Clark County Children's Mental Health Consortium

2020 Vision for Success

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

10-Year Strategic Plan

2017 Status Report

HEALTHY FAMILIES BUILDING HEALTHY COMMUNITIES

CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM
2017 STATUS REPORT ON THE 10-YEAR STRATEGIC PLAN
EXECUTIVE SUMMARY

CLARK COUNTY'S CHILDREN WITH BEHAVIORAL HEALTH NEEDS AND THEIR FAMILIES

National and local studies suggest that 13-20 percent of Clark County's children have experienced a behavioral health disorder within the past year, and 50 percent have suffered from one of these disorders by the time they reach adulthood (SAMHSA, 2013). In 2013, almost twenty percent of Clark County's public middle school students seriously thought about killing themselves, more than 30% had used alcohol or illegal drugs, and over 11% had attempted suicide (Frankenberger et al., 2014). Approximately 10-12 percent of children and adolescents suffer from serious emotional disturbance (SED) each year, experiencing symptoms that significantly impair their ability to function at home, in school and in the community (SAMHSA, 2013). 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).

In spite of disproportionately high levels of teen suicide and depression, Nevada lags significantly behind neighboring states in providing adequate funding for children's behavioral health services that will strengthen families and help youths succeed at home, in school and in their community (Denby, 2013). Family members, providers and stakeholders have also concluded that Nevada needs to reform its children's behavioral health service delivery system to produce the most cost-effective outcomes for youth and their families. **The 2017 Annual Report of *Mental Health America ranked Nevada as the worst state (51st) in providing access to behavioral health care for its youth*** *(Mental Health America, 2016).*

THE CCCMHC 10-YEAR STRATEGIC PLAN: 2020 VISION FOR SUCCESS

As required by NRS 433B, the Clark County Children's Mental Health Consortium's ***10-Year Strategic Plan*** (2010) provides the vision, goals and strategies to overcome the specific service delivery and system challenges identified in Clark County by implementing an evidence-based, system of care approach (Stroul, 2014). Using a set of values and principles which promote a system of care that is community-based, family-driven and culturally competent, the Plan sets forth ***six long-term goals*** for Clark County by the year 2020. Table 1 shows the current status of these six goals.

TABLE 1. YEAR 7 REPORT
10-YEAR STRATEGIC PLAN

Strategic Plan Goals for 2020	Objectives at least partially achieved
1. Coordinated services & supports for youth with SED	0%
2. Comprehensive service array for all youth with behavioral health needs	66%
3. Organized pathway to information, assessment, referral & crisis response	66%
4. Local system management involving families, providers & stakeholders	33%
5. Preventative programs promoting social-emotional development	50%
6. Heightened public awareness of children's behavioral health needs	66%

SHORT-TERM SERVICE PRIORITIES OF THE CCCMHC

The CCCMHC's ***2016 Service Priorities Report*** identified recommended actions for the upcoming biennium to achieve the most short-term, cost-effective system improvements while serving as building blocks for the ***10-Year Strategic Plan. This report*** outlines the ***current status*** of these priorities.

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

CURRENT STATUS: Some Progress

- Include the following **as essential health benefits** to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, Health Insurance Exchanges and other publicly subsidized health coverage plans: **family peer support, mentoring, mental health consultation, mobile crisis intervention, and respite care.**

- **Develop and implement a statewide, universal set of quality standards** that require those children's behavioral health providers who receive Medicaid or other public funding as reimbursement for their services to utilize family-driven, individualized, evidence-based treatment interventions.

- **Review Medicaid rates** for children's behavioral health services to determine if inadequate provider reimbursement contributes to lack of capacity and access for children and families.

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

CURRENT STATUS: Significant Progress

- Provide ongoing funding for DCFS to maintain an evidence-based mobile crisis intervention program with fidelity that meets the needs of Clark County youth experiencing severe psychiatric crises

- Develop interagency protocols and policies with hospitals and managed care providers to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior.

- Expand funding for Family Peer Support to enhance outcomes and reduce recidivism for youths served by mobile crisis intervention.

- In order to support the program and provide timely access to needed services, develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

Priority 3. Expand access to family peer support services for the families of Clark County's children at risk for long-term institutional placement

CURRENT STATUS: No progress

- *Expand funding to provide family peer support for Clark County youths with serious emotional disturbance at risk for long-term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization.*

- *As part of the pilot project established under Assembly Bill 307 of the 2015 Nevada Legislature, provide an intensive level of family peer support for at least 50 Clark County youth with intellectual/developmental disabilities or related conditions who are also diagnosed with behavioral health needs in an effort to prevent long-term institutional placement.*

Priority 4. Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

CURRENT STATUS: Minimal progress

- *Assist the Nevada Office of Suicide Prevention to obtain resources in order to conduct a comprehensive survey of Clark County public, charter, and private schools that will determine the degree to which mental health and/or suicide Prevention screening has been implemented.*

- *DHHS initiatives for mental health and/or suicide prevention screening should support the implementation of an effective model of school-based mental health and suicide prevention screening that is: (1) Evidence-based; (2) Cost-effective; (3) Utilizes active parental consent and (4) Includes procedures and enhanced resources to link identified students with needed services.*

TABLE OF CONTENTS

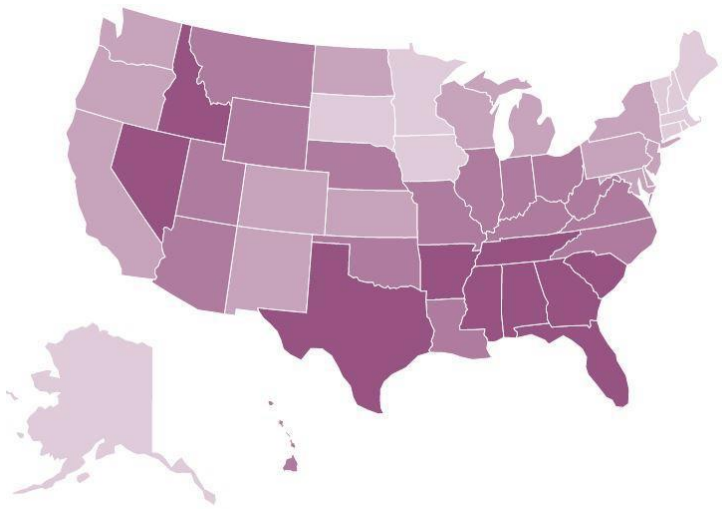
CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM
2017 STATUS REPORT ON THE 10-YEAR STRATEGIC PLAN

I. INTRODUCTION

Clark County's children with behavioral health needs share many of the same characteristics and challenges of children with behavioral health needs across the U.S. 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). 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). In Clark County, studies have suggested that 19.3% of elementary school children have behavioral health care needs and over 30% of adolescents self-reported significant levels of anxiety or depression (CCCMHC, 2010). In 2013, almost twenty percent of Clark County's public middle school students seriously thought about killing themselves, more than 30% had used alcohol or illegal drugs, and over 11% had attempted suicide (Frankenberger et al., 2014).

Some children and youth have greater needs for behavioral health care than others. National studies have found that 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). Local surveys conducted by the Consortium have confirmed that Clark County children in the child welfare and juvenile justice systems also experience a greater need for behavioral health care (CCCMHC, 2010). Approximately 10-12 percent of U.S. Children suffer from ***serious emotional disturbance*** (SED) each year, experiencing symptoms that significantly impair their ability to function at home, in school and in the community (SAMHSA, 2013). With local studies showing at least 6 percent of early elementary school children exhibit signs of SED, it is reasonable to project prevalence rates for all Clark County children and youth with this condition will match the national data (CCCMHC, 2010).

Figure 1. THE STATUS OF CHILDREN'S MENTAL HEALTH CARE IN THE U.S.
BEST (Light Purple) AND WORST (Dark Purple) STATES
NEVADA RANKS 51ST WITH HIGHEST NEED FOR AND LOWEST ACCESS TO MENTAL HEALTH CARE FOR YOUTH AND ADULTS



--From Mental Health America 2017 Report

In December 2015, 200 family members, providers, and other stakeholders attended a Community Forum at UNLV to discuss the mental health of Clark County's children. After a panel discussion and audience input, they reached a consensus that Nevada needs to reform its service delivery system for children with

behavioral health needs (Valley, 2015). The voices at the Community Forum echoed the findings of a state-commissioned report on the status of Nevada's public mental health services which concluded that "Nevada has missed a number of opportunities over the years to strengthen its behavioral health system" and needs "a proactive, strategic plan to implement an integrated system of care approach to behavioral health" (Watson et al, 2013.) The report found that Nevada's behavioral health system has focused on responding to adults with mental health crises, rather than investing its resources in prevention and early intervention for children and youth. The U.S. Substance Abuse and Mental Health Services Administration has provided data to suggest that in recent years, Nevada has increased the percentage of state spending on inpatient hospitalization and centralized administration while decreasing its funding on community-based services for individuals with behavioral health needs (SAMHSA, 2013). In spite of disproportionately high levels of teen suicide and depression, UNLV's Lincy Institute has shown that Nevada lags significantly behind neighboring states in providing adequate funding for children's mental health services that will strengthen families and help youths with mental health needs succeed at home, in school and in their community (Denby, 2013). **The 2017 Annual Report of *Mental Health America ranked Nevada as the worst state (51st) in providing access to behavioral health care for its youth*** *(Mental Health America, 2016).*

The Clark County Children's Mental Health Consortium's **10-Year Strategic Plan**(2010) provides the vision, goals and strategies to implement an evidence-based, system of care approach that will overcome the challenges identified by the Community Forum participants and by recent local, state, and national studies (Stroul, 2014). The CCCMHC **10-Year Strategic Plan** represents a commitment to all our community's children who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic. Using a set of values and principles which promote a system of care that is community-based, family-driven and culturally competent, the Plan sets forth the following long-term goals for Clark County by the year 2020.

10-Year Plan Goals

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

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

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

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

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

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

In 2016, the CCCMHC identified ***four priorities*** that would result in the most short-term, cost-effective improvements in the system while serving as building blocks for the long term plan (CCCMHC, *2016 Service Priorities*). ***Section II*** of this report provides a description of current progress toward implementing these priorities. ***Section III*** describes any revisions to the primary objectives of the 10-Year Strategic Plan. ***Section IV*** provides a status report on each of the Plan's Phase 1, 2, and 3 Objectives targeted for completion by June 30, 2017.

