COMMITTEE ON DEVELOPMENTAL DISABILITIES
2024-2025 ANNUAL REPORT

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COMMITTEE TO REVIEW SUICIDE FATALITIES (CRSF) OVERVIEW

In October of 2013, the Office of Suicide Prevention (OSP) 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. Nevada Revised Statute (NRS) 439.5102 was added to the Nevada Revised Statutes by 2013 Legislature. 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.

Through 2018, the focus was on impacting the twelve recommendations from Year 2. 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.

In 2019 and 2020, the Committee focused on rural community reviews and piloting specific reviews addressing trends of concern such as physician suicide. On March 2nd, 2020, the CRSF met in-person in Pahrump, Nye County for a local community review. On March 17, 2020, Nevada began operating under crisis status with many businesses and public areas closed.

On March 17, 2020, Nevada began operating under crisis status with many businesses and public areas closed. At the same time, those deemed essential employees experienced higher than normal occupational risk and exposure which increased workplace stressors.

The pandemic did impact the functioning of the CRSF as did a high number of staff transitions. Administrative support experienced three different people over the course of a year, greatly challenging staff members to the committee ability to gather documents, crucial to collection and extraction of case information. In 2021 and 2022, the Overdose Data to Action Program worked with the Office of Suicide Prevention to propose a pilot overdose fatality review.

The Committee to Review Suicide Fatalities met twice to consider holding the pilot review. Members of the committee raised concerns over the CRSF holding an overdose fatality review because of some of the challenges related to determining the intent of death. The committee was able to reach consensus related to pulling cases that were left as "undetermined."

OD2A Funds were used to contract with Social Entrepreneurs Inc (SEI) to support and document recommendations from the overdose fatality review exercise. The Overdose Fatality Review Pilot occurred as a second day meeting for the Suicide Fatality Review Committee Meeting in June 2022.

Staff to the committee were challenged with acquiring robust information from case documentation, making in-depth reviews difficult. In the spring of 2024, the CRSF was invited to a national Suicide Mortality Review Academy in Phoenix, AZ. This opportunity enabled the Committee, along with other community subject matter experts, to develop a plan to improve practices and protocols.

This plan will ensure the suicide mortality reviews are productive and effective in developing recommendations for improving suicide prevention policy and programming.

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 and organized based on NRS 439.5104. As of late 2024, the Committee had four vacancies, with several applications pending. As of July 2025, all four pending positions have either been filled or pending Director approval. Dr. Laura Knight, Chief Medical Examiner, Washoe County serves as co-chair, while the other co-chair position is vacant.

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;	Dr. Laura Knight, Chief Medical Examiner, Washoe County Regional	Northern Nevada

	Medical Examiner's Office, Chair of the Committee	
(b) One person who represents providers of health care;	Dr. Terry Kerns, Substance Abuse Law Enforcement Coordinator, Nevada Attorney General's Office	Southern Nevada
(c) One person who represents organizations having expertise in suicide prevention;	Vacant	Pending
(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	Southern Nevada
(e) One person who represents mental health agencies;	Allison Zednicek, CEO, Desert Parkway, Interim CEO for Reno Behavioral Hospital	Southern Nevada
(f) One person who represents law enforcement;	Sergeant Chris Kennedy, Las Vegas Metropolitan Police Department, Homicide Section	Southern Nevada
(g) One person who represents injury prevention;	Cherylyn Rahr-Wood, MSW, Certified Prevention Specialist (CPS) New: August 1st, 2025	Statewide – Southern Nevada
(h) One person who represents Native American tribes;	Vanessa Williams, CHW, Reno-Sparks Tribal Health Center New: August 1st, 2025	Native American - Northern Nevada
(i) One person who represents advocates for individuals and families with mental illness;	Anna Marie Binder, Family Representative with Mental Illness New: August 1st, 2025	Southern Nevada
(j) One person who represents veterans	Stacy Holybee, LCSW, Suicide Prevention Coordinator, Veterans Health Administration	Northern Nevada

Meetings

In accordance with NRS statute 439.5108, suicide fatality case reviews are not subject to open meetings laws and were closed to the public. Minutes were recorded if 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.

The CRSF plans to meet eight times in 2025. The eight meetings will include five business meetings and three case review meetings. The business meetings will last 90 minutes, cover the policies and protocols for the committee, and address some legislative edits to the NRS which governs the committee.

