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**Testimony by Lynn Carrigan, Administrator  
In Support of SCR3**

I am Lynn Carrigan, administrator of the Nevada Public Health Foundation. I am speaking in support of SCR 3 and confining my remarks to rural Nevada.

On December 13, 2002 and January 31, 2003, the Nevada Public Health Foundation and the Office of Rural Health conducted suicide dialogues on interactive video with 14 Nevada communities. We focused on discussing the suicide problem in the communities, the need for resources, and approaches currently in use, particularly in rural Nevada. The broadcast sites included Battle Mountain, Caliente, Carson City, Elko, Ely, Hawthorne, Las Vegas, Lovelock, Owyhee, Pahrump, Reno, Tonopah, Winnemucca, and Yerington. About 85 people participated. In 2002 I gave a suicide awareness class to Nevada's rural community health nurses. Our finding based on this contact is that, in rural Nevada, the need for suicide prevention resources is profound.

Rural communities have certain dynamics that makes suicide more threatening. Suicide rates are higher. I have provided you with rates over two year periods for Nevada communities and a rural aggregate rate. Aggregate rates tend to run three-to-five deaths higher than the state rate; in individual communities the rate can be several times higher. News travels fast in rural communities and has less ground to cover. When someone commits suicide, everyone knows about it. Many may know the decedent or may have had some connection to him or her. And, most rural communities have no resources to deal with suicide or the threat of suicide. Those who spoke with us in the suicide dialogs are apprehensive; that's why they showed up to talk to us. They fear that people will die unnecessarily because they did not take preventive action. They fear that a crisis will occur—a middle school or high school student will commit suicide, for instance—and they will not have the resources to respond appropriately.

The children are a particular concern. On the evaluation form, we asked what resources were needed in the respondent's community. About half said something specific about children or adolescents. They are probably correct to be concerned about the children. The *Nevada Youth Risk Behavior Survey* in 2001 showed that 27% of middle school and 30% of high school students reported feeling so sad and hopeless almost every day for two or more weeks that they stopped doing their usual activities. 16% of middle school and 20% of high school students said they seriously considered suicide during the previous 12 months. 12% of middle school and 11% of high school students said they attempted suicide one or more times during the previous 12 months.

All of the rural communities told us they need resources to prevent suicide and respond when it occurs. The resources they specifically mentioned include:

- Mental health services: More providers for low-income clients, access to adolescent inpatient treatment, access to residential treatment for everybody who needs it, transportation to residential treatment.
- Survivor services: Suicide response teams, survivor support groups, support for families, first responder training.
- Local hotline.
- Education: Prevention education classes, posters, brochures, resources for students, funding for peer education, public awareness education, training for high school students, school nurse training, school counselor training, training for a wide variety of professionals, gatekeeper training.
- Outreach: advertising for hotlines, general outreach programs.
- Community development: Community protocol, community coalitions.
- Everything: Some respondents simply said the need everything. One said, "There are too many [needed resources] to name. I work for [the] High School and also on ambulance service....families don't get enough support....there is not enough help towards prevention of suicide."

The broad scope of the resource deficiency in rural Nevada underlines the need for both SCR3. Communities should develop coalitions to set priorities for developing services based on the local situation and to mobilize community members to become involved in suicide prevention. We believe that local suicide coalitions are one approach that should be encouraged in rural Nevada.

**SUICIDE DEATHS IN NEVADA COUNTIES  
NUMBER AND AGE-ADJUSTED RATES PER 100,000 POPULATION  
2-YEAR PERIODS 1990-2001**

	1990-1991		1992-1993		1994-1995		1996-1997		1998-1999		2000-2001	
County	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
Carson City	21	23.27	31	36.56	29	31.46	21	20.03	37	33.76	22	20.47
Churchill	8	23.01	7	18.74	8	21.18	9	20.39	14	18.58	6	12.64
Clark	376	24.45	420	24.72	445	22.46	458	20.11	502	19.89	513	18.34
Douglas	15	26.49	11	18.64	12	16.22	10	12.85	15	18.12	16	18.66
Elko	17	26.38	17	23.01	28	33.54	18	21.18	17	21.32	19	21.66
Esmeralda	0	X	0	X	1	X	2	X	0	X	0	X
Eureka	1	X	1	X	1	X	1	X	1	X	0	X
Humboldt	11	44.96	7	35.16	4	X	9	31.41	5	15.19	12	36.32
Lander	3	X	5	37.73	6	63.97	2	X	6	43.85	4	X
Lincoln	4	X	0	X	5	63.41	0	X	0	X	1	X
Lyon	17	42.75	17	34.32	12	24.01	21	34.85	15	23.54	21	28.31
Mineral	4	X	3	X	3	X	5	40.03	5	35.13	0	X
Nye	9	31.97	13	28.46	16	39.01	18	31.92	19	29.99	21	32.93
Pershing	4	X	4	X	4	X	1	X	5	28.31	0	X
Storey	2	X	2	X	1	X	1	X	4	X	1	X
Washoe	112	22.54	140	25.94	156	27.52	142	23.26	132	21.02	130	18.81
White Pine	8	41.90	12	61.25	11	57.20	8	38.44	9	41.10	2	X
Rural	124	29.88	130	29.82	141	30.02	130	24.25	152	25.73	125	21.86
State	612	24.92	690	25.78	742	24.65	730	21.29	786	20.95	768	18.76