2025

Division of Child and Family Services Administered Crisis Response Services, Clark County Epidemiologic Profile

NEVADA DIVISION OF CHILD AND FAMILY SERVICES

PLANNING AND EVALUATION UNIT

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Thank you to the following for providing subject matter expertise, review, data, and technical support for this report:

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*To learn more about Nevada's crisis response services, visit **www.knowcrisis.com**.*
*If you are in need of Clark County crisis response services, call **702-486-7865**.*

Recommended Citation

State of Nevada, Department of Health and Human Services – Division of Child and Family Services. *Clark County Crisis Response Services, Epidemiologic Profile.* Carson City, Nevada. May 2025.

Contents

Executive Summary

The purpose of this report is to provide an overview of DCFS-administered crisis intervention and short-term support to youth and families in Clark County dealing with behavioral or mental health issues, utilizing data from January of 2019 through December of 2024. Southern Nevada's DCFS-administered crisis response stabilization services are designed to support families facing behavioral or mental health crises, particularly those involving youth under 18 years of age. The goal is to maintain youth within their home and community environments, reducing emergency department admissions and facilitating access to ongoing support.

Key Findings

Call Volume/Response Trends

- On average, the Clark County Mobile Crisis Response Teams (MCRT) received approximately 2,604 crisis calls annually, with 46% resulting in face-to-face encounters with youth and families. (Youth served)
- 2021 marked the highest volume of crisis calls, with 3,288 calls and 1,601 face-to-face responses. (Call volume)
- In 2024, there were 2,684 crisis calls. This is a notable increase of crisis calls compared to 2022 and 2023.
- Crisis calls fluctuate by month, with the lowest volume occurring in July and the highest in April. Additionally, weekdays generally had higher call volumes than weekends, with Tuesdays identified as the busiest. (Calls by month and day)
- In 2024, 85% of calls occurred from 8:00 a.m. to 10:59 p.m., while 15% of calls were received during the overnight shift.
- Suicidal ideation or behavior accounts for 63% of responses from 2019 to 2024. This stable trend highlights the critical need for ongoing intervention in this area. Other primary reasons included anxiety, depression, aggression, and school-related issues. (Primary reason)

Youth Demographics

- From 2019 to 2024, approximately 58% of youth served were female, while 42% were male. (Sex)
- The majority of youth served were between the ages of 12 and 17, with a median age of 13-14 years. (Age)
- In 2024, 60% of youth identified as White/Caucasian, 30% as Black/African American, and 5% as Asian. (Race/Ethnicity)
- Emergency departments accounted for 43% of referrals; parents/guardians make up 25% of referrals; schools contributed 15-19%. Seasonal trends in referrals demonstrate fluctuations, with emergency department referrals peaking during summer months, while school referrals decrease. (Referral sources)

Outcomes

- On average, 50% of youth assessed were referred to DCFS MCRT for stabilization services, which remained consistent over the years. (Outcomes)
- In 2024, 79% of youth were stabilized through DCFS MCRT services within the community, though this was a slight decline from 84% in 2019. (Outcomes)

Programmatic Challenges/Changes

- Despite the positive outcomes, the mobile crisis response program faces significant challenges, particularly in staffing of mental health counselors, which has strained the ability to provide timely and effective crisis responses. (Staffing)
- In response to resource constraints and evolving community needs, several operational changes were implemented. Starting in November 2024, overnight shifts were eliminated, as call volume data indicated limited demand during these hours. Additionally, crisis response teams ceased hospital-based interventions to focus on

community-based support, addressing the root causes of crises outside of medical settings. (Programmatic Changes)

Background

Clark County DCFS-administered crisis response services are intended to provide crisis intervention and short-term support to Nevada families dealing with a behavioral or mental health crisis. Crisis response services support youth, and families of youth under the age of 18, showing signs of behavioral or mental health issues that pose a threat to the child's stability within their home, school, or community, including but not limited to:

- Anger
- Self-Injury
- School Problems
- Suicidal or homicidal thoughts or behavior
- Extreme parent/child conflict
- Peer conflict such as bullying
- Seeing or hearing things
- Depression/Anxiety

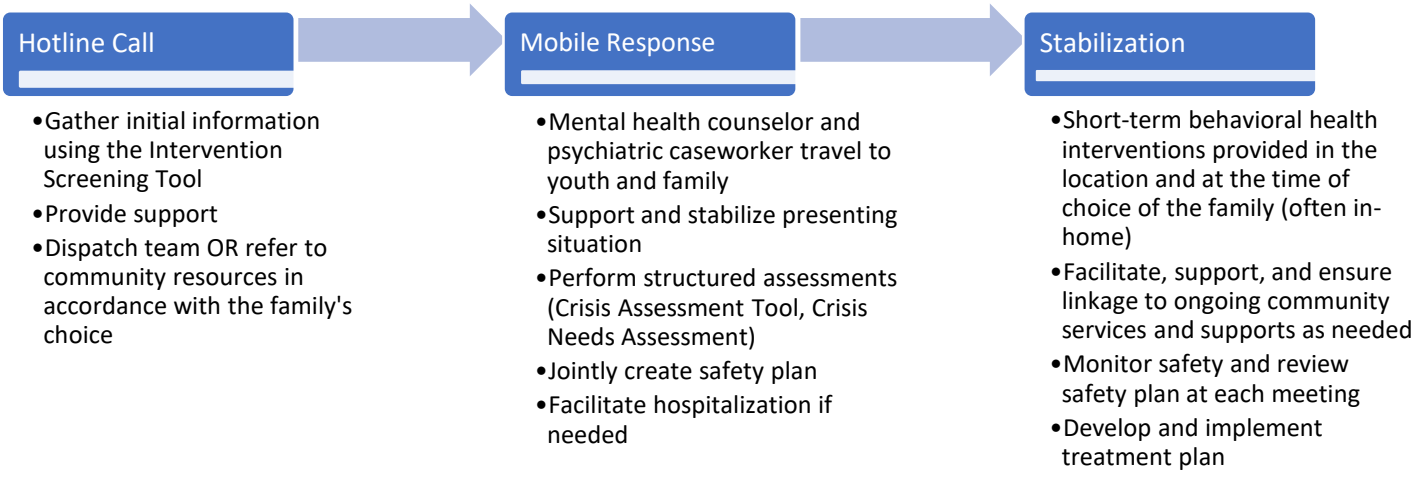
Mission & Objective

- Support and maintain youth in their home and community environment.
- Promote and support safe behavior in youth in their homes and community.
- Reduce admissions to emergency departments due to a behavioral health crisis.
- Facilitate short-term inpatient psychiatric hospitalization when needed.
- Assist youth and families in accessing and linking to ongoing support and services.

Response Values

- Respond immediately to youth and families during times of behavior/mental health crisis.
- Reduce emergency department visits for psychiatric crisis by providing immediate response to youth exhibiting behavioral/mental health crisis.
- Provide services that are family-driven, culturally competent, community-based, and consistent with Nevada System of Care principles.
- Assure safety and continuity of care through individualized strategies implemented by a wraparound-based, team approach.
- Facilitate linkage and access to community services using a Child and Family Team process.

