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POLICY BRIEF

North Dakota State and Tribal Health Policy Forums

Suicide in North Dakota: A Dialogue Across State and Tribal Boundaries

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North Dakota State and Tribal Health Policy Forums

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Suicide in North Dakota: A Dialogue Across State and Tribal Boundaries

Over the past ten years, a population equivalent to a small town in North Dakota has been lost to suicide. More specifically, since 1994, at least 800 people have taken their own lives and hundreds more have attempted. Keys to addressing this preventable tragedy are numerous, but ultimately rest on three broad areas: 1) an understanding of factors associated with suicide, 2) information about specific trends related to the occurrence of suicide (such as race, gender, location, etc.) and 3) an awareness of suicide prevention strategies that address these factors through public policy and community action. These three areas will be explored throughout this brief.

Factors Associated with Suicide

According to the Centers for Disease Control and Prevention (CDC), factors related to suicide may include[1]:

- Mental illnesses such as depression, and post traumatic stress disorder
- Barriers to getting help
- Alcohol and other drug abuse
- Rural isolation and loneliness
- Mental health treatment stigma
- Bullying, harassment, and violence
- Historical trauma/cultural "numbing"

Mental Illness and Barriers to Help

Depression and other mental health disorders are believed to exist in the vast majority of people who take their own life.[2] However, mental illness is diagnosed in only some cases, likely because of lack of access to mental health providers for diagnosis and treatment.[3] With 95% of North Dakota designated a Mental Health Professional Shortage Area, lack of access is a significant problem.[4] This federal designation means that there are a small number of mental health providers relative to both the population and the need for services.

The current state of mental health needs in North Dakota was starkly illustrated at a series of four suicide prevention forums held across the state in July, 2005 involving over 120 community, state and tribal leaders. At each forum, participants reported among other things, a lack of trained mental health professionals and volunteers, as well as a lack of awareness of mental health networks in their community, region, and state. One participant summed it up saying: "I think it [suicide prevention] feels like a drop in the bucket. We experience on a daily basis the lack of staff and resources. I've had 40 suicide attempts in the area since January."

Alcohol and Other Drug Abuse

In North Dakota, substance abuse is a pressing issue and one that has been shown to increase the likelihood of suicide.[5] A national survey on drug use and health released earlier this year ranked North Dakota highest in adult binge drinking.[6] Further, the number of meth-amphetamine arrests across North Dakota during the last three years has increased by 91%.[7] These sobering findings raise the possibility that substance abuse is growing in prominence across the state.

> ***I think it [suicide prevention] feels like a drop in the bucket…we experience on a daily basis the lack of staff and resources. I've had 40 suicide attempts in the area since January***
>
> *- North Dakota State and Tribal Health Policy Forum participant, July 2005.*

Rural Isolation and Stigma

Consistently higher suicide rates are found in rural areas compared to urban ones.[8,9] There are many reasons why, including increased isolation, loneliness, and stigmas associated with seeking mental health ser-

vices in rural settings. Many people with mental health problems fail to seek treatment because of the perceived shame associated with their illness and the fear that others will view them as "crazy".[10] Stigma not only dissuades people from seeking mental health services, but may also impede progress once people are engaged in the treatment process. In rural America this appears to be especially true.[11] Rural stress related to the "farm crisis" and on-going loss of identity (e.g., loss of land, loss of livelihood, loss of community, loss of a way of life) also plays a role in suicides in rural areas.[12,13]

Bullying, Harassment, and Violence

Primarily impacting youth, harassment and bullying often erupts into school violence.[14] The U.S. Department of Education and the U.S. Secret Service studied 37 school shooting incidents involving 41 student attackers.[15] The study included a review of records and in-depth interviews. Findings indicated being bullied played a key role in most of the incidents. They also suggest a link between violent behaviors directed at oneself (i.e., suicidal behaviors) and violent behaviors directed at others.