Each review meeting will last up to 4 hours where the committee will conduct an in-depth review of at least 15 suicide deaths per review, generating recommendations for intervention points that could have prevented these deaths. The CRSF produces an annual report to the Director of Health and Human Services in which actionable recommendations can be implemented in Nevada to reduce the suicide rate for Nevadans.

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.

Suicide Mortality Academy

On March 2nd, 2020, the Committee to Review Suicide Fatalities (CRSF) met face to face in Pahrump, Nye County for a local community review. On March 17, 2020, Nevada began operating under crisis status with many businesses and public areas closed. During COVID, work demands, and staffing changes greatly impacted the ability of OSP to appropriately gather data or documents and plan meetings.

Suicide Mortality Review Academy Overview

A Suicide Mortality Review Committee (SMRC) is a collaborative group of individuals that evaluates suicide deaths in a particular location or jurisdiction with the intent of identifying risk factors for and protective factors against suicide deaths that are unique to that location. The Substance Use and Mental Health Services Administration (SAMHSA) has partnered with the United States Department of Veteran Affairs (VA) to continue efforts around the Governor's Challenge to prevent suicide among service men, women, and their families.

Since the SMR Academy, CRSF has created a draft of amended bylaws, expanding participation of subject matter experts who participate in the case reviews. The Committee would like to make a recommendation of establishing this change in statute.

There were several areas that team leadership wanted to focus on during this site visit, including at-large membership, navigating privacy, and selection of cases.

Other concerns include Increasing non-voting membership to help balance the workload and provide information in specific areas of expertise and making sure that all meetings and relevant documents are housed in a safe, secure space where approved individuals (with signed confidentiality agreements) can readily access information.

Case selection criteria, including specific geographic and demographic populations was reviewed to ensure equitable representation across Nevada. The team identified areas of work that will inform the CRSF moving forward and will be discussed at Open CRSF meetings:

- Establish a Microsoft Teams channel to ensure secure communication with committee members and staff;
- Use of subject-matter experts (SMEs)/follow-up technical assistance/continuing education at team meetings to confirm the most relevant information is being utilized;
- Case selection review: look at tools currently being used and evaluate other potential tools and education methods for team members to ensure consistency of reporting;
- The CRSF has worked with Veterans Administration privacy officers to draft a document solidifying formal collaboration between the north and south to ease and ensure the timely sharing of information
- Team composition: review suggestions/edits, at-large members, SMEs, and

parameters regarding what the larger team should look like;

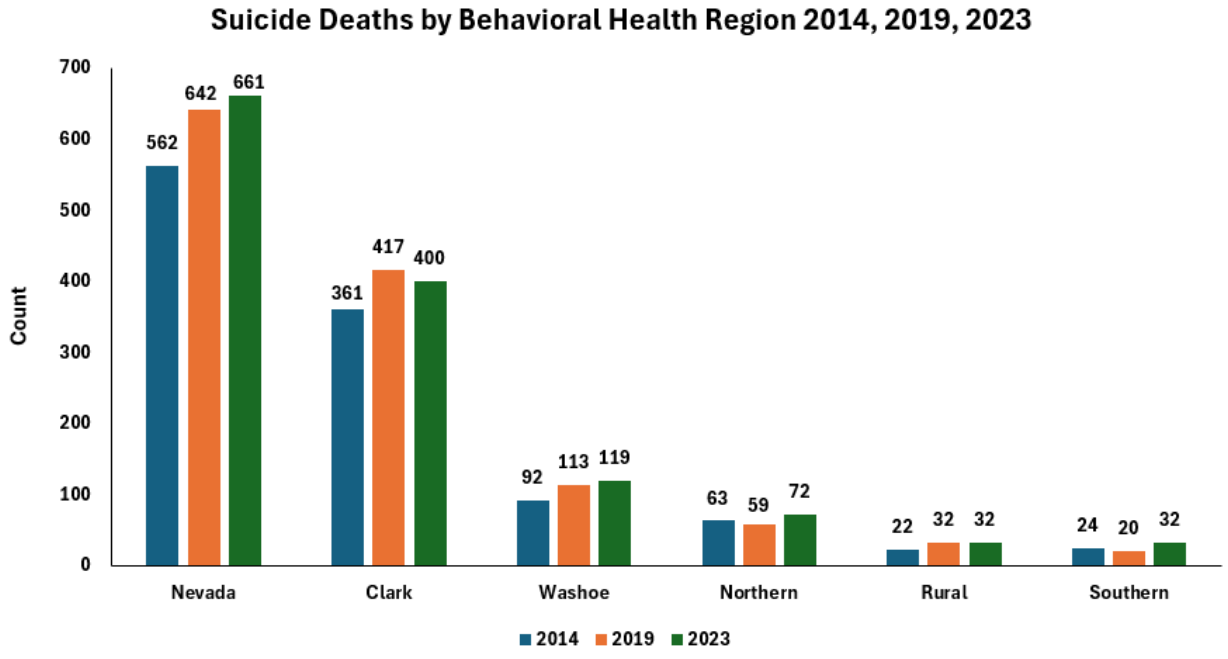
- Help Academy team gain a better understanding of the Suicide Mortality Review process.

