Maryland Suicide Fatality Review Committee Report

2025

October 2024 through September 2025

Health General § 5-1003

Submitted to the Maryland Department of Health

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Executive Summary

The Maryland Suicide Fatality Review Team (State Team) was created under Health–General Article §§ 5-1001 through 5-1003 and Chapters 80 and 81 of the Laws of 2022 to better understand the circumstances surrounding suicide deaths and strengthen prevention strategies statewide. Through a structured, confidential review process, the State team brings together experts from government, healthcare, academia, and lived experience communities to analyze recent suicide fatalities. Through an examination of cases, the State Team develops recommendations to inform policy, practice, services, and resource improvements across Maryland. This 2025 Annual Report fulfills the requirements of § 5-1003 by summarizing activities, findings, and recommendations from October 2024 through September 2025.

In 2023, 599 people died by suicide in Maryland, 54 of whom were young adults between the ages of 19 to 24. In 2025, the State Team prioritized this population because of the unique intersection of life transitions, behavioral health needs, and ready firearm access that heighten suicide risk. Although the State Team prioritized young adults, general summary information may be located in the the "Overview of Suicide in Maryland" and "Demographics of Suicide Fatalities in Maryland" sections.

In 2025, the State Team reviewed 20 firearm-related suicide fatalities among young adults aged 19-24. From each case, the team identified challenges faced by young Marylanders. Themes that emerged in reviews included:

- Histories of traumatic experiences and/or undertreated behavioral health concerns
- Challenges with life transitions, relationships, and criminal justice involvement
- Loved ones who are uncertain about how to help a young adult in suicidal crisis
- Ready access to firearms, including ghost guns and long guns
- Lack of documented follow-up for bereaved families and communities after suicide loss

The State Team developed more than 50 recommendations across six domains to strengthen safety nets for Marylanders at risk of suicide. Recommendations are focused on individuals ages 19-24, but the majority of recommendations are applicable to the general population, such as increased suicide prevention/lethal means safety training, messaging about the availability of 988, follow-up and postvention services, etc. Priority recommendations include:

- Developing and disseminating firearm safe storage messaging to firearm owners
- Implementing long gun purchasing restrictions for individuals under age 21
- Providing follow-up services (including screening for suicide risk/lethal means access) for individuals and families who experience sexual violence and/or domestic violence
- Providing community-based case management for individuals receiving frequent care for suicidal behavior in emergency rooms
- Expanding clinical training for providers to screen for lethal means access and Extreme Risk Protective Orders (ERPOs)

- Improving data sharing between 988 call centers, first responders, and state agencies about suicide deaths

The State Team's recommendations emphasize practical, high-impact actions that advance system change—spanning safe-storage policy, clinical navigation, crisis response, and postvention—to reduce suicide and save lives throughout Maryland.

Introduction

Suicide Fatality Review (SFR) is a multidisciplinary and confidential process that gathers and analyzes information regarding suicide deaths. SFR brings together experts who identify factors contributing to suicide deaths, service gaps, and missed opportunities for intervention. The insights from the SFR inform timely, data-driven recommendations that support state and local prevention efforts.

Maryland Suicide Fatality Review Committee

The Maryland Suicide Fatality Review Committee (State Team) was established by statute Health – General Article §§ 5-1001[1] and 5-1002,[2] and Chapter 81, Maryland Laws of 2022. Per Health – General Article §5-1003,[3] the State Team shall:

- Meet at least quarterly to review suicide deaths;
- Make determinations regarding trends, risk factors, current best practices in suicide prevention, lapses in systemic responses, barriers to safety/well-being for individuals at risk of suicide and strategies for the prevention of suicide deaths;
- Report at least annually to the Governor and the General Assembly on activities and recommendations on changing law or policy, and/or improving the availability of sources of information;
- Undertake annual statistical studies of incidents and causes of suicide mortality, along with trends and patterns of suicide deaths;
- Disseminate findings and recommendations based on studies to policymakers, healthcare providers, health care facilities, and the public; and
- Make aggregate findings of reviews and recommendations for preventive actions periodically available

All activities are conducted in compliance with § 5-1006, which requires that records and discussions remain confidential and exempt from public disclosure.

The State Team is supported administratively by the Maryland Department of Health (MDH) and comprises 14 members, including representatives from State and local government agencies, academic institutions, healthcare providers, and lived experience organizations (see Appendix A). Each member brings a unique perspective and a wealth of expertise to the review process.

The 2025 Annual Report summarizes the State Team's activities from October 2024 to September 2025. It describes trends in suicide rates in Maryland and shares recommendations

[1] Health – General Article §5-1001
[2] Health – General Article §5-1002
[3] Health – General Article §5-1003

and opportunities for preventing suicide in the future in Maryland through impactful policy changes and program implementation.

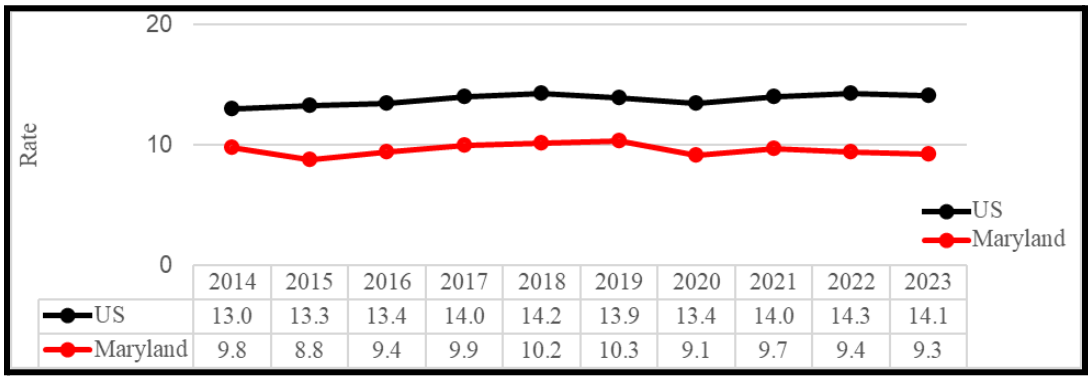
While suicide rates are reported annually, both state and national systems often provide data that is one or more years old. These delays can hinder timely responses to emerging issues. To address this, the State Team reviews detailed information from a variety of data sources and examines more recent instances of suicide, which informs prevention strategies. These strategies include implementing policy changes, allocating resources, enhancing education and training, improving processes within healthcare systems, and utilizing tools and technologies to identify and engage communities affected by suicide.

The State Team shares its findings and recommendations with state and local agencies, policymakers, health-care providers, community-based organizations, and advocates to advance Maryland's goal of reducing suicide across all communities.

Overview of Suicide in Maryland

Suicide deaths have a profound and continuing impact on individuals, families, and communities across Maryland. In 2023, 599 Marylanders died by suicide, representing an age-adjusted rate of 9.26 per 100,000 residents, compared with 14.12 per 100,000 nationally. Suicide rates in Maryland have been lower than the national average over the past decade, with notable declines in 2022 and 2023.[4]

Chart 1. Age-Adjusted Suicide Rates (per 100,000) in the US and Maryland, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
US	13.0	13.3	13.4	14.0	14.2	13.9	13.4	14.0	14.3	14.1
Maryland	9.8	8.8	9.4	9.9	10.2	10.3	9.1	9.7	9.4	9.3

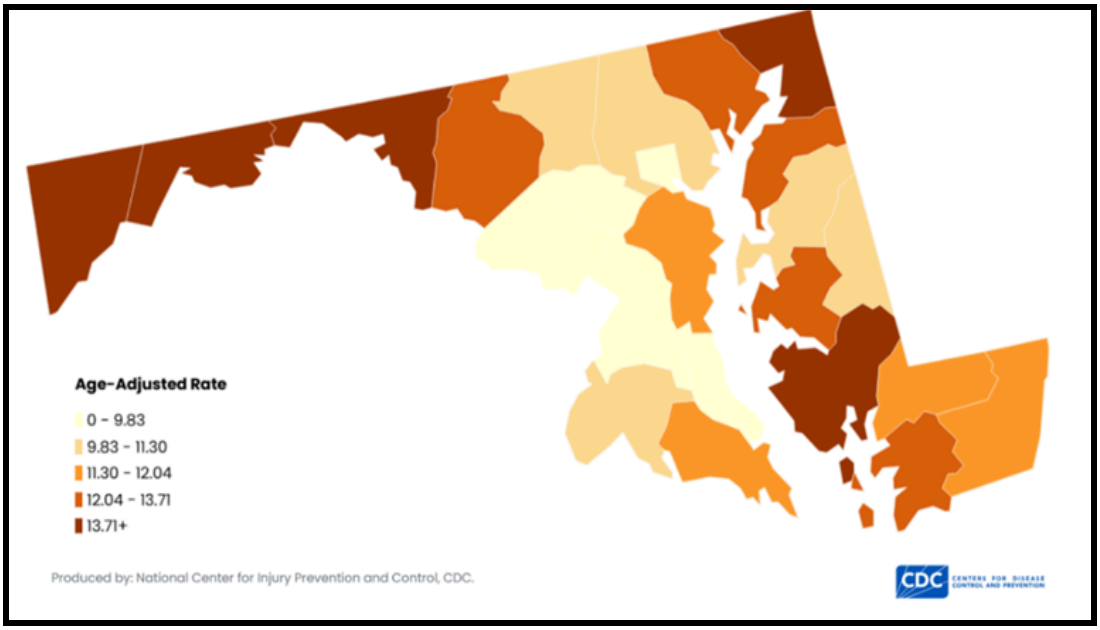
Demographics of Suicide Fatalities in Maryland

The incidence and characteristics of suicide vary across Maryland. Suicide rates (deaths per 100,000) are highest in rural counties in Western Maryland, such as Garrett, Allegany, and

[4]Centers for Disease Control and Prevention. (undated). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). https://wisqars.cdc.gov/

Washington, as well as in counties on the Eastern Shore, including Cecil and Dorchester.[5] Conversely, the counties with the highest total counts of suicide deaths between 2018 and 2023 are more densely populated areas: Anne Arundel, Baltimore, Montgomery, and Prince George's counties and Baltimore City. These five counties together account for 65% of Maryland's population and represent 59% of total suicide fatalities.

Chart 2. Age-Adjusted Suicide Rates (per 100,000) by Maryland County, 2018-2023



Suicide fatality rates differ by sex, age, and race/ethnicity. Nationally, the suicide rate for males is 3.8 times higher than that for females.[6] In Maryland from 2018 to 2023, the age-adjusted suicide rate was four times greater among males than females, with rates of 15.92 suicides per 100,000 males compared to 3.95 per 100,000 females. The Vital Statistics Administration only provides information about sex (male/female). Gender identity and sexual orientation can be explored and discussed during case reviews once more detailed information is obtained, but they are not variables available in the case selection process.