II. STATUS OF THE CCCMHC'S 2016 PRIORITIES

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

Justification:

In addition to critical service gaps, recent studies and family surveys have suggested that the system of behavioral health services in Clark County is complex and difficult to access (CCCMHC, 2014). The UNLV Lincy Institute found that only 29% of Nevada's children with emotional, behavioral or developmental needs were able to access services as compared to 54% of Arizona's children with comparable needs (Denby et al., 2013). Another study found that Nevada's adolescents accessed outpatient treatment at a rate lower than 45 other states (SAMHSA, 2013). A 2014 study commissioned by the Governor's Council on Behavioral Health & Wellness concluded that the current governance structure of the state's public mental health system has led to a lack of coordination between agencies and poor responsiveness to community needs (Brune et al., 2014). As a consequence of these systemic problems Nevada youths with serious emotional disturbance or other disabilities continue to be unnecessarily placed in out-of-state institutions (Valley 2015).

Recommended Action Steps

- Develop and implement a plan for **integrated, local system management** of all publicly funded children's behavioral health services in Clark County.
- Re-structure Medicaid policies and funding to support **a single, accountable entity in Clark County that uses a wraparound approach** to manage the care for youth with serious emotional disturbance. Blend/braid Medicaid and other public resources, allowing flexibility in the care management entity's use of the funding to implement individualized services and supports that strengthen the family, reduce the need for out-of-home placement, and facilitate positive outcomes for each youth.
- Include the following **as essential health benefits** to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, Health Insurance Exchanges and other publicly subsidized health coverage plans: **family peer support, mentoring, mental health consultation, mobile crisis intervention, and respite care.**
- **Develop and implement a statewide, universal set of quality standards** that require those children's behavioral health providers who receive Medicaid or other public funding as reimbursement for their services to utilize family-driven, individualized, evidence-based treatment interventions.
- **Review Medicaid rates** for children's behavioral health services to determine if inadequate provider reimbursement contributes to lack of capacity and access for children and families.

CCCMHC has recommended that Nevada re-structure its children's behavioral health service delivery by implementing local system management of all publicly funded children's behavioral health services, including those administered by the Division of Child and Family Services and the Division of Health Care Financing and Policy. Nevada law already specifies that "the system of mental health services [for children] should be community-based and flexible, with accountability and focus of the services at the local level" (NRS 433B). In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008). A recent state-commissioned report on Nevada's behavioral health programs also recommended more locally-driven, community-based services to address difficulties in service access and outcomes (Watson et al, 2013). The Legislative Committee on Health Care and the Southern Nevada Health Forum both support this recommendation.

Under local systems management, the CCCMHC has also recommended redeployment of Medicaid and other funding to support a ***single***, accountable entity in Clark County that adheres to a System of Care philosophy (Stroul et al, 2008) and uses an evidence-based wraparound approach to coordinate the care for youth with serious emotional disturbance (Bruns et al., 2010). The federal government reported that less than 10% of Nevada children with serious emotional disturbance have access to wraparound case management through the state's mental health system, a penetration rate of less than half the average of other states (Centers for Medicare and Medicaid Services, 2013). A 2009 state-commissioned report found that public children's behavioral health care dollars in Clark County were being spent on care management efforts that were duplicative, inconsistent, and failed to target those youths with the most serious and complex needs (Pires, 2009). Another report commissioned by the Governor's Behavioral Health and Wellness Council describes the benefits of integrated funding and the effective use of care coordinating organization in producing effective service outcomes (Brune et al., 2014). The Center for Health Care Strategies has profiled successful state and community demonstration projects such as the Wraparound Milwaukee Program that have utilized this approach (Simons et al., 2014).

To facilitate the effectiveness of local service delivery, the CCCMHC has also recommended that both traditional behavioral health care providers and care management entities have the ability to provide innovative services such as family peer support, mentoring, mental health consultation, and respite care under health care coverage policies or flexible funding strategies. These strategies are currently underutilized in public children's behavioral care systems in spite of their demonstrated effectiveness in improving outcomes and reducing costs of services (Pires et al., 2013). An extensive national evaluation has demonstrated that a systems of care approach yields positive outcomes for children and families with significant behavioral health needs. In addition, there is a growing body of evidence demonstrating that that implementation of systems of care strategies results in net cost savings derived from reduced use of inpatient psychiatric hospitalization, emergency rooms, residential treatment, and other group care, even when expenditures increase for home- and community-based care and care coordination (Stroul et al., 2014). ***Investment in systems of care strategies in Nevada can divert millions of dollars being spent each year on out-of-state psychiatric placements for youth into more cost-effective community-based treatment strategies (See Figure 2).***

Fig 2. Children in Medicaid Out-of-State Placements

Month	Children Placed	Total Mo Cost	Cost/Mo/Child
Sep 2015	245	$2,307,082.09	$9,416.66
Oct 2015	253	$2,469,016.18	$9,758.96
Nov 2015	253	$2,417,738.19	$9,556.28
Dec 2015	259	$2,507,631.12	$9,681.97
Jan 2016	244	$2,467,581.01	$10,113.04
Feb 2016	238	$2,262,731.40	$9,507.27
Mar 2016	245	$2,405,739.80	$9,819.35
Apr 2016	254	$2,434,480.07	$9,584.57
May 2016	255	$2,594,940.22	$10,176.24
Jun 2016	259	$2,442,829.86	$9,431.78
Jul 2016	252	$2,544,210.99	$10,096.08
Aug 2016	245	$2,487,341.85	$10,152.42
Total 12 Months Cost		$29,341,322.78	N/A

Federal and state reports also continue to highlight the need for a more substantial workforce in Nevada trained to provide quality behavioral health services to children (Denby 2013; Dvoskin, 2014; SAMHSA, 2013). Nevada ranks 50th among states in the number of psychiatrists per capita and 48th among states in the number of psychologists per capita, and has 54 Mental Health Professional Shortage Areas designated by the Health Resources and Services Administration (**HRSA)** of the U.S. Department of Health and Human Services (Beck, 2016). For example, the shortage of child psychiatrists in Southern Nevada results in families facing long waitlists, short medical appointments and few alternative for accessing need care for their children with behavioral health needs (Valley, 2015). Given the workforce shortages, existing Medicaid reimbursement rates should be examined to determine if

they provide incentives for local providers to expand their capacity to serve vulnerable children and families.

CURRENT STATUS: Some Progress

The Nevada Division of Child and Family Services has taken a leadership role in coordinating efforts between the Commission on Behavioral Health and the three regional consortia via a joint subcommittee established in 2012 to address the governance for children's behavioral health service delivery as well as the restructuring of policy and financing strategies. In October 2015, DCFS received a System of Care Expansion and Sustainability Grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. With support from this project, the subcommittee has drafted a strategic action plan that proposes to integrate services for children with serious emotional disturbance under a system of care overseen by DCFS. During the 4-year grant project, DCFS will work with the Nevada Division of Health Care Financing and Policy to restructure the policies and funding for children's behavioral health services. Supported by the Nevada Director of Health and Human Services, this effort will include amendments to the State Medicaid Plan or the submission of a Medicaid Waiver application that will allow blending and braiding of all federal and state funding available for children's behavioral health services. The Medicaid reform will include the addition of innovative services such as: family peer support, mentoring, mental health consultation, mobile crisis intervention, and respite care for children with behavioral health needs.

The Division of Child and Family Services has also pledged to continue funding for training to community stakeholders/partners in evidence-based services. With funding support through the System of Care Expansion and Sustainability Grant, DCFS has already provided training to providers in evidence-based services, including REST (a respite care model), Together Facing the Challenge (a therapeutic foster care model, System of Care Values and Principles, High-Fidelity Wraparound, and Trauma-Informed Care. DCFS also plans to utilize the resources of the System of Care Grant to work with stakeholders in developing quality standards for providers of children's behavioral health services. Through a $1.4 million dollar Workforce Education and Training for Professionals grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), the UNLV School of Social Work Professors Ramona Denby-Brinson and Joanne Thompson have implemented a three-year project in collaboration with local and state behavioral health partners to expand clinical social work education with the goal of producing 108 highly competent practitioners who can intervene on behalf of children, adolescents, and transitional-age youths who are at risk of or who have developed behavioral health disorders.

While Medicaid's proposed biennial budget for FY18-19 includes a rate increase for acute psychiatric hospital providers, no increases have been included to address the lack of access for community-based behavioral health services for children and their families.

Next Steps

With support from the System of Care Expansion and Sustainability Grant, the Behavioral Health Commission's Subcommittee on Children's Mental Health should amend their strategic plan to incorporate specific objectives and action steps that address how local system management and care management will be implemented using blended/braided funding.

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

Recommended Action Steps

- Provide ongoing funding for DCFS to maintain an evidence-based mobile crisis intervention program with fidelity that meets the needs of Clark County youth experiencing severe psychiatric crises
- Develop interagency protocols and policies with hospitals and managed care providers to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior.
- Expand funding for Family Peer Support to enhance outcomes and reduce recidivism for youths served by mobile crisis intervention.
- In order to support the program and provide timely access to needed services, develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

Justification:

Without easy access to crisis intervention and stabilization services in the past, families in Clark County have been forced into utilize local emergency rooms in order to obtain behavioral health care for their children. Some time ago, the National Center for Children in Poverty identified youth emergency room visits for behavioral health care as a national problem (Cooper, 2007). A more recent national study of children's behavioral health services utilization in the Medicaid program showed that eligible adolescents used disproportionately more services--particularly facility-based care-- due to the lack of more cost-effective approaches such as mobile crisis intervention services (Pires et al., 2013).

Youth behavioral health-related visits to local hospital emergency rooms increased steadily from 2010 until 2015. Depression and Anxiety represent the most predominant diagnoses upon admission, and both males and females are equally represented (Greenway, 2017). From earlier studies, it is estimated that almost 40% of these youths have been admitted to emergency rooms due to suicide attempts or threats, with nearly half of youths discharged home without immediate treatment being suicidal, psychotic or depressed (CCCMHC, 2009). The medical director of University Medical Center's Pediatric Emergency Room has called the situation a "health crisis of unbelievable proportions," noting that mental-health related visits to his facility have tripled over the past decade while the county population has increased by only 25%" (Valley, 2015).

Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric hospitalization for youths with complex behavioral health care needs in programs such as those implemented across New Jersey, in Milwaukee, Wisconsin and in Seattle, Washington (AHRQ, 2013). DCFS successfully implemented a pilot program in 2013 which can reduce costs and utilization of inpatient and residential psychiatric treatment if significantly expanded and sustained to fully meet the needs of Clark County's children with behavioral health crises. The 2014 Report of the Governor's Council on Behavioral Health & Wellness recommended expansion of mobile crisis intervention services (Dvoskin, 2014).

