Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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Dear Citizens of Maine,

It is with great pleasure that I present the Maine Suicide Prevention Program Strategic Plan 2012-2017 focused on reducing one of the biggest public health issues facing Maine citizens – suicide. The plan is the result of a collaborative effort of the Maine Suicide Prevention Program (MSPP), the MSPP Advisory Council and many engaged stakeholders who provided input into development of the plan. The MSPP is a multi-agency effort led by the Maine CDC Injury Prevention Program in the Department of Health and Human Services. Other state agency partners include the Departments of Education, Labor, Corrections and Public Safety.

Suicide is widely recognized as a public health problem requiring national attention and urgent action nationwide. Every 14 minutes, someone dies by suicide in the United States. In 2011, 224 Maine citizens, 4 each week, died by suicide. In 2012, a revised U. S. Surgeon General National Strategy for Suicide Prevention was issued to build upon a decade of accomplishments and incorporate recent advances in suicide prevention, reemphasizing that suicide is a major public health problem, which can only be reduced through integrated efforts by all sectors of society.

The purpose of the MSPP Strategic Plan 2012-2017 is to guide Maine's statewide suicide prevention efforts across the lifespan. The Plan's implementation requires the engaged efforts of state and local agencies, decision-makers, health care providers, service organizations, educators, planners, employers, community members, and others to integrate suicide prevention best practices within their settings and initiatives. The Plan contains five overarching goals and utilizes a public health approach to reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens. New opportunities in this plan target primary care settings and engage a widening circle of partners that are fundamental to this effort. Maine has historically been at the forefront of the development, implementation and evaluation of youth suicide prevention programs. The commitment to youth suicide prevention, working with schools and colleges, continues.

No single agency or individual can do this work alone. The Maine Suicide Prevention Program Strategic Plan 2012-2017 is a call to action; providing an excellent blueprint for partners in the public and private sector to use to increase awareness of suicide, promote collaboration, and facilitate opportunities for suicide prevention activities in their communities. Ultimately, the purpose is to prevent the tragedy of suicide from impacting Maine families, schools and communities and, over time, to save thousands of lives and millions of dollars.

Thank you to the members of the Maine Suicide Prevention Program's Advisory Council for their dedication to this plan's development.

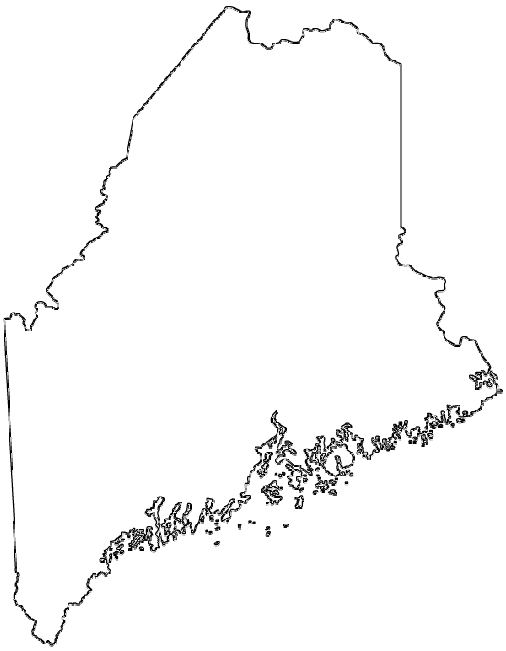
Sincerely,

Sheila A. Pinette

Dr. Sheila Pinette
Director, Maine CDC

Maine Suicide Prevention Program Strategic Plan 2012-2017

To reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens across the lifespan



Maine Suicide Prevention Program
Led by the
Department of Health and Human Services
Maine Center for Disease Control and Prevention

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Maine Suicide Prevention Program
Strategic Plan 2012-2017

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Acknowledgements

This plan was developed by the Maine Suicide Prevention Program, led by the Maine Center for Disease Control and Prevention (Maine CDC) of the Department of Health and Human Services, with input from about 70 individuals from around the state. The program is greatly indebted to everyone who shared their expertise and their perspective on development of this statewide suicide prevention plan for 2012-2017.

A draft of this plan was widely distributed to obtain feedback from government officials, service provider agencies, families, educators, military, health care, public safety and many other sectors. Three public forums were held in Augusta, Bangor and Portland. In addition, an online forum was held and an online survey was sent to those who wanted to provide feedback but could not participate in one of the forums.

The individuals who attended one or more meetings or provided their input in other ways share a strong commitment to preventing suicide in Maine. They represent diverse sectors including families and individuals affected by suicide, state government agencies, community-based organizations, education, health care, public health, colleges and universities, and tribal entities from many geographic regions around the state.

Special thanks goes to the members of the Maine Suicide Prevention Program Advisory Council who, through their discussions, decided to encompass the lifespan in this program plan and who contributed their input to all aspects of plan development. A Maine Suicide Prevention Program Advisory Council member list is in Appendix 2.

Authors and Editors:
Cheryl DiCara, Carrie Horne, Greg Marley, Laura Wilder, and Katharyn Zwicker

The Advisory Council members acknowledge and thank Mary Mayhew, Commissioner, Maine Department of Health and Human Services and Dr. Sheila Pinette, Director, Maine CDC for their support in the creation of this plan and for their dedication to the work of the Maine Suicide Prevention Program.

Executive Summary

Suicide has been widely recognized as a public health problem requiring national attention and urgent action nationwide. Every 14 minutes, someone dies by suicide in the United States. In 2011, 204 Maine citizens, 4 each week, died by suicide. In 2001, acknowledging the devastating impact and costs of suicide, the U.S. Surgeon General issued the first National Strategy for Suicide Prevention. The National Strategy emphasized that suicide is a major public health problem, which can only be reduced through integrated efforts by all sectors of society. Many of the risk and protective factors for suicidal behavior are known, and the evidence for effective suicide prevention

programs is growing. In 2012, a revised National Strategy was issued to build upon a decade of accomplishments and incorporate recent advances in suicide prevention.

Maine has historically been at the forefront of the development, implementation and evaluation of youth suicide prevention programs and has achieved demonstrable success. Since program inception, the percent of students reporting suicide ideation or attempts on the school-based Youth Risk Behavior Survey (YRBS) has significantly declined and the rate of suicide among 10 to 19 year olds decreased by 7 percent from 2001-2005 to 2006-2010. The Maine Suicide Prevention Program (MSPP) is a multi-agency effort led by the Maine CDC's Injury Prevention Program in the Department of Health and Human Services (DHHS). In addition to the DHHS, state agency partners include the Departments of Education, Labor, Corrections and Public Safety.

In 2009, the Maine Youth Suicide Prevention Program began the process of updating Maine's Youth Suicide Prevention Plan and also to initiate the development of a draft Plan for the Prevention of Suicide Among Adults in Maine that was completed in 2011. The adult plan represented the first time that Maine moved beyond its historic focus on youth suicide prevention. The purpose of this 2012-2017 Strategic Plan is to guide Maine's suicide prevention efforts across the lifespan. The implementation of this plan requires the engaged efforts of new stakeholders and partners to integrate suicide prevention best practices within their settings and initiatives.

Suicide and Self-Inflicted Injuries in Maine

Suicide takes nearly 37,000 lives each year in the United States and 1 million lives worldwide. Suicide rates have been increasing in the U.S. and Maine since 2007. In Maine, suicide is the 10th leading cause of death and the leading cause of violent death, killing almost seven times as many Maine citizens each year as homicide. From 2006-2010, 913 Maine residents died by suicide, an average of 183 annually. This represents an increase of 11 percent from the previous 5 years. Preliminary data for 2011 reveal a continued increase with 204 suicides. Suicide is the second leading cause of death for youth and adults ages 15-34.

Males die by suicide at much higher rates than females, 80 percent of suicides are male. For many years, the highest suicide rate has been among white males ages 85 and older. The overall number of suicide deaths and the associated rate of suicide have both increased in adults of working age since 2007. During 2006-2010, the highest rate of suicide was among adults ages 50-54 with the most notable increase among middle aged white males. Comparing the time period of 2001-05 to 2006-10, the rate of suicide in males ages 40-44, 45-49 and 50-54 increased by 40 percent, 35 percent and 65 percent respectively. The rate of suicide among females has also been rising in Maine and in the nation. Females attempt suicide at higher rates.

Many Maine families, schools and communities have been torn by the tragedy of a suicide involving someone they care about. Suicide occurs in all socio-economic groups and at all educational levels. Firearms are the most common method used to complete

suicide and the method most commonly used by males. Hanging and poisoning are the second and third leading suicide methods respectively. Poisoning the most common method used in female suicides.

Suicide attempts significantly outnumber deaths. On average, from 2005-2009, the most recent years for which data are available, there were 2,136 emergency department visits and 1,116 hospital discharges for self-inflicted injury annually. Young people attempt suicide at much higher rates than adults; young females experience the highest rates of hospitalization for self-inflicted injuries. It is estimated that there are as many as 100 youth suicide attempts for every youth suicide and most of these attempts do not result in medical intervention.

Suicide Prevention

The evidence base for suicide prevention has grown in the decade since the first National Strategy for Suicide Prevention. Several strategies have strong evidence of effectiveness from more than one study.[1] These strategies include: screening and treatment for depression in primary care practices and emergency departments, community based education strategies, comprehensive school-based programming, and restriction of highly lethal methods of suicide.

Suicide prevention at the individual and group level relies on an understanding of the risk and protective factors in a person's life. There is no exact combination of risk factors and triggering events that predict an individual's suicide risk. As the research continues to develop, it is becoming clear that some risk factors for suicide are more prevalent than others. Because so many people are potentially at risk, effective prevention strategies must employ a public health approach addressing the entire population.

Maine Suicide Prevention Program Plan

The purpose of the 2012-2017 MSPP Strategic Plan is to guide efforts statewide to prevent suicide across the lifespan. The plan is the result of a collaborative effort of the Maine Suicide Prevention Program (MSPP), the MSPP Advisory Council and many engaged stakeholders who provided input into development of the plan. The plan is intended to be used by state and local agencies, decision-makers, health care providers, service organizations, educators, planners, employers, community members and others interested in preventing suicide in their communities and in their lives. Ultimately, the purpose is to prevent the tragedy of suicide from impacting Maine families, schools and communities and, over time, to save thousands of lives and millions of dollars.

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[1] Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association (JAMA)*, 294(16), 2064-74; Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.

The long-term goal of the MSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens across the lifespan. The MSPP Plan contains five overarching goals that reflect an integration of goals identified in the Maine Youth Suicide Prevention Program Plan and the draft Adult Suicide Prevention Plan. The goals utilize a public health approach to address the lifespan problem of suicide. New opportunities identified in this plan target primary care settings and engage a widening circle of partners that are fundamental to this effort. The commitment to youth suicide prevention, working with schools and colleges, continues.

Maine Suicide Prevention Strategic Plan 2012-2017 Goals:

Because suicide takes a life in Maine every two days…
GOAL 1: Statewide leadership and coordination guides suicide prevention among Maine people.

Because people need access to comprehensive health care…
GOAL 2: Maine's people can access suicide prevention and intervention services in health care settings across the state.

Because preventing suicide is up to all of us…
GOAL 3: Maine's people are protected through integration of effective suicide prevention efforts within public and private organizations statewide.

Because people need to know how to help prevent suicide…
GOAL 4: Professionals working with Maine people are knowledgeable in suicide prevention, intervention and postvention.

Because seeking help saves lives…
GOAL 5: A culture of help-seeking for people in need exists in Maine.

Introduction

In the past decade in the United States, suicide has been widely recognized as a public health problem requiring national attention and urgent action. Many of the risk and protective factors for suicidal behavior are known. The evidence for effective suicide prevention interventions is growing. The U.S. Surgeon General issued the first National Strategy for Suicide Prevention in 2001, emphasizing that suicide is a major public health problem, which can only be reduced through integrated efforts by government, public health, mental health, human services, public safety and education working with communities, schools, employers, families, youth and other public and private partners.

In a 2003 report *Achieving the Promise: Transforming Mental Health Care in America* issued by then President Bush, suicide prevention was included in the first of six goals for the nation. In 2004, Congress passed the Garrett Lee Smith Memorial Act to provide federal funding to states for youth suicide prevention.

In light of significant progress made in the decade since the first National Strategy for Suicide Prevention was issued, the Office of the Surgeon General and the National Action Alliance for Suicide Prevention released an updated National Strategy for Suicide Prevention in 2012 to build upon accomplishments and incorporate recent advances in suicide prevention knowledge. When the first National Strategy was released, there were almost no "Best Practices" for suicide prevention. In 2012, there is a national registry of over 100 Best Practices and the knowledge base continues to grow.

Suicide is preventable. Like chronic health conditions, suicidal behavior is multi-determined. Preventing suicide is similar to preventing a heart attack. The general risk and protective factors are known and practitioners recommend health-promoting actions to their patients, but it is difficult to accurately predict when a heart attack may happen for a particular individual. Early detection and appropriate treatment and supports are necessary components to effective suicide prevention. By raising awareness of suicide prevention and increasing knowledge and intervention skills among a wide range of professionals and service providers, promoting help-seeking and effecting policy change, Maine can achieve lower suicide rates.

Maine Suicide Prevention Program

The Maine Suicide Prevention Program (MSPP), led by the Maine CDC Injury Prevention Program in the Department of Health and Human Services (DHHS), with our partners, is committed to excellence in suicide prevention, intervention, and postvention. Maine was one of the first states to plan, implement and evaluate a suicide prevention program. Multiple state agencies participate in carrying out MSPP activities. In addition to the Maine CDC, state agency partners engaged in suicide prevention include the Maine Substance Abuse and Mental Health Services and Child and Family Services in the DHHS and the departments of Education, Labor, Public Safety and Corrections.

The MSPP employs a public health approach to suicide prevention. The program is based upon the assumption that collaboration among state agency leaders and staff, along with significant involvement from professionals, youth, suicide survivors, organizations and others, is essential to planning and conducting effective suicide prevention activities. Since inception in 1998, the program has maintained an Advisory Council that provides guidance to program development and implementation. Membership includes government and private sector stakeholders.

The work of the MSPP is founded on the shared belief that suicide is preventable. Most suicidal behavior occurs during a time of crisis in an individual's life; when personal coping ability is overwhelmed, feelings of hopelessness prevail, and few or no alternative paths out of the situation are apparent to that individual. Many of these crises are short-lived and resolution of the crisis leads to improved mood and safety. With information, support and intervention, many suicides can be averted. Recovery from physical and emotional pain can allow a person to move forward with their life. Suicide prevention is based on the belief that people can overcome crises and recover from mental illness and live productive lives.

Current MSPP activities include:

Statewide Information Resource Center

Statewide Crisis Hotline answered in-state 24/7; 1-888-568-1112

Web sites containing information and resources for adults and youth

Gatekeeper Training;

Awareness Education Programs and Resources

Training of Trainers to conduct awareness education

Clinician Assessment Training

Annual Conference;

Protocol Guidelines and protocol development training

Training for educators who will teach "Lifelines", Middle School and "Transitions" student lessons

Assistance and Consultation to schools, community agencies, health care providers and others to effectively prevent suicide

Media education and guidelines for safe reporting on suicide

Fact sheets and other resource materials

Suicide and self-inflicted injury data monitoring and analysis

Purpose of the Plan

This strategic plan is intended to serve as a guide to address suicide prevention across the lifespan. It builds on two previously developed Maine plans: one focused on adults and the youth suicide prevention plan. This plan lays out strategies to reduce the burden of suicide across the lifespan by strengthening partnerships between state and local organizations and integrating suicide prevention capabilities into existing programs and services. The plan establishes priorities for suicide prevention initiatives and activities over a five-year period.

This plan is meant to inspire action. Individuals reading this plan are encouraged to take an active role in working to prevent suicide among youth and adults. The resources, authority and skills to conduct effective suicide prevention activities do not reside within a single organization. While the state level program has a significant leadership role to play, only by joining efforts across agencies and communities can Maine realize the common goal of preventing suicide.

The Planning Process

Maine's Suicide Prevention Strategic Plan 2012-2017 is the result of a process obtaining the input of many partners involved in suicide prevention activities in Maine. In 2009, the Maine Youth Suicide Prevention Program engaged in a strategic planning process to update the state's youth suicide plan. This involved acquiring extensive input through a series of facilitated meetings with the Advisory Council and state and contracted staff. Significant individual and group work followed to craft goals and objectives, and the activities to meet those objectives.

In 2010, a small work group of individuals from diverse settings was convened by the program to develop an adult-focused suicide prevention plan. The **Plan for the Prevention of Suicide Among Adults in Maine** was completed in 2011 and represented the first time Maine moved beyond its initial focus on youth suicide prevention.

