

North Dakota Suicide Prevention Plan

2014-2016



With Help There is Hope

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Jack Dalrymple
Governor of North Dakota

Terry Dwelle, M.D., M.P.H.T.M.
State Health Officer

Mary Dasovick
Director, Division of Injury Prevention and Control

Micki Savelkoul
Director, Suicide Prevention Program



Thank you to the North Dakota Department of Health Suicide Prevention Coalition for its help in the creation of this report.

This booklet was produced by the North Dakota Department of Health Suicide Prevention Program.

This publication is available on the North Dakota Department of Health's Division of Injury Prevention and Control website at www.ndhealth.gov/injury.



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State Suicide Prevention Plan Process

This plan has been developed to focus and coordinate suicide prevention efforts in North Dakota. The North Dakota Department of Health's Suicide Prevention Program will guide the implementation of activities in collaboration with national and local partners invested in suicide prevention efforts. This plan is based on best and promising practices for suicide prevention and the 2012 National Strategy for Suicide Prevention Goals and Objectives.

The state plan will be revisited each biennium to ensure that it continues to serve the needs of North Dakotans, as well as reflects the suicide prevention work that is being done in North Dakota. The review will also ensure that state practices reflect national priorities in suicide prevention and education.

This plan provides a brief history of the priority populations in need of suicide prevention help, a recap of suicide prevention work that has been completed by partners across North Dakota, and action steps for work that will be completed from 2014 through 2016.

Unless otherwise noted, the data and graphs in this document are based on occurrent data. Occurrent data looks at suicides that occur in North Dakota, regardless of resident status at the time of death. Occurrent data was used for a variety of reasons. First, people may not claim North Dakota residency because they are temporarily living in North Dakota for school or work, or are experiencing a recent relocation, among other reasons. Second, there is no set length of time required to be considered a resident of North Dakota.

In the past, resident-only data was used for charts and graphs. It is important to note that the occurrent data may not match resident-only data from previous years. When reporting rates, the number of suicides that occurred within a specific demographic is used as the numerator (unless noted that the data is looking only at resident deaths). The denominator is based on the census populations. This method promotes consistency between the resident and occurrent trends, and uses verified census numbers rather than population estimates.

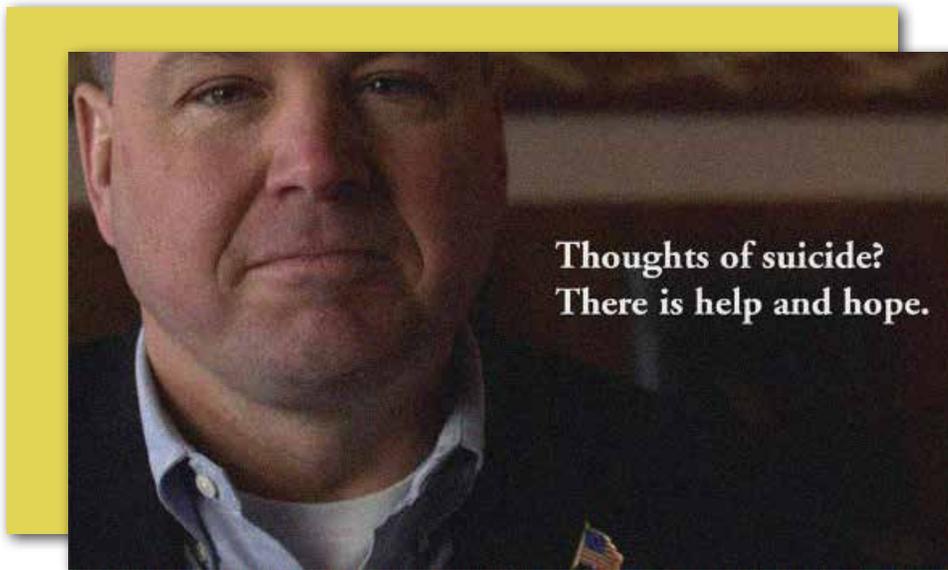
Suicide is a preventable public health problem in North Dakota.



Burden of Suicide in the United States

Approximately 108 Americans die by suicide daily. In 2011, 39,518 suicides occurred in the U.S. – an average of one person dying by suicide every 13.7 minutes. The 2011 suicide rates were the highest since 1996. In 2010, suicide was the tenth leading cause of death overall and the third leading cause of death for those ages 15 to 24.

It is estimated that one million people make a suicide attempt annually and two million experience suicidal thoughts each year (U.S. Centers for Disease Control and Prevention [CDC]). This translates to one attempt every 34 seconds (American Association of Suicidology).