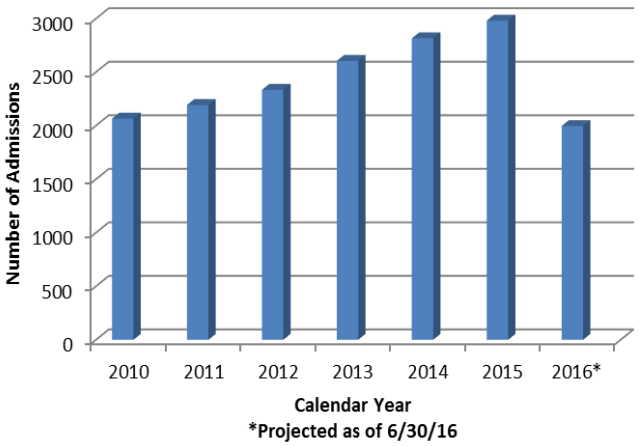
In addition to expanding and sustaining mobile crisis intervention programs, Nevada should explore federal incentives for expanding presumptive Medicaid eligibility approaches in order to develop a family-driven approach that facilitates access to immediate and appropriate community-based care to uninsured and underinsured youths with psychiatric crises.

CURRENT STATUS: Significant Progress

Mobile Crisis Intervention—Supported by Healthy Nevada funds, DCFS implemented the Mobile Crisis Response Team Program (MCRT) in Clark County as a pilot project in January 2014 and

significantly expanded in October 2014 with the same funding source. Currently, the program serves youth in the greater Las Vegas area that are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, extreme parent/child conflict, difficulty adjusting to a serious peer relational issue such as bullying, or any other serious mental health problem. The MCRT serves a key function in the system of care by providing community-based services that the youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department. The ultimate goal of MCRT services is to divert youth from psychiatric hospitalization. The Las Vegas MCRT received 1,177 hotline calls in Fiscal Year 2016, responding to 656 youth in crisis during that time period. The most common reason for calling was due to suicidal ideation. Most intake assessments took place in a hospital emergency room department. The psychiatric hospital diversion rate is nearly 88% for youths served during FY 2016. The youth served have shown significant improvement in functioning and 99.4% of parents/families report being satisfied with the program.

Figure 3. Clark County Youth Behavioral Health Emergency Room Admissions



In October 2016, the Mobile Crisis Response Program in Clark County began offering services 24 hours per day, 7 days per week. The program also placed a full-time crisis team at the Harbor Juvenile Assessment Center on North Pecos Road in Las Vegas, where staff collaborates with other agency professionals to serve children and families in need of behavioral health services and other supports. Through its System of Care Expansion and Sustainability Grant from by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, DCFS has recently funded a rural Mobile Crisis Response Team program that will provide services to the rural areas of Clark County.

Although the overall number of youth behavioral health emergency room admissions has been increasing steadily each year, the rate of these admissions began to decrease in Calendar Year 2015 after the MCRT Program was fully implemented. As shown in Figure 3, nearly 1,000 fewer admissions are projected for calendar year 2016 as compared to 2015 based on data from the first two quarters of the year (Greenway, 2017). In spite of this progress, the MCRT program does not have an ongoing funding source and adequate referral options to ensure its stability and continued success. In the proposed state budget for FY18-19, the program continues to be supported by Healthy Nevada and SAMSHA grant funds, including the family peer support positions provided by Nevada P.E.P. The program has also experienced ongoing challenges in facilitating inpatient services and other types of intensive care needed for some youths served by the program. The MCRT struggles to find appropriate placements and/or services for youth with co-occurring developmental disabilities and behavioral health needs. Additional assessments required by the psychiatric hospitals or managed care providers have also caused delays in linking many other youth to needed services, increasing the length of emergency room stays for these youth and families. In response to this challenge, DCFS has negotiated verbal agreements with the majority of hospitals in Clark County and one of the MCO providers to accept the

initial assessments completed by the MCRT staff. The Nevada Division of Health Care Financing and Policy has also included a requirement in their latest Request for Proposals that Managed Care providers cooperate with state agencies and other essential community providers.

Presumptive Eligibility -- Over the past year, the Department of Health and Human Services has implemented a program that allows hospitals to determine presumptive Medicaid eligibility for their patients. DECF has also partnered with the Division of Welfare and Supportive Services to ensure all DCFS and MCRT consumers are assisted with applications for Medicaid eligibility. DCFS has negotiated a Memorandum of Understanding with the Division of Welfare to provide presumptive eligibility at DCFS service sites that will expedite follow-up services to youths with psychiatric crises and their families.

Next Steps

The Department of Health and Human Services should pursue permanent funding for the newly expanded mobile crisis intervention program. DHHS should also facilitate expansion of the presumptive eligibility option to all local psychiatric crisis programs.

CHILDREN'S MOBILE CRISIS RESPONSE TEAM

MCRT supports youth and families of youth under the age of 18 showing signs of behavioral or mental health issues that pose a threat to the child's stability within their home, school or community, including but not limited to:

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

Priority 3. Expand access to family peer support services for the families of Clark County's children at risk for long-term institutional placement.

Justification:

Family peer support services have been shown effective in improving outcomes for such youths with serious emotional disturbance and their families (Stroul et al., 2008). Studies conducted in Clark County through the federally funded Neighborhood Care Center Project also suggested that family peer support services can result in an increase in stable, community-based placements; improvement in school grades and attendance; and improvement in the child's clinical symptoms (Nevada Division of Child and Family Services, 2005).

Recommended Action Steps

- *Expand funding to provide family peer support for Clark County youths with serious emotional disturbance at risk for long-term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization.*
- *As part of the pilot project established under Assembly Bill 307 of the 2015 Nevada Legislature, provide an intensive level of family peer support for at least 50 Clark County youth with intellectual/developmental disabilities or related conditions who are also diagnosed with behavioral health needs in an effort to prevent long-term institutional placement.*

A national study of children's behavioral health services utilization in the Medicaid Program found than one percent or fewer eligible children with behavioral health needs were receiving nontraditional services such as family peer support, in spite of a mounting body of evidence demonstrating the cost effectiveness of this approach (Pires et al., 2013). Such findings suggest a lack of access to family peer support services; even ***while more and more Nevada families of children with serious emotional disturbance request this program through Nevada PEP each year*** (see Figure 4). Because family peer support services can help reduce reliance on expensive, restrictive residential treatment, the U.S. Centers for Medicare & Medicaid Services issued a bulletin in May 2013 recommending that states provide funding for family peer support as part of their benefit plan for children with significant mental health conditions (CMS 2013). The Governor's Council on Behavioral Health & Wellness also recommended expansion of family peer support programs in its 2014 report (Dvoskin, 2014).

Nevada PEP currently provides family peer support services for families who have children with mental health needs. Families are referred by DCFS programs, schools, and community organizations. Over the last year PEP provided family peer support services to 1,804 families of youth with serious emotional disturbance in Clark County and 2,416 families statewide. 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; Instrumental support and referral; Advocacy support; and Leadership skill building at child and family level as well as at system levels.

Expansion of Family Peer Support is necessary to improve outcomes for children and youth at risk for long-term institutional placement. PEP already partners with DCFS in providing services through the DCFS's Mobile Crisis Response Team, working with 481 families referred from the Clark County MCRT during Calendar Year 2016. Additional funding for family peer support is also desperately needed to provide services to the large numbers of youths at risk for both acute and long-term psychiatric residential treatment being identified each year by the Clark County School District's Mental Health Transition Team. Created in 2014, this team facilitates the development of school-based aftercare support to youths discharged from local psychiatric hospitals. In the 2015-6 academic year, the team provided aftercare support to a total of 1485 youths transitioning back to their home schools after hospital stays. The majority of youth identified by the team lack special education supports and suffer

from depression, bipolar disorders, or other serious mood disorders. While the Mental Health Transition Team connects the youth with needed services as they return to school, the families of these youths also need support to care for these high-risk youths at home. Of those served by the CCSD's Mental Health Transition Team during the 2015-2016 academic year, over 400 youth had at least two psychiatric hospitalizations and almost 200 youth had three psychiatric hospitalizations during that time period.

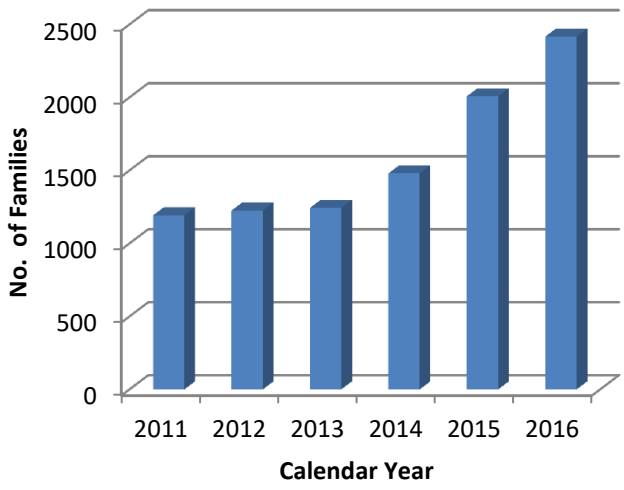
The 2013 Pires et al. study also found that behavioral health expenses for children in Medicaid with a developmental disability were more than double those for other children, pointing to the need for alternative approaches such as family peer support for this population. At least 48 Clark County youths with co-occurring developmental disabilities and behavioral health needs have been served by the Mobile Crisis Response Team over the past year. Linking these youths to community-based services creates one of the greatest challenges for the MCRT. Family peer support can improve outcomes for these children, representing a critical component of any care coordination plan. The CCCMHC recommended that intensive family peer support be incorporated into the pilot project for such youths authorized by Assembly Bill 307 of the 2015 Nevada Legislature and incorporated into NRS 435.035.

CURRENT STATUS: No Progress

Although Nevada P.E.P continues to partner with DCFS's MCRT Program to provide family peer support to youth with psychiatric crises, no new funding has been proposed in the FY 18-19 biennial budget to expand these services to additional youths identified by the Clark County School District's Mental Health Transition Team as high risk for long-term institutional placement due to multiple acute care hospitalizations. The Department of Health and Human Services has pledged to examine other mechanisms for funding family peer support services to this vulnerable population, including the Federal Victims of Crime Grant.

According to NRS 435.035, the Division of Aging and Disability Services (ADSD) and the Division of Health Care Financing and Policy were mandated to establish a pilot program of intensive care coordination and other services for children with co-occurring intellectual disabilities or related conditions and behavioral health care needs to the extent funding was available. In April 2016, ADSD provided a report on the pilot project to the Legislative Committee on Health Care. The report indicated that 30-50% of children and youth with intellectual disabilities also have a co-occurring behavioral health disorders according to national statistics. ADSD identified 43 Nevada children and youth with intellectual disabilities and a mental health diagnosis treated in out-of-state institutions between 2012 and 2015 at a cost of $6,526,876. ADSD's report provided a plan for implementation of the pilot project which included the use of the wraparound model of care coordination for those youth to be served by the program. Although family peer support is an essential component in the implementation of the wraparound model, ADSD did not include this service as part of the pilot project. As

Figure 4. Nevada Families Requesting Support Services through Nevada PEP



of November 2016, no Clark County youths have been identified or served by the pilot project.

