

Nevada Office of Suicide Prevention Action Plan 2017 - 2019

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INTRODUCTION

The Nevada Office of Suicide Prevention (OSP) was created in December 2005 in response to high suicide rates within the state. Since 2005, OSP staff have worked to prevent suicide in Nevada and to support people who have been impacted by a suicide of a friend or family member. OSP is currently housed in the Nevada Department of Health and Human Services (DHHS) Division of Public and Behavioral Health's (DPBH) Bureau of Child, Family, and Community Wellness (BCFCW).

OSP has accomplished numerous goals during its 11-year history. Examples of OSP accomplishments include: sustained implementation of evidence-based practices for screening, including Signs of Suicide middle and high school programs; widespread training of professionals and community members; and development of strong partnerships focused on common goals of prevention. OSP has also successfully obtained grant funding to support suicide prevention in the state.

In October of 2013, OSP began work in collaboration with the Nevada Department of Health and Human Services Director's Office to appoint and establish a statewide Suicide Fatality Review Committee (CRSF) and develop the protocols and tools to establish structure in the first year. Year 2 focused on the actual review process and development of initial recommendations. Although only a few cases are reviewed each year, these are examined in depth to understand the circumstances which led to the suicide fatality and identify areas to improve coordination and communication, as well as potential recommendations for changes to prevent future suicide fatalities. A 2016 report developed by the CRSF illuminated some of the specific issues and concerns for Nevada, and also outlined 12 recommendations. In order to move these recommendations forward, this plan (referred to as the "Action Plan" throughout) was created to guide future work and to serve as a communication tool with stakeholders.

This Action Plan is intended to serve many functions. Most importantly, it will serve as a guide for activities through 2019. The Action Plan incorporates recent developments provided in the National Strategy for Suicide Prevention, including "...a better understanding of how suicide is related to mental illness, substance abuse, trauma, violence, and other related issues; new information on groups that may be at an increased risk for suicidal behaviors; increased knowledge of the types of interventions that may be most effective for suicide prevention; and increased recognition of the importance of implementing suicide prevention efforts in a comprehensive and coordinated way" (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012, p. 11).

The current project moves suicide prevention forward in Nevada by identifying the most urgent and important activities to implement. This project reflects one component of OSP's larger, long term vision to develop:

- a strategic plan which communicates the goals, objectives and strategies to stakeholders across the state;
- a detailed implementation plan resulting in tangible outcomes from activities; and,
- an evaluation plan to measure results.

For every one death by suicide, research shows at least 25 people will attempt suicide, leaving thousands of individuals and their friends and families impacted by suicidal behaviors. Like an iceberg with its mass unseen, those numbers are just the tip of this profound public health problem. Countless others will have such deep depression and despair they contemplate suicide in isolation and do not reach out for help.

(Drapeau & McIntosh, 2016)

OVERVIEW

Suicide impacts individuals, families, friends, and entire communities. Additionally, being a suicide survivor immediately puts a person at-risk for suicide (Centers for Disease Control and Prevention, 2015). From this standpoint, suicide is a critical public health issue, and communities can benefit from a broad range of actions, including reducing factors which put people at risk for suicide, and increasing factors to help protect people from suicidal behavior (Centers for Disease Control and Prevention, n.d.).



Across the United States, suicide rates have increased steadily since 2006, and suicide is the tenth leading cause of death in the nation (Curtin, Warner, & Hedegaard, 2016)

Figure 1: U.S. Suicide Rates

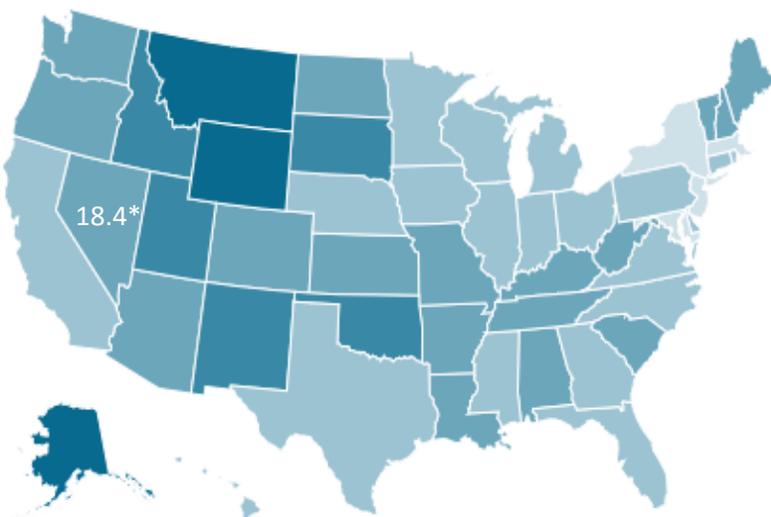


Figure 1 shows the states with the highest suicide rate in darkest colors, and lower rates in lighter colors. Nevada joins several mountain states with high rates of suicide. In 2015, Alaska had the highest age-adjusted rate in the nation (26.8 per 100,000). Washington DC had the lowest age-adjusted rate at less than half the national average of 13.8. Nevada ranked 11th in the nation in 2015 (age adjusted).

