Clark County Children's Mental Health Consortium

2020 Vision for Success

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

10-Year Strategic Plan

2013 Status Report

HEALTHY FAMILIES BUILDING HEALTHY COMMUNITIES

CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM
2013 STATUS REPORT ON THE 10-YEAR STRATEGIC PLAN

I. INTRODUCTION

On January 31, 2010, The Clark County Children's Mental Health Consortium submitted its 10-Year Strategic Plan to the Nevada Commission on Mental Health and Developmental Services and the Nevada Department of Health and Human Services

The CCCMHC 10-Year Strategic Plan represents a commitment to all children in our community who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic. The Plan is based on a set of values and principles that promote a system of care that is community-based, family-driven and culturally competent. Using a public health approach and a neighborhood-based model of service delivery, the plan sets forth the following long-term goals for Clark County by the year 2020.

10-Year Plan Goals

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

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

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

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

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

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

Over the last two years, the shock of mass shootings by troubled young people in Tucson, Aurora, and Newtown have focused the national spotlight upon mental health issues, while government reports continue to document the troubling state of children's mental health services delivery in the nation's communities (Szabo, 2013; U.S. Government Accountability Office, 2012) In addition to the difficulties faced by ***our own*** community's failing service system, Clark County children with behavioral health needs and their families have suffered more than their share of stress from the consequences of the economic recession, which affected our region more than any

other during these recent years. Moreover, the CCCMHC has faced challenges with turnover in state and county administrators, lack of key agency participation, and maintenance of staffing support. In spite of these times and these challenges, we cannot afford to waiver in our commitment to the values and principles of family-driven, community-based and evidence-based services delivery that can propel a positive transformation of our failing system of care for Clark County's children with behavioral health care needs and their families. The CCCMHC 10-year plan called for parents, policymakers and professionals to come together to take ***immediate*** action and support a change in approach to behavioral health service delivery. This report summarizes the status of the CCCMHC 10-Year Plan and the progress made over the last two years in accomplishing the goals and objectives of the plan.

II. REVISIONS TO THE CCCMHC 10-YEAR STRATEGIC PLAN

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

- ***Revised Priority 2- Recommended Action Step*** *In developing a process for hospitals to determine presumptive eligibility as required by federal regulations, DHHS will develop a family-driven approach that ensures youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior, receive* ***immediate*** *and* ***appropriate*** *inpatient or community-based care.*

  Justification: Many youths presenting with psychiatric crises at local emergency rooms meet the eligibility criteria for Medicaid. However, these youths are often discharged without linkage to appropriate treatment due to the Medicaid application process faced by families already stressed by their child's condition. Over 75 local leaders, stakeholders, and family members attending the 2011 Youth Suicide Prevention Summit recommended a family-friendly presumptive eligibility process for youths with suicidal behavior or other severe forms of mental illness. Federal regulations now require hospitals participating in the Medicaid program to perform presumptive eligibility in order maximize access to emergency services for potentially eligible youth and other individuals. States such as New Jersey have successfully used presumptive Medicaid eligibility to help finance cost-effective programs r youth with psychiatric emergencies such as mobile crisis intervention services.

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

- **Revised Objective 1.2 With active support from the DHHS Director, County Manager, and the Judiciary, s*trengthen adherence and commitment to local barrier-busting resource teams***

  Justification: Large numbers of youth are placed in out-of-state residential treatment centers at a tremendous cost to state Medicaid. State and county leaders need to empower local barrier busting teams that have been shown to be effective in developing alternatives to out-of-state and out-of-community placements.

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

- ***Revised Objective 4.4*** *Recommend the DHHS Director and Clark County manager meet with the CCCMHC to* ***develop a plan for re-establishing neighborhood centers*** *that: (1)operate based on a family-driven, system of care approach and (2) provide a full array of services to meet the needs of children with serious emotional disturbances and their families.*

  Justification: Even though established as best practice with support from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, many of the five neighborhood centers established between 2000 and 2004 have been closed due to budget cuts and lack of key agency's commitment to the model. Those neighborhood centers that remain lack the full array of services originally provided for children and families with behavioral health care needs with the development of the centers. ***Families and providers of youth with serious emotional disturbance have indicated that neighborhood-based services represent a critical factor in successful outcomes*****.**

III. STATUS OF 10-YEAR PLAN PRIORITIES

In the 10-Year Plan, the CCCMHC identified ***seven priorities*** that would result in the most short-term, cost-effective improvements in the system while serving as building blocks for the long term plan. In 2012, the CCCMHC recommended ***specific action steps*** for implementation of the seven priorities during the ***2014-2015 biennium***. This section provides a description of current progress toward implementing these priorities.

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

Justification: Health Care Reform represents an opportunity to re-structure children's behavioral health services delivery using the systems of care approach (See Wotring, J. et al., 2011).

2012 Recommended Action Steps

- *Develop mechanism for CCCMHC input into Nevada's Health Care Reform –**Minimal Progress***
- *Include family-to-family support, mentoring, mental health consultation, mobile crisis intervention and respite care as Essential Health Benefits –**No Progress***
- *Build in reimbursement incentives for evidence-based practices-**No Progress***
- *Provide family navigators to assist families of children with SED-**Some Progress***
- *Re-invest savings from health care reform's increased federal financial participation into expanded community-based services-**No Progress***
- *Obtain a 1915I state plan amendment to increase the capacity of Medicaid providers to deliver in-home services and supports that decrease the need for out-of-home care-**No Progress***

Status Report: While state implementation of the Affordable Care Act potentially offers an opportunity to improve behavioral health services for children (Wotring et al., 2011), Nevada has not yet shown much progress in taking advantage of this opportunity. To date, the CCCMHC has had no meaningful involvement in health care reform in order to shape the service system for children and adolescents with behavioral health needs. In order to address this issue, the DCFS Deputy Administrator for Children's Mental Health (who also serves as a CCCMHC member), will be attending the Department's Health Care Reform meetings in order to give consortium input and provide information. Nevada has recently developed the Essential Benefits Package for private insurance companies under health care reform ***without*** including any of the services recommended by the CCCMHC. However, the Silver State Health Insurance Exchange responsible for overseeing the essential health benefits for qualified health plans in Nevada has recently received grant funding for navigators that may assist families in accessing behavioral health services for their children within the new system. Although Nevada has opted to expand Medicaid eligibility criteria in order to qualify for increased federal financial participation under the Affordable Care Act, there is no evidence that any additional federal funding will be re-invested in needed community-based services for children and adolescents with behavioral health needs. Citing the lack of additional state general funds, Nevada Department of Health and Human Services has not applied for the 1915i state plan amendment offered through the Affordable Care Act. This would increase the capacity of the service system to provide in-home behavioral health services and supports necessary to decrease the need for out-of-home care for children and adolescents with serious emotional disturbances. ***Recognizing the lack of substantial progress on these action steps, the Legislative Committee on Health Care recommended that the Nevada Department of Health and Human Services implement these action steps to the extent feasible.***

