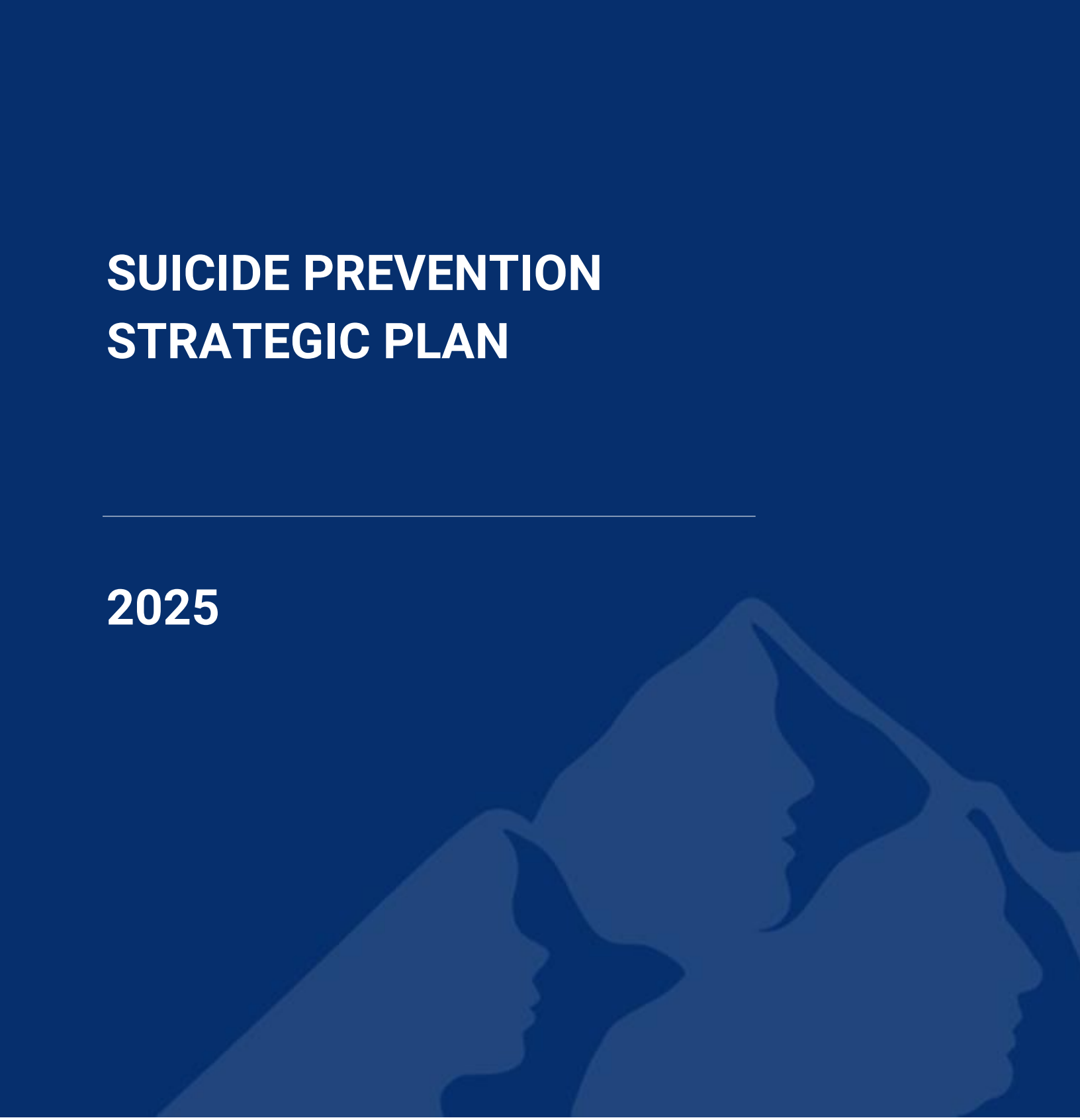
SUICIDE PREVENTION STRATEGIC PLAN

2025



DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Table of Contents

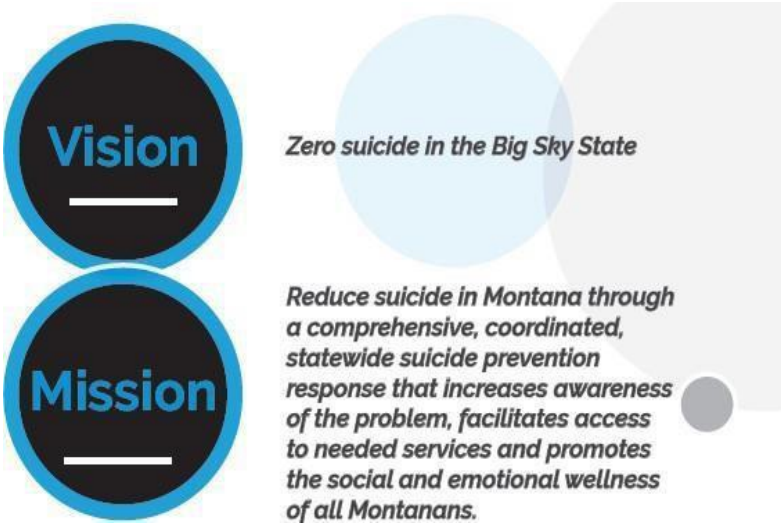
OVERVIEW

The following goals, objectives, and strategies are designed to support a multifaceted, coordinated approach to reducing suicide in our state. The 2025 updated plan will continue to track progress on the strategic activities of each of the five goals. This plan is updated bi-annually.