The Suicide Mortality Review (SMR) Academy process was an important opportunity to rejuvenate and refresh the Nevada Committee to Review Suicide Fatalities with more efficient and productive processes. Through the work of its interagency team and with input from key constituencies, the CRSF played a key role in the Suicide Mortality Team (SMR) selected to represent Nevada. The SMR team developed a plan to improve the implementation of Nevada's CRSF.

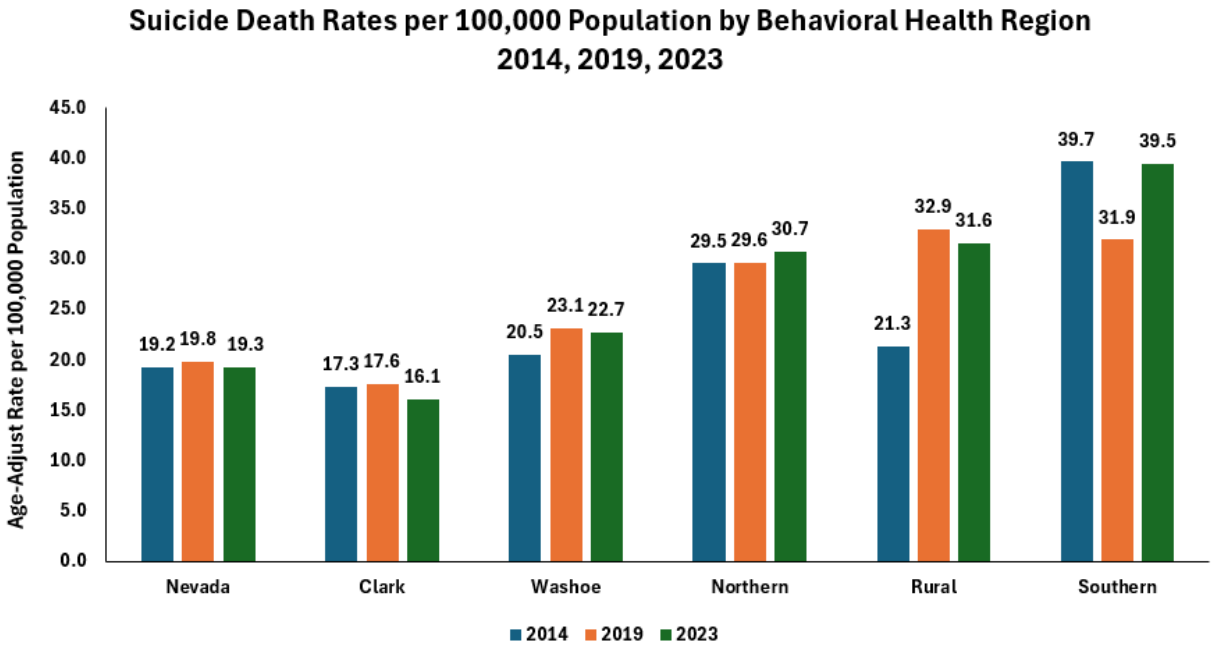
IMPACT OF SUICIDE IN NEVADA

From 2022 National data and 2023 Nevada Provisional Data:

- Nevada had the 11th highest rate of suicide in the nation;
- Suicide is the second leading cause of death for Nevadans ages 12-49;
- 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 12th highest rate (7.7 versus 5.6 US);
- Nevada males had the 15th highest rate (30.6 versus 22.5 US);
- 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; Nevada Elders have the 4th highest rate;
- About one in five people who die by suicide in Nevada are Veterans.



Source: Nevada Office of Analytics, 2023 Data.



Source: Nevada Office of Analytics, 2023 Data.

Suicide Rates by Age:

Although the CRSF can review youth deaths, Nevada's Division of Child and Family Services already reports on child fatalities by suicide. Staff from the Office of Suicide Prevention participate in local Child Fatality Review Committees and the Executive Committee to Review the Death of Children.