Other less extreme forms of violence may be related to suicide as well. A national study of adolescents by the CDC found that students who reported attempting suicide during the preceding 12 months were nearly four times more likely to have reported physical fights than those who reported not attempting suicide.[16]

Historical Trauma

The placement of Native American tribes onto reservations and other similar traumatic or culturally numbing events have been shown to increase the potential for suicide.[17] Acknowledging the role of these events and appropriately incorporating them into culturally sensitive and relevant interventions are critical to successful suicide prevention and mental health intervention.[18,19]

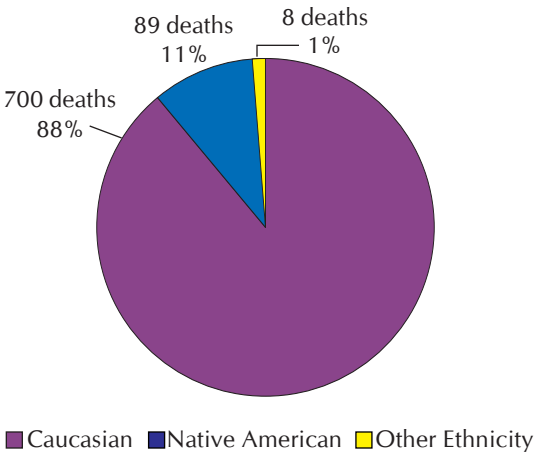
Suicide Trends across North Dakota

Approximately 11 out of every 100,000 Americans complete suicide.[20] Compared nationally, North Dakota has 14.4 suicides per 100,000 people, ranking it 13th in the nation.[21] The actual number of deaths recorded as suicides in North Dakota from 1994-2003 was 797.[22]

Race

Of the 797 suicides recorded from 1994-2003 (see Figure 1), 700 were white, 89 were Native American and eight represented other ethnic minorities.[22] Although 11% of the suicides were committed by Native Americans, they represent only 5% of the state's population.[23] Those most at risk were American Indian adolescents and young adults ages 10-24.[22,24]

Figure 1. North Dakota Suicide, 1994-2003



Gender

Males in North Dakota complete suicide at a rate four times that of females, however females are more than three times more likely to attempt it.[22] Compared across the country, North Dakota males were equivalent to, or exceeded national suicide rates every year from 1994-2003; whereas females met or exceeded the national average four times.[22]

Location

Tribal reservations have the highest age adjusted[a] suicide rates per 100,000 population in North Dakota.[25] A number of participants at the suicide prevention forums expressed concern that these numbers are far below actual rates due to inconsistent record keeping, tracking, and reporting.

North Dakota counties with the highest age adjusted suicides per 100,000 during the five year period 1997-2003 were Billings, Sioux, Benson, Golden Valley, and Eddy.[26]

Costs

The most recent study examining costs pertaining to suicide and suicide attempts was conducted in 1997 by the National Suicide Prevention Resource Center.[27] Findings indicated that in North Dakota the average medical cost per self-inflicted injury was $7,516. The average work-lost cost per case was $9,314. In that same year there were an estimated 382 suicide attempts resulting in hospitalization, bringing the estimated total cost of recorded suicide attempts to over $6.4 million.

Suicide Prevention Strategies

Given the complex nature of suicide, including the fact that suicide is found across all ages, all populations, and all socioeconomic strata, there are a range of options for suicide prevention. They reflect both private and public sector strategies.

Increased Support for Existing Networks

The primary lead for suicide prevention initiatives across North Dakota is the Adolescent Suicide Prevention Task Force coordinated through the Department of Health. This group brings together a number of agencies in the development and implementation of a statewide plan addressing youth suicide. Because of limited resources, one suicide prevention coordinator position is funded to implement youth suicide prevention training in pockets of the state for selected children, teachers, community lay people and mental health professionals. To date, the North Dakota Adolescent Suicide Prevention Task Force has not been able to expand this critical training to target people of all ages, nor has it been able to include groups such as law enforcement, emergency responders, and physicians across the entire state.

What is 211? 211 is an easy-to-remember telephone number that connects people with important community services, and provides referral and crisis intervention service. It is FREE and operator-serviced 24 hours a day, 7 days a week.

