

Draft Adult Suicide Prevention Plan Maine

Maine Centers for Disease Control and Prevention

Department of Health and Human Services Maine

Injury Prevention Program

DRAFT

**Plan for the Prevention of Suicide Among Adults in
Maine**

Draft Adult Suicide Prevention Plan Maine



*Department of Health
and Human Services*

*Maine People Living
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

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Introduction

Suicide is the tenth leading cause of death among Maine citizens, and the leading cause of violent death. From 2004 to 2008, an average of 160 people died by suicide every year in Maine, and this number seems to be increasing. Eight times more than Mainers die by suicide than by homicide. Suicide and suicidal behaviors occur across all age groups, ethnic backgrounds, and socioeconomic groups. The financial cost of suicide and suicidal behaviors from medical care and lost productivity is in the millions of dollars every year. The emotional cost to family, friends, and communities is incalculable.

All too often, suicide is surrounded by silence: silence from the suffering person contemplating suicide, and silence from the larger community whose members do not know how to recognize and respond. The perception that suicide is a *private* tragedy about which nothing can be done hinders public awareness of warning signs, and inhibits coordination among state agencies, service systems, and treatment providers to identify and treat people at risk of suicide. Stigma and fear of discrimination surrounding suicide create reluctance to confront suicide openly; stigma can be so strong that it can keep people from seeking help.

“Suicide gets whispered about more than it gets talked about. I think that’s why so many people are still dying from it. In 2006 there were 33,300 reported suicides [in the United States]. We have to address this epidemic out in the open, without shame. That’s why I’m sharing my story. I’m doing it for you, Dad.”

Michelle Ray Smith, whose father died by suicide on September 29, 2003

The good news is that when suicide is approached as a *public* health problem, suicides can be prevented. Nationally, innovative programs and rigorous research are beginning to demonstrate that suicide rates can be reduced. In Maine, the nationally recognized Maine Youth Suicide Prevention Program (MYSPP) is beginning to see a reduction in suicidal behaviors among Maine youth.

The goal of this Plan is to reduce the suicide rate for adults in Maine ten percent by 2020 – the same target set by *Healthy People 2020*¹ – by engaging Maine’s citizens and governmental entities in proven public health suicide prevention strategies. The Plan establishes priorities for action over a five year period, recognizing that prevention strategies will need to be expanded into other areas in future years. It seeks to build on existing networks of services where suicide prevention is most likely to have the biggest initial impact.

A Public Health Approach To A Public Health Problem

Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. The central mission of public health programs is to improve the health of our communities. Suicide, a leading cause of premature death, is antithetical to this mission.

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Although researchers have identified risk factors for suicide, trying to prevent suicide solely by targeting people at risk is not as effective as using a broad-based public health approach. A useful analogy is to seatbelt use. Most people who drive are never going to be in a potentially fatal auto accident, but to achieve the health benefits of seatbelts, everyone must wear them.

Research from the suicide prevention program undertaken by the Air Force in the 1990s greatly influenced our understanding of how a public health program can prevent suicide. The Air Force program made suicide prevention the responsibility of everyone, implementing a multidimensional approach that included: leadership responsibility at every level of the organization; education of all Air Force personnel; accessible prevention and crisis services in the community; integrated treatment services; commanders tasked as “gatekeepers” with responsibility for referring personnel to needed services; and risk assessment in every Air Force unit. Over a four year period, deaths by suicide decreased by 33 percent. Significant changes in other indicators of community health were realized as well: severe family violence decreased by 54 percent, homicides by 51 percent, and unintentional injury deaths by 18 percent.²

The federal suicide prevention initiative began in 1999 with the *Surgeon General’s Call to Action to Prevent Suicide*,³ and further developed in 2001 with the *National Strategy for Suicide Prevention*.⁴ Subsequently, forty-eight states implemented public health suicide prevention programs. The *National Strategy* currently is under revision to further guide effective suicide prevention across the nation.

Maine’s Public Health Approach to Youth Suicide

Maine became a leader in youth suicide prevention even before the federal initiatives. In 1995, in response to an increase in Maine’s adolescent suicide rate, Governor Angus King created a Task Force to study the problem and recommend action. An extensive planning process led to the creation in 1998 of the Maine Youth Suicide Prevention Program (MYSPP), which continues to be coordinated by the Injury Prevention Program of the Maine Center for Disease Control and Prevention, Department of Health and Human Services. Other state agencies that serve families, including the Departments of Education, Labor, Corrections and Public Safety, conduct youth suicide prevention activities. This work was furthered in 2005 when Governor Baldacci issued an Executive Order directing Children’s Cabinet agencies to strengthen the MYSPP. Among other efforts, this resulted in a strategic planning process to bring Maine’s plan into alignment with federal recommendations for action.

The MYSPP has been nationally recognized for its work, winning numerous awards. It has secured competitive federal grant awards from the National Center for Disease Control and the Substance Abuse and Mental Health Services Administration that have supported youth suicide prevention projects in over thirty Maine communities. MYSPP activities are supported currently with state and federal Maternal and Child Health and federal Preventive

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Health grant funds. Other state agencies contributing to MYSPP activities use various sources of support. Core activities include a statewide Information Resource Center, statewide crisis hotline, a website with extensive resources, materials development, professional training, public awareness education, prevention and intervention protocols for schools, and school-based Lifelines Program. Detailed information about the MYSPP is in Appendix C.

“A benign community ought routinely to provide immediate postventive mental health care for the survivor – victims of suicidal deaths.”

Edwin Shneidman

Although the evaluative work necessary to establish a definitive causal connection between MYSPP efforts and youth suicide behavior would be prohibitively costly, statistics suggest that the MYSPP seems to be having an impact. The number of suicides among Maine youth fluctuates annually, but the suicide rate appears to be declining slightly. The Maine Youth Risk Behavioral Survey shows a reduction in suicidal behaviors between 2001 and 2007. (The uptick in 2009 in students considering and attempting suicide is troubling, and underscores the importance of sustaining efforts to prevent suicide.)

| Maine Youth Risk Behavior Survey Results | | | |
|--|--------------------|-----------------|-------------------|
| Year | Considered Suicide | Planned Suicide | Attempted Suicide |
| 2001 | 18.6% | 16.5% | 9.2% |
| 2007 | 9.2% | 12.9% | 4.8% |
| 2009 | 13.8% | 11.8% | 9% |

A Public Health Network for Suicide Prevention Across the Life Span

Multiple state and local, public and private, organizations exist in Maine that are ideal for implementing adult suicide prevention activities. These organizations offer the opportunity to reach tens of thousands of Maine citizens through existing communication networks. Under the leadership of the MYSPP, many of these organizations work together now on suicide prevention for youth,

The MYSPP has an Advisory Council that provides guidance and feedback to the MYSPP, identifies opportunities to collaborate among member agencies and groups, and actively promotes and advances the work of MYSPP. Those involved in the MYSPP also connect with other organizations through mutual participation on boards and committees, and by providing training and technical assistance to a wide variety of public and private organizations. A partial list of groups with whom MYSPP works includes: schools and universities; state agencies that serve children and families; media organizations; police and sheriff departments; primary care physicians and mental health practitioners; Native American tribes; child welfare agencies; sexual minority youth; and the Veteran’s Administration. As a result, an infrastructure is in place today to begin suicide prevention for adults.

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Many of these organizations recognize the need for suicide prevention programs for adults. In 2010, a needs assessment conducted by the Division of Family Health of the Maine CDC identified suicide prevention as a priority.⁵ Reducing the suicide rate for youth *and* adults is a goal of *Healthy Maine 2020*.⁶ **[CHERYL: the 2020 Healthy Maine goals and objectives have been removed from the internet. What's the status of Healthy Maine 2020? If unpublished, the above sentence should be deleted. Need a cite for the needs assessment in the second sentence– put in endnote 5. If no cite, delete endnote 5.]**

The challenge is this: no organization now has a comprehensive program for adult suicide prevention. Rather, efforts are ad hoc and uncoordinated, dependent on the interests and expertise of interested individuals. The Maine CDC Injury Prevention Program, which administers the MYSPP, has identified the need to collaborate with organizations that have an interest in preventing suicide among adults. This Plan seeks to guide prevention efforts focused on preventing suicide among adults that builds on the work of the MYSPP and its partner organizations.

Planning Process

The impetus for extending suicide prevention from youth to the entire age span is a recent increase in the suicide rate among middle-age adults, creating awareness that the rate of people dying by suicide in Maine will likely increase as Maine's population ages. Because suicide affects everyone, personally or through its financial cost; and because some people in every societal grouping will think about, attempt, or die by suicide; the planning process was designed to consider adult suicide prevention as broadly as possible, and then to establish initial priorities.

