traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.[lxxx] In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality.

Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.[lxxxi]

Until recently, the CTSAB was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended consequences of assisted suicide legislation on people with disabilities. Peace (2012) writes that "Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live."[lxxxii] People with disabilities have a right to responsive suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.

Targeted Recommendations:

- Develop greater scrutiny of someone's intentions to die.
- Identify and train practitioners to develop expertise in the work with disabled people who are suicidal.
- Do not "assume" suicide is a "rational" response to disability.
- Treat mental health conditions as aggressively as with a person without disability.
- CTSAB should encourage and increase participation from the disability community and encourage educational presentations.

Charting the Future: Measuring Our Progress

The overarching goal of any suicide prevention plan is the elimination and reduction of suicide and suicide related behaviors. The PLAN 2020 includes targeted outcomes for 2020. All targets are derived from the analysis of current data. We are tracking one measure of suicide (deaths) and one measure of medically serious attempts (as measured by hospitalization for self-injury). Both measures can be tracked consistently and reliably annually and by demographic group. We have adopted a target of a 10% reduction by 2020, which is in alignment with the mental health goals of Healthy People 2020. Thus, the 2020 targets for the reduction of deaths by suicide is a reduction from the 2012 rate of 10.14 to a 2020 rate of 9.13. We have determined a target of a 10% reduction of hospitalizations for self-injury from 2014 to 2020.[10]

Summary and Conclusions

The impact of suicide and suicidal behaviors have far-reaching implications for individuals, their families, friends and communities. In 2012, more than an average of one person per day died by suicide in Connecticut and thousands more were left to mourn and carry on in the face of devastating loss. As staggering as these losses are, there is hope. Globally, the World Health Organization and in the U.S., the National Action Alliance for Suicide Prevention have pioneered comprehensive suicide prevention strategies

[10] See Appendix I for tables of current hospitalization data