Clark County Children's Mental Health Consortium

2024 Service Priorities Report

2030 Vision for Success

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

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I. INTRODUCTION

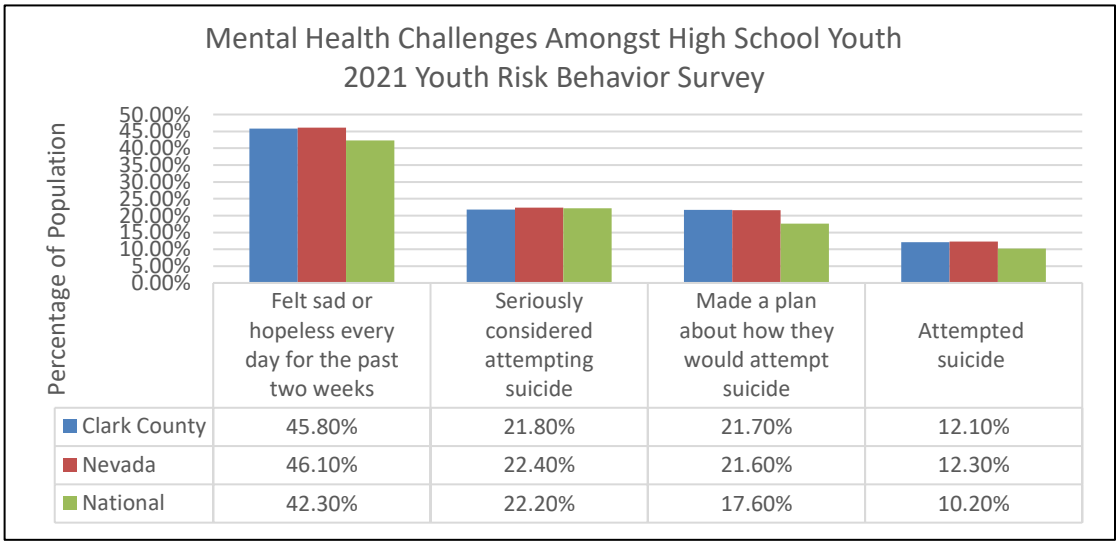
PREVALENCE OF MENTAL HEALTH PROBLEMS

A youth's mental health consists of thoughts, feelings, and behaviors that determine whether that individual can cope with stress, relate to others, make appropriate choices, and learn effectively. Like physical health, mental health is important at every stage of a person's life. Unlike physical health problems, mental health conditions cannot always be seen, but the symptoms can be recognized. Unfortunately, Nevada has consistently ranked 51st for youth mental health access and services in national reports.

Clark County is home to over 70% of the youth in Nevada. As of 2022, there were an estimated 515,202 children in Clark County between the ages of 0-19, representing nearly 22.2% of the county's population (U.S. Census Bureau, 2023). These children mirror the growing cultural and ethnic diversity of the region. Nearly 50% of the county's children 0-19 are from non-white ethnic or racial backgrounds including 44.0% of Hispanic or Latino origin, 14.3% of Black or African-American origin, and 7.8% representing two or more races (U.S. Census Bureau, 2023). There are 3.5% of children under 18 in the county who are foreign-born (U.S. Census Bureau, 2022). With the ever-increasing diversity of the county's population, it is crucial that the programs and services provided to youth and families consider the languages and cultures of Clark County residents.

Clark County's children with behavioral health needs share many of the same characteristics and challenges of children with behavioral health needs across the United States. The U.S Substance Abuse and Mental Health Services Administration (SAMHSA) identifies those with behavioral health needs as having a mental and/or substance abuse disorder that may be recurrent and often serious but treatable (2013). The most recent national studies have confirmed that between 13-20 percent of American children aged 5-18 years have experienced a behavioral health disorder within the past year, and over 1 in 5 adolescents have suffered severe impairment as a result of these disorders (SAMHSA, 2013). By the time U.S. children reach adulthood, approximately one-half have experienced a behavioral health need at some point in their young lives (SAMHSA, 2013). Underscoring the notion that mental disorders begin early in life, these studies have found that symptoms of anxiety disorders often began by age 6, behavior disorders (such as ADHD or conduct disorder) by age 11, mood disorders by age 13, and substance use disorders by age 15. The percentage of teenagers suffering from mental disorders is even higher than the most frequent major medical conditions of adolescence (Merikangas et al., 2010). Even children younger than five years of age may exhibit serious emotional and behavioral problems, with one national study estimating a prevalence rate of 10-14% in this population (Brauner & Stephens, 2006).

Overall, about 38,000 Nevada youth (16.02%) were reported to have experienced at least one major depressive episode in 2023, and approximately 32,000 youth (13.8%) that experienced severe major depression within the last year (Reinert et al., 2022). In addition, the most recent Youth Risk Behavior Survey (YRBS) found that statewide, there was a significant increase ($p < 0.001$) in the number of students who felt sad or



	Felt sad or hopeless every day for the past two weeks	Seriously considered attempting suicide	Made a plan about how they would attempt suicide	Attempted suicide
Clark County	45.80%	21.80%	21.70%	12.10%
Nevada	46.10%	22.40%	21.60%	12.30%
National	42.30%	22.20%	17.60%	10.20%

Source: Anderson et al., 2022

hopeless almost every day for two weeks from 2019 (40.3%) to 2021 (46.2%) (Anderson et al., 2022). This same report indicated that 21.8% of Clark County public high school students seriously considered suicide and 12.1% actually attempted to kill themselves (Anderson et al., 2022).

In 2021, 691 Nevadans of all ages lost their lives to suicide (CDC, 2023). According to the Nevada Office of Suicide Prevention, in 2021 nationally suicide was the second leading cause of death for youth 8-17 years of age. The third leading cause of death for those 18-25 years of age with homicide second. In Nevada suicide was second leading cause of death ages 8 to 43 years of age in 2021. For adults 26 to 39 years of age suicide being second leading cause of death. Preliminary data for 2022 and 2023 shows Nevada has limited reduction in some age groups (Nevada Office of Suicide Prevention, personal communication, December 13, 2023). The Nevada Office of Suicide Prevention has 2022 preliminary data which indicates minimal change in youth and young adult suicides. This data demonstrates the significant ongoing efforts for more prevention measures and treatment services which are available to youth and families prior to entering a crisis state. The Public Health Prevention Model starts long before the struggles of adulthood and are crucial in preventing youth and young adult suicides. A greater investment and focus on these services will help save the lives of our community members.

Youth mental wellness is impacted by a variety of factors which include their interactions in their environment. In recent years, bullying has become a prevalent issue in Nevada. SafeVoice Nevada is a statewide hotline where students, parents and faculty throughout Nevada can make anonymous reports about threats to the safety or well-being of students in any environment. The chart below shows the top five event types over the past three years (McGill, 2021, 2022, 2023). The top five tips have remained consistent over time. A comprehensive report on the implementation of SafeVoice further demonstrates this as it indicates that bullying, suicide threats, school/employee complaint, threat to student, and planned school attack/threat to school are among the most frequent tip types statewide from 2018 to 2022 (Al Stein-Seroussi, 2023).

