Maine Youth Suicide Prevention

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

December 2005

Report To Governor John E. Baldacci

In Response to

Executive Order 33 FY405
To Strengthen the Maine Youth Suicide Prevention Program

Submitted by the staff and committee members of the
Maine Youth Suicide Prevention Program to the Maine Children's Cabinet

TABLE OF CONTENTS

Executive Summary

A strong public health approach to the prevention of youth suicide is essential to its success. Governor Baldacci's call to his Children's Cabinet to strengthen the Maine Youth Suicide Prevention Program (MYSPP) plan comes at a time when the field of suicide prevention is still relatively new. However, a growing body of evidence regarding effective programs and treatments concludes that a reduction in the rate of suicide is, in fact, possible. In the past decade in the United States, suicide prevention has been widely recognized as a public health problem requiring national attention and urgent action. In the 2001 National Strategy for Suicide Prevention, the U.S. Surgeon General emphasized that suicide is a major public health problem, which can only be addressed through an integrated effort by government, public health, education, human services and other public and private partners. Further, in 2003, the President's New Freedom Report, "Achieving the Promise: Transforming Mental Health Care in America," included suicide prevention in the first of six goals for the nation and in 2004, Congress passed the Garrett Lee Smith Memorial Act to provide new federal funding for youth suicide prevention. In September 2005, Maine was awarded one of fourteen grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three year project.

A public health approach has led to a reduction in loss of life from numerous health threats, such as heart disease, and is a useful model for suicide prevention. Like heart disease, the risk and protective factors for suicidal behavior are widely known. Just as heart disease is now understood as a public health problem that results from a combination of different kinds of risk factors, suicide is also a complex health condition with various contributing factors. The odds of developing heart disease are lowest when prevention is comprehensive and starts early in life. Similarly, suicidal behaviors are least likely to develop when there is widespread public awareness and prevention and early intervention services are accessible. Preventing suicide requires a comprehensive approach addressing social, behavioral, and psychiatric risk and protective factors.

For a variety of reasons, many people do not believe that suicide is a problem that could affect them or their community. Myths regarding suicide abound. Many people believe that talking about suicide will cause it when it may be exactly what is needed.[1] Many are unaware of suicide warning signs or how to respond to them.[2] Although there is no single profile, most suicidal individuals do give definite warnings of their suicidal intentions. Tragically, people do not know how to recognize these signs or they do not know how to respond in ways that are helpful. Thus, it is important for everyone to have a basic understanding of the risks and warning signs and how to respond effectively. *Recognizing and responding appropriately to suicidal individuals can and has saved lives.*

In addition to a widespread lack of public awareness, other deeply rooted systemic factors make it difficult to prevent suicide. Mental illness, which often begins in early adolescence and may have even earlier manifestations, frequently underlies suicidal behavior. Many suicide victims suffered from conditions that have high mortality rates. For instance, an estimated 10 to 20% of

[1] Madelyn S. Gould, PhD, MPH; Frank A. Marrocco, PhD; Marjorie Kleinman, MS; John Graham Thomas, BS; Katherine Mostkoff, CSW; Jean Cote, CSW; Mark Davies, MPH Evaluating Iatrogenic Risk of Youth Suicide Screening Programs A Randomized Controlled Trial. *JAMA.* 2005;293:1635-1643.

[2] American Association of Suicidology. Understanding and Helping the Suicidal Individual. www.suicidology.org.

persons with depression, bipolar illness, and schizophrenia will die by suicide.[3] Up to 90% of youth 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.[4] Early diagnosis and treatment are vital.

However, the stigma of having a mental illness can keep people from getting the help they need to recover.[5] Mental health is a critical component of a child's health and ability to learn and grow.[6] Bullying, harassment, and discrimination toward sexual and cultural minorities also stigmatize specific groups and keep them from seeking help.[7] Another systemic problem in Maine, as in the nation, is the lack of timely access to appropriate help including, but not limited to, mental health services.

It is clear that some youth suicides are impulsive in nature and facilitated by easy access to lethal means. For many youth, a suicidal crisis can be very brief, lasting from a few hours to a few days. Access to lethal means, particularly firearms, in the environment of a vulnerable individual is strongly associated with suicide.[8] [9] Because of this, removing access to lethal means is a very important strategy that can prevent an impulsive act of desperation from ending in tragedy.

Suicidal behavior is complex - 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. When someone is suicidal, it is usually due to a combination of external stressors, internal conflicts and/or biological dysfunction. Trauma, depression, anxiety, conduct disorders, substance abuse, and lack of personal skills or supportive resources all contribute to the possibility of suicide, but they do not, by themselves, cause suicide.[10] Early prevention, intervention, and treatment, which address these factors, can reduce suicide attempts. *Suicide is not always preventable, but suicide prevention is ALWAYS worth trying.*

Maine, like the nation, has made progress, yet the rate of youth suicide has declined only slightly. MYSPP activities, including education, training, public awareness, guidelines for schools, improved data collection, and programs for at-risk youth have yielded concrete interim results. 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.* Youth suicide can be prevented through

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[3] National Strategy for Suicide Prevention, A Collaborative Effort of SAMHSA, CDC, NIH, HRSA, and HIS. Suicide, Some Answers. Mental Illness and Suicide – Facts. http://www mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp 4 Aug 2005.

[4] Archives of General Psychiatry/"Psychiatric Diagnosis in Child and Adolescent Suicide" D. Shaffer, M.S. Gould, P. Fisher et al. vol. 53 No. 4, April 1996

[5] US DHHS (U.S. Department of Health and Human Services). 1999. *Mental Health: A Report of the Surgeon General.* Rockville, MD: 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.

