Clark County Children's Mental Health Consortium

2020 Vision for Success

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

10-Year Strategic Plan

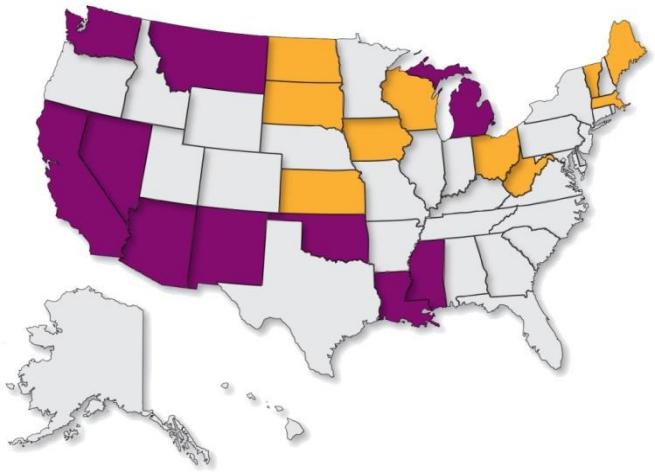
2015 Status Report

CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM
2015 STATUS REPORT ON THE 10-YEAR STRATEGIC PLAN

I. INTRODUCTION

In December 2013, Governor Sandoval released a state-commissioned report on the status of Nevada's public mental health services which concluded that "Nevada has missed a number of opportunities over the years to strengthen its behavioral health system" and needs "a proactive, strategic plan to implement an integrated system of care approach to behavioral health"(Watson et al, 2013.) The report found that in contrast to other states, Nevada's behavioral health system has focused on responding to adults with mental health crises, rather than investing its resources in prevention and early intervention for children and youth. Another 2013 study by the U.S. Substance Abuse and Mental Health Services Administration provided data to suggest that in recent years, Nevada has increased the percentage of state spending on inpatient hospitalization and centralized administration and decreased its funding on community-based services for individuals with behavioral health needs (SAMHSA, 2013). In spite of disproportionately high levels of teen suicide and depression, a recent study by UNLV's Lincy Institute has also shown that Nevada lags significantly behind neighboring states in providing adequate funding for children's mental health services that will strengthen families and help youths with mental health needs succeed at home, in school and in their community (Denby, 2013). **The 2014 Annual Report of *Mental Health America ranked Nevada as the worst state (51st) in providing access to behavioral health care for its youth*** *(Mental Health America, 2015).*

Figure 1. THE STATUS OF CHILDREN'S MENTAL HEALTH CARE IN THE U.S.
BEST(YELLOW) AND WORST (PURPLE) STATES
NEVADA RANKS 51ST WITH HIGHEST NEED FOR AND LOWEST ACCESS TO CHILDREN'S MENTAL HEALTH CARE



Adapted from Mental Health America (2014).

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

10-Year Plan Goals

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

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

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

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

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

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

In the 2014, the CCCMHC identified ***four priorities*** that would result in the most short-term, cost-effective improvements in the system while serving as building blocks for the long term plan (CCCMHC, *2014 Service Priorities*). The ***CCCMHC recommended specific action steps*** for implementation of the four priorities during the next two years. ***Section II*** of this report provides a description of current progress toward implementing these priorities. ***Section III*** describes any revisions to the primary objectives of the 10-Year Strategic Plan. ***Section IV*** provides a status report on each of the Plan's Phase 1 and 2 Objectives that were targeted for completion by June 30, 2015.

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

Justification:

In addition to critical service gaps, recent studies and family surveys have suggested that the system of behavioral health services in Clark County is complex and difficult to access (CCCMHC, 2014). Furthermore, federal and state reports, including the 2014 report of the Governor's Council on Behavioral Health & Wellness, continue to highlight the need for a more substantial workforce in Nevada trained to provide quality behavioral health services to children (Denby, 2013; Dvoskin, 2014; SAMHSA, 2013).

CCCMHC recommends that Nevada re-structure its children's behavioral health service delivery by implementing local system management of all publicly funded children's behavioral health services. In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008). The most recent report on Nevada's behavioral health programs also recommended more locally-driven, community-based services to address difficulties in service access and outcomes (Watson et al, 2013).

Recommended Action Steps

- Develop and implement a plan for **integrated, local system management** of all publicly funded children's behavioral health services in Clark County.
- Re-structure Medicaid policies and funding to support **a single, accountable entity in Clark County that uses a wraparound approach** to manage the care for youth with serious emotional disturbance. Blend/braid Medicaid and other public resources, allowing flexibility in the care management entity's use of the funding to implement individualized services and supports that strengthen the family, reduce the need for out-of-home placement, and facilitate positive outcomes for each youth.
- Include the following **as essential health benefits** to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, Health Insurance Exchanges and other publicly subsidized health coverage plans: **family-to-family support, mentoring, mental health consultation, mobile crisis intervention, and respite care.**
- **Develop and implement a statewide, universal set of quality standards** that require those children's behavioral health providers who receive Medicaid or other public funding as reimbursement for their services to utilize family-driven, individualized, evidence-based treatment interventions.

Under local systems management, the CCCMHC recommends redeployment of Medicaid and other funding to support a ***single***, accountable entity in Clark County that uses a wraparound approach to coordinate the care for youth with serious emotional disturbance. A 2009 state-commissioned report found that public children's behavioral health care dollars in Clark County were being spent on care management efforts that were duplicative, inconsistent, and failed to target those youths with the most serious and complex needs (Pires, 2009).

A report recently released by the Governor's Behavioral Health and Wellness Council describes the benefits of integrated funding and the effective use of care coordinating organization in producing effective service outcomes (Guinn Center for Policy Priorities, 2014). The Center for Health Care Strategies has recently profiled successful state and community demonstration projects such as the Wraparound Milwaukee Program that have utilized this approach (Simon et al., 2014).

To facilitate the effectiveness of local service delivery, the CCCMHC also recommends that both traditional health care providers and care management entities have the ability to provide innovative services such as family-to family support, mentoring, mental health consultation, and respite care, under health care coverage policies or flexible funding strategies. These strategies are currently underutilized

in public children's behavioral care systems in spite of their demonstrated effectiveness in improving outcomes and reducing costs of services (Pires et al., 2013). An extensive national evaluation has demonstrated that a systems of care approach yields positive outcomes for children and families with significant behavioral health needs. In addition, there is a growing body of evidence demonstrating that that the implementation of systems of care results in net cost savings derived from reduced use of inpatient psychiatric hospitalization, emergency rooms, residential treatment, and other group care, even when expenditures increase for home- and community-based care and care coordination (Pires et al., 2014). ***Investment in systems of care strategies in Nevada can divert millions of dollars being spent each year on out-of-state psychiatric placements for youth into more cost-effective community-based treatment strategies (See Figure 2).***