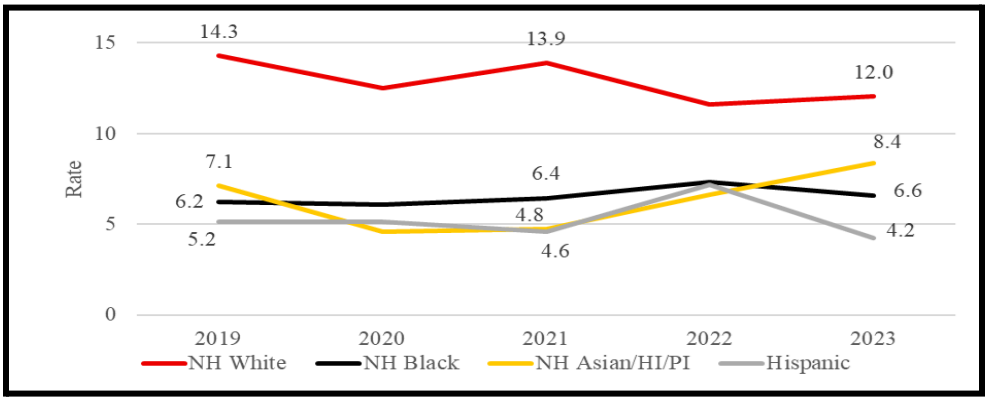
Historically, non-Hispanic White Marylanders have experienced disproportionately high rates of suicide over the past decade; however, recent trends suggest a potential decline in this

[5] National Institute on Minority Health and Health Disparities. (2025). Suicide & Self-Inflicted Injury Death Rates, Table for Maryland by County, All Races (includes Hispanic/Latino), Both Sexes, All Ages, 2019-2023. https://hdpulse.nimhd.nih.gov

[6]Centers for Disease Control and Prevention. (2025). Suicide Data and Statistics. https://www.cdc.gov/suicide/facts/data.html

demographic. Suicide rates among other racial and ethnic groups have shown fluctuations over the past five years.[7]

Chart 3. Age-Adjusted Suicide Rates by Race/Ethnicity in Maryland, 2019-2023



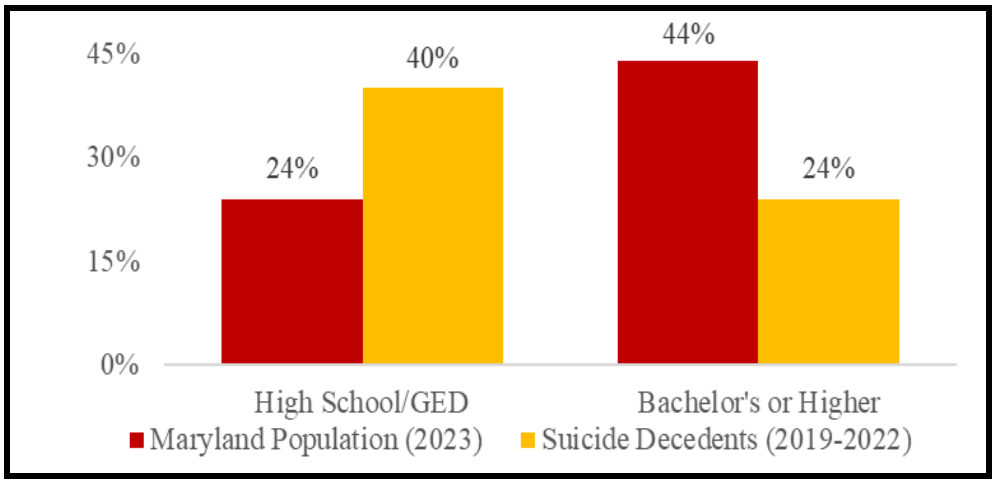
Educational attainment is also linked to differences in suicide mortality in Maryland. As of 2023, approximately 24% of Maryland residents have a high school diploma or equivalent as their highest level of education, while 44% hold a bachelor's degree or higher.[8] Data from the Maryland Violent Death Reporting System (MVDRS) for 2019–2022 indicate that 40% of suicide decedents had a high school diploma or GED, compared with 24% who held a bachelor's degree or higher.[9]

Chart 4. Educational Attainment in Maryland, General Population Compared to Suicide Decedents

[7] Centers for Disease Control and Prevention. (undated). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). https://wisqars.cdc.gov/

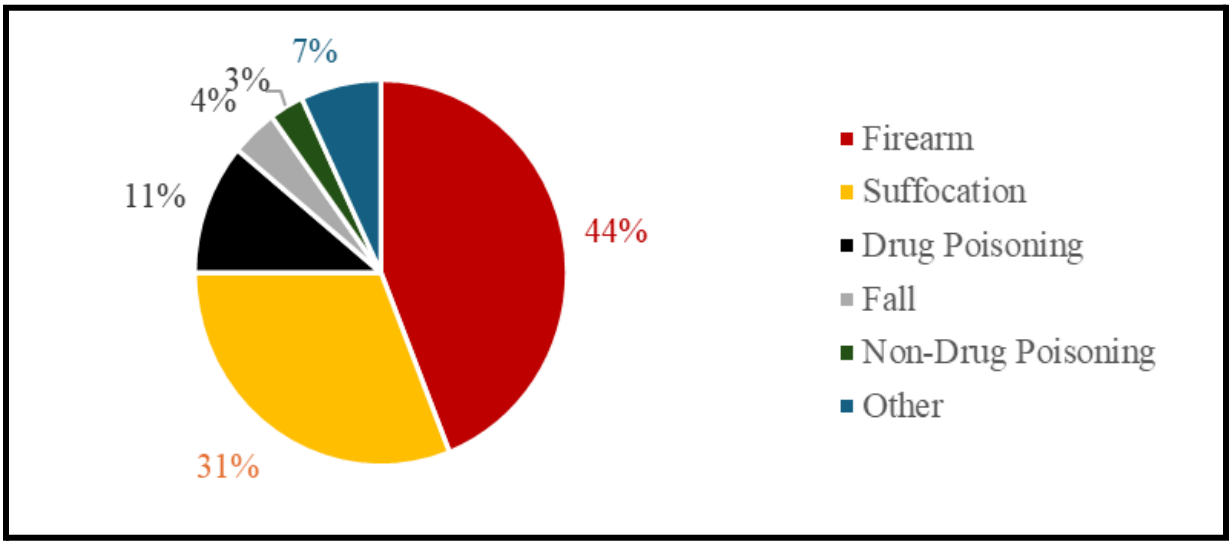
[8]United States Census Bureau. Maryland - Census Bureau Profile. https://data.census.gov/profile/Maryland?g=040XX00US24#education

[9].Maryland Department of Health. (undated). Maryland Violent Death Reporting System. https://health.maryland.gov/phpa/OEHFP/Injury/pages/mvdrs.aspx.



Firearms remain the most common means of suicide in Maryland, particularly among males, non-Hispanic White and non-Hispanic Black residents, and individuals aged 20-29 and those aged 60 and older. For Marylanders under 18 years of age, suffocation is the most common means of suicide. Additionally, non-Hispanic Asian and Hispanic Marylanders also show higher rates of suffocation.[10]

Chart 5. Maryland Suicide Fatalities by Lethal Means, 2018-2023



Historical and Acute Factors

Suicide is a complex public-health crisis arising from multiple interacting factors. The MVDRS collects and organizes information about the circumstances surrounding suicides by abstracting data from medical examiner and law enforcement records. This statewide surveillance system

[10] Centers for Disease Control and Prevention. (undated). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). https://wisqars.cdc.gov/

maintains a comprehensive and up-to-date collection of information concerning violent death incidents occurring throughout Maryland.

Table 1. Selected Circumstances of Suicide, MVDRS (2019-2022)

Circumstance (within the year prior to death)	% of Suicide Decedents (n=2371)
Mental Health Problem	53%
Alcohol Dependence Or Alcohol Problem	18%
Non-Alcohol Related Substance Abuse Problem	14%
Currently in Treatment for a MH or SUD Problem	26%
Physical Health Problems	12%
History of Suicide Attempt	18%
History of Suicidal Ideation	36%
The problem with an intimate partner contributed to the death	20%
Criminal legal problems	5%
Financial problems contributed to the death	7%

Data from 2019 to 2022 indicate that a majority of individuals who died by suicide had experienced a mental-health issue within the year preceding their death. Because mental-health and substance-use conditions may be under-reported, these figures likely represent a conservative estimate of true prevalence.

Table 2. Selected Mental Health Diagnoses for Suicide Decedents with Mental Health Problems, MVDRS (2019-2022)

Mental Health Diagnosis	% of Suicide Decedents with MH Problem (n=1252)
Depression/dysthymia	78%
Anxiety disorder	23%
Bipolar disorder	16%
Schizophrenia	7%
Post-traumatic stress disorder	5%
ADD or hyperactivity disorder	3%
Dementia (e.g., Alzheimer's, Lewy Body Dementia)	2%
Autism Spectrum (including Asperger's Syndrome)	1%

Together, these findings underscore the importance of comprehensive approaches that combine prevention, early intervention, treatment, and postvention strategies across Maryland’s behavioral-health system.

Suicide Fatality Review in Maryland, 2025

Methods and Case Selection for Suicide Fatality Review

The State Team used a systematic sampling method to select review cases, thereby improving the focus of the reviews. Unlike Maryland's Child Fatality Review and Overdose Fatality Review programs, no local or regional teams that perform Suicide Fatality Reviews currently operate; all reviews are conducted at the state level. In 2025, the State Team established specific criteria for case selection.

Using data from Maryland, the State Team chose to focus on firearm-related suicides among individuals aged 19 to 24 in an effort to improve prevention and early intervention services for this population which is disproportionately affected by suicide. To ensure that their recommendations are specific and impactful, the State Team decided to concentrate on cases involving the most common lethal means used by young adults—firearms, which accounted for 42% of suicide deaths in this age group.[11]

According to the American Foundation for Suicide Prevention, suicide is the third leading cause of death for Marylanders aged 15 to 24, while it ranks as the fifteenth leading cause of death for all Maryland residents. Young adults aged 19 to 24 experience an elevated crude rate of 12.6 deaths per 100,000, reflecting their unique developmental transitions and stressors.[12]

This age group experiences a greater volume of transitions compared to others. Young adults undergo significant changes in various areas, including healthcare (transitioning from pediatric to adult care), education (shifting from high school to higher education and/or the workforce), living arrangements (moving from family homes to living independently), and interactions with the justice system (transiting from the juvenile justice system, which is typically focused on rehabilitation, to the adult system which is correctional).