[6] Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, Department of Health and Human Services in collaboration with the Department of Education and the Department of Justice.

[7] Goldsmith, SK., TC Pellmar, AM Keinman, WE Bunney. Reducing Suicide, A National Imperative. The National Academies Press, Washington, D.C. 2002.

[8] The Maine Youth Suicide Prevention Program. Maine Office of Data, Research & Vital Statistics, Maine Hospital Discharge Data and Outpatient Databases and Maine YRBS. (March 2005). *Maine Youth Suicide Fact Sheet*

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

[10] Coleman, Loren. Susan O'Halloran. Preventing Youth Suicide through Gatekeeper Training. 8th edition, 2004.

coordinated efforts and active partnerships involving government, communities, schools, employers, families, and youth. With the issuance of Governor Baldacci's Executive Order to strengthen the program plan, and the positive response received from the Children's Cabinet, the work to strengthen youth suicide prevention activities in Maine has now begun.

This report outlines a strategic expansion of the program that includes:

1) Strengthening participation in implementing MYSPP activities among all Children's Cabinet agencies;
2) Increasing partnerships with key stakeholders outside of state government;
3) Strengthening efforts to include high-risk and particularly vulnerable communities and culturally sensitive populations in planning and implementing program components;
4) Planning for and obtaining funding for new initiatives to increase protective factors and reduce risk factors; and
5) Improving our capacity to collect and analyze data to monitor the health status of our youth, and guide the development and evaluation of our initiatives.

The report contains a workplan outlining current MYSPP activities and those activities to be implemented with increased leadership and participation from Children's Cabinet agencies. Activities to be implemented in three Maine counties, Knox, Piscataquis, and Sagadahoc, through the SAMHSA grant are also outlined. A program evaluation plan for these activities is in development. Further work is necessary to develop a long-term workplan and this will be accomplished by the MYSPP through the Steering and sub-committees to the program.

Maine Youth Suicide Prevention Program History:

The MYSPP is an initiative of the Governor's Children's Cabinet. It is based upon the assumption that collaboration among state agency leaders and staff with significant input from service providers, youth, suicide survivors and others is necessary to plan and conduct youth suicide prevention, intervention and postvention* activities. The MYSPP is housed within, and directed by, staff of the Maine Center for Disease Control and Prevention in the Department of Health and Human Services.

The original program plan was created in 1997 and involved an extensive process that included input from suicide survivors, youth, and a wide variety of clinicians and professionals from around the state. 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 and each agency assumed leadership in implementing specific portions of the plan. In 1999, the Children's Cabinet provided some start-up funds to initiate program activities.

Since inception, the program has been guided by a diverse Steering Committee, with government and private stakeholders, which provides guidance and direction to program development and implementation. For the first seven years of the program, the MYSPP "Action Committee," representing staff members of Children's Cabinet agencies that were charged with implementing and coordinating specific plan activities, met regularly. This group worked to implement and sustain a state level infrastructure. Many activities in the initial 1998 plan are still being implemented.

**Note: postvention refers to a strategy or approach that is implemented after a crisis or traumatic event has occurred.*

Current MYSPP activities include: 1) Statewide Information Resource Center; 2) Statewide Crisis Hotline; 3) Gatekeeper training and technical assistance for multiple audiences; 4) Awareness education programs and resources; 5) Training of trainers to conduct awareness education; 6) Annual suicide prevention conference; 7) School Protocol Guidelines to help schools establish administrative protocols for all facets of suicide prevention and intervention; 8) Training for high school health educators in teaching "Lifelines" student lessons; 9) Training for instructors in the Reconnecting Youth curriculum for high risk youth; 10) Education regarding access to lethal means; 11) Media contagion education and guidelines; and 12) Suicide and self-inflicted injury data collection and tracking.

The MYSPP has many strengths, has received regional and national recognition for its efforts and has given many presentations at regional and national conferences. Maine is contributing 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). The project is being implemented in 12 Maine high schools and will end in July 2006. The Lifelines Program operates under the assumption that a comprehensive approach is required to address the multi-faceted nature of suicide risk. Schools establish protocols, train key individuals as "gatekeepers", build staff awareness, create an environment that supports help seeking among students, develop agreements with mental health providers, and identify and assist students who may be at risk of suicide.

Preliminary evaluation of the Lifelines Program suggests that administrators and staff members in project schools are more prepared to prevent and respond to a crisis. Evaluation of classroom lessons indicates significant gains among students in knowledge, willingness to talk about suicide, and willingness to seek help. It is clear that one important way to further reduce the youth suicide rate in Maine is to expand implementation of the Lifelines Program statewide.

MYSPP Plan Revision Process:

In meetings called by the Governor's Office with key stakeholders in December 2004 and January 2005, a decision was made to issue 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, and anti-bullying, anti-harassment, and anti-discrimination policies and procedures to foster safe school and community environments for Maine youth.

Second, requests were made to the National Suicide Prevention Resource Center (SPRC), the Centers for Disease Control and Prevention (CDC) and the Children's Safety Network (CSN) to help the MYSPP to identify program strengths and gaps. With the assistance of leaders from each of these national agencies, a full day retreat was held at the end of March 2005. A diverse group of stakeholders, both within and outside of state government, participated in the retreat and were given their charge by Maine's First Lady, Mrs. Karen Baldacci. At the retreat, three new MYSPP sub-committees were launched to begin a process of identifying gaps and selecting strategic priorities to strengthen the MYSPP plan. Committees were aligned with goals of the National Strategy for Suicide Prevention and included 1) *Public Awareness*; 2) *School and Community-based Suicide Prevention*; and 3) *Effective Clinical and Professional Practice*s. An

Ad Hoc *Lethal Means Workgroup* was also established to address the important issue of restricting access to lethal means. In addition, the *MYSPP Data Committee* met and developed recommendations for improving data collection and analysis.

