Health & Human Services

North Dakota Suicide Fatality Review Commission

2024 Annual Report

Table of Contents

ACKNOWLEDGEMENTS 3

INTRODUCTION and PURPOSE 5

BACKGROUND 6

METHOD OF COMMISSION REVIEW and LIMITATIONS 8

CASE REVIEW DATA 9

COMMISSION CASE DISCUSSION 13

COMMISSION RECOMMENDATIONS 17

CONCLUSION 19

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 North Dakota Health and Human Services (HHS)Commissioner and include:

- Adriane Knightstep, Disease Control & Forensic Pathology, State Forensic Examiner's Office, HHS
- Brad Hawk, Indian Health Systems Administrator, North Dakota Indian Affairs Office
- Daniel Cramer, Ph.D,. Clinical Director, Regional Human Service Centers
- Jennifer Illich, Executive Director, FirstLink
- John Klug, Chief of Police, Minot Police Department
- Jon Ulven, Ph.D., L.P., Sanford Behavioral Health Fargo
- Kriste Ross, Cass County Coroner's Office
- Kodi Pinks, MPH, Surveillance & Data Management Director, Health Statistics & Performance, HHS
- *Melissa Markegard, MS, CHES, Suicide Prevention Administrator, HHS
- Russ Riehl, Principal, Simle Middle School, Bismarck Public Schools
- Samantha Christopherson, Executive Director, American Foundation of Suicide Prevention
- Sarah Kemp Tabbut, LCSW, Fargo VA Health Care System
- Susan Roe, MD, Clinical Professor of Pathology, University of North Dakota
- Rep. Todd Porter, Owner, Metro-Area Ambulance Service, Inc.

*denotes Commission Coordinator/Presiding Officer

Data

- Kodi Pinks, MPH, Surveillance & Data Management Director, Health Statistics & Performance, HHS
- Tara Haugen, Lead Data Abstractor, Health Statistics & Performance, HHS
- Olivia Persinger, MPH, Epidemiologist, Health Statistics & Performance, HHS

Editors

- Melissa Markegard, MS, CHES, Suicide Prevention Administrator, Behavioral Health Division, HHS
- Laura Anderson - Policy Director, Behavioral Health Division, HHS
- Kodi Pinks, MPH, Surveillance & Data Management, Director Health Statistics & Performance, HHS
- Tracy K. Miller, PhD, MPH, State Epidemiologist, Health Statistics & Performance Section Director, HHS

INTRODUCTION/PURPOSE

During the 2023 legislative session, Gov. 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 North Dakota Health and Human Services (HHS) 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 HHS Commissioner to be incorporated into statewide suicide prevention efforts/ strategies.

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 2024.

BACKGROUND
Suicide in North Dakota

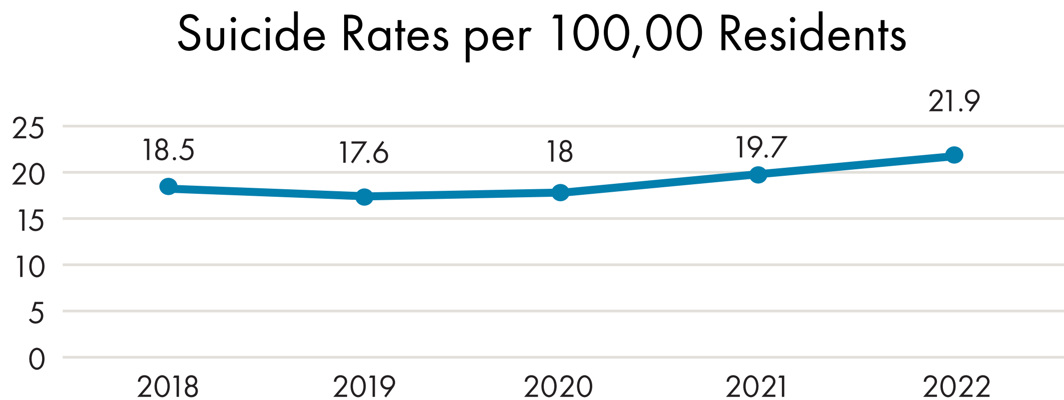
According to the HHS' Vital Records, in 2022, suicide was the ninth leading cause of death in the state, with 171 deaths and a crude death rate of 21.9 per 100,000 residents (Figure 1). Rates were calculated using 2020 Census figures.

Figure 1: Top 10 Leading Causes of Death in North Dakota (ND) in 2022

Leading Causes of Death	Crude death rate per 100,000 Residents
Heart Disease	195.7
Cancer	154.9
Accidents	57.4
Alzheimer's Disease	48.5
Stroke	40.6
COVID-19	40.4
Chronic Lower Respiratory Diseases	39.3
Diabetes	28.2
Suicide	21.9
Chronic Liver Disease/Cirrhosis	18.0

The rate of suicide in ND increased from 18.5 per 100,000 in 2018 to 21.9 per 100,000 in 2022, which is a 27.6% increase (Figure 2).

