Suicide Prevention Coalition

Of Wexford & Missaukee Counties

(Dec, 2010)

[redacted]
Suicide
Prevention
Plan
(2007-2012)

Northern Lakes
COMMUNITY MENTAL HEALTH

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Did you know?

Suicide is the third leading cause of death for 15 to 19 year olds; and the second leading cause of death for college age young people.

Introduction and History

The Wexford Missaukee Suicide Prevention Coalition was formed at the end of 2005. A large group representing many sectors of our community came together to start planning what we could do to prevent suicides, and how we could support family and friends of persons who completed suicide.

Our small community had recently experienced two unnecessary deaths amongst our youth, and left us with a deep wound.

Concurrently, the State of Michigan was asking each Community Collaborative to facilitate suicide prevention planning at the local level, following the recent release of the Michigan Suicide Prevention Plan.

The community came together - mental health workers, ministers, school personnel, counselors, therapists, parents, health care workers, court workers, survivors, the media, community leaders, service clubs, and human service workers – and started the conversation.

We talked about issues that were prevalent in the community – stigma, economic depression, rural isolation, family stress, depression, and kids making bad choices.

We also talked about how unprepared we felt towards addressing the needs of those that may be suicidal.

> ***"Collaboration across a broad spectrum of agencies, institutions, and groups – from schools to faith-based organizations to health care associations – is a way to ensure that prevention efforts are comprehensive."***
>
> ***National Strategy for Suicide Prevention***

Together we formed the Suicide Prevention Coalition of Wexford and Missaukee Counties.

The Coalition agreed upon the following three purposes for its existence:

1. Develop and implement a suicide prevention plan for Wexford and Missaukee counties
2. Share information and resources
3. Foster the development of relationships, awareness, and suicide prevention and treatment initiatives.

Suicide Information and Facts

Definition of Suicide: the act of voluntarily and intentionally taking one's life

More than 90% of people who die by suicide have a diagnosable mental disorder present (including depression).

- Other risk factors include: substance abuse; incarceration; recent severe stressors, social isolation, gender confusion, bullying, minority status.
- Males complete suicide at a rate four times that of females. However, females attempt suicide three times more often than males.
- For youth, suicide is the 3rd leading cause of death (15-19 y.o.)
- It is the second leading cause of death for college age young people.
- The largest number of suicide deaths occurs among our workforce, primarily men ages 25-64.
- Elderly are the highest risk group per capita.
- Gay, lesbian, bi-sexual youth are another very high risk group.
- Most suicides are preventable with appropriate education, awareness and intervention methods.
- For every suicide death, there are an estimated 25 attempts.
- Firearms are the most frequent method used.

Did you Know?

Michigan Deaths in 2007

Suicide	1,123
Homicide	702
HIV/AIDS	186

Michigan Department of Community Health, Vital Statistics, Michigan Mortality

Today:

- An American dies by suicide every 16 minutes
- 1.8 million Americans attempt suicide each year
- 80% of suicide deaths are among men

American Association of Suicidology. *Suicide in the USA* (fact sheet).

Terms and Usage

Deliberate Self-Harm: Deliberate self harm refers to intentional self-injurious behavior where there is no evidence of intent to die. DSH includes various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness.

Gatekeeper: As defined by the National Strategy for Suicide Prevention, key gatekeepers are those people who regularly come into contact with individuals or families in distress.

Intervention: The care of suicidal people by licensed mental health caregivers, health-care providers, and other caregivers with individually-tailored strategies designed to change behavior, mood, environment or biology of individuals and help them identify and satisfy their needs without engaging in self-destructive behavior.

Postvention: Is a term used to describe actions taken after a suicide has occurred largely to help survivors such as family, friends, and coworkers with the loss of a loved one.

Prevention: Strategies or plans designed to stop suicide attempts or completions from occurring by focusing efforts on at-risk individuals, environmental safeguards, and/or the availability of lethal means.

Protective Factor: A protective factor is a characteristic or attribute that has been shown to be associated with an increased probability of not attempting or completing suicide. Protective factors are those skills, strengths, or resources that help an individual deal more effectively with stressful life events. They moderate exposure to risk; they enhance resiliency, and are important to healthy development.

Risk Factor: A risk factor is an aspect of personal behavior or lifestyle, an environmental exposure, or an inborn or inherited characteristic that has been shown to be associated with an increased occurrence of death by suicide. Risk Factors are <u>associated</u> with suicidal behavior and ideation – not predictors or causes of suicide. Simply put, they are correlated with an increased risk that one day an individual will die by suicide. They may be either fixed or variable.

Usage:

- People do not "commit" suicide." People die by suicide. People may commit crimes or commit sins.
- There is no such thing as a "successful" suicide. There are only completed suicides. Suicide is never a success.

Suicidality: Completed suicide or death by suicide:

- Death from self-inflicted injury, poisoning, or suffocation where there is evidence that the act was intentional and led to the person's death.

- The concept of suicide requires that the action was self-inflicted and the person had the intent (purpose, aim, or goal) of death.