DCFS Response Process At-A-Glance



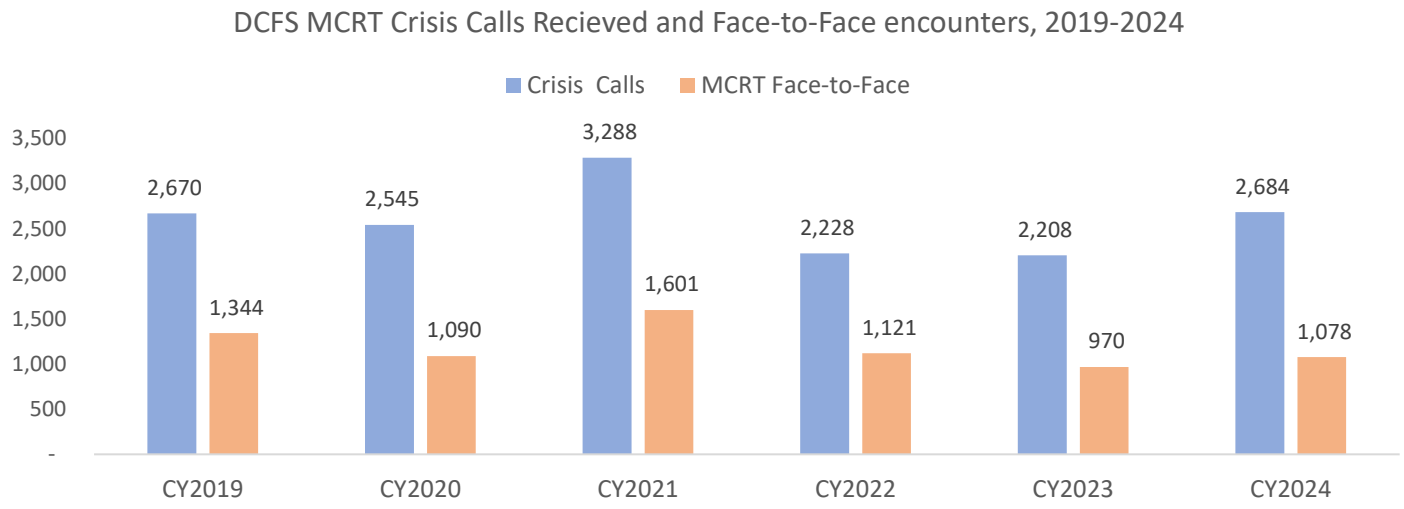
Data Summary

This report summarizes data on DCFS-administered crisis response services in Clark County from January 2019 through December 2024, segmented by calendar year.

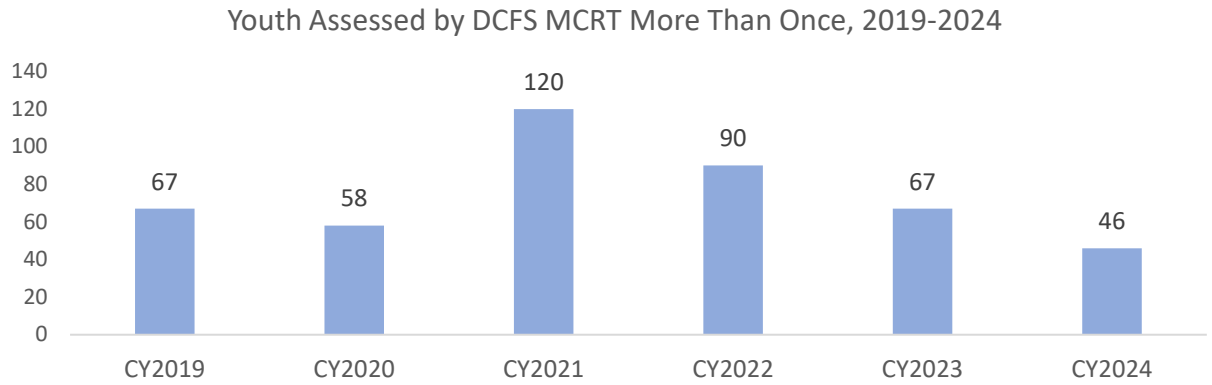
Youth Served

From 2019 to 2024, DCFS Clark County MCRT received an average of 2,604 crisis calls annually, with an average of 46% resulting in a face-to-face encounter with the youth and family. The highest volume of youth served was in 2021, with 3,288 crisis calls and 1,601 face-to-face encounters. For calendar year 2024, there were 2,684 crisis calls received and 1,078 face-to-face responses, equating to a response rate of 40% in 2024.

There was an increase in crisis calls during calendar 2024 compared to 2022 and 2023.

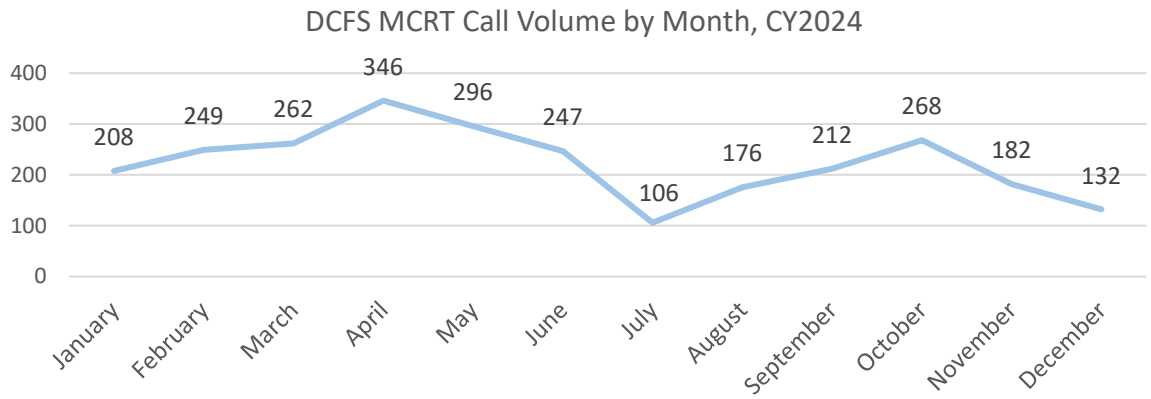


In some cases, youth may utilize crisis response services multiple times within each year. For example, as of December 2024, 46 youth were assessed more than once within the calendar year. Reassessment of youth peaked in 2021, where 19% of clinician time was spent reassessing youth. In 2024, this was down to 9%. The following graph represents the number of youth assessed more than once within each calendar year.

