Clark County Children's Mental Health Consortium

Fifth Annual Plan

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Executive Summary

During Fiscal Year 2005-2006, the Clark County Children's Mental Health Consortium has been working to fulfill the legislative requirement of NRS 433B and to strengthen the local partnership working toward an integrated system of behavioral health care for the children and families in Clark County.

Seventeen CCCMHC members and 63 additional Clark County stakeholders, providers, and parents have actively participated in developing this year's plan.

The Fifth Annual Plan addresses the following areas:

- Provides **new** information on the needs of Clark County children with the most serious and life-threatening behavioral health problems.

- Provides **new** information on needs for improved infrastructure to address the behavioral health needs of Clark County's children.

- **Updates** the information about the behavioral health needs of Clark County's children in the child welfare system, the juvenile justice system, and the public school system.

- Provides **specific recommendations** to address CCCMHC's three priority goals for service delivery improvement:

    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.*

The following table summarizes the CCCMHC's Fifth Plan recommendations.

Clark County Children's Mental Health Consortium
Fifth Annual Plan Recommendations

Children With Serious and Life-Threatening Behavioral Health Problems[1]		
Identified Need	**New Funding Actions**	**Desired Outcome**
720 children entering emergency rooms for behavioral health crises and 62% discharged w/o treatment	DHHS fund $986,400 for mobile crisis response & stabilization services to uninsured, underinsured and Medicaid youths admitted to emergency rooms	Reduce unnecessary use of emergency room services Reduce the rate of psychiatric hospitalization for children
878 public school children with behavioral health crises during school hours	CCSD sustain $1,300,000 in funding for district-wide and school-based crisis services developed by the SSHS Initiative	Improve safety at high-risk public schools, More rapid identification of students with the most serious behavioral health needs
Large numbers of children identified by public schools with crisis service needs and no payment resources	DHHS sustain $100,000 flexible funding pool developed by SSHS Initiative	Improve safety at high risk public schools, More rapid treatment for students with the most serious behavioral health needs
32.4% rate of success obtaining ongoing healthcare coverage for uninsured, hospitalized children	DHHS fund $140,656 per year for family support and psychiatric services for this population	Improve rates of healthcare coverage; improve access to aftercare; reduce recidivism
3156 county youths in the juvenile justice systems with serious emotional disturbance that are unserved or underserved	DHHS fund $1,858,900 to expand the Wraparound In Nevada Program (WIN) to serve an average daily census of 100 youths from the Juvenile Justice System	Increase services to youths with SED in the JJ System reduce residential care; improve school functioning; reduce recidivism
Identified Need	**State Agency Actions**	**Desired Outcome**
Too few qualified providers of mobile crisis response and stabilization services	DHHS recruit more providers of mobile crisis response & stabilization services and link services to the Neighborhood Family Service Centers	Reduce unnecessary use of emergency room services Reduce the rate of psychiatric hospitalization for children
40% uninsured children hospitalized in the State Mental Health System unable to access needed aftercare services	Nevada Medicaid explore strategies to expand Medicaid eligibility for the needed aftercare services	Improve access to aftercare services Reduce need for emergency services Reduce recidivism rates
Identified Need	**CCCMHC Actions**	**Desired Outcome**
Over 200 children per year with behavioral health crises are transported to emergency rooms via Legal 2000s	CCCMHC review and support strategies to reduce the use of Legal 2000s, including possible statutory changes	Reduce unnecessary use of emergency room, law enforcement, and ambulance services; Increased parental involvement in crisis services
Long lengths of stay in emergency room and pediatric departments without appropriate treatment for significant numbers of children needing residential care	CCCMHC review and monitor the outcomes for youths with behavioral disorders requiring emergency room admissions	Identify unmet needs for this population Develop recommendations for meeting the needs of this population
Limited access to aftercare services and ongoing healthcare coverage for uninsured, hospitalized children	CCCMHC monitor aftercare services and outcomes	Identify barriers to aftercare services and healthcare coverage; Remove identified barriers

[1] These children are multi-agency involved and need intensive integrated treatment and support.

Clark County Children's Mental Health Consortium
Fifth Annual Plan Recommendations

Children with Emerging Behavioral Health Problems[2]		
Identified Need	**New Funding Actions**	**Desired Outcome**
High rates of suicide ideation and attempts in public high school students	DHHS fund $40,000 to expand depression screenings from 10 to 20 high schools and add parent advocate to screening program	Increase identification and referral for services; reduce rates of suicide ideation and attempts
Large numbers of young children at risk for serious behavioral health problems	DHHS fund $298,000 to sustain the early access program for young children developed by the Safe Schools, Healthy Students Grant	Reduce needs for special education and treatment services upon entry into public schools
Lack of collaborative system management for Neighborhood Family Service Centers	DHHS and Clark County fund $821,053 a collaborative infrastructure for the Neighborhood Family Service Centers	Improve quality and access to services, including integrated front-end services, improved interagency service coordination; Increase efficiency of planning and resource allocation.
Waiting lists for most publicly funded children's behavioral health and social services	DHHS and Clark County expand service capacity in order to staff a sixth Neighborhood Family Service Center	Reduce waiting lists for services Improve access to community-based services Reduce utilization of residential care
Identified Need	**State Agency Actions**	**Desired Outcome**
Lack of specific financing and administrative plan for implementing system management for Neighborhood Family Service Centers	CCCMHC, and other key state and local decision-makers identify a lead administrative entity and financing plan for implementing Neighborhood Family Service Center Collaborative Infrastructure	Create specific implementation plan with timelines and accountable parties
Identified Need	**CCCMHC Actions**	**Desired Outcome**
Collaborative Programs to address teen suicide prevention	CCCMHC serve as steering committee for implementation of the SAMHSA-funded GLS Youth Suicide Project	Enhance effectiveness of program due to involvement by key stakeholders

[2] These children need early access and treatment targeted to specific symptoms and behavioral health problems.

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 Fifth Annual Plan addresses the following areas:

- Provides **new** information on Clark County children's needs for crisis intervention (response and stabilization).

- Provides **new** information on the needs of Clark County's uninsured children hospitalized in state facilities.

- Provides **new** information on needs for improved infrastructure to address the behavioral health needs of Clark County's children.

- **Updates** the information about the behavioral health needs of Clark County children in the child welfare system, the juvenile justice system, and the public school system.

- Provides **specific recommendations** to address CCCMHC's three priority goals for service delivery improvement:

    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 (response and stabilization).*

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

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

Over the last 12 months since the submission of the Fourth Annual Plan, the members of the Clark County Children's Mental Health Consortium have met nine times. Numerous workgroup meetings have also been convened to address the goals set by the CCCMHC.

In last year's Annual Plan, the CCCMHC set three overarching goals for improvement of behavioral health service delivery for Clark County's children. The CCCMHC also requested new funding for specific activities needed to accomplish these goals. The goals and funding requests are shown 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 (CCSD) 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 response and stabilization services

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

Some progress was made in funding **Recommendation 2.2**, through the Medicaid Behavioral Health Redesign approved by the 2005 Legislature. Nevada Medicaid added mobile crisis response and stabilization as a covered behavioral health service, set new rates for the service, and began recruiting providers for the service. **Recommendation 2.1** requested funding for 100 youths to receive intensive, community-based services through a wraparound approach. Although Clark County Juvenile Justice Services added mental health staff to assess and treat offenders placed in detention, there were no additional community-based services developed specifically for this population.

During FY 2005-2006, the CCCMHC formed three workgroups to address the overarching goals described above. Since July 2005, these workgroups have met a total of 20 times. All CCCMHC members and a total of 37 additional community stakeholders have participated in these workgroups, including private providers, family members, and state and local agency representatives. The Workgroup Charters and Participants are shown in **Appendix A.**

Significant accomplishments of the Clark County Children's Mental Health Consortium in fiscal year 2005-2006:

- The Consortium revised its brochure on signs and symptoms of children's behavioral health problems and distributed these brochures and other materials to parents and teachers through hospital emergency rooms, the CCSD, and the local Columbia TeenScreen Program.

- The Consortium sponsored activities to promote National Children's Mental Health Awareness Day, which included a press conference, a proclamation from the Clark County Commission, and distribution of public awareness materials through the media, the press, and the Neighborhood Family Service Centers.

- The Consortium supported ongoing expansion and evaluation of the Center for Health and Learning's local Columbia TeenScreen Program, recognized by President Bush's Freedom Commission as a promising practice for the prevention of youth suicide.[3]

- The Consortium worked with DCFS to support the implementation of the Garrett Lee Smith Youth Suicide Grant awarded to Nevada in October 2005.

- The Consortium continued to support the Children's Mental Health State Infrastructure Grant Project through participation in committees and stakeholders meetings.

- The Consortium served as the Steering Committee to monitor and provide community input to the CCSD's Safe Schools, Healthy Students Initiative.[4]

- The Consortium collaborated with Medicaid in providing support and education to potential providers of new Medicaid Services.

- The Consortium collected and disseminated information on crisis intervention services available in Clark County for children with mental health problems.[5]

Significant Progress achieved toward improving local behavioral health service delivery:

- DCFS expanded the infrastructure and capacity of the WIN Program by funding permanent state positions to provide the wraparound facilitation for children in the Child Welfare system. Supervisory and management positions were also added to the program budget.

- DCFS also expanded wraparound service coordination for children in parental custody by adding nine psychiatric caseworkers to the Neighborhood Family Service Centers.

- Clark County Department of Family Services added four clinical positions with new State funding to provide assessment and support to foster children placed in higher levels of care.

[3] For more information, see Appendix E
[4] For more information, see Appendix F
[5] For more information, see Appendix H

- Clark County Department of Juvenile Justice Services received County funding to add five clinical positions and a half-time psychiatrist to provide behavioral health services to juveniles in their detention facility.

- The CCSD has increased training for intervention teams, school wide training in positive behavior supports, and improved response to intervention data tracking to guide decision-making.

- CCSD's Safe Schools, Healthy Students Initiative has developed a well-articulated behavioral health response system for students and their families that includes school-based, district-based and 17 community service providers. Preventative and direct services have been provided to pre-school and school age children and families in eight at-risk catchment areas. The district-wide CCSD Threat Assessment/Crisis Response Team has been expanded and strengthened.[6]

- The CCSD has trained at least 100 school intervention teams to address behavioral health issues, trained at least 35 school-based teams in the use of positive behavioral supports, developed innovative approaches to identify children with learning disabilities, and improved data tracking so as to be able to identify students with emerging behavioral health problems.

- Medicaid received funding to support their behavioral health re-design and began recruiting additional providers of community-based behavioral health services for children; including family-to-family support and mobile crisis response and stabilization services.

[6] For more information, see Appendix F

METHODS FOR ASSESSING CHILDREN'S NEEDS

For the Fifth Annual Plan, the CCCMHC reviewed the past four Annual Plans and developed five areas of needs assessment for review by the Consortium on an ongoing basis. The First Annual Plan focused on children in the Child Welfare system. The Second Annual Plan added a focus on youth in the Juvenile Justice system. In the Third Annual Plan, CCCMHC developed a vision and plan for an overall integrated school system including a school-based assessment. In its Fourth Plan, the CCCMHC focused on the need for suicide prevention services for Clark County's High School Students.

Following a review of the children's behavioral health needs assessments conducted for each of the four previous annual plans, the CCCMHC identified the following six areas of need for ongoing monitoring:

- Needs of Clark County's Children for crisis services and early intervention
- Needs for Clark County's Children in Public Schools
- Needs for Children hospitalized in the State Mental Health System
- Needs for Children in the Medicaid System
- Needs for Children in Child Welfare System
- Needs for Children in Juvenile Justice System

Through collaboration with its member organizations, the CCCMHC has developed standardized needs assessment indicators and data-gathering protocols for each target population described above. These standardized indicators and protocols will allow the CCCMHC to address the needs of each population on an annual basis as well as annually monitoring the community's progress in meeting these needs through service delivery improvements. For a complete description of the needs assessment indicators and data-gathering protocols for each target population, please see **Appendix B**.

CHILDREN'S NEED FOR BEHAVIORAL HEALTHCARE SERVICES

Nationally, the Surgeon General's Office highlighted the need to improve behavioral health services for children in its National Action Agenda published in 2001.[7] Whereas the U.S. Department of Health and Human Services has reported that two-thirds of children with any diagnosable disorder are not getting needed treatment, the Surgeon General's Report focused on 10% of all children who have the most serious behavioral health problems, estimating that as many as 80% were not receiving needed treatment.[8]

Are They as Healthy as They Look?

Figure One.

