

**State of Nevada, Department of Health and Human Services  
Division of Public and Behavioral Health**

**Committee to Review Suicide Fatalities**

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Office of Suicide Prevention

Misty Vaughan Allen

4/13/2016

Edition 2.0



***Brian Sandoval, Governor  
Richard Whitley, MS, Director, DHHS  
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## Executive Summary

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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 (CRSF) since the last report was released in October 2014. The report includes progress on infrastructure of the committee and initial recommendations for prevention.

**Significance:** In 2014, Nevada had the 6<sup>th</sup> highest rate of suicide in the nation.

- Suicide is the 8<sup>th</sup> leading cause of death in Nevada; it is the 10<sup>th</sup> leading cause in the U.S.;
- Suicide is the second leading cause of death for Nevadans ages 15-34;
- 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.

### **Committee Recommendations to address the problem:**

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

RECOMMENDATION #2: Acquire additional funding to move statewide suicide prevention efforts forward.

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

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

RECOMMENDATION #5: Follow up on contact with mortuaries to increase opportunities for survivor support.

RECOMMENDATION #6: Develop a relationship with the Board of Pharmacy to facilitate exploration of offering CEUs to pharmacy technicians and pharmacists for taking suicide awareness and prevention courses.

RECOMMENDATION #7: - Partnering with the Board of Pharmacy, work to implement suicide hotline phone number labels on prescription bottles.

RECOMMENDATION #8: Improve the collection of data pertaining to suicide attempts.

RECOMMENDATION #9: Increase outreach to human resources departments of large corporations, other businesses and unions to establish suicide awareness and prevention trainings.

RECOMMENDATION #10: Focus on the connections between substance use disorders and suicide prevention.

RECOMMENDATION #11: Increase public awareness around the *Reducing Access to Lethal Means* program and expand participation of diverse partners to reduce access to other common but more challenging means.

RECOMMENDATION #12: Reduce stigma in the Hispanic community through culturally appropriate outreach.

**Toward the future:**

The Nevada Office of Suicide Prevention (OSP) will support and advance the recommendations found in this report. OSP and the Committee to Review Suicide Fatalities will continue to improve review processes 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. Other areas of improvement should be in documenting sexual orientation and gender identity when completing investigations and reports. Suicide is significant among LGBT, and Nevada has very little accurate data to guide our prevention efforts. Through the extensive expertise of the CRSF and through the willingness to collaborate with diverse partners, OSP will pursue resources, partnerships and the integration of proven prevention strategies to improve the safety from suicide and the wellness of all Nevadans.

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### **Committee to Review Suicide Fatalities Overview and Significance to Nevada**

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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.

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### **Case Selection Methodology<sup>1</sup>**

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Cases are selected randomly by the methodology developed by the State Biostatistician as well as recommendations by the committee members based on data trends or special community concerns such as veteran suicide. This section provides basic statistics about the number of suicides that occurred in Nevada or to Nevada residents during 2013, the latest complete calendar year of death data and suggests potential criteria for sampling the records to ensure that they are representative of various demographic groups. Because the work of the Committee to Review Suicide Fatalities (CRSF) is more qualitative than quantitative, representativeness is the motivating factor for sample selection rather than sample size for statistical power.

In advance of the June 3, 2014 meeting of the committee, a preliminary, random selection of 10 suicides that occurred in Clark County, Nevada in 2012 was furnished to the Clark County Coroner's Office, so that additional information about the cases could be gathered and brought before the committee, so that it could conduct a cursory review in order to estimate an average length of time that a review might take and assess the committee's capacity. Ultimately, the number of cases that CRSF chooses will likely be a factor of the volume of cases that the committee can reasonably process and attentively review, thus, what follows represents relevant considerations for case selection and establishes a bare minimum of cases necessary to ensure demographic representation. With the goal of selection a representative sample, the following demographic variables were considered:

- age group (0-17, 18-24, 25-64, 65+)
- sex (female, male)
- race (White; Black; American Indian, Eskimo, or Aleut; or Asian or Pacific Islander)
- ethnicity (Hispanic, non-Hispanic)

