Clark County Children's Mental Health Consortium

2021 Status Report

2030 Vision for Success

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

I. EXECUTIVE SUMMARY

Nevada has consistently ranked 51st for youth mental health access and services in national reports. Though some improvements have been made over the past 10 years, these changes have not been significant enough to increase our ranking and meet the threshold achieved by other states. The purpose of the Clark County Children's Mental Health Consortium (CCCMHC) is to study the mental health needs of all children in Clark County and to develop recommendations for service delivery reform. The CCCMHC has recognized that the extreme challenges faced by children with behavioral health needs and their families can only be overcome by strategic and sustained planning efforts to develop a more effective system of care for these children. The COVID-19 pandemic has added strain to an already stressed system which is negatively impacting youth and families. The effects from the pandemic will be long lasting especially in the absence of supportive services. The mental health of the children and families in Clark County need to be prioritized.

To help provide Nevada's youth and families with the high-quality care and timely access to services they deserve, the Clark County Children's Mental Health Consortium set 6 goals in the 2020-2030 10-Year Strategic Plan to guide future program and service implementation. This plan is based on a set of values and principles that promote a system of care that is community-based, family-driven, and culturally competent.

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

1. ***ADDRESSING THE HIGHEST NEEDS:*** *Youth with serious emotional disturbance, including those with the highest need, and their families, will thrive at home, school, and in the community with intensive supports and services.*
2. ***COMPREHENSIVE SERVICE ARRAY FOR ALL:*** *Families of youth with any mental and behavioral health needs will have timely access to a comprehensive array of high-quality services when and where needed.*
3. ***NO WRONG DOOR TO SERVICES:*** *Organized pathways to information, referral, assessment, and crisis intervention – coordinated across agencies and providers – will be available for families.*
4. ***PREVENTION and EARLY INTERVENTION IN MENTAL HEALTH:*** *Programs and services will be available to facilitate the social and emotional development of all youth, identify mental and behavioral health issues as early as possible, and assist families in caring for their youth.*
5. ***RAISE AWARENESS and SUPPORT FOR MENTAL HEALTH:*** *Increased public awareness of the behavioral health needs of children and youth will reduce stigma, empower families to seek early assistance, and mobilize community support for system enhancements.*
6. ***LOCALLY MANAGED SYSTEM OF CARE:*** *A partnership of families, providers, and stakeholders committed to community-based, family driven, and culturally competent services will collaborate to manage this system of care effectively at the local level.*

OVERVIEW OF PROGRESS ON TOP 4 SERVICE PRIORITIES OF THE CCCMHC

Just after the completion of the new 10-year plan in 2020, the CCCMHC identified the top 4 of the 11 priorities to improve the system while moving toward the longer-term plan. The CCCMHC reviewed available data and partner reports in order to determine the level of progress achieved for each priority (Regression, None, Minimal, Some, or Substantial).

1. Sustainable funding for the Mobile Crisis Response Team (MCRT)	***No Progress***	***Pg. 6***
2. Family peer-to-peer support should be expanded	***Regression***	***Pg. 6***
3. Fully implement the Building Bridges model of care to support youth and families transitioning from residential care back into the community	***Minimal Progress***	***Pg. 7***
4. More service array options so youth and families can access care at earlier stages to reduce the need for crisis service intervention	***No Progress***	***Pg. 8***

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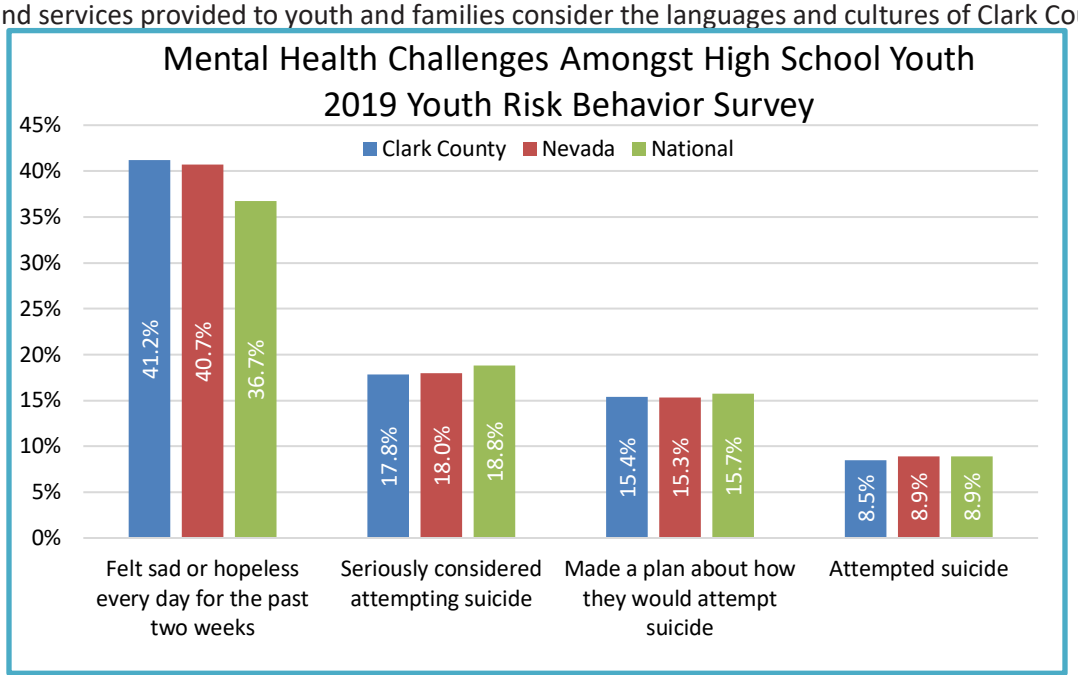
I. INTRODUCTION

