Creation of a Suicide Mortality Review Board in Maine:

In-Depth Evaluations Can Lead to Preventive Measures

by Sarah A. Sherman

BACKGROUND AND EXISTING INITIATIVES

The state of Maine has the highest veterans' suicide rate in the Northeast (Maine, New Hampshire, Massachusetts, Rhode Island, Connecticut, Vermont, New Jersey, New York, and Pennsylvania). In 2022, 43 Maine veterans died by suicide, and 74.4 percent of these suicides were completed with the use of a firearm (US VA 2024). In 2019, the Maine Bureau of Veterans' Services (MBVS) cofounded the Maine Safer Homes Taskforce with a mission to educate veterans and the public on safe storage options for firearms and prescription medications. The task force included community partners such as the Maine Department of Public Safety, the Sportsman's Alliance of Maine, Wabanaki Public Health & Wellness, the Veterans of Foreign Wars, the Veterans Benefits Administration, the American Legion, VA Maine Healthcare System, Maine Vet Centers, the Maine Center for Disease Control, and the Maine Army National Guard Behavioral Health and Suicide Prevention Team.

As part of its mission, the taskforce created two brochures—*Firearms & Medications Safety* and *Gun Safety & Your Health*—which have been distributed statewide.[1] The brochures included information on the creation and use of veteran safety plans and useful tools to ensure crises are handled respectfully and inclusively by all involved. The task force also worked with law enforcement (local police departments and sheriff's departments) and from 2020 to 2025 distributed 3,925 gunlocks statewide. In 2020, the task force became the foundation for Maine's entry into SAMHSA Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families (Governor's Challenges).[2]

The US Department of Veterans Affairs (VA) awarded the Maine team two $750,000 Staff Sergeant Parker Gordon Fox Suicide Prevention Grants. Using those grant funds, Maine has created a suicide-prevention program specifically geared toward veterans, especially those not connected to the VA for their health care. Maine's SSG Fox program includes outreach at primary care offices to identify veterans (especially those at risk of suicide) and to provide baseline mental health screenings, education on suicide risk and prevention, connection to clinical services for emergency treatment, and case management services. This grant program relies on a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts.

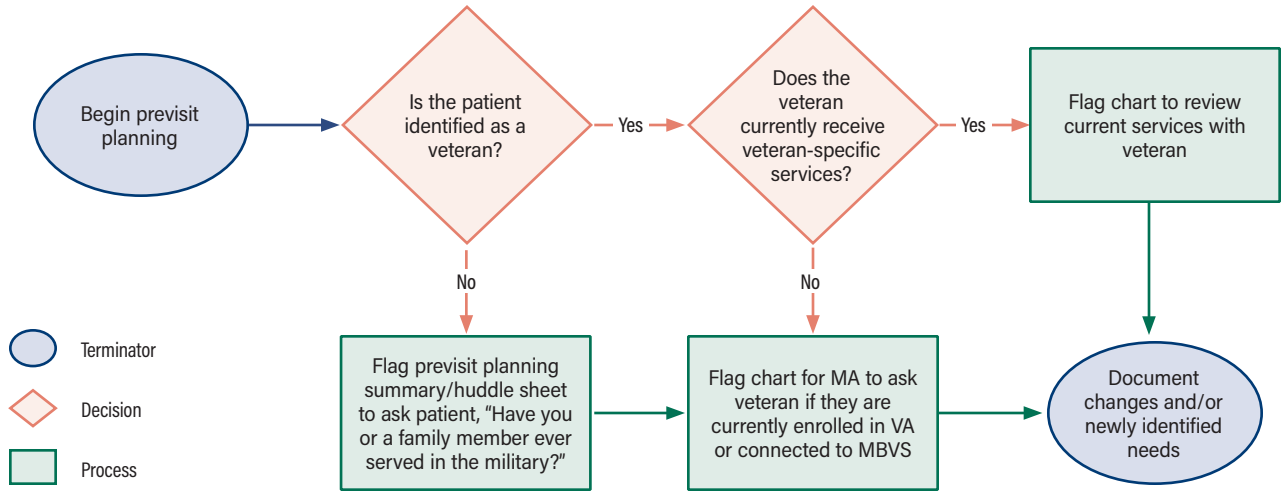
Recognizing that not all veterans receive health care from the VA, MBVS asked the Maine Medical Association–Center for Quality Improvement to educate primary care practitioners about the importance of asking patients whether they ever served in the US military. Healthcare providers were given training (in person or via webinar) and a comprehensive veteran suicide-prevention toolkit, complete with step-by-step workflows and scripts to guide primary care practices through the process of identifying veterans, assessing them for suicide risk, and connecting them to the appropriate community-based case management services (Figure 1).[3]

Those who identify as having served in the military will be screened for suicide risk and then referred to Health Affiliates Maine (contracted partner providing therapy and case management) in connection with the SSG Fox program. Additionally, healthcare providers refer veterans to the MBVS and the VA if they are not connected to benefits or require other assistance.

