SUICIDE PREVENTION PLAN

for

MICHIGAN

2005

Developed by the
Michigan Suicide Prevention
Coalition

Logo Design: L. Franklin

One Year Later

I've Learned … … …

Someone you know and love can be hurting very badly without your knowledge

That life can be tough even when you are faithful

That most people don't know how to help you grieve

Hell can exist on earth

That you can pray daily for someone yet, in the end, their choice prevails

Grief can overtake you … but only temporarily

That everyone grieves differently

That witnessing others grieve is almost more painful than your own hurt

That silence is the most wicked sound I have ever heard

Goodbyes can be hard but they are far easier than no goodbye

That with faith, family, friends and inner strength one can survive anything

and everything

Elly, 2004

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We present this plan with pride, fervent hope, and belief that—with the initiation of the actions set forth in this plan—Michigan's families, schools, neighborhoods, workplaces, and communities will be spared the tragedy and grief of suicide.

Michigan Suicide Prevention Coalition

INTRODUCTION

MICHIGAN NEEDS A SUICIDE PREVENTION PLAN...

Suicide is preventable, yet suicide trends in Michigan are headed in the wrong direction. From 2001 to 2002 alone, the state moved up six spots—from 38th to 32nd—in the rate of suicides in the population when compared to the other states. As we learn more about what communities can do to prevent suicides, it is time for our state to adopt a comprehensive suicide prevention strategy that offers the hope of reducing the number of suicides in Michigan by at least 20% in the next five years.

At one time, the State of Michigan was at the forefront of suicide awareness. Michigan's legislature, following the lead of the U.S. Congress, in 1997 and 1998 approved two resolutions (SR77 and HR374) recognizing suicide as "a serious state and national problem, and encouraging suicide prevention initiatives" (see Appendix A). This state action contributed to the groundswell of ongoing work in this nation to reduce the toll of suicide deaths and attempts.

The Michigan Department of Community Health (MDCH) responded to the state resolutions by forming a work group to begin drafting a state suicide prevention plan. Work continued until the end of 2000, but the group was unable to complete a plan before it became inactive. Michigan communities also responded. Small, community-based groups have addressed suicide in a number of ways, but the work is often fragmented, and has had little impact on overall state suicide rates.

The publication of the National Strategy for Suicide Prevention[1] in 2001 renewed efforts by states to develop their own suicide prevention plans, which are also a prerequisite to access Federal suicide prevention funding. Elsewhere in the nation, 24 state task forces and coalitions now have approved state plans.

In every year since the Michigan legislature approved the suicide prevention resolutions, more than 1,000 Michigan residents have died by suicide. And, each year, an estimated 25,000 more make attempts that often require medical intervention and which can result in short and long-term disability.

Almost five times as many suicides occur each year in this state as deaths from HIV/AIDS, and over one and a half times more suicides than homicides take place annually. In those startling statistics, Michigan is not alone—our experience mirrors the nation's.

It is past time for Michigan to construct, approve, and begin implementation of a

Suicide Facts[2]

M*ost suicides are preventable with appropriate education, awareness and intervention methods.*

F*or every suicide death, there are an estimated 25 attempts.*

E*lderly are the highest risk group per capita.*

F*or youth, suicide is the 3rd leading cause of death.*

M*ore than 90% of people who die by suicide have a diagnosable mental disorder present.*

F*irearms are the most frequent method used.*

coordinated, effective, and proven approach to reducing suicide deaths and attempts, using the National Strategy as a blueprint.

The Michigan Suicide Prevention Coalition (MiSPC), which formed in October 2003, has taken on the task. Our broad-based membership includes public and private organizations and agencies, foundations, individuals involved in suicide prevention, survivors (those who have lost a loved one to suicide), and professionals from around the state (see Appendix B). We have used our combined experience with survivorship, advocacy, and service to present an honest and critical assessment of what prevention efforts in Michigan require.

At a time when there are limited resources and funds available for suicide prevention, it is imperative that Michigan's suicide prevention community works in a collaborative way—with the support of state government and agencies—to implement best practices statewide. The first step is development of this plan and its acceptance by key state officials.

MiSPC members are very aware of the scarcity of state resources to initiate and support new programs. However, coalition members strongly feel that there are steps set forth in this plan that can be undertaken and accomplished with little or no new monetary resources. Successful initiation of the objectives in this plan will build a strong foundation for future efforts and place the State of Michigan and its communities in an excellent position to capitalize on upcoming opportunities for federal funds.

The following plan addresses the major public health problem of suicide for all of Michigan's residents, regardless of age, gender, economic or social background. This broad-based approach is necessary in light of the state's suicide statistics:

Did You Know

U.S. Deaths in 2002[3]

Suicide:	31,655
Homicide:	17,638
HIV/AIDS	14,095

- Suicide is the third leading cause of death for 15 to 19 year-olds; and the second leading cause of death for college age young people;[4]
- Like the rest of the nation, the largest number of suicide deaths occurs among our workforce, primarily men ages 25– 64.;[5]
- And the highest rate (measured in number of suicides per 100,000 population) is among our oldest residents.[6]

There are many at-risk populations within Michigan and the nation. This plan is meant to encompass all of these populations and address suicide risk across the lifespan. However, it does not include specific objectives for each special population. We continue to seek new and emerging practices that have potential for inclusion in future versions of this plan. The focus of this initial version is on building the infrastructure necessary to support prevention efforts across the state and on assisting communities in developing and initiating their own action plans. Every effort was made to assure that the strategy is:

- prevention-focused
- built on data, research, and best practices
- public health focused
- appropriate for community-based mental and public health systems

As with any plan that puts community-based collaboration, coordination, and intervention at its heart, the following assumptions have been made concerning recommendations involving local efforts:

- much of the final planning and execution must occur at the local level;
- all tools and protocols must be appropriate for the local community and its diverse members;
- there should be uniform messages and language across all activities, across all locations, and across all priority groups;
- only the local communities themselves can establish what their priorities will be; and
- all prevention programs and interventions must be delivered in appropriate ways given the specific community and its diversity

In addition to effective implementation, it is essential that we systematically track and evaluate our progress toward goals. This will enable us to provide accurate feedback to government leaders, policy makers, organizations, advocates, and all those involved in implementation of the Michigan Plan for Suicide Prevention. It will also provide the information needed to revise objectives over time, enabling the Michigan Plan to evolve as goals are reached and new "best practices" information becomes available. Thus, in keeping with recommendations described in the National Strategy, all objectives in the Michigan Plan include measurable outcomes or targets that specifically identifying what is to be achieved. All objectives in the Michigan Plan indicate the "data source" for monitoring progress, and one set of objectives is dedicated solely to improving and expanding state surveillance systems related to suicide prevention, so the best possible data for the state is available.