The suicide prevention forums revealed a significant need to get a better handle on activities offered by state and local agencies and grassroots organizations. One illustration of this need was the lack of awareness of the statewide 211 HELPLine by front line mental health staff participating in the forums. The 211 HELPLine is administered by the Mental Health Association of North Dakota and is designed to serve as a 24-hour crisis and referral hotline.

The forums also revealed the lack of coordinated, comprehensive suicide prevention efforts. In the absence of a structured repository for accessing collective knowledge and resources, an uncoordinated system of suicide prevention exists. Acknowledging this point, one legislator stated "What we need is information about what our own state is currently doing to solve the issue…"

Because suicide is affected by a variety of factors, prevention efforts need to be addressed through numerous state and tribal agencies, such as health, education, mental health, juvenile justice, emergency services, and law enforcement. Increased coordination

[a] Rates are age adjusted because there are larger numbers of people in some age categories and fewer people in others. Age adjusting helps to account for these size differences and make comparisons of populations over time.

of these entities could assist policy makers and others in identifying where potential gaps exist, avoid duplication, and maximize resources at both the state and tribal levels.

Increased Access to Mental Health Services through Telemental Health Video Conferencing

Due to the lack of mental health professionals in rural areas, exploring ways to increase access to their services is critical. The use of telemental health video networks can play a key role in this effort.[28] Initial steps implementing these networks include increasing behavioral and primary healthcare provider awareness of the systems, overcoming technical fears by providers, and addressing potential concerns about confidentiality.

Telemental health delivery also can help decrease feelings of stigma in rural areas. This is especially true when patients receive services in primary care or other general settings where others are unaware whether treatment is related to mental illness or other health services.[29] Additionally, telemental health delivery can reduce incidental contact between mental health providers and consumers outside the therapeutic setting if both reside in different communities.[30] These factors protecting anonymity could lead to willingness for some consumers to actively seek needed care.

Research shows that telemental health services:

- Improve access to health services for people in remote rural, frontier, and tribal communities
- Improve the efficiency of specialized mental health services
- Support rural primary and mental health care providers through easier access to peer information, education, supervisory support and peer support [30,31,32]

Increased Access to Mental Health Services through Licensure Compacts

Mental health services could be further expanded through the licensure of professionals via a regional state compact. Compacts allow member states to recognize each other's license. This step could help improve access to services by those living in state border communities, and help in the recruitment and retention of mental health workers from neighboring states desiring to move to North Dakota. A licensing compact could also facilitate telemental health services that might extend across state lines to engage appropriate providers. Similar efforts have already been undertaken by State Boards of Nursing involving 20 states, including North Dakota.[33]

Increasing Access to Mental Health Services through Alternative Degree Programs

Expanding supply and enhancing reimbursement could help improve access to mental health providers in North Dakota. This could occur through expansion of current programs and consideration of other educational models. For example, a two-year associate behavioral technician degree could be developed to provide training on crisis intervention, critical listening, and other basic psychological helping skills. It could be implemented at the community or tribal college level and allow for developing providers whose services could be reimbursable through programs like Medicaid. Such a degree is in the developmental phases at the University of Alaska, Anchorage and is being studied by two tribal colleges in North Dakota.[34]

Anti-Bullying and Harassment Legislation

Those who support anti-bullying legislation believe it is necessary because many schools do not deal with these behaviors effectively and additional protections are needed before crisis situations arise. A National Conference of State Legislatures report states, "There are still people who think that everyone gets bullied, ...and that's just the way it is, and they are hesitant to legislate...but people are coming to see it as an issue they need to address."[35]

Some consider anti-bullying legislation unnecessary or question whether the legislature is the appropriate venue to deal with the issue. They contend that bullying policies should be left to local school districts and that state legislation is political grandstanding with laws overemphasizing one component of school safety.[35]

Currently, in North Dakota, each school board is responsible for setting its own policy for dealing with complaints pertaining to harassment. The North Dakota Department of Public Institution has standards and strongly encourages their implementation but does not require school districts to adopt them nor are students required to meet them.[36] In 2003, the North Dakota Legislature attempted to address the issue of bullying with Senate Bill 2216 which broadly related to the conduct of school students and staff.[37] This bill failed to pass the Senate. The chief complaint was vague language which could expose schools to unnecessary litigation.

