Kalamazoo County Suicide Prevention Plan

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Suicide Prevention Workgroup
Kalamazoo County Multi-Purpose Collaborative Body

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A Call To Action – The Kalamazoo County Suicide Prevention Plan

Executive Summary

As a nation, a community, and as individuals we value life. As parents, siblings, friends, neighbors, classmates, co-workers, and professionals, we all feel a responsibility to protect our most vulnerable community members. The purpose of this document is to describe a community-wide risk focused approach to reduce the horrifying burden of suicide in Kalamazoo County. It should be noted at the outset that there are many excellent programs and activities within the County that address this issue and that all elements of a healthy community have a contributing impact upon the reduction of suicide.

The underpinning moral imperative driving this important community plan is that all life is important and valued and that every individual is considered part of the fabric of our community in Kalamazoo County. The tragic loss of life represented by suicide devastates families and sends shock waves through the entire community. The cost of suicide to our nation, state and community is enormous and the cost in pain and suffering cannot be measured. Suicide is preventable and these rates, costs, and impacts can be lowered if we have the will to do so.

This purpose of this plan is to

- improve information and knowledge;
- improve coordination of current and future efforts;
- focus efforts on best practices;
- identify additional needed activities and programs; and
- place suicide prevention as a quality of life priority in our community.

In full recognition of limited resources, this plan is intended to chart a course for the future through a coherent strategy to maximize current resources and to increase resources in the future.

Reducing suicide, suicide attempts and the impact of suicide behaviors in Kalamazoo County is the realistic goal of this effort. Although much is yet to be learned, there is sufficient knowledge in this field to establish effective practices. As in any other prevention arena, sustained effort over time is essential. Some of the elements of this plan require changes in our culture and in our attitudes. Its elegance, however, is that, in working toward the aims defined, we will make our community safer for all and will

accomplish multiple other positive outcomes as well. Indeed, a caring, knowledgeable, actively engaged, and inclusive community is, in itself, a sound cornerstone for suicide prevention.

The prevention of suicide is a difficult and complex undertaking. How does a community go about the task of preventing a most private act from occurring? In order to make a positive impact on the problem, this plan focuses on a common-sense approach. Goals and objectives address those factors in a community or among defined groups that put them at increased risk for suicide while also increasing the factors that serve to strengthen and protect individuals.
To facilitate the community support required to change the climate and reduce the incidence of suicide in Kalamazoo County, a number of important systemic changes must occur:

- Engagement of community leaders to help change community norms and provide funding
- Identification and reduction of risk and identification and enhancement of protective factors associated with suicide
- Collaboration among community organizations to establish and train a network of "community gatekeepers"
- Coordination of and enhanced access to a broad array of human services to assist individuals in need
- Reduction of the negative attitudes and values associated with mental illness and requesting help
- Continuous community awareness and education.

Developing a network of individuals trained to intervene with people who may be depressed or suicidal can have a positive impact in helping them feel less isolated and out of options. Since 1999, a school-based gatekeeper program in Kalamazoo County has successfully trained thousands of students to act as positive peer supports. In order to address the issue of prevention across the generations a community-wide gatekeeper program must be established that trains people in all walks of life to serve as positive peer supports for those in need

Services and options must be available and their availability widely disseminated in the community to support individuals who are in crisis. It is important to strengthen and enhance the availability of a broad array of community supports for those individuals most in need of positive intervention. It is also important to expand the support network of specialty services and programming that an individual could turn to or be referred to for help.

De-stigmatizing the use of mental health and substance abuse services is important in helping people in crisis reach out for the help they need. Community norms about issues of mental illness and substance abuse must stress that there is no shame in asking for help or in receiving support for personal problems that become unmanageable.

Continuous community education and awareness is vital to the long-term success of this prevention plan. A knowledgeable public is a key factor in building the advocacy necessary to sustain this risk-focused approach and in creating a climate in Kalamazoo County where our most vulnerable populations are accepted, supported, and encouraged to get the help they need.

Values And Guidelines

- As a community and as individuals we value life and feel a responsibility to protect our most vulnerable community members.
- Reducing risk and increasing community supports are the underpinnings for good suicide prevention practice.
- Our purpose is to implement a community-wide risk focused approach to reduce suicide in Kalamazoo County.
- A coordinated and simultaneous effort to increase and/or strengthen protective factors while reducing the risk factors within the community is an attainable objective.
- The entire community is responsible for reducing risk and increasing assets.
- Our community values the process of reaching out and touching one another.

Many individuals contributed to the development of this plan and are listed in appendix. It is our belief and our hope that this plan will improve our community by focusing on solutions for a very vulnerable population, a population that is not limited by age, race, socio-economic status or local address. Suicide is a very democratic phenomenon requiring a community wide effort.

Knowing is not enough; we must apply.
Willing is not enough; we must do

– Goethe

Suicide as a Public Health Problem in the United States

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

Prevention

Few research-based suicide prevention programs are proven to reduce suicidal behaviors. Approaches that utilize integrated suicide prevention efforts include education, provide increased identification and referral, increase access to care, reduce stigma, or apply effective clinical interventions have been shown to reduce deaths and attempts, and are promising for the future. Evaluations of many school-based programs and of the U.S. Air Force program *[British Medical Journal, Dec. 13, 2003]* have shown positive results at the community level. One-time and isolated prevention efforts may have some value, but have not demonstrated sustainable positive impact on suicide behaviors. Studies are currently underway to evaluate and replicate programs that are promising.

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

Recent evidence suggests that effective suicide prevention programs also reduce other violent behaviors. Some interventions have shown promise for the treatment of depressed, despondent or suicidal individuals; however, major efforts are necessary to implement quality care throughout the healthcare delivery system from general medical practice to professional mental health practices. Standards of care for the treatment of disorders with high suicide risk are not clearly defined, disseminated, or widely practiced across the nation.

Impact

Suicide's impact is devastating whether measured in numbers of deaths, attempts, economic and medical benefit costs, or the impact on survivors – those who have lost someone close to them to suicide. Edwin Schneidman, founder of the *American Association of Suicidology,* stated that the worst aspect of suicide is the impact on loved ones, as the "suicidal person puts their psychological skeleton into the closet of the minds of survivors forever."

- **Survivors**
- *It is estimated that each suicide death intimately affects at least six other people.*
- *Based on the more than 742,000 suicides from 1977 through 2001, there are at least 4.45 million survivors in the U.S. (1 of every 64 Americans in 2001).*
- *In 2001 alone, that number grew by nearly 184,000.*
- *There is a suicide—and six new survivors created—every 17 minutes*

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

Risk Factors

While studies indicate that in 90-94% of all suicide deaths, there is a diagnosable and treatable mental illness present, there are other risk factors that contribute to suicide deaths and attempts as well. Frequency of suicide tends to increase with age and the elderly are the highest-risk age group population for suicide (see figure 2). In general terms, the highest demographic risk group is elderly white males, living alone, with a diagnosable mental illness and a substance abuse problem.