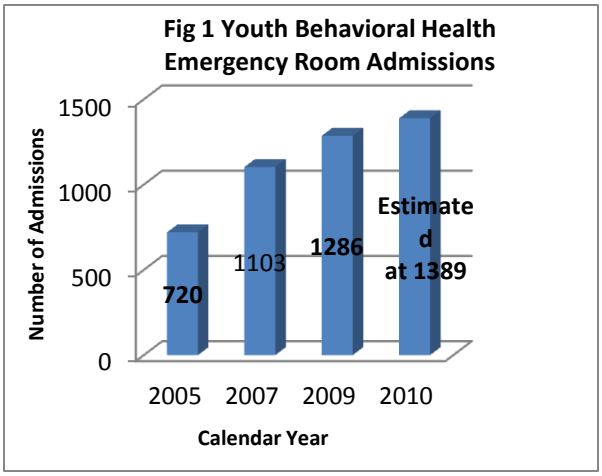
Priority 2. Provide mobile crisis intervention and stabilization services to Clark County youths in crisis—*SOME PROGRESS*

Justification: Increasing numbers of youth in crisis are entering local emergency rooms and pediatric hospitals. Between 2005 and 2009, there was a 40% increase in the number of youth in crisis entering local emergency rooms. Experts at the local and national level conclude that these emergency room admissions unnecessarily burden already overwhelmed emergency room departments without providing any benefits to the children seen (Cooper et al., 2007). The Clark County School District is also identifying more and more youth with mental health crises during school hours (see Clark County Children's Mental Health Consortium's 10-***Year Strategic Plan***, 2010). Mobile Crisis Intervention has been recommended as a cost-effective strategy for Nevada by national experts (See Pires et al., 2009). Many states such as New Jersey are reducing inpatient hospitalization rates for youth through the implementation of this service. Although mobile crisis intervention is a reimbursable service under Nevada Medicaid's Mental Health Program (Chapter 400), providers are not available to serve emergency room referrals due to the inadequate reimbursement structure.

2012 Recommended Action Steps

- *Review and revise the rate structure for mobile crisis intervention and stabilization services to increase provider capacity-**Some Progress***
- *Provide funding and Medicaid policy changes (i.e. presumptive eligibility) for increasing access to mobile crisis intervention and other services for uninsured youths with psychiatric crises entering emergency rooms-**Some Progress***

Status Report: Director Willden informed the CCCMHC that the DCFS budget request for the next biennium includes funding for a small mobile crisis intervention program in Southern Nevada, focusing on uninsured and underinsured youth in parental custody with the purpose of preventing entry into the system. DCFS is also reviewing the feasibility of providing mobile crisis intervention to Medicaid eligible youths as well as some uninsured youths by redeploying existing mental health counselor positions in the agency's Clark County Children's Clinical Services Program. While DCFS may be able to recover their actual costs to provide mobile crisis intervention services from Nevada Medicaid, it is likely that they will not be able to meet the demand for this service. Therefore, Medicaid will still need to make the rate and policy changes necessary to recruit additional providers for their eligible youths. A new code for crisis psychotherapy included in the 2013 CPT Handbook may help with provider recruitment and reimbursement strategies. In addition, other states have used presumptive eligibility in order to facilitate timely access to mobile crisis intervention. A recently revised federal regulation allowing hospitals to determine presumptive eligibility provides the opportunity to develop a process that will facilitate the timely access of Clark County youths with psychiatric emergencies to access mobile crisis intervention services. Director Willden has established a committee to discuss the implementation of presumptive eligibility determinations by Nevada hospitals. With new technology required by health care reform, the state expects to approve Medicaid applications within three days of submission. DCFS has requested to participate on this committee. The CCCMHC Early Intervention and Crisis Workgroup is working with members and stakeholders on mobile crisis intervention implementation issues.



Priority 3. Expand access to neighborhood-based, financial supports and intensive services for Clark County's children with serious emotional disturbance who are living with their families—*MINIMAL PROGRESS*

Justification: These services are needed based on increasing numbers of children needing out-of-home placements through juvenile justice and child welfare; high numbers of uninsured children in Clark County; and the results of the economic recession on families' ability to care for their children. In 2011, Clark County Juvenile Justice Services placed 469 youths with serious emotional disturbance and Clark County Family Services placed 537 children with serious emotional disturbance in treatment homes and residential treatment centers.

2012 Recommended Action Steps

- *Provide funding for placement prevention and reunification support to the families of children involved in or at-risk for entering or re-entering the child welfare or juvenile justice systems-**Minimal Progress***
- *Extend Medicaid family of one Medicaid eligibility to provide temporary coverage to children with serious emotional disturbance returning to their families after out of home care-**No Progress***

Status Report: The results of the 2009 CCCMHC Community Input Survey suggested that neighborhood-based intensive services and financial supports were the most in need of expansion for Clark County youths with serious emotional disturbance who are living with their families. The 10-Year Strategic Plan proposed; 1) expanded Medicaid eligibility programs for youth with SED; 2) waivers or other innovative programs (e.g. Katie Beckett); and 3) creation of a state/local tax or fee as strategies for expansion of these services. Without these types of support for families, Nevada child welfare programs continue to place ***proportionately more children in out-of-home care*** than the national average (Children's Advocacy Alliance, 2011). DCFS continues to provide intensive services and placement prevention/reunification supports to families of children with serious emotional disturbances through its WIN and CCS programs that operate out of five neighborhood-based sites. Local non-profit and faith-based organizations provide some intensive services and supports but they are primarily designed for children in foster care and only available to children who are already eligible for fee-for-service Medicaid. DCFS Wraparound In Nevada (WIN) has been providing intensives services and supports to foster care youth with multiple and complex problems since 2005. Research has shown wraparound is an effective model for youths with serious emotional disturbances that are living at home with their families, as well as those who are involved with the juvenile justice system. It is vital that the community find a way to assist families and keep youth from entering higher levels of care and/or child welfare/juvenile justice custody situations. Although there is no increase in staff resources or placement prevention funding for serving youths other than those in foster care, the DCFS WIN program has changed their admission criteria to include parental custody youth, and youth with juvenile justice involvement.

