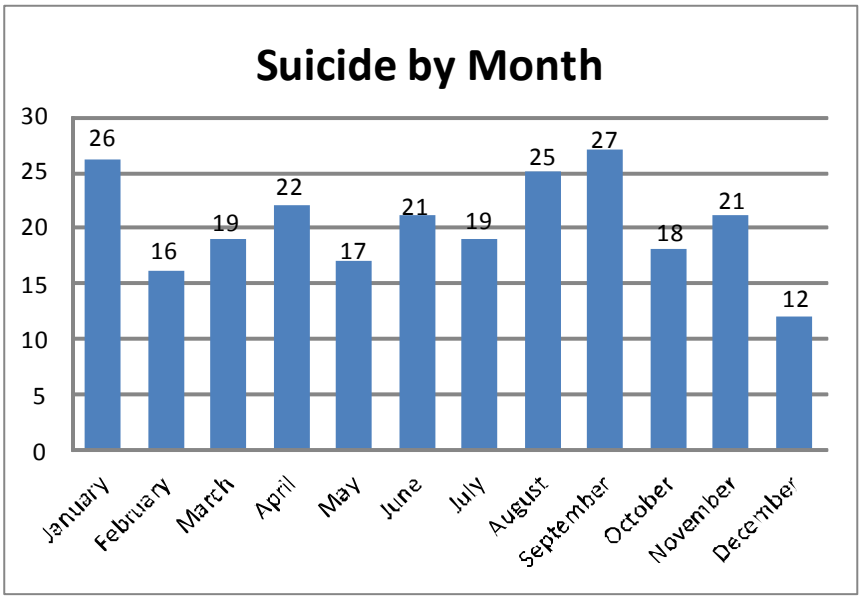
Montana Suicide Review Team (MSR)

Summary Report for January 1, 2014 through December 31, 2014

The MSR team is a statewide effort to identify factors associated with suicide in an effort to develop prevention strategies. The suicide mortality review team is composed of mental health, social service, law enforcement, coroners, and other experts to review suicide deaths. The purpose of the review team is to determine if a suicide was preventable and the factors associated with the suicide. The prevention of suicide is both the policy of the state of Montana and a community responsibility. The suicidal death of a person can be viewed as a sentinel event that is a measure of a community's overall social and economic well-being and health. The MSR team process identifies critical community strengths and needs to understand the unique social, health and economic issues associated with suicide. The goal of the MSR team program is to reduce the inequalities that impact the number of deaths through local community and state collaboration.

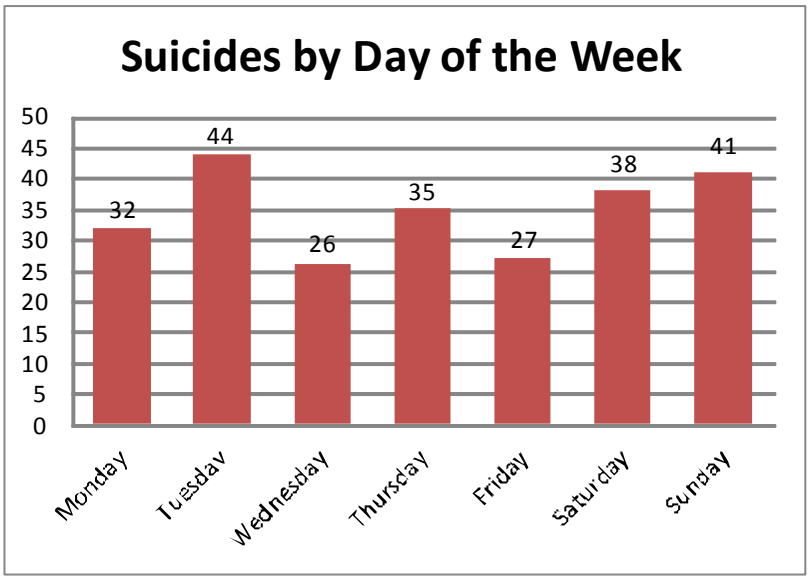
This report is the *final* report for the calendar year 2014 and is based on data collected from coroner reports, death certificates, toxicology reports, health care information, and mental health information on those whose death was identified as a suicide by the coroner. Not all of the previously identified resources were available for all suicide deaths It is important to note that as a preliminary report, the data presented comes from a small sample size, therefore the reliability and statistical significance is marginal. This will improve as the process continues and the sample sizes increase. **NO INFERENCES SHOULD BE MADE CONCERNING THE DATA PRESENTED. THIS IS ONLY MEANT TO GIVE NUMBERS AND PERCENTAGES CONCERNING SUICIDES IN MONTANA.**



What the Data Says

By Month

In 2014 there were 243 suicides in Montana for an average of 20 per month. To the right is the number of suicides per month. January and September had the highest number of suicides.

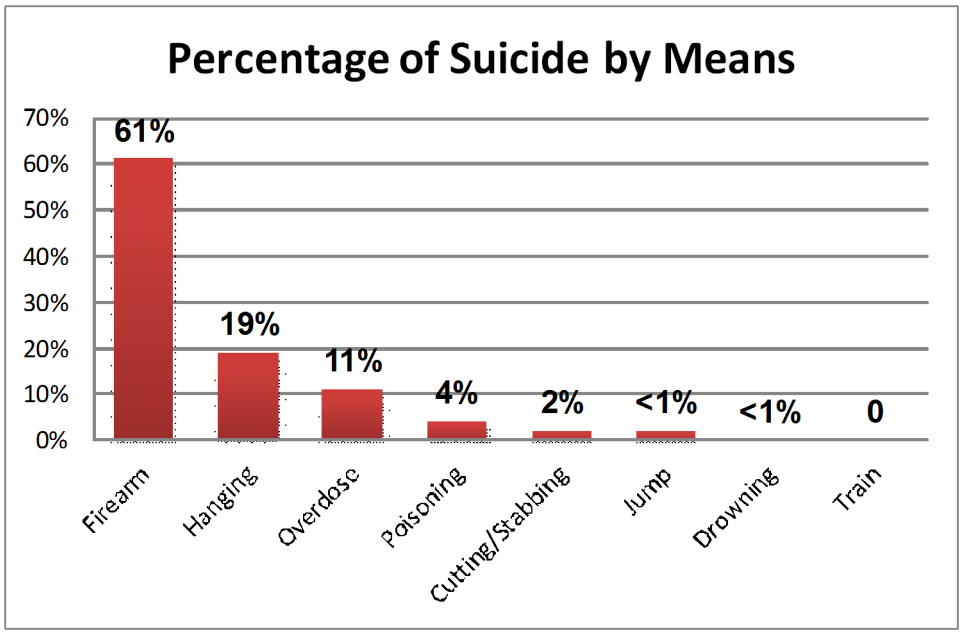


By Day of the Week

Tuesdays and Sundays constitute the highest incidence of suicide in Montana, accounting for 35% of the suicides.

By Means

Firearms continue to be the primary means of suicide in Montana, constituting 61% of the suicides, well above the national average of 52%. Hanging is the second most common means at 19%, followed by overdose at 11%.

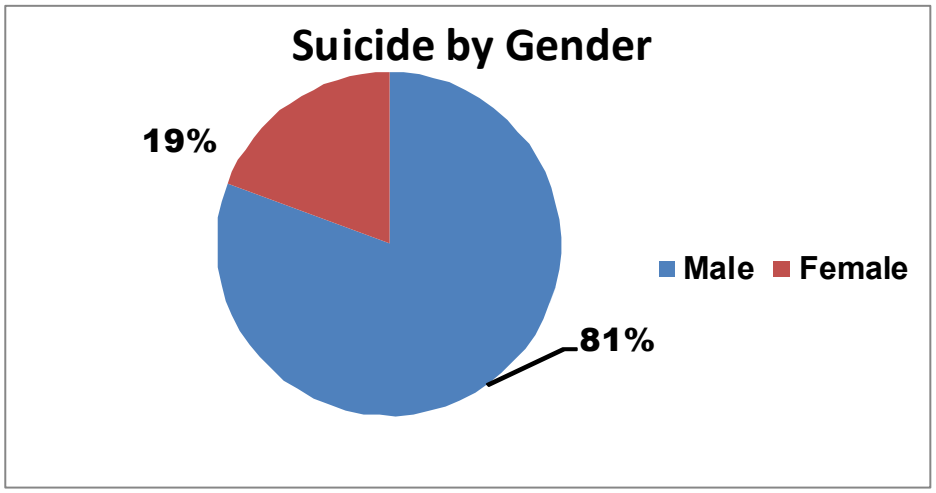


Of the 37 youth (age 24 and under) who have died by suicide, **57% have used a firearm**.

35% of the female suicides in Montana were by firearm, slightly higher than the national average of 31%.

