Suicide Trends and Prevention in Nevada

Matt Wray

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Suicide Trends and Prevention in Nevada*

Introduction

Suicide has been around for as long as human society and it continues to challenge our collective wisdom. Consider this data provided by the National Institute of Medicine:

- Each year about one million people commit suicide worldwide.
- Every year some 30,000 Americans end their lives by suicide, and approximately 650,000 people receive emergency treatment after attempting suicide.
- Every 41 seconds someone in the U.S. attempts suicide; every 16.7 minutes, someone completes suicide; and every day over 85 people die by suicide.
- Suicide is the eighth leading cause of death in the U.S. and the third leading cause of death among American youths.
- Over the last 100 years, suicide in the U.S. has out-numbered homicide by at least 3 to 2.
- Almost 4 times as many Americans died by suicide during the Vietnam War era as died in the course of military action.

The federal government has shown concern for high suicide rates in this country since at least the beginning of the 20th century. However, it was not until the 1960’s that our society began to develop a national strategy for combating suicide. In 1963 John F. Kennedy signed a bill creating community mental health centers throughout the country. During the signing ceremony he pointed out that “the mentally ill can no longer be alien to our affection or beyond the help of our communities.” In 1969, the U.S. Congress established the National Institute of Mental Health to aid people with emotional disturbances. More recently (1999), the U.S. Surgeon General issued “Call to Action to Prevent Suicide,” which urged various institutional players in the country to join forces in developing a comprehensive strategy for dealing with suicide.

Several federal agencies took part in developing a national strategy for suicide reduction, including the National Institute of Mental Health, the National Institute of Drug Abuse, the Veterans Administration, the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and the National Institute on Alcohol Abuse and Alcoholism. The Institute of Medicine formed the Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, which issued a comprehensive report assessing the causes of suicidal behavior and formulating preventive measures. The report
confirmed that biological, psychological, and sociological factors influence suicidal behavior; that many suicides are preventable; that individuals with suicidal tendencies are entitled to treatment; and that society must work hard to take away stigma that has often been associated with individuals prone to suicide and suicidality.

Following these national developments, states and communities mounted systematic efforts to reach out to people with mental health problems. The present report will offer an overview of the suicide trends in Nevada, identify factors that influence suicidal behavior, and outline community resources available to Nevadans with suicidal tendencies, their families, friends, and educators.

**Historical Overview**

For reasons that are not well understood, Nevada has had high rates of suicide throughout its history. Ever since 1929, when the Silver State began registering vital statistics with the federal government, the state rate has been two to three times greater than the national rate. In the most recent decades, Nevada has had one of the highest overall suicide rates in the nation.

- The suicide rate in the Silver State dropped sharply from 32.7 in 1940 to 22.6 in 1960 and remained relatively flat until 1990 when it began to rise again to 23.7 before dropping in 2003 to 18.5.
- With 19.1 suicides per 100,000 residents in 2000, Nevada’s rate was almost twice the national average of 10.7.
- Between 1993 and 2003, the overall rate in Nevada steadily declined from 25.8 to 18.5, but remained about twice the national rate.
- New York and Massachusetts shared the lowest rate at 6.4 suicide rates in the nation with 6.4 suicides per 100,000 residents.
- Nearby states California (8.8) and Utah (13.8) had significantly lower rates than Nevada. At 22.0, Alaska topped the nation.
- In 2003, Nevada had two suicides for every homicide, and more people died from suicides (423) than in motor vehicle accidents (351).

While statistically rare, suicide in Nevada now kills more than 400 people annually. Each year, thousands more attempt suicide – experts estimate that there are about 25 attempted suicides for every one completed. Thousands upon thousands of friends and family members have to live with the pain, grief, and guilt that follows suicide and non-fatal suicide attempts. Tens of thousands more are affected by non-lethal behavioral patterns of self-harm (suicidality or parasuicide) exhibited by themselves or others. The human costs of suicide and suicidality are staggering.
In response to this ongoing crisis, federal, state, and community agencies are beginning to direct more resources to the problem. The response thus far has been promising, even though the magnitude of the problem continues to outstrip available resources.