Suicide Attempt: A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill himself or herself, but failed, was rescued or thwarted, or changed one's mind. A suicide attempt may or may not result in injuries.

Suicide Attempt Survivor: Individuals who have survived a prior suicide attempt.

Suicide Ideation: Self-reported thoughts of engaging in suicide-related behavior. Suicide ideators are individuals who think about suicide, but do not make an explicit attempt.

- They may or may not form intent; they may or may not have a plan.
- Ideation may be transient or ruminative, active or passive, acute or ongoing.

Suicide Survivor: Family member, or significant other, or acquaintance that has lost a loved one or someone close to suicide.

Suicidology: The scientific study of suicide and suicidal behavior.

Treatment: see *"Intervention."*

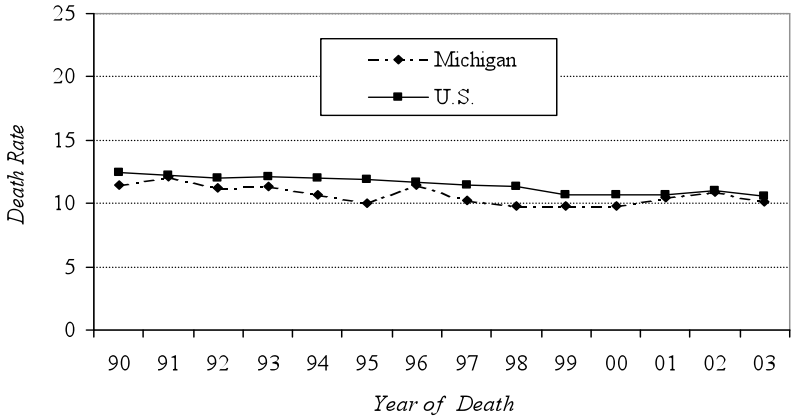
Usage:

- The term "Suicide Survivor" is sometimes used incorrectly to mean a suicide attempt survivor.
- Estimates are that for every suicide there are at least six survivors. Based on this estimate, it has been suggested that there are now at least 4.5 million American survivors of suicide.

Unintentional Injury: Self-inflicted behavior or behavior inflicted by another person with fatal or non-fatal outcome. There is no intent to kill or die.

Definitions are from the Institute of Medicine, 2002, "Reducing Suicide: A National Imperative."

Suicide Rates.
In recent years, the death rate for suicides has declined in the United States. With the implementation of the Michigan Suicide Prevention Plan, it is the hope of the Michigan Suicide Prevention Coalition to see a steady decline in the suicide rate in Michigan.



Death rates are based on 100,000 population.

Suicide Numbers and Rates –
2006 Wexford & Missaukee Counties and Michigan, 2004 US[1]

	Wexford		Missaukee		Michigan		US	
Suicide	Number	Rate	Number	Rate	Number	Rate	Number	Rate
	7	21.9	2	*	1,132	11.2	32,439	11.0

* A rate is not calculated when there are too few events because the width of the confidence interval would negate any usefulness for comparative purposes.

Wexford and Missaukee Counties – suicide numbers.
Missaukee County experienced between 1-3 suicides a year from 1989-2003. Averages:

- 0-1 per youth (age under 25)
- 2 per adult age 25-74
- 0-1 per older adult (age 75 and older)

Wexford County experienced 3-5 suicides a year from 1989-2003. Averages:

- 1 per youth (age under 25)
- 3 per adult age 25-74
- 0-1 per older adult (age 75 and older)

[1] 2006 Michigan Resident Death File, Vital Records & Health Data Development Section, Michigan Department of Community Health;
Population Estimate (latest update 9/2007), National Center for Health Statistics, U.S. Census Populations With Bridged Race Categories;
National Center For Health Statistics, Deaths: Final Data for 2004. National vital statistics reports; vol 55 no 19

Wexford and Missaukee Suicides 2004 – 2010.

	2004	2005	2006	2007	2008	2009	2010
Missaukee	0	2[2]	2[3]	3			
Wexford	9[4]	5[5]	10[6]	2[7]	3	9	4

Source: Review of death certificates Missaukee County and Wexford County.

Wexford and Missaukee Youth Suicides.

Ten Years (1994-2003) Suicides, ages 10-24				
	Total Number	Average annual number	1994-2003 population	Rate
Missaukee	1	.1	29,594	3.4
Wexford	7	0.7	62,580	11.2

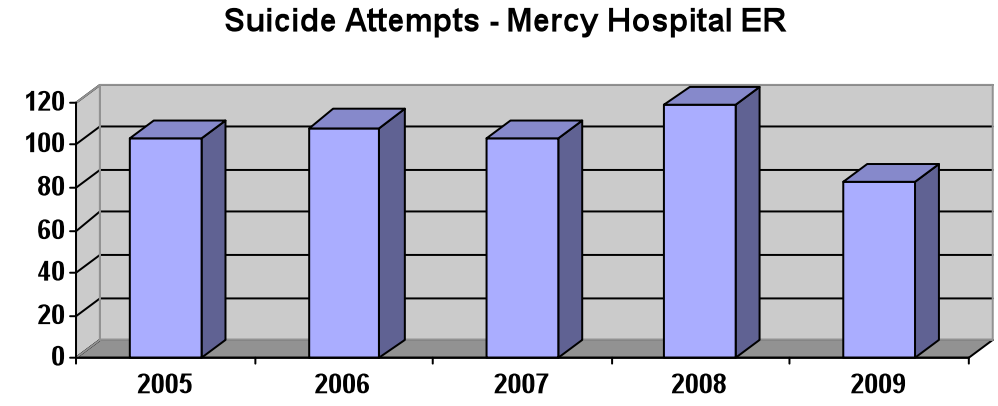
Means of Death.

