State of Nevada, Department of Health and Human Services

Division of Public and Behavioral Health

Committee to Review Suicide Fatalities

Office of Suicide Prevention

Misty Vaughan Allen

2019

Edition 3.0

Steve Sisolak, Governor
Richard Whitley, MS, Director, DHHS
Lisa Sherych, Interim Administrator
Ihsan Azzam, M.D., Ph.D, Chief Medical Officer

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The Committee to Review Suicide Fatalities

Marylyn Scholl, LCSW, Co-Chair
Mike Bernstein, M.Ed., Co-Chair
Gregory Cowper
Lesley Dickson, M.D.
John Fudenberg, D-ABMDI
Sergeant John Harney
Kathy Inglese, DNP, APRN, PMHNP-BC, FNP-BC
Sheila Leslie, MA
Fran Maldonado
David Mills, F-ABMDI
Jamie Elizabeth Ross
Stephanie Woodard, Ph.D.
Beth Handler, MPH
Laura Knight, M.D.
Justin Norton
Cordelia Alexander-Leeder
Heather K. Martin
Rachael Kral
Cherylyn C. Rahr-Wood, MSW
Monica Hoopes

Thank you to the following for providing data and technical support for this report:
Kyra Morgan, MS, Chief Biostatistician, Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH), Office of Analytics
Amy Lucas, MS, Health Resource Analyst II, DHHS-DPBH-Office of Analytics
Jen Thompson, Biostatistician II, Behavioral Health Data Manager, DHHS-DPBH-Office of Analytics

Technical Guidance: Sharon Benson, Senior Deputy Attorney General, Nevada Attorney General's Office

Staff to the Committee from the Division of Public and Behavioral Health:
Misty Vaughan Allen, Statewide Suicide Prevention Coordinator, DHHS-DPBH-Bureau of Behavioral Health, Wellness and Prevention (BBHWP), Office of Suicide Prevention (OSP)
Richard Egan, Training and Outreach Facilitator, DHHS-DPBH-BBHWP-OSP
Janett Massolo, Training and Outreach Facilitator, DHHS-DPBH-BBHWP-OSP
Angela Friedman, Program Assistant, DHHS-DPBH-BBHWP-OSP

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Executive Summary

Introduction: This report is intended to provide an update to the Director of the Nevada Department of Health and Human Services on the work of the Committee to Review Suicide Fatalities (CRSF) since the last report was released in April 2016. The report includes progress on existing recommendations as well new recommendations for prevention identified by the Committee.

In 2017, Nevada had the 11th highest rate of suicide in the nation. This was only the second time Nevada's ranking was out of the top ten. 2016 showed a spike which took the state back to number six:

- Suicide is the second leading cause of death for Nevadans ages 15-34;
- Suicide is the leading cause of death for Nevada youth ages 8-17. More young people die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined;
- Nevada females had the 3rd highest rate (11.0 versus 6.3) in the nation; Nevada males had the 14th highest rate (30.8 versus 22.9).
- 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.

As the Committee database continues to expand, current recommendations build upon those from the 2016 report:

- **RECOMMENDATION #1: Care Event Intervention.**
- **RECOMMENDATION #2: Improved Discharge Protocols.**
- **RECOMMENDATION #3: Follow-Up Post-Discharge**
- **RECOMMENDATION #4: Concurrent Medical Record Research with Cases.**
- **RECOMMENDATION #5: Extended Family Interviews.**
- **RECOMMENDATION #6: Diversification in Outreach.**

As data from the CRSF reviews grows, we are able to gather a more vivid picture of what might be impacting someone with thoughts of suicide. We are also gaining more insight into areas where prevention efforts might be effective. Some of those areas for future work include teaching coping skills and resiliency to better cope in times of challenge with relationships, health concerns, and employment issues. Improving lethal means safety must continue to be a focus as it is one of the few proven prevention strategies to keep our loved ones safe. We need to build more connectedness. Feeling connected to someone or something such as nature, faith, purpose can be life-protecting.

Status of 2016 Committee Recommendations

During the 2016-2018 reviews, the Committee to Review Suicide Fatalities (CRSF), the Office of Suicide Prevention (OSP), and partners made progress toward implementing several Committee recommendations. More work is still needed.

