MONTANA
Department of Public Health & Human Services

Suicide in Montana

Facts, Figures, and Formulas for Prevention

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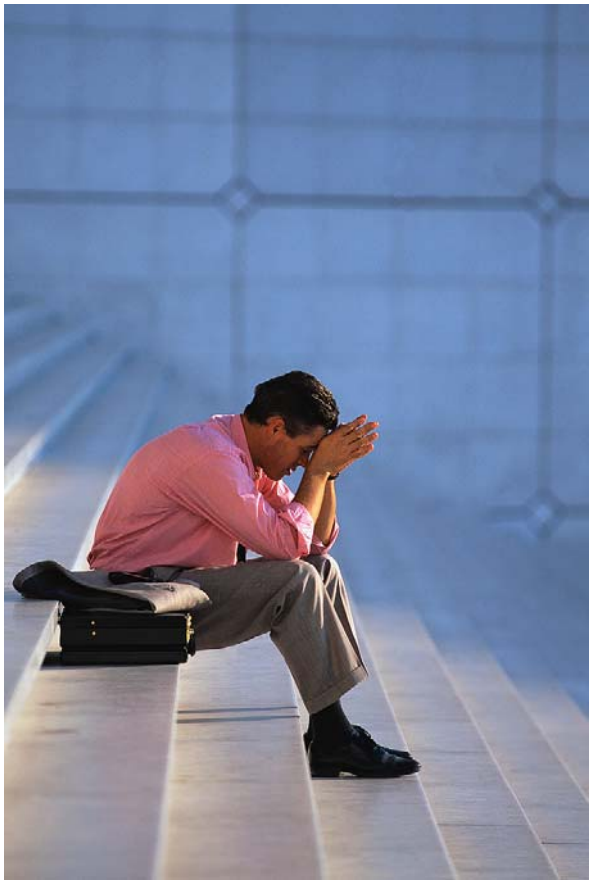


"Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving 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

American Association of Suicidology, (www.suicidology.org)

- In 2006 there were 33,300 suicides in the U.S. (91 suicides per day; 1 suicide every 15.8 minutes). This translates to an annual suicide rate of 10.95 per 100,000.
- Suicide is the eleventh 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.
- Suicides accounted for 55% of the nation's 31,000 firearm deaths in 2005 (CDC, 7/1/08)
- Males (58% firearms; 42% other methods) used firearms more often than their female counterparts (33% firearms; 67% other methods).

Suicide among Children

- In 2006, **216 children ages 10 to 14 completed suicide in the U.S.**
- Suicide rates for those between the **ages of 10-14 increased 51%** between 1981 and 2004.
- Although their rates are lower than for Caucasian children, African American children (ages 10-14) showed the largest increase in suicide rates between 1980 and 1995 (**233%**).
- In the 10 to 14 age group, **Caucasian** children (ranked 3rd leading cause of death) were far more likely to **complete suicide** than **African American** children (ranked 5th leading cause of death).

Suicide among the Young

- Suicide is the 3rd leading cause of death among young (15-24) Americans; only accidents and homicides occur more frequently.
- 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.

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. www.suicidology.org , February 12, 2008*
Journal of the American Medical Association (2006), Vol. 296, No. 5