Top 5 SafeVoice Event Types		
2021	**2022**	**2023**
1. Suicide Threats 2. Handle With Care 3. Cyberbullying 4. School/Employee Complaint 5. Threat to Student	1. Bullying 2. School/Employee Complaint 3. Suicide Threats 4. Threat to Student 5. Planned School Attack/Threat to School	1. School/Employee Complaint 2. Threat to Student 3. Planned School Attach/Threat to School 4. Bullying 5. Suicide Threats

Source: McGill, 2021; McGill, 2022; McGill, 2023

Such instances of physical and emotional harm can have a damaging impact on youth mental health. Research suggests that children and youth who are bullied over time are more likely than those not bullied to experience feelings of rejection, exclusion, isolation, and low self-esteem that can often lead to mental health disorders, poor academic performance, lack of motivation, and/or suicide (Evans et al., 2018; Warner, 2021). Due to the presence of social media and other digital platforms, the access to bullying has grown significantly among youth, presenting an even greater danger to young individuals throughout Clark County. For these reasons, it is imperative that behavioral health services and mental health resources are available and accessible to youth to prevent the long-term effects of bullying.

According to the fiscal year (FY) 23 Nevada Report Card, 33.9% of students with individualized education programs (IEPs) involved in bullying incidents were suspended and 4.9% were expelled (Nevada Department of Education, 2023).

Disciplinary incidents among IEP students in Nevada: Comparison of FY22 and FY23 data				
	2022		2023	
	# Of students suspended	# Of students expelled	# Of students suspended	# Of students expelled
Due to battery to a school employee	286	36	299	49
Due to sale of controlled substances	46	6	42	17
Due to distribution of controlled substances	46	6	42	17
Due to being deemed habitual disciplinary problems	16	1	0	0
Due to possession of a firearm	0	8	0	8
Due to possession of a dangerous weapon	0	78	0	76

Source: Nevada Department of Education, 2023

For a student whose behavior impedes the student's learning or the learning of others, evidence-based behavior interventions and supports should be included in the student's IEP and implemented, and school administrators should consider other district and community-based resources that can provide alternatives to suspension and expulsion. This will also prevent the child from accumulating a series of suspensions that, over time, will result in an inappropriate "change in placement." Clark County schools need to implement restorative justice practices that target behavior management, collaboration with professionals, and reintegration. This is critical for youth who have an IEP that require specialized actions to meet their mental and behavioral health needs. The use of positive behavior interventions and supports (PBIS) would also help to reinforce positive behavior and support students' social, emotional, and mental health.

Another population that is in high need of mental health services are those involved with child welfare and juvenile justice. Estimates of the prevalence of mental health problems are much higher for children involved with child welfare and juvenile justice. National studies show that 7 in 10 youth in juvenile justice have a mental illness, many of which experience symptoms of multiple disorders (Seiter, 2017). Internalizing and externalizing disorders are found to be overrepresented among justice-involved children, including substance use disorders, conduct disorders, anxiety and PTSD, mood disorders, and attention deficit hyperactivity disorder (ADHD) (Sill, 2020). Locally, it is estimated that more than 70% of youth involved in the Clark County juvenile justice system have behavior health disorders and 60% of those with behavioral health disorders have a co-occurring substance use disorder (CCCMHC, 2018).

Across the nation, a variety of funding sources and complex funding mechanisms support the delivery of children's behavioral health services in communities like Clark County. Children's behavioral health care funding has been minuscule as compared to total healthcare spending, disproportionately small as compared to adult mental health funding, and discordant with best practices favoring community-based care over residential treatment.

Children's behavioral health disorders are highly treatable and even sometimes preventable, studies have found long delays, even decades between onset of symptoms and identification and treatment of the disorder (SAMHSA, 2007; SAMHSA, 2013). Whether rich or poor, insured or uninsured, the families of children with serious behavioral health disorders struggle to find appropriate services, often turning to the public systems that provide children's mental health care.

It takes substantial funds from local, state, and federal budgets each year to address the negative consequences of not providing youth with early access to services and supports---through the schools, the child welfare system, the juvenile justice system, and the adult mental health and prison systems. Parents of children with serious mental health needs often struggle to get services for their child as soon as they know something is wrong. Clark County needs to improve early

access to services and to assist families and communities in providing children with environments that support positive emotional and social development. Investing in this “front-end” approach will ultimately free up resources to expand and improve services for children at all levels of need.

CONTINUED IMPACT OF THE COVID-19 PANDEMIC

Negative effects on adolescent mental health have persisted up to two years into the pandemic as youth continue to experience increased symptoms of depression, anxiety, and a decrease in mental well-being (Thorisdottir et al., 2023). The pandemic was a global traumatic event that also shined light on areas of the children’s behavioral and mental health systems that were already under strain. Even though emergency orders related to the pandemic have been lifted across the United States, including in Nevada and Clark County, children and youth are still in need of many mental health supports that are lacking in their communities, or just not available in the state.

Although most students have returned to in-person educational settings, many still face long-term consequences with education and mental health. Social and emotional development was essentially paused during virtual schooling that was required during the pandemic and students are now far behind in their abilities to work as part of a group, follow instructions, and engage in positive social interactions. CCCMHC recommends that school administrators take these facts into account when developing plans to address learning loss due to COVID-19. This includes providing additional support for teachers and school mental health professionals to recognize when students are struggling and training on how to connect families with resources. It is our responsibility to protect and support the children in our community, and we need to ensure that the mental health of youth is a priority.

THE CCCMHC 10-YEAR STRATEGIC PLAN: 2030 VISION FOR SUCCESS

To help provide Nevada's youth and families with the high-quality care and timely access to services they deserve, the Clark County Children's Mental Health Consortium set 6 goals in the 2020-2030 10-Year Strategic Plan to guide future program and service implementation. This 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. Just after the completion of the plan, the CCCMHC identified the top 4 priorities to improve the system while Clark County moves toward full implementation longer-term plan.

10-Year Plan Goals

1. ***ADDRESSING THE HIGHEST NEEDS:*** *Youth with serious emotional disturbance, including those with the highest need, and their families, will thrive at home, school, and in the community with intensive supports and services.*

2. ***COMPREHENSIVE SERVICE ARRAY FOR ALL:*** *Families of youth with any mental and behavioral health needs will have timely access to a comprehensive array of high-quality services when and where needed.*

3. ***NO WRONG DOOR TO SERVICES:*** *Organized pathways to information, referral, assessment, and crisis intervention – coordinated across agencies and providers – will be available for families.*

4. ***PREVENTION and EARLY INTERVENTION IN MENTAL HEALTH:*** *Programs and services will be available to facilitate the social and emotional development of all youth, identify mental and behavioral health issues as early as possible, and assist families in caring for their youth.*

5. ***RAISE AWARENESS and SUPPORT FOR MENTAL HEALTH:*** *Increased public awareness of the behavioral health needs of children and youth will reduce stigma, empower families to seek early assistance, and mobilize community support for system enhancements.*

6. ***LOCALLY MANAGED SYSTEM OF CARE:*** *A partnership of families, providers, and stakeholders committed to community-based, family driven, and culturally competent services will collaborate to manage this system of care effectively at the local level.*

Top 4 Priorities

1. *Sustainable funding for the Mobile Crisis Response Team (MCRT)*

2. *Family peer-to-peer support should be expanded*

3. *Fully implement the Building Bridges model of care to support youth and families transitioning from residential care back into the community*

4. *More service array options so youth and families can access care at earlier stages to reduce the need for crisis service intervention*

II. CCCMHC FOUR PRIORITIES

Priority 1. Provide mobile crisis intervention and stabilization services to Clark County youths in crisis.