Staff in the Injury Prevention Program first recruited a Steering Committee to guide the planning process. Steering Committee members exchanged information about their experiences with suicide among the adults served by their organizations and about opportunities for implementing prevention strategies into their current work. Additional information was gathered from four sources:

- Data on suicidal behavior and deaths in Maine;
- Literature reviews of published studies on suicide deaths and effective prevention programs;
- Interviews with leaders in Maine organizations essential to suicide prevention, with survivors of suicide, and with clinicians who provide treatment; and
- Review of information posted on national suicide prevention internet sites, and of the suicide prevention plans of the other forty-nine states.

This information was reviewed by the Steering Committee, which then guided development of the Plan's focus and strategies. Certain guiding principles – based on research, effective prevention practices, and experience – further shaped the strategies. (The guiding principles are

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listed on page 17.) The final step was Steering Committee and DHHS review of strategies, objectives, and recommended activities.

Plan Priorities

During the planning process, Steering Committee members worked to articulate a vision for suicide prevention across the life span in Maine. The overarching vision was a declining suicide rate and the improvement of mental health among all Maine citizens. Other elements were development of an integrated and accessible system capable of effective and appropriate screening, assessment, and intervention for people at risk of suicide; many people, such as educators and medical, mental health, public safety, emergency service providers, trained to recognize and respond effectively to suicidal behaviors; enhanced evaluation and research capabilities to inform program development; and a staffed and funded Office of Suicide Prevention with many state and local partners.

As work proceeded, the Steering Committee and Injury Prevention Program began to narrow the focus to what could be achieved during a five year period. The overall vision stayed the same: a reduction in the suicide rate in Maine. This became the Plan's goal. Priorities were recommended that met four criteria: they can be implemented through existing networks of DHHS offices and partner agencies; they reflect the research on effective prevention programs; there is at least some direct experience in Maine that the strategies are effective; and they are economically feasible. These priorities are reflected in the Plan's Strategic Directions. The Steering Committee and Injury Prevention Program staff considered other approaches as well, such as working with faith communities and in work places and correctional facilities. After careful consideration, the decision was made that an initial five-year plan attempting to implement suicide prevention in all settings where adults gather was overly ambitious. Future plans should, however, extend adult prevention programs into other arenas.

Role of the Maine Injury Prevention Program, Maine CDC

The MYSPP, administered by the Injury Prevention Program, targets ten to twenty-four year olds, and has primarily focused its efforts on middle and high school aged youth. This plan targets post-secondary youth, middle age adults, and older adults. The Maine CDC intends to integrate the two plans, creating a comprehensive public health approach to suicide prevention across the life span. The Injury Protection Program will:

- Staff the combined suicide prevention programs;
- Provide leadership and collaborate with organizations, professionals, schools, families, and individuals;
- Link partner organizations to prevention information, education, and evidence-based resources;
- Provide training and implementation assistance to integrate effective suicide prevention strategies into the work of partner organizations;
- Promote public awareness of suicide and its prevention; and

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- Obtain and interpret data to monitor suicide rates and the effectiveness of Plan strategies.

The Cost of Suicide

Suicide deaths have immediate and long-term financial, emotional, and social consequences. The cost 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, twenty-five to one hundred others attempted suicide.⁷ The single best predictor for dying by suicide is a previous attempt at suicide. Prevention programs aim to reduce costs by identifying and helping people at risk of suicide, 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 of these costs are known: for example, the costs of emergency room visits and hospitalizations for self-inflicted injuries; others are hidden: for example, the cost of police officers who investigate suicide deaths. The available economic data are startling, but they underestimate the true cost of suicide deaths and attempts.

Direct and Indirect Economic Costs

- The annual medical cost of deaths by suicide in Maine averages \$560,000 (in 2004 dollars).⁸
- The annual medical cost of suicide attempts requiring hospitalization in Maine averages \$8,400,000 (in 2005 dollars).⁹
- The annual lost productivity cost for deaths by suicide in Maine averages \$175,160,000 (in 2004 dollars).¹⁰
- The annual lost productivity cost for suicide attempts requiring hospitalization in Maine averages \$7,833,000 (in 2005 dollars).¹¹

Emotional and Social Costs

As with financial cost, the emotional burden of suicide spreads through the layers of our communities, as families, friends, teachers, employers and co-workers, health care professionals, and public safety officials question what they might have done differently. The most immediate and severe burden, of course, is experienced by family and friends. A conservative

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estimate is that there are six survivors for every person who dies by suicide;¹² thus in Maine, almost one thousand citizens become survivors of suicide every year.

“The person who . . . [dies by] suicide puts his psychological skeleton in the survivor’s emotional closet.”

Edwin Shneidman

The death of a loved one by suicide is itself a risk factor for suicide. Survivors (family members and friends of those who died by suicide) frequently report difficult problems and challenges following the death of a loved one. These include:¹³

- 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 that loved Joe so much.”

Cheryl Morin

Suicide and Suicidal Behavior

The suicide rate in Maine – 15.00 per 100,000 people – is higher than the national rate of 12.86, and the second highest in New England. This is most likely a reflection of Maine’s demographic composition. Suicide rates vary by age, ethnicity, and gender, and are highest among older, white males.¹⁴ According to census data, Maine has the highest percentage of white non-Hispanic people

One Year in Maine (2007) . . .

191 people died by suicide

1,094 people were hospitalized and another 1,911 people were treated in the emergency department for self-inflicted injury

6,700 high school youth and 27,000 adults reported considering suicide

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in the country, and the most rapidly aging population.¹⁵

Historically, the number of people who die by suicide in Maine has been fairly steady. Recently, however, there has been an increase in the number of deaths, from an average of 166 per year from 2003 to 2007, to 186 deaths in 2008 and 187 deaths in 2009.¹⁶ [CHERYL: FTN 16 IS FROM ERIKA LICHTERS PRESENTATION AT THE JUNE SYMPOSIUM. I CAN'T FIND HER PRESENTATION ON YOUR WEBSITE. THIS DATA IS IMPORTANT. COULD YOU POST IT SO WE CAN FOOTNOTE IT?] Although it is too soon to know whether this increase will become a trend upwards in the suicide rate, it is cause for concern.

Suicide as Cause of Death

An average of 170 people die by suicide each year in Maine. Suicide is the leading cause of violent death,¹⁷ killing eight times as many people each year as homicide. For all ages, suicide is the tenth leading cause of death. Suicide, however, is the second leading cause of death for youth and adults age 15-34, the fourth leading cause of death for adults age 35-54, and the eighth leading cause of death for adults age 55-64. Suicide is not among the top ten causes for adults age 65 and older.

The highest suicide rate is among adults age 85 and older. The greatest number of deaths, however, is among adults ages 45-54, followed by adults age 35-44.

| Suicide Deaths in Maine 2003-2007 ¹⁸ | | | |
|---|------------|---------------|---------------------------|
| Age | Number | Rate per 100K | % of Total Suicide Deaths |
| 10-14 | 2 | 0.47 | 0.24 |
| 15-24 | 100 | 11.88 | 12.01 |
| 25-34 | 108 | 14.40 | 12.98 |
| 35-44 | 150 | 15.21 | 18.02 |
| 45-54 | 187 | 17.49 | 22.47 |
| 55-64 | 133 | 16.76 | 15.98 |
| 65-74 | 75 | 15.40 | 9.01 |
| 75-84 | 47 | 13.95 | 5.64 |
| 85+ | 30 | 22.72 | 3.60 |
| Total | 832 | 14.29 | |

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Eighty percent of people who died by suicide are male; rates are highest among men over age 65 years. Among women, the highest suicide rates are those 35 to 64 years of age. There have not been significant changes in suicide rates by gender over time. The best single explanation for the higher suicide rate for men is that twice as many men as women use firearms as the means of death.

Suicidal Behavior as Cause of Injury

Some suicidal behavior that does not result in death comes to the attention of health care professionals, but much does not. Experts estimate that for every death by suicide, another 25 to 100 people attempt suicide.¹⁹ Maine survey data confirms that a significant number of youth and adults consider suicide every year. During 2006-2007, three percent of Maine adults surveyed reported thinking about, planning, or attempting suicide in a twelve-month period.²⁰ During 2009 among high school students, 13.8% reported thinking about suicide, 11.8% planned their suicide, and 9% reported attempting suicide.²¹

The average number of hospitalizations in Maine for self-inflicted injury is 1,075 per year. The rate of hospitalizations per 10,000 population remained fairly steady from 2000 to 2006, from a rate of 8.3 in 2000 to a rate of 10.0 in 2008. Outpatient visits to hospital emergency departments for self-inflicted injury, however, increased significantly from 2000 to 2008. The actual number of emergency department visits more than doubled during that time, and the rate of visits rose from 6.8 in 2000 to 18.0 in 2008 (per 10,000 population).

