

Suicide Prevention Plan for Washtenaw County

Suicide Prevention is a
Public Health **Challenge**

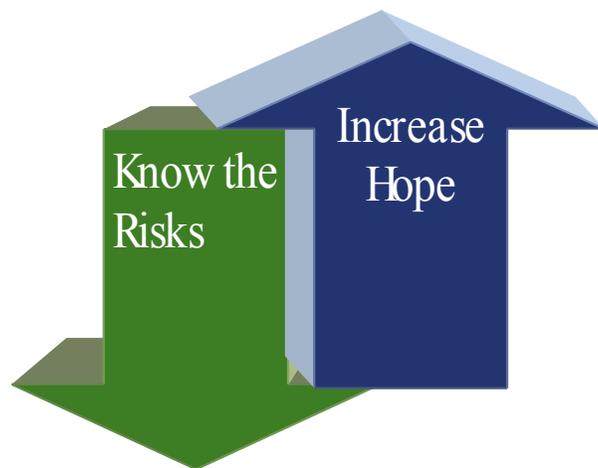


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Mission: To inform and train individuals in Washtenaw County about best practices and access to services for suicide prevention and survivor support.

Vision: A community that is supportive, knowledgeable and engaged in the prevention of suicide.

Foreword

Suicide is preventable. This is the basic belief that underlies the Suicide Prevention Plan for Washtenaw County. Suicide is not only tragic for the individual who dies from suicide, but also for their family, friends and the community. The prevention of suicide requires effort on many different levels; education, training, crisis intervention and planning. For many years we have been working with schools and community organizations to do what we could to prevent suicide, and to help those who have been affected when someone dies by suicide. But, we did it without any comprehensive community-based plan. The following plan is the first step in establishing such a framework.

It has been exciting and gratifying to see the cross section of people who have come together to create this plan. To be comprehensive, it requires input from a wide range of perspectives. Included in the collaborative were survivors, schools mental health staff, and public health professionals. Some work with youth, and others work with adults. The others are concerned citizens.

Two constructs were used to set the framework for the plan. The first construct was to divide the work into three areas; Prevention, Intervention and Post-vention. **Prevention** is what is done through education and training to reduce the risk of suicide. **Intervention** is what is done to intervene with an individual who is contemplating suicide. **Post-vention** is what is done to support those who are impacted by the death of someone who has died by suicide. The second construct is looking at the risk and protective factors of suicide. **Risk Factors** are those issues that converge on an individual to bring them to the emotional point of contemplating suicide. **Protective Factors** are those individual, family and community factors that can work toward supporting individuals and groups to prevent the downward spiral to thoughts of suicide.

The planning group organized itself into three work groups; Prevention, Intervention, and Post-vention. Each developed goals and objectives that were then incorporated into the plan that you see here. The prevention goals and objectives suggest those activities (education, training and planning) that can help create a supportive and knowledgeable community climate regarding the prevention of suicide. This requires the examination of the best practices in suicide prevention. Which ones will be most effective and acceptable in our community?

One area of great need is an effective system to help gain a clear perspective on the frequency of both deaths by suicide and attempts. This information will be important in the planning and adjusting intervention strategies as we move forward. The intervention goals and objectives suggest the importance of having informed and trained individuals in the community regarding the best practices to be used with clear and prompt access to services. The post-vention goals and objectives suggest what can be done to support those that are significantly impacted by the death by suicide of someone that they know. The best practices here can also have a preventative aspect by intervening early with youth that may not have the life experience to cope with this type of loss. In summary, the goals and objectives that make up our plan are just the beginning of a community effort to create a climate of support and caring. We invite you to join us.

Problem Statement

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Suicidal Behavior - Adults

Suicide is the tenth leading cause of death in Washtenaw County and the fourth leading cause of Years of Potential Life Lost (YPLL). Suicide comprises nearly 2% of Washtenaw County deaths each year. Approximately 30 Washtenaw County residents

die by suicide each year, approximately the same number of deaths due to breast cancer, prostate cancer or kidney disease; and higher than deaths due to motor vehicle accidents or homicides.



Overall Washtenaw County mortality rates due to suicide were 8.7 per 100,000 in 2006, while those for Michigan were 11.2 and the U.S were 11.0. during this same time

period.

