Gatekeeper Training 2010 - 2011

Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.

Maine Center for Disease Control

An Office of the Department of Health and Human Services

John E. Baldacci, Governor   Brenda M. Harvey, Commissioner

Maine Youth Suicide Prevention Program

A program of the Maine Center for Disease Control and Prevention since 1998

Statewide Activities Include:

- Crisis Hotline 1-888-568-1112
- Information and Resource Center 1-800-499-0027 (8:00 a.m.—5:00 p.m., M – F)
- Data collection, analysis & dissemination
- Dissemination of print materials
- Training
- Annual conference—April 8, 2011

Resources

Maine Websites

- Maine Youth Suicide Prevention: www.mainesuicideprevention.org
  - Youth Suicide Prevention, Intervention & Postvention Guidelines
  - Fact sheets and resources
  - Separate site for youth
- National Alliance on Mental Illness (NAMI) of Maine: www.namimaine.org

Resources

National Websites

- National Suicide Prevention Resource Center
  www.sprc.org
- American Association of Suicidology (AAS)
  www.suicidology.org
- Substance Abuse and Mental Health Services Administration
  http://mentalhealth.samhsa.gov/
- Centers for Disease Control and Prevention (CDC)
  www.cdc.gov
- Centre for Suicide Prevention
  www.suicideinfo.ca (click on SIEC Alert)

MYSPP Contact Information

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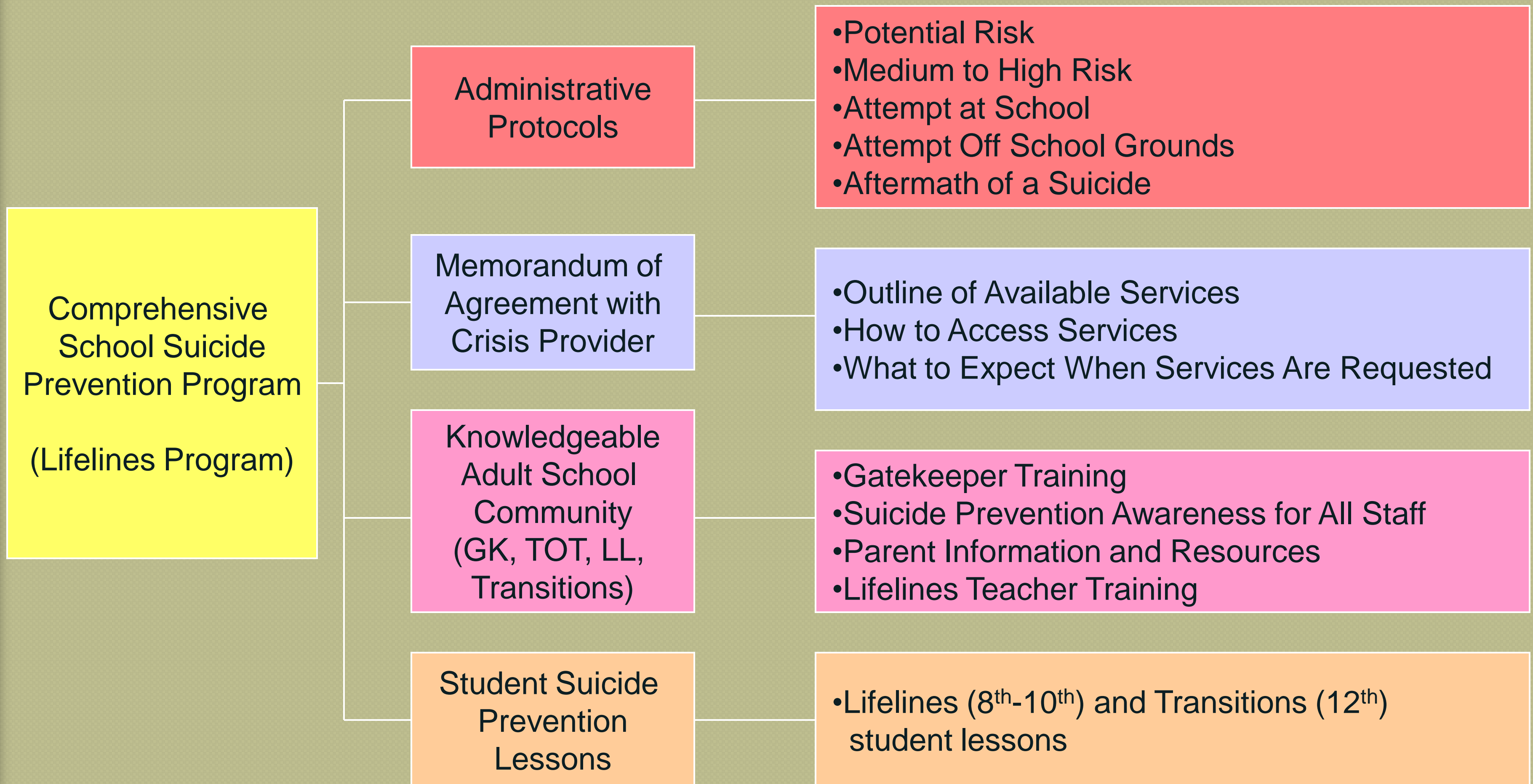
MYSPP Promotes the Following Components of School Readiness to Prevent Suicide



Optional--enhance with the addition of Student Assistance Teams and use of a local referral network

Gatekeeper Training Agenda

- Language Considerations
- Nature of the Problem/U.S. & Maine
- Key Beliefs and Attitudes
- Warning Signs and Risk Factors
- How to Respond to Suicidal Behavior
- Resources for Help
- Working with Parents
- How to be Helpful in the Aftermath of Suicidal Behavior
- Understanding the Needs of Survivors

So What IS a Gatekeeper?

- Someone who:
  - Knows a bit about suicide
  - Believes suicide can be prevented
  - Has basic suicide intervention skills
  - Has the confidence to respond
  - Can assist in the aftermath of suicide
  - Recognizes own comfort level about suicide

Language Considerations

Language Considerations

Must AVOID:

"successful suicide"

"failed attempt"

Please USE:

"suicide" or "died by/of suicide"

"suicide attempt or non-fatal attempt"

Language Considerations (cont.)

Important to Understand:

"committed suicide"

"completed suicide"

"JUST a cry for help"

Please use:

"died by/of suicide"

"a suicide attempt"

Related Language Defined

- Suicidal Behavior
  - Suicidal ideation
  - Suicidal threat
  - Suicide euphoria
  - Suicidal act or “gesture”
  - Suicide pact
- Suicide Survivor

What the Statistics Tell Us

More Americans Die by Suicide Each Year Than by Homicide

Suicide: 34,598

11th ranking cause
11.5 per 100,000

Homicide: 18,361

15th ranking cause
6.1 per 100,000

Almost 2X more people killed themselves than were murdered by others in 2007.

