

Status of the “Montana Strategic Suicide Prevention Plan” October 24, 2003

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Historical Notes as Introduction:

- Montana currently ranks second highest in suicide rate compared to all the states of the US.
- This is not a new phenomenon; for almost the past 100 years Montana’s suicide rates have been significantly higher than the US average. A rate higher than the national average is also found in most of the other states of the Rocky Mountain front. (see appendix)
- In Montana, suicide is the second leading cause of death for children aged 10-14, teens 15-19, young adults 20-24, and also ages 25-35. This is a significant, tragic, and costly problem in Montana. (see appendix)
- Suicide deaths are now recognized as preventable. With coordinated services, programs, and interventions in place, the rate of suicide in Montana could be significantly lowered.
- The Department of Public Health & Human Services is the state-level administrative agency presuming responsibility for oversight of suicide prevention services in Montana. However, no adequate or consistent funding has ever supported this work.
- No state-level position or program exists which is solely dedicated to suicide prevention.
- Collaborative efforts by government and community stakeholders have been a hallmark of the Montana approach to suicide prevention.
- The main policy document on this topic is the Montana Strategic Suicide Prevention Plan, approved by DPHHS in January of 2001.

Creation of the Montana Strategic Suicide Prevention Plan:

- In 2000, a diverse group of professionals coalesced around the recognition of suicide as a preventable public health problem. They agreed to participate in a lengthy planning process to address this problem in a coordinated manner.
- Spearheaded by several DPHHS entities, including the EMSIP Section, Child, Adolescent, & Community Health Section, and AMDD; a collaborative planning process began with a series of facilitated meetings and the formation of a statewide stakeholders’ Steering Committee.
- The project was supported by several grants awarded by HRSA to the EMSC Program, and also by the MCH Block Grant. The Steering Committee worked together over a period of almost a year to draft the “State Strategic Suicide Prevention Plan”.
- This plan was reviewed and approved by DPHHS, and published and distributed in early 2001. (see appendix)

Strategic Directions in Plan:

- The Plan identified Montana’s strengths and weaknesses in terms of suicide issues, and suggested almost thirty “Strategic Directions” to be considered for action over the following five years.
- Of these strategic directions, three key steps were prioritized for collective statewide action. These were: Priority 1) establish a central repository for resources such as data, technical assistance, training, and public & professional information; Priority 2) establish a statewide crisis phone hotline; and Priority 3) develop a grassroots network for citizens, survivors, and local stakeholders active in suicide prevention.
- A strong collaborative effort among the above DPHHS agencies, community activists, and private agency stakeholders has resulted in progress in assessing existing resources and the development of proposals to meet the directives of the strategic plan.

Process and Progress on Strategic Plan:

- With neither dedicated staff nor budget, the key Priorities have not yet been completed. There is no funding to support meetings of the Steering Committee, nor for a dedicated coordinator to direct action steps to address the Priorities as set forth in the plan, or to write proposals to capture funds.
- Despite the lack of designated staff and funding, progress has continued through collaboration between the ad hoc State workgroup, local grassroots initiatives, tribes and other agencies. Significant partners include the Mental Health Association of Montana, the Office of Public Instruction, In-Care Network, Voices of Hope, the Community Mental Health Centers, Critical Illness & Trauma Foundation, Shodair Children’s Hospital, and Indian Health Services.
- A significant new partner is the American Foundation for Suicide Prevention. In 2001, community volunteers established a Montana chapter of AFSP to provide suicide awareness and survivor training throughout the state. This organization has a large membership, a statewide board, and has sponsored regional as well as local trainings. Over 1000 people throughout Montana have learned basic suicide gatekeeper skills through AFSP’s trainings.
- Unfortunately, AFSP of Montana is quickly outgrowing its ability to survive as a totally volunteer entity. None of the agency’s recent applications for funding has been granted. This agency, like many others in Montana, would be helped by a resource center providing technical assistance and funding opportunities, or by the chance to apply directly for funding to support and expand the services they already provide.
- A number of Montana communities have established local suicide prevention groups or coalitions, and have sponsored local suicide awareness training. Some of these groups have written community suicide prevention plans. Some work within their schools to address youth suicide.
- However, without a centralized communication system or network, often these groups work in a vacuum, reinventing resources, and missing out on expertise and support which may be located just a few miles away. It is difficult to track the status of these groups, or even to know of their existence. Completion of Priority steps 1 and 3 (resource center and communication/training network) would be a tremendous support to leverage the grassroots activism represented by these community groups.