Male youth are more likely to die by suicide than females, possibly indicating a need to target outreach to males. Female youth's attempts at suicide generally have lower lethality.

Youths who have experienced negative life experiences can be more prone to suicidal thoughts and even suicide attempts. Comprehensive suicide prevention and awareness following a public health model are shown to decrease suicide rates in Nevada. On average, there are 17 deaths by suicide among ages 10-17 and 51 deaths among ages 18-24 each year.

Historically, Nevada had the highest rates of elder suicide in the entire country. For the first time, Nevada moved out of the top 5 states in 2022 and is now ranked sixth.

Critical factors which increased the risk for older adults are physical 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.

AGE RANGE:

Deaths by Suicide and Rate per 100,000 Population - Nevada Residents 2012-2023								
Year	Age Groups							
	0-17		18-24		25-64		65+	
	Count	Rate per 100K	Count	Rate per 100K	Count	Rate per 100K	Count	Rate per 100K
2012	6	0.9	32	12.2	384	26.3	84	23.4
2013	13	1.9	35	13.0	370	24.9	111	29.7
2014	11	1.6	44	16.2	372	24.7	131	33.9
2015	17	2.4	46	16.9	381	24.9	109	27.4
2016	19	3.0	43	16.9	413	30.6	163	46.2
2017	16	2.2	62	22.5	400	25.4	141	33.3
2018	28	3.9	51	18.0	438	27.2	144	32.7
2019	16	2.2	53	18.2	413	25.2	160	35.2
2020	18	2.4	62	21.0	370	22.3	151	32.1
2021	22	3.1	78	26.2	423	25.5	160	33.0
2022	21	2.9	66	21.5	433	25.8	147	29.2
2023	21	2.9	46	14.4	409	23.9	185	35.6

Rates calculateper 100,000 age and count-specific Nevada population, provided by the Nevada State Demographer (OOA, 2024)

Veterans' Suicide Rates

Nevada's suicide rate among veterans is significantly higher than the national rate. Nevada veteran rates of death from suicide are almost three times non-veteran rates.

Factors such as disability, independent living, health, and personal financial concerns have been shown to contribute to the high rate of suicide deaths in some individuals. The potential effect increases 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] Veteran suicide rates (per 100,000) have varied between 2017 and 2021 with a peak rate of 61.5 per 100,000 veteran population in 2017 compared to the lowest rate of 48.3 per 100,000 veteran population in 2020.

Figure 10. Age Distribution of Population by Veteran Status. Nevada Residents Ages 20+, 2019-2023 Combined.

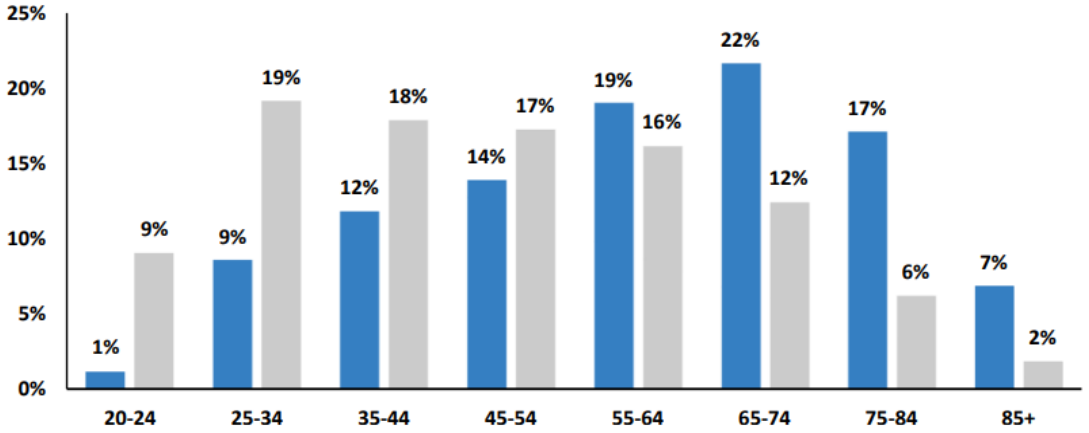
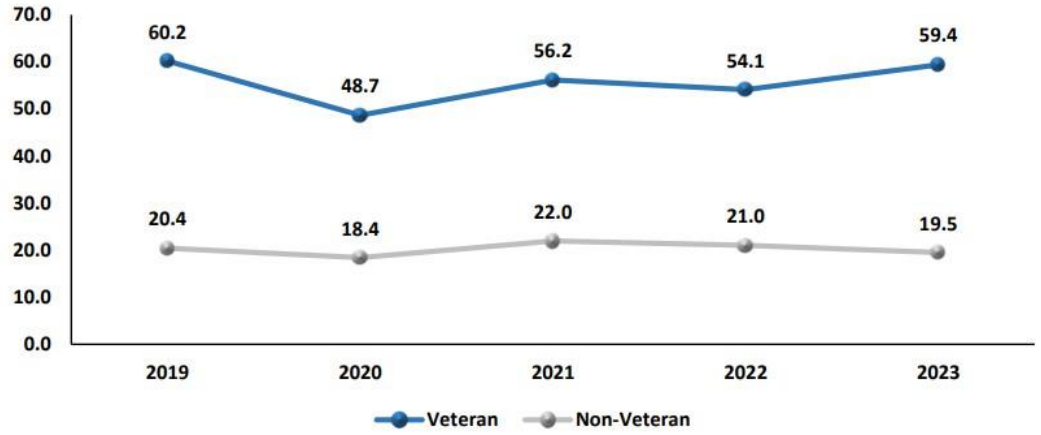


