

Governor's Commission on Suicide Prevention

Maryland Suicide Prevention Plan 2022-2024

Executive Order 01.01.2018.26 D

Maryland Department of Health

January 2025

**Governor's Commission on Suicide Prevention
Maryland Suicide Prevention Plan
2022-2024**

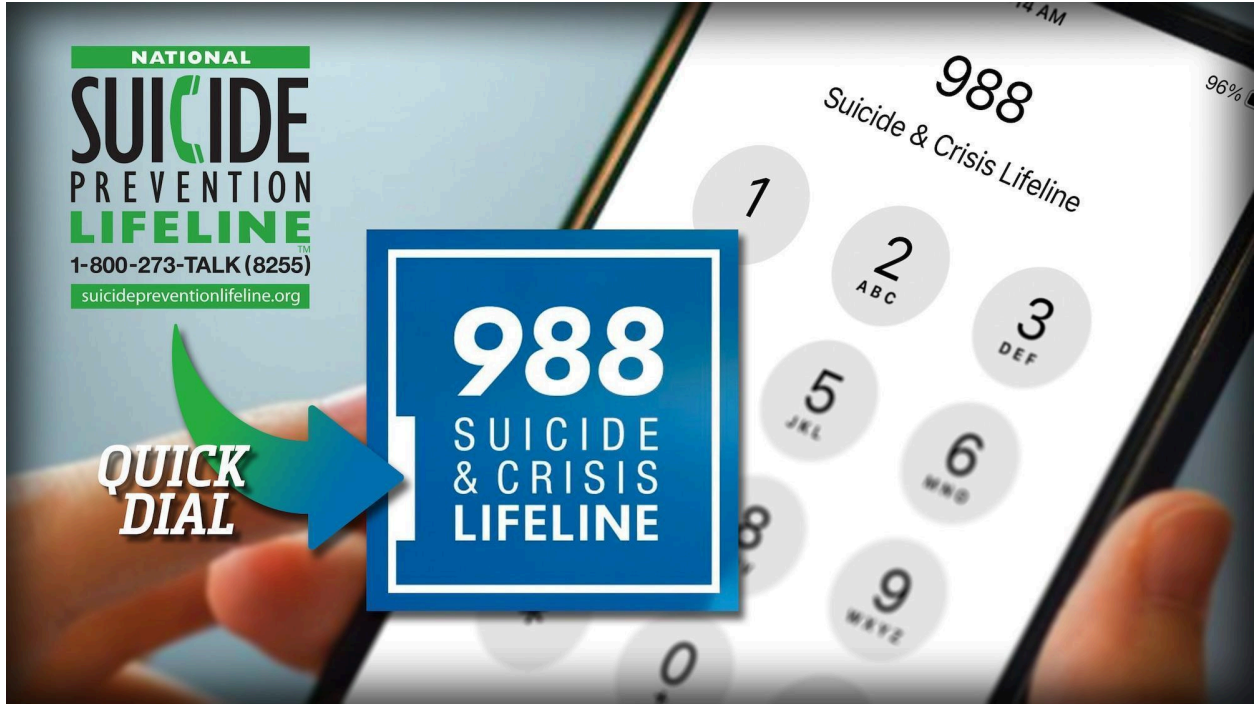


Table of Contents

Maryland Suicide Prevention Plan (2022 – 2024)	2
Executive Summary	2
Executive Summary: Suicide Prevention Plan Framework	3
Executive Summary: Method	4
Executive Summary: Goals	5
Executive Summary: Priority Goals	5
Introduction	7
Commitment to Behavioral Health Equity	9
Maryland Data Overview	11
Evolving and Emerging Trends	12
Impact of the Covid-19 Global Pandemic on Suicide	12
Increased Access to Firearms	13
Suicide Among Black Americans	14
Prevention Goals	15
GOAL 1. Promote and strengthen evidence-informed community strategies to prevent suicide across multiple sectors and settings.	15
Prevention Goals	17
GOAL 2. Address environmental, societal, systemic, and community factors that impact suicide, including reducing disparities in underserved populations.	17
Intervention Goals	18
GOAL 3. Promote and strengthen lethal means safety for at-risk individuals.	18
Intervention Goals	21
GOAL 4. Support the adoption of evidence-based care for suicide risk.	21
Intervention Goals	22
GOAL 5. Promote and strengthen crisis care and care transitions.	22
Postvention Goal	24
GOAL 6. Strengthen and promote care, support, and information to individuals, families, and communities affected by suicide attempts, crises, and deaths.	24
Surveillance Goal	28
Citations	30
Appendix	33
List of Commissioners	33

Maryland Suicide Prevention Plan (2022 – 2024)

Executive Summary

Suicide is a serious public health issue, both nationally and in Maryland. Between 2016 and 2020, Maryland lost 3,108 individuals to suicide. Each of these individuals represents a profound loss to families, friends, and communities. These Marylanders were members of every age group, race, ethnicity, and socio-economic background. Suicide was the second leading cause of death among 10 to 19-year-olds. Rates were highest for men, for people living in rural communities, and for people over age 80 and between ages 55–59. Firearm was the most common method of suicide (43%), followed by suffocation/hanging (31%), and poisoning (16%). Recent trends show alarming increases in suicide rates among Black youth ages 15 – 19 and 20 – 24 and in attempt rates among Black Marylanders of all ages.

With more attention being paid to mental health and suicide prevention than ever before; new research, evidence-informed health care and public health initiatives; and an equity focus on at-risk, underserved, and historically marginalized communities, there is growing optimism that we can significantly reduce suicide and bring hope and healing to those impacted by suicide, suicide crises, and suicidal thoughts.

Governor’s Commission on Suicide Prevention

The Governor’s Commission on Suicide Prevention (the Commission) was created in 2009 to strengthen and coordinate Maryland’s suicide prevention, intervention, and post-suicide services. The Commission is charged with developing a two-year plan that addresses Maryland’s (1) emerging needs; (2) priorities and strategies; (3) promising practices and programs; (4) recommendations for coordination and collaboration among State agencies; and (5) training, to inform the organization, delivery, and funding of suicide prevention, intervention, and post-suicide services. ([See previous Commission plans](#))

The Commission promotes comprehensive and coordinated programs designed to reduce the incidence of suicide and suicide attempts and to promote resilience, hope, and healing within impacted communities.

Executive Summary: Suicide Prevention Plan Framework

The Commission is charged with developing rather than implementing Maryland’s Suicide Prevention Plan. With 2022 being a year of rebuilding—new leadership in the state Office of Suicide Prevention and the Governor’s Commission on Suicide Prevention—the Commission devoted significant thought and discussion to building the following plan framework.

Vision Statement

Communities and systems across Maryland are committed to reducing and preventing suicides and suicidal behaviors, and have comprehensive, multi-faceted, coordinated, and well-funded programs and services that meet the needs and enhance the wellness of all of their residents.

Mission Statement

Develop a 2-year strategic plan for suicide prevention, intervention, and post-suicide/postvention practices, programs, and services that

- Is data driven and evidence-informed;
- Is informed by the voices of at-risk communities and historically marginalized communities;
- Aligns with other state and local jurisdictional behavioral health plans; and
- Provides a framework for identifying and implementing Maryland’s suicide prevention priorities.

Purpose of the Plan

To provide guidance (a road map) and leverage to Maryland’s executive branch, local jurisdictions, policy makers, and advocacy groups.

Primary Audiences

- Maryland Department of Health’s Behavioral Health Administration (BHA)
- Executive Branch, especially agencies represented on the Governor’s Commission
- Local jurisdictions (Core Service Agencies, Local Addictions Authorities, and Local Behavioral Health Authorities)
- Policy makers
- Advocacy groups

Executive Summary: Method

The Commission assessed state and local needs, gaps, strengths, challenges, and priorities by working with executive branch agencies; local jurisdictions (Maryland Association of Behavioral Health Authorities, Inc.—MABHA); commissioners and others representing at-risk population groups and historically marginalized communities; and people with lived experience, including those who lost family members and friends to suicide, who support loved ones through suicide crises, and who struggle with their own suicidal thoughts, attempts, and crises.

The Commission reviewed and monitored surveillance data at the State and national levels. We conducted literature reviews on evidence-based, evidence-informed, and promising practices, as well as practice-based evidence. We reviewed and worked with the authors of other state suicide-prevention related plans (Behavioral Health Advisory Council; Governor’s Challenge for Service Members, Veterans, and their Families).

Recognizing that health and behavioral health disparities are closely linked with social, economic, and/or environmental disadvantage, we devoted significant time to developing a Behavioral Equity Statement (see page 11) that articulated our commitment to addressing systemic and social determinants of health. Each of the Plan’s seven goals includes objectives and strategies to help reduce disparities and increase the likelihood that all Marylanders will have fair and equal access to evidence-informed, high-quality, culturally and linguistically proficient programs and services to reduce suicide attempts and deaths.