Justification

Clark County youth in crisis should have access to an evidence-based mobile intervention and stabilization service**.** 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. To further exacerbate the situation, when youth are in crisis and families use emergency rooms for help, their youth can end up in the hospital for multiple days without a nursing team that is trained to support youth with Serious Emotional Disturbance (SED) and/or co-occuring disorders, parents worry about leaving their child in the hopsital alone to go and attend to their other children, and lengthy waits for approved assessments by the families insurance exntend the crisis and delays proper support and treatment. When mobile crisis teams respond to a youth/family crisis, immediate assessment, referral, and support is mobilized to begin helping the family immediately.

The Nevada Division of Children and Family Services MCRT has been an incredible asset to our community and should have a stable funding source to ensure that it continues to operate on a 24-hour basis to offer these much-needed services to youth and families. All the Nevada DCFS transitioned to the 988 Mental Health Crisis Lifeline that went into effect on July 16, 2022 to serve youth under 18 and their families needing crisis mental health services. The 988 hotline replaced the 10-digit number for the National Suicide Prevention Lifeline and diverts callers away from 911 emergencies. This will make it easier for people to get help for mental and behavioral health-specific concerns. The hotline is open Monday-Sunday for 24 hours a day. The 988 call center provides substantial de-escalation, triage, and care traffic control. They may refer to outpatient care, dispatch mobile crisis, refer to crisis stabilization unit, and dispatch law enforcement through the hotline (Division of Child and Family Services, 2022). We do not yet have data from 988 indicating how often youth are using this resource but are working with them to have regular reports. Also, there have been several concerns since the 988 call line has been launched about long wait times when people are calling for assistance.

The Nevada DCFS reports that the condition of mobile crisis response teams has made some progress but still remains insufficient for the mental and behavioral health needs of children. Specifically in Clark County, from January - December 2023, the DCFA Children's Mobile Crisis Response Team received 2,281 calls and responded to 948 of those calls. Of the youth that received a response 739 were stabilized in the community (78%) versus potentially having to seek care in an in-patient setting (Division of Child and Family Services, personal email communication, January 30,2024). Stabilization in the community includes providing short-term counseling and case management until they can connect families with long-term providers and peer supports.

The Mobile Crisis Planning Grant Project and Core teams have been working hard on developing how Nevada will build mobile crisis teams that will be eligible under enhanced Federal Medical Assistance Percentage (FMAP) offered through Section 1947 of the SUPPORT Act. Currently, DCFS does seek reimbursement from Medicaid for youth that are eligible. It is likely MCRT will pursue a state plan amendment rather than a waiver to ensure our already covered crisis intervention services include the requirements needed and outlined for qualifying mobile crisis teams to receive enhanced FMAP.

While the information above provides details on the DCFS MCRT, additional MCRTs following evidence-based practices could be established to help fill the need in the community. The report from the Department of Justice found that Nevada is failing to ensuring access to community-based services, and this includes crisis support services. This is driving youth and families to hospitals for behavioral health treatment. The State even published a white paper acknowledging that "hospital emergency departments are the primary means by which people in Nevada gain access to necessary behavioral health services" (U.S. Department of Justice, p. 7-8, 2022). Although mobile crisis services should be used to prevent visits to the hospital, in Nevada, MCRT is often not called until a child has arrived at the hospital. State data show that the largest percentage of calls to the state's mobile crisis line comes from hospital emergency departments.

Due to lack of support to parents and families, families are using extreme measures to get help for their children including relinquishing their children to Child Haven, Clark County's emergency shelter for child welfare, and they are also calling the police to seek the arrest of their children for behavioral health-related conduct as they believe this might be a better way to access treatment (U.S. Department of Justice, 2022).

Recommendations

1) Increased and sustained funding should be included in the state's budget to ensure that MCRT can sustain and expand services to youth throughout urban and rural Clark County. This service is especially crucial given the increase of youth and families with mental and behavioral health needs due to the COVID-19 pandemic. In addition, implementation of all mobile crisis response teams should ensure that the evidence-based model for youth is being followed in order to obtain the most effective results.

2) To ensure that Nevada's 988 system is successful, it is recommended that the implementation procedures includes specific recommendations for youth and families that were provided by the National Federation of Families including the following: 1) call staff should receive education on pediatric, child/adolescent development, family systems training/experience, 2) incorporate the use of family and youth peer support in call taking, 3) explore call routing where a caller would choose to speak to a peer or clinician, and 4) when using a real-time regional bed registry to connect to services for those that need it, include community-based services on the list to provide options to the most least restrictive environment within the community.

3) Clark County should have sufficient Mobile Response and Stabilization Services to ensure that any youth in crisis will receive an in-person Mobile Crisis response within 60 minutes of their initial call for help. All Mobile Response providers who respond to youth under the age of 21 in Clark County should be trained in and follow best practice standards as issued by the SAMHSA and the State of Nevada.

4) Recently released guidelines from Substance Abuse and Mental Health Services Administration (SAMHSA) outline the recommendations to respond to youth in crisis are implemented. These include:

- Keep youth in their home and avoid out-of-home placements, as much as possible.
- Provide developmentally appropriate services and supports that treat youth *as* youth, rather than expecting them to have the same needs as adults.
- Integrate family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
- Meet the needs of *all* families by providing culturally and linguistically appropriate, equity-driven services (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022).

Core principles outlined in the National Guidelines for Child and Youth Behavioral Health Crisis Care – Best Practice Toolkit should be adopted:

- Address Recovery Needs
- Provide Trauma-Informed Care
- Include Significant Role for Peers
- Implement Zero Suicide/Suicide Safer Care
- Implement Safety/Security Protocols for Staff and People in Crisis
- Form Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (SAMHSA, 2022).

4) SAMHSA (2022) reinforces that "all youth and families should have access to crisis care that meets their needs, and these needs vary across communities and groups." This means that providers should be trained to respond to diverse families as well as reflect those families. Diversity includes providing care across all geographic locations, ages (infants through youth transitioning to adulthood), race and ethnicities, sexual and gender minorities, immigrants and refugees, youth whom are houseless, youth with intellectual or developmental disabilities, and other important service populations (SAMHSA, 2022).

Projected Costs

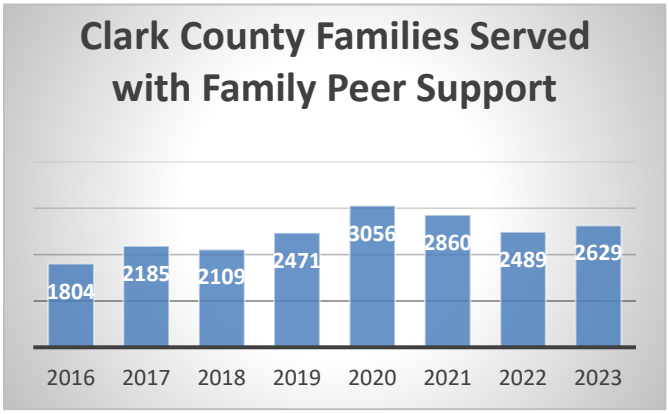
The costs of MCRT will vary depending on the number of youths expected to serve and the level of service. DCFS has the anticipated costs related to the program and therefore should be consulted when making budgetary decisions.

