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

2016 Service Priorities

Clark County Children's Mental Health Consortium

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INTRODUCTION

In December 2015, 200 family members, providers, and other stakeholders attended a Community Forum at UNLV to discuss the mental health of Clark County's children. After a panel discussion and audience input, they reached a consensus that Nevada needs to reform its service delivery system for children with behavioral health needs (Valley, 2015). The voices at the Community Forum echoed the findings of 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 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. The U.S. Substance Abuse and Mental Health Services Administration has provided data to suggest that in recent years, Nevada has increased the percentage of state spending on inpatient hospitalization and centralized administration while decreasing 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, UNLV's Lincy Institute has 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 by the Community Forum participants and by recent local, state, and national studies. 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 2017-2018**, 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 2013, almost twenty percent of Clark County's public middle school students seriously thought about killing themselves, more than 30% had used alcohol or illegal drugs, and over 11% had attempted suicide (Frankenberger et al., 2014). 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 peer support and other innovative services proven effective in meeting their needs (Pires et al., 2013).*

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).

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.

2017-2018 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 in order to ensure quality, accountability, and positive outcomes for Clark County's children and families.** In addition to critical service gaps, federal and state studies have suggested that the system of behavioral health services in Clark County is complex and difficult to navigate (CCCMHC, 2010). The UNLV Lincy Institute found a wide discrepancy in the number of youths able to access services in Nevada as compared to neighboring states. 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). Another study found Nevada's adolescents accessed outpatient treatment at a rate lower than 45 other states (SAMHSA, 2013; Mental Health American, 2016). 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) A 2014 study commissioned by the Governor's Council on Behavioral Health & Wellness concluded that the current governance structure of the state's public mental health system has led to a lack of coordination between agencies and poor responsiveness to community needs (Brune et al., 2014). As a consequence of these systemic problems, Nevada youths with serious emotional disturbance or other disabilities continue to be unnecessarily placed in out-of-state institutions (Valley, 2015).

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). A recent report on Nevada's behavioral health programs recommended more locally-driven, community-based services to address difficulties in service access and outcomes (Watson et al, 2013). The Southern Nevada Health Forum has been advocating for local governance of Nevada's Public Mental Health System for the past two years.

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

Month	Children Placed	Total Mo Cost	Cost/Mo/child
Oct 2014	**249**	$2,446,189.50	$9,824.05
Nov 2014	**243**	$2,389,709.45	$9,834.20
Dec 2014	**235**	$2,376,544.62	$10,112.96
Jan 2015	**225**	$2,287,021.77	$10,164.54
Feb 2015	**225**	$2,020,606.91	$8,980.48
Mar 2015	**230**	$2,307,873.35	$10,034.23
Apr 2015	**231**	$2,209,525.04	$9,565.04
May 2015	**226**	$2,215,472.20	$9,802.97
Jun 2015	**238**	$2,176,245.01	$9,143.89
Jul 2015	**220**	$2,265,612.53	$10,298.24
Aug 2015	**230**	$2,259,816.75	$9,825.29
Sep 2015	**233**	$2,225,401.25	$9,551.08

Under local systems management, the CCCMHC recommends redeployment of Medicaid and other funding to support a single, accountable entity in Clark County that adheres to the System of Care philosophy (Stroul et al., 2008) and uses an evidence-based wraparound approach (Bruns et al, 2010) to coordinate the care for youth with serious emotional disturbance. The federal government has reported that less than 10% of Nevada children with serious emotional disturbance have access to the state mental

health wraparound care management at a penetration rate of less than half the average of other states (CMHS, 2013). 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). A report commissioned by the Governor's Council on Behavioral Health and Wellness described the benefits of integrating funding and the effective use of care coordinating organizations in producing effective service outcomes (Brune et al., 2014). The Center for Health Care Strategies has profiled successful demonstration projects that use integrated care management entities such as Wraparound Milwaukee, producing positive outcomes while reducing utilization and costs for long-term residential care (Bruns et al., 2010; Simon et al., 2014). 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).