Figure 2

Residential Treatment Center Financial Report

Subsets	Out of State RTC Patients			
Time Period: Incurred Month	Patients	Service Count Paid	Net Monthly Payment	Net Pay Per Pat
Sep 2013	192	6,162	$1,804,836.32	$9,400.19
Oct 2013	198	6,230	$1,928,171.16	$9,738.24
Nov 2013	194	5,375	$1,796,649.05	$9,261.08
Dec 2013	190	5,438	$1,827,794.91	$9,619.97
Jan 2014	188	5,453	$1,811,106.10	$9,633.54
Feb 2014	192	4,845	$1,650,109.73	$8,594.32
Mar 2014	203	5,371	$1,861,938.84	$9,172.11
Apr 2014	207	5,531	$1,902,886.97	$9,192.69
May 2014	207	5,694	$1,995,413.20	$9,639.68
Jun 2014	228	6,145	$2,124,681.23	$9,318.78
Jul 2014	234	6,772	$2,331,706.58	$9,964.56
Aug 2014	243	6,677	$2,315,741.46	$9,529.80

CURRENT STATUS: Some Progress

The Governor's Council on Behavioral Health & Wellness has begun to examine the issue of governance for Nevada's public behavioral health systems. The Nevada Division of Child and Family Services has also taken a leadership role in coordinating efforts between the Commission on Behavioral Health and the three regional consortia via a joint subcommittee established in 2012 to address the governance for children's behavioral health service delivery as well as the restructuring of policy and financing strategies. This Children's Behavioral Health System of Care Subcommittee has been asked to provide input to the Governor's Council by December 2014 for consideration.

During the next biennium, the Division of Child and Family Services will continue to support the work of the Children's Behavioral System of Care Subcommittee and the Governor's Council in developing a plan to address governance, policy and financing strategies for children's behavioral health services delivery. DCFS has assigned a "System of Care Chief" and reallocated other positions to support this effort, and will also fund a consultant from the UNR School of Social Work to assist with the development of a strategic plan (Gilliland, 2014).

The Division of Child and Family Services has also pledged to continue funding for training to community stakeholders/partners in evidence-based services. In addition, the UNLV School of Social Work Professors Ramona Denby-Brinson and Joanne Thompson and their team of collaborators have been awarded a $1.4 million Behavioral Health Workforce Education and Training for Professionals grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The purpose of the three-year project is to work with local and state public and behavioral health partners to develop and expand clinical social work education with the goal of producing 108 highly competent practitioners who can intervene on behalf of children, adolescents, and transitional-age youths who are at risk of or who have developed behavioral health disorders.

Next Steps

The Governor's Council should explore system management and financing options that incorporate the four action steps above and that have been shown effective in producing cost savings and positive outcomes for children's mental behavioral health services delivery.

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

Recommended Action Steps

- Expand funding for DCFS to implement an evidence-based mobile crisis intervention program with fidelity that meets the needs of Clark County youth experiencing severe psychiatric crises.
- Develop a family-driven approach that ensures all youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior; receive immediate and appropriate inpatient or community-based care. In order to support timely access to needed services, explore the use of federal incentives for developing presumptive Medicaid eligibility approaches through DHHS.

Justification:

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

Child mental health-related visits to hospital emergency rooms have increased steadily in Clark County over the past five years**.** Depression, Anxiety, Psychosis, Conduct Disorder and Alcohol Abuse represent the most predominant diagnoses upon admission (Greenway, 2014). From earlier studies, it is estimated that almost 40% of these youths have been admitted to emergency rooms due to suicide attempts or threats, with nearly half of youths discharged home without immediate treatment being suicidal, psychotic or depressed (CCCMHC, 2009).

Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric hospitalization for youths with complex behavioral health care needs in programs such as those implemented across New Jersey, in Milwaukee, Wisconsin and in Seattle, Washington (AHRQ, 2013). DCFS has successfully implemented a pilot program in 2013 which can reduce costs and utilization of inpatient and residential psychiatric treatment if significantly expanded to fully meet the needs of Clark County's children with behavioral health crises. The 2014 Report of the Governor's Council on Behavioral Health & Wellness recommended expansion of mobile crisis intervention services (Dvoskin, 2014).

Nevada should also explore federal incentives for presumptive Medicaid eligibility approaches in order to develop a family-driven approach that facilitates access to immediate and appropriate community-based care to uninsured and underinsured youths admitted to emergency rooms. The 2014 Report of the Governor's Council on Behavioral Health & Wellness recommended expansion of mobile crisis intervention services (Dvoskin, 2014).

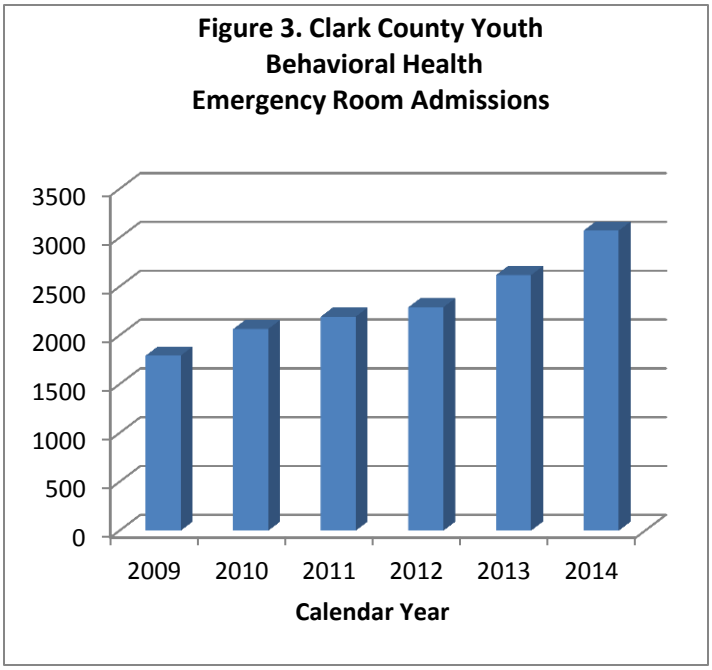
CURRENT STATUS: Significant Progress

Mobile Crisis Intervention -- According to data provided by UNLV's Center for Health Information Analysis, youth psychiatric emergency room admissions in Clark County hospitals have continued to increase during the first half of calendar year 2014 in spite of the implementation of DCFS's pilot program, which only began serving youth and families in the latter part of 2013 (See Figure 3).

In July 2014, the Interim Finance Committee of the Nevada Legislature approved Governor Sandoval's request to expand DCFS's pilot program for mobile crisis intervention services. A total of

nineteen new positions were funded in order to expand the services in Clark County as well as in other regions of the state.

The Mobile Crisis Response Team serves youth in the greater Las Vegas area that are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, extreme parent/child conflict, difficulty adjusting to a serious peer relational issue such as bullying, or any other serious mental health problem. The MCRT serves a key function in the system of care by providing community-based services that the youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department. The ultimate goal of MCRT services is to divert youth from psychiatric hospitalization. Information gathered from mobile crisis response units in other US states indicates that in many cases when children and adolescents are in crisis, they can be safely de-escalated and stabilized in their home and community. This is a favorable outcome for families, preventing the unnecessary use of costly forms of mental health care such as hospitalization and allowing the family to remain united with their child while working through the current mental health crisis with the support of a crisis stabilization team. The Las Vegas MCRT has received 334 hotline calls since January, 2014. The most common reason for calling was due to suicidal ideation. Most intake assessments took place in an emergency department. The hospital diversion rate is 91.3%. Ninety five percent of the families served have been referred for additional mental health and/or community support services. Almost 100 families have been seen for crisis stabilization services. The youth served have shown significant improvement in functioning. Ninety three percent of parents/guardians report being satisfied with MCRT services.