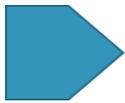
This map is courtesy of the *American Foundation for Suicide Prevention, 2015.*

*Age-adjusted rate per 100,000 in 2015

While no exact figures exist, the financial costs of suicide make the economic case for prevention efforts. According to the Centers for Disease Control and Prevention (CDC) in 2015 the average estimated cost of a single suicide is \$1,164,499, which takes into account lost productivity and medical expenses (Centers for Disease Control and Prevention, 2015). Nationally, the CDC estimates the cost of suicide at greater than \$44.6 billion annually. Another study which adjusted for the increased price of healthcare and underreporting of suicides, estimates the actual national cost of suicide is 2.1 times higher at \$93.5 billion (Shepard, Gurewich, Lwin, Reed, Jr., & Silverman, 2015). Using the CDC estimated cost per suicide, which is likely conservative, the 558 suicides in Nevada in 2015 resulted in upward of \$650 million in lost productivity and medical bills. As this single-year estimate illustrates, the financial impact of suicide is staggering.

Nevada’s rate of suicide is high and demands continued attention. Yet, it is also notable the gap between the rate in Nevada and for the United States (U.S.) overall has narrowed. Rates in Nevada have remained relatively steady since 1999, while the rate for the nation has increased by 24% (Curtin, Warner, & Hedegaard, 2016).

Nevada has also reduced suicide as a leading cause of death, from being the sixth leading cause to the eighth leading cause of death (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015). Suicide remains the tenth leading cause of death for the nation.



Among all states, Nevada was the *only* state (excluding the District of Columbia) with a lower rate in 2014 and 2015 compared to 2005 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015). The factors contributing to this difference are not clear and warrant further study.

Figure 2: Age-adjusted Rate of Suicide
Nevada vs. the U.S. 1999-2015

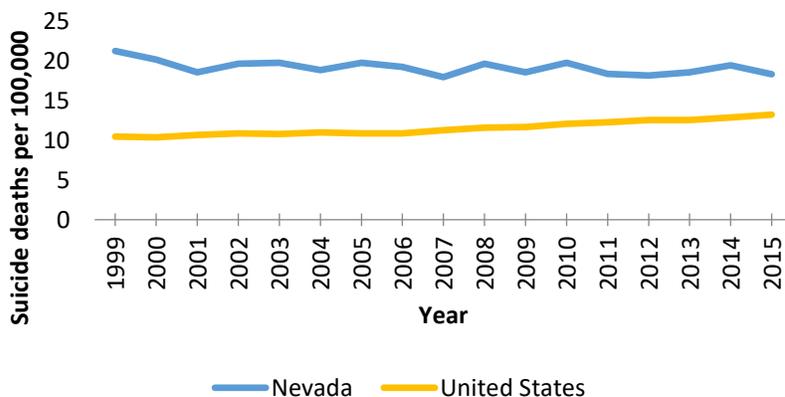


Figure 2 shows rates of suicide death in Nevada compared to the nation. Rates are considerably higher in Nevada than for the U.S. In Nevada, rates have shown variability year to year, with the long-term trend flat (or slightly decreasing), while the rate nationwide has increased.

Data Source: Centers for Disease Control and Prevention; National Center for Injury Prevention and Control., 2017 (Wonder)

Looking More Closely at Suicide in Nevada

Suicide crosses all social, economic, and demographic lines. However, specific groups may be at increased risk. In alignment with this understanding, it is important to identify subgroups which may be at increased risk so prevention efforts can be targeted, relevant, and effective.

PRIORITY POPULATIONS

VETERANS

Nevada's veterans die by suicide 2 to 2.5 times more frequently than their civilian counterparts (Office of Public Health Informatics and Epidemiology, 2016). Nevada's suicide rate among veterans also appears to be considerably higher than the national rate.*

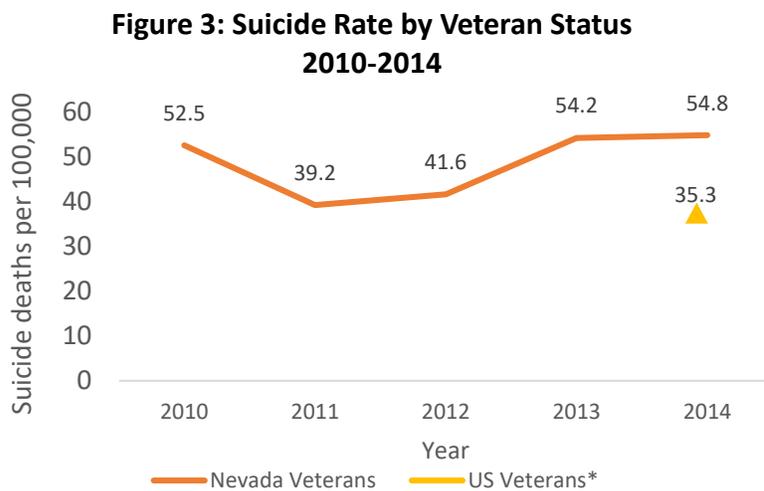


Figure 3 Nevadan Veterans compared to U.S Veterans. In 2014, the rate in Nevada for veterans was 54.8 per 100,000 compared to an estimated 35.3 per 100,000 nationwide.