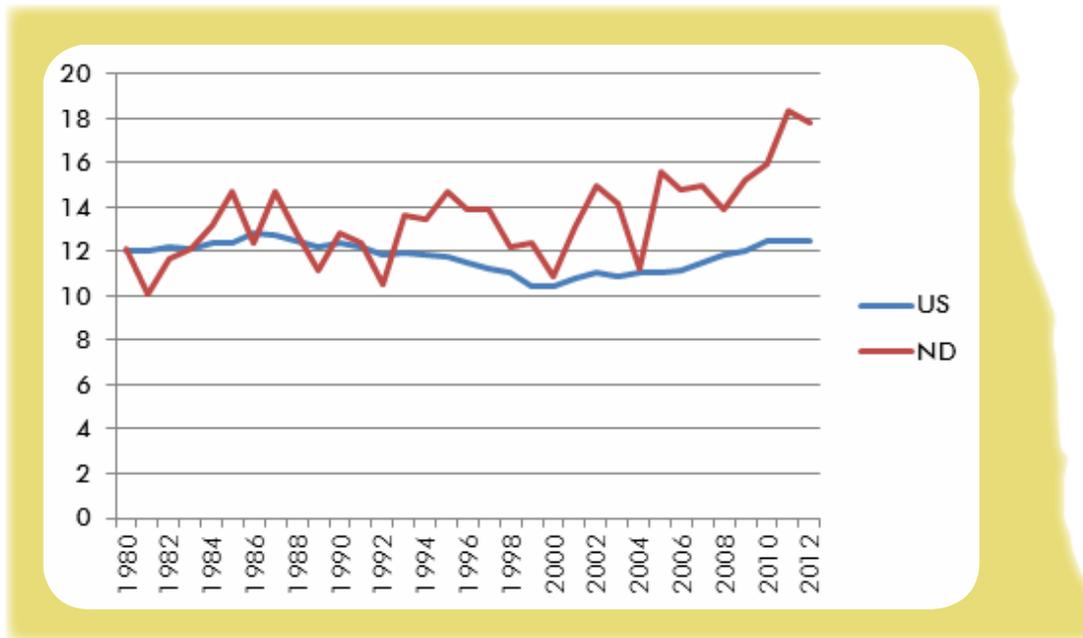


Burden of Suicide in North Dakota

In 2012, 107 North Dakota residents died by suicide; however, an additional 13 people who were not residents also died by suicide in the state, bringing the total occurrent suicides to 120 in 2012. In 2013, 138 North Dakota residents died by suicide, with an additional 18 people who were not residents dying by suicide, bringing the total occurrent suicides to 156 in 2013. In 2013, suicide was the ninth leading cause of death in North Dakota overall, and the second leading cause of death for those between the ages of 15 and 24.

While we know many more North Dakotans attempt suicide than die by suicide, there is no universal data collection system to know how many North Dakotans receive medical treatment annually for a suicide attempt. It has been estimated that for every completed suicide there are as many as 25 more people who attempt suicide but do not die (American Association of Suicidology, 2008). In 2012, 1,501 calls were answered within North Dakota on the National Suicide Prevention Lifeline from people looking for help with suicidal thoughts.

The following graph reveals the suicide rate for North Dakota compared to the United States, including all ages, from 1980 to 2012. Rates are measured per 100,000 in population.



Source: North Dakota Department of Health, Vital Records

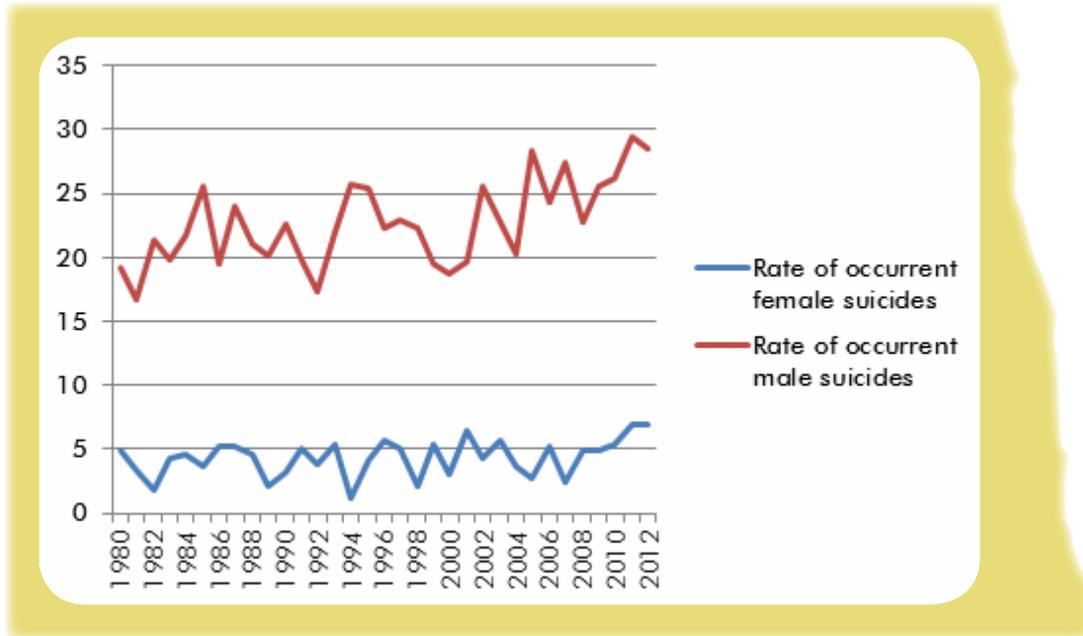
Suicide has devastating consequences for not only family and relationships, but also for society in general. The CDC estimates (updated 2005) that the average suicide costs \$1,061,170 per person. Based on this figure, within the state of North Dakota, our 120 suicides in 2012 cost \$127,340,400 due to combined medical and work loss costs.

120 occurrent suicides within North Dakota in 2012
x \$1,061,170 per person

\$127,340,400

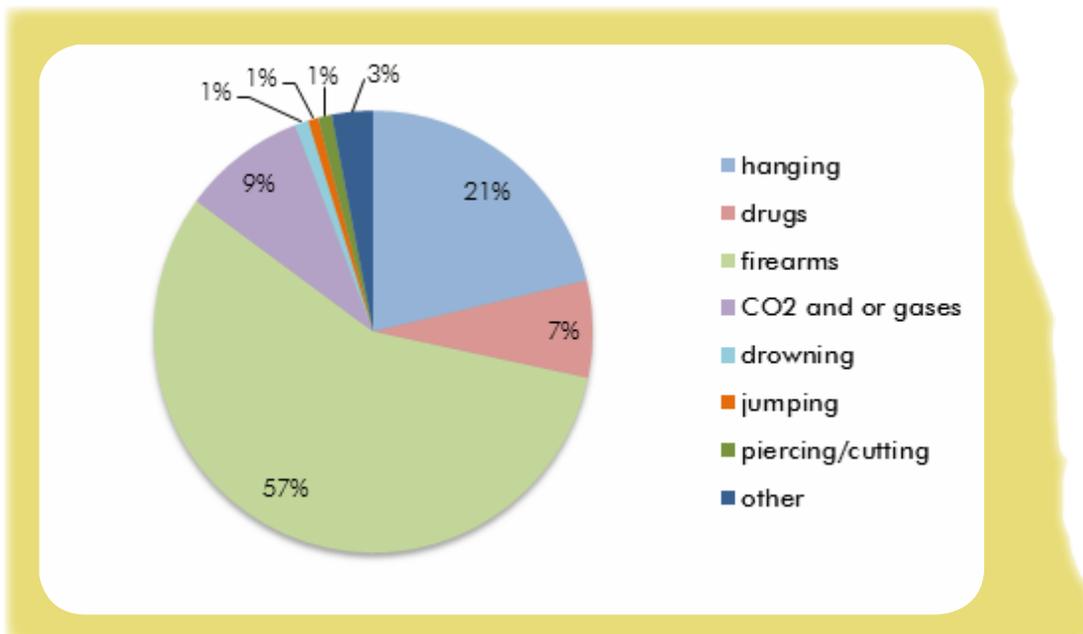


Males typically complete suicide four times more frequently than females. The graph below depicts the suicide rate of males and females in North Dakota from 1980 to 2012. Rates are measured per 100,000 in population.



