PREVENTING SUICIDE

ONE COMMUNITY AT A TIME

NEVADA SUICIDE PREVENTION PLAN

2007-2012

Nevada Suicide Prevention Plan 2007-2012

Office of Suicide Prevention
Department of Health and Human Services
Office of the Director

The Honorable Jim Gibbons
Governor
State of Nevada

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May 2007

Nevada Suicide Prevention Plan
Table of Contents

HARRY REID
NEVADA

DEMOCRATIC LEADER

United States Senate

WASHINGTON, DC 20510–7012

Dear Fellow Nevadans,

The Nevada Suicide Prevention Plan is an important step forward in our shared mission to save lives that would otherwise be lost to suicide. Crafted in response to a national call for action, this document is designed to recognize suicide prevention as a statewide priority and provide a comprehensive framework for suicide prevention, intervention, and postvention in Nevada.

For our state, the need for such a tailored plan is especially urgent. Nevada's per capita suicide rate was the highest in the country from 1990 to 2000, and it continues today to hover at nearly double the national average. Four hundred Nevadans take their own lives every year, each leaving behind a circle of loved ones profoundly affected by the loss. That these deaths are largely preventable only further compounds the tragedy.

Translated into practical reality, the grim statistics tell us that preventing suicides is a formidable challenge that will take the organized action of a wide range of stakeholders, including policymakers, health and mental health professionals, advocacy groups, and community leaders. I am encouraged that their voices are among those represented in the document before you. There is also much reason for hope in light of the work already underway, from raising public awareness to eliminating the barriers that keep at-risk individuals from seeking and receiving help.

The Nevada Suicide Prevention Plan sets forth a coordinated strategy for these ongoing efforts, as well as future initiatives. I strongly support the goals embodied in the plan, not only as a member of the U.S. Senate representing Nevada, but also as a person who has lost a loved one to suicide. Let us all rise to confront the challenge, working to forge lasting solutions that will enhance our response to Nevada's suicide rates and save lives. Together, we can truly make a difference.

Sincerely,

HARRY REID
United States Senator

JIM GIBBONS
Governor

MICHAEL J. WILLDEN
Director

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May 31, 2007

Dear Nevadans,

Suicide has had a devastating impact on the State of Nevada. Each year, more than 400 Nevadans die by suicide, and our suicide rate continues to be almost double the national average. Each person we lose to suicide leaves countless loved ones in unfathomable pain, contemplating what could have been done to prevent such a tragedy.

The State of Nevada has made significant strides in addressing this tragic public health problem. That is why I am honored to present you with the first Nevada Suicide Prevention Plan, which was modeled on the National Strategy for Suicide Prevention: Goals and Objectives for Action.

The Department of Health and Human Services, Office of Suicide Prevention, is committed to maintaining the public-private partnership that was instrumental in the development of this plan, which will serve as an invaluable tool in our efforts to lower the incidence of suicide and suicidal behaviors in Nevada.

The Nevada Suicide Prevention Plan is a "call to action" and a guide to develop local suicide prevention programs, as well as a statewide, comprehensive and collaborative system for prevention, intervention and post-occurrence follow-up. Suicide prevention is an ever-changing discipline. Therefore, the plan is designed to be a dynamic document which will evolve to meet the needs as our state continues its rapid growth.

Thank you for your interest, dedication and support in reducing suicide and suicidal behavior in Nevada. By all of us working together, we will save lives.

Sincerely,

Michael J. Willden
Director

Our Commitment to the Voices of Nevada

This plan represents the voices of Nevadans touched by suicide and those dedicated to suicide prevention. Together we can strive to prevent the tragic loss of life by suicide and spare others the burden of living in the aftermath.

The Office of Suicide Prevention staff is closely connected with individual communities across the state. We seek to actively listen and incorporate their voices into our daily suicide prevention efforts.

We endeavor to infuse culturally competent values and practices in all aspects of our work in suicide prevention. We are committed to being engaged in the diverse communities of Nevada, so that the goals and objectives of the plan encourage safety and willingness to seek help.

Vision of the Office of Suicide Prevention

It is our hope that the Nevada Suicide Prevention Plan will provide a catalyst for collaborative action, improved understanding and increased wellness in communities across Nevada. This plan is based on the strong belief that everyone has a role to play in suicide prevention and that those who address the physical, emotional, psychological and spiritual needs of individuals and communities must work together if we are to be effective.

Mission of the Office of Suicide Prevention

To reduce the rates of suicide and suicidal acts in Nevada through statewide collaborative efforts to develop, implement and evaluate a state strategy that advances the goals and objectives of the National Strategy for Suicide Prevention.

Guiding Principles

- Suicide is a major community and public health issue, requiring a community solution. This will be accomplished most effectively through public and private collaboration. The Nevada Suicide Prevention Plan closely adheres to the recommendations outlined in the National Strategy of Suicide Prevention, which emphasizes the importance of gaining strong and broad support of a variety of organizations and individuals and the coordination of resources and culturally appropriate services at all levels of government - federal, state, tribal, and local - in partnership with the private sector.

- The Nevada Suicide Prevention Plan encompasses the lifespan, because suicide affects people of all ages. A comprehensive suicide prevention plan targets the entire community, is sensitive to the differences in suicide rates across the lifespan, and recognizes the varied roles different age groups can play in suicide prevention program planning.

- As a state consistently suffering the impact of suicide among our residents, Nevada needs to advocate for, invest in, and sustain the state Office of Suicide Prevention and its efforts.

- Successful suicide prevention requires local plans and actions, supported by regional, state and national resources. Each community should be encouraged to develop its own suicide prevention plan adapted to meet local needs and cultivate local strengths. Communities vary in their readiness to recognize a problem and take action; suicide prevention programs must be designed accordingly.

- For the Office of Suicide Prevention to effectively develop, implement and evaluate the Nevada Suicide Prevention Plan, support and guidance from entities such as the Nevada Coalition for Suicide Prevention, local networks and task forces are required. These partnerships should be mutually supportive, advancing the sustainability of the others' efforts and programmatic activities.

- Suicide is often preventable. Many people who die by suicide are ambivalent and unable to see alternative options. In addition, many have illnesses or conditions that are treatable. With effective treatment, most individuals recover with positive outcomes.

- Suicide prevention programs must identify and address risk factors. Protective factors must also be recognized and utilized in prevention efforts. Enhancing protective factors fosters resiliency and mitigates the effects of risk factors, increasing optimism and hope for the individual, families and the community as a whole.

- **Suicide prevention is everyone's responsibility.** Suicide is complex and overlaps many other social issues. Suicide prevention programs should coordinate with other preventive efforts such as those designed to help reduce substance abuse, child abuse and interpersonal violence. Prevention efforts that demonstrate an integrated approach will positively impact protective factors that have a bearing on many of these social issues, as well as suicide. Our communities can become healthier, leading to a stronger and safer Nevada.

Utilization of Our State Plan

The Office of Suicide Prevention intends for the Nevada Suicide Prevention Plan (NSPP) to increase awareness and help make suicide prevention a statewide priority. This plan can be used to direct needed resources to aid in its implementation. The NSPP will also encourage and support collaboration. With such a complex issue as suicide, diverse participation is required.

The Nevada Suicide Prevention Plan:

- Is a call to action of a broad and diverse group of partners, both public and private, to develop and implement policies in support of the NSPP;
- Specifies goals and objectives integrated into a conceptual framework for suicide prevention;
- Provides a sustainable operating structure for collaborative funding, responsibility, and accountability for the state plan development and implementation;
- Can be used to formulate agreements among state agencies and institutions, outlining and coordinating appropriate activities in accordance with the objectives of the NSPP;
- Summarizes the scope of the problem of suicide in Nevada, and provides a consensus on prevention priorities;
- Suggests appropriate activities that can be implemented and evaluated for practitioners, policy makers, service providers, communities, families, agencies and other partners;
- Calls for suicide prevention data collection and evaluation systems, to track information and monitor the progress of benchmarks.

"Most suicides, although by no means all, can be prevented. The breach between what we know and what we do is lethal."

--Dr. Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide*

"We cannot change the past, but together we can shape a different future."

--Former US Surgeon General David Satcher,
The Surgeon General's Call to Action to Prevent Suicide 1999.

History of Suicide Prevention Efforts in Nevada

Historically, Nevada has had one of the highest rates of suicide in the nation. Since 1929, when the State began registering vital statistics with the federal government, Nevada's suicide rate has been two to three times the national suicide rate.[1] Recently there have been efforts to address this serious public health problem in our state, and it is the hope of the Office of Suicide Prevention that this plan will increase the political and public will to do more to prevent suicide.

Legislative momentum for suicide prevention began in 1993, when the Nevada Legislature adopted legislation (AB584) that mandated suicide prevention education in Nevada's secondary schools, but statewide comprehensive school-based suicide prevention education programs are still limited.

In 1997, the Honorable Harry Reid, senior U.S. Senator from Nevada and survivor of his father's suicide, introduced Senate Resolution 84. This landmark legislation recognized suicide as a national problem and called for suicide prevention to be a national priority. SR84 was passed unanimously and became a catalyst for suicide prevention initiatives in the U.S. House of Representatives (HR 212) and then across the nation.

In 1998, the city of Reno hosted the first National Suicide Prevention Conference (*Advancing the National Strategy for Suicide Prevention: Linking Research and Practice*). The ideas generated from the experts, activists and survivors that gathered led to the release of U.S. Surgeon General David Satcher's *Call to Action to Prevent Suicide* the following year. Building on this Call to Action, the *National Strategy for Suicide Prevention: Goals and Objectives for Action* was published in 2001. Surgeon General Satcher's hope for this strategy was to lay the "foundation" for our nation to combat this serious public health problem.

Concurrent to the national movement, community members in Nevada mounted a grass-roots effort to increase and improve suicide prevention resources that were greatly lacking. During the 1999 Nevada Legislative Session, a Senate Concurrent Resolution (SCR11) was adopted that acknowledged the issue of suicide in our state and placed a priority on prevention and access to mental health services for at risk individuals. At the end of the Session, $200,000 was appropriated for a statewide suicide prevention hotline. The Crisis Call Center in Reno manages that hotline, and the funding continues.

A Legislative Subcommittee to study the issue of suicide in Nevada was established in 2001, and an Interim Study of Suicide Prevention was conducted between the 2001 and 2003 Sessions. Hearings were held in Reno, Las Vegas, and Carson City, and experts and advocates testified for the improvement of suicide prevention efforts in Nevada. The Interim Study (SCR3) began a collaborative process to address suicide in our state. A report was presented to Governor Guinn and legislation was drafted and pre-filed in the 2003 Session (see Appendix A).

The primary Interim Study legislation (SB49) considered in the 72nd Session created a statewide suicide prevention program within the Nevada Department of Human Resources (renamed Department of Health and Human Services). This legislation created two positions: a State Suicide Prevention Coordinator in Carson City supported by a Clark County Suicide Prevention Trainer and Network Facilitator. SB49 was adopted in June 2003, became effective on July 1, 2003, but was not funded.

In January 2005, Governor Guinn recommended full funding of SB49 (NRS 439.511 & 439.513) in his 2005–2007 budget and the two positions were filled; the Office of Suicide Prevention commenced in December 2005. The Garrett Lee Smith (GLS) Memorial Act Grant was secured by the Nevada Division of Child and Family Services in late 2005. The Nevada Office of Suicide Prevention provides oversight for grant activities with support from the Youth Suicide Prevention Coordinator. Comprehensive activities, including screening, stigma reduction and gatekeeper training, under the GLS grant promote the direction, mission and purpose of the Office of Suicide Prevention, as well as the development and implementation of the Nevada Suicide Prevention Plan.

Scope of the Problem

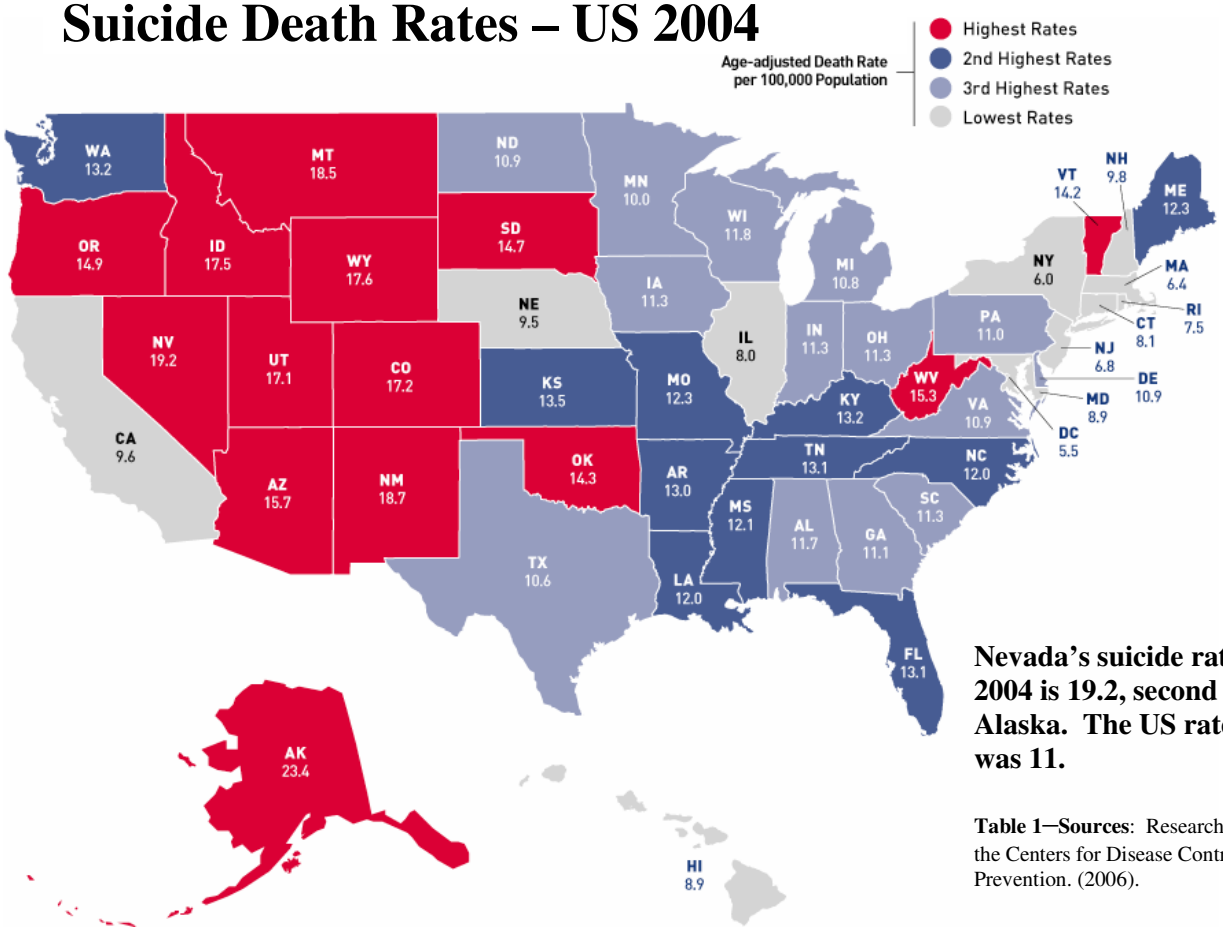
- Each year about one million people die by suicide worldwide.
- Over 32,000 Americans die by suicide annually, and approximately 800,000 people attempt suicide.
- Every 39 seconds someone in the U.S. attempts suicide.
- Every 16.2 minutes someone dies by suicide.
- Every 1 hour 41 minutes an elderly person dies by suicide.
- Every 2 hours 2 minutes a young person dies by suicide.
- Every day over 89 people die by suicide.[2]
- Every 16.2 minutes there are at least six new survivors of suicide loss.
- Suicide is the eleventh leading cause of death in the U.S. and the third leading cause of death among American youths.
- Suicide in the U.S. out-numbers homicide by at least 3 to 2.
- Worldwide, incidents of violent deaths attributable to suicide compare to the incidents of deaths resulting from homicide and war combined.[3]
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease, combined.[4]
- There are twice as many deaths due to suicide than due to HIV/AIDS.
- Many suicides are preventable. Most people want to live; they just need help finding the way out of their pain and despair.

The Nevada Suicide Prevention Plan is founded on the National Strategy for Suicide Prevention (NSSP). Like the NSSP, our state plan is based on current, existing knowledge about suicidal behavior and suicide prevention. And because suicide is a serious public health problem, the Nevada Suicide Prevention Plan follows the public health approach for prevention: 1) Define the problem; 2) Identify risk and protective factors; 3) Develop and test interventions; 4) Implement interventions; 5) Evaluate effectiveness.

