STARK COUNTY HEALTH DEPARTMENT

"Striving Toward a **Healthier** Community."

SUICIDE FATALITY REVIEW ANNUAL REPORT 2022

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INTRODUCTION

In 2016, Stark County experienced a significant increase in teen suicide deaths. Stark County Mental Health and Addition Recovery (StarkMHAR) partnered with the Ohio department of health (ODH) and Centers for disease control and prevention (CDC) to address the increase in teen suicide death. The Northeast Ohio Youth Health Survey was implemented in schools in conjunction with the Stark County Health Department. Through survey results, StarkMHAR was able to address needs teens identified. These changes resulted in a decrease of suicide deaths within this age group.

Suicide deaths of all ages continued to significantly affect Stark County residents. StarkMHAR identified a need to continue to address the increase in suicide deaths of all age groups. In September of 2021, the Ohio Revised Code provided guidelines for counties to establish a Suicide Fatality Review Board under the direction of a health commissioner. In 2022, Kirkland Norris was appointed by the Stark County Commissioners to establish a suicide fatality review board with the purpose of reducing suicide deaths.

PURPOSE AND OBJECTIVES

The primary goal of the suicide fatality review (SFR) process is to reduce the incidence of suicide deaths in Stark County. This will be completed through a multidisciplinary and comprehensive review of individual suicide deaths. The SFR committee will identify, evaluate, and make recommendations to improve community programs and systems that serve Stark County residents.

The Ohio Revised Code 307.643 states "The purpose of the suicide fatality review committee is to decrease the incidence of preventable suicide deaths by doing all of the following:

(A) Promoting cooperation, collaboration, and communication between all groups, professions, agencies, or entities engaged in suicide prevention, education, or mental health treatment efforts.

(B) Maintaining a comprehensive database of all suicide deaths that occur in the county or region served by the review committee in order to develop an understanding of the causes and incidence of those deaths.

(C) Recommending and developing plans for implementing local service program changes and changes to the groups, professions and agencies, or entities that serve local residents that might prevent suicide deaths.

(D) Advising the department of health of aggregate data, trends, and patterns concerning suicide deaths."

This report will provide feedback and recommendations that community leaders and stakeholders have recommended after analyzing suicide deaths that occurred in 2022.

SFR MEETING TIME TABLE AND STRUCTURE

Frequency of Meetings

Meetings are held quarterly, or as often as necessary. The frequency of meetings are determined by how many cases are released for review. Three meetings were held in 2022.

Structure

The county commissioners appointed a health commissioner to establish the SFR committee. ORC 307.642 states, "The review committee shall consist of the following:

1. The chief of police of a police department in the county or region or the county sheriff or a designee of the chief or sheriff;
2. **A public health official or the official's designee;**
3. The executive director of a board of alcohol, drug addiction, and mental health services or the executive director's designee;
4. **A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery."**

The committee also chose to invite the county coroner as well as the county commissioners. Each invited member as the same duty and responsibility as the appointed members.

Voting- Each appointed official pursuant to ORC 307.642 and each agency has one vote on each matter brought before the team.

Quorum- At all meetings of the SFR team, the presence of a least a majority (3 of the 5 appointed officials) shall constitute a quorum for the transaction/purpose of business and voting. When quorum is not met, the SFR team will convene at a different time.

BOARD MEMBERS

Kirkland Norris, R.E.H.S, M.P.H
Health Commissioner

George T. Maier
Stark County Sherriff

Amanda Uhler BSN, RN,
Public Health Official

John Aller, PCC, LICDC
Executive Director of Stark County Mental Health and Addition Recovery

Dr. Maureen Ahmann, D.O
Physician

OTHER MEMBERS

Lauren Persinger, LPCC
Coleman

Janet Weir Creighton
Stark County Commissioner

Elena Aslanides-Kandis M.Ed, LPCC-S
Stark County Mental Health and Addiction Recovery

Aubrey Neuenschwander BSN, RN
Stark County Health Department

Anju Mader M.D
Stark County Mental Health and Addiction Recovery

Ronald Rusnak, M.D.
Stark County Coroner

Tim Berczik
Jackson Fire Department

Maria Middour, MPH, BSN, RN
Stark County Health Department

SFR REVIEW PROCCESS AND DATA SOURCES

The SFR committee is focused on decedents of suicide who resided in Stark County. Recognizing suicide as a public health issue is founded on an understanding of suicidal behavior arising from contextual, biological, environmental, systemic, and social stressors. This approach focuses on prevention by addressing the known factors that increase or decrease the likelihood of suicide.

For each death by suicide, the committee will collect age, sex, race, ethnicity, the year the death occurred, the location of the death, the cause of death, factors that contributed, medical records and any other pertinent information.

Data was collected from medical agency records, public data, community services and local service databases. The cases reviewed in this report were deaths that occurred in 2022. Each case review is discussed among the team to gather a comprehensive understanding of the context of the decedent's life and the events and actions that led for the fatality. The discussions highlight potential contributing factors, intervention implications and recommendations for systemic improvements.

Data sources include: ODH Gateway Mortality Warehouse, behavioral health records, medical records, criminal justice records, death certificates, forensic records, prescription drug records, social service records, and military/veterans' affairs records.