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

Of diagnosable mental illnesses, untreated or under-treated depression is highly correlated with suicide. An estimated 60% of those who die by suicide have an identifiable diagnosis of clinical depression at the time of death. Other mental illnesses associated with increased risk are: Schizophrenia, Bi-Polar Disorder, some anxiety disorders, and Borderline Personality Disorder. Co-morbidity of psychiatric diagnoses is known to increase risk for suicide.

Those incarcerated in jails are the highest risk population in the United States with rates of 47 per 100,000 (the national average for the entire population is less than 12 per 100,000) with most occurring among violent offenders within 48 hours of incarceration. There are multiple other groups at elevated risk for suicide across the life span including Native Americans, the elderly, and white males.

Table I: US Suicide — 2003 Official Final Data

	Number	Per Day*	Rate	% of Deaths	Group (Number of Suicides)	Rate
Nation	31,484	86.3	10.8	1.3	White Male (22,830)	19.5
Males	25,203	69.0	17.6	2.1	White Female (5,655)	4.7
Females	6,281	17.2	4.3	0.5	Nonwhite Male (2,373)	9.1
Whites	28,485	78.0	12.1	1.4	Nonwhite Female (626)	2.2
Nonwhites	2,999	8.2	5.5	0.9	Black Male (1,597)	8.8
Blacks	1,955	5.4	5.1	0.7	Black Female (358)	1.8
Elderly (65+ yrs.)	5,248	14.4	14.6	0.3	Hispanic (2,007)	5.0
Young (15-24 yrs.)	3,988	10.9	9.7	11.9	Native American (322)	10.4
					Asian/Pacific Islander (722)	5.5

Table II: Suicide Rates by Year and Age

(Rates per 100,000 population														
Age/Group	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
5-14	0.8	0.7	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6	0.6
15-24	13.2	13.1	13.0	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9	9.7

25-34	15.2	15.2	14.5	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6	12.7
35-44	15.3	14.7	15.1	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3	14.9
45-54	14.8	15.5	14.7	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7	15.9
55-64	16.0	15.4	14.8	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6	13.8
65-74	17.9	16.9	16.5	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5	12.7
75-84	24.9	23.5	22.8	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7	16.4
85+	22.2	24.0	21.9	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0	16.9
65+	20.5	19.7	19.1	19.0	18.1	18.1	17.3	16.8	16.9	15.9	15.3	15.3	15.6	14.6
Total	**12.4**	**12.2**	**12.0**	**12.1**	**12.0**	**11.9**	**11.6**	**11.4**	**11.3**	**10.7**	**10.7**	**10.8**	**11.0**	**10.8**
Men	20.4	20.1	19.6	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9	17.6
Women	4.8	4.7	4.6	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3	4.3
White	13.5	13.3	13.0	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2	12.1
Nonwhite	7.0	6.8	6.8	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5	5.5
Black	6.9	6.7	6.8	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1	5.1

Means Of Death

In the U.S. a firearm is the method used in more than 50% of suicide deaths. The 2001 data cited in the following table are consistent with data over the past decade. Over half of all suicides in Michigan are committed with firearms. A firearm being kept in the home has been shown to be a risk factor for suicide among adolescents. It is also the most common means of suicide for elderly men. Some studies have demonstrated that voluntary removal of firearms from homes of persons at risk has a positive impact on suicide rates and that substitution of methods does not necessarily occur.

Table III: Suicide Methods

Suicide Methods:	**Number**	**Rate**	**Percent of Total**		**Number**	**Rate**	**Percent of Total**
Firearm suicides	16,907	5.8	53.7%	All but Firearms	14,577	5.0	46.3%
Suffocation/Hanging	6,635	2.3	21.1%	Poisoning	5,462	1.9	17.3%
Cut/Pierce	571	0.2	1.8%	Drowning	339	0.1	1.2%

Suicide as a Public Health Problem in Michigan

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

Did You Know?
At least 6,570 people became suicide survivors in Michigan in 2004
Michigan Deaths In 2004
Suicide: 1,096 / Homicide: 672 / HIV/AIDS: 215

Table IV: Annual Number of Suicides By Age, Race, and Gender, Michigan Residents, 1990-2004 per 100,000 population

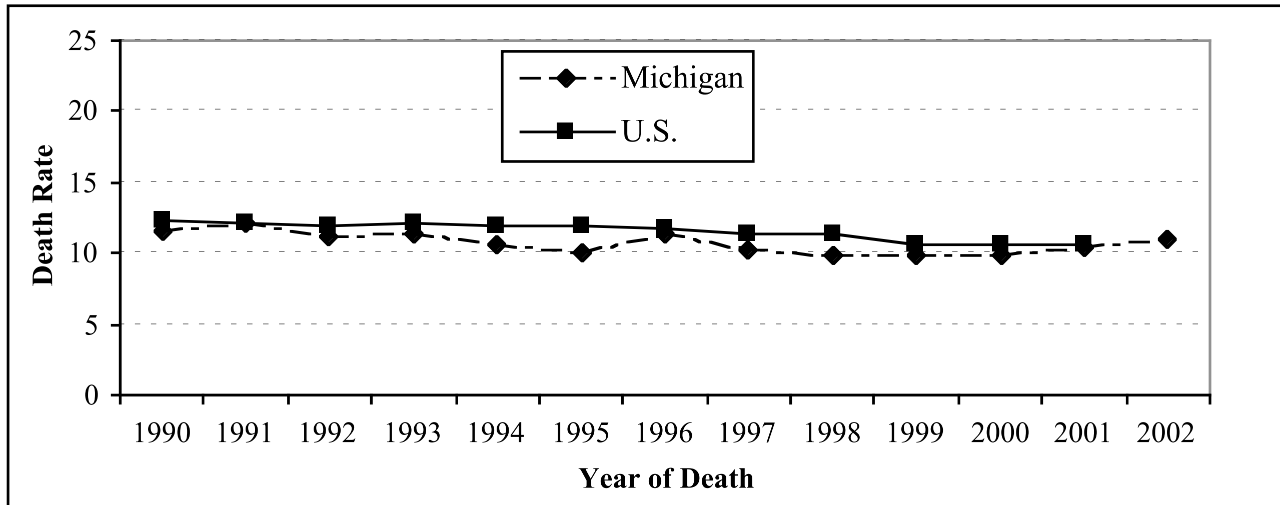
Year	All Races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
1990	11.7	20.5	4.3	12.2	21.2	4.5	8.2	14.9	*
1991	12.4	21.9	4.6	12.9	22.5	4.8	9.6	17.8	*
1992	11.4	19.7	4.2	11.9	20.4	4.5	7.9	14.4	*
1993	11.4	20.3	3.7	11.8	20.7	4.0	8.5	16.6	*
1994	10.7	19.1	3.5	11.1	19.6	3.7	8.2	15.5	*
1995	10.1	17.7	3.5	10.3	18.2	3.5	8.1	14.6	2.8
1996	11.5	20.2	3.9	11.8	20.7	4.1	8.5	15.2	2.9
1997	10.3	18.0	3.5	10.9	18.8	3.8	6.3	11.8	*
1998	9.8	17.5	3.2	10.4	18.6	3.3	6.0	10.9	*
1999	9.8	16.8	3.6	10.3	17.5	3.8	6.9	12.5	*
2000	9.8	16.7	3.7	10.4	17.6	4.0	6.0	11.1	*
2001	10.4	17.6	3.9	11.1	18.7	4.1	6.7	11.6	2.7
2002	10.9	18.5	4.0	11.7	19.7	4.3	6.3	10.8	*
2003	10.0	16.6	3.9	10.8	17.7	4.3	6.4	11.5	*
2004	10.7	17.8	4.2	11.6	19.1	4.5	4.6	7.5	*