In all, almost 100 individuals have participated in the process of revising the MYSPP plan over a 6-month period. Drawing on their diverse knowledge and experience, these individuals reviewed national goals and applicable research, and participated in many meetings to discuss and develop recommendations to the MYSPP. Significant program strengths were noted. Gaps were identified and prioritized to indicate where new program efforts should be directed. The Steering Committee guided the revision process and reviewed the work submitted by the sub-committees. Steering Committee members provided valuable insight in identifying leaders, potential partners and possible resources for the new program plan.

With the continued commitment to this work from the Governor's Office and the Children's Cabinet, the MYSPP will move forward to operationalize the revised plan. If resources are consistently dedicated to implementing the updated plan over a sustained period of time, Maine's efforts to prevent youth suicide will be significantly strengthened. Increasing partnerships with Maine youth, organizations and communities representing vulnerable populations in which cultural sensitivity and respect is also essential to advancing effective youth suicide prevention efforts statewide.

The primary funding sources of the MYSPP include the following:

- Maternal and Child Health block grant (MCH) - supports the MYSPP Coordinator and training contracts.
- Preventive Health and Health Services block grant (PHHS) - supports the MYSPP health planner position and evaluation of selected activities.
- Centers for Disease Control and Prevention (CDC) - supports implementation and evaluation of the Lifelines Program in 12 high schools (ends 7/31/06).
- Substance Abuse and Mental Health Services Administration (SAMHSA) - supports implementation and evaluation of a new comprehensive school and community based project in three Maine counties (9/30/05-9/29/08).
- Project Safe Neighborhoods (PSN) grant - supports implement of some educational activities for 2006.
- Pooled funding from the Children's Cabinet - supports the part time assistance of a graduate student to the program.

The Leading Strategic Issues Uncovered Through This Process Include:

Issues that are Universal in the Field of Suicide Prevention:

- Low public awareness that suicide is a health problem that can be prevented.
- Stigma surrounding obtaining mental and behavioral health services.
- Limited access to services for those who need them in a timely fashion.
- Lack of pre-service (college) education in effective suicide prevention and intervention strategies for professionals entering the fields of elementary, middle secondary and post-secondary education, primary care and other health professions, mental health, public safety and other fields.
- Difficulties involved in restricting access to lethal means around suicidal individuals.
- Complexity of suicidal behaviors combined with lack of strong evidence-based research for effective suicide prevention, intervention and treatment.
- Difficulty in reaching older youth at risk who are not in school settings.

Historic Programmatic Issues for MYSPP:

- Lack of timely access to quality data and an inability to conduct in-depth analysis of Maine data to improve understanding of the youth suicide problem in our state.
- Competing priorities and significant demands on Children's Cabinet agency staff time, which contribute to gaps in leadership and participation in the planning and implementation of MYSPP activities.
- Limited resources to implement suicide prevention training and guidance statewide.
- Limited resources to integrate effective suicide prevention and intervention services into the state and community infrastructure including mental health, behavioral health, family support services, schools, hospitals and other appropriate community settings.
- Lack of widespread approaches that support and encourage the development of protective factors among youth and that produce safe school and community environments free from discrimination, harassment and bullying.

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. Ten goals for enhancing the MYSPP were developed in alignment with the National Strategy for Suicide Prevention:

GOAL 1: By 2010, increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.

GOAL 2: By 2010, increase public awareness that suicide is a preventable public health problem.

GOAL 3: By 2010, develop and implement strategies to reduce the stigma associated with being a consumer of behavioral health services for families and youth and increase help-seeking behaviors.

GOAL 4: By 2010, increase the number of Maine schools and communities that systematically implement comprehensive youth suicide prevention programs statewide.

GOAL 5: By 2010, support initiatives to reduce the risk of youth suicides by reducing access to lethal means.

GOAL 6: By 2010, implement training for recognition of at-risk behavior and delivery of effective treatment to a variety of audiences statewide.

GOAL 7: By 2010, develop and promote effective clinical and professional practices.

GOAL 8: By 2010, improve access to and community linkages with mental health, substance abuse, and suicide prevention services

GOAL 9: By 2010, improve media reporting practices to reduce the potential of suicide contagion.

GOAL 10: By 2010, improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.

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Maine Youth Suicide Prevention Program
Current Program Activities,
Strategic Plan Enhancements and
SAMHSA Project Activities
December 2005

Department of Health & Human Services (DHHS)
- ***Maine Center for Disease Control & Prevention (Maine CDC)**
- ***Office of Substance Abuse (OSA)**
- ***Children's Behavioral Health Services (CBHS)**

Department of Education (DOE)
Department of Public Safety (DPS)
Department of Corrections (DOC)
Department of Labor (DOL)

Goal 1: By 2010, increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Maine objectives under this goal are designed to solicit, & support, collaboration with stakeholders at the national, state, regional & community levels & to integrate suicide prevention into other statewide programs & services for children, teens & young adults, whenever possible & appropriate.	DHHS, Maine CDC					
1. Ensure safe & effective program practice by using best practice research.	DHHS, Maine CDC	**X**				
2. Collaboratively seek & manage grant funding to support suicide prevention activities.	DHHS, Maine CDC, CBHS	**X**				
3. Routinely report on MYSPP activities to the CLASS Committee (crisis service agency leaders).	DHHS, CBHS	**X**				
4. Coordinate with the Keeping Maine's Children Connected initiative.	DHHS, Maine CDC	**X**				