The Nevada Suicide Prevention Plan will define the problem of suicide using the most current available state and national data. It will also examine those risk and protective factors unique to Nevada. With that information, the goals and objectives for action will be presented. The next steps will be to bring this plan to the local level by assessing community readiness and developing suitable strategies and evaluations.

The data to follow will illustrate who is carrying the burden of suicide risk and where this burden is most heavily felt. Certain gender, age groups, cultures, and geographical locations are more at risk for suicide than others, but suicide is not solely about statistics. It is also about individuals, families, communities and our state. It is a global public health problem. Through the implementation of the Nevada Suicide Prevention Plan, it is our belief and hope that we will prevent suicide, one individual, one family and one community at a time.

Suicide Death Rates – US 2004



Nevada's suicide rate/100,000 for 2004 is 19.2, second only to Alaska. The US rate/100,000 was 11.

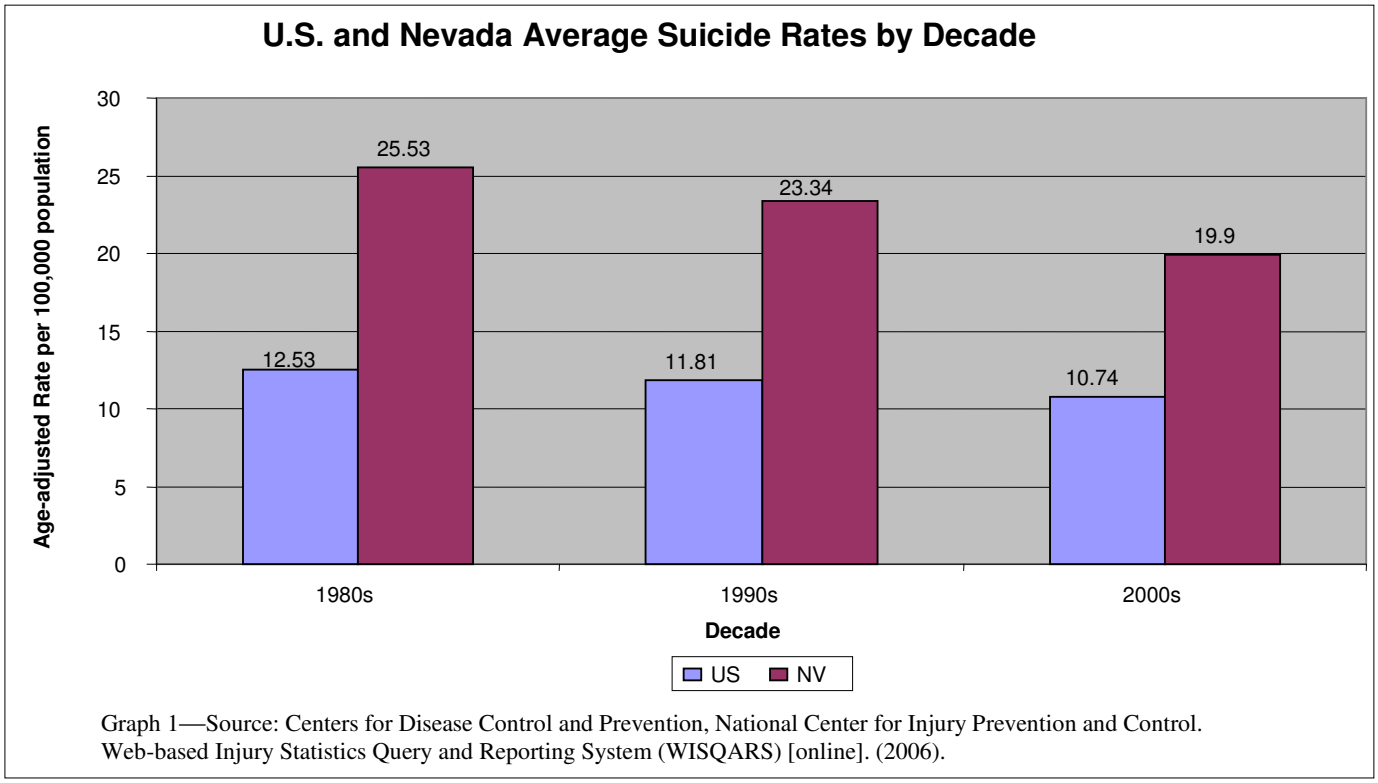
Table 1—Sources: Research!America and the Centers for Disease Control and Prevention. (2006).

Suicide in Nevada

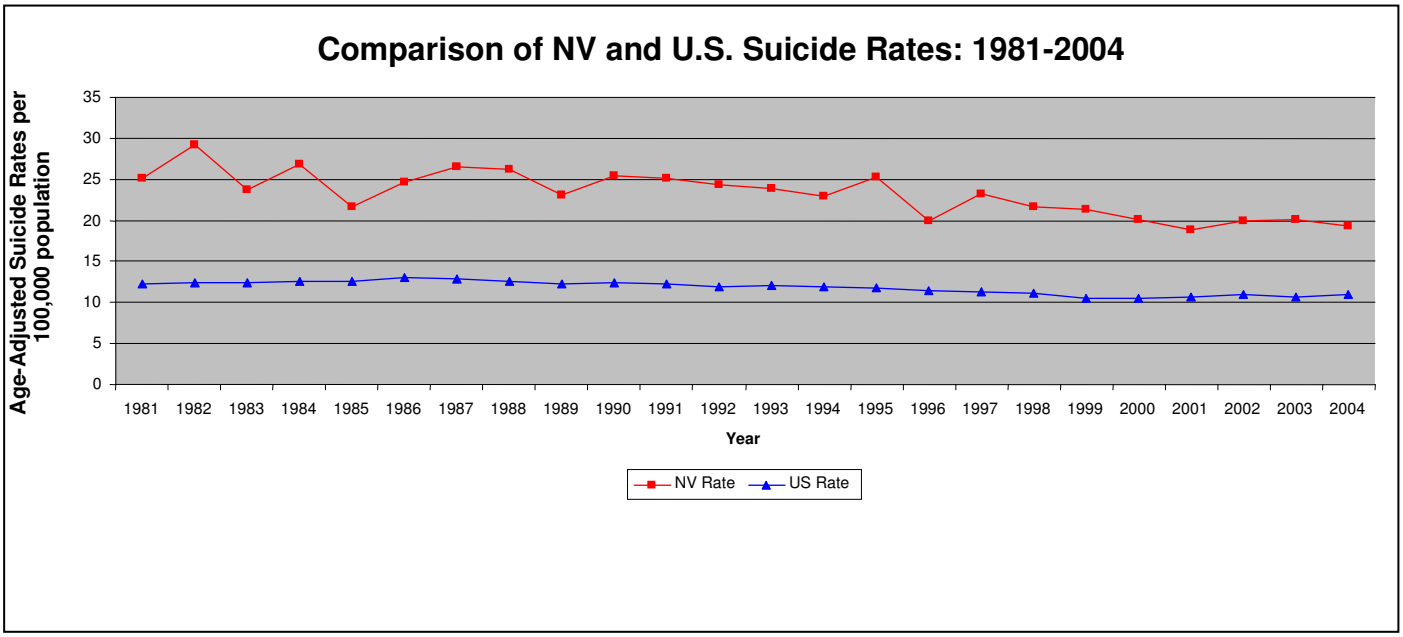
According to the American Association of Suicidology, states on the West Coast of the United States, notably the mountain region, consistently have the highest rates for suicide in the nation. Nevada stands out in that high risk region.

Nevada has historically held one of the highest positions in national rankings, with a rate usually double the national average (Graphs 1 & 2). More than 400 Nevadans take their life annually. For every one death by suicide, research shows that at least 25 people will attempt suicide, leaving thousands of individuals and their friends and families impacted by suicidal behaviors. Like an iceberg with its mass unseen, those numbers are just the tip of this profound public health problem. Countless others will have such deep depression and despair that they contemplate suicide in isolation and do not reach out for help.

In 2004, Nevada ranked second in the Nation for per capita suicides - with a suicide rate (19.2) nearly double the national average rate (11.0). For many years prior to that, Nevada had the highest suicide rate in the U.S. According to the Centers for Disease Control and Prevention and the Nevada Bureau of Health Planning and Statistics, Nevada youth and elderly populations (both high risk groups for suicide) have suicide rates that also exceed the national average. Suicide is the sixth leading cause of death in Nevada (2004) – third leading cause of death for youth 15 – 24 years old (Table 2). More Nevadans die each year by suicide than by homicide, AIDS, or motor vehicle accidents (Graphs 3 & 4).



Graph 1—Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006).



Graph 2—Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006) Available from URL: www.cdc.gov/ncipc/wisqars

- Suicide rates have been decreasing for decades both nationally and at the state level; although in 2001, there was a slight increase.

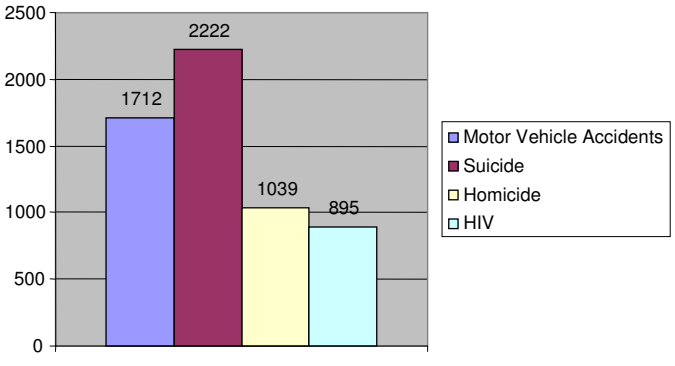
Table 2 **Unintentional Injury** **Suicide** **Homicide**

Leading Causes of Death, Nevada
2004, All Races, Both Sexes

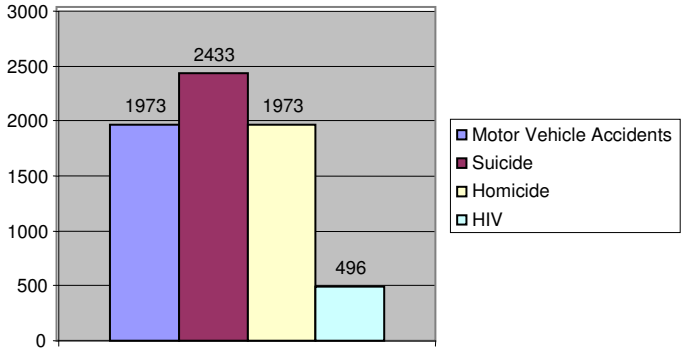
	Age Groups												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 48	Unintentional Injury 11	Unintentional Injury 6	Unintentional Injury 22	Unintentional Injury 128	Unintentional Injury 135	Unintentional Injury 215	Heart Disease 371	Malignant Neoplasms 806	Malignant Neoplasms 1,257	Heart Disease 1,413	Heart Disease 1,121	Heart Disease 4,693
2	Short Gestation 24	Congenital Anomalies 9	Benign Neoplasms 1	Homicide 4	Homicide 50	Homicide 58	Heart Disease 122	Malignant Neoplasms 328	Heart Disease 686	Heart Disease 925	Malignant Neoplasms 1,150	Malignant Neoplasms 429	Malignant Neoplasms 4,119
3	Maternal Pregnancy Comp. 16	Homicide 2	Congenital Anomalies 1	Congenital Anomalies 3	Suicide 37	Suicide 58	Malignant Neoplasms 100	Unintentional Injury 174	Chronic Low. Respiratory Disease 135	Chronic Low. Respiratory Disease 287	Chronic Low. Respiratory Disease 438	Cerebro-vascular 299	Chronic Low. Respiratory Disease 1,124
4	Unintentional Injury 14	Influenza & Pneumonia 2	Malignant Neoplasms 1	Malignant Neoplasms 3	Malignant Neoplasms 13	Heart Disease 38	Suicide 71	Suicide 114	Unintentional Injury 123	Cerebro-vascular 197	Cerebro-vascular 325	Chronic Low. Respiratory Disease 218	Cerebro-vascular 1,030
5	SIDS 12	Malignant Neoplasms 2		Suicide 3	Heart Disease 11	Malignant Neoplasms 30	HIV 34	Liver Disease 89	Cerebro-vascular 119	Septicemia 97	Nephritis 158	Alzheimer's Disease 165	Unintentional Injury 1,021
6	Respiratory Distress 11	Chronic Low. Respiratory Disease 1		Chronic Low. Respiratory Disease 2	Influenza & Pneumonia 3	HIV 12	Homicide 26	Cerebro-vascular 57	Liver Disease 73	Nephritis 91	Influenza & Pneumonia 146	Influenza & Pneumonia 113	Suicide 440
7	Bacterial Sepsis 7	Meningitis 1		Heart Disease 2	Cerebro-vascular 2	Cerebro-vascular 7	Cerebro-vascular 23	Chronic Low. Respiratory Disease 33	Suicide 68	Diabetes Mellitus 73	Septicemia 124	Nephritis 90	Nephritis 425
8	Neonatal Hemorrhage 6	Perinatal Period 1		Diabetes Mellitus 1	Complicated Pregnancy 2	Liver Disease 6	Liver Disease 22	Septicemia 29	Septicemia 62	Influenza & Pneumonia 69	Alzheimer's Disease 105	Septicemia 58	Influenza & Pneumonia 402
9	Placenta Cord Membranes 6			Influenza & Pneumonia 1	Congenital Anomalies 2	Diabetes Mellitus 5	Septicemia 13	Viral Hepatitis 27	Nephritis 54	Liver Disease 61	Diabetes Mellitus 97	Unintentional Injury 57	Septicemia 395
10	Septicemia 6			Septicemia 1	Benign Neoplasms 1	Nephritis 5	Diabetes Mellitus 9	HIV 25	Diabetes Mellitus 46	Unintentional Injury 61	Unintentional Injury 75	Athero-sclerosis 55	Alzheimer's Disease 292
										Suicide 38 #11	Suicide 39 #14	Suicide 12 #16	

WISQARS™ Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Injury Related Deaths Nevada Residents
1993-1998



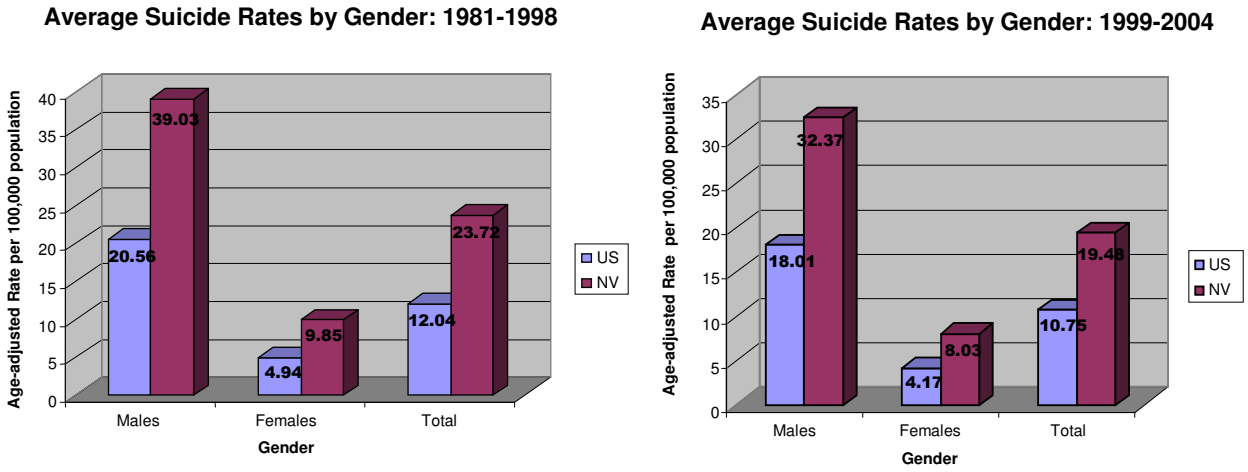
Injury Related Deaths Nevada Residents
1999-2004



Graphs 3 & 4—Source: Nevada Division of Health, Bureau of Health Planning and Statistics. Center for Health Data and Research. (2006).

