NORTH Dakota
Be Legendary.
Health & Human Services

# North Dakota Suicide Fatality Review Commission

## 2025 Annual Report

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# Acknowledgements

**As a Commission, we would like to acknowledge and dedicate this recommendation report to the North Dakota lives that have been lost to suicide, individuals having suicidal experiences, and their family, friends and communities affected. We desire to improve the lives of all who are struggling. You are not alone.**

Members of the North Dakota Suicide Fatality Review Commission are appointed by the NDHHS Commissioner and include:

- Adriane Knightstep, Disease Control & Forensic Pathology, State Forensic Examiner's Office, NDHHS
- Brad Hawk, Indian Health Systems Administrator, North Dakota Indian Affairs Office
- Daniel Cramer, Ph.D. Clinical Director, State-Operated Behavioral Health Clinics, NDHHS
- Derek Arndt, Major, North Dakota Highway Patrol
- Jennifer Illich, Executive Director, FirstLink
- Jon Ulven, Ph.D., L.P., Sanford Behavioral Health Fargo
- Kristie Ross, Cass County Coroner's Office;
- Kodi Pinks, MPH – North Dakota Violent Death Reporting Program Manager, Surveillance & Data Management Director, Health Statistics & Performance, NDHHS
- Lauren Huddle, M.D., Disease Control & Forensic Pathology, State Forensic Examiner's Office, NDHHS
- *Melissa Markegard, MS, CHES, Suicide Prevention Administrator, NDHHS
- Russ Riehl, Principal, Simle Middle School, Bismarck Public Schools
- Samantha Christopherson, Executive Director, American Foundation of Suicide Prevention
- Susan Roe, MD, Clinical Professor of Pathology, University of North Dakota
- Representative Todd Porter, Owner, Metro-Area Ambulance Service, Inc.
- Tammy Monsebroten, LCSW, Fargo VA Health Care System

*denotes Commission Coordinator/Presiding Officer

## Data

- Kodi Pinks, MPH – North Dakota Violent Death Reporting Program Manager, Surveillance & Data Management Director, Health Statistics & Performance, NDHHS
- Olivia Persinger, MPH – Epidemiologist, Health Statistics & Performance, NDHHS
- Tara Haugen – North Dakota Violent Death Reporting Program Coordinator, Health Statistics & Performance, NDHHS

The Commission wishes to thank the many agencies across North Dakota that provide us with the data that allows us to do this important work.

## Editors

- Kodi Pinks, MPH – North Dakota Violent Death Reporting Program Manager, Surveillance & Data Management Director, Health Statistics & Performance, NDHHS
- Laura Anderson , MPH - Policy Director, Behavioral Health, NDHHS
- Melissa Markegard, MS, CHES, Suicide Prevention Administrator, Behavioral Health, NDHHS
- Tracy K. Miller, PhD, MPH – State Epidemiologist, Health Statistics & Performance Section Director, NDHHS

# History and Purpose

During the Sixty-eighth Legislative Assembly of North Dakota, in 2023, Governor Burgum signed House Bill 1390, which created and enacted a new section to Chapter 23-07 of the North Dakota Century Code, relating to the creation of a Suicide Fatality Review Commission.

This mandated that the Department of Health and Human Services establish the state Suicide Fatality Review Commission (Commission). The purpose of the Commission is to decrease the number of preventable suicides through systematic review of North Dakota suicide fatalities conducted by a multidisciplinary team of professionals and subject matter experts.

The reviews are used to generate data driven suicide prevention recommendations, which are shared with stakeholders and the North Dakota Department of Health and Human Services Commissioner to be incorporated into statewide suicide prevention recommendations.

**The Commission shall review suicide deaths that have occurred in the state with the goals of:**

1. Identifying the risk factors, protective factors, systems, and services involved in each case;
2. Recommending policies, protocols, and other actions to improve community, service, and system responses to individuals at risk of suicide; and
3. Providing consultation and coordination for agencies involved in the prevention and investigation of suicide.

The Commission came to fruition in October 2023 with an initial meeting of the appointed members. The first Commission meeting to review cases commenced in January of 2024. Meetings continued to occur quarterly in 2025. Additional information and the SFRC's Annual Reports can be found at: www.hhs.nd.gov/suicide-fatality-review-commission

# Background

## Suicide in North Dakota

According to the North Dakota Department of Health and Human Services' Division of Vital Records, in 2023, suicide was the 9th leading cause of death in the state, with 142 deaths and a crude death rate of 18.2 per 100,000 residents (Figure 1). Rates were calculated using 2020 Census figures.

Figure 1: Top 10 Leading Causes of Death in ND in 2023

| Leading Causes of Death | Crude Death Rate Per 100,000 Residents |
|---|---|
| Heart Disease | 201.3 |
| Cancer | 174.6 |
| Accidents | 52.9 |
| Alzheimer's Disease | 51.0 |
| Chronic Lower Respiratory Diseases | 37.7 |
| Stroke | 33.8 |
| Diabetes | 26.8 |
| Cirrhosis | 20.2 |
| Suicide | 18.2 |
| Nephritis | 16.9 |

Figure 1 description: This table shows the top ten leading cause of death by crude death rate per 100,000 residents. The first leading cause of death is heart disease at a rate of 201.3. The second leading cause of death is cancer at a rate of 174.6. The third leading cause of death is accidents at a rate of 52.9. The fourth leading cause of death is Alzheimer's disease at a rate of 51.0. The fifth leading cause of death is chronic lower respiratory diseases at a rate of 37.7. The sixth leading cause of death is stroke at a rate of 33.8. The seventh leading cause of death is diabetes at a rate of 26.8. The eighth leading cause of death is cirrhosis at a rate of 20.2. The ninth leading cause of death is suicide at a rate of 18.2. The tenth leading cause of death is nephritis at rate of 16.9.

The rate of suicide in North Dakota (ND) went from 17.6 per 100,000 in 2019 to 18.2 per 100,000 in 2023, which is a 3.4% increase (Figure 2).