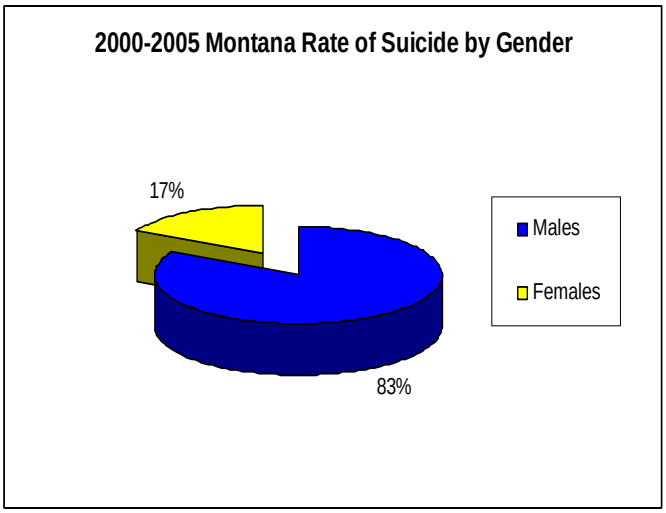
Suicide among the Elderly

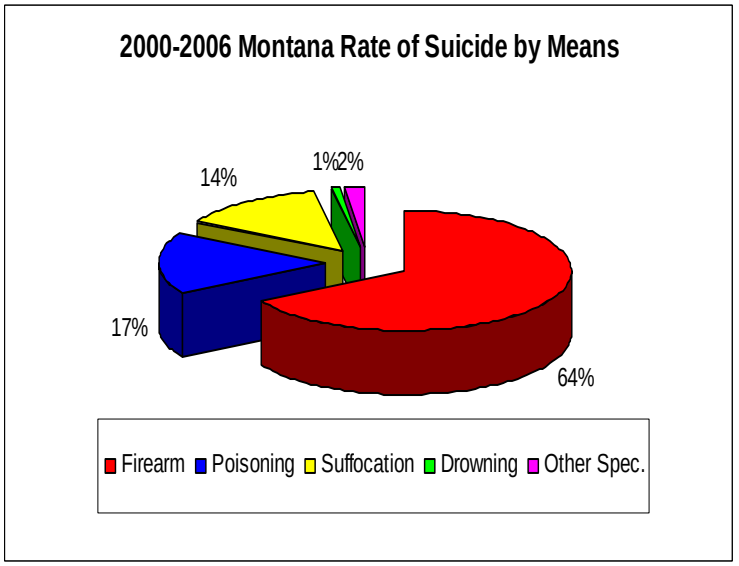
- In 2006, 5,299 Americans over the age of 65 died by suicide for a rate of 14.22 per 100,000 people (The national rate was 11.15)
- The rate of suicide for women typically declines after age 60 (after peaking in middle adulthood, ages 45-49)
- 84.6% of elderly suicides were male; the rate of male suicides in late life was 7.7 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 2006, the suicide rate for these men was 46.3 per 100,000.
- Elders who complete suicide:
  - 77% have contact with primary care physician within a year of their suicide.
  - 58% have contact with primary care physician within a month of their suicide.

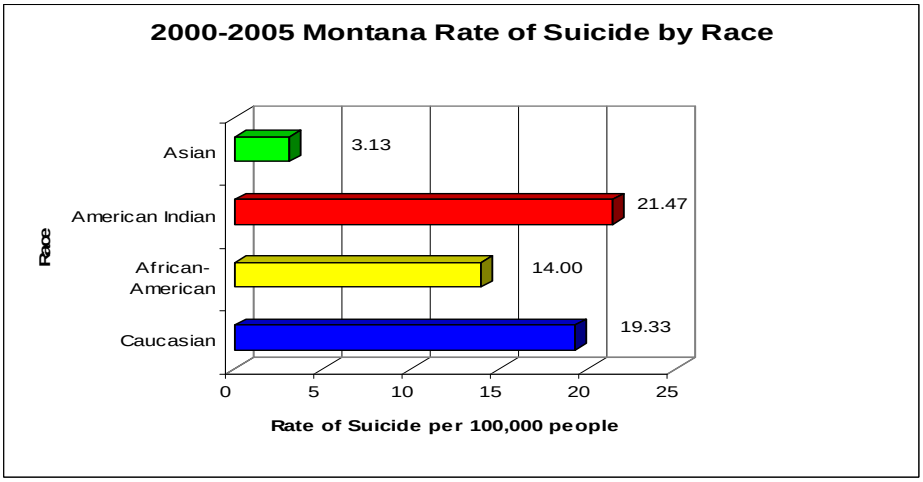
Suicide in Montana

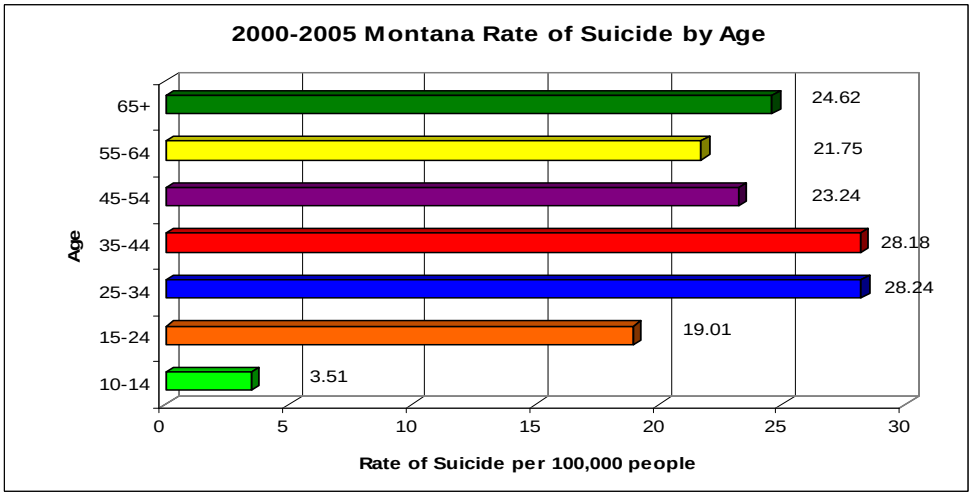
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. May, 2009
Montana Office of Vital Statistics, April, 2009