Gender

- Nevada males kill themselves over four times the rate of females.
- Females attempt suicide about three times the rate of males.
- Average rates for both Nevada males and females are about double the National average rate.
- In 2004, Nevada's population was 51% male and 49% female; the Mental Health and Developmental Services caseload was 55% female and 45% male.[5]

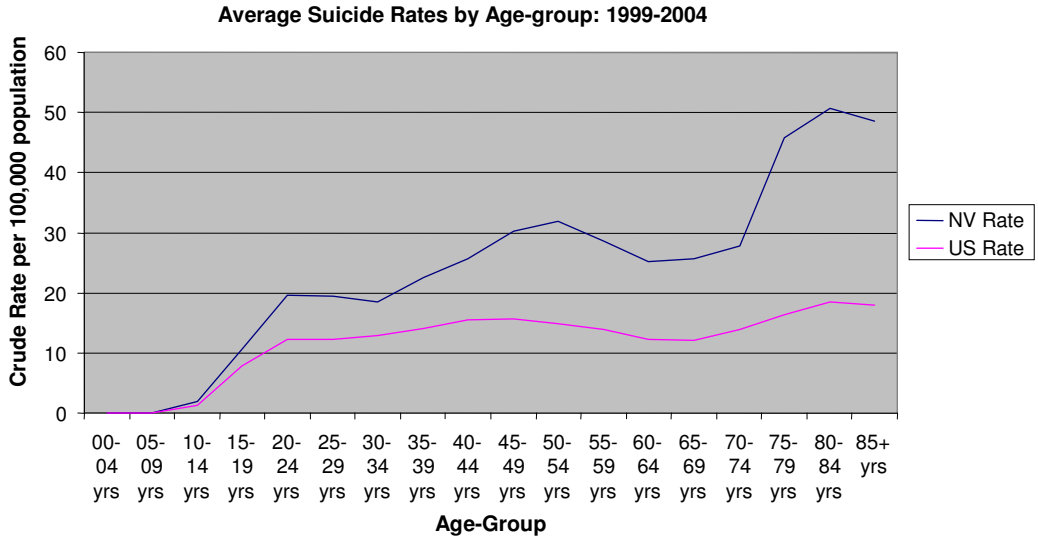


Graphs 5 & 6—Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006).

Age

As demonstrated in Graph 7, suicide rates for Nevadans of all age groups are at least twice the national average. Therefore, the Nevada Suicide Prevention Plan addresses suicide across the lifespan.

- While the suicide rate has been declining since the 1990s for youth and elderly, the rates for middle-aged men and women are increasing.[6]



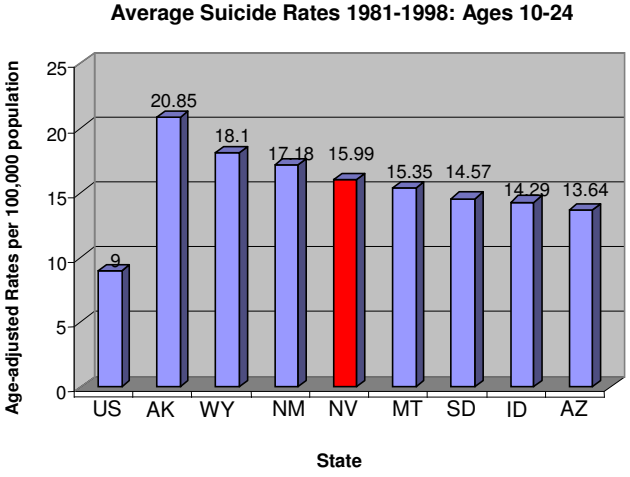
Graph 7—Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006).

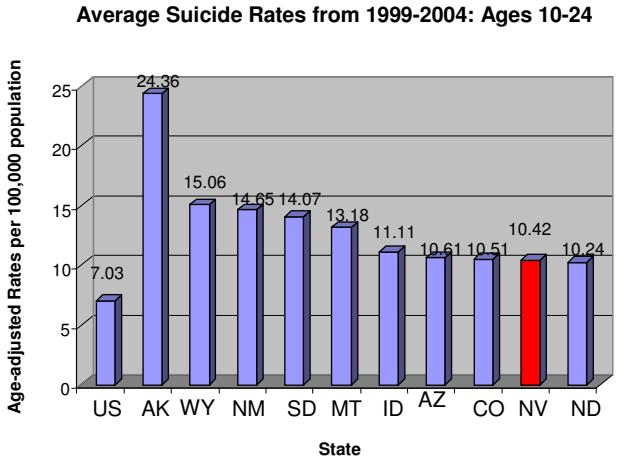
Suicide and Nevada Youth

While rates for youth have decreased slowly since 1992, Nevada youth rates continue to be unacceptably high (10.42 for Nevada versus 7.03 for the U.S.). Life stressors, interpersonal relationship difficulties, lack of problem-solving skills and undiagnosed mental and substance use disorders put our youth at increased risk for suicide attempts and suicide. The combination of risk factors with characteristic impulsivity of the young can be highly lethal.

According to the biennial Youth Risk Behavior Survey, an annual report sponsored by the CDC and conducted in middle and high schools across the country, in 2005:

- 27.8% of Nevada high school students felt so sad or hopeless over a two week period that they stopped doing usual activities.
- 16.1% of Nevada high school students seriously contemplated suicide in the last 12 months, according to the 2005 survey conducted by the Nevada State Department of Education.
- During the same period, 8.7% of high school students in Nevada actually attempted to take their own lives and 3.4% of students had to seek medical attention for their attempt.



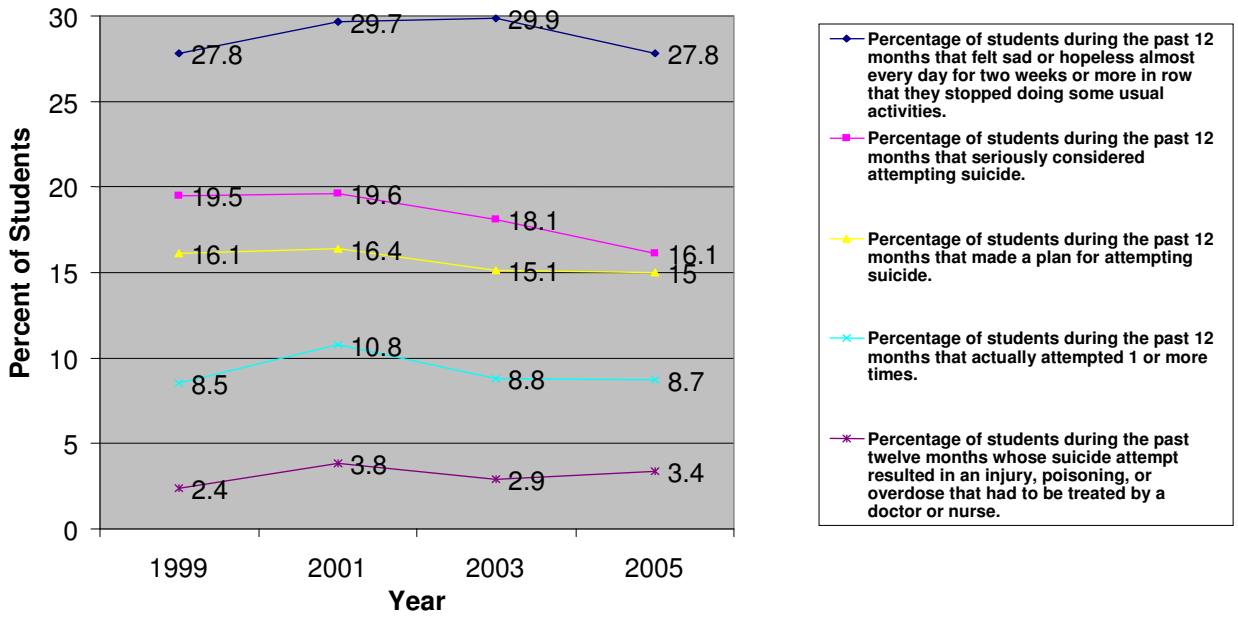


Graphs 8 & 9—Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006).

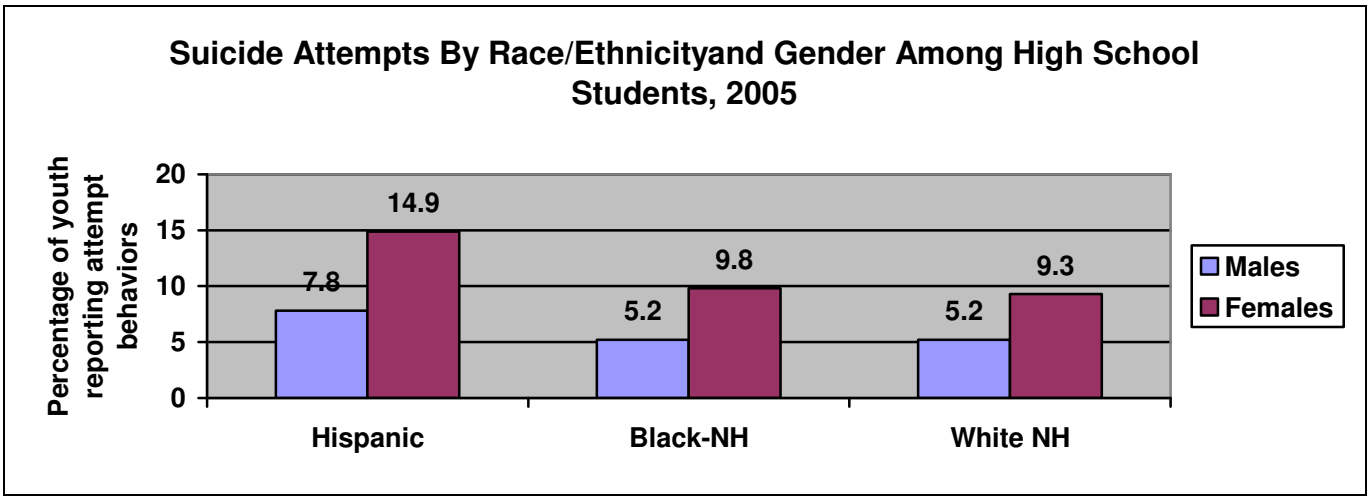
Using Youth Risk Behavior Survey rates from 2005 and data from the U.S. Census Bureau 2005, the following are estimated:[7]

- 21,789 NV youth seriously considered attempting suicide;
- 20,300 NV youth made a plan to attempt suicide;
- 11,774 NV youth attempted one or more times;
- 400 of those NV youth that made an attempt, required treatment by a doctor or nurse.

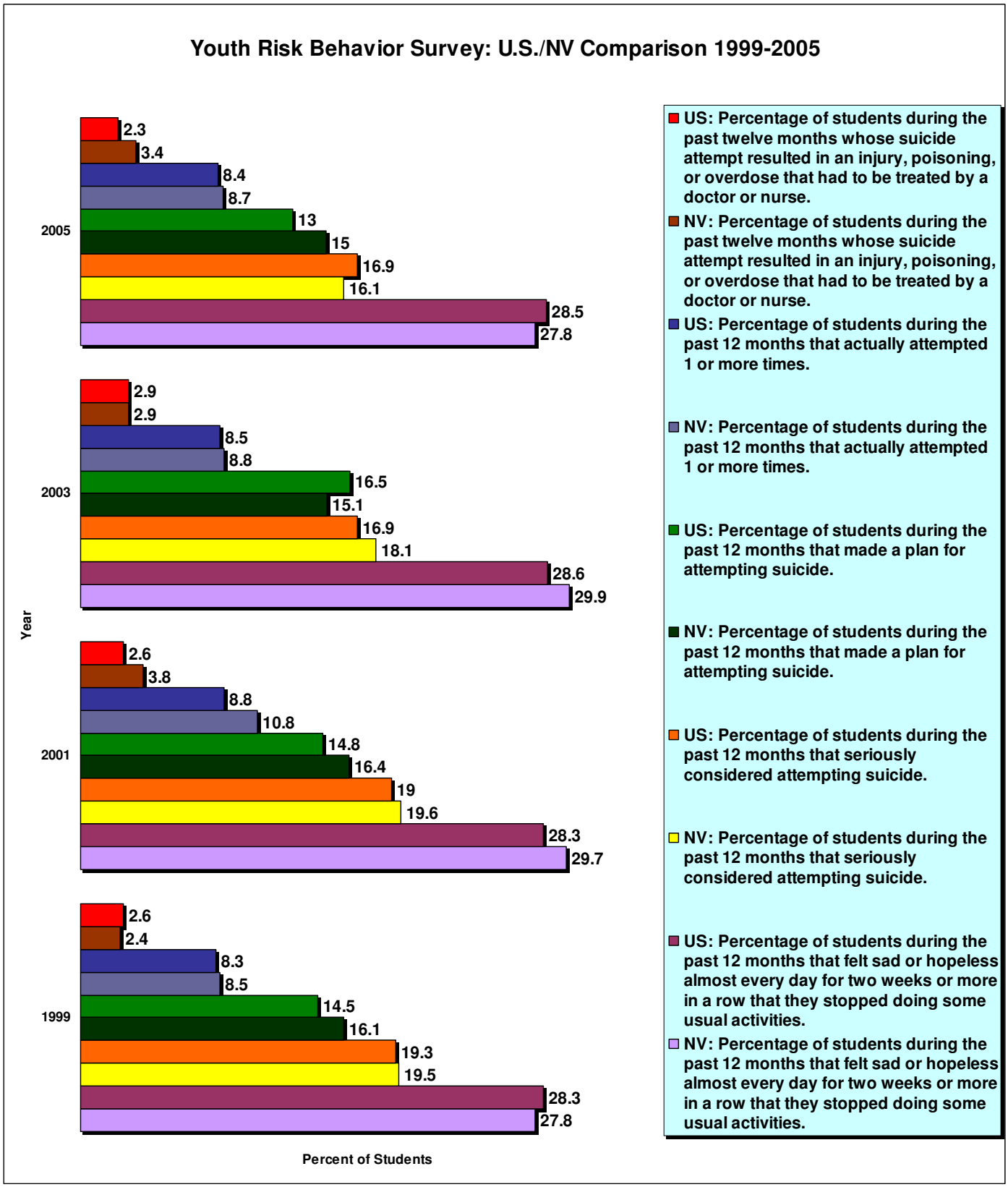
- The Suicide Prevention Resource Center estimates the average medical costs for treatment of suicide attempts was $10,374 (2003). Using that rate for the number of youth that had to be treated (400), our state cost would be $4,149,600.[8]



Graph 10—Source: Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2006).



Graph 11— Source: National Adolescent Health Information Center (2006). Fact Sheet on Suicide: Adolescents and Young Adults. (Utilizing National Center for Injury Prevention and Control's Leading Causes of Death and Fatal Injuries Online Database.) San Francisco, CA: University of California, San Francisco.

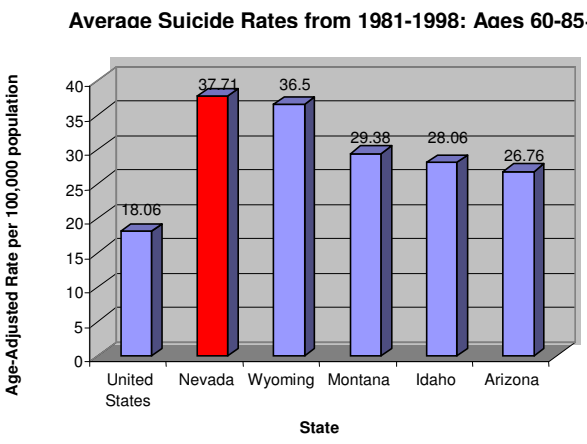


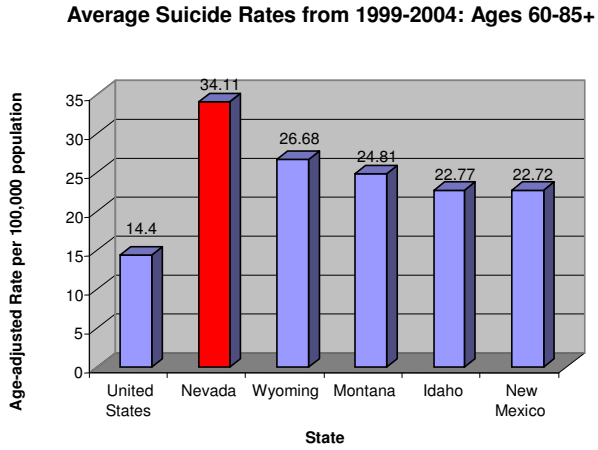
Graph 12—Source: Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2005).

Suicide and Older Nevadans

Nevada has had the highest rates of suicide for over twenty years for people over 65. Among the elderly, major depression is the most common psychiatric disorder but this is not being identified by loved ones or care takers, including many primary care physicians.[9] Research has shown that over 77% of seniors that died by suicide had seen there primary care physician within a year of their death and 58% saw their doctor within the month prior to their suicide.[10] While it is not known to what degree contact with mental health care and primary care providers can prevent suicide, the majority of individuals who die by suicide, particularly older adults, do make contact with primary care providers. Substance use disorders are not as profound risk factors for elder suicide compared to youth, but the co-occurrence of depression and substance use can significantly increase risk. Also stigma relating to help seeking reduces older adults' access to mental health professionals. It must be emphasized, contrary to popular belief, hopelessness and depression are not a normal part of aging.[11]

- Adults over the age of 65 have the highest rates of suicide and Nevada seniors have had the highest rates of suicide in the nation for over 20 years.