Next Steps

The Department of Health and Human Services should secure immediate funding to provide family peer support services to those youths at risk for long-term psychiatric residential treatment who are being identified by the CCSD Mental Health Transition Team. DHHS should also encourage DCFS and the Nevada Division of Aging and Disabilities Services to work together in developing funding for family peer support services that will improve outcomes for youths with co-occurring developmental disabilities and behavioral health care needs

Priority 4. Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

Recommended Action Steps

- *Assist the Nevada Office of Suicide Prevention to obtain resources in order to conduct a comprehensive survey of Clark County public, charter, and private schools that will determine the degree to which mental health and/or suicide Prevention screening has been implemented.*
- *DHHS initiatives for mental health and/or suicide prevention screening should support the implementation of an effective model of school-based mental health and suicide prevention screening that is: (1) Evidence-based; (2) Cost-effective; (3) Utilizes active parental consent and (4) Includes procedures and enhanced resources to link identified students with needed services.*

Justification:

As with physical illnesses, prevention and early intervention for behavioral health problems will reduce costs to public agencies for later, more intensive, and long-term treatment (SAMHSA, 2007). For the average youth, symptoms typically precede a serious disorder by about two to four years (Denby, 2013). Screening can help identify and link youth early with services before symptoms become so intense and debilitating that they require more restrictive, costly care. Although screening should be provided across the age range, it becomes even more critical as children enter adolescence and become more prone to depression and high-risk behaviors (Schwarz, 2009). School-based screening has been shown effective in identifying teens with mental health problems and linking them with needed services (Husky et al., 2011). Even more important, screening for depression coupled with suicide awareness training can reduce the incidence of suicide attempts in adolescents (Azeltine et al., 2004).

Clark County public and private schools have experienced some success in implementing school-based screening programs to identify students with mental health needs and provide them with assistance in obtaining treatment services (CCCMHC, 2010). Between 2011 and 2013, CCSD screened over 17,000 adolescents using the evidence-based Signs of Suicide program. Recognizing the importance of school-based screening approaches, the 2013 Nevada Legislature approved Assembly Bill 386 mandating that Clark and Washoe County School Districts implement and evaluate a school-based program in partnership with community stakeholders to provide students with general behavioral health screenings. In 2014, CCSD implemented a successful one-year pilot program of general mental health screening for middle school children in response to the Legislative mandate.

Screening is one of the steps in actualizing the Clark County School District's preferred approach of building a multi-tiered system of supports that includes selective mental health services interconnected with the District's system of academic supports (See Figure 4.). In this system, preventative behavioral health supports can be initially developed and provided to all students through social-emotional learning programs, while students identified with behavioral health needs, in part through screening, can receive early intervention or intensive support.

CURRENT STATUS: Minimal Progress

The recommended survey of Clark County schools has not yet been completed to determine the degree to which individual schools are conducting suicide risk screenings of middle and/or high school students. Currently, the Nevada Office of Suicide Prevention provides funding for the purchase of Signs of Suicide (SOS) Program kits but does not provide any resources for school-based screening efforts in Clark County.

However, as a part of the Governor's Strategic Plan, the Nevada Division of Child and Family Services (DCFS) has proposed to assist in the implementation of suicide risk screenings for all middle school students across the state. Through its System of Care Sustainability and Expansion Grant, the DCFS has also funded a school-linked mental health center at Valley High School in Las Vegas, which will provide evidence-based suicide risk screenings using the SOS Program in 2017.

During the 2015-2016 academic year, Clark County School District did incorporate the Signs of Suicide (SOS) Educational Program into its eighth and ninth grade Health Class curriculum. Although suicide risk screenings were not conducted as part of the program, teachers did ask the students to complete a response card if they wanted to speak individually with an adult following the specific class session in which the SOS materials were presented. A survey by CCSD suggested that 22,159 or 89.5% of all eighth grade students participated in class sessions which used the SOS program materials. A total of 1,737 or 7.8% of those students requested a follow up conversation with an adult. A total of 23,599 or 94.7% of ninth grade students participated in class sessions using the SOS materials, with a total of 1,258 or 5.3% requesting an individual conversation with an adult following these sessions. While the SOS Education Program is a valuable addition to the Clark County School District's Health curriculum, its effectiveness in reducing suicide risk is not known. Research studies have suggested that the SOS Education Program can be effective in reducing suicide risk when paired with the SOS Screening Program (SAMHSA, 2016). The Clark County School District has successfully conducted suicide risk screenings at selected sites in the past, but lacks the funding resources, staffing and implementation model to expand these efforts across all of its middle schools or high schools.

The 2015 Legislature passed SB 515, Section 23, which provided just under $5.6 million to distribute block grants to school districts and charter schools to provide for contract social workers or other licensed professionals in schools with identified needs from January until May, 2016. The Department of Education's Office for a Safe and Respectful Learning Environment placed 130 professionals at 73 of the neediest schools throughout Nevada in the pilot year of the "Social Workers in Schools Program." In June 2016, the Interim Finance Committee of the Nevada Legislature approved an additional allocation of $11,188,000 for the program in Fiscal Year 2017. During academic year 2015-2016, Clark County schools hired 130 mental health workers which were placed in 73 local schools who demonstrated a need for services through the results of a school climate survey. The Department of Education designated that the funding should be used by schools for Tier 1 or Tier 2 mental health interventions (See Fig. 5) using strength-based, evidence-based programs and best practices. While suicide prevention screening and programs could be implemented with this funding, there is no information yet as to whether any Clark County schools have implemented any of these strategies through this initiative.

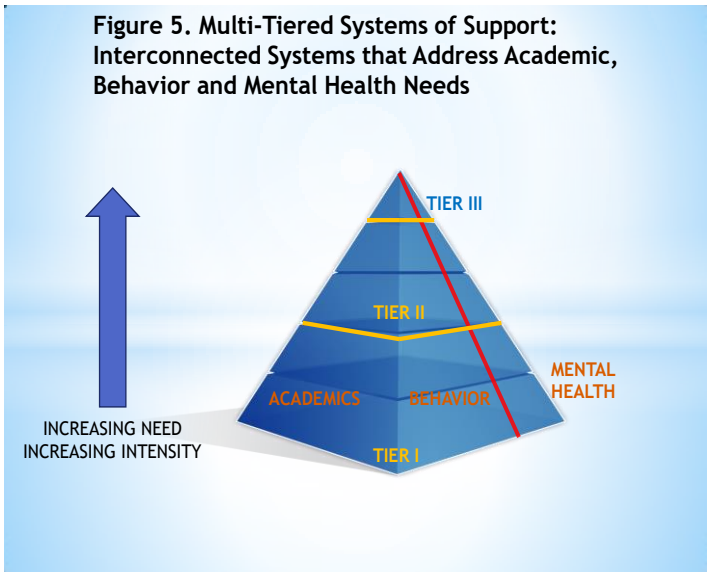


Figure 5. Multi-Tiered Systems of Support: Interconnected Systems that Address Academic, Behavior and Mental Health Needs

Next Steps

The Governor's budget should include dedicated funding for school-based prevention and early intervention approaches that have been proven effective and can be deployed to Nevada school districts in a flexible manner to address their individualized needs.

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

In accordance with requirements set forth in NRS 433B, this section describes the objectives from the ***10-Year Strategic Plan*** that have been revised by the CCCMHC since the ***2015 Status Report*****.**

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

- ***Revised Objective 5.1*** ***Develop and implement effective screening models for middle and high school students.***

  Justification: The original objective recommended implementation of screening throughout Clark County middle and high schools. The Clark County School District has conducted successful pilot screening projects but has been unable to develop a model that can be implemented to scale throughout the community.

- ***Revised*** **Objective 5.5 Education and support will be available to parents of at-risk pre-kindergartners at local elementary schools using an evidence-based model.**

  Justification: When this objective was originally written in 2010, it included a recommendation to implement a model of parent education and support developed in Clark County through a Safe Schools, Healthy Students Initiative funded by the U.S. Department of Health and Human Services. The revised objective suggests that other evidence-based models developed since that time could also be considered.

- ***Revised Objective 5.6*** **Develop and implement a comprehensive plan for training school personnel in early identification and intervention for behavioral health issues and suicide prevention.**

  Justification: When this objective was originally written, it was recommended that the Nevada Office of Suicide Prevention provide funding resources through its Garrett Lee Smith (GLS) federal grant. References to this grant have been eliminated from the objective since the Nevada Office of Suicide Prevention no longer receives this type of funding.

- ***Revised Objective 5.9*** **Use Medicaid funding to expand outreach and early screening to at-risk groups through school-based health clinics and primary care clinics.**

  Justification: When this objective was originally written, Nevada P.E.P. was included as a partner in the recommendation to expand outreach and early screening. Since Nevada P.E.P. no longer receives funding for screening, the objective has been revised.

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

- ***Revised*** **Objective 6.1 State and local funds will be allocated for ongoing public awareness activities.**

  Justification: When this objective was originally written in 2010, it recommended allocation of federal funds from the Garrett Lee Smith Grant funding available through the Nevada Department of Health and Human Services. Since that grant funding is no longer available in Nevada, the recommendation has been changed to seek other state or local funding.

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

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

Below is a report on the status of those strategies and services targeted for implementation during **Phase 1** (7/1/10-6/30/14), **Phase 2** (7/1/13-6/30/15), and a portion of those targeted for **Phase 3** (7/1/15-1/31/2020) of the Plan.

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

Phase 1/2/3 Objectives and Strategies

- **Objective 1.1 Re-structure Medicaid Care Targeted Case Management Policies to support a single, accountable care management entity in Clark County. (a) Blend/braid existing funding to implement the care management entity; and (b) Leverage and redeploy cost savings from re-structuring targeted case management to expand the capacity for care management to youths in juvenile justice and schools.**
  Indicators: Number of youths receiving intensive case management, improved outcomes

  CURRENT STATUS: Minimal Progress. There was a 20***%*** increase in youths referred to the DCFS Wraparound in Nevada program that provides an evidence based practice model. As part of DCFS's System of Care Expansion Grant, sub grantees are being trained in High Fidelity Wraparound and will be required to use High Fidelity Wraparound as a core component of their program. Currently Wraparound in Nevada will provide wraparound service coordination to sub grantees until training is completed.

  Additionally DCFS has contacted the National Wraparound Implementation Center and is in negotiations for a contract for DCFS staff to be trained on the latest wraparound techniques and coaching methods. DCFS will be supplied with the latest wraparound curriculum and fidelity tools to ensure that System of Care Expansion Sub grantees are able to provide the most current wraparound approach to a high fidelity.

  However, many youths with serious emotional disturbance are also receiving targeted case management from other agencies not utilizing a high fidelity wraparound approach, including HMO Medicaid providers, Clark County Child Department of Family Services and Clark County Juvenile Justice Services. DCFS's System of Care Expansion Project is working with these agencies to ensure that youth with serious emotional disturbance can receive high fidelity wraparound case management in coordination with other types of targeted case management and clinical services.

