STATE OF MARYLAND
DHMH

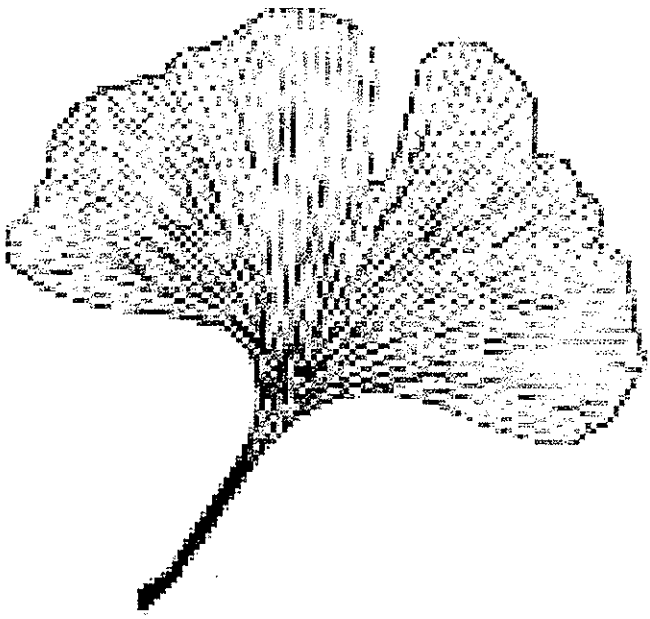
Linkages to Life:

Maryland's Plan for Youth Suicide Prevention

Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
John M. Colmers, Secretary
Arlene Stephenson, Acting Deputy Secretary, Public Health Services
Brian M. Hepburn, M.D., Executive Director

The Maryland Committee on Youth Suicide Prevention

2008



The ginkgo tree is a survivor. It is over 300 million years old. It has survived despite all obstacles and is used as a symbol of healing. We chose the leaf from this tree to represent our message: "A Caring Community Saves Lives". This message too will survive and heal.

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I. EXECUTIVE SUMMARY:

In FY 2007 – 2008, an interagency group drafted *Linkages to Life: The Maryland State Plan For Suicide Prevention, FY 2008-2012,* to update the State's original plan, completed in 1986. This proposed new plan for Maryland is modeled on *The Surgeon General's Call to Action to Prevent Suicide.*[1] The latter publication emphasized suicide as a serious public health problem and recommended the development of a national strategy for suicide prevention. Moreover, the *President's New Freedom Commission on Mental Health* Report recommended: "Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention."[2] The proposed *Maryland State Plan for Suicide Prevention* is based on national strategy recommendations.

The proposed plan aligns with national goal categories:

- Awareness: Goal is to increase and broaden the public's awareness of suicide and its risk factors, and understand suicide is preventable;
- Intervention: Goal is to enhance culturally competent, effective and accessible community based services and programs; and
- Methodology: Goal is to advance the science of suicide prevention.

In addition, the proposed Maryland Plan has added Postvention as a category, to assure effective services to those who have attempted suicide and/or to other people affected by the suicide attempt or completion. For each of the four goal categories, the Plan lists objective/strategies, responsible parties/persons for implementation, time lines, and outcome and performance measures.

The recommendations presented are based on extensive literature reviews, data analysis, multi-agency input and feedback, and evidenced based practices. Furthermore, each of the agencies involved in this process stand ready to assist in the implementation.

The FY 2008-2012 Maryland Suicide Prevention Plan proposes:

1. Establish an Office of Suicide Prevention within the Department of Health and Mental Hygiene Administration;

2. Develop a more coordinated prevention, intervention, and postvention services across the State, to include youth and young adults (up to age 25), including high-risk returning war veterans, and their families;

[1] Department of Health and Human Services, U.S. Public Health Service. "The Surgeon General's Call to Action To Prevent Suicide." Washington, DC. 1999.
[2] The President's New Freedom Commission on Mental Health Report, July 2003.

3. Address core components in youth suicide prevention programs by the local school systems and other educational networks;

4. Increase funding for youth suicide prevention, intervention, and postvention, including increased funding to the Maryland Crisis Hotline programs and capacity building;

5. Develop a Website and new technologies to access and help youth;

6. Infusion of cultural competence throughout services to youth;

7. Develop a youth suicide plan in each child serving agency;

8. Increase inservice training to local departments of correction and to youth detained in local jails;

9. Strengthen the State's capacity to respond to crises and serve at-risk-youth in need;

10. Increase the number and quality of trainers in suicide prevention, intervention, and post-vention;

11. Increase outreach and the number of training geared to gatekeepers and the public around youth suicide issues;

12. Work with faith based organization around youth suicide prevention issues;

13. Implement a model Hospital/Urgent Care suicide postcard follow-up program for at-risk-youth in emergency departments; and

14. Establish a baseline listing of existing support systems for survivors and attempters.

The report concludes there is a desperate need for additional resources to be devoted to helping troubled youth, distraught parents, and others who are touched by the turmoil of youth suicide. The Maryland Committee on Youth Suicide Prevention strongly believes the FY 2008-2012 Plan will to be the vital "linkage to life" to save young lives.

II. INTRODUCTION:

Governmental support and leadership, along with interagency collaboration, coordination and intervention, is required to develop and implement a comprehensive suicide prevention plan. With recognition that there are limited new resources for suicide prevention, it is imperative to develop a plan that is acceptable to key state officials and the advocacy community. The newly developed Maryland plan is based on the strengths of the existing programs and services, and intends to increase collaborative relationships through consensus building and joint program planning and implementation. The primary goals of this proposed plan are to increase awareness, develop and implement the best evidence-based clinical prevention/intervention practices, and advance knowledge about suicide and effective methods of prevention. The goals and many of the objectives/strategies often overlap; however, this overlap contributes to a unified, integrated and coordinated plan.

The proposed five-year plan (fiscal years 2008 through 2012) provides opportunities and challenges to improve upon current Maryland efforts. This plan addresses youth and young adults up to age 25, including returning veterans who are at high risk for suicide. Throughout the country, numerous states are developing suicide prevention plans and many efforts are underway to fund these programs through public and private funding sources. The future success of preventing suicide in Maryland is contingent upon the continuation and expansion of prevention efforts promoted and supported by federal, state, public and private agencies working collaboratively.

As a result of the marked increase in the suicide rate among military personnel deployed to Iraq and Afghanistan this plan addresses returning Maryland veterans. The *Associated Press* reported in 2006: "Of the confirmed suicides last year, 25 were soldiers deployed to the Iraq and Afghanistan wars....which amounts to 40 percent of the 64 suicides by Army soldiers in Iraq since the conflict began in March 2003....accounting for nearly one in five of all noncombat Army deaths." In a 2007 CBS News investigation, which surveyed 45 states, it was reported that in 2005 there were 6,256 veteran suicides—120 every week, 17 a day. In 2008, numerous reports were published pertaining to the increase of suicides among soldiers who served in Iraq and Afghanistan. It was reported the number of suicides among American soldiers increased 20 percent between 2006 and 2007 when 121 died as a result of suicide. Furthermore, a 2008 *Associated Press* report stated "Suicide attempts and other self-injuries....jumped six-fold between 2002 and last year."

Military reports and interviews with soldiers' relatives have shown that some of the service members who committed suicide were kept on duty despite signs and symptom of distress. It has been estimated 25 percent of enlistees and 50 percent of reservists who have returned from the war have serious mental health issues. To date, four Maryland National Guard veterans of this war have committed suicide. Thus, this plan includes young returning Maryland veterans.

BACKGROUND INFORMATION

The State of Maryland has an exemplary 25-year history in the area of youth suicide prevention and intervention. Youth suicide initiatives began with survivors who formed an advocacy organization called Marylanders Against Youth Suicide (MAYS) in the 1980's. Many members of MAYS had felt the devastation of losing loved ones to suicide; thus, they organized across the State to specifically address the problem of youth suicide. In 1986, MAYS and other concerned citizens worked for the passage of Maryland General Assembly resolutions creating a Gubernatorial Task Force on Child, Teenage, and Young Adult Suicide and Other Associated Mental Health Problems.

As a result of these resolutions the first suicide prevention programs commenced in Maryland schools and the first Maryland plan, "*For a Better Tomorrow: A Plan for Youth Suicide Prevention*" was completed (1987). One of the primary objectives in this plan called for the development of the nation's first decentralized hotline network. Under this plan, troubled youth could call one number from anywhere in the State and get immediate help from trained personnel 24 hours a day, seven days a week. The Maryland Youth Crisis Hotline Network, comprised of The Grassroots Hotline, Frederick County Hotline, Life Crisis Center, Community Crisis Services, Inc., Walden/Sierra and the Montgomery County Hotline, was established in 1990. In 2002, the Baltimore Crisis Response became a part of the network.

Additionally, the Governor requested the Department of Health and Mental Hygiene (DHMH), Mental Hygiene Administration to assume responsibility for suicide prevention. In 1987, an administrator was hired and charged by the Governor to establish and chair an Interagency Workgroup on Youth Suicide Prevention. The Workgroup consisted of representatives from the Mental Hygiene Administration (MHA), the Maryland State Department of Education (MSDE), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Alcohol and Drug Abuse Administration, Office of the Chief Medical Examiner, and the AIDS Administration; other departments with a youth focus were added later.

Other major accomplishments over the past 25 years include the following:

- First decentralized crisis hotline in the country (1-800-422-0009). National hotlines 1-800 Suicide and 1-888-273-TALK were based on this model. With the University of Maryland and the Alcohol and Drug Abuse Administration, and the Maryland Youth Crisis Hotline network, developed the first Internet based collection system for a coordinated statewide hotline network, Hotline Online Tracking System (HOTS).
- First Maryland Town Meeting on Suicide.
- First state to establish Youth Suicide Prevention Month.
- State law established suicide prevention programs in the schools in all 24 political jurisdictions. Many school programs provide gatekeeper training, crisis teams, peer helpers, suicide prevention education and referral.

- Convened 19 Annual Suicide Prevention Conferences—Maryland's conference is the oldest and largest State conference in the nation.
- Funding provided to the Hotline network to provide gatekeeper training to State Colleges and Universities.
- Established a DJS task force on suicide prevention that resulted in DJS policy changes.
- Extensive media awareness campaigns included, but not limited to: Public Service Advertisements (PSAs) with the Baltimore Orioles to promote the Maryland Youth Crisis Hotlines; statewide bill board ads; Maryland hotline program highlighted on nationally syndicated show, Inside Edition; assisted to organize national teleconference on youth violence with the Harvard School of Public Health; The American Psychiatric Association highlighted the program in the April 21, 2000 Psychiatric News; partnered with the Mental Health Association of Maryland, the Hotline network and the MHA, on the "Caring for Every Child's Mental Health" campaign; outreached to the faith community included organizing seminars and panel presentations; worked with Marylanders Against Handgun Abuse to present workshops and pass legislation to reduce access to guns in Maryland; collaborated with advocacy groups such as Suicide Prevention Education Awareness for Kids (SPEAK) to do outreach and to get phones on Maryland bridges and student I.D. cards posted with the Maryland Youth Crisis Hotline number; and coordinated with other groups, e.g., Gay and Lesbian Center of Baltimore, Hearts and Ears, to develop workshops on Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) issues.

III. VALUES AND GOALS:

The proposed FY 2008-2012 Maryland Plan is presented based on the following values:

- Address statewide needs;
- Build upon existing system strengths;
- Focus on prevention;
- Utilize data-based decision-making
- Implement evidence-based, best practices; and
- Demonstrate cultural competence.