The primary goals of the Michigan Plan for Suicide Prevention are to increase awareness across the state, to develop and implement best clinical and prevention practices, and to advance and disseminate knowledge about suicide and effective methods for prevention. There is full recognition that the goals and objectives overlap and contribute to a unified, integrated, and coordinated effort. Furthermore, given the ongoing research and evaluation of suicide prevention programs and strategies, we can expect this plan to change and evolve as knowledge is advanced and best practices emerge.

We Present …

Michigan's Suicide Prevention Plan reflects the input of dozens of people from across the state, and incorporates some of the work from the state's first effort in the 1990s at developing a plan. It is based on the most valid information we now have about how to reduce suicide deaths and attempts using a community-based, public health approach.

SUICIDE AS A PUBLIC HEALTH PROBLEM IN THE UNITED STATES

Suicide has been one of the leading causes of death in the United States for decades. Rates of suicide have been relatively constant over the last sixty years, although the last decade shows some encouraging, but modest, decline in rates (see Table 1). Still, the nation experiences more than 30,000 suicide deaths each year, and an estimated 750,000 attempts[7]. The U.S. Centers for Disease Control and Prevention says that suicide is under-reported. The cost in terms of pain and suffering, loss of life, medical payouts and lost productivity, and the impact upon the survivors of suicide, is immeasurable.

Survivors

- *It is estimated that each suicide death intimately affects at least six other people.*
- *Based on the more than 745,000 suicides from 1978 through 2002, there are at least 4.47 million survivors in the U.S. (1 of every 64 Americans in 2001).*
- *In 2002 alone, that number grew by nearly 190,000.*
- *There is a suicide—and six new survivors created—every 16.6 minutes.*

• IMPACT

Suicide's impact in the nation and in our state is enormous, whether measured in numbers of deaths, attempts, economic and medical benefit costs, or the devastation to survivors—people who have lost someone close to them to suicide. Edwin Schneidman, founder of the American Association of Suicidology, has stated that the worst thing about suicide is the impact on loved ones, as the "suicidal person puts their psychological skeleton into the closet of the minds of survivors forever. It is a bitch to have there."

• RISK FACTORS

While suicide is closely correlated with mental illnesses (studies indicate that in well over 90% of all suicide deaths, there is a diagnosable and treatable illness of the brain present[8,9]), there are other risk factors that contribute to suicide deaths and attempts as well. For example, elderly persons are the highest risk population age group for suicide, and frequency of suicide tends to increase with age (see Table 2). In general terms, the highest demographic risk group of non-institutionalized Americans is elderly white males, living alone, with a diagnosable and treatable mental illness and a substance abuse problem.

Those incarcerated in jails are one of the populations at highest risk for suicide in the United States with rates of 54 per 100,000[a] (the national average is less than 12 per 100,000). Another very high risk group are gay, lesbian, and bisexual (GLB) youth. Studies have shown that GLB youth have suicide attempt rates of 3.6-7.1 times higher than their heterosexual peers[10,11]. There are multiple other groups at elevated risk for suicide across the life span. Untreated or under-treated depression is highly correlated with suicide. Around a third of those who die by suicide have an identifiable diagnosis of clinical depression at the time of death. Other mental illnesses also are associated with increased risk including, among others, schizophrenia, bi-polar disorder,

[a] Calculated from data available in: Stephan JJ. *Census of Jails, 1999* (NCJ 186633). Washington, D.C.: U.S. Dept. of Justice, Bureau of Justice Statistics, 2001.

Table 1. US Suicide Rates, 1993–2002

(rates per 100,000 population)

Age/Group	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
5-14	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6
15-24	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9
25-34	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6
35-44	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3
45-54	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7
55-64	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6
65-74	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5
75-84	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7
85+	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0
Total	**12.1**	**12.0**	**11.9**	**11.6**	**11.4**	**11.3**	**10.7**	**10.7**	**10.8**	**11.0**
Men	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9
Women	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3
White	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2
Non-white	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5
Black	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1

Table 2. Suicides in the United States, 2002

	Number	Avg./day	Rate	% of all deaths
Nation	31,655	86.7	11.0	1.3
Males	25,409	69.6	17.9	2.1
Females	6,246	17.1	4.3	0.5
Whites	28,731	78.7	12.2	1.4
Non-whites	2,924	8.0	5.5	0.9
Blacks	1,939	5.3	5.1	0.7
Native Americans	324	0.8	10.5	---
Asians/Pacific Islanders	661	1.8	5.2	---
Elderly (65+ years)	5,548	15.2	15.6	0.3
Young (15-24 years)	4,010	11.0	9.9	12.1

some anxiety disorders, and borderline personality disorder.[8,9] Co-morbidity with other psychiatric diagnoses is known to increase risk for suicide.

While there are well demonstrated biological, psychological, and sociological factors that contribute to suicide, a very complex tapestry of factors lead up to death by suicide. Schneidman concludes that **"**regardless of biology, diagnosis, or demographics, the experience of those who suicide is that they are trying to solve problems that cause them intolerable psychological pain … they don't want to die, they want the pain they feel to stop."

Encompass'd with a thousand dangers,
Weary, faint, trembling with a thousand terrors …
I … In a fleshy tomb, am buried above ground
William Cowper (1731-1800)

- **PREVENTION**

While there are few research based suicide prevention programs that are proven to reduce suicidal behaviors, several are worth noting. Approaches that utilize integrated suicide prevention efforts that include education, increased identification and referral, increased access to care, reduction of stigma, and the application of effective clinical interventions have been shown to reduce deaths and attempts and are promising for the future. A major United States Air Force study[12] and multiple school evaluations have demonstrated positive results at the community level. Other major studies are currently underway to evaluate and replicate programs with potential. One-time and isolated prevention efforts may have some value, but have not demonstrated sustainable positive impact on suicide behaviors. Recent evidence suggests that effective suicide prevention programs also reduce other violent behaviors. Some interventions have shown promise for the treatment of depressed, despondent or suicidal individuals; however, major efforts are necessary to implement quality care throughout the healthcare delivery system from general medical practice to professional mental health practices. Standards of care for the treatment of disorders with high suicide risk are not clearly defined, disseminated, or widely practiced across the nation.