Data Source: Office of Public Health Informatics and Epidemiology, 2016 and U.S. Department of Veterans Affairs, 2016.

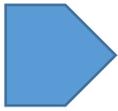
The highest percentage of veteran suicide deaths have occurred among individuals 55 years of age and older (Ritch, 2015). Factors such as disability, independent living, health, and personal financial concerns may contribute to the high rate of suicide deaths among older veterans. The percentage of veterans with a disability is considerably higher than for non-veterans, and among disabled veterans, 68% are disabled by a service-connected condition (Ritch, 2015).

Across the United States, the proportion of suicide deaths resulting from firearms among veterans is higher than the non-veteran or civilian population (U.S. Department of Veterans Affairs, 2016). From 2010-2014 the majority (70%) of Nevada's veteran suicide deaths were caused by firearms or explosives (Ritch, 2015).

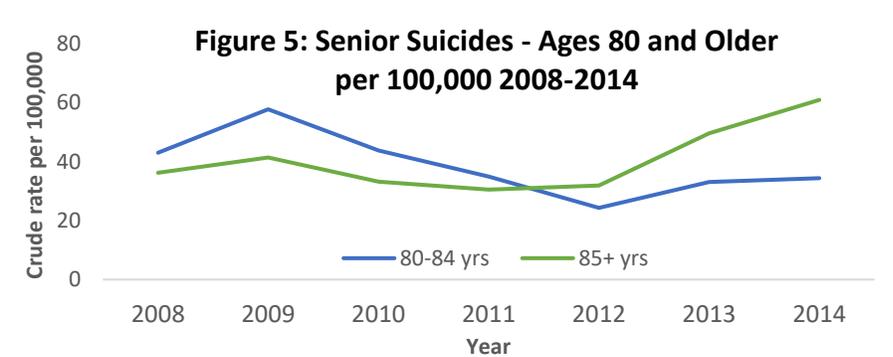
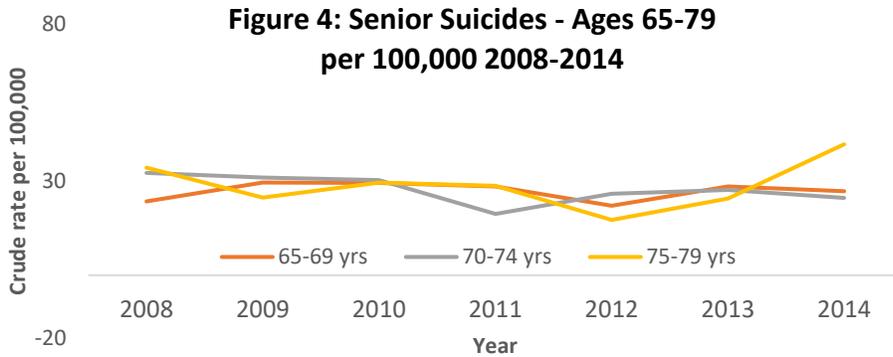
SENIORS

Since 2001, seniors in Nevada have died from suicide at substantially high rates, consistently nearly twice the rates seen nationwide (Centers for Disease Control and Prevention; National Center for Injury Prevention and Control, 2017). From 1999-2015, the average rate for Nevada was 31.5, compared to 15.3 for the United States (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015). Figure 4 shows the suicide trends for

five groups of older adults. In general, the rate of suicide increases throughout the lifespan, with the oldest adults among those most at risk.



Suicide rates for Nevadans age 75 and older have increased since a 2011 low to a high in 2014. Deaths by suicide among the oldest adults, ages 85 and older, also followed an upward trend.



Figures 4 & 5 show the rates of older adult suicides in Nevada from 2008 to 2014. Rates have increased in recent years, and the oldest adults are most at risk of suicide.

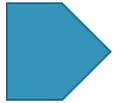
Data Source: Centers for Disease Control and Prevention; National Center for Injury Prevention and Control., 2017 (Wonder)

As with younger adults, those 65 years and older are more likely to have suicidal thoughts if they have depression, other mood disorders, or problems with substance abuse. However, compared to younger cohorts, older adults are more likely to face additional issues which can produce suicidal thoughts, such as ongoing medical conditions, chronic pain, a lack of mobility, or lack of autonomy. Older adults may also be at higher risk of social isolation, undiagnosed depression, or feelings they are a burden (SAMHSA, 2016). These issues point to the need for different strategies and partners to prevent suicide among older adults.

As with Nevada’s veterans, firearms were used in the majority of deaths among older adults, with firearms/explosives the method of seven out of ten senior suicides from 2010-2015. Poisoning was second most common method among older adults, making up 17% of suicides (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015).

