

Maryland Governor's Commission on Suicide Prevention

2018 State Plan



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Maryland
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EXECUTIVE SUMMARY

Pursuant to Executive Order 01.01.2018.26D, the Governor’s Commission on Suicide Prevention is required to submit a state plan on suicide prevention, biennially, to the Governor.

Suicide is a significant public health problem in the United States and Maryland. In 2016,¹ 581 Marylanders died by suicide (9.3 per 100,000), a 6.8% increase from the suicide rate in 2015.² Overall, suicide was the 11th leading cause of death in Maryland.

This 2018 Suicide Prevention Plan of the Governor’s Commission on Suicide Prevention presents an update of current data and information on resources and initiatives taking place in Maryland. Additionally, the following four goals, with corresponding objectives, are offered to guide suicide prevention efforts in the State:

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Goal 2: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Goal 3: Promote suicide prevention as a core component of health care services. Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

Goal 4: Increase the timeliness and usefulness of surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

GUIDING PRINCIPLES

- Suicide is a serious preventable public health problem that negatively affects communities and individual community members.
- Suicide is complex and arises from the interaction of individual mental and emotional risk factors and family, social, and community factors.
- Suicide touches people of all ages and from all walks of life.
- Societal attitudes and conditions have a profound effect on suicide and suicide prevention. Everyone with mental health concerns, including those with suicidal thoughts, is to be accepted and supported, without stigma or discrimination.
- Suicide prevention is the responsibility of the entire community and requires vision, will, and a commitment from the State, communities, and individuals of Maryland. All Marylanders should adopt “zero suicides” as their aspirational goal.
- Knowing when and how to ask about suicide saves lives. It is important for everyone to have the competence and confidence to intervene with persons at risk for suicide.
- Promoting hope and resiliency is central to suicide prevention. Effective suicide intervention and prevention activities promote resiliency, enhance protective factors, and reduce risk factors.

¹ At the time this plan was compiled, 2016 was the most recent year of complete data available the referenced sources. Therefore, for consistency and comparability, 2016 data was used for this 2018 plan.

² Maryland Department of Health, Vital Statistics Administration, Maryland Vital Statistics Annual Report (2016).

- Quality and accessible services, supports, and resources that promote mental wellness and treat mental illnesses are essential to children, youth, their families, and their personal support networks.
- Suicide prevention should be part of adequately funded and supported public and private health systems that address education, awareness, treatment, and community engagement. They should include programs by and for youth, families, schools, integrated public and private health systems, and communities, with special attention paid to protect those known to be at high risk. Suicide prevention programs and program materials need to be culturally informed, respectful, and developed with the groups for which they are designed based on the best available evidence for safe messaging. They should be trauma-informed, reflect the needs of people who have attempted suicide or lost a loved one to suicide, and ensure the needs of vulnerable populations are addressed, such as LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning) youth, young military members, veterans and their families, foster youth, youth with behavioral health disorders and cultural, ethnic, and racial groups.
- Suicide prevention efforts should incorporate knowledge-informed strategies based in research, data, culture, and lived experience. Efforts should be responsive to the social, emotional, cultural, educational, physical, and developmental needs of each child, youth, family, and social support.
- Suicide prevention leaders and supporters should challenge and question routine ways of thinking about suicide and have a curiosity and appreciation of diverse points of view.

BACKGROUND ON THE GOVERNOR’S COMMISSION ON SUICIDE PREVENTION

On October 7, 2009, Governor Martin O’Malley issued Executive Order 01.01.2009.13, establishing the Governor’s Commission on Suicide Prevention (Commission). On October 11, 2018, the Executive Order was amended by Governor Larry Hogan via Executive Order 01.01.2018.26. The Commission’s amended objectives are to:

- 1) assess suicide’s economic and social costs, and impact on the health and wellbeing of Maryland citizens;
- 2) establish a list of existing support systems for survivors, attempters, and their families;
- 3) develop a comprehensive, coordinated, and strategic plan for suicide prevention, intervention, and post-suicide services across the State;
- 4) identify the resources needed to adequately provider those services; and
- 5) promote the delivery of those services by local and state agencies through collaborative efforts that ensure effective and efficient use of local and state resources.

As of the 2018 amendment, the Commission is charged to submit a two-year plan to the Governor that establishes—for the organization, delivery, and funding of suicide prevention, intervention and post-suicide services—the (1) emerging needs, (2) priorities and strategies, (3) promising practices and programs, (4) recommendations for coordination and collaboration among State agencies, and (5) training. The plan shall be developed in consideration of the priorities and strategies in plans established by location jurisdictions.

Under Executive Order 01.01.2009.13, the Commission submitted its initial plan to the Governor in 2012 and subsequent Plan in 2016. This is the first plan in response to the 2018 Executive Order.

THE TWO-YEAR PLAN

I. EMERGING NEEDS

Executive Order 01.01.2018.26D(1) requires that the Commission address the emerging needs in suicide prevention, intervention, and post-suicide services.