Figure 2: Suicide rates, 2018-2022

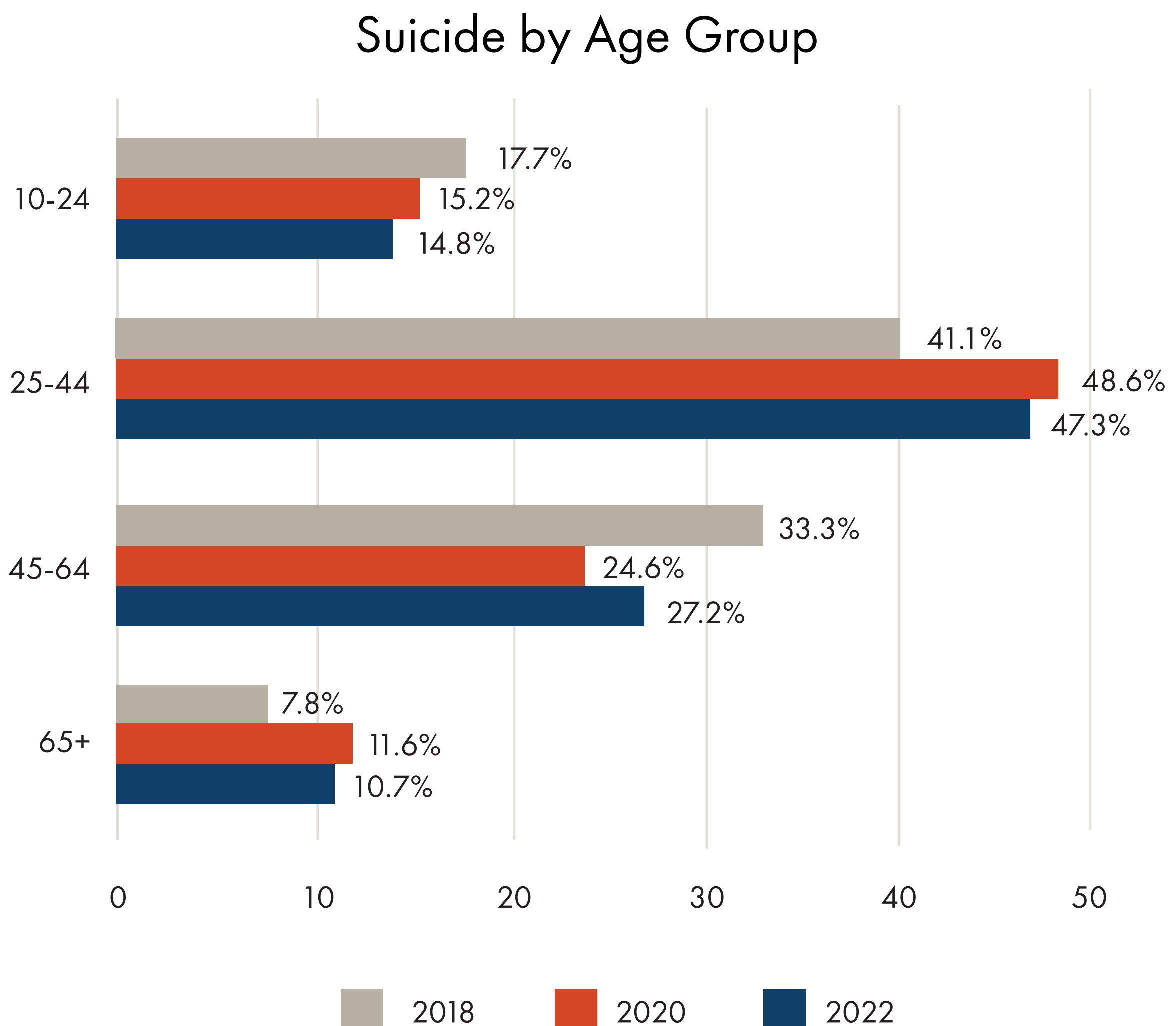


Some groups are at increased risk for suicide. In 2022, the incidence of male suicide deaths was six times that of females in ND. Almost 85% of all suicide deaths in ND were male. Rates of male suicide in ND increased by 33.1% from 27.8 per 100,000 to 37.0 per 100,000 and the rate of female suicide decreased by 33.7% from 9.2 per 100,000 to 6.1 per 100,000.

Among the different racial and ethnic identities in ND, nearly 88% of the suicide deaths in 2022 were among non-Hispanic White residents. Non-Hispanic White residents make up the largest racial group in ND at 82% of the population. American Indian (AI)/Alaskan Native (AN) individuals accounted for 7.1% of the total number of suicides in 2022, and when looking at the rates to account for differences in population size, AI/AN had the highest rate of suicide at 37.7 per 100,000 compared to non-Hispanic Whites at 23.5 per 100,000.

Those aged 25 - 44 in ND had the highest proportion of suicides in 2022 with almost half of the deaths at 46.8%, followed by the 45 - 64-year-olds at 26.9%, 10 - 24-year-olds at 14.6%, and those aged 65 and older at 10.5% (Figure 3). The rate of suicide in the 25 - 44-year-old age group increased by 28.5% from 28.4 per 100,000 in 2018 to 36.5 per 100,000 in 2022.

Figure 3: Suicide by age groups, 2018-2022



METHOD OF COMMISSION REVIEW

1. North Dakota has a specific review board in place for child fatalities, so reviewed cases are limited to adults, age 18 and older. A total of four to six cases were reviewed by the Commission, quarterly. Every effort was made to choose one to two cases from each quadrant of the state. For the 2022 review of suicide deaths, a total of 18 cases were selected from the total number of 184 for in-depth review and discussion. This represents 9.8% of the suicide deaths that occurred in ND in 2022.