The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration reports that at any given time, one in every five young people is suffering from a mental health problem. Two-thirds are not getting the help they need.

Earlier studies by the CCCMHC have confirmed that Clark County's children face the same plight as other children with behavioral health problems across the country. Moreover, the rapid population growth in Clark County presents additional challenges in meeting the needs of these children.

The Surgeon General's National Action Agenda highlights the fact that there is no primary behavioral health system for children. Where services may exist for children, they are fragmented and very difficult for families to navigate.

[7] U.S. Surgeon General National Action Agenda for Children's Mental Health. Washington, DC. Government Printing Office, 2001.
[8] http://www.mentalhealth.org

CRISIS INTERVENTION NEEDS

What are the needs of Clark County's children for behavioral health crisis services and how well are these needs being met?

In 2005, there were at least 720 youths admitted to UMC and Sunrise Emergency Rooms for serious and life-threatening behavioral health problems.[9]

The majority of these youths were adolescents.

A large number of youths (31.6% in 2006 ytd) in mental health crises are being transported to local emergency rooms via legal 2000s, utilizing ambulance and law enforcement resources.

100% received an assessment of their mental health disorder. Private facilities such as Spring Mountain Treatment Center and Montevista provided free emergency room-based assessments for youths admitted to emergency rooms for behavioral health problems.

62% or 449 youths were discharged home without any treatment. These youths and their families were provided referral information upon discharge, but there was no follow-up to determine how many actually were linked with needed community-based services.

Lengths of stay in emergency rooms for Medicaid and Uninsured children (whether discharged home or admitted to a psych facility) were significantly longer than stays for other youths.

52 children were admitted to UMC's pediatric unit for lack of any appropriate inpatient psychiatric placement. Emergency room staff noted that unavailability of placement or payment resource resulted in some children remaining in the pediatric unit for up to 70 days without the benefit of any behavioral health treatment.

UMC Emergency Department Staff identified the need for emergency room diversion and specialized residential care as top priorities for this population. Emergency room personnel noted that emergency room services for this population places an unnecessary burden on already busy emergency room departments without providing any benefits to the children seen.

[9] See Appendix C

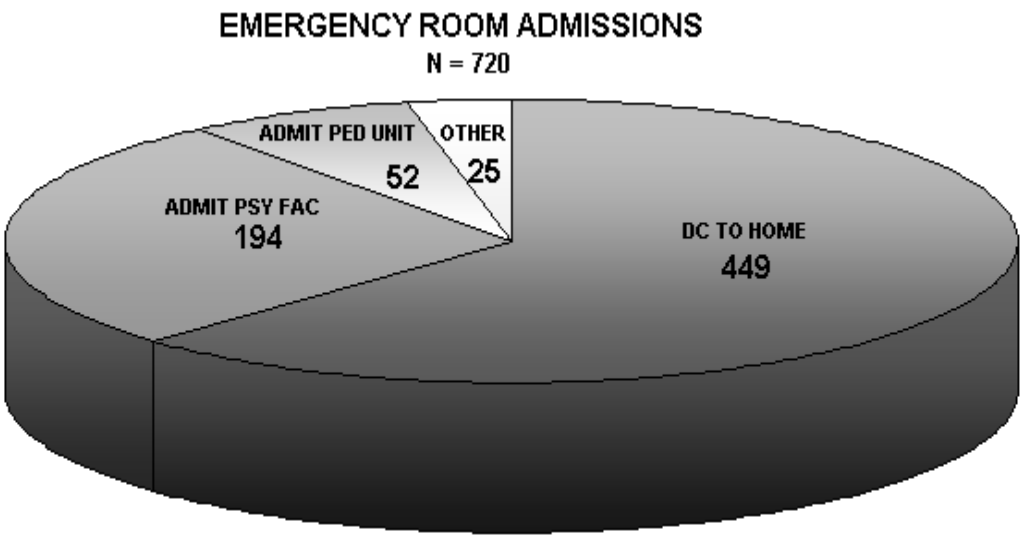

Figure Two. Disposition of the estimated 720 youths following UMC and Sunrise emergency room visits for behavioral health problems in 2005.

NEEDS OF PUBLIC SCHOOL CHILDREN

What are the behavioral health needs for children in public schools and how well are these needs being met?

- Increasing numbers of youths in public schools need immediate Crisis Services. During the 2005-2006 school year, CCSD provided mental health assessment, crisis response or short-term services to 878 students. Of these students, 161 youths were referred to the school-wide crisis team with life-threatening mental health problems, representing a 100% increase over the previous school year. Many of the services being provided are funded through a federal grant which ends July 31, 2006.[10]

- All school children need access to screening and universal behavioral health promotion activities. 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. Of the estimated 291,510 children in the public school system needing universal health promotion activities, less than 10% are receiving these behavioral health promotion services.[11]

[10] See Appendix F

[11] Clark County Children's Mental Health Consortium Third Annual Plan, 2003.

- 19.3% of all elementary school students need some level of behavioral health services and 6.0% need intense integrated services. Of the 27,245 children within the public elementary schools who need early access to behavioral health interventions, 69% or 18,799 children are receiving no school or identified community-based services.[12]

- 6.0% of all elementary school students need intense integrated behavioral health services such as wraparound. Of the 8470 public elementary school children needing this level of service, 62% or 5251 are receiving no school or identified community-based services.[13]

- 27.8% 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, 2005). This same research found 15% of all high school students had seriously considered attempting suicide, 16.4% have made a suicide plan, 8.7% have actually attempted suicide, and 3.2% had required medical attention following the suicide attempts. These percentages all represent improvements over the 2003 Nevada Department of Education Report.

- 14% of high school students screened during the 2005-2006 school year by the Clark County TeenScreen Program were identified as at risk of suicide due to clinically significant levels of depression.[14] Fewer students were identified this school year as compared to the 2004-5 school year (31%). These differences are most likely due to the demographic differences in participating schools between the two school years.

- During the 2005-2006 school year, 48% of high school students identified at risk of suicide by the TeenScreen Program received no known follow-up treatment.[14] This is an improvement over the 2004-2005 school year when 54% of identified students were never treated. A survey of parents suggested that even when treatment was recommended, they did not see the value of professional assistance or did not want to coerce their child into participating in treatment.

- 15.9% of the students eligible for the TeenScreen Program were never screened due to lack of permission from parents.[14] Although this is a significant improvement over the 2004-2005 school year when 37% of parents refused to participate, this year's follow-up suggested that parents and youth 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.

[12] Clark County Children's Mental Health Consortium Third Annual Plan, 2003
[13] Clark County Children's Mental Health Consortium Third Annual Plan, 2003
[14] See Appendix E

NEEDS OF UNINSURED CHILDREN IN STATE FACILITIES

What are the needs of children requiring hospitalization in the State Mental Health System and how are these needs being met?[15]

- **Of an estimated 250 children admitted to Desert Willow Treatment Center in 2005, 96 were uninsured or underinsured.** Nevada Medicaid subsidizes care for these children only while they are placed in a public inpatient facility under a "family of one" option. Upon discharge, these children are no longer eligible for Medicaid benefits under this option.

- **39.5% or 38 of these uninsured children did not receive all the services recommended for them at discharge.** Aftercare services are designed to support the child to function adequately at home, at school and in the community.

- **31.6% or 30 of uninsured children required emergency services within a few months following discharge.** Children with serious behavioral health problems are likely to need re-hospitalization or other emergency services on a recurring basis.

- **65.8% or 63 of these high-risk, uninsured children still were without benefits after discharge.** Without benefits, these children are much less likely to receive the services and supports needed for their families to maintain them at home.

NEEDS OF CHILD WELFARE CHILDREN

What are the needs of children in the Child Welfare System and how well are these needs being met?

- **Previous studies by the CCCMHC[16] have indicated that 85.3% of abused/neglected children need some level of behavioral health services and 40% need intensive levels of community-based supports.** These prevalence rates are consistent with national prevalence figures for abused/neglected children.

- **In 2004[17], the CCCMHC found that the number of children and youth in foster care with severe emotional disorders receiving no services decreased from 13.0% to 2.4%** due to implementation of the WIN Program. Similarly, the proportion of foster children and youth who were underserved has decreased from 46.1% to 11.9%.

- In contrast, the 2004 CCCMHC Plan found that **70% children involved in the Child Welfare System but not yet in foster care are underserved, and 43.8% of these children with SED** are receiving no behavioral health services.

[15] See Appendix D
[16] Clark County Children's Mental Health Services Second Annual Plan, 2003
[17] Clark County Children's Mental Health Consortium Third Annual Plan, 2004

Over the past year, the Clark County Child Welfare Services has experienced a tremendous growth in the number of children requiring their services. The expansion of the WIN Program by the 2005 Legislature and the implementation of the Medicaid Behavioral Health Redesign in 1/2006 will help meet the needs for providing early access to services for this expanding population. Unfortunately, no data are currently available from the State or County to help assess the community's progress in meeting these needs.

Unmet Needs in Public Systems

	Receiving Appropriate Level of Services	Under Served	Children with SED receiving no Services
Clark County School	17.4%	82.6%	62.9%
Clark County Child Welfare	30.0%	70.0%	43.8%
DCFS Child Welfare	88.1%	11.9%	2.4%
Juvenile Justice	28.9%	71.1%	36.7%

Figure Three uses the data from the Child and Adolescent Level of Care Utilization System Screening of 2715 children and youth in the child welfare, juvenile justice and school systems in Clark County compared to the types and amounts of services received to determine how well the need is being met for children and youth in these public systems.

NEEDS OF JUVENILE JUSTICE CHILDREN

What are the needs of the juvenile justice population and how well are these needs being met?

- **79% of the juvenile offenders have a diagnosable disorder and need some level of behavioral health services.**[18] These figures are consistent with national prevalence rates for the juvenile justice population.

- **54% or 8601 of Clark County's Juvenile Offenders have serious behavioral health problems and need intensive levels of community-based services.**

- **36.7% or 3156 of those juvenile offenders with serious behavioral health problems are receiving no behavioral health services.**

[18] These figures are based on a 2003 CCCMHC study published in the Third Annual Plan

In the past two years, behavioral health screening, assessment, and services have been expanded for youths with behavioral health problems in Clark County Juvenile Detention, as well for youths with behavioral health problems committed to state correctional facilities.

Nonetheless, youths residing in the community have difficulty accessing appropriate mental health services though the Neighborhood Family Service Centers due to high-risk behaviors and co-occurring substance abuse problems. Additionally, there are no services designed to provide wraparound service coordination to juvenile offenders with serious behavioral health problems.

NEEDS OF MEDICAID CHILDREN

What are the needs of the children covered by Medicaid and how well are their needs being met?

- In 2002-2003, the CCCMHC estimated that less than 28.3% of children in the AFDC Medicaid population with behavioral health needs were receiving services.

- In 2002-2003, lack of community-based services resulted in 86.3% of Medicaid funding spent on high cost residential care for less than 5% of the children who need services.

The CCCMHC recommended a redesign of Medicaid's Behavioral Health Services to improve access to community-based services for children with behavioral health needs. The 2005 Legislature approved Medicaid's Behavioral Health Redesign Plan, which was implemented January, 2006. The CCCMHC has collaborated with the Nevada Medicaid Program to identify key measures of progress in addressing the unmet needs of this population (see Appendix B). Unfortunately, these data are not yet available.

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 crisis intervention services, targeted case management and family-to-family support services make this problem even worse.

The expansion of wraparound facilitators for child welfare children and parental custody, Medicaid-eligible children has significantly improved care coordination for these populations, but this service is not yet available for many uninsured children and for youths in the juvenile justice system.

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 current methods of access mean that parents of children with serious behavioral health problems 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 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 remains 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 had intermittent periods of employment and unemployment. The medical coverage for the siblings has vacillated between fee-for-service 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 which 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 Four. 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.