Youth and young adults between ages 15 and 34 have the highest rates of hospitalization and emergency department visits. The rates of both hospitalizations and emergency department visits decrease sharply after age 44.

| Hospital Care for Self-Injury in Maine, 2008²² | | |
|--|-----------------------------|------------------------|
| Age Group | Hospitalization Rate/10,000 | Outpatient Rate/10,000 |
| 10-14 | 4.8 | 10.5 |
| 15-19 | 18.0 | 57.0 |
| 20-24 | 17.1 | 46.6 |
| 25-34 | 13.5 | 28.0 |
| 34-64 | 9.5 | 9.1 |
| 65+ | 2.2 | 0.6 |

While men are four times more likely to die from suicide, women are three times more likely to attempt suicide.²³ Women also are more likely to be hospitalized for self-injurious behavior.

| |
|--|
| Hospital Care for Self-Injury by Gender in Maine, 2008²⁴ |
|--|

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| Gender | Hospitalization Rate/10,000 | Outpatient Rate/10,000 |
|--------|-----------------------------|------------------------|
| Female | 12.2 | 20.5 |
| Male | 7.7 | 15.3 |

Means and Location of Suicide and Self-Injury

Firearms are the most common method of suicide across all age groups, and account for more than half of all suicide in Maine. From 2002 to 2006, a firearm was used in 60 percent of male suicides and 29 percent of female suicides. Because men die by suicide at a higher rate than women, the result is a firearm suicide death rate that is ten times higher for males than females.

Poisoning and suffocation (hanging) are the next most common causes, each accounting for about 19 percent of all suicides. Suffocation is more prevalent among younger people and among males, while poisoning is more prevalent among older people and among females.

Methods for self-inflicted injury requiring hospital care are those that are less likely to result in death. The most prevalent self-injury method is poisoning, followed by cutting and other forms of self-injury. This is true for both men and women.

Maine does not yet compile statistics on the location of suicide deaths, but federal data²⁵ indicate that almost all suicides occur at home or in public places (88.7%). Very few people die in supervised settings such as schools or colleges, jails, hospitals, or health care facilities (2.7%). Data from the Maine Violent Death Reporting System,²⁶ **[CHERYL: NEED CITE. IF CITE NOT AVAILABLE DELETE FOOTNOTE BUT NOT DATA]** a pilot program of the MYSPP that reviews deaths for youth between the ages of 10 to 24, align with the 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.”²⁷ Suicide is the result of many complex factors, with new research indicating that suicide requires mental preparation for a person to become capable of taking his or her life.²⁸ Although suicide or suicide attempts may seem impulsive, when individuals are examined more closely they generally have a vulnerability toward suicide, including active suicidal thoughts for some time before an attempt or death by suicide.

Researchers have focused on identifying risk and protective factors, but even this poses a paradox: for example, most people who die by suicide have a mood disorder such as depres-

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sion, 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.²⁹ Risk factors, examples of which are listed below, can be divided into various domains:³⁰

- Biological: age, gender, ethnicity.;
- Psychiatric: mood disorders, drug or alcohol use, suicide attempts, etc.;
- Psychological: hopelessness, lack of coping skills, impulsivity, etc.;
- Medical: chronic physical illnesses such as HIV/AIDS, Huntingtons, central nervous system diseases; renal disease, malignant neoplasms, multiple sclerosis; recent release from inpatient psychiatric care, etc.;
- Social: financial or relationship loss, social isolation, family history of suicide, history of trauma or abuse, legal problems, easy access to lethal means, barriers to accessing health care, exposure to suicide through media or the influence of others, etc.

It is important to note that 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; simultaneously, knowing who is most at risk helps to identify the most effective interventions.

“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.”

Sandy Fisher

Groups at Increased Risk of Suicide

The greatest risk of suicide is posed by people who have made a **previous suicide attempt**. Between 12 and 30 percent of people who have made an attempt will make subsequent attempts within a year.³¹ A similar but lesser risk is thinking about or planning suicide.

Ninety percent of people who die by suicide have **depression** or **other diagnosed mental illnesses**.³² Suicide is the leading cause of early mortality among people who have schizophrenia.³³

Depression and other mood disorders (including anxiety) are, however, the most common diagnoses. Research indicates that between 60 and 85 percent of people who die by suicide suffer from depression.³⁴ In study after study, depression is the single most common risk factor identified in specific population groups, such as older adults and ethnic or sexual minority groups.

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The fact that depression is the most robust 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, demographic groups, and social positions. Almost 21 million adults – 9.5% of the population over age 18 – have a mood disorder, often co-occurring with anxiety and substance abuse. Depression is appearing at earlier ages than in the past, with an average onset at age fourteen.³⁵ 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.³⁶ One study estimated that if major depressive episodes were effectively treated in older adults, the suicide rate would decrease 75 percent in this group.³⁷

Most people across the spectrum of suicide behaviors do not receive treatment for either mental illness or substance abuse. Currently, crisis centers and mental health resources miss most people who need help.³⁸ Eighty percent of adults with a diagnosable mental illness who died by suicide were untreated at the time of their death (the figure is 90% for youth).³⁹ 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.⁴⁰

Substance abuse increases the risk of suicide for adolescents, young adults, and middle-age adults.⁴¹ Alcohol, the most common substance used, facilitates suicide attempts. At least one third of people who die by suicide have an alcohol use disorder;⁴² 25 percent of people were intoxicated at the time of their suicide.⁴³ 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.⁴⁴

The suicide rate is highest among **older adults**, with a rate of 25 per 100,000 deaths among adults age 85 and older. Again, mental illness is a significant factor for older adults. Between 71 and 95 percent of adults age 65 and older who die by suicide have a mental illness, primarily a mood disorder (54-85%).⁴⁵ There is also added risk for suicide from most chronic physical illnesses.⁴⁶ Although most older adults seen in primary care practices who subsequently died by suicide brought physical complaints to their physicians, it was actually mental health factors that were associated with their deaths.⁴⁷

People living in rural areas may have a greater risk of suicide. The 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.⁴⁸ 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.⁴⁹

Race and ethnicity also contribute to suicide risk. In Maine, the highest rates of sui-

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cide deaths are among white, non-Hispanic males. Nationally, American Indians and Native Alaskans have the second highest suicide rate.⁵⁰ Suicide statistics related to American Indians are considered to be unreliable because of either small population size or the small number of reported suicide deaths. Suicide is, however, the leading cause of death among American Indians and Alaskan Natives between ages 15 and 24.⁵¹

A recent report from the Department of Defense 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.⁵² The Veterans Administration estimates that as many as 5,000 **veterans** die by suicide every year.⁵³ 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.⁵⁴

“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 would shame. There is no shame.”

Sandy Fisher

Lesbian Gay Bi-Sexual Transgender (LGBT) status has been considered a risk factor in the past, principally because of the increased presence of depression in this group. This may be changing. Younger LGBT adults have a lower incidence of depression than older LGBT adults,⁵⁵ although studies have found that LGBT youth have a higher rate of suicide attempts than others in their age group.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

Warning Signs and Triggering Events: Knowing When to Intervene

Knowing who is at risk of suicide increases the possibility of obtaining help before an individual is in crisis. Because most people in at-risk groups, however, will not attempt suicide, knowing what may precipitate suicidal behavior and the warning signs that often precede a suicide attempt are an important part of prevention.

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Triggering events are those that lead to humiliation, shame or despair. The event includes real or anticipated loss of relationships, a change in financial status, or a change in health status.⁵⁸

Warning signs are the earliest observable signs that indicate a person is at risk of suicide in the near term: minutes, hours, or days.⁵⁹ The overt and acute signs of a suicidal crisis requiring immediate intervention are:

- Threatening to hurt or kill one's self;
- Seeking the means to kill one's self, such as a gun, rope, or pills; or
- Talking or writing about death, dying, or suicide.

A second set of warning signs indicate the need for a prompt mental health assessment, but not necessarily emergency intervention. These are:

- Dramatic changes in mood;
- Excessive or increased alcohol or drug use;
- Withdrawal from friends, family, or society;
- Anxiety or agitation;
- Dramatic changes in sleep patterns;
- Reckless behavior;
- Feelings of hopelessness, rage, being trapped, or loss of sense of purpose in life.