Thank you to that wonderful woman who kept me on the line long enough
to get help to me. If it had not been for her, I would not be here today.
She gave me back my life. There is no way to put into words when
Someone has saved your life.
Anonymous – letter to a crisis line

- **MEANS OF DEATH**

In the U.S., the method used in more than 50% of suicide deaths is firearms. The 2002 data Table 3 is consistent with data over the past decade. Some studies have demonstrated that voluntary removal of firearms from homes of persons at risk has a positive impact on suicide rates and that substitution of methods does not necessarily occur.

Table 3. Suicide Methods, United States, 2002

Suicide Method	*No.*	*Rate*	*% of total*
Firearms	17,108	5.9	54.0
Suffocation/Hanging	6,462	2.2	20.4
Poisoning	5,486	1.9	17.3
Falls	740	0.3	2.3
Cut/Pierce	566	0.2	1.8
Drowning	368	0.1	1.2
Fire/burn	150	0.1	0.5
All other	775	0.3	2.5
Total	30,622		100.0

SUICIDE AS A PUBLIC HEALTH PROBLEM IN MICHIGAN

Did You Know?

At least 6,108 people became suicide survivors in Michigan in 2003

Did You Know?

Michigan Deaths In 2003[13]

Suicide	1,018
Homicide	644
HIV/AIDS	237

What is a public health problem? It is anything that affects or threatens to affect the overall health and well-being of the public. Compared to causes of death such as heart disease or cancer, suicide as a manner of death is a relatively rare event. And yet, on average, more than 1,000 Michigan residents take their lives each year (see Table 4). This makes suicide the tenth leading cause of death in the state for 2003. For some groups, such as white males ages 10-34 years, suicide is the second or third leading cause of death. In this state, suicide is among the top five leading causes of years of potential life lost below age 75[b,14].

Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and statistics (see Figure 1). Annual estimated economic costs[c] associated with completed and attempted suicide in Michigan are over $1.1 billion annually[15].

The average annual suicide rate[d] for the state has remained relatively flat for more than a decade. Men account for 81% of suicides deaths in Michigan. The highest average annual suicide rate per capita (38.5 per 100,000) is actually among white males ages 75 and older. Other groups of men with high rates are black males ages 30-34 (26.7/100,000), and white males ages 35-54 (24.9/100,000), 25-29 (23.7/100,000), 65-74 (23.7/100,000), and 30-34 (23.2/100,000). The lowest suicide rates are among black women, who have an average annual rate of 2.2 per 100,000 persons.

An analysis of the 2003 Michigan Youth Risk Behavior Survey data found that 18% of Michigan's 9th–12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey[16]. More than one out of every ten students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years (see Figure 2).

[b] The number of years of potential life lost is calculated as the number of years between the age at death and 75 years of age for persons who die before age 75.

[c] Estimated medical costs plus estimated costs of work loss.

[d] Rates are the number of deaths per 100,000 persons in a specified group.

Table 4. Average Annual Number of Suicides By Age, Race, and Sex, Michigan Residents, 1999-2002[5]

Age	White			Black			Other			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
10-14	6	3	8	1	0	2	-	-	-	7	3	10
15-19	41	7	48	6	1	7	2	1	3	49	9	58
20-24	56	9	64	10	1	11	2	1	2	67	10	77
25-29	59	12	71	10	2	12	3	1	3	71	14	85
30-34	65	12	77	13	2	16	1	0	1	80	15	94
35-44	164	46	210	16	5	20	3	1	3	182	52	234
45-54	142	38	181	10	4	14	1	1	2	153	43	196
55-64	73	23	95	3	1	4	1	1	1	77	24	101
65-74	61	11	71	4	1	5	1	1	2	65	12	77
75+	73	14	87	2	1	3	0	0	1	75	15	90
Total	738	174	911	75	17	91	12	6	18	826	196	1,021

Decedents with unknown race (n=5) not illustrated but included in totals.
Numbers in columns and rows may not total exactly due to rounding.

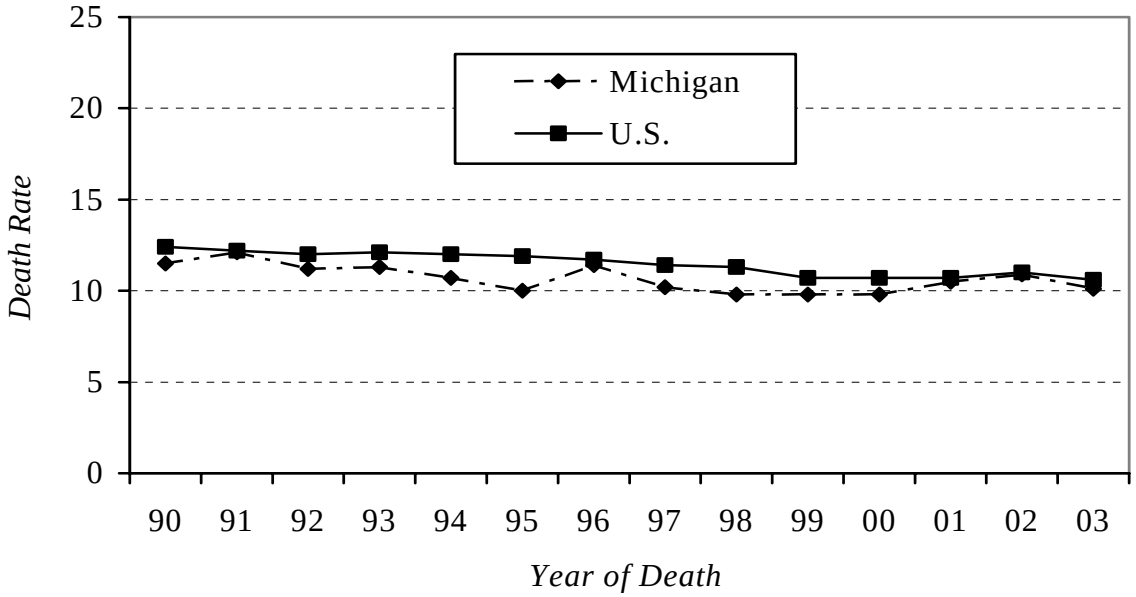

FIGURE 1. Suicide rates, Michigan and U.S. Residents, 1990-2003[17]

