Michigan Suicide Prevention Commission

Initial Report

March 2021

Are you having suicidal thoughts?

Suicidal thoughts by themselves are not dangerous, but how you respond to them can make all the difference. Support is available.

You can call the **National Suicide Prevention Lifeline** 24 hours a day, seven days a week, at **1-800-273-8255 or 1-800-273-TALK.** Press 1 for the Veterans Crisis Line. If you are under 21, you can ask to talk a peer at Teen Link. If you are a TTY user, you can use your preferred relay services or dial 711 then 1-800-273-8255.

If you feel like you need someone to talk to but do not feel like talking on the phone, try texting "Hello" to the Crisis Text Line at 741741, or visit https://suicidepreventionlifeline.org/talk-to-someone-now/ to find chat links to the National Suicide Prevention Lifeline, the Veterans Crisis Line, or the national Disaster Distress Helpline.

Creating a safety plan to help you cope with difficult life circumstances, emotions or thoughts can be lifesaving. If you feel as though you might be at risk of suicide in the future, download the My3 App from the National Suicide Prevention Lifeline. The application can be used to list your crisis contacts, make a safety plan and use emergency resources. For more information please visit the website: https://my3app.org/

Are you concerned about someone else who might be at risk of suicide?

This person is fortunate you are paying attention. Here are five steps you can take to help:

1. **Look for warning signs.** Some common warning signs associated with people who are considering suicide include talking or writing about death, dying or suicide; seeking ways to kill themselves; or directly or indirectly threatening suicide.
2. **Show you care.** This may look different depending on who you are and your relationship to the person, but let the person know you have noticed something has changed and it matters to you. If appropriate, let them tell you how they are feeling and why.
3. **Ask the question.** Make sure you both understand whether this problem is about suicide. "Are you thinking about suicide?" Asking this question as directly as this may be extremely helpful. It does not put the idea in someone's mind who is not already thinking about suicide. Asking as directly as this is often very reassuring to the person in crisis.
4. **Restrict access to lethal means.** Help the person remove dangerous objects and substances like medications, drugs, or alcohol from the places they live and spend time.
5. **Get help.** This person may know who they want to talk to (a therapist, their guardian, their partner). You can also call the **National Suicide Prevention Lifeline** 24 hours a day, seven days a week, at **1-800-273-8255**.

State of Michigan
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Lansing

GRETCHEN WHITMER
Governor

ELIZABETH HERTEL
Director

March 10, 2021

Dear Michigan Residents,

I am pleased to present the Michigan Suicide Commission Initial Report. Statistics regarding suicide are alarming. Suicide rates have increased across the United States and Michigan over the past decade. In 2019, nearly 1,500 Michiganders lost their lives to suicide. Suicide affects Michigan residents of all races, ethnicities, ages, and incomes. The good news is suicide is preventable. We must act now to reduce suicide deaths and attempts in our state.

The Suicide Prevention Commission has established achievable objectives that will save lives. Effective suicide prevention efforts require the engagement and commitment of multiple sectors and agencies. Statewide, we share responsibility to identify at-risk individuals and ensure they receive essential services for behavioral health care and stabilization. Our health systems, individual physical and mental health care providers, schools, and communities must work collectively to reduce suicide deaths and attempts using the best available information and practices.

The preventable nature of suicide makes Michigan's current suicide rates unacceptable. However, through our plans and intentional actions, we can provide the help and resources necessary to save lives. Together, we can make Michigan a model state for suicide prevention, and a place where everyone gets the help they need, when they need it.

Thank you to all those working with us to achieve our goal.

Sincerely,

Joneigh Khaldun MD, MPH, FACEP
Chief Medical Executive/Chief Deputy for Health
Michigan Department of Health and Human Services

Preface

Governor Gretchen Whitmer initiated the Michigan Suicide Prevention Commission following the passage of Public Act 177 of 2019. The Commission was formed in March 2020. The Commission has been charged to work with state departments, nonprofit organizations and universities on researching the causes and possible underlying factors of suicide in the state. The research must focus on populations showing the highest suicide rates in this state in the decade immediately preceding the effective date of this act, and the highest growth in suicide rates during the same time.

Acknowledgements

This plan is dedicated to individuals lost to suicide and people who have suicidal thoughts and engaged in suicidal behavior, their loved ones and anyone impacted. The Commission would like to thank the many survivors, community members, family members, researchers, and policymakers who contributed to the development of this Initial Report. The Commission would like to also acknowledge the participants from the Listening Sessions who offered tremendous insight into what is happening in our state. The Commission would like to extend a special thank you to the survivors of a suicide attempt and loss who shared their stories, experiences and insights. Their candid suggestions are critical for creating opportunities to improve suicide prevention strategies and emphasize the urgency of putting in place sound strategies to prevent loss of life.

The Commission would like to thank all the individuals and organizations who contributed to the Michigan Suicide Prevention Commission Initial Report. Their assistance came in many invaluable forms including providing supplementary articles, writing portions of the report, editing, and serving as subject matter experts.

Executive Summary

Suicide is a serious public health problem across the nation, and Michigan is no exception. Suicide is complex, involving many biological, psychological, social and cultural determinants. Prevention efforts are often challenged by misconceptions about suicidal behavior, by stigma, and by ongoing risk factors that evolve over one's lifetime. Yet, there is hope and always an opportunity to save lives.

Michigan is a leader in developing both policy and community-led solutions to suicide. Suicide prevention coalitions provide training and advocacy. Behavioral healthcare providers treat patients at risk of suicide and save lives. Academic institutions, public health professionals and community-based organizations lend their expertise and resources to address this issue. Suicide prevention requires engagement of private and public partners across multidisciplinary fields and a commitment to wide-scale collaborations that integrate planning and coordinate actions, and Michigan's Suicide Prevention Commission has been developed to maximize that type of broad engagement.

The *Michigan Suicide Prevention Commission Initial Report* 2021 is a two-part report. The first section is the *Preliminary Report* highlighting in-depth data regarding the burden of suicide within the state, identified risk factors and populations at greater risk for death by suicide. The second section includes the Michigan Suicide Prevention Commission initial priorities and recommendations as a comprehensive approach to reduce suicide attempts and deaths

The Initial Report consists of five commission priorities:

1. Minimizing risk for suicidal behavior by promoting safe environments, resiliency and connectedness
2. Increasing and expanding access to care to support those at risk
3. Improving suicide prevention training and education
4. Implementing best practices in suicide prevention for health care systems
5. Enhancing suicide specific data collection and systems

Many of our suicide prevention practices are relatively new and evaluation data is evolving. Lowering the state suicide rate will require long-term investment, groundbreaking policy, and strong community work. It is critically important to acknowledge the many organizations and individuals within the state that have already been leading the way in this work. The *Michigan Suicide Prevention Commission Initial Report 2021* represents another step in that direction.

We are grateful for the dedication and commitment of everyone who participated in creating this plan on behalf of the people of Michigan.

Commission Membership

Co-Chair: Brian Ahmedani, PhD, Director, Center for Health Policy & Health Services Research and Director of Research, Behavioral Health Services at Henry Ford Health System
Co-Chair: Nancy Buyle, School Safety/Student Assistance Consultant, Macomb Intermediate School District
Shaun Abbey, Battalion Chief, Kentwood Fire Department
Zaneta Adams, Director, Michigan Veterans Affairs Agency
William Beecroft, MD, Behavioral Health Medical Director, Blue Cross Blue Shield of Michigan and Blue Care Network
Lily Bothe, Veteran, United States Air Force
Debra Brinson, Interim Executive Director, School-Community Health Alliance
Adelle McLain Cadieux, PsyD, Helen DeVos Children's Hospital; Assistant Professor, Michigan State University
Richard Copen, PhD, Chief Psychologist and Director, Michigan State Police Office of Behavioral Science
Jessica DeJohn, Regional Coordinator, Salvation Army Pathway of Hope
Sarah Derwin, Health Educator, Marquette County Health Department
Amber Desgranges, Grant Program Officer, Michigan Primary Care Association
Corey Doan, Analyst, Michigan Veterans' Facility Ombudsman
Kevin Frank Fischer, Executive Director, National Alliance on Mental Illness
Cathrine Frank, MD, Chair of Department of Psychiatry and Behavioral Health Services, Henry Ford Health System
John Greden, MD, Founder and Director, University of Michigan Depression Center and Rachel Upjohn Professor of Psychiatry and Clinical Neurosciences, University of Michigan
Danny Hagen, Chief, City of Hamtramck Fire Department
Cary Johnson, Correction Officer, Michigan Department of Corrections
John E. Joseph, Chief of Police, Lansing Charter Township
Laurin Jozlin, Clinical Analyst, Oakland Community Health Network
Jennifer Morgan, Medical Administrative Director, Bear River Health at Walloon Lake
Thomas Reich, Sheriff, Eaton County
Ryan Schroelucke, Detective, City of Grosse Pointe Woods Department of Public Safety
Barbara Smith, Executive Director, Suicide Resource & Response Network
Corbin J. Standley, PhD Student, Michigan State University; Board Chair, AFSP Michigan
Kiran Taylor, MD, Chief Medical Officer, Hope Network
Kenneth Wolf, PhD, CEO, Incident Management Team

Language Matters

The topic of suicide is deeply steeped in stigma. Considering the physiology, biochemistry and other factors that influence thoughts and behaviors, suicide should be discussed from a medical perspective. Therefore, we should all strive to use appropriate and clinically correct terminology. Changing the language will reduce the stigmas surrounding the subject and will allow all stakeholders to address suicide as the public health crisis it truly is.

Using people-first language avoids stigmatizing words or phrases and puts the emphasis back on people. This limits the focus on their actions, conditions, and diagnoses.

People first language would include:

- People with (…mental illness, depression, addiction, etc.),
- People who have died by suicide,
- People who have experienced a suicide attempt,
- People bereaved by suicide,
- People impacted /affected by suicide, and
- People with lived experience related to suicide.

General knowledge and use of appropriate terminology when dealing with issues related to suicide helps reduce stigma associated with seeking help. In medical settings, using accurate and appropriate language concerning suicide promotes and facilitates proper and concise care for individuals at risk of suicide as well as those affected by suicide.

When referring to an intentionally self-inflicted death, the clinically correct language is “died by suicide.” The word “commit” has been found to be inaccurate and stigmatizing as “commit” is connected to a criminal act, which is often viewed as an extension of a character defect. Professionals in the suicide prevention community acknowledge suicide occurs when there is a confluence of factors including an emotional crisis in which the brain is reacting to perceived, unbearable stress and the trajectory can be further influenced by mental health conditions that impair the capacity to cope.

Using the term “commit” can deter those who are struggling with such mental health conditions, crises and/or suicidal thoughts from seeking the help they need. An additional shift in the language is the elimination of the word “successful” when discussing suicide as well as “failed” when discussing a suicide attempt that does not result in death. For obvious reasons, success should not be measured as a completed suicide. Clinicians recommend using the word “completed” when referring to someone who dies from suicide.

Those who attempt suicide but do not die are called either “suicide attempt survivors” or “survivors of suicide attempt.” Family, friends, coworkers and others who are affected by an individual’s death by suicide are referred to as “survivors of suicide loss.”

This report also references both behavioral health and mental health. The Commission defines behavioral health as the connection between behaviors and health. Behavioral health is the more inclusive term and less stigmatized than mental health. When “mental health” is used in this document, it refers specifically to an individual’s state of being.

The importance of clear and consistent language for characterizing suicide and suicide-related behaviors is not only needed to decrease stigma but also to provide accuracy of the phenomena. When we replace problematic language with natural and respectful language, we shift how society reacts to and understands suicide. This helps to make the conversation about suicide safer. The way we communicate about suicide needs to avoid further stigma and focus on prevention.

A full listing of terms and expressions used by the Commission and throughout this report can be found in Appendix A: Suicide Prevention Glossary.

COVID-19 Statement

In the spring of 2020, Michigan had one of the highest rates of COVID-19 nationally, ranking seventh in the country for the most positive cases and the third for most deaths (DesOremau, 2020). Governor Gretchen Whitmer issued executive orders to decrease the spread of the disease. While meaningful progress in controlling the pandemic has been made, the pandemic has continued to impact the state on many levels. The unfolding of the current coronavirus 2019 (COVID-19) pandemic has caused unprecedented medical, social, and economic upheaval across the globe.

In August of 2020, the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report that examined the national survey responses between June 24–30, 2020, regarding the mental health of Americans, showed important findings relevant to the Commission's focus (Czeisler, Lane, & Petrosky, 2020). In the forementioned study, 11% of adults over the age of 18 reported having seriously considered suicide within the last 30 days, a figure estimated to be twice as many who reported similarly in 2018. Stratification across groups in that study was also noteworthy, with younger adults, racial/ethnic minorities, essential workers and unpaid adult caregivers reporting greater mental health symptoms.

According to Dr. Christine Moutier, chief medical executive for the American Foundation for Suicide Prevention (2020), the COVID-19 pandemic may increase the risk of population suicide because of its effects on multiple suicide risk factors. A wide range of public survey results have shown substantial increases in symptoms of anxiety and depression associated with COVID-19, including the every two week household pulse survey that showed the week ending February 1, 2021 almost 50% of respondents between ages 18-29 reporting higher levels of anxiety and depression, with Michigan reflecting concerning rates of depression and anxiety in self-reported data (Centers for Disease Control and Prevention, 2021). The unintended consequences from the social distancing measures taken to slow the spread of the pandemic has impacted the mental health and/or physical health of many people.

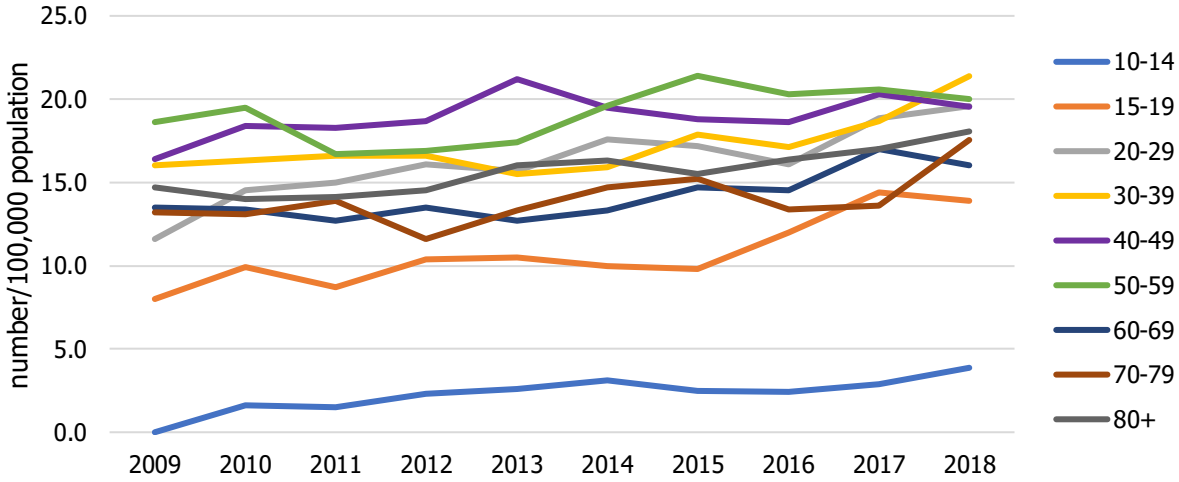
Although some of the data requires further analysis and is not entirely comparable to pre-COVID-19 information, with the anticipated behavioral health impact of the pandemic and the shifting landscape, the Michigan Department of Health and Human Services (MDHHS) has taken additional steps to provide mental health and substance use services, as well as emotional support resources during the COVID-19 pandemic. A broad range of interventions and prevention measures that research has shown to have an impact on reducing risk in the population. These include policy initiatives at all local, state, and federal levels.

More research is needed to understand the long-term effects of how the pandemic is affecting mental health, who is at greater risk and how emerging risks can be counteracted. Efforts will continue to establish resources and streamline access to services and supports, with an understanding that they will need to be sustained throughout the pandemic and beyond.

The Burden of Suicide in Michigan

Data that was gathered prior to the COVID-19 pandemic shows that suicide is the 10th leading cause of injury death in Michigan. Between 2009 and 2019, the rate of suicide among Michigan residents increased 28 percent, from almost 12 deaths per 100,000 population to 15 deaths per 100,000. The average annual suicide rate has remained relatively flat for more than a decade but has been slowly on the rise since 2010.

Figure 1. Suicide Death Rates by Age Group, 2009 - 2018



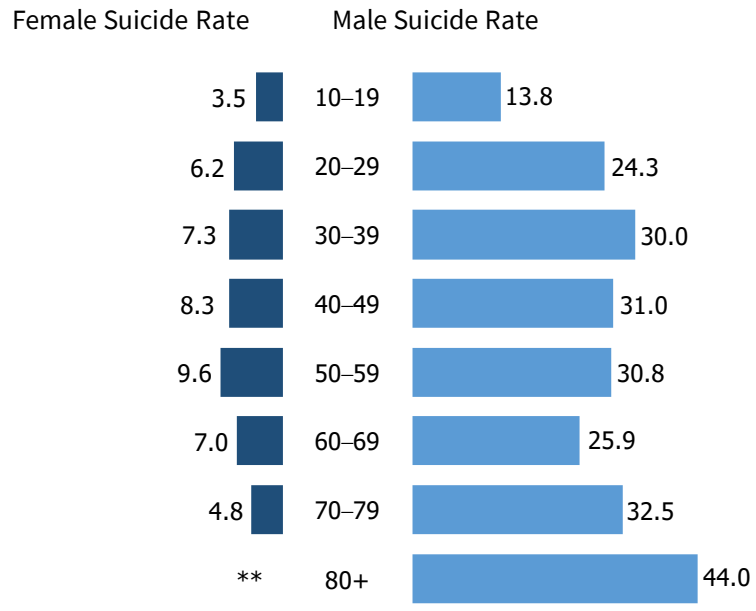
Source: CDC, WISQARS. *Fatal Injury Reports, National, Regional and State 1981-2018*

Demographics

Age and Gender

- Overall working adults ages 30-59 have the highest suicide rates.
- Males account for almost 8 out of 10 of the suicide deaths in Michigan.
- Men at every age are more likely to die by suicide than women because of the use of lethal means.
- The highest suicide rate per capita in 2018 (57.8 per 100,000) was among elderly aged 85 and older.
- While the death rate for men is greater than women, suicide attempts are more common among females than males.