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; Dvoskin, 2014; SAMHSA, 2013). For example, the shortage of child psychiatrists in Southern Nevada results in families facing long waitlists, short medical appointments and few alternatives for accessing needed care for their children with behavioral health needs (Valley, 2015). Given the workforce shortage, existing Medicaid reimbursement rates should also be examined to determine if they incentivize local providers to expand their capacity to serve this vulnerable population.

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 peer 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 fourth 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.

Matthew's Story

Matthew is a 10-year old boy with multiple mental health diagnoses including Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. Matthew lives with his mother, Sarah, who is parenting Matthew and his two siblings on her own. Matthew has been receiving therapy for two years and is seeing a psychiatrist for medication management. Neither of these services is provided in the community where his family lives, so his mother has to remove him from school early once a week to take a bus across the Las Vegas Valley for therapy, rearranging her work schedule to accommodate these appointments as well. She then has to pick up her other children at an after school program upon her return to their community and go home to cook dinner and do homework. Sarah has no family in the community and feels uncomfortable leaving Matthew in the care of friends because his behavior can sometimes be unpredictable and explosive. The school calls her at work at least twice a week to complain about Matthew's behavior. Respite and other supportive services are not available in the healthcare plan from her work. Sarah is becoming increasingly stressed, isolated, and experiences frequent feelings of hopelessness but has no access to respite services which would give her a much needed break and a chance to "recharge". Accessing targeted case management (Wraparound in Nevada) would provide the family with a wraparound facilitator who could help her coordinate services, including respite, and help the family recognize and develop natural supports in the community.

**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 peer 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.

E. Review Medicaid rates for children's behavioral health services to determine if inadequate provider reimbursement contributes to lack of capacity and access for children and families. (new)

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.

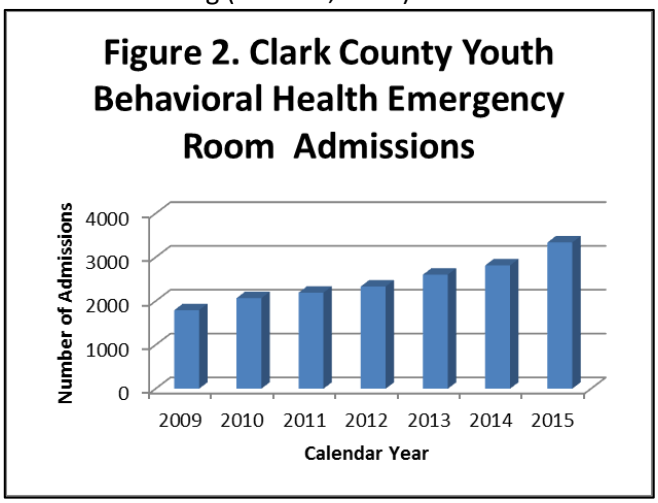
2017-2018 Programs/Services:

Justification:

The second priority of the CCCMHC is to **provide mobile crisis intervention and stabilization services for all Clark County youths in crisis**. Without easy access to crisis intervention and stabilization services in the past, 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 first identified youth emergency room visits for behavioral health care as a serious problem across the United States (Cooper, 2007). A recent national study of children's behavioral health services utilization in the Medicaid program showed that eligible adolescents still use 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. Depression, Anxiety, Conduct Disorder and Alcohol Abuse represent the most predominant diagnoses upon admission to local emergency rooms (Greenway, 2015). From earlier studies, it is estimated that almost 40% of these youths have been admitted to emergency rooms due to suicide attempts or threats. Nearly half of youths admitted are discharged home without immediate treatment, still showing signs of suicidal ideation, psychosis, or depression (CCCMHC, 2010). The medical director of University Medical Center's Pediatric Emergency Room has called the situation a "health crisis of unbelievable proportions," noting that mental-health related visits to his facility have tripled over the past decade while the county population has increased by only 25% (Valley, 2015).