Note: The manner in which underlying cause of death is coded and classified was revised in 1999 to reflect changing medical opinion and practice. The comparability between classification schemes for this particular cause of death is high (1.00), meaning that the change should have little or no impact on the comparisons of mortality statistics over time.

The average annual suicide rate for the state has remained relatively flat for over a decade. It has also, for the most part, closely mirrored the rate for the United States overall. Men account for 81% of the completed suicides in Michigan. The highest suicide rate (38.5) is actually among white males ages 75

and older. Other groups of men with high rates are black males ages 30-34 (26.7), and white males ages 35-54 (24.9), 25-29 (23.7), 65-74 (23.7), and 30-34 (23.2). The lowest suicide rates are among black women, who have an average annual rate of 2.2 per 100,000 persons.

FIGURE 1. Suicide Rates, Michigan and U.S. Residents, 1990-2002



Sources: Vital Records and Health Data Development Section, MDCH; Web-based Injury Statistics Query and Reporting System, U.S. Centers for Disease Control and Prevention; U.S. Census Data

Michigan Youth Risk Behavior Survey

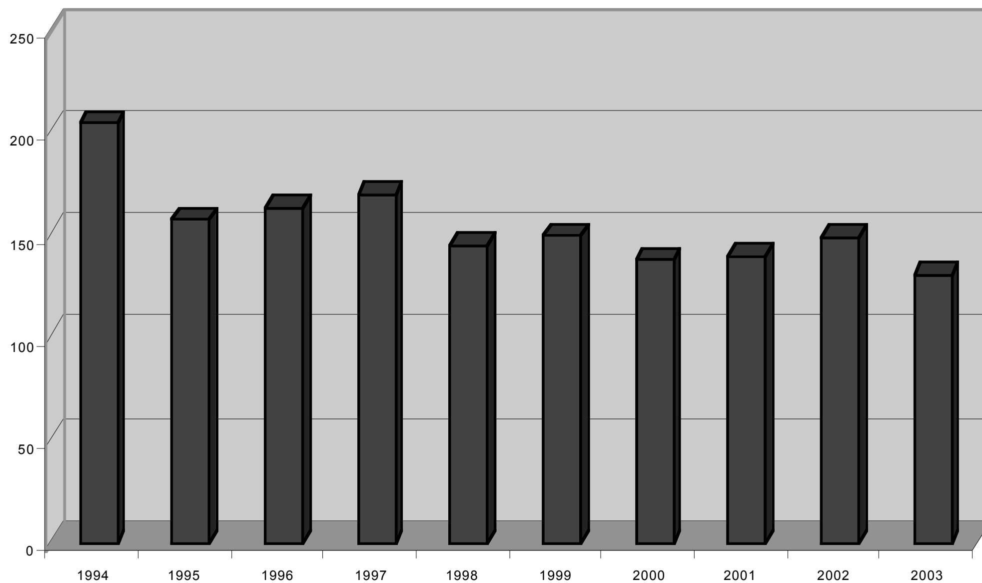
The following table is excerpted from the Michigan Youth Risk Behavior Survey. This survey gathers self-report from Michigan's 9th–12th graders. While trends seem to be somewhat improved over the years reported, the changes are not significant. Of note are the high percentages of youth who engage in the range of suicide behaviors of Ideation, Planning and Attempts. Also of concern is the number of youth that report symptoms of depression. The data on ideation is consistent with national studies.

Table V: MYRB Survey 2004
Depression & Suicide

Item	Behavior	MI 05	MI 03	MI 01	MI 99	MI 97
% of students who ever felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	Sad or hopeless two weeks 12 months	26	30	27	27	
		26.3	30.2	27.3	27.4	N/A
		23.6-28.9	27.3-33.1	25.5-29.0	25.2-29.6	

% of students who seriously considered attempting suicide during the past 12 months	Suicide considered 12 months	16	18	18	20	24
		15.8	18.1	18.1	20.1	23.8
		13.4-18.2	15.7-20.4	16.7-19.5	18.2-22.0	21.1-26.4
% of students who made a plan about how they would attempt suicide during the past 12 months	Suicide planned 12 months	12	14	15	15	19
		12.2	14.2	14.8	15.2	18.6
		9.9-14.6	12.3-16.0	13.8-15.8	13.9-16.5	17.0-20.3
% of students who actually attempted suicide one or more times during the past 12 months	Suicide attempted 12 months	9	11	10	8	10
		9.3	10.5	10.2	7.9	10.4
		7.5-11.1	9.2-11.8	8.7-11.6	6.9-8.8	9.0-11.8
% of students whose attempted suicide resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months	Suicide injury treated 12 months	3	3	4	3	3
		3.3	3.2	3.5	2.9	3.1
		2.2-4.4	2.5-3.9	2.8-4.2	2.1-3.6	2.5-3.7

FIGURE 2: Michigan Youth Suicide 1994-2003



Suicide as a Public Health Problem in Kalamazoo County

Kalamazoo County had the eighth highest number of suicide deaths among all Michigan Counties between 1999 and 2003, with an average of 23.4 deaths per year. Between 2001 and 2003 in Kalamazoo County, suicide ranked as the eighth leading cause of death among males (2.0% of deaths) and tenth leading cause of death among the white population (1.3% of deaths). Suicide was not among the top ten leading causes of death among either the female or black population in this time period.

