

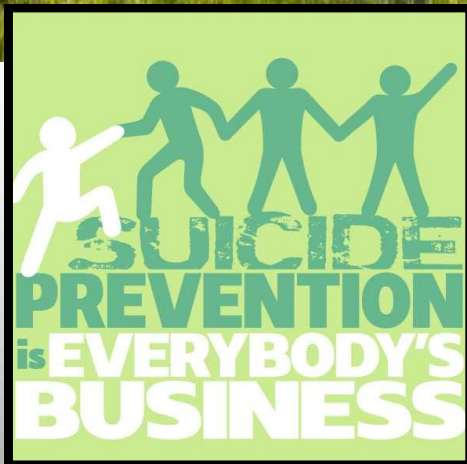


Healthy People. Healthy Communities.

Department of Public Health & Human Services

MONTANA

2016 Suicide Mortality Review Team Report



Over the following pages are the findings and recommendations of the Montana Suicide Mortality Review Team and is based on the review of 555 suicides that occurred in Montana between January 1, 2014 and March 1, 2016.

Table of Contents

Suicide – A Public Health Issue that isn’t going away—US Data (2014)....	3
Suicide Mortality Review Team findings (all populations).....	5
Montana Youth Suicides (ages 11-17).....	20
Montana Youth Risk Behavior Survey.....	30
Suicide among Montana’s American Indians.....	33
Suicide among Montana’s Veterans.....	43
Recommendations of the Montana Suicide Mortality Review Team.....	50
Crisis Resource Poster.....	54

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

United States

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

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

In the United States for 2014:

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

2014, United States Suicide Injury Deaths and Rates per 100,000

All Races, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

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

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

Suicide among the Young (ages 15-24)

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

According to the 2015 National Youth Risk Behavior Survey;

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

Nonfatal Suicidal Thoughts and Behavior

- There were 1,069,325 suicide attempts in the US in 2014. This translates to one attempt every 30 seconds. There are 3 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

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

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

Suicide among the Elderly (US for 2014)

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

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

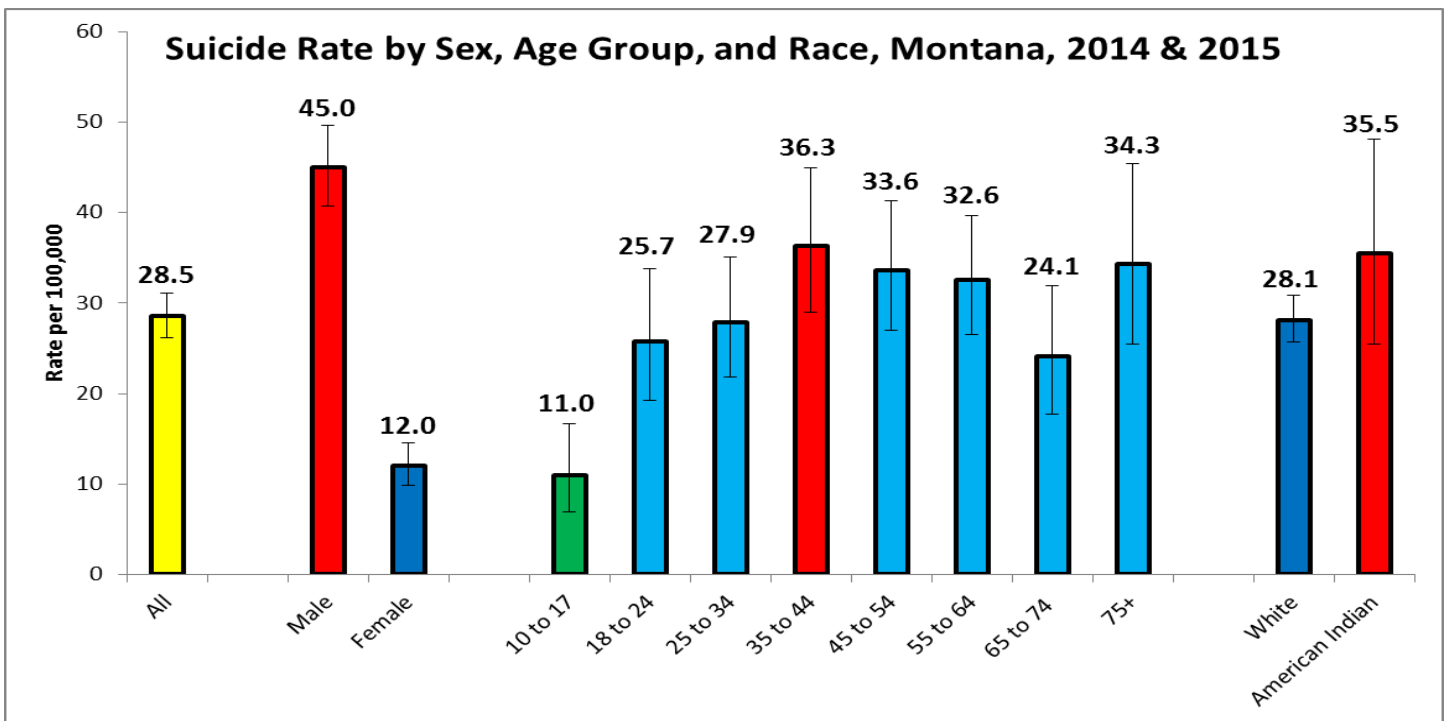
Suicide in Montana: The Findings of the Montana Suicide Mortality Review Team

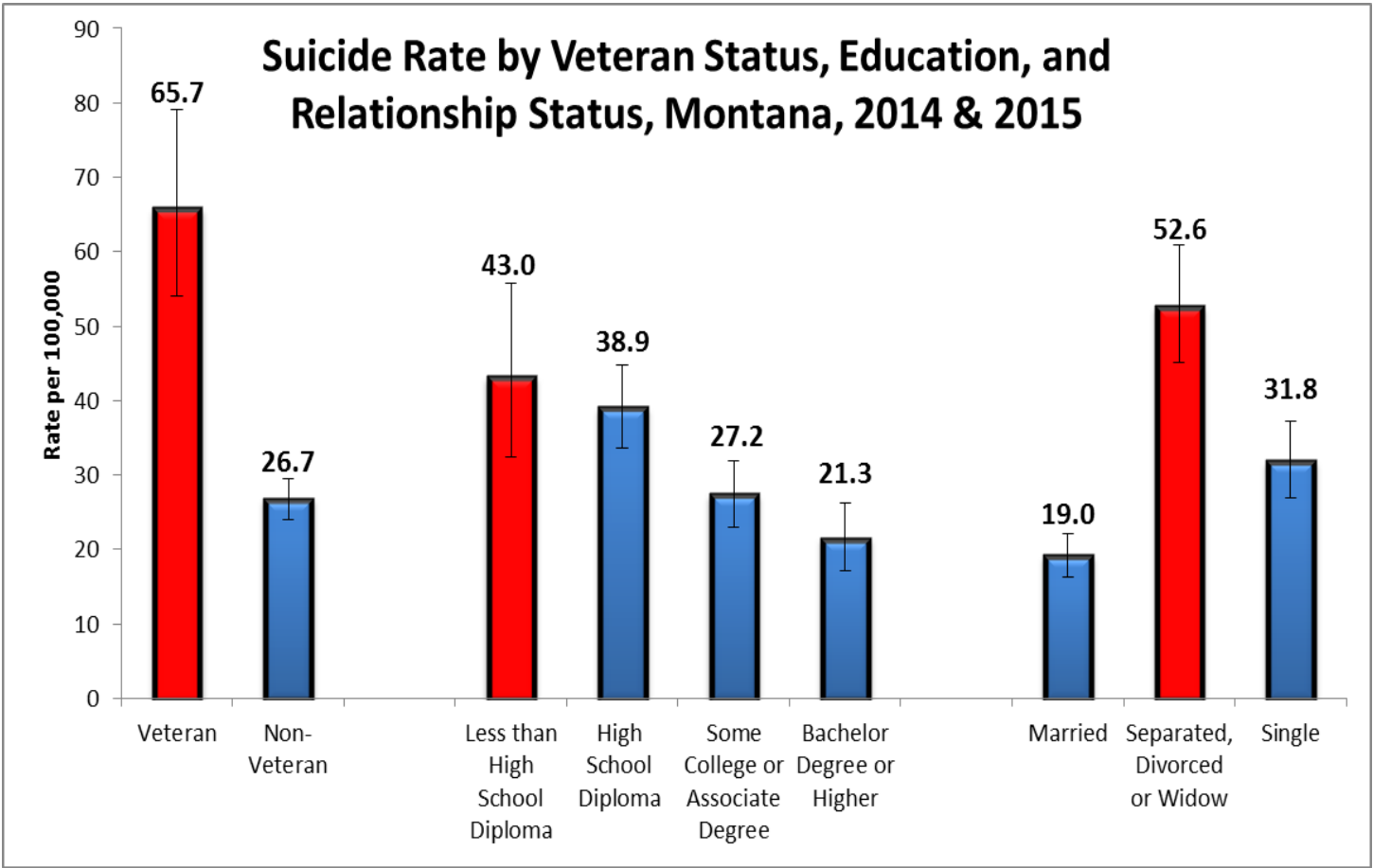
Over the following pages are the findings of the Montana Suicide Mortality Review Team and is based on the review of 555 suicides that occurred in Montana between January 1, 2014 and March 1, 2016. The first set of charts represent all suicides in Montana. This is followed by data specific to youth suicides,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

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

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

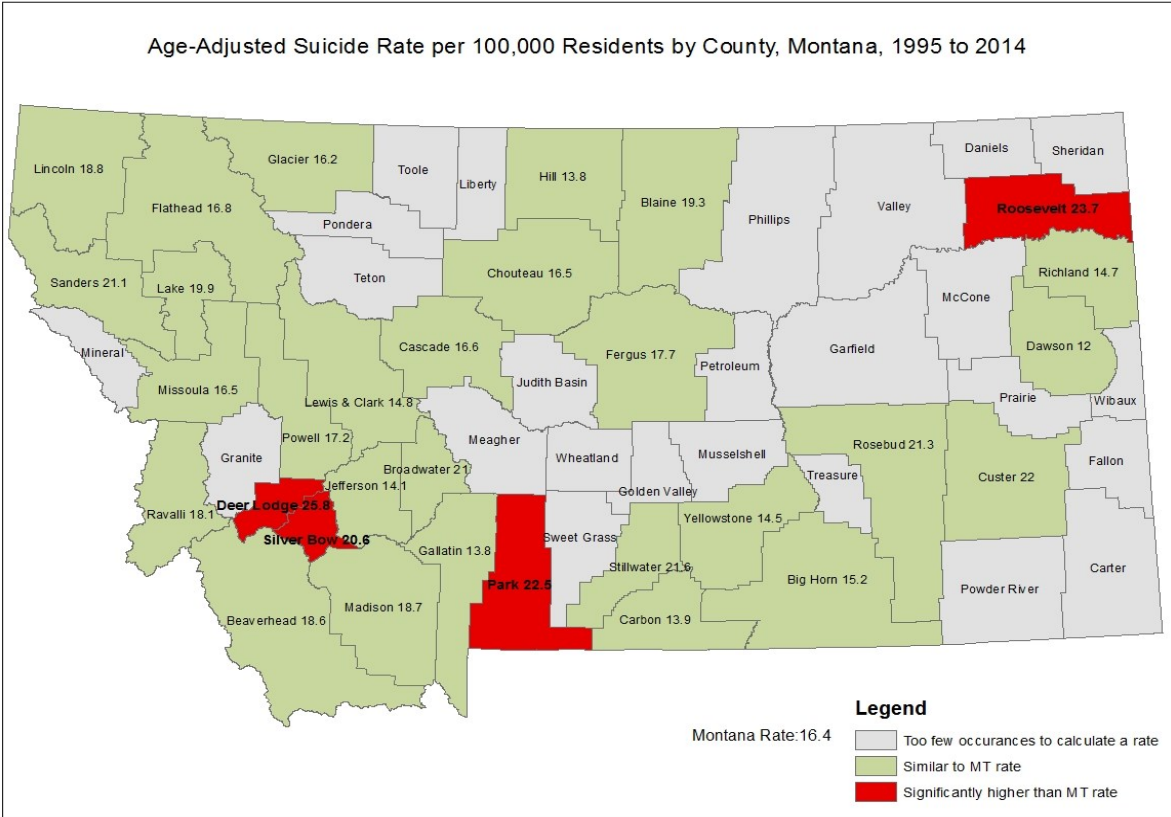
- In Montana, between 2005 and 2014, suicide was the number **two** cause of death for children **ages 10-14**, adolescents **ages 15-24**, and adults **ages 25-44**, behind only unintentional injuries (CDC, 2016)
- Access to lethal means (**firearms**), **alcohol**, a sense of **being a burden**, **social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





Suicide in Montana Counties

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



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

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

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

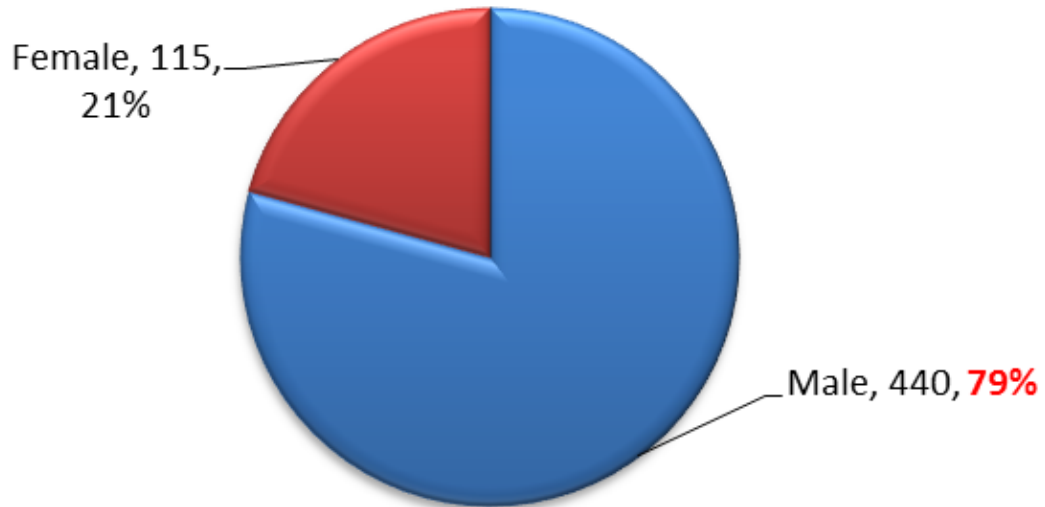
County	Deaths	Population	Age-Adjusted Rate	County	Deaths	Population	Age-Adjusted Rate
Montana	3,183	15,401,557	16.4				
Beaverhead	37	153,333	18.6	McCone	†	30,347	‡
Big Horn	35	186,417	15.2	Meagher	10	31,764	‡
Blaine	24	102,200	19.3	Mineral	17	67,184	‡
Broadwater	21	80,271	21.0	Missoula	349	1,705,929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

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

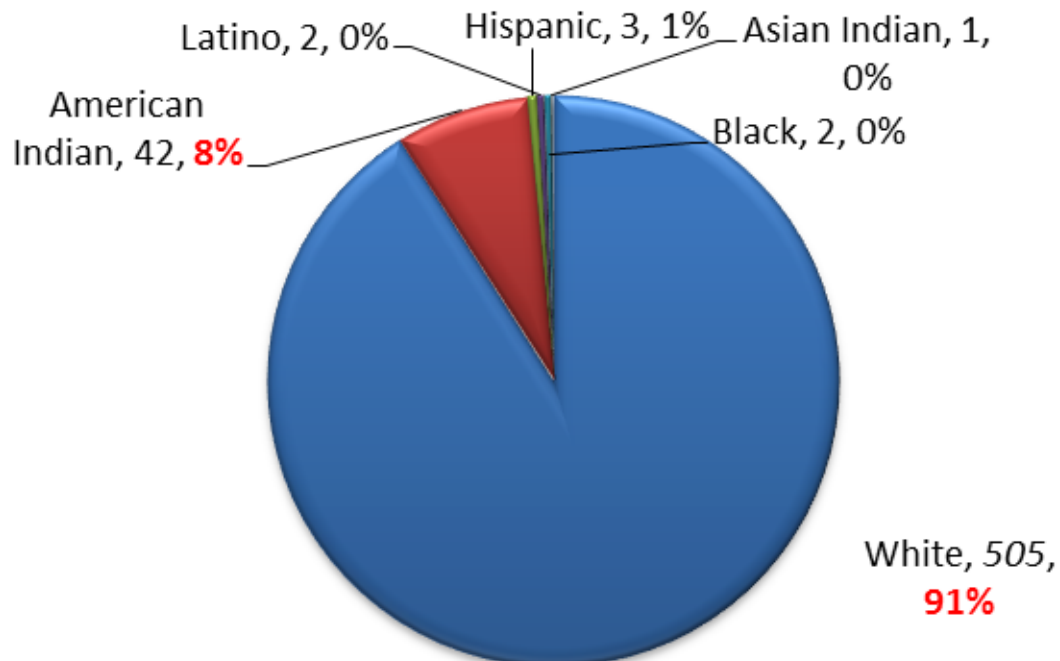
† Fewer than five events;

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

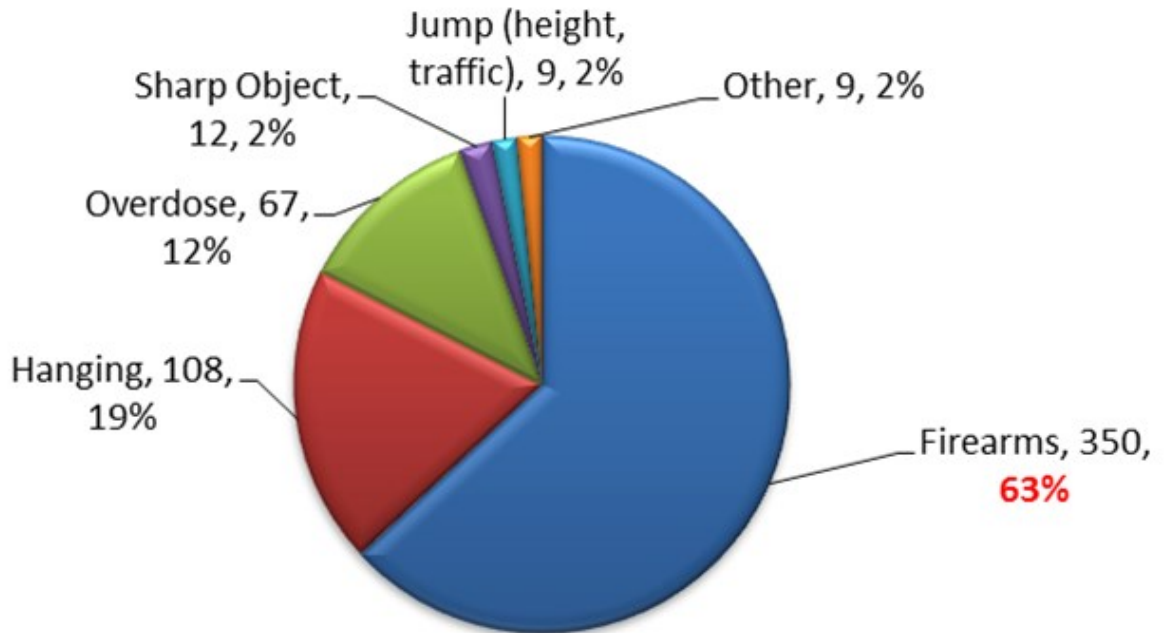
Montana Suicides by Gender (1/1/14-3/1/16)