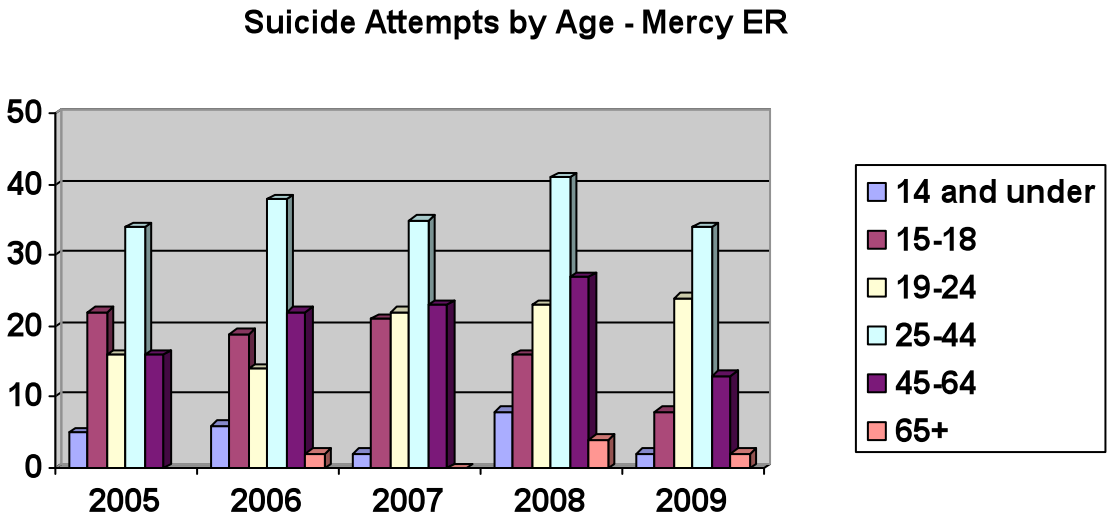
In the US, the method used in more than 50% of suicide deaths is firearms. In Michigan, 52% of suicide deaths are from firearms. Some studies have demonstrated that voluntary removal of firearms from homes of persons at risk of suicide has a positive impact on suicide rates.

- Of the 10 suicides in Missaukee County between 2000 and 2005, 80% were from firearms.
- Of the 27 suicides in Wexford County between 2000 and 2005, 67% were from firearms.

[2] Adult males
[3] 1 youth, 1 senior
[4] 6 adults, 3 seniors (age 65+)
[5] 3 youths, 2 adults
[6] All males; 3 youths, 6 adults, 1 senior
[7] Both Males, 1 adult, 1 senior

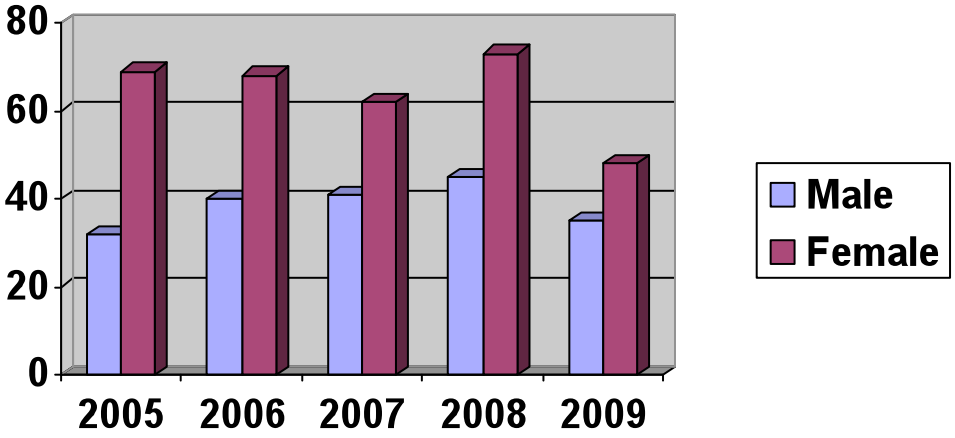
Suicide Attempts.
It has been estimated that for every one suicide completion, there are 25 attempts.[8] This number is much higher amongst youth. To better understand the breadth of the suicide issue in our community, the Suicide Prevention Coalition of Wexford and Missaukee Counties has started to track suicide attempt data available through the local hospital ER.