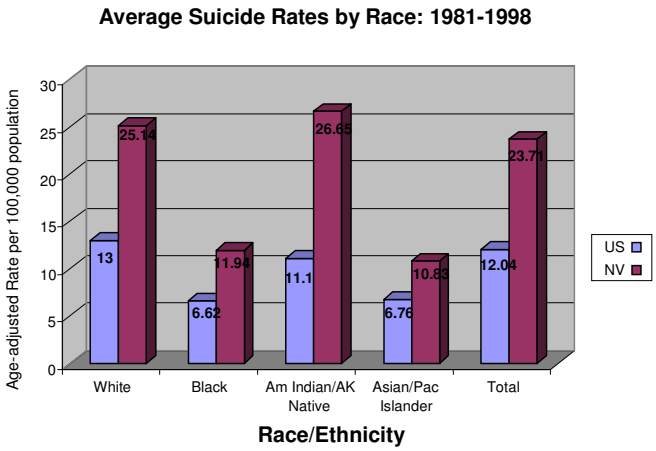


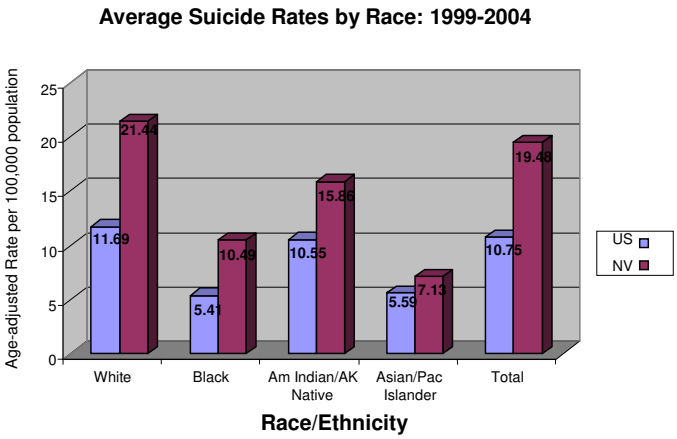


Graphs 13 & 14– Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006). Available from URL: www.cdc.gov/ncipc/wisqars

Race/Ethnicity

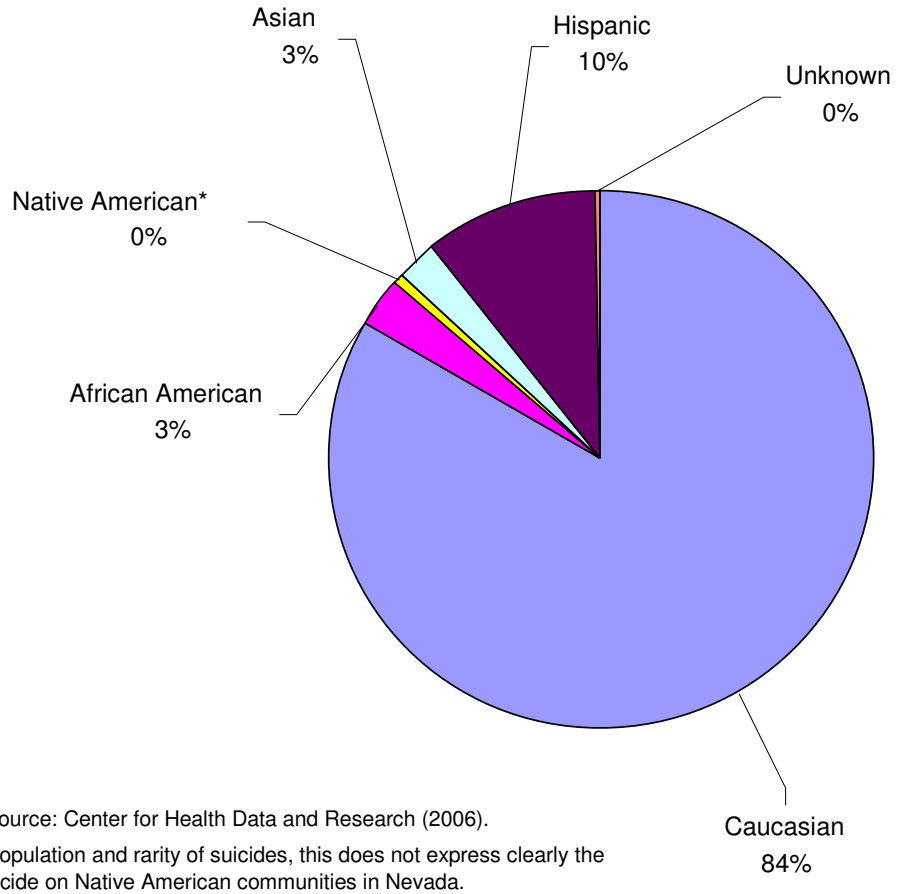
- Among racial/ethnic groups, Whites and Native Americans have the highest average suicide rates – 21.4 for Whites and 16.8 for Native Americans (Graph 15 & 16).
- Rates for African Americans in Nevada are similar to the national average of 10.4 (Graphs 17 & 18), but interestingly, African American women have the lowest rates for suicide of all groups.[12]
- Due to small population sizes, state data is statistically unreliable, but national data shows Native American youth are a vulnerable population with suicide being the 2nd leading cause of death.[13]
- Nevada does not have comprehensive suicide attempt data, but research has shown Hispanic girls are at an increased risk for suicide attempts.[14]





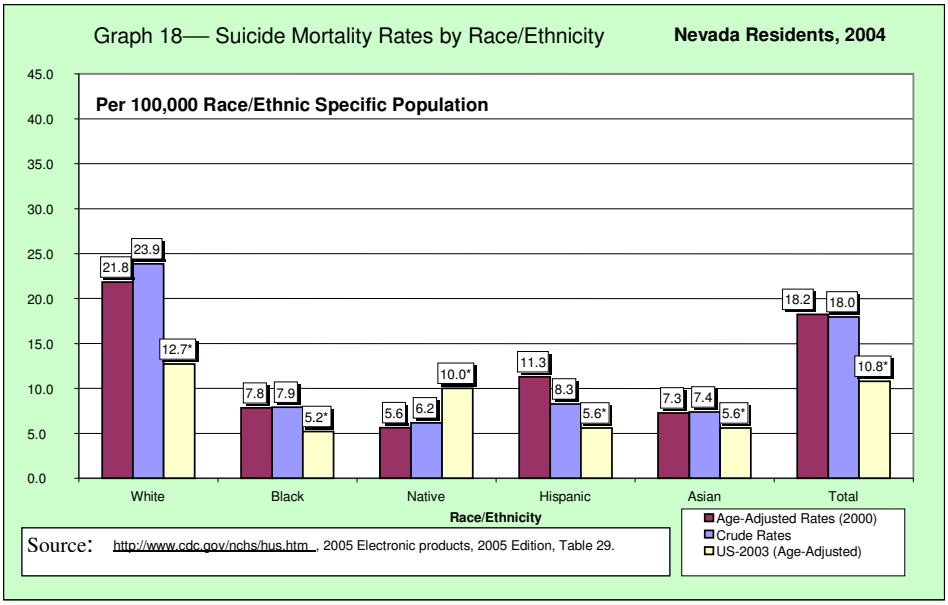
Graphs 15 & 16—Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2006).

Percentage of Nevada Suicide Deaths by Race: 2004



Graph 17—Source: Center for Health Data and Research (2006).

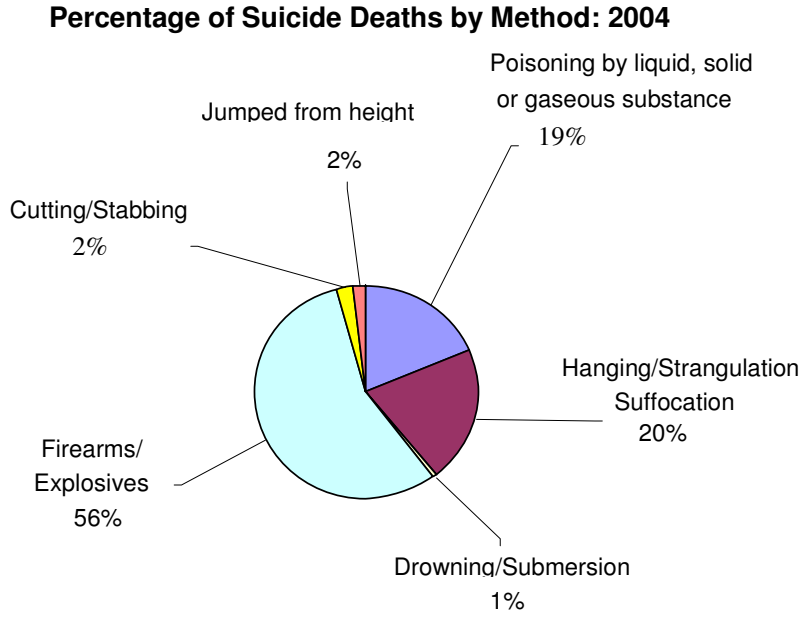
*Due to low population and rarity of suicides, this does not express clearly the impact of suicide on Native American communities in Nevada.



Suicide Method

Part of our western culture is gun ownership. Over 30% of Nevada homes have guns.[15] This fact alone makes a family more at risk for losing a loved one to suicide.[16]

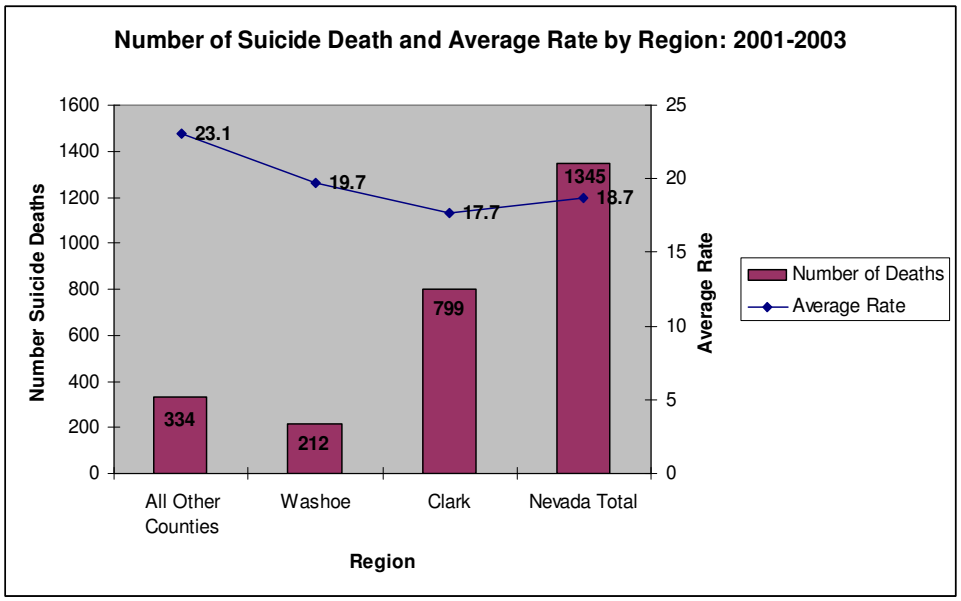
- Nevada residents of all races are more likely to kill themselves with guns than by any other method. Suicide by firearm accounts for almost 60% of all suicides in Nevada (Graph 19).
- Suicide by hanging/strangulation is the second leading method closely followed by poisoning (Graph 19).
- Firearm use is decreasing in our youth, but suicide by hanging/strangulation is increasing for that age group.[17]



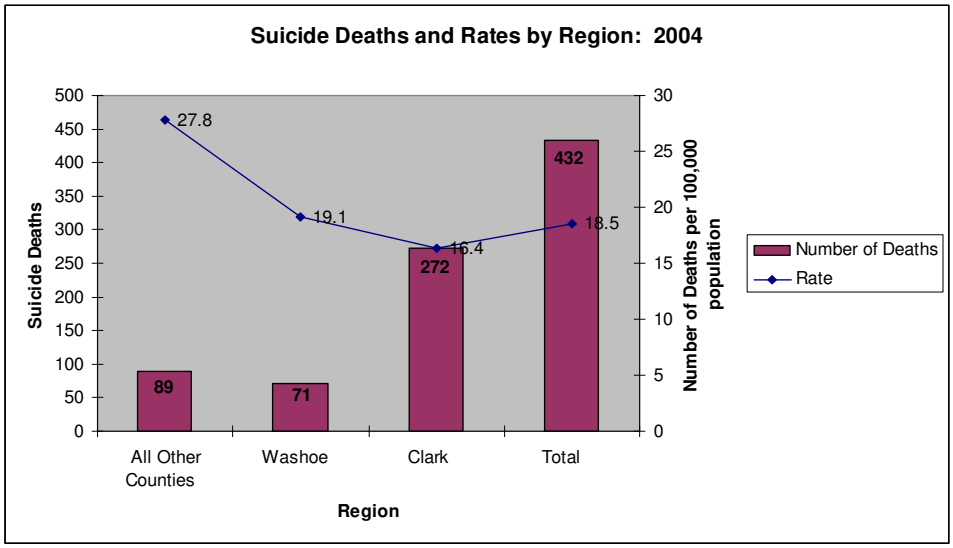
Graph 19—Source: Nevada Division of Health, Bureau of Health Planning and Statistics. (2006).

Geography

- Suicides in rural counties, though very few in number, occur at a much higher rate than suicide in the more populated counties of Washoe and Clark. When comparing rates in rural communities, one must be very careful. Due to the rarity of suicide in smaller populations data is often unreliable. Rates can be exaggerated with one suicide death.



Graph 20—Source: Nevada Division of Health, Bureau of Health Planning and Statistics. (2004).



Graph 21—Source: Nevada Division of Health, Bureau of Health Planning and Statistics. (2004).

- Graphs 20 and 21 depict the difference in rate of suicide by actual number of deaths. Clark County has the lowest suicide rate but the highest number of deaths in the state.

Risk Factors, Warning Signs and Protective Factors

Risk Factors

Risk factors are those circumstances, conditions, stressful events or traits that can increase the likelihood that someone will attempt or die by suicide; they can be environmental, biological, psychological or social in nature. The importance of certain risk factors and the power of their combination varies by age group, gender, race/ethnicity and location. The impact of certain risk factors can be reduced by prevention and intervention while others are much more difficult to impact. While mental illness, family history of suicide, stigma and substance abuse are common risk factors for suicide, communities in Nevada exhibit some unique risk factors. Risk factors are associated with suicidal behaviors; they are not predictive nor are they causes of suicide.[18]

Risk Factors for Suicidal Behavior

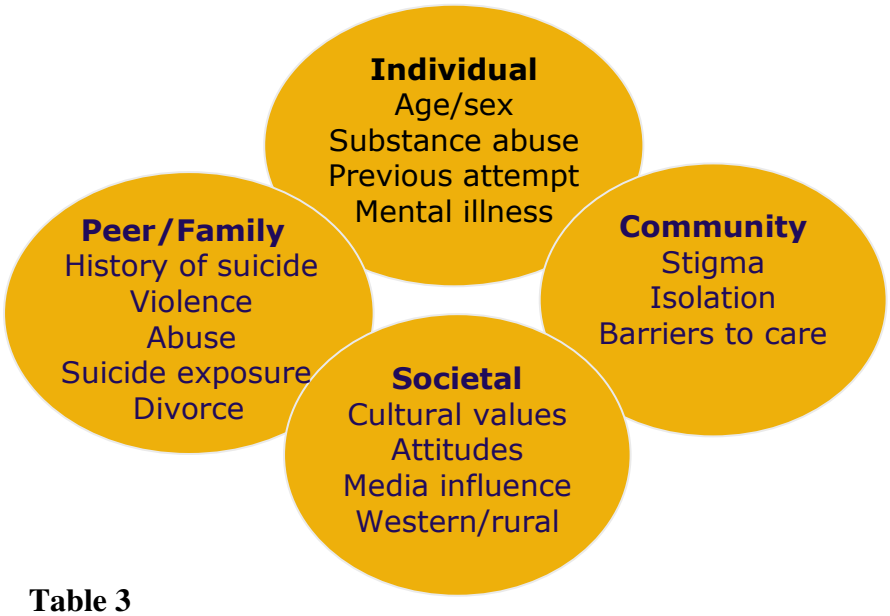


Table 3

Individual

Mental Health

90% of people who die by suicide have a diagnosable mental health and/or substance use disorder at the time of death. It is well known that depression is a leading risk factor for suicide. Nevadans report more psychological stress in all age groups than most other states.[19] This fact contributes to our high rates of suicide. The challenge the State faces is that over 90% of the people that died by suicide in Nevada had not been seen by a mental health professional in the state.[20] Other Axis 1 psychiatric disorders associated with increased risk for suicide are schizophrenia, bi-polar disorder, anxiety disorders, and alcohol and substance use disorders. Personality disorders most associated with suicide are borderline personality disorder and antisocial personality disorders.[21]People with anorexia nervosa have a very high risk for suicide.[22]

- Nevada is one of the states that reports the highest rates of severe depression. Among Nevadans who are over age 26, the rate of depression is the highest in the nation.[23]

- Suicide is the leading cause of death among mental health patients within the first year of seeking mental health treatment.[24]
- The most common diagnosed disorder of patients that died by suicide was depression (42.1%).[25]

Substance Abuse and Other Addictions

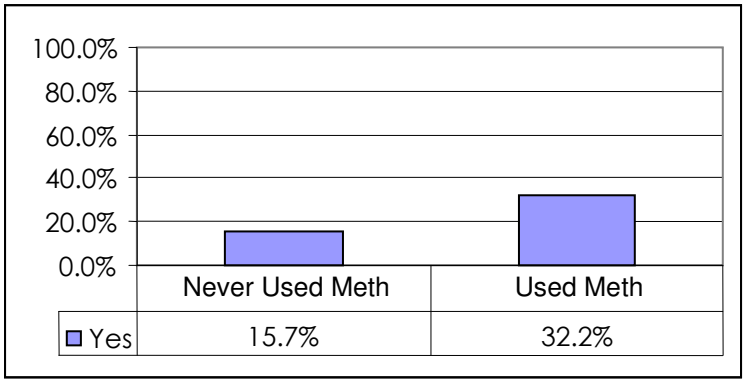
Nevada has one of the highest rates of alcohol and substance use in the nation; yet, effective treatment programs are limited. Given this unique situation, people with addictions have constant opportunities to indulge them in our state. Research shows that substance abuse disorders can play a part in 30%-60% of suicides. The co-occurrence of mental and substance use disorders amplifies risk for suicide and inhibits receipt of appropriate services.[26] Early diagnosis and treatment are vital.