PREVALENCE OF MENTAL HEALTH PROBLEMS

A youth's mental health consists of thoughts, feelings, and behaviors that determine whether that individual can cope with stress, relate to others, make appropriate choices, and learn effectively. Like physical health, mental health is important at every stage of a person's life. Unlike physical problems, mental health problems cannot always be seen, but the symptoms can be recognized. Nevada has consistently ranked 51st for youth mental health access and services in national reports. Mental Health America has found 61.4% of Nevada youth with major depressive episodes have not received the mental health treatment they need (Reinert, Nguyen, & Fritze, 2021); higher than the national average of 59%. In the 2018-2019 National Survey of Children's Health, more than half (60.8%) of Nevada youth who had a mental or behavioral health condition did not receive treatment or counseling (Child & Adolescent Health Measurement Initiative, 2021).

Clark County is home to over 70% of the youth in Nevada. As of 2018, there were an estimated 562,636 children in Clark County between the ages of 0 and 19 years, representing nearly 25.5% of the county's population (US Census Bureau, 2019). These children mirror the growing cultural and ethnic diversity of the region. Nearly 50% of the county's children are from non-white ethnic or racial backgrounds, including 30.7% of Hispanic or Latino origin, 11.2% of Black or African-American origin, and 5% representing two or more races (US Census, 2019). There are over 19,000 children in the county who are foreign-born (US Census, 2019). With the ever-increasing diversity of the county's population, it is crucial that the programs and services provided to youth and families consider the languages and cultures of Clark County residents.



Source: Diedrick, et al., 2019a; Diedrick, et al., 2019b; CDC, 2021

About 34,000 Nevada youth (15.0%) were reported to have experienced at least one major depressive episode in 2020, and approximately 28,000 youth (13.2%) that experienced severe major depression within the last year (Mental Health America, 2021). The most recent Youth Risk Behavior Survey (YRBS) found that 17.8% of Clark County public high school students seriously considered suicide and 8.5% actually attempted to kill themselves (Diedrick et al., 2019a). Statewide, there was a significant increase ($p < 0.01$) in the number of students who felt sad or hopeless almost every day for two weeks from 2017 (34.6%) to 2019 (40.7%) (Diedrick et al., 2019c). According to the Office of Suicide Prevention, as of January 17, 2019, there have been 19 youth below age 18 lost to suicide during the 2018 calendar year. There were more youth suicides in Clark County in 2018 than in the whole state of Nevada during 2017 (for ages 17 years and below). Nevada ranked 9th in the nation for suicide as of 2018, and adolescent suicide rates are consistently higher than the national rate (CDC WISQARS, 2021; Drapeau and McIntosh, 2018). In fact, the most recent year of confirmed data (2018) indicates that suicide was the 2nd leading cause of death for youth aged 15 to 24, and the *leading cause of death* for youth aged 10 to 14 (National Center for Injury Prevention and Control, 2021). However, preliminary data from 2019 provided by the Nevada Office of Suicide Prevention shows 642 Nevadans of all ages lost their lives to suicide that year; potentially moving the state's rank to 7th highest in the nation.

Estimates of the prevalence of mental health problems are much higher for children involved with child welfare and

juvenile justice. Nationally, at least 50% of children and youth in child welfare and approximately 70% of youth in the juvenile justice system have significant mental health disorders (Stagman et al., 2010; SAMHSA, 2013). Locally, it is estimated that more than 70% of youth involved in the Clark County juvenile justice system have behavior health disorders and 60% of those with behavioral health disorders have a co-occurring substance use disorder (CCCMHC, 2018).

STATE SUPPORT FOR MENTAL & BEHAVIORAL HEALTH SERVICES

Across the nation, a variety of funding sources and complex funding mechanisms support the delivery of children's behavioral health services in communities like Clark County. Children's behavioral health care funding is minuscule as compared to total healthcare spending, disproportionately small as compared to adult mental health funding, and discordant with best practices favoring community-based care over residential treatment. Already underfunded, shortfalls in the overall state budget due to the COVID-19 pandemic during 2020 resulted in reductions to agencies and services that help youth with mental and behavioral health needs and their families:

BUDGET ITEM	ORIGINAL ALLOCATION	NEW ALLOCATION	REDUCTION AMOUNT
Southern Nevada Child & Adolescent Services	$13,637,841	$13,483,291	$154,550
Caliente Youth Center, Nevada Youth Training Center, Summit View Youth Center	$24,632,293	$20,964,903	$3,667,390
Developmental Services Operation	$130,492,650	$121,813,360	$8,679,290
Autism Treatment Assistance Program	$9,198,979	$3,506,458	$5,692,521

Source: Nevada DHHS, 2020

A tremendous amount of local, state, and federal dollars is spent each year to address the negative consequences of not providing youth with early access to services and supports---through the schools, the child welfare system, the juvenile justice system, and the adult mental health and prison systems. Parents of children with serious mental health needs often struggle to get services for their child as soon as they know something is wrong. Clark County needs to improve early access to services and to assist families and communities in providing children with environments that support positive emotional and social development. Investing in this "front-end" approach will ultimately free up resources to expand and improve services for children at all levels of need.

2020-2030 CCCMHC STRATEGIC PLAN

The Clark County Children's Mental Health Consortium developed a 10-Year Strategic Plan to guide the community in providing mental health services to children with emotional disturbance and their families as required by Nevada Revised Statute 433B.335. This 10-year strategic plan presents a vision for the future of mental and behavioral health services for youth and their families in Clark County.