(For additional information about other causes of death in Kalamazoo County, please refer to "Section 3.3 Leading Underlying Causes of Death" in the Kalamazoo County Health Surveillance Data Book (http//www.kalcounty.com/hcs/pdf_files/Sect3_3SurveillanceBook.pdf).

Suicide Risk Groups

Males:

Between 2001 and 2003, males in Kalamazoo County were 3.5 times more likely to commit suicide than females (16.2 deaths per 100,000 population vs. 4.6 deaths per 100,000 population), and white individuals were twice as likely to commit suicide as black individuals (10.6 deaths per 100,000 population vs. 5.3 deaths per 100,000 population). This disparity was similar to the disparity in Michigan and in the United States among these populations.

Table VI: Age-Adjusted Mortality Rates per 100,000 Population Due to Suicide, by Gender and Race, Kalamazoo County, MI and United States, 2001 – 03*

Area	Total	Males	Females	White	Black
Kalamazoo County	12.1	16.2	4.6	10.6	5.3
Michigan	10.4	17.6	4.0	11.2	6.5
United States	10.9	18.4	4.2	12.0	5.3

**2002 statistics for the United States*
Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File
Population data source: National Center for Health Statistics, U.S. Census Populations with Bridged Race Categories, updated 9/2004.
United States data source: National Center for Health Statistics. Health, United States, 2004—With Chartbook on Trends in the Health of Americans. Hyattsville, Maryland:2004.

GLBTQ

A Southwest Michigan 2005 survey of Gay, Lesbian, Bisexual, Transgender, and Questioning Youth and Young Adults indicates that this group has elevated levels of substance abuse, mental health treatment, suicide ideation and attempts as compared with their heterosexual counterparts. This data is relatively consistent with National data on suicide behaviors among this cohort.

Age

Suicide ranks differently as a cause of death among different age groups. In Kalamazoo County between 2001 and 2003, suicide was the third leading cause of death among the population under 19 years of age (1.3% of all deaths in this age group), the second leading cause of death among the population 19 to 34 years of age (17.6% of all deaths in this age group), and the sixth leading cause of death among the population 35 to 64 years of age (3.3% of all deaths in this age group). Although suicide's rank as a leading cause of death varied by age group (because of the impact of deaths due to other causes), the rates of death due to suicide among adult age groups were similar (11.4 per 100,000 among 19 to 34 years of age, 14.5 per 100,000 among 35 to 64 years of age, and 11.0 per 100,000 among 65 years of ages and older).

Table VII: Suicide's Rank as a Cause of Death by Age Kalamazoo County and Michigan, 2001 – 2003

Age Group	Kalamazoo County	Michigan
0 – 18 years	#3	#4
19 – 34 years	#2	#2
35 – 64 years	#6	#7
65+ years	#12	#12

Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File

Table VIII: Suicide Rates by Age Group, Kalamazoo County and Michigan 2001 – 2003

Age Group	Kalamazoo County				Michigan			
	Average Annual Number of Deaths	% Of All Deaths in Age Group	Rate per 100,000	+/- 95% CI	Average Annual Number of Deaths	% Of All Deaths in Age Group	Rate per 100,000	+/- 95% CI
0 – 18 years	<3	1.3%	1.1	*	50	2.7%	1.8	0.3
19 – 34 years	7	17.6%	11.4	4.8	279	13.2%	13.0	0.9
35 – 64 years	13	3.3%	14.5	4.6	567	3.0%	14.3	0.7
65+ years	3	0.2%	11.0	7.2	157	0.2%	12.8	1.2

**95% Confidence interval exceeds possible limits*

Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File
Population data source: National Center for Health Statistics, U.S. Census Populations with Bridged Race Categories, updated 9/2004.

Characteristics of Suicide Deaths

About one-third of individuals who committed suicide between 1999 and 2003 in Kalamazoo County had never been married (35.9%), 30.8% were either married or separated, 27.4% were divorced, and 6.0% were widows or widowers. About one-third of suicide deaths occurred in winter months (32.5%), and the fewest occurred in the fall (18.8%).

Table IX: Suicide by Season, Kalamazoo County 1999 – 2003

Month of Death	Number of deaths	Percent of suicide deaths
Dec, Jan, Feb	38	32.5%
Mar, Apr, May	27	23.1%
Jun, Jul, Aug	30	25.6%
Sep, Oct, Nov	22	18.8%

Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File

For most suicide deaths between 1999 and 2003 in Kalamazoo County, the place of injury was at the individuals' homes. Two thirds of deaths occurred at home, and 16.2% of deaths occurred at a hospital.

Table X: Place of Injury for Suicide Deaths in Kalamazoo County, 1999 – 2003

Location of Injury	Number of deaths	Percent of suicide deaths
Home	86	73.5%
School, other institution and public administrative area	6	5.1%
Street and highway	4	3.4%
Trade and service area	4	3.4%
Residential institution	<3	*
Farm	<3	*
Industrial and construction areas	<3	*
Other specified places	12	10.3%

**Percentage masked due to small numbers.*
Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File

Table XI: Place of Death, Suicides in Kalamazoo County, 1999 – 2003

Location at Death	Number of deaths	Percent of suicide deaths
Home	78	66.7%
Hospital	19	16.2%
Other	18	15.4%
Other institution	<3	*
Unknown	<3	*

**Percentage masked due to small numbers.*
Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File

About half of suicide attempts that resulted in death in 2003 involved a firearm, and poisoning was the second highest cause of death, followed by hanging, strangulation or suffocation.

Causes of death are ranked in order of the number of deaths that occurred in a time period. In Kalamazoo County, suicide was the ninth leading cause of death in 2003, when 29 deaths occurred (a crude rate of 12.0 deaths per 100,000 population, or 1.2% of all deaths). This compares with the rate in the State of Michigan for the same period of 10.1 deaths per 100,000 population (crude rates were not significantly different).

Table XII: Method of Suicide in Kalamazoo County, 1999 – 2003

Method of Suicide		Number of deaths	Percent of suicide deaths
Firearm		58	49.5%
Poisoning:	All poisoning	24	20.5%
	Exposure to drugs and other biological substances	*13*	*11.1%*
	Exposure to other gases and vapors	*10*	*8.5%*
	Exposure to other and unspecified Chemicals and noxious substances	*<3*	*
Hanging, strangulation, and suffocation		22	18.8%
Sharp object		7	6%
Drowning and submersion		*<3*	*

Smoke, fire, and flames	*<3*	*
Jumping from a high place	*<3*	*
Other specified means	*<3*	*
Unspecified means	*<3*	*

Percentage masked due to small numbers.
Mortality data source: Michigan Department of Community Health, Division for Vital Records and Health Data Development, Michigan Resident Mortality File

Suicide Attempts

The number of deaths reflects only a portion of all suicide attempts. Another indicator of suicidal behavior in the community is the number of hospitalizations due to suicide attempts. Although the suicide death rate was higher among males than females, when suicide attempts that end in hospitalization and suicide deaths were combined, the crude rate of "attempts or deaths" was higher among females than males in Kalamazoo County in 2003 (75.4 per 100,000 population vs. 61.3 per 100,000 population). By age groups, the highest rates for this combined indicator were people between the ages of 20 and 54.

