Suicide Deaths Affecting Children and Schools in Nevada

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Executive Summary

Trends in completed suicides and self-reported youth survey responses indicate that Nevada's behavioral health crisis increasingly affects school children and their communities. Trends of suicidal ideation among middle and high school students are especially concerning among youth in Clark County, though the crisis extends to all regions and communities in the State. Parent and community organizations, non-profits, local and state agency work have attempted to address the crisis by expanding school and community partnerships and school-based behavioral health services. However, barriers, including funding and workforce needs, create a growing burden for first responders to behavioral health crises affecting school children, staff, and their families. This white paper summarizes the data on youth suicide in Nevada as well as lived experiences of school staff working to address the crisis. Then, it outlines some existing resources and efforts and shares ongoing needs.

Purpose of this Document

This paper presents information about the current effects of suicide deaths on Nevada's school children. These effects include the behavioral health impact on children, youth, and families following the deaths of peers, family members or caregivers, school staff, or other suicides within a student's home and in their school community. The purpose of this paper is to inform legislators and government agencies on the gravity of the current issue and engage continuing support toward prevention, intervention, and postvention system improvements and initiatives, including school, community, and state agency integration of services and sustainable funding for school-based and community-based behavioral health services.

Suicides Affecting Nevada Children

Nevada has historically had high suicide rates. From 1939 to 1999, Nevada ranked number 1 in suicide deaths in the United States. Currently, Nevada ranks number 13 in the nation. While we honor the collaborative efforts across the State resulting in this change, we recognize there is significant work still to be done to prevent suicide. Suicide is the second leading cause of death for age populations 8-44 in Nevada. There are high suicide rates amongst the elderly (65+), Veterans, Native, and LGBTQ+ populations. The Center for Disease Control data project an 11% increase in suicides for 10-17 year-old youth and a projected 17% increase in suicides for 18-24 year-old young adults for the year 2021 and a decrease in all age groups for 2022, though these numbers cannot be confirmed for two years. During the COVID-19 pandemic (2019-2020), suicide rates decreased, possibly due to community support and connectedness, telehealth access, financial assistance, and families spending more time together. However, the increase in 2021 rates reflects stressors: post-COVID 19 stress, financial instability, housing or job loss, food insecurities, and returning to school.

In Nevada, over 60% of suicide deaths are by firearm, with hanging, medication, jumping from a height, or vehicle collision as other common methods. There are more male suicide deaths than female, yet females attempt suicide nearly four times more often than males. Statewide LGBTQ+ suicide data is challenging to obtain; however, the Trevor Project estimates that 1.2 million LGBTQ+ youth attempt suicide each year in the United States.

In 2020, Nevada lost 603 people to suicide, including suicide deaths affecting school children, including the deaths of school students, their peers, parents, and school staff. Suicide deaths by county can be seen in the visual below:

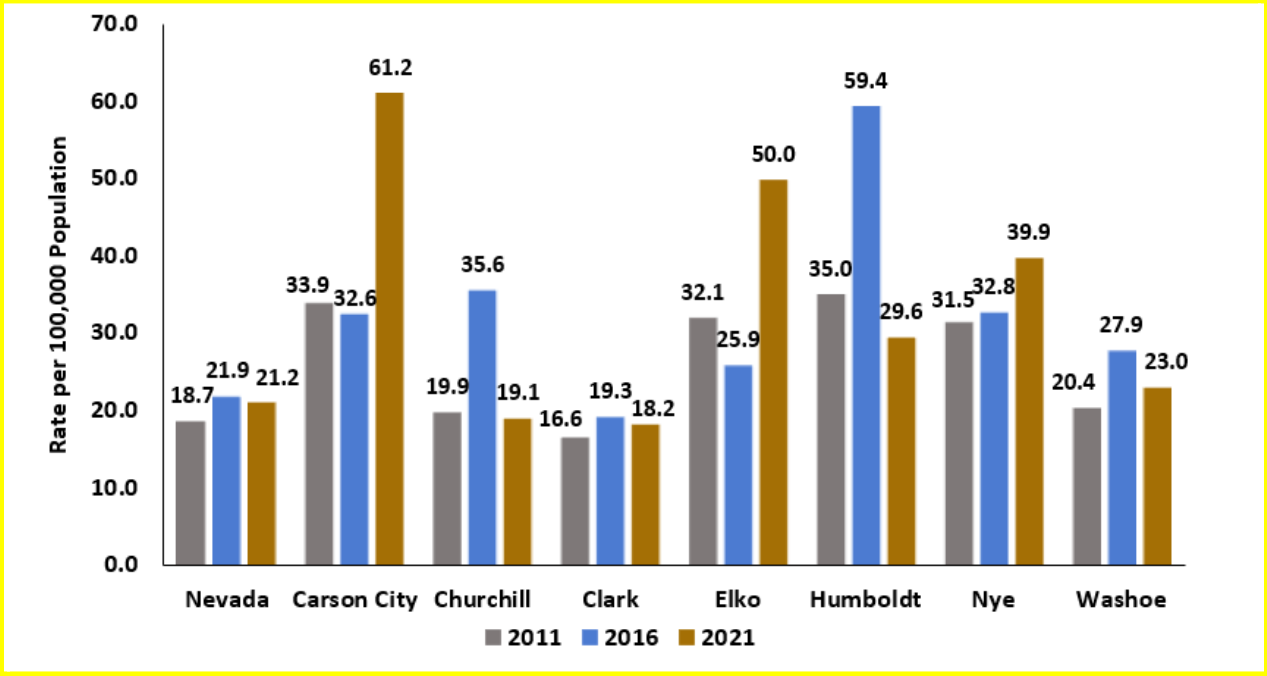


Figure 1. Suicide rate per 100,000 Population 2011, 2016, 2021

The National Alliance on Mental Illness estimates that for every death by suicide, 100-125 people are impacted. Of those people impacted, there is a significant increase in the risk of developing thoughts of suicide or developing a mental health condition. Nevada lost 603 people to suicide in 2020. Based on these estimates, up to 60,000-75,000, people were impacted by a Nevada suicide death in 2020.

Less clear is the impact of a suicide attempt on a family or caregiver within a community. For each death by suicide, it is estimated that there are 25 attempts. Obtaining accurate data on attempts is challenging as the data is limited to self-reported attempts or hospitalizations. The Center for Disease Control estimates 1.2 million suicide attempts in the United States. These attempts only include the reported numbers, therefore not including unreported attempts. It is likely there would be an increase in suicide attempt numbers if the unreported numbers were included. Both suicide deaths and suicide attempts significantly impact communities, families, and students. The aftermath of a suicide can devastate first responders, law enforcement, teachers, family, youth, and their communities.

Youth Suicide Stressors

The Clark County Child Death Review committee produced a Youth Suicide Review Summary (2019) which identified the following stressors as affecting youth who died by suicide:

- Family discord or an argument with parents or guardians
- School problems, especially those that result in expulsions/suspensions
- Access to personal phones/electronics being revoked
- Stressful life events such as the loss of a loved one
- Fights and breakups with a significant other
- A general sense of lack of support from those close to the decedent
- Drug and alcohol abuse
- Chronic mental health issues
- Rape/sexual abuse
- Emotional neglect/abuse
- Problems with the law
- Difficulties experienced because of sexual orientation or gender identity
- Social isolation
- Access to lethal means (firearms)

Many think that talking about suicide directly with youth will give them the idea or cause them to have thoughts of suicide; however, research disproves this theory. Thus the Nevada Office of Suicide Prevention recommends directly talking about suicide with youth as a very effective tool in preventing a suicide attempt. There is a misconception that suicide is contagious, specifically among youth. While suicide has a contagion factor, where a youth already struggling with thoughts of suicide becomes more susceptible to attempt if they see a suicide death in the media or at school, it is not specifically contagious. Social media has become a popular tool for youth to research methods of suicide and talk about suicide among their peers. Societal pressure, bullying, harassment, discrimination, racism, and public figure suicide deaths impact youth and young adults online. Nevertheless, there is limited policy regarding suicide posts online. Please see Nevada suicide deaths by age group from 2019 to 2021 in the graph below:

Year	Age Groups							
	Age 0-17		Age 18-24		Age 25-64		Age 65+	
	Count	Crude Rate	Count	Crude Rate	Count	Crude Rate	Count	Crude Rate
2010	8	1.2	41	16.0	397	27.4	102	30.5
2011	22	3.3	46	17.9	350	24.1	91	26.3
2012	6	0.9	32	12.2	384	26.3	84	23.4
2013	13	1.9	35	13.0	370	24.9	111	29.7
2014	11	1.6	44	16.2	372	24.7	131	33.9
2015	17	2.4	46	16.9	381	24.9	109	27.4
2016	19	2.7	43	15.5	413	26.5	163	39.7
2017	16	2.2	62	22.5	400	25.4	141	33.3
2018	28	3.9	51	18.0	438	27.2	144	32.7
2019	16	2.2	53	18.2	413	25.2	160	35.2
2020	19	2.6	62	21.0	371	22.3	150	31.9
2021	22	3.0	78	25.9	423	25.2	160	32.9

Figure 2. Suicide deaths by age group 2010-2021.