Elderly males have the highest suicide rates in Washtenaw County (see Figure 1). Suicide is the third leading cause of death for persons 15-24 years. In 2001, firearms were used in 54% of youth suicides and 73% of suicides by persons 65 years and older. Overall, the suicide rate for Washtenaw County residents has been declining during 1989-2004¹.

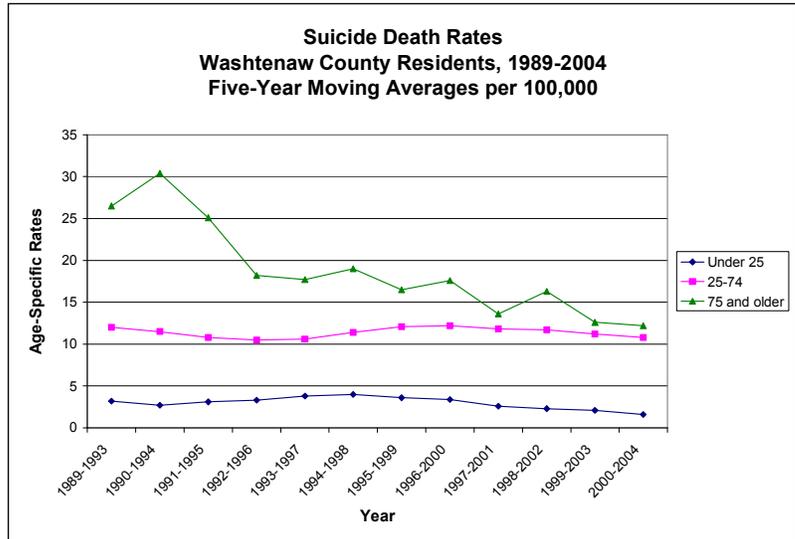


Figure 1

Suicidal Behavior - Youth

According to results from the 2005 Michigan Youth Behavioral Risk Factor Survey (YRBS)², 16% of high school students seriously considered attempting suicide during the past year; 12% made suicide plans; 9% made attempts; and 3% attempted and required medical treatment as a result (see Figure 2)³. While Michigan female high school students are nearly twice as likely to have suicidal thoughts, males are more likely to plan or attempt suicide.

Similarly, while White Michigan high school students are more likely to have suicidal

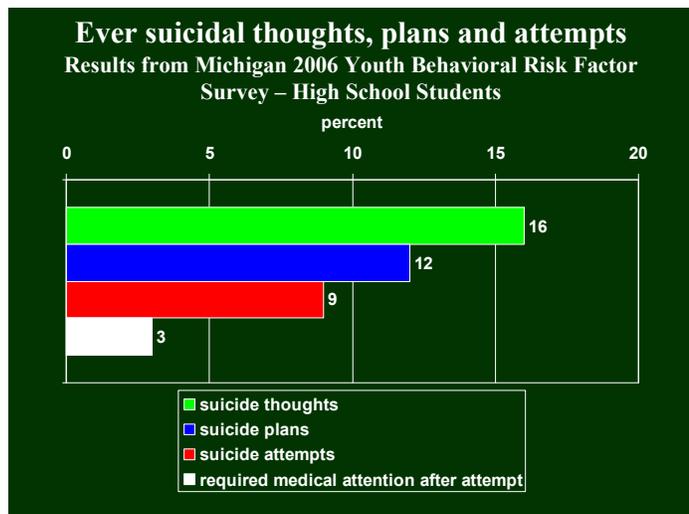


Figure 2

thoughts, Hispanic and American Indian students are at higher risk for suicide plans and attempts. Further, Michigan high school students whose grades are lower are more likely to have suicide ideation, plans and attempts than their counterparts with higher grades.