**Hidden Disparities and Patterns**

Suicide is widely regarded as a private, if tragic, choice – an intensely personal act rooted in subjective will. Research shows, however, that suicidal behavior is not random, that some groups are much more likely to see their members die from self-inflicted wounds. Rather than being an expression of individual will, suicides express group patterns. Also, suicides are clustered in specific regions. In the “suicide belt” of the intermountain West, 8 out of 10 states have rates that are twice the national average. Far from being a random phenomenon, suicide is socially and spatially patterned. This variability is evident in Nevada, where rates vary dramatically by gender, age, race/ethnicity, chosen method, and geographic location.

- Nevada males kill themselves about four times more often than do females, although females attempt suicide about three times more frequently than do males.
- Residents aged 45 and over have very high suicide rates (57.7), with those aged 75 and older showing the highest rates of all (65.8). Youth suicide has declined in our state since the early 1990s, but at 17.5, the rate remains at one and a half times the national average.
- Among ethnoracial groups, Whites and Native Americans have the highest suicide rates – 24.4 for Whites (see Table 1 for Native American rates). Hispanics and Asians have the lowest rates (8.2 and 7.0 respectively). Rates for Blacks residing in Nevada are on par with the national average (10.2).
- Residents of all races are more likely to kill themselves with guns than by any other method. Suicide by self-inflicted gunshot wound accounts for over 60% of all suicides in Nevada.
- Suicide in rural counties, though very few in number, occurs at a much higher rate than suicide in metropolitan counties. (Bear in mind that statistical comparisons between metropolitan and rural county rates are often misleading since rates are based on a denominator of 100,000, and a single suicide in a rural county with a population of 2000 people results in the exceedingly high rate of 50).
- Within Clark County, suicide rates in the cities of Henderson and North Las Vegas are close to the national rate (13.1 and 13.9, respectively), while rates in Boulder City, City of Las Vegas, and unincorporated areas of the county are relatively high (26.7, 15.5, and 23.2 respectively).
Suicide Among Children and Young Adults

A scourge by any measure, suicide is particularly devastating when it involves children, teenagers, and young adults. Consider this national data:

- Suicide rates among adolescents and young adults in America nearly tripled between 1952 and 1996.
- Suicide is the fourth major cause of death for children aged 10-14 and the second leading cause of death in those aged 15-24.
- Every year, suicide kills more teenagers and young adults than AIDS, birth defects, heart disease, cancer, and influenza combined.

Life’s pressures weigh heavily on young adults, including those bound for college. The American Medical Association (AMA) reports that

- Over 1,100 college students die by suicide every year. Young adulthood is the time when certain mental disorders are known to manifest themselves for the first time.
- The number of students with serious depressive episodes who contemplated suicide has doubled between 1988 and 2001.
- 10% percent of college students contemplated suicide at least once.

According to the KIDS COUNT, an annual report sponsored by the Annie E. Casey Foundation and conducted by scholars at the University of Nevada Las Vegas,

- 219 Nevada teens (ages 15-19) died from homicide, accident, or suicide between 2000 and 2002. 22 of these victims, or 11%, died by suicide (67% lost their lives in accidents and 22% died from homicide).
- In 2003, the percentage of suicide among Nevada teens who met a violent death rose to 21.9% (62.5% died in accident and 15.6% through homicide).
- 16.4% of Nevada middle school students and 18.1% of high school students seriously contemplated suicide in the last 12 months, according to the 2003 survey conducted by the Nevada State Department of Education.
- During the same period, 10.8% of middle school and 8.8% of high school students in Nevada actually attempted to take their own lives.
Risk and Protective Factors

Current research on suicide seeks to identify individual and group factors that may produce higher rates (risk factors) and those that may produce lower rates (protective factors). Researchers believe that a more complete understanding of both risk and protective factors will better position us to identify those who are at greatest risk and to make more effective interventions in the suicide process, thereby reducing the overall suicide rate.

Research on risk and protective factors has been voluminous. Researchers in bio-medicine, psychology, and sociology have identified dozens of actual and potential factors. This report briefly highlights five factors suggested by preliminary research which help us understand Nevada’s high suicide rates, including (a) social isolation, (b) population explosion, (c) addictive behavior, (d) mental health crisis, and (e) frontier culture.