Nevada Medicaid continues to provide "family of one" Medicaid to youths placed in institutional care, while providing no support once the youth is discharged from the institution or other out-of-home placement. In spite of the potential to reduce institutional costs through providing aftercare coverage, Medicaid has no plans to offer this benefit in the coming biennium.

Priority 4. Expand access to family-to-family support services for the families of Clark County's children with serious emotional disturbance-*MINIMAL PROGRESS*

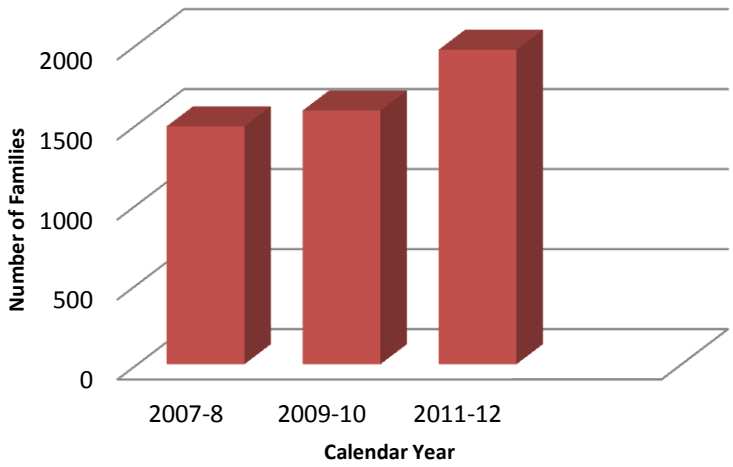
Justification: More and more families who have children with serious emotional disturbances are requesting family-to-family support services with no new increases in funding. In 2011, Nevada PEP provided support targeted at a total of 1008 individuals, a 28.7% increase over 2010. There were 476 *new* families requesting PEP services in 2011, a 29.3% increase from 2010. Family-to-family support is recognized as a cost-effective strategy to improve family functioning and outcomes for children with serious emotional disturbances (See CCCMHC's ***10-Year Strategic Plan***, 2010). The 2009 CCCMHC Community Needs Assessment Survey identified Family-to-Family Support among the top ten services most in need of expansion for Clark County's families who have children with serious emotional disturbance.

Status Report: There has been no expansion in state funding over the four years for family-to-family support services on behalf of families of Clark County's children with serious emotional disturbance, even though the number of families requesting services has significantly increased. The Division of Aging and Disability Services did provide $25,000 in December 2012 to support the Nevada PEP Family Support 360 Program. This temporary funding will help serve approximately 85 families of children with co-occurring intellectual disabilities and behavioral health care needs for approximately three months in 2013.

2012 Recommended Action Steps

- *Expand funding to provide family-to-family support for youths with serious emotional disturbances who are involved in all public systems, including juvenile justice, special education and/or child welfare-**Minimal Progress***

Fig 2. Clark County Families Requesting Support Services through Nevada PEP



The 360 Program's families receive intensive family-to-family support in an effort to reduce the child's likelihood of out-of-home placement or institutionalization. Nevada PEP will have to close the 360 Program after March 1, 2013 without additional state and/or federal funding. **Family-to-family support is a service covered by Medicaid in many other states.**

Priority 5. Expand access to intensive care management using a wraparound model for youths with serious emotional disturbance, including those involved with the juvenile justice system and those living with their families—*NO PROGRESS*

Justification: Increasing numbers of youth involved with juvenile justice require out-of-community and out-of-state placements. It is estimated that approximately 50% of over 15,000 youths involved in Clark County juvenile justice system suffer from serious emotional disturbances, and over half of these youth have such dangerous and disabling conditions that they require immediate treatment (See CCCMHC's ***10 Year Strategic Plan,*** 2010). In 2011, Clark County Juvenile Justice Services placed a total of 188 youths with serious emotional disturbance in out-of-state residential treatment centers. Many families caring for their children at home are forced to request out-of-state placements due to difficulties in accessing intensive services and supports in the community. An average of ***264 youths in out-of-state placements*** between September 2011 and August 2012 ***cost the state's Medicaid program nearly 30 million dollars per year.***

2012 Recommended Action Steps

- *Fund pilot program to provide wraparound case management to youths involved with juvenile justice services who are returning from or at risk of out-of-community placements-**Minimal progress***
- *Provide Medicaid reimbursement to all providers who participate in wraparound case management teams for youths with serious emotional disturbances-**No progress***

Status Report: Although no pilot program has been established, the DCFS Wraparound in Nevada (WIN) Program has now begun providing intensive case management to youths involved in juvenile services that are Medicaid eligible, while those that are uninsured or underinsured can receive intensive case management through DCFS's Children's Clinical Services. A 2009 financing assessment had concluded intensive care management efforts in Clark County were duplicative across agencies, inconsistent, and failed to target youths in with the most serious and complex needs, including those involved with juvenile justice services (Pires, 2009). Even with the services now being provided by DCFS, too many youths with SED in Clark County are still placed in out-of-state residential treatment centers at a yearly cost of nearly $100,000 per youth. Montevista Hospital plans to build a 48-bed residential treatment facility expansion which will allow youths needing residential care to remain in the community, however, these youths will still need intensive case management upon discharge. Nationally recognized programs such as Wraparound Milwaukee are producing positive outcomes for these youths by providing community-based, intensive case management and nonresidential services at an average yearly cost of approximately $50,000 per youth (Pires, 2009, NAMI, 2010). In order to achieve positive outcomes such as the Wraparound Milwaukee program, all providers who participate in wraparound case management teams must be reimbursed for their participation, and Nevada has not made any progress on this issue. Consistent with this CCCMHC priority, a 2012 report from the Nevada Center for Excellence in Disabilities found that returning youths from out of state placement would require much more coordinated intensive, community-based services provided in partnership with local schools.