Table XIII: Suicide Attempts Resulting in Hospitalization and Suicide Deaths Kalamazoo County 2003

Age group	Hospitalized (Survived)			Deaths		
	Male	Female	Total	Male	Female	Total
10-14 years	0	<3*	<3*	0	0	0
15-19 years	<3*	6	8	0	0	0
20-34 years	22	37	59	5	3	8
35-54 years	24	36	60	10	3	13
55-74 years	3	6	9	4	<3*	6
75+ years	0	0	0	<3*	0	<3*
Total	51	86	137	21	8	29

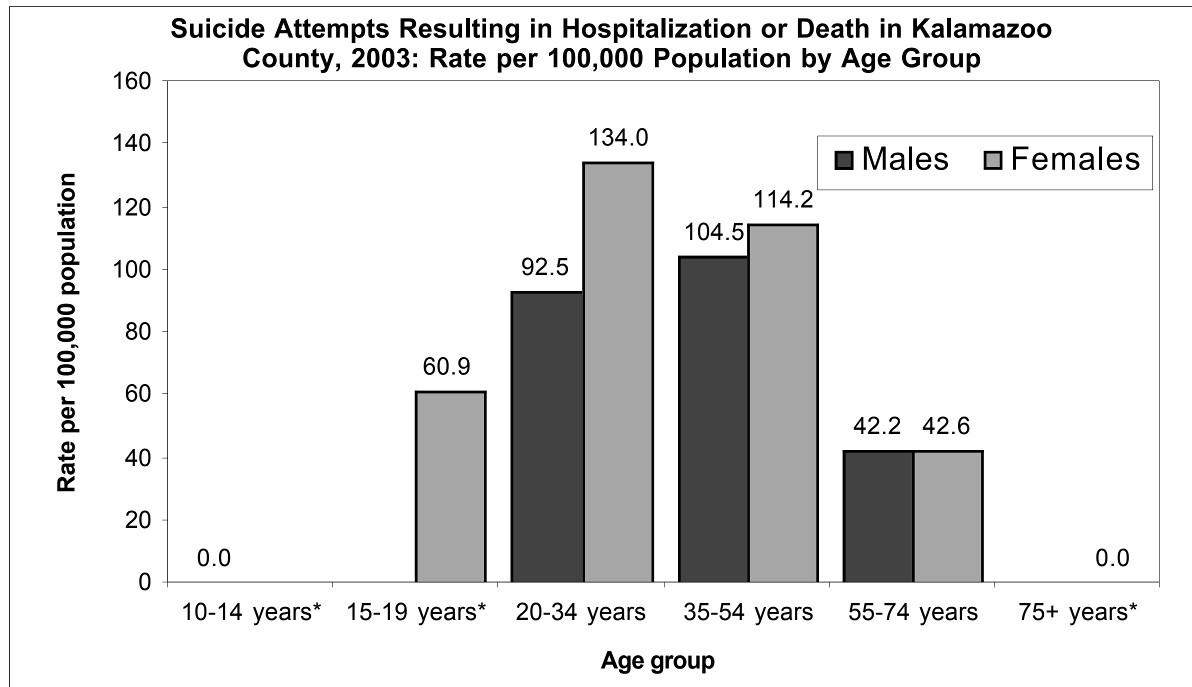
Count masked due to small numbers.
Attempt and Death Source: Michigan Resident Death File and Michigan Resident Hospitalization File, Michigan Department of Community Health

Table XIV: Suicide Attempts Resulting in Hospitalization or *Death Among Kalamazoo County Residents in 2003 Number and Rate per 100,000*

Age group	Counts			Rate per 100,000 population		
	Attempts or deaths	Attempts or deaths	Attempts or deaths	Attempts or deaths	Attempts or deaths	Attempts or deaths
	Male	Female	Total	Male	Female	Total
10-14 years	0	<3*	<3*	0.0	*	*
15-19 years	<3*	6	8	*	60.9	40.8
20-34 years	27	40	67	92.5	134.0	113.5
35-54 years	34	39	73	104.5	114.2	109.4
55-74 years	7	8	15	42.2	42.6	42.4
75+ years	<3*	0	<3*	*	0.0	*
Total	72	94	166	61.3	75.4	68.6

Count masked and rate not reliable due to small numbers.
Attempt and Death Source: Michigan Resident Death File and Michigan Resident Hospitalization File, Michigan Department of Community Health
Population Data Source: 7/1/2003 County Characteristics Estimates File for Internet Display; Population Estimates Program, U.S. Bureau of the Census; release date September 30, 2004.
Rate not reliable due to small numbers

Figure 3



**Rate not reliable due to small numbers for females 10-14yrs, males 15-19 years, males 75+ years.*
Attempt and Death Source: Michigan Resident Death File and Michigan Resident Hospitalization File, Michigan Department of Community Health
Population Data Source: 7/1/2003 County Characteristics Estimates File for Internet Display; Population Estimates Program, U.S. Bureau of the Census; release date September 30, 2004.
Poisoning accounted for the majority of non-fatal suicide attempts in Kalamazoo County that resulted in hospitalization in 2003.

Table XV: Method of Non-Fatal Suicide Attempts Resulting in Hospitalization Kalamazoo County, 2003

Cause	Number	Percent of Hospitalized Attempts (Who Survived)
Sharp Object	<3	*
Jump	<3	*
Poisoning	131	95.6%
Hanging	<3	*
Other	<3	*

**Percentage masked due to small numbers.*
Source: Michigan Resident Hospitalization File, Michigan Department of Community Health

Crisis Line Activity in Kalamazoo County

The local crisis intervention hot line receives an average of 900 calls a year from those considering suicide. These persons are referred for mental health services and some receive follow-up services from the 2-1-1/ HELP-Line. Most of these calls are from persons who are not at immediate and high risk for suicide; however, on the average, over 35 rescues are initiated each year. Rescue procedures are implemented only when there is a suicide in progress. While there is no way of knowing how many lives are saved in these rescues, it is certain that some deaths are prevented. Kalamazoo County residents may reach this service through the local numbers (2-1-1 or 381-HELP) or by contacting either of the two National Suicide Prevention Hot Lines.

Other community crisis services deal with suicidal individuals in large numbers including Community Mental Health 24/7 Access Line, YWCA Domestic and Sexual Assault hotlines, Hospital Emergency rooms and inpatient facilities, *Children's Crisis Response Team* and others.
None of these systems can easily report data and each uses differing definitions.