Source: North Dakota Department of Health, Vital Records

Fire arms are the leading means of suicide in the U.S. and North Dakota. The following graph depicts the means of suicide deaths from 1980 to 2012.



Source: North Dakota Department of Health, Vital Records



Suicide Survivors

There are two types of people who are suicide survivors:

1. People who attempt suicide and survive
2. People who are affected and impacted by the suicide of a loved one

The loss of a loved one by suicide is often very difficult, perhaps one of the most difficult things a person will face in their lifetime. These survivors may feel as if they cannot survive the death of their loved one, and they may need support and community resources to assist with the grieving and healing process.

In the U.S.

No exact figure exists, but it is estimated that a median of between 6 and 32 survivors exist for each suicide, depending on the definition used (Berman, A. L. Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior* 2011. 41(1), 110–116). There are approximately five million survivors in the U.S.

In North Dakota

Using the most conservative estimate, approximately 642 North Dakotans became suicide survivors in 2012, in addition to the thousands of survivors already living in the state. In North Dakota, we recognize that survivors bear a significant emotional weight over the loss of their loved one. There are several ways survivors can connect with each other, such as support groups, community walks or recognition of International Survivors of Suicide Loss Day.

Being a suicide survivor is considered a risk factor for attempting suicide. According to the American Association of Suicidology, the increased risk of suicide in the survivor population is an area that needs further research.

Advice for survivors

- ☞ Feelings of shock, guilt, blame, anger, relief, depression and isolation are common. These feelings are often overwhelming, but are normal.
- ☞ Seek people who are able and willing to listen; this may include friends and family, clergy or professionals.
- ☞ Survivors need to take care of themselves physically, mentally, emotionally and spiritually. They should seek professional help if needed.



Suicide in Adolescents and Young Adults

Adolescents and young adults go through a period of development and self-identity that can also be a time of loneliness and confusion. In the U.S., about 5,000 young people between the ages of 10 and 24 die by suicide each year. Youth suicide rates in the U.S. have tripled since the 1950s.

Nationally, suicide is the third leading cause of death for those between the ages of 15 and 24. In North Dakota, suicide is the second leading cause of death for this age group.

The Youth Risk Behavior Survey (YRBS) is a biennial survey that monitors health risks and behaviors of youth in grades seven through 12.

North Dakota YRBS results for students in grade 7-8	2011	2013
% of students who ever seriously thought about killing themselves	19.2	17.8
% of students who ever made a plan about how they would kill themselves	11.5	12.5
% of students who ever tried to kill themselves	5.0	5.1

Source: North Dakota Department of Public Instruction, YRBS 2011, 2013

North Dakota YRBS results for students in grade 9-12	2011	2013
% of students who felt sad or helpless almost every day for two weeks or more in the past 12 months	23.8	25.4
% of students who seriously considered attempting suicide in the past 12 months	14.7	16.1
% of students who made a plan about how they would attempt suicide in the past 12 months	12.1	13.5
% of students who actually attempted suicide one or more times in the past 12 months	10.8	11.5

Source: North Dakota Department of Public Instruction, YRBS 2011, 2013

Young people consistently say that having caring adults in their lives, such as teachers, coaches, ministers and other trusted adults, is a valuable resource during times of suicidal thoughts (Jason Foundation). In addition to general population risk factors for suicide, special risk factors occur in the adolescent and young adult population.

Special risk factors for suicide in adolescent and young adult population include:

- ☞ Worsening school performance
- ☞ Unhealthy peer relationships
- ☞ Participating in risky behaviors
- ☞ Bullying
- ☞ Fixation on violence and death
- ☞ Unrealistic academic pressures
- ☞ Unrealistic social or family expectations that may create a sense of rejection



Suicide in Middle Adulthood

For many people, middle adulthood (ages 35 to 64) is the prime of their lives. Yet, those in middle adulthood also can face many stressful life events that have contributed to a steadily increasing number of completed suicides in the U.S. and North Dakota over the past several years. In fact, this age group show the largest increases of any age group.

In 2011 (most recent national data), the highest national suicide rate (18.6 per 100,000) was among those 45 to 64 years of age (American Foundation for Suicide Prevention). The suicide rate for this age group in North Dakota in 2013 was 16.2/1000,000. In North Dakota, an increase has been most evident in the white male population in this age group. However, it is also important to note that suicide rates for women also peak in midlife.

Risk factors for suicide in middle adulthood include:

- ⌚ **Loss of youthful dreams** can result in the realization that the perfect ideal life will not be a reality.
- ⌚ **Depression** is most common in midlife and a major factor in midlife suicides. Depression is more than just sadness and can be effectively treated.
- ⌚ **High-risk behaviors** such as substance use, unsafe sexual behavior, reckless spending or self-injury are often used as escapes from depression or loneliness; however, these behaviors often magnify the feelings from which the person is trying to escape.
- ⌚ **Decreased social support** resulting from divorce, job loss or empty nest syndrome may contribute to loneliness, depression and substance use.





Suicide in Older Adults

Depression and suicidal ideation is not a normal part of aging. For some older adults, physical or emotional pain prevents them from finding fulfillment. If their pain is not addressed, they may attempt suicide.

Suicide and suicide attempts in the older adult population tend to occur more often in rural areas than urban. Older Caucasians are more likely to die by suicide than other races. Older adults are less likely to act on suicidal thoughts impulsively; therefore, there is perhaps more time to notice warning signs of suicide and to intervene.