In a 2005, the Washoe County School District and Join Together Northern Nevada conducted an in-depth analysis of the current Youth Risk Behavior Survey results from Washoe County high school students. One of the significant findings was the relationship between methamphetamine use and increased suicidal behaviors (Graphs 22, 23 & 24).

Methamphetamine Use and Suicide

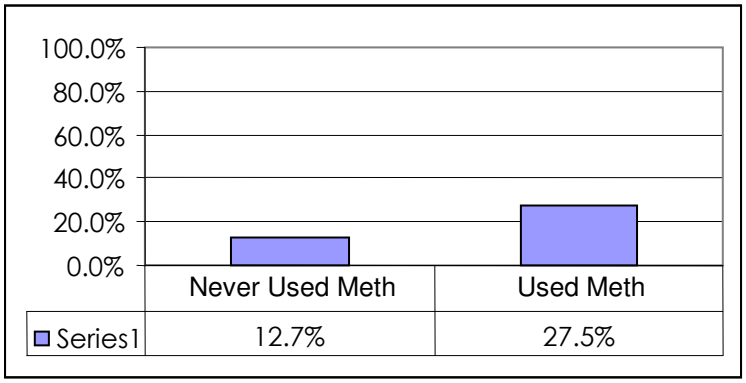
The following tables outline differences in suicide thoughts, plans, and attempts based on whether or not a high school student has used methamphetamine.

In the past 12 months, I seriously considered attempting suicide:



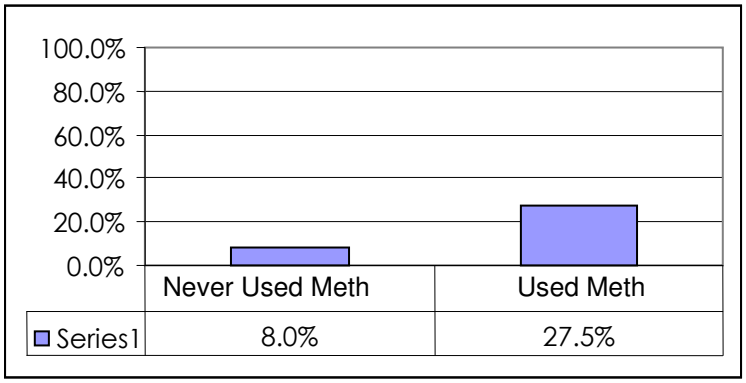
Graph 22

In the past 12 months, I made a plan about how I would attempt suicide:



Graph 23

In the past 12 months, I actually attempted suicide:



Graph 24

All data is from the 2005 Youth Risk Behavior Survey for Washoe County High Schools. 153 youth claim to have used methamphetamine at least once (10.2%), and 37 youth claim to have used Methamphetamine 40 or more times (2.5%).Tables used with permission.

- 45.9% of high school youth who have used methamphetamine 40 or more times have seriously contemplated suicide and have made plans about how they would commit suicide.
- 48.6% of high school youth who have used methamphetamine 40 or more times claim to have attempted suicide in the past year.
- Of these heavy methamphetamine users, 27.0% claim to have 6 or more suicide attempts in the past year.

Previous Attempts/Suicidal Behaviors

Research indicates that one of the most significant predictors of risk for suicide is a previous suicide attempt. If a person has attempted suicide in the past, he or she is much more likely than others to attempt suicide again. This could be due to diminishing fear or habituation of the suicidal behavior.[27] Approximately one third of teenage suicide victims have made a previous suicide attempt and there are 100-200 suicide attempts for every suicide. Older adults attempt 4 times for every suicide, possibly showing that their attempts are thought out or more lethal. Greater premeditation and planning, more access to deadly methods, and greater suicidal intent in the elderly population may cause this higher completion rate.[28]

- Third highest primary presenting disorder of mental health patients in Nevada was "suicide attempt or threat."[29]

Peer/Family

Family History of Suicide

A high proportion of suicides and attempters have had a close family member (sibling, parent, aunt, uncle, or grandparent) who attempted or died by suicide.[30] Familial suicide can be a function of environment or genetics. There is growing evidence of genetic links to increased risk for suicidality, but much work needs to be done in that area.[31] Many of the mental illnesses that are associated with suicide risk appear to have a genetic component as well.[32]

The family environment can impact suicidality due to modeling of suicide and suicidal behaviors, family discord and abuse.[33]

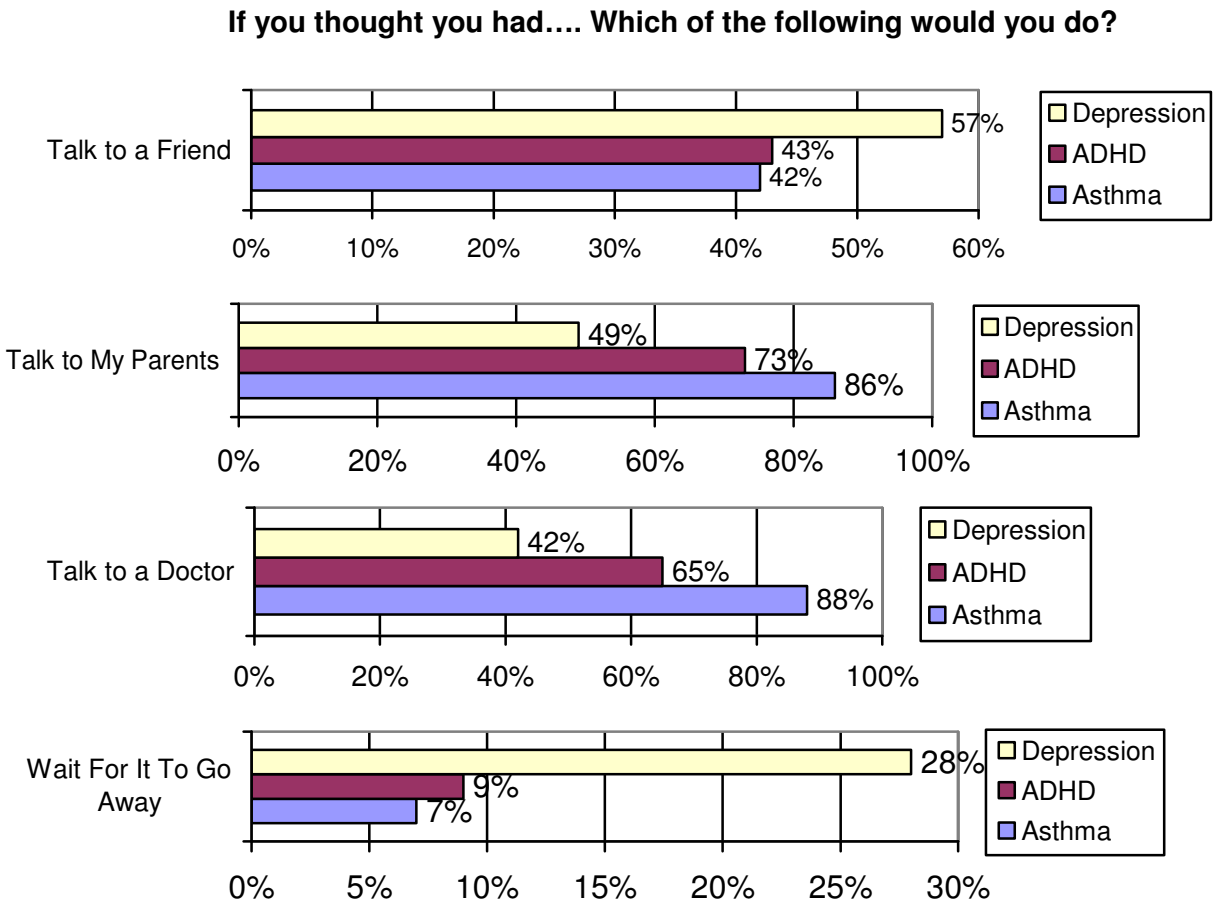
Violence/Abuse

Research indicates that childhood trauma increases the occurrence of mental and substance use disorders, which in turn, increase suicide risk.[34] In its own right, childhood abuse (especially sexual abuse) is an independent risk factor for both adults and adolescents. According to a first-of-its kind study of adolescents in rural Nevada, physical and sexual abuse ranked 2nd and 3rd for risk factors for suicide.[35]

Community

Stigma

Stigma is the fear and misunderstanding of something that prevents people from talking about an issue while also preventing people from seeking help. There is a common misconception that talking about suicide will cause it, when talking about suicide may be exactly what is needed. Many are unaware of suicide warning signs or how to respond to them. Although each person is unique, most suicidal individuals do give definite warnings of their suicidal intentions. Sadly, people do not know how to recognize these signs, or they do not feel confident in responding or willing to respond. It is critically important for everyone to have a basic understanding of the risks and warning signs and how to respond effectively.



Graph 25-Source: Harris Interactive YouthQuery (Respondent ages 10-18) June 14-June 20, 2006; published in Youth and Education Research's *Trends & Tudes*: Volume 5; Issue 8. Online edition: www.harrisinteractive.com/news/newsletters_k12.asp

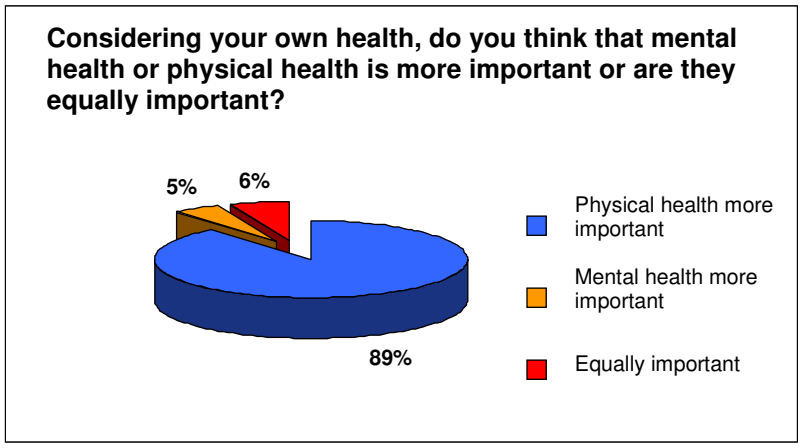
Social Isolation

While social connectedness is a critical protective factor, isolation greatly increases one's risk for suicide. Joiner states that, "the fact that those who die by suicide experience isolation and withdrawal before their deaths is among the clearest in all literature on suicide."[36] Isolation can be due to geography or lack of appropriate transportation, but it is also a product of depression, alcohol and substance abuse, and shame. Isolation can also occur as a result of loss of a loved one, divorce, incarceration or bullying.

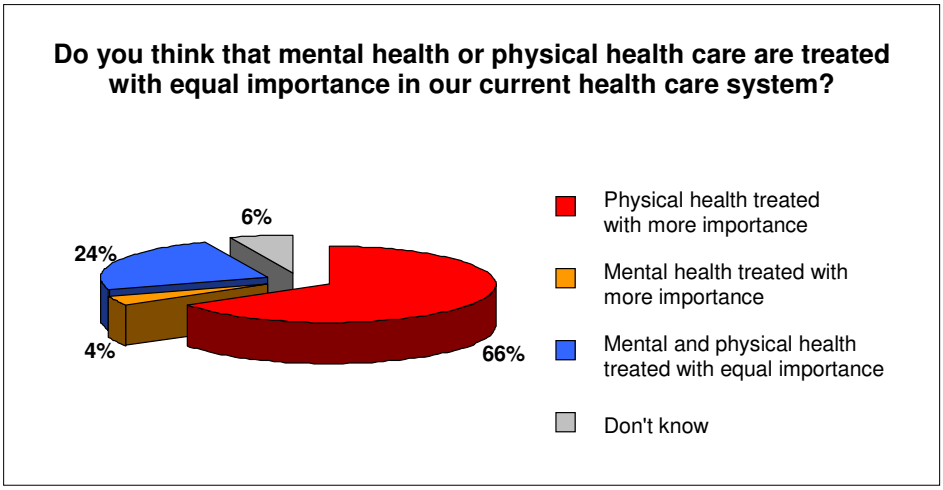
In Nevada, our rapid population growth has created a considerable deficit in available social institutions and social services. Those coming to Nevada for "opportunities" have left social support and often community support. The impact of transiency on Nevada's suicide rates is unclear.[37]

Barriers to Care

Barriers to care might be financial, physical, geographical or personal (stigma or perceived inability to access care). As mentioned, the stigma of having a mental illness can keep people from getting the help they need to recover. It also impacts mental health parity in health care coverage.[38] Mental health is a critical component of overall health, but is undervalued in the current public health system (Graphs 26 & 27). For children, unaddressed mental health concerns can disrupt the ability to learn and grow. Bullying, harassment, and discrimination toward sexual and cultural minorities also stigmatize specific groups, possibly increasing suicide risk and decreasing help seeking behaviors.[39]



Graph 26—Source: Taking Our Pulse: The PARADE/Research!America Health Poll Charlton Research Company. (2006).



Graph 27—Source: Taking Our Pulse: The PARADE/Research!America Health Poll Charlton Research Company. (2006).

An example of the devaluation of mental health care is the lack of depression screening by primary care physicians. Although not as high as for older adults, 40% of adults saw their primary care physician within a month of their suicide.[40]

One seemingly insurmountable barrier is financial. The disparities in health care coverage prevent those most in need from accessing services.[41] Those that do have health insurance most often do not receive mental health care equal to that of other health concerns.