A. Impact of Suicide in Maryland

In 2016, 44,965 people died by suicide in the United States (13.42 per 100,000).³ Suicide is the tenth leading cause of death for all ages, races, and sexes. For age groups between 10 and 34, suicide is the second leading cause of death. For age groups between 35 and 54, suicide is the fourth leading cause of death. In 2016, for people 65 and under that died by suicide, 895,466 years of potential life were lost.

In 2010, there were 316,572 people hospitalized for nonfatal injuries related to self-harm.⁴ Those hospitalizations led to \$3,519,175,000 in medical costs and \$6,300,746,000 of work loss costs for a combined cost of \$9,819,920,000. In 2010, 134,202 people were treated and released from the emergency department for self-harm. This led to a combined cost of \$610,147,000.

In 2016, 581 Marylanders died by suicide (9.3 per 100,000), a 6.8% increase from the suicide rate in 2015.⁵ Overall, suicide was the 11th leading cause of death in Maryland. Suicide was the 1st leading cause of death for ages 10–14, the 3rd leading cause of death for ages 15–34, and the 4th leading cause of death for ages 45–54. The suicide deaths in Maryland alone reflect 10,702 years of potential life lost before age 65.

In 2016, suicide was the:

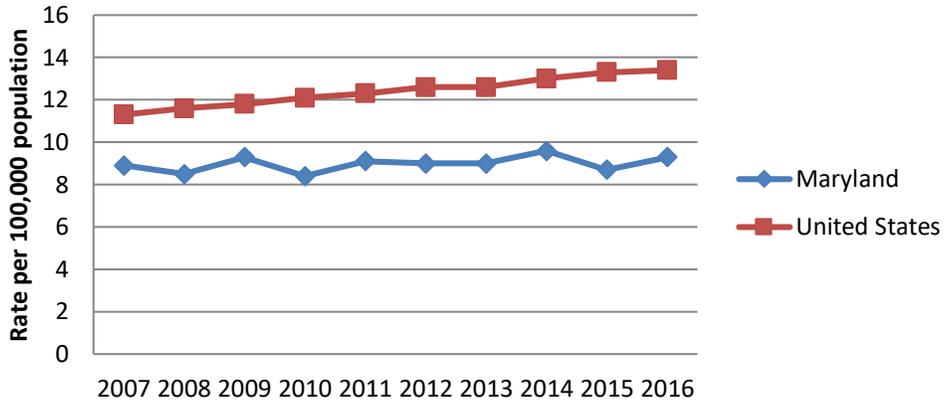
- 2nd leading cause of death for white males ages 15–44.
- 2nd leading cause of death for white females ages 15–24.
- 3rd leading cause of death for black males ages 15–24.
- 4th leading cause of death for white females ages 25–44.
- 4th leading cause of death for white males ages 45–64.
- 5th leading cause of death for black males ages 25–44.
- 8th leading cause of death for white females ages 45–64.
- 8th leading cause of death for white men of all ages.

³ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) (2005), online at www.cdc.gov/injury/wisqars (all Internet materials as last visited Nov. 5, 2018).

⁴ *Ibid.*

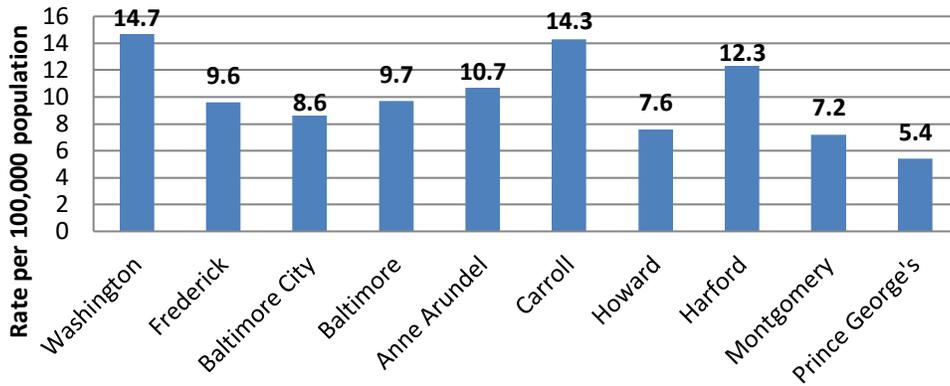
⁵ *Ibid.*

Age-Adjusted Death Rate* for Intentional Self-Harm (Suicide), Maryland and the United States, 2007-2016