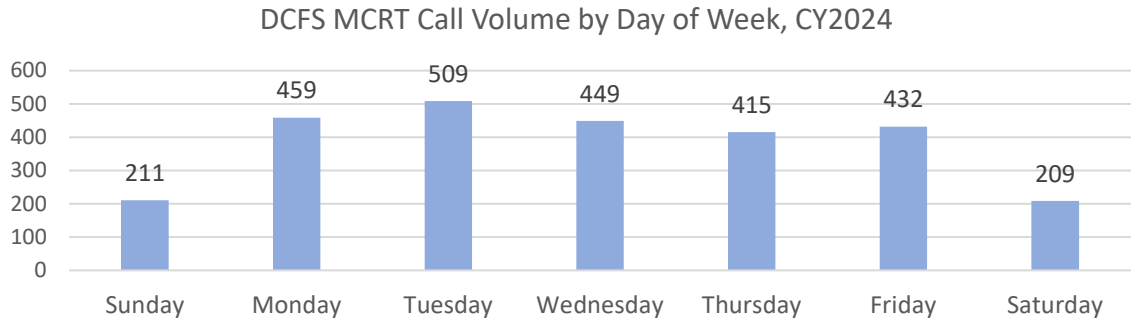


Call Volume

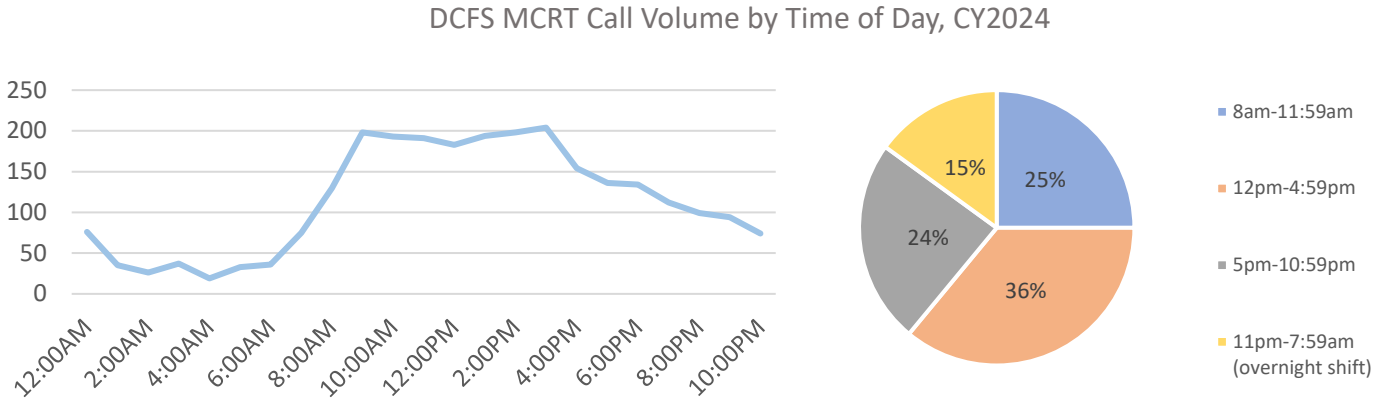
Call volume varies by month, with the lowest call volume of 2024 occurring in July (106 calls) and the highest call volume occurring in April (346 calls). The seasonal decline in crisis calls during summer months suggests there is an interaction between school and mental/behavioral health issues. Further research is needed to fully understand the nature of this relationship.



Call volume also varies by day of the week. Clark County DCFS-administered crisis response teams typically receive fewer calls during the weekend (Saturdays and Sundays), with an average annual volume of 210 calls in 2024, compared to an average annual call volume of 453 calls on weekdays (Monday through Friday). Tuesdays were the busiest days for calls, accounting for 19% of all calls received (N = 509) in 2024.



In 2024, 25% of calls were received between 8:00 a.m. and 11:59 a.m., 36% of calls were received between 12:00 p.m. and 4:59 p.m., 24% of calls were received between 5:00 p.m. and 10:59 p.m., and 15% of calls were received between 11:00 p.m. and 7:59 a.m. (overnight shift).



Calls received overnight (11:00 p.m. – 7:59 a.m.) in 2024 had a 44% response rate, meaning that 44% of calls received during these hours resulted in a face-to-face encounter with the youth and family. When considering call volume coupled with response rate, this equates to approximately one face-to-face response occurring every other night. For the other approximately 56% of calls received overnight, teams did not mobilize or only provided information via phone.

In 2024, the median duration of a call to the crisis response hotline was 20 minutes.

Response Times

When a call is triaged, it gets assigned a disposition which reflects if the response is urgent, emergent, or non-emergent. Urgent responses should be completed within 1 hour of the call, emergent responses should be completed within 12 hours of the call, and non-emergent responses may occur more than 12 hours after the call is received. Response time also varies based on day of the week. The following table shows median response times by disposition and day of the week for CY2024.

DCFS MCRT Median Response Time by Disposition and Day of Week, July – September of 2024

Disposition	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Urgent	1hr 6min	1hr 1min	59min	1hr 5min	1hr 3min	54min	60min
Emergent	2hr 15min	3hr 15min	2hr 22min	2hr 59min	2hr	2hr 31min	2hr 45min
Non-Emergent	17hr 29min	17hr 23min	16hr 51min	18hr 44min	22hr 40min	19hr 29min	19hr

Response time also varies based on time of day. The following table shows median response times by disposition and time of day for the same sample of data, July through September 2024.

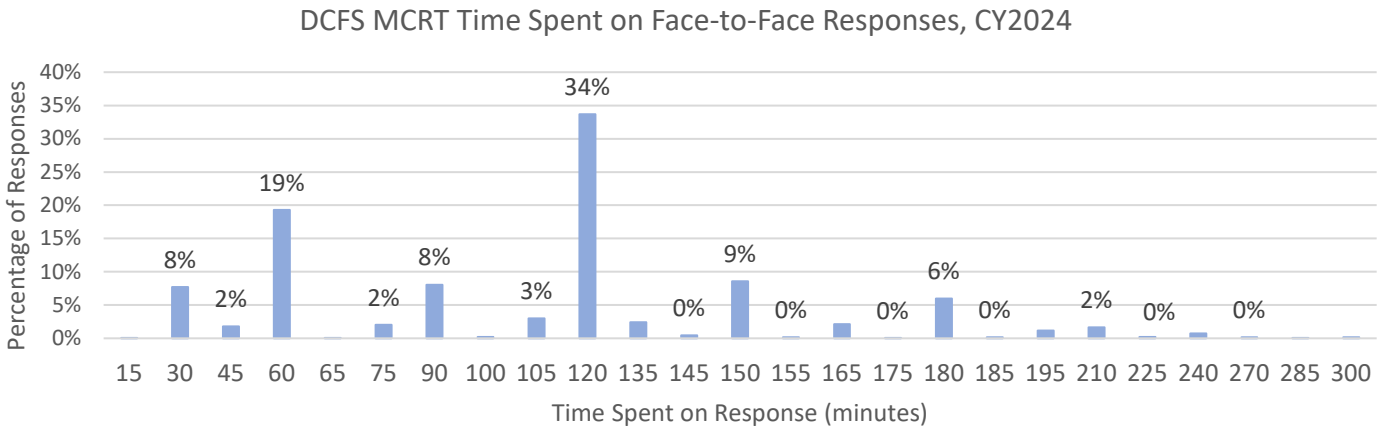
DCFS MCRT Median Response Time by Disposition and Time of Day, July – September of 2024

Disposition	8am-11:59am	12pm-4:59pm	5pm-10:59pm	11pm-7:59am (overnight shift)
Urgent	1hr 1min	1hr 5min	1hr 10min	45min
Emergent	1hr 45min	2hr 9min	3hr 31min	1hr 34min
Non-Emergent	17hr	19hr 23min	20hr 29min	N/A

In rare cases, for varying reasons, responses to overnight calls may occur the following day. Some reasons include:

- **Caregiver request/preference:** For example, because the call for help may have been made after youth was asleep or due to family schedule and availability (e.g., the caregiver may not be able to take off work at the time).
- **Youth not medically cleared:** Referral came in from a hospital, but the youth was not medically cleared and unable to engage in assessment at that time (e.g., youth may be asleep and hospital staff are unable to wake them up).
- **Caregiver was not at hospital to participate:** For example, a hospital may have called for a response and assessment, but the caregiver had to leave the hospital or was out of town, etc.
- **Staffing:** No team was available to respond (sometimes the overnight shift would not have a clinician and could not respond until the following day).

The median amount of time spent with the youth and families on face-to-face responses in 2024 was 120 minutes (2 hours) per response, with outliers ranging from 15 minutes to 5 hours.