The aim of the national strategy, which Maryland is adopting, includes the following goals:

- ***Prevent premature deaths due to suicide across the life span;***
- ***Reduce the harmful after effects associated with suicidal behaviors and the traumatic impact on family and friends; and***
- ***Promote opportunities to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families and communities.***

MARYLAND GOALS – FY 2008 TO 2012

GOAL 1: AWARENESS – *Maryland youth, their families and the professionals who work with them understand suicide is preventable.*

GOAL 2: INTERVENTION – *Culturally competent, effective and accessible community-based intervention services and programs for youth are in place.*

GOAL 3: POSTVENTION – *Effective, culturally competent professional services are accessible to youth who have attempted suicide and/or to other people affected by the suicide attempt or completion.*

GOAL 4: METHODOLOGY – *Maryland will advance the science of youth suicide prevention.*

IV. Demographic and Statistical Information:

Statistical Analysis of Completed Suicides by Youth in MD from 1990-2006

Suicide is a major preventable public health issue in the United States. It is the third leading cause of death for people under the age of 24, and suicide is an increasing problem among the elderly, young African American males, college age young adults and the GLBTQ community. In 2006, Maryland lost 514 people to suicide. This number does not include deaths caused by overdoses, drowning, car crashes, and self-inflicted gun shot wounds that were ruled as accidents.

According to 2006 statistics presented by the National Institute of Mental Health, suicide was the 11th leading cause of death in the U.S., accounting for 32,439 deaths in 2004. The overall rate reported was 10.9 suicide deaths per 100,000 people.

According to the National Institute of Mental Health, in 2004, suicide was the third leading cause of death in children, adolescents and young adults.[3]

Children ages 10 to 14: 1.3 per 100,000
Adolescents ages 15 to 19: 8.2 per 100,000
Young adults ages 20 to 24: 12.5 per 100,000

Youth were more likely to use firearms, suffocation and poisoning than other methods of suicide; however, while adolescents and young adults frequently used firearms, children were more likely to use suffocation. Additionally, four times as many males as females, ages 15 to 19, died by suicide and more than six times as many males as females, ages 20 to 24, died by suicide.

Suicidal behavior is extremely complex. Youth suicide involves risk factors associated with age, sex, ethnicity, and race. Risk factors may occur in combination and also change over time. Research has demonstrated that risk factors include:[4]

- Depression and other mental disorders (more than 90 percent who die by suicide have a mental illness)
- Substance abuse disorders
- Stressful life events in combination with other risk factors
- Prior suicide attempt
- Family history of psychiatric illness or substance abuse

[3] National Institute of Mental Health. "Suicide In the U.S.: Statistics and Prevention," 2006 (rev)

[4] ibid

- Family history of suicide
- Family violence, including physical or sexual abuse
- Firearms in the home (the method used on more than half of suicides)
- Incarceration
- Exposure to the suicidal behavior of others, such as family members, peers or media figures

This section reviews the completed suicides (i.e., deaths attributed to intentional self-injury) by young people in Maryland from 1990-2006. The previous Maryland Plan for Youth Suicide Prevention presented data from 1970-1985. Both reports follow a similar format to facilitate comparison between past and current data. The current data comes from Office of Chief Medical Examiner; data from 1986-1989 were not available. The current review examines the relationship between completed suicide and geographic region (i.e., counties), age (ages 10-24 inclusive), sex, race, and method over time (i.e., years). Data on suicide attempts is presented in the following section.

From 1990-2006, there were 1,219 completed suicides by Maryland youths, as compared to 1,520 documented suicide deaths from 1970-1985. The number of deaths per year ranged from 63 (1996, 2001) to 84 (2003). Tables 1 and 2 present the 2000-2004 suicide rates per 100,000 for Maryland and United States residents aged 10-24. Calculation of crude rates is based on the entire population. Crude rates are the absolute number of cases or deaths in a given population (in Table 1, ages 10-24 in Maryland) during a given time frame (2000-2004) divided by the population in the given geographic area (in Table 1, the size of the total Maryland population). There are no adjustments (e.g., for age) made when a crude rate is presented. At the time of analysis, national data were only available through 2004.

Table 1: 2000 - 2004, Maryland
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 10 to 24

Number of Deaths	Population	Crude Rate
374	5,591,969	6.69

Table 2: 2000 - 2004, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 10 to 24

Number of Deaths	Population	Crude Rate
21,638	307,860,064	7.03

Table 3 examines recent completed suicides by county. Together, these data show the overall Maryland youth suicide rate follows the national trend, but there are geographic regions of Maryland with higher youth suicide rates. Counties with rates higher than 8 per 100,000 are (highlighted below): Allegany, Calvert, Cecil, Dorchester, Queen Anne's, Washington, and Wicomico. Examination of adjusted rates and inclusion of 2005-2006 data did not change the findings except that Worcester County also was identified as having a higher than expected rate. In addition to examining rates, it is important to consider counties with higher frequencies of completed suicides (e.g., Baltimore City, and Baltimore, Prince George's and Montgomery Counties).

Table 3: 2000 - 2004, Maryland Suicide Injury Deaths and Rates per 100,000 by County (All Races, Both Sexes, Ages 10-24)

County, Maryland	Total Population	# Completed Suicides	Crude Rate per 100,000
Allegany County	72,831	9	12.36
Anne Arundel County	509,300	25	4.91
Baltimore County	787,384	46	5.84
Calvert County	88,804	13	14.64
Caroline County	32,617	1	3.07
Carroll County	170,260	11	6.46
Cecil County	99,506	8	8.04
Charles County	140,416	10	7.12
Dorchester County	31,631	5	15.81
Frederick County	222,938	13	5.83
Garrett County	29,859	1	3.35
Harford County	241,402	13	5.39
Howard County	272,452	14	5.14
Kent County	19,983	1	5.00
Montgomery County	932,131	48	5.15
Prince George's County	841,315	51	6.06
Queen Anne's County	46,241	5	10.81
St. Mary's County	98,854	3	3.03
Somerset County	25,774	2	7.76
Talbot County	36,062	2	5.55
Washington County	143,748	12	8.35
Wicomico County	91,987	8	8.70
Worcester County	48,866	3	6.14
Baltimore City	631,366	40	6.34

DATA SUMMARY

- From 1990-2006, there were 1,219 documented suicide deaths completed by Maryland youth aged 10-24, as compared to 1,520 from 1970-1985. The number of deaths per year ranged from 63 (1996, 2001) to 84 (2003).

- The 2000-2004 suicide rate per 100,000 for Maryland residents aged 10-24 (6.69) is comparable to the national rate (7.03), but there are geographic regions of Maryland with higher youth suicide rates (Allegany, Calvert, Cecil, Dorchester, Queen Anne's, Washington, Wicomico, and Worcester Counties for this time period. In addition, several counties had higher frequencies (≥40) of completed suicides (e.g., Baltimore City, and Baltimore, Prince George's and Montgomery Counties).

- The following percentages pertain to the 1,219 completed suicides by individuals under age 25 from 1990 through 2006 in Maryland. While the overall number of completed suicides decreased from the last report, the number of cases in those aged 10-14 increased. In addition, the male-to-female ratio has widened slightly.

Ages	10-14	6%
	15-19	32%
	20-24	62%
	Male	86%
	Female	14%
	White	70%
	Non-white	30% (26% Black)

- The following are the 2006 suicide rates per 100,000 for demographic groups of Maryland residents aged 15-24. Suicide rates among white males and females have decreased since the last report, while the rates among non-white males and females have increased.

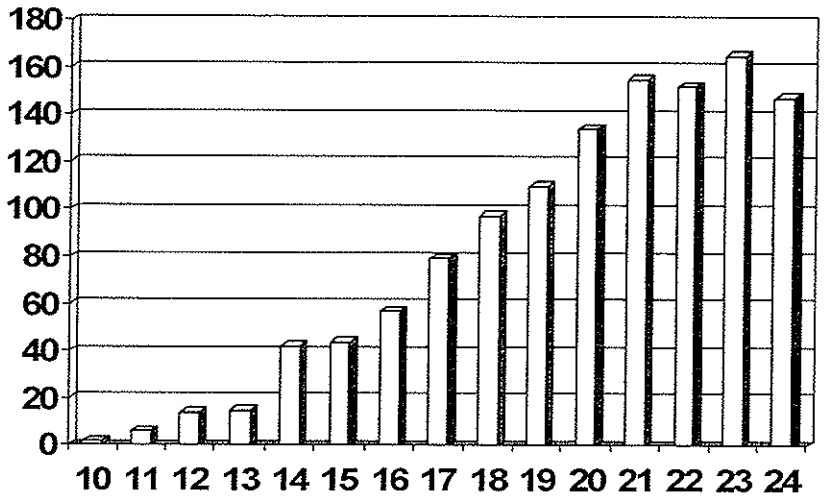
White Male	17.8
Non-white Male	14.2
White Female	4.4
Non-white Female	3.2

- Firearms were used in 51 percent and hanging in 30 percent of all suicides by Maryland youth from 1990-2006. The data support use of firearms and overdose/poisoning has appeared to decrease, while the use of hanging has increased, especially among certain demographic groups. The use of firearms was the most common method selected by white males, black males and males of other races. Hanging was the most common method selected by white and black females, while poisoning/overdose was most common for females of other races.

Effects of Age

Figure 1 shows the number of completed suicides for each age from 1990 to 2006. No suicides by children younger than 10 years old were recorded. For 10, 11 and 12 year olds, 2, 6 and 14 cases, respectively, were recorded. This is in comparison to 0, 5, and 6 completed suicides for the same age groups from 1970-1985. Examination of the figure shows that frequency increased with age and then leveled off somewhat in the 20's age group. The peak was age 23, with 165 cases in that time period. In the 1970-1985 report, the peak was age 24 (215 cases).

Figure 1: Suicide cases by age in Maryland, 1990-2006



The same data is collapsed into three age groups in Figure 2. There were 79 (6% of total) cases by those aged 10-14; 387 (32%) cases by ages 15-19; and 753 (62%) cases by ages 20-24. This data also strongly supports that the frequency of suicides increases with age, and that ages 20-24 are responsible for the majority of completed suicides in youth. During 1970-1985, 62 (4%), 476 (31%) and 982 (65%) completed suicides were recorded for those aged 10-14, 15-19 and 20-24 respectively. Of note, while the overall number of completed suicides decreased from the last report, the number of cases in those aged 10-14 increased.

Figure 3 compares the Maryland rate for those aged 15-24 to the US rates for this age group and all ages from 1990-2006. The Maryland rate is pretty consistently below the other rates. The rate went from 11.17 in 1990 to 9.48 in 2006 (maximum rate: 12.1 in 1994; minimum rate: 7.65 in 2005); from the previous report, the rate went from 4.4 in 1950 to 11.6 in 1980. When the rates for age category were broken down further into those aged 10-14, 15-19, and 20-24, the rates were variable over time; thus, the data must be interpreted cautiously. The rate for 10-14 year-olds in Maryland appears to be rising slightly to trend closer to the national average. For those aged 15-19, the Maryland rate was pretty consistently below the US rate until it peaked in 1999 (9.13 per 100,000) and remained more consistent with the national data; however in more recent years the rate has declined again and should be compared to updated US data when

available. The rate for those aged 20-24 has consistently been higher than those aged 10-14 and 15-19. For 20-24-year-olds, the rate went from 11.7 in 1990 to 14.4 in 2006 with the maximum rate recorded at 17 in 1994; in the previous report, the rate went from 13.5 in 1970 to 16.6 in 1984 with the maximum recorded at 21.2 in 1977.