Priority 2. Family Peer to peer support should be expanded

Justification

Family peer support is a service provided by Nevada PEP that connects parents of children with mental and behavioral health needs to other parents with lived experiences under the goals of: increasing resiliency, decreasing isolation, decreasing internalized blame, increasing realization of importance of self-care for parents, increasing feelings of self-efficacy, and increasing the acceptance and appreciation of the child's challenges with increased ability for families to engage with both formal and informal supports.

Families are referred by DCFS programs, schools, and community organizations. In 2023, Nevada PEP received 203 referrals from Southern Nevada Children's Mobile Crisis Response Team, 332 referrals from the Harbor juvenile justice diversion program, 48 new families from other Division of Child and Family Services programs, and 1,185 family self-referral. Over the last year (2023), Nevada PEP provided family peer support services to 2,629 families in Clark County.



Source: Nevada PEP, 2024

Family peer support was identified as Medicaid billable in the May 2013 Joint CMCS and SAMHSA Informational Bulletin which was based on evidence from major U.S. Department of Health and Human Services (HHS) initiatives that show that these services are not only clinically effective but cost effective as well.

In 2022, the United States Department of Justice investigation in Nevada found that family peer support is not sufficiently available to families to prevent institutionalization, and that changes need to be made to Nevada's Medicaid definitions to allow for adequate provision of family peer support.

The Division of Child and Family (DCFS) services has long recognized the value of family peer support, from partnerships with Nevada PEP on grants from 1993 to contracting for the service beginning in 2012. It is anticipated that Medicaid will work towards including Family Peer Support as a result of the Department of Justice settlement.

In August 2022, DCFS championed a funding increase with ARPA funds for family peer support to begin in January 2023 and run through June 2024. Currently Nevada PEP family peer support specialists follow a two-year national certification process, in October 2022, DCFS also supported a project to develop an in-state family peer support certification process to increase the workforce, make the service more readily available to families through multiple family-run organizations. Both initiatives were recognized as valuable and were supported by the Nevada State Legislature Interim Finance Committee and are in process.

Recommendations

1) Funding for family peer support should continue past the availability of ARPA funds as a part of Nevada's adequate children's mental health service array in line with the Department of Justice findings.

2) Nevada Medicaid should include family peer support as a service in the State Plan for Medicaid eligible children and youth with Serious Emotion Disorders and co-occurring disorders. The return on investment would be reflected in a decrease in costly out of home placements and less separation and strain on families.

Projected Costs

The costs of peer-to-peer support will vary depending on the number of parents served and the role of the staff. Nevada PEP has the anticipated costs related to the program and therefore should be consulted when making budgetary decisions.

Priority 3. Fully implement the Building Bridges model of care to support youth and families transitioning from residential care back into the community.

Justification

It is essential for youth and families to have the appropriate supports in places when exiting residential care to prevent re-entry. The Building Bridges model provides a guide to best practices that should be implemented in the community. The Building Bridges Initiative provides best practice guidelines and standards to create residential and community-based services and supports that are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. The implementation of initiative should be prioritized to ensure families have the resources needed to provide treatment in the least restrictive setting and using the highest quality practices.

The existing DCFS Psychiatric Residential Treatment Facilities in Nevada, which are licensed by the Bureau of Health Care Quality and Compliance (HCQC) and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), provide 24-hour highly structured services for children and youth between ages 6-17 who are severely emotionally disturbed. In order to access these facilities, youth must meet the Medicaid guidelines. The two state operated facilities available is Southern Nevada are Desert Willow Treatment Center and Oasis which has recently closed but is being replaced by another agency. However, as noted by the current numbers served below, there are limitations in access due to an inability to staff the facility even though funding is available. This highlights a staff shortage problem that is occurring nationwide severely reducing access to all healthcare. Even when the facilities are operating at capacity, there are still additional limitations in their ability to serve all youth (i.e. youth with serious behavioral problems, intellectual and/or developmental disabilities) due to lack of staff experience and expertise. This is also true at many private facilities.

Children's Mental Health Facility Population

CMH Facility	Count as of 12/27/2023*	Count as of 1/3/2024*
Desert Willow Treatment Center - Acute Services	2	3
Desert Willow Treatment Center - Residential Services	18	18
PRTF - Enterprise**	-	-
PRTF - North**	10	9
PRTF - Oasis** - Permanently Closed 12/18/23	-	-
Total CMH Facility Population	**30**	**30**

Source: Division of Child and Family Services, 2024

Another critical partner in the implementation of the Building Bridges model is the Clark County School as they play an important role in assisting with youth transitioning from in-patient care back to the school environment. To increase the success of this transition back to the home and school environment, the Mental Health Transition Office (MHTO) works in partnership with schools, families, and community mental health providers to provide communication and consultative related to behavioral interventions and re-entry (transition) supports, community resources, Section 504 accommodations or special education evaluations and services. The most recent data available indicate that there were 1055 students referred to the MHTO in the 2022-2023 school year which is a slight increase from the previous school year (1020 referrals). The youth referred include students in elementary schools (10.14%), middle school (29.19%), and high school (60.6%). Approximately 28% of the students were eligible for one of the special education categories, approximately 46% had a diagnosis of major depressive disorder, and approximately 55% were admitted due to a suicide attempt or suicidal ideation.

Availability of In-Patient Treatment

While it is our goal that every child would be able to receive the treatment they need in community-based settings, this has not been possible with the current resources available in our community. The CCCMHC has expressed concern over the past several years about the limited number of quality residential treatment beds for youth in the community. Residential treatment in Southern Nevada is limited and therefore youth may be placed out of state to receive services, which removes vulnerable youth from their family, friends, and other social support networks and creates complications for reentry into the community. In addition, a recent Legislative Auditor report on the Governmental and Private Facilities for Children– Inspections issued on January 12, 2023, found that 5 of the children's facilities inspected has identified multiple issues that caused the auditors to question whether the facility adequately protected children in care, and those concerns were communicated to the licensing agencies (Legislative Auditor, 2022). Finally, the U.S. Department of Justice conducted an investigation indicated that the State of Nevada unnecessarily institutionalizes children with behavioral health conditions, and determined Nevada is in violation of Title II of the Americans with Disabilities Act and the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).

One ongoing issue that is plaguing the community is the inability to place a group of youth that have been flagged as "problem youth." Facilities are refusing to admit these youth due to their behavioral needs and often these youth have dual diagnosis (more than one mental health disorder) that include behavioral and intellectual diagnoses. It is unfair to the youth and these parents to not have access to the intensive service that are needed. In extreme circumstances, when youth are denied these services, some parents feel they cannot provide care for their children and look to relinquish their children to DCFS.

We need to ensure that we have the ability to provide both quality residential care treatment services as well as community-based services so our youth and families are supported as they return to the community. In addition, CCCMHC will follow the current DOJ investigation and determine if action is needed as more information is available.