Figure 2: ND Suicide Rates, 2019-2023

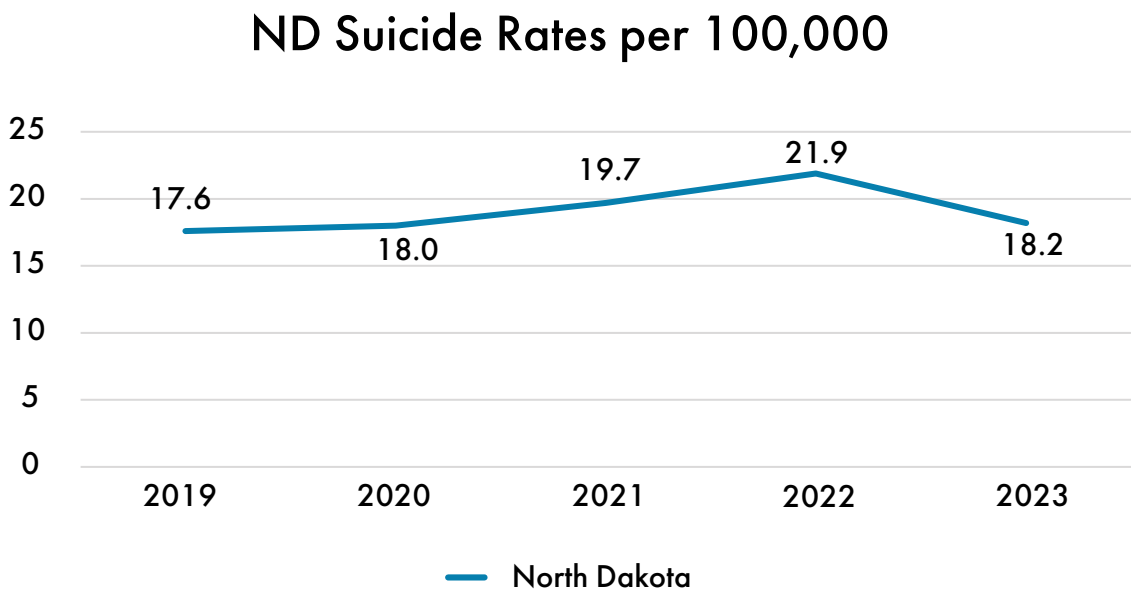


Figure 2 description: This line graph shows suicide rates in North Dakota per 100,000 residents by year. In 2019 the rate was 17.6 per 100,000. In 2020 the rate was 18.0 per 100,000. In 2021 the rate was 19.7 per 100,000. In 2022 the rate was 21.9 per 100,000, the highest of the annual rates during this period. In 2023 the rate was 18.2 per 100,000.

Some groups are at increased risk for suicide. In 2023, the incidence of male suicide deaths was more than 3.7 times that of females. Almost 79% of all suicide deaths in ND were male. Rates of male suicide in ND decreased by 1.1% from 28.4 per 100,000 in 2019 to 28.1 per 100,000 in 2023 and the rate of female suicide increased by 25.4% from 6.3 per 100,000 in 2019 to 7.9 per 100,000 in 2023.

Among the different racial and ethnic identities in ND, 83.8% of the suicide deaths in 2023 were among White, non-Hispanic residents. White, non-Hispanic residents make up the largest racial group in ND at 82.9% of the population. American Indian (AI)/Alaska Native (AN) individuals accounted for 9.2% of the total number of suicides in 2023. When looking at the rates to account for differences in population size, AI/AN had the highest rate of suicide at 33.4 per 100,000 compared to White, non-Hispanic individuals at 18.4 per 100,000.

Those aged 25-44 in ND had the highest proportion of suicides across all age groups. At 48.6%, 25–44-year-olds had the highest suicides by age group in 2020 comprising almost half of all deaths (Figure 3). The rate of suicide in the 65+year-old age group increased by 72.9% from 12.2 per 100,000 in 2019 to 21.1 per 100,000 in 2023.

Figure 3: Suicide by Age Groups, 2019-2023
Years that had missing age information were not included.

