

North Dakota Suicide Prevention Plan 2017-2020





North Dakota

Suicide Prevention Plan

2017-2020

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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 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 the best and promising practices for suicide prevention and the 2012 National Strategy for Suicide Prevention Goals and Objectives.

The state plan will be reviewed each biennium to ensure that it continues to serve the needs of North Dakotans, as well as reflect 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 2017 through 2020.

Unless otherwise noted, the data and graphs in this document are based on occurrent data, which takes into consideration the number of 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, individuals may not claim North Dakota residency because they are temporarily living in the state for school, work, 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 particular population or community is used as the numerator (unless otherwise noted). The denominator used is based on the census populations. This was done for consistency between the resident and occurrent trends, as well as using a verified census count rather than population estimates.

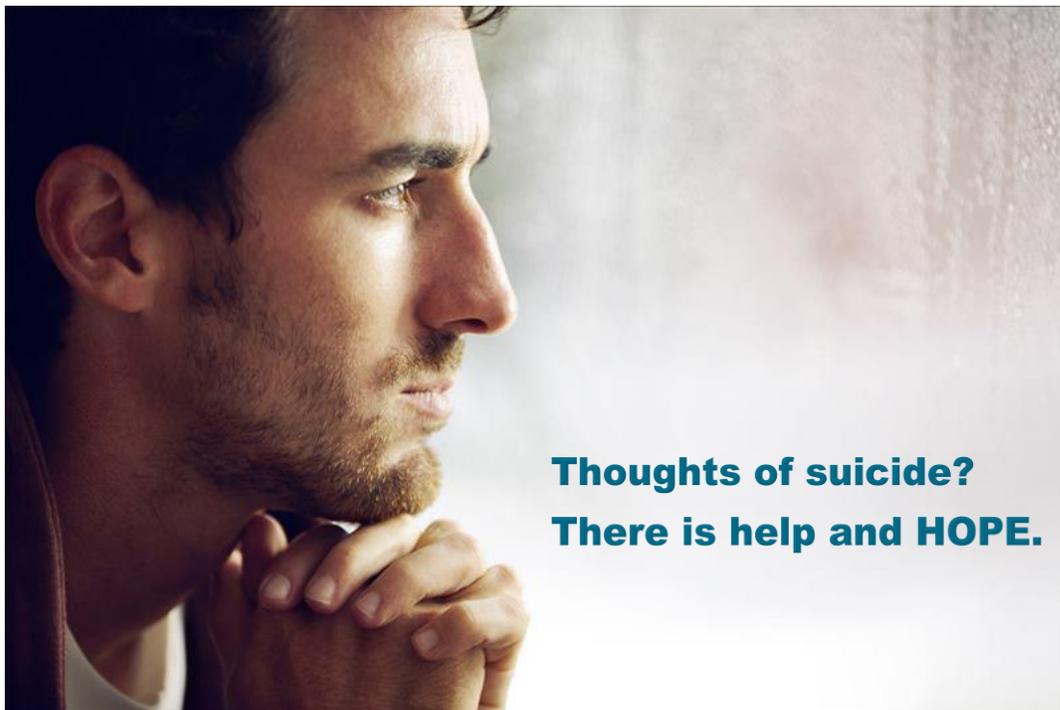


*Suicide is a preventable
public health issue in
North Dakota*



Burden of Suicide in the United States

Approximately 117 Americans die by suicide daily. A total of 42,773 suicides were documented in 2014, which translates to an average of one person dying by suicide every 12.3 minutes. This is the highest rate of suicide in the last 15 years. In 2014, suicide was the tenth leading cause of death overall and the third leading cause of death for those ages 15 to 24. The U.S. Centers for Disease Control and Prevention (CDC) estimates that one million people attempt suicide annually and two million experience suicidal thoughts each year. These statistics translate to one attempt every 34 seconds (American Association of Suicidology).



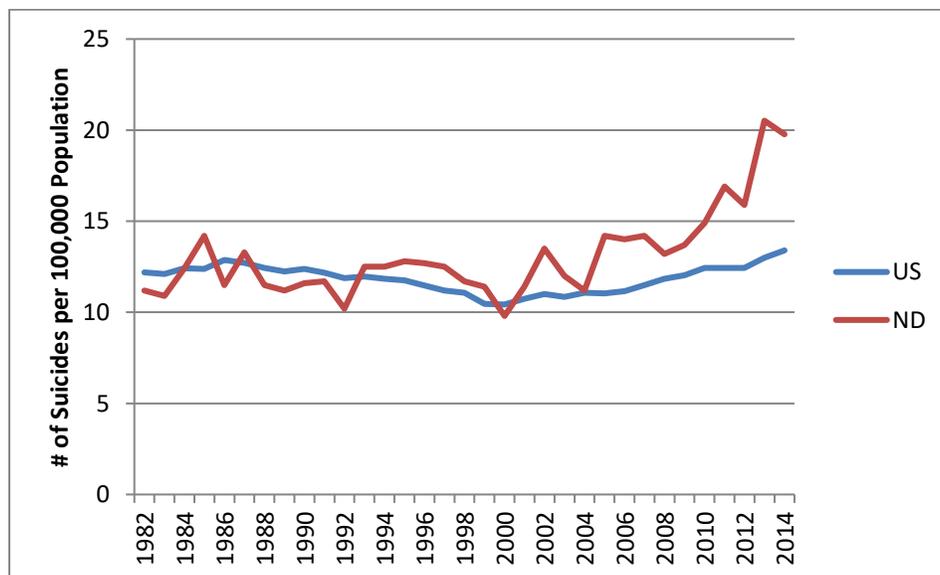
Burden of Suicide in North Dakota

In 2015, 117 North Dakota residents died by suicide. Suicide is 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 many more North Dakotans attempt suicide than die by suicide, North Dakota does not yet have a system to track how many North Dakotans receive medical treatment for injuries resulting from suicide attempts. The American Association of Suicidology estimates for every completed suicide, there are as many as 25 more people who attempt suicide but do not die (2008).