Another major barrier to treatment in Nevada is the challenge of recruitment and retention of mental health care professionals and qualified psychiatric nurses.[42] This leads to long waits for service and fragmentation of those services. According to a report on "The Social Health in Nevada,"[43]

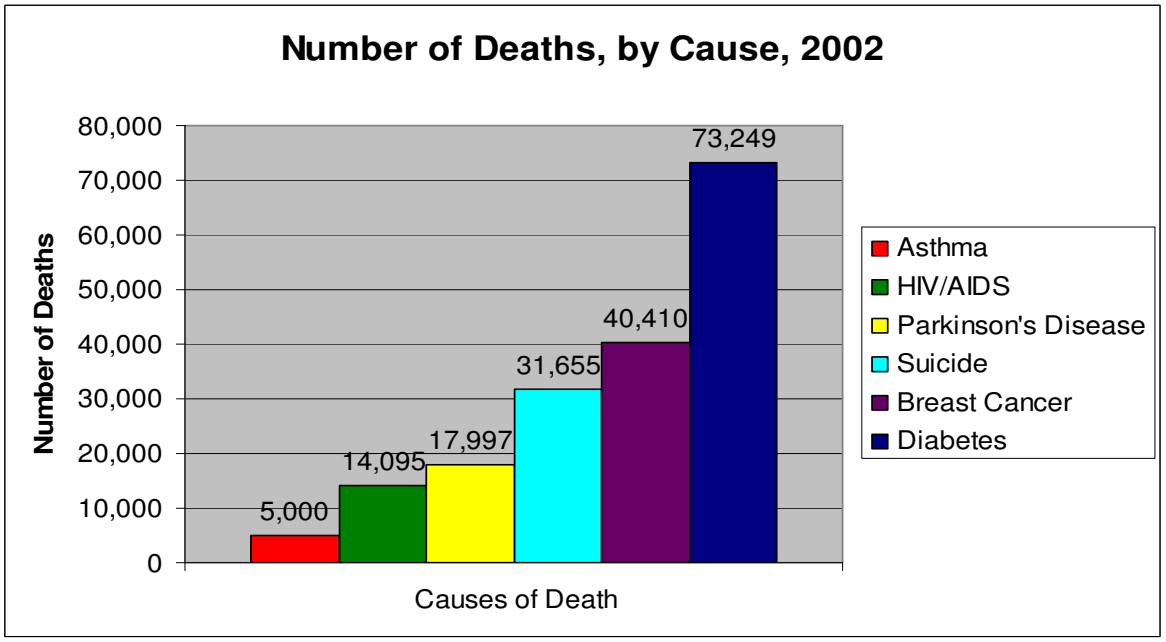
- In 2003, the patient to psychiatrist ratio in Nevada was approximately 700:1, as opposed to the target of 345:1.
- In the same year, there were 36 private psychiatric beds for the entire Clark County region with a population of 1,620,748.
- The State of Nevada estimated that in December 2005, 1595 people waited an average of 85 hours in hospital emergency rooms for access to the public mental hospital (Crowe, 2006).
- As many as 50% of those held in hospital emergency departments are eventually released to the streets without receiving any treatment.
- State officials estimate that about 40% of all clients leave the state psychiatric emergency clinic without being served because of intolerably long waits.

The absence of adequate mental health facilities and professionals to staff them, combined with Nevada residents' self-reported mental health problems, reveals the challenges of this barrier.

Society

Cultural Values and Attitudes

The way society approaches suicide greatly impedes prevention efforts. Stigma perpetuates unawareness and fear, dissuading discussion and resources. It also prevents those at risk and their loved ones from reaching out for help. The tables below demonstrate the disparity in funding due to public perception.



Graph 28—Source: American Foundation for Suicide Prevention Leadership Conference. (2006).
Presentation by Ann Haas, Ph.D.: Used with permission.

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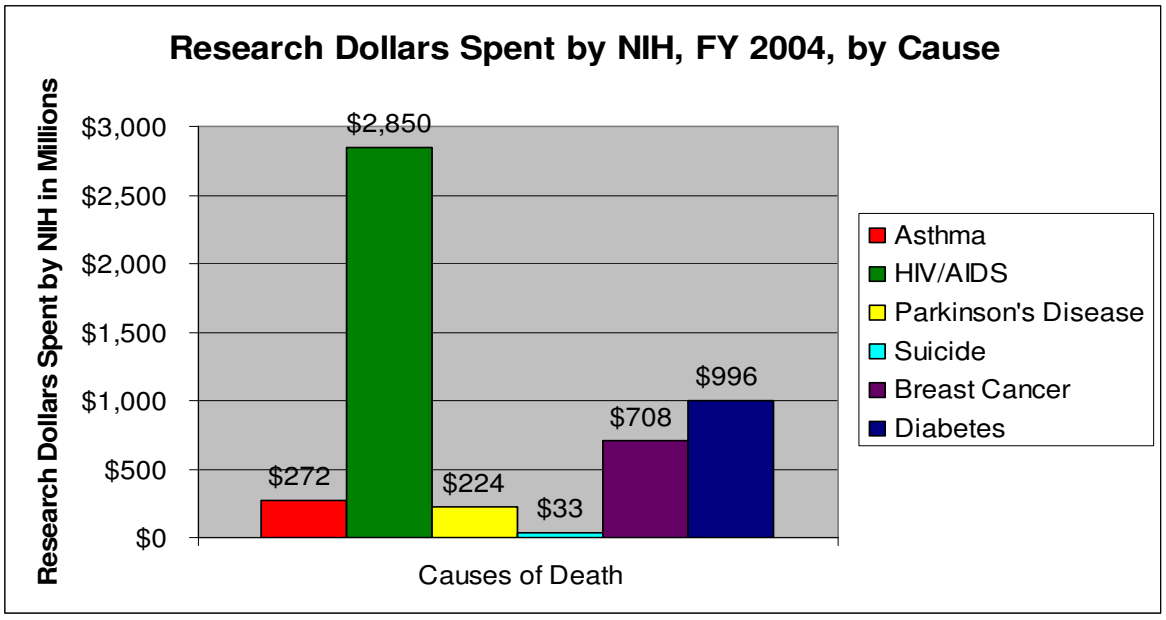

Graph 29– Source: American Foundation for Suicide Prevention Leadership Conference. (2006).
Presentation by Ann Haas, Ph.D.: Used with permission.

Some misconceptions exist around tourism and gambling. As stated by Fildes and Wray, there is a strong public perception that the high rates of suicide are driven by two major factors, tourism and problem gambling. Tourists make up only about 10 percent of all suicides per year. It is unclear to what extent suicides by recent arrivals or gambling-related suicides are contributing factors.[44] The 24-hour lifestyle associated with gambling does encourage many behaviors that are risk factors for suicide, such as increased alcohol and drug use and isolation.

Western/Rural Culture

In his chapter, "Suicide Trends and Prevention in Nevada," Wray describes the impact of our western culture well:

> There are some mediating factors at work, certain historical and cultural forces that affect suicidal behavior. Thus, Nevada's history as a mining and ranching frontier may play the decisive role. Frontier residents place a premium on self-reliance, fostering a "wild west" culture that produces a kind of "go-it alone" libertarian mentality. In such a culture, help-seeking behavior tends to be stigmatized and violence valorized as a legitimate response to difficulties and frustrations. Such historical and cultural legacies may lead Nevadans to the conclusion that suicide is not just an acceptable, but also an especially honorable way to deal with personal troubles and disappointments. Understanding this frontier mentality might help explain why rural areas have higher suicide rates than metropolitan areas and why White men and Native American men have the highest rates of all.[45]

Another aspect of the western/rural culture in Nevada is the extreme economic fluctuations of mining and ranching. Economic conditions of unemployment and community economic depression can increase risk for suicide, but these conditions can also increase other risk factors such as alcohol and substance use, interpersonal relationship stress and depression.[46]

Access to Lethal Means

Guns are the most widely chosen means in Nevada to attempt suicide – and they are undoubtedly the most lethal means for suicide. Given the high rate of gun ownership throughout Nevada and the intermountain West, prevention of access to these lethal means is proven to reduce suicide.[47] Poisoning is the third most used means for suicide in Nevada, and although it is not as lethal, medications are extremely accessible.

Media Influence

Research has shown that the media can influence suicidal behaviors by the way it reports on suicide deaths. Distribution and utilization of the "Media Guidelines for Safe Reporting on Suicide," is a key goal in the Nevada Suicide Prevention Plan. Stories that contain risk factors and warning signs for suicide while also reporting on resources, treatment options and the suicide prevention hotline can decrease the likelihood of suicide contagion.[48] Media portrayals of mental health and substance use disorders may also perpetuate stigma and decrease help-seeking behaviors.

Suicide Warning Signs

Warning signs are behavioral or emotional changes that communicate someone is in crisis or at risk for suicide. In 2006, the American Association of Suicidology developed recommendations and a pneumonic to assist with remembering the most relevant warning signs. In an effort to remain consistent, the following recommendations are taken directly from the American Association of Suicidology website (http://suicidology.org/displaycommon.cfm?an=2):

IS PATH WARM

I – Ideation
S – Substance Abuse

P – Purposelessness
A – Anxiety/agitation
T – Trapped
H – Hopelessness

W – Withdrawal
A – Anger
R – Recklessness
M – Mood Change

Get help immediately by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself.
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means.
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person.

Seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral should you witness, hear, or see someone you know exhibiting any one or more of the following:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped - like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose

Suicide Prevention Lifeline
1-800-273-TALK (8255)
24 hours a day

What to Do if Someone is at Risk for Suicide

The following was developed by The American Association of Suicidology.

- Be direct. Talk openly and matter-of-factly about suicide.
- Be willing to listen. Allow expressions of feelings. Accept the feelings.
- Be non-judgmental. Don't debate whether suicide is right or wrong, or whether feelings are good or bad. Don't lecture on the value of life.
- Get involved. Become available. Show interest and support.
- Don't dare him or her to do it.
- Don't act shocked. This will put distance between you.
- Don't be sworn to secrecy. Seek support.
- Offer hope that alternatives are available but do not offer glib reassurance.
- Take action. Remove means, such as guns or stockpiled pills.
- Get help from persons or agencies specializing in crisis intervention and suicide prevention.

Be Aware of Feelings

Many people at some time in their lives think about suicide. Most decide to live because they eventually come to realize that the crisis is temporary and death is permanent. On the other hand, people having a crisis sometimes perceive their dilemma as inescapable and feel an utter loss of control. These are some of the feelings and thoughts they experience:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of depression
- Can't make the sadness go away
- Can't see a future without pain
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't seem to get control

Suicide Prevention Resources

Nevada Office of Suicide Prevention (OSP)
www.suicideprevention.nv.gov

American Foundation for Suicide Prevention (AFSP)
www.afsp.org

American Association of Suicidology (AAS)
www.suicidology.org

Suicide Prevention Resource Center (SPRC)
www.sprc.org

Suicide Prevention Action Network (SPAN USA)
www.spanusa.org

Surviving Suicide (survivor support)
survivingsuicide.com

Crisis Call Center (suicide prevention hotline)
www.crisiscallcenter.org

Protective Factors

Protective factors are positive conditions, support systems and environments that promote problem-solving, connectedness and resiliency. Protective factors operate in several ways. They can absorb the impact of risk factors, such as appropriate treatment, providing a cushion against negative effects. They may disrupt the processes through which risk factors function as in the case of prohibiting access to lethal means. Finally, they may prevent the initial occurrence of a risk factor, such as cultural beliefs that deter suicide and promote life.

Typical protective factors are:

- **Effective clinical care for mental, physical, and substance use disorders**
- **Restricted access to lethal means**
- **Support through ongoing medical and mental health care relationships**
- **Strong connections to family and community support**
- **Skills in problem solving, conflict resolution, and nonviolent handling of disputes**
- **Cultural beliefs that discourage suicide and support self-preservation**

Like risk factors, protective factors can be unique to different cultures, age groups, gender, and race/ethnicity. Some examples of unique protective factors are listed below.

Youth

- **Positive connections to school**
- **Coping and problem solving skills**
- **Academic achievement**
- **Family cohesion/stability**
- **Help-seeking behaviors**
- **Good relationships with other youth**
- **Positive self worth and impulse control**

Older Adults

- **Supportive family relationships**
- **Sense of purpose and identity**
- **Involvement in community activities**
- **Ability to live independently**
- **Better preparation for retirement, interests and support networks outside of workplace**

Native Americans

- **Access to health care and mental health care**
- **Coping and problem solving skills**
- **Traditional and cultural activities**
- **Family cohesion/stability**
- **Respect for help-seeking behaviors**
- **Cultural values affirming life**
- **Positive self worth and impulse control**

Veterans

- **Unit cohesion and camaraderie**
- **Peer support**
- **Easy access to helping resources**
- **Belief that it is okay to ask for help**
- **Effective coping and problem-solving skills**
- **Social and family support**
- **Sense of belonging to a group or organization**
- **Marriage**
- **Physical activity**

Next Steps

There are many other at risk populations that need to be considered, but due to lack of local data, they are not presented here. It is a goal of the Nevada Suicide Prevention Plan to improve surveillance of suicide and suicidal behaviors so that we can accurately measure where prevention needs are and how they can effectively be addressed. Special populations such as incarcerated individuals, people in certain high-risk populations, people with sexual orientation or identity challenges, people with developmental disabilities, or those with traumatic brain injuries must not be forgotten in our prevention efforts.

The Nevada Suicide Prevention Plan was developed with the intention of re-examining its appropriateness and efficacy on a biennial basis. This process would occur with the guidance of key stakeholders at a statewide summit to evaluate and advance the state plan.

Conclusion

Nevada's present and historically high suicide rates are one of the state's most compelling public health and social issues. Suicide is complex and the measures to reduce and prevent it must be comprehensive and multifaceted.

The Nevada Suicide Prevention Plan that follows utilizes an integrated approach that intends to positively impact protective factors that have a bearing on many of the risk factors and social issues mentioned previously. We must begin by following the goals and objectives; together we can prevent suicide and our communities can become healthier, leading to a stronger and safer Nevada.

Nevada Suicide Prevention Plan

The Nevada Suicide Prevention Plan is based on the goals of the U.S. Surgeon General's National Strategy for Suicide Prevention: Goals and Objectives for Action (2001), with objectives and additional recommendations modified for Nevada.

GOAL 1: PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT CAN BE PREVENTED.

Rationale: If the general public has a better understanding that suicide and suicidal behaviors can be prevented, people feel empowered to take action and express their will to save lives. Increased awareness coupled with the dispelling of myths about suicide and suicide prevention will result in a decrease in the stigma associated with suicide and life-threatening behaviors. Increased awareness will also empower Nevadans to intervene. People need to know suicide can be preventable.

Objective 1: Promote the Office of Suicide Prevention as the official clearinghouse for information, data, training, educational materials, and expertise related to suicide in Nevada.

Action: Establish relationships with existing allied epidemiological workgroups and statewide data sources.

Action: Provide technical assistance related to training, education, and awareness events.

Action: Promote, maintain and monitor the state suicide prevention website: **www.suicideprevention.nv.gov.**

Action: Distribute annual *Nevada Suicide Prevention Update.*

Objective 2: Raise statewide awareness of available crisis services for those at risk for suicide.

Action: Promote Nevada's statewide suicide prevention hotline, the National Suicide Prevention Lifeline: **1-800-273-TALK (8255).**

Action: Identify and promote the use of community-based crisis intervention services.

Objective 3: Increase education and awareness of the impact of suicide in Nevada and empower communities for action.

Action: Support community problem solving through forums, and inter-agency partnerships and coalitions.

Action: Coordinate local awareness events during World Suicide Prevention Day and National Suicide Prevention Week.

GOAL 2: DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION.

Rationale: Due to the complexity of suicide and its prevention, this plan ensures that prevention efforts are comprehensive with collaboration across public and private entities. Suicide prevention truly is everyone's business and it requires complex efforts.

Objective 1: Partner with stakeholders to evaluate and advance the Nevada Suicide Prevention Plan.

Action: Convene a biennial, statewide, stakeholder summit.

Objective 2: Support the development of new local/regional suicide prevention groups or participation in related groups.

Action: Provide follow-up technical assistance to facilitate communication among new and existing community groups/coalitions to address barriers, increase understanding, and explore possible community-based solutions.

Action: Coordinate community core competencies trainings to enhance community readiness for suicide prevention efforts.

Action: Increase available resources to committed groups that will include suicide prevention in their strategic planning activities.

Objective 3: Support and advance current suicide prevention related goals stated in the strategic plans of allied groups.

Action: Provide technical assistance and advocacy to implement the suicide prevention-related activities identified in the strategic plans.

Objective 4: Develop and strengthen collaborative relationships with leaders (senior services agencies, schools, faith communities, businesses, governments, etc.) to promote necessary policy change, and expand funding and other community resources for suicide prevention.

Objective 5: Increase the number of professional, volunteer, and other groups that integrate suicide prevention into their ongoing activities.

GOAL 3: DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE, AND SUICIDE PREVENTION SERVICES.

Rationale: Sixty to ninety percent of all suicidal behaviors are closely linked to some form of mental illness and/or substance-use disorder (Harris and Barraclough, 1997). The stigma associated with these illnesses prevents people from seeking appropriate help. In turn, this stigma has led to insufficient funding of suicide prevention. Stigma is a huge barrier to help-seeking behavior.

Objective 1: Support mental health strategies that build capacity, increasing the availability of treatment for suicidal persons with underlying mental or substance use disorders.

Action: Utilize workgroups to assess infrastructure and/or cultural barriers in accessing mental health, substance abuse, and suicide prevention services.

Action: Support workforce development efforts to increase mental health professionals throughout Nevada, particularly in rural/frontier communities.

Objective 2: Transform public attitudes to view mental and substance use disorders as real illnesses equal to physical illness that respond to specific treatments, and view persons who seek treatment as pursuing basic health care.