There are almost always warning signs when a person is thinking about or planning suicide. Effective suicide prevention programs address the recognition of risk factors and responding to triggering events and warning signs in helpful ways.

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 plans are multidimensional, using a variety of proven or promising strategies. 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.

Three types of programs have strong evidence of effectiveness from more than one study.⁶⁰ They are screening and treatment for depression in primary care practices, Gatekeeper education, and restriction of highly lethal methods of suicide. All three of these programs are included in this Plan's prevention strategies. Promising programs range from inexpensive follow-up methods 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 psychothe-

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rapies.⁶¹ This Plan also includes follow-up methods in a variety of settings. Increased access to mental health treatment, other than that integrated into primary medical care, needs to be considered in future Plans.

Integrating Suicide Prevention into Primary Health Care Settings

Primary care health providers are in a unique position to assess suicidality in their patients.⁶² It is a patient-centered medical home that already uses a chronic disease management model, suitable for assessing for depression and the more than twenty-five other medical 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 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.⁶³ People who have 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.⁶⁴ The numbers are even more striking for older adults, who infrequently use mental health services. For older adults who died by suicide, 20 percent visited a physician within 24 hours of their death, 41 percent within one week, and 75 percent within one month.⁶⁵

The greatest need perceived by people experiencing suicidal thoughts is for therapy or counseling.⁶⁶ 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.⁶⁷

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.⁶⁸ 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.⁶⁹ 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.⁷⁰

An example is the PROSPECT (Prevention of Suicide in Primary Care Elderly) pro-

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gram,⁷¹ which focused on primary care patients 60 years and older who were diagnosed with major or minor depression. Trained case managers helped physicians recognize depression, made treatment recommendations and offered psychotherapy, monitored 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.

Gatekeeper Programs

Gatekeepers “open the gates” to help for people at risk of 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 referral for help. 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 thinking about suicide.

An evaluation of Maine’s Gatekeeper program implemented in public schools – a one day program that includes skills practice – was conducted in 2001-2002 and showed significant increases in respondents’ knowledge of warning signs and risks factors as well as comfort in their ability to intervene. Respondents maintained the effects at six months. To date, over five thousand Gatekeepers have been trained in Maine, and qualitative data indicate that students who are thinking about suicide are being identified earlier, before the crisis point has been reached. Most training participants reported that they had received little or no prior coursework in suicide prevention.

Similar to Maine, most studies of Gatekeeper training programs have focused on high school and college age youth. These studies demonstrate that Gatekeeper training successfully increases participants’ knowledge, changes attitudes about suicide, and develops intervention skills. Programs also demonstrate some evidence of a reduction in the rate of suicidal behaviors.⁷² 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.⁷³

There are different models of Gatekeeper training; programs that do not include skill training have been less 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

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health treatment.⁷⁴ Gatekeeper programs may be ineffective if there are inadequate services to treat people thinking about suicide, or if Gatekeepers are unaware of where and how to refer.

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.⁷⁵ Some of the 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.⁷⁶ 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.

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.⁷⁷

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.⁷⁸ 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.⁷⁹ 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 also increases the effectiveness of crisis telephone lines. Crisis lines are used by seriously 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.⁸⁰

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.⁸¹ Unlike programs focusing on

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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: emotional literacy, problem solving, crisis management, and 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.

An Example of a Prevention Program Using Multiple Approaches⁸²

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.

From 1984 to 2005, two thousand 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 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.

Maine Plan for Suicide Prevention

This Plan sets a ten year goal, establishes priority strategies for the next five years, identifies interim benchmarks to evaluate progress, recommends actions at state and local levels, and identifies next steps that should be considered in future plans.

Some recommended actions are intended for state and local government agencies, some for collaboration with organizations representing people at risk of suicide and suicide survivors, and some are intended for the participation of all citizens interested in suicide prevention. During our lifetimes almost all of us will know someone who has died by suicide, so all of us need to be part of the solution.

Goal

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To prevent suicides and attempted suicides among Maine residents at risk using public health methods that implement effective programs and practices through collaboration with state and local organizations.

Baseline: Maine suicide rate of 15.0 per 100,000 population (average from 2004-2008)

Target: Ten percent reduction, to a suicide rate of 13.5 per 100,000 population in 2020.

Guiding Principles

- Suicide affects 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.
- Using existing information-sharing networks saves resources and reaches more people. Existing partnerships are strengthened and meaningful collaborations formed, so that activities are implemented through existing networks at local, regional, and state levels.
- Expectations are realistic. State and local leaders are encouraged to implement activities that match available resources. Small efforts are worthwhile.
- Using existing information-sharing networks saves resources and reaches more people. Existing partnerships are strengthened and meaningful collaborations formed, so that activities are implemented through existing networks at local, regional, and state levels.

“As it says on our t-shirt this year, A single suicide in our community is one suicide too many.”

Sandy Fisher

Methods

- Research indicates that prevention activities must be sustained over time, so the Plan recommends strong state leadership and partnerships with local government and community organizations.
- The plan builds on Maine Youth Suicide Prevention Program activities, knowledge, resources, and partnerships, especially its connections within the Maine Center for Disease Control and the Maine Department of Health and Human Services.
- Resources are maximized by integrating suicide prevention activities into state and local programs and organizations dedicated to improving the health of Maine’s people.
- People in groups at high risk for suicide are identified within prevention activities.
- Prevention activities are evidence-based or follow promising practices. Priority is given to activities with the greatest evidence of success:
 - Integration of suicide prevention into primary health care

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- Gatekeeper-style programs
- Suicide hotlines
- 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.

Implementing Agencies

State Agencies, especially the Department of Health and Human Services:

Center for Disease Control and Prevention:

Maine Injury Prevention Program

Office of Local Public Health, and Office of Rural Health and Primary Care

Public Health District Offices

Office of Adult Mental Health Services

Office of Consumer Affairs

Office of Substance Abuse

Office of Elder Affairs

Adult Protective Services

Partner Organizations

Area Agencies on Aging

Association of Family Practice Physicians

Association of Osteopathic Physicians

Catholic Archdiocese of Maine

Consumer Affairs Council

Episcopal Diocese of Maine

Equality Maine

Federally-Qualified Community Health Centers

Healthy Maine Partnerships Maine

Adult Protective Services Maine

Association of Social Workers

Maine Association of Substance Abuse Programs

Maine Chiefs of Police Association Maine

Coalition Against Sexual Assault Maine

Coalition to End Domestic Violence Maine

Council of Churches

Maine Criminal Justice Academy

Maine Department of Corrections

Maine Department of Education

Maine Domestic Violence Review Panel

Maine Emergency Management

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Maine Emergency Medical Services
Maine Funeral Director's 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 Minority Health Office
Maine National Guard
Maine Nurse Practitioner Association
Maine Osteopathic Association
Maine Primary Care Association
Maine Psychiatric Association
Maine Quality Counts
Maine Sheriffs Association
Maine State Police
Maine Veterans' Administration Suicide Prevention Program
Medical Examiner's Office
Mental Health Association of Maine
National Alliance on Mental Illness/Maine
Office of the Attorney General
Office of Elderly Services
Office of Substance Abuse
Pathways to Excellence
Peer Support Programs
Penobscot Suicide Prevention Coalition
Physicians for Social Responsibility
Wabanaki Mental Health

Strategic Direction #1

Build a Statewide Structure to Support and Sustain Suicide Prevention

Purpose

Build a structure of state and local organizations to coordinate and maximize resources, to increase knowledge of suicide prevention, and to facilitate integration of suicide prevention into existing health programs.

Opportunities and Barriers

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A relatively small amount of stable funding has enabled the Maine Youth Suicide Prevention Program to provide training, education, data, and links to resources. Similar funding will need to be found for staff to coordinate implementation of this Plan.

Development of a network of individuals and organizations interested in adult suicide prevention was begun during the planning process. Network participants have agreed to disseminate suicide prevention information through their information-sharing mechanisms, such as state-wide email lists and web sites.

Training opportunities into which adult suicide prevention programs can be integrated already exist in key state and local agencies. Some agencies already have agreed to incorporate adult suicide prevention programs into their staff training classes.

Suicide by adults is not yet widely understood to be a public health problem requiring public health solutions.

Objectives

Objective 1: Build a state-level sustainable coalition of people committed to suicide prevention.

Objective 2: Identify, develop, and coordinate existing resources to be used for suicide prevention.

Objective 3: Publicize suicide prevention programs that use best practices methodology and monitor their implementation.

Objective 4: Improve understanding of suicidal behaviors among Maine residents.

Objective 5: Promote and support research on suicide and suicide prevention.