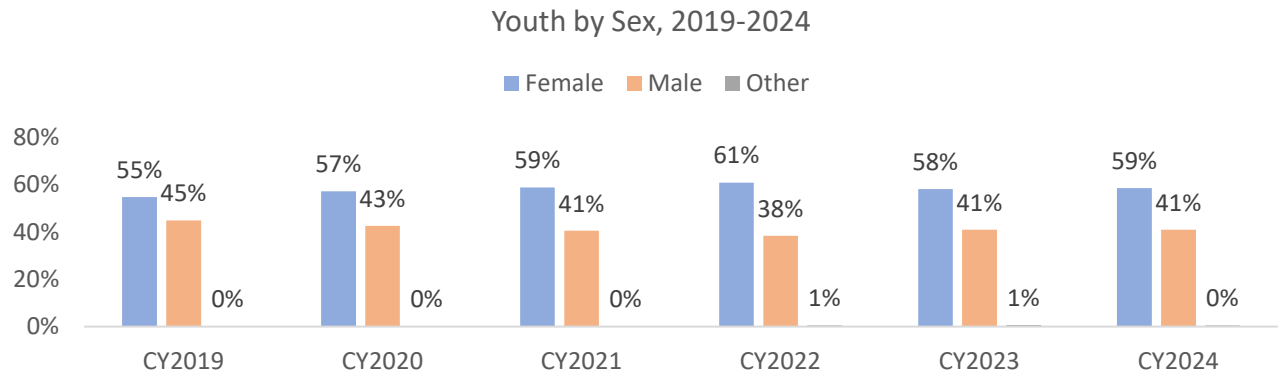


Youth Demographics

Demographics are not collected on all calls that are received by DCFS, rather they are collected when an assessment occurs. The demographics below represent unique youth assessed by a crisis response team and were sourced from the Crisis Assessment Tool (CAT) Extract report in Avatar.

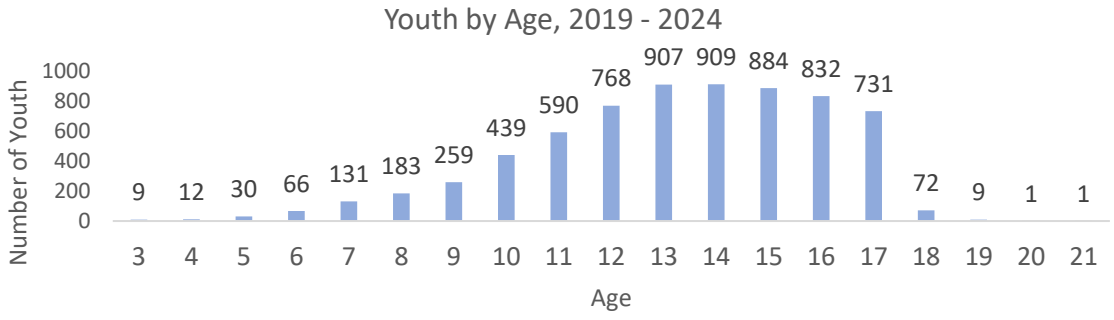
Sex

From 2019 through 2024, approximately 58% of youth served were female, while 42% were male. This distribution is consistent over time.



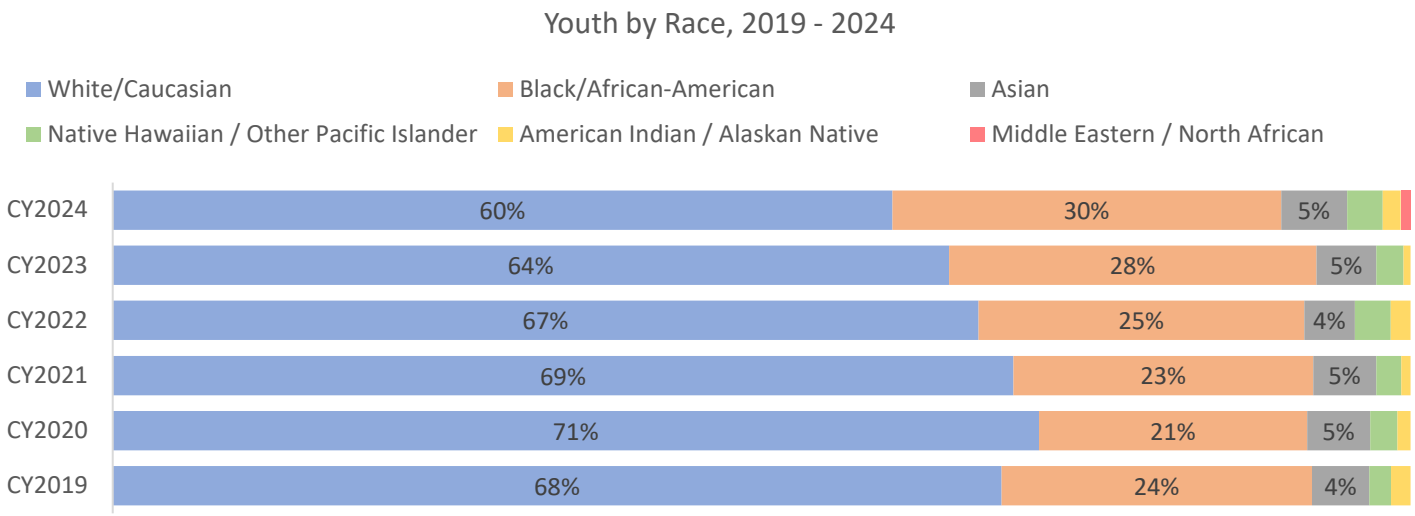
Age

Most youth served were 12-17 years old (74%) with youth ranging in age from under 5 years old (< 1%) to 21 years old (<1%). The median age of youth was consistent at 13-14 years old from 2019 through 2024.



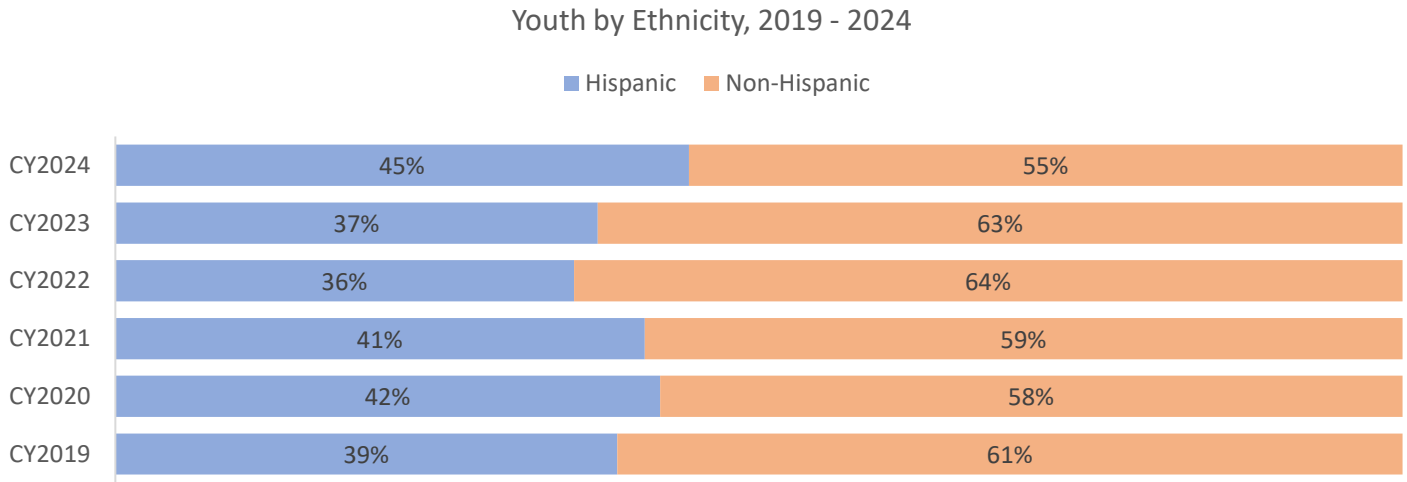
Race/Ethnicity

Data collection completeness for race declined significantly from 2019 to 2024, with 38% of records missing data and an additional 4% of youth declining to answer in 2024. When considering the records with race captured, the proportion of youth who identified as White/Caucasian declined from a high of 71% in 2020 to 60% 2024, and the proportion of youth who identified as Black/African American increased from a low of 21% in 2020 to 30% in 2024. Consistently, approximately 5% of youth served are Asian, 2-3% are Native Hawaiian/Pacific Islander, and 1-2% are American Indian/Alaskan Native.