A survey of 734 Washtenaw County middle school students suggests that the rate of these same suicide risks is approximately 33%

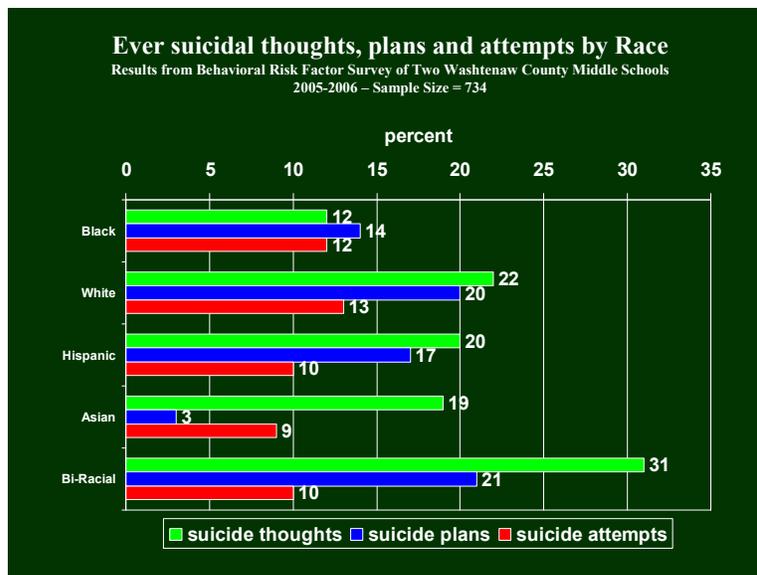


Figure 3

higher in these younger students than those for their older state counterparts. The 2005-2006 middle school survey results are not representative of all middle schools in Washtenaw County, however, results suggest that 22% of these sixth, seventh and eighth graders say they have seriously considered suicide; 16% have made suicide plans; and 12% have actually attempted suicide. Figure 3 above illustrates the self identified racial categories for these students. It is interesting to note that kids who identified themselves as ‘bi-racial’ were 40%

more likely to identify having serious suicidal thoughts, while their attempt rates were similar to other groups. Additionally, Asian students identified approximately average rates of suicidal thoughts, but much significantly lower ‘plan’ rates than their counterparts.

Risk and Protective Factors

Suicide is not necessarily a random event. There are a number of indicators and risk

factors that make a person more vulnerable to death by suicide. In fact, recent research on effective interventions has shown that some aspects of depression and suicide can be prevented or delayed; while some protective factors can be maximized. Some of the risk factors associated include:

- Family history of suicide
- History of trauma or abuse
- Previous suicide attempts
- Substance abuse

- Loss
- Barriers to accessing mental health treatment
- Hopelessness
- Inadequate social support



Figure 4 illustrates the effect of both risk and protective factors.

Individuals have chronic or indelible circumstances that are simply part of their risk profile such as family history or mental illness.

the National Institutes of Mental Health (NIMH), 75% of older adults who die by suicide visited a physician during the month before their death⁵. This represents missed opportunities for primary care depression screening, similar to screening for diabetes, cancer or heart disease.

