHEAD	Intentional self-harm by hanging, strangulation and suffocation
17	MALE	AMERICAN INDIAN	BIG HORN	Intentional self-harm by hanging, strangulation and suffocation
18	MALE	WHITE	CASCADE	Intentional self-harm by other and unspecified firearm discharge
18	MALE	AMERICAN INDIAN	LAKE	Intentional self-harm by jumping or lying before moving object
18	MALE	WHITE	FLATHEAD	Intentional self-harm by crashing of motor vehicle
18	MALE	WHITE	DAWSON	Intentional self-harm by handgun discharge
18	FEMALE	AMERICAN INDIAN	BLAINE	Intentional self-harm by other and unspecified firearm discharge
18	MALE	WHITE	PARK	Intentional self-poisoning by and exposure to nonopioid analgesics,
18	FEMALE	AMERICAN INDIAN	CHOUTEAU	Intentional self-harm by hanging, strangulation and suffocation

N=29
White-20,AI-8, Asian-1
Males-22, Female-7
Firearm-15, Hanging-10,
Jump-2, OD=-1, Auto-1

White 69%, AI 26%
76% Male
52% Firearm, 34% Hang

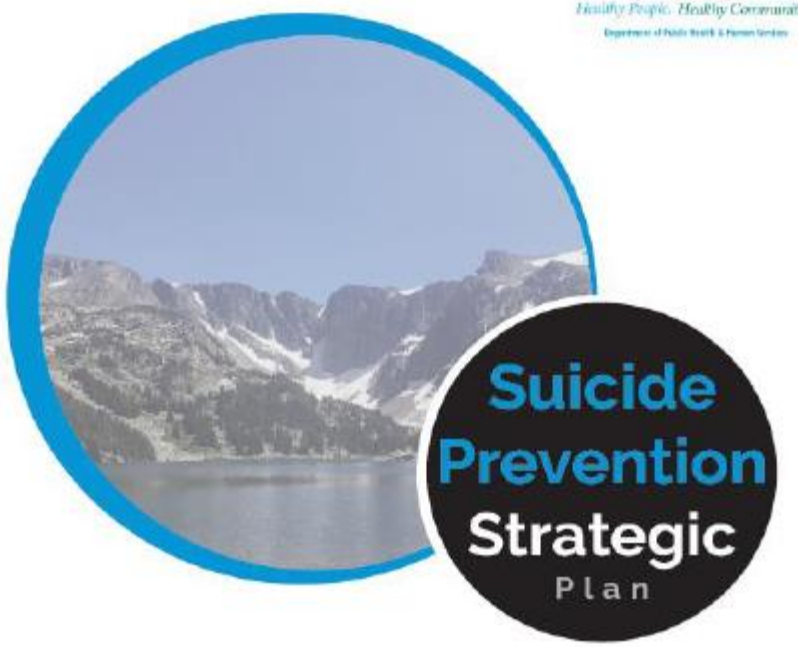
Flathead-5
L&C-3 *
Cascade-3

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

Suicide Prevention Strategic Plan



- **Goal 1**

  Implement a suicide prevention program at the department based upon the best available evidence

- **Goal 2**

  Develop a comprehensive communication plan

- **Goal 3**

  Identify and use available resources needed to guide state, tribal, county, and local efforts, including crisis response efforts

- **Goal 4**

  Build a multi-faceted, lifespan approach to suicide prevention

- **Goal 5**

  Support high quality, privacy-protected suicide morbidity and mortality data collection and analysis


NATIONAL
SUICIDE
PREVENTION
LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