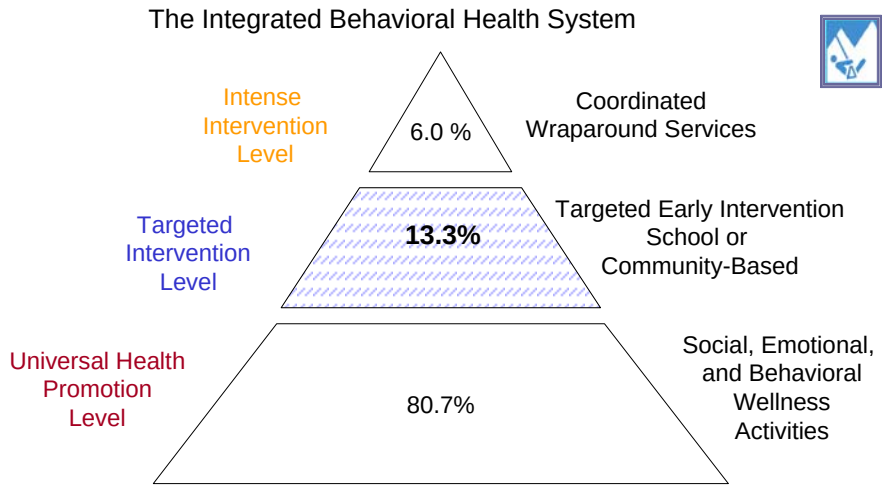

Figure Four New Picture of School – Community Interaction. This diagram shows the community strategy to address the mental health needs of children in the public school system in Clark County. For all students, the strategy will be to provide supplemental classroom supports to teachers to create classroom 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 (response and stabilization) services. Within the school system this would include a range of group and individual services. Outside the school system this would include linkage with Neighborhood Family Service Centers for services such as family support, mobile crisis, and early childhood 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.

An integrated infrastructure is needed to support this model of 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.

The **Neighborhood Family Service Center** service delivery model has been adopted in Clark County to provide the infrastructure to support effective, integrated service delivery. The purpose of the Neighborhood Family Service Centers is to provide: (1) one stop service centers for families in the communities where they live; and (2) collaborative, integrated services for families accessing services across multiple public child serving agencies. Neighborhood Family Service Centers target children and families who need public behavioral health and other social services.

The Child Welfare League of America and the Robert Wood Johnson Foundation have identified the lack of interagency and cross-agency coordination and communication as the most troubling barrier in providing quality care for these vulnerable children and families. These families typically have multiple and complex needs, yet face "daunting economic challenges and must navigate a maze of eligibility requirements, multiple service delivery locations, and inconsistent expectations in fragmented local social service systems."[19]

The Clark County Neighborhood Family Service Center model offers a local blueprint for integrating systems of care as advocated by the Child Welfare League and the Robert Wood Johnson Foundation.[19]

The current five Neighborhood Family Service Centers include the following partners:

State of Nevada Division of Child and Family Services
Division of Health, Nevada Early Intervention Services
Clark County Department of Family Services
Clark County Department of Juvenile Justice Services
Family Resource Centers
Nevada Parents Encouraging Parents
CCSD

The Centers are administered by the Neighborhood Family Service Centers' **Administrative Team** comprised of the Deputy Administrator of the Division of Child and Family Services, the Director of the Department of Family Services, the Director of the Department of Juvenile Justice Services, the Program Manager of Nevada Early Intervention Services, Grants Manager for Family Resource Centers, the CCSD Executive Director of Special Education and Support Services, and Executive Director of Nevada Parents Encouraging Parents.

[19] Hornberger, S., Martin, T. & Collins, J. Integrating Systems of Care: Improving Quality of Care for the Most Vulnerable Children and Families. Washington, DC: CWLA Press, 2006

Neighborhood Family Service Centers have the potential to provide the following support for children and families who rely on public behavioral health and social services:

- Integrated system entry/access
- Integrated Screening and Assessment
- Integrated Outreach and Referral
- Integrated Crisis Management at the Service Delivery and Systems Level
- Family and Youth Involvement in planning, management, and monitoring
- Interagency tracking and evaluation
- School Linkage
- Community Linkage, i.e., partnership-building, volunteers, public awareness
- Flexibility and resources to add more centers

In order to provide these critical functions, Neighborhood Family Service Centers need the following administrative components:[20]

- Formal and locally-based collaborative governance at the policy and financing level established by legislation, executive order, or memorandum of agreement
- Governance includes authority to manage and allocate shared resources
- Financing structure that allows for pooled resources to support collaborative functions
- Governance Structure assumes shared liability across systems for a defined target population
- Day-to-Day management of the collaborative process at each Neighborhood Family Service Center, including the management of the physical facilities
- Integrated case coordination for the target population (Triage and Wraparound)

The Clark County Children's Mental Health Consortium has identified the following barriers to implementing the necessary infrastructure for the Neighborhood Family Service Center Model:

- There is no staff support for the local administrative team
- Local administrators do not all have the final authority to pool resources
- Physical facilities management done by different agencies
- There is no integrated funding to develop a single access point, family support function, or crisis management functions
- There is no staff or other support for interagency tracking and evaluation
- There is no integrated funding to develop community and school linkages, volunteer programs, or public awareness programs

[20] Pires, S.A. Building Systems of Care: A Primer. Washington DC: National Technical Assistance for Children's Mental Health, 2002

Figure Five shows a proposed integrated service delivery infrastructure for the Neighborhood Family Service Centers.

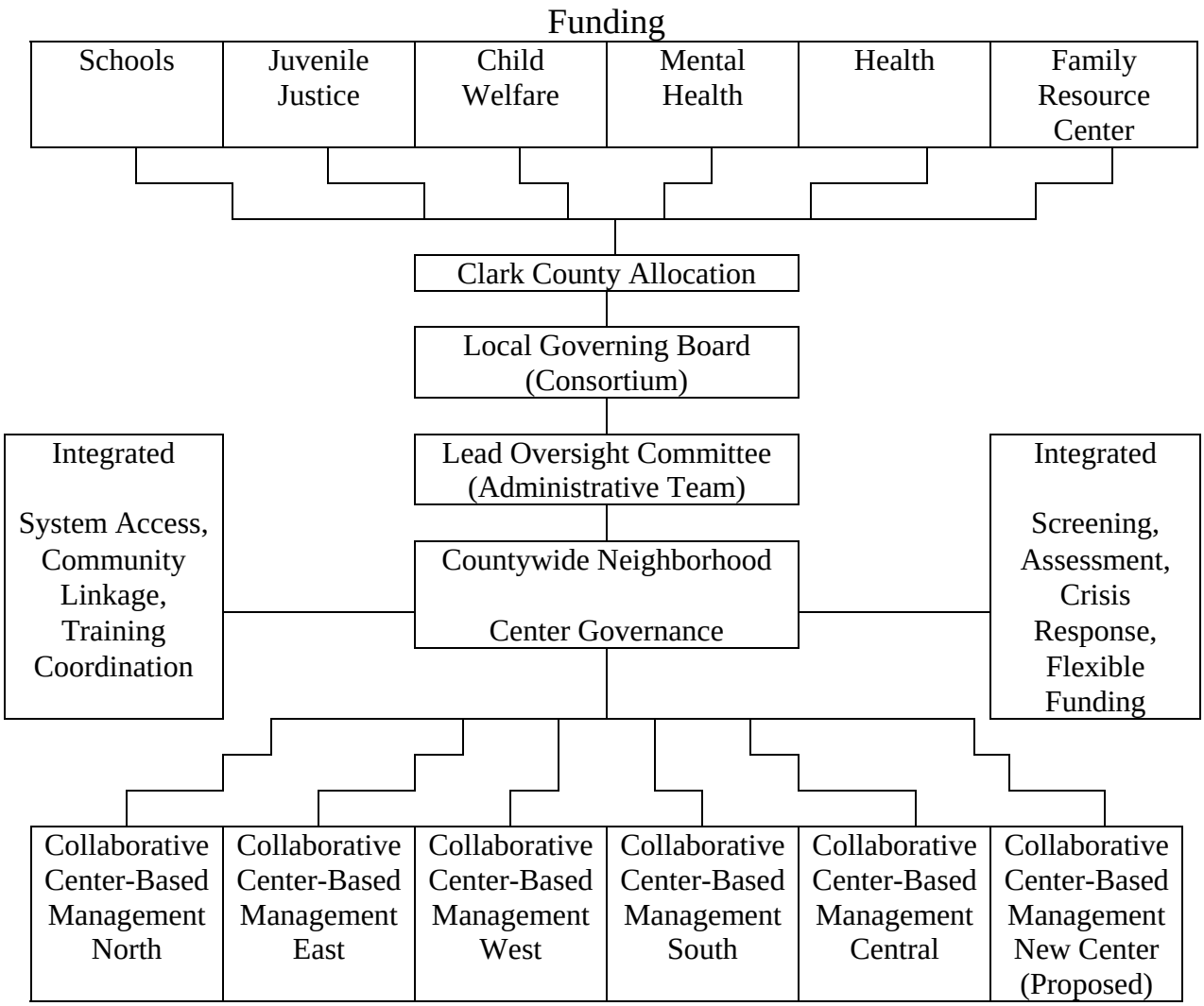

Figure Five shows the proposed Neighborhood Family Service Center Infrastructure

The proposed structure would be governed by a local board or administrative team. While each agency partner would retain their own service providers and budget, some funds would be pooled for key collaborative functions. Countywide collaborative governance would include an executive director, quality assurance and fiscal/grants management staff, and resources for interagency training coordination. Each center would require a collaborative governance structure to include a center manager and to provide integrated system access, community linkage, and integrated screening assessment for multi-agency-involved youth.

Other collaborative functions supported by joint funding would include integrated crisis response and an integrated flexible funding pool.

RECOMMENDATIONS

The Surgeon General's Office identified at least three priorities for improving the nation's behavioral health services for children: (1) the need to promote more public awareness of children's behavioral health issues, (2) the need to increase early identification and treatment services; and (3) the need to improve coordination of services for children with behavioral health needs.

The CCCMHC has followed the U.S. Surgeon General's lead and set three overarching goals for improvement of behavioral health service delivery for Clark County's children. The goals are listed below with specific recommendations for this year's plan:

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

   A. Recommend that the CCCMHC serve as a steering committee to support and oversee the implementation of the Garrett Lee Smith Youth Suicide Prevention Project.

   B. Recommend that DHHS use $40,000 in funding to support TeenScreen services in ten additional Clark County high schools and to provide a parent advocate for the screening program.

   C. Recommend that DHHS seek $298,000 in new funding to sustain the early access program for young children developed by the Safe Schools, Healthy Students Grant.

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

   A. Recommend that DHHS seek new funding for mobile crisis response and stabilization services to an estimated 720 youths yearly to divert these youth from emergency room services and unnecessary hospitalization at a cost of $986,400.

   B. Recommend that providers of mobile crisis services be recruited to serve both Medicaid, underinsured, and uninsured youths and that the services be linked to the Neighborhood Family Service Centers.

   C. Recommend that the CCCMHC review and support strategies to reduce the use of legal 2000s, to include possible statutory changes.

   D. Recommend that the CCCMHC review and monitor outcomes for youths requiring emergency room services for serious behavioral health problems.

   E. Recommend that CCSD use grants or other funds to sustain the current level of vital district-wide and school-based crisis services at a cost of $1.3 million.

F. Recommend that DHHS seek $100,000 in new funding to sustain short-term flexible services to public school students in crisis. These funds have been previously provided by the Safe Schools Healthy Students Grant which ends July 31, 2006. In the future, these funds should be administered by and deployed through the Neighborhood Family Service Centers.

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

A. Recommend that DHHS seek $1,858,900 in new funding for expansion of the WIN Program to provide intensive, community based services to an average daily census of 100 Clark County juvenile offenders.

B. Recommend that Nevada Medicaid explore strategies to expand Medicaid eligibility to cover aftercare services for youth exiting the state's psychiatric hospital (Desert Willow Treatment Center).

C. Recommend that DHHS seek $140,656 in new funding to provide psychiatric and family support services for uninsured youths exiting the state's psychiatric hospital (Desert Willow Treatment Center).

D. Recommend that the CCCMHC monitor aftercare services and outcomes for uninsured youths hospitalized at the state's psychiatric hospital (Desert Willow Treatment Center).

E. Recommend that the state and county seek funding to expand service capacity in order to staff a sixth Neighborhood Family Service Center.

F. Recommend that the state and county seek $821,053 in new funding to support a jointly-funded, collaborative infrastructure for the Neighborhood Family Service Centers.

G. Recommend that in collaboration with the CCCMHC, key state and county decision-makers identify a lead entity to administer the Neighborhood Family Service Centers and develop a plan for financing and implementing the collaborative infrastructure identified by the CCCMHC.

For specific details on funding recommendations, see Appendix G.