CHILDREN AND YOUTH

Suicide has been the third leading cause of death for children and young adults, ages 10-24 in the United States and the second leading cause of death for children in Nevada from 2000 to 2014 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015).



Rates of suicide among youth and young adult have varied dramatically, but recently stayed close to the national average. Continued attention on youth and children is critical to progress toward zero suicides.

Figure 6: Nevada Suicide Rates vs. the U.S. for Children and Young Adults Ages 10 to 24

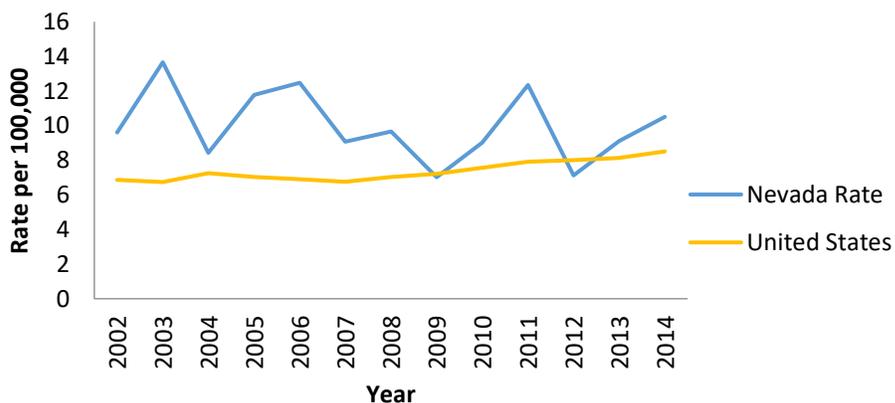


Figure 6 illustrates the rate of suicide among children and young adults, ages 10 to 24 per 100,000 in Nevada compared to the United States.

Data Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015.

Among youth, suicide attempts, ideation, and contagion, are particularly important related issues. Defined by the National Strategy for Suicide Prevention, suicidal behavior is a spectrum of activities related to thoughts and behaviors which include suicidal thinking, suicide attempts, and completed suicide (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012). Suicidal ideation is self-reported thoughts of engaging in suicide-related behavior. A suicidal act (also referred to as suicide attempt) is a potentially self-injurious behavior with evidence the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries. Contagion is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts. A ten-year trend analysis report for the 2015 Youth Risk Behavior Survey conducted by the CDC indicates between 2005 and 2015 the percentage of students in 9th to 12th grade who seriously considered attempting suicide in Nevada increased. Additionally, between 2005 and 2015 more than 11% and up to 14.5% of students report attempting suicide one or more times in the year previous to being surveyed (Lensch, et al., 2015).

As with veterans, firearms play a prominent role in youth suicide; according to the Children’s Safety Network, 49% of Nevada’s youth suicides in 2008-2012 were committed with a firearm (Children's Safety Network, 2015).

MIDDLE AGE ADULTS

The rate of suicide both in the nation and in Nevada is high for those in the middle age group. In 2015, the estimated age-adjusted rate for people 55-64 was 29.1, second only to the oldest adults (31.6 for the population 85 and older) (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015).



People middle age (45-64) are considerably more at risk than younger people including youth. In general, risk of suicide increases with age.

**Figure 7: Adult Suicide Rates per 100,000
2008-2014 in Nevada**

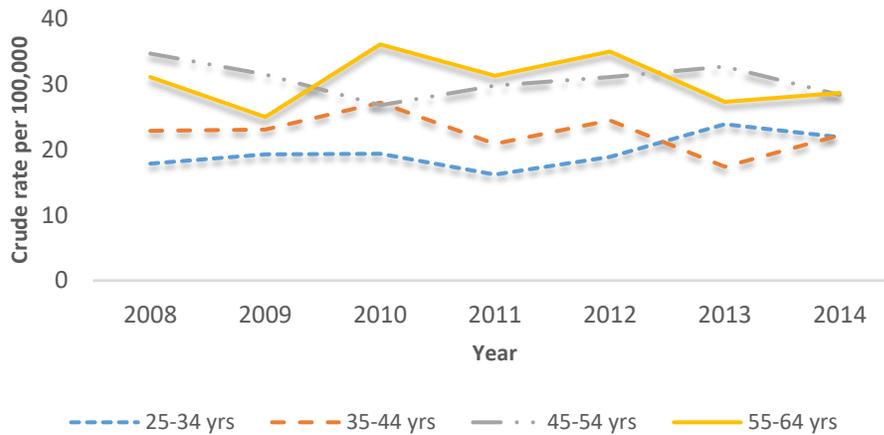


Figure 7 shows among the adult population, rates are highest among middle aged adults, ages 45-64. *Data Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015.*

The suicide rate among middle age adults has been increasing nationwide – and a recent study showed while “all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases” (Case & Deaton, 2015, p. 1). Physical pain, addiction, and declines in mental health, have been hypothesized to contribute to the national increase in suicide observed among this group. A broad number of circumstances may contribute to this rise; however, on the whole, it is reasonable to consider risk factors have increased, while some protective factors have decreased (Keating & Bernstein, 2016).

