Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

The Maine Injury Prevention Program Strategic Plan Revision 2007-2010

ACKNOWLEDGEMENTS

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The Maine Injury Prevention Program gratefully acknowledges the support of its funders: Maternal Child Health Block Grant, Preventive Health and Health Services Block Grant, Maine Department of Public Safety, National Center for Injury Prevention and Control in the Centers for Disease Control and Prevention, and the Substance Abuse, Mental Health Services Administration.

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INTRODUCTION

Program Background

The Maine Injury Prevention Program (MIPP) is located in the Division of Family Health (DFH) within the designated state health agency, the Maine Center for Disease Control and Prevention in the Department of Health and Human Services. The MIPP has served as the lead agency for injury prevention for children, adolescents and young adults since 1983 when a fledgling child passenger safety education program was developed, in collaboration with the Maine Bureau of Highway Safety, in hospitals and agencies statewide.

The history of the MIPP is one of strong and long standing partnerships. The MIPP has grown and changed in response to developments in the injury prevention field, needs expressed by public and private entities including schools, public safety groups, legislators, public health nurses, community agencies among others, and according to staffing capacity and funding resources.

The MIPP has made many notable contributions to the prevention of intentional and unintentional* injuries in Maine. In 1998, the MIPP staff received an Outstanding Achievement award from the Bureau of Health for securing Maine's first CDC Fire Prevention Grant. In 2002, Maine was one of the first states to undergo a STIPDA sponsored State Technical Assistance Team "STAT" assessment process to measure the program in the five core components of effective injury prevention practice. In 2003, Maine led the country in implementing a statewide voucher system program for the distribution of child passenger safety seats. The MIPP often plays an important role on issues relating to child passenger safety legislation. In 2003, the MIPP provided data and best practice information to support passage of a primary child passenger safety seat law. In 2004, the MIPP was nationally recognized by the Suicide Prevention Action Network (SPAN) for its leadership in the field of youth suicide prevention. In 2005 and 2006, the Child Passenger Safety Coordinator received awards for work on the Maine Transportation Safety Coalition and the Northeast Transportation Safety Conference. In 2007, MIPP staff worked alongside other traffic safety advocates to provide supportive information essential to passage of a primary seat belt law for all Maine residents.

*The term "Unintentional injury" is defined as an event in which: 1) injury occurs in a short period of time – seconds or minutes, 2) the harmful outcome was not sought or 3) the outcome was the result of one of the forms of physical energy in the environment or normal body functions being blocked by external means, e.g. drowning.[1] The term "Intentional injury" is used to refer to injuries resulting from purposeful human action, whether directed at oneself or others that is intended to cause harm.[2] (See Appendix A)

[1] Injury Prevention and Public Health; Practical Knowledge, Skills, and Strategies; Christoffel, T. Gallagher, S.; Aspen Publications 1999.
[2] Same as Footnote 1.

Traditionally, injuries have been regarded as random, unavoidable "accidents." In the last decade, a better understanding of the nature of injuries as predictable and preventable events has lead to the development of effective prevention strategies for unintentional and intentional injuries.[3]

Purpose of Plan

Maine Injury Prevention Program Vision:

Working together to keep Maine people safe from unintentional and intentional injuries.

Maine Injury Prevention Program Mission:

To provide leadership and coordination to agencies statewide, to integrate effective injury and violence prevention into their organizational practices.

Historically, the MIPP has focused primarily on the prevention of child, teen and young adult injuries. In 2003, with assistance from the Children's Safety Network, the MIPP developed a strategic plan to guide program staff, agency administrators and partners towards integrating the core components of injury prevention in a state health department and improving the MIPP capacity to reduce unintentional and intentional injuries. At that time, the MIPP chose four priority areas on which to focus: child passenger safety, home safety, youth suicide and youth violence prevention. Included in that plan was an evaluation of progress in five years. This plan represents a strategic revision of the original 2003 plan to guide staff and partners through 2010.

Revising the MIPP plan at this time is based on several factors. Most significant is the strategic redirectioning that has taken place at multiple levels of the overall organization. In the past two years, the Department of Health and Human Services (DHHS), the Maine Center for Disease Control and Prevention (Maine CDC, formerly the Bureau of Health) and the Division of Family Health (DFH) have undergone strategic planning processes. Decisions made through these processes significantly impact the organization and capacity of the MIPP. (See Appendix B)

In 2005, as part of the Maine CDC reorganization, the MIPP was moved from the Division of Community Health to the DFH. The recent reorganization of the DFH resulted in a new administrative reporting structure and one less position in the MIPP. Currently, an effort is underway to develop a regional public health infrastructure including eight new public health districts where no local public health entities previously existed. All of these changes offer opportunities and challenges to the MIPP and require significant rethinking of current program plans, priorities and staffing needs.

In this strategic plan revision, with increasing availability of reliable injury data, the MIPP is moving from an exclusive focus on the youngest state residents to addressing the four leading causes of serious injury and death across the lifespan. Using data to identify the most serious causes of injury in Maine, in combination with an increasing emphasis on employing the five core components of injury prevention, will effectively lead the program in new directions for the future.

[3] Making a Difference: State Injury and Violence Prevention Programs 2006.

Careful consideration was given to the development of a plan that will have the most positive impact, integrate with the state and emerging regional public health infrastructure and recognize the limits of resources, including funding and staffing capacity, to reduce the burden of injury in the Maine population.

Integral to this planning process was the continued use of the STAT Assessment of the MIPP conducted in 2002, technical assistance from the national Children's Safety Network, input from members of the CDC Integrated Core Injury Prevention Project Injury Prevention Workgroup (IPG) and feedback from agency administrators. This input assisted the MIPP to better define the focus of the plan and ensure that it is grounded in the guiding principles and strategic themes of the agency as well as the core components of injury prevention. Additionally, a Strengths, Weaknesses, Opportunities and Threats (SWOT) Assessment was conducted by program staff.

The first section of the plan provides a summary of the overall document, information on the injury problem in Maine, the legislation and other mandates that impact injury prevention and a description of the most significant infrastructure issues pertinent to the MIPP.

The last section contains the MIPP strategic plan for 2007 to 2010 in each of the four identified priority areas of: 1) motor vehicle traffic crash injuries, 2) suicide and suicidal behavior, 3) falls among older adults, and 4) unintentional poisoning. Detailed annual workplans will be developed by staff with collaborators to describe the specific activities and timelines to be undertaken each year of this strategic plan.

Maine Injury Prevention Program Priority Areas

The MIPP used the following criteria to select the injury priority areas:

1. Injury surveillance, utilizing reliable morbidity and mortality data, allows monitoring of the incidence and prevalence of the priority area.
2. Injury data indicate that the priority area is a leading cause of injury fatalities and/or injury hospital discharges among Maine residents.
3. Significant health care and other cost to Maine people (e.g. lost wages, short and long term disabilities) are reduced by addressing the priority area.
4. Funding sources and other mandates (e.g. the five-year needs assessment conducted by Maternal and Child Health) recognize and support the importance of addressing the priority area.
5. Policymakers and stakeholders support addressing the priority area.
6. Effective evidence-based models, interventions, and /or promising practices are available to address the priority area.

Ongoing analyses of injury mortality and morbidity data are planned to allow the MIPP to monitor these priority areas and identify new or emerging priorities. (See Appendix C)

EXECUTIVE SUMMARY

Introduction

The Maine Injury Prevention Program (MIPP) has served as the lead agency for injury prevention for children, teens and young adults since 1983. The MIPP is located in the Department of Health and Human Services (DHHS), Division of Family Health (DFH) in the designated state health agency, the Maine Center for Disease Control and Prevention (Maine CDC), formerly the Bureau of Health.

The history of the MIPP is one of leadership based on strong, long standing partnerships. The MIPP has been the recipient of several awards and recognitions in the areas of child passenger safety and youth suicide prevention. A myriad of legislative and other mandates support injury and violence prevention activities in the state.

In 2003, with assistance from the Children's Safety Network, the MIPP developed a strategic plan to guide program staff, agency administrators and partners to increase its capacity to reduce unintentional and intentional injuries. At that time, the MIPP primarily focused on child passenger safety, child safety in the home, youth suicide and youth violence prevention.

This document represents a strategic revision of the 2003 plan to guide staff, administrators and injury prevention partners through 2010. The impetus to revise the program plan comes from several factors. First, multiple levels of the overall organization - the DHHS, the Maine CDC and the DFH - have recently undertaken strategic planning processes. These changes significantly impact the organization, capacity and future direction of the MIPP.

Second, a new regional public health infrastructure including eight new public health districts is under development. While these changes are exciting and challenging to the MIPP, significant rethinking of program plans, priorities and staffing needs is required.

Third, in 2005, the MIPP was fortunate to receive five years of funding for an Integrated Core Injury Prevention and Control Project through a cooperative agreement with the federal Centers for Disease Control and Prevention (CDC). This agreement and accompanying funding has directly improved the capacity of the MIPP to develop a coordinated, strategic approach to reducing injury morbidity and mortality in Maine.

Injury Problem in Maine

Injury is an important public health problem in Maine. Injury deaths and disabilities significantly impact the health and well-being of individuals across the lifespan. From 2000-2004, injury was the underlying cause of death for 3,365 Mainers, an average of 673 injury deaths each year of this five year period. Unintentional injuries were the leading cause of death for residents aged 1-44 and the 6th leading cause of death among all ages combined. Suicide was the 2nd leading cause of death among 15-34 year olds and the 10th leading cause of death among all ages combined. Injury deaths were more common among males than among females.

The three leading causes of injury deaths were unintentional motor vehicle traffic crashes, suicide, and unintentional poisonings. Seven out of ten (71%) injury deaths were due to unintentional causes.

Less than one percent of all injuries result in death. It is estimated that, for every injury death in Maine, there are approximately 12 hospitalizations for which injury is the principal diagnosis. From 2000-2004, there were 40,873 injury hospital discharges of Maine residents from non-federal acute care hospitals in the state, an average of 8,175 injury discharges per year. The three leading causes of injury hospitalizations during 2000-2004 were unintentional falls, unintentional motor vehicle traffic crashes, and self-inflicted poisonings. Nearly three-fourths (74%) of injury-related hospital discharges were known to be due to unintentional causes. Hospital discharges were more common among females than among males for injuries. The population most at risk for injuries varies considerably by cause of injury.

The Children's Safety Network Economics & Data Analysis Resource Center estimates the annual cost of fatal injuries in Maine at more than $1.8 billion. This includes $7.8 million in medical costs, $595.3 million in work loss costs, and $1.2 billion in quality of life costs. (Costs are in 2004 dollars and based on the number of 1999-2002 injury fatalities in Maine.)

Maine Injury Prevention Program Plan

The field of injury and violence prevention encompasses multiple types of interventions to reduce a variety of injury outcomes along a continuum of minor injuries to serious life-changing disabilities to death.

A solid and stable injury prevention infrastructure in the state health agency is essential to reducing the burden of injury in the state. By providing state leadership, systematically coordinating efforts and building collaborations with diverse partners, the MIPP plans to efficiently direct its resources to address the leading injury problems in the Maine population.

This MIPP strategic plan revision is a working document highlighting Maine’s injury problems and serving as a guide for the MIPP and its partners for the three year period between 2007 and 2010. Incorporated into the development of this plan are the Maine CDC strategic themes of excellence, efficiency and effectiveness; the three core functions of public health of assurance, assessment and policy development and the ten essential services of public health. (See Appendix D) This methodology will have the most meaningful impact and integrate with the current state and emerging regional public health infrastructure, within the limits of resources, to reduce the burden of injury in the Maine population.

This plan revision, with increased availability of reliable injury data, moves the program into new directions for the future - from an exclusive focus on Maine’s youngest residents to the four leading causes of serious injury and injury death across the lifespan. The four identified priority areas are: motor vehicle traffic crashes, suicide and suicidal behavior, falls among older adults and unintentional poisoning. Enhancing Maine’s injury and violence prevention infrastructure to ensure that the work is comprehensive and sustainable over time is also an identified priority.

Detailed annual work plans will be developed with collaborators to guide specific activities and timelines to be undertaken each year of this strategic plan. New MIPP goals are listed below.

Maine Injury Prevention Program Goals

The goals and objectives for each priority area were formed around the State and Territorial Injury Prevention Directors Association (STIPDA) core components of injury prevention: 1) collecting and analyzing injury data; 2) designing, implementing and evaluating interventions; 3) building a solid infrastructure for injury prevention; 4) providing technical support and training; and 5) collaborating with diverse groups to affect public policy.

Infrastructure: Build the infrastructure within the state health agency needed to effectively prevent injuries and violence statewide.

Motor Vehicle Traffic Crash Injuries: Reduce the burden of injuries and deaths resulting from motor vehicle traffic crashes.

Suicide and Self-Inflicted Injuries: Reduce the burden of suicide and suicidal behaviors among Maine residents.

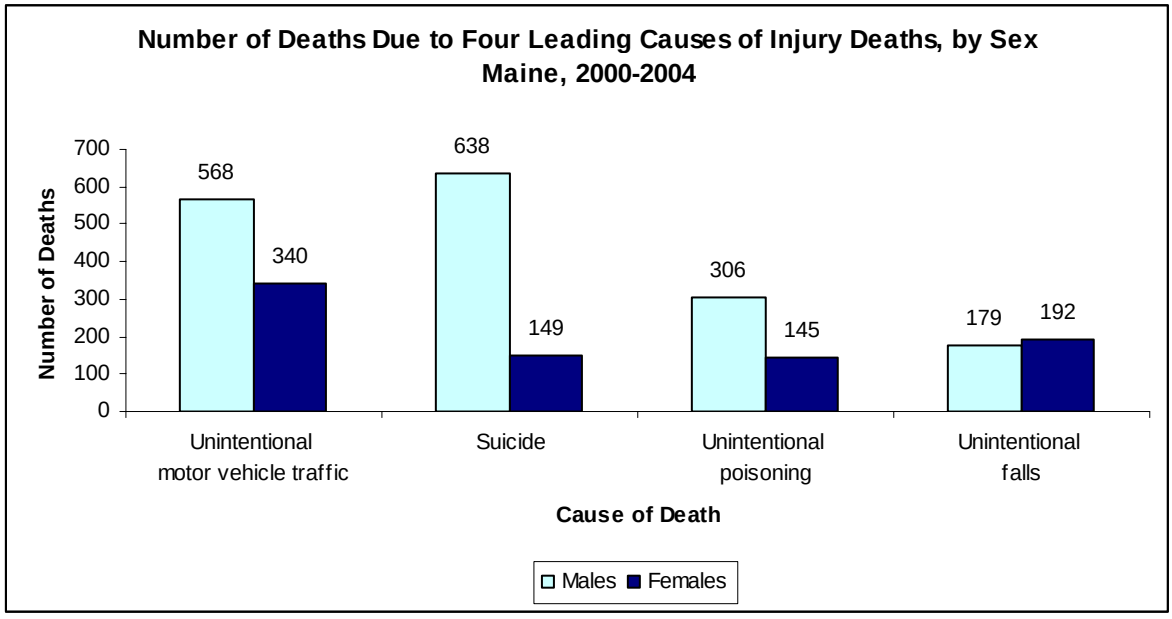
Falls Among Older Adults: Reduce the burden of injuries and deaths due to unintentional falls among Maine residents ages 65 and older.

Unintentional Poisoning: Reduce the burden of unintentional poisoning deaths and injuries among Maine residents.

BURDEN OF INJURY IN MAINE

Injury is an important public health problem in the United States and in Maine. Deaths and disabilities from injuries take a significant toll on the health and well-being of individuals across the lifespan. This section presents basic information about injury-related deaths and hospital discharges among Maine residents, including how common injuries are, who is affected, and how these injuries happen.

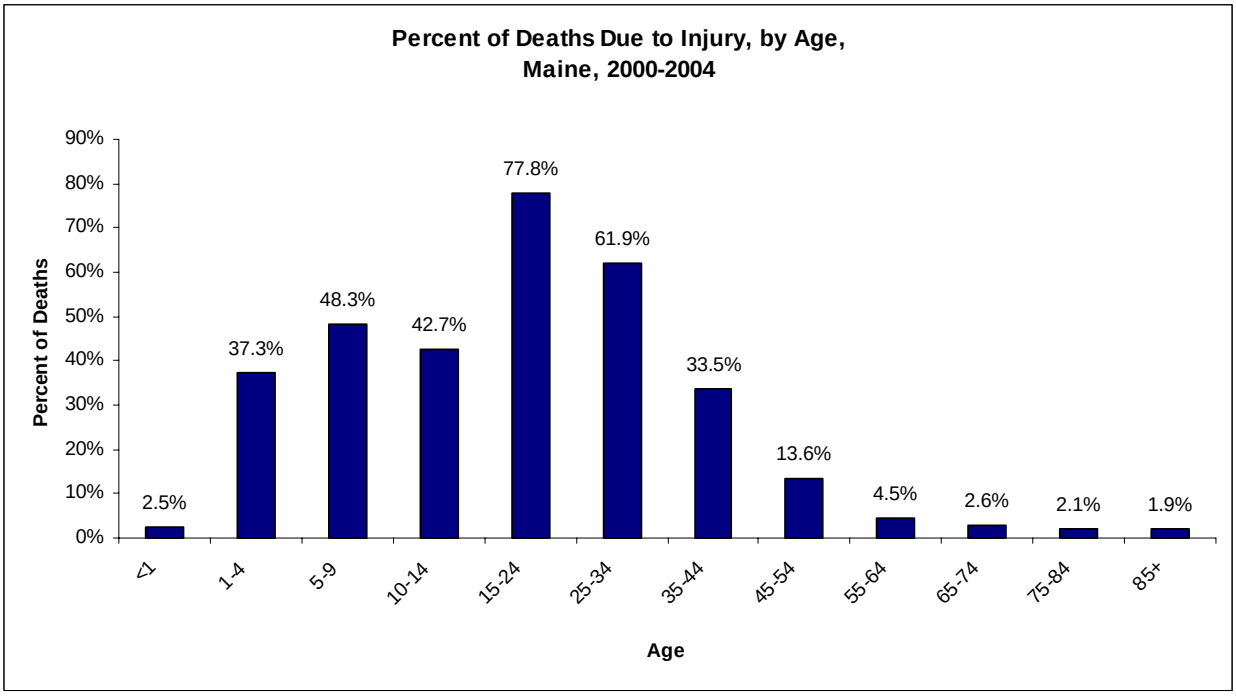
Injury was the underlying cause of death for 3,365 Mainers during 2000-2004 – an average of 673 injury deaths per year. During this period, unintentional injuries were the leading cause of death for residents aged 1-44 and the 6th leading cause of death among all ages combined. Suicide was the 2nd leading cause of death among 15-34 year olds and the 10th leading cause of death among all ages combined. Homicide deaths were relatively uncommon, with an average of 18 such deaths per year. The four leading causes of injury deaths in Maine during 2000-2004 were unintentional motor vehicle traffic incidents, suicide, unintentional poisoning, and unintentional falls. The majority (82%) of unintentional fall deaths occurred among adults aged 65 and over. Seven out of ten (71%) injury deaths were due to unintentional causes. (See Appendix C)



Data source: Maine death certificate statistical datasets, 2000-2004

The average annual injury death rate in 2000-2004 was 51.9 per 100,000 Maine residents. The age-specific rates ranged from a low of 7.1 per 100,000 among 10-14 year olds and 7.3 per 100,000 among 5-9 year olds to a high of 296.9 among 85+ year olds.