Figure 2. Michigan Suicide Death Rates* by Sex, 2018



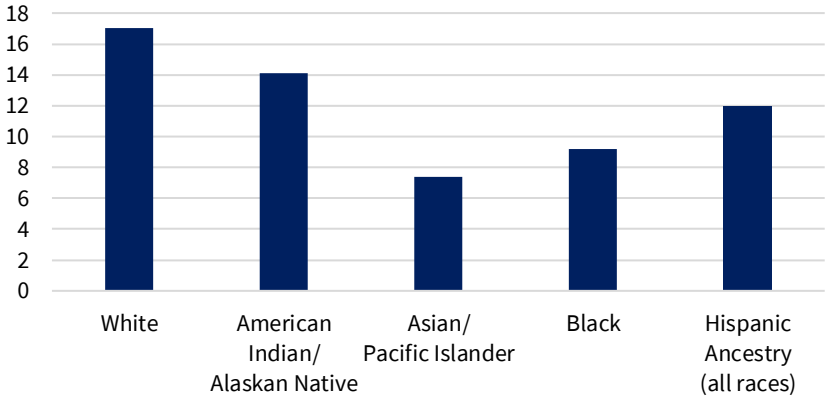
* Deaths per 100,000 pop **Too few deaths to report

Source: CDC, WISQARS. *Fatal Injury Reports, National, Regional and State 1981-2018*

Race and Ethnicity

- The white population has the highest suicide rates of all racial groups.
- The highest number of deaths in the state is for White residents.
- From 2017 to 2018 their suicide death rate for Black residents jumped from 5.8/100,000 to 9.5/100,000, driven primarily by an increase in the suicide rate for Black males from 9.4 to 16.2/100,000.

Figure 3. Suicide Rates by Race and Hispanic Ancestry, Michigan, 2018

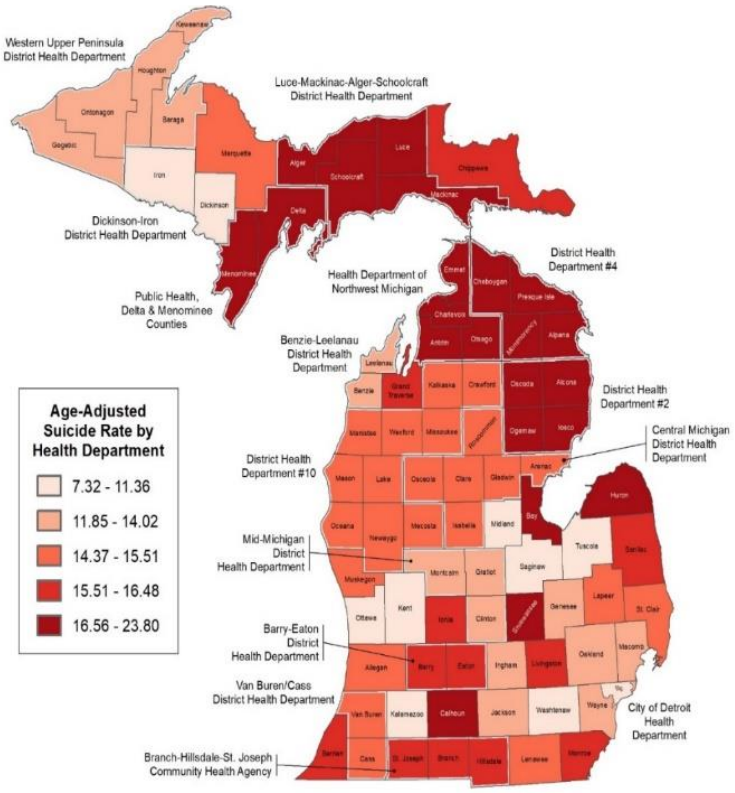


Source: CDC, WISQARS. *Fatal Injury Reports, National, Regional and State 1981-2018*

Geographical Distribution

- While the number of suicides is greater in more populous urban areas; suicide rates are generally higher in more rural areas.
- The northeastern half of the Lower Peninsula and eastern portion of the Upper Peninsula have the highest age-adjusted suicide rates.

Figure 4. Geographical Distribution Map



Source: Michigan Violent Death Reporting System

Occupation

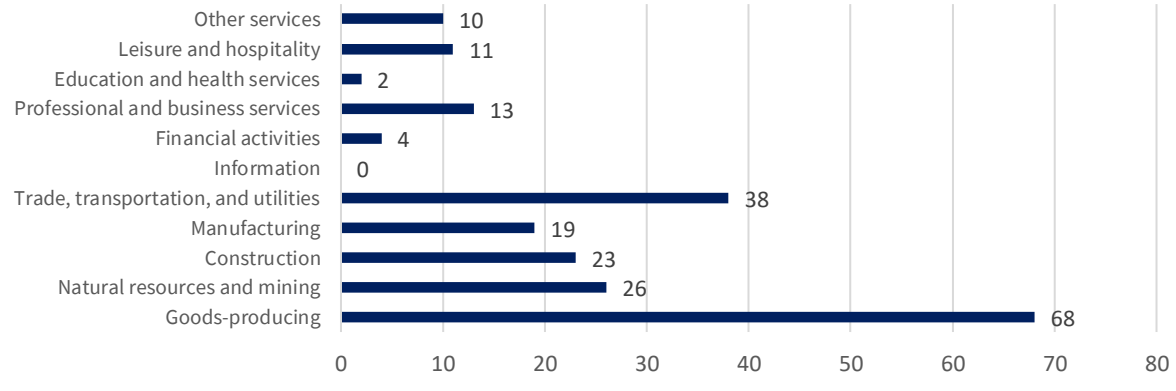
While information is not consistently available on the current occupation of Michigan suicide decedents, death certifications do contain the field "usual occupation" which is typically used to capture the type of work the person performed during most of their working life. A second field captures the type of business or industry in which they worked.

Table 1: Number of Michigan Suicide Deaths by Occupation (2018)	
Transportation and material moving	**32**
Construction and extraction	**24**
Management	**22**
Installation, maintenance and repair	**15**
Production	**12**
Sales and related occupations	**11**
Farming, fishing, and forestry	**9**
Protective service	**7**
Office and administrative support	**5**
Building and grounds cleaning and maintenance	**5**
Food preparation and serving related occupations	**4**
Art, design, entertainment, sports and media occupations	**3**
Healthcare practitioners and technical occupations	**1**
Healthcare support	**1**

Source: Census of Fatal Occupational Injuries (CFOI), 2018

In Michigan, the highest number of suicides are women ages 19-64, those working in medical/healthcare related professions and homemakers. The highest number of suicides for men within the same age range held jobs in construction, automotive and food/hospitality related businesses.

Figure 5. Michigan Suicide Deaths by Industry (2018)



Source: Census of Fatal Occupational Injuries (CFOI), 2018

Socioeconomic Status

Research suggests that suicide attempts are associated primarily with greater socioeconomic disadvantage but not consistently (Burrows & Laflamme, 2009). Younger people are more likely to die by suicide in poverty-stricken areas.

One study looked at nearly 21,000 cases of suicide from 2007 to 2016 and found that children between the ages of 5 and 19 were 37 percent more likely to die by suicide if they were from communities where 20 percent of more lived below the federal poverty levels (Hoffman, Farrell, & Monuteaux, 2020).

"Kids that are poor are already at a disadvantage. That stress can be very overwhelming and can worsen underlying depression, bipolar disorder, or substance use, which can ultimately lead to unfortunate outcomes."

Dr. A. Lee Lewis
Medical University of South Carolina

High Risk Populations: The Intersectionality of Suicide Across the Lifespan

The Michigan Suicide Prevention Commission identified several groups at a heightened risk for suicide and suicidal behaviors. These populations also reflect an increased risk at the national level. Limitations associated with the collection of suicide-related data can make it difficult to obtain reliable estimates for specific populations, and if collected, the information may not be readily available. In instances where Michigan-specific data is not available, the use of national data and trends are highlighted.

Active Military/Service Members[1]

Nationally, there were 541 confirmed or pending suicide deaths for calendar year (CY) 2018. There were 325 suicide deaths among service members in the Active Component, 81 deaths in the Reserve, and 135 deaths in the National Guard, respectively (Department of Defense Under Secretary of Defense for Personnel and Readiness, Calendar Year 2018).

Table 2: Annual Suicide Counts and Rates by Department of Defense

	CY 2016		CY 2017		CY 2018	
DOD Component/Service	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**
Active Component	**280**	**21.5**	**285**	**21.9**	**325**	**34.8**
Army	130	27.4	114	24.3	139	29.5
Marine Corps	37	20.1	43	23.4	58	31.4
Navy	52	15.9	65	20.1	68	20.7
Air Force	61	19.4	63	19.6	60	18.5
Reserve	**80**	**22.0**	**93**	**25.7**	**81**	**22.9**
Army Reserve	41	20.6	63	32.1	48	25.3
Marine Corps Reserve	19	--	10	--	19	--
Navy Reserve	10	--	9	--	11	--
Air Force Reserve	10	--	11	--	3	--
National Guard	**122**	**27.1**	**133**	**29.8**	**135**	**30.6**
Army National Guard	108	31.3	121	35.5	118	35.3
Air National Guard	14	--	12	--	17	--
All Components Total	**482**		**511**		**541**	

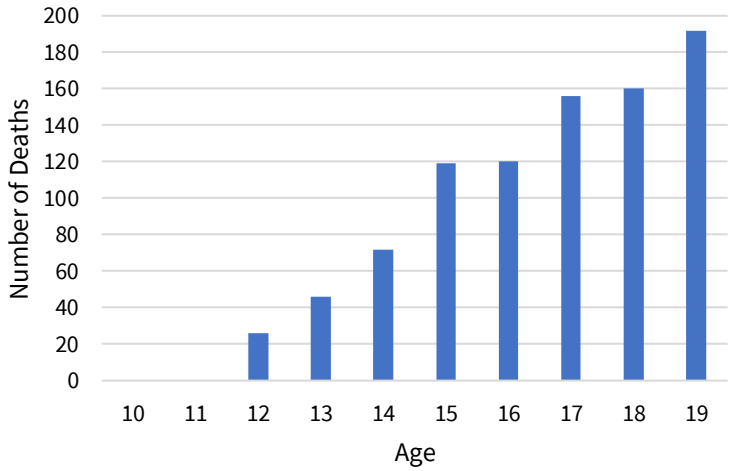
Source: Department of Defense Under Secretary of Defense for Personnel and Readiness, 2018

[1] Michigan does not have any Active Military Bases.

Children & Adolescents

- The 2017 Michigan Youth Risk Behavior Survey data found that 21 percent of Michigan's 9th – 12th graders seriously considered attempting suicide.
- Almost one in every 10 students indicated they attempted suicide during that time.

Figure 6. Adolescent Suicide Deaths by Age, Michigan, 2009–2018



Correction Officers

- Between 3 and 7 Michigan Department of Corrections (MDOC) employees died by suicide every year from 2016-2018. When comparing to the national average, MDOC's average rate of 4.7 deaths per 12,281 employees per year is about 38.27 per 100,000 which is 2.45 times the national average (Desert Waters Correctional Outreach and Gallium Social Sciences, 2019).
- A recent study found that the suicide rate among Correctional Officers (COs) is twice as high as the suicide rate of police officers and the general population (New Jersey Police Suicide Task Force, 2009)
- One of the few studies of CO suicide presented by the Bureau of Labor Statistics (BLS) Census of Fatal Occupational Injuries, shows 38 percent of the intentional fatalities suffered by COs were suicides by self-inflicted gunshot wounds (Konda, Reichard, & Tiesman, 2012).

Criminal Justice-Involved

- Between 2014 and 2017 of all suicides with known circumstances, 9.5 percent occurred within the context of a legal stressor.
- Nationally, individuals incarcerated in local jails have a rate of 50 suicide deaths per 100,000 in 2014 (Noonan, 2016).

Emerging Adults

- In the decade from 2009 through 2018, the suicide death rate for 18-25-year olds in Michigan increased 73 percent from 10.8 per 100,000 to 18.7 per 100,000.
- The U.S. suicide death rates for young adults 18 to 24 years old is 16.5 per 100,000 (Centers for Disease Control and Prevention. National Center for Injury Prevention and Control, 2020)

First Responders

- Nationwide, the risk of suicide among police officers is 54 percent greater than among American workers in general (Police Executive Research Forum, 2019).
- In Michigan, nine locals reported a total of twelve suicides since 2000 and 15 percent of fire fighters have attempted suicide (Michigan Professional Fire Fighers Union).

Health Care Contacts

- Eighty-three percent of those who die by suicide had a healthcare visit before their death, most in a primary care setting (Ahmedani, et al., 2014).
- White individuals are more likely to make visits to a healthcare provider before a suicide attempt (Ahmedani, et al., 2015).
- Across all levels of healthcare, including outpatient medical specialty and primary care, inpatient hospitals and emergency rooms, individuals who died by suicide were more likely to make a healthcare visit compared to matched controls (Ahmedani, et al., 2019).

Homeless

- Of all deaths by suicide in Michigan between 2014 and 2017, with known circumstances, 0.87 percent were among homeless individuals.
- Individuals experiencing homelessness have greater morbidity and mortality rates than the general population and experience more co-morbidities than their housed counterparts (Lebrun-Harris, Baggett, & Jenkins, 2012).
- Suicide rates among homeless populations are estimated at nine times that of the US general population (112.5 suicide deaths per 100,000 versus the U.S. national average of 12.5 per 100,000) (Centers for Disease Control and Prevention, 2014).

Table 3: 2014 Homeless Death by Suicide Counts

	Death Counts	Percentage
All	106	100
Male	92	86.7
Female	14	13.3

Source: National Healthcare for the Homeless Council, 2018

LGBTQ+ Youth

- An analysis of data from the 2015, 2017, and 2019 *Youth Risk Behavior Survey* found that LGB high school aged students consistently demonstrated higher suicide risk across all five indicators in the survey than their heterosexual peers (Johns, et al., 2020).
- The 2017 Youth Risk Behavior Survey found that sexual minority youth were significantly more likely than their heterosexual peers to report:
    - Experiencing persistent feelings of sadness or hopelessness.
    - Seriously considering making a suicide attempt.
    - Making a suicide plan.
    - Attempting suicide.
    - Requiring medical attention after a suicide attempt.
- The Trevor Project represents the experience of over 40,000 LGBTQ youth ages 13-24 across the U.S. (The Trevor Project, 2019). Their National Survey found:
    - Forty percent of LGBTQ respondents seriously considered attempting suicide in the twelve months prior to taking the survey, with more than half of transgender and nonbinary youth having seriously considered suicide.
    - Forty-eight percent of LGBTQ youth reported engaging in self-harm in the twelve months prior to taking the survey, including over 60 percent of transgender and nonbinary youth.

Loss Survivors

- Of the 18,764 suicides captured in the National Violent Death Reporting System (NVDRS) in 2015 (Stone, et al., 2018):
    - 1,497 (8.0%) experienced the death of a loved one.
    - 1,181 (6.3%) experienced a non-suicide death.
    - 379 (2.0%) experienced suicide of a family member or friend.

Middle Age Men

- In Michigan, high suicide rates exist among white male ages 55–59 (37.9/100,000), 75–79 (34.4/100,000), 50–54 (36.9/100,000), and 45–49 (35.5/100,000).
- Eighty percent of all deaths by suicide in the U.S. are among men aged 45-54 (SAMHSA, 2019).

Veterans

- Of suicides in Michigan, between 2014 and 2017 with known circumstances, 15.77 percent were among current or former military members (Centers for Disease Control and Prevention, 2020).
- In 2017, the suicide rate for veterans in Michigan was not significantly different than the national veteran suicide rate but was significantly higher than the overall national suicide rate, which Michigan closely mirrors.

Table 4: Veteran Suicide Rates, Michigan 2017

Age Group	# Veteran Suicides	Veteran Suicide Rate/100,000	General Population Suicide Rate/100,000
Total	170	28.9	18.0
18-34	27	64.3	17.1
35-54	41	31.8	19.7
55-74	73	26.6	17.2
75+	29	20.3	17.0

Source: US Department of Veterans Affairs, 2019

"Any suicide is one too many. There's no reason that we can't change the reality of the statistics that we see"

Anna Mueller
University of Chicago Illinois

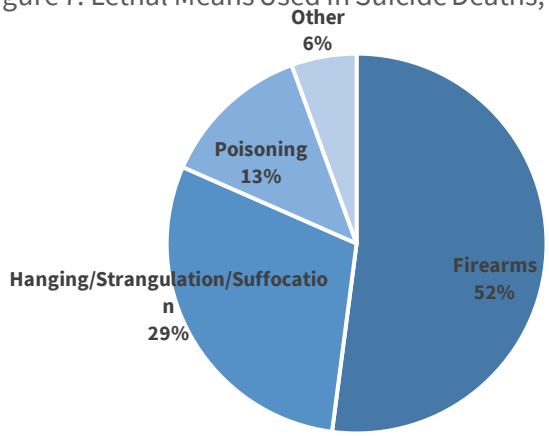
Identified Causes for Increase in Rates

Causes of suicide are complex and vary among individuals and across age, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors.