In 2015, 1,870 North Dakota residents called the National Suicide Prevention Lifeline requesting support for suicidal thoughts or actions (reported by North Dakota's crisis-line service provider, Firstlink Fargo).

The following graph compares the suicide rate (per 100,000 people) in the United States and North Dakota.



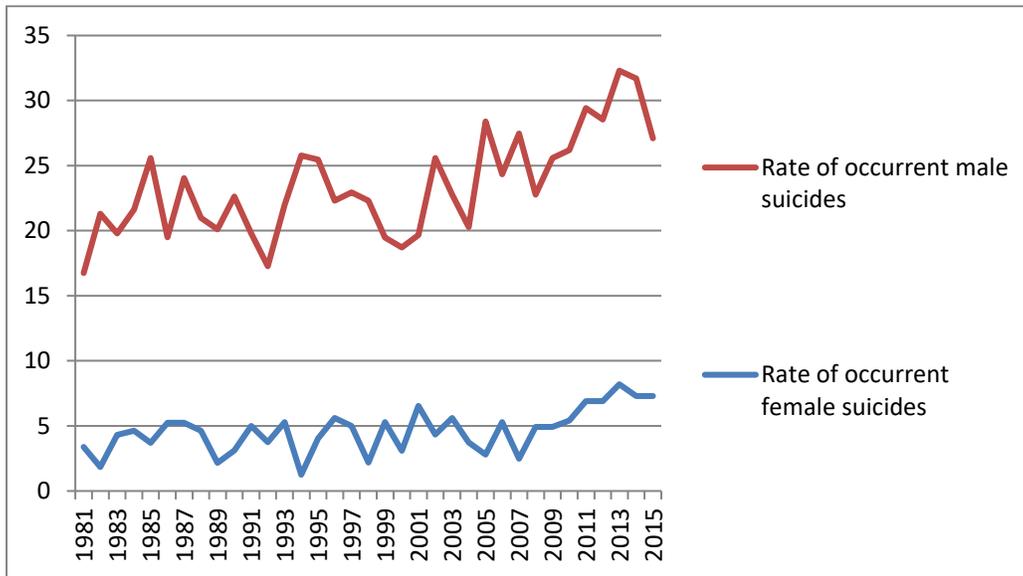
Suicide Rates per 100,000 in North Dakota and the U.S.A. from 1980-2014

Source: North Dakota Department of Health, Vital Records

Suicide has devastating consequences for not only family and relationships, but also society in general. CDC estimates that the average suicide costs the decedent's family and community \$1,164,499 (updated June 2015 based on 2010 figures). Based on this estimate, the 117 suicides that took place in North Dakota in 2015 cost \$136,246,380 due to combined medical and work loss costs.

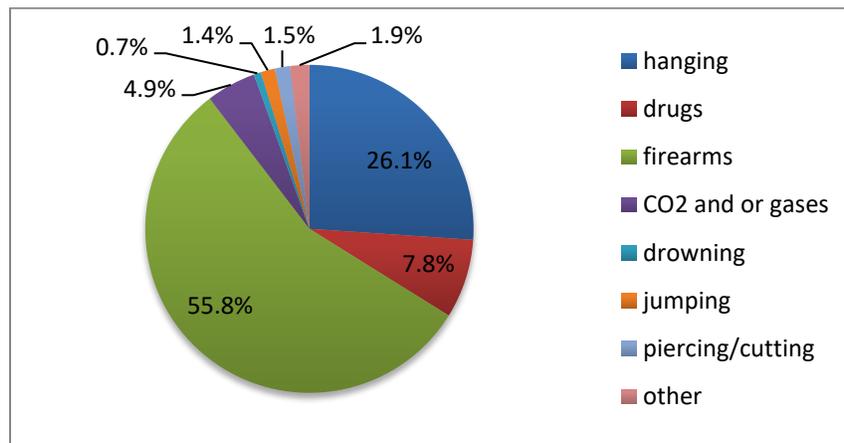


Males typically complete suicide four times more frequently than females. The graph below depicts the suicide rate of males and females in North Dakota from 1980 to 2015.



ND Suicide Rate for Men and Women as measured per 100,000 from 1980-2015
Source: North Dakota Department of Health, Vital Records

Firearms are the leading means of suicide in the U.S. and North Dakota. According to the Harvard C.H. Chan School of Public Health, access to firearms is a risk factor for suicides. While firearm owners are not more suicidal than non-owners, their suicide attempts are more likely to be fatal. Many suicide attempts are made with little planning during a short-term crisis period. If highly lethal means are made less available to impulsive attempters, and they substitute less lethal means or temporarily postpone their attempt, survival odds increase.



Lethal Means Used in North Dakota Suicide Deaths from 1980 to 2015
Source: North Dakota Department of Health, Vital Records

Suicide Survivors

There are two types of people referred to as suicide survivors:

1. People who attempt suicide and survive.
2. People who have lost a loved one to suicide.

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

In the U.S., it is estimated that 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 5 million survivors in the U.S.

In North Dakota, using the most conservative estimate (Berman, A.L.,2011), it is calculated that 702 North Dakotans became new suicide survivors in 2015, 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.

Some advice for survivors

- ☞ Feelings of shock, guilt, blame, anger, relief, depression and isolation are common. These feelings are often overwhelming, but 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.