In 2025, the State Team reviewed 20 firearm-related suicide cases among individuals aged 19-24 during five meetings in 2025, representing 37% of available eligible cases (n=53). Cases were selected from suicide fatalities that occurred between January 1, 2023 through March 31, 2025. Four meetings focused on specific geographic regions of Maryland, and cases were randomly selected from available cases within the region. A fifth special session focused on individuals who were enrolled in colleges or universities.

The team gathered case information from a variety of sources, including Office of the Chief Medical Examiner (autopsy and toxicology reports), patient records, insurance claims,

[11]Centers for Disease Control and Prevention. (undated). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) https://wisqars.cdc.gov/
[12]American Foundation for Suicide Prevention. (undated). Maryland profile. https://afsp.org/facts/maryland

emergency medical services reports, public court records, law enforcement reports, prescription drug monitoring records, and online search engine results (see Appendix C).

Case Characteristics and Findings

Case Review Demographics

Case selection was designed to reflect the diversity of Maryland's communities while also representing the demographics of firearm suicide fatalities among individuals aged 19-24.

All of the reviewed decedents had graduated from high school or obtained a GED, with 35% having attended some college without earning a degree. None of the decedents reviewed were service members or had ever served, according to available records. The case reviews were distributed across Maryland, ensuring that at least four cases were reviewed from each region: Central Maryland, Southern Maryland, the Eastern Shore, and Western Maryland (see Appendix C for the list of jurisdictions in each region). Of the reviewed cases, 16 decedents lived in metropolitan areas, 2 in micropolitan areas, 1 in a small town, and 1 in a rural area.[13]

Table 3. Selected Demographics of Suicide by Firearm, Ages 19-24 – Available and Reviewed Cases

Demographic	% of Available Cases (n=53)	% of Reviewed Cases (n=20)
Age Groups		
Ages 19-21	40%	45%
Ages 22-24	60%	55%
Race/Ethnicity*		
NH White	45%	60%
NH Black	40%	30%
NH Asian/Pacific Islander	6%	5%
Hispanic	6%	5%
Unknown	3%	0%
Sex		
Male	87%	85%
Female	13%	15%

Source: OCME/VSA (Jan 1, 2023 – Mar 30, 2025)

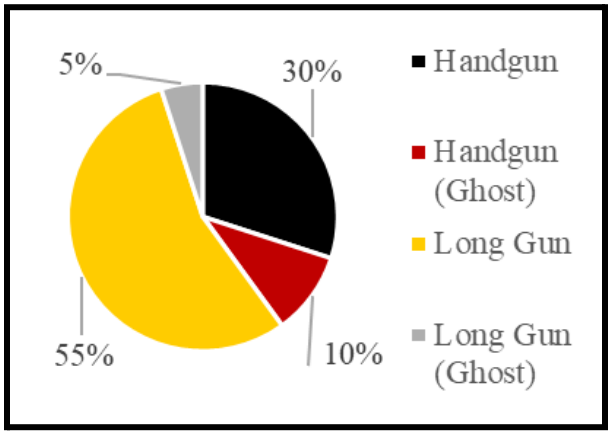
*NH indicates non-Hispanic. Race/Ethnicity categories are collapsed in OCME/VSA data.

Characteristics of Firearms

[13] Zip code level classification from USDA Rural-Urban Commuting Area (RUCA) Codes.

Among the reviewed cases, 53% involved handguns, 43% involved long guns (rifles and shotguns), and 4% involved firearms of unknown types. A majority of the suicides examined were committed using long guns. Additionally, 15% of the cases involved unserialized and unregistered firearms, commonly referred to as "ghost guns." In most instances, the individual who died by suicide was also the owner of the firearm used.

Chart 6. Firearm Types in Reviewed Cases



Mental Health, Suicide, and Substance Use History

Evidence of mental health and/or substance use concerns was found in 90% of the reviewed cases. Among those with mental health issues, 55% had a history of depression or depressive episodes. Attention-deficit/hyperactivity disorder (ADHD) was identified in 35% of the cases, while anxiety disorders were noted in 20%. Autism Spectrum Disorder and Bipolar II disorder were observed in 10% of the reviewed cases.

Toxicology results were available for 85% of the cases, and among those, 47% tested positive for substances. Prescription antidepressants, specifically selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), were present in 23% of the cases that had positive toxicology results.

Additionally, 60% of the reviewed cases indicated a history of suicidal ideation, with 25% reporting a past suicide attempt. A history of non-suicidal self-injury (NSSI) was noted in 35% of the cases, with evidence of such behavior found in autopsies for 20% of the reviewed cases. A suicide note was present in 35% of cases. Records also indicated that in 60% of the reviewed cases, the decedent consumed substances and/or alcohol recreationally. Treatment records for alcohol and/or substance use issues were noted in 15% of the cases, with alcohol being the most commonly detected recreational substance in the toxicology results.

Contact with Systems

Thirty percent of the reviewed decedents did not have health insurance at the time of their death. Among those who were insured, 30% had Medicaid claims. Additionally, in two cases, decedents utilized Workers' Compensation to cover care for workplace injuries.

Twenty-five percent of the reviewed decedents had a prior criminal conviction, with the majority having a record of probation. At the time of their death, 45% of the reviewed decedents were employed, with trade professions being the most common, accounting for 15% of the cases. Furthermore, 25% of the reviewed decedents were attending a community college or university.

Personal Relationships

In 65% of cases, someone who had a relationship with the deceased expressed concern about the individual at the time of their death. In 25% of these cases, at least one person was present and/or directly communicating with the decedent immediately before their passing. Family, friends, and partners were most frequently those aware of risk. Additionally, a recent argument with an intimate partner was noted in 15% of the reviewed cases.

In 10% of cases, a coworker or employer notified the family of the deceased due to concerns about the individual not showing up to work. In 75% of the cases, someone with a personal relationship to the decedent was the one who discovered them unresponsive or deceased.

Key Themes and Contributing Factors

During the review of cases, the State Team identified five recurring themes that influenced the lives of young adults who died by firearm suicide. Many of the decedents had underlying risk factors, lacked consistent support during critical life transitions, and had access to firearms during moments of suicidal crisis. Although supportive loved ones were present in many of their lives, they often felt uncertain about how to assist a suicidal individual and connect them to the necessary resources during a crisis. For a detailed breakdown of the prevalence of these themes and factors, please refer to Appendix D.

Identified Risk Factors

In the 2025 case reviews, several risk factors emerged as potential contributors to the lifetime suicide risk among young Marylanders who died by firearm suicide. Many of the individuals reviewed experienced trauma, faced external or internal stigma related to help-seeking, and/or struggled with unmet mental-health or substance-use needs.

History of Trauma and ACEs

Traumatic experiences can have a lifelong impact on individuals. Certain traumatic events that occur during childhood, known as adverse childhood experiences (ACEs), can lead to lasting

effects and are associated with an increased risk of suicide.[14] The majority of reviewed decedents were exposed to at least one ACE. The most common ACE noted among decedents was divorce/separation of parents during childhood. Childhood physical abuse, exposure to domestic violence, and parental incarceration impacted 10% of reviewed decedents, respectively. Two individuals were exposed to multiple ACE types. Sexual assault was noted in 10% of cases. Encounters related to ACEs and trauma were either documented through law enforcement or court records, with no follow-up documented for families impacted. This highlights the need for routine trauma-informed follow-up when children experience ACEs, as early intervention may reduce long-term suicide risk.

Un- or Undertreated Mental Health and Substance Use Concerns

Reviewing suicide fatalities revealed persistent gaps in behavioral healthcare and treatment for young adults. While data from the MVDRS indicated that 53% of suicide decedents from 2019-2022 had a mental health and/or substance use concern, by reviewing a wider array of data sources, the State Team found that 90% of the cases reviewed had some evidence of such concerns. In 80% of cases, a concern was identified by next-of-kin and/or by clinical records. For the remaining 10% of cases, no next-of-kin or treatment records were available, but toxicology indicated that prescription antidepressants had been taken at least five days prior to death. In 35% of cases, evidence of non-suicidal self-injury was noted.

- **No history of treatment.** Some young adults reviewed did not enter into mental health and/or substance use treatment. In a third of reviewed cases, decedents had no autopsy or patient records that indicated they ever received treatment for behavioral health needs. In two cases, next-of-kin described acute behavioral symptoms in the week prior to death, but no outreach or connections to care were established. Next-of-kin for two other decedents described suspecting behavioral health needs based on long-term observation, but indicated that decedents did not seek treatment. The remaining two decedents had a history of violence towards others documented in law enforcement and court records, but had no records indicating they ever entered into mental health treatment.
- Unclear **treatment adherence.** Of the decedents who had received treatment for behavioral health, the majority had a formal diagnosis in patient records. Depression was the most common diagnosis, followed by ADHD, anxiety disorders, and substance use disorders. Prescription medication was part of treatment in 55% of reviewed cases. For 35% of decedents, a psychiatric medication was prescribed and likely taken within the past year. Adherence to psychiatric medication varied. In 20% of cases, a prescription antidepressant (SSRI/SNRI) was detected in toxicology results, indicating that the decedent had been taking antidepressants as recently as five days prior to death. For some

[14] Centers for Disease and Control. About Adverse Childhood Experiences. (2025). Adverse Childhood Experiences (ACEs). https://www.cdc.gov/aces/about/index.html

decedents, prescription medications were discontinued in the months or weeks prior to suicide. Multiple individuals were described as non-adherent with psychiatric medication.

- **Lack of care continuity.** The vast majority of reviewed decedents did not access continuous care in the years preceding suicide. Documented care often occurred in emergency departments (EDs) or in urgent cares (UCs). While referrals were documented in most ED/UC records for psychiatric concerns, warm handoffs to continued care were not documented in discharges. Available records indicated that of ED/UC cases, only 63% continued outpatient care after discharge from hospitalization. In 30% of reviewed cases, the decedent was uninsured at the time of death. Of all the cases reviewed, only two individuals had affirmative accounts from next-of-kin about having regular contact with a behavioral health provider at the time of their death. These gaps underscore the importance of continuous, coordinated care and timely and appropriate follow-up after emergency or urgent-care visits.

Major life transitions

Young adulthood is a period of tremendous change.[15] Between the ages of 19 and 24, many individuals graduate from K-12 schooling, begin pursuing higher education or career aspirations, experience new living situations, navigate intimate partnerships, and explore aspects of identity. While this developmental stage can present great opportunity, stressful new life circumstances can also contribute to the risk of suicide. Among the cases reviewed, themes of stress related to major life changes appeared frequently.