Figure 2: Suicide cases by age group in Maryland, 1990-2006

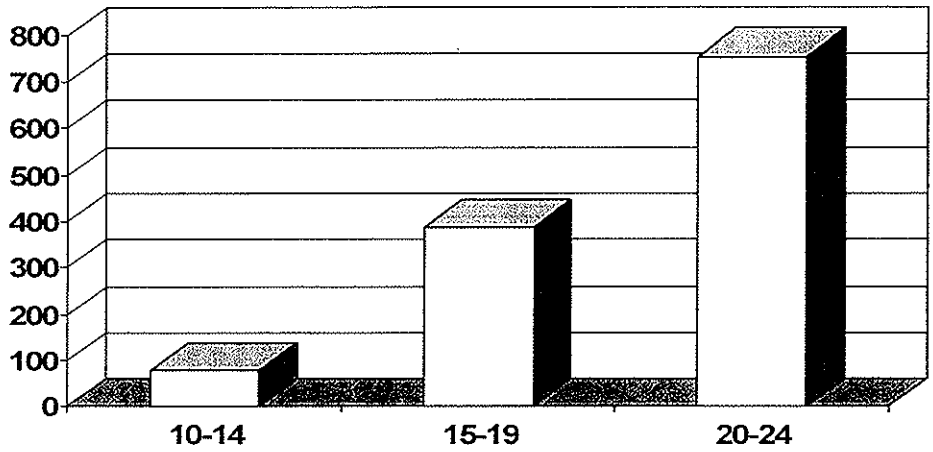
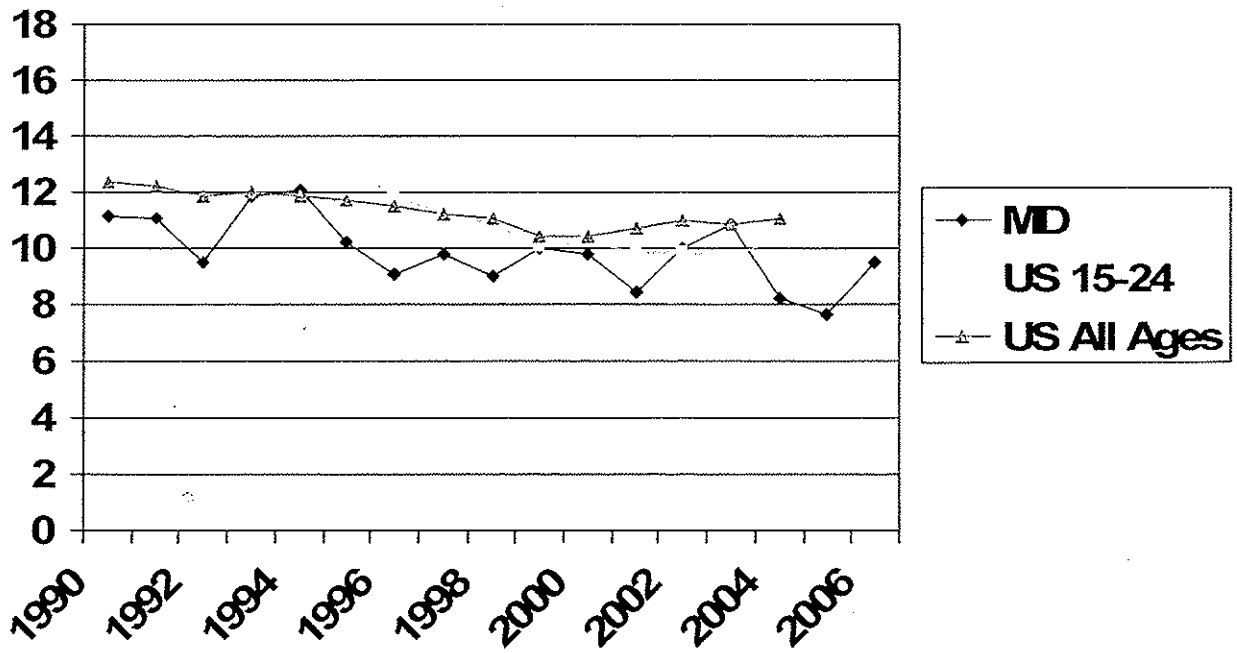


Figure 3: Suicide rates for ages 15-24 from 1990-2006

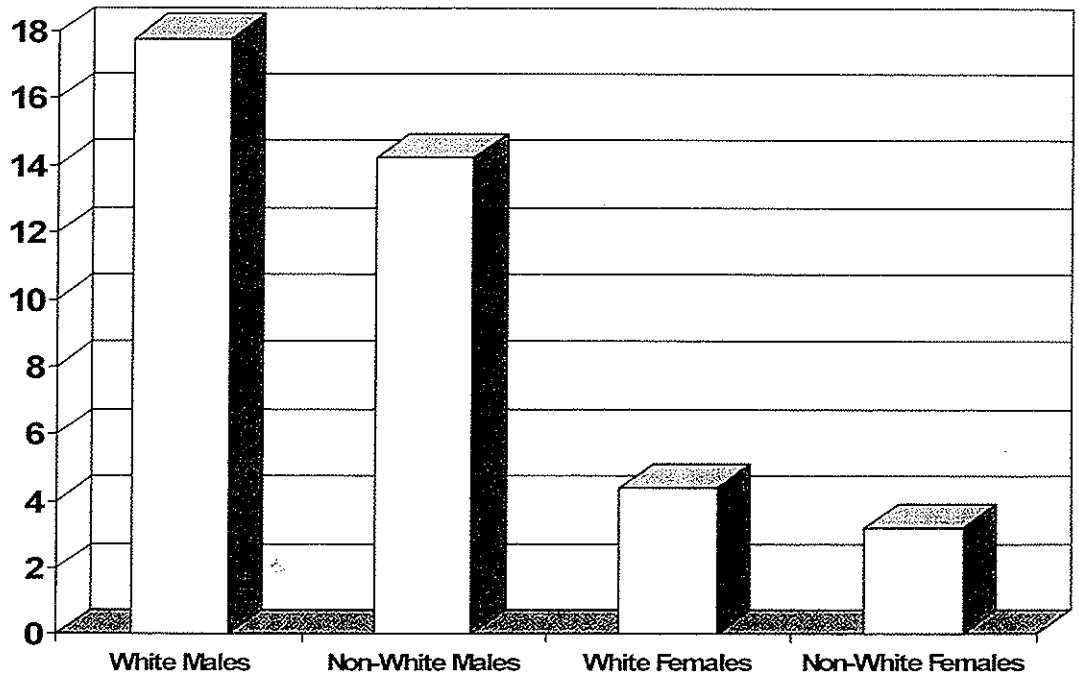


Effects of Sex and Race

From 1990-2006, there were 1,046 (86% of total) suicides completed by males in Maryland, as compared to 173 (14%) by females (approximately 6:1 ratio). The previous report indicated 82% of completed suicides were males (18% female) and the ratio was 5.2 males: 1 female (1982, 15-24 year olds). Thus, over 1990-2006, the male-to-female ratio has appeared to widen slightly.

From 1990-2006, there were 846 (70% of total) completed suicides by whites, 321 (26%) by blacks, and 50 (4%) by other races/ethnic groups; data points were missing for 2 cases. From 1970-1985, 83 percent of completed suicides were by whites (17% non-whites). Figure 4 shows the suicide rates for 15-24 year-olds in each of four demographic groups for 2006: white males (17.8), non-white males (14.2), white females (4.4), and non-white females (3.2). In the previous report, the 1982 rates were as follows for the same age group: white males (25.3), non-white males (10.8), white females (4.9), and non-white females (1.7). Thus, for 2006, higher suicide rates among white males are evident; however they have decreased since the last report, while the rates among non-white males have increased. Similarly, rates for white females have decreased slightly, while they have increased for non-white females.

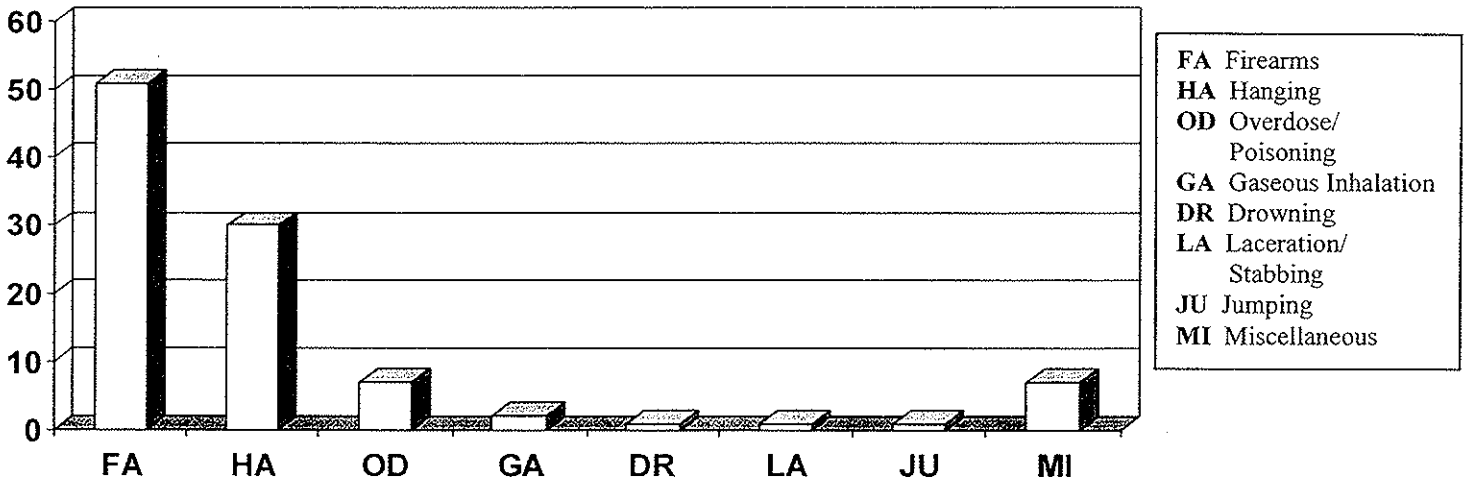
Figure 4: Maryland 2006 suicide rate by race and sex, Ages 15-24



Suicide Methods

For this report, suicide methods have been categorized into eight groups: firearms (FA), hanging (HA), overdose and poisoning (OD), gaseous inhalation (GA), drowning (DR), laceration (LA), jumping from height (JU) and miscellaneous/other causes (MI). Figure 5 represents the 1,219 Maryland suicides by individuals under 25 from 1990 through 2006. Percentages of this total by choice of method are shown. In the later figures, gaseous inhalation is included with the overdose/poisoning category.

Figure 5: Percent of total Maryland suicide cases for 1990-2006 by method



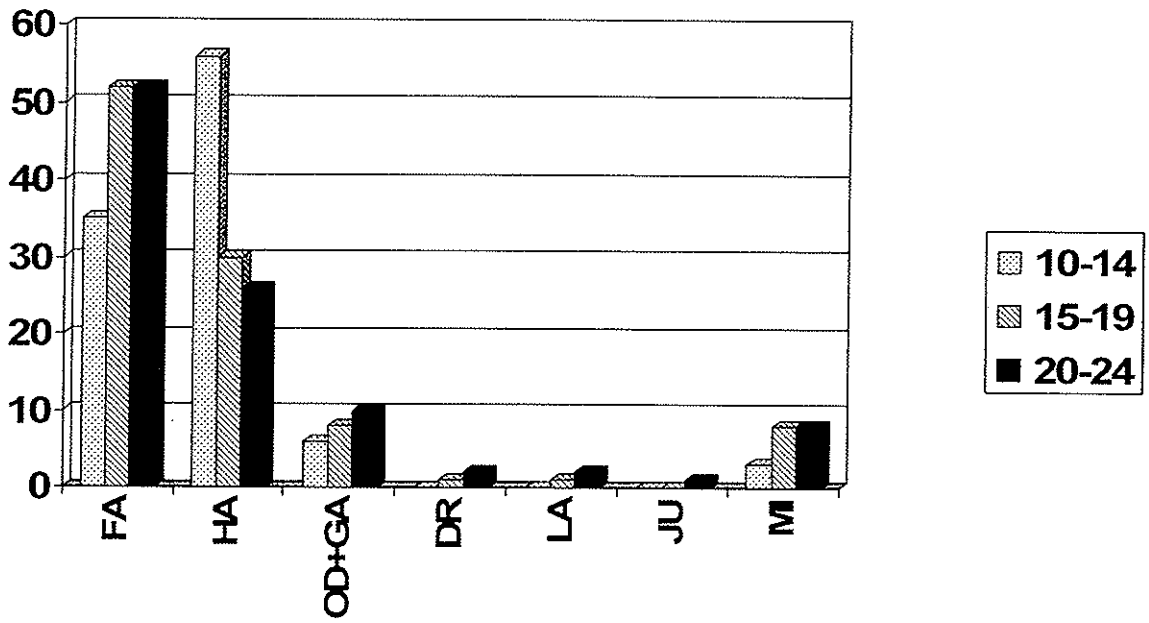
Fifty-one percent of all of the suicide deaths in this age range resulted from the use of firearms. Hangings accounted for the next most frequent cause of death at 30 percent of the cases. The overdose/poisoning and gaseous inhalation (mostly carbon monoxide) categories together accounted for 9 percent. Jumping from height, drowning, and laceration each were responsible for one percent or less of documented deaths. The miscellaneous category accounted for about 7% of reported cases. During 1970-1985, the percent of total Maryland suicide cases for this age range by method were as follows: 54% firearms; 19% hanging; 19% overdose/poisoning including gaseous inhalation; and less than 2.5% each for the remaining categories. The most striking differences between the current and previous report are that the number of youth completing suicide by hanging has increased while overdose/poisoning has decreased.

