Clark County Children's Mental Health Consortium

2022 Service Priorities report

2030 Vision for Success

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

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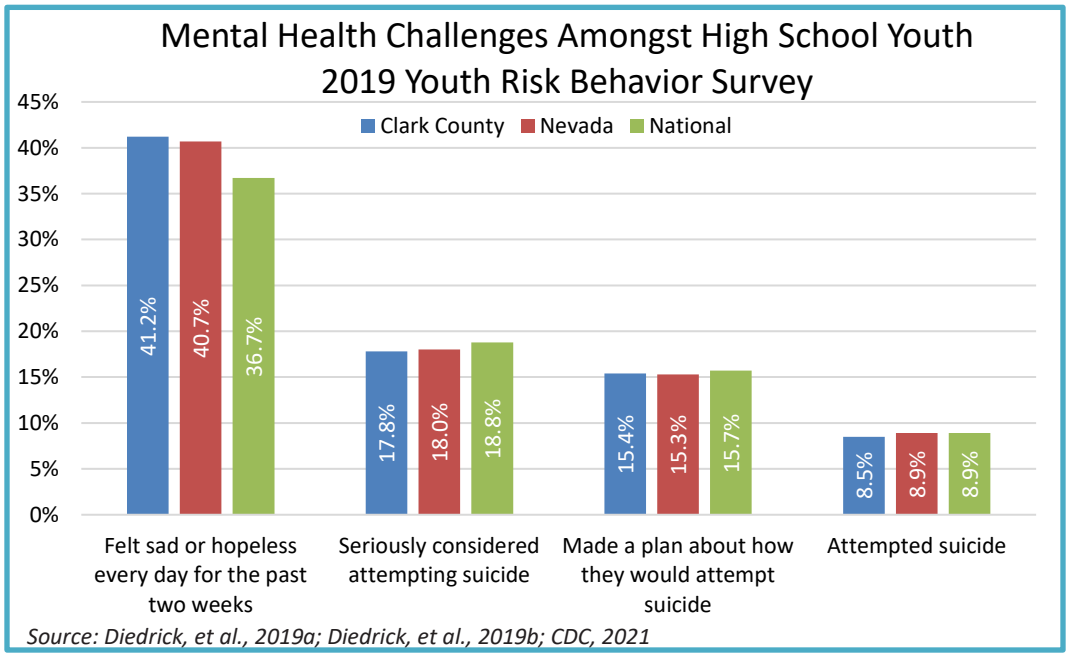
I. INTRODUCTION

PREVALENCE OF MENTAL HEALTH PROBLEMS

A youth's mental health consists of thoughts, feelings, and behaviors that determine whether that individual can cope with stress, relate to others, make appropriate choices, and learn effectively. Like physical health, mental health is important at every stage of a person's life. Unlike physical problems, mental health problems cannot be seen, but the symptoms can be recognized.

The newest report from Mental Health America has ranked Nevada 51st in the nation for the fourth year in a row when it comes to children's overall mental health. Mental Health America has found 65.2% of Nevada youth with major depressive episodes have not received the mental health treatment they need (Reinert et al., 2021); higher than the national average of 59.6%. 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 2020, there were an estimated 514,221 children in Clark County between the ages of 0 and 18 years, representing nearly 22.7% of the county's population (US Census Bureau, 2020). These children mirror the growing cultural and ethnic diversity of the region. Nearly 57% of the county's children are from non-white ethnic or racial backgrounds, including 31.6% of Hispanic or Latino origin, 13.1% of Black or African-American origin, and 4.9% representing two or more races (US Census, 2020). 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 26,000 Nevada youth (11.8%) were reported to have experienced at least one major depressive episode in 2021, and approximately 35,000 youth (15.11%) that experienced severe major depression within the last year (Reinert et al., 2019). The most recent Youth Risk Behavior Survey (YRBS) found that 18% of Clark County public high school students seriously considered suicide and 8.9% 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).