Goal 1: By 2010, increase public/private partnerships dedicated to implementing and sustaining the Maine Youth Suicide Prevention Program.	**Lead Department**	**Timeline**				
		Completed	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Strategic Plan Enhancements						
1. Increase participation & coordination of activities among Children's Cabinet & other agencies & organizations with the MYSPP to better integrate youth suicide prevention into related activities & services, & to plan & coordinate implementation:						
a) Identify MYSPP Steering Committee members from all Children's Cabinet agencies;	Children's Cabinet	**X**				
b) Reconvene MYSPP Sub-committees upon designation of leaders from CC agencies. Leaders are pending for two committees.	DHHS, Maine CDC		**X**			
2. Identify opportunities to integrate suicide prevention through collaboration between Children's Cabinet agencies & school & community based initiatives.	Children's Cabinet & Senior Staff		**X**	**X**	**X**	**X**
SAMHSA Project Activities						
1. Develop & implement a model for youth serving programs, including professional & voluntary organizations, employers, & others, to integrate suicide prevention/intervention activities.	SAMHSA contracted project coordinator with DHHS, Maine CDC		**X**	**X**	**X**	**X**
2. Conduct outreach to organizations that support sexual minority youth.				**X**		
3. Initiate relationships with representatives of Maine's Native American Community & develop appropriate collaboration to prevent youth suicide.				**X**		
4. Establish relationships with representatives of Maine's Faith Community to explore opportunities for collaboration & provide supportive resources.				**X**		

Goal 2: By 2010, increase public awareness that suicide is a preventable public health problem.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Provide a statewide access point for current & accurate youth suicide prevention data, information & resource materials.	DHHS, OSA	**X**				
2. Routinely publicize the statewide crisis hotline number, IRC & website.	All Agencies	**X**				
3. Develop & disseminate annual updates of youth suicide data via fact sheets.	DHHS, CHP		**X**			
4. Provide statewide "training of trainers" courses & resource materials to prepare speakers.	DHHS training contractors	**X**				
5. Provide suicide prevention awareness education programs at conferences & for key organizations.	DHHS training contractors	**X**				
6. Sponsor an annual awareness education event during world/national suicide prevention awareness week.	DHHS, Maine CDC				**X**	
7. Work with youth to develop & provide youth focused educational programs & resources.	DHHS	**X**				
8. Routinely gather & disseminate information on suicide warning signs, risk & protective factors.	DHHS, Maine CDC	**X**				

Goal 2: By 2010, increase public awareness that suicide is a preventable public health problem.	**Lead Department**	**Timeline**				
Strategic Plan Enhancements		**Completed**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Deliver MYSPP training & education programs to more audiences throughout the state.	DHHS, Maine CDC DHHS training contractors		**X**	**X**	**X**	**X**
Children's Cabinet agency staff participating in program activities can help by: 1. Being trained to deliver 1-2 hour suicide prevention awareness educations sessions & presenting to key groups with whom they work; 2. Identifying new audiences & opportunities for MYSPP trainers to provide awareness education; 3. Disseminating & promoting announcements of MYSPP training programs statewide, & 4. Contributing to the development of educational pieces to increase public awareness.	Designated Children's Cabinet agency staff		**X**	**X**	**X**	**X**
Update & improve the MYSPP Web site 1. Work is underway, new template is completed to meet state regulations. 2. Content being updated.	DHHS, OSA, Maine CDC		**X**			
SAMHSA Project Activities						
Conduct focus group dialogues with youth to help develop public awareness messages in three counties.	SAMHSA contracted project coordinator with DHHS, Maine CDC					**X**

Goal 3: By 2010, 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.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Develop stigma reducing resources & messages in partnership with youth.	DHHS, Maine CDC through MYAN contract	**X**				
2. Sensitize every MYSPP training participant to methods of reducing stigma through values clarification exercises & use of language.	DHHS training contractors	**X**				
3. Enhance understanding of survivor issues & risk information relative to gender, race & age.	DHHS training contractors	**X**				
4. Through Lifelines lessons, reduce stigma & build youth help-seeking skills for behavioral health problems.	DHHS training contractors	**X**				
5. Integrate suicide prevention strategies into School Based Health Centers.	DHHS, Maine CDC	**X**				
6. Provide information & referral, training, & support to youth & families.	DHHS, CBHS	**X**				

Goal 3: By 2010, 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.	**Lead Department**	**Timeline**				
		Completed	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Strategic Plan Enhancements						
1. Develop culturally sensitive methods that each Children's Cabinet agency can employ to support increasing appropriate help seeking among youth & families in need of behavioral health services.	DHHS, Maine CDC		**X**	**X**	**X**	**X**
2. Develop prepared statements, such as press releases, with correct information about mental illness, substance abuse & suicide for public distribution.	Involved agency staff		**X**	**X**		
SAMHSA Project Activities						
1. Explore ways to reduce the stigma of seeking help for behavioral health services through focus groups with youth in SAMHSA project communities.	SAMHSA contracted project coordinator with DHHS, Maine CDC			**X**	**X**	**X**
2. Explore barriers to obtaining confidential & timely services for at-risk youth & families.				**X**	**X**	**X**
3. Improve cultural sensitivity of activities with Native American & sexuality minority youth in three counties.				**X**	**X**	**X**
4. Involve families of suicide victims in public awareness education activities.						**X**