Percentages of individuals in each age group by choice of method are indicated in Figure 6. The majority of those aged 10-14 committing suicide involved hanging, with firearms the second most common choice. Both the 15-19 and 20-24 age groups employed firearms in greater than 50% of their suicides, with hanging the second most common choice. The percentage of individuals choosing the overdose/poisoning method increased with age. The only major

difference from the last report was that hanging surpassed overdose/poisoning as the second most common method among 20-24 year-olds.

Method selection for males and females is graphically depicted in Figure 7. Clearly, firearms represent the primary method used by males, with hanging the second and overdose/poisoning the third most common causes. Females were most likely to choose hanging as their method of suicide, with firearms the second and overdose/poisoning the third most common causes, but the discrepancies were not as large as in males. Comparing to the 1970-1985 data, the findings for males are similar; however, for females, the prior report documented firearms, overdose/poisoning and hanging as the three most common methods respectively.

Figure 6: % of total Maryland suicide cases by method and age, 1990-2006



Key: **FA**=Firearms; **HA**=Hanging; **OD**=Overdose/Poisoning; **GA**=Gaseous Inhalation; **DR**=Drowning; **LA**=Laceration/Stabbing; **JU**=Jumping; **MI**=Miscellaneous

For the purposes of this analysis, non-whites were separated into black and other races (see Figure 8). Both whites and non-whites were most likely to choose firearms as the primary suicide method, which is consistent with the 1970-1985 report. In addition, for both whites and non-whites, the second and third choices were hanging and overdose/poisoning respectively if the miscellaneous methods are separated out. Compared to the 1970-1985 data, hanging surpassed overdose/poisoning as the second most common choice among whites. Interestingly, the discrepancy between firearms and hanging was not as large for other races as it was for whites and blacks.

Figure 7: % of total Maryland suicide cases by method and sex, 1990-2006

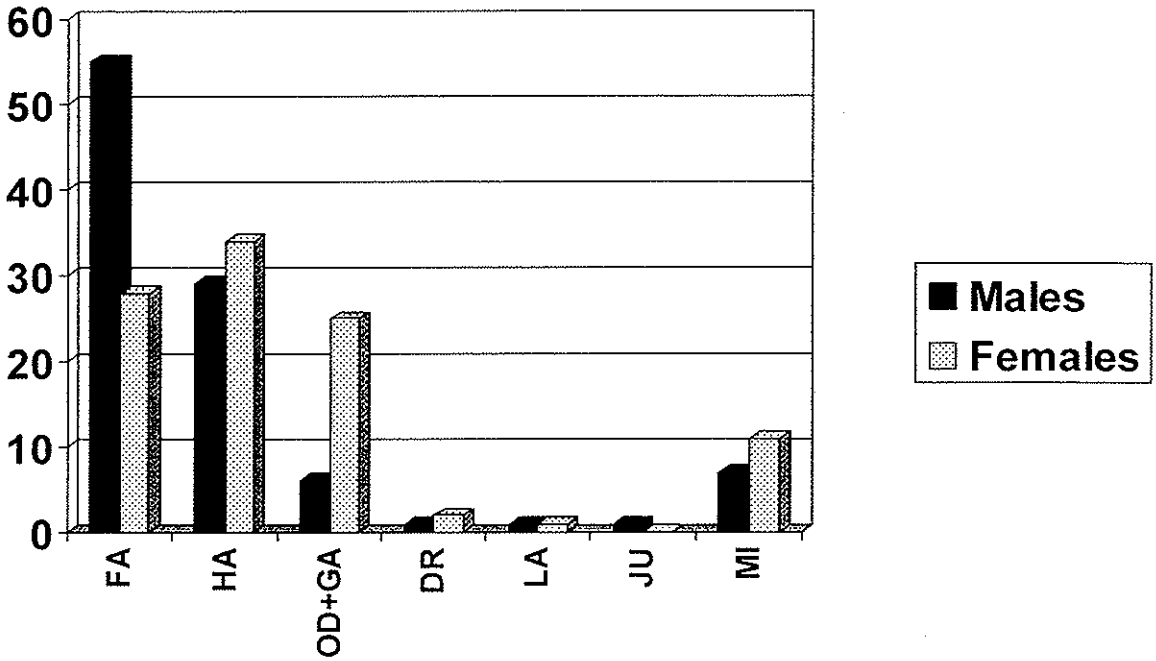


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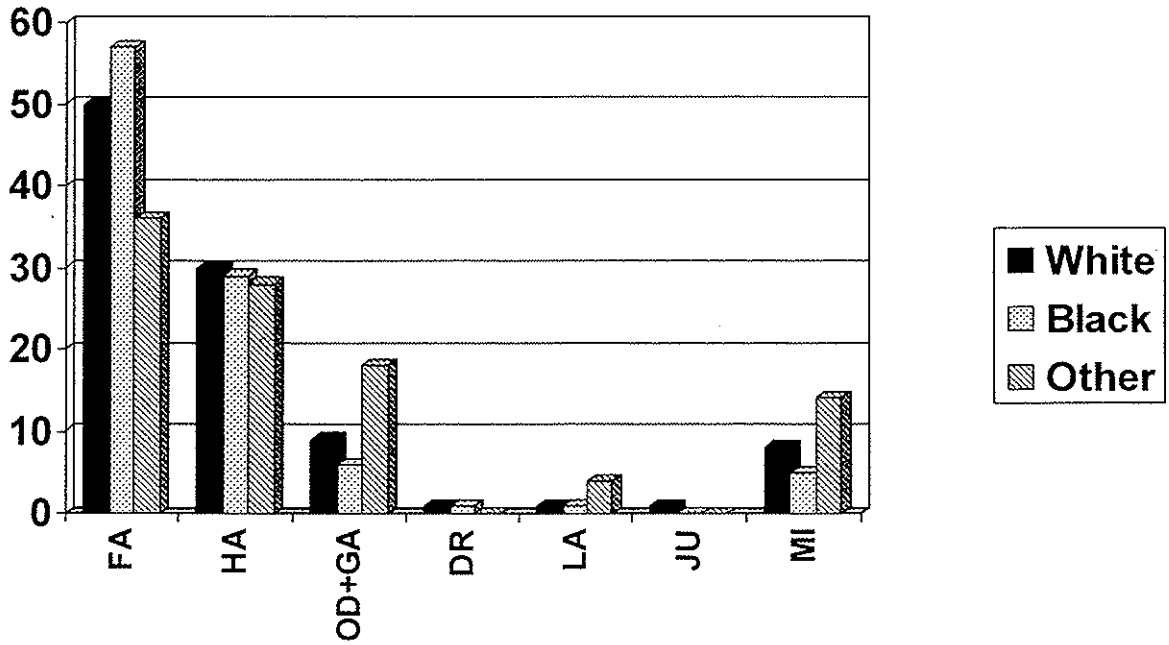
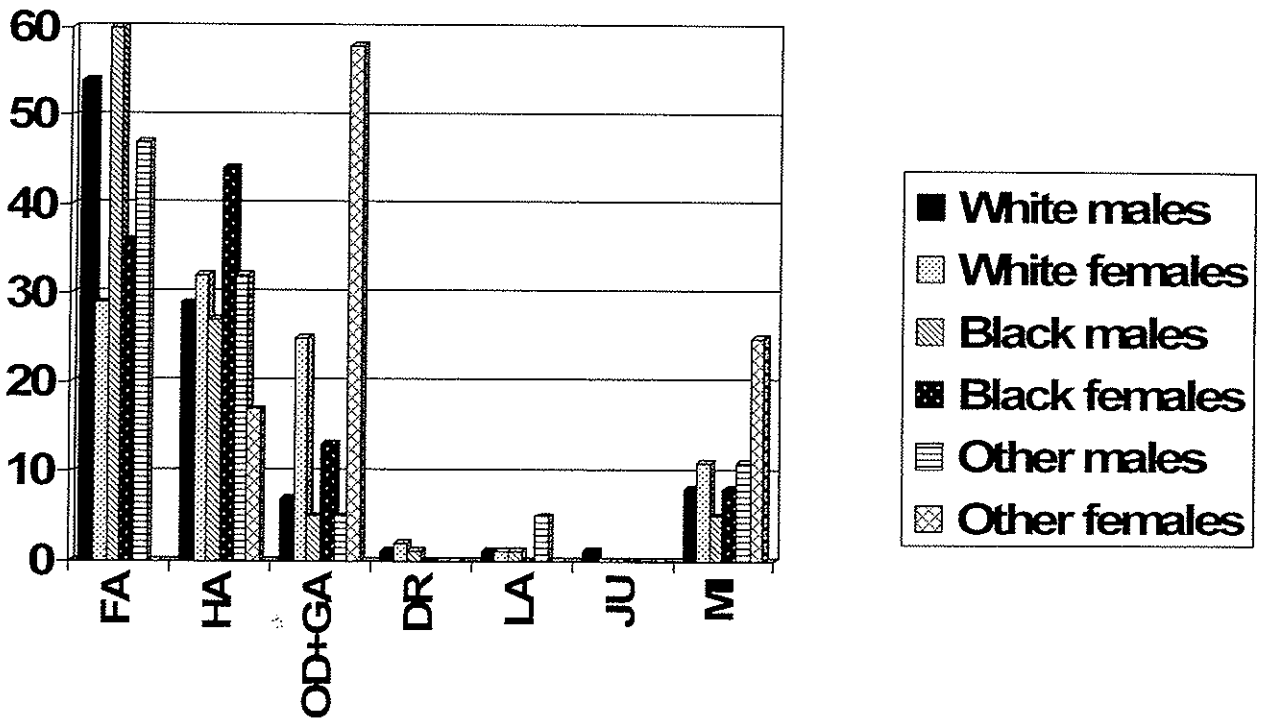
Figure 8: % of total Maryland suicide cases by method and race, 2000-2006



Percentages for selection of each method by race and sex are shown in Figure 9. It is striking that white males, black males, and males of other races had similar patterns of findings with firearms, hanging, and overdose/poisoning the three most common choices respectively. Among white and black females, hanging, firearms and overdose/poisoning were the three most common choices respectively. For females of other races, overdose/poisoning and hanging were the two most common choices; however, this demographic group had a high number of suicides classified as miscellaneous which may be because they were not able to be classified more specifically. In the last report, all demographic groups were most likely to choose firearms as the primary method of suicide.