In 2019, 642 Nevadans of all ages lost their lives to suicide (Xu, Murphy, Kochanek, & Arias, 2021). According to the Office of Suicide Prevention, in 2019 suicide was the leading cause of death for youth 12-19 years of age, and the second leading cause of death for those 20-49 years of age. Preliminary data from 2018 to 2020, for those 17 and under shows a possible 25% decrease in the number of suicides, however, there is a possible 21% increase in the same time period for those 18-

24 (Office of Suicide Prevention, 2022). These data demonstrate the significant ongoing need for more prevention efforts and treatment services that are available to youth and families prior to entering a crisis state. A greater investment and focus on these services will help save the lives of our youth.

COVID-19 EFFECTS ON MENTAL HEALTH

Unfortunately, throughout 2021, the COVID-19 Pandemic persists and continues to greatly impact our community, and even more—youth and their families. When there is a lack of supportive services available, children are more susceptible to long-term negative impacts on their mental and physical health. School continues to be a struggle and for many students, they are also struggling with feelings of fear of illness, grief from the loss of people and important milestones in their lives, and isolation. With these challenges, resources to support mental wellness are imperative. As we currently lack adequate resources to help, youth and families are going into crisis and ending up in the emergency room or in-patient facilities for services. These services also, are overwhelmed and not able to adequately service youth and families. The U.S. Surgeon General released a mental health advisory due the pandemic's devastating impact on youth mental health that outlines a series of recommendations such as:

- Recognize that mental health is an essential part of overall health,
- Empower youth and their families to recognize, manage, and learn from difficult emotions,
- Ensure that every child has access to high-quality, affordable, and culturally competent mental health care,
- Support the mental health of children and youth in educational, community, and childcare settings. And expand and support the early childhood and education workforce,
- Address the economic and social barriers that contribute to poor mental health for young people, families, and caregivers, and
- Increase timely data collection and research to identify and respond to youth mental health needs more rapidly. This includes more research on the relationship between technology and youth mental health, and technology companies should be more transparent with data and algorithmic processes to enable this research. (U.S. Department of Health and Human Services, 2021).

These advisories are not released lightly and are reserved for very urgent matters. The Surgeon General acknowledges that mental health challenges are widespread among youth, however there is hope as these challenges are treatable and many times preventable. But it is our obligation to act now.

Clark County Children with Behavioral Health Needs

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

Some children and youth have greater needs for behavioral health care than others. 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).

Whereas children's behavioral health disorders are highly treatable and even sometimes preventable, studies have

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

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

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

10-Year Plan Goals

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

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

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

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

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

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

Top 4 Priorities

1. *Sustainable funding for the Mobile Crisis Response Team (MCRT)*
2. *Family peer-to-peer support should be expanded*
3. *Fully implement the Building Bridges model of care to support youth and families transitioning from residential care back into the community*
4. *More service array options so youth and families can access care at earlier stages to reduce the need for crisis service intervention*

II. CCCMHC FOUR PRIORITIES

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

Justification

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 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. Just in the third quarter of 2021 (July-Sept), there were 983 calls to the hot line, 367 youth were assessed, and 288 youth were stabilized with a safety plan. This resulted in a 78% hospital diversion rate. The number of youths served this year increased compared to the same quarter in 2020 (see table below). For the 2021 third quarter, over 80% of those who returned satisfaction surveys reported they were satisfied with the service received and were likely to recommend MCRT.

