Clark County Children's Mental Health Consortium

Fourth Annual Plan

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Clark County Consortium
Fourth Annual Plan for Mental Health Services

INTRODUCTION AND OVERVIEW

The Clark County Children's Mental Health Consortium has been meeting and working to fulfill the legislative requirements of **NRS 433B and to strengthen the local partnership working toward creating an integrated system of behavioral health care** for the children and families of Clark County.

The Fourth Annual Plan addresses the following areas:

- Updates the information about how well need is met in the child welfare and juvenile justice systems.
- Provides new information on the mental health characteristics of the school population in Clark County related to suicide prevention.
- Uses assessments from all three systems to develop a comprehensive model of behavioral health services within Clark County.
- Summarizes the progress over the past four years that has been made to address the unmet needs for behavioral health services.
- Provides additional support for the five major recommendations made in the CCCMHC's Third Annual Plan including:
    1. Expansion of behavioral wellness activities for Clark County's elementary school children.
    2. Development of an integrated, targeted early-response system within the schools.
    3. Expansion of intensive intervention services for children with SED in the child welfare system.
    4. Provisions of intensive interventions for youth with SED throughout the juvenile justice system.
    5. Improvement of the necessary system infrastructure to support community wide behavioral health services.
- Sets forth three broad goals that will serve as the focus of CCCMHC implementation efforts for the coming year:
    1. To improve public awareness of mental health, reduce stigma, and increase support for behavioral health services and skill building activities that promote behavioral wellness.
    2. To improve access to needed mental health services with initial efforts focusing on improved crisis services and early access to needed intervention.
    3. To improve the infrastructure and coordination across and within systems.
- Recommends a change in the plan format to biannual assessments which will create more time for implementation activities.

ACTIVITIES AND ACCOMPLISHMENTS OF THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Over the last 12 months since the submission of the Third Annual Plan, the members of the Clark County Children's Mental Health Consortium have met ten times. Numerous workgroup meetings have been convened that have included other stakeholders and family members in the work of the Consortium.

The Consortium has focused on the following activities: informing legislative committees, agency staff, and state and local groups on the findings of the first three reports, implementing local action steps, working with state departments and divisions to address the action steps of the Third Annual Plan, and further assessing the need for behavioral health services and how well it is met for Clark County students at risk for suicide.

The Consortium made five major recommendations in its Third Annual Plan. Progress has been in addressing three of the five recommendations.

Significant accomplishments of the Clark County Children's Mental Health Consortium in fiscal year 2004-2005:

- The Consortium supported the expansion and evaluation of the Clark County Health District's local Columbia TeenScreen Program, recognized by President Bush's Freedom Commission as a promising practice for the prevention of youth suicide.
- The Consortium worked with DCFS to develop a federal grant request to expand the Columbia TeenScreen Program, provide training for school staff: teachers, coaches, counselors and school nurses; primary care medical staff; and youth religious staff in suicide prevention; and provide public education on suicide prevention.
- The Consortium added to its membership representatives of the Clark County Health District and the local chapter of the American Academy of Child and Adolescent Psychiatry.
- The Consortium also expanded its membership to include a representative from the Division of Mental Health, Southern Nevada Adult Services, to facilitate improved transition services.
- The Consortium co-sponsored a Conference on Collaborations in Children's Mental Health Care in conjunction with the American Academy of Child and Adolescent Psychiatry.
- The Consortium developed a brochure for parents on children's mental health signs, symptoms, and local resources.
- The Consortium conducted an assessment of the need for behavioral health services within the Clark County School district's high school population.
- In collaboration with Nevada Parents Encouraging Parents, the Consortium conducted focus groups for parents of children with emotional problems.
- The Consortium supported the Children's Mental Health State Infrastructure through participation in committees and stakeholders meetings.
- Members of the Consortium have been actively involved in the committees doing the redesign of Medicaid services.

Significant progress achieved toward improving local behavioral health service delivery:

- DCFS expanded the capacity of the Wraparound in Nevada (WIN) Program to serve an additional 100 children and youth in Clark County, bringing the total capacity to 327 children and youth.
- Following the work for the third annual plan the Clark County School District has increased training for intervention teams, school wide training in positive behavior supports, and improved response to intervention data tracking to guide decision-making.
- The Clark County School District's Safe Schools and Healthy Students Initiative has been progressing to build stronger prevention, direct intervention, post-intervention systems and to directly address bullying prevention.
- DCFS developed a draft MOU between Adult and Children's Mental Health Services to improve coordination.
- Clark County Juvenile Justice Services expanded the Juvenile Detention Alternative Initiative in partnership with the Anne E. Casey Foundation to address overcrowding in detention.
- DCFS and DFS developed a protocol for accessing mental health services after integration of child welfare services in the county.
- Legislation was passed to extend Medicaid eligibility for youth emancipating from foster care.
- Changes in Medicaid eligibility were made to allow children and youth in the custody of a public agency to retain coverage when they are reintegrated with their families.