- residency (Nevada, out-of-state)
- county of death (Carson City, Churchill, Clark, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, Washoe, White Pine)
- military service (veteran, non-veteran)
- cause-of-death [international classification of diseases (ICD) code ]

#### Method of Sampling Death Certificates for the Committee to Review Suicide Fatalities:

Together, age group, sex, race, and ethnicity comprise the primary demographics; county of death and military service secondary demographic characteristics; and cause-of-death, the method-of-suicide. 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. 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. All committee members are required to sign a confidentiality agreement at all review meetings to remind participants of the confidential nature of the review process and create a record of participants for each case review meeting. During the initial stages of the committee it was identified, the team should have a review tool in order to capture consistent data on suicide that are reviewed. For each case reviewed, the CRSF completes a data collection tool to capture basic statistics for tracking and reporting information on cases reviewed. This tool also tracks recommendations for improvement. The data collection tool was developed with guidance from other Nevada fatality review committees, including the Executive Committee to Review the Death of Children, the Clark County Child Fatality Review Committee and the Domestic Violence Fatality Review Committee. Other states also shared their collection tools. This tool continues to evolve as the Committee's needs for review improvement are discovered.

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### Suicide in Nevada

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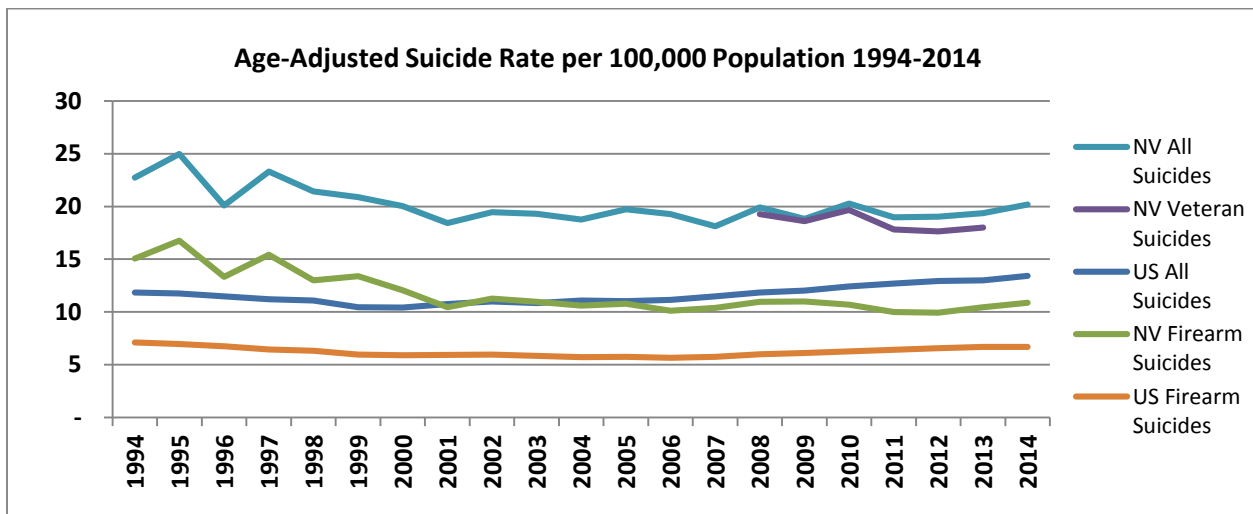
In 2014, Nevada had the 6<sup>th</sup> highest rate of suicide in the nation with 20.4 suicide deaths per 100,000.

