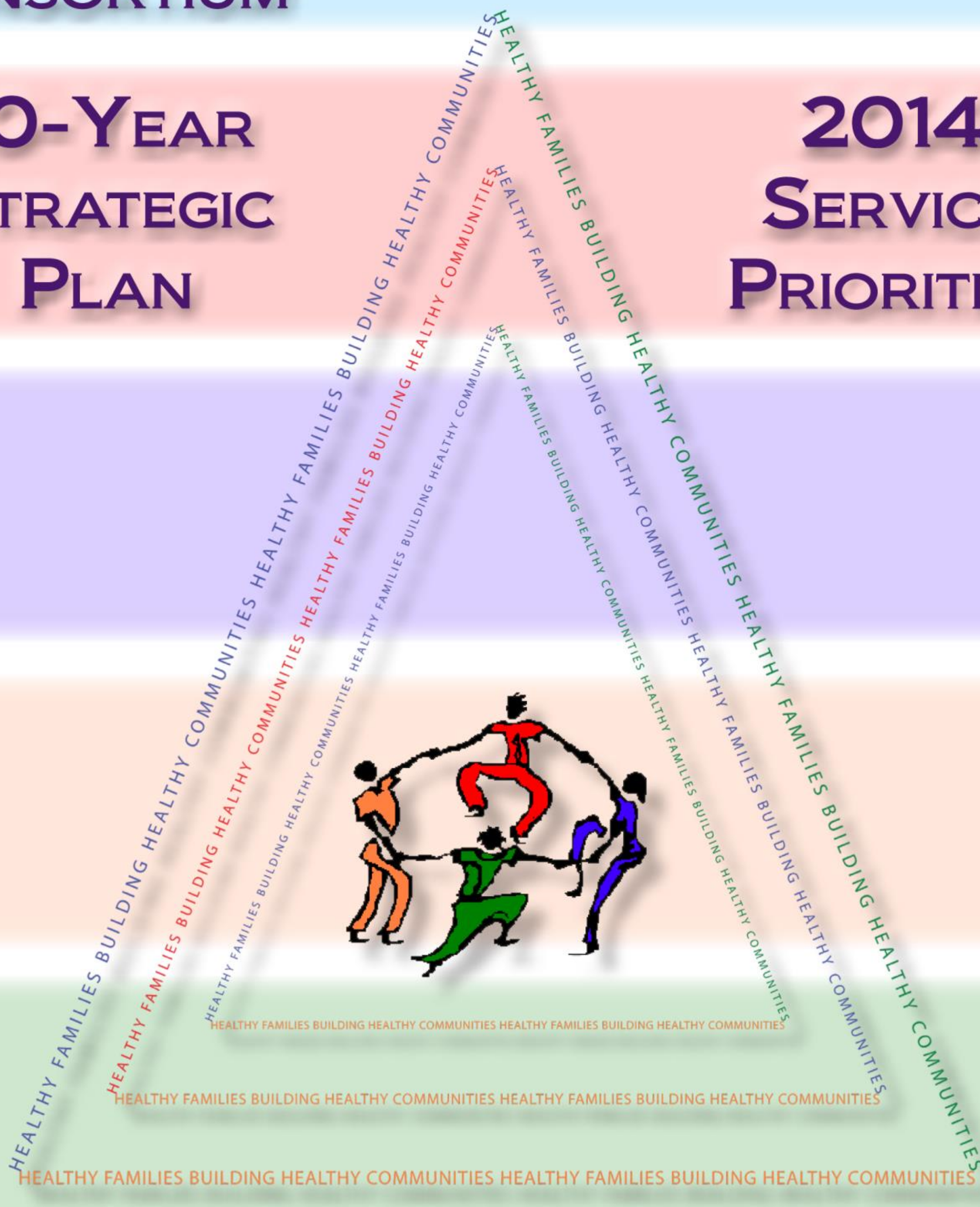
Clark County Children's Mental Health Consortium

2020 Vision for Success

Children and families in Clark County will have timely access to a comprehensive, coordinated system of behavioral health services and supports.