Method selection can be examined alternately by considering the degree to which each demographic group utilized individual methods. Firearms, for instance, while high in all male demographic groups, were most likely selected by black males. Hanging was most likely selected by black females, while overdose/poisoning was most likely selected by females of other races. Laceration, which includes stabbing, was most likely selected by males of other races. This contrasts with the previous report: firearms (white males); hanging (non-white males); overdose/poisoning (white females); and less-common methods (non-white females).

Figure 9: % of total Maryland suicides by method, race and sex, 1990-2006

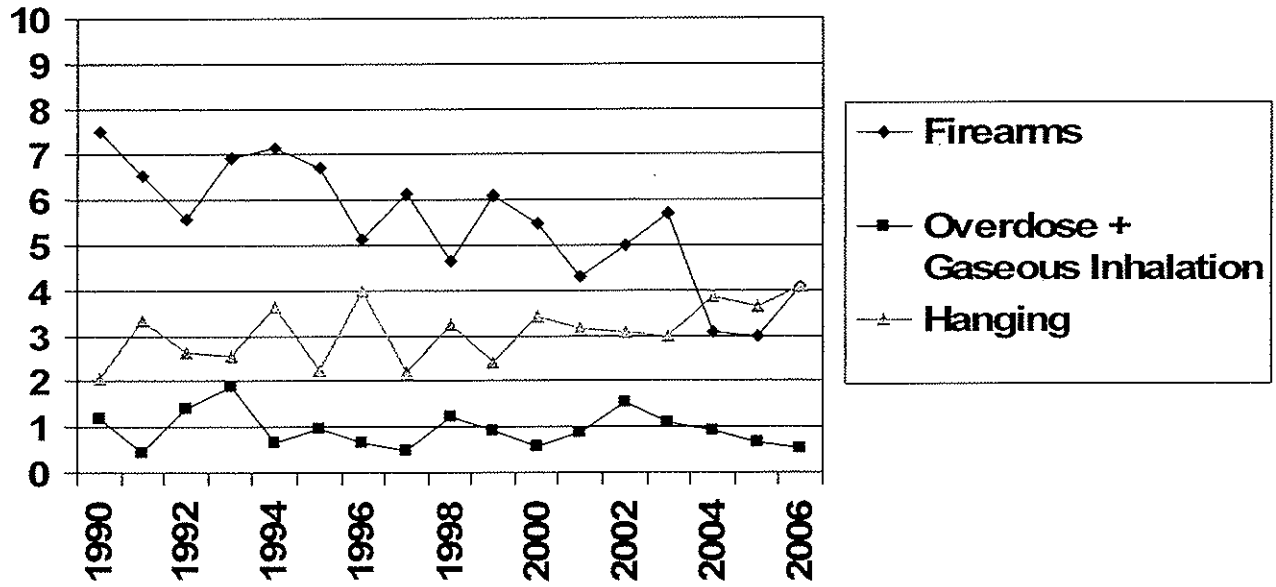


Key: **FA**=Firearms; **HA**=Hanging; **OD**=Overdose/Poisoning; **GA**=Gaseous Inhalation; **DR**=Drowning; **LA**=Laceration/Stabbing; **JU**=Jumping; **MI**=Miscellaneous

Suicide Method Selection Trends

Figure 10 (next page) shows the rates per 100,000 for selected methods by those aged 10-24 from 1990-2006. This data supports that use of firearms has appeared to decrease, while the use of hanging has increased. Rates for overdose/poisoning have remained relatively stable. This data is in contrast to the prior report which indicated an increase in the firearm rate.

Figure 10: Maryland youth suicide rate for selected methods, 1990-2006



Other Data on Completed and Attempted Suicide in MD Youth

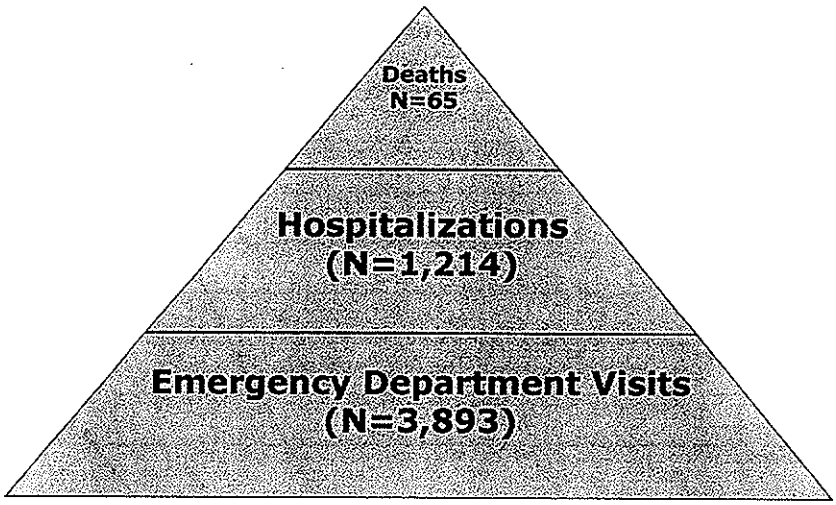
The following more detailed data refer to a sub-group of completed suicides from 2003-2005 in youth aged 0-18 (see Figure 11).[5] This data comes from the Maryland Violent Death Reporting System, which gathers information from the following sources:

- Maryland Office of Vital Statistics
- Maryland Office of the Chief Medical Examiner
- Police Reports
- Crime Lab Reports
- Supplemental Homicide Reports
- Maryland Health Services Cost Review Commission (Hospital Discharge Data)

Figure 11: Youth Suicides and Attempted Suicides

[5] Suicide Prevention Resource Center. "Maryland Suicide Prevention Fact Sheet." 2007.

in Maryland: Ages 0 – 18, 2003-2005



Source: Partnership for a Safer Maryland (May 2, 2006)

- Of the 65 youth suicides, circumstances of suicide were known in 80% (52) of the cases.
- Of the 52 victims with known circumstances:
  - Approximately 44% (23) had current mental health problems
  - Approximately 35% (18) left a suicide note
  - Approximately 27% (14) had a crisis in the past two weeks
- Of the 58 tested for antidepressants at autopsy, 20.7% tested positive for antidepressants.
- The youngest attempted suicide was in a five year old
- Over 70% of the youth who attempted suicide were female (see Figure 12).
- The majority of persons who attempted suicide were white (66.5%).
- The majority of suicide attempts were caused by poisoning (see Table 4).
- Montgomery County had the most suicide attempts (246) during this time period, followed by Prince George's County (149) and Baltimore County (145). Attempts may be higher in these jurisdictions due to the respective size of the youth populations.

Figure 12: Hospitalized Attempted Suicide by Gender and Age, 2003-2005

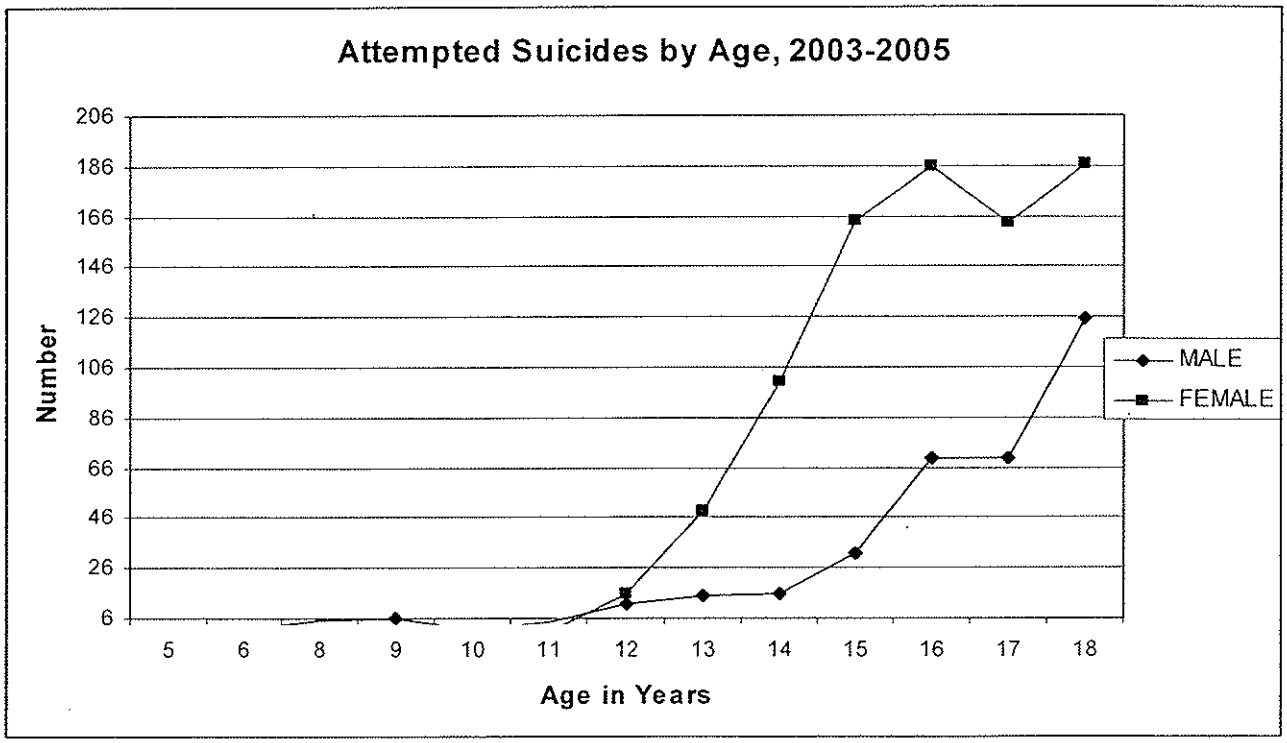


Table 4: Hospitalized Attempted Suicide by Manner

Manner	Total
Cutting/Piercing	259
Firearms	7
Hanging	10
Strangulation/Suffocation	#
Jumping High Place	14
Other Unspecified	56
Poisoning	877

Cells less than 6 are removed to preserve confidentiality

V. PROCESS, FINDINGS AND RECOMMENDATIONS:

The Maryland Committee on Youth Suicide Prevention began work on the proposed youth suicide prevention plan in September 2007. This plan, *Linkages to Life: Maryland's Plan for Youth Suicide Prevention,* was completed in February 2008. The five-year plan proposes an array of promising prevention, intervention, and postvention services for the entire State of Maryland. Special focus is placed on enhanced efforts in rural counties where mortality rates are highest in the State. The program is founded on a partnership of State and local government agencies, medical schools at Johns Hopkins University and the University of Maryland, and numerous private sector partner agencies.

This plan outlines broad State and local infrastructure development and service improvements in local schools statewide, which may enhance delivery of instruction about suicide prevention within the State's voluntary Health Education curriculum for students in 8th grade and high school. The project will also provide statewide training for a wide variety of educational personnel, including teachers, administrators, and those in the Student Services (e.g., school counselors, school psychologists, social workers, nurses, and pupil personnel workers) and paraprofessional workforce on suicide prevention and intervention.

Local partnerships of school districts, Core Service Agencies, Health Departments, behavioral health authorities, juvenile justice, child welfare officials, and a wide range of private providers and advocacy groups will be created. These local partnerships will receive technical assistance in focused suicide programs, collaborations with emergency departments and emergency medical services, and focus on other special populations of high-risk youth. This plan has a particular focus on transition aged youth (ages 18 to 21 years) and returning war veterans (up to 25 years of age) who also are at high-risk. Research shows that transition aged youth are most at risk for suicide completion in Maryland.

Counties with the highest mortality rates shall be accorded priority in the implementation of projects and will receive additional technical assistance and resources from the State and its expert partners. The program will tap into exceptionally strong resources for research and evaluation through the academic partners. Featured among the resources will be focused data development agendas and outcome research that will advance the field of suicide prevention in Maryland and across the nation. Additionally, this plan utilizes the resources and expertise of the statewide Maryland Youth Crisis Hotline Network.