Injury was the underlying cause for 78% of deaths among 15-24 year olds and 62% of deaths among 25-34 year olds in 2000-2004. Injury was, in fact, the leading cause of premature mortality or early death, as measured by years of potential life lost, in Maine during this 5-year period. Unintentional injury, suicide, and homicide combined were responsible for more than 65,000 years of potential life lost before 65 years of age.



Data source: Maine death certificate statistical datasets, 2000-2004

Injury deaths represent less than one percent of all injury outcomes. The MIPP estimates that for every injury death in Maine, there are approximately 12 hospitalizations for which an injury is the principal diagnosis. In 2000-2004, there were 40,873 injury hospital discharges of Maine residents from non-federal acute care hospitals in the state – an average of 8,175 such discharges per year.

The average annual injury hospital discharge rate in 2000-2004 was 630 per 100,000 Maine residents. The age-specific rates ranged from a low of 145.2 per 100,000 among 5-9 year olds to a high of 5,411.4 per 100,000 among 85+ year olds. The four leading causes of injury hospitalizations during 2000-2004 were unintentional falls, unintentional motor vehicle traffic incidents, self-inflicted poisoning, and unintentional poisoning. Seven out of 10 (70%) unintentional fall hospitalizations were among 65+ year old Mainers. Nearly three-fourths (74%) of injury hospital discharges were known to be due to unintentional causes. (See Appendix C)

During 2000-2004, injury deaths were more common among males than among females. Conversely, injury-related hospital discharges were more common among females than among males. The population most at risk for injuries varies by cause of injury. For example, 85+ year old women are at highest risk of injury hospitalization due to unintentional falls, while 15-24 year old and 75+ year old males are at highest risk of death due to motor vehicle traffic incidents. Young women, aged 15-19, consistently have the highest rate of hospitalization for self-inflicted injuries of any age/sex group in Maine.

We are unable at this time to look for possible economic or race/ethnicity disparities in injury hospitalizations or deaths. Neither the hospital discharge nor the death certificate dataset include income information. The hospital discharge dataset does not include race/ethnicity. Race/ethnicity is included in the death certificate dataset; however small numbers, even when combining several years of data, would result in unstable estimates. Questions have been raised about the accuracy of race/ethnicity data in the death certificate dataset.[4]

The Children's Safety Network Economics & Data Analysis Resource Center estimates the annual cost of fatal injuries in Maine at more than $1.8 billion. This includes $7.8 million in medical costs, $595.3 million in work loss costs, and $1.2 billion in quality of life costs. (Costs are in 2004 dollars and based on the number of 1999-2002 injury fatalities in Maine.) The MIPP does not, at present, have state-specific data on the cost of nonfatal injuries in Maine.

Further data on unintentional motor vehicle traffic injuries, suicide and self-inflicted injuries, falls among older adults, and unintentional poisoning are presented in later sections of this strategic plan. Additional injury data is found in the MIPP's annual report on injury in Maine.

[4] Graber JM, Corkum BE, Sonnenfeld N, Kuehnert PL. Underestimation of cardiovascular disease mortality among Maine American Indians: the role of procedural and data errors. *American Journal of Public Health* 2005;95:827-830. Available from: http://www.ajph.org/cgi/reprint/95/5/827.

INJURY AND VIOLENCE PREVENTION MANDATES

Legislation, regulations and policies that support injury prevention have been demonstrated to save lives. This section cites key selected Maine specific policies/laws/mandates relevant to injury prevention.

Motor Vehicle

The Maine Legislature recently passed an update of the adult seat belt law that will strengthen the law through enforcement. Once the change comes into effect in 2008, law enforcement officers will be able to stop drivers for not wearing their seat belt. Previously drivers could not be stopped for not wearing a safety belt. The MIPP actively supported the 2003 CPS law and the 2007 enhancement of the adult seatbelt law in Maine with data and by acting as a resource to the legislature.

1983 - Title 29A Motor Vehicles - §2081 Use of Safety Seat Belts
Children aged 0 to 4 years must be secured in a child safety seat.

1987 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
Children aged 4 to 13 years must be secured in a child safety seat or safety belt.

1989 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
Law expands to include children 4-16 years.

1991 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
Law expands to include persons 4 to19 years of age.

1993 - Title 29 A Motor Vehicles - §1311. Intermediate License
Graduated license for teen drivers.

1993 - Title 29A Motor Vehicles - §2062 Operating a Motorcycle
Headgear must be worn by children under age 15 while riding on a motorcycle; while riding on or operating an off-road vehicle; or when operator is operating under a learner's permit.

1994 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
Driver made responsible for securing children under 4 years of age in a child safety seat.

1995 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
Statewide referendum requiring adults 19 and older to use safety belts. Could only be enforced if the police officer had detained the operator for a suspected violation of another law.

1997 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
Passengers 18 Years and older must wear a seat belt - may only be enforced if driver is stopped for another traffic violation.

1999 - Title 29A Motor Vehicles - §2322 Operating a Bicycle
Persons under 16 years of age who operate or are a passenger on a bicycle on a public roadway shall wear a helmet.

2003 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
A child who weighs less than 40 pounds must be secured according to manufacturer's instructions in a child safety seat; a child who weighs at least 40 pounds but less than 80 pounds and who is less than 8 years of age must ride in a federally approved child restraint system; a child who is less than 12 years of age and who weighs less than 100 pounds must be properly secured in the back seat of the vehicle, if possible; a person who is under 18 years of age and at least 8 years of age or who is under 18 years of age and more than 4 feet 7 inches in height must be properly secured in a safety seat belt.

2007 - Title 29 A Motor Vehicles - §2081 Use of Safety Seat Belts
As amended by PL 2005, c. 12, Pt. AAA, §3, is further amended to read: When a person 18 years of age or older is a passenger in a vehicle that is required by the United States Department of Transportation to be equipped with seat belts, the passenger must be properly secured in a seat belt. This may be enforced as a primary violation.

2007 - Title 29 A Motor Vehicles - § 2116 Use of Electronic Devices by Minors while Operating Motor Vehicles
A person who has not attained 18 years of age may not operate a motor vehicle while using a mobile telephone or handheld electronic device.

2007 - Sec.2. 29-A MRSA §2081, sub-§3, B,
Ss amended by PL 2003, c. 380, §3 and affected by §5, is further amended to read: B. The operator shall ensure that a child who is less than 18 years of age and at least 8 years of age or who is less than 18 years of age and more than 4 feet, 9 inches in height is properly secured in a seat belt.

Suicide

1987 - Title 34-B MRSA Chapter 3 - Mental Health, subchapter I §3007, Teenage Suicide Prevention Program
Established a mandate to the Departments of Education and Mental Health, Mental Retardation and Substance Abuse Services to develop a teenage suicide prevention strategy and a model suicide prevention program to be presented in the secondary schools of the State.

1995 - Executive Order 13 FY 94/95 Governor King - Adolescent Suicide and Self-destructive Behavior Task Force
Task force composed of a variety of individuals from families and different professions who were charged with identifying problems and concerns related to suicide among Maine youth and making recommendations for action to the governor.

2000 - Sec. 1 5 MSRA §12004-L, Subchapter §12 Chapter 439 An Act to Establish the Council on Children and Families and to Ensure the Continuation of the Governor's Children's Cabinet
Established the Governor's Children's Cabinet in statute to initiate and oversee programs, policies and services which includes safe homes, civil and caring school environments and reducing suicide among Maine youth and improving access to appropriate prevention and intervention services.

2005 - Executive Order E033 FY 04/05 Governor Baldacci to Strengthen the Maine Youth Suicide Prevention Program (MYSPP).

2006 - Public Law 2005, Chapter 55
The Legislature charged the Joint Advisory Committee on Select Services for Older Persons to study and report on elder suicide.

2007 - Federal H.R. 327, Joshua Omvig Veterans Suicide Prevention Act
To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to develop and implement a comprehensive program designed to reduce the incidence of suicide among veterans.

Falls

2006 - L.D. 1707 Resolve, Directing the Commissioner of Health and Human Services to Develop Strategies to Keep Senior Citizens Safe from Falls
This resolve created the Maine Falls Prevention Coalition. The coalition was charged with developing a blueprint for the future of falls prevention for older adults in Maine. This includes conducting a review of the effects of falls of older adults on health care costs, the potential for reducing the number of falls of older adults and the most effective strategies for reducing falls and health care cost associated with falls.

2007 – Sec. 3 § 18000; Acquired Brain Injury Advisory Council established
Council established to provide independent oversight, advice, and make recommendations to the Commissioner, the Director of the Office of Adults with Cognitive and Physical Disability Services, the Director of the Maine Center for Disease Control and Prevention and the Director of the Office of MaineCare Services.

Poisoning

2000 - 'Sec. 1. - 22 MRSA c. 252-B Chapter 252-B – Poison Control Center - §1346.
Designated the Maine Poison Center, located at the Maine Medical Center, as the official state poison control center. Renamed the Northern New England Poison Center.

MAINE INJURY PREVENTION PROGRAM INFRASTRUCTURE

Infrastructure includes the staff, partners, financial and other resources that support the core injury prevention functions of: 1) collecting and analyzing injury data; 2) designing, implementing and evaluating interventions; 3) building a solid infrastructure for injury prevention; 4) providing technical support and training; and 5) collaborating with diverse groups to affect public policy. [5]

State law in Maine delegates primary public health jurisdiction and authority to state and local agencies. It is the responsibility of these agencies to assure residents of all ages a healthy and safe environment. To further extend the public health infrastructure statewide, development of eight new regional public health districts based on county lines and associated local community health coalitions is in process.

The MIPP is located in the Division of Family Health (DFH) within the designated state health agency, the Maine Center for Disease Control and Prevention (formerly Bureau of Health), in the Department of Health and Human Services (DHHS).

Unlike some public health prevention activities where monitoring, intervention and evaluation all occur within the health sector (e.g. immunization against childhood diseases); injury prevention often involves a variety of partners from other sectors, depending upon the type of injury being addressed. The MIPP has routinely worked with education, social services, public safety, corrections, parole, probation, emergency medical services, traffic safety, chronic disease prevention, and other sectors. The MIPP will work with the emerging public health infrastructure and other sectors involved in promoting public health and safety to achieve integration of effective injury and violence prevention activities within these sectors.

The State and Territorial Injury Prevention Directors Association (STIPDA), a national organization of injury prevention professionals established in 1992, conducts State Technical Assistance Team "STAT" assessments on request. The "STAT" assessment is designed to help state programs strengthen their ability to reduce death and disability associated with injury and violence. In 2002, the MIPP underwent an assessment to measure the program's progress in the five core components of effective injury prevention practice. The STAT team interviewed numerous stakeholders, met with staff and reviewed a large quantity of material prepared by staff. The STAT summarized their findings and delivered a set of recommendations in a report to the program. This report provided useful information to MIPP planning and was utilized in developing this strategic plan revision.

The following section of the plan provides information on the current status of the MIPP infrastructure. It is organized around the STIPDA core components of a comprehensive state health department injury prevention program and uses the 2002 STAT assessment of the MIPP and a survey conducted by STIPDA in 2005.

[5] STIPDA 2005 State of the States Survey: Highlights Report, Atlanta, GA: State and Territorial Injury Prevention Directors Association, 2006.

State Mandate

The "State of the States Report" conducted by STIPDA 2005 notes the importance of an official governmental mandate to raise the visibility of an important health or safety issue. Such a mandate for injury and violence prevention is recommended by STIPDA to develop and maintain core injury prevention capacity to reduce the burden of injuries.[6]

Maine does not have a specific mandate for injury or violence prevention core program structure in the state health department. However, there are numerous mandates that dictate and support addressing the selected injury priority areas of the program.

Strategic Plan

STIPDA strongly recommends that injury and violence prevention programs develop a strategic plan. They note that many states used the STAT process to develop or improve their state plans.[7]

Maine was one of 44 (90%) states to have a state injury prevention plan in 2005. Funding from the CDC Integrated Core Injury Prevention cooperative agreement has provided the impetus to the MIPP to work with key partners to revise and expand its program plan, embrace a data driven approach and undertake a major shift in focus from children, teens and young adults exclusively, to focus on prevention of leading injuries across the lifespan.

Workforce

STIPDA states that a full time director of injury prevention is essential for operationalizing comprehensive statewide injury and violence prevention activities. In addition to the leadership position, STIPDA recommends that injury prevention programs include staff in positions of data analysis, program implementation and evaluation, training and technical assistance and public policy to carry out core injury program functions.[8] Nationally, 37 (76%) of states surveyed in 2005 had a fulltime director.

Maine was fortunate to have a full time manager of unintentional injury and another for intentional injury prevention from 1998 until July 1, 2007. As part of the DFH reorganization, the unintentional injury manager position was eliminated. This reorganization required a significant re-prioritization of program staffing assignments in order to fulfill the responsibilities of providing statewide leadership in unintentional and intentional injury prevention efforts and that re-prioritization process continues.

[6]STIPDA 2005 State of the States Survey: Highlights Report, Atlanta, GA: State and Territorial Injury Prevention Directors Association, 2006.
[7] Same as Footnote 5.
[8] Same as Footnote 5.

The program manager for intentional injury prevention will resume the role of MIPP Director and will continue to serve as the state coordinator for the Maine Youth Suicide Prevention Program. One of the program's two Public Health Educator III positions will be assigned new functions and responsibilities. The focus of this position will change from providing training programs and educational resources, to assuming leadership of the planning and implementation of training programs and dissemination of best practice injury prevention interventions across the lifespan and identifying key partnership opportunities for same. This reorganization is intended to provide the necessary technical support, collaboration, linkages and oversight to injury and violence prevention to best utilize the skills of staff members and build upon collaborations with partners and stakeholders. Lastly, the MIPP's data analyst/program evaluator position has been vacant since April 2004. This vacancy severely limits the MIPP's capacity to fully utilize available data and conduct program evaluation. Every effort is being made to fill this position.

Funding

The 2005 STIPDA "State of the States Report" notes that, although injury is a leading cause of death, dedicated and ongoing federal funding does not exist for injury and violence prevention as it does for other public health priorities.[9]

MIPP funding is comprised of ongoing and short term categorical funding sources.

Ongoing funding to support staff and activities includes:

- Maternal and Child Health Block Grant;
- Preventive Health and Health Services Block Grant;
- Maine Bureau of Highway Safety sub grants (National Highway Traffic Safety Administration (NHTSA) funds);
- State legislative appropriations for poison prevention;
- In-kind support, primarily in the form of staff time, from agencies of the Governor's Children's Cabinet (selected youth suicide prevention activities)

Current short-term categorical support sources include:

- Centers for Disease Control and Prevention (CDC) – for Integrated Core Injury Prevention and Control activities (8/1/05-7/31/10)
- Substance Abuse and Mental Health Services Administration (SAMHSA) - supporting implementation and evaluation of a comprehensive youth suicide prevention school and community based project in three Maine counties (9/30/05-9/29/08)

[9] STIPDA 2005 State of the States Survey: Highlights Report, Atlanta, GA: State and Territorial Injury Prevention Directors Association, 2006

Obtaining and maintaining ongoing funding to support core program functions continues to be a challenge for the program. The following excerpt from the 2002 STAT assessment of the MIPP provides valuable insight. "The major force limiting the impact of the MIPP is its lack of resources. With so little discretionary funding, and with very little non-categorical funding, the MIPP finds it difficult to take advantage of new opportunities and fulfill its obligation to build state and local capacity. Strategic investments in the MIPP's capacity, as well as increased attention of MIPP staff to enhance collaborative relationships, would go a long way toward laying a stronger foundation for integrating injury prevention into public health in Maine".[10]

Data

Because of the wide range of types of injuries, population groups affected and circumstances under which injuries occur, STIPDA recommends the use of eleven different datasets to monitor injury. [11] (See Appendix E). Use of these datasets allows programs to develop an understanding of injury problems in a given area by tracking fatal and non-fatal injuries, identifying trends and risk factors and helping to evaluate the effectiveness of interventions.

The MIPP has access to nine of the eleven recommended datasets and uses several other Maine specific available datasets. When resources permit, the MIPP purchases epidemiology services to build and enhance ongoing injury surveillance activities. Recent program accomplishments in injury surveillance include the development of a suicide and self-injury surveillance system, and responses to specific data requests provided to partners such as the Maine Falls Prevention Coalition, the State Fire Marshal's Office and state legislators to assist in the preparation of reports to their respective stakeholders.

Design, Implement and Evaluate Programs

STIPDA recommends that "State injury and violence programs collaborate with internal and external stakeholders to promote the development, implementation and evaluation of injury and violence prevention programs. Ideally, these prevention programs serve a wide range of populations, address multiple types of injury and violence, are built upon evidence based research showing that the programs are effective, include a multi-faceted evaluation, and disseminate evaluation findings. A state injury and violence prevention program also can support and monitor injury prevention activities at the local level." [12]

The STAT assessment of the MIPP noted: "The MIPP has some successful collaborations. Examples include its exemplary activities in the area of youth suicide prevention and its widespread involvement in child passenger safety. With leadership and only a modest resource investment, the MIPP could energize other organizations to work towards the MIPP goals, and act as a broker for resources from other organizations as they join with the MIPP to address compelling injury problems."[13]

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[10] An Assessment of the Maine Injury Prevention Program, conducted by the State and Territorial Injury Prevention Directors Association, May 2002
[11] Same as Footnote 9.
[12] Same as Footnote 9.
[13] An Assessment of the Maine Injury Prevention Program, conducted by the State and Territorial Injury Prevention

Along with the MIPP, several organizations, such as the Bureau of Highway Safety and other members of the Maine Transportation Safety Coalition, Medical Care Development's Training Program, the state Fire Marshall's Office, the Maine Children's Cabinet, and the Maine Safe Kids Coalition, have taken leadership roles for implementing various injury and violence prevention activities. However, to reduce the burden of injury in Maine, the breadth of resources dedicated to injury prevention must expand. Through the CDC Integrated Core Injury Prevention cooperative agreement and with reprioritizing the MIPP focus, the MIPP is cultivating new partnerships and building on prior collaborations. In addition, the MIPP will work with the emerging regional public health infrastructure to integrate injury prevention interventions statewide.

As a direct result of the CDC Integrated Core Injury Prevention cooperative agreement, the MIPP convened an Injury Prevention Group (IPG), representing a wide variety of agencies and organizations. Through the IPG, four injury specific workgroups, representing motor vehicle traffic, suicide, falls and unintentional poisoning, were created. Each group is charged with selecting and planning collaborative implementation and evaluation of interventions for their respective topics.

Technical Support and Training

In order for injury prevention activities to be successful, it is absolutely critical that staff members and partners keep up with the research literature and are able to adopt and adapt best practice interventions. In the 2005 STIPDA survey, 94% of the state injury and violence prevention programs conducted in-person training by offering workshops, conferences and educational presentations. Also, 83% of the programs responded to technical assistance requests and 56% offered practical experience for students.[14]

The MIPP has a solid track record of providing training and technical assistance in child passenger safety, youth suicide prevention, home safety, bullying prevention and firearm safety. With the recent reorganization, it will not be possible for the MIPP to continue to maintain the same level of training, workshops and conferences as provided in the past. The primary focus of MIPP training and technical assistance will be falls among older adults, and motor vehicle traffic, suicide prevention and unintentional poisoning across the lifespan. Training and education needs outside of the MIPP capacity to respond will be referred to other resources where possible and appropriate. An extensive resource list of injury and violence prevention resources is being updated to aid in identifying these resources.