10-Year Strategic Plan

2014 Service Priorities



Clark County Children's Mental Health Consortium
2014 Priorities

INTRODUCTION

In December 2013, Governor Sandoval released a state-commissioned report on the status of Nevada's public mental health services which concluded that "Nevada has missed a number of opportunities over the years to strengthen its behavioral health system" and needs "a proactive, strategic plan to implement an integrated system of care approach to behavioral health"(Watson et al, 2013.) The report found that in contrast to other states, Nevada's behavioral health system has focused on responding to adults with mental health crises, rather than investing its resources in prevention and early intervention for children and youth. Another 2013 study by the U.S. Substance Abuse and Mental Health Services Administration provided data to suggest that in recent years, Nevada has increased the percentage of state spending on inpatient hospitalization and centralized administration and decreased its funding on community-based services for individuals with behavioral health needs (SAMHSA, 2013). In spite of disproportionately high levels of teen suicide and depression, a recent study by UNLV's Lincy Institute has also shown that Nevada lags significantly behind neighboring states in providing adequate funding for children's mental health services that will strengthen families and help youths with mental health needs succeed at home, in school and in their community (Denby, 2013).

The Clark County Children's Mental Health Consortium's ***10-Year Strategic Plan***(2010) provides the vision, goals and strategies to implement an integrated system of care approach that will overcome the challenges identified in recent local, state, and national studies, successfully addressing the full range of children's behavioral health needs identified in Clark County. The CCCMHC ***10-Year Strategic Plan*** represents a commitment to all our community's children who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic. The Plan is based on a set of values and principles that promote a system of care that is community-based, family-driven and culturally competent. Using a public health approach and a neighborhood-based model of service delivery, the plan sets forth the following long-term goals for Clark County by the year 2020.

10-Year Plan Goals

1. Children with serious emotional disturbance and their families will thrive at home, at school and in the community with intensive supports and services.

2. Children with behavioral health needs and their families will access a comprehensive array of effective services when and where needed.

3. Families seeking assistance will find an organized pathway to information, referral, assessment and crisis intervention coordinated across agencies and providers.

4. The system will be managed at the local level through a partnership of families, providers and stakeholders committed to community-based, family-driven, and culturally competent services.

5. County-wide programs will be available to facilitate all children's healthy social and emotional development, identify behavioral health issues as early as possible, and assist all families in caring for their children.

6. Heightened public awareness of children's behavioral health needs will reduce stigma, empower families to seek early assistance and mobilize community support for system enhancements.

Working in partnership with the State Children's Behavioral Health Consortium and the two other regional consortia, the Clark County Children' Mental Health Consortium calls for parents, policymakers and professionals to come together and take ***immediate*** action to support a change in approach to children's behavioral health service delivery. This report identifies ***four priorities for Fiscal Years 2015-2016,*** as well as specific services necessary to produce the most immediate, cost-effective system improvements. These priorities serve as building blocks for the CCCMHC's ***10-Year Strategic Plan,*** which has been submitted to the Director of the Department of Health and Human Services and the Commission on Behavioral Health.

