State of Nevada, Department of Health and Human Services

Division of Public and Behavioral Health

Committee to Review Suicide Fatalities

Office of Suicide Prevention

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Edition 2.0

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Purpose: To provide an update to the Director of Health and Human Services on the progress of the Committee to Review Suicide Fatalities since the last report was released in October 2014. The report includes progress on infrastructure of the committee and initial recommendations for prevention.

Office of Suicide Prevention Background

In October of 2013, the Office of Suicide Prevention in the Division of Public and Behavioral Health began work in collaboration with the Director's Office to appoint and establish a statewide suicide fatality review committee and develop the protocols and tools to establish structure in the first year. Year 2 focused on the actual review process and development of initial recommendations. Although only a few cases are reviewed each year, these are examined in depth to understand the circumstances that led to the suicide fatality and identify areas to improve coordination and communication, as well as potential recommendations for changes to prevent future suicide fatalities. Cases are selected by the committee members based on data trends or special community concerns such as veteran suicide. Confidentiality procedures include all members signing a confidentiality agreement at all review meetings to remind participants of the confidential nature and create a record of participants for each case review meeting. Recommendations made as a result of team reviews will be shared with the Director of Health and Human Services by the Suicide Prevention Coordinator in an effort to coordinate efforts and focus statewide initiatives related to the prevention of suicide.

Committee to Review Suicide Fatalities Overview and Significance to Nevada

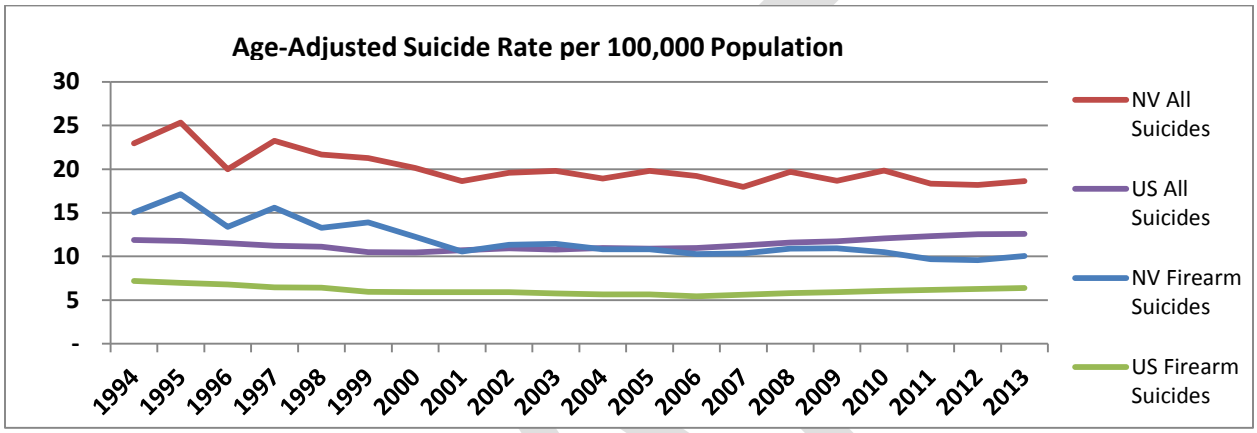
The Committee to Review Suicide Fatalities is based on other fatality review committees in the state and nation considered to be best practice tools. The process includes a multidisciplinary review team which compiles information to review suicide deaths. The review process allows the committee to identify opportunities for prevention and develop recommendations to improve systems that impact the prevention of suicide. In 2013, Nevada had the 6th highest rate of suicide in the nation.

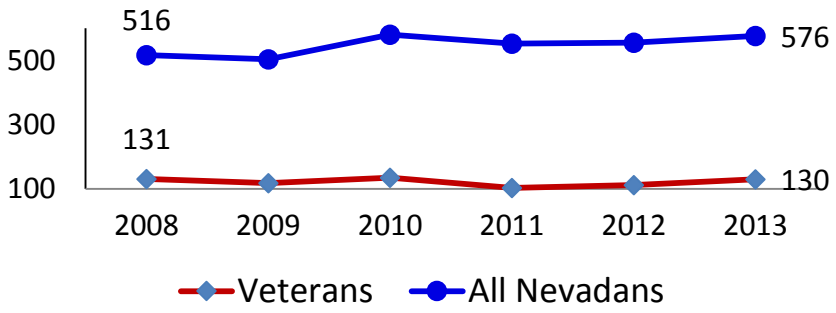
Facts

- Suicide is the 6th leading cause of death in Nevada; it is the 10th leading cause in the U.S.;
- Suicide is the second leading cause of death for Nevadans ages 10-34;
- More people die by suicide than motor vehicles crashes and homicides;
- More young people die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined;

- The methods of suicide most often used are firearms, hanging, and poisoning;
- The risk for suicide is highest among middle-aged Caucasian males followed by Caucasian males over 65;
- More than one in five people who die by suicide are Veterans.