As part of a continued effort to build a strong suicide prevention infrastructure, the Department of Public Health and Human Services (DPHHS) also participates in statewide meetings with key stakeholders and partners on a yearly basis.

ALIGNMENT WITH DPHHS STRATEGIC GOALS

The following plan outlines key strategies to reduce the suicide rate in Montana and aligns with DPHHS's 2019- 2024 strategic plan to improve and protect the health, well-being, and self-reliance of all Montanans. The Suicide Prevention Strategic Plan correlates directly to DPHHS's goals to promote health equity and improve population health; strengthen the economic and social well-being of Montanans across the lifespan; ensure all children and youth achieve their highest potential; effectively engage stakeholders; and ensure core business services are efficient, innovative, and transparent. The following plan aligns with the 2024 National Strategy for Suicide Prevention (U.S. Department of Health and Human Services (HHS), National Strategy for Suicide Prevention. Washington, DC: HHS, April 2024).



GOALS, OBJECTIVES, AND STRATEGIES

GOAL 1

Implement a suicide prevention program led by the suicide prevention office based upon the best available evidence.

Objective 1.1
Dedicate core staff positions to carry out essential functions of DPHHS's suicide prevention efforts.

Strategies

1.1.1 Sustain statutory suicide prevention coordinator and suicide prevention manager for the DPHHS Suicide Prevention Program.

1.1.2 Support and partner with the Director of American Indian Health to provide resources to tribal nations that reflect a cultural understanding.

Objective 1.2
Implement bi-annual suicide prevention action plan.

Strategies

1.2.1 The DPHHS suicide prevention office will continue to implement and update the state strategic suicide prevention action plan at a minimum of every two years, as required by statute.

1.2.2 A statewide stakeholder group will be updated on the progress of the Montana Suicide Prevention Strategic plan at the yearly stakeholder meeting. The DPHHS suicide prevention office will provide regular updates and consultation as needed to internal DPHHS staff.

Objective 1.3
Coordinate and integrate DPHHS's suicide prevention activities through the Suicide Prevention Program, encouraging cross-department collaboration and integration of programs across funding sources within state government.

Strategies

1.3.1 Improve communication and coordination across non-profit organizations and state branches, divisions, and programs to better collaborate on suicide prevention efforts through annual stakeholder meetings initiated by the

suicide prevention coordinator to provide for coordination of all suicide prevention efforts.

1.3.2 Policy and educational documents (i.e. website, postvention plan, state plan etc.) will be shared across these branches, divisions, and programs.

1.3.3 Continue to improve communication and coordination for crisis services through the 988 stakeholders' coalition.

1.3.4 Continue to improve communication and coordination for service members, veterans and their families through the Governor's Challenge stakeholder coalition.

Objective 1.4

Provide recommendations for changed or amended policies to DPHHS-based or published data, best practices, and state-specific data analysis.

Strategies

1.4.1 Maintain a link between the DPHHS suicide prevention coordinator and national experts in the field of suicidology to ensure a comprehensive approach to evidence-based practices and metrics. This will be achieved through consultation with the National Council for Mental Well Being, the American Foundation for Suicide Prevention, the American Association of Suicidology, the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Veteran's Administration's data experts, and other regional and federal centers.

GOAL 2

Develop a comprehensive communication plan.

Objective 2.1

Research effective suicide prevention messaging and explore resources to create and disseminate public awareness messaging.

Strategies

2.1.1 Identify key internal and external stakeholder groups and a plan for outreach with targeted messaging strategies, including the 988 Stakeholder's Coalition and Governor's Challenge Coalition.

2.1.2 Promotion of 988 and suicide awareness in aging adult programs with emphasis on 211 to address social determinants specific to aging adults and other high-risk populations.
2.1.3 Explore use of existing public-facing platforms, including social media, to disseminate suicide prevention messaging and resources.
2.1.4 Continue to expand the current Montana 988 project communication effort to additional partners, including veterans' organizations, colleges, high schools, disability services, and aging services.
2.1.5 Continue to expand the current public information campaign for 988 for American Indian/Alaska Native (AI/AN) communities to additional tribal communities and urban Indian health centers.

Objective 2.2
Direct resources towards identifying and implementing evidence-based strategies to reduce access to lethal means through messaging for target groups.

Strategies
2.2.1 Work with substance abuse prevention experts to continue to promote safe storage and disposal of prescription medications.
2.2.2 Disseminate best practices from local county "Safer Communities Montana" and peer-established safe storage programs (i.e. Safe Place in Deer Lodge). Support initiatives around safe firearm storage and pharmaceutical disposal program through statewide media campaigns and trainings.
2.2.3 Continue to partner with subject matter experts and community stakeholders, such as the Veterans' Affairs (VA) and the Indian Health Service (IHS), to hold focus groups and study how to message best practice strategies, including reducing access to lethal means for high-risk individuals experiencing acute suicidality and/or mental health crisis.