Clark County Children with Behavioral Health Needs

Clark County's children with behavioral health needs share many of the same characteristics and challenges of children with behavioral health needs across the U.S. The most recent national studies have confirmed that between 13-20 percent of American children aged 5-18 years have experienced a behavioral health disorder within the past year, and over 1 in 5 adolescents have suffered severe impairment as a result of these disorders (SAMHSA, 2013). By the time U.S. children reach adulthood, approximately one-half have experienced a behavioral health need at some point in their young lives (SAMHSA, 2013). Underscoring the notion that mental disorders begin early in life, these studies have found that symptoms of anxiety disorders began by age 6, behavior disorders (such as ADHD or conduct disorder) by age 11, mood disorders by age 13, and substance use disorders by age 15. The percentage of teenagers suffering from mental disorders is even higher than the most frequent major medical conditions of adolescence (Merikangas et al., 2010). Even children younger than five years of age may exhibit serious emotional and behavioral problems, with one national study estimating a prevalence rate of 10-14% in this population (Brauner, 2006). In Clark County, studies have suggested that 19.3% of elementary school children have behavioral health care needs and over 30% of adolescents self-reported significant levels of anxiety or depression (CCCMHC, 2010). In 2009, almost one-quarter o Clark County's public middle school students seriously thought about killing themselves, more than 30% had used alcohol or illegal drugs, and over 13% had attempted suicide (CCCMHC, 2010). Some children and youth have greater needs for behavioral health care than others. National studies have found that at least 50% of children and youth in child welfare and approximately 70% of youth in the juvenile justice system have significant mental health disorders (Stagman et al., 2010, SAMHSA, 2013). Local surveys conducted by the Consortium have confirmed that Clark County children in the child welfare and juvenile justice systems also experience a greater need for behavioral health care (CCCMHC, 2010).

Children with serious emotional disturbance (SED) experience symptoms that significantly impair their ability to function at home, in school and in the community. The most recent studies suggest that 10-12 percent of U.S. children exhibited signs of SED in the past year (SAMHSA, 2013). With local studies showing at least 6 percent of early elementary school children exhibit signs of SED, it is reasonable to project prevalence rates for all Clark County children and youth with this condition will match the national data (CCCMHC, 2010).

Whereas children's behavioral health disorders are highly treatable and even sometimes preventable, studies have found long delays, even decades between onset of symptoms and identification and treatment of the disorder (SAMHSA, 2007; SAMHSA, 2013). Similar to national studies showing that 75% to 80% of children and youth in need do not receive mental health services (Stag man et al, 2010), a Clark County study showed that 70% of elementary school children identified with behavioral health disorders were not receiving any special services or treatment (CCCMHC, 2010). ***Whether rich or poor, insured or uninsured, the families of children with serious behavioral health disorders struggle to find appropriate services, often turning to the public systems that provide children's mental health care.*** *Like others across the nation, many Clark County families have been forced to relinquish custody to child welfare or juvenile justice in order to access services and supports for their children (U.S. General Accounting Office, 2003). National studies have shown that privately-insured families with children in need of mental health care face significantly greater financial barriers than families with children without mental health needs (Stagman et al., 2010). Seventy-nine percent of children with private health insurance and 73 percent with public health insurance have unmet mental health needs (Stagman et al., 2010). Even when children with SED receive treatment, only a fraction can access the wraparound care coordination, family-to-family support and other innovative services proven effective in meeting their needs (Pires et al., 2013).*

PRIORITIES

Priority 1. Re-structure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families.

2015-2016 Programs/Services:

Justification:

In order to improve the condition of Nevada's children with behavioral health needs, the CCCMHC's first priority is to ***re-structure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families.*** In addition to critical service gaps, family surveys have suggested that the system of behavioral health services in Clark County is complex and difficult to access (CCCMHC, 2010). The UNLV Lincy Institute found that despite relatively low reported rates of most mental health disorders among Nevada's children, there was a wide discrepancy in the number of these youths able to access services. While 54% of Arizona's children and 46% of Colorado's children with emotional, behavioral or developmental needs received counseling or treatment, only 29% of Nevada's children with these special needs received comparable services (Denby et al., 2013). A later study found Nevada's adolescents accessed outpatient treatment at a rate lower than 45 other states (SAMHSA, 2013). The most recent study of Nevada's system found large disparities in access to public behavioral health programs for minority groups such as Hispanics and Asians (Watson et al., 2013). Furthermore, federal and state reports continue to highlight the need for a more substantial workforce in Nevada trained to provide quality behavioral health services to children (Denby, 2013; SAMHSA, 2013). As a consequence of these systemic problems, Nevada youths with serious emotional disturbance or other disabilities are being placed in out-of state institutions at unprecedented rates. In recognition of the lack of positive outcomes for children's behavioral services in Nevada, the 2012 Legislative Committee on Health Care supported a re-structuring of the public system to the extent possible.