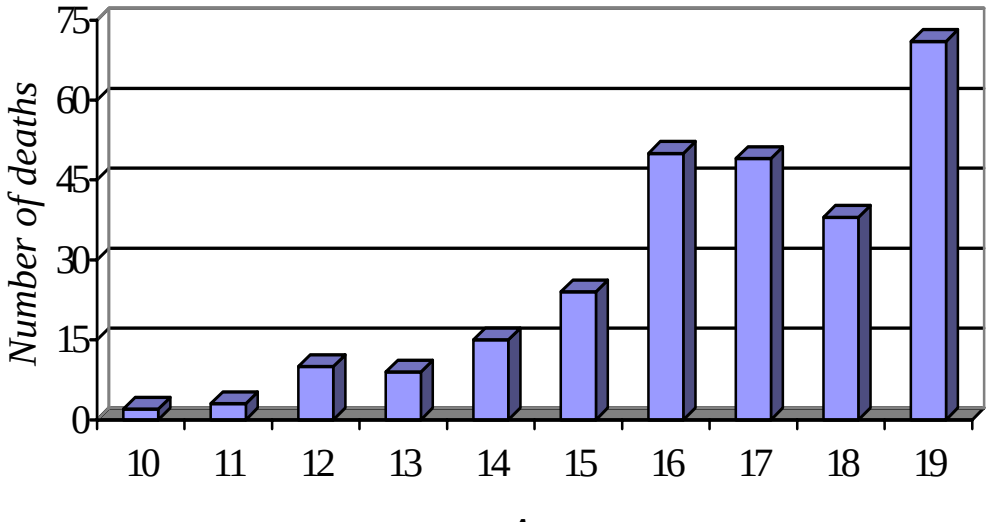

Figure 2. Adolescent suicide deaths, Michigan, 1999-2002[18]

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GOALS AND OBJECTIVES

The Michigan Plan addresses the problem of suicide with an integrated approach to suicide prevention over the lifespan. Based upon the preponderance of evidence in the suicide prevention field as well as that learned through other prevention activities, to be truly effective, any prevention program must be multi-modal, integrated, and widely accepted. By implementing this type of plan we will, over time, have an impact on the incidence of suicide in Michigan. The commitment of a wide diversity of organizations, government leaders at the state and local level, community leaders, private sector leaders and private citizens is needed to effectively implement this plan.

The plan's overarching goal (Goal #1) is to reduce the incidence of suicide attempts and death. The members of MiSPC feel that this will be best accomplished through increased awareness across the state, implementation of best clinical and prevention practices, and advancement and dissemination of knowledge about suicide and effective methods for prevention. Given the ongoing research and evaluation of suicide prevention programs, we can expect that this plan will change as knowledge is advanced and best practices emerge. The following categories are the general framework for planning and there is full recognition that the goals and objectives overlap and contribute to a unified, integrated and coordinated effort.

Goal #1
Reduce the Incidence of Suicide Attempts and Deaths Across the Lifespan

Objective 1.1 Reduce the number of suicide attempts among Michigan youth, a population for which we have baseline data

DATA SOURCE: Youth Risk Behavior Survey results and emergency services surveillance systems.

Objective 1.2 Reduce suicide deaths among Michigan populations, utilizing evidence-based best practices focused on the unique needs of each community.

DATA SOURCE: Michigan Department of Community Health vital records

AWARENESS

Broaden the Public Awareness of Suicide and its Risk Factors

Goal #2
Develop Broad Based Support for Suicide Prevention

Objective 2.1 Identify and support a state-level management/leadership structure for oversight of the Michigan Suicide Prevention Plan.

2.1.1 Establish and staff an Office of Suicide Prevention (OSP) in Michigan. This Office should be embedded within the Michigan Department of Community Health with a reporting relationship to the Department Director in order to foster a collaborative, public/private partnership between the Department and the Michigan Suicide Prevention Coalition, as well as support collaboration across administrations and offices within MDCH.

2.1.2 Within one year, establish a Michigan Suicide Prevention Advisory Council (Michigan SPAC) comprised of a broad coalition of public and private sector representatives to oversee the implementation of the Michigan Suicide Prevention Plan.

DATA SOURCES: State organizational chart, membership roster and record of meetings of the Michigan SPAC, record of MDCH and Michigan Suicide Prevention Coalition joint meetings. This objective will be evaluated jointly by the MDCH and the Michigan Suicide Prevention Coalition.

Objective 2.2 Utilize the state's existing Community Collaboratives to take the lead to identify the appropriate leadership in each community to establish Local or Regional Suicide Prevention Coalitions and to seek broad and diverse participation at the local level. While the process can begin immediately, these coalitions should be established within 18 months.

DATA SOURCE: Membership rosters of Local or Regional Suicide Prevention Coalitions

Objective 2.3 The OSP, in collaboration with local coalitions, will utilize broad based public-private support to blend resources of stakeholders in support of suicide prevention.

DATA SOURCE: Record of OSP initiatives involving public/private support for prevention strategies or programs

Objective 2.4 The OSP, in collaboration with local planning efforts, will utilize broad-based public-private support to seek additional funds for suicide prevention.

DATA SOURCE: Record of OSP collaborative initiatives that seek funding, and which result in funds for suicide prevention

Objective 2.5 The OSP will compile and make publicly available a Resource Directory that includes state and community reports referenced in the Plan.

DATA SOURCE: The Resource Directory and publicly available information on how it can be accessed.

Goal # 3
Promote Awareness and Reduce the Stigma

Objective 3.1 The OSP will develop, within its first year and by coordinating with public and private sectors and assisting in local efforts, a comprehensive plan to implement a state-wide campaign promoting awareness that suicide is a preventable public health problem that reaches all citizens in Michigan.

This would be followed in year two by implementation of at least one component of the comprehensive plan—a public awareness campaign that promotes the concept that suicide is preventable and that focuses on reducing the stigma of mental illness and improving help-seeking behaviors.

DATA SOURCES: Publicly available comprehensive state plan and Michigan SPAC report concerning the scope of the implemented public awareness component.

Objective 3.2 Within one year, the OSP, in partnership with the Michigan Association of Suicidology (MAS), the Michigan Chapter of the Suicide Prevention Action Network (SPAN), and other public and private entities, will expand participation in symposiums held within the state on suicide prevention.

DATA SOURCES: Number of symposiums throughout the state on suicide prevention, their geographic locations, attendance and program content.

Objective 3.3 The OSP, during year one, will assist with educating the media on their critical role in suicide prevention, including mental illnesses and substance abuse, and collaborate to ensure responsible media practices in the coverage of these topics. Use of the nationally recognized *Reporting on Suicide:*

Recommendations for the Media (U.S. Centers for Disease Control and Prevention) will be encouraged. OSP will assist with availability of curriculum for state journalism schools.

DATA SOURCE: Documentation of dissemination of media guidelines

Objective 3.4 Within one year, the Suicide Prevention Advisory Council will increase the awareness of policy makers by educating officials on the impact that suicide, mental illnesses, and substance abuse have on other policy areas, such as health care, law enforcement, and education.