Progress Specific to Priority #2 (crisis hotline)

- Existing crisis line services were assessed in late 2001 and results were reported to the Steering Committee. The SAMHSA funded national “Hopeline Network Project” or “1-800-SUICIDE” project was explored for Montana’s crisis line. Currently 1-800-SUICIDE calls originating in

Montana are taken in Spokane WA. Funding another state to take Montana's suicide calls was one model considered.

- All four Community Mental Health Centers, (Western Montana Community Mental Health Center – main office Missoula, Golden Triangle Community Mental Health Center--main office Great Falls, South Central Community Mental Health Center--main office Billings and Eastern Community Mental Health Center – main office Miles City), provide crisis telephone services 24/7/365. Due to the expense of providing crisis telephone services and limited professionals in very rural counties of the state, answering services are frequently used after hours and on weekends to relay crisis calls to the on-call crisis worker.
- The Steering Committee did not believe current crisis telephone services were responsive to suicidal individuals and wanted a trained suicide prevention responder to answer the hotline quickly 24/7/365 and for the crisis line to have the capacity to take many crisis calls at one time.
- Steering committee members worked throughout 2002 with the Community Mental Health Center Directors and other stakeholders on Priority #2. To provide a state-of-the-art crisis hotline and help reduce the prevalence of suicides in Montana, an in-state centralized crisis line model was developed.
- In November 2002, the Injury Prevention Program sponsored a one-day facilitated stakeholder meeting so stakeholders from around the State could review several different crisis line models and make a recommendation as to which model to use in Montana.
- At this meeting the Stakeholders voted to support an in-state centralized crisis line model versus a designated suicide line or an out-of-state crisis center taking Montana's suicide calls. A subcommittee was delegated to write up the proposal.
- This subcommittee met several times and in May 2003 completed the "In-State Centralized Crisis Line" proposal, which included an implementation plan and budget. (See appendix.)
- Several national funding sources were investigated by members of the Steering Committee and local stakeholders. Voices of Hope applied for three separate grants the summer of 2003 to fund the crisis line proposal. These grants were highly competitive and not specifically for suicide prevention activities; none of them was funded.

Proposals to meet specific Priority Steps:

What follows are the workgroup's proposals for possible direction in the future.

Priority #1: "Establish a central resource for accessing technical assistance, training, "best practices" information, and updated listings of community resources..."

Proposal 1) Support the Voices of Hope "Crisis Resource Center" proposal through a contract arrangement. Voices of Hope is the only nationally certified or American Association of Suicidology (AAS) crisis center in Montana. The VOH office is co-located with one of Montana's 4 community mental health centers in Great Falls, Golden Triangle CMHC. VOH submitted several grant proposals this summer to the National Library of Medicine to fund a crisis resource center. The grants are highly competitive and to date, none of the VOH proposals has been funded. (see appendix)

Many requirements of maintaining AAS certification and operating a crisis line would also meet some of the requirements of operating a resource center. VOH is required to collect and evaluate data on the crisis calls they receive; provide on-going state of the art training and supervision to staff on dealing with various types of crisis calls, particularly suicide; develop and keep current comprehensive resource

directories for communities served by the crisis line; maintain current on best practice standards for suicide prevention; and establish and maintain collaborative relationships with professional face-to-face responders and resources in the communities served.

The VOH proposal would create and maintain a Crisis Resource Digital Library, utilize existing national, state and local resources, provide health information to agencies/ individuals, distribute bi-monthly bibliographies, etc. The resource center would develop “tool kits” and elicit professionals to volunteer at the local level to assist communities and schools that have just experienced a suicide, and need additional support quickly. The VOH proposal and budget is included in the appendix.

VOH has operated a crisis line in Cascade County for many years. In conjunction with this they provide training opportunities for their own staff as well as the community. For example, they have held their annual “Crimes Against the Mind and Body Conference” for the past 8 years on various crisis topics. This year’s conference was on preventing youth suicide. Conference topics vary based on their crisis line assessment of community needs. They also hold bi-monthly 1-2 hour workshops for staff and local social service agencies. The VOH Crisis Line Coordinator has extensive experience in operating an AIDS Resource Center in King County, Washington.