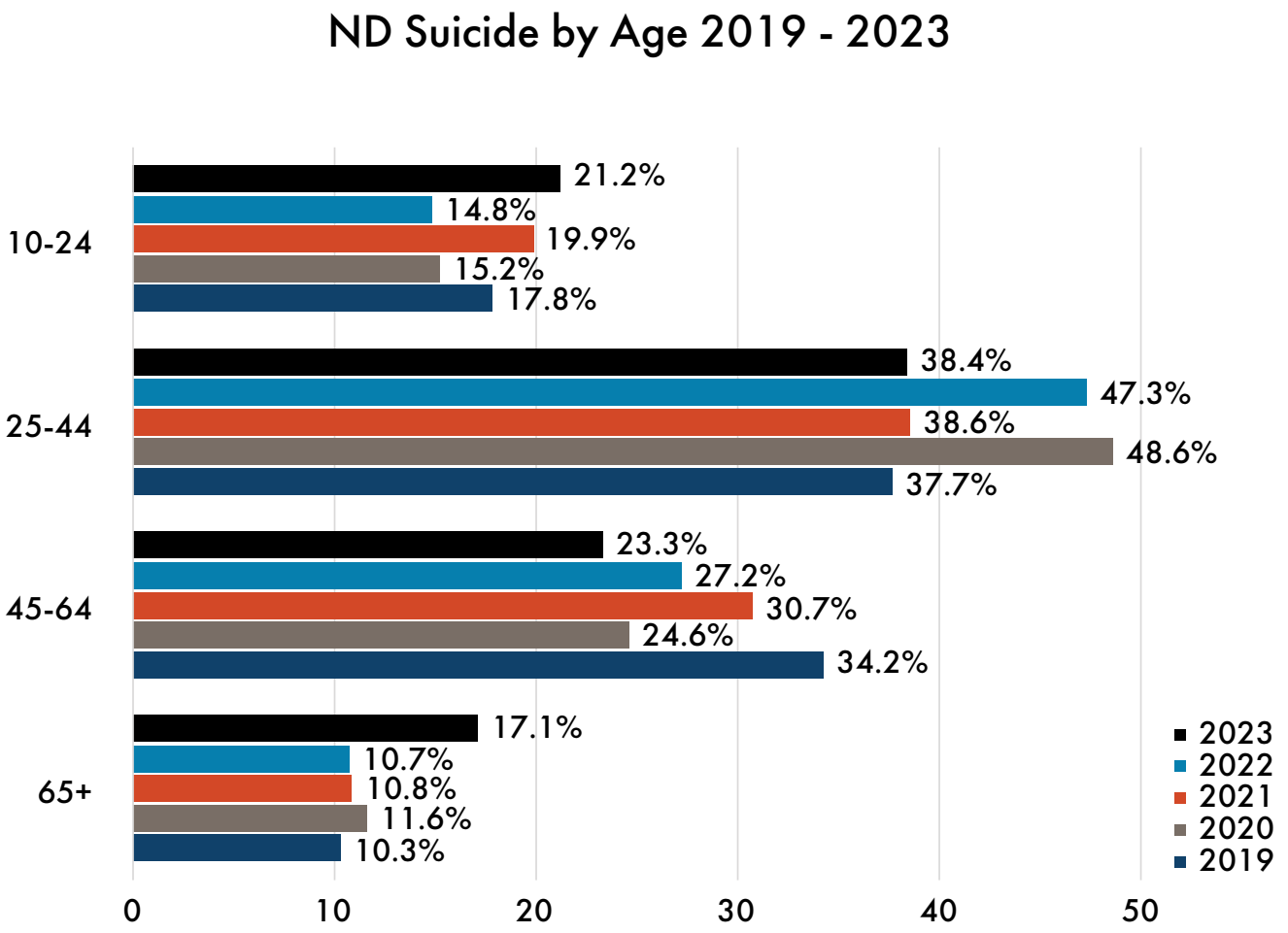


Figure 3 description: This bar graph shows suicide by age groups from 2019 to 2023. In 2019, 10- to 24-year-olds were 17.8%, 25- to 44-year-olds were 37.7%, 45- to 64-year-olds were 34.2% and 65 and older year olds were 10.3%. In 2020, 10- to 24-year-olds were 15.2%, 25- to 44-year-olds were 48.6%, 45- to 64-year-olds were 24.6% and 65 and older year olds were 11.6%. In 2021, 10- to 24-year-olds were 19.9%, 25- to 44-year-olds were 38.6%, 45- to 64-year-olds were 30.7% and 65 and older year olds were 10.8%. In 2022, 10- to 24-year-olds were 14.8%, 25- to 44-year-olds were 47.3%, 45- to 64-year-olds were 27.2% and 65 and older year olds were 10.7%. In 2023, 10- to 24-year-olds were 21.2%, 25- to 44-year-olds were 38.4%, 45- to 64-year-olds were 23.3% and 65 and older year olds were 17.1%.

## Method of Commission Review

1. The North Dakota Violent Death Reporting (NDVDR) Program provided a file containing a list of all suicide deaths in North Dakota that occurred between January 1, 2023 and December 31, 2023. Since ND already has a specific review board in place for child fatalities, the suicide death files were limited to adults, age 18 and older. A total of four to seven cases were reviewed by the Commission quarterly in 2025. Every effort was made to choose one to two cases from each quadrant of the state. For the 2023 review of suicide deaths, 21 cases were selected from the total number of 146 for in-depth review and discussion. This represents 14.4% of the suicide deaths that occurred in ND in 2023.
2. Case information is obtained from the North Dakota Violent Death Reporting (NDVDR) Program. The NDVDR Program collects information on suicides from death certificates, coroners/medical examiner reports, law enforcement reports, toxicology results, electronic health records, and ambulance run data. Chapter 23-07 of the North Dakota Century Code, relating to the creation of a Suicide Fatality Review Commission, provides the state Suicide Fatality Review Commission statutory authority to obtain relevant records for the purpose of suicide case reviews. Case narratives are created by the NDVDR Program team which contains demographic information, medical history, associated risk factors for suicide, and other relevant information for case reviews.
3. Cases are reviewed confidentially by the Commission to identify evidence-based suicide prevention recommendations. For each case, committee members rely on available documentation to determine systemic prevention opportunities.
4. Trends across cases are identified and analyzed to highlight the most frequently recommended suicide prevention strategies and to determine areas of intervention opportunities that could help prevent future suicide deaths.

## Limitations

The cases reviewed by the Commission are not representative of all suicide deaths that occurred in ND in 2023. Furthermore, thorough reviews were difficult to conduct on certain cases due to limited information contained in the coroner/medical examiner reports and law enforcement reports. Some of the decedents did not have any medical records or ambulance run data, which captures information on healthcare encounters and health status. Lastly, some risk factors, such as adverse childhood experiences, were not well documented in the records available and have a high proportion of missingness.

# Case Review Data

The data provided on pages 9-20 comes from the North Dakota Violent Death Reporting (NDVDR) Program. The numbers represent both ND residents and out-of-state residents where the initial injury causing the death occurred in ND. These numbers will not match Vital Records data because they are not based on ND residency.

## Demographics

Male suicide deaths composed 71.4% of the cases reviewed. White non-Hispanics comprised 76.2% of cases, followed by American Indian/Alaska Natives (19.0%), and Hispanics (9.5%). Most of the decedents (38.1%) were between the ages of 20-29. Approximately one-third of the cases had some college credit but no degree (33.3%). Just over half of cases had never been married (57.1%). Lastly, 14.3% were current or former military personnel (Figure 4).

