



STATE OF MARYLAND  
**DHMH**

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Maryland Department of Health and Mental Hygiene

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Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary  
Brian M. Hepburn, M.D., Executive Director

September 28, 2012

Maryland Commission on Suicide Prevention  
Spring Grove Hospital Center  
55 Wade Avenue, Dix Bldg.  
Catonsville, MD 21228

The Honorable Martin O'Malley, Governor  
100 State Circle  
Annapolis, MD 21401

Dear Governor O'Malley:

On behalf of the Maryland Commission on Suicide Prevention, I am pleased to submit the Commission's 2012 two-year plan to strengthen and coordinate Maryland's services in the areas of suicide prevention, intervention, and post-vention (post suicide).

I would like to thank everyone who has assisted with the development of this plan.

Respectfully,

Brian Hepburn, M.D.   
Chair

Enclosure

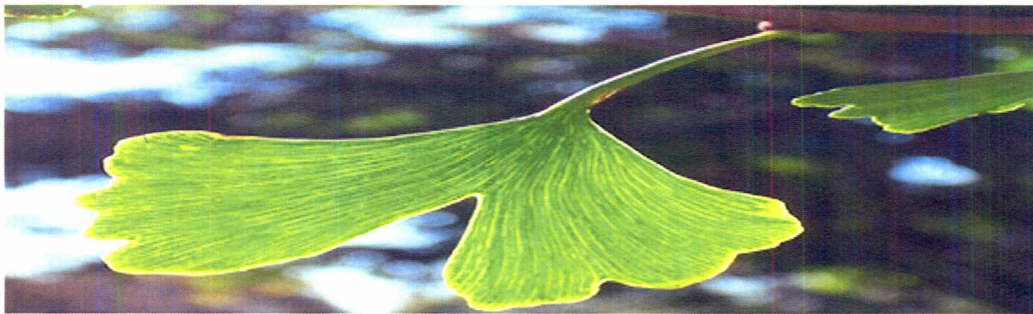
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# **Maryland Commission on Suicide Prevention**

## **Two-Year Plan to the Governor**



**Brian Hepburn, M.D., Chairman**

**September 2012**

## EXECUTIVE SUMMARY

*Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009. And death is only the tip of the iceberg. For every person who dies by suicide, more than 30 others attempt suicide. Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors (p. 10).*

- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012.

On October 7, 2009, Governor Martin O'Malley issued Executive Order 01.01.2009.13, establishing the Governor's Commission on Suicide Prevention (the Commission). Over the course of three years, 21 Commissioners brought their professional expertise and personal experiences with suicide and its consequences to bear in crafting their recommendations.

The work of the Commission is aligned with national suicide prevention efforts, especially in the State's historic and continuing emphasis on youth suicide prevention. The Commissioner's Plan (the Plan) also puts forth a strengthened focus on preventing suicide not only with high risk groups like veterans, lesbian, gay, bisexual, transgender and questioning individuals, and persons who are unemployed but also at critical high-risk periods, such as following an unsuccessful suicide attempt. Additionally, based on the Public Health Model, the Plan's three overarching goals and eight related strategies operate at three levels:

- Universal: prevention efforts applicable to all members of a population;
- Selected: more focused education and skill-building applicable to selected sub-groups who are at-risk for a preventable occurrence; and
- Indicated: focused interventions providing intense education and skill development related to specific risks of an indicated subpopulation.

The Plan's three Goals are:

1. Increase and broaden the public's awareness of suicide, its risk factors, and its place as a serious and preventable public health concern.
  - i. Increase evidence-based or best practice training opportunities for professionals;
  - ii. Increase awareness through community education; and
  - iii. Increase State policy and leadership efforts.
2. Enhance culturally competent, effective, and accessible community-based services and programs;
3. Assure effective services to those who have attempted suicide or others affected by suicide attempt or completion.