Access to Means

- In the United States, more than half of all suicide deaths are the result of firearms and are the leading cause of suicide death in Michigan (Weir, 2019).
- Persons employed in occupations with access to firearms, medicines or drugs and carbon monoxide, more frequently use their access to said lethal means to end their lives than those without access (Milner, Witt, Maheen, & LaMontagne, 2017)

Figure 7: Lethal Means Used in Suicide Deaths, Michigan, 2018



Source: CDC, WISQARS. *Fatal Injury Reports, National, Regional and State, 1981-2018*

Alcohol and Drug Use

- In one study of 13,317 suicide deaths 9,913 tested positive for ≥ 1 substances when toxicology testing was conducted (Stone, et al., 2018):

Table 5: NVDRS Substances Detected and Suicide Death (1996-2016)

Substance Detected	Total Tested	Total Positive	% Positive
Alcohol	10,950	4,442	40.6
Opioids	8,554	2,279	26.6
Benzodiazepines	8,124	2,464	30.3
Cocaine	7,978	499	6.3
Amphetamines	7,615	736	9.7
Marijuana	6,569	1471	22.4
Antidepressants	5,425	2,214	40.8

Source: Stone, D. M. et. Al Vital Signs: Trends in State Suicide Rates - United States, 1999-2016 and Circumstances Contributing to Suicide - 27 States, 2015. *Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report, 67*(22).

Chronic Medical Conditions

- Of the suicides in Michigan, between 2014 and 2017, with known circumstances, 24.68 percent had a co-occurring physical health problem (Centers for Disease Control and Prevention, 2020).
- Most physical health conditions are associated with increased risk of suicide, several increase risk even after adjusting for mental health conditions (Ahmedani, et al., 2017).
- People with multiple chronic conditions have greater risk for suicide (Ahmedani, et al., 2017).

History of Suicide Attempts

- Of the suicides in Michigan between 2014 and 2017 with known circumstances, 19.81 percent had a history of suicide attempts and 23.74 percent had a history of suicidal thoughts or plans (Centers for Disease Control and Prevention, 2020).
- A prior history of attempted suicide is the strongest single predictive factor of suicide (World Health Organization, 2014).
- It is estimated there are 10 to 40 nonfatal suicide attempts for every completed suicide (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).
- The NVDRS found from 27 states – including Michigan (Stone, et al., 2018):
    - 5,990 (31.9%) had a history of ideation
    - 3,732 (19.9%) had a history of attempts
- One of every 100 suicide attempt survivors will die by suicide within one year of their first admission to an emergency unit, a risk approximately 100 times that of the general population (Hawton, 1992).

Economic Climate

- When indicators of national economic performance are poor there is typically an associated rise in the suicide rate and suicide rates have often fallen when living conditions have improved (Weir, 2019).
- The NVDRS found from 27 states – including Michigan 2,941 individuals (16.2%) who died by suicide experienced job/financial problems.

Mental Illness

- According to one study, approximately half of people have a mental health diagnosis before they die by suicide (Ahmedani, et al., 2014).
- The same study found approximately 33 percent have a behavioral health visit before they die by suicide (Ahmedani, et al., 2014).
- Feelings of hopelessness and an inability to make positive changes in one's life are to consistent psychological precursors to suicidal behaviors (American Foundation for Suicide Prevention, 2020).

Table 6: NVDRS Mental Health Conditions and Suicide Death (1996-2016)

Characteristic	Total No.	%
Depression/Dysthymia	**7076**	**75.2**
Anxiety disorder	**1579**	**16.8**
Bipolar disorder	**1431**	**15.2**
Schizophrenia	**509**	**5.4**
PTSD	**424**	**4.5**
ADD/ADHD	**226**	**2.4**
Not specified	**760**	**8.1**
Current depressed mood	**3,962**	**42.1**

Source: Stone, D. M. et. Al Vital Signs: Trends in State Suicide Rates - United States, 1999-2016 and Circumstances Contributing to Suicide - 27 States, 2015. *Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report, 67*(22).

"At the individual level, there is never a single cause of suicide. There are always multiple risk factors.

Dr. Christine Moutier
American Foundation for Suicide Prevention

Initial Report Planning Process

Information Gathering

The Commission has committed to an extensive data-gathering process to assure that there was an inclusive information collection. Methods included a survey, virtual listening sessions, and key informant interviews. In addition, members of the public have been able to participate and contribute their thoughts, feelings, and opinions throughout the monthly Commission meetings.

Survey

A survey was developed to learn more about the community's thoughts, suggestions, priorities and vision on this public health issue. The surveys were distributed through the Michigan Department of Health and Human Services – Injury & Violence Prevention Section listserv and through the Commissioners' networks. There were 111 responses to the survey.

Virtual Listening Sessions

In December of 2020, MDHHS hosted a series of virtual listening sessions to solicit broad input on recommendations and priorities for the Commission. The listening sessions attracted nearly 200 participants.

Participants engaged in an interactive, facilitated dialogue and answered questions on the key aspects of prevention efforts in their communities to highlight opportunities, gaps, and barriers. Participants were asked:

- What is the most critical barrier in your community to prevent suicide and why?
- What do you see as major risk factors for suicide in your community and why?
- What resources are missing in your community to prevent suicide?

The comments, suggestions and other information gathered during this outreach process were synthesized and integrated. They yielded a wealth of information and numerous suggestions about what should be included in the commission's recommendations. Given the breadth of comments, common themes had emerged that merited additional reflection and consideration for inclusion in the recommendations.

The questions and themes from the virtual listening sessions have been captured in Appendix B.

Engaging Subject Matter Experts

As part of the research for this Initial Report, the Michigan Suicide Prevention Commission met with local and national leaders in suicide prevention. Staff worked with representatives from the Michigan Department of Health and Human Services as well as other government and private partners.

The Commission engaged with leaders from the American Foundation for Suicide Prevention, the University of Michigan, Henry Ford Health System, John D. Dingell VA Medical Center, and other notable organizations.

Aligning with National Strategy

The Michigan Suicide Prevention Commission final recommendations are grounded in the National Suicide Prevention Strategy, 2012. This report was a joint effort by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. Recently as January 2021, the new administration's U.S. Department of Health and Human Services and the Office of the Surgeon General issued a call to action to implement these recommendations. The National Strategy's goals and objectives fall within four strategic directions, which—when implemented collectively—may be most effective in preventing death by suicide.

1. Create supportive environments that promote health and empower individuals, families, and communities.
2. Enhance clinical and community preventive services.
3. Promote the availability of timely treatment and support services; and
4. Improve the suicide prevention surveillance collection, research, and evaluation.

The Michigan Suicide Prevention Commission aligned their recommendations with the National Strategy and incorporated findings from the listening sessions and other best practices in the field. The Commission believes this approach can be used to best promote wellness, increase protection, reduce risk and stigma and encourage effective treatment and recovery. Thereby, ultimately resulting in fewer suicide attempts and deaths.

Cultural Considerations

Across the state of Michigan, there are diverse groups of people, lifestyles, cultures, ages, races, and ethnicities and suicide behaviors can vary among the diverse groups. Therefore, it is imperative that any recommendations for suicide prevention address the need for culturally competent practices. Prevention approaches should also be heavily informed by the values, needs, and strengths of the groups and individuals being served. Some risk and protective factors vary depending on the group targeted for suicide prevention efforts.

Suicide prevention efforts within communities of color require culturally and linguistically competent approaches that recognize contributing factors. This includes acculturative stress, racism, prejudice, and the sense of alienation and marginalization (National Organization for People of Color Against Suicide, 2003-2004). These factors also become barriers to help-seeking and access to and quality of treatment. Therefore it is imperative to engage stakeholders from diverse cultural backgrounds in local and statewide suicide awareness and prevention efforts. Our practices must respect, acknowledge, and make considerations for the target populations' beliefs, cultures, and linguistic differences.

In Michigan and nationally, there are unacceptable health disparities for children, youth, and young adults who identify as lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) and may have further challenges given intersectionality with other marginalized identities. These disparities persist because LGBTQ+ children, youth, and young adults often face discrimination, stigma, bias, and limited access to LGBTQ+ informed health care. Research has also shown that youth and young adults with multiple, intersecting marginalized identities are at increased risk for suicide. As such, research and prevention must focus both on marginalized identities and on their intersections (Standley, 2020)

It is incredibly important for those in health and behavioral health settings to be knowledgeable about the specific groups being served so that screenings, assessments, safety planning, and treatment planning will be reflective and received. While the field is still emerging, culturally responsive and intersectional prevention should broaden the range of risk assessment questions, use the latest instruments, and seek out culturally attuned, intersectionally-focused intervention programs (Clay, 2018).

The Suicide Prevention Resource Center suggests prevention efforts should:

- Research and understand the cultural context of the community targeted by your program.
- Ensure that your team includes a diverse representation of members from your target population throughout the planning, implementation, and evaluation processes.
- Tailor information and resources to respectfully address your target population's values, beliefs, culture, and language. Use alternative formats (e.g., audiotape, large print, storytelling) whenever appropriate.
- Create an open dialogue with group members to allow cultural considerations to be communicated, such as preferences regarding personal space, geography, familiarity, and terminology (i.e., words that should be used or avoided).

To be effective, prevention approaches cannot be one size fits all. It is important to explore and develop culturally relevant resources for groups at disproportionate risk of suicide and offer opportunities for these interventions to take place where groups at risk spend most of their time. The Michigan Suicide Prevention Commission Strategic Recommendations reflect a desire to increase cultural responsiveness and competency across the state and be inclusive in the work necessary to reduce suicide in Michigan.

Commission Priorities & Recommendations

Only when we are capable and willing to spotlight suicidal behavior will we, as Michiganders, be better able to assist those who suffer in silence to find their voice.

Members of this Commission believe that the recommendations put forth in this report can only be effective through a collaborative approach between citizens, professionals and individuals working together. Taking into consideration the varying dynamics and demographics each county experiences will help ensure that the recommendations that are implemented will be effective, efficient and unique to the demands that data in each county highlights.

The following recommendations from the Michigan Suicide Prevention Commission reflect a comprehensive approach to suicide prevention. To adequately approach suicide prevention in Michigan, the activities identified address programs, policies, practices and services across the continuum of primary prevention through clinical care. We believe that the work of preventing suicide in Michigan is everyone's concern. Those who work directly with individuals who have expressed suicidal thinking are encouraged and hopefully inspired to deeply engage in this vitally important work.

The Michigan Suicide Prevention Commission has set out to reach an aspirational goal of achieving zero suicides in our state. Each of the recommendations presented is based on best-practice standards developed through extensive research and represents Commission members' best attempt to align with recommendations heard directly through the Initial Report planning process and based on an understanding of evolving best practices, as well as strengths and constraints of the current economic climate. As a Commission, we collectively propose that to uphold our recommendations, and thereby make tangible and lasting changes, we advise that the State develop a new branch within DHHS to support/coordinate all the suicide prevention activities recommended in this report.

The Commission has adopted several key suicide prevention recommendations under five priority areas:

1. Minimizing risk for suicidal behavior by promoting safe environments, resiliency and connectedness.
2. Increasing and expanding access to care to support those at risk of suicide.
3. Improving suicide prevention training and education.
4. Implementing best practices in suicide prevention for healthcare systems.
5. Enhancing suicide specific data collection and systems.

The Suicide Prevention Commission Recommendations can be found in Appendix F.

Priority #1 Minimizing risk for suicidal behavior by promoting safe environments, resiliency and connectedness.

Suicide and suicidal ideation can affect anyone, regardless of socioeconomic status, cultural background, or any other demographic indicator. However, as this report has identified, there are some populations that are group that are at higher risk for suicide. Protective factors are conditions, attributes or characteristics in an individual, family, community or large system that mitigates or reduces the likelihood that an individual at risk of suicidal behavior will be negatively affected/impacted by that risk. These factors, when present, may give a person the skills or support to get through difficulties while maintaining their health and wellness.

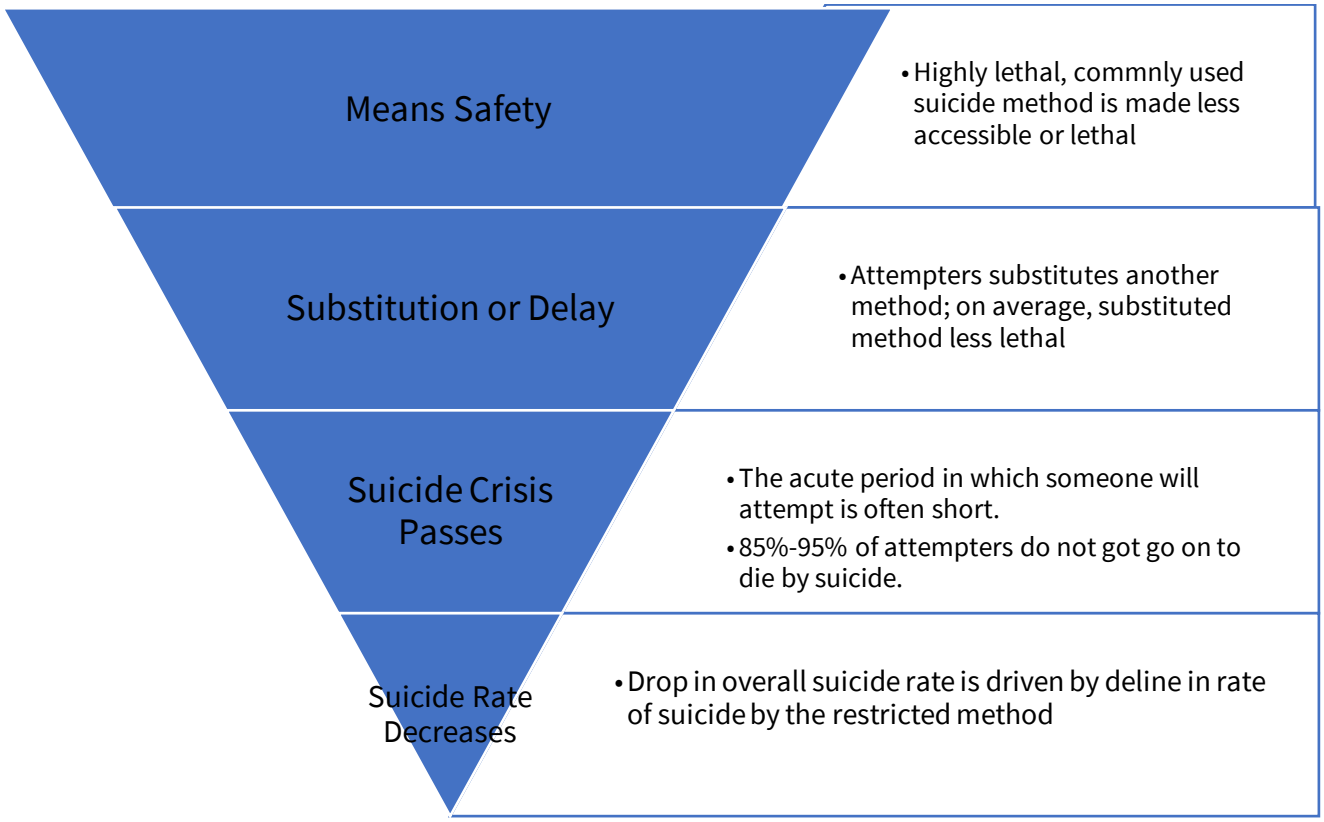
Protective Factors at Various Levels

Individual	Relationship	Community	Societal
• Skills in problem solving, conflict resolution and nonviolent handling of disputes	• Strong connections to family and community support • Support through ongoing medical and mental healthcare relationships	• Effective clinical care for mental, physical and substance use disorders • Access to a variety of clinical interventions and support for help seeking • Opportunity to belong to clubs or activities	• Reduced access to lethal means of suicide • Cultural and religious beliefs that discourage suicide and support self-preservation

Effective prevention efforts must recognize risk factors can be dynamic, changing over a person's lifetime and potentially internal to each person. Risk factors to look out for are, but are not limited to, depression, mania, psychosis, alcohol or substance abuse, hopelessness, severe anhedonia, severe to moderate anxiety or panic, acute stressors, global insomnia, eating disorder, traumatic brain injury, chronic severe pain. It is important to also be cognizant of recognizing static risk factors such as history of suicide attempts, Veteran, transgender, history of suicide attempt, history of psychiatric admission, family history of suicide, ED mental health visits. Identifying internal risk factors is key to the detection of risk and intervention, as is the dissemination of information about how risk factors contribute to suicidal behavior and how those factors can be managed (Bernert, 2018).

Reducing Access to Lethal Means Among Individuals with Identified Suicide Risk

Lethal means are the mechanisms people might use in a suicide attempt that are likely to result in serious injury or death (for example, but not limited to, firearms, medications, sharp instruments or poisons). Limiting or reducing an at-risk person's access to lethal means (means reduction) effectively prevents suicides (Barber & Miller, 2014).



