



S U I C I D E I N

M O N T A N A

Facts, Figures, and Formulas for Prevention

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

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

Suicide Fact Sheet

Source: Center for Disease Control – WISQARS website, <http://www.cdc.gov/injury/wisqars/index.html>, (September, 2012),
2009 National Vital Statistics Reports (March, 2012)

- ❖ For the first time, suicide has surpassed car accidents as the No. 1 cause of injury-related death in the United States. There has been a 15% increase in the number of suicides in the United States between 2000-2009. (American Journal of Public Health, November, 2012)
- ❖ In 2010 there were **38,364 suicides in the U.S.** (105 suicides per day; 1 suicide every 13.7 minutes). This translates to an annual suicide rate of 12.43 per 100,000.
- ❖ Suicide is the tenth leading cause of death.
- ❖ 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 50% of all completed suicides.
- ❖ Up to 45% of individuals who die by suicide visit their primary care provider within a month of their death.
- ❖ 20% of those who die by suicide visited their primary care provider within 24 hours of their death

Suicide among Children

- ❖ In 2010, **274 children ages 5 to 14 completed suicide in the U.S. (increase from 265 in 2008)**
- ❖ Suicide rates for those between the **ages of 5-14 increased 60%** between 1981 and 2010.

Suicide among the Young

- ❖ Suicide is the 3rd leading cause of death among young (15-24) Americans; only accidents and homicides occur more frequently. In **2010, there were 4,600 suicides by people 15-24 years old** (increase from 4,371 in 2009)
- ❖ 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.
- ❖ Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- ❖ Within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- ❖ *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- ❖ The biggest factor associated with adolescent suicidal ideations is parental disconnect (not feeling validated or accepted by their parents)

Suicide among our Veterans

Source: Losing the Battle: The Challenge of Military Suicide (Oct. 2011). Center for a New American Security

- ❖ The VA estimates the suicide rate for young veteran men between the ages 18-29 is around 56 per 100,000 (compared to 20 for non-vet males 18-29)
- ❖ In the US, a veteran dies by suicide every 80 minutes, 18 a day, or 6,500 suicides a year.
- ❖ The suicide rate for the Army is 20 per 100,000, compared to 12 for the nation.
- ❖ In Montana, between 2002 and 2011, there were 460 suicides by Montana veterans of all ages, giving us a rate of approximately 53 per 100,000. (Montana Office of Vital Statistics, Aug, 2012)

Suicide among College Students

- ❖ It is estimated that there are more than **1,100 suicides on college campuses per year**.
- ❖ **1 in 12** college students has made a suicide plan (**2nd leading cause of death**)
- ❖ In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
 - **9.5% of students had seriously contemplated suicide.**
 - An estimated **24,000 suicide attempts** occur annually among US college students age 18-24 (JAMA).

Source: American Association of Suicidology webpage. <http://www.suicidology.org/web/guest/stats-and-tools/statistics> , May 24, 2010, *Journal of the American Medical Association* (2006), Vol. 296, No. 5