Benchmarks

1. A state-level coordinating body broadly representative of state and local agencies, groups representing at-risk individuals, clinicians and service providers, and survivors of suicide. To be achieved by the end of Plan Year 1.
2. Clearly delegated shared responsibility for oversight of implementation and evaluation. To be achieved by the end of Plan Year 1.
3. Documentation of existing resources dedicated to suicide prevention and development of new resources as needed. To be achieved by the end of Plan Year 2.
4. State-level staff tasked to coordinate Plan implementation. To be achieved by the end

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of Plan Year 2.

STATE: Recommended Actions

Form a state-level partnership of Maine CDC and DHHS offices, Veterans organizations, professional and community organizations, groups representing at-risk persons, and survivors of suicide to coordinate implementation of activities and dissemination of information through their networks.

Identify resources within partnership organizations that can be used for suicide prevention activities.

Develop and use information-sharing technologies to coordinate and publicize Plan activities and research.

Update the MYSPP web site to include adult suicide prevention resources.

Establish a research and evaluation committee to provide expertise and evaluation to local prevention programs.

Review nationally-published research on suicide prevention and disseminate findings.

Collect monthly suicide data from the Medical Examiner's Office.

Continue to include suicide related questions on statewide MIYHS[SPELL THIS OUT] and Behavioral Risk Factor Surveillance System surveys, and analyze and disseminate findings.

Update the Maine Suicidal Behavior Surveillance documents and Fact Sheets on an annual basis.

Establish representation with the appropriate death and serious injury review panels in Maine.

Advocate for ongoing suicide case review and release of information for prevention planning purposes.

LOCAL: Recommended Actions

Designate a liaison within each Maine CDC Public Health District to identify and link to local resources, and coordinate with local prevention programs to integrate suicide prevention activities.

Identify local leaders among clinicians, service providers, community organizations, groups representing at-risk persons, and survivors who will coordinate staff training disseminate information about suicide and suicide prevention in Maine.

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Next Steps

Prepare for expansion of suicide prevention activities into other arenas where adults gather, such as faith communities and businesses, by forming partnerships with the Maine Council of Churches, Maine Department of Economic and Community Development, Maine Chamber of Commerce, and Maine Association of Employee Assistance Programs.

Establish specific evaluation criteria for prevention programs implemented through this Plan and prepare for evaluation.

Establish a fellowship program in suicidology in one of the public universities in Maine.

Develop, in collaboration with university partners, a five year suicide research agenda that builds on the work on the MYSPP.

Strategic Direction #2

Integrate Suicide Prevention and Treatment into Primary Medical Care

Purpose

Research demonstrates 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. Intervention – screening, assessment, treatment, and referral – through primary care and emergency department practices has the most potential for identifying and assisting the greatest number of people across the lifespan who have attempted or are contemplating suicide.

Opportunities and Barriers

Research-based screening tools and protocols have been field-tested with demonstrated success. Toolkits, training, and other resources for primary care physicians are available.

Maine and national initiatives actively are promoting the integration of mental health assessment and treatment into primary health care. Maine's twenty federally-qualified health centers are in the process of implementing this approach.

Federal legislation to extend health insurance to 30 million uninsured citizens and to remove preexisting condition restrictions will make primary health care and mental health and substance treatment available to many more citizens in Maine.

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Primary care practices and emergency departments (other than the federally-qualified health centers) have not received training and do not have uniform protocols for screening for depression and suicidality and for referral to mental health and substance abuse treatment.

Limits on health insurance coverage make it difficult to refer people contemplating suicide for effective mental health and substance abuse treatment. Adults with public insurance have funding but often face lengthy waits for treatment and lack of continuity once treatment begins. Adults with private insurance have more timely access, but often have insurance-imposed limits on the type and length of treatment.

Objectives

Objective 1: Educate primary care practitioners on the efficacy of and methodology for suicide screening and treatment referral.

Objective 2: Partner with the Maine Primary Care Association to integrate suicide prevention screening, assessment, and treatment within mental health care in Maine's federally-qualified Community Health Centers.

Objective 3: Partner with the Maine Hospital Association to implement uniform screening and referral protocols in hospital emergency departments for people at risk of suicide.

Objective 4: Support work that increases the availability of primary care and mental health and substance abuse treatment.

Benchmarks

1. Suicide prevention protocols and behavioral health treatment are integrated into fifty percent of the federally-qualified Community Health Centers. To be achieved by the end of Plan Year 5.
2. Suicide prevention protocols and behavioral health/substance abuse treatment referral protocols are integrated into fifty percent of hospital Emergency Departments. To be achieved by the end of Plan Year 5.
3. Thirty percent of primary care practitioners unaffiliated with Community Health Centers or hospital-based practices have receiving training and/or materials on suicide prevention methods and protocols. To be achieved by the end of Plan Year 3.

STATE: Recommended Actions

Survey primary care practices to determine to what extent screening (for depression, trauma, and

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suicide), suicide prevention protocols, and behavioral health care are part of primary health care practices.

Conduct a symposium with Community Health Centers and other key stakeholders to establish a common vision for suicide prevention in these centers, to increase understanding of needs and barriers, to build relationships and to develop and implement collaborative activities.

Research available best practices for integration of suicide prevention within primary care, such as the Suicide Prevention Resource Center/Western Interstate Commission for Higher Education Primary Care Toolkit.

Develop a website that has information for use by primary care and emergency department personnel, such as state mental health laws regarding commitment, mental health admissions policies, mental health resources, Medicaid rules, and state and local resources.

Partner with the Maine Health Care Access Foundation to determine unmet needs and effective responses for people contemplating suicide with underlying mental health and substance abuse issues.

Provide data and cost information on suicide to organizations that advocate for insurance parity between insurance reimbursement for mental health and substance abuse treatment and other types of health care.

LOCAL: Recommended Actions

Identify professional training opportunities for primary care and emergency department personnel, and offer training and materials on suicide prevention at these events.

Partner with the Maine Primary Care Association to include depression, trauma, and suicide screening, assessment, suicide prevention protocols, and behavioral health care in primary care provided by Federally Qualified Community Health Centers.

Partner with the Maine Hospital Association to include depression, trauma, and suicide screening, assessment, suicide prevention protocols, and behavioral health care in primary care provided by practices affiliated with Maine hospitals.

Partner with the Maine Medical Association to include depression, trauma, and suicide screening, assessment, suicide prevention protocols, and behavioral health care in unaffiliated primary care practices.

Partner with Pathways to Excellence to distribute to primary health care providers information on suicide prevention research and advances in suicide prevention in Maine primary health care practices.

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Develop, in conjunction with primary care providers, appropriate postvention strategies for medical settings.

Identify feasible methods to obtain and compile data from primary care and emergency department personnel on the number of referrals to mental health and substance abuse treatment for people contemplating suicide.

Identify feasible methods to obtain and compile data from mental health and substance abuse treatment programs on the number of people referred by primary care and emergency departments because of suicidality who subsequently received treatment.

Next Steps

Identify the primary care practices and emergency departments that have not implemented suicide prevention protocols.

Develop Maine-specific materials and presentations on the impact of integration of suicide prevention and behavioral health treatment into primary care practices, and prepare to disseminate widely throughout the state.

Reassess unmet needs for behavioral health and substance abuse treatment in Maine for people contemplating suicide.

Strategic Direction #3

Implement Priority Suicide Prevention Programs in Department of Health and Human Services State and Community Offices

Purpose

Community DHHS programs provide services in a variety of settings to people who may be at high risk for suicide. Leadership from state DHHS offices is necessary to decide which priority programs are preferred for particular settings. Community programs are in the best position to deliver services and supports to people who have attempted or are contemplating suicide.

Opportunities and Barriers

Other than primary medical care, human service agencies offer the best opportunity to reach adults at risk of suicide.

State DHHS offices have clearly defined opportunities and resources for training state and local service providers. During the planning process, state DHHS personnel indicated a high level of willingness to use their resources to integrate suicide prevention training and programs into their current work.

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An easily adaptable web site, resource library, training curricula and materials, and expert data collection and analysis on youth suicide prevention are in place in the Injury Prevention Program and in the Office of Substance Abuse Information Resource Center.

Maine already operates suicide hotlines for people in crisis and warmlines for people with behavioral health needs.

As State funds contract during this difficult economic environment, employees are being asked to do more work with fewer resources. Suicide prevention training programs must be replicable with the least amount of effort necessary for success.

Suicide prevention is not now a priority in the education of mental health and substance abuse professionals. Pre-employment training programs do not include suicide prevention in their curricula, nor is suicide prevention training a requirement for state certification or licensing. As a result, most mental health and substance abuse professionals enter practice with little information about suicide or how to prevent it.