We developed goals, objectives, strategies, and priorities based on analysis of information gathered, as indicated by the following table.

Criteria for Goals, Objectives, and Priorities

	Data- and evidence-informed	Voices of lived experience, historically marginalized, and at-risk communities	Actionable / Implementable	High likelihood of making progress within the next 2 years	Comments
Goals	X	X			
Objectives	X	X	X		
¹Priorities	X	X	X	X	“,”

¹ High likelihood” may involve low-hanging fruit; existing initiatives, opportunities for funding, etc.

Executive Summary: Goals

Prevention Goals

- **GOAL 1.** Build and strengthen evidence-informed community strategies to prevent suicide across multiple sectors and settings.
- **GOAL 2.** Address environmental, societal, systemic, and community factors that impact suicide, including reducing disparities in underserved populations.

Intervention Goals

- **GOAL 3.** Promote and strengthen lethal means safety for at-risk individuals.
- **GOAL 4.** Support the adoption of evidence-based care for suicide risk.
- **GOAL 5.** Strengthen crisis care and care transitions.

Postvention Goal

- **GOAL 6.** Strengthen and promote care, support, and information to individuals, families, and communities affected by suicide attempts, crises, and deaths.

Surveillance Goal

- **GOAL 7.** Improve the quality, timeliness, and use of suicide-related data.

Executive Summary: Priority Goals

The Commission selected two priority goals for the 2022-2024 State Suicide Prevention Plan: **Goal 3 (Lethal Means Reduction)** and **Goal 6 (Postvention)** beginning with Objectives 6.1 and 6.2, and extending beyond those objectives when possible.

GOAL 3: Promote and strengthen lethal means safety for at-risk individuals.

Rationale: Evidence shows the effectiveness of interventions such as: the safe storage of firearms, medications, and other household products; providing lethal means counseling and safety devices to patients; and intervening at suicide hotspots (e.g., erecting barriers on bridges that attract suicidal jumpers). Additionally, leverage exists through Maryland's Commitment to Veterans (within the Maryland Department of Health's Behavioral Health Administration), which will be piloting a lethal means training program for primary care providers treating the military/veteran community.

GOAL 6: Strengthen and promote care, support, and information to individuals, families, and communities affected by suicide attempts, crises, and deaths.

- Objective 6.1 Develop and disseminate a state resource guide of evidence-informed and promising programs, services, and resources available in Maryland for

-
- individuals bereaved by suicide (“loss survivors”);
 - people who have survived a suicide attempt or crisis (“attempt survivors”); and
 - families and friends supporting individuals at risk for suicide.

Objective 6.2 Identify postvention needs and gaps in Maryland.

Rationale: Strong input from multiple, diverse Commissioners with lived experience led us to select Postvention as a priority. Although Commissioners represent varied agencies, organizations, and populations, many have lived experience losing family members and friends to suicide, supporting loved ones through suicide crises, and struggling with their own suicidal thoughts, attempts, and crises. Feeling isolated and dealing with intense pain, Commissioners were confronted with fragmented systems in which they bore the burden of figuring out what services and supports were available, where to find them, and how to access them. When programs and services were available, Commissioners found that they were not accessible, equitable, or culturally or linguistically appropriate. The Commission is determined to turn this situation around.

Introduction

Suicide is a serious public health problem nationally and in Maryland. Between 2016 and 2020, Maryland lost 3,108 individuals to suicide. Each of these individuals represents a profound loss to families, friends, and communities. They were members of every age group, race, ethnicity, and socio-economic background. Suicide was the second leading cause of death among 10 to 19-year-olds. Rates were highest for men, for people living in rural communities, and for people over age 80 and between ages 55–59. Firearm was the most common method of suicide (43%), followed by suffocation/hanging (31%), and poisoning (16%). Recent trends show alarming increases in suicide rates among Black youth ages 15 – 19 and 20 – 24 and in attempt rates among Black Marylanders of all ages.

With more attention being paid to mental health and suicide prevention than ever before, with new research, evidence-informed health care and public health initiatives, and an equity focus on at-risk, underserved, and historically marginalized communities, there is growing optimism that we can significantly reduce suicide while bringing hope and healing to those impacted by suicide, suicide crises, and suicidal thoughts.

Governor’s Commission on Suicide Prevention

Executive Order 01.01.2018.26 (Amended Executive Order 01.01.2009.13) was signed by Governor Larry Hogan on October 11, 2018 to modernize the Governor’s Commission on Suicide Prevention (the Commission). The Commission was created in 2009 to strengthen and coordinate Maryland’s suicide prevention, intervention, and postvention services. The amended executive order better aligned the Commission’s duties with changing times and expanded its membership to be more representative in age, profession, and life experience.

The Commission is charged with developing a two-year plan that addresses Maryland’s (1) emerging needs; (2) priorities and strategies; (3) promising practices and programs; (4) recommendations for coordination and collaboration among State agencies; and (5) training, to inform the organization, delivery, and funding of suicide prevention, intervention, and post-suicide services. (See previous Commission plans)

To ensure the best use of resources for the delivery of a continuum of services to prevent, intervene in, or recover from suicide, the Commission promotes a coordinated, collaborative and comprehensive effort by State and local agencies. In addition, the Commission identifies the impact of suicide on the health and well-being of Maryland citizens; assesses the economic and social costs of suicide; identifies necessary resources to provide suicide prevention, intervention and post-suicide services; and promotes a collaborative and efficient organization and delivery of services to those affected by suicide.

Suicide Prevention Plan Framework

It is important to note that the Commission is charged with developing, not implementing, Maryland’s Suicide Prevention Plan. With 2022 being a year of rebuilding—new leadership in the state Office of Suicide Prevention and the Governor’s Commission on Suicide

Prevention—the Commission devoted significant thought and discussion to building the following plan framework.

Vision Statement

Communities and systems across Maryland are committed to reducing and preventing suicides and suicidal behaviors, and have comprehensive, multi-faceted, coordinated, and well-funded programs and services that meet the needs and enhance the wellness of all of their residents.

Mission Statement

Develop a 2-year strategic plan for suicide prevention, intervention, and post-suicide/postvention practices, programs, and services that

- Is data driven and evidence-informed;
- Is informed by the voices of at-risk communities and historically marginalized communities;
- Aligns with other state and local jurisdictional behavioral health plans; and
- Provides a framework for identifying and implementing Maryland’s suicide prevention priorities.

Purpose of the Plan

To provide guidance (a road map) and leverage to Maryland’s executive branch, local jurisdictions, policy makers, and advocacy groups.

Primary Audiences

- Maryland Department of Health’s Behavioral Health Administration (BHA)
- Executive Branch, especially agencies represented on the Governor’s Commission
- Local jurisdictions (Core Service Agencies, Local Addictions Authorities, and Local Behavioral Health Authorities)
- Policy makers
- Advocacy groups

Method

The Commission

- Assessed needs, gaps, strengths, challenges, and priorities
 - a. Analyzed national, state, and jurisdictional data and literature, considering numbers, rates, trends, and emerging trends.
 - b. Gathered information about existing services and programs, needs, and gaps from
 - i. Local jurisdictions (Maryland Association of Behavioral Health Authorities, Inc.—MABHA)
 - ii. Executive branch agencies represented by commissioners
 - iii. At-risk population groups and historically marginalized communities represented by commissioners
 - iv. People with lived experience, including those who lost family members and friends to suicide, who support loved ones through suicide crises, and who struggle with their own suicidal thoughts, attempts, and crises

-
- c. Reviewed current plans and priorities, collaborating with the Behavioral Health Advisory Council; Governor’s Challenge for Service Members, Veterans, and their Families; and local jurisdictions (MABHA).
 - d. Reviewed literature for evidence-based, evidence-informed, and promising practices, as well as practice-based evidence.
 - Developed goals, objectives, strategies, and priorities based on analysis of information gathered, as indicated by the following table.

Commitment to Behavioral Health Equity

Behavioral health equity is the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.^[1]

The Governor’s Commission on Suicide Prevention is fully committed to promoting behavioral health equity and to advancing programs, practices, and policies that ensure everyone has a fair and just opportunity to be as healthy as possible.

We recognize that health and behavioral health disparities are closely linked with social, economic, and/or environmental disadvantage. Health inequities are endemic—in some cases codified into law—and continue to affect groups who have systematically and historically experienced greater obstacles to health based on race; ethnicity; gender; socioeconomic status; geographic location; sexual orientation or gender identity; religion; age; immigration or refugee status; language; cognitive, sensory, or physical disability; having survived a suicide attempt, crisis, or loss; and other characteristics historically linked to institutional discrimination and exclusion.^[2] We refer to these groups as “historically marginalized.”