Goal 4: By 2010, increase the number of Maine schools and communities that systematically implement comprehensive youth suicide prevention programs statewide.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Provide technical assistance to school personnel implementing MYSPP suicide prevention, crisis intervention & postvention protocol guidelines.	DOE, DHHS contracted trainers	**X**				
2. Facilitate the development of agreements (MOAs) between local crisis agencies & schools.	DHHS, CBHS DOE	**X**				
3. Provide annual Reconnecting Youth Teacher Training & technical support instructors of at-risk students.	DHHS, OSA			**X**		
4. Provide Lifelines training to health instructors who will implement student lessons.	DHHS contracted trainers, DOE	**X**				
5. Provide MYSPP gatekeeper training sessions statewide.	DHHS contracted trainers	**X**				
6. Educate ALL MYSPP participants about safe steps to building a comprehensive approach to youth suicide prevention.	All agencies	**X**				
7. Support Maine schools implementing effective conflict management & bullying prevention programs to foster safe school for *all* youth.	DHHS, Maine CDC DOE	**X**				
8. Respond to local communities to provide assistance in the event of multiple youth suicides**.**	DHHS, Maine CDC	**On request**				

Goal 4: By 2010, increase the number of Maine schools and communities that systematically implement comprehensive youth suicide prevention programs statewide.	**Lead Department**	**Timeline**				
		Completed	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Strategic Plan Enhancements						
1. Incorporate & disseminate findings from CDC project into MYSPP program services & resources.	CDC contracted project coordinator in consultation with DHHS, Maine CDC, DOE			**X**	**X**	
2. Update & distribute the MYSPP Suicide Prevention, Intervention, & Postvention School Guidelines to all school systems in Maine.					**X**	
3. Increase the number of Maine schools implementing effective conflict management & bullying prevention programs to foster safe school for *all* youth.	DHHS, Maine CDC, DOE				**X**	
4. Assist local communities to implement effective positive youth development strategies to foster safe environments for *all* youth.	DHHS, OSA	**As resources permit**				
5. Research & promote models for effective programming for high-risk youth.	DOE			**X**		
6. Using the Coordinated School Health Program approach, support/promote effective practices by school SAT team members, nurses & counselors.			**X**	**X**	**X**	
SAMHSA Project Activities						
1. Provide training, guidance & assistance to six additional high schools to implement the Lifelines Program.	SAMHSA contracted project coordinator in consultation with DHHS, Maine CDC,			**X**	**X**	**X**
2. Integrate effective suicide prevention/intervention procedures in Student Assistance Teams practices in project schools.			**X**	**X**	**X**	**X**
3. Develop & integrate suicide prevention protocols & practices into after-school programs & community-based services for out of school teens.					**X**	**X**
4. Support two Maine colleges to implement a comprehensive approach to youth suicidal & related high-risk behaviors.				**X**	**X**	**X**
5. Develop & implement culturally sensitive approaches to reach young adults not enrolled in school settings.				**X**	**X**	**X**

Goal 5: By 2010, support initiatives to reduce the risk of youth suicides by reducing access to lethal means.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Routinely analyze & disseminate self-inflicted injury & suicide mortality data including cause of death.	DHHS, CHP		**X**			
2. Include lethal means education in all Gatekeeper Training & Awareness education programs.	DHHS training contractors, Maine CDC	**X**				
3. Develop & disseminate educational messages & materials to increase public awareness of the importance of restricting access to lethal means around suicidal youth.	DHHS, Maine CDC	**X**				

Goal 5: By 2010, support initiatives to reduce the risk of youth suicides by reducing access to lethal means.	**Lead Department**	**Timeline**				
Strategic Plan Enhancements		**Completed**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Develop & implement activities to educate & assist with reducing access to lethal means for potentially suicidal youth.						
1. Increase development & distribution of educational messages & materials to increase public awareness of the importance of restricting access to lethal means around suicidal youth.	DHHS, Maine CDC,		**X**	**X**	**X**	**X**
2. Collaborate with selected organizations to develop & distribute a standardized procedure for law enforcement & ER staff for safeguarding weapons at the request of a family member.	DHHS, Maine CDC		**X**	**X**	**X**	
3. Partner with primary care clinicians, ER staff & other health care providers to adopt a screening tool to be used in health care settings to assess the presence of lethal means in homes with children & teens.	DHHS, Maine CDC Attorney General's Office			**X**	**X**	
4. With Maine EMS, design, develop & disseminate a standardized procedure for emergency response personnel to assess for the presence of lethal means when responding to emergencies where a concern for suicide is identified.	DHHS, Maine CDC		**X**	**X**		
5. Pilot inclusion of suicide warning signs & lethal means restriction in student handbooks with three schools.	DHHS, Maine CDC			**X**		

Goal 6: By 2010, implement training for recognition of at-risk behavior and delivery of effective treatment to a variety of audiences statewide.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Annually provide gatekeeper training programs statewide to individuals routinely in direct contact with youth.	DHHS contracted trainers DHHS, Maine CDC	**X**				
2. Routinely provide technical assistance to trainees.	DHHS contracted trainers	**X**				
3. Provide Lifelines instructor training.	DHHS contracted trainers with DOE	**X**				
4. Provide Reconnecting Youth instructor training.	DHHS, OSA			**X**		
5. Develop/deliver advanced level suicide prevention training.	DHHS contracted trainers		**3/30/06**			
6. Provide a dissemination conference to provide implementation evaluation findings of CDC Lifelines Project.	CDC project coordinator with DHHS contracted trainers University contractors with			**5/3/06**		
7. Annually provide conflict management, peer mediation & bullying prevention training to middle & high schools.	DHHS, Maine CDC	**X**				
8. Continuously use best practice & program evaluation findings to improve training programs.	DHHS, Maine CDC, with DHHS contracted trainers & evaluators	**X**				