Objectives

Objective 1: Provide data, leadership and resources to support integration of priority suicide prevention strategies into state agencies and state-sponsored programs.

Objective 2: Increase the number of clinicians and support personnel trained in the skills needed for suicide screening, risk assessment, and response.

Objective 3: Implement community Gatekeeper programs in local DHHS-affiliated programs.

Objective 4: Implement follow-up activities for people who have been identified in DHHS-affiliated programs as attempting or contemplating suicide.

Benchmarks

1. Training materials on depression and suicide screening, risk assessment, and follow-up response are available and used to train one hundred DHHS-affiliated clinicians and support personnel. To be achieved by the end of Plan Year 4.
2. Twenty-five percent of people receiving services through the Offices of Adult Mental Health Services, Substance Abuse Services, Elder Services, and CDC public health nurses are screened for depression and/or suicide and referred for appropriate treatment. To be achieved by the end of Plan Year 5.

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3. Suicide prevention materials and protocols reflecting best practices for gatekeeper programs, hotlines, and follow-up activities are available for implementation. To be achieved by the end of Plan Year 2.
4. Community Gatekeeper programs are implemented in four local or regional programs serving clients of DHHS who are in at-risk groups for suicide. To be achieved by the end of Plan Year 5.
5. Hotline and Warmline programs provide follow-up activities to all callers who are identified as at risk of suicide. To be achieved by the end of Plan Year 2.
6. Psychiatric hospitals and in-patient psychiatric units in general hospitals provide follow-up activities upon discharge to all people hospitalized because of suicide attempts or risk of suicide. To be achieved by the end of Plan Year 2.

STATE: Recommended Actions

Screening and response

Survey behavioral health programs, substance abuse programs, elder residential and home health care programs, public health nurses, and licensed clinical social workers to determine a baseline of the number trained in depression and suicide screening, risk assessment, and response; the type of training; and perceived need for training.

Gather current materials on best clinical practices for suicide screening, risk assessment and response and post on the Maine Suicide Prevention Program website. With state leaders, develop a uniform protocol for depression and suicide screening, response, and referral.

Identify opportunities to train clinicians and services providers in state DHHS and contract agencies, specifically public health nurses, substance abuse prevention programs, elder services assessors, adult protective service workers, nursing and residential care facilities workers, hospital-based and community behavioral health care staff, and peer support personnel.

Gather data on the number of people screened for depression and/or suicide, and the subsequent action taken by the screeners.

Follow-up activities

With state leaders, develop a protocol for follow-up activities after contact with DHHS-affiliated programs and services associated with suicide prevention or behavioral health treatment.

Gatekeeper programs

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With state leaders, determine the methodology for best developing gatekeeper programs through local and regional DHHS offices and Public Health Districts.

Determine the types of gatekeeper programs best suited to specific local and regional offices and the clients served.

Modify the selected Gatekeeper protocols and materials for use by Maine programs serving groups at risk of suicide.

LOCAL: Recommended Actions

Screening and response

Partner with the Maine Psychiatric Association and Mental Health Association of Maine to offer presentations and exhibits at professional meetings on suicide risk assessment and response.

Partner with the Maine Association of Substance Abuse Programs (specifically the Maine Alliance for Addiction Recovery) to include suicide prevention in their annual Recovery Works day.

With the assistance of the DHHS State Education and Training Unit and community agencies, provide training to clinicians and service providers on depression and suicide screening and response.

Integrate the uniform screening and response protocol, modified as necessary for specific at-risk groups, into public health nursing nurse programs, adult protective services programs, substance abuse programs, elder care programs, and behavioral health programs.

Pilot the Nursing Homes Suicide Prevention Toolkit from the national Suicide Prevention Resource Center in five Maine nursing homes.

Follow-up activities

Implement the follow-up protocol for callers of hotlines or warmlines who disclosed suicidal thoughts or plans.

Implement the follow-up protocol for patients with suicide attempts or thoughts after discharge from inpatient mental health treatment.

Gatekeeper programs

With state and local leaders, survey local agencies that serve groups at risk for suicide for suitability and interest in Gatekeeper programs.

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Identify four community agencies serving groups at risk of suicide and implement Gatekeeper programs in those agencies.

Next Steps

Partner with the University of Maine social work, counseling and education departments to develop and implement curriculum modules teaching suicide awareness and intervention and assessment skills to undergraduate and graduate clinical students.

Sponsor demonstration programs in two Maine public health districts to integrate suicide prevention into multiple aspects of community life.

Strategic Direction #4

Increase Awareness of and Competency in Suicide Prevention

Purpose

Awareness about suicide warning signs and methods for reducing access to lethal means of suicide, by family, friends, and first responders, but also by the general public, can help to prevent suicide. Organizations other than those directly related to health and human services also reach people at risk of suicide and need accurate information about suicide and its prevention.

Opportunities and Barriers

Healthy Maine Partnerships, a network of community organizations dedicated to improving the health of Maine citizens, offer the opportunity for widespread dissemination of information about suicide warning signs and suicide prevention.

The Maine Youth Suicide Prevention Program has written materials and other resources on suicide warning signs, intervention, and prevention methods easily adapted to adults.

The Veteran's Administration in Maine has a suicide prevention program that successfully collaborates with the Maine Youth Suicide Prevention Program.

Training on suicide is available now through the Maine Criminal Justice Academy, and with additional resources could be expanded to reach public safety officers throughout the state.

Reducing access to lethal means, such as locking firearms, removing unused prescription drugs, or placing safety barriers around bridges, has reduced suicide rates in communities where these methods have been used.

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Constitutional rights and cultural norms make restricting access to lethal means, especially firearms, difficult.

Objectives

Objective 1: Increase the number of adults who know what to do when they or someone they know is contemplating or has attempted suicide.

Objective 2: Integrate lethal means education and counseling into public safety programs, primary medical and emergency department care, and behavioral health consumer organizations.

Benchmarks

1. A web site with current information on suicide prevention programs in Maine and resources for behavioral health and substance abuse treatment is widely publicized and linked to implementing and partnership organizations. To be achieved by the end of Plan Year 1.
2. Through an email network of this Plan's partnership organizations, bi-annual updates on suicide prevention and treatment resources are distributed to these organizations' membership. To be achieved by the end of Plan Year 1.
3. Information about suicide warning signs and how to get help is distributed through the Healthy Maine Partnership network to two hundred community organizations throughout the state. To be achieved by the end of Plan Year 3.
4. Training on reduction of access to lethal means is available annually to public safety and emergency medical services personnel. To be achieved by the end of Plan Year 2.

STATE: Recommended Actions

Partner with the Maine Minority Health Office and Tribal leaders, with input from minority populations, to modify materials and training programs and resources to improve cultural competency.

Revise the MYSPP website to encompass suicide prevention across the life span. Encourage other state agencies and partnership organizations to link to this site.

Partner with the Office of Substance Abuse to include resources for suicide across the lifespan in the OSA Information Resource Center library.

Develop a master email list of partnership organizations willing to distribute suicide prevention updates to their members. Bi-annually update materials on suicide facts, recognition of

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warning signs, risk and resiliency factors, prevention programs, referral for intervention and postvention services, and training opportunities. Post these on the program web site and disseminate widely through email.

Partner with the Maine Veteran's Administration Suicide Prevention program and Maine National Guard to disseminate information about the elevated risk for suicide among veterans, services at the VA and other veterans' organizations, through the MSPP website, conference presentations and other outreach efforts.

Continue to collaborate with the Maine Criminal Justice Academy to maintain training on suicide prevention in the police academy and to require that public safety officer training be updated annually.

LOCAL: Recommended Actions

Collaborate with Healthy Maine Partnerships to post written materials and links to electronic resources on suicide warning signs and treatment referral sources in communities statewide.

Post written and materials and links to electronic resources, including information on warning signs and referrals for treatment in primary health care offices, mental health treatment program offices, private therapist and counselor offices, substance abuse treatment program offices, and hospital emergency departments.

Train Public Health District staff in all eight districts on suicide warning signs, prevention, and treatment resources.

Partner with the Maine Emergency Medical Services Office to offer training to emergency medical technicians and other first responders on suicide warning signs and intervention methods.

Partner with the Maine State Police, the Maine Chiefs of Police Association, and the Maine Sheriff's Association to establish and widely distribute protocols for public safety organizations on removing or securing firearms and other lethal means of suicide.

Partner with the Maine Primary Care Association, Maine Hospital Association, And Mental Health Associates of Maine to provide information on the importance of and methods to assess the availability of lethal means of suicide in the homes of potentially suicidal individuals.