Note: Race distribution is calculated on records with a race value captured and excludes records with unknown race.

Data collection completeness for ethnicity also declined significantly from 2019 to 2024, with 36% of records indicating unknown or missing data in 2024. When considering the records with ethnicity captured, 45% of youth assessed in 2024 were of Hispanic ethnicity. 2024 saw the highest proportion of Hispanic youth served with minor fluctuations in previous years.



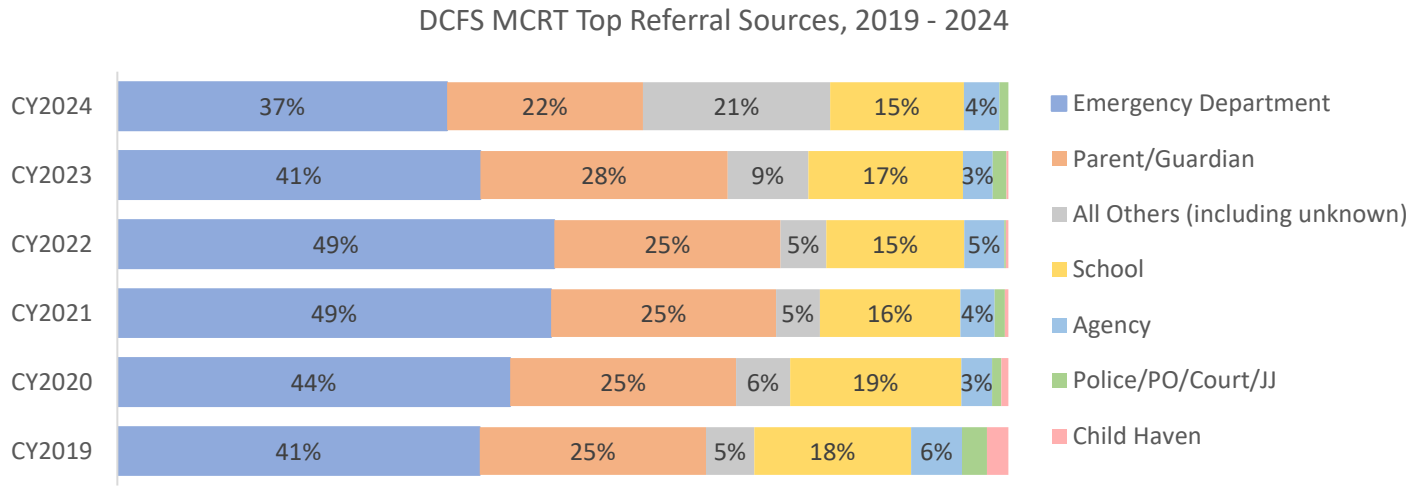
Note: Ethnicity distribution is calculated on records with an ethnicity value captured and excludes records with unknown ethnicity.

Referral Sources

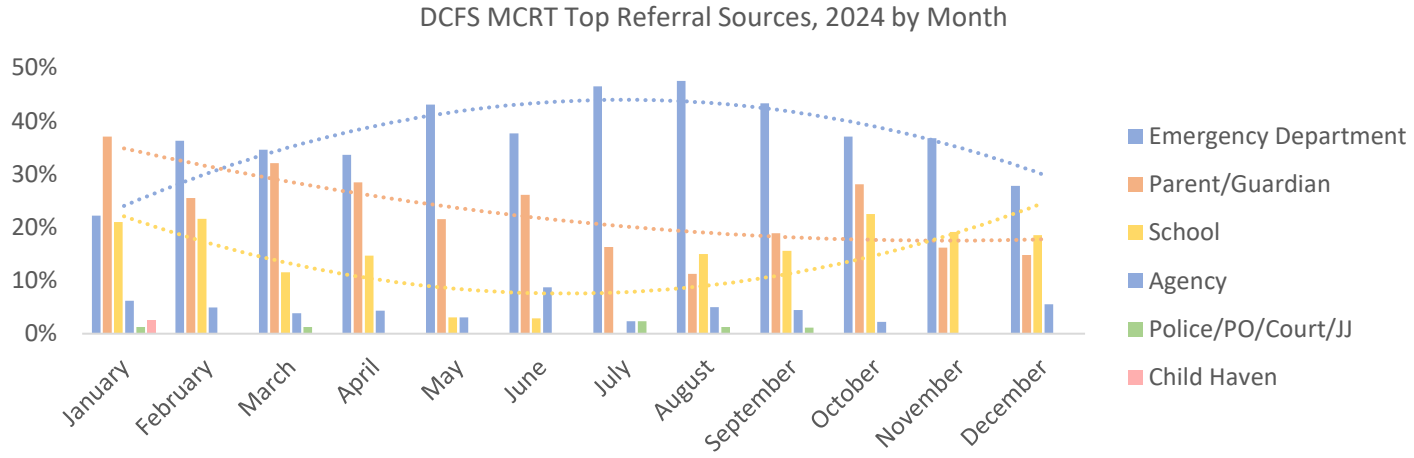
The top six DCFS MCRT referral sources are presented below, which make up between 82% to 95% of referrals in any given year. The data was sourced from the intervention screening in Avatar. The "Agency" category consists of community mental health agencies, private doctor's offices, The Harbor, etc.

- Emergency departments accounted for 44% of all DCFS MCRT referrals that resulted in a face-to-face encounter. Historically, emergency departments have contacted DCFS crisis response services when youth are brought to the hospital for mental/behavioral health reasons.
- Parent/guardians accounted for approximately 25% of all DCFS MCRT referrals each year.
- Schools are the third highest referral source, accounting for 15-19% of DCFS MCRT referrals annually.

Data collection completeness for referrals also declined from 2019 to 2024, with 17% of records indicating unknown or missing data in 2024. Records with unknown or missing referral source data are included in the "All Others (including unknowns)" category below.



Trends in referral sources are seasonal, as demonstrated in the following graph, which considers 2024 by month. More specifically, DCFS MCRT referrals from schools decrease significantly in May through July, referrals from parents are lowest in the late summer months (July through September), and referrals from emergency departments are highest during both of these periods, May through September.

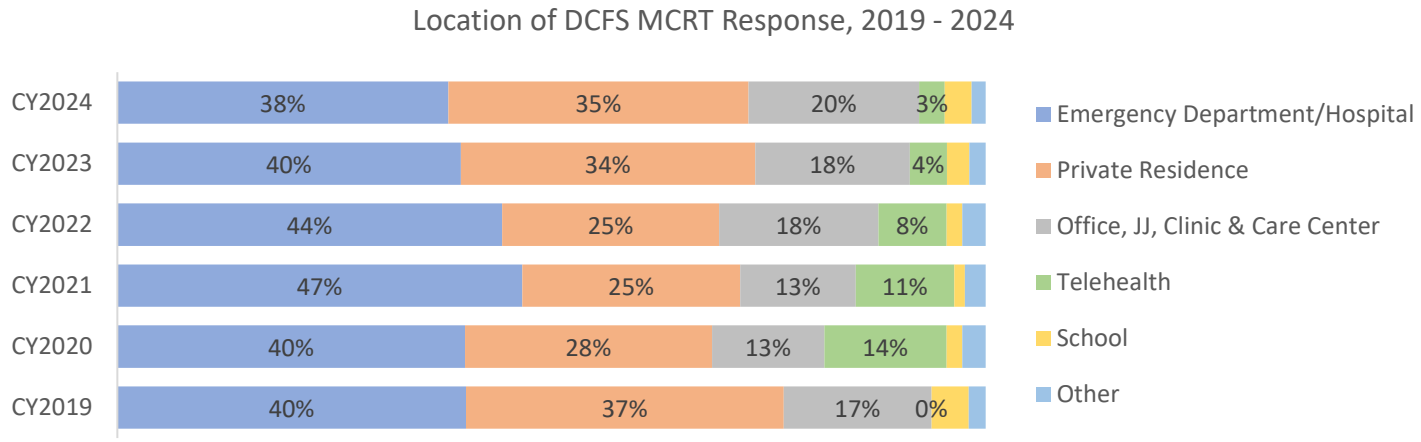


There are also differences in referral patterns based on the time of day of the call, specifically when considering day versus night calls. Seventy percent (70%) of overnight calls resulting in a face-to-face response originated from an emergency department, while 14% were referred by a parent/guardian or the youth themselves.