2. Case information is obtained from the 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 contain demographic information, medical history, associated risk factors for suicide, and other relevant information for case reviews.

3. Cases are reviewed confidentially by the Commission and evidence-based prevention recommendations are identified. For each case, committee members rely on the available documentation to determine systemic recommendations for suicide prevention.

4. Trends among the cases are highlighted and identified, allowing analysis of the most frequently recommended suicide prevention strategies and the ability to determine areas of missed opportunities for intervention to prevent future suicide deaths.

LIMITATIONS

The cases reviewed by the Commission are not representative of all suicide deaths that occurred in ND in 2022. 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 health care encounters and health status. Lastly, some risk factors, such as sexual orientation and adverse childhood experiences, were not well documented in the records available and have a high proportion of missingness.

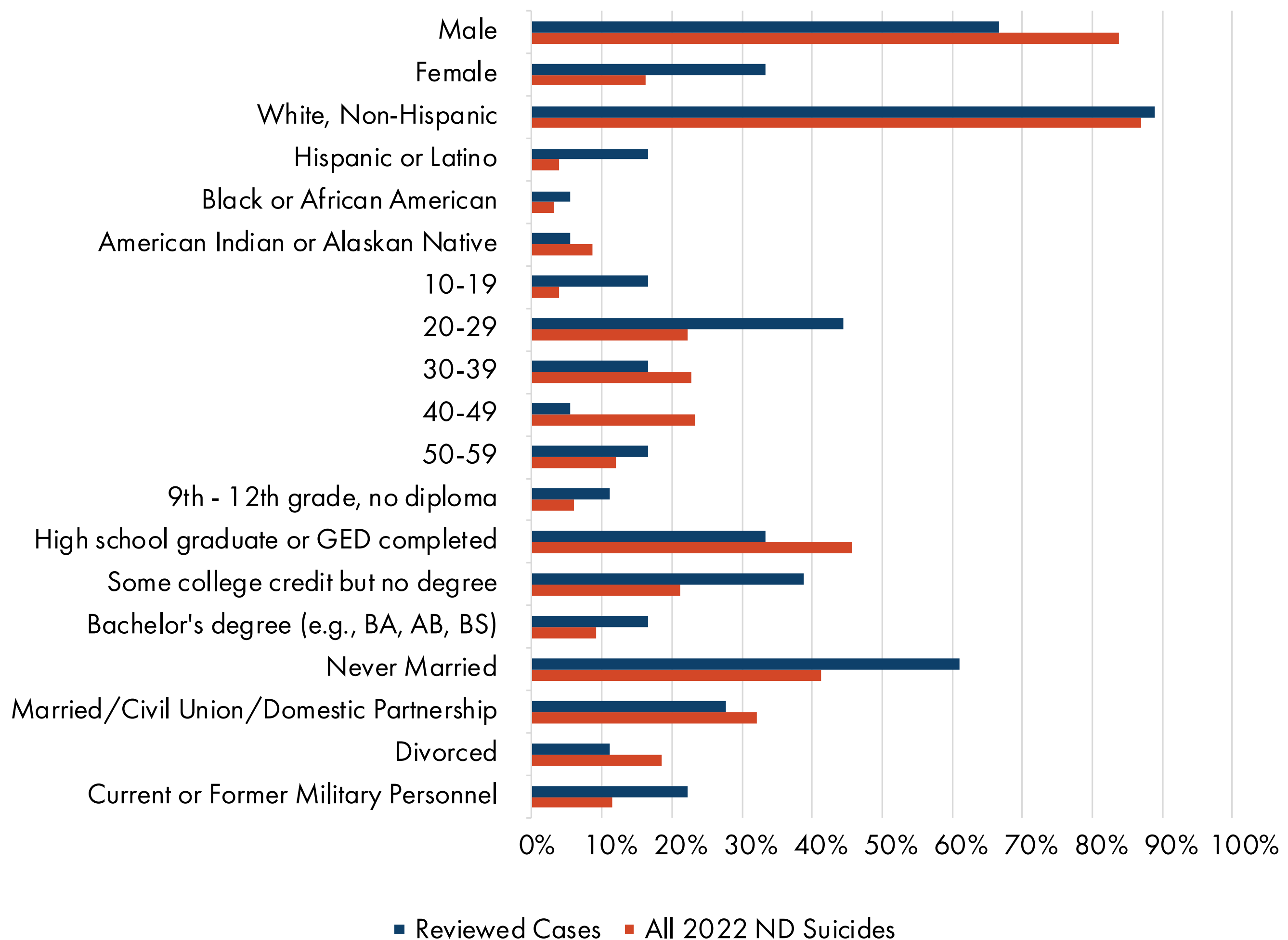
CASE REVIEW DATA

The data provided in the rest of this report comes from the 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 it's not based on ND residency.

Demographics

Male suicide deaths composed 66.7% of the cases reviewed. White non-Hispanics comprised 83.3% of cases, followed by Hispanics (16.7%), African American/Black (5.6%), and American Indian/Alaska Natives (5.6%). Most of the decedents (44.4%) were between the ages of 20-29. Approximately one-third of the cases had some college credit but no degree (38.9%). Just over half of cases had never been married (61.1%). Lastly, almost a quarter of selected cases (22.2%) were Current or Former Military Personnel (Figure 4).