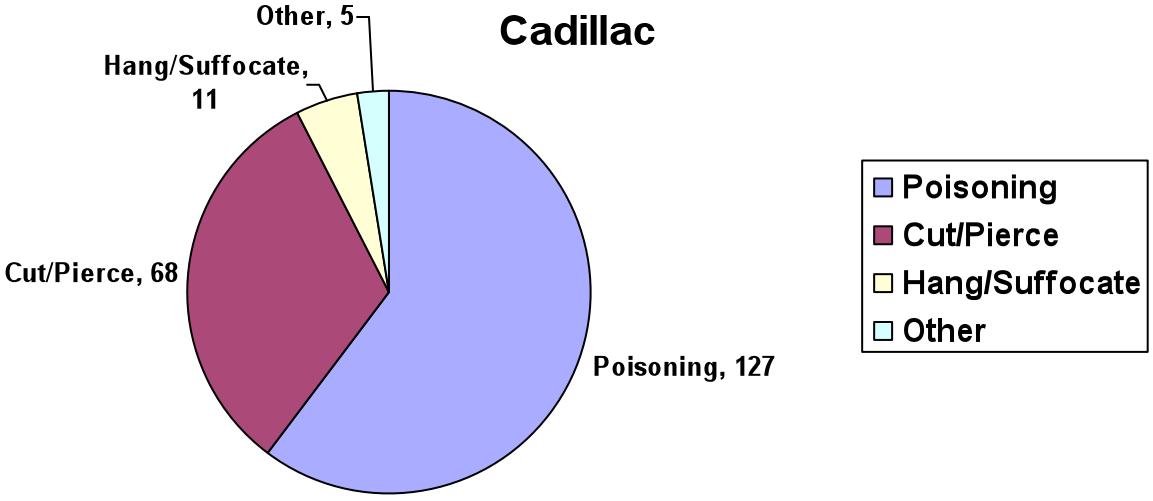


[8] American Association of Suicidology. *Suicide in the USA* (fact sheet)

Suicide Attempts by Gender - Mercy Hospital, Cadillac



Suicide Attempts by Method - Mercy Hospital, Cadillac



2005 and 2006

Risk Factors and Warning Signs

Risk Factors.
Things that increase the likelihood that someone will harm themselves.

- Previous suicide attempts
- Mental illness, particularly depression
- Alcohol / substance abuse
- Family history of suicide
- Family history of abuse or neglect
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Loss (relational, employment, financial)
- Physical illness
- Easy access to lethal means
- Unwillingness to seek help
- Isolation
- Cultural belief that suicide is a noble act
- Local or noteworthy and publicized suicides

Warning Signs.
Things that indicate a person is in crisis and that suicide is a likely outcome without intervention.

- Threatening self-harm
- Expressions of hopelessness
- Talking or writing about death
- Expressing rage; seeking revenge
- Increased alcohol / substance use
- Withdrawing from family or friends
- Giving away prized possessions
- Making “final” arrangements or tying up “loose ends”
- Sleeping disorders (too much, too little)
- Lack of interest in the future
- Sudden mood improvement without any changes in situation/health

Framework for Prevention[9]

The prevailing prevention model in the interdisciplinary field of prevention science is the *Universal, Selective, and Indicated* (USI) prevention model. This USI model focuses attention on defined populations—from everyone in the population, to specific at-risk groups, to specific high-risk individuals—i.e., three population groups for whom the designed interventions are deemed optimal for achieving the unique goals of each prevention type.

Universal strategies or initiatives address an entire population (the nation, state, local, county or community, school or neighborhood). These prevention programs are designed to influence everyone, reducing suicide risk though removing barriers to care, enhancing knowledge of what to do and say to help suicidal individuals, increasing access to help, and strengthening protective processes like social support and coping skills. Universal interventions include programs such as public education campaigns, school-based "suicide awareness" programs, means restriction, education programs for the media on reporting practices related to suicide, and school-based crisis response plans and teams.

Selective strategies address subsets of the total population, focusing on at-risk groups that have a greater probability of becoming suicidal. Selective prevention strategies aim to prevent the onset of suicidal behaviors among specific subpopulations. This level of prevention includes screening programs, gatekeeper training for "frontline" adult caregivers and peer "natural helpers," support and skill building groups for at-risk groups in the population, and enhanced accessible crisis services and referral sources.

Indicated strategies address specific high-risk individuals within the population—those evidencing early signs of suicide potential. Programs are designed and delivered in groups or individually to reduce risk factors and increase protective factors. At this level, programs include skill-building support groups in high schools and colleges, parent support training programs, case management for individual high-risk youth at school, and referral sources for crisis intervention and treatment.

[9] Reducing Suicide: A National Imperative (2002), Institute of Health, SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney, *Editors*, Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health

Suicide Prevention Plan
Wexford & Missaukee Counties, Michigan

The overarching goal of the Suicide Prevention Coalition is to reduce the number of suicides in Wexford and Missaukee counties. It is the coalition's belief that most suicides are preventable with appropriate education, awareness and intervention methods.

"Suicide is preventable."

The plan addresses prevention, intervention and treatment endeavors and supports and recommends the use of evidence-based best practices focusing on the unique needs of our community.

