



Pima County Suicide Prevention Task Force

Minutes

Logistics

Time:	3:00 PM – 4:00 PM
Date:	Tuesday April 18, 2023
Invitees:	Pima County Collaborative Partners
Attendees	<p>Julie Mack, Arizona Complete Health Arisia Lee, Pima County Health Department Erin Gibson, Pima County Sheriff's Department lead on substance use & mental health Sara Lind, Pima County Health Department Dedra Clark-McGee, Pima County Health Department Hollie Watson-Smith, Pima County Health Department Julia Chavez, Arizona Complete Health, Tribal Programs Specialist Morgan Hines, Teen Lifeline Adriana Laigo, Pima County Health Department Monica Rivera Katie Wilkinson, Real Life. Real Talk. Coordinator, Planned Parenthood Lynn Oelke, Tucson Medical Center Mercedeh Reamer, Arizona Department of Health Services George Beverly Junior, Community Activist Rex Scott, Pima County Board of Supervisors Mayra Jeffrey, Pima County Health Department Leah Morales, Pima County Health Department</p>
Meeting Purpose:	Partner Introductions and Overview
Location:	ZOOM Meeting

Agenda

Item #	Description	Presenter
1	<p>Introductions</p> <ul style="list-style-type: none"> Lynn Oelke. Works at the Tucson Medical Center Wellness Department. Working on building a new suicide prevention initiative for TMC's staff and is here to learn about community resources that are available. Sara Lind. Works at the Pima County Health Department as a Program Coordinator for Suicide Mortality Review and will be presenting today. George Beverly. Is a community activist. Is from Oregon and now lives in Pima County. <p>Meeting Purpose</p> <ul style="list-style-type: none"> Goal – Look at what's happening in Pima County. Offer Postvention services. 	All
2	<p>Overview Suicide Mortality Review Board</p> <p style="text-align: center;">Local Suicide Mortality Review (SMR) Committee</p> <hr style="width: 30%; margin: auto;"/> <p style="text-align: center;">Pima County Health Department Community Mental Health and Addiction</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>PIMA COUNTY HEALTH DEPARTMENT</p> </div> <div style="text-align: center;"> <p>A Healthy Pima County Every one. Every where. Every day.</p> </div> </div> <p style="text-align: center;">Contents</p> <ul style="list-style-type: none"> • Overview of SMR • Investigation Process • Individual Case Review • Preliminary Year 1 Findings • Closing <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>PIMA COUNTY HEALTH DEPARTMENT</p> </div> <div style="text-align: center;"> <p>A Healthy Pima County Every one. Every where. Every day.</p> </div> </div>	Sara Lind Hollie Watson-Smith

Purpose

- Establish and maintain a local team to perform in-depth investigation of Pima County suicides.
- The team will use proven public health response strategies to identify:
 - Risk factors
 - Intervention points
 - Prevention methods
- The team will distribute the data to target and to guide direct service agencies who are positioned to encounter the high risk populations.



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- We want to have people in Pima County who know the Suicide mortality review system.
- Team to ID risk factors in each case.
- Goal is to gather as much information as possible about the cases and provide the community with recommendations.
- This is the first year of the suicide mortality review. Year 1 was just completed. The next step is to provide recommendations.

Overview of Suicide Mortality Review

- Multi-agency/disciplinary team conducts **confidential** case reviews of suicides
- Members are recruited based on specific expertise to help advise and investigate during case review
- Members contribute during reviews based on their scope of experience and expertise
- Team collects investigative findings, expert opinions, and recommendations from members to make decisions



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Committee Scope

Within

- Identify risk factors and trends to inform prevention and treatment efforts
- Share relevant findings with stakeholders to enhance coordination
- Identify systemic barriers related to policy, procedure, and structure

Outside

- Identifying fault or blame of a specific provider or agency
- Recommending punitive actions
- Attempting to hold individuals or agencies accountable
- Using review findings to support a legal strategy



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- The committee is trying to get a picture of what the person's life looked like up until the suicide.
- The committee is not subject to subpoena. The review can't be used in legal strategy.