In 2013, the 65 and older age group in North Dakota had a suicide rate of 10.3/100,000.

Risk factors of suicide in older adults include:

- ⌚ **Loss of self-esteem** can be a contributor to thoughts of suicide. Feelings of uselessness, hopelessness or anger because of the aging process can lead to thoughts of suicide.
- ⌚ **Depression** is more than just “sadness.” Depression is a major risk factor in suicide attempts and completed suicides in older adults. It is important to know that depression can be treated effectively.
- ⌚ **Substance use** is sometimes used to cope with feelings of depression or loneliness; however, substance use often magnifies the feeling that the person is trying to escape.
- ⌚ **Chronic illness** can affect some older adults with serious and painful results. Physical pain, in addition to feelings of hopelessness and depression, can lead to suicidal thoughts or actions.
- ⌚ **Isolation** from family and friends may make an older person more susceptible to loneliness, depression and substance use.





Suicide in Lesbian, Gay, Bisexual and Transgender (LGBT) Population

Precise numbers on the connection between sexual orientation and suicide risk vary, but people who identify themselves as LGBT are two to three times more likely to attempt suicide, even if they are not depressed (Haas AP, Eliason M, Mays VM, Mathy RM, Cochran SD, D’Augelli AR, Silverman MM, Fisher PW, Hughes T, et al. [2010]; Suicide and suicide risk in lesbian, gay, bisexual and transgender populations: review and recommendations. *Journal of Homosexuality*, 58 (1), 10–51). The risk is also high for those who identify as transgender. Nearly half of young transgender people have seriously thought about taking their lives, and one quarter report having made a suicide attempt (Grossman, A.H. & D’Augelli, A.R. (2007); *Transgender Youth and Life-Threatening Behaviors; Suicide and Life-Threatening Behaviors*.37(5), 527-37.).

Youth: The 2011 National School Climate Survey issued by the Gay, Lesbian and Straight Education Network (GLSEN) found that most LGBT high school students were verbally or electronically harassed because of sexual identity or gender expression. Students who were harassed were more likely to skip school, drop out, and experience low self-esteem and depression.

Adults: Identifying as LGBT is also a risk factor for adults. Lack of acceptance, bullying, discrimination and exclusion have all been cited as contributing factors to rates of suicide (Cochran, Mays, & Sullivan, 2003; de Graaf, et al., 2006; King et al., 2008; Mays and Cochran, 2001; McCabe, Bostwick, Hughes, West & Boyd, 2010).

Risk factors of suicide in the LGBT population include:

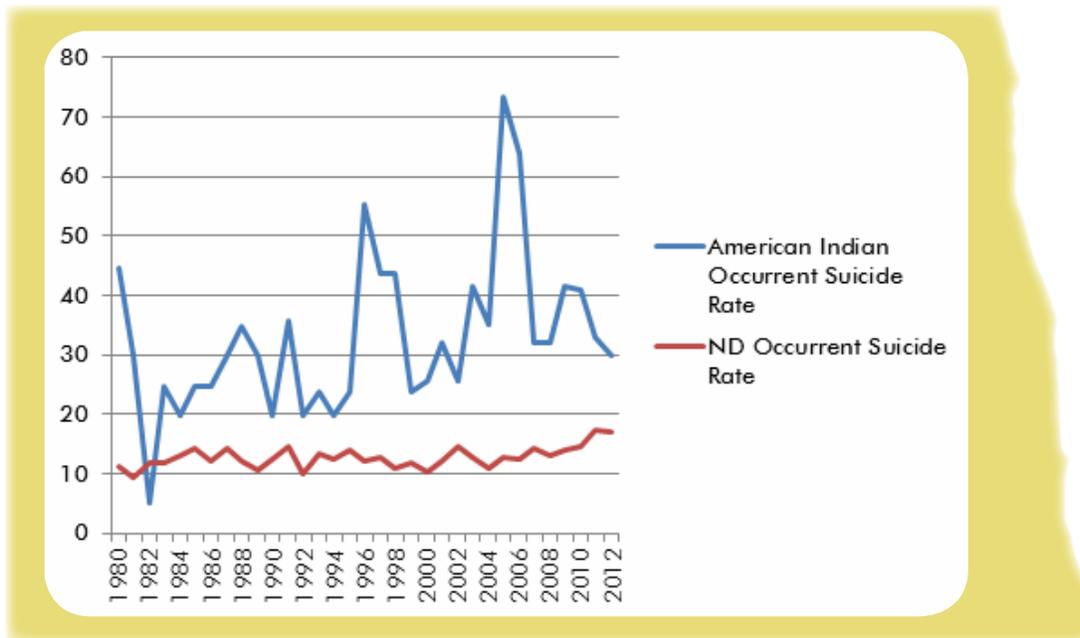
- ☞ **Harassment** is a major suicide risk factor for LGBT people. Nearly eight out of 10 students have experienced harassment at school in the past year (CDC, www.cdc.gov/lgbthealth/youth.htm). Sixty percent reported they felt unsafe while at school.
- ☞ **“Coming out,”** or disclosing oneself as homosexual, can be a critical and dangerous time. Research indicates that the first year after disclosure of sexual orientation to one’s parents is a prime period for suicide attempts. Teens who are rejected by their families are at more than eight times the risk for a suicide attempt (CDC, www.cdc.gov/lgbthealth/youth.htm).
- ☞ **Substance use** can involve alcohol as well as prescription or illegal drugs, and is a major risk for suicide. The interaction between the brain’s chemistry, substances and personal problems can be overwhelming and lead to thoughts of suicide.



Suicide in the American Indian Population

The term American Indian/Alaska Natives (AI/AN) encompasses many ethnic and cultural groups, tribes and traditions. The reasons why suicide rates are high among the AI/AN population are complex, but some include the prevalence of more serious mental health disorders which are related to suicide, including anxiety, substance use and depression.

The graph below depicts the occurrence of the total suicide rate in North Dakota compared to the American Indian suicide rate in North Dakota. Rates are measured by the population per 100,000.

