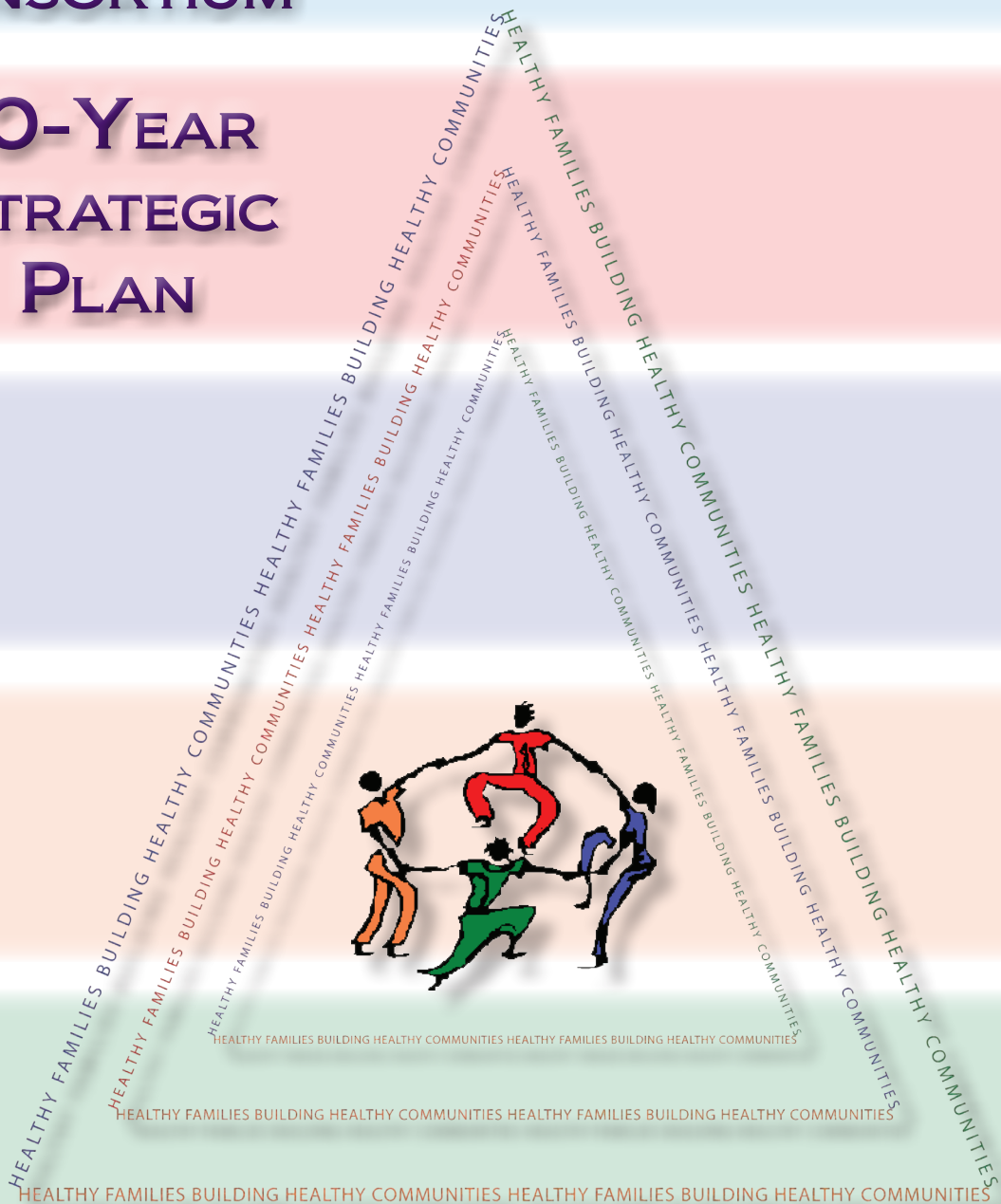


CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

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





ACKNOWLEDGEMENTS

On behalf of the Clark County Children’s Mental Health Consortium, I would like to thank the following consortium members, family members, community providers and other stakeholders who participated in a workgroup over the last six months to develop this plan. These individuals have worked tirelessly to identify the needs of our community and craft solutions that will help us meet our goals. They are:

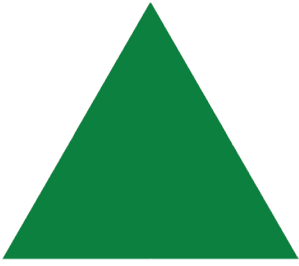
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I would also like to thank the Nevada Division of Child and Family Services and Nevada Parents Encouraging Parents for providing in-kind support to the planning process. Special thanks goes to Karen Taycher of Nevada Parents Encouraging Parents for her leadership as chair of the planning workgroup. The development of this comprehensive plan would not have been possible without the work of Dr. Christa Peterson, consultant to the CCCMHC, and the administrative support of Julie Alston, Division of Child and Family Services.

Financial support for the planning process and preparation of this report was provided by Nevada’s Child and Adolescent State Infrastructure Project (CA-SIG). The Nevada CA-SIG is funded through the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Grant no. 1 HS5 SM56551.

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January 31, 2010





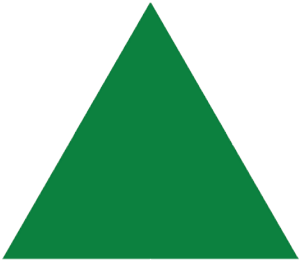
EXECUTIVE SUMMARY

The Clark County Children’s Mental Health Consortium has developed this 10-Year Strategic Plan to guide our community in providing mental health services to children with emotional disturbance and their families as required by Nevada Revised Statutes 433B.335. This 10-year strategic plan represents a commitment to all children in Clark County and their families, who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic. The Clark County Children’s Mental Health Consortium has recognized that the extreme challenges faced by children with behavioral health problems and their families can only be overcome by strategic and sustained planning efforts to develop a more effective system of care for these children.

Facing the current economic times and the failure of the current system of care for Clark County’s children, now is the time for parents, policymakers, and professionals to come together and support a change in approach to behavioral health service delivery. This plan is based on a set of values and principles that promote a system of care that is community-based, family-driven and culturally competent. Using a public health approach and a neighborhood-based model of service delivery, this plan will achieve the following long-term goals for Clark County by the year 2020.

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 recognition of the broad scope of this 10-year strategic plan, the consortium has identified priorities for the next biennium. The following strategies provide the most short-term, cost effective improvements in the system, while serving as building blocks for the long term plan.

Priorities

- ▲ **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.**

Identified Needs: Failure of current policy and funding strategies to improve access and quality of services promote positive outcomes for children with the most serious problems; and strengthen families’ ability to care for their children. Identified as a top priorities by Clark County’s families, caseworkers, and providers.

Desired Outcomes: Fewer children in out-of-home care; policies and standards that promote appropriate community-based care; cost-savings from inefficient and ineffective programs; positive clinical, school, and community outcomes for children.

- ▲ **Provide mobile crisis intervention and stabilization services to Clark County youths in crisis.**

Identified Needs: Increasing numbers of youth in crisis entering local emergency rooms and pediatric hospitals; increasing number of youths in crisis identified during school hours; high readmission rates for psychiatric hospital and other institutional care.

Desired Outcomes: Effective, responsive treatment for youths in crisis and their families; decrease in utilization of local hospitals for youth psychiatric emergencies; decrease in utilization of psychiatric inpatient care and other out-of-home placements; cost savings.

- ▲ **Expand access to neighborhood-based, financial supports and intensive services for Clark County’s children with serious emotional disturbance who are living with their families.**

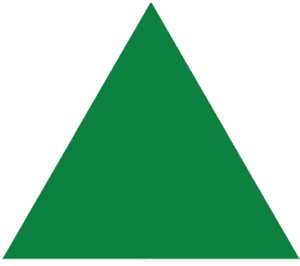
Identified Needs: Lack of access to these services for children with serious emotional disturbance who are living with their families; high use of out-of-home placements in the child welfare and/or juvenile justice systems for these children; identified as a priority by Clark County families, caseworkers and providers.

Desired Outcomes: Improvements in home, school and community functioning for children with serious emotional disturbance; reduction in need for out-of-home Placements; reduced costs for foster care and other placements.