GOAL 3

Identify and use available resources needed to guide state, tribal, county, and local efforts, including crisis response efforts.

Objective 3.1
Oversee an overall suicide prevention training plan for prevention and intervention training within communities.

Strategies

3.1.1 Monitor the updated online toolkit resource with self-guided online educational resources for providers, residents, and different target populations.

3.1.2 Deliver a coordinated state-provided train-the-trainer program.

3.1.3 Maintain a database of trainers who have been trained in Question, Persuade, Refer (QPR) or suicide safe care for health care settings to use in spreading these trainings statewide.

3.1.4 Support Montana's university system in embedding suicide safe care training and principles into all curriculums for physical and behavioral health providers with internal capacity within the faculty to continue training.

3.1.5 Engage health care providers in planning for and delivering targeted training for suicide safe care. Specific high-risk populations include AI/AN, pediatrics, people with physical disabilities, and geriatrics.

3.1.6 Increase military cultural competency in primary care providers and identification of veterans seeking health care through continued participation in the Governor's Challenge to Prevent Veteran Suicide.

Objective 3.2

Strengthen the crisis response system infrastructure in Montana through active partnerships with providers, funders, and community stakeholders.

Strategies

3.2.1 Maintain and strengthen the suicide crisis response infrastructure in Montana through support of the three-suicide prevention/mental health crisis lifeline centers (988).

3.2.2 Coordinate with other Behavioral Health and Developmental Disabilities Division (BHDD) sections to enable an "Air Traffic Control" level of crisis management based on the "Crisis Now" model developed by the National Action Alliance for Suicide Prevention (NAASP) and the National Association of State Mental Health Program Directors (NASMHPD).

3.2.3 Support the use of Mental Health First Aid, Crisis Intervention Training, and other evidence-supported crisis interventions for law enforcement, first responders, and hospital emergency room staff.

3.2.4 Engage AI/AN representation in planning for crisis response system supports, including 988, for both urban and reservation-based Indian health centers.

3.2.5 Partner with community crisis service providers (Mobile Crisis Teams (MCTs), 911 Public Safety Answering Points (PSAPs), crisis stabilization facilities) to

encourage the development of integrated crisis behavioral health care systems.

GOAL 4

Build a multifaceted, lifespan approach to suicide prevention.

Objective 4.1
Support efforts to ensure a systematic approach to provide suicide safe care by partnering with health care and behavioral health programs.

Strategies

4.1.1 Partner with organizations and initiatives that encourage the development of integrated behavioral health care models across Montana, creating "no wrong door" access to individuals with behavioral health concerns, including IHS and tribal health providers, pediatrics, and aging adults.

4.1.2 Support the use of universal depression and anxiety screening, substance use disorder (SUD) screening, suicide risk assessment, safety planning, lethal means counseling and follow-up contact within the health care community, including pediatrics, people with physical disabilities, and aging adults.

4.1.3 Support the use of suicide safe care with school counselors, first responders, behavioral health providers, and human resource personnel.

4.1.4 Support the use of universal depression and anxiety screening, SUD screening, suicide risk assessment, safety planning, lethal means counseling, and follow-up contact within urban Indian health centers and tribal health departments.

Objective 4.2
Develop a network of trainers to ensure a systematic approach to provide suicide safe care to health care and behavioral health programs.

Strategies

4.2.1 Provide suicide safe care training to health professionals through a network of trainers that has been developed and track the number of trainings completed.

Objective 4.3
Develop and support suicide prevention programs to address suicide prevention with at-risk groups in Montana.

Strategies

4.3.1 Develop and support suicide prevention programs for AI through the development of a local advisory council on each reservation and in each urban Indian health center. Theses local councils will provide representation to a state-level advisory council that will provide guidance to DPHHS on suicide prevention policies and practices for tribal groups.

4.3.2 Promote the use of the PAX Good Behavior Game in all elementary schools through school-based trainings and referrals to the University of Montana Health Center for Children, Families, and Workforce Development

4.3.3 Promote the use of QPR, Youth Aware of Mental Illness (YAM), and Signs of Suicide (SOS) in secondary education through school-based trainings.

4.3.4 Through the Governor's Challenge, develop and support suicide prevention programs for Service Members, Veterans Suicide Intervention Officer (SIO)., and Military Families (WMVF) by partnering with veteran services organizations, Montana National Guard and Reserve, and the Department of Veterans' Affairs (VA).

4.3.5 Collaborate with the Department of Labor to train employees in suicide awareness through "SAFETYFEST" conferences, providing resources to human resource directors, and training for companies and corporations.

4.3.6 Develop and support suicide prevention programs for LGBTQ through the development of culturally-responsive publicity materials through the Montana 988 project and promotion of the Trevor Project.

4.3.7 Increase gatekeeper trainings with a focus on aging adults for first responders, senior care givers, senior centers, and faith-based leaders to include utilizing the Columbia Suicide Severity Rating Scale.

Objective 4.4

Establish policies, model practices, and develop resources in preparation for post-suicide response (postvention), including in the event of a suicide cluster.

Strategies

4.4.1 Promote the online suicide postvention toolkit for communities across Montana through meeting with key stakeholder groups and community trainings.