Clark County Mobile Crisis Response Team 3rd Quarter Overview

	July-Sept 2020	July-Sept 2021	
Calls to the Hot Line	754	983	⬆
Youth Assessed	253	367	⬆
Youth Stabilized with a Safety Plan	210	288	⬆

In the past year, through COVID emergency relief funds, DCFS was able to hire 1 additional team for MCRT in Clark County as well as purchase telehealth licenses and additional equipment. Continued access to telehealth licenses is now part of DCFS's operating budget and should be funded in the future. MCRT was able to secure American Rescue Plan Act funding to expand MCRT in Clark County through June 2023 and MCRT was approved for 4 additional teams. A MCRT team consists of 1 mental health clinician and 1 psychiatric caseworker. MCRT has already on-boarded 1 team, is completing the process of onboarding 2 teams, and is recruiting the 4th team.

Sustainable, long-term funding is being pursued as well as funding to continue to expand MCRT to meet the demand of our community. A grant through the American Rescue Plan dollars was received by DCFS in 2021 for mobile crisis response teams as well as to build out MCRTs through Medicaid. DCFS will be using some of these funds to apply for a Medicaid waiver in order to obtain reimbursement for services provided by MCRTs.

Another crisis support service that is being established in Nevada is the creation of a 988 behavioral health crisis or suicidality support line. The goal of this support is, "Everyone in Nevada will have immediate access to effective and culturally informed behavioral health services, crisis services, and suicide prevention through 988 and the Crisis Response System." The vision of this service is that "The Crisis Response System and 988 will serve as the foundation of Nevada's behavioral health safety net. We will reduce behavioral health crises, strive to attain zero suicides in our state, and provide a pathway to recovery and well-being." Over the past year, a planning workgroup has met to discuss how this system would be implemented to ensure that there are appropriate accommodations for youth and families, and that the system connects with existing services such as MCRT. This 988 service is intended to go live July 16, 2022.

Recommendations

1) Mobile Crisis Response Teams (MCRTs) should be adequately funded in the state budget as service for youth and families in both urban and rural counties in Nevada.

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

Projected Costs

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

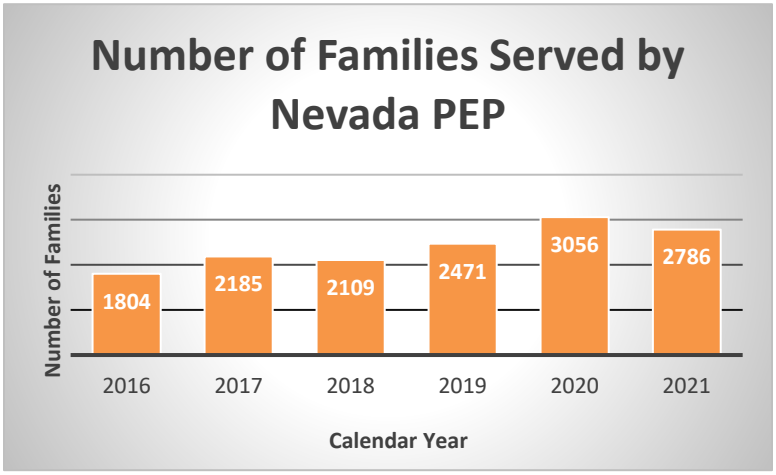
Priority 2. Family Peer to peer support should be expanded

Justification

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

Family peer support services are particularly important in Nevada, where families in both urban and rural areas face unique challenges accessing mental and behavioral health care. Some barriers include distance to providers, lack of culturally and linguistically competent services, uncoordinated service access points, and a limited array of services statewide. On December 7, 2021, the U.S. Surgeon General issued an advisory on youth mental health crisis across the country due to the impacts of the COVID-19 pandemic. Now more than ever before, Nevada families need support to know how to help their children. Family peer support specialists support families to navigate barriers and complexities of accessing services and they provide information to improve mental wellness.

Family peer support services are aligned with the System of Care philosophy, an evidence-based organizing framework and value-based system that Nevada adopted in 1998. System of Care is defined as, "a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them function better at home, in school, in the community and throughout life." A coordinated children's mental health system of care aims to reduce the need for out-of-home/out-of-state treatment.