RECOMMENDATION #1:	**STATUS TO DATE**
Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings.	The Division of Public and Behavioral Health is bringing Zero Suicide to Nevada. This initiative is based on seven elements (Lead, Train, Identify, Engage, Treat, Transition and Improve) which will transform health and behavioral health systems. A Zero Suicide Coordinator has been hired in partnership with the Center for the Application of Substance Abuse Technology (CASAT). Implementation of Zero Suicide would support adoption of Recommendation 1.
Rationale and Future Action: *National research indicates 45% of the people who died by suicide saw their primary care provider within a month of their suicide, with 20% of those people seeing their provider within 24 hours. With the limited mental health resources and the strong stigma concerning mental illness in our state, primary care providers are often the first point of contact for those exhibiting high risk of suicide. The 2016 data from the WCMEO found 22% of decedents had a care event at the ER or with their primary care provider from 24 hours up to one month prior to suicide. This equates to 39 deaths to suicide.*[1]	
RECOMMENDATION #2:	**STATUS TO DATE**
Acquire additional funding to move statewide suicide prevention efforts forward.	The Division of Public and Behavioral Health is supporting the Zero Suicide Initiative by utilizing block grant and opioid grant funding. A four-year strategy is being developed to ensure successful implementation.
RECOMMENDATION #3:	**STATUS TO DATE**
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.	Clark County Medical Examiner's Office is developing a protocol to inform the VA when a Veteran dies by suicide.
RECOMMENDATION #4:	**STATUS TO DATE**
Increase outreach to those affected by decedents' suicide deaths through Coroner's Office staff and others.	The Office of Suicide Prevention is tasked with developing a pamphlet specific to suicide bereavement and supports for use by coroners throughout the state. Work with

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	Medical Examiners and county coroners to build relationships
RECOMMENDATION #5:	**STATUS TO DATE**
Follow up on contact with mortuaries to increase opportunities for survivor support.	The CRSF is exploring implementation of a toolkit similar to the NAMI New Hampshire Survivor Packet. There are opportunities and challenges to address before sending out packets to survivors, including possibly reaching out to mortuaries, obtaining data from the Coroners' offices, working with other agencies, avoiding invalid addresses, family consent, and associated costs.
RECOMMENDATION #6:	**STATUS TO DATE**
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.	Outreach to the Pharmacy Board has led to the opportunity to submit articles to the Board of Pharmacy newsletter. OSP is working with the VA on these articles. This will also inform pharmacists about training opportunities statewide. During the 2017 legislative session, suicide prevention awareness and education was mandated for most healthcare providers. This legislation has increased opportunities and exposure to research, training and tools to improve suicide prevention and intervention among our providers.
Rationale: *Based on data from the CDC WISQARS database years 2010 – 2017, on average, 17.37% of suicides in Nevada are due to an overdose of prescription medications. In 2016, the number of suicides by medication reached its highest at 113 persons. In 2017, the number of suicides by medication reached 105 persons. But this number could be even higher. Five hundred and one point six (501.6) deaths by unintentional drug poisoning occurred per year on average between 2010 and 2016. It is impossible to determine if these unintentional deaths could have instead been suicides.*[2]	
RECOMMENDATION #7:	**STATUS TO DATE**
Partnering with the Board of Pharmacy, work to implement suicide hotline phone number labels on prescription bottles.	Due to data supporting a prevention opportunity through pharmacists, this recommendation is going to be revisited.
Rationale: *Of the 172 cases reported to the WCRMEO, 19.05% of decedent's toxicology reported yielded positive results for antipsychotic medication. Antidepressants, antianxiety, and antipsychotic medications were noted for each case. Additionally, 22.1% of all decedents were either prescribed an antipsychotic by a medical professional or the prescription was found in their home. These data show an avenue for potential contact with a person who is struggling with evident suicide ideation. The*	

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addition of a crisis hotline number of these prescription bottles could have been the last point of contact for intervention for these individuals.[3]

RECOMMENDATION #8:	**STATUS TO DATE**
Improve the collection of data pertaining to suicide attempts.	With the support of the regional medical examiners' offices, the Office of Suicide Prevention and the School of Community Health Sciences, three interns have been hired to develop data collection tools including scripts used to sensitively gather information from decedent's loved-ones. By examining decedent's records in great depth, information about past attempts, including means is being gathered.

Rationale and Future Action: *The collection of data is imperative to understanding suicide risk factors and behaviors in Nevada. Future research could be more accurately served with better information and documentation on past suicide attempts, history of self-harm, smoking status, recreational drug use, last care event, last hospitalization stay, last emergency department visit, chronic pain, education level, religious affiliation, addiction status, sexuality, gender identification, family mental health history, homicidal ideation, addiction status, whether they were adopted/fostered, and social media use. It is recommended to develop a standardized Suicide Assessment Tool so data collection may be more complete and analysis can show stronger associations. Practice as well as prompts may aid in discussing difficult topics when interviewing families of decedents. The Suicide Assessment Tool, as well as any other collection tools, should be shared with the Sheriff-Coroner offices of other counties. The State of Nevada is currently gathering data in the newly initiated Nevada Violent Death Reporting System. A data dashboard for suicide is being developed to provide a more usable interface to inform prevention efforts at both the local and state level.*

RECOMMENDATION #9:	**STATUS TO DATE**
Increase outreach to human resources departments of large corporations, other businesses, and unions to establish suicide awareness and prevention training.	Outreach is continuously occurring to increase awareness within large corporations and human resource departments. Data on the employment status of decedents in Northern Nevada was captured by the Public Health intern. See table below.