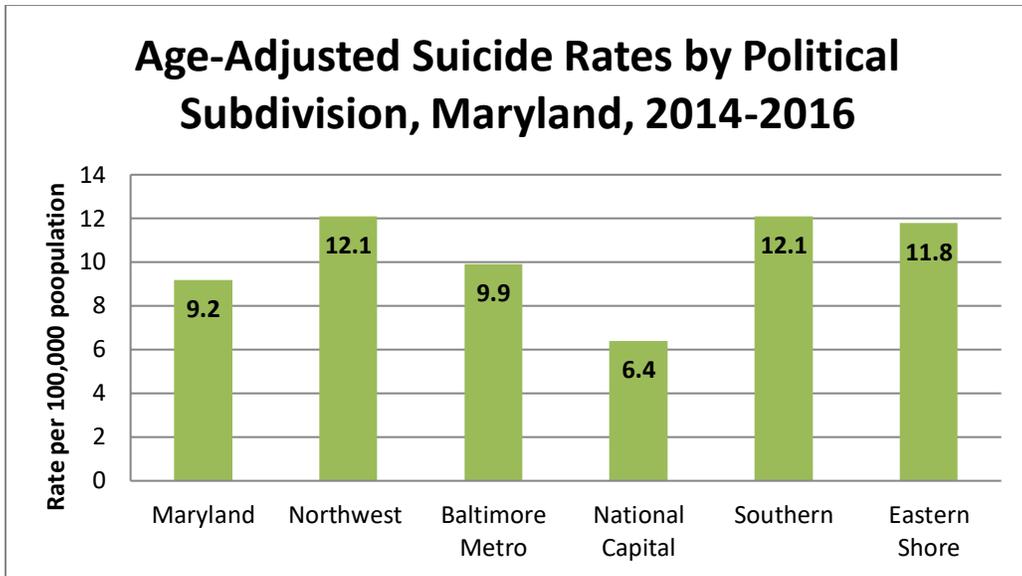


Source: CDC WISQARS Data

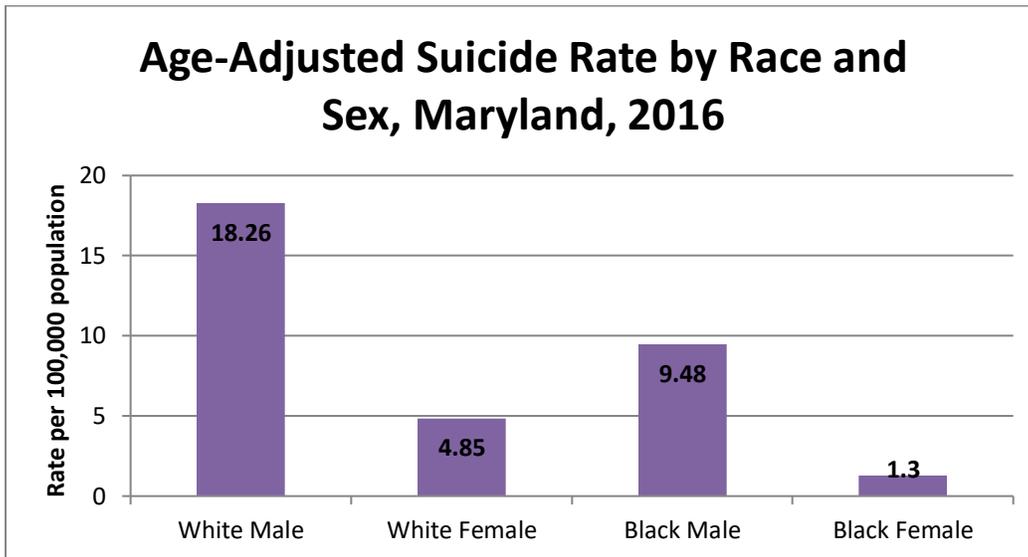
Age-Adjusted Suicide Rates (All ages) by County, Maryland, 2016



Source: Maryland Vital Statistics Annual Report 2016



Source: Maryland Vital Statistics Annual Report 2016



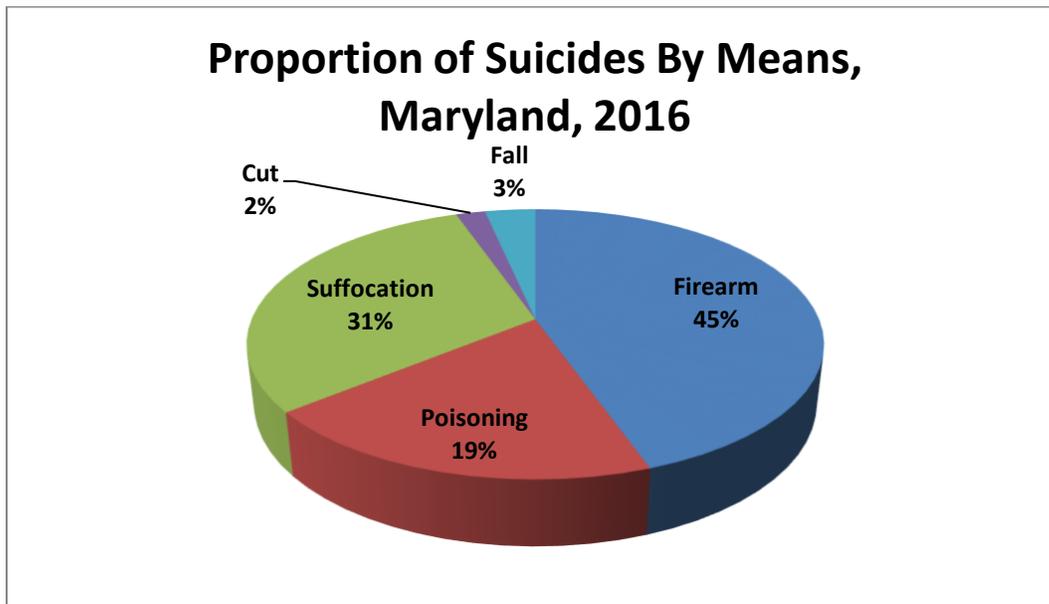
Source: Maryland Vital Statistics Annual Report 2016