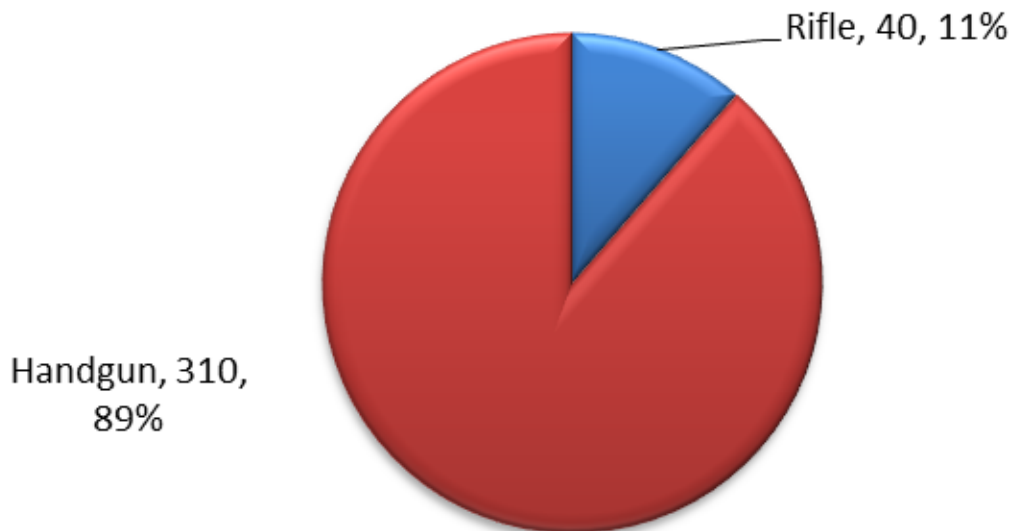
Montana Suicides by Ethnicity (1/1/14-3/1/16)



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

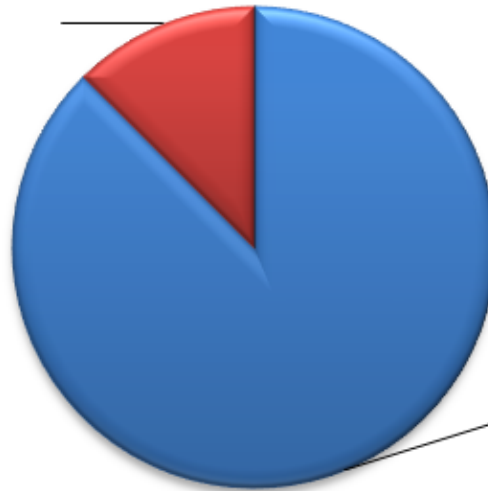


Montana Suicides by Type of Firearm (1/1/14 - 3/1/16)



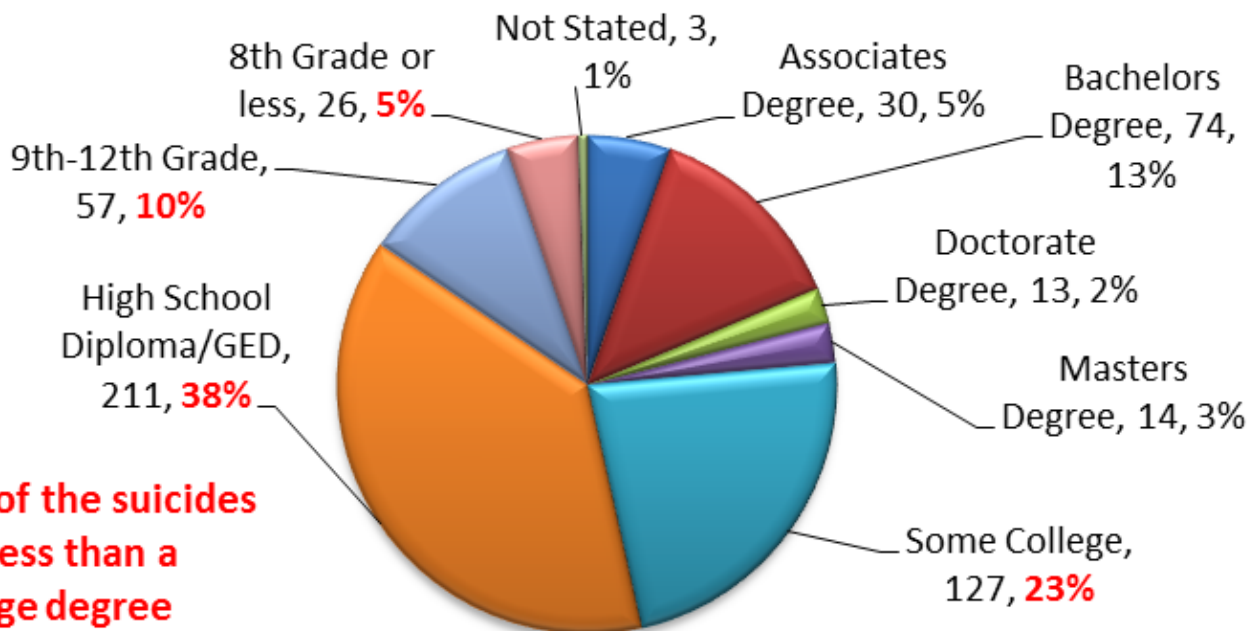
Firearm Deaths in Montana 2010-2014

Other Firearm
Deaths, 106,
12%

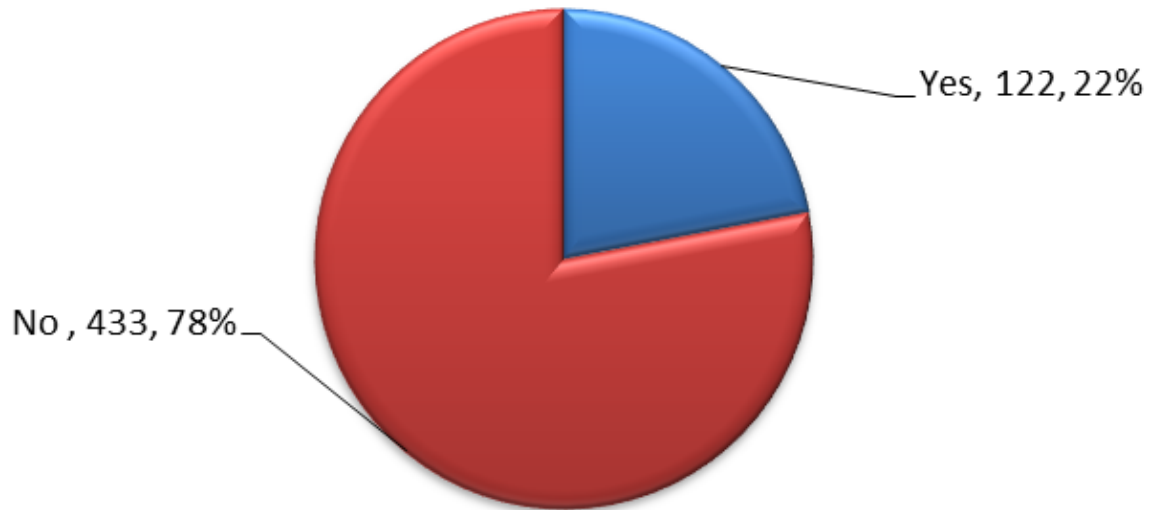


Firearm
Suicides, 745,
88%

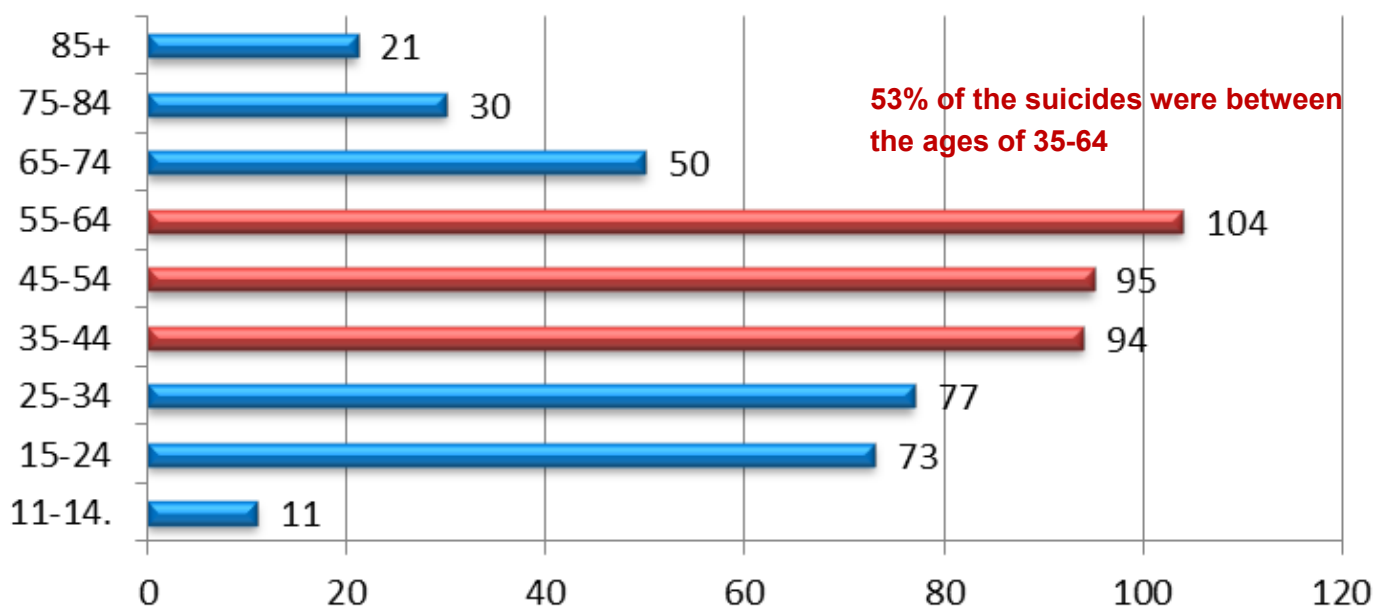
Montana Suicides by Education (1/1/14 - 3/1/16)



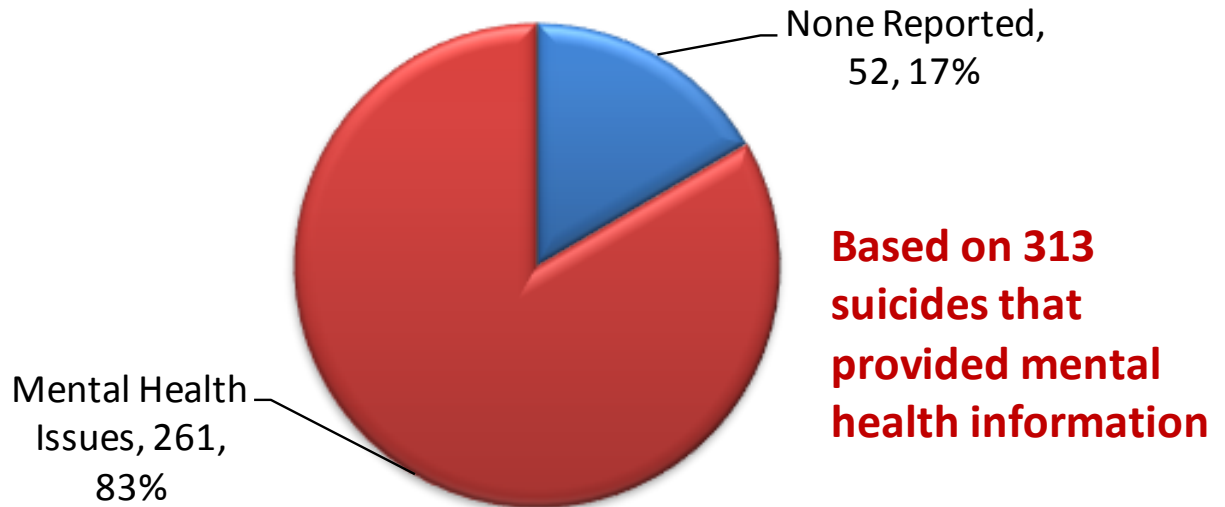
Montana Suicides who were Veterans (1/1/14 - 3/1/16)



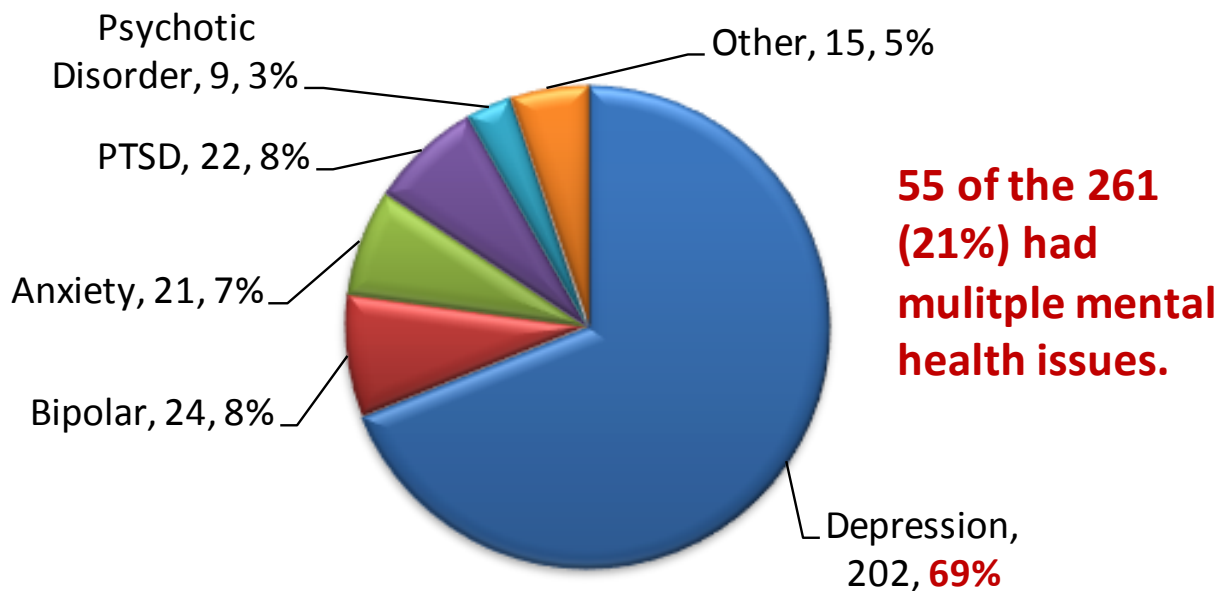
Montana Suicides by Age Range (1/1/14 - 3/1/16)



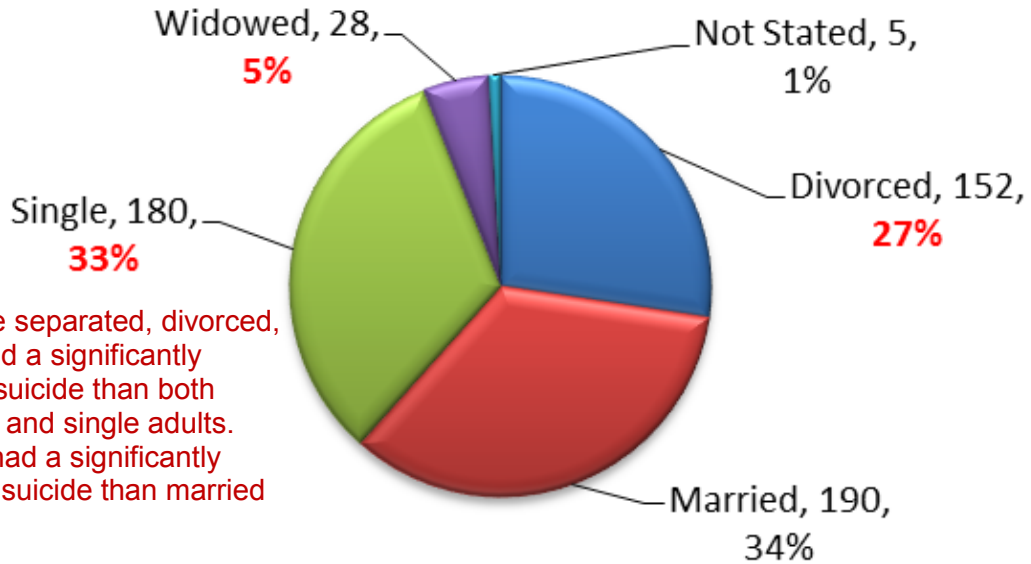
Montana Suicides with Identified Mental Health Issues



Montana Suicides By Type of Mental Health Disorder

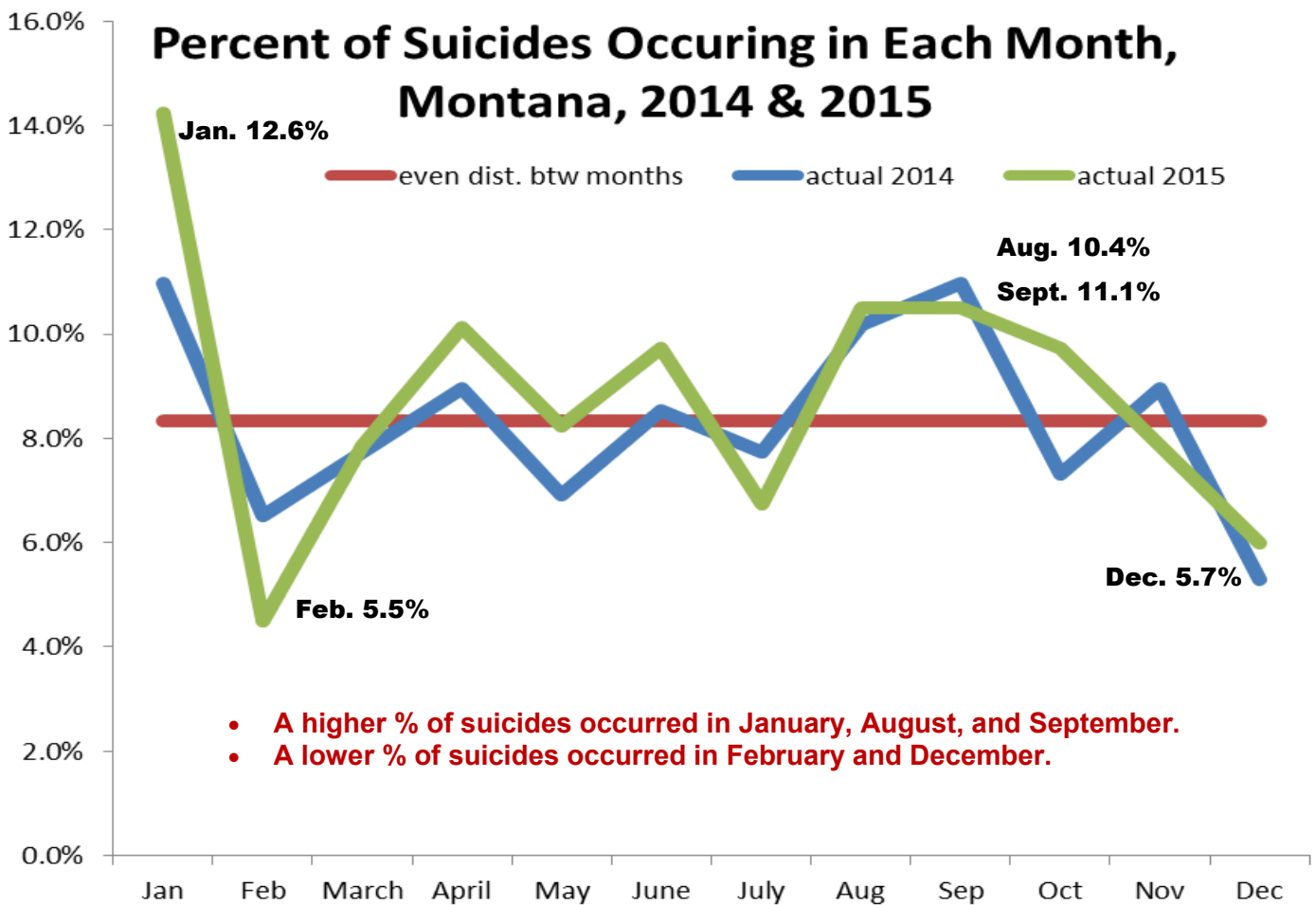


Montana Suicides by Relationship Status (1/1/14 - 3/1/16)