In 2011, following an Advisory Council decision to expand the program focus to adults and youth, a small work group synthesized a set of goals, objectives and activities for lifespan suicide prevention, working from the youth and adult plans, research and national guidance documents. A draft of this plan was widely distributed to solicit feedback from the people of Maine to ensure a responsible and responsive approach to suicide prevention. In order to gain diverse, professional and public feedback, four venues were planned so that statewide participation could be available. Three public forums were hosted in Augusta, Bangor and Portland, Maine. One forum was hosted virtually through a "Go-To-Meeting" format. Those who could not participate in the scheduled forums were sent a link to an on-line survey to give their feedback.

Invitations to participate in the forums and the on-line survey were emailed to a variety of people including state government officials and employers, school staff, suicide survivors, public safety and corrections officials, LGBT advocates, health care professionals, members of the clergy, those working in military or veteran's affairs, mental health agencies and health agencies. Overall, hundreds of e-mail invitations were sent to encourage participation. In addition, specific invitations were made to key stakeholders identified by the planning committee. People were invited to provide feedback directly to planning committee members if they were unable to participate in any of the public venues. All feedback was gathered into an aggregate report to the program for use in revising the goals, objectives, and activities contained in the Maine Suicide Prevention Strategic Plan. Quotes from the stakeholder process are interspersed throughout this plan.

Background

Maine Suicide Prevention Program History

The Maine Youth Suicide Prevention Program (MYSPP) began as an initiative of Governor Angus S. King's Children's Cabinet which included the commissioners of the Departments of Health and Human Services, Education, Corrections, Labor and Public Safety. The original MYSPP plan was created in 1997 through an extensive process that included input from suicide survivors, youth, and many clinicians and professionals from around the state. That plan was updated in 2007.

When implementation began in 1998, staff in every agency of the Governor's Children's Cabinet were instructed to include youth suicide prevention as a priority using existing agency funds. Each agency was asked to assume leadership in implementing specific parts of the plan in order to build and sustain a state level infrastructure. The plan was built upon the Governor's Task Force recommendations and the best available information at the time. In 1999, the Children's Cabinet provided funds to initiate priority program activities. Many activities in the initial plan are still being implemented.

Since inception, the MYSPP has received regional and national recognition for its efforts. Staff and partners have made many presentations at state, regional and national events. Maine has contributed to the national suicide prevention evidence base through its work, most notably through implementing and evaluating *Lifelines*, a comprehensive school-based program, with a grant from the U.S. Centers for Disease Control and Prevention (CDC). This project was conducted in 12 Maine high schools from 2002-2006. Project evaluation enabled the program to bring the *Lifelines* student lessons into the National Registry of Evidence-based Programs and Practices (www.nrepp.com).

In September 2005, the MYSPP was awarded a Garrett Lee Smith Memorial Act (GLS) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year youth suicide prevention project reaching 6 Maine high schools and selected community agencies. In 2006, an additional grant award to conduct an in-depth evaluation of the SAMHSA project was obtained from the U.S. CDC. In 2008, a second SAMHSA GLS three-year grant award was received and another 11 Maine high schools, several Maine tribes and Maine colleges became engaged in implementing suicide prevention programs. Through the two SAMHSA funded projects, 17 schools and 29 community agencies serving these school communities identified over 500 youth at risk and referred them for help.

In 2011, the program, with the Advisory Council, decided to expand the focus from youth aged 10-24 to a lifespan focus. This decision was based on emerging data showing that the highest and fastest growing rate of suicide in Maine is among adults. At that time, the program became the Maine Suicide Prevention Program (MSPP).

Components of the Maine Suicide Prevention Program 2012

Statewide Crisis Hotline 1-888-568-1112: A statewide crisis hotline automatically connects in-state callers to the crisis service provider in the area from which they are calling. This line is for ALL individuals in crisis or concerned friends or loved ones and provides immediate, local assistance in a crisis situation 24/7.

Statewide Information Resource Center (IRC) 1-800-499-0027
http://osairc.informe.org The Office of Substance Abuse and Mental Health Services IRC in the Department of Health and Human Services has a wide selection of suicide prevention materials. Resources include print and audio- visual educational materials.

MSPP Website: www.maine.gov/suicide contains resources, downloadable materials and links to national suicide prevention sites.

Guidance and Support for School-based Prevention Policies and Crisis Intervention Teams: Careful, advanced planning is crucial to preventing suicide, managing a crisis, and preventing additional crises in the school setting. School Administrative Unit (SAU) administrators and Crisis Intervention Teams have an essential role to play to assist youth in crisis while maintaining control of the learning environment. Part of advanced planning for an effective crisis response is the development of written cooperative agreements between School Administrative Units and local Crisis Service providers.

School-based plans and procedures: Procedures to guide staff in effectively identifying, screening and assisting students at risk for a variety of issues, including suicide, are vitally important. MSPP School Guidelines help school administrators establish crisis intervention and suicide prevention procedures.

MSPP Training: Training is a cornerstone of the MSPP. Because suicide can happen in any age group, in any community, in families of any income or educational level, everyone has a role to play in learning about preventing suicide. A variety of training and education programs provide learning opportunities to increase knowledge and practice intervention skills to prevent suicide. MSPP is committed to offering quality educational opportunities to mental health clinicians, and individuals working in schools, colleges and health care settings who need risk assessment and intervention skills and resources.

Student Suicide Prevention Education: Training for schools in *Lifelines*, an evaluated suicide prevention curriculum, Transitions and Middle School Lessons are offered. These programs are designed to integrate into comprehensive school health education and address a variety of youth risk behaviors and build youth help-seeking skills.

Lethal Means Education: An impulsive act by a suicidal person can be fatal. From 2006-2010, 53 percent of all suicides among Maine residents involved a firearm. A number of studies have shown that, when lethal means are less available or those that are available are less deadly, suicide rates by that method, and overall suicide rates, decline. [2]

[2] Harvard School of Public Health, Means Matter Basics

A Public Health Approach To A Public Health Problem

In the past decade, suicide has been widely recognized as a public health problem requiring national attention and urgent action in the United States. Prior to the issuance of the National Strategy to Prevent Suicide, suicide was viewed as a mental health issue, and only the highest risk groups were addressed, primarily through clinical intervention. These strategies only had a modest effect on population suicide rates, and as a result, population-based strategies are now promoted to reduce suicide in the entire population.[3] Within the last two decades a public health approach to suicide prevention has emerged based upon a good understanding of the biological and psychosocial factors that contribute to suicidal behaviors. The 2001 National Strategy for Suicide Prevention issued by the U.S. Surgeon General emphasized that suicide is a significant public health problem, which requires integrated efforts by all sectors of society, and applications of a broad range of interventions, programs and policies.

Because suicide is such a serious public health problem, public health methods are promoted as the most effective means to address it. The public health approach represents a rational and organized way to organize prevention efforts and ensure their effectiveness. The basic-steps of the Public Health approach are: 1) clearly define the problem; 2) identify risk and protective factors; 3) develop and test interventions; 4) implement interventions; and 5) evaluate effectiveness.

Maine follows this approach. An important foundation to interventions is an array of training programs which serve as the cornerstone of the Maine Suicide Prevention Program (MSPP). The MSPP offers a variety of training and education programs that provide a face-to-face learning opportunity to dispel myths, address misconceptions, increase knowledge and *practice intervention* skills to prevent suicide. Because suicide can happen in any age group, in any community, in families of any income or educational level, *everyone has a role to play in preventing suicide* and can benefit from education and training.

Training and education in effective suicide prevention strategies are essential for professionals in direct contact with individuals who may be at risk. Training facilitates the early identification, effective support and appropriate treatment of persons at risk. Suicide prevention is most effective when direct service staff are trained and suicide prevention knowledge is integrated into organizations and agencies across the spectrum from service agencies, health care providers, first responders to employers. Addressing suicide prevention in schools, community-based agencies and organizations and health care settings is vital to the health and well-being of all persons living in Maine.

[3] PSF Yip, "A Public health Approach to Suicide Prevention". Hong Kong Journal of Psychiatry 2005; 15: 29-31.

The Costs of Suicide

Suicide deaths have immediate and long-term emotional, financial, and social consequences. The impact of suicide is not, however, limited to untimely death. Many more people survive suicide attempts than die by suicide. Nationally, researchers estimate that for every person who dies by suicide, 25 to 100 others attempted suicide.[4] The rate of suicide attempts is highest in adolescents and young adults. The single best predictor for dying by suicide is a previous suicide attempt. Prevention programs strive to reduce the burden of suicide by identifying people at risk of suicide and getting them the help they need, ideally before they make an attempt.

While families suffer the greatest impact from suicide deaths and attempts, the economic burden is spread through many layers of society: families, employers, government, insurers, and taxpayers. Some costs are known: for example, emergency department visits and hospitalizations for self-inflicted injuries; other costs are hidden: such as the cost of police officers who investigate suicide deaths or threats. The available economic data are startling, but they underestimate the true financial cost of suicide deaths and attempts.

Direct and Indirect Economic Costs

- The annual medical cost of deaths by suicide in Maine averages $573,841.48 (in 2010 dollars)
- The annual medical cost of suicide attempts requiring hospitalization in Maine averages $15,139,952 (in 2010 dollars)
- The annual lost productivity cost for deaths by suicide in Maine averages $206,977,005 (in 2010 dollars)
- The annual lost productivity cost for suicide attempts requiring hospitalization in Maine averages $16,222,580 (in 2010 dollars)

Source: Children's Safety Network Economics & Data Analysis Resource Center, at Pacific Institute for Research & Evaluation (PIRE), Calverton, MD, 6/2013. Incidence Data: Fatal injury incidence obtained from the National Center for Health Statistics Multiple Cause-of-Death File, 2006-2010, divided by 5 to annualize. Incidence of hospital admissions based on 2009 data from Maine and obtained from the Maine State Inpatient Databases (SID), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). Incidence of hospital admissions exclude patients who were dead at the time of discharge, readmission cases, transfers (e.g., from another short or long-term care facility), medical misadventures, and/or suffered non-acute injuries. All counts based upon the patients' state of residence. All costs were adapted using state specific price adjusters and calculated in year 2010 dollars.

[4]McIntosh, JL. (2009). *U.S.A. Suicide 2006: Official Final Data*. Washington, DC: American Association of Suicidology. Retrieved from http://www.suicidology.org.

Emotional and Social Costs

The emotional burden of suicide spreads through the layers of our communities, impacting families, friends, peers, teachers, employers and co-workers, health care professionals, and public safety officials in many ways. The most immediate and severe burden is experienced by the family and friends closest to the victim. A conservative estimate is that there are six survivors for every person who dies by suicide;[5] thus in Maine, almost 1000 citizens become survivors of suicide yearly. In this plan, a suicide survivor is defined as someone who lost a family member or friend to suicide. People who attempted suicide and survived their attempts are also called suicide survivors.

"The person who dies by suicide puts his psychological skeleton in the survivor's emotional closet."...Edwin Shneidman, referred to as the "father of suicidology" by experts in the field.

The death of a loved one by suicide is itself a risk factor for suicide. Survivors frequently report difficult problems and challenges following the suicide death of a loved one. These include:[6]

- A prolonged and intense search for the reason for the suicide
- Feelings of rejection by the deceased
- A distorted sense of responsibility for the death and the ability to have prevented the suicide
- Feelings of being blamed, by others or themselves, for causing the problems that led to the suicide; and
- Elevated levels of anger, family dysfunction, and feelings of social stigmatization

The widespread costs of suicide, the deep impact of suicide on survivors, and the fact that suicide itself can lead to additional deaths by suicide, underscore the importance of a public health approach to suicide prevention.

"I learned about suicide and suicide prevention after the worst nightmare in my life, through the loss of my 19 year old son, Joe Day, who died on November 18, 2005 by suicide. I cannot tell you the devastation this has brought to me, my family, and all the people who loved Joe so much."…Cheryl Morin

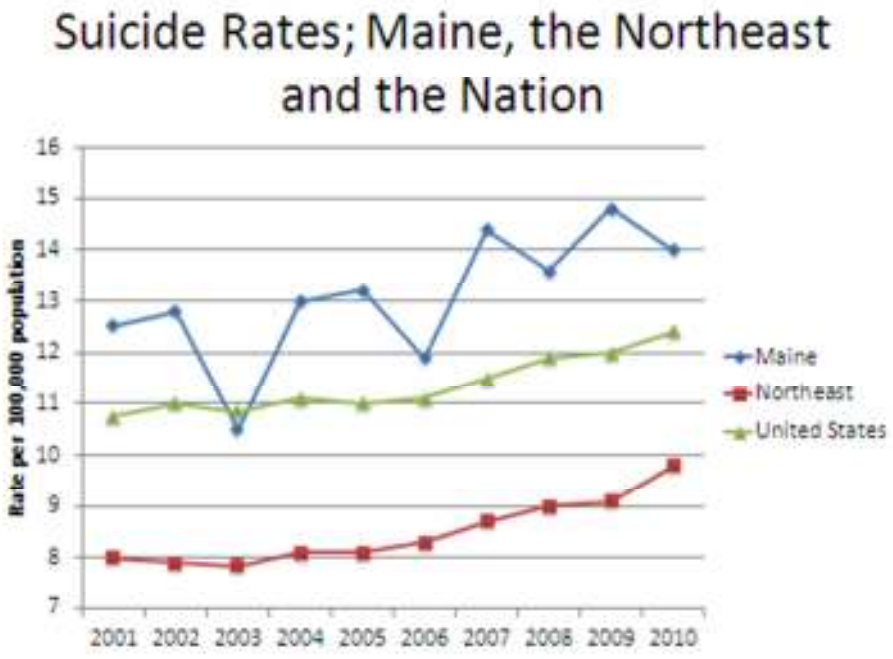
[5]American Association of Suicidology (2007). *Suicide in the U.S.A*. Retrieved from www.suicidology.org/associations/1045/files/Suicides in the US.pdf.
[6]National Association of State Mental Health Program Directors. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Alexandria, VA: National Association of State Mental Health Program Directors.

Suicide and Suicidal Behavior

Suicide as Cause of Death

The suicide rate in Maine is currently higher than the national rate; and the second highest in the Northeast. This is, in part, a reflection of Maine's demographic composition, rural nature and high gun ownership. Suicide rates vary by age, ethnicity, and gender, and are highest among white males, both of working age and seniors.[7] According to 2010 census data, Maine has the highest percentage of white non-Hispanic people in the country, and the most rapidly aging population.[8]

Historically, the rate of suicide in Maine has been fairly stable. Recently there has been an increase in the number of deaths, from an average of 162 per year between 2001 and 2005, to an average of 183 deaths from 2006 to 2010. In 2011, preliminary data indicate that 204 Maine citizens died by suicide.[9] This increase is cause for concern and provides a strong impetus for action.



Data Source: 2000-2010 U.S. CDC WISQARS; 2011 preliminary Maine Medical Examiner's Office data

[7]Minino AM, Anderson RN, Fingerhut LA, et al. (2006) Deaths: Injuries 2002. *National Vital Statistics Reports*, 54 (10). Hyattsville, MD: National Center for Health Statistics.
[8]Miller, K. (2010). Census: Maine Oldest, Whitest State in Nation. *Bangor Daily News*, April 20, 2010. Retrieved from http:bangordailynews.com/detail/105991.html.
[9]U.S.CDC WISQARS 2000-2010; 2011 preliminary Maine Medical Examiner data

Suicide is the leading cause of violent death in Maine [10] killing almost seven times as many people each year as homicide between the years 2002-2010. For all ages combined, suicide is the tenth leading cause of death. Suicide is the second leading cause of death for youth and adults ages 15-34, the fourth leading cause of death for adults ages 35-54, and the eighth leading cause of death for adults ages 55-64. Suicide is not among the top ten causes for adults over age 65 as other medical issues increase mortality.