Figure 4: Demographics of Cases Reviewed Compared to All 2023 ND Suicides

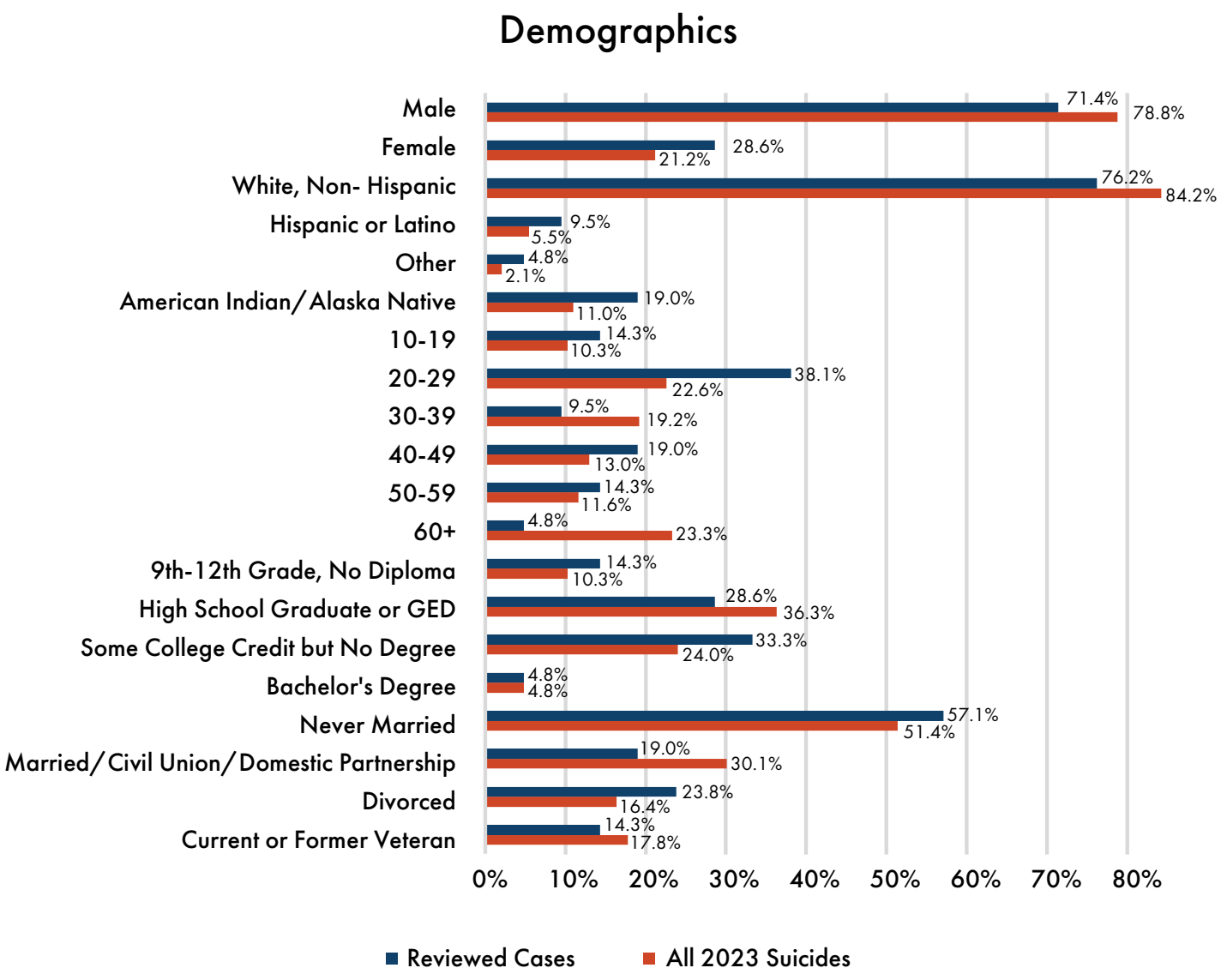

Figure 4 description: This bar graph compares demographics of reviewed cases and all suicide cases in 2023. Males made up 71.4% of reviewed cases and 78.8% of 2023 cases. Females made up 28.6% of reviewed cases and 21.2% of 2023 cases.

White, non-Hispanic individuals made up 76.2% of reviewed cases and 84.2% of 2023 cases. Hispanic or Latino individuals made up 9.5% of reviewed cases and 5.5% of 2023 cases. Other race groups made up 4.8% of reviewed cases and 2.1% of 2023 cases. American Indian and Alaska Native individuals made up 19.0% of reviewed cases and 11.0% of 2023 cases.

10 to 19 year olds made up 14.3% of reviewed cases and 10.3% of 2023 cases. 20 to 29 year olds made up 38.1% of reviewed cases and 22.6% of 2023 cases. 30 to 39 year olds made up 9.5% of reviewed cases and 19.2% of 2023 cases. 40 to 49 year olds made up 19.0% of reviewed cases and 13.0% of 2023 cases. 50 to 59 year olds made up 14.3% of reviewed cases and 11.6% of 2023 cases. 60 plus year olds made up 14.3% of reviewed cases and 10.3% of 2023 cases.

Individuals with 9-12th grade education with no diploma made up 14.3% of reviewed cases and 10.3% of 2023 cases. Individuals with a high school degree or GED made up 28.6% of reviewed cases and 36.3% of 2023 cases. Individuals with some college credit but no degree made up 33.3% of reviewed cases and 24.0% of 2023 cases. Individuals with a bachelor's degree made up 4.8% of reviewed cases and 4.8% of 2023 cases.

Individuals who were never married made up 57.1% of reviewed cases and 51.4% of 2023 cases. Individuals who were married, in a civil union, or domestic partnership made up 19.0% of reviewed cases and 30.1% of 2023 cases. Individuals who were divorced made up 23.8% of reviewed cases and 16.4% of 2023 cases. Individuals who were current or former veterans made up 14.3% of reviewed cases and 17.8% of 2023 cases.

## Incident Details

Among the suicide deaths reviewed by the Commission, firearms were involved in over half of cases (57.1%), followed by hanging, strangulation, or suffocation (23.8%). (Figure 5). Among suicide deaths involving a firearm, 66.7% used a handgun. Documentation showed that among the firearm suicide deaths, about 33.3% were stored loaded and 41.7% were not locked.

Figure 5: Method Type Used in the Cases Reviewed Compared to All 2023 ND Suicides.