- ▲ **Expand access to family-to-family support services for the families of Clark County’s children with serious emotional disturbance.**

Identified Needs: Increasing number of families requesting family-to-family support each year; identified as a priority by Clark County families, caseworkers and providers

Desired Outcomes: Improved access to services through family support and education; improvements in home, school, and community functioning for youths with serious emotional disturbance; decreased stress for families; improvement in families’ ability to care for their children.



^ **Expand access to intensive care management using a wraparound model for youth with serious emotional disturbance, including those involved with the juvenile justice system and those living with their families.**

Identified Needs: Lack of access to intensive, effective case management, especially for youths in the juvenile justice system and those living at home.

Desired Outcomes: Reduction in symptoms and improved functioning at home, in school and in the community; fewer re-offenses and improved community safety; reduced costs for out-of-home placement and institutional care.

^ **Support early childhood preventative programs that strengthen families' ability to promote the social and emotional development of their children.**

Identified Needs: Large numbers of young children with risk factors for behavioral health problems, such as diversity, poverty, maltreatment and homelessness; identified as top priority by Clark County families, caseworkers, and providers.

Desired Outcomes: Reduced need for special education and treatment upon entering school; decrease in later involvement with juvenile justice; cost savings to a variety of public systems.

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

Identified Needs: Failure to identify school students with emerging behavioral health needs; lack of access to early treatment for students identified with behavioral health problems; large number of students in crisis.

Desired Outcomes: Earlier access to treatment; better academic and social functioning for students identified and treated; improved identification of youths at risk of suicide; reduced need for special education services; cost savings.

The Clark County Children's Mental Health Consortium will work tirelessly to implement this plan in partnership with the Nevada Department of Health and Human Services, the Nevada Mental Health and Developmental Services Commission, and other community partners and families.

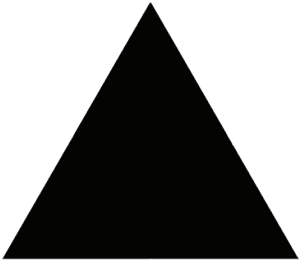


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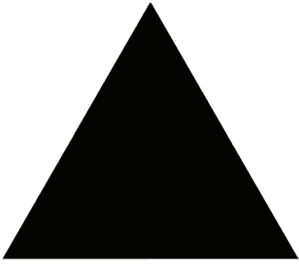


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INTRODUCTION

Overview

The Clark County Children’s Mental Health Consortium has developed this 10-Year Strategic Plan to guide the community in providing mental health services to children with emotional disturbance and their families as required by Nevada Revised Statute 433B.335. This 10-year strategic plan represents a commitment to all children in Clark County and their families, who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic.

The Surgeon General’s National Action Agenda(2001) first highlighted the fact that the U.S. has no coordinated behavioral health system for children. While services may exist for children, they are fragmented and very difficult for families to navigate. Families of youth with behavioral health disorders face a daunting task in obtaining needed services for their children. In one study, 48% of parents reported they had to quit work to care for their children, and 27% indicated that their employment had been terminated because of work interruptions due to care responsibilities(Rosenzweig et al., 2004).

Across the nation, a variety of funding sources and complex funding mechanisms support the delivery of children’s behavioral health services in communities like Clark County. Children’s behavioral health care funding is minuscule as compared to total healthcare spending, disproportionately small as compared to adult mental health funding, and out of sync with best practices favoring community-based care over residential treatment. The current state and national expenditure patterns fail to address the needs of identified children as well as those at risk for mental health problems(Cooper et al., 2008). Nevada ranks well below the national average in per capita public mental health spending (Pires, 2009) and Clark County spends proportionately less than the other regions to provide children’s mental health care. It has been shown that overall child-welling is linked to public mental health spending levels (Annie E. Casey Foundation, 2005).

On a federal, state, and local level, the challenges faced by children with behavioral health problems and their families can only be overcome by strategic and sustained efforts to develop effective systems of care for these children. **The purpose of this plan is to launch those efforts by providing:**

- ▲ An overall vision and goals for a behavioral health system of care in Clark County,
- ▲ A description of the needs of Clark County’s children for behavioral health services,
- ▲ Identification of the obstacles preventing children and families from accessing needed services,
- ▲ A set of objectives and strategies for overcoming obstacles and realizing the vision,
- ▲ Priorities and costs for the behavioral health system.