Maine 5 year average 2003 – 2007

All ages:	**166 per year**
10 – 24:	**20 per year**

Maine 2007

Suicides 191

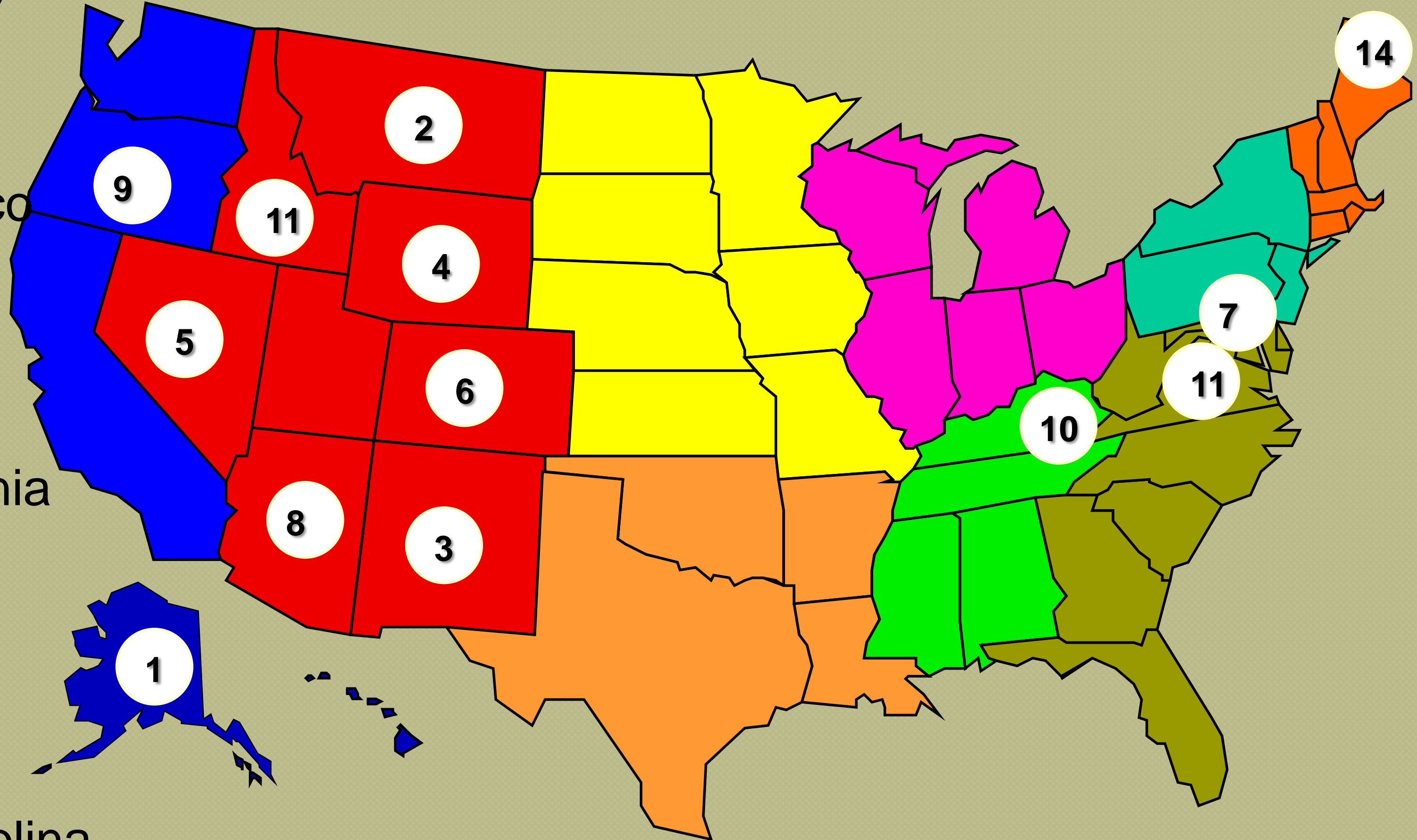
Homicides 21

USA State Suicide Rates
Ranking of Top States--2007

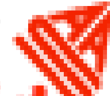
USA 11.5

ME 14.5

1 Alaska
2 Montana
3 New Mexico
4 Wyoming
5 Nevada
6 Colorado
7 West Virginia
8 Arizona
9 Oregon
10 Kentucky
11 Idaho
11 North Carolina