The second component of Maine's Governor's Challenges work was the creation of Veterans and Community Connections Expos, which began in the fall of 2022 (Table 1). The expos are part of an organized effort to increase veterans' access to the state and federal earned benefits and to raise awareness about veterans' community organizations and the programs they offer. Over the last three years, most four-hour-long expos have served between 300 and 600 veterans, depending on location. Expos also are the perfect opportunity to provide safe storage options, and to date 11-gun safes have been given away at the events.

The VA and SAMHSA's Governor's Challenges program have recognized Maine's two programs—the outreach to primary care practitioners and community expos—as best practices and have shared information about the programs with other states across the country. As a sign of the expos' usefulness, Executive Director of the Togus Regional

FIGURE 1: **Example Workflows for Step 1—Previsit Planning to Identify Veterans**



Notes: VA = VA Maine Healthcare System; MBVS = Maine Bureau of Veteran Services

Office Jennifer Bover noted that benefits to Maine veterans have increased by more than $29 million since 2022 including compensation, pension, dependency and indemnity compensation, and survivor's pension.

STEPS TOWARDS THE SUICIDE MORTALITY REVIEW BOARD

In 2024, the VA awarded MBVS a $300,000 cooperative agreement to investigate creating a suicide mortality review board. If such a board were warranted, it would become a free-standing review board in the state and could collaborate with some of the already established boards where subject overlap was evident, such as the Child Death and Serious Injury Review Panel (1992); the Domestic Abuse Homicide Review Panel (1997); the Maine Elder Death Analysis Review Team (2003); the Maternal, Fetal, and Infant Mortality Review Panel (2005); the Maine Deadly Force Review Panel (2019); the Accidental Drug Overdose Review Panel (2021); and the Aging and Disability Mortality Review Panel (2021).[4]

TABLE 1: **Veterans and Community Connections Expos**

Date	Location of Expo	Town	County
09/24/2022	Cabela's	Scarborough	Cumberland
02/25/2023	Anah Shriners	Bangor	Penobscot
03/27/2023	Togus VAMC	Augusta	Kennebec
06/28/2023	Penobscot Nation Boat Landing	Indian Island	Penobscot
07/14/2023	Cary Medical Center	Caribou	Aroostook
08/03/2023	Rumford CBOC	Rumford	Oxford
09/27/2023	Hardwicke's Country Store	Calais	Washington
11/11/2023	Cabela's	Scarborough	Cumberland
02/04/2024	Pineland VAST	New Gloucester	Cumberland
04/26/2024	Holiday Inn	Bangor	Penobscot
06/07–09/2024	Spuds Speedway	Caribou	Aroostook
09/14/2024	Acadia National Cemetery	Jonesboro	Washington
11/03/2024	Cabela's	Scarborough	Cumberland
01/11/2025	University of Maine	Orono	Penobscot
03/31/2025	Skowhegan Fairgrounds	Skowhegan	Somerset

*Chart courtesy of the Togus VA Regional Benefits Office.

A suicide mortality review board is designed to bring multidisciplinary organizations together to discuss risk factors and circumstances surrounding death by suicide and to recommend local prevention strategies. For Maine, it was a natural progression from the Governor's Challenges work to form a suicide mortality committee, comprised of multiple strategic

partnerships, to achieve the goals of the VA's cooperative agreement. Partners in the work include the Maine Center for Disease Control, the Department of Health and Human Services, the VA, the Office of Chief Medical Examiner (OCME), community organizations, and licensed clinical social workers familiar with suicide-prevention programs. Because of these partnerships, Maine's suicide mortality committee is well rounded and knowledgeable in all aspects of suicide prevention, suicide completion, and services to family members and friends following a suicide.

