

Committee to Review Suicide Fatalities Overview of Humboldt County Deaths by Suicide 2018

Overview

The purpose of this report is to provide feedback to the Humboldt County Sheriff's Office (HCSO) and the host community after a suicide fatality review was completed in response to multiple suicide deaths in 2018. Several of those deaths occurred within a 30-day period. We would like to thank Sheriff Allen and Under-Sheriff Malone for welcoming this review and assisting in the planning. We are also very appreciative of the participation from HCSO deputies (35 deputies with 20 on patrol and 15 working in the jail). The team and other invited community members answered questions and helped the Committee to Review Suicide Fatalities (CRSF) identify recommendations to enhance and strengthen suicide prevention in their agency and community. The CRSF determined that there were no obvious connections between the decedents, but there were common risk factors. Below we have compiled a list of opportunities for improved prevention strategies the team identified in the community as well as resources and suggested strategies for implementation. The CRSF felt this review was an open and productive discussion that can help local law enforcement and other first responders continue to respond to their best ability, not only for the improved safety of the community they are serving but also their own safety as responders in crisis situations.

Opportunities Identified by the Review

Opportunity 1: Increase Awareness - While conducting the case review, the team recognized the need to help family and friends increase their awareness of the signs their loved-one might be at risk of suicide. Past attempts, suicide threats, life crises such as financial issues and relationship challenges occurred in most cases reviewed.

Proposed Response for Prevention: Stigma surrounding mental health concerns, addiction and suicide creates a barrier to caregivers and support systems from offering help when concerned about someone. This same stigma truly incapacitates someone with thoughts of suicide or mental and behavioral health concerns from asking for help. We need to strengthen our connectedness, thereby strengthening our communities. Suicides that occur during an argument indicate not all suicides are planned; lethal means counseling could occur with people at risk, not only with people who disclose suicide plans. Given the consistency of life crises preceding suicide, areas of outreach that could also impact our families greatly would include religious leaders, social services staff, divorce and defense attorneys, domestic violence agencies, industries at high-risk for suicide, including construction, first responders, the healthcare community, agriculture, ranching, and mining. Each of these fields 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. It is recommended that the HCSO continues to work with Humboldt Connections to develop intensive public information campaigns on depression, mental health, addiction, suicide and prevention to reduce stigma and increase skills and community connection. Examples of training/interventions:

- Strengthening capacity and technical support of the local organizations through specialized training on engaging family members on how to support their loved ones with lived experience to keep them safe, strengthen networking with existing coalitions, and strengthen local crisis response. Bring in NAMI (National Alliance on Mental Illness) trainings to help family caregivers, build peer support and reduce stigma; <https://namiwesternnevada.org/>;
- VA program to strengthen relationships i.e.: Warriors to Soul Mates, skills-based workshops;
- Humboldt Connections could develop a Connectedness campaign and other awareness campaigns;

Opportunity 2: Peer Support -Through discussion with Humboldt County Sheriff's deputies during the review, these first responders identified a need and desire for additional peer support training.

Proposed Response for Wellness: The Washoe County Medical Examiner's Office and the Office of Suicide Prevention will connect with the Humboldt County Sheriff's Office to recommended peer support and/or CIT training options for development to meet their local needs.

- CIT debriefing
- Police Employee Assistance Program (PEAP LV <https://www.lvmpd.com/en-us/Pages/PoliceEmployeeAssistanceProgram.aspx>)
- Northern Nevada Peer Support Network; nnpsn.com

Issue 3: Reducing Access to Lethal Means - Eighty-eight percent of the suicide deaths reviewed were by firearms.

Proposed Response for Prevention: Comparing suicide methods, firearms are the most lethal method of suicide. If those at risk for suicide were prevented from accessing a gun, there would likely be fewer suicide deaths, even if those who attempted substituted another method. Educating loved ones of those at risk for suicide could reduce access to any household guns by making sure they are safely secured or removed from home until the person recovers. Family members, providers, gun owners, and others could work together to develop messaging and storage options that are sensitive to local values and realities. Rural communities have higher rates of suicide which could be greatly impacted by lethal means safety programs.

- Develop committee to address education for gun shops etc., and campaigns for safe storage of lethal means to include medications; <https://www.sprc.org/comprehensive-approach/reduce-means>
- Partner with the Nevada Coalition for Suicide Prevention and its program to increase lethal means safety;
- Implement a process for lethality assessments if firearms are present in the home during welfare checks;

Opportunity 4: Implement Zero Suicide in Healthcare and Mental Healthcare Connections: In 67% of the cases, the decedents were diagnosed with mental health

disorders. Medication compliance continues to be has been noted to be a concern for some of the dece Forty-four percent of the decedents diagnosed with a mental illness were known to be prescribed medications. If others received prescribed medication it was not apparent. Whether they were taking their medication appropriately at the time of death is unknown.

Reached out to agencies/healthcare: Of the cases reviewed, only 22% of decedents were known to be actively in contact with healthcare or behavioral health agencies for support for their depression. Distance to travel to get help could have been an issue.