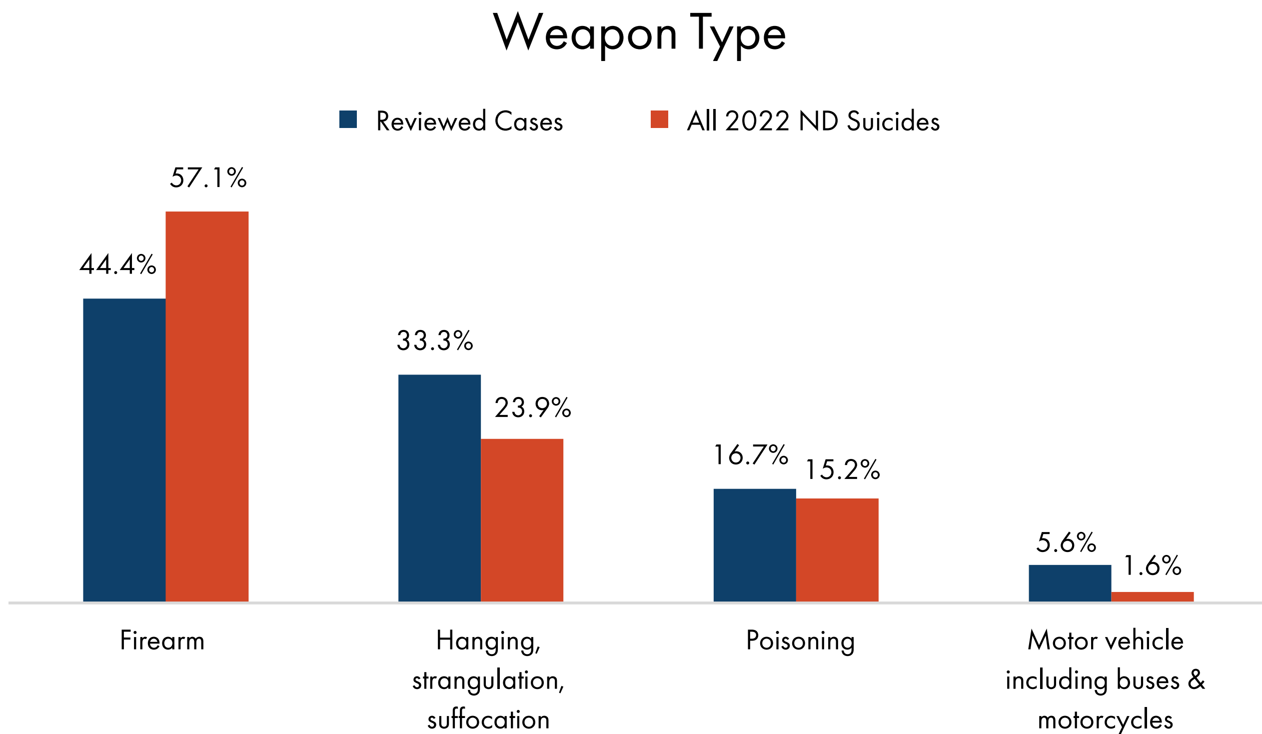
Figure 4: Demographics of cases reviewed compared to all 2022 ND Suicides



Incident Details

Of the suicide deaths reviewed by the Commission, nearly half (44.4%) were completed using a firearm, followed by hanging, strangulation and suffocation (33.3%) (Figure 5). Among suicide deaths involving a firearm, 87.5% used a handgun. Documentation showed that among the firearm suicide deaths, about 50.0% were stored loaded and 37.5% were not locked.

Figure 5: Weapon type used in the cases reviewed compared to all 2022 ND suicides.