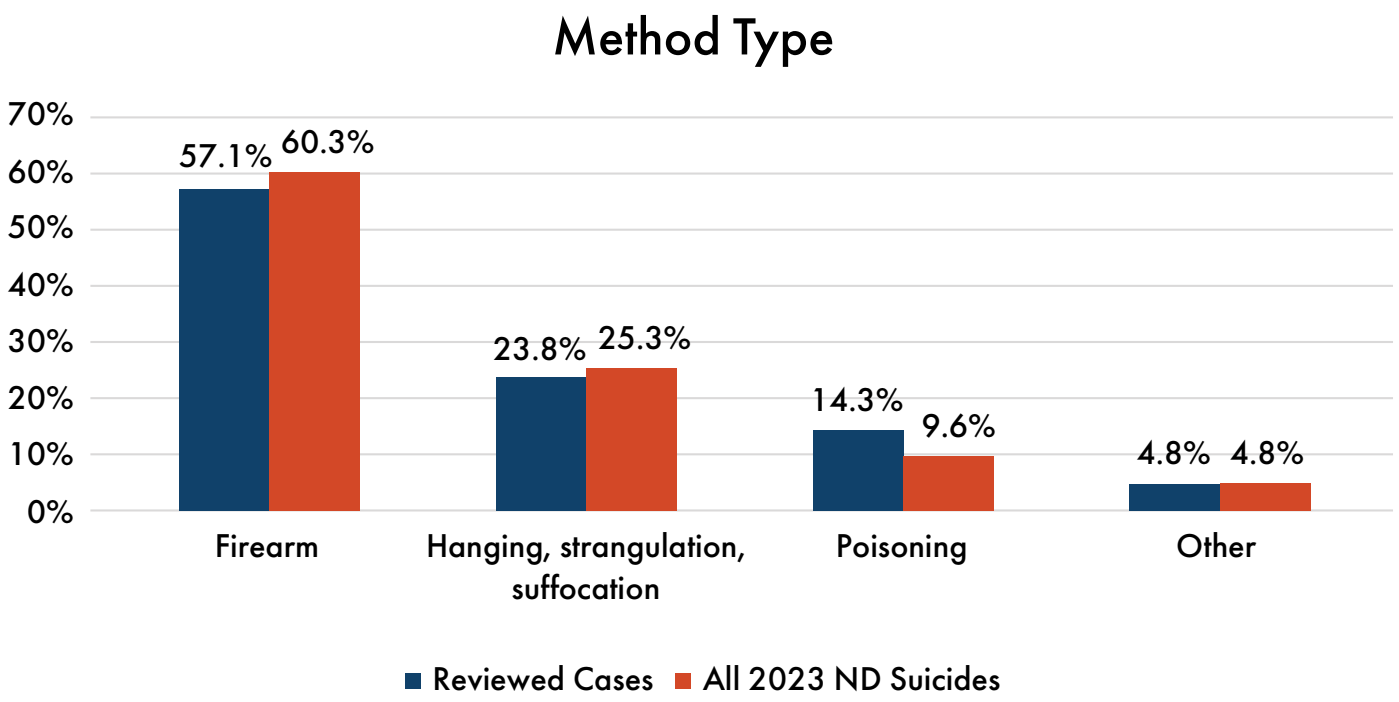


Figure 5 description: This bar graph compares weapon fatality types in 2023. Firearm fatalities made up 57.1% of the reviewed cases and 60.3% of 2023 cases. Hanging, strangulation and suffocation fatalities made up 23.8% of the reviewed cases and 25.3% of 2023 cases. Poisoning fatalities made up 14.3% of the reviewed cases and 9.6% of 2023 cases. Other fatalities made up 4.8% of the reviewed cases and 4.8% of 2023 cases.

## Physical Health

One in three (33.3%) of the cases reviewed had documentation of at least one contributing physical health problem. Among the documented physical health problems, other illnesses were the most prevalent (71.4%), followed by chronic pain (42.8%). Approximately one-third (38.1%) had a health care encounter within 30 days of their death and 23.8% of the cases had encounters occurring between one and six months prior to death. Additionally, 14.3% of the cases had been diagnosed with COVID-19 just prior to or at the time of their death.

## Behavioral Health History

Two-thirds (66.7%) of all reviewed cases had documentation of a mental health problem. The mental health problem identified most often was depression/dysthymia at 92.9% followed by anxiety disorder at 64.3% (Figure 6). Over three-quarters (81.0%) of the reviewed cases had reportedly been in a depressed mood leading up to their death. Less than half (42.9%) of the reviewed cases were currently in mental health/substance use treatment and over half (57.1%) had received treatment for mental health or substance use problems at some point in their lives.

Figure 6: Mental Health Problem Reported in Cases Reviewed Compared to All 2023 ND Suicides.

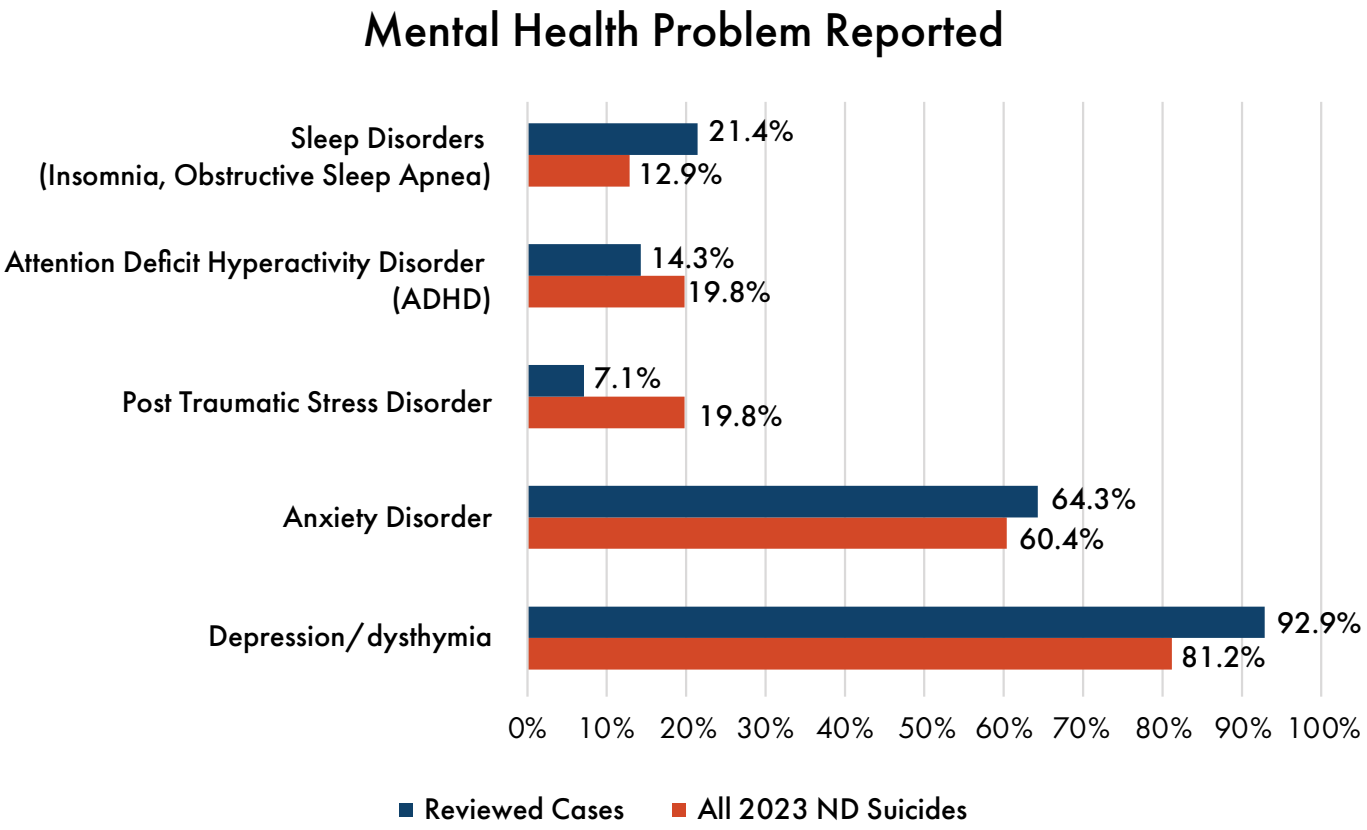


Figure 6 description: This bar graph shows mental health problems reported among reviewed cases and all 2023 cases. Individuals with diagnosed sleep disorders made up 21.4% of reviewed cases and 12.9% of 2023 suicides. Individuals with diagnosed attention deficit hyperactivity disorder made up 14.3% of reviewed cases and 19.8% of 2023 suicides. Individuals with diagnosed post-traumatic stress disorder made up 7.1% of reviewed cases and 19.8% of suicides. Individuals with diagnosed anxiety disorders made up 64.3% of reviewed cases and 60.4% of 2023 suicides. Individuals with diagnosed depression or dysthymia made up 92.9% of reviewed cases and 81.2% of 2023 suicides.