Fig 3. Children in Medicaid Out-of-State Placements

Time Period	Children Placed	Total Mo Cost	Cost/Mo/child
Sep 2011	**263**	$2,484,390.44	$9,446.35
Oct 2011	**269**	$2,625,477.36	$9,760.14
Nov 2011	**267**	$2,505,015.78	$9,382.08
Dec 2011	**273**	$2,537,660.15	$9,295.46
Jan 2012	**265**	$2,507,657.68	$9,462.86
Feb 2012	**266**	$2,334,499.47	$8,776.31
Mar 2012	**272**	$2,477,227.64	$9,107.45
Apr 2012	**282**	$2,490,465.64	$8,831.44
May 2012	**276**	$2,538,989.60	$9,199.24
Jun 2012	**261**	$2,248,558.81	$8,615.17
Jul 2012	**237**	$2,167,096.91	$9,143.87
Aug 2012	**231**	$2,069,616.05	$8,959.38

Priority 6. Support early childhood preventative programs that strengthen families' ability to promote the social and emotional development of their children—*SOME PROGRESS*

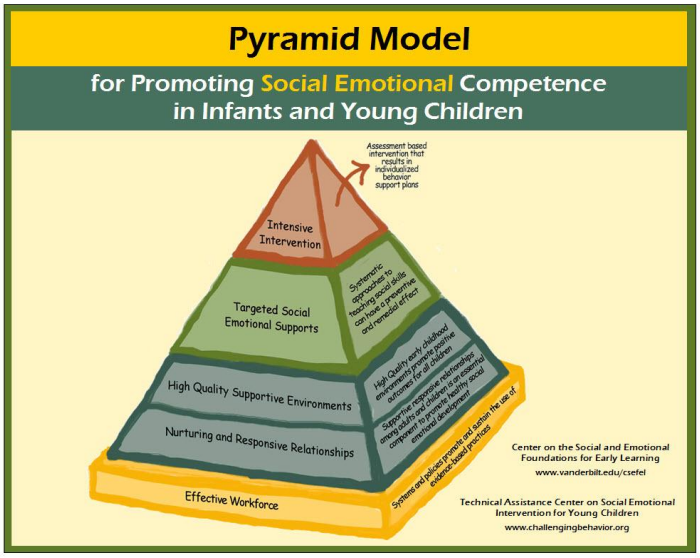
Justification: DCFS Families, Providers, and Stakeholders rated preventative services as the top priority for expansion in the 2009 CCCMHC Community Input Survey. Risk factors for mental health problems can now be pinpointed during the toddler years (Webster-Stratton et al., 2001). Family-focused, evidence-based early childhood preventative programs can have a profound effect on parenting behaviors and the developmental trajectories of children whose life course is threatened by multiple risk factors. Prevention efforts in the early childhood years have demonstrated both short-term and long-term effectiveness in contributing to the overall mental well being of children, as well as in reducing later costs of delinquency, substance abuse, health-risk sexual behaviors and school failure. SAMHSA (2007) has reported that some interventions that occur early in life may continue to produce benefits through a person's lifetime. The CCCMHC 10-Year Strategic Plan recommended that education and support be made available to all parents of at-risk pre-kindergartners (**Objective 5.5)**. In partnership with the Nevada Department of Education, the Nevada Division of Child and Family Services, Nevada PEP, the Nevada Division of Health's Maternal and Child Health Advisory Committee, and the Clark County School District, the CCCMHC is supporting TACSEI as an effective model for the promotion of social-emotional development in at-risk young children through parent and teacher training programs.

2012 Recommended Action Steps

- *Provide funding through the Child Care Development Block Grant for a trainer to provide parent education through the implementation of the TACSEI model in Clark County child care centers-**Some Progress***

Status Report: The Nevada Maternal and Child Health Program, Bureau of Child, Family and Community Wellness provided a one year sub-grant through Nevada PEP to fund 10 hours per week for each of three different positions: a Southern Nevada Training Consultant, a Southern Nevada Evaluation Consultant and a Parent Engagement Coordinator. In addition, DCFS has three staff members certified to provide TACSEI training/consultation to teachers in private child care centers and preschools. The Clark County School District has continued to expand implementation of the TACSEI model. Fifteen Early Childhood Special Education instructional interventionists and project facilitators have been trained as trainers to provide parent and teacher education. All of the 500 Clark County School District Early Childhood and Early Children Special Education teachers have been trained in the model. In addition, the Early Childhood Special Education program is providing ongoing TACSEI skills training for early childhood staff at thirteen schools which are serving as TACSEI demonstration sites.

Fig 4. TACSEI Model



Priority 7. Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs—*SOME PROGRESS*

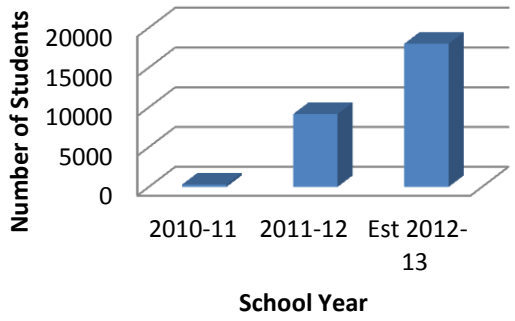
Justification: The rate of teen suicides has more than doubled over the last two years in Clark County. At the 2011 Clark County Youth Suicide Prevention Summit meeting, community leaders, providers, families and stakeholders recommended the expansion of school-based screening as the highest priority to address this serious issue. School-based screening using the TeenScreen Program is a strategy proven effective in early identification and prevention of suicide and mental health problems.

