Study of Suicide Prevention

Legislative Counsel Bureau
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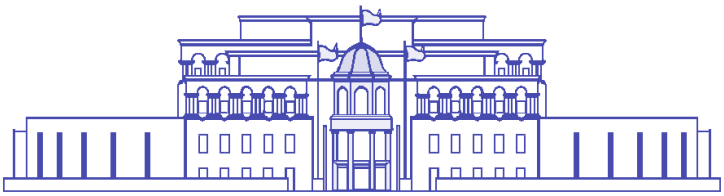

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TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

STUDY OF SUICIDE PREVENTION

This summary presents the recommendations approved by the Legislative Commission's Subcommittee to Study Suicide Prevention. The Subcommittee submits the following proposals for consideration by the 72nd Session of the Nevada Legislature:

RECOMMENDATIONS FOR LEGISLATIVE MEASURES - SUBCOMMITTEE BILL DRAFT REQUESTS (BDRS) FOR BILLS OR RESOLUTIONS

1. Draft and enact legislation requiring the development of a Nevada State Suicide Prevention Plan and establishing a Statewide Suicide Prevention Program within the Director's Office of Nevada's Department of Human Resources (DHR). The purpose of the state plan/program is to reduce the number of attempted and completed suicides in Nevada. The state plan should address the risk factors related to suicide and identify populations most at risk, and it should be distributed statewide and made available to the public not later than January 3, 2005.

The State Suicide Prevention Plan shall be modeled after existing state plans in Georgia and several other states, which incorporate goals from the United States Surgeon General's 2001 report, *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Nevada's state plan should focus on the Surgeon General's goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who are the first contacts with individuals at risk of suicide.

The Statewide Suicide Prevention Program will include the establishment and funding of two personnel positions to develop and implement suicide prevention programs in Nevada. One position would be the Statewide Suicide Prevention Coordinator based in the Director's Office of DHR in Carson City, and the other position would be a Suicide Prevention Trainer & Networking Facilitator based in the office of a government or nonprofit agency in Clark County. Funding for these positions may depend on a combination of government (federal, state, and local) and nongovernmental money. The Governor is urged to include this program as part of the DHR budget, and the Legislature is urged to approve a budget to support the program.

The Director of DHR shall be required to submit a copy of the state plan and a report on the program to the Governor and the Director of the Legislative Counsel Bureau (for distribution to the Legislature) on or before January 3, 2005.

Statewide Suicide Prevention Coordinator

Under the direction of the Director of DHR, the Statewide Suicide Prevention Coordinator will be responsible for developing, disseminating, and implementing a statewide suicide awareness and prevention plan and program throughout Nevada, including public education activities, gatekeeper training, and enhancement of crisis services. The Coordinator will conduct suicide prevention public awareness and media campaigns in all 17 Nevada counties, beginning first in Clark County.

Furthermore, the Coordinator will link suicide assessment and intervention trainers to schools, community centers, nursing homes, and other facilities serving persons most at risk of suicide. The position will coordinate the establishment of local advisory groups in each county to offer additional support to the program's efforts. Working with suicide prevention advocacy groups, community coalitions, managers of existing nationally accredited/certified crisis hotlines, and staff of mental health agencies in the state, the Coordinator will identify and address the barriers that interfere with providing services to at-risk groups, such as the elderly, Native Americans, youth, and residents of rural communities. The Coordinator will also develop and maintain a state suicide prevention Internet Web site with links to appropriate resource documents, accredited/certified suicide hotlines, licensed professionals, state and local mental health agencies, and national organizations.

The Coordinator will review current research on data collection for factors related to suicide, and develop recommendations for improved surveillance systems and uniform data collection. In addition, the position will develop and submit proposals for funding from federal government agencies and nongovernmental organizations. Finally, the Coordinator would provide oversight and technical assistance to the Suicide Prevention Trainer & Networking Facilitator based in Clark County.

Suicide Prevention Trainer & Networking Facilitator

Under the oversight of the Statewide Suicide Prevention Coordinator, the Suicide Prevention Trainer & Networking Facilitator will assist in disseminating and implementing the state suicide prevention plan and program in Clark County. This position will provide suicide prevention information and training to mental health agencies, social service agencies, churches, public health clinics, school districts, law enforcement agencies, emergency medical personnel, health care providers, and various community organizations. In addition, the position will assist in developing and carrying out public awareness and media campaigns targeting Clark County groups at risk of suicide.

The Trainer & Facilitator will assist in developing a network of community-based suicide prevention programs in Clark County, including the establishment of one or more local suicide prevention advisory groups. This position will facilitate sharing information

and consensus building among multiple constituent groups in the county, including public agencies, community organizations, suicide prevention advocacy groups, mental health providers, and various representatives of the at-risk population groups.

(BDR 40--288)

2. **Urge, by drafting and adopting a resolution, governmental and nongovernmental agencies in Clark County to cooperate in establishing a Clark County suicide prevention program to provide effective and diverse suicide prevention programs for its communities. Funding for these programs should include a combination of government (federal, state, and local) and nongovernmental money. The proposed suicide prevention program would include the following:**

   - **Evidence-based programs to reduce risk factors and enhance protective factors for suicidal behavior across the life span of individuals;**
   - **Distribution of awareness and educational materials to reduce the stigma associated with suicide;**
   - **A 24-hour suicide hotline accredited or certified by a nationally recognized organization in the field of suicide prevention (and supported by a continuation and increase in the Clark County local governments' existing funding for suicide prevention programs);**
   - **Service referral for at-risk individuals;**
   - **Development of a Clark County Resource Directory and/or Internet Web site for suicide prevention and survivor assistance;**
   - **Effective and accessible suicide intervention training for gatekeepers and first responders, including school district personnel;**
   - **Media education and guideline distribution; and**
   - **Suicide survivor services.**

   (BDR R--289)

3. **Urge, by drafting and adopting a resolution, that each community in Nevada form a coalition of agencies and service providers to address suicide prevention, education, response, and treatment (adapted to community resources and needs), with the goals of reducing suicides in each community and providing survivor support. (BDR R--291)**

4. **Urge, by drafting and adopting a resolution, that the Clark County Health District: (1) plan and coordinate a public information campaign on suicide prevention; and (2) expand community injury prevention efforts and increase the corresponding financial commitment. (BDR R--290)**

RECOMMENDATIONS FOR POSSIBLE LEGISLATIVE ACTIONS OR MEASURES TO BE CONSIDERED BY OTHER LEGISLATIVE COMMITTEES

5. Draft and send a letter to the Legislative Committee on Education recommending that it consider requesting legislation requiring all public school teachers, including elementary education teachers, to complete certain courses in suicide prevention prior to license renewal. Such legislation could require that Nevada's Regional Training Programs for the Professional Development of Teachers and Administrators provide teachers and administrators with information and training specific to suicide issues, including identifying and intervening with pupils at high risk of suicide.

6. Draft and send a letter to the Legislative Committee on Education requesting that it consider requesting legislation for an appropriation of state funds to provide additional counseling positions in public middle schools and high schools, and state funds for counselors at the elementary school level.

7. Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues recommending consideration of requesting that the Governor and the Legislature approve increased funding for mental health services throughout Nevada and particularly for rural mental health agencies to provide emergency response and ongoing services to suicide survivors, those who have attempted or threatened suicide, and those determined to be at high risk for suicide.

8. Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues requesting consideration of the following recommendations from the Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition:

- **Allow more people in crisis to have access to treatment and allow first responders, police, fire, and paramedics, a timely return to service by: (1) creating a centralized drop-off location for triage with funding provided by state and local governments and area hospitals; (2) developing a mechanism for providing permanent, long-term funding to support CPI and mental health services such as increasing the tax on the sale of liquor; (3) considering changing NRS 433A.330, which requires the mentally ill to be transported to hospitals for medical screening or authorize paramedics to transport patients, who meet specific criteria, directly to a Mental Health and Developmental Services (MHDS) facility or other qualified facilities for treatment; and (4) funding mobile crisis units that can make assessments in the field and reduce the need for transporting patients to hospitals.**

- **Increase services to the seriously mentally ill in southern Nevada by (1) adding sufficient crisis observation beds and adequate staff to care for the increasing number of patients who need mental health care, including those with co-occurring disorders; (2) adding sufficient in-patient beds and staffing for treatment after patients have been assessed and stabilized at a triage facility, emergency room, or MHDS facility; (3) establishing a client data base to provide easy access to available services, track patients through various programs and prevent duplication of services; (4) providing centralized and coordinated case management and outpatient services; (5) contracting with the Program for Assertive Community Treatment to perform personalized, intensive case management; and (6) ensuring that all possible federal funding has been accessed.**

- **Establish and fund a mental health court in southern Nevada.**

The letters from the Subcommittee should also include a statement in support of providing funding for mental health courts in northern Nevada and throughout the state.

9. **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of requesting legislation to amend the statutes pertaining to minors and alcohol. Although current law makes it unlawful for a minor to be purchasing, consuming, or possessing an alcoholic beverage, testimony indicated that law enforcement cannot arrest minors who have already consumed, but are not at the time consuming, an alcoholic beverage. Amend the statutes with provisions similar to the Reno Municipal Code whereby it is unlawful for a person under the age of 21 to "be impaired to any degree by the use of an alcoholic beverage." The purpose of this amendment is to require that such minors be required to undergo evaluation and possible treatment for alcohol and/or drug abuse.**

10. **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of the recommendation from the Task Force on Emergency Room Overcrowding (also known as the CPI Task Force) and the Southern Nevada Mental Health Coalition requesting legislation to expand the civil protective custody statute (NRS 458.270) to pertain to persons with substance abuse and mental illness.**

STATEMENTS TO BE INCLUDED IN THE SUBCOMMITTEE'S FINAL REPORT

11. **Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature approve the necessary state funding to provide MHDS with the computer equipment and related software necessary to collect and analyze data regarding suicide rates for MHDS clients and their family members.**

12. **Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature support state funding for the Reno Crisis Call Center to establish, in Clark County, a service similar to its existing crisis call center and suicide prevention hotline.**

13. **Include a statement in the Subcommittee's final report recommending that the Board of Regents of the University and Community College System of Nevada (UCCSN), the UCCSN Chancellor, and the President of the University of Nevada, Las Vegas (UNLV) assist in providing university faculty, staff, and students to help coordinate and staff suicide prevention programs in Clark County.**

One possible plan would be to coordinate educational, survivor support, and crisis line services through the Psychology Department at UNLV. A faculty member could serve in a coordinating role, responsible for overseeing the various support programs and supervising graduate students who would provide direct services. Services provided by graduate students could include educational programming for gatekeepers, at-risk groups and concerned community members, support groups for survivors, and coverage for the suicide crisis line. Additionally, graduate students could recruit volunteers from the community and from the undergraduate psychology program who would be trained to provide crisis intervention services and would assist with the crisis line work. Crisis line training and coverage would be specifically developed to meet accreditation/certification requirements with a short-term goal of obtaining crisis line accreditation/certification. This plan would provide continuity of preventative and intervention services as well as provide long-term stability in the delivery of ongoing services.

14. **Include a statement in the Subcommittee's final report recommending enhancing community gatekeepers' education and training by requiring two hours of continuing education in suicide prevention, including identification, diagnosis, referral, and treatment, as a requirement for renewal of license for health care professionals.**

15. **Include a statement in the Subcommittee's final report recommending that the DHR Health Division's Emergency Medical Services Program develop a formalized education and training program in suicide prevention for emergency medical services (EMS) managers and personnel. Among other things, the program should raise awareness of EMS personnel at risk for suicide. In addition, the program should provide EMS personnel with a directory of suicide prevention agencies and programs to leave at scenes of trauma.**

16. **Include a statement in the Subcommittee's final report recommending that Nevada school districts address adolescent suicide by adherence to a theoretical framework which incorporates three levels of intervention: (1) primary intervention – when a suicide occurs; (2) secondary intervention – treatment activity with survivors, other students, parents, school personnel, and so forth; and (3) tertiary intervention – suicide prevention activities and programs.**

In addition, recommend that the school districts consider hiring additional trained professionals, including counselors, school psychologists, and social workers, to: (1) conduct assessments, implementation, follow-up, and to provide treatment (including primary, secondary, and tertiary interventions); (2) perform interventions in school settings; (3) establish relationships with parents, students, and other professionals; (4) maintain effective networks with the community; (5) address the mental health of troubled students; and (6) support the school student services staff.

17. **Include a statement in the Subcommittee's final report recognizing the importance of including substance abuse and other co-occurring disorders in a Nevada statewide suicide prevention plan. In addition, the statement should recognize that the enhancement of the delivery of co-occurring treatment and services may assist in reducing Nevada's suicide rate.**

18. **Include a statement in the Subcommittee's final report recognizing that any state suicide prevention program should address the relationship between youth suicide and the use of alcohol and drugs by minors.**

19. **Include a statement in the Subcommittee's final report supporting the work of the President's New Freedom Commission on Mental Health. Also include in the final report a summary of the Commission's findings and recommendations regarding suicide prevention.**

REPORT TO THE 72nd SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY SUICIDE PREVENTION

I. INTRODUCTION

The Legislative Commission, at its meeting on September 6, 2001, created an interim subcommittee, comprised of four Senators and four Assembly members, to study suicide prevention in Nevada.

The following legislators served on the Subcommittee:

Senator Ann O'Connell, Chairwoman
Senator Randolph J. Townsend
Senator Valerie Wiener
Senator Mark Amodei
Assemblyman David E. Humke
Assemblyman David R. Parks
Assemblywoman Sheila Leslie
Assemblywoman Debbie Smith

Legislative Counsel Bureau (LCB) staff services for the Subcommittee were provided by Donald O. Williams, Chief Principal Research Analyst, and Kennedy, Senior Research Secretary, of the Research Division; and Jan K. Needham, Principal Deputy Legislative Counsel, of the Legal Division.

The Subcommittee held a total of five meetings, including the final meeting and work session, during the course of the study. Except for a meeting held in Reno, these public hearings were conducted through simultaneous videoconferences between legislative meeting rooms at the Legislative Building in Carson City and the Grant Sawyer State Office Building in Las Vegas.

During the course of this interim study, the Subcommittee obtained extensive expert and public testimony concerning Nevada's high rate of suicide, which has been the highest rate of any state in the nation, and the need for effective suicide prevention programs. It received testimony and correspondence from concerned citizens, clergy, educators, surviving family members of suicide victims, national and local suicide prevention advocates, medical researchers, licensed health care providers, law enforcement officials, emergency and fire service personnel, retired persons, and representatives from various public health and mental health agencies. Federal, state, and local officials contributed significant information and suggestions throughout the study.

At its final meeting and work session, the Subcommittee adopted 19 recommendations, including four bill draft requests (BDRs), for consideration by the 2003 Legislature. The recommendations address the following major topics:

- Developing and Implementing a Nevada State Suicide Prevention Plan and Program;
- Improving Local Suicide Prevention Services;
- Enhancing Suicide Prevention Education and Training for Key Gatekeepers;
- Addressing Suicide Prevention in Public Schools;
- Increasing State Mental Health Services; and
- Recognizing the Relationship of Substance Abuse and Other Co-Occurring Disorders to Suicide.

In this document, the Subcommittee has attempted to present its findings and recommendations in a concise form. A great amount of data was gathered during this study, and much of the information was provided in exhibits that became part of the minutes of the Subcommittee's meetings. All supporting documents and minutes of meetings are on file with the Research Library of the LCB. Additional Subcommittee information may be available on the Nevada Legislature's Internet Web site: www.leg.state.nv.us.

The Subcommittee recognizes the important contributions made to its study by the following persons (among many others):

Linda L Flatt, Community Organizer, Suicide Prevention Action Network USA (SPAN-USA)
Misty Allen, Crisis Line Coordinator, Crisis Call Center, Reno
Cindy Marchant, Suicide Prevention Network of Douglas County, Gardnerville
Jeanne Palmer and Mike Bernstein, Health Education Department, Clark County Health District
Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health & Developmental Services
Michael J. Willden, Director, Nevada's Department of Human Resources

II. SUICIDE IN NEVADA AND THE UNITED STATES

The Subcommittee appointed by the Legislative Commission was directed to conduct a study of suicide prevention in Nevada and report its findings and recommendations. The following sections discuss the problems and issues identified by the Subcommittee.

A. PROBLEMS AND ACTIONS RELATING TO SUICIDE IN NEVADA

For many years, Nevada has ranked among the states with the highest rates of suicide and is

usually ranked first. It has consistently maintained a rate more than twice the national average.

1. Legislative Actions

Recognizing the seriousness of the state's suicide problem and the personal toll it has taken on the surviving family members, friends, and the community as a whole, the Nevada Legislature in recent sessions has attempted to address the problem. The 1999 Legislature adopted Senate Concurrent Resolution No. 11 (File No. 107, *Statutes of Nevada 1999*), which expresses the Legislature's support for community-based efforts for suicide prevention and treatment as well as programs for families and others who have lost someone to suicide. The resolution also encourages the development and promotion of related mental health services to assist persons at risk of suicide.

The 1999 Legislature also approved state funding for a statewide suicide prevention hotline. Section 18 of Senate Bill 560 (Chapter 544, *Statutes of Nevada 1999*) appropriated $200,000 over the 1999-2001 biennium from the State General Fund to Nevada's Division of Mental Health and Developmental Services (MHDS) to contract with community-based agencies to provide enhanced suicide hotline services and expanded suicide hotline services statewide. The 2001 Legislature continued this funding for hotline services by appropriating $100,000 each year of the 2001-2003 biennium under the MHDS budget.

The 2001 Legislature also considered Senate Concurrent Resolution No. 3, which would have directed the Legislative Commission to appoint an interim committee to study the problem of suicide and the feasibility of creating a statewide strategy to prevent suicide. Although S.C.R. 3 was adopted in the Senate, it was one of the measures unexpectedly delayed in the Assembly when time ran out at the end of the regular session. Recognizing that a majority of the members of both houses of the Legislature supported creating such an interim study, the Legislative Commission, at its meeting on September 6, 2001, created the interim Subcommittee to Study Suicide Prevention. The Subcommittee was given a rather broad mandate—to study suicide prevention—and was not limited to the provisions that were included in S.C.R. 3.

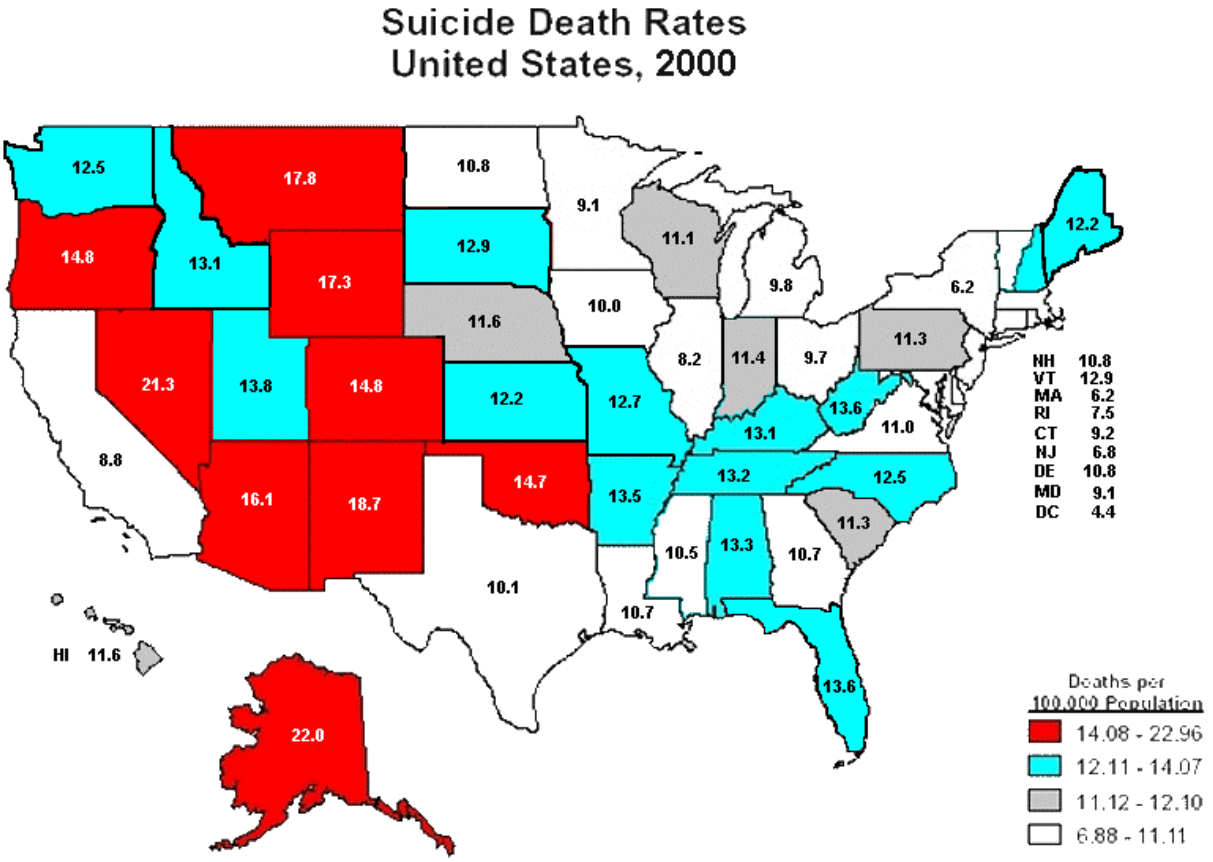
2. Problems Identified by Subcommittee

a. Nevada's High Rate of Suicide

The most recent rankings of suicide rates among the states are for 1998/1999 and 1999/2000. In 1998/1999, Nevada was reported to have a suicide rate of 22.3 per 100,000 population, the highest rate among the 50 states, as compared with the national state average rate of 10.7. In the most recent rankings (1999/2000), Nevada was reported to have a suicide rate of 21.3 per 100,000 population, second only to Alaska, as compared with the national average rate of 10.7.[1]

[1] "Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2000," by American Association of Suicidology, September 21, 2002, suicide state data page: 2000. (*Including the District of Columbia.)

Figure 1
Suicide Prevention Action Network USA



During its interim study, the Subcommittee discovered that the national and state research indicates Nevada's high rate of suicide is evident among all age groups and socio-economic populations in the state, including youth, elderly men, Native Americans, and residents of rural communities. This same research consistently has found that the vast majority of suicide victims are residents of Nevada and **not** tourists.

At its meeting in Las Vegas on November 9, 2001, the Subcommittee received a presentation of suicide statistics from a lead researcher of the federally funded suicide prevention research center based in Las Vegas. John Fildes, M.D., Chief of the Division of Trauma and Critical Care in the Department of Surgery at the University of Nevada School of Medicine in Las Vegas, made the presentation. He is also Co-Investigator of the Suicide Prevention Research Center, which is funded by the federal Centers for Disease Control and Prevention to study suicide in the intermountain western states.

Dr. Fildes presented the Subcommittee with the following suicide statistics and related information:

- For many years, Nevada has had the highest rate of suicide in the nation. Rate is defined as the number of suicides per 100,000 population. During the years of 1994 through 1998, Nevada's suicide rate averaged 21.8 per 100,000 population, while the national average rate was 10.8. Theories that Nevada's access to gambling may account for the high percentage rate are discounted because New Jersey (the second oldest state with legalized gambling) has one of the lowest suicide rates.

- Eight of the top ten suicide rated states are located in the intermountain West and have been in the top ten for the past 15 to 20 years, demonstrating that Nevada's neighboring states share high suicide rates as well. It is not clear why western states tend to have higher suicide rates.

- Unique features of the intermountain western states include a high Native American population, rural settings, lack of access to health care issues, population densities, different health care and mental heath care programming, and a cultural overlay (the personality of individuals in the intermountain west may be different).

- The leading causes of death in Nevada include (highest ranked first): (1) heart disease; (2) cancer; (3) pulmonary disease; (4) stroke; and (5) suicide. There are more suicide deaths than deaths from diabetes, motor vehicle crashes, liver disease, kidney disease, and infection. Nevada has twice as many suicides as homicides and Human Immunodeficiency Virus (HIV)-related deaths. There are four times as many suicides as deaths from Alzheimer's disease.

- Methods of completed suicides in Nevada include (highest ranked first): (1) firearms; (2) ingestions/poisoning; and (3) suffocation or asphyxiation. Firearms are the main method of suicide for youth and the elderly. Most suicide victims in the general population were male and used firearms.

- Information on suicide deaths is distilled from death certificates and vital statistics records. Suicides rates by ethnicity for the past five years are (highest ranked first): (1) Native American at 24.2; (2) White (includes Mexican and Puerto Rican) at 22.8; (3) Black at 13.7; and (4) Asian at 9.8.

- The total population of individuals who completed suicide as stratified by age indicates persons in their 20s, 30s, and 40s have the highest occurrence of suicides;

- The total population of individuals who completed suicide as stratified by age indicates that the phenomenon predominates in men. The rate of suicide for men aged 60 through 80 years is astronomically high considering the fewer numbers of individuals in this age category due to death by natural causes;

- The rate of suicide deaths by counties in Nevada shows that smaller counties by population (such as White Pine, Esmeralda, and Eureka) had higher rates than larger counties (Clark and Washoe).

- Statistics indicate that Nevada is not a "destination state" for suicides. In 1995, there were 435 suicides and the majority of the death certificates listed Nevada as the state of residency. In 1995, there were 50 deaths by suicide of non-Nevadans (of those 50 victims, 66 percent died in Clark County and 14 percent died in Washoe County). Additionally, 90 percent of completed suicides in Las Vegas had death certificates that listed that city as the victim's registered residency (Reno had 89 percent).

See Appendix A for more recent suicide statistics presented in an updated report (December 2002) from Dr. Fildes and the Suicide Prevention Research Center.

b. Inadequate State and Local Programs

The Subcommittee reviewed the existing state and local programs relating to suicide prevention and discovered that they do not adequately address the state's high suicide rate. Although some services are provided through the facilities and programs of the Division of MHDS and various private and other public health care institutions, many of these services are focused on persons after they have attempted suicide and not on prevention prior to an incident.

At the first meeting of the Subcommittee, representatives of the Clark County Health District, the Nevada Public Health Foundation, and the Suicide Prevention Action Network USA (SPAN-USA) presented strong evidence of the need for state, local, and private sector involvement to address the lack of effective suicide prevention programs in Nevada, particularly in Clark County. Later in the course of the interim study, the Clark County Health District compiled and submitted a report that concludes, among other things, that there is a lack of coordination of the existing suicide prevention resources in Clark County. (See Appendix B, "An Initial Assessment of Suicide Prevention Resources and Services in Clark County.")

Throughout the study, the Subcommittee received testimony and correspondence concerning the need to provide increased mental health services statewide and particularly in Clark County and the rural counties. Testimony supported the need for increased mental health beds in Clark County to address the county's significant population of mentally ill homeless. Further testimony emphasized the need to provide additional state resources to fund mental health courts, establish mobile mental health crisis units, support rural mental health clinics, and provide treatment for persons with substance abuse and other co-occurring disorders. At two of the Subcommittee's meetings, there was extensive testimony concerning the relationship of suicide to substance abuse and other co-occurring disorders (dual diagnosis including various addictions and forms of mental illness).

At its meeting on February 1, 2002, the Subcommittee heard presentations from representatives of the clergy, law enforcement, emergency medical services, and fire service personnel regarding their education and training programs in suicide prevention and intervention. In addition, representatives of various health and mental health professional licensing boards in Nevada presented an overview of their education and training requirements in suicide prevention, intervention, and treatment. At its Reno meeting on March 22, 2002, a representative of the State Department of Education (SDOE) presented information on the current licensing requirements for Nevada teachers. Based on all these presentations, the Subcommittee concluded that these key professions are not currently receiving adequate education or training relating to suicide.

The Subcommittee's meetings on November 9, 2001, and March 22, 2002, included testimony regarding suicide prevention programs in Nevada's public schools. Representatives of the SDOE and the school districts in Clark and Washoe Counties testified on the current programs and services to pupils under their jurisdiction.

An education consultant with the SDOE admitted the need to improve suicide prevention programs in Nevada's schools. He briefed the Subcommittee on the results of the SDOE *Nevada Youth Risk Behavior Survey* (YRBS) administered to the middle and high school populations in the previous year. The consultant noted the following survey results for high school students: (1) nearly 30 percent of students experienced depression over a two week period which caused them to cease normal activity; (2) nearly 20 percent of students have seriously considered attempting suicide; (3) 16.4 percent of students have made a suicide plan; (4) nearly 11 percent of students attempted suicide one or more times; (5) nearly 4 percent of students that attempted suicide required medical intervention for injury, poisoning, or overdose; and (6) data can be cross-referenced to additional surveys to determine patterns with co-occurring conditions. The YRBS survey establishes a pattern within the school population, but it does not allow for intervention because the survey respondents are anonymous.

In his further testimony, the SDOE consultant revealed that there are very few references to suicide in the state's new Health Content Standards in health and physical education classes. He stated that the current requirements for suicide prevention education include the following: (1) pupils at grade 5 must define suicide and depression; (2) pupils at grade 5 must also explain the steps in obtaining assistance for a friend or family member who shows the warning signs of suicide; (3) pupils at grade 8 must list the warning signs of suicide; and (4) pupils at grade 12 must explain the steps in obtaining assistance for a friend or family member who shows the warning signs of suicide.

Representatives of the Clark County School District discussed their crisis response teams and other services to deal with suicide incidences and pupils at risk of suicide. A representative of the Washoe County School District noted that suicide prevention is an important part of the district's curriculum but that school personnel need additional information and training on suicide prevention. Based on the testimony from these school

district representatives and the SDOE staff, the Subcommittee concluded that school personnel need better education and training in suicide prevention and intervention. In addition, the Subcommittee recognized that the schools at all grade levels need additional staff resources -- particularly school counselors, school social workers, and school psychologists.

To illustrate the tragedy of suicide among Nevada's pupil population, selected newspaper articles relating to the recent suicide deaths of three children (one in Clark County, one in Douglas County, and one in Virginia City) are included in Appendix C.