We embrace our duty not only to promote access to evidence-informed, high-quality, culturally and linguistically proficient programs and services; but also to address social determinants of health such as economic instability, social exclusion, inequities in health care access and quality, unemployment, adverse childhood experiences, and food and housing insecurity.^[3]

Equity is particularly critical in Maryland because according to the 2020 U.S. Census, **Maryland is the most racially diverse state on the East Coast**, with the largest increase driven by growth among its smaller racial and ethnic groups, specifically Asian, Hispanic, and multi-racial. No group is internally homogeneous; there are wide variations among and within urban, suburban, and rural communities. A few examples of how these disparities manifest within the field of suicide prevention:

A few examples of how these disparities manifest within the field of suicide prevention:

- We have limited data on what treatments are most effective for many historically marginalized groups. Suicide prevention research has historically focused on educated, insured/employed, white populations; individuals from underserved, racial, ethnic, and other marginalized communities are underrepresented. This has resulted in methodologic

scientific bias, with minimal information about the impact of different treatments on diverse populations and cultures. Individuals from underserved, racial, ethnic, and other marginalized communities—who may be more likely to conduct research with marginalized populations and use culturally-informed and appropriate methodology (e.g., participatory research models)—are also underrepresented as research scientists.

- We have neither accurate data, nor established systems to gather those data, on who attempts and/or dies by suicide within historically marginalized and at-risk groups. Death certificates often misidentify the race and ethnicity of people of color, especially Native Americans and other non-White groups. Veteran status is also often inaccurate. Although the literature reveals that LGBTQ+ people disproportionately attempt suicide and report suicidal ideation compared to cisgender people, it remains unclear whether they are at higher risk for suicide because gender identity and sexual orientation are not systematically captured in death investigations.
- Aggregation of data for smaller demographic groups can also contribute to inaccurate conclusions, such as when Asian and Pacific Islander people are combined into a single “Asian” category instead of classification into culturally and linguistically appropriate groups, or when people of migrant origin are not further classified by legal migration status. (Note that legal migration status impacts people’s ability to access health care and other services.)
- Historically marginalized groups have greater barriers in accessing mental health providers, magnified by the limited number of providers who are culturally or linguistically proficient. Racially/ethnically diverse communities, immigrant and refugee communities, and rural communities all tend to be underserved. In 2020, 84% of U.S. psychologists were White^[4] and in 2016, only 10% of psychiatrists were Black, Latino, or Native American.^[5]
- Research shows that suicide rates increase during “economic recessions marked by high unemployment rates, job losses, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old. ...[t]he available evidence suggests that strengthening economic supports may be one opportunity to buffer suicide risk.”^[6]

How is equity operationalized in the 2022 - 2024 Maryland Suicide Prevention Plan?

Equity is a cross-cutting theme within the Plan, with a focus on increasing access to resources and one entire goal, Goal 2, devoted to larger, systemic issues. Each of the seven goals includes objectives and strategies to help reduce disparities and increase the likelihood that all Marylanders will have fair and equal access to evidence-informed, high-quality, culturally and linguistically proficient programs and services to reduce suicide attempts and deaths. Because every individual, family, and community in Maryland deserves the same fair and equitable access to, and experience with, life-saving services.

Maryland Data Overview

- **585 Marylanders died by suicide in 2020.**^[28]
- The suicide rate was **9.2 per 100,000** in 2020, an **11% decrease from 2019.**^[29]
- In 2020, MD had a suicide attempt rate of **407 per 100,000** (400 males per 100,000 and 431 females per 100,000; 460 White Marylanders per 100,000 and 477 Black Marylanders per 100,000).^[30]
- Almost four times as many Marylanders died by suicide in 2019 than in alcohol-related motor vehicle accidents.^[31]
- Approximately 1 in 9 individuals (11.6%) who died by suicide had a reported **physical health problem**, 2016–2020.^[31]
- Approximately **1 in 7** individuals (14%) who died by suicide had a reported **job and/or financial problem.**^[31]
- **1 in 5** individuals (19.4%) who died by suicide had a reported **intimate partner issue**, 2016–2020.^[31]
- **1 in 5** adults (20.1%) from 2016-2020, **disclosed suicide intent** to a friend or peer. ^[31]

Demographics

- In 2020, the age adjusted suicide rate was higher in **males** (15.6 per 100,000 for males and 3.5 per 100,000 for females).^[29]
- Suicide rates were **highest** among:
 - **Males** (15.6 per 100,000 to 3.5 per 100,000 female), 2020. ^[29]
 - **White Marylanders**, 2016–2020.^[29]
 - Individuals aged **80-84, 85+**, and **55–59**, 2016–2020.^[29]
 - Adults **25-29** and **80-84**, 2020. ^[29]
 - **Rural** counties, 2016–2020.^[29]
 - **Construction industry** workers, 2003-2019. ^[35]

Circumstances of Suicide Deaths

- **Firearm** was the **most commonly used method** of suicide in 2020 with 267 firearm suicides (46% of all suicides).^[34]
- Nearly **1 in 5** individuals (18.3%) who died by suicide had a **previous suicide attempt**, 2016–2020.^[31]
- **Prescription medications** were the **most common type of substances** that contributed to death among poisoning suicides, 2016–2020.^[31]
- Among suicide deaths involving toxicology testing, **alcohol was present in 1 in 3 individuals** (33.8%), 2016–2020.^[31]
- Approximately 1 in 5 individuals (21.2%) who died by suicide had a reported **alcohol issue that contributed to suicide**, 2016–2020.^[31]

Suicide among Veterans^[32]

- Veterans accounted for almost **1 in every 6** suicide deaths of Marylanders aged 18 and older, 2019.
- The most suicides occurred in veterans **80 years and older**.
- In 2019, 97% of suicide deaths among Maryland veterans were **men**.
- The majority of suicides by veterans were by **firearm** (63%).

Suicidal Behaviors by Youth

- **178 adolescents** (ages 10–19) **died by suicide**, 2016–2020.^[31]
- Suicide was the **second leading cause of death** among 10- to 19-year-olds, 2016–2020.^[31]
- **Females** ages 18–24 had the highest rates of **emergency department visits and hospitalization** stays with self-harm injuries, 2016–2021.^[30]
- **Black** youth had a **higher suicide rate** than white youth aged 15-19 (**8.95** per 100,000 vs. **6.27** per 100,000, respectively) and 20–24 (**12.01** per 100,000 vs **9.27** per 100,000), 2020.^[31]
- **1 in 6** (18.0%) high school students and **1 in 5** (22.9%) middle school students **seriously considered suicide** in the last year, 2021.^[33]
- **1 in 6** (16.2%) high school students and **1 in 7** (14.3%) middle school students **made a plan to attempt suicide**, 2021.^[33]

- **1 in 11** (8.8%) middle school students reported **attempting suicide**, 2021.^[33]
- **1 in 5** adolescents (age 10-19) (18.2%) **disclosed suicide intent** to a friend or peer, 2016-2020.^[33]
- Adolescents who died by suicide were more likely to have a reported **family problems** compared with adults (13.3% versus 3.4%), 2016–2020.^[33]

Evolving and Emerging Trends

Impact of the Covid-19 Global Pandemic on Suicide

Dr. Joshua Gordon, Director of the National Institute of Mental Health, recently wrote:

Over the last few years, people have been concerned about the pandemic's impact on suicide rates. So far, data suggest that the overall suicide rate in the U.S. has remained steady. But there is concerning evidence that the pandemic has disproportionately affected suicide risk in historically underserved communities. For example, data suggest that people in minority racial and ethnic groups experienced greater increases in suicidal thoughts during the pandemic.^[1] Additional data indicate that suicide rates may be rising among some young adult racial and ethnic minority groups.^[2]

The pandemic exacerbated many population-level risk factors for suicide. These include a lack of social connectedness (brought on by rapid changes in social structure, economic turmoil, and social isolation),^[3] ready access to lethal means, and poor access to mental health care.