Proposal 2) The Department’s Prevention Resource Center could house a suicide prevention website and resource center. This would provide electronic access to the many programs and “best practice” materials already developed by National and international sources. We recommend a .5 FTE position to design, implement, and maintain the resource center/website, and an additional .5 FTE to provide ongoing promotion of the resource to stakeholders and the public, as suggested in the Strategic Plan.

The center would serve as a central data repository combining all Montana-specific statistical data on suicide. It would also be a resource clearinghouse for information and training for local communities, agencies, professionals, and policy developers.

For example, excellent materials and training courses are available from the Living Works Education Center, Calgary Alberta. Another resource is the National Center for Suicide Prevention Training, which receives a large CDC grant to provide suicide-specific information and classes online. The Suicide Prevention Resource Center is a third national resource partner.

Priority #2: “Provide for a statewide crisis hotline accessible to every Montana citizen by telephone.”

Proposal 1) Utilize Voices of Hope to provide services as outlined in their “Statewide Suicide Crisis Hotline” proposal. Voices of Hope has provided crisis hotline services for many years in Cascade county. Golden Triangle works with VOH and provides VOH office space. VOH triages crisis calls for Golden Triangle Community Mental Health Center. If a face-to-face professional response is required due to imminent danger, Golden Triangle and/or the police are called to respond. The other 3 Community Mental Health Centers also provide crisis telephone services and face-to-face professional response as needed per imminent danger.

Center Directors and their staff met frequently over the last 2 years with members of the Steering Committee and VOH to discuss centralizing crisis telephone services. The 4 CMHCs have entered into an interagency agreement with VOH to provide emergency consultation for crisis calls as needed and emergent appointments for crisis line callers who need a professional appointment within 48 hours. VOH will elicit additional local professionals to provide emergent appointments for those in need of a follow-up appointment. This would create a 2-tier model in which VOH would take all the crisis calls and refer imminent danger and emergent calls to community responders.

VOH has provided crisis call data with the 4 CMHCs to the Addictive and Mental Disorder Division since 1999. VOH collects more data on crisis calls than AMDD currently does. Data on the nature of the crisis,

heavy call periods, disposition of the call, gender, age, etc is important information from which to develop future resource and training needs.

Priority #3) Develop a grassroots network and training center for citizens, survivors, and local stakeholders in suicide prevention activities.

Some notes about grassroots efforts toward training: This priority includes an action step to plan a statewide conference for early in year 2 of the plan. We have looked into grants to support a training conference; currently there appears to be a dearth of funding for this, and without a dedicated coordinator, it is doubtful that DPHHS could sponsor such an event. Despite this, a number of local, statewide, and regional suicide-focused conferences and trainings have been held in the past 3 years.

The Mental Health Association of Montana held a suicide prevention-focused state conference in early 2001. IRECC attempted a regional suicide meeting in 2000 that essentially failed due to lack of publicity. Suicide awareness and intervention has been a topic at every recent Spring Public Health Meeting, and several of the Fall MPHA Meetings as well. School teachers and administrators received training at OPI's 2003 Montana Behavioral Initiative Summer Institute, and have requested additional sessions at the 2004 conference. In-Care Network has addressed the issue of Native American suicide in their annual youth conferences. A team of 5 Montanans participated in a youth suicide prevention conference in Seattle last year, and in October 2003 a team of 16 participated in a bi-regional conference in Colorado.

In 2001, the Kalispell community sponsored a "Train the Trainer" series for QPR intervention, and in the Spring of 2003 AFSP Montana sponsored a regional training for facilitators of suicide survival groups. In October 2003, Missoula's Suicide Prevention Network sponsored a 2-day train-the-trainer, and was so swamped they had to turn away interested participants. The Fetal, Infant, and Child Mortality Review Teams requested and received suicide awareness training, as did the Montana Pediatric Association. Over a thousand youth, in groups ranging from 4-H to churches to high schools and colleges have been trained in the QPR method of suicide awareness. Hundreds more have been reached by Yellow Ribbon Campaigns in local communities. Voices of Hope hosted a national speaker at their 2-day youth suicide prevention conference this Fall, along with many local and state resources.