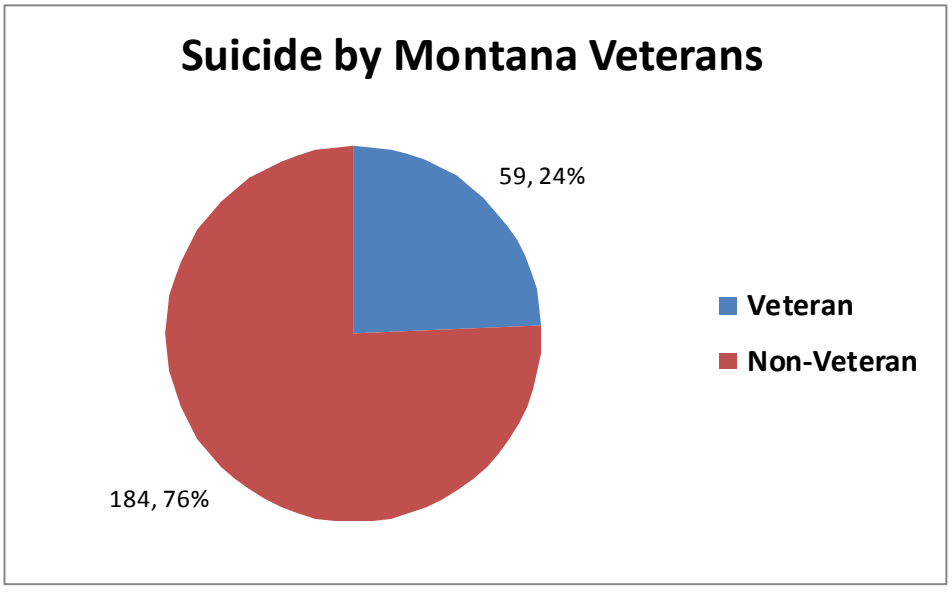
By Gender

Males have had the highest suicide completion in Montana, accounting for 81% of the suicides. 196 men died by suicide compared to 47 females. This gives a ratio of approximately 4:1 for men. This is on target with national statistics.



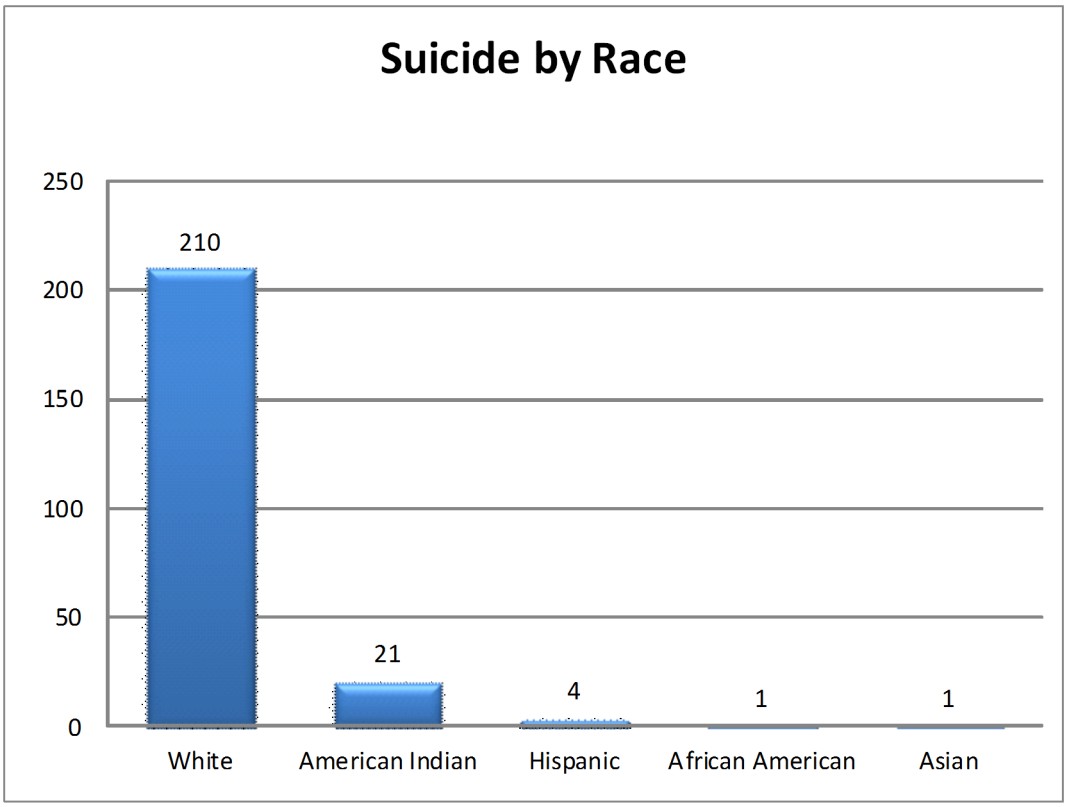
Suicide by Montana Veterans

In 2014, 59 Montana veterans died by suicide, which is 24% of the total suicides in the state. Nationally, veterans account for nearly 20% of the total suicides in the nation.



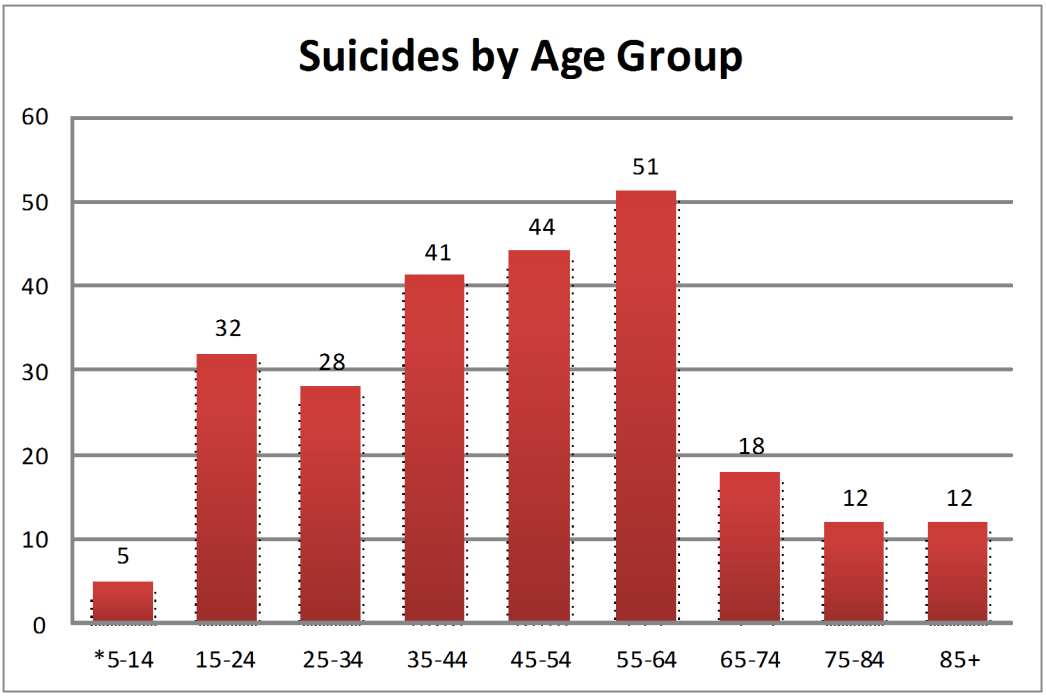
By Race

By numbers alone, Whites have died by suicide at a much higher frequency. Out of the 243 suicides in 2014, 216 were White, 21 were American Indian, 4 were Hispanic, 1 was Asian, and 1 was African American. ***However, numbers don't accurately depict the severity of the issue***. According to the US Census for Montana, in 2013, Whites constitute nearly 90% of the population, while American Indians comprise 6.5% of the population, Hispanics 3.3%, and African Americans 0.6%. **It is the *rate* of suicide among these different ethnicities that indicate the severity of the problem. However, with such a small sample size (low population and only one year of data), we cannot calculate rate with any statistical significance.**