Presumptive Eligibility -- Over the past year, the Department of Health and Human Services has begun to implement a program that allows hospitals to determine presumptive Medicaid eligibility for their patients. Provider training has been initiated and hospitals will be able to implement the program on January 1, 2015.

Next Steps

The Department of Health and Human Services should pursue permanent funding for the newly expanded mobile crisis intervention program, ensuring that resources are added to provide adequate clinical supervision and quality of services. DHHS should also expedite implementation of the hospital presumptive eligibility program and expand presumptive eligibility approaches to improve early access to community-based care for children with behavioral health crises.

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

Justification:

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

Recommended Action Steps

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

A national study of children's behavioral health services utilization in the Medicaid Program found than one percent or fewer eligible children with behavioral health needs were receiving nontraditional services such as family-to-family support, in spite of a mounting body of evidence demonstrating the cost effectiveness of this approach (Pires et al., 2013). Such findings suggest a lack of access to family-to-family support services; even ***while more and more Nevada families of children with serious emotional disturbance request this program through Nevada PEP each year*** (see Figure 4).

The 2013 Pires et al. study also found that behavioral health expenses for children in Medicaid with a developmental disability were more than double those for other children, pointing to the need for alternative approaches such as family-to-family support for this population. Because family-to-family support services can help reduce reliance on expensive, restrictive residential treatment, the Centers for Medicare & Medicaid Services issued a bulletin in May 2013 recommending that states provide funding for family-to-family support as part of their benefit plan for children with significant mental health conditions (CMS, 2013). The Governor's Council on Behavioral Health & Wellness recommended expansion of family-to-family support programs in its 2014 report (Dvoskin, 2014).

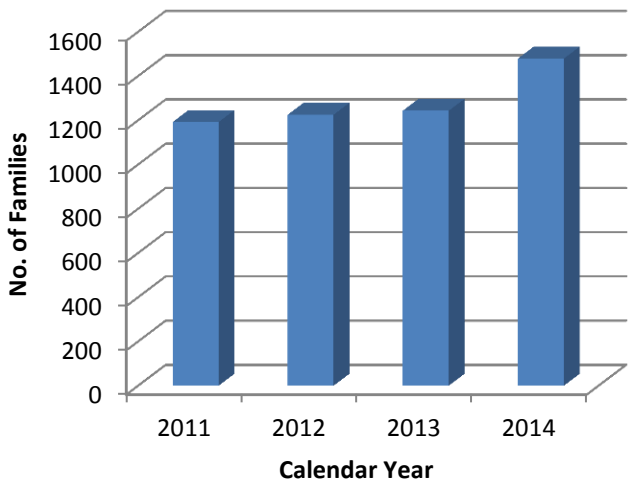
Nevada PEP currently provides family-to-family support services for families who have children with mental health needs. Families are referred by DCFS programs, schools, and community organizations. Over the last year PEP provided family-to-family support services to 1,129 families of youth with serious emotional disturbance in Clark County. PEP partnered in the development and implementation of DCFS's Mobile Crisis Response Team, working with 66 of the families from that new program. Families who contact PEP for support receive individualized and unique support to meet their needs which may include: Informational and educational support; Instructional and skills development support; Emotional and affirmation support; Instrumental support and referral; Advocacy support; and Leadership skill building at child and family level as well as at system levels.

The demographics of the children whose families PEP supports are interesting to note: 66% are boys; 40% are Hispanic; 60% have a serious emotional disturbance combined with another disability; and 88% live at home with their families. Families served in Clark County report that: 61% have Medicaid; 28% have private insurance; and 12% are uninsured. Families often contact PEP when they are having difficulty partnering with schools, developing IEPs, discipline and suspension issues. PEP has supported families at 280 different schools in Clark County.

CURRENT STATUS: Minimal Progress

The funding approved in June 2014 by the Interim Finance Committee to expand DCFS's mobile crisis intervention services also included a small amount of funding to add additional family-to-family support services for youths identified by the mobile crisis teams, with the intent of reducing the number of youths at risk for long term institutional placement. This new funding for family-to-family support is included in the FY 16-17 Governor's Biennial Budget Request.

Figure 4. Nevada Families Requesting Support Services through Nevada PEP



However, ***more and more Nevada families of children with serious emotional disturbance request family-to-family support through Nevada PEP each year*** (see Figure 4). For example, large numbers of youths at risk for both acute and long-term psychiatric residential treatment have been identified by the Clark County School District's Mental Health Transition Team. Created in 2014, this team facilitates the development of school-based aftercare support to youths discharged from local psychiatric hospitals. Just in the first two months of the 2014-2015, the team has identified and served 315 youths needing academic and behavior support to re-enter school. The families of these youths also need support to care for these high-risk youths at home. In a recent letter to the CCCMHC Chairperson, Director of Health and Human Services Gilliland indicated that the Division of Child and Family Services will continue to look for funding strategies to increase family-to-family support for youths who have been institutionalized.

Next Steps

The Department of Health and Human Services should secure immediate funding to provide family-to-family support services to those youths at risk for long-term psychiatric residential treatment who are being identified by the CCSD Mental Health Transition Team. DHHS should also encourage DCFS and the Nevada Division of Aging and Disabilities Services to work together in developing funding for family-to-family support services such as PEP's 360 Center Program that will improve outcomes for youths with co-occurring developmental disabilities and behavioral health care needs

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

Recommended Action Steps

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

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

Justification:

Prevention services were rated as the top priority for expansion in a 2009 survey of over 100 Clark County families, caseworkers and providers. For the average youth, symptoms typically precede a serious disorder by about two to four years (Denby, 2013). Screening can help identify and link youth early with services before symptoms become so intense and debilitating that they require more restrictive, costly care.

Clark County public and private schools have experienced success in utilizing school-based screening programs to identify students at risk for suicide and link them with needed services. Recognizing the importance of school-based screening approaches, the 2013 Nevada Legislature approved Assembly Bill 386 mandating that Clark and Washoe County School Districts implement and evaluate a school-based program in partnership with community stakeholders to provide students with general behavioral health screenings. The CCCMHC recommends funding for the Clark County School District to expand its screening program using an evidence-based model implemented with fidelity. The success of screening also depends on increased funding for parent awareness and support strategies. The Governor's Council on Behavioral Health & Wellness has recommended additional mental health resources for Nevada schools (Dvoskin, 2014).

Finally, the CCCMHC supports additional funding for the Office of Suicide Prevention to expand its Reducing Access to Lethal Means program. More resources are needed to provide public awareness and parent education in Clark County about youth suicide risk cause by the availability of firearms and potentially lethal medications. In other states, these strategies have proven effective in reducing suicide rates among both adults and youth.