Fig 1. Children in Medicaid Out-of-State Placements

Time Period	Children Placed	Total Mo Cost	Cost/Mo/child
Sep 2011	**263**	$2,484,390.44	$9,446.35
Oct 2011	**269**	$2,625,477.36	$9,760.14
Nov 2011	**267**	$2,505,015.78	$9,382.08
Dec 2011	**273**	$2,537,660.15	$9,295.46
Jan 2012	**265**	$2,507,657.68	$9,462.86
Feb 2012	**266**	$2,334,499.47	$8,776.31
Mar 2012	**272**	$2,477,227.64	$9,107.45
Apr 2012	**282**	$2,490,465.64	$8,831.44
May 2012	**276**	$2,538,989.60	$9,199.24
Jun 2012	**261**	$2,248,558.81	$8,615.17
Jul 2012	**237**	$2,167,096.91	$9,143.87
Aug 2012	**231**	$2,069,616.05	$8,959.38

In order to initiate actions to address this priority, the CCCMHC recommends that Nevada implement local system management of all publicly funded children's behavioral health services in Clark County, including those administered by the Division of Child and Family Services and the Division of Health Care Financing and Policy. Nevada law already specifies that "the system of mental health services [for children] should be community-based and flexible, with accountability and focus of the services at the local level" (NRS 433B). In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local

level to manage the system of behavioral health care (Stroul et al., 2008). The most recent report on Nevada's behavioral health programs also recommended more locally-driven, community-based services to address difficulties in service access and outcomes (Watson et al, 2013).

Under local systems management, the CCCMHC recommends redeployment of Medicaid and other funding to support a ***single***, accountable entity in Clark County that uses a wraparound approach to coordinate the care for youth with serious emotional disturbance. A 2009 state-commissioned report found that approximately one-third of public children's behavioral health care dollars in Clark County were spent on some type of care management, but that these efforts were duplicative, inconsistent, and failed to target those youths with the most serious and complex needs (Pires, 2009). Clark County families, caseworkers and providers also rated the system as failing to provide coordinated care plans for children with serious emotional disturbance in a comprehensive survey conducted by the CCCMHC in 2009. Integrated care management entities such as Wraparound Milwaukee have produced positive outcomes while reducing utilization and costs for long-term residential care (Suter et al., 2008). Results from the Centers for Medicare & Medicaid Services' Psychiatric Residential Treatment Facility Waiver Demonstration Project also showed the value of integrated case management in achieving better outcomes for children and families at a significant cost-savings (Pires et al., 2013).

To facilitate the effectiveness of local service delivery, the CCCMHC also recommends that both traditional health care providers and care management entities have the ability to provide innovative services such as family-to family support, mentoring, mental health consultation, and respite care, under health care coverage policies or flexible funding strategies. These strategies are currently underutilized in public children's behavioral care systems in spite of their demonstrated effectiveness in improving outcomes and reducing costs of services (Pires et al., 2013). In order to improve the quality of children's behavioral health care, the CCCMHC has made a third recommendation to develop statewide standards that require all providers who receive Medicaid or other public funding as reimbursement to utilize family-driven, individualized, evidence-based treatment interventions. As a model, Nevada can utilize the process developed for its SAPTA providers.

