

I: State Information

State Information

Plan Year

Start Year:

2012

End Year:

2013

State DUNS Number

Number

80-904-559

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name

DHHS

Organizational Unit

Office of Substance Abuse

Mailing Address

11 SHS

City

Augusta

Zip Code

04333-0011

II. Contact Person for the Grantee of the Block Grant

First Name

Guy

Last Name

Cousins

Agency Name

Office of Substance Abuse

Mailing Address

11 SHS

City

Augusta

Zip Code

04333-0011

Telephone

207-287-2595

Fax

207-287-4334

Email Address

Guy.cousins@maine.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

7/1/2010

To

6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="William Boeschenstein"/>
Title	<input type="text" value="Chief Operating Officer"/>
Organization	<input type="text" value="Department of Health and Human Services"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	William Boeschstein
Title	Chief Operating Officer
Organization	Department of Health and Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Maine will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	<input type="text" value="William Boeschstein"/>
Title	<input type="text" value="Chief Operating Officer"/>
Organization	<input type="text" value="Department of Health and Human Services"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Identify and analyze strengths, needs, and priorities of the States behavioral health system?

What of these will the state take into consideration with the specific populations that are the current focus of the Block Grants, the changing healthcare environment and SAMHSA's strategic initiatives?

Various public and private organizations in Maine have projects underway that focus on implementing primary and behavioral health care integration. Many FQHC's and some primary care practices are already implementing this model. Maine also has a pilot project focused on Medical Homes. Our Co-Occurring State Integration Initiative (COSII) project has initiated a Task Force that will develop a report on barriers and opportunities along with recommended policies, procedures and strategies for implementing bi-directional integration. This report will be presented to the State Advisory Council on Health Systems Development in response to a goal in the 2010-2012 State Health Plan. On November 18th, Maine Primary Care Association along with HRSA, SAMHSA, and others will hold a kick off meeting on Behavioral Health Care Integration in Maine that will be attended by OSA. We expect to have an ongoing involvement with this three year initiative. Finally, OSA is actively involved on all committees of the Managed Care initiative, which is heavily focused on health care integration in Maine Care (Medicaid) services.

Maine's Medicaid system is working to develop managed care through a value-based purchasing project. At present, the most prevalent model that has come forward is the creation of Health Homes as the preferred model of primary care and behavioral health integration.

Maine has a team of "content experts" that are working together to address behavioral health integration. Because of the limitations (staff capacity) to have one person delegated to this, we are utilizing the teams' strengths in particular areas and communicating on a regular basis. Additionally, the SSA contributed to the State's Health Plan and is working with the COSII Task Force to implement integration on a larger scale. This task force is comprised of state staff, provider organizations, clients/consumers, and other various stakeholders within behavioral health and primary care.

The Office of Substance Abuse (OSA) contracts all funding to community providers across the state. OSA works with these providers and the provider association to encourage communication with primary care and discussion about the benefits of working in collaboration. With the passing of the Affordable Care Act, OSA believes that these conversations will turn into action.
http://www.saasnet.org/PDF/Implementing_Healthcare_Reform-First_Steps.pdf

Maine continues to move toward greater collaboration to integrate substance abuse (SA) and mental health (MH). Efforts include a combined set of standards and regulatory language, the use of a universal screening tool, and greater collaboration between the two areas of expertise to coordinate care. The COSII initiative has promoted significant changes and works between the two disciplines at the State level and has worked with over 30 agencies as pilot sites to help them implement integrated care. We have developed co-occurring Clinical Guidelines that are available to both SA and MH agencies, and now require co-occurring competency of all providers statewide.

At minimum, address the following populations: Statutory: IVDU, Adolescents, Children and Youth at risk for MH SA etc., Women who are pregnant, parents with SA who have dependent children, Military and families, American Indians/Alaska Natives.

IVDU:

The OSA Treatment Data System (TDS) reports 3,186 admissions for IVDU by providers who receive State and federal funding for SA treatment. Males were 1.5 times more likely to be treated for IVDU than females. Two public health districts, Cumberland and Downeast had much higher rates of admissions when compared to the percentage of the population living in those districts. (Cumberland has 21.2% of Maine's population, but 29.63% of those treated live in Cumberland; for Downeast it was 6.6%

and 8.66%, respectively). Almost 43% of all treated IVDUers in Maine live in Cumberland or Central districts. The 2009 MIYHS shows that 7.3 % of males and 3.8% of females in high school have used drugs intravenously. 5.4% of 12th graders, 7% of 11th graders, 5% of 10th graders, and 4.2% of 9th graders reported they used drugs intravenously at some point in their life. From the Maine HIV program strategic prevention plan, they reported that 7% of new HIV diagnoses were identified as IVDU. Per the Maine Infectious Disease program, the rate of TB in 2009 was .7 cases per 100,000 population (9 cases for the entire state). Of the 9 TB cases, 1 was an IVDU, 2 used non-injected drugs, and 3 used alcohol excessively.

Pregnant Women:

TDS reports 238 women were pregnant at admission. 93.6% were white, 4.2% Black, 1.3% American Indian, and 2.9% Hispanic (2010 census shows 95.2% of Maine's population are white; 1.2% are Black; .6% are American Indian; and 1.3% Hispanic). Behavioral Risk Factor Surveillance Survey (BRFSS) reported that between '06-'09, the percent of pregnant women who drank in the past 30 days (month) ranged from a low of 4.8% to a high of 17.5%. In '09, pregnant women were noticeably less likely to have ever been told by a doctor that they have an anxiety or depressive disorder.

The Pregnancy Risk Assessment Monitoring System (PRAMS) reported stable percentages of women who drank in the last trimester of pregnancy between '96-'08. PRAMS also indicated that between '04-'08, women who were older or who made in excess of \$50k had noticeably higher percentages of having used alcohol in the last trimester of pregnancy.

The TDS reported that between '05-'10 the percent of pregnant women being treated for a primary substance of synthetic opioids and methadone/buprenorphine has increased sharply.

Adults in Treatment with Dependent Children:

5,425 admissions to treatment in SFY 2011 were parents with dependent children.

The Maine State Office of Child and Family Services reported that between January 1, 2010 and December 31, 2010 there were 572 reports of drug affected babies. Also during this same time frame, of the child protective assessments conducted where there was evidence of abuse, 78.9% found substance abuse to be a risk factor.

Behavioral Risk Factor Surveillance System (BRFSS) reports that in '09, adults who have children were more likely to have ever been told by a doctor that they have an anxiety or depressive disorder than those w/out children. From '06-'09, adults with children were more likely to have drunk in the past 30 days (month) than those w/out children. In '09, adults with children were more likely to have drunk in the past 30 days (month) and have ever been told by a doctor that they have an anxiety or depressive disorder than those w/out children.

Children/Youth:

TDS reports that there were 637 clients under 18 who were admitted to treatment for SA in SFY 2011 (this is a decrease of 65 clients from SFY 2010). Over 36% are from western district; and over 52% are from western and Midcoast districts). Early initiation and use of alcohol drugs has been shown to be a risk factor for future substance abuse disorders. The 2009 Maine Integrated Youth Health Survey (MIYHS) reported 30-day substance use rates in high school youth: 21.3% binge drank; 34.7% drank alcohol; 23.7% smoked marijuana; 19.7% smoked cigarettes; 11.3% used a prescription drug without a prescription. The majority of High School (HS) students who ever drank or smoked marijuana did so between the ages of 13-16.

The Maine Youth Drug and Alcohol Use Survey (MYDAUS) reported that between '04-'08 the % of HS students saying it's easy to get marijuana or alcohol is easy has averaged about 2/3rds. The percentage of HS students who perceive great risk from heavy drinking, binge drinking, and smoking marijuana regularly has remained stable. HS students report a noticeably higher likelihood of being caught by their parents than by police for drinking alcohol. HS students also report a noticeably higher

likelihood that they think parents rather than neighborhood adults feel it would be wrong to drink or smoke marijuana regularly.

The National Survey on Drug Use and Health (NSDUH) reported that between '02-'09 the percent of Mainers ages 12-25 who drank, binge drank, misused Rx drugs, have ever used cocaine (ages 18-25 only), or smoked marijuana in the past 30 days (month) has remained stable. The % of Mainers ages 18-25 who perceive great risk from binge drinking has remained stable. % of 12-25 year-olds who perceive great risk from smoking marijuana regularly has also remained stable. Between '02-'09, 18-25 year-olds had noticeably higher %'s than 26+ year-olds re: those experiencing serious psychological distress in past year; rates have also slightly increased for the former age group. For 17-25 age group, percentages have been stable regarding those experiencing at least 1 major depressive episode.

Per Department of Public Safety - Uniform Crime Report (DPS-UCR) and the U.S. Census, the rates per 10k of alcohol- and drug-related arrests by juveniles (17 or younger) in Maine have remained stable between '05-'09. Juvenile rates have been approximately ½ that of the adult (18+) rates.

Per Maine Department of Transportation (MDOT), alcohol-related motor vehicle crash rate for 16-20 year-olds went up sharply between '08-'09 and surpassed '07 levels.

Per National Vital Statistics System (NVSS), substance abuse + overdose deaths per 100k for 12-20 year-olds increased sharply between '08-'09.

Native Americans:

In the 2009 MIYHS survey of 9th-12th grade students, those identifying themselves as Native American reported higher rates of use than their peers for the following 4 substances/patterns (30 day): Binge drinking 26.8%; Alcohol use 40.3%; Marijuana 30.2%; Cigarettes 27.8%; and Prescription drugs 16.2%.

The BRFSS reported that between 2001-2008, the percent of Native Americans in Maine has remained stable at about 1.1% of the population. Between '06-'09, the percent of Native Americans who drank in the past 30 days decreased from 54.3% to 32.2%, the last 3 years being noticeably lower than non- Native Americans.

Military/Veterans:

According to a contact at the Maine Army National Guard station, there are approximately 4,300 reservist (all branches), national guardsmen, and coast guard in Maine. In SFY 2011, approximately 6.4% of admissions to Substance Abuse Treatment in Maine were Veterans. We hope to partner and share information with the Veterans Administration (VA) in Maine around substance abuse treatment. Currently we do not know how many veterans are treated through the VA for substance abuse services. In the past couple of years the VA in Augusta Maine has agreed to allow their prescribers to register and use the States PMP to run reports on patients.

The BRFSS reported from 2003 through 2008, the percent of veterans in Maine has decreased from 17.7% to 14.6%. From 2006 through 2009, the percent of veterans who drank in the past 30 days was similar non-veterans. During that same time period, a vast majority of veterans reported being male (average of 93.1%). Can address targets: Homeless, rural SA individuals, underserved racial/ethnic minorities and LGBTQ, persons with disabilities

LGBTQ:

The BRFSS reports that the percentage of heterosexual/straight individuals in Maine has remained consistent between 2004 and 2009 at an average of 97.2%. During this same time period, those who reported being homosexual, gay, or lesbian increased from 1.3% to 1.6% and those reporting to be bisexual increased from 0.6% to 1.1%. Those reporting to be of "Other" orientation decreased from 0.5% to 0.3%. Between 2006 and 2009, those identifying as LGBTQ had lower percentages with respect to having consumed alcohol in the past 30 days than those identifying as heterosexual/straight.

The MIYHS 2009 survey for high school students (grades 9-12) showed much higher rates of binge drinking, 30 day drinking, marijuana use, prescription drug misuse, and cigarette smoking in the Gay, Lesbian, Bisexual, and Questioning students than those who identified themselves as straight. 45.6% of students identifying as Gay/Lesbian compared to 19.4% of students identifying as straight reported binge drinking in the 30 days prior to the survey (in other words, GL students were 2.3 times as likely to have binge drank than straight students). Those identifying as Gay/Lesbian were 4 times as likely to have misused Prescription drugs, 2.3 times as likely to have used marijuana, and 3 times more likely to have smoked cigarettes than those identifying as straight.

Prevention Targets: Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to community, school, family, and business norms through laws, policy and guidelines enforcement.

The assessment process for 2011 prevention planning identified two priorities for prevention in Maine: Underage population – alcohol use, marijuana use, prescription drug misuse and inhalant abuse. 18-25 year old population – binge/high-risk alcohol use, prescription drug misuse, and marijuana use.

The SAPT block grant supports environmental strategies statewide through grants to the Healthy Maine Partnerships in coordination with the Enforcing Underage Drinking Laws-funded initiatives working on environmental strategies through local law enforcement.

Current strategies work to address community norms through working with local retailers (RBS trainings and responsible server initiatives); local law enforcement (increased enforcement and communication with adults in the community); local businesses (Healthy Maine works online assessment tool with resources and assistance to implement strategies in businesses); local schools (school healthy coordinators work to implement a comprehensive substance abuse policy in their school district, as well as other prevention programming). Prevention providers across the state also engage with the Maine Alliance to Prevent Substance Abuse to educate the public about state-wide laws and policy initiatives.

Prevention Targets: Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies.

Maine’s current level of resources for individual strategies is limited, therefore targets are limited.

SAPT BG supports a handful of evidence-based prevention strategies in schools and local agencies across Maine. These were awarded based on successful application showing need in their area and viability of selected program to meet their local needs. Programs funded included use of Project Success, LifeSkills, Project Alert, CAST, and Lions Quest. OSA also supports 4 grantees who are implementing Student Intervention and Reintegration Program (SIRP), which is an evidence-based intervention for students referred to the program. This diversion program is based on Prime for Life curriculum.

For this coming year, OSA will determine next steps in universal, indicated and selected prevention strategies across the state, since the current competitive grant cycle will end June, 2012.

Within the State of Maine’s Medicaid system (Maine Care) coverage for individuals who would thus be eligible in 2014 category already exists and will continue to be utilized. Maine would continue to obligate federal funding to those populations who would continue not to be eligible for Medicaid or other commercial insurances.

Recovery services have not been covered for the SA population in Maine as a “clinical” service under Medicaid. Most of Maine’s providers are accessing the Medicaid system and if they are not, outreach. Recovery Systems of Care (ROSC) are being developed in Maine and there are plans to develop a Recovery Services Center in Maine’s largest city, Portland with the opening of the center planned for Fall

2011.

SMHA's and SSA's work together to provide guidance and leadership with respect to a bi-directional approach of behavioral health and primary care services by OSA has been participating in discussions regarding integration policy initiatives facilitated by the Maine Health Access Foundation (MEHAF) with a variety of state level stakeholders participating, from the Maine Primary Care Association, Maine Hospital Association, to Adult Mental Health to name a few. MEHAF has funded a few behavioral / primary care integration pilots in the state. OSA has begun the work to create connections with the primary care system. Work is underway to better screen for the presence of a SA disorder and create a process of access to appropriate resources whether they are in the facility or by referral. The provision of recovery support services for individuals with mental health or substance use disorders by The SAPTBG funding will be considered when developing adequate infrastructure to support Recovery Oriented is being conducted by the provider association in partnership with the Office of Substance Abuse.

Planning Steps:

Step 1.

Maine's Behavioral Health System is under the purview of the Maine Department of Health and Human Service. It currently consists of the following offices; Office of Substance Abuse, Office of Adult Mental Health, Office of Child and Family Services, Office of Adults with Cognitive and Physical Disabilities, Office of Elder Services, Office of Family Independence, The Maine Centers for Disease Control, and the Office of Maine Care Services.

The role of the SSA is to provide leadership in the realm of the prevention, intervention, treatment and recovery of individuals with addiction, their families and communities. The Office of Substance Abuse collaborates with all state agencies and community partners, develops, monitors and improves the lives of those affected by addiction across the lifespan. Prevention services include environmental strategies through the Health Maine Partnerships within each of the 8 public health districts across the state, with most recently a 9th Tribal Public Health District added in Maine legislation; Student Intervention and Reintegration Program and a handful of model curriculum supported in schools throughout the state. Intervention Services include Maine Driver Evaluation and Education Program. Treatment Services include ASAM - PPC2 Levels of Care as listed in the following Detoxification Management, Residential Care, Intensive Out Patient, Out Patient, Co-Occurring Treatment and Medication Assisted Treatment.

The Office of Substance Abuse is centralized in the capital of the state, contracts with providers statewide to administer necessary services. Through these contracts OSA contributes resources at the public health district level, though unlike other offices, do not have staff located at the public health district level OSA staff are responsible for the contract monitoring, providing technical assistance and site visits to ensure quality of services being provided. The Prevention system is currently supported at the state level with a variety of funding streams supporting a variety of initiatives.

Existing funders:

State of Maine General Fund

Fund for Healthy Maine (Tobacco Settlement Funds)

SAMHSA's Substance Abuse Prevention and Treatment Block Grant

U.S. Department of Education (via MOU with Maine Department of Education (DOE)

Safe and Drug Free Schools and Communities Act (close out September 30, 2011)

Building State Capacities Grant (close out September 30, 2011)

State Epidemiological Outcomes Workgroup grant (11/1/2011 - 10/30/2014)

Office of Juvenile Justice and Delinquency Prevention, Enforcing Underage Drinking Laws - Block Grant and Discretionary Grant

A combination of funding streams support initiatives that support the prevention

work in the community, such as the OSA Prevention media campaigns: MaineParents.net; PartySmarter; and WorkAlert. Enforcing Underage Drinking Laws supports alcohol compliance checks statewide, law enforcement mini grants, and the higher education alcohol prevention partnership.

From the drafted 2011 Office of Substance Abuse State Prevention Plan, gaps identified in Maine's prevention system were:
Need for funding via the HMP infrastructure (consistent and adequate funding) (gap: end of SAMHSA Strategic Prevention Framework – State Incentive Grant).
Need for statewide consistent prevention messaging – media.
Need for support of primary prevention in the schools (gap: loss of SDFS funding and minimal other funding).
Need for clear education/messaging that increases understanding of perception of harm and costs associated with use.

Maine's behavioral health shortage areas are Medication Assisted Treatment; comprehensive behavioral health services statewide – residential services for adolescent abusers with co-occurring disorders.

Maine has struggled with an aging workforce and little recruitment in the field of addiction services. We have been attempting to work with higher education to infuse addictions related coursework as a requirement in counseling and social work programs, but have repeatedly run up against the college's accreditation processes and licensing boards (Social workers, clinical counseling). Currently, we have one university that has taken this on in their community mental health program (Southern New Hampshire University). The COSII Initiative has sponsored a Committee focused on workforce issues that has met with Licensing Boards and has partnered with academic and training programs to offer and require more integrated course work. The initiative has developed a Certificate program, has authored a curriculum on integrated care, and has offered statewide trainings on integration. With the movement in the Substance Abuse arena to a proposed national scope of practice and career ladder, Maine will need at least five to ten years to meet the criteria as it stands now. Additionally, more collaboration is needed with Dept of Labor, whose efforts at workforce development tend to inadvertently neglect the behavioral health workforce issues and focus exclusively on physical health care workers. Progress with Licensing Boards and Academic programs will continue to be spotty and slow until changes occur at the national level in terms of accreditation standards and licensing requirements.

Maine contracts with an intermediary to provide behavioral health workforce development and are in regular communication about what needs training and follow up is necessary to get providers ready for changes and entice others to enter the field. Some resources that would be helpful are: effective approaches to engage higher education in offering curriculum/programming that ready the existing workforce and encourage new people to enter it. The lack of legitimacy of the field has held down salary and wages so much that it is not a sustainable profession to be part of, so market analysis of the behavioral health field in terms of adequate/appropriate average salary could be beneficial in getting people interested in the this work.

Include a description of how these systems address the needs of diverse racial, ethnic and sexual gender minorities. These systems work in tandem to address the needs of diversity in the following ways: Provision within contracts that states there is "no wrong door" when accessing services, assurance of cultural considerations with regard to race, gender and ethnicity via non-discrimination clause in regulatory and contract language, provision of education and training to increase awareness and appropriate service matching.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

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Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Main data sources reviewed include:
TDS, NSDUH, BRFSS, MIYHS, YRBSS, UCR

Maine's rates of persons who needed treatment but did not receive treatment has improved slightly, although not significantly, in age groups under 26. From the 2007-2008 and the 2008-2009 NSDUH reports for Maine rates went from, 5.02% to 4.13% of 12-17 year olds, 17.03% to 16.68% of 18-25 year olds, and 5.2% to 5.23% of 26+ year olds "needed but did not receive treatment for alcohol use". During this same time frame, those who needed but did not receive treatment for illicit drug use went from, 4.31% to 4.15% of 12-17 year olds, 9.29% to 8.92% of 18-25 year olds, and 1.61 to 1.7% of those 26 years old or older. <http://oas.samhsa.gov/2k8State/stateTabs.htm>

wait list data: During the first 8 months of SFY 2011 there were 2,175 people on the waiting list to enter treatment. During June 2011 there were 285 people on a waiting list to enter treatment at OSA contracted agencies.

Nationally, as in Maine, alcohol is the drug of choice for both youth and adults. Youth Risk Behavior Surveillance System (YRBSS) data cannot be compared to the MIYHS so in order to compare Maine data to national data, YRBSS is used. In the 2009 data, 42% of high school students across the nation have had at least one drink in the 30 days prior to the survey compared to 32% of Maine high school students. No comparison data is available for binge drinking and the percentage of high school students having used marijuana in the 30 days prior to the survey is very similar at 20.8% nationally and 20.5% in Maine.

2009 YRBSS Grades 9-12	Maine	National
30 Day Alcohol Use	32.2%	41.8%
30 Day Binge Drinking	--	24.2%
30 Day Marijuana Use	20.5%	20.8%

Behavioral Risk Factor Surveillance System (BRFSS) data shows that Maine is close to the national average when it comes to 30 day alcohol use for ages 18 to 24 at 49% and 49.8%, respectively. Maine has a higher percentage of binge drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion) than the nation, 29.2% versus 25.1%. The same holds true for heavy drinking (adult men having more than two drinks per day and adult women having more than one drink per day) with Maine's percentage of 18 to 24 year olds at 7.4% and the United States at 6.2%.

2009 BRFSS Ages 18-24	Maine	National
30 Day Alcohol Use	49%	49.8%
Binge Drinking (Alcohol)		29.2% 25.1%
Heavy Use (Alcohol)	7.4%	6.2%

In 2004 the State of Maine, Office of Substance Abuse, was awarded a Strategic Planning Framework State Incentive Grant which allowed for the creation and support of a statewide prevention/health promotion infrastructure that:

- ensured every community in Maine had the opportunity to participate in strategic prevention planning;
- cultivated a skilled prevention workforce;
- implemented a prevention plan;
- implemented evidence-based and culturally competent prevention programs, policies, and practices; and
- evaluated results.

When the grant ended in 2010, there was movement in a positive direction that resulted in key data that can be used in further program planning at the State level. That data included ensuring the work that is being implemented statewide is focused and prescriptive that allows for the combination of strategies, yet flexible enough to meet community needs, making decisions both funding and programming, based on the available data, investing in workforce and systems development is the key to sustainability, and to evaluate the programming to ensure it is an effective and efficient use of funds.

As stated before, alcohol is the drug of choice in Maine. The 2009 MIYHS survey

results show that 34.7% of Maine high school students had used alcohol in the 30 days prior to the survey. Approximately 21% had consumed five or more alcoholic drinks in one setting. Beginning in ninth grade about half the students who reported having drunk in the past 30 days also report having binge drank. Approximately 59% of tenth graders and 63% of eleventh and twelfth graders who reported having drunk in the past 30 days also report binge drinking. The 2009 MIYHS data also reveals that substance use in all three categories (30 day alcohol, binge drinking, and 30 day marijuana us) increases the most between eighth and ninth grade.

Source: MIYHS, 2009.

According to the 2008 BRFSS survey, 59% of young adults in Maine over the age of 18 consumed at least one alcoholic drink in the past 30 days, 16% binge drank (five drinks in one occasion), and 7% heavily used alcohol (more than one or two alcoholic drinks per day).