The means by which people attempt or die by suicide plays an important role in developing effective prevention strategies. Creating safer environments for those at risk of suicide means lessening the chances for someone who is thinking about or planning to ultimately die by suicide.

Temporarily removing access to lethal means when someone is experiencing thoughts of suicide may interrupt an attempt, providing additional valuable time for others to intervene. Studies in a variety of countries have indicated that when access to a highly lethal and leading suicide method is reduced, the overall suicide rate drops driven by a decrease in the restricted method (Harvard T.H. Chan School of Public Health, 2021).

A suicide attempt using a firearm leads to death in 85 to 90 percent of cases; an attempt by medication overdose or a sharp instrument leads to death about 1 to 2 percent of the time (Barber & Miller, 2014). Though limiting access to materials used in hanging can be more difficult (particularly in restrictive settings such as jails and hospitals), limiting or reducing access to lethal means is possible at the individual and community levels. For example, placing barriers at the edge of tall buildings and bridges, using signage at known locations for suicide attempts, limiting ligature points in very high-risk areas, safe storage of firearms and medications and reducing access to common poisons are proven public health strategies. Providing education and resource materials points of sale of liquor and firearms can also be effective. Putting time, distance and other barriers between a person with thoughts of suicide with thoughts of suicide and the most lethal means can make the difference between life and death.

Building Community Connectedness and Resilience

Most suicide prevention strategies focus on supporting individuals already in crisis, but a comprehensive approach requires efforts that create healthy, thriving and resilient communities. Research shows protective factors such as access to and utilization of behavioral health supports, positive social norms and connectedness can reduce the onset of suicidal behavior (Wilkins, Tsao, Hertz, Davis, & Klevens, 2014). Connectedness is the sense of belonging a person has among family, friends, peers, and community; how connected people are to health and social services; and how well services collaborate with each other. Connectedness can be used as a protective factor, as it reduces social isolation, a known risk factor for suicide. People who are socially connected have more opportunities to ask for or get help during a crisis, and families' connectedness to community resources can serve as a protective factor against suicide risk (Suicide Prevention Resource Center).

Resilience is a person's capacity for positive outcomes and/or protection from negative outcomes despite challenges. Resilience is often associated with coping, or people's individual ability manage both every day and extreme stressors. Communities can build resilience by strengthening cultural values and identities, reinstituting collective history, spirituality, language and health in practices through collective action (Joe, Canetto, & Romer, 2008). Therefore it is imperative that we create and sustain programs that improve connectedness, especially in high-priority communities and groups experiencing serious and ongoing stressors. Increasing social connectedness and resiliency can reduce stigma and isolation.

Incorporating Social-Emotional Learning (SEL) Into Schools

Social-emotional learning (SEL) is the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions (Collaborative for Academic, Social, and Emotional Learning, 2021). Many youth suicide prevention programs focus on identifying students already at risk of suicide and connecting them to resources. SEL programs have been found to improve student's social-emotional skills, attitudes about self and others, connection to school, positive social behavior, and academic performance; they also reduced students' conduct problems and emotional distress (Payton, et al., 2008). There are vast opportunities to create programs to integrate social and emotional learning in early education as an upstream solution for primary suicide prevention. This presents an opportunity to further link education and behavioral health

Postvention as Prevention

When a person dies by suicide, many others are deeply affected. Those bereaved or affected by a death by suicide require special consideration given that research seems to indicate that those significantly impacted are at heightened risk for suicide than those not impacted (Pittman, Osborn, King, & Erlangsen, 2014).

According to the Suicide Prevention Resource Center (2020) postvention is an organized response in the aftermath of suicide to accomplish the following:

- To facilitate the healing of individuals from the grief and distress of suicide loss
- To mitigate other negative effects of exposure to suicide
- To prevent suicide among people who are at high risk after exposure to suicide

There is a growing awareness that more work needs to be done to support and treat all individuals and groups that are affected by a person's death by suicide comprehensively and effectively. All settings should incorporate postvention as a component of a comprehensive approach to suicide prevention.

Recommendations to minimize risk for suicidal behavior by promoting safe environments, resiliency, and connectedness include:

a. Develop and sustain a coordinated central point of access at the state level where suicide prevention resources and training are accessible to the community.
b. Support the implementation of best practice suicide prevention programs that utilize safe messaging.
c. Develop, expand, and publicize local survivor leadership groups for community peer supports.
d. Increase the public's knowledge of risk factors for suicide, recognition of warning signs in individuals, and preparedness to support and respond to those individuals.
e. Promote social and emotional development skill-building education programs for families in high-need communities.
f. Create and sustain a statewide postvention workgroup responsible for developing and implementing guidelines for responding effectively after the death of someone by suicide.
g. Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
h. Partner with firearm advocacy groups, as well as liquor sales commission, and retailers (shooting clubs, manufacturers, firearm retail insurers, concealed handgun instructors, hunting groups, law enforcement, veteran groups, farm and ranch associations) to increase suicide prevention awareness.
i. Work with military agencies, veterans organizations and law enforcement to establish specialized trainings/projects to reduce potential for suicide-related death by firearms.
j. Create or identify materials to educate individuals, families, and clinical providers about limiting access to lethal means, e.g., storage of alcoholic beverages, prescription drugs, over-the-counter medications and poisons.

Examples of possible strategies and actions minimize risk for suicidal behavior by promoting safe environments, resiliency, and connectedness

Everyone

a. Increase suicide prevention trainings in non-mental health related settings.
b. Create and support culturally relevant community settings that foster healthy connections and that can serve as alternatives to traditional treatment settings.
c. Increase community programming that promotes social connectedness.
d. Work with employers to include healthy living and mental health education and suicide prevention programming in their employee training programming.
e. Promote and distribute tools/strategies to support safe storage of lethal means (such as gun locks, safes and medication lock boxes/bags, etc.)
f. Promote and distribute materials and resource linkages at places where alcohol is sold.

Educators

a. Promote teaching of social and emotional health and coping skills in K–12 schools and colleges.
b. Promote student health and mental health while intentionally attending to students who may exhibit or be at risk of suicide or suicidal ideation.
c. Work with secondary education (college level) programs to engage in dialogue, education with similar messaging.
d. Ensure schools have individuals trained in crisis intervention on site and tip lines to call if there are concerns from one youth to another.
e. Educate families on reducing access to lethal means and what can be done to reduce the risk of suicide for youth at home.

Healthcare Settings

a. Develop policies and procedures for providers to routinely assess for access to lethal means and educate clients/patients on safe storage (inside and outside the home) recommendations.
b. Require suicide screening in emergency rooms, hospital admission, primary care providers (at new appointments, yearly physical examinations) and if signs of depression, anxiety, psychosis or substance use in all behavioral healthcare settings.
c. Consider stereotypes and stigmas that may prevent individuals and their families from seeking help or prevent providers from accurately assessing the needs of their patients.
d. Partner with substance use prevention programs on medication take-back events and messaging around safe storage of medications (and chemicals) as an overdose prevention strategy.
e. Use collaborative care models as a means of helping to identify patients at risk and to intervene and work with insurers to support this initiative.

State Agencies

a. Use media campaigns that focus on both risk and protective factors.
b. Promote programs and policies that build social connectedness and promote positive mental and emotional health.
c. Develop guidelines and educational plans for the training of health and behavioral health providers on lethal means counseling.
d. Expand programs that distribute locked prescription boxes and lethal means counseling.

Priority #2: Increasing and expanding access to care to support those at risk for suicide

Services that deliver appropriate, timely, accessible, health, mental health and substance use disorder care have the potential to prevent suicide. Unfortunately, the success of suicide prevention services traditionally depends on the people who are at risk seeking the services they need. Services that specifically address suicide risk are often limited to select settings and may not include the delivery of integrated healthcare services. This variability in clinical practices can hinder the delivery of effective programs. Additionally, rural communities commonly experience shortages in services, particularly for individuals with complex needs.

Standard of Care Recommendations

People at risk of suicide are often seen in healthcare settings. By promoting elements of care that should be standard and helping healthcare organizations to implement them, people at risk of suicide can be identified, supported and kept safe. The National Action Alliance for Suicide Prevention has outlined significant gaps in our current healthcare infrastructure that can be addressed by standards of care recommendations (National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, 2018).

Strengthening Access and Delivery

When a person in crisis seeks treatment, it should be accessible, appropriate, and respectful. Lack of access to behavioral healthcare is one of the contributing factors related to underuse of behavioral health services. There are barriers such as coverage of behavioral health conditions in health insurance policies and provider shortages in underserved areas. Prevention efforts should highlight strengths in the system and should not create additional burdens for individuals seeking treatment. To accomplish this, an extensive review of payment options, and delivery of physical and behavioral health services should be reviewed. Additionally, prevention efforts targeting populations less likely to be insured should address insurance coverage to improve access to health care services. Collaborative care models demonstrate primary care providers have the most ability to identify at risk populations.

Workplace Suicide Prevention

Most workplaces have an Employee Assistance Program (EAP) a program that is designed to offer medical support for their employees. Given the stress associated with many professions and high-risk occupations, employers must realize the need to include mental health and dedicated prevention programs in their health policies. By doing so, employers can play a significant role in helping reduce the number of suicides. Experts recommend suicide prevention plans as part of EAP should address stigma reduction, create awareness and develop programs for sensitization (White Swan Foundation, 2015). EAPs should be ready to work with organizations to develop training programs for managers and employees on how to recognize signs of depression, anxiety, substance misuse, and other well-documented

underpinnings for suicide risk. Policies need to be in place directing employees on what to do when at-risk employees are identified.

Telehealth and Telemedicine Options

Technology has an important role in suicide prevention and its use will continue to grow. Technology can provide opportunities for effective outreach and suicide prevention but as a tool cannot replace the need to carefully manage cases involving persons at risk for suicide. Mobile monitors and telehealth approaches may increase access to monitoring risks as well as progress, especially in rural communities by enhancing timely access to care targeting suicide risk. Research on telehealth approaches to suicide care is still emerging but promising (Gilmore & Ward-Ciesielski, 2017). Telehealth approaches may be particularly beneficial for some individuals. Value has been shown for those in rural settings with no easily available clinical providers, aged individuals, those with transportation restrictions, and those with disabilities. Further evaluation of technology-based programs to identify best practices, assesses cost-benefit and provide empirical support for their use is needed.

The benefits of telehealth have been resoundingly demonstrated since traditional, in-person clinical visits became restricted because of coronavirus. Sustaining coverage for such visits and eliminating unnecessary barriers such as using telehealth across state lines will further enhance these "virtual" care approaches.

Crisis Lines

Crisis response can include a variety of crisis services including warm lines, crisis lines, crisis stabilization support and short-term crisis residential care. Models such as prevention hotlines, text/chat services can provide 24-hour support. This may include conducting suicide assessments, intervention, providing referrals to appropriate services, helping individuals develop safety plans, and connecting people with emergency resources. Under effective models, suicide prevention hotline, text, and chat services provide 24-hour support to conduct a suicide assessment and intervention, provide referrals to appropriate services, help individuals develop safety plans, and connect people with mobile crisis or emergency resources. One study of crisis line staff, who received Applied Suicide Intervention Skills Training (ASIST), showed callers had reported feeling less depressed and overwhelmed, an increased level of hopefulness, and an overall lower risk of completing suicide (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013). In the event other providers and personal supports are unavailable, crisis lines can be a lifeline for people at risk for suicide.

In July 2022, 988 will officially become the national three-digit dialing code for the National Suicide Prevention Lifeline, replacing the current phone number of 1-800-283-TALK (8255). The intention behind the change is to establish an easy to remember three-digit number,

such as “911” for when people are in a state of mental emergency. The objective of transitioning the nation to this three-digit dialing code is to allow people who are experiencing a mental health crisis to be able to connect with someone who can help them faster than ever before. The national three-digit phone number can improve access to vital crisis services, improve the efficacy of suicide prevention efforts, and reduce the stigma about mental health and getting help (National Suicide Prevention Lifeline, 2020).

Exploring and Potentially Expanding the Use of Peer Supports Including Suicide Survivors

“Peers” include a broad range of individuals, such as close family members, friends, trusted mentors, fellow students or veterans, and other individuals who share the experience of living with a mental health or substance use issue that may even have progressed to include having experienced suicidal thoughts or behaviors. Peers develop trust with a person experiencing similar challenges by sharing knowledge, giving encouragement, being available, offering to help, and supporting in a sustained fashion a person’s path to recovery. Peer support can be viewed an effective and affordable way to help people achieve and maintain recovery from all manner of illnesses.

Peer-led support models have gained increasing popularity in suicide prevention. There has been positive effects of peer-led supports for people with behavioral health problems and those bereaved by suicide, little is known about the types of lived experience peer support programs in suicide prevention and their impacts on people at risk of suicide (Schlichthorst, Ozols, Reifels, & Morgan, 2020).There is more to be determined about how to integrate peer supports safely and effectively into care systems and suicide prevention.

Recommendations to increase and expand access to care to support those at risk include:

1. Sustain and expand funding to support comprehensive suicide prevention efforts in the state.
2. Explore and consider implementing evidence-based peer support programs as a model for suicide prevention as more evidence becomes available.
3. Continue to support and expand the use of easily accessed suicide prevention hotlines, warmlines, text lines and other crisis lines.
4. Encourage new public-private partnerships including federal and local government and community-based organizations serving populations disproportionately impacted by suicide.
5. Explore and implement alternative models of care for individuals at high risk for suicide at-risk patients (crisis response options, residential crisis etc.)
6. Encourage and educate the public at large, including employers and their employees to work with employee assistance programs to promote suicide prevention awareness and information about services offered and to promote easy access to behavioral health treatment services.
7. Continue to work toward implementation and expansion of the Michigan Crisis and Access Line (MiCAL) and linkage to the national suicide prevention lifeline resources.

Examples of possible strategies and actions to increase and expand access to care to support those at risk:

Everyone

a. Widely market and disseminate existing local behavioral health resource guides and other prevention materials and how to use them.
b. Encourage peers with lived experience to staff telephone/chat/text-based supports.
c. Deliver suicide prevention training to people who are in positions to identify warning signs of suicide and refer those at risk to culturally appropriate services and supports.
d. Identify needs and provide services to people currently lacking accessible clinical services, such as targeting telehealth and virtual care.
e. Identify and access approaches and avenues that increase the likelihood that those who are in need will ask for help.
f. Assist with outreach strategies to ensure all eligible people are enrolled in some form of healthcare coverage or health insurance that includes coverage for mental health services.

Educators

a. Raise awareness of crisis resources in K–12 schools and higher education.
b. Support programs that assist youth and others in getting appropriate care before reaching a crisis point.
c. Develop comprehensive suicide prevention programs within high schools and higher education institutions.

Healthcare Settings

a. Link community clinics and providers to hospitals by creating strong partnerships between community-based organizations and hospitals to assist with the continuity of care.
b. Improve discharge planning procedures to identify and address patient barriers to accessing follow-up care.
c. Use telehealth/telemedicine to facilitate access to mental health evaluation and treatment in settings where they may not be readily available.
d. Establish referral agreements between providers to ensure patients have timely access to follow-up care.
e. As research becomes clear, consider integrating those peers with lived experience as suicide survivors or individuals with mental health or substance use challenges into emergency departments and other settings to support individuals in need
f. Increase the number of culturally responsive mental health providers through workforce development.

State Agencies

a. Support state contracted behavioral providers and others to have suicide prevention education/awareness components integrated into the delivery of their services, within allowable funding requirements.
b. Continue to enhance policy and protocol for suicide prevention among law enforcement, correctional staff and individuals in custodial/carceral settings.
c. Identify and pursue grant opportunities to support suicide prevention efforts.
d. Develop a strategy for the adoption and sustained support of 988.
e. Conduct an inventory of peer support programs in Michigan to add to a sustained registry and identify gaps in access.

Priority #3: Improving suicide prevention training and education

Trainings to raise suicide awareness, improve clinician's skills and guide response to a death by suicide are widely available in Michigan but are underutilized. There was an overwhelming amount of feedback from the Listening Sessions that suggested "seats could not be filled" during many of their local trainings. Although training alone does not solve the problem of increased suicide within the state, increasing the number of trained community gatekeepers does play a significant role in supporting individuals who may need extra assistance.

Gatekeeper training involves educating individuals in the community to recognize warning signs for suicide and how to responds appropriately. These trainings should be available to the public and designated professions to increase the number of individuals prepared to support people in crisis.

A full listing of available gatekeeper and other training programs are available in Appendix C.

Ensure High Quality Suicide Recognition and Referral Trainings are Available

Recognition and referral training helps individuals without clinical training play a key role in suicide prevention. This approach is for concerned community members such as educators, faith-based leaders, parents, law enforcement, and others who regularly encounter people at risk. Expanding access to training for community members will expand the safety net comprised of individuals who can recognize and respond effectively to suicide risk and crisis. Efforts should promote access to both in-person and electronic evidence-based prevention training for high burden and rural communities. As many members of the Commission are trained in a variety of suicide prevention methods, there is growing need to adopt a train-the-trainer model to expand opportunities to the public who will be engaged in prevention efforts.