- **Objective 1.2 with active participation from Clark County Management, CCSD Student Services, the Eighth Judicial Court, family members, and other stakeholders, the Nevada Department of Health and Human Services will facilitate the development and implementation of a community-wide, interagency process for reviewing and reducing out-of-state and out-of-community placements of children with serious emotional disturbance.**
  Adherence to MOU; *Decrease in Out-of-State and Out-of-Community Placements, Increase in number of children staffed by the teams*

CURRENT STATUS: No Progress. While agencies such as Nevada Division of Child and Family Services, Clark County Department of Family Services, and Clark County Juvenile Justice Services have each been working independently to develop strategies that may reduce the number of youths placed in out-of-state residential treatment centers, no collaborative, interagency process exists for reviewing out-of-state and out-of-community placements of youths with serious emotional disturbance in an effort to develop alternative local treatment options.

- **Objective 1.3 Expand Medicaid eligibility to cover home-based counseling and other family supports for youth with SED who are: (a) at risk for re-hospitalization or placement in child welfare or juvenile justice; and (b) uninsured and underinsured children with SED who need these services to prevent first-time hospitalization or residential care.**
  Indicators: Increase in number of children served, increased family satisfaction, improved family functioning

  CURRENT STATUS: Minimal Progress. While children and youth with serious emotional disturbance continue to receive the benefits of Medicaid coverage while in out-of-home placements and residential treatment centers under a "Family of One" eligibility status, many children lose access to these benefits and services within a month of returning home unless the family can obtain Medicaid coverage based on another eligibility category. Services to support the family in caring for the child at home are at best disrupted by changes in Medicaid coverage, or may be completely unavailable to the child upon returning home.

  Since the expansion of Medicaid under the Affordable Care Act, more children have access to counseling and supports following hospitalization or residential placement. Through a collaboration with the Nevada Division of Welfare and Supportive Services, DCFS's Mobile Crisis Response Team is facilitating Medicaid eligibility for uninsured and underinsured youths experiencing a psychiatric crisis, expanding access to community-based services that can prevent first-time hospitalization. A new Medicaid State Plan Amendment also allows children to maintain pre-existing HMO Medicaid coverage once they enter out-of-home placement. Although this change may facilitate continuity of care upon entry to and exit from out-of-home care, no foster children have yet opted into this option.

- **Objective 1.4 Establish tax or fee to expand financial supports for youths with serious emotional disturbance.**
  Indicators: Increase in number of children receiving financial supports. Increased satisfaction of families and improved family functioning.

  CURRENT STATUS: No Progress. DCFS administers a small Placement Prevention Fund to provide financial support for youths with serious emotional disturbance. This funding is crucial and key in supporting stable housing, providing food, clothing or recreation for youths with SED and their families. In addition, this financial resource can prevent much more costly out-of-home placements. This funding has fluctuated over recent years and does not meet the needs of this population. DCFS is researching the possible utilization of a Home and Community Based Waiver program, as other states have found success through waiver packages.

- **Objective 1.5 Expand family peer support services through innovative Medicaid programs, blended/braided funding. Indicators:** Increase in funding for family peer support services, increase in families served

CURRENT STATUS: No Progress. The Division of Health Care Financing and Policy has shown an interest in revising its policies to include family peer support services as a Medicaid funded program. Medicaid already reimburse for peer support services provided to adults with serious mental illnesses. Medicaid has held informal meetings with the Nevada Division of Child and Family Services and Nevada P.E.P. DCFS's System of Care Expansion Grant has identified as a goal the adoption of a national certification requirement for family peer support providers as a first step in increasing capacity and access to this service.

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

  CURRENT STATUS: Minimal Progress. The Nevada Aging and Disabilities Services Division, Division of Public and Behavioral Health, and Division of Child and Family Services held quarterly collaboration meetings for the purpose of reviewing the needs of individual youths with co-occurring developmental disabilities and behavioral health problems, developing procedures for co-served (children and youth up to the age 24), maximizing funding/resources across the divisions, and developing a MOU between the three divisions. A draft Memorandum of Understanding (MOU) was completed by this committee and forwarded to the Deputy Directors of ADSD, DPBH, and DCFS for their review and approval. Due to several changes in Administrators in each division, this process has not been completed. However, the quarterly collaborative meetings will continue to meet in order to achieve its objective to identify appropriate and available services to co-served children and to make revisions to the MOU that will be re-presented to Administrators for approval and implementation in early 2017

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

Phase 1/2/3 Objectives and Strategies

- **Objective 2.1 Identify evidence-based and promising practice models for most needed services. (a) Re-structure Medicaid rates to provide incentives for these practices; and (b) Standardize reimbursement incentives statewide for public and private insurers.**
  Indicators: Public and private insurer reimbursement rates for Evidence-Based and Promising Practices

  CURRENT STATUS: Some Progress. Across the United States, there have been significant advances in the development of evidence-based and promising practices for children's behavioral problems. DCFS's System of Care Expansion Grant has identified evidence-based and promising practices currently used by public behavioral health providers in Clark County. These include: Parent-Child Interaction Therapy (PCIT); Trauma Informed Care (TIC); Together Facing The Challenge (TFTC); Aggression Replacement Training (ART); Family Check-Up (FCU); Seeking Safety Non-violence; Trust Based Relational Intervention Caring For Children Who Have Experienced Trauma; Trauma Informed Partnering For Safety And Permanence – Model Approach To Partnerships In Parenting (TIPSMAPP); Wraparound; Pathways; Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP); The Boys Town Model; and Technical Assistance Center on Social Emotional Intervention (TACSEI)/ Nevada TACSEI – Pyramid Model Partnership.

Through the SOC Expansion Grant, DCFS has also conducted a gaps analysis to determine which children's behavioral health services are needed in regions across the state. Once the results have been finalized, DCFS will identify evidence-based practices for the most needed services and provide training to providers.

The Nevada Division of Child and Family Services already provides local training on key evidence-based practices for children's mental health, including: wraparound case management; motivational interviewing; parent-child interaction therapy; and trauma-focused cognitive behavior therapy.

Although evidence-based practices have been identified and training provided, neither public nor private insurers provide incentives for appropriate use of evidence-based practices. While Medicaid policy requires providers of substance abuse services to ensure the use of evidence-based models of treatment, there is no such requirement for Medicaid providers of children's mental health services.

- **Objective 2.2 Increase the capacity to provide home and community-based services to uninsured and underinsured children by redeploying funds from higher levels of care and expanding insurance coverage.** ***Indicators:*** Annual increase in funding/number of children and families receiving behavioral health services.

CURRENT STATUS: Some Progress. In its second year of implementation, DCFS's System of Care Grant Expansion Grant has a primary goal of increasing home and community based services. This includes providing funding to providers within the communities through the grant, in efforts to decrease the number of youth in higher levels of care. Through the Affordable Care Act, significantly more Clark County youths have the necessary healthcare coverage to facilitate access to community-based services. As DCFS experiences a decreased need for funding higher levels of care, including acute hospital and residential placements, resources will be reallocated to support less restrictive options.

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

CURRENT STATUS: Substantial Progress**.** Nevada has contracted with a variety of agencies to provide navigators which assist families in obtaining healthcare coverage. Currently there are thirty navigators statewide that are certified through the Department of Insurance. Other outreach strategies have also been implemented to help families understand and apply for benefits through the health care exchange. Although data are not available on the success of these efforts with families who have children with behavioral health care needs, the overall number of uninsured children has decreased dramatically, from over 20% to approximately 10% of the overall child population, and Medicaid enrollees have reached an all-time high.

- **Objective 2.4 Leverage school funding to implement school-based services for ADHD and Depression. Develop neighborhood-based, school-linked provider network for other behavioral health issues in collaboration with the system management entity.**
  Indicators: Proportion of schools offering each type of services; number of children served; achievement levels of children completing the programs.

CURRENT STATUS: Minimal Progress. The Clark County School District (CCSD) does not implement district-wide, school-based programs for students presenting with ADHD or depression.

CCSD continues to offer its Medical Consultant Clinic (MCC) to provide medical evaluation, medical diagnoses, and management recommendations through a certified child psychiatrist for students with suspected psychiatric or behavioral disorders that interfere with educational performance. Additionally, some school-based education services (intervention; individual and small group counseling) may be developed and provided for students with ADHD, depression, or other clinical diagnoses, depending upon the student's presenting educational needs. Finally, CCSD has two established school based health centers that offer mental health counseling services: Basic High School and Valley High School. All CCSD school based health centers follow a medical model such that basic mental health screening is included in routine practices.

Additionally, the district continues to operate its Mental Health Transition Team which is charged with facilitating the return of students from local hospital/treatment center placements to CCSD schools. Communication and collaborative relationships are fostered between the CCSD Mental Health Transition Team and a) local hospitals, b) parents/families, and c) individual schools for the benefit of returning students (e.g., promoting the development of individualized reentry plans for transition services and supports). For the 2015-2016 school year, the Mental Health Transition Team processed requests for assistance involving 1,485 students. Nearly 45% of those students had received the clinical diagnosis of major depressive disorder upon hospitalization.

- **Objective 2.5 Expand Medicaid Program and blend/braid funding to expand substance abuse services.**
  Indicators: Increase in funding levels

CURRENT STATUS: No Progress. The Medicaid Program now credentials and reimburses providers of substance abuse services rather than the Division of Behavioral and Public Health. Medicaid changed provider qualifications for the substance abuse agency model to allow SAPTA certified providers without SAPTA funding to be Medicaid providers. Some substance abuse providers have experienced challenges over the past three years in transitioning to this new system of reimbursement. Although, DHCFP continues to work collaboratively with DPBG and SAPTA providers on this effort, Medicaid funding levels for substance abuse services have not significantly increased as a result of the transition.

During the first six months of Fiscal Year 2016, 158 youths received substance abuse services through the Medicaid Fee-For-Service program. Statewide, the number of youths aged 13-17 years receiving substance abuse services increased only slightly from 681 to 702 between FY 2014 and FY 2015. Substance abuse services were provided for only .8% of all Medicaid FFS clients in the first six month of FY 2016, while behavioral health services were provided for 8.4% of the pediatric FFS Medicaid population.

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

CURRENT STATUS: Some Progress. First, the partnership between the Clark County Department of Family Services and the Clark County Juvenile Justice DCFS continues to support the University School of Medicine Child and Psychiatric Fellowship program. Research has shown that the majority of physicians stay in the community in which they completed their Fellowship program. Second, UNLV has been approved to open a local school of medicine which will increase physicians in the

community and increase the capacity for integrated healthcare experiences for families in the community in the near future. In addition, the UNLV Mental and Behavioral Health Coalition has been working on additional methods to improve access and quality services through mental health workforce development in Nevada. For example, a survey was conducted to determine the barriers of graduate-level mental health students remaining in Nevada to practice in the community after graduation. The top five reasons for leaving include family, environment, going back to their home state, weather, and to continue education (i.e., pursue PhD in marriage and family therapy). While many of the top reasons for leaving may not be able to be addressed, some of the top reasons for staying included recognition of workforce shortage in Nevada, affordability of housing, and career sustainability. These features could be capitalized on to continue to grow multiple mental health professions in our community. Finally, there is discussion of revising the licensing process in the state during the 2017 legislative session which has the possibility to increase the number of providers in the community.