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

2012

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	Youth and Young Adults at risk for Substance Use/Abuse	Youths under 18 and young adults 18 - 25.
2	Pregnant Women with Substance Use Disorders	Women of child bearing years engaged in high risk use.
3	IVDU'ers	Persons with present or past history of drug use.
4	Persons in Need of Intervention/Treatment (Targeted population groups)	Criminal Justice and homeless Youth Native American TB/HIV

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

2012

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Youth and Young Adults at risk for Substance Use/Abuse	Reduce the misuse of alcohol, prescription drugs, and marijuana among 18-25 year olds by 6/30/2013.	<ol style="list-style-type: none"> 1.Engage the Healthy Maine Partnership coalition public health infrastructure to implement evidence-based environmental strategies in their district to reduce misuse of alcohol. 2.Create statewide messages and material for use by prevention providers on high risk alcohol use. 3.Support the enforcing underage drinking laws environmental strategies statewide. 4.Provide evidence-based programming opportunities to institutes of higher education throughout the state based on data and evidence of effectiveness. 5.Support the PMP 	30 day alcohol, marijuana, prescription drug use (NSDUH)	Description of Collecting and Measuring Changes in Performance Indicator: Will us the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At sub-state levels where broken down by age groups we will use the States Behavioral Risk Factor Surveillance Survey (BRFSS) to assess sub-state changes, and the Maine Higher Education Alcohol Prevention Partnership (HEAPP) higher education survey to assess higher education student changes.

promotion project with resources to educate the public about the dangers of misusing prescription medications.
6.Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices

1.Engage the Healthy Maine Partnership coalition public health infrastructure to implement evidence-based environmental strategies in their district to reduce use and misuse of alcohol.
2.Support the PMP promotion project with resources to educate health care providers and the public about the misuse of prescription medications.
3.Support the PMP with resources to educate health care providers about evidence based responsible prescribing practices.
4.Create statewide messages and material for use by prevention providers on alcohol, marijuana and prescription medications.
5.Support the

30 day alcohol use, binge drinking, marijuana, and psychotherapeutics (NSDUH)

Will use the Federal Survey, National Survey on Drug Use and Health (NSDUH) as pre-populated in the NOMS to report State level changes in rates. At substate levels where broken down by age groups we will use the Maine Integrated Youth Health Survey (MIYHS) a population based school health survey.

Youth and Young Adults at risk for Substance Use/Abuse

Reduce the use, misuse, and abuse of alcohol, marijuana and prescription medications among youth.

enforcing underage drinking laws environmental strategies statewide. 6. Provide evidence-based universal, indicated and selected population prevention programming throughout the state based on data and evidence of effectiveness.

Pregnant Women with Substance Use Disorders

IVDU Pregnant Women - To reduce morbidity for IVDU pregnant women in the state of Maine by 6/30/13.

1. Monitoring access and retention measures per contract with providers
2. Monitoring wait list reporting to ensure this population is being served within required time frames.
3. Use of Motivational Interviewing and Cognitive-Behavioral Treatment Strategies
4. Discussion of unmet needs begin resolved through care coordination
5. Competency training for providers on gender-responsive care
6. Post-treatment contacts at 3, 6, 9, and 12 months completed by providers

Changes in TDS data points and disposition on wait list.

1. Treatment Data System (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, GAF improvement and services provided/referrals. Baseline data can be extracted to show changes over the next 18 months with the implementation of the above strategies. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans, and a report on the providers tracking of post treatment contacts with individual's services by the agency.

Pregnant Women with Substance Use Disorders	Retention and Social Connectedness: Increase access to prevention messages and opportunities for families communicating about drug use by 6/30/13.	1. Provide information and Technical Assistance to Block Grant providers about the role of prevention and its impact on families 2. Provide adequate resources (media messages, pamphlets, access to coalitions) to providers	Changes in TDS data points and disposition on wait list.	1. Annual Site Visits: a modification will be made to the template form to ensure this is monitored annually by OSA staff.
Pregnant Women with Substance Use Disorders	To reduce morbidity for pregnant women in the state of Maine by 6/30/13.	1. Monitoring access and retention measures per contract with providers 2. Monitoring wait list reporting to ensure this population is being served within required time frames. 3. Use of Motivational Interviewing and Cognitive-Behavioral Treatment Strategies 4. Discussion of unmet needs begin resolved through care coordination 5. Competency training for providers on gender-responsive care 6. Post-treatment contacts at 3, 6, 9, and 12 months completed by providers	Changes in TDS data points and disposition on wait list.	1. Treatment Data System (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, GAF improvement and services provided/referrals. Baseline data can be extracted to show changes over the next 18 months with the implementation of the above strategies. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans, and a report on the providers tracking of post treatment contacts with individual's services by the agency.

IVDU'ers	Retention and Social Connectedness: Increase access to prevention messages and opportunities for family communicating about drug use by 6/30/13.	1. Provide information and Technical Assistance to Block Grant providers about the role of prevention and its impact on families 2. Provide adequate resources (media messages, pamphlets, access to coalitions) to providers	Changes in TDS data points and disposition on wait list.	1. Annual Site Visits: a modification will be made to the template form to ensure this is monitored annually by OSA staff.
IVDU'ers	To reduce morbidity and increase use of evidence-based practice for IVU in the state of Maine by 6/30/13.	1. Ensure access to services for individuals or appropriate referrals to those who have capacity. 2. Monitoring wait list reporting to ensure this population is being served within required time frames. 3. Provide education about various evidence-based treatment modalities including Medication Assisted Treatment 4. Participation in workforce development trainings sponsored by OSA and Workforce Development contracted provider 5. Provide education and implement training related to core competencies for practitioners utilizing Medication Assisted Treatment 6. Monitoring access and retention measures per contract	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, GAF improvement and services provided/referrals. Baseline data can be extracted to show changes over the next 18 months with the implementation of the above strategies. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to ensure competencies have been communicated and supported by administration.

with providers

Persons in Need of Intervention/Treatment (Targeted population groups)	Criminal Justice and/or Homeless – Increase Access/Capacity and Stability in housing to this population by 6/30/13.	1. Employ NIATx process improvement aims at both provider and systems level	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment and living arrangements. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to include NIATx Process and a report on the providers tracking of post treatment contacts with individual's services by the agency. Improvement exposure/training
Persons in Need of Intervention/Treatment (Targeted population groups)	Native Americans – Reduce Morbidity – decrease use of substances of abuse and mental illness symptomatology	1. Increase awareness/knowledge of cultural competency by asking the 5 tribes in Maine to assist in workforce development 2. Increase collaboration with tribes to assure appropriate interventions are used with this population	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to A/R measures, completion of treatment, services provided and referrals. 2. Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to include education/training for working with American Indians and a report on the providers tracking of post treatment contacts with individual's services by the agency.
Persons in Need of Intervention/Treatment (Targeted population groups)	Retention and Social Connectedness: Increase access to prevention messages and opportunities for family communicating about drug use by 6/30/13.	1. Provide information and Technical Assistance to Block Grant providers about the role of prevention and its impact on families 2. Provide adequate resources (media messages, pamphlets, access to coalitions) to providers.	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS)
Persons in Need of Intervention/Treatment (Targeted population groups)	TB/HIV – Reduce Morbidity in this population by 6/30/13.	1. Collaborate and blend funding with the Maine Centers for Disease control to screen, test, and treat	Changes in TDS data points and disposition on wait list.	1. Treatment Data System/Wait list (TDS) can give OSA data relative to Wait Lists, A/R measures, completion of treatment, and referrals for medical interventions

this population.

Persons in Need of Intervention/Treatment (Targeted population groups)	Youth – Reduce Morbidity – decrease use of substances of abuse by 6/30/13.	1.Expanded use of technology with youth 2.Education/training on youth development and proven strategies that work with this population 3.Access to recovery supports in the community	Changes in TDS data points and disposition on wait list.	1.Treatment Data System/Wait list (TDS) can give OSA data relative to A/R measures, completion of treatment, services provided and referrals. 2.Annual site visits conducted with each Block Grant provider will include a review of client charts and staff professional development plans to include education/training for working with youth and a report on the providers tracking of post treatment contacts with individual's services by the agency.
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Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy
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Start Year:

2012

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	Not Required.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 	<input type="text" value="N/A"/> <input type="text" value="6"/>
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	<input type="text" value="N/A"/> <input type="text" value="6"/>
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 	<input type="text" value="N/A"/> <input type="text" value="6"/>
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 	<input type="text" value="N/A"/> <input type="text" value="6"/>
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 	<input type="text" value="N/A"/> <input type="text" value="6"/>
Recovery Supports	<ul style="list-style-type: none"> • Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care 	<input type="text" value="N/A"/> <input type="text" value="6"/>
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services 	<input type="text" value="N/A"/> <input type="text" value="6"/>

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

N/A 6

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

N/A 6

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

N/A 6

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

N/A 6

System improvement activities

N/A 6

Other

N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$299,000	\$75,000	\$131,863	\$	\$
Information Dissemination	Selective	\$	\$	\$	\$	\$
Information Dissemination	Indicated	\$	\$	\$	\$	\$
Information Dissemination	Unspecified	\$85,712	\$	\$127,698	\$	\$
Information Dissemination	Total	\$384,712	\$75,000	\$259,561	\$	\$
Education	Universal	\$106,821	\$89,009	\$51,046	\$	\$
Education	Selective	\$71,879	\$7,004	\$26,648	\$	\$
Education	Indicated	\$71,879	\$7,004	\$26,647	\$	\$
Education	Unspecified	\$	\$	\$42,500	\$	\$
Education	Total	\$250,579	\$103,017	\$146,841	\$	\$
Alternatives	Universal	\$	\$	\$	\$	\$
Alternatives	Selective	\$	\$	\$	\$	\$
Alternatives	Indicated	\$	\$	\$	\$	\$
Alternatives	Unspecified	\$	\$	\$	\$	\$
Alternatives	Total	\$	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$41,576	\$14,009	\$23,682	\$	\$
Problem Identification and Referral	Selective	\$40,023	\$7,004	\$12,966	\$	\$
Problem Identification and Referral	Indicated	\$30,303	\$7,004	\$12,966	\$	\$
Problem Identification and Referral	Unspecified	\$73,212	\$	\$75,571	\$	\$
Problem Identification and Referral	Total	\$185,114	\$28,017	\$125,185	\$	\$

Community-Based Process	Universal	\$ 212,750	\$	\$ 56,863	\$	\$
Community-Based Process	Selective	\$	\$	\$	\$	\$
Community-Based Process	Indicated	\$	\$	\$	\$	\$
Community-Based Process	Unspecified	\$ 85,712	\$	\$ 85,198	\$	\$
Community-Based Process	Total	\$ 298,462	\$	\$ 142,061	\$	\$
Environmental	Universal	\$ 523,000	\$ 116,741	\$ 208,727	\$	\$
Environmental	Selective	\$	\$ 14,009	\$ 10,000	\$	\$
Environmental	Indicated	\$	\$ 14,009	\$ 10,000	\$	\$
Environmental	Unspecified	\$ 98,212	\$ 88,724	\$ 94,824	\$	\$
Environmental	Total	\$ 621,212	\$ 233,483	\$ 323,551	\$	\$
Section 1926 Tobacco	Universal	\$	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$ 100,000	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$ 100,000	\$	\$	\$	\$
Other	Universal	\$ 135,113	\$ 88,724	\$	\$	\$
Other	Selective	\$	\$	\$	\$	\$
Other	Indicated	\$	\$	\$	\$	\$
Other	Unspecified	\$	\$ 533,820	\$	\$	\$
Other	Total	\$ 135,113	\$ 622,544	\$	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year:

End Year:

Date of State Expenditure Period From:

Date of State Expenditure Period To:

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$4,419,754	\$27,000,000	\$500,000	\$6,397,584	\$	\$
2. Primary Prevention	\$1,975,192	\$	\$1,062,061	\$997,199	\$	\$
3. Tuberculosis Services	\$	\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$	\$	\$	\$450,000	\$	\$
5. State Hospital		\$	\$	\$	\$	\$
6. Other 24 Hour Care	\$	\$	\$	\$	\$	\$
7. Ambulatory/Community Non-24 Hour Care	\$	\$	\$	\$	\$	\$
8. Administration (Excluding Program and Provider Level)	\$290,000	\$	\$200,000	\$4,200,000	\$	\$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$6,684,946	\$27,000,000	\$1,762,061	\$12,044,783	\$	\$
10. Subtotal (Rows 5, 6, 7, and 8)	\$290,000	\$	\$200,000	\$4,200,000	\$	\$
11. Total	\$6,684,946	\$27,000,000	\$1,762,061	\$12,044,783	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist
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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment		\$ <input type="text"/>		\$ <input type="text"/>		\$
2. Quality Assurance		\$ <input type="text"/>		\$ <input type="text"/>		\$
3. Training (Post-Employment)		\$ <input type="text"/>		\$ <input type="text"/>		\$
4. Education (Pre-Employment)		\$ <input type="text"/>		\$ <input type="text"/>		\$
5. Program Development		\$ <input type="text"/>		\$ <input type="text"/>		\$
6. Research and Evaluation		\$ <input type="text"/>		\$ <input type="text"/>		\$
7. Information Systems		\$ <input type="text"/>		\$ <input type="text"/>		\$
8. Total	\$	\$	\$	\$	\$	\$

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

The Maine Office of Substance Abuse has a public library and 1-800 number for access to information on prevention, treatment providers and community partners and information throughout the state. There is a plan underway with the office's agency monitoring team to update the treatment directory should a provider obtain less than adequate re-licensure from the Division of Licensing and Regulatory Services so that an individual can make an informed choice about accessing a particular provider. There is also a link to the Maine 211 number so that any individual accessing information via that line has a direct link to the treatment provider directory for information should the Information and Resource Center be closed. Annually the Maine Office of Substance Abuse conducts a Client Satisfaction Survey to access client's perspectives of the service system as it relates to Substance Abuse. Feedback is regularly solicited from prevention providers about support needed and materials created for their local audiences.

Providers that have contracts with the Maine Office of Substance Abuse are required to use ASAM – PPC2 to assess for level of need for services, within that the clients "readiness for change is assessed" and they are offered a menu of available services and are allowed to make informed choices about the services they receive. Additionally, the expectation for the individualized treatment planning process is client-directed and reviewed each time there is contact. Currently individuals do not have direct control of the financial (budgeting) aspect of services in Maine

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

Maine's Treatment Data System collects unique client level encounter data. Also, within the Maine Department of Health and Human Service we have a link created that allows client data from Substance Abuse, Adult Mental Health and Medicaid clients to match up.

If not, respond to the following as to how it plans to do this, the process to do this, the resources needed to do it, and a timeline for developing such capacity:

Our data system and data extract process is very adaptable and can be updated/enhanced to provide any data that are needed to support the grant as long as the needs are identified and defined by SAMHSA. Maine's data system within the SSA provides other outcome and performance information outside of the National Outcome Measures. We have an oracle based Treatment Data System (TDS) which captures client and agency level data from agencies who receive funding from the State; some of this data is uploaded from this system into the Federal TEDS system. We also have a Prescription Monitoring Program system (PMP) which pulls data from pharmacies who dispense drugs in Maine. The data is collected by an out of state vendor (Health Information Designs), cleaned and is then provided to the State of Maine which houses it in an Oracle database. Both the TDS and PMP data systems are maintained by the State's Office of Information Technology.

TDS includes information on the Provider, the level of care, type of service they provide, and cost per unit. The TDS also includes the following information on clients: Dates of contact and treatment; age, race, ethnicity, gender, and county of residence; insurance; veteran status, education, marital and dependent status; pregnancy status; living arrangements; employment; income; source of income; prior treatments in SA and MH; violence and incarceration information; primary presenting problem; drug use and route of administration; age at first use; MAT status; OUI offense; Global Assessment Functioning Scale score; self-help group attendance; and gambling.

PMP collects data on the prescription dispenser, the prescriber regarding location. It also collects information on patients on the date dispensed and prescribed, address, gender, age, schedule II-IV drugs that were dispensed including days supply, quantity dispensed, and strength.

MACWIS (Maine Automated Child Welfare Information System) MACWIS is a secure database (login credentials are necessary) that is used by many Agencies within the Department of Health and Human Services. The database contains highly confidential information regarding clients and children throughout the State; however, MACWIS is only used by OSA to verify License Status of agencies.

KIT Prevention collects data on contracted prevention providers and measures outcomes and collects reach and counts. For prevention services targeted to specific individuals, a variety of demographics and session counts are also collected.

The Prevention Services uses the KIT Prevention System through a contract with KIT Solutions, Inc, of Pittsburg, PA. Prevention providers are not required to have a national provider identifier. KIT Prevention does create a unique identifier for providers that can be used to aggregate services and other information. KIT Prevention also has unique participant identifiers that allows for unduplicated counts of participants and the ability to aggregate services by participants, but only for selected, indicated and universal direct prevention programs.

In the PMP system, providers and dispensers each have unique DEA numbers, which are included, and searches may be performed by this unique identifier. The State also requires the provider to edit this if the DEA number changes, and the State receives information on DEA numbers which have been cancelled or lapsed.

TDS includes the Federal ID number for each substance abuse treatment provider within the database. Aside from the federal id numbers in the TDS and PMP systems, we also capture agency/provider name and addresses which can be used to cross check when aggregating data.

In PMP log in codes are needed. In the TDS system, log in codes are needed.

Client level data is available from most of the data systems listed above. The data systems do include client identifiers: The PMP uses an algorithm of multiple identifiers to identify a client; the TDS system uses a unique client id. Set by the state system which is uploaded into TEDS system. The unique client id is shared by our Medicaid system and Mental Health system. Both of these methods allow us to aggregate and subtract out duplicate counts from the data.

Maine has not switched to ICD-10 as of summer 2011, but are in the process of updating the PMP system to allow for this change (currently transitioning to ASAP 4.1 standards). Other state systems (Medicaid/Medicare, etc.) are scheduled to be switched to ICD-10 coding by 2013.

Medicaid data or linked Medicaid-behavioral health data are used occasionally, not on a regular basis. OSA is currently in communication with the Medicaid Office to get on their calendar for receiving regular reports around substance abuse.

Does your state's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, HER's, Federal IT requirements or similar issues?

Maine's Office of Information Technology (OIT) participates in HIT meetings held by the State Office of the Coordinator who received funding to move HIT forward in Maine. See below for more information. OIT, MaineCare, and the SSA participated the Design Management Care meetings hosted by MaineCare, to develop an integrated HRE system across the State.

Does your state have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

Is your state Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability behavioral health IT system reform, and meeting Federal IT data standards?

There was some funding for this, ARRA funding has been used for this, but it has to become self-sustaining system in the near future. OSA has participated in some of the meetings around Health Information Technology, but has not been at the table much around Health Information Exchange. It has been within the past few months that OSA's presence has been requested/invited to participate in these discussions.

Maine has a coordinating body responsible for the development of a statewide HIT strategy and the Department's Health and Human Services Commissioner is a member (SSA/SMHA are under this Commissioner). From the Governor's Office two entities were appointed with responsibility for expanding and coordinating Health Information Technology. The first is the Office of the State Coordinator for HIT (appointed through the "recovery act") which operates within the Governor's Office of Health Policy and Finance. The second is the Governor appointed "Health Information Technology Steering committee" made up of the following members: Director, Governor's Office of Health Policy & Finance; Commissioner of the Department of Health and Human Services; Commissioner of the Department of Professional and Financial Regulation; Superintendent of Insurance; Director of the Dirigo Health Agency; Director of health information exchange organization; and individuals representing or with expertise in hospital systems, health care providers, home health providers, FQHC's, health care quality, behavioral health provider, insurance industry, business, health care data information, University/college system, racial and ethnic minority communities, and a health law or health policy expert.

Maine is in the process of developing policies, standards, and technical protocols governing the HIT infrastructure. The SSA is engaged in conversations with the provider association and community to ensure they are developing the capacity to be able to fully participate in future reimbursement and data reporting systems. The provider association, with the support of the SSA is engaged in a technical

assistance project with NIATx (Network for Improving Addiction Treatment). This project was tailored to help providers ready themselves for the changes related to the healthcare reform.

The Medicaid System is going through a broad change in their IT system, and vendor. Now called Maine Integrated Health System (MIHS) Centers for Medicaid office is coming to certify the system September 2011. The first release of the system was in September 2010, testing and upgrades are continuing. They are expecting certification of the system in September 2011.

An optional strategy in the Prescription Monitoring Program (PMP) promotion project is to work with health care systems to incorporate PMP data into their EHR system.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

OSA has a data platform that allows us to utilize data input into the system to gauge performance measures and outcomes. All contracted organizations have standard reporting requirements to ensure the same information is tracked across levels of care. Because of the work that OSA did with NIATx and the STAR-SI grant, all contracted outpatient and intensive outpatient providers hold incentivized contracts to increase performance. These measures have been in place for 3 years and OSA is looking at expansion of the measures to include basing contracted units targets/cost per unit in provider budgets, expansion into other levels of care, and in the RFP process for treatment services SFY 2014 utilizing historical data over the three years as a measure of successful applications being awarded.

Prevention outcomes are identified and tracked in the KIT Prevention system. Quarterly monitoring and technical assistance are provided by OSA prevention staff and adjustments made throughout the provision of services to meet local needs and to reach identified outcomes.

Quarterly performance measures in contracts are reviewed and reconciled by OSA staff, this includes Agreement Administrators, Data and Research, and Treatment Team members working with inputs and making decision based on data if TA is necessary. Additionally, provider organizations receive monthly reports of their performance and quarterly reconciliations related to incentive payments. This allows them to track their performance and reach out for TA as needed.

Monthly, providers receive automated reports to continuously monitor their progress and outcomes. Quarterly, treatment specialists and agreement administrators reconcile the data by reviewing the performance measures and assessing progress on outcomes and payment as a result. Annually, contracts are reviewed and assessed for continuation, increase, decrease, or termination based on performance. Stakeholder input is requested and provided ongoing. Inclusion of individuals in recovery is garnered via the client satisfaction survey and focus groups and surveys conducted by the Women's Addiction Services Council (WASC), treatment specialists, and the Maine Alliance for Addiction and Recovery MAAR).

All licensed providers in the State of Maine are required in regulation to report critical incidents in their organizations. There is a work to standardize and improve this process with the use of an electronic means of reporting (the current process requires faxing or scanning an original document because of the need for staff and supervisor signatures).

Once these are reported, treatment staff at OSA reaches out to the agency to investigate if there is further information needed, whether the staff at the agency needs support, and if information is missing and needed; provides technical assistance to increase accuracy of data collection. Complaints about individuals within an organization are addressed by the Board of Alcohol and Drug Counselors or the board that is appropriate to that individual professional licensure. Information on the disposition of the complaint investigation are public information and accessible to all. All complaints about agencies/provider organizations are referred to the Division of Licensing and Regulatory Services. OSA works in tandem with DLRS and is notified should there be a Corrective Action Plan for a provider organization. If at all possible, OSA works with individuals and provider organizations to resolve grievances within the organization and to use that information to inform and improve practice. If resolutions cannot be achieved at that level, then it is referred to the DLRS or respective board of licensure.

Maine's Department of Health and Human Services, Office of Quality Improvement is currently working with the Commissioner and her team on creating a quality improvement plan for the department and its Offices which will include the Office of Substance Abuse. We do not currently have a formal written CQI plan.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

Through the continued relationship-building process with the five tribal communities, the Office of Substance Abuse is beginning to learn the strengths, needs and gaps that exist within the tribal communities and within the Native American population. In preparation of this particular planning application, staff from the Office of Substance Abuse met as a group, with three of the five tribes in September to begin discussions around strengths, gaps and resources that currently exist or are needed within these communities. OSA sees this as a beginning of a process that will help strengthen our ability to provide effective services statewide. The notes from the meeting between OSA and the tribes were shared with all five of the tribal communities, and in turn OSA asked for feedback from all five (the three that were present at the meeting and from the two that were not). The five tribal communities here in Maine are currently included in a variety of planning processes in connection with the Office of Substance Abuse:

- The Office of Minority Health participates on a variety of workgroups/planning/ and advisory boards.
- OSA has served as a liaison on several occasions, connecting tribal members with other State Agency partners.
- In 2011, LD 121 was passed which created a 9th public health district referred to as the Tribal Public Health District. This legislation will ensure that there is tribal representation actively involved in Maine's public health infrastructure. Maine's public health infrastructure covers the entire state and it is through this infrastructure that prevention invests in to address environmental prevention needs statewide.
- At this time, OSA is in the process of contract negotiations to include the Tribal Public Health District in the work being done across the state with the Healthy Maine Partnerships addressing substance abuse environmental strategies.
- OSA is also in the process of contract negotiations with the Tribal Public Health District to partner in the Prescription Monitoring Program Promotion Project along with the other eight public health districts in the state.
- OSA was recently awarded the SPF State Prevention Enhancement Grant through SAMHSA which will aide in the creation of a five year OSA Prevention Strategic Plan. As a result of this award, the two Tribal Public Health Liaisons have signed a letter of commitment agreeing to serve on the OSA Prevention Advisory Board for the next year thereby bringing tribal representation to the table during this planning process.
- When invited, OSA attends the Tribal Health Director's meetings that occur quarterly and participates in any other meetings/trainings that the Tribal Health Director's recommend.
- In 2009, all five tribes began the process of developing and implementing a Tribal Health Needs Assessment that will provide each tribe with data specific to each individual tribal regarding various health disparities among community members. OSA committed \$10,000 to the Tribal Health Needs Assessment to include questions pertaining to substance abuse. At this time the tribes are in the process of analyzing and discussing internally the results of their data.