Children seen in emergency rooms are often admitted to psychiatric inpatient care. In 2013 Clark County psychiatric hospitals admitted more than 7,200 children, a 45% increase over 2009 (Valley, 2015). Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric hospitalization for youths with complex behavioral health care needs in programs implemented across New Jersey, in Milwaukee, Wisconsin and in Seattle, Washington (AHRQ, 2013). Based on the success of other states and communities, DCFS implemented a mobile crisis team pilot program in January 2014, expanding the services in October 2014 after the Governor's Council on Behavioral Health & Wellness successfully advocated for additional funding (Dvoskin, 2014).



The DCFS Mobile Crisis Response Team (MCRT) currently serves youth in the greater Las Vegas area that are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, extreme parent/child conflict, difficulty adjusting to a serious peer relational issue such as bullying, or any other serious mental health problem. The ultimate goal of MCRT services is to divert youth from psychiatric hospitalization whenever possible The Las Vegas MCRT received 990 calls during 2015 and provided services to 675 youth and families in response to these calls. Suicide ideation represents the most common reason for calls to the program. Most intake assessments take place in an emergency room department or a private residence. However, the MCRT frequently responds directly to referrals from the Clark County School District and the Department of Juvenile Justice. A total of 88% of youths served were diverted from psychiatric hospitalization. Ninety five percent of the families served were referred for additional mental health and/or community support services. The Mobile Crisis Team has partnered closely with Nevada

PEP, immediately linking families for the support needed to keep the child at home whenever possible. As more youth in crisis are referred to the MCRT, additional funding will be needed for family support through Nevada PEP. The youth served through the MCRT have shown significant improvement in functioning and 93% of parents/guardians report being satisfied with the program.

In spite of their success, the MCRT has experienced challenges in facilitating inpatient services and other types of intensive care needed for some youths served by the program. The MCRT struggles to find appropriate placements and/or services for youth for co-occurring developmental disabilities and behavioral health needs. Additional assessments required by the hospitals or managed care providers have also caused delays in linking many other youth to needed services, increasing the length of emergency room stays for these youth and families. The CCCMHC is recommending that DCFS develop interagency protocols and policies with hospitals and managed care providers to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior.

Over the past year, the Nevada Department of Health and Human Services implemented a program that allows hospitals to determine presumptive Medicaid eligibility for their patients. The Nevada Department of Health and Human Services should explore the expansion of presumptive eligibility to all youths requiring the services of DCFS Mobile Crisis Intervention program. This strategy would result in less reliance on emergency room services and more rapid access to community-based providers, while creating a stable funding source for the program.

*David's Story**

David is a 13-year old boy diagnosed with multiple mental health disorders who has a history of multiple acute psychiatric hospitalizations. David struggles with behavior at school, at home and in the community but has an especially hard time controlling his impulsivity and aggressive outbursts in the school setting. David's mother is able to manage his behaviors at home but even after placement in a specialized school setting, David is often in trouble at school. On one occasion, he became physically violent with another student and afterwards told school staff that "he didn't want to live anymore." David was transported to the local hospital emergency room, where the staff contacted the DCFS Mobile Crisis Response Team (MCRT). The immediate situation was addressed, Mom agreed to work with MCRT and their assessment indicated that David could return home that night, which avoided another acute psychiatric hospital admission. MCRT developed a safety plan with mom and set a follow-up home appointment for the following day. After a month of intensive services with MCRT, the family was transitioned to more traditional therapy services and referred to the Wraparound in Nevada program. Over a year later, David's school behaviors are better, the family is participating in therapy, his medication is stable, and the family is preparing to graduate from Wraparound. **Not the child's actual name*

Recommendations:

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

B. Develop interagency protocols and policies with hospitals and managed care providers to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior. (new)

C. Expand funding for Family-to-Family Peer Support to enhance outcomes and reduce recidivism for youths served by mobile crisis intervention.

D. In order to support the program and provide timely access to needed services, develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services. (new)

Projected Costs:

$2,055,000 per year for 1500 youths. Projected costs are 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 peer support services for the families of Clark County's children at risk for long-term institutional placement.