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

Phase 1/2/3 Objectives and Strategies

- **Objective 3.1 Implement 2-1-1 or 800 number for behavioral health system entry**
  Indicators: Numbers and types of calls to 1-800 number

  CURRENT STATUS: Minimal Progress. Nevada 211 was implemented in February of 2006 to provide free connection to critical health and human services information about local community resources. This service is available in a single statewide location that can be accessed via voice, text, and online. Although this system has been running for 8 years, the services provided are often inadequate and not kept up to date. The call center staff are not trained on all service areas therefore do not always know the appropriate referral sources, especially for behavioral health care needs, and the information available on the site is often out of date and incomplete. A well-functioning system that assists families in finding the appropriate services is needed and it is important that this service is different than a mere directory. Over the past two years, Nevada 2-1-1 has been taken over by the Financial Guidance Center and the website has gone over many revisions. Currently the home page of the website has a feature to assist families in searching for mental health resources. The mental health page also includes several main topics including counseling, assessment, and emergency services. While this is an improvement, when actually trying to access services, the search function has not been adjusted and therefore the connection to services remains lacking. In addition, the phone service does not offer information consistent to the website and individuals on the phone do not appear to have specific training in mental and behavioral health which would afford more comprehensive assistance to those who call. While Nevada 2-1-1 could provide the necessary framework to connect families to services, it remains a larger investment is needed in order for this system to provide accurate, complete, and current services available in local communities with regard to mental and behavioral health needs. So while progress has been made toward this goal, we still have a long way to go until this objective has been met.

- **Objective 3.2 Implement a cross-agency program of mobile crisis intervention services that will be available to divert youths in crisis from costly emergency rooms, inpatient care and juvenile detention by: (a) Re-structuring Medicaid's Mobile Crisis and Stabilization Policies to increase**

provider capacity; (b) Blending/braiding existing funds to implement a cross-agency contract for mobile crisis program for Medicaid, Child Welfare and Juvenile Justice involved youths; and (c) Expanding crisis intervention to all youths in crisis, including privately insured and uninsured.
Indicators: Decrease in youths accessing emergency rooms for psychiatric problems; decrease in inpatient psychiatric bed utilization

CURRENT STATUS: Substantial Progress. The expansion of DCFS's mobile crisis intervention program has increased the community's capacity to divert youths in crisis from costly emergency rooms, inpatient care and juvenile detention. Las Vegas was recently able to expand their Mobile Crisis response services to 24 hour per day/7 days per week, which has allowed for increased service delivery. The youth served have shown significant improvement in functioning, and nearly 85% of youth served through Mobile Crisis Response Team have avoided hospitalization.

In addition, The Harbor is a juvenile assessment center devoted to diminishing the number of juveniles in the juvenile justice system through early identification of risk and with early intervention. Youth are screened and referred to mental health services, substance abuse, and family supports and resources. This is a multi-agency effort with staff from Clark County Juvenile Justice Probation Services, Clark County Department of Family Services, DCFS Mobile Crisis/Mental Health, Clark County School District, medical professionals, Southern Nevada Adult Mental Health Services and the Nevada Division of Welfare and Supportive Services. The center is partnering with community services for longer term supports and services identified in the assessment process. This center has begun its operations, and has ongoing expansion plans.

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

  CURRENT STATUS: No Progress. The Commission has not yet developed policy or regulation.

- **Objective 3.4 Implement memorandum of understanding for standardized intake assessment, crisis management and service planning protocols across public and private providers and enhance Neighborhood Center Infrastructure to provide these services.**
  Indicator: Proportion of public and private providers adopting standardized tools

  CURRENT STATUS: Some Progress. In the spring of 2016, DCFS sponsored a two day planning session with Dr. John Lyons of the Praed Foundation, developer of the Child and Adolescent Needs and Strengths Tool (CANS). Stakeholders across Nevada were invited to participate in the development of a CANS specifically geared toward children in Nevada. Two versions were finalized, one geared toward the early childhood population and one for school age children. Trainings for providers were held in Reno and in Las Vegas. Successful completion of these trainings resulted in the certification of numerous providers as reliable raters of the CANS. Additional work submitted demonstrating an understanding of the use of the CANS in the treatment planning process resulted in numerous providers being considered "Super Users". This designation allows those providers to assist others to prepare for online certification. DCFS is using System of Care funding to consult with the Praed Foundation to develop an implementation plan for system wide use of the CANS in hopes that it can be used as a standardized assessment and assist in determining service intensity. This would result in smoother transitions for families moving between providers. Learning collaborative for CANS users would also be established under the implementation plan.

- **Objective 3.5 Coordinate intake, crisis intervention, service planning and service delivery across public and private providers at a neighborhood level, beginning with organized information and referral networks.**
  Indicators: Description of coordinated system; number of youth linked with crisis or other services

  CURRENT STATUS: ***No Progress.*** For fiscal reasons, Clark County Department of Family Services (CCDFS) centralized their staff rather than maintaining them at Neighborhood Care Centers. Instead, CCDFS staff continue to participate in scheduled child and family teams and other multidisciplinary collaborations at Neighborhood Care Centers and other locations. In addition, the CCDFS-contracted mental health providers maintain offices around the valley, to ensure client access to mental health services from various geographical areas. The CCDFS Family Clinical Program coordinates with DCFS Mobile Crisis Response Team (MCRT) to ensure sufficient crisis intervention and follow-up. CCDFS is also an active participant with the DCFS System of Care (SOC) Expansion Project to ensure adherence to the standards established by SOC.

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

Phase 1/2/3 Objectives and Strategies

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

  ***CURRENT STATUS: Minimal Progress*.** As authorized by NRS 433.317, the Commission and the three regional consortia have developed a "Children's System of Care Behavioral Health Subcommittee." This subcommittee is comprised of voting members from each Consortia and the Commission. The subcommittee is responsible for reviewing the service delivery plans from each regional consortium and developing a statewide plan for the provision of children's mental health services.

  The role of the regional/state consortia planned in DCFS's System of Care Expansion Grant is to help expand the availability of community based children's behavioral health services that are consistent with System of Care principles and values. They will do this by recruiting prospective providers, developing regional training capacity and providing training, developing the provider network in response to the findings of the gaps analysis and developing partnerships with state funded medical professional schools for the provision of services, fellowships, externships and internship programs.

- **Objective 4.2 Develop and implement a plan for local system management by: (a) establishing a formal relationship between CCCMHC and a system management entity; (b) establishing the role of the local system management entity in providing integrated case management, crisis intervention, provider networks, and intake/referral.**
  Indicators: Identification of funding support; contracts and/or Memorandums of Understanding

  CURRENT STATUS: No Progress. In 2015, the Mental Health Commission's Children's Behavioral Health System of Care Subcommittee worked in conjunction with the Governor's Council for Behavioral Health and Wellness to advocate for local governance. Since that time, discussions have

between Division of Child and Family Services and the Division of Healthcare Financing and Policy (DHCFP) have explored funding options and reimbursable activities under a potential local governance plan. These discussions will continue in 2017.

- **Objective 4.3 develop a partnership between the local system management entity, the CCMHC and the Statewide Family Network to facilitate the implementation of cross-agency training and other workforce development activities.**
  Indicators: Number of annual trainings, number and type of participants

  CURRENT STATUS: Some Progress. DCFS continues to receive funding through the Mental Health Block Grant to support community wide trainings. DCFS Children's Mental Health, Nevada PEP, community providers, and representatives of the CCMHC regularly collaborate to provide trainings and workforce development activities. The Accountability and Workforce Development Workgroup of the State Consortium is attended by members of diverse groups including child welfare, representatives from juvenile justice, community providers, Nevada PEP, and DCFS Children's Mental Health. This workgroup receives reports concerning collaborative efforts to educate the community and workforce. Through these partnerships, training has been provided in Clark County on the following evidence-based programs, including: Parent-Child Interaction Therapy, Motivational Interviewing, Solution Focused Brief Therapy, Trauma Informed Care, Wraparound, Systems of Care, Positive Behavior Supports, Suicide Prevention, and Family Check-Up. Other partnerships between DCFS and the Statewide Family Network include collaborating to provide System of Care and Wraparound Training, participating on interview teams and in training new hires. Through System of Care Expansion Grant, local community providers will be trained in in High Fidelity Wraparound as well as SOC values and principles.

- **Objective 4.4. With active participation from the Governor's Council on Behavioral Health and Wellness, the DHHS Director, the Clark County Manager, families and other key stakeholders, the CCCMHC will identify: (1) The full array of services needed to meet the needs of children with serious emotional disturbance; and (2) A local approach to service delivery that is based on proven family-driven, system of care principles.**
  Indicator: Integrated management structure; Memorandums of Understanding

  CURRENT STATUS: Minimal Progress. The SOC Providers Standards and Evidence Based Practices workgroup of the Children's Behavioral Health Subcommittee has begun to identify the current Nevada behavioral health service array as well as a current list of available evidence based practices. DCFS has utilized funding from its System of Care Expansion Grant to contract with Hydaker Consulting who has completed a SOC Readiness Implementation Survey and also with Strategic Process, who has completed a Nevada Gaps Analysis. We plan to use these two documents to best identify the most needed children's behavioral health services and any gap in our current service array. The SOC will then work on funding solutions to best meet these needs

- **Objective 4.5. Redeploy cost savings from deep-end services to expand role of system management to coordinate information and referral for all children with behavioral health problems.**
  Indicator: Increase in number and types of children and families screened, referred and linked with services.

CURRENT STATUS: Some Progress. DCFS Children's Mental Health, through the System of Care Grant, has begun planning and implementation on shifting its role from that of a direct care provider to a role of providing training, oversight, and assistance to agencies providing home and community based services. In addition, DCFS has begun the process of shifting its service array to that of "front end" assessment, referral and case management, as well as "safety net" services. For example, DCFS has already redeployed some of its staff to the Harbor Juvenile Assessment Center and used others to expand the capacity of the Mobile Crisis Response Team.

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

  CURRENT STATUS: No Progress. Targeted Case Management continues to be available only to Fee for Service Medicaid clients through a State or County entity, and efforts are not coordinated at a local management level.

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

  CURRENT STATUS: Some Progress. As previously discussed in Objective 3.4, DCFS is proposing that the Nevada Child and Adolescent Needs and Strengths tool (NVCANS) be adopted by community providers as a standardized assessment and service intensity instrument. An implementation plan will be presented to the state consortium in order to garner statewide support for this proposal. As the role of DCFS transitions to a safety net provider, assessment center, and utilization management entity, efforts will be made to create agreements with providers as outlined in the System of Care Subcommittee's Strategic Plan.