METHODS FOR ASSESSING CHILDREN'S AND SYSTEM NEEDS

For the Fourth Annual Plan, the CCCMHC reviewed and updated the assessment for the first three plans, added additional information from an assessment of suicide risk for students in the Clark County Schools, gathered information from family focus groups, and reviewed progress addressing past recommendations. The Year One report focused on children in the Child Welfare system. Year Two added a focus on youth in the Juvenile Justice system. Year Three added a school-based assessment and through the third annual report, the CCCMHC developed a vision and plan for an overall integrated system. This year the CCCMHC focused on the need for suicide prevention services in Clark County's High Schools. The Consortium also spent considerable time reflecting on ways to use to use all the assessment information collected over the past four years to drive system planning and change.

The Consortium reviewed youth suicide statistics provided by the Nevada Health Division and the Clark County results of the Youth Behavior Risk Survey administered by the Nevada Department of Education.

The CCCMHC also collaborated with the TeenScreen Program administered by the Clark County Health District to identify the behavioral health needs of Clark County's high school population. The TeenScreen program was developed by Columbia University and is endorsed by President Bush's New Freedom Commission as an exemplary suicide prevention program.

The CCCMHC reviewed the results of the screenings as well as the results of a survey conducted by Gary Waters, MSW, Ed.S., the Clinical Coordinator for the local TeenScreen Program administered by the Clark County Health District. Mr. Waters surveyed participants who were screened and received services from the TeenScreen Program. The families of students identified and served by the program reported a high degree of satisfaction with the services.

The CCCMHC also developed and implemented two additional surveys to measure how well the needs of these students were being met. The first survey was designed to determine the reasons why children and families refused to participate in the program. The second survey was designed to evaluate participants' ability to access effective services from outside community providers.

CHILDREN'S NEED FOR BEHAVIORAL HEALTHCARE SERVICES

The combined and updated assessment of need identified the following:

1. **A retrospective view of challenges across all systems suggests the overall need for behavioral health services for children, youth, and their families is increasing.** School, health, and family support staff are seeing more children in need, who are exhibiting significant problems at earlier ages and with greater levels of severity.

2. **All school children need access to screening and universal behavioral health promotion activities.** The findings from the assessments in each system point to the need to develop a system that supports children and families in a way to avoid entrance into public service systems, such as: child welfare, juvenile justice and special education. By providing public education, environments that support wellness through behavioral health promotion activities, many children could avoid deeper involvement in the system. A comprehensive behavioral health system must include behavioral health promotion for all school children. Currently 80.7% of children in the school system avoid the need for formal mental health services. If behavioral health promotion activities were offered to more students, up to 90% of school children could avoid the need for mental health services. Nevada ranks as the state with the fifth highest rate of teenage suicide in the country. Behavioral health promotion activities need to include: early screening for behavioral health problems and suicide in the teen years.

3. **19.3% of all elementary school students need some level of behavioral health services and 6.0% need intense integrated services.** The results of the assessment process for the Clark County school system are shown in Figure One. Based on the screening and assessment the level of need was determined for six levels of the CALOCUS. 80.7% of the children scored at the zero level indicating that they only need health promotion support. 13.3% of the children were assessed to need level one through three services which are targeted interventions. 6.0% of the children were assessed at levels four through six which require intense and coordinated services.

4. **Suicide is the second leading cause of death for 15 to 24 year old Nevadans with a rate of 17.5 suicides for every 100,000 youth.** Whereas suicide accounts for 1.3% of all deaths and 12.3% of deaths for 15- to 24-year-olds nationally, in Nevada they account for

19.1% of all deaths for 15- to 24-year-olds (Kochanek et al, 2004; Nevada State Health Division, 2003)

5. **30% of high school students self-reported depression of a magnitude sufficient to impact completion of daily tasks at some point in the previous 12 months (Nevada Department of Education, 2003).** This same research found 20% of all high school students had seriously considered attempting suicide, 16.4% have made a suicide plan, 11.0% have actually attempted suicide, and 4% had required medical attention following the suicide attempts.

6. **31% of high school students screened by the Clark County TeenScreen Program were identified as at risk of suicide due to clinically significant levels of depression.**

7. **85.3% of abused/neglected children need some level of behavioral health services and 40% need intensive levels of community-based supports.**

8. **79% of the juvenile offenders need some level of behavioral health services and 54% need intensive levels of community-based services.**

9. **An integrated infrastructure is needed to support effective and accessible behavioral health service delivery.** This infrastructure should include: public engagement and outreach, system management, integrated access, collaborative service processes, utilization management, workforce development, integrated financing, and ongoing utilization focused evaluation.