2017-2018 Programs/Services:

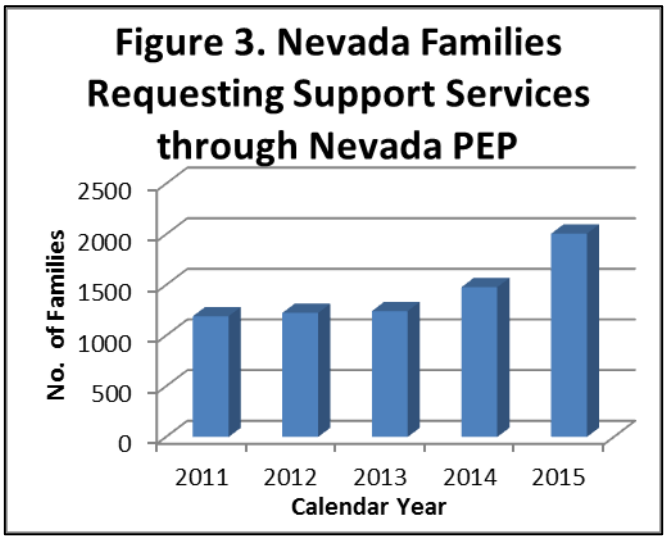
Justification:

As a third priority, the CCCMHC recommends that **Nevada expand access to family-to-family peer support services for the families of Clark county's children at risk for long-term residential placements.** Youths with these co-occurring disorders are disproportionately represented among large numbers of Nevada youth currently being placed in out-of-state residential institutions.

Family-to-family peer support services have been shown effective in improving outcomes for such youths 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 peer 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).

A national study of children's behavioral health services utilization in the Medicaid Program found that one percent or fewer eligible children with behavioral health needs were receiving nontraditional services such as family-to-family peer 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 peer support services; even while more and more Nevada families of children with serious emotional disturbance request this program through Nevada PEP each year (see Figure 3). Because family-to-family peer 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 peer support as part of their benefit plan for children with significant mental health conditions (CMS, 2013). The Governor's Council on Behavioral Health & Wellness also recommended expansion of family-to-family peer support programs in its 2014 report (Dvoskin, 2014).

Nevada PEP currently provides family-to-family peer support services for families who have children with mental health needs. Families are referred by DCFS programs, schools, and community organizations. Over the last year PEP provided family-to-family peer support services to 1,129 families of youth with serious emotional disturbance in Clark County. Families who contact Nevada PEP for support receive individualized and unique support to meet their needs which may include: Informational and educational support; Instructional and skills development support; Emotional and affirmation support; Instrumental support and referral; Advocacy support; and Leadership skill building at child and family level as well as at system levels.



Nevada PEP has partnered in the development and implementation of DCFS's Mobile Crisis Response Team, serving 327 Clark County families referred by MCRT in 2015. The funding approved in June 2014 by the Interim Finance Committee to expand DCFS's mobile crisis intervention services also included a small amount of funding to add additional family-to-family peer support services for youths identified by the mobile crisis teams, with the intent of reducing the number of youths at risk for long term institutional placement. This new funding for family-to-family peer support included in the FY 16-17 Governor's Biennial Budget Request should be sustained in the next biennium to keep pace with the growing need.

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 peer support for this population. At least 24 Clark County youths with co-occurring developmental disabilities and behavioral health needs have been served by the Mobile Crisis Response Team over the past year. Linking these youths to community-based services creates one of the greatest challenges for the MCRT. Family-to-family peer support can improve outcomes for these children, representing a critical component of any care coordination plan. The CCCMHC recommends that intensive family-to-family peer support be incorporated into the pilot project for such youths authorized by Assembly Bill 307 of the 2015 Nevada Legislature.