Social Isolation and Low Social Capital

Early research on suicide postulated that suicide rates would be highest in areas and among groups where individuals experience social isolation, where the population was least connected through traditional bonds of social networks and social institutions. Thus, areas experiencing rapid demographic change, sporting weak social institutions, and marked by low levels of civic engagement and integration (sometimes called low social capital”) were expected to have higher suicide rates. Why? Because members of such communities lack social supports and networks – the protective factors that help us weather personal crises and find or rediscover meaning in their lives. Studies show that Nevada faces major challenges on all these fronts. Our state has undergone a demographic explosion; it has developed relatively weak social institutions; and it scores low on social capital indicators. This cluster of problems, some observers believe, best explains not only our high overall rate, but also the social and geographical variation in suicidal behavior.

Population Growth and Demographic Change

Social isolation can result from rapid population growth as well as reflect the characteristics of the specific groups of people who are moving into the area. Such population changes can affect the suicide rate. For instance, a large number of the retirees and seniors moving to Nevada may be particularly vulnerable to isolation and suicide, especially when they lose a spouse or close friend, face an unexpected financial crisis, or struggle with chronic or terminal health problems. The result can be an upward pressure on the
overall suicide rate. Conversely, the in-migration influx of ethnoracial groups with historically low suicide rates, such as Latinos, may exert a downward pressure on the overall rate. Indeed, the fact that Nevada’s suicide rate remains high despite sharply rising numbers of Latino residents is unusual and needs to be explained.

**Problem Gambling and Other Addictions**

There is empirical evidence linking suicide to alcohol and substance use disorders, known as AUDs and SUDs.

- The National Institute of Health estimates that AUDs and SUDs affect up to 90% of all people who die by suicide nationwide.
- Between 1999 and 2002, over 94% of those who committed suicide in Clark County tested positive for alcohol or drugs at time of death.

While such evidence is not necessarily indicative of underlying substance abuse, it suggests that suicide is not the act of a sober mind. There is a good deal of anecdotal evidence that other addictions may play a significant role in driving up our suicide rates. For example, addictions related to gambling, cigarettes, and sex are hard to control or treat in an environment that offers unlimited 24 hour access to all three.

Even though AUDs and SUDs afflict many Nevadans, affordable, effective treatment programs are scarce. Compounding the problem is the fact that while many of these behaviors are stigmatized in other parts of the country, in Nevada they form a prominent part of the social and cultural landscape and function as an economic engine. Given this unique situation, people with addictions may be more inclined to indulge them in our state than anywhere else.

Apart from AUDs and SUDs, the connections between addictions and suicide are not well established. Yet we know that such addictions can, and often do,

- Create severe financial strains
- Precipitate major psychological depression and other mental health problems
- Erode social and familial support
- Increase a sense of isolation
- Cause irreversible physical health problems

Such conditions increase suicide risk for both individuals and affected groups.
With regard to problem gambling, it should be noted that in Nevada’s urban counties (Washoe & Clark), there is a strong public perception that the high rates of suicide are driven by two major factors, one of which is suicide related to problem gambling. The other perceived factor is suicides by tourists (many of whom come to gamble) and recent arrivals to the state. Suicides by tourists are not driving the high rate – statewide they account for less than 8 to 10 percent of all suicides. It is unclear to what extent suicides by recent arrivals or gambling-related suicides are contributing factors.

**Suicide and Mental Health**

95% of people who complete suicide have a diagnosable psychiatric illness at the time of death, according to the *Journal of American Medical Association*. At the same time, 80% of people consider psychiatric illnesses to be a character flaw and blame life emergencies like divorce and bankruptcy rather than depression for the decision to end one’s life. Understanding that depression is the leading cause of suicide, that mental health issues are behind more than 90% of lethal suicidal acts, is critically important for suicide prevention.

The mental health crisis in Nevada contributes to our high suicide rates. The historically underdeveloped mental health infrastructure in both rural and metropolitan areas throughout the state plays a major role.