Since its inception in 2001, the CCCMHC has extensively studied the needs of our community's children. Our members have worked tirelessly to craft solutions to improve services and outcomes for our children. This 10-year plan is driven by the vision, goals, and principles described below. Recent studies have shown that as many as one in six children and transition age youth in the U.S. have a treatable mental health condition (Whitney and Peterson, 2019), meaning that as many as 86,291 youth under the age of 18 in Clark County are in need of services. Our plan strives to meet these needs for youth and their families to receive the high-quality, effective services they deserve. To better understand the unique needs of the county's population, the Clark County Children's Mental Health Consortium conducted a Children's Mental Health Community Input Survey, parent and stakeholder interviews, and reviewed the most recent data from partner organizations to understand the current gaps in the county's mental and behavioral health service delivery systems.

To help provide Nevada's youth and families with the high-quality care and timely access to services they deserve, the Clark County Children's Mental Health Consortium has updated its 10-Year Strategic Plan to guide future program and service implementation. This plan is based on a set of values and principles that promote a system of care that is community-based, family-driven, and culturally competent. Using a public health approach and working with families and community partners, the Clark County Children's Mental Health Consortium will work to achieve the following long-term goals for Clark County by the year 2030.

GOALS

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

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REVISIONS TO THE 10-YEAR STRATEGIC PLAN

In accordance with requirements set forth in NRS 433B, the CCCMHC must report on any changes to objectives from the 10-Year Strategic Plan that have been revised. Since the new strategic plan was released in January 2020, no revisions have been made by the CCCMHC.

THE IMPACT OF COVID-19 ON CHILDREN'S MENTAL HEALTH

The COVID-19 pandemic has greatly impacted our community, particularly youth and families. We understand from past experience that disasters and community traumas have long term negative impacts on mental health. In particular, children and youth have experienced disrupted relationships (e.g., with teachers or childcare providers) and have lost opportunities to interact and play with peers. Children with disabilities and special needs in many cases bear additional burden as parents and caregivers attempt to meet their needs in the home setting in the absence of the array of supports and services to which they are accustomed.

Prior to the COVID-19 pandemic, youth that need mental health services in Nevada struggled to obtain assistance with only about 40% receiving the help they need. A national survey conducted by the CDC indicated that since March, at least 60% of US adults have reported feeling anxious for at least a few days each week, about half of US adults report feeling depressed for at least a few days each week, and the majority of parents agree that the pandemic made the 2019-2020 school year "extremely stressful" for them (American Psychological Association, 2020). We do not have similar metrics for children, but can extrapolate that the population-level burden of COVID-19 mental health impact is quite significant.

According to the Division of Child and Family Services' Mobile Crisis Response Team (MCRT), regarding youth in Southern Nevada, MCRT received a record number of calls to the hotline in September 2020 (343), representing an increase of 15% from September 2019 (299). Students began virtual learning on August 24th and 48 crisis response assessments were completed from August 24th through September 30th. This is in comparison to 40 completed crisis response assessments between July 1st and September 30th, 2019, an increase of 25% despite two fewer weeks of instruction in 2020 compared to 2019.

The CCCMHC has also received testimony from parents and mental health professionals in the community that the methods the school district or teachers are using for student accountability can be harmful to students. We have received reports that teachers are being punitive in the online environment, such as calling out kids in class who are nervous or anxious about talking on Zoom without considering their fears. In addition, some teachers are threatening that students will be held back due to their grades. Unfortunately, we even have had a report that a student, that prior to the pandemic was an A/B student, has been admitted to a mental health facility due to the stress of being told they may have to repeat the year because their grades are now Ds and Fs. During this time when stress is high for everyone, including the teachers, it seems that above all else compassion and understanding is needed so students and families feel supported rather than punished for this situation that is not within their control. Teachers need to consider examining the feasibility of the workload, implement positive behavior supports, and understand that online learning is not for everyone.

The CCCMHC sent the following recommendation to the Clark County School Board for consideration:

1) Children and families need to be provided quality support services, for students that are either/both learning virtually or in person, to be successful. The school district is still required to remain compliant with section 504 of IDEA and a virtual environment is not a reason to reduce IEP services. In addition, if in person services are offered, the choice to remain virtual should not be a reason to reduce to stop services, or designate a parent as non-compliant.
2) Additional support should be given to teachers to be able to recognize when students are struggling and know how to connect families to resources such as mobile crisis.
3) Improved and consistent policies are needed regarding workload, homework submission, and attendance.
4) Consider not failing students in the fall semester and extend their ability to pass classes in the spring and summer of 2021. This is a strategy being implemented in several parts of the country to avoid penalizing students who have been experiencing extreme stress during the pandemic.

All of these factors leave youth and families needing more support from their community. It is our responsibility to protect and support the children in our community, and we need to ensure that the mental health of youth is a priority.

II. STATUS OF THE CCCMHC 11 PRIORITIES

Just after the completion of the new 10-year plan in 2020, the CCCMHC identified the top 11 priorities to improve the system while moving toward the longer-term plan. There are 5 levels of progress that were established by the CCCMHC which include Regression, No Progress, Minimal Progress, Some Progress, or Substantial Progress. The CCCMHC reviewed available data and partner reports in order to determine the level of progress achieved for each priority. The final determinations for each priority are presented below.