DATA SOURCE: Documentation of dissemination of educational materials to policy makers.

Objective 3.5 Within two years, the OSP will identify and encourage the use of effective, best practices in prevention and awareness programs to mental health agencies, educational settings, law enforcement agencies, and other involved programs.

DATA SOURCE: Documentation of "best practices" information disseminated in regional and state conferences, workshops, etc.

Objective 3.6 Expand public awareness efforts that contribute to this goal and seek public and private partnerships to encourage help-seeking behaviors and to represent mental illnesses as diseases that are treatable.

DATA SOURCE: Reports from relevant state offices, the OSP, and the Michigan SPAC.

INTERVENTION

Enhance Services and Programs, Both Population Based and Clinical Care

Goal #4
Develop and Implement Community-Based Suicide Prevention Programs

Objective 4.1 In each of the next five years, increase the number of local and/or regional suicide prevention collaboratives.

DATA SOURCE: Annual reports from OSP of Community Collaborative involvement.

Objective 4.2 Within the next two years, through collaboration and partnerships, increase the number of communities or counties that are implementing an evidence-based early intervention strategy for children who have experienced significant childhood trauma.

DATA SOURCE: Local and community data on program implementation gathered by Community Collaboratives and provided to OSP.

Objective 4.3 Encourage all communities to develop services for survivors of suicide and promote utilization of these services.

DATA SOURCES: Evidence that guidelines and technical assistance with provision of survivor services were made available to communities.

Objective 4.4 Within the next three years, the OSP and the Michigan Department of Education will partner to develop legislative proposals for state policy best practice guidelines that support schools in implementing and expanding evidence-based suicide prevention and response policies and programs.

4.4.1 Disseminate information to raise awareness among Michigan legislators, school administrators, educational associations, public and mental health advocacy groups, and parent groups regarding the impact of mental health on learning and lifelong health outcomes, and the role

of coordinated school health and safety programs in addressing mental health problems in schools.

4.4.2 Develop proposed policies for the State Board of Education that encourage coordinated, evidence-based suicide prevention and response policies and programs, identify the characteristics of effective suicide prevention and response strategies, and further the Board's existing policies on coordinated school health and safety programs.

DATA SOURCES: Documentation of stated policies, legislative proposals and outcomes; Michigan SPAC reports on each point.

Objective 4.5 Within two years, frame guidelines for evidence-based suicide prevention programming using a collaboration of school health partners, including the Michigan Departments of Education and Community Health, the Comprehensive School Health Coordinators Association, local school districts, community mental health agencies, Community Collaboratives, parent groups, suicide prevention advocacy groups, and others interested in the health and well-being of Michigan children and youth. The guidelines will be disseminated statewide to public and private education settings and will address objectives and resources for:

- Healthy environment and positive school climates that embrace the broad diversity of all youth and include sequential social-emotional skills curriculum addressing problem solving, help seeking, and decision making; physical and emotional safety for all students; proactive and positive school-wide discipline; and healthy and orderly physical environment
- Measures that decrease risk factors and enhance protective factors.
- Identification of students at-risk for suicide, including gatekeeper training for staff and students, screening, and peer support.
- Administrative issues, including policies and procedures, program support and maintenance, broad based diversity training, crisis response teams, evaluation of programs, duty, responsibility and liability
- Intervention strategies, involving school-community partnerships which facilitate referrals, 24 hour crisis response, and student re-entry support following a crisis
- Responding to a death by suicide, including to the needs of the school community and working with media – recommend using the CDC Guidelines for containment of suicide clusters and Guidelines for Media Coverage of Suicide.
- Family and community partnerships

- Dissemination to all Michigan Public and Private educational settings

DATA SOURCES: Record of collaboration (described above) in developing guidelines; and publicly available, comprehensive guidelines for evidence-based suicide prevention programming in schools

Goal #5
Promote Efforts to Reduce Access to Lethal Means and Methods of Suicide

Objective 5.1 Within three years, the OSP working in collaboration with the appropriate professional organizations, will increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.

DATA SOURCE: Establish baseline data (OSP, the Michigan SPAC and/or Community Collaboratives) for at least one category of health provider, enabling an evaluation of outcomes for this group(s) within three years.

Objective 5.2 Within three years, the OSP, in collaboration with local suicide prevention efforts, will assure that at least 50% of the households in the state are exposed to public information campaigns designed to reduce the accessibility of lethal means, including firearms, in the home.

DATA SOURCE: Record of penetration of public information campaigns

Goal #6
Improve the Recognition of and Response to High Risk Individuals Within Communities

Objective 6.1 Utilize Community Collaboratives to identify the number of "gatekeepers" in their communities who are trained to recognize at-risk individuals and intervene.

6.1.1 Within three years, expand the number of gatekeepers.

DATA SOURCE: Community Collaborative reports about available gatekeepers in their areas.

As defined in the National Strategy for Suicide Prevention, key gatekeepers are those people who regularly come into contact with individuals or families in distress. They are professionals and others who must be trained to recognize behavioral patterns and other factors that place individuals at risk for suicide and be equipped with effective strategies to intervene before the behaviors and early signs of risk evolve further. Key gatekeepers include, but are certainly not limited to:

- Teachers and school staff
- School health personnel
- Clergy and others in faith-based organizations
- Law enforcement officers
- Correctional personnel
- Workplace supervisors
- Natural community helpers
- Hospice and nursing home volunteers
- Primary health care providers
- Victim advocates and service providers
- Mental health care and substance abuse treatment providers
- Emergency health care personnel
- Individuals and groups working with gay, lesbian, bi-sexual, and transgender populations
- Members of tribal councils and staff of health centers serving Native Americans in Michigan
- Persons working with isolated senior citizens
- Funeral directors

Objective 6.2 Within two years, the OSP and the Michigan SPAC will develop and disseminate a model for community "capacity assessment" for suicide prevention. This will include a template for resource identification. Its purpose will be to not only assist communities in identifying all available assets related to suicide prevention and intervention, but also any critical gaps and deficits.

DATA SOURCE: Documentation of dissemination of the model to communities.

Objective 6.3 Within one year the OSP and the Michigan SPAC will identify and distribute guidelines for suicide risk screening to primary care settings, emergency departments, mental health and substance abuse settings, senior programs, and the corrections system.

DATA SOURCE: Publicly available copies of materials and distribution lists

Objective 6.4 Within three years, the Michigan Department of Corrections will adopt and disseminate system wide policies and practices for suicide prevention in accordance with the American Correctional Association Standards for

Emergency Care and Training, or the National Commission on Correctional Health Care.