The Office of Substance Abuse foresees the following needs for future planning and partnerships:

- OSA will continue to work with the Tribal Health Directors and other partners on the development of data sharing language between the Maine Office of Substance Abuse and the five tribal communities.
 - Working with all five tribes to develop culturally appropriate materials for the tribes in addressing substance abuse across the continuum; and
 - Increasing awareness around which tribes have law enforcement agencies, schools and worksites on the reservation in order for OSA to create appropriate partnerships with these entities.
- OSA will continue to consult with each tribal community in the State to ensure their involvement in the needs assessment, planning, and service delivery process. This will be done by continuing communication whether face to face, email or telephone on a regular basis to continue developing the relationship between the tribes and the Office of Substance Abuse.

OSA, when invited will continue to spend time with each individual tribe, learning about the culture and the needs. This will be done through active listening, learning and recognizing discussions regarding what works and what does not work

within their culture. OSA will continue to provide personal emails as one way of communicating pertinent information versus putting everyone on listserv and will support face to face meetings with tribal members over other forms of communication.

OSA will continue to invite tribal members to conferences, events and trainings. OSA will extend invitations for tribal members to participate on various planning committees, workgroups and/or advisory boards. Input from the tribal communities will be sought on any issue that has the potential to impact the tribes.

Grant opportunities will be communicated with the tribes in a timely fashion and whatever is written by OSA about the tribes in all grant applications will be shared and communicated with the tribes for feedback and input again in a timely fashion. OSA will work with the tribes during the application process and when discussing potential work/programming that will impact tribal communities. In addition, letters of support will be requested in a timely manner and OSA staff will be available to work with the tribes throughout the process. OSA will be cognizant of its reporting requirements and consider what is essential to meet those requirements. OSA is available for technical assistance and support and will offer a reminder of that service on a regular basis regardless of whether or not any of the tribes hold a current contract with OSA.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

OSA will work with existing providers to assess their readiness for full implementation of the Affordable Care Act by utilizing the assessment tool NIATX offers. OSA will then work with providers to gather baseline data on their current ability to bill commercial insurance.

OSA will work with providers to increase their ability to diversify their revenue streams and attempt to rely less on the SAPTBG and Medicaid funding. This will allow us to demonstrate to SAMHSA the over/underutilization of SAPTBG funding and better allocate resources and contracted services to better performers.

The necessary resources for OSA to implement utilization strategies would include increased knowledge of the commercial insurance structures/policies/rules/regulations/credentialing by insurers in Maine.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Youth and Young Adults at risk for Substance Use/Abuse	30 day alcohol, marijuana, prescription drug use (NSDUH)	<input type="checkbox"/>
Youth and Young Adults at risk for Substance Use/Abuse	30 day alcohol use, binge drinking, marijuana, and psychotherapeutics (NSDUH)	<input type="checkbox"/>
Pregnant Women with Substance Use Disorders	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Pregnant Women with Substance Use Disorders	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Pregnant Women with Substance Use Disorders	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
IVDU'ers	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
IVDU'ers	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>
Persons in Need of Intervention/Treatment (Targeted population groups)	Changes in TDS data points and disposition on wait list.	<input type="checkbox"/>

Footnotes:

The Maine Office of Substance Abuse has information within the Maine Department of Health and Human Services' Performance Metrics Dashboard, available on line at:

<http://gatewaytest.maine.gov/dhhs-apps/dashboard/Default.aspx>

The Dashboard initiative promotes information sharing for DHHS managers, staff, stakeholders and customers. It has information on the work DHHS performs for the people of the State. This tool will provide access to many different types of measurement – from community level health indicators that are tracked for public health improvement purposes, to measures of service provision and quality across all DHHS Offices.

The Dashboard is also designed to assist in understanding the work of DHHS, monitoring performance, communicating results, identifying areas for increased focus, and supporting a culture of accountability and responsibility throughout the Department. This tool will continue to change overtime as measures are refined and improved, and as strategy changes based on program continuous improvement plans.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

Provide and update of the states suicide prevention plan to include populations that may be most at risk (America's service men and women and their families)



*Maine Center for Disease
Control and Prevention*
*An Office of the
Department of Health and Human Services*

Maine Center for Disease Control And Prevention

Maine Youth Suicide Prevention Program Plan September 2007



Maine Youth Suicide Prevention

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

**Developed by the Maine Youth Suicide Prevention Program
and MYSPP Committee members**

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MYSPP PLAN EXECUTIVE SUMMARY

Introduction

In the past decade in the United States, suicide has been widely recognized as a public health problem requiring national attention and urgent action. In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention emphasizing that suicide is a major public health problem, which can only be reduced through integrated efforts by all sectors of society.

Many of the risk and protective factors for suicidal behavior are known. The evidence for effective suicide prevention programs is limited, but growing. Maine is one of the states at the forefront of implementing and evaluating youth suicide prevention programs.

The Maine Youth Suicide Prevention Program (MYSPP) is a multi-agency effort coordinated by the Injury Prevention Program in the Maine Center for Disease Control and Prevention (Maine CDC), Division of Family Health in the Department of Health and Human Services. The long term goal of the MYSPP is: *To reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth ages 10-24.*

In 1997, the original MYSPP plan was created through an extensive process that included input from suicide survivors, youth, and a wide variety of clinicians and professionals statewide as a result of a task force established by Governor Angus King. Since that time, there has not been an appreciable reduction in the youth suicide rate in Maine. *However, reports of suicidal behavior among high and middle school students show a steady, measurable decline from 1999 to 2007.* MYSPP activities have yielded concrete interim results, most notably in training gatekeepers and in implementation of the comprehensive school-based Lifelines Program¹ in Maine high schools. Both of these activities have been evaluated and have been shown to increase adult confidence in identifying those at risk for suicide and in boosting student's help-seeking behaviors.²

In 2005, Governor John Baldacci issued an Executive Order to strengthen the MYSPP. A strategic planning process to improve the program plan was initiated by Maine's First Lady, Mrs. Karen Baldacci, who charged stakeholders, both within and outside of state government, with participating in the process.

This document represents a comprehensive plan with ten goals mirroring the National Strategy for Suicide Prevention. The objectives and activities contained within the plan goals represent the thoughtful recommendations of approximately 100 individuals who engaged with the MYSPP in this strategic planning process. As resources dedicated to implementing the recommended activities are limited, it is not possible to implement all recommendations made herein. However the plan provides a useful guide to the program and its partners in advancing youth suicide prevention efforts into the future and funding will be sought to support key priorities.

¹ Kalafat, J. Underwood, M. *Lifelines: A School Based Adolescent Suicide Response Program*. Kendall/Hunt Publishing Co., Dubuque, IA. 1989.

² Madden, M., Haley, D., Hart, S., Kalafat, J., Saliwanchik-Brown, C. *An Evaluation of Maine's Comprehensive School-based Youth Suicide Prevention Program*. 2007

Suicide and Self-Inflicted Injuries in Maine

Suicide is the 2nd leading cause of death for Maine residents ages 15-24, and the 3rd leading cause of death for 10-14 year olds.* Between 2000-2004, 115 Maine youth ages 10 – 24, or an average of 23 youth per year, died by suicide. In that five year period, Maine youth ages 10 –24 died by suicide at a higher rate, 8.8 per 100,000, than the Northeast regional rate of 5.3/100,000 and the national rate of 7.0/100,000. Due to the high rates of suicide among the young, suicide is the fourth leading cause of years of potential life lost in Maine.

Non-fatal self-injuries, suicidal ideation and suicide attempts, are larger problems among youth than in the adult population. From 2001-2005, 1,677 youth ages 10-24 were hospitalized for self-inflicted injuries, the 2nd leading cause of injury hospitalizations in this age group after motor vehicle related injuries. The 2001-2005 rate of self-injury hospitalization among youth ages 10-24 was 12.7 per 10,000 compared to 8.6 per 10,000 among those over age 25.

It is estimated that there are 25 to 100 suicide attempts by adolescents and young adults for every death by suicide. In the Maine 2005 Youth Risk Behavior Survey, 13 percent of Maine high school and 19.8 percent of middle school students reported seriously considering suicide in the past year. Six percent of high school and 8.5 percent of middle school students reported making at least one attempt.

The national Suicide Prevention Resource Center (SPRC) estimates medical cost per suicide in Maine at \$3,780. Due to the high incidence of suicide at young ages, the estimated work loss cost per suicide is \$1,079,323.

Maine Youth Suicide Prevention Program Plan

The plan presented herein was created in direct response to Governor Baldacci's Executive Order and will be adjusted and implemented as new resources become available, activities are completed and objectives are achieved. Flexibility must be maintained so that the program can respond to emerging issues in Maine and new research in the field of suicide prevention. The plan will be used to guide program implementation. Any revisions made will seek to honor the contributions of those involved in crafting the objectives and activities contained within the plan.

The MYSPP Plan contains ten goals that mirror those in the National Strategy for Suicide Prevention. During the strategic planning process, objectives were prioritized and ordered accordingly under each goal and possible lead departments and potential partners were identified. It was not possible to engage all stakeholder groups concerned about suicide prevention in this planning effort. To implement this plan, ongoing outreach is necessary to the potential leaders and partners identified in the plan. Specific activities to meet objectives are described in a separate working document for use by those directly involved in carrying out the activities.

*The leading cause of death to this age group is motor vehicle crashes.

The long-term goal of the MYSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth aged 10-24.

To attain this goal, a comprehensive and sustained approach is necessary. The ten goals for enhancing the MYSPP are in alignment with the National Strategy for Suicide Prevention:

GOAL 1: Increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.

GOAL 2: Increase public awareness that suicide is a preventable public health problem.

GOAL 3: Develop and implement strategies to reduce the stigma associated with being a consumer of behavioral health services for families and youth and to increase help-seeking behaviors.

GOAL 4: Increase the number of Maine schools and communities statewide that implement effective youth suicide prevention activities.

GOAL 5: Support initiatives to decrease the risk of youth suicides by reducing access to lethal means.

GOAL 6: Implement training for recognition of at-risk behavior and appropriate response to a variety of audiences statewide.

GOAL 7: Develop and promote effective clinical and professional practices.

GOAL 8: Improve access to and community linkages with mental health, substance abuse, and suicide prevention services.

GOAL 9: Improve media reporting practices to reduce the potential of suicide contagion.

GOAL 10: Improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.

INTRODUCTION

MAINE YOUTH SUICIDE PREVENTION

PROGRAM PLAN

OVERVIEW

In the past decade in the United States, suicide has been widely recognized as a public health problem requiring national attention and urgent action. Many of the risk and protective factors for suicidal behavior are known. The evidence for effective suicide prevention programs is limited, but growing. The U.S. Surgeon General issued the National Strategy for Suicide Prevention in 2001, emphasizing that suicide is a major public health problem, which can only be reduced through integrated efforts by government, public health, mental health, human services, public safety and education working with communities, schools, employers, families, youth and other public and private partners. In a 2003 report *Achieving the Promise: Transforming Mental Health Care in America* issued by President Bush, suicide prevention was included in the first of six goals for the nation. In 2004, Congress passed the Garrett Lee Smith Memorial Act to provide federal funding to states for youth suicide prevention.

Maine is one of the states at the forefront of implementing and evaluating evidence-based youth suicide prevention programs. Current Maine Youth Suicide Prevention Program (MYSPP) activities include: 1) Statewide Information Resource Center; 2) Statewide crisis hotline; 3) Web sites for adults and youth; 4) Gatekeeper training and technical assistance for multiple audiences; 5) Awareness education programs and resources; 6) Training of trainers to conduct awareness education; 7) Annual suicide prevention conference; 8) School protocol guidelines and a protocol development workshop to help schools establish administrative protocols for suicide prevention, intervention and crisis management in the event of a suicide 9) Training for high school health educators in teaching “Lifelines” student lessons; 10) Training for instructors in the Coping and Support Training (C.A.S.T.) curriculum for high risk youth; 11) Education on restricting access to lethal means; 12) Media contagion education and guidelines; 13) Fact sheets, information booklets, and other resource materials; and 14) Suicide and self-inflicted injury data monitoring and analysis. In addition, the MYSPP is currently working on improving several program components and resources to increase effectiveness with specific populations at risk.

MYSPP HISTORY

The MYSPP was developed as an initiative of the Governor’s Children’s Cabinet which includes the commissioners from the departments of Health and Human Services, Education, Corrections, Labor and Public Safety. The MYSPP is housed within, and coordinated by, the Division of Family Health in the Maine Center for Disease Control and Prevention of the Department of Health and Human Services. Since inception, the program has been advised by a Steering

Committee that provides guidance to program development and implementation. Membership includes government and private stakeholders.

Since 1998, the MYSPP has employed a public health approach to address youth suicide. The program is based upon the assumption that collaboration among state agency leaders and staff, along with significant input from service providers, youth, suicide survivors and others, is necessary to plan and conduct youth suicide prevention activities. The long-term goal of the MYSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth ages 10-24.

The original program plan was created in 1997 through an extensive process that included input from suicide survivors, youth, and a wide variety of clinicians and professionals from around the state. Many activities in the initial plan are still being implemented.

When program implementation began in 1998, every Children's Cabinet agency was instructed to include youth suicide prevention as a priority area using existing agency funds. Each agency was asked to assume leadership in implementing specific portions of the plan in order to build and sustain a state level infrastructure. In 1999, the Children's Cabinet provided some start-up funds to initiate program activities.

The MYSPP has received regional and national recognition for its efforts and has given numerous presentations at state, regional and national conferences. Maine has contributed to the national suicide prevention evidence base through its work, most notably through implementing and evaluating the Lifelines Program, a promising school-based program, with a grant from the Centers for Disease Control and Prevention (CDC).

This project was implemented in 12 Maine high schools from 2002-2006. In September 2005, the MYSPP was awarded a Garrett Lee Smith Memorial Act grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year youth suicide prevention project. In 2006, an additional grant award to conduct an in-depth evaluation of the SAMHSA project was obtained.

STRATEGIC PLANNING PROCESS

In February 2005, following consultation with key stakeholders, the Governor's Office issued an Executive Order directing Children's Cabinet agencies to strengthen the MYSPP. Two things happened in direct response to the Executive Order. First, the Children's Cabinet created an ad hoc *Safe School and Community Climate Committee* to increase the implementation of effective positive youth development approaches, anti-bullying, anti-harassment, and anti-discrimination policies and procedures to foster safe school and community environments for Maine youth. This work resulted in legislation requiring all Maine schools to establish or modify their policies and procedures to address bullying and harassment and the development of model policies for school systems.

Second, the MYSPP initiated a strategic planning process. A full day retreat was held at the end of March 2005 with facilitators from the National Suicide Prevention Resource Center (SPRC), the Centers for Disease Control and Prevention (CDC) and the Children's Safety Network (CSN). A diverse group of stakeholders, from within and outside of state government, participated in the retreat and were given their charge by Maine's First Lady, Mrs. Karen Baldacci. Four new committees were launched to begin a process of identifying gaps and selecting strategic priorities to strengthen the MYSPP plan.

The committees were formed to align with the goals of the National Strategy for Suicide Prevention and included: 1) *Public Awareness*; 2) *School and Community-based Suicide Prevention*; 3) *Effective Clinical and Professional Practices*; and 4) *Lethal Means Restriction*. Co-leaders, one from a state agency and one external to state government, worked with their committee members to produce recommendations to the MYSPP. A fifth committee, the *Data and Evaluation Committee*, met once outside of the retreat and drafted recommendations for improving data collection and analysis.

Development of the plan would not have been possible without the many hours spent by those who participated at and since the retreat. Almost 100 individuals participated in the process of revising the MYSPP plan. Drawing on their diverse knowledge and experience, these individuals reviewed national goals and applicable research, and participated in multiple meetings to discuss and develop recommendations for action to the MYSPP. While significant program strengths were noted, gaps were identified and priorities were set to indicate where new program efforts could be directed.

The Steering Committee provided oversight of the process by reviewing the work submitted by the committees. Steering Committee members offered valuable insight in further developing some of the goals, and identifying leaders, potential partners and possible resources for the new program plan. A report containing a response to the Executive Order and a 2006 MYSPP workplan was issued in December 2005.

SUPPORTS AND CHALLENGES TO SUICIDE PREVENTION IN MAINE

Supports

The MYSPP is fortunate to have the endorsement and support of the DHHS, the Governor's Office and the Children's Cabinet for this very important work. Collaboration is key to the success of any public health initiative and many public as well as private stakeholders have partnered with MYSPP. Schools from throughout the state continue to exhibit strong interest in learning more to enhance their prevention infrastructure and plan for effective responses to suicidal behavior.

The program has a modest amount of consistent funding, which it uses to good advantage, supporting a part-time coordinator and a training contract. More than 500 training programs have been provided across the state to over 15,000 people. The MYSPP has established strong relationships with local schools, mental health providers, colleges and universities and other key organizations. The state level infrastructure allows the program to disseminate its messages and interventions to receptive audiences, using resources efficiently.

With two federal grants acquired by the program, the MYSPP has expanded prevention initiatives to 20 Maine communities, bringing resources and programs, and generating new information on effective strategies in rural youth suicide prevention to the field.

Challenges

Suicide prevention, like any public health issue, faces multiple challenges.

The following are some of the more salient barriers in the suicide prevention field:

- Public awareness that suicide is a health problem that can be prevented is not widespread.
- Stigma surrounds obtaining services for mental health and substance abuse conditions, particularly in rural areas where the suicide rates are the highest.
- Waiting time to access non-crisis mental health services is often lengthy.
- Pre-service (college) education in effective suicide prevention and intervention strategies for professionals entering the fields of education, health care, public safety and other fields is not widely available.
- Suicide behavior is not widely perceived by the healthcare community as a problem that they can recognize and address.
- Restricting access to lethal means around suicidal individuals is not widely understood and accepted as an important method of reducing suicide.
- Suicidal behaviors are complex. Strong, evidence-based research for effective suicide prevention, intervention and treatment is not well developed.
- Reaching older youth and disconnected youth at risk, who are not in school settings, is difficult.

Some specific challenges faced in Maine:

- Timely access to and in-depth analysis of morbidity and mortality data to improve understanding of the youth suicide problem and trends in our state are lacking.
- State agency staff involved in the program consistently experience multiple competing demands on their time.
- Few school or community based suicide prevention programs exist in the state.
- Resources to implement best practice suicide prevention activities statewide are limited.

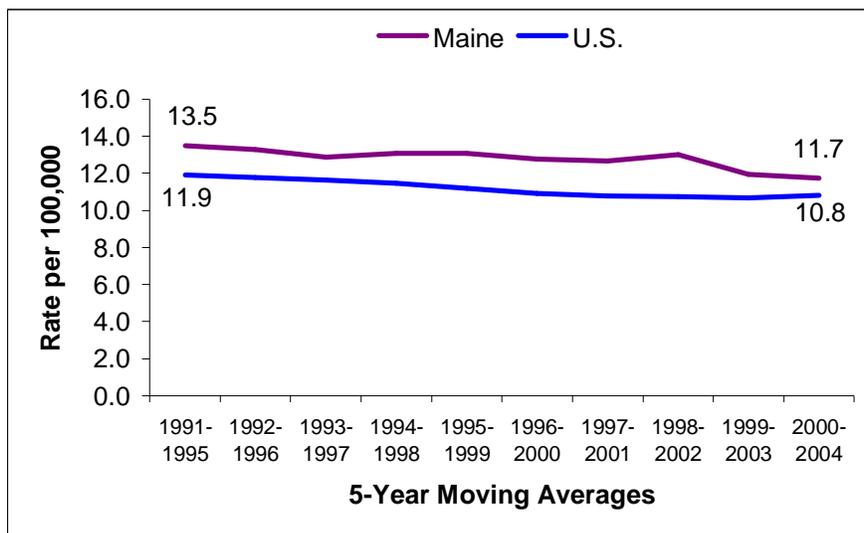
SUICIDE AND SELF-INFLICTED INJURIES IN MAINE

Suicide is a significant public health problem in the United States and in Maine, impacting families, friends, school systems and entire communities.

Suicide is the 11th leading cause of death in the United States, claiming over 32,000 lives annually. It is the leading cause of intentional injury death for persons ages 10 and over in Maine and was the 10th leading cause of death overall for Maine residents from 2000-2004, the most recent five-year period for which data are available. In the same period, the Maine suicide rate of 11.7 per 100,000 population was ranked 27th highest age-adjusted suicide rate in the United States for all ages; higher than the national average rate of 10.8 per 100,000 and the Northeastern rate of 7.7 per 100,000.

Overall, suicide rates in Maine and the U.S. have decreased since the early 1990s. The average suicide rate for 1991-1995 in Maine was 13.5 per 100,000. For 2000-2004, the rate was 11.7 per 100,000. Over this same time period, the U.S. rate declined from 11.9 per 100,000 in 1991-1995 to 10.8 in 2000-2005.

Age-adjusted suicide rates in Maine and the U.S., 1995-2004, all ages



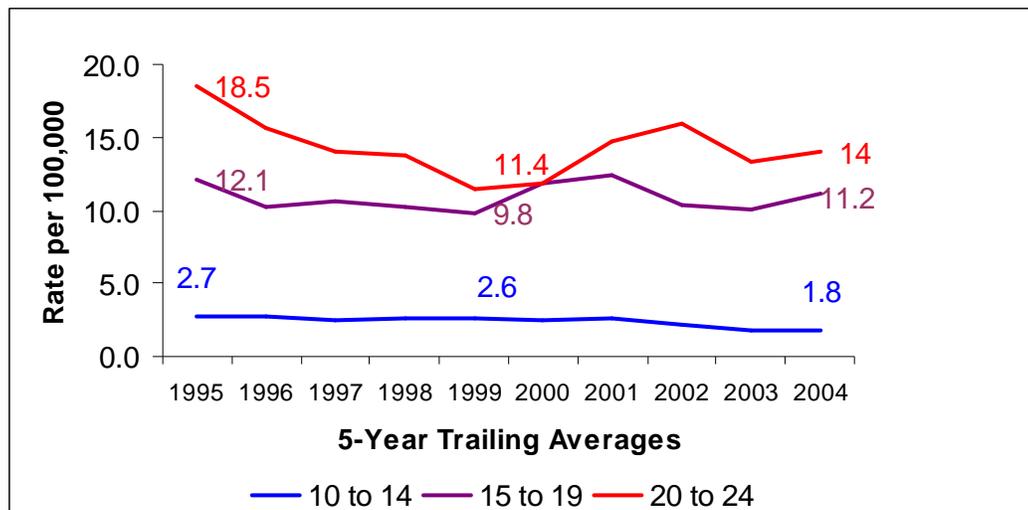
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

From 2000 through 2004, 789 Maine residents died by suicide, an average of 158 each year. Eighty-five percent (674) of these suicides were persons over age 24; 15 percent (115) were youth aged 10-24 (eight youth aged 10-14; fifty-two 15-19 year olds; and fifty-five young adults aged 20-24). Suicide is the 2nd leading cause of death for Maine residents ages 15-34; the 3rd leading cause of death for 10-14 year olds and the 4th leading cause of death for those ages 35-54.

The MYSPP focuses upon suicide prevention among 10-24 year olds. Between 2000-2004, Maine's suicide rate among youth and young adults ages 10-24 was 8.8 per 100,000. This is higher than the Northeast regional rate of 5.3/100,000 and the national rate of 7.0/100,000.

Among youth in Maine, especially those between 15-24, the suicide rate declined between 1991-1999, but has since varied with no discernable trend. The average suicide rate among Maine youth 10-24 was 10.9 per 100,000 in 1991-1995. Between 2000-2004, this average had dropped to 8.9 per 100,000.