#### **Facts:**

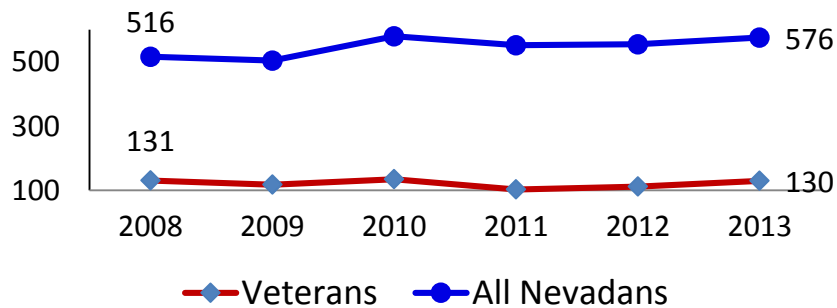
- Suicide is the 8<sup>th</sup> leading cause of death in Nevada; it is the 10<sup>th</sup> leading cause in the U.S.;
- Suicide is the second leading cause of death for Nevadans ages 15-34;
- More people die by suicide than motor vehicles crashes and homicides;

- 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 2014; American Association of Suicidology). (2016). U.S.A. Suicide 2014: Official final data.



**Veteran Suicide Rate per 100,000 Population 2008-2013**



## Team Creation and Coordination in Nevada

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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 gathers 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

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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 two, with three resignations, one coming at term end. The Office of Suicide Prevention extends appreciation to Michael Murphy, Sgt. Annette Mullen, Captain Leslie Mays, Senator Debbie Smith, Dr. Melissa Piasecki, and Joanne Libertelli 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 is currently one vacancy for a representative of Native American tribes. Staff to the CRSF has reached out to Native American organizations, coalitions and communities to fill this position. The members of the Committee elected Heather Shoop as the new chairperson in year two.

<b><i>The Committee must consist of the following 10 members appointed by the Director:</i></b>	<b><i>Appointed Member</i></b>	<b><i>Region</i></b>
(a) A county coroner or medical examiner or his or her designee;	Michael Murphy: 2013-2015 John Fudenberg, Clark County Coroner (2015-Current)	Southern Nevada
(b) One person who represents providers of health care;	Dr. Melissa Piasecki, University of NV School of Medicine (2013-2015) Kathy Ingelse, DNP, APRN, PMHNP-BC, FNP-BC, Orvis	Northern Nevada

	School of Nursing (2015-Current)	
(c) One person who represents organizations having expertise in suicide prevention;	Dr. Lesley Dickson, Nevada Psychiatric Association (2013-Current)	Southern Nevada
(d) One person who represents organizations having expertise in the treatment of substance abuse and prevention;	Heather Shoop, CADC, WestCare (2013-Current)	Southern Nevada
(e) One person who represents mental health agencies;	Joanne Libertelli, RN, MS Spring Mountain Treatment Center (2013-2016) VACANT	Southern Nevada
(f) One person who represents law enforcement;	Sergeant Annette Mullin, Las Vegas Metropolitan Police (2013-2014) Sergeant John Harney, Las Vegas Metropolitan Police Department (2015- Current)	Southern Nevada
(g) One person who represents injury prevention;	Michael Bernstein, M.Ed, Southern Nevada Health District and the Nevada Coalition for Suicide Prevention (2013-Current)	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;	Senator Debbie Smith (2013-2016) VACANT	Northern Nevada
(j) One person who represents veterans	Leslie Mays, Captain Nevada National Air Guard (2013-2014) Marlyn Scholl, LCSW, Veterans Health	Northern Nevada



	Administration (2015- Current)	
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Technical Guidance:

Sharon Benson, Senior Deputy Attorney General

Kyra Morgan (State Biostatistician) and Daniel Mackie (State Epidemiologist), State of Nevada, Biostatisticians, 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

### Meetings

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The CRSF met six times by teleconference and three times face-to-face, in which 21 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 identification 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 were then recorded and cases were brought back during subsequent reviews to complete with additional information.

## **Reporting**

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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 any trends or patterns in suicide fatalities in Nevada or serious injuries or risk factors concerning those fatalities, in addition to any recommendation made for changes in any law, policy, or practice that may assist the Committee in preventing suicide fatalities or related serious occurrences. Any report submitted must not include any confidential or privileged information. This report for year two adheres to these requirements.