What we hope to achieve (expected outcomes):

1. Our community will own the belief that suicide prevention is everyone's business and we all play an important role in the process.

2. Our community gatekeepers will know how to identify individuals at risk and take appropriate next steps for intervention.

3. Our community will be aware of the prevalence and seriousness of depression and suicidal ideation. People know where and how to seek help.

4. We lessen the stigma related to depression and other mental illnesses and increase the ability for people to seek help.

5. Our community is aware of (and takes appropriate action to lessen) the contributing factors of suicide including but not limited to:
    1. Access to lethal means
    2. Drugs and alcohol
    3. Bullying and abuse

6. Our community recognizes the importance of instilling hope and maximizing personal assets in persons that may be suicidal.

Goals and Objectives

The Suicide Prevention Plan for Wexford & Missaukee Counties is based on the National Strategy for Suicide Prevention and covers the lifespan of the individual.

To accomplish our goal of reducing the number of preventable suicides, the Wexford Missaukee Suicide Prevention Coalition has established or adopted the following goals and objectives.

1. Promote awareness that suicide is a public health problem that is preventable.

2. Develop broad based support for suicide prevention.

3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, suicide prevention, and associated services.

4. Develop and implement community based suicide prevention programs.

5. Promote efforts to reduce access to lethal means and methods of self harm.

6. Improve the recognition of and response to high risk individuals within the community.

7. Expand and encourage utilization of evidence based approaches to prevention and treatment.

8. Improve access to and community linkages with mental health and substance abuse services

9. Improve and expand surveillance and reporting systems

Goal #1

Promote awareness that suicide is a public health problem that is preventable.

"The work of suicide prevention must occur at the community level, where human relationships breathe life into public policy."
- David Satcher, MD, PhD, Sixteenth Surgeon General United States

The stronger and broader support for a public health initiative, the greater its chance for success. If the general public understands that suicide and suicidal behaviors can be prevented, the suicide rate can be lowered.

Objective 1.1

Promote awareness of issues that, without proper intervention, may lead to suicide, like depression and other mood disorders, recent trauma or loss, relationship problems, financial problems, job loss, etc.

Objective 1.2

Address the topic in the community – schools, churches, media, civic, medical organizations, law enforcement, businesses, etc

- Develop presentation materials for speaking engagements
- Promote awareness of local resources
- Provide resources for suicide prevention: brochures, wallet cards, crisis numbers, magnets
- Implement a community awareness campaign like “Yellow Ribbon” and / or host an annual community awareness event like “National Survivors of Suicide Day,” Depression Screening, Suicide Awareness Week, workshops, media campaign, etc.

Goal #2

Develop broad based support for suicide prevention.

Because there are many paths to suicide, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups–from schools to faith-based organizations to health care associations–is a way to ensure that prevention efforts are comprehensive. Such collaboration can also generate greater and more effective attention to suicide prevention than can these groups working alone.

Objective 2.1

The Human Services Leadership Council will endorse and support community wide prevention planning for Suicide. The Suicide Prevention Coalition will become a workgroup and priority goal of the HSLC.

Objective 2.2

Northern Lakes Community Mental Health will assume a leadership role in the development and maintenance of the Coalition to ensure its viability. This includes providing staff support and other resources for the Coalition as needed and available.

Objective 2.3

The Suicide Prevention Coalition will strive to include broad based public and private membership to blend resources of stakeholders in support of suicide prevention.

Objective 2.4

Provide direction for schools, medical personnel, social service agencies, faith-based community, funders, law enforcement, information and referral help lines and others in implementation of the Suicide Prevention Plan.

Goal #3

Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, suicide prevention, and associated services.

Suicide is closely linked to mental illness and to substance abuse, and effective treatments exist for both. However, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination. The stigma of suicide itself–the view that suicide is shameful and/or sinful--is also a barrier to treatment for persons who have suicidal thoughts or who have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, and those who have survived the suicide of a loved one suffer not only the grief of loss but often the added pain stemming from stigma.

Objective 3.1

Educate community groups about the risk factors of suicide, including depression and other mood disorders and increased use of drugs and alcohol.

Objective 3.2

Support the efforts of NLCMH and other mental health and substance abuse organizations to promote antistigma activities and messages.

Objective 3.3

Promote help seeking behaviors by educating community groups and providing examples.

Objective 3.4

Provide opportunities for the media to assist with portraying the importance of seeking help for mental illness by feeding story ideas.

- Ensure responsible media practices in the coverage of these topics by providing:
  - *Reporting on Suicide: Recommendations for the Media* (US Centers for Disease Control and Prevention) or
  - *At-a-Glance: Safe Reporting on Suicide* (Suicide Prevention Resource Center) http://www.sprc.org/library/at_a_glance.pdf

Goal #4

Develop and implement community based suicide prevention programs.

Research has shown that many suicides are preventable; however, effective suicide prevention programs require commitment and resources.

Planning and program development should be fostered to ensure the integration of suicide prevention into organizations and agencies that have access to groups of individuals for other purposes.