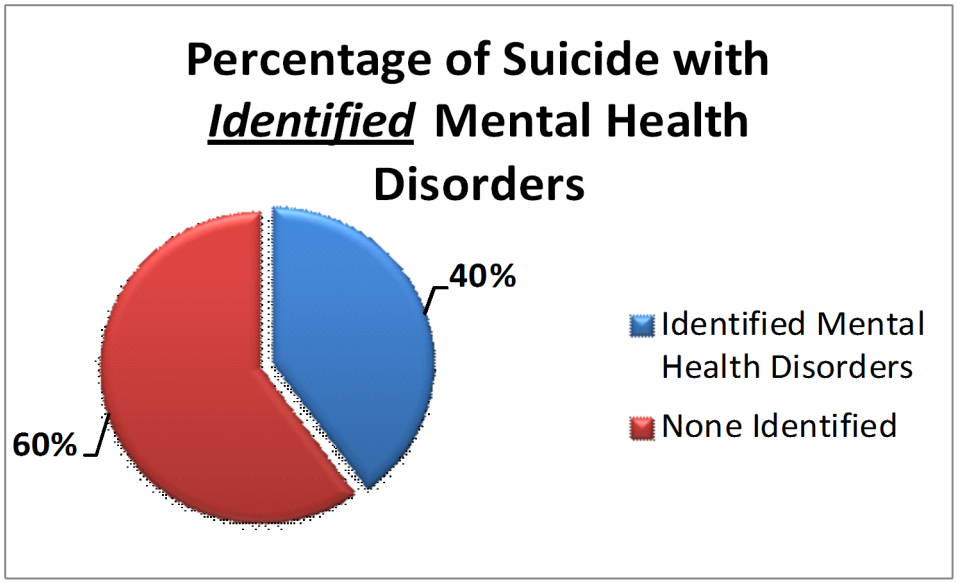


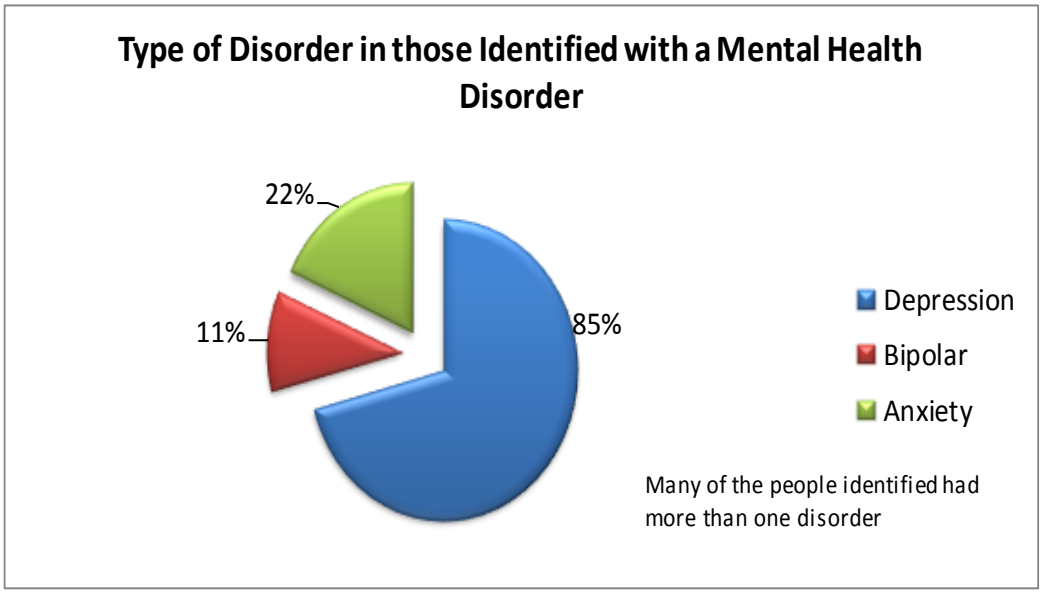
By Age Group

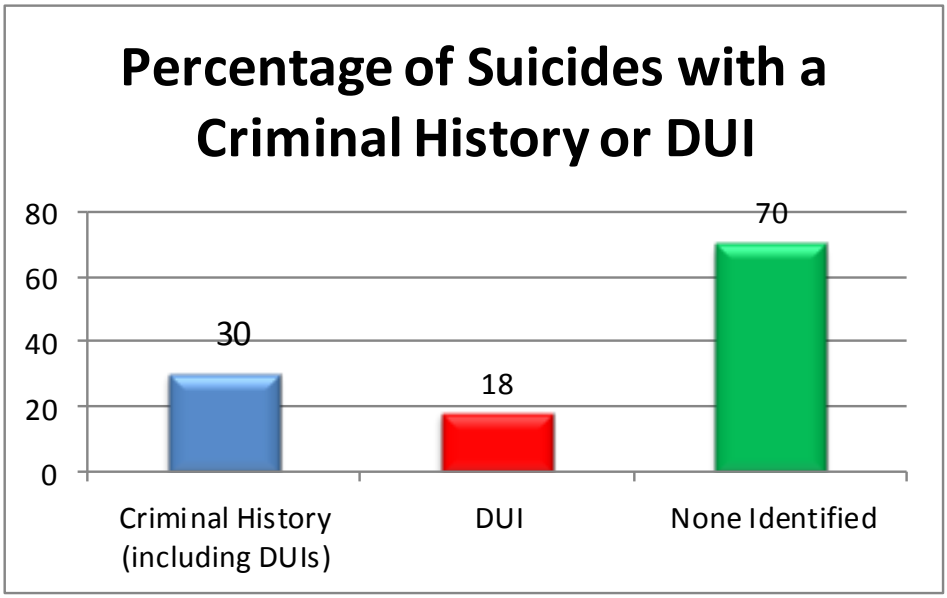
In 2014, the age group with the highest incidence of suicide has been 45-64 year olds. This falls in line with national data that has the same age groups as being the top 2 in suicides. Issues that started to arise in this age group include mental health issues, health issues, and relational losses.

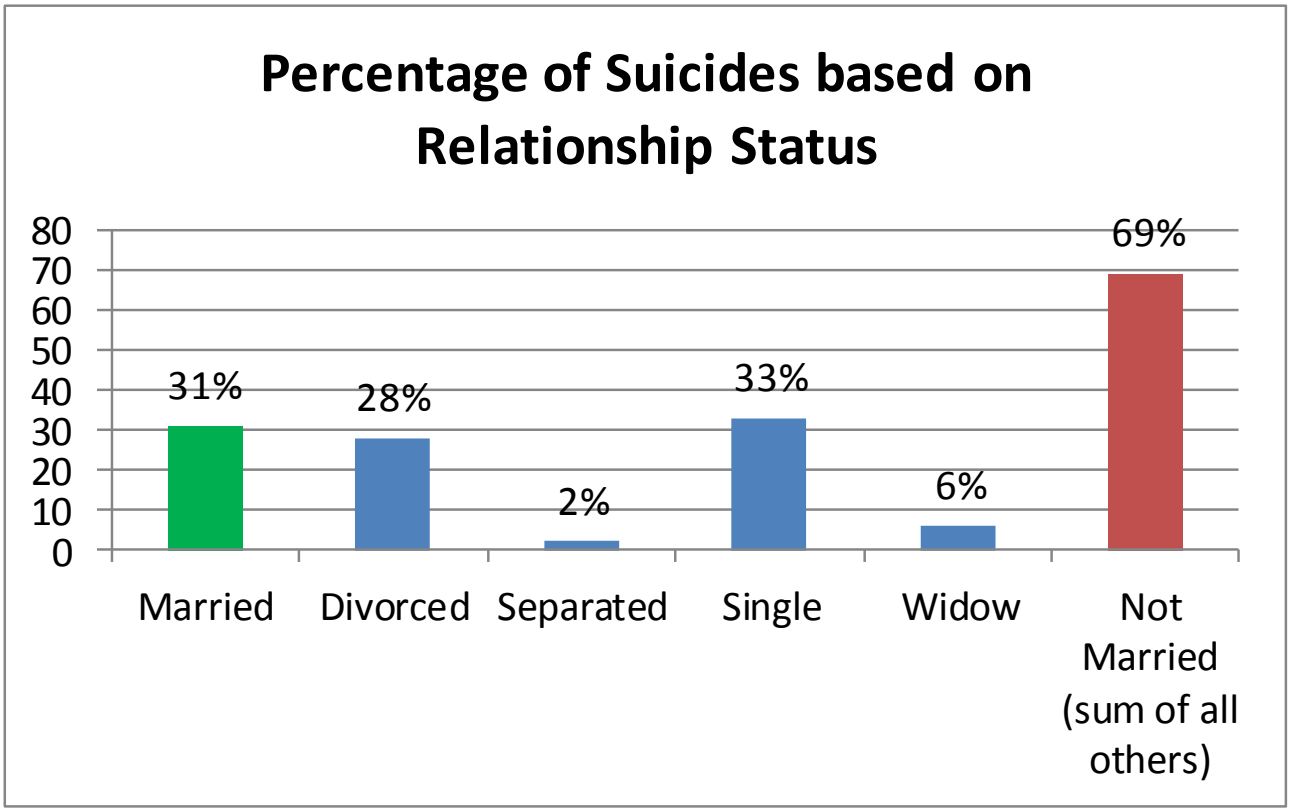


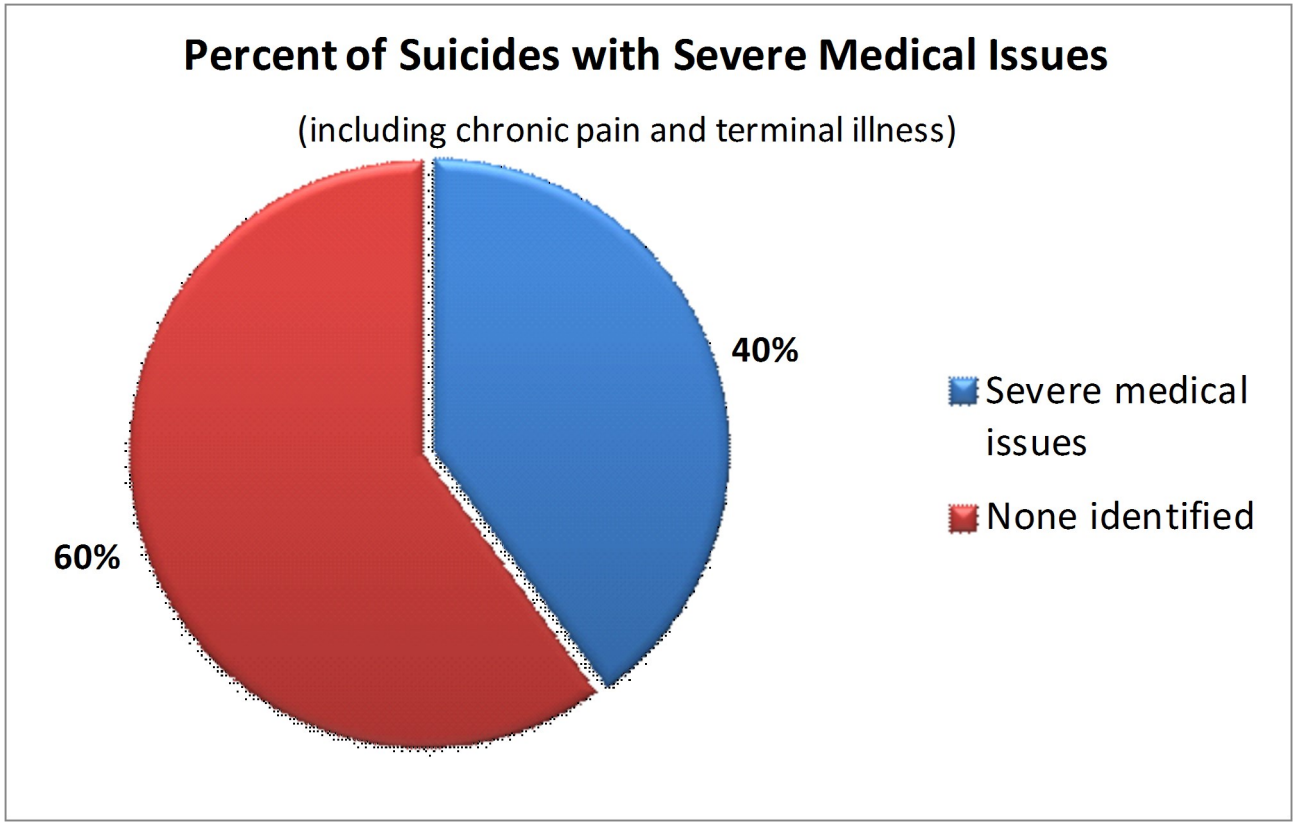
Other observations made from the 2014 data