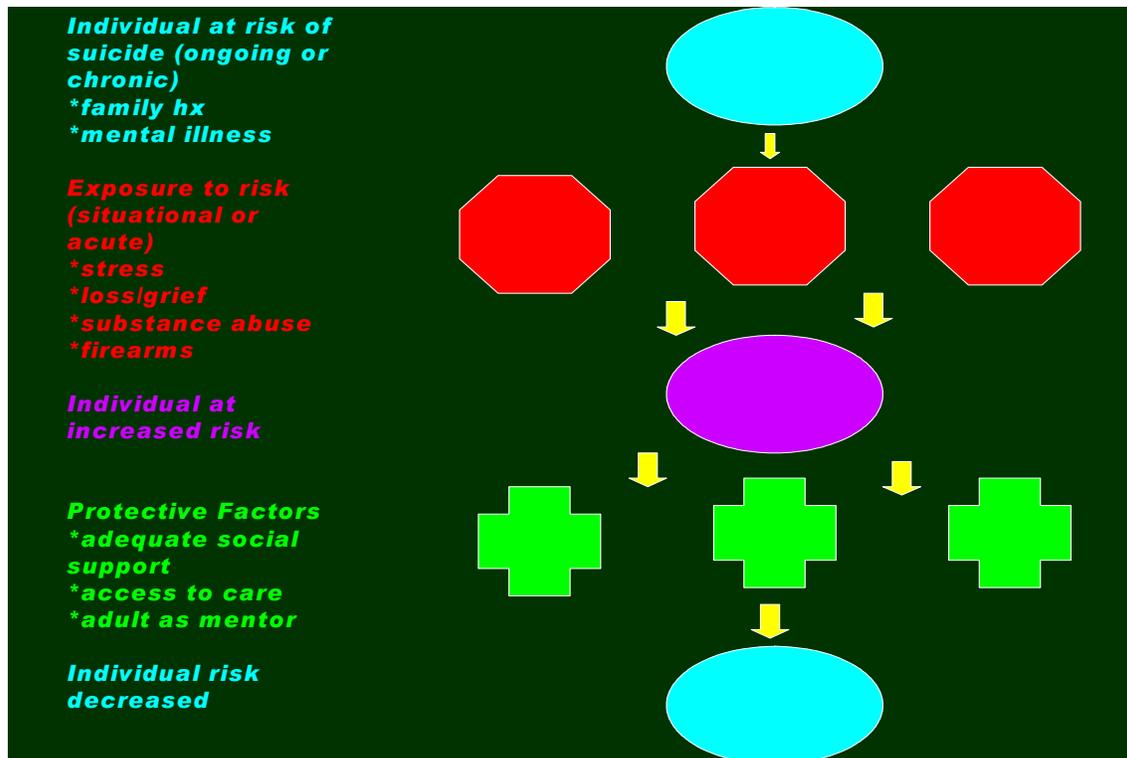


Figure 4

Factors that are protective include:

However, certain situational or acute risk factors, such as substance abuse or access to firearms, may render individuals at greater risk for death by suicide. According to the Suicide Prevention Research Center⁴, protective factors can increase resilience and coping mechanisms that can help neutralize or reduce an individual's risk. Examples of these include a solid social support network, access to a reliable, loving adult as well as access to primary health care. According

- Effective clinical care for physical, mental and substance abuse disorders
- Family and community support
- Skills in problem solving, conflict resolution and non violent handling of disputes
- Cultural and religious beliefs that encourage self preservation

Local Prevalence of Various Suicide Risk and Protective Factors

Mental illness, substance abuse, trauma and abuse National estimates suggest that between 21-26% of Washtenaw County adults have a diagnosable mental illness at any one time⁶. At least 7% of the population has mood disorders including major depression, bipolar depression or dysthymia⁷. Regarding substance abuse, 7% of adult county residents report using illicit drugs in the past year, 14% binge drink, and 6% are heavy drinkers. The U.S. Substance Abuse and Mental Health Services Agency (SAMHSA) estimates that 40-60% of people who die by suicide were intoxicated at the time of the suicide⁸. Nine percent of adult county residents have ever been threatened with intimate partner violence. Further, Washtenaw County has excess rates for both substantiated child abuse and sexual assault rates compared to Michigan and the U.S.

The 2005 Washtenaw County Health Improvement Plan (HIP) survey of 2000 county households indicates a number of concerning results regarding mental health risk factors that may predispose persons to depression and suicide risk. As mentioned above, depression is a risk factor for suicide. According to SAMHSA⁹, 2-15% of people diagnosed with major depression die by

suicide. Approximately 60% of people who die by suicide have had a mood disorder¹⁰.

Poor Mental Health

One indicator of depression is nationally tested survey questions regarding the number of days of 'poor mental health.' The HIP survey data showed that 10% of Washtenaw County residents had ten or more poor mental health days in the past month (PMHDPM). While this indicator may not be diagnostic for chronic, persistent mental illness, it does suggest that at least a third of these individuals' lives are spent with significant mental or emotional stress and coping challenges. The prevalence of this depression and other suicide risk factors are shown in Figure 5. Fourteen percent of Washtenaw County residents binge drink, 7% abuse substances and over a third identify ten or more days of not enough sleep or rest.