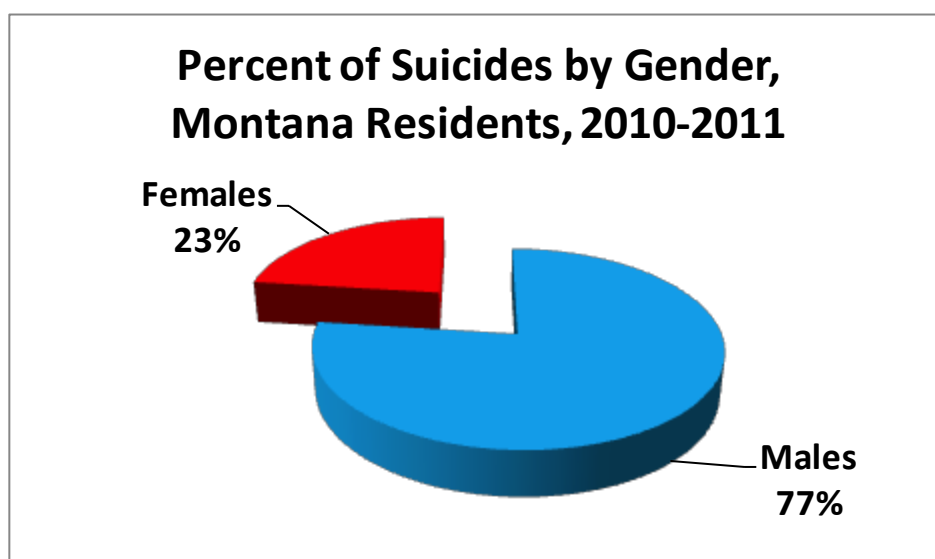
Suicide among the Elderly

- ❖ In 2010, 5,994 Americans over the age of 65 died by suicide for a rate of 14.9 per 100,000
- ❖ The rate of suicide for women typically declines after age 60 (after peaking in middle adulthood, ages 45-49)
- ❖ 85% of elderly suicides were male; the rate of male suicides in late life was 7 times greater than for female suicides.
- ❖ White men over the age of 85, who are labeled "old-old", were at the greatest risk of all age-gender-race groups. In 2010, the suicide rate for these men was 50.2 per 100,000.
- ❖ Elders who complete suicide:
 - 73% have contact with primary care physician within a month of their suicide. Nearly half of those people visited with their primary care physician within two weeks of their suicide.

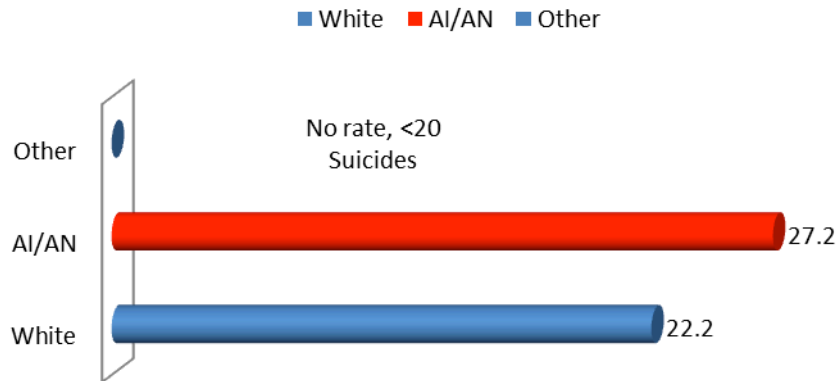
Suicide in Montana

Data Source: 2009 National Vital Statistics Reports (April, 2012), American Association of Suicidology website (www.suicidology.org), Montana Office of Epidemiology and Scientific Support (August, 2012)

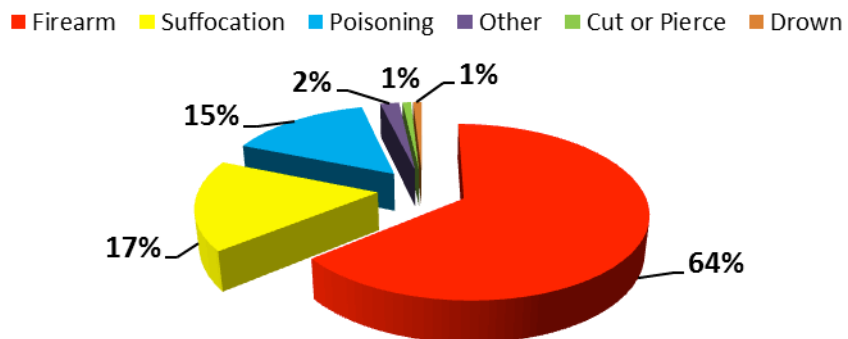
- ❖ For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past thirty years. **In a report for 2009 data released in the National Vital Statistics Report, Montana has the highest rate of suicide in the nation** (219 suicides for a rate of 22.5 compared to a national rate of 12)
- ❖ Suicide has ranked as the 7th or 8th leading cause of death for Montanans for more than two decades. Gender differences are similar with national statistics, with males at greater risk.
- ❖ In Montana, the highest rate of suicide is among American Indians (27.2 per 100,000) although they only constitute 6% of the state's population. Caucasians are second at 22.2 per 100,000.
- ❖ Firearms (64%), suffocation (17%), and poisoning (15%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.
- ❖ In Montana in 2010 there were 29 youth suicides (ages 15-24) for a rate of 21.66. This compares to the national rate for the same age group of 10.54.
- ❖ 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.
- ❖ Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- ❖ Over the past ten years (2000-2009), suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-34.
- ❖ For 2010 and 2011, there were **74** suicides for Montanans over the age 65, for an **average of 37 per year**. This gives Montana a rate of approximately **24.74 per 100,000**.
- ❖ Studies show that for every completed suicide, there are 6 survivors. Given there are approximately 180-200 suicides in Montana every year, that means there are 1,080-1,200 new survivors every year in Montana.