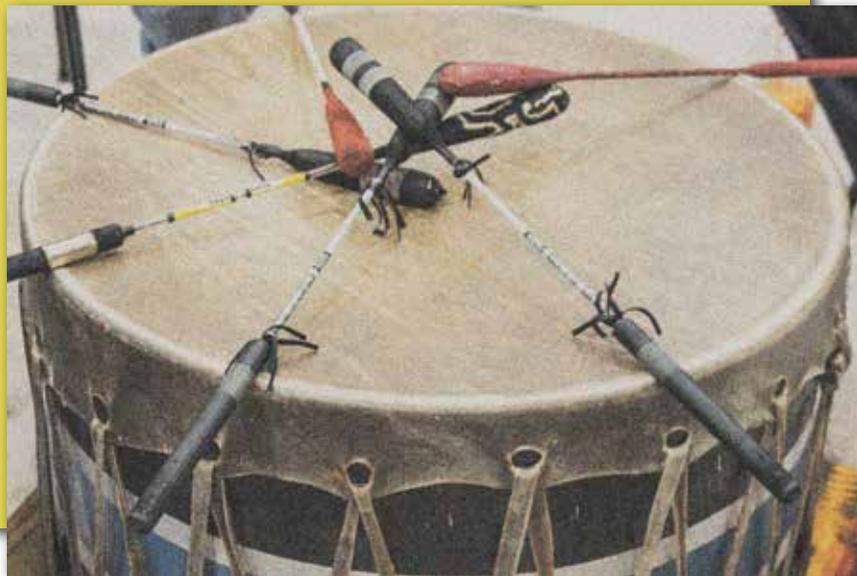


Source: North Dakota Department of Health, Vital Records



Risk factors of suicide in the American Indian population include:

- ④ **Alcohol and drug use** is an ongoing risk factor. In 2005-2006, of American Indians/Alaska Natives, 37.1 percent of those in the U.S. who died from suicide and were tested for alcohol were legally intoxicated. (Morbidity and Mortality Weekly Review. June 19, 2009; 58(23):637-4).
- ④ **Contagion** is the idea that youth may be at particular risk because American Indian/Alaska Natives have considerable exposure to suicide.
- ④ **Discrimination** is as important a predictor of suicide ideation as poor self-esteem or depression. Mental health services aren't easily accessible due to a lack of funding and a lack of culturally appropriate services. In addition, mental health service shortages and high turnover rates for professionals, as well as the stigma of receiving mental health treatment, make the mental health system hard to access.
- ④ **Historical trauma** exists in the American Indian/Native American culture. The idea that attempts have been made to eliminate the culture with such means as the sending of children to boarding schools and prohibition of the practice of language and culture contributes to high rates of suicide.
- ④ **Alienation** causes a loss of well-being when the individual feels emotionally disconnected from his or her family of origin or culture. This can lead to depression.
- ④ **Acculturation** is the changing of a culture as it mixes with other cultures. In some national studies, American Indian/Alaska Natives with greater acculturation reported increased psychosocial stress, less happiness and greater use of drugs to cope with stress.





Suicide in the Military

In the United States

Veterans are at a higher risk for suicide, with an annual rate that increased 50 percent from 2001 to 2008 (The War Within: Preventing suicide in the U.S. military, Rand Cooperation. 2011). In the U.S., a veteran dies by suicide every 80 minutes. This equates to approximately 18 suicides per day or 6,500 suicides per year (Losing the Battle: The Challenge of Military Suicide, 2011). Military veterans are twice as likely to die from suicide as people who have never served in the military.

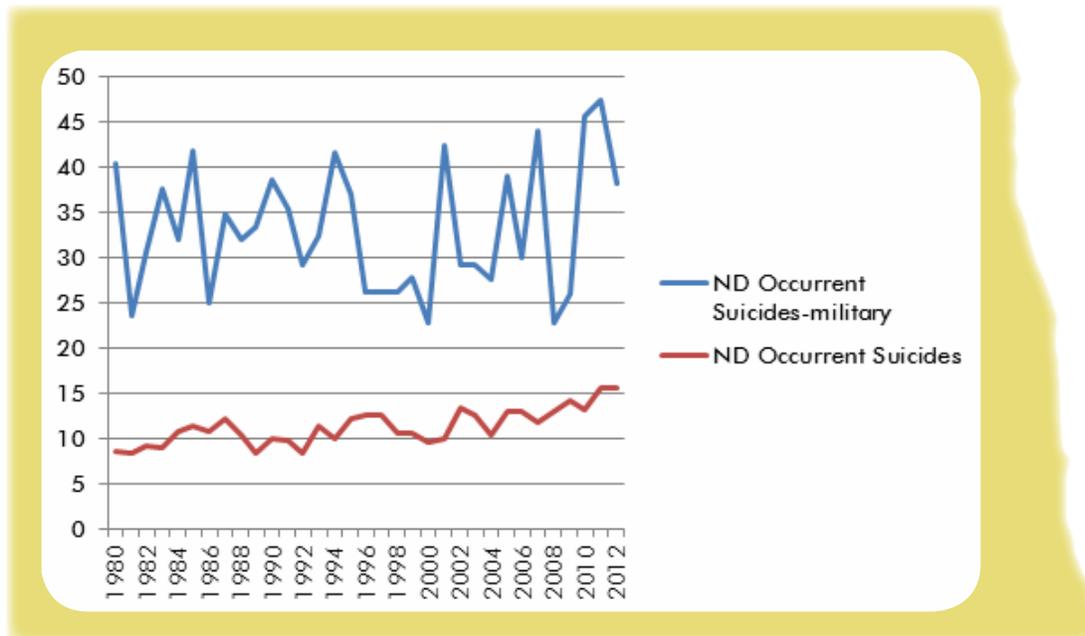
Research about suicide by members of the military indicates that risk factors include: male, depression, substance abuse and relationship issues. (James LC, Kowalski TJ. Suicide prevention in an army infantry division: a multi-disciplinary program. Mil Med 1996; 161:97-101). More than 90 percent of Army suicides involve substance abuse, primarily alcohol.