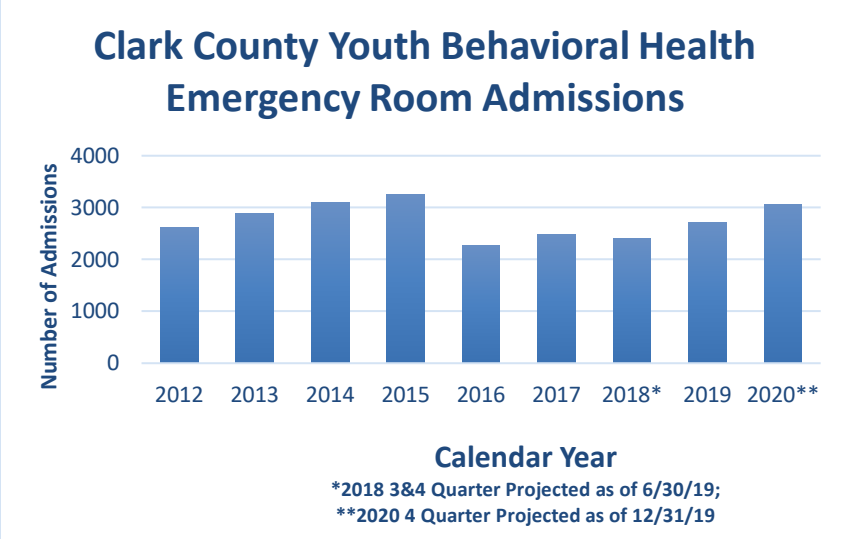
1. SUSTAINABLE FUNDING FOR THE MOBILE CRISIS RESPONSE TEAM (MCRT)

The MCRT has been an incredible asset to our community and should have a stable funding source to ensure that it continues to operate on a 24-hour basis to offer these much needed services to youth and families.

CURRENT STATUS: NO PROGRESS

All Clark County youth in crisis should have access to a mobile intervention and stabilization service**.** Without easy access to crisis intervention and stabilization services, families in Clark County have been forced to utilize local emergency rooms in order to obtain behavioral health care for their children.

The COVID-19 pandemic has triggered a financial crisis for the State of Nevada and its local government entities. DCFS has worked to secure federal emergency funding for a temporary expansion of our Children's Mobile Crisis Program. The expansion added one team in Clark County, along with additional resources such as laptop computers, vehicles, and telehealth software licenses. The expansion of MCRT's telehealth capacity has allowed for additional families to be served by the Las Vegas team around-the-clock in regions of the state where 24-hour crisis services are not otherwise available. The funding utilized to increase capacity is a temporary source therefore, sustainable funding has still not been secured for this critical resource.



NEXT STEPS

Increased and sustained funding should be included in the state's budget to ensure that MCRT can sustain and expand services to youth throughout urban and rural Clark County. This service is especially crucial given the increase of youth and families with mental and behavioral health needs due to the COVID-19 pandemic.

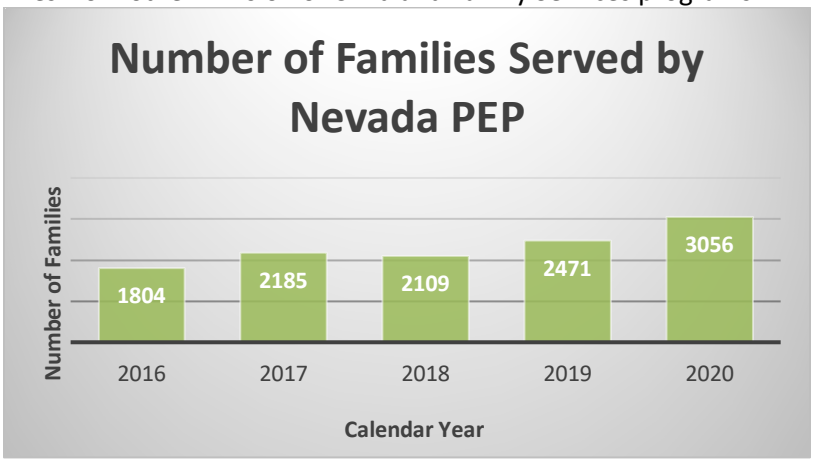
2. FAMILY PEER-TO-PEER SUPPORT SHOULD BE EXPANDED

The community identified the need for peer-to-peer support services for families. Currently there are very few options available. Therefore, support to expand this current resource is essential. One method to expand these services would be to include Family Peer Support in the state Medicaid Plan as a covered service.

CURRENT STATUS: REGRESSION

Nevada PEP currently provides family peer support services for families who have children with mental health needs. The providers of family peer support services are family members or youth with "lived experience" who have personally faced the challenges of raising a child with serious mental health conditions. Families who contact Nevada PEP for support receive individualized and unique support to meet their needs, which may include informational and educational support; instructional and skills development support; emotional and affirmation support; information and referral; and advocacy support.

Families are referred by DCFS programs, schools, and community organizations. Nevada PEP received 120 referrals from Southern Nevada Children's Mobile Crisis Response Team, 100 referrals from the Harbor juvenile justice diversion program, and 104 new families from other Division of Child and Family Services programs.



Over the last year (2020), PEP provided family peer support services to 3,056 families of youth with serious emotional disturbance in Clark County. Even though the number of families served is a 24% increase over 2019, **THE FUNDING FOR FAMILY PEER SUPPORT DECREASED BY 23% ON JANUARY 1, 2020.** The effect of this decrease in funding is that each family waits longer for family peer support services and receives less one-on-one support.

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

The SOC Grant is supporting the expansion of family peer support; however, this has been focused in the rural areas. While this is important, it is outside of Clark County. DCFS has initiated conversations with the Division of Healthcare Financing and Policy to consider this service as a part of the Medicaid State Plan. However, no progress has been made to date. In addition, due to reported COVID-19 fiscal constraints, no additional funds have been proposed by DHHS for family peer support for FY21/22.

NEXT STEPS

Funding for family peer support should be restored and increased due to the devastating effects of COVID-19 on families in Clark County, particularly because of the well-known increase of children and youth with mental healthcare needs in Clark County.