Incorporate Suicide Prevention Training in Schools

As of October 2020, 19 states and the District of Columbia passed laws mandating suicide prevention training for public school personnel (American Foundation for Suicide Prevention, 2020). Many of these suicide prevention laws focus on training teachers and other school staff for grades K-12, although some also require student training on warning signs and how suicide risk can be exacerbated by substance use. Though Michigan does not require suicide prevention training in schools, Section 380.1171 (also known as the Chase Edwards Law) of The Revised School Code encourages

"The board of a school district or board of directors of a public school academy is encouraged to provide age-appropriate instruction for pupils and professional development for school personnel concerning the warning signs and risk factors for suicide and depression and the protective factors that help prevent suicide."

The Michigan Suicide Prevention Commission recommends schools consider implementing training such training, incorporating the goals laid out in the law. Efforts should be made in every instance to also implement such training for faculty, staff, students beyond K-12 but to include higher educational institutions where basic training can be offered on warning signs, protective factors and community resources.

Suicide Prevention Education for Health Professionals

While healthcare professionals are uniquely positioned to identify individuals who may be at risk for suicide and facilitate access to treatment, this is only possible if providers are equipped with the necessary skills and knowledge to assess and intervene or appropriately refer. There is considerable variation in suicide prevention training for healthcare professionals across the nation.

As of June 2020, only nine states have passed legislation mandating healthcare professionals complete training on suicide prevention (American Foundation for Suicide Prevention, 2020). In many instances there are policies that highly encourage training. Michigan has public acts that include statements regarding initiatives that train healthcare practitioners in suicide prevention. Despite the explicit recommendation on education on suicide prevention from the 2012 National Strategy for Suicide Prevention, few states require this education.

Suicide Prevention Commission Requirements for Licensure

Suicide prevention education is a key component in efforts to advance care, increase awareness and heighten responsiveness. It is imperative that we as a state increase the knowledge and skills of effective evidence-based suicide prevention practices among the behavior and healthcare workforce. There should be more suicide specific continuing medical education (CMEs) and continuing education units (CEUs) for individual active in these fields. According to Graves, Mackelprang, Van Natta, & Holliday (2018) aspiring behavioral health and healthcare professionals enrolled in behavioral health and healthcare educational programs are not being trained in suicide prevention.

This Commission believes in advocating for suicide risk assessment, prevention, and treatment to be mandatory areas for licensure and certification and incorporating prevention elements into higher education curriculums for mental and physical healthcare professionals.

Recommendations to improve suicide prevention training and education include:

1. Collaborate with licensing and certifying organizations to ensure that healthcare professionals receive formalized training in suicide prevention/intervention as part of the licensing/credentialing process.
2. Increase capacity and improve trainings on evidence-based suicide assessment, treatment, and management for health professionals and expand the list of health professions required to receive training.
3. Collaborate with the Michigan Department of Education to help ensure standard suicide prevention training for K-12 for school counselors, teachers, and others.
4. Require, as appropriate, content on suicide risk assessment, treatment, and management in health sciences and social service programs taught in higher education.

Examples of possible strategies and actions to improve suicide prevention training and education:

Everyone

a. Partner with underrepresented groups and high-risk populations to start culturally relevant conversations within communities about suicide risk and how to seek help.
b. Identify the best entry point for introducing suicide prevention trainings to an organization or system.
c. Promote workplace behavioral health supports and Crisis Intervention Training Programs.
d. Collaborate with workplaces to provide trainings on recognizing a suicidal crisis, how to provide accommodations and support re-entry to work post crisis.
e. Increase suicide prevention trainings in non-behavioral health related settings.
f. Identify and use more evidence-based online suicide prevention trainings to allow greater access.

Educators

a. Craft or identify evidence-based guidelines for suicide prevention and intervention training for behavioral health, nursing, medical education programs, and professional development.
b. Provide gatekeeper trainings to members of boards of education to demonstrate the need for suicide prevention programming and potential responses to deaths by suicide.
c. Identify youth leaders and train them as Gatekeepers using evidence-based programs.

Healthcare Settings

a. Mandate suicide prevention workforce development requirements for licensed health and behavioral health providers.
b. Fund and staff suicide assessment, treatment and management training based on community profiles and needs.
c. Educate personnel at all levels in healthcare organizations in suicide prevention.

State Agencies

a. Inventory effective suicide assessment, treatment and management trainings available within the state. Additional attention should be paid to trainings focused on marginalized and at-risk groups while maintaining the use of cultural and evidence-based practices.
b. Conduct outreach to key stakeholders to understand need and offer training opportunities.
c. Integrate suicide prevention training into state agency staff training.
d. Explore the benefits and cost of requiring additional health professions to have suicide prevention training for certifications.
e. Enhance training capacity at the local level by facilitating more train-the-trainer events.
f. Create opportunities to update community, clinical and educational agencies about new findings in suicide prevention.

Priority #4: Implementing suicide prevention best practices in healthcare settings

Across health and behavioral health care settings there are many opportunities to identify and provide care to those at risk for suicide. Access to evidence-based screening, assessment, and treatment is vital for preventing suicide in at-risk individuals. Providers therefore must be equipped to identify and respond to individuals who may be suicidal. When providers use evidence-based tools and resources they can deliver services that lead to improved outcomes for clients.

Incorporate Suicide Prevention into Primary Care

Primary care is often a first line of contact for individuals who are reluctant or unaware that they may be appropriate for seeking out mental health services directly. However, there are often barriers that impair primary care physicians from addressing mental health concerns with patients. Primary care providers can act by establishing protocols for screening, assessment, intervention and referral. Suicide screening in primary care settings and facilitating referrals to mental health services are opportunities to strengthen the continuity of care for many high-risk populations and individuals facing stigma for seeking mental health services. Primary care providers play a key role in ensuring continuity of care by transmitting patient health information to emergency care or behavioral health care providers, creating seamless care transitions.

Standardize Suicide Risk Assessment and Management

Best practice for screening and risk assessment in health care settings includes provider knowledge of risk and protective factors, warning signs, procedures for categorizing risk and making clinical decisions based on risk. Standardization is an opportunity to make the entire process of identifying risk and connecting people to services more transparent and collaborative for the person at risk (Jobes, Gregorian, & Colborn, 2018). Standardizing risk screening, assessment and management has the potential to reduce clinical and legal concerns about errors in judgement that may impact risk. This is not to suggest all organizations and entities should ask the same questions, but questions should be asked, and appropriate actions should follow. Healthcare and behavioral healthcare systems should use evidence-based tools to screen all individuals. This will increase the likelihood that individuals at risk for suicide will be identified. Those identified at risk should then be directed to appropriate pathways of care.

Improve Care Transitions

The risk of suicide attempts and death is highest within the first 30 days after a person at risk for suicide is discharged from an emergency department or an inpatient psychiatric unit of a hospital (Knesper, 2010). To improve care transitions and reduce risk, partnerships should be developed between emergency departments, human service departments, community-based behavioral health providers, primary care providers and other stakeholder support organizations. These care transitions should be safe and timely by providing linkages to culturally appropriate outpatient mental health and substance use disorder providers (Suicide Prevention Resource Center, 2013). Phone calls from clinical personnel, peers, educators and others help monitor progress and alleviate risk.

Discharge plans must include a collaborative process to create a safety plan and to identify appropriate aftercare services. There should be a plan for transitioning a person to another care setting or provider and a process for following-up with a person using written correspondence, email, text message or other form of communication.

Zero Suicide

Henry Ford Health System developed and championed the original model of zero suicide prevention in healthcare systems, which has since been adopted nationally and internationally as an evidence-based model for suicide prevention in a healthcare setting (Henry Ford Health System, 2021) There are now various programs designed to achieve zero suicides. Tailoring may be appropriate depending on an organization's contextual environment. The zero suicide aim is built on the understanding that often those individuals who may be contemplating suicide fall through the cracks within organizations that do not have a comprehensive approach. Zero suicide strategies focus on bridging the gaps in care and improving the quality of care for patients in health and behavioral health settings.

Recommendations to implement suicide prevention best practices in health care systems:

1. Adopt zero suicide as an aspirational goal statewide by preventing all suicide deaths through healthcare and community supports.
2. Promote the adoption of zero suicide prevention care strategies for health care providers and institutions.
3. Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings.
4. Expand the use of evidence-based screening, assessment, and suicide-specific treatments for those at risk.
5. Standardize and promote a statewide comprehensive assessment tool inclusive of suicide prevention elements.
6. Improve care transitions for people with suicidal thoughts and behaviors who are discharged from emergency departments, inpatient settings, and other care settings.
7. Support primary care practices in adopting suicide prevention protocols to build suicide care pathways.

Examples of possible strategies and actions to implementing suicide prevention best practices in health care systems:

Everyone

a. Involve survivors of suicide attempts and survivors of suicide loss in developing protocols, policies and procedures.
b. Work with community support systems that serve high risk populations to adopt the aspirational goal of "zero suicide"

Healthcare Settings

a. Educate systems on the zero suicide gold standard of timely access for each type of service.
b. Explore peer support resources and consider the development of peer support groups for individuals living with suicidal experiences.
c. Promote and support the adoption of procedures aligned with national requirements and evidence-based practices for national patient safety goals and protocols specific to suicide.
d. Ensure that best practices for supporting patients at discharge from services, including self-management and safety plans, are included in health professional's mandated training.
e. Encourage healthcare systems to make opportunities available for those affected by suicide, personally or professionally, to have an active role in system protocol improvement.
f. Use systems approaches to improve timely and effective care for patients at risk.
g. Encourage behavioral health providers to utilize evidence-based treatments that address suicidal thoughts and behaviors directly.
h. Assure that initial screening for suicidal behavior is conducted and accurately documented during hospital or emergency department intake.

State Agencies

a. Support state contracted behavioral providers to have suicide prevention. education/awareness components integrated into the delivery of their services, within allowable funding requirements.
b. Support the evaluation and expansion of peer support programs.
c. Conduct an inventory of existing zero suicide models within the state and other emerging best practices for suicide prevention in healthcare settings.

Priority #5: Enhancing suicide specific data collection and data systems

Suicide prevention is driven by data and having an accurate and comprehensive understanding of the impact of suicide and suicide attempts is critical for prevention planning. Like other public health challenges, preventing suicide demands a strong data infrastructure and evaluation. Data must be standardized, routinely collected and monitored. Deficiencies in data collection limit the understanding of the full extent of suicidal behavior. These efforts are further complicated by inconsistent definitions of suicidal behavior, therefore impacting data monitoring.

The Suicide Prevention Resource Center (2020) outlines several steps to strengthen data systems and collection efforts including:

- Allocate sufficient funding and personnel to support high-quality, privacy-protected suicide data collection and analysis.
- Identify, connect with, and strengthen existing data sources.
- Develop the skills and a plan for regularly analyzing and using the data to inform action.

It is vital to ensure that populations at high-risk are represented throughout the data collection process. This includes engaging stakeholders about available data options or creating new ones. This will assist in locating existing data on specific populations, exploring gaps and expanding the use of qualitative data to create more comprehensive narratives.

Develop a Statewide Suicide Prevention Office

State health departments and office of suicide prevention are required to fulfill a variety of functions and infrastructure in many states has presented significant challenges. There is no designated funding stream for suicide prevention activities and resources often change. This leads to suicide prevention infrastructure often being limited and underfunding – making it difficult to understand and impact suicide rates to achieve sustainability. To reverse these trends, the Suicide Prevention Commission recommends designating a new entity responsible for solely monitoring and implementing essential functions of suicide prevention including data monitoring, collection, and analysis.

Building New and Expanding Current Data Systems

Establishing a centralized electronic reporting system to capture data related to deaths by suicide, suicide attempts, and suicidal behaviors can enhance current capacities. Exploring new data collection and reporting resources could include additional demographics not typically captured including gender identity, sexual orientation and vulnerable group membership. Technical guides can offer suggestions for ways to acquire data and navigating potential obstacles to acquisition. The Michigan Violent Death Reporting System (MiVDRS) within the Michigan Department of Health and Human Services is the current statewide public health surveillance system linking data from law enforcement, medical examiners and vital statistics on deaths by suicide to inform the design and implementation of tailored prevention and intervention efforts.

Standardizing and Enhancing Capacity for Investigating and Reporting Suicide Deaths

Currently, there are no federal or state statutes in place that definitively protect medical examiners when it comes to releasing suicide related data. In fact, there are no guidelines or regulations in place for medical examiners to reference if asked to release data or information that may or may not be considered "sensitive information." Furthermore, there is also no standardization in Michigan for the data collected by medical examiners in cases of death by suicide.

The use of toxicology testing aids accurate determination of underlying causes of suicide and enables those seeking to reduce suicides to take targeted preventive steps. The reliability of toxicology results relies heavily on the fidelity of the specimen collection process. To determine which substances are involved in a particular death, forensic pathologists rely on the performance of toxicology testing on blood and other samples collected at or shortly after the drug-related death by suicide. These insights are invaluable as cause of death is determined and helps to capture trends that may inform suicide prevention efforts.

Suicides are investigated by medical examiners or medical examiner investigators. Typically, a medical examiner's office or the county sheriff's office has one or more Medical Examiner Investigators who conduct the death scene investigation. Without a state level mandate for training of death scene investigators, there is an expected variability in the quality and quantity of data collected on deaths by suicide. Additionally, without specific guidelines addressing exactly what medical examiners can and cannot disclose, some medical examiners are justifiably less inclined to share data that may be vital to prevention efforts. The state can benefit from promoting standardized death investigation guidance for all stakeholders who play a role in investigating deaths by suicide. High quality data on deaths by suicide are important to support data-driven prevention strategies.

Data should be examined with a diversity and equity lens. Reports related to bias in suicide death determinations may make it difficult to understand unique aspects of suicide in particular populations and accurate counts related to suicide risk (Rockett, et al., 2010). As research emerges in this area, medical examiners should be provided education to enhance consistency of cause and manner of death determinations.

Ongoing Research & Evaluation

While evaluation of prevention efforts remains a gap in Michigan and nationally, evaluation is a critical component of comprehensive suicide prevention approaches. Researchers have looked at successful prevention programs and identified "9 Principles of Effective Prevention Programs." One of those principles—Outcome Evaluation—suggests a systematic outcome evaluation be conducted to determine whether a program or strategy worked (Nation, et al., 2003). Coalitions, local health departments, health systems and other stakeholders should support the evaluation of existing programs and technologies in local communities to better understand strengths, areas in need of improvement and overall impact of prevention efforts. Additional measures should be taken to review program evaluation data regularly to inform decision making around future program implementation.

A listing of current National Institutes of Health (NIH) Research grants can be found in Appendix D. A listing of current Substance Abuse and Mental Health Services Administration (SAMHSA) grants can be found in Appendix E.

All stakeholders must support research that advances suicide prevention, including the latest survey methods, clinical assessment, and technology. Relationships should be built with local colleges, universities and other academic research organizations to identify capacity for research and support research aligned with local and state suicide prevention goals.

Machine Learning and Artificial Intelligence

Artificial intelligence (AI) and machine learning (ML) have emerged as an innovative means of investigating large datasets to enhance risk detection (Bernert, et al., 2020). Artificial intelligence tools have been used to detect the behavior and mental activities of individuals. Machine learning is a statistical technique that can pinpoint suicide risk prediction variables including both clinical and demographic information. This then creates a composite score calculated from the highlighted variables that could help stratify suicidal risk for patients seen in various settings. These tools can assist responders and providers in interacting with individuals and address the problem early on.

An algorithm in one study of hospital admission data that included age, gender identity, zip code, diagnostic history, and medication was 84 percent accurate in predicting whether someone who was seen at the hospital for either a non-suicidal injury or suicide attempt would attempt suicide in the following week (James, Witten, Hastie, & Tibshivani, 2013) Algorithmic approaches have been developed to identify suicidal ideation risk and could be adapted as clinical decision tools aiding in suicide screening and risk monitoring using pre-existing technologies (Simon, et al., 2018). Leaders in the health insurance industry are potentially important partners in these efforts.

Suicide Death Review Teams

Suicide Death Review Teams (SDRT) are an innovative approach to capturing more data on deaths by suicide in various communities. Using these death review teams for clinical and forensic review of deaths by suicide, including psychological autopsy approaches, should be considered. Team members can include medical examiners, law enforcement representatives, subject matter experts and others with legal access to confidential information. These SDRTs can be used to enter data into a singular database for ongoing monitoring and community planning. The state could potentially improve overall cohesiveness for this type of data collection and its application to prevention work.

Recommendations to enhance suicide specific data collection and systems include:

1. Standardize evidence-informed death scene investigation forms to improve the completeness of data collected on deaths by suicide.
2. Adopt data standards/definitions based on Centers for Disease Control and Prevention best practices.
3. Examine data for any racial/ethnic biases in determination of cause and manner of death as a suicide and subsequent reporting and educate medical examiners on this potential risk.
4. Build and staff a repository of data related to suicide in the state.
5. Identify opportunities and reporting mechanisms for machine learning and artificial intelligence to monitor and intervene for individuals with trends/patterns for suicidality.
6. Improve qualitative review and documentation of suicide risk among special populations through interviews, focus groups, etc.
7. Assure that initial screening for suicidal behavior is conducted and accurately documented during hospital or emergency department intake with proper follow up approaches.
8. Regularly review data to inform decision making on future program implementation.
9. Recommend standardized training to include toxicology draws and regular auditing of training for medical examiners and medical examiner investigators in the investigation and reporting of death by suicide.

Examples of possible strategies to enhance suicide specific data collection and systems:

Everyone

a. Identify existing data sources for deaths by suicide data to define the problem of suicidal behaviors, develop interventions and disseminate effective preventive practices.
b. Encourage local coalition and others to use data to inform prevention efforts.