CURRENT STATUS: Some Progress

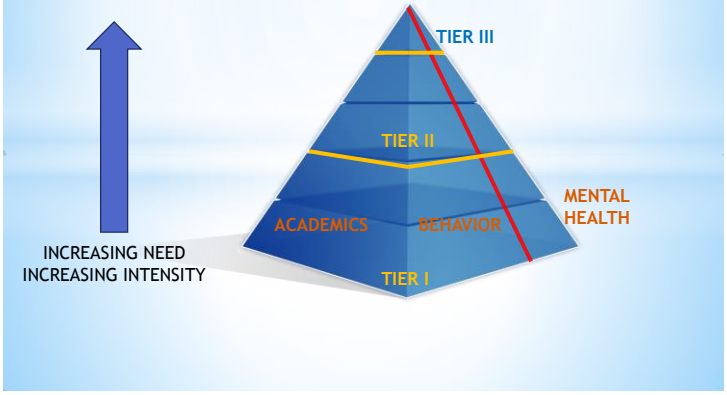
The Children's Behavioral Health System of Care Subcommittee will continue to address school-based interventions and has made a recommendation to the Governor's Council on Behavioral Health & Wellness that the state provide new block grant funding for school-based interventions that include: screening for suicide risk and general behavioral health needs, mental health assessment and linkage, and targeted early interventions for suicide prevention, bullying prevention and positive behavior supports.

Clark County School District has recognized the need for multi-tiered systems of support to promote student well-being and academic achievement (see Figure 5). Although the CCSD did not receive any funding for school-based screening efforts, they conducted a pilot screening program with eighth graders in two middle schools during the 2013-2014 academic year as directed by Assembly Bill 386 of the 2013 Nevada Legislature. CCSD developed and implemented the screening program in

partnership with key community stakeholders, including consortium members, providers, and family members. Funding will be needed to continue or expand this program.

The Nevada Coalition for Suicide Prevention (NCSP) partnered with the Office of Suicide Prevention (NOSP), Nevada Firearms Coalition (NVFAC) and the Executive Committee to Review the Death of Children to develop a comprehensive public information and education materials around suicide prevention through securing firearms. We are currently distributing materials statewide. Materials have been shared with the Clark and Washoe county gun shops, shooting ranges, and firearm training centers, Division of Child and Family Services, Nevada Department of Education, and the Washoe and Clark County School District.

Figure 5. Multi-Tiered Systems of Support: Interconnected Systems that Address Academic, Behavior and Mental Health Needs



Next Steps

The Governor's budget should include dedicated funding for school-based prevention and early intervention efforts consistent with the action steps above that can be deployed to Nevada school districts in a flexible manner to address their individualized needs.

III. REVISIONS TO THE CCCMHC'S 10-YEAR STRATEGIC PLAN

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

- ***Revised* Objective 1.2 With active participation from Clark County Management, CCSD Student Services, the Eighth Judicial Court, family members, and other stakeholders, the Nevada Department of Health and Human Services will facilitate the development and implementation of a community-wide, interagency process for reviewing and reducing out-of-state and out-of-community placements of children with serious emotional disturbance.**

  Justification: Large numbers of youth with serious emotional disturbance continue to require out-of-state and out-of-community placement at a tremendous cost to state Medicaid. State and county leaders need to collaborate in developing an effective process to reduce the need for these placements. Strategies should include: (1) resources to create community-based alternatives for individual youths at risk and their families as well as (2) processes that inform decision makers and facilitate system reform.

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

- ***Revised* Objective 4.4 With active participation from the Governor's Council on Behavioral Health and Wellness, the DHHS Director, the Clark County Manager, families and other key stakeholders, the CCCMHC will identify: (1) The full array of services needed to meet the needs of children with serious emotional disturbance; and (2) A local approach to service delivery that is based on proven family-driven, system of care principles.**

  Justification: The community needs to come together in order to develop a consensus on the best approach to local service delivery for youth with serious emotional disturbance and their families. In previous years, state and local child-serving agencies, families and providers supported a neighborhood-based approach. Community input and lessons learned from DCFS's implementation of neighborhood centers should be utilized to develop and implement a revised plan that will improve coordination and quality of services as well as produce favorable outcomes for youth and their families.

IV. STATUS OF 10-YEAR PLAN GOALS, STRATEGIES, AND SERVICES

The CCCMHC's 10-year Plan is broad and comprehensive in scope in order to actualize the vision of a system that will best serve the children of Clark County. Rather than using a "Band-Aid" approach to address each service delivery "crisis," the Plan's strategies and services are phased in over the next 10 years to accomplish the daunting task of implementation.

Below is a report on the status of those strategies and services targeted for implementation during **Phase 1** (7/1/10-6/30/14) and **Phase 2** (7/1/13-6/30/15) of the Plan.

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

Phase 1/2 Objectives and Strategies

- **Objective 1.1 Re-structure Medicaid Care Targeted Case Management Policies to support a single, accountable care management entity in Clark County. (a) Blend/braid existing funding to implement the care management entity; and (b) Leverage and redeploy cost savings from re-structuring targeted case management to expand the capacity for care management to youths in juvenile justice and schools.**
  Indicators: Number of youths receiving intensive case management, improved outcomes

  CURRENT STATUS: No Progress. Fewer youth are being referred to the DCFS Wraparound in Nevada program that provides an evidence based practice model. The majority of Medicaid eligible youth are on a HMO. The HMO's do not provide evidence based wraparound services.

- **Objective 1.2 With active support from the DHHS Director, County Manager, and the Judiciary, *strengthen adherence and commitment to local barrier-busting resource teams.***
  Indicators: Adherence to MOU; *Decrease in Out-of-State and Out-of-Community Placements, Increase in number of children staffed by the teams*

  CURRENT STATUS: No Progress. This objective has been re-written to facilitate the development and implementation of new, more effective strategies for reducing out-of-state and out-of community placements (see revised objective in Section III).

- **Objective 1.3 Expand Medicaid eligibility to cover home-based counseling and other family supports for youth with SED who are: (a) at risk for re-hospitalization or placement in child welfare or juvenile justice; and (b) uninsured and underinsured children with SED who need these services to prevent first-time hospitalization or residential care.**
  Indicators: Increase in number of children served, increased family satisfaction, improved family functioning

  CURRENT STATUS: No Progress. While children and youth with serious emotional disturbance continue to receive the benefits of Medicaid coverage while in out-of-home placements and residential treatment centers under a "Family of One" eligibility status, many children lose access to these benefits and services within a month of returning home unless the family can obtain Medicaid coverage based on another eligibility category. Services to support the family in caring for the child

at home are at best disrupted by changes in Medicaid coverage, or may be completely unavailable to the child upon returning home.

- **Objective 1.5 Expand family-to-family support services through innovative Medicaid programs, blended/braided funding.**
  Indicators: Increase in funding for family-to-family services, increase in families served

  CURRENT STATUS: Minimal Progress. The Division of Health Care Financing and Policy has shown an interest in revising its policies to include family-to-family support services as a Medicaid funded program. Peer-to-peer support services are already reimbursable under Medicaid policy. Medicaid has held informal meetings with the Nevada Division of Child and Family Services (DCFS) and Nevada PEP, who provides family-to-family support under contract with DCFS. However, no other progress has been made.