HOW WELL CHILDREN'S NEEDS ARE MET

For Children in Child Welfare. With the integration of Child Welfare services, the dynamics of service access are changing. In the CCCMHC's Third Annual Plan, it was reported that great strides had been made in providing behavioral health services for children in the DCFS side of the Child Welfare system (e.g., those children in long term care). These children and youth were much more likely to be receiving the services they needed and having positive outcomes. This was related to the WIN initiative. It was noted that the overall quality of services was improving but that the rapid expansion of capacity was resulting in uneven quality and thus outcomes. For children in the Clark County Child Welfare Services, there was a much greater amount of unmet need reported in last year's Plan:

- 70% of children with a need for behavioral health services were underserved.
- 43.8% of children with severe emotional disturbance were receiving no services.

During the past year, the transition of Child Welfare services to Clark County was completed and DCFS has retained public Children's Mental Health services. This has required a great amount of change but the county and state have worked together to develop protocols and coordination mechanisms to make this work. The result is a Child Welfare system that is unified but no longer integrated with Children's Mental Health Services. Overall, the services for children in long-term foster care have deteriorated slightly (both in access and quality) but the services for children in

earlier stages of the system have improved. At the same time, the level of behavioral health needs for children entering the system seem to be increasing. One story describes the types of problems faced and the problems of the fragmented infrastructure.

> ***Case Example:*** *James has experienced a number of moves in placement and a variety of services from the child welfare, juvenile justice, and children's mental health systems. We are challenged by how to best serve this young man and achieve safety, well-being, and permanency for him.*
>
> *James was initially referred for children's mental health services in January 2002. James suffered from serious emotional disturbance as well as exhibiting oppositional behavior and academic problems. He had frequent mood and behavior escalations where he became verbally and physically aggressive towards his family. He received in-patient psychiatric, treatment group home services, intensive clinical case management, intensive home-based therapy and medication services. His mother had the active support of a Family Specialist from Nevada PEP throughout. He was referred for services again in 2003 upon his discharge from residential treatment after six months of treatment and received services from DCFS Children's Mental Health and Nevada PEP for two years. He maintained in his home with these supports until February 2005.*
>
> *James was brought into protective custody and Child Haven in February of 2005 after his mother refused to pick him up from Juvenile Detention. He had been charged with battery against her. James has periods of time in which he becomes out of control emotionally. At times, during his stay in Child Haven, James would become despondent and hopeless. On other occasions, he would become angry and aggressive, sometimes walking the grounds of Child Haven under supervision, throwing rocks at windows and buildings, running away, and shouting obscenities.*
>
> *Since his protective custody and stay at Child Haven, James was hospitalized twice for suicidal and homicidal ideation. He was staffed for admission to Desert Willow Treatment Center's residential treatment program on May 31, 2005, and denied. Desert Willow's recommendation was for James to be returned home with wraparound support and intensive services. James received some intensive community-based therapeutic services in Child Haven beginning in early June. James was admitted to Spring Mountain Treatment Center on or about June 15 where he is now in their Residential Treatment Center program.*
>
> *This is a child and family who could have benefited from the availability of mobile crisis intervention services Although James received medication, psychiatric services and counseling prior to his involvement in child welfare services, he continued to exhibit serious and chronic emotional disturbance. Entrance into the child welfare system may have been averted with more intensive and 24-hour crisis services.*
>
> *His case also illustrates the importance of improved coordination between juvenile justice, child welfare, and children's mental health.*

For youth in the juvenile justice system. Several reports have supplemented the assessments done by the Clark County Consortium in defining how well the behavioral health needs for youth in the juvenile justice is met. Last year it was reported that:

- Within the juvenile justice system, 71.1% of youth with a need for mental health services are underserved.
- In the juvenile justice system 36.7% of youth with SED are receiving no behavioral health services.

During the past year the Clark County Juvenile Justice Services has improved behavioral health services through the Juvenile Detention Alternative Initiative in partnership with the Anne E. Casey Foundation. The initiative is designed to address overcrowding in detention by increasing alternative community resources. This has included developing a 16-bed treatment facility for girls, expanding electronic monitoring so youth can live at home and reducing the time for filing petitions from 8 to 2.5 days. In addition, a social work position has been added to the public defenders office to support youth on parole to reduce recidivism. At the same time the need for behavioral health services for youth in Juvenile Justice continues to increase and overall access has not increased in the past year.

For children in the Clark County School System

Elementary School
The assessment of the elementary school children in the Clark County School District for the CCCMHC's Third Annual Plan documented that although there is less need for behavioral health services for the general population of children than for those in the child welfare and juvenile justice systems, the children who do need services are less likely to get them.