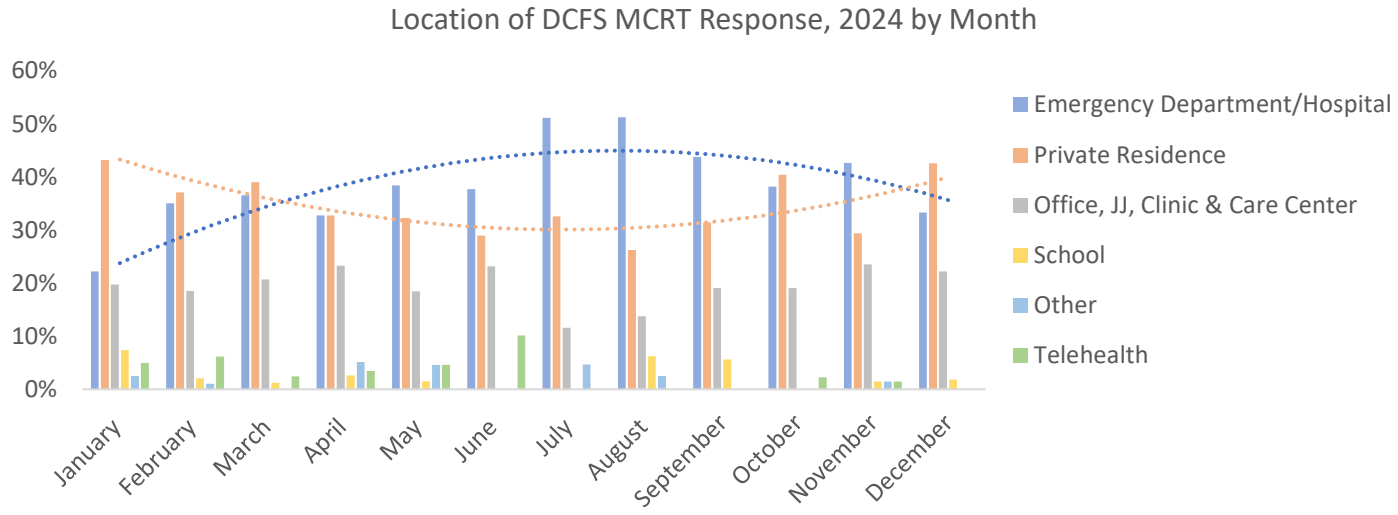
Location

When a call is received by the DCFS crisis response hotline, initial information is gathered such as referral source, youth/family information, the reason for the call, etc. After collecting pertinent information, the call is staffed with a clinical supervisor who determines what the response type will be (face-to-face encounter, info/support given, education provided, etc.). When the call warrants a face-to-face encounter, a team is deployed to the location of the youth and family and a Crisis Assessment Tool (CAT) is administered. This tool is used to assess acuity, determine the outcome of the response, and course of treatment. The following graphs displaying location are only for calls that resulted in a face-to-face encounter.

- On average from 2019 through 2024, 42% of all face-to-face encounters took place at an emergency department and 31% took place at a private residence.



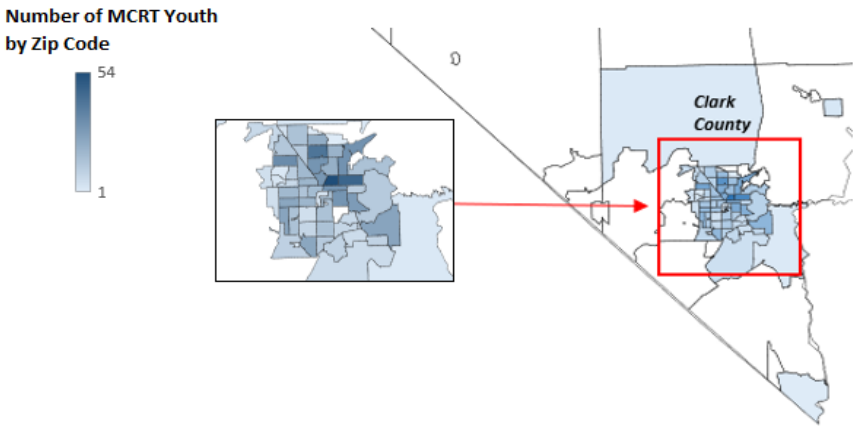
Trends in response locations also follow a seasonal pattern, with responses to private residences being highest in October through March. Conversly, the percentage of calls responded to in a hospital are highest in July through September.



Like referral patterns, there are differences in response location based on the time of day of the call, specifically when considering day versus night calls, with approximately 92% of overnight responses occurring in an emergency department and less than 6% occurring in a home or private residence.

It is also important to understand where the need for crisis response services is distributed geographically. The following map shows the distribution of youth resident zip codes for 2024 Clark County DCFS crisis response youth. It is important to note that Clark County is a tourist destination and some of the youth served may not live in the county or in Nevada.

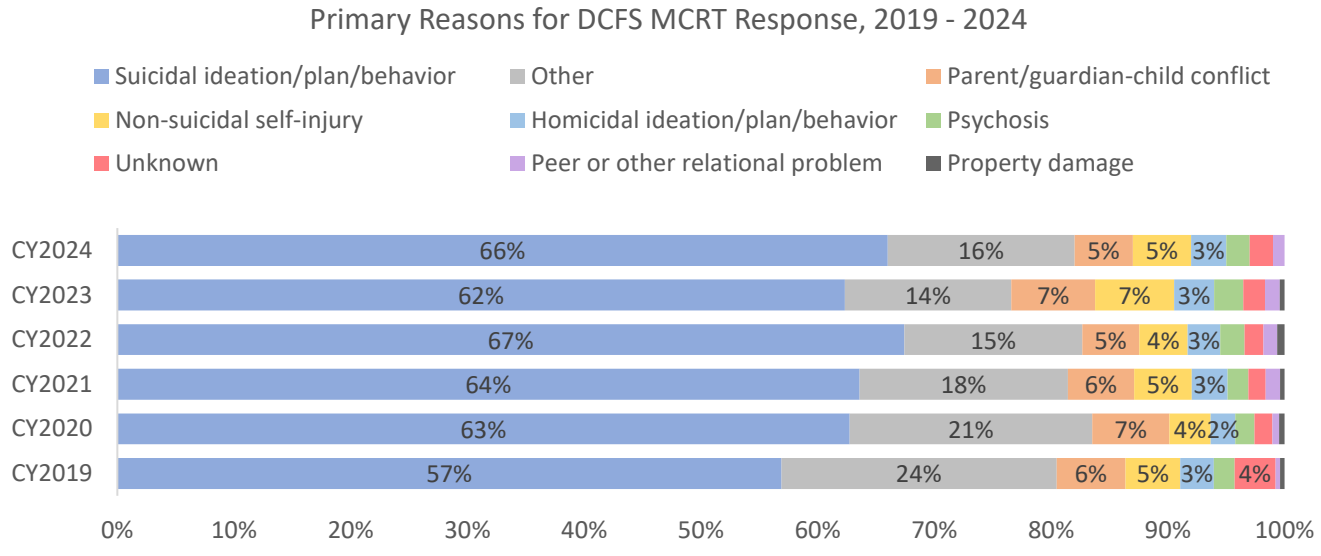
Youth Residential Zip Code Map, 2024



Primary Reasons for Response

The following graph displays the primary reasons for DCFS MCRT responses from 2019 through 2024. The primary reason is determined by the clinician at the time of the response. Responses represent when crisis response teams make face-to-face contact with the youth and family to conduct an assessment and determine course of treatment. Sixty-three percent (63%) of DCFS MCRT responses from 2019 through 2024 were due to suicidal ideation/plan/behavior. This is a stable trend with no indication of seasonality or significant change over time.