## **Partnering to Improve Our Understanding of Veteran Suicide**

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Marlyn Scholl with the Veterans Health Administration, has worked diligently to gain support and approval of a Memorandum of Understanding (MOU). This MOU is made by and between the Nevada Committee to Review Suicide Fatalities (CRSF), and the Department of Veterans Affairs Sierra, Nevada Health Care System (VA) to allow the VA to share pertinent information and records relating to Veteran suicides in a confidential manner to the CRSF in a mutual effort to determine trends, risk factors and strategies for suicide prevention. The CRSF and the VA believe that the sharing of information pursuant to this MOU will be beneficial to both Veterans and the State of Nevada. The MOU is moving forward and will continue to be explored in 2016.

## **Common Risk and Protective Factors Discovered Through the Review Process**

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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.<sup>2,3</sup> The factors in bold were commonly discovered through the CRSF process and percentages are representative of the cases reviewed only. Due to the limited number of cases reviewed to this point, these are preliminary findings.

### 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*

*Gambling disorder*

**Substance abuse disorders 50%**

**Serious or chronic health condition and/or pain 20%**

Environmental Factors

Exposure to another person's suicide (contagion), or to graphic or sensationalized accounts of suicide (real life, media or Internet)

**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**

Lack of social support or connectedness

Feelings of burdensomeness

LGBT with lack of family or societal support or in a hostile environment

Religious doctrine for LGBT

Historical Factors

**Family History of Suicide**

Family History of Mental Health Conditions

**Previous Suicide Attempts 30%**

Childhood Abuse, Trauma

**Veteran status 15%**

Discrimination and homophobia (and biphobia and transphobia)

Coming out at a young age (LGBT)

The National Strategy for Suicide Prevention states: "Protective factors are not just the opposite or lack of risk factors. Rather, they are conditions that promote strength and resilience and ensure that vulnerable individuals are supported and connected with others during difficult times, thereby making suicidal behaviors less likely." Through the review process, the Committee has come up with twelve recommendations to enhance and promote protective factors that will reduce the impact of those risk factors determined most prevalent.

Opportunities to recognize suicide risk in the reviewed cases were often through primary care providers and pharmacies. The Committee also recognized opportunities for prevention through admission to an emergency department or mental health facility for assessments and 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.

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**Committee to Review Suicide Fatalities Year Two Recommendations**

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

RATIONALE: Research shows that after hospitalization the risk for suicide increases over the next thirty days.<sup>4</sup> Members of the Committee recommend establishment of protocols that

provide continuity of care and appropriate outpatient follow-up for persons at risk for suicide. Referring emergency department patients to follow-up services is a critical piece of developing a thorough discharge plan.<sup>5</sup> The Committee recognizes the barriers that currently exist to appropriate follow-up care with ever-increasing admissions to 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 suggests the booklet, “Caring for the Adult Patient with Suicide Risk: A consensus guide for emergency departments.” A similar guide for pediatric patients will be sought out and encouraged as a resource in the emergency response community. The Committee recommends 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 emergency department, and provide caring outreach post-discharge when risk can be highest. Community programs exist that collaborate with psychiatric hospitals for follow-up such as the MOST team, Crisis Call Center and DCFS’s Mobile Crisis Response Team. These 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. Funding to support these important programs and the collaboration with hospitals is crucial to solidify the safety net of this recommendation. According to the recently released Joint Commission Sentinel Event Alert, “identifying, developing and integrating comprehensive behavioral health, primary care and community resources so these people don’t fall through the cracks. For hospitals and EDs, critical is discharge follow-up and care transitions. Closing this post-discharge engagement gap between settings is vital for immediate and ongoing safety. “Owning” responsibility for a high-risk individual in the community, once they leave the hospital yet before they’ve walked into the outpatient clinic for their first post-discharge appointment, may not come naturally to providers, yet is key to keep people safe from suicide.”<sup>6</sup>

**RECOMMENDATION #2: Acquire additional funding to move statewide suicide prevention efforts forward.**

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

**RECOMMENDATION #3: Ensure notification is sent to the Veterans Health Administration by each Coroner’s Office whenever they are aware of a military member or veteran 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 uniform suicide investigation form. The Committee supports the development of protocols to ensure reports of veterans suicide deaths are sent from Clark and Washoe Counties to the VA. The two county offices use the same case management software and have the same ability to send automatic reports via email. Committee members suggested developing an education module for those who complete the forms to build consistency.