Notably, over a quarter of the reviewed cases had documentation of a prior suicide attempt (28.6%) and over half (57.1%) had documentation of suicidal thoughts or plans at some point in their life. Over half (57.1%) of the reviewed cases disclosed intent to die by suicide and of those who disclosed intent, the most prevalent disclosures were made to a friend/colleague at 41.7% followed by other family members at 25.0%. Also, 33.3% of the reviewed cases had left a handwritten or electronic suicide note at the scene.

## Substance Use History

The use of substances, including alcohol, continues to play a role in suicides. Out of the 146 suicides in 2023, 44.4% had alcohol in their system. One in three of the reviewed cases had a documented alcohol problem (38.9%) and/or other substance use problem (33.3%). An alcohol problem is defined by NDVDR as a person having alcohol dependence including cases where the individual was perceived by self and others to have a problem with, or to be addicted to, alcohol. It also includes individuals that were participating in an alcohol rehabilitation program or treatment. Other substance use is defined by NDVDR as a person having non-alcohol related substance misuse problems including cases where the individual was perceived by self and others to have a problem with, or to be addicted to, drugs other than alcohol. It also includes individuals that were participating in a drug rehabilitation program or treatment. Toxicology analysis was conducted on (88.9%) of the cases and almost all of those analyzed had at least one drug in their system at the time of death (93.8%), which includes alcohol at 27.8%. The toxicology results include both prescribed and/or illicit drugs (Figure 7).

Figure 7: Toxicology Present in Cases Reviewed Compared to All 2023 ND Suicides

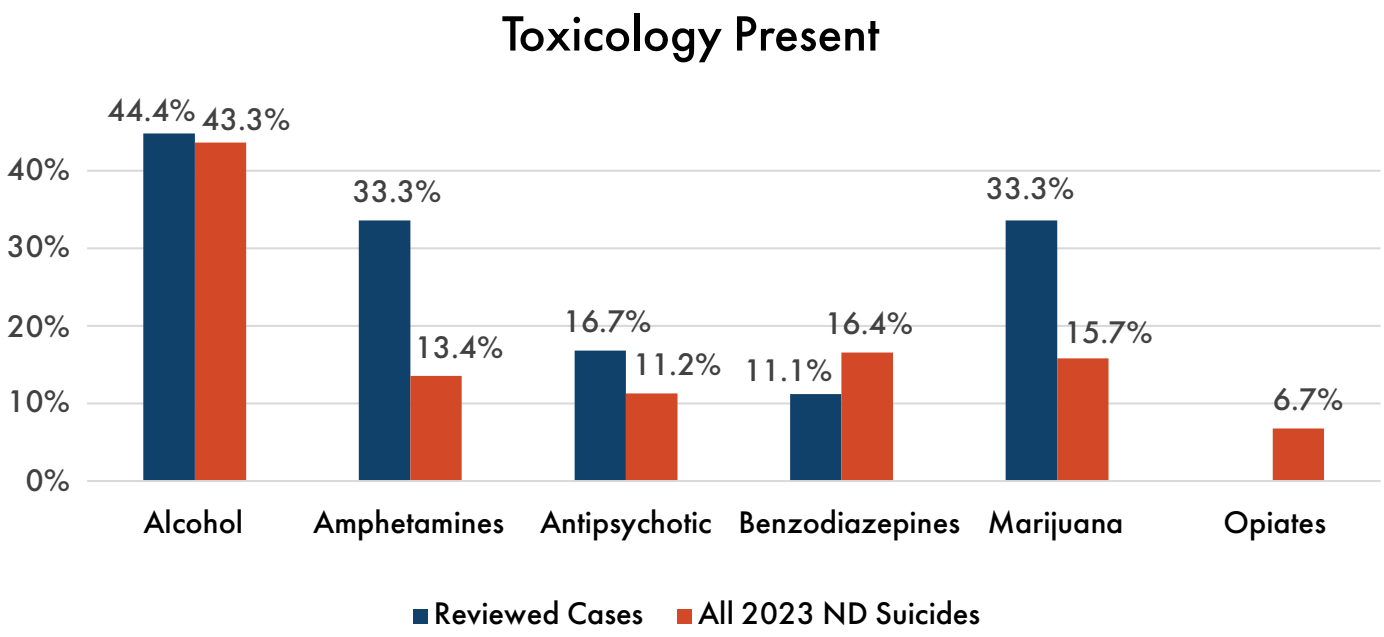


Figure 7 description: This bar graph shows toxicology results present among reviewed cases and all 2023 cases. Individuals with alcohol present made up 44.4% of reviewed cases and 43.3% of 2023 suicides. Individuals with amphetamines present made up 33.3% of reviewed cases and 13.4% of 2023 suicides. Individuals with antipsychotics present made up 16.7% of reviewed cases and 11.2% of 2023 suicides. Individuals with benzodiazepines present made up 11.1% of reviewed cases and 16.4% of 2023 suicides. Individuals with marijuana present made up 33.3% of reviewed cases and 15.7% of 2023 suicides. Individuals with opiates present made up 0% of reviewed cases and 6.7% of 2023 suicides.

## Life Stressors

The SFRC continues to note patterns that emerge in North Dakota suicide deaths through the fatality review process. The following perceived crisis events or adverse life-altering circumstances leading up to death have been identified in multiple cases reviewed including a sudden end or perceived change in a relationship, a pending or unwanted change in employment, the potential of or pending legal consequences, and pending foreclosure/eviction. Significant sleep disruption and experiencing chronic pain or a diagnosed terminal illness are also things the SFRC sees regularly in death review cases.

Over a third (38.1%) of the reviewed cases had documentation of intimate partner problems (e.g., divorce, separation, infidelity, etc.) and a quarter (28.6%) had family relationship problems (e.g., family discord). In 19.0% of the reviewed cases, the individuals had an argument or conflict preceding their death. Other stressors identified were contributing criminal legal problems (14.3%) and civil legal problems (4.8%). One-third (33.3%) of the reviewed cases were experiencing job problems and over a quarter (28.6%) of cases were experiencing financial problems. Almost one-fifth (19.0%) of the reviewed cases were experiencing a recent eviction or loss of home.

# Commission Recommendations and Case Discussion

## Health Care

1. **Improve access to appropriate behavioral health care services and maximize the opportunity to intervene by:**
   a. Implementing screenings earlier for individuals at an increased risk of suicide, at the primary care and emergency department level.
   b. Increasing collaboration with and education provided by Local Public Health nurses.
      - Strengthening suicide risk screening, promoting safe weapon storage and enhancing overall lethal means safety practices.
   c. Providing additional training for family and loved ones as part of behavioral health treatment.
   d. Improving coordination between providers through the use of shared medical records.
   e. Increasing community awareness of support organizations that can assist during immediate crisis and throughout recovery.
   f. Establish care-coordination systems within medical settings to ensure timely follow-up, monitoring, and connection to ongoing suicide-prevention supports for individuals at increased risk.
   g. Coordinating treatment plans for individuals with multiple diagnoses.