Educators

a. Promote the Youth Risk Behavior Surveillance System in Michigan and Michigan Profile for Healthy Youth (MiPHY) to schools and the public to increase participation and secure representative state-level data.
b. Use state-level data and national research findings to target areas for service provision and identify gaps in resources.
c. Add suicide-related risk factor questions to school-based data collection instruments.
d. Connect with local school jurisdictions to examine ideation data among youth.

Healthcare Settings

a. Train health and behavioral healthcare systems to identify, collect, report and manage quality suicide-related data, including attempt data.
b. Develop a database to capture elements to link repeat emergency department visits, inpatient admissions and measure readmission rates and rates of post-discharge mortality by suicide.
c. Inform health and behavioral healthcare systems about the myriads of sources and uses of suicide-related data.
d. Educate healthcare providers and medical examiners on the importance of coding suicide-related events and cause and manner of death accurately and with reduction of potential biases.
e. Regularly evaluate whether suicide prevention interventions are having the desired effect.

State Agencies

a. Create a unit of government within the state health department specifically dedicated to suicide prevention activities.
b. Identify and apply for funding opportunities to sustain and expand the state's ability to report key data accurately and quickly.
c. Explore the data reporting needs of specific communities and/or demographic groups, including preferred dissemination formats.
d. Assure that suicide-related questions are periodically included in the statewide annual Behavioral Risk Factor Surveillance System survey of state residents ages 18 and up.
e. Support data sources to enhance the quality and consistency of their data collection and reporting into state systems.
f. Make available user-friendly data materials in a single place and advertise this resource to agencies, communities, and the public.
g. Develop data sets that overlay high risk populations with Department of Health and Human Services data.
h. Evaluate suicide prevention programs to monitor progress toward goals.
i. Develop and provide guidance to Suicide Death Review Teams.

Next Steps

This Initial Report highlights the evidence based and evidence informed suicide prevention programs statewide. The Suicide Prevention Commission has an aspirational goal of pursuing zero suicide and plans to do so by maximizing resources, leveraging partnership, advocating for systems change and securing additional funding. An immediate charge of this Commission is for the MDHHS to update it is statewide Suicide Prevention Plan to incorporate recommendations found here and best practices.

While the Michigan Suicide Prevention Commission takes offers the recommendations provided in the Initial Report, the Commission acknowledges that the solutions involve a broader level of engagement at the societal, community, and individual level. Everyone has a role in putting this plan into action. Many individuals and organizations interested in suicide prevention are already doing necessary and important work. For those actively involved in suicide prevention, this Initial Report can provide guidance and a framework as you proceed with your work. Other, newer initiatives should borrow from this document, and chart progress against the overall goals outlined in this plan. There are many opportunities to coordinate with other organizations statewide that may be working toward the same or complementary goals.

This report includes many broad strategies appropriate to the statewide population. Realizing some populations are at higher risk of suicide than others, special care should be paid to ensure services are culturally responsive and appropriate. Representatives of populations at increased risk participated throughout the process of this Initial Report. Targeted population-based interventions are necessary, and the Commission intends to engage groups associated with higher risk and specific geographic regions for ongoing dialogue to ensure needs are being met and discuss how more specific and tailored recommendations can be made.

The Commission will connect with stakeholders to track progress on implementation, the status and success of specific strategies and actions. This will also be an opportunity to solicit feedback on the strengths and weaknesses of the recommendations. As required per legislation, the Commission will develop an annual progress report on these recommendations to be shared with the legislature, appropriate state agencies and other stakeholders.

The Michigan Suicide Prevention Commission will continue to promote and support the recommendations found in this report and identify new and innovative recommendations in the years to come.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

References

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., . . . Solberg, L. I. (2014). Healthcare contacts in the year before suicide death. *Journal of General Internal Medicine, 29*(6), 870-877.

Ahmedani, B. K., Stewart, C., Simon, G. E., Lynch, F., Lu, C. Y., Waitzfelder, B. E., . . . Williams, K. (2015). Racial/ethnic differenes in health care visits made before suicide attempt across the United States. *Medical Care, 53*(5), 430-435.

Ahmedani, B. K., Westphal, J., Autio, K., Elsiss, F., Peterson, E. L., Beck, A., . . . Simon, G. (2019). Variation in patterns of health care before suicide: A population case-control study. *Prevention Medicine, 127*.

Ahmedani, B., Peterson, E. L., Hu, Y., Rossom, R. C., Lynch, F., Lu, C. Y., . . . Simon, G. (2017). Major physical health conditions and risk of suicide. *American Journal of Preventive Medicine, 53*(3), 308-315.

American Foundation for Suicide Prevention. (2020, August). *Risk factors and warning signs*. Retrieved from American Foundation for Suicide Prevention Web site: https://afsp.org/risk-factors-and-warning-signs

American Foundation for Suicide Prevention. (2020). *State Laws: Suicide Prevention in Schools (K-12).* Washington DC: American Foundation for Suicide Prevention. Retrieved from https://www.datocms-assets.com/12810/1586436500-k-12-schools-issue-brief-1-14-20.pdf

American Foundation for Suicide Prevention. (2020). *State Laws: Training for Health Professionals in Suicide Assessment, Treatment and Management.* https://www.congressweb.com/assets/BackgroundDocuments/70147535-0C42-B1F3-E3DB3ED529C97A80/Health%20Professional%20Training%20Overview.pdf: American Foudnation for Suicide Prevention.

Barber, C., & Miller, M. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda. *American Journal of Preventive Medicine, 47*(3S2), S264-S272.

Bernert, R. A. (2018). *Emerging best practices and innovations in suicide prevention: Toward an updated strategic plan for California.* Sacramento: Mental Health Services Oversight and Accountability Commission. Retrieved from http://mhsoac.ca.gov/sites/default/files/

Bernert, R. A., Hilberg, A. M., Melia, R., Kim, J. P., Shah, N. H., & Abnousi, F. (2020). Artificial Intelligence and Suicide Prevention: A Systematic Review of Machine Learning

Investigations. *International Jounral of Environmental Research and Public Health, 17*(16), 5929. doi:doi: doi: 10.3390/ijerph17165929

Burrows, S., & Laflamme, L. (2009). Socioeconomic disparities and attempted suicide: state of knowledge and implications for research and prevention. *International Journal of Injury Control and Safety Promotion, 17*(1), 23-40.

Centers for Disease Control and Prevention. (2020). *National Violent Death Reporting System (NVDRS) Query.* Retrieved August 5, 2020, from https://wisqars.cdc.gov:8443/nvdrs/nvdrsDisplay.jps

Centers for Disease Control and Prevention. (2021). *Anxiety and Depression: Household Pulse Survey*. Retrieved from Centers for Disease Control and Prevention Web site: https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm

Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. (2020, August 14). *Web-based Injury Statistics Query and Reporting System (WISQARS).* Retrieved from Centers for Disease Control and Prevention Web site: https://webappa.cdc.gov/cgi-bin/broker.exe

Clay, R. A. (2018). The cultural distinctions in whether, when and how people engage in suicidal behavior. *American Psychological Association CE Corner, 49*(6).

Collaborative for Academic, Social, and Emotional Learning. (2021). *What is SEL?* Retrieved from Collaborative for Academic, Social, and Emotional Learning Web site: https://casel.org/what-is-sel/

Czeisler, M. E., Lane, R. I., & Petrosky, E. (2020, June 24-30). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic. *MMWR Morb Mortal Wkly, 69*, pp. 1049-1057. doi:http://dx.doi.org/10.15585/mmwr.mm6932a1external icon

Desert Waters Correctional Outreach and Gallium Social Sciences. (2019). *Descriptive study of Michigan Department of Corrections Staff Well-being: Contributing Factors, Outcomes, and Actionable Solutions.* Desert Waters Correctional Outreach and Gallium Social Sciences.

DesOremau, T. (2020, April 30). *Michigan still 3rd in US for most coronavirus deaths with nearly 3,80*. Retrieved from MLIVE: https://www.mlive.com/public-interest/2020/04/michigan-still-3rd-in-us-for-most-coronavirus-deaths-with-nearly-3800.html

Gilmore, A. K., & Ward-Ciesielski, E. F. (2017). Perceived risk and use of psychotherapy via telemedince for patients at risk for suicide. *Journal of Telemedicine and Telecare*. doi:doi:10.1177/1357633X17735559

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). *Reducing suicide: A national imperative.* Washington, DC: Institute of Medicine National Academies Press.

Gould, M. S., Cross, W., Pisani, A. R., Munfakh, J. L., & Kleinman, M. (2013). Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline. *Suicide and Life-threatening behavior, 43*(6), 676-691.

Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2018). Suicide Prevention Training: Policies for Health Care Professionals Across the United States as of October 2017. *American Journal of Public Healt, 108*(6), 760-768. doi:https://doi.org/10.2105/AJPH.2018.304373

Harvard T.H. Chan School of Public Health. (2021). *Means Matter.* Retrieved from Harvard T.H. Chan School of Public Health Web site: https://www.hsph.harvard.edu/means-matter/means-matter/

Hawton, K. (1992). Suicide and attempted suicide. In E. S. Pankel, *Handbook of Affective Disorders* (p. 635). New York: Guilford.

Henry Ford Health System. (2021). *Henry Ford Zero Suicide: Suicide Prevention Guidelines for Health Care Providers*. Retrieved from Henry Ford Health System Web site: https://www.henryford.com/services/behavioral-health/zero-suicide#:~:text=Henry%20Ford%20Zero%20Suicide%20Suicide%20Prevention%20Guidelines%20for,and%20modify%20suicide%20risk%20for%20patients%20with%20depression.

Hoffman, J. A., Farrell, C. A., & Monuteaux, M. C. (2020). Association of Pediatric Suicide with County-Level Poverty in the United States, 2007-2016. *JAMA, 174*(3), 287-294.

James, G., Witten, D., Hastie, T., & Tibshivani, R. (2013). *An Introduction to Statistical Learning: with Applications in R.* New York: Springer Publishing.

Jobes, D. A., Gregorian, M., & Colborn, V. A. (2018). A stepped care approach to clinical suicide prevention. *Psychological Services, 15*(3), 243-250.

Joe, S., Canetto, S. >., & Romer, D. (2008). Advancing prevention researc on the rule of culture in suicide prevention. *Suicide & Life-threatening behavior, 38*(3), 354-362.

Johns, M. M., Lowry, R., Haderxhanj, L. T., Rasberry, C. N., Robin, L., Scales, L., . . . Suarez, N. (2020). Trends in Violence Victimization and Suicide Risk by Sexual Identity Among High School Students - Youth Risk Behavior Survey. *MMWR Suppl* , 19-27.

Kaplan, M. S., McFarland, B. H., Huguet, N., Conner, K., Caetano, R., Gisbrecht, N., & Nolte, K. B. (2013). Acute alcohol intoxication an sucidie: a gender-stratified analsys of the National Violent Death Reporting System. *Injury Prevention, 19*(1), 38-43.

Knesper, D. J. (2010). *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit.* Newton: Suicide Prevention Resource Center.

Konda, S., Reichard, A., & Tiesman, H. (2012). Occupatoinal injuries among U.S. Correctional Officers. *Journal of Safety Research, 43*, 181-186.

Le, H., Khan, B. A., Murtaza, S., & Shah, A. A. (2020). The increase in suicide during the COVID-19 pandemic. *Pyschiatric Annals, 50*(12), 526-530.

Lebrun-Harris, L. A., Baggett, T. P., & Jenkins, D. M. (2012). Health status and health care experiences among homeless patients in federally supported health centers: Findings from the 2009 patient survey. *Health Services Research*, 992-1017.

Michigan Professional Fire Fighers Union. (n.d.).

Milner, A., Witt, K., Maheen, H., & LaMontagne, A. D. (2017). Access to means of suicide, occupation and the risk of suicide: a national study over 12 years of coronial data. *BMC Psychiatry, 17*(125).

Moutier, C. (2020). Suicide Prevention in the COVID-19 Era: Transforming Threat into Opportunity. *JAMA Psychiatry*.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrisey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist, 58*, 449-456.

National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). *Recommended stadnard care for people with suicide risk: Making health care suicide safe.* Washington, DC: Education Development Center, Inc.

National Organization for People of Color Against Suicide. (2003-2004). *Cultural Competency: Developing Strategies to Engage Minority Populations in Suicide Prevention.* Silver Spring: National Organization for People of Color Against Suicide.

National Suicide Prevention Lifeline. (2020). *988 Planning Grants*. Retrieved from National Suicide Prevention Lifeline Web site: https://suicidepreventionlifeline.org/988-planning-grants/

New Jersey Police Suicide Task Force. (2009). *New Jersey Police Suicide Task Force Report.* Trenton. Retrieved from http://www.nj.gov/lps/library/NJPoliceSuicideTaskForceReport-January-30-2009-Final(r2.3.09).pdf

Noonan, M. (2016). *Mortality in state prisons, 2001-2014-statistical tables.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Payton, J., Weissburg, R. P., Durlak, J. A., Dymnicki, A. B., Taylor, R. D., Schellinger, K. B., & Pachan, M. (2008). *The positive impact of social and emotional learning for kindergarten to eigth-grade students: Findings from three scientific reviews.* Chicago: Collaborative for Academic, Social, and Emotional Learning.

Pittman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *Lancet Psychatry*, 86-94.

Police Executive Research Forum. (2019). *An occupational risk: What every police agency should do to prevent suicide among its officers.* Washington, DC: Police Executive Research Forum.

Rockett, I. R., Wang, S., Stack, S., De Leo, D., Frost, J. L., Ducatman, A. M., . . . Kapusta, N. D. (2010). Race/ethnicity and potential suicide misclassification: window on a minority suicide paradox? *BMC Pscyhiatry, 10*(35).

Roy, A., Nikolitch, K., McGinn, R., Jinah, S., Klement, W., & Kaminsky, Z. A. (n.d.). A machine learning approach predicts future risk to suicidal ideation from social media data. *npj Digit. Med, 3*(78). doi:doi: https://doi.org/10.1038/s41746-020-0287-6

SAMHSA. (2019). *People at Greater Risk of Suicide*. Retrieved from SAMHSA Web Site: https://www.samhsa.gov/suicide/at-risk

Schlichthorst, M., Ozols, I., Reifels, L., & Morgan, A. (2020). Lived experience peer support programs for suicide prevention: a systematic scoping review. *International Journal of Mental Health Systems, 14*(65). doi:https://doi.org/10.1186/s13033-020-00396-1

Simon, G. E., Johnson, E., Lawrence, J. M., Rossom, R. C., Ahmedani, B., Lynch, F. M., . . . Shortreed, S. (2018). Predicting suicide attempts and suicide deaths following outpatient visits using electronic health records. *American Journal of Psychiatry, 175*(10), 951-960.

Standley, C. J. (2020). Expanding our paradigms: Intersectional and socioecological approaches to suicide prevention. *Death Studies*. doi:10.1080/07481187.2020.1725934

Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., . . . Crosby, A. E. (2018, June 8). Vital Signs: Trends in State Suicide Rates - United States, 1999-2016 and Circumstances Contributing to Suicide - 27 States, 2015. *Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report, 67*(22).

Suicide Prevention Resource Center. (2013). *Continuity of Care for Suicide Prevention: The Role of Emergency Departments.* Waltham.

Suicide Prevention Resource Center. (n.d.). *Risk and protective factors.* Retrieved from Suicide Prevention Resource Center Web site: https://www.sprc.org/about-suicide/risk-protective-factors

The Trevor Project. (2019). *The Trevror Project National Survey on LGBTQ Youth Mental Health.* West Hollywood: The Trevor Project.

Weir, K. (2019, March). Worrying trends in US suicide rates. *Monitor on Psychology, 50*(3), p. 24.

Wexler, L., & Gone, J. P. (2012). Culturally responsive suicide prevention in Indigenous communities: Unexamined assumptions and new possibilities. *American Journal of Public Health, 102*(5), 800-806. doi:10.2105/AJPH.2011.300432

White Swan Foundation. (2015, July 27). *Why suicide prevention must figure in your employee assistance program*. Retrieved from White Swan Foundation Website: https://www.whiteswanfoundation.org/workplace/why-suicide-prevention-must-figure-in-your-employee-assistance-program

Wilkins, N., Tsao, B., Hertz, M., Davis, R., & Klevens, J. (2014). *Connecting the dots: An overview of the links among multiple forms of violence.* Atlanta: National Center for Injury Prevention and Control.

World Health Organization. (2014). *Preventing Suicide: A Global Imperative.* Geneva. Retrieved from www.who.int

Appendices

Appendix A: Suicide Prevention Glossary

Affected by suicide –all those who may feel the impact of suicidal behaviors, including those bereaved by suicide, and community members and others.

Attempt survivor – see suicide attempt survivor

Behavioral health – issues, problems or challenges including mental and substance use disorders, severe psychological distress, and suicidal thinking or behavior

Bereaved by suicide – family members, friends, and others affected by the suicide of a loved one.

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

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

Connectedness – the connections a person has among family, friends, peers, and community; how connected people are to health and social services; and how well services collaborate.

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 per

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

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

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

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.

Lethal Means – instruments, objects, or materials used for suicidal behavior that have a high rate of causing death.

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

Mental health – a person's capacity to fully use his or her mental abilities, experience social and cognitive development, interact with others, and experience well-being.

Peer – a person with lived experience from mental or behavioral health challenges, specifically experience from a suicidal crisis.

Prevention – a strategy or approach that reduces the likelihood of risk onset, 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 a person will experience a suicidal crisis.