B. Access to Lethal Means

Access to lethal means is a well-documented risk factor for suicide. The lethality of means varies across method, from 1–2% for medication overdoses or cutting wounds to 85–90% for firearms.⁶ Consistent with national trends, majority of the suicides in Maryland were the result of firearms. The rationale for reducing access to lethal means is established from several observations in the field: many suicidal crises last a short period of time, the method used depends on its ready

⁶ Barber and Miller, Reducing a Suicidal Person’s Access to Lethal Means of Suicide, *American Journal of Preventative Medicine*, S264–S272 (2014).

availability, the lethality of means varies across method, and about 90% of people who survive suicide attempts do not go on to die by suicide.⁷



Source: CDC WISQARS Data

C. Groups with Increased Suicide Risk

The National Strategy for Suicide Prevention references groups with an increased risk for suicide. These groups include:

- Suicide attempt survivors
- Suicide loss survivors
- LGBTQ
- Individuals with disabilities and behavioral health conditions
- Native Americans
- Older adult males
- Individuals in the justice and child welfare systems
- Those who engage in non-suicidal self-injury
- Military members, veterans, and their families

D. Suicide Attempt Survivors

Ninety percent of suicide attempt survivors do not go on to die by suicide later in life.⁸ Of the 90% of suicide attempt survivors, 23% attempted suicide again and survived, 70% did not attempt suicide again, and 7% died by suicide.

⁷ Barber and Miller, Reducing a Suicidal Person's Access to Lethal Means of Suicide, American Journal of Preventative Medicine, S264–S272 (2014).

⁸ Harvard T.H. Chan School of Public Health, Means Matter, Attempters' Longterm Survival, online at <https://www.hsph.harvard.edu/means-matter/means-matter/survival/>.

E. Suicide Loss Survivors

Research suggests that each death by suicide impacts at least 147 people and of those affected, more than six experience a major life disruption as a result of the suicide loss.⁹ Based on these estimates, there are more than 5.2 million survivors of suicide loss (or 1 in 62 Americans) living in the United States. Having lost someone to suicide is a documented risk factor for future suicide attempts or suicide.

F. Sexuality

Nationally, 28% of lesbian, gay, and bisexual (LGB) students reported having been bullied through email, chat rooms, instant messaging, websites, or texting.¹⁰ The prevalence of electronic bullying of LGB students was twice the prevalence of all heterosexual students reporting electronic bullying (14.2%). While 34.2% of LGB students had been bullied on school property, 18.8% of heterosexual students.

National Youth Risk Behavior Survey – in the last 12 months			
Measure	All Students	Heterosexual	LGB
Electronically bullied	15.5%	14.2%	28%
Bullied on school property	20.2%	18.8%	34.2%
Physical Dating Violence	9.6%	8.3%	17.5%
Sexual Dating Violence	10.6%	9.1%	22.7%
Felt sad or hopeless	29.9%	26.4%	60.4%
Seriously considered attempting suicide	17.7%	14.8%	42.8%
Made a suicide plan	14.6%	11.9%	38.2%
Attempted suicide one or more times	8.6%	6.4%	29.4%
Made a suicide attempt that resulted in treatment by a doctor or nurse	2.8%	2%	9.4%

Source: CDC Morbidity and Mortality Weekly Report, Volume 65, No. 9

G. People with Mental and Substance Use Disorders

Mental health and substance use disorders are well-documented risk factors for suicide. Of those who died by suicide with a known mental health condition, 75% had a diagnosis of depression.¹¹ Problematic substance use was present 28% of cases. Of those that received toxicology testing, 74% were positive for at least one substance: the most prevalent being alcohol (53%) and opioids (41.8%). 27.4% were currently receiving mental health or substance use treatment while 35.8% had a history of receiving mental health or substance use treatment.

⁹ Drapeau and McIntosh, American Association of Suicidology, Suicide Data Page (2016).