American Association of Suicidology



Divisional Differences in USA Suicide

Suicide highest in the Mountain States

Pacific 11.1

Mountain 16.8

West North Central 12.3

East North Central 10.9

Middle Atlantic 8.5

New England 9.3

South Atlantic 12.1

East South Central 13.8

West South Central 11.2

National Rate 11.5 per 100,000 population

2007 Data

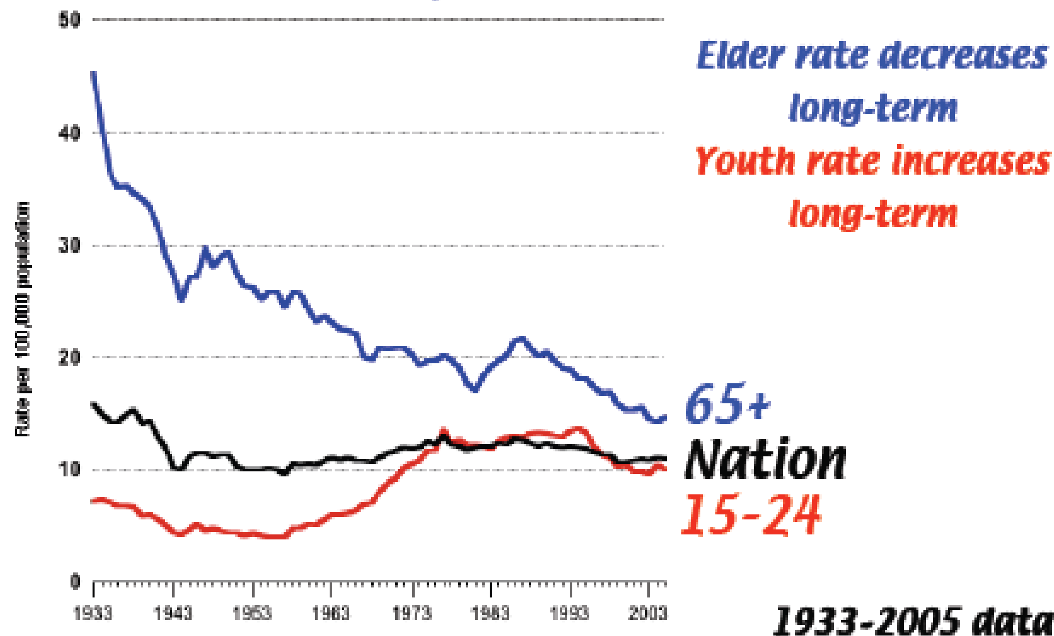
Maine's Trends are Similar to Nation

American Association of Suicidology 2005 Official USA Statistics Overhead Set

American Association of Suicidology

USA Suicide Rates - Trends

National rates steady to recent slight tendency toward decrease



American Association of Suicidology

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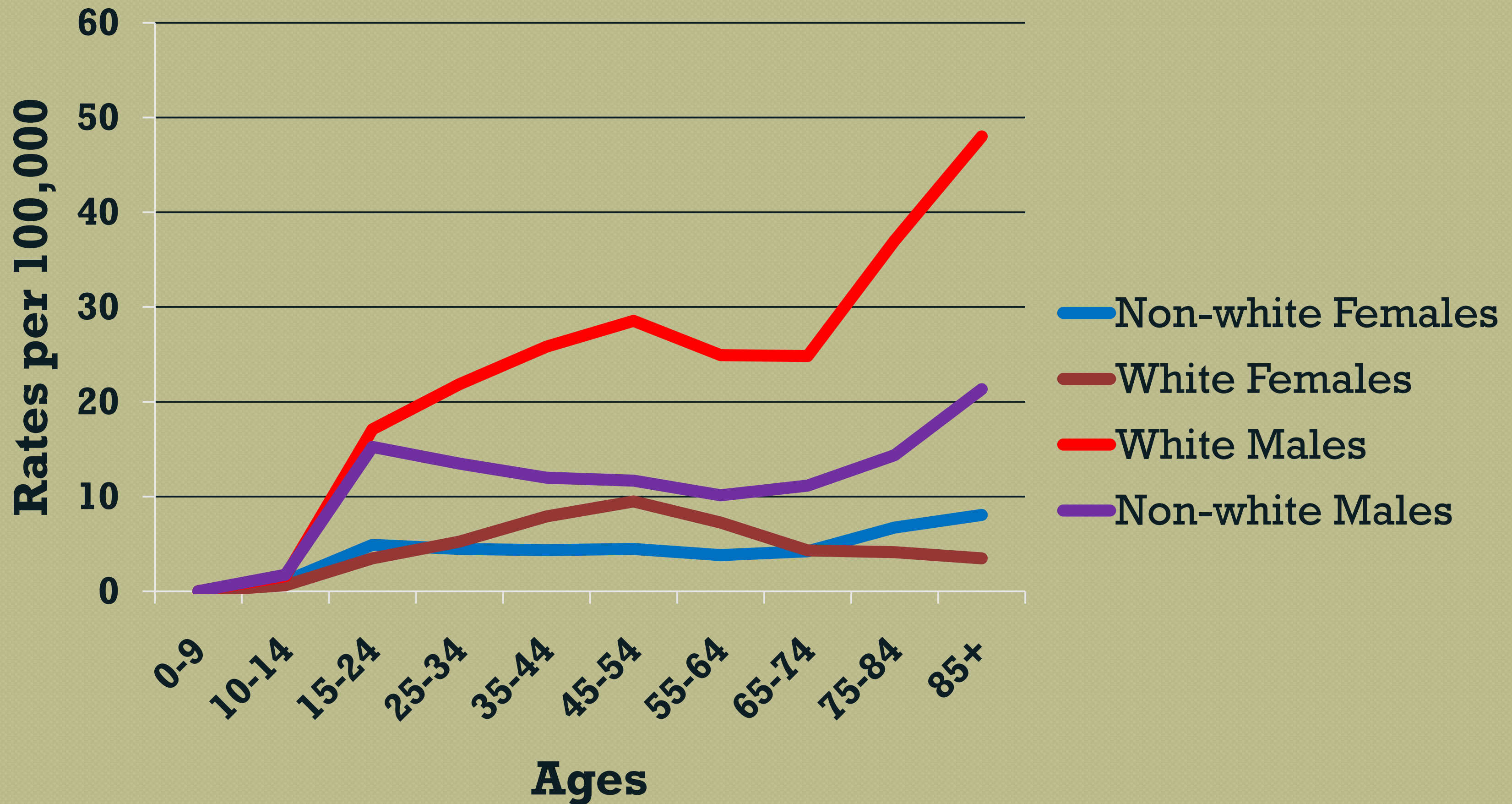
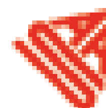
Suicide Rates: Gender, Race, & Rate

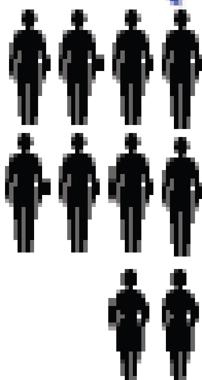


Source: WISQARS



Of every 10 suicides:

Sex/Gender



8 Men

2 Women

Race & Sex/Gender

7 White Men

2 White Women

1 Nonwhite (.7 Male, .2 Female)

Race

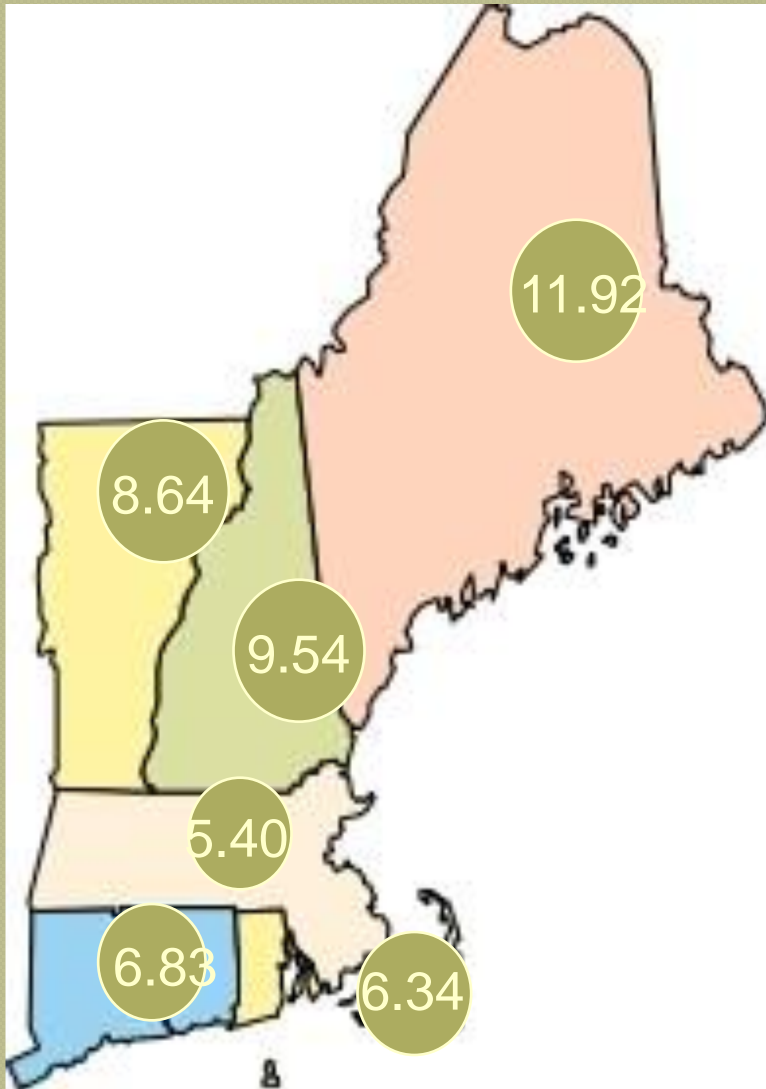
9 Whites

1 Nonwhite

2005 Data

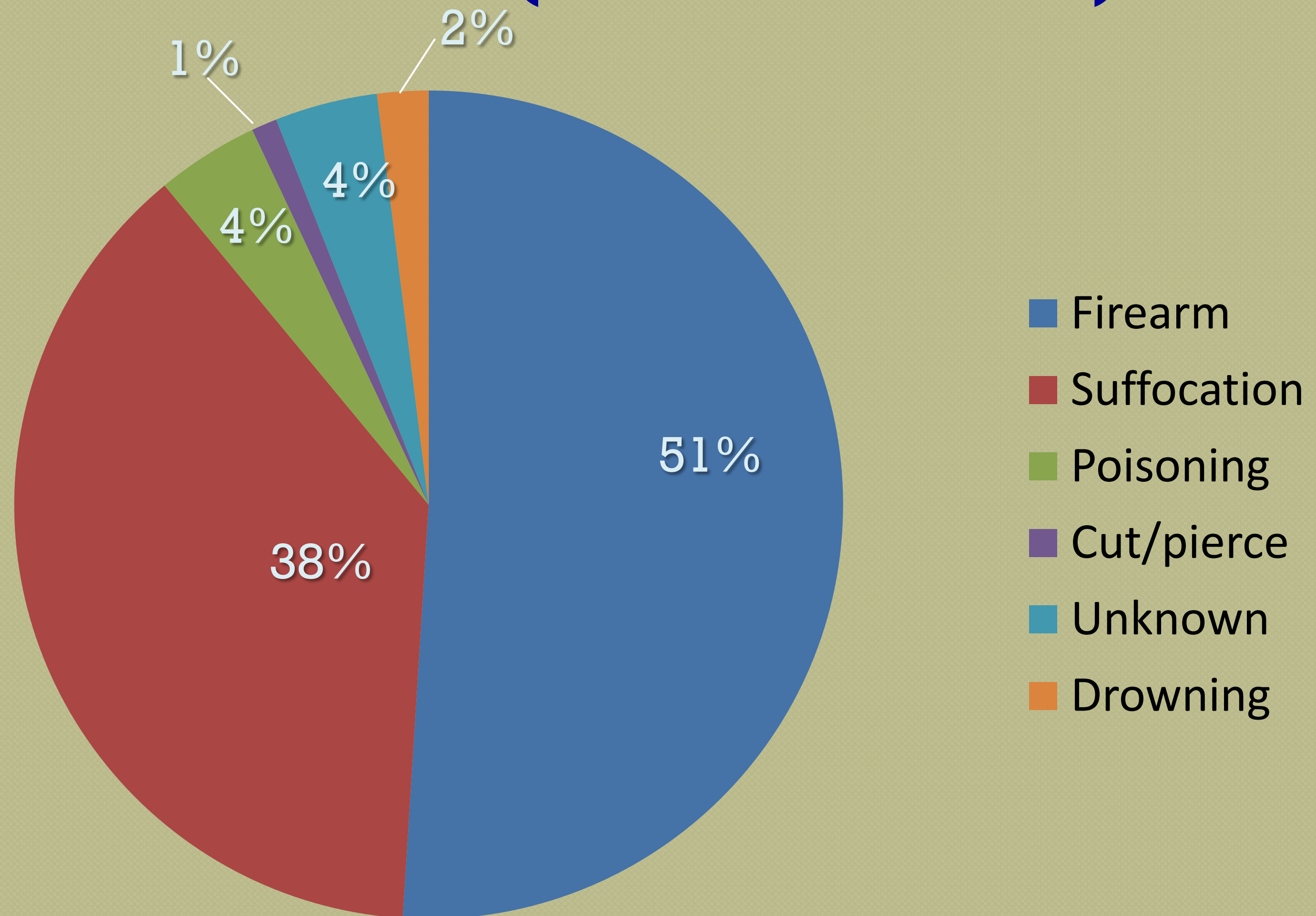
Suicide in New England

(15-24 Years of Age) (Mean rates 2003-2007)



Rank/State	Youth	Adult (25 and older)
Maine	11.92	15.81
New Hampshire	9.54	15.18
Vermont	8.64	17.97
Connecticut	6.83	10.31
Rhode Island	6.34	10.60
Massachusetts	5.40	9.39

Maine Youth, 15-24, Suicides by Method (2003—2007)



Profile of College Suicidal Behavior

- College is a protective factor (unless over 25)
- Suicide rate--half that of young adults not in college
- Seriously considered suicide in their life
  - 18% of undergrads
  - 15% of grads report
- 4-6% report repeated episodes of suicidal ideation and for 2% it is regular for several years
- 2nd leading cause of death for college youth 20-24
- Suicide rarely happens on campus.
- Women in graduate school at highest risk for suicide

Suicide in Young Children

- Rare, but it happens (ages 5-14)
- Approx 275 per year in U.S., 1-2 in Maine
- US vital statistics does not list suicide as a cause of death under 10
- Often called "accidental"
- Means: ropes, riding bikes into traffic…
- Research very limited

Children & the Concept of Death

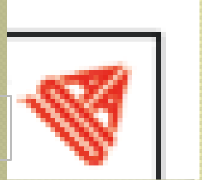
- Concept of death develops gradually and changes given time and experience

- Must understand that death is final, universal, inescapable and unpredictable (and that it applies to them!)

- In a large sample of K-3rd graders, 50% understood all aspects, 80% understood most of it. By 5th grade, almost all understood to a large degree

- As to the meaning of the word "suicide," 10% of 1st graders, 50% of 3rd graders, and 95% of 5th graders understood

MONTHLY VARIATION IN SUICIDE



American Association of Suicidology

Mean Daily Number ~ 89.4

Spring, Summer Peak in Suicides typically

2005 Data

Suicide Variation by Days of Week

Mean Number of Suicides

100
90
80
70
60
50
40
30
20
10
0

Sun Mon Tue Wed Thu Fri Sat

Mean Daily Number = 89.4

American Association of Suicidology

Monday, Tuesday highest; Sunday, Saturday lowest

2005 Data

SUICIDE ATTEMPTS

Attempted Suicide

- Previous attempt is the single greatest predictor of future suicidal behavior
- Risk remains elevated for the first year after the attempt
- Data on attempts in Maine comes from hospitalization data and Youth Risk Behavior Survey

Attempted Suicides

Estimated that there are 25 attempted suicides for each death by suicide

Suicide

Moscicki et al.