President's New Freedom Commission on Mental Health Recommendations

President George W. Bush launched the New Freedom Commission on Mental Health to address problems in the current mental health delivery system that allows Americans to fall through the cracks. Among other things, the 2003 report to the President recommended:

- Improved strategies to increase the number of trained professionals and alternate providers of mental health services who are competent to work in rural communities.
- Early identification, screening, diagnosis, treatment and recovery services that are delivered by competent professionals and accessed close to home.
- Broad public education programs - including those delivered in school settings -to increase rural residents' understanding of mental illness, warning signs and risk factors for suicide, and how to respond appropriately when someone is suicidal.[38]

State Suicide Prevention Activities Across the Nation

Efforts to prevent suicides vary tremendously from state to state.[39] A few states introducing legislation that might be applicable to North Dakota include:

California

- ✓ Passed a resolution encouraging public and private organizations to develop/ implement strategy for suicide prevention.
- ✓ Recognize every first full week in May as 'Suicide Prevention Week.'

Louisiana

- ✓ Legislated suicide prevention programming in public schools.

New Hampshire

- ✓ Established a committee to study and examine the ways to reduce youth suicide.
- ✓ Expanded duties for a state agency, the Health Education Review Committee, to include specific consideration for youth suicide prevention proposals.

New Jersey

- ✓ Established the New Jersey Elderly Person Suicide Prevention Advisory Council in the Department of Human Services.
- ✓ Filed annual reports on the needs and services for elderly persons, who are identified at being at risk of suicide.

Oklahoma

- ✓ Created the Healthy and Fit Kids Act of 2004 requiring a Safe and Healthy School Advisory Committee at each public school to study strategies to address youth injury and suicide prevention.

Recommendations for North Dakota

Participants at the suicide prevention forums identified a number of priorities for suicide prevention in North Dakota. Specific recommendations for state and tribal leadership consideration included:

- Enhance and expand awareness of the 211 HELPLine.
- Initiate a comprehensive study of suicide prevention services across agencies to examine gaps and duplication of effort
- Raise awareness by declaring a suicide prevention day, week or month.
- Enhance collaboration across government and tribal agencies (i.e., education, health, human services, and public safety) and between and community partners to:
  - Pool resources
  - Identify best practices
  - Locate funding opportunities
  - Identify potential partnerships (and enhance current ones)
- Enhance systems for collecting and accessing North Dakota suicide prevention data and resources.
- Increase access to mental health services across the state. Possible methods include:
  - Support telemental health video conferencing
  - Legislate licensure compacts
  - Establish alternative degree programs
- Expanded training for personnel such as public health nurses, emergency responders, and law enforcement.
- Design and support a statewide suicide prevention plan that spans all age groups.

Conclusion

There are a number of factors that contribute to suicide, such as substance abuse, mental illness, barriers to getting help, historical trauma, and stigma associated with seeking mental health services. Because of the complex nature of suicide, prevention efforts need to take multi-faceted approaches that involve a wide range of public and private institutions. Using this type of strategy could serve North Dakota well. It was apparent from the suicide prevention forums held across the state in July that currently there exists an uncoordinated patchwork of local, community and state suicide prevention activities.

Possible solutions to preventing suicide are numerous, but regardless of the type of approach taken, critical components include, 1) increasing access to mental health services, 2) developing more structured and comprehensive systems for collecting suicide prevention knowledge, data, and resources, 3) understanding current resources dedicated to suicide prevention, and, 4) enhancing collaboration across agencies.

At one of the suicide prevention forums held this summer, tribal chairman Ken Davis of the Turtle Mountain band of Chippewa Indians summed up the current state of suicide prevention efforts: "We need to listen to our youth…they [the state] need to take a good hard look... we think its getting better [suicides] but it's not. The suicide problem is getting worse." Without action to address the lack of mental health providers and lack of comprehensive and ongoing coordination of suicide prevention efforts across the state, there is no reason to think that suicide will decrease in frequency in North Dakota.

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