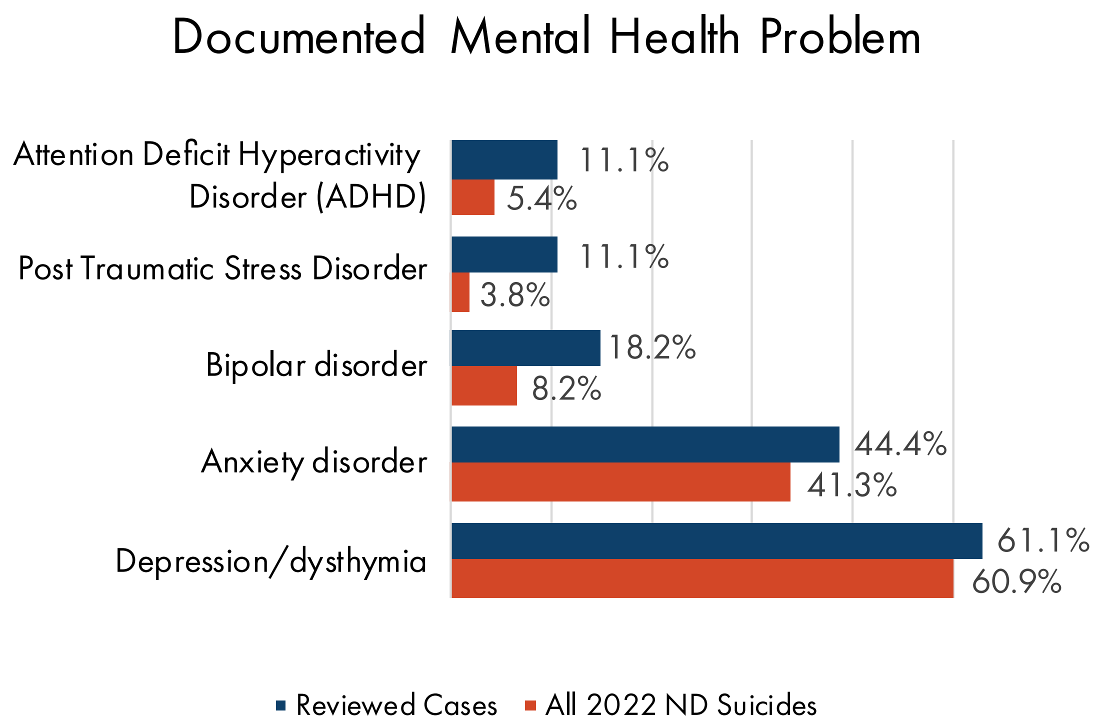
Physical Health

Just over a quarter (27.8%) of the reviewed cases had documentation of at least one contributing physical health problem. Among the documented physical health problems, chronic pain was the most prevalent (80.0%), followed by other illnesses (60.0%). Over half of the cases (55.6%) had a health care encounter within 30 days of their death and 16.7% of the cases had encounters occurring between one to six months prior to death. Additionally, half of the cases had previously been diagnosed with COVID-19, with 88.9% testing positive within six months of their death and 33.3% testing positive at the time of their death.

Behavioral Health History

Over half (61.1%) of all reviewed cases had documentation of a mental health problem. The mental health problem identified most often was depression/dysthymia at 61.1% followed by anxiety disorder at 44.4% (Figure 6). Over three-quarters (83.3%) of the reviewed cases had reportedly been in a depressed mood leading up to their death. Over half (55.6%) of the reviewed cases were currently in mental health/substance use treatment and two-thirds (66.7%) were treated 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 2022 ND suicides.

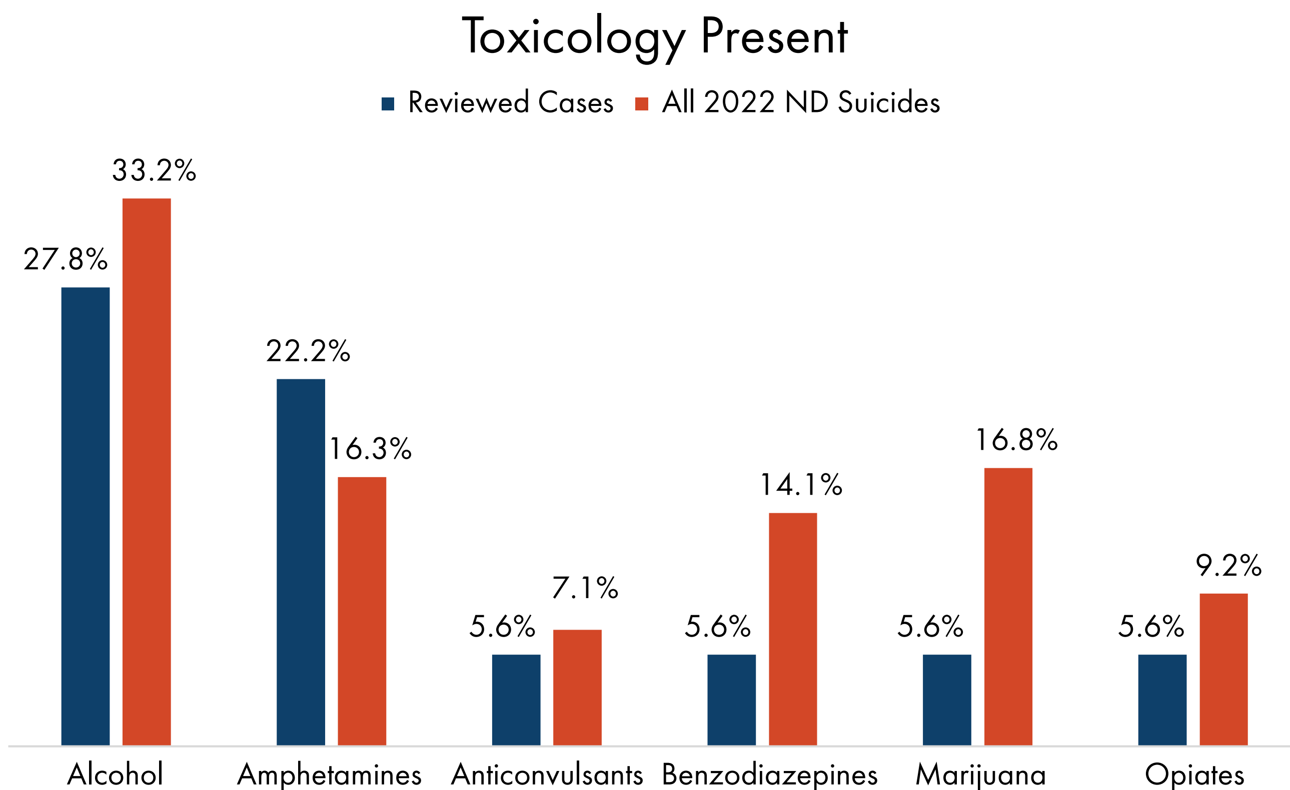


Notably, over a third of the reviewed cases had documentation of a prior suicide attempt (33.3%) and over half (55.6%) had documentation of suicidal thoughts or plans at some point in their life. Over half (55.6%) of the cases disclosed intent to die by suicide and of those who disclosed intent, the most prevalent disclosures were made to previous/current intimate partners at 40% followed by other family members at 30%. Also, 55.6% of the individuals had left a handwritten or electronic suicide note at the scene.