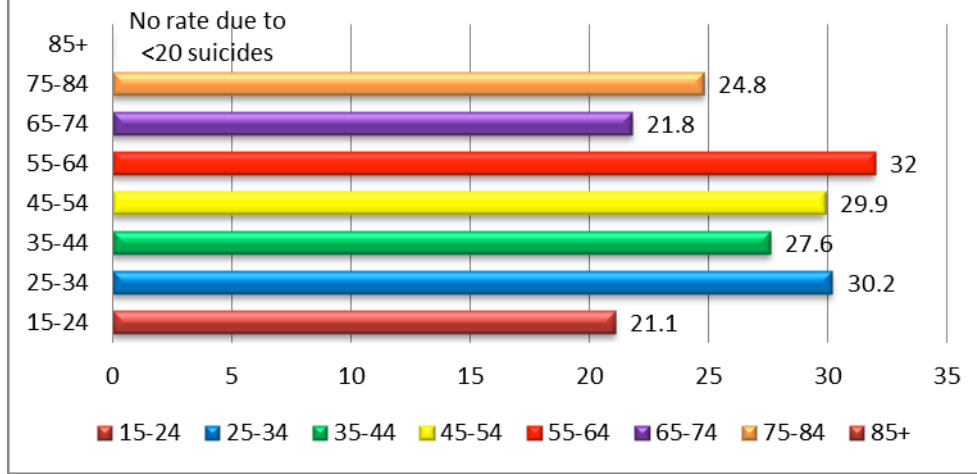
Crude Suicide Rates by Ethnicity, Montana Residents, 2010-2011