- **Objective 1.6 Strengthen partnerships between DCFS, MHDS and other agencies to improve services to children with co-occurring developmental disabilities and behavioral health problems**
  Indicators: Improved Memorandums of Understanding

  ***CURRENT STATUS: Minimal Progress*.** The State Divisions continue to meet on a monthly basis to problem solve any barrier's to client services, as well as to develop a Memorandum of Understanding.

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

Phase 1/2 Objectives and Strategies

- **Objective 2.1 Identify evidence-based and promising practice models for most needed services. (a) Re-structure Medicaid rates to provide incentives for these practices; and (b) Standardize reimbursement incentives statewide for public and private insurers.**
  Indicators: Public and private insurer reimbursement rates for Evidence-Based and Promising Practices

  CURRENT STATUS: Minimal Progress. Across the United States, there have been significant advances in the development of evidence-based and promising practices for children's behavioral problems. However, there is little evidence that these practices have yet been incorporated into the broad service array for Clark County's children (Pires, 2009). The Nevada Division of Child and Family Services regularly provides training on key evidence-based practices for children's mental health, including: wraparound case management; motivational interviewing; parent-child interaction therapy; and trauma-focused cognitive behavior therapy. However, neither public nor private insurers provide incentives for appropriate use of evidence-based practices. While Medicaid policy requires providers of substance abuse services to ensure the use of evidence-based models of treatment, there is no such requirement for Medicaid providers of children's mental health services.

- **Objective 2.3 Strengthen outreach programs to assist families in obtaining healthcare coverage.**
  Indicators: Increase in families enrolled in Medicaid/NV Check-up; decrease in uninsured

  ***CURRENT STATUS: Some Progress*.** Nevada has contracted with a variety of agencies to provide navigators which assist families in obtaining healthcare coverage. Other outreach strategies have also been implemented to help families understand and apply for benefits through the health care exchange. However, data are not available on the success of these efforts with families who have children with behavioral health care needs.

- **Objective 2.4 Leverage school funding to implement school-based services for ADHD and Depression. Develop neighborhood-based, school-linked provider network for other behavioral health issues in collaboration with the system management entity.**
  Indicators: Proportion of schools offering each type of services; number of children served; achievement levels of children completing the programs

  CURRENT STATUS: Minimal Progress. The Clark County School District offers a Medical Consultant Clinic (MCC) to provide medical evaluation, medical diagnoses and management recommendations through a certified child psychiatrist for students with suspected psychiatric or behavioral disorders that interfere with educational performance. The clinic is also an appropriate referral resource for students who need a differential clinical diagnosis (e.g., ADHD vs. Anxiety or Depression; etc.), or who need evaluation for other psychiatric concerns to aid a team with either special education eligibility or educational programming issues. The MCC may be accessed as part of, or as an extension to, a formal special education evaluation wherein outstanding diagnostic issues are present. In these cases, special education procedures still apply. The clinic may also be accessed for medical consultation with a school team regarding a general education student with presenting educational needs.

  CCSD does not currently implement district-wide, school-based intervention services for students presenting with ADHD or Depression. Some school-based education services (intervention; individual and small group counseling) may be developed and provided for students with ADHD, depression, or other clinical diagnoses, depending upon their presenting educational needs.
  However, the Division of Behavioral and Public Health has revised its standards for credentialing school-based health centers to include standards for the provision of mental health services to students in collaboration with school districts. Effective September 26, 2014, CCSD renewed an agreement with the Foundation for Positively Kids to expand services at the Martinez Elementary School Health Center from basic health services (immunization) to include mental health services such as mental health screening, individual and group psychotherapy by licensed professionals, pediatric psychiatric services, and assistance to families with referrals to community resources when indicated. Services at this school-based health center are offered to CCSD students under the age of eighteen.

- **Objective 2.5 Expand Medicaid Program and blend/braid funding to expand substance abuse services.**
  Indicators: Increase in funding levels

  CURRENT STATUS: No Progress. Although the Medicaid Program now credentials and reimburses providers of substance abuse services rather than the Division of Behavioral and Public Health, this transition has reportedly decreased the number of substance abuse providers and reduced access to

services for youths identified by Clark County Juvenile Services. Data are not yet available to examine the utilization of Medicaid-funded substance abuse programs by Clark County youths.

- **Objective 2.6 Expand capacity and improve quality for psychological and psychiatric assessments and service through private and public insurance resources.**
  Indicators: Increase the proportion of children enrolled in public/private insurance programs who access behavioral health services

  CURRENT STATUS: Some Progress. In partnership with Clark County Department of Family Services and Clark County Juvenile Justice DCFS is supporting the University School of Medicine Child and Psychiatric Fellowship program for the first time in Clark County. Research has shown that the majority of Physicians stay in the community in which they completed their Fellowship program.

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

Phase 1/2 Objectives and Strategies

- **Objective 3.1 Implement 2-1-1 or 800 number for behavioral health system entry.**
  Indicators: Numbers and types of calls to 1-800 number

  CURRENT STATUS: Minimal Progress. Nevada 211 was implemented in February of 2006 to provide free connection to critical health and human services information about local community resources. This service is available in a single statewide location that can be accessed via voice, text, and online. Although this system has been running for 8 years, the services provided are often inadequate and not kept up to date. The call center staff are not trained on all service areas therefore do not always know the appropriate referral sources, especially for behavioral health care needs, and the information available on the site is often out of date and incomplete. A well-functioning system that assists families in finding the appropriate services is needed and it is important that this service is different than a mere directory. Nevada 2-1-1 could provide the necessary framework to connect families to services if a larger community investment is made into this existing service in order for this system to provide accurate, complete, and current services available in local communities with regard to mental and behavioral health needs. So while progress has been made toward this goal, we still have a long way to go until this objective has been met.

- **Objective 3.2 Implement a cross-agency program of mobile crisis intervention services that will be available to divert youths in crisis from costly emergency rooms, inpatient care and juvenile detention by: (a) Re-structuring Medicaid's Mobile Crisis and Stabilization Policies to increase provider capacity; (b) Blending/braiding existing funds to implement a cross-agency contract for mobile crisis program for Medicaid, Child Welfare and Juvenile Justice involved youths; and (c) Expanding crisis intervention to all youths in crisis, including privately insured and uninsured.**
  Indicators: Decrease in youths accessing emergency rooms for psychiatric problems; decrease in inpatient psychiatric bed utilization

  CURRENT STATUS: Some Progress. The expansion of DCFS's mobile crisis intervention program has increased the community's capacity to divert youths in crisis from costly emergency rooms, inpatient care and juvenile detention. As of October, 2014, the Mobile Crisis Response Team (MCRT) services are available Monday-Friday, 8 A.M. until 11:00 P.M. and Saturday-Sunday from 12

P.M. until 11:00 P.M. During Calendar Year 2014, the Las Vegas MCRT program received 334 hotline calls. The most common reason for calling was due to suicidal ideation. Most intake assessments took place in an emergency department. The hospital diversion rate is 91.3%. Ninety five % of the families served have been referred for additional mental health and/or community support services. Almost 100 families have been seen for crisis stabilization services. The youth served have shown significant improvement in functioning. Ninety three % of parents/guardians report being satisfied with MCRT services.