Additional funding for family-to-family peer support is also desperately needed to provide services to the large numbers of youths at risk for long-term psychiatric residential treatment identified each year by the Clark County School District's Mental Health Transition Team. Created in 2014, this team develops school-based aftercare for youths discharged from psychiatric hospitals. In the 2014-15 academic year, the team provided aftercare support to 1485 youths transitioning back to their home schools after hospital stays. During the first half of this school year, the team has already served 773 youths. The majority of youth identified by the team lack special education supports and suffers from depression, bipolar disorders, or other serious mood disorders. While the Mental Health Transition Team connects youth with needed services as they return to school, the families also need support to care for these high-risk youths at home. Almost 200 youths identified by the CCSD Team have already had at least two psychiatric hospitalizations so far this year.

*Jenna's Story**

Jenna is a 12-year old girl with co-occurring mental health and developmental disabilities. Jenna's family had accessed multiple services over the years, all with various levels of what mom termed "very limited success or failure." Jenna's behaviors at school had escalated with no clear indication of what was triggering the behaviors. Although mom was often able to redirect Jenna, there had been some instances when that was not possible. In these instances, Jenna had run from the home and the police had been called for assistance. The private acute psychiatric hospitals in the area would not accept Jenna because of her developmental disability and mom often felt her only choice was to take Jenna to the emergency room for assistance and then to Desert Willow Treatment Center if there was a bed available. Jenna had been placed in long term residential placement in the past for a period of 6 months which mom felt had little lasting effect. The CCSD Mental Health Transition Team assisted when her daughter was discharged from a short stay at Desert Willow Treatment Center. As part of that transition, the family was referred to Nevada PEP for family support. The parents received family-to-family peer support from their Nevada PEP Family Specialist and learned about options for different resources in the community. Mom has also accessed Nevada PEP for Positive Behavior Interventions trainings and support groups to meet other family members who were experiencing similar issues. Mom feels better equipped now and has not had to call the police or go to the emergency room for assistance in four months.

**Not the child's actual name*

Recommendations:

A. Expand funding to provide family-to-family peer 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 and referred from the CCSD Mental Health Transition Team.

B. As part of the pilot project established under Assembly Bill 307 of the 2015 Nevada Legislature, provide an intensive level of family-to-family peer support for at least 50 Clark County youth with intellectual/developmental disabilities or related conditions who are also diagnosed with behavioral health needs in an effort to prevent long-term institutional placement. (revised)

Projected Costs:

$600,000 per year for Program A (200 youths) and $**150,000 per year** for Program B (50 youths). Costs based on Nevada PEP cost per family of $3,000 for 75 hours of family-to-family peer 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.

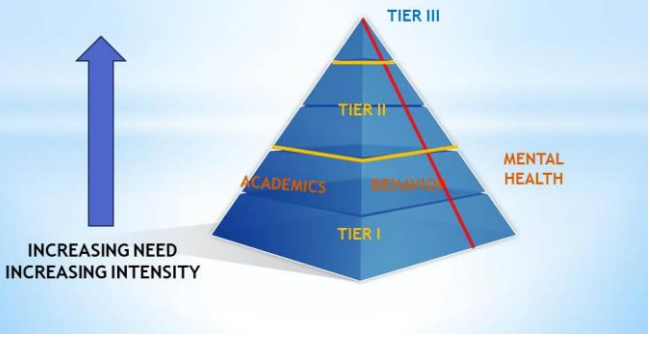
2017-2018 Programs/Services:

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). 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. Although screening should be provided across the age range, it becomes even more critical as children enter adolescence and become more prone to depression and high-risk behaviors (Schwarz, 2009). School-based screening has been shown effective in identifying teens with mental health problems and linking them with needed services (Husky et al., 2011). Even more important, screening for depression coupled with suicide awareness training can reduce the incidence of suicide attempts in adolescents (Azeltine et al., 2004).

Clark County public and private schools have experienced some success in implementing school-based screening programs to identify students with mental health needs and provide them with assistance in obtaining treatment services (CCCMHC, 2010). Between 2011 and 2013, CCSD screened over 17,000 adolescents using the evidence-based Signs of Suicide program. Recognizing the 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. In 2014, CCSD implemented a pilot program of general mental health screening for middle school children in response to the Legislative mandate. In spite of the success of both of these screening programs, substantial funding and a more efficient process must be developed before CCSD can initiate wide-scale screening efforts across all community schools.