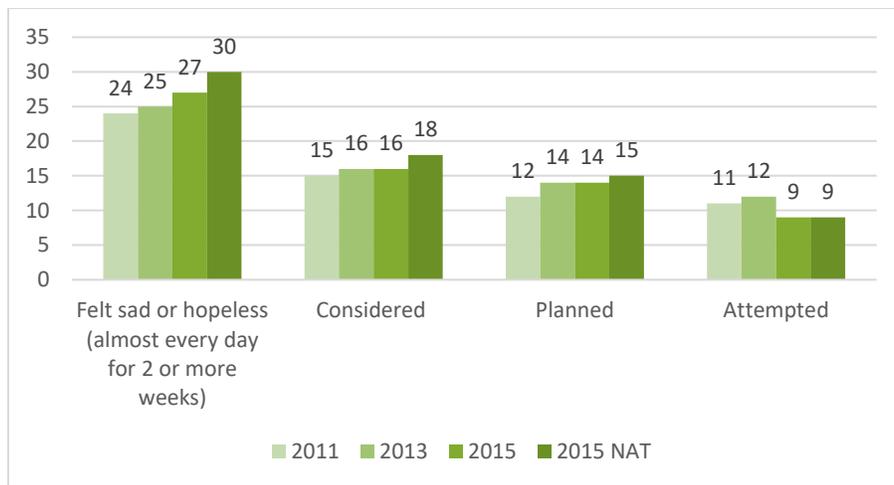


Suicide in Adolescents and Young Adults

Teenagers and young adults go through a period of development and self-identity that can also be a time of loneliness and confusion. According to CDC national vital records, 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 7 through 12.



Suicide-Related Behaviors (Grades 9-12)

Source: North Dakota Department of Public Instruction, YRBS 2011, 2013, 2015, and National 2015 data

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, specific risk factors occur in the adolescent and young adult population. These 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 35-64) is the prime of their lives. Those in middle adulthood can also face many stressful life events. This has contributed to a steadily increasing number of completed suicides in the U.S. and North Dakota over the past several years. In fact, they show the largest increases in any age group.

In 2011 (most recent national data), middle-aged adults accounted for the most significant proportion of suicides (56%), and from 1999-2010, the suicide rate among this group increased by almost 30% (CDC Suicide Facts at a Glance, 2015). In recent years, North Dakota has experienced a significant increase in suicide among Caucasian men in middle adulthood. This increase roughly reflects the population changes that began with what has been called North Dakota's oil boom. However, it is also important to note that suicide rates peak for women 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 often pose as escapes from depression or loneliness; however, these behaviors frequently magnify the feelings that the person is trying to avoid.
- ☞ Decreased social support resulting from divorce, job loss or empty nest syndrome may contribute to loneliness, depression and substance use.

*With help,
there is hope.*



Suicide in the Older Adult Population

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 may be more time to notice warning signs of suicide and intervene.

Risk factors for suicide in the older adult population 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 there are effective treatments for depression.
- ☞ 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 severe 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.

*Talk to someone, or
call the National
Suicide Prevention
Lifeline at
1.800.273.TALK (8255)*



Suicide Among Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and Others (LGBTQ+)

LGBTQ+ include individuals who have a sexual orientation (i.e., enduring a set of physical and emotional attractions) toward members of the same-sex (e.g., lesbian, gay, bisexual) and individuals with a gender identity (i.e., enduring internal sense of being a man, a woman, or neither) which is different than their sex assigned at birth (American Psychological Association, 2008). The term LGBTQ+ also encompasses identities which transcend traditional binary views of romantic attraction (e.g., asexual, polyamorous, pansexual, etc.) and gender (e.g., gender-queer, bigender, agender, etc.), and identities represented by the queer plus (i.e., Q+) portion of the acronym (Bornstein, 1998; Wilchins, 2002).

LGBTQ+ individuals account for an estimated four percent of the U.S. population and two percent of North Dakota's population (Gates, 2011). Despite medical and psychological research demonstrating the normalcy of these identities and expression (American Psychological Association et al., 2015; Swaab & Garcia-Falgueras, 2009), the LGBTQ+ community experiences higher rates of discrimination than the general public.

Rates of Suicide in the LGBTQ+ Population

The LGBTQ+ population experiences higher rates of suicide than most other populations. Existing empirical literature indicates that LGBTQ+ youth are 3.4 times more likely to attempt suicide than their non-LGBTQ+ peers. Transgender individuals are ten times more likely to attempt suicide than the general population (Clements-Nolle, Marx, & Katz, 2006; Grossman & D'augelli, 2006; Haas, Rodgers, & Herman, 2014). Homeless LGBTQ+ youth make up 40 percent of the homeless population. Sixty-two percent of members of LGBTQ+ adults report attempting suicide, while 29 percent of their straight peers report attempting suicide (Haas et al., 2010).



The 2013 National School Climate Survey issued by the Gay, Lesbian and Straight Education Network (GLSEN) found that most LGBTQ+ high school students had been 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.