Data are not yet available to assess the long-term impact of the expanded program on pediatric emergency room admissions and inpatient hospitalization of youth with serious emotional disturbance, however, mechanisms should be established to monitor these indicators over the next biennium.

- **Objective 3.3 Mental Health Commission to adopt policy and/or regulations clarifying procedures for voluntary and involuntary hospitalization of children.**
  Indicators: Written regulation or policy and numbers trained

  CURRENT STATUS: No Progress. The Commission has not yet developed policy or regulation. DCFS is working with local hospitals to identify the numbers of youth who have been involuntarily hospitalized in order to provide information to assist the Commission in considering this issue.

- **Objective 3.4 Implement memorandum of understanding for standardized intake assessment, crisis management and service planning protocols across public and private providers and enhance Neighborhood Center Infrastructure to provide these services.**
  Indicator: Proportion of public and private providers adopting standardized tools

  CURRENT STATUS: Minimal Progress. In April 2010, the Nevada Children's Behavioral Health Consortium adopted the Children's Uniform Mental Health Assessment (CUMHA) and asked member agencies and provider to sign letters of commitment agreeing to utilize this standardized intake tool. Since that time, many agencies and providers have continued to use the CUMHA. A workgroup of the Nevada Children's Behavioral Health Consortium committee recently revised the intake tool to add a trauma screen and suicide screen. Representatives from the Nevada Division of Child and Family Services, Clark County Family Services and Juvenile Justice Services, Washoe County Social Services and Juvenile Justice Services, Rural Clinics, and Medicaid participated in the workgroup. Standardized service planning protocols have not yet been developed at the local or state level, and there continues to be confusion regarding responsibility for coordination of mental health service provision.

- **Objective 3.5 Coordinate intake, crisis intervention, service planning and service delivery across public and private providers at a neighborhood level, beginning with organized information and referral networks.**
  Indicators: Description of coordinated system; number of youth linked with crisis or other services

  CURRENT STATUS: ***No Progress.*** Clark County Department of Family Services has decided to abandon the Neighborhood Care Center philosophy for fiscal reasons, and they are centralizing CCDFS services. This will make it difficult for children and families to receive coordinated access to services throughout the valley.

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

Phase 1/2 Objectives and Strategies

- **Objective 4.1 Strengthen role of state and local consortia; support legislation to include the state consortium as a subcommittee of the Mental Health Commission.**
  Indicators: Increased participation; increased funding; amended legislation

  ***CURRENT STATUS: Some Progress*.** The Commission and the three Consortia's have developed a "Children's System of Care Behavioral Health Subcommittee." This subcommittee is comprised of voting members from each Consortia and the Commission. This subcommittee also represents the Children's Issues on the Governor's Council for Behavioral Health and Wellness.

- **Objective 4.2 Develop and implement a plan for local system management by: (a) establishing a formal relationship between CCCMHC and a system management entity; (b) establishing the role of the local system management entity in providing integrated case management, crisis intervention, provider networks, and intake/referral.**
  Indicators: Identification of funding support; contracts and/or Memorandums of Understanding

  CURRENT STATUS: No Progress. The Children's Behavioral Health System of Care Subcommittee continues to work in conjunction with the Governor's Council for Behavioral Health and Wellness on developing the Governance Structure for Children's Mental Health Services that will allow such a plan to move forward.

- **Objective 4.3 Develop a partnership between the local system management entity, the CCMHC and the Statewide Family Network to facilitate the implementation of cross-agency training and other workforce development activities.**
  Indicators: Number of annual trainings, number and type of participants

  CURRENT STATUS: Some Progress. DCFS continues to receive funding through the Mental Health Block Grant to support community wide trainings. Over the last biennium, training was also funded through the Funds for a Healthy Nevada which supported the DCFS's Mobile Crisis Program. DCFS Children's Mental Health, Nevada PEP, community providers, and representatives of the CCMHC regularly collaborate to provide trainings and workforce development activities. The Accountability and Workforce Development Workgroup is attended by members of diverse groups including child welfare, representatives from juvenile justice, community providers, Nevada PEP, and DCFS Children's Mental Health. This workgroup receives reports concerning collaborative efforts to educate the community and workforce. Through these partnerships, training has been provided in Clark County on the following evidence-based programs, including: Parent-Child Interaction Therapy, Motivational Interviewing, Solution Focused Brief Therapy, Trauma Informed Care, Wraparound, Systems of Care, Positive Behavior Supports, Suicide Prevention, and Family Check-Up. Other partnerships between DCFS and the Statewide Family Network include collaborating to provide System of Care and Wraparound Training, participating on interview teams and in training new hires. DCFS has also created a Systems of Care Chief to promote training and workforce development that reinforces the principles and values of Systems of Care for Children's Mental Health.

- **Objective 4.4 Recommend the DHHS Director and Clark County Manager meet with the CCCMHC to develop a plan for re-establishing neighborhood centers that: (1) operate based on a family-driven system of care approach and (2) provided a full array of services to meet the needs of children with serious emotional disturbances and their families.**
  Indicator: Integrated management structure; Memorandums of Understanding

  CURRENT STATUS: No Progress. Due to the lack of progress, this objective has been re-written (see Section III).

- **Objective 4.6 Re-structure Medicaid targeted case management policies and funding to create regional care management entities under the direction of local system management.**
  Indicators: Increase in blended/braided funding for intensive case management; standardization of service contracts

  CURRENT STATUS: No Progress. Targeted Case Management continues to be available only to Fee For Service Medicaid clients through a State or County entity.

- **Objective 4.7 Partner with state consortium to develop standardized performance and outcome measures for the local system.**
  Indicator: Progress toward implementing statewide system

  CURRENT STATUS: Minimal Progress. The Children's Behavioral Health System of Care Subcommittee continues to work in conjunction with the Governor's Council for Behavioral Health and Wellness on developing the Governance Structure for Children's Mental Health Services that will allow state and local entities to work toward accomplishing this objective.

- **Objective 4.8 Through the local system management entity, develop performance-based contracts with providers linking standards of care, outcomes and reimbursement.**
  Indicators: Written standards and policies, provider contracts, performance and outcome reports

  CURRENT STATUS: Some Progress. The Department of Family Services (DFS), the Division of Child and Family Services (DCFS) and the Department of Juvenile Justice Services (DJJS) formed a partnership to establish higher standards of care than required by Medicaid for the Mental Health Rehabilitative services of Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR) that are provided to the children and families served by these agencies. Providers of BST and PSR services submit applications and complete a vetting process that links standards of care and outcomes in order to become Approved Providers. All providers are already established Medicaid providers so reimbursement is not linked.

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

Phase 1/2 Objectives and Strategies

- **Objective 5.1 Develop and implement effective screening models for middle and high school students through GLS Grant.**
  Indicators: Number and type of students screened; decrease on YRBS risk indicators

  CURRENT STATUS: Some Progress. In accordance with Assembly Bill 386 (AB386), the Clark County School District completed a successful pilot project for mental health screening during the 2013-2014 school year. Two school sites were selected as part of this pilot project, Kathleen and Tim Harney Middle School (Harney MS) and Grant Sawyer Middle School (Sawyer MS), because the student populations in those schools closely matched the overall demographics of the District. Only eighth grade students were selected for the screening, where the Harney MS eighth grade population totaled 600 and the Sawyer MS population totaled 399.