Action: Support Garrett Lee Smith Youth Suicide Prevention Grant collaboration in development and implementation of a Clark County anti-stigma media campaign promoting the recognition of mental health as an essential part of child health.

Action: Educate seniors and their caregivers to define their health care needs comprehensively, to recognize the interaction between their mental health and all aspects of their physical health.

GOAL 4: DEVELOP AND IMPLEMENT COMMUNITY-BASED SUICIDE PREVENTION AND POSTVENTION PROGRAMS.

Rationale: Comprehensive and coordinated efforts are necessary to develop, implement and evaluate interventions. Local public/private collaboration can ensure that appropriate prevention programs will be applied to best address the unique risk factors and protective factors of each community.

Objective 1: Encourage implementation of evidence-based programs that are included on the National Registry of Evidence-based Programs and Practices (NREPP) sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Action: Build state capacity to provide technical assistance around evidence-based programs.

Objective 2: Increase the proportion of counties and communities with comprehensive suicide prevention plans that incorporate evidence-based programs and practices.

Action: Facilitate the development of local suicide prevention plans.

Objective 3: Strategize with communities ready to adapt components of a comprehensive suicide program piloted in Clark County through the Garrett Lee Smith Memorial Act grant.

Action: Diligently work to maintain current SAMHSA funds for youth suicide prevention program.

Action: Secure new Garrett Lee Smith Memorial Act funds from SAMHSA to initiate programs for higher education campuses and tribal communities.

Action: Fully engage in the cross-site national evaluation, as well as a locally based program evaluation for the Garrett Lee Smith Memorial Act Youth Suicide Prevention Program.

Action: Involve parents, students, and other family members in all aspects of suicide prevention programs, including planning, and implementation.

Action: Develop strategic plan for replication of piloted programs in local communities.

Objective 4: Enhance statewide suicide bereavement services.

Action: Develop a statewide network of suicide bereavement support groups.

Action: Increase the number of trained suicide bereavement support group facilitators.

Action: Survey existing youth bereavement support services in communities and school-based settings.

Action: Identify and implement model youth bereavement support services.

Objective 5: Support innovative strategies that reach individuals at risk of suicidal behavior.

Objective 6: Strengthen collaboration between the Office of Suicide Prevention and the Nevada Coalition for Suicide Prevention to mobilize efforts to assist communities in crisis.

Action: Develop a collaborative agreement which outlines the process for identifying the necessary resources for a community in crisis.

Action: Identify and secure financial resources to support the agreement.

GOAL 5: PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM.

Rationale: Research has shown that limiting access to lethal means (firearms, medications, carbon monoxide emissions) will prevent some impulsive suicides, especially among young people. Training for those in contact with people at risk for suicide (families, professionals, etc.) about proper storage and limiting access can save lives.

Objective 1: Educate physical and mental health care providers, senior caregivers and correctional facilities on the assessment of lethal means in the home and actions to reduce lethal means and suicide risk.

Action: Develop printed materials for parents and caregivers to increase home safety after a suicide attempt or known suicidal ideation.

Action: Encourage facilities and agencies to include home safety material as part of their formal discharge process.

Action: Encourage discharge nurses, physicians, law enforcement, first responders and pharmacists to verbally share information and educate on safety measures relating to safe storage of firearms, other family members' medications and the patient's own prescription medication(s).

Objective 2: Develop pilot mass media information campaign designed to reduce access to lethal means.

Action: Identify medium, campaign partners, and message content.

Objective 3: Support the discovery of new technologies to prevent suicide.

GOAL 6: IMPLEMENT TRAINING FOR RECOGNITION OF AT RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT.

Rationale: Many of the conditions associated with suicidal behaviors have effective treatments; unfortunately, many professionals are not adequately trained to recognize people at risk for suicide. Improved access to training and screening will increase the number of people at risk for suicide who receive the treatment or help they need.

Objective 1: Improve education for mental and physical health care providers.

Action: Increase awareness among primary care providers that depression is not a normal part of aging.

Action: Develop relationships with licensing boards, professional associations, and schools of higher learning to identify opportunities for enhancement of professional education for suicide.

Action: Investigate and implement evidence-based training programs.

Objective 2: Provide training for senior caregivers, clergy, teachers, and other educational staff, law enforcement, correctional workers, veteran's service providers, attorneys, etc. on how to identify and respond to persons at risk for suicide.

Action: Develop a selection of trainings to address high risk groups across the lifespan such as, seniors, Native Americans, gays, lesbians, bisexuals, transgender, and youth.

Action: Develop relationships with licensing boards, professional associations, and schools of higher learning to identify opportunities for enhancement of professional education for suicide.

Action: Investigate and implement evidence-based training programs.

Objective 3: Provide suicide prevention gatekeeper training to the community.

Action: Identify audiences for training opportunities.

Action: Identify and implement appropriate evidence-based training programs.

Objective 4: Increase professional staff development opportunities for the Office of Suicide Prevention.

Action: Secure funding for advanced training opportunities.

GOAL 7: ENGAGE PROFESSIONAL ORGANIZATIONS IN THE DEVELOPMENT AND PROMOTION OF EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES.

Rationale: Through continued education, professionals from diverse fields can be a part of the assessment, treatment and follow-up care of people at risk for suicide. With the provision of appropriate and ever-improving trainings, people at risk for suicide can have the intervention and support they need before a suicidal crisis occurs.

Objective 1: Encourage the development/implementation of standardized policies and procedures for assessing suicidal risk in primary care settings, emergency medical services, correctional facilities, mental health and substance abuse treatment clinics.

Action: Support the identification of research-based, age-appropriate behavioral health screening instruments and selection of standardized instruments.

Action: Enhance education and awareness of suicide prevention for emergency department personnel, utilizing the Joint Commission on Accreditation of Health Care Organizations 2007 Patient Safety Goals on Suicide and appropriate lethal means safety.

Action: Train first responders on their role in suicide prevention.

Objective 2: Utilize existing train the trainer programs offered through the Suicide Prevention Resource Center.

Action: Coordinate an Assessing and Managing Suicide Risk competencies program to enhance professional skills of mental health providers for suicidal persons in treatment.

Objective 3: Incorporate suicide risk screening in primary care for the lifespan.

Action: Utilize post-natal screening for mothers visiting pediatricians and obstetricians and gynecologists for routine health care.

Action: Educate on the importance of depression screening in primary care settings for Nevada's senior population.

GOAL 8: IMPROVE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

Rationale: Services to prevent suicide must be available to all Nevadans where and when needed. Structural, financial, transport, and resource barriers must be identified and remedied. Outreach must also be improved so that Nevadans are aware of the services that exist to meet their needs. Culturally competent values and practices must be infused into all aspects of our work in suicide prevention, promoting safety and increasing the willingness of all Nevadans to seek help.

Objective 1: Support initiatives addressing mental health parity at the state and national levels.

Objective 2: Support the growth of membership in the Nevada Coalition for Suicide Prevention, inviting a wider geographic, racial, and ethnic representation.

Action: Increase the representation of the coalition membership in order to promote cross-referrals between agencies and enhance understanding of services represented through the coalition in order to improve community linkages and service access.

Objectives 3: Integrate mental health and suicide prevention into health and social services outreach programs for at-risk populations.

Action: Enhance the Office of Suicide Prevention's knowledge of existing crisis management teams and suicide/suicide attempt policies and protocols in school districts.

Action: Identify existing health and social service programs that target at-risk populations.

Action: Provide technical assistance around strategies to integrate health and suicide prevention.

Action: Expand existing mobile outreach programs for seniors.

Action: Support the expansion of Crisis Intervention Team programs for law enforcement to increase the number of trained officers, and encourage similar training for other first responders.

Objective 4: Assist community-based services with defining, implementing and evaluating screening and referral guidelines to ensure continuity of care.

GOAL 9: IMPROVE REPORTING AND PORTRAYALS OF SUICIDAL BEHAVIOR, MENTAL ILLNESS, AND SUBSTANCE ABUSE IN THE ENTERTAINMENT AND NEWS MEDIA.

Rationale: Research has shown that media can influence suicide rates in positive or negative ways and perpetuate stigma, which affects help-seeking behavior. Encouragement of the media through educational opportunities in how to safely report on suicide and how to positively portray people living with mental health disorders and seeking help if necessary, as an important factor in reducing stigma.

Objective 1: Provide a clear and consistent message to media entities pursuing information on issues relating to mental illness, substance use disorders, suicide, and suicidal behaviors.

Action: Develop a list of identified key spokespersons that can effectively address issues relating to mental illness, substance use disorders, suicide, and suicidal behaviors, which will be made available to interested media representatives.

Action: Identify specific publications and programs that could be used to educate the public.

Objective 2: Develop and foster ongoing relationships with members of the media.

Action: Invite and encourage active participation of media representatives in the Nevada Coalition for Suicide Prevention.

Action: Identify media members who specifically respond on health/medical issues.

Objective 3: Widely and consistently distribute media guidelines through collaborative multi-agency efforts.

Action: Office of Suicide Prevention will establish relationships with the Nevada Broadcasters Association to promote guidelines as best practices in media portrayals.

Action: Office of Suicide Prevention will identify processes for disseminating guidelines to print media.

Action: Create statewide media monitoring process to provide informed support of appropriate coverage in order to avoid misleading or hurtful depictions of suicide, mental illness, substance use disorders, or mental health and substance abuse treatments.

Action: Encourage journalism and communication programs in higher education systems to include in their curricula guidance on the portrayal and reporting of mental illness, substance use disorders, suicide, and suicidal behaviors.

GOAL 10: PARTNER WITH OTHER AGENCIES AND ACADEMIC RESEARCHERS WHO ARE ADVANCING SUICIDE PREVENTION RESEARCH EFFORTS.

Rationale: Advancing research and evaluation increases the knowledge base for effective interventions to prevent suicide. The provision of sound knowledge impacts policy-makers decisions and can influence resources, leading to prevention plans and programs that work.

GOAL 11: IMPROVE AND EXPAND SURVEILLANCE SYSTEMS.

Rationale: Surveillance is the observation, monitoring and collection of data about suicide which is key in planning suicide prevention efforts. Improving the data available in Nevada and nationwide

will enhance our knowledge of individual risk factors and community-wide trends, leading to improved services for communities at a local level and the state as a whole.

Objective 1: Improve data collection efforts around non-fatal attempts and completed suicides.

Action: Collaborate with existing epidemiological workgroups in related areas on projects that cross morbidity and mortality, and further the academic understanding of suicide.

Action: Create a suicide epidemiological workgroup.

Action: Build capacity statewide to prepare for application and implementation of the National Violent Death Registry.

Objective 2: Encourage the development and implementation of standardized protocols for death scene investigations.

Sources of Data

It is the intention of the Office of Suicide Prevention (OSP) to become a clearinghouse of suicide-related information for the State of Nevada. While the OSP doesn't currently collect data, we are using data collected by the Nevada State Health Division, Bureau of Health Planning and Statistics and the Centers for Disease Control, Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal data base.[2] The charts in this report compare state and national data from 1981 through the most current year, 2004. In 1999, the injury mortality data coding changed from the *Ninth Revision of the International Classification of Diseases* (ICD-9) system to the ICD-10 system. This system is notably different from the coding used for 1998 and earlier data. Because of the different coding systems, one may not be able to compare numbers of deaths and death rates computed for some external causes of injury based on 1999 and later data to those based on data from 1998 and earlier. Consequently, one must use caution when doing trend analysis of numbers of deaths and death rates across these years. The charts in this plan group data based on the coding changes.[49]

How Rates are Determined

WISQARS Fatal figures the crude rate per 100,000 by dividing the number of deaths in a particular population by the total number of people in that population, then multiplying that ratio by 100,000. Some injuries are more prevalent among certain age groups than among others. For example, deaths from falls occur more often among older Americans than among any other age group. Age adjustment allows one to compare injury rates without concern that differences in those rates are caused by variations in the age distributions between populations or among the same population over time.

When reports are requested for all ages in a particular population, WISQARS Fatal automatically calculates age-adjusted rates. However, for reports requested by standard age groups and custom age ranges, only crude rates per 100,000 are available. The method used to calculate age adjustment does not allow WISQARS Fatal to compute age-adjusted rates by age groups.

Limitations of Data

Suicide rates allow for the monitoring of trends over time and the comparison between countries, states and regions. Due to differences in defining suicide and suicidal behaviors, determination of suicidal intent, extent of investigations in different communities and the managing of data, there are many inaccuracies. (*Reducing Suicide*. 2002).

New approaches are needed in surveillance and data collection to ensure more accuracy in the monitoring of this very complex public health issue.

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Appendices

Appendix A

Study of Suicide Prevention – 2003

BULLETIN NO. 03-11

This summary presents the recommendations approved by the Legislative Commission's Subcommittee to Study Suicide Prevention.

Please go to www.suicideprevention.nv.gov or,

For a copy of a full report with appendices of this interim study, contact:

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Appendix B

NEVADA SUICIDE PREVENTION PLAN IMPLEMENTATION TIMELINE AND PRIORITIES 2007-2012

GOAL 1: PROMOTE AWARENESS THAT SUICIDE IS A PUBLIC HEALTH PROBLEM THAT CAN BE PREVENTED.

PRIORITY: ***Objective 1: Promote the Office of Suicide Prevention as the official clearinghouse for information, data, training, educational materials, and expertise related to suicide in Nevada.***

Activity	Suggested Partners	Benchmark	Timeline
Establish relationships with existing allied epidemiological workgroups and statewide data sources.	Center for Health Data and Research SAPTA Epidemiological work groups	SP Coord. will strive to collect current suicide data SP Coord. will participate in work group meetings.	1/31/2007
Provide technical assistance related to training, education, and awareness events.	AAS, SPRC	Track number of inquiries for assistance.	Ongoing
Promote, maintain and monitor the state suicide prevention website: www.suicideprevention.nv.gov.	DOIT	Monitor number of hits received per month.	Ongoing
Distribute annual *Nevada Suicide Prevention Update.*	Commission on MHDS	Report distributed.	Annually

PRIORITY: ***Objective 2: Raise statewide awareness of available crisis services for those at risk for suicide.***

Activity	Suggested Partners	Benchmark	Timeline
Promote Nevada's statewide suicide prevention hotline, the National Suicide Prevention Lifeline: 1-800-273-TALK (8255).	Crisis Call Center	Monitor increase in number of calls.	Ongoing
Identify and promote the use of community-based crisis intervention services.	CIT, TIP, Crisis Call Center, other crisis-related hotlines	Establish baseline directory of services.	12/31/07

PRIORITY: ***Objective 3: Increase education and awareness of the impact of suicide in Nevada and empower communities for action.***

Activity	Suggested Partners	Benchmark	Timeline
Support community problem solving through forums, inter-agency partnerships and coalitions.	Community coalitions, public	Increase the number of community coalitions dedicated to suicide prevention by 3.	6/30/2007
Coordinate local awareness events during World Suicide Prevention Day and National Suicide Prevention Week.	State and Community coalitions	Increase the attendance at local awareness events and increase, by 2, the number of communities participating in National Suicide Prevention Week.	9/30/2007

GOAL 2: DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION.

PRIORITY: ***Objective 1: Partner with stakeholders to evaluate and advance the Nevada Suicide Prevention Plan.***

Activity	Suggested Partners	Benchmark	Timeline
Convene a biennial, statewide, stakeholder summit.	Nevada Coalition for Suicide Prevention; Governor's Commission on Mental Health and Developmental Services Task Force for Suicide Prevention; Nevada Public Health Foundation	Evaluate and update the Nevada Suicide Prevention Plan and timeline.	5/31/2008 and every biennium thereafter.

PRIORITY: ***Objective 2: Support the development of new local/regional suicide prevention groups or participation in related groups.***

Activity	Suggested Partners	Benchmark	Timeline
Provide follow-up technical assistance to facilitate communication among new and existing community groups/coalitions to address barriers, increase understanding, and explore possible community-based solutions.	Hospital administration, EMS, Law enforcement, mental health, school administration	Explore barriers to communication in 3 additional communities	12/31/2007
Coordinate community core competencies trainings to enhance community readiness for suicide prevention efforts.	Elko County, Lyon County	Offer one CCC training per year.	12/31/2007
Increase available resources to committed groups that will include suicide prevention in their strategic planning activities.	Community partners.	Successful award of grant funding.	6/30/2008

PRIORITY: ***Objective 3: Support and advance current suicide prevention related goals stated in the strategic plans of allied groups.***

Activity	Suggested Partners	Benchmark	Timeline
Provide technical assistance and advocacy to implement the suicide prevention-related activities identified in the strategic plans.	Mental Health and Developmental Services, the Inter-Tribal Council, Indian Health Board, Indian Health Services, Division of Child and Family Services, Juvenile Justice Services, mental health consortiums, SAPTA, Aging Services and other state and county entities.	Track implementation/completion of shared goals and objectives of 3 entities.	12/31/07

Objective 4: Develop and strengthen collaborative relationships with leaders (senior services agencies, schools, faith communities, businesses, governments, etc.) to promote necessary policy change, and expand funding and other community resources for suicide prevention.