Rationale and Future Action: *Washoe County Medical Examiner data has shown the construction industry and mining have higher rates of suicide in Northern Nevada. Outreach to these industries is ongoing but challenging.*

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RECOMMENDATION #10:	STATUS TO DATE
Focus on the connections between substance use disorders and suicide prevention.	The State of Nevada and partners are working with Opioid grant strategies to combat these two highly linked public health concerns.
Rationale: *Deaths from despair (alcohol, drugs and suicide) are increasing. Screening and safety planning is recommended when any of these concerns presents during treatment of health care event. Partnership with CASAT can offer greater coordination among the different programs to provide services addressing mental health, substance use, and physical health. This coordination has ranged from sharing information between service providers to delivering different services in the same setting. These linkages will help provide Nevadans with multiple access points to behavioral health care.*	
RECOMMENDATION #11:	**STATUS TO DATE**
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.	Through multiple grants from the Executive Committee to Review Child Fatalities, the Nevada Coalition for Suicide Prevention and OSP have continued to build upon the Reducing Access to Lethal Means program. For 2019, this program will expand to increase use of CALM and materials during discharge from a hospital or inpatient care. OSP continues to work with the Washoe County Railway Auxiliary Team as an example of a program used in suicide prevention efforts. The CRSF has recommended other sheriff's offices consider the use of this program.
Rationale and Future Action: *Firearms continue to be the primary method of suicide for Nevadans. Raising awareness and emphasizing the safe storage of firearms for those with children in the home, Veterans, or those exhibiting high-risk behavior, is recommended as a way of reducing access to lethal means. The issue of chronic pain or terminal illness has been observed as a strong factor in many of the elderly suicides occuring in Nevada. A third of the suicides which have occurred involve issues of severe chronic pain or terminal illness. Aggressive pain management by primary care or earlier referral to palliative care would be indicated to improve the quality of life for those suffering.*	
RECOMMENDATION #12:	**STATUS TO DATE**
Reduce stigma in the Hispanic community through culturally appropriate outreach.	This recommendation continues to be a challenge. Outreach efforts through faith organizations are ongoing. The Executive Committee on Child Deaths has awarded funding to explore and develop appropriate avenues for improved outreach.

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Impact of Suicide in Nevada

In 2017, Nevada had the 11th highest rate of suicide in the nation. This was only the second time Nevada's ranking was out of the top ten. The rate in 2016 spiked which took the state back to number six:[4]

- Suicide is the second leading cause of death for Nevadans ages 15-34;
- Suicide is the leading cause of death for Nevada youth ages 8-17. More young people die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined;
- Nevada females had the 3rd highest rate (11.0 versus 6.3) in the nation; Nevada males had the 14th highest rate (30.8 versus 22.9).
- More people die by suicide than motor vehicles crashes and homicides;
- 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.

A recent report from the Centers for Disease Control and Prevention highlighted suicide as a leading cause of death in the US, with rates increasing in every state except Nevada from 1999 through 2016.[3] During this period, Nevada's rate decreased by 1%.[5] It must be noted in 1999, Nevada had one of the highest rates in the nation, so other states are now catching up. But it also must be recognized other states with high rates still increased over this time frame. The Committee to Review Suicide Fatalities (CRSF) will make recommendations to continue this downward trend, helping achieve the state strategy goals of decreasing our rates for elders, middle aged men and women and veterans to the national average by 2020.[6]

Youth Suicide Rates

Although the CRSF can review youth deaths, the state of Nevada, Division of Child and Family Services provides excellent reporting on child fatalities by suicide. In 2016, deaths by suicide were higher in the 10 – 14 age group compared with the 15 – 17 age group. This is inconsistent with national data, which shows deaths from suicide increase considerably across the pre-teen and teen years. In 2016, more females died by suicide than males. This is also inconsistent with national data, which shows males in the 10 – 14 and 15 – 17 age groups died by suicide at more than twice the rate of females in 2016. Finally, use of a firearm was the most common method of death by suicide, accounting for 9 of 20 deaths reviewed. Of these, 7 were male and 2 were female.[7] Preliminary 2018 data from the Nevada Electronic Death Registry System shows rates across almost all age groups held steady or even decreased, though of concern, was a sharp rise in the suicide rate for youth under 18 years of age, where Clark County experienced a 90% increase in suicide death between 2017 (10 deaths) and 2018 (19 deaths).