988

Montana Crisis Call Centers

Voice of Hope

Local Number
Lifeline
211

Help Center 211

Local Number
Lifeline
211

Lifeline Call Center

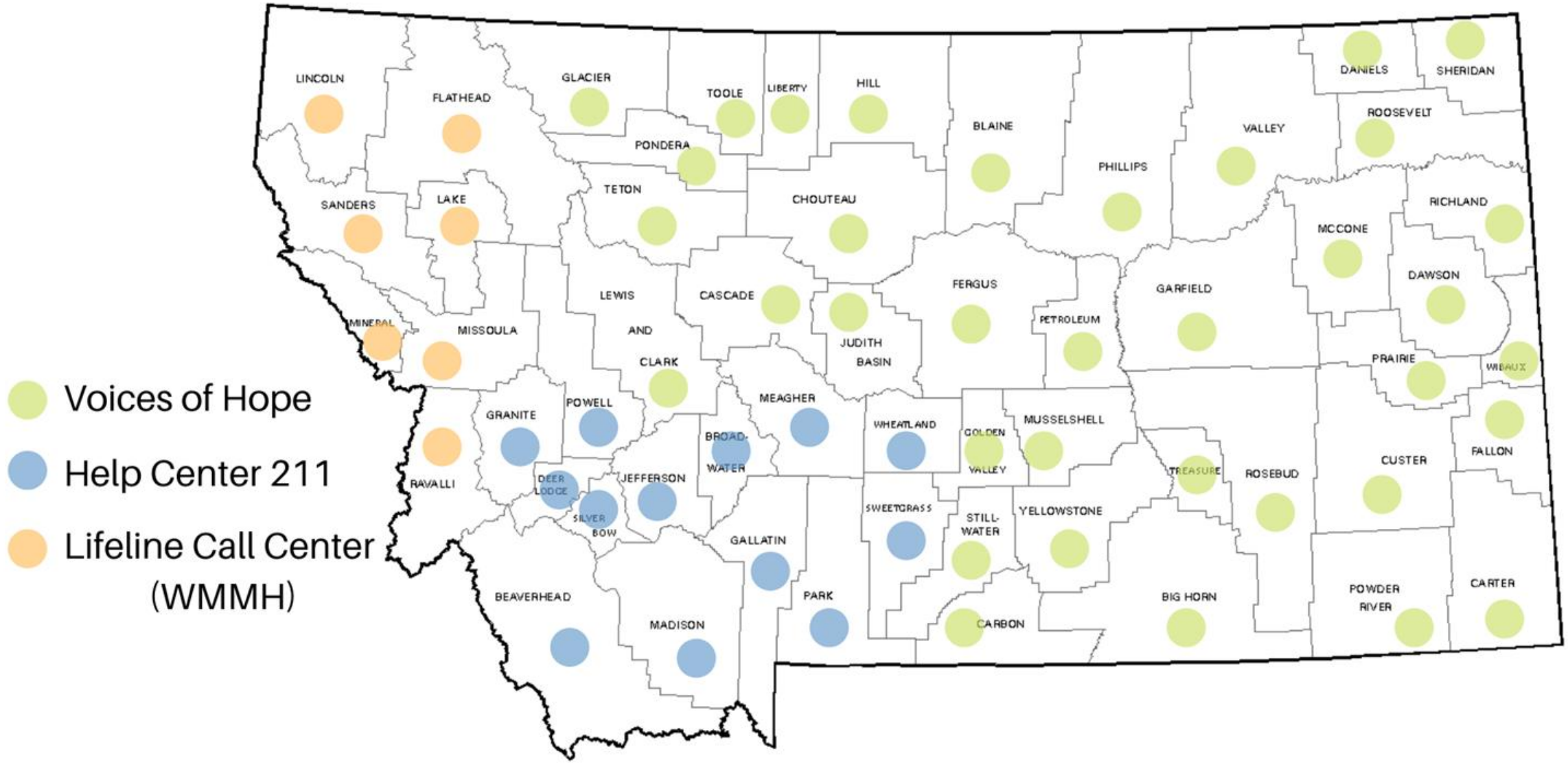
Lifeline

Planning Considerations

Eight core 9-8-8 planning and implementation considerations will drive project activities and provide the structure around which grant awardees will create both draft and final 9-8-8 implementation plans. The eight components are:

1. 24/7 statewide coverage for 9-8-8 calls, chats and texts must be achieved in every state and territory.
2. States and territories must provide strategies for identifying and supporting funding streams which boost the financial stability of Lifeline-member centers in their region.
3. Capacity building at the centers answering 9-8-8 contacts must occur based on call, chat, text and follow-up volume growth projections.
4. State and territory agencies must comprehend and account for the operational, clinical and performance standards for all of the Lifeline member centers in their region.
5. Multi-stakeholder input through a 9-8-8 implementation coalition.
6. Have systems in place to maintain local resource and referral listings, as well as assure linkages to local community crisis services (including 911 PSAPs, mobile crisis teams and other outreach alternatives to law enforcement/EMS response).
7. State and territory agencies shall ensure all centers in their region are able to provide follow-up services to 9-8-8 callers.
8. Consistency in public messaging is critical at the national and state/territory level regarding 9-8-8, its distinction from 9-1-1 and the range of services 9-8-8 provides.

