Recommendations

The Nevada Office of Suicide Prevention contracted a position to analyze the 2016 suicide cases that occurred within the Washoe County Regional Medical Examiner's Office jurisdiction. The jurisdiction includes all Nevada counties; excluding Clark, Lincoln and White Pine: as well as five California counties; Lassen, Alpine, Plumas, Modoc, and Sierra. There were 172 cases analyzed for descriptive statistics on regional suicide. Additionally, through analyzing the cases, several recommendations were identified to improve suicide prevention efforts and future research.

Care Event Intervention

22% of cases had a noted care event with their primary care provider, emergency department, or hospitalization within one month prior to suicide completion. At a hospital or emergency department, seven cases were seen 48 hours prior to suicide, four cases were seen between 48 hours and one week prior to suicide, and eight cases were seen between one week and one month prior to suicide. At a primary care provider, five cases were seen within 48 hours prior to suicide, two cases were seen between 48 hours and one week prior to suicide, and twelve cases were seen between one week and one month prior to suicide.

Based on this information, there is clearly a missing link in the patient-provider interaction. From this data, the recommendation is that emergency room providers, hospitalists, and primary care providers ask about thoughts of self-harm, suicidal ideation, and depression/anxiety at every encounter as a routine part of their physical examination of the patient. Psychiatric health must be documented in every review of systems. There must be extra care taken to address this issue with patients when there is a documented history of mental illness, past suicidal ideation, drug/alcohol abuse, or terminal illness.

Too often if appears that providers only focus on immediate and life-threatening ailments, such as heart attack, stroke, or trauma; however, it is apparent that mental health can pose such a life-threatening risk. Providers must be trained in how to genuinely address mental health in order to help prevent suicide.

Follow-Up Calls Post-Discharge

Another recommendation is to implement mandatory follow-up calls within 10-12 hours of discharge for every suicidal ideation and suicide attempt patient. Many times patients are discharged with instructions to follow up with a mental health care provider within one week; however, one can see that this time frame is too late for many patients.

Improved Discharge Instructions

There must be an implementation of more comprehensive resources provided at discharge. Patients could find step-by-step guidelines for making a follow-up appointment, lists of suicide prevention organizations, and information on crisis lines to be very useful in preventing further suicidal ideation and subsequent attempts.

Concurrent Medical Record Research with Cases

For future research, the Office of Suicide Prevention should obtain funding and recruit an intern/student position that collects more medical record information from the decedent's providers concurrently with new cases. If the intern is working as new cases come in, then they can easily attain more information such as prescription history, treatment plans, and patient-provider interactions. This data can be used to paint a more complete medical history picture of decedents prior to suicide.

Improved Data Collection

Some information that would be interesting or pertinent to suicide prevention was often missing or rarely documented in the case files. Future research could be more accurately served with better information and documentation on self-harm history, familial history of mental health and suicidal ideations or attempts, gender identity and sexual orientation, disabilities, profession and employment, school performance (if enrolled in school), crisis line utilization, and social media usage.

These information points could be included on the worksheet that is utilized by death investigators; however, they are not necessarily required to determine cause of death, which is the primary goal of the death investigator. An intern or student researcher could assimilate these data through independent research and interviews with family and friends.

Extended Family Interviews

Finally, suicide prevention efforts could be aided by more detailed data collection from family members, friends, and people who interacted with the decedent prior to suicide. As time passes, family and friends are able to start seeing clear red flags that in the moment they missed. An intern could be utilized to contact family and friends to attain more detailed personal information about the decedent. This information could reveal key prevention opportunities or precipitating circumstances that were previously missed, unknown, or ignored.

Conclusion

Suicide prevention is key to creating a happier and healthier community. Public health practitioners must make changes to research methods and prevention techniques in order to assure the healthiest community possible.