In order to achieve these Goals, the Commissioners propose the following eight strategies, ranked in order of priority. Specific tasks related to each strategy are described in the body of this report:

1. Establish a baseline listing of existing services and supports across prevention, intervention and post-vention (attempters and survivors);



2. Enhance the use and capacity of suicide prevention hotlines;
3. Identify, plan for and implement Evidence-based and Promising Practices to address unmet needs across prevention, intervention and post-vention as well as professional and community training in awareness of suicide risk and education in accessing resources.
4. Develop and execute an effective suicide prevention community education campaign to increase awareness and knowledge and decrease risk across the age span;
5. Recognize and address the needs of high-risk populations, such as:
  - a) Returning veterans of the armed services;
  - b) Persons who have made suicide attempts
  - c) Lesbian, gay, bisexual, transgender and questioning individuals (LGBTQ);
  - d) Persons who are unemployed; and
  - e) Youth and adults who have been victims of bullying and/or harrassment.
6. Recommend to the Maryland State Department of Education that they work with the local school systems' personnel to discuss best practices that are considered post-vention strategies related to student deaths that are the result of suicide.
7. Suicide prevention efforts should be planned and implemented with strong ties to the Maryland Public Health System. Staffing dedicated to the implementation of this Plan, as well as coordination and leadership in all State suicide prevention efforts, should be well defined within the Maryland Mental Hygiene Administration structure.
8. Continue the work of the Governor's Suicide Prevention Commission by extending the Commission's authority to assist and advise the Mental Hygiene Administration in the implementation of these recommendations; to identify emerging issues in suicide prevention and intervention; and to focus attention and recommend action on these emerging issues.

By defining three primary goals, each emphasizing the science base of suicide prevention, as well as the cultural competence, effectiveness and accessible nature of all outreach, services, and supports, the Commission has set the future direction of Maryland's suicide prevention efforts. The Commission's work provides clear priorities and achievable strategies for the organization, delivery, and funding of State suicide prevention, intervention and post-vention (suicide) services for years to come.

The Commissioners are pleased to provide their final recommendations in this report. These recommendations meet the two-year plan requirements as set forth in the Executive Order.



# THE REPORT

## BACKGROUND

On October 7, 2009, Governor Martin O'Malley issued an Executive Order (01.01.2009.13) establishing the Governor's Commission on Suicide Prevention, referenced as "the Commission" for the purposes of this report. The Executive Order requires the Commission to make recommendations and develop a two-year plan to strengthen and coordinate Maryland's services in the areas of suicide prevention, intervention, and post-vention (post suicide). The Governor appointed twenty one (21) Commissioners and designated a Chairperson. A list of the appointed Commissioners is provided in Appendix 3 as well as an attendance roster for Commission meetings. Commissioners may serve up to two consecutive three-year terms.

The first meeting of the Commission was convened on May 17, 2010 under the leadership of the Secretary of the Department of Health and Mental Hygiene (DHMH) and Chaired by Henry Westray as the Secretary's designee. Mr. Westray resigned the chair for health reasons. At the direction of the Governor, the Commission was co-chaired by Rosemary King Johnston, Executive Director, Governor's Office for Children (GOC), and Dr. Brian Hepburn, Executive Director, Mental Hygiene Administration, Department of Health and Mental Hygiene (DHMH), and staffed by the Department of Health and Mental Hygiene. In June, 2012, Mrs. Johnston retired from State service at which time Dr. Hepburn continued as the Commission's sole chair.

### 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION: GOALS AND OBJECTIVES FOR ACTION

In September, 2012, near the completion of the Commission's three year term, the National Strategy for Suicide Prevention Task Force, led by Surgeon General Regina M. Benjamin, MD, MBA released the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. This document is an updated call to action building on the first National Strategy for Suicide Prevention issued in 2001. Despite the fact that the Maryland Governor's Commission on Suicide Prevention formulated and completed its recommendations before the 2012 National Strategy for Suicide Prevention was published, it will be cited throughout this report as illustration of and expansion on the Commission's recommendations. The National Strategy's goals and objectives fall within four strategic directions with which the Maryland Commission's recommendations are in sync:

- ✓ Create supportive environments that promote healthy and empowered individuals, families and communities;
- ✓ Enhance clinical and community preventive services;
- ✓ Promote the availability of timely treatment and support services; and
- ✓ Improve suicide prevention surveillance collection, research, and evaluation.