2012 Recommended Action Steps

- *Provide DHHS funding through the Office of Suicide prevention to maintain and/expand school-based screening for suicide prevention in Clark County using the TeenScreen Program-**Some Progress***
- *Provide DHHS funding through the Office of Suicide Prevention to coordinate a parent education and public awareness campaign about the risk of youth suicide cause by availability of firearms and potentially lethal medications-**Some Progress***

Status Report: The CCCMHC's 10-Year Plan recommended school-based screening programs for early identification of behavioral health issues and suicide risk (**See Objectives 5.1 and 5.2).** Since the 2012 report, the CCCMHC has continued working with the Nevada Office of Suicide Prevention and Nevada PEP to develop partnerships that promote school-based youth suicide prevention efforts. During the 2011-12 school year, Nevada PEP screened 165 middle school and high school students in rural and private schools through a subgrant from the Office of Suicide Prevention (OSP). Through additional funding support from OSP, Nevada PEP continued these efforts during the 2012-2013 school year, screening approximately 260 students thus far. The Clark County School District adopted the Signs of Suicide (SOS) Prevention Program as an alternative to TeenScreen. During the 2011-12 school year, 9,000 students participated in the program from 1 middle school and 3 high schools. A total of 686 students (7.6%) were identified at some suicide risk, 35 of which required intensive intervention due to their high risk level. The implementation of the SOS Program has continued during the 2012-13 school year. More than 8,400 students have participated so far this year from 4 middle schools and 5 high schools, with 579 (6.9%) of participating students identified at risk for suicide, and 60 of those students requiring intensive interventions. Using a collaborative team of trained school counselors, social workers, school psychologists, and nurses, screening will continue throughout the remainder of this school year and next year. During state fiscal year 2012-13, the Nevada Office of Suicide Prevention will implement a Reducing Access to Lethal Means program through a $10,000 grant from the Nevada Child Death Review Committee. The OSP will partner with the Center for the Prevention of Youth Violence to adapt the Rhode Island Suicide Proof campaign for use in Nevada. Targeted toward decreasing suicides among 10 through 18 year old youths, the program will directly educate parents on strategies to limit children's access to weapons and other lethal means through a website, brochures, posters and a media campaign. Healthcare professionals, law enforcement, and school personnel will also receive training on methods to engage and educate parents and other caregivers about lethal means restriction. The CCCMHC will partner with the Office of Suicide Prevention to support local program implementation.

Fig 5. Students Participating in TeenScreen or SOS Program



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

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

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

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

Phase 1 Objectives and Strategies

- **Objective 1.1 Re-structure Medicaid Care Targeted Case Management Policies to support a single, accountable care management entity in Clark County. Blend/braid existing funding to implement the care management entity**
  Indicators: Number of youths receiving intensive case management, improved outcomes

  Current Status: No Progress. A 2009 statewide financing assessment concluded although one-third of the public children's behavioral health care dollars in Clark County are spent on some type of intensive care management, these efforts are duplicative across agencies, inconsistent, and fail to target youths with the most serious and complex needs (Pires, 2009). Consequently, The CCCMHC 10-Year Strategic Plan suggested that DCFS could only provide intensive case management using a wraparound model to less than 5% of youths with SED in Clark County. The number of youths with SED receiving this type of intensive case management has not increased significantly over the past two years. DCFS and Clark County Family Services have begun a pilot project to provide targeted case management to children in child welfare custody through an approach which blends/braids funding from the two agencies and Nevada Medicaid.

- **Objective 1.2 Strengthen adherence and commitment to local barrier-busting resource teams**
  Indicators: Adherence to MOU; *Decrease in Out-of-State and Out-of-Community Placements, Increase in number of children staffed by the teams*

  Current Status: No progress. Based on national best practices for community-based children's mental health services delivery (Stroul et al., 2008), the CCCMHC worked to develop and implement the Clark County Barrier-Busting Memorandum of Understanding (MOU). This MOU establishes neighborhood-based resource teams to assist in development of services for youths at risk of out-of-community placement. Unfortunately, these teams are failing to achieve their potential benefit for children with serious emotional disturbances and their families. With the closure of some neighborhood centers, key service providers no longer come together consistently in these teams to promote collaborative community-based interventions for youth and families with the most challenging circumstances. Without barrier-busting by these neighborhood teams, more youth are at risk of out-of-community placements. In addition, key agencies such as Clark County Juvenile Justice Services no longer participate in the community-wide team that meets regularly in a last resort effort to find community-based resources for youths referred for out of-community

placements. The CCCMHC needs to review the Barrier-Busting Memorandum of Understanding and seek improved processes, commitment and collaboration.

- **Objective 1.3 Expand Medicaid eligibility to cover home-based counseling and other family supports for youth with SED who are at risk for re-hospitalization or placement in child welfare or juvenile justice**
  Indicators: Increase in number of children served, increased family satisfaction, improved family functioning

  Current Status: No Progress. The CCCMHC has conducted surveys of over 150 families of youths hospitalized at the DCFS Desert Willow Treatment Center. These youths were covered by Medicaid while hospitalized; however, they lost coverage at discharge. Less than 50% were able to obtain healthcare coverage to support aftercare services. (**See *10-Year Strategic Plan*, Appendix B**). In addition, families often face extreme economic challenges when necessary services and supports are accessible through one payer source, such as Medicaid, but not available when the family becomes eligible for private insurance. The inability to blend payer sources and assure continuity in services and supports is one of six top barriers identified by Clark County families, caseworkers and providers in a 2009 survey. The CCCMHC's ***Ten-Year Strategic plan*** recommends expanded Medicaid eligibility for youth with SED, waivers, or other innovative programs (e.g. Katie Beckett) to provide funding for needed services.

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

  Current Status: Some Progress. DCFS and MHDS continue to utilize a memorandum of understanding that was developed in 2009 which includes a process for jointly serving this population. Clark County will be added to an existing workgroup in the North/Rural area that is reviewing the MOU and developing a process for ensuring youth with co-occurring disorders receive appropriate services. In addition, Nevada PEP established the *Family Support 360 Program* in 2010 to serve families of children with co-occurring developmental disabilities and behavioral health needs. For the last three years, this program served at least 100 families per year through a 5-year $1,000,000 grant from the U.S. Department of Health and Human Services, Administration for Children and Families. Federal funding was *prematurely* terminated on November 30, 2012 due to congressional budget cuts. The Nevada Division of Aging and Disability Services have provided temporary funding for a 90-day extension of this program. *Alternative funding is needed to continue the program after March 1, 2013.*

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

Phase 1 Objectives and Strategies

- **Objective 2.1 Identify evidence-based and promising practice models for most needed services; Re-structure Medicaid rates to provide incentives for these practices**
  Indicators: Public and private insurer reimbursement rates for Evidence-Based and Promising Practices

Current Status: No Progress. Across the United States, there have been significant advances in the development of evidence-based and promising practices for children's behavioral problems. However, there is

little evidence that these practices have yet been incorporated into the broad service array for Clark County's children (Pires, 2009). Clark County needs to identify specific treatments that match community needs and demographics, and then identify incentives for implementation. Over the past year, the Nevada Children's Behavioral Health Consortium has begun to explore this issue through its Workgroup on Accountability and Workforce Development. The CCCMHC has not had the authority or resources to begin this process at a local level in partnership with insurers, providers, and families. Providers of substance abuse services must be certified to receive funding from the State Substance Abuse Prevention Treatment Requirements for certification to include utilization of evidence-based treatment for substance abuse. Examples of required practices include Motivational Interviewing, Cognitive-Behavior Therapy, Matrix Model; and Motivational Enhancement/Cognitive-Behavior Therapy. Clark County Department of Family Services will be implementing a pilot project in October, 2012 aimed at implementing and evaluating best practices for 30 children with serious emotional disturbances in the foster care system in an effort to improve outcomes for the children and their families (both biological and foster) and decrease the use of psychotropic medications.