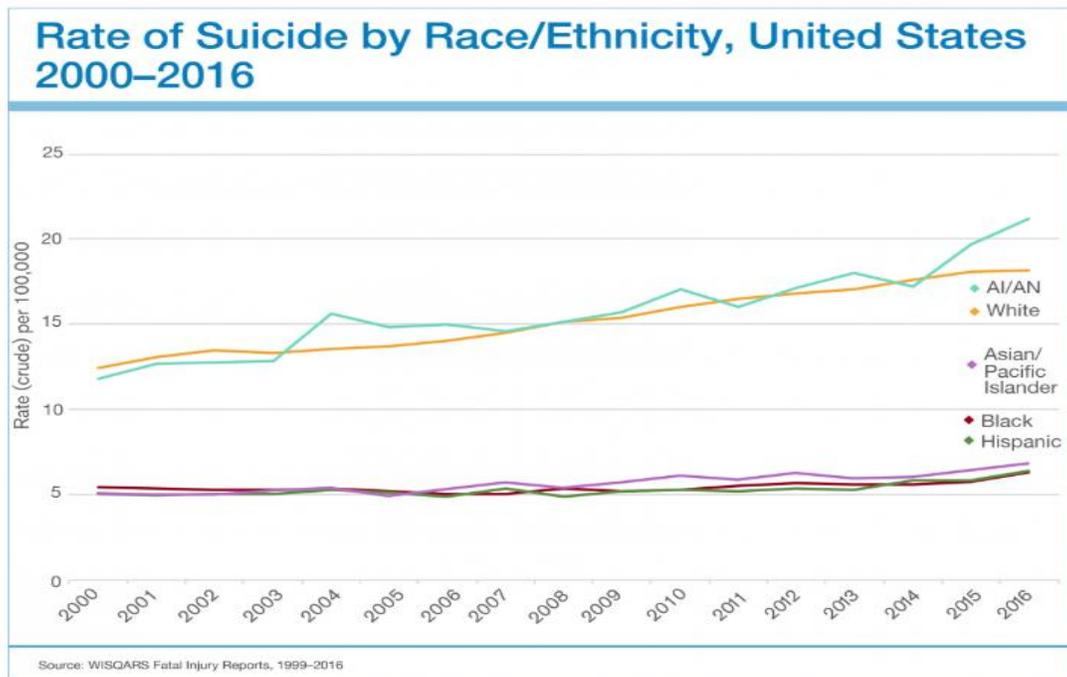
¹⁰ Kann, Olsen, McManus, et al., Sexual Identify, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12, United States and Selected Sites (2015), MMWR Surveill Summ. (2016), 65.

¹¹ Stone, Simon, Fowler, et al., Vital Signs: Trends in State Suicide Rates—United States, 1999–2016 and Circumstances Contributing to Suicide—27 States, MMWR Morb. Mortal Wkly Rep., 67:617–624 (2018), online at <http://dx.doi.org/10.15585/mmwr.mm6722a1>.

H. Native Americans

American Indian/Alaska Natives (AI/AN) have the highest suicide rates of any racial or ethnic group in the United States. In 2015, the suicide rate for AI/AN was 21.5 per 100,000.¹²

Intentional self-harm was the fifth leading cause of death for AI/AN in Maryland between 2010 and 2014. While the suicide rate among AI/ANs between 2010 and 2014 was 5.8 per 100,000 and much lower than the rate for non-Hispanic white, it is believed the lower rate is due partly because of racial misclassification in death certificates.



Source: Suicide Prevention Resource Center.

I. Older Adult Males

In Maryland, in 2016, the suicide rate for males ages 50 to 85+ was 22.47 per 100,000 which is substantially higher than the state suicide rate.¹³ There are many factors contributing to suicide risk in older adults, including mental and physical health conditions, overall functioning, and social factors including lack of social connectedness, bereavement, and financial problems.¹⁴

¹² Leavitt, Ertl, Sheats, Petrosky, Ivey-Stephenson, Fowler, Suicides Among American Indian/Alaska Natives—National Violent Death Reporting System, 18 States, 2003–2014, *MMWR Morb. Mortal Wkly Rep.*, 67:237–242 (2018), online at <http://dx.doi.org/10.15585/mmwr.mm6708a1>.

¹³ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) (2005), online at www.cdc.gov/injury/wisqars (all Internet materials as last visited Nov. 5, 2018).

¹⁴ Conwell, Van Orden, & Caine, Suicide in Older Adults, *The Psychiatric Clinics of North America*, 34(2), 451–468 (2011), online at <http://doi.org/10.1016/j.psc.2011.02.002>.

J. Individuals in the Justice and Child Welfare Systems

Children in the juvenile justice and child welfare systems and adults in the justice system often have a number of adverse childhood experiences that can contribute to an increased risk of suicide. Mental health disorders, substance abuse, impulsivity, abuse, loss, and legal problems are closely associated with increased suicide risk and are prevalent in these groups.

K. Military Members, Veterans, and Their Families

In 2015, veterans accounted for 14.3% of suicide deaths despite comprising 8.3% of the adult population in the United States.¹⁵ The veteran suicide rate was 2.1 times higher compared with non-veteran adults. Suicide rates are higher among veterans ages 18–34 compared with veterans ages 55 and older, though veterans over 55 account for 58% of veteran suicide deaths.

According to the U.S. Department of Veterans Affairs, in 2014, there were 89 veteran suicide deaths in Maryland.¹⁶ The national veteran suicide rate was 38.4 per 100,000 and the Maryland veteran suicide rate was 23.1 per 100,000. While Maryland’s veteran suicide rate was significantly lower than the national veteran suicide rate, it is still significantly higher than Maryland’s overall suicide rate.

II. PRIORITIES AND STRATEGIES

Executive Order 01.01.2018.26D(1) requires that the Commission address the priorities and strategies in suicide prevention, intervention, and post-suicide services. This “priorities and strategies” section is a culmination of current state suicide prevention objectives derived from the State Behavioral Health Plan as well as current grants and projects.