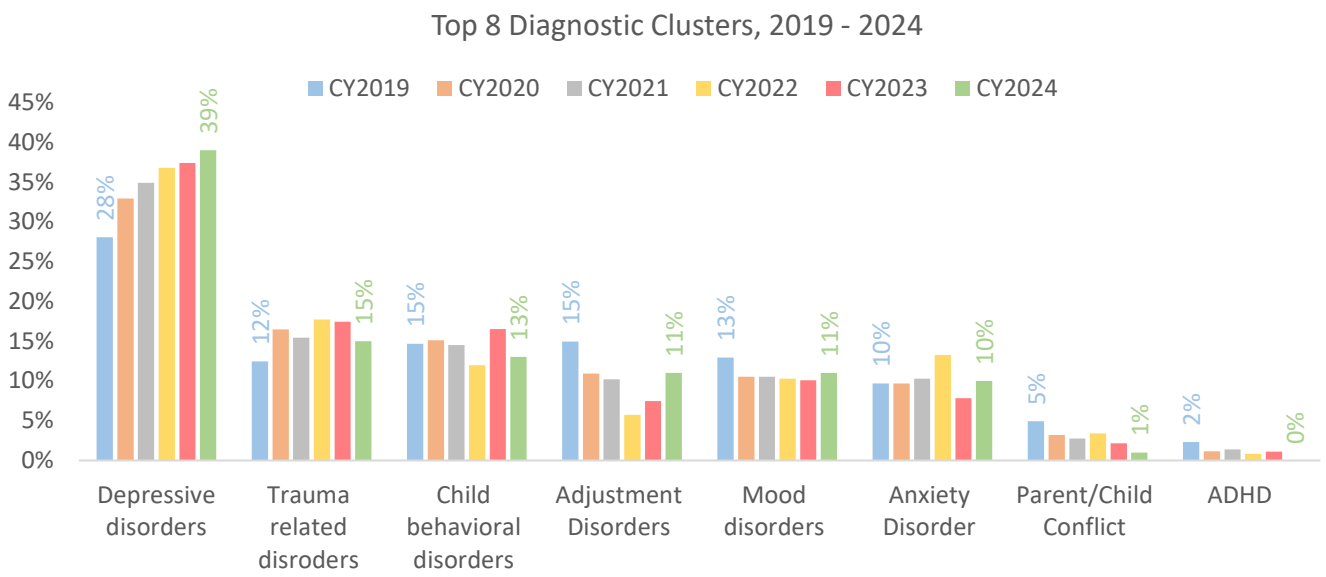
"Other" is a broad category that captures an array of other reasons for the response. These include anxiety, depression, physical aggression, and school-related issues, among others.



Diagnostic Clusters identified by MCRT Clinicians

The diagnoses of the youth served by DCFS-administered crisis response services are wide ranging. For the sake of brevity, clusters were created based on the primary DSMV/ICD-10 diagnosis. These data represent primary diagnoses only, although youth may have multiple diagnoses related to the crisis intervention, this report captures the primary reason for the response.

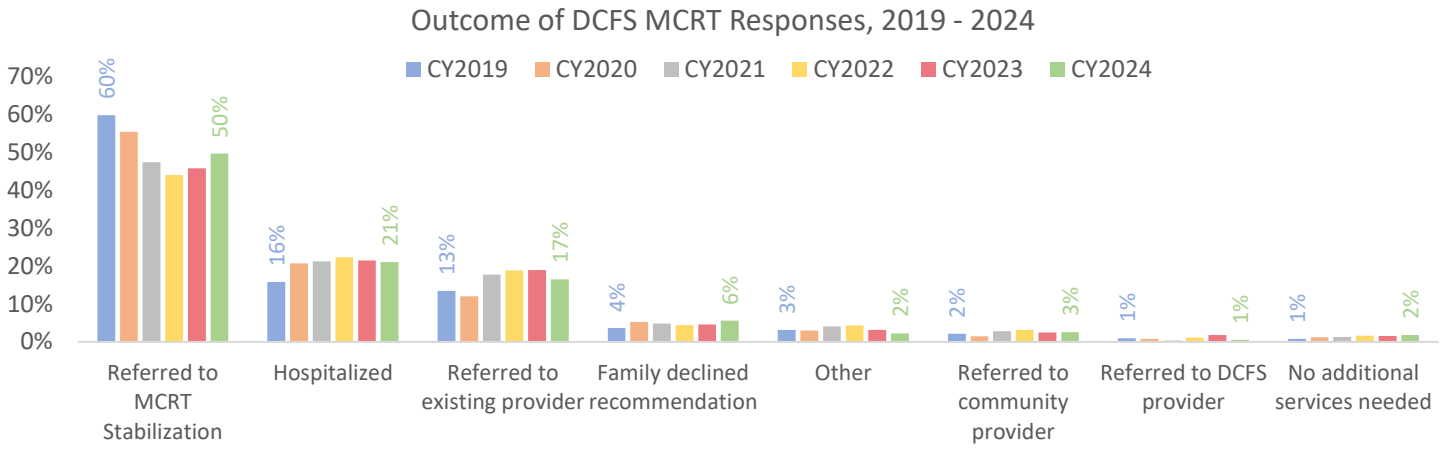
- Primary diagnoses of depressive disorders increased from accounting for approximately 28% of responses in 2019 to 39% of youth primary diagnoses in 2024. Depression is highly correlated with suicidal ideation/plan/behavior which is also the most frequent primary reason for response.
- Diagnoses for trauma related disorders also increased from 2019 to 2024.
- Primary diagnoses related to parent/child conflicts and AHDH declined from 2019 to 2024.



Outcomes

The outcome of a face-to-face encounter is determined by the clinician, caseworker, clinical supervisor, and parent/guardian. At the time of the encounter the clinician administers the CAT assessment to the youth while the caseworker completes a needs assessment with the youths' parents/caregivers. After both assessments are complete the clinician and caseworker deliberate with the family and together determine what the best recommendation should be. The eight main recommendations post-assessment are stabilization services, acute hospitalization, referral to existing provider, family declined recommendation, referral to new community provider, referral to DCFS provider, other, and no additional services needed. Stabilization services consist of in-home individual/family therapy and care coordination provided by a crisis response team up to 45/60 days or until they are connected to a long-term provider in the community. Acute hospitalization is recommended when youth cannot be safely stabilized while remaining in their homes and communities and require this higher level of intervention to ensure safety.

- On average from 2019 through October 2024, 50% of all youth assessed were referred to stabilization services. The highest rate of referral to stabilization services occurred in 2019, which was 60%. In 2024, 50% of responses were referred to stabilization.
- When a youth is not referred to inpatient care, the youth is considered stabilized in the community. In 2024, 79% of youth responded to were stabilized in the community, a decrease from 84% in 2019.