Challenges in Academic Pathways

Every reviewed decedent graduated from high school/obtained a GED. Among reviewed cases, 35% went on to attend some college. None had completed their degree at the time of death. Behavioral health challenges intersected with academic priorities for decedents who were college students. Decedents included individuals who died by suicide shortly after being accepted into university, enrollees in community college after a period of post-high school employment, and individuals in recovery from substance use disorder. There were no documented interventions by academic institutions for any of the decedents attending higher education. Caregivers were aware of students' behavioral health needs, but were not documented sharing information with academic institutions.

Entering the Workforce

Providing additional support for young adults entering the workforce after high school is

[15] Rod, N. H., Davies, M., de Vries, T. R., Kreshpaj, B., Drews, H., Nguyen, T. L., & Elsenburg, L. K. (2025). Young adulthood: a transitional period with lifelong implications for health and wellbeing. *BMC global and public health*, *3*(1), 25. https://doi.org/10.1186/s44263-025-00148-8

particularly important for young adults with behavioral health needs.[16] In 45% of reviewed cases, the decedent was employed at the time of death. In multiple cases, individuals were employed as trade professionals or first responders. Several worked in entry-level delivery or trade jobs, with documented workplace stressors. Individuals had varying stressful experiences at work. In one case, the decedent expressed frustration about low wages. Another decedent died by suicide after sustaining a workplace injury. Two individuals expressed a strong interest in joining the military but were unable to do so for medical reasons. Pathways for entry into the workforce can be limited, exposing a critical gap in resources for job seekers and early career individuals seeking alternative pathways to advance.

Navigating Relationship Conflict

Relationships with family members, friends, and significant others are central to the lives of many young adults. Supportive relationships can be protective factors against suicide, while relationship conflicts can precipitate crises.[17] Shame and rejection for young adults can be devastating, particularly when paired with the threat of the dissolution of a romantic relationship. Research shows that young men are at elevated risk for suicide immediately after a relationship breakdown, which was corroborated by trends in reviewed cases.[18] In 15% of reviewed cases, an argument with a significant other occurred in the 24 hours prior to suicide; arguments were related to infidelity and pregnancy. These cases reinforce evidence that relationship conflict is a critical trigger for suicide in young adults, suggesting a need for targeted supports such as counseling and crisis outreach.

Cohabitating with Relatives

As young adults enter the workforce, attaining financial independence and stable housing can be major stressors. Families often support and cohabitate with adult children during this transitional period. Most young adults under 25 live with their parents or other relatives in the US,[19] which was a trend reflected in reviews. In 50% of cases reviewed, the decedent was noted as living with relatives at the time of death. In 10% cases, the decedent was confirmed to be living with a significant other. In a quarter of cases, the decedent experienced housing insecurity in the year prior to death, which in some cases was related to conflict with cohabitating parents. Parents and caregivers experience a transitional period of their own as they navigate cohabitation with adult

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[16] Tayfur, S. N., Prior, S., Roy, A. S., Maciver, D., Forsyth, K., & Fitzpatrick, L. I. (2022). Associations between Adolescent Psychosocial Factors and Disengagement from Education and Employment in Young Adulthood among Individuals with Common Mental Health Problems. *Journal of youth and adolescence*, *51*(7), 1397–1408. https://doi.org/10.1007/s10964-022-01592-7

[17] Holman, M. S., & Williams, M. N. (2022). Suicide Risk and Protective Factors: A Network Approach. *Archives of suicide research : official journal of the International Academy for Suicide Research*, *26*(1), 137–154. https://doi.org/10.1080/13811118.2020.1774454

[18] Wilson MJ, Scott AJ, Pilkington V, et al. (2025). Suicidality in men following relationship breakdown: A systematic review and meta-analysis of global data. *Psychological Bulletin*., 151(7):819-860. doi:10.1037/bul0000482

[19] United States Census Bureau. (2024). Historical Living Arrangements of Adults. https://www.census.gov/data/tables/time-series/demo/families/adults.html

children, but the availability and accessibility of formal supports and services to assist with maintaining healthy, supportive relationships are typically limited.

Criminal Justice History and Impulsivity

Young adults with a history of criminal justice involvement face an increased risk of suicide, particularly in crisis situations after experiencing court proceedings.[20] In Maryland, crime reporting data from 2023 showed that individuals aged 19-24 made up 13% of arrests while only accounting for 7% of the state's population.[21] Young adults aged 18-26 are also disproportionately represented in criminal justice supervision, making up 20.3% of individuals under parole and probation while representing 11% of Maryland's population.[22] Criminal justice history was a factor noted in a quarter of reviews, with a history of probation present in 20% of cases. In two cases, justice-involved individuals perpetrated felony crimes in the 24 hours prior to death. For both individuals who had recently perpetrated a crime, no history or proximate signs of suicidal ideation were noted in records. Fears of criminal-legal consequences appeared to contribute strongly to an impulsive decision to die.

In the Moment of Crisis

The transitional nature of young adulthood often introduces challenges. When combined with underlying risk factors, encountering unexpected hardship or conflict can rapidly precipitate crises. For the majority of decedents, there were multiple opportunities to intervene and prevent suicide during the period of acute risk. If equipped appropriately, loved ones and first responders can take life-saving action to support young adults in the moment of crisis.

Others Aware of Risk

Many young adults cohabitate with family, lean on friendships for support, and form strong emotional connections to intimate partners. As a result, individuals with personal relationships with young adults are often best positioned to notice warning signs of mental health crisis and suicide. In the majority of reviews, someone with a personal relationship to the decedent reported interacting with them in the 24 hours prior to death. In a third of reviewed cases, at least one person was aware of the decedent's imminent risk of suicide in the 24 hours prior to death. Five decedents made an explicit statement about a desire to die, while one made statements that a parent interpreted as having an immediate intent to die. In cases where an explicit indication was not present, several decedents made cryptic statements and/or discontinued communication with

[20] Kemp, K., Poindexter, B., Ng, M. Y., Correia, V., Marshall, B. D. L., Koinis-Mitchell, D., & Tolou-Shams, M. (2022). Early Identification of Suicide Risk Factors Among Justice-Involved Youth. *Criminal justice and behavior*, *49*(5), 730–744. https://doi.org/10.1177/00938548211059504

[21] Maryland Department of State Police. (2023). *2023 Uniform Crime Report*. https://mdsp.maryland.gov/Document%20Downloads/Crime%20in%20Maryland%202023%20Uniform%20Crime%20Report.pdf

[22] Department of Parole and Probation, Maryland Department of Public Safety and Correctional Services. (undated). COVID-19 Dashboard. https://dpscs.maryland.gov/covid-19/index.shtml

a loved one in a way that raised concern for them.

Actions taken by those who were aware of the decedent's risk of suicide varied widely. Concerned individuals with relationships to decedents often tried to handle crisis situations without directly intervening or involving first responders, hesitating to call emergency services until decedents went missing or were discovered unresponsive. In 20% of reviewed cases, the concerned person consulted or enlisted the help of a trusted friend or loved one before taking further action. For three decedents, a concerned loved one was present at the scene of death and attempted to convince the decedent to stay alive. In two cases, concerned loved ones tried to take a firearm from the decedent and were unsuccessful.

Law enforcement support was the external resource used in the moment of crisis most frequently in reviewed cases, with a law enforcement wellness check or a missing person's search made for 35% of decedents. Law enforcement was present at the scene for 3 decedents at the time of death. The 988 Suicide and Crisis Lifeline was used in two cases, but contact was discontinued by the decedent in both cases.

Access to Firearms

For young adults at risk of suicide, having access to a firearm during a crisis can dramatically increase the likelihood of a fatal attempt.[23] While firearms are used in a small proportion of suicide attempts, ninety percent of suicide attempts using firearms result in death.[24] [25]

Firearms and ammunition used in reviewed cases were obtained in a variety of ways. In the majority of cases where an owner was documented, firearms were owned by the decedent. In 25% of cases, the decedent had multiple firearms with them at the time of death. "Ghost guns" and long guns become easily accessible for individuals at risk of suicide without regulation, widespread implementation of lethal means screening, and use of tools like Extreme Risk Protective Orders (ERPOs). An EPRO is a civil court order that temporarily prohibits firearm access for an individual who poses a danger to themselves or others, or presents with certain risk behaviors. "Ghost guns" (unregistered firearms that are typically homemade) were used in 15% of reviewed cases. In multiple cases, individuals with a history of inpatient psychiatric hospitalization(s) were able to purchase a long gun shortly prior to suicide.

For the vast majority of reviewed cases, firearms were not stored securely. Use of a firearm safe

[23] Ajluni, V., & Amarasinghe, D. (2024). Youth suicide crisis: identifying at-risk individuals and prevention strategies. *Child and adolescent psychiatry and mental health*, *18*(1), 58. https://doi.org/10.1186/s13034-024-00753-9

[24]Miller M, Azrael D, Hemenway D. (2024). The epidemiology of case fatality rates for suicide in the northeast - *.Ann Emerg Med.*43(6):723-30. doi: 10.1016/j.annemergmed.2004.01.018. PMID: 15159703.

[25]Spicer RS, Miller TR. (2000). Suicide acts in 8 states: incidence and case fatality rates by demographics and method. *Am J Public Health* 90(12):1885-91. doi: 10.2105/ajph.90.12.1885. PMID: 11111261; PMCID: PMC1446422

was noted in one case, and restriction of ammunition access was noted in one case. No other safe storage practices were noted. In 45% of cases, a cohabitant knew that the decedent had access to a firearm in their shared residence. In 10% of cases, a cohabitant knew about firearms in the residence but believed that the decedent did not have access to the weapon. Outside of limited examples, lethal means restrictions were not documented prior to death. This points to the urgency of firearm safe-storage education, lethal means counseling, and ERPO use to prevent access during crises.

Young adults who engage in firearm hunting or sporting may be at higher risk of death by suicide, particularly using long guns. Among Americans who own firearms, the majority report they do so for personal or familial protection.[26] Those that own firearms for hunting or sporting may not perceive a risk of suicide associated with long guns.[27] In 25% of cases, decedents were identified as hunters in obituaries. In each of these cases, a long gun was used by the decedent in their suicide.

Concomitant Substance Use

Substance use can amplify the risk of suicide for young adults in crisis.[28] Individuals with substance use disorders are more likely to think seriously about suicide, and substances and impair judgment and impulse control[29] In several reviewed cases, evidence of substance use was recorded in combination with access to firearms during a suicidal crisis.

Toxicology results were positive for one or more substances in 40% of reviewed cases. Recent consumption of alcoholic beverages was indicated in 20% of cases. Sedatives, stimulants, and opioids also appeared in individual cases. Toxicology results were not available for scene inspection cases, which are cases where the OCME decides against performing a full autopsy based on the circumstances of the suicide.