- The universal behavioral health promotion (i.e., classroom-based activities to promote social and emotional development) proven useful in avoiding the need for many behavioral health services is provided for **less than 10% of children** within the school system.
- Of the **9,097 children** within Clark County elementary schools who are projected to need targeted early intervention school based intervention level of behavioral health care, **69% are receiving no services**.
- Of the **7,797 children** within the Clark County elementary schools who are projected to need intensive integrated services, **62% are receiving no school services** or identified community-based services.
- Teachers report that the level of behavior and mental health problems within their classrooms has increased over the past five years and that these problems are impacting the quality of instruction for all children.

Although the funding for additional positions was not approved during the last legislative session, the Clark County School system has made progress in developing the system to address behavioral health needs in the schools which has included:

- District-wide training for school-based intervention teams to improve the consistency and quality of the response to behavioral health crisis and to increase the use of evidence-based practices by these teams. This training has included a focus on cultural and linguistic competency to address issues of over representation and English as a second language.
- School-wide training in positive behavior supports to improve behavioral health promotion activities and early intervention response.
- Increased and improved use of post-planning and post-intervention data to improve ongoing decision-making.

High School

During Fiscal Year 05-06, the TeenScreen Program provided screenings for depression and suicide risk in seven of Clark County's High Schools. 7163 ninth graders in these schools were eligible to participate in the screening program. The families of 4566 students agreed to participate in the program. Of these students, 31% scored positive for depression. Of those students identified with depression, 44% were able to access behavioral health counseling services through the TeenScreen Program or other community providers. Families who were able to access services through the TeenScreen Program reported a high degree of satisfaction with the services. However,

- **54% of youths identified with depression did not receive services.** Consistent with other CCCMHC assessments, most children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many more children experiencing severe disorders than would occur with early intervention.

- **37% of the students eligible for the TeenScreen Program were never screened due to lack of permission from parents.** The follow-up survey conducted by the Consortium suggested that parents lacked information and awareness of the value of such screening and services. More parental involvement and education is needed to maximize the effectiveness of this Program.

- **20% of Clark County ninth graders identified by TeenScreen as significantly depressed dropped out of school before any services could be provided.**

- School response staff need better education and training in suicide prevention and intervention. National TeenScreen data indicate that **74% of students who are contemplating suicide and 50% of students who made a prior suicide attempt were not known to be having problems by school personnel. 69% pf students suffering from depression had not been identified**.

- **Although some services are provided that address suicide, most focus on persons after they have attempted suicide, not on prevention.** A lack of coordination of existing suicide prevention resources results in duplication and limited effectiveness.

- **Nevada Department of Education's ninth-grade health course content areas have four required learning objectives regarding suicide prevention that need to be implemented more broadly over the high school years.**

- **Key gatekeepers (e.g., educators, health professionals, law enforcement, clergy, emergency medical staff, etc) are not receiving adequate training related to suicide.**

In response to the unmet needs to provide comprehensive suicide prevention services, DCFS collaborated with the Consortium to develop and submit a request to the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Administration for a three-year, $1.3 million grant to implement a statewide youth suicide prevention plan, and improve suicide prevention services in Clark County. If funded, the project will begin on October 1, 2005. The goals of the proposed project are to:

- Refine the current state suicide plan into a comprehensive and statewide plan.

- Develop and implement a comprehensive pilot project in Clark County that will strengthen the public/private partnership, implement evidence-based programs to promote protective and reduce risk factors for suicide, mount a public education campaign to reduce stigma and promote suicide awareness, provide screening and referral for ninth-grade students, and for youth in the child welfare and juvenile justice system, develop a coordinated continuum of services to support the identified needs of youth and suicide survivors, and provide training for gatekeepers to support suicide prevention.

- Disseminate lessons and materials from the Clark County pilot statewide.

- Develop an evaluation system that monitors the implementation of the project, the process and quality of services, and the outcomes and costs of services and supports to drive decision-making to support good outcomes for youth and their families.

ASSESSMENT OF SYSTEM NEEDS

For the third annual report, a system and infrastructure assessment was done through a three-stage process to identify needed organizational supports, the current level of support and prioritize areas of need. The State of Nevada used this information to submit a Children's Mental Health State Infrastructure Grant (SIG) request to the U.S. Substance Abuse and Mental Health Services Administration. The Nevada SIG request was funded by SAMHSA in October 2004.

The Clark County Consortium prioritized the findings from the assessments and identified five areas of infrastructure development that should be the priority areas for infrastructure development using SIG resources. These include:

- Develop a partnership across service systems and with family members to create a shared vision and integrated plan for behavioral health services for children and families across all child-serving agencies in Nevada.

- Implement flexible fiscal policies that promote individualized behavioral health services and supports. Current funding strategies create barriers to getting the right services to many children.
- Develop a public engagement campaign to reduce stigma and build public support for behavioral wellness. The stigma of behavioral health disorders keeps many families from seeking services until the problems become severe. This stigma also decreases the chances of children being successful in our schools and communities.
- Shift the focus to prioritizing early identification and easy access to services before problems become severe. Currently services are focused on the most restrictive services for the children and youth with the most severe problems.
- Produce good, consistent data on the outcomes, quality and cost benefit of behavioral health services across systems.