Suicide death rates among youth age 10-24 years in Maine, 1995-2004



based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

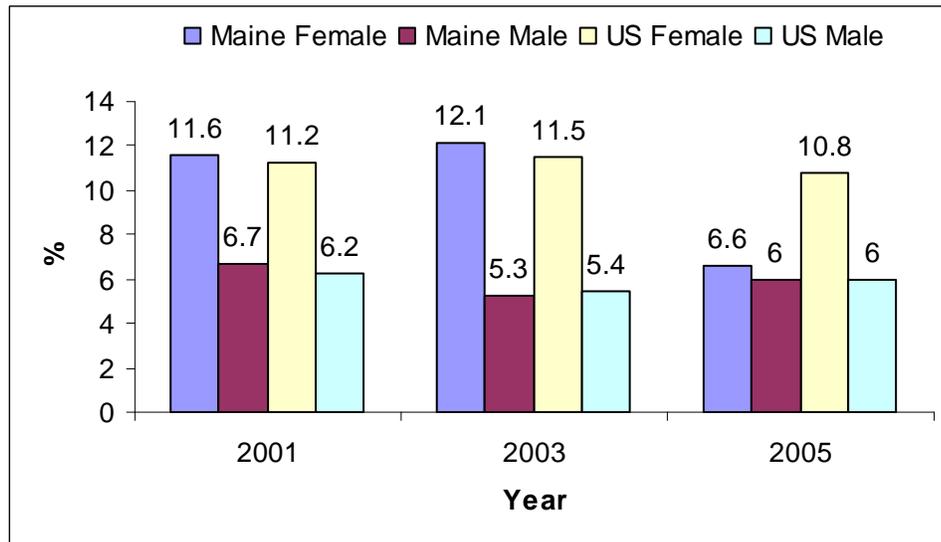
ol. Web-

Suicide claims more lives of young people than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined. Due to the high rates of suicide among the young, suicide is the fourth leading cause of years of potential life lost in Maine. More young people in our state die by suicide than homicide. There are four to five suicides for every homicide among Maine youth.

Suicide deaths, though very tragic, are the tip of the iceberg particularly among youth. Rates of suicidal behavior among youth are thought to be far higher than in adult populations. It is estimated that there are 25 to 100 suicide attempts by adolescents and young adults for every youth suicide.

Self-reported suicide attempts in Maine have decreased over time, especially among girls, according to data from the Maine Youth Risk Behavior Survey (YRBS), a representative survey of high school students in Maine. In 2001, 11.6 percent of Maine high school girls reported attempting suicide within the past year; in 2005, this dropped to 6.6 percent. Among boys we did not see a similar large decline over this 5-year period; 6.7 percent reported attempting suicide in 2001, compared to 6 percent in 2005. Suicide ideation has also decreased in Maine youth over time. In 1997, 30 percent of Maine middle school students reported considering attempting suicide within the previous 12 months. This number decreased to 19.8 percent in 2005.

***Self-reported suicide attempts among Maine and U.S.
High school students by sex, YRBS 2001-2005***

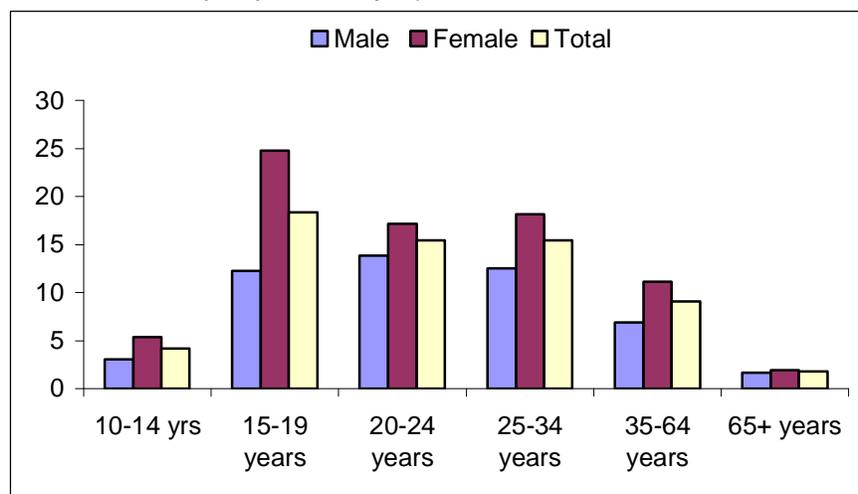


Source: Maine Youth Risk Behavior Survey, 2001, 2003, 2005

Despite the decline in self-reported suicide attempts, youth in Maine are more likely than adults to be hospitalized for self-injury. In Maine, from 2001-2005, 1,677 youth under age 24 were hospitalized for self-inflicted injuries.

Adolescent girls age 15-19 have consistently exhibited the highest rate of self-injury hospitalization in the state. The 2001-2005 rate of self-injury hospitalization among youth ages 10-24 was 12.7 per 10,000 compared to 8.6 per 10,000 among those over age 25. Intentional self-inflicted poisoning was the 3rd leading cause of injury hospitalizations in all ages combined.

***Age and Gender-Specific Rates of Hospitalization (per 10,000) for
Self-Inflicted Injury in Maine, 2000-2004***



Source: Maine Uniform Hospital Discharge Database, Maine Health Data Organization

Risk Factors

Suicidal behavior is complex. When someone is suicidal, it is usually due to a combination of external stressors, internal conflicts, and biological dysfunction. There is no one set of risk factors that fits all suicidal individuals or accurately predicts the imminent danger of suicide for a specific individual. Several studies and data from Maine reveal that suicide rates vary by demographic characteristics such as gender, race/ethnicity, and sexual orientation. Other prominent risk factors for suicide include a family history of suicide, living alone, being unemployed and owning a gun. Trauma, depression, anxiety, conduct disorders, substance abuse, and lack of personal skills or supportive resources also contribute to the possibility of suicide, but they do not, by themselves, cause suicide.

Race/Ethnicity

Across the U.S., white, non-Hispanic males experience the highest rates of suicide. The second highest rate is among American Indians and Native Alaskans. Maine's suicide rate among white, non-Hispanics is higher than the Northeast region's white, non-Hispanic rate, but is not significantly higher than the national white non-Hispanic rate. Racial/ethnic differences do not account for Maine's elevated suicide rates.

Gender

Four of five suicide victims in Maine are males. Of the 789 suicides in Maine from 2000-2004, 640, or 81 percent, were males, with those ages 20 through 59 representing more than half (54 percent) of Maine's suicides.

Females are more likely than males to be hospitalized for intentional self-injury. Between 2000 and 2004, the rate of hospitalizations for self-inflicted injury was higher for females in every age group to age 64 when compared to males. The highest rate of hospitalization for intentional self-harm is among females ages 15-19.

Data from the 2001-2005 Maine Youth Risk Behavior Surveys reveal that high school girls are more likely than boys to report considering or planning a suicide attempt. Between 2001-2005, almost 1 in 4 (23.6 percent) high school girls and 1 in 6 (16.1 percent) high school boys reported considering or planning a suicide attempt. Girls were also more likely than boys to actually attempt suicide (10.0 percent vs. 6.0 percent).

Sexual Orientation

Some research suggests that suicide risk is higher among homosexual youth due to the challenges many face when dealing with the stigma of homosexuality. In Maine, high schools students who report same sex or bisexual contact are more likely than youth who reported opposite sex or no sexual contact to report both suicide ideation and attempts. Based on data from the 2001-2005 YRBS, almost 40 percent of youth who reported same sex/bisexual contact considered suicide or planned an attempt in the previous 12 months compared to 21 percent of youth who had opposite sex contact only and 15 percent of youth who had never had sexual contact. Almost than 1 in 4 (23 percent) youth who reported same sex/bisexual contact attempted suicide in the past year.

Mental Illness

It is widely believed that from 60 percent to 90 percent of suicide victims meet the criteria for some form of mental illness, most commonly severe depression or other mood disorders and anxiety or conduct disorders. According to the 2005 Maine Youth Risk Behavior Survey (YRBS), 1 in 5 (20.6 percent) adolescents reported symptoms of depression in the past year. Between 2001-2005, 53 percent of the adolescents who reported depressive symptoms considered or planned a suicide attempt and 22 percent reported attempting suicide. Based on hospitalization data from 2001-2005, 83 percent of individuals hospitalized for intentional self-injury had a co-occurring mental disorder diagnosis.

Substance Abuse

Substance use is highly related to mental illness, suicide ideation, and suicide attempts in both youth and adults. In both the U.S. and Maine, substance use, especially alcohol use, is common among adolescents. According to the 2005 YRBS, 43 percent of Maine and U.S. high school students consumed alcohol and 1 in 4 had five or more drinks in a row within the past month. Twenty-two percent of Maine high school students used marijuana and 3.2 percent used cocaine within the past month. Among Maine high schools students, smoking any cigarettes in the past month is associated with suicide ideation (Maine YRBS, 2001-2005); more than 1 in 3 (36 percent) youths who smoked 20 days or more reported suicide ideation in the past year. Youth who smoked were about three times more likely than non-smokers to report attempting suicide in the past year. Youth who reported suicide ideation and attempts were also more likely to report recent binge drinking and use of illegal drugs, such as marijuana, cocaine, heroin, steroids, and unauthorized prescription medication.

Trauma/Victimization

Several studies have found that a history of sexual assault, ongoing domestic violence, and experiencing other traumatic events increase one's risk of attempting suicide. Using data from Maine's 2001-2005 Youth Risk Behavior Surveys, high school students who report being the victim of dating violence in the past year were two times more likely than non-victims to report suicide ideation (37 percent vs. 17 percent) and suicide attempts (17 percent vs. 7 percent) in the past year.

Almost half (46 percent) of students who had been the victims of sexual assault during their lifetime reported suicide ideation in the past year compared to 17 percent of non-victims; 1 in 4 sexual assault victims attempted suicide in the past year.

Being the target of racially offensive remarks, and those who had been attacked based on their race or ethnicity, at school, or on the way to school, also increased the risk for suicide ideation and attempts. The same held true for victims of comments or attacks based on sexual orientation. About one-third of victims of racial harassment/attacks and 44 percent of victims of harassment/attacks based on sexual orientation considered or planned a suicide attempt in the past year. One in 5 victims of harassment based on sexual orientation attempted suicide in the past year.

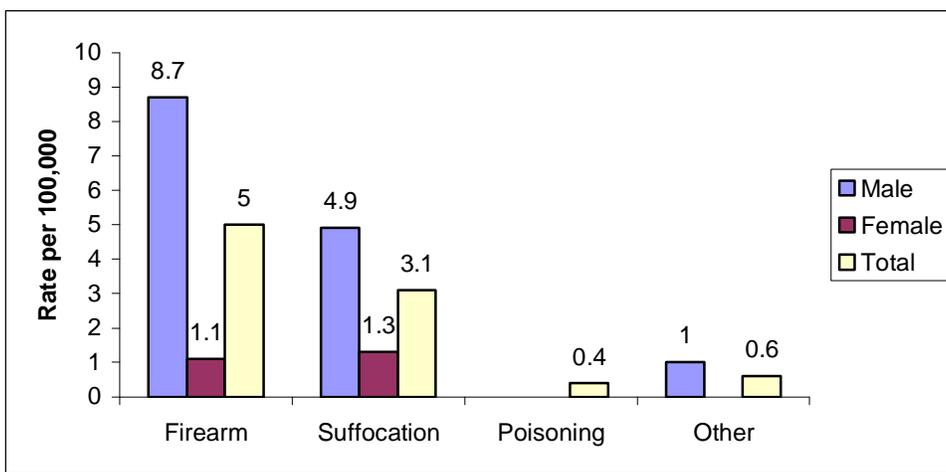
Nearly half of students (43 percent) who reported staying home from school in the past year because they felt unsafe considered or planned a suicide attempt and 27 percent actually attempted suicide.

Method

The lethality of the method determines the difference between a non-fatal attempt and a death by suicide. Firearm and hanging victims have less chance for survival than those using a less lethal method, such as poisoning.

Access to firearms is a significant factor in youth suicide, because most suicide attempts by firearm are fatal. From 2000 to 2004, a firearm was used in nearly 6 of 10 youth suicides, almost 60 percent of male and 40 percent of female youth suicides. The second leading method of youth suicide during this time was hanging, accounting for nearly 4 of 10 suicides. Between 2000 and 2004, hanging accounted for 34 percent of male suicides and 44 percent of female suicides among youth ages 10 to 24.

Causes of suicide by gender among 10-24 year olds in Maine, 2000-2004

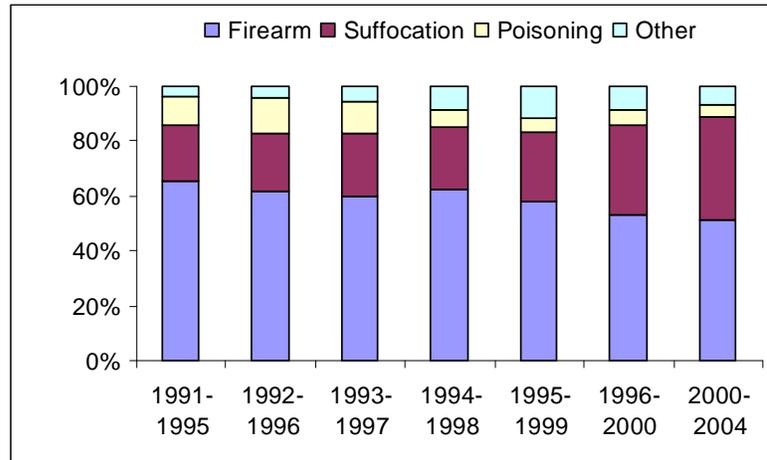


Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

Over time, there has been a gradual shift in the methods used by youth who die by suicide. In a recent national MMWR report³, national data revealed that there has been a recent increase in suicides among girls in the U.S., and the primary method of suicide shifted from firearms to hanging/suffocation. In Maine we are unable to examine the gender breakdown by method due to small numbers, but since the early 1990s, firearm suicides among youth ages 10-24 have declined, while suicides by hanging/suffocation have increased. Between 1991-1995, hanging/suffocation accounted for 20 percent of suicides among youth ages 10-24; between 2000-2004, almost 1 in 3 (32 percent) suicides among young were committed by hanging/suffocation.

³ Lubell KM, Kegler SR, Crosby AE, Karch D. Suicide trends among youth and young adults age 10-24 years - United States - 1990-2004. *MMWR*, 56(35): 905-908.

Percent of suicide methods among 10-24 year olds in Maine, 1991-2004



Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) [cited 2007 Oct. 4]. Available from URL: www.cdc.gov/ncipc/wisqars

Injury Costs

In 2000, the total national burden of suicide was estimated at \$125 billion. This includes direct health care costs and indirect costs related to the loss of productive life. The national Suicide Prevention Resource Center (SPRC) estimates medical cost per suicide in Maine at \$3,780. Due to the elevated incidence of suicide at young ages, the estimated work-loss cost per suicide is \$1,079,323. For non-fatal suicide attempts, the estimated medical cost per suicide is \$11,200 and the estimated work-loss cost per case is \$10,867.

MAINE YOUTH SUICIDE PREVENTION PROGRAM PLAN

The plan contains the goals, objectives and activities recommended by the numerous stakeholders who engaged in the planning process with the Maine Youth Suicide Prevention Program (MYSPP) in response to Governor John Baldacci's 2005 Executive Order. It represents the best thinking of those involved and is intended to strengthen and guide the MYSPP and partners into the future. *It is acknowledged that all recommendations made cannot be implemented given current resources.* Nevertheless, this plan provides a collection of goals, objectives and activities to be given consideration as resources become available.

The plan will be adjusted as research in the suicide prevention field progresses and as activities are implemented and objectives are achieved. Any revisions made will seek to honor the contributions of those involved in crafting the plan activities and objectives.

The plan contains 10 goals that align with the National Strategy for Suicide Prevention. During the strategic planning process, objectives were prioritized and ordered accordingly under each goal. In addition, descriptions are provided for all of the goals and a rationale is given for each of the objectives. Where possible, lead departments and potential partners were identified, though every organization named as a potential partner has not yet been approached. Specific activities are described in a separate working document to guide those directly involved in implementing them. Several of the activities are being implemented and evaluated with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), or have been evaluated previously. Evaluation plans for most objectives have been drafted, and will be utilized as funding becomes available. Evaluation plans are not contained within this document.

The MYSPP appreciates the significant and thoughtful efforts of those involved in the process of developing the plan, and gratefully acknowledges their contributions. It is important to note that the input gained from this process reflects the ideas and work of those who engaged in the process. It was not possible to engage all stakeholder groups concerned about suicide prevention in this planning effort. Much work remains to be done. In some cases, the groups or organizations named as potential leaders or partners have yet to be contacted. In other cases, defining baselines and planning feasible and effective activities to meet identified objectives needs to occur.

Continued and strengthened involvement of the state agencies of the Governor's Children's Cabinet with health, mental health, education, and safety personnel in the field, families and communities all around the state is necessary to achieving results. With resources dedicated to implementing the plan over a sustained period of time, Maine's efforts to prevent youth suicide will be significantly enhanced and the goal of reducing youth suicide and suicidal behaviors among Maine children, teens and young adults realized.

Maine Youth Suicide Prevention Program (MYSPP) Goal 1

Increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.

Background:

Suicide has been widely recognized as a public health problem in the United States in recent years, requiring national attention and urgent action. In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention. This publication characterizes suicide as a major public health problem, which can only be reduced through integrated efforts by government, public health, education, human services and other public and private partners. Because there are many paths to suicide, prevention must address psychological, biological, and social factors in order to be effective. Leadership, collaboration and coordination across a broad spectrum of agencies, institutions, and groups are necessary to ensure that prevention efforts are effective.⁴

Description:

Objectives under this goal are designed to solicit and support leadership, improve coordination of activities and increase collaboration among stakeholders at the state, regional and community levels in order to enhance support and integration of suicide prevention activities. Outreach to increase partnerships with unique populations to develop culturally competent suicide prevention resources is also an identified priority.

Objective 1.1: Increase leadership, coordination and collaboration across disciplines and with public and private stakeholders at the state, regional and community levels in order to enhance support for, and implementation of, youth suicide prevention activities.

Population Focus:

Youth-serving private and public organizations
Children's Cabinet agencies

Rationale:

While several state agencies and private stakeholders are active in youth suicide prevention efforts, improved collaboration and coordination is necessary to ensure that suicide is understood as a statewide problem and that limited resources are used efficiently. The knowledge and resources that each contributes has the potential to significantly enhance the prevention efforts of individual agencies and the MYSPP as a whole. Consistent commitment and enhanced collaboration among Children's Cabinet agencies will lead to increased integration of suicide prevention efforts into each agency's mandates, priorities and activities. Partnerships will help establish momentum for the plan and will provide continuity over time, as well as legitimacy through the involvement of key groups.

⁴ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 50.

Lead Department:

- Department of Health and Human Services (DHHS), Maine Center for Disease Control & Prevention (Maine CDC)

Potential Partners:

- Children's Cabinet Agencies
- MYSPP Steering Committee members

Objective 1.2: Enhance collaborations and partnerships with groups and organizations that reach youth populations at increased risk of suicidal behaviors.

Population Focus:

Groups and organizations working with or providing services to high risk youth

Rationale:

Some youth are at increased risk for suicidal behavior. The MYSPP intends to reach out to specific groups and organizations that are in a unique position to assist high-risk youth. Expanding partnerships is intended to increase awareness and extend the reach of suicide prevention resources to high-risk youth.

MYSPP committees recommended that collaborations be cultivated with three specific groups: faith communities, Native American tribes and organizations serving lesbian, gay, bi-sexual, transgendered and questioning (LGBT) youth.

Faith Communities

Faith communities offer support and guidance to their members and communities at large during stressful times. Because of their unique position, faith leaders can also play an important role in suicide prevention by de-stigmatizing mental illness, substance use problems, suicidal and other related health risk behaviors. Preparation of members of the faith community in basic suicide prevention knowledge and skills will increase the effectiveness of their response to persons at risk of suicide and to the needs of survivors of suicide.

Native American Tribes

Across the U.S., American Indian and Alaskan Natives have the highest rate of suicide among the 15 to 24 age group.⁵ Studies of American Indians and Alaska Natives in other parts of the country have indicated that social and cultural changes and the pressure to conform to "white" culture are linked to higher suicide rates.⁶

The vast majority (98.5 percent) of Mainers are white and the native population is relatively small (0.5 percent). There are 8,576 American Indians⁷ living in or near five small rural communities in Aroostook, Penobscot, and Washington Counties. The small absolute number of American

⁵ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (producer). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. Available online from: <http://www.cdc.gov/ncipc/wisqars/default.htm>. (2004).

⁶ Goldsmith, S. K., Pellmar, T. C., Keinman, A. M., Bunney, W. E., Reducing Suicide, A National Imperative. The National Academies Press, Washington, D.C. 2002; p 49.

⁷ US Census, American Community Survey Summary Tables, <http://factfinder.census.gov>. 2003.

Indians in Maine makes reliable data collection and analysis of suicidal behaviors among these youth in the state difficult. However, we know from a study in Maine, from 1993-1997, the age-adjusted mortality rate due to suicide for American Indians in Maine at that time was 30 percent higher than that of the overall population.⁸ In order to better understand the extent of suicidal behaviors and corresponding needs among Native youth, collaboration with the Tribes in Maine is essential to build culturally competent responses.

Providers and Organizations Serving Lesbian, Gay, Bi-sexual, Transgendered and Questioning Youth (LGBTQ)

The evidence that LGBTQ youth disproportionately engage in suicidal behaviors is strong. The public health, medical, and social science research literature is compelling in demonstrating an association between sexual orientation and suicidal behaviors. A growing body of research concludes that LGBTQ youth are more likely than heterosexual youth to contemplate and attempt suicide.^{9 10 11} The 1999 Surgeon General's Call to Action to Prevent Suicide states that there is growing concern about an association between suicide risk and bisexuality or homosexuality for youth, particularly males. It is vital to reach out to sexual minority youth with information and education by partnering with schools, health care providers and other organizations serving these youth.

Agencies Serving High Risk Youth

It is widely believed that from 60 percent to 90 percent of suicide victims meet the criteria for some form of mental illness, most commonly severe depression or other mood disorders, and anxiety or conduct disorders. These conditions often occur in combination with substance abuse.¹² According to the 2000 National Household Survey on Drug Abuse, youths who reported use of any illicit drug other than marijuana were three times more likely than youths who did not use these substances to be at risk for suicide.¹³ Also at high risk are youth in the juvenile justice system. Of the more than 11,000 incarcerated youth in the nation, over half suffer from diagnosable, yet untreated mental illnesses.¹⁴ Within this group, more than 17,000 incidents of suicidal behavior are recorded in juvenile facilities each year.¹⁵ Efforts will be made to engage agencies serving high risk youth as resources permit.

⁸ Health Status and Needs Assessment of Native Americans in Maine: Final Report, Kuehnert, P., Maine Bureau of Health, January 15, 2000.

⁹ Remafedi, G. Sexual Orientation and Youth Suicide. *JAMA: Journal of the American Medical Association*, Volume 282, Number 13. 1999; p 1291-1292,

<http://ejournals.ebsco.com.prxy3.ursus.maine.edu/direct.asp?ArticleID=471CBCAD04516A0E2010>

¹⁰ Garofalo, R., Wolf, R. C., Wissow, L. S., Woods, E. R., Goodman, E. Sexual Orientation and Risk of Suicide Attempts Among a Representative Sample of Youth. *Archives of Pediatrics & Adolescent Medicine*, 153. 1999; p 487-493.

¹¹ Leah, R., Brener, N. D., Donahue, S. F., Hack, T., Hale, K., Goodenow, C. Associations Between Health Risk Behaviors and Opposite-, Same-, and Both-Sex Sexual Partners in Representative Samples of Vermont and Massachusetts High School Students. *Arch of Pediatrics & Adolescent Medicine*, 156. 2002; p 349-355.

¹² National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service. 2001.

¹³ National Household Survey on Drug Abuse; The NHSDA Report: Substance Use and the Risk of Suicide Among Youths; Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA), July 12, 2002.

¹⁴ Teplin, L. A. & McClelland, G. *Psychiatric and Substance Abuse Disorders among Juveniles in Detention: An Empirical Assessment*. Paper presented at the convention of American Psychological—Law Society, Redondo Beach, CA. March 1998.

¹⁵ Hayes, L. M. Juvenile Suicide in Confinement: A National Survey. *Corrections Today*, 26. July 2000; p 26.

Lead Department:

- DHHS:
 - Maine CDC
 - Children’s Behavioral Health Services (CBHS)
 - Office of Substance Abuse (OSA)

Potential Partners:

- MYSPP Steering Committee
- Training contractors
- Faith communities/associations
- Office of Minority Health
- Native American Tribes
- Organizations serving LGBTQ youth
- Maine Youth Action Network (MYAN) and other organizations directly serving Maine youth
- National Alliance for the Mentally Ill of Maine (NAMI Maine)
- Health care and social service providers

Objective 1.3: Annually, increase the number of youth-serving programs statewide, including state-based efforts, professional and voluntary organizations, and others, that integrate suicide prevention and intervention activities into their programs.