- 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 2006 data released by the American Association of Suicidology in April, 2009, Montana has the 3rd highest rate of suicide in the nation**. (www.suicidology.org)
- 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.
- Over-time, the differences in the rate of suicide between American Indians and Caucasians in Montana is minimal when considered over-time (however, the rate of suicide among 15-24 year old American Indians is three times the national average. *Source: the Native American Youth Leadership Conference as reported in the Helena Independent Record on August 4, 2005*).
- Firearms (64%), poison (18%), and suffocation (14%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.
- Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- Over the past seven years (2000-2006), suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-34.
- Between 2000 and 2008, there were **491** suicides for Montanans over the age 55, for an **average of 55 per year**. This gives Montana a rate of approximately **25 per 100,000**.
  - 418 males (**85%**), 73 females
  - 477 Caucasians (**97%**), 14 American Indians
  - 370 out of the 491 were by firearm (**75%**), 42 by overdose, 34 by hanging, 27 by gases/vapors
- Studies show that for every completed suicide, there are 6 survivors. Given that there are approximately 180-200 suicides in Montana every year, that means there are 1,080-1,200 NEW suicide survivors every year in Montana. For information concerning Montana survivor support groups, go to www.AFSP.org and look under "surviving suicide loss"


2000-2005 Montana Rate of Suicide by Gender
17%
83%
Males
Females


2000-2006 Montana Rate of Suicide by Means
14%
1%
2%
17%
64%
Firearm
Poisoning
Suffocation
Drowning
Other Spec.

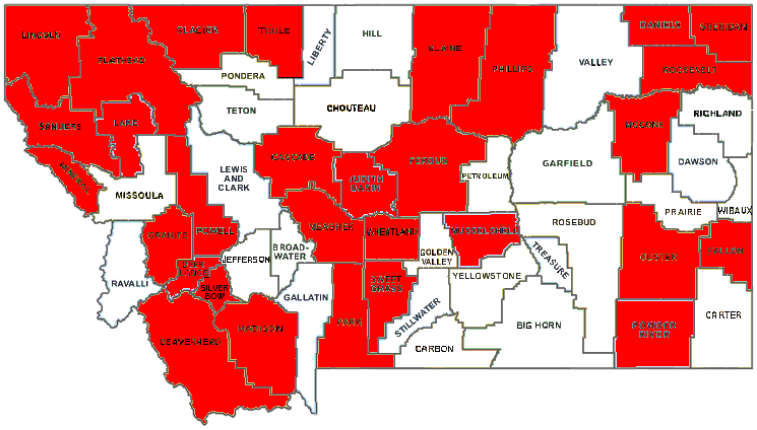

2000-2005 Montana Rate of Suicide by Race
Race
Asian
American Indian
African-American
Caucasian
3.13
21.47
14.00
19.33
0
5
10
15
20
25
Rate of Suicide per 100,000 people


2000-2005 Montana Rate of Suicide by Age
Age
65+
55-64
45-54
35-44
25-34
15-24
10-14
24.62
21.75
23.24
28.18
28.24
19.01
3.51
0
5
10
15
20
25
30
Rate of Suicide per 100,000 people

Suicide in Montana's Counties

(**Source**: Montana DPHHS, 2007 Montana Vital Statistics)