2. **Increase the use of the Suicide Care Pathway across all health systems, as recommended by the 2024 National Strategy for Suicide Prevention, by ensuring it is integrated into electronic health records and identifiable across systems by:**
   a. Improving emergency department and inpatient hospital discharge practices following a suicide attempt or suicidal ideation crisis by establishing and implementing formalized follow-up protocols and case management. Currently, follow-up support is offered through FirstLink with referrals to their Care and Support Program.
   b. Increasing clinician education on both suicide prevention and postvention practices.

3. **Implement best practices for suicide prevention in health care systems e.g., the Zero Suicide framework by:**
   a. Providing Counseling on Access to Lethal Means (CALM) training for all health care providers and pharmacists.
   b. Implementing evidence-based care for suicide prevention such as Brief Cognitive Behavioral Therapy.
   c. Improving quality of care patients receive through routine suicide risk screening and the use of CALM interventions.
   d. Expanding pharmacy-level interventions, including gatekeeper training for pharmacists and safer prescribing practices for individuals with a known history of suicide risk to reduce access to lethal means.
   e. Increasing interventions for patients and families affected by chronic/terminal illnesses through collaboration with ND Medical Association, American Academy of Pediatrics, American Academy of Family Physicians and other associations and professional groups as appropriate.

4. **Increase access to remote mental health management resources—including telehealth therapy, psychiatry, addiction support services, virtual support groups, and peer support—to address the needs of individuals experiencing:**
   a. Grief and loss following miscarriage.
   b. Emotional and psychological distress following tumor removal or other significant surgical procedures.
   c. Adjustment and coping challenges following a recent cancer diagnosis.
   d. Chronic pain.
   e. Ongoing mental health needs related to long-term medical conditions or prognoses (e.g., ulcerative colitis, diabetes).

5. **Increase access to care for substance use disorder.**

6. **Increase provider education on concussion and head injury as risk factors for suicide; expand suicide risk screening during routine appointments, such as sports physicals; and ensure all concussions and head injuries are consistently documented in medical records.**

7. **Improve competency by increasing training for health care staff to better screen individuals struggling with mental health issues by implementing automatic usage of the Columbia-Suicide Severity Rating Scale (C-SSRS) screening tool, providing 988/counseling on access to lethal means safety/suicide prevention within:**
   a. Emergency Departments.
   b. Patients struggling with chronic pain.
   c. Patients struggling with insomnia (trouble sleeping).
   d. Patients with known substance use disorders and/or substance misuse.
   e. Patients who have recently had a substantial change in health for known/unknown reasons (surgery, ongoing medical prognosis, terminal illness diagnosis).
   f. Patients recently experiencing a miscarriage.

## Criminal Justice/Legal System

1. **Create or improve standards of care within the criminal justice system by improving care coordination post-release by:**
   a. Implementing warm hand-offs to behavioral health treatment and/or peer support.
      - Requiring collaborative safety planning as a standard practice for individuals while in custody and prior to discharge or release.
   b. Implementing targeted interventions for high-risk populations, such as an opt-out model for therapy as a condition of probation.

2. **Increase intervention for individuals involved with the legal system by increasing trainings on evidence-based suicide prevention practices, including safety planning, the Columbia-Suicide Severity Rating Scale (C-SSRS) screening, and enhancing suicide prevention awareness with gatekeeper trainings among professionals within the criminal justice and legal system including but not limited to:**
   a. Department of Corrections and Rehabilitation (DOCR) staff
   b. Attorneys and Public Defenders
   c. Public Safety Telecommunicators (PSTs)

3. **Improve the quality and consistency of welfare checks by requiring the use of the Columbia–Suicide Severity Rating Scale (C-SSRS) when contact is made with individuals identified as being at risk of suicide.**

## Crisis Response

1. **Increase the use of the State-Operated Behavioral Health Clinic mobile crisis response across North Dakota by:**
   a. Analyzing current utilization rates across regions.
   b. Examining response practices, including when services are provided in person versus by phone.

2. **Increase access to appropriate mental health/substance use services (e.g. transport, referral to treatment).**

3. **Increase training on evidence-based suicide risk screening using the Columbia–Suicide Severity Rating Scale (C-SSRS) and on crisis care for first responders, including Emergency Medical Services (EMS), fire personnel, law enforcement, and Public Safety Telecommunicators (PSTs).**

4. **Develop and implement standardized protocols for warm hand-offs within the State-Operated Behavioral Health Clinics and between the State-Operated Behavioral Health Clinics and outpatient care providers.**

5. **Expand the use of peer support professionals with lived experience related to suicide to provide direct, meaningful connection and support to individuals at risk.**

## Community

1. **Increase protective factors for all North Dakota citizens within the communities where they live, work, and play by:**
   a. Improving access to social support resources, including housing, employment, transportation, food assistance, and rental assistance.
   b. Improving social connectedness at the community level.
   c. Increasing education and awareness of population-based mental health and wellness resources.
   d. Promoting the importance of parental time, access to resources and conflict resolution skills to support family well-being.
   e. Encouraging regular engagement with nature as a protective factor.
   f. Increasing understanding in how social determinants of health play a role in overall behavioral health and suicide risk.
   g. Providing 211 and 988 information in informational packets distributed through veterinary services following the loss of a pet, and increasing referrals to and use of FirstLink's Care and Support Program after pet loss.
   h. Providing 211 and 988 information in informational packets as part of foreclosure and eviction processes.

i. Expanding collaboration with faith-based organizations to support community mental health and well-being.
j. Increasing awareness of the needs of New American families and improving access to resources.

**2. Implement Multi-Tiered System of Supports - Behavioral Health School Integration (MTSS B) statewide within schools as part of an overall goal of prevention.**

a. Implementing Multi-Tiered System of Supports - Behavioral Health School Integration (MTSS B) statewide within schools as part of an overall prevention goal
   - Tier 1: in the classroom; high quality instruction
   - Tier 2: outside support; counselor, academic intervention
   - Tier 3: more intense support; social workers, community supports, therapist/counselor

**3. Reduce access to lethal means among individuals at acute risk of suicide by promoting the safe storage of medications, firearms, and other potentially lethal household items by:**

a. Increasing availability and knowledge of how to access gun safety courses, which cover safe handling, safe usage, safe cleaning and storage, malfunction, alcohol and handling a firearm, locking firearms.
b. Expanding safe storage messaging, including education on the risks associated with firearm access during periods of substance use or acute crisis, and information on how to access firearm safety training.
c. Include educational materials on suicide prevention and the 988 Suicide & Crisis Lifeline with all firearm purchases through retailers, and explore the feasibility of incorporating suicide risk screening (e.g., C-SSRS) at the point of purchase.
d. Develop and disseminate Parents Lead educational materials on firearm safety in coordination with firearm safety courses to ensure age-appropriate and accurate information.
e. Increasing opportunities for pharmacists and clinicians to support overdose prevention and reduce access to lethal means. Examples include blister pack medications and prescribing or dispensing lower quantities of medications for individuals at elevated suicide risk.
f. Increasing medication take-back including permanent kiosks, mail-back envelopes, rural drop-off sites, regular "clean-out your meds" campaigns.
g. Increase seasonal and targeted media messaging (e.g., during hunting season) to promote firearm locking and safe storage practices.
h. Addressing the relationship between intoxication, impulsivity and firearm access through community education and public messaging.