A study of suicide mortality of veterans being treated for depression in the Veterans Affairs Health System reported that “unlike the general population, older and younger veterans are more prone to suicide than are middle-aged veterans.” (Zivin K, Kim HM, McCarthy JF, Austin KIL, Hoggatt KJ, Walters H, Valenstein M. Suicide mortality among individuals receiving treatment for depression in the veterans affairs health system: Associations with patient and treatment setting characteristics. American Journal of Public Health. 2007; 97:12).

In North Dakota

In North Dakota, suicide rates for those who have served in the military at some point in their lives are consistently around 15 to 20 percent of the total yearly suicide deaths. The national average is 20 percent.

The graph below depicts the total suicide rate in North Dakota compared to the suicide rate of North Dakotans who reported serving in the armed forces. Rates are measured by the population per 100,000.



Source: North Dakota Department of Health, Vital Records



Suicide and Substance Use

There is a link between suicide and substance use, which can include prescription drugs, alcohol or illegal substances. The National Institute on Drug Abuse states that teens who engage in high-risk behaviors, such as using drugs, alcohol and tobacco, report significantly higher rates of depression, suicidal thoughts and suicide attempts. Additionally, binge drinking among teens has been identified as a predictive factor for suicidal thoughts.

A cause for concern in North Dakota is that, according to the Youth Risk Behavior Survey (YRBS) that was conducted in 2013, 6 percent of students in middle school and 21 percent of students in high school reported that they had consumed five or more drinks of alcohol in a row within a couple of hours, on one or more of the past 30 days, which constitutes binge drinking.

A study concerning alcohol and suicide found that in the suicide deaths studied, 33.3 percent tested positive for alcohol. Of those, more than 56 percent had blood alcohol content over .08, which is legally intoxicated (Morbidity and Mortality Weekly Report, 2009).

The rise in drug abuse over the past 30 years is believed to be a contributing factor in the increase in youth suicides, specifically among adolescent males.

Suicide and Mental Health

People with a mental illness may have a heightened risk of suicidal thoughts. When coupled with substance use, the risk increases. While 95 percent of individuals with a mental illness and/or substance use disorder will never complete suicide, several decades worth of data from numerous studies found evidence suggesting that as many as 90 percent of individuals who do complete suicide experience a mental or substance use disorder, or both (Center for Substance Abuse Treatment, 2008).



Underlying Principles of the North Dakota Suicide Prevention Plan

Suicide is largely preventable.

Suicide is preventable and always caused by contributing events. No single event causes suicide to occur. The majority of people who die by suicide each year show signs that they are thinking about suicide long before they act on their thoughts. Early identification of warning signs and effective treatment drastically reduces the risk of someone dying by suicide. Learning about suicide and suicide prevention will assist North Dakotans in recognizing the warning signs. Perhaps this knowledge could help someone prevent the loss of a loved one or friend who is in crisis.

Everyone can help prevent suicide.

Just as suicide affects everyone, suicide prevention involves everyone. Suicide prevention requires the vision, the will and a commitment from the state, communities and individuals within North Dakota. While treatment should be done by a qualified professional that specialize in behavioral health, everyone can learn to recognize the warning signs that someone is thinking about suicide. People who are in contact with those who are suicidal are often the first line of defense for suicide prevention. These “gatekeepers” can be family members, social acquaintances, or those in more formal relationships, such as physicians, teachers and hairdressers. It is important that people feel empowered to intervene when they perceive someone to be at risk for suicide.

Many professions also can play a part in suicide prevention and education. That is why professional partners are so important – those that help watch for warning signs of suicide and those that offer intervention services within the populations they work with, as well as those that help to spread the word that suicide is preventable.

We must eliminate the stigmas associated with suicide.

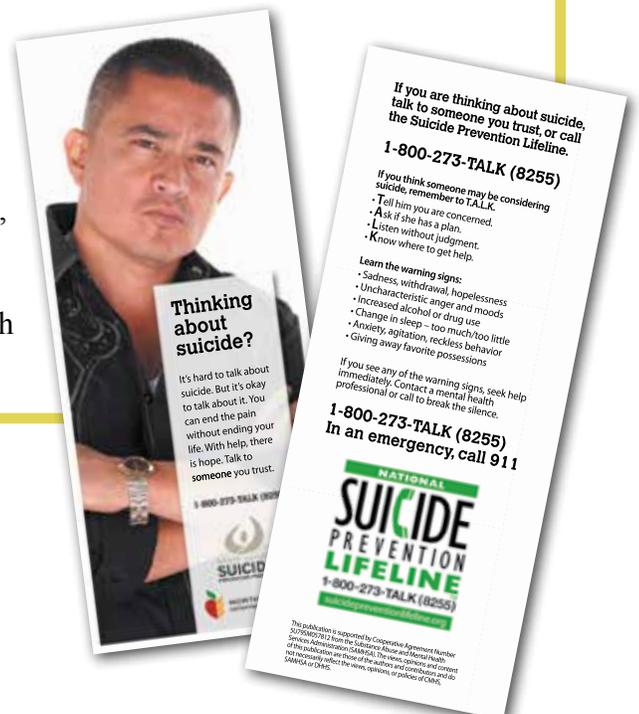
Suicidal thoughts and attempts, along with suicide itself, carry a social stigma. The factors that often lead to suicide, such as substance use, mental illness and depression, also carry social stigma. Because of stigma, people who are having suicidal thoughts often will not reach out for help, either from professionals, friends or family. If we decrease or eliminate the stigma around suicide, more people may be willing to get help, and more people may be diverted from suicidal behavior.