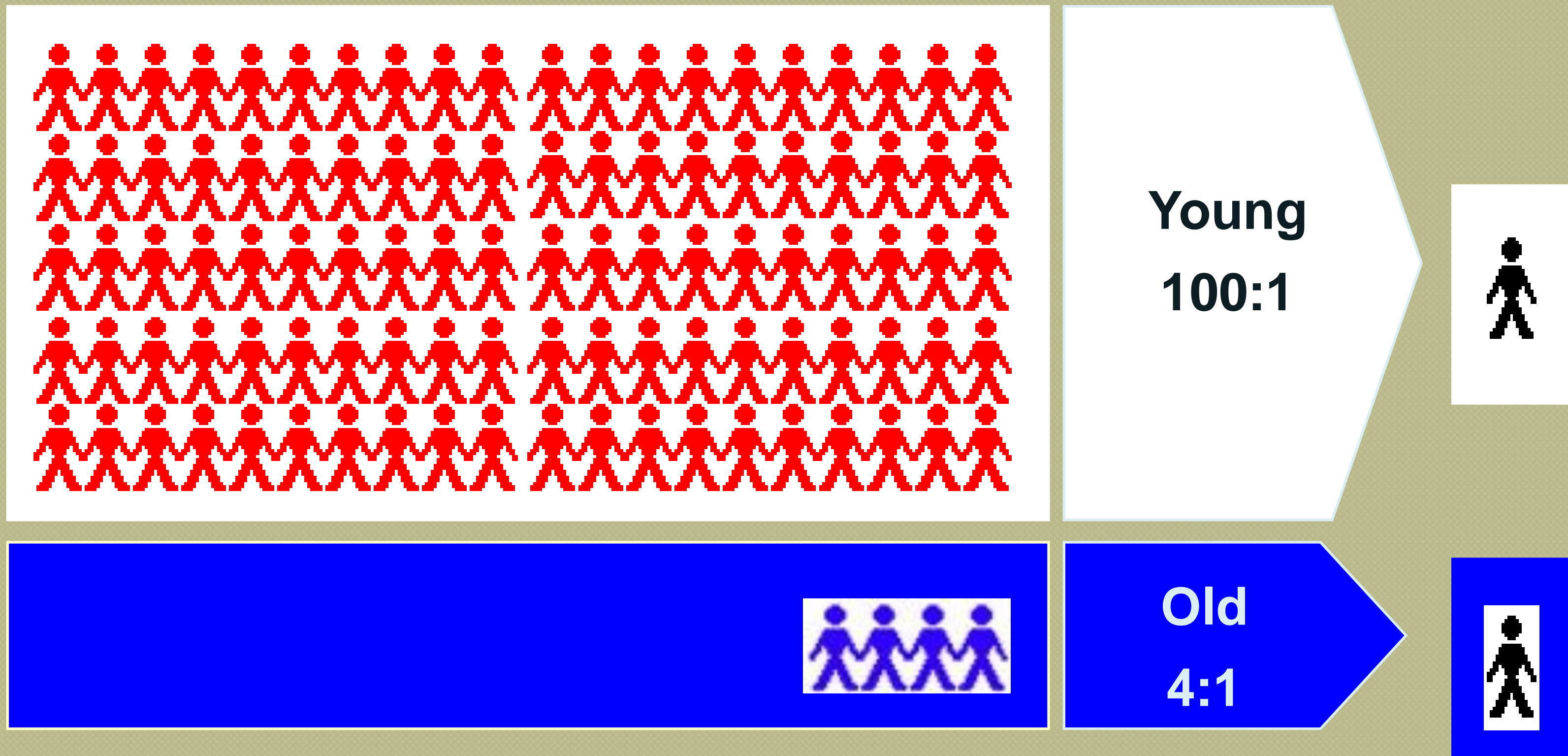
Attempted Suicides

4,775 Mainers

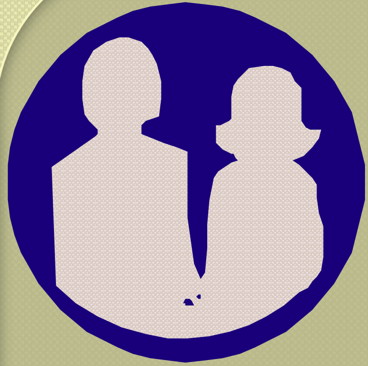
Ratio implies 864,950 suicide attempts annually in USA

Attempted Suicide & Age

Attempts are most common among the young



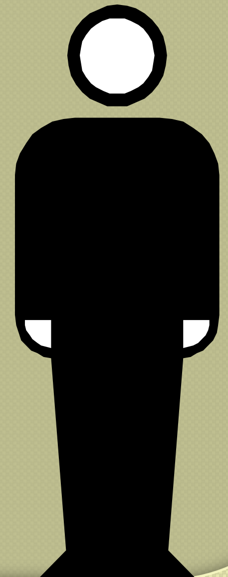
Estimates of youth suicide attempts to completions are as high as 300:1



Attempted Suicide - Sex/Gender

Estimates are that there are

3 female attempts for each 1 male attempt



In the typical high school classroom…

1 male and 2 females have probably attempted suicide in the past year

Sexual Orientation and Attempt Rates

- Consensus has not been reached regarding the degree to which same-sex sexual orientation is a risk factor for suicide.
- Multiple studies show ATTEMPT rates 2-4 times higher for GLBTQ youth and some studies show higher death rates as well ~ more research needed.
- Critical risk factors include substance abuse, depression, abuse, victimization, bullying, etc.

Reasons for Self-Injury

- To manage intolerable feeling
- To feel alive
- To express feelings…revenge, anger, shame
- Relieve stress or pressure
- To create distance from others

Reasons (cont.)

- To distract from painful feelings or memories
- To get attention and fight boredom
- To copy others…to belong
- To practice for suicide (rarely, but sometimes)

More Serious Forms of Self-injury

- On parts of body not visible—breasts, genitals, inside of thighs, face or eyes
- Any injury requiring sutures or medical attention
- Cutting lengthwise on arms

Recent books on this topic
Treating Self-Injury by Barent Walsh (includes school protocol)
Helping Teens Who Cut by Michael Hollander

Beliefs and Attitudes

What Do These Widely Held Beliefs Have in Common?