  CCSD used the Behavior Assessment System for Children – Second Edition, Behavioral and Emotional Screening System Student Self-report Form (BESS) as the initial screening instrument, administering the Behavior Assessment System for Children – Self Report (BASC-2) as a follow-up assessment to provides more specific information regarding students identified at-risk for emotional or behavioral problems including those experiencing internalizing, externalizing, and/or personal adjustment problems. Results from the BASC-2 instrument revealed a fairly large percentage of students with elevated scores at Harney MS (n=37) and at Sawyer MS (n=16); that is, of the students who completed both the BESS and BASC-2, 84% at Harney MS scored within the at-risk or clinically significant range and 89% of students at Sawyer MS scored within the at-risk or clinically significant range for possible emotional or behavioral issues. The site-based intervention team at each school reviewed and discussed the students' scores, additional information collected, and any anecdotal information provided by the school counselors. Parent meetings were then held individually at both Harney MS and Sawyer MS. The majority of students' needs were viewed as significant enough to warrant recommendations by the school intervention team for both a community-based referral and site-based intervention.

- **Objective 5.2 Develop and implement school-based screening programs for elementary school children.**
  Indicators: Number of elementary school children screened annually and number linked to services

  CURRENT STATUS: No Progress. Clark County School District has focused its efforts on screening models for secondary school students and has not begun to address this objective.

- **Objective 5.3 Develop and implement standards and reimbursement incentives for screening in primary care settings.**
  Indicators: Proportion of physicians using standardized tool

  CURRENT STATUS: Some Progress. With the implementation of the Affordable Care Act, primary care physicians must be reimbursed for behavioral health and other preventative screenings provided to children and youth. Even prior to the implementation of ACA, Nevada Medicaid reimbursed providers for children's behavioral health screenings under the EPSDT program. However, there are no Nevada data on the extent to which pediatricians and primary care physicians are currently being reimbursed by other benefit programs for behavioral health screenings and whether they are using standardized tools recommended for best practice such as the Pediatric Symptom Checklist developed by the American Academy of Pediatrics.

- **Objective 5.4** Through **education funding, implement evidence-based preventative programs for bullying prevention, social/life skills training, and positive behavioral supports in public schools by (a) inventorying current programs; and (b) expanding successful programs.**
  Indicators: School policies and/or regulations; number of schools with programs and number of students participating

  CURRENT STATUS: Some Progress. The Clark County School District (CCSD) has mobilized collaboration among key district partners to develop and implement an anti-bullying initiative. Key partners in this collaboration have included: Equity and Diversity Education Department; Education Services Division; School Police Department; Instruction Unit; Guidance and Counseling Department including the Safe and Drug Free Schools Program; and the Student Services Division including Psychological Services and Wraparound Services. A resource and needs analysis completed by the Anti-bullying Task Force concluded that CCSD has:

  - Policies and regulations in place that address bullying, cyber-bullying, safe and respectful learning environment, and discipline.
  - Mechanisms for reporting incidents of bullying to district, school, and law enforcement personnel.
  - Discipline protocols in place in policies, regulations, and documents including "Behaving Positively at School for Elementary Students" and "Secondary Behavioral Guidelines."
  - Professional development and resources that meet legislative requirements established which are implemented by Equity and Diversity Education Department, Curriculum and Professional Development Division, and Education Services Division.
  - Approved health curriculum in Grades K-5, 8, and 9 with standards related to Injury/Violence Prevention and Safety, Safety, and Self-esteem Strands which are embedded in Social Studies (Civics), Technology (Digital Citizenship), Guidance and Counseling, Psychological Services (Response to Instruction), and Signs of Suicide Instructional Program.
  - CCSD Internal Bullying Prevention Committee to develop topics and supports related to safe and respectful learning environment including bullying, and to develop a rubric for reviewing vendor and presenter requests.
  - Bullying/cyber-bullying informational posters and pamphlets, *It Stops Here – Bullying and Cyber-bullying,* are available online and in hard copy.

  Recommendations stemming from the CCSD Anti-bullying Task Force have included:

  - Strengthening notification and reporting requirement for bullying,
  - Defining and measuring administrative responsibilities,
  - Enhancing curriculum and interventions,
  - Improving professional development,
  - Developing a plan for accountability to ensure compliance at every level of implementation, and
  - Updating policies and regulations to reflect language in the current state statutes.

  Consequently, the Clark County School District is actively pursuing a course of system-level change to better prepare for and address issues of student bullying in the schools.

  Similarly, the Clark County School District has acknowledged the need to develop Multi-tiered Systems of Support (MTSS) in the schools. The need for positive behavioral interventions and supports (PBIS) is identified within the Clark County School District's Response to Instruction (RTI) Operations Manual. Key principles associated with RTI and PBIS include early screening, evidence-based instruction and intervention practices delivered at multiple (tiered) levels, continuous progress monitoring, collaborative problem solving, and data-based decision making. Training and technical support for PBIS are currently provided to CCSD schools on a limited basis (Foundations and CHAMPS curricula, Safe & Civil Schools, Inc.). 2014-2015 school year goals for PBIS within the

Clark County School district are foundational to future growth and include: increased awareness by school principals of the need for school-based PBIS practices; expansion of the number of schools implementing school-wide PBIS practices (Foundations Pilot Program); expansion of the number of schools implementing PBIS-related classroom management practices (CHAMPS Pilot Program); and expanding the number of licensed staff who are capable of training school-based teams in PBIS practices. The Clark County School District is also hoping to collaborate with the Nevada Department of Education (NDE) under a federal School Climate Transformation Grant obtained by NDE to bring additional PBIS training and technical support directly to CCSD schools.

- **Objective 5.6 Develop and implement a comprehensive plan for training school personnel in early identification and intervention for behavioral health issues and suicide prevention through the GLS Grant.**
  Indicators: Proportion and type of staff trained annually

  CURRENT STATUS: Substantial Progress. The Clark County School District has recognized the importance of training school personnel for suicide intervention and early prevention. First, all CCSD school counselors, school nurses, school psychologists, and school social workers have been trained in the District's Suicide Intervention Protocol, which centers on structured interviews with students and parents for confirmation of risk and estimation of level of risk for self-harm in individual students. Second, for the 2013-2014 school year, the Clark County School District embarked on implementing the Signs of Suicide (SOS) Education Program in all eighth and ninth grade Health classes district wide. Recent survey responses from Health teachers and counselors indicated that at least 50 CCSD schools (48% of comprehensive CCSD secondary schools) included viewing by school staff of the SOS "Trusted Adults" training video as an integral part of their SOS Program implementation. Expansion of the SOS Program, including staff training, across CCSD eighth and ninth grade Health classes is expected to continue for the 2014-2015 school year. Third, the District was recently awarded a federal Project AWARE Grant for the 2014-2015 and 2015-2016 school years, which will enable CCSD to train 30 instructors and subsequently, 1,600 local adults in the Youth Mental Health First Aid (YMHFA) Program. Training in YMHFA will enable these adults to better detect and respond to mental illness in school age children, and to encourage these youth and their families to seek treatment. With these action steps, the District is progressively developing staff commitment and capacity for early identification of youth with behavioral health issues as well as crisis intervention in more serious situations.