Regional and Geographic Trends in Suicides Affecting Youth/ School Communities

Survey data from the Youth Risk Behavior Surveillance System indicate that suicide trends across the state are following similar trends year over year.

Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance (YRBS) is a self-report survey of adolescent health behaviors designed by the Center for Disease Control and Prevention in cooperation with federal and state agencies, including those overseeing education and health. Nationally, the YRBS has become the primary source of information on the most critical health risk behaviors of high school and middle school students. The YRBS data is increasingly used by leading educators, public health officials, and others to improve school health policies and programs. The Nevada YRBS is a biennial, anonymous, and voluntary survey of students in 6th through 12th grade in regular public, charter, and alternative schools.

The results of this survey help better understand the health and well-being of youth throughout Nevada, and the findings are used to help set the national and State agenda for prevention and intervention programming.

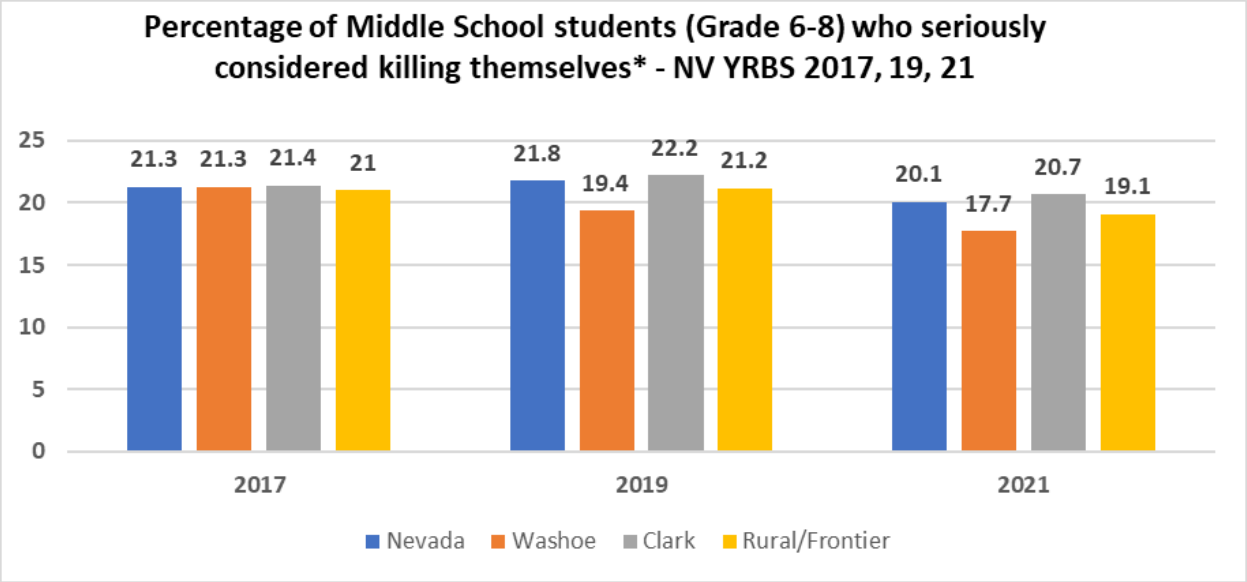


Figure 3. Percentage of Middle School Students (Grade 6-8) who seriously considered killing themselves NV YRBS 2017, 2019, 2021

The 2021 YRBS survey data indicate that suicidality among middle school students (grades 6-8) remains near 20% across Nevada during the 12 months prior to the survey. While there was an increase in middle-aged school students seriously considering killing themselves between the 2017 and 2019 YRBS Survey, there was a slight decrease across all regions in the State during 2021 for that same question asked.

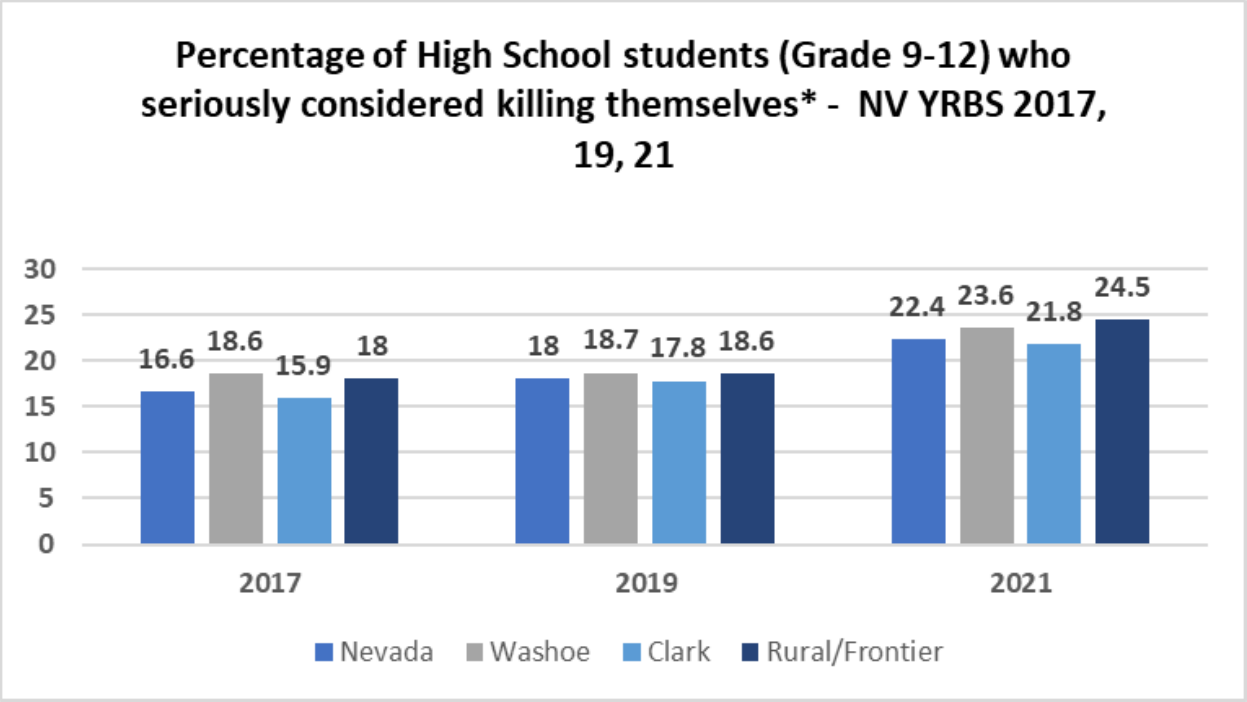


Figure 4. Percentage of High School Students (Grade 9-12) who seriously considered killing themselves NV YRBS 2017, 2019, 2021.

There has been a steady incline in rates of Nevadan High School students who seriously considered killing themselves. The rate between 2017 and 2019 was slightly higher in contrast to the 2021 rates, which shot up drastically.

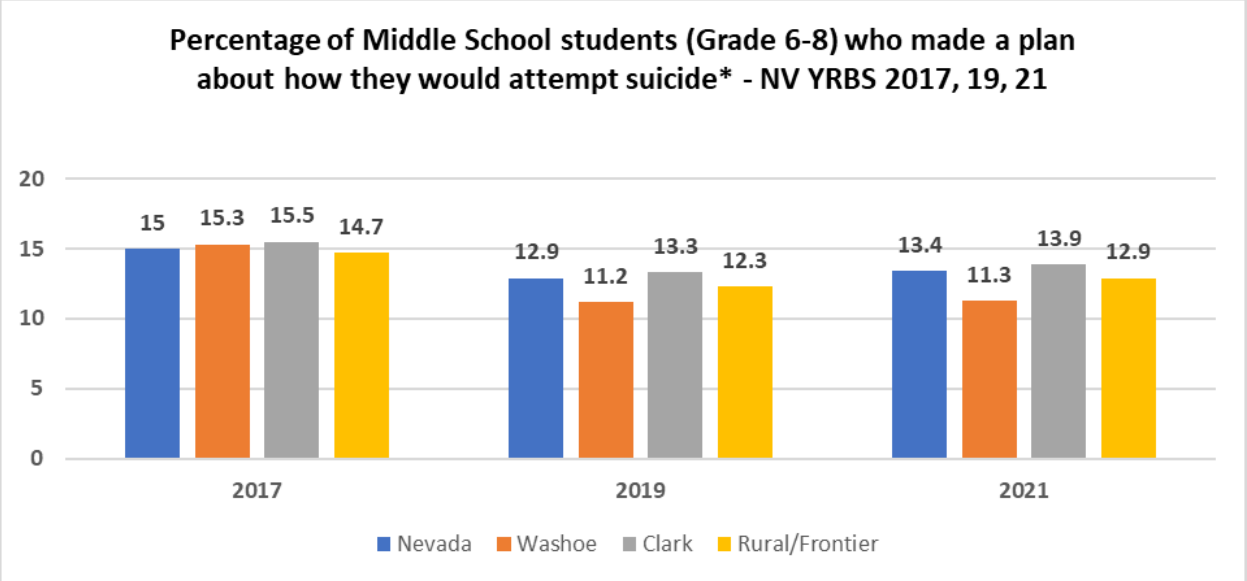


Figure 5. Percentage of Middle School students (grades 6-8) who made a plan about how they would attempt suicide during the 12 months before the survey.