**4. Integrate behavioral health services and supports in the workplace by:**

a. Establishing workplace suicide prevention interventions when drug or alcohol testing is required.
b. Increasing employer education and awareness on suicide prevention and mental health to support all employees.
c. Enhancing training for Human Resources staff and managers/supervisors on responding to heightened emotional distress during disciplinary or corrective actions.
d. Providing 211 and 988 information in informational packets during layoffs, terminations, or other job-loss circumstances.
e. Implementing suicide prevention gatekeeper training for Human Resource teams.
f. Reducing punitive or stigmatizing consequences for employees who seek mental health assistance or support.
g. Expanding education on Employee Assistance Program (EAP) services to help decrease family stress and improve family and home dynamics.
h. Normalizing and increasing mental health support for first responders.

**5. Increase gatekeeper training for community and families to help identify individuals who may be at risk of suicide and how to respond effectively by:**

a. Educating on the importance of safety planning.

b. Increasing knowledge about those who may be at increased risk such as a sudden or perceived change in an important relationship or a change in life circumstances.
c. Expanding education and awareness of population-based mental health and wellness resources, with particular emphasis on reaching youth during times when they may be disconnected from school supports, such as long breaks, summer and holiday periods, and weekends.

**6. Increase early intervention by reducing stigma and promoting help-seeking behavior that support suicide prevention by:**

a. Expand public health messaging on mental health, suicide prevention, the 988 Suicide & Crisis Lifeline, stigma reduction, recognizing warning signs, and knowing how and when to seek help.
b. Utilizing employer and employee testimonials to normalize help-seeking and encourage early outreach for support.
c. Implementing seasonal and time-specific messaging during periods when stressors may be less visible, such as back-to-school transitions, holiday breaks, and the end of the school year.
d. Developing targeted suicide prevention messaging for community service sectors, including internet service providers and other essential services.
e. Increasing public health messaging on concussions/head injury as an increased risk factor for suicide.
f. Providing clearer and more explicit messaging about what constitutes a crisis, including financial distress, changes in family dynamics, and housing instability due to eviction or foreclosure.
g. Increasing public awareness/knowledge of suicide risk for those with chronic pain, chronic sleep disturbance/lack of sleep.
h. Expanding upstream prevention efforts in partnership with business and industry, including workplace mental health education and training.
i. Strengthening collaboration with faith-based organizations to support community-wide prevention efforts.
j. Developing stronger statewide awareness of the needs of New American families and improve access to resources.

**7. Improve access to postvention services, including support for individuals bereaved by suicide and survivors of suicide attempts, such as family members, first responders (sudden or perceived change in an important relationship and law enforcement), clinicians, train conductors, coworkers, and others affected, by:**

a. Providing timely and accessible postvention resources following a suicide death or attempt within a community.
    - Increase usage of existing resources that schools can provide for children and youth who have lost a family member or experienced witnessed trauma, struggling with witnessed trauma including but not limited to the Handle with Care Program through Families Flourish ND.
b. Strengthening follow-up and ongoing support for survivors during the first year following the death of a loved one by increasing utilization of FirstLink's Care and Support Program, the American Foundation for Suicide Prevention's Healing Conversations, or by implementing a community-based suicide postvention response model such as a Local Outreach to Suicide Survivors (LOSS) Team. LOSS is a national postvention model that provides immediate, peer-based support to people bereaved by suicide, helping them connect with resources, community, and hope.
c. Increasing the use of the State-Operated Behavioral Health Clinic's Mobile Crisis Teams following a suicide-related event to support affected families and individuals.

**8. Improve death investigation in North Dakota by:**

a. Increasing knowledge and use of the Suicide Critical Risk Assessment Profile (SCRAP) form among coronors, death investigators, and law enforcement officers investigators and law enforcement officers to enhance available information that will better inform future recommendations.
    - Additional information necessary for fatality review regarding Adverse Childhood Experiences (ACEs) including abuse and trauma history even if decedent is an adult.

- Additional information necessary for fatality review from families on things such as Fetal Alcohol Syndrome (FAS), head trauma (concussions, traumatic brain injuries).
- Additional information on the decedent's behavioral health treatment and therapy history, when appropriate.
- Additional discussion with employer.

b. Providing education to coroners/death investigators on importance of a thorough investigation and how the information is used by the Suicide Fatality Review Commission used by the North Dakota Suicide Fatality Review.
c. Increasing connection between coroners/death investigators and on-scene Emergency Medical Services (EMS) involved.
d. Enhancing postvention support for family members by ensuring coroners and death investigators provide information on available resources and services following a death.
e. Improving death notification practices for health care providers involved in the individual's care.
f. Increasing the presence or availability of supportive professionals—such as chaplains, therapists, or mobile crisis teams—at death scenes when appropriate.

## Conclusion

The North Dakota Suicide Fatality Review Commission successfully met its goal to complete thorough case reviews of a sample of suicide deaths that occurred in North Dakota in 2023 (21/146 suicide deaths) to identify evidence-based prevention measures.

The Commission's findings highlight a broad range of prevention strategies, including reducing access to lethal means; improving access to suicide loss and suicide attempt survivor support services; expanding gatekeeper training for community members; strengthening social connectedness; reducing stigma and promoting help-seeking behavior; enhancing resource provision for individuals at risk regardless of suicide risk assessment outcomes; increasing training for health care providers to improve the identification and treatment of depression; expanding access to appropriate behavioral health services; and improving access to essential social supports such as housing.

Moving forward, the Commission plans to incorporate analysis of epidemiologic trends provided by the North Dakota Violent Death Reporting (NDVDR) Program across all suicide deaths in North Dakota, in conjunction with ongoing in-depth case reviews, to further inform statewide suicide prevention efforts.

For additional information on Suicide Prevention in North Dakota, visit www.hhs.nd.gov/behavioral-health/prevention/suicide

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