1. Talking about suicide will cause it.
2. People who talk about suicide don't really die by suicide.
3. Suicide happens without warning signs.
4. Suicidal behavior is just a way to get attention…to manipulate!
5. If someone wants to die by suicide, there isn't anything we can do to stop them.
6. Only mental health professionals are trained to intervene…not me!

Three Questions For YOU!

1. What makes these beliefs so enduring in our culture?

2. If you happened to be suicidal, how might you feel if you heard conversation reflecting these myths?

3. What good could come from actually talking openly about suicide?

Our Words Reflect Our Beliefs

Attitudes (Words heard)	**Myth Behind the Words** (Beware…An Element of Truth)
"Listen, I hear this talk a lot…and I suggest you ignore it or you'll hear more of it!" (parent)	
"Statistically speaking, suicide is a rare phenomenon, and rare phenomenon are notoriously hard to predict. We can not predict suicide because we don't know the causes of suicide." (administrator)	
"We DO NOT and WILL NOT talk about "it" here." (school administrator)	

It all begins with ATTITUDE!

- Understanding the reality behind the myths of suicide builds a foundation on which to base suicide prevention and intervention.
- When administrators and individuals believe that suicide can be averted, they will implement programs/steps to do just that.

Just to be CLEAR…the FACTS

- Talk about suicide will NOT cause it.
- Almost all who die by suicide DO talk about it to at least one other person.
- There are almost always warning signs.
- We must pay attention EVERY time.
- Suicide can often be prevented.
- Anyone can learn to intervene.

LEGAL IMPLICATIONS

Suicide Prevention Planning to Protect Schools and Agencies

Courts Want Evidence that Practitioners and Professionals Act in a "Prudent and Reasonable Manner."

That means:

1. Attend to the "possibility of suicide"

2. Evaluate that risk (or take the steps to make certain that the risk is assessed)

3. Respond reasonably to that evaluation

In Summary…

"If we don't look for the problem, we don't have the problem…" **(typical '90s statement!)**

The above philosophy no longer holds…

- Youth KNOW about the problem and are very anxious to talk about it
- Often they tell an adult, and that adult needs to know what to do
- Lawsuits are a real concern (safety contracts are not recommended and have not held up in court)
- Protocols are an enormous help-you do not have to be an "expert" to be prepared to handle a suicidal crisis

Warning Signs
Risk Factors
Protective Factors

Essential Questions

- How do warning signs and risk factors differ AND does it matter?
- How does the average person know when to take action?
- Can protective factors *really* help someone who is considering suicide?

Why the Need to Clarify?

- Goal #1 of the US Surgeon General's Strategy for Suicide Prevention is to promote the idea that suicide is a public health problem and is preventable….

- Warning Signs are necessary to create public health messages with the goal being identification, referral, and prevention (as with heart attacks, diabetes, cancer etc.)

Definitions

- **Warning Signs**-the earliest observable signs that indicate the risk of suicide for an individual in the near-term (within minutes, hours or days.)
- **Risk Factors**-long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death. (statistically significant)
- **Protective Factors**-the positive conditions, personal and social resources that promote resiliency and reduce the potential of suicide and other high-risk behaviors.

First Tier: Overt & Acute Signs of a Suicidal Crisis
(AAS/Consensus/'06)

1. Someone threatening to hurt or kill themselves
2. Someone looking for the means (gun, pills, rope etc.) to kill themselves
3. Someone talking or writing about death, dying or suicide

Get the Facts and Take Action

- Call 911 or seek other immediate help when you hear, say or see any of these behaviors

Warning Signs Mnemonic
(from AAS Consensus Working Group!)

I **Ideation /** threatened or communicated
S **Substance Abuse** / excessive or increased?

P **Purposelessness /** no reasons for living
A **Anxiety** /agitation / insomnia
T **Trapped /** feeling no way out
H **Hopelessness /** nothing will ever change

W **Withdrawal** from friends, family, society
A **Anger** (uncontrolled)/ rage / seeking revenge
R **Recklessness/** risky acts / unthinking
M **Mood Changes** (dramatic)

Tier Two: Needs Mental Health Assessment, but not Necessarily a Mental Health Emergency

Seek help by contacting a Mental Health Professional or call for a referral if anyone is exhibiting one or more of these behaviors:

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless/engaging in risky activities
- Feeling trapped (like there is no way out)
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety agitation, unable to sleep/sleeping all the time
- Dramatic changes in mood
- No reason for living; no sense of purpose in life

Depression: Key Warning Signs

- Someone who has a significantly depressed mood for more than 2 weeks and may also:
  - Be withdrawing from family and friends
  - Have reduced interest or pleasure in life
  - Have disturbed sleep or appetite; too little or too much
  - Feel hopeless regarding possible improvement
  - Has difficulty thinking, concentrating or seems confused
  - May be thinking about death and/or suicide often.

DSM IV-TR, 2000.

Possible Verbal Warning Signs

- **Direct**

  "I wish I were dead."

  "I'm going to end it all."

- **Less Direct**

  "I'm tired of it all."

  "You'll be better off without me."

  "What's the point of living?"

  "I won't be needing these things anymore."

Warning Signs Identified in Maine HS Students in Recent CDC Grant

	#	% Male	% Females
Verbal statements	101	**45%**	51%
Significant stress/problems	91	**44%**	45%
Change in emotional stability	85	**46%**	40%
Self-injury/cutting	58	**18%**	34%
Behavior change	53	**25%**	26%
Drop in grades	44	**30%**	17%
Relationship Breakup	34	**23%**	13%
Written statements	33	**14%**	16%

Risk Factors are Found in Different Domains….

- Family Risk Factors
- Personal /Behavioral Risk Factors
- Environmental/Social Risk Factors

Risk Factors	**PERPETUATING CONDITIONS** (chronic, long-standing, unchangeable)	**PREDISPOSING CONDITIONS** (whether old or new-these increase risk)	**PRECIPITATING CONDITIONS** (acute and current)
FAMILY	■Family history of suicide, mental illness, substance abuse ■Race ■Gender	■Unrealistic parental expectations ■Abuse (emotional, physical, sexual)	■Major family conflict ■Exposure to suicide of family member ■Anniversary of death ■Moving often
PERSONAL BEHAVIORAL	■Loss through death, abandonment, divorce	■Previous suicide attempt ■Mental illness ■Substance abuse ■Extreme Perfectionism ■Poor coping/social skills ■Impulsive	■Current acute Mental Illness ■Severe stress/anxiety ■Isolation ■Rejection ■Relationship break-up ■Increased use of substances
ENVIRONMENTAL SOCIAL	■Inconsistent, neglectful or abusive parenting ■Sexual orientation	■Experience of repeated loss ■Chronic severe stress ■Ongoing harassment	■Active suicide cluster in community ■Access to lethal means ■Bullying, harassment ■Loss of freedom (e.g., incarceration)