The percentage of Nevada middle school students who planned a suicide dropped significantly between 2017 and 2019, but in 2021 the number of middle school students who planned how to attempt suicide made an upward trajectory. This specific data point is crucial to watch and monitor as making a suicide plan is a considerable risk of dying by suicide. In these data, it is notable that Washoe County middle school students and rural/frontier students have demonstrated decreases compared to their peers in Clark County.

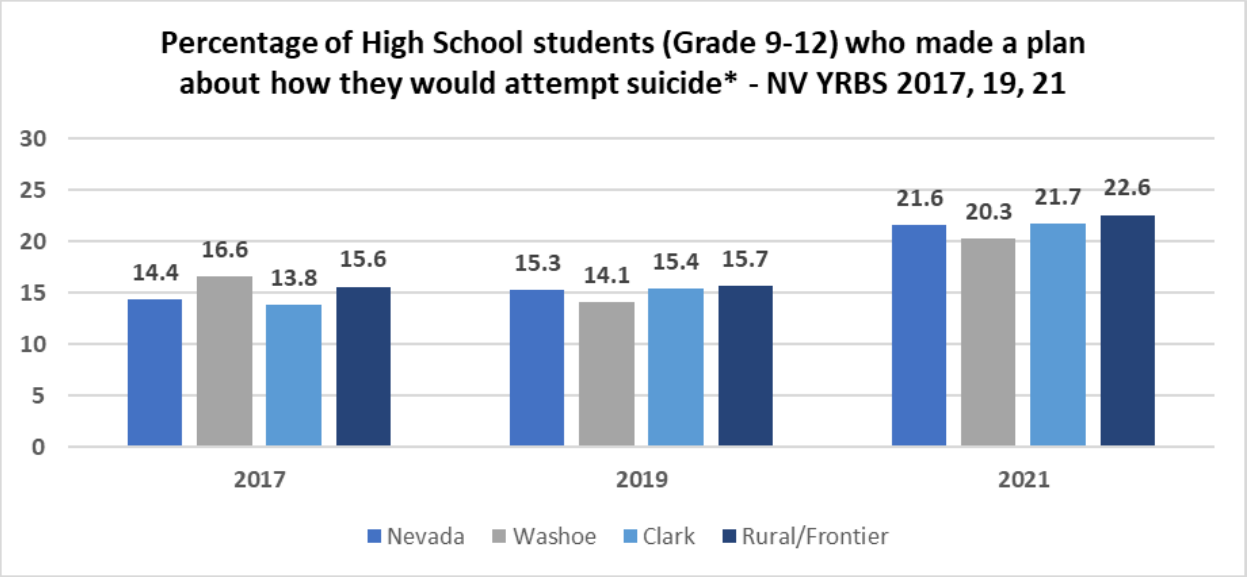


Figure 6. Percentage of High School students (grades 9-12) who made a plan about how they would attempt suicide during the 12 months before the survey.

The percentage of Nevada high school students planning a suicide increased significantly between 2017 and 2019, but in 2021 the number of high school students who planned how to attempt suicide made a substantial upward trajectory. This specific data point is crucial to watch and monitor as making a suicide plan is a huge risk of dying by suicide.

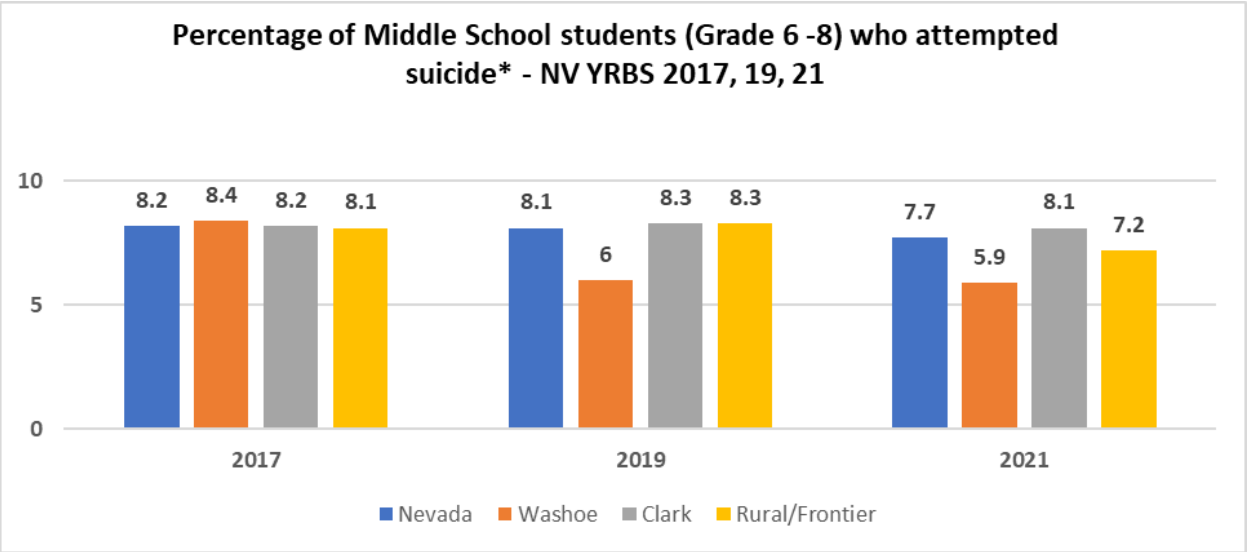


Figure 7. Percentage of Middle School students (grade 9-12) who attempted suicide in the 12 months prior to the survey.

Nevada has shown great strides in working with the Nevada Department of Education, school districts, and our middle schools on suicide prevention and postvention programs. The downward trajectory of middle school students who attempted suicide shows potential promise as Nevada navigates working with the state school districts in collaboration with state and community mental health agencies. Notably, these data points show that Washoe and Rural/Frontier areas reflect decreases compared with middle school students in Clark County.

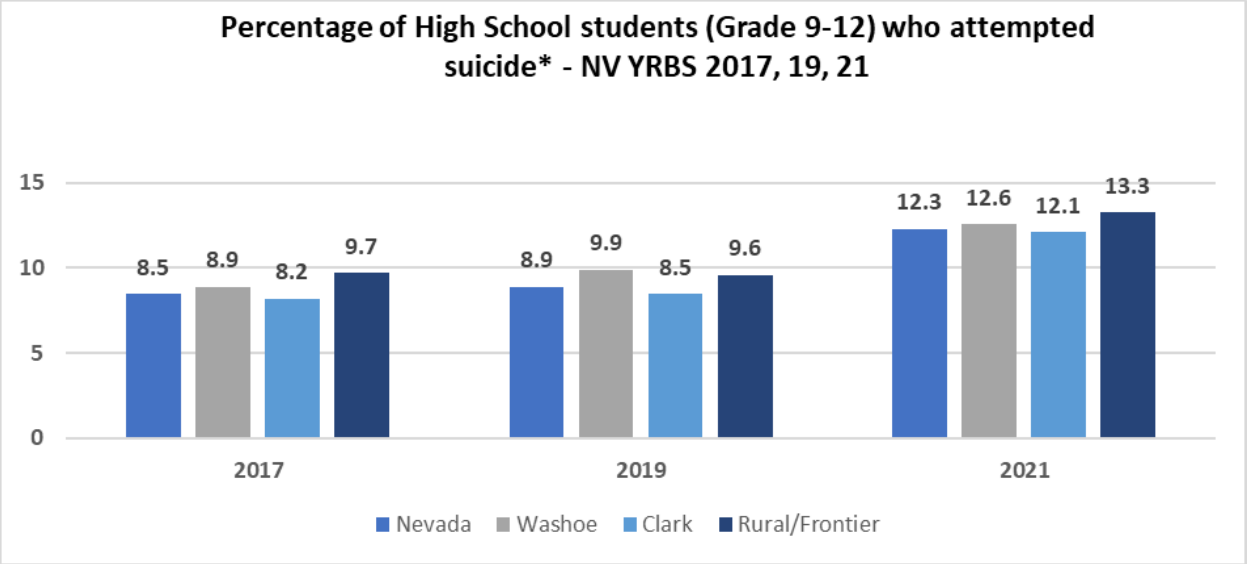


Figure 8. Percentage of High School students (grade 9-12) who attempted suicide in the 12 months prior to the survey.

During the 2017 and 2019 YRBS survey collection, there was no drastic change in the number of

high school students who attempted suicide. However, in 2021 the rise of high school students attempting suicide rose drastically in all areas.