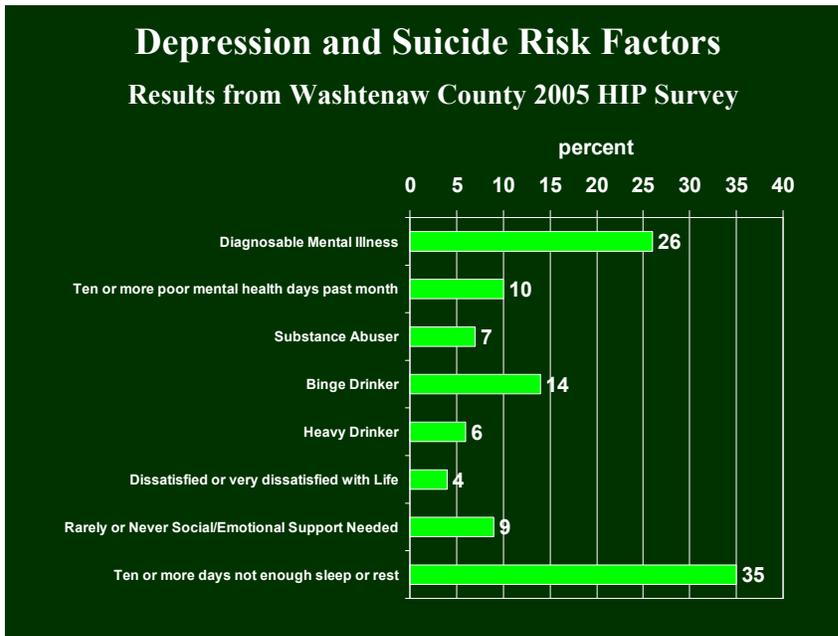


Figure 5

Figure 6 demonstrates the proportion of these risk groups that identify ten or more poor mental health days in the past month (PMHDPM). The Washtenaw County groups that have the greatest average days of PMHDPM are those in fair or poor health (7.4%); those with less than a high school education (6.9%) and Black persons (5.4%). Of those who identify having all 30 days of PMHDPM, only 29% are being treated by a mental health professional; 24% of those with ten or more PMHDPM are being seen.

Lack of Life Satisfaction

Additional risk factors that contribute to the likelihood of suicide are social support and hopelessness. Both life satisfaction and social support have long term effects on the risk of suicide¹¹. The HIP survey includes questions that proximate both of these regarding adequacy of social and emotional support, as well as life

satisfaction. Four percent of county residents identify being ‘dissatisfied’ or ‘very dissatisfied’ with life. Residents least likely to be satisfied with their life include those in fair or poor health, minority persons. (except Asians), and those in the \$35,000 - \$74,000 annual income categories.

Inadequate Social Support

Nine percent of Washtenaw County residents say they have ‘rarely’ or ‘never’ get the social or emotional support needed. This rate is nearly 25% higher than the Michigan

rate of 7.3%. Groups least likely to get the social and emotional support they need include minority groups and persons 50 years and older. According to the U.S. Centers for Disease Control, older adults who almost never visit with friends or relatives report much lower quality of life, including mentally unhealthy and

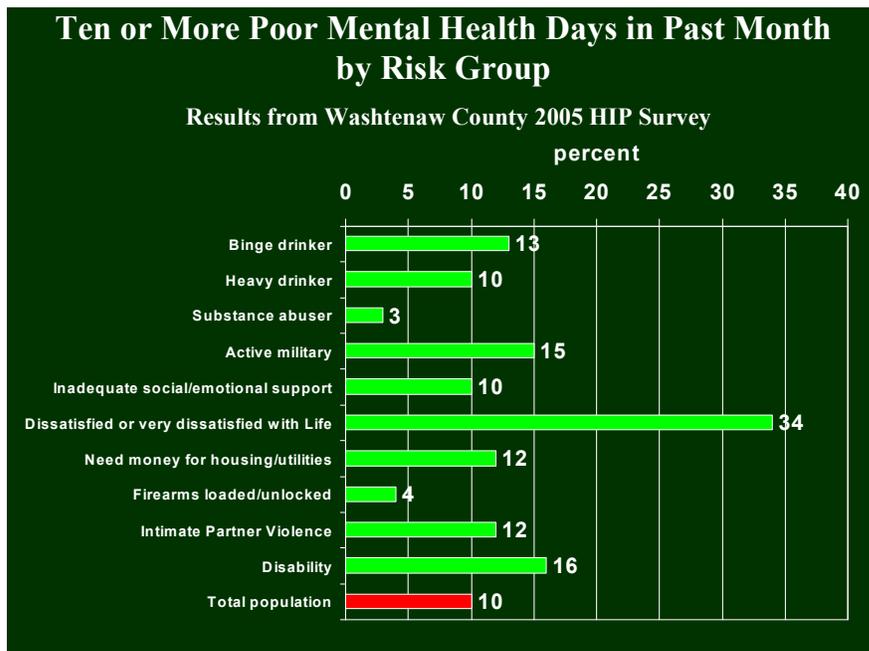


Figure 6

depressive symptoms¹². Moreover, recent studies have also shown that Americans had 33% fewer friends in 2004 compared to 1985¹³.