4.4.2 Review existing crisis response infrastructure and models in communities to leverage and develop response teams for postvention (e.g., school crisis

response model, Fetal, Infant, Child, Maternal Morbidity Review (FICMMR) teams, and regional emergency preparedness programs).

4.4.3 Promote the 988 tribal call centers as the hub of prevention and postvention efforts in Indian country using example models that have emerged in tribal communities.

4.4.4 Coordinate with Montana National Guard and Reserve headquarters, veteran service organizations, the VA, and other agencies and peer networks aimed at reducing veteran and service member suicide to ensure that their suicide prevention standard operating procedures include postvention plans of action.

4.4.5 Through collaboration with the Office of Public Instruction (OPI) and community trainings, promote the use of the Montana Crisis Action School Toolkit on Suicide (CAST-S) in all Montana schools to reduce the risk of suicide contagion.

Objective 4.5

Maintain a statewide suicide prevention task force and receive feedback on actions taken to date and on improvements to the state strategic suicide prevention plan.

Strategies

4.5.1 Convene task force annually to review progress and receive feedback on action plan and assess strategic plan.

GOAL 5

Support high-quality, privacy-protected suicide morbidity and mortality data collection and analysis.

Objective 5.1

Increase the use of data to understand the problem of suicide and effectively target interventions.

Strategies

5.1.1 Improve surveillance of suicide mortality data and suicide risk factors through the National Violent Death Reporting System (MT-VDRS) with funding from the Centers for Disease Control and Prevention (CDC).

5.1.2 Encourage the use of MT-VDRS training opportunities for coroners to increase the review of psychological factors in deaths ruled as suicide.

5.1.3 Analyze existing population-level data to ascertain specific risk factors for suicide to better target evidence-based practices for suicide prevention.

Objective 5.2
Establish a system for using and communicating data.

Strategies

5.2.1 DPHHS Office of Epidemiology and Scientific Support (OESS) will compile an annual data report on suicide morbidity and mortality in Montana based on data sets available from MT-VDRS and identify recommendations.

5.2.2 DPHHS will provide suicide-specific grief resources to next of kin identified on all death certificates ruled a suicide.

MONTANA SUICIDES BY THOSE WHO SERVED IN THE ARMED FORCES

The following information concerning Montanans who died by suicide and served in the armed forces is provided as required by HB 549, which was passed by the 2023 Montana Legislature.

NATIONAL DATA CONCERNING VETERAN SUICIDES

Source: the U.S. Department of Veterans Affairs' 2023 Veteran Suicide Prevention Annual Report

Key Findings

- In 2021, suicide was the 13th-leading cause of death for veterans overall, and the second-leading cause of death among veterans under age 45.
- There were 6,392 veteran suicide deaths in 2021. This was 114 more than in 2020.
- In 2021, there were 6,042 suicide deaths among veteran men and 350 suicide deaths among veteran women.
- The unadjusted rate of suicide in 2021 among U.S. veterans was 33.9 per 100,000, up from 32.6 per 100,000 in 2020.
- In 2021, unadjusted suicide rates were highest among veterans between ages 18 and 34, followed by those aged 35 to 54.
- In 2021, the unadjusted suicide rate was 46.3 per 100,000 for AI/AN veterans;

36.3 per 100,000 for white veterans; 31.6 per 100,000 for Asian, Native Hawaiian or Pacific Islander veterans; 17.4 per 100,000 for black or African American veterans; and 6.7 per 100,000 for veterans of multiple races.

- Among U.S. adults who died from suicide in 2021, firearms were more commonly involved among veteran deaths (72.2%) than among non-veteran deaths (52.2%).
- Within the overall unadjusted suicide rate for veterans in 2021 (33.9 per 100,000), its largest component was firearm suicide mortality (24.5 per 100,000), followed by suffocation suicide mortality (5 per 100,000), poisoning suicide mortality (2.7 per 100,000) and suicide involving other methods (1.8 per 100,000).

2023 NATIONAL VETERAN SUICIDE PREVENTION CALL TO ACTION: 7 THEMES

Source: the U.S. Department of Veterans Affairs' 2023 Veteran Suicide Prevention Annual Report

1. **Promote secure firearm storage for veteran suicide prevention**. Firearm ownership and storage practices vary among veterans. One in three veteran firearm owners store at least one firearm unlocked and loaded. This unsafe storage practice is more frequent among veteran firearm owners who seek Veterans Health Administration (VHA) care (38%) than among other veterans who own firearms (31.9%). As seen across years of veteran suicide data, veteran suicide deaths disproportionately involve firearms; veteran suicide rates exceed those of non-veterans; and differentials in suicide rates by veteran status are greater for women than for men.

   Promoting secure storage of firearms has been found to reduce suicide. This is not about taking away firearms, but about promoting time and space during a time of crisis.

2. **Implement and sustain community collaborations focused upon community-specific veteran suicide prevention plans**. Over 60% of veterans who died by suicide in 2021 were not seen in VHA in 2020 or 2021, and over 50% had received neither VHA nor VBA services. In order to reach all veterans, we must continue to expand our work in the

community through the SP 2.0 Community Based Intervention (CBI) Program. This includes the joint VA and SAMHSA Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families, which encompasses all 50 states, 5 territories, and work in over 1,700 local community coalitions. This also includes the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) awarding $52.5 million to 80 community-based organizations in 43 states, the District of Columbia, and American Samoa in fiscal year (FY) 2023.