- With 42% of its population reporting poor mental health in the past 30 days, Nevada has the highest rate of mental illness among the 50 states.
- At the same time, 2005 per capita spending on mental health ranks Nevada 38th out of 50 states.

Presently, state legislators are considering expanding mental health services to include mental health triage units in Las Vegas, but continued funding is not secure. The absence of adequate mental health facilities and professionals to staff them, combined with Nevada residents’ self-reported mental health problems, reveals a major problem. Even those seeking professional help for their psychological distress may find that they do not receive the services and treatment they need in order to survive. Nevada is nowhere near meeting the mental health needs of its citizens.

**Gun Ownership and a Frontier Culture**

Guns are one of the most lethal means available to attempt suicide – far more effective than overdoses, strangulation, or cutting. Given the high rate
of gun ownership throughout Nevada and the intermountain West region in general, it is logical to suspect a direct link between increased access to lethal means (i.e., guns) and the high regional suicide rate. However, international data shows that higher levels of gun ownership do not always correlate with higher levels of suicide. For example, personal gun ownership is more prevalent in Switzerland than in our country, but suicide rates are higher in the United States.

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

This list of risk factors is not exhaustive. These and other factors must be further studied. We need to study such suicide fostering causes before we can make definitive claims about which factors are most important and why.

**Suicide Warning Signs and Prevention Measures**

Suicide may appear to come without warning, but studies identify several signs that should alert attentive observers to possible suicidal tendencies. Here are some of the most common warning signs:

- Feeling helpless and resigned, going through sudden mood shifts
- Having trouble sleeping, breaking eating habits, avoiding usual routines
- Expressing morbid thoughts, talking about suicide, spinning dark-minded stories
- Losing interest in normal pleasures, giving away prized possessions
- Tying up loose ends, settling business affairs, making final arrangements
- Previous suicide attempts, suicidal behavior in the family.

If you know someone who appears suicidal, take the following steps known to help potential suicide victims:
Given the stigma attached to suicide, it is imperative to engage the troubled person in a dialogue. Try to find out if the person has considered suicide, set up a time line, developed a plan of action, and secured the means necessary to end life.

If lethal actions appear imminent, call 911, seek help of neighbors, or take the person to a hospital emergency room. Never let your commitment to a friendship and protecting confidential information override your commitment to saving a life.

Do not shame the person in distress, or contest the individual’s perception, or argue that the situation is not as bad as it seems. Suicidal thinking is not based on ordinary logic, and your insisting otherwise is likely to increase the sense of hopelessness, guilt, and isolation.

With over 90% of suicide traced to depression, it is vital to obtain professional help. Tell the person that his or her condition is treatable, that help is available, and urge the person to contact a physician or a psychiatrist.

Do not let your resolve weaken. Follow through on your commitment to help, assist with placing the telephone call, accompany the person to the doctor’s office, make sure professional help is rendered promptly.

(For further information on where to turn for help, please consult the community resources section of this report).

**Federal, State, and Community Response**

In recent years, government agencies and community groups have stepped up efforts to publicize suicide as a major social problem. In 1999, Surgeon General David Satcher launched a national suicide prevention campaign. His plan spelled out the following necessary steps:

- defining the problem
- identifying causes and risks
- developing and testing interventions
- evaluating the effectiveness of interventions

In 1998, the **Suicide Prevention Research Center** (SPRC) was established at the University of Nevada School of Medicine with the support of Nevada U.S. Senator Harry Reid, himself a suicide survivor. Since then, SPRC has had its federal funding renewed but once.

The 2003 Nevada legislative session earmarked funds for the establishment of a suicide prevention coordinator charged with developing and
implementing a statewide strategy for suicide intervention programs. In addition, a suicide prevention trainer and network facilitator position has been created in Clark County. In 2005, approximately $355,000 was appropriated over the next biennium for these purposes. The same year, the Nevada Division of Child and Family services announced its intentions to secure federal funding to continue the Columbia Teen Screen, a nationally recognized school-based program designed to identify and assist suicidal teens.