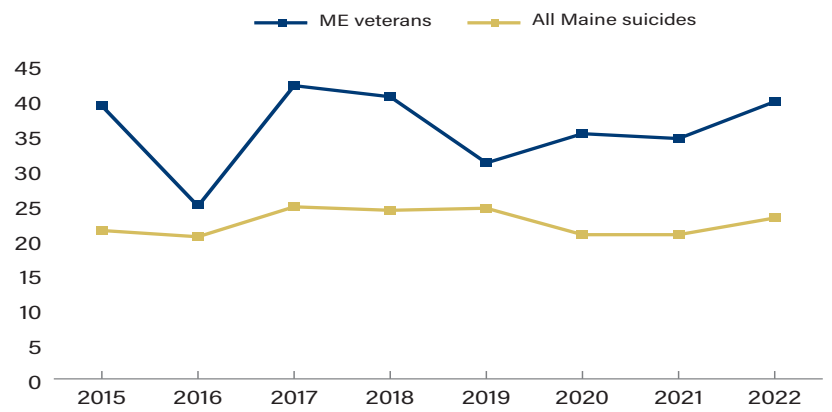
The committee is acting in an advisory capacity to explore the creation of a Suicide Mortality Review Board in Maine, with the goal that the committee's research will lead to legislation that creates an independent board. According to Kiley Wilkens-O'Brien (team leader for Maine's Suicide Mortality Review Committee),

> the ultimate goal of this project is to implement effective public health interventions that account for the unique geographies, cultural contexts, and social drivers of health within Maine. By examining these losses of life, we can highlight life-threatening conditions in communities and identify where current systems of care have knowledge and/or resource gaps. Armed with this information, we can work to develop a more comprehensive, community-based strategy to prevent future suicide deaths. Every Mainer's life matters. We should be curious to learn what factors have led our neighbors to meet this end." (Wilkens-O'Brien, personal communication)

Maine's Suicide Mortality Review Board will support the development, expansion, and maintenance of suicide mortality reviews and committees and will promote safety training, education, and community outreach with an emphasis on veterans and Indigenous communities in Maine. MBVS is invested in such work because of Maine's comparably high veteran suicide rate (Figure 2). According to the report *Characteristics of Completed Suicides Among Maine Residents Who Served in the Military, 2015 to 2021,* by Jamie Wren and Marcella Sorg (2024: 1),

> between 2015 and 2021, 1,728 Mainers died by suicide. Of these, 337 had a history of military service. Among Maine residents who died by suicide from 2015 to 2021, 1 in 5 had a history of military service. Individuals with a history of military service were more likely to be male, older, have a high school education, be married or widowed, die by firearm, die in their residence, experience a physical health problem, be diagnosed with post-traumatic stress disorder, and have experienced a non-suicide death of a family member or friend that contributed to their death.

FIGURE 2: **All Maine Suicides vs Maine Veteran Suicide Rate, 2015–2022**



Note: Rate per 100,000 people.
Source: Adapted from Wren and Sorg (2024).

FUTURE DIRECTION AND POLICY RECOMMENDATIONS

Maine has a centralized, statewide chief medical examiner system that investigates unattended deaths across the state, as part of the Maine Office of Attorney General. The Maine OCME investigates approximately 3,500 deaths annually and has two full-time board-certified forensic pathologists and one per diem board-certified forensic pathologist. The OCME currently participates in many fatality review panels, such as the Domestic Violence Homicide Review Panel, the Child Serious Injury and Fatality Review Panel, the Overdose Review Panel, and the Maternal and Fetal Mortality Review Panel.

The OCME also actively participates in mortality surveillance projects for the federal Centers of Disease Control and Prevention (CDC). Since 2014, Maine has participated in the National Violent Death Reporting System, which conducts surveillance on all homicides, suicides, deaths of undetermined intent, and accidental firearm fatalities that occur within the state. Maine was also an inaugural member of the CDC's State Unintentional Drug Overdose Reporting System, which collects data, including veteran status, on all unintentional fatal overdoses.

The MBVS continues to build its relationships with the OCME and with Jamie Wren, the project director of the Maine Violent Death Reporting System

(MEVDRS), who works closely with MBVS on the SSG Parker Gordon Fox Veteran's Suicide Prevention program. According to Wren (personal communication), "Establishing a Suicide Mortality Review panel in Maine would enable exploration into areas of suicide loss not well understood and help to provide public health stakeholders with greater information that can be used to help prevent further suicide losses."

MBVS worked closely with the MEVDRS to identify populations disproportionately affected by suicide—including veterans and Wabanaki community members—for review by the suicide mortality review panel. MEVDRS collects over 600 variables related to a violent death, including victim demographics, cause and manner of death, and circumstances of the death reported by law enforcement and the OCME, as well as weapon information, including firearm access. Victim demographics include information on whether the victim ever served in the US military, as captured on the death certificate. The partnership with MEVDRS will provide MBVS access to quality, timely, and population-specific data on suicides in Maine.