Summary of Suicide in Kalamazoo County

Kalamazoo County's experience with suicide is similar to that of the State and the Nation. Overall rates for Kalamazoo County are slightly higher than the State and National rates. However, given the relatively low numbers involved, the difference is not statistically significant. The highest death rates are among males and the white population. When hospitalizations for suicide attempts are combined with suicide deaths in Kalamazoo County, the highest attempt rates are among females and ages 20-54 yrs (both males and females). While suicide ranks higher as a leading cause of death in the populations under 19 years and 19 to 34 years compared to older ages, this is due in part because with increasing age, the risk of dying from other causes increases, not because of a decrease in risk of death by suicide.

It is encouraging that youth and elderly suicide rates in Kalamazoo County may be slightly below the comparison rates (although differences are not significant), but it would be highly speculative to attribute lower rates to any particular factor in our community. Data on suicide attempts that reach emergency rooms has been available in recent years, and while these figures clearly under-represent the number of suicide attempts, they may be useful in evaluating prevention efforts in the future.

There were four (4) deaths by suicide in the Kalamazoo County Jail over the course of 100,000 bookings over a time span of more than eleven years. During this same time frame, there were at least ninety three (93) attempts by jail inmates. These rates are significantly below the national rates for incarcerated offenders and are lower than the community rates.

Risk and Protective Factors

As a nation, a community and as individuals we value life. As parents, siblings, friends, neighbors, classmates, co-workers and professionals, we all feel a responsibility to protect our most vulnerable community members. Our purpose is to describe a community-wide risk focused approach to reduce the horrifying burden of suicide in Kalamazoo County.

Work by the National Academy of Sciences, the Surgeon General of the United States and others have identified a number of risk and protective factors that can increase or decrease an individual’s likelihood of committing suicide. Many of these risk and protective factors can be addressed systematically at the community level. Risk factors are those biological, psychological, cultural and social conditions that contribute to the likelihood that an individual will intentionally commit suicide. Protective factors are personal beliefs and individual characteristics, access to quality care, environmental constraints, bonding and community support. These factors counter risk factors or provide buffers against them. They protect by either reducing the impact of the risk or by changing the way a person responds to the risk.

A risk-reduction approach will assist the community to address the factors that enable suicide to fester. A first step is to assess the level of risk and protective factors for suicide in Kalamazoo County. Based on

this assessment, specific strategies will be developed to address those risk and protective factors prioritized and to define efforts to promote awareness, education and support for vulnerable community members.

Bio-psychosocial Risk Factors:

1) Mental Illness and Substance Abuse – more than 90% of all suicides are associated with diagnoses including Depression, Bi-Polar Disorder, Schizophrenia, anxiety disorders, some personality disorders, and alcohol and other drug abuse. The risk factors increase with the presence of multiple disorders.
2) Hopelessness – the presence and degree of hopelessness is highly correlated with suicide, regardless of diagnosis;
3) History of severe childhood abuse, especially sexual abuse, is known to increase lifelong risk for suicide;
4) Family history of suicide is known to increase risk;
5) History of suicide attempts.

Environmental Risk Factors:

1) Job or financial loss;
2) Relational or social loss;
3) Easy access to lethal means, especially firearms;
4) Local clusters of suicides that have contagious influence.

Socio-cultural Risk Factors:

1) Lack of social support and sense of isolation;
2) Stigma associated with help-seeking behaviors;
3) Barriers to accessing health care, especially mental health and substance abuse treatment;
4) Certain beliefs such as the belief that suicide is a noble resolution for a personal or political dilemma;
5) Exposure to media coverage of suicide and/or influence of others who have died by suicide.

The presence of multiple risk factors will increase lifetime risks for suicide. Care should be taken to assess for risk, using a bio-psychosocial model. It is more often the interaction of the risk factors rather than a single risk factor that will lead to suicide.

Protective Factors Against Suicide

The following protective factors are drawn from the Surgeon General as reflected in the *National Strategy for Suicide Prevention, 2001* and expanded by the National Academy of Science, Institute of Medicine study *Reducing Suicide, A National Imperative, 2002.*

1) Easy access to a variety of clinical interventions;
2) Effective clinical care for mental, physical, and substance abuse disorders, including support services;
3) Restricted access to highly lethal means of suicide, especially firearms;
4) Strong connections to family and community support;
5) Skills in problem solving, conflict resolution and nonviolent handling of disputes;
6) Cultural and religious beliefs that discourage suicide and support self preservation;
7) Optimism and belief in the ability to cope and to solve problems.

Goals and Objectives

The Kalamazoo Suicide Prevention Plan addresses the problem of suicide at the local level and is consistent with the *National Suicide Prevention Strategy (2001)* and the *Michigan Plan for Suicide Prevention(2005)*. The premise of the plan is that prevention is best achieved through broad community commitment to multi-modal and integrated approaches. Evidence from the field of suicide prevention and prevention in general supports this approach. In order to accomplish this plan, a broad range of local organizations, leaders, programs, volunteers, and the general community must be engaged. Working to develop partnerships with the state and federal efforts is considered essential along with building local resources to support these efforts.

The overarching goal of this Plan is to reduce the incidence of suicide attempts and death in our community. We believe that this is best achieved by increased awareness, reduction of stigma, development of strong clinical practices in multiple settings, improved surveillance, and a learning approach to suicide prevention. Recent research findings suggest that an effective suicide prevention strategy will yield other significant benefits for communities. As a field, there is significant knowledge available but the pursuit of effective practices remains a creative endeavor with ongoing need to evaluate and learn from prevention efforts.

The following Goals and Objectives represent the framework for implementation with full recognition that these activities will overlap and contribute to a unified, integrated, and coordinated effort.

Goal 1: Increase Protective Factors - Develop Broad Based Support for Suicide Prevention

Objective 1.1 The Multi-Purpose Collaborative Body (MPCB) will serve as the community coordinating network for this plan and will advocate for suicide prevention funding and coordination.
Measure: Endorsement of the Plan by the Multipurpose Collaborative Body

Objective 1.2 MPCB member organizations will work toward the objectives of this plan
Measure: Each member of the MPCB will report activities undertaken within their organizations in support of this plan on an annual basis.

Objective 1.3 The MPCB will facilitate designation of a lead agency to coordinate local efforts with state and federal efforts. This agency will work with an on-going Suicide Prevention Workgroup (SPWG) designated by the MPCB. The SPWG will provide progress reports to the MPCB regularly and as necessary.
Measure: Designation of Lead Agency and a SPWG. Reports will be provided by SPWG to the MPCB on progress of the plan and new or emerging elements.