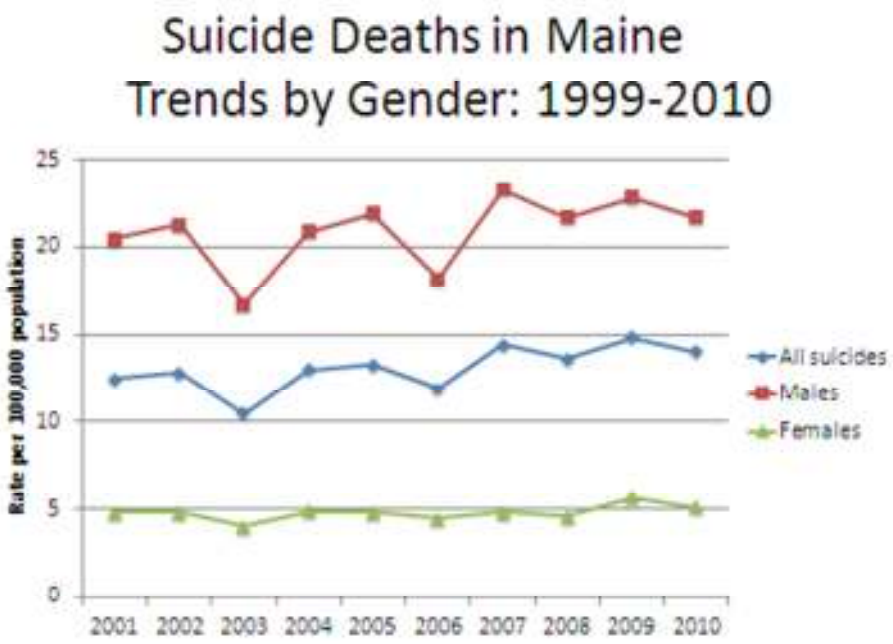
Suicide Across the Lifespan: Rates and Percent of Total for 2001-05 and 2006-10

Age Group	2001-05 Number	Rate per 100K	Percent of Total	2006-10 Number	Rate per 100K	Percent of Total	%Change in Rate
10-19	48	5.21	5.9%	42	4.84	4.6%	-7.1%
20-24	53	13.94	6.5	62	15.27	6.8	+9.5%
25-29	54	15.80	6.67	57	15.15	6.2	-4.1%
30-34	70	17.26	8.6	47	13.01	5.1	-24.6%
35-39	76	15.91	9.4	73	17.42	8.0	+9.5%
40-44	73	13.35	9.0	97	20.14	10.6	**+80.8%**
45-49	84	15.52	10.4	103	18.82	11.3	**+21.2%**
50-54	84	16.81	10.4	126	23.38	13.8	**+39.1%**
55-59	70	17.04	8.6	85	17.28	9.3	+1.4%
60-64	41	13.18	5.0	60	15.03	6.6	+14.0&
65-69	41	15.98	5.0	45	15.36	4.9	-3.8%
70-74	41	18.01	5.0	31	13.38	3.4	-25.7%
75-79	21	10.79	2.6	30	15.38	3.4	**+42.5%**
80-84	24	17.21	2.9	25	16.71	2.7	-2.9%
85+	30	24.41	3.7	30	21.70	3.4	-11.0%
	T=810			T=913			

Data from *Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC

Eighty percent of Maine citizens who die by suicide are male; rates have traditionally been highest among men over age 85, though the rates have increased sharply among middle aged men over the past half-decade. Comparing the time period of 2001-05 to 2006-10, the rate of suicide in males ages 40-44, 45-49 and 50-54 increased by 40 percent, 35 percent and 65 percent respectively. Among women, the highest suicide rates are experienced by those 35 to 64 years of age. The greatest gender disparity in suicide rates is among elders and youth. Nationally, almost 85 percent of suicides after age 65 are male; in Maine, 92 percent of suicides in elders were men in years 2001-05.[11] Males comprised 85.5 percent of the completed suicides in youth age 10-24 in years 2005-09. The best single explanation for the higher suicide rate for men is that a much greater percentage of men use firearms as the means for their suicide attempts.

[10] *Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC Website: http://www.cdc.gov/ncipc/wisqars/default.htm.
[11] *Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC Website: http://www.cdc.gov/ncipc/wisqars/default.htm.



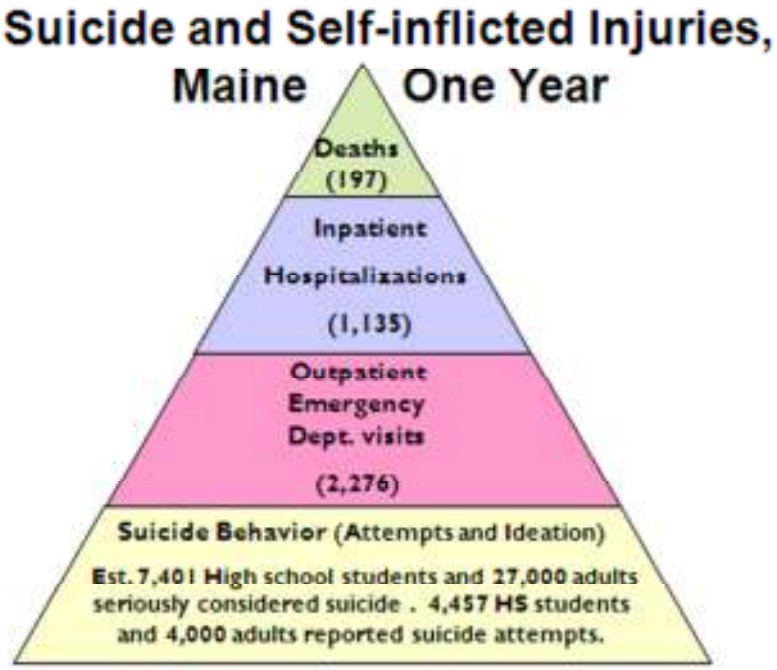
Data Source: 2000-2010 U.S. CDC WISQARS; 2011 preliminary Maine Medical Examiner's Office data

Suicidal Behavior as Cause of Injury

Some non-fatal suicidal behavior comes to the attention of health care professionals, but much does not. Experts estimate that for every death by suicide, another 25 to100 people attempt suicide, depending on the age group. Suicide attempts result in significant health care costs, such as hospital and emergency department visits.[12] Maine survey data confirm that a significant number of youth and adults report considering suicide every year. During 2006-2008, three percent of Maine adults surveyed reported thinking about, planning, or attempting suicide in the previous twelve-month period.[13]

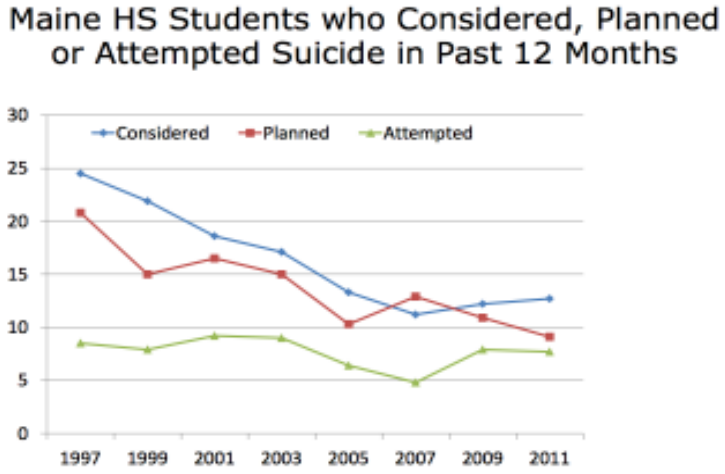
[12]McIntosh, JL. (2009). *U.S.A. Suicide 2006: Official Final Data*. Washington, DC: American Association of Suicidology. Retrieved from http://www.suicidology.org. *See also* Centers for Disease Control and Prevention. (2009). Suicide Facts at a Glance, Summer 2009. Retrieved from http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf. The number of attempts varies by age. For young adults age 15 to 24 years, there are 100-200 attempts for every completed suicide; for older adults, there are approximately four suicide attempts for every completed suicide.

[13]State of Maine, Center for Disease Control and Prevention. (2007). Maine Behavioral Risk Factor Surveillance System 2006-2007. Retrieved from http://www.maine.gov/dhhs/boh/phs/odrvs/brfss/index.shtml.



Data Source: 2000-2010 U.S. CDC WISQARS; 2009 Hospital Discharge database, 2011 MIYHS Survey, 2006-08 BRFSS Data

During 2011 among high school students, an estimated 12.7 percent reported seriously considering suicide, 9.1 percent planned their suicide, and 7.7 percent reported attempting suicide. An estimated 4,030 seventh and eighth grade students reported that they had ever seriously considered suicide and 1,656 had ever made an attempt.[14] The good news is that these numbers represent a significant decline in the percent of students reporting suicide ideation or attempts since the initial survey in 1997.



Data Source: 1997-2007 YRBS; 2009-2011 MIYHS YRBS Module

[14]State of Maine, Center for Disease Control and Prevention. (2007). Maine Behavioral Risk Factor Surveillance System 2006-2007. Retrieved from http://www.maine.gov/dhhs/boh/phs/odrvs/brfss/index.shtml.

From 2005-2009, the average number of hospitalizations in Maine for self-inflicted injury was 1,100 per year. The rate of hospitalizations, per 10,000 population, has remained fairly steady from 2005 to 2009, at an age-adjusted rate of about 10.4 hospitalizations per 100,000 population[15]. Outpatient visits to hospital emergency departments for self-inflicted injury increased significantly from 2000 to 2009. The actual number of emergency department visits more than doubled during that time, and the rate of visits rose from 10.2 in 2000 to 21.9 in 2009 (per 10,000 population).

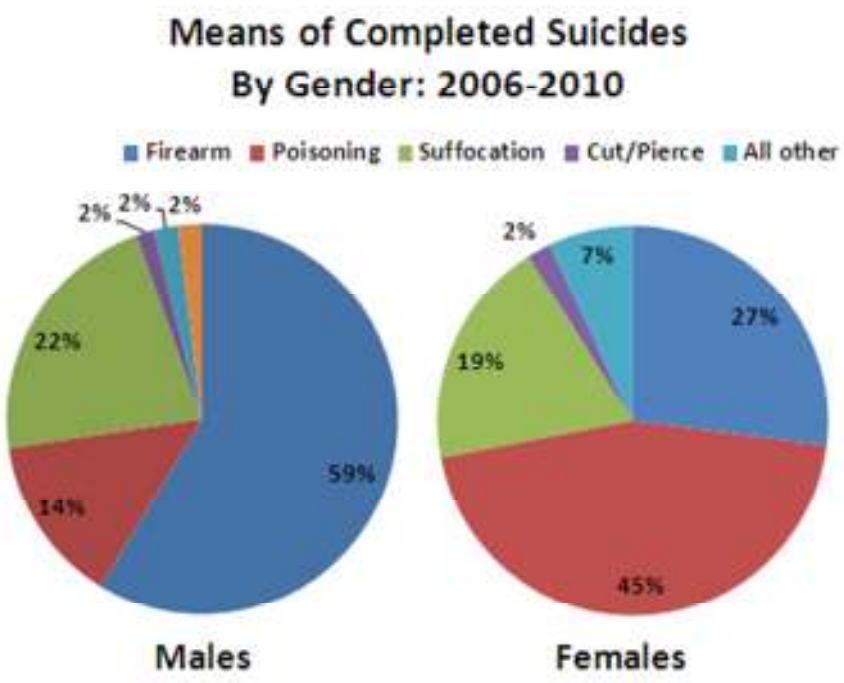
Youth and young adults between ages 15 and 34 have the highest rates of hospitalization and emergency department visits and combined, making up a significant majority of self-inflicted injury visits. The rates of both hospitalizations and emergency department visits decrease sharply after age 44.

While men are four times more likely to die by suicide, women are three times more likely to attempt suicide with the highest gender disparity among young adults.[16] Women are more likely to be hospitalized for self-injurious behavior. Though the overall rate for self-injury emergency department visits in the years 2005-09 was 18.3, the rate for females was 22.7[17].

Means of Suicide and Self-Injury

Firearms are the most common and most lethal method of suicide across all age groups, accounting for just over half (53%) of all suicides in Maine. From 2006 to 2010, a firearm was used in 59 percent of male suicides and 27 percent of female suicides.[18] Because men die by suicide at a higher rate than women, the result is a firearm suicide death rate that is much higher for males than females. Concern about firearm availability and its associated impact on suicide is due to the very high lethality of firearms when compared to other means of suicide.

[15] State of Maine, Maine Health Data Organization. (2005-2009). Hospital Discharge Inpatient Data and Hospital Emergency Department Data. Retrieved from http://mhdo.maine.gov/imhdo/datasetsavailable.aspx.
[16] Krug EG, Dahlberg LL, Mercy JA, et al. (2004). *World Report on Violence and Health*, May 2004. Retrieved from who.int/violence_injury_prevention/violence/world_report/wrvh1/en.
[17] State of Maine, Maine Health Data Organization. (2005-2009). Hospital Discharge Inpatient Data and Hospital Emergency Department Data. Retrieved from http://mhdo.maine.gov/imhdo/datasetsavailable.aspx.
[18] *Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC Website: http://www.cdc.gov/ncipc/wisqars/default.htm.



Data Source: 2000-2010 U.S. CDC WISQARS; 2011 preliminary Maine Medical Examiner's Office data

Poisoning and suffocation (hanging) are the next most common methods in completed suicides, each accounting for about 20 percent of all suicides between 2006-10. Suffocation accounts for an equal proportion of suicides among both males and females, while poisoning is the leading cause of suicide death in females. These three methods account for over 90% of all suicide deaths.

For youth age 10-24 years, the means used in completed suicides from 2005-2009 was almost equally divided between firearms and suffocation (hanging). These two methods accounted for 88 percent of youth deaths with poisoning responsible for slightly more than 7 percent.[19]

Methods for self-inflicted injury requiring hospital care are those less likely to result in death. The most prevalent self-injury method resulting in hospital care is poisoning, then cutting and other forms of self-injury. This is true for males and females.

[19] State of Maine, Center for Disease Control and Prevention. (2011). *Youth Suicide Deaths in Maine; 2005-2010.* Joseph Riddick.

Location of Suicide and Self-Injury

Maine does not compile statistics on the location of suicide deaths, but federal data[20] indicate that almost all (88.7 percent) suicides occur at home or in public places. Very few people (2.7 percent) die in supervised settings such as schools or colleges, jails, hospitals, or health care facilities. A recent study conducted by the MSPP reviewing data from the Maine Violent Death Reporting System,[21] revealed that youth between the ages of 10 to 24, align with national data on place of death.

Causes of Suicide and Suicidal Behaviors

Why people engage in suicidal behavior is the most vexing question confronting research about suicide, and the most important question for suicide prevention. As the American Foundation for Suicide Prevention says, "Suicide is not a disease – but can be the worst possible outcome of many illnesses and conditions." [22] Suicide is the result of many complex factors, with current thought indicating that suicide requires mental preparation for a person to become capable of taking his or her life. [23] Although suicides or suicide attempts may seem impulsive, when individual cases are examined more closely they generally have a vulnerability toward suicide, including several identified risk factors and warning signs for suicide. Many persons at risk for suicide have active suicidal thoughts for some time before an attempt or death by suicide.

> *"I will live the rest of my life wishing I had known what I know today. My hope is that by telling my story, no one will have to say I wish I had known. I can no longer save my son, but I hope to save other families from having to live with the pain that my family will live with for the rest of our lives."*...Sandra Fisher

Researchers have focused on identifying risk and protective factors, but even this poses a paradox: for example, many people who die by suicide have a mood disorder such as depression, but most people with depression do not kill themselves. Current thinking is that the interaction of multiple risk factors, buffered by certain protective factors, often combined with a triggering event, influences a person's decision to die by or to attempt suicide. [24]

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[20]U.S. Centers for Disease Control and Prevention. (2008). Surveillance for Violent Deaths – National Violent Death Reporting System, 16 Sates, 2005. *Morbidity and Mortality Weekly Report*, 57(14), April 2008.

[21]State of Maine, Center for Disease Control and Prevention. (2011). *Youth Suicide Deaths in Maine; 2005-2010.* Joseph Riddick.

[22]American Foundation for Suicide Prevention. (2009). *Suicide Prevention Priorities for Health Reform 2009.* Retrieved from http://healthyamericans.org/assets/files/Suicideprevention.pdf.

[23]Joiner, T. (2010). *Myths about Suicide*. Cambridge, MA: Harvard University Press.

[24]National Association of State Mental Health Program Directors. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Alexandria, VA: National Association of State Mental Health Program Directors.

Risk factors can be divided into various domains; some examples are:[25]

- **Societal:** Unsafe media portrayals of suicide, or availability of lethal means
- **Community:** Few available sources of supportive relationships or barriers to healthcare
- **Relationship:** High conflict or violent relationships, family history of suicide
- **Individual:** Mental illness, substance abuse, previous suicide attempt, impulsivity/aggression

There is no exact combination of risk factors and triggering events that predict an individual's suicide risk. As the research continues to develop, it is becoming clear that some risk factors for suicide are more prevalent than others. These considerations are important when developing a public health-oriented prevention plan: because so many people potentially are at risk, effective prevention strategies need to involve everyone; knowing who is at risk helps to identify the most effective interventions. [26]

Groups at Increased Risk of Suicide

The greatest risk of suicide is posed by people who made a **previous suicide attempt**. Between 12 and 30 percent of suicide attempters will make subsequent attempts within a year. [27] Studies have shown that following a significant suicide attempt, approximately 10 percent of suicide attempters will die by suicide within 10 years.