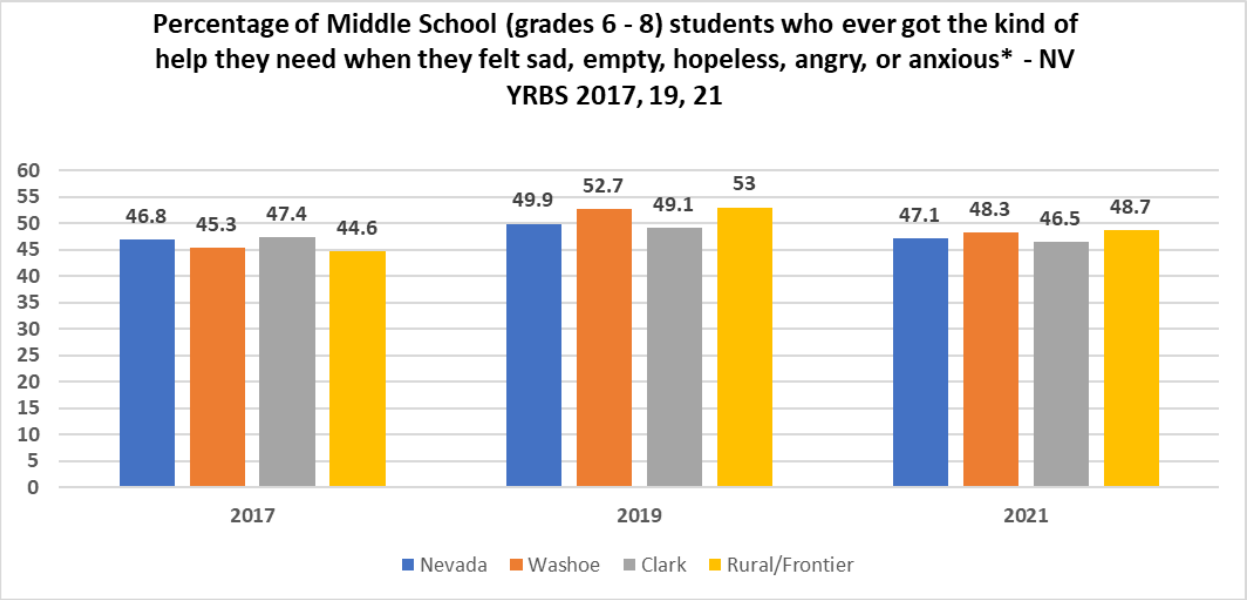


Figure 9. Percentage of middle school students (grades 6-8) who got the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious during the 12 months prior to the survey.

These data points indicate that middle school students' perceptions of whether they can access help for strong, negative emotions increased significantly in 2019, but by 2021 had decreased again to slightly above the 2017 reported levels. It is still being determined why the perceptions of access to help declined. However, some factors may result from the Covid-19 pandemic, such as the impact of parents returning to work while schools were still closed. In Clark County, the perceptions of access to help indicate a total decrease from 2017 to 2021 rates of perceived access to help, whereas Washoe and the Rural/Frontier areas demonstrated a slight increase between 2017-2021.

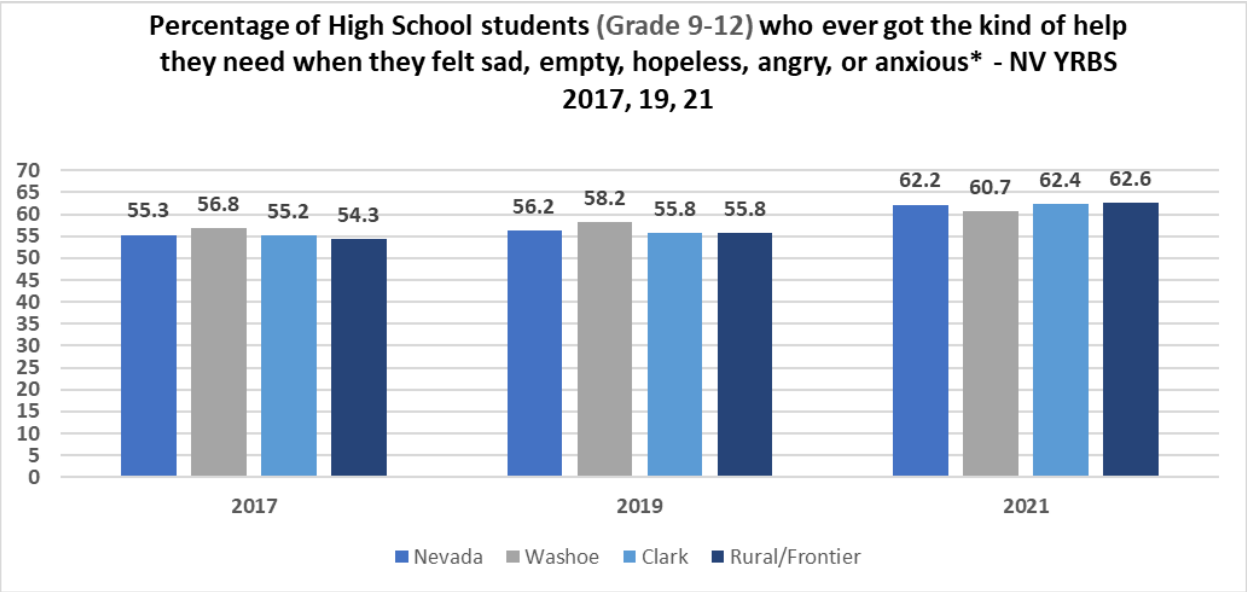


Figure 10. Percentage of High School students (grades 9-12) who got the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious during the 12 months prior to the survey.

Nevada High School students experienced a significant increase in their perception of whether they have been able to access help when experiencing strong, negative emotions. This significant increase in the data from 2017-2021 is a possible indicator that efforts to increase student access to school-based behavioral health providers and partnerships between schools and community-based providers are having a positive result.

Feedback from Community and School Based Behavioral Health Providers on Trends

A sampling of school districts indicate some of the trends in rural and urban communities.

The Healthy Communities Coalition (Lyon and Storey Counties) report that school behavioral health providers are seeing fewer high school students self-reporting for suicidal ideation and an increase in reporting of ideation by concerned peers and adults. The school social workers are receiving questions from students asking, "what is reported?" before disclosing. Additionally, many instances of parents responding in a negative way have created a perception that students are fearful of coming forward if they are experiencing suicidal thoughts. Other behavioral health providers, particularly in middle/intermediate schools, share that they have seen an increase in ideation over the past few years and a considerable rise in anxiety and depression levels since the pandemic's start. They perceived that middle school students are more comfortable reaching out and talking to adults.

Additionally, staff are reporting increases in substance use, with providers at school viewing this as self-medicating. More students are seeking help with addiction, and social workers are concerned about the correlation between substance use and increased suicidal ideation. Behavioral health providers in elementary schools indicated they are surprised to see how many younger kids are struggling, especially 3rd and 4th graders, stating, "I want to die," verbalizing

violence, and acting out in a violent manner. They also report that little children are engaging in self-harming, choking themselves with a necklace, smacking their heads against the wall, or other distressing behaviors. For all students, an identified need to provide support, education, and training to parents and guardians and provide additional support to teachers. There definitely is a need for environmental and community engagement; providing family-friendly events is paramount.

Generally, school behavioral health staff note low motivation, lack of energy, anger, decreased interest/care in school, increased self-harm, and increased substance use (primarily but not only vaping, alcohol, and marijuana). Overall, an increase in risk behaviors is being observed. Gender identity and suicide ideation have been brought forward, sharing that approximately 75% of gender-fluid students suffer from depression, anxiety, and little to no family support. High rates of absences and tardies are also noted.

Clark County (2020-2021) had a predicted decrease of 23.53% in suicides for ages 10-17. The decline is perhaps partly attributable to Clark County School District's proactive approach to supporting at-risk students. The pandemic put a sense of urgency on approaching students in distress. In addition to providing support directly related to COVID-19, previously identified at-risk students would need continued support. During this time, CCSD regrouped to develop outreach methods to monitor students needing help. Early interventions include identifying students at risk for self-harm and may have been struggling with depression, anxiety, suicidal thoughts, and substance misuse. However, it is notable that the predicted lower rate of students completing suicide in Clark County must be considered in the context of the high rates of suicidal behaviors and ideation reported by youth in the YRBS. Therefore it is optimistic that rates of completed suicides are reducing, yet risk behaviors related to suicide, as reported by students, are increasing.

Mental Health Disparities for Minority Students affect Youth Suicide

While about half of the lifetime cases of mental health conditions begin by age 14, fewer than 1 in 3 youth with major depression receive consistent care. According to the National Association of Secondary School Principals (2022), the percentage is worse for Black youth with depression. In addition to this national trend, Nevada data indicate that Black people in Nevada are reporting increases in suicidal ideation (Office of Suicide Prevention). Minority students face additional barriers to accessing care, and these challenges include:

- Black families, including their school-age youth, are more likely to live in neighborhoods with higher violence, environmental hazards, and other factors that negatively impact health.
- Behaviors of distress exhibited by Black students in the classroom are more often perceived as disruptive and result in disciplinary and juvenile justice-related responses rather than healing ones.
- Suicide attempts are higher among Latina or Hispanic female teenagers than non-Hispanic white female and Hispanic male peers, with more than 1 in 4 Latina or Hispanic female high schoolers having suicidal thoughts.
- Many Black/African American, Indigenous/Native American, Latino/Hispanic, Asian, Middle Eastern, and Pacific Islander families do not discuss mental health and mental

illness because it is seen as a sign of weakness or believed to not exist at all.