The Nevada Division of Child and Family Services (DCFS) is working to increase their capacity to facilitate and provide family-driven, youth-guided, and culturally and linguistically appropriate mental health services and to increase access to evidence-based mental health interventions. Both objectives

are promoted and supported by expanding access to family peer support services. Family peer support services are provided by Nevada PEP and constitute an important part of a comprehensive System of Care.

Families are referred by DCFS programs, schools, physicians, and community organizations. In 2021, Nevada PEP received 149 referrals from Southern Nevada Children's Mobile Crisis Response Team, 262 referrals from the Harbor Juvenile Assessment Centers, and 93 new families from other Division of Child and Family Services programs. Nevada PEP provided family peer support services to 2,786 families of youth with behavioral health needs in Clark County.

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

Recommendations

1) 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.

2) 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.

Projected Costs

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

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

Justification

It is essential for youth and families to have the appropriate supports in places when exiting residential care to prevent re-entry. The Building Bridges model provides a guide to best practices that should be implemented in the community. The Building Bridges Initiative provides best practice guidelines and standards to create residential and community-based services and supports that are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. The implementation of this 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 Division of Child and Family Services (DCFS) Psychiatric Residential Treatment Facilities in Nevada, which are licensed by the Bureau of Health Care Quality and Compliance (HCQC) and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), provide 24-hour highly structured services for children and youth between ages 6-17 who are severely emotionally disturbed. In order to access these facilities, youth must meet the Medicaid guidelines. The two state operated facilities available is Southern Nevada are Desert Willow Treatment Center and Oasis. However, as noted by the current numbers served below, there are limitations in access due to an inability to staff the facility even though funding is available. This highlights a staff shortage problem that is occurring nationwide severely reducing access to all healthcare. Even when the facilities are operating at capacity, there are still additional limitations in their ability to serve all youth (i.e. youth with serious behavioral problems, intellectual and/or developmental disabilities) due to lack of staff experience and expertise. This is also true at many private facilities.

State Operated Children's Mental Health (CMH) Facility Population - Current # Served as of 01/05/2022	
Desert Willow Treatment Center - Acute Services	1
Desert Willow Treatment Center - Residential Services	7
Psychiatric Residential Treatment Facility – Oasis	5
Total CMH Facility Population	13

(Nevada Division of Children and Family Services, 2022)

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. Some of the work that has been done to work toward this include Positive Behavioral Interventions Supports infrastructure work at Desert Willow Treatment Center, Oasis, and with high-end Juvenile Justice staff in Clark County, and developed and updated multiple trainings that are available for all DCFS staff for continuing education and staff development some of which include: System of Care, Introduction to Developmental Disabilities/Mental Health, and Culturally and Linguistically Appropriate Service Standards.

It is important that as we continue to improve mental and behavioral health services for youth and family in our community, we prioritize services that keep youth in their homes with their families. Currently the United States Department of Justice (DOJ) is investigating whether the State of Nevada unnecessarily institutionalizes children with behavioral health conditions, in violation of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et seq., and the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 which led to ADA's "integration mandate," which requires that individuals with disabilities receive services in the most integrated setting appropriate to their needs (1999). As we do not have any updates on the progress of this investigation, it does demonstrate that we need to improve effort in Clark County to provide intensive home services and other services at various levels to meet the needs of the families.

Recommendations

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

2) For those youth that require residential services, Clark County needs to increase local resources to successfully keep those youth in the community to the maximum extent possible, rather than sending them out of state for services. This is especially needed for youth with both intellectual and development disabilities and mental health needs as many residential services are not prepared to accept these youth due to lack of knowledge and experience. We need to ensure that we have the ability to provide both quality residential care treatment services as well as community-based services so that our youth and families are supported as they return to the community.