Protective Factors – Kids

Results from the largest, most comprehensive adolescent health survey conducted by the National Institute of Child Health and Human Development¹⁴ identified that close and caring relationships with adults are highly protective for decreasing the risk of suicidal intentions and thoughts, but also for risky sexual behavior, substance abuse and sexually transmitted disease.

As seen in Figure 7, results from the 2005 and 2006 Washtenaw County middle school surveys suggest that kids who identify “never” having an adult who helps or supports them are four times more likely to have attempted suicide than kids who say they “always” have a helpful or supportive adult in their life. Data not shown here suggest similar differences for these same kids who identify having an adult “mentor” compared to those who say they do not.

Washtenaw County Health Improvement Plan 2020 Objectives Related to Suicide and Depression

As a result of examining the information described above, as well as numerous other sources, the Washtenaw County Community Health Committee identified a number of critical health objectives for 2020

related to suicide and mental health for county residents. These include:

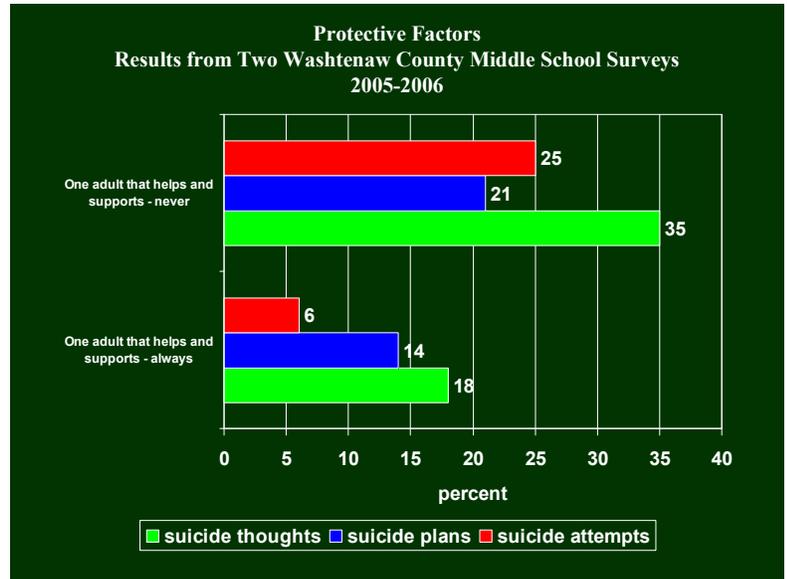


Figure 7

Adults

- Increase the proportion of Asian American adults who have sufficient social support from 73% to 91%.
- Decrease the proportion of African Americans with 15 or more poor mental health days per month from 16% to 7%

Kids

- Increase the proportion of middle school students with a ‘C’ average or lower who identify at least one supportive adult in their lives from 76% to 85%.
- Reduce the proportion of middle school students who have ever had suicidal thoughts from 23% to 10%.
- Reduce suicide attempt rates in middle school students who have ever used marijuana from 22% to 9%.

Achieving Suicide and Mental Health Objectives

According to the World Health Organization, the most effective strategies to prevent suicides include physicians screening for depression combined with prescribing prescription of antidepressant drugs to patients suffering from depression. Additionally, limiting access to lethal means of suicide has been shown to effectively prevent suicides. For youth, effective primary prevention programs include multicomponent school based strategies¹⁵. These school based suicide prevention programs, which target behavior, social support and coping skills helped to improve ego identification, reduced risk factors and enhanced protective factors. Effective adult interventions include¹⁶:

- Problem solving therapy
- Emergency contact card
- Antidepressants
- Dialectic behavior therapy
- Cognitive behavior therapy

SAMHSA's National Registry of Evidence Based Programs and Practices¹⁷ describes interventions that include recovery from depression, self reported symptoms of depression, hopelessness and suicide prevention skills for youth. The majority of these successful interventions include a number of common aspects: screening, coping and social skill development, strengthening social supports and policies

that promote help seeking. Examples of these best practices include the American Indian Life Skills Development program, which is a school based curriculum covering topics such as building self-esteem, identifying emotions and stress, increasing communication and problem-solving skills, recognizing and eliminating self-destructive behavior, learning about suicide, role-playing around suicide prevention, and setting personal and community goals.