Red Counties At or above the 80th percentile in suicide nationally



2000-2007 Rate of Suicide for Montana Counties

Rate is per 100,000 people

County	# of Suicides	Rate	County	# of Suicides	Rate
BEAVERHEAD	19	26.7*	MADISON	16	28.6*
BIG HORN	15	14.7	MEAGHER	4	26*
BLAINE	12	22.4*	MINERAL	7	22.6*
BROADWATER	6	16.9	MISSOULA	146	18.1
CARBON	13	16.8	MUSSELSHELL	9	25.4*
CARTER	2	19.1	PARK	36	28.5*
CASCADE	133	20.5*	PETROLEUM	0	0
CHOUTEAU	7	15.9	PHILLIPS	7	20.8*
CUSTER	29	32*	PONDERA	8	16.3
DANIELS	3	20.4*	POWDER RIVER	4	28.2*
DAWSON	11	15.8	POWELL	11	19.6*
DEER LODGE	22	30.4*	PRAIRIE	0	0
FALLON	5	23.1*	RAVALLI	57	18.6
FERGUS	21	22.9*	RICHLAND	11	15
FLATHEAD	140	21.8*	ROOSEVELT	17	20.5*
GALLATIN	107	17.4	ROSEBUD	12	16.3
GARFIELD	0	0	SANDERS	25	29.5*
GLACIER	24	22.5*	SHERIDAN	6	20.5*
GOLDEN VALLEY	1	11.7	SILVER BOW	64	24.1*
GRANITE	5	21.8*	STILLWATER	10	14.9
HILL	21	16	SWEET GRASS	7	23.9*
JEFFERSON	13	15.5	TETON	6	12.1
JUDITH BASIN	4	22.8*	TOOLE	9	21.4*
LAKE	43	19.6*	TREASURE	1	16.8
LEWIS & CLARK	86	18.7	VALLEY	10	17.3
LIBERTY	0	0	WHEATLAND	5	29.9*
LINCOLN	32	21.4*	WIBAUX	0	0
MCCONE	3	20.8*	YELLOWSTONE	184	17.1

Counties in Red (or *) indicate a Suicide Rate at or above the 80th Percentile Nationally

***SOURCE**: 2007 Montana Vital Statistics, Office of Vital Statistics, Montana DPHHS.*

Montana Rate **19.6 (2000-2007)**
National Rate **10.9 (2000-2006)**

What Direction are we heading?

According to the Center for Disease Control:

- Between 1994 and 2003 there was a decline in suicide among those between 10 and 24 of almost 29%.

Possible reasons for decrease:

- New safety measures for keeping guns out of children's hands (trigger locks, lock boxes, removing the guns from the home).
- Greater acceptance of gay and lesbian youth.
- Effective use of antidepressant medication.

Then…

Increase in Youth Suicide Rates between 2003 and 2004

- In the Netherlands the youth suicide rate increased 49% between 2003-2004.
- In the U.S. the suicide rate increased 8% between 2003-2004 for youth 10-24 (14% for infancy to age 19)
- In the U.S. this is the largest year to year change in suicide rates in this population since CDC began systematic data collection in 1979.

Source*: Mortality and Morbidity Weekly Report, Center for Disease Control, September 7, 2007.*

Early Evidence on the Effects of Regulators' Suicidality Warnings on SSRI Prescriptions...Gibbons et al. Am J Psychiatry.2007; 164: 1356-1363

Why the Change?

One Possible Factor

- A 2003 British Study revealed that children taking Paxil showed twice as many suicidal thoughts and potentially suicidal behaviors as children getting no medication.
- 2004: the FDA reviewed 23 clinical trials involving more than 4,300 youths who received any of 9 different antidepressant medications.
- Results: 4% of youths taking medication reported suicidal thoughts or behaviors vs. 2% of those taking a placebo.
- September, 2004: the FDA issues a "black box" warning for all antidepressants used to treat depression in children and adolescents.
- SSRI prescriptions for young people decreased by 22% in the U.S. and the Netherlands since that time.

Source: *Early Evidence on the Effects of Regulators' Suicidality Warnings on SSRI Prescriptions...Gibbons et al. Am J Psychiatry.2007; 164: 1356-1363*

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.

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

Warning Signs of Suicide

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

Ideation	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.
Substance Abuse	Increased alcohol or drug use
Purposelessness	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
Anxiety	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
Trapped	Feeling trapped (like there's no way out and things will never get better)
Hopelessness	Hopelessness, no future orientation
Withdrawal	Withdrawal from friends, isolating from family and society
Anger	Rage, uncontrolled anger, seeking revenge, irritable
Recklessness	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
Mood 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.

Five factors to use to access 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, **P**ersuade, **R**efer

Do	**Don't**
• Voice concern • Ask if they have a plan • Tell someone else	• 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
- 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.

REMEMBER: *Depression is Treatable!*

Depression is the most treatable of all psychiatric disorders

- 70% treatment success rate with a combination of antidepressants and therapy
- Only 30-40% with either by themselves.

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.
- **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

- **Suicide Prevention Toolkit for Rural Primary Care Physicians** – Assessment and intervention material for physicians in rural communities.
- **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., Ialongo, W.W., Anthony, J.C. (June, 2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. Drug and Alcohol Dependence, 95(1), S60-S73.)**

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

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, 407-752-7266
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 Academy of Child and Adolescent Psychiatry (800) 333-7636
Call or visit www.aacap.org for referrals or information, including Facts for Families, a series of fact sheets that include information on depression, teen suicide, health insurance, how to seek help, and other topics.

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 Mental Health Association (800) 969-NMHA (6642)
Call for local referral and written information on depression or visit www.nmha.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)