This national document will continue to inform and shape the further development of Maryland's suicide prevention efforts as the Commission continues its work to advise and assist in the implementation of its recommendations over the coming years. The full text of the National Strategy for Suicide Prevention: Goals and Objectives for Action can be found at [www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html)

## COMMISSION'S WORK

*Suicide prevention is not exclusively a mental health issue. It is a health issue that must be addressed at many levels by different groups working together in a coordinated and synergistic way. Federal, state, tribal, and local governments; health care systems, insurers, and clinicians; businesses; educational institutions; community-based organizations; and family members, friends, and others—all have a role to play in suicide prevention (p. 11).*

In early 2011, the Commission began its formulation of Goals and Strategies by reviewing a “crosswalk” or Comparative Summary of two documents, Maryland’s Plan for Youth Suicide Prevention (2008) and the Mental Hygiene Administration’s Position Paper on Suicide Prevention for the Adult and Older Adult Populations (2009). In this Comparative Summary, the concerns and recommendations of these two efforts were considered and synthesized, noting both their similarities and differences. Through the development and synthesis of the documents, it became clear that the concerns and proposed recommendations expressed in each were more similar than different. Both emphasize that suicide is an important public health concern that is preventable. Utilizing the Goals in the Youth Suicide Prevention Plan as a comparative structure, the crosswalk clearly illustrated the numerous common concerns across the age spectrum. The full text of the Comparative Summary is included in Appendix 1c.

The Commissioners established the following three Goals to guide the remainder of their work. Based on the Public Health Model, these three overarching Goals and eight related strategies operate at three levels:

- Universal: prevention efforts applicable to all members of a population;
- Selected: more focused education and skill-building applicable to selected sub-groups who are at-risk for a preventable occurrence; and
- Indicated: focused interventions providing intense education and skill development related to specific risks of an indicated subpopulation.

## PROPOSED GOALS

1. Increase and broaden the public’s awareness of suicide, its risk factors, and understand that suicide is preventable.
  - i. Increase evidence-based or best practice training opportunities for professionals;
  - ii. Increase awareness through community education; and
  - iii. Increase State policy and leadership efforts.
2. Enhance culturally competent, effective, and accessible community-based services and programs;
3. Assure effective services to those who have attempted suicide or others affected by suicide attempt or completion.

To “advance the science of suicide prevention” was seen as a value that could be embedded in each of the three proposed Goals and their related strategies. Efforts to develop Goal 2 would focus on the prevention of and effective intervention in suicidal behavior. Goal 3 would maintain its focus on post-vention concerns. Additionally, each of the three Goals would



emphasize the culturally competent, effective, and accessible nature of outreach, services, and supports.

## RECOMMENDED STRATEGIES

*"...suicide is a complicated issue that requires equally complex solutions. Effective solutions need to incorporate multiple approaches at multiple levels. Effective prevention programs and policies stress the importance of wellness, resiliency, and protective factors; effective suicide response and intervention programs address risk factors, mental health and substance abuse services, and crisis response for those who are struggling with suicidal behaviors; and effective support programs are required for those who have been touched by suicide or suicidal behavior "(p.6).*

Described below are the eight strategies recommended by the Commission in order of priority. Of the strategies proposed, three (3) are considered immediately achievable with either redirection of existing staff and funding or at no additional cost and five (5) have elements of both immediate implementation as well as long term commitments of staff and funding of one year or longer. In rank order, a description of the high priority strategies and their proposed components follows.