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

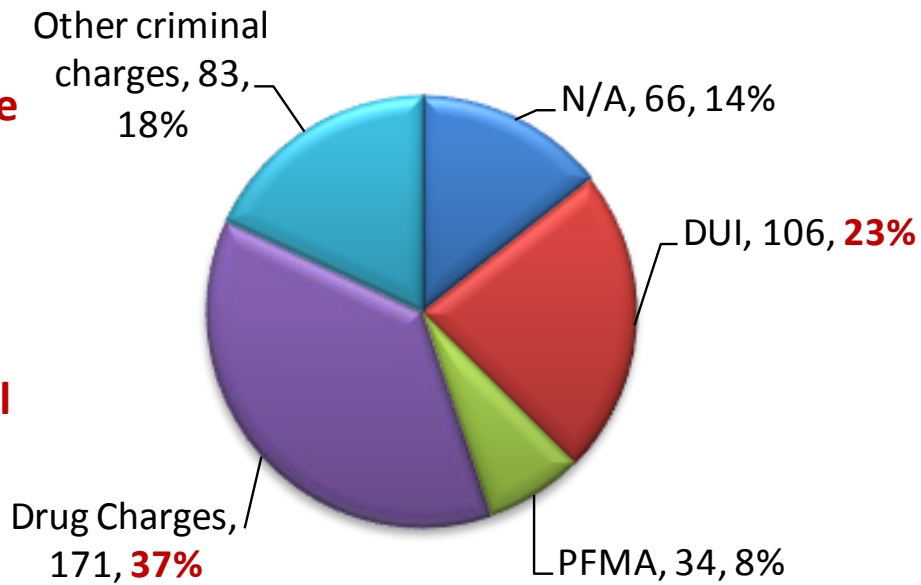
Percent of Suicides Occuring in Each Month, Montana, 2014 & 2015



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

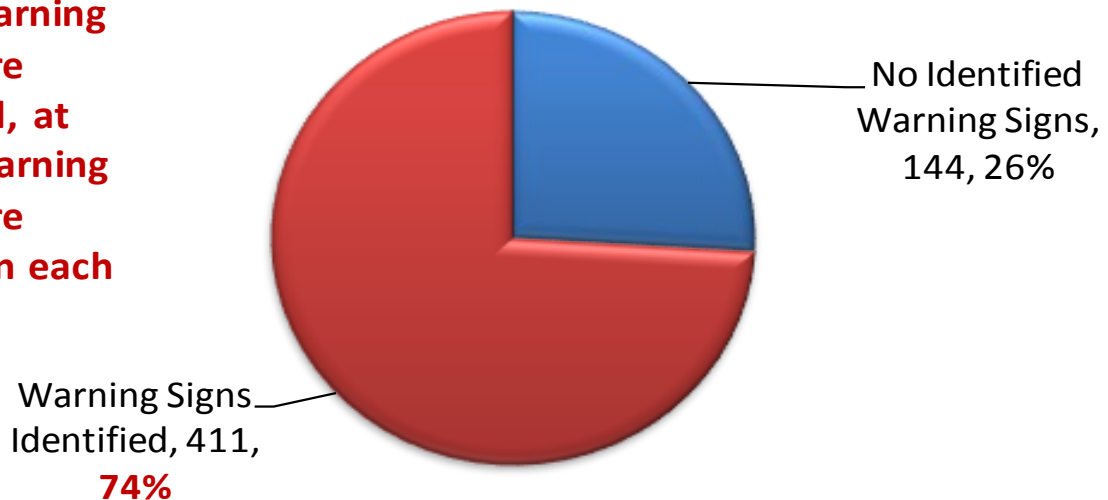
Montana Suicides based on Criminal History (1/1/14 - 3/1/16)

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



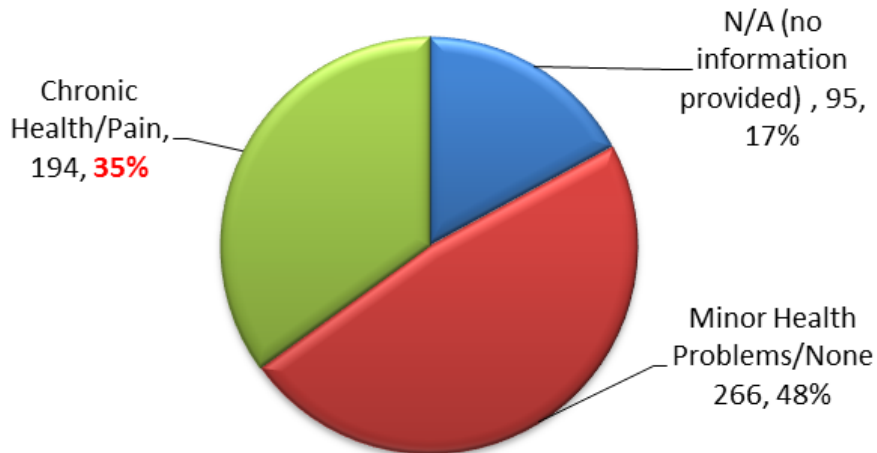
Montana Suicides with identified Warning Signs

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



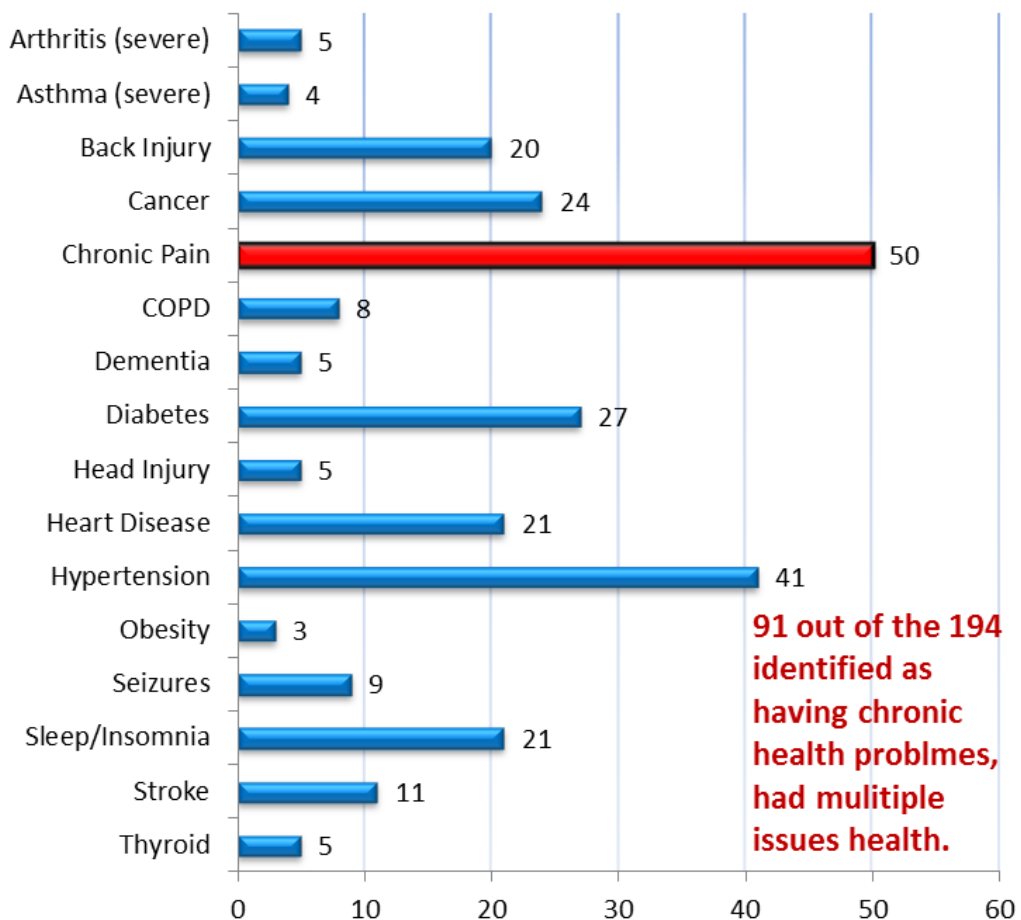
Montana Suicides by Identified Health Issues

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



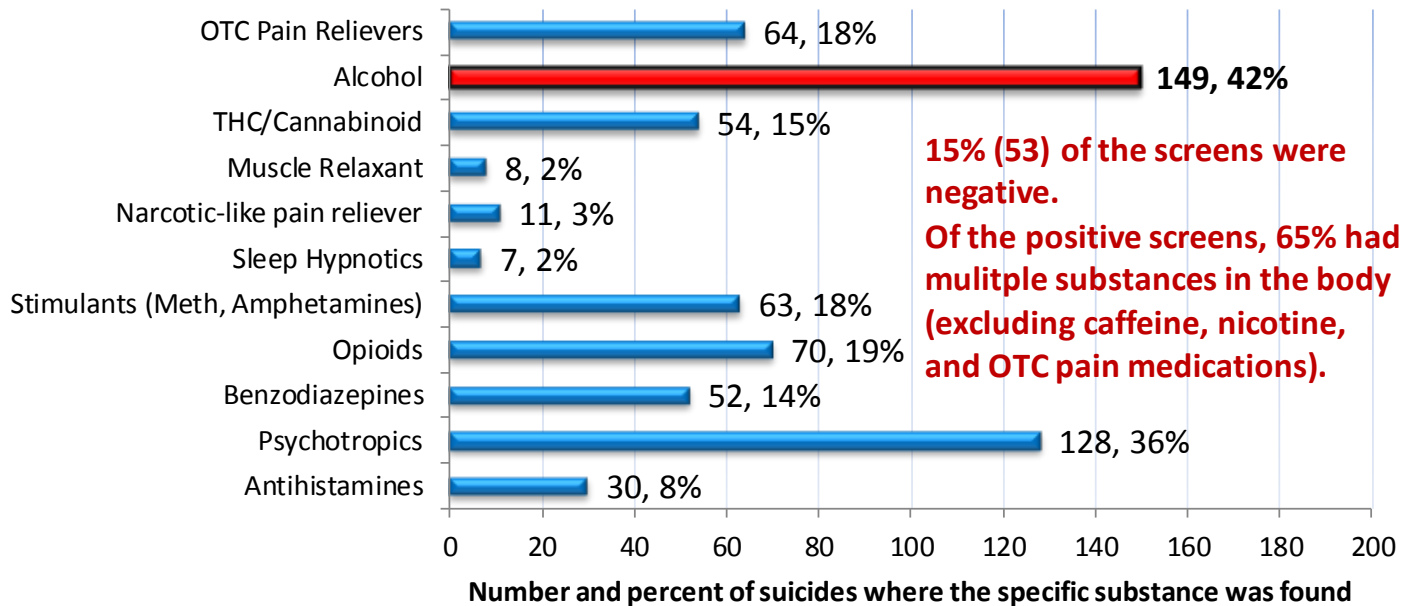
Most Frequent Health Issues identified in Montana Suicides

(based on 194 with identified health issues)