Research on past disasters and epidemics shows an increase in self-reported behavioral health symptoms, but the impact on suicide rates is generally not seen in the immediate aftermath of these events. One exception is the increase in suicide rates in Hong Kong following the SARS outbreak, with a particularly high rate among people 65+, one of the most vulnerable groups.^[4]

As noted by Dr. Gordon, emerging data, and media accounts, the pandemic disproportionately impacted vulnerable and historically underserved populations. In Maryland, it became clear early in the pandemic that Black people were among the hardest hit. During the first lockdown, Black suicides nearly doubled relative to historic norms, while White suicide numbers decreased significantly.^[5]

Adolescents, especially Black, Hispanic, those who identify as Other/Multiple race, and LGBTQ+ teens, are also acutely impacted by the pandemic. The Maryland Department of Health conducted an online survey of high school students between May and June 2021.^[6] Results showed:

- Approximately 1 in 5 Maryland teens had seriously considered attempting suicide the past year.
- 44% of students listed as Other/Multiple races seriously considered attempting suicide in the past year; 37% Black or African American students; 12% White students; 14% Hispanic students. Asian students were significantly less likely the past year to consider suicide (6%)
- LGBTQ+ students were significantly more likely to consider suicide (57%) as compared to cisgender students (15%).

Nationally, the proportion of mental health-related emergency department visits among 12 to 17-year-olds increased by 31% from 2019 to 2020. Suspected suicide attempts for girls rose by 50.6% and for boys rose by 3.7%.^[7]

Increased Access to Firearms

Firearms are the most common method of suicide in the United States and in every state, including Maryland.^[8] Even one unsecured firearm elevates suicide risk, not only for the firearm purchaser or owner, but also for all members of the household.^[9]

Since the beginning of the pandemic in early March 2020, demand for firearms in Maryland has skyrocketed. According to the FBI National Instant Criminal Background Check System (NICS), firearm background checks in Maryland have almost doubled when compared to the previous five years and have remained elevated (see Figure 1).^[10] Data from NICS background checks are the nationally accepted metric for monitoring firearm purchases, although they are not a one-to-one indicator; multiple firearms can be purchased with a single background check.

National studies indicate that between 10% to 34% of firearm purchasers since March 2020 are likely first-time firearm purchasers, increasing the risk of unsafe storage practices and exposing new households to firearms.^{[11],[12]} Results of a study conducted in New Jersey, Minnesota, and Mississippi indicated that “surge purchasers” (first-time gun buyers between 2020-2021) were more likely than non-gun owners and established gun owners to report life-time and past-year suicidal ideation.^[13] Even more worrisome in the context of suicide risk, national surveys reported that among these new surge purchasers, 33% had a household member with a mood disorder, 11% had a household member with diagnosed dementia, and 38% reported that their mental health had gotten a little or a lot worse in the past month.^[14]

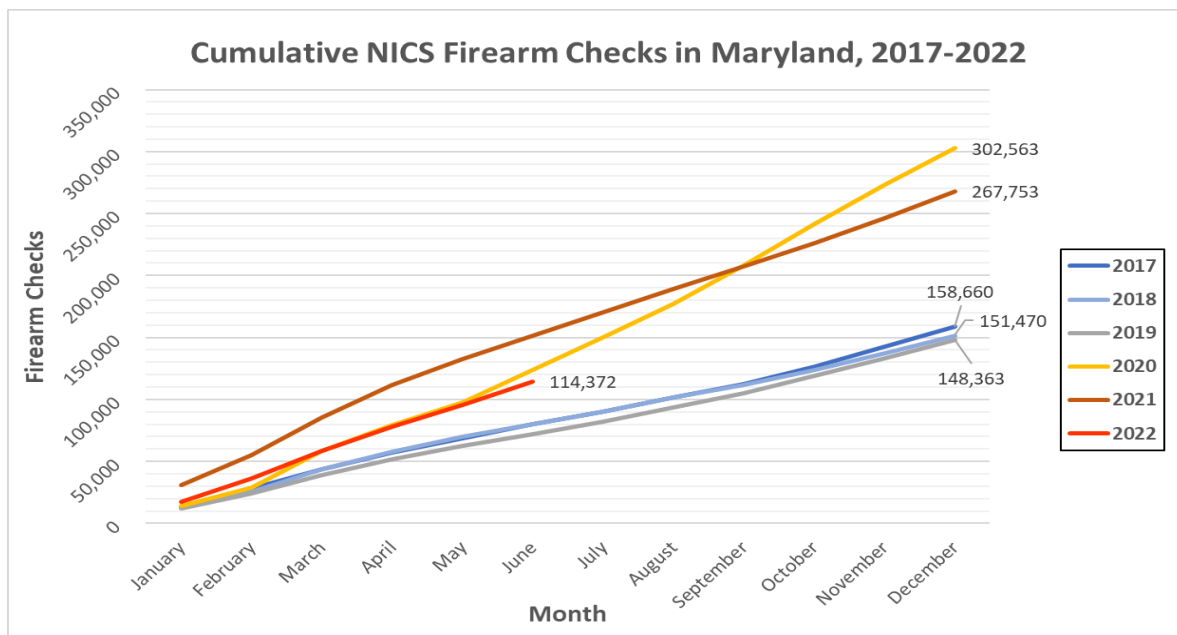


Figure 1. Cumulative NICS Firearm Checks in Maryland, 2017-2022.

Suicide Among Black Americans

In 2019, the Congressional Black Caucus’s Emergency Task Force on Black Youth Suicide and Mental Health studied a disturbing trend reported in the literature: although the suicide rates among children ages 5–19 remained stable across the country over two decades, the rate for Black youth—especially Black boys—increased significantly while it decreased significantly for white youth.^[15] This is in contrast to the fact that historically the suicide rate among Black Americans has been lower than that of white individuals across all age groups. These were the first national studies to observe higher suicide rates among U.S. black individuals compared to white individuals. It is important to note that although the overall numbers of children who die by suicide is very low (averaging 33 deaths annually), this 20-year trend is alarming. The Congressional Task Force Report examined causes and solutions for Black youth suicide and mental health needs and produced practice and policy recommendations.

“In youth ages 10 to 19 years, suicide is the second leading cause of death, and in 2017, over 3,000 youth died by suicide in this age group. Over the past decade, increases in the suicide death rate for Black youth have seen the rate rising from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017. Black youth under 13 years are twice as likely to die by suicide and when comparing by sex, Black males, 5–11 years, are more likely to die by suicide compared to their White peers. Finally, the suicide death rate among Black youth has been found to be increasing faster than any other racial/ethnic group. Although Black youth have historically not been considered at high risk for suicide or suicidal behaviors, current trends suggest the contrary.”^[16]

Trends in suicide-related ED and hospital visits in Maryland from 2012 to the end of 2020 show a gradual increase in inpatient care encounters involving suicide ideation and attempt among Black Marylanders, regardless of age (unpublished data from the Maryland Suicide Data Warehouse). In addition, Bray and colleagues^[17] found suicide mortality appeared to double among Black Marylanders during the first three months of the pandemic as compared with the means in 2017 to 2019. In contrast, suicide rates among White Marylanders nearly halved compared with the means of 2017 to 2019.

Prevention Goals

GOAL 1. Promote and strengthen evidence-informed community strategies to prevent suicide across multiple sectors and settings.

Background

Suicide is a complex behavior that rarely has a single cause. It is influenced over time by relationships, by the communities in which individuals live, and by broader environmental, societal, and systemic factors.

Evidence-informed clinical treatment and interventions are effective. Additionally, research tells us that a range of protective factors, such as family and community support, connectedness, and access to high-quality mental health care can reduce the risk of suicidal thoughts and behaviors. Preventing suicide requires a comprehensive approach that combines multiple, integrated strategies within healthcare systems and the community. No single entity can do this alone.

The Maryland Department of Health Behavioral Health Administration, which houses the Office of Suicide Prevention, is well-positioned to facilitate this comprehensive approach through state-level interagency collaboration, working with local jurisdictions, leveraging existing programs, identifying funding opportunities, and launching state-wide initiatives.

Objective 1.1: Promote and strengthen the delivery of evidence-informed suicide prevention programs provided by state and local agencies.

Strategy 1.1a: Collaborate with state agencies to identify and strengthen their programs and protocols that reduce suicide risk and strengthen protective factors, including among high-risk and historically marginalized populations.

- Given the impact of the pandemic on youth mental health, this should include (but not be limited to) working with the Maryland State Department of Education to facilitate:
 - Suicide prevention consultation and training services for school-based professionals.
 - Evidence-informed comprehensive suicide prevention programming^{[1],[2]} in all middle and high schools, beginning with protocols for (1) helping students at risk of suicide and (2) responding to a suicide death.
 - Implementation of evidence-informed mental health training for students, such as social-emotional learning programs, which teach coping and problem-solving skills^[3] and peer norm programs, which can increase referrals of suicidal friends to adults.^[4]
- **Strategy 1.1b:** Connect with the Association of Independent Maryland Schools and other stakeholders to explore interest in pursuing suicide prevention training and programming for staff and students outside of the Maryland public school system.
- **Strategy 1.1c:** Work with local jurisdictions to assess and address current strengths, needs, and gaps in suicide prevention programming, including among high-risk and historically marginalized populations.