Figure 4. Multi-Tiered Systems of Support: Interconnected Systems that Address Academic, Behavior and Mental Health Needs



Screening is one of the steps in actualizing the Clark County School District's preferred approach of building a multi-tiered system of supports that includes selective mental health services interconnected with the District's system of academic supports (See Figure 4.). In this system, preventative behavioral health supports can be initially developed and provided to all students through social-emotional learning programs, while students identified with behavioral health needs, in part through screening, can receive early intervention or intensive support.

Currently, the Nevada Department of Health and Human Services (DHHS) is not providing any funding for school-based screening efforts in Clark County. The CCCMHC recommends that DHHS's Office of Suicide Prevention conduct a survey of Clark County public, private and charter schools to determine the extent to which they have implemented mental health screening programs. DHHS should also provide funding support to implement an evidence-based model of school-based mental health and suicide prevention screening that is cost-effective, utilizes parental consent, and includes procedures and resources to link identified students with needed services.

*Sally's Story**

Sally is a 16-year old sophomore attending school in Clark County. Sally's mom and dad had noticed that she had been sad and withdrawn lately, but thought it was just a typical adolescent phase. They tried to talk to her and get her to open up but Sally said that they were making a big deal out of nothing and that she was fine. Later that week, mom received a consent request for a school-wide screening activity, which she signed for Sally to participate. During the screening, Sally was found to be at risk for attempting suicide. Sally talked with the school counselor and shared that she was feeling very depressed and angry over a recent breakup with her boyfriend. The counselor immediately called Sally's parents and a decision was made to have Sally assessed that same day at an acute psychiatric hospital. Sally was admitted for a short stay and discharged. Sally's parents followed through with all of the hospital's recommendations, started family counseling and got Sally involved in a positive youth group. Sally's parents feel that the screening not only saved their daughter's life, but also led them to counseling and has opened lines of communication among all of them.

**Not the child's actual name*

Recommendations:

A. Assist the Nevada Office of Suicide Prevention to obtain resources in order to conduct a comprehensive survey of Clark County public, charter, and private schools that will determine the degree to which mental health and/or suicide prevention screening has been implemented. (new)

B. DHHS initiatives for mental health and/or suicide prevention screening should support the implementation of an effective model of school-based mental health and suicide prevention screening that is: (1) Evidence-based; (2) Cost-effective; (3) Utilizes active parental consent; and (4) Includes procedures and enhanced resources to link identified students with needed services. (new)

Projected Costs:

The Nevada Departments of Education and Department of Health and Human Services should evaluate current funding sources for school-based social climate and mental health programs in order to redeploy a portion of the funding toward screening programs for Clark County schools.

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
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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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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.

REFERENCES

Agency for Healthcare research & Quality, Health Care Innovations Exchange (2013). ***Service delivery innovations profile: 24-Hour mobile mental health crisis team reduces hospitalization for children with complex behavioral and emotional needs***, U.S. Department of Health and Human Services. http://www.innovations.ahrq.gov/content.aspx?id=1719.

Azeltine, R.H., & DeMartino, R. (2004). An outcome evaluation of the SOS suicide prevention program***. American Journal of Public Health***, 94, 446-451.

Brune, N.E. & Carreon, V. (2014). ***Mental health governance: A review of state models and guide for Nevada decision makers.*** Las Vegas, NV: Guinn Center for Policy Priorities.

Bruns, E.J., Suter, J.C. (2010). Summary of the wraparound evidence base. In E. J. Burns & J.S. Walker (Eds.), ***The Resource guide to wraparound***. Portland, OR: National Wraparound Initiative.

Centers for Medicare & Medicaid Services (2013). Coverage of behavioral health services for children, youth, and young adults with significant mental health conditions. May 7, 2013***. Joint CMCS and SAMHSA Informational Bulletin***. http://medicaid. gov/Federal-Policy-Guidance/Downloads/CIB- 05-07-2013.pdf.