- **Objective 4.8 Through the local system management entity, develop performance-based contracts with providers linking standards of care, outcomes and reimbursement.**
  Indicators: Written standards and policies, provider contracts, performance and outcome reports

  CURRENT STATUS: Some Progress. The Department of Family Services (DFS) and the Department of Juvenile Justice Services (DJJS) formed a partnership to establish higher standards of care than required by Medicaid for the Mental Health Rehabilitative services of Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR) that are provided to the children and families served by these agencies. Providers of BST and PSR services submit applications and complete a vetting process that links standards of care and outcomes in order to become Approved Providers. All providers are already established Medicaid providers so reimbursement is not linked.

  DCFS's System of Care Expansion Grant project has established an objective for the third year of funding (10/2017-2018) to develop performance-based contracts with publicly-funded providers of children's behavioral health services.

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

Phase 1/2/3 Objectives and Strategies

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

  CURRENT STATUS: Minimal Progress. In accordance with Assembly Bill 386 (AB386), the Clark County School District completed a successful pilot project for general mental health screening of middle school students during the 2013-2014 school year. Students with parental consent at two middle schools were screened using the Behavioral and Emotional Screening System (BESS) for the initial screening and the Behavior Assessment System for Children (BASC-2) as a follow-up for children identified at-risk. School personnel met individually with the parents of children who need referrals for school-based or community-based interventions. Although the program proved successful in linking students with needed services, the district lacks the infrastructure and funding for full implementation of the model in secondary schools throughout Clark County.

  Each middle and high school throughout the district has available to them the Signs of Suicide Program screening materials, giving staff the ability to implement screening for selected students when circumstances warrant the need. If a student is suspected of experiencing suicide ideation, CCSD's Suicide Intervention Protocol also provides well-established procedures for assessment and immediate intervention. In the 2015-2016 school year, specially qualified school personnel conducted structured interviews with at least 2100 identified secondary school students and their families across the district and its sponsored chartered schools consistent with the Suicide Intervention Protocol.

- **Objective 5.2 Develop and implement school-based screening programs for elementary school children.**
  Indicators: Number of elementary school children screened annually and number linked to services

  CURRENT STATUS: Minimal Progress. The Clark County School District (CCSD) does not conduct district-wide universal screening for students' social/emotional/behavioral functioning.

  However, CCSD does have well-established procedures (Suicide Intervention Protocol) for the assessment of and immediate intervention with, elementary and secondary school students who are suspected of suicidal ideation. For the 2015-2016 school year, specially qualified personnel conducted structured interviews with at least 753 identified elementary students and their families across CCSD and CCSD-sponsored charter schools as part of implementing the district's Suicide Intervention Protocol.

- **Objective 5.3 Develop and implement standards and reimbursement incentives for screening in primary care settings.**
  Indicators: Proportion of physicians using standardized tool

  CURRENT STATUS: Minimal Progress. With the implementation of the Affordable Care Act, primary care physicians must be reimbursed for behavioral health and other preventative screenings

provided to children and youth. Even prior to the implementation of ACA, Nevada Medicaid reimbursed providers for children's behavioral health screenings under the EPSDT program. The Nevada Division of Health Care Financing and Policy continues to educate providers on reimbursement for screenings though the Medicaid EPSDT Program

There are no Nevada data on the extent to which pediatricians and primary care physicians are currently being reimbursed by other benefit programs for behavioral health screenings and whether they are using standardized tools recommended for best practice such as the Pediatric Symptom Checklist developed by the American Academy of Pediatrics.

- **Objective 5.4 Through education funding, implement evidence-based preventative programs for bullying prevention, social/life skills training, and positive behavioral supports in public schools by (a) inventorying current programs; and (b) expanding successful programs.**
  Indicators: School policies and/or regulations; number of schools with programs and number of students participating

  CURRENT STATUS: Substantial Progress. An assortment of programs and professional learning opportunities are provided within the Clark County School District in alignment with Policy 5137, Safe and Respectful Learning Environment (SRLE). Multiple divisions and departments within the district are engaged including the Equity and Diversity Education Department, the Education Services Division, the Educational Opportunities Unit, and the Student Services Division. Basic services/supports are already established including periodic revisions to district policy and regulations related to SRLE and the operation of a website for anonymous reporting of bullying (n = 7,630 reported incidents of bullying in 2015-2016). Various trainings related to SRLE are regularly provided (e.g., mandatory bullying awareness/sensitivity training for all employees; mandatory administrator training on discipline procedures related to bullying; best practices for promoting positive behavioral interventions and supports in schools). For example, 30,706 district employees viewed the mandatory assigned curriculum for SRLE in 2014-2015, and 35,807 district employees viewed the mandatory assigned curriculum for SRLE in 2015-2016.

  Recent district efforts have increasingly focused on the expansion of successful programs related to anti-bullying, social skills training, and positive behavioral interventions and supports. For example:

  - 45 CCSD schools are currently completing their first year of training for School-Wide Positive Behavioral Interventions and Supports (PBIS) following the model endorsed by the National Center for Positive Behavioral Supports (School Climate Transformation Grant).
  - All CCSD Early Childhood Special Education programs are aligned with practices endorsed by the Technical Assistance Center on Social Emotional Intervention (TACSEI).
  - 25 CCSD schools are currently completing their third year of training for "Operation Respect/Welcoming Schools" that focuses on social-emotional learning for students.
  - The Sanford Harmony curriculum for social emotional learning is currently being implemented in 80 elementary CCSD schools (i.e., within elementary curriculum and/or the early childhood special education programs).
  - !30 mental health providers, predominantly licensed social workers, have been placed in 73 CCSD schools (SB 515).
  - HOPE2 school grants offered by the Education Services Division have supported licensed school social worker support for an additional 23 CCSD schools as well as positive school climate initiatives in 84 CCSD schools.

- The Equity and Diversity Education Program helps track and support the implementation of a variety of other character education and social emotional learning programs in CCSD schools (e.g., 7 Habits of Happy Kids, Capturing Kids Hearts, Coping Skills k-12, Kelso Choices, Love and Logic, etc.).

Future efforts within the district are expected to involve greater expansion of successful programs as well as greater integration of these services within school-based, multi-tiered systems of support for academics, behavior, and social-emotional functioning.

- **Objective 5.5 Education and support will be available to parents of at-risk pre-kindergartners at local elementary schools using an evidence-based model.**
  Indicators: Number of schools and participants

  CURRENT STATUS: No Progress. The Clark County School District has no plans as yet with respect to this objective. School-based Response to Instruction (RTI) team services are already available to students in those schools that operate Title I preschool programs. Early Childhood Special Education programming and services continue to be provided in CCSD elementary schools across the district.

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

  CURRENT STATUS: Substantial Progress. The Clark County School District (CCSD) continues to provide training to key school personnel for suicide intervention and early prevention. First, all CCSD school counselors, school nurses, school psychologists, and school social workers (i.e., standing members of school-based intervention teams for mental health) have been trained in the District's Suicide Intervention Protocol, which centers on structured interviews with students and parents for confirmation of risk and estimation of level of risk for self-harm in individual students. Ongoing, standardized training in the Suicide Intervention Protocol is provided through the Department of Student Threat Evaluation and Crisis Response, Psychological Services, with recent expansion of this training to include new school administrators. Training for the functional development of school-based intervention teams continues to be provided by the CCSD Mental Health Transition Team, Psychological Services. Second, the district has continued to utilize its Project Aware federal grant to enable training with local adults in the Youth Mental Health First Aid (YMHFA) Program. YMHFA enables adults to better detect and respond to mental illness in school age children, and to encourage youth and their families to seek treatment. Through the Office of Suicide Prevention, Project Aware federal funding will continue to support these efforts.

- **Objective 5.7 Families will have regular access to effective, low cost parent training and education programs at neighborhood-based locations across the county.**
  Indicators: Number of sessions and participants annually.

  CURRENT STATUS: Substantial Progress. Nevada P.E.P. provides parent education workshops and webinars for families of children at-risk of and with mental health needs. In 2016, Nevada P.E.P. conducted 25 workshops covering Positive Behavior Interventions, Bullying and Attention Deficit Hyperactivity Disorder, with a total of 244 parents attending the trainings.

  The Clark County Department of Family Services (DFS) provides over 200 parent education programs yearly throughout Clark County to over 3,000 parents, caregivers and youth, using evidence-based curricula such as the Triple P Program for children aged 2-11 years, the Teen Triple P

Program, and the Stepping Stones Triple P Program for parents of children with a disability. Families can access the Primary Triple P Program of brief 1-to-1 parenting consultations as well as the group programs. Through their Parenting Project, DFS also provides evidence-based programs for high-risk families, which include: Nurturing Parents and Families for parents of children six months through four years of age, the ABCs of Parenting for parents of children aged 5-10 years, the Nurturing Skills for Families in Substance Abuse Treatment and Recovery, the Baby care Program for expectant and new parents, and the Staying Connected with Your Teen program for parents and youth aged 11-17 years.

The Nurturing Parent Program for high-risk families is also provided by the Salvation Army in Mesquite, and the Nevada Communities Prevention Coalition contracts with private providers in other rural areas to conduct Active Parenting classes. Other parent education programs are offered by the UNLV Institute for Children's Research and Policy through its Prevent Child Abuse Nevada project. Other organizations providing low-cost or free parent education include: East Valley Family Services, Dignity Health at St. Rose Dominican Hospital, Bridge Counseling, UNLV Educational Outreach, Family Solutions, and Palo Verde Child & Family Services.

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

CURRENT STATUS: Some Progress. Clark County Department of Juvenile Justice Services continues to provide screenings on 100% of youth who are detained. For the calendar year of 2013, 3,043 youth were detained and screened with the Massachusetts Youth Screening Instrument –Second Version (MAYSI-2). In Calendar Year 2015, 2,848 youth were detained and screened. It is believed that 336 screenings were completed on Field Probation youth for 2013. In addition, in calendar year 2015, 595 youth at the Probation Intake level were screened through the Substance Abuse Assessment and Referral Program (SAARP) utilizing the Problem Oriented Screening Instrument for Teenagers (POSIT).

Clark County Department of Family Services completes a screening related to mental health (including suicide risk), domestic violence, and substance abuse for all children at the time that they enter Child Haven. Case managers gather information on mental health needs at the time of removal and at each subsequent change of placement. Identified concerns and treatment needs are also provided to the caregiver at that time.

- **Objective 5.9 Use Medicaid funding to expand outreach and early screening to at-risk groups through school-based health clinics and primary care clinics.**
  Indicators: Annual Medicaid expenditures for Clark County outreach and screening

CURRENT STATUS: Minimal Progress. The Nevada Division of Public and Behavioral Health has revised its credentialing policies for school-based health centers to include standards for the provision of mental health screening and services, however, no data are available on the utilization of early screening services in school-based health centers and primary care clinics.