Projected Costs

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

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

Justification

As the pandemic continues, the related strain on mental wellness persists. Many are experiencing tremendous amounts of loss such as friends, family members, milestone experiences, jobs, homes, grief, isolation, and stress compound making daily coping a struggle. As families seek services to improve their mental wellness, mental health professionals are also facing tremendous challenges. As the field was already strained prior to the pandemic, increase caseloads combined with having to individually cope with the same stressors as the families they treat, many are burnt out and also need a break. These stresses on our mental health system are reducing access to already limited care and will lead to more individuals in crisis. Youth and families need access to quality home and community-based services. It is necessary to have available integrated community services to reduce on out of home and out of state placement to avoid unnecessary segregation and institutionalization.

In order to increase services in the community, the Nevada Division of Public and Behavioral Health received funding for Certified Community Behavioral Health Clinics (CCBHC). Currently there are 5 CCBHC locations in Clark County. They offer community-based mental and substance use disorder services, care coordination and case management to address all needs of the individual, and crisis and mental health screening services for youth. The intent of these clinics is to support all members of the community regardless of ability to pay. While it is reported that these clinics are still available for treatment, many families indicate inability to receive services in the community. This may be because many families do not know about the services offered at CCHBCs or that they are eligible to receive services from these locations. To identify barriers that exist, consistent data collection at the CCHBCs should include service availability by age, service use by age, and quality of services provided by age. Also, additional outreach should be directed toward families to help increase awareness about the availability of community-based care for youth and families.

The Clark County Department of Family Services (DFS) and the Nevada Division of Child and Family Services (DCFS) report that there has been no notable increase in the availability of services at various levels. 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 current 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 for 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 Olmstead decision in 1999 which required stats to administer programs and activities in the most integrated setting appropriate to the needs of individuals with disabilities. Part of satisfying this decision is for states to have a plan that indicates how this will be accomplished knows as the Olmstead Plan. The mission, vision, and guiding principles in the State’s Olmstead plan align well with the CCCMHC plan and the plan specifically includes ensuring there is a continuum of high-quality services for children, youth, and adults. The status of the implementation of this plan is unknown.

Desert Regional Center (DRC) currently provides the family support programs to prevent out-of-home placement by assisting the family in caring for their children in their natural homes. If children are under the custody of state/county

family services and reside in licensed foster homes, family support programs can also be provided to children who live in these homes. Families who request family supports must meet financial guidelines of household income of 300% or below Federal Poverty Guidelines. Some examples of DRC Family Support Programs include respite, self-directed family support services, purchase of service supplement, family preservation program, and supported living arrangements services for children.

In 2007, DRC initiated the Youth Intensive Services (YISS) program to address placement and other support needs of children who have Intellectual and/or Developmental Disabilities who also may have a concurrent Mental Health Disorder, in Southern Nevada. Children eligible for YISS program are typically age 8 and older (some young adults). Developmental Specialists under the YISS team have smaller caseload sizes than DRC's non-YISS Developmental Specialists. The YISS team is currently comprised of 1 Developmental Specialist Supervisor, 7 Developmental Specialists, 1 Mental Health Counselor and a 1 Licensed Psychologist. During Fiscal Year 2021, the YISS team provided DRC case management services to 93 youth (youth up to 18 years of age).

Despite having this program available, youth with dual diagnosis continue to experience problems obtaining the proper treatment. In 2015, AB307 was passed to establish a pilot program to provide intensive care coordination services to these children and their families. However, this problem persists. DRC has had preliminary statewide discussions associated with our new biennial budget to include a request for more Developmental Specialists who have a smaller caseload for the possible expansion of the YISS program model. During the month of November 2021, Nevada Aging and Disability Services Division (ADSD) collaborated with DCFS and conducted cross-trainings between staff from both programs explaining our programs. The trainings begin on Monday 11/8/21 with overviews of DCFS programs for DS staff. Beyond the trainings to all staff, ADSD/DRC have identified specific YISS Developmental Specialists who will be available to staff specific cases with DCFS/DFS and support these cases within a Wraparound DRC/DCFS/DCF model. ADSD/DRC Intake staff have begun to meet weekly with DFS staff to triage with families the screening of children (or parents) who may be eligible for ADSD/DRC services. The goal of having DRC's intake staff available to DFS is to quickly identify eligible children when applying for DRC services and ensure children that are suspected of having an eligible condition are properly assessed by DRC's Psychology/intake department. These processes should result in better access to services in a timely manner.