A second example of a successful program includes the United States Air Force Suicide Prevention Program (AFSPP)¹⁸, which is a population-oriented approach to reducing the risk of suicide. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. AFSPP's 11 initiatives include:

1. Leadership Involvement
2. Suicide Prevention in Professional Military Education
3. Guidelines for Use of Mental Health Services
4. Community Preventive Services
5. Community Education and Training
6. Investigative Interview Policy
7. Critical Incident Stress Management
8. Integrated Delivery System (IDS)
9. Limited Privilege Suicide Prevention Program
10. Behavioral Health Survey
11. Suicide Event Surveillance System

Goals and Objectives

Prevention

Goal 1: Promote awareness that suicide is preventable.

Objective 1.1: Implement and coordinate a county-wide awareness campaign that focuses on the community at large (population wide).

Objective 1.2: Implement and coordinate targeted collaborations for education activities as a part of the county-wide awareness campaign.

Objective 1.3: Reduce access to lethal means and methods of self-harm by identifying groups/organizations to receive education materials, presentations, or trainings.

Goal 2: Develop, implement and evaluate suicide prevention programs and resources.

Objective 2.1: Identify and review existing resources and programs to produce program/resource inventory by community sector and identify best practices.

Goal 3: Develop a sustainable surveillance system.

Objective 3.1: Create a surveillance system that will regularly collect and review data on contacts and interventions made by law enforcement, health care, or human services agencies that have contact with individuals making suicidal threats and/or behaviors. Such as: veteran service organizations, schools, etc.

Objective 3.2: Establish a suicide review committee (much like the Child Death Review Committee) to determine if suicide death was preventable and to implement additional prevention measures.

Goal 4: Promote National Suicide Hotline use and investigate the possibility of initiating a local suicide hotline that serves all populations.

Objective 4.1: Post suicide hotline information at high risk locations, such as parking structures and bridges.

Objective 4.2: Determine if having local suicide hotline would increase prevention and provide greater access to local resources.

INTERVENTION

Goal 5: Improve early identification of individuals contemplating suicide.

Objective 5.1: Target organizations that have contact with or serve high-risk populations.

Objective 5.2: Inform agencies and organizations that have contact with high risk populations as to how to identify, engage with, and successfully refer or transfer suicidal individuals to the appropriate next level of care.

Goal 6: Increase the number of mental health practitioners using best practice suicide assessment tools.

Objective 6.1: Identify and promote use of best practice suicide assessment tools.

Objective 6.2: Encourage mental health service providers and organizations to develop suicide intervention policies and procedures based on evidence based practices.

POST-VENTION

Goal 7: Provide support services to families, schools, an others who had a relationship or involvement with someone who has died by suicide.

Objective 7.1: Routinely offer post-suicide psychological crisis intervention services to individuals, groups, organizations, or schools impacted by a suicide.

Objective 7.2: Routinely offer post-suicide psychological crisis intervention services to first responders and other support personnel who may be affected by a suicide.

Objective 7.3: Provide resource materials for family and friends of survivors including survivor outreach service with home visit and support materials.

Objective 7.4: Identify and share with law enforcement officers recommended strategies re: sensitive communication (notification, interviews, and investigations) to survivors.

Goal 8: Seek funding (grants, in-kind resources) for the implementation of the Washtenaw County Suicide Prevention Plan.

Objective 8.1: Identify partners to assist with implementing.

Objective 8.2: Identify Federal, State and local funding opportunities to implement priority goals and objectives.

Glossary of Suicide Prevention Terminology¹⁹

Activities – the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Adolescence – the period of physical and psychological development from the onset of puberty to maturity.

Advocacy groups – organizations that work in a variety of ways to foster change with respect to a societal issue.

Affective disorders – see mood disorders.

Anxiety disorder – an unpleasant feeling of fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Best practices – activities or programs that are in keeping with the best available evidence regarding what is effective.

Biopsychosocial approach – an approach to suicide prevention that focuses on those biological, psychological and social factors that may be causes, correlates, and/or consequences of mental health or mental illness and that may affect suicidal behavior.

Bipolar disorder – a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Causal factor – a condition that alone is sufficient to produce a disorder.