Figure 8. Suicide Age-Adjusted Rates (per 100,000 Population) by Year and Veteran Status. Nevada Residents Ages 20+, 2019-2023.



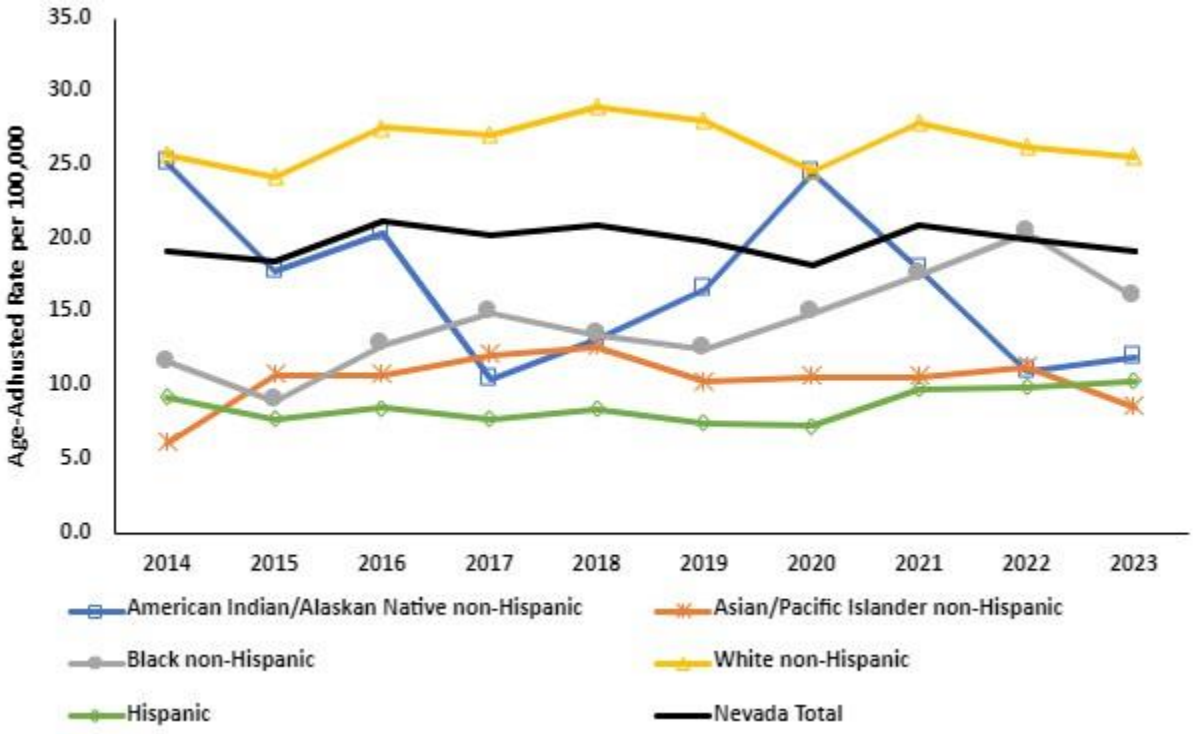
Data Source: Nevada Electronic Death Registry System

Race/Ethnicity Suicide Rates

Hispanic populations make up 10.4% of suicide fatalities in U.S., but as of 2020 there was a 14.9% of fatalities in Nevada. This has doubled from 7.5% of the population in 2010.