Source: Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report for 2013; American Association of Suicidology). (2015). U.S.A. suicide 2013: Official final data.





Team Creation and Coordination in Nevada

The Committee to Review Suicide Fatalities is authorized by Nevada Statute (NRS) Chapter 439.5102. AB29 was enrolled in June, 2013 – the purpose is to prevent future deaths by suicide in Nevada by making recommendations for law, policy, practice changes, staff training and public education based on data from suicide fatality reviews. The Committee will gather information from national review committees and teams across the country that have been examining individual deaths to understand and evaluate: the death investigations; the causes of

deaths; the systems that touched the life of the deceased; the relevant risk and protective factors; and the actions that should be taken to improve systems and catalyze prevention.

Committee Members and Structure

October 1, 2013, the Director of the Department of Health and Human Services appointed the required members of the Committee to Review Suicide Fatalities. According to statute, after the initial term, each member of the Committee shall serve for a term of three years and may be reappointed. Each member of the Committee serves at the pleasure of the Director. Membership has changed in year 2, with three resignations, one coming at term end. I would like to extend my appreciation to Michael Murphy, Sgt. Annette Mullen and Dr. Melissa Piasecki for their service in helping to build the foundation of the CRSF and demonstrating how to properly complete a fatality review. Their expertise will be missed. There are currently two vacancies representing Native American tribes and organizations having expertise in suicide prevention. The members of the Committee elected Heather Shoop as the new chairperson in year two.

The Committee must consist of the following 10 members appointed by the Director:	***Appointed Member***	***Region***
(a) A county coroner or medical examiner or his or her designee;	John Fudenberg, Clark County Coroner	Southern Nevada
(b) One person who represents providers of health care;	Dr. Melissa Piasecki, University of NV School of Medicine Dr. (currently vacant)	Northern Nevada
(c) One person who represents organizations having expertise in suicide prevention;	Dr. Lesley Dickson	Southern Nevada
(d) One person who represents organizations having expertise in the treatment of substance abuse and prevention;	Heather Shoop, WestCare	Southern Nevada

(e) One person who represents mental health agencies;	Joanne Libertelli, Spring Mountain Treatment Center	Southern Nevada
(f) One person who represents law enforcement;	Sergeant Annette Mullin, Las Vegas Metropolitan Police (Sergeant John Harney appointed as LE representative)	Southern Nevada
(g) One person who represents injury prevention;	Michael Bernstein, SNHD and the Nevada Coalition for Suicide Prevention	Southern Nevada
(h) One person who represents Native American tribes;	VACANT	Rural Nevada
(i) One person who represents advocates for individuals and families with mental illness;	Debbie Smith	Northern Nevada
(j) One person who represents veterans	Marlyn Scholl, VHA	Northern Nevada

Technical Guidance:
Sharon Benson, Senior Deputy Attorney General
Jay Kvam, State of Nevada, Biostatistician, Division of Public and Behavioral Health
Luana Ritch, Ph.D., Quality Assurance Specialist 3, Mental Health Administrative Progress, Planning & Quality, DPBH

Staff to the Committee from the Division of Public and Behavioral Health:
Misty Vaughan Allen, Office of Suicide Prevention (OSP), Bureau of Child, Family & Community Wellness
Richard Egan, Training and Outreach Facilitator, Office of Suicide Prevention (OSP), Bureau of Child, Family & Community Wellness
Janett Massolo, Training and Outreach Facilitator, Office of Suicide Prevention (OSP), Bureau of Child, Family & Community Wellness
Angela Friedman, Program Assistant, Office of Suicide Prevention (OSP), Bureau of Child, Family & Community Wellness