Objective 4.1

Use the Suicide Prevention Coalition and other community stakeholders to prioritize (by identifying high risk populations) and develop plans to reach target audiences such as:

- Youth
- Elderly
- Men in the work place, the unemployed
- College age, Veterans, Gay people

Objective 4.2

Seek out and access private and public funding sources to assist with the implementation of prevention plans for target populations and community at large.

Goal #5

Promote efforts to reduce access to lethal means and methods of self harm.

Evidence from many countries and cultures shows that limiting access to lethal means of self-harm may be an effective strategy to prevent self-destructive behaviors. Often referred to as "means restriction," this approach is based on the belief that a small but significant minority of suicidal acts are, in fact, impulsive and of the moment; they result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Thus, a self-destructive act may be prevented by limiting the individual's access to the means of self-harm.

Objective 5.1

Educate community groups about actions to reduce access and associated risks of firearms, medications, poisons, etc.

Objective 5.2

During times of individual crises, promote efforts to reduce access to lethal means of self harm.

Objective 5.3

Investigate the possibility of implementing better gun safety.

Goal #6

Improve the recognition of and response to high risk individuals within the community.

Studies indicate that many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite the increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with persons in need of these specialized assessment techniques and treatment approaches. In addition, many health professionals lack training in the recognition of risk factors.

Key gatekeepers–people who regularly come into contact with individuals or families in distress– need training to recognize factors that place individuals at risk for suicide, and to learn appropriate interventions. Key gatekeepers include teachers and school personnel, clergy, police officers, primary health care providers, mental health care providers, law enforcement, correctional personnel, and emergency health care personnel, hairdressers and bartenders.

Objective 6.1

Identify and train "gatekeepers" in the community. Key gatekeepers (those that are most likely to come into contact with someone who is suicidal) will be identified and provided with gatekeeper training.

- Improve recognition of and response to high risk individuals within the community
- Develop skills in brief risk assessment
- Understand local resources and how to access them

Objective 6.2

Develop an education and training committee consisting of trained gatekeepers and members of the Suicide Prevention Coalition to develop abbreviated community gatekeeper training in order to develop additional layers of trained community gatekeepers amongst parents, family members, clergy, school staff, community members, etc.

- Include role playing / practice of skills in training.

Goal #7

Expand and encourage utilization of evidence based approaches to prevention and treatment.

One way to prevent suicide is to identify individuals at risk and to engage them in treatments that are effective in reducing the personal and situational factors associated with suicidal behaviors. Another way to prevent suicide is to promote and support the presence of protective factors, such as problem solving skills, conflict resolution, positive support systems, and access to care. Promoting the presence of protective factors can contribute significantly to reducing risk.

Objective 7.1

Members of the Suicide Prevention Coalition will strive to use evidence based or promising practices in any coalition planned prevention or treatment program.

Objective 7.2

The Suicide Prevention Coalition will share researched based fact sheets, policies, and guidelines to assist community providers in the development of effective practices. Some examples:

- Suicide-risk screening in primary care and other settings
- Fostering the education of family and other supports for persons receiving treatment of mental health and substance abuse disorders with risk of suicide
- Ensuring that persons treated for trauma, sexual assault or physical abuse in emergency departments receive information on mental health services for follow up

Objective 7.3

Provide appropriate treatment and follow up care for persons who have attempted suicide

- Work with the Emergency Services departments of Mercy Hospital and Northern Lakes Community Mental Health, and other first responders to develop community appropriate protocol

Objective 7.4

Provide appropriate follow up care/supports to survivors of suicide

- by developing a Survivors of Suicide support group or a list of trained survivors who are willing to come alongside an new survivor for support
- by promoting interactive, web based support

Goal #8

Improve access to and community linkages with mental health and substance abuse services

Barriers to access and affordability of health care may be influenced by financial, structural and personal factors. Financial barriers include not having enough health insurance or not having the financial capacity to pay for services outside a health plan. Structural barriers include the lack of primary care providers or the lack of availability based on ability to pay. Structural barriers also include the lack of some services and facilities, especially in areas where resources are limited and capacity is diminished. Personal barriers include cultural or spiritual differences, language barriers, not knowing when or how to seek care, or concerns about confidentiality or discrimination.

Reducing barriers is an important step in preventing suicide.

Objective 8.1

Identify ways to increase access to mental health and substance abuse services in the community

- Meet with community service providers to discuss access issues
- Identify key contacts for school personnel (and other organizations) at each agency to help ensure access for high risk individuals
- Increase screening opportunities

Objective 8.2

Identify existing community resources for assessment, treatment, and follow up care

- Make this list available to schools, providers, physicians, etc., and update routinely

Objective 8.3

The local CMH, in collaboration with the Michigan Association of Community Mental Health Boards, will support policies and / or legislation that provide coverage for evaluation and treatment of mental illnesses and substance abuse that is equal to coverage associated with other physical health care conditions.

Goal #9

Improve and expand surveillance and reporting systems

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are used to track trends, identify new problems, to provide evidence to support new activities, target high risk populations for interventions, and to assess the impact of prevention efforts.