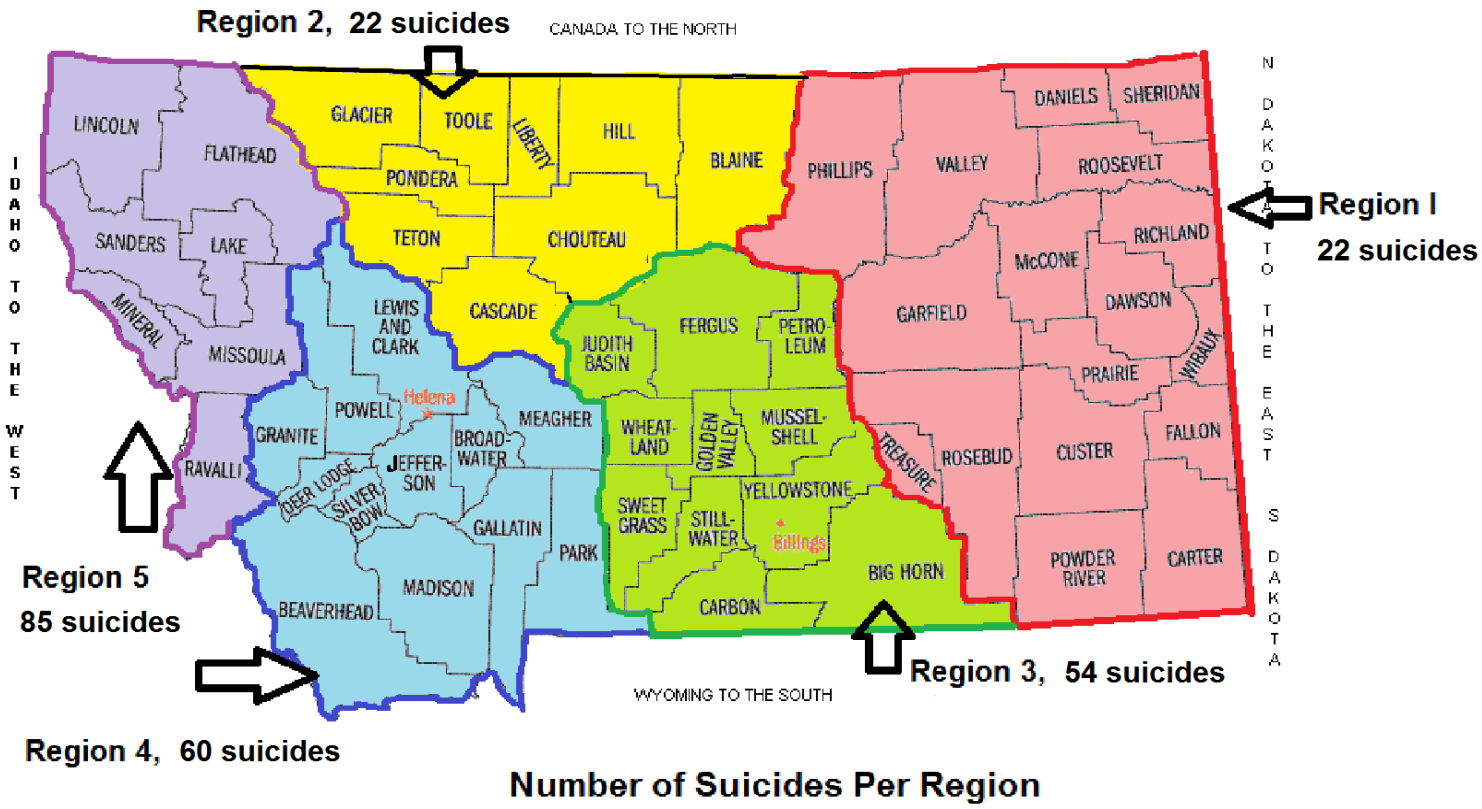




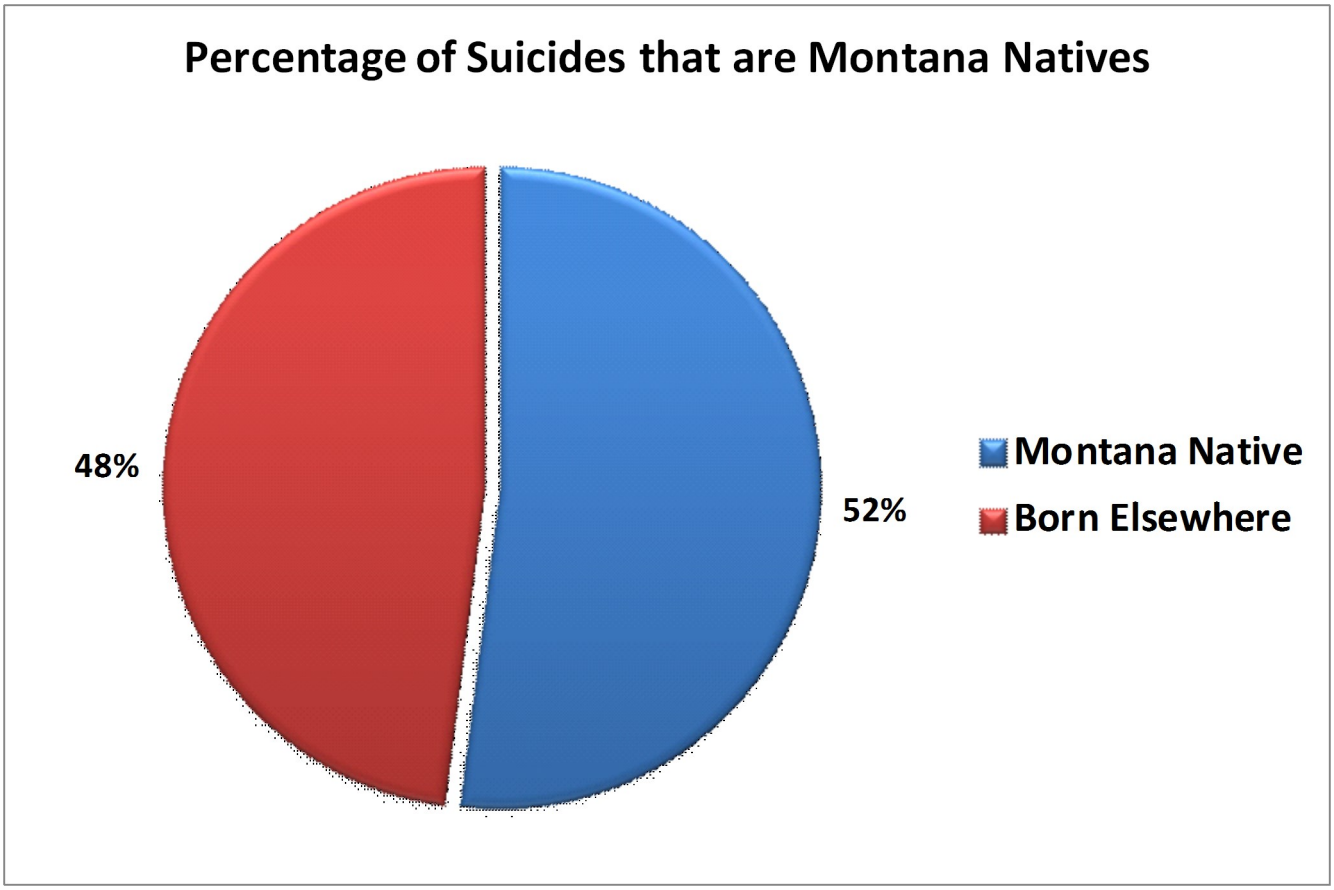


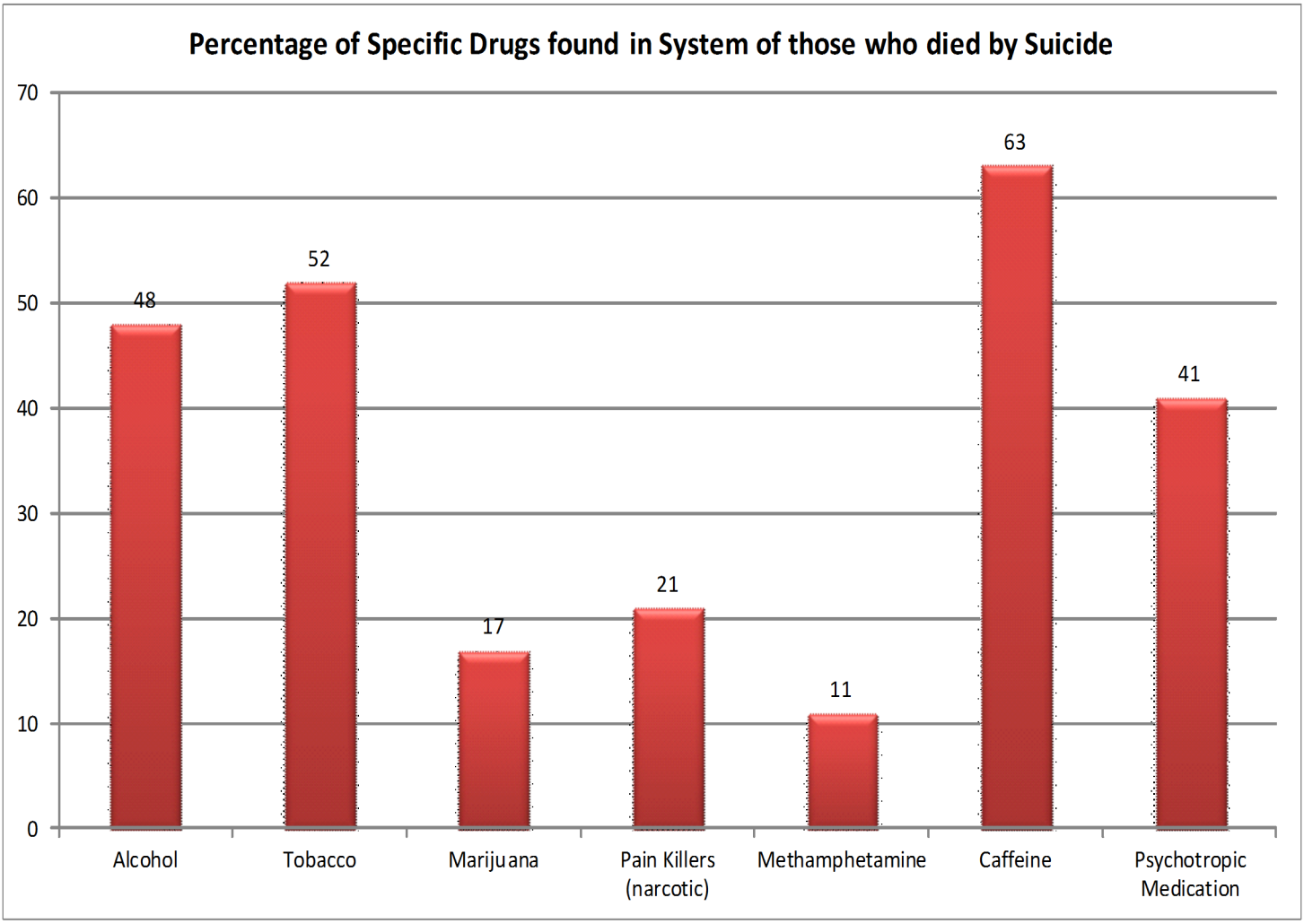

Percentage of Suicides based on Relationship Status
80
70
60
50
40
30
20
10
0
31%
28%
2%
33%
6%
69%
Married
Divorced
Separated
Single
Widow
Not Married (sum of all others)

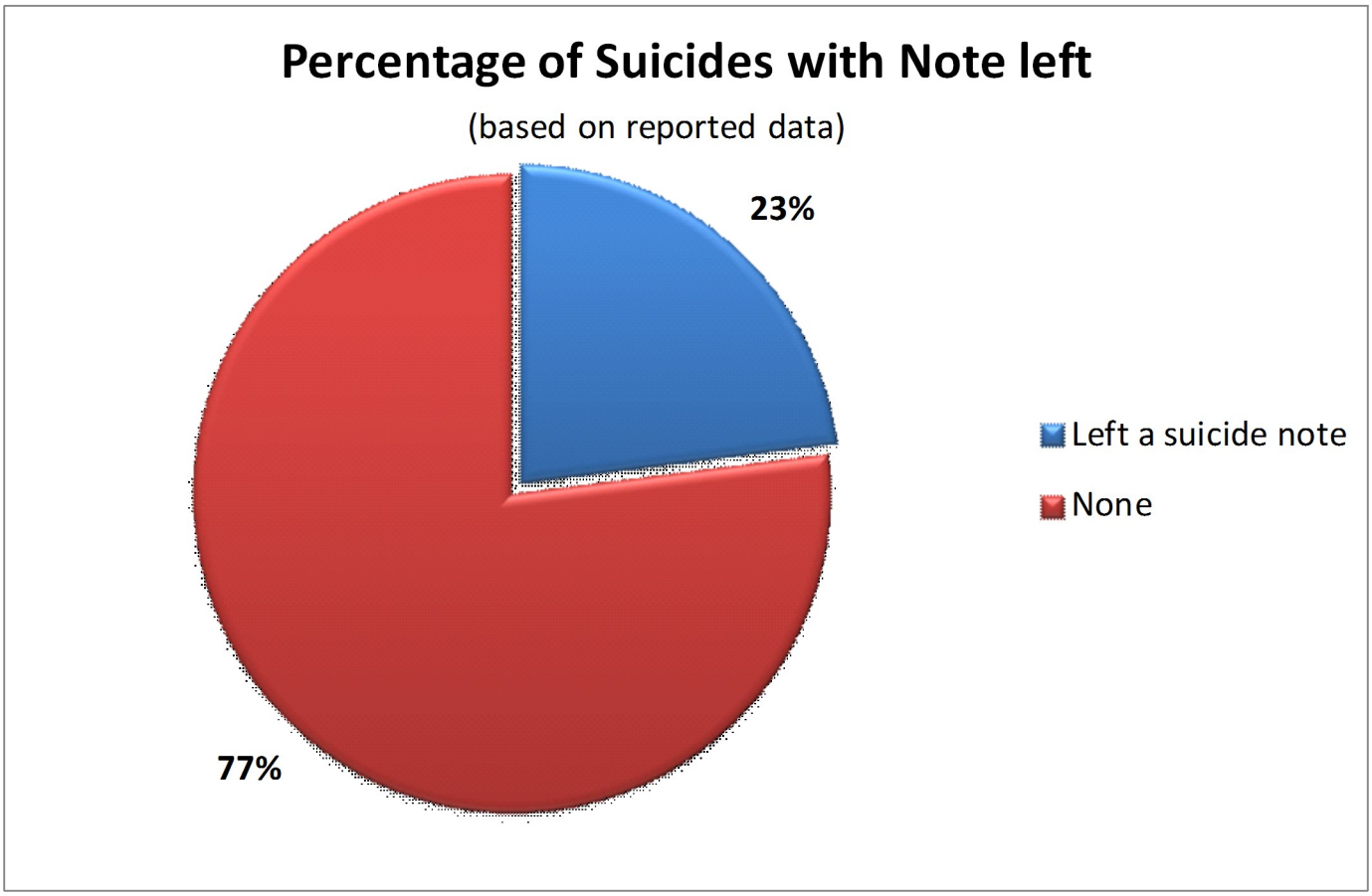

Percent of Suicides with Severe Medical Issues
(including chronic pain and terminal illness)
40%
60%
Severe medical issues
None identified