Directors Association, May 2002.

[14] STIPDA 2005 State of the States Survey: Highlights Report, Atlanta, GA: State and Territorial Injury Prevention Directors Association, 2006.

Public Policy

Public policy changes, such as passenger safety laws, safe storage of firearms, and instituting safety policies and regulations in high risk settings, contribute substantially to the reduction of injuries. It is recommended that state injury prevention programs review and provide input on proposed legislation, develop health department testimony, provide information on the effectiveness of state or local policies, provide surveillance data to inform policymakers and identify model legislation or policies for the health department, prevention advocates and policymakers.[15]

MIPP staff members perform these functions either directly through the DHHS or in collaboration with program partners as these functions relate to the four identified priorities.

Key Issues

- A significant amount of administrative staff time is required to obtain funding, manage grants and budgets, and develop reports on disparate timelines and with varying requirements.
- A central issue for state injury and violence prevention programs is the need to change the public perception surrounding injury to increase understanding that injuries are predictable and preventable.
- Many areas of injury and violence prevention are not viewed as key public health priorities and are not included in the state health plan.
- Stable funding is necessary to assure a core statewide capacity to support an injury and violence prevention infrastructure that effectively conducts injury surveillance, provides coordination and leadership and plans, implements and evaluates injury prevention interventions.
- Timely, detailed, accessible, accurate and complete injury morbidity and mortality data essential to monitoring trends, describing the circumstances of and factors involved in injuries, establishing risk factors, and evaluating the impact of program interventions are not consistently available.
- Demand for injury prevention resources is diverse and constant and frequently overstretches program capacity.
- Recruiting and maintaining qualified staff necessary to fulfill the core injury prevention functions is an ongoing challenge.
- Governmental prohibitions on travel limit staff opportunities to remain current in the field and learn about effective implementation of best practice approaches.

[15] STIPDA 2005 State of the States Survey: Highlights Report, Atlanta, GA: State and Territorial Injury Prevention Directors Association, 2006

Infrastructure Goal: Build the infrastructure within the state health agency needed to effectively prevent injuries and violence statewide.

Objective 1: Stabilize funding for core injury and violence prevention within the state health agency by 2010.

Activities:

- Maintain current funding to support core staffing capacity.
- Identify opportunities for stable funding to support implementation and evaluation of injury and violence prevention interventions.
- Utilize current and explore new partnerships that can support the ongoing implementation and evaluation of interventions.
- Utilize non-traditional staffing resources such as graduate students and volunteers to assist with research, implementation and evaluation of injury and violence prevention activities.
- Explore ways to generate program funding such as increasing fees for training services.

Objective 2: Reorganize the MIPP to efficiently utilize available resources and integrate the five core components of injury prevention by April 2008.

Activities:

- Review, revise and disseminate the MIPP strategic plan.
- Reorganize staffing to meet identified priorities using the five core components of injury prevention.
- Encourage, support and facilitate accessing training opportunities for MIPP staff and partners.
- Select prioritized plan objectives for focused evaluation efforts.
- Identify and implement methods to most effectively disseminate information on injury prevention resources and best practice information.
- Assist coalitions to identify local resources to implement interventions.

Objective 3: Select prioritized injury prevention strategies for integration into the state health plan by 2010.

Activities:

- Disseminate injury and cost savings data to inform and educate policymakers and partners about the cost and life savings benefits of including key injury and violence prevention within the state health plan.
- With state leaders, identify key injury and violence prevention initiatives for potential inclusion in the state health plan, such as poisonings related to prescription and over the counter medication misuse, that link with the state health plan goal of reducing health care costs and improving quality of care.

Objective 4: Integrate injury prevention strategies into the emerging network of public health districts by 2010.

Activities:

- Recommend and advocate for inclusion of key injury measures in the "Core Public Health Indicators" list being developed for use by the public districts.
- Develop injury prevention data recommendations for use by districts and Comprehensive Community Health Coalitions to assist in their decision making to identify local injury and violence prevention priorities.
- Network with partners to identify resources and select key injury and violence prevention activities to promote to the public health districts and coalitions.
- Utilize webinars, conference calls and other non-travel educational options to disseminate recent injury prevention research and effective program models.
- Provide assistance in the design and implementation of evaluation strategies to partners in the public health districts and coalitions.
- Disseminate injury prevention information and resources through partnerships and collaborations.

MAINE INJURY PREVENTION PROGRAM PLAN
GOALS FOR EACH PRIORITY AREA

Introduction

Redefining the role of the Maine Injury Prevention Program is necessary to effectively and efficiently meet the injury prevention needs of the state including policymakers, members of the public, service providers and the diverse organizations serving Maine residents.

In 2005, the MIPP received five years of funding through a cooperative agreement with the federal Centers for Disease Control and Prevention (CDC) for an Integrated Core Injury Prevention and Control Project. This funding has significantly impacted the program capacity to develop a coordinated, strategic approach to reducing injury morbidity and mortality in Maine.

A strategic reorganization of the MIPP, utilizing staffing capacity to the best advantage and incorporating core injury prevention components, agency strategic themes of excellence, efficiency and effectiveness and the ten essential public health services, is occuring to accommodate the myriad of changes impacting the program.

While MIPP goals and activities will necessarily be limited in scope, the new focus on developing and providing data, expertise and technical assistance and collaborations with injury and violence prevention partners, should pave the way to effectively addressing the state's leading injury and violence prevention priorities.

This plan revision is intended to create a solid foundation to guide injury prevention and control activities for the three year period between 2008 and 2010.

The next section of this document contains the MIPP strategic plan for each of the four identified priority areas of motor vehicle traffic, suicide and suicidal behavior, falls in older adults and unintentional poisoning for 2008 to 2010.

Detailed annual workplans will be developed with collaborators to describe specific activities and associated timelines to be undertaken each year of this strategic plan.

Focused evaluation efforts of selected activities, utilizing Logic models and measurement frameworks, will be developed. Process and outcome level evaluation plans will be developed to assess whether activities are carried out as planned and desired outcomes are achieved.

MAINE INJURY PREVENTION PROGRAM
STRATEGIC GOALS

Maine Injury Prevention Program Plan
Goals for Motor Vehicle Traffic Crash Injury Prevention

Introduction

Maine is a large rural state with few large population centers and unique transportation safety issues. Maine's highways and roadways are vital to the state's economy and way of life and yet each year many Maine families suffer the effects of life-changing injuries and the loss of loved ones due to motor vehicle crashes. In 2004, motor vehicle crashes claimed 43,432 lives across the U.S., 122 of them in Maine.

Through decades of public and private partnerships at the federal, state, and local levels, motor vehicle travel has become safer. Although six times as many Americans drive today as did in 1925, covering ten times as many miles in eleven times as many vehicles, the annual death rate from motor vehicle crashes per 100 million miles traveled has decreased 90%. Despite this, approximately 40,000 people in the United States still die each year from injuries suffered in motor vehicle crashes. More than 40% of these crashes are alcohol-related.

Efforts to reduce injuries and deaths from motor vehicle traffic crashes are best addressed in a collaborative fashion. The Guide to Community Preventive Services supports the effectiveness of three community-based intervention strategies to prevent motor vehicle occupant injuries: 1) Reducing alcohol-impaired driving, 2) Increasing the proper use of child safety seats, and 3) Increasing the use of safety belts.

The Maine Transportation Safety Coalition (MTSC), established in 1997, provides a venue for transportation safety advocates from the public and private sector to meet, assess need, and act. The MTSC is active in the prevention of motor vehicle related injuries throughout the lifespan and is comprised of representatives from state, local and national transportation agencies, private for-profit and non-profit agencies, and individual safety advocates. The MTSC was integral to the passage of one of the most comprehensive child passenger safety laws in the nation in 2002 and has influenced multiple laws to improve teen driving safety. The Coalition's most recent success was the passage of a primary seat belt law in 2007. MIPP staff actively participate in the MTSC, by contributing to data analysis and dissemination, promoting the implementation and evaluation of effective motor vehicle safety interventions, providing technical assistance and training to support motor vehicle safety efforts at state and local levels, and collaborating with groups representing diverse population segments in the state to identify policy solutions surrounding motor vehicle safety.

In Maine, a viable, productive, and visible Bureau of Highway Safety (BHS) administers federal funds from the National Highway Traffic Safety Administration (NHTSA). The BHS funds a number of statewide and local projects aimed at reducing motor vehicle related deaths and

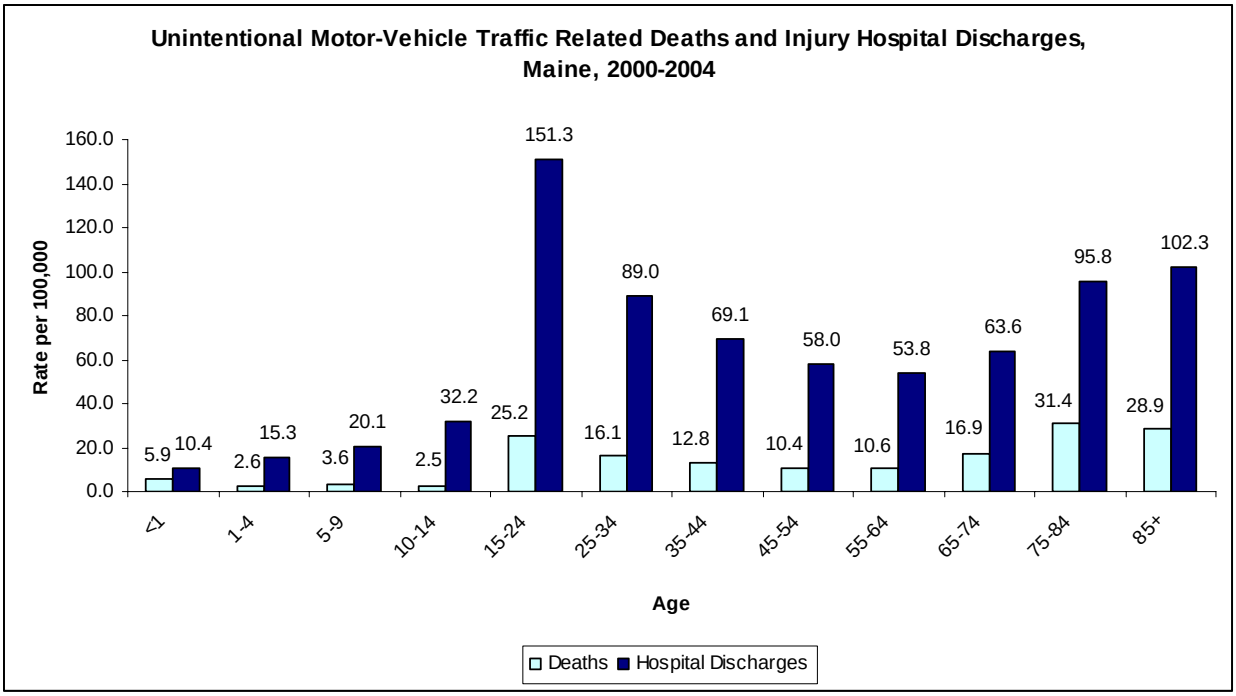
injuries on Maine's roadways including speed enforcement, driving under the influence, younger and older drivers, as well as a comprehensive statewide child passenger safety program (CPS).

The MIPP has worked closely with the BHS' CPS program for many years and a MIPP staff member has managed the CPS program since 1990 when the BHS first funded a MIPP housed Traffic Safety Educator position. Initially the BHS' CPS program included other aspects of highway safety such as pedestrian safety, bicycle safety and young drivers. However as the CPS portion of the program grew and evolved from a loaner program to a distribution program, the BHS prevention efforts have developed into an exclusive CPS focus. Since 2002, through the BHS' CPS program, the MIPP has distributed over 2,000 car seats annually to income eligible families. The program includes fitting stations, through which an additional 375 car seats are distributed annually, training for CPS technicians, awareness training, and training in transporting preschoolers and children with special needs in school vehicles.

The MIPP will continue its involvement in other traffic safety issues through collaboration with key partners.

Motor Vehicle Traffic Crash Injuries Facts and Trends

Unintentional motor vehicle traffic crashes were the number one cause of injury related deaths and the second leading cause of injury hospitalizations across all ages combined in Maine in 2000-2004. Unintentional motor vehicle traffic crashes were one of the three leading causes of injury deaths and hospitalizations in every age group (<15 years, 15-24, 25-44, 45-64, and 65+) during this 5-year period.



Data source: Maine death certificate statistical datasets and hospital discharge datasets, 2000-2004

The age groups at highest risk of death due to a motor vehicle traffic crash are 15-24 year olds and 75+ year olds. Teens and young adults (15-24 year olds) are at highest risk of being hospitalized for an injury sustained in a motor vehicle traffic incident. The age groups at next highest risk of sustaining injuries serious enough to require hospitalization are 75+ year olds and 25-34 year olds.

Risk Factors

Young Children

The bone and muscle structure of infants and younger children cannot withstand crash forces without protection designed for their stage of development; however, they are often allowed to "graduate" from each stage of restraint system prematurely. According to Partners for Child Passenger Safety, the risk of injury in a crash rises as children age and the child moves from a rear facing safety seat, to a forward facing seat, to a booster seat, and finally to a seat belt. Parents may not have a positive attitude about car seat use and may not encourage use by children. Parents also may not be aware of the need for proper restraint systems after the age of 4. Seat belts are designed for mid-range adult males and do not fit small children well.

Because of the rural nature of the state, sidewalks are often not present, moving pedestrians into roadways. In addition, although Maine has a bike helmet law for children, it has not been enforced and has only recently gained strength by adding a consequence for not wearing helmets.

Young Drivers

Young drivers lack experience, feel indestructible, and are more likely to be risk takers, all of which leads to inappropriate driving behaviors. A 2007 CODES study entitled "The Impact of speeding and Other Unsafe Driving Behavior (UDB) on Injury and Cost Outcomes; Maine Crash Outcome Data Evaluation Systems Results" identified that for each of the twelve different UDB behaviors identified in the study, young drivers had involvement rates per licensed driver higher than other age groups.[16]

Older Drivers

Failing eye sight, reflexes and hearing may lead to unsafe driving behavior. Leading crash characteristics of the older driver are different than those for younger drivers. They include crossing the centerline or running off the road, medical conditions, failure to yield the right of way and being drowsy or sleepy. [17]

Native American, Immigrant Populations, and other Disparate Populations

Language, cultural customs and lack of awareness of programs and policies may affect willingness or ability to obtain services and/or education needed to transport their families safely.

[16] The Impact of speeding and Other Unsafe Driving Behavior on Injury and Cost Outcomes; Maine Crash Outcome Data Evaluation Systems Results, Maine Health Information Center 2007
[17] Same as 16

Injury Costs

The Children's Safety Network (CSN) Economics and Data Analysis Resource Center estimates the total annual cost of unintentional motor vehicle traffic fatalities among Maine residents at $580.3 million (in 2004 dollars.) This includes $2.3 million in medical costs, $191.9 million in work loss costs, and $386.2 million in quality of life costs.

Key Issues

- A central issue for motor vehicle safety is that serious injuries from car crashes are predictable and preventable.
- Drivers' perceptions of the risk of speeding and other unsafe driving behaviors vary considerably among specific behaviors.[18]
- The availability of compatible data is essential to measuring success of motor vehicle injury prevention programs.
- Recruiting and maintaining qualified child passenger safety technicians is integral to a comprehensive CPS program.
- Addressing issues in disparate populations requires knowledge of the culture of the population.

Promising and Proven Effective Motor Vehicle Injury Prevention Practices

The Task Force on Community Preventive Services, the National Safety Council, and Mothers Against Drunk Driving (MADD) developed recommendations for motor-vehicle injury prevention strategies based on their reviews of best practices nationwide. Their recommendations emphasize strengthening seat belt legislation and increasing enforcement, combined with focused education. The Task Force on Community Prevention Services found that child passenger safety seat give away programs are most effective when they include an education component.[19] Graduated Drivers Licensing (GDL) has been proven as effective in reducing injuries and deaths from motor vehicle traffic crashes. Developing supporting interventions that complement GDL success, while continuing to evaluate, revise, and re-evaluate for both effectiveness and sustainability is recommended.[20] Current research indicates that programs addressing common errors made by older drivers in both classroom and on-road settings enhance senior driving performance.[21]

[18] Same as 16
[19] Guide to Community Services – Motor Vehicle Occupant Injury www.thecommunityguide.org/mvoi/default.htm.
[20] T M Senserrick - Reducing young driver road trauma: guidance and optimism for the future ,Inj Prev 2006
[21] RA Marottoli, MD, MPH – Yale University & VA Connecticut Geriatrics "Enhancement of Driving Performance Among Older Drivers" 2007

Maine Injury Prevention Program
Accomplishments to Prevent Motor Vehicle Traffic Crash Injuries

Original Plan Goal: The Maine injury Prevention Program will conduct activities to reduce the incidence of unintentional injuries.

Since 2003, the MIPP has provided eight 32 hour National Highway Safety Administration (NHTSA) Child Passenger Safety Technician trainings statewide resulting in 111 Certified CPS Technicians. Because the CPS Technician training requires a time commitment to which many who serve children and families cannot commit, the MIPP, with the support of the BHS, provides a variety of shorter NHTSA CPS trainings for hospital workers, day care providers, WIC providers, and Maine Department of Health and Human Services utilizing NHTSA one-day curricula in locations throughout the state. Approximately 16 members of two of the four Native American tribes in Maine attended one-day CPS awareness trainings entitled *Safe Native American Passengers (SNAP)*. During the spring and summer of 2006, 136 school bus drivers, bus aides, and bus mechanics attended a four hour awareness training entitled *Transporting Pre-school Children on School Vehicle*s. The trainings were based on the NHTSA CPS for the School Bus curricula and were offered at six locations throughout the state.

Training for 23 CPS Technicians using the *SAFE TRAVEL FOR ALL CHILDREN: Transporting Children With Special Health Needs* curriculum developed by NHTSA in cooperation with Dr. Marilyn Bull of Riley Hospital in 2004 was provided. One participant became an instructor for the course. The course is being offered again in August of 2007.

The MIPP staff worked with the Maine Transportation Safety Coalition (MTSC) to collect data covering all modes of transportation in Maine. The results were published in 2004 as the *Status of Transportation in Maine*. Yearly "report cards" providing current data are published and disseminated to legislators and motor vehicle safety advocates statewide. The Motor Vehicle workgroup, of the CDC Integrated Core Injury Prevention & Control Project, researched national and local programs for young drivers. They are working with the Bureau of Highway Safety, the Department of Transportation and AAA–New England to determine how current programs can be evaluated. Because the funding for the Traffic Safety Educator is sole-source funding and is primarily focused on the young child, there are limited resources available to work toward reducing deaths and hospitalizations of young drivers or increasing seat belt use by young drivers. Additional funding and increased staff will alleviate this problem.[22]

[22] Objective 2.3 & 2.4 MIPP Plan 2000-2010. Page 27

Maine Injury Prevention Program Motor Vehicle Traffic Crash Injuries Prevention Revised Goal 2007 – 2010

Revised Goal: Reduce the burden of injuries and deaths resulting from motor vehicle traffic crashes.
Note: Multiple strategies could be used to reduce injuries and deaths from motor vehicle crashes; however, the availability of seatbelt use data enables us to best measure our work.