DATA SOURCE: Record of policies and practices for suicide prevention

Objective 6.5 Within three years, require that all state funded colleges and universities develop suicide prevention policies, and implement one or more prevention strategies patterned after evidence-based approaches

DATA SOURCE: Publicly available policy statement(s) and record of implemented strategies.

Objective 6.6 Within two years, require Community Mental Health programs to implement suicide prevention training for all direct service personnel. They will also adopt policies and practices for suicide prevention/intervention including identification, intervention, discharge, and tracking of outcomes.

DATA SOURCE: Record of training sessions and percentages of direct service personnel who participated; documentation of policies

Goal #7
Expand and Encourage Utilization of Evidence-based Approaches to Treatment

Objective 7.1 The OSP and the Michigan SPAC, in collaboration with the National Suicide Prevention Resource Center, will identify best practices for emergency departments and inpatient facilities that help ensure engagement in follow-up care upon a suicidal patient's discharge. The OSP and Michigan SPAC will disseminate this information.

DATA SOURCE: Provision of best practices documents and records of dissemination

Objective 7.2 Within 18 months, MDCH, in collaboration with the Michigan Association of Community Mental Health Boards, will assure that up-to-date evidence-based standards of care are distributed to the Public Mental Health/Substance Abuse system.

DATA SOURCE: Evidence of distribution

Objective 7.3 Within 18 months, MDCH, in collaboration with the Michigan Association of Community Mental Health Boards (MACMHB), will identify quality care/utilization management guidelines for effective response to suicidal risk or

behavior and assure that these guidelines are incorporated into the state managed care plan.

DATA SOURCE: Identification of guidelines and incorporation into the managed care plan

Goal # 8
Improve Access to and Community Linkages With Mental Health and Substance Abuse Services

Objective 8.1 MDCH, in collaboration with the Michigan Association of Community Mental Health Boards and the Community Collaboratives, will identify and disseminate model programs that address co-occurring disorders of mental health and substance abuse, as this combination of disorders significantly increases suicide risk.

DATA SOURCE: Publicly available document describing model programs; record of dissemination

Objective 8.2 Support policies and/or legislation that provide coverage for evaluation and treatment of mental illnesses and substance abuse that is equal with coverage of other illnesses and conditions.

DATA SOURCE: Policy and/or legislative outcomes

Objective 8.3 Within each of the next five years, increase the number of communities promoting the awareness and utilization of 24-hour crisis intervention services that provide full range crisis and referral services. These services may be locally based or linked to the national hotline. It is desirable that these services be AAS certified.

Once the baseline is established the annual cumulative goal increases will be as follows:

2006	20%
2007	30%
2008	40%
2009	50%
2010	60%

DATA SOURCE: MDCH mental health services audit

METHODOLOGY

Advance the Knowledge of Suicide and Best Practices for Prevention

Goal #9
Improve and Expand Surveillance Systems

Objective 9.1 The Michigan Department of Community Health will produce reports, not less than annually, that will include data on suicide and suicide attempts. This data will include demographics, trends, methods, locale, and other information. This data will serve as a key tool in the evaluation of the Michigan Suicide Prevention Plan.

DATA SOURCE: MDCH reports

Objective 9.2 Promote the use of standardized protocols for death scene investigations throughout Michigan.

DATA SOURCE: MDCH implementation report

Death scene investigation reports provide key information on circumstances and means of death. While use of a standardized protocol should improve the information available through Medical Examiner case files, the OSP and the Michigan SPAC should also examine how this information can be accessed and used through other systems.

Objective 9.3 Through an ongoing collaboration between the Michigan Departments of Education and Community Health and local public school districts, continue to conduct surveillance of youth risk behavior, including behavior related to suicide and depression, using the Youth Risk Behavior Survey developed by the Centers for Disease Control and Prevention and the Michigan Department of Education.

9.3.1 Biannually, within one year of data collection, fact sheets related to the results of the 2003 Michigan YRBS most pertinent to depression and suicide, by age, gender, and race, will be widely disseminated in printed format and on-line.

9.3.2 Within two years, disseminate fact sheets related to the results of the 2005 Michigan YRBS, adding rates for Native American youth, in printed format and on-line.

DATA SOURCE: Report of YRBS results and records of dissemination

Objective 9.4 The results of the surveillance activities described above will be used to plan and evaluate state, regional, and local suicide prevention activities.

DATA SOURCE: Copies of written plans and evaluation reports.

Goal #10
Support and Promote Research on Suicide and Suicide Prevention

Objective 10.1 The OSP and Michigan SPAC will encourage use of the national registry of evidence-based suicide prevention programs and clinical practices, located at the national Suicide Prevention Resource Center's website, www.sprc.org.; and provide regular reports about evidence-based approaches.

DATA SOURCE: Evidence of regular distribution of information about the SPRC and its website; compilation of evidence-based approaches.

Objective 10.2 Facilitate the development of public/private partnerships and community-based coalitions to build support for, and request funding for, suicide prevention research within the State of Michigan, including efforts to identify evidence-based strategies for various at-risk populations in the state.

DATA SOURCE: Evidence of collaborative efforts to seek funds

Objective 10.3 Determine the social and economic costs of untreated mental illnesses and substance abuse, and support strategies for reducing these costs.

Objective 10.3.1 Investigate, within three years, either statewide or in at least one defined region and/or for one defined at-risk population, the social and fiscal costs of untreated mental illness and alcohol/substance abuse to the State of Michigan.

DATA SOURCE: Publicly available report on social and economic costs

Objective 10.3.2 Based on the above investigation, consider the social and/or economic cost benefit(s) for parity in coverage of health benefits for mental illnesses and substance abuse.

DATA SOURCE: Publicly available cost benefit report

Objective 10.4 The OSP, with input from all community and state partners, will prepare and disseminate an annual progress report for the Michigan Suicide Prevention Plan.

DATA SOURCE: The OSP's annual reports

RECOMMENDED RESOURCES

The American Association of Suicidology: www.suicidology.org

American Foundation for Suicide Prevention: http://www.afsp.org/index-1.htm

The Canadian Association for Suicide Prevention: http://www.suicideprevention.ca/

Centers for Disease Control and Prevention http://cdc.gov/ncipc/factsheets/suicide-overview.htm

Children's Safety Network: http://www.childrenssafetynetwork.org/

Children's Safety Network, Economics & Data Analysis Resource Center: http://www.edarc.org/

Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE (eds.). *Reducing Suicide: A National Imperative*. Washington, D.C.: The National Academies Press, 2002.