Youth rates for the remaining counties increased 60%, from 5 deaths in 2017 to 8 deaths in 2018.

Elderly Suicide Rates

Nevada has ranked highest in the nation for suicide by older adults for decades. The rate of suicide among seniors 65 years and older is more than double the national rate for seniors. Critical factors which increase risk for older adults are: health and mental health concerns, relationship issues, loss, chronic pain, a sense of burdensomeness and a lack of connectedness. These issues point to the need for different strategies and partners to prevent suicide among older adults.

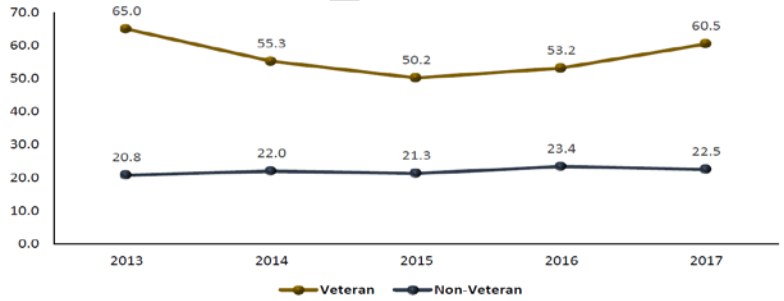
Suicide in Elderly (Age 65+) by County of Residence and Year: Nevada Residents, 2013-2017

County of Residence		Year				
		2013	2014	2015	2016	2017
Clark County	N.	66	81	68	90	86
	Rate	25.9	30.8	25.2	32.3	29.9
Washoe County	N.	24	21	23	40	20
	Rate	41.2	34.7	36.6	61.2	29.5
Rest of State	N.	21	29	17	32	32
	Rate	34.2	45.9	26.2	48.1	47.1
Total	N.	111	131	108	162	138
	Rate	29.7	33.9	27.2	39.5	32.6
Nevada Total Suicides	N.	530	557	544	626	610
	Rate	18.3	19.2	18.1	20.6	20.0

Veterans Suicide Rates

Nevada's suicide rate among veterans is significantly higher than the national rate. Nevada veteran rates are almost three times non-veteran rates. Factors such as disability, independent living, health, and personal financial concerns may contribute to the high rate of suicide deaths among older veterans (Nevada Office of Public Health Informatics and Epidemiology, 2017).

Veteran Suicide Rate per 100,000 Population 2013-2017



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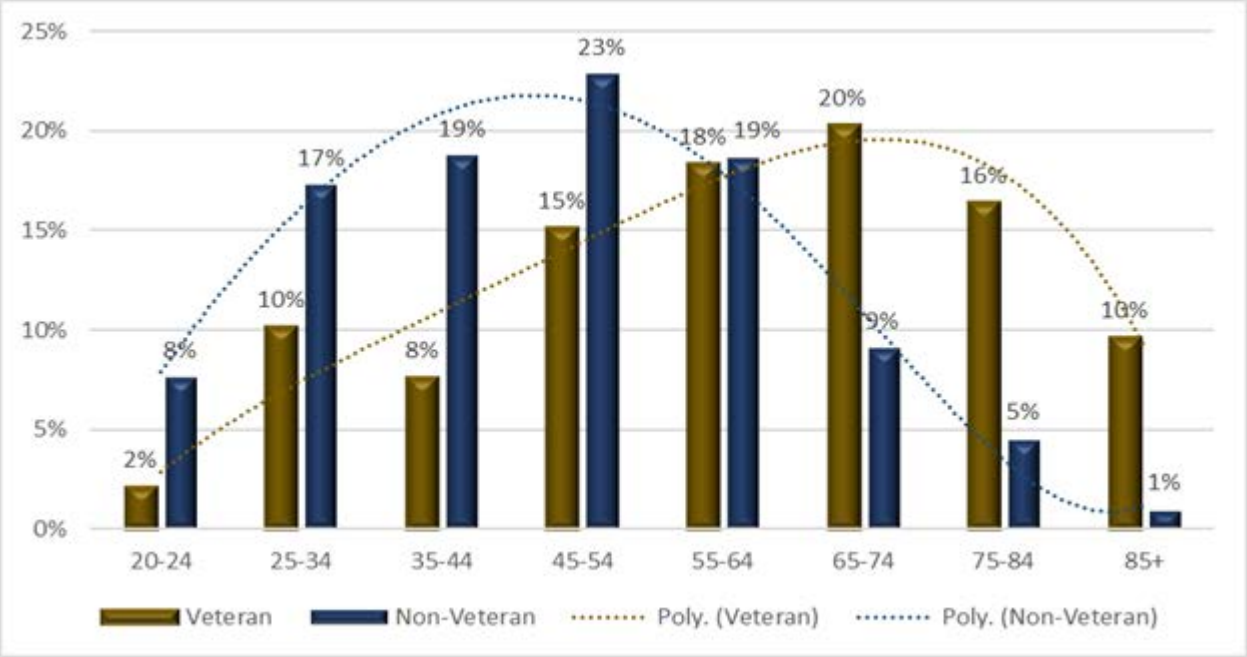
Age Distribution of suicide-related deaths by Veteran Status 2010-2017, Nevada residents combined.