From 2024 to 2025, Maine's Suicide Mortality Review Committee completed the following tasks:

- established and developed relationships with the Maine State Police and OCME and its death investigation system;
- identified populations of veterans and indigenous community members as its focus;
- explored existing suicide or death review efforts in the state of Maine;
- conducted appropriate landscape analyses to better understand existing needs, processes, and infrastructure to support the advancement of the first three bullet items;
- educated relevant organizations on the importance and impact of suicide mortality reviews to gain buy-in from key organizations in establishing the Suicide Mortality Review Committee;
- developed and document processes, procedures, and policies;
- conducted at least one community outreach and training;
- partnered with Maine's chief medical examiner, who signed a letter of support to form a committee for the cooperative agreement application; and
- worked with state government to ensure the committee has legal authority via a memorandum of understanding or legislative authority.

Maine's Suicide Mortality Review Committee has created partnerships with other organizations working to understand and mitigate the risks of suicide. The committee sought motivated partners who brought something critical to the table via their interests, influence, or assets. The committee codesigned a partnership model to ensure that key stakeholders work together, drawing on collective skills, assets, networks, programs, and knowledge, and ensured that they align their programs to work to decrease suicide risk across the state.

The Suicide Mortality Review Committee identified risk factors for, and protective factors against, suicide deaths that are unique to the state of Maine. The committee identified suicide deaths within the state, gathered data that can help spot common trends among cases, and reported the findings in a clear, accessible, and consistent manner. Based on these findings, the committee made recommendations on specific interventions intended to reduce the number of suicide deaths. The committee also analyzed datasets to answer specific questions about suicide, mental health, substance use, and epidemiological samples; aggregated datasets that permit analysis; and shared the newly combined dataset for research. Additionally, the committee leveraged its existing relationship with the MEVDRS to identify populations disproportionately affected by suicide, including veterans.

By using a variety of data sources and collection methods, Maine's Suicide Review Mortality Committee documented gaps in existing programs and identified existing services for suicide support (including suicide prevention, intervention, and postvention) in our state. The committee engaged the mental health community and suicide support organizations in identifying gaps through open communication and collaborative efforts. Moving forward, the committee needs to navigate changes in law or policy to establish the legal authority needed for the creation of a Suicide Review Mortality Board. The committee also developed an inventory of existing suicide-prevention programs including the Veterans Crisis Line, the Maine Crisis Line, the Kcitpahsuwet (Suicide Prevention Program), the Wabanaki Care Line at Wabanaki Public Health & Wellness, the Department of Health and Human Services' Maine Suicide Prevention Program and Resources, and NAMI Maine.[5]

Maine's Suicide Mortality Review Committee established and strengthened existing collaborations by setting clear goals and expectations, scheduled regular meetings, and engaged members in collaborative joint strategies. The committee shared results, success stories, and lessons learned to create a

successful suicide prevention model that can be used throughout the state of Maine and laid the foundation for the establishment of a Suicide Mortality Review Board.

NOTES

1 https://www.mainepreventionstore.com/collections/mental-health

2 SAMSHA stands for Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services. More information about the Governor's and Mayor's Challenges is available at https://www.samhsa.gov/technical-assistance/smvf/challenges

3 The toolkit is available at https://mainephysicians.org/programs/mma-center-for-quality-improvement/our-work/prevention/.

4 Recommendations from Maine's existing boards have led to policy and legal changes including LD 814—An Act Regarding Court Orders for Completion of a Batterers' Intervention Program in Domestic Violence Cases; changes to Maine law that increase accountability for those who commit abuse; increased resources for victims/survivors; expanded Adult Protective Services capacity, and permanent funding for the Elder Service Connections program.

5 Veterans Crisis Line (Dial 988 then Press 1 or Text 838255), the Maine Crisis Line (1-888-568-1112—Call, Text, Chat); the Kcitpahsuwet (Suicide Prevention Program) and the Wabanaki Care Line (1-844-844-2622) at Wabanaki Public Health & Wellness; Department of Health and Human Services—Maine Suicide Prevention Program and Resources, and NAMI Maine (800-464-5767).

REFERENCES

US VA (Department of Veterans Affairs). 2024. *Maine Veteran Suicide Data Sheet, 2022.* https://www.mentalhealth.va.gov/docs/datasheets/2022/2022_State_Data_Sheets_Maine_508.pdf.

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Sarah A. Sherman serves as the director of strategic partnerships for the Maine Bureau of Veterans' Services. She is the cofounder of the Maine Safer Homes Taskforce, Maine Justice Action Committee, colead of Maine's Governor's Challenge Team, and represents the Bureau on Maine's Suicide Mortality Review Committee. Currently, she is a nationally credentialed advocate, serves as the Department of Defense, Veterans and Emergency Management's tribal liaison, and is a member of the FBI's Maine Threat Assessment Group.