Lifeline Call Center Coverage Map



Montana American Indian Zero Suicide Grant

- Focus on American Indian Adults
- Grant from SAMHSA
- September 30, 2020 through September 29, 2023
- Total amount: $2,800,000; $700,000 per year

Main Goals:

1. Establish a suicide care policy promoting suicide safe care as an organizational priority.

2. Create a confident and competent workforce where at-risk individuals are identified.

3. Ensure all patients who are at risk receive immediate, safe and personalized treatment

Partners

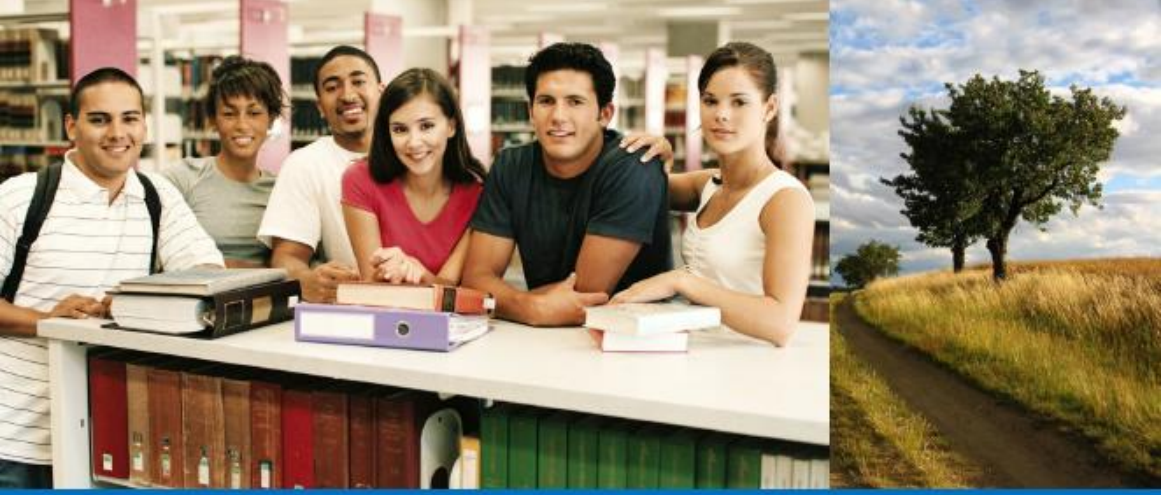
1. All Nations Health Center – Missoula
2. Billings Urban Indian Health and Wellness Center – Billings*
3. Blackfeet Tribal Health Center – Browning
4. Butte Native Wellness Center – Butte
5. Confederated Salish and Kootenai Tribal Health – Ronan
6. Fort Belknap Tribal Health – Harlem
7. Fort Peck Tribal Health – Poplar
8. Northern Cheyenne Tribal Health – Lame Deer*

*only participating in training

Accomplishments:

- All-site calls have led to a good exchange of information between Tribal Health Facilities and Urban Indian Health Centers.
- Trainings have been done with all partners
- Tribal Consultation has led to increased collaboration between the state and Tribal Partners, which has led to more partners
- NativeWellness Life, a Native owned magazine, has been a strong conduit of education, outreach and support
- Facilities have been creative: having Zoom classes in ribbon skirt making and beading, supporting individual patients with the ability to have fresh food grown at home, and the development of community gardens.
- Partners have developed clear policies and procedures and trained all staff to support their patients that may be at risk of suicide.