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

  Current Status: Some Progress. Without healthcare coverage, families have great difficulty accessing most behavioral health services for their children. In 2011, Nevada ranked 51st in the nation in children without health insurance. Nevada's rate of uninsured children is more than double the national average, with 16.2% of the state's children without health care coverage (Children's Advocacy Alliance, 2012). In October 2013, the Silver State Health Insurance Exchange will link with the New Medicaid and Nevada Check Up eligibility engine. This will provide a single entry point where families can be evaluated for exchange based insurance subsidies, Medicaid and Nevada Check Up eligibility. As mentioned above, the exchange will have Navigators to assist individuals and families with health care coverage needs.

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

  Current Status: Some Progress. Over the past year, the availability of resources in Clark County has greatly increased. However, there continues to be concerns regarding the quality of services, and accountability standards. Clark County Family Services has partnered with local providers to ensure that every child entering foster care receives a physical and a complete psychological assessment. The Nevada Division of Child and Family Services provides comprehensive assessments to every child less than six years of age who removed from their home due to abuse/neglect.

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

Phase 1 Objectives and Strategies

- **Objective 3.2 Re-structure Medicaid's Mobile Crisis and Stabilization Policies to increase provider capacity; Blend/braid existing funds to implement a cross-agency contract for mobile crisis program for Medicaid, Child Welfare and Juvenile Justice involved youths.**

Indicators: Decrease in youths accessing emergency rooms for psychiatric problems; decrease in inpatient psychiatric bed utilization

Current Status: Some progress. Although mobile crisis intervention is a covered service under Medicaid's current behavioral health service policies, access to such services has been limited by the lack of providers who can address youths in crisis from a cross-system perspective. Easy access to crisis intervention and stabilization services for youths with behavioral health disorders is an essential part of any community behavioral health system (Cooper et al., 2007). Without this resource, already overwhelmed emergency rooms are unnecessarily burdened without any sustainable benefits to the youths in crisis and their families. Youth pediatric emergency room admissions have steadily increased over the last five years (See Figure 1). The Director of the Nevada Department of Health and Human Services informed the CCCMHC that DCFS has included funding in the 2013-15 proposed biennial budget for a small mobile crisis intervention program. DCFS also plans to re-allocate some existing positions from their Children's Clinical Services program to supplement this funding request. In addition to accepting referrals from local emergency rooms, the proposed program will need to address cross-agency collaboration with Clark County Family Services and Juvenile Justice Services, who often serve as first responders to the psychiatric crises of youths in the community. The success of this program will also require timely access to inpatient hospitalization for some of the youths referred for services and streamlined processes for medical clearance.

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

  Current Status: No Progress. Over the last four years, the CCCMHC has worked to increase family involvement and reduce the involuntary hospitalization of youths with psychiatric crises. In partnership with the Las Vegas Metropolitan Police Department, police officers have been trained to address youths experiencing mental health crises and their families. In January 2011, the CCCMHC facilitated the inclusion of school police officers in these trainings. Nonetheless, there is still confusion about the specific procedures for utilizing involuntary hospitalization with youths. Nevada Revised Statutes 433a allows the use of involuntary hospitalization for all individuals with mental illness, and specifies that regulations ***shall*** be adopted to guide this process. Procedures for the hospitalization of children continue to be implemented very differently across the State.

- **Objective 3.4 Implement memorandum of understanding for standardized intake and service planning protocols across public and private providers**
  Indicator: Proportion of public and private providers adopting standardized tools

  Current Status: Some Progress. In April, 2010, the Nevada Children's Behavioral Health Consortium adopted the Children's Uniform Mental Health Assessment and asked member agencies and providers to sign letters of commitment agreeing to utilize this standardized intake tool. The Children's Behavioral Uniform Mental Health Assessment is now being used across the State by public and private providers. Standardized service planning protocols have *not* yet been developed at the local or state level, and there continues to be confusion regarding responsibility for coordination of mental health service provision.

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

Phase 1 Objectives and Strategies

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

- ***Current Status: Some Progress.*** In 2011, Nevada Revised Statute 433B was amended to allow the CCCMHC to: (1) accept and administer grants, gifts and donations; (2) request funding through the Department of Health and Human Services during the state biennial budget process; and (3) enter into contracts and participate in activities to improve children's mental health service delivery. The 2011 legislature approved a budget of $15,000 annually to support the work of the CCCMHC during the 2012-13 biennium. Director Willden included the same amount of funding for the CCCMHC in the proposed budget for the 2014-15 biennium. The CCCMHC has encountered challenges in utilizing the approved funding to fulfill its statutory duties. The CCCMHC chair and other members must rely on the DCFS administrator and other staff to fulfill requirements for the development of contracts and other fiscal monitoring procedures. The CCCMHC chairperson has the responsibility to fulfill the statutory requirements of the consortium but lacks the authority for the expenditure of the approved budget. The Mental Health Commission has established a subcommittee to look at Children's Mental Health issues as required by NRS 433B. Although the Commission has invited representatives from the state and regional consortia to participate in this subcommittee, only Commission members have voting authority. Without additional legislation, the current relationship between the consortia and the Mental Health Commission will remain unchanged.