Confidentiality

- Closed meetings
- Civil liability protection for team members and those that provide information
- Members may not be questioned in civil or criminal proceedings regarding info presented in meeting



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- **Strict confidentiality is maintained.**

Overview

SMR Process

- Pima County Health Department identifies random selection of cases from previous year
- PCHD Program Coordinator begins gathering information from various sources: Office of the Medical Examiner, law enforcement, Health Information Exchange (HIE)
- Program coordinator identifies additional sources of information such as behavioral health agencies, hospitals, crisis response center, LTCs, group homes, etc.
- Program coordinator puts information together into a summary and timeline for presentation to committee



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- **Create a summary and timeline for each case that is presented to the committee.**

Overview

Our Local Committee



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Individual Case Review



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Case Narrative

- Demographics
- Incident details
- Medical history
- Behavioral history
- Life stressors



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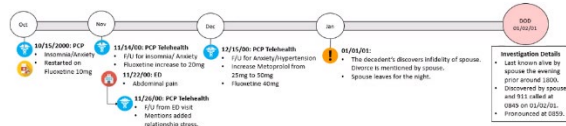
- The following is included in an individual case review:
 - Details of the fatal incident.
 - Toxicology.
 - Note.
 - Drug involvement.
 - Chronic conditions.
 - Hospitalizations.
 - Behavioral health diagnosis.
 - Changes in employment.
 - Changes in school status.
 - Changes in intimate relationships.

Case Narrative

CASE REVIEW - Case #			
DOD:		Official COD:	Method:
Toxicology Performed:	Results:		
Injury location:	Who discovered:		
Suicide note:	Suicide note format:		
Communication prior:	Explain:		
Anyone present at time of injury?:	Who?:		
Evidence of substance involvement:	Explain:		
Act of violence or pact:	Explain:		
Last known alive:	By Who?:		
Case Description			
Age:	Race:	Ethnicity:	Education level:
Assigned sex:	Gender identity:	Sexual orientation:	
Relationship status:	Domestic violence history:		
Marital status:	Criminal justice history:		
Employment:	Occupation:		
Mental health diagnosis:	Substance use diagnosis:		
Previous attempts:	Most recent attempt:		
Residence Information			
Type of residence:	Length of residency:		
Residing with:			
Recent Life Stressors (Describe all that apply.)			
<input type="checkbox"/> Suicide of family/friend	<input type="checkbox"/> Employment/School	<input type="checkbox"/> Financial	<input type="checkbox"/> Legal - Civil
<input type="checkbox"/> Death of family/friend	<input type="checkbox"/> Physical health	<input type="checkbox"/> Recent argument	<input type="checkbox"/> Relationship(s)
<input type="checkbox"/> Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Residence
Medical History			
Chronic condition:			
Recent serious injury/diagnosis:	Reason for visit:		
Health insurance:	Has PCP?:	If yes, where?:	
Date last seen by PCP:	Reason for visit:		
Date last seen in ED:	Reason for visit:		
Last known medical hospitalization admit date:	Reason for hospitalization:		Discharge Date:
Behavioral Health History			
Date last seen in ED (psychiatric):	Reason for visit:		
Last known psychiatric hospitalization admit date:	Reason for hospitalization:		Discharge Date:

- The case narrative is 5 pages in length and attempts to show a comprehensive look at the individual's life before the completed suicide.

Timeline of Events leading up to DOD



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- This is an example of what a timeline might look like. It is not a timeline from an actual case.

Case Findings & Recommendations

CONTRIBUTING FACTORS AND RECOMMENDATIONS WORKSHEET
Please use a new sheet for each individual case.

CASE REVIEW		CASE NUMBER	
PREVENTABILITY A suicide is considered preventable if there is at least some chance that death could have been averted through reasonable actions.		Was this death preventable?	Yes No Some chance Some chance No chance Unsure Not applicable
What were the factors contributing to death? A contributing factor is anything that influenced or impacted the outcome of suicide. Please list all factors and indicate contribution.		What specific actions could have been done to potentially change the outcome of suicide?	
Contributing Factor (use Contributing Factor description for each factor)	Description of Contributing Factor	Recommendation(s)	Category (for search only)



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- Committees members use their expertise to provide recommendations to keep a similar death from occurring in the future.

CONTRIBUTING FACTOR DESCRIPTIONS
List and examples are not intended to be exhaustive. Use "Other" when situation necessitates.