A. State Suicide Prevention Objectives

The Behavioral Health Administration (BHA), of the Maryland Department of Health (MDH), has published its FY17 Behavioral Health Plan for the State of Maryland.¹⁷ Within this Plan there are two objectives that address suicide prevention. While the FY17 Behavioral Health Plan features two objectives addressing suicide prevention, the Commission Plan expands beyond those objectives to address multiple areas in the field of suicide prevention. The below objectives (Objective 2.2 and 5.1 are from the FY17 Behavioral Health Plan for the State of Maryland).

Objective 2.2

Promote efforts to address suicide and overdose prevention.

Objective 2.2A

¹⁵ U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. Facts about Veteran Suicide: June 2018.

¹⁶ U.S. Department of Veterans Affairs. Maryland Veteran Suicide Data Sheet 2014.

¹⁷ <https://bha.health.maryland.gov/Documents/FY%202017%20State%20Behavioral%20Health%20Plan-Final.pdf>

Continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.

Indicators:

- Implementation of deliverables of suicide prevention grants, *i.e.*, the Garrett Lee Smith Suicide Prevention Grant for youth ages 10–24.
- Training to teachers, primary care, and other professionals implemented.
- Annual Suicide Prevention conference conducted with inclusion of training sessions on issues and needs of special needs populations, such as veterans and individuals who are lesbian, gay, bisexual, and transgender (LGBT).
- Participating in and addressing recommendations from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Zero Suicide Policy Academy and Suicide Prevention Resource Center’s virtual communities of practice Webinars.
- Promotion of increased number of “followers” for the Maryland Crisis Network Facebook account and the Maryland Suicide Prevention Twitter account.
- Dissemination of print materials, information cards, brochures, posters, t-shirts, and online videos created for a suicide prevention marketing campaign to promote the Maryland Crisis Hotline number.

Objective 5.1

Develop and disseminate workforce training and education tools, as well as core competencies to address behavioral health issues.

Objective 5.1D

Promote and implement a well-trained behavioral health workforce on suicide prevention, intervention and postvention.

Indicators:

- Implementation of training on screening, assessment and follow-up of individuals who report a chief complaint of psychological distress.
- Implementation of suicide prevention and intervention training to teachers, pediatric and primary care clinicians, and behavioral health providers.
- Increased adoption and uptake of the Kognito Gatekeeper Training Program for school staff, veterans, peer support specialists and academia faculty.
- Data utilized to inform planning initiatives and to guide best practices on suicide prevention.

B. Garrett Lee Smith Grant

BHA was awarded a five-year grant by the SAMHSA for youth suicide prevention. The grant provides \$735,000 per year to address specific goals and objectives. The funding and grant period end in September 2019. Maryland’s Suicide Prevention and Early Intervention Network (MD-SPIN) provides a continuum of suicide prevention training, resources, and technical assistance to advance the development of a comprehensive suicide prevention and early intervention service system for youth and young adults. MD-SPIN will increase the number of youth, ages 10–24, identified, referred and receiving quality behavioral health services, with a focus on serving high

risk youth populations (LGBTQ, transition age, veterans and military families, youth with emotional and behavioral concerns) and in target settings (schools, colleges/universities, juvenile services facilities, primary care, emergency departments).

Led by BHA, key partners include the University of Maryland Department of Psychiatry, the Johns Hopkins University Bloomberg School of Public Health, the Maryland Coalition of Families, the Community Behavioral Health Association of Maryland, and the public education system (1,424 public kindergarten to 12th grade schools; 30 public universities, colleges, and community colleges; and 12 juvenile facilities programs).

MD-SPIN will serve youth and young adults (64% White, 27.9% Black, 4.3% Hispanic, 9% of families below the poverty level statewide, with local jurisdictions up to 26% poverty). Despite a suicide rate consistent with the national average, MD youth report higher rates of suicidal ideation (16.2%) and suicide attempts (10.9%). We anticipate training 1,574 (1,000 secondary school staff, 500 higher education staff, 24 primary care providers (PCPs), 10 emergency department (ED) and inpatient providers, 20 youth/young adult peers, and 20 family members) individuals in year one; 4,172 (1,000 primary school, 2,000 secondary school, 1,000 higher education, 72 PCPs, 20 ED and inpatient providers, 40 peers, and 40 family) individuals in year two; and 6,304 (1,500 primary, 3,000 secondary, 1,500 higher education, 144 PCPs, 40 ED and inpatient, 60 peers, and 60 family) individuals in year 3, and 6,988 (2,000 primary, 3,000 secondary, 1,500 higher education, 288 PCPs, 40 ED and inpatient, 80 peers, and 80 family) individuals in each year four and year five, with 26,026 youth identified as being at risk for suicide and referred for additional evaluation/services if each person trained identifies one person.