Since its inception in 2001, the CCCMHC has extensively studied the needs of our community’s children. Our members have worked tirelessly to craft solutions to improve services and outcomes for our children. This 10-year plan is driven by the vision, goals, and principles described below. Our plan strives to meet the needs of an estimated 118, 830 children in Clark County with behavioral health problems, as well as the 38,942 of those children who suffer from serious emotional disturbance. Recognizing that children’s mental health is a public health crisis, we include universal strategies for promoting the emotional health and well-being of all children and families in our community.



Children’s Mental Health

Characteristics of the “Next Generation” System

- ▲ Flexible Funding for rapid response to new practices
- ▲ Attention beyond children with SED to those at risk
- ▲ Dedicated Funding for Prevention and Early Intervention
- ▲ Increased supports for all parents and families
- ▲ Implementation of system of care values
- ▲ Attention to quality, culturally competent services
- ▲ Increased workforce capacity
- ▲ Data-driven clinical and administrative decision-making
- ▲ Increased attention to functional outcomes for children
- ▲ Integrated delivery systems

Adapted from Cooper et al (2008)

Vision and Goals

The Clark County Children’s Mental Health Consortium Vision for 2020 is that:

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

In order to realize the vision, this plan is designed to accomplish the following 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.*

Guiding Philosophy for the System of Care

The Clark County Children’s Mental Health Consortium supports a systems of care philosophy of service delivery. A “Systems of Care” philosophy crosses agency and program boundaries, and approaches the services and support requirement of families holistically (Pires, 2002). A system of care is a “comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families” (Stroul et al., 1986). Core values of a system of care specify that services should be community based, child centered and family focused, and culturally competent. The guiding principles of the system of care philosophy dictate that service should be:

The guiding principles of the system of care philosophy

- ▲ Comprehensive, with a broad array of services
- ▲ Individualized to each child and family
- ▲ Provided in the least restrictive, appropriate setting
- ▲ Coordinated both at the system and service delivery levels
- ▲ Involve families and youths as full partners
- ▲ Focused on early identification and intervention (Stroul, 2002)

In concert with this nationally recognized guiding philosophy, the CCCMHC embraces the Values and Attributes of the Nevada Children’s Behavioral Health Consortium.

Values and Attributes of the Nevada Children's Behavioral Health Consortium

Family Driven: Families have a key-decision role in the care of their own children as well as in policies and procedures governing care for all children in their own community, state, and tribe. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; and determining the effectiveness of all efforts to promote the mental health and wellbeing of children and youth.

Youth Guided/Youth Directed/Youth Driven: Recognizes that youth must be heard and listened to but that in order for their full, authentic involvement we must provide them with tools and opportunities to participate in the process.

Strengths-based: Recognizes and builds upon each family's unique strengths which are the cornerstone for immediate and future success.

Comprehensive Array of Traditional and Non-traditional Services: Includes the full range of services and supports from public and private agencies, and the community. Non-traditional services can include, but are not limited to, recreation, faith-based, and the performing arts. These services must be accessible in a timely and meaningful manner to support positive outcomes for families.

Common Intake and Assessment: Commitment by all partners to the collection of common information that with proper consent can be shared across systems.

Outcomes, Evaluation, and Quality Improvement: Outcomes are evaluated at the individual, agency, and system levels to measure the quality of care. Results from evaluation and quality improvement processes are used to make decisions and to guide policy making. Evaluation and quality improvement activities include:

Evaluation and quality improvement activities

- ▲ How to best meet the needs of children, youth and families;
- ▲ Determining if services and supports are working and used;
- ▲ Determining the cost of services and supports;
- ▲ Assessing the need for additional resources and services;
- ▲ Providing feedback to those who provide services and information; and,
- ▲ Continually assessing the system of care's capacity to respond to feedback and implement change.

Evaluation and quality improvement aids in building a system of care by examining what we are doing and how we can do it better. The results of all evaluations and quality improvement activities are provided to families, system partners and community stakeholders.

Workforce Practices: Provides state-of-the art and effective organizational supports to workforce development initiatives and continuous improvement processes in service development and delivery. State of the art workforce development practices include an organizational culture which supports worker well-being, evidence based practice in recruitment, retention, and selection strategies, clinical supervision programs, mentoring, evaluation and goal setting, team building, organizational culture change management, and other related initiatives. The intention is to facilitate family and youth choice in achieving positive outcomes for children and families, and to support the service delivery system.