Suicides rates were higher for Nevada adults within every racial and ethnic group compared with U.S. rates. This disparity is even more profound in our rural communities where suicide rates are consistently higher than the other communities in the state.

Suicide Rate by Race/Ethnicity, 2014-2023



The suicide rate for White non-Hispanic were significantly higher than the Nevada overall rate for each year from 2012 to 2021, with 29.1 per 100,000 population in 2021. The suicide rate for American Indian/Alaskan Native non-Hispanic was above the total Nevada rate from 2012 to 2015 and 2020 but was not significantly higher based on 95% confidence intervals.

The suicide rate for the Hispanic population is significantly lower than overall Nevada rates for all years. In 2020, the Nevada rate for the Hispanic/Latino population was near the national rate at 7.9% vs. 7.5% for the U.S.

Frontier/Rural Nevada Suicide Rates

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

transportation, poverty, cultural barriers and stigma. Geographical rates of suicide in Nevada's counties varied considerably. Some of the highest 2021 rates were in Nevada's frontier counties including Carson City (61.2%), Elko (50.0%), and Nye (39.9%), as identified on the DHHS Nevada Suicide Dashboard, OFFICE OF ANALYTICS - DATA & REPORTS and Table 5, with decreases in Nevada overall, as well as in Clark, Churchill, Humboldt, and Washoe Counties.

Gender

In 2022, 79.4% of suicide fatalities in the U.S. were males, while 77.7% of suicide fatalities in Nevada were males. This represented almost a 1.5% increase from 2021 (76.0%).

Across the U.S. and in Nevada, rates of death from suicide for women have been, and continue to be, lower than the rates for men.

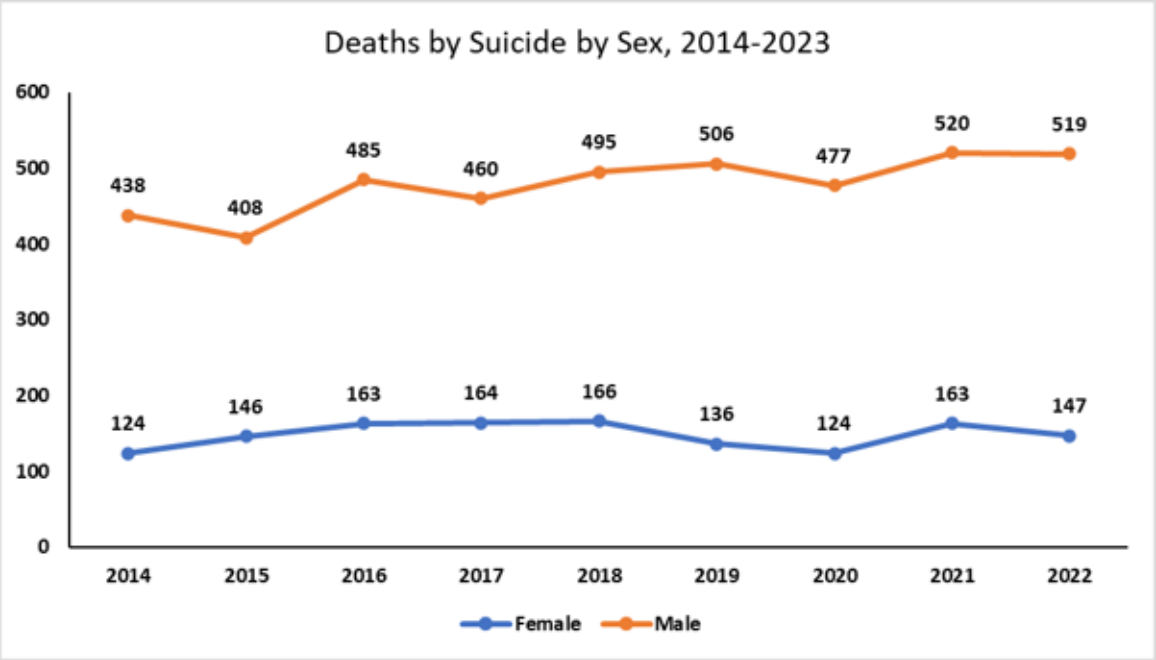
Looking at suicide attempt data collected from Nevada hospitals, females present at statistically higher rates than males for both emergency department encounters and inpatient admissions.

The number of female suicide attempts are higher than male suicide attempts. Males are significantly more likely to use a firearm in their method of suicide. Males choose firearms as the method of suicide in over 61% of cases, while females used firearms in only 35% of cases.