- **Objective 5.8 Assist local child welfare and juvenile justice agencies to implement universal screening mechanisms for behavioral health issues and suicide risk.**
  Indicators: Proportion of youth screened

  Current Status: Some Progress. Clark County Department of Juvenile Justice Services continues to provide screenings on youth who are detained. For the calendar year of 2013, 3,043 youth were detained and screened with the Massachusetts Youth Screening Instrument –Second Version (MAYSI-2). Screenings that focus on mental health, suicidality and substance abuse provided by the Family Empowerment Program (FEP) to additional youth seen by Probation Services at the Neighborhood Care or Probation Centers also occur. It is believed that 336 screenings were completed on Field Probation youth for 2013. In addition, in calendar year 2013, 665 youth at the Probation Intake level were screened through the Substance Abuse Assessment and Referral Program (SAARP) utilizing the Problem Oriented Screening Instrument for Teenagers (POSIT).

Clark County Department of Family Services completes a screening related to mental health (including suicide risk), domestic violence, and substance abuse for all children at the time that they enter Child Haven. Case managers gather information on mental health needs at the time of removal and at each subsequent change of placement. Identified concerns and treatment needs are also provided to the caregiver at that time.

- **Objective 5.9 Use Medicaid funding and a partnership with Nevada PEP to expand outreach and early screening to at-risk groups through school-based health clinics and primary care clinics.**
  Indicators: Annual Medicaid expenditures for Clark County outreach and screening

  CURRENT STATUS: Minimal Progress. The Nevada Division of Public and Behavioral Health has revised its credentialing policies for school-based health centers to include standards for the provision of mental health screening and services, however, no data are available on the utilization of early screening services in school-based health centers and primary care clinics.

- **Objective 5.10 Partner with the Nevada Office of Suicide Prevention to train child welfare caseworkers and probation and parole officers in the early identification of youths with behavioral health issues and suicide risk.**
  Indicators: Number youths identified and linked with services by trained caseworkers and parole/probation officers

  CURRENT STATUS: Some Progress. The Department of Child and Family Services (DCFS) Youth Parole Division has provided the Clark County Department of Juvenile Justice Services (DJJS) access to Shields of Care training. As a result, Clark County Juvenile Justice Services has updated and modified their in-house training provided to probation officers that includes a "Mental Health 101" class that addresses behavioral health issues and suicide prevention and is POST-approved. The Nevada Office of Suicide Prevention has attended the in-house trainings. In 2014, probation officers referred 2,277 youth for evaluation by clinical services' staff.

  County Department of Family Services offers training opportunities to staff and caregivers on various children's mental health topics. Training topics include: Mood Disorders in Young Children; Failure to Thrive and Child Neglect; Attachment Issues of Childhood: An Overview; Introduction to Infant & Early Childhood Mental Health; ADHD, Anxiety & Sensory Deficits in Young Children; and Drug Exposed Babies.

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

- **Objective 6.1 Establish new funding for Continue Public Awareness Activities through the GLS Youth Suicide Initiative.**
  Indicators: Number, type and outcomes of awareness activities yearly

  CURRENT STATUS: Some Progress. At this point in time Nevada is no longer receiving GLS Youth Suicide Initiative funding to support awareness activities. The Nevada Office of Suicide Prevention applied for continued GLS funding for 2015 but did not receive an award. Since the GLS funding has no longer been available the CCCMHC has supported awareness activities through approximately $1500 from the yearly budget through DHHS supported by DCFS. Yearly awareness activities have been centered on the National Children's Mental Health Awareness Day each May. These activities

are coordinated by the CCCMHC's Public Awareness and Behavioral Health Workgroup.

Most recently, in 2014, the Workgroup partnered with the Nevada Office of Suicide Prevention and the Clark County School District to create awareness and follow up of the Signs of Suicide (SOS) education program that is being delivered in eighth and ninth grade Health Classes throughout CCSD. CCCMHC sponsored a poster contest open to all eight and ninth grade students who received the SOS course content. The content of the posters focus on the SOS curriculum and must include certain requirements including the suicide hotline phone and text numbers. Posters are judged on content, creativity and originality. Winners are chosen from both middle school and high school. Winners are announced on Children's Mental Health Awareness Day. Winning posters are printed in 17 x 22 sizes and distributed to all Nevada high schools and middle schools to be displayed. Posters are also available on the website of the Nevada Coalition for Suicide Prevention.

- **Objective 6.2 CCCMHC will work with Nevada Department of Education to include training on mental health awareness and suicide prevention in curriculum standards.**
  Indicators: Nevada Department of Education Regulations

  CURRENT STATUS: Some Progress. Although Nevada Department of Education regulations have not been changed to include mental health awareness and suicide prevention as required curriculum components, the Clark County School District has voluntarily incorporated suicide prevention awareness into its secondary school health classes by requiring the implementation of the Signs of Suicide Educational Program. This program teaches youth to "acknowledge, care, and tell someone" if they or a friend have feelings of depression or thoughts of suicide.

  The Department of Education has partnered with the Office of Suicide Prevention to bring Safe Talk training to school administrators across the state. DOE has also received a grant that will allow them to bring Youth Mental Health First Aid training to adults that work with youth in other settings across the state.

- **Objective 6.3 CCCMHC will work with professional associations, Southern Nevada Health District, and Nevada PEP to support the development and dissemination of mental health awareness information to parents at primary care settings.**
  Indicators: Proportion of primary care facilities with available materials

  ***CURRENT STATUS*: *Some Progress*.** CCCMHC members conduct ongoing outreach to increase the awareness of children's mental health needs in Clark County. Nevada PEP continues to support the dissemination of suicide prevention awareness brochures and other materials at local health fairs and through media outlets. The Southern Nevada Health District uses its website to promote children's mental health awareness materials produced in collaboration with the CCCMHC. Each year, members disseminate the most recent findings of the CCCMHC to local advocacy and professional organizations such as the Nevada Psychological Association and the Children's Advocacy Alliance as well as to local and state policy makers, and members of the judiciary.

ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Current Membership

Janelle Kraft-Pearce, Chairperson
Las Vegas Metropolitan Police Department
Dan Musgrove, Vice Chairperson
Business Community Representative
Mike Bernstein
Southern Nevada Health District
Jennifer Bevacqua
Nevada Youth Care Providers Association
Lisa Durette, M.D.
American Academy of Child & Adolescent Psychiatry
Charlene Frost
Parent Representative
Jacqueline Harris
Provider of Substance Abuse Services
Amanda Haboush-Deloye, Ph.D.
Nevada Institute for Children's Research & Policy
Phyllis Keen
Foster Parent
Terri Keener
Clark County Family Services
Heather Lazarakis
Nevada Division of Health Care Financing & Policy
Karen Miller
Parent Representative
Karen Taycher
Nevada Parents Encouraging Parents
Robert Weires
Clark County School District
Kelly Wooldridge
Nevada Division of Child & Family Services
Cheri Wright
Clark County Juvenile Justice Services

Mission

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

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