Recommendations

1) It is imperative that given the current staffing needs and continual impacts from COVID -19, a strong focus should be on providing more intensive in-home services. These services are provided to a child whose mental health or behavioral disorders have severely affected the family environment to a point where they are at risk of being removed from the home. By giving more attention to these services, youth and families can stay together and do so in the least restrictive environment.

2) For those youth that require residential services, Clark County needs to increase local resources to successfully keep those youth in the community to the maximum extent possible, rather than sending them out of state for services. This is especially needed for youth with both intellectual and development disabilities and mental health needs as many residential services are not prepared to accept these youth due to lack of knowledge and experience.

3) CCCMHC members should continue to work with community partners to determine how to ensure youth who are being refused admission to residential facilities have access to treatment so youth and families receive what they need and deserve.

4) The CCCMHC should follow-up with recent investigations from the Department of Justice and help support plans to increase these services for youth. We need to ensure that we have the ability to provide both quality residential care treatment services as well as community-based services so that our youth and families are supported as they return to the community.

Projected Costs

The costs of implementing Building Bridges model of care will vary depending what is being implemented. Therefore, it is recommended to consult with DCFS when making budgetary decisions.

Priority 4. More service array options so youth and families can access care at earlier stages to reduce the need for crisis service intervention

Justification

Youth and families need access to quality home and community-based services. It is necessary to have available integrated community services to reduce on out of home and out of state placement to avoid unnecessary segregation and institutionalization.

Children who have a demonstrated need for community-based services to avoid institutionalization often cannot access that care. For example, in-home therapy is not provided with the intensity or frequency needed to prevent institutional placement. The care that is available is often office-based treatment settings limited to once-a-week appointments. In addition, this model is reinforced through Nevada's Medicaid billing structure as it requires prior authorization for more than 26 visits per calendar year, which is insufficient to serve children with high needs (U.S. Department of Justice, 2022).

Even crisis service such as mobile crisis response teams have capacity issues that can leave families to seek care from the emergency room or other institutional settings. In addition, upon release from residential treatment, most youth do not get directly connected with community-based services or program such as Wraparound Nevada (U.S. Department of Justice, 2022). The lack of community-based services has also led to the institutionalization of many youths in the child welfare and juvenile justice systems. The U.S. Department of Justice investigation found that "within a random sample of treatment records of Nevada children who recently experienced residential treatment, over 75% included evidence of current or past involvement in the child welfare and/or juvenile justice systems." (U.S. Department of Justice, 2022). In addition, the lack of community-based services also increases a youth's risk for involvement with juvenile justice and at times child welfare as some parents relinquish their rights due to their lack of ability to obtain the sufficient resources to provide care to their children (U.S. Department of Justice, 2022).

A prominent issue among psychiatric facilities is that youth are experiencing refusals for admission due to a variety of reasons, such as having a history with the facility, being identified as having destructive behavior, or not being able to mix well with other individuals in the facility. This is particularly concerning as youth are not able to receive the health services they need and those held in the emergency room may not be properly discharged after a six-day period.

The U.S. Department of Justice investigation found that Nevada failed to ensure appropriate discharge planning from hospitals or residential treatment facilities. The report also indicated that for state-run facilities, discharge planning is generally limited to making appointments with psychiatrists and therapists. In addition, it was reported that for out-of-state residential treatment facilities, the State does not participate in discharge planning. The lack of discharge planning and direct warm hand offs to ensure that youth and families receive the treatment they need leads to a cycle of crisis and institutionalization (U.S. Department of Justice, 2022). Medical facilities often overlook the initial screening and evaluation of mental and behavioral health needs which is needed to provide more appropriate foundation for discharge plans.

In primary care settings, Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) is currently underutilized due to low rates and confusion by providers about how to include behavioral health care. Many parents of youth are also not aware that they can request a screening at any time, and that a mental health care provider is also qualified to complete a screening. Further, EPSDT services can be completed within a school setting if the parent is not able to take their child to an annual visit to see the child's provider. Greater education and awareness of EPSDT services

is needed for parents, primary care providers, and youth mental health providers to allow for timely intervention and support to reduce the risk of long-term mental and/or behavioral health issues.

There has been some progress improving access to services in the community. The Nevada Division of Public and Behavioral Health received funding for Certified Community Behavioral Health Clinics (CCBHC). Currently there are is one CCBHC with two locations in Clark County, Bridge Counseling. They offer community-based mental and substance use disorder services, care coordination and case management to address all needs of the individual, and crisis and mental health screening services for youth. The intent of these clinics is to support all members of the community regardless of ability to pay. According to recent consumer satisfaction survey reports, many families indicate greater levels of satisfaction with receiving services in the community. Youth and parents working with Bridge Counseling associates generally agreed that CCBHCs had convenient locations and service availability (Nevada Division of Healthcare Financing and Policy, 2022). Consumers also reported that staff were culturally sensitive and respected their beliefs/background, allowed for participation in treatment, and provided a sense of social connectedness. Consumers believed that they received the help they needed and outcomes were achieved in the areas of school, daily life, friendships, and family relationships.

To further expand community-based services, DCFS entered into a Care Management Entity (CME) contract with Magellan Healthcare, named "Connect Nevada: Strengthening Youth, Empowering Families." The go-live date is February 1, 2024. Working with providers and organizations across the state, Magellan will serve children/youth aged 3 through 20 who have complex behavioral health needs and are at risk for out-of-home placement. Magellan will coordinate and provide access to services such as High-Fidelity Wraparound, Intensive Care Coordination, Intensive Home-Based Treatment, emergency and planned respite, family peer and youth peer support using a robust, strengths-based approach focusing on family and youth voice. For more information, please visit https://www.magellanhealthcare.com/magellan-of-nevada/.

Another example includes the Southern Nevada Health District which has added a Licensed Clinical Social Worker (LCSW) to their behavioral health team to expand access to behavioral health services. Now, a Psychiatric Advanced Practice Registered Nurse (APRN) and two LCSW are now available for youth with the addition of a clinic site. In addition, the expansion of certified community behavioral health clinics should increase access to mental health treatment for youth and families. Currently there is no data available to determine the use of these facilities by families to determine if an impact has been made.

In addition, some progress has been made for screening, assessment, and Care Coordination for youth in foster care with high mental health needs. At Department of Family Services (DFS) Child Haven shelter, children under age five (5) are screened by nurses, DCFS Early Childhood Mental Health Services, and Nevada Early Intervention Services (NEIS) for Early and Periodic Screening, Diagnostic, and Treatment (EPSDTs), developmental challenges, and signs of mental health problems. Supportive services are initiated right away and follow the child into their foster home or biological home when reunified. DFS has also developed contracted Care Coordination teams to identify behavioral health needs earlier and ensure that services are started and continued, regardless of foster home changes or reunification. Day programs that were paused during the pandemic have started to re-open, as well as newly developed Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) for additional therapeutic support after acute hosptialization or to help prevent escalation to higher levels of care such as Residential Treatment Centers. For youth with Intellectual and Develomental Disabilities (IDDs), Desert Parkway has a new acute care unit that has specialized staff and curriculum to address the comorbid needs of youth with developmental deficits, as well as mental health treatment. DFS has also contracted with several companies for enriched support for IDD youth who can benefit from Applied Behavioral Analysis (ABA) therapy or social skills training through sports modalities.