Goals of MD-SPIN are to:

1. Enhance culturally competent, effective, and accessible community-based services and programs by developing a network that includes technical assistance and support;
2. Broaden public awareness of suicide by utilizing MD-SPIN to support marketing and dissemination and diffusion efforts related to suicide prevention for youth/young adults;
3. Increase evidence-based training opportunities for professionals and others who work with high risk groups by training a diverse, multidisciplinary group of youth and adults across the State using online suicide prevention programs (*i.e.*, Kognito) and evidence-based resources to promote continuity of care; and
4. Ensure effective services to those who have attempted suicide or others affected by suicide attempt or death by developing a state training and technical assistance model to promote referral and access to and follow through with high quality care.

C. Maryland Crisis Connect

The Maryland Crisis Hotline began in 1990 as a youth suicide prevention line. In 2014, the line expanded to serve adults with mental health needs. In 2015, the line expanded again to take substance use calls.

The Maryland Crisis Hotline is available 24/7 to callers in need of crisis intervention, risk assessment for suicide, homicide or overdose prevention, support, guidance, and information or linkage to community behavioral health providers. The Maryland Crisis Hotline also provides

assistance to accessing resources such as naloxone education, recovery support, veteran’s services, and family services as available and appropriate for the individual.

Trained crisis counselors are available to assist individuals struggling with issues such as substance use, depression, anxiety, suicidal/homicidal ideation or intent, physical and sexual abuse, eating disorders, sexual identity concerns, running away, relationship problems, divorce, sexually transmitted disease, school issues or any other identified concern.

In April 2018, the Maryland Crisis Hotline partnered with 211 Maryland to establish Maryland Crisis Connect. Marylanders can now access the state crisis hotline by calling 2–1–1 and pressing option 1 to speak with a counselor about a mental health or substance use crisis. Marylanders can also access resources by visiting MDCrisisConnect.org and using the statewide resource database or crisis chat or by texting their zip code to 898–211.

New System Goals for Maryland Crisis Connect:

- Create unified consistent management structure for call centers
- Have one “storefront” for all regardless of which call centers is reached
- Solve problems with call routing via cell towers, not number on phone
- Have shared universal database for all call centers
- Have consistent data reporting to BHA for system management
- Align with law that identifies 211 as statewide line

III. PROMISING PRACTICES AND RECOMMENDATIONS

Executive Order 01.01.2018.26D(1) requires that the Commission address the recommendations for coordination and collaboration among state agencies for suicide prevention, intervention, and post-suicide services.

Maryland’s Suicide Prevention Plan has been developed using goals and objectives from the 2012 National Strategy for Suicide Prevention. The National Strategy for Suicide Prevention was produced by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention that represents work of advocates, clinicians, researchers, survivors, and others. The National Strategy provides a framework for suicide prevention on national, state, and local levels. These goals and objectives address community engagement, workforce development, and data surveillance. The Commission acknowledges these goals and objectives as aspirational. Given our current resources, the Commission will identify two to three objectives to implement over the next two years.

GOAL 1: INTEGRATE AND COORDINATE SUICIDE PREVENTION ACTIVITIES ACROSS MULTIPLE SECTORS AND SETTINGS.

Objective 1.1

Integrate suicide prevention into all relevant health care reform efforts.

- a) Implement universal screening for suicide risk in emergency departments.
- b) Develop guidelines for primary care physicians to integrate universal screening into routine questioning during patient visits.

- c) Establish meaningful partnerships with organizations that serve high-risk populations.

Objective 1.2

Reduce the stigma associated with suicidal behaviors and mental and substance use disorders.

- a) 1.2a: Develop and implement a statewide suicide prevention campaign.

Objective 1.3

Increase the knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

- a) Develop and implement a statewide suicide prevention campaign similar to the Know the Signs campaign.
- b) Promote suicide prevention and awareness training including but not limited to safeTALK, Applied Suicide Intervention Skills Training (ASIST), Question Persuade Refer (QPR), and Talk Saves Lives.
- c) Continue to develop the online training modules through MD-SPIN and embed the modules on a public accessible website.

Objective 1.4

Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 1.5

Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

- a) Encourage and recognize news organizations that develop and implement policies and practices addressing safe and responsible reporting of suicide and other related behaviors.
- b) Develop, implement, monitor, and update guidelines on the safety of online content for new and emerging communication technologies and applications.
- c) Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

GOAL 2: DEVELOP, IMPLEMENT, AND MONITOR EFFECTIVE PROGRAMS THAT PROMOTE WELLNESS AND PREVENT SUICIDE AND RELATED BEHAVIORS.

Objective 2.1

Strengthen the coordination, implementation, and evaluation of comprehensive state and local suicide prevention programming.

- a) Hold focus groups and develop a survey to assess current strengths and needs in state and local suicide prevention programming.
- b) Facilitate regional meetings to discuss strategies and best practices for suicide prevention programming and implementation with local jurisdictions.

Objective 2.2

Strengthen the efforts to increase access to and delivery of effective programs and services for mental and substance use disorders.

- a) Awareness campaigns for Maryland Crisis Connect.