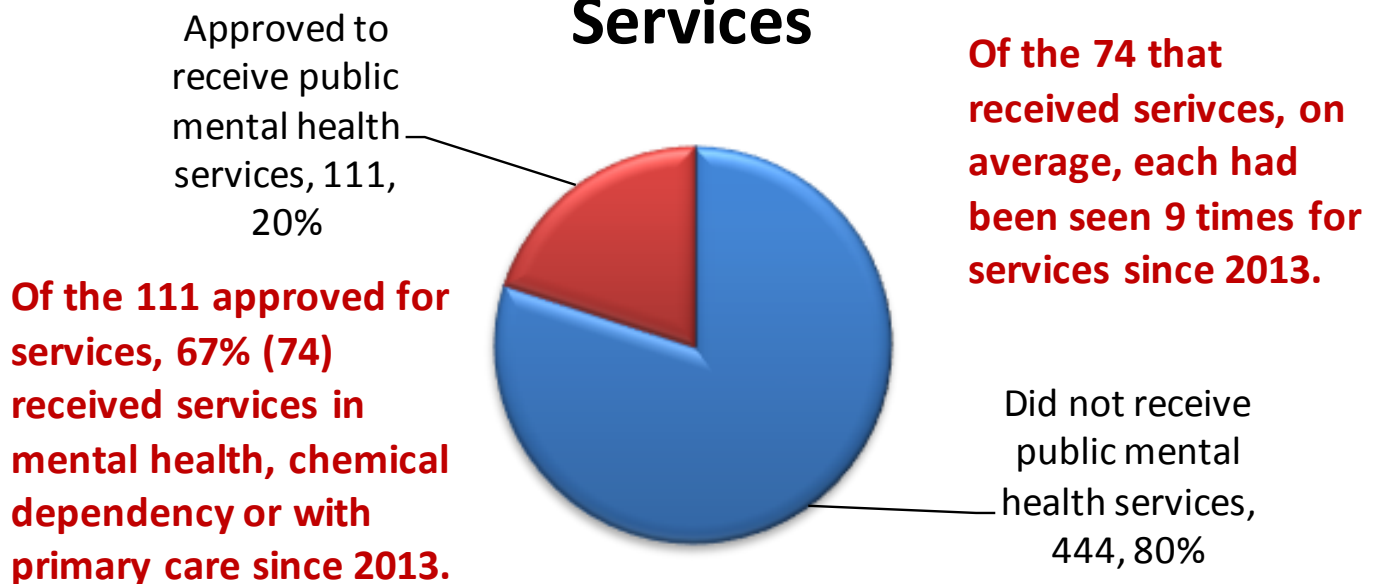


Montana Suicides based on Toxicology Reports

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

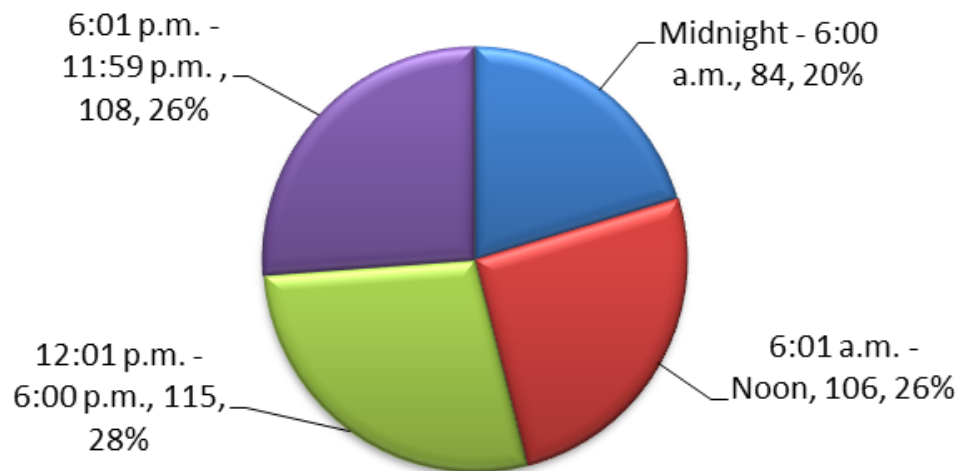


Montana Suicides that received Publically Funded Mental Health Services

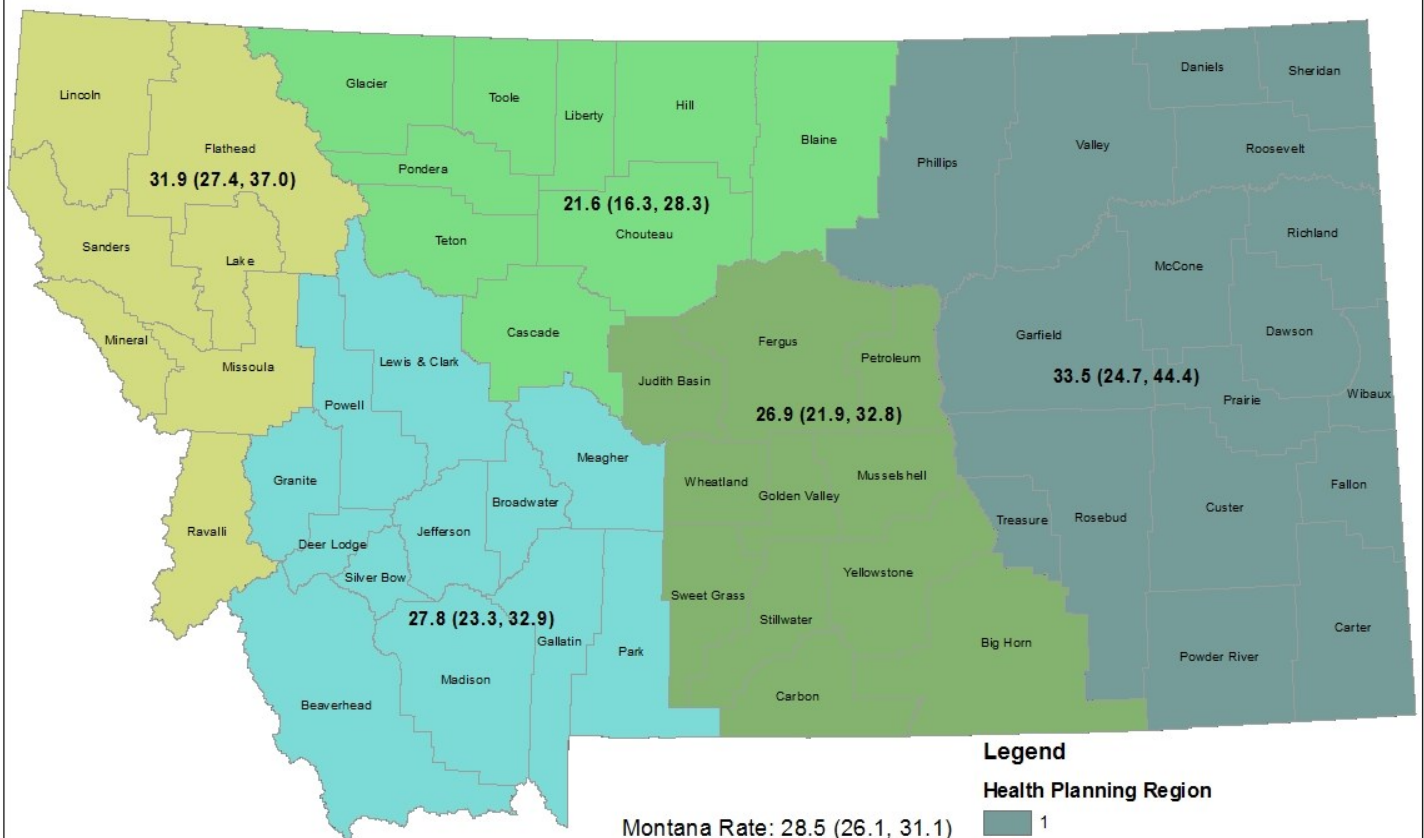


Montana Suicides by Time of Death

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



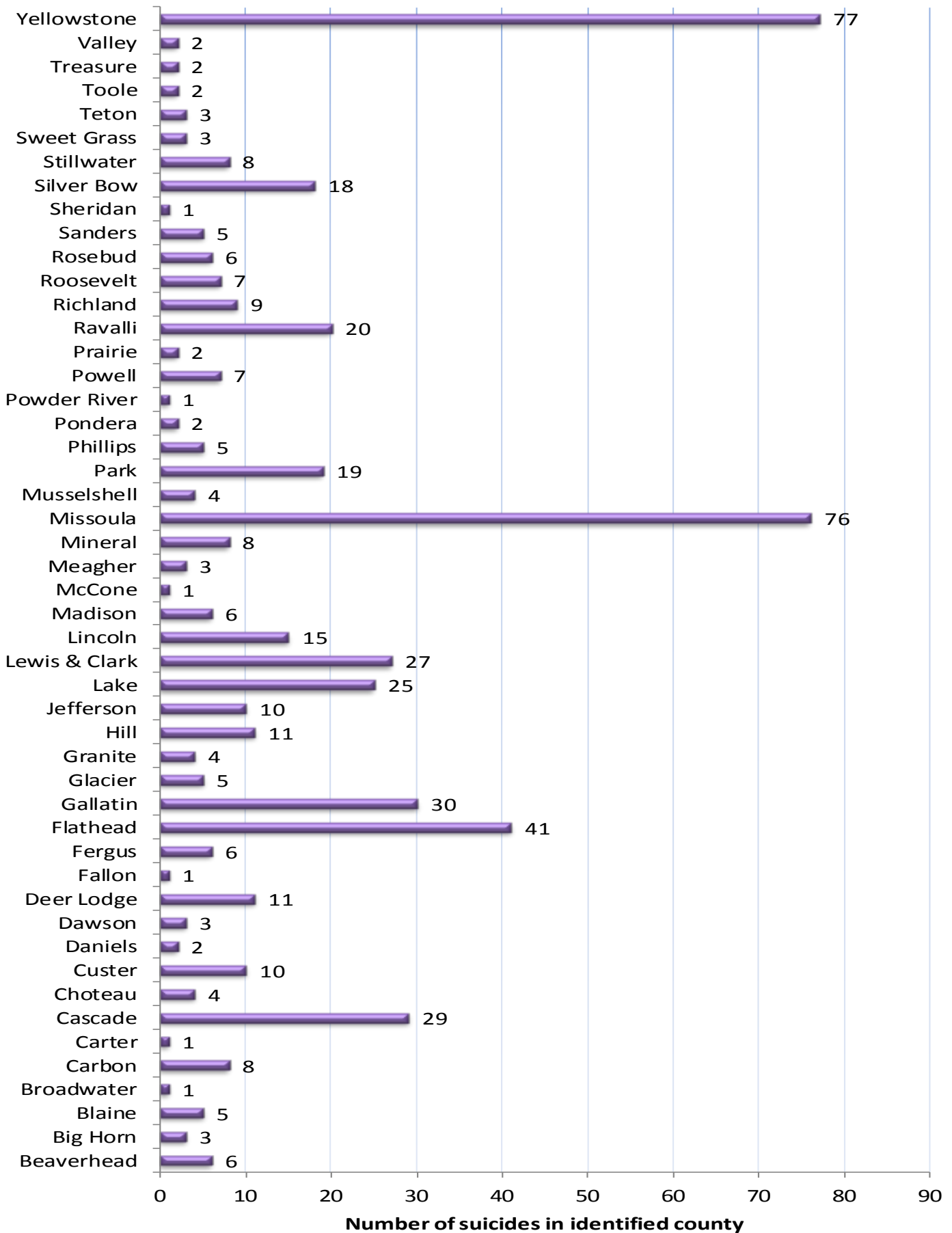
Suicide Rate per 100,000 Residents by Health Planning Region, Montana, 2014 & 2015



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

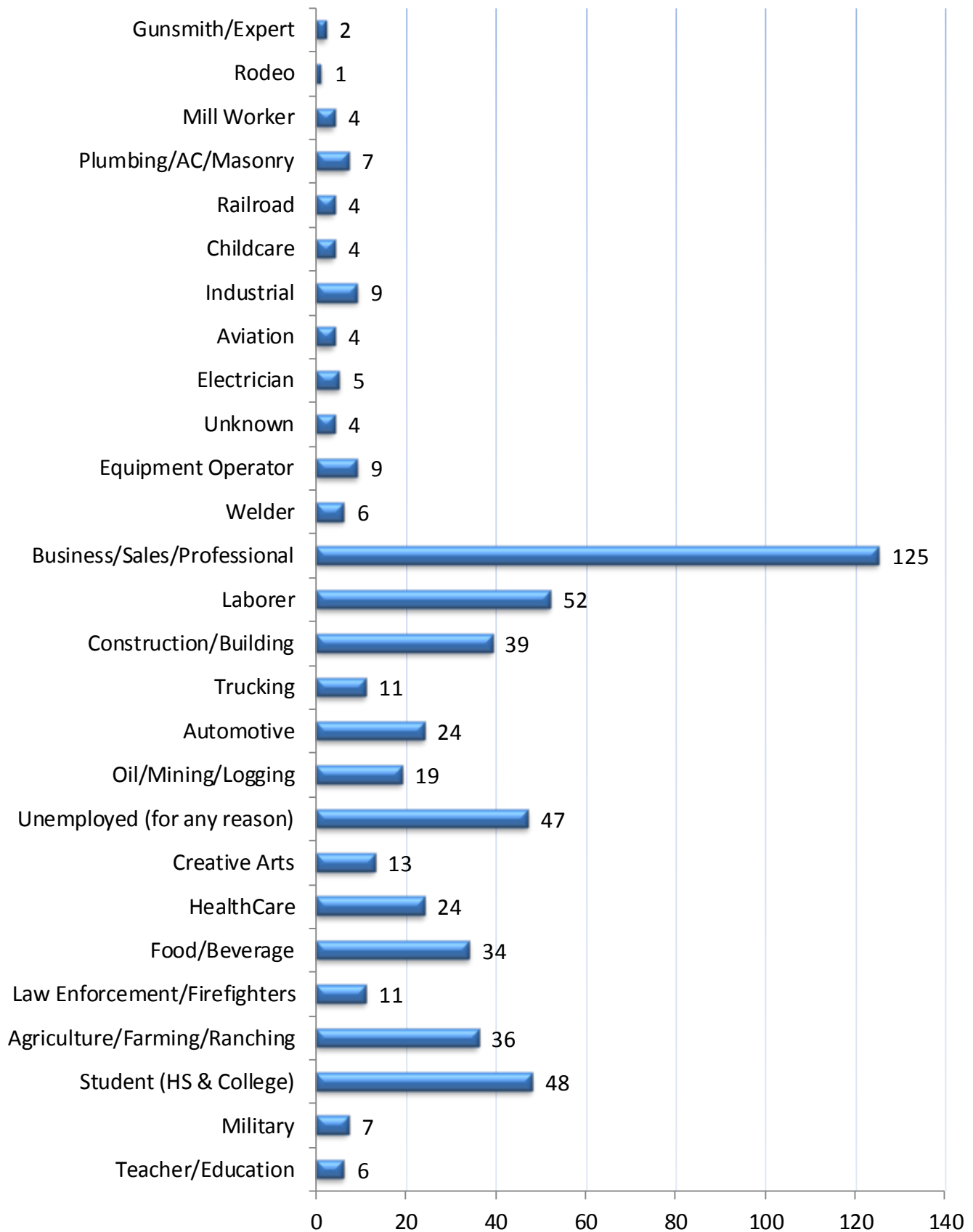
Montana Suicides by County of Residence

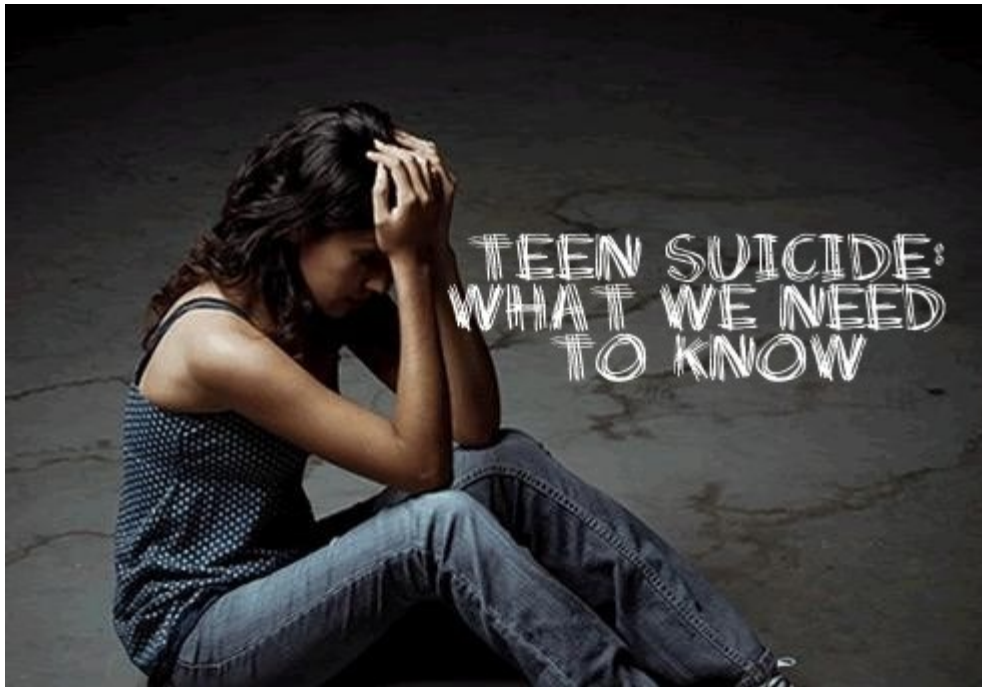
(1/1/14 - 3/1/16)



Montana Suicides by Occupation

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





Montana Youth Suicides

Ages 11-17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Youth Suicides (11-17) Montana by Ethnicity

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

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

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

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

Youth Suicides (11-17) Montana Males by Ethnicity

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

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

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

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

Youth Suicides (11-17) Montana Females by Ethnicity

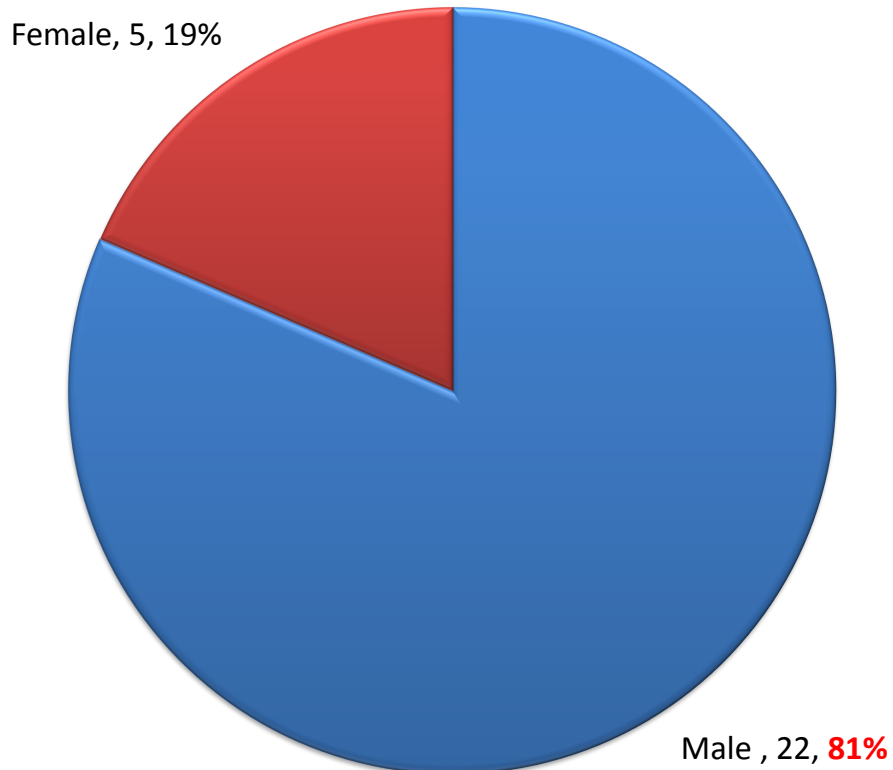
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Females, Ages 11 to 17
ICD-10 Codes: X60-X84, Y87.0, *U03

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

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

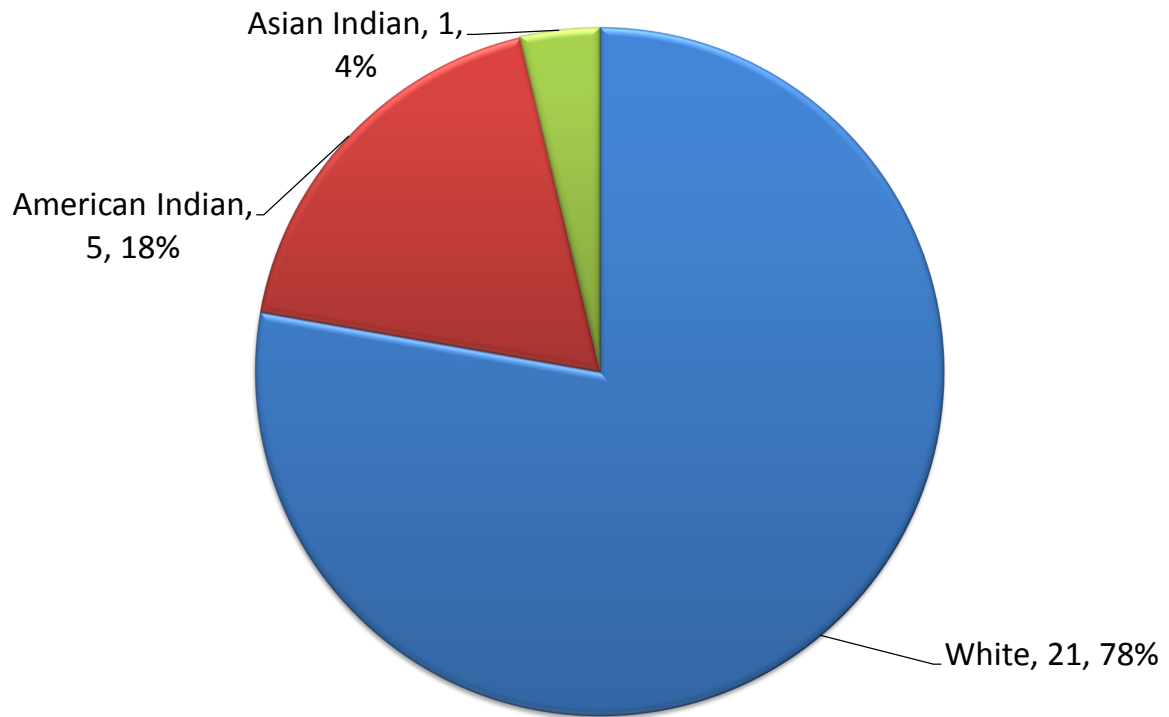
Number of Deaths	Population***	Crude Rate
13*	44,908	28.95*

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



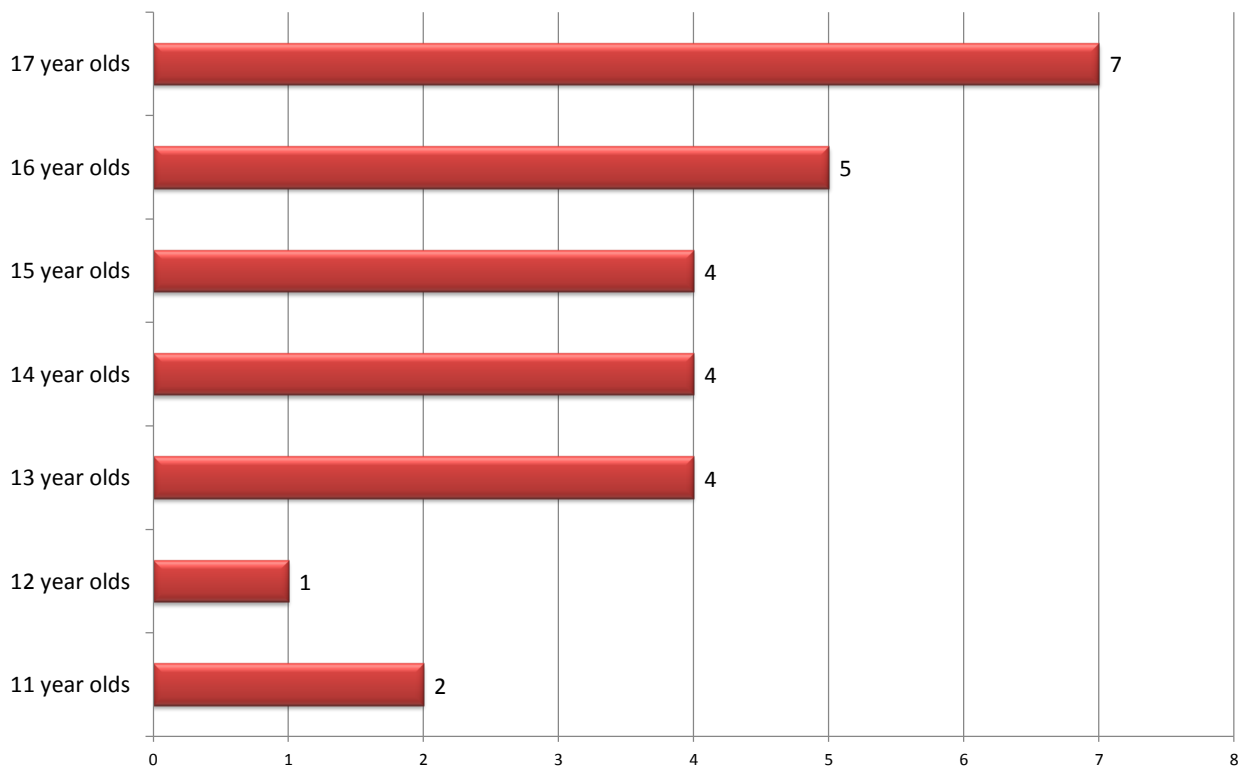
Youth Suicides (11-17) by Race

(January 1, 2014-March 1, 2016)