According to the Nevada Special Surveillance Report: Veterans Suicide 2013-2017, "The trend shows an increase in non-veteran suicide deaths as age increases until the 45-54 age group, followed by a steady decline. This is different in the veteran population, where suicide deaths increase as age increases until the 65-74 age group before they start to decline. This demonstrates veteran suicides are skewed to an older population. The differences in the age distributions between veteran and non-veteran suicides represented above are likely due to the differences in the age distributions of those populations in general."[8]

Race/Ethnicity Suicide Rates

In Nevada, the rates for suicide were highest among people who were white (non-Hispanic) with Native American rates second highest. Suicide rates were higher in Nevada within every racial and ethnic group compared with U.S. rates; Suicide crosses all racial and ethnic boundaries (Nevada Office of Public Health Informatics and Epidemiology, 2016). Opportunities exist to improve prevention using attempt data by race and ethnicity.

Suicide Count and Age-Adjusted rate (Per 100,000) by Race/Ethnicity and Resident County: 2012-2017 Aggregate

Race/Ethnicity	Clark County		Washoe County		All Other Counties	
	N.	Rate	N.	Rate	N.	Rate
White, non-Hispanic	1,673	25.4	500	26.5	484	27.3

Black	159	11.9	7	11.4	2	5.0
Native American	17	19.6	11	24.9	17	25.4
Asian	127	9.6	23	13.0	3	9.6
Hispanic	257	7.3	34	6.3	41	14.2
Other/Unknown	10	~	4	~	1	~
Total	2,243	17.7	579	21.4	548	24.8

Frontier/Rural Nevada Suicide Rates

In our rural/frontier communities, rates of suicide continue to be high. Primary and behavioral health care remain a critical issue throughout Nevada with a health and mental health workforce shortage areas across much of the state. Access is also limited by transportation, poverty, cultural barriers and stigma.

Committee to Review Suicide Fatalities Overview

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 which 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. In Years 3 and 4, focus has been on impacting the twelve recommendations from Year 2. Also, OSP and CRSF have built a strong relationship with the University of Nevada, School of Community Health Sciences to develop a meaningful internship opportunity, expanding data collection on suicide death records.

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. As of late 2018, the Committee is currently complete according to statute. The members of the Committee elected Marlyn Scholl as Chairperson with Mike Bernstein as Co-chair.

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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 (2015-Current); Proxy David Mills	Southern Nevada
(b) One person who represents providers of health care;	Kathy Ingelse, DNP, APRN, PMHNP-BC, FNP-BC, Orvis School of Nursing (2015-Current)	Northern Nevada
(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;	Jamie Elizabeth Ross, Executive Director PACT Coalition for Safe and Drug-Free Communities Coalition (2018-Current)	Southern Nevada
(e) One person who represents mental health agencies;	Gregory Cowper, Director of Business Development, Montevista Hospital	Southern Nevada
(f) One person who represents law enforcement;	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;	Fran Maldonado, Tribal Liaison, Division of Child and Family Services	Rural Nevada
(i) One person who represents advocates for individuals and families with mental illness;	Sheila Leslie, (2017-current), Retired, Washoe County Social Services, Consultant, Sagepine Strategies	Northern Nevada
(j) One person who represents veterans	Marlyn Scholl, LCSW, Veterans Health Administration (2015-Current)	Northern Nevada

Meetings

The Committee to Review Suicide Fatalities has bimonthly teleconferences and meets face-to-face twice per year. Since 2014, 71 cases have been reviewed. In accordance with NRS statute 439.5108, suicide fatality case 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 were aggregated, de-identified, and individual identification removed for analysis and reporting. All in-person reviews started and ended with open meetings.

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Reporting

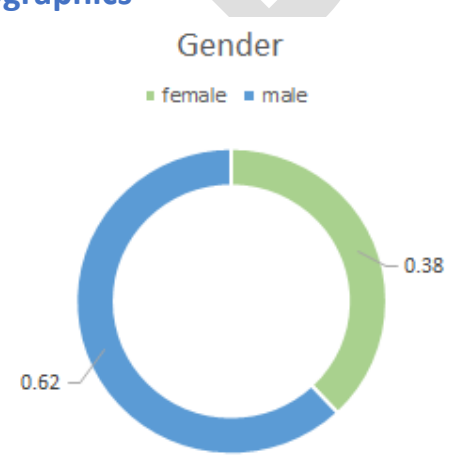
The Committee is required to submit an annual report to the Director concerning the activities of the Committee. The report must include, without limitation, a statement setting forth any trends or patterns in suicide fatalities in Nevada or serious injuries or risk factors concerning those fatalities, in addition to any recommendation made for changes in any law, policy, or practice which may assist the Committee in preventing suicide fatalities or related serious occurrences. Any report submitted must not include any confidential or privileged information. This third report incorporating data from 2017 and 2018 adheres to these requirements.