Highlight of Suicide Prevention Efforts from 2005 to 2013

The North Dakota Suicide Prevention Program has worked with many state partners to develop and implement suicide prevention programs and reduce suicide rates across North Dakota. Partnerships and collaborative efforts have:

- ☞ Received state general funds to support infrastructure and a full-time suicide prevention director
- ☞ Established infrastructure and regular meetings for the Suicide Prevention Coalition
- ☞ Expanded suicide prevention community partners
- ☞ Provided gatekeeper training, including Question, Persuade, Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST), to community members
- ☞ Provided training opportunities to community members, including medical professionals, social workers, teachers, journalists, law enforcement and emergency medical providers, as well as others
- ☞ Offered new services to people seeking help, such as the Callback Program, a collaborative effort between medical providers and the National Suicide Prevention Lifeline
- ☞ Incorporated wellness and resiliency messages into trainings and programs to encourage help-seeking behavior
- ☞ Developed Public Service Announcements and print material specifically for youth, veterans and American Indians
- ☞ Incorporated suicide prevention speakers into the Injury Prevention and Control Conference
- ☞ Provided grants to local organizations for suicide prevention activities
- ☞ Coordinated International Survivors of Suicide Day activities
- ☞ Coordinated statewide Out of the Darkness walks, expanding to several new communities
- ☞ Implemented online screening programs within the college and university systems and increase access to services
- ☞ Supported legislation that requires middle and high school staff to participate in two hours of suicide prevention training every two years
- ☞ Created multiple documents, including fact sheets, for use in professional settings, such as schools, medical facilities and social service offices
- ☞ Increased data collection through partnerships with coalitions and local groups



**North Dakota Suicide Prevention
Plan Goals
2014-2016**





STRATEGY 1

Develop and implement effective programs that promote wellness and prevent suicide related behaviors.

Goal 1: Promote best practice programs.

- Action Step:* Through 2016, maintain and enhance existing best practice programs – ASIST, QPR, SOS, Kognito and other appropriate programs.
- Action Step:* By 2016, collect 75 percent of training participant testimonies to enhance quantitative promotion of trainings and more accurately describe training outcomes.
- Action Step:* By 2015, develop a document that compares best practice programs by service area, target population, cost, cultural competency, and distribute as a quick reference for community partners.

Goal 2: Promote FirstLink’s Callback Program for Suicide Prevention Lifeline callers, as well as people referred from community agencies.

- Action Step:* By 2014, develop and implement a promotion plan for the Callback Program.
- Action Step:* By 2014, develop consistent messaging for the Callback Program.
- Action Step:* By 2014, create a one-page fact sheet for professionals about the Callback Program for easy distribution in a wide array of settings (human service centers, medical facilities, etc.).
- Action Step:* By 2015, begin use of multimedia and social media for promotion of this program.
- Action Step:* By 2016, increase the number of medical professionals routinely screening for suicidal ideation and referring to the Callback Program by 25 percent.

Goal 3: Promote and develop wellness activities.

- Action Step:* Ongoing through 2016, conduct regular meetings in partnership with the Indian Affairs Commission and tribal coordinators.
- Action Step:* By 2015, conduct a literature review of the connection between bullying and suicide, and develop talking points for consistent messaging.
- Action Step:* By 2015, promote effective suicide prevention factors, such as resiliency, communication skills, mental wellness, connectedness and positive self-esteem to middle and high school students (i.e., American Indian Life Skills Curriculum); provide Parents LEAD website and educational materials to providers and community partners by collaborating with the North Dakota Department of Human Services, Division of Substance Abuse and other partners.
- Action Step:* By 2016, develop a comparison sheet for dissemination by local leaders for wellness programs that assist in reducing barriers to help-seeking behaviors across all ages and populations.



STRATEGY 2

Integrate and coordinate activities across multiple sectors and settings, including training for community and clinical service providers on suicide prevention and suicide-related behaviors.

Goal 1: Offer suicide prevention sessions at conferences across the state.

1. Injury Prevention and Control Conference
2. Mental Health Conference
3. School conferences

Goal 2: Implement effective training and program activities for the following higher risk populations:

Youth 10-18

- Action Step:* Ongoing through 2016, increase knowledge that suicide is preventable through best practice training programs, and teach parents and teachers how to identify warning signs of suicide and make referrals.
- Action Step:* By 2014, make suicide prevention materials available in a wide variety of settings (print, online, face-to-face, etc.)
- Action Step:* By 2015, identify needs of high-risk and socially-isolated groups.

Young adults 18-24

- Action Step:* Ongoing through 2016, train probation and parole officers in suicide prevention.
- Action Step:* By 2014, identify appropriate connections to enhance suicide prevention education, such as the bar bystander project.
- Action Step:* By 2016, implement formal suicide prevention training within nursing and social work departments at two of the higher education institutions .
- Action Step:* By 2016, partner with worksite wellness to offer depression and suicidal ideation screenings.
- Action Step:* Ongoing through 2016, continue working with the Optimal Pregnancy Outcomes Program and Family Planning clinics across North Dakota to administer depression and suicidal ideation screening.
- Action Step:* By 2015, identify the needs of high-risk and socially-isolated groups.

American Indians

- Action Step:* By 2015, conduct regular meetings with all tribes.
- Action Step:* Ongoing through 2016, develop a listserv for tribal participants to ensure awareness of training opportunities.
- Action Step:* Ongoing through 2016, make suicide prevention materials available in a wide variety of settings (print, online, face-to-face, etc.) using culturally competent pictures and language.



Veterans/Military/Paramilitary

Action Step: By 2014, identify partners to ensure suicide prevention messaging is culturally competent.

Action Step: By 2015, conduct regular meetings with military partners and disseminate NDCares strengths, weaknesses, opportunities and threats (SWOT) analysis.

Action Step: By 2015, develop a listing of military trainings and disseminate to partners.

Action Step: By 2015, continue suicide prevention training with emergency medical providers.

Action Step: Ongoing through 2016, continue suicide prevention training with veterans' service officers and law enforcement across the state.

Young adults 25-34

Action Step: By 2015, engage clergy members in depression and suicidal ideation training.

Action Step: By 2016, engage obstetricians, gynecologists and medical community in depression and suicidal ideation screening.

Action Step: Ongoing through 2016, increase number of people accessing Parents Lead for educational opportunities.

Action Step: Ongoing through 2016, disseminate quarterly suicide prevention education to non-traditional partners (such as realtors, lawyers and landlords) to encourage help-seeking behavior.

Adults 35-lifespan

Action Step: By 2016, partner with worksite wellness programs to offer depression and suicidal ideation screenings.

Action Step: By 2015, promote effective prevention factors such as resiliency, communication skills, mental wellness, connectedness and positive self-esteem; disseminate resources, such as the website and educational materials by Parents Lead, to providers and community partners by collaborating with the North Dakota Department of Substance Abuse and other partners.