Resources and Trainings



MONTANA'S CAST-S

Crisis Action School Toolkit on Suicide

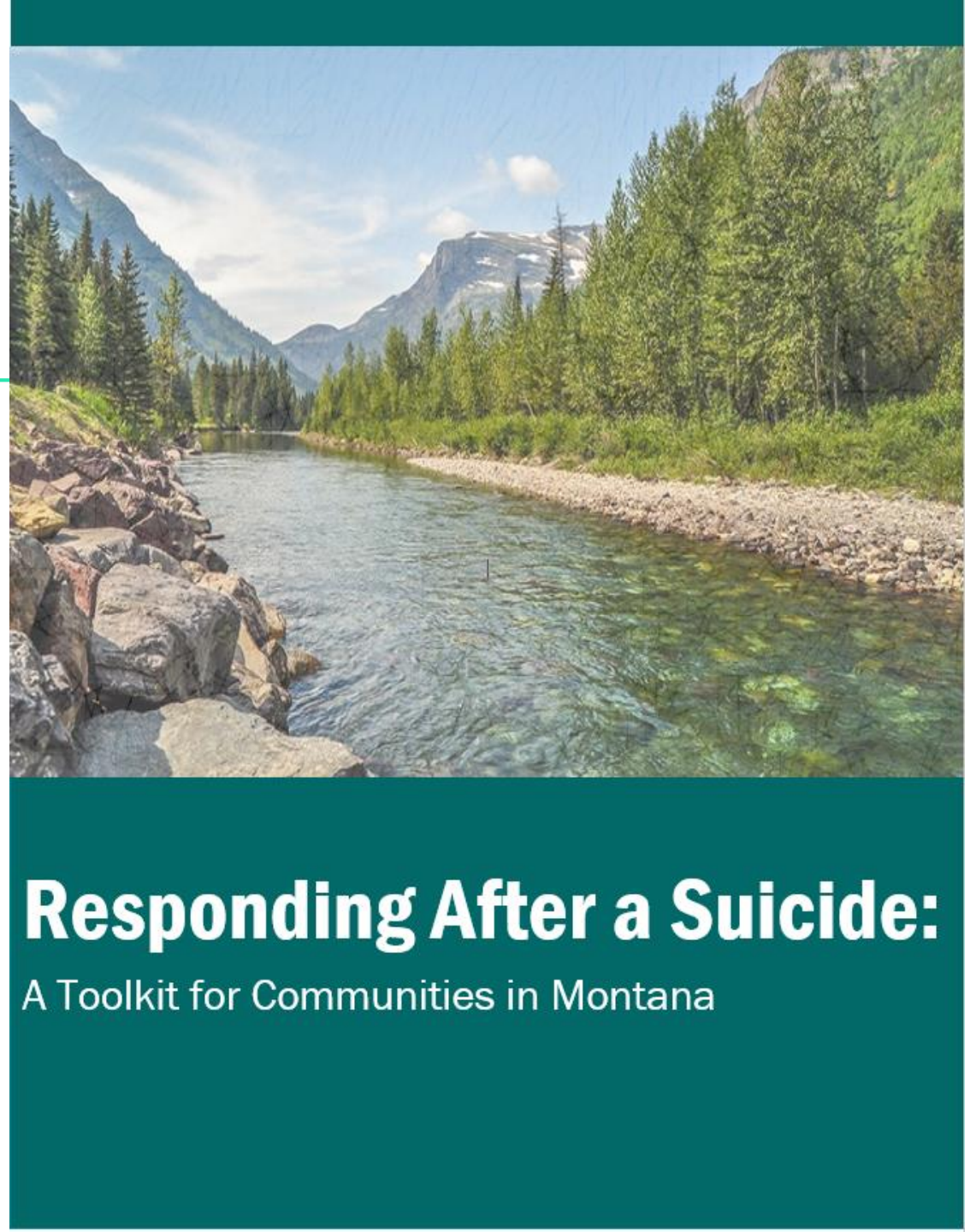
2017

Other Suicide Prevention Resources for Schools

- Assists high schools and school districts in designing and implementing strategies to prevent and respond to suicides and promote behavioral health. Includes tools to implement a multi-faceted suicide prevention program that responds to the needs and cultures of students and postvention guidelines.
- Available free at www.dphhs.mt.gov/suicideprevention

Montana Postvention Toolkit

This toolkit is meant to be used after a suicide occurs in your community. It provides a series of action steps that you can take to safely offer support and reduce the risk of additional suicides from occurring in your community. These efforts are collectively referred to as **suicide postvention** because the response occurs *after* a suicide has happened. This toolkit was specifically designed to be used in communities in Montana and pulls together helpful community, state-wide, and national postvention resources. Having a community-wide response has been found to be helpful in prevention efforts.



Evidenced-Based Suicide Prevention Programs

QPR

- A two-hour training that provides anybody the basic tools on how to intervene with a suicidal person

Other Evidenced-Based Suicide Prevention Programs

ASIST

A two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers are taught to recognize the warning signs and to intervene with appropriate assistance.

Other Evidenced-Based Prevention Programs

Mental Health First Aid

Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders.

Other Evidenced-Based Suicide Prevention Programs

SOS: Signs of Suicide

School-based program which aims to raise awareness of suicide and reduce stigma of depression There is also a brief screening for depression and other factors associated with suicidal behavior.

Mental Health Promotion in our high schools

YAM YOUTH AWARE OF MENTAL HEALTH

Youth Aware of Mental Health (YAM)

YAM is an interactive program for adolescents promoting increased discussion and knowledge about mental health, suicide prevention, and the development of problem-solving skills and emotional intelligence.