Michigan Department of Community Health, Vital Records and Health Data Development Section: http://www.mdch.state.mi.us/pha/osr/index.asp?Id=4

Michigan State University, School of Journalism. Victims and the Media Program: http://victims.jrn.msu.edu/

National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

U.S. Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS):* http://www.cdc.gov/ncipc/wisqars/default.htm

National Commission on Correctional Healthcare: http://www.ncchc.org/index.html

American Foundation for Suicide Prevention,American Association of Suicidology, Annenberg Public Policy Center. *Reporting on Suicide: Recommendations for the Media*: http://www.afsp.org/education/recommendations/5/1.htm

National Institute of Mental Health—Suicide Prevention: http://www.nimh.nih.gov/suicideprevention/index.cfm

New Zealand Ministry of Youth Development—Youth Suicide Prevention: http://www.myd.govt.nz/sec.cfm?i=21

Schneidman, Edwin. *The Suicidal Mind*. New York: Oxford University Press, 1996.

Suicide Prevention Action Network: http://www.spanusa.org/

Suicide Prevention Resource Center: http://www.sprc.org/

World Health Organization. *SUPRE—the WHO worldwide initiative for the prevention of suicide*: http://www.who.int/mental_health/prevention/suicide/supresuicideprevent/en/

APPENDIX A:
SENATE RESOLUTION NO. 77[e]

A resolution to recognize suicide as a serious state and national problem and to encourage suicide prevention initiatives.

Whereas, Suicide is the ninth leading cause of all deaths in the state of Michigan and the third cause for young persons ages 15 through 24. In 1995, suicide claimed over 960 Michigan lives, a number greater than the number of homicides. In addition, suicide attempts adversely impact the lives of millions of family members across the country; and

Whereas, The suicide death rate has remained relatively stable over the past 40 years for the general population. However, the rate has nearly tripled for young persons. The suicide death rate is highest for adults over 65; and

Whereas, These deaths impose a huge unrecognized and unmeasured economic burden on the state of Michigan in terms of potential life lost, medical costs incurred, and the lasting impact on family and friends. This is a complex, multifaceted biological, sociological, and societal problem; and

Whereas, Even though many suicides are currently preventable, there is still a need for the development of more effective suicide prevention programs. Much more can be done, for example, to remove stigmas associated with seeking help for emotional problems. Prevention opportunities continue to increase due to advances in clinical research, in mental disorder treatments, in basic neuroscience, and in the development of new community-based initiatives. Suicide prevention efforts should be encouraged to the maximum extent possible; now, therefore, be it

Resolved by the Senate, That we

(1) Recognize suicide as a statewide problem and declare suicide prevention to be a state priority;

(2) Acknowledge that no single suicide prevention program or effort will be appropriate for all populations or communities;

(3) Encourage initiatives dedicated to preventing suicide, helping people at risk for suicide and people who have attempted suicide, promoting safe and effective treatment for persons at risk, supporting people who have lost someone to suicide, and developing an effective strategy for the prevention of suicide; and

(4) Encourage the development, promotion, and accessibility of mental health services to enable all persons at risk for suicide to obtain these services without fear of any stigma.

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[e] The wording of the resolution passed by the House of Representatives on September 22, 1998, was essentially the same as that used in the Senate resolution.

APPENDIX B:
MICHIGAN SUICIDE PREVENTION COALITION

Ms. Karen Amon	Touchstone Services
Ms. Susan Andrus	ThumbResources.org
Ms. Ain Boone	Survivor; MAS
Ms. Robin Bell	Michigan Public Health Institute (MPHI)/Child Death Review Program (CDR)
Ms. Patricia Brown	Survivor; Michigan Association of Suicidology (MAS)
Ms. Bonnie Bucqueroux	Michigan State University, Victims in the Media Program
Mr. Michael Cummings	Joseph J. Laurencelle Foundation
Ms. Joan Durling	Shiawasee Community Mental Health Authority
Ms. Glenda Everett-Sznoluch	Survivor; MAS Youth Suicide Prevention
Ms. Cathy Goodell	Mental Illness Research Association (MIRA)
Mr. Eric Hipple	MIRA; Stop Suicide Alliance; Survivor
Dr. Hubert C. Huebl	NAMI (National Alliance for the Mentally Ill) Michigan
Ms. Peggy Kandulski	President, MAS; Survivor
Dr. Cheryl King	University of Michigan Department of Psychiatry
Dr. Alton Kirk	Associated Psychological Services
Mr. Sean Kosofsky	Triangle Foundation
Ms. Sabreena Lachainn	Survivor; Journey for Hope
Ms. Mary Leonhardi	Administrator, Detroit Waldorf School
Mr. Larry G. Lewis (MiSPC Chair)	Vice-President MAS; C.O. Suicide Prevention Action Network (SPAN) of Michigan
Ms. Vanessa Maria Lewis	Advanced Counseling Service; MAS
Ms. Mary Ludtke	Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families
Ms. Karen Marshall	Stop Suicide Alliance; Community Education About Mental Illness and Suicide (CEMS) of Oakland County CMH; Survivor
Ms. Lynda Meade	MPHI/CDR
Ms. Marilyn Miller	MDCH, Office of Drug Control Policy
Ms. Lindsay Miller	MPHI/CDR
Mr. Micheal Mitchell	Emergency Telephone Service, Neighborhood Services Organization (NSO), Detroit
Mr. William Pell	Gryphon Place, Kalamazoo
Ms. Carol Pompey	Indiana Coalition, Miles, Michigan
Ms. Judi Rosen-Davis	MAS
Mr. Tony Rothschild	Common Ground Sanctuary
Ms. Patricia Smith	MDCH, Injury and Violence Prevention Section
Mrs. Elly Smyczynski	Survivor
Ms. Merry Stanford	MiSPC liaison from the Michigan Department of Education
Mr. Michael Swank	Bay-Arenac Behavioral Health
Mr. William Tennant	Mental Health Association in Michigan