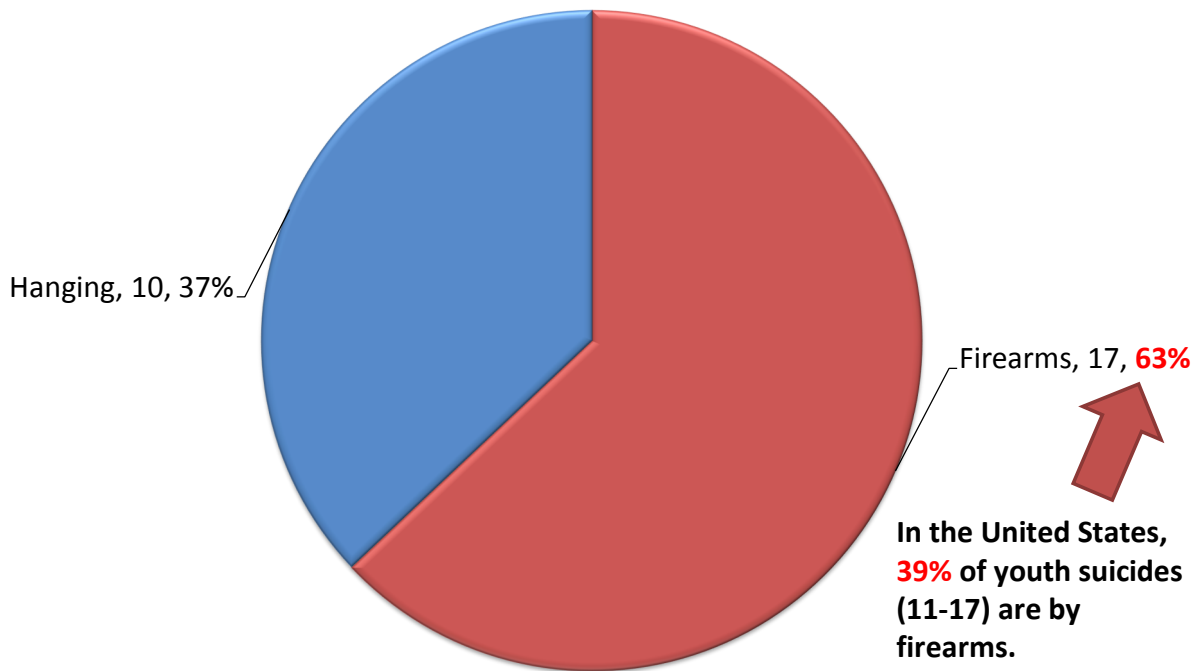


Youth Suicides (11-17) by Age

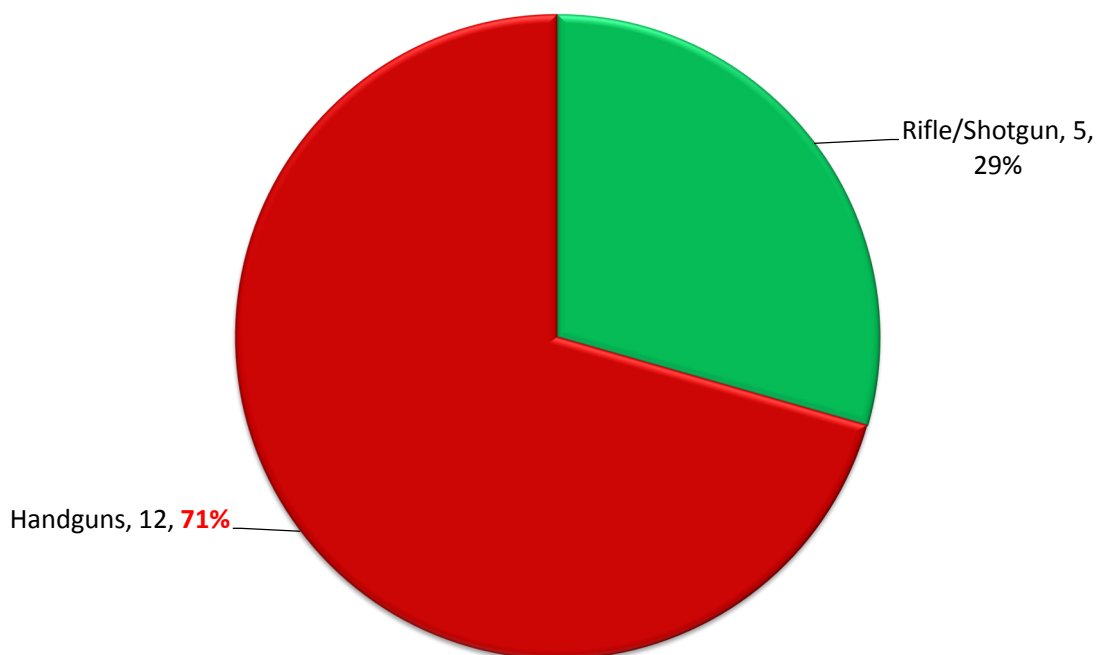
(January 1, 2014-March 1, 2016)



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

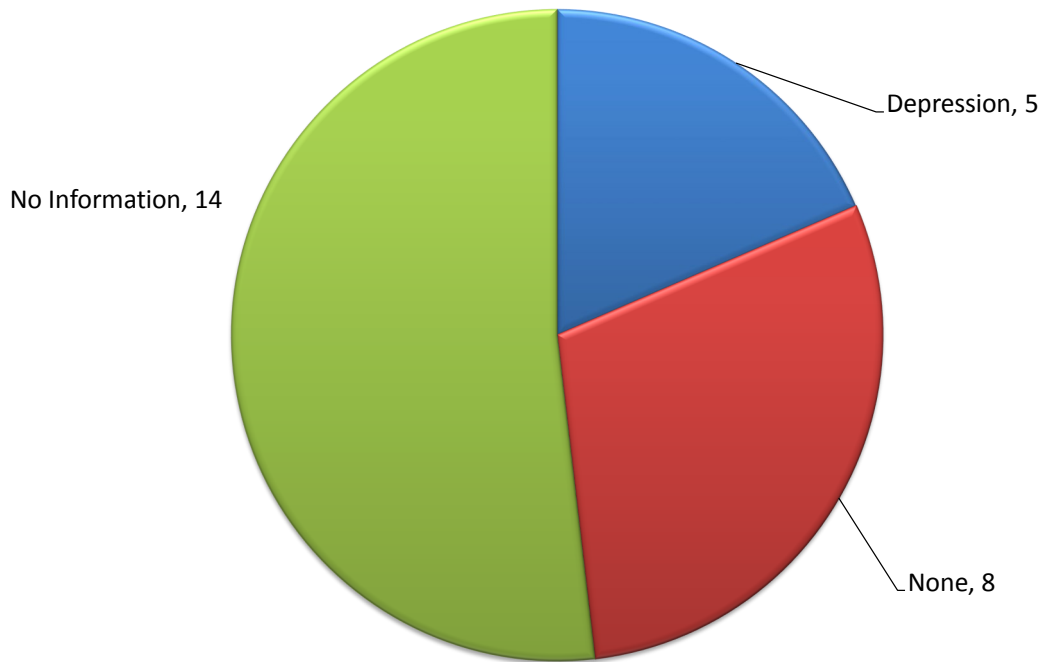


Youth Suicides (11-17) by Type of Firearm (January 1, 2014-March 1, 2016)



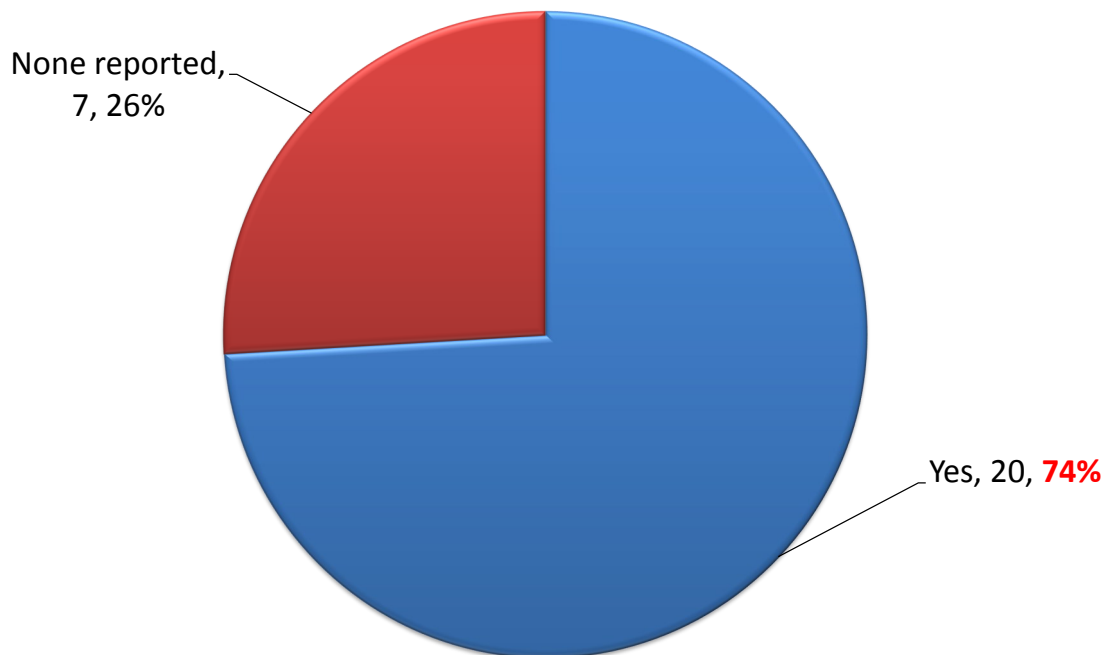
Youth Suicides (11-17) with Identified Mental Health Issues

(January 1, 2014-March 1, 2016)



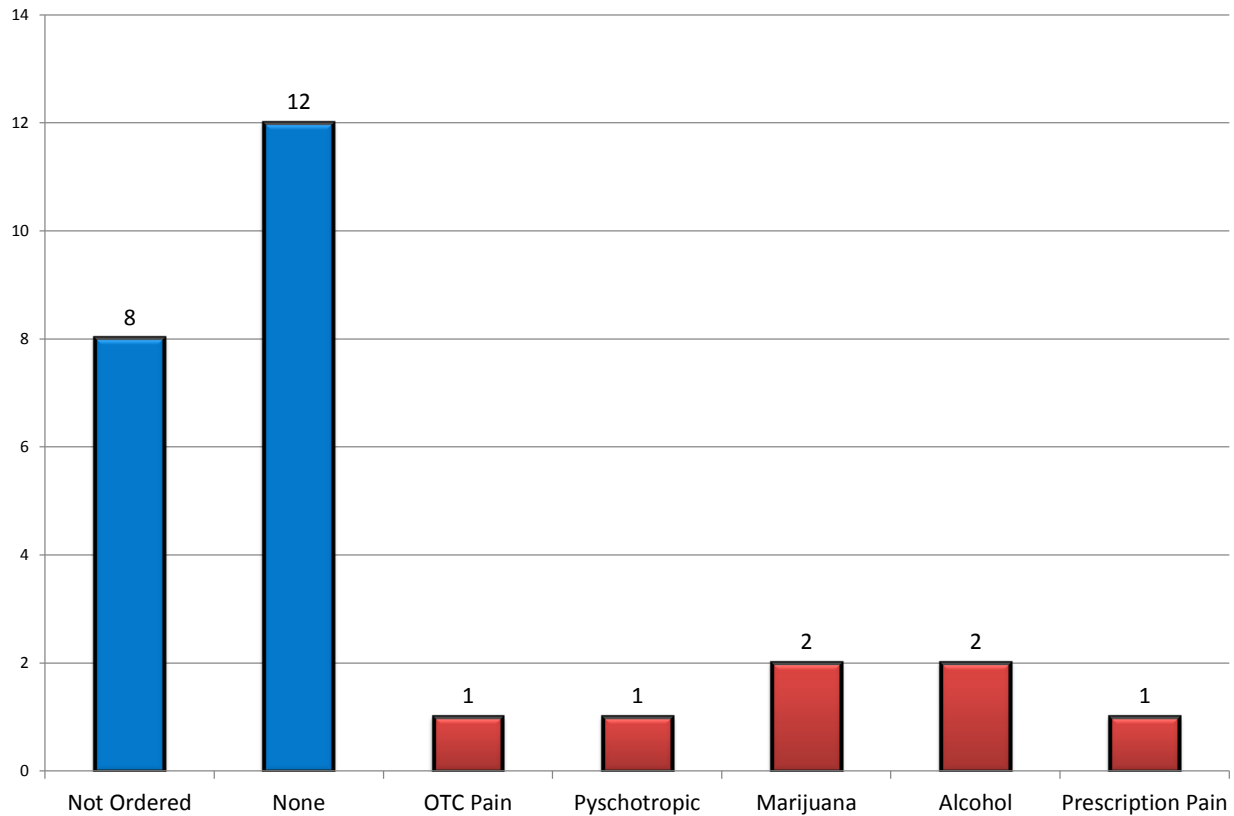
Youth Suicides (11-17) with identified Warning Signs

(January 1, 2014-March 1, 2016)



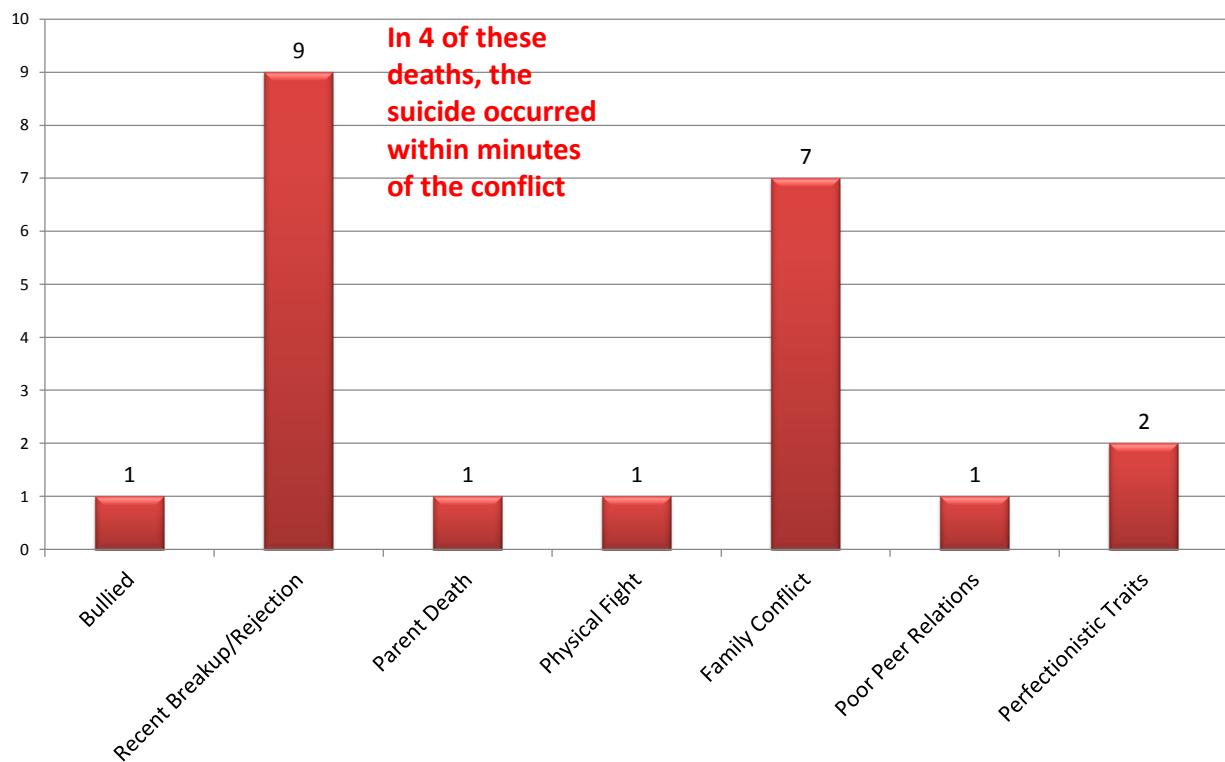
Toxicology Findings on Youth Suicides

(January 1, 2014-March 1, 2016)

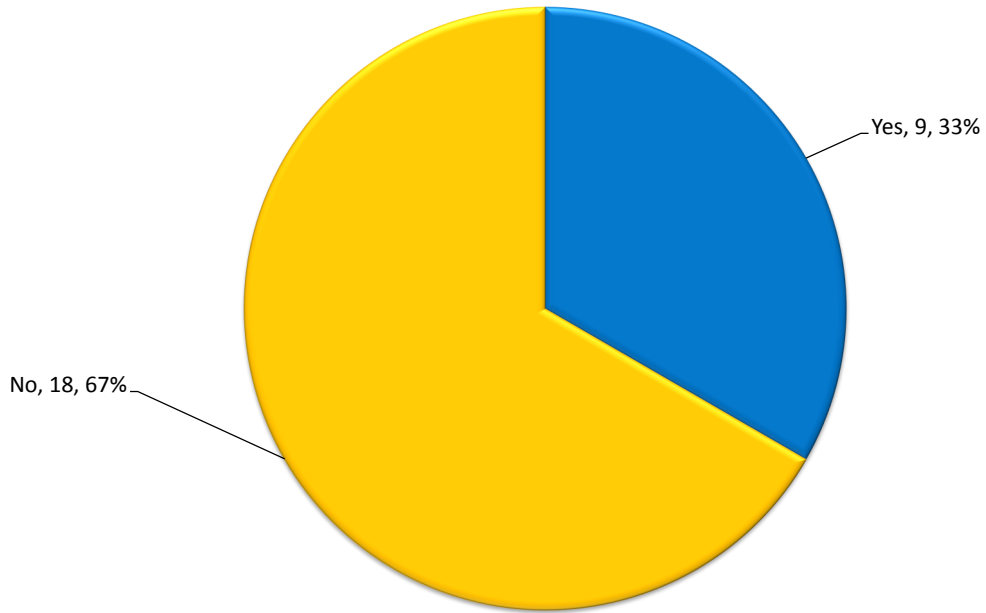


Youth Suicides (11-17) with known Relational Conflicts

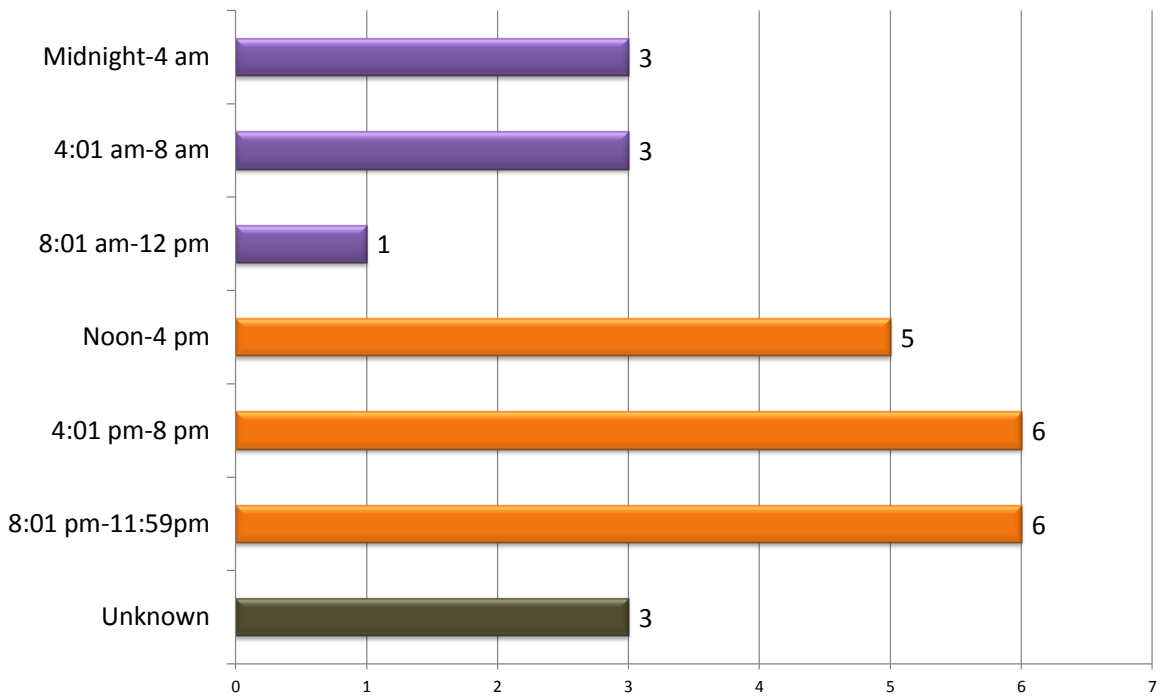
(January 1, 2014-March 1, 2016)