Population Focus:

Staff from organizations, agencies, institutions and other groups statewide that have a youth focus or special interest in youth, or are in a position to observe suicidal behavior and take action when necessary

Rationale:

Considering the known risk and protective factors for suicidal behaviors, a public health approach implemented at multiple levels is necessary to prevent youth suicide. Violence prevention depends upon the collaboration of government, business, civic, religious, and cultural organizations. Maine has many programs designed to build protective factors and/or address various youth risk behaviors. These programs and systems help to reduce the possibility of suicide. However, in order to identify and refer youth at risk for suicide, it is essential that program staff, school personnel, peers, parents, service providers and others in local communities who regularly interact with youth, acquire specific suicide prevention knowledge and basic intervention skills. Though partnerships with schools, substance abuse prevention programs, and mental health crisis agencies are expanding, a more systematic approach to suicide prevention is needed within these and other agencies and systems. Connections must be strengthened with the foster care system, correctional system, programs for youth in transition, and programs for out of school youth.

Many programs attempt to address multiple issues simultaneously, but may not have considered or included suicide prevention among them. As some risk factors place youth at risk for more than one problem at the same time, utilizing an intervention that impacts one or more risk or protective factors provides an opportunity for change in more than one identified problem. When

a program consciously integrates suicide prevention components (for example, encouraging help-seeking for emotional distress), the program is likely to be even more effective overall in reducing occurrences of multiple health or social problems.¹⁶

Lead Department:

All Children's Cabinet agencies:

- DHHS:
 - Maine CDC
 - CBHS
- Department of Labor (DOL)
- Department of Corrections (DOC)
- Department of Public Safety (DPS)
- Department of Education (DOE)

Potential Partners:

- MYSPP Steering Committee
- Employers
- Professional Associations
- Volunteer Organizations
- NAMI Maine
- Local mental health organizations
- Local Communities for Children and Youth
- Keeping Maine's Children Connected
- MYAN and other organizations serving Maine youth
- Other organizations to be identified statewide

¹⁶ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 53.

Maine Youth Suicide Prevention Program (MYSPP) Goal 2

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

Background:

The stronger and broader the support for a public health initiative, the greater the opportunity for success. As youth suicide is a relatively rare event, many people are unaware of suicide warning signs or how to respond to them; yet suicidal behavior is reported by 13 percent of high school and 20 percent of middle school students in Maine.^{17 18} Because the risk and protective factors for suicide are well known and most suicidal individuals give warning signs of their suicidal intention, it is important that everyone in direct contact with youth have a basic understanding of the risks and warning signs and how to respond effectively.

Greater awareness that suicide is a serious public health problem results in knowledge change, which, in turn, can influence beliefs and behaviors.¹⁹ Better awareness coupled with dispelling myths about suicide and suicide prevention can result in a decrease in the stigma associated with suicidal behaviors and an increase in the early identification of individuals at risk.

Description:

A large-scale campaign to increase public awareness and understanding of suicide prevention was strongly recommended by the committee developing this goal. Such a campaign is not feasible given resource limitations. Thus, public awareness activities are focused on improvement of the program website and prevention materials, dissemination of the statewide crisis hotline number and other available helping resources. An annual awareness event is held during National Suicide Prevention Awareness Week, the Week of World Suicide Prevention Day, September 10, to highlight suicide prevention activities and accomplishments and to acknowledge the contributions of those involved.

Objective 2.1: Increase public awareness that suicide is a public health problem, suicide is preventable, and help is available.

Population Focus:

General public

Rationale:

The factors that contribute to the development, maintenance, and exacerbation of suicidal behaviors are better understood from a public health perspective.²⁰ Utilizing a public health approach, suicide may be seen as a preventable problem, with pathways to self-injury that may lend themselves to intervention. A public health approach takes into account the psychological,

¹⁷ American Association of Suicidology. Understanding and Helping the Suicidal Individual. www.suicidology.org.

¹⁸ 2005 Maine Youth Risk Behavioral Survey

¹⁹ Bringing the Public Health Approach to the Problem of Suicide. *Suicide and Life-Threatening Behavior*, 28, p 325-327.

²⁰ Silverman, M. M., Maris, R. W. The Prevention of Suicidal Behaviors: An Overview. *Suicide and Life-Threatening Behavior*, Volume 25, Number 1, Spring. 1995; p 10-21.

emotional, cognitive, and social factors that have been shown to contribute to suicidal behaviors.²¹ Social and political forces will be mobilized when the belief that suicidal behaviors are preventable is widespread. If the general public understands that suicide can be prevented, and people are made aware of the roles that individuals and groups can play in prevention, they may be more inclined to take action. All suicides cannot be prevented, but suicide prevention is ALWAYS worth trying.

Lead Department:

- DHHS:
 - Maine CDC
 - OSA
 - CBHS

Potential Partners:

- All Children’s Cabinet agencies
- NAMI Maine
- Media

Objective 2.2: Annually increase knowledge of MYSPP resources for youth suicide prevention in Maine among key state and local stakeholders.

Population Focus:

State agency staff, program partners, legislators and other policymakers, and other state and local stakeholders

Rationale:

To enable key state and local stakeholders to support and participate in suicide prevention, they must be aware of resources available. These resources include suicide prevention programs and trainings, current data, and informational materials. Publicizing these resources to a large, diverse group of key stakeholders ensures they have the information needed to make informed decisions and to advocate for suicide prevention activities statewide.

Lead Department:

- DHHS:
 - Maine CDC
 - OSA

Potential Partners:

- Training contractors
- MYSPP training program participants
- Children’s Cabinet members

²¹ Potter, L. B., Rosenberg, M. L., Hammond, W. R.. Suicide in Youth: A Public Health Framework. Journal of the American Academy of Child and Adolescent Psychiatry. Volume 37, Number 5, May. 1998; p 484–487.

Maine Youth Suicide Prevention Program (MYSPP) Goal 3

Develop and implement strategies to reduce the stigma associated with being a consumer of behavioral health services for families and youth and to increase help-seeking behaviors.

Help-seeking behaviors are defined as actions taken by a person who utilizes different sources of informal (parents and peers) and formal (counselors, teachers, or mental health professionals) support.

Background:

There is a strong stigma related to seeking and utilizing behavioral health services in our society. Stigma has been identified as the most formidable obstacle to progress in the arena of mental health.²² It frequently causes many people to hide their symptoms and avoid treatment. Sadly, only one out of two people with a serious form of mental illness seeks treatment for their disorder.²³ Due to the historic bias and prejudice against those with mental illnesses, health care, mental health care, and substance abuse treatment have traditionally been viewed as separate types of treatment. Persons who need mental health care or substance abuse treatment avoid seeking it, and insurance companies often do not pay for it at the same level of other medical care. Increasing public understanding about mental health and mental illnesses requires action at every level in both the public and private sectors.

²² U.S. Department of Health and Human Services, Rockville, MD. Mental Health: A Report of the Surgeon General: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. 1999.

²³ Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (2002). National Household Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J. et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, 36, 987-1007.

Farmer, E. M. Z., Mustillo, S., Burns, B. J., & Costello, E. J. (2003). The epidemiology of mental health programs and service use in youth: Results from the Great Smoky Mountains Study. In M.H. Epstein, K. Kutash, & A. Duchnowsk (Eds.), *Outcomes for Children and Youth with Behavioral and Emotional Disorders and Their Families: Programs and Evaluation Best Practices* 2nd ed., [in press]

The first step to reducing the stigma surrounding mental health and substance abuse problems is to employ public education activities designed to provide factual information about these conditions and to suggest ways to enhance mental health. A successful model exists with the anti-smoking campaigns that promote physical health. Increasing public knowledge that mental health and substance abuse problems are treatable and that obtaining behavioral health services is a normal part of overall healthcare will help to “create conditions that enable persons in need of mental health and substance abuse services to receive them.”²⁴ Eliminating stigma will also help reduce the isolation of these individuals from society.²⁵

Description:

Maine’s objectives under this goal are built upon several key themes. Increasing widespread public awareness that mental health and substance abuse problems are treatable conditions and an important part of overall healthcare is a major focus. The second theme is based on developing new partnerships to integrate anti-stigma messages into existing public awareness campaigns to increase access to behavioral health services, including substance abuse treatment and suicide prevention services. Finally, building sensitivity to the needs of youth and families at-risk and increasing appropriate help seeking are recommended.

Objective 3.1: Increase the proportion of the general public in Maine who are aware that mental health problems frequently are treatable, and that obtaining mental health and substance abuse services is a part of overall healthcare.

Population Focus:

General public

Rationale:

Research clearly shows that mental health and substance abuse problems are risk factors for suicide.²⁶ The National Strategy for Suicide Prevention points out research showing that 60 to 90 percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder. It also cites a study that found over 90 percent of adolescent suicide victims or suicide attempters had a psychiatric illness (most commonly mood, disruptive and substance/alcohol abuse disorders).²⁷ The National Strategy further states: “Despite the fact that effective treatments exist for these disorders and conditions, the stigma of mental illness and substance abuse prevents many persons from seeking assistance; they fear prejudice and discrimination.”

²⁴ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001.

²⁵ President’s New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care In America. July 2003.

²⁶ Harris, E. D., & Barraclough, B. Suicide as an Outcome for Mental Disorders. *British Journal of Psychiatry*, 170. 1997; p 205-228.

²⁷ Shaffer, D., et al. Psychiatric Diagnosis in Child and Adolescent Suicide. *Archives of General Psychiatry*, Volume 53, Number 4. 1996; p 339-348.

Male youth have been shown to be particularly unlikely to seek help.²⁸ Youth who are unwilling or unable to ask for help or to connect with potential helpers are at an increased risk for suicide. It is therefore important that young people are able to identify and access helping professionals.²⁹

The perception that mental health problems are a result of a character flaw or limited will-power is widespread. Consequently, conditions that are treatable remain untreated. When people understand that mental disorders are real illnesses that are responsive to specific treatments, more persons will seek treatment and the suicide rate will be reduced. Normalization of help-seeking behaviors for substance abuse, mental health and suicide prevention services will increase the number of persons at risk for suicide who seek and receive help.³¹

Lead Department:

- DHHS:
 - Maine CDC
 - CBHS
 - OSA
- DOE

Potential Partners:

- NAMI Maine
- Task Force on Early Childhood
- Maine Youth representing diverse backgrounds
- University Residential Directors
- Media

Objective 3.2: Identify ways to decrease stigma and public misperceptions surrounding mental health and substance abuse health issues/conditions.

Population Focus:

General public

Rationale:

The stigma attached to mental illness and substance abuse prevents persons who may be at risk of suicide from seeking help for treatable problems. The stigma of suicide itself can reduce the number of people who seek help, while adding to emotional burdens. Reducing stigma related to mental health conditions and substance abuse will increase the number of persons from all groups who receive appropriate treatment for disorders associated with suicide.³²

²⁸ Canetto, S. S. Meanings of Gender and Suicidal Behavior during Adolescence. *Suicide and Life-Threatening Behavior*. Volume 27, Number 4, Winter. 1997.

²⁹ McWhirter, J., McWhirter, B., McWhirter, E., & McWhirter, R. *At Risk Youth: A Comprehensive Response*. Brooks/Cole, Belmont, CA. 2004.

³⁰ Holt, M. K., Winzeler, A. *A Primer on Bullying*. UNH Center on Adolescence

³¹ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 59.

³² National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 61.

Maine is a rural state with many small towns. Stigma associated with mental health conditions appear to be particularly pronounced among older adults, ethnic and racial minorities, and residents of rural areas.³³ In order for people to receive the services they need, it is important that they not conceal their symptoms and are not embarrassed or ashamed about seeking treatment.

Lead Department:

- DHHS:
 - Commissioner’s Office
 - OSA
 - CBHS

Potential Partners:

- NAMI Maine
- Advocacy groups
- American Foundation for Suicide Prevention (AFSP – Survivor Speakers’ Bureau)
- Maine media outlets
- Maine youth
- Parent/Family Organizations
- ME Assoc. of Substance Abuse Programs
- ME Assoc. of Prevention Programs
- ME Assoc. of Mental Health Providers
- Governor’s Office of Health Policy and Finance
- Keeping Maine’s Children’s Connected
- Healthy Maine Partnerships
- Contracted trainers

Objective 3.3: Provide opportunities for school-aged youth to understand the importance of seeking help for mental health or substance abuse conditions.

Population Focus:

Youth ages 10-18

Rationale:

Intolerable stress, inadequate problem-solving abilities, and lack of supportive connections are all risk factors for suicide. Among teens, at least one in five suicide victims appears to have been suffering from clinical depression at the time of their suicide.³⁴ Yet, according to the 2000 NSDUH (National Household Survey on Drug Abuse) survey, only 36 percent of youths at risk for suicide during the previous year received mental health treatment.³⁵ As the total number of survey respondents for Maine was small, caution must be used with this finding.

³³ President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care In America*. July 2003.

³⁴ Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. Preventing Teenage Suicide: A Critical Review. *Journal of the American Academy of Child and Adolescent Psychiatry*. Volume 27, Number 6. 1998; p 675-687.

³⁵ Office of Applied Studies, Substance Abuse and Mental Health Services Administration. *Substance Use and the Risk of Suicide Among Youth*. National Household Survey on Drug Abuse, The NHSDA Report. July 12, 2002.

The extent to which the stigma around seeking mental health or substance abuse services impacts youth help-seeking attitudes is unknown. Unwillingness to seek care may also be attributable to lack of knowledge about these services or other barriers such as access issues. Teens and young adults are also guided in their willingness to seek care by parental attitudes, and by the availability of systems and providers who are culturally competent.

Most suicidal youths confide their concerns to their peers far more often than to adults.³⁶ However, youth usually do not have the skills to help a friend through a crisis alone. Having awareness and skills to seek help for themselves and for friends is critical in ensuring that youth in crisis receive the level of support needed. The Lifelines Program increases the likelihood that school gatekeepers (administrators, faculty, and staff) and peers who come into contact with youth at-risk can more readily identify suicidal behavior, provide an appropriate response, know how to obtain help, and be consistently inclined to take action.³⁷ Research shows that when a suicide prevention awareness curriculum focuses on suicide as it relates to mental health problems, more students will seek help, leading to an increased awareness about mental illness and a reduction in suicide rates.^{38 39 40} In Maine's implementation and evaluation of the Lifelines student lessons, an increase in help-seeking among youth was demonstrated.⁴¹

Lead Department:

- Department of Education (DOE)
- DHHS:
 - Maine CDC
 - CBHS

Potential Partners:

- DHHS Contracted trainers
- Maine school staff members and the Coordinating School Health Program
- NAMI of Maine
- Maine Medical Center, Portland Identification & Early Referral Program (MMC, PIER)
- Odyssey Program
- Center for Grieving Children
- MYAN and other youth advocacy support organizations

³⁴ Kalafat, J., Underwood, M., O'Halloran, S. Lifelines, A School-Based Response to Youth Suicide. Maine Youth Suicide Prevention Program. October 2003.

³⁵ Kalafat, J., Underwood, M., O'Halloran, S. Lifelines, A School-Based Response to Youth Suicide. Maine Youth Suicide Prevention Program. October 2003.

³⁸ Ciffone, J. Suicide Prevention: A Classroom Presentation to Adolescents. *Social Work*, 38. 1993: p 197–203.

³⁹ Kalafat, J. Prevention of Youth Suicide; Weissberg, R. P., Gullotta, T. P., Hampton, R. L., Ryan, B. A., & Adams, G. R. *Enhancing Children's Wellness*, Thousand Oaks: CA: Sage. Volume 8; p 175–213.

⁴⁰ Ryerson, D. Suicide Awareness Education in Schools: The Development of a Core Program and Subsequent Modifications for Special Populations or Institutions. *Death Studies*, 14. 1990; p 371–390.

⁴¹ Madden, M., Haley, D., Hart, S., Kalafat, J., Saliwanchik-Brown, C. An Evaluation of Maine's Comprehensive School-based Youth Suicide Prevention Program. 2007.

Maine Youth Suicide Prevention Program (MYSPP) Goal 4

Increase the number of Maine schools and communities statewide that implement effective youth suicide prevention activities.

Background:

Comprehensive approaches in school and community settings have proven effective in suicide prevention⁴². Through a grant from the Centers for Disease Control and Prevention (2002-2006), the MYSPP worked with 12 high schools to implement and evaluate the comprehensive school-based Lifelines Program. Evaluation results have demonstrated the desired outcomes. The program is ongoing in the project schools, and youth in need of intervention continue to be identified and referred by school staff members and peers. Youth seek help from trusted adults at higher than previous rates. Planning for the aftermath of a death by suicide (postvention) has helped school staff in two of the project schools to meet the significant challenges of managing the school environment after a suicide and to more effectively handle other crises.

During the time that I have been working with Maine's Statewide Youth Suicide Prevention Program, I have been impressed with their community-based systems approach, which I consider necessary for effective prevention. They have developed an overall project logic model as well as logic models and goals and objectives for each initiative across a spectrum of interrelated programs. Their efforts to evaluate both the implementation and outcomes of the Lifelines school-based youth suicide response program will likely result in it moving from a Promising Program designation to an Evidence-Based program. Their current plan for expanding the involvement of other schools and agencies is a critical next stage in their statewide project.

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Past President, American Association of Suicidology

Description:

Several of the objectives in this goal incorporate what has been learned from implementation and evaluation of the comprehensive Lifelines Program into MYSPP training programs, school protocol guidelines and associated resources. The MYSPP protocol guidelines contain a component to help school personnel assist at-risk students and maintain control of the school environment in a crisis. Administrative protocols, along with agreements between schools and local crisis agencies, aid in building links to services needed by at-risk teens. MYSPP provides all components of the Lifelines training, and, with SAMHSA funding (2005-2008), will provide technical assistance to six additional high schools to implement the comprehensive Lifelines Program. Also included is an objective to integrate mental health key concepts into comprehensive school health education curricula at the middle school level. To prevent suicide among college students and out-of-school youth and young adults, expansion of suicide prevention efforts to universities, colleges, employers and other community agencies serving these populations is recommended.

⁴² National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001.

Another critical component of a comprehensive approach is the continuing need to identify and implement effective approaches to assist high-risk youth to develop the life skills and coping strategies necessary to leading productive lives.

Objective 4.1: Increase the number of Maine high schools with trained staff implementing the Lifelines Program.

Population Focus:

Middle and high school systems statewide

Rationale:

Teen suicide is a real and serious threat and no school is immune from it. With efforts to update school crisis response plans comes the realization that a school-based suicide prevention program is an essential component. Such a program formally recognizes the school’s commitment to the prevention of adolescent suicide and increases the likelihood that proactive measures will be taken. The MYSPP has chosen to implement the Lifelines Program as a cornerstone of school-based suicide prevention efforts. The purpose of the Lifelines Program is to “enhance the ability of all members of a school community to recognize troubled students, and to provide them with step-by-step procedures for intervening in a suicidal crisis.”⁴³ Lifelines Program components include: 1) Administrative guidelines/protocols to guide effective responses to suicidal expressions or behavior, including postvention following a suicide attempt or death; 2) Memoranda of Agreement with Crisis Service Providers outlining referral procedures and prevention /intervention services to be provided to the school; 3) Educational programs for all faculty, staff and parents in the school community to include suicide information, indicators of at-risk students and response and referral protocols; 4) Student lessons that teach peers to recognize suicidal behavior, respond appropriately, know how to get help from a trusted adult and be consistently inclined to do so.

Student lessons are instituted only after adults are trained and protocols are in place. Kalafat and Elias (1994) evaluated an early version of the *Lifelines student lessons*⁴⁴ and found that students who participated in the classes, showed significant gains in relevant knowledge about suicide and significantly more positive attitudes toward help seeking and intervening with potentially suicidal peers. Maine’s project evaluation is demonstrating similar results.⁴⁵ Given that the Lifelines Program is a proven, effective suicide prevention strategy, it is important to train teachers to deliver the student lessons across the state.

Lead Department:

- DHHS, Maine CDC
- DOE

⁴³ Kalafat, J., and Ryerson, D. The Implementation and Institutionalization of a School-Based Youth Suicide Prevention Program. *The Journal of Primary Prevention*, Volume 19, Number 3. 1999; p 157-175.

⁴⁴ Kalafat, J., & Underwood, M. *Lifelines: A School-Based Adolescent Suicide Response Program*. Kendall/Hunt Publishing Co., Dubuque, IA, 1998.

⁴⁵ Madden, M., Haley, D., Hart, S., Kalafat, J., Saliwanchik-Brown, C. An Evaluation of Maine’s Comprehensive School-based Youth Suicide Prevention Program. 2007.

Potential Partners:

- DHHS, CBHS
- DHHS, Coordinating School Health Program
- Lifelines Training Contractor, Medical Care Development (MCD)
- Maine school administrators, pupil services staff and health instructors
- Local crisis service providers

Objective 4.2: Increase the number of middle schools that integrate key concepts related to mental health and help-seeking within comprehensive school health education.

Population Focus:

Maine Middle Schools

Rationale:

In the 2005 Youth Risk Behavior Survey in Maine, the rate among middle school students reporting suicidal thoughts, ideation and behaviors surpassed their high school counterparts.⁴⁶ This trend indicates the need for suicide prevention education to begin in middle school. In order to facilitate this process, key stakeholders, health teachers and the Department of Education must be engaged in identifying and integrating mental health key concepts related to suicide into the comprehensive school health education curriculum.

Lead Department:

- Department of Education (DOE)

Potential Partners:

- Contracted trainers
- NAMI Maine

Objective 4.3: Annually, increase the number of community-based organizations, institutions and other groups serving middle and high-school aged youth during non-school hours that have gatekeepers trained to intervene and prevent suicide.

Population Focus:

Staff in community-based organizations such as recreation programs, mentoring programs, church groups, Boy/Girl Scouts, after school arts programs, theater groups and other youth oriented programs

Rationale:

Community-based programs provide a wide variety of opportunities in many different settings, all of which have the potential to provide important support and safety to the youths they serve. No matter what their focus, these programs are very likely to play a key role in preventing a youth suicide as well as in the aftermath of a suicide in the community. It is important that community organizations have trained staff and established protocols for 1) how to appropriately respond to suicidal behavior and 2) how to manage the aftermath of a suicide crisis.

⁴⁶ Centers for Disease Control and Prevention. 2005 Youth Risk Behavior Survey. www.cdc.gov/yrbss. Accessed July 24, 2006.

Some organizations are structured so that all staff are trained to intervene directly with youth, while other organizations are structured so that all staff have suicide prevention training and very clear guidelines on who will actually coordinate intervention efforts. All staff in these community-based organizations need to be clear about their professional roles/boundaries and personal/organizational liability issues when responding to these types of events. All staff must be educated about the contagion factor as it relates to suicidal behavior and suicides.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Interdepartmental Coordinating Committee
- Communities for Children and Youth

Objective 4.4: Increase the number of post-secondary educational institutions with staff trained to assist students at risk of suicide and to appropriately involve their families.

Population Focus:

Primary care, mental health and substance abuse service providers, residential life faculty in post-secondary educational institutions in Maine.

Rationale:

Graduating from high school and beginning a post-secondary education program is a key transition period in a young person's life. For many, this is the first time living away from home as well as a time to transition from childhood health care providers to new health care providers. However, the need for adult supports still exists. Post-secondary institutions play a critical role in promoting the health of the young adult population.

Common health issues addressed on college campuses include alcohol and drug use, unsafe sexual activity and STDs, and interpersonal violence. Many campuses have innovative programs that address decision-making and communication skills, programs and policies to decrease alcohol abuse, and task forces that organize campus activities surrounding particular health issues.⁴⁷

One-fourth of all individuals in the U.S. ages 18-24 are full- or part-time college students, suggesting that a large proportion of young adults could be reached through college-based suicide prevention efforts.⁴⁸ In 2000, the census data showed that one third of persons ages 18-24 years were either full- or part-time undergraduate or graduate students living in Maine.⁴⁹ Thus, college-based suicide prevention efforts would serve about a third of the 18-24 population.

⁴⁷Centers for Disease Control and Prevention. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA. 2004.

⁴⁸National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U S Department of Health and Human Services, Public Health Service. 2001; p 66.

⁴⁹Maine State Planning Office. Complete Census 2000, 2000 Edition, Augusta: SPO. 2000.
<http://maine.gov/spo/economics/census>.

While for many individuals, college serves as a protective factor, there are two groups who might be at higher risk for suicide: 1) those who enter college with a pre-existing mental health condition and 2) those who develop a mental health condition once in college. Just as with the general population, depression plays a large role in suicide. “Ten percent of college students have been diagnosed with depression.” The majority of young adults ages 18 and older who are diagnosed with depression do not receive appropriate or even any treatment at all.”⁵⁰ Primary and mental health care providers who have the skills to assist youth at-risk of suicide increase the likelihood of appropriate interventions when faced with a suicidal individual. It is also important to facilitate appropriate family involvement in the young person’s treatment.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Post-secondary institutions in Maine
- Maine College Health Association
- DOL
- DHHS Programs

Objective 4.5: Annually, increase the number of community-based organizations serving youth who are not in secondary or post secondary educational settings with staff who are prepared to intervene to prevent suicide.