OTHER DEMOGRAPHIC CONSIDERATIONS

Gender

In the U.S., rates of suicide for women have been, and continue to be, lower than the rates for men. However, a recent report showed for females, the age-adjusted suicide rates increased between 1999 and 2014 for all racial and ethnic groups except non-Hispanic Asian or Pacific

Islanders (Curtin, Warner, & Hedegaard, 2016). In Nevada, roughly three out of four deaths by suicide are males (Office of Public Health Informatics and Epidemiology, 2016). Looking at recent suicide attempt data collected from Nevada hospitals, males present at double the rate of females, a trend which should be explored. Nationally, female attempt rates are considerably higher than male attempt rates (Office of Public Health Informatics and Epidemiology, 2016).

Figure 8
Statewide Weekly Male/Female Attempts
8/14/16 - 12/17/16

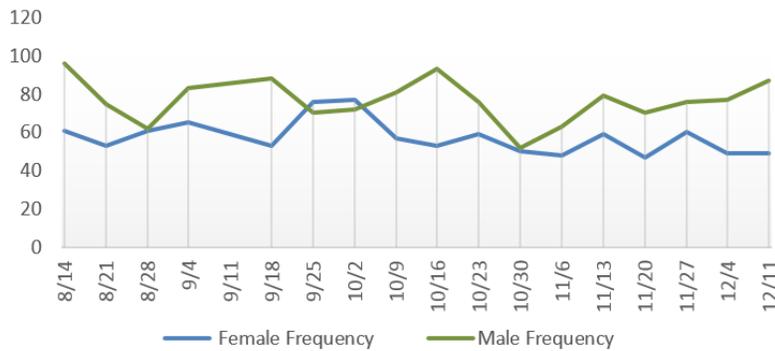
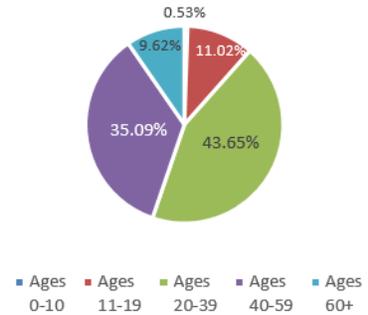


Figure 9
Percentage of Attempts by Age Group
8/14/16 - 12/17/16



Race and Ethnicity

In Nevada, the age-adjusted rates for suicide were highest among people who were white (non-Hispanic) with age-adjusted rates, and were also high among people who were Native American. Suicides occurred within every racial and ethnic group; the issue crosses all racial and ethnic boundaries (Office of Public Health Informatics and Epidemiology, 2016). Opportunities exist to improve prevention using attempt data by race and ethnicity.

Geography

Age-adjusted rates of suicide from 2001-2014 in Nevada’s counties varied considerably. Some of the highest average rates were among Nevada’s frontier counties including Esmeralda, Nye, Mineral, Humboldt, and White Pine (Office of Public Health Informatics and Epidemiology, 2016). These communities also offer unique opportunities to implement comprehensive suicide prevention initiatives due to connectedness and ability to work across systems.

People in Juvenile and Criminal Justice Systems

Among youth in contact with the juvenile justice system, there is increased risk for suicide ideation and suicidal behaviors. Across the United States, death from suicide is estimated at three times the risk for youth involved with juvenile justice compared to those who are not in the juvenile justice system (National Action Alliance for Suicide Prevention: Youth in Contact with Juvenile Justice System Task Force, 2013). Adults who are incarcerated as well as those recently released are also at high risk (Noonan, Rohloff, & Grinder, 2015). Surveillance systems within and across justice systems offer a key opportunity for prevention.

Other Groups with Higher Risk

In addition to the priority populations identified in this report, many other groups may be at higher risk for suicide compared to the general population. They include people who have witnessed or are bereaved by suicide, people involved with child welfare settings, people who have attempted suicide, people with medical conditions, people with mental or substance use disorders, people who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ), members of the armed forces and their families, and people who have engaged in non-suicidal self-injury (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012).