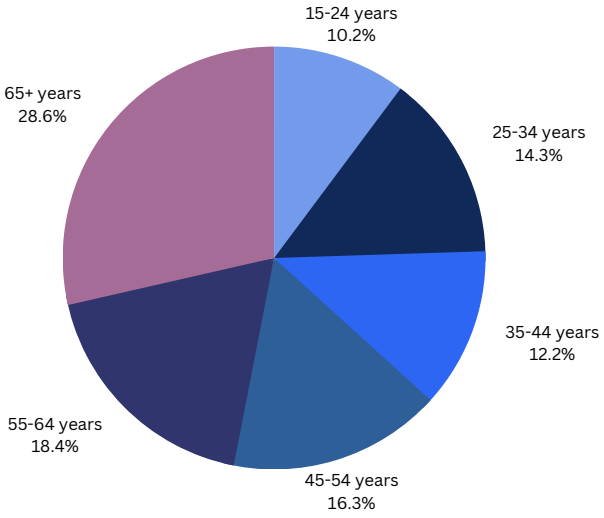
SFR ANNUAL REPORT SURVEY

Table 1: County Metrics

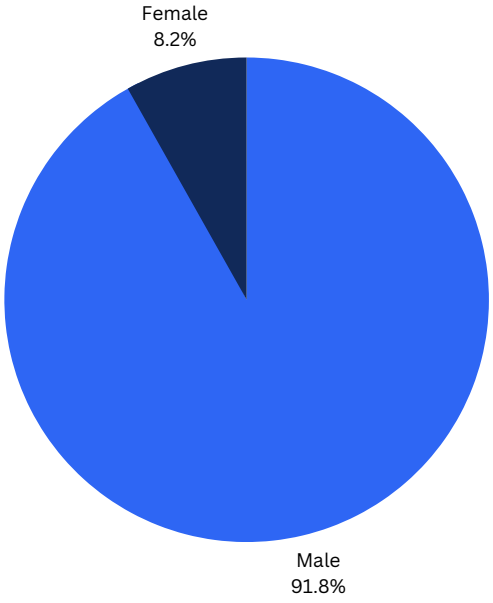
Total number of cases reviewed by SFR Committee	**7**

No previous years were reviewed by this committee in 2022. All cases reviewed occurred in 2022.