Culturally and Linguistically Competent/Responsive: Recognizes that every family has individual cultural values. Services are responsive with an awareness and respect of the importance of values, beliefs, traditions, customs, and parenting styles of families. Services also take into account the varying linguistic needs of individuals who speak different languages, have varying literacy skills, and who need a variety of communication formats.

Community-based Services and Supports: Afford families early intervention and services in the communities where they live. Such services and supports allow families to remain intact and recognizes that children, youth and families thrive in the context of their homes, communities and schools.

Public Health Approach to the System of Care

In partnership with families, our community members have come together to support a public health approach to children's mental health. Historically, local, state, and federal public health agencies are responsible for monitoring and improving the overall health and well-being of children. The public health approach has been successful over the last twenty years in improving children's physical health through anti-smoking campaigns, promotion of seat belt and car seat use, and childhood obesity prevention programs.

The Surgeon General, Institute of Medicine, and Healthy People 2010 Initiative have recognized that children's mental health is as important as their physical health in achieving long-term well-being and success.

A recent Institute of Medicine report has stated “We cannot improve our overall health care system adequately unless we pay equal attention to addressing the issues surrounding mental and substance abuse disorders.” (National Research Council et al., 2009) In the past, children’s mental health services have been delivered using a medical model. Policies, services and funding have been focused only on children who have been identified with the most serious mental health problems.

The public health model has a broader and more balanced approach to delivery of services. The public health approach includes: (1) promoting good mental health and preventing problems for all children in the community, (2) providing early access to services for children who are starting to have mental health problems, and (3) providing intensive services to those children with the most serious mental health problems.

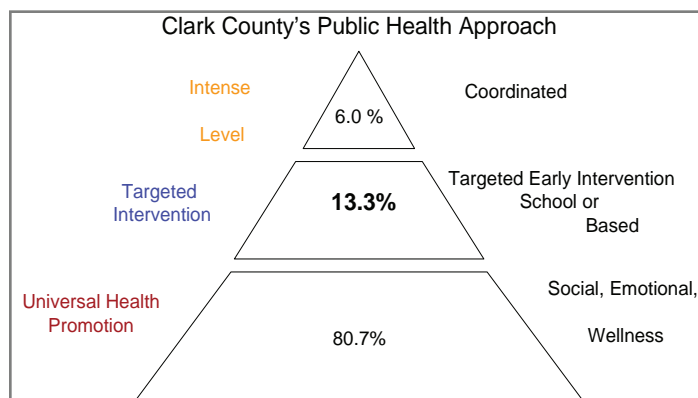


Figure 1. Clark County Service Delivery Approach. This diagram shows the community strategy to address the mental health needs of children in Clark County. For all children the strategy will be to provide community and school supports that promote social and emotional development and behavioral wellness. For 13.3% of the children, there will be additional in school based and neighborhood based targeted early intervention. For those 6% of the students with the most intense needs, services will be a coordinated through a collaborative care management entity.

The values of a public health approach are consistent with systems of care philosophy of family-driven, community based, and culturally competent services that are the foundation of the guiding principles for this plan. Both focus on all the needs of the child and family, and require cross-agency collaboration to be successful. Both focus on developing unique strategies for each community, rather than a “one size fits all” approach. Both models recognize the importance of focusing on child and family strengths, and creating supportive environments for children at various levels of need.

Researchers have made significant progress over the last several years in identifying risk factors that can lead to children’s mental health problems, as well as protective factors that can work to prevent these problems. There are often long delays—sometimes decades—between the time that children first show problems and when they get treatment.

Studies have shown that these delays can lead to more severe, difficult-to-treat mental illnesses. Through a public health approach, children with risk factors for mental health problems can be identified early through screening and public education. Effective programs have been developed that can prevent these children from developing problems or greatly reduce their impact. These programs are also effective in reducing juvenile delinquency, substance abuse, health-risking sexual behaviors and school failure, and poverty in adulthood.