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

3. FULLY IMPLEMENT THE BUILDING BRIDGES MODEL OF CARE TO SUPPORT YOUTH AND FAMILIES TRANSITIONING FROM RESIDENTIAL CARE BACK INTO THE COMMUNITY

It is essential for youth and families to have the appropriate supports in places when exiting residential care to prevent re-entry. The Building Bridges model provides a guide to best practices that should be implemented in the community.

CURRENT STATUS: MINIMAL PROGRESS

The Building Bridges Initiative provides best practice guidelines and standards to create residential and community based services and supports that are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. The implementation of initiative should be prioritized to ensure families have the resources needed to provide treatment in the least restrictive setting and using the highest quality practices.

The existing DCFS Psychiatric Residential Treatment Facilities in Nevada, which are licensed by the Bureau of Health Care Quality and Compliance (HCQC) and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), provide 24-hour highly structured services for children and youth between ages 6-17 who are severely emotionally disturbed. In order to access these facilities, youth must meet the Medicaid guidelines.

Although DCFS is not currently funding an implementation of the Building Bridges Initiative specifically, DCFS remains committed to the principles of Building Bridges and will use all available resources to ease transitions and to support high-needs youth in remaining in their homes and communities. In addition, DCFS is currently building an Intensive In-Home Step-Down Team within MCRT. The team will utilize short-term intensive in-home clinical and wraparound care coordination to support re-entry into home, school, and community when very high-needs, multi-system-involved youth are returning from higher level of care placements such as residential treatment. Finally, DCFS is planning another meeting with Building Bridges to determine the next steps moving forward with implementation and any associated costs which would need to be requested during the next legislative session.

NEXT STEPS

The CCCMHC has expressed concern over the past several years about the limited number of residential treatment beds for youth in our community. While it is our goal that every child would be able to receive the treatment they need in community-based settings, this has not possible with the current resources available in our community. Residential treatment in Southern Nevada is limited and therefore youth may be placed out of state to receive services, which removes vulnerable youth from their family, friends, and other social support networks and creates complications for reentry into the community. In addition, the U.S. Department of Justice has opened an investigation to determine whether the State of Nevada unnecessarily institutionalizes children with behavioral health conditions, in violation of Title II of the Americans with Disabilities Act and the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).

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

4. MORE SERVICE ARRAY OPTIONS SO YOUTH AND FAMILIES CAN ACCESS CARE AT EARLIER STAGES TO REDUCE THE NEED FOR CRISIS SERVICE INTERVENTION

Youth may not always have access to the level of care they need in a timely manner which then escalates to a crisis situation. To prevent escalation when possible, youth and families need access to quality intensive home services, respite care, individual and family therapy, and care coordination services (such as wraparound).

CURRENT STATUS: NO PROGRESS

On June 22, 1999, the US Supreme Court ruled in the landmark Olmstead v. L.C. decision that unnecessary segregation and institutionalization of people with disabilities is a form of discrimination and prohibited under the Americans with Disabilities Act (ADA). To remedy or avoid such discrimination, states are required to provide integrated community services and avoid over reliance on out of home and out of state placements.

Over the past year there has been an increased need for services, but no notable increase in the availability of services at various levels. For instance, DCFS's MCRT and clinical services are unable to utilize Category 16 funding for psycho-social rehabilitation (PSR) services for uninsured youth, as funds are solely allocated for acute psychiatric hospitalizations in the community.

In order to increase the array of services available in the community and decrease the need for crisis intervention, DCFS has included plans, within the current System of Care Expansion and Implementation strategic plan, to build capacity in the service array to include more evidence-based/informed services, respite, intensive in-home and school-based services and to expand High Fidelity Wraparound and tiered care coordination. Funding is being made available to support this work. However, the expansion dollars are focused on rural Nevada. Therefore, it is unclear how this will impact expansion for Clark County.

DHCFP has been working with DCFS to develop a larger service array from children and families prior to their involvement with child welfare. The Medicaid Innovation committee will be doing this work and will be soliciting stakeholder engagement over the next year.

Finally, DCFS recently released a 5-year strategic plan that includes five keys to transformation, the first being "robust community engagement." This key is intended to determine services, programs, and systemic processes to meet the needs of children, youth, families, individuals, and community partners. While the main tasks surround the need to identify gaps and reduce inefficiencies, there is no mention of any intention to increase services or to expand the array of services available. However, the 2018 Nevada Behavioral Health Plan serves as the Olmstead plan for behavioral health care for children and adults, and does outline the steps that should be taken to ensure community integration. The mission, vision, and guiding principles in the State's Olmstead plan align well with the CCCMHC plan and the plan specifically include ensuring there is a continuum of high-quality services for children, youth, and adults. The status of the implementation of this plan is unknown.

NEXT STEPS

Investments need to be made by the state and local entities in order to increase available treatment services as well as support services (early childhood education programs, afterschool programs, etc.) in order to provide comprehensive supports to families and youth with mental and behavioral health needs. In addition, physicians should be encouraged to integrate behavioral health services within primary care settings so that families are able to access a more comprehensive service array, supporting the unique and pervasive needs of youth and their families. Finally, members of the CCCMHC should be involved in the planning and implementation of the Nevada Behavioral Health Plan which is supposed to increase momentum in 2021.

5. ADDITIONAL SUPPORT FOR PROFESSIONAL TRAINING INCLUDING CANS TRAINING

In order to increase professional development opportunities around youth mental health, the consortium organizes and annual symposium. Additional support for the symposium to include national speakers would be beneficial to the community along with staff support to provide content specific training – such as the Child and Adolescent Needs and Strengths (CANS) training.