Objective 5: Increase the number of professional, volunteer, and other groups that integrate suicide prevention into their ongoing activities.

GOAL 3: DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE, AND SUICIDE PREVENTION SERVICES.

PRIORITY: ***Objective 1: Support mental health strategies that build capacity, increasing the availability of treatment for suicidal persons with underlying mental or substance use disorders.***

Activity	Suggested Partners	Benchmark	Timeline
Utilize workgroups to assess infrastructure and/or cultural barriers in accessing mental health, substance abuse, and suicide prevention services.	MH Consortiums	Participation in local MH consortiums and Statewide Consortium workgroups.	Ongoing
Support workforce development efforts to increase mental health professionals throughout Nevada, particularly in rural/frontier communities.	MHDS, MH Consortiums, DCFS	Track increase in number of professionals hired.	7/31/08

PRIORITY: ***Objective 2: Transform public attitudes to view mental and substance use disorders as real illnesses equal to physical illness that respond to specific treatments, and view persons who seek treatment as pursuing basic health care.***

Activity	Suggested Partners	Benchmark	Timeline
Support Garrett Lee Smith Youth Suicide Prevention Grant collaboration in development and implementation of a Clark County anti-stigma media campaign promoting the recognition of mental health as an essential part of child health.	DCFS, CCCMHC, SNHD	Implementation of anti-stigma campaign. UNLV evaluation	Campaign 1: 12/31/2006 Campaign 2: 8/31/07 Campaign 3: 3/31/08
Educate seniors and their caregivers to define their health care needs comprehensively, to recognize the interaction between their mental health and all aspects of their physical health.	Div. Aging Services (from Aging Services Plan 04-07); OPD recommendations	Reduction in percentage of people 75+ who go untreated with a severe disability, compared to the 1997 Census survey of Income and Program Participation baseline.	12/31/2008

GOAL 4: DEVELOP AND IMPLEMENT COMMUNITY-BASED SUICIDE PREVENTION AND POSTVENTION PROGRAMS.

PRIORITY: ***Objective 1: Encourage implementation of evidence-based programs that are included on the National Registry of Evidence-based Programs and Practices (NREPP) sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).***

Activity	Suggested Partners	Benchmark	Timeline
Build state capacity to provide technical assistance around evidence-based programs.	Suicide Prevention Resource Center		12/31/2008

PRIORITY: ***Objective 2: Increase the proportion of counties and communities with comprehensive suicide prevention plans that incorporate evidence-based programs and practices.***

Activity	Suggested Partners	Benchmark	Timeline
Facilitate the development of local suicide prevention plans.	NCSP, MH Consortia	Development of 2 local suicide prevention plans.	12/31/2007

PRIORITY: *Objective 3: Strategize with communities ready to adapt components of a comprehensive suicide prevention program piloted in Clark County through the Garrett Lee Smith Memorial Act grant.*

Activity	Suggested Partners	Benchmark	Timeline
Diligently work to maintain current SAMHSA funds for youth suicide prevention program.	MH Consortia, DCFS	Continuation of SAMHSA grant funds.	12/31/2008
Secure new Garrett Lee Smith Memorial Act funds from SAMHSA to initiate programs for higher education campuses and tribal communities.	University of Nevada, Intertribal Council and Health Board	Secure award of new funding.	9/31/2008
Fully engage in the cross-site national evaluation, as well as a locally based program evaluation for the Garrett Lee Smith Memorial Act Youth Suicide Prevention Program.	Orc-Macro, SAMHSA	Report on effectiveness of Youth Suicide Prevention Program.	6/30/2009
Involve parents, students, and other family members in all aspects of suicide prevention programs, including planning, and implementation	MCH board; NV PEP		6/30/07
Develop strategic plan for replication of piloted programs in local communities.		Replication of program in at least two communities.	2010

PRIORITY: *Objective 4: Enhance statewide suicide bereavement services.*

Activity	Suggested Partners	Benchmark	Timeline
Develop a statewide network of suicide bereavement support groups.	SOSL groups in Hawthorne, Reno, Elko, Gardnerville, and Las Vegas	Quarterly meeting held between group facilitators.	6/30/2007
Increase the number of trained suicide bereavement support group facilitators.		Increase the number of trained facilitators in rural communities by 30%.	6/30/2008
Survey existing youth bereavement support services in communities and school-based settings.	national	Create a list of successful services.	6/31/2007
Identify and implement model youth bereavement support services.	Solice Tree, SPRC	Implementation of at least one youth suicide bereavement support group.	2010

Objective 5: Support innovative strategies that reach individuals at risk of suicidal behavior.

Objective 6: Strengthen collaboration between the Office of Suicide Prevention and the Nevada Coalition for Suicide Prevention to mobilize efforts to assist communities in crisis.

Activity	Suggested Partners	Benchmark	Timeline
Develop a collaborative agreement which outlines the process for identifying the necessary resources for a community in crisis.	MHDS (Goal 5.2.1), NCSP	Develop crisis/postvention plan.	9/30/2008
Identify and secure financial resources to support the agreement.	MHDS (Goal 5.2.2), NCSP	Fund collaboration efforts.	9/30/2008

GOAL 5: PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM.

PRIORITY: ***Objective 1: Educate physical and mental health care providers and correctional facilities on the assessment of lethal means in the home and actions to reduce lethal means and suicide risk.***

Activity	Suggested Partners	Benchmark	Timeline
Develop printed materials for parents and caregivers to increase home safety after a suicide attempt or known suicidal ideation.	CCCMHC, DCFS, Child Death Review, TIP	Distribution of After an Attempt pamphlet	12/2007
Encourage facilities and agencies to include home safety material as part of their formal discharge process.	Montevista Hospital, Desert Springs Treatment Center, Juvenile Justice, Desert Willow, Child Death Review Team, CCCMHC, NCSP	Policy changes and training	3/31/08
Encourage discharge nurses, physicians, law enforcement, first responders and pharmacists to verbally share information and educate on safety measures relating to safe storage of firearms, other family members' medications and the patient's own prescription medication(s).	Child Death Review Teams	Policy changes and training	3/31/08

Objective 2: Develop pilot mass media information campaign designed to reduce access to lethal means.

Activity	Suggested Partners	Benchmark	Timeline
Identify medium, campaign partners, and message content.		PSA developed and aired	2010

Objective 3: Support the discovery of new technologies to prevent suicide.

GOAL 6: IMPLEMENT TRAINING FOR RECOGNITION OF AT RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT.

PRIORITY: ***Objective 1: Improve education for mental and physical health care providers.***

Activity	Suggested Partners	Benchmark	Timeline
Increase awareness among primary care providers that depression is not a normal part of aging.	Senior Services agencies, Nevada Division for Aging Services	Increase % primary care physicians that screen for depression.	2008
Develop relationships with licensing boards, professional associations, and schools of higher learning to identify opportunities for enhancement of professional education for suicide.		Increase in course content or CEU credits required related to suicide prevention.	12/31/2007
Investigate and implement evidence-based training programs.	SPRC	Incorporation of training programs appropriate for various professional groups into OSP training menu.	2007

PRIORITY: *Objective 2: Provide training for senior caregivers, clergy, teachers, and other educational staff, law enforcement officers, correctional workers, veteran's service providers, attorneys, etc. on how to identify and respond to persons at risk for suicide.*

Activity	Suggested Partners	Benchmark	Timeline
Develop a selection of trainings to address high risk groups across the lifespan such as, seniors, Native Americans, gays, lesbians, bisexuals, transgender, and youth.	SPRC	Create menu of diverse, evidence-based trainings	Ongoing
Develop relationships with licensing boards, professional associations, and schools of higher learning to identify opportunities for enhancement of professional education for suicide.		Make contact with 5 boards/associations to establish relationships and gain approval or programs for continuing education.	6/30/07
Investigate and implement evidence-based training programs.		Incorporation of training programs sensitive to and appropriate for diverse groups into OSP training menu	Ongoing

PRIORITY: *Objective 3: Provide suicide prevention gatekeeper training to the community.*

Activity	Suggested Partners	Benchmark	Timeline
Identify audiences for training opportunities.		# trainings completed per evaluations	Ongoing
Identify and implement appropriate evidence-based training programs.		Incorporation of wide array of training programs appropriate for communities to select from.	Ongoing

PRIORITY: *Objective 4: Increase professional staff development opportunities for the Office of Suicide Prevention.*

Activity	Suggested Partners	Benchmark	Timeline
Secure funding for advanced training opportunities.		Attendance by OSP staff at evidence-based trainings.	12/31/08

GOAL 7: ENGAGE PROFESSIONAL ORGANIZATIONS IN THE DEVELOPMENT AND PROMOTION OF EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES.

Objective 1: Encourage the development/implementation of standardized policies and procedures for assessing suicidal risk in primary care settings, emergency medical services, correctional facilities, mental health and substance abuse treatment clinics.

Activity	Suggested Partners	Benchmark	Timeline
Support the identification of research-based, age-appropriate behavioral health screening instruments and selection of standardized instruments.	Division of Child and Family, Division of Mental Health and Developmental Services, Division of Health, Division of Health Care Finance and Planning, counties and behavioral health providers; Emergency Department Supervisors	Usage of evidence-based, appropriate and effective instruments increases.	2009
Enhance education and awareness of suicide prevention for emergency department personnel, utilizing the Joint Commission on Accreditation of Health Care Organizations 2007 Patient Safety Goals on Suicide and appropriate lethal means safety.	Emergency Nurses Association; Emergency Department Supervisors	Emergency Department Policy Change	2007-2009
Train first responders on their role in suicide prevention.	Center for Education and Health Services Outreach	Train 25% of EMS statewide.	2008

Objective 2: Utilize existing train the trainer programs offered through the Suicide Prevention Resource Center.

Activity	Suggested Partners	Benchmark	Timeline
Coordinate an Assessing and Managing Suicide Risk competencies program to enhance professional skills of mental health providers for suicidal persons in treatment.	SPRC, AAS, OSP, NPHF	25% of mental health clinicians will be trained.	2012

Objective 3: Incorporate suicide risk screening in primary care for the lifespan.

Activity	Suggested Partners	Benchmark	Timeline
Utilize post-natal screening for mothers visiting pediatricians and obstetricians and gynecologists for routine health care.	MCH Board, Div. of Health	25% of pediatricians and OBGYN screen for suicidality.	2012
Educate on the importance of depression screening in primary care settings for Nevada's senior population.	Div. of Aging Services	50% of primary care physicians routinely screen for depression.	2012

GOAL 8: IMPROVE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

PRIORITY ***Objective 1: Support initiatives addressing mental health parity at the state and national levels.***

PRIORITY ***Objective 2: Support the growth of membership in the Nevada Coalition for Suicide Prevention, inviting a wider geographic, racial, and ethnic representation.***

Activity	Suggested Partners	Benchmark	Timeline
Increase the representation of the coalition membership in order to promote cross-referrals between agencies and enhance understanding of services represented through the coalition in order to improve community linkages and service access.		Double participation in NCSP.	12/31/07

PRIORITY: *Objectives 3: Integrate mental health and suicide prevention into health and social services outreach programs for at-risk populations.*

Activity	Suggested Partners	Benchmark	Timeline
Enhance the Office of Suicide Prevention's knowledge of existing crisis management teams and suicide/suicide attempt policies and protocols in school districts.	County districts, NDE	Make contact with 3 school districts to review policies related to postvention.	6/2008
Identify existing health and social service programs that target at-risk populations.		Investigate and develop list of existing resources.	12/2007
Provide technical assistance around strategies to integrate health and suicide prevention.		Investigate potential partners and make list.	12/2008
Expand existing mobile outreach programs for seniors.	MHDS, CCCMHC (per 2007 Strategic Plan)	Development of a plan for mobile crisis outreach.	2008
Support the expansion of Crisis Intervention Team programs for law enforcement to increase the number of trained officers, and encourage similar training for other first responders.	CIT teams	Training available to first responders other than law enforcement.	2008

Objective 4: Assist community-based services with defining, implementing and evaluating screening and referral guidelines to ensure continuity of care.

GOAL 9: IMPROVE REPORTING AND PORTRAYALS OF SUICIDAL BEHAVIOR, MENTAL ILLNESS, AND SUBSTANCE ABUSE IN THE ENTERTAINMENT AND NEWS MEDIA.

PRIORITY: *Objective 1: Provide a clear and consistent message to media entities pursuing information on issues relating to mental illness, substance use disorders, suicide, and suicidal behaviors.*

Activity	Suggested Partners	Benchmark	Timeline
Develop a list of identified key spokespersons that can effectively address issues relating to mental illness, substance use disorders, suicide, and suicidal behaviors, which will be made available to interested media representatives.		Creation of database.	12/2007

PRIORITY: *Objective 2: Develop and foster ongoing relationships with members of the media.*

Activity	Suggested Partners	Benchmark	Timeline
Invite and encourage active participation of media representatives in the Nevada Coalition for Suicide Prevention.		Media representation increased on NCSP.	2007

PRIORITY: *Objective 3: Widely and consistently distribute media guidelines through collaborative multi-agency efforts.*

Activity	Suggested Partners	Benchmark	Timeline
Office of Suicide Prevention will establish relationships with the Nevada Broadcasters Association to promote guidelines as best practices in media portrayals.		Make contact with Nevada Broadcasters Assoc.	12/2007
Office of Suicide Prevention will identify processes for disseminating guidelines to print media.		Plan to distribute guidelines developed and utilized.	2007 Ongoing
Create statewide media monitoring process to provide informed support of appropriate coverage in order to avoid misleading or hurtful depictions of suicide, mental illness, substance use disorders, or mental health and substance abuse treatments.		Monitor published articles	6/2008
Encourage journalism and communication programs in higher education systems to include in their curricula, guidance on the portrayal and reporting of mental illness, substance use disorders, suicide, and suicidal behaviors.		Curriculum related to Media guidelines developed and implemented.	2012

GOAL 10: PARTNER WITH OTHER AGENCIES AND ACADEMIC RESEARCHERS WHO ARE ADVANCING SUICIDE PREVENTION RESEARCH EFFORTS.

GOAL 11: IMPROVE AND EXPAND SURVEILLANCE SYSTEMS.

PRIORITY: *Objective 1: Improve data collection efforts around non-fatal attempts and completed suicides.*

Activity	Suggested Partners	Benchmark	Timeline
Collaborate with existing epidemiological workgroups in data related areas on projects that cross morbidity and mortality, and further the epidemiologic understanding of suicide.	Health Planning and Statistics, U. of Nevada	Attendance at epidemiology meetings.	2007
Create a suicide epidemiological workgroup.	NCSP		2007
Build capacity statewide to prepare for application and implementation of the National Violent Death Registry.		Award of funding to participate in NVDR.	2009

Objective 2: Encourage the development and implementation of standardized protocols for death scene investigations.

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Northern Nevada Adult Mental Health Services
Southern Nevada Adult Mental Health Services
Division of Health, Bureau of Health Planning and Statistics
Child Fatality Review Teams
Southern Nevada Health District
State Injury Prevention Task Force
County Coroners

Community Organizations

Nevada Coalition for Suicide Prevention and its member agencies
Clark County Children's Mental Health Consortium
Washoe County Children's Mental Health Consortium
Rural Children's Mental Health Consortium
Suicide Prevention Network of Douglas County
Pyramid Lake Suicide Prevention Task Force
Crisis Call Center
Elko County Suicide Prevention Network
Indian Health Services
Washoe County Senior Services
Human Services Network
Nevada Public Health Foundation

National Organizations

Suicide Prevention Resource Center
American Foundation for Suicide Prevention
Centers for Disease Control and Prevention
American Association for Suicidology
Suicide Prevention Action Network
National Suicide Prevention Lifeline

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States/Other Suicide Prevention Plans

The following state plans inspired the Nevada Suicide Prevention Plan:
Georgia Suicide Prevention Plan
Maine Youth Suicide Prevention Plan
Alaska Suicide Prevention Plan
Florida Suicide Prevention Strategy
Suicide in Colorado

Other Nevada Strategies and Plans

Maternal Child Health Strategic Plan
Children's Mental Health Consortia
Bureau of Family Health Services and Bureau of Health Planning and Statistics.
Human Services Strategic Plan for Reno, Sparks and Washoe County
Mental Health and Developmental Services Needs Assessment Report, 2006.

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