In addition to receiving testimony about suicide among Nevada teenagers, almost every Subcommittee meeting included comments from senior citizens who pointed out the need for the state to address the high rate of suicide among the elderly population. At the Subcommittee's Reno meeting, two professors from the University of Nevada, Reno (UNR) presented evidence of a high rate of suicide in Nevada's rural counties and the need for the state to develop a suicide strategy that recognizes the unique culture of the rural communities. The prevalence of suicide attempts among Nevada's young Latinos, particularly Latinas, was described by another UNR professor and later by a school social worker. A mental health administrator for the Indian Health Services in Reno testified on the high rate of suicide among Native Americans (Indians) in Nevada, and he recommended the development of a statewide suicide prevention program with a significant focus on the Native American population.

Despite hearing much testimony about the inadequacy of existing services and programs, the Subcommittee received extensive information on two existing suicide prevention programs in Nevada that it judged to be good. One is the Crisis Call Center in Reno, which serves all of Nevada through its statewide suicide prevention hotline that is funded through the Division of MHDS. The Reno Crisis Call Center operates Nevada's only suicide prevention hotline certified by the American Association of Suicidology (AAS). The second program is the Yellow Ribbon Program in Douglas County, a community-based suicide prevention program coordinated by the Suicide Prevention Network of Douglas County. The Subcommittee decided that these and other model program elements should be incorporated into a statewide suicide prevention program

B. THE NATIONAL STRATEGY FOR SUICIDE PREVENTION

In recent years, there has been increased attention focused on suicide prevention at the national level. David Satcher, M.D., Ph.D., former Surgeon General of the United States, led the Federal Government's efforts to make America aware that suicide is a serious public health problem. The Surgeon General's national strategy has been adopted by many states and implemented through the development of state suicide prevention plans.

At the beginning of the interim study, Senator O'Connell, Chairwoman of the Subcommittee, asked the Subcommittee members and staff to review three important national reports relating to suicide prevention in the United States.

The first report is *The Surgeon General's Call to Action to Prevent Suicide 1999*. This is the Surgeon General's report that introduces a blueprint for addressing suicide—Awareness, Intervention, and Methodology, or AIM—an approach derived from a jointly sponsored national conference on suicide prevention convened in Reno in October of 1998.

The second report is *Suicide Prevention: Prevention Effectiveness and Evaluation*, a document released in 2001 by the Suicide Prevention Advocacy (Action) Network (SPAN-USA). The SPAN publication presents the organization's plan or visual model of its mission, and it explains important suicide prevention and evaluation concepts.

Finally, the third report, also released in 2001, is the Surgeon General's detailed plan following up on his 1999 report. It is *National Strategy for Suicide Prevention: Goals and Objectives for Action*, which recognizes suicide as a major public health problem and presents a national suicide prevention strategy with 11 goals and their related objectives for action. To make it easier to reference these goals, the *Summary* of this report was available to the Subcommittee members and the public at each Subcommittee meeting. The Surgeon General's goals (see Figure 2) served as the starting point of the Subcommittee's study of how best to address suicide prevention in Nevada.

Figure 2

National Strategy for Suicide Prevention: Goals and Objectives for Action
The Goals of the U.S. Surgeon General

1. Promote awareness that suicide is a public heath problem that is preventable;
2. Develop broad-based supports for suicide prevention;
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services;
4. Develop and implement suicide prevention programs;
5. Promote efforts to reduce access to lethal means and methods of self-harm;
6. Implement training for recognition of at-risk behavior and delivery of effective treatment;
7. Develop and promote effective clinical and professional practices;
8. Improve access to and community linkages with mental health and substance abuse services;
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media;
10. Promote and support research on suicide and suicide prevention; and
11. Improve and Expand Surveillance Systems [2]

[2] *National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. Department of Health and Human Services, Public Health Service, Rockville, Maryland, 2001, pp. 15-16.

At the Subcommittee's first meeting, Nevada's United States Senator Harry Reid, then the Assistant Majority Leader of the Senate, made (via videotape) a presentation outlining the suicide legislation in Congress (Senate Resolution 84, 105th Cong. [1997]), and his involvement with prioritizing suicide high on a national scale. Senator Reid mentioned the importance of the Surgeon General's national strategy, and he advocated the use of more education and suicide prevention programs on state and federal levels.

In Las Vegas on May 24, 2002, representatives of the National Conference of State Legislatures, SPAN-USA, the American Association of Suicidology, and the National Hopeline Network (1-800-SUICIDE) presented the Subcommittee with information on state suicide prevention plans and programs in other states. The founders of SPAN-USA testified concerning their efforts in developing the Georgia Suicide Prevention Plan, and they noted that many state plans, including Georgia's plan, incorporate the goals and objectives of the Surgeon General's national strategy. Appendix D contains "The Georgia Suicide Prevention Plan."

According to Davis C. Hayden, Ph.D., with the Psychology Department of Western Washington University, there are 18 states that have suicide prevention plans and all the remaining states are in the process of developing or considering developing such plans. The states identified by Dr. Hayden with existing plans include Colorado, Kansas, Louisiana, Maine, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Virginia, Washington, and Wisconsin.[3]

III. SUBCOMMITTEE RECOMMENDATIONS

At its final meeting and work session on August 16, 2002, the Subcommittee adopted 19 recommendations under the topics of developing a state suicide prevention plan, improving local suicide prevention services, enhancing education and training for gatekeepers, addressing suicide prevention in the public schools, increasing state mental health services, and recognizing the relationship between suicide and co-occurring disorders. These proposals, which include four BDRs, are submitted for consideration by the 2003 Legislature. Appendix F contains the list of BDRs.

Organized by topic headings, the following sections of the report discuss the Subcommittee's recommendations.

[3] *State Plans for Suicide Prevention Web Page* (http://www.ac.wwu.edu/~hayden/spsp/right.html), by Davis C. Hayden, Ph.D., Psychology Department, Western Washington University, Bellingham, Washington, January 18, 2003.

A. NEVADA STATE SUICIDE PREVENTION PLAN AND PROGRAM

The Subcommittee spent a great amount of time and effort studying Nevada's suicide problem, particularly existing suicide prevention efforts in the state as compared with programs in other states and at the national level. As a result of the study, the Subcommittee concluded that suicide is one of the Nevada's most serious public health problems and, therefore, requires a comprehensive and statewide approach

Throughout the course of the study, mental health experts and citizens recommended that Nevada develop a State Suicide Prevention Plan and appoint personnel to develop and implement the plan. Suicide prevention advocates and various surviving family members suggested that Nevada's plan be modeled after existing state plans in Georgia and several other states, which incorporate goals from the United States Surgeon General's 2001 report, *National Strategy for Suicide Prevention: Goals and Objectives for Action*. See Appendix D, "The Georgia Suicide Prevention Plan."

The Subcommittee developed the position that Nevada should create a state plan that focuses primarily on the Surgeon General's goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who are the first contacts with individuals at risk of suicide. With the approval of the other Subcommittee members, Chairwoman O'Connell submitted a detailed proposal to Governor Kenny C. Guinn and the Director of the Department of Human Resources (DHR) to develop a state suicide prevention plan and program. Based on the cost estimates prepared by DHR fiscal staff, the program would cost $192,252 in Fiscal Year (FY) 2003-2004 and $170,426 in FY 2004-2005.

At its work session, the Subcommittee adopted the following recommendation, which reflects the proposal previously submitted to Governor Guinn and the DHR, to develop a state suicide prevention plan and establish a statewide program:

> **Draft and enact legislation requiring the development of a Nevada State Suicide Prevention Plan and establishing a Statewide Suicide Prevention Program within the Director's Office of Nevada's Department of Human Resources (DHR). The purpose of the state plan/program is to reduce the number of attempted and completed suicides in Nevada. The state plan should address the risk factors related to suicide and identify populations most at risk, and it should be distributed statewide and made available to the public not later than January 3, 2005.**
>
> **The State Suicide Prevention Plan shall be modeled after existing state plans in Georgia and several other states, which incorporate goals from the United States Surgeon General's 2001 report, *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Nevada's state plan should focus on the Surgeon General's goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who are the first contacts with individuals at risk of suicide.**

The Statewide Suicide Prevention Program will include the establishment and funding of two personnel positions to develop and implement suicide prevention programs in Nevada. One position would be the Statewide Suicide Prevention Coordinator based in the Director's Office of DHR in Carson City, and the other position would be a Suicide Prevention Trainer & Networking Facilitator based in the office of a government or nonprofit agency in Clark County. Funding for these positions may depend on a combination of government (federal, state, and local) and nongovernmental money. The Governor is urged to include this program as part of the DHR budget, and the Legislature is urged to approve a budget to support the program.

The Director of DHR shall be required to submit a copy of the state plan and a report on the program to the Governor and the Director of the Legislative Counsel Bureau (for distribution to the Legislature) on or before January 3, 2005.

Statewide Suicide Prevention Coordinator

Under the direction of the Director of DHR, the Statewide Suicide Prevention Coordinator will be responsible for developing, disseminating, and implementing a statewide suicide awareness and prevention plan and program throughout Nevada, including public education activities, gatekeeper training, and enhancement of crisis services. The Coordinator will conduct suicide prevention public awareness and media campaigns in all 17 Nevada counties, beginning first in Clark County.

Furthermore, the Coordinator will link suicide assessment and intervention trainers to schools, community centers, nursing homes, and other facilities serving persons most at risk of suicide. The position will coordinate the establishment of local advisory groups in each county to offer additional support to the program's efforts. Working with suicide prevention advocacy groups, community coalitions, managers of existing nationally accredited/certified crisis hotlines, and staff of mental health agencies in the state, the Coordinator will identify and address the barriers that interfere with providing services to at-risk groups, such as the elderly, Native Americans, youth, and residents of rural communities. The Coordinator will also develop and maintain a state suicide prevention Internet Web site with links to appropriate resource documents, accredited/certified suicide hotlines, licensed professionals, state and local mental health agencies, and national organizations.

The Coordinator will review current research on data collection for factors related to suicide, and develop recommendations for improved surveillance systems and uniform data collection. In addition, the position will develop and submit proposals for funding from federal government agencies and nongovernmental organizations. Finally, the Coordinator would provide oversight and technical assistance to the Suicide Prevention Trainer & Networking Facilitator based in Clark County.

Suicide Prevention Trainer & Networking Facilitator

Under the oversight of the Statewide Suicide Prevention Coordinator, the Suicide Prevention Trainer & Networking Facilitator will assist in disseminating and implementing the state suicide prevention plan and program in Clark County. This position will provide suicide prevention information and training to mental health agencies, social service agencies, churches, public health clinics, school districts, law enforcement agencies, emergency medical personnel, health care providers, and various community organizations. In addition, the position will assist in developing and carrying out public awareness and media campaigns targeting Clark County groups at risk of suicide.

The Trainer & Facilitator will assist in developing a network of community-based suicide prevention programs in Clark County, including the establishment of one or more local suicide prevention advisory groups. This position will facilitate sharing information and consensus building among multiple constituent groups in the county, including public agencies, community organizations, suicide prevention advocacy groups, mental health providers, and various representatives of the at-risk population groups.

(BDR 40--288)

B. LOCAL SUICIDE PREVENTION SERVICES

During the course of its study, the Subcommittee discovered that there is not a coordinated community suicide prevention program in Clark County. In addition, there is not a locally-based crisis center or suicide prevention hotline that is accredited or certified by a nationally recognized organization in the field of suicide prevention. Finally, there is a serious need in Clark County for a comprehensive suicide prevention program that includes a public awareness campaign, a community resource directory, and the delivery of appropriate services. Appendix B contains a memo, dated July 23, 2002, from Mike Bernstein, Health Educator II with the Clark County Health District, with an attachment, "An Initial Assessment of Suicide Prevention Resources and Services in Clark County."

Based on these findings, the Subcommittee voted unanimously to:

Urge, by drafting and adopting a resolution, governmental and nongovernmental agencies in Clark County to cooperate in establishing a Clark County suicide prevention program to provide effective and diverse suicide prevention programs for its communities. Funding for these programs should include a combination of government (federal, state, and local) and nongovernmental money. The proposed suicide prevention program would include the following:

- **Evidence-based programs to reduce risk factors and enhance protective factors for suicidal behavior across the life span of individuals;**

- **Distribution of awareness and educational materials to reduce the stigma associated with suicide;**

- **A 24-hour suicide hotline accredited or certified by a nationally recognized organization in the field of suicide prevention (and supported by a continuation and increase in the Clark County local governments' existing funding for suicide prevention programs);**

- **Service referral for at-risk individuals;**

- **Development of a Clark County Resource Directory and/or Internet Web site for suicide prevention and survivor assistance;**

- **Effective and accessible suicide intervention training for gatekeepers and first responders, including school district personnel;**

- **Media education and guideline distribution; and**

- **Suicide survivor services.**

(BDR R--289)

Representatives of the Clark County Health District testified at the Subcommittee's meetings on November 9, 2001, and May 24, 2002. They revealed that suicide prevention is one of the District's top priorities, and they recommended that the District be involved in public awareness campaigns and other suicide prevention efforts. In response to these recommendations, the Subcommittee voted in the affirmative to:

> **Urge, by drafting and adopting a resolution, that the Clark County Health District: (1) plan and coordinate a public information campaign on suicide prevention; and (2) expand community injury prevention efforts and increase the corresponding financial commitment. (BDR R--290)**

The Subcommittee discovered that there is a lack of public awareness of the seriousness of the suicide problem and a lack of coordination and communication between existing private and public agencies, particularly in communities in Clark County and many of the rural counties. To address this problem, the Subcommittee voted unanimously to:

> **Urge, by drafting and adopting a resolution, that each community in Nevada form a coalition of agencies and service providers to address suicide prevention, education, response, and treatment (adapted to community resources and needs), with the goals of reducing suicides in each community and providing survivor support. (BDR R--291)**

C. SUICIDE PREVENTION EDUCATION AND TRAINING FOR KEY GATEKEEPERS

The U.S. Surgeon General has identified the key gatekeepers in suicide prevention as those people who regularly come into contact with individuals or families in distress. Some examples of key gatekeepers are clergy, police officers, emergency medical personnel, primary health care providers, mental health professionals, and school personnel. Goal 6 in the Surgeon General's *National Strategy for Suicide Prevention: Goals and Objectives for Action* is to "Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment." At its meeting on February 1, 2002, the Subcommittee learned that most of the licensed health professions in Nevada have not received training to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment.

In response to the need for educating and training health professionals in suicide prevention, the Subcommittee voted unanimously to:

> **Include a statement in the Subcommittee's final report recommending enhancing community gatekeepers' education and training by requiring two hours of continuing education in suicide prevention, including identification, diagnosis, referral, and treatment, as a requirement for renewal of license for health care professionals.**

At its meetings on February 1 and May 24, 2002, the Subcommittee learned that emergency medical services (EMS) personnel play an important role in dealing with suicide victims and their families. However, the Subcommittee also learned that these key gatekeepers are not adequately trained to deal with suicide cases. In response, the Subcommittee adopted the following recommendation:

> **Include a statement in the Subcommittee's final report recommending that the DHR Health Division's Emergency Medical Services Program develop a formalized education and training program in suicide prevention for emergency medical services (EMS) managers and personnel. Among other things, the program should raise awareness of EMS personnel at risk for suicide. In addition, the program should provide EMS personnel with a directory of suicide prevention agencies and programs to leave at scenes of trauma.**

D. SUICIDE PREVENTION IN PUBLIC SCHOOLS

Although the Surgeon General has identified teachers and other educational staff as key gatekeepers in suicide prevention, the Subcommittee learned that teachers and other school personnel in Nevada currently are not receiving training to recognize pupils at risk of suicide and are not being trained in the appropriate interventions for suicidal persons. To address this situation, the Subcommittee voted to:

Draft and send a letter to the Legislative Committee on Education recommending that it consider requesting legislation requiring all public school teachers, including elementary education teachers, to complete certain courses in suicide prevention prior to license renewal. Such legislation could require that Nevada's Regional Training Programs for the Professional Development of Teachers and Administrators provide teachers and administrators with information and training specific to suicide issues, including identifying and intervening with pupils at high risk of suicide.

At its meeting in Las Vegas on May 24, 2002, the Subcommittee learned that more funding is needed for counseling positions in Nevada's public schools because the current ratios of students to counselors are 400 to 1 in high school and 500 to 1 in middle school. Testimony also indicated that there are no state funds for counselors at the elementary school level. Furthermore, the testimony noted the important role of school counselors regarding suicide prevention, intervention, and treatment. In response to this testimony, the Subcommittee voted to:

Draft and send a letter to the Legislative Committee on Education requesting that it consider requesting legislation for an appropriation of state funds to provide additional counseling positions in public middle schools and high schools, and state funds for counselors at the elementary school level.

At the meeting in Reno on March 22, 2002, a school social worker who directs a family resource center presented the Subcommittee with a model for adolescent suicide prevention. She suggested that all Nevada school districts be encouraged to adopt this model, which is partly based on a program used in the Washoe County School District. The Subcommittee agreed with this suggestion and adopted the following recommendation:

Include a statement in the Subcommittee's final report recommending that Nevada school districts address adolescent suicide by adherence to a theoretical framework which incorporates three levels of intervention: (1) primary intervention – when a suicide occurs; (2) secondary intervention – treatment activity with survivors, other students, parents, school personnel, and so forth; and (3) tertiary intervention – suicide prevention activities and programs.

In addition, recommend that the school districts consider hiring additional trained professionals, including counselors, school psychologists, and social workers, to: (1) conduct assessments, implementation, follow-up, and to provide treatment (including primary, secondary, and tertiary interventions); (2) perform interventions in school settings; (3) establish relationships with parents, students, and other professionals; (4) maintain effective networks with the community; (5) address the mental health of troubled students; and (6) support the school student services staff.

E. STATE SUPPORT FOR SUICIDE PREVENTION AND MENTAL HEALTH SERVICES

Throughout the study, the Subcommittee heard various witnesses testify regarding the need to increase the availability of mental health services statewide. There was a particular emphasis on the need to increase funding for rural mental health clinics and for additional mental health beds in Clark County.

Recognizing the relationship of mental health services to suicide prevention, the Subcommittee voted in the affirmative to:

> **Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues recommending consideration of requesting that the Governor and the Legislature approve increased funding for mental health services throughout Nevada and particularly for rural mental health agencies to provide emergency response and ongoing services to suicide survivors, those who have attempted or threatened suicide, and those determined to be at high risk for suicide.**

At the Subcommittee's meeting in Las Vegas on May 24, 2002, representatives of the Las Vegas Metropolitan Police Department (Metro) testified concerning the serious need for additional mental health beds to deal with the mentally ill homeless population in Clark County. Following up on this testimony, the Metro budget staff submitted specific recommendations developed by the Task Force on Emergency Room Overcrowding (also know as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition. Recognizing that this issue should be brought to the attention of the appropriate ongoing statutory committees, the Subcommittee voted in the affirmative to:

> **Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues requesting consideration of the following recommendations from the Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition:**
>
> - **Allow more people in crisis to have access to treatment and allow first responders, police, fire, and paramedics, a timely return to service by: (1) creating a centralized drop-off location for triage with funding provided by state and local governments and area hospitals; (2) developing a mechanism for providing permanent, long-term funding to support CPI and mental health services such as increasing the tax on the sale of liquor; (3) considering changing NRS 433A.330, which requires the mentally ill to be transported to hospitals for medical screening or authorize paramedics to transport patients, who meet specific criteria, directly to a MHDS facility or other qualified facilities for treatment; and (4) funding mobile crisis units that can make**

assessments in the field and reduce the need for transporting patients to hospitals.

- **Increase services to the seriously mentally ill in southern Nevada by (1) adding sufficient crisis observation beds and adequate staff to care for the increasing number of patients who need mental health care, including those with co-occurring disorders; (2) adding sufficient in-patient beds and staffing for treatment after patients have been assessed and stabilized at a triage facility, emergency room, or MHDS facility; (3) establishing a client data base to provide easy access to available services, track patients through various programs and prevent duplication of services; (4) providing centralized and coordinated case management and outpatient services; (5) contracting with the Program for Assertive Community Treatment to perform personalized, intensive case management; and (6) ensuring that all possible federal funding has been accessed.**

- **Establish and fund a mental health court in southern Nevada.**

The letters from the Subcommittee should also include a statement in support of providing funding for mental health courts in northern Nevada and throughout the state.

At the Subcommittee's meeting in Reno on March 22, 2002, testimony indicated that the Division of MHDS is not collecting data to determine the number of its clients who have recovered from suicidal ideations versus the number who later completed suicide. Testimony also indicated that data is not gathered on the incidence of suicide among family members of MHDS clients. Carlos Brandenburg, Ph.D., Administrator of the Division of MHDS, stated that his Division needs upgraded computer technology in order to collect vital suicide statistics. In response to this information, the Subcommittee voted to:

Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature approve the necessary state funding to provide Nevada's Division of Mental Health and Developmental Services (MHDS) with the computer equipment and related software necessary to collect and analyze data regarding suicide rates for MHDS clients and their family members.

The Reno Crisis Call Center is the only nationally certified crisis center in Nevada, and it also operates the statewide suicide prevention hotline. Although the statewide hotline currently serves residents in Clark County, the Reno Crisis Call Center recognizes the need to expand its services to include a crisis call center actually located in Clark County. In response to a suggestions made by suicide prevention advocates, the Subcommittee agreed to:

Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature support state funding for the Reno Crisis Call Center to establish, in Clark County, a service similar to its existing crisis call center and suicide prevention hotline.

To meet the needs of providing suicide prevention services in Clark County, the Clark County Community Organizer for SPAN-USA and a representative of the Psychology Department at the University of Nevada, Las Vegas (UNLV) advised the Subcommittee that they had discussed arranging for psychology faculty and students to assist in providing suicide prevention services in Clark County. Although the Psychology Department at UNLV was the only department to develop a specific proposal in cooperation with SPAN-USA, the Subcommittee recognized that other departments at UNLV, such as counseling and social work, may also be interested in developing a proposal to provide suicide prevention services in the community. In response to suggestions made by suicide prevention advocates, the Subcommittee agreed to:

Include a statement in the Subcommittee's final report recommending that the Board of Regents of the University and Community College System of Nevada (UCCSN), the UCCSN Chancellor, and the President of the University of Nevada, Las Vegas (UNLV) assist in providing university faculty, staff, and students to help coordinate and staff suicide prevention programs in Clark County.

One possible plan would be to coordinate educational, survivor support, and crisis line services through the Psychology Department at UNLV. A faculty member could serve in a coordinating role, responsible for overseeing the various support programs and supervising graduate students who would provide direct services. Services provided by graduate students could include educational programming for gatekeepers, at-risk groups and concerned community members, support groups for survivors, and coverage for the suicide crisis line. Additionally, graduate students could recruit volunteers from the community and from the undergraduate psychology program who would be trained to provide crisis intervention services and would assist with the crisis line work. Crisis line training and coverage would be specifically developed to meet accreditation/certification requirements with a short-term goal of obtaining crisis line accreditation/certification. This plan would provide continuity of preventative and intervention services as well as provide long-term stability in the delivery of ongoing services.

In recognition of the efforts of President George W. Bush's Commission on Mental Health, Senator Townsend, a member of the Commission, and Chairwoman O'Connell suggested that the Subcommittee support the work of the Commission, particularly any of its recommendations concerning suicide prevention. The Subcommittee voted to:

Include a statement in the Subcommittee's final report supporting the work of the President's New Freedom Commission on Mental Health. Also include in the final report a summary of the Commission's findings and recommendations regarding suicide prevention.

Appendix E contains the Suicide Prevention Subcommittee's draft report, including findings and policy options, of the President's New Freedom Commission on Mental Health.[4]

F. SUBSTANCE ABUSE AND OTHER CO-OCCURRING DISORDERS

At the Subcommittee's meeting on March 22, 2002, a representative of Mothers Against Drunk Driving (MADD) presented research suggesting that teenagers who abuse drugs or alcohol are more likely to progress from thinking of suicide to actually attempting suicide. Stating that Nevada has an extremely high alcohol usage rate among its youth, she recommended legislation to close a loophole in the current statute regarding alcohol use and possession by minors. In response to this concern, the Subcommittee voted in the affirmative to:

> **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of requesting legislation to amend the statutes pertaining to minors and alcohol. Although current law makes it unlawful for a minor to be purchasing, consuming, or possessing an alcoholic beverage, testimony indicated that law enforcement cannot arrest minors who have already consumed, but are not at the time consuming, an alcoholic beverage. Amend the statutes with provisions similar to the Reno Municipal Code whereby it is unlawful for a person under the age of 21 to "be impaired to any degree by the use of an alcoholic beverage." The purpose of this amendment is to require that such minors be required to undergo evaluation and possible treatment for alcohol and/or drug abuse.**

As previously stated, representatives of Metro testified about the serious need for additional mental health beds to deal with the mentally ill homeless population in Clark County and submitted recommendations developed by the Task Force on Emergency Room Overcrowding (also known as CPI Task Force) and the Southern Nevada Mental Health Coalition. One of those recommendations was to expand the civil protective statute from its existing provisions concerning persons with alcohol abuse to add provisions for persons with substance abuse and mental illness. Because the Subcommittee decided that this issue should be referred to the Standing Committees on Judiciary, it voted in the affirmative to:

> **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of the recommendation from the Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition requesting legislation to expand the civil protective custody statute (NRS 458.270) to pertain to persons with substance abuse and mental illness.**

At its meetings on March 22 and May 24, 2002, the Subcommittee heard extensive testimony concerning the link between suicide and substance abuse and other co-occurring disorders. The

[4] "An Outline for the Draft Report of the Subcommittee on Suicide Prevention," President's New Freedom Commission on Mental Health, December 3, 2002.

testimony indicated that suicide prevention plans and programs should address this link. In response to these expressed concerns, the Subcommittee voted in the affirmative to:

> **Include a statement in the Subcommittee's final report recognizing the importance of including substance abuse and other co-occurring disorders in a Nevada statewide suicide prevention plan. In addition, the statement should recognize that the enhancement of the delivery of co-occurring treatment and services may assist in reducing Nevada's suicide rate.**

As previously mentioned, a representative of MADD presented the Subcommittee with references to research suggesting that teenagers who abuse drugs or alcohol are more likely to progress from thinking of suicide to actually attempting suicide. To further address this issue, the Subcommittee voted in the affirmative to:

> **Include a statement in the Subcommittee's final report recognizing that any state suicide prevention program should address the relationship between youth suicide and the use of alcohol and drugs by minors.**

IV. SELECTED REFERENCES AND RESOURCES

Publications

"An Initial Assessment of Suicide Prevention Resources and Services in Clark County," by Mike Bernstein, Health Educator II, Clark County Health District, July 23, 2002.

"An Outline for the Draft Report of the Subcommittee on Suicide Prevention," President's New Freedom Committee on Mental Health, December 3, 2002.

The Surgeon General's Call to Action to Prevent Suicide 1999, published by the Department of Health and Human Services, United States Public Health Service, Washington, D.C., 1999.

Suicide Prevention – Prevention Effectiveness and Evaluation, published by the Suicide Prevention Advocacy Network (SPAN) USA, Inc., Atlanta, Georgia, 2001.

National Strategy For Suicide Prevention: Goals and Objectives for Action, published by the U.S. Department of Health and Human Services, Public Health Service, Rockville, MD, 2001.

"Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2000," published by the American Association of Suicidology, Washington, D.C., September 21, 2002.

"New Freedom Commission on Mental Health: Preventing Suicide and Reducing the Burden of Suicidal Behaviors," by Eric D. Caine, M.D., John Romano Professor of Psychiatry, and Kerry L. Knox, Ph.D., Assistant Professor of Community and Preventive Medicine, and of Psychiatry, Center for the Study and Prevention of Suicide, Department of Psychiatry, University of Rochester Medical Center, Rochester, New York, 2002.

"Effects of Exercise Training on Older Patients With Major Depression," reprinted from the *Archives of Internal Medicine*, October 25, 1999, Volume 159, Copyright 1999, American Medical Association, presented by Glen Martin, Volunteer, Retired Senior Volunteer Program, and Member/Representative, American Association of Retired Persons, Carson City, Nevada.

"Suicide in Nevada's Hinterlands: A Cultural Perspective," by Marie I. Boutté, Ph.D., Department of Anthropology, University of Nevada, Reno, Nevada. Manuscript published in *Disease and Medical Care in the Mountain West: Essays on Region, History, and Practice*. Edited by Martha L. Hildreth and Bruce T. Moran. University of Nevada Press, 1998.

State Plans for Suicide Prevention Web Page (http://www.ac.wwu.edu/~hayden/spsp/right.html), by Davis C. Hayden, Ph.D., Psychology Department, Western Washington University, Bellingham, Washington, January 18, 2003

"Violent Acts of Sadness: The Tragedy of Youth Suicide," by Julie Thomerson, ***State Legislatures***, National Conference of State Legislatures, May 2002, pages 30-34.

Reducing Suicide: A National Imperative, SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney, editors. Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health, Institute of Medicine, published by National Academy Press, Washington, D.C., 2002.

"Substance Use and the Risk of Suicide Among Youths," The National Household Survey on Drug Abuse (NHSDA) Report, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, July 12, 2002.

"The Georgia Suicide Prevention Plan," prepared by Julie W. Chambliss, Ph.D., Suicide Prevention Advocacy Network (SPAN), Marietta, Georgia, June 30, 2001.

Organizations and Contact Persons

Linda L. Flatt, Nevada Community Organizer, Suicide Prevention Action Network USA (SPAN-USA), Henderson, Nevada. Internet Web site: http://survivingsuicide.com.

Suicide Prevention Research Center, Las Vegas, Nevada (702-671-2338).

SPAN-USA. Internet Web site: www.spanusa.org.

Misty Allen, Crisis Line Coordinator, Crisis Call Center, Reno, Nevada (1-877-885-HOPE [4673]). Internet Web site: www.crisiscallcenter.org.

American Foundation for Suicide Prevention. Internet Web site: www.afsp.org.