Primary care – clinical services that are aimed at general physical health and well-being.

Recovery – a concept of living a hopeful, meaningful, and fulfilling life despite behavioral health challenges.

Resilience – a person's capacity for positive outcomes and/or protection from negative outcomes despite challenges.

Risk factors – characteristics, situations, or other elements in a person's life that make it more likely that they will develop a disorder or experience a suicidal crisis.

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

Screening tools – instruments and techniques used to evaluate individuals for increased risk of certain health problems.

Stigma – The combination of bias, negative stereotypes, fear, avoidance, same, discrimination, and/or abuse that is associated with a labelled condition or circumstance.

Suicidal ideation – Thoughts of engaging in suicide-related behavior.

Suicide – death caused by self-inflicted injury, poisoning, or suffocation, a fatal suicide attempt.

Suicide attempt – a self-inflicted injury, poisoning, or suffocation with some intent to die.

Suicide attempt survivor – a person who survived a prior suicide attempt.

Appendix B: Suicide Prevention Commission Listening Session Analysis

Suicide Prevention Commission Listening Session #1 – December 1, 2020

Q: What is the most critical barrier in your community to prevent suicide and why?

Key Themes:

1. Lack of facilities, resources, funding, lack of public (and possibly physician) awareness, and lack of a source where there is a coordination of services.
2. Lack of financial support (funding) in areas such as public hospitals, state hospitals that are Medicaid funded, and youth facilities – especially in rural areas. Only one private hospital where insurance will cover care.
3. Teaching others how to see the signs, gain the knowledge and experiences, skills, and tools to know where they need to go ask for help or seek help.

Recommendations:

1. Increase visibility of issue and thereby increase funding,
2. increase awareness of suicide signs and places to go to seek help and designate a specific person or organization to advocate and serve as a resource for entire population or individual communities/counties.
3. Have a specific individual – or a position made – for someone who is responsible for talking to the community and identifying what their specific needs are (thorough needs assessment, finding out what services are available, and ensuring coordination among providers and the community or county that they serve).
4. Increased lobbying toward funding for mental health services, resources, and facilities.
5. Increased funding for campaigns, media, billboards, prevention specialist positions, and towards forming coalitions in designated areas to address issues and stigmas related to how someone can ask for help, increasing suicide prevention and mental health services.

Q: What do you see as the major risk factor for suicide in your community and why?

Key Themes:

1. Lack of knowledge, inconsistent use of mental health assessments (not uniformed), COVID and the associated isolation that comes from COVID, unemployment.
2. Not having training available to the people who need it (lay people and professionals).

Recommendations:

1. Move the community towards people looking out for each other – being able to offer help and support in simple ways.

2. Educate the community about the simple, no cost, and not time-consuming things people can do for each other.
3. Creating some sort of mentoring groups where people can educate and empower each other. Mental Health First Aid.
4. Increase capacity to make more trainings (mental health first aid, youth mental health first aid, safe talk, etc.) available more frequently and offer them in enough times and places to make them convenient for more people to participate in the community.
5. Reduce isolation resulting from COVID - make people feel more connected.

Q: What resources are missing in your community to prevent suicide?

Themes:

1. More Youth focus resource suicide prevention commission committees (county/regional level) are needed,
2. Regional level resources for individuals that are not Medicaid eligible,
3. Lack of coordination of services and knowledge of resources for the LGBTQ+, veterans, and peer support communities.

Recommendations:

1. Peer-to-peer (developed out of University of Michigan) peer-to-peer suicide prevention and mental health, and a Program called SOS, Mental Health First Aid, and Team Mental Health First Aid. Blue Envelop Campaign (Spectrum Health) or training staff members in suicide awareness. QPR, Trauma informed practice training, Be Nice Campaign – suicide prevention intervention.

Suicide Prevention Commission Listening Session #2 – December 3, 2020

Q: What is the most critical barrier in your community to prevent suicide and why?

Key Themes:

1. Reducing stigma in staff about needing additional training and learning new methods, techniques, and information when it arises. Generally, being aware and open of any new changes. Reducing stigma among professional staff in schools about the need for additional training, prevention and response on best practices.
2. Coordination of services, particularly in the hospital systems.
3. COVID and associated feeling of isolation.
4. The Death Review – there are no death review teams at the county level.
5. LGBTQ+ and aging adult suicides are unreported/under-reported.
6. Medical examiners are too afraid to ask family's directly about LGBT information because they do not want to ask, "such a question." Lack in collection of data and lack of collecting the right data.
7. Funding to use on credible messengers and organizations, where people can go out into the community and prevent suicide before it occurs and getting people out of the cycle of gun violence.
8. Training is to establish comfort in asking the right or necessary questions, and to ensure that the questions that are being asked are consistent all around.

Recommendations:

1. Lobby to get language in a bill that would make it mandatory for communities to get together for suicide and overdose deaths in tandem with doing the child death reviews. Also, to provide inclusive language to legally cover medical examiners to release medical information and data.
2. A legislation being passed would get more funding to address underrepresented communities.
3. Include training that encourages people to be able to ask someone's friends or family, who has contemplated suicide, what do you know about this person? Did they come out to their family and what was their reaction? Were they bullied at school?
4. Get a legislation passed that would address getting more funding to properly train, ask questions, and collect accurate data on the LGBTQ+ and Senior Suicide communities.

Q: What do you see as the major risk factor for suicide in your community and why?

Key Themes:

1. Lack of knowledge about available resources and how to coordinate a better system of care, as well as lack of education and training, cultural barriers (training surrounding culture), inconsistent use of mental health assessments (not uniformed), and lack of community education.
2. Cultural barriers.
3. COVID and the associated isolation that comes from COVID.
4. Education on HIPAA and suicide deaths – what is okay to share? What is not?
5. Educational campaigns for people that fall through the cracks like isolated seniors, people in rural areas, and ways in which we can support farmers.
6. Education and training to let people know about stigmas and address why we need to address the risk factors of suicide and not just suicide death itself.
7. Funding from payers to support social work in mental health and providers.

Recommendations:

1. Learn to listen and ask better questions via required training, education on HIPAA and suicide death, get more funding from payers.
2. Incorporating evidence-based practices in education and trainings.

Q: What resources are missing in your community to prevent suicide?

Themes:

1. Mental health screenings.
2. Youth focus resource suicide prevention commission committees (county/regional level),
3. regional level resources for individuals that are not Medicaid eligible,
4. Education on LBGTQ+, veterans, peer-support, stigma resources that are available.

Recommendations:

1. Training geared toward faith-based leaders, volunteers, and youth workers who have a more person relationship with community.
2. Utilize suicide survivors in foreseeing – what would have or could have made a difference for you? Who could have asked? How are you still here? Is there something that could have stopped you? Was there something that happened? Were you able to reach out to the crisis text line? What was the thing that worked the best?
3. Training on correct questions to ask and have a plan if necessary.
4. Make questionaries geared toward multiple different variations (age appropriate).

Suicide Prevention Commission Listening Session #3 – December 10, 2020

Q: What is the most critical barrier in your community to prevent suicide and why?

Key Themes:

1. Lack of knowledge on first steps - there are no definitive answers as to what or where there are first steps, and or where to go to seek help. There is a gap in knowing what is available to lay people and their community.
2. Stigmas in a society in dealing with suicide. Stemming from places like hospitals and doctors' offices, with suicide screenings, to schools only addressing suicide from a bullying standpoint and not focusing on discussions about the importance of mental health.
3. In rural counties, a barrier is not prioritizing suicide prevention strategies, especially in the youth.
4. Schools cannot educate families and students on suicide because they are understaffed and do not have enough funding.
5. There is no state mandate, no procedures, no specific language, no properties in place, and no funding for mental health/suicide prevention in schools. Therefore it "only becomes a problem when it happens."
6. COVID and associated feelings of isolation. Because students do not have to physically come into school, and many of them do not turn on their cameras, teachers and or counselors lack the ability to check in on them.
7. Lack of inclusive place for LGBTQ+ people or people with depression or specific mental health issues to go and connect with each other.

Recommendations:

1. When it comes to mental health, look at our entire society and system as a whole and change the way that it is addressed in places like schools (preschool and up), hospitals, etc. – mental health needs to be involved in the school policy from early on.
2. Looking at high level places (schools, colleges, hospitals, places of worship, high risk professional fields) and incorporate suicide prevention training, mental health screenings, open discussion, programming, education and awareness of resources for all people.
3. Creating and facilitating inclusive programs for LGBTQ+ or creating a designated place or program to focus on specific mental health issues and not just broadly focus on mental health.
4. Getting more funding to pay for more educators and counselors in schools.
5. Look at key places, as a society, where suicide discussions can be embedded at a state level – create mandates, procedures, specific language for mental health interventions.

Q: What do you see as the major risk factor for suicide in your community and why?

Key Themes:

1. Stigma – people view mental health and suicide as taboo and are less likely to seek help.
2. Those who are abusing and using substances – more likely to carry through with suicide when they are under the influence. If suicide is linked to the substance use where is it that we need to integrate evidence-based programs to prevent suicide?
3. Funding for the state: that includes substance abuse and suicide prevention.
4. COVID – remote learning environment is not functional for some students and challenges them in a way that may lead to risk factors. Peer pressure and academic standards can also serve as risk factors- especially if students are dealing with mental health issues already.
5. Black/Brown Community – focus currently (since the 1980's) on white community in terms of mental health - but there is not enough concern when it comes to people of color. Fear that minority will be left behind. Mistrust with minority community between mental health providers.

Recommendations:

1. Taking away the stigma of talking about mental health, but not taking away the stigma from the fact that suicide is not the solution.
2. Creating and funding for more evidence-based programs to prevent suicide.

Q: What resources are missing in your community to prevent suicide?

Key Themes:

1. Teachers feel that they do not have enough resources and trainings (district or community wide) – lack of training, lack of knowledge and lack of awareness.
2. Reducing the Taboo of training related to talking about mental health and suicide among teachers. Increase comfort for teachers addressing a suicide issue and empower them to respond to an issue especially if counselors are not available.
3. Reinforcing a mandate by the Department of Education and the State. Mandating that there is ongoing education and training to all staff about suicide education – not just teachers but everyone in academic ecosystem.

Recommendations:

1. Teaching cognitive behavior therapies, increasing Peer-to-peer programs and peer led interventions ('You Matter' or Headspace).
2. Designate days for mental health programs more than once a week, creating a resource mapping lifeline on a county level.

3. Bilingual assistance to utilized crisis.
4. Tapping into survivors as someone with suicide experience.
5. Exercises in examining our internal biases, invest in peer-to-peer programs across the board and having it built into our societal system.
6. Coalitions are huge resources that are not being utilized effectively to share resources and work together.
7. "ACES" training and Lincoln High School – First Aid mental health clinics available in the schools. Can we tackle insurance barriers, or training barriers by hiring professionals that provide mental health services to students in the schools?
8. Open a place that was in a community that had training ongoing for parents – nutrition, cell phones, etc. But also, are trained in trauma-based interventions, QPR, Assist, to have conversations with people and relationships with the people in the community when individuals require care (in a separate private care instead of a hospital). A place that focuses on building relationships and not focused on behavioral interventions.

Suicide Prevention Commission Listening Session #4 – December 10, 2020

Q: What is the most critical barrier in your community to prevent suicide and why?

<u>Key Themes:</u>

1. Lack of integration of services and training in schools, LGBTQ+ communities, and among the elderly – specifically certain trainings are very costly.
2. Lack of coordination of services and follow up (schools, providers, parents, therapists).
3. Lack of connecting resources that may already be there – there may be tools but there is a gap in getting them into the hand of those who need them.
4. Stigma - Filling classrooms for trainings (parents, aunts, uncles, those raising youth) do not attend trainings due to stigma. And no one knows where to go if services are needed.
5. Gap in adolescent centered services, although there is technology there is no specific "safe" place for them to go.
6. Tools and resources for those who do not speak English.
7. Stigma can be a barrier itself – providing alternative places where someone can get services.

<u>Recommendations:</u>

1. Improve tools available in schools to maintain and sustain suicide training.
2. Work with the LBGTQ community who are at increased risk, addressing the identified factors (stigma, lack of support), and Zero Suicide.
3. Creating bilingual tools and resources for people that do not speak English.

Q: What do you see as the major risk factor for suicide in your community and why?

Key Themes:

1. Limited resources especially during COVID – lacking socializing and having a reason to get out of the house. Forced isolation and lack of socialization, especially for groups that are marginalized, can play a huge risk factor.
2. Social media can play a role in increasing loneliness and isolation. Information that may contribute to being a risk and a safety factor for suicide (double edge).
3. Lack of clinicians trained in suicide prevention interventions and universities lack knowledge about social emotional learning. Poor teacher retention and lack of preparedness from said teachers to teach social emotional learning.
4. Bullying in schools and link with social media –cyberbullying. Cyberbullying may be difficult to track.

Recommendations:

1. Learn how to normalize education to help kids basic conflict coping skills to manage themselves,
2. Improved coverage for provision of services
3. bullying and cyberbullying training, safe messaging, stigma training.
4. Increasing trainings and empowering confidence for primary care faculty can help free up space for mental health care services or limited psychiatric providers.
5. Increase funding for sufficient psychiatric providers.

Q: What resources are missing in your community to prevent suicide?

Key Themes:

1. Funding is a huge problem.
2. Huge gap in someone providing support for majority of youth.
3. Coordination for training, mental health survivors, mental health professionals in pre-K-12 buildings.
4. Linking with law enforcement with mental health training.
5. Allow days for mental health in schools.
6. requiring mental health at licensing level, training individuals who interact with youth.

Recommendations:

1. Funding for training and coordination of training – QPR can be good across several different settings. Coordination for training for clinicians and primary care physicians.
2. Mandating age-appropriate curriculum on mental healthcare – incorporating it in school curriculum.

3. Have mental health professionals in all buildings k-12. Have school-based health clinic in every school – having emotional support people and mental health professional in every school to provide necessary services.
4. At a State level, get someone to write funding grants for schools.
5. Have more peer-support training available.

Appendix C: Evidence Based Programs & Practices in Michigan

AFSP Healing Conversations (HC)
Website: www.afsp.org/HealingConversations
Formerly known as the Survivor Outreach Program. Trained AFSP volunteers, who are themselves survivors of suicide loss, offer understanding and guidance in the weeks and months following a suicide death.
Length: 2 hours
Cost: Free

AFSP More Than Sad
Website: www.afsp.org
Videos teach students and educators how to be smart about mental health (teens, parents, teachers). Two videos, Teen Depression and Preventing Teen Suicide, with downloadable facilitator tools.
Length: 25 min each
Cost: FREE

AFSP Suicide Bereavement Clinician Training Program
Website: www.afsp.org
Focused overview of the impact of suicide on survivors and the clinical and support responses that are needed. Intended for clinical professionals seeking to bolster their knowledge and understanding of—and empathetic regard for—people bereaved by suicide. Intended for physicians/psychiatric nurses, psychologists, certified counselors, social workers, and licensed marriage and family therapists. Also open to clergy, pastoral counselors, school personnel, and interested others. The workshop includes didactic and video presentations, group discussion, and case examples.
Length: 1-day (6.5 hours)
Cost: $

AFSP Talk Saves Lives: An Introduction to Suicide Prevention
Website: www.afsp.org
A community-based presentation that covers the general scope of suicide, the research on prevention, and what people can do to fight suicide. Attendees will learn the risk and warning signs of suicide, and how, together, we can help prevent it.
Length: 45-60 min
Cost: Free

Applied Suicide Intervention Skills Training (ASIST)
Website: https://www.livingworks.net/
Comprehensive training that is for any "gatekeeper" age 16 years and older (those most likely to be in contact with the person). This is what the National Suicide Prevention Lifeline uses.
Length: 2 days
Cost: $

Ask, Care, Escort (ACE) Suicide Intervention Training
Website: https://www.armyg1.army.mil/hr/suicide/default.asp
ACE is only available to authorized U.S. Army personnel. Teaches about the risk factors and warning signs of suicide, how to intervene with those at risk of suicide (Asking, Caring, and Escorting).
Length: 1.5 hours
Cost: Free

Assessing and Managing Suicide Risk (AMSR)
Website: http://zerosuicideinstitute.com/amsr
Clinician specific training, AMSR presents five of the most common dilemmas faced by providers and the best practices for addressing them. Various curricula for outpatient, substance use.
Length: 1 day
Cost: $

Be A Link! ® Community Gatekeeper Training
Website: www.yellowribbon.org
Adult gatekeeper program that teaches how to identify the warning signs and risk and protective factors of suicide for youth, how to talk with teens/youth, and how to understand school liabilities, policies, and procedures. Additional training tracks are available for school staff, first responders, faith leaders, and youth peer leaders.
Length: 2 hours
Cost: $

Connect Suicide Postvention Training
Website: https://theconnectprogram.org/
Helps service providers respond in a coordinated and comprehensive way in the aftermath of a suicide or any sudden death. More than "just training," Connect fosters relationship building and the exchange of resources among participants. Prior to the training, connect staff work with the host agency to identify and incorporate local cultural issues and begin planning how the training will be applied and sustained.
Length: 2 days
Cost: $

Connect Suicide Prevention/Intervention Training
Website: https://theconnectprogram.org/
Increases the capacity of professionals and communities to prevent suicide across the lifespan. It uses a public health approach and incorporates key elements of the National Suicide Prevention Strategy. The Connect Prevention Training also offers online modules for Healthcare or Mental Health Providers and School Personnel.
Length: 6 hours
Cost: $