The Role of Schools in Suicide Prevention, Intervention & Postvention

Schools have a critical role in preventing suicide. There are six components to suicide prevention that subject matter experts have identified as the key components to be implemented to include; protocols for helping students at risk of suicide, protocols for responding to suicide death, staff education and training, parent education, student education, and screening (SAMHSA, 2012).

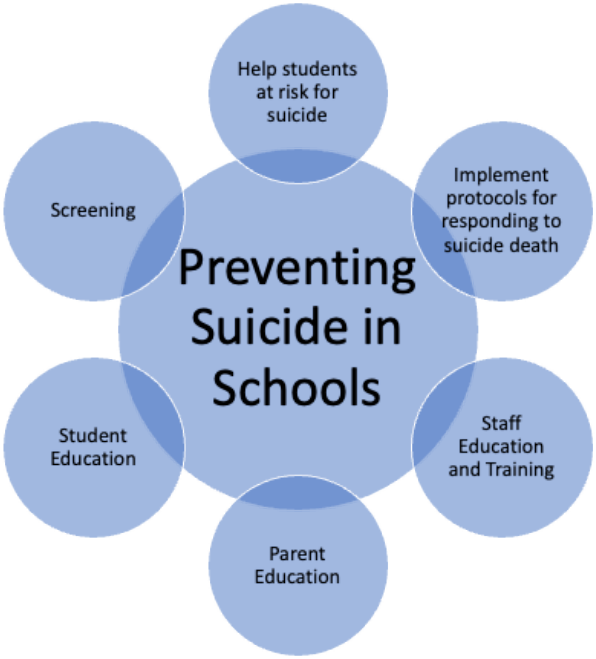
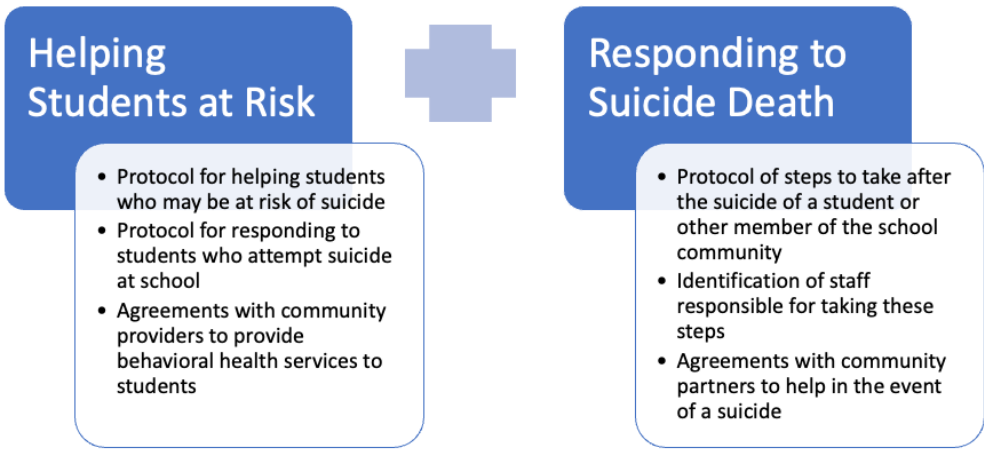


Figure 11. Six Components of Suicide Prevention in Schools.

The components above are complementary strategies and work best in concert with one another. However, it may take time for schools to develop the multi-tiered infrastructure to implement comprehensive training, prevention programming, screening, interventions and supports, and crisis response plans. For schools just getting started, there are two essential components that every site should have in place; having protocols for helping students at risk for suicide and protocols for responding to a suicide death (see Figure 12). The additional components strengthen as a school implements a robust Multi-Tiered System of Support (MTSS) framework.



Schools have a dual role in addressing suicide that includes helping students at risk and responding when a school population has experienced a suicide death. These two roles are described in Figure 12.

Figure 12. The dual role of schools in addressing suicide.

School Climate Data

Nevada annually administers a School Climate Survey across all districts that explores student self-report on various aspects of school connectedness, including areas of Relationships, Emotional Safety, and Physical Safety, among others. The Center for Disease Control defines "school connectedness" as students' belief that peers and adults in the school support, value, and care about their individual well-being as well as their academic progress (2022). School connectedness is a protective factor for youth that increases their likelihood of positive health behaviors, attendance, and graduation. School connectedness also functions as a protective factor to decrease the probability of students engaging in risky behaviors, emotional distress, and suicidal ideation (Steiner, et al., 2019).

Data from the Nevada School Climate Survey enables stakeholders to assess trends and themes of school connectedness in their student populations. To engage in a deeper exploration, schools may utilize the Data Tool to filter results by the reported experience of students by different grades, genders, and races. *The aggregated school-wide results mask potential disparities in how some groups of students report on aspects of their experience of school connectedness.*

Perspectives of School Mental Health Practitioners on Strengths, Challenges and Needs

The School Mental Health Practitioners (SMHP) is a committee hosted by the Nevada Department of Education's Office for a Safe and Respectful Learning Environment, in which school counselors, school social workers, school psychologists, and other mental health personnel working in school communities collaborate around practices and policy affecting their

professions.

On December 16, 2022, this committee discussed the experiences, challenges, and strengths of schools responding to suicides and other deaths within their communities. School mental health practitioners from diverse communities participated. Perspectives included concerns about the increase in deaths affecting school communities and the burden on practitioners, school staff, and students. Some of the identified challenges included:

- Each event is different. Responders arriving to support a school community after a loss cannot anticipate the emotional climate in a school building when responding to a death. Administrators' decisions on how to respond can influence the outcomes of postvention efforts. The better postvention guidelines are followed, the better the response and outcome of postvention efforts.
- Administrators may lack post-intervention training, as these trainings are often available to mental health staff as a primary audience. Site leaders may benefit from training in mental health postvention.
- The number of deaths affecting school communities is overwhelming. In the Las Vegas area, crisis teams report that all-cause deaths of students and staff doubled in the 2020-2021 school year, likely due to COVID-19 and stressors related to COVID-19. All-cause deaths were about 1.5 the usual rates last year (2021-2022), and this 2022-2023 school year is still trending higher than pre-COVID-19 numbers.
- A single school may experience several events in a short period of time, with individual school staff members engaging in prevention, intervention, and postvention efforts in the same week with different students and their families. These activities include intervening with students who are identified as suicidal, consulting with parents whose children have attempted suicide, and responding in postvention efforts after a completed suicide. Additionally, school mental health practitioners may provide informal support to teachers, administrators, or other staff affected by mental health concerns or the loss of a colleague or student.
- Secondary trauma and compassion fatigue are growing concerns. School mental health practitioners report that they must learn to compartmentalize their feelings, and may have fewer support options. They also fear being perceived as cold or detached by their colleagues when they do not react emotionally to an emerging crisis. They feel a lot of responsibility for managing the feelings of others and putting their own feelings on hold.
- Staff shortages in mental health professions at school, and staff shortages among community providers affect the ability of schools to engage in prevention, intervention, and postvention and limit capacity to do this work. In some cases, schools cannot follow best practices because of the inability to staff the responses adequately.
- Fear, stigma, and reluctance to talk about suicide still affect the ability of schools to interact with the issue confidently, and especially in small communities, can prevent or hinder postvention responses in schools from engaging in best practices.

Some strengths and resiliency factors identified by the SMHP include:

- The 2016 Postvention Guide is a helpful resource, and when followed school postventions go more smoothly. However, this document needs to be updated.

- Shifts in attitudes toward awareness, including in populations that historically have experienced more stigma, including rural areas and communities of color, positively impact school response efforts.
- When Employee Assistance Programs (EAP) are available, staff are more able to connect to resources to support their own coping with compassion fatigue and secondary traumas. The SMHP have seen this as a positive in areas where EAP is available.
- Cross-department partnerships between crisis response teams, school mental health practitioners, Multi-Tiered-Systems of Support (MTSS) teams, and social emotional learning (SEL) resources have helped schools engage in responding to events.

Comments from school mental health practitioners demonstrated vulnerability and overwhelm, but also hope for the future:

- "It's hard for me to think about postvention on its own. It's an important piece of an overall culture, how we talk about death, mental health, suicide. Generally speaking we are not very good at it."
- "Children cannot learn math when they are still processing the loss of a peer that used to sit in the desk next to them."
- "We don't have the space and time allocated for training, or the feelings of grief and anger that come with a death. This needs to be explicitly prioritized."
- "When I was a kid, we didn't have the resources we have now. I feel very hopeful for the future, and having these departments and resources, even if we have a ways to go."

School-based Behavioral Health

In order to support students, behavioral health providers responding to school adjacent suicide deaths, families and school staff, there is a need to resource the school based behavioral health system in a streamlined and intentional system. Providing increased access to mental health information and services through schools is a more equitable response than when only provided to families outside of school (National Association of Secondary School Principals, 2022; George, 2017).