American Foundation for Suicide Prevention Nevada Chapter. Internet Web site: www.afspnv.org.

Sue Eastgard, Director, Washington State Youth Suicide Prevention Program. Internet Web site: www.yspp.org.

Yellow Ribbon Suicide Prevention Program. Internet Web site: www.yellowribbon.org.

American Association of Suicidology. Internet Web site: www.suicidology.org.

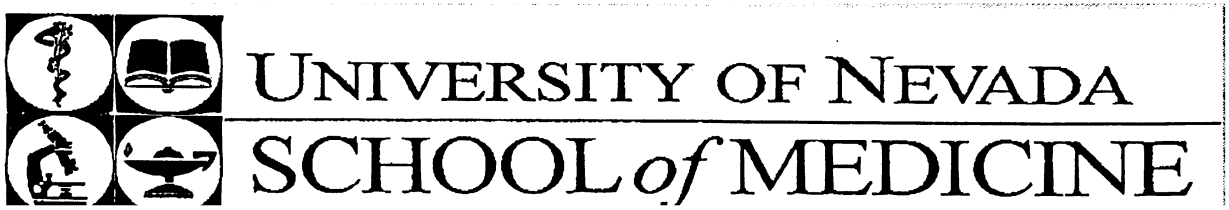
Marian Thomas, Trauma Intervention Programs (TIP) of Southern Nevada, Las Vegas (702-459-1055). Internet Web site: www.tipnational.org.

Reese Butler, Executive Director, Kristin Brooks Hope Center, and Administrator, The National Hopeline Network 1-800-SUICIDE, Purcellville, Virginia. Internet Web site: www.hopeline.com.

V. APPENDICES

APPENDIX A

"Update of the Report of the Suicide Prevention Research Center to the State of Nevada's Legislative Commission's Subcommittee to Study Suicide Prevention"



December 2002

Suicide Rates per 100,000 Population in the USA 1995-2000

(Top Three, Bottom Three and National Avg.)

Data obtained from CDC WISQARS interactive database

	Crude Rates
• Nevada	22.9
• Montana	19.6
• Alaska	19.4
• **National average**	**11.3**
• New York	7.1
• New Jersey	7.1
• District of Columbia	6.5

States with the Highest Suicide Rates 1995 -2000

Data obtained from CDC WISQARS interactive database

	Crude Rates
1. Nevada	22.9
2. Montana	19.6
3. Alaska	19.4
4. Wyoming	18.5
5. New Mexico	18.0
6. Arizona	16.8
7. Colorado	15.9
8. Oregon	15.7
9. Idaho	15.3
10. South Dakota	14.8

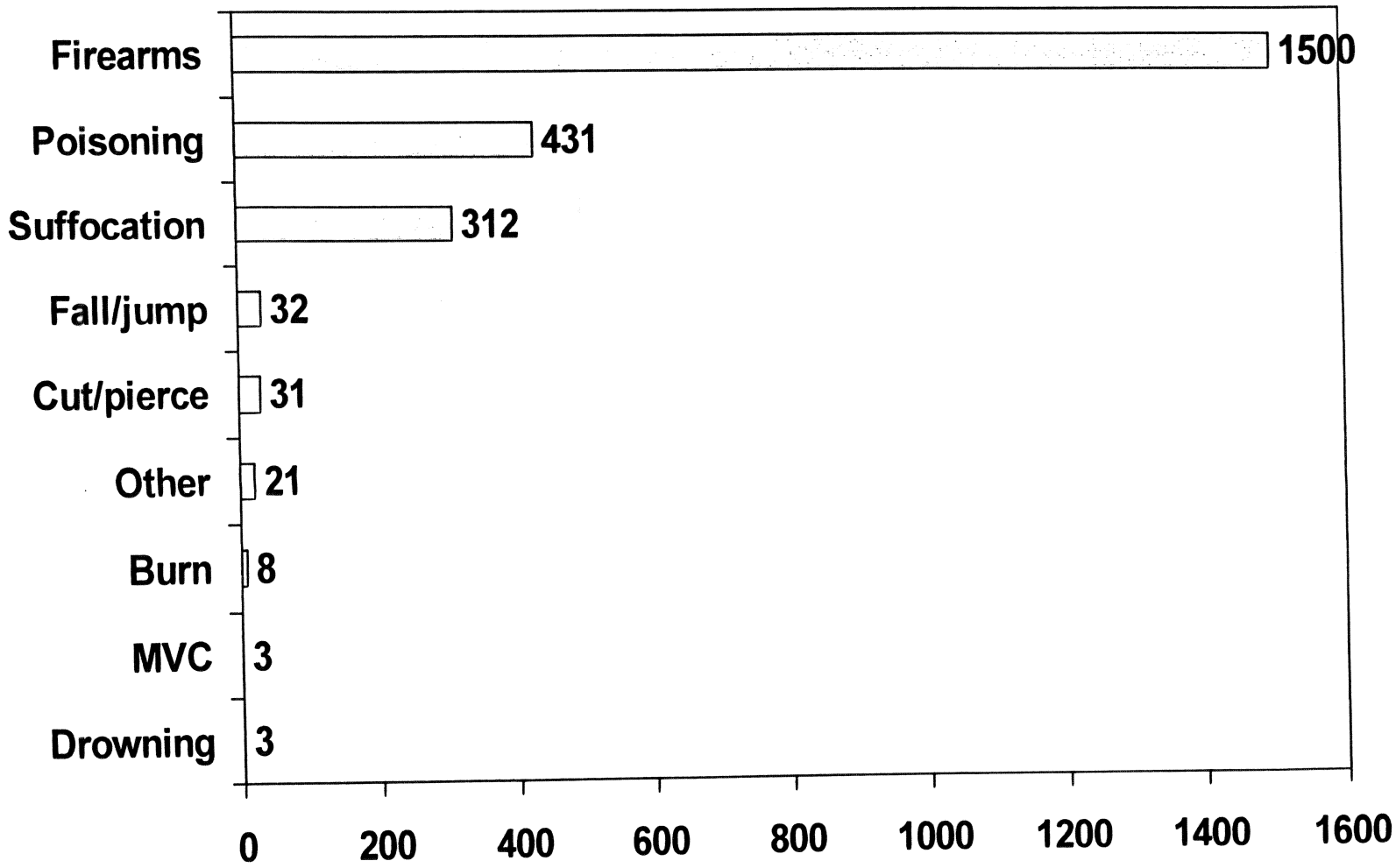
Leading Causes of Death in Nevada 1995-2000

Data obtained from CDC WISQARS interactive database

• Heart Disease	23,978
• Cancer	20,189
• Pulmonary Disease	7,716
• Stroke	4,870
• **Suicide**	**2,342**
• Motor Vehicle	1,917
• Diabetes	1,535
• Liver Disease	1,509
• Kidney Disease	1,496
• Sepsis	1,405
• Homicide	1,026
• Alzheimer's	768
• HIV	698

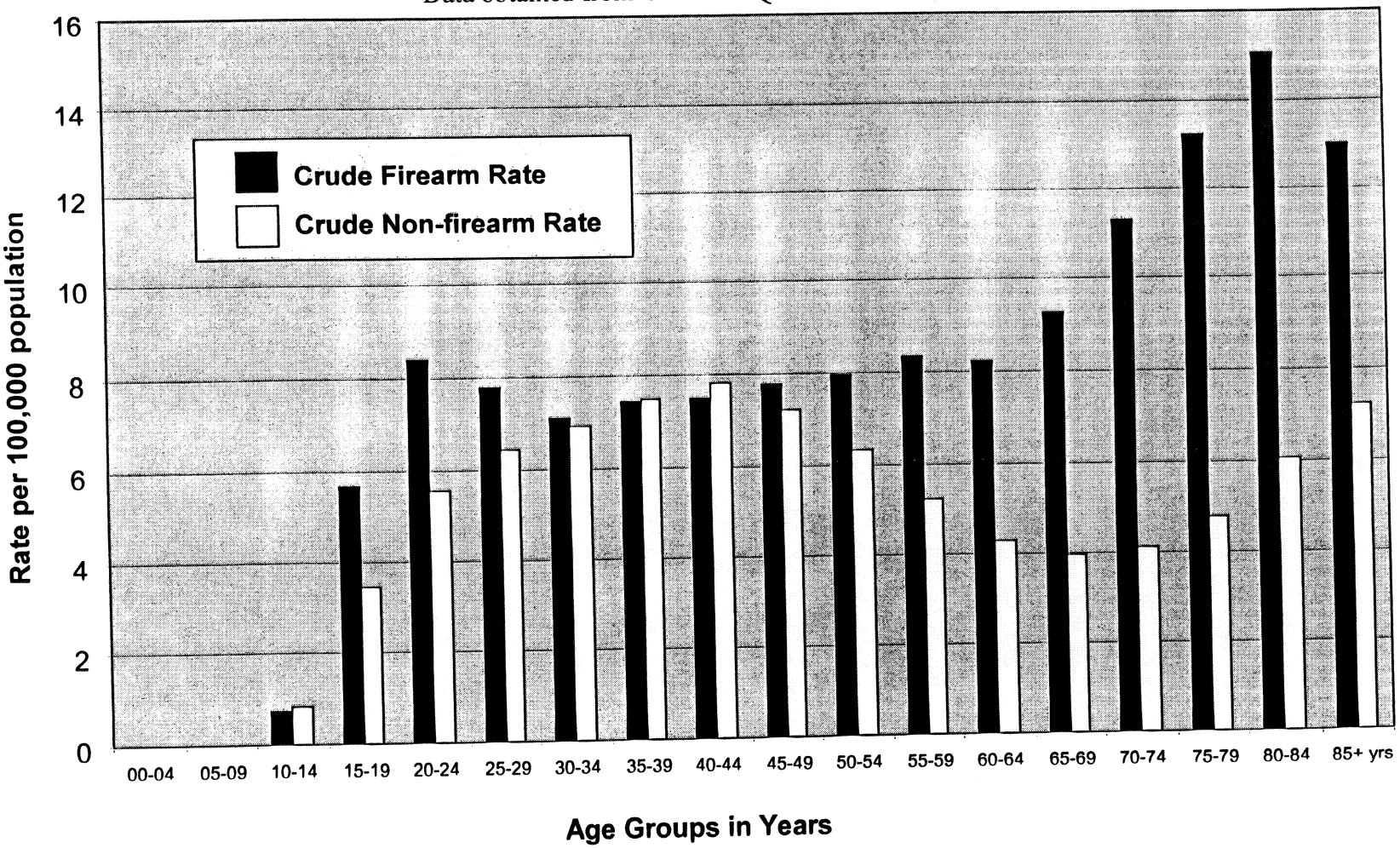
Nevada Suicides by Cause of Death 1995-2000

Data obtained from CDC WISQARS interactive database



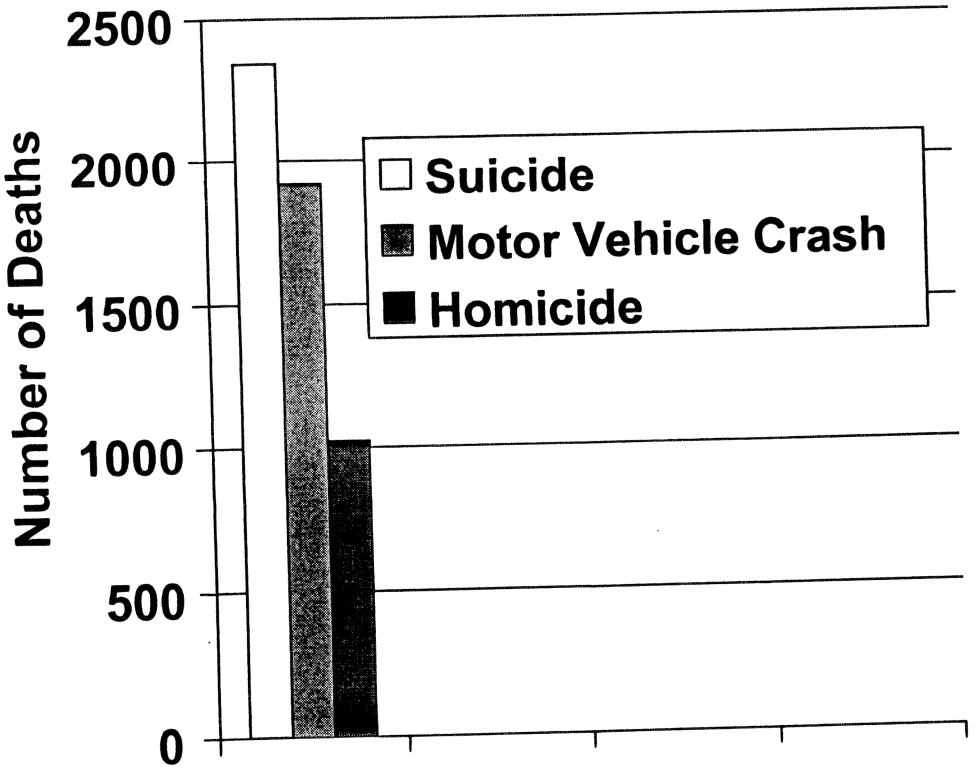
Firearm and Non-Firearm Suicide Death Rates by Age, US, 1995-2000

Data obtained from CDC WISQARS interactive database



Injury Related Deaths in Nevada 1995-2000

1995-2000 Data obtained from CDC WISQARS interactive database

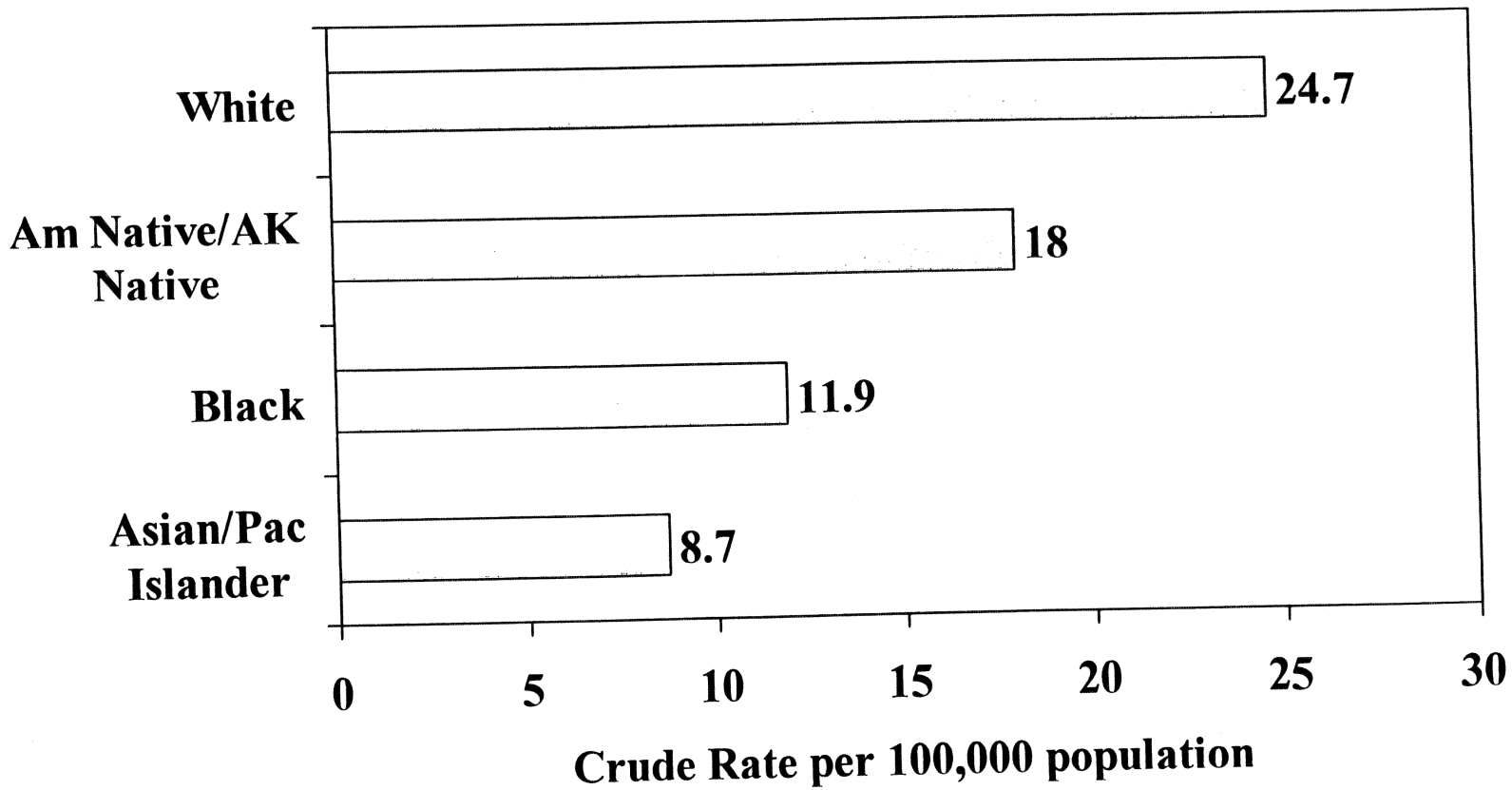


During 1995-2000, Nevada suicides outnumbered motor vehicle related deaths by 384.

This situation is found in only four other states (Alaska, Washington, New Hampshire and Hawaii)

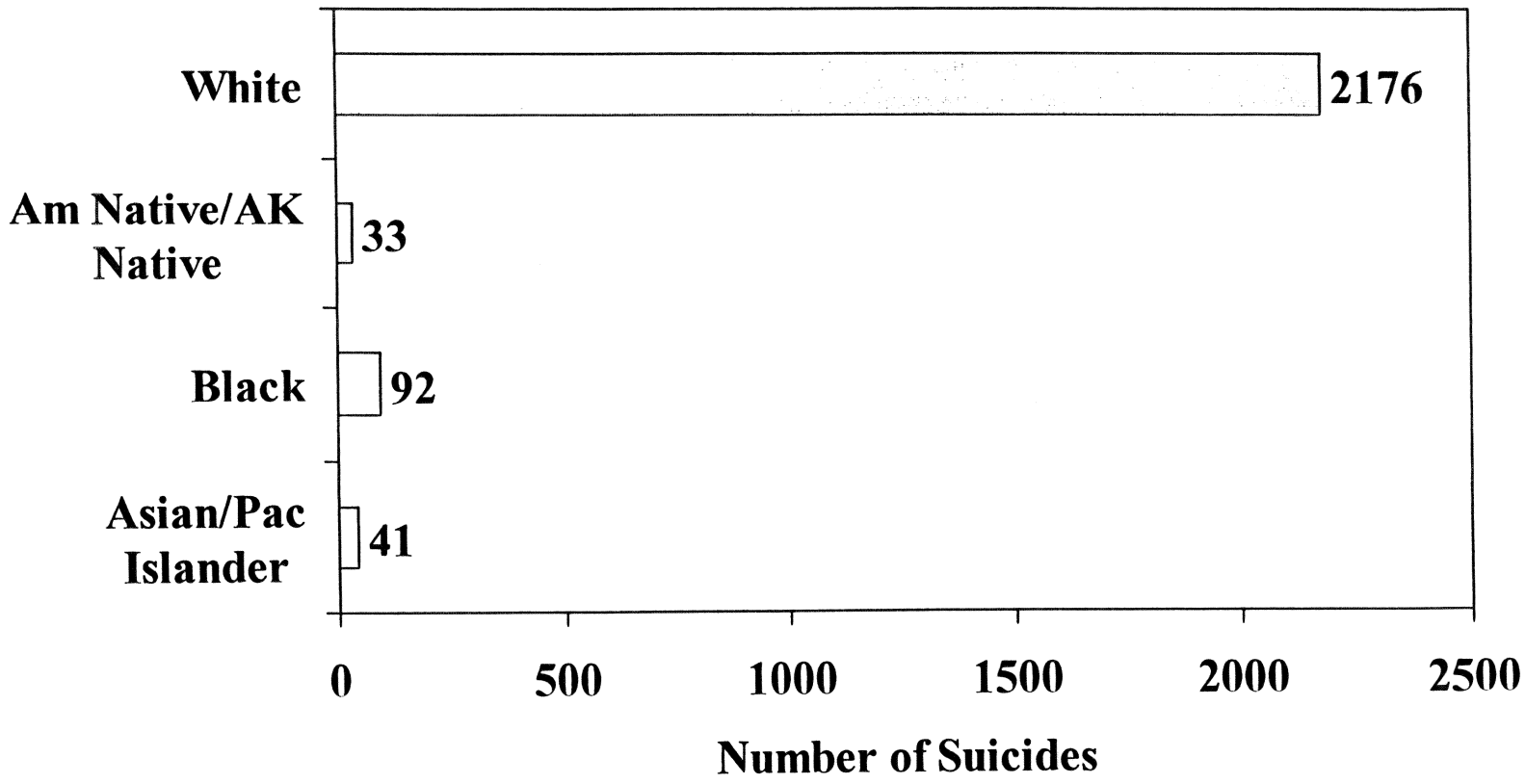
Nevada Suicide Rates by Race/Ethnicity 1995-2000

Data obtained from CDC WISQARS interactive database



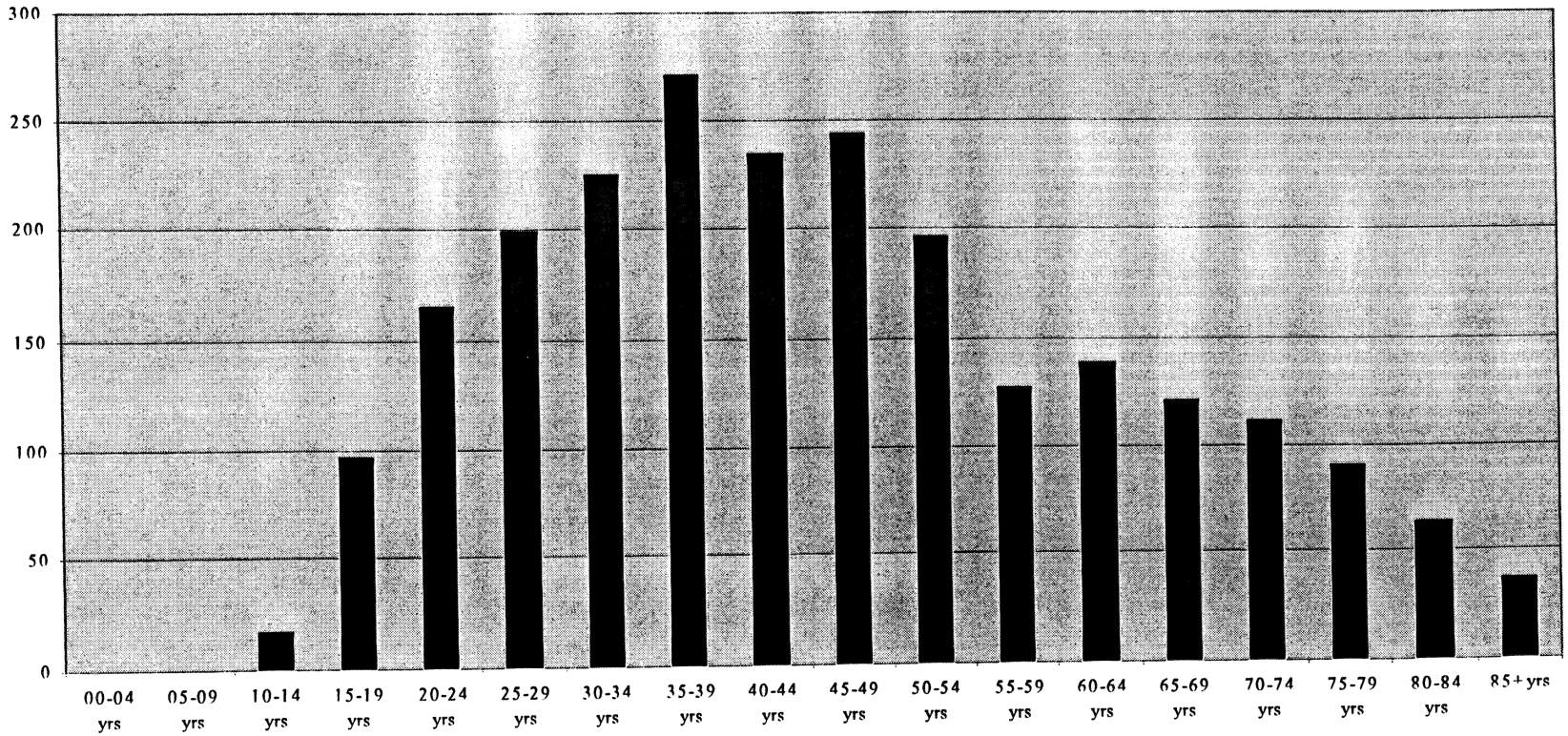
Nevada Suicides by Race/Ethnicity 1995-2000

Data obtained from CDC WISQARS interactive database



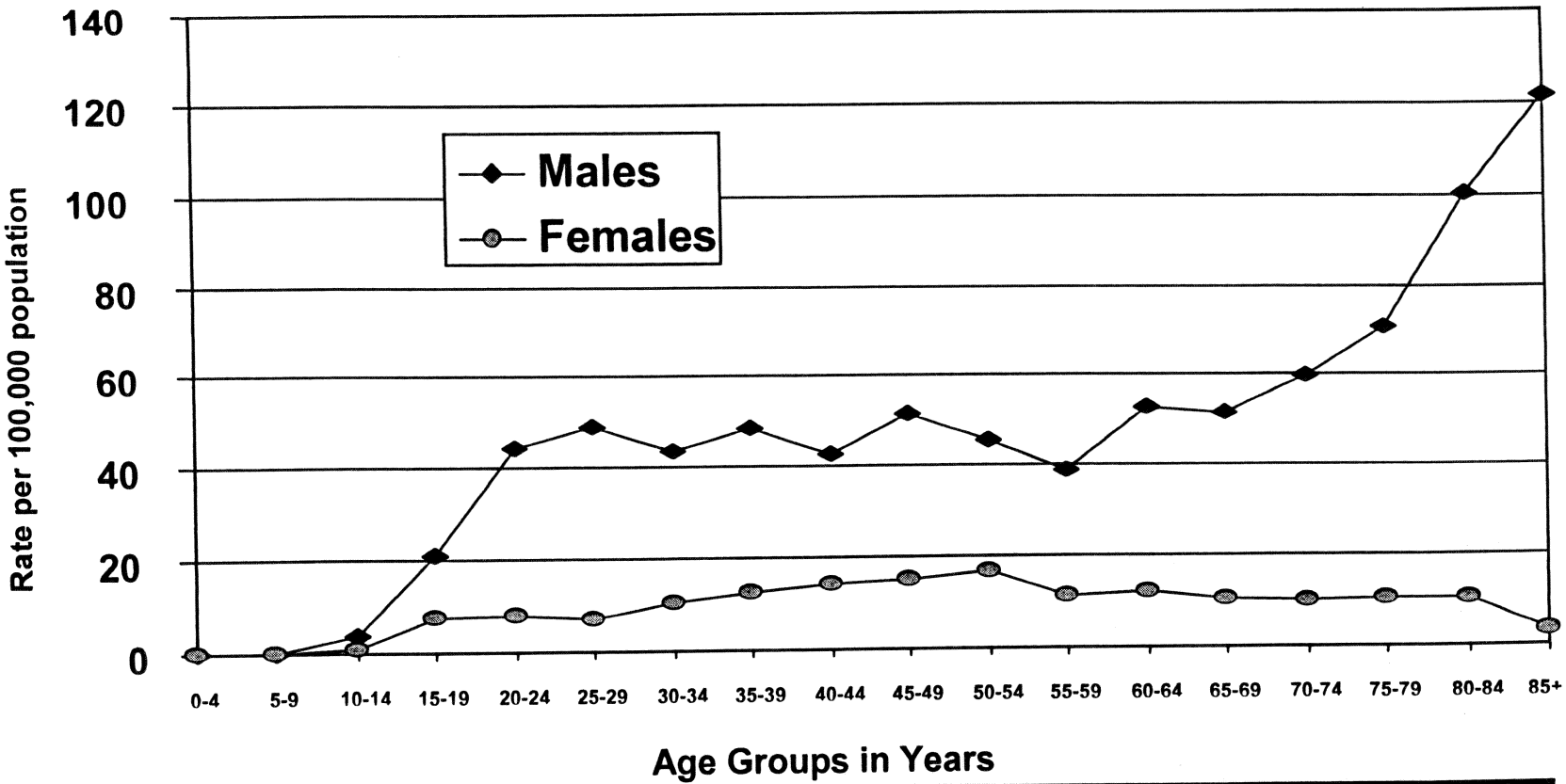
Age Breakdown of Nevada Suicides for 1995-2000