Substance Use History

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 2022 ND suicides



Life Stressors

Over half (55.6%) of the reviewed cases had documentation of intimate partner problems (e.g., divorce, separation, infidelity, etc.) and one-third (33.3%) had family relationship problems (e.g., family discord). In 38.9% of the cases, the individuals had an argument or conflict preceding their death. Other stressors identified were contributing criminal legal problems (33.3%) and civil legal problems (11.1%). One-third (33.3%) of the cases were experiencing job problems and almost one-fifth (16.7%) of cases were experiencing financial problems. Nearly a quarter (22.2%) of the cases were experiencing a recent eviction or loss of home.

COMMISSION CASE DISCUSSION

The following discussion points are based on findings from the Commission. There are overlapping members of the Commission on both the Cass County Suicide Fatality Review Team and the Child Fatality Review Panel. While specific cases are not discussed between groups, these overlapping members are able to provide a well-rounded knowledge of all suicide cases reviewed in North Dakota each year.

These should be utilized to decrease suicide in communities throughout North Dakota by incorporating them into community and statewide suicide prevention efforts.

Health Care

Improve access to appropriate mental health care services by:

- Increasing access to specific evidence-based care for trauma.
- Increasing access to specific evidence-based care for suicide prevention.
- Implementing mental health screenings as part of discharge planning from rehabilitation settings.
- Increasing community awareness of support organizations to assist during the immediate crisis and into recovery.
- Improving support for individuals with past childhood or adult trauma (domestic violence, sexual assault, loss of a loved one, etc.).
- Providing additional training for family and loved ones as part of mental health treatment.

Increase usage of the Suicide Care Pathway across all health systems (as recommended by the National Strategy for Suicide Prevention 2024) established in health records and identifiable across systems by:

- Increasing implementation of best practices for prevention in health care systems (i.e. Zero Suicide).
- Improving emergency department and inpatient hospital discharge practices following a suicide attempt or suicidal ideation crisis through established follow-up protocols and case management.
- Increasing access to remote mental health management resources (telehealth therapy/psychiatry/addiction support appointments, virtual support groups, peer support).
- Leveraging HHS programs such as Community Connect and Medicaid 1915(i).
- Utilizing Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care | National Action Alliance for Suicide Prevention (theactionalliance.org).
- Increasing pharmacy involvement by rating lethality of prescriptions as routine medical care (relative risk to lethality).
- Increasing collaborative safety planning as standard for discharging from inpatient hospitalization as well as implement safety planning trainings, with each health care site dedicating champions for risk assessments and safety planning.
- Improving integration of all health systems across North Dakota.
- Increasing involvement of family/friends in care whenever possible.

Increase training for health care staff to better screen individuals struggling with mental health issues by implementing usage of the Columbia-Suicide Severity Rating Scale (C-SSRS) screening tool within:

- Emergency Departments.
- Patients struggling with chronic pain.
- Patients struggling with insomnia (trouble sleeping).
- Patients with known substance use disorders and/or substance misuse.
- Patients who have recently had a substantial change in health for known/unknown reasons.

Provide lethal means safety training for all health care providers and pharmacists.

Encourage licensing boards to require suicide specific trainings/continuing education in suicide prevention.

Criminal Justice/Legal System

Improve standards of care within the criminal justice system by improving care coordination post-release by:

- Warm hand off to alcohol/substance use treatment and/or peer support.
- Collaborative safety plan as standard for discharge/release.
- Potential interventions with high-risk populations such as an opt-out of therapy as part of probation.

Increase education and training on evidence-based suicide prevention and intervention for corrections health and custody staff:

- Safety planning
- C-SSRS

Increase education and training on evidence-based suicide prevention and intervention for professionals within 'waiting periods' (pending charges, awaiting trial, awaiting sentencing) of the criminal justice/legal system such as lawyers, public defenders, and Department of Corrections and Rehabilitation (DOCR).

Implement screening of individuals incarcerated at arrival into the system for potential dependents who are involved in the imprisonment experience and assigning a social worker to those children to follow them through their experience of losing a parent to the system.

Crisis Response

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

Increase education and training on evidence-based suicide prevention and intervention for first responders (EMS, Fire, Law Enforcement, etc.).

Develop protocol for warm hand offs within Human Service Center (Community Behavioral Health) Clinics and to outpatient care.

Increase the usage of peer support directly related to suicide.

Community

Increase protective factors for all North Dakota citizens within the communities where they live, work, and play by:

- Improving access to social support resources such as housing, employment, insurance, transportation, etc.
- Improving social connectedness at the community level.
- Increasing education and awareness of population-based mental health and wellness resources.
- Establishing the importance of parental time, resources, and conflict resolution.
- Increasing access to food, rental assistance, and other assistance needs.