Finally, substantial ARP/ESSER dollars were committed to increase services in the community, but with only limited results shared thus far. This investment included:

- **School based mental health providers:** The Clark County School District (CCSD) is collaborating with Invo's Multidisciplinary Program to Address Childhood Trauma (IMPACT) to provide intensive services to students presenting with emotional and behavioral needs. IMPACT interventions incorporate coping skills training, stress reduction, increased self-awareness, and enhanced personal empowerment. They support teachers in proactive and reactive reinforcement strategies to shape appropriate student classroom behaviors. IMPACT is currently providing mental health therapeutic services in 44 CCSD schools. CCSD is partnering with the United Citizens Foundation's School-Based Mental Health Program to provide individual and group counseling, psychoeducation, and collaborative interventions in schools under the goals of empowering students to develop coping skills, build resilience, and prosper academically and emotionally. The program also emphasizes the importance of involving families in the therapeutic process. This program is currently being implemented in 15 CCSD locations including 14 schools and the Family Engagement Center. CCSD is also implementing Hazel's Early Assessment, Response, and Treatment (HEART) Program through teletherapy services that include early identification and screening; short-term teletherapy sessions; counseling, stabilization and treatment planning; crisis consultation support; and, case management and coordination to support the transition of students to long-term providers in the community. Hazel HEART is an optional resource available to students across all CCSD schools. Finally, CCSD is also partnering with Care Solace to help individuals find mental health care providers and substance use treatment centers. Their Care Companion™ team is available 24 hours per day, seven days per week, and 365 days per year to connect individuals to carefully verified providers in your community. Care Solace is an optional resource available to students, staff, and families at no cost. They connect individuals with providers accepting all medical insurances including Medicaid, Medicare, and sliding scale options for those without insurance. Securing a consistent funding source for these programs is essential for ensuring a sustained impact on the availability of mental health supports for youth and expansion of these services to more students within the school district.
- **A unified Medicaid billing system for schools:** The Nevada Department of Education (NDE) and Division of Healthcare Financing and Policy (DHCFP) are partnering to build a system that better supports school health services. This goal is paramount because national data shows that 80% of children receive their mental health support and services through a school system. To date, this partnership has provided school guidance documents (School-Based Behavioral Health Toolkit and Collaborative Roles), training, technical assistance, and currently host monthly state partnership calls to support expanded services. Furthermore, to help support the school districts to retain their school health workforce after the pandemic dollars, NDE has also funded two school-based electronic health record systems that are HIPAA and FERPA compliant, and will support districts in billing for Medicaid approved services. This will bring additional dollars to help continue these important mental health services. Currently 9 districts can bill Medicaid for expanded support. Although this partnership is key, Nevada's current approach to school mental health is still fragmented, with no single entity in charge of accountability. Not only do Nevada's school districts lack adequate resources and staffing to develop comprehensive behavioral health systems, but they also receive little oversight, guidance, and training. Thus, our partnership strives expand to include, other state and local partners to improve the school mental health system.
- **Nevada's Children's System of Care in order to intervene early to help families:**
    - Wraparound case coordination and intensive case management
    - Increases in services for children and youth with complex behavioral health and developmental disabilities
    - Expansion of mobile crisis response teams to respond to children at school
    - Expansion of family support
    - Expansion of direct services

- Workforce support (Completion of Parental Involvement and Family Engagement (PIFE) course work approved by the Nevada Department of Education is now a general requirement for all initial educator licensing in the State of Nevada).

Children with Intellectual and Development Disabilities (IDDs) and Mental and Behavioral Health Needs

Youth with intellectual and developmental disabilities (IDDs) and mental and behavioral health needs unfortunately struggle to access essential support. Not only is their distress not understood, but categorical funding structures also often prevent the ability to access appropriate treatment which can escalate behaviors. The U.S. Department of Justice investigation findings indicate that Nevada is lacking in intensive in-home supports and services, and this is even more profound for families with children who have a both behavioral health needs and intellectual and developmental disabilities (U.S. Department of Justice, 2022)**.** "Because children with intellectual and developmental disabilities, particularly those with aggressive behaviors, cannot receive the intensive and consistent services they need to avoid institutionalization, many enter residential treatment facilities" (U.S. Department of Justice, p. 16, 2022).

Desert Regional Center (DRC) currently provides family support programs to prevent out-of-home placement by assisting the family in caring for their children in their natural homes. If children are under the custody of state/county family services and reside in licensed foster homes, family support programs can also be provided to children who live in these homes. Some examples of DRC Family Support Programs include respite, self-directed family support services, purchase of service supplement, family preservation program, and supported living arrangements services for children. All families who receive family support must meet financial guidelines of household income of 300% or below Federal Poverty Guidelines. This is a limitation as there are many services that can be billed to Medicaid such as ABA services or in-home therapies.

In 2007, DRC initiated the Youth Intensive Services (YISS) program to address placement and other support needs of children who have Intellectual and/or Developmental Disabilities who also may have a concurrent Mental Health Disorder, in Southern Nevada. Children eligible for the YISS program are typically aged 8 and older (some young adults). Developmental Specialists under the YISS team have smaller caseload sizes than DRC's non-YISS Developmental Specialists. The YISS team is currently comprised of 1 Developmental Specialist Supervisor, 7 Developmental Specialists, 1 Licensed Psychologist and 1 Mental Health Counselor. During Fiscal Year 2023, the YISS team provided case management services to 104 youth under the age of 18. During Fiscal Year 23, DRC also created a Complex Adult Response Team (CART), in which some youth that were previously being supported by the YISS team transitioned (youth to adult) to the CART program. The purpose of the Complex Adult Response Team (CART) is to intensely manage cases of adult individuals with complex support needs. DRC-served adult individuals that get assigned to CART will be provided with increased observation, enhanced communication among team members, as well as valuable consultation from the Psychological Services department, all with the goal of increasing stability in the community. Cases may include, but would not necessarily be limited to, the following:

1. DRC-served individuals involved in court cases that involve actual incarceration and/or frequent status checks by the court.
2. DRC-served individuals in serious jeopardy of losing placement due to frequency/duration/severity of maladaptive and/or dangerous behaviors.
3. DRC-served individuals with frequent admissions to psychiatric hospitals combined with a lack of stability in community placements.

During this past calendar year, the below initiatives have occurred/continued from the previous year to improve services to children.

- DRC Intake and Psychology staff meet weekly with DFS staff at Child Haven to triage with Child Haven staff assessing children who may be eligible for ADSD (Aging and Disability Services Division)/DRC services. The goal of having DRC's Intake and Psychology staff available to DFS is to quickly identify eligible children when applying for DRC services and ensure children that are suspected of having an eligible condition are properly assessed by DRC's Psychology/Intake departments.