Appendix A
Workgroup Participants and Charters

Workgroup Participants

The CCCMHC extends its appreciation to the following individuals who participated in workgroup activities during the 2005-2006 fiscal year:

Robert Borders	Donna Jaegers	Anita Post
Ramona Brinson	Sally Jost	T. J. Rosenberg
Stella Bryskin	Sandal Kelly	Joy Salmon
Tom Criste	Viki Kinnikin	Lisa Santwer
Cynthia Escamilla	Daniella Kurcz	Linda Tanner-Delgado
Tammy Ewing	Joanne Libertelli	Darlene Terrill
Natalie Filipic	Nancy Lindler	Valerie Tines-Braggs
Linda Flatt	Barbara Ludwig	Yolanda Trevino
Matt Gyger	William P. Miller	Jodi Tyson
Rich Harrison	Maikwe Parsons	Barb Urdey
Kim Hungerbolt	Christa Peterson	Rosemary Virtuoso
Joy Ifill	Ann Polakowski	Gary Waters
		Alethea Zavitz

Workgroup Charters

During the 2005-2006 fiscal year, the CCCMHC formed three standing workgroups to address the three overarching goals of the Consortium. The Charter for each workgroup is shown below:

Workgroup #1: Public Awareness and Behavioral Wellness

Workgroup #1 will focus on improving public awareness of and support for behavioral health services and skill building activities that promote behavioral wellness.

Goal 1. Develop and implement strategies to recognize the importance of the mental health of children and reduce the stigma of using mental health services

Action Step 1. Develop and implement strategies for dissemination brochure and information from Annual Plans.

Action Step 2. Develop speaking points for community presentations.

Action Step 3. Reproduce executive summary of each Annual Plan.

Action Step 4. Hold a press conference to disseminate findings of Annual Plan.

Action Step 5. Survey Providers listed in CCCMHC Brochure and solicit feedback.

Goal 2. Build Awareness and engage the community in strengthening the systems of meeting the emotional and behavioral needs of children.

Action Step 1. Engage school officials in a collaborative process to improve school-based services (Counseling, Safe School Program, and Nursing).

Action Step 2. Provide findings of Annual Plan to CCSD Board of Trustees.

Action Step 3. Engage consumers, agencies and local businesses to support CCMHC.

Workgroup #2: Crisis Services and Early Intervention

Workgroup #2 will focus on improving access to needed mental health services with initial efforts focusing on improved crisis services and early intervention.

Goal 1. Improve access to existing crisis services through increased coordination and consumer awareness.

Action Step 1. Identify and describe existing crisis services and develop a flow chart for accessing these services.

Action Step 2. Develop a resource directory or website to educate consumers and providers about crisis services.

Action Step 3. Facilitate communication and information sharing between child-serving agencies with clients in crisis through court orders or other agreements.

Action Step 4. Develop interagency staffing committee to overcome barriers to crisis services in the most difficult cases or when demands for crisis services exceed capacity (e.g., hospital or RTC beds).

Goal 2. Improve early access to services through increasing the number and type of providers of these services.

Action Step 1. Work with Nevada Medicaid to identify and engage potential providers of crisis intervention services.

Action Step 2. Develop strategies for increasing the number of psychiatric services providers, to include the training of nurse practitioners.

Action Step 3. Support the CCSD in implementing a school-based early access model utilizing walk-in counselors, nurses, and/or other school personnel.

Goal 3. Explore use of wraparound with juvenile probation and youth parole populations in Clark County.

Action Step 1. Monitor the current utilization of and unmet need for wraparound with the juvenile probation and youth parole population.

Workgroup #3: Infrastructure and Coordination

Workgroup #3 will focus on Improving the infrastructure and coordination across and within systems.

Goal 1. Improve the state infrastructure for children's mental health services.

Action Step 1. Provide local representation and input for state infrastructure project workgroups and action teams.

Action Step 2. Provide reports and updates to the CCCMHC on activities related to the State Infrastructure project.

Goal 2. Provide meaningful needs assessment information for effective annual planning by the CCCMHC.

Action Step 1. Develop and prioritize performance indicators for annual needs assessment.

Action Step 2. Review and evaluate assessment tools and strategies utilized by the CCCMHC and its member organizations.

Action Step 3. Develop and implement strategies to obtain needs assessment information.

Goal 3. Increase the CCCMHC's effectiveness in facilitating local improvements in children's mental health service delivery.

Action Step 1. Review recommendations from the CCCMHC's annual plans and update progress toward implementing these recommendations.

Action Step 2. Identify barriers to fully implementing recommendations made by the CCCMHC's annual plans.

Action Step 3. Develop and implement marketing strategies to help gain external support for implementing CCCMHC recommendations.

Action Step 4. Identify other organizations and groups who support the implementation of the CCCMHC's recommendations.

Action Step 5. Develop and implement communication strategies with other local groups/ organizations with similar goals to the CCCMHC.

Action Step 6. Determine legislative reporting responsibilities of the CCCMHC in collaboration with other local consortia.

Appendix B
Ongoing Needs Assessment Indicators

Target Population	Data Source	Needs Indicator
Children in the Child Welfare and Juvenile Justice Systems	Self-report by Agency	% children in public care needing outpatient and intensive services (CPS, Foster Care, JJ) % served, underserved , unserved
Children in the Medicaid System	Medicaid Database	Inpatient vs. community-based service utilization by Medicaid HMO, Fee-for-Service, and Checkup Clients Utilization of residential treatment center bed days (in-state and out-of-state) by various types of Medicaid recipients Utilization of Medicaid services by zip code, age, ethnicity, gender, length of stay, co-morbidity, and custody stratus Data on Medicaid Behavioral Health Denials, and Appeals Utilization of multiple aid codes by recipients.
Children in the Public School System	CCSD database	# students identified w/emotional/behavioral disorders by the district-wide crisis intervention team. # students referred to district-wide student intervention teams
Children in the Public School System	TeenScreen Report	# Children engaged in TeenScreen # Children screened positive #Children served, unserved, underserved Satisfaction with services
Children with serious behavioral health crises	Self-report by Hospitals	#Children admitted to hospital emergency rooms for suicide attempts; other mental health problems; disposition types; % legal 2000s; lengths of stay by payor source
Uninsured children hospitalized in the state inpatient facility	Survey of youths discharged from DWTC	#uninsured youths admitted to inpatient care needing aftercare services

Appendix C
Survey of Emergency Room Admissions

Purpose of the Survey. As part of the needs assessment for the CCCMHC's Fifth Annual Plan, information was gathered from the emergency room departments of the two largest hospitals in Clark County serving the pediatric population. Emergency Room Managers from University Medical Center and from Sunrise Children's Hospital provided quantitative and qualitative data on youths admitted to emergency rooms for serious and life-threatening behavioral health problems.

The CCCMHC's Workgroup on Infrastructure and Coordination received feedback from the emergency room managers, law enforcement representatives, psychiatric hospital staff, and stakeholders which suggested that an increasing number of youths in Clark County are being admitted to emergency rooms for serious behavioral health problems.

Emergency room personnel suggested the youths admitted for behavioral health problems expended relatively more emergency room resources than other emergency room admissions. Additionally, emergency room services for these youths did NOT result in better access to needed behavioral health services.

Survey Methods. Emergency Room Managers at the two hospitals were asked to provide the total number of admission for youths under 18 years of age for calendar year 2005. Other information requested included the following:

Total number of readmissions
Disposition of each admission
Pay Source for each admission
Diagnosis for each admission
Legal Status of each admission (e.g., Legal 2000)
Length of stay for each admission

Survey Results. University Medical Center provided data for eleven months of 2005 (January 1, 2005, to November 30, 2005). Extrapolation was used to estimate annual data for 2005. Sunrise Children's Hospital provided data from January 1, 2005, to December 31, 2005. These data were combined to provide the total estimates shown in the Plan.

Table 1 below shows the number and percentage of admissions by disposition for each hospital and across both hospitals.

Table 1. Disposition of Youth Emergency Room Admissions

Disposition	University Medical Center		Sunrise Children's Hospital		Both Hospitals	
	Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Discharged Home	169	46.4%	280	78.6%	449	62.3%
Transfer Psychiatric Unit	127	34.9%	67	18.8%	194	26.9%
Transfer Pediatric Unit	52	14.3%	0	0	52	7.2%
Other	16	4.3%	9	2.5%	25	3.5%
Total Admissions	364	999%	356	99.9%	720	99.9%

Only Sunrise Hospital was able to provide lengths of stay data by payor source. These data are shown in Table 2.

Table 2.		RANK				COUNT			DISPOSITION				LOS	TOTAL	DISTRIBUTION				
		PAT	LOS	REM	DIF	F	M	PAT	EXP	HOM	TRN	OTH	OUT	LOS	NEONA	PEDI	ADOL	ADULT	GERI
AMA	Against Medical Advice																		
	03 MEDICAID					1		1		1				1			1		
	08 PPO						2	2		2				2			2		
	09 MANAGED MEDICAID					1		1		1				1			1		
	99 SELF PAY					1	1	2		2				2			2		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
AMA	Against Medical Advice TOTAL	4	2			3	3	6		6				6			6		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
HHS	DISCH C/O HOME HEALTH SR																		
	07 HMO					1		1		1				5		1			
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
HHS	DISCH C/O HOME HEALTH SR TOTAL	8	6			1		1		1				5		1			
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
HOM	ROUTINE HOME/SELF CARE (																		
	03 MEDICAID					#	33	56		56				62		18	38		
	05 COMMERCIAL					3	4	7		7				8		1	6		
	06 CHAMPUS					2	3	5		5				5		1	4		
	07 HMO					#	22	52		52				52		11	41		
	08 PPO					#	37	86		86				89		16	70		
	09 MANAGED MEDICAID					16	17	33		33				34		10	23		
	10 FEDERAL						1	1		1				1			1		
	15 CHARITY					2	3	5		5				5			5		
	99 SELF PAY					18	17	35		35				67		6	29		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
HOM	ROUTINE HOME/SELF CARE (TOTAL	1	4			#	#	##		280				323		63	217		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
MV	MONTE VISTA (65)																		
	03 MEDICAID					2	6	8				8		8		1	7		
	05 COMMERCIAL						1	1				1		1		1			
	06 CHAMPUS						1	1				1		1			1		
	07 HMO						1	1				1		1		1			
	08 PPO					4	4	8				8		8		2	6		
	09 MANAGED MEDICAID					2	1	3				3		3		1	2		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
MV	MONTE VISTA (65) TOTAL	3	3			8	14	22				22		22		6	16		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
OTH	DISCH ANOTHER TYPE FAC (																		
	03 MEDICAID					1		1			1			1			1		

Table 2.		RANK				COUNT			DISPOSITION				LOS	TOTAL	DISTRIBUTION				
		PAT	LOS	REM	DIF	F	M	PAT	EXP	HOM	TRN	OTH	OUT	LOS	NEONA	PEDI	ADOL	ADULT	GERI
	08 PPO					1		1			1			1			1		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
OTH	DISCH ANOTHER TYPE FAC (TOTAL	5	8			2		2			2			2			2		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
PSY	XFR TO PSYCH. FACILITY (																		
	03 MEDICAID					7	10	17				17		29		6	11		
	07 HMO					1	3	4				4		4			4		
	08 PPO					4	6	10				10		10		1	9		
	09 MANAGED MEDICAID					5	2	7				7		7			7		
	99 SELF PAY					2	3	5				5		11		1	4		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
PSY	XFR TO PSYCH. FACILITY (TOTAL	2	5			#	#	43				43		61		8	35		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
PSYELO	PE Psychiatric Elopeme																		
	08 PPO						1	1		1				1			1		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
PSYELOPE	Psychiatric Elopeme TOTAL	7	7				1	1		1				1			1		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
WC W	ESTCARE - DETOX (05)																		
	99 SELF PAY					1		1			1			1			1		
						---	---	---	---	---	---	---	---	-----	----	-----	-----	-----	----
WC	WESTCARE - DETOX (05) TOTAL	6	1			1		1			1			1			1		
------	----------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-------	-----	--------	------	------	------	------	-----
						---	---	---	---	---	---	---	---	---- -	---- -	----	-----	-----	-----	----
GRAND	TOTALS					#	#	##		288	3	65		421 3		78	278		

Neither hospital was able to provide legal status data for 2005, however, University Medical Center provided legal status data for the first quarter of 2006 as shown in Table 3. These data suggested that nearly a third of the emergency room admissions were made via the Legal 2000 process.

Table 3. University Medical Center
2006 First Quarter Youth Emergency Room Admissions by Legal Status and Disposition

Disposition	Voluntary		Legal 2000		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Transfer to Psychiatric Facility	14	21.5%	16	53.3%	30	31.6%
Transfer to Pediatric Unit	8	12.3%	5	16.7%	13	13.7%
Discharged Home	41	63.1%	9	30%	50	52.6%
Other	2	3.1%	0	0%	2	2.1%
Total Admissions	65	68.4%	30	31.6%	95	100%

Neither hospital was able to provide specific diagnostic data for review by the CCCMHC. However, the CCCMHC hopes to monitor the diagnostic characteristics of those 52 youths requiring admission to UMC's Pediatric Unit for lack of other residential resources to meet these children's needs.