Data obtained from CDC WISQARS interactive database



Nevada Suicide Death Rates, by Age and Gender, 1995-2000

Data obtained from CDC WISQARS interactive database

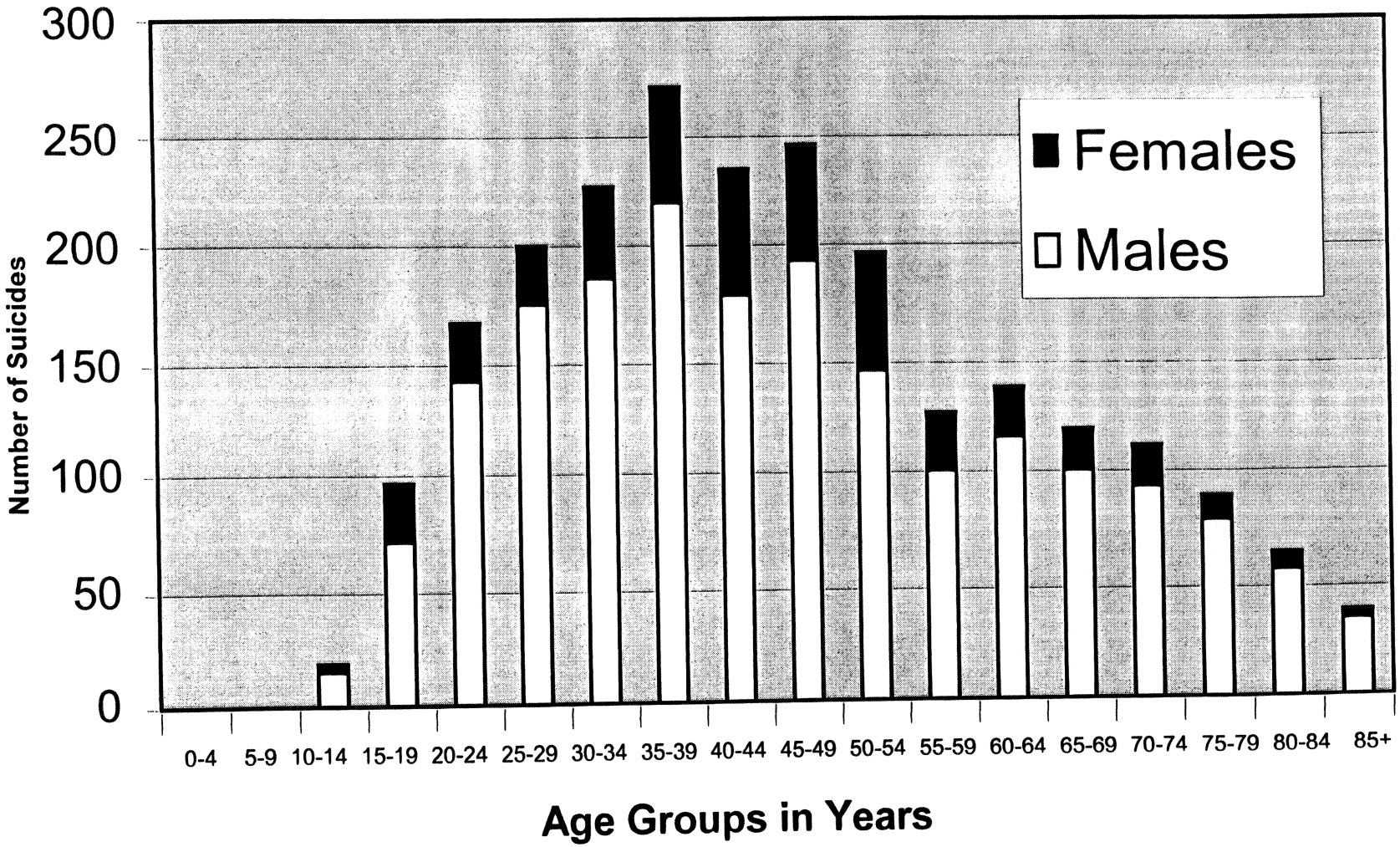


Actual Number of Suicides 1995-2000

	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Male	0	0	14	72	141	175	184	218	179	191	146	100	113	100	94	77	55	34
Females	0	0	3	25	24	24	41	53	56	53	50	27	25	20	17	13	8	2

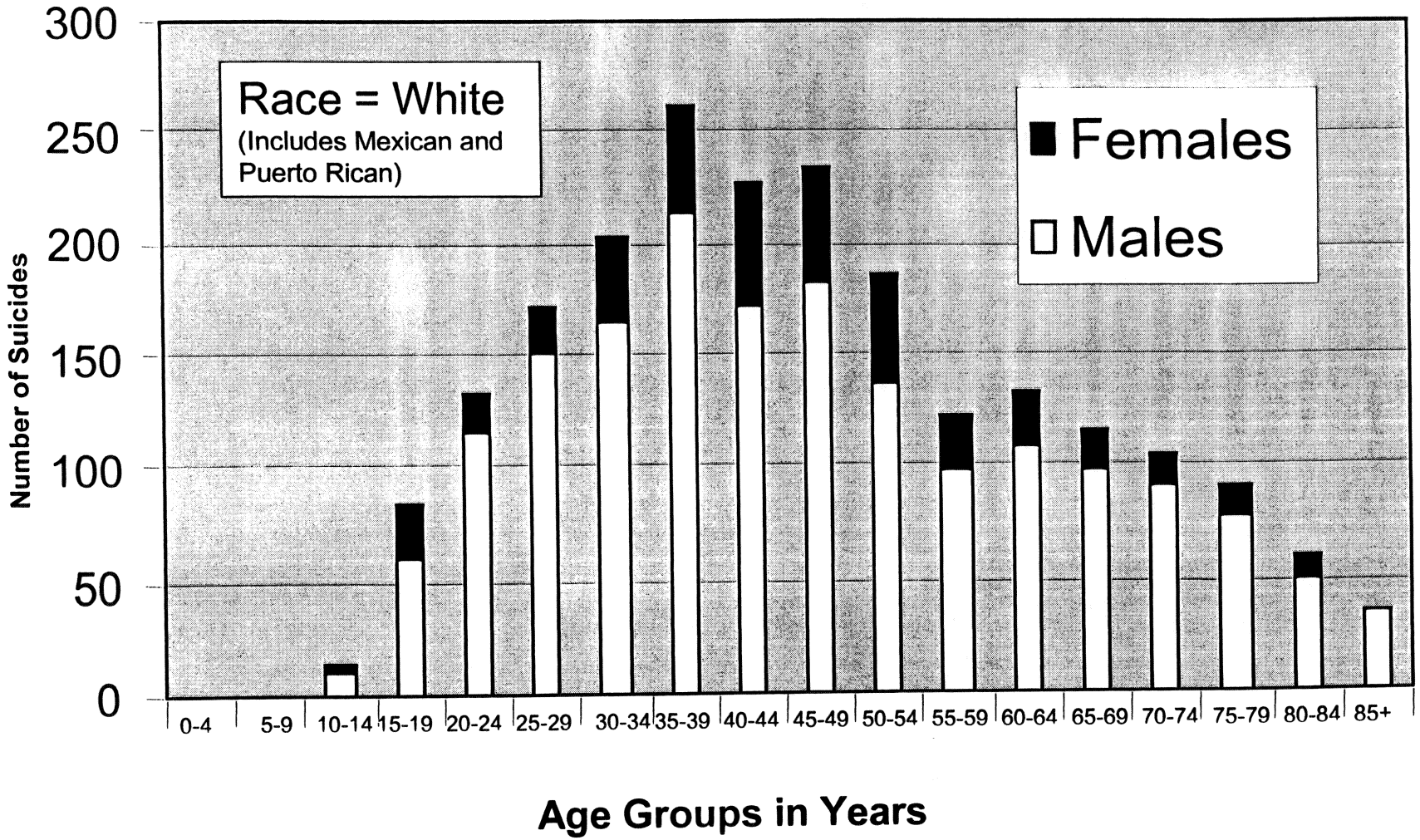
Age and Gender Distribution for Nevada Suicides for 1995-2000

Data obtained from CDC WISQARS interactive database



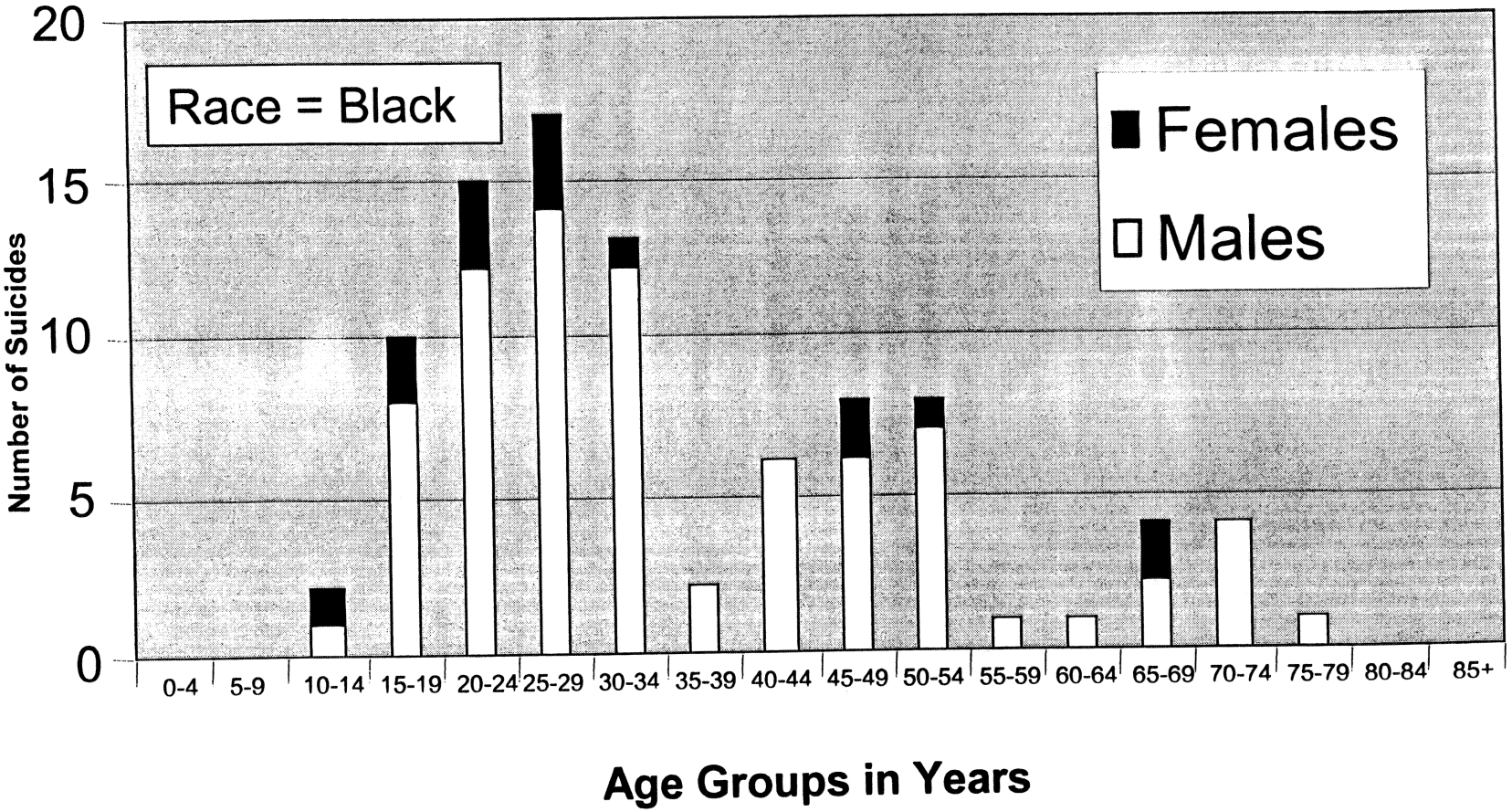
Age and Gender Distribution by Race for Nevada Suicides for 1995-2000

Data obtained from CDC WISQARS interactive database



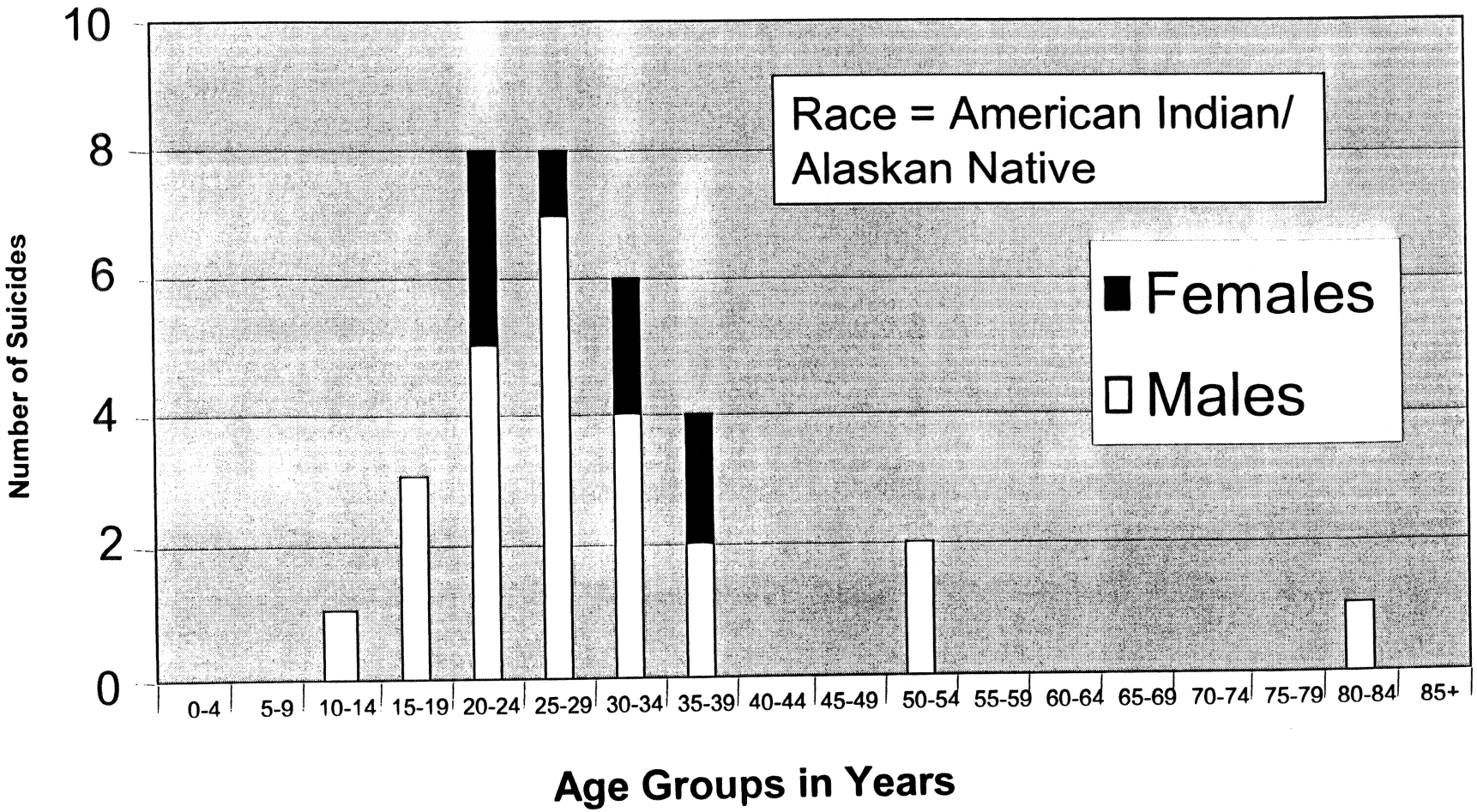
Age and Gender Distribution by Race for Nevada Suicides for 1995-2000

Data obtained from CDC WISQARS interactive database



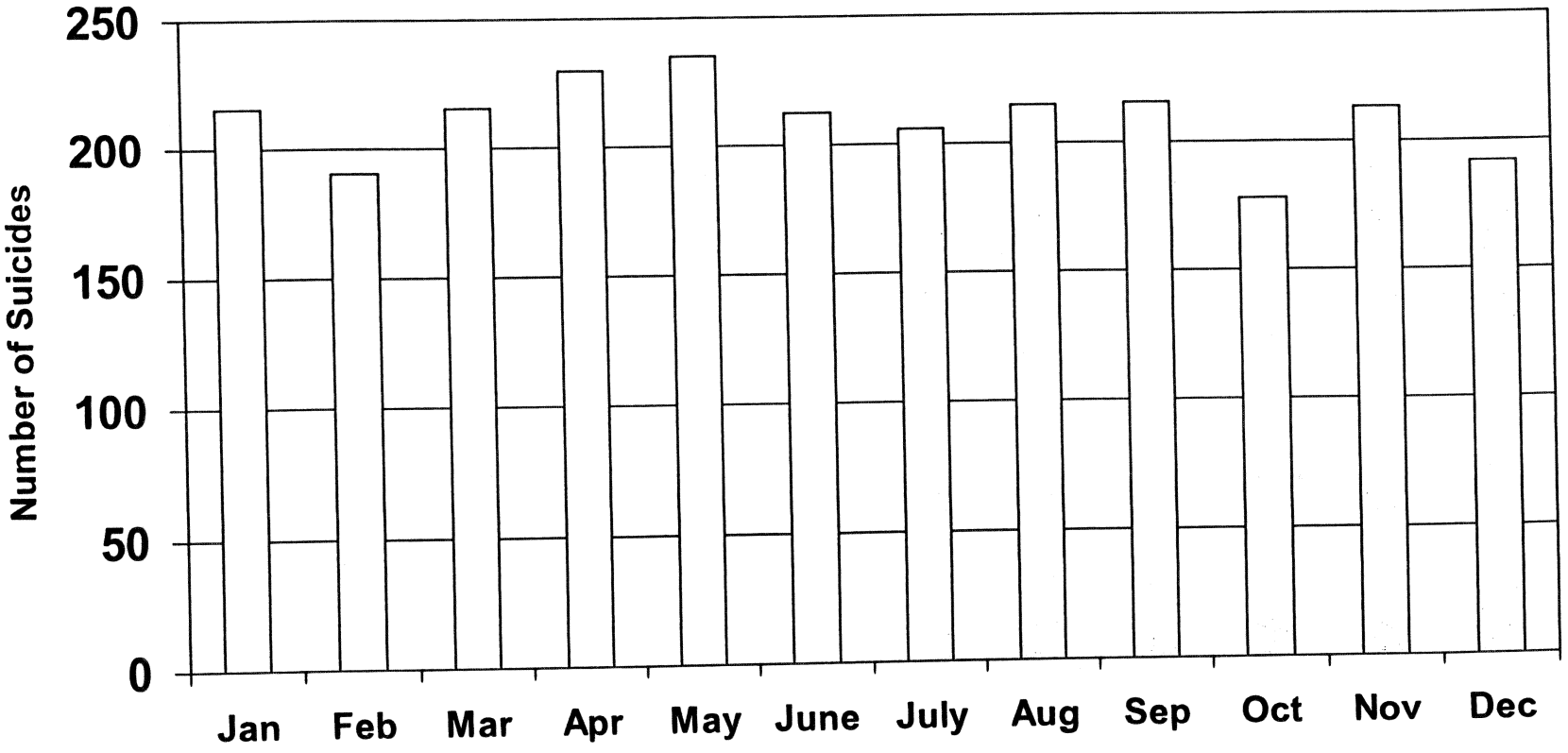
Age and Gender Distribution by Race for Nevada Suicides for 1995-2000

Data obtained from CDC WISQARS interactive database



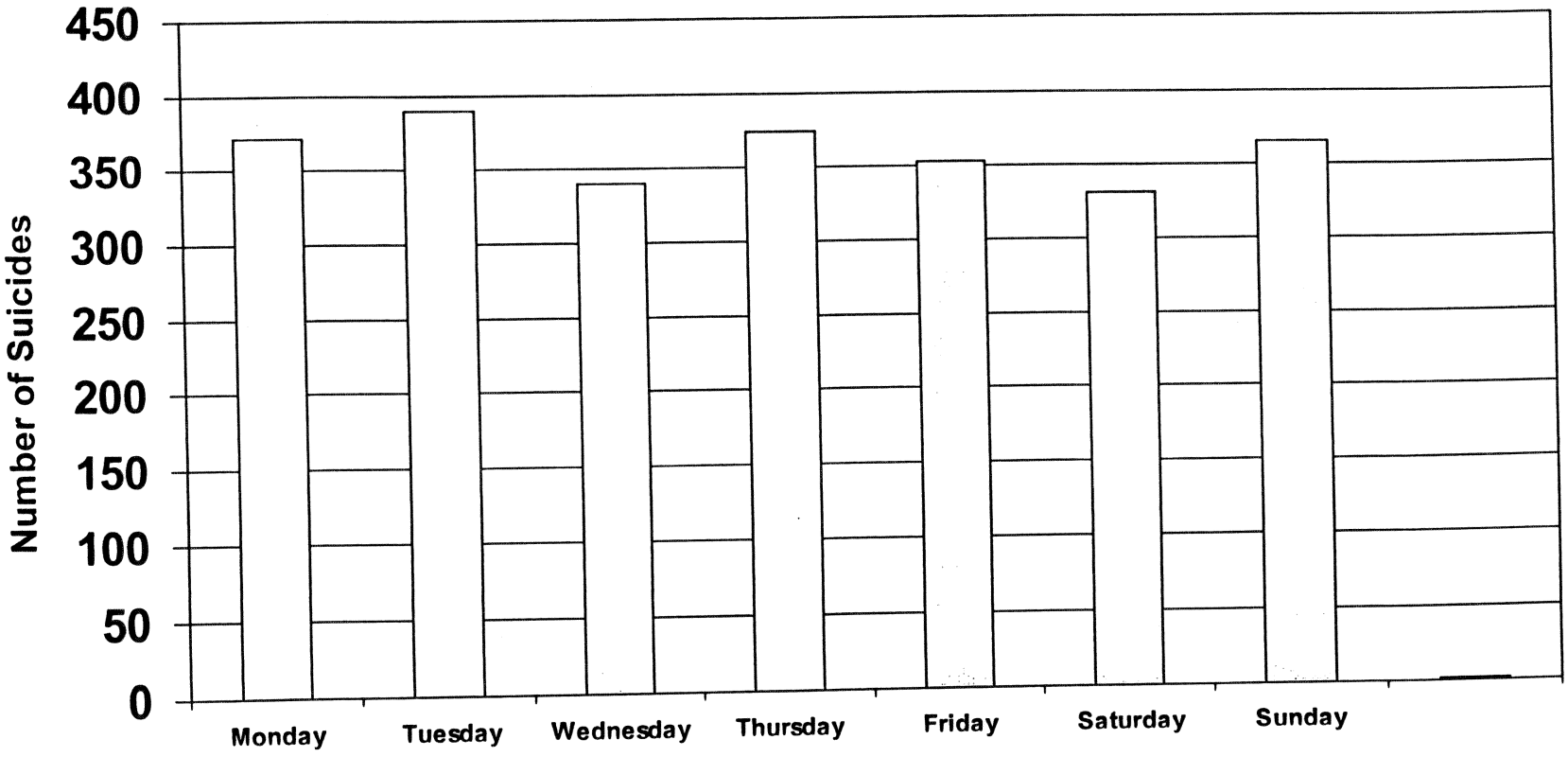
Monthly Distribution - Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics



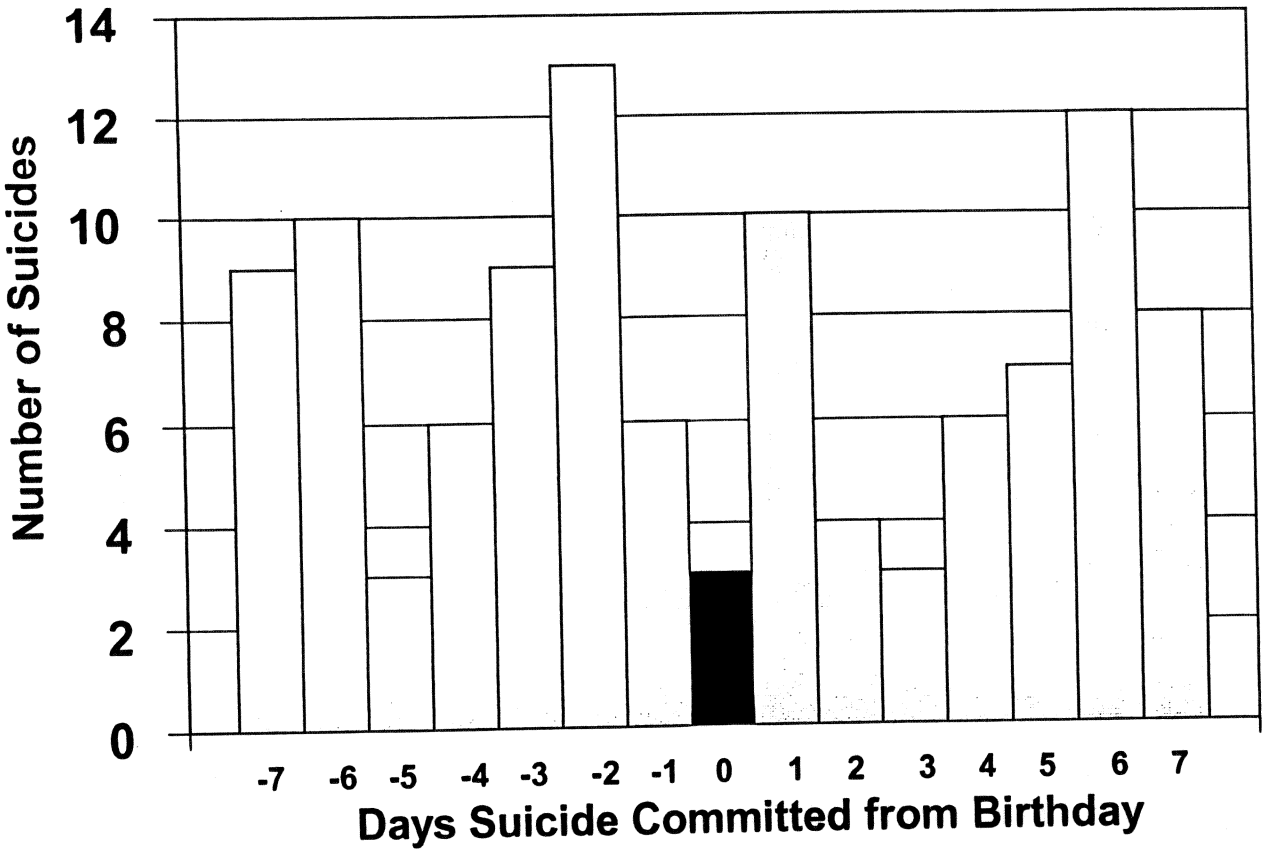
Day of the Week Distribution
Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics



Suicides Completed within Seven Days of a Birthday
Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics



State of Residency Distribution – Top 12 Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics

State of Residency	# Suicides	% of NV Suicides
Nevada	2252	89.3
California	121	4.8
Arizona	24	1.0
Utah	17	0.7
Texas	9	0.4
Florida	8	0.3
Colorado	8	0.3
Washington	7	0.3
Idaho	6	0.2
New York	5	0.2
Pennsylvania	5	0.2
Montana	5	0.2

Top Death Cities of the 2252 Nevada Residents Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics

City of Death	Number of Deaths	Number Who Died in the Same City of Residency*	Percentage Who Died in the Same City of Residency*
Las Vegas	875	672	77
Other Clark County Towns	369	329	89
Reno	288	238	83
Henderson	101	91	90
Carson City	77	73	95
North Las Vegas	67	50	75
Sparks	63	53	84
Other Washoe County Towns	60	39	65
Other Nye County Towns	49	43	88
Other Elko County Towns	34	26	76
Other Lyon County Towns	33	30	90
Boulder City	25	20	80
Elko	24	15	63
Above Cities Total	2,065	1,679	81
All Nevada Cities	2,252	1,825	81

** For this report, residents identified under the "Other Towns" groupings counted as a match if they died in the same "Other Towns" groupings.*

Death Counties of the 270 non-Nevada Residents Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics

County of Death	Number of Deaths	Percentage of Deaths
Clark	188	69
Washoe	44	16
Elko	14	5
Douglas	6	2
Carson City	3	1
Lincoln	3	1
Mineral	3	1
White Pine	3	1
Churchill	1	<1
Esmeralda	1	<1
Lander	1	<1
Lyon	1	<1
Nye	1	<1
Pershing	1	<1
Eureka	0	0
Humboldt	0	0
Storey	0	0

Top Death Cities of the 270 non-Nevada Residents Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics

County of Death	Number of Deaths	Percentage of Deaths
Las Vegas	139	54
Other Clark County Towns	39	14
Reno	38	14
Other Elko County Towns	11	4
Other Washoe County Towns	5	2
North Las Vegas	4	<2
Boulder City	3	<2
Carson City	3	<2
Other Mineral County Towns	3	<2
Other Lincoln County Towns	3	<2
Henderson	3	<2
Stateline	3	<2
Other Whitepine County Towns	2	<2
Elko	2	<2

There were 12 other cities with 1 death

Birth Locations - Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics

(page 1 of 2)

State (or Country)	# Suicides	% of Nevada Suicides	Resident of NV	% of original Birth State
California	490	19.4%	424	86.5%
Nevada	257	10.2%	253	98.4%
Other Foreign Born*	143	5.7%	112	78.3%
New York	131	5.2%	119	90.8%
Illinois	99	3.9%	87	87.9%
Utah	85	3.4%	75	88.2%
Pennsylvania	83	3.3%	74	89.2%
Michigan	77	3.1%	69	89.6%
Texas	69	2.7%	64	92.8%
Mexico	68	2.7%	62	91.2%
Washington	64	2.5%	52	81.3%
Ohio	61	2.4%	52	85.2%
Unknown	60	2.4%	54	90.0%
Colorado	53	2.1%	48	90.6%
Missouri	46	1.8%	40	87.0%
Minnesota	42	1.7%	36	85.7%
New Jersey	40	1.6%	38	95.0%
Wisconsin	38	1.5%	33	86.8%
Arizona	36	1.4%	30	83.3%
Indiana	33	1.3%	30	90.9%
Massachusetts	32	1.3%	28	87.5%
Oklahoma	31	1.2%	31	100.0%
Oregon	31	1.2%	27	87.1%
Idaho	28	1.1%	25	89.3%
Iowa	28	1.1%	28	100.0%
Kansas	28	1.1%	26	92.9%
New Mexico	27	1.1%	25	92.6%
Montana	25	1.0%	24	96.0%
Nebraska	25	1.0%	19	76.0%

* Countries other than Canada, Mexico and Cuba

Birth Locations - Nevada Suicides for 1995-2000

Data obtained from Nevada Vital Statistics

(page 2 of 2)

State (or Country)	# Suicides	% of Nevada Suicides	Resident of NV	% of original Birth State
Louisiana	23	0.9%	22	95.7%
Arkansas	21	0.8%	18	85.7%
Florida	21	0.8%	20	95.2%
Tennessee	19	0.8%	17	89.5%
Canada	18	0.7%	16	88.9%
Maryland	17	0.7%	16	94.1%
Connecticut	14	0.6%	12	85.7%
Mississippi	14	0.6%	14	100.0%
Wyoming	14	0.6%	13	92.9%
Kentucky	13	0.5%	13	100.0%
North Carolina	13	0.5%	11	84.6%
South Dakota	12	0.5%	10	83.3%
Hawaii	9	0.4%	8	88.9%
North Dakota	9	0.4%	9	100.0%
Georgia	8	0.3%	8	100.0%
Alabama	8	0.3%	6	75.0%
Alaska	8	0.3%	6	75.0%
West Virginia	8	0.3%	8	100.0%
Cuba	7	0.3%	6	85.7%
South Caroling	7	0.3%	7	100.0%
Virginia	7	0.3%	6	85.7%
District of Columbia	5	0.2%	4	80.0%
New Hampshire	5	0.2%	5	100.0%
Rhode Island	4	0.2%	4	100.0%
Maine	3	0.1%	3	100.0%
Delaware	2	0.1%	2	100.0%
Puerto Rico	2	0.1%	2	100.0%
Vermont	1	0.0%	1	100.0%
Total (both pages)	2522	100.0%	2252	89.3%

APPENDIX B

"An Initial Assessment of Suicide Prevention Resources and Services in Clark County"

Health Education

Memo

To: Don Williams, Chief Principal Research Analyst, Research Division

From: Mike Bernstein, Health Educator II

CC: Jeanne Palmer, Health Education Manager

Date: 7/23/2002

Re: Initial Assessment of Suicide Prevention Resources and Services in Clark County

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Linda Flatt contacted me and asked me to send you a copy of the assessment that we just completed. It is by no means exhaustive but it is the first attempt to see what is currently available in Clark County. I was asked by Dr. Rena Nora to present this report to the Governor's Commission on Mental Health at their August 23, 2002 meeting. I plan on being at the Sawyer Building for the meeting on August 16th.