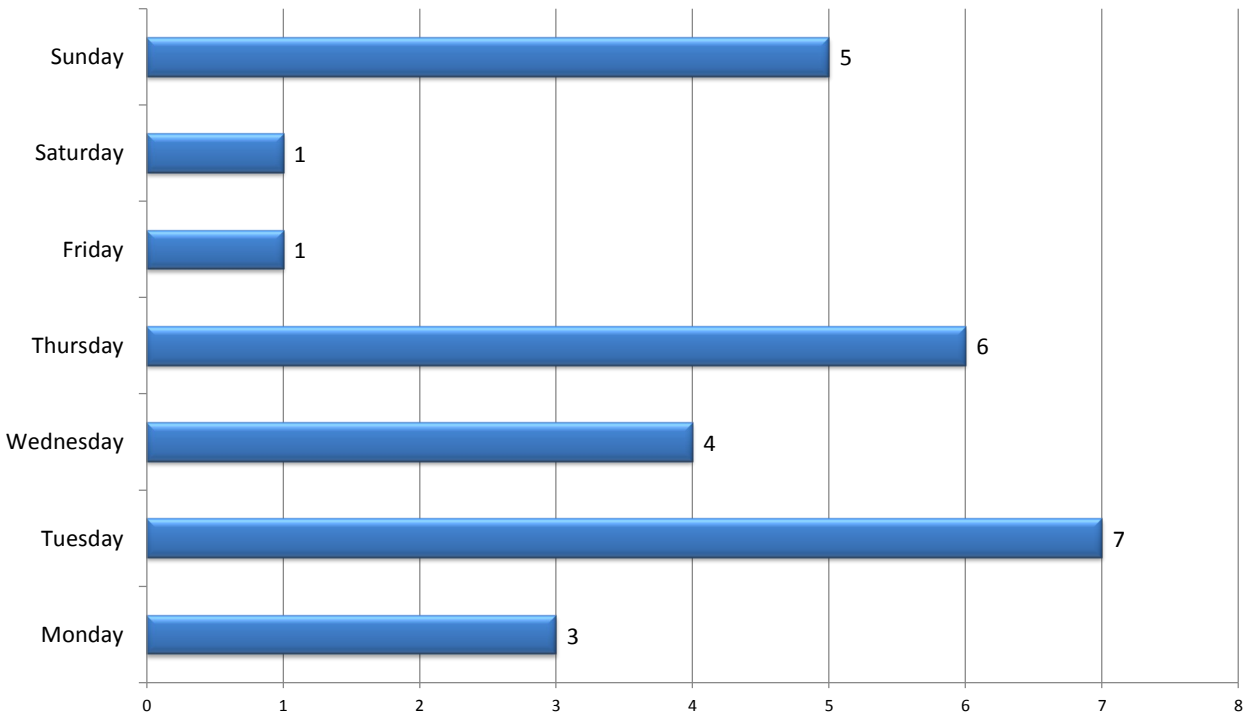
**Youth Suicides (11-17)
where a note was left
(January 1, 2014-March 1, 2016)**



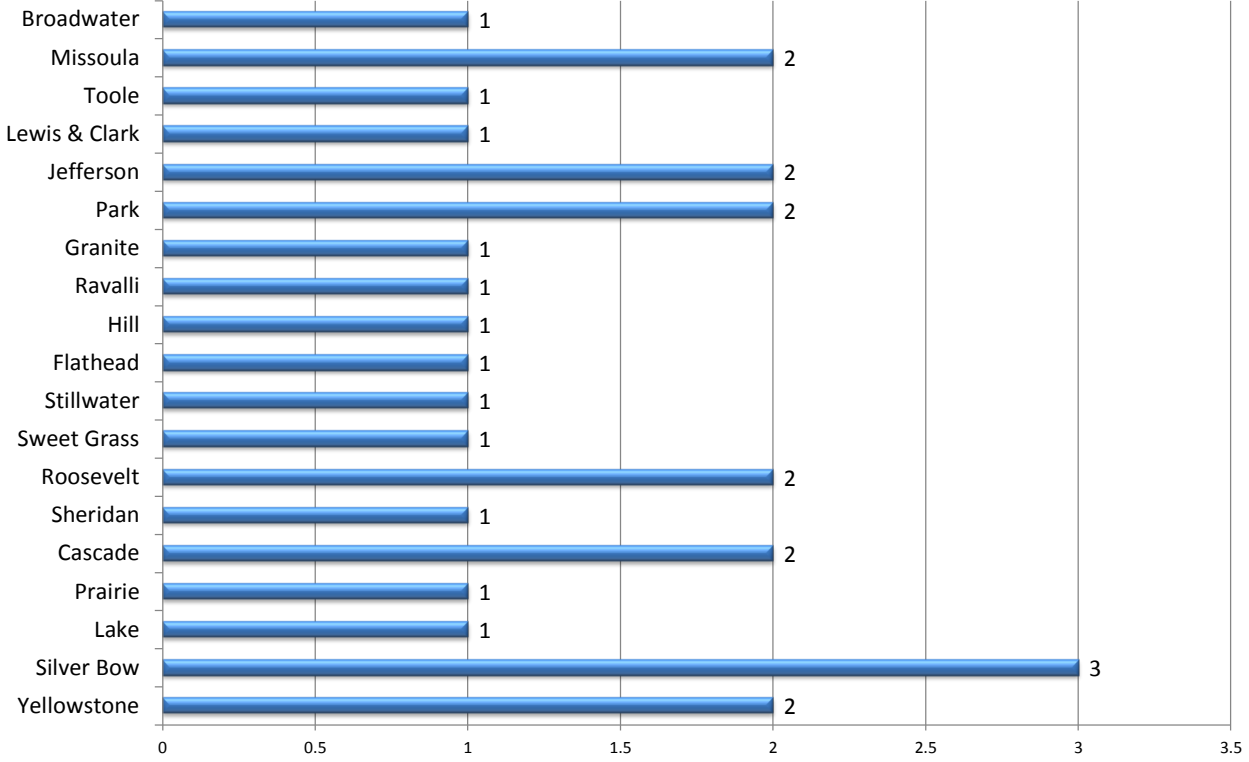
**Youth Suicides (11-17) by Time of Day
(January 1, 2014-March 1, 2016)**



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



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



Montana Youth Risk Behavior Survey – Montana Youth and Suicide

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

2015 Montana Youth Risk Behavior Survey Results Comparative Tables

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

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

2015 Youth Risk Behavior Survey Results

Montana – 10-year Trend Analysis Report

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

2015 Montana Youth Risk Behavior Survey

Suicide Report

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

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

2015 Montana Youth Risk Behavior Survey

Suicide Report

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

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



Suicide Among American Indians

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

Although nationally, Caucasians have the highest rate of suicide (15.4/100,000), with American Indians/Alaskan Natives being second (10.8/100,000), the rates are quite different when we talk about Montana, especially among American Indian youth. Over the past 10 years, Montana is averaging approximately 19 American Indian suicides a year, for a rate of 27.3/100,00 compared to 200 suicides for Caucasians in Montana over the same period of time for a rate of 22.11/100,000. This rate is largely due to the difference in population size. American Indians only constitute approximately 6% of Montana's population, compared to 90% Caucasian.

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

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

Suicides among American Indians, US vs MT

(Based on the CDC's WISQARS)

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

2005 - 2014, United States Suicide Injury Deaths and Rates per 100,000

Am Indian/AK Native, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

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

2005 - 2014, Montana Suicide Injury Deaths and Rates per 100,000

Am Indian/AK Native, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

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

Suicides among American Indians by Race

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

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

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

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

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

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

Suicides among American Indians by Gender

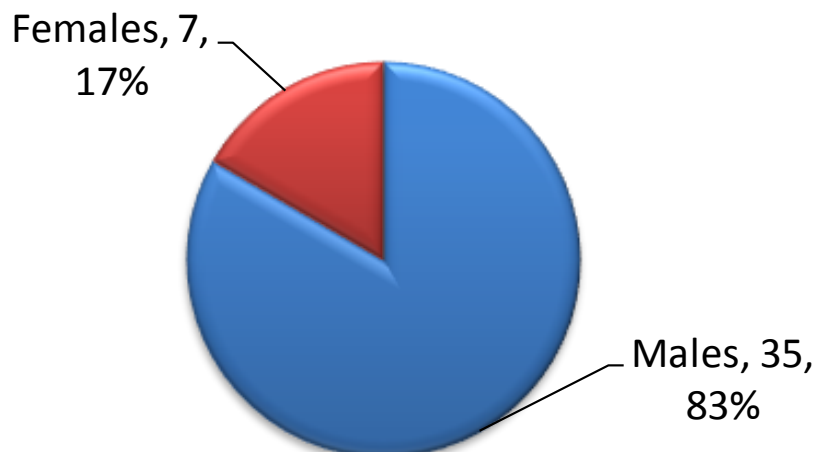
2005 - 2014, Montana
 Suicide Injury Deaths and Rates per 100,000
 Am Indian/AK Native, **Females**, All Ages
 ICD-10 Codes: X60-X84, Y87.0,*U03

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

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

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

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



Suicide among American Indians, ages 11-24

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

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

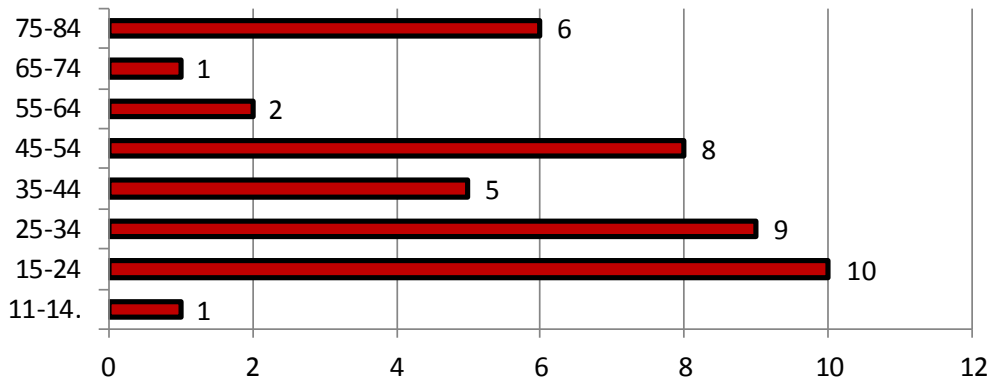
2005 - 2014, Montana
Suicide Injury Deaths and Rates per 100,000
White, Both Sexes, Ages 11 to 24
ICD-10 Codes: X60-X84, Y87.0,*U03

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

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

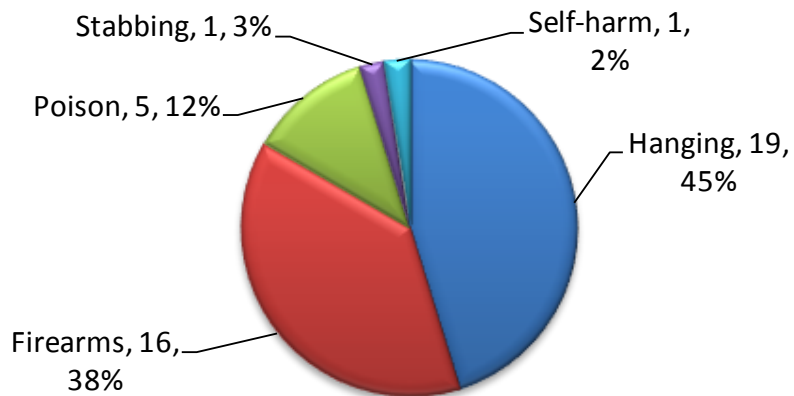
Number of Deaths	Population***	Crude Rate
76	177,489	42.82

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

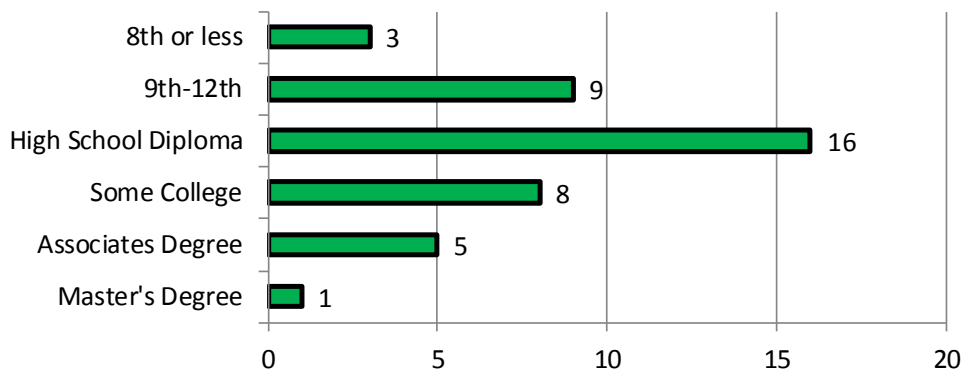


Unlike national and Montana percentages where firearms are the most common means of suicide, among Montana's American Indians, hanging was the most prominent means used.

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



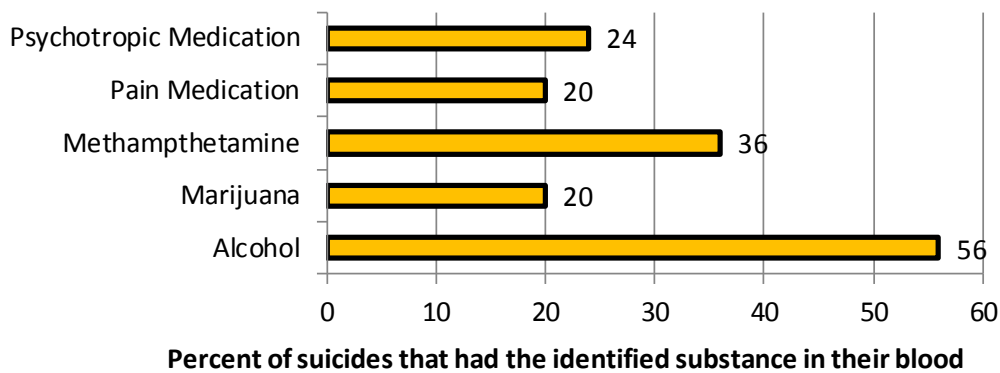
Educational Level of American Indian Suicides in Montana (1/1/14-3/1/16)



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

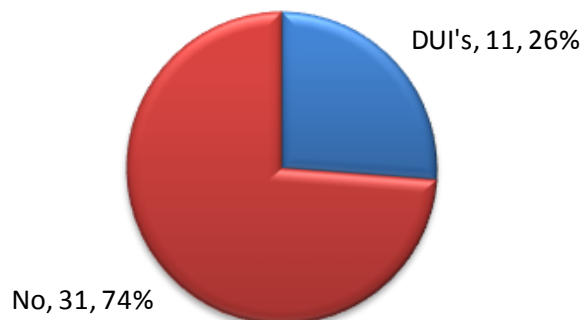
Toxicology reports of American Indian Suicides for 2014-2015

(% based on 25 received toxicology reports)

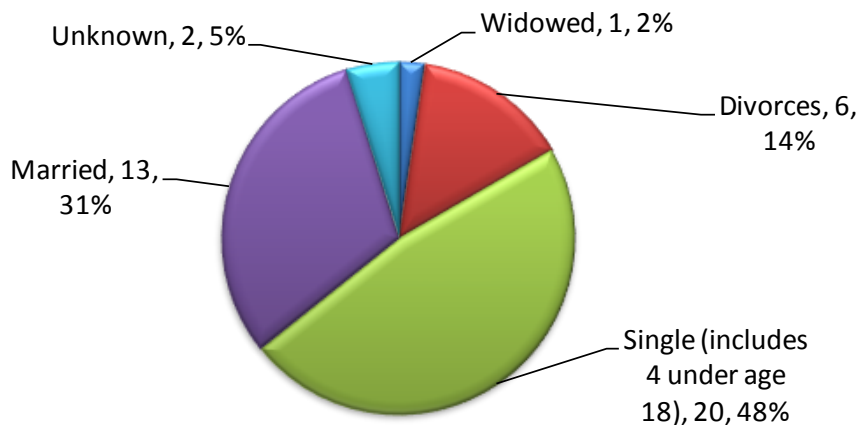


This is based on a small number of toxicology reports and only represents a percentage of those reports received. In 17 of the 25 toxicology reports, multiple substances were found (excluding caffeine, nicotine, and OTC medications.)

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

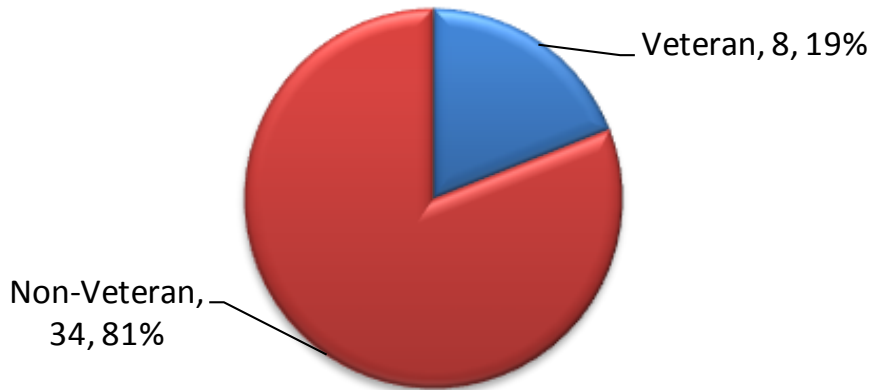


American Indian Suicides by Relationship Status

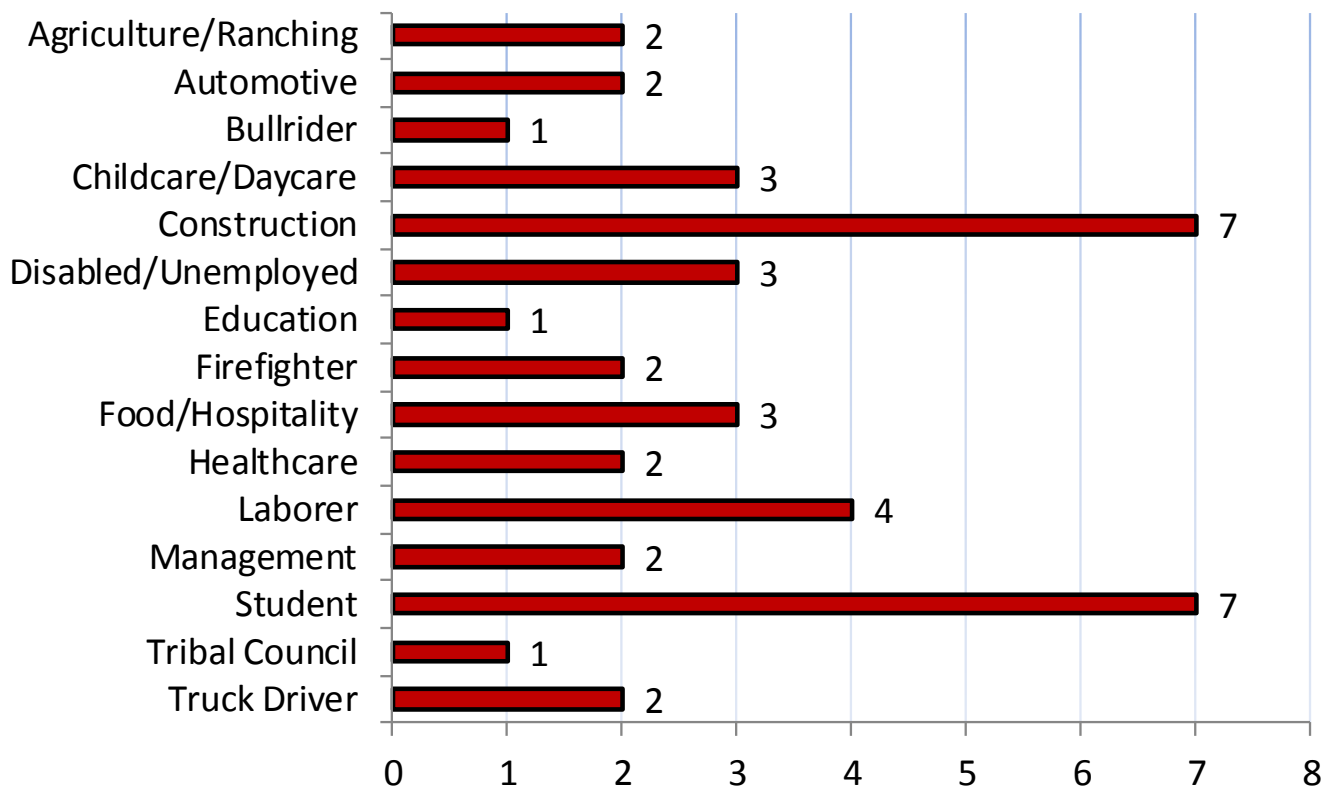


64% of American Indian suicides were either divorced, widowed, or single.