Meeting Schedule

The CRSF met four times by teleconference and twice face-to-face, in which 15 cases were reviewed. In accordance with NRS 439.5108, suicide fatality reviews are not subject to the open meeting laws and were closed to the public. Minutes were recorded as long as the recording was secured in accordance with Nevada Open Meeting Law Manual 10.04. Data from case reviews was aggregated, de-identified, and individual identifications removed for analysis and reporting. Both in-person reviews started and ended with open meetings. The final meeting was open to the public to review the draft annual report and recommendations to the Director. This meeting of the Committee complied with the requirements of the State of Nevada Open Meeting Law, contained in NRS Chapter 241. A Public Comment item was included after each agenda item to allow members of the public to address the Committee. Agendas were developed by administrative support staff in cooperation with the Chairperson. Committee members suggested, for consistency, that a staff member should collect and present the information for all cases. Prior to each in-person meeting, the cases were reviewed and entered into the data collection tool. Staff presented each case, and additional expert information was added to the collection tool. Requests for follow-up information from committee members was then recorded and cases were brought back during subsequent reviews to complete with additional information.

Reporting

The Committee shall annually submit to the Director a report concerning the activities of the Committee. The report must include, without limitation, a statement setting forth: (a) Any trends or patterns in suicide fatalities in this State or serious injuries or risk factors concerning those fatalities; and (b) In addition to any recommendation made pursuant to section 4 of this act, any recommendations for changes in any law, policy, or practice that may assist the Committee in preventing suicide fatalities in this State or related serious occurrences.(c) A report submitted pursuant to subsection 2 must not include any confidential or privileged information.

MOU between VHA and CRSF

Marlyn Scholl shared the MOU has been approved as is without any need for changes by her supervisor and the Chief of Mental Health. The MOU is moving forward.

Common Risk and Protective Factors Discovered Through the Review Process

According to the National Strategy for Suicide Prevention, risk factors are characteristics that make it more likely that a person will think about suicide or engage in suicidal behaviors. The

most often cited risk factors are listed below. Those in bold were commonly discovered through the CRSF process.

Health Factors

Mental health conditions. 40%
Depression.
Bipolar (manic-depressive) disorder.
Schizophrenia.
Borderline or antisocial personality disorder.
Conduct disorder.
Psychotic disorders, or psychotic symptoms in the context of any disorder
Anxiety disorders.
Substance abuse disorders. 50%
Serious or chronic health condition and/or pain. 20%

Environmental Factors

Contagion would include exposure to another person's suicide, or to graphic or sensationalized accounts of suicide.
Access to Lethal Means including firearms and medications. 60%
Prolonged Stress Factors which may include harassment, bullying, relationship problems, domestic violence and unemployment. >30%
Stressful Life Events which may include a death, divorce, job loss or incarceration.

Historical Factors

Family History of Suicide.
Family History of Mental Health Conditions.
Previous Suicide Attempts. (1/3)
Childhood Abuse, Trauma.
Veteran status 35%

Protective factors are conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby decreasing risk for thoughts of suicide or behaviors. Opportunities to recognize suicide risk in the reviewed cases were often through primary care providers, pharmacies and through admission to an emergency department or mental health facility for assessments or after a suicide attempt. Increased education in suicide awareness, screening and intervention could improve access to care, follow up after discharge and continuity of care for patients at risk for suicide, substantially reducing the number of suicide deaths and suicide attempts that occur after discharge.

Committee to Review Suicide Fatalities Year 2 Recommendations

RECOMMENDATION #1: Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments and other hospital settings.

RATIONALE: Research shows that after hospitalization the risk for suicide increases over the next thirty days, leading the members to recommend establishment of protocols that provide continuity of care and appropriate outpatient follow up care for persons at risk for suicide. Referring ED patients to follow-up services is a critical piece of developing a thorough discharge plan.[1] The committee recognizes the barriers that currently exist to appropriate follow up care with the abundance of admissions in emergency departments and mental health hospitals. Exploring effective programs where hospitals follow up with patients after release, ensure the patient is still taking the medication and is connected to outpatient services will help the person stay well. The committee suggested the booklet, "Caring for the Adult Patient with Suicide Risk: A consensus guide for emergency departments" be encouraged as a resource in the ER community. The Committee recommended exploring current programs to facilitate patient connection to services within the community which would encourage follow through with discharge plans, reduce return visits to the ED, and provide caring outreach during peak risk periods. Programs, such as the Crisis Call Center, that maintain memorandums of understanding with some psychiatric hospitals for follow-up, the MOST team, and DCFS's mobile crisis are all programs that can introduce patients and their families to alternatives which might help avoid visiting an emergency department if services are needed in the future, thereby reducing the demand on EDs, which are often not set up to provide trauma-informed care to patients at risk for suicide.