Connect Survivor Voices
Website: https://theconnectprogram.org/
SurvivorVoices: Sharing the Story of Suicide Loss is a National Best Practice program that teaches those bereaved by suicide how to speak safely and effectively about their loss. Survivors of suicide loss are key partners in suicide prevention and postvention. While some individuals who take SurvivorVoices may never share their story publicly, participation in the training helps them with their own grief process and connects them with other survivors. For those who go on to share their stories publicly, they often use this new connectedness to energizes suicide prevention and bereavement support efforts (e.g., starting a survivor of suicide loss support group, hosting a teleconference site, starting a Life Keeper quilt project, initiating a suicide awareness event).
Length: 2 days
Cost: $

Discover You
Youth program (Evidenced Based foundation). 20,000 students in juvenile homes and have engaged in Discover You" over the past 10 years throughout the Great Lakes Bay Region with 90% requesting the program year after year reporting improved attitudes, behaviors and student to student interactions and fewer disciplines. A unique combination of social and emotional learning and positive psychology and demonstrated outcomes. Discover You is an 18-hour program that can be implemented in the health class or by other educator in the school using a written program and advisor trained and certified to support continued education. Supported by Michelle McQuaid.

esuicideTALK
Website: https://www.livingworks.net/
Online program, enabling anyone with an Internet connection to develop awareness about suicide and its prevention in a safe, customizable online space. Ideal for all English speakers age 15 and older who want to take the first steps toward suicide awareness and prevention. By helping to dispel the fear and stigma around suicide, esuicideTALK contributes to an open and supportive community where people at risk can get the help, they need to stay safe.
Length: 1-2 hours
Cost: $

4 What's Next
Website: https://4whatsnext.org/
4 What's Next is a primary prevention program that builds resiliency in high school students by giving them the tools to handle stress and distress now and in their future.
Cost: $

Gizmo's Pawesome Guide to Mental Health Curriculum
Website: https://www.gizmo4mentalhealth.org/
A fun, flexible, turn-key curriculum for elementary youth that introduces the Gizmo's Pawesome Guide to Mental Health (Guide) using an animated PowerPoint, implementer discussion guide, and activities for youth. It may be implemented in various settings, such as public/private/parochial/ therapeutic schools, treatment locations, camps, and before or after school programs. Utilizes the evidence-based Safety Plan (Stanley and Brown, 2012) as the framework.
Length: 1 class period
Cost: FREE

Henry Ford Health System Zero Suicide Model Guidelines
Website: https://www.henryford.com/services/behavioral-health/zero-suicide
In 2001, Henry Ford Behavioral Health was the first to pioneer and conceptualize "zero suicides" as a goal and develop a care pathway to assess and modify suicide risk for patients. The program led to over a 75% reduction of suicide and has been sustained over time. In the years since Henry Ford first envisioned "zero" as the goal, a worldwide zero suicide movement has emerged. Mental health organizations and governments across the globe have embraced the idea and designed a growing number of programs intended to prevent suicide deaths. These guidelines include a step-by-step approach for implementing a series of evidence-based care improvement processes within health systems.
Cost: FREE

Mental Health First Aid
Website: https://www.mentalhealthfirstaid.org/
Learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.
Length: 8 hours
Cost: FREE

Question, Persuade, Refer (QPR) Gatekeeper Training Program
Website: https://qprinstitute.com/
Teaches how to identify and interrupt a potential crisis and direct that person to the proper care. Includes role-playing resulting in participants leaving the training with stronger confidence in serving as a gatekeeper utilizing best practices.
Length: 90 minutes
Cost: FREE

safeTALK
Website: https://www.livingworks.net/
Described as a suicide "alertness" training. Apply the TALK steps: Tell, Ask, Listen, and Keep Safe. Learn how to connect someone experiencing suicidal thoughts to community resources for help.
Length: 3 hours
Cost: FREE

Shield of Care
Website: https://www.tn.gov/behavioral-health/
For juvenile justice programs. Teaches how to understand the risk and protective factors of suicide, how to increase self-efficacy to prevent suicide, and to understand suicide prevention strategies and skills.
Length: 8 hours
Cost: FREE

Signs of Suicide Program (SOS)
Website: https://www.mindwise.org/suicide-prevention/
SOS Signs of Suicide (SOS) is a universal, school-based prevention program designed for middle school (ages 11-13) and high school (ages 13-17) students. The goals of this program are to decrease suicide and suicide attempts by increasing student knowledge and adaptive attitudes about depression; encourage personal help-seeking and/or help-seeking on behalf of a friend; reduce the stigma of mental illness; acknowledge the importance of seeking help or treatment; engage parents and school staff as partners in prevention through "gatekeeper" education; and encourage schools to develop community-based partnerships to support student mental health.
Length: 1 class period
Cost: $

Appendix D: National Institutes of Health (NIH) Research Grants

Over the past several years, several grants directly related to research on suicide and its prevention have been awarded by the National Institutes of Health to researchers at Michigan universities and research institutions, including the following:

24-Hour Risk for Suicide Attempts in a National Cohort of Adolescents
Award #: R01MH113482
PI: Cheryl A. King
University of Michigan
A study to determine 24-hour warning signs for adolescent suicide attempts; whether (and how) 24-hour warning signs differ for subgroups of adolescents with different profiles of baseline suicide risk factors; and whether baseline scores on a behavioral test of implicit suicide ideation (Suicide-Implicit Association Test) identify a unique subgroup of adolescents at risk for suicide attempt who explicitly deny suicidal thoughts, and if so, whether this subgroup is characterized by a distinct pattern of warning signs.

A Public Health Approach to Understanding Suicide in Long-Term Care
Award #: R21MH108989
PI: Briana M. Mezuk
University of Michigan
An investigation of the relationship between long-term care, housing transitions in later life, and completed suicide among older adults using a large, prospective, population-based registry of suicide deaths.

An Evaluation of the National Zero Suicide Model Across Learning Healthcare Systems
Award #: U01MH114087
PI: Brian K. Ahmedani
Henry Ford Health System
The zero suicide model merges a series of evidence-informed processes and interventions into a single model to improve suicide prevention practices in health systems by closing gaps in care. This project conducts a comprehensive process and outcome evaluation of the implementation of this model across 6 large, diverse health systems.

Developing Text-Based Support for Parents of Suicidal Adolescents After Emergency Department Visits: A Multi-Component Intervention Pilot
Award #: R34MH124767
PI: Ewa K. Czyz
University of Michigan
Development and piloting of an adaptive, text-based intervention for parents of suicidal youth transitioning from ED care, comprised of two texting components targeting interrelated domains: (1) parental provision of adolescent-focused support to promote safety

and well-being of suicidal adolescents and (2) parent-focused support directed at enhancing parents' own well-being.

Developing an Adaptive Intervention for Suicidal Adolescents Following Inpatient Hospitalization: A Pilot SMART
Award #: K23MH113776
PI: Ewa K. Czyz
University of Michigan
A Sequential, Multiple Assignment, Randomized Trial (SMART) pilot of a Motivational Interview (MI)-enhanced safety planning intervention (MI-SafeCope).

Effectiveness and Implementation of a Peer Mentorship Intervention (PREVAIL) to Reduce Suicide Attempts Among High-Risk Adults
Award #: R01MH115111
PI: Paul N. Pfeiffer
University of Michigan
Assessment of the effectiveness of the PREVAIL intervention with adult patients admitted to an inpatient psychiatric unit for suicide risk.

Electronic Bridge to Mental Health (eBridge) for College Students
Award #: R01MH103244
PI: Cheryl A. King
University of Michigan
A large-scale, randomized controlled intervention trial across multiple universities to address the following specific aims: (1) determine the impact and effectiveness of the previously developed eBridge web-based screening and intervention on linkage to mental health services, mental health outcomes (suicidal thoughts and behaviors, depression, alcohol/substance misuse), and academic outcomes (grade point average, retention).

Emergency Department Screen for Teens at Risk for Suicide (ED-STARS)
Award #: U01MH104311
PI: Cheryl A. King
University of Michigan
A multi-site collaborative project to develop and test a computerized adaptive screen (CAS) for predicting suicide attempts, as well as) develop and validate a parsimonious CAS-based algorithm for risk stratification to facilitate the triage of youths.

Facilitating Use of the National Suicide Prevention Lifeline in Alcohol Patients
Award #: R01AA027513
PI: Mark A. Ilgen
University of Michigan
A randomized controlled trial of the impact on individuals with Alcohol Use Disorders and a previous suicide attempt of a brief intervention (Crisis Line Facilitation) compared to enhanced usual care on utilization of the NSP Lifeline as well as suicide attempt(s).

Family Safety Net: Developing an Upstream Suicide Prevention Approach to Encourage Safe Firearm Storage in Rural and Remote Alaskan Homes
Award #: R61MH125757
PI: Lisa M. Wexler
University of Michigan
Research to inform the development of the Family Safety Net (FSN), a public health approach that builds on the collectivist, family-centric orientation of Alaska Native people by universally engaging adult family members of youth in increasing their home safety.

Feasibility, Acceptability, and Preliminary Effectiveness of a Cognitive-Behavioral Suicide Prevention-Focused Intervention Tailored to Adults Diagnosed with Schizophrenia Spectrum Disorders
Award #: R34MH123609
PI: Lindsay A. Bornheimer
University of Michigan
Evaluation of the acceptability and preliminary effectiveness of a modified version of the Cognitive Behavioral Suicide Prevention for psychosis (CBSPp), a promising intervention requiring protocol and implementation modifications to increase its utility in community mental health

Peer Mentorship to Reduce Suicide Risk Following Psychiatric Hospitalization
Award #: R34MH103447
PI: Paul N. Pfeiffer
University of Michigan
Develop and pilot test a peer mentorship intervention for psychiatrically hospitalized patients at high risk for suicide.

Promoting Community Conversations about Research to End Native Youth Suicide in Rural Alaska (PC CARES)
Award #: R01MH112458
PI: Lisa M Wexler
University of Michigan

Using a community-based, participatory research approach, track the effect of PC CARES on participants' knowledge, attitudes and behavior, and identify key factors influencing these outcomes over time, as well as documenting the community-level impact of PC CARES.

Suicide Risk Reduction in the Year Following Jail Release: The SPIRIT Trial (Suicide Prevention Intervention for At-Risk Individuals in Transition
Award #: U01MH106660
PI: Jennifer E. Johnson
Michigan State University
Evaluation of the effectiveness and cost-effectiveness of SPI for reducing suicide events (attempts, suicide behaviors, and suicide-related hospitalizations and emergency department visits) and attempts among 800 suicidal pretrial jail detainees from two jails in the year following jail release.

Treatment Utilization Before Suicide
Award #: R01MH103539
PI: Brian K. Ahmedani
Henry Ford Health System
Most individuals who die by suicide make general medical visits prior to their death, but do not have a documented mental health condition. This project uses data from eight Mental Health Research Network affiliated health systems to investigate the association between other, non-psychiatric clinical factors and suicide risk. Evidence from this study can be used to inform the development of targeted suicide prevention efforts in general medical settings.

Appendix E: Substance Abuse and Mental Health Services Administration (SAMHSA) and other Federal Suicide Prevention Grants.

In addition to suicide specific research grants received by researchers at Michigan universities and research institutions, several universities, other organizations and a community college in Michigan have received Suicide Prevention Grants from the federal Substance Abuse and Mental Health Services Administration, including:

EASTERN MICHIGAN UNIVERSITY
Program: SAFE Now: Stigma and Fear End Now
PI: Ellen Gold
Grant Award #: SM061802
Project Period: 2014–2017

GRAND RAPIDS COMMUNITY COLLEGE
Program: GRCC Campus Suicide Prevention Program
PI: Lynnae Selberg
Grant Award #: SM062523
Project Period: 2016–2019

HENRY FORD HEALTH SYSTEM
Program: Implementing Zero Suicide in Emergency Departments with Diverse Populations in Michigan
PI: Brian K. Ahmedani
Grant Award #: H79SM083419
Project Period: 2020 – 2025

HENRY FORD HEALTH SYSTEM
PI: Brian K. Ahmedani
Grant Award #: SM083419-01

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Program: Preventing Suicide in Michigan Men (PRiSSM)
PI: Jennifer DeLaCruz
Project Period: 2020-2025

MICHIGAN STATE UNIVERSITY
Program: FACES
PI: Jan Collins Eaglin
Grant Award #: SM058974
Project Period: 2009–2011

OAKLAND UNIVERSITY
Program: Grizzlies Response: Awareness & Suicide Prevention (GRASP) at Oakland University
PI: Michael MacDonald
Grant Award #: 5 SM060542
Project Period: 2012–2015

SAGINAW VALLEY STATE UNIVERSITY
Program: SVSU Mental Health Prevention and Awareness Project
PI: Eddie Jones II
Grant Award #: SM060503
Project Period: 2012–2015

UNIVERSITY OF MICHIGAN
Program: UM Campus Suicide Prevention
PI: Cynthia Ewell Foster
Grant Award Number: 1 U79 SM062492
Project Period: 2016–2019

WAYNE STATE UNIVERSITY
Program: Suicide Prevention Initiative
PI: Jeffrey Kuentzel
Grant Award #: SM080101
Project Period: 2017–2020

Appendix F: Suicide Prevention Commission Recommendations

Commission Priority	Recommendation
Minimizing risk for suicidal behavior by promoting safe environments, resiliency and connectedness.	1. Develop and sustain a coordinated central point of access at the state level where suicide prevention resources and training are accessible to the community. 2. Support the implementation of best practice suicide prevention programs that utilize safe messaging. 3. Develop, expand, and publicize local survivor leadership groups for community peer supports. 4. Increase the public's knowledge of risk factors for suicide, recognition of warning signs in individuals, and preparedness to support and respond to those individuals. 5. Promote social and emotional development skill-building education programs for families in high-need communities. 6. Create and sustain a statewide postvention workgroup responsible for developing and implementing guidelines for responding effectively after the death of someone by suicide. 7. Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. 8. Partner with firearm advocacy groups, as well as liquor sales commission, and retailers (shooting clubs, manufacturers, firearm retail insurers, concealed handgun instructors, hunting groups, law enforcement, veteran groups, farm and ranch associations) to increase suicide prevention awareness. 9. Work with military agencies, veterans organizations and law enforcement to establish specialized trainings/projects to reduce potential for suicide-related death by firearms. 10. Create or identify materials to educate individuals, families, and clinical providers about limiting access to lethal means, e.g., storage of alcoholic beverages, prescription drugs, over-the-counter medications and poisons.
Increasing and expanding access to care to support those at risk of suicide	11. Sustain and expand funding to support comprehensive suicide prevention efforts in the state. 12. Explore and consider implementing evidence-based peer support programs as a model for suicide prevention as more evidence becomes available. 13. Continue to support and expand the use of easily accessed suicide prevention hotlines, warmlines, text lines and other crisis lines. 14. Encourage new public-private partnerships including federal and local government and community-based organizations serving populations disproportionately impacted by suicide.

	15. Explore and implement alternative models of care for individuals at high risk for suicide at-risk patients (crisis response options, residential crisis etc.) 16. Encourage and educate the public at large, including employers and their employees to work with employee assistance programs to promote suicide prevention awareness and information about services offered and to promote easy access to behavioral health treatment services.
Improving suicide prevention training and education	17. Collaborate with licensing and certifying organizations to ensure that healthcare professionals receive formalized training in suicide prevention/intervention as part of the licensing/credentialing process. 18. Increase capacity and improve trainings on evidence-based suicide assessment, treatment, and management for health professionals and expand the list of health professions required to receive training. 19. Collaborate with the Michigan Department of Education to help ensure standard suicide prevention training for K-12 for school counselors, teachers, and others. 20. Require, as appropriate, content on suicide risk assessment, treatment, and management in health sciences and social service programs taught in higher education.
Implementing best practices in suicide prevention for healthcare systems	21. Adopt zero suicide as an aspirational goal statewide by preventing all suicide deaths through healthcare and community supports. 22. Promote the adoption of a zero suicide prevention care strategies for health care providers and institutions. 23. Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings. 24. Expand the use of evidence-based screening, assessment, and suicide-specific treatments for those at risk. 25. Standardize and promote a statewide comprehensive assessment tool inclusive of suicide prevention elements. 26. Improve care transitions for people with suicidal thoughts and behaviors who are discharged from emergency departments, inpatient settings, and other care settings. 27. Support primary care practices in adopting suicide prevention protocols to build suicide care pathways.

Enhancing suicide specific data collection and systems	28. Standardize evidence-informed death scene investigation forms to improve the completeness of data collected on deaths by suicide. 29. Adopt data standards/definitions based on Centers for Disease Control and Prevention best practices. 30. Examine data for any racial/ethnic biases in determination of cause and manner of death as a suicide and subsequent reporting and educate medical examiners on this potential risk. 31. Build and staff a repository of data related to suicide in the state. 32. Identify opportunities and reporting mechanisms for machine learning and artificial intelligence to monitor and intervene for individuals with trends/patterns for suicidality. 33. Improve qualitative review and documentation of suicide risk among special populations through interviews, focus groups, etc. 34. Assure that initial screening for suicidal behavior is conducted and accurately documented during hospital or emergency department intake with proper follow up approaches. 35. Regularly review data to inform decision making on future program implementation. 36. Recommend standardized training to include toxicology draws and regular auditing of training for medical examiners and medical examiner investigators in the investigation and reporting of death by suicide