Evidence of cannabis use was available in multiple cases. Data from the 2023 Maryland Cannabis Use Baseline Study indicated that the highest rates of current cannabis use were among young adults, with 16.7% of respondents aged 18-20 and 11.8% of respondents aged 21-25 attesting to past month cannabis use.[30] OCME has only recently begun testing for the presence of cannabinoids in toxicology, which resulted in limitations in detecting cannabis use. However,

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[26]Schaeffer K. (2024). Key facts about Americans and guns. Pew Research Center. https://www.pewresearch.org/short-reads/2024/07/24/key-facts-about-americans-and-guns

[27]Lee DB, Simmons M, Sokol RL, Crimmins H, LaRose J, Zimmerman MA, Carter PM. (2024) Firearm suicide risk beliefs and prevention: The role of fear of community violence and firearm ownership for protection.*J Psychiatr Res.* 171:340-345. doi: 10.1016/j.jpsychires.2024.01.034. Epub 2024 Feb 2. PMID: 38350311.

[28] Kumar, K., Saini, S.S. (2025). The Lethal Mix: Substance Abuse and Suicidal Behaviour. In: Kumar, U. (eds) Handbook of Suicide Prevention. Springer, Singapore. https://doi.org/10.1007/978-981-96-1403-5_18

[29]The Pew Charitable Trusts. (2025). Substance Use Disorder Increases Risk of Suicidal Thoughts and Attempts. https://pew.org/42MNn2f

[30]Maryland Medical Cannabis Commission. (2023). Maryland Cannabis Use Baseline Study https://dlslibrary.state.md.us/publications/Exec/MDH/NMLMCC/HG13-4401(b)_2022.pdf

cannabis paraphernalia was present at the scene of suicide in 20% of cases. Cannabis was also the most common recreational substance that appeared in cases, with clinical and police report records indicating that 50% of decedents had used cannabis at some point.

The Scene of Suicide and Postvention

The locations of suicide varied amoung the young adults who died by firearm suicide. In the majority of reviewed cases, decedents died in a location outside of their residence. A suicide note was documented in 35% of reviewed cases. In 15% of cases, unusual details about the scene of suicide were noted by death investigators and/or by law enforcement.[31] While the cases were initially investigated as suspicious and eventually ruled suicides, documentation about the decision-making process to rule out homicide was not well-documented in autopsy or police investigation reports.

How suicides were witnessed or discovered in reviewed cases also varied. Witnessing or discovering a suicide can be traumatic, and referrals to services for grieving families or affected first responders were not documented for most cases. In cases where a loved one discovered the decedent, many were described as distraught and unable to answer questions from investigators. Ongoing support for individuals who are navigating complex suicide bereavement and trauma related to suicide can help prevent suicides in the future. Models that include psychoeducation, support from trainer peers, arts-based programs, workplace interventions, and specialized psychotherapy have shown success in supporting survivors of suicide loss.[32] Unfortunately, in most reviewed cases, only 25% of cases had any evidence of support provided for bereaved loved ones. Crisis response services and mobile crisis were contacted to provide resources to families in 15% of cases. No referrals to services were noted for first responders who witnessed or discovered a scene of suicide. Expanding postvention resources for both families and first responders could reduce the ripple effects of suicide and prevent further loss.

Recommendations

Case reviews illuminated a multitude of opportunities to improve outreach, education, treatment, and services for Marylanders. Recommendations are intended to address gaps in systems that touch the lives of young adults in Maryland, helping to strengthen a safety net that can save lives and prevent suicide.

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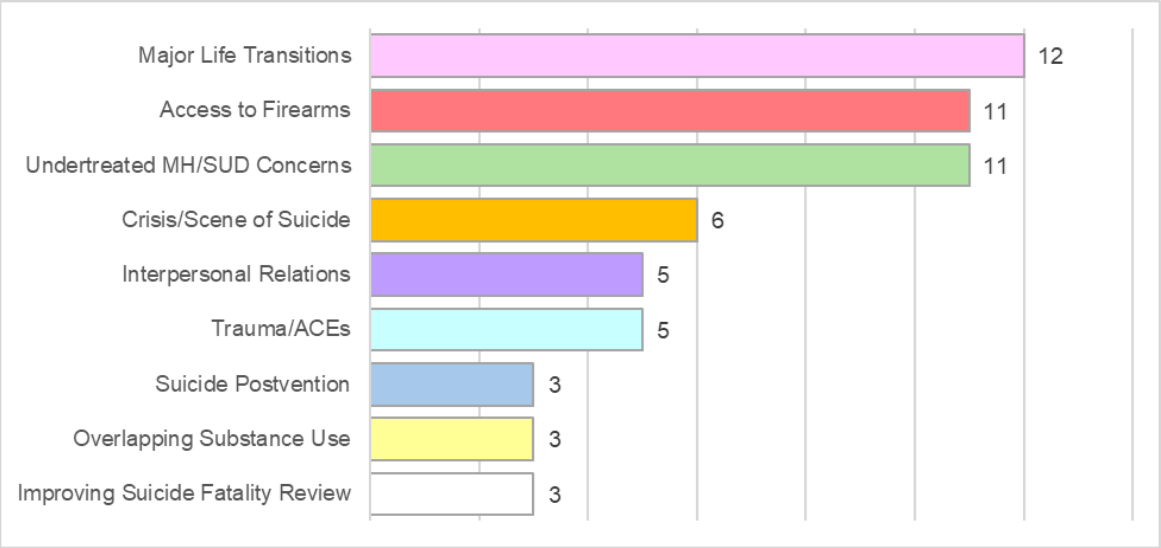
[31] Unusual details typically include position of the body, and complex or complicated suicide. See Töro, K., & Pollak, S. (2009). Complex suicide versus complicated suicide. *Forensic science international*, *184*(1-3), 6–9. https://doi.org/10.1016/j.forsciint.2008.10.020 and Arun M, Palimar V, Kumar PG, Menezes RG. (2010). Unusual methods of suicide: complexities in investigation. *Medicine, Science, and the law*, 50(3):149-153. DOI: 10.1258/msl.2010.010021. PMID: 21133267. https://europepmc.org/article/med/21133267

[32]Ramamurthy C, Fraser T, Krysinska K, Hawgood J, Kõlves K, Reifels L, Reavley N, Andriessen K. (2025). Effectiveness of suicide postvention service models and guidelines 2014-2024: A scoping review. *Prev Med.*195:108279. doi: 10.1016/j.ypmed.2025.108279. Epub 2025 Apr 10. PMID: 40220932.

The State Team's highest priority recommendations are organized by theme and domain. Each of the recommendations below connects to the themes identified in case review.

Chart 7. Key Themes by Number of State Team Recommendations



Recommendations have been categorized further into 6 domains, which describe implementing strategies and organizations: Education, Policy, Services, Clinical, Training, and Data. For the full list of recommendations, see Appendix E.

I. Education

Widespread public awareness and education in key suicide prevention topic areas has the power to destigmatize help-seeking and equip communities to connect to resources during crises. Education recommendations are focused on safe firearm selling practices and storage, universal education for loved ones, reducing stigma in key populations, and messaging about the impact of substance use and firearm access during suicidal crises.

- **Firearm safe storage messaging.** Developing and disseminating information about safely storing firearms can help reduce access to firearms for individuals at risk of suicide. Key messages can include information about elevated suicide risk in households with firearms, types of safe storage options, and information about voluntary safe storage

sites. Messages that are gun-friendly, emphasize home protection, and discuss in-home options for safe storage can be effective with firearm owners.[33]

- **Universal education about suicide prevention and 988.** Equipping communities with certain baseline information about suicide prevention and 988 can save lives. Messaging often focuses on use of 988 by individuals in crisis, missing the critical role of helping friends, families, and intimate partners. All Marylanders should receive messaging about warning signs of suicide and using 988 for guidance and referrals during crises.
- **Stigma reduction messaging for special populations.** Stigma surrounding mental health and substance use treatment is endemic in many communities, but beliefs and concerns vary widely. Messaging tailored to specific concerns (myths about medication, fears of law enforcement responses, worries about professional consequences, etc.) in populations with elevated rates of suicide can help reduce stigma. Key populations for stigma education messaging include first responders,[34] justice-involved individuals, Black/Brown communities,[35] [36]hunting/sporting communities, and colleges/universities.[37]

II. Policy

The systems encountered by individuals who are at risk of suicide are complex, but certain targeted structural changes can have an enormous impact on reducing the likelihood of fatal suicide attempts. Policy recommendations are focused on suicide prevention approaches that require legislative or regulatory frameworks related to firearm selling practices, enhancing suicide crisis and postvention responses, improve the continuity of healthcare, and bolster suicide prevention in workplaces and academic institutions.

- **Long gun purchasing restrictions for individuals under age 21.** In Maryland, handgun purchasers must be over age 21 and be licensed through the Maryland State Police. Long guns (rifles and shotguns) are more accessible and are disproportionately used by young Marylanders in suicide attempts.[38] Currently, Marylanders over the age of 18 can purchase long guns. By raising the minimum age for purchasing long guns, Maryland can

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[33]Anestis MD, Bryan CJ, Capron DW, Bryan AO. (2022). Evaluation of Safe Firearm Storage Messaging in a Sample of Firearm-Owning US Military Service Members.*JAMA Netw Open*5(10):e2235984. doi:10.1001/jamanetworkopen.2022.35984

[34] Bond, A. E., & Anestis, M. D. (2023). Understanding Capability and Suicidal Ideation among First Responders. *Archives of suicide research : official journal of the International Academy for Suicide Research*, *27*(2), 295–306. https://doi.org/10.1080/13811118.2021.1993397

[35] Goodwill J. R. (2024). Reasons for Suicide in Black Young Adults: A Latent Class Analysis. *Journal of racial and ethnic health disparities*, *11*(1), 425–440. https://doi.org/10.1007/s40615-023-01530-8

[36] Elhman, D.C., et al. (2022). Changes in Suicide Rates — United States, 2019 and 2020. *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, 71(8): 306-312. https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7108a5-H.pdf

[37] Oh, H. Y., Marinovich, C., Jay, S., Zhou, S., & Kim, J. H. J. (2021). Abuse and suicide risk among college students in the United States: Findings from the 2019 Healthy Minds Study. *Journal of affective disorders*, *282*, 554–560. https://doi.org/10.1016/j.jad.2020.12.140

[38] Nestadt PS, MacKrell K, McCourt AD, Fowler DR, Crifasi CK. (2020). Prevalence of long gun use in Maryland firearm suicides.*Inj Epidemiol*.;7(1):4. doi: 10.1186/s40621-019-0230-y. PMID: 32127045; PMCID: PMC6996182.

align with eight other states in the nation and help protect young adults at risk of suicide.[39] Pursuing the application of existing licensing requirements for handguns to long guns would increase the impact of this policy.[40]

- **Behavioral Health/Grief Specialists within or in collaboration with the medical examiner's office.** Many individuals and families who are impacted by suicide loss navigate complex emotions as they grieve, and can be at increased risk of suicide themselves.[41] OCME has direct contact with bereaved loved ones, which can be enhanced by embedding behavioral health/grief specialists to provide support and services. A study of a highly utilized, long-standing grief services program at the New Mexico Office of the Medical Investigator found that individuals who experienced traumatic loss by suicide made up 26% of utilization, second only to homicide (29% of utilization).[42] [43] Grief counselors in the New Mexico program were able to provide essential support to bereaved loved ones by providing information, helping during viewings of scene information, and assisting with body transportation planning. Other successful programs that integrate behavioral health support with medical examiner services exist in New York City;[44] Philadelphia, Pennsylvania;[45] and Denver, Colorado.[46]

III. Services

Individuals at risk of suicide interact with services across Maryland, many of which provide holistic support for needs outside of clinical settings. Creating, expanding, and connecting services for individuals and families can help prevent suicide through upstream approaches. Services recommendations are focused on support after traumatic events (including Adverse Childhood Experiences (ACES), housing insecurity, and suicide loss) and during major life transitions.