Population Focus:

Community agencies serving youth ages 18-24 who are not in high school or post-secondary educational settings

Rationale:

In 2000, Maine census data showed that two-thirds of persons ages 18-24 were not enrolled in any type of post-secondary education.⁵¹ Since this is a large population of young people who are not being reached in educational settings, it is important to reach out to community-based organizations, associations, employers and other entities connecting with youth in that age group.

The suicide rate among the 18-24 year-old age group in Maine is higher than the national and regional suicide rates.⁵² Between 2000-2004, Maine’s rate was 15.1/100,000, while the national rate in the same period was 11.7/100,000 and the regional rate was 9.0/100,000.

⁵⁰ National Mental Health Association and the Jed Foundation: Safeguarding your Students Against Suicide-Expanding the Safety Net: Proceedings from and Expert Panel on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses. 2002.

⁵¹ Maine State Planning Office. Complete Census 2000, 2000 Edition, Augusta: SPO. 2000.
<http://maine.gov/spo/economics/census>.

⁵² Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS), <http://www.cdc.gov/ncipc/wisqars/>

Lead Department:

- DHHS, Maine CDC
- DOE, Adult and Community Education, truancy, dropout and homeless
- DOL, Committee on Transition

Potential Partners:

- MYAN
- OUTRIGHT
- Tribal health leaders and Tribal representatives
- Health Service Providers
- Homeless shelters
- Communities for Children and Youth/Prevention Coalitions
- Maine Medical Center

Objective 4.6: Increase the number of secondary schools with staff members trained to implement best practice and/or promising programs designed to improve outcomes for at-risk students.

Population Focus:

Maine secondary schools including alternative schools

Rationale:

The increased potential for suicide in some youths is indicated by the presence of suicidal thoughts, prior suicide attempts, ongoing depression and/or drug or alcohol involvement. Prevention strategies for these high-risk youths need to focus on building life skills, enhancing social supports, and making mental health and substance abuse treatment services accessible and responsive to these youths at risk and their families.

In response to the serious problem of suicide in the United States, hundreds of suicide prevention programs have been created and employed across the country. However, accessible evidence concerning the effectiveness of these programs with high risk youth is limited. The Suicide Prevention Resource Center (SPRC) has an up-to-date online registry of evidence-based suicide prevention programs. Many of the programs are in the school domain, but few are especially designed for high-risk youths. Among the designated best practice programs is Coping and Support Training (C.A.S.T.), a school-based intervention for students at-risk for suicide who require an intensive intervention.

Lead Department:

- DHHS:
 - OSA
 - Maine CDC

Potential Partners:

- Contracted trainers
- Maine Schools

Maine Youth Suicide Prevention Program (MYSPP) Goal 5

Support initiatives to decrease the risk of youth suicides by reducing access to lethal means.

Note: Lethal Means is defined as any instrument or object utilized to carry out a self-destructive act (i.e., firearm, poison, medication, rope, chemicals and/or other hazardous material).

Background:

As firearms have high lethality, the majority of suicide attempts by firearm are fatal. From 2000-2004, firearms were used in more than half (57 percent) of all youth suicides among Maine residents ages 12-24. In that five year period, there were a total of 79 firearm deaths among 12-24 year olds, 65 of which were suicides. The second leading method of youth suicides in this period was hanging, accounting for 41, or 36 percent of youth suicides.

It has been demonstrated that a large percentage of youth suicides occurred as the result of an impulsive act. One study conducted by the Harvard Injury Control Research Center and the American Association of Suicidology asked individuals ages 15-24 how much time elapsed between the moment they decided to commit suicide and the time they took action. Nearly one quarter stated that less than five minutes passed.⁵³ Another study showed that 25 percent of 153 survivors of near lethal suicide attempts acted within five minutes of the impulse to do so and 71 percent acted within one hour.⁵⁴ Other studies that followed victims of nearly lethal attempts found that 10 to 20 years later, 90 percent or more had not died by suicide.⁵⁵

Imagine a 14-year-old running out of the kitchen after an argument with a parent. The youth reaches into a closet, takes a loaded firearm, and pulls the trigger. A life is suddenly and sadly lost. Now imagine there is no gun, and in the 15-20 minutes it takes to find a rope, gather pills or fill the garage with fumes, the anger felt may have passed and/or a family member may have intervened to help. For some youth, the best form of suicide prevention is putting time and distance between the impulse to die and a lethal weapon.

Restricting access to lethal means has been cited as one of the most effective ways to reduce youth suicide.⁵⁶ An analysis of suicide data in Northeast states showed that states with higher ownership rates have higher suicide rates.⁵⁷ The National Council for Suicide Prevention, a group of 10 national organizations dedicated to reducing suicide, supports education, awareness and policies to reduce the access to firearms by persons determined to be a risk to themselves.

⁵³ Harvard Injury Control Research Center and the American Association of Suicidology. A Public Health Approach to Preventing Suicide. June 2003.

⁵⁴ Swahn, M. H., Potter, L. B. Factors Associated with the Medical Severity of Suicide Attempts in Youth and Young Adults. 2001.

⁵⁵ Barber, C. Fatal Connection; The Link Between Guns and Suicide. Advancing Suicide Prevention, Volume 1, Issue 2, July/August. 2005.

⁵⁶ Hemenway, D. Private Guns, Public Health. The University of Michigan Press, Ann Harbor. 2004.

⁵⁷ Miller, M., Hemenway, D., Azrael, D. "Firearms and Suicide in the Northeast" *Journal of Trauma*, 57. 2004; p 626-632.

Description:

The four objectives in this goal are designed to reduce access to lethal means for young people at risk of suicide. First, public awareness education efforts must be increased in order to raise awareness among adults about the importance of restricting access to all types of lethal means. Second, is increasing the number of primary and behavioral health care clinicians, public safety officials who routinely assess for the presence of all types of lethal means in the home and educate about the actions to reduce associated risks. Third and fourth are policy solutions to strengthen the Child Access Prevention (CAP) Law in Maine and to require parental permission for the purchase of a long gun by persons up to age 18.

Objective 5.1: Increase awareness among adults in Maine about the importance of restricting access to all types of lethal means for at-risk individuals.

Population Focus:

General public, MYSPP web users and training participants

Rationale:

Public information campaigns have been shown to be effective in changing health behavior and improving public health. Successful public information campaigns have decreased tobacco use, increased seat belt use and decreased the incidence of drunk driving.⁵⁸ Evidence from many countries and cultures has shown that limiting access to lethal means is an effective strategy to prevent self-destructive behaviors in at-risk individuals.⁵⁹ The success of campaigns described previously indicates that similar efforts to educate the public about restricting access to lethal means in the home could also be successful.

Law enforcement officials are trained to safely remove lethal means from a dangerous situation. However, while law enforcement officials are trained and available to assist with removing lethal means from the environment of a suicidal person, this practice is not widely known by the public and not all law enforcement agencies have procedures about removing lethal means from the environment of a suicidal person.

Lead Department:

- DHHS, Maine CDC
- DPS
- DOE

⁵⁸ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 75.

⁵⁹ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 71.

Potential Partners:

- Law Enforcement and Emergency Medical Technicians (EMTs)
- Department of Inland Fisheries & Wildlife (DIF/W)
- OSA
- Public Health Nursing
- Schools
- Youth and Parents
- Community agencies, organizations and businesses
- The Office of The Maine Attorney General
- US Attorney's Office
- Sportsman's Alliance of Maine and other Hunting and Rod and Gun Clubs
- Maine Coalition Against Domestic Violence
- Media Outlets
- Legislators

Objective 5.2: Increase the number of primary care providers, behavioral health clinicians and public safety officials who routinely assess the presence of all types of lethal means in the home and educate about the actions to reduce associated risks.⁶⁰

Population Focus:

Primary care providers, behavioral health clinicians, and public safety officials

Rationale:

It has been shown that the presence of a lethal means, particularly a firearm, in the home is associated with increased rates of suicide.⁶¹ One study showed that, among parents whose children visited an emergency department for a mental health assessment or treatment, those who received injury prevention education from hospital staff were significantly more likely to limit access to lethal means of self-harm than are families who did not receive such education.⁶² Currently, there are no universally accepted guidelines for the assessment of suicidal risk in primary health care and emergency department settings. Such guidelines would assure that these assessments would become part of the routine protocol for providing clinical care to all individuals seen in these health care settings and would assist in the process of making clinically appropriate referrals for mental health and substance abuse treatment.⁶³

Lead Department:

- DHHS, Maine CDC
- The Office of The Maine Attorney General
- DPS: State Police / Emergency Medical Services (EMS)

Potential Partners:

- ME Mental Health Association
- ME Assoc. of Family Physicians
- ME Criminal Justice Academy
- ME Chapter of American Academy of Pediatrics
- Northern New England Poison Center
- Residential Programs
- Local Law Enforcement
- OSA
- Emergency Room Staff
- Medical Care Providers and/or Personnel
- Intimate Partner Violence Prevention Organizations

⁶⁰ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 74.

⁶¹ Center to Prevent Handgun Violence Brochure.

⁶² Grossman, K. M. Suicide and Violence Prevention: Parent Education in the Emergency Department. 1999.

⁶³ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 91.

Objective 5.3: Provide data and research to demonstrate the benefits of strengthening the Child Access Prevention (CAP) Law in Maine.

Population Focus:

Safety advocates and Maine citizens

Rationale:

CAP laws hold adult owners of firearms criminally responsible if a child under age 18 gains access to a gun that is not made reasonably inaccessible or does not have a device to lock the gun in place. Multiple studies have shown that strengthening Child Access Prevention (CAP) laws can increase child safety. A study conducted by researchers at the Johns Hopkins Bloomberg School of Public Health provides evidence that the CAP laws for firearms enacted by 18 states significantly reduced suicide rates among young people ages 14-17.⁶⁴ Evidence from a study in Houston, Texas suggests that CAP Laws have been successful in reducing deaths due to unintentional and suicide firearm injuries among children under age 16.⁶⁵ Holding adult owners of firearms criminally responsible for improper storage combined with widespread public awareness education would provide a strong message about the obligation of adults to keep youth safe from intentional and unintentional firearm injuries. Maine’s CAP law currently states that “gun owners may be held responsible if they leave a gun easily accessible to a child under 16 years old,” but there are broad exemptions under this law. While Maine has a low rate of unintentional deaths by firearms,⁶⁶ the incidence of suicide deaths by firearms is high.

Lead Department:

- DHHS:
 - Maine CDC
 - CBHS
- DPS: State Police / EMS

Potential Partners:

- Maine Citizen’s Against Handgun Violence
- Maine representatives of the Million Mom March
- Sportsman’s Alliance of Maine
- Medical Community
- Legislators
- Law Enforcement
- Local EMTs
- Parents and Youth

⁶⁴ Johns Hopkins Bloomberg School of Public Health. *Gun Laws Requiring Safe Storage Prevent Some Youth Suicides*. Journal of American Medical Association. 2004.

⁶⁵ www.bradycampaign.org/facts/faqs/?page=cap

⁶⁶ Scruggs, R. Why Kids Just Can’t Say No (presented by The Sportsman’s Alliance of Maine). 2003; p 10.

Objective 5.4: Provide data and research that demonstrates the benefits of strengthening the law requiring parental permission for the purchase of a long gun by persons up to age 18.

Population Focus:

Legislature and Maine Citizens

Rationale:

A literature review of the effectiveness of firearm legislation indicates that restricting access to firearms through legislation and enforcement reduces youth suicide. Substitution of other means does not appear to offset the benefits of restriction.⁶⁷ Current Maine law restricts selling or giving handguns to juveniles under age 18, and restricts selling or giving rifles or shotguns to juveniles under 16, except for supervised loans of firearms or for limited lawful activities such as hunting. There is no limit on youth possessing firearms, nor parental permission required to possess a firearm.

Lead Department:

- DHHS:
 - Maine CDC
 - CBHS
- DPS: State Police / EMS

Potential Partners:

- Maine Citizen’s Against Handgun Violence
- Maine representatives of the Million Mom March
- Sportsman’s Alliance of Maine
- Medical Community
- Maine Legislators
- Law Enforcement
- Local EMTs
- Parents and Youth

⁶⁷ Hemenway, D. *Private Guns Public Health*. University of Michigan Press. 2004.

Maine Youth Suicide Prevention Program (MYSPP) Goal 6

Implement training for recognition of at-risk behavior and appropriate response to a variety of audiences statewide.

Background:

Training and education programs offer a face-to-face opportunity to dispel myths, address misconceptions, increase knowledge and improve attitudes about suicide prevention. As pre-service (college) education in effective suicide prevention and intervention strategies for professionals entering the fields of education, health care, public safety and other fields is not universally available, continuing education in effective suicide prevention strategies is essential for those working directly with youth. Training for the individuals in close contact with youth facilitates the early identification and referral of persons at risk. Suicide prevention education must be integrated into programs and activities that already exist and included in the agendas of communities and state groups.⁶⁸

Description:

Objectives under this goal are focused on increasing knowledge, skills and confidence levels among key personnel in schools, colleges and communities in Maine. Basic suicide prevention awareness and skills trainings will be delivered to general and selected audiences. Adults attending the sessions will be trained to identify and assist youth at risk of suicide.

Objective 6.1: Increase knowledge, confidence, and skills among a wide variety of individuals trained to identify and respond appropriately to youth at-risk of suicide.

Population Focus:

Individuals routinely interacting with youth, ages 10-24 and those working with, providing services to, or having consistent contact with youth

Rationale:

Creating a network of individuals trained to identify and respond appropriately to youth at-risk of suicide accomplishes three things. First, it ensures that individuals are trained to intervene appropriately with suicidal youth; second, these individuals know how to connect youth to the appropriate services, and third, it ensures that individuals are supportive to the youth during the process, thus providing a safe and trusting environment for them. More adults in Maine trained to handle suicidal situations will result in an increase in successful interventions that save more young people's lives.

It is vital to increase the confidence of adults who are trained to respond to youth when intervening in a suicidal situation. Continued in-service trainings reinforce current skills,

⁶⁸ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 53.

refresh awareness and commitment to suicide prevention, and provide support to those who have dealt with difficult situations.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Training contractors
- DHHS, Behavioral Health Offices
- Children’s Cabinet agency training staff and contractors
- Communities for Children and Youth
- Representatives from Gatekeeper Training audiences

Objective 6.2: Annually, increase the number of staff in youth-serving organizations and individuals working with youth who have received youth suicide prevention awareness education.

Population Focus:

Individuals routinely interacting with youth, ages 10-24, and those working with, providing services to, or having consistent contact with youth

Rationale:

Anyone working closely with youth can learn to conduct a basic three-step suicide intervention once they have received a basic suicide prevention awareness education program (60-90 minutes) offered by a trained gatekeeper. Not all adults who are part of a young person’s support network see themselves as “gatekeepers,” but they may be in a better position, through regular contact with a young person, to identify a need for help. These adults may be in the role of teacher, employer, relative, coach, or neighbor. Enlarging the pool of people who know the risk factors and warnings signs, how to ask the questions about suicidal intent, and what resources are available, broadens the safety net for all youth.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Training contractors
- Children’s Cabinet agency training staff
- Communities for Children and Youth
- DOL
- NAMI Maine
- AFSP, Maine Chapter
- CBHS
- DOE
- DPS

- DOC
- Sub-contractors of all Children’s Cabinet agencies
- Healthy Maine Partnerships

Objective 6.3: Increase the number of secondary schools with school-based primary and mental health care providers trained to assist youth and families at risk of suicide.

Population Focus:

School-based primary and mental health care providers

Rationale: The 2000 National Household Survey on Drug Abuse found that, while most youth who reported some risk for suicide had not received any type of treatment (65 percent), 15.1 percent reported seeing a school counselor, school psychologist or teacher.⁶⁹ Teens spend a great deal of time in school. School personnel, including primary and mental health care providers, can play an important role in suicide prevention and intervention. Training in effective suicide prevention and intervention will provide them with increased knowledge and confidence to directly address their concerns with a student. With support from the MYSPP, linkages between schools and local mental health providers will be strengthened as well in order to facilitate referrals and case management.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- DHHS:
 - CBHS
 - OSA
 - Maine CDC
- DOE, Student Assistance Team Unit (SAT)

Objective 6.4: Annually, increase the number of community based primary health care providers who are trained to identify and assist youth, young adults and families at-risk of suicide.

Population Focus:

Community based physicians, nurses, physician assistants, nurse practitioners, crisis response providers, psychologists, social workers and substance abuse treatment providers

⁶⁹ Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Substance Use and the Risk of Suicide Among Youth. National Household Survey on Drug Abuse, The NHSDA Report, July 12, 2002.

Rationale:

Community based primary health care professionals, crisis workers and substance abuse treatment providers are in key positions to identify, intervene, and refer youth and young adults at-risk of suicidal behavior. Many suicidal individuals make contact with their primary care physicians within a few weeks prior to their death.⁷⁰ A number of studies indicate that many professionals are inadequately prepared in these areas.⁷¹ Training of community-based professionals can effectively expand the identification and treatment of individuals at risk of suicide, and ensure an efficient use of limited resources.

Lead Department:

- DHHS:
 - Maine CDC
 - CBHS
 - OSA

Potential Partners:

- University of New England
- Muskie School for Public Service
- Department of Professional and Financial Regulation
- NAMI Maine
- Maine Family Practice Association
- Managed Care Consumer Assistance Program
- ME Chapter American Academy of Pediatrics
- National Association of Social Workers, Maine Chapter
- University of Maine System

⁶⁸ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 82.

⁷¹ Key, J., Marsh, L., Darden, P. Adolescent Medicine in Pediatric Practice: A Survey of Practice and Training. American Journal of Medical Science, Geb; 309(2). 1995: p 83-87.

Maine Youth Suicide Prevention Program (MYSPP) Goal 7

Develop and promote effective clinical and professional practices.

Background:

Clinical practices that have been identified to prevent suicide in youth include:

- Early identification
- Early intervention
- Treatment of co-morbid problems (e.g. depressed mood, hopelessness, helplessness, agitation, severe anxiety, pervasive insomnia, alcohol and drug abuse, and conduct problems);
- Follow through with natural and community supports as well as professional services;
- Effective clinical treatments and interventions.

Additional strategies that are more universal, such as promoting and supporting the presence of protective factors including a safe and supportive environment, skills in problem solving, conflict resolution and nonviolent handling of disputes are also appropriate for at-risk individuals. A cognitive behavioral approach to treatment strengthens these protective factors of problem solving and coping skills. Recently, it has been documented that cognitive therapy could reduce repeat suicide attempts by as much as 50 percent.⁷²

Description:

Objectives under this goal are designed to ensure appropriate and effective identification and intervention for at risk individuals including the implementation of aftercare treatment programs for individuals who have exhibited suicidal behavior and the expansion of training and use of evidence based treatment models for persons with mood and other associated disorders.

Objective 7.1: Engage at least one survivor organization, two family member organizations and at least two provider organizations in the development and/or adaptation of suicide prevention educational materials about the identification, assessment and treatment of mental health and substance abuse and associated risk of suicide.

Population Focus:

Families, community members, psychiatric and substance abuse treatment facility personnel

⁷² Journal of the American Medical Association (JAMA); study by Beck, Brown, University of Penn and colleagues. August 3, 2005.

Rationale:

Family and community members are key stakeholders and should be engaged in the effort to develop guidelines for materials that identify individuals at risk for suicide through stigma reduction, monitoring and intervening with persons at risk for suicide for dissemination to families. It has been shown that educating family members about how to understand, monitor, and intervene with family members at risk for suicide results in better management and treatment of those identified individuals⁷³ Organizations such as NAMI Maine have conclusively demonstrated the value of family education and support network education to improve the care of individuals who are at risk. Because the exact timing of suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network are knowledgeable about potential risks for suicide and about how to protect an individual from harm.⁷⁴

Lead Department:

- DHHS, CBHS

Potential Partners:

- NAMI Maine
- Gaining Empowerment Achieves Results (Gear)
- MMC, Division of Child and Adolescent Psychiatry
- AFSP, Maine Chapter
- MMC, PIER
- Center for Grieving Children
- ME Assoc. of Mental Health Service Providers
- ME Assoc. of Substance Abuse Programs

Objective 7.2: Develop and implement suicide prevention discharge guidelines in 80 percent of inpatient, residential treatment, and youth detention facilities.

Population Focus:

Facility providers, outpatient providers, youth, family members, and school personnel serving youth up to age 21

Rationale:

At the time of transition from intensive out-of-home facilities back to the community, children and youth experience a significant decrease in structure, support, treatment intensity and pro-social supports. This leads to increased stress and increased use of dysfunctional coping mechanisms. Children, teens and young adults recently discharged from out-of-home facilities are at an increased risk of suicide attempts. Studies indicate that there is a very high association between youth involved with the corrections system and increased risk for suicide.⁷⁵ This risk remains after the young person is released from

⁷³ Richman, J. Family Therapy for Suicidal People. NY: Springer Sylvania. 1980.

⁷⁴ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 85.

⁷⁵ Harris & Barraclough, 1997; Inskip, Harris & Barraclough, 1998; Tanney, 2000.

the correctional system. Youth re-entering homes and schools have less structure and may have fewer supports to help them cope with suicidal thoughts.⁷⁶

Incarcerated mentally ill youth are routinely transferred from state rehabilitative facilities to the community upon the termination of their sentences. Upon release, these youth, like other juvenile offenders requiring specialized forms of treatment, have a poor prognosis for successful community reintegration and adjustment.⁷⁷ Wood's study on the transition of incarcerated youth indicates that higher levels of intersystem discharge planning and community treatment services are needed for incarcerated mentally ill youth upon community release.⁷⁸

Lead Department:

- DOC
- DHHS:
 - CBHS
 - Child Welfare Services (CWS)

Potential Partners:

- DOE
- Keeping Maine's Children Connected
- AFSP Maine Chapter
- Correctional Facilities
- NAMI Maine
- Psychiatric Hospitals
- School Districts
- Residential Treatment Facilities
- Community service providers
- Family members

Objective 7.3: Increase the proportion of primary and mental health care and emergency department settings that have adopted standardized assessment, intervention and follow-up guidelines for youth suicide prevention.

Population Focus:

Primary care providers, emergency room staff, school based health center personnel, educational personnel, post-secondary health centers and mental health and substance abuse treatment providers

⁷⁶ Wood, P., Trupin, E., Turner, A., Vander Stoep, A., Stewart, D. (NCMHJJ website: *The Community Transition of Incarcerated Mentally Ill Youth: An Outcome Study*. Washington State Department of Social and Health Services, Seattle, WA. 1999.

⁷⁷ Altzchul and Armstrong, Intensive Aftercare for High-Risk Juveniles: A Community Care Model. Program Summary, Office of Juvenile Justice and Delinquency Prevention. 1994. Stewart, Boeky, Truptn, Mental Health Screening of Youth in IRA with Significant Emotional and Behavioral Problems. 1999.

⁷⁸ Wood, P., Trupin, E., Turner, A., Vander Stoep, A., Stewart, D. (NCMHJJ website: *The Community Transition of Incarcerated Mentally Ill Youth: An Outcome Study*. Washington State Department of Social and Health Services, Seattle, WA. 1999; p 7.

Rationale:

Persons at risk for suicide first present in emergency departments, primary health care settings, and in school-based health centers with a variety of concerns, including mental illness and substance use disorders, physical abuse, recent losses, and painful physical illnesses that can place them at increased risk for suicide.⁷⁹ These settings are identified as increasingly important for access to behavioral health services. In addition to assessing these individuals for suicide and associated problems, it is essential that they get connected to and follow through with the appropriate resources. Only then can they receive the treatment they need to decrease the risk of suicide. Development and dissemination of assessment, referral, and follow up guidelines would assure that these assessments become part of the routine protocol for individuals at risk for suicide, who are seen in health care settings.⁸⁰

Lead Department:

- DHHS:
 - Office of MaineCare Services (OMS)
 - Maine CDC, Teen & Young Adult Health Program (TYAHP)
 - CBHS

Potential Partners:

- Maine Hospital Association
- Mental Health Council
- Mental Health Provider Organization
- American College of Emergency Physicians, Maine Chapter
- Maine Primary Care Association
- ME Assoc. of Substance Abuse Programs
- School-based Health Center and educational personnel

Objective 7.4: Increase to 100 percent the young adult, teen and child serving state departments in Maine that have adopted best practice guidelines for suicide prevention and intervention.