Conclusions. The survey results suggest that Clark County children are being unnecessarily served by local emergency rooms at a tremendous cost that results in relatively few benefits. The majority of youths admitted were discharged home without any immediate behavioral health treatment.

Other communities have been successful in reducing such emergency room admissions through use of mobile crisis response and stabilization services. Mobile Crisis Response and Stabilization Services can be successful in providing immediate assessment, crisis response and stabilization of youths with serious behavioral health problems without tying up critical emergency room resources.

The availability of mobile crisis response and stabilization services can also significantly reduce the need for psychiatric inpatient treatment.

The growing use of the Legal 2000 process to transport youths in crisis appears to be a reaction of the community to the lack of responsive, community-based services. Further review of this process is necessary to relieve the burden it places on emergency room services.

Appendix D
Survey of Aftercare Needs for Youths Served by Desert Willow Treatment Center

Purpose of the Survey

Children with serious behavioral health problems often require hospitalization in order to prevent harm to self or others, and to reduce acute symptoms resulting from conditions such as schizophrenia, post-traumatic stress disorder, and bipolar disorder. Desert Willow Treatment Center provides short-term hospitalization and residential care to youths with the most serious and life-threatening conditions. Nearly 40% of youths served by DWTC are uninsured or underinsured at the time of hospitalization. Medicaid subsidizes the care of these youths while in the hospital under a benefit called "family of one."

Aftercare services are one of the factors associated with successful outcomes for hospitalized youths with serious behavioral health problems.[21] CCCMHC members reported anecdotally that some families' members experience difficulty in accessing aftercare services following their youth's hospitalization. Uninsured and underinsure families are typically referred to DCFS programs at the Neighborhood Family Service Centers for aftercare services. However, DCFS does not provide a full range of aftercare services. For example, DCFS does not directly provide day treatment services for these youths, but may refer to private providers in the community.

The purpose of conducting this survey was to assess families' access to needed aftercare services following discharge from Desert Willow Treatment Center

Survey Methods

It is estimated that Desert Willow Treatment Center served approximately 100 "family of one" youths on a yearly basis. A total of 58 "family of one" youths were discharged from Desert Willow Treatment Center between July 2005 and February 2006. These youths were selected as the target population for the survey.

During April 2006, DCFS staff developed a six-item telephone survey to address some of the issues pertinent to aftercare services. During April 2006, DWTC staff successfully contacted the parent or legal custodian of 38 of the 58 "family of one" youths in the sample. Staff completed the survey instrument with each family in a telephone interview. Families were asked to rate each item on a five-point scale. Families were also asked to provide open-ended comments in response to each item. Attempts to contact the remaining 20 families were unsuccessful.

[21] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Survey Results

Table 1 shows the distribution of the survey respondents by Desert Willow Treatment Center Unit. Seventeen of the respondents were from the Adolescent Acute Unite (AAP). Six respondents were from the Children's Acute Unit (CAP). Thirteen respondents were from the two Residential Treatment Units (RTC1 and RTC2). Two respondents were from the Specialized Adolescent Treatment Center Unit (SATP).

TABLE ONE. PARTICIPANTS BY PROGRAM UNIT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	AAP	17	44.7	44.7	44.7
	CAP	6	15.8	15.8	60.5
	RTC1	7	18.4	18.4	78.9
	RTC2	6	15.8	15.8	94.7
	SATP	2	5.3	5.3	100.0
	Total	38	100.0	100.0	

Table 2 shows the lengths of stay for the youths of families participating in the survey.

TABLE TWO. PARTICIPANTS BY LENGTHS OF STAY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	< 1 MO	13	34.2	34.2	34.2
	1-3 MO	17	44.7	44.7	78.9
	3-6 MO	4	10.5	10.5	89.5
	6-9 MO	3	7.9	7.9	97.4
	9-12 MO	1	2.6	2.6	100.0
	Total	38	100.0	100.0	

Table Three shows the responses for each of the six items on the survey.

TABLE THREE. RESPONSES FOR EACH SURVEY QUESTION

HOW IS YOUR CHILD DOING SINCE HE/SHE WAS DISCHARGED?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	POOR	7	18.4	18.4	18.4
	FAIR	8	21.1	21.1	39.5
	GOOD	7	18.4	18.4	57.9
	VERY GOOD	9	23.7	23.7	81.6
	EXCELLENT	7	18.4	18.4	100.0
	Total	38	100.0	100.0	

SINCE DISCHARGE, HAS YOUR CHILD NEEDED ANY EMERGENCY OR RESIDENTIAL SERVICES?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	12	31.6	31.6	31.6
	NO	25	65.8	65.8	97.4
	DK	1	2.6	2.6	100.0
	Total	38	100.0	100.0	

IS YOUR CHILD RECEIVING (HAS RECEIVED) ALL SERVICES RECOMMENDED AT DC FROM DWTC?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	23	60.5	60.5	60.5
	NO	15	39.5	39.5	100.0
	Total	38	100.0	100.0	

TABLE THREE. RESPONSES FOR EACH SURVEY QUESTION (CONT'D)

HOW WOULD YOU RATE THE SERVICES THAT YOUR CHILD IS NOW RECEIVING?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	POOR	4	10.5	10.5	10.5
	FAIR	1	2.6	2.6	13.2
	GOOD	6	15.8	15.8	28.9
	VERY GOOD	7	18.4	18.4	47.4
	EXCELL ENT	11	28.9	28.9	76.3
	NA	9	23.7	23.7	100.0
	Total	38	100.0	100.0	

HAVE YOU APPLIED FOR MEDICAID AND/OR OTHER INSURANCE SINCE YOUR CHILD'S DC FM DWTC?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	14	36.8	36.8	36.8
	NO	24	63.2	63.2	100.0
	Total	38	100.0	100.0	

DO YOU CURRENTLY HAVE MEDICAID AND/OR OTHER INSURANCE COVERAGE?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	13	34.2	34.2	34.2
	NO	25	65.8	65.8	100.0
	Total	38	100.0	100.0	

Table Four shows the open-ended comments provided by survey respondents by Program Unit.

TABLE FOUR AFTERCARE SURVEY OPEN-ENDED COMMENTS

AAP Comments

- Son has improved, still has issues. Has only spent night once in last 7-8 months.
- "Dr. didn't care what I had to say." "My child is a schizophrenic. He's 18 years old, needs adult mental health."
- "Want to give a big thumbs up to entire staff at DWTC. They were very professional and handled tough situations very well."
- Medication issue should have been evaluated better. Meds made her a total zombie. Mother feels diagnosis was wrong.
- When at DWTC, wish they would have informed her better about what was going on. Didn't see therapist for almost a week and didn't tell her about abnormal blood work- "But it turned out not to be a big deal."
- He visits grandparents now, and is doing well living with mother.
- Didn't follow up with therapy. Provider wanted $80.00 a session several times a week and she can't afford that. Still has Medicaid bills from stay at DWTC—copays or what insurance didn't pay for her "self-mutilation" dx.
- DWTC seemed to be getting somewhere with her, she was opening up, but then asked for a pass and ran away. States she wouldn't be accepted back at DWTC because of no insurance. On March 18th she got a nasty email from her granddaughter saying "leave me alone" Grandma continues to write e-mails to her asking her to come home, thinks she is staying with a girlfriend.
- First two weeks did well, up to two months okay, then met up with friends/ stopped taking meds/ started doing drugs. She returned home and has an appointment with a therapist at DCFS.
- He is learning to pull himself out of his bad days. Services at DWTC is really good. He's doing well and very thankful to the staff at DWTC. IT took him a few times of going to DWTC to finally realize what he is capable of.
- Parent recommended to give more help to the families about the condition of the kid, because it's very hard to deal with the child. DWTC was very supportive to her , but she thinks they let him out too soon, and more intensive therapy would have helped. He could have used a little bit more 1:1 time and group talking. He's doing great now, and DWTC was wonderful.
- Just found out that prior to moving to NV, pt was living in TX and she was sexually abused and she never told anyone. She is dealing with that now with her counselor. Parent was very happy with DWTC. Pt has her ups and downs but she is doing much better now.
- Father is very concerned of kid's behavior and feels helpless. He attended one therapy session only and ran out of medication. Father would like him to go back to DWTC but he hasn't done self-harm or harm to others.

CAP Comments

- "Best care he received in 8 years." "Better presentation of the Top of the Mountain program" Parents generally intimidated and lost in the system. Would be effective if they teamed with parent advocates to guide them through services.

- In DWTC three times. DWTC assumed it was child abuse – accused parents of child abuse. Found out he has FAS. Put their other kids "through a lot w/CPS interviews." "We had a really bad experience with DWTC." That's why he's in a private psychiatric facility now. States DWTC told her husband he wasn't a good parent. States their son was "catered to" (played games, loved it) and feels staff was biased towards them and took their son's side, believed he was abused. States he was rehospitalized at DWTC after attacking police officer and mother, the staff upon admission had him go play video games. Mother said he wanted to come back to DWTC to play games and have fun.

- "Everything went fairly well." "I was very pleased with what DWTC had to offer. I'm not sure what worked but he is fine now."

- The parent is going to put her in community childcare, so she goes to school. She hasn't pushed Medicaid or disability because of her income, she was denied.

SATP Comments

- "Doing very well." "We appreciate what DWTC did for him."

RTC II Comments

- DWTC said they would do neuropsych testing but nobody did it, can't get anyone to do it. Attitude after DWTC is much better.
- "They screwed us as a family, they tricked us into taking her out, said if she did poorly they will take her back" and when she called to ask to take her back, DWTC said "no." Said she wrote a letter to TX team and they still refused to take her back. "It is negligence" they have thought about getting a lawyer, DWTC left them "high and dry." States she has lost her job, quit her job to take care of her and get Medicaid. "I have nothing good to say about DWTC."
- DWTC never finished aftercare referral to Mojave. "Everything fell through." Found a psychiatrist and therapist who takes Medicaid on her own. My experience with DWTC: I would never recommend it to anyone. I didn't like how therapy was handled. Therapist kept pushing wrong issues. I expected more from DWTC. "I was sadly disappointed." One technician was very supportive and helpful, that's it.
- Prefers DWTC to other psychiatric facilities in the community. " I really feel like he benefited the most from being at your place." Thinks the staff were "great."
- Patient told mom there are really cool things in Reno RTC, Mom wonders how he knows these things, and if he's trying to push to go back. "Was really good at DWTC. He knew how to play the people in DWTC. Intake coordinator doesn't call back, so she gave up. He doesn't want to take his meds, he keeps beating around the bush with his meds. He feels he doesn't need it. When he doesn't take his meds, he's a total different person.

RTC I Comments

- " I think the services we received at DWTC were very beneficial."
- "The probation officer is helping contact drug diversion programs available for my daughter after discharge, is 8 months depending on where she is going to live."
- "There are less services for children than adults." "Got no services after discharge from DWTC." Treatment at DWTC was okay/helpful. Parent was told they would get rehab skills and insurance said no. She is waiting until he is 17 and a half to get adult mental health treatment. They have no coverage because of trying to change to FFS. States she makes too much money on disability. He got taken off NV Checkup.
- Treatment at DWTC was "excellent." Immediately received follow-up services with outpatient psychiatrist and therapist at the West site, very pleased.
- Thought DWTC tx was good. "Say thank you to everyone for me/us."
- "Was spoiled by the clinician." Thinks the clinician is "great." Thinks DWTC was great.

Conclusions

Over 60% of families reported that their youths were functioning at a good to excellent level. In spite of these positive outcomes, nearly one-third of the youths still required emergency or residential services during the aftercare period. Nearly 40% of families reported that they were not able to access all the needed aftercare services. Of greatest concern, two-thirds of the youths remained uninsured during the aftercare period.

Lack of insurance benefits was often cited by the families as a barrier to receiving needed aftercare services. Families also requested family to family support to help find and access needed services and benefits.

Appendix E
Evaluation and Assessment of the Clark County TeenScreen Program 2005-2006[22]

Overview

This evaluation and assessment is the final report of activities of a mental health screening program conducted in Clark County, Nevada and the second such evaluative process conducted under the sponsorship of the State of Nevada, Department of Health and Human Services, Division of Child and Family Services. The first evaluation was conducted in fiscal years 2004-2005, and this report encompasses the academic years of 2005-2006. This report reflects parental responses to an adolescent mental health screening, referral and treatment service conducted in part by the Center for Health and Learning in conjunction with the Columbia TeenScreen Program and offered in the CCSD (Las Vegas, Nevada) primarily in high school health classes. The University of Nevada-Las Vegas and various other community partners, organizations and health service providers also participated in this program during the 2005-2006 academic year.