An Initial Assessment of Suicide Prevention Resources and Services In Clark County

Introduction and Background

For the past 17 years Nevada has led the nation in suicide rate per 100,000 population. The average rate of suicide for the past 11 years in the U.S. is 11.63 compared to 22.64 for Nevada. Our state consistently averages twice the national rate. The suicide rate for Clark County in 2000 was 18.3 - only slightly lower than the state average. For the past five years, over 64% of Nevada suicides were by residents of Clark County.

In May 2001, the U.S. Surgeon General announced the National Strategy for Suicide Prevention: Goals and Objectives for Action. As per legislation passed in Nevada in 2001, the Legislative Commission's Subcommittee to Study Suicide Prevention has been meeting to determine how Nevada can begin to develop and implement a comprehensive statewide strategy and suicide prevention plan based on the goals of the Surgeon General's 2001 report. They will make recommendations to the Governor and the legislature for the 2003 session.

During this time, a Clark County Suicide Prevention Partnership has been formed by the Nevada Public Health Foundation, SPAN – Nevada, the Nevada Chapter of the American Foundation for Suicide Prevention and the Clark County Health District to find funding to develop a non-profit, full service suicide prevention resource center in Clark County. Setting up a Clark County Suicide Prevention Resource Center will be a valuable asset in the development and implementation of a comprehensive statewide strategy and plan. Up to this point, no one has ever determined what suicide prevention resources currently exist in Clark County. In order to properly assess community needs and what programs are currently in operation in Clark County, the Health District conducted this initial assessment.

At the current time in Clark County there is no organized effort aimed at suicide prevention, and most people working in the health and injury prevention fields are not aware of any comprehensive list of suicide prevention resources. Currently, the only existing information for the community-at-large is a list of county resources compiled by the Crisis Call Center in Reno. This list is also available only at limited locations. The initial target for this survey information is the local health community and related organizations that can provide information to those that request it. Knowing what suicide prevention resources are available is only a first step in the development of a comprehensive suicide prevention program.

Method

There are a number of established national suicide prevention resources and two have local Nevada Chapters. One chapter consists of one organizer and has no

All of the agencies noted a need for improvement in the quantity and range of suicide prevention services offered throughout the county, including a focus on the relationship between substance abuse and suicide. Only four of the agencies indicated having implemented any type of public awareness campaign about suicide prevention in the past. Finally, eight of the nine agencies surveyed here reported being willing to participate in a countywide partnership for the development of a comprehensive suicide prevention strategy for Clark County.

Actual Survey Results

Throughout this report of results, acronyms will be used to identify each of the nine agencies included in this survey. A legend of all formal agency names and corresponding acronyms used is provided here:

- **SPCCC** – Suicide Prevention Center of Clark County
- **SNAMHS** – Southern Nevada Adult Mental Health Services
- **PEHS** – Psychiatric Emergency Health Services
- **SMHOS** – Senior Mental Health Outreach Services
- **DFA** - Division for Aging
- **MH** – Montevista Hospital
- **LMHGU** – Lake Mead Hospital Geropsych Unit
- **VHGU** – Valley Hospital Geropsych Unit
- **CCSS** – Clark County Social Services

Each agency surveyed offered a different combination of several basic services in the area of suicide prevention and post-treatment:

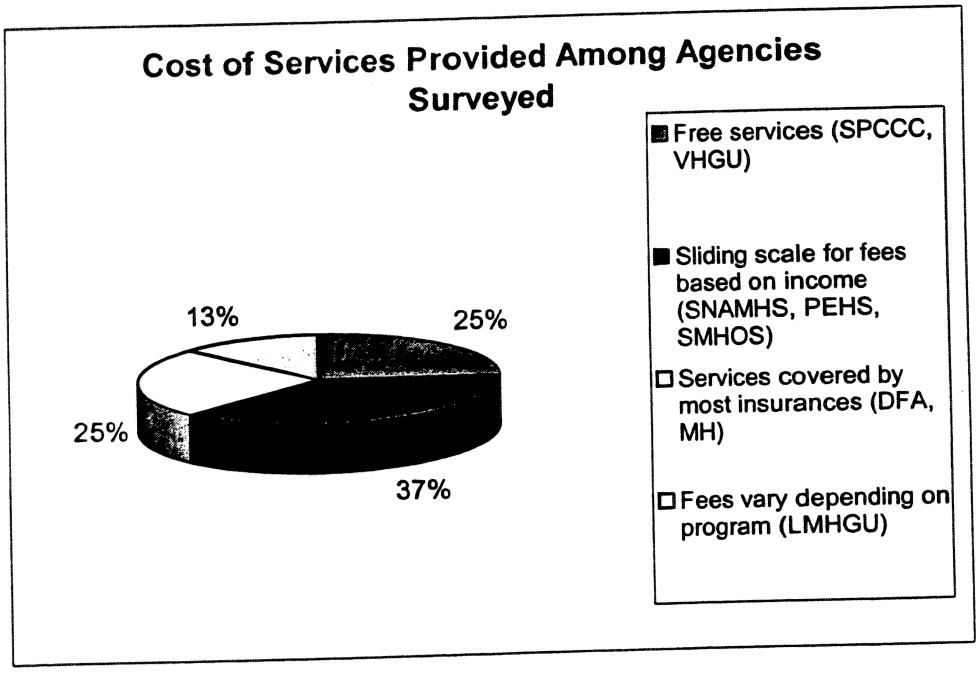
Agency Surveyed	Risk Assessments for Potential Suicides	Intervention Counseling/Referral Services	Identifying and Responding to Populations at Risk	Survivor Services
SPCCC	✓	✓	✓	✓
SNAMHS	✓	✓	✓	✓
PEHS	✓	✓	✓	✓ (partially)
SMHOS	✓	✓	✓	✓ (partially)
DFA	✗	✓	✗	✗
MH	✓	✓	✓	✗
LMHGU	✓	✓	✗	✗
VHGU	✓	✓	✓	✗
CCSS	✗	✓ (partially)	✗	✗

✗ - Service not offered
✓ - Service offered

Most agencies surveyed featured similar routes of access for those seeking services:

- 77.7% of agencies (Psychiatric Emergency Health Services and Clark County Social Services being the exceptions) allow potential clients to phone in for appointments, by professional- or self-referral
- Two of nine agencies (Southern Nevada Adult Mental Health Services and Psychiatric Emergency Health Services), or 22.2%, accept walk-ins

Client costs for services provided also varied from agency to agency:



Lack of insurance does not seem to be a major obstacle in securing suicide-related services among the agencies surveyed:

- Five of nine agencies, or 55.5% of those surveyed (the Suicide Prevention Center of Clark County, Southern Nevada Adult Mental Health Services, Psychiatric Emergency Health Services, Senior Mental Health Outreach Services and the Division for Aging) accept people without insurance
- 33.3% of agencies (Montevista Hospital, Valley Hospital Geropsych Unit, and Lake Mead Hospital Geropsych Unit) offer services to those lacking insurance on a case-by-case basis, or for certain types of services (i.e. only inpatient/emergency room services)
- Clark County Social Services does not offer any services in this area

variety of services offered. This was also a voluntary survey and there was no assessment made as to the quality of the services that are offered. So we do not currently know or have any research being conducted on the effectiveness of these services as to the prevention or ideation of suicide.

While some of the agencies reported being involved in public awareness efforts, the reported campaigns seemed more like spot educational efforts than the type of community awareness campaigns that are called for in the Surgeon General's report. Such media campaigns will require the type of funding and coordination of agencies and organizations that currently does not exist in Clark County.

The Legislative Commission's Subcommittee to Study Suicide Prevention has recommended to the Governor that Nevada develop a State Suicide Prevention Plan and appoint personnel to develop and implement the plan. The plan should be modeled after and incorporate goals from the United States Surgeon General's 2001 report. Nevada should begin by focusing on goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who may be first contacts with individuals at risk of suicide. Clark County contains nearly 70% of the state's population and the majority of completed suicides occur here as well. Any serious attempt to reduce the suicide rate in Clark County will require a strong effort at the development of the above mentioned goals through the cooperation and coordination of all of the agencies and individuals who can play a part through a county wide coalition or partnership. This group in itself will be an important component of an overall statewide strategy.

All of the agencies and organizations surveyed or listed in this report need to come together and bring additional interested community partners and individuals to the Clark County Suicide Prevention Partnership to support the Subcommittee's recommendations and any related legislation that is proposed during the 2003 session. This partnership will be essential to the development of a state plan and its implementation in Clark County. It is obvious that prevention, treatment and post-vention services need to be enhanced, developed and coordinated throughout the county. In many cases new sources of funding need to be found to carry out much of this work. The results of this survey indicate that there is much effort needed to develop a coordinated comprehensive community program in Clark County to reduce our suicide rate.

Educational Conferences

Crisis Call Center (Reno)
PO Box 8016
Reno, NV 89507
Phone: 775-784-8085
Fax: 775-784-7083
Hotline Coordinator: Misty Allen
Recipients of $100,000.00 annual state funding in the 1999 Legislative Session – refunded in 2001

Nevada Public Health Foundation
1601 Fairview Drive, Suite G
Carson City, NV 89701
Phone: 775-884-0392
Fax: 775-884-0274
Administrator: Lynn Carrigan
Lynn is currently writing a grant for proposed funding of a Clark County Suicide Prevention strategy

American Association of Suicidology
4201 Connecticut Avenue, NW,
Suite 408
Washington, DC 20008
Phone: 202-237-2280
Fax: 202-237-2282
www.suicidology.org

Post-vention Services

Trauma Intervention Program, Inc.
1823 Covey Lane
Las Vegas, Nevada 89115
Phone: 702-894-0903
Crisis Team Manager: Marian Thomas
Volunteers from the organization accompany police and firemen on trauma calls

APPENDIX C

Selected Newspaper Articles Relating to Certain Teen Suicides

Memorial service to be held Thursday

A memorial service will be held Thursday at Carson Valley United Methodist Church for 13-year-old Eric Steven Marchant, who died Monday.

According to the Douglas County Sheriff's Office, the boy hanged himself at his residence.

Deputies and paramedics responded to a call Monday morning at the home and attempted to revive Eric, who died about an hour later, after he was taken by CareFlight to Washoe Medical Center, according to the sheriff's office.

Eric just completed the 7th grade at Carson Valley Middle School. He was the son of Lawrence and Cindy Marchant of Gardnerville.

Counseling is available for parents and friends of Eric and his family to deal with the teen-ager's death. Cary Cochran, coordinator of the Life Stress Center in the Gardnerville Ranchos, encouraged residents to call 265-5223. The Life Stress Center is located at 1276 Pit Road in Gardnerville.

Similar referrals are also available through Douglas Mental Health at 782-3671.

Pastor Pete Nelson will officiate at a memorial service for Eric on Thursday at 2 p.m. at Carson Valley United Methodist Church.

In addition to his parents, Eric is survived by his sister Shelly Marchant of Sacramento and his grandparents.

(See obituary on page 11)

OBITUARY

Eric Marchant

Eric Steven Marchant of Gardnerville died June 22 at his residence.

He was 13.

Eric was born April 5, 1985, in Lewiston, Idaho, to Lawrence Steven and Cynthia Ann Struck Marchant. He had been a Gardnerville resident for 4-1/2 years, coming from Wisconsin.

He had just completed the 7th grade at Carson Valley Middle School. Eric enjoyed reading and writing. He loved music and was an avid fan of "The X Files."

A brother, Joshua, died in 1981.

Eric is survived by his parents of Gardnerville and sister Shelly Marchant of Sacramento; paternal grandparents John and Helen Marchant of Rochester, N.Y., and maternal grandparents, Joyce and Zain Wilcox of Orofino, Idaho and Harry Struck of Rufus, Ore.

A memorial service for Eric will be held Thursday, June 25, at 2 p.m. at Carson Valley United Methodist Church with Pastor Pete Nelson officiating. Private inurnment will follow.

Walton's Douglas County Mortuary is in charge of arrangements.

Eric Marchant

The Record-Courier
Gardnerville, Nevada
Wednesday, June 24, 1998

CHILD SUICIDE

At 11:55 Tuesday evening, May 21, Storey County Deputies and Emergency Medical Service Providers responded to an apparent suicide in the Mark Twain Estates. The victim, 12-year-old Michael George Echo was pronounced dead at his residence. Deputies from Lyon County together with a Storey County Sheriff's Chaplin also assisted. Additional information will be available pending further investigation.

Virginia City Register
Virginia City, Nevada
May 24, 2002

MORE ON CHILD SUICIDE

As the Sheriff's Department continues the investigation of the suicide of 12 year old Michael Patrick Echo questions continue to be asked.

The Register has been contacted by numerous people by phone and in person asking difficult questions. In summary the questions are:

1. Why would a child of 12 want to kill himself?
2. Why after the child had told numerous people during the day at school that he intended suicide that night, was he allowed to go home on the bus? Why didn't the school keep him in their custody until help was secured?
3. After school authorities contacted his father, why didn't the father take some action that would have prevented the tragedy?
4. Why did the boy have access to the rifle he used?
5. Why did his father and step-mother go out for the evening and leave him alone?
6. Will charges be brought against the boy's father?

The truth may be that the school did all that it legally could do. If the father assured authorities that he would take care of the situation, then the authorities had gone as far as they could at that point. Had he not cooperated with the authorities, they may have been able to take further action.

In our little county there is no precedent for this situation. Sheriff Whitten said, that because of this horrible incident new policy must be formed.

Our sources tell us that the father had talked with the boy on the fatal day, and believed that there was no real problem. Although, people might question the father's judgment, it is at least understandable that the father believed he knew his son well enough to believe that there was no problem.

We also understand that all of the evidence shows, so far, that the child did commit suicide and that the father is genuinely devastated. The District Attorney is investigating the possibility of any charges against the child's parents.

All of the questions regarding this tragedy may never be adequately answered. We at the Register will endeavor to keep you abreast of all events as they develop.

Virginia City Register
Virginia City, Nevada
May 31, 2002

Boy, 16, jumps from Stratosphere

LAS VEGAS SUN

A 16-year-old Las Vegas boy jumped to his death after he scaled two fences on the 109th floor of the Stratosphere Tower Saturday night.

Levi Walton Presley jumped from the outdoor observation deck about 6 p.m. Saturday, landing on the driveway to the hotel by Las Vegas Boulevard, Metro Police said.

Presley's death was ruled a suicide by the Clark County coroner's office.

Stratosphere security guards were alerted by an alarm system that Presley had climbed over the first 5-foot fence, said Mike Gilmartin, a hotel spokesman.

"The officer got there in about 10 to 15 seconds (after the alarm), but he didn't give the officer a chance," Gilmartin said. "(Presley) he climbed over the (second 10-foot high) fence, waved and then jumped."

In January 2000 a 24-year-old Utah man also scaled the two security barriers and jumped off the 1,149-foot tower to his death.

Las Vegas Sun
Las Vegas, Nevada
July 15, 2002

APPENDIX D

"The Georgia Suicide Prevention Plan"

The Georgia Suicide Prevention Plan

Two of my son's classmates committed suicide. One was a former classmate who had transferred to an alternative school; the other a friend to whom he was particularly close, as we were to her family. On the eve of my son's high school graduation, amid the hustle and bustle, smiles and cheers, are the tears of a school community for one who will not walk across the podium, will neither stand with her classmates nor make the round of graduation parties. As I weep for joy for my son's success, these tears will be mixed with tears of despair and anguish for her family as they watch her twin brother cross the stage alone.

– A Georgia Mother

Death by suicide is not a gentle deathbed gathering: it rips apart lives and beliefs, and sets its survivors on a prolonged and devastating journey.

—Kay Redfield Jamison,
Night Falls Fast: Understanding Suicide

Funding For Operation of the
SUICIDE PREVENTION ADVOCACY NETWORK (SPAN)

Preparation of this ***Georgia Suicide Prevention Plan*** **(Plan)**
has been made possible by
"Funding for operation of the Suicide Prevention Advocacy Network (SPAN)"
as provided in the **Georgia FY 2001 Budget,** page 278 as shown below.

DEPARTMENT OF HUMAN RESOURCES – FY 2001 Budget Summary

ENHANCEMENT FORM

ENHANCEMENTS	
Division of General Administration and Support	
1. Complete statewide implementation of Family Connection	2,100,000
2. Funding for post-adoptive training for staff and private providers designed to ensure childrens' placements with adoptive families are permanent	1,367,116
3. Provide fundsfor DHR complete systems (514,534,828 total funds). Funding includes $5,333,696 to cover operating deficits in current systems; $700,000 for master license agreements: $2,000,000 for the sunrise 2000 system; and $1,494,000 for Public Health data systems and six positions including $985,000 for vital records document imaging, $237,000 for the Statewide Electronic notifiable Disease Surveillance Systems, and $272,000 for the Public Health web site. An additional $63,500 (74,608 total funds) is recommended for new Adult Protective Services case workers.	9,591,276
4. Create a new Office of Children's Advocate. Add four new positions.	300,000
Division of Public Health	
1. Provide statewide coverage of mental health prevention services	1,000,000
2. Funding for operation of the Suicide Prevention Advocacy Network (SPAN)	250,000

The content of the Plan is solely the responsibility of SPAN USA.
The content of the Plan does not necessarily represent the official views of the Georgia Department of Human Resources.

DEDICATED TO

All Georgians who have been touched by suicide –
that we might prevent these tragic losses

TOGETHER WE CAN

SALUTE TO

DAVID SATCHER, MD, PhD

Georgia Survivors of Suicide salute Surgeon General David Satcher for his outstanding leadership in mobilizing public support behind the challenge to address the National Public Health problem that suicide and suicidal behavior represent.

With his tireless energy and his attention to *listening,* Dr. Satcher has translated the message from "grassroots" people into action.

THE GEORGIA SUICIDE PREVENTION PLAN
PREPARED BY

Julie W. Chambliss, PhD

EDITED BY

Debra Bailey Helwig

PUBLICATION DESIGN BY

Linda Cornelius

CONSULTATIVE ASSISTANCE FROM

Judith Byrnes, Public Health Educator
Lucy Davidson, MD, EdS
Carol Koplan, MD
Marti Vogt, Mental Health Educator

FIRST Lifekeeper® MEMORY QUILT

Georgia ***Faces of Suicide***

May 1998

Sandy Martin, a native Georgian raised in Cabbagetown (Atlanta), survives the suicide death of her only child, Tony. She is a charter member of SPAN USA and is currently President. During the first *National Suicide Prevention Awareness Event* (1996) Washington DC, as Sandy carried Tony in her heart and dreams, the seed to "Keep Life" was sown.

Since then, Sandy founded the *Lifekeeper Foundation*® that creates artwork and poetry and produces *Lifekeeper*® jewelry for sale. Technical guidelines and assistance for ***Faces of Suicide*** Quilts that Sandy started is also available through the Foundation. Visit their website at http://www.lifekeeper.org

Lifekeeper® ***Faces of Suicide*** Quilts carry the message that suicide prevention is about **saving lives.**

Suicide occurs in our families, so suicide prevention must also take place in our families, communities and counties.

Acknowledgements

Georgia Division of Public Health (DPH)

Kathleen E. Toomey, MD, MPH
Director

Kenneth E. Powell, MD, MPH
Chief, Chronic. Dis., Injury/
Environ. Health Epidem.

Steve Davidson, M.Ed.
Program Director,
Injury Prevention Section

Mental Health, Mental Retardation, and Substance Abuse (MHMRSA)

Jerry Lovrien, MA
Director

Suzanne Lindsey, MA, LPC
Child /Adolescent MH Program

Suicide Prevention Advocacy Network, USA (SPAN USA)

Elsie and Gerald (Jerry) Weyrauch
Founders

Laurell Reussow
Plan Monitor

Sandra Martin, President
Founder, *Lifekeeper* Foundation

Doris Smith, Immediate past
president of SPAN USA and Co-Founder
of Nat.Org.People of Color Against Suicide

National Mental Health Association of Georgia (NMHAG)

Cynthia Wainscott
Executive Director

Kristine Medea
Director, Clinical Education

Susan Shu-Hsien Tu
Support Service Coordinator

Ellyn Jaeger
Public Policy Director

Steering Committee Members

Iris Bolton, Executive Director
Link's National Resource Center for
Suicide Prevention/Aftercare

Michael R. Carpenter
Student Assistance Consultant,
Cobb Co. Schools

Liz Jones,Coordinator
Prevention/Intervention Center,
Cobb County Schools

Doreen Schultz, Assoc. Director
Link's National Resource Center for
Suicide Prevention/Aftercare

Frank Y. Smith, Consultant,
School Psychological Services

Advisory Council Members

Georgia Department of Education
Marian Lynn Abney (Marietta)
John Adams (Columbus)
Brenda Ballard (Marietta)
Deanne Bergen (Brunswick)
Annetta Berry (Columbus)
Judith M. Boivin (Atlanta)
Patti Brown (Commerce)
La Chundra Brundage (Hamilton)
Greta Willoughby Bunch (Rome)
Vera Bundrick (Fitzgerald)
Tracey L. Byram (McDonough)
Louis F. Caputo (Savannah)
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Bryn Carlson (Covington)
Janis Casey (Americus)
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Tod Citron (Marietta)
Jeffery W. Clance (Calhoun)
Doris M. Clanton (Atlanta)
Molly M. Clay (Atlanta)
Blanche Clinefelter (Augusta)
Charles F. Cook (Athens)
Julie Andrews Cook (Sandersville)
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Don Daves (Cumming)
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Charles R. Everitt Jr. (Lakeland)
Kristine Evjen (Atlanta)
Pat Edwards (Athens)
George Fisher (Hahira)
Laura Flumeifelt (Valdosta)
Gerry Folsom (Quitman)
Shelia W. Frances (Jasper)
Larry Fricks (Atlanta)
Jean Gearing (Atlanta)
Judith Geter (Irwinton)
Amy Gibby (Hiawassee)
Ken Greene (Winder)
Donna D. Greeson (Chatsworth)
Stephanie Phillips-Hardy (LaGrange)
Mary Hassel (Atlanta)
Melissa Heard (Dallas)
Tricia Hernandez (Atlanta)
Patty A. Herrin (Fitzgerald)
Joe Hulett (Vidalia)
Libby Jackson (Athens)
Cynthia A. Jenik (Carrollton)
Emerson Jones (Atlanta)
Maurice Jones (Douglasville)
James E. Kantner (Atlanta)
Theresa L. Kratz (Griffin)
Gary Lambert (Atlanta)
Scott Lawson (Thomasville)
Suzanne Lindsey (Atlanta)
Carla Linkous (Douglas)
Mark Mooneyhan (Waycross)
Dawne Morgan (Atlanta)
Dianne Morrison (Winterville)
Marian Nadybal (Marietta)
Robin Nash (Decatur)
Amber Norris (Lawrenceville)
Cyndy Pattillo (Columbus)
Amy Rediger (Baxley)
Anne W. Resseau (Augusta)
Tarry Rogers (Reidsville)
Debbie Rose (Savannah)
Brenda Rowe (Atlanta)
Sharon Rugg (Marietta)
Tamika Sanders (Fort Gaines)
Susan Sarsany (Jackson)
Jeff Scarbrough (Riverdale)
Annette Scott (Albany)
Delois Scott (Decatur)
Monte Smith (Eastman)
Sue L. Smith (Atlanta)
Elaine Smout (Rome)
Brenda Stansell (Rome)
Mari Stephens (Atlanta)
Tim Stewart (Norcross)
Doreen Swaim (Athens)
Tim Sweatman (Commerce)
David R. Titus (Grovetown)
Joe Troope (Adel)
Kenneth L. Turner (Gordon)
Frances C. Veal (Sandersville)
Sally Wallace (Fayetteville)
Kathy Dale Wright (Lithonia)

And special thanks to the 800 GEORGIANS who helped in the development of the plan by participating in focus groups and completing surveys

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Roy E. Barnes
GOVERNOR

Dear Fellow Georgians:

It is my honor today to present the first *Georgia Suicide Prevention Plan.* This plan is designed to significantly reduce suicides, which not only claim more lives in our state than homicide, but also are the eighth leading cause of death in Georgia. Our plan, developed by a public-private partnership, integrates state and community prevention activities and welcomes the support and financial commitment of the Office of the Governor and the Georgia General Assembly.

The Public Health Division of the Georgia Department of Human Resources, the Suicide Prevention Advocacy Network (SPAN USA) and the National Mental Health Association of Georgia engaged nearly 1,000 Georgians in the year-long effort to assess suicide prevention needs statewide and to write a comprehensive prevention plan to meet those needs. The plan is modeled on the United States Surgeon General's 1999 Call to Action to the states.

Georgia's plan reflects our commitment to fight this silent, tragic killer which the United States Surgeon General has identified as a preventable national public health problem. I urge every Georgian to join our prevention brigade, as we reclaim our loved ones and their lives.

Sincerely,

Roy E. Barnes
Governor

DHR

Gary B. Redding, Acting Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director

Georgia Department of Human Resources • Division of Public Health
2 Peachtree Street, NW • Suite 15-470 • Atlanta, Georgia 30303-3186 • Tel: (404) 657-2700 • Fax: (404) 657-2715

August 1, 2001

Mr. and Mrs. Gerald H. (Jerry) Weyrauch
Suicide Prevention Advocacy Network
5034 Odins Way
Marietta, GA 30068

Dear Mr. and Mrs. Weyrauch:

I congratulate you on the completion of the Georgia Suicide Prevention Plan. Your efforts will serve as a resource for our state as we make suicide prevention a public health priority.

Suicide kills an average of 848 Georgians every year. I encourage everyone to become familiar with your plan and take appropriate actions to join in the battle to save lives.

Sincerely,

Kathleen E. Toomey, M.D., M.P.H.
Director
Division of Public Health

KET/jbm

cc: Michael R. Smith
Steve Davidson

Table of Contents

Executive Summary

Suicide is a serious public health problem in Georgia. It is the ninth most common cause of death, taking the lives of more Georgians than murder. In fact, among Georgia youth and young adults ages 15-24, suicide is the third leading cause of death. Each year 850 Georgians of all ages die by suicide and about 17,000 seek emergency care for injuries related to suicide attempts.
This is a tragedy, because many suicides are preventable. The good news is that you can help prevent them.

What can one family or one couple in Georgia do to prevent suicide? *A lot.* Here's an example:

The Suicide Prevention Advocacy Network USA (SPAN USA) was founded in Marietta, Georgia by the family of Terri Ann Weyrauch, MD, as a result of Terri's 1987 suicide. This national grassroots, non-profit organization, which was officially launched in 1996, brought the concept of "political will" into suicide prevention. As a result of their national success, SPAN USA formed a partnership with a number of Georgia public and private organizations in 1999 to do something about the problem of suicide in Georgia.

Responding to their plea for help, Governor Roy Barnes and the Georgia Legislature provided funding in the FY 2001 Georgia State Budget for SPAN USA to develop the Georgia Suicide Prevention Plan. Since then, many Georgians representing different fields and backgrounds have participated in the plan's development. The National Mental Health Association of Georgia (NMHAG) and the Georgia Department of Human Resources Division of Public Health have been key organizational partners. Now you can make a difference too!

A Framework for Suicide Prevention

The Georgia Suicide Prevention Plan (Plan) provides a framework for getting everyone in Georgia-including you-involved in preventing suicide. The Plan is designed to guide individual people, agencies, and organizations, in local communities as well as regional and state levels. One goal of this Plan is to change individual attitudes and knowledge about suicide. Equally important, the Plan seeks to promote suicide prevention in many of the systems in Georgia that touch our lives. These include education, health care, media, the workplace, faith communities, and criminal justice.

The overall aims of the Plan are to:

- prevent deaths due to suicide across the life span,
- reduce the occurrence of other self-harmful acts,
- reduce the suffering associated with suicidal behaviors and the traumatic impact of suicide on loved ones, and
- provide opportunities and settings to enhance resilience, resourcefulness, respect, nonviolent conflict resolution, and interconnectedness for individuals, families, and communities.

"Suicide could happen in your family too. Please, we need your help in fighting mental illness and saving precious lives."
—A Georgia youth who lost her teenage brother to suicide

The Plan is based on recommendations and information from:

- The Surgeon General's *Call to Action to Prevent Suicide 1999*
- The National Strategy for Suicide Prevention: Goals and Objectives for Action
- Suicide in Georgia: 2000, a state public health report, and
- Input from many concerned individuals and groups in Georgia.