3. **Continue expansion of readily accessible crisis intervention services**. The nation saw a reduction of access to mental health services initially during the COVID-19 pandemic. Veterans desired access that was not in-person and available whenever they needed it, and VHA care rapidly expanded remote care services delivery. Continued expansion of access to 24/7/365 services through the Veterans Crisis Line (VCL) 988 expansion and through COMPACT Act implementation paved the way for more emergency services for veterans in acute suicidal crisis to be provided at no cost, whether enrolled in VA or not.

4. **Improve tailoring of prevention and intervention services to the needs, issues, and resources unique to veteran subpopulations**. Creating culturally sensitive and responsive interventions to meet each population's needs will be required to address what 2021 data revealed to us, including growing suicide rates in AI/AN veteran populations, younger veterans, transitioning service member populations, women veterans, and more. A one-size-fits-all veteran suicide prevention strategy will not be effective in meeting the needs of the diverse population of veterans.

5. **Advance suicide prevention meaningfully into non-clinical support and intervention services, including financial, occupational, legal, and social domains**. Suicide risk factors include issues outside of mental health and require meaningful upstream interventions across the nation, as denoted in the White House Strategy Reducing Military and Veteran Suicide (2021). Impacts related to homelessness and legal issues were seen for veterans in 2021, as outlined above. A whole-of-nation approach for upstream interventions in employment, housing, legal support, and financial strain is needed to address veteran suicide prevention.

6. **Increase access to and utilization of mental health services across a full continuum of care.** The COVID-19 pandemic saw increased distress in the veteran population with initial decreases in utilization of mental health services, while tele-mental health services expanded. During the pandemic, weekly patient encounters at VHA decreased by 3% for ongoing suicide attempt care, while new treatment initiation for suicide attempts decreased 30%. Making access to a continuum of evidence-based mental health treatments as easy as possible is an important part of the public health approach to suicide prevention.

7. **Integrate suicide prevention within medical settings to reach all veterans.** Data showed that a significant percentage of VHA veterans who died by suicide did not have a VHA mental health or substance use disorder diagnosis. There is a need to creatively address the needs of those at risk who may never seek mental health services and who may have other risk factors outside of mental health (e.g., pain, cancer, sleep disturbance) through expansion of suicide screening, assessment, and safety planning into all medical settings within VHA and within community care.

MONTANA DATA FOR SUICIDES BY THOSE WHO SERVED IN THE ARMED FORCES, 2022-2023

Source: Montana DPHHS OESS, March 2024.

Between 2022 and 2023, Montana saw a reduction in suicides by those who serviced in the Armed Forces between. The number of suicides dropped from 74 in 2022 to 49 in 2023, **a 34% decrease**.

Over the two-year period, 96% of the suicides were by males. Ninety-six percent of the of the suicides were identified as white. The highest age range varied over the two-year period. Veterans ages 70–79 accounted for 24% of the suicides in 2022. In 2023, the highest age range was among veterans ages 50-59 at 18%. For the two-year period, 81% of the suicides were by firearm.

2022 MONTANA SUICIDES BY THOSE WHO SERVED IN THE ARMED

N=74

GENDER		
FEMALE	3	
MALE	71	96%

AGE RANGE	
18-29	10
30-39	10
40-49	5
50-59	9
60-69	11
70-79	18
80-89	7
90+	4

24%	HISPANIC	1

RACE		
WHITE	69	93%
AMER. INDIAN	3	
BLACK	1	

MEANS		
FIREARM	61	82%
HANGING	5	
SHARP OBJECT	4	
SELF-POISONING	2	
JUMP	2	

2023 MONTANA SUICIDES BY THOSE WHO SERVED IN THE ARMED

N=49

GENDER		
FEMALE	2	
MALE	47	96%

AGE RANGE	
18-29	3
30-39	8
40-49	8
50-59	9
60-69	7
70-79	7
80-89	5
90+	2

18%	HISPANIC	1

RACE		
WHITE	48	98%
AMER. INDIAN	0	
BLACK	0	

MEANS		
FIREARM	39	80%
HANGING	5	
SHARP OBJECT	0	
SELF-POISONING	5	
JUMP	0	

RISK AND PROTECTIVE FACTORS:

Risk Factors:

- Prolonged family separation during deployments.
- A “suck-it-up” culture with regards to mental illness. Although progress has been made, the perception remains that seeking treatment will jeopardize your career.
- A high-stress, zero-defect culture where a failure to meet standards results in significant pressure and harassment by peers and leaders.
- Non-judicial punishment under the Uniform Code of Military Justice, which often results in immediate reduction in rank and forfeiture of pay, causing extreme financial stress.
- An acquired and highly-developed capacity for the use of firearms as a lethal means.

- Significant stress upon retirement or voluntary/involuntary separation from the service. Unlike many other careers, military service provides a well-defined and high-status identity. Losing it can be extremely traumatic.
- Female combat veterans are at much higher risk of suicide where a firearm is the lethal means due to much greater acquired capacity than their civilian counterpart.
- Military spouses are a greater risk due to social isolation during deployments and abrupt shifts in professional and parenting responsibilities.
- Military children are a greater risk due to the prolonged absence of one of their parents during deployments and frequent changes in schools and social groups.