Contributors to this report were members of the Maryland Committee on Youth Suicide Prevention. This broad based interagency committee was established many years ago under the auspices of the Maryland Mental Hygiene Administration. In FY 2007, seven workgroups were formed for the purpose of writing a new five-year plan and to seek additional grant funding to address suicide prevention and intervention in Maryland. The seven workgroups were as follows: (1) Review of the 1987 Maryland Plan, (2) Prevention Strategies and Resources, (3)

Intervention Strategies and Resources, (4) Postvention Strategies and Resources, (5) Review of the Literature and Other State Plans, (6) Review of the Federal Suicide Prevention Plan, and (7) Data and Methodology.

Scope of the Report and General Conclusions

The overarching theme of this report is:

- Suicide is preventable, is a real health problem, is complex, and there needs to be a comprehensive continuum of services and approaches to solve this problem among youth;
- Service and outreach should be culturally competent;
- Services should be universal in its approach, yet targeted to youth at risk for suicide;
- Services have to be community based with a youth and family focus;
- Should have a public health and mental health approach;
- Affects the whole community; and
- State and local partnerships are essential.

Findings:

- Although Maryland has seen much progress since the first suicide prevention plan was written in 1987, there is still much work to be done.

- Suicide continues to be the 3rd leading cause of death for youth in Maryland. In 2004, Maryland ranked 44th among states in all deaths due to suicide. That year, there were 500 deaths at a rate of 9.0 per 100,000. (American Association of Suicidology)

- From 2000-2004 the crude suicide death rate for Maryland youth 10 to 24 (374 deaths) was 6.69. Although this was below the crude suicide death rate nationally (7.03) there are still counties above the Maryland and National suicide rates for youth.

Five Counties in Maryland with the highest adjusted rates for youth suicides include:

2000-2006

Allegany County
Dorchester County
Calvert County
Worcester County
Cecil County

Five counties in Maryland with the highest number of youth suicides include:

Prince George's County
Montgomery County
Baltimore County
Baltimore City
Anne Arundel County

Conclusions:

- When this plan is implemented it will improve public awareness of youth and young adult suicide and the availability of resources;
- The plan will help overcome stigma and decrease youth and young adult suicide;
- Ensure delivery of state-of-the-art prevention, intervention and postvention approaches;
- Provide programs in a culturally competent manner; and
- Facilitate entry into treatment for youth and young adults.

RECOMMENDATIONS:

1. Establish an Office of Suicide Prevention within the Department of Health and Mental Hygiene Administration.

2. Develop more coordinated prevention, intervention, and postvention services across the state for youth, young adults (including veterans) and their families.

3. Local schools systems, and other educational networks, will address core components in youth suicide prevention programs.

4. Increase funding for youth suicide prevention, intervention, and postvention, including increased funding to the Maryland Youth Crisis Hotline programs and capacity building.

5. Develop a Website and new technologies to access and help youth.

6. Infuse cultural competence throughout services to youth and their families.

7. Each child serving agency will have a youth suicide prevention plan.

8. Increase inservice training to local departments of correction and to youth detained in local jails.

9. Strengthen the State's capacity to respond to crises and serve at-risk-youth in need.

10. Increase the number and quality of trainers in suicide prevention, intervention, and post-vention.

11. Increase outreach and the number of training geared to gatekeepers and the public around youth suicide issues.

12. Work with faith based organization around youth suicide prevention issues.

13. Implement a model Hospital/Urgent Care suicide postcard follow-up program for at-risk-youth in emergency departments.

14. Establish a baseline listing of existing support systems for survivors and attempters.

There is a desperate need in Maryland for additional resources to be devoted to helping troubled youth, distraught parents, and others who are touched by the turmoil of youth suicide. The Maryland Committee on Youth Suicide Prevention strongly believes the FY 2008-2012 Maryland plan will to be the vital "linkage to life" to save young lives.

GOAL 1: AWARENESS	***Maryland youth, their families and the professionals who work with them understand suicide is preventable.***			
OBJECTIVES/STRATEGIES	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
1.1 In FY 2008, establish an Office of Suicide Prevention within the Department of Health and Mental Hygiene.	-Mental Hygiene Administration -Department of Health and Mental Hygiene (DHMH)	FY 2008	All youth suicide prevention, intervention, and post-vention efforts, including the execution of this plan, will be coordinated and evaluated by one centralized entity.	Office established and staffed. Statewide Suicide Prevention Plan developed, approved and updated regularly.
1.2 By FY 2009, the Office of Suicide Prevention will implement the Maryland Youth Suicide Prevention Plan, facilitate public awareness and marketing efforts, and serve as a resource to all other State agency efforts in youth and young adults (including young returning war veterans) suicide prevention.	-DHMH -Maryland Office of Suicide Prevention	FY 2008 – FY 2010	Maryland's efforts in suicide prevention are coordinated, outcome driven and visible to the public.	Marketing plan completed and implemented; campaign materials distributed; college radio and television stations use materials; and annual plan implementation reports. Marketing plan coordinated with "What a Difference A Friend Makes" SAMSHA Ad Council campaign and VA efforts in Maryland.
1.3 By FY 2010, local school systems, and other educational networks, will address the following core components in youth suicide	-Maryland Office for Suicide Prevention -Maryland State	FY 2008 – FY 2010	Children and youth in school settings learn about suicide risk, prevention and intervention from their educational programs. Faculty and family of students in	Schools report baseline data describing current implementation of suicide prevention programs.

prevention school programs: • Implement the Maryland Health Education Voluntary State Curriculum. • Address evidence-based practices, practice-based evidence or results supported practices. • Provide annual training to newly hired professional and support staff about the identification of, initial response to, and effective culturally competent referral of suicidal students. • Periodically, but no less than once every three years, provide refresher training to professional and support staff about effective identification and appropriate referrals of suicidal youth. • Periodically, but no less than once every three years, provide advanced training for Student Services professionals about evidence-based and culturally competent, youth suicide prevention practices. • Include a process for	Department of Education (MSDE) -Local Education Agencies -Maryland Assoc. of Non-public Special Education Facilities -Association of Independent Maryland Schools -Maryland Higher Education Commission (MHEC) -Maryland Interagency Transition Council		school settings learn about suicide risk, prevention and intervention.	Schools evaluate youth suicide prevention efforts at least annually. Local school systems report utilization of 100% of the core components after project initiation. Teachers report increased knowledge related to suicide prevention lessons. Teachers and students report satisfaction with lessons. Students report positive changes in knowledge, attitudes and behaviors, including increased awareness of the Hotline. Trained school system personnel are available throughout the State. Training recipients report satisfaction. Training recipients report

screenings of suspected suicidal youth that result in referral for effective counseling and support. • Annually inform secondary students and their families about risk factors of suicide. • Empower and encourage students to seek support for peers who may be suicidal. • Provide post-vention services following a completed suicide including, but not limited to, individual and/or group student counseling; coordination with community agencies (e.g., crisis center, police, community mental health, etc.). • Infuse cultural competence in all prevention strategies. • Convene interested colleges and universities to identify needs for implementation of coordinated campus based awareness and prevention projects.				positive changes in knowledge, attitudes and behaviors, including increased awareness of the Hotline. Training recipients document basic referral information, such as frequency counts. Student Services evaluation of postvention services provided. Needs assessment for youth in higher education conducted. Participating higher education institutions report data describing current and new implementation of suicide prevention programs. Recipients report increased knowledge of the content of campus-based activities, if appropriate.

OBJECTIVES/STRATEGIES ***AWARENESS continued:***	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
1.4 By FY 2012, secure funding to support the Maryland Crisis Hotline programs, public awareness, and capacity building.	-Maryland Office of Suicide Prevention	FY 2008 – FY 2012	Maryland Youth Crisis Hotline is well known and utilized throughout the State and has the capacity to comprehensively respond to community and individual needs.	-Strategic plan to generate funding for capacity building and marketing of hotline. -Attainment of grant funding. -Increased Hotline awareness reported by targeted samples of MD citizens. -Hotline reports increase in number of calls by youth and individuals seeking services for youth. Record number of calls from veterans.
1.5 By FY 2008, develop a website that will serve as a statewide clearinghouse for information, research, and resources and as an access point and outreach tool for youth and the public about positive mental health and suicide prevention. (www.networkofcare.org)	-Maryland Office of Suicide Prevention -Mental Hygiene Administration -Department of Health and Mental Hygiene -MD Youth Hotline Network	FY 2008 – FY 2010	Maryland youth access information regarding positive mental health and interact with peers and professionals for support through the website. Professionals and the public access resources and information about positive mental health accessible from one central location.	Frequency of 'hits' and searches conducted on the website. Include resources for veterans in Maryland seeking mental health services.
1.6 Annually coordinate and host the suicide prevention conference and suicide prevention month activities that infuse cultural competence.	-Maryland Office of Suicide Prevention	FY 2008 and annually thereafter	The professional community and general public, including survivors, gain knowledge and skills and are committed to preventing youth suicide.	Conference attendance of 400 or more participants; annual forum and resource dissemination for survivors.

OBJECTIVES/STRATEGIES ***AWARENESS continued*:**	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
1.7 By FY 2010, each child serving State agency, and its appropriate sub-administrations, in consultation with the Maryland Office of Suicide Prevention, will develop a culturally competent comprehensive suicide prevention plan, to include goals, objectives and strategies that are included in the overall State Suicide Prevention Plan.	-Maryland Office of Suicide Prevention -Department of Health and Mental Hygiene -Maryland State Department of Education -Department of Juvenile Services (DJS) -Department of Human Resources	FY 2008 - FY 2010	All child serving State agencies focus on suicide prevention and work collaboratively to address youth suicide in Maryland.	Maryland Office of Suicide Prevention collaborated with State agencies on the development of individual agency plans. Agency plans incorporated in State overall Plan. The plans include training of staff and direct services personnel in the provision of accessible suicide prevention services. A process for plan implementation and evaluation has been established.
1.8 By FY 2010, develop and offer an in-service training to local Department of Corrections focusing on culturally competent suicide prevention and intervention with youth detained in local jails.	-DHMH -Maryland Office of Suicide Prevention	FY 2008 - FY 2010	Staff training program developed and implemented in local jails.	Attendance tracking sheet. Recipients report satisfaction with training and positive changes in knowledge, attitudes and behaviors related to suicide prevention and intervention.

OBJECTIVES/STRATEGIES *AWARENESS continued*:	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
1.9 By 2010, work collaboratively with local, national organizations and the Suicide Prevention Resource Center to educate the public about lethal means (including firearms, drugs, and poisons) in the home.	-DHMH -Maryland Office of Suicide Prevention	FY 2008 - FY 2010	Community awareness increased and access to lethal means of suicide reduced.	Documentation of meetings with local and national organizations. Educational campaign developed and implemented to reduce access to lethal means and methods.
1.10 By 2011, include a workshop or panel presentation on lethal means at Maryland's Annual Suicide Prevention Conference.	-DHMH -Maryland Office of Suicide Prevention	FY 2011 and annually thereafter	Mental health community educated on lethal means/methods of suicide and efforts by professionals to reduce access implemented.	Panel presentation at Annual Conference.
1.11 By 2009, increase the number of statewide faith based organizations to receive training pertaining to youth suicide prevention and the Maryland Youth Crisis Hotline.	-DHMH -Maryland Office of Suicide Prevention	FY 2008 - FY 2009	More faith based organizations are knowledgeable of resources and promote suicide prevention.	Curriculum developed and trainings provided to diverse faith based communities. Review curriculum and list of trainings provided.
1.12 By 2008, include a panel presentation, comprised of diverse faith based organizations, at Maryland's Annual Suicide Prevention Conference.	-DHMH -Maryland Office of Suicide Prevention	FY 2008 and annually thereafter	Increase faith based organizations involvement with the mental health community; promotion of knowledge of resources and promotion of prevention of suicide.	Panel presentation at Annual Conference.