At the community level, concerned citizens, activists, and volunteers have organized survivor support groups and have staffed volunteer suicide hotlines. Several Nevadans currently work for or in close cooperation with national non-profit organizations such as the Suicide Prevention Action Network (SPAN), American Foundation for Suicide Prevention (AFSP), and the Jason Foundation, which focuses on youth suicide. Such efforts are concentrated in the metropolitan counties of Washoe (Reno) and Clark (Las Vegas), while in Nevada’s fifteen rural counties where the need is great, too few grassroots efforts exist.

Led by Linda Flatt of Henderson, volunteer organizers established in March of 2005 a statewide institution – the Nevada Coalition for Suicide Prevention (NCSP) – to support the Nevada suicide prevention efforts across the state and region. NCSP serves as a liaison for national groups.

**The Work Ahead**

Several measures can help address the problem and reduce the incidence of suicide in Nevada:

- Increasing advocacy from politicians, legislators, business, and community leaders, public and mental health professionals, and members of the media to raise public awareness of the statewide suicide problem.
- Continuing efforts by concerned citizens and community organizers to promote suicide intervention strategies and to pressure federal, state, and local governments to respond proactively to the crisis.
- Improving data collection on suicide and suicidality at the local, county, and statewide level is needed, as are measures to improve reliability of data at all levels.
- Raising funds for systematic research that identifies and assesses the specific factors involved in producing our high suicide rate.
- Spearheading evaluation research that assesses the effectiveness of state and local suicide prevention strategies and programs.
• Promoting statewide development and implementation of evidence-based intervention programs. Such programs could be aimed at identifying and reaching out to groups and individuals most at risk for suicide.
• Working out effective strategies for reducing suicide risk factors, such as social isolation, low social capital, and poor mental health.

This final recommendation connects suicide prevention and research efforts to other measures designed to improve social health in our state. Healthy communities and healthy states can save lives.

Conclusion

Nevada’s tragically high suicide rate remains a complex, unsolved problem, and one of the most pressing social health challenges. Suicide may well be an indication of deeper social malaise plaguing the Silver State and Nevadans must take seriously the possibility that something unusually violent plagues our communities, something which results in a tendency to inflict an intentional self-harm and of which we are perhaps only dimly aware.

The present report has identified several factors behind the historically high suicide rates in the Silver State. The most important among these factors are social isolation, population explosion, addictive behavior, mental health crisis, and frontier culture. To ameliorate the Nevada situation, we need to take several urgent steps, starting with improved data collection, building more mental health facilities, augmenting community resources, and mounting a state-wide campaign to educate Nevadans about the risk factors they face as residents of this state.

Data Sources and Suggested Readings


Community Resources

Nationwide Resources

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention provides a wealth of information and statistics related to suicide and suicidality in the United States. 1600 Clifton Road, N.E., Atlanta, GA 30333 USA. Tel. 404-639-3534 or 800-311-3435. Web link: http://www.cdc.gov/ncipc/.

National Suicide Prevention Lifeline is an anonymous toll free hotline for anyone experiencing suicidal thoughts or emotions. Tel. 800-273-TALK or 800-779-4TTY. Funded and organized by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Web link: http://www.samhsa.gov.

The Suicide Prevention Resource Center (SPRC), established in 2002, supports suicide prevention with the best of science, skills and practice to advance the National Strategy for Suicide Prevention (NSSP). SPRC provides prevention support, training, and resource materials to strengthen suicide prevention networks and is the first federally funded center of its kind. Web Link: http://www.sprc.org.

Nevada-based Resources

Nevada Office of Suicide Prevention is a state mandated and funded office working to expand and coordinate suicide prevention efforts in all Nevada counties. Contact: Misty Vaughan Allen, MA, Suicide Prevention Coordinator. 505 E. King St., Room 600, Carson City, NV 89701. Phone: 775-684-3475. E-mail: mvalen@dhhs.nv.gov. In southern Nevada, contact Linda L. Flatt, Suicide Prevention Trainer and Networking Facilitator, 4220 S. Maryland Parkway, Building B, Suite 302, Las Vegas, NV 89119. Phone: 702-486-8225. Email: lflatt@dhhs.nv.gov.