Facing the current economic times and the failure of the current system of care for Clark County’s children, now is the time for parents, policymakers, and professionals to support this approach in our community. We already know that at least 2/3 of children with significant mental health problems are not getting the services they need, when they need them (U.S. Substance Abuse and Mental Health Services Administration, 2009). A tremendous amount of local, state, and federal dollars are spent each year to address the negative consequences of not providing these children with early access to services and supports—through the schools, the child welfare system, the juvenile justice system, and the adult mental health and prison systems. Parents of children with serious mental health problems often struggle to get services for their child as soon as they know something is wrong. The vision of the public health approach is to improve early access to services and to assist families and communities in providing children with environments that support positive emotional and social development. Investing in this “front-end” approach will ultimately free up resources to expand and improve services for children at all levels of need.

Neighborhood-Based Model of Service Delivery

Our consortium supports a neighborhood-based approach to integrated service delivery. The Neighborhood Family Service Center model has been adopted in Clark County to provide the infrastructure to support effective, integrated service delivery. The purpose of the Neighborhood Family Service Centers is to provide: (1) one stop service centers for families in the communities where they live; and (2) collaborative, integrated services for families accessing services across multiple public child serving agencies. Neighborhood Family Service Centers target children and families who need public behavioral health and other social services. Endorsed by the the Child Welfare League of America and the Robert Wood Johnson Foundation, this model has been operating in Clark County for the last 10 years. Neighborhood-based services offer the promise of quality care for all vulnerable families, are consistent with system of care principles, and provide the most natural setting for a public health approach (Hornberger et al, 2006).

Currently, five Neighborhood Family Service Centers operate in Clark County.

Neighborhood Center Partners

- ▲ State of Nevada Division of Child and Family Services
- ▲ Division of Health, Nevada Early Intervention Services
- ▲ Clark County Department of Family Services
- ▲ Clark County Department of Juvenile Justice Services
- ▲ Family Resource Centers
- ▲ Nevada Parents Encouraging Parents
- ▲ Clark County School District

The infrastructure must be strengthened to support this model of effective and accessible behavioral health service delivery in implementing the universal, targeted, and intensive strategies of the public health approach. This infrastructure should include: public engagement and outreach, system management, integrated access, collaborative service processes, utilization management, workforce development, integrated financing, and ongoing utilization focused evaluation.

Prevalence of Mental Health Problems

A child’s **mental health** consists of thoughts, feelings, and behaviors that determine whether that child can cope with stress, relate to others, make appropriate choices, and learn effectively. Like physical health, mental health is important at every stage of a child’s life. Unlike physical problems, mental health problems can’t always be seen, but the symptoms can be recognized. Some symptoms of childhood mental health problems include depression, anxiety, conduct, eating and attention deficit/hyperactivity disorders.

The U.S. Department of Health & Human Services Substance Abuse and Mental Health Services Administration reports that at any given time, one in every five children are suffering from a mental health problem. National studies of the prevalence of serious emotional disturbance in the United States have estimated that 9 to 13% of youths aged 9 to 17 years experience serious emotional disturbance with substantial functional impairment, and 5-9% of youths have serious emotional disturbance with extreme functional impairment (Friedman et al, 1996). Between 9.5% and 14.2% of children between birth and five years old also experience serious emotional problems.(Brauner, et al. 2006).

Similarly, the U.S. Surgeon General (2001) has reported that of an estimated 1 in 10 children with serious emotional disturbance, at least 80% are unserved or underserved.

The Clark County Children’s Mental Health Consortium screened significant samples of public school children and reviewed their service histories (Clark County Children’s Mental Health Consortium Plan, 2004). The results showed that 19.3% of Clark County’s elementary school children needed mental health treatment, 6% had serious problems, and almost 70% were receiving no known services (CCCMHC Plan, 2004). More recently, it has been found that over 30% of youths in the county’s public high schools self-reported depressive symptoms during the 2008-2009 school year (Clark County School District, 2009).