Within the schools, to increase services over the past year, the Clark County School District has mandated that each school maintain a Multi-disciplinary Leadership team dedicated to collaborative problem solving and support in addressing the mental health needs of students. The CCSD Board of School Trustees also authorized contracting with Hazel Health and PM Pediatrics in Fall 2021 to bring telehealth services (health services and behavioral health therapy) to all CCSD schools progressively over the next couple of years. CCSD has already utilized ARP and ESSER funds to help maintain Panorama behavioral universal screening practices with students as well as to introduce Care Solace care coordination services that help link families with community providers for mental health. The Clark County School District is presently awaiting final approval for and receipt of new ARP ESSER III funding dedicated to purchasing one or more social emotional learning curricula to be utilized with students in K-12 as well as for creating additional licensed school counselors and school social workers positions in CCSD schools.

Recommendations

1) Larger investments should be made to provide the array of System of Care Core Services that include intensive care coordination (evidenced based wraparound services), evidence based intensive in-home services, Mobile crisis and stabilization services (mentioned in Priority 1), parent and youth peer support services (mentioned in Priority 2), respite care, and flexible funding. See glossary for definitions of each service.

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

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

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

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

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

7) Ensure that all school staff members are appropriately trained in and implement authentic culturally responsive family engagement strategies focused on developing school community connectedness.

8) Professional training should be provided to all school staff to better recognize when students are struggling and know how to connect families to community resources. This includes 1) mandatory (AB114 2019) training in suicide prevention with school staff; and 2) recommended ongoing professional learning opportunities for school staff related to student mental health/wellness.

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

Projected Costs

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

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

In accordance with requirements set forth in Nevada Revised Statutes (NRS) 433B, this section describes the objectives from the ***10-Year Strategic Plan*** that have been revised by the CCCMHC since the ***2021 Status Report***. There have not been any changes to the any of the objectives from the 10-Year Strategic Plan since the 2021 Status Report.

IV. CCCMHC -2021 Review of Activities

In 2021, the Clark County Children' Mental Health Consortium participated in many different activities in order to enhance youth mental wellness. Examples of some of these activities include participating in Children's Week at the Legislature, conducting the 2021 Children's Mental Health Summit, and writing letters to address key issues in the community. A brief description of a few of the activities are provided below.

First, over the course of the past year, as well as previous years, members of the CCCMHC have partnered significantly with other community partners such as Legal Aid of Southern Nevada, Clark County Department of Family Services, and with the Clark County District Attorney's Office to find ways to fill gaps in mental health care for youth and families, provide better services, and general advocacy around mental health issues.

Participation in Children's Week at the Legislature in another example of how our group advocated in partnership for increased investments in youth mental health. Children's week occurred March 8-12, 2021 in a virtual format. Wednesday March 10th was dedicated to mental health. The CCCMHC coordinated a morning discussion on the importance suicide prevention for youth and an afternoon panel lead by Youth Move Nevada. These discussions helped policy makers have a better understanding of the needs of youth and families in our community.

The 4th annual Southern Nevada Summit on Children's Mental Health was held on May 3 via a virtual format, as a safety precaution in response to the COVID-19 pandemic. A total of 47 individuals attended the summit. Attendees were provided a full day of training consisting of 5 different presentations on May 3rd, and a half-day, 4-hour training on the Nevada System of Care on May 4th. Licensed professionals were able to claim up to 9 hours of Continuing Education Units from this summit, in addition to 2 credit hours provided separately for attending the suicide prevention training provided by the Nevada Office of Suicide Prevention. Overall, those who completed the evaluation surveys were satisfied with the learning opportunities provided.