Caleb's Story*

Caleb is a 9 year-old boy with serious emotional disturbance who has been placed in a residential treatment center out of state for the past six months. Prior to placement, Caleb's mom struggled to manage her son's behaviors in the home. As a single mom, she lost multiple jobs when her work was disrupted by constant calls from Caleb's school about his violent outbursts. As a result of these outbursts, mom had no choice but to hospitalize Caleb multiple times in a local, acute psychiatric facility, each time with a recommendation for outpatient treatment. However, Mom was unable to find providers close to her home, which made regular outpatient visits particularly difficult due to transportation issues. Mom was able to continue medications for her son, but ongoing counseling was not achieved. After Caleb's last hospitalization, the hospital's psychiatrist recommended a residential placement for Caleb. Caleb was placed in an out-of-state residential treatment center. Desert Willow Treatment Center in Las Vegas was not available to the family due to Caleb's age and there was a waiting list at Reno's Willow Springs Treatment Center. The out-of-state residential treatment center is now recommending discharge and mom is worried about finding treatment providers here in Las Vegas and does not know where to turn. She is also concerned that all of the treatment team meetings were held over the phone and she has felt disconnected from his treatment and lacks confidence in her abilities to manage his behaviors at home. This family could have benefited from community-based programs offered close to their home, along with intensive targeted case management and home-based services and supports, possibly eliminating the need for inpatient treatment. ***Not the child's actual name.***

Recommendations:

A. Develop and implement a plan for integrated, local system management of all publicly funded children's behavioral health services in Clark County.

B. Re-structure Medicaid policies and funding to support a single, accountable entity in Clark County that uses a wraparound approach to manage the care for youth with serious emotional disturbance. Blend/braid Medicaid and other public resources system, allowing flexibility in the care management entity's use of the funding to implement individualized services and supports that strengthen the family, reduce the need for out-of-home placement, and facilitate positive outcomes for each youth.

C. Include the following as essential health benefits to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, Health Insurance Exchanges and other publicly subsidized health coverage plans: family-to-family support, mentoring, mental health consultation, mobile crisis intervention, and respite care.

D. Develop and implement a statewide, universal set of quality standards that require those children's behavioral health providers who receive Medicaid or other public funding as reimbursement for their services to utilize family-driven, individualized, evidence-based treatment interventions.

Projected Costs:

This priority may be implemented through the redeployment of resources currently dedicated to the management of the system and through blending and braiding state and federal funds from those agencies currently providing children's behavioral health services.

Priority 2. Provide mobile crisis intervention and stabilization services to Clark County youths in crisis.

2015-2016 Programs/Services:

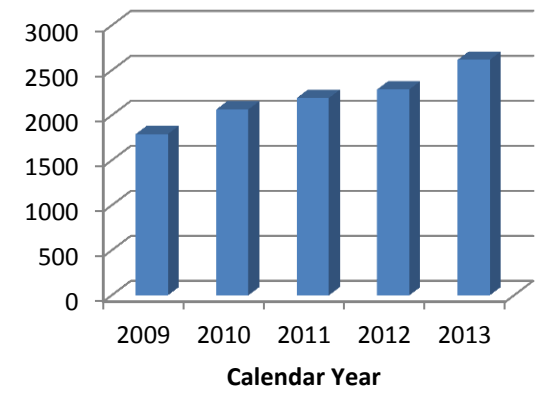
Justification:

As a second priority, the CCCMHC recommends that ***DCFS provide mobile crisis intervention and stabilization services to Clark County youths in crisis.*** Without easy access to crisis intervention and stabilization services, families in Clark County have been forced to utilize local emergency rooms in order to obtain behavioral health care for their children. The National Center for Children in Poverty has identified youth emergency room visits for behavioral health care as a national problem (Cooper, 2007). A national study of children's behavioral health services utilization in the Medicaid program showed that eligible adolescents used disproportionately more services--particularly facility-based care-- due to the lack of more cost-effective approaches such as mobile crisis intervention services (Pires et al., 2013).

Child mental health-related visits to hospital emergency rooms have increased steadily in Clark County over the past five years as shown in Figure 2 (UNLV Center for Health Information Analysis, 2013). Youth admitted to local emergency rooms over the last five years average 14.9 years of age. Depression, Anxiety, Psychosis, Conduct Disorder and Alcohol Abuse represent the most predominant diagnoses upon admission. From earlier studies, it is estimated that almost 40% of these youths have been admitted to emergency rooms due to suicide attempts or threats, with nearly half of youths discharged home without immediate treatment being suicidal, psychotic or depressed (CCCMHC, 2009).

Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric hospitalization for youths with complex behavioral health care needs in programs such as those implemented across New Jersey, in Milwaukee, Wisconsin and in Seattle, Washington (AHRQ, 2013).

Fig. 2. Clark County Youth Behavioral Health Emergency Room Admissions



DCFS has begun to implement a pilot program which needs to be expanded over the next two years. Nevada should also explore federal incentives for presumptive Medicaid eligibility approaches in order to develop a family-driven approach that facilitates access to immediate and appropriate community-based care to uninsured and underinsured youths admitted to emergency rooms.

William's Story*

William is a 14-year-old boy diagnosed with multiple mental health disorders who is experiencing difficulties with behavior at school, at home and in the community including verbal outbursts, threatening comments, and physical aggression toward peers. William's dad is able to redirect him fairly easily, however his mom has problems redirecting and worries for her safety and the safety of William's siblings when dad is at work. One afternoon, William's behaviors escalated and he told his mom that he was going to beat her up and then physically moved toward her in a manner that led mom to believe he was serious. Mom removed herself and the other children from William's presence and called the police. William was arrested and taken to juvenile detention. Mobile Crisis intervention and stabilization could have prevented William from being arrested, stabilized the immediate situation and aided in finding appropriate services such as intensive counseling, family preservation services, respite care, and/or Rehabilitative Mental Health services to help the entire family. ***Not the child's actual name***

Recommendations:

A. Expand funding for DCFS to implement an evidence-based mobile crisis intervention program with fidelity that meets the needs of Clark County youth experiencing severe psychiatric crises.

B. Develop a family-driven approach that ensures all youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior, receive immediate and appropriate inpatient or community-based care. In order to support timely access to needed services, explore the use of federal incentives for developing presumptive Medicaid eligibility approaches through DHHS.

Projected Costs:

$2,055,000 per year for 1500 youths**.** Projected costs are based on approximately 1500 youths admitted to emergency rooms in 2009 (see CCCMHC's ***10-Year Strategic Plan***) at an estimated cost based on an average of 10 hours of mobile crisis intervention per youth and family at the Medicaid rate of $137.00 per hour.

Priority 3. Expand access to family-to-family support services for the families of Clark County's children at risk for long-term institutional placement.

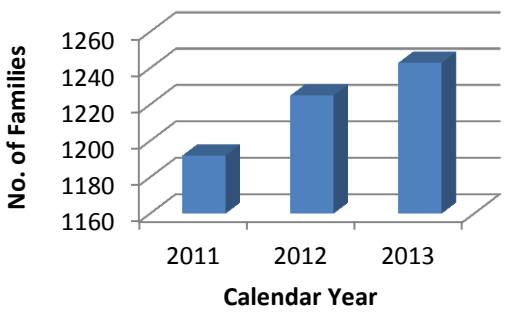
2015-2016 Programs/Services:

Justification:

As a third priority, the CCCMHC recommends that: ***Nevada expands access to family-to-family support services for the families of Clark County's children at risk for long-term residential placement***. In particular, the CCCMHC recommends funding to implement a pilot project for 200 youths with serious emotional disturbance at risk for institutional placement who have been discharged from acute psychiatric hospitalization, as well as an additional 200 youths with co-occurring developmental disabilities and mental health needs at risk for long-term residential care. These youths are disproportionately represented among the unprecedented numbers of Nevada youth currently being placed in out-of-state residential institutions.

Family-to-family support services have been shown effective in improving outcomes for children with serious emotional disturbance and their families (Stroul et al., 2008). Studies conducted in Clark County through the federally funded Neighborhood Care Center Project also suggested that family-to-family support services can result in an increase in stable, community-based placements; improvement in school grades and attendance; and improvement in the child's clinical symptoms (Nevada Division of Child and Family Services, 2005).