A constellation of risks

Victimization=Dating violence, sexual assault, threatened at school, property damaged at school, unsafe at school, racial harassment, sexual orientation harassment

Risk behaviors=low grades, multiple sexual partners, substance use, smoking, binge drinking, fighting at school, weapon to school, eating disorder

Risk Factors in College Students

- Pre-existing and/or emerging MH condition in a new and unfamiliar environment
- Stress…academic, social, financial, compounded by lack of sleep, improper diet
- Substance abuse (32% report BINGE drinking…% is higher for males!)
- Difficulties w/ Transition
- Out of sync with cohort i.e. 25 year old freshman

Suicide in YOUNG Children (-14)

Warning Signs (very similar to previous list):

- Talk of intent to die
- Multiple childhood “accidents” in those over 6

Risk Factors:

- Early loss of a primary attachment
- Tend to have more than one mental disorder and tend toward internalizing vs. externalizing
- Chronic, serious family discord/hostility, violence, mental illness, suicide, abandonment issues, interpersonal tension, abuse/neglect

Very Important to Remember…

- There is no particular set of risk factors that accurately predict imminent danger.

- There is no “typical” suicidal person- there are ALWAYS varying degrees of multiple factors.

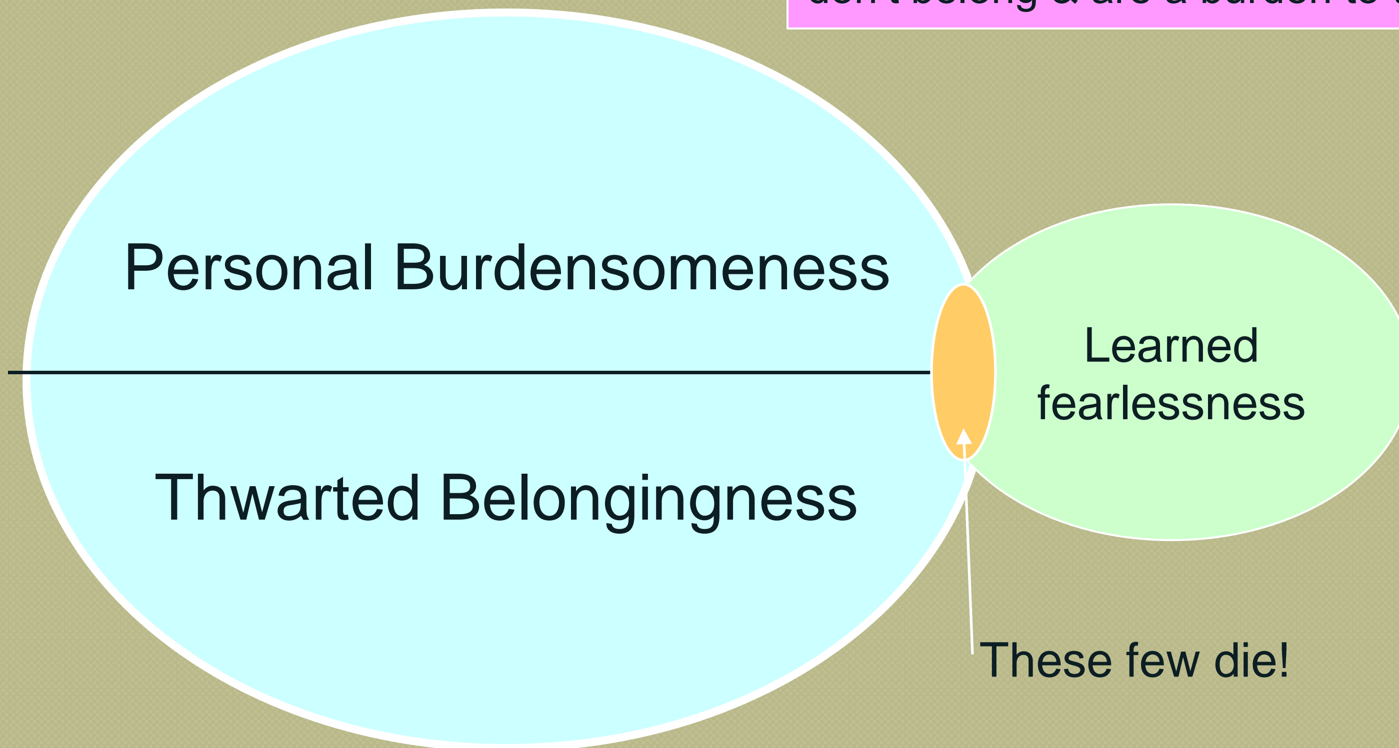
Protective Factors

- **Skills** to think, communicate, solve problems, manage anger
- **Purpose & value in life**-hope for future, pets
- **Personal characteristics** -good health, positive outlook, healthy choices, spirituality or religious belief
- **Safe Environment –** restricted access to lethal means
- **Supports**-Supportive parents, friends, teachers and other caring adults

Why People Die By Suicide by Thomas Joiner, PhD

1.Must develop the *capacity* to die by suicide (w/suicidal behavior, drug use, etc. etc.)

2. Must have the *desire* to die (belief that you don't belong & are a burden to those you love)



From a Suicidal Person's Point of View

- **Crisis** point has been reached
- **Pain** is unbearable
- **Solutions** seem unavailable
- **Thinking** is affected
- **Ambivalence** exists
- **Communication** of pain a must!

Suicide Analysis

Youth Suicides

- Tend to be impulsive
- Poor life coping skills
- Mood disorder
- Substance abuse
- Serious family or relationship problems

Adult Suicides

- Usually premeditated
- Facing major transition
- Relationship failure
- Alcohol dependence
- Major depression

Intervention Unlikely Unless…

- Someone recognizes the signs and the invitation to intervene
- Remember youths are:
  - unlikely to self-refer to MH clinic
  - unlikely to call crisis line
  - unlikely to directly ask for help

Suicide Prevention is Up to All of US!

Invitations to Help

FEELINGS

Desperate
Angry
Guilty
Worthless
Lonely
Sad
Hopeless
Helpless

THOUGHTS

"All of my problems will end soon"
"No one can do anything to help me now"
"I just can't take it anymore"
"I wish I were dead"
"Everyone will be better off without me"
"I won't be needing these things anymore"
"I can't do ANYthing right"
"I can't think straight"

ACTIONS

Giving away possessions
Withdrawal (family, friends, school, work)
Loss of interest in hobbies
Abuse/use of alcohol, substances
Reckless behavior
Extreme mood swings
Increased impulsivity
Self-mutilation (maybe)

PHYSICAL

Lack of interest in appearance
Changes in appetite, weight
Change in sleep patterns

In Summary

- There are almost always warning signs.
- There are multiple levels of risks and risks fall in several different domains.
- Suicidal behavior is very complicated.