Goal 6: By 2010, implement training for recognition of at-risk behavior and delivery of effective treatment to a variety of audiences statewide.	**Lead Department**	**Timeline**				
		Completed	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Strategic Plan Enhancements						
1. Develop & deliver training for school administrators in effective suicide prevention procedures.	DHHS, Maine CDC through DHHS contracted trainers		**3/30/06**			
2. Provide suicide prevention training for staff in juvenile correctional facilities.	DOC	**Ongoing**				
3. Identify new audiences to attend training to increase the number of individuals prepared to conduct awareness education sessions & deliver the training.	Children's Cabinet agency staff		**X**	**X**	**X**	**X**
4. Identify opportunities to integrate suicide prevention within training programs for family & youth service providers.	DHHS		**X**			
5. Increase the number of middle schools that integrate key concepts related to mental health & help-seeking within comprehensive school health education.	DOE	**Ongoing**				
SAMHSA Project Activities						
1. Update MYSPP training programs to enhance cultural sensitivity.	SAMHSA contracted project coordinator with DHHS, Maine CDC			**X**	**X**	
2. Provide training to improve the capacity of staff to recognize & intervene effectively with suicidal behavior in community-based services, programs, & organizations directly serving families & youth.				**X**		
3. Provide training to conduct awareness education to community partners.					**X**	
4. Develop & provide training in suicide prevention & intervention to post-secondary institutions.					**X**	
5. Develop & deliver training programs for mental health providers & primary care clinicians.					**X**	
6. Explore evidence-based programs for high-risk youth & conduct training.						**X**

Goal 7: By 2010, develop and promote effective clinical and professional practices.	**Lead Department**	**Timeline**				
		Ongoing	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Current MYSPP Activities						
1. Collaboration among corrections, mental health & substance abuse to develop/implement standardized policy & procedures for assessing suicidal risk among incarcerated juveniles. 2. Review & select effective assessment tools for use in screening incarcerated juveniles.	DHHS DOC OSA	**X**		 **X**		
Strategic Plan Enhancements						
1. Establish protocols for treatment & follow-up of clients. 2. Design & implement an evaluation of new protocols.	DHHS, CBHS, Maine CDC DHHS, CBHS			**X**		 **X**
SAMHSA Project Activities						
1. Identify best practice models for enhancing access & delivery of mental health services. 2. Increase the proportion of child & youth serving providers having policies, procedures, & evaluation protocols designed to assess suicide risk & conduct interventions. 3. Develop & implement guidelines for culturally sensitive assessment of suicide risk of persons receiving care in primary & behavioral health care settings. 4. Increase the proportion of suicidal patients discharged from emergency departments who pursue their follow-up plans. 5. Develop & disseminate standards for culturally sensitive educational programming on treatment of mental illness & substance abuse with risk of suicide.	DHHS contracted project coordinator with DHHS, Maine CDC			**X** **X**	 **X** **X**	 **X**

Goal 8: By 2010, improve access to and community linkages with mental health, substance abuse and suicide prevention services.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Maintain & publicize the statewide crisis hotline.	DHHS, CBHS	**X**				
2. Collaborate with AFSP Maine to identify survivors of suicide (SOS) support groups statewide & distribute this information.	DHHS, Maine CDC	**X**				
Strategic Plan Enhancements						
1. Expand screening, assessment & treatment protocols to ALL correctional facilities & community based justice programs.	DHHS					
2. Explore development of screening, assessment & treatment protocols in county jails.	DOC					
SAMHSA Project Activities						
1. Expand screening, assessment & treatment protocols for mental illness & suicide risk to correctional facilities & community based justice programs in three counties.	SAMHSA contracted project coordinator in consultation with DHHS, Maine CDC & local mental health agency coordinators		**X**	**X**	**X**	
2. Improve community access, assessment, & engagement for young adults, age 18-24 out of traditional systems.					**X**	
3. Develop guidelines for mental health screening & referral of students in schools & post-secondary institutions & improving linkages to mental health & substance abuse services.					**X**	
4. Develop guidelines for effective comprehensive support programs for suicide survivors.						**X**
5. Increase the proportion of outreach programs that integrate support & referral for at risk youth & their families.					**X**	

Goal 9: By 2010, improve media reporting practices to reduce the potential of suicide contagion.	**Lead Department**	**Timeline**				
		Ongoing	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Current MYSPP Activities						
1. Routinely update, maintain & distribute media guidelines for media & school administrators.	DHHS, Maine CDC	**X**				
2. Provide workshops for media representatives on contagion & safe reporting practices.	DHHS training contractors	On request				
3. Provide media contagion education in the Gatekeeper training curriculum.	DHHS training contractors	**X**				
4. Provide suicide prevention & related information for publication by local news outlets.	DHHS, Maine CDC	On request				
5. Solicit media attendance at MYSPP events.		**X**				
Strategic Plan Enhancements						
1. Post media guidelines on updated MYSPP Website.	DHHS, Maine CDC & OSA		**X**			
2. Engage the media in educating the public in safe & responsible ways about behavioral health & suicide prevention by developing & disseminating feature stories & providing material for guest editorial columns & other media venues.	DHHS agency staff		**X**	**X**	**X**	**X**
SAMHSA Project Activities						
1. Involve media representatives in the development & distribution of media guidelines for reporting on suicide.	SAMHSA contracted project coordinator in consultation with DHHS, Maine CDC			**X**	**X**	**X**
2. Partner with media representatives & suicide survivors to design effective workshops for media representatives on safe reporting practices, improve resource information for reporting on suicide, & acknowledge good reporting practices.					**X**	**X**