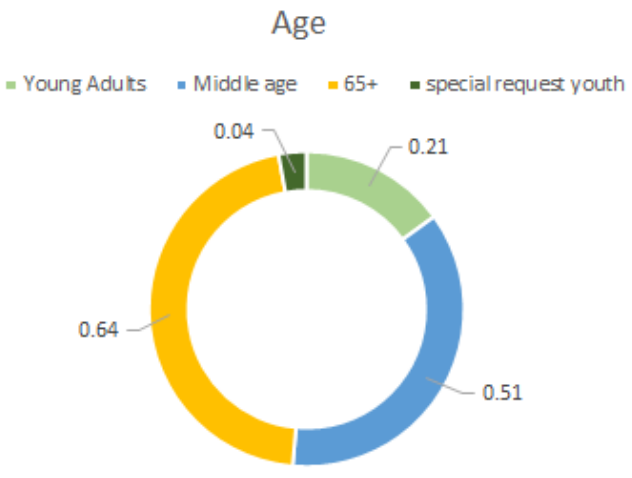
Cases Reviewed: 2014-2018

Seventy-one cases have been reviewed by the committee since its inception. While the CRSF uses an extensive data-collection tool, a great deal of information is just not known or is challenging to collect. Nevada state statutes prescribe each county has a coroner. In the majority of NV counties, this duty falls to the Sheriff's Office. The two largest counties, Washoe and Clark, have combined Medical Examiner-Coroner offices by county code, staffed by forensic pathologist Medical Examiners. These two regional offices provide autopsy services to the other smaller counties, but the initial death investigations are still completed on those deaths by the various county sheriff's deputies acting in a coroner role. The information captured is not standardized from one county to the next.

The CRSF with the support of the Medical Examiners offices recommended working with interns working to improve how information is gathered and develop standardized tools, scripts and methodology. The Nevada Office of Suicide Prevention has worked with the University of Nevada, Reno's School of Community Health Sciences and the Washoe County Medical Examiner's Office to supervise two Master's level interns. Their focus has been to analyze suicide cases which occurred within the Washoe County Regional Medical Examiner's Office (WCRMEO) jurisdiction. The jurisdiction includes northern Nevada counties (excluding Clark, Lincoln and White Pine), as well as five California border counties (Lassen, Alpine, Plumas, Modoc, and Sierra). Through summarizing and analyzing the cases, several themes were observed, and recommendations were identified which have informed this report.

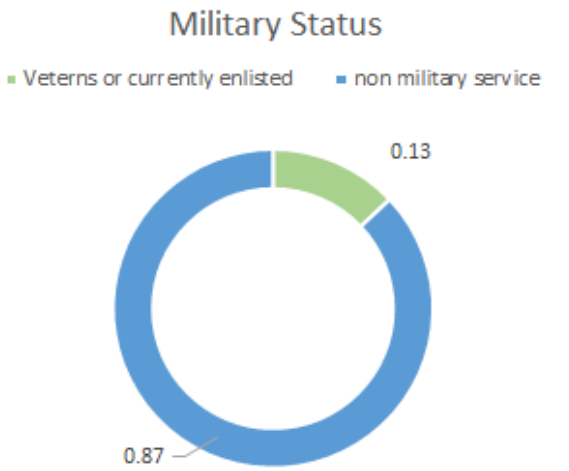
Demographics

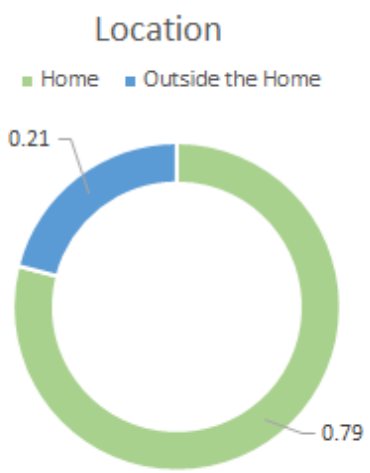




Gender. Thirty-eight percent (38%) of reviewed cases were female; 62% of cases were male. Currently, non-binary gender data is not collected. Work is being done with medical examiners and coroners toward more inclusive data-collection around gender and orientation.