How To Respond to Suicidal Behavior

Reasons Youth Hesitate to Ask Adults for Help

- Don’t know what to expect from adults…aren’t sure adults know what to do
- Don’t want to admit needing help
- Don’t want to upset/anger parents-do NOT want to be lectured
- Don’t know how to describe feelings
- Prefer to confide in peers

Why People Hesitate to Intervene

- Inability/lack of knowledge
- Worry about doing/saying the “right” thing
- Feelings of inadequacy
- Belief in myths of suicide

Gatekeeper's Role

- Be present--listen…and listen some more
- Talk about suicide (direct, clear, calm)
- Ask about suicide
- Keep safe
- Get help

GKs do NOT have to solve all of the problems!

What May Be Harmful

- Ignoring or dismissing the issue
- Acting shocked or embarrassed
- Challenging, debating or bargaining
- Giving harmful advice

Rules for Gatekeepers

- Do not judge, lecture, get angry
- Do not promise secrecy
- Do not get over-involved
- Do not leave the suicidal person alone

Three-Step Intervention

1. **Show You Care—Listen carefully—Be genuine**

   “I’m concerned about how you are feeling.”

2. **Ask the Question—Be direct but caring & non-confrontational**

   “Are you thinking about suicide?”

3. **Get Help—Do not leave him/her alone**

   “You’re not alone. Let me help you.”

Use “CPR” to Estimate the Risk

Once you have been “invited” to intervene with someone talking about suicide, consider asking for more information.(CPR for Gatekeepers comfortable enough to use it)

1. **Current suicidal thoughts and/or plans?** (how/when/where/who else knows?/avoid why)
2. **Prior suicidal behavior/attempt(s)?** (experience w/family or friends?/personal history/when/what kept you alive?)
3. **Resources** (help individual identify any possible physical/emotional supportive resources)

How to Refer Youth for HELP

1. Contact the parent and engage them in seeking help.
2. The next best is that you make the arrangements and take person for help or call help in to where you are.
3. Gain a commitment from parent that the recommended help will be sought
4. Follow-up!!

Resources for Help

- **To address the Crisis**
  - Statewide Crisis Hotline (1-888-568-1112)
  - Local Crisis Agency, Mental Health Clinicians and Facilities
  - Hospital emergency room staff or PCP office in rural areas

- **For follow-up, support & information**
  - Private counselors/therapist
  - Religious leaders
  - 211
  - Information & Resource Center (1-800-499-0027)

School Resources for Help

- Any Trusted Adult
- School Administrators
- Teachers
- School Nurses
- School Resource Officer
- Social Workers & Guidance Counselors
- Peer Helpers and their Adult Advisors
- Coaches

Levels of Care Decisions

- The Crisis System has a mandate to stabilize a person in crisis using the "least restrictive level of care" including:
  - Inpatient Hospitalization for those at acute immediate risk.
  - A short-term residential crisis bed to assist in assessment and engage treatment.
  - Return home with a Crisis Plan that might include:
    - Intensive face-to-face crisis stabilization follow-up
    - Referral for follow-up with established providers
    - Phone contact with the crisis team
    - Engaging family social and professional supports
    - Developing a coping card.

School Based Postvention Guidelines

In the Aftermath of a Student Suicide

MANY THINGS TO THINK ABOUT ~ Follow Your Protocols

- Keep the school open
- Consult your crisis plan
- Plan for media involvement
- Contact the family
- Return personal belongings
- Communicate the news
- Determine intervention groups
- Offer grief counseling
- Support staff members
- Acknowledge complexity
- Provide fact sheets

School Memorials After Suicide

- Consider very carefully! Delicate issues are raised.
- Be consistent no matter what the cause of death.
- Discourage whole-school memorials.
- Provide grief support that does not glorify, romanticize, or sensationalize suicide (or any other death!)
- Channel energies into projects that help the living e.g., donate funds to help agencies or to assist the family with funeral expenses; Create a memory scrap book for the family.
- Go to www.mainesuicideprevention.org for postvention guidelines and resources.

Supporting Parents Through Their Child's Suicidal Crisis

Engaging Parents

Helper / Professional Person	Parent / Guardian
1. SAFETY of youth	1. Maintain some equilibrium
2. Professional responsibilities	2. What to do; Where to turn for help
3. Gaining cooperation of parents	3. SAFETY of youth

TAKE ACTION…
Remove the Method

1. **Inform** parents of your concern about the risk of suicide for their child

2. **Explain** that they can reduce the risk by removing ALL lethal means from the house-especially firearms

3. **Educate** about how to limit access to means

How to be Supportive After a Suicide Attempt

- Support family/friends
- Acknowledge the impact, the fear
- Avoid judging, blaming
- Emphasize safety and removal of all lethal means from household
- Encourage appropriate help

Survivors of Suicide

Number of Suicide Survivors

It is estimated that there are at least

6 survivors

for each death by suicide

A
"suicide survivor"
is someone who has lost a loved one to death by suicide

1146 Mainers in 2007

Ratio implies at least 207,588 survivors *each year*

For the Living, All Death is Not the Same

Three Types of Death:

- **Completion** *(timely, expected, natural,) (simple grief)*
  loss → hurt → sadness → grief → peace

- **Interruption** *(untimely, unexpected, unnatural) (complicated grief because there are no final answers)*
  loss→ shock → hurt → anger → grief → question & torment

- **Self-interruption** *(untimely, unexpected, unnatural AND self-inflicted) (grief further complicated by "could/should haves")*
  loss → shock → hurt → anger → grief → question & torment → guilt & regret

Survivors of Suicide:

- Struggle to make meaning of the loss
- Suffer from overwhelmingly complicated feelings
- May take a long time to grieve
- Youth survivors have special issues

Common Student Reactions to Suicide

- **Shock & Denial** (hysterical to remarkably unresponsive)
- **Anger & Protection** (want someone to blame, may direct anger at adults in deceased's life)
- **Guilt** (sometimes they blame selves)
- **Anger** at the deceased (stupid thing to do!)
- **Anxiety** (if s/he could do it, maybe I could, too)
- **Loneliness** (everything feels empty without friend)
- **Hope & Relief** (pain and hurt eventually subside)

How YOU can be Supportive After a Suicide

- Acknowledge the loss
- Use the name of the deceased
- Share your presence
- Share a special memory/story
- Acknowledge the good things
- Stay in touch
- Recommend Grief Support Center

Take Care of Yourself

- Acknowledge the intensity of your feelings
- Seek support, de-brief
- Share your feelings
- Avoid over – involvement
- Know that you are not responsible for another person’s choice to end their life

Before You Leave…

Any Questions?

We need your Evaluation.

You need your Certificate of Attendance!

Thank You . . .

For learning about suicide prevention

Maine Youth Suicide Prevention

Education, Resources and Support

It's Up to All of Us