Risk Factors for Suicide in the LGBTQ+ Population

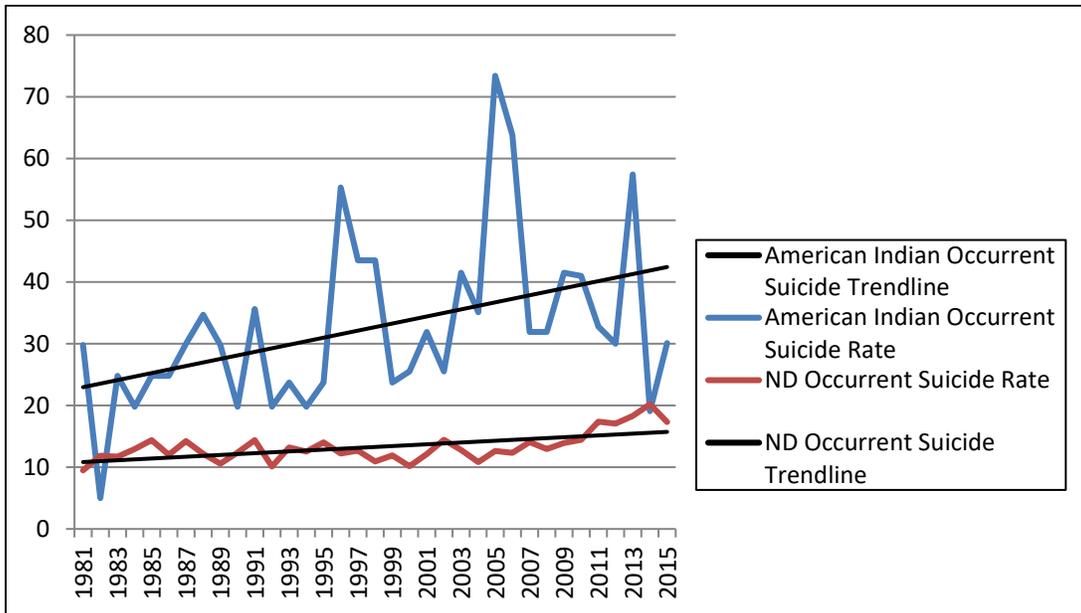
- ☞ **Harassment** is a major suicide risk factor for LGBTQ+ people. Nearly 8 out of 10 students have experienced harassment at school in the past year (Centers for Disease Control and Prevention), <http://www.cdc.gov/lgbthealth/youth.htm>). Sixty percent reported they felt unsafe while at school.
- ☞ **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 (Centers for Disease Control and Prevention, <http://www.cdc.gov/lgbthealth/youth.htm>). Lack of familial support has been established to be a significant factor in poor mental health, poor physical health, lower socio-economic status, poor academic performance, criminality and the current rate of LGBTQ+ youth homelessness (40% of the homeless population (Centers for Disease Control and Prevention, Office of Disease Prevention and Health Promotion, 2016).
- ☞ **Increased Risk for Mental Illness.** Due to lack of acceptance, LGBTQ+ individuals experience higher rates of mental illness and suicide than any other population (Goldstein, 2013), and are three times more likely to experience mental illness than the general population (National Alliance on Mental Illness, 2016).
- ☞ **Greater Likelihood of Victimization.** A larger proportion of LGBTQ+ individuals report physical assault (25-55%), sexual harassment (84%), parental abuse (34-46%), and bullying (49%) by both peers and teachers than the general population (Kosciw, Greytak, Palmer, & Boesen, 2014).
- ☞ **Lack of Access to Affirming Healthcare.** Current data indicate that existing healthcare providers are woefully unprepared to treat LGBTQ+ people (Shipherd, Green, & Abramovitz, 2010). As such, this population is less likely to seek mental health care services out of fear of being mistreated or emotionally abused by mental health professionals (Blumer, Green, Knowles, & Williams, 2012).
- ☞ **Substance Use and Abuse.** The LGBTQ+ population has higher rates of usage and abuse of controlled and illicit substances including alcohol (twice as likely), marijuana (three times as likely) and cocaine (eight times as likely) (Ward et al., 2014).
- ☞ **HIV/AIDS Status.** The LGBTQ+ population has a disproportionately high rate of HIV/AIDS. As a result, nearly half of transgender individuals who are HIV-positive are likely to make a suicide attempt (Haas et al., 2014). However, the rate of LGBTQ+ persons who are HIV-positive and make a suicide attempt is decreasing due to increased access to antiretroviral treatments (Haas et al., 2011).



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 serious mental health disorders which are related to suicide, such as anxiety, substance use and depression.

The graph below depicts the occurrence of the total suicide rate in North Dakota (per 100,000) compared to the American Indian suicide rate in North Dakota.



American Indian and All Other Populations in North Dakota From 1980-2015
North Dakota Department of Health, Vital Records

The American Indian suicide rate appears to fluctuate dramatically because the number of American Indian North Dakota residents is small compared to other populations. The blue line rises substantially with each suicide within the AI/AN community. The black trend lines are added to the graph to more accurately illustrate the larger suicide trends in both populations over the years.

Risk Factors for Suicide in the North Dakota American Indian Population

- ☞ Contagion is used to describe when multiple people within the same social or geographic community die by suicide within a short time frame. Proximity and relationship to suicide may put individuals at greater risk of suicide. American Indians may be at higher risk of suicide because AI/AN have much exposure to suicide.
- ☞ Discrimination is as important a predictor of suicide ideation as poor self-esteem or depression.
- ☞ Mental health services are difficult to access for many American Indians in North Dakota. Barriers to care include a lack of quality service providers and funding on reservations, personal transportation and payment barriers, as well as stigma.
- ☞ Stressful environments result from few economic resources or social supports for many American Indian families on and off reservations in North Dakota.
- ☞ Trauma from adverse or violent experiences increases suicide risk. American Indians are at higher risk of physical assault.
- ☞ Historical Trauma is the trauma resulting from past efforts to eliminate American Indian cultures throughout the United States with such means as the sending of children to boarding schools and prohibiting their language and cultural activities. The fallout from reported boarding school child abuse and other historical traumas contribute to suicide risk today.
- ☞ Family breakdown may result from historical trauma, economic struggles, discrimination, or family histories of substance use disorders.
- ☞ Alienation or feeling emotionally disconnected from his or her family of origin or culture may cause a loss of well-being or lead to depression. Alcohol and drug use is an ongoing risk factor. In 2005-2006, 37.1 percent of AI/AN in the U.S. who died from suicide and had tested positive for alcohol were legally intoxicated (Morbidity and Mortality Weekly Review. June 19, 2009; 58(23):637-4).
- ☞ Acculturation is the changing of a culture as it mixes with other cultures. In some national studies, AI/AN with greater acculturation reported increased psychosocial stress, less happiness and increased use of drugs to cope with stress.