Increase early intervention by:

- Increasing the usage of 988 and warmlines.
- Increasing public awareness/knowledge of suicide risk for those with chronic pain, narcolepsy/lack of sleep.
- Decreasing stigma by normalizing and increasing mental health help-seeking behavior.
- Increasing access to support and positive connections for those individuals navigating their own identity.

Increase gatekeeper training for community members to identify people who may be at risk of suicide and how to respond effectively by:

- Educating on safety planning.
- Increasing knowledge about those who may be at increased risk such as a change in intimate partner or a change in life circumstances, recent high school graduate, etc.

Implement behavioral health into workforce safety by:

- Creating workplace suicide prevention intervention when a drug testing is required.
- Increasing education and awareness for employers on suicide prevention and mental health for all employees.
- Employer encouragement of wellness and connectedness.
- Increasing support for co-workers of those who die by suicide.
- Improving training to Human Resources and managers/supervisors on big emotions during disciplinary actions, providing and encouraging Employee Assistance Program (EAP), etc.
- Reducing punitive effects for seeking mental health assistance/support.
- Increasing education on EAP services to decrease family stress, improve family dynamics/home environment.
- Normalizing and increasing mental health supports for first responders (opt out vs. opt in).

Reduce access to lethal means by people who are at acute risk of suicide (safe storage of medications, firearms, ammunition, and household products) by:

- Providing CALM training/additional education to families about suicide risk and how to limit access to lethal means.
- Addressing access to lethal means for those with acute mental health crises.
- Providing education for families about additional suicide risk along with reducing access to lethal means.

Improve access to suicide loss and suicide attempt survivor support by:

- Providing resources for postvention after a death has occurred within a community.
- Improving follow up and support for survivors within the first-year post-death of a loved one.

Improve death investigation in North Dakota by:

- Increasing use of the Suicide Critical Risk Assessment Profile (SCRAP) form by coroners/death investigators to enhance available information that will better inform future recommendations.
- Providing education to coroners/death investigators on importance of a thorough investigation and how the information is used within the Suicide Fatality Review Commission across North Dakota.
- Providing training and resources for coroners and death investigators on survivor resources.
- Expanding access to the SCRAP to investigating law enforcement officers.

COMMISSION RECOMMENDATIONS

Based on the discussion points outlined previously, the Commission identified and prioritized the following priority recommendations. These recommendations were selected to best serve those at risk for suicide with the goal to reduce rates of suicide in North Dakota.

Decrease Stigma and Increase Help-Seeking Behavior

Out of the 18 cases that were reviewed, 55.6% of the cases utilized the health care system within 30 days prior to their death. This information can be used to target suicide prevention activities across all health care settings, especially within emergency departments.

Increase Training for Health Care Staff to Better Screen and Treat Depression

When looking at all the 184 deaths by suicide, over half of them were in a current depressed mood leading up to their deaths (63.6%). These individuals may have benefited from better screening practices and treatment options for depression. For example, while it is common practice for primary care doctors to screen for depression, it often appeared decedents might have been connected to helpful treatment if it was more common for specialty practitioners to conduct depression screenings, as well.

Improve Social Connectedness

Of the 184 deaths by suicide, 67.9% were individuals who fell into the categories of divorced, widowed, separated, or never married. Research shows that unmarried individuals are at higher risk of suicide compared to their married counterparts and our review indicates that this might, in part, be due to lack of social connectedness. Since employment can serve as another natural social support, the Commission found one-fourth of all decedents were either retired or unemployed, suggesting further instances of isolation.

Reduce Access to Lethal Means by People Who Are at Acute Risk for Suicide

In 2022, North Dakota had 184 total deaths by suicide. The primary method used was firearms at 57.1%, followed by hanging, strangulation, and suffocation at 22.3%, and poisoning at 14.1%. The most common firearm type used was handguns at 73.0%. In 18.1% of the deaths involving firearms, the firearms were easily accessible, loaded, and not locked. In two instances, the firearms were stolen.

Improve Access to Suicide Loss and Suicide Attempt Survivor Support

At this time, it is unknown how many next of kin or friends were present at the scene of the death. Of the 184 deaths by suicide, 40.8% had an intimate partner problem that was identified. A quarter of the cases had an argument/conflict proceeding their death and in almost half of those cases, the injury that led to their death occurred during the argument (45.9%). While losing a loved one by suicide is always difficult, being present during the terminal event adds an extra layer of trauma that often goes unaddressed. Future reviews will attempt to gather this information.

Increase Gatekeeper Training for Community Members

The Commission identified gatekeeper training as a helpful preventive measure. Of the 184 deaths by suicide, 41.1% recently disclosed suicidal thoughts or intent to die ahead of their deaths. Most of the disclosures were made to a previous or current intimate partner at 54.0%.

Improve Resource Provisions for Those at Risk Regardless of Suicide Risk Assessment Results

Of the 184 deaths by suicide, 55% of decedents had no history of suicidal thoughts or plans noted within their case data. Due to this, they might not have screened positive on a suicide risk assessment. However, most of the decedents had other known risk factors that could have been identified by medical providers including belonging to a high-risk group such as veterans or those with other mental health issues. These indications alone should prompt providers to offer patients mental health resources regardless of whether the individual self-reports suicidal ideation or not.