There are currently six school-based providers in Clark County that provide primary care services and receive Medicaid reimbursement, either as a School-Based Health Center or a Federally Qualified Health Care Center.

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

  CURRENT STATUS: Some Progress. The Division of Child and Family Services (DCFS) Youth Parole Division and the Clark County Department of Juvenile Justice Services (DJJS) provide Shields of Care training to their staff. Clark County Juvenile Justice Services also provides in-house training to probation officers that includes a Shields of Care--Suicide Prevention class that addresses behavioral health issues and suicide prevention and is POST-approved. In 2015, probation officers referred 4,721 youth for evaluation by clinical services' staff, a 107% increase over 2014.

  County Department of Family Services offers training opportunities to staff and caregivers on various children's mental health topics. Training topics include: Mood Disorders in Young Children; Failure to Thrive and Child Neglect; Attachment Issues of Childhood: An Overview; Introduction to Infant & Early Childhood Mental Health; ADHD, Anxiety & Sensory Deficits in Young Children; and Drug Exposed Babies.

  Through the Nevada State Office of Suicide Prevention, Suicide GateKeeper Train the Trainer course has been developed to assist foster care agencies in providing evidence-based suicide prevention training to their foster parents. Suicide Alertness training (safeTALK) is available to all community members at least once a month. The safeTALK class is evidence-based and certified for continuing education credits in many disciplines. AB 93 which requires Behavioral Health professionals in the state of Nevada to take at least two credit hours in suicide prevention has sparked increased attendance in the SafeTALK course. Applied Suicide Intervention Skills Training (ASIST) is available in Clark County four times yearly and also meets the AB 93 Mandate. The attendance by child welfare, juvenile justice and foster parents has increased considerably over the past year due to AB 93 and the increase in required foster parent annual training hours. Youth Mental Health First Aid also covers this requirement for two hours of Suicide Prevention training.

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

Phase 1/2/3 Objectives and Strategies

- **Objective 6.1 Establish state or local funding for Continued Public Awareness Activities**
  Indicators: Number, type and outcomes of awareness activities yearly

  CURRENT STATUS: Some Progress. CCCMHC has supported awareness activities through approximately $1500 from its yearly budget of state general funds. Yearly awareness activities have been centered on the National Children's Mental Health Awareness Day each May. These activities are coordinated by the CCCMHC's Public Awareness and Behavioral Health Workgroup. The workgroup has also created a website (CCCMHC.org) to use for promoting awareness of children's behavioral health needs and services.

  Funding from DCFS's System of Care Expansion Grant will be allocated to create a website and a newsletter promoting SOC principles and practices as well as grant activities.

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

Indicators: Nevada Department of Education Regulations

CURRENT STATUS: Minimal Progress. NRS 389.021 requires the establishment of regulations for study in the prevention of suicide. Nevada Department of Education regulations (NAC 389.455) include the avoidance of self-harm as a requirement of the high school curriculum but do not include mental health awareness and suicide prevention as required curriculum components. However, the Clark County School District has voluntarily incorporated suicide prevention awareness into its secondary school health classes by requiring the implementation of the Signs of Suicide Educational Program. This program teaches youth to "acknowledge, care, and tell someone" if they or a friend have feelings of depression or thoughts of suicide. Additionally, the Department of Education has partnered with the Office of Suicide Prevention and the school district to bring Safe Talk and Youth Mental Health First Aid training to school staff as well as adults that work with youth in other settings across the state. Training in these areas enable adults to better detect and respond to mental illness in school age children, and to encourage these youths and their families to seek treatment.

NRS 388.172 does require each Nevada school district to conduct a training program for administrators in suicide associated with bullying and cyber-bullying and appropriate methods to respond to incidents of violence or suicide.

- **Objective 6.3 CCCMHC will work with professional associations, Southern Nevada Health District, and Nevada PEP to support the development and dissemination of mental health awareness information to parents at primary care settings.**
  Indicators: Proportion of primary care facilities with available materials

***CURRENT STATUS*: *Some Progress*.** CCCMHC members conduct ongoing outreach to increase the awareness of children's mental health needs in Clark County. Nevada PEP continues to support the dissemination of suicide prevention awareness brochures and other materials at local health fairs and through media outlets. The Southern Nevada Health District uses its website to promote children's mental health awareness materials produced in collaboration with the CCCMHC. In 2016, the Office of Suicide Prevention in conjunction with the Nevada Coalition for Suicide Prevention directly reached 7,100 community members through 163 separate events in Southern Nevada. Each year, members disseminate the most recent findings of the CCCMHC to local advocacy and professional organizations such as the Nevada Psychological Association and the Children's Advocacy Alliance as well as to local and state policy makers, and members of the judiciary.

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

Current Membership

Dan Musgrove, Chairperson
Business Community Representative

Amanda Haboush-Deloye, Ph.D., Vice-Chairperson
Children's Advocate Representative

Ryan Gustafson, Secretary
Nevada Division of Child and Family Services

Jennifer Bevacqua
Nevada Youth Care Providers Association

Leslie Brown
Nevada Division of Aging and Disabilities Services

Richard Egan
Nevada Office of Suicide Prevention

Charlene Frost
Parent Representative

Jacqueline Harris
Provider of Substance Abuse Services

Deepa Hasija, M.D.
Psychiatric Community Representative

Terri Keener
Clark County Family Services

Jessica Johnson
Southern Nevada Health District

Heather Lazarakis
Nevada Division of Health Care Financing & Policy

Karen Miller
Parent Representative

Donna Smith
Foster Parent Representative

Karen Taycher
Nevada Parents Encouraging Parents

Robert Weires
Clark County School District

Cheri Wright
Clark County Juvenile Justice Services

Mission

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

The CCCMHC's 10-Year Strategic Plan

is available on the DCFS website at: http://dcfs.nv.gov/Meetings/CCCMHC

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VI. REFERENCES

Agency for Healthcare research & Quality, Health Care Innovations Exchange (2013). ***Service delivery innovations profile: 24-Hour mobile mental health crisis team reduces hospitalization for children with complex behavioral and emotional needs***, U.S. Department of Health and Human Services. http://www.innovations.ahrq.gov/content.aspx?id=1719.

Azeltine, R.H., & DeMartino, R. (2004). An outcome evaluation of the SOS suicide prevention program***. American Journal of Public Health***, 94, 446-451.

Beck, A.J. (2016). Opportunities for Strengthening Behavioral Health Workforce Capacity in Nevada. Presented at the ***Nevada Statewide Workforce Development Forum.*** Las Vegas, NV: UNLV Lincy Institute, October 7, 2016.

Brune, N.E. & Carreon, V. (2014). ***Mental health governance: A review of state models and guide for Nevada decision makers.*** Las Vegas, NV: Guinn Center for Policy Priorities.

Bruns, E.J., Suter, J.C. (2010). Summary of the wraparound evidence base. In E. J. Burns & J.S. Walker (Eds.), ***The Resource guide to wraparound***. Portland, OR: National Wraparound Initiative.

Centers for Medicare & Medicaid Services (2013). Coverage of behavioral health services for children, youth, and young adults with significant mental health conditions. May 7, 2013***. Joint CMCS And SAMHSA National Bulletin***. http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07- 2013.pdf.

Clark County Children's Mental Health Consortium (2010). ***10-Year strategic plan: 2020 vision for success***. Las Vegas, NV.

Clark County Children's Mental Health Consortium (2014). **2014 service priorities**. Las Vegas, NV.

Cooper, J.L. et al. (2007). ***Child and youth emergency mental health care: A national problem***. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

Denby, R. et al. (2013). ***How are the Children: Challenges and opportunities in improving children's mental health.*** Social Services Series No. 1. The Lincy Institute at the University of Nevada Las Vegas.

Dvoskin, J.A. (2014). ***State of Nevada Governor's Advisory Council on Behavioral Health and Wellness proposed council recommendations.*** Carson City, NV: Nevada Division of Health and Behavioral Health.

Frankenberger, D., Clements-Nolle, K., Zhang, F., Larson, S., & Yang, W. (2014***). Nevada Youth Risk Behavior Survey (YRBS): Clark County analysis***. Reno, NV: University of Nevada, Reno.

Greenway, J. (2017). Personal Communication. ***Center for Health Information Analysis***, University of Nevada, Las Vegas.

Husky, M.M., Sheridan, M., McGuire, L., & Olfson, M. (2011). Mental health screening and follow-up care in public high schools. ***Journal of the American Academy of Child & Adolescent Psychiatry***, *50*, 881-891.

Mental Health America (2016). ***Prevention and early intervention B4Stage4: The state of mental health in America 2016.*** Alexandria, VA: Mental Health America.

Nevada Division of Child and Family Services (2005). ***Final Report of the Neighborhood Care Center Project***. Carson City, NV: Division of Child and Family Services.

Pires, S.A. and Mayne S. (2009). ***Report on behavioral health spending for children and adolescents in Nevada Across public child-serving systems***. Washington, DC: Human Service Collaborative.

Pires, S.A. et al. (2013). ***Identifying opportunities to improve children's behavioral health care: An analysis of Medicaid utilization and expenditures.*** Faces of Medicaid Data Brief, December 2013). Center for Health Care Strategies. http://www.chcs.org.

Simons, D. et al. (2014). ***Intensive care coordination using high-quality Wraparound for children with serious behavioral health needs: STATE AND COMMUNITY PROFILES.*** Hamilton, NJ: Center for Health Care Strategies, Inc.

Stagman, S. & Cooper, J.S. (2010). ***Children's Mental Health: What every policymaker should know.*** New York: National Center for Children in Poverty, Columbia University Mailman School for Public Health.

Stroul, B.A. et al. (Eds.) (2008). ***The System of Care Handbook***. Baltimore, MD: Brookes Publishing Company.

Stroul, B. et al. (2014). ***Return on investment in systems of care for children with behavioral health challenges.*** Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2007***). Promotion and prevention in mental health: Strengthening parenting and enhancing child resilience***. DHHS Publication No.CMHS-SVP-0175. Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2013). ***Behavioral health, United States, 2012***. HHS Publication No. (SMA) 13-4797. Rockville, MD: Substance Abuse and Mental Health Service Administration.

Valley, Jackie (2015, 6 December). Children in crisis: Pediatric mental health "The Polio of our generation. ***Las Vegas Sun***, pp. 1, 8-9).

Valley, Jackie (2015, 20 December). Children in crisis: Here's how we can do better on mental health care. L***as Vegas Sun***, pp. 1, 8-9.

Watson, L. & Marschall, K. (2013). ***Comprehensive gaps analysis of behavioral health services***. Carson City, NV: Nevada Department of Health and Human Services, Division of Public and Behavioral Health.