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[39]Everytown for Gun Safety. (2025). Minimum Age to Purchase .https://everytownresearch.org/rankings/law/minimum-age-to-purchase/

[40]Peck SC. (2024). Minimum Age Firearm Purchase Laws, by Themselves, Don't Prevent Youth Suicide. *Am J Public Health*;114(8):766-768. doi: 10.2105/AJPH.2024.307734. Epub 2024 Jun 13. PMID: 38870431; PMCID: PMC11224626. https://pubmed.ncbi.nlm.nih.gov/38870431/

[41] Suicide Prevention Resource Center. (2025). Provide for Immediate and Long-Term Postvention. https://sprc.org/effective-prevention/a-comprehensive-approach-to-suicide-prevention/provide-for-immediate-and-long-term-postvention/ .

[42]Berry RS, Aurelius MB, Barickman N, Lathrop SL.(2013). Utility of a grief services program for medical examiners' offices. *J Forensic Sci* 58(2):380-4. doi: 10.1111/1556-4029.12043. Epub 2012 Dec 27. PMID: 23278521.

[43]University of New Mexico Office of the Medical Investigator. (undated). Grief Services. https://hsc.unm.edu/omi/services/for-families/grief-services/

[44] New York City, Office of Chief Medical Examiner. Family Services Centers. https://www.nyc.gov/site/ocme/locations/family-services-centers.page .

[45] https://www.phila.gov/services/mental-physical-health/get-bereavement-support/

[46] City of Denver, Medical Examiner. (undated). Family Advocate Support Team (FAST). https://denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Medical-Examiner/Family-Advocate-Support-Team

- **Follow-up services after domestic violence (DV), intimate partner violence (IPV), and sexual violence.** Individuals and families impacted by DV, IPV, and sexual violence can experience a variety of adverse outcomes, including elevated risk of suicide[47][48]. Agencies and organizations that serve these impacted populations can provide a life-saving touchpoint. In addition to other trauma-informed services, service providers can screen for risk of suicide, provide screening about lethal means (including firearms), and can facilitate filing for ERPOs as needed. This strategy can be coupled with official partnerships at the state level between suicide behavioral health, and domestic violence prevention organizations.
- **Behavioral health outreach for justice-involved youth and young adults.** Individuals who have experiences with the criminal justice system have elevated rates of suicide.[49] [50] Research on help-seeking in intimate partnerships affected by incarceration points to barriers to service access, including a shortage of culturally specific services and fearfulness/distrust of institutions.[51] Increasing access to peer-based services, grief and bereavement services, and services that support pre-trial and post-conviction transitions can help prevent suicide for justice-involved individuals.[52] Equipping families and loved ones of justice-involved individuals with crisis resources that are not criminalizing can improve connections to support during suicidal crisis.
- **Robust postvention services for suicide loss survivors and individuals impacted by suicide loss.** Exposure to suicide can lead to negative outcomes, including an increased risk of suicide. One study estimated that a single suicide death can affect 115 people, with 1 in 5 exposed reporting "a devastating impact or caused a major life disruption."[53]In addition to providing immediate suicide postvention resources through the OCME and mobile crisis teams, ongoing suicide postvention resources can be expanded. Behavioral health providers should be trained to support individuals navigating traumatic grief.

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[47]Center for Disease Control and Prevention. (2025). About Adverse Childhood Experiences. Adverse Childhood Experiences (ACEs). January 31, 2025. https://www.cdc.gov/aces/about/index.html

[48] McManus S, Walby S, Barbosa EC, Appleby L, Brugha T, Bebbington PE, Cook EA, Knipe D. (2022). Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England.*Lancet Psychiatry* 9(7):574-583. doi: 10.1016/S2215-0366(22)00151-1.

[49] Slade K, Borschmann R. (2025) Suicide prevention following conviction within the criminal justice system: a review of good practice using a social-ecological framework.*BMC Glob Public Health* 3(1):79. doi: 10.1186/s44263-025-00199-x. PMID: 40903769; PMCID: PMC12409944.

[50]Mackenzie JC, Cartwright T, Borrill J. (2018) Exploring suicidal behaviours by probation clients-a qualitative near-lethal study. *J Public Health* (Oxf) 40(1):146-153. doi: 10.1093/pubmed/fdx005. PMID: 28159980.

[51]McKay T, Comfort M, Landwehr J, Kennedy E, Williams O. (2010). Partner Violence Help-Seeking in Couples Affected by Incarceration: Overcoming Barriers - RTI Press Policy Brief. Research Triangle Park (NC): RTI Press; 2010–. PMID: 33326194.

[52] Slade K, Borschmann R. (2025). Suicide prevention following conviction within the criminal justice system: a review of good practice using a social-ecological framework. *BMC Glob Public Health*, 3(1):79. doi: 10.1186/s44263-025-00199-x. PMID: 40903769; PMCID: PMC12409944.

[53]Suicide Prevention Research Center. (undated). Provide for Immediate and Long-Term Postvention – Suicide Prevention Resource Center .https://sprc.org/effective-prevention/a-comprehensive-approach-to-suicide-prevention/provide-for-immediate-and-long-term-postvention/

IV. Clinical

For many individuals at risk of suicide, entering and remaining connected to clinical treatment for an underlying mental health and/or substance use challenge can have a powerful protective impact. Clinical recommendations are focused on providing clinicians with essential tools and information for suicide prevention, coordinating care for patients, and increasing the presence and use of navigators.

- **Case management for suicide attempt and individuals with frequent Emergency Department (ED) use**. EDs treat many individuals who are at risk of suicide. Individuals with complex psychiatric needs may frequently utilize the emergency department to address their care needs. Implementing case management through dedicated case managers and/or team strategies can prevent suicide among this vulnerable population. Dynamic case management approaches that use collaborative, multifaceted approaches within provider teams and between healthcare organizations have shown success in reducing utilization and improving patient outcomes.[54] [55] [56]
- **ERPO navigators in clinical settings**. In 2018, Maryland became the first state in the nation to enact an ERPO law that authorized clinicians to file ERPO petitions. An ERPO filing initiates a civil court proceeding, which can result in a temporary or permanent restriction of firearm purchasing and possession for individuals at risk of harming themselves or others. A study of Maryland physicians found that 92% encountered patients who they would consider for an ERPO at least a few times per year, but the majority reported concerns about administrative burden and impact on patient relationships. For 87% of respondents, having a coordinator manage the process was selected as an effective strategy to address barriers to ERPO use.[57] ERPO navigators are being piloted in Baltimore City and Western Maryland. An analysis and expansion of pilots could extend the reach of a high-impact intervention.

V. Training

Service providers and clinicians may want to support individuals at risk of suicide, but may not have tools necessary to identify and intervene before, during, and after a suicidal crisis. Training

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[54] Miller IW, Camargo CA Jr, Arias SA, Sullivan AF, Allen MH, Goldstein AB, Manton AP, Espinola JA, Jones R, Hasegawa K, Boudreaux ED; ED-SAFE Investigators. (2017). Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. *JAMA Psychiatry*74(6):563-570.doi:10.1001/jamapsychiatry.2017.0678. PMID: 28456130; PMCID: PMC5539839.

[55]Malebranche M, Grazioli VS, Kasztura M, Hudon C, Bodenmann P. (2021) Case management for frequent emergency department users: no longer a question of if but when, where and how.*CJEM*.23(1):12-14. doi: 10.1007/s43678-020-00024-4. Epub 2020 Dec 10. PMID: 33683597; PMCID: PMC7726608.

[56]Tuller D. (2022). A New Way To Support Frequent Emergency Department Visitors. *Health Aff* (Millwood). 41(7):934-938. doi: 10.1377/hlthaff.2022.00680. PMID: 35787077.https://pubmed.ncbi.nlm.nih.gov/35787077/

[57] Frattaroli S, Hoops K, Irvin NA, McCourt A, Nestadt PS, Omaki E, Shields WC, Wilcox HC. (2019). Assessment of Physician Self-reported Knowledge and Use of Maryland's Extreme Risk Protection Order Law. *JAMA Netw Open,* 2;2(12):e1918037. doi: 10.1001/jamanetworkopen.2019.18037. PMID: 31860108; PMCID: PMC6991220.https://pubmed.ncbi.nlm.nih.gov/31860108 /

can equip gatekeepers with skills to prevent suicide. Training recommendations are focused on firearm safety, identifying and responding to suicide risk, and the role of key gatekeepers.

- **Lethal means screening and ERPO training for clinical providers**. Lethal means safety screening is widely recognized as a strategy to reduce risk of suicide, and is an essential component of effective suicide prevention and safety planning. Data from the Joint Commission revealed that only 28% of accredited hospitals developed a plan for lethal means safety with patients identified as at risk for suicide.[58] In a study of Maryland physicians focused on use of ERPOs to restrict firearm access for patients at risk of harming themselves or others, 86% endorsed training as a strategy to address barriers to ERPO use[59]Increasing clinical use of lethal means screening can help prevent suicide.
- **Suicide crisis response training for law enforcement.** Law enforcement is called to respond to many cases that involve a suicidal individual in crisis, particularly if a firearm is present. As part of general training, law enforcement who are dispatched to respond to a suicidal individual should receive training in signs and symptoms of mental health conditions, crisis de-escalation, writing effective emergency petitions, and filing ERPOs.

VI. Data

Integrating and improving data sources about individuals who die by suicide can provide vital insights, which can in turn inform prevention efforts. Data recommendations are focused on increasing available data through collaboration with key agencies.

