Senate Bill 94 Public Health – Maryland Suicide Fatality Review Committee
Finance Committee
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Position: Favorable

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Chair
Governor's Commission on Suicide Prevention

My name is Eileen Zeller and after a career in public health and suicide prevention, I retired from the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018, where I was Lead Public Health Advisor in the Suicide Prevention Branch.

I am chair of the Governor's Commission on Suicide Prevention. The Commission is charged with reducing suicide through a number of strategic actions, including but not limited to (1) developing a comprehensive, coordinated, strategic plan and (2) recommending adequate resources to address suicide prevention, intervention and post-suicide services across the state for Maryland citizens.

SB 94 provides topline suicide data for Maryland, which I won't repeat. I just want to say that the Marylanders we lose every year to suicide are not just data points. Every one of the 657 Marylanders who died by suicide in 2019 was someone's child, parent, grandparent, friend, neighbor, student, teacher, and on and on.

Our job at the Commission is to look at the data and trends and make recommendations to reduce the number of future suicides. Our work and frankly our effectiveness is limited because we don't have the data and information we need. The Suicide Fatality Review Committee will give us that information.

We have very little information about Marylanders older than 18 who die by suicide, who make up approximately 97% of Maryland's suicides (637 people):

- Every unexpected death among youth up to age 17 must be reviewed by Child Fatality Review Teams (CFRTs). In 2019, child and adolescent suicide deaths represented 3% of Maryland's suicides.

  Note that some CFRTs have told us that they don't have local suicide experts, and although they feel they do a good job of reviewing many child suicides they are stymied when, for instance, they find no warning signs or red flags after a child's death. The fact that SB94 states the Suicide Fatality Review Committee "shall coordinate" with CFRTs means CFRTs can get assistance with these difficult cases.

- Deaths that are drug related, including suicides, can be reviewed by Overdose Fatality Review Teams (OFRTs). In 2019, 15.5% (99) of Maryland's suicides were by poisoning,

but because OFRTs can select the cases they review, they likely do not review each of those suicides.

I ask you to review Dr. Lanny Berman's written testimony, which goes into depth about how the Suicide Fatality Review Committee could provide critical data not currently available from CFRTs, OFRTs, or the Maryland Violent Death Reporting System.

The following are examples of States that have used data from Suicide Fatality Review Teams to develop suicide prevention strategies:

Oregon

- The Oregon Review Team discovered that several people had dropped off their pets at animal shelters before killing themselves. As a result, the state began training animal shelter staff, who have already intervened to prevent several suicides.

- Oregon also identified eviction as a major risk factor. As a result, law enforcement began adding crisis line information to the eviction paperwork. Also, a member of the mental health crisis response team (a licensed clinician) was sent to each eviction in the county. Within two years, they reduced eviction-related suicides from 30 to one.

New Hampshire

- The New Hampshire team learned that a significant number of adults who died by suicide had been treated in an emergency room (for a variety of reasons) within weeks of their discharge. As a result, nearly 100% of state emergency rooms now conduct universal screening for suicidality.

- The team discovered that among the 144 firearm suicides that occurred over a two-year period ending 6/30/09, nearly one in ten used guns that were purchased or rented within a week of the suicide (usually within hours). In fact, in the course of less than a week, three people (with no connection to each other) bought a firearm from the same store and killed themselves within hours of the purchase. As a result, a small group of firearm retailers, range owners, and mental health/public health practitioners met to explore whether there was a role for gun stores in preventing suicide. This evolved into the New Hampshire Gun Shop Project, which (13 years later) continues to work with gun stores/firing range owners about how to avoid selling or renting a firearm to a suicidal customer, and encourages those business owners to display and distribute suicide prevention materials tailored to their customers. At last count, 48% of New Hampshire gun shops were participating in the program and the project has spread to 20 other states.

Kentucky

- Kentucky found that 24 – 30% of adults who died by suicide had been treated in their state behavioral health system. As a result, they surveyed their community mental health center staff and state psychiatric hospital staff on their training in suicide assessment. They found that many behavioral health clinicians felt they lacked the skills (43%) and did not have the support necessary (33%) to effectively engage with and treat suicidal individuals. Kentucky has been

moving forward in improving suicide care in these systems by training public and private sector clinicians in assessing and managing suicide risk and implementing the Zero Suicide model of suicide care.

The data collected and analyzed by Suicide Fatality Review Committee can give us insight into intervention points where we can improve clinical and public health policy and practice to prevent suicide.

On behalf of the Governor's Commission on Suicide Prevention, I urge a favorable report on SB94.