Population Focus:

State departments serving children, teens and young adults and contracted providers of clinical services

Rationale:

Child-serving state agencies often receive inquiries from the public seeking help. These agencies are often working with people who face multiple life challenges and are therefore at higher risk for suicide. In addition, state agencies should set standards for their own operations that model the best practices desired in community-based partners organizations. Following a “no wrong door” policy, all agency personnel should be prepared to assist those who are seeking help for themselves or a loved one who may be

⁷⁹ Harris & Barraclough, 1997; WHO, 2000a, 2000c

⁸⁰ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001; p 91.

suicidal. Policies, procedures and training can prepare personnel to respond effectively, as well as to support these personnel in dealing with difficult cases. Such policies should not replace the hot and warm lines supported by DHHS, but make personnel aware of these resources, and appropriate referral sources.

Lead Department:

- DHHS:
 - CBHS with all child, teen and young adult serving state departments including the Quality Improvement Division

Potential Partners:

- Clinical service providers

Objective 7.5: Increase by 20 percent the number of primary care offices and school based health centers that use the Care Model for patients with depression.

Population Focus:

Primary care providers including school based health centers

Rationale:

The “Chronic Care Model” (Care Model) incorporates the following: 1) Development of a Diagnosis Specific Registry to help a practice with a population-based approach to depression; 2) Use of an assessment tool (a patient self report measure for depression) to facilitate the initial diagnosis and monitor recovery over time; 3) Patient Self Management (patients taking an active role in their treatment); 4) Contact with a care manager (who follow the patient’s progress, lack of progress, side effects, and self management) during the active phase of illness.

Use of the Care Model as applied to the treatment of depression improves care in a number of ways: 1) it provides the basis for increased training for primary care physicians and nurses, increasing their comfort with the diagnosis of depression and their effectiveness in treating chronic depression; 2) it allows for the monitoring of improvement in care; 3) it encourages engaging the patient in responsibility for their care, thereby increasing follow-up and treatment management success; and 4) it allows identification of missed appointments. This treatment is an investment in maintaining health, with associated improved functioning and savings in resources.⁸¹

Lead Department:

- DHHS:
 - CBHS
 - OMS

⁸¹ Accelerating Change Today (A.C.T.) for America’s Health, May 2002, The National Coalition on Health Care and the Institute for Health Care Improvement, Article “Connecting the Dots: Health Plans Pivotal Role in Chronic Illness Improvement”.

Potential Partners:

- School based health centers
- MMC
- NAMI Maine
- Community Providers
- Primary care providers
- Maine Care Model Pilot Programs
- Learning Collaborative on Depression

Objective 7.6: Increase by 25 percent the number of patients at risk for suicide with a follow up plan from the crisis service provider, that pursue the proposed mental health follow-up plan.

Population Focus:

Crisis service providers

Rationale:

All youth in Maine hospital emergency departments, or in community settings who present with evidence of suicidal ideation or behavior, are seen by a mobile crisis team worker with few exceptions. However, crisis workers may not routinely contact these individuals to learn if the follow-up plan is being implemented. Efforts to focus on improved follow-up care for suicidal youth, therefore, should focus on mobile crisis team workers and improving the timely availability of evidence based community treatment services (psychiatric assessment and treatment, evidence based psychotherapies, and intensive in home treatment services where necessary).

Clinical studies have shown the importance of training personnel to address suicide attempts and treat the underlying cause(s) intensively. Family members of adolescents should be educated about the dangers of ignoring suicide attempts and the benefits of follow-up treatment to reduce the reoccurrence of attempted suicide. Family members should be actively included in the treatment planning and implementation. Youth also should be integrally involved in treatment planning. Without follow-up treatment, significant improvement in clinical status is extremely unlikely. Both the patient and the health care delivery system benefit from better linkages between emergency and appropriate follow-up care. Adolescents experiencing multiple evaluations, lengthy waiting periods and poor communication during the process are significantly less likely to become involved in the aftercare.

Lead Department:

- DHHS
 - CBHS
 - Adult Behavioral Health Services (ABHS)

Potential Partners:

- Community crisis service providers
- Family members
- NAMI Maine
- ME Assoc. of Mental Health Service Providers
- ME Assoc. of Substance Abuse Programs

Objective 7.7: Increase the number of mental health and substance abuse providers assessing trauma survivors for suicide risk, including in correctional settings.

Population Focus:

Emergency Department personnel, mental health professionals, substance abuse treatment professionals, Department of Corrections Staff, local correctional facilities and community based justice programs

Rationale:

Risk factors of adolescent suicide include the following: the use of illegal drugs; history of abuse by a significant other; issues resulting from gay, lesbian, transgender and questioning youth status (LGBT); minority cultural status and co-occurring mental illnesses. In addition, post traumatic stress disorder is significantly associated with other risk factors for suicidal behavior: anxiety, depression, mood instability, substance abuse, trouble concentrating and disruptive behaviors. Therefore, preventing and treating trauma-based disorders are very likely to significantly decrease the factors associated with suicidal behavior.

Lead Department:

- DHHS, CBHS

Potential Partners:

- Maine Trauma Network
- National Trauma Network
- Victims Advocates
- Sexual Assault Nurses Examiner Program
- Sexual Assault Crisis Centers
- Coalition to End Domestic Violence
- Community Providers

Objective 7.8: Increase the number of first responders and health professionals who receive best practice training and support that addresses their own exposure to suicide.

Population Focus:

First responders, funeral directors, clergy, primary care physicians, mental health and substance abuse therapists

Rationale:

Suicide survivors, whether professional or personally connected to the victim, are at increased risk of repeated trauma when exposed to further suicide. First responders who are routinely exposed to suicide are likely to be in this position and yet are often conditioned to ignore their own needs in responding to others. By supporting first responders with training that acknowledges the increased stress they may experience and encouraging help-seeking for these individuals, their effectiveness can be increased and burn-out can be reduced.

Lead Department:

- DHHS, CBHS
- DPS: State Police / EMS

Potential Partners:

- EMS Providers
- Law Enforcement
- American Red Cross
- Maine Emergency Management Agency
- NAMI Maine
- AFSP, Maine Chapter
- Clergy Association(s)
- American Social Work Association, Maine Chapter
- American Psychiatric Association, Maine Chapter
- American Psychological Association, Maine Chapter

Maine Youth Suicide Prevention Program (MYSPP) Goal 8

Improve access to and community linkages with mental health, substance abuse, and suicide prevention services.

Background:

Increasing access to mental health services and substance abuse services can help individuals experiencing suicidal behaviors as well as those with conditions that increase the risk of suicide. Through public insurance programs and mental health parity laws for private insurance, some barriers to care have been reduced in Maine. However, lack of insurance, underinsurance and other factors continue to create access barriers, which need to be eliminated. Linkages between schools, community agencies and mental health and substance abuse treatment programs need to be established. The use of a multi-systemic collaborative approach is crucial to early identification and successful treatment of at-risk youth.

The elimination of health disparities and the improvement of the quality of life for all Americans are central goals for Healthy People 2010.⁸² Some of these health disparities are associated with differences of gender, race or ethnicity, education, income, disability, geographic location, or sexual orientation. Many of these factors place individuals at increased risk for suicidal behaviors, as well as increasing barriers to early identification and specialty services such as child and adolescent psychiatric treatment.

Description:

This goal is designed to prevent suicide by ensuring that individuals who are at high risk due to mental health and/or substance use problems have access to prevention and treatment services.

Objective 8.1: Increase the proportion of health and/or social service outreach programs that integrate suicide screening, assessment, support and referral.

Population Focus:

Agencies that serve at-risk children, teens and young adults ages 18-24 who are not regularly involved in school or work and their families

Rationale:

Disconnected youth experience disproportionate difficulty with accessing appropriate mental health services. Integrating suicide prevention into outreach programs for these youth will increase early identification and connect them to appropriate services. In addition, transition periods have been increasingly recognized as times of greater risk. Resiliency factors have been identified that support coping skills for symptoms of mental

⁸² U.S. Department of Health and Human Services. (2000). Healthy People 2010 (2nd ed.). Washington, DC: U.S. Government Printing Office. U.S. Public Health Service. (1999). The Surgeon General's Call to Action to Prevent Suicide. Washington, DC: Author.

illness and suicide ideation. Young adults who are alienated from family, social, and community supports are at higher risk for disconnection from other systems of supports. Engagement of these at-risk teens and young adults will serve to mitigate suicide risk.

Lead Department:

- DOE
- DHHS, CBHS
- DOL

Potential Partners:

- DHHS:
 - Maine CDC: TYAHP and Public Health Nursing Program
 - Foster Care
 - OSA
- DOC
- School Based Health Center staff
- Keeping Maine’s Children Connected
- Realize ME

Objective 8.2: Increase the number of correctional facilities and community-based justice programs that have screening assessments and treatment protocols in place for mental illness and suicide risk.

Population Focus:

18-24 year old prison population and juveniles involved in justice system community settings

Rationale:

After leaving the public school setting, there exist few opportunities for screening to identify and intervene with individuals at risk. The public safety and correctional systems have become one place where young people struggling with mental illness and substance abuse issues can access screening, assessment and treatment for suicidal behaviors. The Maine Juvenile Justice system, in collaboration with Children’s Behavioral Health Services, has instituted mental health screening for all incarcerated juveniles and young adults. A similar screening program, the Massachusetts Assessment Youth Screening Inventory (MAYSI), is being piloted in three counties by the DOC.

Lead Department:

- DOC
- DHHS, ABHS

Potential Partners:

- Juvenile Community Corrections Officers (JCCOs)
- DHHS, CBHS
- Community-based Crisis Service Providers

Objective 8.3: Increase by 10 percent the number of Maine secondary schools and post-secondary institutions that adopt best practice guidelines for mental health and substance abuse screening and referral of at-risk students.

Population Focus:

Secondary schools and post-secondary institutions in Maine

Rationale:

Suicide is the second leading cause of death among Maine youth aged 15-24. Screening efforts have demonstrated success in identifying youth at risk for mental illness or substance abuse in some school-based programs, however, limited resources for such programs require that they be chosen carefully and implemented based on available research. Mental health screening tools need to be reviewed and evaluated to see if they are effective at decreasing suicide in youth. Less evidence has been established for screening programs for the college-aged, but since rates for suicide are higher for the age group, outreach to colleges is critical to address the older population.

Lead Department:

- DOE, SAT
- DHHS:
 - CBHS
 - TYAHP
- DOC

Potential Partners:

- Maine public schools, colleges, and universities
- Mental health providers

Objective 8.4: Develop program resources for support of suicide survivors with stakeholder buy-in.

Population Focus:

Suicide survivors

Rationale:

Suicide survivors are at increased risk for suicide themselves. Support of the families, friends and relations of suicide victims is an important suicide prevention strategy. Survivors can also serve as resources in developing suicide prevention, assessment and follow-up supports.

Lead Department:

- DHHS:
 - Maine CDC
 - CBHS
 - OSA Information Resource Center

Potential Partners:

- Training contractors
- AFSP, Maine Chapter
- NAMI Maine
- Hospice Centers conducting suicide survivor support groups
- Center for Grieving Children

Objective 8.5: Develop and implement in at least two of Maine’s managed care and/or health insurance plans (including MaineCare) quality care/utilization management guidelines for effective response to suicidal risk or behavior.

Population Focus:

Families and individuals at risk of suicide

Rationale:

Providing guidelines for effective response to suicide risks will allow the State to determine whether this significant problem is being identified and addressed according to national standards and best practices responses. Distribution and adoption of such guidelines helps to create a comprehensive approach across systems. Only with this information can a system-wide planful response be developed and implemented.

Lead Department:

- DHHS, CBHS

Potential Partners:

- OMS
- ME Assoc. of Health Plans
- NAMI Maine
- Managed Care Association

Objective 8.6: Increase by 10 percent the number of school districts in which school-based mental health, substance abuse and suicide prevention services are available to all students in need.

Population Focus:

Maine School Districts, local mental health and substance abuse treatment service providers

Rationale:

Increased early identification, recognition and treatment of risk factors for youth suicide will decrease the youth suicide rate. Mental illness and substance abuse are identified risk factors for suicidal behavior. Approximately 20 percent of youth suffer from mental illness (7 to 12 million).⁸³ Recent studies reveal that the earlier in life a mental disorder begins, the slower a person or their family is to seek treatment and the more persistent the

⁸³ National Institute for Mental Health website

illness becomes. Untreated mental illness can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses and substance abuse. In addition, despite the fact that there are presently effective treatments for dealing with mental illness, there are long delays, sometimes decades, between the first onset of symptoms and individuals seeking and receiving treatment.⁸⁴ Some studies claim that as many as 90 percent of youth who die by suicide suffer from a diagnosable mental illness at their time of death.⁸⁵ Schools are an easier and appropriate point of access for youth to identify the need for services, and to receive information on treatment resources.⁸⁶

Lead Department:

- DOE
- DHHS:
 - Maine CDC, TYAHP
 - CBHS
 - OSA

Potential Partners:

- Substance abuse and mental health providers
- School districts

Objective 8.7: Respond to requests from local schools and communities to provide resource information in situations where contagion appears to be a factor.

Population Focus:

Maine schools and communities with multiple youth suicides in a short time period

Rationale:

Suicide contagion, as defined by the National Strategy for Suicide Prevention: Goals and Objectives for Action, is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts. Contagion assumes either direct or indirect awareness of the prior suicide. Various suicide contagion pathways may exist: direct contact or friendship with a victim, word-of-mouth knowledge, and indirect transmission through the media.⁸⁷ There is ample evidence from the literature on suicide clusters to support the contention that suicide is “contagious”.⁸⁸

⁸⁴ National Co-morbidity Survey Replication (NCS-R) in the Archives of General Psychiatry.

⁸⁵ Shaffer, D., Gould, M. et al. Psychiatric Diagnosis in Child and Adolescent Suicide. Archives of General Psychiatry, Volume 53, Number 4, April. 1996; p 339-348.

⁸⁴ Mental Health: A Report Surgeon General. 1999

⁸⁶ Gould, M. S., Wallenstein, S., Kleinman, M. Time-Space Clustering of Teenage Suicide. American Journal of Epidemiology, Volume 131, Number 1. 1990.

⁸⁶ Gould, M. S. Suicide and the Media. Annals New York Academy of Sciences.

⁸⁶ Gould, M. S., Wallenstein, S., Kleinman, M. Time-Space Clustering of Teenage Suicide. American Journal of Epidemiology, Volume 131, Number 1. 1990.

⁸⁶ Gould, M. S. Suicide and the Media. Annals New York Academy of Sciences.

⁸⁷ Gould, M. S., Wallenstein, S., Kleinman, M. Time-Space Clustering of Teenage Suicide. American Journal of Epidemiology, Volume 131, Number 1. 1990.

⁸⁸ Gould, M. S. Suicide and the Media. Annals New York Academy of Sciences.

One such study determined that the incidence of suicide and suicidal behavior in an area under observation was markedly elevated compared to national and local normative data when the area had a recent number of suicides occur.⁸⁹ Because contagion is a dangerous process by which one suicide may facilitate another,⁹⁰ it is important that the MYSPP respond appropriately to requests for assistance from local schools and community organizations in the aftermath of a suicide. Such assistance includes guidance about utilizing crisis services appropriately, resource information, guidelines for speaking to the media in ways that do not add to the threat of contagion and information on children's grief.

Lead Department:

- DHHS
 - Maine CDC
 - CBHS
- DOE, SAT

Potential Partners:

- Contracted trainers
- School and community leaders and organizations
- Medical Examiner's Office
- DHHS, Maine CDC, Epidemiology Team
- DOC

⁸⁹ Brent, D. A., Kerr, M. M., Goldstein, C., Bozigar, J., Wartella, M., Allan, M. J. An Outbreak of Suicide and Suicidal Behavior in a High School. *Journal of American Academy of Child Adolescence*. Volume 28, Number 6. 1989.

⁹⁰ Hazell, P. Adolescent Suicide Clusters: Evidence, Mechanisms, and Prevention. *Australian and New Zealand Journal of Psychiatry*, 27. 1993; p 653-665.

Maine Youth Suicide Prevention Program (MYSPP) Goal 9

Improve reporting practices to reduce the potential of suicide contagion.

Background:

Working with media and program partners statewide to promote safe reporting practices can save lives. Emphasis is on the importance of following the national consensus reporting recommendations to avoid contagion among vulnerable Maine youth. Contagion is defined as a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.⁹¹

Description:

Maine's objectives take a multi-pronged approach with a focus on providing education, training, guidelines, and information to representatives of the media, gatekeepers, school administrators, clinicians, helping professionals and suicide survivors in order to improve reporting practices. Part of the approach is to involve media in a positive role of partnering with the MYSPP and interested parties to educate the public in safe and responsible ways through feature stories, editorials and other venues where media can help to promote suicide prevention and help-seeking behaviors.

Objective 9.1: Increase the number of media representatives in Maine who are knowledgeable about safe reporting practices regarding suicide and media contagion.

Population Focus:

Members of all types of media and program partners statewide

Rationale:

There is considerable evidence that some suicide reporting practices in the mass media, including newspaper articles, may contribute to an increase in the number of suicides.⁹² Publicizing graphic and repetitive representations of suicides (including the method used and how obtained), and glorifying the suicide victim appear to increase the actual number of suicides by the "copycat effect",⁹³ a well-researched form of behavior contagion. Research consistently finds a strong relationship between reports of suicide in the media and subsequent increases in suicide rates. Since 1990, the effect of media coverage on suicide rates has been documented in many countries, including the United States. These effects show that the risk of suicide following exposure to another person's suicide was 2 to 4 times higher among 15 to 19 year-olds than among other age groups.⁹⁴

⁹¹ National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. 2001.

⁹² Gould, M., Jamieson, P., Romer, D. Media Contagion and Suicide Among the Young. *American Behavioral Scientists*, Volume 46, Number 9, May. 2003.

⁹³ Coleman, L. The Copycat Effect: How the Media and Popular Culture Trigger the Mayhem in Tomorrow's Headlines. 2004.

⁹⁴ Gould, M., Jamieson, P., Romer, D. Media Contagion and Suicide Among the Young. *American Behavioral Scientists*, Volume 46, Number 9, May. 2003.

Since the media strongly influences community attitudes, beliefs and behaviors, and plays a vital role in politics, economics and social practice, it is important to understand the impact that reporting on suicide can have. Research shows that use of phrases like “successful suicides” and “failed attempts” can have detrimental effects.⁹⁵ This use of language gives the message that to kill oneself is a “success” and that a non-fatal attempt is a “failure.” The verb “committed” is usually associated with sins or crimes. Suicide is better understood in a behavioral health context than a criminal context.⁹⁶ If the media were to consistently follow the guidelines set by the American Foundation for Suicide Prevention, it is thought that not only would suicide contagion decrease, but the amount of negative stigma around suicide and mental illness would decrease as well.

Mass media play a significant role in today’s society by providing a wide range of information in a variety of ways. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances.⁹⁷ They can also highlight opportunities to prevent suicide by promoting the use of behavioral health services as a part of overall healthcare and providing information on where to get help. The more people are aware that suicide is a public health problem and that help is available, the more effective suicide prevention in Maine will be.

Lead Department:

- DHHS:
 - Commissioner’s Office
 - Maine CDC
 - OSA

Potential Partners:

- Representatives of print, television and radio media
- Local suicide prevention partners
- AFSP, Maine Chapter
- Suicide survivors
- Behavioral health and suicide prevention experts
- Schools of journalism and broadcasting

Objective 9.2: Increase the number of stories in print and electronic media about suicidal behavior, mental illness and related issues that use accurate and responsible depictions and promote help-seeking behavior.

⁹⁵ Suicide and the Media: A study of the media response to *Suicide and the Media: The Reporting and Portrayal of Suicide in the Media, A Resource*. Jim Tully and Nadia Elsaka School of Political Science and Communication University of Canterbury 2004.

⁹⁶ At-a-Glance: Safe Reporting on Suicide. Suicide Prevention Resource Center. http://www.sprc.org/library/at_a_glance.pdf August 9, 2005.

⁹⁷ Reporting on Suicide: Recommendations for the Media. Centers for Disease Control and Prevention National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, Annenberg Public Policy Center. <<http://www.afsp.org/education/recommendations/5/index.html>>

Population Focus:

Members of all types of media and program partners statewide

Rationale:

Working with media representatives to utilize safe reporting practices creates opportunities for media representatives to develop interesting stories, meet their needs and prevent unintended consequences of unsafe reporting.

Increased knowledge about mental health and substance abuse issues among media representatives allows for the dissemination of accurate reports. Accurate print and electronic media leads to an increased public knowledge and understanding of the issues surrounding suicide.

Not only are knowledge and understanding key factors in suicide prevention, but promoting help-seeking behaviors is also critically important. The media has tremendous potential to take on this role as it reaches a large portion of the public. When print and electronic media promote the message that behavioral health services are a part of overall healthcare and disseminate information on available resources to the public, the general awareness of suicide prevention strategies and available helping resources is heightened.

Lead Department:

- DHHS:
 - Commissioner's Office
 - Maine CDC
 - OSA

Potential Partners:

- Suicide survivors
- Suicide prevention experts
- MYSPP Steering Committee
- NAMI Maine
- AFSP, Maine Chapter
- Media personnel
- Partner communities

Objective 9.3: Increase understanding of the key issues surrounding media contagion through education and technical assistance to participants of MYSPP training and education programs.

Population Focus:

Training/education program participants statewide

Rationale:

When a youth suicide occurs, news reporters often seek comments from those closest to the victim. It is important that school staff and other community based gatekeepers are prepared to respond in ways that are respectful of surviving family, friends and

community members by using sensitive language and promoting the available helping resources.

In order for people to respond appropriately, it is essential that they are not only given guidelines to help ensure accuracy and sensitivity after a youth suicide occurs, but receive education on how and why to utilize them.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Contracted Trainers
- NAMI Maine
- AFSP, Maine Chapter
- Maine and national experts in suicide prevention
- Partner organizations and communities statewide
- Media
- Local community-based organizations

Maine Youth Suicide Prevention Program (MYSPP) Goal 10

Improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.

Background:

Availability of quality data is critical for monitoring trends, establishing risk factors and evaluating the impact of program interventions. However, suicide and self-inflicted injury reporting is not always consistent, may not be accurate, and complete information on suicide death or attempts is not consistently available in current data collection systems.

MYSPP currently monitors suicide using the death certificate database maintained by Maine's Office of Data, Research and Vital Statistics (ODRVS). This information is supplemented by information from Maine's Office of the Chief Medical Examiner (OCME). Information on self-inflicted injuries comes from inpatient and outpatient hospitalization data. Data on self-reported suicidal ideation and behavior are obtained from the Maine Youth Risk Behavior Survey (YRBS) and the Behavioral Risk Factor Surveillance System (BRFSS).

It is important to strengthen and improve suicide surveillance practices so that suicide mortality (death certificates), morbidity (hospital discharge) and risk factor (YRBS and BRFSS) data for Maine residents are routinely collected, analyzed, interpreted, disseminated and utilized in prevention programming to reduce the occurrence of suicide and suicide attempts in Maine. For example, the hospital discharge database records all discharges in Maine's 39 non-federal hospitals. Suicide attempts are included in the E-codes for intentional self-harm. However, E-coding is optional and rates of E-coding vary by hospital. This variability makes it difficult to draw conclusions about geographic differences in the rates of intentional self-injury.

In addition, demographic data including education, income, and race/ethnicity are not available in the hospital discharge database, making it difficult to use these data to identify those at highest risk. By seeking to improve e-coding rates, our understanding of intentional self-injury will be enhanced.

Description:

Objectives under this goal are designed to enhance the quality, collection, analysis and use of data describing suicide and suicidal behaviors utilizing multiple datasets. To develop these objectives, a Data Committee met and worked together using Goal 11 of the National Strategy for Suicide Prevention which calls for improved collection and tracking of suicidal behaviors. Other proposed enhancements to the current system include: maintaining ongoing self-report information on suicide ideation and related risk factors among youth and young adults; helping schools develop data systems for the early identification of high-risk youth; improving the quality of medical examiner data in suicide deaths; and developing linked data and systems and conducting in-depth analyses

to help increase our collective understanding of the factors that precipitate a suicide death.

Objective 10.1: Utilizing the MYSPP Suicidal Behavior Surveillance Plan, continue to improve and maintain the collection, analysis and dissemination of suicide and self-injury data to guide the focus and direction of suicide prevention efforts.