It is estimated that up to 90 percent of people who die by suicide suffer from **depression** or **other diagnosable mental illnesses**. [28] Many of these individuals were not diagnosed or in treatment before their death. Suicide is the leading cause of early mortality among people who have schizophrenia. [29] Depression, other mood disorders and anxiety, are the most common diagnoses. Research indicates that between 60 and 85 percent of people who die by suicide suffer from depression. [30] In study after study,

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[25] Dahlberg LL, Krug EG. Violence—a global public health problem

[26] Caine, ED. (2005). *Suicide Prevention in 2005 – Moving from Identified Risk Factors to Prevention Programs*, University of Rochester CSPS, 2005. Presentation to meeting of National Council on Suicide Prevention, New York City, January 20, 2005. Retrieved from http://www.omh.state.ny.us/omhweb/savinglives/volume1/vol1_a_publichealthstrategy.htm.

[27] Vaiva G, Vaiva G, Ducrocq F, et al. (2007). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: randomized controlled study. *British Medical Journal*, 332(7552), 1241-1245.

[28] Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association,* 294(16), 2064-74; Nock M, Borges G, Bromet E, et al. (2008) Suicide and Suicidal Behavior. *Epidemiological Review*, 30(1), 133-154.

[29] National Association of State Mental Health Program Directors. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Alexandria, VA: National Association of State Mental Health Program Directors.

[30] Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association,* 294(16), 2064-74; Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry,* 51(3), 143-154; Conwell Y, Duberstein PR, Hirsch JK, et al. (2009). Health Status and suicide in the second half of life. *International Journal of Geriatric Psychiatry*.

depression is the single most common risk factor identified in specific population groups, such as older adults and ethnic or sexual minority groups.

The fact that depression is the most common risk factor for suicide confirms the importance of a public health approach to suicide prevention. Depression and other mood disorders affect people of all ages, geographic locations, socioeconomic levels and educational levels. Almost 21 million adults – 9.5 percent of the population over age 18 – have a mood disorder, often co-occurring with anxiety disorders and substance abuse. About half of Americans will be diagnosed with one of these disorders sometime in their life, with first onset of symptoms usually in childhood or adolescence. Median age of onset is much earlier for anxiety and impulse-control disorders (11 years) than for substance use (20 years) and mood disorders (30 years). Half of all lifetime cases of mental illness start by age 14 and three-fourths by age 24. [31]

Effective treatment exists for mood disorders, but the National Institute for Mental Health estimates that only 20 percent of people diagnosed with depression receive treatment consistent with current practice guidelines. [32] One study estimated that if major depressive episodes were effectively treated in older adults, the suicide rate would decrease 75 percent in this group. [33]

Most people across the spectrum of suicidal behaviors do not receive treatment for either mental illness or substance abuse. Currently, crisis centers and mental health resources are not accessed by most people who need help. [34] Eighty percent of adults with a diagnosable mental illness who died by suicide were untreated at the time of their death (this figure is 90 percent for youth). [35] National risk behavioral surveys have found that for young adults in college, 85 percent with depression who were thinking about suicide were not receiving any treatment. [36]

"I will continue to speak out about suicide and depression because I am determined to remove the stigma associated with suicide and to help people talk about it without shame. There is no shame."…Sandra Fisher

[31]Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*. 2005 Jun;62(6):593-602

[32]National Institute of Mental Health. (2010) *Science Update: Just Over Half of Americans Diagnosed with Major Depression Receive Care*, January 4, 2010. Retrieved from http://www.nimh.nih.gov/science-news/2010/just-over-half-of-americans-diagnosed-with-major-depression-receive-care.shtml

[33]Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America,* 31(2), 333-356.

[34]Joffe P. (2008). An empirically supported program to prevent suicide in a college student population. *Suicide and Life Threatening Behavior*, 38(1), 87-103.

[35]Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association,* 294(16), 2064-74.

[36]Tompkins TL, Witt J. (2009). The short-term effectiveness of a suicide prevention gatekeeper training program in a college setting with residence life advisers. *Journal of Primary Prevention*, 30(2), 131-149.

Substance abuse increases the risk of suicide for adolescents, young adults, and middle-age adults. [37] Acting as a disinhibitor, alcohol is involved in up to 64 percent of suicide attempts or completions, many of them associated with a combination of impulsivity, anger, and relationship losses. [38] At least one-third of people who die by suicide have an alcohol use disorder; [39] the findings from several autopsy studies reveal that 25 percent of all individuals who died by suicide were intoxicated at the time of death. [40] While depression and alcohol abuse frequently co-occur in people who are suicidal, depression can be a consequence of the substance abuse. One study of people with a history of alcohol abuse who attempted suicide found that while 87 percent had depression, for 55 percent their depression was alcohol-induced, which rapidly resolved with substance abuse treatment. [41]

The suicide rate is typically high among white **older men**. Mental health is a significant risk factor for suicide in older adults, along with isolation. Between 71 and 95 percent of adults, ages 65 and older who die by suicide, have a mental illness, primarily a mood disorder (54-85 percent). [42] There is added risk for suicide from most chronic physical illnesses. [43] Although many older adults seen in primary care practices who subsequently died by suicide brought physical complaints to their physicians, it was actually mental illness factors that were associated with their deaths. [44]

Men in their mid-adult years, from their early 20s through their 50s, account for the largest number of suicides and the majority of years of life lost due to suicide. [45] Studies suggest that the factors that may increase the risk for suicidal behaviors in this group are similar to those among other age groups and in both sexes: mental illness that can be discerned from retrospective analyses (particularly mood disorders), substance use

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[37]Garlow, SJ. (2008). Depression, desperation, and suicidal ideation in college students: results from the American Foundation for Suicide Prevention College Screening Project at Emory University. *Depression and Anxiety*, 25(6), 482.

[38]Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press. Retrieved February 12, 2008, from http://www.nap.edu/catalog.php?record_id=10398.

[39]Conner KR, Hesselbrock VM, Schuckit MA, et al. (2006). Precontemplated and impulsive suicide attempts among individuals with alcohol dependence. *Journal of Studies in Alcoholism,* 67(1), 95-101.

[40]Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press. Retrieved February 12, 2008, from http://www.nap.edu/catalog.php?record_id=10398.

[41]Conner KR, Hesselbrock VM, Schuckit MA, et al. (2006). Precontemplated and impulsive suicide attempts among individuals with alcohol dependence. *Journal of Studies in Alcoholism,* 67(1), 95-101.

[42]Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America,* 31(2), 333-356; Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry,* 51(3), 143-154.

[43]Conwell Y, Duberstein PR, Hirsch JK, et al. (2009). Health Status and suicide in the second half of life. *International Journal of Geriatric Psychiatry*.

[44]Pfaff JJ, Almeida OP. (2005). Detecting suicidal ideation in older patients: identifying risk factors within the general practice setting. *British Journal of General Practice,* 55(513), 269-273.

[45] Knox K, Caine E. Establishing priorities for reducing suicide and its antecedents in the United States. *Am J Public Health*. 2005;95 (11):1898-1903.

disorders (particularly alcohol abuse), and access to lethal means. [46] These factors are likely to be exacerbated by other risk-related characteristics that occur more frequently among males, such as the underreporting of mental health problems, a reluctance to seek help, engagement in interpersonal violence, distress from economic hardship (e.g., unemployment), and dissolution of intimate relationships. [47][48]

People living in rural areas appear to have a greater risk of suicide. Rural states have the highest suicide rates in the country. One study of people diagnosed with bipolar disorder found that people in rural areas had higher rates of suicide attempts when compared to people with similar life situations living in urban areas. [49] This may be a result of higher poverty rates, a higher percentage of older adults in rural populations, the impact of stigma in small communities, and decreased access to mental health services.[50] The greater sense of isolation from social and professional support and intervention adds to the increased risk in rural areas. According to the 2010 US Census, Maine is considered the most rural state in the nation, with almost 62 percent of its citizens living outside an urban setting.

Race and ethnicity contribute to suicide risk. In the United States, the highest rates of suicide deaths are among American Indians and Native Alaskans with 17.48 suicides per 100,000 and Non-Hispanic Whites with 15.99 suicides per 100,000.[51] Suicide statistics related to American Indians are considered to be unreliable because of the small population size, the small number of reported suicide deaths and death records that lack designation of ethnicity. Suicide is, however, a leading cause of death among American Indians and Alaskan Natives in the U.S. between ages 15 and 24.[52]

A Department of Defense report found that suicide by **active military personnel** in the Army and Marines "increased sharply" from 2005 to 2009, with the rate more than doubling in the Army during this period.[53] The Veterans Administration (VA) estimates

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[46] Tondo L, Baldessarini RJ, Hennen J, et al. Suicide attempts in major affective disorder patients with comorbid substance use disorders. *J Clin Psychiatry.* 1999; 60 Suppl 2:63-69.

[47] Oliffe JL, Phillips MJ. Men, depression and masculinities: A review and recommendations. *J Mens Health.* 2008; 5(3):194-202.

[48] Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol.* 2003; 58(2):5-14.

[49]Gamm, L.D., L. Hutchison, B.J. Dabney, et al, eds. (2003). *Rural Healthy People 2010: Volume 2*. College Station, TX: Texas A&M University System Health Science Center.

[50]Suicide Prevention Action Network. (2005). Lost in rural America. *Advancing Suicide Prevention*, July/August 2005, 16-20.

[51] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. Suicide Rates Among Persons Ages 10 years and Older by Race/Ethnicity, United States, 2005-2009. http://www.cdc.gov/ViolencePrevention/suicide/statistics/rates01.html.

[52]*Web-based Injury Statistics Query and Reporting System*. (2005). Retrieved from National Center for Injury Prevention and Control, CDC Website: http://www.cdc.gov/ncipc/wisqars/default.htm

[53]U.S. Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. (2010). *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives*. Washington, D.C: Department of Defense.

that as many as **5,000 veterans** die by suicide every year.[54] The elevated risk for suicide is highest among those who have severe mental illness; combat-related post-traumatic stress disorder (PTSD); traumatic brain injury, amputation or disfigurement; military sexual trauma; and spinal cord injuries. A study of veterans receiving care through the VA found that suicide occurs in different patterns than in the general population. Suicide risk is higher for younger rather than older veterans, especially when PTSD is present, and suicide rates are more equal for male and female veterans than in the general population.[55] Based on the 2010 US census, Maine has the second highest proportion of veterans in the country at 10.4 percent.

Lesbian, Gay, Bi-Sexual and Transgender (LGBT) status is considered a risk factor for suicide though the actual numbers and rate of suicide in this population is difficult to know accurately. Sexual orientation is not information that is collected, or necessarily known at the time of death. Studies have found that LGBT youth have a significantly higher rate of suicide attempts than others in their age group. The driving force behind LGBT suicidal behavior is seen as the familial and societal stigma and rejection associated with minority sexual status. [56]

Despite a significant decrease in the rate of suicides in prisons and jails, primarily because of the strong focus by corrections departments on identifying and managing inmates at risk of suicide, suicide by **incarcerated people** remains a leading cause of death in state prisons and local jails. The suicide rate in jails is three times higher than in prisons. Although many risk factors contribute, mental illness is the most common; half to two-thirds of inmates have a mental illness that increases their risk for suicide.[57]

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[54]U.S. Department of Veterans Affairs. (2007). *Healthcare Inspection: Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention.* Report No. 06-03706-126, May 10, 2007. Washington, D.C.: VA Office of the Inspector.

[55]Zivn J, Kim M, McCarthy JF, et al. (2007). Suicide mortality among individuals receiving treatment for depression in the Veterans Affairs Health System: associations with patient and treatment setting characteristics. *American Journal of Public Health*, 97(12), 2193-2198.

[56]Ryan C. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual youth and adults. *Pediatrics,* 123, 346-352.

[57]Blasko B. (2008). Suicide risk assessment in jails. *Journal of Forensic Psychology Practice,* 8(1), 473.

Suicide Prevention: Research-based Best Practices

Recent published studies of suicide prevention programs clarify what types of prevention programs work and why, and what types should be discarded as ineffective or harmful. The best suicide prevention programs are multidimensional and use a variety of proven or promising strategies often called "best practices". While continued research is needed and program impact must continue to be evaluated, more knowledge about preventing suicide is available now than in the past.

From 2003 to 2005, the Suicide Prevention Resource Center (SPRC) in collaboration with the American Foundation for Suicide Prevention (AFSP) developed a registry of evidence-based programs for suicide prevention to answer an objective of the 2001 National Strategy for Suicide Prevention to "establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors."[58] The goals of this Evidence-Based Practices Project (EBPP) were to review the effectiveness of suicide prevention programs and to create an online registry of information about these programs.

In 2005, SAMHSA began reviewing and listing programs for suicide prevention and intervention in their National Registry of Evidence Based Programs and Practices (NREPP). To be considered for registry listing, programs must have incorporated what are known to be effective, safe and ethical practices; have demonstrated face validity; and/or have been based on an expert review. The NREPP, and the full list of Evidence Based Practices on this registry, can be accessed at http://www.nrepp.samhsa.gov/.

Five categories of Evidence Based Programs for Suicide Prevention and Intervention have been identified through the SPRC/AFSP EBPP. They are:

- Community-Based Programs
- Emergency Room Programs
- Primary Care
- School-based Programs; and
- Service Delivery Programs

Several strategies have strong evidence of effectiveness from more than one study.[59] They include: screening and treatment for depression in primary care practices and emergency departments, community based education strategies, comprehensive school-based programming, and restriction of highly lethal methods of suicide.

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[58] US Department of Health and Human Services, 2001, National strategy for Suicide Prevention (NSSP), Objective 10.3, p 115.

[59] Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association (JAMA)*, 294 (16), 2064-74; Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.

Promising strategies range from inexpensive follow-up with clients after a suicide attempt to long-term psychotherapy. The use of specific promising medical and psychotherapies is for clinicians to decide on behalf of their patients, but those with evidence to support their effectiveness are use of anti-depressive and mood-stabilizing medication, and cognitive behavioral, dialectical, and problem-solving psychotherapies.[60] See Appendix 5 for promising information on clinical treatment of suicidal behavior and psychosocial interventions.

Integrating Suicide Prevention into Health Care Settings

Primary care health providers are in a unique position to assess suicidality in their patients.[61] Primary Care Providers serve as patient-centered medical homes that use a chronic disease management model, suitable for assessing for depression and the more than 25 other illnesses that have been identified with significantly elevated risks for suicidal behavior. Primary care providers serve people of all age groups, gender, race and ethnicity, as well as subgroups at elevated risk of suicide, such as veterans and LGBT individuals. Many risk factors and warning signs are easily observed in primary care settings, and primary care providers regularly include patient education in their practices.

In the United States, primary care, including school-based health centers, is the number one source for mental health care, and in many areas, especially rural ones, it is the patient's only source for mental health treatment of any kind.[62] People who died by suicide are more than twice as likely to have seen a primary care provider than a mental health provider before their death. For all age groups, 45 percent of people who died by suicide saw their primary care provider within one month of their death, and 77 percent within one year of their death.[63] The numbers are even more striking for older adults, who infrequently use mental health services. For older adults who died by suicide, 20

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[60]Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association,* 294(16), 2064-74.

[61]Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf.

[62]Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf.

[63]Luoma, JB, Martin CE, Pearson J. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, 159(6), 909-916. Numerous subsequent studies have confirmed these findings. *See also* Tadros G, Salib E. (2006). Elderly suicide in primary care. *International Journal of Geriatric Psychiatry,* 22(8), 750-756; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association,* 294(16), 2064-74; Pfaff JJ, Almeida OP. (2005). Detecting suicidal ideation in older patients: identifying risk factors within the general practice setting. *British Journal of General Practice,* 55(513), 269-273; Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America,* 31(2), 333-356.

percent visited a physician within 24 hours of their death, 41 percent within one week, and 75 percent within one month.[64]

The greatest need perceived by people experiencing suicidal thoughts is for therapy or counseling.[65] Common barriers to receiving treatment include: the person not realizing that he or she needs help; not believing that treatment works; stigma associated with a diagnosis of mental illness or substance abuse; lack of insurance; waiting lists for services; limited number of available psychiatrists, especially in rural areas; not knowing how or where to get help; and problems with transportation, child care, or scheduling appointments.[66]

Primary care providers are in the forefront of integrated suicide prevention programs to address these problems. Mental health care is one of the six areas identified by primary care providers as important for research.[67] At the same time, providers recognize the importance of training: as of 2003, fewer than 50 percent of primary care providers felt competent to manage suicide.[68] In Maine, federally-qualified Community Health Centers have begun the process of integrating suicide prevention into their practices. Assessment is performed by primary care providers, and mental health treatment is either provided on-site by psychiatrists and therapists, or through formal referral and treatment protocols with off-site mental health providers. Published studies using random controlled trials of integrated primary care, suicide assessment, and treatment for depression have found significant decreases in suicidal behavior.[69]

An example is the PROSPECT (Prevention of Suicide in Primary Care Elderly) program,[70] which focused on primary care patients, 60 years and older, diagnosed with major or minor depression. Trained case managers helped physicians recognize depression, made treatment recommendations and offered psychotherapy, monitored

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[64]U.S. Department of Health and Human Services. (2009). *National Strategy for Suicide Prevention: At a Glance – Suicide Among the Elderly*. Retrieved from http://www.mentalhealth.samhsa.gov/suicideprevention/elderly.asp. *See also* Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America,* 31(2), 333-356.