Suicide in the Military

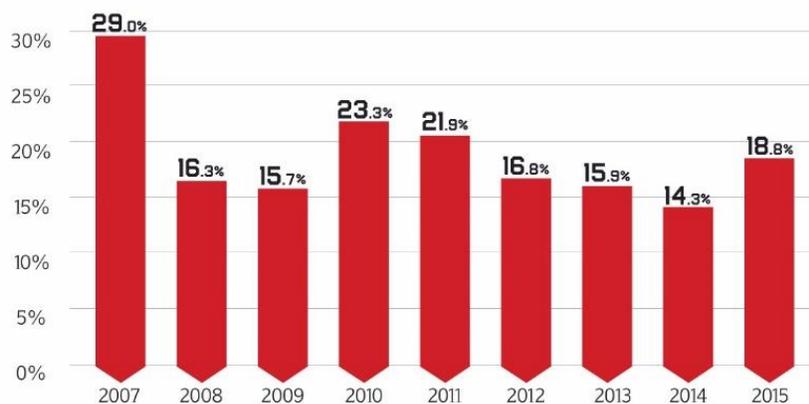
In the United States, veterans are at higher risk of suicide than those that have not served in the military. In 2014, 7,400 veterans died by suicide, making up 18 percent of all suicides in America that year, while Veterans only make up nine percent of the U.S. population. According to new data revealed by the Department of Veterans Affairs, roughly 20 veterans die by suicide every day nationwide. Veteran suicides increased 50 percent from 2001 to 2008 (The War Within: Preventing Suicide in the U.S. military, Rand Cooperation. 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 armed forces indicated that risk factors include: male, depression, substance abuse and relationship issues (James LC, Kowalski TJ) (Mil Med 1996; 161:97-101). More than of 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.; American Journal of Public Health. 2007; 97:12).

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.

ND INDIVIDUALS WHO LOST THEIR LIVES TO SUICIDE WHO WERE OF VETERAN STATUS



Percent of Total Annual Suicide Deaths That Were Veteran or Service Member Suicides
Source: North Dakota Department of Human Services, Behavioral Health Division in collaboration with ND Cares Coalition. Data 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 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 and the more recent epidemic of opioid use is believed to be a contributing factor in the increase in youth suicides, specifically among adolescent males.

According to the Youth Risk Behavior Survey (YRBS) that was conducted in 2013 in North Dakota, six 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, that is, within a couple of hours, in one or more of the past 30 days, which constitutes binge drinking.

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 complete suicide experience a mental or substance use disorder, or both (Center for Substance Abuse Treatment, 2008).

Violence, Trauma, Adverse Childhood Experiences and Suicide

Research shows that there is a relationship between violence and suicide among victims of domestic and sexual abuse, as well as other forms of violence. Like suicide, domestic violence is often stigmatized and hidden; the exact link between domestic violence and suicide is not known. Richard McKeon, Ph.D., chief of the suicide prevention branch at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), states that survivors of intimate partner violence are twice as likely to attempt suicide multiple times.

Adverse Childhood Experiences (ACEs), negative and traumatic childhood experiences such as child abuse have been linked to mental illness, substance use disorder and many other suicide risk factors and disorders in adulthood. It is, therefore, no surprise that ACEs are also linked to



suicide attempts. One study published by the Journal of Preventive Medicine (Felitti, VJ. et al. May 1998. Volume 14, Issue 4, Pages 245–258) found that persons who had experienced four or more ACEs had a 4- to 12-fold increase in health risks for alcoholism, drug abuse, depression and suicide attempts. The study concluded that there is a strong, graded relationship between exposure to abuse during childhood and multiple risk factors including suicide.

Underlying Principles of the North Dakota Suicide Prevention Plan

Suicide is Largely Preventable

Suicide is preventable and always has contributing factors. No single event causes suicide to occur. The majority of people who die by suicide show signs of suicidality long before they attempt suicide. Early identification of warning signs, effective intervention and 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, all North Dakotans can help prevent suicides. Suicide prevention requires vision, will and a commitment from the state, communities and individuals within North Dakota. While treatment must be provided by a qualified professional, everyone can learn to recognize suicide warning signs. People who are in contact with those at risk of suicide 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 for people to feel empowered to intervene when they perceive someone to be at risk for suicide.

Professionals can play an influential role in suicide prevention and education. Partners in behavioral health, education and other disciplines help identify clients or students at risk of suicide and offer effective intervention services. Professionals can also provide suicide prevention training to their communities to spread the word that suicide is preventable.

The Stigmas Associated With Suicide Should Be Eliminated

Social stigma continues to challenge suicide prevention efforts. Stigma and shame often plague those experiencing suicidal thoughts as well as those who have survived a suicide attempt or loss. Suicide risk factors like substance use, mental illness and depression also carry a social stigma. Stigma prevents many at risk of suicide from reaching out for help from professionals, friends or family. If we eliminate the stigma around suicide, more people will get help and more lives will be saved.



Highlights of Suicide Prevention Efforts from 2013-2016



The North Dakota Suicide Prevention Coalition (NDSPC) and the North Dakota Department of Health (NDDoH) Suicide Prevention Program have implemented many suicide prevention programs to help prevent suicides across North Dakota. Progress has been made through partnerships and collaborative efforts.