Goal 10: By 2010, improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.	**Lead Department**	**Timeline**				
Current MYSPP Activities		**Ongoing**	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
1. Evaluate Maine data sources for their usefulness in a suicide surveillance system & routinely monitor the incidence of suicidal behavior.	DHHS epidemiologist	**X**				
2. Identify data quality issues & work with coders to resolve these issues.	DHHS, CHP			**X**		
3. Provide training as indicated to coders/health personnel.	DHHS, CHP					**X**
4. Annually compile & analyze youth suicide morbidity & mortality data.	DHHS, CHP		**X**			
5. Compile & disseminate reports to multiple stakeholders statewide.	DHHS, Maine CDC		**X**			
6. Quarterly convene MYSPP data committee to review & act upon data issues to improve data quality & access.	DHHS, CHP		**X**	**X**	**X**	**X**

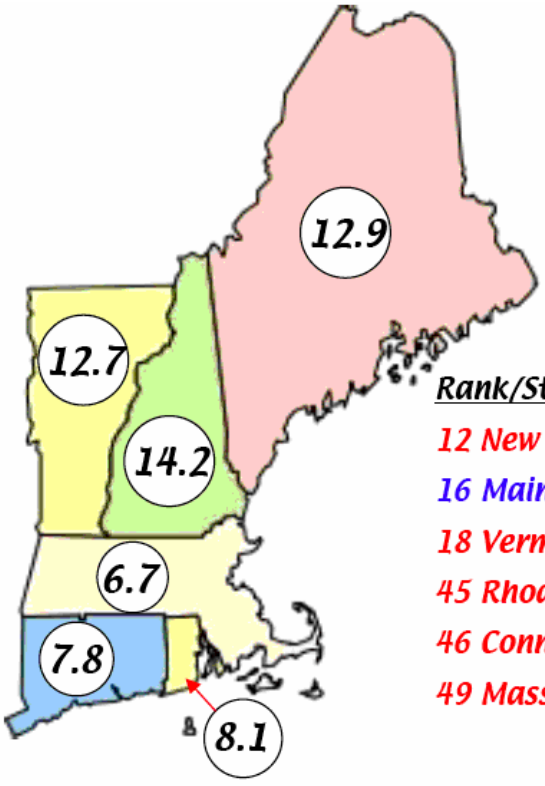
Goal 10: By 2010, improve the understanding of fatal and non-fatal suicidal behaviors among Maine youth.	**Lead Department**	**Timeline**				
		Completed	**1/06-3/06**	**4/06-6/06**	**7/06-9/06**	**10/06-12/06**
Strategic Plan Enhancements						
1. Promote inclusion of questions on suicide & related risk & protective factors on departmental surveys of students.	DHHS, Maine CDC		**X**			
2. Obtain quarterly reports from the Medical Examiner to inform prevention work.	DHHS, CHP with data source agency reps & USM epidemiologist		**X**	**X**	**X**	**X**
3. Develop an expanded protocol for death scene investigation of youth suicide to collect additional information on risk factors & circumstances involved in youth suicides to better inform prevention planning. ** Protocol implementation cannot be accomplished w/o additional resources.*	MYSPP data committee			**X**		
SAMHSA Project Activities						
1. Explore methods to increase the early identification of at-risk students using SAT including data tickler system.	SAMHSA project coordinator DHHS, Maine CDC & DOE		**X**	**X**		
2. Examine barriers to data sharing among community agencies & develop solutions to improve identification & appropriate follow-up of at-risk youth.	SAMHSA project evaluators		**X**			
3. Develop systems to monitor follow-up of identified youth at-risk.				**X**		

Maine Youth Suicide and Self-Inflicted Injury Facts

In-depth epidemiological information on youth suicide in Maine is lacking, here is what we do know.

Suicide:

- Suicide is the 2nd leading cause of death for youth aged 15-24, and the 3rd leading cause of death for youth aged 10-14 in Maine.
- Between 1998-2002, the suicide rate among Maine youth was 25% above the national average, the 17th highest in the country, and the 2nd highest in New England.[11] These rates reflect in part the rural nature of Maine. Nationally, suicide rates are approximately 1/3 higher in rural areas than in core metro areas.[12] In a small rural state like Maine, with an overall youth suicide rate that exceeds the national rate, the problem of youth suicide significantly impacts most communities in the state, with traumatic effects for families, friends, and community members.
- From 1999-2003* there were 805 suicides in Maine. Of those suicides, 106 were youth: eight aged 10-14; forty-six aged 15-19; and fifty-two aged 20-24.
- More young people die by suicide than from homicide. For every homicide among 15-24 year olds, there are 5 to 6 suicides.
- More male youth die by suicide than female. Of every 5 suicides, 4 are males.



15-24 years of age
Mean rates 1998-2002

National rate = 10.2

Rank/State	Mean Rate	Mean Number
12 New Hampshire	14.2	22.6
16 Maine	12.9	21.0
18 Vermont	12.7	10.8
45 Rhode Island	8.1	12.0
46 Connecticut	7.8	32.0
49 Massachusetts	6.7	54.6

All rates are per 100,000 population

Thanks to John L. McIntosh, Ph.D., Department of Psychology, Indiana South Bend for producing this map.

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

[12] Goldsmith, SK., TC Pellmar, AM Keinman, WE Bunney. Reducing Suicide, A National Imperative. The National Academies Press, Washington, D.C. 2002.