Throughout Montana both lay people and professionals are hungry for training specific to suicide. A communications and training network would be eagerly received, and utilized by people in every corner of the state.

Proposal 1) Create a central training director/coordinator housed in either EMS or the PRC. Duties would include managing a listserv for open communication within the Montana suicide prevention community, coordinating training opportunities, and organizing a bi-annual conference. Utilize VISTA volunteers as community organizers to work within the 4 Community Mental Health regions.

Proposal 2) Several components of the VOH proposals described above for priorities #1 and #2 would benefit the development of a grassroots network and could be coordinated with the development of the crisis line and resource center as they are implemented. The VOH crisis line proposal already includes regional part time resource coordinators in each area to maintain current resource directories, and their resource center proposal includes training for interested community stakeholders and organizing an annual conference.

Funding Estimates and How-tos

- Dedicate \$30,000 to convene an annual suicide prevention training conference with local stakeholder/advocate and professional training tracts.
- Use \$75,000 to support a statewide crisis line and implementation of the 1/800/SUCIDE national suicide crisis line number. The national project would contribute an additional \$25,000 in

technical and AAS certification assistance. This could be housed within the VOH operation in Great Falls. This seems an excellent and appropriate use of bioterrorism funds, if possible.

- It would take \$200,000 to complete an interactive web-based central resource database at the Golden Triangle MHC, Great Falls. This database has already been implemented by Golden Triangle. VOH, which is co-located with Golden Triangle, can contract to use this resource as the support system for a crisis phone system.
- We need \$75,000 per year to fund a 1.0 FTE Suicide Prevention Coordinator with VISTA volunteer support, and a materials and technical assistance resource center within the PRC/DPHHS. The center could both provide hard copy and electronic resources for use by professional and lay people.
- It would take \$125,000 annually to fund training in suicide prevention awareness for medical professionals, local crisis intervention teams, mental health professionals, and law enforcement officers. All these people are in the front line for suicide prevention, yet most aren't up to speed on best practice suicide prevention counseling techniques.
- Montana needs to fundamentally enhance the mental health provider infrastructure to increase services available, especially for those with no mental health insurance. Even with insurance, wait times to see a qualified provider are often 3 weeks--too long with a suicidal adolescent. The VOH crisis hotline proposal addresses this in part by including interagency agreements with the 4 CMHCs to provide an emergent appointment within 48 hours for crisis callers. Non-emergent appointments do generally take 3 weeks.
- Increase funding to the mental health centers by at least \$100,000 each annually to hire more providers for this critical coverage, and to pay for services to uninsured clients. Some of these funds need to be allocated for paying practical day-to-day expenses to assure clients can get to therapy. \$250,000 per center would be better; cost of this would be \$1.0 million annually – perhaps a combination of state and federal funds.
- Finally, we need \$1.5 million as a match to federal funding for patients in hospital psychiatric units (many of these have closed across the state due to heavy losses on the non-insured, etc.)
- The bottom line? Funding all these proposals will take \$3.0 million at the state level, using a large portion of these funds to match federal Medicaid and Medicare funds.
- The proposals set forth in this report are intended to provide a solid infrastructure to begin addressing the priorities set forth in the Strategic Plan. They are a beginning, not an ending. There are many excellent “best practice” plans and programs that could be utilized in Montana once we have this basic infrastructure in place.

Workgroup Summary

Hopelessness is often associated with suicide. We know suicide is a multi-faceted problem, without a simple solution, or a single solution. But we are hopeful, because we know that suicide is preventable. We are hopeful because Montana has a great resource in its Strategic Suicide Prevention Plan. This Plan is the product of countless hours of input by dozens of dedicated people over a number of years. It is a thoughtful, professional plan that is supported by hundreds of grassroots activists all over the state.

Because we know suicide is preventable, we are hopeful about making a difference for families all over the state who are affected by the needless tragedy of suicide. And we are hopeful because we have been able to delineate in this status report a number of proposals that will make a difference in lowering the suicide rate in Montana. Thank you for your interest in making a positive change for the good of Montana.