- ☞ NDDoH Suicide Prevention Program received state general funding to support over 30 regional and local community suicide prevention projects and a full-time suicide prevention director.
- ☞ NDSPC established infrastructure and regular meetings for the coalition.
- ☞ NDSPC and NDDoH expanded suicide prevention community partners.
- ☞ North Dakota passed legislation requiring all middle and high school educators to receive two hours of suicide prevention training annually and eight hours of behavioral health training every two years.
- ☞ American Foundation for Suicide Prevention, North Dakota Chapter (AFSP ND Chapter), Department of Public Instruction (DPI) and other NDSPC partner organizations created multiple documents, including evidence-based suicide prevention training fact sheets for use in professional settings such as schools, medical facilities and social service offices.
- ☞ NDDoH and NDSPC partners have provided evidence-based gatekeeper training, including Question, Persuade, Refer (QPR) for Suicide Prevention; More than Sad; Sources of Strength; and Applied Suicide Intervention Skills Training (ASIST) to communities statewide.
- ☞ NDDoH provided training opportunities to community members including medical professionals, social workers, teachers, journalists, law enforcement and emergency medical providers.
- ☞ FirstLink expanded the Follow-Up Program, a program to provide free follow-up phone service to those at risk of suicide to include phone calls and service to clinics and emergency rooms.
- ☞ AFSP ND Chapter and NDDoH and other coalition partners incorporated wellness and resiliency messages into training and programs to encourage help-seeking behavior.
- ☞ NDSPC and NDDoH provided statewide Public Service Announcements and print material for the highest risk groups of youth, working-age males, veterans and American Indians.
- ☞ Regional Education Associations (REAs) and DPI held Trauma Sensitive School training in schools across North Dakota.
- ☞ DPI, NDDoH and several REAs started the evidence-based comprehensive peer mentoring program, Sources of Strength, in over eleven districts across North Dakota.
- ☞ NDDoH provided a suicide prevention track at the 2016 Injury Prevention Conference.
- ☞ NDDoH provided grants to local organizations for suicide prevention activities.
- ☞ AFSP ND Chapter coordinated International Survivors of Suicide Day activities.
- ☞ AFSP ND Chapter coordinated statewide Out of the Darkness walks, expanding to several new communities.
- ☞ North Dakota Center for Persons with Disabilities (NDCPD) completed a Suicide Prevention Community Needs Assessment for the western, energy-impacted regions of North Dakota and made recommendations.
- ☞ NDDoH, AFSP, and other NDSPC organizations worked to increase data collection through partnerships with state agency data workgroups and local partners.



Goals and Strategies

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

Strategy I.A. Promote evidence-based programs.

Action Step A.1: The North Dakota Suicide Prevention Coalition (NDSPC) will update the interagency on-line suicide prevention training calendar and trainer list by January of 2017. The list will be maintained on an ongoing basis.

Action Step A.2: The NDSPC members responsible for suicide prevention training will enhance existing evidence-based programs such as: Applied Suicide Intervention Skills and Training Workshop (ASIST), More than Sad, Signs of Suicide (SOS), Sources of Strength and other programs listed on SAMHSA's Suicide Prevention Resource Center (SPRC) Evidence-Based Registry (EBR) on an ongoing basis.

Action Step A.3: The NDSPC and the North Dakota Department of Health (NDDoH) will support Regional Education Associations (REAs) and the American Foundation for Suicide Prevention North Dakota Chapter (AFSPND) to provide evidence-based training to area schools on an ongoing basis.

Outcome Measure I.A. By 2020, 75 percent of North Dakota middle and high schools will provide Substance Abuse and Mental Health Services Administration (SAMHSA) certified evidence-based suicide prevention training to educational staff. *(Estimated baseline is less than 50 percent.)*

Strategy I.B. Promote the National Suicide Lifeline and FirstLink's Follow-up Program throughout the state of North Dakota as community-wide suicide prevention resources.

Action Step B.1: The North Dakota Department of Health (NDDoH) will use media contracts to promote the National Suicide Lifeline and FirstLink's Follow-Up Program on an ongoing basis.

Action Step B.2: FirstLink will complete a one-page fact sheet for professionals about the National Suicide Lifeline and FirstLink's Follow-up Program for easy distribution in a wide array of settings (human service centers, medical facilities, schools, faith-based organizations, etc.) by February 2017.

Action Step B.3: FirstLink will guide the development of consistent media messaging for the National Suicide Lifeline and FirstLink's Follow-up Program by January 2018.

Action Step B.4: The NDSPC and suicide prevention partners will use multimedia and social media for promotion of the Suicide Lifeline and FirstLink's Follow-up Program.

Action Step B.5: FirstLink and NDSPC Health Liaisons will meet with health system administrators and medical professionals to increase the number of medical professionals screening for suicidal ideation and referring to FirstLink's Follow-Up Program by May 2018.

Outcome Measure I.B. By 2020, FirstLink will increase partnering healthcare settings by 30 percent. *(2017 baseline is 5 sites.)* Study results will show 80 percent of respondents received care which they perceived as beneficial as indicated via self-report in SAMHSA's Follow-Up Program Study report.



Strategy I.C. Develop strong stakeholder relationships and promote wellness activities in all communities across North Dakota.

Action Step C.1: The NDSPC members will utilize FirstLink’s database to present accurate local resource information to legislators and community leaders on wellness programs that assist in reducing barriers to help-seeking behaviors across all ages and populations by January 2017.

Action Step C.2: The NDSPC will maintain and expand partnerships with each Tribal Suicide Prevention coordinator and other stakeholders on an ongoing basis.

Action Step C.3: The NDSPC and partners will promote effective protective factors for suicide prevention such as resiliency, communication skills, mental wellness, connectedness and positive self-esteem to middle and high school students (i.e., Sources of Strength, Trauma-Sensitive Schools, Resiliency, Imagine Thriving and other preventive programs) on an ongoing basis.

Action Step C.4: The NDSPC will collaborate with North Dakota Department of Human Services Division of Behavioral Health to distribute educational materials created by Parents LEAD to providers and community partners by September 2017.

Action Step C.5: The NDSPC will research and promote preventive resources for North Dakota’s highest risk groups of adult males such as Mantherapy.org by January 2018.