ACCESS TO SUICIDAL MEANS	DISCOURAGEMENT	LOCAL RESOURCES
Letter written to family, medications, prescription bottles were readily available.	Treatment of mental illness/other stressor (e.g., job loss, divorce, loss of loved one, etc.)	Light event which led to loss of hope of death that had a psychological impact on individual (e.g., discrimination, incarceration, admission, sentencing, reporting to an attorney, etc.)
ADVERSE INTELLIGENCE	Event results in the workplace that results in a dramatic change in employee's status or job security (e.g., being demoted, laid off, furloughed, business closure, workplace accident, etc.)	LOSS OF INDEPENDENT LIVING
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Loss of primary or secondary residence due to foreclosure, seizure, or other financial distress or other personal or professional crisis (e.g., bankruptcy, foreclosure, long term care, senior living, abandonment of public housing, etc.)
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	LEFT HOME/ABANDONED HOME
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Event where a person's physical safety was in immediate danger, such as without injury (e.g., involved in shooting, kidnapping, hostage, sexual assault, robbery, etc.)
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	OTHER TRIGGER
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	An event or incident where an individual experiences acute or chronic stressors that cause functional impairment, impaired ability to care for oneself, impaired ability to interact with others, impaired ability to work, impaired ability to manage finances, impaired ability to manage legal affairs, impaired ability to manage health care, impaired ability to manage other responsibilities, etc.
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	SIGNIFICANT ABANDONMENT
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Event that resulted in the loss of a significant relationship (e.g., death, divorce, etc.)
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	SOCIAL ISOLATION/ISOLATION
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Social support from family and/or friends was inadequate or nonexistent.
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	TRIGGER
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Systemic or community barriers (e.g., mental health services, access to health care, etc.)
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	UNDETERMINED MENTAL DISORDER**
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Any diagnosed or suspected mental disorder that without evidence of an initial trigger (e.g., diagnosis or abandonment) led to death within 24 hours of diagnosis.
ADVERSE PERSONAL STRESSORS	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	OTHER
Event resulted in loss of income, housing, or other resources, especially if they were critical to survival.	Individual was hospitalized or hospitalized in near future to fight infection, blood clot, or other, experiencing prolonged hospitalization.	Other factor not mentioned that contributed to person's death. Please describe.

*Only to be used if there is evidence that the individual's death was preventable.
**Only to be used if there is evidence of a mental disorder.



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Preliminary Year 1 Findings

Year 1 Overview

- Total of 5 meetings held between March 2022 and January 2023
- Reviewed 27 suicide deaths that occurred in 2021
 - 70% males/30% females
 - Decedents ranged in age from 17 to 92
 - 15% had prior military experience
 - 48% left a note
 - 63% died in own residence, 19% in motor vehicle
 - 59% had history of prior suicidal ideation
 - 19% had history of one or more suicide attempts

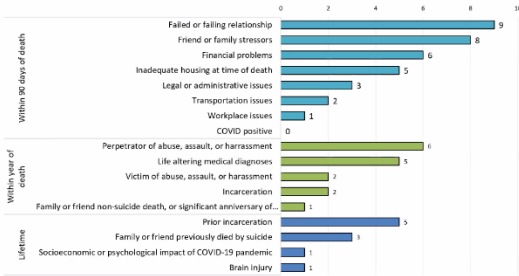


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- The goal of year 1 was to review 10% of deaths that occurred due to suicide in Pima County. This goal was met.
- 27 cases were reviewed in year 1.

Preliminary Year 1 Findings

Potential Stressors Identified through Record Review

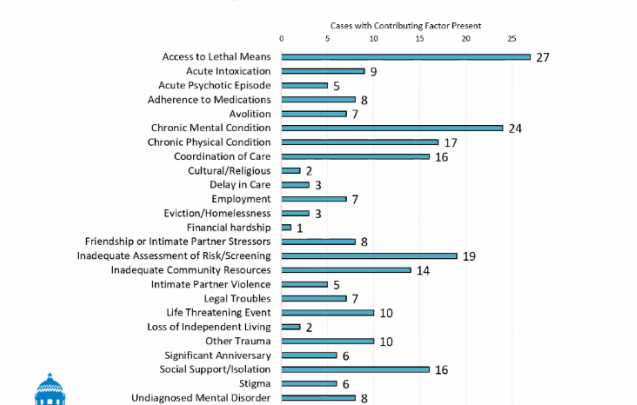


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- These are out of 27 cases.
 - So for 9 of the cases, there was a potential stressor of a failed relationship.