ELIGIBILITY FOR BEHAVIORAL HEALTHCARE SERVICES

The current system of eligibility is one of the primary system characteristics that cause the fragmented and discontinuous system. The multiple forms of eligibility, different benefit packages, different providers, and eligibility processes of the different agencies and public programs are a maze that few parents can successfully navigate. The very limited availability of targeted case management and limited funding for parent to parent advocacy and support make this problem even worse. The addition of WIN facilitators has significantly improved care coordination for children and youth in the DCFS child welfare system, but this is not available for most children.

While there have been progress for some children (e.g., children being reunited with families and youth transitioning out of foster care), the overall perception is that eligibility has not improved and access barriers are one of the primary challenges of the current system.

METHODS FOR OBTAINING BEHAVIORAL HEALTHCARE SERVICES

There are multiple ways for children and families to obtain services. Parents can go directly to providers and use private insurance, public insurance or pay directly for the services. Individualized and coordinated services are often expensive and not covered by private insurance. For the past two years, efforts have been underway to redesign the public health insurance programs funded through Medicaid. It is unclear if the recommended changes in the redesign are sufficient to improve access and flexibility of services. Nonetheless, it is clear that significant changes to the Medicaid benefits and process for authorizing services are necessary before the desired improvements to access and flexibility of services can be achieved.

The currents methods of access mean that parents of children with severe emotional disorders often do not have financial resources to pay for the services their children need without going through public systems. This forces many children into the child welfare and juvenile justice systems to obtain services.

PROCESS FOR OBTAINING BEHAVIORAL HEALTHCARE SERVICES

Children access services through the provider that receives funding for the services (e.g., their own physician, psychologist, managed care provider, or public system service coordinator). Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system. Best practice ratings ranked collaboration and integrated of services as one of the highest priorities but one that was most often not met.

Although the Medicaid managed care provider and all of the public systems triage initial intakes and focus services on children with the most intense needs., the process for obtaining services remaining lengthy and confusing for families and clinicians.

> ***Case Example:*** *A single mother struggles with services for her two children. One of the children has depression and ADHD; the other child has early mood disorder, which may progress to bipolar disorder. Their mother has been between jobs and had employment. The medical coverage for the siblings has vacillated between full state Medicaid and HMO Medicaid. They did very well on a combination of medications and regular psychotherapy. Their mother went from receiving many negative calls from the school and the children from frequent RPCs, to weeks without negative feedback. Then, the mother opened her own business, lost HMO-driven Medicaid, and was placed on full state Medicaid. Shortly thereafter, the children became out of control AND one was expelled from school – all because mother's new Medicaid benefits were unable to cover the medications and psychotherapy, which HAD been covered by the HMO-driven Medicaid – a treatment plan on which both children had been extremely stable. The daughter, who has depression, had begun to express suicidal ideations and felt increasingly irritable and sad due to the three months during which she was unable to obtain medications – the same medications she had been taking while being covered under the HMO Medicaid Program.*

METHODS FOR OBTAINING ADDITIONAL MONEY

Nevada has one of the fastest growing populations in the country, but funding for children's behavioral health services had shown little increase in the past. The WIN Program has expanded individualized services for 327 children in the child welfare system. This has helped this population of children but not others. There are ways in which the funding within the current system could be used more effectively but this can only happen if the state level Departments and Divisions with support from the State Legislature work together to form a less fragmented system that is flexible to meet the needs of children and families. Members of the Clark County Mental Health Consortium are working to secure this support for children and families.

VISION FOR AN INTEGRATED BEHAVIORAL HEALTH SYSTEM

The vision for the integrated system is shown in Figure Three. The base of the system is behavioral health promotion for all children. Behavioral health promotion originates from parents, early education and care providers, school environments, and health providers. The role of the system is to provide public engagement and special supports to these individuals to give them the knowledge and resources to provide activities and environments that promote behavioral wellness. Behavioral health promotion activities would be sufficient to avoid the need for mental health treatment for more than 80% of all children, and if provided consistently, should reduce the number of children who need intervention services.