Fig. 3. Nevada Families Requesting Support Services through Nevada PEP



A national study of children's behavioral health services utilization in the Medicaid Program found than one percent or fewer eligible children with behavioral health needs were receiving nontraditional services such as family-to-family support, in spite of a mounting body of evidence demonstrating the cost effectiveness of this approach (Pires et al., 2013). Such findings suggest a lack of access to family-to-family support services, even ***while more and more Nevada families of children with serious emotional disturbance request this program through Nevada PEP each year*** as shown in Figure 3.

The 2013 Pires et al. study also found that behavioral health expenses for children in Medicaid with a developmental disability were more than double those for other children, pointing to the need for alternative approaches such as family-to-family support for this population.

Because family-to-family support services can help reduce reliance on expensive, restrictive residential treatment, the Centers for Medicare & Medicaid Services issued a bulletin in May 2013 recommending that states provide funding for family-to-family support as part of their benefit plan for children with significant mental health conditions (CMS, 2013).

Jenny's Story*

Jenny is a 15-year-old girl who has had multiple acute psychiatric hospitalizations and participated in outpatient partial programs to address her bipolar disorder, Asperger's syndrome and anxiety disorder which place her at risk for long term residential treatment. Jenny's parents had concerns that Jenny was becoming 'institutionalized' from the many psychiatric hospitalizations, and they worried that a placement in long-term residential treatment would make her even more 'institutionalized'. Jenny's parents felt alone with no one to talk to who could understand what their family was going through. They struggled to navigate the service system and find supports, respite services, and rehabilitation services to help their family. The family reached out to Nevada PEP, and was shortly thereafter contacted by a family specialist who had had similar experiences and challenges with her own daughter. The family now feels that they are not as isolated and have become better prepared to explore resources in the community including therapy providers, case management options, and access to funding for respite services in order to prevent Jenny from needing more inpatient treatment. Meanwhile, they have taken advantage of parent support groups and trainings available at Nevada PEP including Positive Behavior Interventions, IEP Clinic, and Skills for Effective Parent Advocacy. They now feel better able to manage their daughter's behaviors, can advocate for Jenny to get special education supports at school to help with her social skills and anxiety issues that have been impacting her education. There has been a dramatic improvement in their daughter's academics, behaviors and overall functioning.

Not the child's actual name

Recommendations:

A. Expand funding to provide family-to-family support for Clark County youths with serious emotional disturbance at risk for long-term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization.

B. Expand funding to provide family-to-family support for Clark County youths with co-occurring developmental disabilities and behavioral health needs that are at risk for long-term residential treatment by implementing a pilot project for 200 youths.

Projected Costs:

$600,000 per year for Program A and **$600,000 per year** for Program B. Costs based on $3,000 per family per year to provide 75 hours of family-to-family support.

Priority 4. Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

015-2016 Programs/Services:

Justification:

The Consortium's fourth priority is to: ***Develop partnerships between schools and behavioral health providers in order to implement school-based and school-linked interventions for children identified with behavioral health care needs.*** As with physical illnesses, prevention and early intervention for behavioral health problems will reduce costs to public agencies for later, more intensive, and long-term treatment (SAMHSA, 2007). Prevention services were rated as the top priority for expansion in a 2009 survey of over 100 Clark County families, caseworkers and providers. For the average youth, symptoms typically precede a serious disorder by about two to four years (Denby, 2013). Screening can help identify and link youth early with services before symptoms become so intense and debilitating that they require more restrictive, costly care. Clark County public and private schools have experienced success in utilizing school-based screening programs to identify students at risk for suicide and link them with importance of school-based screening approaches, the 2013 Nevada Legislature approved Assembly Bill 386 mandating that Clark and Washoe County School Districts implement and evaluate a school-based program in partnership with community stakeholders to provide students with general behavioral health screenings. The CCCMHC recommends funding for the Clark County School District to expand its screening program using an evidence-based model implemented with fidelity. The success of screening also depends on increased funding for parent awareness and support strategies. Finally, the CCCMHC supports additional funding for the Office of Suicide Prevention to expand its Reducing Access to Lethal Means program. More resources are needed to provide public awareness and parent education in Clark County about youth suicide risk cause by the availability of firearms and potentially lethal medications. In other states, these strategies have proven effective in reducing suicide rates among both adults and youth.