Objective 1.4 The Kalamazoo County Suicide Prevention Plan will be widely shared with the broad community and the media as part of the promotion, education, and advocacy of suicide prevention
Measure: Press release by MPCB upon endorsement of the Plan and distribution to all major human services organizations in Kalamazoo County.

Objective 1.5 The MPCB and the SPWG will seek partnerships and collaborations throughout the community in support of this plan.
Measure: Documentation of collaborative activities.

Objective 1.6 The SPWG will develop a written logic model in support of this plan within six months of endorsement.

Goal 2: Increase Protective Factors - Promote Awareness of Suicide as a Preventable Public Health Problem, and Reduce the Public Disapproval Associated With Receiving Mental Health, Substance Abuse and Suicide Prevention Services

Objective 2.1 The SPWG and community agencies will collaborate with the state Office of Suicide Prevention to use materials and messages developed by that office and will contact the State Office within six months of the endorsement of this plan.

Objective 2.2 SPWG members and the lead agency will identify and disseminate information regarding training and seminars in suicide prevention. Members of SPWG will seek to attend national conferences on suicide prevention
Measure: Documentation of training and seminars promoted and/or attended.

Objective 2.3 MPCB member agencies will review the plan and distribute information for use within their agencies that serves to de-stigmatize mental illness and encourage help seeking
Measure: Each member organization will annually report on at least one information distribution conducted within their organizations for staff and consumers.

Objective 2.4 SPWG together with Western Michigan University, will develop web based information that increases knowledge about suicide, reduces stigma associated with suicide and mental illness, encourages help-seeking, and provides information about community resources for intervention and prevention services.
Measure: Web site is established with links to websites of MPCB organizations and other human service agencies in the community.

Objective 2.5: Increase public awareness and guide perception concerning suicide, depression and help-seeking. Engage the media and other campaigns in publicizing signs and symptoms, what is not normal behavior, treatment successes for average persons, and awareness of helping resources.
Measure 1: At least one news report or article will appropriately cover suicide.
Measure 2: SPWG will regularly disseminate the American Association of Suicidology endorsed Media Guidelines to major local media outlets and will offer consultation regarding news coverage of suicide.

Goal 3: Increase Protective Factors and Reduce Risk Factors - Develop and Implement Community-Based Suicide Prevention Programs

Objective 3.1 The agencies designated in this plan in conjunction with the MPCB and the SPWG will define and implement activities that support school based gatekeeper education for youth, provide Gatekeeper Training to faculty and staff and provide parent education, by utilizing local programs or adopting a program from the evidence based and promising programs listing published through the Suicide Prevention Resource Center. All school districts in Kalamazoo County will be encouraged and supported in developing suicide prevention programs for their districts by the '07-08 school year.
Measure*:* Districts will share a summary of their plans with the SPWG for inclusion in the report to the community

Objective 3.2 The agencies designated in this plan in conjunction with the MPCB and the SPWG will define and implement activities that increase early identification and intervention services for children who have experienced severe childhood trauma. Best Practices guidelines will be developed and disseminated to organizations with programs for victims of childhood trauma.
Measure*:* Documentation of the development and dissemination of guidelines.

Objective 3.3 The agencies designated in this plan in together with the MPCB and the SPWG will define and implement activities that identify community gatekeepers and support

gatekeeper training across the lifespan. Groups to be trained will be prioritized and a timeline developed.
Measure: Documentation of prioritized list and training delivered.

Objective 3.4 The agencies designated in this plan will meet with the MPCB and the SPWG to define activities that maintain and increase services for Survivors of Suicide. These will include strategies to respond to immediate suicides, specialized grief counseling, support group services, and other educational supports for those impacted by suicide.
Measure: Documentation of services defined and plan for service delivery.

Objective 3.5 The agencies designated in this plan in conjunction with the MPCB and the SPWG will define and implement activities that improve access to mental health and substance abuse services.
Measure: Partners in this plan (e.g. KCMHSAS, Bronson Hospital, Borgess Health Alliance) will provide data regularly as needed to SPWG on access to mental health/substance abuse care in Kalamazoo County.

Objective 3.6 The SPWG will identify effective strategies for outreach and suicide prevention to older adults and other special populations and will recommend a strategy and/or programming to address these populations. Increased supports for social engagement activities, expanded gatekeeper training of providers and volunteers, expanded outreach for mental health services, and specialized educational approaches to reduce stigma and encourage help seeking are several of these strategies.
Measure: Development of a plan that is then endorsed by the MPCB for action by the relevant community agencies and services.

Goal 4: Increase Protective Factors - Improve Recognition of and Response to High Risk Individuals

Objective 4.1 Identify and increase the number of trained Gatekeepers to identify and intervene with at-risk individuals. Prioritize groups to be trained based on those who most frequently encounter higher risk individuals. Train Gatekeepers to recognize signs of depression and suicidal ideation specific to different populations.
Measure*:* Number of new Gatekeepers trained and which age and risk groups are addressed.

Key Gatekeepers, as defined in the *National Strategy for Suicide Prevention,* are those people who regularly come into contact with individuals or families in distress. They are professionals and others who are trained to recognize behavioral factors that place individuals at risk for suicide. Gatekeepers are equipped with effective strategies to intervene before the behaviors evolve further. Key Gatekeepers include, but are not limited to:

- Teachers and school staff, including school health personnel
- Clergy and others in faith-based organizations
- Criminal justice personnel
- Workplace supervisors
- Natural community helpers

- Volunteers in community organizations such as Hospice and nursing homes, meals on wheels, etc.
- Primary health care providers, including emergency health care personnel
- Mental health care and substance abuse treatment providers
- Persons working with vulnerable populations such as gay, lesbian, bi-sexual, and transgender, homeless, chronically ill, etc.
- Personnel in agencies that serve specific ethnic populations such as Native Americans, Hispanics, non-English speaking, etc.
- Caregiver support resources, support and bereavement groups and counseling services

Objective 4.2 The Kalamazoo County Sheriff's Department will continue to collaborate with KCMHSAS to provide suicide assessment of detainees in the County Jail. The Department will review and incorporate enhancements that are appropriate using *The American Correctional Association Standards for Emergency Care and Training*, or the *National Commission on Correctional Health Care*
Measure: Documentation of death by suicide and attempts in jail and new and enhanced practices implemented.

Goal 5: Reduce Risk Factors – Advocate For Evidence Based Clinical Services For Depressed And/Or Suicidal Individuals And For Victims Of Childhood Trauma

Objective 5.1 The SPWG will continuously identify effective clinical practices and disseminate evidence-based practice information to mental health, substance abuse, and agencies and programs throughout Kalamazoo County.
Measure*:* Documentation of activity.