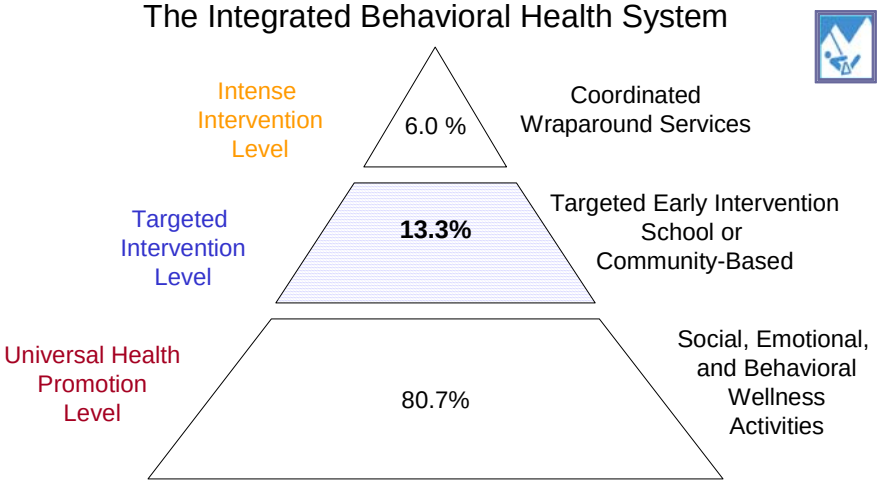

Figure Three New Picture of School-Community Interaction. This diagram shows the community strategy to address the mental health needs of children in the public school system in Clark County. For all students the strategy will be to provide supplemental classroom supports to teachers to create classroom activities and environments that promote social and emotional development and behavioral wellness. For 13.3% of the children there will be additional in school supports that will provide targeted early intervention within the school environment. For those 6% of the students with the most intense needs, services will be a combined effort of the schools and outside providers.

The second level of the system is for targeted early access and intervention services. Within the school system, this would include a range of group and individual services. Outside the school system, this would include a basic benefit of early intervention and intervention services.

The third level of the system is for children who have more intensive needs that require coordination across entities. This is the level of service that is provided through programs such as WIN.

RECOMMENDATIONS

The CCCMHC decided to set three overarching goals for improvement of behavioral health service delivery for Clark County's children. These goals are:

1. To improve public awareness of and support for behavioral health services and skill building activities that promote behavioral wellness.

2. To improve access to needed mental health services with initial efforts focusing on improved crisis services and early intervention.

3. To improve the infrastructure and coordination across and within systems.

The Consortium recognizes that progress has been achieved by funding for previously recommended initiatives such as the expansion of the WIN Program, the Children's Mental health State Infrastructure Project (SIG), and the Medicaid redesign. **Nonetheless, other CCCMHC recommendations for funding need to be addressed in order to help accomplish these goals as shown (in italics) below**:

1. **To improve public awareness of mental health, reduce stigma, and increase support for behavioral health services and skill-building activities that promote behavioral wellness:**

   1.1 Funding for plan to address Clark County School District student mental health needs.

2. **To improve access to needed mental health services with initial efforts focusing on improved crisis services and early access to needed interventions:**

   2.1 Funding for plan to address juvenile justice mental health needs.
   2.2 Funding for plan to implement mobile crisis intervention services.

3. **To improve the infrastructure and coordination across and within systems:**

   3.1 Implementation of the Nevada State Infrastructure Project Plan to address the organization and system infrastructure needs

The italicized funding plans are included in Appendix B and are the current priorities of assistance requested for funding and agency efforts.

The three overarching goals will also guide the local work of the CCCMHC. At the July 2005 meeting of the Consortium, workgroups were formed for each goal and specific action plans will be developed that can be achieved with local resources.

Appendix A
CCMH Consortium Third Annual Plan Recommendations
Update on Implementation

Below are the Recommendations from the 2004 Clark County Children's Mental Health Consortium's Annual Plan. Progress toward addressing these recommendations is shown in italics.

1. **Expand behavioral health promotion activities throughout the elementary schools in Clark County**

   Although the plan to increase behavioral health promotion activities in the Clark County Elementary schools was not funded, the assessment activities from last years report resulted in a greater awareness of the behavioral health needs of these students. Individual teachers and staff have done a better job identifying children and referring services. In addition, some teachers and staff have added behavioral health promotion activities to their classroom schedules. In addition, School wide training in positive behavior supports to improve behavioral health promotion activities and early intervention response. The Safe Schools and Healthy Students projects are resulting in school wide changes in the way these schools are providing behavioral health promotion, early intervention and post-intervention services. The school system is learning from this experience and hopes to build from these experiences in other schools in coming years.

2. **Implement a systematic approach to targeted early intervention for children with behavioral health problems in the Clark County School District**

   Although the funding for additional positions was not approved during the last legislative session, the Clark County School system has made progress in developing the system to address behavioral health needs in the schools which has included:

   a. District-wide training for school-based intervention teams to improve the consistency and quality of the response to behavioral health crisis and to increase the use of evidence-based practices by these teams. This training has included a focus on cultural and linguistic competency to address issues of overrepresentation and English as a second language.
   b. Increased and improved use of post-planning and post-intervention data to improve ongoing decision-making.