Objective 1: Increase seatbelt use among young drivers (16-24) by 1% by 2010.
Baseline:
a. 50.1% of Maine high school students reported they always wear a seat belt when riding in a car driven by someone else (2005).
b. 60.7% of Maine 18-24 year olds reported they always use seat belts when they drive or ride in a car (2006).
Data Source:
a. High school students: Youth Risk Behavior Survey (YRBS)
b. 18-24 year olds: Behavioral Risk Factor Surveillance System (BRFSS)

Objective 2: Increase seatbelt use among older (65+) drivers by 1% by 2010.
Baseline: 80.8% of 65+ year old Mainers reported they always use seat belts when they drive or ride in a car (2006).
Data Source: BRFSS

Objective 3: Increase correct restraint use among children 0-8 by 1% by 2010.
Baseline: 6% correctly installed
Data Source: Check Up Event Data

Strategy: Improve and maintain the collection, analysis and dissemination of injury data to guide the focus and direction of the motor vehicle safety interventions.

Activities:

- Improve and maintain the surveillance of motor vehicle related injuries statewide.
- Conduct analyses of motor vehicle injury data with a focus on high risk groups.
- Utilize data to update program activities.
- Routinely disseminate current motor vehicle injury data to policymakers and other stakeholders through the MIPP website.

Strategy: Promote the implementation and evaluation of motor vehicle safety interventions that are based on current evidence based and/or promising practices.

Activities:

- Research best practices and promising approaches to motor vehicle injury prevention; increase awareness and promote implementation of these approaches.
- Facilitate the evaluation of motor vehicle safety interventions and utilize evaluation findings to modify interventions and prepare funding applications.
- Share evaluation findings with key stakeholders.

Strategy: Provide technical assistance and training to support motor vehicle injury prevention efforts at the state and local levels.

Activities:

- Provide technical assistance and evaluation training to stakeholders and partners.
- Through partnerships, identify and disseminate training and technical assistance in best practice models that promote motor vehicle safety.
- Develop linkages at the local, district and state levels to identify available and accessible motor vehicle injury prevention resources for training and technical assistance.
- Contribute to the development of training that supports injury prevention efforts focused on high risk groups.

Strategy: Collaborate with groups representing diverse population segments within the state to identify policy solutions surrounding motor vehicle safety.

Activities:

- Facilitate the collaboration of key stakeholders at the local, district and state levels to enhance support for, and implementation of, motor vehicle injury prevention policies.
- Provide the legislature with pertinent public health data related to motor vehicle injuries.
- Link disparate populations such as American Indians, Hispanic/Latino, and immigrant populations to culturally competent educational opportunities and safety information.

Motor Vehicle Resources

Maine Injury Prevention Program: www.maine.gov/dhhs/bohdcfh/inj/index.html
1-800-698-3624

Maine Bureau of Highway Safety: http://www.maine.gov/dps/bhs/homepage.htm
207-626-3840

Maine Bureau of Motor Vehicles: http://www.maine.gov/sos/bmv/index.html
207-624-9000

Maine Department of Transportation: http://www.maine.gov/mdot/
207-624-3278

Maine Safe Kids Coalition: http://www.gpcog.org/info.php?p=NDQ3MDEuNTg=
207-774-9891

National Highway Transportation Safety Administration (NHTSA): - www.nhtsa.dot.gov
1-888-327-4236

AAA Northern New England: - www.aaanne.org
207-780-6916

Children's Safety Network: - http://www.childrenssafetynetwork.org/
617-618-2230

Maine Injury Prevention Program Plan
Goals for Suicide Prevention and Self-Inflicted Injuries

Introduction

Suicide is the eleventh leading cause of death in the United States, claiming 32,000 lives annually. Suicide is a significant public health problem in Maine impacting families and entire communities. Each year about 160 lives are lost to suicide in Maine.

Myths regarding suicide abound. Many people do not believe that suicide is a problem that could affect their family or their community. However, in the past decade in the United States, suicide has been widely recognized as a public health problem requiring national attention and urgent action. In the 2001 National Strategy for Suicide Prevention, the U.S. Surgeon General emphasized that suicide is a major public health problem, which can only be reduced through integrated efforts by government, public health, education, human services and other public and private partners. In the 2003 report *Achieving the Promise: Transforming Mental Health Care in America* issued by the President, suicide prevention was included in the first of six goals for the nation. In 2004, Congress passed the Garrett Lee Smith Memorial Act to provide federal funding to states for youth suicide prevention.

A strong public health approach to the prevention of suicide is essential to successfully reducing the suicide rate in our state. Suicide prevention requires a comprehensive approach addressing social, behavioral, and psychiatric risk and protective factors. Coordinated efforts and active partnerships involving government, communities, schools, employers, and families are needed to reduce suicide in Maine. Many of the risk and protective factors for suicidal behavior are known. Suicidal behaviors are least likely to develop when there is widespread public awareness and prevention, and early intervention and treatment services are accessible. The evidence for effective suicide prevention programs and treatments is limited, but growing. Maine is one of the states at the forefront of implementing and evaluating evidence-based youth suicide prevention programs to contribute to the science of suicide prevention.

The Maine Youth Suicide Prevention Program (MYSPP) is a multi-agency effort coordinated by the MIPP Program Manager in the Maine Center for Disease Control and Prevention (Maine CDC). Since its initiation in 1998, the MYSPP has employed a public health approach to address youth suicide. Currently, there are no suicide prevention activities addressing all age or risk groups in Maine, though with additional resources, several of the activities of the MYSPP could be expanded to other age groups. In 2007, the MYSPP developed a comprehensive plan with nine goals mirroring the National Suicide Prevention Strategy.
Major activities of the MYSPP include:

- Providing a statewide crisis hotline and information resource center,
- Disseminating public awareness educational resources,
- Conducting a variety of training programs,
- Developing prevention/intervention guidelines for schools,
- Analyzing and disseminating data,
- Providing guidance and technical assistance to schools.

In February 2006, as part of the Chapter 55 Report *Improving Access and Delivery of Mental Health Services to Older Persons* delivered to the 122nd Maine Legislature, the Joint Advisory Committee on Select Services for Older Persons (JAC) partnered with the University of Maine Center on Aging to study elder suicide in Maine. A report containing recommendations for elder suicide prevention was subsequently issued to the JAC and the Department of Health and Human Services. (See Appendix F**)**

Under the Maine CDC funded Injury Prevention Group (IPG), a small workgroup is collaborating with the program to recommend suicide prevention priorities and strategies to address these priorities. A list of priorities was established and the group continues to work on developing effective strategies for implementation. (See Appendix G)

Suicide and Self-Inflicted Injuries Facts and Trends

Suicide is a serious health problem in Maine as it is nationally. It is the leading cause of intentional injury death for persons aged 10 and over in Maine and the 10th leading cause of death overall for Maine residents from 2000-2004. In 2000-2004, the most recent five-year period for which data are available, Maine had the 27th highest age-adjusted suicide rate in the United States for all ages. This suicide rate of 11.7 per 100,000 population was higher than the national average rate of 10.8 per 100,000 and the Northeastern rate of 7.7 per 100,000.

The table below shows the 2000-2004 crude and age-adjusted suicide rates in Maine, the Northeast, and the U.S. for all races and for the white, non-Hispanic population. National vital statistics data show that suicide rates vary by race and ethnicity and are highest among white, non-Hispanics.[23] Due to small numbers, estimates of suicide rates among minority populations in Maine are not stable and therefore are not reported here.

Suicide Rates in Maine, Northeast, and U.S. 2000-2004, All Ages

Suicide Rates:		Crude Rate	Age-Adjusted Rate
Maine	***All Races***	12.17	11.70
	White Non-Hispanic	12.28	11.78
Northeast	***All Races***	7.92	7.71
	White Non-Hispanic	9.18	8.74
United States	***All Races***	10.81	10.75
	White Non-Hispanic	13.15	12.57

*Northeast includes ME, VT, NH, CT, RI, MA, NJ, and NY - Data Source: NCHS Database

The Northeastern region generally has the lowest suicide rates in the nation. This lower suicide rate in the Northeast is driven by the low rates in the states with higher populations (Massachusetts, Connecticut and Rhode Island). The three northern New England states (Maine, New Hampshire and Vermont) with smaller, more rural populations, experience higher suicide rates than do the more urban states in the region.

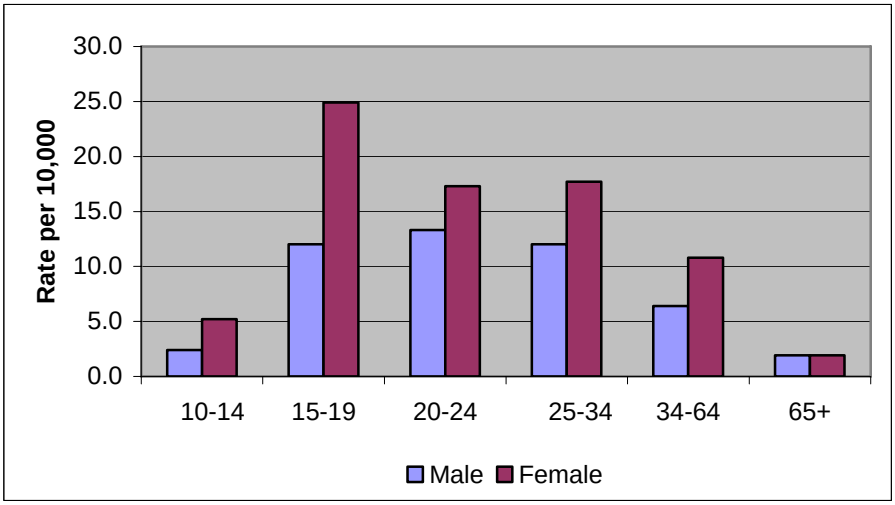
[23] Miniño AM, Anderson RN, Fingerhut LA, Boudreault MA, Warner M. Deaths: Injuries, 2002. National Vital Statistics reports; vol. 54 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2006.

In the five year period from 2000-2004, 789 Maine residents died by suicide, an average of 158 per year. Eighty-five percent (674) of suicides were persons over age 24; 15% (115) suicides were among young people aged 10-24. Suicide is the 2nd leading cause of death for Maine residents aged 15-34; the 3rd leading cause of death for 10-14 year olds and the 4th leading cause of death for those aged 35-54. Suicide is the 10th leading cause of death for Mainers for al l ages combined.

The highest suicide rate, at 70.2 per 100,000, is among males aged 85 and older, accounting for 25 deaths from 2000-2004. The largest number of suicides in one age category was 89 suicides among individuals aged 35-39. Maine teens and young adults (15 –24) died by suicide at a higher rate, 12.5 per 100,000, than the regional youth suicide rate of 7.6/100,000 and the national youth suicide rate of 9.9/100,000.

From 2000-2004, 3,862 adults over age 24 and 1,621 youth under age 24 were hospitalized for self-inflicted injuries. Of these hospitalizations, intentional self-inflicted poisoning was the 3rd leading cause of injury hospitalizations in all ages combined. The highest intentional self-injury hospitalization rates are among teens and young adults age 15-34. The highest rate (24.9 per 10,000) of hospitalization for intentional self-harm occurs among females ages 15–19. The highest hospitalization rate among males was among those aged 20-24 with a rate of 13.3 per 10,000.

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



Data Source: Maine Uniform Hospital Discharge Database

Risk Factors

Suicidal behavior is complex. There is no one set of risk factors that fits all suicidal individuals or accurately predicts the imminent danger of suicide for a specific individual. When someone is suicidal, it is usually due to a combination of external stressors, internal conflicts, and biological dysfunction. Prominent risk factors include physical illnesses, a family history of suicide, living alone, being unemployed and owning a gun. Trauma, depression, anxiety, conduct disorders, substance abuse, and lack of personal skills or supportive resources all contribute to the possibility of suicide, but they do not, by themselves, cause suicide.

Race/ethnicity

Across the U.S., white, non-Hispanic males experience the highest rates of suicide deaths. The second highest suicide rate is among American Indians and Native Alaskans.[24] Maine's suicide rate among white, non-Hispanics is higher than the Northeast region's white, non-Hispanic rate, but is not significantly higher than the national white non-Hispanic rate. Racial/ethnic differences do not account for Maine's elevated suicide rates.

Gender

Four of five suicides in Maine are males. Of 789 suicides in Maine during 2000-2004, 640, or 81%, of all suicides were males. Males aged 20 through 59 represent more than half (54%) of Maine's suicides. However, females are more likely than males to be hospitalized for intentional self-injury. Between 2000 and 2004, the rate of hospitalizations for self-inflicted injury was higher for females in every age group as compared to males, except for individuals over age 65, among whom male and female rates were approximately equal. Between 2000-2004, females were hospitalized for intentional self-injury at a rate of 11.1 per 10,000 compared to 7.1 per 10,000 males.

Data from the 2001-2005 Maine Youth Risk Behavior Surveys, a representative survey of high school students in Maine, reveal that high school girls are more likely than boys to report considering or planning a suicide attempt. Between 2001-2005, almost 1 in 4 (23.6%) high school girls and 1 in 6 (16.1%) high school boys reported considering or planning a suicide attempt. Girls were also more likely than boys to actually attempt suicide (10% vs. 6%).

Age

Suicide rates among Maine residents are highest for individuals over age 85, but the number of suicides is highest among those aged 35 to 39. Suicide claims more lives of young people than cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined. Due to the high rates of suicide among the young, suicide is the fourth leading cause of years of potential life lost in Maine.

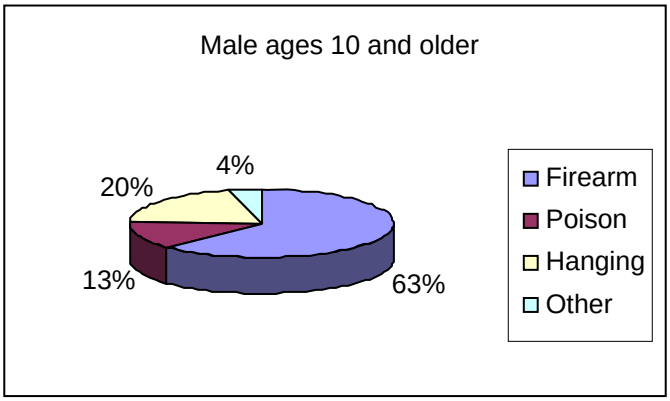
Non-fatal self-injury and suicidal behavior is a more significant problem among youth than it is in the adult population. It is estimated that there are 25 to 100 suicide attempts by adolescents and young adults for every death by suicide.[25]

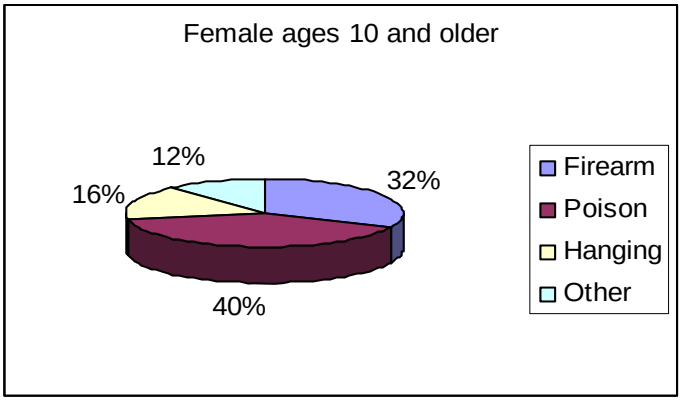
[24] Reducing Suicide, a National Imperative, 2002
[25] AAS fact sheet entitled Suicide in the USA

Method

The lethality of the method used determines the difference between a non-fatal attempt and a death by suicide. Firearm and hanging victims have less of a chance for survival than those using a less lethal method, such as poisoning. Suicide by firearm was the leading cause of suicide for all ages for 2000-2004. In Maine between 2000-2004, 431 or 55% of the 789 suicides were by firearm. Hanging, strangulation and suffocation was the 2nd leading method, representing 149 or 19% of all suicides. Poisoning was the 3rd leading method used, accounting for 138 or 17% of all suicides. The data show that 60% (384) of male suicide victims used firearms, while thirty-two percent (47) of females used firearms. In contrast, 40% (60) of females died by poisoning while 12% (78) of males died by this method.

Percent of Suicide Methods by Gender in Maine, Ages 10 and Older, 2000-2004





Data Source: NCHS Database

Overall in Maine, poisoning is the leading method of intentional self injury; of those hospitalized for intentional self-injury, poisoning was the method for 83%. Seventy-seven percent of males and 85% of females who are hospitalized for intentional self-injury use this method. Cutting is the second most common method of self-injury hospitalizations. Ten percent of these hospitalizations can be attributed to this method.

Mental Illness

It is widely believed that from 60% to 90% of suicide victims meet the criteria for some form of mental illness, most commonly severe depression or other mood disorders and anxiety or conduct disorders. These conditions often occur in combination with substance abuse. [26]

According to the 2005 Maine Youth Risk Behavior Survey (YRBS), 1 in 5 (20.6%) adolescents reported symptoms of depression in the past year. Between 2001-2005, 53% of the adolescents who reported depressive symptoms considered or planned a suicide attempt and 22% reported attempting suicide.

Sexual Orientation

Female suicide attempt rates are much higher than male attempts rates, but when broken down by gender, sexual orientation was only statistically significant for males. Attempt rates for those who are transgender appear to be the highest of all groups, but more research is needed to confirm.[27] In Maine, high schools students who reported same sex or bisexual contact were more likely than youth who reported opposite sex or no sexual contact to report both suicide ideation and attempts. Based on data from the 2001-2005 YRBS, almost 40% of youth who reported same sex/bisexual contact considered suicide or planned an attempt in the previous 12 months compared to 21% of youth who had opposite sex contact only and 15% of youth who had never had sexual contact. Almost 1 in 4 (23%) of youth who reported same sex/bisexual contact attempted suicide in the past year.

Trauma/Victimization

Several studies have found that a history of sexual assault, ongoing domestic violence, and experiencing other traumatic events increase one's risk of attempting suicide.[28] [29]Data from Maine's Youth Risk Behavior Survey showed that high school students who reported being the victim of dating violence in the past year were two times more likely than non-victims to report suicide ideation (37% vs. 17%) and suicide attempts (17%vs. 7%) in the past year. Almost half (46%) of students who had been the victims of sexual assault during their lifetime reported suicide ideation in the past year compared to 17% of non-victims; 1 in 4 victims actually attempted suicide in the past year.

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

[27] Russell, Stephen T., PhD, and Joyner, Kara, PhD. *Adolescent Sexual Orientation and Suicide Risk: Evidence from a National Study, American Journal of Public Health, pp.1276-1281, August 2001, Vol. 91, No.8.*

[28] Dube SR, Anda RF, Felitti VJ, Chapman D, Williamson DF, Giles WH. Childhood Abuse, household dysfunction, and the risk of suicide throughout the lifespan: Findings from Adverse Childhood Experiences Study. Journal of the American Medical Association, 2001;286:3089–3096.