Clark County Children's Mental Health Consortium (2010). 10-Year strategic plan: ***2020 vision for success***. Las Vegas, NV.

Clark County Children's Mental Health Consortium (2014). **2014 service priorities**. Las Vegas, NV.

Cooper, J.L. et al. (2007). ***Child and youth emergency mental health care: A national problem***. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

Denby, R. et al. (2013). ***How are the Children: Challenges and opportunities in improving children's mental health.*** Social Services Series No. 1. The Lincy Institute at the University of Nevada Las Vegas.

Dvoskin, J.A. (2014). ***State of Nevada Governor's Advisory Council on Behavioral Health and Wellness proposed Council recommendations.*** Carson City, NV: Nevada Division of Health and Behavioral Health.

Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. (2014***). Nevada Youth Risk Behavior Survey (YRBS): Clark County analysis***. Reno, NV: University of Nevada, Reno.

Greenway, J. (2015). Personal Communication. ***Center for Health Information Analysis***, University of Nevada, Las Vegas.

Husky, M.M., Sheridan, M., McGuire, L., & Olfson, M. (2011). Mental health screening and follow-up care in public high schools. ***Journal of the American Academy of Child & Adolescent Psychiatry***, 50, 881-891.

Mental Health America (2016). ***Prevention and early intervention B4Stage4: The state of mental health in America 2016.*** Alexandria, VA: Mental Health America.

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). ***Journal of the American Academy of Child and Adolescent Psychiatry***, 49(10), 980–989.

Nevada Division of Child and Family Services (2005). ***Final Report of the Neighborhood Care Center Project***. Carson City, NV: Division of Child and Family Services.

Pires, S.A. and Mayne S. (2009). ***Report on behavioral health spending for children and adolescents in Nevada Across public child-serving systems***. Washington, DC: Human Service Collaborative.

Pires, S.A. et al. (2013). ***Identifying opportunities to improve children's behavioral health care: An analysis of Medicaid utilization and expenditures.*** Faces of Medicaid Data Brief, December 2013). Center for Health Care Strategies. http://www.chcs.org.

Simons, D. et al. (2014). ***Intensive care coordination using high-quality Wraparound for children with serious behavioral health needs: STATE AND COMMUNITY PROFILES.*** Hamilton, NJ: Center for Health Care Strategies, Inc.

Stagman, S. & Cooper, J.S. (2010). ***Children's Mental Health: What every policymaker should know.*** New York: National Center for Children in Poverty, Columbia University Mailman School for Public Health.

Stroul, B.A. et al. (Eds.). (2008). ***The System of Care Handbook***. Baltimore, MD: Brookes Publishing Company.

Stroul, B. et al. (2014). ***Return on investment in systems of care for children with behavioral health challenges.*** Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2007***).*** ***Promotion and prevention In mental health: Strengthening parenting and enhancing child resilience***. DHHS Publication No.CMHS-SVP-0175. Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2013). ***Behavioral health, United States, 2012***. HHS Publication No. (SMA) 13-4797. Rockville, MD: Substance Abuse and Mental Health Service Administration.

U.S. General Accounting Office (2013). ***Child welfare and juvenile justice: Federal agencies could play a stronger role in helping states to reduce the number of children placed solely to obtain mental health services*** (GAO Report No. GAO-03-397). Washington, DC: U.S. General Accounting Office.

Valley, Jackie (2015, 6 December). Children in crisis: Pediatric mental health "The Polio of our generation. ***Las Vegas Sun***, pp. 1, 8-9).

Valley, Jackie (2015, 20 December). Children in crisis: Here's how we can do better on mental health care. ***Las Vegas Sun***, pp. 1, 8-9.

Watson, L. & Marschall, K. (2013). ***Comprehensive gaps analysis of behavioral health services***. Carson City, NV: Nevada Department of Health and Human Services, Division of Public and Behavioral Health.