The Pieces of the Plan

There are three large pieces that make up the Plan. These pieces represent its **foundation**, its **building blocks**, and its **keystone**.

The **foundation** of the Plan uses the **public health approach** for suicide prevention. This five-step public health model defines the problem, identifies risk and protective factors, develops and tests interventions to reduce risks and increase protective factors, implements interventions, and evaluates effectiveness. The public health model for suicide prevention is a systematic approach to developing and implementing interventions that are effective in reducing suicide.

The **building blocks** of the Plan are arranged as opportunities for Awareness, Intervention, and Methodology (AIM) to improve suicide prevention. These **major action steps** are presented as goals and objectives.

The **keystone** of the Plan is **implementation**; that is, putting the Plan to work.

Goals and Objectives of the Plan

Action Step: *AWARENESS*

Goal 1. Promote awareness that suicide is a serious public health problem and that many suicides are preventable.

Objectives for Goal 1 include:

- developing and implementing public information campaigns designed to increase all Georgians' knowledge of suicide prevention and an understanding of the role of risk and protective factors.
- establishing regular Georgia suicide prevention conferences.
- providing information through the Internet.

Goal 2. Develop broad-based support for suicide prevention.

Objectives for Goal 2 include:
- increasing the active participation of individuals, groups, communities, agencies, faith communities, and professional organizations in Georgia suicide prevention.
- developing the Plan Steering Committee and Advisory Council.

Goal 3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Objectives for Goal 3 include:
- changing public attitudes to view mental and substance abuse disorders as real illnesses that respond to specific treatments.
- increasing the proportion of Georgians with underlying mental or substance abuse disorders who receive appropriate treatment.

Action Step: INTERVENTION

Goal 4. Develop and implement community-based suicide prevention programs.

Objectives for Goal 4 include:
- increasing coordination among government agencies, and also between government agencies and private organizations, as they work to implement the Plan.
- increasing the number of evidence-based suicide prevention programs in schools, colleges, and universities, work sites, correctional institutions, aging programs, and community service programs.
- establishing policies and procedures in each setting for referral of persons at risk and for crisis response.

Goal 5. Promote efforts to reduce access to lethal means of self-harm.

Objectives for Goal 5 include:
- increasing the proportion of primary care clinicians, other health care providers and health and safety officials, who routinely assess the presence of lethal means in the home and educate about actions to reduce associated risks.
- developing and distributing materials to educate about actions to reduce the accessibility of lethal means of self-harm.

Goal 6. Implement training for recognition of at-risk behavior and delivery of effective treatment.

Objectives for Goal 6 include:
- improving education for nurses, physician assistants, physicians, social workers, psychologists, and counselors in the assessment and management of suicide risk, and the identification and promotion of protective factors.
- providing training for community members in recognizing and responding to persons at risk of suicide.
- providing education for family members of persons at elevated risk.

Goal 7. Develop and promote effective professional practices and support services.

Objectives for Goal 7 include:

- improving assessment and treatment of persons at risk for suicide.
- incorporating screening in primary care settings.
- training those who provide immediate response following a suicide to understand the unique needs of survivors and interact with tact and sensitivity.
- making appropriate mental health and substance abuse disorder treatment services available for persons with mental disorders, substance abuse disorders, or a history of trauma or abuse.
- fostering the education of family members and significant others of persons receiving mental health and substance abuse disorder treatment about the risk of suicide.

Goal 8. Improve access to and community linkages with mental health and substance abuse services.

Objectives for Goal 8 include:

- increasing the number of insurance plans that cover mental health and substance abuse care on par with coverage for physical health care.
- integrating mental health, substance abuse, and suicide prevention into health and social services outreach programs.
- incorporating screening and referral of persons at risk into many settings including schools, colleges, correctional institutions, clinics, and youth-serving programs.
- implementing support programs for persons who have survived the suicide of someone close to them.

Goal 9. Improve reporting and portrayals of suicidal behavior, mental illnesses, and substance abuse in the entertainment and news media.

Objectives for Goal 9 include:

- establishing a Georgia coalition of public and private organizations to promote accurate and responsible media representation of suicidal behaviors and mental illnesses.
- increasing the proportion of TV programs and news reports in Georgia that follow recommended guidelines for accurate and responsible portrayal of suicidal behavior and mental illnesses.
- including guidance on the portrayal and reporting of mental illnesses, suicide and suicidal behaviors in journalism courses of study.

Action Step: *Methodology*

Goal 10. Promote and support research and evaluation on suicide prevention.

Objectives for Goal 10 include:

- increasing funding (public and private) for suicide prevention research and evaluation conducted in Georgia, and for studies on how to put scientific knowledge into practice at the state, regional, and community levels.

- providing training and technical assistance on the evaluation of suicide prevention programs implemented in Georgia.
- increasing the number of jurisdictions in Georgia that will collect and provide information for follow-back studies on suicides.

Goal 11. Improve and expand systems for data collection.

Objectives for Goal 11 include:

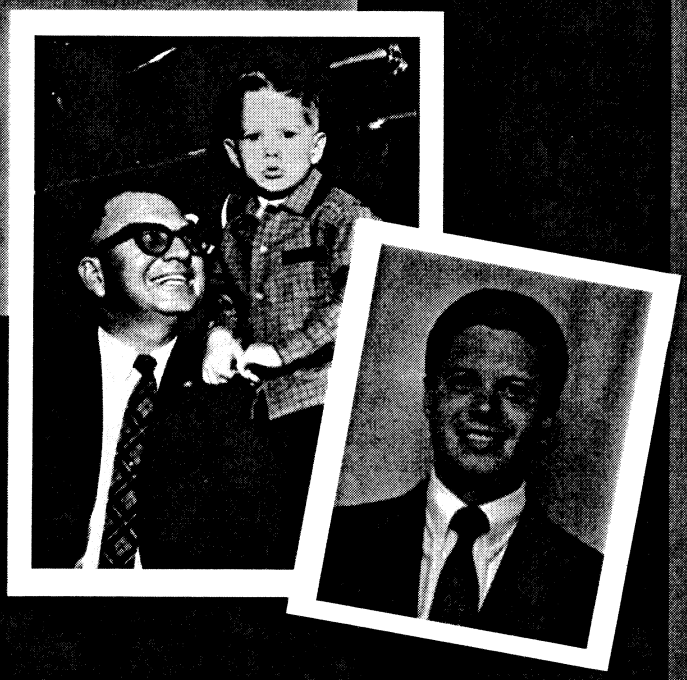
- increasing the number of hospitals in Georgia that collect uniform and reliable data on suicidal behaviors by coding external cause of injuries and determining associated costs.
- implementing a violent death reporting system in Georgia that includes suicides and collects information not currently available from death certificates.
- using standard procedures for death scene investigations in Georgia counties.
- producing annual reports on suicide and suicide attempts in Georgia, such as *Suicide in Georgia: 2000*, which integrate information from multiple state data management systems.
- developing community level indicators for progress in suicide prevention to signal achievement of results.

Putting the Plan to Work

The keystone of the Plan is implementation—getting the Plan to work. This is where you can make a difference. In addition to the work of state agencies, implementing the plan will require broad participation and collaboration from individuals and groups in local communities. Professionals and community volunteers must work side-by-side, and public agencies and private organizations will have to expand their partnerships to make a difference in suicide prevention.

Suicide Prevention in Georgia is truly everyone's business!
The essential next steps are designed to:

- increase support, participation, and collaboration for suicide prevention,
- develop an operating structure or coordinating body for the Plan that reflects a public/private partnership and includes stakeholders,
- involve communities in suicide prevention planning at the local level,
- provide opportunities for people to share ideas and work together through statewide conferences and local community forums,
- make technical assistance and resources for suicide prevention widely available,
- develop and/or identify useful indicators to benchmark community progress in suicide prevention,
- improve program evaluation and surveillance, and
- provide progress reports on the Plan implementation.



Suicide too often kills multiple family members

Father and Son:

William Shannon Bruce, Jr.
Jan. 30, 1914 -Jul. 6, 1966

John Martin Bruce (Marty)
Aug. 24, 1957- Nov. 15, 1993

Mother and Son :

Darlene Meyer Breland
June 30,1960 - June 5,2000

Eric Michael Meyer
June 16,1980 - Nov. 1,1999

Section 1: The Foundation
Recognizing the Need for Action

The Problem of Suicide in Georgia

Suicide is a tragedy that claims the lives of hundreds of Georgians each year –mothers and daughters, fathers and sons, brothers and sisters, friends, neighbors. Who completes suicide? People you meet at work, the grocery store, the gym, and places of worship; children in our schools, young adults in colleges and universities, and older people. Maybe someone you know. Maybe someone you love.

"I was shocked to learn that the suicide rate where I live is so high. What can I do?"
–A fellow Georgian

Did you know that in Georgia:

- 850 people a year die of suicide, making it the ninth leading cause of death among Georgians of all ages; it is the third leading cause of death among young Georgians ages 15-24.
- 44 percent of Georgia counties had suicide rates above the national rate.
- More Georgians die by suicide than homicide.
- An estimated 17,000 Georgians will seek emergency care this year for injuries related to suicide attempts.

These disturbing facts about suicide *(taken from Georgia Division of Public Health, 2000; CDC National Mortality Statistics; McCraig & Strussman, 1997)* show that it remains a serious public health problem in Georgia.

And there is more. These numbers are troubling, but they do not include many, many others who attempt suicide but never go to the hospital. They do not include unreported suicides. Suicide deaths are undercounted because death certificates may misclassify the cause of death as accident or by undetermined causes. Pressure to not report a death as suicide may come because many people wrongly see suicide as a mark of disgrace or shame–a stigma on themselves and their families. This stigma of suicide places a cruel burden on surviving family members and friends, who may, in hiding a suicide, be left to mourn in silence and secret.

Maybe someone you know. Maybe someone you love.

The Georgia Suicide Prevention Plan (Plan) will change how we think and act to prevent suicide. Working together through the Plan is intended to:

- Prevent deaths due to suicide across the life span.
- Reduce the occurrence of other suicidal behaviors.
- Reduce the suffering associated with suicidal behaviors and the traumatic impact of suicide on significant others.
- Provide opportunities and settings to enhance resilience, resourcefulness, respect, nonviolent conflict resolution, and inter-connectedness for individuals, families, and communities.

"Clearly we have major problems in the area of mental health that need our attention NOW."

–A fellow Georgian

Development of the Plan

Only recently, knowledge has become available to help us approach suicide as a preventable problem with realistic opportunities to save many lives. The Georgia Suicide Prevention Plan (referred to throughout this document as Plan) is framed upon these advances in science and public health. The Plan is connected with national efforts to develop strategies for suicide prevention that can be carried out by public and private partners in communities across the country.

There has been international interest in suicide prevention for many years. In 1993, the United Nations (UN) and World Health Organization (WHO), in collaboration with the Canadian partnership led by Living Works Education and Alberta's Suicide Information and Education Centre (SIEC), hosted an international conference in Calgary, Canada. Representatives from twelve countries attended the conference. The results of that meeting were documented in a booklet called *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies (United Nations 1996)*. The UN *Guidelines* were developed as a way to facilitate the development of national strategies for the prevention of suicidal behaviors within the socio-economic and cultural context of any interested country (*Ramsey 2001*).

In 1987, Terri Ann Weyrauch, MD died by suicide. After her death, her parents began to volunteer with several local and national suicide prevention groups. Asked to review an early draft of the Guidelines, they sensed that the document provided the missing element needed for a suicide prevention effort in the U.S. The Weyrauchs conducted a year-long national survey to seek support for an activist grassroots organization that would promote the "political will" needed to move the federal government to "do something about the high rates of suicide nationally."

The Suicide Prevention Advocacy Network USA (SPAN USA), a national, non-profit advocacy organization, was founded in January 1996, "to create and implement a national suicide prevention strategy" based on the UN Guidelines. SPAN USA members include suicide survivors (persons close to someone

who completed suicide), suicide attempters, and the people who support them. SPAN USA's efforts to marshal political will for suicide prevention generated Congressional Resolutions recognizing suicide as a national problem and suicide prevention as a national priority.

SPAN USA propelled the creation of an innovative public/private partnership that worked jointly to sponsor a National Suicide Prevention Conference in Reno, Nevada, in October 1998 (SPAN USA Reno Conference). SPAN USA and the Centers for Disease Control and Prevention (CDC) commissioned briefing papers to summarize the evidence base for suicide prevention among at-risk populations and to make recommendations for public health action to be considered during the Conference (Silverman, Davidson, and Potter, 2001).

SPAN USA Reno Conference participants included researchers, health, mental health and substance abuse clinicians, policy makers, suicide survivors, consumers of mental health services, and community activists and leaders. They discussed presentations of the briefing papers and engaged in careful analysis of what was known and what needed to be learned about suicide and its potential responsiveness to a public health model for suicide prevention. Working in regional, multidisciplinary groups, participants at the SPAN USA Reno Conference offered many additional recommendations. An expert panel successively refined the recommendations into a list of 81.

A I M

Awareness
Intervention
Methodology

Moving forward with the work of the SPAN USA Reno Conference, the Surgeon General issued his *Call to Action to Prevent Suicide* in July 1999, emphasizing suicide as a serious public health problem (USPHS, 1999). The Surgeon General's Call introduced a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM). AIM describes 15 broad recommendations containing goal statements, general objectives, and recommendations for implementation that are consistent with a public health approach to suicide prevention. AIM represents a consolidation of the highest-ranked of the 81 SPAN USA Reno Conference recommendations according to their scientific evidence, feasibility, and degree of community support.

The recommendations of both the SPAN USA Reno meeting and *The Call to Action* have been refined with a view to developing a comprehensive plan outlining national goals and objectives that would stimulate the subsequent development of defined activities for local, State and Federal partners. SPAN USA has worked to build the Georgia Suicide Prevention Plan in concert with this national strategy while incorporating specific state needs and interests.

National goals and objectives were refined as part of a broadly inclusive process which has invited critical examination by scientific, clinical, and government leaders; other professionals; and the general public. Revised draft goals and objectives were also posted on the World Wide Web, inviting comment. During 2000, public hearings were held in Atlanta, Boston, Kansas City, and Portland to provide a face-to-face forum for additional input and clarification. Key experts across the country provided additional review. These experts included scientists, survivors, researchers, consumers, public health leaders, advocates, clinicians, and business leaders.

SPAN USA has mobilized support in community meetings across the state. Following this series of focus group meetings and community meetings, SPAN USA adapted state-appropriate goals and objectives from the National Strategy for the Plan.

Governor Roy Barnes and the Georgia Legislature appropriated funds in fiscal year 2001 for SPAN USA to develop the Plan. SPAN USA partnered with the Georgia Department of Human Resources, Division of Public Health and the National Mental Health Association of Georgia to write the Plan. The result of that work is the document you are now reading.

The Georgia Suicide Prevention Plan Concept

This Plan to prevent suicide is a comprehensive and integrated approach to reduce the loss and suffering from suicide and suicidal behaviors across the life span. It encompasses the promotion, coordination, and support of activities that will be implemented across Georgia as culturally appropriate, integrated programs for suicide prevention among Georgians at the state, regional, county, and community levels.

A broad public/private partnership is essential for developing and implementing a state suicide prevention plan. Interwoven within the Plan are three key ingredients for action to improve suicide prevention: **1) a knowledge base, 2) the political will to support change and generate resources, and 3) a social strategy to accomplish change.**

Developing a suicide prevention plan provides an opportunity to convene public and private partners across many sectors of society–state government, public health, education, human services, faith

Benefits of a State Plan

- Raise awareness and help make suicide prevention a statewide priority. This can help direct resources of all kinds to the issue.
- Provide opportunities to use public-private partnerships and the energy of survivors to engage people who may not consider suicide prevention part of their mission. A state plan supports collaboration across a broad spectrum of agencies, institutions, groups, and community leaders as implementation partners.
- Link information from many prevention programs to avoid unintentional duplication and share information about effective prevention activities.
- Direct attention to measures that benefit all people in Georgia and, by that means, reduce the likelihood of suicide, before vulnerable individuals reach the point of danger.

communities, volunteer organizations, advocacy, and business–to sustain a true, Georgia-wide effort.

Suicide is an outcome of complex interactions among neuro-biological, genetic, psychological, social, cultural, and environmental factors. Multiple risk and protective factors interact in suicide prevention. Development of a State Plan can bring together multiple disciplines and perspectives to create an integrated system of interventions across multiple levels, such as the family, the individual, schools, the community, and the health care system.

Collaborating in a State Plan can help develop priorities. Resources are always finite and priorities direct resources to projects that are likely to address the greatest needs and achieve the greatest benefits. Some kinds of expertise are not available across all communities. A State Plan can provide assistance with valuable kinds of expertise to strengthen community programs.

Key Elements of a State Plan

A State Plan has many interrelated elements contributing to success in reducing the toll from suicide. They include:

- A means of engaging a broad and diverse group of partners to develop and implement the Plan with the support of public and private policies
- A sustainable and functional operating structure for partners with authority, funding, responsibility, and accountability for the state plan development and implementation
- Agreements among state agencies and institutions outlining and coordinating their appropriate segments of the State Plan
- A summary of the scope of the problem and consensus on prevention priorities
- Specified goals, and objectives integrated into a conceptual framework for suicide prevention
- Appropriate activities that can be evaluated for practitioners, policy makers, service providers, communities, families, agencies, and other partners
- A data collection and evaluation system to track information on suicide prevention and benchmarks for Plan progress

"The costs of suicide in terms of the effects it has on families and friends and on the community are much greater than the costs of prevention."

–A Georgia counselor

Using the Public Health Approach to Prevent Suicide

The Plan represents a highly blended synthesis of perspectives from researchers and scientists, practitioners, leaders of private non-governmental organizations and groups, federal agencies, survivors, and community leaders. Because the Plan is meant to be useful for applications outside the tightly controlled research environment, it builds onto the limited realm of scientific evidence in suicide prevention. While goals and objectives must be consistent with available scientific evidence and support the expansion of the scientific knowledge base, they are intended for use in other environments of public policy and community action.

The goals and objectives in the Plan are among many elements needed, but not the entire Plan. The blend of evidence represented in the goals and objectives helps guide an informed selection of activities for suicide prevention across the broad spectrum of communities in Georgia. The state dialogue to determine specific activities to accomplish each objective will be an extension of the consensus reached on these higher order goals and objectives. In that subsequent step, responsibility and accountability for carrying out activities will be accorded in the details of how each activity should be accomplished, by whom, and with what resources.

Several broad public health themes for the Georgia Plan are interwoven throughout this document. These themes are valuable considerations as groups and individuals across Georgia move forward in designing and strengthening suicide prevention activities. The six themes are as follows:

1 Draw attention to a wide range of actions so that specific activities can be developed to fit the resources and areas of interest of people in everyday community life as well as professionals, groups, and public agencies. As the ninth leading cause of death among Georgians, suicide affects families and communities everywhere across the state. Suicide prevention is everyone's business.

2 Seek to integrate suicide prevention into existing health, mental health, substance abuse, education, and human services activities. Settings that provide related services, such as schools, workplaces, clinics, medical offices, correctional and detention centers, eldercare facilities, faith communities, and community centers are all important venues for seamless suicide prevention activities.

3 Guide the development of activities that will be tailored to the cultural contexts in which they are offered. While population-based interventions are applicable without regard to risk status, it does not mean that one size fits all. The cultural and developmental appropriateness of suicide prevention activities derived from the Plan are a vital design and implementation consideration.

4 Seek to eliminate disparities that erode suicide prevention activities. This is an important commitment in the Georgia Suicide Prevention Plan. Health care disparities are attributable to such differences as race or ethnicity, gender, education or income, disability, age, stigma, sexual orientation, or geographic location.

5 Emphasize early interventions to promote protective factors and reduce risk factors for suicide. As important as it is to recognize and help suicidal individuals, progress depends on measures that address problems early and promote strengths so that fewer people become suicidal.

6 Seek to build statewide capacity to conduct integrated activities to reduce suicidal behaviors and prevent suicide. Capacity building will ensure the availability of the resources, experience, skills, training, collaboration, evaluation, and monitoring necessary for success.

Moving forward with the Plan can bring suicide prevention into the forefront of Georgia's public commitment to health and well-being. Working together in a coordinated and systematic way towards implementing appropriate activities for each objective will lead to measurable progress.

The foundation for developing and implementing the Georgia Suicide Prevention Plan is the five-step public health model presented in *National Strategy for Suicide Prevention: Goals and Objectives for Action.* The public health approach is designed to organize prevention efforts and resources in such a way that they reach large groups or populations of people systematically and effectively.

The five-step public health model is outlined here. It links defining the problem, identifying risk and protective factors, developing and testing interventions, implementing, and evaluating interventions. The steps can and often do occur at the same time and depend on one another.

Step 1: Clearly Defining the Problem

Surveillance is the ongoing process of collecting information about the "who, what, when, where, how, and how many" of suicide in Georgia. Needs assessment is another valuable contribution to the first step of the Public Health model because it helps us clearly define the existing conditions that affect the problem.

Surveillance information can tell us how much of a burden suicide is to the state and the community. Surveillance reports can show trends in risk and protective factors for suicide. State surveillance data for the Plan came from the publication called *Suicide in Georgia: 2000.* Some of the highlights of that report may surprise you. For example, did you know that:

- suicide rates are five times higher for males than for females in Georgia?
- the suicide rate among Georgia African-Americans aged 15-24 was 40 percent higher in 1996-1998 than it was in 1984-1986?
- suicide rates are two times higher for whites than African-Americans in Georgia?
- the suicide rate for Georgia's rural counties is more than 17 percent higher than the urban county rate?

Step 2: Identifying Causes through Risk and Protective Factors Research

The base for suicide prevention comes from observing suicide risk factors, suicide protective factors, and their interactions.

Suicide risk factors are things that increase the potential for a person's suicide or suicidal behavior. A person's age, gender, or ethnicity can increase the impact of certain risk factors or combinations of risk factors for them. Understanding risk factors can help counteract the myth that suicide is a random act or results from stress alone.

Suicide protective factors are things that reduce the potential for a person's suicide or suicidal behavior. Protective factors include attitudes and behaviors.

Both risk and protective factors include a wide variety of characteristics of individuals and groups. These characteristics include things like a person's family history, biology, psychology, and socio-cultural situation. They also include environmental conditions, such as easy access to the highly lethal means of suicide or easy access to help and treatment services.

The following Risk and Protective Factors for Suicide are identified in the *National Strategy for Suicide Prevention: Goals and Objectives for Action.*

Risk Factors for Suicide

Biological, Psychological and Social Risk Factors

- Previous suicide attempt
- Mental disorders—particularly mood disorders such as depression and bipolar disorder, anxiety disorders, schizophrenia, and certain personality disorder diagnoses
- Alcohol and substance abuse disorders
- Family history of suicide
- History of trauma or abuse
- Hopelessness
- Impulsive and/or aggressive tendencies
- Some major physical illnesses

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Exposure to the influence of others who have died by suicide, including media exposure

Protective Factors for Suicide

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal methods of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Information about risk and protective factors contributes to selecting useful interventions for suicide prevention. But much remains to be learned; especially about how these risk and protective factors interact across the life course and how community suicide prevention programs can best integrate this information.

Reducing Risk Factors

Interventions are actions or programs that can reduce the effect of risk factors and/or increase protective factors. An example of an intervention would be providing effective treatment for depressive illness.

Some risk factors cannot be changed, such as a previous suicide attempt, but even these may have a signal purpose. They can serve as reminders of the heightened risk of suicide when the individual is ill or suffering adversity.

Enhancing Protective Factors

If we want to prevent suicide, enhancing resilience and protective factors is as important as reducing risk. Unfortunately, positive resistance to suicide is not permanent. This means that activities to support and maintain protection against suicide need to be repeated and ongoing

Step 3: Develop and Test Interventions

This step has several parts. First, it involves developing interventions, which are prevention actions or programs that can reduce the impact of risk factors or support protective factors. Rigorous scientific testing of interventions before they are put in place widely is important to ensure that the interventions are safe, ethical, and practical. There are several stages to this testing, beginning with efficacy studies that look at whether an intervention works under ideal conditions.

If the answer is "yes, they work under ideal conditions," then effectiveness studies may be carried out under real world settings. This further testing with larger groups can lead to refinements and improvements in the intervention and understanding critical factors in implementing the intervention that may affect the people for whom it works.

Step 4: Implement Interventions

Prevention science in other areas such as substance abuse prevention and violence prevention shows some principles for effective action that apply to suicide prevention initiatives too. When we begin to implement the goals and objectives of Plan, we should base our efforts on these prevention principles. Here are the prevention principles to keep in mind:

1) Piecemeal, "here and there" prevention efforts may be weak; comprehensive programs are much more effective. For example, some community suicide prevention programs might include media campaigns and policy changes. These kinds of campaigns are much more effective when they are accompanied by programs that touch people personally in settings like schools, sports events, faith communities, and the workplace.

2) Suicide is related to many other problems facing Georgia's communities and cannot be addressed alone. As a result, suicide prevention programs should coordinate with other prevention efforts such as those designed to help reduce substance abuse.

3) We need suicide prevention programs that can address the unique needs of people in each stage of life. This means suicide prevention programs must be developmentally appropriate and must address protective and risk factors across all age groups.

4) Suicide prevention programs must be culturally sensitive.

5) Prevention programs are stronger when they are long-term, with repeated opportunities to reinforce targeted attitudes, behaviors, and skills.

6) Family-focused prevention efforts have a greater effect than goals that focus on parents only or children only.

7) Prevention efforts tend to be stronger when they address multiple risk and protective factors. The higher the level of risk, the stronger the suicide prevention effort must be and the earlier it should begin.

8) To prevent suicide, we need to develop healthy communities across Georgia. We can do this through coordinated prevention programming with a local focus. Each community needs to develop its own suicide prevention plan that is tailored to meet local needs and build on local strengths.

9) Suicide prevention program planning and implementation must involve people, agencies, and organizations that represent the community broadly with respect to age, ethnicity, faith, occupation, sexual orientation, socioeconomic status, and cultural identity.

10) Training programs must seek to develop skills and not just work to increase knowledge. Effective training for skills requires multiple opportunities to *practice* the skills themselves, not just learn about them.

11) Public information campaigns about suicide prevention need to be ongoing efforts in order to maintain awareness. They should be developed with the assistance of persons knowledgeable about social marketing.

Step 5: Evaluate Effectiveness

"The lack of evaluation research is the single greatest obstacle to improving current efforts to prevent suicide among adolescents and young adults."

Morbidity and Mortality Weekly Report (MMWR)
April 22, 1994, Vol. 43/No. RR-6

Evaluations need to occur following the development and testing of interventions (Step 3) and following implementing interventions in the community (Step 4). Ideally, program planners will choose programs that have been fully evaluated and shown to be effective. Sometimes interventions are chosen which have not been fully evaluated, but are thought to be "promising" based on initial or partial evidence. Other available interventions follow known prevention principles or expert recommendations and might be considered "best practices" but lack evidence of effectiveness. A community should build in an evaluation to determine whether any intervention selected works under local conditions. ***Community suicide prevention programs must budget the time and money to build in evaluation right from the start!***

Determining the costs associated with sustaining programs and comparing those costs to the benefits of the programs is another important aspect of evaluation. This cost evaluation may help you receive continuing funding to sustain your program.

Web resources listed at the end of the Plan provide useful sources of information about designing and carrying out evaluations.

Working Together to Save Lives

"We as a society cannot let this go on any longer. We can't keep sweeping it under the carpet and hoping nobody notices."

— A Georgia Survivor

Mobilizing Communities for Action

The heart of the Plan is a call to *you*—caring people in local communities all over the state—asking you to take action to prevent suicide.

The Plan itself started with one family who lost a daughter to suicide. The family brought together a small group of people they had met who also wanted to address suicide prevention. The group started meeting together once a month to explore how they could mobilize the state to take action. Others joined them, and the Plan you are now reading is the result. You can use a similar process in your community.

Working Locally, One Suicide Prevention Champion by One

Effective suicide prevention efforts have to take place at the local level. The state and regional levels provide necessary support, but it's really up to the local communities to bring the action home. All it takes to start mobilizing a local community for suicide prevention is one person—any person from any walk of life. The group that person talks to about suicide prevention might be a woman's club, a ministerial alliance, or maybe a family resource center. The truth is, the starting point doesn't matter; *getting started* does. It matters that the person or group is determined to address the problem of suicide where they live and that they build a coalition of interested community and professional partners for action.