- **Data sharing between 988 call centers, local first responder teams, and state agencies.** By increasing data matching and sharing between 988 call centers and organizations dispatched for crisis response, outcomes related to suicide death can be analyzed for process improvement. State agencies, including fatality review teams, can use insights from analysis to advocate for enhanced crisis response and support services.
- **Guidelines for suicide investigations.** State-level standards for gathering information related to suicides will likely agencies in developing effective prevention strategies based on stronger evidence.

Conclusion

The State team's collective expertise in government, healthcare, academia, and lived experience were used to develop recommendations to inform policy, practice, services, and resource improvements across Maryland. Its review of 20 firearm-related suicide fatalities among young

[58] Chitavi SO, Patrianakos J, Williams SC, Schmaltz SP, Ahmedani BK, Roaten K, Boudreaux ED, Brown GK. (2024). Evaluating the Prevalence of Four Recommended Practices for Suicide Prevention Following Hospital Discharge. *Jt Comm J Qual Patient Saf,* 50(6):393-403. doi: 10.1016/j.jcjq.2024.02.007. Epub 2024 Feb 23. PMID: 38538500.https://pubmed.ncbi.nlm.nih.gov/38538500/

[59] Frattaroli S, Hoops K, Irvin NA, McCourt A, Nestadt PS, Omaki E, Shields WC, Wilcox HC. (2019). Assessment of Physician Self-reported Knowledge and Use of Maryland's Extreme Risk Protection Order Law. *JAMA Netw Open,* 2;2(12):e1918037. doi: 10.1001/jamanetworkopen.2019.18037. PMID: 31860108; PMCID: PMC6991220.https://pubmed.ncbi.nlm.nih.gov/31860108/

adults aged 19-24 several key themes emerged, including common histories of un- or undertreated behavioral health concerns, challenges with transitioning to independent adulthood, prior or current criminal justice involvement, ready access to firearms, and families uncertain how to assist their loved one prior to the suicide and without access to sufficient resources such as grief counseling after their loss. The recommendations developed by the State Team reflect its best efforts to strengthen safety net services for Marylanders at risk of suicide, and an emphasis on actionable policies to reduce suicide and save lives throughout the state.

Appendix A - Membership

Health – General Article §5-100 and Senate Bill 94 (Chapter 81, Acts of 2022) provides that the State Team shall be a multidisciplinary team. For case reviews conducted in 2025, members included:

1) **State Team Chair & Healthcare Provider - Paul Nestadt, MD** – Psychiatrist and Associate Professor, Johns Hopkins School of Medicine
2) **State Team Co-Chair & MD Mortality and Quality Review Representative - Helayne Sweet, PhD** – Principal Health Care Systems Engineer, MITRE
3) **State Team Secretary & Secretary of Health, designee – Jen Pauliukonis, MPH** – Executive Director, MDH Center for Firearm Violence Prevention and Intervention
4) **Deputy Secretary of Behavioral Health Administration, designee – Dionne Bowie, LCPC** – Direction, MDH BHA Office of Integrated Wellness and Prevention
5) **Chief Medical Examiner, designee – Russell Alexander, MD** – Assistant Medical Examiner, Office of the Chief Medical Examiner
6) **Academic/Suicidologist Expertise – Holly Wilcox, PhD** – Professor, Johns Hopkins Bloomberg School of Public Health
7) **Academic/Psychological Autopsy Expertise – Alan Berman, PhD** – Psychologist and Adjunct Professor, Johns Hopkins University School of Medicine
8) **Suicide Prevention Organization – Steven A. Schonfeld, MD** – Retired Pulmonary Intensivist and Volunteer, American Foundation for Suicide Prevention
9) **Law Enforcement and/or Correctional Services – Lt. Steven Thomas, CCISM** – CIT and Peer Support Coordinator, Anne Arundel County Police
10) **Service Members and Veterans Services – Joy Ashcraft. LMSW** – Integrated Primary Prevention Specialist, Maryland Army National Guard
11) **Maryland Association of Behavioral Health Authorities (MABHA), Southern MD – Jaime Barnes, NCC, LCPC** – Assistant Director, St. Mary's Health Dept. Behavioral Health Division
12) **Maryland Association of Behavioral Health Authorities (MABHA), Western MD - Brooke Kerbs, LMSW** – Director of Child and Adolescent Services, Washington County Mental Health Authority
13) **Academic/Data Analytics Expertise – Hadi Kharrazi, MD, PhD, MHI** – Associate Professor, Johns Hopkins Bloomberg School of Public Health

14) **Crisis Response Expertise – Edgar Wiggins** – Retired Mental Health & Crisis Program Specialist, Independent Consultant

Former State Team Members who contributed to 2025 Case Reviews include:

1) **Secretary of Health, designee – Erin McMullen, MPP, MSN, RN**
2) **Substance Use Disorder Prevention Expertise – Michelle Hardy, RN, BC, MSPH**
3) **Maryland Violent Death Reporting System, designee – Carley Graves**

Appendix B - Data Sources

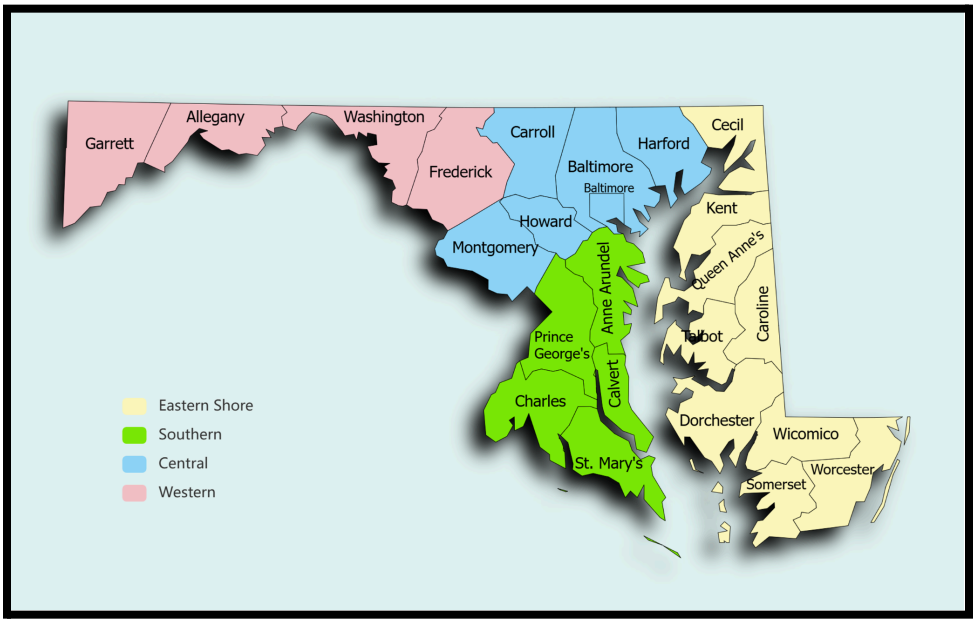
1. **Chesapeake Regional Information System for Our Patients**, Health Information Exchange (CRISP). CRISP hosts the State Team's secure case management system, where information about suicide decedents in Maryland is collected and stored. The CRISP case management system is accessible only for Maryland Department of Health Staff who support the State Team. CRISP also provides access to patient health records for suicide decedents.
2. **Vital Statistics Administration** (VSA). The VSA houses data used to report on births, deaths, marriages, divorces, fetal deaths, and a number of other vital events. VSA data is provided to the State Team directly through the CRISP secure data system.
3. **Office of the Chief Medical Examiner** (OCME). The OCME provides autopsy reports and toxicology results to the State Team. OCME is the statewide agency designated by law to investigate deaths that are sudden and unexpected, result from injury, occur under unexplained or suspicious circumstances, or when a person is not attended to by a physician.The objective of the forensic investigation and autopsy is to determine the cause and manner of an individual's death.
    - Cause of Death: The underlying medical condition, disease, or injury that begins a lethal chain of events resulting in death.
    - Manner of Death: Describes the way in which a death occurs, which may be Homicide, Suicide, Accidental, Natural, or Undetermined.
4. **Health Services Cost Review Commission** (HSCRC). The HSCRC provides information about patient health records which is matched and accessed through the CRISP case management system.
    - Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient), collected by the HSCRC.
5. **Maryland Institute for Emergency Medical Services Systems** (MIEMSS).- MIEMSS provides the State Team with records from emergency medical services (EMS) encounters for suicide decedents.
    - The Maryland Institute for Emergency Medical Services Systems (MIEMSS) oversees and coordinates all components of the statewide EMS system in accordance with Maryland statutes and regulations.
6. **Maryland Public Behavioral Health System** (PBHS). The PBHS provides the State Team with records related to behavioral healthcare covered for individuals who are uninsured and/or require Medicaid reimbursement for behavioral healthcare
    - The PBHS is a statewide system of care that provides behavioral health services to Medicaid beneficiaries, dual eligibles, and the uninsured.

7. **Prescription Drug Monitoring Program** (PDMP). The PDMP provides the State Team with information about prescription medications.
    - The PDMP monitors the prescribing and dispensing of drugs that contain controlled substances (CS). CS dispensers, including pharmacies and healthcare practitioners, report CS information on Schedules II through V dispensed to a patient or a patient's agent in Maryland.
8. **Public Courts Records** - Maryland Case Search provides the State Team with records about justice system involvement for suicide decedents.
9. **Law Enforcement Reports** - Law enforcement reports are provided through the Law Enforcement/Correction representative on the State Team. Information is obtained through the LInX system, which is accessible to certified law enforcement.
10. **Public Obituaries** - Provides social history information about suicide decedents for the State Team.
11. **Maryland Violent Death Reporting System** (MVDRS). The MVDRS is a statewide surveillance system that organizes and maintains a timely, detailed body of information concerning violent death incidents (homicide, suicide, deaths of undetermined manner, and accidental firearm-related deaths) occurring in the state of Maryland. The MVDRS is a subsidiary of the National Violent Death Reporting System (NVDRS), administered and funded by the Centers for Disease Control and Prevention (CDC). MVDRS data is used in reporting, but is not currently used for development of fatality review cases due to data lag.

Appendix C - Regions of Maryland

In order to ensure that cases would be selected from all parts of Maryland, the State Team divided Maryland into regions of focus. Four regions were created, which accommodated region-based case selection that accounted for constraints in available cases and volume of reviews for 2025.