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

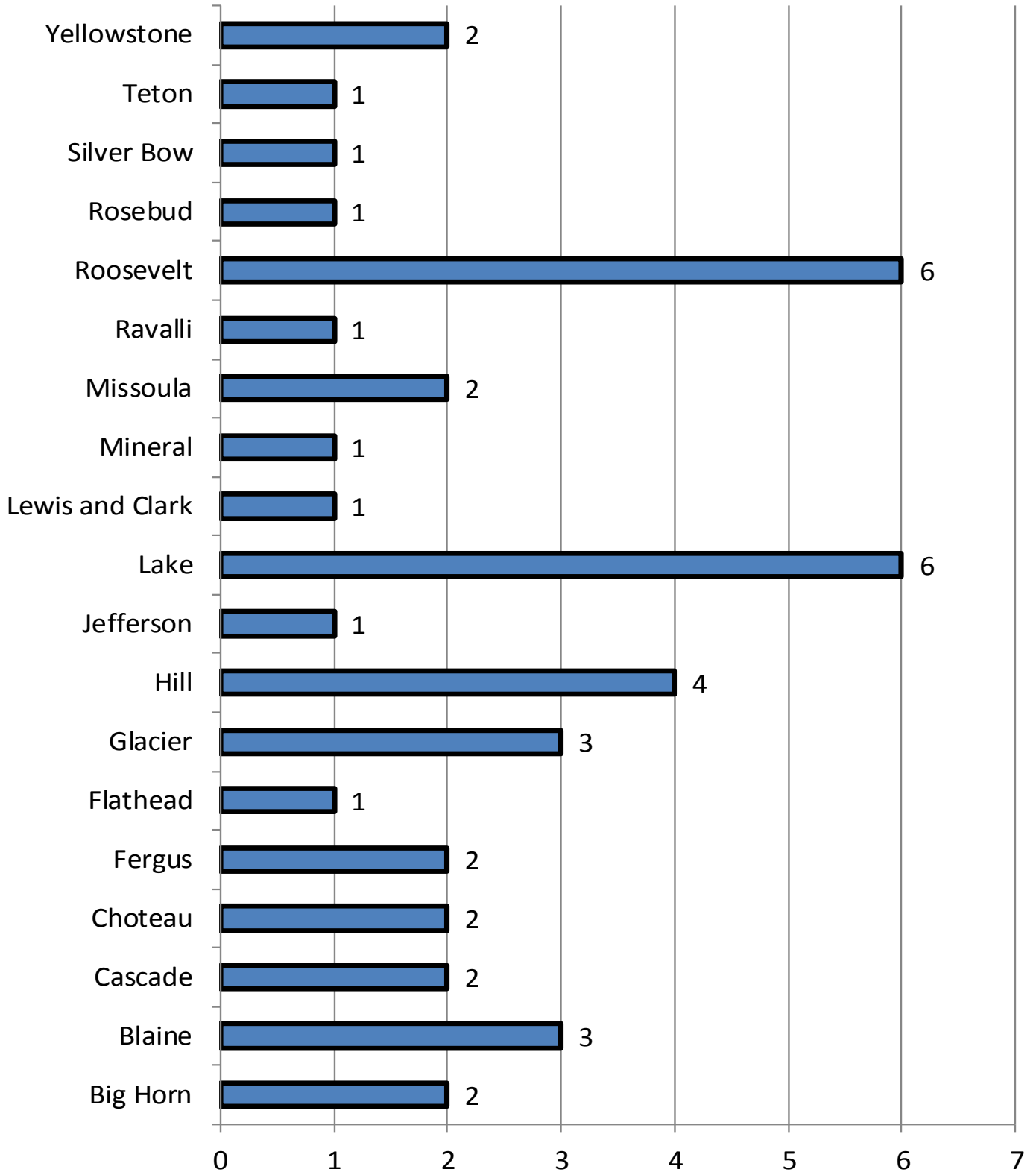


American Indian Suicides by Occupation (1/1/14-3/1/16)

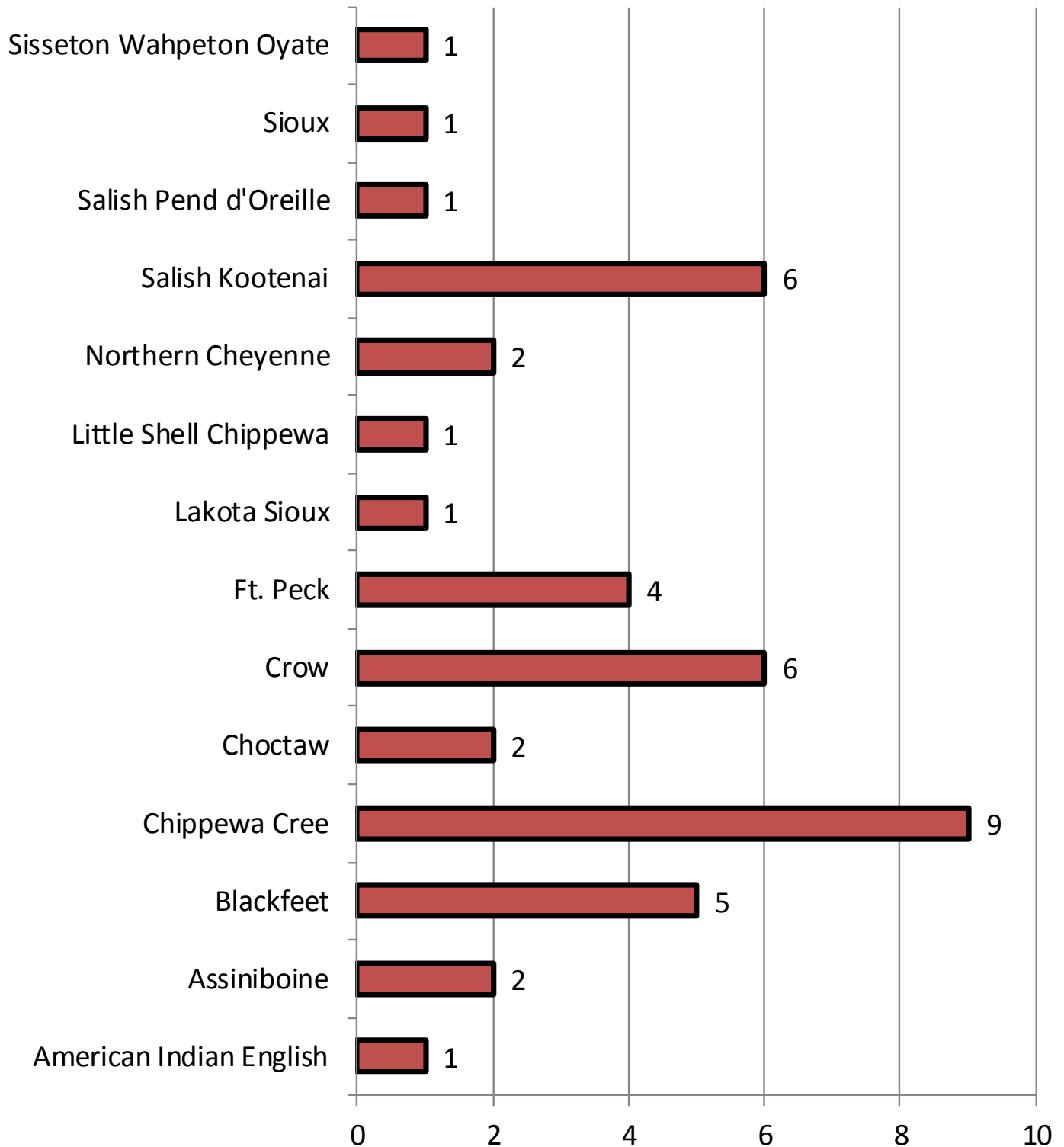


County of Residence of American Indian Suicides in Montana

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



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





Statistics concerning Veteran Suicides in Montana.

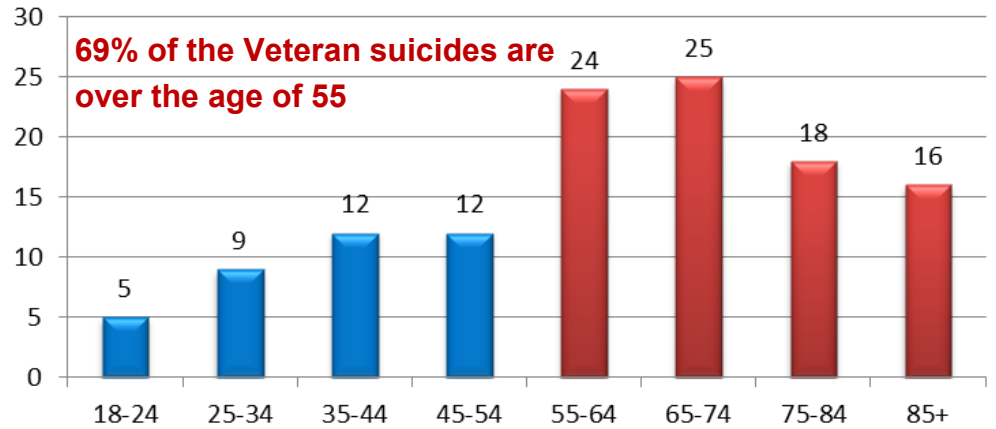
The following information was obtained by the Montana Suicide Mortality Review Team and includes 121 veteran suicides that occurred in Montana between January 1, 2014 and March 1, 2016.

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

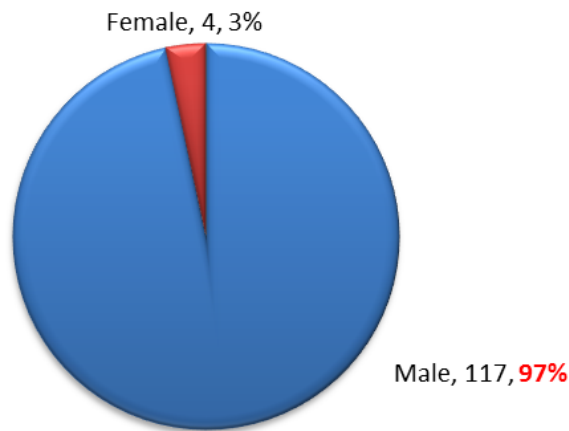
DUE TO THE SMALL SAMPLE SIZE, NO INFERENCES SHOULD BE MADE CONCERNING THE DATA PRESENTED. THIS IS ONLY MEANT TO GIVE NUMBERS AND PERCENTAGES CONCERNING VETERAN SUICIDES IN MONTANA .



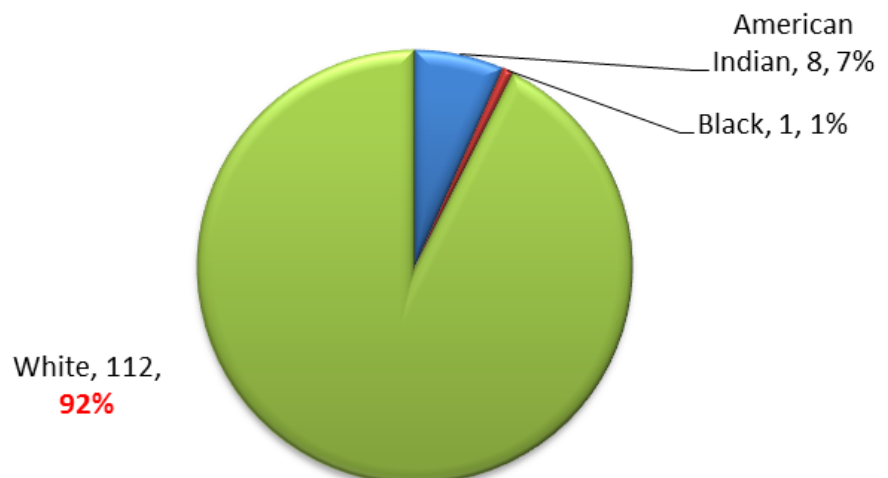
Montana Veteran Suicides by Age Range



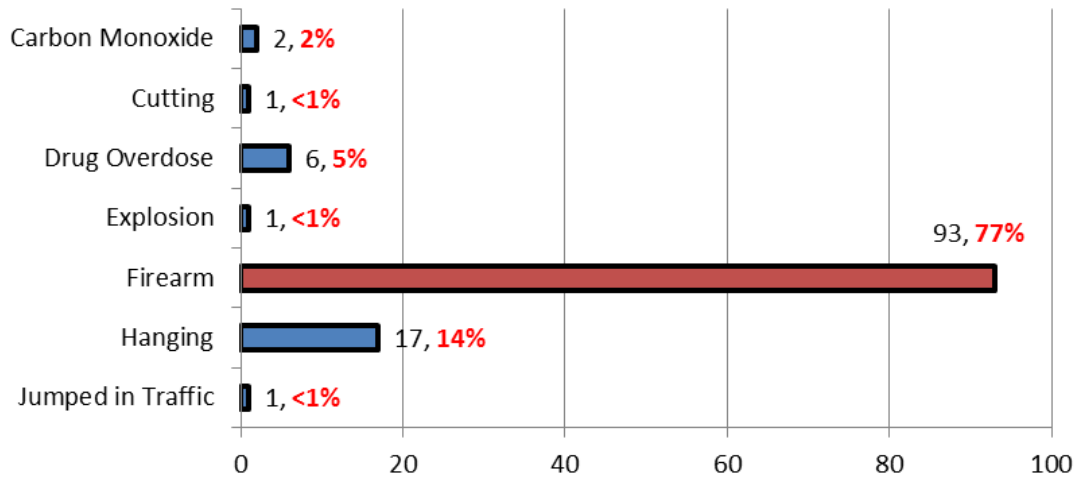
Montana Veteran Suicides by Gender



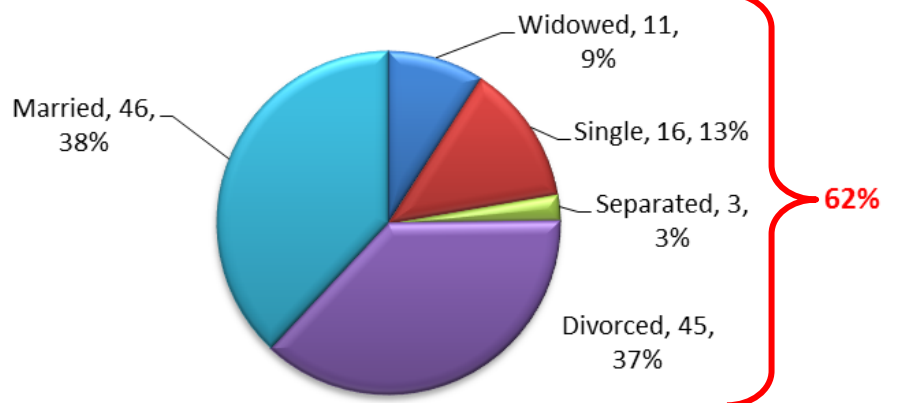
Montana Veteran Suicides by Race



Montana Veteran Suicides by Means

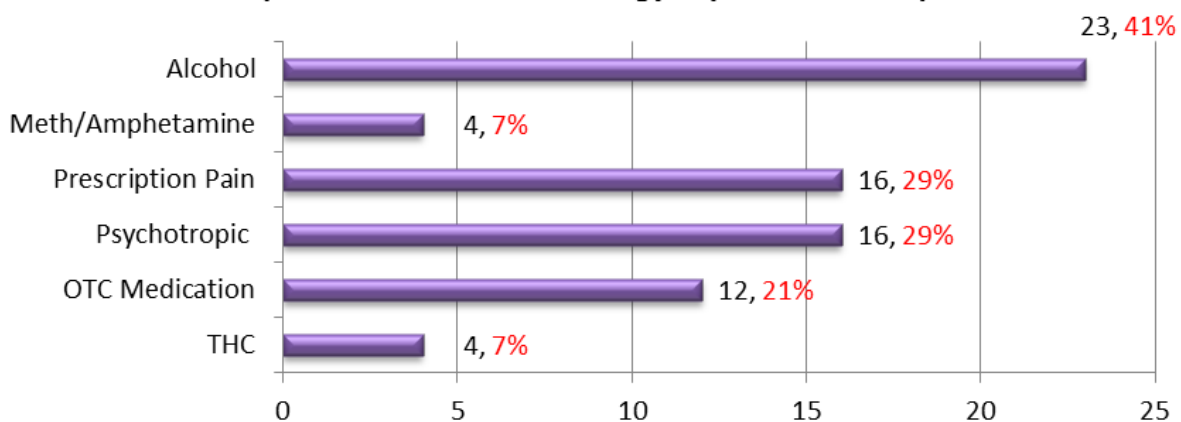


Montana Veteran Suicides by Relationship Status



Toxicology findings of Montana Veteran Suicides

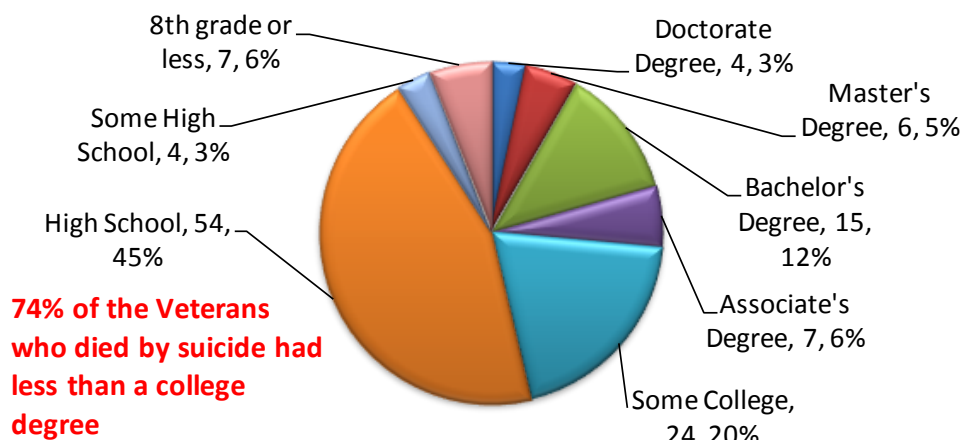
(% is based on 56 toxicology reports received)