CURRENT STATUS: SOME PROGRESS

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose information integration tool that is designed to be the output of a collaborative assessment process. The purpose of the CANS is to accurately represent the shared vision of the child/youth serving system (children, youth, and families). As such, completion of the CANS is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system.

DCFS has supported the training and certification of 5 statewide certified trainers in the Nevada Child and Adolescent Needs and Strengths tool, which includes three trainers within DCFS, a trainer at Clark County Department of Family Services and a trainer at Washoe County Human Services Agency. The statewide certified trainers are currently working with a consultant to move the initial CANS training from an in-person to a virtual format and expect to offer the first virtual training in 2021.

Clark County Department of Family Services (DFS) ensures that all of their clinicians in Family Clinical Services are trained and certified in the CANS. They encourage the use of the CANS information when they consult with a child's team and refer community counselors working with children in Child Welfare to DCFS if they have not yet received the CANS training. DFS clinicians are able to complete a CANS if a child's therapist has not yet been trained to do it or if an update is needed right away for team consultation. The Social Work and Psychology trainees who complete practica at DFS are also required to take the CANS training and utilize this measure in their assessments and treatment planning.

Within the Clark County School District, some training on administration of Nevada-CANS was undertaken with school social workers during the 2019-2020 school year as optional tool in working with students. More recent focus has been placed on training and implementation of the Children's Uniform Mental Health Assessment (CUMHA) and other assessments that directly align with Medicaid billable services. In collaboration with the Nevada Department of Education, CCSD Wraparound Services is moving forward with initial Medicaid billable services cases, although no actual Medicaid reimbursement claims have been filed as of January 2021.

NEXT STEPS

The virtual CANS training should be conducted in conjunction with the next Children's Mental Health Symposium to increase opportunities for professional training on the tool and agencies should continue to work to use consistent assessments to reduce burden to families. Inexpensive online training is also available for the CANS so more advertisement should be increased to community providers to increase the use of the tool.

6. APPROPRIATELY FUND MEDICAID TO ENSURE CHILDREN RECEIVE THE SERVICES THEY NEED

It is important for DCFS to advocate so that the Medicaid budget includes sufficient funds to ensure that youth and families can access all the services they need to be healthy and successful. There are currently certain services that are not reimbursed by Medicaid but are allowable at the federal level. In addition, as Medicaid is developing a new Request for Proposals for managed care organizations (MCO), it is essential that the providers that offer the best care to youth and families should be the main consideration when the final selection occurs, and cost should not be a barrier to selecting that MCO. The CCCMHC has developed a list of recommendations for the RFP which are included in Appendix C of the 2020-2030 10-year plan.

CURRENT STATUS: REGRESSION

Over the past few years, DHCFP has worked to develop a new Request for Proposals (RFP) for Managed Care Organizations. Currently, DHCFP is in the quite period and cannot speak the document until it is posted which is anticipated to occur in January or February of 2021.

In August of 2020, Nevada Medicaid had to implement a 6 percent across-the-board rate reduction approved by legislators during the 2020 special session to balance a billion dollar shortfall in the state's budget. This reduction is hard felt by health care providers who have been advocating for rate increases over the past several years.

NEXT STEPS

Once the RFP is released, the CCCMHC should review the document to determine the extent the suggestions put further were incorporated. In addition, to the extent possible, CCCMHC should be involved in the review process of proposals to comment on proposals that have added mental health benefits for children and families.

In addition, the CCCMHC should advocate for the restoration and increase of provider rates given that mental health and substance use disorder benefits are essential to help families recover from the impacts of the pandemic. It is imperative that mental health parity is prioritized to maximize families' abilities to access services.

Finally, the CCCMHC should follow up to determine if Nevada will receive the 6.2 percentage point increase in the federal Medicaid match which was approved in 2020 as part of the Families First Coronavirus Response Act, and if received how are the funds being spent. Examples of how states may use the funds include assisting with rising Medicaid enrollment costs, general budget shortfalls, or to mitigate provider rate and/or benefit cuts.

7. DCFS SHOULD SUPPORT RESOURCES TO RE-IMPLEMENT NEIGHBORHOOD RESOURCES CENTERS

Families experience many barriers to accessing care including services not being available in their area as well as the lack of transportation to get to services. Having the option to access multiple services at one location could ease some of this burden**.**

CURRENT STATUS: REGRESSION

Neighborhood Family Service Centers in Clark County included multiple agencies co-located within a single building or building complex and used a wraparound process for delivery of care management and intensive supports to youth with serious emotional disturbance and their families. Changes in agency administrators lessened commitment to the model of these service centers, and reallocated funding for neighborhood centers to other projects. There was only one remaining Neighborhood Family Service Center left in Clark County and the community-based services co-located with DCFS were no longer in the space. Because DCFS has other offices in the area that provide services, during the 2022-2023 DCFS Budget Presentation by Ross Armstrong, it was recommended that the funding for the leased office space of the center be eliminates thereby closing the center.

Even though Neighborhood Family Service Centers no longer exist as they did in the past, a new effort with similar principals of creating community-based locations to access a variety of services was established in 2016. The Harbor was created to specifically divert youth from detention by providing access to treatment and community-based services in a single location. Staff at The Harbor work with youth to determine their immediate needs and connects youth and their families to the appropriate services. Between Oct. 2016 and Nov. 2020 approximately 10,500 youth have been served by one of the two Harbor locations, and approximately 2,000 just over this past year. While the majority of youth are referred due to interactions with the police as an alternative to detention, The Harbor does allow families to self-refer and walk into the facility for support. Over the past year, approximately 20% of the youth served (n= 395) youth were walk-in clients, and approximately 24% served were walk-in clients from 2016-2020 (n= 2,511).