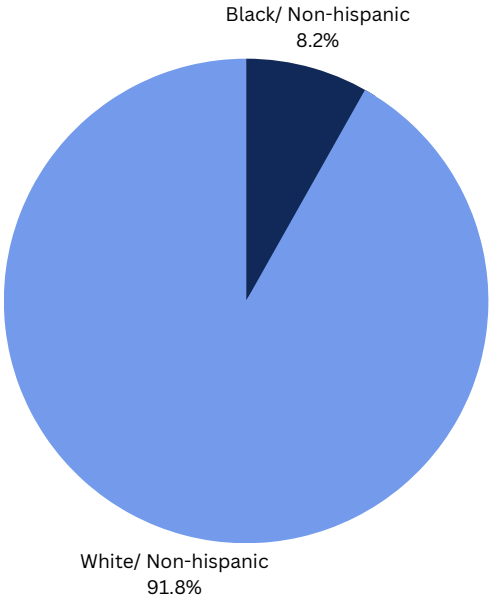
Graph 1: Age Metrics



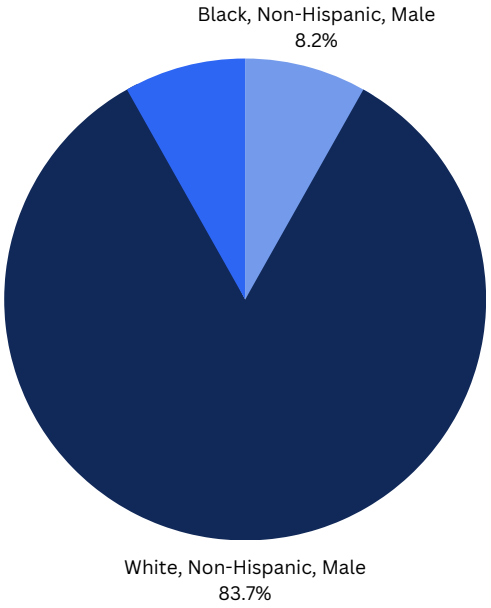
Graph 2: Sex Metrics



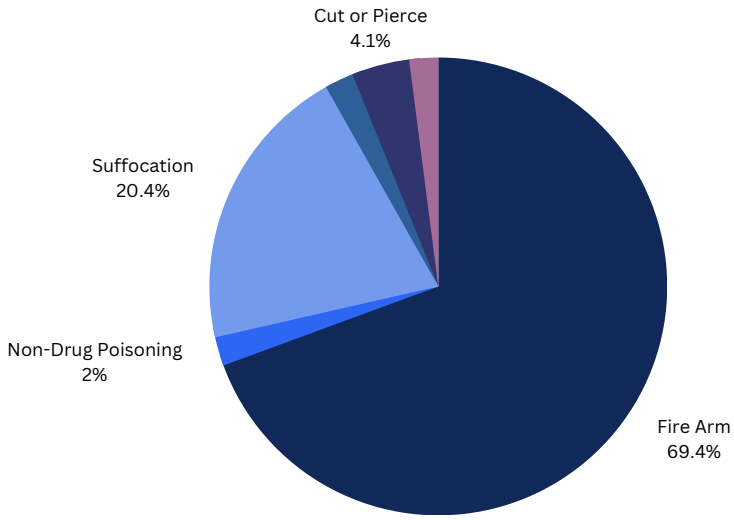
Graph 3: Race/Ethnicity Metrics



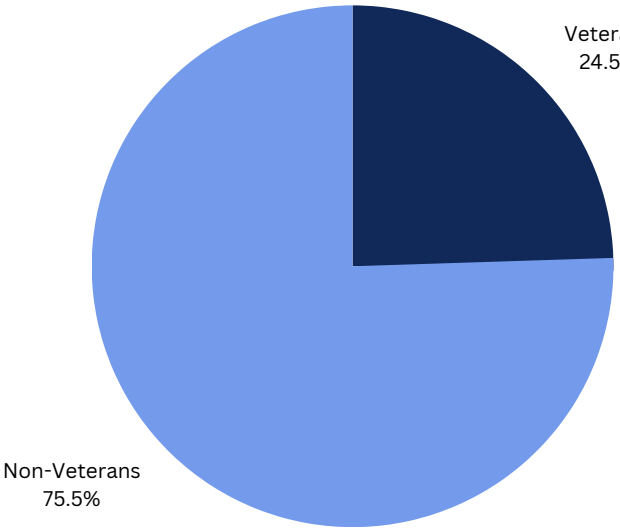
Graph 4: Race/Ethnicity/Sex Metrics



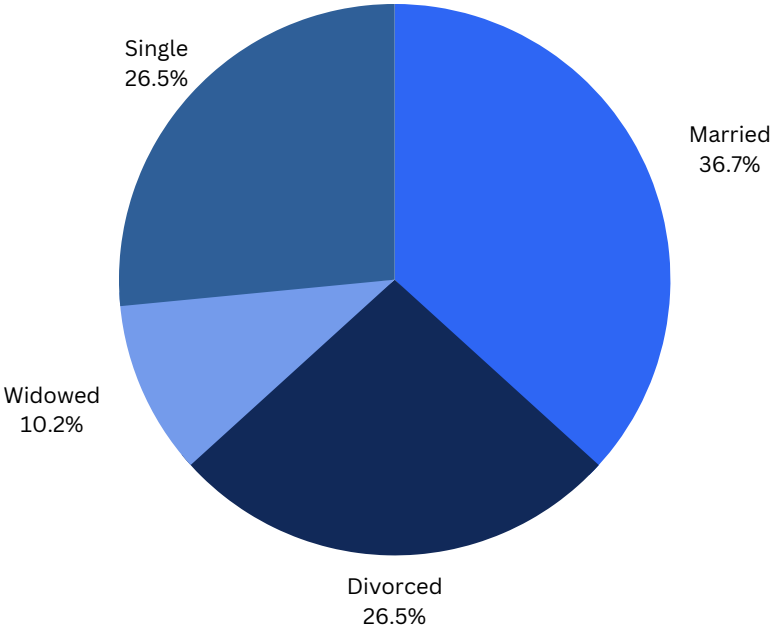
Graph 5: Method Metrics



Graph 6: Armed Services Metrics



Graph 7: Marital Status Metrics



STARK COUNTY SUMMARY INFORMATION

Trends/ Patterns

Sex	91.8% Male	8.2% Female		
Race	91.8% White	8.2% Black/African American		
Ethnicity	100% Non-Hispanic			
Method	69.4% Firearm	20.4% Suffocation	4.1% Cut or Pierce	6.1% Other

STARK COUNTY SUICIDE FATALITY REVIEW

2022 Recommendations

- When someone is given a terminal illness diagnosis, recommend an automatic referral to a behavioral health specialist. This specialist should make contact with the individual 1-2 days after receiving the diagnosis.
- Educate case managers, social workers, and medical personnel on how to interact with combative patients, including adding a suicide screening.
- Community education on how to safely store guns and times when guns should be removed from the home.
- When a screening is completed for suicidal ideation or depression, recommend temporarily removing guns or other weapons from the home.
- Make a safety plan, consider part of the plan to have another adult stay with the suicidal person at all times, similar to a children's safety plan.
- Educate the public on what to do if you have a mental health concern, when and where to seek help.
- Educate the public on how to help someone going through a mental health crisis.
- Increase primary care providers to be actively involved in behavioral health care for continuity of care.
- Provider education on HIPPA and ability to release records for continuity of care.
- Provider education related to utilizing Mobile Crisis.
- Limiting access to firearms.
- Screenings upon purchasing weapons to include depression, suicidal thoughts.
- Importance of following provider medication and follow-up recommendations.
- Encourage legislation change to allow death with dignity.
- Increased social support organizations for military personnel.
- Provider education about how to utilize PHQ-9 effectively.

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