   During the past year the pilot project to provide Columbia TeenScreen was expanded to seven schools and funding has been secured to expand this to ten schools in the fall. A summary of data about the TeenScreen program was completed by Gary Waters, M.S.W., Ed.S, Clinical Coordinator for the local Columbia TeenScreen-Nevada administered by the Clark County Health District. The summary of Columbia TeenScreen-Las Vegas activities for the 2004-2005 academic year and includes ongoing activities and services to schools, students and families as of June 1, 2005:

Statewide Summary Data

1)	Suicide/depression education lectures:	116
2)	Students offered screening in 9th-/10th-grade classes:	7163
3)	Students screened to date:	4544
	Positive:	406
4)	Students recommended for therapy/intervention:	231
	Number refused:	76
	No shows:	37
5)	Students who received a clinical service* from ANY TeenScreen staff:	632
6)	Students referred to other providers for nonclinical** service:	409
7)	Teachers and instructional personnel trained in TeenScreen services:	54
8)	Clinical staff/interns providing education, screening, and clinical services:	8
9)	Administrative support staff:	1
10)	Consulting staff (grant development, accountability, connectivity, etc):	2
11)	Schools Screened:	9
	Urban (Las Vegas):	7
	Rural (Nevada):	2

* Includes ALL services, clinical interview, counseling, follow-up, clinical social work, and referral.

** Includes any service, contact, recommendation, consultation, clinical intervention assistance, referral or other related activity generated by the screening activity).

In addition, a follow-up survey with parents and students who did not participate or did not follow up on recommended services suggested that for the majority of them the reasons were related to lack of information and engagement in the process suggesting increased efforts in these areas for future implementation.

In response to the unmet needs to provide comprehensive suicide prevention services, DCFS collaborated with the Consortium to develop and submit a request to the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Administration for a three-year, $1.3 million grant to implement a statewide youth suicide prevention plan and improve suicide prevention services. If funded, the project will begin on October 1, 2005. The goals of the proposed project are to:

- Refine the current state suicide plan into a comprehensive and statewide plan.

- Develop and implement a comprehensive pilot project in Clark County that will strengthen the public/private partnership, implement evidence-based programs to promote protective and reduce risk factors for suicide, mount a public education campaign to reduce stigma and promote suicide awareness, provide screening and referral for ninth-grade students, and for youth in the child welfare and juvenile justice system, develop a coordinated continuum of services to support the identified needs of youth and suicide survivors, and provide training for gatekeepers to support suicide prevention.

- Disseminate lessons and materials from the Clark County pilot statewide.
- Develop an evaluation system that monitors the implementation of the project, the process and quality of services, and the outcomes and costs of services and supports to drive decision-making to support good outcomes for youth and their families

3. **Expand intervention services for children in the child welfare system by funding WIN services for an additional 150 children and youth with SED in the Clark County Department of Family Services system. Services should be provided to abused/neglected children with SED as early as possible without regard to Medicaid eligibility.**

   During the past fiscal year, the WIN Program has expanded its capacity to serve children with SED in the child welfare system. As of March 2005, the caseload in Clark County has increased from 235 children to 327 children.

   In addition, the WIN program has been stabilized by making 66 contracted facilitator positions into state positions.

4. **Expand intensive interventions for youth in the juvenile justice services by:**

   In addition to the activities described below, the Clark County Juvenile Justice department has implemented more elements of the juvenile detention alternative initiative including:
   - Developing a specialized 16-bed treatment facility for girls with treatment needs.
   - Increasing electronic monitoring and house arrests to allow more youth to stay at home.
   - Reducing petition time from 8 to 2.5 days.
   - Adding a social work position to the Public Defender's Office to support youth on probation.
   - Recruiting donors for an additional halfway house for youth returning from detention.

   a. **Providing funding for a pilot project for 100 youth in the Clark County Juvenile Justice system with severe emotional disorders. This would require the addition of eight wraparound facilitators and the behavioral health services these youth and their families need. It is recommended that this pilot be done in one or two of the Neighborhood Care Centers in Clark County.**

      DCFS established an intensive case management pilot program for youths with complex mental health and substance abuse needs under the care of Youth Parole Services in Las Vegas. The approach of the Program is family centered, strength based and youth focused. 59 youth have been served since the inception of the program. During the first part of 2005, the staff of the intensive case management pilot program and their manager met with the managers of the neighborhood care centers; working to improve collaborative efforts in order to achieve better outcomes with the youth. The staff has

additionally met with and scheduled regular ongoing meetings with the neighborhood care center intake coordinators. As part of the ongoing meetings, a working group has been formed in order to address the transitional needs of youth entering the adult mental health system.

b. Provide funding for telehealth psychiatric services in the three Nevada juvenile training facilities (CYC, NYTC, and Summit View).