Nevada Coalition for Suicide Prevention is a volunteer membership based organization that serves to coordinate and direct community, county, and statewide suicide prevention and intervention efforts 205 N. Stephanie St., Ste. D #149, Henderson, NV 89074. Tel. 702-451-4338.

American Foundation for Suicide Prevention, Nevada Chapter provides education and networking resources for those involved in suicide prevention efforts and support for survivors of suicide. 300 Vallarte Drive, Henderson, NV 89014. Tel. 702-451-4338.

Clark County Health District is the governmental agency charged with caring for and improving the physical and mental health of citizens and communities in southern Nevada. 625 Shadow Lane, Las Vegas, NV 89106. Tel. 702-759-1268.
Nevada Division of Mental Health and Developmental Services is the state government agency responsible for caring for and improving the mental health of Nevada’s citizens. Kinkead Building, Room 602, 505 E. King Street, Carson City, NV 89701. Tel. 775-684-5943.

Southern Nevada Adult Mental Health Services provides depression screening and a wide range of other mental health services in Clark county. 6161 W. Charleston Blvd., Las Vegas, NV 89146. Tel. 702-486-6238.

Nevada Department of Education, Center for Health and Learning coordinates mental health screening programs in the Clark County School District. 1820 E. Sahara Suite 205, Las Vegas, NV 89104. Tel. 702-486-6694.

Crisis Call Center is the main statewide suicide prevention hotline, operating 24/7/365. PO Box 8016, Reno, NV 89507. Business Tel. 775-784-8085. Crisis lines: 775-784-8090 or Toll free 877-885-HOPE (877-885-4673).

Jason Foundation (Teen Suicide Prevention Program) is devoted to providing information and resources to reduce the incidence of teen suicide and suicidality in southern Nevada. Montevista Hospital, 5900 W. Rochelle Avenue, Las Vegas, NV 89103. Tel. 702-251-1347.

Rural Clinics Community Mental Health Centers is the main organization behind efforts to coordinate and expand mental health provision in Nevada’s rural counties. 503 North Division Street, Carson City, NV 89703-4104. Tel. 775-687-1000. Fax: 775-687-3419.

This report is prepared by Dr. Matt Wray, Department of Sociology, University of Nevada, Las Vegas. You can contact the author by writing to Department of Sociology, University of Nevada Las Vegas, 4505 Maryland Parkway, Box 455033, Las Vegas, NV 89154-5033. Telephone: 702-895-0750. Email: mwray@unlv.nevada.edu. I wish to give special thanks to Bo Bernhard and Dmitri Shalin for editorial assistance and to Linda Flatt for help in identifying community resources. I am grateful to the Nevada Center for Health Data and Research for permission to reproduce the tables.

Supplementary Materials

NOTE: Rates provided in this report are not age-adjusted unless so indicated. Sources include the National Center for Health Statistics and the
Nevada Bureau of Vital Statistics. Unless otherwise stated, rates are from the year 2000.

**Table 1.**

![Graph showing Suicide Crude Mortality Rates (Per 100,000) by Race/Ethnicity, Nevada Residents, 1994-2003](image)

**Table 2.**
Table 3.

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Suicide Deaths by County of Residence, Nevada, 1991-2003

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Table 5.

Suicide Rates for 50 states and District of Columbia (2002)

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**Total** 10.99

*Source: Centers for Disease Control WISQARS*
Table 6.

National Suicide Rates per 100,000 for Selected Countries (2001)*

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* The more recent total suicide rate for 1996 was 21.6, but rates by sex were not available.

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*This report stems from the Justice & Democracy forum on the Leading Social Indicators in Nevada that took place on November 5, 2004, at the William S. Boyd School of Law. The report, the first of its kind for the Silver State, has been a collaborative effort of the University of Nevada faculty, Clark County professionals, and state of Nevada officials. The Social Health of Nevada report was made possible in part by a Planning Initiative Award that the Center for Democratic Culture received from the UNLV President's office for its project "Civic Culture Initiative for the City of Las Vegas." Individual chapters are brought on line as they become available. For further inquiries, please contact authors responsible for individual reports or email CDC Director, Dr. Dmitri Shalin shalin@unlv.nevada.edu.