Action Step C.6: The NDSPC will develop and distribute suicide prevention materials describing the association between bullying and suicide for all partners’ use by May 2018.

Action Step C.7: The NDSPC members will research and share information on policies, materials and programs shown to decrease suicide risk. NDSPC members will support prevention efforts in their communities and workplaces on an ongoing basis.

Outcome Measure I.C: By 2020, increase evidence-based upstream/primary suicide prevention programs like Sources of Strength from 10 schools to 60 schools. Qualitative and quantitative assessment results will show the impact on risk and protective factors amongst 30 percent of students attending schools where Sources of Strength will be implemented. *(2017 baseline is 10 schools.)*

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

Strategy II.A. Offer suicide prevention sessions at annual conferences across the state.

1. Behavioral Health Conference, 2018
2. Educational conferences, August 2019
3. Mental Health Summits (VA Affairs, United Tribes), September 2019

Outcome Measure II.A. By 2020, two partner conferences will include a full suicide prevention track for clinicians, public health professionals and/or other community members. (2017 baseline is zero.)

Strategy II.B. Research and implement effective training and program activities for the following higher risk populations:

1. Adolescents and Young Adults

Action Step 1.a: The NDSPC training members will continue to increase awareness that suicide is preventable through best practice training programs that teach adults how to identify warning signs of suicide and to make appropriate referrals.

Action Step 1.b: The NDSPC members will distribute suicide prevention materials such as American Foundation for Suicide Prevention's (AFSP) Model School Policy to education partners.

Action Step 1.c: The NDSPC school trainers will incorporate postvention resources, such as AFSP's After a Suicide: A Toolkit for Schools, within suicide prevention training.

Action Step 1.d: The NDSPC will collaborate with local advocacy groups to provide culturally competent programs and services for high-risk groups such as LGBTQ+ youth and culturally isolated youth by August 2017.

Action Step 1.e: The NDSPC members will communicate the importance of behavioral wellness and coping skills through education within their area schools on an ongoing basis.

Action Step 1.f: The NDSPC Health Liaisons will connect with the North Dakota University System, the North Dakota Board of Higher Education and each university to advocate for suicide prevention training in psychology 101. NDSPC members will connect with nursing, social work, medical, and teacher preparation departments at ND higher education institutions.

Action Step 1.g: The NDDoH will support ND colleges and universities in applying for federal grants to enhance psychosocial supports for college students such as mentoring programs and screening and referral projects by November 2019.

Outcome Measure II.B.1 (Adolescents and Young Adults). By 2020, YRBS results will show a two percent reduction among youth reporting a suicide attempt within the last twelve months. (2013 baseline is 12 percent.)

2. Middle Adulthood

Action Step 2.a: The NDDoH will determine how many primary healthcare systems use a suicide prevention screening tool for adult patients and make appropriate referrals by March 2017.

Action Step 2.b: FirstLink and NDSPC Health Liaisons will meet with healthcare administrators and clinics to increase screening, brief intervention and referral practices by November 2017.

Action Step 2.c: The NDDoH will work with Suicide Prevention Fund clinical grantees to be in compliance with the Suicide Prevention Depression Screening Grant Protocol as verified through the Ahlers reporting system and other electronic records by January 2018.



Action Step 2.d: The NDSPC Health Liaison will connect with peace officer training academies and institutions to embed suicide prevention training like QPR by January 2019.

Action Step 2.e: The NDSPC will identify local partners to advance suicide prevention education and campaigns on lethal means and bystander interventions amongst local partners by January 2018.

Action Step 2.f: The NDSPC and the NDDoH will connect with worksite wellness to explore programming options for behavioral health and suicide prevention such as depression and suicidal ideation screening and referral programs by November 2017.

Action Step 2.g: The NDDoH will continue support of the Family Planning clinics across North Dakota to administer depression and suicidal ideation screening. The NDDoH will partner with the University of North Dakota Master of Public Health program to assess project outcomes by January 2018.

Action Step 2.h: The NDSPC will connect with all medical system contacts, including obstetricians and gynecologists to advocate for a Zero Suicide Academy to train on depression and suicidal ideation screening, brief intervention, and referral by January 2018.

Action Step 2.i: The NDSPC, the NDDoH and the NDAFSP will hold a Zero Suicide Academy in collaboration with one healthcare system or organization by January 2019.

Action Step 2.j: The NDSPC members will promote Parents Lead materials to stakeholders and local partners. Website analytics will show an increase in Parents Lead materials by January 2019.

Action Step 2.k: The NDDoH will support the implementation of the Zero Suicide comprehensive model across all public health and medical settings by promoting on-going conference calls and mentoring between the Zero Suicide Academy trainers and healthcare administrations' implementation teams by March 2019.

Outcome Measure II.B.2 (Middle Adulthood). By 2020, incorporate Zero Suicide's comprehensive model within North Dakota's public health and/or healthcare systems. Increase universal screening, brief intervention, referral and follow-up practices by ten percent as evidenced by a 0.5 percent decrease in deaths by suicide among middle adulthood residents. *(2015 baseline rates per 100,000 – ages 25-34: 34.4; ages 35-44: 35.9; ages 45-54: 20.7.)*

3. Older Adults

Action Step 3.a: The NDSPC will disseminate suicide prevention education to non-traditional partners (e.g. realtors, lawyers, landlords) each quarter to encourage help-seeking behaviors beginning in September 2017.

Action Step 3.b: The NDSPC will research, compile, and develop suicide prevention resources of different forms (print, multimedia, face-to-face) for statewide distribution on an ongoing basis.

Action Step 3.c: The NDSPC, North Dakota Center for Persons with Disabilities (NDCPD), and the NDDoH will provide SafeTALK and other evidence-based suicide prevention training to community partners like the Long Term Care Association, county social service Quality Service Provider (QSP) training agencies, nursing homes, and other groups that support older adults by February 2018.