-
- Identify sources for sustainable funding and provide incentives for local jurisdictions to employ suicide prevention coordinators that enable them to implement their suicide prevention plans.
 - Provide incentives and resources for local jurisdictions to address the needs of high-risk and historically marginalized groups.
 - **Strategy 1.1d:** Facilitate collaborations that leverage state, regional, and local suicide prevention programming, including those serving high-risk and historically marginalized populations.

Objective 1.2: Increase knowledge of suicide warning signs and resources, what to say to someone who is suicidal, and how to connect them with care.

- **Strategy 1.2a:** Promote suicide prevention and mental health awareness training (e.g., Question Persuade Refer- “QPR”: [QPR Institute](#); [Talk Saves Lives](#), [safeTALK](#); [Applied Suicide Intervention Skills Training \(ASIST\)](#); [Mental Health First Aid “MHFA”](#) and [Youth - Mental Health First Aid](#)).
- **Strategy 1.2b:** Promote statewide suicide prevention resources, such as from the Governor’s Challenge to Prevent Suicide among Service Members, Veterans, and their Families ([Governor’s Challenge Communications Toolkit](#)), 988, etc.

Objective 1.3: Promote workplace mental health and suicide prevention awareness.

- **Strategy 1.3a:** Collaborate with Maryland’s construction industry to increase awareness of and involvement with the [Construction Financial Management Association](#) and [Construction Industry Alliance for Suicide Prevention](#) [Construction Industry Alliance for Suicide](#). (Note that between 2003-2019, Maryland’s construction industry had significantly higher numbers and rates of suicide than any other industry.^[51])
- **Strategy 1.3b:** Encourage the use of materials and programs developed through the [2022 partnership between American Foundation for Suicide Prevention and the Occupational Safety and Health Administration](#), to foster workplace mental health and suicide prevention awareness “by developing information and products in multiple languages that reflect diversity in the workforce and encourage workers’ sense of belonging.”

Objective 1.4: Leverage existing resources (e.g., [FaithHopeLife](#), [Soul Shop](#)) to facilitate development of a statewide initiative to equip faith leaders from diverse creeds and cultures with the tools they need to prevent suicide and provide care, comfort, and resources for those affected by suicide.

Objective 1.5: Encourage safe and responsible media reporting by promoting the free online course [Responsible Reporting on Suicide for Journalists](#) and distributing [Best Practices and Recommendations for Reporting on Suicide](#).

Prevention Goals

GOAL 2. Address environmental, societal, systemic, and community factors that impact suicide, including reducing disparities in underserved populations.

Background

Per the Commitment to Behavioral Health Equity, the Governor’s Commission is fully committed to promoting behavioral health equity and to advancing programs, practices, and policies that ensure everyone has a fair and just opportunity to be as healthy as possible. We embraced our duty to not only promote access to evidence-informed, high-quality, culturally and linguistically proficient programs and services, but also to address systemic and social determinants of health.

Each of the goals in this plan includes objectives and strategies to help reduce disparities and increase the likelihood that all Marylanders will have fair and equal access to opportunities, programs, and services to reduce suicide attempts and deaths.

However, Goal 2 addresses larger systemic issues, which are more complex, longer-range, and more resource-intensive than most goals and objectives in the Plan. Preventing suicide requires combining multiple, integrated strategies at the policy, healthcare, and community levels, and—as previously stated—no one entity can do it alone.

Objective 2.1: Provide Medicaid recipients with equitable access to evidence-based, outcome-driven primary care services that effectively integrate behavioral health and primary care services.

Objective 2.2: Address higher demands for community mental health and substance use care by leveraging federal funding opportunities to strengthen the capacity of Maryland’s community behavioral health service network.

Objective 2.3: Strengthen the workforce so that it meets the behavioral health needs of Maryland’s diverse populations, including in the state’s 63 federally designated mental health professional shortage areas (including 16 entire counties).

- Strategy 2.3a: Implement strategies to attract, adequately compensate, and retain behavioral health workforce, including tuition, loan, and retention incentives.
- Strategy 2.3b: Review and consider implementing the future recommendations of the newly established Workgroup on Black, Latino, Asian American Pacific Islander, and Other Underrepresented Behavioral Health Professionals.

Objective 2.4: Advocate for the establishment of a more fair and equitable Maryland Medicaid reimbursement rate for the services of community health workers, peer to peer providers, and family navigators.

Objective 2.5: Facilitate updates to the Maryland Department of Health and Behavioral Health Administration’s web pages, especially 988 pages, to be more welcoming to diverse populations, including people who do not speak English.

Objective 2.6: Expand the capacity to develop all Behavioral Health Administration and Office of Suicide Prevention materials in multiple languages.

Intervention Goals

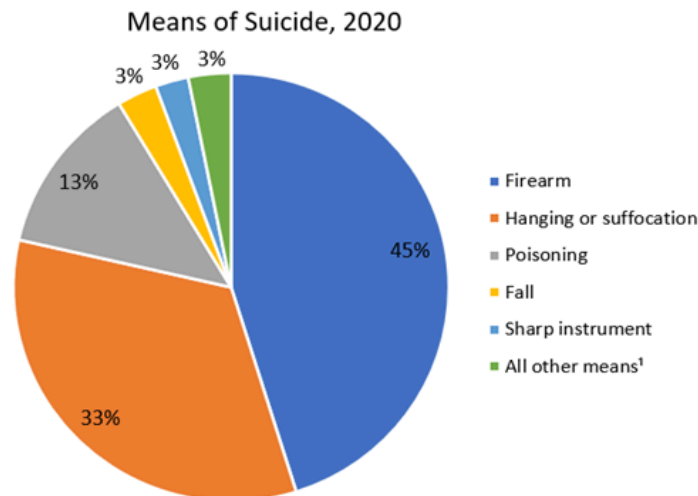
GOAL 3. Promote and strengthen lethal means safety for at-risk individuals.

The Governor’s Commission on Suicide Prevention has identified Goal 3, as one of its two Priority Goals through 2024.

Background

People who die by suicide are diverse, but all have one thing in common: the use of lethal means. In Maryland, the most common means is firearms—accounting for 44.9% (4,198) of all suicides from 2003 to 2019.^[7] That is followed by hanging/suffocation (30.9% - 2,829 deaths) and poisoning (suicides that are drug-related – 15.3% - 1,429).

The pie chart below shows a similar pattern among Marylanders who died by suicide in 2020.^[8] If all firearm suicides were prevented that year, 260 lives would have been saved.



¹All other means includes: drowning, explosive, fire or burns, motor vehicle, and other.

Research shows that lives can be saved through interventions including safe storage of firearms, medications, and other household products; providing lethal means counseling and safety devices to patients; and intervening at suicide hotspots (e.g., erecting barriers on bridges that attract suicidal jumpers).^[9] Contrary to a popular myth, most people will not “find another way” when their preferred method is unavailable or difficult to access.^[10]

National evidence is growing that Extreme Risk Protective Order (ERPO or “red flag”) laws may be effective in preventing suicide. Maryland’s ERPO law allows family, law enforcement, and certain clinicians to petition the court to temporarily remove firearms from a person deemed to be at risk to themselves or others. Preliminary analysis of 1,363 petitions filed in Maryland between October 2018 and June 2020 indicates that in 517 (38%) of cases, the petitioner requested an ERPO in response to suicide risk. District Court judges (or commissioners for interim orders) granted 95% (353 out of 370) of interim orders, 82% (392 out of 476) of temporary orders, and 74% (318 out of 427) of final orders. (Note that petitions do

not always follow a linear progression that involves all three types of orders. Petitions may begin at the interim or temporary stage, and may or may not proceed to a final order hearing.) (S. Frattaroli, personal communication, September 23, 2022).

Objective 3.1: Train for health and behavioral health providers in lethal means safety and safety planning.

- **Strategy 3.1a:** Encourage providers who interact with at-risk individuals to routinely assess for access to lethal means.
- **Strategy 3.1b:** Increase the numbers of primary care providers trained in lethal means safety and safety planning for the military/veteran community by promoting the Maryland Behavioral Health Administration’s “Trained Military Assistance Provider” (TMAP) pilot program.
- **Strategy 3.1c:** Collaborate with Maryland Behavioral Health Administration’s Commitment to Veterans to expand the TMAP program beyond the pilot phase, emphasizing the program’s utility for treating all patients, including gun owners who may be suicidal.
- **Strategy 3.1d:** Promote the free online training “Counseling on Access to Lethal Means” to primary care and behavioral health providers.

Objective 3.2: Develop and disseminate lethal means safety materials in multiple languages, and tailored for diverse populations and distribution channels.