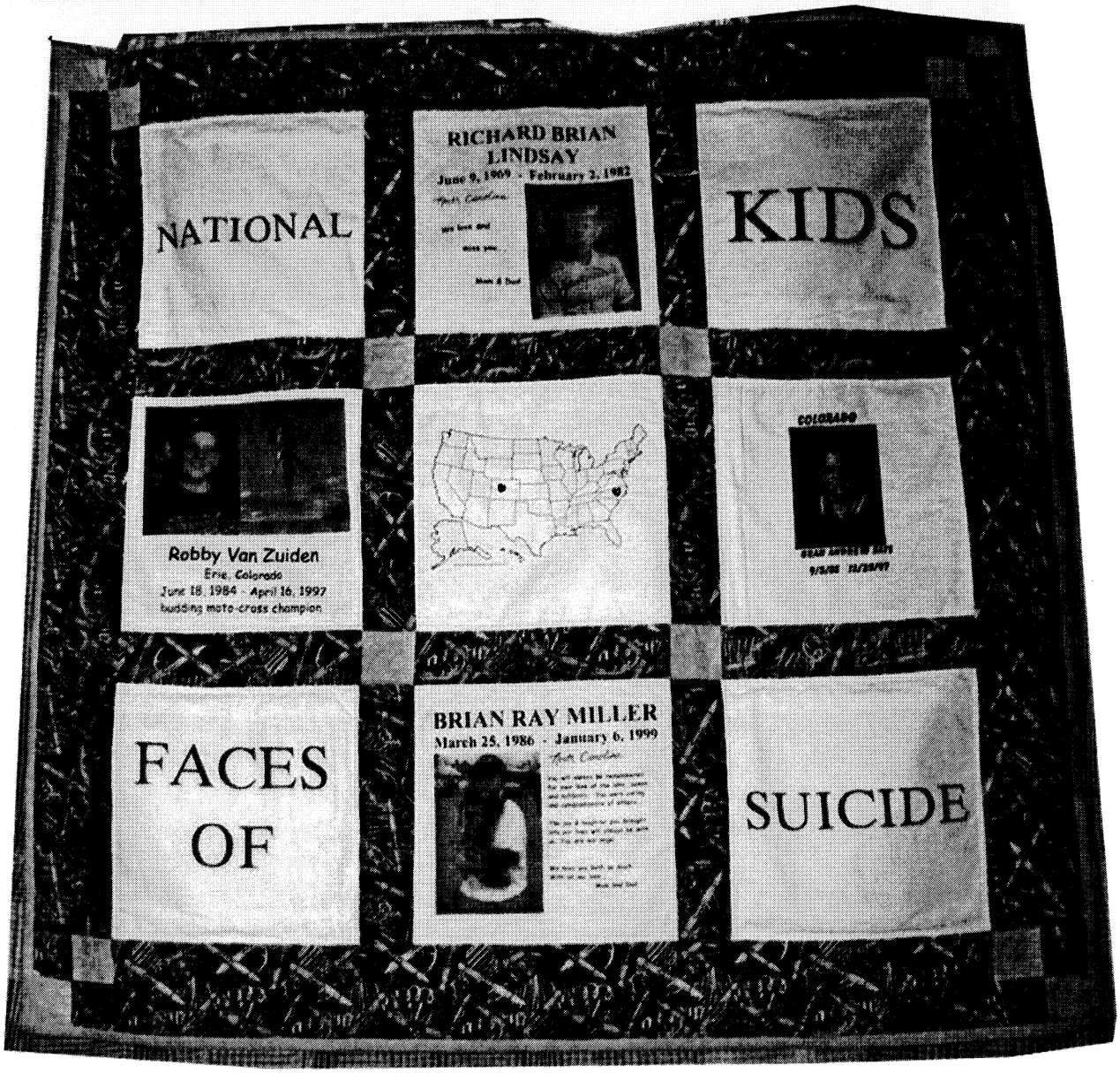
The first step in mobilizing your community is to recognize that the problem of suicide touches many people in every area, including yours. A lot of people may not know that fact, but would want to help if they knew. Many may know someone at risk for suicide, or may have been deeply touched by suicide already, but they may not know how to get involved. You can be a motivator in all these cases. As you start to take action, you will meet more and more people that will want to work with you.

Remember, suicide prevention
in your area starts with you.
Whoever you are and wherever you are,
you can *mobilize your community to*
develop and launch a
suicide prevention initiative.

You can help save lives.

The National Kid's Quilt

This quilt shows some of the faces of children age 12 and under who died by suicide.
The CDC reports that for 1996 through 1998 the 3rd leading cause of death in youth 10-20 is suicide.



"I am of the opinion
that it is society's
discrimination of the
illnesses that
lead to suicide, that so
often make these illnesses
too painful to bear!"

–Georgia Suicide
newsletter contributor

Comprehensive Goals to Prevent Suicide

The Plan gives a framework for getting everyone in Georgia—including *you*—involved in preventing suicide. The Plan is designed to guide individual people, agencies, and organizations, both in local communities and at the regional and state levels. One intention of this Plan is to change individual attitudes, knowledge, and behaviors about suicide. Equally important, the Plan seeks to affect all the systems in Georgia that touch our lives, including education, health care, the media, business, faith, and criminal justice, and to motivate them to help prevent suicide.

The previous section of the Plan told you a little about why suicide prevention is important, how the Plan came into existence, and why we need to evaluate any actions we take in our work for suicide prevention.

This section gives actual goals and ideas you can use. The information offered is not to be considered a "prescription" for what you must do in your community. You know your community best. Consider the ideas below as a menu from which you can select those you believe will work best. By acting on *any* of the ideas listed in this section, you will have a direct impact on suicide prevention efforts in Georgia.

The **building blocks** of the Plan are eleven goals with related objectives based on the *National Strategy for Suicide Prevention: Goals and Objectives for Action.* A goal is a targeted outcome—a result to aim for—which will promote the reduction of suicide. The goals in the Plan are grouped together under three headings ***A***wareness, ***I***ntervention, and ***M***ethodology – ***AIM***.

Any single step you take, any one objective you try to tackle, can help prevent suicide. If you take on one goal in your community, and someone else does the same thing in theirs, and on and on, together we will be building a powerful force to save lives in Georgia!

- **Plan Objectives:** For each goal, there are a number of related objectives, which can serve as direction guides. Their purpose is to help you focus on how to achieve the goals.
- **Action Ideas:** Each objective has an action idea, to stimulate your thinking about ways to implement or support that objective in your local community.
- **Evaluation:** If you are carrying out suicide prevention activities, part of your time and your budget needs to be devoted to evaluating the outcomes from your project. Please see the listing of Web resources for information about conducting sound evaluations.

"We need to help people that have no hope or money. We need to support them and not throw them away."

—A Georgia mother who lost a daughter to suicide

Action Step: AWARENESS

The problem of suicide in Georgia is serious—after all, suicide takes more lives than murder in our state. More Georgians need to be made aware of this! And at the same time, they need to be told that many suicides are preventable, and *they* can help fight suicide.

There is no single way to reach every person in Georgia and make them more aware of the problem of suicide but some of the useful approaches are:	
• Public information campaigns • Forums at the community level where friends, neighbors, and professionals can come together and learn about suicide prevention opportunities • Regional and state conferences • Web sites	Summary A variety of approaches are needed to reach all the different types of people that make their home in Georgia.

Goal 1. Promote awareness that suicide is a serious public health problem and that many suicides are preventable.

Objective 1.1 Develop and implement public information campaigns designed to increase all Georgians' knowledge of suicide prevention and an understanding of the role of risk and protective factors in prevention.

Action idea: Develop information materials that community members can distribute to neighbors, friends, and co-workers. Call 1-770-740-0632 —the Plan office —for ideas. Materials should describe suicide risk and protective factors, present available community resources, explain how to join in the effort to prevent suicide in Georgia, and discuss how to increase help-seeking behaviors.

Objective 1.2 Establish regular Georgia suicide prevention conferences designed to foster collaboration with stakeholders on prevention strategies and to inform communities.

Action idea: Hold public forums across the state at the regional level and in local communties. These forums should present the Plan and encourage regions and communities to act on implementing the Plan.

Objective 1.3 Increase the number of public and private Georgia institutions active in suicide prevention that deliver clear and culturally sensitive information through the Internet.

Action idea: Access the Plan web site for information about Plan activities and links to resources for suicide prevention: www.georgiasuicidepreventionplan.org.

Goal 2. Develop broad-based support for suicide prevention.

The only really effective way to prevent a public health problem like suicide is for people from every walk of life, every faith, every ethnic background, and every age group to work together. Taking action to prevent suicide is more than just the job of mental health professionals—*every* Georgian has a part to play in saving lives! Working together will achieve success in preventing suicide.

Objective 2.1 Increase the number of people in Georgia actively involved in some aspect of suicide prevention.

Action idea: At the community level, put outreach activities in place that build on the public information campaigns and actively recruit people from all parts of the community to participate in the Plan.

Objective 2.2 Increase the number of local communities in Georgia actively working to implement the Plan.

Action idea: Recruit and train at least one member of each community in Georgia to be a community organizer for suicide prevention.

Objective 2.3 Include suicide prevention education in ongoing programs and activities carried out by prevention organizations, professional, volunteer, and other groups across Georgia.

Action idea: Visit leaders of these community groups to engage their participation and support in integrating suicide prevention into ongoing programs. Examples of the groups include child abuse, substance abuse, domestic violence, tobacco, and gambling prevention organizations. Other groups include Family Connection Programs, Community Service Boards, Boys and Girls Clubs, United Way Agencies, and faith-based service providers.

Objective 2.4 Increase the number of faith communities in Georgia that adopt policies and prorams promoting suicide prevention.

Action idea: Identify faith communities at both the state and community level. Visit their leaders to ask for their cooperation and support. Provide suggested policies and programs promoting suicide prevention, and ask the faith leadership to implement them in their organizations.

Objective 2.5 Expand the Plan Steering Committee with representatives from both the public and private sectors including scientists, suicide survivors, consumers of mental health services, educators, clinicians, community volunteers, public health leaders, and corporate/nonprofit advocates. This Committee provides oversight for Plan implementation, and it works towards collaboration between state wide agencies and organizations.

Action idea: Coordinate with existing prevention programs in related areas, such as substance abuse, child abuse, and gambling prevention; faith communities, Cooperative Extension Service, Community Service Boards, Family Connections, and others.

Objective 2.6 Expand the Plan Advisory Council to provide advice and support for implementation.

Action idea: Recruit active Advisory Council members that are broadly representative of Georgia. The Advisory Council will hold meetings in various parts of Georgia.

Goal 3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Suicide is often closely linked to mental illness and to substance abuse, and both can be effectively treated. However, the stigma of mental illness and substance abuse prevents many people from getting treatment they need and may also cause family members to try to hide what's happening instead of reaching out for help. They are afraid of how others will react. They are afraid they will face discrimination and prejudice. Stigma has been identified as a strong barrier to future progress in the area of mental health and suicide prevention. Each Georgian can play a significant part in overcoming the barrier of stigma, so that people can receive the help they need.

Objective 3.1 Increase the proportion of the people in Georgia that view mental and other health as co-equal and inseparable components of overall health.

Action idea: Train community volunteers to give educational presentations at local civic groups.

Objective 3.2 Increase the proportion of the people in Georgia that view mental disorders as real illnesses that respond to specific treatments.

Action idea: Develop a public awareness campaign that shows mental illnesses as treatable disorders and not character failings.

Objective 3.3 Increase the proportion of the people in Georgia that view consumers of mental health, substance abuse, and suicide prevention services as pursuing fundamental care and treatment for overall health.

Action idea: Develop a speakers bureau that can make community presentations.

Objective 3.4 Increase the proportion of those suicidal persons in Georgia with underlying mental disorders who receive appropriate mental health treatment.

Action idea: Work to ensure that mental health services are culturally sensitive.

Action Step: INTERVENTION

Goal 4. Develop and implement community-based suicide prevention programs.

Objective 4.1 Improve collaboration among government agencies and among public/ private partners in implementing the Plan at the state, regional, and local levels.

Action idea: Representative governmental groups include the Georgia Department of Human Resources (Divisions of Public Health, Mental Health, Mental Retardation and Substance Abuse, Aging Services, and Family and Children's Services); the Georgia Department of Education, Juvenile Justice, Pardon and Paroles, Community Service Boards, County Health Departments, the Department of Highway Safety and the Department of Public Safety. Non-governmental groups include SPAN USA, the National Mental Health Association of Georgia, the National Alliance for the Mentally Ill, the Georgia Council on Child Abuse, the Family Connection, the Georgia Council on Substance Abuse, the Georgia Prevention Network, and Cooperative Extension Service, among many others. Identify a lead agency or organization to coordinate implementation of the Georgia Plan.

Objective 4.2 Establish institutional policies and procedures for referral of persons at risk and for crisis response.

Action idea: Provide knowledgeable presenters to assist with in-service education programs that will keep school system personnel updated about referral and crisis response procedures.

Objective 4.3 Increase the number of school districts with evidence-based programs that are designed to address childhood and adolescent distress and prevent suicide. Call 1-770-740-0632 (The Plan office) for ideas.

Action idea: Support parent-teacher groups and school system personnel in identifying a district-wide suicide prevention program to put into place.

Objective 4.4 Increase the number of colleges and universities in Georgia with evidence-based programs designed to address young adult distress and prevent suicide.

Call 1-770-740-0632 (The Plan office) for ideas.

Action idea: Work with student counseling service directors at colleges and universities in Georgia to select and implement programs.

Objective 4.5 Increase the number of employers in Georgia that make evidence-based prevention programs for suicide available to their employees.

Action idea: Coordinate activities with employee assistance professionals and human resources directors at local companies.

Objective 4.6 Improve suicide prevention programs for both adult and juvenile offenders in Georgia's correctional institutions, jails, and detention centers.

Action idea: Invite staff and community advisory board members from correctional institutions to conferences and meetings on mental health services and suicide prevention.

Objective 4.7 Increase the number of elder service organizations that include evidence-based suicide prevention programs designed to identify older people at risk for suicidal behavior and refer them for treatment.

Action idea: Work with directors of the nursing homes in communities to conduct a needs assessment for suicide prevention programs for their residents.

Objective 4.8 Increase the number of family, youth and community service organizations and providers in Georgia with evidence-based suicide prevention programs.

Action idea: Establish round table meetings for local youth-serving organizations to exchange information and promote incorporation of suicide prevention into their ongoing programs.

Objective 4.9 Improve and coordinate crisis help line services in Georgia.
Action idea: Evaluate existing coverage and outcomes to identify areas for improvement.

Goal 5. Promote efforts to reduce access to lethal means of self-harm.

Objective 5.1 Increase the proportion of primary care clinicians, other health care providers and health and safety officials who routinely ask about the presence of lethal means of self-harm in the home and educate about actions to reduce associated risks.

Action idea: Partner with hospital associations, managed care organizations, and professional medical health organizations to provide opportunities for clinicians and other health care providers to learn about decreasing access to lethal means of self-harm.

Objective 5.2 Develop and distribute materials to educate about actions to reduce the accessibility of lethal means of self-harm.

Action idea: Engage community leaders and prevention specialists in development of appropriate materials.

Goal 6. Implement training for recognition of at-risk behavior and delivery of effective treatment.

Many of the conditions associated with suicidal behaviors have effective treatments. Unfortunately, many people are not trained to recognize persons at risk for suicide who could benefit from treatment. Even many health professionals do not have the training to provide proper assessment and treatment, and may not know when to refer persons for specialized care.

This goal addresses the need to provide training to key community gatekeepers as well as professionals. Gatekeepers are community members who regularly come into contact with people who may be at risk for suicide.

Objective 6.1 Provide continuing education for primary care providers that includes the recognition of persons at risk for suicide, information on screening programs, assessment and management of suicide risk, effective treatments, and appropriate conditions for referral to specialty care.

Action idea: Include workshops on suicide prevention at annual meetings of professional associations.

Objective 6.2 Incorporate suicide prevention materials in training programs for physician assistants, physicians, medical residents, nursing care providers, and other health professionals. This training should cover the assessment and management of suicide risk and identification and promotion of protective factors.

Action idea: Work with directors of education at professional schools in Georgia to include suicide prevention training in the basic curriculum. This training should cover the assessment and management of suicide risk and identification and promotion of protective factors.

Objective 6.3 Increase the number of clinical social work, counseling, and psychology graduate programs in Georgia that include suicide prevention training. This training should cover the assessment and management of suicide risk and identification and promotion of protective factors.

Action idea: Work with directors of education at these professional programs to include suicide prevention training in the basic curriculum. This training should cover the assessment and management of suicide risk and identification and promotion of protective factors.

Objective 6.4 Increase the number of social workers, poison control center personnel, outreach workers, case managers, and home visitation program providers who receive job-

related suicide prevention training. This training should cover the assessment of and response to suicide risk and behaviors.

Action idea: Work with the Department of Family and Children's Services to incorporate training on the assessment and response to suicide risk and behaviors into ongoing in-service education.

Objective 6.5 Increase the number of clergy from all faith communities in Georgia who are trained in identification of and response to suicide risk and behaviors, and who are trained to tell the difference between mental disorders and faith crises.

Action idea: Provide speakers to the local ministerial alliance to assist in training programs.

Objective 6.6 Increase the number of educational faculty and staff and youth development staff working outside school settings who receive training on identifying and responding to children and adolescents at risk for suicide.

Action idea: Work with local school systems and youth-serving organizations to provide gatekeeper training for all staff, e.g., teachers, school counselors, bus drivers, custodians, coaches, playground supervisors, and after-school program staff.

Objective 6.7 Increase the number of juvenile justice, justice, correctional and public safety system personnel in Georgia who receive training on identifying and responding to persons at risk for suicide.

Action idea: Work with youth detention centers to provide gatekeeper training for all their staff.

Objective 6.8 Improve education programs and support services available to family members and others in close relationships with people at risk for suicide and survivors of suicide.

Action idea: Work with community mental health centers to incorporate education programs for family members and others in close relationships with people at risk for suicide.

Objective 6.9 Increase the number of community helpers, such as mail carriers, hairdressers, Meals on Wheels volunteers, and senior service volunteers who are trained to recognize, respond to, and refer for help people at risk of suicide and associated mental and substance abuse disorders.

Action idea: Work with local Meals on Wheels programs to provide gatekeeper training to staff and volunteers.

Goal 7. Develop and promote effective professional practices and support services.

Implementing this goal will help to ensure that at-risk people receive the assessment and treatment services they need. It presents ways to help provide appropriate training for key people who deliver these services, and it seeks to ensure that a full range of services will be provided. These services include follow-up for at-risk people so that treatments are continued to reach maximum benefits. Reaching these service providers and helping them do more for suicide prevention can save many lives.

Objective 7.1 Increase the proportion of patients treated for self-destructive behavior by Georgia hospital emergency departments that pursue the proposed mental health follow-up plan.

Action idea: Work with hospital associations to develop tracking procedures that can confirm mental health follow-up appointments.

Objective 7.2 Promote the incorporation of guidelines to use in assessing suicidal risk among people receiving care in primary health care settings, including survivors of suicide, emergency departments, and specialty mental health and substance abuse treatment centers.

Action idea: Sponsor the distribution of posters for emergency rooms that list important steps in assessing suicide risk.

Objective 7.3 Increase the number of mental health and substance abuse treatment centers in Georgia that have clear suicide prevention policies, procedures, and evaluation programs. These programs should be designed to assess suicide risk and to intervene to reduce suicidal behaviors.
Action idea: Work with local mental health and substance abuse directors to offer community and staff in-service suicide prevention education.

Objective 7.4 Enhance screening for depression, substance abuse and suicide risk as a basic standard of care for all state-supported healthcare programs in Georgia's primary care settings, hospice, and skilled nursing facilities.

Action idea: Sponsor depression screening days.

Objective 7.5 Promote guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (especially those discharged from inpatient hospital units and mental health institutional settings).

Action idea: Work with local directors of specialty treatment centers and offer community participation in developing guidelines that include education and psychological support to families and significant others of those who have exhibited suicidal behavior.

Objective 7.6 Certain people in Georgia provide key immediate services to suicide survivors as first responders, for instance, emergency medical technicians, public safety officers, funeral directors, and clergy. Provide training that specifically addresses these first responders' own exposure to suicide and the unique needs of survivors.

Action idea: Organize suicide survivors in the community to provide seminars on recognizing and managing the personal impact of suicide on first responders.

Objective 7.7 Increase the availability of appropriate mental health and substance abuse disorder treatment services in Georgia for persons with mental disorders, substance abuse disorders, or a history of trauma or abuse. Increase the number of patients served who complete their course of treatment or continue indicated maintenance treatment.

Action idea: Local clinicians follow up with a call or letter to encourage their patients with depression that have discontinued treatment to resume it.

Objective 7.8 Increase the number of hospital emergency departments in Georgia that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.

Action idea: Encourage volunteer training in suicide prevention and victim support. Link them to hospital emergency departments as a resource.

Objective 7.9 There are people in Georgia receiving care for the treatment of mental health and substance use disorders that are at-risk for suicide. Develop guidelines for providing education to their family members and significant others. Implement the guidelines in Georgia facilities such as general and mental hospitals, mental health clinics, and substance abuse treatment centers.

Action idea: A partnership made up of service providers in a community can work together with some family members to develop education guidelines and implement them in their respective facilities.

Objective 7.10 Extend and improve comprehensive support services for survivors of suicide.

Action idea: Provide training for group facilitators and community meeting spaces for survivor of suicide support groups.

Goal 8. Increase access to and community linkages with mental health and substance abuse services.

Services to prevent suicide must be available when and where people need them. That means providing services in lots of different places. Financial barriers such as not having health insurance must come down. Structural barriers such as lack of health care professionals to meet the need must

be overcome. You can help put any one of a variety of outreach goals in place that address personal barriers, such as not knowing what to do or when to seek care, or concerns about confidentiality or discrimination.

Objective 8.1 Compile and update a guide to Georgia suicide prevention resources and services (A Georgia Suicide Prevention Resource Directory.) Provide linkages to The National Suicide Prevention Resource Center.

Action idea: Provide current suicide prevention information to Georgia's existing help lines.

Objective 8.2 Make Georgia the leading state in health insurance plans that cover mental health and substance abuse services on par with coverage for other health.

Action idea: Educate state senators and representatives and the insurance commissioner, in order to build the necessary support for substantial parity legislation. In addition, community members can work with employee organizations and local employers to provide benefits for mental health coverage at the same level as coverage for physical health care.

Objective 8.3 Increase the number of Georgia counties with health and/or social services outreach programs for at-risk populations. These outreach programs should include mental health and substance abuse services and suicide prevention activities.

Action idea: Work with county health and social service agencies to address the need for all staff who make home visits and/or provide case management services to the elderly to be trained to make appropriate referrals to mental health services.

Objective 8.4 Support guidelines for mental health and substance abuse screening with referral procedures for students in schools, colleges and universities. Expand the availability of site-based nurses and counselors to provide assessment and referral after screening.

Action idea: Parents could work with the local school board to institute policies and procedures for assessment, referral, and follow-up to local service providers that would offer same-day initial appointments for high-risk students.

Objective 8.5 Support consistent use of guidelines for mental health screening in sites with at-risk populations such as correctional facilities, detention centers, crisis centers, family planning clinics, recreation centers, youth-serving organizations, homeless shelters, employee assistance offices, and alcohol /drug treatment programs.

Action idea: Community members can support ongoing continuing education in screening for providers and the availability of licensed professionals to provide referral services.

Objective 8.6 Support quality care/use management guidelines that detail appropriate responses to suicidal risk or behavior. Implement these guidelines in managed care and health insurance plans that operate in Georgia.

Action idea: Work with managed care organizations in Georgia to develop and implement clinical practice guidelines for suicide risk assessment and management.

Goal 9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

Evidence indicates that the way suicide, mental illnesses, and substance abuse are presented in the media may affect the suicide rate.

Objective 9.1 Establish a Georgia coalition of public and private organizations to influence media practices. This group can promote the accurate and responsible representation of suicidal behaviors and mental illnesses and informed media coverage of suicide prevention.

Action idea: Identify survivors and community advocates who will be active participant members of the coalition.

Objective 9.2 Increase the proportion of entertainment and news programs and print coverage in Georgia that reflect accurate and responsible portrayal of suicidal behavior, mental illnesses, and related issues.

Action idea: Offer regular seminars for editors and producers that identify appropriate coverage and misleading or dangerous depictions of suicide, mental illnesses, and treatments.

Objective 9.3 Encourage Georgia journalism schools to include guidance in their course of study on the portrayal and reporting of mental illnesses, substance use disorders, suicide, and suicidal behaviors.

Action idea: Bring survivors and prevention specialists together with journalism professors in developing curriculum materials.

Action Step: *Methodology*

Goal 10. Promote and support research and evaluation on suicide prevention.

Advancing research and evaluation increases the knowledge base for effective interventions to prevent suicide. This knowledge can inform decision-making among community groups as they seek to provide quality programs that will make a difference.

Objective 10.1 Increase public and private funding for suicide prevention research and evaluation conducted in Georgia, and for studies on how to put scientific knowledge into practice in Georgia at the state, regional, and community levels.

Action idea: Develop community-researcher-practitioner networks for better suicide prevention research in Georgia.

Objective 10.2 Support development of and access to a registry of prevention activities with demonstrated effectiveness for preventing suicide and suicidal behaviors.

Action idea: Local suicide prevention program planners could review the registry to help guide their selection of activities.

Objective 10.3 Provide training and technical assistance on the evaluation of suicide prevention programs implemented in Georgia.

Action idea: Develop and distribute user-friendly toolkits on program evaluation.

Objective 10.4 Increase the number of jurisdictions in Georgia that will regularly collect and provide information for follow-back studies on suicides.

Action idea: Follow-back studies of suicide gather additional information after a death that can be useful in prevention. Develop community support for follow-back studies so that local jurisdictions will be willing to participate.

Goal 11. Improve and expand surveillance systems.

Remember that surveillance is the ongoing process of collecting information about the "who, what, when, where, how, and how many" of suicide in Georgia. Surveillance systems are key to planning for suicide prevention. We must get information about suicide both from sources developed for this purpose (like vital statistics and medical examiner databases) and from other sources like mental health agencies, psychiatric hospitals, child death review team reports, and emergency departments. To realize success in preventing suicide we need better indicators to measure community-level results and expanded surveillance systems. By helping implement the objectives for this goal, you are helping to improve data available to make informed decisions about suicide prevention.

Objective 11.1 Develop and refine standard procedures for death scene investigations, and implement these procedures in all Georgia's counties.

Action idea: Provide scientific information about suicide to coroners and medical examiners developing procedures, so the appropriate kinds of investigation evidence can be sought to accurately identify deaths that were suicide.

Objective 11.2 Develop and test a protocol to assist Georgia hospitals in collecting uniform and reliable data on suicidal behaviors by coding external causes of injury and determining associated costs.

Action idea: The Department of Human Resources Division of Public Health could conduct a trial of the protocol and report back findings and recommendations.

Objective 11.3 Implement a violent death reporting system in Georgia that includes suicides and collects information not currently available from death certificates.

Action idea: Use local Fatality Review Committees to provide additional information.

Objective 11.4 Produce reports on suicide and suicide attempts in Georgia, integrating data from multiple state data management systems.

Action idea: Support publication of regular Georgia suicide surveillance reports from the Department of Human Resources Division of Public Health.

Objective 11.5 Establish surveillance systems of risk behaviors for suicide among youth and adults in Georgia.

Action idea: Local community members need to ask their school boards and superintendents to administer the CDC Youth Risk Behavior Survey (YRBS) throughout the school system including all questions about suicidal thinking and behaviors.

Objective 11.6 Develop a set of community level indicators for progress in suicide prevention. Indicators are measures that signal achievement of community level results.

Action idea: Initiate a process for identifying indicators keyed to the Plan and make indicator information accessible in communities across Georgia.

"We need help now.
The young people here
are greatly at risk."

—A Georgia minister

A Continuous Improvement Process

The Plan represents the best efforts of a group of dedicated people who welcome your ideas for community prevention activities and user feedback on the Plan. Please contact us at:

The Georgia Suicide Prevention Plan
5034 Odins Way, Marietta, GA 30068

Phone: **770-740-0632** (local Atlanta)
Fax: **770-642-1419**
E-mail: **GSPP@spanusa.org**

This Plan is a living document. That means it is expected to change and to further develop over time, as new opportunities, new community participants, new research, and new conditions arise. Whether you have been involved in the initial development of the Plan or are just now joining, you can make a difference by contributing to the Plan's continued development.

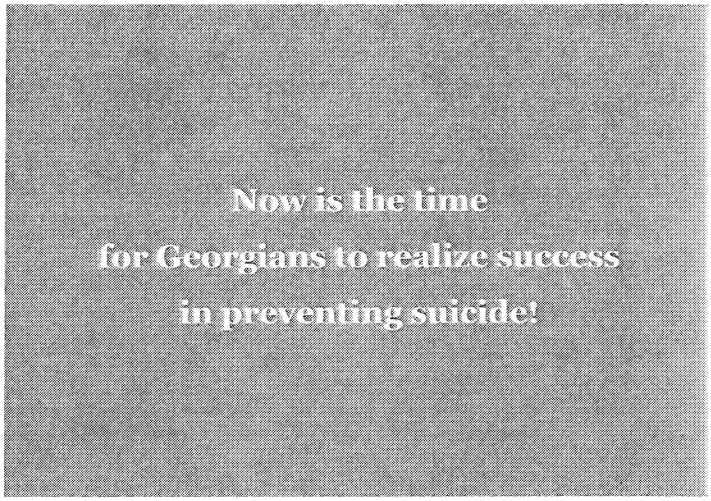
Taking Action

This Plan is comprehensive and wide-ranging. Putting the Plan into action will take place in phases. For the Plan to work, every one of us must be involved. The keystone of the Plan is implementation—getting the Plan to work. This is where **you** are important. In addition to the work of state agencies, implementing the Plan requires broad participation and collaboration from each of us in our own communities. Professionals and community volunteers must work side-by-side, and public agencies and private organizations will have to expand their partnerships so that together Georgia can make a lasting difference in suicide prevention.

Suicide Prevention in Georgia is truly everyone's business!

The essential next steps are designed to:

- ✔ increase support, participation, and collaboration for suicide prevention,
- ✔ develop an operating structure or coordinating body for the Plan that reflects a public/private partnership,
- ✔ involve communities in suicide prevention planning at the local level,
- ✔ provide opportunities for people to share ideas and work together through statewide conferences and local community forums, make technical assistance and resources for suicide prevention widely available,
- ✔ develop or identify useful indicators to benchmark community progress in suicide prevention,
- ✔ improve program evaluation and surveillance, and
- ✔ provide progress reports on Plan implementation.