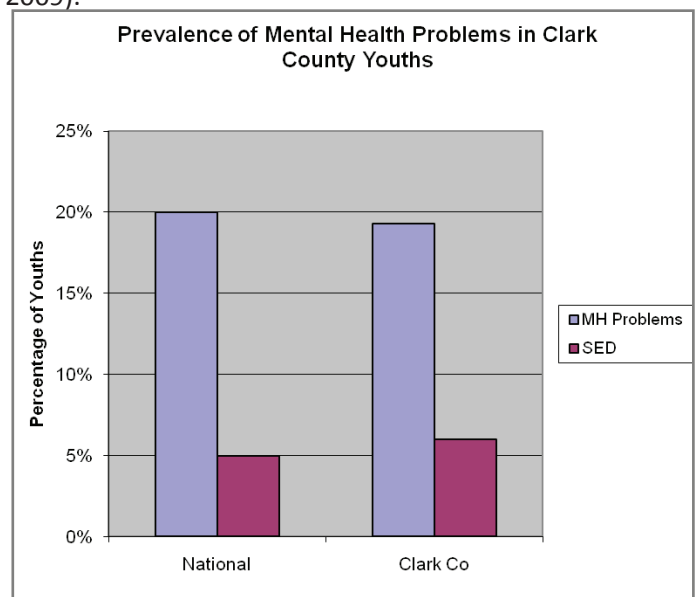


Figure 2. Estimated prevalence of Mental Health Problems from U.S. and local studies.

Estimates of the prevalence of mental health problems are much higher for children involved with child welfare and juvenile justice. A review of the research literature indicates that between one-half and three-fourths of the children involved in child welfare have significant behavioral health needs, including those in foster care and those remaining in their own home (Landsverk et al, 2006). The National Survey of Child and Adolescent Well-Being determined that nearly half (47.9%) of children aged 2-14 years with completed child welfare investigations had clinically significant emotional problems and only 25% of those with mental health needs had received any services. In a comprehensive study conducted in 2002-3, the CCCMHC found that an estimated 83% of abused/neglected children in Clark County needed some level of behavioral health services(CCCMHC Plan 2003). Based on these prevalence rates, there were an estimated 3100 abused/neglected children with behavioral health service needs in 2007.

About 1400 or 40% of these children were suffering from serious emotional disturbance and needed intensive levels of community-based supports (CCCMHC Plan 2008).

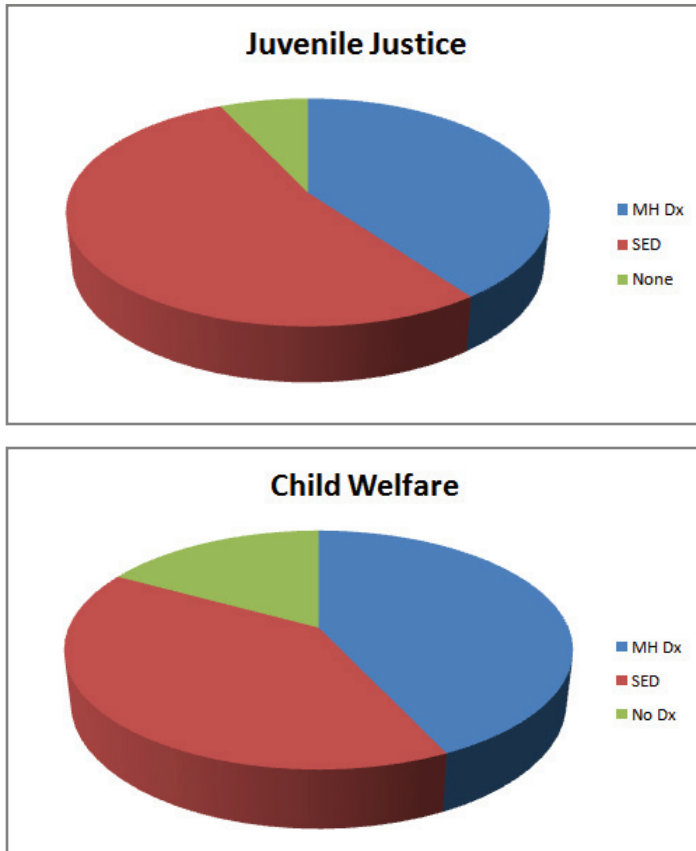


Figure 3. Prevalence of mental health problems in Clark County's Child Welfare and Juvenile Justice Systems (CCCMHC, 2003)

Untreated behavioral health problems early in life frequently lead to a number of negative consequences later in life such as involvement in the juvenile justice system (U.S. Substance Abuse and Mental Health Services Administration, 2007). Findings from a number of recent studies show that nationally, anywhere from 65% to 70% of youths in juvenile justice have a mental health disorder and more than half had at least two diagnoses. National studies have also shown that 27% of the youths involved entering juvenile justice systems experience disorders so severe and disabling that they require immediate treatment. The CCCMHC has estimated that more than 75% of youths involved in the Clark County juvenile justice system have behavior health disorders (CCCMHC Plan, 2003). National studies have shown that only one-third of youths with behavioral health problems entering the juvenile justice system have ever received prior treatment in the community.