Action Step: Ongoing through 2016, continue depression and suicidal ideation screenings within medical facilities with appropriate referrals to local agencies.

Action Step: Ongoing through 2016, make suicide prevention materials available in a wide variety of settings (print, online, face-to-face).

Goal 3: Support the integration of mental health and suicide prevention within helping professions.

Action Step: Ongoing through 2016, continue grant opportunities for medical facilities (primary care, Emergency Departments, public health, federally qualified health centers) focusing on ongoing screening and referral to mental health services, engaging 25 percent of medical facilities across North Dakota.

Action Step: Ongoing through 2016, make suicide prevention materials available in a wide variety of settings (print, online, face-to-face).



Action Step: By 2015, disseminate suicide prevention education in eight existing newsletters across the state.

Action Step: By 2015, work with Southwestern District Health Unit and clergy training to include suicide prevention education and activities in community trainings.

Action Step: By 2016, reach 10 percent of the parish nurse and clergy community with suicide prevention training.





Risk Factors for Suicide

There are many risk factors for suicide. Some risk factors are genetic and cannot be changed; others are short lived and situational. Just because risk factors are present does not mean that someone will attempt or complete suicide; however, any warning signs that are associated with a change in behavior should be closely monitored.

Chronic risk factors

Risk factors that are permanent and cannot be changed:

- ☞ Demographics: Caucasian, American Indian, male, older age, separation or divorce, early widowhood
- ☞ History of suicide attempts (especially if more than one attempt)
- ☞ Prior suicidal ideation
- ☞ History of self-harming behavior
- ☞ History of suicide or suicidal behavior in the family
- ☞ Parental history of violence, substance abuse, divorce or hospitalization for major psychotic disorders
- ☞ History of trauma, or physical or sexual abuse
- ☞ History of psychiatric hospitalization
- ☞ History of violent behaviors
- ☞ History of impulsive and reckless behaviors

Other chronic risk factors:

- ☞ Major Axis I psychiatric disorder, especially:
 - Mood disorder
 - Anxiety disorder
 - Schizophrenia
 - Substance use disorders (drug and alcohol abuse or dependence)
 - Eating disorders
 - Body dysmorphic disorder
 - Conduct disorder
- ☞ Axis II personality disorder, especially cluster B
- ☞ Axis III medical disorder, especially if it involves functional impairment and/or chronic pain
 - Traumatic brain injury
- ☞ Comorbidity of Axis I disorders (especially depression and alcohol use, or dependence)
- ☞ Low self-esteem
- ☞ Attitude of acceptance toward suicide
- ☞ Exposure to another's death by suicide
- ☞ Lack of self- or familial acceptance of sexual orientation
- ☞ Smoking
- ☞ Perfectionism



Acute risk factors

If these are present, they increase the risk of a potential suicide attempt or death in the near future.

- ☞ Demographics, recently divorced or separated, with feelings of victimization or rage
- ☞ Suicide ideation (threatened, communicated, planned or prepared for suicide)
- ☞ Current self-harming behavior
- ☞ Recent suicide attempt
- ☞ Excessive or increased use of drugs or alcohol
- ☞ Acute distress due to perceived loss, defeat, rejection, etc.
- ☞ Recent discharge from a psychiatric hospital
- ☞ Anger, rage, revenge-seeking or other aggressive behavior
- ☞ Isolation and withdrawal from usual activities, friends, interests, school or work
- ☞ Anhedonia – the inability to experience pleasure
- ☞ Anxiety or panic
- ☞ Agitation
- ☞ Insomnia
- ☞ Persistent nightmares
- ☞ Suspiciousness, paranoia, ideas of persecution
- ☞ Severe feelings of confusion or disorganization
- ☞ Command hallucinations, especially ones urging harm to self or others
- ☞ Intense affect states (desperation, intolerable aloneness, self-hate, etc.)
- ☞ Dramatic mood changes
- ☞ Hopelessness
- ☞ Poor problem solving
- ☞ Cognitive constriction (thinking in black and white terms and not able to see shades of gray)
- ☞ Rumination (continuously focusing on distress)
- ☞ Inability to see reasons for living
- ☞ Inability to imagine possible positive future events
- ☞ Feeling like a burden
- ☞ Recent diagnosis of chronic or terminal condition
- ☞ Feeling trapped, like there is no way out other than death
- ☞ Loss of purpose or loss of meaning
- ☞ Negative or mixed attitude toward receiving help
- ☞ Recklessness or excessive risk-taking behavior, especially any that is out of character
- ☞ Any real or perceived events causing shame, guilt, despair, humiliation, unacceptable loss of face or status, legal problems, financial problems, and feelings of rejection and abandonment

(Information adapted from the U.S. Centers for Disease Control and Prevention.)

Help IS available.



If you are having suicidal thoughts, the most important thing you can do is talk to someone you trust. If you have no one to talk to, call the National Suicide Prevention Lifeline at 1.800.273.TALK(8255).

Remember:

- ☞ Suicidal thinking is usually associated with problems that can be treated. Several tries at treatment are sometimes necessary before the right combination is found.
- ☞ If you are unable to think of solutions other than suicide, it is not that solutions don't exist, only that they are not apparent to you. Therapists and friends can often help you see possible solutions.
- ☞ Suicidal crises are almost always temporary. Although it might seem as if your unhappiness will never end, it is important to realize that crises are usually time-limited. Don't let suicide rob you of better times that will come your way.
- ☞ Problems are seldom as great as they appear at first glance. Stressful events can seem catastrophic at the time they are happening. Months or years later, they usually look smaller and more manageable.
- ☞ Reasons for living can help sustain a person in pain. You might be able to strengthen your connection with life when you remember what has gotten you through hard times in the past.

Information adapted from the American Association of Suicidology.

**Please reach out to someone.
Don't keep suicidal thoughts to yourself.**

For more information, contact:

Suicide Prevention Program

Division of Injury Prevention and Control

North Dakota Department of Health

600 E. Boulevard Ave., Dept. 301

Bismarck, N.D. 58505-0200

www.ndhealth.gov/suicideprevention

1.701.328.4580



NORTH DAKOTA
DEPARTMENT of HEALTH



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