Action Step 3.d: The NDDoH will support suicide prevention training for clergy members and will develop a list and functional referral system to connect certified chaplains to rural residents in crisis by January 2018.

Outcome Measure II.B.3 (Older Adults). By 2020, increase universal screening practices in primary care settings, brief intervention, referral, and follow-up practices by 10 percent. Decrease deaths by suicide among adults ages 55 and older by five percent. *(2015 baseline rates per 100,000 – ages 55-65: 15.9; ages 65+: 12.3.)*



4. LGBTQ+

Action Step 4.a: Dakota OutRight, a North Dakota LGBTQ+ Service Advocacy organization, will appoint a liaison to participate in NDSPC meetings, planning and other activities by January 2017 and on an ongoing basis.

Action Step 4.b: Dakota Outright will perform a cultural competency audit of all NDSPC and NDDoH Suicide Prevention materials by September 2017.

Action Step 4.c: The NDSPC will work with an LGBTQ+ Liaison to create culturally competent LGBTQ+ materials by March 2018.

Action Step 4.d: The NDSPC and the NDDoH will coordinate and support a three-tiered competency training for crisis workers as well as to emergency response professionals providing suicide prevention interventions state-wide. The first tier will be completed by September 2017.

Action Step 4.e: The NDSPC will support the inclusion of culturally competent questions regarding gender identity and sexual orientation within surveys and other study models to inform North Dakota's future targeted LGBTQ+ prevention interventions.

Outcome Measure II.B.4 (LGBTQ+). By 2020, 75 percent of crisis workers providing telephone suicide crisis counseling will complete a cultural sensitivity training which meets the standards of North Dakota's LGBTQ+ Service Advocacy organization, Dakota OutRight. One hundred percent of all NDSPC materials will be culturally sensitive as determined by Dakota OutRight. *(2017 baseline is zero.)*

5. American Indians

Action Step 5.a: The NDSPC Board will initiate communication with each tribal designee by February 2017 and on a quarterly basis after that to identify new tribal stakeholders as well as to assess changing needs.

Action Step 5.b: The NDSPC Health Liaison will update the NDSPC list serve to include new tribal participant information by March 2017 and on an ongoing basis.

Action Step 5.c: Tribal NDSPC members will inform efforts to make suicide prevention materials available in a wide-variety of settings (print, multimedia, face-to-face) using culturally competent pictures and language.

Action Step 5.d: The NDSPC members will provide evidence-based suicide prevention programs and training within Bureau of Indian Education (BIE) schools. Training like Sources of Strength, SafeTALK or other gatekeeper training will be provided to each BIE school district on an annual basis.

Action Step 5.e: The NDSPC will continuously support efforts by the North Dakota Indian Affairs Commission to increase employment and service opportunities for American Indians on reservations and across North Dakota.

Outcome Measure II.B.5 (American Indian Communities). By 2020, 60 percent of educators working on tribal lands in North Dakota will have training in evidence-based suicide prevention practices. *(Estimated baseline is less than 50 percent.)*



6. Service Members, Veterans, Family Members, and Survivors

Action Step 6.a: The North Dakota National Guard will continue suicide prevention training throughout North Dakota Communities.

Action Step 6.b: The North Dakota National Guard will continue to participate in community sponsored suicide prevention events.

Action Step 6.c: The NDSPC will work in collaboration with the National Guard and North Dakota Cares coalition to ensure suicide prevention messaging is culturally competent for service members, veterans, family members, and survivors.

Action Step 6.d: The NDSPC and the National Guard will develop a listing of suicide prevention training, facilitated by the North Dakota National Guard, and disseminate to statewide partners by January 2018.

Action Step 6.e: The Department of Human Services in collaboration with North Dakota Cares Coalition will develop and implement a statewide Star Behavioral Health Program (SBHP), a tier-based continuing education program that develops cultural competency for behavioral health professionals by January 2018.

Outcome Measure II.B.6 (Service Members, Veterans, Family Members, and Survivors): By 2020, the number of North Dakota Army National Guard Service Members trained in Applied Suicide Intervention Skills and Training (ASIST) will increase by 50 percent. *(2017 baseline is being established.)*

Strategy II.C: Support the integration of suicide prevention strategies within behavioral health professional settings.

Action Step C.1: The NDDoH will continue competitive funding opportunities for all health based systems, focusing on suicide risk factor screening, best practice brief intervention, referral and follow-up service projects.

Action Step C.2: The NDSPC, the AFSP and other key partners will disseminate suicide prevention education through various professional communications throughout the state by January 2018.

Action Step C.3: The NDSPC will support parish, nurse and clergy community with suicide prevention education as it relates to behavioral health intervention.

Action Step C.4: The NDSPC and the NDDoH will meet with university administration, licensure boards and educators to promote curriculum expansion in medical and helping professions that include suicide prevention strategies.

Outcome Measure II.C: By 2020, increase the number of higher education school programs with a suicide prevention theory and practice requirement within the North Dakota University System by 25 percent. *(2017 baseline is two.)*



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. 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 carefully 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.)

- ⊕ 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.)



If You Are Thinking About Suicide

If you are experiencing thoughts of suicide, know that you are not alone. As many as one in six people will think about suicide at some point in their lives.

Please know that there is help available

The most important thing you can do is talk to someone you trust. If there is no one you feel you can talk to, call the National Suicide Prevention Lifeline at **1.800.273.8255** or **1.800.273.TALK**.

Please 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.)

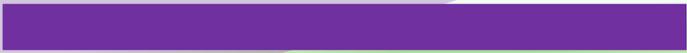


*Please, reach out to someone.
Don't keep suicidal thoughts
to yourself.*



REMEMBER,





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