GOAL 2: INTERVENTION	***Culturally competent, effective and accessible community-based intervention services and programs for youth are in place.***			
OBJECTIVES/STRATEGIES	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
2.1 By FY 2010, strengthen the State's capacity to respond to crises and serve at risk youth in need of culturally competent and evidence-based or best practice mental health services to prevent suicide through public information dissemination and increasing access to hotlines; urgent care appointments; and crisis residential stabilization beds.	-DHMH -Maryland Office of Suicide Prevention -Core Service Agencies -Maryland Youth Crisis Hotlines -Department of Juvenile Services -Department of Human Resources -Private providers	FY 2008 – FY 2010	Twenty-four hour accredited crisis response/access exists statewide for youth at risk via telephone, utilization of alternative communication systems, and face-to-face mobile crisis team contact. Early and immediate clinical intervention available through accessible urgent care appointments to prevent crisis situations from escalating, including an emphasis on substance abuse services and telepsychiatry in rural underserved areas of the State. Crisis residential and/or 23-hour holding/stabilization beds accessible and available to each jurisdiction for youth in psychiatric crisis that have met the requirements for Emergency Petition.	-Every jurisdiction advertises and links at risk youth to MD Youth Crisis Hotline Network. -MD Youth Crisis Hotline Network information available to discharge planners at youth facilities. -Every jurisdiction has a plan for 24/7 crisis response for at risk youth, including access to urgent care appointments. -MD Youth Crisis Hotline statistics. -List of hospitals with youth psychiatric beds disseminated widely.

OBJECTIVES/STRATEGIES *INTERVENTION continued:*	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
2.2 By FY 2011, increase the number and quality of trainers in evidence-based or best practice suicide prevention and intervention for at risk youth in Maryland.	-DHMH -Maryland Office of Suicide Prevention; -Maryland State Department of Education; -Department of Juvenile Services. -Department of Human Resources - Core Service Agencies; - Maryland Youth Crisis Hotlines; - Local advocacy groups: NAMI & MHA; -Private providers. -Maryland Interagency Transition Council	FY 2008 - FY 2011	Throughout Maryland qualified instructors provide evidence-based training to youth, family members, professional providers and the faith community on suicide prevention and intervention.	25 Applied Suicide Intervention Skills Training (ASIST) or other evidence-based intervention model trainers are available throughout the State. 25 SAFETalk or other evidence-based prevention model trainers are available throughout the State. Trained school system personnel are available throughout the State. Conduct ASIST or other evidence-based intervention model training with at least 5 faith based organizations. Attendance tracking sheet. Recipients report satisfaction with training and positive changes in knowledge, attitudes and behaviors.

OBJECTIVES/STRATEGIES *INTERVENTION continued:*	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
2.3 By FY 2011, increase the number of evidence-based or best practice suicide prevention trainings provided statewide to youth, family members and professional providers.	-DHMH -Maryland Office of Suicide Prevention -Maryland State Department of Education -Department of Juvenile Services -Department of Human Resources -Core Service Agencies -Maryland Youth Crisis Hotlines -First Responders -Police Departments; -ADAA -Maryland Higher Education Commission	FY 2008 - FY 2012	Suicide intervention information and training (including risk factors for suicide, such as depression, alcohol/drug abuse) provided statewide to varied audiences.	Training/attendance tracking sheet, including list of groups trained, dates and number of trainings provided, and number of people trained annually. Presentations reviewed. Recipients report satisfaction with training and positive changes in knowledge, attitudes and behaviors on evaluations.

OBJECTIVES/STRATEGIES *INTERVENTION continued:*	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
2.4 By FY 2011, increase knowledge, skills and ability of diverse religious leaders to intervene with at risk youth and their families using evidence-based or best practices.	- Maryland Office of Suicide Prevention -Mental Health Associations -NAMI -Church Leaders -Interfaith Alliances - Maryland Youth Crisis Hotlines -2-1-1's -Core Service Agencies -Crisis providers -SPEAK -Building Men and Women for Others, Inc. -Pastoral Counseling Center -Loyola Pastoral Counseling	FY 2008 - FY 2011	Trained religious leaders are available in each jurisdiction and are working with at-risk youth and their families. Religious leaders utilize resource lists and faith-based agencies to assure appropriate information and referrals are offered to youth and their families. Ongoing work group of religious leaders and mental health providers convened in each jurisdiction/region to develop collaborative projects to reduce youth suicide.	Train at least 25 religious leaders (a limited number of which will be trained as trainers) from various groups in an evidence-based program (e.g., ASIST). Religious leaders have suicide prevention materials including lists of mental health intervention and treatment resources for each jurisdiction. Religious leaders report satisfaction with training and positive changes in knowledge, attitudes and behaviors on evaluations.

OBJECTIVES/STRATEGIES *INTERVENTION continued:*	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
2.5 By FY 2012, implement evidence-based or best practices programming, including follow-ups for at risk youth, especially suicide attempters, seen in Emergency Departments.	-DHMH -Maryland Office of Suicide Prevention -Maryland Youth Crisis Hotlines -Local Emergency Departments -Core Service Agencies	FY 2010 - FY 2012	Staff will be trained about how to better identify and work with youth at-risk for suicide and their families in the ED setting. Consistent follow up procedures will begin to be utilized statewide for at risk youth seen in Maryland Emergency Departments. More youth will receive follow up mental health care. Fewer youth previously seen in Emergency Departments will return for suicidal ideation and behaviors.	Staff training tracking sheet. Recipients report satisfaction with training and positive changes in knowledge, attitudes and behaviors. Educational suicide prevention materials for youth and families distributed in EDs. Systems (e.g., Hotline) to track follow-up procedures (e.g., postcards, telephone calls) with at risk youth who were treated in EDs developed and utilized. Increased rates of youth attendance and adherence to follow up care. Reduced recidivism rate of youth previously seen in EDs each year.

GOAL 3: POSTVENTION	***Effective, culturally competent professional services are accessible to youth who have attempted suicide and/or to other people affected by the suicide attempt or completion.***			
OBJECTIVES/STRATEGIES	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
3.1 By FY 2009, establish a baseline listing of existing support systems for survivors and attempters.	-Hotlines -Dept. of Health and Mental Hygiene -Maryland Office of Suicide Prevention, -MD State Dept. of Education -MD Higher Education Commission	FY 2009	Resource list describing existing supports available in Maryland widely distributed to survivors and attempters for the purpose of linking them to professional mental health providers in their communities.	Statewide survey and resource list completed and available for distribution to include statewide and national resources.
3.2 By FY 2010, identify gaps in support systems for survivors and attempters and develop consensus multi-agency strategies to address gap filling.	-Hotlines -Dept. of Health and Mental Hygiene -Maryland Office of Suicide Prevention -Dept. of Human Resources -Dept. of Juvenile Services	FY 2008 - FY 2010	An agreed upon multi-agency State Plan to fill gaps is developed and started by key stakeholders to find human and financial resources needed to provide supports and services.	Gaps in support services identified and strategies developed by community stakeholders to fill the gaps. Written plan available for review.

GOAL 3: POSTVENTION	***Effective, culturally competent professional services are accessible to youth who have attempted suicide and/or to other people affected by the suicide attempt or completion.***			
OBJECTIVES/STRATEGIES	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
3.3 By FY 2012, support systems for survivors and attempters are funded and accessible.	-State agencies listed in 3.2 -Private providers	FY 2008 - FY2012	Support systems begin to be funded, operational and accessible statewide for survivors and attempters.	Programs report on activities and statistics through tracking sheets. Recipients report satisfaction with activities and positive changes in knowledge, attitudes and behaviors on evaluations.
3.4 By FY 2011, educate mental health and human service providers, including the faith community and educators, on best practices for working with survivors, attempters and their significant others to include appropriate media response to suicide.	-Hotlines -DHMH -Maryland Office of Suicide Prevention -MSDE -DJS -Department of Human Res. -Mental Health Advocacy groups -MD Interagency Transition Council	FY 2008 - FY 2011	Evidence-based or best practices postvention culturally competent training program developed and implemented statewide. Human service providers are trained, provided CEUs if appropriate, and are successfully working with survivors and attempters, and their significant others (family members, friends) to lessen distress, and promote recovery and positive mental health and reduce cluster suicides.	Attendance tracking sheet, including list of groups trained, dates and number of trainings provided, and number of people trained annually in postvention. Presentations reviewed. Recipients report satisfaction with training and positive changes in knowledge, attitudes and behaviors on evaluations.

GOAL 3: POSTVENTION	***Effective, culturally competent professional services are accessible to youth who have attempted suicide and/or to other people affected by the suicide attempt or completion.***			
OBJECTIVES/STRATEGIES	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
3.5 By 2010, research, develop and utilize online tools for youth to access information and resources via the internet and hand held devices.	-Hotlines -2-1-1 -Dept. of Health and Mental Hygiene -Maryland Office of Suicide Prevention	FY 2008 - FY 2010	Youth are utilizing internet technology to learn about the warning signs and risk factors of suicidal behavior. Youth have access to information to receive help and services for suicidal behavior.	Documentation of website, on-line resource directory, MySpace page, and chat group development and utilization data. Feasibility pilot study conducted on alternative communication systems used by youth.
3.6 By FY 2010, develop and work with hospitals, clinics, and other mental health treatment agencies to follow up with suicidal individuals being discharged.	-Hotlines -DHMH -Maryland Office of Suicide Prevention, -DJS -DHR -Mental Health Advocacy groups -MD Interagency Transition Council -MHEC	FY 2008 - FY 2010	Youth are receiving follow up contact after being discharged from a mental health treatment facility to encourage on-going mental health treatment. Youth have access to additional information to receive help and services for suicidal behavior.	Systems to document follow-up with discharged youth developed and utilized. Increase rates of youth attendance and adherence to follow up care.

GOAL 4: METHODOLOGY	***Maryland advanced the science of youth suicide prevention***			
OBJECTIVES/STRATEGIES	**Responsible Person(s) & Involved Parties**	**TIME-LINES**	**OUTCOME**	**PERFORMANCE MEASURE**
4.1 By 2012, through the implementation of the five-year plan, new strategies, promising and evidence based practices will be tested, replicated and utilized as appropriate throughout the State.	All people and agencies identified in the Plan.	2008-2012	The State of Maryland advances and promotes the science of youth suicide prevention. Maryland successful practices are replicated in other states and noted as evidence-based practices.	The Plan identifies measurements for each objective which will be quantified and successful practices shall be presented in Maryland reports and official documents.