Objective 5.2 The SPWG and MPCB will identify and encourage training and information programs that address successful clinical practice in serving those who are depressed and/or suicidal.
Measure*:* A listing of seminars will be identified and distributed

Objective 5.3 The SPWG and MPCB will advocate for treatment appropriate for special groups in natural settings (e.g. in-home counseling for the elderly, school-based for youth) to increase the likelihood that they will be used.
Measure:

Objective 5.4 The SPWG and MPCB will educate primary care physicians who prescribe psychotropic medications on the unique signs and issues of elderly and other at-risk groups.
Measure*:*

Objective 5.5 The SPWG and MPCB will encourage and advocate for evidence-based innovative approaches to impact depression and abuse.
Measure*:*

Goal 6: Improve Knowledge to Reduce Risk and Increase Protective Factors - The Community Will Improve Local Surveillance, Support Research, and Evaluate Local Prevention Efforts.

Objective 6.1 The lead agency and the SPWG will gather local data on suicide in order to evaluate this plan, and to report on progress to the MPCB and to the community. Public Health mortality data and suicide attempt data will be utilized.
Measure: Annual report to MPCB and community.

Objective 6.2 SPWG will develop a team to review deaths and in order to monitor patterns, seek expanded knowledge of suicides in Kalamazoo County and make recommendations about prevention strategies.
Measure:

Objective 6.3 The SPWG will take steps and offer recommendations to community organizations which can improve surveillance data.

Goal 7: Increase Protective Factors and Decrease Risk Factors - Limit Access to Lethal Means and Methods of Suicide

Objective 7.1 All community gatekeeper training programs and crisis services will include content on assessing access to lethal means, including firearms, and actions to take in the home to reduce risks. Training will also include family awareness of means such as medications, cars, self-neglect and alcohol. It will be important to empower and inform informal as well as formal contacts.
***Measure*:** Documentation of content of training programs.

Objective 7.2 Community leaders will define and implement strategies to reduce the accessibility of lethal means, including firearms, in the home.
Measure: Documentation of efforts

Appendix A

Current Local Suicide Prevention Programs
Overview of Current Suicide Prevention Programs in Kalamazoo County

Since risk factors for suicide include mental illness, substance abuse, social isolation, and physical health, it can be argued that all human services programs, and community development play a part in preventing suicide. Interventions that address mental health and substance abuse serve to socially integrate and support people and by extension perform a suicide prevention function.

Some programs that have objectives that specifically address suicide prevention in Kalamazoo County are:

1) ***Kalamazoo County Community Mental Health and Substance Abuse Services:***
   a. Suicide assessment of those incarcerated in the County Jail -- can lead to treatment, jail diversion, or to safety precautions in the jail setting.
   b. 24-hour Access Line -- provides crisis intervention and referral for those at risk of suicide.
   c. Emergency Mental Health and Children's Emergency Teams -- provide assessment and intervention for those at risk for suicide. Some outreach is available through these teams.
   d. An array of substance abuse and mental health treatment services serve to address the risk factors associated with these disorders.

2) ***Kalamazoo County Medical Examiners Office:*** Provides surveillance of death by suicide and publishes annual reports on causes of death along with some demographic data. Data from this source can be an input for suicide prevention.

3) ***Survivors of Suicide Support Group:*** A collaboration between Community Mental Health and Gryphon Place for those who have lost someone to suicide. (Survivors of suicide are at higher risk of suicide than the general population).

4) ***Gryphon Place***
   a. 2-1-1/HELP-Line -- provides a 24/7 crisis hotline. This is a nationally certified suicide prevention service in Southwest Michigan connected to the national suicide prevention hotlines. This is both a prevention as well as an intervention service.
   b. Gatekeeper Suicide and Other Violence Prevention Program -- provides school-based prevention programs at the 7th and 9th grade levels to area schools. Over 3,000 students a year are trained in how to identify and help at-risk peers. Offers training for school personnel.
   c. Suicide Prevention Training and Education – provides community suicide prevention training and education services. Gatekeeper skills trainings are offered to multiple community groups.

5) ***Hospital Psychiatric Services:*** Borgess Health Alliance and Kalamazoo Regional Psychiatric Hospital each provide inpatient mental health services to those who are at significant risk or have made suicide attempts.

6) ***Area Police Agencies:*** Provide 9-1-1 services in collaboration with crisis services when medical outreach or welfare checks are indicated.

7) ***Medical Centers and Hospitals:*** Emergency room staff identify, treat and refer suicidal individuals. In 2002, twenty eight youth were treated for non-fatal suicide attempts.

8) ***Counseling agencies and private practices:*** Provide mental health and substance abuse treatment and psychiatric services.

9) ***Mental Health, Substance Abuse and Other Community-based Prevention Programs:*** Numerous prevention services are provided that may have value in prevention of suicide; however, are not specifically designed for suicide prevention.

10) ***Critical Incident Stress Management Teams:*** These services provide suicide post-vention to schools and community settings. Teams are trained within school settings through collaboration with the Region 12 Strategic Alternatives in Prevention Education (SAPE) Safe and Drug Free Schools consortium sited at Calhoun County Intermediate School District, area school systems, and Gryphon Place. Gryphon Place Teams directly serve other community organizations and first responders.

Appendix B

Suicide Prevention Work Group Participants

Jeannie Byrne, *Kalamazoo County Health and Community Services*

Michelle Calco, *Community Partner*

Luanne Cali, *Interested Citizen*

Dee Callander, *Kalamazoo Public Schools*

K. Cody-Fitzpatrick, *Kalamazoo County Community Mental Health and Substance Abuse Services*

Guy Golomb, *Gryphon Place Board of Directors*

Kathy Gruder, *Borgess Health Alliance*

Denise Hartsough, *Greater Kalamazoo United Way*

Dale Hein, *Kalamazoo County Health and Community Services*

Joni Idzkowski, *Health Services Bureau, Kalamazoo County*

Janet Jones, *Multi-Purpose Collaborative Body*

Kathy Lewis-Ginbaugh, *Western Michigan University Counseling Center*

Sarah McKenzie, *Bronson Methodist Hospital, Social Work Department*

John Mecomber, *KCMHSAS, Regional Coordinating Agency*

Margaret Patton, *Borgess Health Alliance*

Bill Pell, Gryphon Place

Dave Petts, *Western Michigan University Substance Abuse Services (USAS)*

Sharon Roepke, *Gay & Lesbian Resource Center*

Phil Royster, *KCMHSAS Supported Education*

Peggy Sattler, *Area Agency on Aging, Kalamazoo County*

Thomas Shull, *Sheriff's Department, Kalamazoo County*

Karen M. VanDeusen, *Western Michigan University, School of Social Work*

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Sean Wierenga, *KCMHSAS Access Center*