DCFS has implemented the use of videoconferencing technology at the three juvenile training facilities (CYC, NYTC, and Summit View), along with the two largest parole offices located in Las Vegas and Reno. CYC and NYTC experienced the loss of their primary psychiatrist due to an airplane crash shortly after receiving their equipment. The two psychiatrists taking over the duties at NYTC and CYC respectively needed to see all clients for a first visit, which precluded the use of the equipment to date during SFY 05. CYC has a new contract with an Ely psychiatrist beginning in June 2005, replacing the interim psychiatrist from Las Vegas. Both psychiatrists have been informed and encouraged to make use of the telehealth equipment, and have indicated a desire to schedule the use of the equipment for brief follow-up visits such as medication checks in the future.

c. Fund mobile crisis intervention services for youth with behavioral health problems that are at risk for entering juvenile justice system.

To date, no additional funding has been added to state or local budgets for mobile crisis intervention services for youth at risk of entering the juvenile justice system.

5. Strengthen the organizational and systems infrastructure by:

- **a. Developing in partnership with family members a common shared vision and integrated plan for behavioral health services for children and families across all child-serving agencies in Nevada.**
- **b. Implementing flexible fiscal policies that promote individualized behavioral health services and supports.**
- **c. Developing a public engagement campaign to reduce stigma and build public support for behavioral wellness.**
- **d. Prioritizing early identification and easy access to services before problems become severe.**
- **e. Requiring and gathering consistent and useful date to assess the impact of services.**

In October 2004, DCFS received a $3.7 million, five-year Children's Mental Health State Infrastructure Grant from the U. S. Substance Abuse and Mental Health Services Administration (SAMHSA). The goals of the project are designed to address all of the recommendations in 5.a. through 5.e. The CCCMHC has been an active partner in the project, participating in committees and stakeholders meetings.

Appendix B
CCCMH Third Annual Plan
Pending Recommendations[1]

PLAN FOR ADDRESSING SCHOOL MENTAL HEALTH NEEDS. Through the process of completing the school assessment for this report and developing the new pilot project for the Safe Schools/Healthy Students initiative the Clark County School District in conjunction with the Clark County Consortium has developed a plan to address the mental health needs of the children within the district. The Consortium supports this plan because the school is a central part of all children's lives and the focus on promotion should have a positive impact on all children while the focus on targeted intervention should better meet the needs of children and families while effectively and cost efficiently integrating school and community resources to meet the mental health needs of these children. The primary goal of the plan is to remove barriers to academic achievement. The objectives are:

- Support for teachers and classrooms to provide improved learning environments.
- Early identification of social-emotional and behavioral needs of elementary school-aged children.
- Increased access to student intervention services (classroom modeling/small group and individual counseling).
- Seamless delivery of services.
- Connect to parents of children with needs.
- Establish linkages to community services.

The plan is to support funding for the addition of 50 positions to provide support for teachers and to manage the Student Intervention Teams (SIT) that will provide the targeted early intervention response for 5,000 elementary school children across the district. The positions are to be filled with a combination of School Psychologists, Social Workers, and contract positions at a cost of $2,700,000. To support the behavioral health promotion activities in the classrooms, $75,000 of instructional supplies is to be purchased and distributed among all employees using a library style system. To support 2,500 hours of teacher involvement in training and planning activities there will be a need for $100,000 in extra duty pay. **The total cost of this plan is $2,875,000. Of this amount, it is estimated that a portion could be recovered through increased federal participation.**

PLAN FOR ADDRESSING JUVENILE JUSTICE MENTAL HEALTH NEEDS. The assessment of needs identified 763 youth within the juvenile justice system who need intensive levels of behavioral health services who are not receiving them. The plan is to implement a pilot project through two of the neighborhood care centers to provide WIN services for 100 of these youth. **To meet the needs of these children through WIN would cost $1,858,900. Of this amount it is estimated that $278,835 could be recovered through increased federal participation.**

[1] These are the requests from last year's plans that were not funded for the coming fiscal year. The CCCMHC feels these should remain priority and will work to get them funded in the future.

PLAN FOR MOBILE CRISIS INTERVENTION SERVICES

Mobile Crisis Intervention Services are needed for the youth with mental health disorders who are at risk for entering the juvenile justice system. Mobile Crisis Services are best deployed through the five neighborhood care centers in Las Vegas.

The Consortium had adopted a model of mobile crisis intervention that provides immediate care from qualified mental health professionals and paraprofessionals to a youth having a psychiatric emergency. Available between the hours of 8 a.m. and midnight, trained staff screen for emergencies by telephone, provide crisis triage, and dispatch a two-person intervention team. Home-based or community-based crisis intervention averaging up to six hours in duration is provided to support the youth's caregiver and decrease the likelihood of hospitalization or out-of-home care. To meet this need for 200 youths per year would cost $124,800[2].

[2] Cost estimate is based on an hourly rate of $104 per hour and an intervention episode of six hours. Hourly rate based on the Nevada Provider Rates Task Force Strategic Plan for Phase II Services, August 15, 2002.