Michigan's Plan is Dedicated to Those Who Have Lost Their Lives to Suicide

Mary Gallinagh Beghin	October 25 1967
Danny Sullivan	1970
Robert Taylor	1970
Laura LaCharite	February 25 1971
Thomas J. Caldwell	April 15 1972
Joyce Hebert-Donaldson	May 12 1974
Tippy	1976
Beverly Taylor	January 28 1977
Brian Anthony Bucek	July 6 1978
Gregory Allan Florian	June 11 1980
Jeff Anderson	November 11 1982
John Sevakis	February 1 1983
Herbert Derby	August 16 1986
Robert John Buckner	May 2 1986
Michael G Fix	May 9 1986
Lawrence M. Nortan	February 8 1987
Nicole Marie Peterson	April 25 1989
Leonard K. West	May 11 1990
Gerry Stephani	September 21 1990
Jason Ruppal	January 21 1991
Helen Skarbowski	August 26 1992
Marcus John Codd	August 6 1992
Mark Bogatay	December 15 1992
Justin Oja	December 4 1992
Simran Nanda	January 12 1992
John Hookenbrock	1993
Theresa Boyce	April 17 1993
Jason Michael Briggs	February 23 1993
Kenny Howard	1994
Ethan Gilbert	April 4 1994
Nikki Freeman	April 9 1994
Rick Jackson	December 25 1994
Ted Tyson	January 10 1994
Jeff Joiner	January 18 1994
David Thompson	January 2 1994
Muhammond Brown	March 10 1994
Peter VanHavermat	Jun-95
Robert James Toft	December 2 1995
Scott Herald Stevenson	January 31 1995
Ken Bon	March 28 1995
Bryce Green	August 28 1996
David Williamson	February 27 1996
Carl Hookana	January 17 1996
Greg Erickson	July 20 1996
Heather Mays	March 7 1996
Jesse Ross Everett	November 30 1996
Shelley Dawn Markle	October 7 1996
Keith Ellison	July 17 1997
Eric Robert Shafer	June 21 1997
Terry Lee Garner	November 19 1997
Terry Baksic	October 10 1997
Scott Mayer	December 1 1998
Curtis Joseph Stucki	February 2 1998
Greg Pascoe	February 2 1998
Jason Michael Harrold	June 27 1998
Todd Stackowicz	October 28 1998
William Henry Hebert	October 8 1998
Joel Scott Serlin	September 22 1998
Deryl Roy Davis	September 7 1998
Chris Pace	September 9 1998
Chuck Rowe	1999
Cody Burton	1999
Eric Byrd	1999
Robert Houck	April 5 1999
Gerald Auth	August 22 1999
John Knowlton	August 28 1999
Mark Eric Maxwell	August 7 1999
David (DJ) Jones	December 8 1999
Brian Walker	February 20 1999
Jamie Lynn Jenkins	July 12 1999
Peggy Tinker Pijor	July 18 1999
Dwight Antcliff	June 6 1999
Marcus Hodge	May 20 1999
Thomas Baker	November 1 1999
Thomas James Brundage	October 14 1999
Corey Hayslit	September 20 1999
David Earnest Butcher	Apr-00
Anna Trolla	April 4 2000
Jeffrey Daniel Hipple	April 9 2000
Tara McClelland	August 10 2000
Carol Verlee Sommers	December 10 2000
Richard Scott Hubar	January 26 2000
David A. Dill	January 3 2000
Steve Clark	June 22 2000
Brian Burnham	June 5 2000
Clayton James Rogers	June 7 2000
Dennis New	May 13 2000
Kurt Liebetreu	May 13 2000
Kurt Liebetrev	May 13 2000
Jeff Rey Reuter	May 18 2000
Doris Zwicker	October 18 2000
Thomas W. Moxlow	September 19 2000
John Chris Pieron	September 23 2000
Brian Tiziani	2001
Heinz C. Prechter	July 6, 2001
James Thomma Jr.	April 29 2001
Mark Manning	August 14 2001
Chad Baughey	August 15 2001
Rhonda Roodland-Robinson	August 18 2001
Susan Elizabeth Young	August 21 2001
Troy James Duperron	August 5 2001
Gilbert Hernandez	February 11 2001
William Aloysius Petrick	February 23 2001
James David McDonald	January 15 2001

Brian Richard Triplet	January 7 2001
Christopher Jay Spivey	July 13 2001
Dennis W. Young	June 16 2001
Daryl Jermaine Jones Jr.	June 18 2001
Detective Sgt. Richard D. Irvin	March 20 2001
Matthew Richard Coy	March 23 2001
Larry Alan Thomas	May 6 2001
Philip "PJ" Heim Jr.	May 8 2001
Natricia Burray-Ciefiolka	November 11 2001
Russell Meehan	September 7 2001
Greg Grisham	September 9 2001
Brian Gearhart	April 6 2002
Kurt Vullard	August 29 2002
Amy Marie Powell	August 31 2002
Yale D. Mettetal	December 8 2002
Christine Marie Klein	February 26 2002
Bruce Ward	January 16 2002
Thomas Kobrehel	July 7 2002
Ralph Patterson	June 17 2002
Reggie Williams	June 25 2002
Jennifer Sturtz	June 4 2002
Brent Lindstrom	March 5 2002
Gina Elizabeth Jackson	May 1 2002
Michael Alan Aldelson	May 14 2002
George Bardon	November 18 2002
Terri Bozyk	November 18 2002
Martin Wilford Boone Jr.	November 4 2002
Eric Daniel Dorbin "Big E"	October 14 2002
Danny "Amos" Taylor	2003
Jimmy Glenn Farley	April 10 2003
Russell Lee Bingham	April 22 2003
Michael Loney	January 20 2003
Chase Edwards	March 3 2003
Fred Zaplitny	May 17 2003
Jim Epperson	May 3 2003
Robert O'Brien	November 13 2003
Sharon Miller	October 14 2003
Ryan Osterman	September 11 2003
Corey Maslanka	September 17 2003
Brittany Moore	April 17 2004
Christopher James Ritter	April 23 2004
Donna Harmenan	August 17 2004
Joe Wolfe	August 8 2004
Justin Turner	December 24 2004
Ruth Wyatt	February 8 2004
Shilpa	January 5 2004
Mark Spengler	June 28 2004
Bobby Ruttledge	March 16 2004
Raymond Lepage	March 18 2004
Zachary Bentley	March 3 2004
Brandon Goodreau	May 10 2004
Ryan Currie	16
Jim Tuscany	21
Matt Erber	23
Terri Marrison	25
Donna Niebraydowski	29
Bill Gibson	33
Alvan "Bud" Merriman	38
Karen Edwards	52
Thomas E. Robinson	54
Charlie Vandervennet	1-Aug
Chris Cozzi	
Colin McIntyre	
David Chase	
Debbie Bogle	
Debbie DeMoss	
Douglas Ray DeVine	
Francisco Nuno II	
Ila Riddnour	
James Graham	
Jeff McEwen	
Lee Harding	
Mike Loft	
Mike Sandell	
Nakia Gordon	
Randy Tochalowski	
Richard D. Irvin	
Samuel Mutschler	
Steve R. Warner	

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