Program Service Summary

Listed below is a summary of key activities of the program over the past year and includes statistical indicators of participation by students, teachers and schools.

1.	Suicide /depression education lectures provided	61
2.	Students offered assessment screening in ninth-grade health classes	9212
3.	Students participating in screening	7743
4.	Number of students who were "positive" to the screening*	621
5.	Students recommended for further mental health services	357
6.	Number of hours of no-cost counseling /therapy provided to students	1301
7.	Number of students who refused services beyond screening	98
8.	No shows for professional services	74
9.	Students who received some form of clinical services from program staff**	581
10.	Students referred to health providers for nonmental health service***	89
11.	Teachers and instructional personnel trained in intervention services	48

*Describes the number of students whose score on the assessment/screening survey indicated a potential need for additional health services-specifically mental health services related to adolescent depression and possible suicidal ideation.

**Includes ALL services, clinical interview following screening, 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.

NOTE: Survey formats used for the initial assessment and subsequent clinical appraisal were the Columbia TeenScreen questionnaire, the SOS-Screening for Mental Health questionnaire. The Beck Depression Inventory (BDI), a standardized clinical instrument, was also used in select clinical interviews with students following initial screening. The BDI was used as a comparative tool for research and quality assurance purposes.

Methodology and Construction of the Parental Survey

[22] Final Report prepared for State of Nevada, Department of Health and Human Services, Division of Child and Family Services. Gary Waters, MSW, Ed.S., Center for Health and Learning, www.healthlearning.org, June 2006

The survey conducted this year, as in the past year, focused on parental responses to inquiries regarding their perceptions and experiences with the array of services offered and/or received by them during the 2005-2006 academic year. The quality of the services was a primary interest, as were the level of the family ability to access care services recommended and the perception of the quality of care received in the multiple levels of services available to children and families through this program.

The survey questionnaire split responders into main two categories, those that consented to the mental health screening of their child and those that did not. The survey did not collect information from parents who did not respond, affirmatively or negatively, to the request for parental consent.

All parents who consented to the mental health screening of their child were asked four preliminary questions. If their responses were negative or "No" to two questions: "Did you find the TeenScreen process helpful to you?" AND "Does your child have insurance benefits to cover the cost of mental health services?", they were not required to complete Questions 5 through 18 and were directed to go directly to Question 19. All surveys included basic voluntary information on race, ethnicity, gender, student and parent identifying information, and the assurance of strict confidentiality.

Survey Item Assessment and Clarification

In the previous survey, the parental direction inserted after Question 4 and prior to Question 19 indicated the information to be obtained in Questions 19-21 were "ONLY" if their child had not received mental health services in the past year. This question seemed most relevant if continued services were recommended by screening staff at the conclusion of the clinical interview each child received if their screening score indicated a potential mental health problem may exist. Left unaltered, the previous survey could potentially exclude parents whose children were screened but were "negative" to the need for further mental health care.

Because this survey was distributed to parents whose children screened both "Positive" and "Negative" to the need for further mental health care, the parental directions this year were clarified so that all parents answered Questions 1-4 and only parents whose children screened "positive" were asked to complete Questions 5-21. There is a concern that the previous survey did not adequately reflect the perceptions of parents whose children were "Negative" in the screening process – as the previous survey does not seem to differentiate between these two important data sets.

Questions for Parents Who Consented to Mental Health Screening

The survey for parents who consented to screening consisted the introductory four questions that were to be answered "Yes" or "No." Thirteen questions (Questions 5-16) and Question 20, with subquestions "a" through "h" required parents to respond on a five-level scale from "Strongly Agree" to "Strongly Disagree." "Strongly Agree" carried a weight of five scale points and "Strongly Disagree" carried a weight of one point. Questions 17, 18, 19, 20-i, and 21 were

questions requiring a written narrative response. Questions 19 and 20 a-i were specifically focused on parents who agreed to screening but had not received mental health services.

Questions for Parents Who Did Not Consent to Mental Health Screening

Parents who did not provide written parental permission to participate in the mental health screening program were asked four questions in which the scaling was identical to those who consented to screening with one question for narrative completion and one question a "Yes" or "No."

Parental Survey Collection Process

654 parents were accessed through voluntary information provided through the parental consents distributed to students at the onset of the program. This consent process provided for the name, address and contact information to be voluntarily provided to program (screening) personnel. Participation in the program of screening was not required of anyone, and in some cases the parental consent forms for permission to participate in the screening process were not returned by the parents making contact with them difficult or impossible. Parental consent forms were the primary source of information by which the evaluation and assessment survey was distributed to parents. If information on the parental consent form indicated a contact telephone number, personal contact was made to parents who did not respond within 15 days of distribution of the survey to encourage their participation and/or to obtain survey information verbally over the telephone. Mailing of parental surveys began on April 3, 2006. The first response was received on April 12, 2006 the last response was received June 5, 2006. 312 surveys were returned and/or contact made with parents. Approximately 17% of the survey contacts were conducted by telephone.

Total Mailings	654
Errors (address incorrect/family moved)	121
No response	221
Returned	312

Findings

Respondent information regarding race, ethnicity and gender data is not yet tabulated. Of the responses received as of June 5, 2006, the following data has been obtained:

Survey Data for All Screened Students*

1. Did you find the TeenScreen process helpful to you? Y= 174 /N= 45
2. Does your child have insurance benefits to cover the cost of mental health services? Y= 223 / N= 89
3. Is your child currently receiving mental health services? Y= 32 / N= 157
4. Has your child received any mental health services in the past year? Y= 23 / N= 97

*Some parents did not answer all questions

Survey Data for Students Recommended for and Participating in Continued Therapeutic Care

Scale: Strongly Disagree (1) Disagree (2) Undecided (3) Agree (4) Strongly Agree (5)

5. Overall I was satisfied with the services my child received. 4.5
6. The location of the services was convenient for us. 4.6
7. I helped to choose my child's treatment goals and type of therapy. 1.8
8. I participated in my child's treatment. 3.5
9. The provider treated me with respect. 4.8
10. The provider respected my family's religious/spiritual beliefs. 3.1
11. The provider communicated in a way that was easily understandable. 3.4
12. The provider was sensitive to my cultural/ethnic background. 4.1
13. Following mental health services, my child became better at handling daily life. 3.2
14. Following mental health services, my child got along better with family members. 2.4
15. Following mental health services, my child did better in school. 3.4
16. Following mental health services, my child was better able to cope. 3.1
17. What was the most helpful thing about the mental health services you received? (May check more than one response)
    1. Knowledge of community resources 156
    2. Knowing my child needed help 43
    3. Support for health needs 65
    4. Being able to speak to someone 7
    5. Knowing somebody cared about my child other than the family/parents 14
    6. Having a resource for my child through school 9
    7. Child feeling better about school environment 21
    8. Issues my child is struggling with were noticed and addressed 121
    9. No cost help 154
    10. Understanding and caring by others 117
    11. Better understanding of my child's needs 57
    12. Did not feel it was especially helpful 4
    13. I already knew (or suspected)this information bout my child 36
    14. No response 79

18. What would improve the mental health services you received?
    1. Closer to home
    2. Evening hours
    3. Language assistance (central African dialect)

Survey Data for Students Recommended for but Did Not Receive Continued Therapeutic Care

19. My child did not receive mental health services for the following reasons:
    1. My child did not want to participate 4.1 (68)
    2. I felt my child did not need services 4.3 (23)
    3. The agency/provider was not able to start services when we needed them 1.4 (2)
    4. The location of the services was not convenient for us 1.2 (5)
    5. The services were not available at a time convenient for us 1.3 (8)
    6. The fee for services was not affordable for us 1 (3)
    7. We had difficulty communicating with the provider 1.6 (4)
    8. The paperwork was too confusing to complete 1.1 (3)

20. Describe what would have been most helpful for your child and family at the time your child was screened.
    1. More about services available to my child and the family 11
    2. Help with legal problems 1
    3. Help with academics of my child 9
    4. Understanding school rules and procedures 4

Survey for Unscreened Students

1. I did not feel my child needed to be screened. 4.2
2. My child did not want to participate. 4.5
3. I prefer not to share this type of information with school personnel 4.8
4. I was not fully aware of the process and purpose of information collected (and could be sharing it with school personnel or others) 3.1
5. Please write other reasons your child did not participate here. (summary)
    1. Family privacy
    2. None of your business
    3. I do not want the school involved in my family in this way
    4. We are taking care of this ourselves
    5. Prefer not to say
    6. No reason, I just do not want to participate
6. Would you like to receive information about having your child screened in the future? Y= 2 / N= 31

Summary

The following key summary findings are offered for further study and consideration:

1. The process of intervention appears helpful to parents.
2. Insurance benefits may not have a drastic effect on access to care.
3. Students are powerful elements in selecting whether or not to participate in the program.
4. Parents will support students in their decision to participate, or not.

5. Parents and students are reluctant to disclose mental health information or history with anyone, especially school personnel, regardless of a strong emphasis and assurances of confidentiality and privacy.
6. Many parents are aware of and know how to access community mental health services.
7. Parents and students appear to like and can access referrals made to them for continued care.
8. Ethnicity and communication in the delivery of therapeutic services does not appear problematic.
9. Parents appear to have a favorable impression of the care their child received.**
10. Parents do not report or verbalize administrative problems or difficulties in accessing the process of assessment, screening, referral or after-care.

**It is important to note here that this is the perception of the parents and does not mean their child is actually doing better in school or has been able to obtain more effective coping skills. This is simply a parental perception, not definitive and documented health improvement.

Summary Process Comments

The Columbia TeenScreen Program has been implemented exactly as it has in two previous years. The selection of training and screening personnel, identification of sites to be offered screening, site –based training of school personnel, and the actual screening process are identical to previous years and in compliance and alignment with the standards set by Columbia University in accordance with the terms of usage of the screening instrumentation in Nevada. However, this year, the screening instrument has become a longer instrument for students to process during the screening event. Columbia University introduced an improved and expanded screening tool, and the entire staff was trained on this instrument and its usage by Columbia University personnel in September, 2005. The new instrumentation contains all of the original questions and clinical criteria; however there are several new pages of follow-up questions which demand greater student attention and time on task to complete. As such the process of screening has been slowed slightly from previous years. The new instrumentation usage standards are a 2005 requirement of the Columbia TeenScreen Program administration within Columbia University.

This program has received a significant amount of attention and support from school administration within the schools in which screening occurs. As the impact of this program on parents perceptions may be affected by strong organizational supports. In addition, regional administrative leadership throughout the CCSD is becoming increasingly aware of this program. This is the second year that a school, new to the screening process and screening events, has independently requested TeenScreen at their school.

Issues for Further Study or Review

This survey of parental perceptions was based largely on the process of obtaining parental consent and responding to it with additional questions related to program quality. In the process of delivery of this program by staff and the parental survey of quality of the program it became clear that the concept of informed consent should be visited. A program of this magnitude and scope depends heavily on the establishment of trusting relationship with both parents and youth.

The law, and various program guidelines, has attempted to promote this relationship by creating a format and protocol for protecting parents and care providers and thereby establishing certain privileges embedded in the concept of informed consent and the consenting process. It is essential for the program and staff to be certain they have communicated all of the essential facts regarding the process in which consent is to be obtained. Only when parents and students are fully and duly informed are both parties assured that the fundamental trusting relationship exists. To this end, the necessary elements of informed consent, as viewed by this program staff are:

Capacity

The parents and youth must be able to understand what they are consenting to, including the consequences which could be applied in all foreseen circumstances. Further study of the concept of capacity would help refine program efforts to assure that parents and students are truly capable of the process of consent.

Knowledge

The parents and youth should know the range of risks and benefits of the program, including its boundaries and limitations, including the alternative assessments and procedures available to them from program providers or community resources. While every possible risk may not be known, it is accepted they cannot fully be disclosed. However, every effort should be made to inform parents and youth of all risks of participation especially as it pertains to involuntary disclosures and involvement of other persons or agencies in individual or family matters should questions be responded to in certain ways. Further examination of how students determine what is best for them seem appropriate as they each need to be informed about the full range of potential participation in a program of this type involves.