Chronic Disease/Illness: In 56% of the cases, the decedents lived with chronic and/or terminal diseases.

Days since last healthcare visit: Medical records were not available for all cases. Of those available, 22% saw a physician within less than three weeks of death, 11% within four months, 11% within eight months and 11% within two years of death.

Proposed Response for Prevention: Health and behavioral health care providers are important for prevention. Zero Suicide is a set of evidence-based principles and practices for preventing suicide within health and mental health systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under care are preventable. Zero Suicide requires a system-wide approach to improve outcomes and close gaps. 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. Focusing on those who visit primary care providers and hospitals with a mental health or substance abuse issue could intervene earlier with those at risk of suicide. Having discussions with support systems about reducing access to firearms and medications can save lives.

Opportunity 5: Substance Use - Of the toxicology reports available: 11% showed an overdose of prescribed medication, 22% showed excessive alcohol, 11% showed excessive alcohol and THC, 11% had resuscitation medications, and 11% had a clear report- "none detected." Alcohol was the substance that most frequently tested positive among people who died by suicide with toxicology tests performed (67% of all cases).

Proposed Response for Prevention: Twenty-two percent of decedents were reported to have been in behavioral healthcare. Care systems potentially could develop ways to flag those whose distress is not improving and find alternate strategies. Reducing access to medicines that can increase risk (like opioids and benzodiazepines) and limiting other medications accessible at home to non-toxic quantities may help reduce harm from overdose. Resources to support and evaluate this work would need to be identified.

Opportunity 6: Increase Understanding of Community Challenges -Through communication with law enforcement agencies during the review, CRSF, Office of Suicide Prevention staff and mental health clinical staff could better understand law enforcement experiences and community needs through "ride-alongs."

Proposed Response for Prevention: Those working in mental health and suicide prevention should partner with law enforcement agencies and other first responders to find opportunities to learn from their experiences in their communities.

Opportunity 7: Enhanced Death Investigation Training for Sheriff's Deputies - In Humboldt County, 10-12 deputies act as coroners. 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 most 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 differences in these systems have led to inconsistencies in the data collected during death scene investigations, especially in suicides. Gaps have been identified due to the sometimes more limited information collected during investigations conducted by coroners. Some reasons for this gap include funding and staffing levels that can impact the decision for transporting a decedent to a medical examiner's office and training and education differences (online trainings). The document below will provide guidance for conducting a suicide death investigation in order to ensure more complete suicide death scene investigations throughout Nevada, helping to standardize data collection among all counties.

Proposed Response for Prevention: Support the development of Enhanced Death Investigation Training provided by the WCMEO, utilizing the *WCMEO Manual for investigations: Guidelines for Conducting a Suicide Death Scene Investigation*;

Review Demographics

Gender: 89% male.

Age group: 22% were Elders; 78% Middle Age.

Childhood Trauma: 22% of the decedents had experienced childhood trauma. Childhood trauma is unknown in the others.

Means: 22% deaths were by hangings, 88% were by firearms.

Means known to family and friends: Preventing access to lethal means regarding hangings is not obvious. In 56% of the cases, family and friends were aware of the firearms.

Prior Attempts: 22% of decedents had attempted previously. Friends and family members were aware of the firearms.

Family/Friends witnessed struggle: In 100% of cases, family and/or friends mentioned instances of the decedent having struggles in his or her life. In 22% of cases, the immediate threats of suicide were not acted upon. In 22% of cases, the decedents were receiving help

which friends and family may have felt was the best help available, although not possibly adequate. In 33% of cases, the family members seemed to not recognize the signs of suicide. In 11% of cases, intoxication of others prevented helping the decedent. In 11% of cases, others were concerned and may have recognized the signs, later checking up on the decedent.

Threatened Suicide: 56% of the cases noted suicide threats; 44% of cases did not mention suicide threats. In 33% of the cases mentioning suicide threats, the friends and family members were aware of accessibility to the firearms.

Relationship Issues: In 67% of the cases, quarrelling or fighting existed in the decedents' lives. In 56% of the cases, the decedent had lost one or more persons who were important in their lives. Relationship issues were unknown in 33% of the cases.

Financial issues: 56% of the decedents experienced financial troubles. Of those, 33% were employed.

Near residence: 67% decedents were in or near their residence when they died or made the attempt to die. Three were away from home.

Location Instability: 44% of the decedents had lived in the Winnemucca area for less than five years. Three lived in the area longer than five years. It is unknown how long one of the decedents had lived in the area. One decedent was traveling through Winnemucca.

Next Steps and Conclusion:

The Committee to Review Suicide Fatalities will continue to be a source of guidance and support as communities strive to develop comprehensive and responsive strategies to prevent suicide. Some of those areas for future work include teaching life 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. Finally, opportunities for learning through open and frank discussions within our communities will increase our understanding of the challenges faced by our families, our first responders and those struggling to heal and recover from thoughts of suicide and attempts. With our continued efforts to reach communities across Nevada and gain insight into the diverse challenges and success, it is our hope to build statewide connectedness.