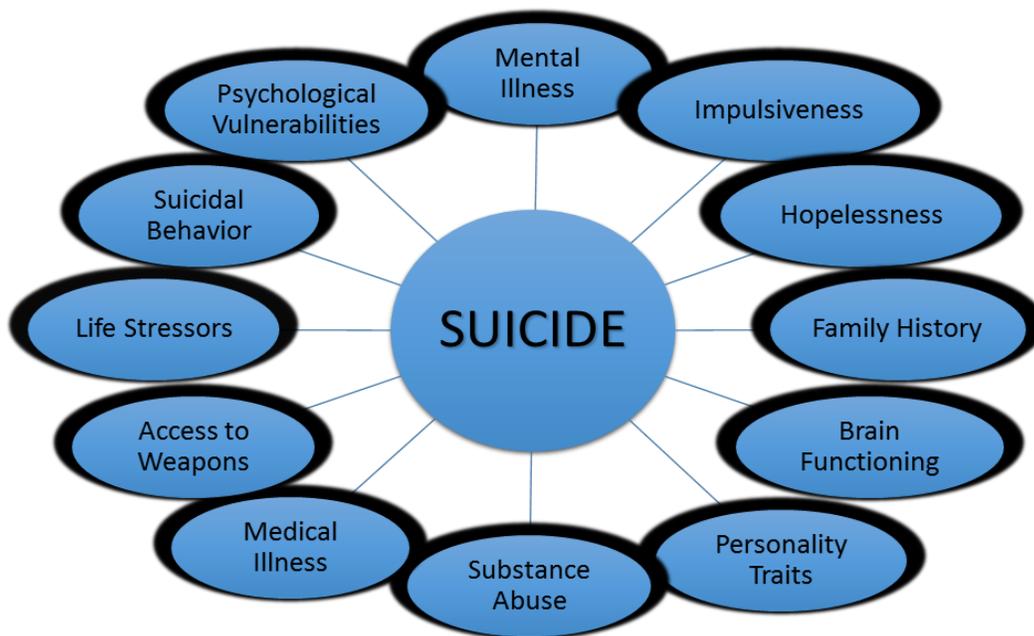
According to the American Foundation for Suicide Prevention, 90% of people who die by suicide have a mental disorder at the time of their deaths (2017). Biological and psychological treatments can help address the underlying health issues which put people at risk for suicide.

INDIVIDUAL RISK FACTORS

Many factors including issues which are transitory or accumulated over the lifespan can increase the risk of suicidal thoughts and behaviors. Examples include:

- a serious mental illness,
- physical illness,
- alcohol or other abuse,
- a painful loss,
- exposure to violence,
- social isolation, and
- access to lethal means.

FIGURE 10: RISK FACTORS FOR SUICIDE



PROTECTIVE FACTORS

In contrast, protective factors reduce risk of suicide. Protective factors include:

- access to strong social support network,
- effective mental health care,
- connectedness to individuals,
- reduction in access to lethal means,
- family, community, and social institutions, and
- problem solving skills.

ASSESSMENT OF CURRENT SITUATION IN NEVADA

To develop the Action Plan, Office of Suicide Prevention staff assessed strengths, weaknesses, opportunities, and threats. This information was used to help define priorities for action, build on assets and also to address the most critical needs within the state.

STRENGTHS

- Nevada's suicide rate has not increased in recent years, which is in contrast to other western states and the nation as a whole. Prevention efforts can continue to impact and reduce rates toward zero suicides.
- Office of Suicide Prevention staff are experienced and committed to positive change. Strong relationships between OSP and other organizations, coalitions, etc. help to foster broad collaborative action.
- Several evidence-based programs are already in place in Nevada; for example, Signs of Suicide (SOS).
- Through grant funding, relationships across Nevada were formed and have been sustained. These grants also helped to position the state for additional funding for related issues such as mental health services and supports.
- Grant funding also furthered prevention outcomes. A national study showed counties which implemented Garrett Lee Smith (GLS) programming had lower rates of suicide attempts within the target populations (Garraza, Walrath, Goldston, Reid, & McKeon, 2015). Nevada received GLS funds in previous years.
- Prevention efforts in Nevada's diverse communities are increasing and improving.
- Many providers and community members have increased their own skills to recognize when someone is at risk of suicide and are now empowered to offer help.
- During Nevada's 78th (2015) Legislative Session, Assembly Bill (AB) 93 mandated two hours of suicide prevention training for mental and behavioral health providers, and recommended training for other healthcare providers. This system change has helped to move the conversation about suicide prevention to the forefront.

WEAKNESSES

- Funding the Office of Suicide Prevention is becoming more challenging as sources of revenue are declining and competing priorities are increasing. As demand for services

within the state has increased, the resources to meet the need have decreased. Sustainable funding and staffing is critical, including staffing to support growth of relationships within diverse groups and communities (e.g. geography, circumstance, etc.).

- In Nevada, electronic health records (EHR) are not widely utilized or linked, creating a barrier to federal funding streams. This also impacts continuity of services between providers.
- OSP is not as closely linked to some of the other state initiatives working on mental health and behavioral health interventions (e.g. block grant initiatives).
- Many people experiencing problems cannot access services, including those in the public systems like criminal justice, until or unless they are in crisis. Upstream preventions are not adequate and are not currently aligned to the national strategy of providing care in the least restrictive setting.