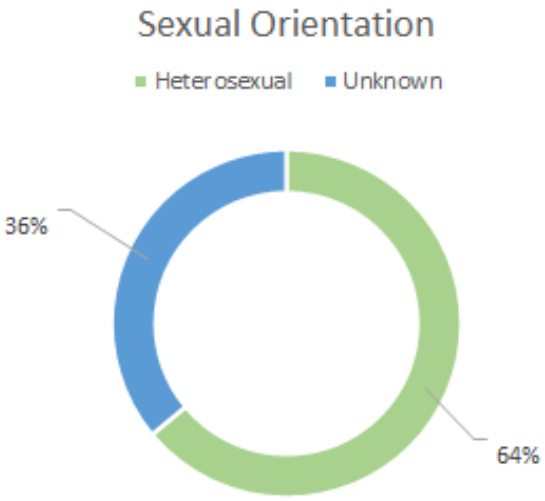
Age. Twenty-one percent (21%) of those who died were young adults, 51% were middle-aged and 24% of those ages 65+. Four % of the cases reviewed were specially requested youth.

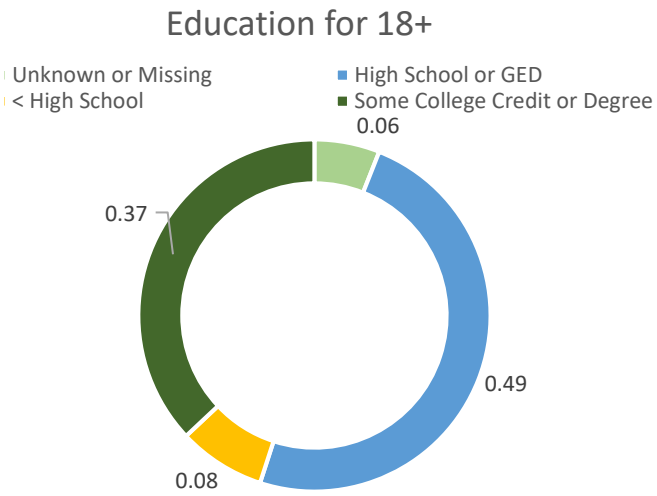




Veterans/military status. Thirteen percent (13%) were identified as veterans or currently serving in the military.

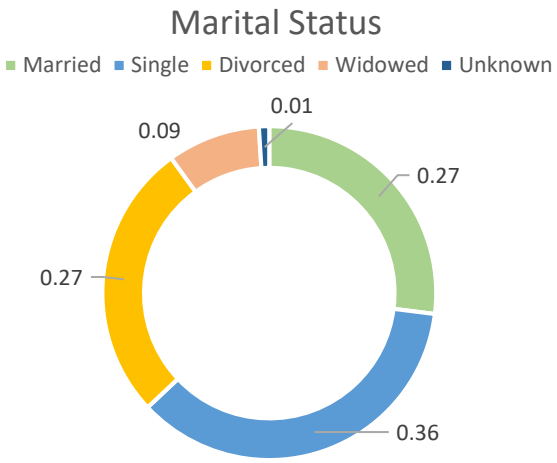
Location of suicide. Seventy-nine percent (79%) were home at the time of death.





Sexual orientation. 64% were identified as heterosexual; 36% unknown.

Educational level. Among victims ages 18+, 6% had an unknown or missing education level, 49% were a high school or GED graduate, 8% had less than high school education, and 37% had some college credit or a college degree.



Marital status. Twenty-seven percent (27%) decedents were married, 36% were single, 27% were divorced, 9% were widowed, and 1% had another or unknown marital status.

Key Findings

According to the Centers for Disease Control and Prevention's 2018 report, "Vital Signs," many factors contribute to suicide among those with and without mental health conditions:[9] Contributing factors in bold were commonly discovered through the CRSF process and percentages are representative of the seventy-one cases reviewed to date. Many are in alignment with national data.

Source: CDC. *Vital Signs*, 2018

- Relationship problem (42%)
- Crisis in the past or upcoming two weeks (29%)
- Problematic substance use (28%)
- Physical health problem (22%)
- Job/Financial problem (16%)
- Criminal legal problem (9%)
- Loss of housing (4%)

Source: *NV CRSF Case Reviews*

- Toxicology
- Mental Health Problems and Treatment
- Personal crisis
- Relationship problems
- Disclosed suicide intent
- Job and/or financial problems
- Alcohol/substance use-related problems.

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Other key findings from the CRSF include health, environmental and historical factors.