Voluntary

Parents and youth should never be coerced into participation in this program, and as such, "incentives" for participation are not appropriate. The concept of true and informed consent is severely compromised when pressure from incentives are linked to participation in the program. This could be viewed as "buying" clients or participants and could be viewed as coercion, especially if a person has some degree of diminished capacity as a result of the very illness or behavioral attribute which the program is intending to assess. Studying the motivation for participation of students and parents is most appropriate to insure that participants are not manipulated by outside issues or internal and unstated needs of program developers or originators.

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Appendix F
Report on the Safe Schools Healthy Students Initiative

INTRODUCTION

In 2001, the Nevada State Legislature passed Assembly Bill 1, which amends Chapter 433B of the Nevada Revised Statutes. This bill established a mental health consortium in every county with a population of 100,000. In Clark County, a twelve-member Mental Health Consortium began its work with collaboration with the CCSD in submitting a grant proposal to the U.S. Departments of Education, Justice, and Health and Human Services to establish a 'Safe Schools/Healthy Students' (SS/HS) Program. In mid 2003, the three-year grant was awarded with the program administered by the CCSD under the guidance of the present Southern Nevada Children's Mental Health Consortium. The program is about to embark upon its fourth year of activities under a no-cost extension.

PROGRAM THEORY, GOALS, AND OBJECTIVES

The program theory is that . . . "If a complete system for assuring safe schools and coordinating mental health service delivery is designed and implemented, comprehensive and effective services may be delivered to students and families. In this way schools will become safer and students in schools will be healthier, thus helping schools to meet their educational goals and allowing students, to profit more fully from their educational experiences."

The goal of the project is to:

Develop and implement a comprehensive, sustainable system of prevention, assessment, intervention and treatment programs and services to enhance the safe and healthy development and learning of children, youth, and families.

This goal is approached through working toward objectives under seven related elements of the program, including activities to:

- Create and maintain safe school environments so that acts of violence by students will be reduced, and students parents and staff will perceive schools as safe and secure learning environments.

- Prevent and reduce substance and drug and alcohol use in schools.

- Implement a system that identifies children, youth, and families who are in need of preventive and/or treatment intervention services, provides timely access for each of the identified youth or family members to appropriate, affordable mental health services within the school or community, and ensures that students identified as threats to self or others receive mental health assessments and appropriate treatment and services.

- Implement a system that identifies pre-school children from high-risk families who are in need of services for psychosocial or emotional development problems, supports family members and childcare providers of pre-school children with psychosocial and emotional development problems, and, provides effective intervention and treatment services for identified pre-school children.

- Modify/design and implement safe school policies through the school improvement process as well as provide recommendations for district-wide safe school policies.

- Develop a plan to sustain safe school environments and an integrated mental health services delivery system.

PROGRAM MANAGEMENT AND SERVICE DELIVERY

The CCSD Safe Schools/Healthy Students Initiative is conducted under the auspices of the District's Office of School Safety and Crisis Management [OSSCM]. The program is overseen by the OSSCM Director and managed by an SS/HS Program Coordinator. Program staff consists of six school-based Student Success Advocates, five licensed counselors, six psychologists, and a team of seven counselors and psychologists who specialize in pre-school and early childhood issues.

The SS/HS Program provides threat assessment/crisis response and follow-up services to all schools in the district and offers mental health identification, referral and treatment services, group prevention/early intervention programs, and other support services to students and families at eight at-risk schools in two administrative regions. The eight program schools include four elementary schools, two middle schools and two high schools.

Threat Assessment/Crisis Response Services. Each Threat Assessment Team consists of SS/HS-based counselors and psychologists, with cooperation with other CCSD personnel, including school administration, school police, and school staff. A student identified as being in crisis or as posing a threat to others is immediately evaluated by a SS/HS Threat Assessment Team and a treatment and follow-up plan is developed and implemented for psychiatric, psychological, counseling, mental health and/or substance abuse treatment services for the student and family. These services may be provided by SS/HS staff, other CCSD personnel or by community-based agencies under contract with SS/HS.

Mental Health Service Delivery Systems for School-Age and Pre-School Children and Families. The SS/HS Program has established a Mental Health Service Delivery System for students at the eight participating schools and for pre-school students and families who live in the geographic region of the schools. The major focus of this program element is to identify high-need and/or at-risk students and families and to provide them with appropriate programs and services.

A key aspect of the system is a network of 17 community-based agencies who provide mental health, social and other support services for those students and families who may not be appropriately assisted by SS/HS licensed staff or other CCSD personnel.

Student Success Advocates [SSAs] are assigned to these schools, as are specific SS/HS licensed staff members. The SSAs act as the gatekeepers to services and may assist the school staff in obtaining services, refer students to SS/HS counselors and/or psychologists, assist students and families in accessing resources and/or provide direct referral to community agencies under contract with SS/HS. SS/HS licensed staff may provide mental health services to students and families at each school in conjunction with SSAs and school-based staff, and/or may refer the students to cooperating agencies, as appropriate.

Licensed SS/HS staff members offer group prevention/intervention programs to students at the elementary and middle school levels addressing social behavior, violence, bullying, and substance abuse [in cooperation with CCSD Safe and Drug-Free Schools Program]. In addition, SS/HS counselors provide counseling groups at the elementary and secondary levels that address anger management, reduction of violent behavior, resiliency, and other individual issues.

Early Intervention Programs

The SS/HS Early Childhood Mental Health Service Delivery System is offered in conjunction with the State of Nevada Department of Child and Family Services. Early childhood counselors are based at four participating elementary schools and offer mental health services to families and pre-school/kindergarten children within the geographical areas of these schools. Services include parent-infant home visiting, mental health counseling, and prevention and/or counseling groups in the areas of effective parenting, social skills, and child care.

Development of Safe School Policies In addition to these direct service programs, SS/HS management is working with regional administrators and principals to create safer school environments and to develop school-based policies and procedures to maintain and enhance safety of children in schools.

PERFORMANCE

Since its inception in 2003, the SS/HS Program has provided effective mental health and other support services to a number of students and their families. Each year has seen significant increases in the number of programs offered and individuals served. With the advisement of the Southern Nevada Children's Mental Health Consortium, an unprecedented cooperative system of service delivery has been developed with the State of Nevada Department of Child and Family Services, other state, county, and CCSD-based agencies, private and nonprofit agencies, and other community-based services

Levels of Service

During the past school year, the SS/HS Program provided services and referrals to individuals and families, as follows:

	Threat Assess./Response	Individual Mental Health Services	Prevention/ Counseling Groups	TOTALS
Threat Assessment Team Responses	425	--	--	425
SS/HS Licensed Staff	--	454	146	600
		School-Based Mental Health Services	**Parent-Infant Home Visits**	
Early Childhood Staff	--	325	67	392
		Support/ Referral Services		
Student Success Advocates	--	421	--	421

The data show that staff of the SS/HS Program provided a variety of mental health services to students and their families in the eight participating schools and district-wide, as needed. One hundred forty-six students participated in group counseling or prevention programs at their schools, and 67 parents of infants received home visiting services. The SSAs at the eight participating schools provided services to 421 students by offering initial support, making referrals to the SS/HS Program or other appropriate community-based resources or agencies and acting as an informational resource to the students and their families. The Threat Assessment/Crisis Response Team responded to 425 calls from schools throughout the district.

Performance Indicators

In order to determine changes in school safety climate, level of substance use and level of destructive acts, school disciplinary records [SASI, Deans' Database, hand counts] are used to determine number of incidents in 20 categories, including 'Substances Prohibited to Possess or Use,' Acts Against Persons,' and 'Acts Against Property.' In addition, CCSD Police Incident

Records are used to determine the number of violent incidents serious enough to warrant police intervention at the request of the school principals.

A review of this past school year's disciplinary reports (up to January 2006) involving acts against persons and property shows that the incidence of this type of behavior has continued to decline at the schools. The exceptions are slight increases in the incidence of aggressive physical contact among students at one middle school and the occurrence of vandalism at the two elementary schools. During this period, school administrators and deans at the program schools have noticed a leveling off or decrease of obvious substance use and drug-related activity at their sites, a finding supported by a review of related disciplinary incidents at the schools.

Principals and key staff at each of the program schools have noted that, because of the SS/HS program and the presence of the SSAs at the schools, the students now have immediate access to adult assistance as needed. School counselors and teachers have stated that the SSAs and SS/HS licensed staff persons have provided invaluable resources in identifying students in need of services and have helped to reduce the time between problem identification and delivery of appropriate services.

Each elementary school principal has stated that the SS/HS Early Childhood Program has been especially helpful by providing community-based resources, and social and mental health services in support of families of pre-school and kindergarten children as the children start their schooling.

Surveys were administered to school staff members to receive their judgments regarding services provided by the Threat Assessment/Crisis Response Teams for a sample of 66 crisis cases. The respondents were unanimous in rating the services as timely and either 'good' or 'exceptional.' From 86% to 93% of the respondents reported that the team quickly responded to their needs, that the provision of crisis services was comprehensive, and that communication and assistance to staff was appropriate and helpful. Seventy-one percent agreed that the team provided effective assistance in helping the school get back to normal functioning after the incident in question. All parents who completed a questionnaire regarding the effectiveness of threat assessment/crisis management services regarding their children were satisfied with the services provided, and all school administrators felt that the Threat Assessment Team facilitated cooperative working relationships between families and schools.

Student Performance Indicators

Pre- and post-service changes in academic performance, attendance and number of disciplinary incidents were analyzed for a sample of 400 students who were provided SS/HS services during the 2005-2006 school year. In reviewing this information, it should be noted that many of the students had experienced poor grades due to their mental health problems, and had exhibited significant negative behaviors prior to inclusion in the SS/HS Program. This information shows that the students have reversed or at least checked those trends.

This information is supported by parents whose children participated in the SS/HS 'School Violence Intervention/Prevention Program,' all of whom reported significant improvement in their children's behavior and attitudes toward violence.

GRADES	Improved	Lower	Same
	51%	6%	43%
ATTENDANCE	**Improved**	**Worse**	**Same**
	32%	13%	55%
NUMBER OF DISCIP-LINARY INCIDENTS	**Fewer**	**More**	**Same**
	42%	16%	42%

In conclusion, the Safe Schools/Healthy Students Program in conjunction with the efforts of the Children's Mental Health Consortium has set up and reinforced a system of care that has impacted students and their families who have encountered mental health needs within this community. As a "seed" program, these efforts have demonstrated the importance of a system that will address and provide mental health support to students and their families. A positive impact is evident in educational performance. Surveys underscore the positive perceptions and outcomes. Continuation of the program will benefit children with mental health needs and their families in the schools as well as within the community.

Appendix G
Funding Requests for Plan Recommendations

<u>Recommendation 1B.</u> Recommend that DHHS use $40,000 in funding to support TeenScreen services in ten additional Clark County high schools and to provide a parent advocate for the screening program.

In October 2005, the Nevada Division of Child and Family Services received a three-year, $450,000 per year grant award from SAMHSA to implement a Garrett Lee Smith Memorial Youth Suicide Prevention Initiative in Nevada. The CCCMHC supported the original grant request, which included a proposal to expand Clark County's TeenScreen Program from 10 Clark County High Schools to 20 Clark County High Schools. The SAMHSA funding includes funds for 10 high schools; other state or federal funding is needed to support an additional 10 high schools. In the past, the Clark County TeenScreen Program has utilized grants from the Trust Fund to fund the program.

It is estimated that an additional $18,000 per year will be needed to expand the TeenScreen Program from 10 schools to 20 schools. This funding would support the Center for Health and Learning in administering the screening and providing follow-up services to identified youths. An addition $22,000 per year is needed to fund a half-time family specialist through Nevada Parents Encouraging Parents. The family specialist is needed to work with the Center for Health and Learning in engaging and assisting families of youth identified as at risk of suicide.

<u>Recommendation 1C.</u> Recommend that DHHS seek $298,000 in new funding to sustain the early access program for young children developed by the Safe Schools, Healthy Students Grant.

The Safe Schools, Healthy Students Initiative has implemented a school-based early childhood access program that serves nearly 400 infants, toddlers and preschoolers per year. Infants and young children at-risk for behavioral health problems or already exhibiting behavioral health problems received school-based individual or group counseling, family counseling or home visiting services. This program has been effective in preventing more serious problems when the child is enrolled in school

Five professional staff and one part-time supervisor are necessary to maintain the program once the SSHS Grant ends July 31, 2006. Estimated cost for 5.5 staff and operating expenses is $298,000.

<u>Recommendation 2A.</u> Recommend that DHHS seek new funding for mobile crisis response and stabilization services to an estimated 720 youths yearly to divert these youth from emergency room services and unnecessary hospitalization at a cost of $986,400.