Chart 8. Map of Maryland Regions Used by State Team



Western Maryland

- Allegany
- Frederick
- Garrett
- Washington

Central Maryland

- Baltimore City
- Baltimore County
- Carroll
- Harford
- Howard
- Montgomery

Southern Maryland

- Anne Arundel
- Calvert
- Charles
- Prince George's
- St. Mary's

Eastern Shore

- Caroline
- Cecil
- Dorchester
- Kent
- Queen Anne's
- Somerset
- Talbot
- Wicomico
- Worcester

Appendix D - Table of Selected Key Themes

Table 4. Key Themes and Contributing Factors in State Team Reviewed Cases, 2025

Key Theme/Contributing Factor	% of Reviewed Cases (n=20)
Underlying Risk Factors	
ACEs	55%
Parental Separation/Divorce	40%
Childhood physical abuse	10%
Domestic violence	10%
Parental incarceration	10%
Multiple ACEs	10%
Undertreated MH/SUD Concerns	
Indications of Non-Suicidal Self Injury (NSSI)	35%
Indications of MH/SUD Concern	90%
Depression/Depressive Episodes	55%
ADHD	35%
Anxiety	20%
Substance Use Disorders	15%
No Records of Treatment	30%
Records of Treatment	70%
Prescription Medication	55%
Records of Formal Diagnosis	50%
Emergency Room/Urgent Care for BH Concern	40%
Ever treated for Suicidal Ideation	30%
History of Emergency Petition(s)	15%
Uninsured at Time of Death	30%
Major Life Transitions	
Academics	
High School Graduate/GED	100%
Attended some college	35%

Key Theme/Contributing Factor	% of Reviewed Cases (n=20)
University	15%
Community College	10%
Workforce - Employed at time of death	45%
Relationship Conflict - Contributing Argument w/ Intimate Partner	15%
Housing	
Cohabitating with Relatives	50%
Cohabitating with Intimate Partner	10%
Housing Insecurity in Year Prior to Death	25%
Criminal Justice History	
Any History	25%
Post-conviction Incarceration and/or Probation	20%
Moment of Crisis	
Someone with personal relationship interacted within 24 hours of death	80%
Someone aware of suicide risk at time of death	30%
Someone concerned consulted a loved one for help	20%
Someone with personal relationship present at scene of death	15%
Missing person's search or wellness check conducted by law enforcement	35%
988 Suicide & Crisis Lifeline used	10%
Access to Firearm	
Decedent owned firearm used in suicide	50%
Decedent part of hunting/sporting community	25%
Cohabitant relative owned firearm used in suicide	10%
Owner unknown	40%
Multiple firearms accessible at scene of death	25%
Cohabitant aware of decedent access to firearm	45%
Firearm Type	
Handgun	40%
Long Gun	60%
Obtained shortly prior to suicide	15%
Ghost Gun	15%
Overlapping Substance Use	
Positive toxicology results	40%
Alcoholic beverages	20%
Prescription antidepressants (SSRIs & SNRIs)	20%
Sedatives	10%
Stimulants	10%
Toxicology not available	15%
History of cannabis use	50%
Cannabis paraphernalia on scene	20%
Scene of Suicide	
Location	
Outdoor location	35%
Decedent's residence	45%
Vehicle	20%
Suicide note present	35%
Witnessed directly by law enforcement	15%
Firearm discharge heard by cohabitant	20%
Decedent discovered unresponsive/deceased	85%
By law enforcement	30%
By intimate partner	15%
By stranger(s)	10%

Key Theme/Contributing Factor	% of Reviewed Cases (n=20)
By friends/family friend(s)	30%
By sibling(s)	20%
By parent(s)	20%
Survivors of suicide loss referred to support	25%
By CIT/Mobile Crisis	15%

Source: Multiple Sources (see Appendix C)

*NH indicates non-Hispanic. Race/Ethnicity categories are collapsed in OCME/VSA data.

Appendix E - List of All State Team Recommendations by Domain

I. Education

Recommendation	Focus Area
Develop and disseminate firearm safe storage messaging to firearm owners and the general public	Access to Firearms - Owners
Provide universal education to empower families and loved ones to prevent suicide at touchpoints, including education about using 988 for guidance and referrals during crises	Interpersonal Relations
Create suicide and mental health treatment stigma reduction messaging for special populations (first responders, justice-involved individuals, Black/Brown communities, hunting/sporting communities, and colleges/universities)	Un- or Undertreated MH/SUD Concerns
Inform firearm retailers and ranges about the risk of suicide and their role in prevention	Access to Firearms - Sellers
Provide universal education to youth and young adults (supportive peers) about suicide prevention	Interpersonal Relations
Create educational campaigns about suicide and access to firearms while under the influence of substances	Overlapping Substance Use
Pursue a public awareness campaign with entertainment/sports organizations to reach young adults	Undertreated MH/SUD Concerns

II. Policy

Recommendation	Focus Area
Implement long gun purchasing restrictions for individuals under age 21	Access to Firearms - Owners
Establish standards for law enforcement investigating suicide cases and documenting decision-making	Crisis/Scene of Suicide – Law Enforcement
Embed Behavioral Health Scientists/Investigators in the Office of the Chief Medical Examiner to connect bereaved loved ones to resources and obtain information	Suicide Postvention
Create a statewide collaboration between domestic violence prevention organizations and suicide prevention organizations	Trauma/ACEs
Integrate health information exchanges (HIE) with the Prescription Drug Monitoring Program PDMP to flag prescription pick up/adherence	Un- or Undertreated MH/SUD Concerns

Ensure that all Maryland colleges/universities participate in a nationally recognized suicide prevention program	Major Life Transitions - Academics
Establish overdose and suicide prevention compliance standards for public entities, including universities, to provide referrals to sober living facilities	Overlapping Substance Use
Provide continuity of healthcare for individuals who move to Maryland from out of state	Un- or Undertreated MH/SUD Concerns
Reinstate federal regulations related to "ghost guns"(unregistered firearms)	Access to Firearms – Owners
Establish a state center for grief services for sudden/traumatic loss, including suicide loss	Suicide Postvention
Develop stronger automated messaging for individuals in crisis when making suicide-related web searches	Crisis/Scene of Suicide
Require firearm sellers and gun ranges to provide literature about suicide prevention to customers	Access to Firearms - Sellers
Create a "secret shopper" program for gun shops to collect data on whether policies are being implemented	Access to Firearms - Sellers
Create pathways for licensed professionals to receive suicide prevention support without losing licensure	Un- or Undertreated MH/SUD Concerns
Create a statewide collaboration with workplaces to implement policies for suicide prevention, including notifying emergency contacts for “no shows” and Employee Assistance Programs	Major Life Transitions - Workforce

III. Services

Recommendation	**Focus Area**
Provide follow-up services and screening for suicide risk/lethal means access for individuals and families who experience sexual violence, domestic violence, and/or intimate partner violence	Trauma/ACEs
Provide behavioral health supports and outreach specialists for justice-involved youth & young adults during and after judicial proceedings	Major Life Transitions - Criminal Justice History
Provide robust postvention services for survivors of suicide loss, impacted community members, and witnesses/discoverers of suicide deaths by enhancing state and community resources (mobile crisis teams, support groups, LOSS Teams, counseling services, etc.)	Suicide Postvention
Implement peer support programs at workplaces (trade professions, first responders, delivery services, food services)	Major Life Transitions - Workplaces
Expand and strengthen family navigator services	Interpersonal Relations
Provide counseling and/or navigator services for emerging adults during major life transitions (graduation, job-seeking, moving)	Major Life Transitions
Provide support for families experiencing financial difficulties, including foreclosures and contract/lien cases, by providing mental health and community resources at key contact points (evictions, courts, benefits offices)	Trauma/ACEs
Extend services available for college students with academic challenges, on probation, expelled, or otherwise discontinuing attendance	Major Life Transitions - Academics
Develop a Youth Crisis Line	Crisis/Scene of Suicide
Provide services to support youth and young adults who experience a parental separation or divorce	Trauma/ACEs

Provide services for individuals who experience loss of financial resources, housing, and/or insurance	Major Life Transitions - Workforce
Create programs to help emerging adults navigate relationship challenges	Interpersonal Relations
Create alternative pathways for individuals who are interested in serving in the military but are ineligible for service	Major Life Transitions - Workforce

IV. Clinical

Recommendation	Focus Area
Provide case management for individuals receiving frequent care for suicidal behavior in emergency rooms	Un- or Undertreated MH/SUD Concerns
Provide navigators for filing ERPOs in applicable clinical settings	Access to Firearms - Providers
Ensure warm handoffs and care coordination are provided for patients who are emergency petitioned/hospitalized for suicide-related concerns	Un- or Undertreated MH/SUD Concerns
Inform providers about patient outcomes related to suicide death	Un- or Undertreated MH/SUD Concerns
Increase coordination of care between provider types (therapists, psychiatrists, ERs, etc.)	Un- or Undertreated MH/SUD Concerns
Create a checkbox in electronic health record (EHR) forms for providers to screen for lethal means safety	Access to Firearms - Providers
Provide family navigators for pediatric mental health concerns	Trauma/ACEs
Promote provider guidance and training for considering risk of suicide when prescribing medication	Un- or Undertreated MH/SUD Concerns
Support alternate hours/telehealth options for clinical mental health services to increase access for shift workers	Major Life Transitions - Workforce

V. Training

Recommendation	Focus Area
Provide clinical training for providers to screen for lethal means access and ERPO	Access to Firearms - Providers
Provide training for law enforcement to respond to individuals at risk of suicide (de-escalation, using emergency petitions & ERPO)	Crisis/Scene of Suicide – Law Enforcement
Train medical care leadership about legal liability and care outcomes related to lethal means screening	Access to Firearms - Providers
Provide gatekeeper training for student leaders at colleges/universities	Major Life Transitions - Academics
Provide training for gun shop owners about suicide prevention, including sale of long guns	Access to Firearms - Sellers
Create a state microcredentialing program with essential suicide prevention education which can provide continuing education credits for licensed professionals	Un- or Undertreated MH/SUD Concerns
Provide gatekeeper and crisis intervention training for sober living facilities staff	Overlapping Substance Use

Provide gatekeeper training for parole and probation officers	Major Life Transitions - Criminal Justice History
Provide gatekeeper training for workplaces (particularly delivery services, food services) of youth and young adults	Major Life Transitions - Workforce
Provide gatekeeper training for religious leaders	Interpersonal Relations

VI. Data

Recommendation	**Focus Area**
Improve information sharing and data matching between 988 call centers, local first responder teams, and state agencies about suicide deaths	Crisis/Scene of Suicide
Allocate resources and update guidelines for law enforcement and field investigators to conduct more comprehensive investigations of suicide deaths	Crisis/Scene of Suicide
Leverage interorganizational partnerships to obtain new data sources for suicide fatality review, including from human services, private insurers, the VA, juvenile services, and local health departments	Improving Fatality Review
Conduct interviews of service professionals for suicide fatality reviews to enhance the information available in records	Improving Fatality Review
Conduct interviews of Next-of-Kin and pursue psychological autopsies for suicide fatality reviews to understand social history and proximate risk	Improving Fatality Review