Figure 13 demonstrates the ways that school-based behavioral health services support student outcomes, reduce exclusionary discipline factors such as those that Clark County Child Death Study Review (2019) indicated are a contributing factor to suicide, and additionally improve teacher outcomes such as feelings of efficacy, school safety, and school health and culture. Student outcomes that improve within a strong school-based behavioral health system include improved academic success, improved social competence, reduced bullying, and reduced substance use. (George, 2017).

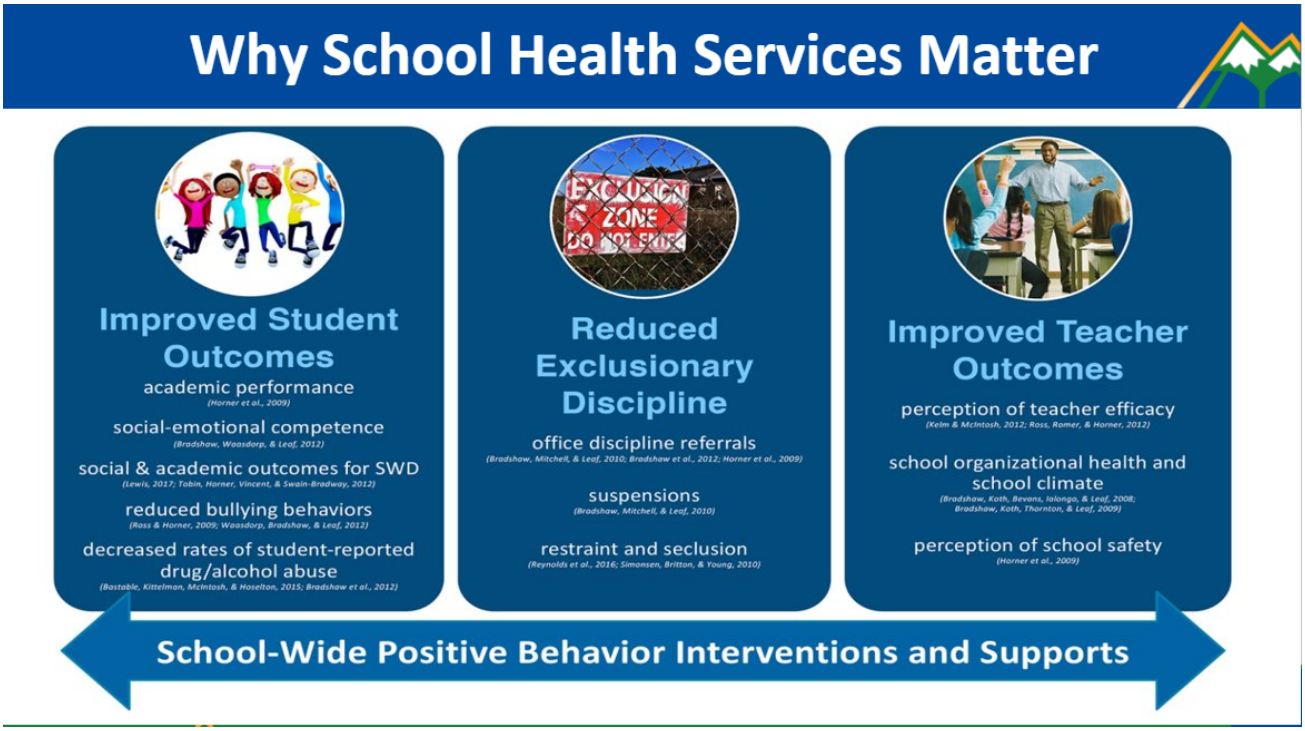


Figure 13. Why School Health Services Matter (George, 2017).

Over 70% of students who successfully engage in mental health treatment initiated services through school, and school-based mental health services reduce disparities in access to behavioral health care. When basic needs are not met and students stay in distress over long periods of time, executive functioning skills necessary for academics decline (National Association of Secondary School Principals, 2022).

Multi-tiered System

The Multi-Tiered System of Support (MTSS) is a best practice framework for student support via a continuum of evidence-based actions and is utilized as a best practice by the SAMHSA Mental Health Technology and Transfer Center (MHTTC). Within a Multi-Tiered System of Support, universal practices are established at Tier 1 to provide foundational support to all students. Students who need more targeted or intensive support are provided those evidenced-based practices and approaches implemented at Tier 2 and 3. MTSS is rooted in the belief that all students can succeed, and that with the right support, they can achieve their full potential. Nevada's Core Elements, Figure 14, emphasize equity and access to all students.

Figure 14. Nevada Core Elements of MTSS

Integrated System of Support to Enhance Social, Emotional, and Behavior Wellness and Suicide Prevention

Integrated services including Positive Behavioral Interventions and Supports (PBIS) and School Mental Health enable schools to meet the needs of the whole child, including suicide prevention work, called an Integrated System Framework (Knoster & Epson, 2019). In this framework, student behavioral support and suicide prevention efforts share overlapping goals and strategies across the three tiers that create a continuum of practices.

Examples of prevention interventions within an Integrated System Framework (Figure 15) include:

- Mental health screenings: Regular mental health screenings can help identify students who may be at risk of suicide and provide them with the support they need.
- Risk assessment tools: There are a number of risk assessment tools that can be used to identify students who may be at risk of suicide. These tools typically involve a series of questions that assess a student's level of risk, allowing schools to align support and make referrals.
- Support groups: Support groups provide a safe and supportive environment for students struggling with thoughts of suicide. These groups can be led by school counselors, social workers, or other trained professionals.

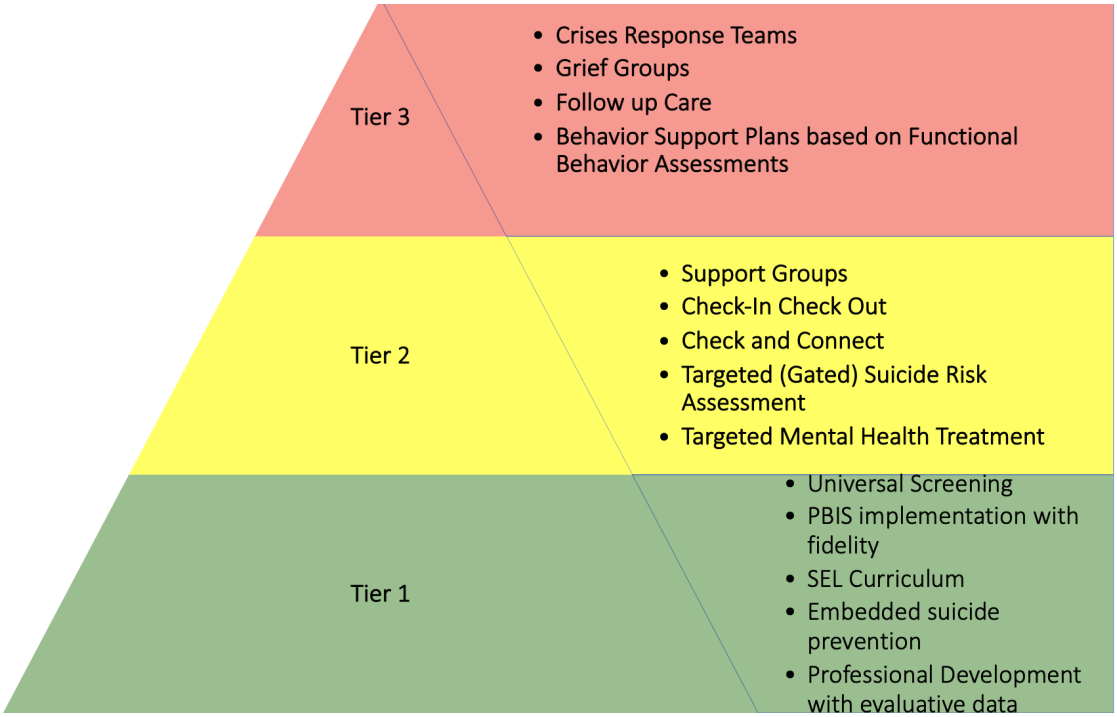


Figure 15. Integrated System of Support

Additionally, MTSS can support suicide postvention strategies after a suicide attempt or a suicide loss. These strategies can help students cope with the aftermath of a suicide and prevent future suicide attempts. Examples of postvention interventions (Figure 15) include:

- Crisis response teams: Trained crisis response teams provide support to students in the wake of a suicide attempt or loss. These teams can include school counselors, social workers, and other trained professionals, including community partners.
- Grief support groups: Grief support groups allow students to talk about their feelings and get support from their peers after a suicide loss. These groups, led by trained staff, help students navigate the grieving process and cope with their emotions.
- Follow-up care: It is important to ensure that students who have attempted suicide receive ongoing care and support after the initial crisis has passed. This can include follow-up counseling, support from school staff, and referrals to community resources.

Education and Training:

Ongoing professional development is essential in supporting suicide prevention. In addition to school based behavioral health and community behavioral health providers, school leaders, faculty, staff, and parents can be trained in evidence-based ways to respond to someone who is struggling. Gatekeeping training and specific intervention training are imperative for individuals to work together in supporting students (Knoster & Perales, 2020).