Population Focus:

Data sources, Epidemiology support and program stakeholders

Rationale:

Access to accurate information about the circumstances contributing to suicides is needed to improve understanding of fatal and non-fatal suicidal behaviors among Maine youth. By increasing the quality and accessibility of data through more timely collection, in-depth analysis and interpretation, more effective prevention and intervention activities can be designed. Routine dissemination of data to policymakers and the public can raise awareness of the nature of youth suicide in our state. With funding from the Centers for Disease Control and Prevention (CDC), Division of Disability Outcomes and Programs, from 2002-2006, the MYSPP reviewed suicide surveillance databases and analyzed suicide and self-inflicted injury data. In 2005, a surveillance system was developed for the ongoing systematic collection of data on suicidal behavior to monitor trends and guide policy and program decisions. A suicide surveillance report was issued and disseminated in 2006. Ongoing utilization of and improvements to the MYSPP Suicidal Behavior Surveillance System are necessary to monitor trends and the impact of program activities.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- DHHS:
 - Maine CDC
 - Epidemiology Support
 - Office of Data, Research & Vital Statistics (ODRVS)
- Office of the Chief Medical Examiner
- Maine Health Data Organization
- Maine Hospital Association
- Association of Health Records Coders

Objective 10.2: (a) Maintain on-going collection of survey data on suicide risk and related factors among youth in school systems and young adults (b) Develop and implement procedures to use the data collected from these systems to guide program and policy decisions.

Population Focus:

Children's Cabinet agency staff, policymakers, agencies and schools with an interest in gathering or utilizing these data

Rationale:

Survey data are used to assess the prevalence of suicide ideation and self-reported suicide attempts. Despite many of the limitations inherent in self-report surveys, they are one of the few sources of data on adolescent mental health, suicide ideation, and related risk factors. In addition, many suicide attempts that do not require medical attention may only be captured through a survey. Therefore, it is critical that MYSPP continue to play an active role in the development and implementation of Maine youth and adult health surveys.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Maine CDC Epidemiology Support
- Children's Cabinet agency data staff

Objective 10.3: Assist local schools to increase the early detection of students at risk by piloting a systematic method of collecting and analyzing available school data.

Population Focus:

Public and private schools statewide

Rationale:

MYSPP leaders and program partners strongly believe that early identification of at-risk students can facilitate important connections to helping resources in local communities. It is an important way to further reduce youth suicide in our state. Maine school systems face multiple challenges in identifying and referring at-risk youth. Through federal funding, the MYSPP has worked with local high schools to pilot a school-based data system to increase the early identification of at risk students who need referrals for services.

Lead Department:

- DHHS, Maine CDC
- DOE, SAT

Potential Partners:

- Maine schools piloting the data tickler system
- Project Evaluators
- DHHS, CBHS
- Keeping Maine's Children Connected Initiative
- UMO Center for Community Inclusion, Childlink

Objective 10.4: Increase the quality and accessibility of Medical Examiner suicide data to the MYSPP on youth up to age 24.

Population Focus:

Police, funeral directors and local Medical Examiners

Rationale:

While medical examiners, coroners and police officers often collect valuable information about the circumstances surrounding a suicide death, the information typically remains inaccessible in case folders and filing drawers. The public health approach to injury prevention is evidence-based. It pools information about the “who, when, where and how” of all incidents to better understand the “why.”⁹⁸ Only with the detailed data from a comprehensive set of sources can we better understand the nature of the youth suicide problem in Maine and thus inform prevention activities.

Lead Department:

- Maine Attorney General’s Office, Office of the Chief Medical Examiner

Potential Partners:

- DHHS, Maine CDC
- DHHS, Maine CDC Epidemiology Support

Objective 10.5: Expand and enhance the Maine Child Death and Serious Injury Review Panel process to increase understanding of the risk factors associated with violent child deaths and serious injuries.

Population Focus:

Maine Child Death and Serious Injury Review Panel members

Rationale:

The Maine Child Death and Serious Injury Review Panel reviews selected violent child death and serious injury cases on a monthly basis. The mission of the panel is to provide a multidisciplinary, comprehensive case review of child fatalities and serious injuries in children. The purpose is promoting prevention, increasing the responsiveness of the child protective system, and fostering education of both professionals and the public. Currently, the Panel reviews selected child deaths up to age 18 that appear to be related to child abuse and/or neglect. These reviews may be initiated by the Commissioner of the DHHS, the Office of Child and Family Services, or by any Panel member. The Panel serves as a citizen review panel for the DHHS as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247. The state statute permits confidentiality of the Panel’s work and grants the Panel the power to subpoena relevant case documentation and testimony. The Panel is therefore able to conduct in-depth retrospective reviews of all

⁹⁸ A Public Health Approach to Preventing Suicide. Harvard Injury Control Research Center and the American Association of Suicidology. June 2003.

relevant records, which is supplemented by oral presentations by involved service providers.

While the Panel has investigated some child and teen suicides, 75 percent of the cases reviewed are children under the age of five. Even when suicides are investigated, this information is not made available to inform prevention activities. During the past year, the Child Death Review Panel has enhanced its' reviews and reports to become more systematic and uniform. Also, the new Maternal and Infant Mortality and Resiliency Review Panel, which had its first meeting in July 2007, has representation from the Child Death Review Panel. *These developments substantially enrich the potential for policy and system change.* In addition to strengthening the review process, expanding and enhancing the Maine Child Death and Serious Injury Review Panel could enable the panel to include all violent deaths to children to age 18. As a result, valuable new information about child deaths from suicides, homicides, and firearms that are not related to child abuse would be gained. This information is of vital importance in the design and implementation of best practices to prevent violent child deaths.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Child Death Review Panel
- Maine CDC
- Maine CDC Epidemiology Support

Objective 10.6: Conduct specialized studies to examine in depth, specific issues in youth suicide when resources permit.

Population Focus:

Epidemiology staff and program stakeholders

Rationale:

Surveillance does not provide in-depth analysis addressing specific questions. For that reason, it can never replace well-conducted, specialized studies to examine more complicated dynamics of a specific issue in a population.

Lead Department:

- DHHS, Maine CDC

Potential Partners:

- Maine CDC
- Maine CDC Epidemiology Support

Maine Youth Suicide Prevention Program Plan Appendices

Governor Baldacci Executive Order

Glossary of Terms

Public Health Approach to Suicide Prevention

AN ORDER TO STRENGTHEN MAINE'S YOUTH SUICIDE PREVENTION EFFORTS

WHEREAS, the health and safety of Maine's young people is of utmost importance to the health of our state; and

WHEREAS, suicide is the second leading cause of death for Maine's young people aged 15-24, taking a total of 115 young lives from 1998-2002, an average of 23 each year; and

WHEREAS, the suicide rate among Maine youth is 50percent above the national average, the eighth highest in the country and the highest in New England; and

WHEREAS, every child's death is a tragedy and suicide claims more young people's lives than homicide, cancer, heart disease, AIDS and birth defects combined; and

WHEREAS, it is estimated that for every young life claimed by suicide there are up to 100 non-fatal suicide attempts by youth; and

WHEREAS, in any given high school classroom, it is likely that there are two female and one male student who are actually contemplating taking their lives; and

WHEREAS, with advanced planning, training and education, school personnel and students can play a significant role in identifying and assisting suicidal students; and

WHEREAS, increasing public awareness of suicide warning signs and how to recognize and respond effectively to suicidal behavior can save lives; and

WHEREAS, the loss of a friend or loved one to suicide is one of the most devastating events that can be suffered by Maine families and communities; and

WHEREAS, it is incumbent upon State government to provide leadership as well as resources to address preventable health problems;

NOW, THEREFORE, I, John E. Baldacci, Governor of the State of Maine, do hereby declare that Maine's youth suicide prevention efforts be strengthened, and by the authority vested in me, do hereby order that:

1. The Commissioners of the agencies appointed to the Governor's Children's Cabinet shall:
 - Assign specific staff persons to participate in a strategic planning process in order to:
 - i. Update and revise the statewide Maine Youth Suicide Prevention Program (MYSPP) implementation plan, which shall include roles and responsibilities for each Department represented on the Children's Cabinet;
 - ii. Outline strategies to improve the quality and accessibility of data pertaining to suicide and self-injury, within the revised implementation plan;
 - iii. Submit the revised MYSPP statewide implementation plan to the Office of the Governor by August 31, 2005; and
 - iv. Assess and propose regulatory or legislative actions that are likely to contribute to the reduction of youth suicide and suicide attempts.
 - Identify and seek financial resources to support the activities of the revised statewide MYSPP plan priorities.
2. The Department of Health and Human Services, Bureau of Health shall continue to provide leadership to the MYSPP in collaboration with the agencies that participate in the Governor's Children's Cabinet.
3. These agencies shall form partnerships with members of the private sector including service providers, suicide survivors and youth organizations to strengthen Maine's efforts to prevent youth suicide.

Implementation Costs:

The costs for implementing the tasks included in this Executive Order shall be absorbed by the participating agencies.

Effective Date:

The effective date of this Executive Order is February 18, 2005.

John E. Baldacci, Governor

Glossary of Terms Used in MYSPP Plan

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.

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.

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.

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

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.

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

Governor's Children Cabinet: The Commissioners (or his/her designee) of Departments of State government that provide services to youth and their families. Those Departments are Corrections, Education, Health and Human Services, Labor, and Public Safety. The Children's Cabinet is chaired by the First Lady.

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.

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, 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.

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).

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

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.

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.

Morbidity: The relative frequency of illness or injury, or the illness for injury rate, in a community or population.

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

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.

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

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.)

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 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.

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.

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).

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.

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.

Teens: Persons aged 13-19.

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.

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.

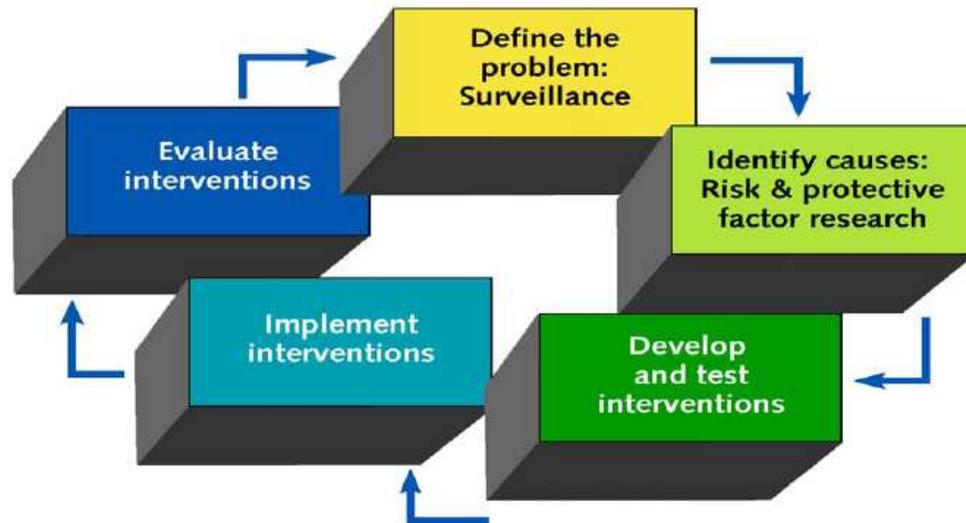


Suicide Prevention: The Public Health Approach

The National Strategy for Suicide Prevention advocates a public health approach to suicide prevention. Public health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.

The public health approach is widely regarded as the approach that is mostly likely to produce significant and sustained reductions in suicide. It uses five basic evidence-based¹ steps in a systematic way. These steps are applicable to any health problem that threatens substantial portions of a group or population.

The Public Health Approach to Prevention



The steps may be sequential, or overlap. For example, the techniques used to define the problem, such as determining the frequency with which a particular problem arises in a community, may be used in assessing the overall effectiveness of prevention programs. Evaluating interventions must be built into implementation, and information gained from evaluations should guide the development of new interventions.

This document has been published by the Suicide Prevention Resource Center at EDC as a collection of resources, promising initiatives and other helpful information on the subject of suicide prevention. It is the reader's sole responsibility to determine whether any of the information contained in these materials is useful to them. This material is based upon work supported by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration under grant No. 1 U79 SM55029-01. Any opinions, findings and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

¹ Evidence-based: Programs that have undergone scientific evaluation and have proven to be effective.

Suicide Prevention: The Public Health Approach

Applying the Public Health Approach to Suicide Prevention

1. Define the problem: Surveillance²

Suicide Surveillance – Collecting information about the rates of suicidal behaviors³. This can include the collection of information about individuals who attempt or die by suicide, their circumstances, and the effects on others. Data on suicidal behavior is available from the Centers for Disease Control and Prevention at <http://www.cdc.gov/nchs/fastats/suicide.htm>. (See the SPRC fact sheet, “Sources of Data on Suicidal Behavior,” for sources of data on your state, territory or community.)

2. Identify causes

Suicide is best understood as a very complex human behavior, with no single determining cause. The factors that affect the likelihood of a person attempting or completing suicide are known as *risk⁴* or *protective⁵* factors, depending on whether they raise or lower the likelihood of suicidal behavior. Risk factors include mental illness and loss of a loved one. Protective factors include support networks and access to mental health care.

While people who attempt or complete suicide typically experience a combination of risk factors, there is often one precipitating factor that leads the person to attempt suicide. However, a person with many risk factors may not attempt to commit suicide if his or her risk factors are balanced by protective factors.

3. Develop and test interventions

Interventions might attempt to influence some combination of psychological state, physical environment, and cultural conditions. It is important to test intervention methods to ensure that they are safe, ethical, and feasible. Interventions that are successful in one setting may not be universally applicable. Comprehensive suicide prevention programs are believed to have a greater likelihood of reducing the suicide rate than are interventions that address only one risk or protective factor. Collaboration between community leaders and coalitions that cut across traditionally separate sectors can increase effectiveness.

Formative evaluation, including pre-testing, permits necessary revisions before the full effort goes forward. Its purpose is to maximize success of the program prior to implementation. Thorough consideration needs to be given to the possibility of increase in demand for services that do not exist in the community.

² Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

³ Suicidal behaviors: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

⁴ Risk factors make it *more* likely that individuals will develop a disorder; they may include biological, psychological, or social factors in the individual, family, and environment.

⁵ Protective factors that make it *less* likely that individuals will develop a disorder; they may include biological, psychological, or social factors in the individual, family, and environment.





Department of Health and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

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IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Maine would request the following technical assistance:

- What approaches are most effective in working toward integration with primary care?
- Request facilitation of a process to develop a Data Strategic Plan that includes Health Information Technology/Electronic Health Record.
- With the separation of the various block grants, there exists a “mine and yours” mentality that flies in the face of integration. What can SAMHSA offer to help states conform to what is considered best practice? Can the data requirements be comparable? The reporting requirements? There is a fear (resistance) to blending the resources and treating the person as a whole when faced with accountability of how and what the funds were used for.

Maine has been working with other New England states to share information and some resources. With our new project officer, there has been great contact and follow-up to questions we have had since the ACA passed and with the new SAPTBG application. It would be beneficial to have more contact with the NE ATTC for workforce development and blending products and pool resources from states to apply for grants and enhance the use of EBP. Develop Cross-state Learning Collaboratives through teleconference as we have done through the COSIG grant.

Maine has a coordinating body responsible for the development of a statewide HIT strategy and the Department’s Health and Human Services Commissioner is a member (SSA/SMHA are under this Commissioner). From the Governor’s Office two entities were appointed with responsibility for expanding and coordinating Health Information Technology. The first is the Office of the State Coordinator for HIT (appointed through the “recovery act”) which operates within the Governor’s Office of Health Policy and Finance. The second is the Governor appointed “Health Information Technology Steering committee” made up of the following members: Director, Governor’s Office of Health Policy & Finance; Commissioner of the Department of Health and Human Services; Commissioner of the Department of Professional and Financial Regulation; Superintendent of Insurance; Director of the Dirigo Health Agency; Director of health information exchange organization; and individuals representing or with expertise in hospital systems, health care providers, home health providers, FQHC’s, health care quality, behavioral health provider, insurance industry, business, health care data information, University/college system, racial and ethnic minority communities, and a health law or health policy expert.

Maine is in the process of developing policies, standards, and technical protocols governing the HIT infrastructure. The SSA is engaged in conversations with the provider association and community to ensure they are developing the capacity to be able to fully participate in future reimbursement and data reporting systems.

The provider association, with the support of the SSA is engaged in a technical assistance project with NIATx (Network for Improving Addiction Treatment). This project with tailored to help providers ready themselves for the changes related to the healthcare reform.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

The efforts engage individuals and families in developing, implementing and monitoring that state substance abuse treatment system have been sporadic. There are very few individual and families that have been comfortable enough with disclosure to heighten their visibility by working with the State Office of Substance Abuse. Additionally, once an individual and/or family are engaged there are often other barriers that impact their ongoing involvement.

The Maine Alliance for Addiction and Recovery and their array of recovery communities across the state routinely involve recovering members in the discussions of increasing the development and access to recovery oriented services.

Through the subcontract with the Maine Alliance of Addiction and Recovery ongoing communication and scheduled trainings for the recovering community occur. This is inclusive of adults and family members currently. Additional work is necessary to address the under 18 population.

Routinely scheduled meetings and event discuss and strategize how to meet the needs of individuals and families, but rarely does it involve individuals or families directly. This is an area in which OSA and the SUD field needs to improve upon. OSA conducts an Annual Client Satisfaction Survey, but this yields satisfaction only among the client/individual population.

This varies agency by agency as well as by the willingness of the individual being served. All providers are oriented to the research and are encouraged to access the family in the treatment episode and beyond

OSA has on staff a position that acts as a liaison with the Maine Alliance for Addiction and Recovery to support activities and communication with the recovering community. Representative tasks are outlined below:

- Provide contract monitoring and oversight;
- Assist treatment providers with training, implementation, quality assurance, and treatment program integrity issues;
- Conducts site visits to monitor program implementation and performance;
- Provide technical assistance and support to treatment providers regarding licensing, contracting requirements and re-imburement,
- Assist the Treatment Manager in the development and implementation of comprehensive continuum of substance abuse treatment services for adolescents and adults statewide;
- Provide consultation and support to treatment providers and programs;
- Coordinate relevant training and ongoing staff development programs to support treatment providers working with the adolescent and adult population;
- Liaison to the Maine Alliance for Addiction Recovery (recovery support services)
- Medication Assisted Recovery development.
- Represent OSA at meetings, trainings, review teams, and public events as directed.

In addition, OSA funds the Maine Alliance for Addiction and Recovery to help strengthen and expand recovery opportunities throughout the state. The goals of this organization are listed below:

- MAAR speaks for and represents Maine citizens and organizations that support the mission of the organization.
- MAAR will continue to develop and facilitate the maintenance and growth of the statewide Maine Recovery Communities Coalition
- MAAR will provide education and technical assistance to develop recovery support services throughout the State.
- MAAR maintains an active and representative Advisory Committee including members from all regions of the state. This Committee meets monthly at the MASAP headquarters in Augusta.
- MAAR coordinates and implements Recovery Month activities annually during the month of September and other recovery events throughout the year.

- The MAAR Coordinator and Peer Recovery Support Specialist will assist in the development, in collaboration with the Office of Substance Abuse, MASAP and its members, the MAAR Advisory Committee and statewide MAAR membership, of a statewide infrastructure to implement a Maine Recovery Oriented System of Care
- The MAAR Coordinator will have administrative oversight for the development, implementation and ongoing supervision of the Portland Recovery Center.
- The MAAR Peer Recovery Support Specialist will function as the statewide Coordinator and co-Trainer for the peer recovery support models developed by MAAR, including Recovering Women's Leadership Training and Recovery Coaches.
- The MAAR Peer Recovery Support Specialist will facilitate All Recovery support meetings in Augusta and develop, with the MAAR Coordinator, additional All Recovery support meetings throughout Maine.
- The MAAR Recovery Support Specialist will serve as co-trainer and staff support person for the Maine Recovery Coach Academy
- MASAP maintains a 1 FTE MAAR Coordinator and 0.5 FTE MAAR Peer Recovery Support Specialist for purposes of developing, managing and promoting the organization.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

Nothing to report at this time.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

OSA required, in contract, that all treatment providers become co-occurring capable by June, 2011. We continue to provide outreach, technical assistance and training to treatment providers on integrated care. Over time, the models being developed in current pilot projects on integrated primary and behavioral health will be implemented as a matter of course in more practices across the state. Maine is currently looking to develop Health homes and provisions for Special Populations in lieu of high risk pools.

Maine SSA staff work in tandem with other Departmental Offices (Office of Adult Mental Health, Office of Elder Services, Office of Cognitive and Physical Disabilities, and the Office of Child and Family Services) on a committee called the Complex Case Group. This group brings forth cases that have multiple levels of service needs, but any one need will not meet criteria for eligibility for a service within an office. It is the culmination of all the needs that delineates the complex case. The SSA serves on the Adult Services Consortium (ASC) and information of cases resolved/unresolved by the Complex Case Group are reported to this committee. It is the role of the ASC to help with policy change to support access to services for these complex clients in our behavioral health system, thus reducing overall costs and providing integrated care.

OSA has been at the table as capacity allows being an integral part of the planning process with health care reform in our state. The depth and intricate nature of the law leaves us having to prioritize our involvement at each and every level.

OSA's Director, Guy Cousins, is involved with the initiative "Money Follows the Person". OSA is part of the Managed Care Design committee (Medicaid 1915i) that is working on a request for proposal for this service infrastructure in Maine. Through the design process, the discussion of Health Homes is being considered as an effective concept that is all inclusive. Discussion has not occurred where these have been split in two categories such as serious mental illness, children with serious emotional disturbance, individuals with SA disorders, or individuals with Co-occurring disorders.

OSA worked with the Maine Health Access Foundation on the Integration Initiative Policy Committee and the development of a policy work plan which will enhance support for integrated behavioral health and primary care in Maine.

OSA has been working collaboratively with the Maine National Guard and the Veteran's Administration to ensure services are provided in a culturally sensitive and appropriate way. Maine SSA staff is invited to the table and actively participates in development of appropriate resources to our military service member and their families. A member of the Maine National Guard is an active member of the Prevention Team at OSA, regularly attending staff meetings and providing coordination of prevention services in Maine.

OSA has a close working relationship with the Department of Corrections, including community based, county jail system and the institutions. Access to primary care has been problematic for these individuals as they reenter the community for two reasons; lack of capacity of primary healthcare physicians and being uninsured. Efforts are underway, as part of case planning to secure these pieces prior to release.

OSA prevention and treatment staff collaborate to coordinate SA education to other Department staff, including all regional offices of the Office of Child and Family Services.

OSA collaborates with the Maine Center for Disease Control and Prevention, braiding contracting funds to Maine's public health infrastructure - Healthy Maine Partnership coalitions statewide, which work to address obesity, substance abuse, and chronic disease related to or affected by tobacco use. This partnership leverages strong local relationships statewide to integrate substance abuse prevention messages into a variety of activities.

OSA prevention has a strong partnership with the Department of Corrections and

Department of Public Safety, as well as law enforcement agencies statewide in regards to the work of the Enforcing Underage Drinking Laws grant from OJJDP. OSA is currently working on a statewide strategic plan with partners as a result of a three-year discretionary award. This planning process and resultant implementation steps will strengthen these relationships. This process is also identifying ways to increase our collaboration with the judicial system in Maine.

OSA collaborates with the Office of the Attorney General and the Maine CDC&P to carry out the requirements of the SYNAR Amendment. This long-standing partnership has ensured that Maine has been well under the non-compliance rate since the beginning of this work. Maine also is a recipient of an FDA contract to conduct additional inspections, and this work is well coordinated with the SYNAR work for seamless reporting.

OSA has been the administrator of the Department of Education's Safe and Drug-Free Schools and Communities Act funding since its inception. This has ensured a strong collaboration with the Department of Education. For the 2011 year, OSA and DOE are administering the Building State Capacities grant, which is an opportunity to bring together state partners to plan future support of substance abuse and violence prevention in the schools. OSA also has a strong working relationship with Coordinated School Health, integrating work on substance abuse prevention and policy in the schools in Maine.

The Maine Youth Suicide Prevention Program is a multi-department initiative coordinated by the Maine CDC. OSA serves as the clearinghouse for this project and works with advising bodies to coordinate services and initiatives.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

Nothing to submit at this time.

IV: Narrative Plan

Table 11 List of Advisory Council Members

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Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	0	
Individuals in Recovery (from Mental Illness and Addictions)	0	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	0	0%
State Employees	0	
Providers	0	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	0	0%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

with time limitations of drafting this plan for the submission deadline, OSA will submit this plan and at the same time start a feedback process. OSA commits to the following:

By 10/31/11 OSA will post the drafted plan on the OSA website and solicit feedback via survey monkey - linked both off the OSA website and sent to a variety of listservs to ensure reach of providers statewide.

By 8/31/2012, OSA will solicit feedback about the prevention components of this and other prevention plans in order to complete the 5-year strategic prevention plan as part of the SPF State Prevention Enhancement grant.

By 9/30/12, OSA will update this plan based on feedback generated.