Objective 9.1

Implement a system to track suicides in Wexford and Missaukee counties by reviewing death certificates.

Objective 9.2

Work with the local hospital emergency room to track suicide attempts (method, age, gender).

Objective 9.3

Analyze and share local data, as appropriate, to various stakeholder groups.

Objective 9.4

Develop and disseminate among community stakeholders fact sheets related to the annual or semi-annual results of the Michigan Youth Risk Behavior Survey (Michigan YRBS) and / or the Michigan Profile for Healthy Youth (MiPHY) most pertinent to depression and suicide.

Youth Suicide Reduction Plan

The Suicide Prevention Coalition has a focused prevention plan for youth that has resulted in funding by the now completed Garret Lee Smith Memorial prevention grant. It was based on an integrated and blended approach of 3 key components:

1. Education and Awareness
2. Resiliency and Assets
3. Treatment Access

> ***"At risk youth do not seek help, and usually do not follow through with referrals to community services."***
>
> Guidelines for school based prevention programs

Goals:

1. Increase basic suicide prevention education to youth, families, school personnel, and others that work with youth
    a. Implement the Signs of Suicide program within each public (and possibly private) school system
2. Build resiliency in youth
    a. Increase protective factors through Sources of Strength training
3. Build peer led prevention efforts
    a. Implement the Sources of Strength program in clubs, youth groups, classrooms, after-school programs, etc.
    b. Identify potential youth leaders and provide training
4. Develop ways to receive input from youth regarding suicide and other risky behavior prevention efforts
    a. Round table discussions, groups
    b. Surveys (Rock at the Dock, Natural Helpers trainings, etc)
5. Develop and disseminate youth-centered messages such as:
    a. Not keeping secrets
    b. Peer responsibility to, above all, protect the life of their friends and acquaintances
    c. Identifying appropriate adults to turn to for support
    d. Be nice
6. Develop a strategy to reach the high risk population of young people who are not in traditional educational system
    a. Juvenile justice
    b. Alternative schools
    c. Clubs/businesses where drop outs may be found
    d. Foster care
7. Identify ways to connect youth to resources when needed
    a. Develop and disseminate Teen Help cards
    b. Examine the feasibility of youth drop in centers
    c. Strengthen relationships with existing youth programs and provide them with resource information for youth

Expected Outcomes:

- Youth will have a better understanding of the signs and symptoms of depression and understand it is a treatable illness

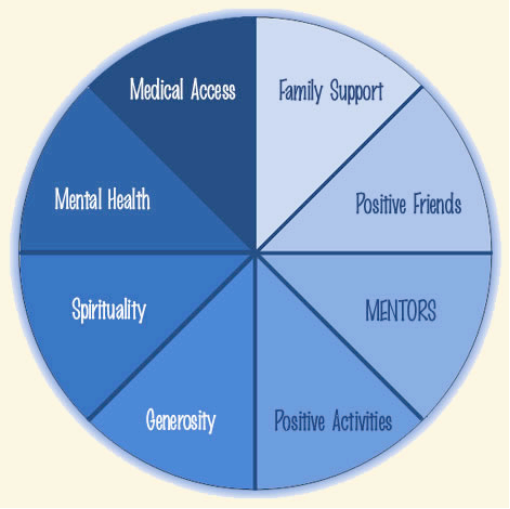
- Youth will recognize the risk factors and warning signs of suicide
- Youth will be able to identify at least one caring and trusted adult they can turn to
- Youth will know when to break the code of silence

Recommendations for Schools:[10]

- In-service all staff every two years (including cooks, bus drivers, janitors)
- Provide peer gatekeeper training and involve teen leaders
- Conduct quick screening for suicide / depression for all students
- Provide some sort of small group / talking circle group within school setting
- Encourage and participate in mentoring involving staff, community, faith-based
- Have intervention and referral protocol
- Plan for a crisis response team for traumatic incidents

Lessons Learned

- Teens are already intervening with their peers about suicide, usually without adult knowledge
- Kids learn best with activity. The curriculum has very little lecture in it.
- Spend more time on sources of strength and protective factors than warning signs.
  - Let kids share stories about where their strength comes from



The eight sources of strength that increase a teen's resiliency to suicide are:

- Medical Access
- Mental Health Access
- Family Support
- Positive Friends
- Caring Adults
- Positive Activities
- Generosity
- Spirituality

North Dakota Adolescent Suicide Prevention Task Force

[10] Mark LoMurray, North Dakota Adolescent Suicide Prevention Project

APPENDIX

Local Resources for Depression and Suicide

Web Resources

Acknowledgements

Community Resources for Depression & Suicide
Wexford & Missaukee Counties, Michigan