Some examples of gatekeeping training for school staff include Youth Mental Health First Aid,

Safe Talk, ASIST, and Suicide 101 training. These training resources can be accessed in collaboration between schools, communities, and the Nevada Office of Suicide prevention.

Data driven, specific intervention training enables school staff to intervene early, by building skills and increasing connection within the student's school community. Some examples of these supports include check in/check out, behavioral skills training, and group and individually focused therapeutic interventions. These interventions and supports are delivered by qualified and trained staff within the school setting.

Aligning MTSS with suicide prevention and post-vention efforts is essential to ensure that all students receive the support they need. Integrating and implementing these efforts into the MTSS framework, schools can create a comprehensive approach to student support that addresses the diverse needs of each student. By doing so, we work together to prevent suicide and support students in their journey towards success.

Sustainable Funding for SBBH: Leveraging Medicaid Funding

Nevada school districts are incredibly limited on access to school based behavioral health providers, ratios often 1 provider to 1,000+ students. Districts report limited funding for increased workforce and inability to fiscally support the ongoing staff and training needs for supporting students, families, and school staff. The Nevada Department of Education in partnership with Nevada Department of Health and Human Services (Nevada School Health Services Interdepartmental Team) has the goal of identifying alternative funding resources through federal, state grants and Medicaid reimbursement opportunities. Nevada is one of only 18 states that allows for school-based behavioral health services to be billed as Medicaid qualified services. This innovative billing structure provides school districts with additional revenue resources, other than education funds to support youth and family behavioral health. The School Health Services team provides guidance, toolkits, training and technical assistance to school districts about implementation and integration of school-based behavioral health, supporting the fiscal goal of Medicaid reimbursement. A long-term goal would be utilizing Medicaid reimbursement funding streams to improve student-to-behavioral provider ratios, increasing a school-based safety net for youth struggling with suicidality.

This work to enable Medicaid billing in schools requires the work of individuals across state agencies with insights from community partners and institutions of higher education.

Model School District Policy on Suicide Prevention:

The American School Counselor Association, the National Association of School Psychologists, and The Trevor Project (2019) collaborated to develop a research-based and easily adaptable *Model School District Policy on Suicide Prevention* for middle and high schools. This model policy gives educators and school administrators a comprehensive way to implement suicide prevention policies in their local community. The model policy identifies specific, actionable steps to support school personnel; sample language for student handbooks; suggestions for involving parents and guardians in suicide prevention; and guidance for addressing in-school suicide attempts. In addition to educators and school leaders, school-based mental health professionals such as counselors and psychologists are essential in putting a policy into practice

to enhance the whole school environment.

More than half of all U.S. states require educators to receive training to prevent suicide. With recommendations rooted in best practices, the Model School District Policy on Suicide Prevention can complement state requirements and help schools achieve an inclusive, comprehensive suicide prevention plan.

Available Resources

Nevada state and community agencies have created a series of resources to support schools in addressing school mental health, including suicide prevention, as an attempt to respond to the impact of suicide on school children and their communities. Some of the available resources include:

Community Chest:

Community Chest is a non-profit agency serving children and families in northwestern Nevada since 1991. They provide holistic solutions to build and sustain strong families and communities. Currently, three centers in Northern Nevada provide services to help people help themselves. Their youth programs Comstock Kids and VC Soars, are highly sought-after before and after-school programs. With the support of volunteers, agency staff, and public and private revenue, Community Chest develops, offers, and sponsors services that make a difference in the lives of Nevada's youth and families. Community Chest is a proud member of the Health Services Hub. This location is a consumer-centered school and community-based hub that coordinates the delivery of healthcare and social services for all community members, including the most vulnerable.

Community Prevention Coalitions:

Several local-level prevention coalitions have a long-standing history of serving local communities across the State. These coalitions serve one to four counties, and most of their work is focused on preventing substance misuse or abuse among youth. However, as mental health is closely tied to substance use status, most (if not all) of these coalitions have also endeavored to provide programming and/or services to address youth mental health concerns, including suicide prevention. While each of these coalitions has its own grant programs and services they offer, the focus and need across the State is for more robust community mechanisms to prevent suicide among children and youth universally.

Community prevention coalitions partner with school districts to deliver suicide prevention programming, including the Signs of Suicide (SOS) curriculum. For example, this year, the Healthy Communities Coalition in Lyon County noted increased demand from schools wanting to provide SOS curriculum to their students; more schools are seeking help, and schools are expanding the program's reach within their schools to cover more students or grade levels. In the Fall 2022 semester, Healthy Communities served 1232 youth in Lyon County Schools, with more education days scheduled for Spring 2023, compared to 663 youth in Fall 2021. This year, Healthy Communities also started HOPE Squads, a peer-to-peer suicide prevention program, in

Lyon County Middle and High schools. Along with the SOS program and HOPE Squad, Healthy Communities has co-located social workers and community health workers in schools to attempt to support increasing needs for behavioral health services and resource

linkage. These increasing needs are seen throughout the State, with prevention coalitions working to support the efforts in community-specific ways.

Co-Responding Teams with Law Enforcement:

Some communities in Nevada utilize co-responding teams who work with law enforcement or community agencies. In these teams, trained responders can support individuals suffering a behavioral health crisis. These resources include the Mobile Outreach Safety Teams (MOST), co-responders with law enforcement. MOST teams are available in Washoe, Lyon, and Douglas Counties. The Mobile Crisis Response Team (MCRT) serves youth and their families statewide to access crisis stabilization, referral, and limited case management. The Trauma Intervention Program (TIPS) of Northern and Southern Nevada provides trained volunteers to assist with traumatic events.

County Behavioral Health Task Forces:

The Elko County Behavioral Health Task Force was re-launched in November 2022. At the time this document was published, the Task Force focused on finding meaningful local solutions to escalating mental health needs within communities across the county, including youth. The biggest challenges to launching these solutions are sustainable funding, community openness to implementing youth-focused suicide prevention efforts, and stigma surrounding mental illness and suicide.

The Humboldt County Behavioral Health Task Force has focused on bringing local efforts in Humboldt County regarding mental health and substance use together under one roof to improve communication and remove silos. The Task Force has focused recent efforts on identifying issues related to referral networks and other barriers to appropriate access to care. The task force's work has uncovered issues related to finding qualified and available providers to provide services to youth who need treatment, as well as the need to find funding to fill the gap left by the end of previous Project Aware funding.

Handle with Care:

Since January 1, 2020, the Handle with Care program has enabled a law enforcement officer or agency to create a school notification when a public school student is exposed to a traumatic event or other events that may affect the student's ability to succeed at school. The Handle with Care notification intends to alert schools when a student has experienced a traumatic event outside the school day. The alert ensures schools are made aware of a situation involving the student and can provide support or extra care if needed.

Humboldt Connections:

Humboldt Connections is a non-profit organization focused on preventing suicide in Humboldt

County (Nevada). While the organization's suicide prevention efforts are not limited to a specific age group, Winnemucca and other communities in Humboldt County have most closely embraced the need to focus on suicide prevention efforts for children and teens. The organization focuses its work on raising awareness about suicide and available services, as well as reducing stigma associated to acknowledging mental health concerns and seeking treatment.

Juvenile Services Mental Health Diversion Programming:

Diversion programming for behavioral health initiatives in Nevada includes efforts to stop the progression of unmet behavioral health needs to criminal activity. For example, Humboldt County Juvenile Services includes more than juvenile probationary services but also works to provide wrap-around services for youth and their families. Additionally, the agency focuses on providing mental health care for youth within their programs and provides life and emotional skill-building curriculum to improve their clients' resilience. Examples of programming include parenting resources, multidimensional family therapy (MDFT), and peer groups.

Mobile Crisis Response and Stabilization Services:

The Mobile Crisis, Response, and Stabilization Services program through DCFS and DPBH provides rapid, face-to-face clinical intervention, assessment, and stabilization support for youth ages 0-18 presenting with a behavioral health crisis. A crisis is defined by the individual, allowing youth and families to determine the point during their crisis continuum where they need additional support. Services are provided in two distinct phases, crisis response which can last around 72 hours, and stabilization services, which can stay in place for up to 8 weeks. All youth in Nevada are eligible to receive crisis services by calling 702-486-7865. In the urban areas of Nevada, services are provided in person. In Nevada's rural and frontier areas, telehealth is utilized for timely access for all youth in any area of the State.

Regional Behavioral Health Policy Boards:

During the 79th (2017) session of the Nevada Legislature, legislation was passed (AB 366) to amend Nevada Revised Statutes (NRS 433.425 - 433.4295) to create behavioral health regions, each to be represented by multi-disciplinary policy boards. The purpose of the Regional Behavioral Health Policy Boards is to advise DHHS divisions and the Governor's Commission on Behavioral Health regarding the needs, challenges, assets, opportunities, and gaps related to behavioral health in their respective regions. The programmatic and policy gaps that affect children's mental health and suicide prevention have consistently been an issue with which the Regional Behavioral Health Policy Boards are greatly concerned, particularly in the wake of the closures associated with the COVID-19 pandemic response. As of the time of publication of this document, each of the active Policy Boards has submitted concerns to state bodies regarding youth mental health and suicide prevention.