Web Resources for Information about Suicide and Suicide Prevention

Evaluation Information

Georgia Suicide Prevention Plan
http://www.georgiasuicidepreventionplan.org

Primer on Evaluation from the U.S. Department of Justice
http://www.bja.evaluationwebsite.org

The Public Health Approach to Evaluation
http://www.cdc.gov/eval

Taking Stock: A Practical Guide to Evaluating Your Own Programs
http://www.horizon-research.com/public.htm

National and International Organizations Working for Suicide Prevention

American Association of Suicidology
http://www.suicidology.org

American Foundation for Suicide Prevention
http://www.afsp.org

Faith in Action (the Robert Wood Johnson Foundation)
http://www.fiavolunteers.org

Georgia Suicide Prevention Plan
http://www.georgiasuicidepreventionplan.org

Jason Foundation, Inc.
http://www.jasonfoundation.com

The Link's National Resource Center for Suicide Prevention and Aftercare
http://www.thelink.org

National Organization for People of Color Against Suicide
http://www.nopcas.com

National Hopeline Network – 1-800-SUICIDE
http://www.hopeline.com

Organizations of Attempters and Survivors of Suicide Interfaith Services
http://www.oassis.org

Samaritans
http://www.samaritans.org.uk

Suicide Awareness Voices of Education
http://www.save.org

Suicide Prevention Advocacy Network USA
http://www.spanusa.org

Suicide Prevention Efforts in Canada
http://www.suicideinfo.ca

Suicide Prevention Research Center
http://www.suicideprc.com

World Health Organization Suicide Prevention Efforts
http://www.who.int/mental_health/Topic_Suicide/suicide1

Yellow Ribbon Suicide Prevention Program
http://www.yellowribbon.org

National Strategy for Suicide Prevention

Comprehensive National Strategy for Suicide Prevention Web Site
http://www.mentalhealth.org/suicideprevention

Suicide Prevention Advocacy Network, USA
http://www.spanusa.org

Surgeon General's: Call to Action to Prevent Suicide 1999
http://www.spanusa.org

State Suicide Prevention Efforts

Children's Safety Network National Injury and Violence Prevention Resource Center. This site lists (by state) rates and methods of suicide in children aged 10 and up.
http://www.injuryprevention.org/info/data.htm

Georgia Suicide Prevention Plan
http://www.georgiasuicidepreventionplan.org

State Resources for Child Injury and Violence Prevention
http://www.edc.org

Suicide Data

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control Data
http://www.cdc.gov/ncipc/osp/data.htm

Costs of Completed and Medically Treated Suicide
http://www.edc.org/HHD

Maternal and Child Health Bureau Block Grant Data
http://www.mchb.hrsa.gov (click on Grant Guidance)

Web Based Injury Statistics Query and Reporting System (WISQARS)
http://www.cdc.gov/ncipc/wisqars

Suicide and Suicide Prevention Information

Crisis Management in Schools Following a Suicide
http://www.ed.gov/databases/ERIC_Digests/ed315700.html

Evangelical Lutheran Church in America. A Message on Suicide Prevention
http://www.elca.org/dcs/suicide_prevention.html

National Institute Mental Health Frequently Asked Questions about Suicide
http://www.nimh.nih.gov/research/suicidefaq.cfm

National Institute of Mental Health Selected Bibliography on Suicide Research – 1999
http://www.nimh.nih.gov/research/suibib99.cfm

The National Institute of Mental Health report on Research on Women's Mental Health
http://www.nimh.nih.gov/wmhc/highlights.cfm

National Institute Mental Health Suicide Fact Sheets
http://www.nimh.nih.gov/research/suifact.htm

Providing Immediate Support for Survivors of Suicide
http://www.ed.gov/databases/ERIC_Digests/ed315708.html

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U.S. Department of Health and Human Services. *Healthy People 2010.* 2nd ed. Washington, DC: U.S. Government Printing Office, November, 2000.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC, 1999

Glossary of Terms Used in the Georgia Plan

Assessment - The ongoing process of information gathering, examination, and evaluation to a) determine risk, b) identify contributing factors which may be modified, c) diagnose, if applicable, d) choose optimal interventions or treatments, and e) track the impact of interventions or treatments.

Attempters – See Suicide attempt and Suicide survivors

Community capacity – The characteristics of communities that affect their ability to identify, mobilize, and address social and health problems and the cultivation and use of transferable knowledge, skills, systems and resources that affect community and individual level changes consistent with population health-related goals and objectives. (Goodman et. al., 1998)

Connectedness – A person's sense of belonging with others. A sense of connectedness can be with family, school, workplace, and community.

Effectiveness – Effectiveness studies test the real world impact of interventions that have been shown to be efficacious under controlled conditions. These studies are needed to determine whether results from studies carried out under very controlled situations may be generalized to other settings.

Efficacy – Efficacy studies are used to develop and refine interventions under experimental conditions. These settings are usually controlled to represent ideal conditions.

Epidemiology – The study of statistics and trends in health as applied to the whole community or population.

Evidence-based programs – Those programs that have some research showing that the program was associated with the intended beneficial outcome(s).

Follow-back study – A study carried out after a death to provide information from persons or from existing records that will add to the information sources used by the coroner or medical examiner in determining the cause of death. Example: the collection of the same categories of information about persons who had died by suicide and persons who had died from heart disease in order to compare the two groups and help understand their risk and protective factors.

Gatekeeper training – Training for community members who have face-to-face contact with many others as part of their usual routine. Training usually includes recognition of persons at risk of suicide and information on how to refer for treatment or supporting services, as appropriate.

Interventions – Actions or programs that can reduce the effect of risk factors and/or increase protective factors. An example of an intervention would be providing effective treatment for depressive illness.

Mental Health Screening – Surveys done by health care professionals, schools, and others to identify people who have a mental illness and to refer them to mental health professionals.

Outcome – A measurable change that can be attributed to an intervention or a program.

Outreach programs – Programs with staff that go into communities to deliver services or recruit participants.

Population-based interventions – Interventions targeting populations or communties rather than individuals.

Primary care – The care system that provides the first point of contact for those in the community seeking general assistance; for example, family practitioners or pediatric nurse clinicians.

Program evaluation – The process used to measure the outcomes of a program or service.

Providers – Professionals who offer health, mental health, treatment, or social services.

Protective factors – Those characteristics and circumstances that reduce the likelihood of suicide or suicidal behaviors.

Resilience – Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors – Those characteristics and circumstances that make it more likely for suicide or suicidal behaviors to occur.

Stakeholders – The groups and individuals that care about or are affected by suicide prevention decisions and policies.

Substance use disorders – Disorders in which drugs, including alcohol, are used to such an extent that social and occupational functioning is impaired and control or abstinence becomes impossible.

Suicidal behavior – Suicidal behavior includes a range of activities related to suicide and self-harm, including suicidal thinking, self-harming behaviors without thoughts of death, and suicide attempts.

Suicide –Intentional, self-inflicted death.

Suicide attempt – (Also Attempters) Nonfatal behavior that is intended to end one's own life, and which may produce self-injury.

Suicide attempt survivors – Individuals who have previously attempted suicide.

Suicide survivors – Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide. In other publications this term may be used to refer to suicide attempt survivors.

Surveillance – The regular monitoring of health conditions in the population through the systematic collection, evaluation, and reporting of measurable information. Surveillance can be used to understand trends.

EDITOR'S NOTE: Many entries in this Glossary quote or adapt usage from *National Strategy for Suicide Prevention: Goals and Objectives for Action, Commonwealth Department of Health and Aged Care 2000, Promotion, Prevention and Early Intervention for Mental Health – A Monograph, and Promoting the Mental Health and Wellbeing of Children and Young People.*

"I often wonder, in this hurried, harried world we live in...does anyone truly care?"

—A Georgia social worker

"We must let people contemplating suicide know that someone cares and that there are people available to help them, that there IS help."

A Georgia father who lost a son to suicide

Saving Lives In Georgia

Together We Can!

APPENDIX E

"An Outline for the Draft Report of the Subcommittee on Suicide Prevention,"
President's New Freedom Commission on Mental Health

Subcommittees of the President's New Freedom Commission on Mental Health

Subcommittee Roster

Subcommittee Report Summaries

Rights and Engagement	January 9, 2003
Rural Issues	January 9, 2003
Mental Health Interface	January 8, 2003
Older Adults	January 8, 2003
Co-occurring Substance Abuse and Disorders	December 2, 2002
Evidence-Based Practices	November 26, 2002
Suicide Prevention	December 3, 2002
Crimial Justice	December 2, 2002

An Outline for the Draft Report of the Subcommittee on Suicide Prevention

December 3, 2002

The Public Health Challenge of Suicide

Suicide is a serious public health challenge that has not received the attention and degree of national priority it deserves. Centers for Disease Control and Prevention (CDC) data indicate that in 1999 there were 29,199 deaths from suicide, there were more than 152,000 hospital admissions for self-harming behaviors, and more than 700,000 visits to hospital emergency rooms for similar problems. Overall, suicide was the 11th leading cause of death among Americans in 2000. It also is noteworthy that suicide was the third leading cause of death among youth aged 10-14, third among those 15-24, second among those 25-34 years, and fourth among those 35-44 years. While there are about twice as many deaths from suicide each year as from AIDS, spending on suicide research and prevention was approximately $40 million compared to $3.2 billion for HIV/AIDS research and prevention.

The urgent need for action on suicide prevention is the subject of a number of recent reports and congressional resolutions. The U.S. Surgeon General signaled heightened national awareness of the problem with his *Call to Action* in 1999. This was followed by the *Goals and Objectives for the National Strategic Plan for Suicide Prevention*. The Institute of Medicine (IOM) underscored its recognition this year of suicide prevention as a significant public health problem with the publication *Reducing Suicide: A National Imperative*. We can develop new suicide prevention programs and evaluate their impact without waiting for more fundamental research findings. What is called for is an integrated approach to establishing suicide prevention efforts, focused both on **sites for action** to capture populations not often seen in medical settings and attention to **groups bearing elevated risk burdens.**

Innovative Programs

The US Air Force suicide prevention program takes an integrated and multilayered population-based approach that has been shown to be effective. Evaluation suggests there are several key components of that program. Sustained, focused leadership that conveys the urgency of preventing suicide is essential. This energetic top-down process must be integrated with creative, locally knowledgeable implementation—resulting in a dynamic down-up-down quality of interaction. An overall "take-home" message from the USAF suicide prevention program is that when we reduce the stigma of seeking help for mental disorders we save lives and reduce violence in the community. A second implicit message is just as important: Successful prevention efforts will depend upon the community providing accessible and effective care for those who seek help.

Another type of program that has been found to be effective is a highly focused intervention with a specific high-risk population. In Monroe County, NY, for example, a community coalition was assembled that included community care providers, the County

Office of Mental Health, the local criminal justice systems, the courts, and the university department of psychiatry. Program staff reached out to persons who had serious mental illness and were chemically dependent as they were being released from jail or discharged from the local state psychiatric facility, or to individuals the courts identified as high risk for repeated incarceration. The program staff—a team of culturally attuned, "street wise" clinicians and case workers—provided intensive case management, careful evaluation of medical and psychiatric problems, and alternative supervised housing, in active partnership with probation and court-based personnel. During the study period there were no suicide attempts, assaults, or other reportable incidents among the participants. The results included dramatic reductions in jail time, psychiatric hospitalization, and high consumer satisfaction. Cost savings from reduced jail and hospital expenditures were about 3 times the cost of the program.

Policy Options

Suicide is a public health problem that requires broad based public health solutions. A fundamental premise of this report is that expertise, guidance, and funding sources need to be linked and coordinated at the Federal and state levels, adapted and monitored at the state level, and largely carried out locally. Three critical problems must be addressed:

1) Reducing the stigma for seeking care;
2) Ensuring access to necessary care; and,
3) Reducing the fragmentation of services within the mental health system and among other critical settings, such as schools, courts, and work sites.

This may require changes in our approach to funding health care services. Lasting success in preventing suicide will depend on maintaining a well-coordinated array of national, state, and local activities that become "institutionalized," with accountability from both elected and appointed leaders. Specific key policy options include the following:

1. Develop leadership within the Department of Health and Human Services (HHS)—with authority stemming from the Office of the Secretary—to coordinate all Federal suicide research and prevention efforts over a sustained period. Provide sufficient authority to coalesce and shape multiple Federal institutional forces in a common direction.

2. Design, implement, and rigorously evaluate Court Integrated Mental Health Services to deal with persons seen in family court (associated with domestic disputes and threats) and criminal court (associated with domestic violence, substance abuse, and crises among those with persisting mental disorders). Support these services with Medicare and Medicaid waivers—along with analogous mechanisms through the criminal justice systems.

3. Create public health oriented national centers of excellence through the National Institute of Mental Health (NIMH) to support research focused on developing and

testing novel interventions to prevent suicide and attempted suicide. The research agenda should include both high-risk group and population-oriented methods.

4. Establish Federal and state surveillance systems for reporting suicide and attempted suicide, with reliable and valid reporting standards and strict confidentiality safeguards. Support tightly monitored evaluation programs at the local level that use standard outcome measures and can expand our evidence base on suicide prevention program effectiveness.

5. Assert the central coordinating role of state mental health authorities as links between Federal and local suicide prevention efforts. This requires a reaffirmation of historic state commitments to caring for people with serious mental illness, and reflects states' unique ability to implement program initiatives in collaboration with local agencies, and to assure linkage among community agencies and clinical providers.

6. Develop broad-based Community Suicide Prevention Coalitions. "Community Coalitions" are defined, for the purposes of this report, as the engines for local collaborative action, reflecting the efforts of mixed nongovernmental and local governmental agencies, established on a foundation of rigorously evaluated community prevention initiatives. We recognize that each "community" may have distinctive coalitions that may differ in many respects while sharing a common commitment to suicide prevention (e.g., efforts to prevent suicide among youth or among elders).

APPENDIX F

Suggested Legislation

BDR 40-288	Creates Statewide Program for Suicide Prevention within Department of Human Resources.
BDR R-289	Urges agencies in Clark County to cooperate in establishment of plan for suicide prevention in Clark County.
BDR R-290	Urges Clark County Health District to plan and coordinate public information campaign relating to suicide prevention and expand injury prevention efforts in Clark County.
BDR R-291	Urges each community in Nevada to form coalition of agencies and service providers to reduce number of suicides and provide support for survivors.

BDR 40-288

SUMMARY—Creates Statewide Program for Suicide Prevention within Department of Human Resources. (BDR 40-288)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State: Yes.

AN ACT relating to suicide prevention; creating a Statewide Program for Suicide Prevention within the office of the Director of the Department of Human Resources; creating positions within the Statewide Program for Suicide Prevention to coordinate the Statewide Program and to provide training and facilitate networking relating to suicide prevention in certain counties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 439 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *1. There is hereby created within the office of the Director a Statewide Program for Suicide Prevention. The Department shall implement the Statewide Program for Suicide Prevention, which must, without limitation:*

(a) Create public awareness for issues relating to suicide prevention;

(b) Build community networks; and

(c) Carry out training programs for suicide prevention for law enforcement personnel, providers of health care, school employees and other persons who have contact with persons at risk of suicide.

2. The Director shall employ a Coordinator of the Statewide Program for Suicide Prevention. The Coordinator:

(a) Must have at least the following education and experience:

(1) A bachelor's degree in social work, psychology, sociology, counseling or a closely related field, and 5 years or more of work experience in behavioral health or a closely related field; or

(2) A master's degree or a doctoral degree in social work, psychology, sociology, counseling, public health or a closely related field, and 2 years or more of work experience in behavioral health or a closely related field.

(b) Should have as many of the following characteristics as possible:

(1) Significant professional experience in social services, mental health or a closely related field;

(2) Knowledge of group behavior and dynamics, methods of facilitation, community development, behavioral health treatment and prevention programs, and community-based behavioral health problems;

(3) Experience in working with diverse community groups and constituents; and

(4) Experience in writing grants and technical reports.

3. The Coordinator shall:

(a) Provide educational activities to the general public relating to suicide prevention;

(b) Provide training to persons who, as part of their usual routine, have face-to-face contact with persons who may be at risk of suicide, including, without limitation, training to recognize persons at risk of suicide and providing information on how to refer those persons for treatment or supporting services, as appropriate;

(c) Develop and carry out public awareness and media campaigns in each county targeting groups of persons who are at risk of suicide;

(d) Enhance crisis services relating to suicide prevention;

(e) Link persons trained in the assessment of and intervention in suicide with schools, public community centers, nursing homes and other facilities serving persons most at risk of suicide;

(f) Coordinate the establishment of local advisory groups in each county to support the efforts of the Statewide Program;

(g) Work with groups advocating suicide prevention, community coalitions, managers of existing crisis hotlines that are nationally accredited or certified, and staff members of mental health agencies in this state to identify and address the barriers that interfere with providing services to groups of persons who are at risk of suicide, including, without limitation, elderly persons, Native Americans, youths and residents of rural communities;

(h) Develop and maintain an Internet or network site with links to appropriate resource documents, suicide hotlines that are nationally accredited or certified, licensed professional personnel, state and local mental health agencies and appropriate national organizations;

(i) Review current research on data collection for factors related to suicide and develop recommendations for improved systems of surveillance and uniform collection of data;

(j) Develop and submit proposals for funding from agencies of the Federal Government and nongovernmental organizations; and

(k) Oversee and provide technical assistance to the person employed to act as a trainer for suicide prevention pursuant to section 3 of this act.

4. As used in this section:

(a) "Internet or network site" means any identifiable site on the Internet or on a network and includes, without limitation:

(1) A website or other similar site on the World Wide Web;

(2) A site that is identifiable through a Uniform Resource Locator; and

(3) A site on a network that is owned, operated, administered or controlled by a provider of Internet service.

(b) "Systems of surveillance" means systems pursuant to which the health conditions of the general public are regularly monitored through systematic collection, evaluation and reporting of measurable information to identify and understand trends relating to suicide.

Sec. 3. *1. The Coordinator of the Statewide Program for Suicide Prevention shall employ a person to act as a trainer for suicide prevention and facilitator for networking for Southern Nevada.*

2. The trainer for suicide prevention:

(a) Must have at least the following education and experience:

(1) Three years or more of experience in providing education and training relating to suicide prevention to diverse community groups; or

(2) A bachelor's degree, master's degree or doctoral degree in social work, public health, psychology, sociology, counseling or a closely related field, and 2 years or more of experience in providing education and training relating to suicide prevention.

(b) Should have as many of the following characteristics as possible:

(1) Significant knowledge and experience relating to suicide and suicide prevention;

(2) Knowledge of methods of facilitation, networking and community-based suicide prevention programs;

(3) Experience in working with diverse community groups and constituents; and

(4) Experience in providing suicide awareness information and suicide prevention training.

3. The trainer for suicide prevention must be based in a county whose population is 400,000 or more.

4. The trainer for suicide prevention shall:

(a) Assist the Coordinator of the Statewide Program for Suicide Prevention in disseminating and carrying out the Statewide Program in the county in which the trainer for suicide prevention is based;

(b) Provide information and training relating to suicide prevention to emergency medical personnel, providers of health care, mental health agencies, social service agencies, churches, public health clinics, school districts, law enforcement agencies and other similar community organizations in the county in which the trainer for suicide prevention is based;

(c) Assist the Coordinator of the Statewide Program for Suicide Prevention in developing and carrying out public awareness and media campaigns targeting groups of persons who are at risk of suicide in the county in which the trainer for suicide prevention is based;

(d) Assist in developing a network of community-based programs for suicide prevention in the county in which the trainer for suicide prevention is based, including, without limitation, establishing one or more local advisory groups for suicide prevention; and

(e) Facilitate the sharing of information and the building of consensuses among multiple constituent groups in the county in which the trainer for suicide prevention is based, including, without limitation, public agencies, community organizations, advocacy groups for suicide prevention, mental health providers and representatives of the various groups that are at risk for suicide.

Sec. 4. The Coordinator of the Statewide Program for Suicide Prevention created by section 2 of this act shall initiate the public awareness and media campaigns for suicide prevention required pursuant to that program in a county whose population is 400,000 or more.

Sec. 5. On or before January 3, 2005, the Director of the Department of Human Resources shall submit a copy of the Statewide Program for Suicide Prevention and a report concerning the status of the Statewide Program for Suicide Prevention to the Governor and to the Director of the Legislative Counsel Bureau for transmittal to the Legislature.

Sec. 6. This act becomes effective on July 1, 2003.

BDR R-289

SUMMARY—Urges agencies in Clark County to cooperate in establishment of plan for suicide prevention in Clark County. (BDR R-289)

_____ CONCURRENT RESOLUTION—Urging agencies in Clark County to cooperate in the establishment of a plan for suicide prevention in Clark County.

WHEREAS, For the past 17 years, the State of Nevada has led the nation in the rate of suicide, consistently averaging twice the national rate; and

WHEREAS, For the past 5 years, over 64 percent of completed suicides in our state occurred in Clark County, and during the year 2000, the rate of suicide in Clark County, which contains almost 70 percent of the State's population, was 18.3 per 100,000, only slightly lower than the average for the entire State; and

WHEREAS, An extensive survey of existing agencies for suicide prevention located within Clark County has revealed a substantial lack of programs for public awareness regarding suicide prevention and a definite need for development and improvement of the quantity and range of services offered for suicide prevention throughout Clark County; and

WHEREAS, The survey also made apparent the need for a greater degree of coordination and communication among existing agencies in Clark County that provide resources relating to suicide and the prevention of suicide; and

WHEREAS, There is currently no organized effort in Clark County aimed at suicide prevention, and most of those employed in the health and injury prevention fields are not aware of any comprehensive list of resources relating to suicide prevention; and

WHEREAS, Any serious attempt to reduce the rate of suicide in Clark County will require a strong effort through the cooperation and coordination of agencies in the County to achieve a countywide coalition and partnership that can be an important component of an overall statewide strategy; now, therefore, be it

RESOLVED BY THE _____ OF THE STATE OF NEVADA, THE _____ CONCURRING, That governmental and nongovernmental agencies in Clark County, including, without limitation, the Clark County Board of Commissioners, the Clark County Health District, mental health agencies, social service agencies, churches, public health clinics, school districts, law enforcement agencies, emergency medical personnel, providers of health care and other similar community organizations and groups within Clark County, are hereby urged to cooperate in the establishment of a coordinated, comprehensive plan for suicide prevention for the communities within the County; and be it further

RESOLVED, That the plan provide for effective and diverse programs for suicide prevention which can be implemented in the communities of Clark County, including, without limitation, programs that will:

1. Through evidence-based methods, reduce risk factors and enhance protective factors for suicidal behavior in persons of all ages;

2. Distribute educational materials which will increase the awareness of and reduce the stigma associated with suicide;

3. Create a telephone hot line for suicide prevention which is operated 24 hours per day, accredited or certified by a nationally recognized organization in the field of suicide prevention, and supported by existing funding for programs for suicide prevention by local governments in Clark County;

4. Refer persons who are at risk of committing suicide to services through which they can obtain appropriate assistance;

5. Develop a Clark County resource directory or an Internet website, or both, for suicide prevention and for assistance for survivors of suicide;

6. Train first responders and persons who regularly come into contact with persons or families in distress, such as clergy, police officers, emergency medical personnel, primary health care providers, mental health providers and school personnel;

7. Educate the public through the news media and distribution of guidelines regarding the availability of related services; and

8. Provide appropriate services to survivors of suicide; and be it further

RESOLVED, That the funding for these programs include a combination of nongovernmental support as well as support from federal, state and local governmental sources; and be it further

RESOLVED, That the _____ of the _____ prepare and transmit a copy of this resolution to the Clark County Board of Commissioners, Clark County Health District, Clark County Social Services, Suicide Prevention Center of Clark County, Nevada Public Health Foundation, Nevada

Chapter of the American Foundation for Suicide Prevention, Suicide Prevention Action Network USA, Inc., Nevada Hospital Association, Psychiatric Emergency Services, Senior Mental Health Outreach Program, Elder Abuse and Neglect Unit of the Las Vegas Metropolitan Police Department, Lake Mead Geropsych Unit, Valley Hospital Geropsych Unit, Montevista Hospital, Southern Nevada Health Care System of the Veterans' Health Administration, Director of the Department of Human Resources, Ombudsman for Aging Persons of the Aging Services Division of the Department of Human Resources, Administrator of the Health Division of the Department of Human Resources, Agency Director of the Southern Nevada Adult Mental Health Services of the Division of Mental Health and Developmental Services of the Department of Human Resources, and Administrator of the Division of Child and Family Services of the Department of Human Resources.

BDR R-290

SUMMARY—Urges Clark County Health District to plan and coordinate public information campaign relating to suicide prevention and expand injury prevention efforts in Clark County. (BDR R-290)

_____ CONCURRENT RESOLUTION—Urging the Clark County Health District to plan and coordinate a public information campaign relating to suicide prevention and expand injury prevention efforts in Clark County.

WHEREAS, As a result of the National Suicide Prevention Conference convened in Reno, Nevada, in October 1998, the Surgeon General of the United States issued *The Surgeon General's Call To Action To Prevent Suicide* in July 1999, emphasizing suicide as a serious public health problem; and

WHEREAS, Continuing attention to issues relating to suicide prevention and the significant role of services relating to mental health and substance abuse in suicide prevention are reflected in *Mental Health: A Report of the Surgeon General* and in the nation's public health agenda, *Healthy People 2010*; and

WHEREAS, In 2001, the Surgeon General released his *National Strategy for Suicide Prevention: Goals and Objectives for Action*, which establishes a framework for action and guides the development of an array of services and programs aimed at reducing the nation's rate of suicide and suicidal behavior; and

WHEREAS, The *National Strategy* approaches suicide as a public health problem, an approach that has helped the nation effectively address problems as diverse as tuberculosis, heart disease and unintentional injury; and

WHEREAS, Nevada has consistently ranked at the top of the listing of states with the highest suicide rates, and consistently averaged twice the national suicide rate; and

WHEREAS, Suicide is the fifth leading cause of death in Nevada, exceeded only by heart disease, cancer, pulmonary disease and stroke, and Nevada is the only state in which suicides outnumber deaths related to motor vehicles; and

WHEREAS, Clark County contains nearly 70 percent of the population of Nevada, a majority of the completed suicides occur there and the number of deaths by suicide in Clark County each year has increased from 223 in 1991 to 292 in 2001; and

WHEREAS, The Clark County Health District is the local public health agency serving residents and visitors in Clark County and has included suicide prevention, under the category of reducing injuries, in its top six priority areas in the project known as "Healthy Clark County 2010," which implements the national public health agenda; and

WHEREAS, Public health and mental health providers recognize that Clark County lacks a comprehensive suicide prevention program, and because suicide prevention has been identified as a critical public health problem and the Clark County Health District is the lead public health agency in the County; now, therefore, be it

RESOLVED BY THE _____ OF THE STATE OF NEVADA, THE _____ CONCURRING, That the Clark County Health District is hereby urged to:

1. Plan and coordinate a public information campaign on suicide prevention; and

2. Expand injury prevention efforts relating to suicide prevention in Clark County and increase the Health District's financial commitment to support such efforts; and be it further

RESOLVED, That the _____ of the _____ prepare and transmit a copy of this resolution to the Chief Health Officer for the Clark County Health District and each member of the District Board of Health of Clark County.

BDR R-291

SUMMARY—Urges each community in Nevada to form coalition of agencies and service providers to reduce number of suicides and provide support for survivors. (BDR R-291)

_____ CONCURRENT RESOLUTION—Urging each community in Nevada to form a coalition of agencies and service providers to reduce the number of suicides and provide support for survivors.

WHEREAS, For at least 2 decades, Nevada has ranked at the top of the listing of states with high rates of suicide and has maintained a rate that is twice the national average; and

WHEREAS, National and state research indicates that Nevada's high rate of suicide is evident for all age groups and all socioeconomic populations in the State, particularly for youth, elderly men, Native Americans and residents of rural communities; and

WHEREAS, The same research has found that the vast majority of Nevada's suicide victims are actually residents of Nevada, and not tourists as is the typical assumption; and

WHEREAS, In 2001, the Surgeon General of the United States issued a plan to reduce the nation's high rate of suicide in his report *National Strategy for Suicide Prevention: Goals and Objectives for Action*, which recognizes the importance of gaining strong and broad support for suicide prevention through public awareness that suicide is a serious public health problem which is preventable; and

WHEREAS, According to the Surgeon General, it is important that suicide prevention be integrated into existing programs and activities at the community level, and one of the goals of the *National Strategy* is to develop and implement community-based programs for suicide prevention; and

WHEREAS, One of the objectives under this goal is to increase the number of states that have comprehensive plans for suicide prevention which coordinate across governmental agencies, involve the private sector and support the development, implementation and evaluation of such plans in each community; and

WHEREAS, Plans created by states may help communities address the local issues important in suicide prevention, for example, such issues as the rate of suicide being affected by the norms and cultural values of a community and the rate of suicide varying with factors such as the percentage of the population that resides in rural areas and the ethnic composition of the population; and

WHEREAS, Another goal of the *National Strategy* is to improve access to and community linkages with mental health and substance abuse services, and a related objective is to increase the number of cities and counties with outreach programs for health and social services that incorporate mental health services and suicide prevention for populations at risk of suicide; and

WHEREAS, Research conducted by public health and mental health agencies in Nevada indicates that there is a lack of public awareness of the seriousness of the suicide problem and a lack of coordination and communication between existing private and public agencies, particularly in communities in Clark County and many of the rural counties; now, therefore, be it

RESOLVED BY THE _____ OF THE STATE OF NEVADA, THE _____ CONCURRING, That in response to the Surgeon General's goals relating to community-based programs for suicide prevention and linkages with mental health and substance abuse services, each city and county in Nevada is hereby urged to form a coalition of agencies and service providers to address suicide prevention through education, response and treatment, with the goals of reducing suicides in each community and providing support for the surviving family and friends of suicide victims; and be it further

RESOLVED, That the local programs for suicide prevention should be developed based on each community's resources and needs; and be it further

RESOLVED, That the _____ of the _____ prepare and transmit a copy of this resolution to the Nevada Association of Counties, Nevada League of Cities and Municipalities, Director of the Department of Human Resources, Nevada Public Health Foundation, Nevada Chapter of the American Foundation for Suicide Prevention, Suicide Prevention Action Network USA, Inc., Dean of the University of Nevada Cooperative Extension at the University of Nevada, Reno, Executive Director of the Nevada Indian Commission, Nevada Chapters of the American Association of Retired Persons, Nevada Parent-Teacher Association, Nevada Hispanic Services, Inc., Nevada Association of Latin Americans, and Nevada Chapters of the National Association for the Advancement of Colored People.