Improve Access to Appropriate Mental Health Services

Of the 184 deaths by suicide, 54.9% were treated for mental health or substance misuse at some point in their life. Improving access can mean many things, including but not limited to, moving an individual to a higher level of care, adjusting diagnoses to a more appropriate fit, or improving medication management, or adding services and supports where they are lacking.

Improve Access to Social Support Services Such as Housing, etc.

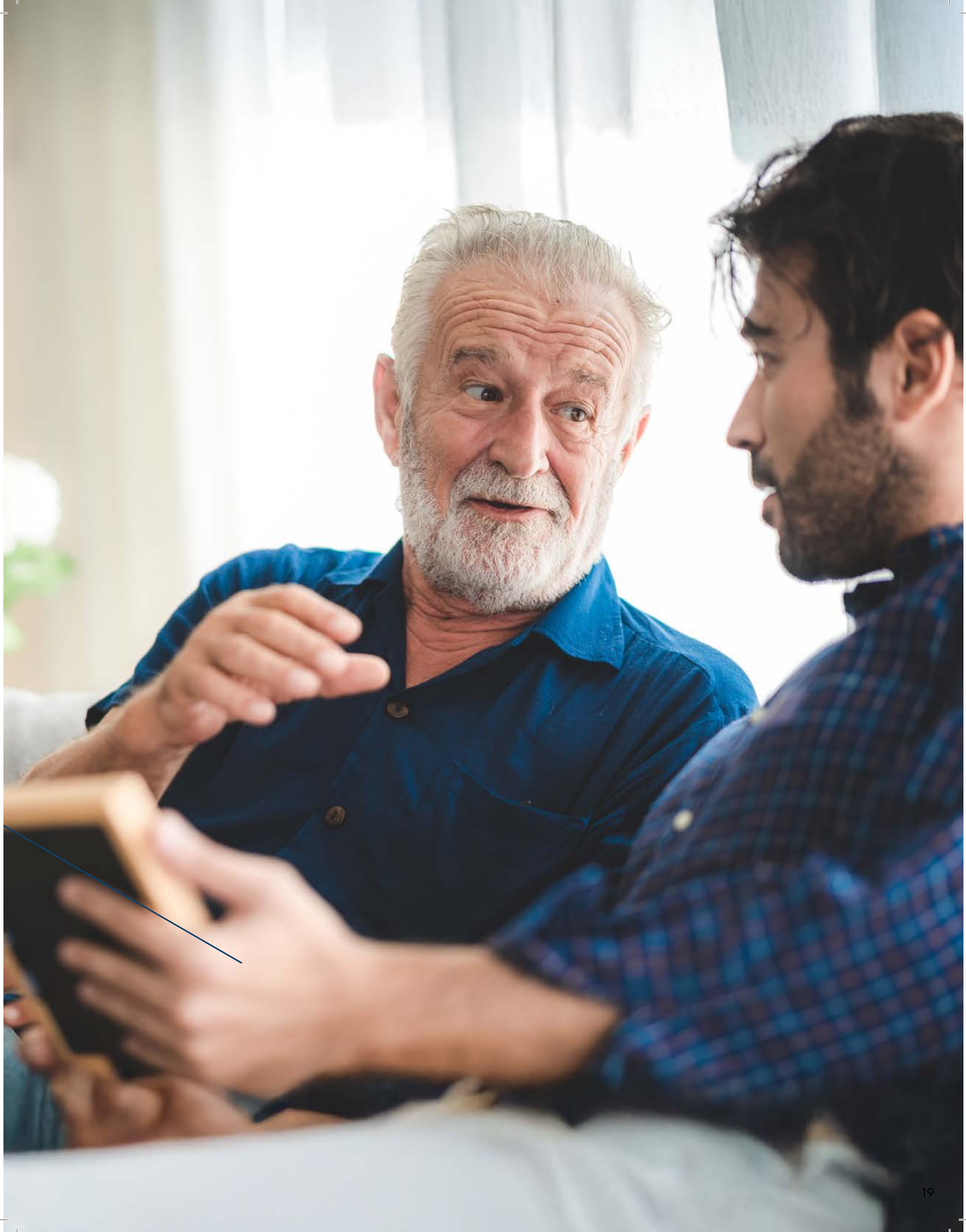
When looking at all 184 deaths due to suicide, approximately four percent of them had experienced eviction or loss of home leading up to their death. Another 11.4% had financial problems listed as a source of stress in their life prior to death.

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 2022 (18/184 suicide deaths) to identify evidence-based prevention measures.

The findings of the Commission suggest a wide array of prevention opportunities including reducing access to all forms of lethal means, improving access to suicide loss and suicide attempt survivor support, increasing gatekeeper training for community members, improving social connectedness, decreasing stigma and increasing help-seeking behavior, improving resource provisions for those at risk regardless of suicide risk assessment results, increasing training for health care staff to better screen and treat depression, improving access to appropriate behavioral health services, and improving access to social support services such as housing.

Going forward, the Commission intends to also review epidemiologic trends provided by the NDVDR program within all the suicide deaths in North Dakota along with the selected case reviews.



NORTH
Dakota
Be Legendary.
Health & Human Services