Percent of Suicides by Means, Montana Residents, 2010-2011



Crude Suicide Rate by Age, Montana Residents, 2010-2011

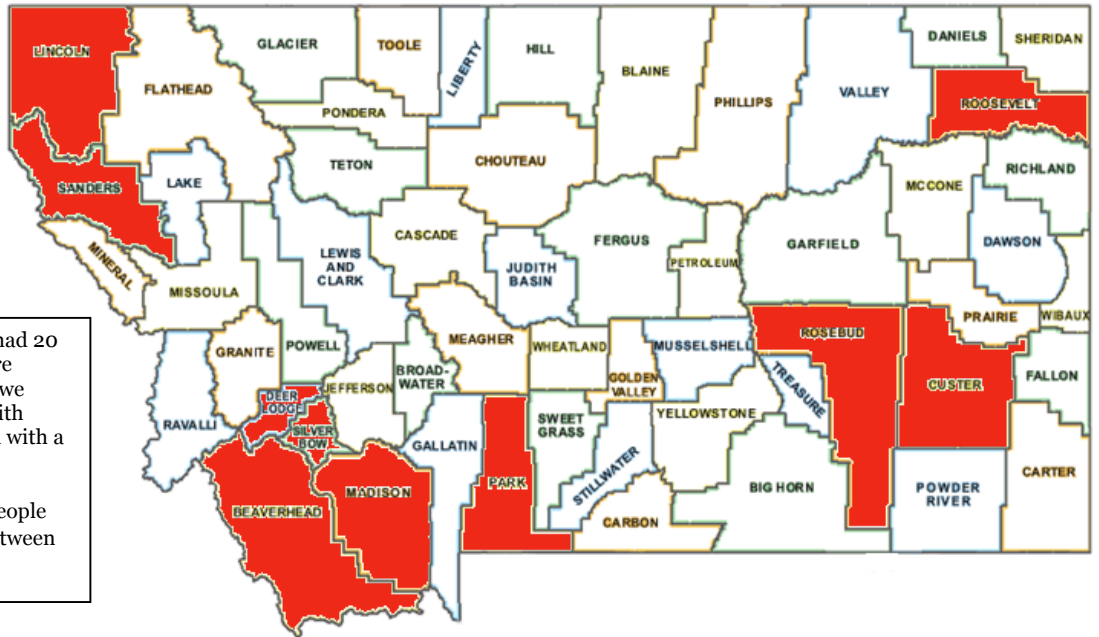


FREQUENCY AND RATE OF SUICIDE BY COUNTY OF RESIDENCE MONTANA RESIDENTS, 1997 - 2011

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

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.



County	Suicides	Population	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		

County	Suicides	Population	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		

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		

Social Factors Associated With Suicide

Suicidal behavior is associated with a wide variety of social factors, but correlates most highly with:

- Social Isolation (isolation from peers or social relationships that are troubled)
- Social Disorganization (society lacks the regulatory constraints necessary to control the behavior of its members.)
- Downward Social Mobility (socioeconomic)
- Rural Residency

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

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

REMEMBER: *Depression is Treatable!*

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

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

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

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

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

Warning Signs of Suicide

Here's an Easy-to-Remember Mnemonic for the Warning Signs of Suicide: **IS PATH WARM?**

I deation	Expressed or communicated ideation threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or talking or writing about death, dying or suicide, when these actions are out of the ordinary.
S ubstance Abuse	Increased alcohol or drug use
P urposelessness	No reason for living; no sense of purpose in life, start giving things away because there's no purpose in keeping anything, no reason to maintain their hygiene
A nxiety	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
T rapped	Feeling trapped (like there's no way out and things will never get better)
H opelessness	Hopelessness, no future orientation
W ithdrawal	Withdrawal from friends, isolating from family and society
A nger	Rage, uncontrolled anger, seeking revenge, irritable
R ecklessness	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
M ood Change	Dramatic mood changes, flat affect, depressed mood, acting out of character

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

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

“Have you had thoughts of killing yourself?” or “Are you suicidal?”

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

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

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

Four factors to use to assess the current level of risk (given an attempt)

The strongest behavioral warning is an attempted suicide.

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

Talking with a Suicidal Person using QPR

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

Question, Persuade, Refer

<u>Do</u>	<u>Don't</u>
<ul style="list-style-type: none">• Voice concern• Ask if they have a plan• Tell someone else	<ul style="list-style-type: none">• Leave the person alone• Be sworn to secrecy• Act shocked• Challenge or dare• Argue or debate

QPR

Tips for Asking the Suicide Question

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

Remember: How you ask the question is less important than that you ask it

QUESTION

Direct Approach:

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

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

How NOT to ask the suicide question

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

PERSUADE

HOW TO PERSUADE SOMEONE TO STAY ALIVE

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

Then Ask:

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

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

REFER

- ❖ Suicidal people often believe they cannot be helped, so you may have to do more.
- ❖ The best referral involves taking the person directly to someone who can help (therapist, emergency room, pastor, police).
- ❖ The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- ❖ The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

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

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.
- ❖ **SOS: Signs of Suicide** - School-based program which combines a curriculum that 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.
- ❖ **Teen Screen** - Identifies youth, through a screening instrument, who are at-risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation.
- ❖ **Parents as Partners** – A 9 page booklet that helps parents recognize the symptoms of depression and the warning signs of suicide in their children and how to intervene.
- ❖ **Crisis Intervention Training** - CIT came out of the Memphis Police Dept. and is a training for law enforcement officers to help them manage mental health issues when they respond to a call.