Finally, the CCCMHC has written a number of letters addressed to partners and policymakers that could implement the appropriate changes to better the mental health status of Nevada youth. In early 2021, a press release was written, further addressing the issue brought to light by Mental Health America's report ranking Nevada as 51st in the nation in children's overall mental health. The document also elaborates on the impact that COVID-19 brought upon Clark County's students. Additionally, CCCMHC acknowledged strategies that could be implemented in support of CCSD youth and their families during the pandemic.

The CCCMHC continued dialogue with the Division of Insurance about minimum standards for children with mental or emotional health care concerns. This issue is ongoing to determine the current state of Essential Health Benefit exclusions regarding mental health. The CCCMHC also wrote to the Clark County School Board to urge members to utilize the American Rescue Plan Grant money to increase afterschool and out-of-school time programs so that they can be more inclusive for children with mental and behavioral health needs. Of all the afterschool and out-of-school time programs in Clark County, only 5.9% of them reported an ability to accommodate youth with severe levels of behavioral

health and intellectual needs. By investing in higher quality afterschool and OST programming, Nevada could provide equitable and solid foundations for lifelong learning and success to all CCSD Students.

CCCMHC wrote to the Department of Education and members of the CCSD School Board to address the well-being of the students who receive their education with the support of an Individualized Educational Program (IEP) or Section 504 Plan. This letter was intended to urge CCSD School Board Members to prioritize methods that would provide additional support to families utilizing this educational resource. The letter included the following recommendations:

- Establishing and maintaining a welcoming, supportive environment for students, families, and outside professionals who know and work with the student.
- Ensuring all staff at each school are trained in and implement Positive Behavior Interventions and Supports (PBIS) throughout the in-person and distance school environments.
- Ensuring all staff at each school are trained in and implement authentic culturally responsive family engagement strategies focused on developing school community connectedness.
- Providing opportunities for students to share their voice about their school experience and encouraging students to become effective self-advocates.
- Regardless if learning is taking place virtually or in-person, children and families need to be provided quality support services to be successful. The school district is still required to remain compliant with Section 504 and IDEA. A virtual education environment is not a reason to reduce the necessary supports and services.
- 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.

Closer towards the end of 2021, a second press release was given because Nevada received the 51st ranking again. This document was intended to provide recommendations to try and better the mental health status of Nevada youth for the upcoming year. Recommendations included the following:

- Improving mental health supports for Nevada's youth – while raising Nevada's children's mental health ranking – could be achieved by prioritizing the following recommended strategies:
- Increase the types of support services available and capacity for current treatment services for youth and their families;
- Expand capacity for school and community-based services to prevent depression and youth suicide and develop neighborhood-based, school-linked provider network to address mental and behavioral health needs.
- Expand youth mental and behavioral health awareness and suicide prevention in schools and community-based programs.
- Increase network capacity to help expand community-based services including efforts to support recruitment and retention of mental health professionals trained to work with youth.
- Promote collaboration between Medicaid, SAPTA, and other funding sources to provide appropriate services for youth in need of both substance use and mental and behavioral health services.

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

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

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

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

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

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

3. Mobile crisis response and stabilization - Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise.
Residential crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.

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

guardians, or caregivers of children and youth with mental health conditions, as well as peer-to-peer support services for youth.

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

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

Trauma-Informed Systems and Evidence-Based Treatments Addressing Trauma

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

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

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

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

CURRENT MEMBERSHIP

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
Domonique Rice
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
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
Lori Follett
Division of Health Care Financing and Policy
Medicaid Services Representative
Alexa Rodriguez
Department of Juvenile Justice
Juvenile Justice Representative
Syd M. Quadri
University of Nevada, Las Vegas School of Medicine
Psychiatric Community 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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