[65]Pagura J, Fotti S, Katz LY, et al. (2009). Help seeking and perceived need for mental health care among individuals in Canada with suicidal behaviors. *Psychiatric Services*, 60(7), 943-949.

[66]Suicide Prevention Resource Center. (2007). *US Suicide Prevention Fact Sheet*. Retrieved from http://www. cdc.gov/nchs/data/databriefs/db07.pdf; 23/945-946.

[67]Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf.

[68]Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf.

[69]Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry,* 51(3) 143-154; Unutzer J, Tang L, Oishi S, et al. (2006). Reducing suicidal ideation in depressed older primary care patients. *Journal of the American Geriatric Society*, 54(10), 1550-1556.

[70]Alexopoulos GS, Reynolds CF, Bruce ML, et al. (2009). Reducing suicidal ideation and depression in older primary care patients: 24-month outcomes of the PROSPECT study. *American Journal of Psychiatry*, 166(8), 882-90.

depression symptoms, and followed up with patients during the one year trial and one year after mental health treatment was completed. Results were compared to a control group that received the usual care offered in the practices. Researchers found that the PROSPECT-treated adults were more likely to receive medication and/or psychotherapy, had a decrease in the severity of their depression symptoms and a higher rate of remission from depression, and had more than twice as great a reduction in suicidal behavior during treatment and one year after treatment. An ancillary result was that the PROSPECT group had an overall lower mortality rate than the control group, unrelated to death by suicide.

There is growing interest in **emergency departments (EDs)** as sites for suicide prevention. In the developed world, the majority of life-threatening and medically severe suicides attempts are treated in EDs. In fact, EDs are the first to see the less medically severe attempts and those who present with suicidal ideation. While suicidologists are paying increasing attention to EDs as sites for screening and intervention, traditionally, suicide prevention has not been a focus for emergency physicians and other ED staff. For these reasons, there is a need a need for improved collaboration between experts in emergency medicine, psychiatry, and suicide prevention.

Substantial advances have been achieved in understanding suicide risk factors. Interventions designed to reduce re-attempts are being tested for use by professionals working in primary care and ED settings. However, there have been fewer studies conducted with respect to screening, risk assessment, and management of suicidality, particularly within the ED setting. More research is needed on the most effective treatments for individuals considered to be at risk - from brief interventions, to a course of psychotherapy and/or medication, or inpatient hospitalization.

In 2009, the NIMH funded the ED Safety Assessment and Follow-up Evaluation (ED-SAFE) trial as an effort to develop the evidence base for effective suicide screening and case management for adults who present for emergency medical care. The proposed initiative aims to build upon the findings from this research by stimulating development and validation of screening tools for reliably characterizing suicide risk status among youth who present for emergency medical care. Developing such tools will meet a critical need of ED staff who currently lack practical and effective strategies to screen, triage, and make treatment decisions for at risk youth.[71]

Maine primary care physicians and health centers have utilized best practice resources compiled for the identification and treatment of persons at risk of suicide in the primary care setting. Of particular importance is the *Suicide Prevention Toolkit for Rural Primary Care Practices* developed by the Western Interstate Commission for Higher Education (WICHE) and the Suicide Prevention Resource Center (SPRC). This Toolkit is a compendium of resources for use in primary care settings complete with resources for providers to use with patients.[72]

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[71] Goldstein A. (2012) Emergency Department Suicide Prevention in Youth. Concept clearance 2012, Preventive interventions Research Program. www.nimh.nih.org

[72] A Primer for Primary Care Providers. Boulder, Colorado: Western Interstate Commission for Higher Education. http://www.sprc.org/for-providers/primary-care-tool-kit

Gatekeeper Programs

Gatekeepers "open the gates" to help for people at risk of suicide. Gatekeepers programs are much more than suicide awareness: they not only impart knowledge but also train people in the skills needed to immediately intervene when a person appears to be considering suicide. It is important to train as many gatekeepers as possible in a particular setting in three skills:

- Identification of risk factors and warning signs of suicide,
- Communication skills for asking people if they are thinking about suicide, and
- Making appropriate referrals for help.

Evaluations of Maine's Gatekeeper program, a one day program that includes skills practice, have shown significant increases in respondents' knowledge of warning signs and risks factors and increased confidence in their ability to intervene. Respondents maintain the training program effects at six months. To date, over 5,000 Gatekeepers have been trained in Maine, and qualitative data indicate that students who are thinking about suicide are identified earlier, before a crisis point is reached. Most training participants report that they receive little or no prior training in suicide prevention.

Most studies of Gatekeeper training programs have focused on programs reaching youth. These studies demonstrate that Gatekeeper training successfully increases participants' knowledge, changes attitudes about suicide, and develops intervention skills. Programs have also demonstrated some evidence of a reduction in the rate of suicidal behaviors.[73] A 2007 study in Quebec found that 63 percent of trainees had intervened with suicidal youth, and an earlier study of Native American youth in New Mexico, which included gatekeeper components, reported a 73 percent reduction in suicidal behaviors, although there was no decrease in the suicide rate.[74]

There are different models of Gatekeeper training; programs that include skill training are most successful. Maine's experience is that it is essential to include active learning techniques in training, and to integrate Gatekeeper programs with other strategies. In particular, Gatekeepers need adequate referral networks for crisis management and mental health treatment.[75]

Lifelines: A School-based Suicide Prevention Program

Lifelines is a comprehensive, school-wide suicide prevention program for middle and high school students. The goal of *Lifelines* is to promote a caring, competent school

[73]Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.
[74]Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.
[75] Wyman PA, Brown CH, Inman J, et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting Clinical Psychology,* 76(1), 104-15.

community in which seeking help is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret. *Lifelines* seeks to increase the likelihood that school staff and students will know how to identify at risk youth, provide an appropriate initial response, and obtain help, and be inclined to take such action.

Lifelines includes a set of components to be implemented sequentially: a review of resources and establishment of administrative guidelines and procedures for responding to a student at risk; training for school faculty and staff to enhance suicide awareness and an understanding of the role they can play in identifying and responding to suicidal behavior; a workshop and informational materials for parents; and implementation of lessons for students to inform them about suicidal behavior and discuss their role in suicide prevention.

The research reviewed for this summary assessed the *Lifelines Student Lessons*, the last component to be implemented in the *Lifelines* program. It consists of four 45-minute or two 90-minute lessons that incorporate elements of the social development model and employ interactive teaching techniques, including role-play. Health educators and/or guidance counselors teach the lessons within the school health curriculum. The *Lifelines Student Lessons* were developed specifically for students in grades 8-10 but can be used with students through 12th grade. *Lifelines* has been widely used in Maine and is being implemented in many other states. Early versions of *Lifelines* were developed and implemented in New Jersey; the first evaluated version was implemented in 1990. A subsequent evaluation was conducted in Maine from 2003 to 2006. Maine has provided *Lifelines* teacher training since 2000. As of 2009, an estimated 33 Maine schools were implementing the curriculum. Twenty-nine schools in Maine have been funded by Federal grants to implement and evaluate the comprehensive program.[76]

> *"As one of Justin's Aunts, I can assure you that his death at age 14 touched more lives than anyone could ever imagine…even 20 plus years later. We need to be willing to really listen and take action to get the help our loved one needs."*...Katharyn Zwicker

[76] Underwood M, Kalafat J, Maine Youth Suicide Prevention Program led by the Maine CDC. Lifelines, A Suicide Prevention Program.

Reducing Access to Lethal Means of Suicide

Studies in other countries suggest that reducing access to a particular means of suicide reduces the rate of suicide by that method.[77] Some methods that led to a reduced suicide rate are reducing the pack size of analgesic medicine; substituting nonlethal medications for lethal ones; installing barriers at sites that are popular for suicide; and reducing access to firearms, the most lethal of all means of suicide.

Studies of suicide deaths among youth and older adult males who used firearms indicate that death is most likely when handguns are in the home, and are stored unlocked and loaded.[78] Promoting safe firearms storage – keeping guns unloaded, storing guns separately from ammunition, and locking both guns and ammunition – may reduce the risk of suicide by firearm, especially in people prone to impulsive behavior.

Emergency Department (ED) Means Restriction Education is an intervention for the adult caregivers of youth (ages 6-19 years) who are seen in EDs and determined through a mental health assessment to be at risk for suicide. Studies show that the presence of a gun in the household increases suicide risk, yet parents who take their adolescent to an ED for a suicide attempt are often not warned about restricting their child's access to firearms and other lethal means. ED Means Restriction Education is designed to help parents and adult caregivers of at risk youth recognize the importance of taking immediate action to restrict access to firearms, alcohol, and prescription and over-the-counter drugs in the home. The intervention gives parents and caregivers specific, practical advice on how to dispose of or lock up firearms and substances that could be used in a suicide attempt. Examples are firearm locking devices or locked medicine cabinets, turning in firearms to local police, or moving the item to another location outside the home. By encouraging reduced access to lethal means, the intervention also aims to lessen the risk of violence directed at others, including homicide.

The intervention is designed to be delivered in a brief period consistent with the demands of busy EDs. The intervention consists of three components or messages that can be delivered by a trained health care professional, such as a physician, nurse, social worker, or mental health specialist. The components are 1) informing parents, when their child is not present, that the child is at increased suicide risk and why (e.g., "Adolescents who have made a suicide attempt are at risk for another attempt"); 2) telling parents they can reduce this risk by limiting their child's access to lethal means; and 3) educating and problem solving with parents about how to limit access to lethal means.

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[77] Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13.

[78] Grossman, DC, Mueller BA, Riedy, C, et al. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. *Journal of the American Medical Association,* 293(6), 707-714; Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America,* 31(2), 333-356.

Follow-up Support after Suicidal Behavior

A previous suicide attempt is the single greatest risk factor for subsequent attempts and for death by suicide; the risk seems to be particularly acute immediately after discharge from an inpatient psychiatric program. In one study, 43 percent of people who died by suicide had been discharged within one month from inpatient psychiatric care, and 47 percent died before their first follow-up visit.[79]

Inpatient programs that send letters or make follow-up telephone calls, or that have counselors who coordinate follow-up services, reduce the rate of subsequent attempts.[80] A random controlled trial of a program that made telephone follow-up calls one month after people were discharged from an emergency department because of a suicide attempt reduced the rate of subsequent attempts over the next year by almost 50 percent.[81] An important caveat is that one month was too long: in another study, a sixth of the 600 individuals in the study attempted suicide again during the one month period before follow-up contact.

Follow-up support increases the effectiveness of crisis telephone lines. Crisis lines are used by suicidal callers, with some effectiveness. In one study, 11 percent of suicidal callers spontaneously reported the call prevented them from hurting or killing themselves. Follow-up outreach is needed particularly for suicidal callers with a history of suicide attempts, or with callers who still have a persistent intent to die at the end of the call. [82]

Examples of Prevention Programs Using Multiple Approaches

In 1984, the **University of Illinois** adopted a policy requiring any student who threatened or attempted suicide to attend four sessions of professional assessment, or be required to withdraw from school. Students believed to be at risk of suicide following the assessment were referred to treatment, other types of support, and were followed-up for compliance. This policy combined elements of gatekeeper programs, follow-up programs, and treatment programs. This study is an example of an empirically supported program to prevent suicide in a college student population.

From 1984 to 2005, 2,000 students were referred for assessment under the policy. During this time the suicide rate at the university fell by almost 50 percent, from 6.91 to 3.87 suicides per 100,000 students. (During the same time period, suicide rates increased almost 30 percent in twelve comparable universities). No student involved in the program chose to withdraw rather than to complete the assessment. Only one student, because of

[79]Hunt IM, Kapur N, Webb R, et al. (2009). Suicide in recently discharged psychiatric patients: a case-controlled study. *Psychological Medicine*, 39(3), 443-449.
[80]Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13.
[81]Vaiva G, Vaiva G, Ducrocq F, et al. (2007). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: randomized controlled study. *British Medical Journal,* 332(7552), 1241-1245.
[82]Kalafat J, Gould MS, Munfakh JL, et al. (2007). An evaluation of crisis hotlines outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-52.

particularly complex treatment needs, was asked to leave the university, and this student later returned and graduated with honors. Not a single student referred to the program died by suicide during his or her remaining time at the university. The entire cost of the program, for a campus with more than 35,000 students, was $50,000 per year in training, administrative, and assessment expenses.[83]

Another example is the ***United States Air Force Suicide Prevention Program*** (AFSPP), a population-oriented approach to reducing the risk of suicide. The program was founded upon the concept that decreasing suicides meant implementing a community approach in which prevention and assistance were a focus long before someone became suicidal. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. AFSPP's 11 initiatives include:

- Leadership Involvement
- Suicide Prevention in Professional Military Education
- Guidelines for Use of Mental Health Services
- Community Preventive Services
- Community Education and Training
- Investigative Interview Policy
- Critical Incident Stress Management
- Integrated Delivery System
- Limited Privilege Suicide Prevention Program
- Behavioral Health Survey
- Suicide Event Surveillance System

The U.S. Air Force first implemented the program with active-duty personnel in 1996. Reported results are based on data from the exposed cohort (1997-2002) and an unexposed cohort (1990-1996). A study examined data through 2007. Personnel exposed to the program experienced a 33 percent reduction of risk of completing suicide compared with those prior to implementation. Compared with Air Force personnel during 1990-1996, those exposed to the program in 1997-2002 also experienced:

- A 54 percent reduction of risk for severe family violence ($p < .0001$)
- A 51 percent reduction of risk for homicide ($p = .05$)
- A 30 percent reduction of risk for moderate family violence ($p < .0001$)
- An 18 percent reduction of risk for accidental death ($p = .05$) [84]

[83] Joffe P. (2008). An empirically supported program to prevent suicide in a college student population. *Suicide and Life Threatening Behavior*, 38(1), 87-103.

[84] SAMHSA's national registry of Evidence based programs and practices (NREPP). United States Air Force Suicide Prevention Program. http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=121

Maine Suicide Prevention Plan
2012-2017

Guidelines for suicide prevention initiatives in Maine

- Suicide affects Maine people of all ages, ethnicity, gender, and economic status, and must be addressed across the life span.

- Silence about suicide, mental illness, and substance abuse reinforces stigma and shame. Breaking silence supports people to seek help.

- In every prevention and intervention activity, the most important standard is DO NO HARM. Staff, whether volunteer or paid, are appropriately trained and use appropriate standards of practice.

- All suicide prevention activities are culturally competent and age appropriate.

- Lifespan suicide prevention activities built upon a foundation of partnerships between state agencies, regional & local organizations and citizen groups.

- Efforts are strengthened and meaningful collaborations formed, so that activities are implemented through existing networks at local, regional, and state levels.

- Expectations for change are realistic. State and local leaders are encouraged to implement activities that match available resources and infrastructure.

- Research indicates that suicide prevention activities must be sustained over time to derive the benefits; the plan recommends strong state leadership and partnerships with local government and community organizations.

- The plan builds on Maine Youth Suicide Prevention Program experience, knowledge, resources, and partnerships, especially its connections within the Maine Center for Disease Control and the Department of Health and Human Services and the long-standing connection to the Maine school community.

- Resources are maximized by integrating suicide prevention activities into state and local programs and organizations dedicated to improving the health of Maine's people. In a time of shrinking federal and state budgets, activation of local and regional organizations and partnerships will bring the flexibility and creativity needed to implement suicide prevention to vulnerable people across the state and throughout the lifespan.

- Coordinated efforts are essential to leverage additional resources from all appropriate public and private sources.

- People in groups at heightened risk for suicide are identified and prevention activities are prioritized to effect change in these groups.