[29] Seedat S., Stein MB, Forde DR. Association between physical partner violence, posttraumatic stress, childhood trauma, and suicide attempts in a community sample of women. Violence and Victims. 2005;20(1):87-98.

Youth who reported that they had been the target of racially offensive remarks or attacked based on their race or ethnicity at school or on the way to school were also more likely to report suicide ideation and attempts compared to students who did not endure this behavior. About one-third of victims of racial harassment/attacks considered or planned a suicide attempt in the past year. One in five victims of harassment based on sexual orientation reported attempting suicide in the past year. Nearly half of students (43%) who reported staying home from school in the past year because they felt unsafe considered or planned a suicide attempt and 27% actually attempted suicide.

Substance Abuse

Substance abuse is highly related to both suicide ideation and attempts in both youth and adults.[30] [31] Among Maine high schools students, smoking any cigarettes in the past month was associated with suicide ideation (Maine YRBS, 2001-2005); more than 1 in 3 (36%) youths who smoked 20 days or more reported suicide ideation in the past year; youth who smoked were about three times more likely than non-smokers to report attempting suicide in the past year. Youth who reported suicide ideation and attempts were also more likely to report recent binge drinking and use of illegal drugs, such as marijuana, cocaine, heroin, steroids, and unauthorized prescription medication.

Injury Costs

In 2000, the total national burden of suicide was estimated at $125 billion. This includes direct health care costs and indirect costs related to the loss of productive life. The national Suicide Prevention Resource Center (SPRC) estimates medical cost per suicide in Maine at $3,780 for an annual total of $597,420. Due to the high incidence of suicide at young ages, the estimated work-loss cost per case is $1,079,323. For non-fatal suicide attempts, the estimated medical cost per suicide is $11,200 and the estimated work-loss cost per case is $10,867. [32]

[30] Karch DL, Barker L, Strine TW. Race/ethnicity, substance abuse, and mental illness among suicide victims in 13 US states: 2004 data from the National Violent Death Reporting System. Injury Prevention. 2006 Dec;12 Suppl 2:ii22-ii27.

[31] Rowan AB. Adolescent substance abuse and suicide. Depression and Anxiety. 2001;14(3):186-91.

[32] Suicide Prevention Resource Center http://www.sprc.org/stateinformation/pdf/statedatasheets/me_datasheet.pdf

Key Issues

Following are key issues related to suicide prevention.

Data Quality and Accessibility

- Death data are available from two sources in Maine: the death certificate database and the medical examiner's files and database. Most analyses can be completed with the death certificate database, which is obtained from the Office of Data Research and Vital Statistics annually. The medical examiner's database can be used to update data on suicide deaths, since the death certificate database has a lag period of between one and two years. Medical examiner's files are also used to supplement data from death certificates by including information on the circumstance of death and from interviews with family and friends. A project merging one year of death certificate and medical examiner data was conducted to provide the most comprehensive data on suicide deaths. This linkage project cannot occur on an ongoing basis due to resource limitations.

  The hospital discharge database records all discharges in Maine's 39 non-federal hospitals. Self-injuries are coded using **E-codes* for intentional self-harm. It is not possible, to separate self-injurious behaviors with suicidal intent from those without suicidal intent. E-coding is optional and rates of E-coding vary by hospital. This variability makes it difficult to draw conclusions about geographic differences in the rates of intentional self-injury. An additional data issue is that demographic data including education, income, and race/ethnicity are not available in the hospital discharge database making it difficult to use these data to identify those at highest risk.

  **E-codes or "external cause of injury" codes are diagnostic categories, using the 9th revision of the International Classification of Diseases (ICD-9). E-codes provide data on the cause, rather than the type, of injury. For example, a traumatic head injury, coded with an N-code, could result from, a car accident or gunshot wound, both coded with different E-codes.*

- Survey data are used to assess the prevalence of suicide ideation and self-reported suicide attempts. The Youth Risk Behavior Survey is administered every other year in Maine and is used to assess suicidal ideation and attempts among students in middle and high schools. By 2009, the YRBS will be combined with several other surveys of school-aged youth. This will increase the depth of understanding of the risks and protective factors related to youth suicide. Although these data provide valuable information on the prevalence of depression, suicidal behaviors and related factors in the student population, many high risk youth, especially homeless teens and teens who have dropped out of school, are not included in this data source. The Behavioral Risk Factor Surveillance System (BRFSS), a representative statewide telephone survey of adults in Maine, has recently included questions to assess the prevalence of suicidal ideation and attempts among Maine residents over age 18. However, the BRFSS is a telephone survey, therefore individuals without land-line phones and those who are institutionalized or homeless are not included. BRFSS data should however provide a picture of suicidal behavior among adults in Maine.

Limited Evidence Base

- The evidence base for suicide prevention is growing but remains limited compared to other public health problems. Best practice strategies, when they exist, are often not tested in rural states like Maine or are too costly to implement.

Program Evaluation

- While the risk and protective factors for suicide are known, effective strategies for measurably reducing suicide rates in the population remain largely unknown. For this reason, it is crucial to evaluate the impact of suicide prevention strategies wherever possible. Evaluation results should be used to influence decision-making for implementation of future suicide prevention activities. Through evaluation, the MYSPP has been able to obtain federal funding and subsequently to demonstrate promising results of some key activities. Most notable are the evaluation of its gatekeeper training program and the impact of Lifelines student lessons.

Resource Limitations

- There is presently no known resource in Maine dedicated to suicide prevention across the lifespan except for a newly developed Office of Veteran's Suicide Prevention established with federal funds in every state.

Promising and Proven Effective Suicide Prevention Practices

The National Strategy for Suicide Prevention, the Centers for Disease Control and Prevention and other state, regional and national organizations have recognized the necessity of employing a comprehensive approach to suicide prevention. The evidence base for suicide prevention is limited but growing.

Potential Challenges Specific to Suicide and Self-Inflicted Injury Prevention

- Data on suicidal behaviors, regardless of the data source, are not always consistent or timely and may not be completely accurate. There is a lack of specific data on all suicides. Suicide attempts cannot be distinguished from self-injuries that are not suicidal in intent preventing complete understanding of the problem.
- Pre-service education (college) in effective suicide prevention and intervention strategies for professionals entering the fields of education, health care, public safety is not widely available.
- Suicidal behavior is not widely perceived by the health community as a major injury problem that they can recognize and address.
- Suicidal behaviors are complex. Strong, evidence-based research for effective suicide prevention, intervention and treatment is not well developed.
- The need to restrict access to lethal means around suicidal individuals is not generally understood or accepted as an important way to prevent suicide.
- Few school or community based suicide prevention programs currently exist in the state.
- Public awareness that suicide is a health problem in Maine and that prevention strategies are available is not widespread.

- There continues to be a stigma in the general population surrounding seeking treatment for suicidal behavior and mental illness.
- The waiting time for accessing mental health services is often lengthy.
- Identifying and reaching those individuals at highest risk in any age group is difficult.

The Maine Injury Prevention Program
Accomplishments to Prevent Youth Suicide and Self-Inflicted Injuries

Original Plan Goal: The Maine Injury Prevention Program will conduct activities to reduce the incidence of intentional injuries including suicide and violence.

The MIPP Intentional Injury Prevention Program Manager is also the coordinator of the multi-agency Maine Youth Suicide Prevention Program (MYSPP). There have been several notable accomplishments of the MYSPP since the original plan was written in 1998. In 2002, MYSPP was awarded a four-year grant from the Centers for Disease Control and Prevention to implement a Targeted School/Community-based Youth Suicide Prevention Project. This project implemented the comprehensive school-based *Lifelines Program* in 12 Maine schools. An evaluation report on this project is forthcoming. A project implementation report, *Notes From the Field*, was developed and disseminated on the Lifelines Project implementation.

During 2003-2004, a review of suicide surveillance databases and analysis of suicide and self-inflicted injury data was conducted, resulting in the development of a suicide surveillance system in 2005. A suicide surveillance report was issued and disseminated in 2006. In September 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the MYSPP a three-year youth suicide prevention grant for the implementation and evaluation of a youth suicide prevention project in three local communities and to address youth suicide prevention among selected high risk groups.

During 2006, with funding from the Maternal Child Health Block Grant and the Office of Substance Abuse, the MYSPP website was significantly improved. The site now contains information and resources useful to addressing suicide prevention across the lifespan. Also in 2006, a Suicide Survivors kit for newly bereaved family members and friends of suicide victims of all ages was developed and distributed to Funeral Directors statewide and the program successfully disseminated a national anti-stigma campaign aimed at the friends of 18-24 year olds with mental illness.

Since MYSPP inception in 1998, a total of 496 training programs have reached more than 14,200 participants statewide. Evaluation results of training programs have consistently been excellent and are used to modify and improve training programs. Finally, the MYSPP has partnered with the Maine Youth Action Network and Maine youth to create a number of products for dissemination to youth and to develop and deliver educational programs to youth.

Maine Injury Prevention Program
Suicide and Self-Inflicted Injuries Prevention Goals 2007-2010

Revised Goal: Reduce the burden of suicide and suicidal behaviors among Maine residents.

Objective 1: Reduce the rate of suicide across the lifespan by 1% by 2010.
Baseline: 2000-2004 suicide rate: 13.71 per 100,000 population for persons over age ten.
Data Source: Death certificate data

Objective 2: Reduce the rate of suicide attempts among Maine youth by 1% by 2010.
Baseline: avg. 2001, 2003, 2005 reported rate of suicide attempts made: 8.2%.
Data Source: YRBS data

Objective 3: Reduce the rate of self-inflicted injury hospitalizations among Maine youth by 1% by 2010.
Baseline: 2000-2004 self-inflicted injury hospitalization rate: 12.7 per 10,000 youth age 10-24 years.
Data Source: Hospital discharge database

Note: each of the strategies and activities below relate to all of the objectives.

Strategy: Improve and maintain the collection, analysis and dissemination of suicide and self-injury data to guide the focus and direction of suicide prevention efforts.

Activities:

- Improve the quality and accuracy of suicide related data by addressing identified inconsistencies and problems.
- Conduct ongoing analyses of suicide and self-inflicted injury data across the lifespan utilizing death certificate, hospital discharge, YRBS and BRFSS datasets.
- Routinely disseminate information on the incidence of suicide, suicide attempts and risk factors to diverse groups statewide through a variety of methods.
- Investigate new sources of data to enhance suicide and self-inflicted surveillance.

Strategy: Promote the implementation and evaluation of current evidence-based and/or promising suicide prevention interventions for populations at elevated risk of suicide.

Activities:

- Facilitate dissemination of current information by linking to the National Suicide Prevention Resource Center (SPRC) website.
- Increase the dissemination of evidence-based suicide prevention practices/interventions to Maine schools, colleges, correctional institutions, employers, community organizations, service providers and in public safety settings.
- With partners, implement and evaluate evidence-based suicide prevention programs that are culturally competent as they become available and as resources permit.
- Facilitate the evaluation of suicide prevention interventions and utilize evaluation findings to modify interventions and prepare funding applications.

Strategy: Develop state level leadership to provide technical assistance and training to support suicide prevention efforts at the state and local levels.

Activities:

- Offer education and training programs statewide to increase awareness of the warning signs of suicide and how to respond to high-risk suicidal behaviors.
- Provide ongoing training of staff and partners to enhance knowledge of recent research and best practice approaches.
- Collaborate with partners to reach potential audiences such as those from schools, state and community agencies, hospitals, public safety, home health care, clergy and public health, with training and education programs on effective suicide prevention interventions.

Strategy: Collaborate with groups representing diverse population segments within the state to identify policy solutions surrounding suicide prevention.

Activities:

- Coordinate and collaborate across disciplines and with public and private stakeholders at the state, district and community levels in order to enhance support for, and implementation of, suicide prevention activities for high risk groups across the lifespan.
- Promote the efforts of partners in addressing suicide prevention through provision of resources, training and guidance through their organizations and service networks.
- Promote and encourage the adoption of suicide prevention protocols in schools, colleges and community agencies statewide.
- Develop and disseminate model policies and procedures that promote the safe storage of firearms and the removal of firearms from the environments of suicidal individuals.
- Annually disseminate Fact Sheets on suicide in Maine to policymakers including legislators and state agency personnel.
- Share intervention evaluation findings with policymakers.

Suicide Prevention Resources

Maine Youth Suicide Prevention Program at **www.mainesuicideprevention.org**

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control at **www.cdc.gov/ncipc**

National Suicide Prevention Resource Center at www.sprc.org

American Association of Suicidology at **www.suicidology.org**

National Institute of Mental Health at **www.nimh.nih.gov**

Suicide Prevention Advocacy Network at **www.spanusa.org**

National Strategy for Suicide Prevention at **www.mentalhealth.org**

American Foundation for Suicide Prevention at **www.afsp.org**

Suicide Awareness Voices of Education at **www.save.org**

Children's Safety Network at www.childrenssafetynetwork.org

Maine Injury Prevention Program Plan
Goals for Falls Prevention Among Older Adults

Introduction

Unintentional falls were the leading cause of injury deaths and injury hospitalizations among older (i.e., 65+ old) Maine residents during 2000-2004. Each year during this five year period, an average of 61 Maine residents aged 65+ years died as a result of a fall and an average of 2,481 Maine residents aged 65+ years, were hospitalized as a result of injuries due to a fall. Nationally each year, 1 in 3 older adults fall, and 30% suffer injuries that decrease mobility and independence; hip fractures, the most serious of all fall-related fractures, is a leading contributor to death (25% of hip fracture patients die within one year), disability and decreased quality of life among older adults.[33]

The number of older Mainers injured in falls could well rise as Maine's population ages. Maine currently has the oldest population by median age in the U.S. and ranks 3rd highest among states in the percentage of its population that is over 65 years old. Census data indicates that 14.4% of Maine's population was age 65 or over in 2000. [34]

Maine's Office of Elder Services and vast number of partners including the Area Agencies on Aging, provide extensive leadership in the development of community-based evidence-based programs to help older adults live actively and independently in their community.

The MIPP historically centered its falls prevention activities on infants, children and youth, birth to age 24. Partnering efforts in falls prevention for older adults began in 2003 with a member of the MIPP staff participating on the Matter of Balance Advisory Committee, comprised of an extensive group of agencies and organizations focused on older adult health and safety issues. The MIPP provided the Committee resources in the forms of data, technical assistance and input into the development of the Committee's Strategic Plan.

In 2007, the Maine Department Health and Human Services Office of Elder Services (OES) was awarded a three-year grant from the Administration on Aging, *Empowering Older People to Take More Control of their Health Through Evidence-Based Prevention Programs*. This Health and Human Services grant supports Maine's senior aging services provider organizations such as senior centers, nutrition programs, senior housing projects and faith-based organizations.

[33] Falls Free: Promoting a National Falls Prevention Action Plan: National Action Plan, National Council on Aging, 2005.

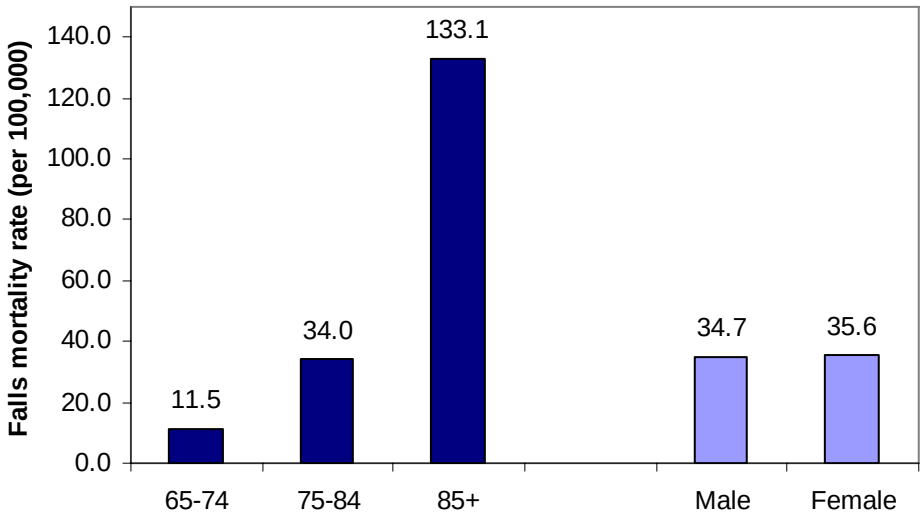
[34] Injuries Due to Falls Among Older Adults in Maine: What Can the Data Tell Us? Mervis C. Presentation at the Maine Falls Prevention Summit, July 13, 2006.

Falls Facts and Trends

Each year in Maine, one of every three adults age 65 or older falls.[35] In the 2006 Behavioral Risk Factor Surveillance System Survey, 17% of 65+ year old Maine respondents reported that they had fallen within the past three months. Nearly one-quarter (23%) of those who fell reported that a fall had caused them to limit their regular activities for at least a day or to go see a doctor.[36]

The risk of death from falls increases with increasing age among older Mainers. In 2000-2003, the average annual falls mortality rate among 85+ year olds was more than 11 times higher than the rate among 75-74 year olds. The falls mortality rate was similar among males and females during this four year period. Over half (53%) of the falls that resulted in death were known to have occurred in the person's home. Another 27% were known to have happened in residential institutions, that include, but is not limited to, nursing homes. Location was unknown for 8% of fall deaths.[37]

Unintentional Falls Mortality Rate, by Age and Sex, 65+ Year Old Maine Residents, 2000-2003



There are nearly 41 fall injury hospital discharges for every fall death among older Maine residents. The risk of injury hospitalization due to falls among older adults also increases with increasing age. The average annual falls injury hospital discharge rate during 2000-2004 was almost eight times higher among 85+ year olds than among 65-74 year olds. Females were about twice as likely to be hospitalized due to a fall injury as were males. The location where the fall took place was not known for most (67%) fall injury hospitalizations.[38]

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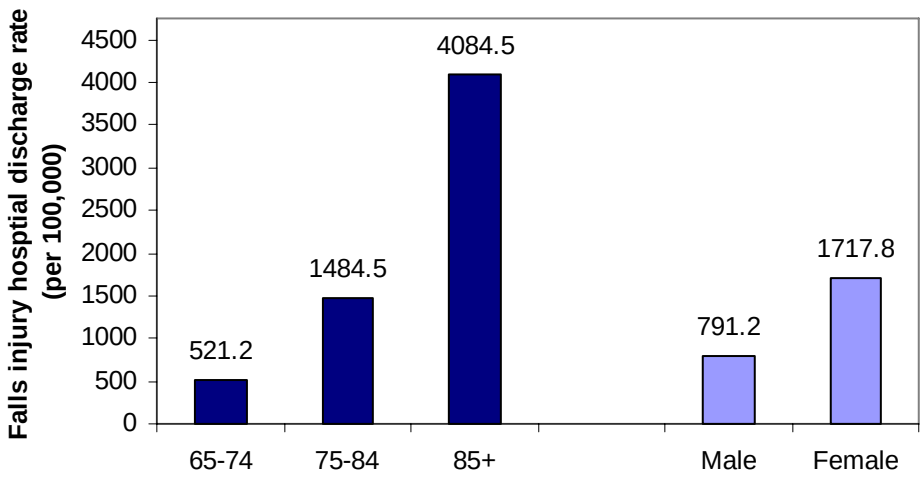
[35] Maine Falls Prevention Report to the Legislature. 2006.
[36] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System: Maine Core Questions Data Report, 2006.
[37] Injuries Due to Falls Among Older Adults in Maine: What Can the Data Tell Us? Mervis C. Presentation at the Maine Falls Prevention Summit, July 13, 2006.
[38] Same as Footnote 28.