While the Harbor does not replace the continued need for more neighborhood resource centers that provide access to multiple agencies and services at one location, it demonstrates an understanding of the need and appetite for services to be offered in this manner.

NEXT STEPS

The CCCMHC will continue to advocate for more integrative services to reduce barriers to accessing quality services.

8. ENFORCE MENTAL HEALTH SCREENINGS DURING EPSTD VISITS

Primary care physicians should be conducting mental health screenings during well checks in order to identify needs and refer to services as early as possible. It is critical that these screenings are being conducted to avoid long term negative consequences.

CURRENT STATUS: MINIMAL PROGRESS

Over the past year, members of the CCCMHC have met with Medicaid staff and managed care providers to determine the best method for ensuring that all services offered through EPSTD visits are conducted. Medicaid did not recommend using a monetary reduction method for not completing the full list of checks done at this visit and did not appear to have current mechanism in place to determine if all services were provided. It was recommended to discuss a value-added service approach with the managed care organizations so that providers would receive incentives for providing proof that certain services, such as screening are performed. This information was relayed to many of the MCOs that were meeting with community partners, however, given the RFP has not yet been released, it is unknown if this suggestion will be included in any of the proposals submitted.

Another effort to increase mental health screening at pediatric visits is through the DCFS Pediatric Mental Health Care Access (PMHCA) project. There are two program measures that address pediatric primary care provider screening for behavioral health concerns:

- Number of children and adolescents seen by primary care providers who enrolled in a pediatric mental health care access program and who received a screening for a behavioral health condition.
- Percentage of children and adolescents who screened positive for a behavioral health condition and received treatment from primary care providers enrolled in a pediatric mental health care access program or a referral to a behavioral clinician.

No data are currently available for this project as it has just begun enrolling providers at the end of 2020.

In addition, DCFS has drafted a training for providers that encourages the use of validated screening tools. DCFS has been working with Medicaid to better understand their process for capturing this data and reimbursement for the services so that they can include this information in the training. Upon finalization, the training will be CME accredited and then shared with all providers across the state. However, to address immediate concerns about youth mental health during the pandemic, DHCFP in conjunction with DPBH released a bulletin in 2020 educating providers on these screenings (https://www.medicaid.nv.gov/Downloads/provider/web_announcement_2358_20201119.pdf).

The Clark County Department of Family Services also prioritizes mental health screenings as part of EPSDT to all children who enter DFS custody during the intake process. This occurs in various ways, including onsite at Child Haven Emergency

Shelter and when children enter DFS care into a foster care home. Screenings are completed by contracted pediatrician partners, Family Clinical Services (FCS) clinicians, and community pediatric and mental health providers. An initial mental health acuity screening is completed at intake when a child enters through the Child Haven emergency shelter and are followed up by the DFS clinicians. Referrals are made right away to community providers for more comprehensive assessment and services, if needed. Developmental screening is also done during Child Haven intake, including the administration of The Ages & Stages Questionnaire (ASQ). Referrals are made to community providers for more comprehensive assessment and services. The ASQ screenings were established in late 2019 as a partnership project with DFS and DCFS Early Childhood Mental Health Services (ECMHS). The ASQ is a developmental screening tool that pinpoints developmental progress in children aged one month to 5.5 years. ECMHS follows up with any children who need treatment and/or supports. Children under the age of three who are involved in substantiated cases of child abuse or neglect go directly to Nevada Early Intervention services (NEIS) who tracks and coordinates screening, comprehensive assessment, and treatment through various community providers, including Positively Kids. Children who enter DFS custody and go directly into a relative, fictive kin, or foster home can receive screening, assessment, and treatment through First Med. Foster families can also access the child's own community pediatrician or other care providers for EPSDT and mental health screening if they are already established with these providers. The caseworker helps coordinate and track the services children receive.

NEXT STEPS

Members of the CCCMHC should follow up with the RFP process to encourage Medicaid to prioritize proposals that include methods to increase screening and other services that are vital for children and families. In addition, DCFS should continue to prioritize educating providers about the importance of conducting mental health screenings.

9. INCREASE FLEXIBLE FUNDING FOR FAMILIES

Families are often in need of short-term financial support for services that are essential to functioning, could reduce stress, and improve the mental health wellbeing of the entire family. A steady funding stream should be available for families to access these supports that are not available through other social systems.

CURRENT STATUS: REGRESSION

DCFS keeps a fund of flexible dollars that can be used in this way and is given out to families as needed. The current SFY 21 budget for these funds is $37,571. For the upcoming biennium, that amount is reduced to $29,827 for each year of the biennium.

NEXT STEPS

The CCCMHC will continue to advocate for increased flexible funding allocated to DCFS or the county to help families of children with serious emotional disturbance pay for supports and services not covered by a payer source.

10. ENSURE HIGH FIDELITY WRAPAROUND

Successful wraparound programs need to follow evidenced based procedures in order to ensure best outcomes. The necessary supports need to be in place so staff can implement this model to fidelity, so our youth and families have the best outcomes.

CURRENT STATUS: MINIMAL PROGRESS

According to the Division of Child & Family Services (DCFS) report submitted by Ross Armstrong, DCFS Administrator, in December 2020, Wraparound in Nevada had a caseload of 91 youth receiving High Fidelity Wraparound (HFW), with 49 youth on the waitlist. The DHHS Office of Analytics, in their July 2020 Behavioral Health Chart Pack, reported in July 2020 that in Clark County, Wraparound in Nevada (WIN) High Fidelity Wraparound (HFW) Coaches had a caseload of 44 youth and 4 were on the waitlist. This is a large reduction in caseload when compared with July 2018 (95 caseload; 3 waitlist) and July 2019 (81 caseload; 1 waitlist).