### STRATEGY #1

*Immediate Implementation*

Establish a baseline listing of existing services and supports across prevention, intervention and post-vention (attempters and survivors).

Before proposing new or expanded services and supports, a comprehensive baseline of existing resources across agencies and organizations, state and local jurisdictions needs to be centrally assembled and made available to the public. Recommended steps in this process include:

- Use the current resource list for youth post-vention services (and other existing resource lists as completed to date) as a foundation upon which to build a comprehensive list.
- Use existing resources listed on Network of Care.
- Employ Commission website as well as linkages on MHA, MSDE and Veterans Affairs' websites to both collect and disseminate information.
- Note services and supports that address the needs of special populations such as veterans and their families; lesbian, gay, bisexual, transgender and questioning individuals; victims of bullying; unemployed individuals; and other populations added over time.

### STRATEGY #2

*Immediate and Long-term (1 Year) Implementation*

Enhance the use and capacity of suicide prevention hotlines.

Seen as the most immediately achievable of the proposed strategies, steps to begin implementation of enhanced use and capacity of suicide prevention hotlines were undertaken by a task force led by MHA staff in the spring and summer of 2012. The full text of their

recommendations can be found in Appendix 6. A summary of their action step recommendations are as follows:

- Rename the Maryland Youth Crisis Hotline as the Maryland Crisis Hotline.
  - Employ marketing campaign to inform Maryland residents of the availability of this resource in times of crisis for all Maryland residents across the lifespan.
- While the Maryland Crisis Hotline is available to all Maryland residents, it is recommended that the Veteran Hotline remain the main resource for veterans to access in time of crisis because of their familiarity and comfort with this resource. However, all Maryland Crisis Hotline staff are and will continue to be trained to assist veterans should they call that hotline.
- Increase funding to the Maryland Crisis Hotline in order to support increased usage as a result of marketing across the age span. Increased revenue will be used to fund:
  - Hiring and maintaining qualified staff
  - Investment in resources and technologies to meet the changing needs of those in crisis
  - Outreach services by Hotline staff to hospitals in an effort to divert persons in crisis

The process and product of the suicide prevention hotline workgroup serves as a model of the Commission's vision of how staff-supported implementation work across all eight strategies can continue.

#### STRATEGY #3

#### *Immediate and Long-term (2 year) Implementation*

Identify, plan for and implement Evidence-based and Promising Practices to address unmet needs across prevention, intervention and post-vention as well as professional and community training in awareness of suicide risk and education in accessing resources.

In an effort to infuse science-based practice across all suicide prevention, intervention and post-vention services and supports, especially in advancing effective community education and outreach, the Commission recommends that the continuation of existing efforts or the initiation of new services and supports be based on research-supported practices. Recommended steps in this process include:

- Explore inclusion of technical assistance in identifying evidence-based and promising practices (EBPs) to fill unmet needs in suicide prevention efforts into existing research contracts between the University of Maryland and the Mental Hygiene Administration and Governor's Office for Children.
- Priority in the implementation of EBPs to fill service gaps should be given to meeting the needs of those who attempt suicide and are seen in Emergency Rooms, Urgent Care centers and other community-care facilities.
- Prioritize outreach to and training in suicide prevention and intervention to:
  - Primary care physicians; and
  - Non-traditional community contacts such as bartenders, hair dressers and others who have extensive interpersonal contact with community residents.

Existing evidence-based practice models with non-traditional community contacts, such as those found in California, should be used as references.

- As community-based services continue to expand, an increasingly important role to identify and address suicidal behavior falls on all community-based workers in all fields



of human services. These workers should be provided with educational opportunities in suicide prevention and intervention as part of their ongoing professional training requirements to ensure the development of core competencies.

- Parents should be provided with community-based suicide prevention and intervention educational opportunities.
- In keeping with the emphasis on the Public Health Model in the prevention of suicide, increased use of Mental Health First Aid as an education and intervention tool should be encouraged.