APPENDIX A:

INTERAGENCY PLANNING COMMITTEE MEMBERS

Planning Chairperson: Henry Westray Jr., Mental Hygiene Administration

WORKGROUP 1: Review of the 1987 Maryland Plan
Chairperson: Henry Westray Jr., DHMH/MHA
- Kelly Coston, Maryland State Department of Education
- Lisa Hurka Covington, SPEAK
- Pam Putman

WORKGROUP 2: Prevention Strategies and Resources
Chairperson: Maisha Davis, MARFY
- Brian Bartels, Maryland State Department of Education
- Sharon Boettinger, Frederick County Public Schools
- Lisa Hurka Covington, SPEAK
- Kelley Green, Yellow Ribbon Suicide Prevention Program of the Delmarva
- Christine McKee, Mental Health Association of Maryland
- Becky Roosevelt, Department of Health and Mental Hygiene

WORKGROUP 3: Intervention Strategies and Resources
Chairperson: Suzi Borg, Mental Health Association of Frederick County
- Brian Bartels, Maryland State Department of Education
- Thomas Buckley, Community Crisis Services, Inc.
- Timothy Jansen, Community Crisis Services, Inc.
- Rachel, Larkin, MHA of Montgomery County
- Elisabeth Orchard, Life Crisis Center
- Ray Sheets, Grassroots Crisis Intervention Center
- Dianne DeSantis, Grassroots Crisis Intervention Center
- Rhonda Cooperstein, NAMI/MD

WORKGROUP 4: Postvention Strategies and Resources

Chairperson: Thomas Buckley, CCSI

- Sheldon Lapan, Office of the Chief Medical Examiner
- Sharon Lipford, Harford County Office on Mental Health
- Liz Park, Greenbelt CARES
- Richard Scott, Maryland State Department of Education

WORKGROUP 5: Review of the Literature and Other State Plans

Chairperson: Suzi Borg, Mental Health Association of Frederick County

- Terry Bohrer, Maryland Association of Core Service Agencies (MACSA)
- Thomas Buckley, Community Crisis Services, Inc.
- Tim Jansen, Community Crisis Services, Inc.
- Rachel Larkin, Mental Health Association of Montgomery County
- Elisabeth Orchard, Life Crisis Center
- Ray Sheets, Grassroots Crisis Intervention Center

WORKGROUP 6: Review of the Federal Suicide Prevention Plan

Chairperson: Maisha Davis

- Cyntrice Bellemy-Mills, DHMH, MHA
- Iris Reeves, DHMH/MHA
- Kenneth Barrett

WORKGROUP 7: Data and Methodology.

Chairperson: Mary Cwik, Johns Hopkins University

- Sheldon Lapan, Office of the Chief Medical Examiner
- John Walkup, Johns Hopkins University

WORKGROUP 8: Cultural Competence

Chairperson: Iris Reeves, Mental Hygiene Administration

-Donna Barnes, National Organization for People of Color Against Suicide
-Cyntrice Bellemy-Mills, Mental Hygiene Administration
-Kelly Coston, Maryland State Department of Education
-Henry Westray Jr., Mental Hygiene Administration

APPENDIX B:

MARYLAND COMMITTEE ON YOUTH SUICIDE PREVENTION

(Alphabetical order)

Lynne Albizo, JD and Pat Harvey
NAMI/Maryland
804 Landmark Drive, Suite 122
Glen Burnie, Maryland 21061

Jack Altfather
Department of Human Resources
311 West Saratoga Street, 5th floor
Baltimore, Maryland 21201

Donna Barnes, Ph.D.
President
National Organization for People of Color Against Suicide (NOPCAS)
P.O. Box 75571
Washington, D.C. 20013

Kenneth Barrett
Old Mill High School
600 Patriot Lane
Millersville, Maryland 21108

Brian Bartels, M.A., NCSP, School Psychology Specialist
Maryland State Department of Education
Division of Student, Family, and School Support
200 West Baltimore Street
Baltimore Maryland 21201

Sharon S. Boettinger, Supervisor of Counseling and Student Support
Frederick County Public Schools
7516 Haywood Road
Frederick, Maryland 21702

Terezie S. Bohrer, RN, MSW, CLNC,
Mental Health Association of Maryland, President
Maryland Association of Core Service Agencies, Consultant
16304 Bawtry Court
Bowie, Maryland 20715

Suzi Borg, Hotline Director
Mental Health Association of Frederick County
263 West Patrick Street
Frederick, Maryland 21701

Thomas Buckley, MHS, Deputy Director
Community Crisis Services, Inc.
P.O. Box 149
Hyattsville, Maryland 20781

Peter Cohen, M.D.
Maryland DHMH/Alcohol and Drug Abuse Administration
55 Wade Avenue
Catonsville, Maryland 21228

Kelly Coston, Safe and Drug-Free Schools Specialist
Maryland State Department of Education
Division of Student, Family, and School Support
200 West Baltimore Street
Baltimore Maryland 21201

Lisa Hurka Covington, Founder and President
Suicide Prevention Education Awareness for Kids (SPEAK)
P.O. Box 36802
Baltimore, Maryland 21286

Mary F. Cwik, Ph.D., Postdoctoral Fellow
Johns Hopkins Medicine
Division of Child and Adolescent Psychiatry
600 North Wolfe St./CMSC 346
Baltimore, Maryland 21287-3325

Maisha Davis, MSW, Deputy Director
Membership Development & Member Services
Maryland Association of Resources for Families and Youth (MARFY)
1517 South Richie Highway, Suite 102
Arnold, Maryland 21012

Dianne DeSantis
Grassroots Crisis Intervention Center
6700 Freetown Road
Columbia, Maryland 21044

Esther Diggs
Maryland Department of Juvenile Services
120 West Fayette Street
Baltimore, Maryland 21201

Ellis Goodman
217 East Redwood Street, Suite 1300
Baltimore, Maryland 21202

Bryna Grant, MS, Health Services Administrator
Maryland DHMH/AIDS Administration
500 North Calvert Street, 5th Floor
Baltimore, Maryland 21202

Kelly Green
Yellow Ribbon Suicide Prevention Program Delmarva Chapter
P.O. Box 96
Berlin, Maryland

Anne Hellman
Upper Chesapeake Health Link
501 South Avenue
Havre de Grace, Maryland 20718

Tim Jansen, LGSW, Director
Community Crisis Services, Inc.
P.O. Box 149
Hyattsville, Maryland 20781

Frank Kros, Executive Director
The Children's Guild
6802 McClean Boulevard
Baltimore, Maryland 21234

Sheldon Lapan, MHS, Research Epidemiologist
DHMH/Office of Chief Medical Examiner
111 Penn Street
Baltimore, Maryland 21201

Rachel Larkin, LCSW, Director
Montgomery County Hotline
Mental Health Association of Montgomery County
1000 Twinbrook Pkwy
Rockville, Maryland 20851

Sharon Lipford, LCSW-C
Harford County Office on Mental Health
206 S. Hays Street
Bel Air, Maryland 21014

Christine McKee, MS, Director of Community Relations
Mental Health Association of Maryland
711 West 40th Street, Suite 460
Baltimore, Maryland 21211

Cyntrice Bellamy-Mills, M.S., M.Ed.
Administrator of DJS/SBMH Programs
Mental Hygiene Administration
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, Maryland 21228

Lynne Muller, Ph.D., Coordinator
Office of School Counseling
9610 Pulaski Park Drive
Baltimore, Maryland 21220

Elisabeth Orchard, M.A., Hotline Director
Life Crisis Center, Inc.

P.O. Box 387
Salisbury, Maryland 21803

Liz Park, Ph.D., Director
Greenbelt CARES
25 Crescent Road
Greenbelt, Maryland 20770

Malanie Parrish
Upper Chesapeake Health Link
501 South Avenue
Havre de Grace, Maryland 20718

Joan Patterson
Maryland DHMH/Office of Child and Maternal Health
201 West Preston Street, Room 309
Baltimore, Maryland 21201

Robert Pitcher, Director
Mental Health Management Agency of Frederick County
22 South Market Street, Suite 8
Frederick, Maryland 21701

Pam Putman, RN, MPH
Maryland DHMH/CMCH
201 West Preston Street, Room 309
Baltimore, Maryland 21201

Iris Reeves, MSW, Coordinator
Maryland DHMH/Mental Hygiene Administration
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, Maryland 21228

Becky Roosevelt, M.A.
Maryland DHMH/Center for Preventive Health Services
201 West Preston Street, Room 306
Baltimore, Maryland 21201

Christine Rowley
Maryland DHMH/Alcohol and Drug Abuse Administration
55 Wade Avenue

Catonsville, Maryland 21228

Rob Schmidt, LCPC, NCC, Behavioral Specialist
Talbot County Public Schools
P.O. Box 1029
Easton, Maryland

Richard Scott, D.Min, School Counseling Specialist
Maryland State Department of Education
Division of Student, Family, and School Support
200 West Baltimore Street
Baltimore Maryland 21201

Maryland Beth Stapleton, Director, Positive Outcomes for Youth
Governor's Office for Children
301 West Preston Street, 15th Floor
Baltimore, Maryland 21201

Jane Walker, Executive Director
Maryland Coalition of Families for Children's Mental Health
10632 Little Patuxent Parkway, Suite 119
Columbia, Maryland 21044

John Walkup, M.D.
Johns Hopkins School of Medicine
600 North Wolfe Street
Baltimore, Maryland 21287

Henry Westray, Jr., MSS, Committee Chair
Administrator, Maryland Suicide Prevention Program
Maryland DHMH/Mental Hygiene Administration
Spring Grove Hospital Center-Mitchell building
55 Wade Avenue
Catonsville, Maryland 21228

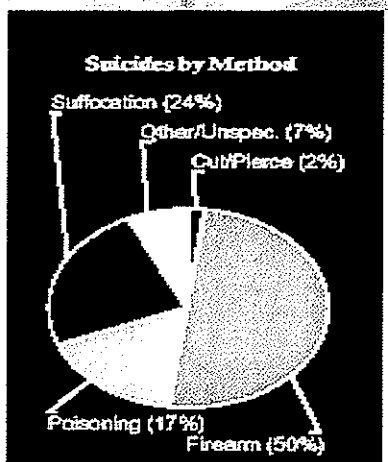
Carol Zahn
Maryland Department of Juvenile Services
Behavioral Health Services
120 West Fayette Street
Baltimore, Maryland 21201

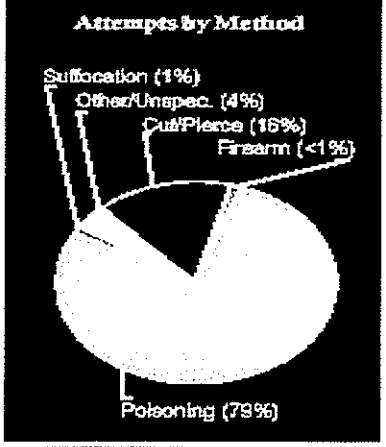
APPENDIX C:

SUICIDE PREVENTION RESOURCE CENTER MARYLAND SUICIDE FACT SHEET

SPRC
SUICIDE PREVENTION RESOURCE CENTER

MARYLAND SUICIDE FACT SHEET





Phone: 877-GET-SPRC
877-438-7772
TTY: 617-964-5448
Web: www.sprc.org
Email: info@sprc.org
Mail: SPRC
55 Chapel Street
Newton, MA 02458-1060

Suicides, 2000-2004

Statewide

- 13th ranking cause of death
- Average of 479 residents died by suicide each year
- Suicide rate: 9.4 per 100,000
- Average of 5 suicides every 4 days

Gender

- Males: 80% of suicides; rate 15.7 per 100,000; 11th ranking cause of death
- Females: 20% of suicides; rate 3.6 per 100,000; 18th ranking cause of death
- Male suicide rate 4.4 times greater than female rate

Race/ Ethnicity

- White Non-Hispanic (NH): 81% of suicides; rate 12.2 per 100,000
- Hispanic: 1% of suicides; rate 2.9 per 100,000
- Black NH: 15% of suicides; rate 5.1 per 100,000
- Other NH: 3% of suicides; rate 5.6 per 100,000
- White NH suicide rate 2.4 times greater than Black NH rate

Age

- 70+ years: highest suicide rate; 13% of suicides; rate 2.1 times greater than rate for 15 to 19 year

Method

- Firearm: leading method; rate 4.7 per 100,000; 5th ranking cause of injury deaths
- Suffocation: 2nd leading method; rate 2.2 per 100,000; 6th ranking cause of injury deaths
- Poisoning: 3rd leading method; ra 1.6 per 100,000; 7th ranking cause of injury deaths
- If half of **undetermined intent** poisonings were self-inflicted, suicides in this state would rise 62%

Costs

- Average medical cost per case: $3,229
- Average work-loss cost per case: $1,430,363

Average Annual Self-Inflicted Injuries by Age Group, Maryland Residents