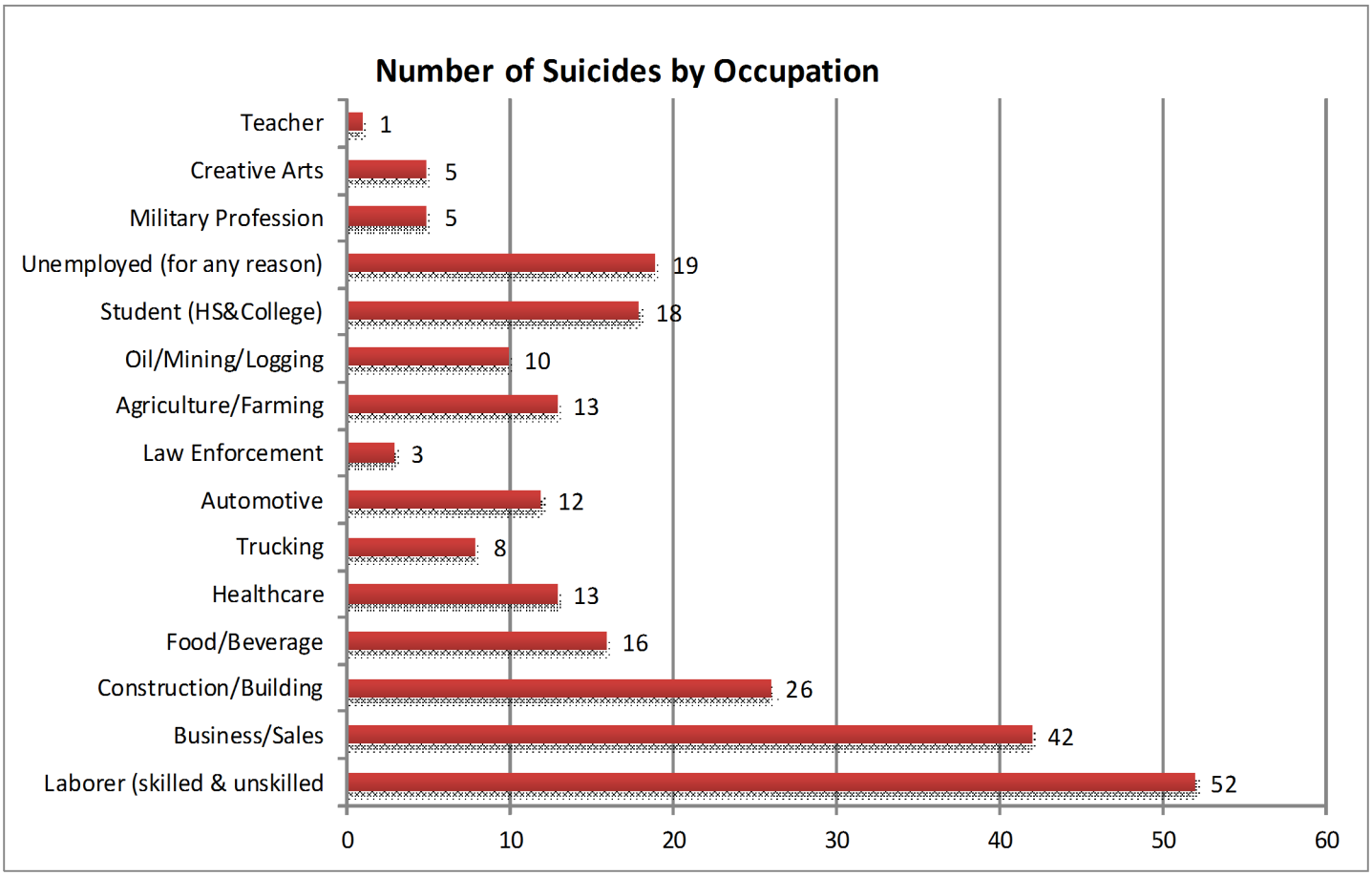


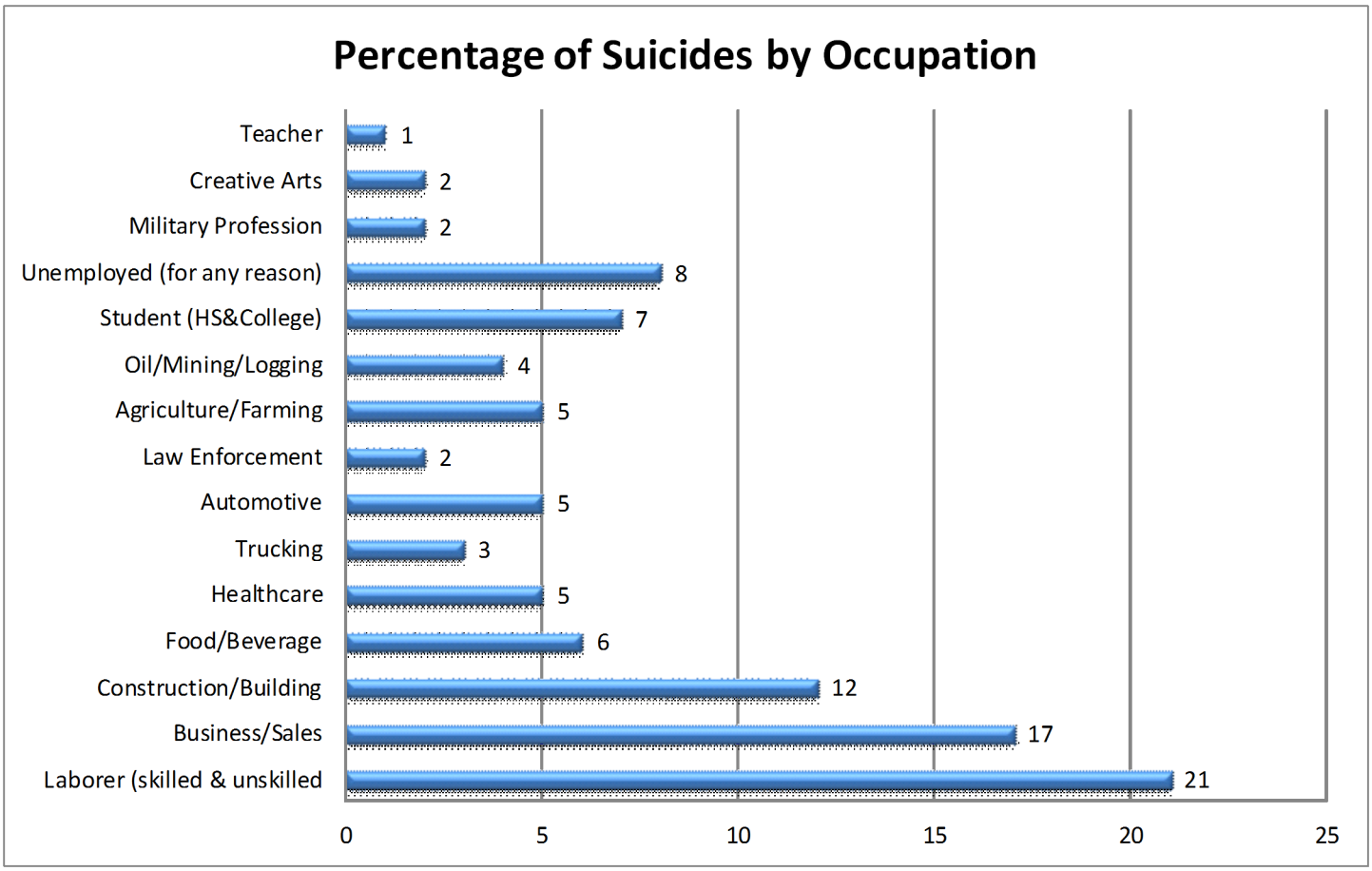
Number of Suicides Per Region




Percentage of Specific Drugs found in System of those who died by Suicide
70
60
50
40
30
20
10
0
48
52
17
21
11
63
41
Alcohol
Tobacco
Marijuana
Pain Killers (narcotic)
Methamphetamine
Caffeine
Psychotropic Medication


Percentage of Suicides with Note left
(based on reported data)
23%
77%
Left a suicide note
None