- **4.2 Develop and implement a plan for state and local system management; establish formal relationship between CCCMHC and local system management**
  Indicators: Identification of funding support; contracts and/or Memorandums of Understanding

- ***Current Status: No Progress.*** The CCCMHC 10-Year Strategic Plan identifies a need for state and local system management that ensures services and supports are responsive to the community's values, needs, and diversity. Without a formally established children's mental health authority at the state level, public and private providers of children's behavioral health lack the leadership to service children and families with a common vision, values, or standards consistent with the systems of care philosophy known to produce positive outcomes. Outcomes for children and families will also be improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008). A local cross-system infrastructure is needed to manage neighborhood-based centers and provide a mechanism for braided/blended funding streams. There has been no further progress in regards to the creation of a local system of management for children's mental health. Lack of a state authority and local management has led to continued concerns about quality of care, knowledge and skill of the workforce, and utilization of evidence-based practices. Nonetheless, the Clark County Children's Mental Health Consortium and the Division of Child and Family Services continue to have a collaborative relationship. Members of DCFS serve on the consortium and DCFS has provided support for day-to-day operations in recent months.

- **4.4 Blend/braid existing funds to support local system management of the neighborhood centers**

Indicator: Integrated management structure; Memorandums of Understanding

Current Status: Diminished Progress. Unfortunately, many of the neighborhood centers have been closed due to budget cuts and lack of key agency's commitment to the model. Those neighborhood centers that remain lack the full array of services originally provided for children and families with behavioral health care needs with the development of the centers. ***Families of youth with serious emotional disturbance had indicated that neighborhood-based services represent a critical factor in successful outcomes*.**

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

  Current Status: No Progress. Children with SED and their families who have the most complex needs are receiving case management services from multiple agencies and providers. Many of these efforts are duplicative and create additional stress on the child and family. The CCCMHC 10-Year Strategic Plan recommends state and local agencies providing targeted case management to create a single focus of accountability by blending funding streams and revising current policy.

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

  Current Status: Some Progress. In September, 2010, The Nevada Children's Behavioral Health Consortium selected and approved the following outcome indicators for children's mental health programs:
  1) the Child and Adolescent Functional Assessment Scale to assess child functioning; 2) the Caregiver Strain Questionnaire to assess family functioning; and 3) a parent-child satisfaction survey to assess satisfaction with services. These outcome indicators have not been implemented across all public behavioral health service providers. An interagency workgroup is meeting to discuss how to better inform families, providers and foster parents about rehabilitative services covered under Medicaid, expectations, required level of participation, and strategies for collaboration.

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

Phase 1 Objectives and Strategies

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

  Current Status: Some Progress. The CCCMHC's 10-Year Plan recommended school-based screening programs for early identification of behavioral health issues and suicide risk**.** Since the 2012 report, the CCCMHC has continued working with the Nevada Office of Suicide Prevention and Nevada P.E.P. to develop

partnerships that promote the implementation of school-based youth suicide prevention efforts. During the 2011-12 school year, Nevada PEP screened 165 middle school and high school students in rural and private schools through a subgrant from the Office of Suicide Prevention. Students were screened at Faith Lutheran Middle and High School, the largest private school in Nevada, and at Pahrump Valley High School and Rosemary Clark Middle School. Even though the GLS federal grant ended September 30, 2012, the Office of Suicide Prevention provided additional funding support to continue and expand Nevada PEP's screening efforts during the 2012-2013 school year. During this school year more private schools such as Agassi Prep are initiating screening programs, while other schools such as Faith Lutheran are independently maintaining their screening programs. During the 2012-3 school year, 260 private school students have participating in the screening program thus far. In addition, the Clark County School District has formally adopted the Signs of Suicide (SOS) Prevention Program as an alternative to TeenScreen. During the 2011-12 school year, 9,000 students participated in the program from 1 middle school and 3 high schools. A total of 686 students (7.6%) were identified at some suicide risk, 35 of which required intensive intervention due to their high risk level. The implementation of the SOS Program has continued during the 2012-13 school year. More than 8,400 students have participated during the first half of this year from 4 middle schools and 5 high schools, with 579 (6.9%) of participating students identified at risk for suicide, with 60 of those students requiring intensive interventions. Using a collaborative team of trained school counselors, social workers, school psychologists, and nurses, screening will continue throughout this school year and next year.

- **5.4 Inventory school-based programs and funding sources for bullying prevention, life skills training and positive behavioral supports**

  Indicators: School policies and/or regulations; number of schools with programs and number of students participating

  ***Current Status: Some Progress*.** The long-term cost effectiveness of prevention programs has been well documented (SAMHA, 2007). Prevention services were rated as the top priority for expansion in a 2009 survey of over 100 Clark County families, caseworkers and providers. School-based prevention programs have the potential to address the underlying causes of many behavioral health problems in children while also supporting academic achievement (Hoagwood et al, 2007). The Clark County School District (CCSD) has mobilized collaboration among key district partners to develop and implement an anti-bullying initiative. Key partners in this collaboration include: Equity and Diversity Education Department, Education Services Division, School Police Department, Safe and Drug Free Schools Program, School-Community Partnership Department, Student threat Evaluation and Crisis Response Department, and Wrap-Around Services Department. Highlighted activities this past year included:

  - Revision to CCSD Policy 5137 and Regulation 5141 that address bullying and cyber-bullying.
  - CCSD collaborated with community partners including the Nevada Office of Suicide Prevention and Nevada PEP to develop an online suicide awareness video. The video was made available for viewing by staff during the Week of Respect: October 1-5, 2012 (*Anti-Bullying Bill of Rights Act, P.L.2010*, *c*.122). Effective August 2013, this bullying awareness video will be required viewing for all district staff.
  - Bullying awareness training activities, as provided by the Equity and Diversity Education Department, are ongoing. These trainings have targeted district teachers and administrators, staff at specific schools, and more recently, parents for specific schools.
  - The CCSD Anti-bullying Initiative calls for the development of strong community-partnerships. The district is communicating with the Public Education Foundation regarding possible future funding for

anti-bullying activities. However, current activities are primarily supported by community partners and limited support from CCSD department budgets.

The need to develop Positive Behavioral Interventions and Supports (PBIS) is identified within the Clark County School District's Response to Instruction (RTI) Operations Manual. Key principles associated with both RTI and PBIS include early screening, evidence-based intervention practices delivered through a multi-tiered intervention system, continuous progress monitoring, collaborative problem solving, and data-based decision making. Training and technical support for PBIS are provided to schools on a limited basis (Safe & Civil Schools Model). Nevada PEP also provides PBIS and RTI training workshops for families. In 2012, PEP provided twenty-three PBIS workshops with over 500 participants. PEP also provides RTI Workshops for families and community providers on an ongoing basis. Last year, nine RTI workshops were provided to over 100 participants.