- Desert Regional Center participates in weekly multi-agency meetings that include DFS, DCFS, and the Legal Aid Center of Southern Nevada, to discuss cases of children who are primarily in detentions, Residential Treatment Centers that need assistance with step-down supports or children who are in lesser restrictive environment that require out-of-home placements.
- DRC now has providers of Shared Living and Supportive Living Arrangements that provide treatment support services for children in out of home placements. Within the Shared Living environment, similarly to a children's foster home setting, everyone residing in the Shared Living home must demonstrate and provide a nurturing, respectful and supportive environment to the children placed in the home, as demonstrated through observations, home visits and environmental reviews. Within the Supported Living Arrangements environment, homes should be equipped with preferred age-appropriate activities that support staff to encourage and facilitate participation from children. Support staff should actively engage with the children in a positive, nurturing, respectful manner while also maintaining safe, healthy boundaries, as demonstrated through observations, home visits and environmental reviews. The home should have consistent, predictable routines with expectations clearly outlined to support continuity and security. These should be communicated in a method that corresponds with each child's level of development and understanding.
- Developmental Services was approved through ARPA (American Rescue Plan Act) Fiscal Recovery Funds to develop Specialized Intensive Services for Developmental Services Intensive Behavioral Support Homes. Some funding of this program will be dedicated to adults who have intensive behavioral support needs. The other portion will be focused on children that have intensive behavioral support needs. The expectation of these homes is they will consist of direct support staff with higher levels of training competency, and associated higher wages, combined with an array of professional services individualized to the person's needs to potentially include behavioral consultation, psychological and psychiatric services, nursing services, occupational therapy, and any other specialty service needed by the person.
- ADSD received a new grant to develop respite opportunities for families of children with dual diagnosis. It is a 5-year project with ADSD working with several partners including DCFS, Nevada Pep, and the Nevada Center for Excellence in Disabilities.

Recommendations

1) Larger investments should be made to provide the array of System of Care Core Services that include intensive care coordination (evidenced based wraparound services), evidence based intensive in-home services, Mobile crisis and stabilization services (mentioned in Priority 1), parent and youth peer support services (mentioned in Priority 2), respite care, and flexible funding (See glossary for definitions of each service). A consistent and stable funding source must also be prioritized to ensure that youth mental and behavioral health programs in CCSD schools remain supported past ARPA funds. School district staff should continue to work with local and state partners to refine a proper documentation process and develop a unified Medicaid billing system for mental and behavioral services.

2) Increase evidence based wraparound care coordination services, treatment services, and educational supports for youth with an intellectual disability and behavioral health needs.

3) Increase access to comprehensive supportive services for children and youth with behavioral health needs (e.g. childcare services, early childhood education programs, afterschool programs, etc.).

4) Physicians should be encouraged and incentivized integrate behavioral health services within primary care settings so that families are able to access a more comprehensive service array, supporting the unique and pervasive needs of youth and their families. This could be done by providing value added services for physicians to provide additional documentation that mental health screenings were performed during visits, especially for those under Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, specifically with respect to mental health and substance use disorder screenings and services. There should be more sufficient data that is collected by physicians and other providers to show if EPSDT is being used for youth behavioral health.

5) With regards to insurance carriers, expand covered behavioral health care service array and increase network capacity to help expand community-based services including efforts to support recruitment and retention of mental health professionals trained to work with youth.

6) Members of the CCCMHC should be involved in the planning and implementation of the Nevada Behavioral Health Community Integration Strategic Plan.

7) Continue to ensure that all staff working with youth are committed to the practice of cultural competency and humility. School staff members should remain appropriately trained in and implement authentic culturally responsive family engagement strategies focused on developing school community connectedness. Youth foster care staff should receive training on Culturally and Linguistically Appropriate Services (CLAS). In addition, facilities should incorporate the Trauma-Informed Care (TIC) model to ensure nursing and other staff with client contact are trained and competent with TIC.

8) Adopt and promote requirements of NRS 388.256 or 394.1693 to all schools (public, charter, and private). These requirements include suicide prevention policies, procedures, professional training, and postvention needs to all school staff in order to better address students who are struggling. The paramount goal is to know how to connect families to community resources. The efforts should include: 1) Written suicide prevention guidance to school staff; 2) Required 5-year review schedule of said procedures; and (3) Include recommended ongoing professional learning opportunities for school staff related to student mental health/wellness.

9) The CCBHCs should enhance data collection efforts and reporting to better understand service availability, utilization, and quality of care for youth and families, and work with the person appointed as the children's mental health authority to ensure that these programs meet the needs of youth and families. CCBHCs should also increase media promotion efforts to ensure that families and communities are aware of the services available.

10) The U.S. Department of Justice recommended that the "State could reasonably modify its system by expanding the availability of these services, supporting and managing its provider network to increase quality and access, assessing children and diverting them to community-based services before they enter institutions, and, for children already in institutions, engaging them in discharge planning to quickly and successfully return home" (U.S. Department of Justice, p.2, 2022). The State should also adjust rules and procedures to increase provider participation in Medicaid and conduct a rate analysis to adequately reimburse providers for their services (U.S. Department of Justice, 2022).

11) Improve discharge planning procedures at all facilities both in state and out of state to ensure that youth and families have the best reintegration experience possible to limit re-institutionalization. The work to discharge a patient should start immediately upon entry to a facility and needs to include the family (U.S. Department of Justice, 2022). Upon discharge, most community-based mental health outpatient programs and other services will have a community liaison or intake coordinator. A case manager should be able to get into contact with this individual at the target outpatient facility to coordinate a ROI (release of information) and facilitate the start of services for youth and their families. For youth being discharged from out-of-state facilities, Nevada insurance companies with Medicaid contracts need to offer complex case management services to ensure direct warm hand-offs and plans for youth and families to receive the treatment they need. Families with youth involved in child welfare and/or juvenile justice system should also have greater access to behavioral health resources which are crucial for parents to know how to care for their children and help prevent the cycle of institutionalization.

12) CCCMHC should receive updates from DCFS on new services implemented with ARPA funding for accountability as well as for assistance in increasing community awareness. DCFS and Medicaid should also work to have sufficient and consistent public reporting practices to measure the success of youth and families obtaining services.

13) Due to the U.S. Department of Justice investigation findings, state officials have acknowledged that there are some issues with whom should serve children in this population as well as the insufficient array of accessible services. ADSD should continue to work with partners to increase communication about services available for families of children with

dual diagnosis, especially for those that are not in DFS custody. This partnership should also include private hospitals that provide mental health support services for youth.

Clark County needs more professionals that have expertise in working with youth with dual diagnosis and intensive in-home treatment should be provided as needed. This will reduce the number of youths with dual diagnosis in crisis situations, limit the use of the ER for treatment, and hopefully reduce the number of children who cannot access services because facilities refuse to admit them due to the severity of their behaviors.

Projected Costs

The costs of implementing of any of these recommendations will vary depending what is being implemented. Therefore, it is recommended to consult with each agency involved in the service provision when making budgetary decisions.

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

In accordance with requirements set forth in Nevada Revised Statutes (NRS) 433B, this section describes the objectives from the ***10-Year Strategic Plan*** that have been revised by the CCCMHC. There have not been any changes to the any of the objectives from the 10-Year Strategic Plan since the 2023 Status Report.

IV. CCCMHC -2023 Review of Activities

In 2023, the Clark County Children' Mental Health Consortium participated in many different activities in order to enhance youth mental wellness. Examples of some of these activities include participating in Children's Week at the Legislature, conducting the 2023 Children's Mental Health Summit, and writing letters to address key issues in the community. A brief description of a few of the activities are provided below.