Unintentional Falls Injury Hospital Discharge Rate, by Age and Sec, 65+ Year Old Maine Residents, 2000-2004



From 1990-2002, the number of people age 65 and older in the U.S. increased 13% from 31.2 million to 35.3 million, while the number of falls for this age same age group, increased 94%, from 6,601 to 12,837.[39]

Risk Factors

Most falls are predictable and preventable; however, personal and environmental factors increase the risk of falling.

Age / Gender

Emergency room visits in 2004, among 65+ Maine residents, shows that rates of unintentional fall injuries were higher in females (4,7900/100,00) than males (2,807.1/100,00). Falling and attendant injury increases with age 2,449.7/100,000 for 65-74 year olds, rising to 8,269.9/100,000 for 85+ year olds.[40]

Physical Mobility and Coordination

Lower extremity weakness, generalized de-conditioning and poor endurance, musculo-skeletal stiffness and rigidity, slow reaction time to changes in balance, and slow walking speed, all increase the risk of falls in older adults.

Medications Management

Changes in cognitive and physical function, dizziness or lightheadedness, balance difficulties, confusion and sedation are behaviors and/or symptoms signal a need for a comprehensive physical assessment. Medication use can cause these changes and require interventions aimed at medication modification to reduce the risk of falls.

[39] Maine Falls Prevention Coalition Report to the Legislature, 2006.
[40] Same as Footnote 30.

Home Safety

The largest percentage of unintentional falls occurs at home; and 93% of patients are discharged to the community where social services are not currently designed to address fall risks. [41] Poor lighting, clutter, scatter rugs, in and around the home, are identified environmental risk factors. The elimination and/or repairing of such hazardous conditions are strategies that can significantly reduce falls in older adults.

Environmental Safety

Outdoor hazards include uneven pavement or surfaces, cracks, slippery walking surfaces, snow/ice, steps, floor mats, poor lighting, obstacles in walkways and tree roots.

Chronic Disease Issues

Many elderly Maine residents suffer with one or more chronic health problems, including arthritis, diabetes, cancer, lung disease, cardiovascular disease, hypertension, and depression. The struggle to manage numerous chronic conditions often leads to isolation, decreased physical activity and loss in muscle strength and balance, which increases the risk of falls.

Other Risk Factors

Poor vision, hearing impairment, postural hypotension and a previous fall are also considered as serious risk factors. Falls and fear of falling often contribute to inactivity, which increases morbidity and mortality associated with chronic diseases and the costs of caring for persons with those diseases.

Injury Costs

The impact and cost of falls to individuals, their families, the health care system, and the state budget will only grow, as Maine's over age 65 population increases. The Children's Safety Network Economics and Data Analysis Resource Center estimates the total annual cost of unintentional fall fatalities among Maine residents aged 65 and older at $48.7 million (in 2004 dollars.) This includes $2 million in medical costs, $4.6 million in work loss costs, and $42.1 million in quality of life costs.[42] [43] [44]

[41] Maine Inpatient Dataset. 2006.
[42] Children's Safety Network Economics & Data Analysis Resource Center , at Pacific Institute for Research and Evaluation. Medical Cost of Fatal Injuries by Age Group, Maine. Calverton, MD, 2005.
[43] Children's Safety Network Economics & Data Analysis Resource Center , at Pacific Institute for Research and Evaluation. Work Loss Cost of Fatal Injuries by Age Group, Maine. Calverton, MD, 2005.
[44] Children's Safety Network Economics & Data Analysis Resource Center , at Pacific Institute for Research and Evaluation. Quality of Life Cost of Fatal Injuries by Age Group, Maine. Calverton, MD, 2005.

Key Issues

Following are several key issues related to fall prevention.

Raising Awareness and Funding Support

Reframing of the public's current view that falls are an inevitable consequence of aging to the understanding that falls are caused by known risks and can be prevented by incorporating fall prevention messages into ongoing public health campaigns. Currently, fragmentation of opportunity, delivery, and inconsistent quality make it difficult to send consistent messages, find programs and information, and access a continuum of programs. Competing priorities impact the already limited funding streams for older adult falls prevention programs and activities.

Ensuring a Multi-disciplinary Approach

As clearly outlined in the 2006 Maine Falls Prevention Coalition Report to the Legislature, falls are multifactorial in nature and fall prevention requires multidisciplinary, cross cutting strategies to succeed.[45]

Promising and Proven Effective Falls Among Older Adults Prevention Practices

Scientific evidence is clear, the most effective interventions are multifactorial, designed to target key risk factors. In accordance with recommendations of the *National Falls Free™ Action Plan*, effective interventions are predicated upon multidisciplinary collaborations utilizing cross cutting strategies.

Potential Challenges Specific to Falls Prevention Among Older Adults

- Increasing awareness among the general public that falls among older adults are often predictable and preventable.
- Identifying funding sources and community-based resources to assist older adults in accessing home assessments and making appropriate home repair and modifications.
- Expanding and enhancing the delivery system (including developing effective referral methods) for home modification, home safety and related safety services.
- Incorporating older adult fall prevention appropriately into public health activities of the Maine State Health Plan and Maine CDC's Healthy Maine Partnerships.

[45] Maine Falls Prevention Coalition Report to the Legislature. 2006.

Maine Injury Prevention Program
Accomplishments to Prevent Falls Among Older Adults

Original Plan Goal: The Maine Injury Prevention Program will conduct activities to reduce the incidence of unintentional injuries.

In 2005, the MIPP was fortunate to receive five years of funding for an Integrated Core Injury Prevention and Control Project through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). This data driven approach identified falls to be a leading cause of injury and death among Maine's older adults. As a result, a small workgroup to address falls among older adults was created within the larger Injury Prevention Group.

In 2006, the Maine Legislature created the Maine Falls Prevention Coalition, and charged the coalition with developing a blueprint for falls prevention for older adults. This legislative action is an expansion of an earlier successful statewide collaboration to implement and disseminate *A Matter of Balance,* an evidence-based intervention program specifically designed to reduce fear of falling, stop the fear of falling cycle, and improve activity levels among community dwelling older adults. In recent research regarding the Maine volunteer lay leader model, participants experienced significant increases in falls prevention, falls management, falls control, and a reduction in falls at six weeks, and six and 12 months.

The MIPP actively participates on this Maine Falls Prevention Coalition and routinely provides extensive injury and death data to the Coalition. In July 2006, the MIPP partnered with the Coalition to conduct a falls prevention symposium. The symposium, attended by representatives of the health and medical sectors, public and private agencies, and state officials, had two goals:

- To convey important research findings about falls among the elderly to Maine policymakers; and
- To listen to those policymakers describe their own experiences and insights about the causes of falls, and gather ideas about possible solutions.

A detailed report, identifying the outcomes of the day, was generated and distributed to participants. Additionally, components of the report were incorporated into the agenda of the Blaine House Conference on Aging hosted by Governor John Baldacci in September 2006 and, in the first report presented by the Maine Falls Prevention Coalition to the Legislature in November 2006.

Discussions among members of the Falls Workgroup and the Poison Workgroup, of the Injury Prevention Group, are underway to address the link between medication misuse in older adults and the increased risk for falls.

Maine Injury Prevention Program
Falls Prevention Among Older Adults Goals 2007-2010

Revised Goal: Reduce the burden of injuries and deaths due to unintentional falls among Maine residents ages 65 and older.

Objective 1: Reduce the rate of unintentional fall deaths among adults ages 65 and older by 1% by 2010.
Baseline: 35.2 per 100,000 (average annual rate for 2000-2003.)
Data Source: Death certificate data.

Objective 2: Reduce the rate of injury hospitalizations due to unintentional falls among Maine residents ages 65 and older, by 1% by 2010.
Baseline: 1,328.8 per 100,000 (average annual rate for 2000-2004.)
Data Source: Hospital discharge data

The strategies and activities below refer to both Objective 1 and Objective 2.

Strategy: Improve and maintain the collection, analysis and dissemination of fall morbidity and mortality data to guide the focus and direction of fall prevention efforts.

Activities:

- Improve the quality and accuracy of falls related data.
- Improve and maintain the surveillance of fall injuries statewide.
- Conduct analyses of falls injury and death data.
- Disseminate data to policymakers and other key stakeholders.

Strategy: Promote the implementation and evaluation of fall prevention interventions based on current evidence-based and/or promising practices for populations at increased risk of falls.

Activities:

- Research and increase awareness of best practices or promising approaches to falls prevention; and promote implementation where appropriate.
- Contribute to the implementation and evaluation of falls prevention programs, focusing on high risk groups.
- Share evaluation findings with key stakeholders.
- Utilize evaluation findings to assist, as appropriate, intervention planning; and to prepare funding applications.

Strategy: Provide technical assistance and training to support falls prevention efforts at the state and local levels.

Activities:

- Contribute to the development of linkages at the local, district and state levels to identify appropriate falls prevention resources, training and technical assistance and facilitate the development of training and prevention efforts.
- Collaborate with partners to reach potential audiences such as those from state and community agencies, hospitals, home health care, and public health, with training and education programs on effective falls prevention interventions.

Strategy: Collaborate with groups representing diverse population segments within the state to identify policy solutions surrounding falls prevention.

B

Activities:

- Facilitate the coordination and collaboration of key stakeholders at the local, district and state levels to enhance support for, and implementation of, falls prevention policies as appropriate.

Falls Prevention Resources

Maine Office of Elders Services - http://www.maine.gov/dhhs/beas/
207-287-9200

Maine Injury Prevention Program - http://www.maine.gov/dhhs/bohdcfh/inj/index.html
207-287-5356

National Council on Aging – National Falls Free Coalition – www.healthyagingprograms.org
202-479-1200

Consumer Product Safety Commission – http://www.cpsc.gov
Hotline 1-800-638-2772

Home Safety Council – www.homesafetycouncil.org
202-330-4900

Falls Prevention Center of Excellence – http://www.stopfalls.org
213-740-1364

Children's Safety Network – http://www.childrenssafetynetwork.org
617-618-2230

State and Territorial Injury Prevention Directors Association – http://www.stipda.org
770-690-9000

Maine Injury Prevention Program Plan
Goals for Unintentional Poisoning Prevention

Introduction

The Institute of Medicine determined that more than 4 million poisonings occur annually in the United States, 300,000 of which lead to hospitalization. According to the Centers for Disease Control and Prevention in 2004, the death rate from poisoning increased by 56% between 1991 and 2001. Poisoning was the second leading cause of injury-related death, responsible for nearly 31,000 deaths annually.[46]

Unintentional poisoning was the 2nd most common cause of injury deaths among Mainers (all ages combined) in 2000-2004. There was an average of 90 unintentional poisoning deaths among Maine residents each year during this five year period.[47] Of particular concern is the fact that age-adjusted unintentional poisoning mortality rate increased from 4.2 per 100,00 in 2000 to 9.2 per 100,00 in 2004 .[48]

The MIPP historically focused its injury prevention efforts on infants, children and youth, birth to age 24. The MIPP's poison prevention efforts have been limited to participation on the Maine Inhalant Task Force, dissemination of educational materials, data support, technical assistance, resource linkages and inclusion of poison prevention materials in presentations and exhibits to schools, child care agencies, and the general public.

The Maine Center for Disease Control and Prevention administers the legislatively appropriated funding to the Northern New England Poison Center (NNEPC.) through the MIPP. The funding supports statewide surveillance, education and outreach services. The relationship between the MIPP and the NNEPC is one of longstanding collaboration in the areas of prevention education through presentations and exhibits at MIPP sponsored conferences and health and safety events.

Unintentional Poisoning Facts and Trends

Unintentional poisonings were the 4th most common cause of injury hospital discharges during this time period, with an average of 300 such discharges each year.[49]

In Maine, during 2000-2004, 455 persons died from unintentional poisoning deaths across all ages; 309 were males, while 146 were females. Eighty-two deaths represented the 18-25 year old group; 54 males and 28 females.[50]

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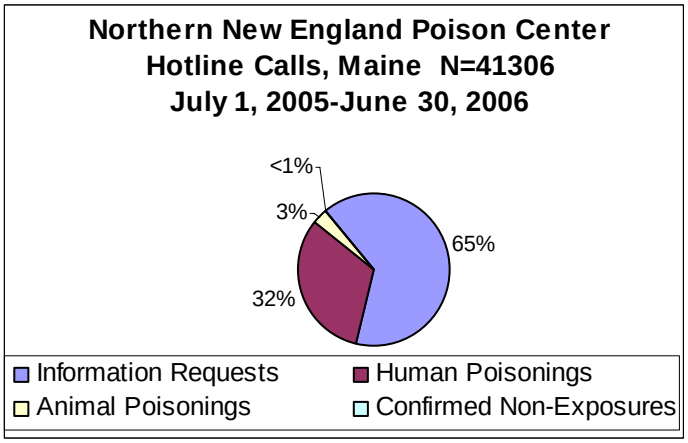
[46] Northern New England Poison Center Report to Maine CDC. 2006.
[47] 10 Leading Causes of Injury Deaths, by Age Group, Maine, 2000-2004. Mervis C.
[48] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS), 2007 [cited 2007 Dec 5]. Available from URL: **www.cdc.gov/ncipc/wisqars**.
[49] 10 Leading Causes of Injury Hospital Discharges, by Age, 2000-2004. Mervis C.
[50] Unintentional Poisoning Deaths and Rates per 100,000. CDC WISQARS. 2000-2004.

In 2001, 70 of the 90 drug deaths were caused by pharmaceuticals, and in 2002 148 of the 166 drug deaths were caused by pharmaceutical. More than 20% of high school seniors have used prescription drugs to get high.[51]

The current call volume for the Northern New England Poison Center is over 40,000 per year in Maine and over 70,000 when calls from New Hampshire and Vermont are included. Inquiries include requests both for general information and assistance with actual exposures. Approximately 15,000 of the 40,000 calls from Maine are about actual exposures and 49% involve children under the age of six.[52]



The 2006 Maine Youth Drug and Alcohol Use Survey (MYDAUS) indicated that the prevalence rates for female students were higher than for male students for use of inhalants (over the lifetime) and prescription drugs (over the lifetime.) There were no differences between males and females for the use of alcohol, inhalants and prescription drugs (use within the past month.)[53]

Risk Factors

Age / Gender

For older adults, an already compromised health status, poor vision, decreased hearing, memory loss and medication mismanagement are factors which increase the risk of unintentional poisoning. Additionally, the potential for polypharmacy and their interactions, and the hesitancy of older adults to contact the poison center for assistance.

Increased mobility, inquisitiveness and the developmental phase of testing their environment by tasting, places children between the ages of 0-5 years at great risk of unintentional poisoning.

[51] 2006 MYDAUS Survey www.maine.gov/dhhs/osa. Office of Substance Abuse Website.
[52] Northern New England Poison Center Report to Maine CDC. 2006.
[53] 2006 MYDAUS Survey www.maine.gov/dhhs/osa. Office of Substance Abuse Website.

A lack of comprehension of the potentially devastating consequences regarding the use of alcohol, tobacco, marijuana, inhalants and the misuse of prescription and over the counter medications place young people of middle and high school age at risk for unintentional poisoning.

Injury Costs

The Children's Safety Network Economics and Data Analysis Resource Center estimates the total annual cost of unintentional poisoning fatalities among Maine residents at $238.5 million (in 2004 dollars.) This includes $320,202 in medical costs, $86 million in work loss costs, and $152.3 million in quality of life costs.[54][55][56]

Key Issues

Following key issues related to poison prevention.

Raising Awareness and Knowledge

Most poisonings are unintentional in nature and involve chemicals found in common household products and medicines. However, the lack of recognition by an individual of the potential harm a given product can cause is the reason for the poisoning incident.[57]

Ensuring a Multi-disciplinary Approach

The issue of unintentional poisonings is complex, requiring a broad spectrum of partners in order to implement the most effective strategies for each.

Promising and Proven Effective Unintentional Poisoning Prevention Practices

Research conducted by the U.S. Department of Health and Human Services and its National Centers for Disease Control and Prevention concluded that for every dollar spent on poison centers, $7 in medical costs are saved.[58]

The NNEPC located in Portland, Maine, is the regions, largest available resource regarding poison prevention. The toll free number is available statewide. The NNEPC houses a statewide surveillance database of real time data which is available to the Maine CDC. The NNEPC is monitored by the AAPCC in Washington, D.C. The NNEPC also provides outreach and education services statewide.

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[54] Children's Safety Network Economics & Data Analysis Resource Center, at Pacific Institute for Research and Evaluation. Medical Cost of Fatal Injuries by Age Group, Maine. Calverton, MD, 2005.
[55] Children's Safety Network Economics & Data Analysis Resource Center, at Pacific Institute for Research and Evaluation. Work Loss Cost of Fatal Injuries, by Age Group, Maine. Calverton, MD, 2005.
[56] Children's Safety Network Economics & Data Analysis Resource Center, at Pacific Institute for Research and Evaluation. Quality of Life Cost of Fatal Injuries, by Age Group, Maine. Calverton, MD, 2005.
[57] Northern New England Poison Center Report to the ME CDC. 2006.
[58] Northern New England Poison Center Report to the ME CDC. 2006.

Potential Challenges to Unintentional Poisoning Prevention

- Increasing awareness that unintentional poisoning is preventable.
- Identifying funding sources and community-based resources to deliver unintentional poison prevention education.
- Incorporating unintentional poison prevention appropriately into public health activities of the Maine State Health Plan and the eight newly forming districts.
- Potential funding cuts could affect the NNEPC's ability to conduct outreach and education services and most critically respond to calls.

Maine Injury Prevention Program
Accomplishments to Prevent Unintentional Poisoning

Original Plan Goal: The Maine Injury Prevention Program will conduct activities to reduce the incidence of unintentional injuries.

In 2005, the MIPP was fortunate to receive five year funding for an Integrated Core Injury Prevention and Control Project through the Centers for Disease Control and Prevention (CDC). As a result of this data driven approach, unintentional poisoning was identified as one of the leading causes of injuries and deaths to Maine residents. A small workgroup was formed within the larger Injury Prevention Workgroup, to address the issue.

In July 2007, the Unintentional Poison Prevention Workgroup collaborated with the NNEPC and the Office of Substance Abuse (OSA) to conduct: *Prescription Medication Misuse: A Community Challenge* Symposium. (Note: Prescription medication misuse is defined as prescription medication being used for purposes other than for which it was prescribed.) The event brought together representatives of the medical and health care sectors, public safety, private agencies, education and the pharmaceutical community to identify strategies to address reducing prescription medication misuse by reducing availability. The day included presentations on the piloted Unused Medication Disposal Program and the OSA's Prescription Monitoring Program. A report highlighting the day's activities was prepared and distributed to attendees.