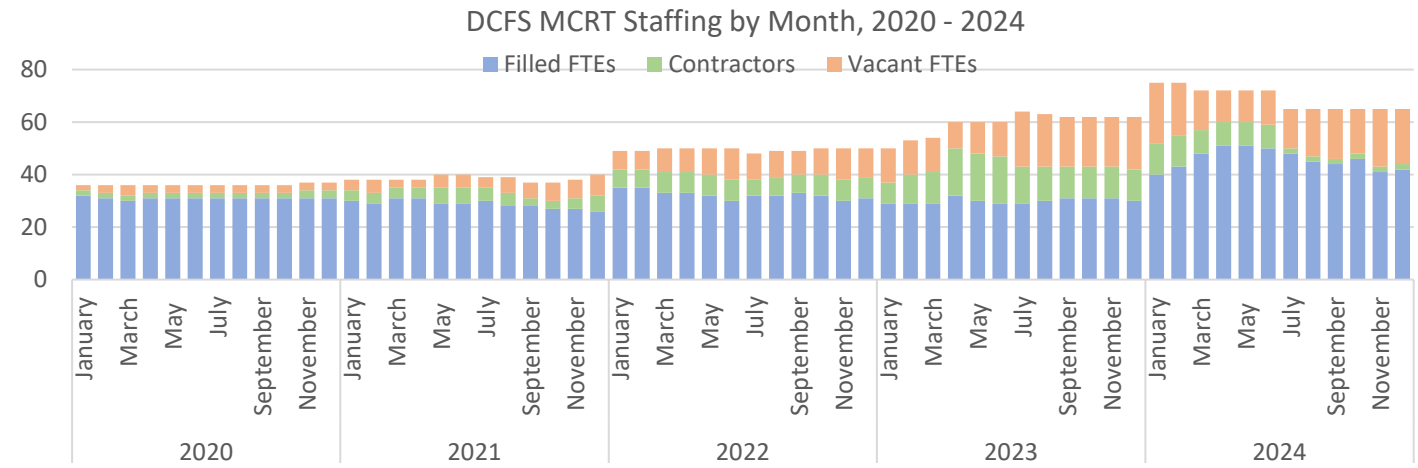


In essence, stabilization means helping the child and family transition from a state of crisis to one of safety and stability, supported by a tailored plan that includes short-term counseling, community linkage, and the necessary tools to manage and mitigate future crises effectively. This includes ongoing support to maintain the stability achieved during the initial response, including in-home or community-based clinical interventions, assistance with implementing crisis and safety plans, connecting the child and family with community supports, and service planning. The stabilization phase can last up to 60 days depending on the child and family's needs. After initial stabilization, youth are referred to community resources for ongoing treatment.

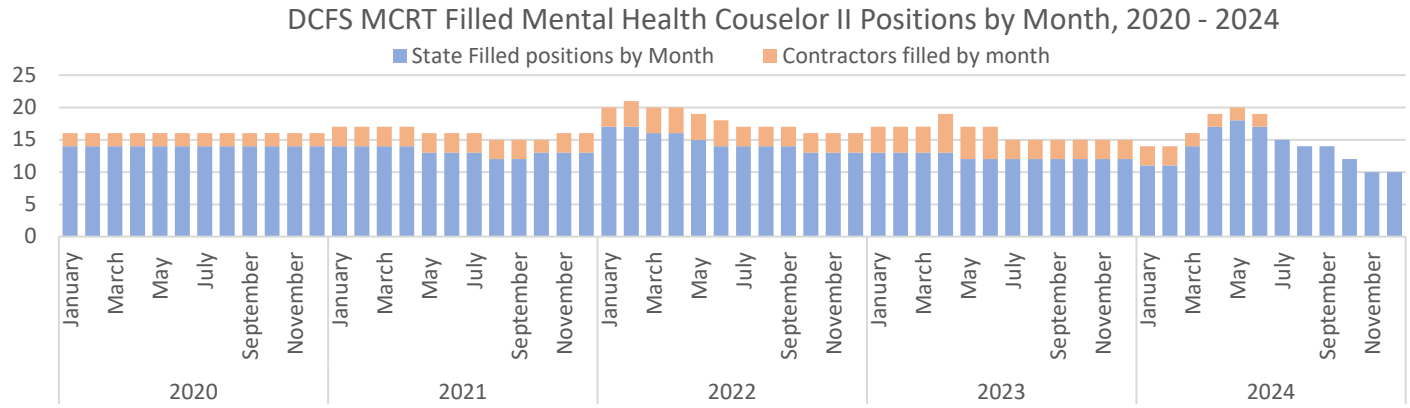
Programmatic Challenges

Staffing Constraints

Hiring and retaining staff to support Clark County DCFS-administered crisis response services proves increasingly challenging. In 2020, the program was supported by approximately 31 filled state full time equivalents (FTEs) in any given month, with an additional 2-3 contract staff, and carried an average of three vacancies (10% of FTEs). By 2023, although the number of positions allocated to support DCFS-administered crisis response services was higher than in previous years, many of these positions remained vacant. This caused the vacancy rate to increase to 53% for FTEs. An additional 13 contract staff were brought on to fill gaps. In 2024, contract support declined to nine staff by March and then down to just two contract staff in July through December, while the FTE vacancy rate remained high, averaging 39% throughout the year.



Mobile crisis services are typically staffed with a combination of clinical mental health counselors, psychiatric caseworkers, both clinical and casework managers, and administrative support. Most pertinent to carrying out mobile crisis response activities are Mental Health Counselor IIs, as these are the clinicians in the field who can complete a CAT. The following graph highlights DCFS MCRT staffing constraints for these key clinical roles, demonstrating critical staffing shortages beginning in the second half of 2024.



Programmatic Changes and Next Steps

The primary goal of DCFS-administered crisis response services is to provide immediate, on-site intervention to individuals experiencing a mental health or behavioral crisis. This approach aims to prevent escalation, reduce the need for emergency room visits, and minimize the use of law enforcement or hospitalization. Crisis response teams typically work to de-escalate the situation, assess the individual's needs, offer support, and connect them to appropriate community resources or mental health services. By intervening quickly and in the community, crisis response teams help ensure individuals receive the care they need in a less restrictive and more supportive environment. In efforts to ensure State resources are appropriately allocated to achieve these goals, several programmatic changes have recently been implemented.

In early November of 2024, Clark County DCFS-administered crisis response teams reduced their hours and stopped staffing an overnight shift from 11:00 p.m. through 7:59 a.m. This decision was made based on resource limitations and after a thorough review of call and response volume data indicated the overnight team was being deployed approximately once every other day. In late November of 2024, Clark County DCFS-administered crisis response teams discontinued staffing on state holidays, due to similar circumstances. Currently, calls that come in on a holiday or after hours, when crisis services are not staffed, or come in toward the end of shifts, go to a call center run by the Division. When callers require a face-to-face response, staff are dispatched the following morning or the next working day.

In January of 2025, Clark County DCFS-administered crisis response teams stopped responding to hospitals in an effort to devote resources to the community and focus resources on those most vulnerable. This shift in operational focus to community-based interventions, such as responding directly to individuals in the field or in private residences, rather than in hospital settings, is an effort to better address the root causes of crises outside of medical facilities, address resource constraints that limit the capacity to respond to emergency rooms, and reduce duplication of services in a setting that has a shared responsibility to stabilize patients in mental or behavioral health crisis.

The Division of Child and Family Services is currently conducting a gaps analysis that will evaluate Nevada's mobile crisis and stabilization services against national best practices. This analysis aims to identify training needs, conduct further analysis into data and outcomes, and explore socioeconomic factors affecting the populations served. Furthermore, the analysis will emphasize the importance of ongoing quality assurance and continuous improvement to ensure the effectiveness and sustainability of the services.