Institute practices to counsel patients and family members on securing or removing lethal means from the home for all patients who are treated in primary health care practices, emergency departments, and mental health practices for suicidal behaviors.

Partner with Peer Support programs of the Adult Mental Health Office of Consumer Affairs and NAMI/Maine and to disseminate information on what family members and friends can

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do to safely remove or secure lethal means from individuals who exhibit warning signs for suicide.

Next Steps

Partner with the Department of Labor to determine feasible strategies to reduce suicide through prevention programs in Employee Assistance Programs and other workplace services.

Partner with other state agencies and organizations, such as the Attorney General's Office, Maine Council of Churches, Domestic Violence Coalition, and the Sexual Assault Coalition, to explore development of feasible strategies for suicide prevention programs in their organizations.

Strategic Direction #5

Promote Help-Seeking for Adults in Need

Purpose

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. Opening a societal discussion about the prevalence of suicide and its causes, and improving the availability of effective treatment can begin to break down these barriers.

Opportunities and Barriers

Depression is more widely understood and discussed in our society than in the past. Public figures continue to come forward to explain their experience with and recovery from depression.

Effective treatment for depression, substance abuse, and other forms of illness contributing to suicide are available now.

Stigma associated with mental illness, substance abuse, and suicide continues to exist, preventing adults from seeking treatment. Our society must continue to learn how to discuss these issues without shame.

Objectives

Objective 1: Determine unmet needs for behavioral health and substance abuse treatment for people contemplating suicide.

Objective 2: Provide information on suicide and unmet treatment needs to organizations seeking increased access to and funding for behavioral health and substance abuse treatment.

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Objective 3: Educate individuals on how to advocate for their own and their family's mental health care.

Objective 4: Reduce the stigma associated with suicide, mental illness, and substance abuse.

Objective 5: Improve reporting and portrayals of suicide in mass media.

Benchmarks

1. Data on the availability of effective treatment for the underlying causes of suicide, use of treatment, and unmet treatment needs is compiled and reported to the Maine Health Care Access Foundation and other organizations whose mission is to improve use of treatment resources. To be achieved by the end of Plan Year 2.
2. Education materials have been distributed to one thousand adults on how to intervene and seek treatment for people at risk of suicide. To be achieved by the end of Plan Year 5.
3. Education events featuring speakers who are survivors of suicide have been attended by one thousand adults in a wide variety of community settings. To be achieved by the end of Plan Year 5.
4. Seventy-five percent of media outlets in Maine have adopted and use protocols for appropriate reporting of suicides. To be achieved by the end of Plan Year 4.

STATE: Recommended Actions

Survey clinicians and consumer groups to determine the most effective behavioral health and substance abuse treatments for people at risk of suicide.

Conduct focus groups with suicide survivors (both those who have survived their own attempts and those who have lost a loved one to suicide) to understand prevention and treatment needs.

Partner with DHHS Offices of Adult Mental Health Services, Elder Affairs, and Substance Abuse, and the Maine Health Care Access Foundation to compile data on the availability of and unmet needs for effective behavioral health and substance abuse treatment.

Develop or adapt materials for suicide survivors for use in mental health and primary medical care, emergency department, behavioral health, and substance abuse treatment settings.

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Partner with NAMI/Maine, the Offices of Adult Mental Health Services and Substance Abuse, and the Maine Health Care Access Foundation to develop materials on where to obtain behavioral health and substance abuse treatment and how to pay for it.

Partner with NAMI/Maine, Peer Support programs, behavioral health and substance abuse treatment programs, and Area Agencies on Aging to establish a speaker's bureau of adults of all ages who once contemplated suicide and have returned to health. Develop screening process and select those who are several years out from their attempt and able to deliver a prevention message.

Recruit and train these individuals to speak to community groups about their experiences with treatment and recovery and about suicide prevention.

Review and adapt as necessary protocols for appropriate reporting on and portrayals of suicide in mass media.

LOCAL: Recommended Actions

Collaborate with Healthy Maine Partnership programs to provide education event in local communities using the speaker's bureau participants. Publicize the message that behavioral health and substance abuse treatment are used by people of all ages and social status, and that treatment works to prevent suicide and promote the return to health.

Partner with NAMI/Maine to offer training events on how to negotiate with treatment providers and insurance companies to obtain appropriate behavioral health and substance abuse treatment.

Sponsor an annual suicide prevention forum for media, public health and behavioral health professionals, and survivors of suicide.

Routinely respond to media portrayals of suicide so that media recognize and use safe reporting practices.

Work with news reporters to ensure that information on helping resources are always listed in relevant stories.

Next Steps

Evaluate the effectiveness of education materials and training events, modify as needed, and expand into additional community settings.

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Appendix A

Glossary of Terms

Adolescent: A person between the ages of 14 and 24.

Aftercare treatment programs: Programs that provide treatment and support recovery after an initial episode requiring residential or hospital treatment.

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: Is the optimum functioning and development of a individual in all important spheres of his/her life including family and peer relationships, involvement with school and community, physical health, and play or recreational pursuits.

Best practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.

Bisexuality: Being attracted to members of both sexes.

Cognitive behavioral approach: Cognitive Behavioral Treatment is a treatment method that focuses on here and now behaviors, thoughts and responses and uses a 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.

Consumer: A person who currently receives mental health services or who received such services in the past.

Contagion: A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Coroner: A public officer whose primary function is to investigate by inquest any death thought to be of other than natural causes.

Crisis response plan: A document that spells out the procedures to be followed in the event of threatening situations.

Crisis team: A group of individuals trained and assembled for the purpose of responding to the needs of other during and after a crisis event/situation. All schools in Maine are required to have a crisis response team and plan.

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Culturally competent: A set of values, behaviors, attitudes, and practices reflected in the work of 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 somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Disconnected youth: Youth, through age 24, who are out of school, out of work, often homeless, and/or have aged-out of child welfare and state benefits, including the foster care system, and generally not consistently connected to healthcare and/or treatment services.

E-codes: External cause of injury codes are diagnostic categories, using the 9th revision of the International Classification of Diseases (ICD-9). E-codes provide data on the cause, rather than the type, of injury. Example: a traumatic head injury, coded with an N-code, could result from a car crash or gunshot wound, both coded with different E-codes.

Effective: Prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in the target group more than in a comparison group.

Epidemiology: The study of statistics and trends in health and disease across communities.

Evaluation: The systematic investigation of the value and impact of an intervention or program.

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

Executive order: A document issued by the Governor requiring certain actions to be taken.

First responder: 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 routinely in direct contact

with a specified target audience 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 proportion of the population.

Help-seeking behavior: Actions taken by a person who utilizes different sources of informal (parent and peers) and formal (counselors, teachers, or mental health professionals) support.

Homicide: The killing of one person by another.

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Homosexuality: Sexual desire for and/or sexual activity with others of one's own sex.

Incarcerated youth: Refers to young people who are detained and being housed in a prison, jail,

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detention center, etc.

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.

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 intentional injuries.

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

Insomnia: Chronic inability to sleep.

Lethal means: Any instrument or object utilized to carry out a self-destructive act (i.e. firearm, poison, medication, rope, chemicals and/or other hazardous material).

LGBTQ: Lesbian, gay, bisexual, transgender, questioning youth.

Long gun: A gun with a long barrel that is fired from the shoulder - (rifle or shotgun)

Means: The instrument or object whereby a self-destructive act is carried out (e.g. firearm, poison, medication).

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 a government unit to ascertain causes of deaths, especially those 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% coverage for physical illness then they would have to provide the same percentage 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 cognitive, emotional or social abilities.

MIPP: Maine Injury Prevention Program – the Maine Injury Prevention Program is housed within the Maine Center for Disease Control and Prevention and serves as the lead agency in the state for injury and suicide prevention in Maine. In addition to coordinating the MYSPP, the MIPP also addresses suicide across the lifespan, among other leading causes of injury. The MIPP provides training, data, and links to prevention resources statewide.

Mobile crisis team: Mental health clinicians trained to perform suicide assessments/evaluations in multiple places such as an emergency room 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

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community or population.

Mortality: The relative frequency of death, or the death rate, in a community or population.

MYSPP: Maine Youth Suicide Prevention Program – the MYSPP employs a public health approach to address youth suicide. The MYSPP is based upon collaboration among state agency leaders and staff. The long-term goal of the MYSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine children, teens, and young adults.

National Strategy for Suicide Prevention: A comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course. This document was issued in 2001 and contains 11 goals and 68 objectives designed to be a catalyst for social change.

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Non-fatal suicidal behavior: Another term for suicide attempt.

Outcome. A measurable change in the health of an individual or group of people that is attributable to an intervention.