Participation in Children's Week at the Legislature is an example of how our group advocated in partnership for increased investments in youth mental health. Children's week occurred March 13-16, 2023 at the Nevada legislature. Tuesday, March 14th was dedicated to mental wellness. The day began with a networking breakfast, during which community advocates and attendees had the opportunity to meet with Nevada legislators. Participants were invited to sit on the floor during senate and assembly floor sessions throughout the day. These discussions helped policy makers have a better understanding of the needs of youth and families in our community.

The 6th annual Southern Nevada Summit on Children's Mental Health was held on May 1st via a hybrid format. A total of 56 individuals attended the summit. Attendees were provided a full day of training consisting of five different presentations on May 1st. On May 2nd, Youth Mental Health First Aid training was administered. Licensed professionals were able to claim up to 6 hours of Continuing Education Units from this summit, in addition to 2 credit hours provided separately for attending the suicide prevention training provided by the Nevada Office of Suicide Prevention. Overall, those who completed the evaluation surveys were satisfied with the learning opportunities provided. The CCCMHC also raised awareness of Children's Mental Health Acceptance Week during the summit and promoted it to the community through media platforms.

For Children's Mental Health Day, representatives around the state of Nevada went to Carson City on May 11th to spread information on the importance of children's mental health. CCCMHC members shared several resources, including county reports, to provide legislators with the latest data and recommendations to inform their decisions on children's mental health policies during the 2023 Legislative Session.

In October 2023, members of the CCCMHC provided resources at the CCSD Staff Development Day Professional Learning Conference at the Westgate hotel and casino. A total of 700 CCSD counselors attended the conference to receive training on strategies to support students' mental health and academic success. Members shared brochures about the CCCMHC, the CCCMHC 2023 Status Report, and informational flyers from Prevent Child Abuse Nevada, Courage First Athlete Helpline, and The Nevada Afterschool Network.

Finally, the CCCMHC has written a letter addressed to policymakers that could implement the appropriate changes to better the mental health status of Nevada youth. In late May 2023, a letter was written to address the revisions to Assembly Bill No. 285 and 330 regarding student discipline in schools, particularly for their harmful effects on the development and outcomes of children with disabilities and behavioral health challenges. The letter also elaborated on the impact of exclusionary discipline and encouraged more effective uses of restorative practices. Additionally, CCCMHC acknowledged strategies that could be implemented in support of CCSD youth with disabilities and their families.

V. Glossary of System of Care Core Community and Home-based Services

Community and home-based services provide the highest quality services accessible to families in the least restrictive setting possible and allow children to remain in their homes, neighborhood schools, and communities. *These services should be evidence-based treatments that are trauma informed.*

Core Community and Home-based Services within Systems of Care include the following. The definition of each

1. Intensive care coordination, wraparound approach- Intensive care coordination includes assessment and service planning, accessing and arranging for services, coordinating multiple services, including access to crisis services. Assisting the child and family to meet basic needs, advocating for the child and family, and monitoring progress are also included.

The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports. The wraparound "facilitator" is the intensive care coordinator who organizes, convenes, and coordinates this process. The wraparound approach is done by a child and family team for each youth that includes the child, family members, involved providers, and key members of the child's formal and informal support network, including members from the child serving agencies. The child and family team develops, implements, and monitors the service plan. Information about wraparound can be found on the website of the National Wraparound Initiative at http://www.nwi.pdx.edu/wraparoundbasics.shtml.

2. Intensive in-home services - Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and prevent out-of-home placement in inpatient or PRTF settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child and family intensively, gradually transitioning them to other formal and informal services and supports, as indicated.

3. Mobile crisis response and stabilization - Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting

where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise. Residential crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.

4. Parent and youth peer support services - Parent and youth support services include developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities. The providers of peer support services are family members or youth with "lived experience" who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or a caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth. Almost all of the PRTF demonstration states and many CMHI projects included peer-to-peer support services for the parents, guardians, or caregivers of children and youth with mental health conditions, as well as peer-to-peer support services for youth.

5. Respite care - Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite services provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings. All CMHI and PRTF demonstrations provide some form of respite care.

6. Flex funds - Flex funds may be used under certain Medicaid authorities to purchase non-recurring, set-up expenses (such as furniture, bedding, or clothing) for children and youth. For example, flex funds may be requested for the one-time payment of utilities or rent or other expenses as long as the youth and family demonstrate the ability to pay future expenses. Flex funds can be particularly useful when a youth is transitioning from the residential treatment setting to a family or to independent living. It should be noted that flex funds can be used for purposes other than transition, such as academic coaching, memberships to local girls or boys clubs, etc. Flex funds are only available to individuals participating in various Medicaid waivers and/or the 1915(i) program.

Trauma-Informed Systems and Evidence-Based Treatments Addressing Trauma

Across the country, including system of care sites and the PRTF demonstration states, there is an increased awareness of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. More information on the ACE study can be found at: http://www.cdc.gov/ace/findings.htm

To begin addressing the trauma needs, many states are providing training and coaching for their clinicians in evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT). Many states are also exploring new policies and practices to ensure that they have trauma-informed systems of care that will be less likely to re-traumatize the children and youth they serve. To assist in developing new policies, practices, training, and coaching for trauma-informed care, a manual and documentary film is being developed in a cooperative effort with the participating states.

The definitions for each of these services was taken from the Joint CMCS and SAMHSA Informational Bulletin published on May 7, 2013, subject Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions.

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VII. ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

CURRENT MEMBERSHIP

Rebecca Cruz-Nañez, Chair
Southern Nevada Health District
Health District Representative

Richard Egan, Vice-Chair
Nevada Office of Suicide Prevention
Suicide Prevention Representative

Dr. Christine F. Moninghoff
Division of Child and Family Services
DCFS Representative

Dan Musgrove
Strategies 360
Business Community Representative

Dr. Sid Khurana
Healthy Minds
Psychiatric Community Representative

Jennifer Bevacqua
Eagle Quest Nevada Youth Care Providers
NV Youth Service Provider Representative

Karen Taycher
Nevada PEP
Parent Representative

Jackie Harris
Creative Solutions Counseling Center
Substance Abuse Service Providers Representative

Lori Follett
Division of Health Care Financing and Policy
Medicaid Services Representative

Robert Weires
Clark County School District, Psychological Services
Clark County School District Representative

Jessica Sasso
The Harbor Juvenile Assessment Centers
Juvenile Justice Representative

Charlene Frost
Magellan Healthcare
Parent Representative

Amanda Haboush-Deloye
Nevada Institute for Children's Research and Policy
Children's Advocate Representative

Gujuan Caver
DHHS, Aging and Disability Services Division
Mental Health & Developmental Services Representative

Erin McQueen
Henderson Police Department
Metropolitan Police Representative

Hunter Cain
Foster Parent Representative

Meambi Newbern-Johnson
Department of Family Services
Child Welfare Representative

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 to the Mental Health and Developmental Services Commission 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.

CCCMHC
Clark County Children's Mental Health Consortium

For more information about the Clark County Children's Mental Health Consortium:

Contact: Rebecca Cruz-Nañez,
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