Nevada has traditionally been limited to analyzing gender identity based on death certificates offering a choice of male or female. It is important to note the dearth of current research among transgender and gender nonconforming populations.

Currently, the state vital records system offers the additional options of “non-gender specific” or “unknown” for gender on death certificates. Based on the current president’s executive order, going forward, Nevada will report on gender recognized.

Number of Suicides by Sex, 2014-2023



Source: Office of Analytics, Nevada Statewide Epidemiological Profile Report.
2024 Nevada Epidemiologic Profile

STATUS OF COMMITTEE RECOMMENDATIONS

Since the 2019 report, the Committee to Review Suicide Fatalities (CRSF), the Office of Suicide Prevention (OSP), and partners made progress toward implementing several Committee recommendations.

RECOMMENDATION #1:	STATUS TO DATE
Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings.	With the development of the Crisis Response Section, the state is working with communities to implement and improve discharge and follow-up with 988, mobile crisis response teams and crisis stabilization units. The 988 Coalition is being developed to work with communities to address specific local needs and address feedback of crisis response.
RECOMMENDATION #2:	STATUS TO DATE
Acquire additional funding to move statewide suicide prevention efforts forward.	The Office of Suicide Prevention has been brought within the Crisis Response Section. With the passage of SB390, a .35 cent fee on certain telephone lines will go toward sustainability of 988 and Nevada Crisis Response. This will increase infrastructure and funding support. OSP has also received a 5-year grant to implement youth suicide prevention programming in Elko, Churchill and Carson City.
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.	Ongoing directly with the VA. DHHS has also established an updated standing letter authorizing the sharing of information with the VA Health System in Nevada.

RECOMMENDATION #4:	STATUS TO DATE
Increase outreach to those affected by decedents' suicide deaths through Coroner's Office staff and others.	OSP is seeking funding to support Nevada's Medical Examiners to hire Data Abstractors and Postvention Specialists to support families after a death by suicide.
RECOMMENDATION #5:	STATUS TO DATE
Follow up on contact with mortuaries to increase opportunities for survivor support.	Currently, capacity to properly address this recommendation is lacking. Survivor Support continues to be a tremendous need, including the expansion of Survivors of Suicide Loss Support (SOSL) groups. OSP is working with other grief support entities to explore expansion into peer support for SOSL.
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.	OSP has been approved to offer continuing education from the Board of Pharmacy. 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.
RECOMMENDATION #7:	STATUS TO DATE
Improve the collection of data pertaining to suicide attempts.	AB181 was passed during the 2021 legislative session, and regulations were approved in 2023, mandating the reporting of attempted suicide by certain healthcare facilities including hospitals (rural as well), community triage centers, and psychiatric hospitals. Currently

	working with Bitfocus to develop a module to capture suicide attempt reporting.
RECOMMENDATION #8:	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. Great strides have been made, especially with the construction industry, including Peer support teams, unions, firefighters, and the Statewide Safety Consultation and Training Section (SCATS).
RECOMMENDATION #9:	STATUS TO DATE
Focus on the connections between substance use disorders and suicide prevention.	The Office of Suicide Prevention has now been moved within the Bureau of Behavioral Health, Wellness and Prevention. The Bureau is currently engaging community partners in key informant interviews and focus groups to develop a statewide strategy. This will improve alignment with substance use and suicide prevention.
RECOMMENDATION #10:	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.	Passage of SB294 and implementation. Developed training for community and families around safe firearm storage being crucial for families, particularly those with youth at home. Teens are often curious and impulsive, and despite well-meaning warnings from adults, they may still be tempted to explore firearms if they find them. This 3-hour training helps families with firearms in the home store them safely, in compliance with Nevada laws.

RECOMMENDATION #11:	STATUS TO DATE
Reduce stigma in the Hispanic community through culturally appropriate outreach. (Due to new data, this goal has been expanded to other marginalized communities impacted by suicide.)	The Office of Suicide Prevention aims to expand our reach on prevention efforts to underserved communities where there has previously been limited support or training opportunities. Nevada has a unique population landscape and outreach efforts for Spanish speaking, Native American Tribes, Deaf and Hard of Hearing communities, and the Rancher/Farmer populations are greatly needed and will be prioritized in the coming years. As this work continues to grow, OSP has expanded the Trainer Network to include several bilingual Spanish/English trainers; OSP has also developed Suicide 101 in Spanish. Transformation Transfer Initiative funding has been awarded to focus on Native American Youth and the Deaf and Hard of Hearing Communities.