- Suicide prevention programs and activities adhere to available evidence-based or promising practices where they are available for the target population and setting. Priority is given to activities with the greatest evidence of success. They include but are not limited to:
    - Integration of suicide prevention into primary health care practice and Emergency Department settings,
    - Gatekeeper-style programs with an evidence base of success with the target group,
    - Awareness training
    - *Lifelines*
    - Workplace suicide prevention protocols
    - Suicide hotlines and mobile crisis response and follow-up,
    - Follow-up activities after contact with persons contemplating suicide,
    - Reduction of access to lethal means

- A statistically significant reduction in suicide rates takes a number of years to achieve. Interim benchmarks are identified for each strategy where appropriate.

Lead Agencies, Implementing Organization and Statewide Partners

Suicide prevention is up to all of us and many diverse partners are needed.

Implementation and support of a comprehensive lifespan suicide prevention plan requires the involvement of a significant number of primary and supporting partners to ensure success. Leadership is needed at the state, regional and local levels. Implementation requires partnership between governmental and private organizations involved in planning, regulating, funding and supporting efforts that impact the way we live our lives.

The public meetings held to review the draft plan provided clear feedback that a central coordinating body has been essential to the success of suicide prevention efforts in Maine over the past 12 years. The Suicide Prevention Coordinator has been housed in the Maine Injury Prevention Program (MIPP) of the Maine Center for Disease Control and Prevention (Maine CDC) since inception of the program. The role of the Suicide Prevention Coordinator encompasses leadership, keeping the momentum going, planning and guiding suicide prevention efforts across partnering organizations, monitoring the nature and extent of the problem, providing content expertise and knowledge of national evidence-based practice models, limiting duplication of efforts and providing assistance in implementation and evaluation.

> *"In order for the plan to be effective, there needs to be partnerships with other agencies. You gain power by partnering."*…From a stakeholder meeting

Public-private partnerships play an essential role of carrying out the elements of a statewide suicide prevention plan. Much of the actual work of addressing the needs of individuals at increased risk for suicide occurs at the local level through a myriad of the local partners that form an essential safety net across Maine. A list of State Agencies and Partner Organizations involved in implementing suicide prevention programming is in Appendix 4. This list is not comprehensive, but reflects a range of organizations and people who are, or have been, involved in suicide prevention efforts in Maine or who have been recommended to become involved.

Goals, Objectives and Activities to Prevent Suicide in Maine

The work of the Maine Suicide Prevention Program is founded on the shared belief that many suicides can be prevented. Most suicidal behaviors occur during a time of crisis in an individual's life; when personal coping ability is overwhelmed, the person feels hopeless, and sees few or no alternative ways to solve the crisis. Many of these crises are short-lived, and resolution of the crisis can lead to improved mood and safety. Information, support and appropriate intervention can avert many suicides and recovery from the physical and emotional pain can allow a person to move forward with their life. Suicide prevention is based on the belief that people can recover from mental illness and substance abuse and live productive lives.

Maine's Suicide Prevention Strategic Plan 2012-2017

*** NOTE:** **S** refers to **State Level** and reflects a need for state level oversight, leadership or programming;
C refers to **Community Level** for those activities that would take place at the local level**.**

Because suicide takes a life in Maine every two days…

Goal 1: Statewide leadership and coordination guides suicide prevention among Maine people. (Performance Measure: The number of individuals possessing content area expertise to implement the Maine Suicide Prevention Program Plan through the Maine Suicide Prevention Program's Advisory Council.

A coordinating and overseeing infrastructure of state and local organizations is necessary to maximize use of available human, programmatic and monetary resources, to increase knowledge of effective suicide prevention and to integrate suicide prevention into existing programs and services. The most effective coordination requires leadership and a centralized body of expertise to act as a clearinghouse of information and training and to provide support and assistance to regional and local initiatives.

Local residents know their regions and the people and regional stressors on their lives. Implementation must occur on a local level in order to reach those most in need.

> *"Without a centralized program, who implements the plan?"*…From a public stakeholder meeting

Objective 1: Increase coordination, collaboration and leadership at the state and community levels to support suicide prevention activities.

Activity 1: Support a statewide Suicide Prevention Program Coordinator position to inform and guide the implementation of suicide prevention program activities in Maine. (S & C)
Activity 2: Form sustainable state and local partnerships to lead the advancement of suicide prevention across the lifespan in Maine. (S & C)

Activity 3: Maintain the commitment of state and partner organizations to integrate suicide prevention efforts. (S & C)

Activity 4: Develop and maintain a listing of state and local community suicide prevention stakeholders and activities to enhance coordination and communication. (S)

Activity 5: Collaborate with national, regional and other state suicide prevention programs. (S)

Objective 2: Strengthen the Maine Suicide Prevention Program Advisory Council to broaden representation from diverse stakeholders and enhance leadership capacity at the state, regional and local levels.

Activity 1: Identify and seek commitments from stakeholder groups representing constituents across the lifespan to be represented on the Advisory Council. (S)

Activity 2: Build connections to Public Health District Coordinating Councils and other regional entities in order to enhance suicide prevention initiatives regionally across the state. (S & C)

Activity 3: Enhance connection to and representation from Maine's Tribal Communities. (S)

Activity 4: Identify leadership for the Advisory Council among community members with expertise and interest in suicide prevention. (S & C)

Objective 3: Maintain capacity to provide data and informational resources to stakeholders and Maine citizens.

Activity 1: Implement a Maine Violent Death Reporting System to systematically collect suicide and violent death data. (S)

Activity 2: Ensure that suicide and self-injury questions are included on surveys administered to Maine people across the lifespan. (S)

Activity 3: Collect, analyze and disseminate death certificate, hospital discharge, emergency department and other relevant data on suicide and violence in Maine. (S)

Activity 4: Gather and distribute information on evidence based suicide prevention programs and interventions to Maine partners and stakeholders. (S)

Activity 5: Use data to develop educational materials to inform Maine citizens and stakeholders about suicide risks across the lifespan. (S)

Activity 6: Provide resource materials for the public and professionals through a state level resource center and website with links to evidence-based resources. (S)

Activity 7: Produce and disseminate an annual report on suicide and violence in Maine. (S)

Objective 4: Identify and seek support for the implementation of effective suicide prevention programming in Maine.

Activity 1: Identify funding opportunities to prevent suicide across the lifespan and disseminate information to partners. (S & C)

Activity 2: Seek funding to support state and local level implementation of evidence-informed suicide prevention programs and services. (S & C)

Activity 3: Build upon collaborations among public and private sectors when seeking funding. (S &C)

Activity 4: Provide training and assistance to enhance effective implementation of evidence-informed for suicide prevention programs and services. (S & C)

Because people need access to comprehensive health care…
Goal 2: Maine's people can access suicide prevention and intervention services in health care settings across the state.

(Performance Measure: The number of health care providers implementing evidence based suicide prevention screening tools as a standard of care.)

Research shows that people, including those at high risk for suicide, more frequently visit their primary care providers or hospital emergency departments, rather than mental health care providers, when they are thinking about suicide and during times of crises. The ongoing stigma associated with mental illness and suicide creates a barrier to people getting the help they need from a mental health provider.

Intervention – screening, assessment, treatment, and referral – through primary care and emergency department practices has the potential for identifying and assisting

the greatest number of people across the lifespan who have attempted or are contemplating suicide. To prevent suicide, people need to be able to access the care they require. Integration of physical health and behavioral health services at the practice level, and coordination of referrals and services with existing mental health resources in communities is vital to this effort.

> *"The goal for this particular area should be that there is no wrong door to access services."*…From a stakeholder meeting

Objective 1: Increase the number of Primary Care Practices that implement evidence-based suicide prevention interventions as a standard model of care.

Activity 1: Educate primary care practitioners on the efficacy of and methodology for integrated suicide screening, assessment, treatment and referral. (S & C)

Activity 2: Partner with the Maine Primary Care Association and other Primary Care organizations to integrate suicide prevention screening, assessment, and treatment within behavioral health care in Maine's Federally Qualified Health Centers. (S & C)

Activity 3: Partner with the Maine Assembly on School-based Health Care to ensure that evidence-based standardized suicide screening and intervention programs are used in all School-based Health Centers. (S & C)

Activity 4: Seek additional partners to bring behavioral health integration and evidence-based suicide prevention practices into health care practices for all ages across Maine. (S & C)

Objective 2: Increase the number of health care settings that routinely screen for depression and assess for risk of suicide using evidence-based, standardized instruments

Activity 1: Partner with primary care offices and School-based Health Centers to implement evidence-based screening (eg. Patient Health Questionnaire depression screen like PHQ-9) and treatment protocols for patients with depression. (S & C)

Activity 2: Partner with the Maine Hospital Association and the Maine Crisis Network to implement uniform suicide risk screening and referral protocols in hospital emergency departments (S &C).

Activity 3: Partner with the Maine Crisis Network to implement uniform screening and referral protocols in diverse health care settings for people at risk of suicide and seen for a risk assessment. (S & C)

Activity 4: Partner with Maine's Mental Health Crisis Providers to develop and adopt a uniform set of protocols to inform suicide risk assessment, intervention, follow-up and postvention with Maine's people at risk for suicide. (S & C)

Activity 5: Engage relevant stakeholder agencies and review and disseminate research to develop appropriate screening and assessment instruments for use in diverse settings across Maine. (S & C)

Objective 3: Increase the number of health care settings that implement the use of standard practices to monitor and follow-up with individuals screened as at risk for suicide and referred on to outpatient support.

Activity 1: Develop and implement discharge planning guidelines for health care settings that include the use of written follow-up plans for individuals at risk for suicide. (S & C)

Activity 2: Develop materials and procedures to ensure that at risk clients, who receive a written, individualized follow-up plan from the assessing provider, receive the recommended follow-up care. (S & C)

Because preventing suicide is up to all of us…

Goal 3: Maine's people are protected through integration of effective suicide prevention efforts within public and private organizations statewide. **(Performance Measures: The number of schools that implement evidence based or promising practice suicide prevention programming. The number of schools with suicide prevention, intervention and postvention protocols.)**

Effective programs and practices that can help reduce the incidence of suicide among Maine people must be implemented at the state, regional and local levels. State leadership is necessary to guide the implementation of promising and evidence-informed programs for various settings and for use with people across the lifespan. Successful suicide prevention requires partnerships with the diverse local and regional groups and organizations that come into contact with people most at risk.

Objective 1: Increase the number of public and private organizations statewide that implement effective suicide prevention programs and practices within their organizations.

Activity 1: Identify and reach out to key public and private organizations for integration of evidence-based or promising suicide prevention strategies. (S & C)

Activity2: Promote the integration of evidence-based suicide prevention programming for organizations in Maine including, schools, colleges, correctional

centers, employers, community groups and other community-based organizations. (S & C)

Activity 3: Seek funding to support integration of promising and evidence-based suicide prevention programs and to evaluate the impact of these programs. (S)

Activity 4: Disseminate data and information on training/education opportunities and links to evidence-based resources that support integration of suicide prevention strategies into state agencies, state-contracted organizations and local programs and organizations. (S & C)

Objective 2: Increase the number of direct service organizations that are prepared to identify and intervene with individuals, across the lifespan, who are at risk for suicide.

Activity 1: Provide guidance and assistance to organizations to develop and implement suicide prevention and intervention protocols to best serve the population. (S & C)

Activity 2: Provide guidance and assistance to agencies that provide suicide screening, assessment and referral resources for at risk individuals. (S & C)

Activity 3: Promote wide awareness and use of the Statewide Maine Crisis Hotline (1-888-568-1112) and the National Suicide Prevention Lifeline (1-800-273-8255) as a means of accessing assistance and support for individuals at heightened risk of suicide. (S & C)

Activity 4: Provide guidance and assistance to ensure that all Maine correctional facilities follow the National Commission on Correctional HealthCare standards for suicide prevention. (S)

Activity 5: Provide guidance and assistance to ensure that community corrections programs use standardized suicide assessment and treatment protocols and develop working relationships with mental health crisis, substance abuse and other community referral agencies. (S & C)

Activity 6: Interface and collaborate with veteran and active military organizations to ensure that their personnel are prepared to address the increased risk of suicide present in veterans and active military personnel. (S & C)

Activity 7: Provide information and assistance to DHHS Child and Family Services and other appropriate organizations to ensure that youth in foster care, transitioning out of foster care or those in other high-risk settings are supported in maintaining safety and stability. (S)

Activity 8: Provide information, resources and best-practice interventions to organizations serving, supporting and representing GLTBQ youth and adults. (S & C)

Activity 9: Develop, modify and disseminate screening tools and response protocols for at-risk groups for integration within community programs and services. (S & C)

Activity 10: Provide information and assistance to state licensing agencies to develop regulations requiring suicide prevention standards for facilities caring for populations at risk for suicide. (S)

Objective 3: Increase the number of employers that integrate effective suicide prevention programs within their organizations.

Activity 1: Disseminate model suicide prevention and intervention protocol guidelines to Maine employers, prioritizing those who hire individuals from vulnerable populations. (S & C)

Activity 2: Provide assistance to employers that integrate suicide prevention, intervention and postvention protocols within their organizations and their Employee Assistance Programs. (S & C)

Activity 3: Provide assistance to employers for educating employees about suicide prevention and establishing intervention programs. (S & C)

Objective 4: Increase the number of schools (elementary through post-secondary) that implement evidence-based or promising suicide prevention programming.

Activity 1: Support schools to implement comprehensive, evidence-informed suicide prevention programming such as the *Lifelines* model. (S & C)

Activity 2: Promote the adoption of suicide prevention expectations into the job descriptions of all school-based clinical and behavioral health staff. (C)

Activity 3: Support schools to maintain and update Comprehensive School Health Education (CSHE) curricula K-12 to include mental health key concepts. (S & C)

Activity 4: Support schools to implement best practice and promising programs designed to improve outcomes for all students including improvements to school climate and bullying prevention. (S & C)

Activity 5: Disseminate resources that promote health during periods of significant student transitions such as moving schools, graduating high school, taking a new job, etc. (S & C)

Objective 5: Improve access to and community linkages among schools, mental health, substance abuse, correctional services and suicide prevention services statewide.

Activity 1: Promote the development and functioning of "provider referral networks" in Maine's Public Health districts, college and school communities, tribes and other settings. (S & C)

Activity 2: Provide support to service providers, schools, employers and other programs to follow evidence-based guidance for referral and routine follow-up with people who are known to have attempted suicide or expressed suicidal ideation. (S & C)

Objective 6: Increase the number of faith-based organizations adopting policies and programs promoting suicide prevention and effective intervention/postvention.

Activity 1: Develop/disseminate appropriate suicide prevention/intervention education and resource material for clergy and faith-based community. (S & C)

Activity 2: Provide assistance to places of worship and existing coalitions of faith-based organizations to integrate suicide prevention efforts into their work. (S & C)

Objective 7: Increase the number of survivors of suicide who receive support and acceptance during their grief and who participate in suicide prevention efforts statewide.

Activity 1: Provide professional organizations with information on suicide survivor needs and support resources; include this information in all MSPP training programs. (S)

Activity 2: Convene, train and support a volunteer Suicide Survivor Speakers Bureau to help increase awareness of the impact of suicide and to spread effective suicide prevention messages. (S & C)

Activity 3: Promote access to suicide survivor support and grief support groups across the state. (S & C)

Activity 4: Provide Funeral Directors with access to resources to support newly bereaved suicide survivors. (C)

Because people need to know how to help prevent suicide…

Goal 4: Professionals working with Maine people are knowledgeable in suicide prevention, intervention and postvention. (Performance Measures: The number of school and university personnel who attend gatekeeper training. The number of schools requesting technical assistance related to suicide prevention, intervention, postvention protocols.)

An effective way to identify and assist those who are actively suicidal or at increased risk for suicide is through the actions of a knowledgeable professional community. An adequately trained and alert professional health, public health, behavioral health, public safety, education, labor, and corrections workforce is vital in the effort to identify and intervene with those at risk for suicide. Training and education programs are a cornerstone of suicide prevention programs. Access to up-to-date education and training and best-practice curricula is essential to prepare professionals in effective suicide prevention. Knowledge saves lives.

> *"The greatest thing about the Maine Suicide Prevention Program is how they offer training at an affordable (or no cost) rate. It makes it that much more available for individuals and agencies to participate."*…From a stakeholder meeting

Objective 1: Increase the number of professional organizations that develop, implement and promote effective clinical and professional practices for suicide prevention in Maine.