Counseling & Crisis Intervention: Organizations			
Northern Lakes Community Mental *Health* 527 Cobbs St, Cadillac	Individual & family counseling, crisis intervention, psychiatric services, evaluation	775-3463 1-800-492-5742 1-800-442-7315 (after hours) www.northernlakescmh.org	Medicaid Some insurances Sliding scale No one is denied crisis service
Catholic Human Services 421 S Mitchell St, Suite 2 Cadillac	Family & individual counseling, alcohol & drug services	775-6581 www.catholichumanservices.com	Fee for service based on ability to pay (sliding scale)
Staircase Youth Services	Crisis intervention & counseling for youth	1-888-267-6086 1-800-292-4517 http://staircaseyouth.com	No charge
Third Level Crisis Center	24 hour phone line for crisis and service referral	1-800-442-7315 www.thirdlevel.org	No charge
Mercy Hospital 400 Hobart St, Cadillac	If you are in crisis (and / or suicidal), go to the emergency room!	1-800-33-MERCY (231) 876-7200 http://mercycadillac.munsonhealthcare.org	No one is denied crisis service
Emanuel Lutheran Counseling Center	Will take referrals from other agencies for mild to mod – low income	1-231-775-7281	No one denied service, $20.00 per session

Licensed Counselors & Therapists			
Life Skills Psychological Services, PC 805 Carmel St, Cadillac	-Individual, marital, family, and group psychotherapy -Seven different therapists	(231) 775-6517	Most insurances No Medicaid, HMO Some payment plans
Sheri Sheese, ACSW,CSW 108 Beech St. Cadillac	Adolescents and adults, including depressive and anxiety disorders, life transitions, substance abuse recovery	(231) 884-0473	Preferred Choices Other payments
Deanna Rosser, LMSW ACSW LMFT 124 S Mitchell St Cadillac	Individual and family psychotherapy, adolescent issues, depression, anxiety	(231) 775-2744	Most insurances Please call to check
Jim Skiera LMSW LMFT 302 Cass St. Cadillac MI	Individual (adult and teen) and family psychotherapy.	(231) 775-3255	Most insurances Please call to check

Grief Support - Please call to verify schedules			
Mercy Hospice Brad Center	Individual support for bereavement / suicide	(231) 779-5990	No Charge
Grief Share/Divorce Care Emmanuel Lutheran Church Contact: Chad Koehn	Divorce Care – Starts Sept 13 (13 weeks) Grief Share – Starts Sept 14 (13 weeks)	(231) 775-3261	Donation
Grief & Loss Support Group Hospice of Michigan	Individual & community support for grief & loss 3rd Wednesday of every month from 6-7:30 @ Baked Beans Coffee in Lake City 2nd Wednesday of every month from 1-2:30 @ Hospice of Michigan office in Cadillac	(231) 779-9570	No Charge
Wexford Bereaved Parents Support Group Jean Schnitker Mercy Hospital	Offers support and guidance in working through the grief of losing a child. Last Monday of every month at 7:00 in Mortimer Room	(231) 876-3844	No Charge
Michael's Place Traverse City	Healing for Grieving Children and Families Call for more information	(231) 947- MIKE (6453)	No Charge
Suicide Survivors Support NLCMH – Ken Nydam	Information/Resources for support for survivors of suicide (individual and family)	(231) 876-3280	No Charge

Web Resources

www.save.org	Suicide Awareness Voices of Education ➢ Suicide and depression basics ➢ Suicide prevention ➢ Coping with loss
www.incrisis.org	On line screening tool for youth 11 to 17 years old based on what you see and know.* **This report is not a psychological evaluation and should not replace a visit to a qualified health or mental health professional.*
www.sprc.org	Suicide Prevention Resource Center ➢ Suicide prevention basics
www.suicidology.org	The American Association of Suicidology is an education and resource organization. ➢ Research ➢ Prevention ➢ Students ➢ Survivors
www.spanusa.org	Suicide Prevention Action Network ➢ Suicide Prevention ➢ Community Organization ➢ Resources
www.yellowribbon.org	Yellow Ribbon is a community-based prevention program using a universal public health approach to empower and educate professionals, adults and youth.
www.metanoia.org	The mission of Metanoia is to break down barriers that keep people from getting the help they need ➢ On line therapists ➢ How to choose a therapist
www.afsp.org	American Foundation of Suicide Prevention- The AFSP is the only national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research and education, and to reaching out to people with mood disorders and those affected by suicide.
www.nami.org	National Alliance on Mental Illness- The nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illnesses and their families.
www.samhsa.gov	Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services SAMHSA's mission is on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders.
www.suicidepreventionlifeline.org	Suicide Prevention Lifeline ➢ Help Line: 1-800-273-TALK
http://psychcentral.com/resources/Suicide_and_Crisis/Support_Groups/	Psych Central provides links for Support Groups for suicide and crisis, including survivors of suicide

Acknowledgements:

This Suicide Prevention Plan was written by Shari Spoelman, community coordinator, with assistance from Mary Hubbard, Coalition chairperson, and Rachelle Rife, youth suicide prevention coordinator, and the other members of the Suicide Prevention Coalition of Wexford and Missaukee Counties. It has been updated periodically by subsequent staff who have carried on the work of its founders.

This plan is intended to be a guide for suicide prevention planning in our community. It is our hope and intention that it will be updated as needed to reflect the work of the Suicide Prevention Coalition and other community initiatives.