Other Evidenced-Based Prevention Programs

Good Behavior Game

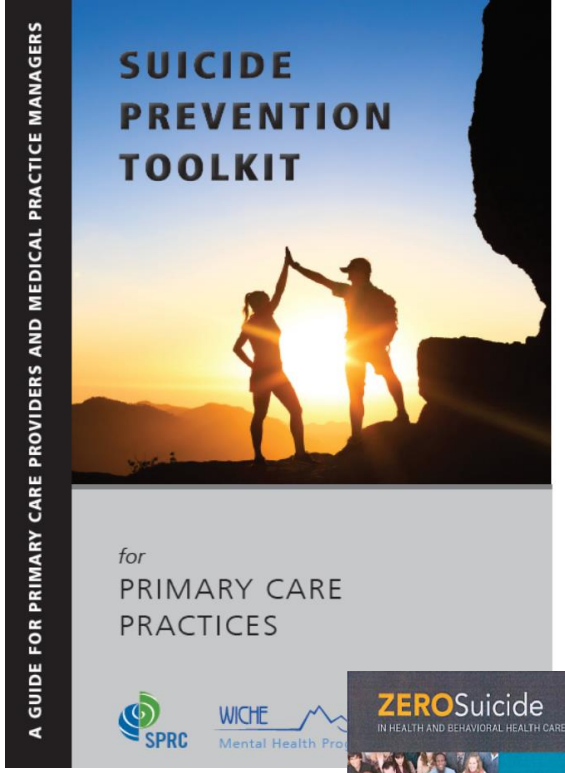
The classroom management strategy is designed to improve aggressive/disruptive classroom behavior. It is implemented when children are in 1st or 2nd grade in order to provide students with the skills they need to respond to later, possibly negative, life experiences and societal influences. Studies have suggested that implementing the "Good Behavior Game" may delay or prevent onset of suicidal ideations and attempts in early adulthood.

Other Resources

Suicide Prevention Toolkit for Primary Care Physicians

Suicide assessment and intervention kit designed for healthcare providers practicing in rural communities.

- Training provided every semester for college students in nursing, P.A., social work, counselors, psychology.
- Project ECHO for pediatricians
- Training at numerous medical conferences
- Training for the Montana Medical Association



Skill Building in Healthcare Providers

- Collaboration with the NCMW to provide train-the-trainer in Suicide Safe Care
- DLI (Board of Behavioral Health) and DPHHS collaborated to require all licensed behavior health providers in Montana to have 2 hours of suicide prevention every year.
- Working with CPI @ Columbia to allow licensed behavior health providers in Montana to have access to training modules to earn CEUs.

NATIONAL COUNCIL for Mental Wellbeing

Montana Department of LABOR & INDUSTRY

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

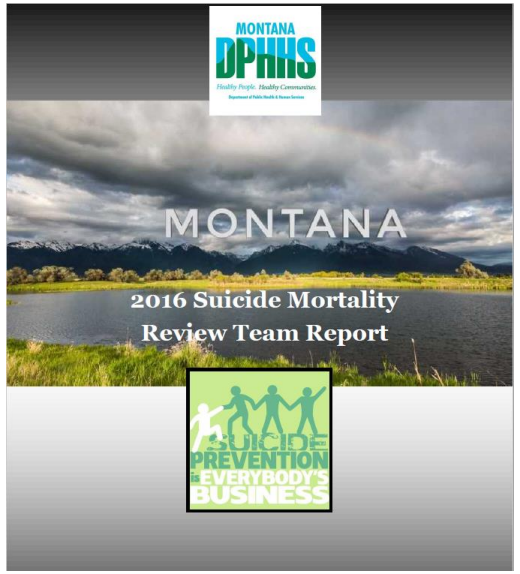
Data Surveillance

- Montana is now part of the CDC's National Violent Death Reporting System, reviewing every suicide that occurs in the state to better understand the demographics and factors in order to better focus prevention efforts.
- Grief resources provided to the next of kin for every suicide.
- The Suicide Prevention Coordinator is part of the State FICMMR team reviewing youth suicides and the state domestic violence mortality review (murder suicides).

National Violent Death Reporting System
NVDRS

PublicHealth IN THE 406

MONTANA
FETAL, INFANT, CHILD & MATERNAL MORTALITY REVIEW



HB118 Grants

Tamarack Grief Resource Center (Missoula, Browning, CSKT, NW Montana)

Rural Behavioral Health Institute (Park, Madison, Gallatin Counties)

Eastern Montana Community Mental Health Center (17 Counties)

Alluvion Health (Great Falls)

RiverStone Health (RSH) (Billings)

Lewis & Clark County

Cedar Creek Integrated Health


ANY
QUESTIONS?