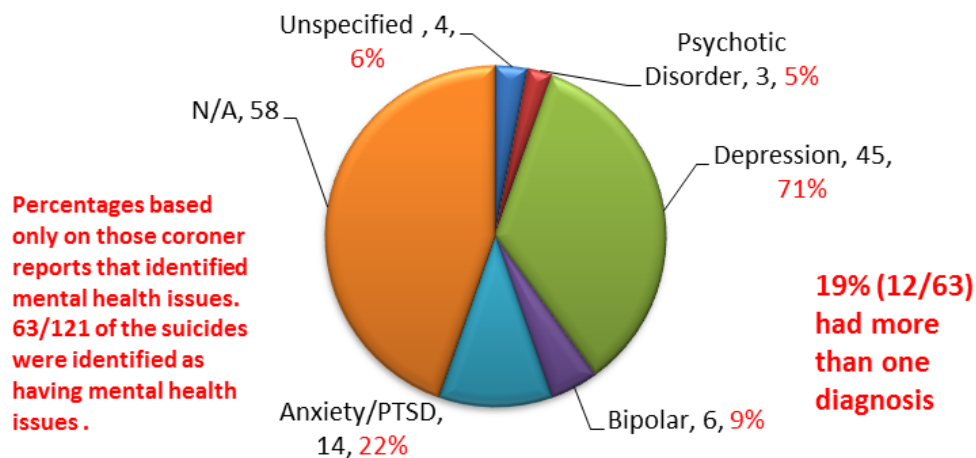
Montana Veteran Suicides with Chronic Pain/Health Issues



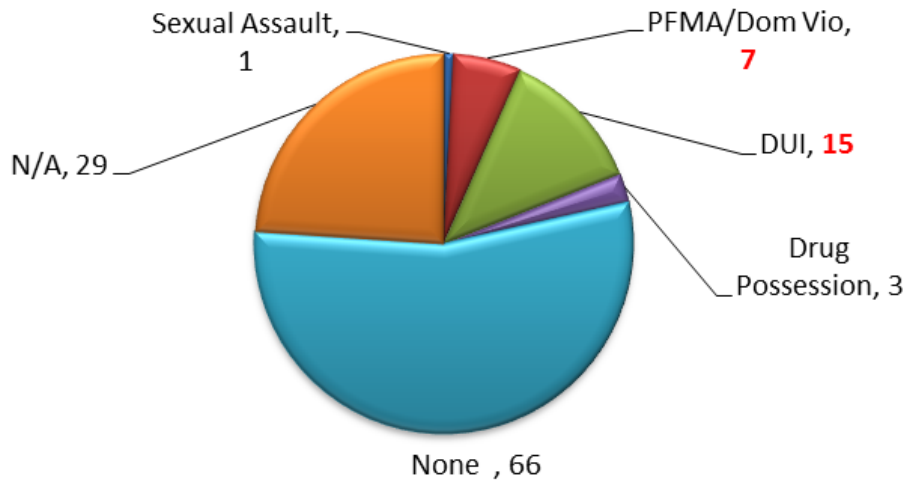
Montana Veteran Suicides by Education Level



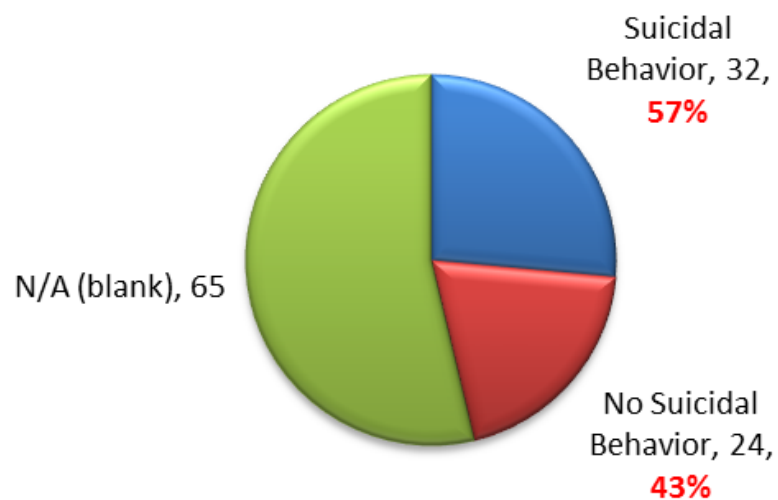
Montana Veteran Suicides with identified Mental Health Issues



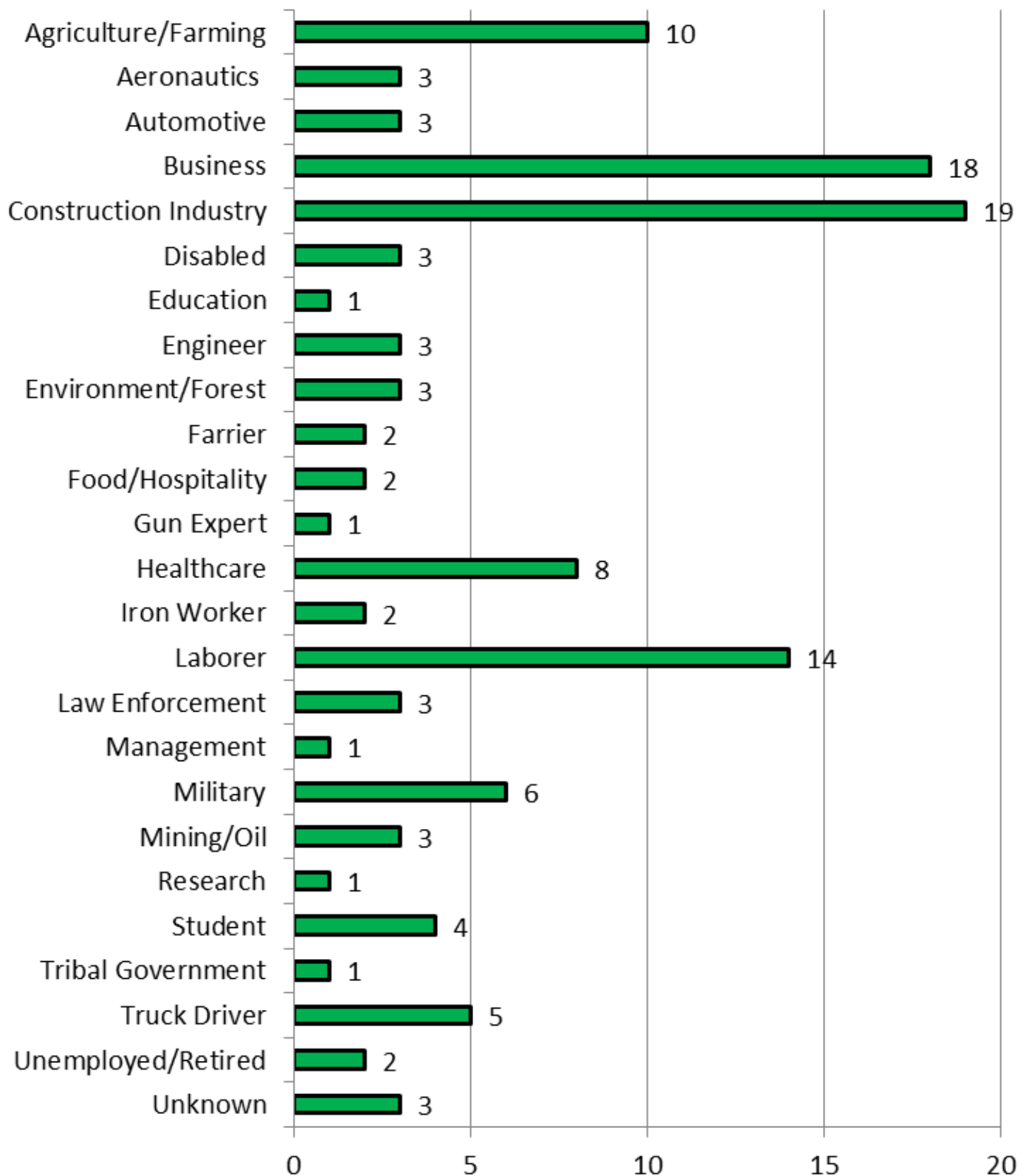
Montana Veteran Suicides with Criminal History



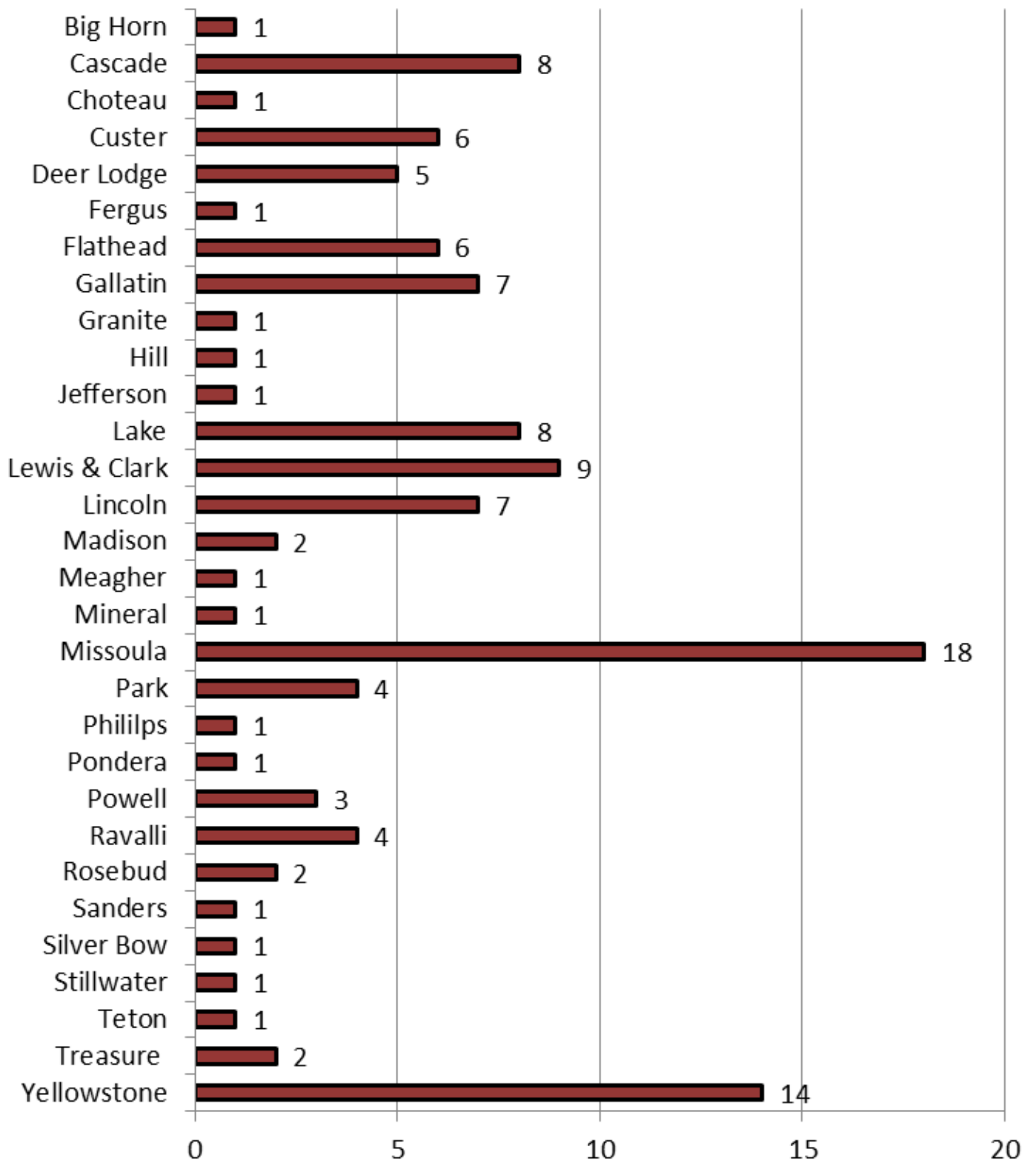
Montana Veteran suicides with history of previous suicidal behavior (% based on n=56)



Montana Veteran Suicides by Occupation



Montana Veteran Suicides by County



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

Policy Level Interventions

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

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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

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

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

add columns + +

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

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____
	Somewhat difficult _____
	Very difficult _____
	Extremely difficult _____

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

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

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

◆ **Columbia Suicide Severity Rating Scale**

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

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

Step 1: Identify Risk Factors					
C-SSRS Suicidal Ideation Severity	48 hr	Month	Lifetime (Worst)		
1) Wish to be dead <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>	Yellow	Yellow	Yellow		
2) Current suicidal thoughts <i>Have you actually had any thoughts of killing yourself?</i>	Orange	Orange	Yellow		
3) Suicidal thoughts w/ Method (w/no specific Plan or intent or act) <i>Have you been thinking about how you might kill yourself?</i>	Orange	Orange	Yellow		
4) Suicidal intent without Specific Plan <i>Have you had these thoughts and had some intention of acting on them?</i>	Red	Red	Yellow		
5) Intent with Plan <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>	Red	Red	Yellow		
C-SSRS Suicidal Behavior: <i>"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"</i>	48 hr	3 Months	Lifetime		
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Red	Red	Orange		
<table border="0"> <tr> <td style="vertical-align: top;"> Current and Past Psychiatric Dx: <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Alcohol/substance abuse disorders <input type="checkbox"/> PTSD <input type="checkbox"/> ADHD <input type="checkbox"/> TBI <input type="checkbox"/> Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic) <input type="checkbox"/> Conduct problems (antisocial behavior, aggression, impulsivity) <input type="checkbox"/> Recent onset Presenting Symptoms: <input type="checkbox"/> Anhedonia <input type="checkbox"/> Impulsivity <input type="checkbox"/> Hopelessness or despair <input type="checkbox"/> Anxiety and/or panic <input type="checkbox"/> Insomnia <input type="checkbox"/> Command hallucinations <input type="checkbox"/> Psychosis </td> <td style="vertical-align: top;"> Family History: <input type="checkbox"/> Suicide <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Axis I psychiatric diagnoses requiring hospitalization Precipitants/Stressors: <input type="checkbox"/> Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated) <input type="checkbox"/> Chronic physical pain or other acute medical problem (e.g. CNS disorders) <input type="checkbox"/> Sexual/physical abuse <input type="checkbox"/> Substance intoxication or withdrawal <input type="checkbox"/> Pending incarceration or homelessness <input type="checkbox"/> Legal problems <input type="checkbox"/> Inadequate social supports <input type="checkbox"/> Social isolation <input type="checkbox"/> Perceived burden on others Change in treatment: <input type="checkbox"/> Recent inpatient discharge <input type="checkbox"/> Change in provider or treatment (i.e., medications, psychotherapy, milieu) <input type="checkbox"/> Hopeless or dissatisfied with provider or treatment <input type="checkbox"/> Non-compliant or not receiving treatment </td> </tr> </table>				Current and Past Psychiatric Dx: <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Alcohol/substance abuse disorders <input type="checkbox"/> PTSD <input type="checkbox"/> ADHD <input type="checkbox"/> TBI <input type="checkbox"/> Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic) <input type="checkbox"/> Conduct problems (antisocial behavior, aggression, impulsivity) <input type="checkbox"/> Recent onset Presenting Symptoms: <input type="checkbox"/> Anhedonia <input type="checkbox"/> Impulsivity <input type="checkbox"/> Hopelessness or despair <input type="checkbox"/> Anxiety and/or panic <input type="checkbox"/> Insomnia <input type="checkbox"/> Command hallucinations <input type="checkbox"/> Psychosis	Family History: <input type="checkbox"/> Suicide <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Axis I psychiatric diagnoses requiring hospitalization Precipitants/Stressors: <input type="checkbox"/> Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated) <input type="checkbox"/> Chronic physical pain or other acute medical problem (e.g. CNS disorders) <input type="checkbox"/> Sexual/physical abuse <input type="checkbox"/> Substance intoxication or withdrawal <input type="checkbox"/> Pending incarceration or homelessness <input type="checkbox"/> Legal problems <input type="checkbox"/> Inadequate social supports <input type="checkbox"/> Social isolation <input type="checkbox"/> Perceived burden on others Change in treatment: <input type="checkbox"/> Recent inpatient discharge <input type="checkbox"/> Change in provider or treatment (i.e., medications, psychotherapy, milieu) <input type="checkbox"/> Hopeless or dissatisfied with provider or treatment <input type="checkbox"/> Non-compliant or not receiving treatment
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<input type="checkbox"/> Access to lethal methods: Ask <u>specifically</u> about presence or absence of a firearm in the home or workplace or ease of accessing					

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

State Legislature Interventions

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

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



- ◆ At the elementary school level, resiliency and coping skills training is recommended for all 1st and 2nd grade students utilizing the PAX Good Behavior Game. For tribal schools, the Indigenous version of the PAX Good Behavior Game is recommended.



- ◆ At the middle school level, Question, Persuade, Refer (QPR) gatekeeper training for all education staff that includes teachers, support staff, bus drivers, custodians, and food service personnel is recommended. For all school counselors, Applied Suicide Intervention Skills Training (ASIST) is recommended. For all middle schools, the Signs of Suicide (SOS) School-based program for middle schools is recommended. Finally, based on the national recommendations made by the U.S. Prevention Task Force, it is recommended that all middle school students be screened for depression and that all schools develop district-wide crisis response protocols to respond to those students identified as being at higher risk.



- ◆ At the high school level, Question, Persuade, Refer (QPR) gatekeeper training for all education staff that includes teachers, support staff, bus drivers, custodians, and food service personnel is recommended. For all school counselors, Applied Suicide Intervention Skills Training (ASIST) is recommended. For all middle schools, the Signs of Suicide (SOS) School-based program for middle schools is recommended. For high schools, we also encourage the piloting of other promising practices, such as the Youth Aware of Mental Health program (YAM). Based on the national recommendations made by the U.S. Prevention Task Force, it is also recommended that all high school students be screened for depression and that all schools develop district-wide crisis response protocols to respond to those students identified as being at higher risk.



- **Standardize State Coroners** – Recommend standardized training, standardized reporting and regular auditing of training and reporting due to a lack of adherence to standards and vast discrepancies between coroners in the reporting of suicide deaths in Montana.

- **Crisis Response** – Continued support to phone and text-message crisis lines; enhance community coordination from crisis lines; support community specific crisis response protocols (Fort Peck Crisis Response Protocol); continued support of crisis response teams (CRT) and crisis homes; and continued support of Crisis Intervention Training (CIT) for law enforcement.

Federal Level Interventions

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

Suicide Research in Montana

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

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

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



SUICIDE PREVENTION

CRISIS TEXT LINE |

TM

Text MT to 741-741

A free, 24/7 text line
for people in crisis.

NATIONAL

SUICIDE
PREVENTION
LIFELINE

TM

1-800-273-TALK (8255)

suicidepreventionlifeline.org