Mobile Crisis Response and Stabilization Services are one of three services that have been shown to be effective in preventing emergency room visits and reducing inpatient hospitalization for youths with serious behavioral health problems.[23] The CCCMHC has developed a model of mobile crisis team service delivery that is consistent with evidence-based programs (see Appendix I).

The CCCMHC has estimated that at least 720 youths per year with serious behavioral health problems visit local emergency rooms. The vast majority are discharged home without immediate treatment or hospitalized in psychiatric inpatient facilities. Mobile Crisis Response and Stabilization Services will reduce emergency room visits for many of these youths and divert others from inpatient hospitalization.

In January 2006, Nevada Medicaid added mobile crisis response and stabilization as a covered service and set the rate at $137.00 per hour. Other proven mobile crisis response and stabilization programs have estimated that 10 hours of mobile crisis services per youth is necessary to achieve the desired outcomes. The total funding request is based on 720 youths X 10 hours of mobile crisis services X $137.00 per hour for a total of $986,400.

<u>Recommendation 2E.</u> Recommend that CCSD use grants or other funds to sustain the current level of vital district-wide and school-based crisis services at a cost of $1.3 million.

The CCSD has developed a school-based and district-wide behavioral health crisis response as part of its Safe Schools Healthy Students Grant that will end July 31, 2006. At least 879 students per year have been referred for crisis services and linked with necessary community and/or school based services. Continued funding is needed to support nine licensed staff (five counselors and four psychologists), one administrative staff, six-non licensed direct service staff (Student Success Advocates), and one clerical staff. Salaries including fringe benefits are estimated at $1,173,086 and operating expenses at $126, 914.

<u>Recommendation 2F.</u> Recommend that DHHS seek $100,000 in new funding to sustain short-term flexible services to public school students in crisis. These funds have been previously provided by the Safe Schools Healthy Students Grant which ends July 31, 2006. In the future, these funds should be administered by and deployed through the Neighborhood Family Service Centers.

The CCSD has developed a school-based and district-wide behavioral health crisis response as part of its Safe Schools, Healthy Students Grant. At least 878 students per year have been

[23] Yannacci, M.P.P. and Rivard, J.C *Synthesis of Reviews of Children's Evidence-Based Practices*. Washington, DC: National State Mental Health Program Directors Research Institute, in press, 2005. U.S. Dept of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Institute of Mental Health, 1999.

referred for crisis services and linked with necessary community and/or school based services. Flexible funds were provided by the Grant to link uninsured and underinsured youths and families with short-term services until other types of public assistance could be obtained. The funding was primarily used for three types of services: acute psychiatric bed days; respite care bed days, and psychiatric diagnosis.

Recommendation 3A. Recommend DHHS seek expansion of the WIN to provide intensive, community based services to an average daily census of 100 Clark County juvenile offenders at an estimated cost of $1,858,900.

The CCCMHC has estimated that over 3000 Clark County juvenile offenders with serious emotional disturbance are not getting any services. The Consortium recommends that DCFS implement a pilot project through two of the neighborhood care centers to provide WIN services for an average daily census of 100 youthful offenders with serious emotional disturbance. It is estimated that it would cost $18,589 per year per slot to meet the needs of these 100 children through WIN. The total cost is estimated at $1,858,900. Of this amount it is estimated that $278,835 could be recovered through increased federal participation.

Recommendation 3C. Recommend that DHHS seek $140,656 in new funding to provide psychiatric and family support services for uninsured youths exiting the state's psychiatric hospital (Desert Willow Treatment Center).

A half-time family specialist is needed to assist families of uninsured youths in getting all appropriate aftercare services and healthcare benefits upon discharge from Desert Willow Treatment Center. The estimated cost for a half-time family specialist provided through Nevada Pep is $22,000. The CCCMHC also identified psychiatric outpatient services as the most critical aftercare service. A half-time psychiatrist is needed to provide these services for uninsured youths at the five neighborhood family service centers. Current waiting lists for these services prevent many uninsured youths from getting psychiatric aftercare services in a timely manner after being discharged from Desert Willow Treatment Centers. The cost for a half-time psychiatrist is estimated at $118,656, which includes salary, fringe benefits and operating expenses.

Recommendation 3E. Recommend that the state and county seek funding to expand service capacity in order to staff a sixth Neighborhood Family Service Center.

Agency partners at the Neighborhood Family Service Centers include children's mental health services programs operated by DCFS, child welfare programs operated by Clark County Department of Family Services, early childhood programs operated by the Nevada Division of Health; juvenile probation services operated by Clark County Department of Juvenile Justice Services, and family support services operated by Nevada Parents Encouraging Parents, family resource centers operated by the Department of Health and Human Services, and school social services operated by CCSD. All of these programs have provided information that their programs will undergo expansion in the next two years to meet the growing needs of the Clark County population. None of the current five Neighborhood Family Service Centers have the capacity to house expanded programs.

Recommendation 3F. Recommend that the state and county seek $821,053 in new funding to support a jointly funded, collaborative infrastructure for the Neighborhood Family Service Centers.

The CCCMHC's proposed model for Neighborhood Family Service Center Infrastructure includes resources to provide countywide governance and resources to provide center-based collaborative governance at one model center for a total cost of $821,053. The following staffing resources are needed for effective countywide collaborative governance at an estimated cost of $459,697:

Countywide Collaborative Management
Executive Director 1.0 FTE
Administrative Assistant 1.0 FTE

Collaborative Quality Assurance
Quality Assurance Specialist 1.0 FTE

Fiscal Management of Pooled Resources
Management Analyst 0.5 FTE

Interagency Training Coordination
Training Coordinator 1.0 FTE

The following staffing resources are needed for effective center-based governance at an estimated cost of $361,357 per center:

Center-Based Collaborative Governance
Center Manager 1.0 FTE
Administrative Assistant 1.0 FTE

Integrated System Access
Receptionist 1.0 FTE

Community Linkage
Volunteer Coordinator - recruit, train and oversee volunteers 1.0 FTE
Family Support Worker - public awareness, outreach 0.5 FTE

Integrated Screening and Assessment
Psychiatric Social Worker 1.0 FTE

Appendix H
Clark County Children's Mental Health Consortium
Current Clark County Behavioral Health Crisis Services
Survey of Community Providers

Provider	Svc Type	Target Pop	Referral Source	Biling-ual Staff	Payment Require-ments	Access Process	Available Hrs/Dy	Capacity dy/year
Briarwood	none	13-21 yr	Worker	None	Med/Pri Ins.	Worker		15/15
Behavioral Health Options	Walk-in Clinic ER Svcs.	0-17 years	Self-referred thru employer	Yes	Private Ins.	Calls or Walk-ins	24 hrs/7 days per week	n/a
Commun Counseling	OP Therapy	6-21 yr +21 yr	Self	Yes	Sliding Scale	Calls or Walk-ins	8-8 M-F 8-6 Sat	40/80
DCFS	OP/INP	0-18 yr	Providers	Yes	Sliding Scale, Med/Pri Ins	Calls or Walk-ins	OP 8-5 M-F INP 24/7	OP250/? INP 20/?
Bridge	OP	0-18 yr	Providers	Yes	Sliding Scale	Calls Appts only	M-F 8-5 Sat 8-12	2 crisis appt/wk
CC Dept. of Family Svcs	OP	0-18 yr In custody	Shelter or Foster Care	No	N/A	N/A	N/A	N/A
Girls/Boys Town	Shelter Care	10-18 yr Not suic	Court DFS	Some	Sliding Scale	Calls Walk-ins	24/7	18/350
CC Dept. of Juvenile Justice Svc	OP	8-17 yr In custody	Court Detention	No	N/A	Internal Calls	24/7 On-call	20/300
Harmony Health Care	OP Mobile ER Respons	3-18 yr	Self-referred Thru employer	Yes	Group Insur. Provider		24/7 On-call	4000+ for therapy
Human Behavior Institute	ER Svcs. Daytime Walk-ins	0-17 yrs	Self-referred Thru employer	Yes	Group Insur. Provider	Call for Appt	24/7 On-call	2800
Montevista Hospital	Assessm ents Hospitali zation	4-21 yrs.	Self-referred or Provider-referred	Yes	Private Ins or Medicaid	Calls or Walk-ins	24/7	28 beds/ 25 partial hosp.
Mohave Mental Health	OP, OP Crisis only for clients	6-18 yrs	Providers	Yes	Medicaid Only	Call for Appt	M-F 8-5	OP 270/? Med 410/?

Provider	Svc Type	Target Pop	Referral Source	Biling-ual Staff	Payment Require-ments	Access Process	Available Hrs/Dy	Capacity dy/year
North Vista Hospital	None 3-4 hr Hold in ER	0-18 yrs	Providers Self	Some	Not for ER	EMS Walk-ins	24/7 On-call	20/yr
Olive Crest	Crisis OP	3-18 yrs In Foster Care	Foster Care Workers	Some	Medicaid/ State	Workers calls in	24/7 On-call	
Red Rock Guidance Center	OP	3-18 yrs		Yes	Medicaid Sliding Scale	Calls Walk-ins	24/7 On-call	700/7000
Safe Alternatives for Youth (SAFY)	1-800 Number	0-18 yrs	Worker, Provider or Self if Medicaid	No	Medicaid Private Insur	Calls	???? Use 911 when not available	287 crisis calls in 2005
St. Rose Hospital	None for children							
Clark County School District	School-based assess-ment & response	5-18 yrs	School staff-social wkrs, coun selors, psychs.	Some	None required	Calls from school admini-strator	24/7 on-call	400/year
Southern Hills Hospital	Medical Screen-ing	0-18 yrs	Providers Schools Pahrump Self	Some	None for medical screening	EMS or Walk-ins	24/7	Only a few children and youth
Spring Mountain Treatment Center	24-hour Mobile Crisis Assessmt INP	12-17 yrs	Providers Self	Yes	Medicaid Private Ins. Walk-ins stabilized	Call for appt Walk-in Assessm t free	24/7	70 beds
Summerlin Hospital	Medical Screen Only	0-18 yrs	Providers Self	Yes	None for Medical Screen.	EMS Walk-ins	24/7	1 or 2 at a time Not very many/yr
Sunrise Children's Hospital	Medical Screen Only	0-18 yrs	Providers Self	Yes	None for Medical Screen	EMS Walk-ins	24/7	unknown
UMC Hospital Pediatric ER	Medical Screen Only	0-18 yrs	Providers Self	Yes	None for Medical Screen	EMS Walk-ins	24/7	4/?
Westcare	Crisis Residtl Shelter Care	10-17 yrs Not actively suicidal	Police DFS Self Street Outreach	Yes	Sliding Scale	EMS Walk-ins Worker	24/7	Crisis Res. 300/mo Shelter 70 beds

Shading denotes those providers with after-hours crisis services and their target population.

Appendix I
Mobile Crisis Response and Stabilization
Proposed Service Delivery Model

GOAL: Provide immediate care from qualified mental health professionals and paraprofessionals (parents) to any child or adolescent requiring assistance with a psychiatric emergency.

- Perceived as highly responsive by families
- Assists with immediate stabilization and short term
- Decreases need for out-of-home placements and hospitalizations

ACCESS: Phone availability 8:00 a.m. to 12 Midnight 7 days a week

- Trained staff screen for mental health emergencies over the telephone
- Provides crisis triage
- Dispatches intervention team
- Non crisis calls offered referral information

DIRECT SERVICE COMPONENTS:

- Rapid (within five minutes) telephone follow-up by a trained Mobile Crisis Response and Stabilization Staff
- Phone screening, assessment, de-escalation
- Triage and referral
- Referral to DCFS or other psychiatric services within 72 hours
- Provide written materials regarding resources to families
- Established agreements to acute care admission with all child and adolescent psychiatric facilities
- Home-based or community-based crisis intervention by licensed mental health professionals and paraprofessionals (on average two to six hours in duration)
- Crisis intervention includes assessment, crisis resolution and stabilization with referral and follow up
- Concurrent capacity to handle multiple emergencies throughout the greater Las Vegas area
- Short-term intensive child/adolescent and family treatment up to five sessions/contacts based on need and family's desires
- Collaborate with Neighborhood Care Centers' Intake Coordinators for access to DCFS services
- Care coordination including linkage with treatment providers and community collaboratives and School Safety Management Office
- Collaborative community outreach information and education
- Develop a data tracking system for services and provide outcome measurements
- Bilingual capacity is required
- School involved immediately for post crisis success in school
- Coordinate with 211 system