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

  Current Status**: **Some Progress. The Clark County School District has recognized the importance of training school personnel in early identification of suicide prevention. With the implementation of the Signs of Suicide Prevention Program in the Clark County School District, all district school psychologists, school nurses, school counselors, and social workers have been trained in this program, including use of the program's early identification screener for risk of suicidal ideation. These same staff members have been trained in the District's Suicide Intervention Protocol, which centers on structured interviews for confirmation of risk and estimation of level of risk. Beginning next school year, all District personnel will be required to complete an online Suicide Prevention Awareness program. With these action steps, the District has developed the staff commitment and capacity for early identification of youth with behavioral health issues as well as crisis intervention in more serious situations.

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

  Current Status: Some Progress. Clark County Department of Juvenile Justice Services continues to provide screenings on youths who are detained using the MAYSI screening tool. This service has been expanded to include screenings provided to additional youth seen by Probation Services at the Neighborhood Care or Probation Centers. Clark County Family Services screens all children and youth taken into protective custody using the Mental Health Screening Tool (MHST). The MHST screens for behavioral health problems and suicide risk/ideation. DFS clinical staff follow up to link any identified youths with the necessary treatment or intervention. When a child enters foster care, the Uniform Psychological/Psychosocial Assessment (UPPA) is completed to evaluate behavioral health issues, including suicide risk and depression.

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

Current Status: No Progress. Since 2010, Nevada Office of Suicide Prevention has not provided specific training to probation and parole officers; however, several youth parole officers have completed ASIST training in the past. The Youth Parole Program needs to re-establish its partnership with Nevada Office of Suicide Prevention to continue providing ASIST training to parole officers in Clark County. Currently, at Clark County Department of Juvenile Justice Services, probation officers receive in-house training through a POST-approved "Mental Health 101" class that includes suicide prevention topics. Currently, child welfare workers through Clark County Family Services are interested in but not required to receive suicide prevention training. Clark County Family Services does require families licensed as specialized foster care providers to complete suicide prevention awareness training.

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

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

Current Status: Some Progress. The CCCMHC sponsored two major public awareness activities during 2011 and 2012. The CCCMHC Public Awareness and Behavioral Wellness Workgroup coordinated these events in partnership with the Clark County School District and with funding support from the Nevada Office of Suicide Prevention, Montevista Hospital and Seven Hills Hospital. In May, 2011, CCSD recruited local High School Theatre, Drama Classes, Key Clubs, Student Councils and/or Video Production Clubs to produce a 5 - 15 minute video production depicting strategies for overcoming the effects of bullying. The Work Group selected videos from Southwest Technical Academy (runner up) and Advanced Technologies Academy (first place) as the top two winners of a $250 award. Additionally, the video from Advanced Technology Academy was awarded the grand prize. The CCCMHC sponsored a team of two students and a teacher from Advanced Technologies Academy to present their video at a Nevada Legislature luncheon hosted by the Governor and the First Lady to commemorate Children's Mental Health Awareness Day on May 3, 2011 in Carson City. Locally, the workgroup also coordinated assemblies for all sixth grade students at O'Callaghan Middle School on Children's Mental Health Awareness Day. Under the leadership of CCSD's Wraparound Program, school social workers and workgroup members presented a research-based bullying prevention program to the students. The program received coverage from TV 8 news and was broadcast that evening.

In May 2012, the workgroup again coordinated implementation of the bullying prevention program at O'Callaghan Middle School. The program was presented to 15 sixth grade science classes. After the presentations, students were invited to submit up to 10 posters from each class that depict the anti-bullying message. Students and Workgroup members selected top posters for awards. Posters were judged by seventh grade students who received a similar presentation the previous year.

During National Mental Health Month in May 2012, CCCMHC provided funding for the Southern Nevada Health District to coordinate a children's mental health anti-stigma media campaign. SNHD arranged to have one of the public service announcements previous produced by the CCCMHC air on local channels 3, 5, 8 and 13 from April 30 – May 9, 2012. The spot aired a total of 182 times during that period. Calls to the Neighborhood Care Center for information regarding Children's Mental Health were tracked during the 10 day period and increased as a result of airing of the PSA.

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

Indicators: Nevada Department of Education Regulations

Current Status: No Progress. In 2009, the Nevada Department of Education amended their regulations governing curriculum requirements for elementary and secondary health education. References to "suicide prevention" were eliminated from the requirements. The CCCMHC is committed to ensuring behavioral health and suicide prevention awareness is included in health education classes. The CCCMHC has not yet initiated contact with the Nevada Department of Education regarding this objective.

ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Current Membership

Jacqueline Harris, Chair
Bridge Counseling Associates, Substance Abuse Provider*
Vacant, Vice-Chair
Parent*
Mike Bernstein
Southern Nevada Health District
Jennifer Bevacqua
Nevada Youth Care (Foster Care)Providers Association*
Lisa Durette, M.D.
Private Provider of Mental Health Care*
Vacant
Nevada Division of Mental Health & Developmental Svcs.
Janelle Kraft Pearce
Las Vegas Metropolitan Police
Kelly Woolridge
Nevada Division of Child & Family Services*
Karen Miller
Parent Representative*
Cherie Wright
Clark County Juvenile Justice Services*
Lisa Ruiz-Lee
Clark County Family Services*
Jason Bouchard
Nevada Division of Health care Financing and Policy*
Karen Taycher
Nevada Parents Encouraging Parents
Robert Wieres
Clark County School District*
Vacant
Business Community Representative*

Membership required by Nevada Revised Statutes 433B.333

Mission

The Consortium was created by the passage of Assembly Bill 1 of the 2001 Special Session of the Nevada Legislature to study the mental health needs of all children in Clark County and to develop recommendations for service delivery reform. The Consortium is required to conduct a needs assessment and submit a 10-Year Strategic Plan and Annual Reports to the 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.333-339.

CCCMHC Activities

CCCMHC members meet monthly to address the needs and challenges of local children's mental health services delivery. In addition to the membership, stakeholders and family members actively participate in three workgroups that meet monthly as well. The CCCMHC acknowledges the efforts of the Infrastructure Workgroup that worked diligently to prepare this status report.

For more information, contact: Jacqueline Harris, CCCMHC Chair, c/o Division of Child & Family Services 6171 W. Charleston Blvd. #8 Las Vegas NV 89146. Ph. (702)486-6120

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