Protective Factors:

- Unit cohesion: Soldiers who feel like an integral part of their team are less likely to suffer from perceived burdensomeness and social isolation.
- Command climate: When commanders and senior non-commissioned officers are engaged and broadcast their support for soldiers in need of mental health treatment, risk is greatly reduced. When command teams put families first and make sure spouses and children are not forgotten during deployments, risk is reduced.
- Training: Suicide intervention training like Applied Suicide Intervention Skills Training (ASIST) and the Army's Ask, Care, Escort-Suicide Intervention (ACE-SI) are very effective in instilling a suicide prevention (SP)/suicide intervention (SI) attitude in units. Soldiers react extremely well to being given the tools to intervene and in creating a climate of openness and empathy in their unit. The Department of Defense resiliency training helps service members develop coping strategies and protective factors based on cognitive behavioral therapy skills.
- Postvention: There is a need for improved suicide postvention resources. When a suicide happens in a unit, it is devastating because the team cannot function effectively without that member. Contagion is often swift and acute, and commanders are often unprepared to intervene effectively.
- Pre-, during-, and post-deployment mental health treatment: Availability of consistent and high-quality physical and behavioral health care.

CURRENT MONTANA INITIATIVES AIMED AT REDUCING SUICIDES AMONG OUR VETERAN POPULATION

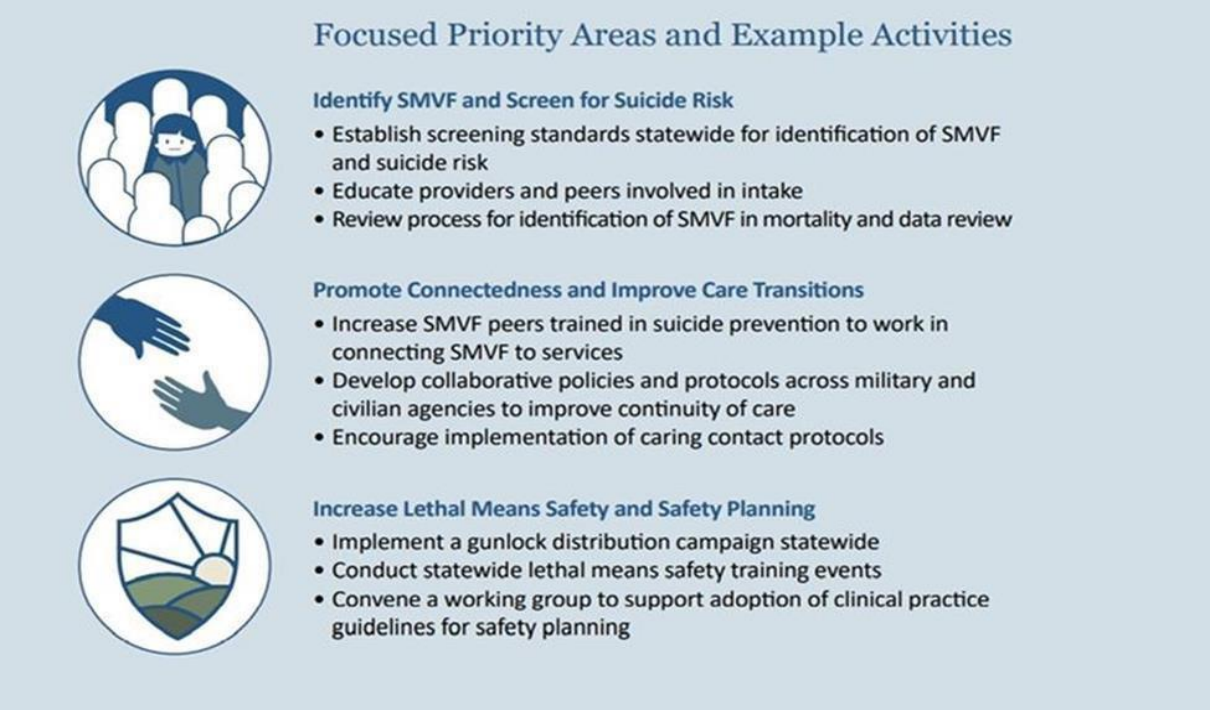
Suicide Prevention Program Manager (crisis/veteran focus)
The Suicide Prevention Program Manager (SPPM) focuses on the 988/VCL implementation for Montana and is working collaboratively with Montana VA and Montana National Guard on implementing the Governor's Challenge to Prevent Veteran Suicide. The SPPM is a retired veteran who previously served as the suicide prevention coordinator for the Montana National Guard

Governor's Challenge to Prevent Veteran Suicides
SAMHSA has partnered with the VA to bring the Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and the Families (SMVF) to states, territories, and communities across the nation. Fifty-four states and territories are currently taking part in the Governor's Challenge and are working to develop and implement statewide suicide prevention best practices for SMVF using a public health approach.