PHQ-9: The Patient Health Questionnaire (PHQ-9) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the nine DSM-IV criteria.

Post traumatic stress disorder: When a person has experienced a traumatic event in which he/she were both threatened and experienced intense fear or helplessness and: a) re-experienced symptoms of the trauma; b) persistently avoid reminders of the trauma; and c) experience increased arousal or tension.

Postvention: A coordinated and comprehensive set of specific interventions to be implemented after a crisis or traumatic event 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 health condition divided by the total number of people in the population. (For less common conditions, prevalence is often expressed per 100,000 people, for example, rather than as a percentage.)

Primary Care Providers: Health professionals serving in a primary care setting, including physicians, physicians assistants, nurse practitioners, and nurses who are chosen by an individual to serve as his or her health care professional. A Primary Care Provider is responsible for handling a variety of health-related problems, keeping a medical history and medical records on the individual, and/or referring the person to specialists as needed.

Prognosis: A prediction of the probable course and outcome of a disease.

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: Guideline for actions to take. MYSPP developed a Protocol document that helps schools be better prepared to address suicide prevention, intervention, and postvention.

Public health: Regulatory and voluntary focus on effective and feasible risk management actions at the national 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

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severity of effect. See Appendix C for additional information.

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 health outcomes.

Risk factor: Long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death.

School-based: Services provided on school grounds by either school personnel or by community

organizations that have arrangements with schools.

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

Self harm or self-injury: The various methods by which individuals injure themselves, such as

cutting, self-battering, taking overdoses or deliberate recklessness.

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

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Sexual orientation: Refers to a complex web of emotions, behaviors, fantasies, attitudes and attractions. There are three possible sexual orientations: heterosexual, homosexual and bisexual

(attracted to both males and females).

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

Stakeholder: Entities, including organizations, groups and individuals, who are affected by and

contribute to decisions, consultations and policies.

Stigma: Stigma is 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. Stigma leads the public to avoid people with mental disorders. It reduces access to resources and leads 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 substance abuse.

Suicide: Self-inflicted death with evidence (implicit or explicit) of the intent to die.

Suicide attempt: A 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.

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Suicide ideation: Thoughts about dying by suicide are clinically referred to as “suicidal ideation”.

Suicide survivor: Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

Survivors. Family members, significant others, or acquaintances who have experience the loss by suicide of someone in their life.

Trauma survivor: Refers to a person who has experienced trauma.

Warning sign: The earliest, observable signs that indicate the risk of suicide for an individual in the near-term (within minutes, hours, or days).

Years of potential life lost (YPLL): A measure of premature mortality (early death). YPLL provides insight into the impact of injury-related death on society compared to other leading causes of death.

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Young adults: Persons aged 20-24

Youth Risk Behavior Survey: A biennial survey of middle and high school students conducted

as part of a national effort by the U.S. Centers for Disease Control and Prevention to monitor health-risk behaviors of the nation's students.

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Appendix B Resources

Section 1: Crisis and warm lines, state first, national second

Section 2: Maine web sites. Indicate that these sites have links to many others, including national and Maine specific data, and suicide fact sheets and prevention materials

MIPP
MYSPP
OSA IRC
NAMI Maine

Section 3: National resources, specifically

SPRC
SPAN
AAS American Association of Suicidology
WISQARS
National Violent Death Reporting System (NVDRS)
<http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm>

Warmline

Warmline offers telephone support services for non-crisis situations, including, but not limited to: Support, social connection, sharing personal victories, overcoming fear, grief or sadness, developing effective strategies for the future, assistance with referrals to community resources, talking to someone when feeling sad, lonely, discouraged a place to learn about access to recovery programs, a place to connect with peers who have experienced mental illness and recovery.

- **The Maine Warmline toll free number is: 1-866-771-9276 or 1-866-771 (WARM)**
This is a peer staffed warmline operated by Amistad 5pm to 8am daily
- **Portland**
Amistad offers a peer staffed Warmline open from 5pm –8am daily.
Local number: 207-772-9276
- **Brunswick**
The Learning & Recovery Center at Sweetser operates a peer staffed Warmline (207)373-4278 or 1-800-434-3000 x4278
Staffed 24 hours seven days a week.

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- **Penobscot, Piscataquis , Washington and Hancock Counties.**
CH&CS sponsors the Northeast Crisis Services Warm Line, for people with mental illness and their family and friends who are seeking someone to talk with in a non-emergency situation.
For callers in the local calling area for Bangor, the number is (207)945-5625.
Callers outside of the local calling area can call toll free, (800) 490-8748.
- **Aroostook County**
(207)768-3304
Staffed 24 hours seven days a week.

The NAMI Maine help line, 1-800-464-5767 - is a confidential non-crisis help line, available Monday through Friday, between 8:00 am and 4:30 pm. NAMI also be reached at 207-622-5767.

We will help you:

- navigate the mental health or criminal justice systems
- understand your rights
- talk through the issues that are of concern
- figure out where to get the assistance you need or who to talk to next
- find a service in Maine or elsewhere
- get information about a law, a program, or a policy

Just ask and we will either advise you immediately or do some research and get back to you!

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Appendix C

Maine Youth Suicide Prevention Program

Include a paragraph at the beginning on the MYSPP.

Statewide Crisis Hotline 1-888-568-1112

A statewide crisis hotline operated by the DHHS Behavioral Health Office connects callers to crisis service providers in their area. This line is for all individuals in need of immediate local assistance in any crisis situation and is accessible statewide 24/7.

MYSPP Web Site www.maine.gov/suicide

The web site is managed through the DHHS Office of Substance Abuse. It contains extensive information on MYSPP programs, suicide statistics and research, prevention initiatives, directions for how to get help, and links to other state and national resources.

Statewide Information Resource Center <http://www.maine.gov/dhhs/osa/irc/index.htm>

The DHHS Office of Substance Abuse Information Resource Center distributes a wide selection of suicide prevention information materials for adults and adolescents. Resources include print and audio-visual education materials, Maine and national data and other information.

Data and surveillance activities

Suicide data are routinely monitored and analyzed by the MYSPP. Special studies are done to gather specific information on the nature and causes of suicide among Maine's youth.

School-based Suicide Prevention, Crisis Intervention, and Postvention Protocol Guidelines

MYSPP protocol guidelines help school administrators establish crisis intervention and suicide prevention procedures, a crucial tool for advanced planning to prevent suicide, manage a crisis, and intervene effectively in various crises occurring in a school setting.

Training

Through funding from the Maine Injury Prevention Program, Maine CDC, DHHS, a contract with Medical Care Development, Inc. supports multiple suicide prevention training programs. To date, the MYSPP has trained over 19,000 adults and youth in schools, other human service agencies, and private and public organizations. Training includes the following

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programs.

- *Gatekeeper Training* is a one day basic introduction to suicide prevention that builds intervention skills. Participants learn how to recognize suicidal behavior, the importance of responding and how to respond effectively, and where to find helping resources.
- *Training of Trainers* is a four-hour program that prepares individuals who have a basic suicide prevention background to offer a 60-90 minute suicide prevention awareness session in their school, organization or community.
- *Lifelines Training* has two components: a day long session that prepares health teachers to deliver *Lifelines Student Lessons*; and interactive lessons delivered by these trained teachers to that teach students how to identify suicidal behavior, respond appropriately, and obtain help for their friends and themselves. In December 2009, Maine's work on the Lifelines Student Lessons was placed on the National Registry of Evidence-based Programs.⁸³
- *Suicide Prevention Protocol Development Workshop* is offered on-line with assistance available once the coursework is completed. The likelihood of schools or youth serving agencies encountering a suicidal youth is real and few events are more painful or potentially disruptive. Protocols provide guidance on steps to take in order to safely assist youth and staff by providing them with direction, structure and support.
- *Suicide Assessment for Clinicians* is a day-long workshop designed to prepare a new or seasoned therapist to understand the risk of suicide in a variety of populations and how to approach and complete an effective suicide risk assessment.

Transitions Training for Educators is built on the concepts presented in the Lifelines lessons and provides "booster" sessions and additional resources to help high school seniors cope with upcoming changes. To assist educators to present these lessons, a one day training, which includes practice, is required.

- *Beyond the Basics of Suicide Prevention Conference*: this annual conference features state and national speakers who provide in-depth information on topics relevant to suicide prevention.

Through funding from the Maine Injury Prevention Program, Maine CDC, DHHS a contract with the University of Maine supports Restorative Justice training programs and technical assistance to Maine schools.

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Appendix D

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Appendix E

Suicide Prevention: The Public Health Approach

INSERT description.

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Appendix F

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