*Suicide places a heavy burden on the nation in terms of the emotional suffering that families and communities experience as well as the economic costs associated with medical care and lost productivity. And yet suicidal behaviors often continue to be met with silence and shame. These attitudes can be formidable barriers to providing care and support to individuals in crisis and to those who have lost a loved one to suicide (p.10).*

#### STRATEGY #4

#### *Immediate and Long-term (2 year) Implementation*

Develop and execute an effective suicide prevention community education campaign to increase awareness and knowledge and decrease risk across the age span.

This strategy was seen as critical to the success of suicide prevention efforts. It is a combination of redirection of existing staff and new program funding. The approach should be unified in message and diverse in methods of outreach. Recommended steps in this process include:

- Identify high priority audiences and message.
  - Gather and evaluate existing survey information on suicide prevention across the State. Consult with local suicide prevention programs to establish what is currently being done in this area and how a unified outreach effort could work collaboratively with local efforts.
- Fold identified messages into existing efforts in suicide prevention such as the Mental Hygiene Administration's Suicide Prevention Conference (and other Mental Health Conferences as appropriate) and Suicide Prevention Month activities.
- Connect suicide prevention efforts with Youth M.O.V.E. and other youth groups such as Active Minds.
- Employ a broad based social marketing campaign, based on the accepted model, using identified audiences and message through a variety of media.

#### STRATEGY #5

#### *Immediate and Long-term (2 year) Implementation*

Across prevention, intervention and post-vention services and supports, recognize and address the needs of high-risk populations such as:

- Returning veterans of the armed services and their families;
- Persons who have made suicide attempts
- Lesbian, gay, bisexual, transgender and questioning individuals (LGBTQ);
- Persons who are unemployed; and
- Youth and adults who are the victims of bullying and/or harassment.



The needs of these and other high-risk populations should be addressed across prevention, intervention and post-vention services through a three-step process. That three step process includes:

- Research and identification of risks and needs;
- Identification of Evidence Based or Promising Practices that are specific to those needs; and
- Utilization of research to identify other special populations who may be at high risk.

**STRATEGY #6**

*Immediate Implementation*

Recommend to the Maryland State Department of Education that they work with the local school systems' personnel to discuss best practices that are considered post-vention strategies related to student deaths that are the result of suicide.

In light of the impact that suicide has on fellow students within a school community, it is considered critical that:

- Each school system have in place best practices to address the emotional needs of young people following a death by suicide; and
- Local school systems (LSS) take this opportunity to ensure that all students, parents and family members, and staff know to whom within each LSS they can report concerns about a student in distress and what actions can be expected to occur as a result of a report.

**STRATEGY #7**

*Immediate and Long-term (1 year) Implementation*

Suicide prevention efforts should be planned and implemented with strong ties to the Maryland Public Health System. Staffing dedicated to the implementation of this Plan, as well as coordination and leadership in all State suicide prevention efforts, should be well defined within the Maryland Mental Hygiene Administration structure.

As the Commissioners considered what next steps could be taken toward implementation of their recommendations, the need for ongoing staff support and leadership became clear. In order to make informed decisions, research into current capacities and practices is required; securing the engagement of knowledgeable and interested stakeholders is needed; and the analysis of the cost effectiveness of implementation is critical.

Given the Mental Hygiene Administration's current behavioral health reorganization, the time is ripe for the inclusion of dedicated suicide prevention staff to be made part of the Administration's permanent structure. At least one Full Time Employee to serve as lead coordinator/director and one Full Time Employee support staff should be tasked to lead the State's suicide prevention, intervention and post-vention efforts including serving as staff to this Commission.

**STRATEGY #8**

*Immediate Implementation*

Continue the work of the Governor's Suicide Prevention Commission by extending the Commission's authority to assist and advise the Mental Hygiene Administration in the implementation of these recommendations; to identify emerging issues in suicide prevention and intervention; and to focus attention and recommend action on these emerging issues.

