**House Bill 48 Public Health – Maryland Suicide Fatality Review Committee**
**Health and Government Operations Committee**
**January 26, 2022**
**Support**

**Eileen Zeller, MPH**
**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 2017, where I was Lead Public Health Advisor in the Suicide Prevention Branch. I managed a team of public health professionals responsible for national grant programs including the National Suicide Prevention Lifeline, Suicide Prevention Resource Center, and Garrett Lee Smith State and Tribal Youth Suicide Prevention programs.

I am chair of the Governor's Commission on Suicide Prevention. We were happy to recently welcome Delegate Cullison as one of our newest Commissioners. Other members include (but are not limited to) representatives from Executive Branch departments; local health officers and substance use directors; organizations such as the Mental Health Association of Maryland (which I represent); people with lived experience (e.g., suicide attempt survivors, family members who have lost loved ones to suicide); and people representing different racial, cultural, and ethnic communities and other marginalized or high-risk groups.

Among its responsibilities, the Commission is charged with (1) developing a comprehensive, coordinated, strategic state plan and (2) recommending adequate resources to address suicide prevention, intervention and post-suicide services across the state.

Our work and our effectiveness are handicapped because we do not have the data and information we need.

We currently base our plan and recommendations on valuable, but broad data: numbers and rates of Marylanders who died by suicide broken down by demographics, jurisdiction, and the methods they used. We get a bit more context from the Maryland Violent Death Reporting System, such as toxicology results; whether someone had a mental or physical health problem; whether there were financial stressors; and whether they were a victim of intimate partner violence.

85% of Maryland's suicides are not reviewed by a state fatality review team. (Child Fatality Review Teams[i] [CFRT] are required to review every unexpected death among youth up to age 17. In 2019, youth suicide deaths represented 3% of Maryland's 657 suicides. Overdose Fatality Review Teams review deaths that are drug related, including suicides. In 2019, 12% of Maryland's suicides were overdoses.)

Here are examples of information we don't have:

- Who did the decedent have contact with in the weeks, days, and hours before their death?
- Which systems did they touch: Were they seen in an emergency room? Did they visit a primary care physician or any other health care professional? Did they see an attorney? Were they active in a faith community?
- How did the person use social media?
- What was their sexual orientation and their gender identity?
- Did they have a close family member in the Armed Forces? If they were a veteran, what was their deployment history?

We need these kinds of details to get a more complete picture—to look for points where we could have intervened and trends that allow us to tailor our recommendations and state plan so that they are responsive to the needs of Marylanders. The Suicide Fatality Review Committee would give us that information.

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 before killing themselves, several people had dropped off their pets at animal shelters. 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 eviction paperwork. In one county, a member of the mental health crisis response team (a licensed clinician) was sent to each eviction. 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 occurring 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 less than one 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 to 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 HB48.

Respectfully submitted,

Governor's Commission on Suicide Prevention
Eileen Zeller, Chair

[i] 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 HB48 states the Suicide Fatality Review Committee "shall coordinate" with CFRTs means CFRTs can get assistance with these difficult cases.