Cases Reviewed: 2020-2022

Ninety-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 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 information captured is not standardized from one county to the next.

THE COMMITTEE TO REVIEW SUICIDE FATALITIES FUTURE FOCUS

Through the review process, and utilizing what has been learned regionally, the Committee has produced several updated 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; these continue to be areas in need of great improvement toward reducing the number of suicide deaths.

Many of the recommendations continue to directly refer to Nevada's health care systems. Due to Nevada's participation in the Federal and State Suicide Mortality Review Academy, the Substance Abuse and Mental Health Services Administration hosted the academy in Reno, NV, January 28-30, 2025.

Representatives from OSP and Washoe County Regional Medical Examiner's Office participated as subject matter experts to support new and developing suicide mortality review committees from other states. Additional recommendations from the review process are:

RECOMMENDATION #1: Review suicide by firearm in a more in-depth manner.

Senate Bill 294 is legislation that requires the Office of Suicide Prevention (OSP) to create and maintain a website with materials linked to various resources related to suicide prevention. This includes information for the public, law enforcement, healthcare providers, and others. The website provides information on suicide prevention (including how to recognize the signs of suicide and keep loved ones safe), community resources and hotlines, mental health agencies, organizations, and suicide safety information. OSP is also required to provide educational outreach on suicide prevention to the public, law enforcement, and healthcare providers. The office is tasked with training individuals who

have face-to-face contact with people at risk of suicide. The training focuses on how to recognize individuals experiencing suicidal thoughts and how to connect them to resources. The legislation emphasizes the importance of connecting trained individuals to schools, community centers, nursing homes, and other facilities with individuals at risk of suicide. In this effort, OSP is in the process of revitalizing our materials for the Reduce Access to Lethal Means Program, which are scheduled and adjusted for 2025. These materials include website graphics update, Firearm Securing Devices brochure, Two Securing Firearms posters, Gun Safety Rules brochure, SAFER postcard, Safer at Home Brochure, and Tips for Firearm Dealers and Ranges info sheets.

RECOMMENDATION #2: Improved Discharge Protocols.

There is a recommendation from multiple community partners to implement a more comprehensive resource tool provided at hospital discharge. Resources should be developed and distributed to support emergency departments in providing information to patients and families following discharge after a suicide attempt.

RECOMMENDATION #3: Improved Care Transitions and Follow-Up Post-Discharge.

National data show individuals with a recent discharge from an emergency department are at higher risk for suicide, especially in the month following discharge. Further, approximately 70% of individuals discharged from emergency departments after a suicide attempt do not attend a follow-up appointment with a mental health provider.

It is recommended to implement mandatory follow-up calls within 24 hours post discharge for every person with suicide ideation or a suicide attempt.

Many times, patients are discharged with instructions to follow up with a mental health care provider within one week; however, this time frame is too late for many patients.

Every effort must be made to discharge the patient to their support person or care provider. If possible, identify and coordinate with already established providers:

- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to outreach, engagement, and support; risk reassessment; reviewing, updating, and

facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.

- Engage peer support workers and specialists in follow-up contacts.

CONCLUSION

During the inception of this Annual Report, several challenges and changes occurred to the infrastructure of The Nevada Department of Health and Human Services, as of 7/1/2025, going forward, the CRSF will refer to DHHS as The Department of Human Services (DHS).

Both DHS and the Nevada Office of Suicide Prevention will continue to support and advance the recommendations found in this report.

The Committee to Review Suicide Fatalities continues 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 (NVDRS), the establishment of the Crisis Response Unit and Crisis Response System, and implementation of suicide attempt data collected in real time, there will be access to more complete data.

As data from the CRSF reviews grows, the Office of Data Management (ODM), Crisis Response System (CRS), OOA and OSP can gather a more vivid picture of what might be impacting someone with thoughts of suicide. The OSP continues to gain more insight into areas where prevention efforts might be effective.

Some of those areas for future work include teaching skills and resiliency to better cope in times of challenge with relationships, health concerns, social media safety, 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 will continue to build more connectedness and/or connectiveness. Feeling connected to someone or something such as nature, faith, purpose can be life protecting.

Through data-driven decision-making, wisdom shared by those with suicide-centered, lived-experience, persistence and perseverance, the CRSF, CRS, OOA, OSP, and the Department of Human Services will continue to implement these recommendations throughout the state, prioritizing the health and well-being of all Nevadans.