Challenge Objectives:

- Convene a state/territory (Governor's Challenge) or city/community (Mayor's Challenge) interagency military and civilian team of leaders to develop an implementation plan to prevent suicide among SMVF that will advance the VA's National Strategy for Preventing Veteran Suicide and incorporate evidence-based strategies from the CDC's Suicide Prevention Resource for Action.
- Engage with city, county, territory, and state stakeholders to enhance and align local and statewide suicide prevention efforts.
- Understand the issues surrounding suicide prevention for SMVF.
- Increase knowledge about the challenges and lessons learned in implementing best policies and practices by using state/territory-to-state/territory and community-to-community sharing.
- Implement promising, best, and evidence-based practices to prevent and reduce suicide at the local level.
- Define and measure success, including defining assignments, deadlines, and measurable outcomes to be reported.

Montana Governor's Challenge: Focused Priority Areas



Montana National Guard

The Montana National Guard provides suicide intervention training with the goal of having at least one SI-trained individual per unit at company level and above serving as a Suicide Intervention Officer (SIO).

The Montana National Guard also conducts a yearly Unit Risk Inventory that contains five questions pertaining to suicide risk. When these inventories indicate high risk, members of the Montana National Guard Risk Reduction Team provide a briefing to the command team and offer training and other mitigation measures.

The Montana National Guard has produced a Suicide Prevention Standard Operating Procedure (SOP) that includes the responsibility of units to provide SIOs, the composition of suicide responses teams, and "battle drills" for conducting intervention and postvention actions.

Goal

- The Montana National Guard will provide suicide prevention trainings to all guard members.

Measurable Outcomes

- The Montana National Guard will screen all guard members annually through the Unit Risk Inventory.
- Any guard member who screens at high risk will be connected to the Montana National Guard's Risk Reduction Team.

SUICIDE AND THE PRESCRIPTION DRUG REGISTRY

During the 2023 Legislative Session, the Montana Legislature passed SB 284, an act revising laws related to reporting of drugs taken by or prescribed to individuals whose deaths were ruled to be suicides. This bill requires a report on toxicology and controlled substance information in deaths ruled to be suicides.

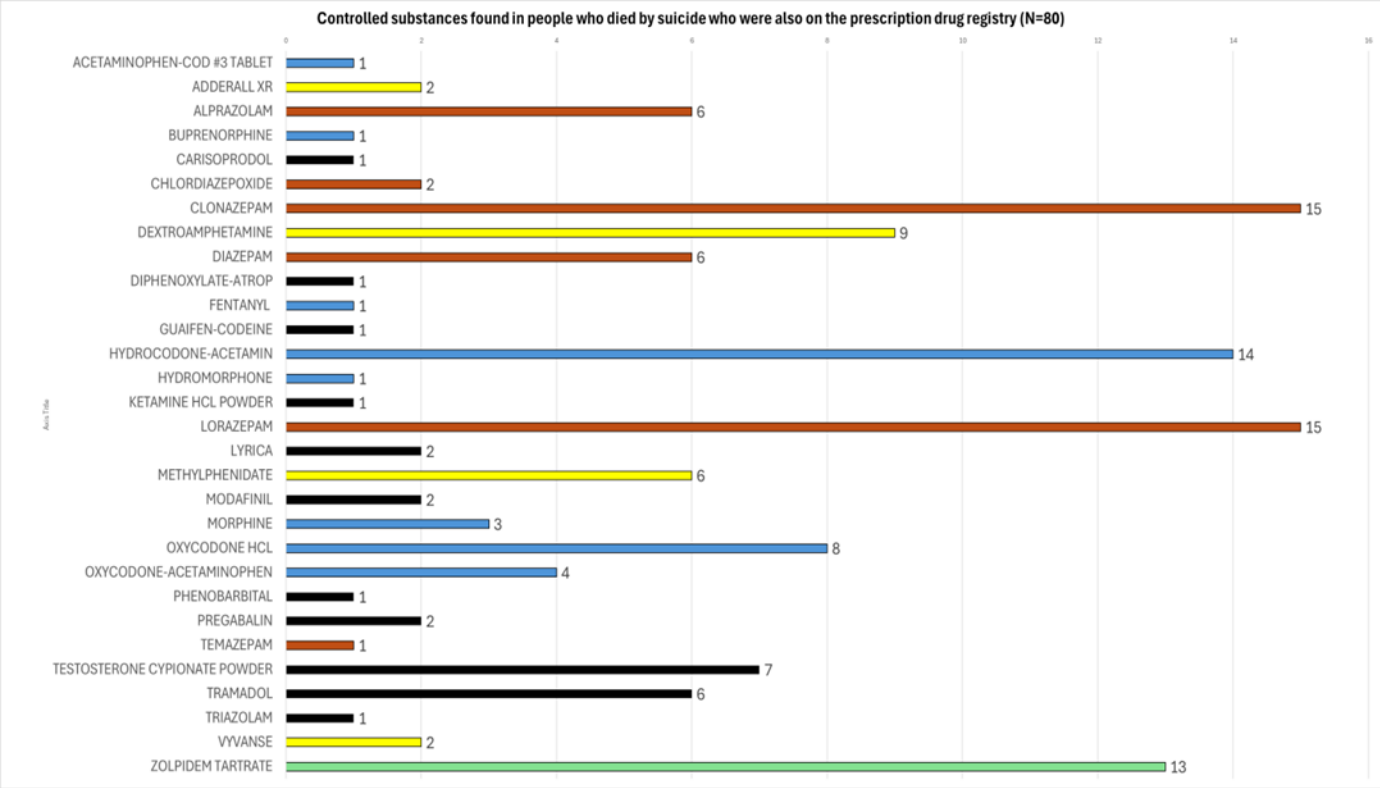
The following data is based on suicides that occurred in Montana in 2023. The suicides were cross-referenced with the Prescription Drug Registry. Eighty of the suicides were also identified on the Prescription Drug Registry. Thirty controlled substances were identified. The chart below depicts which controlled substances were prescribed to the 80 people who died by suicide. These medications were prescribed within 90 days of the death date.