Wraparound in Nevada is currently in the process of recertifying High Fidelity Wraparound (HFW) Coaches, as well as training new Coaching Candidates in HFW to support fidelity to the models. In addition, WIN is interviewing for Psychiatric Caseworker positions in Clark County, and have implemented an onboarding academy to support the training and development of new staff. WIN is also partnering with DCFS MCRT through the Mental Health Block Grant, which is intended to decrease wait times between referral and HFW being accessed. Finally, in addition to using the existing fidelity monitory tools associated with the program, WIN is implementing a new documentation review tool and the Planning and Evaluation Unity is working on a 2020 evaluation report which should be release in early 2021.

NEXT STEPS

Over the next year, CCCMHC should continue to request regular updates about the progress of the implementation of high-fidelity wraparound services and request to review the final 2020 evaluation report for outcomes related to model fidelity and positive outcomes for youth.

11. INCREASE SUPPORT FOR SCHOOL LINKED/BASED PROGRAMS

Schools are becoming more involved in prioritizing social- emotional learning and mental health for youth and families. Schools should have more support to implement prevention programming, evidence-based mental health screening practices, and referral services to connect youth to services when appropriate.

CURRENT STATUS: SOME PROGRESS

The Clark County School District began the 2020-2021 school year by providing guidance to schools on supporting the social emotional learning and mental health needs of students. Highlighted examples of broadly completed professional development trainings included: Introduction to Social & Emotional Wellness (required of all school staff); Suicide Prevention (required of all district staff, in compliance with Nevada SB204); Employee Self Care (open to all staff); Suicide Intervention Procedures (required of all mental health school-based intervention team members); and Trauma 101 (open to all mental health school-based intervention team members).

The Clark County School District recently began implementation of the “Lifeline” project, which is focused on addressing the social-emotional and mental health needs of students in grades 3 through 12. Central to the Lifeline Project is the development of a school-based collaborative problem-solving team, the Multidisciplinary Leadership Team, to help identify, assess, and provide tiered interventions and supports for at risk students. The project uses the Panorama system, an evidence-based, commonly used software system for measuring wellbeing and social-emotional learning in schools. After receiving a screening proctored by a teacher, students can self-identify as wanting to talk to someone, or the Panorama system will identify them as high risk. Identified students will receive an assessment at their local school and will be referred to school-based or community-based services as needed. CCSD’s goal is to assess students in-person whenever possible, as they believe that a critical loss associated with virtual learning is the loss of the student-teacher/school connection and the ability of schools to identify students in need by observing their behaviors in school

each day. CCSD hopes to connect in-person with students identified at-risk in order to fully assess any concerns and determine appropriate next steps. Any parents who are not comfortable with the in-person assessment can opt to receive the same services through a virtual appointment. As of January 2021, sixty-eight (68) CCSD school were participating in the Lifeline Project. Progressive expansion of both MLT development and universal screening practices is anticipated across CCSD schools in the future.

The Clark County School District is continuing with planning and implementation of services and supports following a Multi-Tiered Systems of Supports (MTSS) framework for serving students, as consistent with the Superintendent's Focus: 2024 Strategic Plan. MTSS is an overarching framework to progressively define district goals and better coordinate district resources, personnel, and services to address the academic, behavioral, and social emotional learning/mental health needs of all students.

Division of Child and Family Services: Support for Medicaid Billing in Schools
DCFS and the Division of Healthcare Financing and Policy are partnering to provide support to Nevada schools who are implementing new procedures for Medicaid billing for behavioral health services. A Clinical Program Planner II will be hired through DCFS and will be jointly supervised at DCFS and DHCFP. This position will provide a number of different supports to schools such as training, technical assistance, review of policy and regulations to create billing guidance, identification of clinical best practices, assistance with evidence-based practice implementation, and development of quality assurance and continuous quality improvement systems. Medicaid revenue will be re-invested in school mental and behavioral health services.

NEXT STEPS

CCCMHC should advocate for more concrete steps to increase social emotional learning in schools and to consider how social emotion learning can be paired with or informed by mental health screening. In addition, the CCCMHC will continue to monitor the progress of expanding social emotional learning and screening programs in all schools in the district.

III. REFERENCES

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

CURRENT MEMBERSHIP

Dan Musgrove, Chair
Strategies 360
Business Community Representative

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

Susie Miller, Secretary
Division of Child & Family Services
DCFS Representative

Jennifer Bevacqua
Nevada Youth Care Providers Association
NV Youth Service Provider Representative

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

Rebecca Cruz-Nañez
Southern Nevada Health District
Health District Representative

Dana DiPalma
Las Vegas Metropolitan Police Department
Metropolitan Policy Representative

Richard Egan
Nevada Office of Suicide Prevention
Community Representative

Char Frost
Nevada Parents Encouraging Parents
Parent Representative

Jackie Harris
Creative Solutions Counseling Center
Substance Abuse Service Providers Representative

Lisa Linning
Clark County Department of Family Services
Child Welfare Representative

Karen Taycher
Nevada Parents Encouraging Parents
Parent Representative

Robert Weires
CCSD Psychological Services
Clark County School District Representative

MISSION

The Consortium was created by the passage of Assembly Bill 1 of the 2001 Special Session of the Nevada Legislature to study the mental health needs of all children in Clark County and to develop recommendations for service delivery reform.

The Consortium is required to conduct a needs assessment and submit a 10-Year Strategic Plan to the Mental Health and Developmental Services Commission and the Nevada Department of Health and Human Services. Required membership and activities for the Consortium are described in Nevada Revised Statutes 433B.333-335.

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

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