OPPORTUNITIES

- Efforts mandated by the Clay Hunt Suicide Prevention for American Veterans Act passed by the United States Congress and signed into law in February 2015, may give those on the frontline of Nevada's fight against suicide the ability to steer veterans to the Veterans Administration for preventive services. Opportunities to partner with these federal services may improve care specific to veterans.
- Suicide awareness and screening can take place using the existing healthcare workforce.
- Research can help to inform practice in Nevada. Programs and initiatives showing successes can provide strategic direction. For example, the Suicide Prevention Resource Center (SPRC) has compiled programs which are promising as well evidence-based (Suicide Prevention Resource Center, 2017).
- Collaborative groups working on issues related to mental health, safety, and other community health issues offer an opportunity to further advance suicide prevention.
- The OSP can work strategically and with leaders to reach more people throughout the state. There is broad interest in suicide prevention, and leaders are likely to be interested in learning how they can support it, regardless of sector or role. By working to educate, influence, and collaborate with leaders from healthcare, business, nonprofit organizations, and coalitions, the reach of effective strategies is multiplied considerably.
- The national focus on the Zero Suicide Initiative (National Action Alliance) is proven to be effective in reducing rates within a closed system (e.g. U.S. Air Force) when implemented with fidelity (McKeon, 2013).
- OSP can strengthen the alignment between suicide prevention strategies and state mental and behavioral health initiatives (e.g. block grant initiatives).
- OSP can work to strengthen screening and supports for people of all ages to ensure people get the help they need prior to crisis or emergency.
- OSP can identify and pursue additional funding opportunities such as grants and sub-awards from other programs.

THREATS

- Suicide is a difficult and complex problem without simple solutions. Some of the most straightforward solutions—such as reducing access to means—can be politically difficult, while some of the more universally accepted strategies—such as improved access to high quality mental health services—are costly and difficult to implement.
- Funding for suicide prevention is limited in Nevada. Additional resources are needed to implement recommendations put forward by the Committee to Review Suicide Fatalities.
- Despite having a national strategy in place and considerable attention to suicide at the national level, the rate of suicide has increased considerably between 1999 and 2014. Further research, effective prevention practices, and system changes are still needed to address the complexity of suicide.

STRATEGIC DIRECTION

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

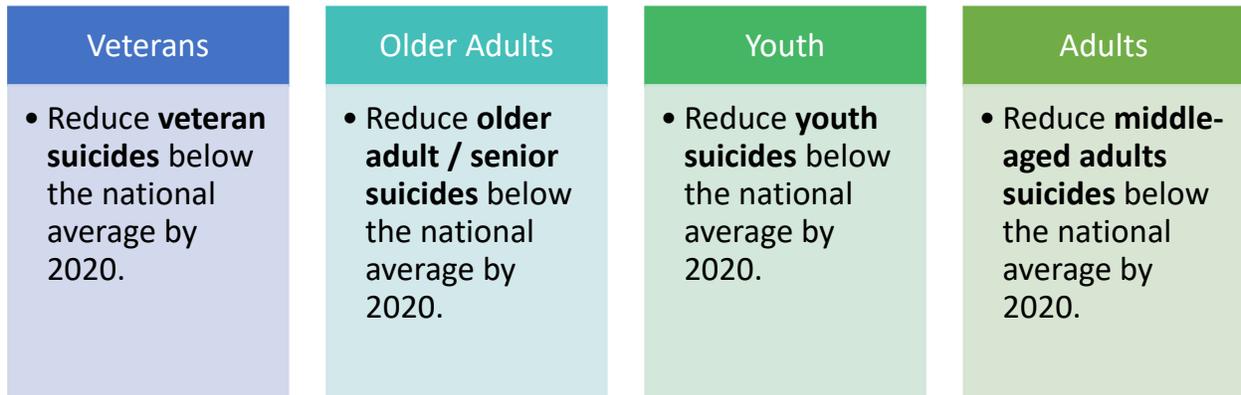
The vision for Nevada’s Suicide Prevention Action Plan is to catalyze collaborative action, improve understanding, and increase wellness in communities across Nevada. This Action Plan is based on the strong belief everyone has a role to play in suicide prevention, and those individuals and groups addressing the physical, emotional, psychological, and spiritual needs of individuals and communities must work together if they are to be effective. Many organizations and agencies working at the state and local level are working to address and prevent suicide. This plan is intended to help connect these efforts, enhance collaboration, and illuminate best practices available for prevention as identified by state and national sources.



All activities in this plan are intended to accomplish a singular outcome: to continue the downward trajectory of Nevada’s suicide rate.

Nevada’s leaders are working to address suicide. Governor Sandoval’s *Nevada’s Strategic Planning Framework* (Sandoval, 2016) identified objectives to reduce suicide among Nevada’s veterans, senior citizens, and youth to rates lower than the national average by 2020. In alignment with the framework, four specific populations and targets have been identified for focus.

Figure 11: Governor’s Strategic Framework to Reduce Suicide



APPROACH

Nevada’s Plan is based on research focusing on the unique state, and local needs and circumstances. These findings and recommendations were integrated with the U.S. Department of Health and Human Services’ *National Strategy for Suicide Prevention*. In alignment with the National Strategy for Suicide Prevention, Nevada is working in four related strategic directions.

STRATEGIES



Strategies are designed to work at multiple levels:

- **Universal** strategies target the entire population.
- **Selective** strategies are appropriate for subgroups which may be at increased risk for suicidal behaviors.

- **Indicated** strategies are designed for individuals identified as having a high risk for suicidal behaviors, including someone who has made a suicide attempt.