- **Strategy 3.2a:** Facilitate the development of resources in consultation with representatives from diverse populations and gatekeepers likely to serve people at risk for suicide. Examples of distribution channels include, but are not limited to, pharmacies, health and behavioral health care offices, emergency departments, faith settings, school counseling offices, and senior centers.

Objective 3.3: Work with partners (e.g. local law enforcement, and hospitals) to promote medication take-back days and locations of medication disposal boxes.

Objective 3.4: Promote safe firearm storage practices among firearm owners.

- **Strategy 3.4a:** Support efforts to provide easy access to free gun locks.
- **Strategy 3.4b:** Increase awareness and use of the Maryland Safe Storage Map (developed by the Johns Hopkins Bloomberg School of Public Health) by:
 - Raising awareness of its existence, especially among first responders, crisis lines, mobile crisis teams, and providers.
 - Work with partners (e.g. law enforcement) increasing the number of businesses and law enforcement agencies willing to consider requests for temporary, voluntary gun storage.

-
- Encouraging the regular updating of the Maryland Safe Storage Map.

Objective 3.5: Explore the feasibility of implementing Gun Shop Projects across the state, in which gun owner groups collaborate with suicide prevention advocates and public health professionals to promote firearm suicide prevention. (A national partnership between the American Foundation for Suicide Prevention and the National Shooting Sports Foundation aims to distribute suicide prevention materials to gun owners.)

Objective 3.6: Promote awareness and appropriate use of Maryland’s Extreme Risk Protective Order (ERPO/Red Flag) law.

- Strategy 3.6a: Provide ERPO education to groups likely to come into contact with people in crisis, including court personnel, law enforcement and other first responders, crisis centers, mobile crisis teams, emergency department staff, health and behavioral health providers, faith leaders, and domestic violence centers.
- Strategy 3.6b: Advocate for the extension in perpetuity or the elimination of the December 2024 sunset provision of 2021 Regular Session - House Bill 1186 Chapter (from the 2021 General Assembly session), which authorizes the Office of the Attorney General to access certain information from the District Court concerning protective orders (including ERPOs) “for research purposes to determine how these orders are being used and the impact, if any, on the incidence of homicides, assaults, and suicides by firearms in the State....” These data should be available for research purposes to inform policy and practice.
- Strategy 3.6c: Reduce barriers for health care providers to file ERPO petitions by allowing remote testimony from clinicians and by piloting the use of ERPO navigators in health care settings.
- Strategy 3.6d: Examine the potential inequities by race and ethnicity in public perceptions and use of Maryland’s ERPO law.^[11]

Intervention Goals

GOAL 4. Support the adoption of evidence-based care for suicide risk.

Background

Evidence-based and evidence-informed practices for suicide care should be a core component of clinical care settings, including primary care offices, emergency departments, inpatient and outpatient mental health facilities, and other health systems.^[12]

Studies show that many people who die by suicide are treated by a health care provider in the weeks or months before their deaths. One frequently cited study found that 83% of decedents received health care in the year before their death, and medical specialty and primary care visits without a mental health diagnosis were the most common types of visits.^[13] These visits were missed opportunities to detect suicide risk, address safety, and connect people to care.

As with domestic violence and perinatal depression, obstetricians-gynecologists have unique opportunities to detect and respond to suicide risk among their patients.^[14] During a recent 12-year period, suicidal ideation and intentional self-harm increased significantly among women with substance use issues the year before and after giving birth.^[15]

The “Zero Suicide” framework is the gold standard for evidence-based care for suicide risk in health systems.^{[16][17]} In recognition of the fact that not all systems are ready to implement this challenging initiative, the majority of objectives within Goal 4 are based on the minimum standards of care recommended by the National Action Alliance for Suicide Prevention^[18] and the U.S. Surgeon General’s Office.^[19]

The Maryland Department of Health’s Behavioral Health Administration (BHA) has oversight responsibility for publicly-funded inpatient and outpatient community behavioral health services. As of this writing, BHA’s draft 2022 Behavioral Health Plan includes a goal to “Improve quality of care in the public behavioral health system through increased availability and use of evidence-informed and promising practices, training and workforce development and quality assurance...” The primary focus will be on objectives that align with BHA’s draft plan to increase the likelihood for making progress within the next two years.

Objective 4.1: Facilitate the adoption of Recommended Standard Care for People with Suicide Risk | SAMHSA in all publicly-funded inpatient and outpatient community behavioral health settings.

Objective 4.2: Increase the number of clinicians in the public behavioral health system who receive training in identifying suicidality in patients with a mental health or substance use condition, safety planning, and caring contacts. (See Goal 3, Objectives 3.1 and 3.5).

Objective 4.3: Promote training for behavioral health providers in the public and private sectors, in evidence-based and evidence-informed psychotherapies for suicide risk.

Objective 4.4: Promote training for primary care providers and obstetricians-gynecologists in identifying suicidality in patients with a mental health or substance use condition, in conducting safety planning, and in using caring contacts. (See Goal 3, Objective 3.1).

Intervention Goals

GOAL 5. Promote and strengthen crisis care and care transitions.

Background

The Behavioral Health Administration (BHA) made crisis care central to one of the goals in its 2022 draft Behavioral Health Plan: “Increase access to behavioral health services and supports through the design and implementation of a statewide, integrated crisis system, enhanced care coordination, and use of technology innovations.” The Governor’s Commission supports this goal and anticipates that BHA’s final plan will address strategies it is currently advancing, such as integrating 988 with crisis response services, expanding the reach of mobile crisis teams and crisis stabilization units for children and adults (including the family-centric Mobile Response and Stabilization Services), and developing funding structures for these services.

Care transitions—especially from inpatient care to community outpatient care—are fundamental to preventing suicide. Research shows that the risk of suicide in the month following discharge from inpatient psychiatric care is 200-300 times higher than for the general population, with the highest risk in the first few days after discharge.^{[20],[21]} The National Action Alliance for Suicide Prevention recommends that inpatient and outpatient providers accept joint responsibility for care transitions to ensure safe, seamless transfer of care.^[22]

Objective 5.1: Ensure that culturally and linguistically competent behavioral health crisis walk-in services and crisis stabilization units are available for adults and children 24/7 across Maryland.

Objective 5.2: Ensure that culturally and linguistically competent mobile crisis teams are available for adults and children 24/7 across Maryland.

Objective 5.3: Promote, train, and incentivize inpatient, outpatient, and crisis providers to accept joint responsibility and follow Best Practices in Care Transitions for Individuals with Suicide Risk^[21]. Within a culturally and linguistically competent context, this includes:

- “Developing relationships, protocols, and procedures that allow for rapid referrals.
- “Making a follow-up phone call within 24 hours of discharge from psychiatric hospitalization, a crisis stabilization unit, or an emergency department to check in with the patient, and maintaining contact until the person attends the first outpatient appointment.
- “Involving individuals with lived experience to inform practices.
- “Involving family members and natural supports, including trained peer specialists, to increase social and emotional support, solve practical problems, and promote hope and ongoing recovery.

-
- “Providing education to family members and natural supports.
 - “Providing brief interventions, such as safety planning and caring contacts, to reduce suicide risk during care transitions.”^[23]

Objective 5.4: Develop or establish reimbursement for crisis services, care transition services, and for peer providers in crisis care and care transition roles.

- Strategy 5.4a: Develop or establish reimbursement for crisis services.
- Strategy 5.4b: Develop or establish reimbursement for care transitions.
- Strategy 5.4c: Develop or establish reimbursement for peers in crisis care and care transition roles, including emergency departments, mobile crisis teams, behavioral health crisis walk-in services, and crisis stabilization units. (See Goal 2, Objective 2.4)

Postvention Goal

GOAL 6. Strengthen and promote care, support, and information to individuals, families, and communities affected by suicide attempts, crises, and deaths.

The Governor’s Commission on Suicide Prevention has identified Goal 6, Postvention, beginning with Objectives 6.1 and 6.2, and extending beyond those objectives when possible, as one of its two Priority goals through 2024.

Background

Late in 2021, the Governor’s Commission discussed which issue to prioritize in the upcoming year and reached unanimous consensus on postvention. Many Commissioners had lived experience losing family members and friends to suicide, supporting loved ones through suicide crises, and struggling with their own suicidal thoughts, attempts, and crises. Feeling isolated and dealing with intense pain, Commissioners were confronted with fragmented systems, in which they bore the burden of figuring out what services and supports were available, where to find them, and how to access them. When programs and services were available, Commissioners sometimes found that they were not accessible, equitable, or culturally or linguistically appropriate. When help was most needed, the experience instead contributed to hopelessness and loss of dignity.

The Commission created a task force, led by Commissioner Dr. Dorothy Kaplan, to identify Maryland’s postvention needs, programs, services, and gaps, and to make implementable recommendations for evidence-informed and promising programs and policies. Their vision was for Maryland to be a national leader in implementing suicide postvention solutions for loss and attempt survivors and the friends and families supporting those at risk for suicide.