While the initial work of the Governor's Commission on Suicide Prevention is complete, much remains to be done in Maryland to curb the incidence of suicide across the age span. By extending the authority of the Commission, an interdisciplinary body, experienced and personally committed to seeing this work through, can continue to advise and assist in the implementation of these recommendations. It is also important to regularly convene an advisory group that can assess and appropriately react to emerging issues in suicide prevention. The recent school shooting incident in Baltimore County where, by some reports, the shooter was suspected of acting against others in order to execute his own death is one example of current events that require consideration of their potentially damaging effects. What is the appropriate response? How can such events be prevented in the future?

Recommended steps in this process include:

- Reappointment of current Commissioners interested in continuing their service for a second three-year term.
- Expand Commissioners to include representatives of:
  - County jurisdictions
  - First responders
  - Public relations and community information professionals
  - Other family members or interested individuals who would broaden the Commission's scope of personal or professional experience with suicide
- Regularly convene Commission meetings on a bi-monthly basis to maintain active engagement and continuity of thought on important issues.

## CONCLUDING REMARKS

The Commission, established by Governor Martin O'Malley in October, 2009, has taken significant steps in furthering the State's suicide prevention efforts. By defining three primary goals, each emphasizing the science base of suicide prevention, as well as the cultural competence, effectiveness and accessible nature of all outreach, services, and supports, the Commission has set the direction of Maryland's suicide prevention efforts for the future. The Commission's work provides clear priorities and achievable strategies for the organization, delivery, and funding of State suicide prevention, intervention and post-vention services for years to come.

The next steps, implementation of the Commission's proposed strategies to achieve these goals, will require a different approach. Supported by staff dedicated to suicide prevention, the Commission will continue to function in advising and assisting in ongoing suicide prevention, intervention and post-vention efforts.

## APPENDICES

### Appendix 1

- a) Mental Hygiene Administration's Position Paper on Suicide Prevention for the Abuse and Older Adult Population – November, 2009
- b) Linkages to Life: The Maryland State Plan for Suicide Prevention: FY2008-2012 (2008)
- c) Comparative Summary: Maryland's Plan for Youth Suicide Prevention (2008) and Mental Hygiene Administration's Position Paper on Suicide Prevention for the Adult and Older Adult Populations (2009)
- d) A Consolidated Suicide Prevention Plan: First Steps
- e) Strategy Impact/Cost Matrix
- f) Update on Youth Suicide Data in Maryland 2010, Johns Hopkins Medicine
- g) Department of Veteran Affairs: National Suicide Prevention Program (3/14/2011)
- h) Youth Crisis Hotline
- i) Hotline Locations Map

### Appendix 2

- a) Executive Order 01.01.2009.13
- b) Governor's Commission on Suicide Presentation – Summary of Executive Order

### Appendix 3

- a) Governor's Commission on Suicide Prevention Membership Listing/ Attendance Record

### Appendix 4

- a) Meeting – May 17, 2010
  - i. Agenda
  - ii. Minutes
- b) Meeting – December 9, 2010
  - i. Agenda
  - ii. Minutes
- c) Meeting – March 14, 2011
  - i. Agenda
  - ii. Minutes
- d) Meeting – June 13, 2011
  - i. Agenda
  - ii. Minutes
- e) Meeting – September 12, 2011
  - i. Agenda
- f) Meeting – November 21, 2011
  - i. Agenda
  - ii.
- g) Meeting – February 27, 2012
  - i. Agenda
  - ii.
- h) Meeting – April 23, 2012



- i. Agenda
- ii.
- i) Meeting – July 16, 2012
  - i. Agenda
  - ii.

#### Appendix 5

- a) Summary of the Commission's Deliberation and Recommendation Process

#### Appendix 6

- a) Suicide Prevention Hotline Recommendations