Activity 1: Engage relevant stakeholders, in the development, review and adaptation of evidence-based or promising suicide prevention training materials for use with Maine clinicians and professionals working with at risk populations. (S & C)

Activity 2: Provide best practice suicide prevention, intervention and postvention training and education to Maine clinicians and professionals working with people at risk of suicide. (S)

Activity 3: Modify or create and disseminate suicide prevention training modules to address the needs of governmental, professional, educational and volunteer organizations statewide. (S)

Activity 4: Integrate effective professional/clinical suicide prevention practices and training for staff members in direct service roles with populations at risk for suicide. (C)

Objective 2: Increase the proportion of clinicians and professionals in Maine who are knowledgeable about the increased risk of suicide associated with a traumatic history and who develop trauma informed practices.

Activity 1: Promote the integration and use of assessments for adverse childhood events or another standardized trauma history assessment for clients seen by health, mental health and substance abuse providers. (S & C)

Activity 2: Provide education and support for professionals working with Maine trauma survivors to develop trauma-informed practices and procedures. (S & C)

Activity 3: Promote the use of suicide prevention awareness and education materials to staff and volunteers working with victims of domestic violence and sexual assault. (S & C)

Objective 3: Increase the number of trained suicide prevention gatekeepers in multiple settings who maintain their skills.

Activity 1: Develop and implement gatekeeper training for a variety of audiences serving people of all ages statewide. (S & C)

Activity 2: Provide follow-up, consultation, continuing education and practice updates to trained gatekeepers statewide. (S)

Objective 4: Increase knowledge of the risk of suicide associated with access to lethal means and implement effective methods to reduce access to lethal means for people at increased risk for suicide.

NOTE: Lethal means include firearms, medications, drugs and other common means used for suicide.

Activity 1: Educate Maine professionals working with people at-risk for suicide to routinely ask about the presence of all types of lethal means in the home and educate their clients and their families about actions to reduce associated risks. (S)

Activity 2: Provide training and information to law enforcement officials and other first responders about the importance of removing lethal means from the environment of suicidal individuals. Provide law enforcement and first-responders model protocols and tools to assess for the presence and guide the removal of lethal means from the environment of suicidal individuals. (S)

Activity 3: Disseminate data and research describing the benefits of strengthening lethal means access procedures regulations to prevent suicide. (S & C)

Activity 4: Promote public awareness about the importance of restricting access to all types of lethal means around vulnerable individuals as an important way to prevent suicide. (S & C)

Objective 5: Increase the readiness of Maine professionals to address suicide risk through the provision of continuing education opportunities that provide advanced knowledge in suicide-related topics.

Activity 1: Provide an annual conference that increases understanding and knowledge of recent advances in the field of suicide prevention (Beyond the Basics of Suicide Conference). (S)

Activity 2: Promote and support a broad range of educational presentations for professionals working with vulnerable populations across the lifespan that address suicide prevention, intervention and postvention topics. (S & C)

Activity 3: Create and/or modify education and training offerings on suicide prevention in various formats, including electronic, to meet the needs of a diverse professional audience. (S & C)

Activity 4: Provide research data, information and training on the association between self-injury and suicide to multiple audiences in Maine. (S & C)

Because seeking help saves lives…

Goal 5: A culture of help-seeking for people in need exists in Maine **(Performance Measure: The number of individuals and agencies that report increased awareness of helping resources at the local and state levels available for persons in need of treatment services.)**

As long as suicide is seen as a private tragedy, associated with individual and familial shame and failure, it is difficult for suffering people and their families to seek help. Creating the opportunity for open discussion about the prevalence of suicide and its risk factors, including mental illness and depression, and changing the perception of seeking help, can begin to break down these barriers. To effectively address suicide, it must be safe to talk about suicide.

> *"My 18 year old son's death by suicide on July 14, 2007 forever changed the lives of our entire family and it is impossible to describe the pain that losing Ryan has brought into our lives. He was a talented athlete, a great friend, and he loved to laugh. We never thought we could lose him to suicide. Anything we can share about suicide and suicide prevention that means other families will not experience this loss is important to us."*
> …Rachel Morales

Objective 1: Increase public awareness that suicide is a preventable public health problem and help is available.

Activity 1: Develop, disseminate and promote media messages to increase the number of adults who know how to get help when they or someone they know is contemplating or has attempted suicide. (S & C)

Activity 2: Develop and maintain the Maine Suicide Prevention Program website as a dynamic resource for suicide prevention information and data to professional, lay and youth audiences and as a resource for training opportunities related to suicide prevention. (S)

Activity 3: Promote awareness of Maine Suicide Prevention Program resources for suicide prevention among key state and local stakeholders and the general public. (S & C)

Activity 4: Promote the continued use of the Maine Substance Abuse and Mental Health Services Information Resource Center as a clearinghouse and access point for suicide prevention information and resources for all Maine people. (S & C)

Objective 2: Increase the understanding of the general public in Maine that mental health problems are treatable, and that mental health and substance abuse prevention and treatment services are part of overall health care.

Activity 1: Educate individuals on how to advocate for their own and their family's mental health care needs. (S & C)

Activity 2: Identify and promote ways to decrease stigma and misperceptions surrounding mental illness, suicidal behavior, and substance abuse issues/conditions. (S & C)

Activity 3: Provide information and resources to people, organizations, communities and others to underscore the importance of seeking help in moments of distress. (S & C)

Objective 3: Improve media reporting practices about suicide to reduce stigma and increase public awareness that suicide is a preventable public health problem and help is available for those in need.

Activity 1: Educate media representatives about safe reporting practices regarding suicide. (S)

Activity 2: Monitor print and electronic media sites and provide feedback encouraging accurate and responsible depictions about suicidal behavior, mental illness and related issues. (S & C)

Activity 3: Provide education and assistance to participants of MSPP training and education programs in order to increase understanding of the key issues surrounding media contagion. (S & C)

Activity 4: Promote the development and dissemination of media and social media messages that normalize help-seeking behavior. (S & C)

Objective 4: Increase active outreach to identified populations at higher risk of suicide and attempts through traditional media, social media and other venues.

Activity 1: Partner with visible community and statewide organizations to identify champions within at-risk groups to increase help-seeking messages. Promote the message that help-seeking behavior is a sign of strength. (S & C)

Activity 2: Partner with organizations and programs serving Maine's elders to increase effective outreach efforts targeting isolated, depressed and terminally ill elders lacking adequate supports. (S & C)

Activity 3: Partner with active military, veteran organizations and programs to ensure optimal suicide prevention outreach activity to Maine's military personnel and families and veterans. (S & C)

Activity 4: Explore and pursue effective ways to access and engage groups at higher risk for suicide such as non-college bound youth ages 19-25 and middle-age men to address their increased risk for suicidal behavior. (S &C)

Activity 5: Develop and disseminate educational material guiding the appropriate use of various forms of social media for suicide prevention for parents, educators and organizations, especially those working with youth and young adults. (S & C)

Activity 6: Provide outreach to and build working relationships with Maine's Tribal Communities to work collaboratively to support suicide prevention efforts. (S & C)

Activity 7: Partner with organizations, groups and families to ensure effective outreach and proactive suicide prevention efforts among Maine's LGBTQ youth and adults. (S & C)

APPENDICES

APPENDIX 1:
GLOSSARY OF TERMS

APPENDIX 2:
MSPP ADVISORY COUNCIL

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APPENDIX 1
Glossary of Terms

Adolescent: A person between childhood and adulthood usually understood to be between ages of 10 and 24; sometimes 19-24 is referred to as young adult.
Aftercare treatment programs: Programs that provide treatment and support recovery after an initial episode that required residential or hospital treatment.
Anxiety Disorder: A common mental illness group defined by persistent feelings of uneasiness, worry and fear that cause significant difficulty in daily functioning. Anxiety disorders include agoraphobia, PTSD, Panic Attacks and Generalized Anxiety.
Baseline: The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.
Behavioral Health: A general concept, referring to the reciprocal relationship between human behavior, individually or socially, and the well-being of the body, mind, and spirit. The term is commonly used to describe a field of scientific study encompassing mental health and substance abuse.
Behavioral Health Integration: The intentional process of co-location of behavioral health practitioners and services into the practice flow of a primary care setting.
Best practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.
Cognitive Behavioral Treatment: Treatment method that focuses on here and now behaviors, thoughts and responses. Uses variety of techniques to teach adaptive behaviors and skills (affect identification, planned responses, desensitization, relaxation, etc.)
Co-morbidity: The co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.
Conduct disorder: A repetitive and persistent behavior pattern during which the basic rights of others or major age-appropriate norms or rules are ignored and often violated. A diagnosis of conduct disorder is likely if the behaviors continue for a period of six months or longer.
Contagion: A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.
Crisis response plan: A document that spells out the steps to be followed in the event of threatening situations to assist a person to return to baseline and keep the environment safe for that person and others.
Crisis team: A group of individuals trained and assembled for the purpose of responding to the needs of others during and after a crisis event/situation. All schools in Maine are required to have a crisis response team and plan.
Culturally competent: A set of values, behaviors, attitudes, and practices reflected in the work of a person, an organization or program that enables it to be effective across culture; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.
Depression: A constellation of emotional, cognitive and physical signs and symptoms, including sustained sad mood or lack of pleasure. Clinical depression is highly correlated with suicidal thoughts.

Effective: Programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in a target group more than in a comparison group.
Epidemiology: Study of statistics and trends in health and disease across communities.
Evaluation: Systematic investigation of the value and impact of intervention or program.
Evidence-based: Programs or practices that have undergone formal evaluation and proven to be effective at achieving the desired impact.
First Responder: Professional who works at the scene of an accident, crime or other traumatic event; For example, emergency medical technicians, firefighters, law enforcement officers, funeral directors, and clergy.
Gatekeeper: Term used to define the role of the individuals who are trained to know basic suicide prevention steps. Gatekeepers are trained to recognize and respond appropriately to warning signs of suicidal behavior and to assist at risk individuals in getting the help they need.
Goal: A broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.
Health disparities: The disproportionate burden of disease, disability and death among a particular population or group when compared to the general population.
Help-seeking behavior: Actions taken by a person to obtain informal or professional support and assistance in times of need.
High Risk: An individual or a group that is statistically shown to have elevated risk when compared to the population as a whole. May also refer to the behaviors that place an individual at increased risk.
Infrastructure: An underlying base or foundation especially for an organization. Infrastructure includes staff, facilities, equipment, etc. needed for the functioning of a system or organization.
Information and Resource Center (IRC): A program of the Office of Maine Substance Abuse and Mental Health Services that functions as a clearinghouse of information and materials on substance abuse and suicide that is available to all Maine people.
Intentional injury: Injuries resulting from purposeful human action, whether directed at oneself or others that are intended to cause harm. Suicide and self-inflicted injury are examples of intentional injuries.
Intervention: A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.
Lethal means: Any instrument or object utilized to carry out a lethal, self-destructive act (i.e. firearm, poison, medication, rope, chemicals and/or other hazardous material).
LGBTQ: An abbreviation or acronym used to refer to someone who identifies as being **a** member of a sexual minority including lesbian, gay, bisexual, transgender or questioning.
Lifespan: The period of time between birth and death.
Maine Integrated Youth Health Survey (MIYHS): A biennial survey of middle and high school students conducted in Maine as part of a national effort by the U.S. CDC to monitor health-risk behaviors of the nation's students.
Means: The instrument or object used to carry out a self-destructive act (e.g. firearm, poison, medication). See also lethal means.
Means restriction: Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Medical Examiner: A physician officially authorized by the state to determine causes of deaths, especially those deaths suspected of not occurring under natural circumstances.
Mental health parity laws: Some states have passed legislation requiring insurance companies to provide full coverage of psychiatric services equivalent to medical services. EX: If they provide 80 percent coverage for physical illness then they would have to provide the same percent of coverage for behavior health services.
Mental illness (disorder): A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's daily functioning.
MIPP: The Maine CDC Injury Prevention Program serves as the lead state agency for injury and suicide prevention. The MIPP provides training, data, and links to prevention resources statewide. The MIPP coordinates the MSPP and partners with key groups to address other leading causes of injury.
Mobile crisis team: Mental health clinicians trained to assess and respond to the needs of an individual experiencing behavioral health crisis. This includes performing suicide assessments/evaluations in multiple settings such as an emergency department, client's home, school, etc.
Mood disorders: Mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders.
Morbidity: The relative frequency of illness or injury, or the illness for injury rate, in a community or population.
Mortality: Relative frequency of death, or the death rate, in a community or population.
MSPP: The Maine Suicide Prevention Program is a multi-state agency program led by the Maine CDC which employs a public health approach to address suicide across the lifespan. The MSPP is based upon collaboration among state agency leaders and private sector groups and organizations. The long-term goal of the MSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens.
National Strategy for Suicide Prevention: A comprehensive and integrated approach to reduce the loss and suffering from suicide and suicidal behaviors across the lifespan. This document was initially issued in 2001 as a catalyst for social change and was updated and re-released in 2012.
Non-fatal suicidal behavior: A term for a suicide attempt which does not end in death.
PHQ-9: The Patient Health Questionnaire (PHQ-9) is a 9 question self-administered diagnostic instrument for screening for depressive disorders.
Partners: Entities, including organizations, groups and individuals working together toward a common goal.
Post-Traumatic Stress Disorder (PTSD): A type of anxiety disorder brought on by exposure to severe trauma that was life threatening or perceived as life threatening and which causes great difficulty in functioning normally.
Postvention: A coordinated and comprehensive set of specific interventions to be implemented after a crisis or traumatic event such as a suicide has occurred.
Prevalence: The percent of the population with a particular condition or characteristic. Calculated as the number of people in a population who have the health condition divided

by the total number of people in the population. Prevalence may be expressed as a rate per 10,000 or 100,000 people, for example, or as a percentage.

Primary Care Provider (PCP): Health professionals serving in a primary care setting, including physicians, physician assistants, nurse practitioners, and nurses who routinely provide health care services and who make referrals for specialty services for patients when indicated.

Protective Factor: The positive conditions, personal and social resources that promote resiliency, protect and buffer the individual, and reduce the potential for high-risk behaviors, including suicide.

Protocol: A set of procedures or guidelines describing actions to take in a given situation. MSPP developed protocol guidelines to help schools and agencies be prepared to address suicide prevention, intervention, and postvention.

Public Health: Regulatory and voluntary focus on effective and feasible risk management actions at the national, state and community level to reduce human exposures and risks, with priority given to reducing exposures with the biggest impacts in terms of the number affected and severity of effect.

Referral Network: Organizations or professionals that a school, agency or other organization might turn to for assistance, support, intervention or treatment for individuals needing services.

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

Risk Factor: Long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death and other adverse outcomes.

Screening: Administration of a tool to identify individuals in need of more in-depth evaluation or treatment.

Self-harm or Self-injury: Terms used to describe self-inflicted injury, such as cutting, self-battering, taking overdoses, or burning oneself. Sometimes referred to as non-suicidal self- injury and *generally* not assessed as suicidal in nature.

Sexual Minority: Refers to gay men, lesbian women and bisexual and transgendered persons. These groups are considered to be a minority because of several commonalities with other minority groups, including separate cultural norms, use of language and terminology, and the experience of being discriminated against because of their social minority status.

Sexual Orientation: Refers to an emotional, romantic, or sexual attraction that one feels toward men, toward women, or toward both. Sexual orientation ranges along a continuum generally described in terms of *heterosexual*—attraction to the other sex—*homosexual*—attraction to the same sex—and *bisexual*—attraction to both sexes.

Social Support: Assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services from family, friends, religious communities or other individuals and groups.

Stakeholder: Entities, including organizations, groups and individuals, who are affected by and contribute to decisions, consultations and policies. Stakeholders have an investment in a program, entity or an issue.

Stigma: Commonly defined as the use of stereotypes and labels when describing someone. Stigmatization of people with mental disorders is manifested by bias, distrust,

stereotyping, fear, embarrassment, anger, and/or avoidance. It may reduce access to resources and lead to low self-esteem, isolation, and hopelessness.
Substance Abuse: The misuse of drugs including alcohol. For persons under age 21, all drug use (except with a doctor's prescription) is termed substance abuse.
Suicide: Self-inflicted death with evidence (implicit or explicit) of the intent to die.
Suicide Attempt: Non-fatal self-injurious behavior for which there is evidence that the person intended to kill him/herself.
Suicidal Behavior: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and death by suicide.
Suicide Ideation: Clinical reference to thoughts about dying by one's own deliberate actions.
Suicide Survivor: Family members, significant others, friends, colleagues or acquaintances who are strongly affected by the loss of a loved one due to suicide.
Suicide Attempt Survivor: An individual who has attempted suicide and lived.
Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.
Warning Sign: The earliest, observable signs that indicate the risk of suicide for an individual in the near-term (within minutes, hours, or days).
Young adults: Persons aged 20-24.
Youth Risk Behavior Survey (YRBS): A biennial survey of middle and high school students conducted as part of a national effort by the U.S. CDC to monitor health-risk behaviors of the nation's students.