Health Factors:

Mental health conditions 40%

Substance abuse disorders 21%

Serious or chronic health condition and/or pain 20%

Gambling disorder 4%

Environmental Factors:

Access to Lethal Means including firearms and medications 66%

Prolonged Stress Factors which may include harassment, bullying, relationship problems, domestic violence, and unemployment 48%

Stressful Life Events which may include death, divorce, job loss or incarceration 27%

Exposure to another person's suicide (contagion), or to graphic or sensationalized accounts of suicide (real life, media or Internet) 13%

Historical Factors:

Previous Suicide Attempts 32%

Veteran status 13%

There are many gaps in information known to impact risk for suicide. This missing information would be important for suicide prevention efforts across sectors and communities. The CRSF recommends enhancement of data collection in future reviews, psychological autopsies, family interviews and development of data collection tools, striving for information below:

Lack of social support or connectedness, feelings of burdensomeness, sexual orientation, gender identity, religious affiliation/spirituality, family history of suicide, family history of mental health conditions, childhood abuse or other trauma.

The Committee to Review Suicide Fatalities Future Work

Committee to Review Suicide Fatalities Recommendations

Through the review process, and utilizing what has been learned regionally, the Committee has produced six recommendations to enhance and promote protective factors to 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 as well as loved ones. 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 continue to be areas in need of great improvement toward reducing the number of suicide deaths. Many of

the recommendations from 2016 and this current report directly refer to Nevada's health care systems. The state is in the process of implementing the Zero Suicide model which has seven pillars toward better depression care and suicide-safer health care. Zero Suicide implementation would address several of the following recommendations.

RECOMMENDATION #1: 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. Implementation of Zero Suicide continues to be imperative.

RECOMMENDATION #2: Improved Discharge Protocols. There must be an implementation of more comprehensive resources provided at discharge. Resources should be developed and distributed to support emergency departments in providing information to patients and families following discharge for a suicide attempt

RECOMMENDATION #3: Follow-Up Post-Discharge. It is recommended 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 this time frame is too late for many patients. Every effort must be made to discharge patient to their support person or care provider. National data show individuals with a recent discharge from an emergency department are at higher risk for suicide, especially in the month following discharge.6 Further, approximately 70 percent of individuals discharged from emergency departments after a suicide attempt do not attend a follow-up appointment with a mental health provider.[10] Continuity of care and follow-up services are both key components of the Zero Suicide framework.

RECOMMENDATION #4: Concurrent Medical Record Research with Cases. For future research, the Office of Suicide Prevention should obtain funding and recruit an intern/student position to collect 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.

RECOMMENDATION #5: Extended Family Interviews. 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 recognize clear red flags in the moment which they missed. This information could reveal key prevention opportunities or precipitating circumstances previously missed, unknown, or ignored.

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RECOMMENDATION #6: Diversification in Outreach.

The number one potential rationale for those who died by suicide in 2017 was being faced with a divorce or break up (20.2%).[11] Of this number 6.4% of all decedent's potential rationale regarded facing legal troubles. The Washoe County courthouse filing office receives any legal filing from criminal to divorce. This area of outreach could be impacted by working more closely with domestic violence agencies, law enforcement and first responders. Data from local and national sources highlight a number of industries at high-risk for suicide, including construction, first responders, the healthcare community, agriculture and ranching, and mining. Each of these professions should be supported in developing a comprehensive approach to suicide prevention. Efforts to increase awareness among LGBTQ+ and the development of culturally appropriate resources must continue to be a priority.

RECOMMENDATION #7: Partnering to Improve Our Understanding of Veteran Suicide

Due to our high Veteran suicide rate in Nevada (more than 1 in 5 Nevada suicide deaths is by a Veteran), the Committee reached out to the Department of Veterans Affairs Sierra, Nevada Health Care System (VA). Through a Standing Letter of Request for Information from the Department of Health and Human Services, the CRSF will be able to review shared redacted suicide fatality cases obtained by the Suicide Prevention Specialists' office. This standing letter has allowed 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 share the belief the sharing of information will be beneficial to both Veterans and the State of Nevada. Support of this agreement requesting ongoing information will be shared with the Southern Nevada Veterans Healthcare System.

Conclusion

The Nevada Department of Health and Human Services and the Nevada Office of Suicide Prevention will support and advance the recommendations found in this report. The Committee to Review Suicide Fatalities will continue to improve the review processes while building upon new research and national and state strategies. With Nevada's participation in the National Violent Death Reporting System, there will be access to more complete data. As data from the CRSF reviews grows, we are able to gather a more vivid picture of what might be impacting someone with thoughts of suicide. We are also gaining more insight into areas where prevention efforts might be effective. Some of those areas for future work include teaching coping skills and resiliency to better cope in times of challenge with relationships, health concerns, and employment issues. Improving lethal means safety must continue to be a focus as it is one of the few proven prevention strategies to keep our loved ones safe. We need to build more connectedness. Feeling connected to someone or something such as nature, faith, purpose can be life-protecting.

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