Meredith's Story

Meredith is a 13-year old 8th grader attending a public middle school in Clark County. Meredith's parents both work and are devoted to both of their children and who make sure to have dinner together every night. They feel confident that their home and family is secure and loving. Meredith's school sent home a permission slip for a school-based screening that Meredith's parents signed consent for. Meredith was found at risk of suicide ideation during the screening and while speaking to school personnel admitted to being very depressed, feeling bullied at school and using illegal substances that she obtained from other students. Meredith's parents were called and offered resources to help meet their daughter's needs. They immediately set up therapy services for their daughter and they feel that without the screening their daughter may not have gotten the help that she needed. Meredith is working with her therapist on coping skills. Meredith's parents feel that since the bullying was reported, the school has worked with them and their daughter seems much happier to go to school.
Not the child's actual name

Recommendations:

A. Provide DHHS funding to maintain and/or expand school-based mental health and suicide prevention screening in the Clark County School District using an evidence-based model implemented with fidelity. Prioritize funding for (1) parent awareness and engagement strategies to increase participation and (2) parent support through an evidence-based model such as the Parent Connector Project to facilitate linkages of identified students to needed services.

B. Provide DHHS funding through the Office of Suicide Prevention to expand its means reduction program to include a public awareness and family education campaign about the risk of youth suicide caused by availability of firearms and potentially lethal medications.

Projected Costs:

$100,000 per year for school-based screening and parent support activities**. $50,000 per year** for the dissemination of education and awareness materials on means reduction. Projected costs based on current screening program funded by SAMHSA's Garrett Lee Smith Youth Suicide Prevent Grant through the Nevada Office of Suicide Prevention.

ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Current Membership

Janelle Kraft-Pearce, Chairperson
Las Vegas Metropolitan Police Department
Dan Musgrove, Vice Chairperson
Business Community Representative
Mike Bernstein
Southern Nevada Health District
Jennifer Bevacqua
Nevada Youth Care Providers Association
Lisa Durette, M.D.
American Academy of Child & Adolescent Psychiatry
Jacqueline Harris
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Amanda Haboush-Deloye, Ph.D.
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Phyllis Keen
Foster Parent, Majestic Community Services
Karen Miller
Parent Representative
Lisa Ruiz-Lee
Clark County Family Services
Karen Taycher
Nevada Parents Encouraging Parents
Robert Weires
Clark County School District
Kelly Wooldridge
Nevada Division of Child & Family Services
Cheri Wright
Clark County Juvenile Justice Services

Mission

The Consortium was created by the passage of Assembly Bill 1 of the 2001 Special Session of the Nevada Legislature to study the mental health needs of all children in Clark County and to develop recommendations for service delivery reform. The Consortium is required to conduct a needs assessment and submit a 10-Year Strategic Plan and Annual Reports to the Commission on Behavioral Health and the Nevada Department of Health and Human Services. Required membership and activities for the Consortium are described in Nevada Revised Statutes 433B.333-335. The CCCMHC's ***10-Year Strategic Plan*** Is available on the DCFS website at: http://www.dcfs.state.nv.us/DCFS_ChildMentalHealth_CCCMHC.htm.

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For more information about the Clark County Children's Mental Health Consortium, please contact: Janelle Kraft-Pearce, c/o Lori Brown, Division of Child and Family Services, NNCAS/ATC, 480 Galletti Way, Building 8N, Sparks, NV 89431.
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