Postvention has traditionally been defined as activities that reduce risk and promote healing after a suicide death. Building on the work of the National Action Alliance for Suicide Prevention^[24] and the Colorado National Collaborative,^[25] the Task Force broadened the definition:

Postvention practice guides a caring, organized, and evidence-based response to a suicide attempt, crisis, or death that implements targeted programs and activities for individuals, families, and communities to facilitate healing, provide a safe space to process grief, and mitigate risk of negative psychological outcomes including contagion and suicidal thoughts and behaviors.

The following objectives and strategies reflect the Task Force’s work to create a comprehensive postvention system in Maryland

The Governor’s Commission on Suicide Prevention has prioritized Postvention for (and Goal 3, Lethal Means Safety) 2023-2024, beginning with Objectives 6.1 and 6.2, and extending beyond those objectives when possible.

Objective 6.1: Develop and disseminate a state resource guide of evidence-informed and promising programs, services, and resources available in Maryland for individuals bereaved by suicide (“loss survivors”); people who have survived a suicide attempt or crisis (“attempt survivors”); and families and friends supporting individuals at risk for suicide.

- **Strategy 6.1a:** Disseminate and promote postvention resource guides in multiple user-friendly formats and languages, tailored to diverse communities and groups. It is recommended that the first guide be a support group directory.
- **Strategy 6.1b:** Ensure that 988 crisis centers, 211 providers, and other information and referral services provide up-to-date postvention information.
- **Strategy 6.1c:** Update the guides regularly.

Objective 6.2: Identify postvention needs and gaps in Maryland.

- **Strategy 6.2a:** Gather perspectives from the following groups—including those from underserved and historically marginalized communities—regarding unmet needs and how to meet those needs:
 - suicide loss survivors;
 - suicide attempt survivors; and
 - families and friends supporting individuals at risk for suicide.
- **Strategy 6.2b:** Gather input from key informants such as suicide postvention organizations, support group leaders, mobile crisis teams, first responders, 988 crisis centers, and faith communities.
- **Strategy 6.2c:** Recommend actions based on an analysis of the results.

Objective 6.3: Provide training and materials to community groups, schools, organizations, workplaces, the media, and others likely to interact with people bereaved by or exposed to suicide or suicide attempts.

- **Strategy 6.3a:** Work with first responders (law enforcement, EMTs, and fire fighters) and the Office of the Chief Medical Examiner to ensure that information and referral resources are provided at the scene or notification of a suicide, or as soon as possible afterwards.
- **Strategy 6.3b:** Develop a statewide initiative to help funeral professionals better understand the effects of suicide loss and equip them with information and resources to help their clients bereaved by suicide.
- **Strategy 6.3c:** Leverage existing resources (e.g., [FaithHopeLife](#), [Soul Shop](#)) to develop a statewide initiative that equips faith leaders from diverse creeds and cultures with the tools they need to prevent suicide and provide care, comfort, and resources for those affected by suicide. (See Goal 1, Objective 1.4)

-
- Strategy 6.3d: Encourage school systems across Maryland to have postvention plans in place before a suicide occurs, as part of their more comprehensive suicide prevention plans. (See Goal 1, Objective 1.1)
 - Strategy 6.3e: Train journalists in Best Practices for Reporting on Suicide to help prevent contagion, contribute to community healing, and promote help-seeking in the aftermath of a suicide. (See Goal 1, Objective 1.5)

Objective 6.4: Encourage local jurisdictions to convene stakeholders and develop a comprehensive, coordinated, equitable response plan for loss and attempt survivors, in communities and across caregiving systems, from immediate to long-term support. Jurisdictions should consider including strategies in Objectives 6.5 and 6.6.

Objective 6.5: Strengthen and promote care, support, and information for loss survivors.

- Strategy 6.5a: Ensure that loss survivors and people exposed to suicide to receive information and referral resources that are culturally and developmentally appropriate, including peer support programs.
- Strategy 6.5b: Expand the reach of existing programs supporting suicide loss survivors such as Healing Conversations and International Survivors of Suicide Loss Day events.
- Strategy 6.5c: Examine the feasibility of launching evidence-informed programs that provide proactive outreach, peer mentors, and on-site support to loss survivors, including those from historically marginalized communities (e.g. expanding the role of mobile crisis teams; launching Local Outreach to Suicide Survivors [LOSS] teams; partnering with victim-advocates and peer helpers; and interventions modeled after Tragedy Assistance Program for Survivors (TAPS) programs).
- Strategy 6.5d: Promote training for mental health professionals in suicide bereavement, complicated grief in suicide loss survivors, and grief treatment for suicide loss survivors (e.g., Suicide Bereavement Clinician Training).
- Strategy 6.5e: Pilot a traumatic bereavement center in a local jurisdiction to provide culturally and linguistically competent grief support to adults and children who have experienced suicide loss.
- Strategy 6.5f: Expand statewide suicide grief support resources for children, teens, and young adults, including:
 - Training facilitators to conduct youth suicide bereavement groups using best practices such as The Dougy Center Model.
 - Examining the feasibility of establishing a youth suicide bereavement camp.

Objective 6.6: Strengthen and promote care, support, and information for individuals who have survived a suicide attempt or crisis (“attempt survivors”).

- Strategy 6.6a: Expand access to evidence-informed and culturally appropriate crisis care, care transitions, and treatment for suicide attempt survivors. (See Goal 5)
- Strategy 6.6b: Expand access to certified peer specialists and peer navigators.
- Strategy 6.6c: Develop and promote support groups for people who have survived a suicide attempt or crisis, led or co-facilitated by a peer leader.
- Strategy 6.6d: Disseminate and promote self-help materials for people who have survived a suicide attempt or crisis.

Objective 6.7: Strengthen and promote care, support, and information for families and friends supporting individuals at risk for suicide.

- Strategy 6.7a: Disseminate and promote self-help materials for family and friends supporting individuals at risk for suicide.
- Strategy 6.7b: Develop and promote programs and policies that engage families, friends, and caring others in supporting those at risk for suicide.

Surveillance Goal

GOAL 7. Improve the quality, timeliness, and use of suicide-related data.

Background

Collecting and disseminating timely and accurate suicide-related data are crucial for monitoring emerging trends, identifying impacted groups, guiding suicide prevention work, assessing progress, and informing public policy. Local jurisdictions in Maryland that gather suicide-related data currently secure most of it from local hospitals (attempt data from emergency departments and inpatient units) and 911 reports.

In 2020, Maryland lost 585 people to suicide. Experts estimate that there are 25 suicide attempts for every death by suicide, meaning that in 2020, 14,625 Marylanders made non-fatal suicide attempts. Some people were hospitalized, and even more were treated in emergency departments (or other settings) or not treated at all. During the pandemic, CDC found that nationwide emergency department visits for suspected suicide attempts increased significantly among adolescents, especially for girls.^[26]

The CDC gathered the data using its National Syndromic Surveillance Program (NSSP), which provides near real-time electronic patient encounter data received from emergency departments and other health care settings. It is most commonly used to detect and monitor epidemics, overdoses, and other public health concerns. Maryland does not currently use NSSP to monitor suicide attempts or ideation.

Maryland is fortunate to have a unique resource in its surveillance toolkit with the potential for improving suicide risk identification and prevention. Developed by Johns Hopkins University, the Maryland Suicide Data Warehouse (MSDW) links a diverse set of data sources including hospital and emergency discharges, health information exchange data, commercial insurance claims, medical examiner data, electronic health record data from five health systems, and place-based social determinants of health (e.g., housing, employment, education, crime). Grant funding from the National Institute of Mental Health ends in 2024.^[27]

Objective 7.1: Increase access to near real-time data related to suicide deaths and attempts.

- **Strategy 7.1a:** Provide local jurisdictions with regular timely suicide death reports.
- **Strategy 7.1b:** Create a near real-time statewide data dashboard that can be accessed by local jurisdictions.
- **Strategy 7.1c:** Utilize CDC's National Syndromic Surveillance Program to monitor near-real time patient suicidal ideation and suicide attempts in emergency departments to rapidly track and react to changing patterns in suicidal behavior.

Objective 7.2: Examine the feasibility of the Maryland Department of Health maintaining the Maryland Suicide Data Warehouse after the federal grant funding ends in 2024.

Objective 7.3: Determine methods to improve the accuracy of demographic and related information for suicide decedents, possibly by adding valid and reliable questions on sexual orientation/gender identity, race, ethnicity, and veteran status to death investigations.