Maine Injury Prevention Program
Unintentional Poisoning Prevention Goals 2007-2010

Revised Goal: Reduce the burden of unintentional poisoning deaths and injuries among Maine residents.

Objective 1: Reduce the rate of unintentional poisoning deaths among Maine residents by 1% by 2010.
Baseline: 7.0 per 100,000 (average annual rate for 2000-2004.)
Data Source: Death certificate data.

Objective 2: Reduce the rate of unintentional poisonings hospital discharges among Maine residents by 1% by 2010.
Baseline: 23.1 per 100,000 (average annual rate for 2000-2004.)
Data Source: Hospital discharge data.

The strategies and activities outlined below apply to Objectives One and Two.

Strategy: Improve and maintain the collection, analysis and dissemination of poison injury data to guide the focus and direction of poison prevention efforts.

Activities:

- Improve the quality and accuracy of poison-related data
- Improve and maintain the surveillance of poison injuries statewide.
- Conduct analyses of poison injury data with a focus on high risk groups.
- Disseminate data to policymakers and other key stakeholders.

Strategy: Promote the implementation and evaluation of poison prevention interventions that are based on current evidence-based and/or promising practices.

Activities:

- Research and increase awareness of best practices and promising approaches to poison prevention; and promote implementation where and as appropriate.
- Contribute to the implementation and evaluation of poison prevention programs, focusing on high-risk groups.
- Share evaluation findings with key stakeholders.
- Utilize findings to assist, as appropriate, interventions; and to prepare funding applications.

Strategy: Provide technical assistance and training to support poison prevention efforts at the state and local levels.

Activities:

- Contribute to the development of linkages at the local, district and state levels to identify appropriate poison prevention resources, training and technical assistance and facilitate the development of prevention efforts.
- Collaborate with partners to reach potential audiences such as those from schools, state and community agencies, hospitals, home health care, and public health, with training and education programs on effective unintentional poison prevention interventions.

Strategy: Collaborate with groups representing diverse population segments within the state to identify policy solutions surrounding poison prevention.

Activities:

- Facilitate the coordination and collaboration of key stakeholders at the local, district and state levels to enhance support for, and implementation of, poison prevention policies as appropriate.

Poison Prevention Resources

Northern New England Poison Center at - http://www.nnepc.org
1-800-222-1222

Maine Injury Prevention Program - http://www.maine.gov/dhhs/bohdcfh/inj/index.html
207-287-5356

National Council on Aging – http://www.ncoa.org
202-479-1200

Consumer Product Safety Commission – http://www.cpsc.gov
Hotline 1-800-638-2772

Home Safety Council – www.homesafetycouncil.org
202-330-4900

Children's Safety Network – http://www.childrenssafetynetwork.org
617-618-2230

State and Territorial Injury Prevention Directors Association – http://www.stipda.org
770-690-9000

GLOSSARY OF TERMS AND ACRONYMS

- **BRFSS** – Behavioral Risk Factor Surveillance Survey
- **BHS** – Bureau of Highway Safety
- **CDCP** – Centers for Disease Control and Prevention
- **CODES** – Crash Outcome Data Evaluation System
- **CPS** – Child Passenger Safety
- **CSN** – Children's Safety Network
- **DHHS** – Department of Health and Human Services
- **E-codes** – External Cause of Injury Code used to represent what caused an injury, i.e., a motor vehicle crash.
- **ED / ER** – The emergency department / emergency room of a hospital
- **EMS-C** – Emergency Medical Services for Children
- **FARS** – Fatal Accident Reporting System
- **Gatekeeper Training** – A process by which individuals acquire basic suicide prevention and intervention skills.
- **GDL** – Graduated Drivers License
- **HM 2010** – Healthy Maine 2010, a set of state goals in line with the national public health goals
- **Hospitalization** – Admission to a hospital for at least one overnight stay
- **HP 2010** – Healthy People 2010, a set of national public health goals for the nation to reach by year 2010
- Intentional injury is used to refer to injuries resulting from purposeful human action, whether directed at oneself or others. Intentional injuries include self inflicted and interpersonal acts of violence intended to cause harm.
- **IOM** – Institute of Medicine
- **ME CDC** – Maine Center for Disease Control & Prevention
- **MCHBG** – Maternal Child Health Block Grant
- **MDOT** – Maine Dept. of Transportation
- **MIPP** – Maine Injury Prevention Program
- **MOB** – Matter of Balance
- **Morbidity** – Frequency of number of deaths in proportion to a population: Death Rate
- **Mortality** – Frequency of the onset of injuries. Used to describe non-fatal injuries.
- **MTSC** – Maine Transportation Safety Coalition
- **MYSPP** – Maine Youth Suicide Prevention Program
- **N-Code** – Nature of Disease Code used to describe the type of injury sustained, i.e. a head injury
- **NCOA** – National Council on Aging
- **NFPA** – National Fire Protection Association
- **NHTSA** – National Highway Traffic Safety Administration
- **NNEPC** – Northern New England Poison Center
- **OSA** – Office of Substance Abuse
- **PHBG** – Preventive Health Block Grant
- **Rate/100,000** – A common form of measuring a public health issue. By dividing the number of incidents by the population, Maine can be compared to other states and the U.S. as a whole. The result is multiplied by 100,000 to come to the rate of injury or disease per 100,000 people. Formula: Number (#) of Injuries/Population for age and geographic group) x 100,000.
- **SAMHSA** – Substance Abuse Mental Health Services Administration

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

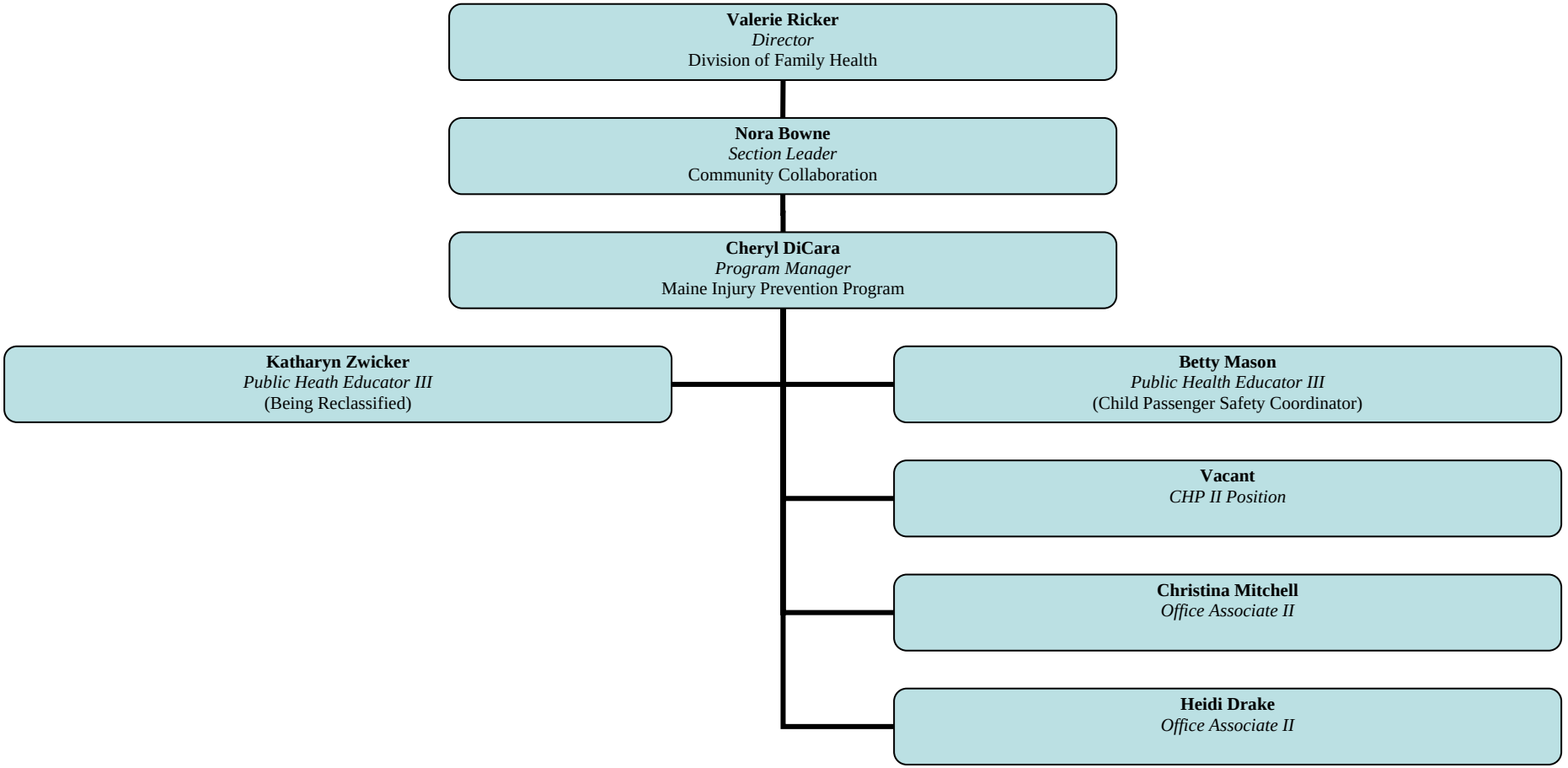
- **SBS** – Shaken Baby Syndrome
- **STIPDA** – State and Territorial Injury Prevention Directors Association
- **Unintentional** is used to refer to injuries that were unplanned. Unintentional injuries can be defined as events in which: 1) injury occurs in a short period of time – seconds or minutes, 2) the harmful outcome was not sought or 3) the outcome was the result of one of the forms of physical energy in the environment or normal body functions being blocked by external means, e.g. drowning.[59]
- **YPLL** – Years of Potential Life Lost "Years of potential life lost (YPLL) is a measure of premature mortality (early death). YPLL provides insight into the impact of injury-related death on society compared to other leading causes of death. For a given cause category, WISQARS Fatal calculates the years lost before age 65 (YPLL-65) through two steps. First, the system subtracts each deceased person's age at death from 65. Next, the system adds the results -- the "years lost" -- for all deceased people in that category." (from: http://www.cdc.gov/ncipc/wisqars/fatal/help/helpfile.htm#yppl)
- **YRBS** – Youth Risk Behavior Survey

[59] Injury Prevention and Public Health; Practical Knowledge, Skills, and Strategies; Christoffel, T. Gallagher, S.; Aspen Publications 1999.

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

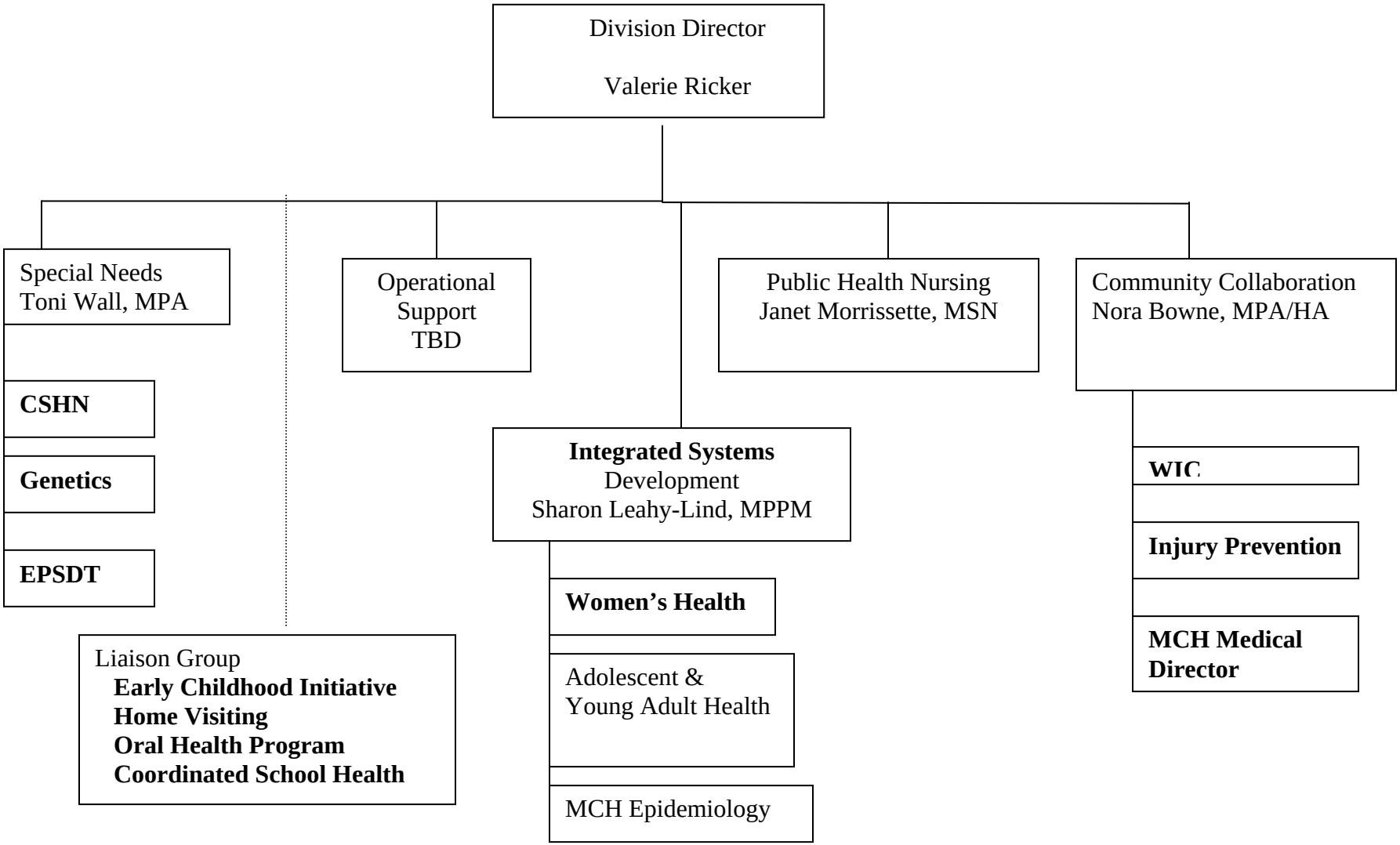
Maine Injury Prevention Program
Organizational Chart

Updated 11/19/07



Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

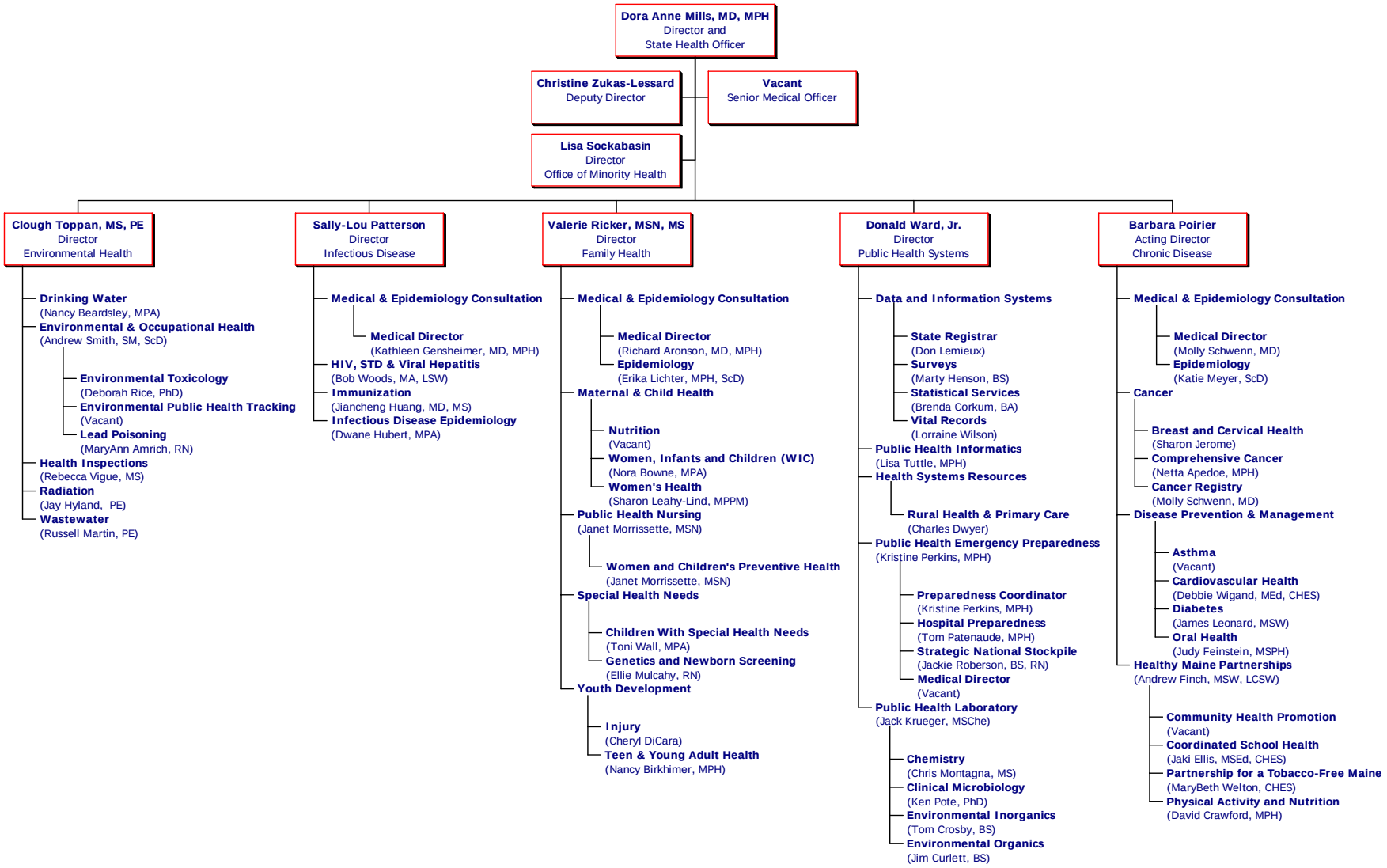
DIVISION OF FAMILY HEALTH



Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

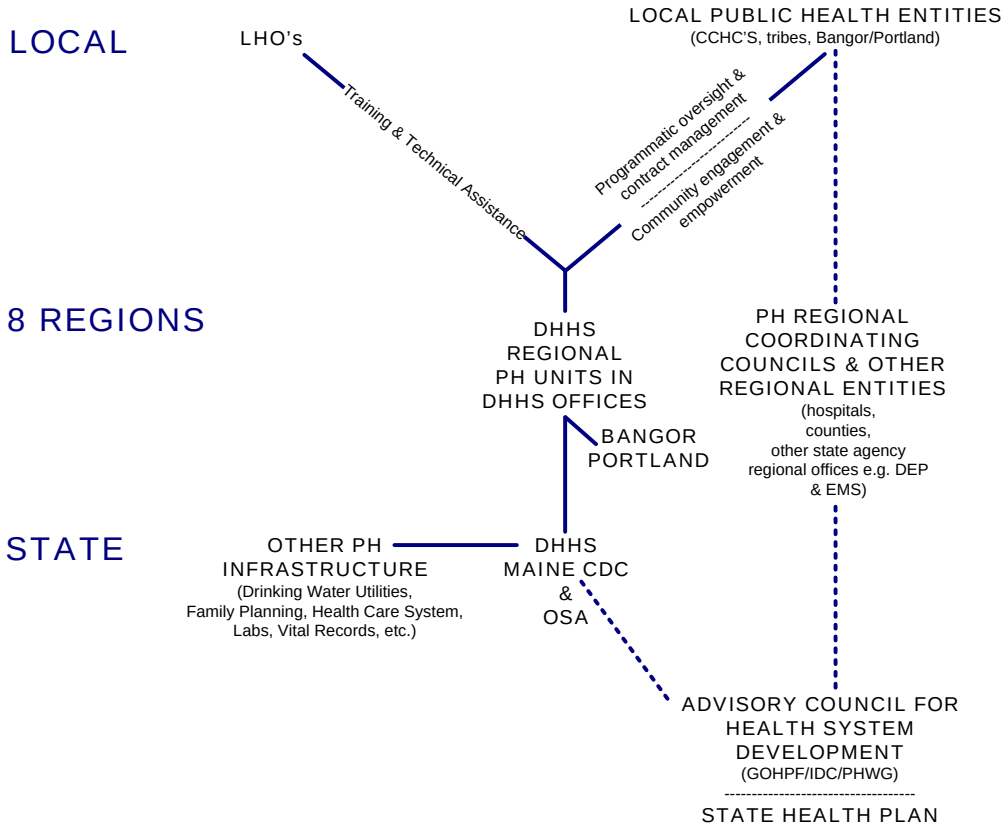
Maine Center for Disease Control and Prevention