Cognitive/cognition – the general ability to organize, process, and recall information.

Community – a group of people residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans – plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

Comorbidity – the co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.

Connectedness – closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Consumer – a person using or having used a health service.

Contagion – a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Culturally appropriate – a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture – the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Elderly – persons aged 65 or more years.

Environmental approach – an approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology – the study of statistics and trends in health and disease across communities.

Evaluation – the systematic investigation of the value and impact of an intervention or program.

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective.

Follow-back study – the collection of detailed information about a deceased individual from a person familiar with the decedent's life history or by other existing records. The information collected supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Frequency – the number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors which can repeat over time.

Gatekeepers – those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal – a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health – the complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health and safety officials – law enforcement officers, fire fighters, emergency medical technicians (EMTs), and outreach workers in community health programs.

Healthy People 2010 – the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

Indicated prevention intervention – intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intentional – injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries. **Intervention** – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

Means restriction – techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping).

Mental disorder – a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

Mental health – the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

Mental health problem – diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Mental health services – health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness – see mental disorder.

Mood disorders – a term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states; included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

Morbidity– the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality – the relative frequency of death, or the death rate, in a community or population.

Objective – a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often.

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs – programs that send staff into communities to deliver services or recruit participants.

Personality disorders – a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress.

Postvention – a strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors – factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Psychiatric disorder – see mental disorder.

Psychiatry – the medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.

Psychology – the science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Public information campaigns – large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

Public Health Approach – the systematic approach using five basic evidence-based steps, which are applicable to any health problem that threatens substantial portions of a group or population. The five steps include defining the problem, identifying causes, developing and testing interventions, implementing interventions and evaluating interventions.

Rate – the number per unit of the population with a particular characteristic, for a given unit of time.

Residency programs – postgraduate clinical training programs in special subject areas, such as medicine.

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools – those instruments and techniques (questionnaires, check lists, selfassessment forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention – intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm – the various methods by which individuals injure themselves, such as selflaceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Self-injury – see self-harm.

Sociocultural approach – an approach to suicide prevention that attempts to affect the society at large, or particular subcultures within it, to reduce the likelihood of suicide (such as adult-youth mentoring programs designed to improve the well-being of youth).

Social services – organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

Social support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Specialty treatment centers (e.g., mental health/substance abuse) – health facilities where the personnel and resources focus on specific aspects of psychological or behavioral well-being.

Stakeholders – entities, including organizations, groups and individuals, which are affected by and contribute to decisions, consultations and policies.

Stigma – an object, idea, or label associated with disgrace or reproach.

Substance abuse – a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

Suicidal act (also referred to as suicide attempt) – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Suicidal behavior – a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior.

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicide attempt survivors – individuals who have survived a prior suicide attempt.

Suicide survivors – family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Unintentional – term used for an injury that is unplanned; in many settings these are termed accidental injuries.

Universal preventive intervention – intervention targeted to a defined population, regardless of risk; (this could be an entire school, for example, and not the general population per se).

Utilization management guidelines – policies and procedures that are designed to ensure efficient and effective delivery (utilization) of services in an organization.

Supplemental definitions of terms used in the field of suicide prevention:

Prevention network – coalitions of change-oriented organizations and individuals working together to promote suicide prevention. Prevention networks might include statewide coalitions, community task forces, regional alliances, or professional groups. Public health - the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.

List of Participants

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Sarah J. Freedman	Washtenaw County Public Health Department
Scott Jeffrey	

Shannon	
Sharon S. Sheldon	Washtenaw County Public Health Department
Susan Lee	Washtenaw County Public Health Department
Tasha Kelley	
Trish Meyer	U of M Depression Center
Wendy Beardsley	Survivor/Parent Activist

Endnotes:

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- ⁴ Suicide Prevention Resource Center: Risk and Protective Factors for Suicide – 2001 <http://www.sprc.org/library/srisk.pdf>
- ⁵ Older Adults: Depression and Suicide Facts. National Institutes of Mental Health. 2008. <http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml>
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- ⁸ National Strategy for Suicide Prevention: Suicide – Some Answers. <http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp>
- ⁹ National Strategy for Suicide Prevention: Suicide – Some Answers. <http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp>
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