Objective 2.3

Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

- a) Promote the free online training “Counseling on Access to Lethal Means” to providers.
- b) Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means.
- c) Partner with the Maryland Licensed Firearms Dealer Association, firearm ranges, and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.
- d) Develop and implement new safety technologies to reduce access to lethal means (ie. create a communication loop between healthcare providers, prescribers, and pharmacies when an individual is at risk for suicide, or restricting pack sizes for potentially lethal medications)
- e) Develop a comprehensive listing of safe storage facilities in Maryland.
- f) Disseminate gun locks and promote safe firearm storage habits.
- g) Sponsor medication take-back days and ongoing methods for disposal of unwanted medications.
- h) Develop a statewide means safety campaign with specific emphasis on rural areas.
- i) Raise awareness of HB1302 (CH0250) - Public Safety – Extreme Risk Protective Orders.

Objective 2.4

Provide training to community groups and clinical service providers on the prevention of suicide and related behaviors.

- a) Provide training to targeted gatekeeper professions including law enforcement, teachers, and faith-based communities.

Objective 2.5

Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior and the delivery of effective clinical care for people with suicide risk.

- a) Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.
- b) Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.
- c) Develop and implement protocols and programs for clinicians, clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

GOAL 3: PROMOTE SUICIDE PREVENTION AS A CORE COMPONENT OF HEALTH CARE SERVICES. PROMOTE THE ADOPTION OF “ZERO SUICIDES” AS AN ASPIRATIONAL GOAL BY

HEALTH CARE AND COMMUNITY SUPPORT SYSTEMS THAT PROVIDE SERVICES AND SUPPORT TO DEFINED PATIENT POPULATIONS.

Objective 3.1

Promote timely access to assessment, intervention, and effective care for individuals with heightened risk for suicide. Promote continuity of care and the safety and wellbeing of all patients treated for suicide risk in emergency departments or hospital inpatient units.

- a) Establish linkages between providers of mental health and substance abuse services and community-based programs, including peer-support programs.
- b) Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate and to promote rapid follow up after discharge.
- c) Develop and implement protocols to ensure immediate and continuous follow-up after discharge from an emergency department or inpatient unit.
- d) Expand the availability of mobile crisis teams, crisis intervention teams, and 24/7 crisis centers in all local jurisdictions.

Objective 3.2

Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

- a) Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.
- b) Develop, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk.
- c) Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.
- d) Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire duration of care for persons with suicide risk.
- e) Promote the safe disclosure of suicidal thoughts and behaviors by all patients.
- f) Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental and/or substance use disorders.
- g) Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

Objective 3.3

Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

- a) Develop listing for effective comprehensive support programs for individuals bereaved by suicide.
- b) Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.
- c) Add a chair to the Governor's Commission on Suicide Prevention to represent the American Indian/Alaskan Native community, LGBTQ community, and a suicide attempt survivor.

- d) Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
- e) Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

GOAL 4: INCREASE THE TIMELINESS AND USEFULNESS OF SURVEILLANCE SYSTEMS RELEVANT TO SUICIDE PREVENTION AND IMPROVE THE ABILITY TO COLLECT, ANALYZE, AND USE THIS INFORMATION FOR ACTION.

Objective 4.1

Improve the timeliness of reporting vital records data.

Objective 4.2

Improve the usefulness and quality of suicide-related data.

- a) Collaborate with school districts to use Youth Risk Behavior Surveys to better understand suicidal ideation and attempts among school-aged youth.
- b) Adopt recommended self-directed violence uniform definitions and data elements developed by the CDC.
- c) Improve data linkage across agencies and organizations, including hospitals, psychiatrics and other medical institutions, and police departments to better capture information on suicide attempts.
- d) Establish a Suicide Fatality Review team.
- e) Collaborate with state child fatality review team for information collected about youth suicides.

Objective 4.3

Improve and expand state and local public health capacity to routinely collect, analyze, report, and use suicide-related data to improve prevention efforts and inform policy decisions.

Objective 4.4

Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Objective 4.5

Develop and support a repository of research and resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

IV. TRAINING

Executive Order 01.01.2018.26D(1) requires that the Commission address training in suicide prevention, intervention, and post-suicide services. Training is an integral component of suicide prevention including current initiatives and recommendations. Below, various training initiatives led by BHA are outlined.

A. Annual Suicide Prevention Conference

The Annual Suicide Prevention Conference is held to provide information and education on the latest topics related to suicide prevention. The conference takes place each year on the first Wednesday in October. The planning committee acquires speakers to present workshops on engaging topics related to suicide prevention including survivors of suicide, risk assessment, evidence-based practices, etc. The conference target audience is behavioral health professionals, peers, students, survivors of suicide, and interested community members.

B. Lunch and Learn Series

BHA recently launched a “lunch and learn” series on the third Thursday of every month from 12 to 1 p.m. The “lunch and learn” presentations focus on topics related to mental health and suicide prevention and are offered in person or via webinar.

C. Applied Suicide Intervention Skills Training, safeTALK, and Kognito

BHA offers Applied Suicide Intervention Skills Training (ASIST) and safeTALK workshops to the community and at the request of agencies. In May 2018, BHA hosted its first “train the trainer” for safeTALK and has trained 26 safeTALK trainers as of November 2018. Through the MD-SPIN grant, Kognito modules are available online at no cost to Marylanders. There are modules for K–12 educators, peers, military, and higher education faculty and students.