Self-Inflicted Injuries:

- Suicidal behavior among young people is a much larger public health concern than what is represented in death statistics. Youth suicidal behavior is more likely to result in an emergency department or hospital visit than among older people. From 2002-2004, there were 1,029 hospital admissions in Maine for self-injuries among youth aged 10-24 or 343 a year. Children aged 10-14 made 116 visits; adolescents aged 15-19 made 532 of these visits, young adults between the ages of 20-24 made 381 visits.
- Females aged 15-19 had the highest overall rate, 22.7/100,000 between 2002-2004, of hospitalization for self-inflicted injuries across all age groups.

Associated Risk Factors:

- In 2002, 10,956 Maine children under age 18 received behavioral health services, and an additional 2000 were on waiting lists.[13] Furthermore, half of the leading diagnoses for inpatient hospitalizations for children ages 13-17 are for mental health diagnoses.
- Childhood trauma, witnessing domestic violence, and being a victim of or perpetrating interpersonal violence are risk factors linked to suicide.[14] Maine DHHS received 574 substantiated reports of child sexual abuse and 5,364 domestic violence assaults in 2003.[15] Over half of these were in households with children under age 12.[16]
- Access to and availability of firearms is a significant factor in youth suicide, because most suicide attempts by firearm are fatal. In 1999-2003, a firearm was used in 5 of 10 youth suicides, 51% of male and 32% of female youth (ages 10-24) suicides.
- The second leading method of youth suicide is hanging, accounting for more than 4 of 10 suicides.
- Poisoning is the most common method of non-fatal self-inflicted injuries for both males and females.
- The likelihood of students, families, school staff, or community members encountering a suicidal youth is real. According to the Maine YRBS:
    - One in eleven Maine high school students report that they have attempted suicide within the past twelve months.[17] Seventeen percent of Maine high school students report having considered suicide, and 15% report having made a plan. These rates are similar to national data,[18] and reflect higher rates for girls than boys. Middle school students show higher rates considering suicide (20%), lower rates for planning an attempt (12%), and similar rates to high school students for attempting (9%).
    - One in four high school students reported feeling so sad or hopeless for two weeks or more to the point that they stopped some usual activities.[19]

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[13] Maine Department of Health and Human Services, Children Behavioral Health Services
[14] Goldsmith, SK., TC Pellmar, AM Keinman, WE Bunney. Reducing Suicide, A National Imperative. The National Academies Press, Washington, D.C. 2002.
[15] The Maine Coalition to End Domestic Violence, http://www mcedv.org/news/statistics.htm
[16] U.S. Department of Justice, *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*, March 1998
[17] Maine Youth Risk Behavior Survey, Maine Department of Education, 2003
[18] Centers for Disease Control and Prevention, YRBS, 2003.
[19] Maine Youth Risk Behavior Survey, Maine Department of Education, 2003

- In aggregated data from 1995, 1997, 2001, & 2003, same-sex contact students in middle and high schools were at higher risk for suicide than opposite-sex contact students; same-sex males were almost 4 times more likely to report attempting suicide.[20]
- From 1997 to 2003, middle school students who considered suicide has decreased from 30% to 20%.
- Ten percent of high schoolers report being forced to have sex, 27% report being in a physical fight, and 12% report that a boyfriend or girlfriend physically hurt them.
- School related risk factors also exist for our young adults.[21] Although Maine's high school graduation rate is one of the highest in the nation, 52% of recent high school graduates enroll in college in the year following graduation, a rate that is slightly below the national average. The percentage of Maine adults with a college degree is lower than all but six states.[22]
- Substance abuse is a continuing concern throughout Maine and a risk factor for suicide. Despite decreases over the last nine years, Maine youth continue to use alcohol at a higher rate than their counterparts nationally - 30% of youth in grades 6-12 reported drinking during the last 30 days. Marijuana use has followed a similar pattern, although the gap between national and Maine youth marijuana use is larger. 15% of Maine youth reported using marijuana in the last 30 days. Maine youth also report use of methamphetamines and inhalants more than youth nationwide.[23]
- Youth who are not working or attending school, are at higher risk for suicide.[24] 14.3% of 16-19 years olds and 8.3% of 20-24 year olds are unemployed in Maine.[25]

Distributed by the Maine Youth Suicide Prevention Program, Information Resource Center
1-800-499-0027 or http://www.maine.gov/suicide

Notes:

**2003 mortality data are preliminary*
Data from the Maine Office of Data, Research, & Vital Statistics, Maine Hospital Discharge Databases, and Maine YRBS.
Distributed by the Maine Youth Suicide Prevention Program Updated August 2005

[20] Meyer, Katie, Mark Griswold. Sexual minority youth and suicidal ideation and behavior. July 2005.
[21] Maine data on these factors comes from the Maine Youth Drug and Alcohol Use Surveys (MYDAUS).
[22] *A Fresh Look at College-Going Rates in Maine*, Dr. Samuel M. Kipp, III Kipp Research and Consulting, December, 2000
[23] Maine Youth Risk Behavior Survey, Maine Department of Education, 2003
[24] Goldsmith, SK., TC Pellmar, AM Keinman, WE Bunney. Reducing Suicide, A National Imperative. The National Academies Press, Washington, D.C. 2002.
[25] Maine Department of Labor, Employment status of the Civilian Noninstitutional Population by age, Maine 2003

ACKNOWLEDGEMENTS

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FOR LEADERSHIP AND FORSIGHT ON BEHALF OF THE STATE OF MAINE:
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