STRATEGIC PRIORITIES, STRATEGIES AND ACTION STEPS

This section of the Action Plan synthesizes information about Nevada’s four priority areas and target populations, their alignment to national strategies, and shows key action steps. These action steps were developed based on recommendations from the Committee to Review Suicide Fatalities and aligned with the National Strategy (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012). They are only the first steps on the longer journey to continue the downward trajectory of Nevada’s suicide rate.

Priority 1. Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings.

Target Populations. Lifespan (all ages)

Alignment to the National Strategies

- Promote suicide prevention as a core component of healthcare services. National Strategy –Goal 8
- Integrate and coordinate suicide prevention activities across multiple sectors and settings. National Strategy –Goal 1
- Develop and implement protocols for delivering services to individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. National Strategy –Goal 8.2

Action Steps

1. Work to understand existing practices within Nevada hospitals using a survey and additional outreach.
2. Use data from survey (see step 1 above) to assess what is in place and identify system gaps.
3. Share suicide prevention plan and use to engage partners in strong prevention efforts.
4. Support suicide prevention training for healthcare providers by working to build capacity for training and education.
5. Participate in dialogue regarding suicide prevention among all primary care providers.
6. Hold informational interviews with key leaders to understand barriers to patient follow up.
7. Identify any areas of policy or practice where the Office of Suicide Prevention and other state agencies can support improvement.

8. Engage partners to understand the Health Insurance Portability and Accountability Act (HIPAA) as an opportunity, not a barrier, to providing follow up care.
9. Foster and support collaborations between emergency departments and other healthcare providers to deliver services for individuals with suicide risk collaboratively, responsively, and in the least restrictive settings.

Priority 2. Utilize syndromic surveillance (attempt data) and partnerships throughout *Continuity of Care for Suicidality Workgroup* to recognize and monitor trends in real time and develop a system of follow-up care and minimize repeated attempts.

Target Populations. Lifespan (all ages), Veterans

Alignment to the National Strategies

- Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. (National Strategy –Goal 11.3)

Action Steps

1. Continue development and use of syndromic surveillance data.
2. Complete study to understand feasibility of attempt data. Include issues of privacy; permission to collect and identify opportunities to systematically collect and analyze; data sharing.
3. Explore amending legislation to include attempt data collection.
4. Amend existing law to include collection of attempt data.

Priority 3. Enhance data collection to capture information about specific characteristics of the population including veterans, active duty military and families, LGBTQ, and race/ethnicity.

Target Populations. Lifespan (all ages)

Alignment to the National Strategies

- Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. (National Strategy –Goal 11.3)

Action Steps

1. Use National Violent Death Reporting System and Committee to Review Suicide Fatalities data to recognize trends and opportunities.
2. Establish workgroup to advise on reporting military/veteran deaths.
3. Work with coroners' offices to develop protocols for reporting on veteran suicide deaths.

4. Work with coroners' offices and medical examiners across the state to share protocols.
5. Assess challenges and make changes as needed to protocols once established.
6. Continue development of a memorandum of understanding (MOU) being developed with the key partners on the expansion of data use.

Priority 4. Address sustainability of efforts through funding, infrastructure, and system change.

Target Populations. Lifespan (all ages)

Alignment to the National Strategies

- Promote effective programs and practices to increase protection from suicide risk. (National Strategy –Goal 3.1)
- Develop and sustain public-private partnerships to advance suicide prevention. (National Strategy –Goal 1.4)
- Integrate suicide prevention into all relevant healthcare reform efforts. (National Strategy –Goal 1.5)

Action Steps

1. Support expansion of Mobile Crisis Response Teams (Nevada Department of Health and Human Services, Division of Child and Family Services within Washoe, Clark, and Rural Counties).
2. Continue to develop school-based screening capacity across the state.
3. Support development of walk-in crisis centers.
4. Identify barriers to using electronic health records.
5. Provide support for expansion of electronic health records.
6. Share data, plans, and awareness about suicide in Nevada.

Nevada's Guiding Principles for Suicide Prevention Efforts

1. **Our Efforts are Stronger When We Engage Community.** Foster positive dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention;
2. **Equity Must be a Focus.** Address the needs of vulnerable groups; seek to understand the cultural and situational contexts of groups, and seek to eliminate disparities;
3. **Our Outcomes Should be Sustainable.** Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
4. **Our Work Must Address Root Causes.** Promote changes in systems, policies, and environments to facilitate the prevention of suicide and related problems;
5. **Our Work Must be Integrated.** Bring together public health and behavioral health to better address the whole health needs of people;
6. **Addressing Lethal Means is a Critical Lever for Change.** Promote efforts to reduce access to lethal means among individuals with identified suicide risks; and
7. **Our Work is Informed by Data.** Apply the most up-to-date knowledge base for suicide prevention and engage in monitoring and evaluation to understand what works.
8. **Seek out additional grant funds to support suicide prevention.**
 - Adapted for Nevada, based on *2012 National Strategy for Suicide Prevention*

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