APPENDIX 2
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APPENDIX 3
Resources

Maine Resources

Maine Crisis Hotline **1-888-568-1112**
(Voice/TTY)

A 24 hour hotline to access crisis services for a range of behavioral health crisis situations including suicide assessment and intervention help. Calls are answered by trained behavioral health clinicians located in the crisis service center closest to the caller's location.

Maine Warm Line **1-866-771-9276**

A peer staffed Intentional Warm Line operated 24 hours a day and offering telephone support for adults in non-crisis situations. Connect with trained peers who have experienced mental illness and recovery.

NAMI Maine Help Line **1-800-464-5767**
Mon.-Fri., 8am-4:30pm

Provides confidential non-crisis help for consumers of mental health services and their family members, and offers support and assistance with information about mental illness and the support & treatment system, understanding your rights and where to get the help you need.

Maine Suicide Prevention Program **1-800-698-3624**
http://www.maine.gov/suicide/ **TTY users call**
Maine Relay 711

Statewide prevention program led by the Maine CDC/DHHS in collaboration with other state agencies and private sector partners. The mission of the program is to increase statewide public awareness about suicide and suicide prevention; reduce the incidence of suicidal behavior among citizens; and improve access to appropriate prevention and intervention services. The program website offers information and resources for all concerned and links to training and national resources.

Maine Child Abuse and Neglect Hotline **1-800-452-1999**
TTY users call
Maine Relay 711

24 hour hotline of Maine's Department of Human Services Child Protection Division to report suspected child abuse or neglect.

Maine Coalition Against Sexual Assault (MECASA) **1-800-871-7741**
www.mecasa.org **TTY 1-888-458-5599**

The Maine Coalition Against Sexual Assault is organized to put an end to sexual violence and to ensure that there will be ongoing support and services for victims and survivors.

Maine Office of Substance Abuse & Mental Health Services **1-800-499-0027**
Information and Resource Center (IRC) **TTY users call**
http://osairc.informe.org/ or email osa.ircosa@maine.gov **Maine Relay 711**

The IRC houses a collection of books, videos/DVDs, and pamphlets which are searchable online. Library materials are available on loan, and pamphlets and handouts are distributed free statewide.

Northern New England Poison Center (NNEPC) **1-800-222-1222**
http://www.nnepc.org **TTY users call**
Maine Relay 711

The NNEPC provides immediate treatment advice for poison emergencies, as well as information about poisons and poison prevention, 24 hours a day, seven days a week.

National Resources

National Suicide Prevention Lifeline **1-800-273-TALK (8255)**
A 24-hour hotline available to anyone in suicidal crisis or emotional distress. Home of the **Veterans Crisis Line; press "1" for veterans.** Website links to additional information and resources for those in crisis and their family and friends.

American Association of Suicidology (AAS)
http://www.suicidology.org
The national professional organization of the people involved in suicide prevention across the U.S. and abroad. Resource for information, training and program development support.

American Foundation for Suicide Prevention (AFSP) **1-212-363-3500**
http://www.afsp.org
A national not-for-profit organization dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. Its primary efforts include: funding scientific research, offering educational programs for professionals and providing programs and resources for survivors of suicide loss and people at risk.

Means Matter
http://www.hsph.harvard.edu/means-matter/index.html
"Means reduction" (reducing the odds that an attempter will use highly lethal means) is an important part of a comprehensive approach to suicide prevention. This site contains links to studies, frequently asked questions and resources.

National Action Alliance for Suicide Prevention
http://actionallianceforsuicideprevention.org/
The public-private partnership advancing the National Strategy for Suicide Prevention (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. Its vision is a nation free from the tragic experience of suicide.

National Strategy for Suicide Prevention 2012
http://www.samhsa.gov/nssp
This updated National Goals and Objectives for Action is a report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. It outlines the national strategy to guide suicide prevention actions. Includes 13 goals and 60 objectives across four strategic directions: wellness and empowerment; prevention services; treatment and support services; and surveillance, research, and evaluation.

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://samhsa.gov/prevention/suicide.aspx
A resource listing providing individuals, families, professionals, and organizations with information and resources to seek help, provide assistance, and/or implement suicide prevention programs in their communities. Lists multiple links to additional suicide prevention resources.

Suicide Prevention Resource Center (SPRC) **1-877-438-7772**
www.sprc.org
This website, home to the national SPRC initiated by the 2001 Surgeon General's National Suicide Prevention Strategy, contains over 490 web pages and 250 library resources on suicide prevention ranging from mental health news to strategic tools for developing suicide prevention programs. The site includes individual state suicide prevention pages, news and events, online library, training, and links to other web sites.

The Centre for Suicide Prevention of Calgary, Canada
http://www.siec.ca
An education center which provides information and resources for suicide prevention. The center provides library and information services, fact sheets and other resources.

Web-based Injury Statistics Query and Reporting System (WISQARS)
www.cdc.gov/ncipc/wisqars/
Available online from the U.S. CDC, WISQARS is in interactive database system that provides customized reports of injury data at the national and state level. An important and easily mastered tool for gathering data about suicide, homicide and injury mortality on the state and national levels.

APPENDIX 4 PARTNERS
Maine State Agencies involved in Implementing Suicide Prevention Programming

State Agencies

Department of Health and Human Services:
- Maine Center for Disease Control and Prevention:
  - Maine CDC Injury Prevention Program
  - Division of Local Public Health
  - Rural Health and Primary Care
  - Office of Health Equity
  - Maine State Public Health Nurses
  - Adolescent and School Health
  - Public Health District Offices
- Office of Substance Abuse and Mental Health Services
  - Prevention Intervention Treatment Recovery Support Services
  - Data and Quality Management
  - Information and Resource Center
- Office of Child and Family Services
- Office of Aging and Disability Services

Department of Defense, Veterans & Emergency Management

Department of Education (DOE)
- Coordinated School Health

Department of Labor (DOL)
- Unemployment Services
- Vocational Rehabilitation Services

Department of Corrections (DOC)

Department of Professional and Financial Regulation (DPFR)

Department of Public Safety (DPS)
- State Police
- Emergency Medical Services (EMS)

Maine Attorney General
- Office of the Chief Medical Examiner

Partner Organizations for Implementing Suicide Prevention Programming Regionally and Locally

American Academy of Pediatrics, Maine Chapter
American Association of Retired Persons Maine
American Foundation for Suicide Prevention
American Psychiatric Association, Maine Chapter
American Psychological Association, Maine Chapter
American Red Cross
Area Agencies on Aging
Association of Family Practice Physicians
Association of Osteopathic Physicians
Boy Scouts and Girl Scouts
Boys to Men
Catholic Archdiocese of Maine
Colleges and universities
Community Health and Counseling Services
Consumer Affairs Council
Co-Occurring Collaborative Serving Maine
County Governments
County Correctional System
Domestic Violence Service Providers
Drug Free Communities
Emergency Medical Services Providers
Employers
    Wellness Committees
    Employee Assistance Programs
    Human Resource Departments
Employment/Career Centers/Unemployment supports
Episcopal Diocese of Maine
Equality Maine
Family Planning Association of Maine
Federally Qualified Health Centers
Food banks and food pantries
Fraternal Organizations and other Civic Groups
Funeral Directors
Gaining Empowerment Achieves Results (Gear)
Gay Lesbian and Straight Education Network (GLSEN)
GLTB Support and Advocacy Organizations and programs
Health Insurance Carriers
Health Service Providers
Hearty Girls, Healthy Women
Healthy Maine Partnerships
Home Health personnel
Home Visiting Programs
Homeless services providers for youth and adults

Hospice Programs
Law Enforcement
Legislators
Mail Carriers
Maine Trauma Network
Maine Association of Family Physicians
Maine Association of Social Workers
Maine Association of Substance Abuse Programs
Maine Association of Prevention Programs
Maine Association of Mental Health Providers
Maine Employers Mutual Insurance Companies/Workers Compensation
Maine Citizen's Against Handgun Violence
Maine Chiefs of Police Association
Maine College Health Association
Maine Coalition Against Sexual Assault
Maine Coalition to End Domestic Violence
Maine Council of Churches
Maine Criminal Justice Academy
Maine Crisis Network and Crisis service providers
Maine Domestic Violence Review Panel
Maine Emergency Management
Maine Emergency Medical Services
Maine Funeral Directors Association
Maine Health Care Access Foundation
Maine Health Care Association
Maine Higher Education Council
Maine Homicide, Suicide, Aggravated Assault Review Panel
Maine Hospital Association
Maine Indian Tribal-State Commission
Maine Medical Association
Maine National Guard
Maine Nurse Practitioner Association
Maine Osteopathic Association
Maine Practice Improvement Network
Maine Press Association
Maine Primary Care Association
Maine Psychiatric Association
Maine Public Health District Coordinating Councils
Maine Quality Counts
Maine Sheriffs Association
Maine State Police
Maine Veterans' Administration Suicide Prevention Program
Maine Youth Action Network (MYAN)
Meals on Wheels Programs
Media, social, print, television and radio
Medical Care Development

Medical Examiner's Office
Mental Health Association of Maine
Mental Health Treatment and Support Providers
Municipal and Town Government
National Alliance on Mental Illness of Maine
National Association of Social Workers, Maine Chapter
Natural Helping Networks
New England School of Broadcasting
Northern New England Poison Control
Parent/Family Organizations
Pathways to Excellence
Peer Support Programs
Penobscot Suicide Prevention Coalition
Physicians for Social Responsibility
Public Safety Dispatchers
Religious Organizations Statewide, Regional and Local
Rod and Gun Clubs
Salvation Army
School systems
Sexual Violence Service Providers
Sexual Assault Nurse Examiner Program
Sportsman's Alliance of Maine
Substance Abuse Prevention Coalitions (Regional and Local)
Substance Abuse Providers
Suicide Survivor Speaker's Bureau
Suicide survivors
The Center for Grieving Children
The Unity Project
Traumatic Brain Injury Programs and support services
Tribal health leaders and Tribal representatives
University of Maine Center on Aging
Veterans Administration
Victim Advocates
Volunteer Organizations
Wabanaki Mental Health Center
Youth groups/organizations

APPENDIX 5
Clinical Treatment of Suicidal Behavior

In randomized controlled trials, **cognitive behavioral therapy (CBT)** interventions have been shown to be effective in reducing repeated suicide attempts.[85] [86] Of particular interest is **dialectical behavioral therapy (DBT)**, an intensive and long-term intervention featuring a combination of behavioral, cognitive, and supportive elements developed to treat patients with borderline personality disorder. DBT has been extensively documented and found to reduce suicide attempts among patients with recent suicidal and self-harm behaviors and borderline personality disorder.[87][88]

A review of psychological and psychosocial interventions after attempted suicide found that psychodynamic interpersonal therapy may also be effective in reducing suicidal ideation, habitual self-harming behavior, and suicide attempts among patients with borderline personality disorder.[89] [90]

Common interventions among empirically supported psychological treatments for suicidal patients include: clear treatment framework; defined strategy for managing suicide crises; close attention to affect; active, participatory therapist style; and use of exploratory and change-oriented interventions.[91] The National Registry of Evidence-based Programs and Practices lists several specific programs with significance to suicide prevention and intervention across the lifespan, including Cognitive Behavioral Therapy for Late-Life Depression; Dialectical Behavior Therapy; Multi-Systemic Therapy with Psychiatric Supports; and Trauma Focused Coping.

Cognitive Behavioral Therapy (CBT) for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his

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[85] Stanley B, Brown G, Brent DA, Wells K, Poling K, Curry J, Kennard BD, Wagner A, Cwik MF, Klomek AB, Goldstein T, Vitiello B, Barnett S, Daniel S, Hughes J. Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. J Am Acad Child Adolesc Psychiatry. 2009 Oct; 48(10):1005-13.

[86] Tarrier N, Taylor K, Gooding P. Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. Behav Modif. 2008 Jan; 32(1):77-108.

[87] Koerner K, Linehan MM. Research on dialectical behavior therapy for patients with borderline personality disorder. Psychiatry Clin North Am. 2000 Mar; 23(1):151-67.

[88] Robins CJ, Chapman AL. Dialectical behavior therapy: current status, recent developments, and future directions. Journal Personality Disorder. 2004 Feb; 18(1):73-89.

[89] Guthrie E, Kapur N, Mackway-Jones K, Chew-Graham C, Moorey J, Mendel E, Francis FM, Sanderson S, Turpin C, Boddy G. Predictors of outcome following brief psychodynamic-interpersonal therapy for deliberate self-poisoning. Australia New Zealand Journal Psychiatry. 2003 Oct; 37(5):532-6.

[90] Falk Leichsenring, D.Sc.; Eric Leibing, D.Sc. The Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders: A Meta-Analysis. *American Journal Psychiatry 2003; 160:1223-1232.* 10.1176/appi.ajp.160.7.1223.

[91] Weinberg I, Ronningstam E, Goldblatt M, Schechter M, Wheelis J, Maltsberger JT. Strategies in the Treatment of Suicidality: Identification of Common and Treatment-Specific Interventions in Empirically Supported Treatment Manuals. J Clin Psychiatry 2010 June 71:6: 699-705.

colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated as outpatients. The intervention includes strategies to facilitate learning with this population, such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with greater use of structure and modeling behavior. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. Where appropriate, emphasis is also placed on teaching patients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 50- to 60-minute sessions following a structured manual.

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric) is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity. Youth receiving MST-Psychiatric typically are between the ages of 9 and 17. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations while allowing youth to spend more time in school and in home-based placements. Like standard MST, on which it is based, MST-Psychiatric has its foundation in social-ecological and social learning systems theories. It includes specific clinical and training components for staff designed to address (1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.

MST-Psychiatric teams intervene primarily at the family level, empowering parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. The intervention assists parents and caregivers in engaging their children in pro-social activities while disengaging them from deviant peers. In addition, it addresses individual and systemic barriers to effective parenting. The intervention is delivered in the family's natural environment (e.g., home, school,

community) daily when needed and for approximately 6 months. A MST-Psychiatric team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings.

Trauma Focused Coping (TFC), sometimes called Multimodality Trauma Treatment, is a school-based group intervention for children and adolescents in grades 4-12 who have been exposed to a traumatic stressor (e.g., disaster, violence, murder, suicide, fire, accident). The intervention targets posttraumatic stress disorder (PTSD) symptoms and other trauma-related symptoms, including depression, anxiety, anger, and external locus of control.

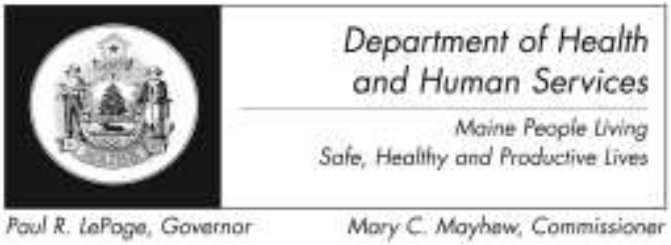
TFC uses a skills-oriented, peer- and counselor-mediated, cognitive behavioral approach. The intervention is delivered in 14 weekly, 50-minute sessions, providing youth with gradual exposure to stimuli that remind them of their trauma. The sessions move from psycho-education, anxiety management skill building, and cognitive coping training to activities involving trauma narratives and cognitive restructuring. Implementation of TFC requires a master's-level clinician and should include a co-facilitating school counselor when administered in a school setting. [92]

Psychosocial Interventions

There is evidence that outpatient psychosocial and psychoeducational programs reduce risk factors for suicide. A 2009 study considered the impact of a 20 week outpatient program on people who had a history of repeated suicide attempts.[93] Unlike programs focusing on people with a single diagnosis, participants in this program had a variety of difficulties: depression, bipolar disorder, eating disorders, substance abuse, anxiety, and various cognitive and impulsivity problems. Small groups met weekly with trained facilitators, including peer facilitators when possible. The program consisted of four modules of skill development: 1) emotional literacy, 2) problem solving, 3) crisis management, and 4) interpersonal relationships. At the conclusion of the training, participants reported a significant reduction in depression symptoms and feelings of hopelessness, and an increase in life satisfaction, problem solving skills, and the ability to describe one's feelings.

[92] SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). www.nrepp.samhsa.gov.

[93] Bergman, Y, Links PS. (2009). Reducing potential risk factors for suicide-related behavior with a group intervention for clients with recurrent suicide-related behavior. *Annals of Clinical Psychiatry,* 21(1), 17-25.



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