SUMMARY OF FINDINGS

Of the 80 suicides identified as also being on the Prescription Drug Registry:

- 56% were prescribed a benzodiazepine.
- 43% were prescribed an opioid.
- 24% were prescribed a stimulant.
- 16% were prescribed a non-benzodiazepine receptor modulator.
- 49% were prescribed two or more medications.
- 43% of the prescriptions were paid for by Medicare/Medicaid.
- 41% of the prescriptions were paid for by private insurance.

Benzodiazepine	Stimulant	Other
Opioid	Non-benzodiazepine receptor	



The following graph includes the primary medical use of each of the controlled substances.

Controlled Substance	#	Primary use of controlled substance
ACETAMINOPHEN-COD #3 TABLET	1	Opioid used to help relieve mild to moderate pain
ADDERALL XR	2	Used to treat attention deficit hyperactivity disorder
ALPRAZOLAM	6	The most commonly prescribed psychotropic medication in the United States. Alprazolam is frequently prescribed to manage panic and anxiety disorders.
BUPRENORPHINE	1	A synthetic opioid developed in the late 1960s and is used to treat pain and opioid use disorder
CARISOPRODOL	1	Used to relax certain muscles in your body and relieve the discomfort caused by acute (short-term), painful muscle or bone conditions.
CHLORDIAZEPOXIDE	2	An FDA-approved medication used for treating mild-to-severe anxiety disorder, preoperative apprehension and anxiety, and withdrawal symptoms of acute alcohol use disorder in adults.
CLONAZEPAM	15	A benzodiazepine drug used for the acute treatment of panic disorder, epilepsy, and nonconvulsive status epilepticus.
DEXTROAMPHETAMINE	9	Used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy (sleep disorder).
DIAZEPAM	6	Used to treat anxiety, muscle spasms and seizures or fit
DIPHENOXYLATE-ATROP	1	Helps stop diarrhea by slowing down the movements of the intestines.
FENTANYL	1	A potent synthetic opioid drug approved by the Food and Drug Administration for use as an analgesic (pain relief) and anesthetic.
GUAIFEN-CODEINE	1	Guaifenesin/codeine is a fixed-dose combination cold medicine used for the treatment of cough.
HYDROCODONE-ACETAMIN	14	This combination medication is used to relieve moderate to severe pain. It contains an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen).
HYDROMORPHONE	1	This medication belongs to the opioid class of medications and is utilized to effectively manage and treat moderate-to-severe acute pain and severe chronic pain in patients.
KETAMINE HCL POWDER	1	Ketamine is used as an adjunct in general anesthesia as well as a sedative in minor surgical or diagnostic procedures
LORAZEPAM	15	This medication is used to treat anxiety. Lorazepam belongs to a class of drugs known asbenzodiazepines
LYRICA	2	This medication is used to treat pain caused by nerve damage due to diabetes, shingles infection, or spinal cord injury.
METHYLPHENIDATE	6	Methylphenidate is used to treat attention deficit hyperactivity disorder (ADHD).
MODAFINIL	2	Modafinil is a non-amphetamine central nervous system (CNS) stimulant with wakefulness-promoting properties. It is used in the treatment of conditions that cause excessive daytime sleepiness.
MORPHINE	3	Morphine is a non-synthetic narcotic with a high potential for abuse and is derived from opium.
OXYCODONE HCL	8	Oxycodone immediate-release tablets, capsules, and oral solution are used to relieve severe, acute pain. It is an opioid.
OXYCODONE-ACETAMINOPHEN	4	Oxycodone and acetaminophen combination is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated.
PHENOBARBITAL	1	Phenobarbital is a member of the barbiturate drug class. This drug is effective in anti-seizure management, treatment for status epilepticus, and insomnia
PREGABALIN	2	Pregabalin is a medication that treats nerve pain by calming overactive nerves in your body.
TEMAZEPAM	1	Temazepam is used to treat insomnia (trouble with sleeping). This medicine is for short-term (usually 7 to 10 days) use only. Temazepam is a benzodiazepine.
TESTOSTERONE CYPIONATE POWDER	7	Testosterone cypionate injection is indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone.
TRAMADOL	6	Tramadol belongs to the group of medicines called opioid analgesics. It acts in the central nervous system (CNS) to relieve pain.
TRIAZOLAM	1	Used to treat insomnia
VYVANSE	2	Used to treat attention deficit hyperactivity disorder
ZOLPIDEM TARTRATE	13	This is a non-benzodiazepine receptor modulator primarily used in the FDA-approved short-term treatment of insomnia aimed at patients with difficulty falling asleep