Objective 7.4: Encourage the Suicide Fatality Review Committee to:

- Examine factors contributing to suicide deaths among youth who have been in the child welfare and the juvenile justice system.
- Address Maryland's high proportion of undetermined overdose deaths to ascertain factors that might help clarify decedents' intent.

Citations

[1] Substance Abuse and Mental Health Services Administration. (2012). *Preventing Suicide: A toolkit for high schools*. HHS Publication. No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

[2] American Foundation for Suicide Prevention & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools (2nd ed.)*. Waltham, MA: Education Development Center.

[3] Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). *Preventing suicide: A technical package of policies, programs, and practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[4] Ibid

[5] Maryland Department of Health's Center for Environmental, Occupational, and Injury Epidemiology. (2022). Circumstances of suicide deaths in Maryland: Data from the 2003-2019 Maryland Violent Death Reporting System (MVDRS). <https://bit.ly/3BxtMFq>

[6] Office of Disease Prevention and Health Promotion, Office of the Secretary, HHS. Health Equity in Healthy People 2030. Retrieved on August 27, 2022 from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030>

[7] Maryland Department of Health's Center for Environmental, Occupational, and Injury Epidemiology. (2022). Circumstances of suicide deaths in Maryland: Data from the 2003-2019 Maryland Violent Death Reporting System (MVDRS). <https://bit.ly/3BxtMFq>

[8] Maryland Department of Health's Center for Environmental, Occupational, and Injury Epidemiology. Data from the 2020 MVDRS. (Not yet published)

[9] Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). *Preventing Suicide: A technical package of policies, programs, and practices*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[10] Ibid

[11] Pear, V.A., Schleimer, J.P., Aubel, A.J., Buggs, J., Knoepke, C.E., Pallin, R., ...Kravitz-Wirtz, N. (2022). Extreme risk protection orders, race/ethnicity, and equity: Evidence from California, *Preventive Medicine*. <https://doi.org/10.1016/j.ypmed.2022.107181>

[12] U.S. Department of Health and Human Services Office of the Surgeon General, & National Action Alliance for Suicide Prevention. (2021). *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. HHS.

[13] Ahmedani, B.K., Simon, G.E., Stewart, C., Beck, A., Waitzfelder, B.E., Rossom, R., ...Solberg, L.I. Health care contacts in the year before suicide death. *J Gen Intern Med*. 2014 Jun;29(6):870-7. doi: 10.1007/s11606-014-2767-3. Epub 2014 Feb 25. PMID: 24567199; PMCID: PMC4026491.

[14] Forray, A., & Yonkers, K.A. (2021). The Collision of Mental Health, Substance Use Disorder, and Suicide. *Obstetrics & Gynecology*. doi: 10.1097/AOG.0000000000004391. PMID: 33957654.

[15] Admon, L.K., Dalton, V.K., Kolenic, G.E., Ettner, S.L., Tilea, A., Haffajee, R. L.,....Zivin, K. (2020). Trends in Suicidality 1 Year Before and After Birth Among Commercially Insured Childbearing Individuals in the United States, 2006-2017. *JAMA Psychiatry*. DOI: 10.1001/jamapsychiatry.2020.3550

[16] Grumet, J.G., Hogan, M.F., Chu, A., Covington, D.W., & Johnson, K.E. (2019). Compliance standards pave the way for reducing suicide in health care systems. *Journal of Health Care Compliance*.

[17] National Action Alliance for Suicide Prevention: Clinical Care & Intervention Task Force. (2011). *Suicide care in systems framework*. Washington DC: Education Development Center, Inc.

[18] National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). *Recommended standard care for people with suicide risk: Making health care suicide safe*. Washington, DC: Education Development Center, Inc.

[19] U.S. Department of Health and Human Services Office of the Surgeon General & National Action Alliance for Suicide Prevention. (2021). *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. HHS.

[20] Chung, D.T., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. *BMJ Open*, 9(3), e023883. <http://dx.doi.org/10.1136/bmjopen-2018-023883>

[21] National Action Alliance for Suicide Prevention. (2019). *Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care*. Washington, DC: Education Development Center, Inc.

[22] Ibid.

[23] U.S. Department of Health and Human Services Office of the Surgeon General, & National Action Alliance for Suicide Prevention. (2021). *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. HHS.

[24] National Action Alliance for Suicide Prevention: Research Prioritization Task Force. (2014). *A prioritized research agenda for suicide prevention: An action plan to save lives*. Rockville, MD: National Institute of Mental Health and the Research Prioritization Task Force.

[25] Reed, J., Quinlan, K., Labre, M., Brummett, S., & Caine, E.D. (2021). The Colorado National Collaborative: A public health approach to suicide prevention. *Prev Med*. 152(Pt 1):106501. doi: 10.1016/j.ypmed.2021.106501. Epub 2021 Sep 16.

[26] Yard, E., Radhakrishnan, L., Ballesteros, M.F., Sheppard, M., Gates, A., Stein, Z.,....Stone, D. (2021). Emergency department visits for suspected suicide attempts among persons aged

12-25 years before and during the COVID-19 pandemic - United States, January 2019-May 2021. *MMWR Morb Mortal Wkly Rep.* 2021 Jun 18;70(24):888-894. doi: 10.15585/mmwr.mm7024e1.

[27] NIH Grantome. Project Information: 1R01MH124724-01. (2018). Available at: <https://grantome.com/grant/NIH/R01-MH124724-01>. Accessed Sept. 29, 2022.

[28] WONDER: CDC's Wide-ranging ONline Data for Epidemiologic Research <https://wonder.cdc.gov/>

[29] WISQARS: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2017) [cited Year Month (abbreviated) Day]. Available from URL: www.cdc.gov/injury/wisqars

[30] CRISP - Data Source: CRISP Chesapeake Regional Information System for our Patients, HSCRC Mix data as of May 1, 2022. Data Source Disclaimer: This report was produced using proprietary computer software created, owned and licensed by the 3M company. Further distribution of reports that contain patient and/or code level data is not permitted without advanced written approval by 3M. All copyrights in and to the 3MTM software (including the selection, coordination and arrangement of all codes) are owned by 3M. All rights reserved.

[31] MVDRS: Maryland Violent Death Reporting System <https://health.maryland.gov/phpa/OEHFP/Injury/Pages/mvdrs.aspx>

[32] Maryland Department of Health's "Veterans and Armed Forces Member Suicides in Maryland Annual Report 2020"

[33] YRBS 2021 [2021 Maryland Youth Pandemic Behavior Survey YPBS-21 Detailed Report](#)

[34] VSA Vital Statistics Administration 2020 Report. Data are not available for publication or public distribution until the VSA publishes their yearly annual report found <https://health.maryland.gov/vsa/Pages/reports.aspx>

[35] CFMA Construction Financial Management Association <https://cfma.org/suicideprevention> along with CIASP, the Construction Industry Alliance for Suicide Prevention. <https://preventconstructionsuicidSuicidePreventionResource.com/>

Appendix

List of Commissioners

Full Name	Seat
Edward Bartlinski	Community: Police, Local Corrections or Fire and Rescue Services
Kristy E. Blalock	Rep of Maryland Addictions Directors Council
Lynda Bonieskie	Designee of Sec of Dept. Public Safety and Correctional Services
Dionne Bowie	Designee of Dept. Sec for Behavioral Health Administration
Dana S. Burl	Designee of Sec of Dept. of Veterans Affairs
Jada Carrington	Community: Young adult aged 18-25
Amanda Celentano	Designee of Secretary of Dept. of Aging
Bonnie Cullison	Designee of Speaker of the House
Johanna M. Dolan	Community: Substance-Abuse Recovery
Adelaide Eckardt	Designee of Senate President
William Jernigan	Designee of Ex. Director - Gov. Office for Children
Kevin Johnson	Community: Faith
Dorothy A. Kaplan	Community: Suicide Prevention Group
Georgette Lavetsky	Designee of Dept. Sec for Public Health
Cynthia Macri	Community: Asian American and Pacific Islander
Julie L. Matheny	Community: Family Member of an individual who died by suicide
Henry J. Meiser	Community: High School Student
Amelia Noor-Oshiro	Community: Survivor of a Suicide Attempt
Margo Quinlan	Community: LGBTQ+
Kirsten Robb-McGrath	Designee of Secretary Dept. of Disabilities
April D. Turner	Designee of Superintendent Dept. of Education
Monica Guerrero Vazquez	Community: Hispanic/Latino
Andrea Walker	Rep of Maryland Association of County Health Professionals (MACHO) (Co-Lead Suicide Prevention Plan)
Kristin Washington	Community: Active/Former member of US Armed Forces
Holly Wilcox	Community: Academic (CO-CHAIR)
Eileen F. Zeller	Rep of the Mental Health Association of Maryland (CHAIR)