In addition, each Policy Board is assigned a Regional Behavioral Health Coordinator (RBHC) to work on its behalf. Among the duties of the RBHCs is to meet with local stakeholders throughout the communities in the regions they serve to determine specific needs, gaps, challenges, and assets, then to communicate the findings from those discussions to their respective Policy Boards. Issues and barriers related to building a meaningful system to prevent

suicide among youth and to protect their mental health have been brought to the attention of each of the RBHCs from various sectors, including schools, youth-serving organizations, parents, offices from within the criminal justice system, hospitals, behavioral health providers, and others. These barriers include the following:

- Inconsistent implementation of social-emotional learning (SEL) and Multi-Tiered Systems of Support (MTSS) programs across the school districts of the state.
- Lack of available community-based behavioral health providers for youth in nearly all communities.
- Lack of school-based mental health providers for youth in several school districts.
- Lack of access to appropriate and safe inpatient, residential, or intensive mental health care for children and teens.
- Hesitance on the part of administrators in several school districts to improve or expand programming related to suicide prevention, including universal screening and/or partnership with outside organizations to fill treatment or service gaps the schools are otherwise unable to fill. This hesitation often stems from backlash previously received from school boards or parent groups.
- Lack of awareness on the part of parents and other adult community members regarding the youth's need for behavioral health services.
- Apprehension on the part of parents or other adults in the community to expand youth suicide prevention efforts and utilize treatment options for youth who are considered at risk for suicide. Frequently, this is related to personal or religious beliefs surrounding mental illness but may also be associated with concerns related to confidentiality, involvement of protective services from the Division of Child and Family Services (DCFS), and other founded or unfounded concerns.

SafeVoice:

SafeVoice is a 24-hour tip-taking and response system focused on school safety and student well-being that relies on key relationships with the Nevada Department of Public Safety, local/school law enforcement, designated school teams, and behavioral health response professionals. Tipsters can remain anonymous. Reports can be taken via phone at 833-216-7233, on the website safevoicenv.org, or with the SafeVoice app.

Suicide Post-Vention Toolkit:

Postvention is a term often used in the suicide prevention field. The definition below is from the U.S. national guidelines developed by the Survivors of Suicide Loss Task Force. Postvention is an organized response in the aftermath of a suicide to accomplish any one or more of the following:

- To facilitate the healing of individuals from the grief and distress of suicide loss
- To mitigate other adverse effects of exposure to suicide
- To prevent suicide among people who are at high risk after exposure to suicide

In 2015, the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide

Prevention released a report where the following vision gave the taskforce inspiration. “A world where communities and organizations provide everyone who is exposed to suicide access to effective services and support immediately - and for as long as necessary - to decrease their risk of suicide, to strengthen their mental health, and to help them cope with the grief.”

When a suicide occurs, it can disrupt the foundation of the school and the larger community to the core. How school leaders respond can help minimize negative effects and reinforce resilience. In fact, effective postvention efforts serve as the first line for the prevention of potential suicide contagion among vulnerable members of the school community. *After a Suicide: A Toolkit for Schools* provide step-by-step guidance, templates, and resources all in one place. It is a vital resource to help school administrators and crisis teams plan for and implement appropriate postvention strategies to facilitate communications, support grieving students and staff, identify at-risk individuals, and more.

Trauma Recovery Demonstration Grant:

In October 2019, the Nevada Department of Education was awarded a five-year five-million-dollar federal grant by the United States Department of Education (USDOE). The Trauma Recovery project serves Nevada students (Pre-K through grade 12) who have experienced trauma, qualify as low-income/uninsured or low-income/underinsured, and who, without therapeutic interventions, their success and performance in school would be negatively impacted. One of the initial aims of the grant project was to determine if a gap in therapeutic services exists for low-income students receiving Medicaid and low-income students not. Having concluded year three of the project, the data suggests that a gap in accessing trauma-specific interventions for low-income students do exist, as the project has served over 800 youth statewide, and enrollment continues to grow as new students are identified.

The grant reimburses the licensed mental health provider, and there is never a cost for the enrolled family. The funding fills a critical need, and the therapeutic interventions have been life-saving in some instances. The trauma experienced by some youth has been the loss of a parent, family member, or primary caregiver due to suicide; the funding also supports treatment for youth with suicidal ideations.

With just under two years of federal funding remaining for this project, it will be essential to work towards sustainable funding so that access and treatment options for Nevada's low-income students will continue to exist.

Zero Suicide Statewide Initiative:

Nevadas’ focus on a robust crisis response system gave way to the statewide implementation of Nevadas Zero Suicide. A health and behavioral health care system-wide approach to suicide prevention. Zero Suicides robust strategic framework focuses on implementing suicide prevention care, policies, protocols, and training throughout each system or organization adopting the program. The model starts with a focus on buy-in from leadership on down through the staff. Implementation of Zero Suicides is aspirational and has been proven to work by reducing suicides. Currently, in Nevada, multiple hospitals, behavioral health partners, stakeholders, and communities have been working on implementing Zero Suicide.

Within the rural regions across Nevada, we saw an exceptional demand and buy-in from hospitals and stakeholders. For instance, Elko took this one step closer by creating an Elkos Zero Suicide Coalition. They have been taking this model to their community, not just their providers and hospitals. Once again, being innovative with programs and models in Nevada. As Nevada continues to build up the crisis response system, Zero Suicide should be the model for prevention within all of our hospitals, behavioral health partners, and communities.

Zero Suicides Elko County is a nonprofit organization built from grass-roots efforts to address noted gaps related to access and quality of local mental health care. The organization's founders had each lost a child to suicide and sought to fix the local service and communication gaps that assisted their loved ones in "falling through the cracks." The organization's current efforts are focused on assisting the local school district with planning for appropriate suicide response, postvention, and recovery activities that respect the needs of students, families, teachers, and school staff. Zero Suicides Elko County is also working with local high schools to launch "Hope Squad" programs to allow students to take an active role in suicide prevention, resilience, and peer support.

Conclusion: Recommendations for Policy and Actions to Support Prevention, Intervention, and Postvention:

This document has outlined the ways that the behavioral health and suicide crisis in Nevada is affecting school children and outlined available resources for responding to these needs. However, in many cases, access remains fragmented by region, siloed by agency or system, and limited by lack of funding and workforce. These barriers impact the ability of behavioral health professionals to support the children and youth of Nevada. In order to support the needs of educators, schools, and communities as they respond to suicide affecting Nevada schools, some areas of need stand out. Some specific actions that would support the school and community-based professionals working to reduce suicide and improve behavioral health include:

Access:

- Provide a single system of delivery. Students should be able to reliably access a culturally responsive system of care within their communities that integrates support from both school and community-based resources
- Utilize an MTSS Integrated System Framework to ensure that students are able to access coordinated care that is matched to their needs, with the least level of restriction as best practice
- Create avenues to deliver evidence-based suicide prevention and mental health awareness training for school employees, including mental health professionals, but also for administrators, teachers, and support staff
- Mental health is for all. Restorative and social-emotional academic development activities support the reduction in disparate groups' behavioral health needs
- Improve reimbursement rates for behavioral health services in Nevada, including Medicaid. Currently, Nevada rates are significantly lower than other states, exacerbating the provider shortage and limiting the ability to refer children in need of psychiatric residential treatment care to other states

- Coordinate efforts between helplines, such as Safe Voice, NAMI Warmline Teen Text Line, and 988 to cover the gaps in requests for help
- Specific training for school and district administrators for conducting successful postvention will support confidence in responding to tragedies and improve outcomes
- Expansion of youth mobile response and stabilization services (MRSS), including expanding eligibility to transitional age youth (through age 21+), increased funding streams for supporting the service, increasing the capacity of teams to respond quickly in all regions, and ensuring all plans include both crisis response and stabilization components

Sustainability:

- Sustainable funding streams for school-based behavioral health services, such as supporting mechanisms allowing the schools to bill for Medicaid-eligible services and braiding funding streams while establishing these avenues, will increase access to care as current systems rely on grant funding and cliff funding that is set to expire.
- Workforce Development Pipelines for School and Community Behavioral Health Providers continue to be a pressing need.

Unique Community Needs in a Diverse State:

- Accessible community-based services, appropriate diversion from institutional settings, and increased support for student transitions back to their schools from institutional settings are needed
- Community agencies network together for a coordinated response, utilizing phone trees to ensure local helping resources can respond to support schools with postvention efforts when needed
- Support for the building of policies at the school district level regarding screening, referral for treatment, and use of evidence-based or best practices
- Considerations for urban and rural needs affecting access and sustainability based on geographic, socio-economic, and demographic trends that indicate areas of need

Nevada has a long tradition of grassroots and local initiatives creating innovations to support the needs of our diverse population. By learning from the best practices in research and in experience of those working in our communities, we hope to integrate and accentuate the practices that can create an integrated system of care to cover the existing gaps and increase needs.

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