Number of Suicides by Occupation
Teacher
Creative Arts
Military Profession
Unemployed (for any reason)
Student (HS&College)
Oil/Mining/Logging
Agriculture/Farming
Law Enforcement
Automotive
Trucking
Healthcare
Food/Beverage
Construction/Building
Business/Sales
Laborer (skilled & unskilled
1
5
5
19
18
10
13
3
12
8
13
16
26
42
52
0
10
20
30
40
50
60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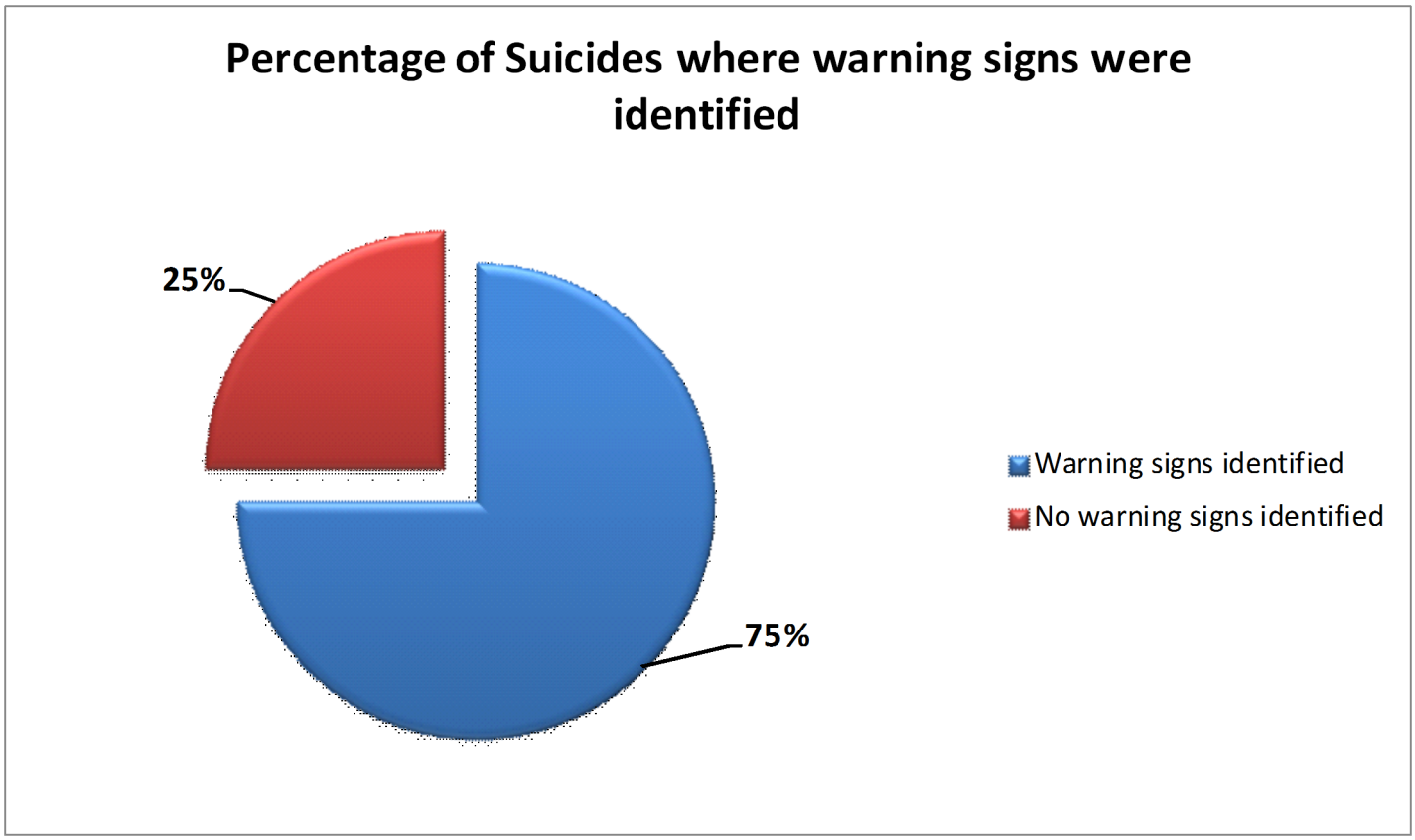
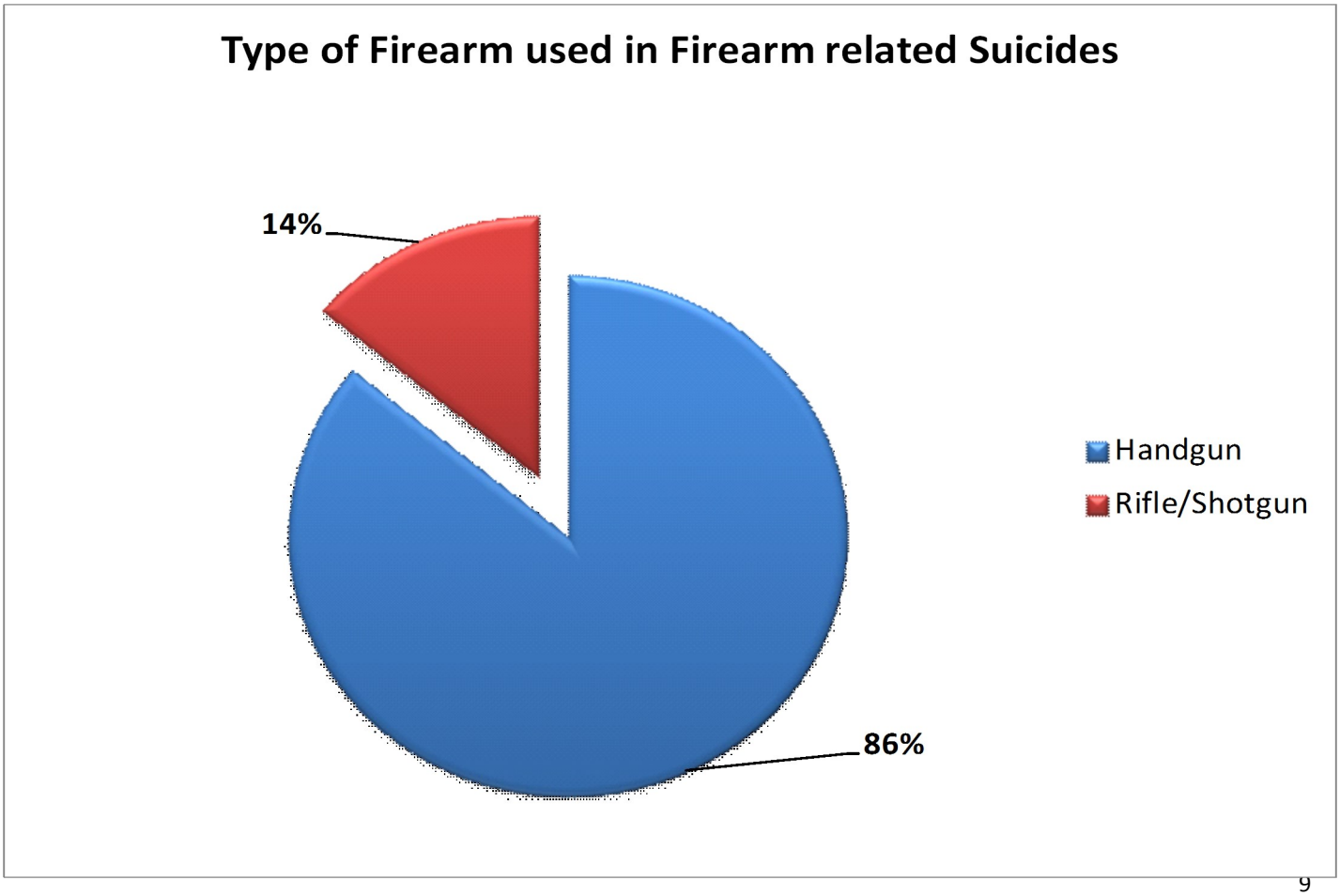
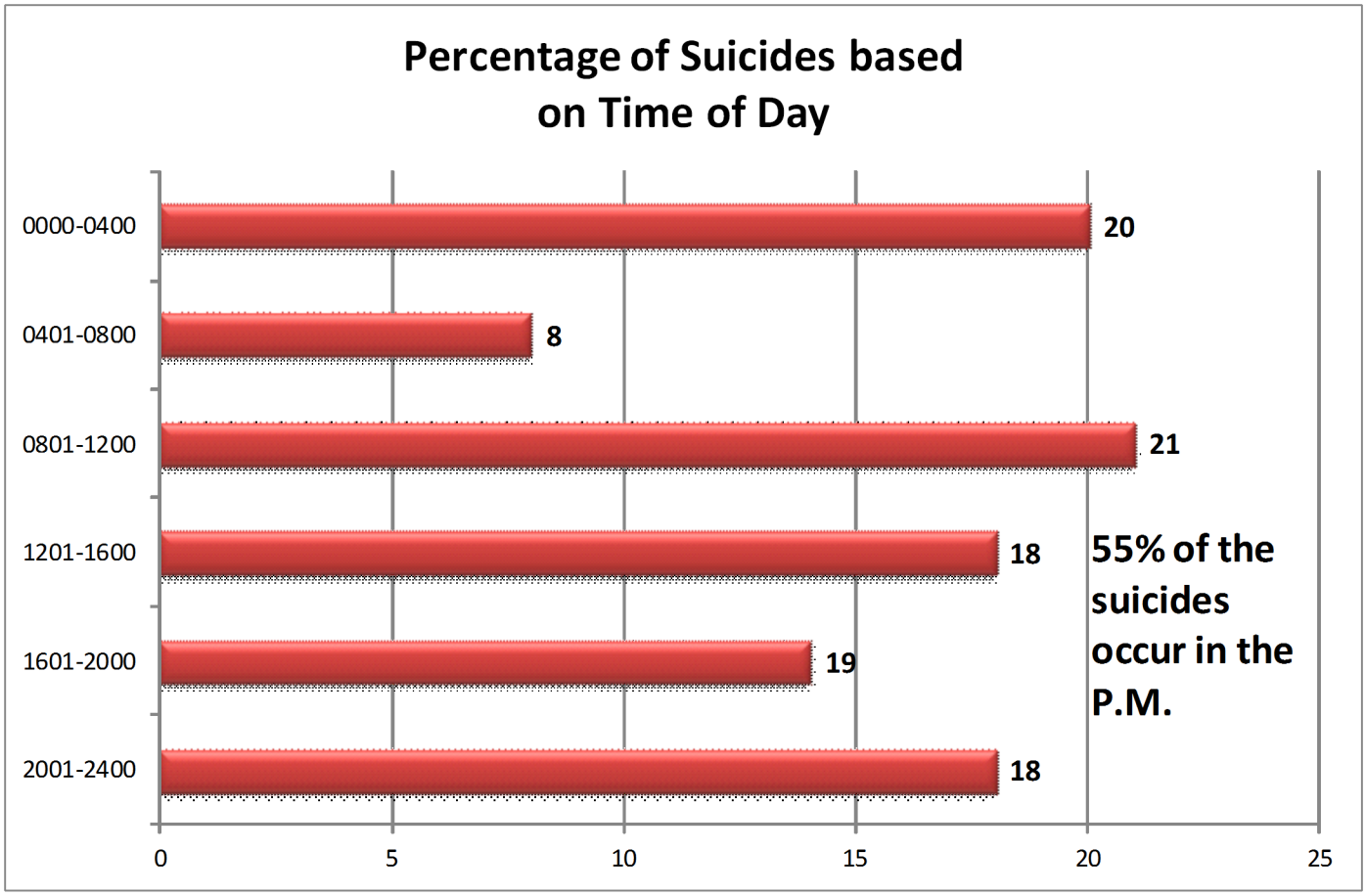
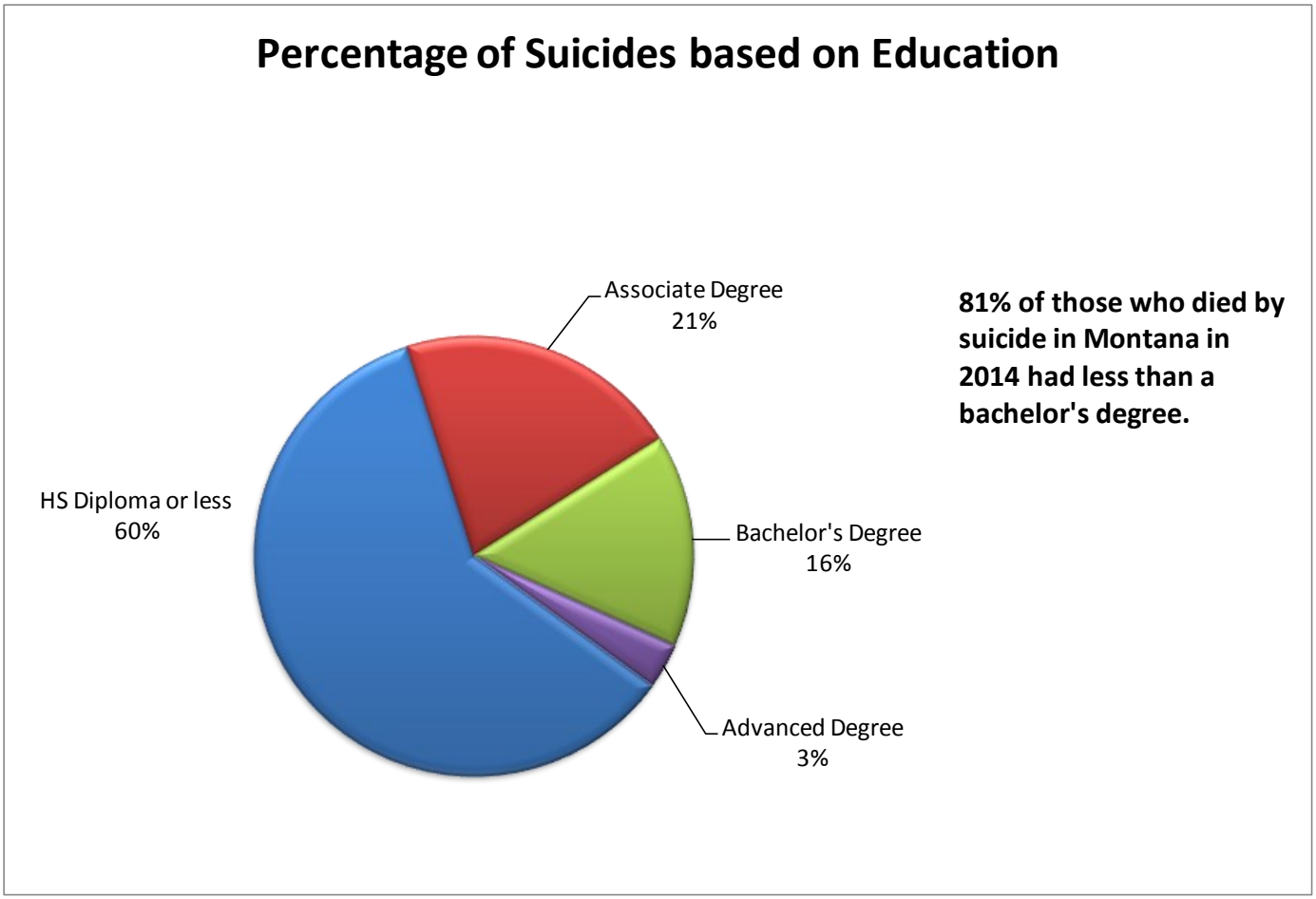
Automotive
Trucking
Healthcare
Food/Beverage
Construction/Building
Business/Sales
Laborer (skilled & unskilled
1
2
2
8
7
4
5
2
5
3
5
6
12
17
21
0
5
10
15
20
25