Preliminary Year 1 Findings

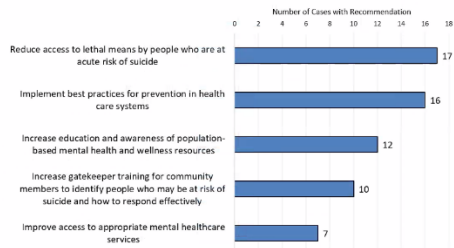
Contributing Factors Identified by Committee



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- These are out of 27 cases.
 - So in all 27 cases the person who completed a suicide had access to lethal means.

Most Common Recommendation Categories Identified by Committee



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- Decrease access to lethal means.
 - Gun locks/safes.
 - Increase messaging to the community about decreasing access to lethal means.
 - Increased training.
 - More restrictions to online orders of lethal means.
 - Decrease access to firearms for those at risk of suicide.
- Implement the following:
 - Improving quality and access to care for people with eating disorders.
 - Give health care providers access to ALL of a patient's health history.
 - Availability and awareness of counseling resources.
 - Creation of low cost health care resources.
 - Promote using the crisis line for loved ones.
 - Family education for elders in decline.
 - Increase availability of QPR training.
 - Promote community trainings for community members with mental illness.
 - Need for long-term services and wraparound care for people with chronic conditions.
 - Specialized treatment plans for those at a high risk of suicide.
- When the annual report has been completed, the goal is to have concise recommendations to share with the public and specific recommendations to share with providers.

Questions & Comments

Is there demographic information for military veterans, specifically for black and brown people?

- For this small of a sample size, we don't have that information.
- As years increase, we should have a better answer.

Homelessness is hard to quantify because it is not recorded on the death certificate.

Do families have the opportunity to opt out if they do not want their loved one used for research?

- We are not conducting next of kin interviews. We are thinking of including their input in the future.
- Loved ones are not aware that we are conducting these reviews.
- Everyone signs a confidentiality statement.

Tribal population information like this is confidential. You might look into mentioning to tribal communities that this is taking place. It is important to give them this information and also to give them the opportunity to opt out

How are the 10% of cases chosen?

- Random number generator.
- Only look at cases of deaths that occurred in Pima County, also have to be a resident of Pima County.

Closing

Contacts and Resources

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Mark.Person@Pima.gov

• A.R.S. Title 36-199:
<https://www.azleg.gov/viewdocum ent/?docName=https://www.azleg.gov/ars/36/00199.htm>

• ARS Title 35-199.01
<https://www.azleg.gov/viewdocum ent/?docName=https://www.azleg.gov/ars/36/00199-01.htm>



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Partner Updates Teen Lifeline

- Teen Lifeline is expanding into Tucson
- This is a brand new program that was launched this year.
- Making contacts with hospitals and health centers in inpatient facilities, so that patients can opt into the program at discharge and a coordinator will contact them 15 times in a year, send care packages.
- If you are interested in this program contact Morgan.
- This summer Teen Lifeline will hire a Team members for – 1. providing training and education to schools and families, 2. A Community Liaison for partnerships and outreach.
- The hotline and peer counseling program will also be coming to Tucson.

All
Morgan Hines

	<ul style="list-style-type: none"> • Morgan's info: morgan@teenlifeline.org <p>American Foundation for Suicide Prevention (ASFP)</p> <ul style="list-style-type: none"> • ASFP is sponsoring 2 programs in May <ul style="list-style-type: none"> ○ Talk Saves Lives: An Introduction to Suicide Prevention for Latinx and Hispanic Communities ○ Introduction to Supporting Those At Risk • Visit their website for more information: https://afsp.org/ • <p>Healthy Pima</p> <ul style="list-style-type: none"> • The Community Health Improvement Plan has been finalized and printed. If you would like a copy contact Arisia. • Healthy Pima puts out a monthly newsletter. If you would like to receive it or include something in it, contact Arisia. • If you have updates to the Action Plan, contact Arisia. • Arisia.Lee@pima.gov 	<p>Gina Gillis</p>
4	Pima County Health Department: Suicide Death Trends	<p>Arisia Lee Hollie Watson-Smith</p>