Other Potential Resources

(go to www.prc.mt.gov/suicideprevention to download these programs)

- ❖ **Suicide Prevention Toolkit for Rural Primary Care Physicians** – Assessment and intervention material for physicians in rural communities.
- ❖ **Suicide Prevention Toolkit for Senior Living Communities** – Assessment and intervention material for assisted living programs and nursing home.
- ❖ **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. (Wilcox, H.C, Sheppard, K., Hendricks, B., Jeanne, M, Poduska, N.S., Jalongo, 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.)

For additional information about these programs or other evidenced-based practices, go to http://www.sprc.org/featured_resources/bpr//ebpp.asp or <http://www.nrepp.samhsa.gov/index.htm>

Suicide Prevention Resources

Montana Suicide Prevention Website at www.prc.mt.gov/suicideprevention

In the event of an immediate crisis, **Call 911**, law enforcement, or take the person to the **nearest hospital emergency room or clinic**.

Montana Statewide Suicide Hotline - 1-800-273-TALK, TTY: 1-800-799-4TTY (4889). *National number then routed regionally to either Voices of Hope or the Help Center depending on prefix of phone number.*

Helpline Mental Health Center, Billings (406) 252-5658
The Community Crisis Center, Billings, 704 N 30th, MT 59102, 259-8800
Voices of Hope, Great Falls, North Central and North East Montana, 406-268-1330
The Help Center, Bozeman, South Central and South East Montana, 406-586-3333
District XI Human Resource Council, Missoula, South West Montana, 406-728-3710
United Way of NW Montana, North West Montana, 406-752-7266
Center for Mental Health, Helena, 443-5353
Hays Morris House Crisis Line, Butte, 1-800-221-0106
Shodair Children’s Hospital (Acute Crisis Unit), Helena, 800-447-6614

American Association of Suicidology (202) 237-2280

Call for written material on suicide and suicide prevention or visit www.suicidology.org

American Foundation for Suicide Prevention (888) 333-AFSP (2377)

For more information on suicide prevention, call toll free or visit www.afsp.org

Depression and Bipolar Support Alliance (800) 826-3632

Call national organization for local chapters and written information on depression or visit www.dbsalliance.org

National Alliance for the Mentally Ill (800) 950-NAMI (6264)

Call Help Line for local support group and/or additional materials on depression, or visit www.nami.org

National Suicide Prevention Lifeline 800-273-TALK (8255)

Provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider www.suicidepreventionlifeline.org

Planting Seeds of Hope, 406-252-2550, 222 North 32nd Street - Suite 401, Billings, MT 59101. *Suicide prevention program for Native Americans. The PSOH program includes Montana's Blackfeet, Crow, Northern Cheyenne, Fort Peck and Fort Belknap, and Wyoming's Wind River Indian populations.*

Suicide Prevention Resource Center (SPRC) 877-GET-SPRC (438-7772)

Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. Includes materials for students, parents, school staff, and others. Includes state suicide data on state pages www.sprc.org.

**Depression is
Treatable
Suicide is
Preventable**

If you are in crisis and want help,
call the Montana Suicide
Prevention Lifeline, 24/7, at

1-800-273-TALK

(1-800-273-8255)



QPR Training Exit Survey

Location of training: _____

Date of training: _____

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

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

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Ideation | <input type="checkbox"/> Trapped | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Recklessness |
| <input type="checkbox"/> Purposelessness | <input type="checkbox"/> Buying life insurance | <input type="checkbox"/> Mood change |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Withdrawal | |

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

- Question Persuade Secret Refer

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

- | | | |
|---|--|---|
| <input type="checkbox"/> 1-800-273-TALK | <input type="checkbox"/> Toolkit for senior living comm. | <input type="checkbox"/> ASIST |
| <input type="checkbox"/> SOS for schools | <input type="checkbox"/> Teen Screen | <input type="checkbox"/> QPR |
| <input type="checkbox"/> Toolkit for physicians | <input type="checkbox"/> Ignoring the warning signs | <input type="checkbox"/> Crisis Intervention Training |

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

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

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

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

How can we improve this training?

Thank you for your feedback