April, 2007



Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

OFFICIAL MAINE PUBLIC HEALTH INFRASTRUCTURE



GOAL: TO MAKE MAINE THE HEALTHIEST STATE IN THE NATION

MARCH 2007

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

MATRIX OF CURRENT CORE INJURY DATA SOURCE UTILIZATION IN MAINE

Data Set	Description	Data set routinely available to MIPP	Routine report released by data set manager
Vital Statistics	E-coded death certificate records	Yes	No
Hospital Discharge	E-coded hospital discharge records	Yes	No
Hospital Outpatient	E-coded hospital outpatient visits, including emergency department visits	Yes	No
Fatality Analysis Reporting System (FARS)	Fatal traffic crashes	Yes	Annually
National Occupant Protection Use Survey	Observed Seat Belt use – Last study was in 2003	Yes	Yes
Behavioral Risk Factor Survey	Survey of adult health conditions and risk behaviors	Yes	Upon Request
Youth Behavioral Risk Factor Survey	Survey of youth health risk behaviors	Yes	Biannually
Medical Examiner	Record of all injury deaths.	Yes	No
Child Death & Serious Injury Review Panel	Review of deaths of children from abuse and neglect, last reported 1995	Yes	2004 data released in 2006
Uniform Crime Report (UCR)	Record of all arrests in Maine	Yes	Annually
EMS Database	EMS patient/run forms from ambulance services from across the state of Maine	Must request permission	No
Additional Maine Data Sets			
CODES	Linked data set of police reports, EMS run reports, emergency room, hospital discharge and death certificate records for 1995 – 1997	No	Upon Request
Toxic Exposure Surveillance System (TESS), Poison Control	Records of Poison Center phone calls for information, treatment and referral	Yes	Annually
Inland Fish and Wildlife	ATV, snowmobile and watercraft injuries & deaths	Yes	Yes
Occupational Injuries in Maine	Work related injuries, including deaths	Yes	Yes
Maine Child Health Survey	Examines the health of Kindergarten, third and fifth graders in Maine. Have limited	Yes	No

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

	questions regarding injury		
PRAMS – Pregnancy Risk Assessment Monitoring System	Maternal attitudes and experiences, before during and shortly after pregnancy	No	Available on project-to-project basis
National Survey of Children's Health	Examines the physical and emotional health of children 0 to 17 years (Maine estimates available)	Yes	Yes

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

10 Leading Causes of Death, by Age Group
Maine, 2000-2004, All Races, Both Sexes

	Age Groups												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 90	Unintentional Injury 28	Unintentional Injury 27	Unintentional Injury 22	Unintentional Injury 355	Unintentional Injury 303	Unintentional Injury 365	Malignant Neoplasms 1,272	Malignant Neoplasms 2,517	Malignant Neoplasms 4,035	Heart Disease 4,872	Heart Disease 6,121	Heart Disease 15,896
2	Short Gestation 59	Malignant Neoplasms 11	Malignant Neoplasms 9	Malignant Neoplasms 15	Suicide 107	Suicide 119	Malignant Neoplasms 348	Heart Disease 726	Heart Disease 1,322	Heart Disease 2,494	Malignant Neoplasms 4,845	Malignant Neoplasms 2,401	Malignant Neoplasms 15,565
3	SIDS 29	Congenital Anomalies 10	Congenital Anomalies 3	Suicide 8	Malignant Neoplasms 39	Malignant Neoplasms 73	Heart Disease 274	Unintentional Injury 284	Chronic Low. Respiratory Disease 388	Chronic Low. Respiratory Disease 965	Chronic Low. Respiratory Disease 1,513	Cerebro-vascular 1,885	Cerebro-vascular 4,081
4	Placenta Cord Membranes 21	Benign Neoplasms 5	Benign Neoplasms 1	Heart Disease 6	Heart Disease 19	Heart Disease 56	Suicide 161	Suicide 157	Diabetes Mellitus 247	Cerebro-vascular 495	Cerebro-vascular 1,382	Alzheimer's Disease 1,494	Chronic Low. Respiratory Disease 3,907
5	Maternal Pregnancy Comp. 19	Influenza & Pneumonia 4	Heart Disease 1	Congenital Anomalies 4	Homicide 19	Homicide 17	Diabetes Mellitus 49	Diabetes Mellitus 106	Cerebro-vascular 191	Diabetes Mellitus 447	Alzheimer's Disease 769	Chronic Low. Respiratory Disease 927	Alzheimer's Disease 2,429
6	Intrauterine Hypoxia 14	Homicide 3	Homicide 1	Influenza & Pneumonia 4	Congenital Anomalies 8	Diabetes Mellitus 13	Liver Disease 45	Liver Disease 103	Unintentional Injury 161	Unintentional Injury 204	Diabetes Mellitus 652	Influenza & Pneumonia 865	Unintentional Injury 2,404
7	Bacterial Sepsis 11	Cerebro-vascular 2	Nephritis 1	Septicemia 2	Influenza & Pneumonia 7	Influenza & Pneumonia 10	Cerebro-vascular 42	Chronic Low. Respiratory Disease 87	Liver Disease 130	Nephritis 179	Influenza & Pneumonia 446	Nephritis 453	Diabetes Mellitus 1,939
8	Neonatal Hemorrhage 10	Heart Disease 2		Cerebro-vascular 1	Septicemia 4	Cerebro-vascular 9	HIV 29	Cerebro-vascular 74	Suicide 98	Liver Disease 156	Nephritis 395	Diabetes Mellitus 422	Influenza & Pneumonia 1,557
9	Respiratory Distress 8	Six Tied 1		Chronic Low. Respiratory Disease 1	Diabetes Mellitus 3	HIV 6	Homicide 21	Viral Hepatitis 37	Nephritis 78	Influenza & Pneumonia 145	Unintentional Injury 329	Unintentional Injury 319	Nephritis 1,144
10	Unintentional Injury 7	Six Tied 1		Pneumonitis 1	Eight Tied 1	Liver Disease 6	Chronic Low. Respiratory Disease 20	HIV 27	Septicemia 67	Alzheimer's Disease 141	Parkinson's Disease 259	Pneumonitis 213	Suicide 789

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2007 Oct 10]. Available from URL: www.cdc.gov/ncipc/wisqars.

10 Leading Causes of Injury Deaths, by Age Group
Maine, 2000-2004, All Races, Both Sexes

	Age Groups												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Unintentional MV traffic 4	Unintentional MV traffic 7	Unintentional MV traffic 14	Unintentional MV traffic 11	Unintentional MV traffic 216	Unintentional MV traffic 121	Unintentional Poisoning 136	Unintentional MV traffic 107	Unintentional MV traffic 73	Unintentional MV traffic 81	Unintentional MV traffic 105	Unintentional Fall 152	Unintentional MV traffic 908
2	Unintentional Suffocation 2	Unintentional Drowning 5	Unintentional Fire/burn 6	Suicide Firearm	Unintentional Poisoning 77	Unintentional Poisoning 119	Unintentional MV traffic 134	Suicide Firearm 85	Suicide Firearm 62	Suicide Firearm 51	Unintentional Fall 103	Unintentional Suffocation 59	Unintentional Poisoning 451
3	Unintentional Fire/burn	Unintentional Fire/burn	Unintentional Drowning 3	Suicide Suffocation 4 each (tie)	Suicide Firearm 61	Suicide Firearm 54	Suicide Firearm 63	Unintentional Poisoning 84	Unintentional Fall 26	Unintentional Fall 49	Unintentional Suffocation 52	Unintentional Unspecified 51	Suicide Firearm 430
4	Undetermined Suffocation	Unintentional Pedestrian, other	Unintentional Other land transport 2	Unintentional Drowning	Suicide Suffocation 37	Suicide Suffocation 29	Suicide Poisoning 41	Suicide Poisoning 32	Suicide Poisoning 22	Unintentional Suffocation 22	Unintentional Unspecified 32	Unintentional MV traffic 35	Unintentional Fall 371
5	Adverse effects	4 each (tie)		Unintentional Other land transport	Unintentional Other land transport 11	Suicide Poisoning 21	Suicide Suffocation 38	Suicide Suffocation 24	Unintentional Poisoning 13	Unintentional Unspecified	Suicide Firearm 29	Suicide Firearm 21	Unintentional Suffocation 170
6	1 each (tie)	Homicide Unspecified	Unintentional Fall	3 each (tie)	Homicide Firearm	Homicide Firearm	Unintentional Drowning 17	Unintentional Fall 15	Unintentional Other land transport 9	Adverse effects 11 each (tie)	Adverse effects 20	Adverse effects 11	Suicide Suffocation 149
7		Unintentional Struck by, against 3 each (tie)	Homicide Suffocation	Undetermined Suffocation 2	Unintentional Other transport 10 each (tie)	Unintentional Other land transport 12 each (tie)	Unintentional Fall 14	Unintentional Drowning 13	Unintentional Suffocation 8	Suicide Poisoning 10	Unintentional Drowning 9	Unintentional Fire/burn 7	Suicide Poisoning 138
8		Unintentional Poisoning	Unintentional Pedestrian, other	Five Tied 1	Unintentional Drowning 9	Unintentional Drowning	Unintentional Other land transport 12	Unintentional Fire/burn	Unintentional Drowning 6	Unintentional Poisoning 9	Unintentional Fire/burn 7	Unintentional Poisoning	Unintentional Unspecified 114
9		Unintentional Suffocation 2 each (tie)	1 each (tie)		Homicide Cut/pierce 6	Unintentional Other spec, classifiable 8 each (tie)	Homicide Firearm	Unintentional Other transport 11 each (tie)	Five Tied 5	Unintentional Fire/burn 6	Unintentional Natural/ environmental 6	Unintentional Natural/ environmental 6 each (tie)	Unintentional Drowning 78
10		Unintentional Fall 1			Two Tied 5	Unintentional Fall 6	Unintentional Other spec, classifiable 9 each (tie)	Unintentional Suffocation 10		Three Tied 5	Suicide Poisoning 5	Two Tied 3	Unintentional Fire/burn 64

Note: The numbers in this table are the number of Maine residents who died in 2000-2004 from a particular underlying cause of death.
Data source: Maine death certificate statistical datasets, 2000-2004

10 Leading Causes of Injury Hospital Discharges, by Age
Maine, 2000-2004, All Races, Both Sexes

Rank	Age Groups												
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Unintentional Fall 38	Unintentional Fall 152	Unintentional Fall 190	Unintentional Fall 260	Unintentional MV traffic 1,299	Self-inflicted Poisoning 725	Self-inflicted Poisoning 938	Unintentional Fall 1,239	Unintentional Fall 1,535	Unintentional Fall 2,492	Unintentional Fall 4,961	Unintentional Fall 4,953	Unintentional Fall 17,656
2	Unintentional Poisoning 16	Unintentional Poisoning 135	Unintentional MV traffic 77	Unintentional MV traffic 144	Self-inflicted Poisoning 915	Unintentional MV traffic 667	Unintentional Fall 902	Unintentional MV traffic 599	Unintentional MV traffic 372	Unintentional MV traffic 304	Unintentional MV traffic 320	Unintentional Unspecified 144	Unintentional MV traffic 4,680
3	Unintentional Fire/burn 14	Unintentional Other spec, classifiable 53	Unintentional Pedal cyclist, other 46	Unintentional Transport, other 117	Unintentional Fall 456	Unintentional Fall 478	Unintentional MV traffic 725	Self-inflicted Poisoning 565	Self-inflicted Poisoning 163	Unintentional Poisoning 125	Unintentional Unspecified 163	Unintentional MV traffic	Self-inflicted Poisoning 3,511
4	Assault Other spec, classifiable 10	Unintentional Fire/burn 43	Unintentional Transport, other 35	Unintentional Struck by, against 101	Unintentional Transport, other 343	Unintentional Transport, other 236	Unintentional Transport, other 245	Unintentional Poisoning 210	Unintentional Poisoning 122	Unintentional Overexertion 117	Unintentional Poisoning	Adverse effects 124 each (tie)	Unintentional Poisoning 1,499
5	Unintentional Suffocation	Unintentional MV traffic 42	Unintentional Struck by, against 34	Self-inflicted Poisoning 95	Unintentional Poisoning 250	Unintentional Poisoning 178	Unintentional Poisoning 224	Unintentional Transport, other 174	Unintentional Overexertion 85	Unintentional Unspecified 111	Adverse effects 150 each (tie)	Unintentional Overexertion 61	Unintentional Transport, Other 1,359
6	Unintentional Other spec, classifiable Assault Unspecified 8 each (tie)	Unintentional Natural/ environmental 26	Unintentional Natural/ environmental 20	Unintentional Pedal cyclist, other 63	Unintentional Struck by, against 189	Unintentional Struck by, against 105	Unintentional Struck by, against 127	Unintentional Overexertion 127	Unintentional Transport, other 73	Adverse effects 99	Unintentional Overexertion 113	Unintentional Poisoning 53	Unintentional Struck by, against 903
7		Unintentional Struck by, against 19	Unintentional Poisoning Unintentional Other spec, classifiable 13 each (tie)	Unintentional Poisoning 23	Undetermined intent Poisoning 129	Unintentional Overexertion 82	Unintentional Overexertion 101	Unintentional Struck by, against 121	Unintentional Unspecified 62	Unintentional Transport, other 70	Unintentional Struck by, against 48	Unintentional Struck by, against 39	Unintentional Overexertion 796
8	Unintentional MV traffic 7	Unintentional Suffocation 15		Unintentional Cut/pierce 22	Assault Struck by, against 104	Undetermined intent Poisoning 75	Undetermined intent Poisoning 100	Undetermined intent Poisoning 93	Unintentional Struck by, against 59	Self-inflicted Poisoning 62	Unintentional Transport, other	Unintentional Other spec, NEC 28	Unintentional Unspecified 718
9	Unintentional Unspecified 4	Unintentional Unspecified 11	Unintentional Fire/burn 10	Unintentional Overexertion 21	Unintentional Overexertion 78	Unintentional Other spec, classifiable 60	Unintentional Other spec, classifiable 89	Unintentional Unspecified 76	Adverse effects	Unintentional Struck by, against 59	Unintentional Other spec, classifiable 41 each (tie)	Unintentional Other spec, classifiable 26	Adverse effects 553
10	Two Tied 3	Assault Other spec, classifiable 9	Unintentional Cut/pierce 8	Undetermined intent Poisoning 16	Unintentional Fire/burn 65	Unintentional Cut/pierce 58	Unintentional Fire/burn 73	Unintentional Other spec, classifiable 69	Unintentional Fire/burn 48 each (tie)	Unintentional Other spec, classifiable 45	Unintentional Natural/ environmental 40	Unintentional Natural/ environmental 18	Unintentional Other spec, classifiable 501

2005 to 2010 MCH priorities

Improve birth outcomes

Improve the safety of the MCH population, including the reduction of intentional and unintentional injuries

Improve the respiratory health of the MCH population

Increase the proportion of the MCH population who are at a healthy weight and physically active

Improve the mental health system of services and supports for the MCH population

Foster conditions to improve oral health services and supports for the MCH population

Foster the conditions that enable the CSHN Program to move from a direct care focus to a community-based system of care that enables the whole CSHN population to achieve optimal health

Foster conditions to expand the medical home model to a comprehensive health home system for the entire MCH population

Improve cultural and linguistic competence within the system of services for the MCH population

Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs

Eleven Core Data Sets for State Injury Surveillance[60] as Recommended by the State and Territorial Injury Prevention Directors Association (STIPDA)

1. Vital records (death certificates)
2. Hospital discharge
3. Fatality Analysis Reporting System (FARS)
4. Behavioral Risk Factor Surveillance System (BRFSS)
5. Youth Risk Behavior Surveillance System (YRBSS)
6. Emergency department
7. Medical Examiner (ME) records
8. Child death review
9. National Occupant Protection Use Surveys (NOPUS)
10. Uniform Crime Reporting System (UCR)
11. Emergency medical services (EMS)

[60] Planning Comprehensive Injury Surveillance in State Health Departments Working Group. *Consensus Recommendations for Injury Surveillance in State Health Departments*. Atlanta, GA: State and Territorial Injury Prevention Directors Association, September 1999.

Recommendations Regarding Elder Suicide Prevention
Produced by the Joint Advisory Committee on Select Services for Older Persons (JAC)

1) The Department (Health and Human Services) will initiate efforts to reduce elder suicide including, but not limited to, working with stakeholders to review the MED assessment to determine if questions need to be added or modified in order to serve the additional purpose of an effective depression screen.

2) The Department will work with JAC by convening a workgroup that includes others interested in and knowledgeable of suicide prevention in order to:

a) Heighten awareness of the number of suicides committed by elders;
b) Review the existing suicide prevention efforts being used with youth in Maine to see what techniques and approaches would be applicable to adults;
c) Identify best practices in suicide prevention programs in Maine and other states;
d) Review evidence-based research available through the National Suicide Prevention Center to determine which approaches would work best in Maine; and
e) Review and encourage the development of grant applications that seek to reduce adult and elder suicide.

Potential List of Suicide Prevention Priorities
Identified by the Maine IPG Suicide Priority Workgroup

1. Effectively reaching 18-24 year olds, especially those not in colleges
2. Effectively reaching trauma victims
3. Effectively reaching adults
4. Effectively reaching elders
5. Effectively reaching Native Americans or other disparate populations
6. Reducing access to lethal means and educating about the importance of this strategy
7. Engaging clergy in suicide prevention efforts
8. Reducing stigma of seeking help for mental illness, suicidal behaviors and related issues
9. Providing effective suicide prevention trainings for DHHS caseworkers
10. Providing effective suicide prevention training for primary care providers
11. Adding module on suicide prevention to pre-service education for teachers, social workers, doctors, nurses and CNAs
12. Providing effective mental health/suicide prevention training for home visitors
13. Conducting Suicide prevention interventions in Corrections settings

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