Expansion of data use agreements between these various entities to include permissible data use could enable exploration of linkages with death certificate data to measure effect of ED follow up protocols in Recommendation 1.

**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 that work with families after traumatic loss. The second purpose would be to glean information from survivors of suicide loss that might inform the process to improve prevention opportunities. A script will be developed to reach out to families utilizing consistent and sensitive language similar to a psychological autopsy.

**RECOMMENDATION #5: Follow up on contact with mortuaries to increase opportunities for survivor support.**

RATIONALE: According to the Substance Abuse and Mental Health Services Administration *Guide for Funeral Directors*, the funeral service industry can play a "crucial" role as a lifesaving resource for those impacted by suicide loss.<sup>7</sup> Several of the CRSF cases exhibited missed opportunities for survivors to receive resources and support after a suicide loss, proceeding to end their own lives years later. The Clark County Coroner offered support in outreach to mortuaries. His office has contracts with the five largest mortuaries in Clark County and can include in the contract or strongly recommend a task to the mortuaries. The Committee will examine how to build upon Clark County relationships for expansion across Nevada.

**RECOMMENDATION #6: Develop a relationship with the Board of Pharmacy to facilitate exploration of 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 for reducing access to lethal means such as medications. The Committee will explore offering CEUs to pharmacy technicians and pharmacists for taking suicide awareness and prevention courses.

**RECOMMENDATION #7: - Partnering with the Board of Pharmacy, work to implement suicide hotline phone number labels on prescription bottles.**

RATIONALE: According to the CDC 2014 Health Report,<sup>8</sup> almost fifty percent of the population used at least one prescription medication in the last 30 days. The opportunity to reach a large number of Nevadans can be achieved 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 #8: 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, and to greatly help with this effort, Nevada is applying to be a part of the National Violent Death Registry. 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 #9: Increase outreach to human resources departments of large corporations, other businesses and unions to establish suicide awareness and prevention trainings.**

RATIONALE: Research has shown unemployment and job loss may cause stressors that can greatly increase risk for suicide; this has been supported in CRSF reviews although numbers are too small to show a trend. Opportunities to train staff in the state's Division of Welfare and Supportive Services and Department of Employment, Training and Rehabilitation, the Society of Human Resources Management are important as well as disseminating and implementing national efforts to reach greater numbers of employers through the toolkit "Construction Industry Blueprint: Suicide Prevention in the Workplace."<sup>9</sup>

**RECOMMENDATION #10: 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.

**RECOMMENDATION #11: Increase public awareness around the Reducing Access to Lethal Means program and expand participation of diverse partners to reduce access to other common but more challenging means.**

RATIONALE: According to research from the Harvard School of Public Health, "Means reduction" (reducing a suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention."<sup>10</sup> Jumping from a great height such as a tall building or a bridge is a highly lethal method. "Erecting barriers at popular suicide jump sites has been largely effective in stopping or dramatically reducing suicide deaths from that jump spot. Most studies have also found that erecting a barrier does not result in more jumps from nearby sites." The Committee will work to develop relationships with the Nevada Department of Transportation, Bridge Division, Operation Lifesaver Rail Safety Education, and the hotel and casino industry, as well as other potential partners to develop prevention strategies for high structures, railways, and other potential means.

**RECOMMENDATION #12: Reducing stigma in the Hispanic community through culturally appropriate outreach.**

RATIONALE: While the majority of risk factors apply to all ethnic groups, there are additional risk factors that might be more prevalent in the Hispanic-Latino community such as generational differences, customs and beliefs; added stress for recent immigrants and reduced access to mental health care. In turn, protective factors can be familialism and social support, religiosity and moral objection to suicide, and culturally appropriate behavioral healthcare.<sup>11</sup>

**The Committee to Review Suicide Fatalities Future Work**

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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 to improve the review processes 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. Other areas of improvement should be in documenting sexual orientation and gender identity when completing investigations and reports. Suicide is significant among LGBT, and Nevada has very little accurate data to guide our prevention efforts. 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.

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**Citations**

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