RECOMMENDATION #2: Resources available for suicide prevention do not adequately meet the burden of suicide in Nevada.

RATIONALE: Nevada's rate of suicide is increasing after ten years of slightly decreasing or holding steady. While the Office of Suicide Prevention works diligently to maximize current resources, increase initiatives that improve prevention across various populations and foster strong partnerships, resources to support these efforts have remained stagnant. The CRSF recommends additional funding to move statewide suicide prevention efforts forward.

RECOMMENDATION #3: Ensure notification is sent to the Veterans Health Administration by each Coroners' Offices whenever they are aware of a military member or veteran's death.

RATIONALE: Nevada needs to fill data gaps and enhance data collection tools and systems by encouraging coroners, medical examiners, and law enforcement to adopt an existing or adapted standardized suicide investigation form. Expand data use agreements between these various entities to include permissible data use to use emergency department and inpatient hospitalization discharge data to explore linkages with death certificate data to measure effect of ED follow up protocols.

RECOMMENDATION #4: Increase outreach to those affected by decedents' suicide deaths through Coroner's Office staff and others.

RATIONALE: The Committee identified the need to reach out to families who have lost loved ones to suicide. This recommendation serves two purposes. Survivors of suicide loss are at increased risk for suicide themselves. The members discussed the possible need for a "loss team" to follow up with family or others to offer resources for grief support. They discussed

the approach and timing of informing others of their increased risk and involvement with the funeral homes and mortuaries as well as existing community entities the work with families after traumatic loss. The second purpose would be to glean information from survivors of suicide loss that might improve prevention opportunities. A script will be developed to reach out to families utilizing consistent and sensitive language similar to a psychological autopsy.

RECOMMENDATION #4: Explore offering CEUs to pharmacy technicians and pharmacists for taking suicide awareness and prevention courses.
RATIONALE: Collaboration with the Board of Pharmacies could pave the way for training and awareness opportunities to improve early identification and awareness of reducing access to lethal means such as medications.

RECOMMENDATION #5: Increase help-seeking through awareness of hotlines on labels of prescription bottles or caps.
RATIONALE: Ninety-five percent of the population can be reached with a message on prescription bottles. The Committee suggests applying a label with the suicide prevention and substance use prevention phone numbers to prescription bottles.

RECOMMENDATION #6: Improve the collection of data pertaining to suicide attempts.
RATIONALE: Suicide attempt data is hard to collect as not all who attempt suicide go to a facility and not all attempts are documented. Also discerning between firearm accidents and medication overdose versus suicide attempts is difficult. The state is beginning to improve data collection. Possible situations could arise where hospitals wish to discharge a person who is physically ready but not mentally ready for discharge. Patients might rationalize, minimize, or deny the attempt, and dismiss inpatient and outpatient counseling. Hospital files may be missing mental health notes or the notes may get lost within an extensive medical file. As medical records are electronically documented, discovering peripheral codes related to suicide may be easier.

RECOMMENDATION #7: Increase outreach to human resources departments of large corporations to establish suicide awareness and prevention trainings.
RATIONALE: Unemployment and job loss may cause stressors that can greatly increase risk for suicide. Opportunities training staff in the state's Division of Welfare and Supportive Services and Department of Employment, Training and Rehabilitation are important.

RECOMMENDATION #8: Focus on the connections between substance use disorders and suicide prevention.
RATIONALE: The state of Nevada has several strategic plans with initiatives to improve outcomes related to substance use disorders and suicide prevention. The Committee encourages the integration of these efforts.

The Committee to Review Suicide Fatalities Next Steps

The Nevada Office of Suicide Prevention will support and advance the recommendations found in this report. OSP and the Committee to Review Suicide Fatalities will continue improve our reviews while exploring new and innovative opportunities and recommendations for prevention in the coming year. OSP is grateful to the members of the CRSF and their service as advisors in the development of this report. After a decade of suicide prevention efforts in Nevada, OSP recognizes that our state and national rates are rising. We need to make systems-level changes that impact the whole person if we are to stop this trend. Through the extensive expertise of the CRSF and through our willingness to collaborate with diverse partners, we will pursue resources, partnerships and the integration of proven prevention strategies to improve the safety from suicide and the wellness of all Nevadans.

1. Suicide Prevention Resource Center. (2013). Continuity of care for suicide prevention: The role of emergency departments. Waltham, MA: Education Development Center, Inc.