Percentage of Suicides where warning signs were identified
25%
75%
Warning signs identified
No warning signs identified


Type of Firearm used in Firearm related Suicides
14%
86%
Handgun
Rifle/Shotgun


Percentage of Suicides based on Time of Day
0000-0400
0401-0800
0801-1200
1201-1600
1601-2000
2001-2400
20
8
21
18
19
18
0
5
10
15
20
25
55% of the suicides occur in the P.M.


Percentage of Suicides based on Education
Associate Degree 21%
Bachelor's Degree 16%
Advanced Degree 3%
HS Diploma or less 60%
81% of those who died by suicide in Montana in 2014 had less than a bachelor's degree.

Observations noted concerning collecting information about Montana suicides

Inconsistent reporting by coroners – For the most part, the cooperation received by coroners around the state has been excellent. However, there is a great lack of consistency and large discrepancies noted from one county to another when it comes to the reports generated by coroners. There also appears to be a discrepancy from elected coroners compared to coroners who are part of a law enforcement department, with elected coroners being less responsive. The baseline for comparison is the protocol and practices taught in the Basic Coroners class at the Montana Law Enforcement Academy, which emphasizes developing a narrative of the events and factors that lead up to the death (suicide). This includes identifying issues related to mental illness, past attempts, family history, health issues (including identifying primary care providers), financial problems, relational problems, and other warning signs that indicate intent or risk. There is a discrepancy concerning the quality and quantity of the reporting of deaths by suicide from one coroner to another.

Improved quality of death certificates – The Montana Office of Epidemiology and Scientific Support has been very collaborative in aiding our ability to identify pertinent information concerning deaths by suicide in Montana. The death certificate has evolved over the past two years into a vital document that provides key information concerning factors associated with suicide deaths in our state.

Improved ability to provide resources to family members who have lost a loved one to suicide – Due to our ability to identify primary survivors on the death certificate, we have been able to reach out and offer support resources to survivors within weeks of the death. Prior to this, many survivors did not receive any services and were often left to grieve in silence. Survivors of suicide are three times the risk of completing suicide themselves, and with the strong stigma associated with suicide, many do not seek services.

Poor Collaboration and Communication between State and Tribal Entities—Due to geographic factors, social disorganization, and a lack of collaborative streamlining of resources and communication, many of the suicide prevention resources available are underutilized.

Improved collaboration with the Montana State Crime Lab – Our ability to obtain toxicology reports to complete the coroner's reports has improved, which has allowed us to better understand the role that varying substances may have played in the death.

High number of suicides by non-native Montanans – 53% of the suicides in Montana in 2014 were by people not born in the state of Montana. Further investigation and research is needed to better understand this issue. One theory may be that many people move to Montana for a slower pace of life or a new beginning, and that the social isolation that is evident in Montana becomes a risk factor along with limited resources.

Interventions identified that may decrease suicide risk

Community awareness and training in suicide awareness – Research indicates that 70% of the people who complete suicide gave warning signs. Through August 31, 2014, warning signs were identified in approximately 75% of the completed suicides in Montana. The warning signs are usually a combination of verbal statements, specific high risk behaviors, along with situational factors. Continued community awareness campaigns and trainings to help people better understand the warning signs of suicide, how to intervene, and resources that are available may help identify those at risk and connect them with appropriate community resources prior to an attempt being made.

Depression Screening by Primary Care Providers – Research indicates that 45% of the people who complete suicide saw their primary care provider within a month of their suicide, with 20% of those people seeing their provider within 24 hours. With the limited mental health resources and the strong stigma concerning mental illness in our state, primary care providers are often the first point of contact for those exhibiting high risk of suicide. Universal screening of depression in primary care settings would help decrease stigma associated with mental illness and help identify patients that may be suffering from an underlying mental health issue, which increases their risk of suicide. **Closer assessment of those who have a history of concussions or traumatic brain injuries is also recommended.**

Firearm Safety Program – Firearms continue to be the primary method of suicide for our youth. In Montana, 75% of youth suicides occur with firearms (compared to 40% nationally for youth). Concerning all firearms related suicides in Montana, 91% of the suicides occurred with a handgun. Raising awareness and emphasizing the safe storage of firearms for those with children in the home or those exhibiting high risk behavior, is recommended as a way of reducing access to lethal means.

Earlier referral for Hospice services – The issue of chronic pain or terminal illness has been observed as a strong factor in many of the elderly suicides that occur in Montana. A third of the suicides that have occurred involve issues of severe chronic pain or terminal illness. Aggressive pain management by primary care or earlier referral to hospice services would be indicated to improve the quality of life for those suffering.

Depression screening as part of DUI convictions – 21% of those who completed suicide had a history of DUI's and 41% of those who died by suicide had alcohol in their system at the time of their death. As part of the sentencing for those convicted of a DUI, depression screening and mental health treatment would be indicated.

American Indian Elder Consortium - Many tribes utilize elder wisdom to address suicide prevention intervention and postvention. The elders are tied directly to the vitalization of cultural traditions. We recommend that each tribal community engage their tribal elders in the generational transfer of cultural traditions to the youth in the spirit of prevention; suicide, substance abuse, violence, etc.

Wellness checks/Crisis Intervention Training – 90% of the time, law enforcement are the first responders to a suicide crisis. Wellness checks on people reported as being at high risk should be encouraged and promoted in the law enforcement community. Continued training in Crisis Intervention Training, Mental Health First Aid, and Question, Persuade, and Refer (QPR) would provide law enforcement with the necessary tools to interact with those at high risk. This training is already part the basic training at the Montana Law Enforcement Academy, but should be encouraged as an on-going training at the county level in law enforcement departments around the state.

Depression Screening and Suicide Prevention Training in Montana Schools - According to the 2013 Montana Youth Behavior Risk, 26% of Montana high school students reported that in the past 12 months, they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. Almost 17% seriously considered suicide in the past 12 months. 13% made a plan of how they would attempt suicide, and nearly 8% of Montana high school students made one or more suicide attempts in the past12 months. Universal screening for depression in all students, mental health awareness for parents, and suicide prevention trainings for all educators would better identify those at risk for suicide.

Coping skill and resiliency skill development in elementary age children. - Skills in problem solving, conflict resolution and nonviolent handling of disputes has been identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a protective factor against suicide. Evidence-based programs such as the PAX Good Behavior Game and Sources of Strength have shown to promote skill building in youth that provide protective factors well into their adult years. Implementation of this type of program in our elementary and middle schools would benefit Montana's youth for generations to come.

Addition of a State American Indian Suicide Prevention Coordinator – There is such great need for coordinated suicide prevention activities among the American Indian population in Montana. There are a number of resources available to the American Indian population, however, due to geographic factors and a lack of collaborative streamlining of resources and communication, many of these resources are underutilized.

Specific groups that should receive suicide prevention training

- Educational staff (teachers, administrators, bus drivers, custodial, meal services, counselors)
- Law Enforcement (officers , tribal police, detention staff, parole and probation officers)
- Clergy
- Healthcare providers to include primary care (those who have direct patient contact), nurses (LPN, RN), chiropractors, physician assistants, naturopaths, behavioral health providers, Indian Health Service, and CNA's.
- College Resident Assistants
- Judges (district and tribal) and public defenders
- Public Assistance employees
- Tribal elders
- Bartenders
- Chemical Dependency
- Firearm retailers
- VA employees (those who have direct client contact)