Community Mental Health and Addiction

Summary

Fatal Overdoses

Suicides

Homicide

Coming Soon

2306

Overdose Deaths Since 2017

1440

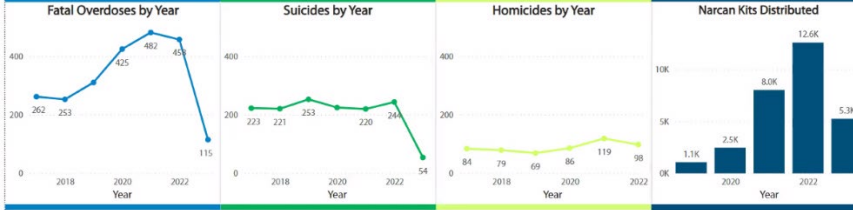
Suicide Deaths Since 2017

535

Homicide Deaths Since 2017

29K

Narcan Kits Distributed



Fatality data is collected from death certificate and autopsy records. Data is based on point in time surveillance of fluid data sets that change frequently. To protect confidentiality, indicators with counts of five or less are suppressed.

Community Mental Health and Addiction

Summary

Fatal Overdoses

Suicides

Homicide

Coming Soon



To protect confidentiality, indicators with counts of five or less are suppressed, with exception of overall monthly counts. Fatality data is collected from death certificate and autopsy records. Data is based on point in time surveillance of fluid data sets that change frequently.

Community Mental Health and Addiction

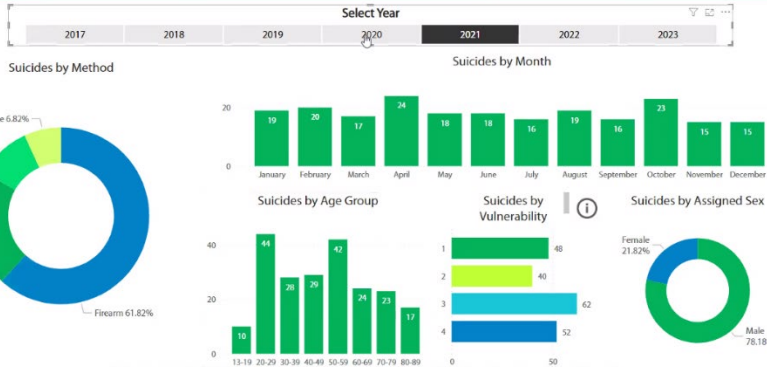
Summary

Fatal Overdoses

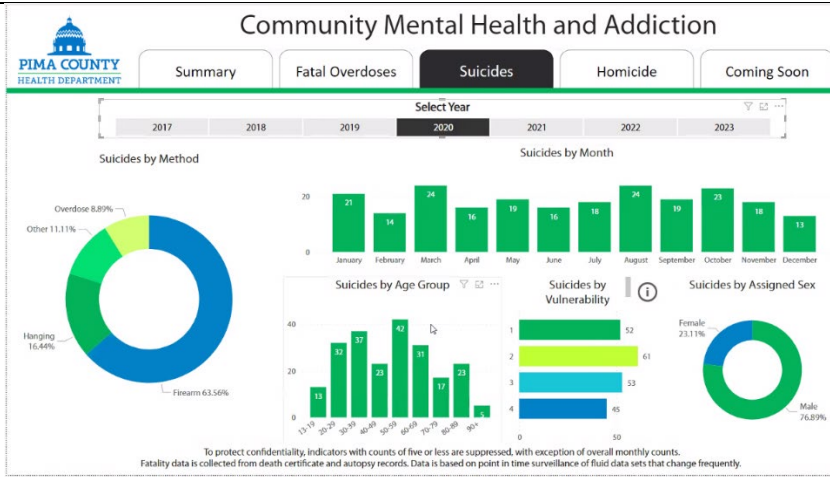
Suicides

Homicide

Coming Soon



To protect confidentiality, indicators with counts of five or less are suppressed, with exception of overall monthly counts. Fatality data is collected from death certificate and autopsy records. Data is based on point in time surveillance of fluid data sets that change frequently.



- 54 confirmed suicides for the year.
- Intentional overdoses are higher than previous years, at 9% right now.
- Intentional overdoses for February and March is low compared to previous months.
- April is looking like it might get higher for intentional overdoses.
- Suicides by age group
 - 60-79 years old – these numbers are not normally this high. Right now this age group is on track to be high again this year.
 - 20-29 years old is the group that usually has the highest numbers, not 60-79 years old.

5	General Announcements	All
6	Closure / Next Steps	All
7	Task Force meets quarterly on the last Tuesday of the month – Next Meeting = 7/25/23 – 3:00 – 4:00 - 10/31/23	All