There is growing recognition that a vast majority of the youths suffering from substance abuse problems have co-occurring mental health diagnoses. **Behavioral health problems** is a term utilized in this plan to include the full range of mental health, substance abuse and co-occurring disorders commonly found in children and youth.

Profile of Clark County's Children

As of July 1, 2009, there were an estimated 615,700 children in Clark County between the ages of 0 and 19 years, representing nearly 30% of the county's population (Nevada Demographers Office, 2009). These children mirror the growing cultural and ethnic diversity of the region. Nearly 44% of the county's children are from non-white ethnic or racial backgrounds, including 32.4% of Hispanic or Latino origin, 8.1% of Black or African-American origin and 5.5% representing two or more races. There are over 33,000 children in the county who are foreign-born (Daneshvary, 2008).

Nevada's youth are rated the 7th most vulnerable in the nation, with higher than average rates of suicide, high school dropouts, and per capita juvenile incarceration. With the majority of the state's population, Clark County's children are no exception. (Every Child Matters Education Fund, Centers for Disease Control and Prevention, and U.S. Department of Education, 2009). In 2009, almost one-quarter of Clark County's public middle school students seriously thought about killing themselves, almost 30% tried alcohol, and over 50% had been in a physical fight at school. Over 35% of high school students had been offered, sold, or given an illegal drug on school property, over one-third had tried marijuana, and over 13% had attempted suicide (Clark County School District, 2009). Over 15,000 youths were referred to the Clark County Juvenile Justice Services last year.

Factors Affecting the Mental Health of Clark County's Children

Research has shown that there are a number of factors which increase the risk for children's mental health problems (Isaacs et al., 1994). The following specific factors are significant in increasing the risk among Clark County's children.

Population Diversity

The cultural and ethnic diversity of Clark County's children present barriers to early identification and treatment of behavioral health problems. Utilization patterns for public mental health services suggest racial/ethnic disparities in access to services, with youths of Hispanic origin receiving services at disproportionately low rates (Daneshvary, 2008). Most of Clark County's 33,000 foreign-born children are not citizens. An increasing number of illegal immigrants do not have medical insurance, earn lower wages, and lack the knowledge and support to access behavioral health resources for their children.

Clark County public high school students from Hispanic and mixed race origins are more likely to feel socially isolated at school and significantly more likely to attempt suicide. The transience of public school students results

in feelings of isolation and greater risk for depression and other behavioral health problems (Southern Nevada Health District, 2009).

Economic Conditions

Even when Clark County's economy was doing well, the service delivery systems faced extreme challenges as a result of the overwhelming growth, lack of appropriate tax structure focused on education and social services and conservative fiscal spending trends. Clark County's children are even more vulnerable a result of the economic recession that began in 2008. The unemployment rate has nearly doubled over the last year and is currently above the national average at 13.1%. Clark County home foreclosures are among the highest in the nation, tripling over the last two years (Center for Business and Economic Research, 2009). Calls to Nevada's emergency help line (2-1-1) have increased 22 percent since the recession began (Las Vegas Review-Journal, 10/28/09). While TANF and Medicaid recipients are increasing, Government programs are faced with significant cuts as sales and gaming taxes continue falling well below projected levels. Clark County has seen an increase in self-reported depression and substance use by high school students this year that experts suggest is a direct reflection of the economic times (Richmond, 2010).

Poverty and Homelessness

Children facing poverty and homelessness are always at high risk for developing mental health conditions. At least sixteen percent of Clark County's children were living in poverty in 2005 and that number has significantly increased under the current economic conditions as predicted by the extreme growth in food stamp recipients over the last year (Isaacs, 2009). For example, the Three Square Food Bank in Las Vegas has seen a 68% increase in demand over last year in the number of households served. Of those served, 42.5% were children under the age of 18 years. Almost 50% of public school students currently qualify for free and reduced lunch assistance. There have been approximately 5600 children identified as homeless this year in the Clark County School District, a 41.9% increase over last year. (Applied Analysis, 2009)

Health Care Coverage

At least 19.1% or 117,599 of Clark County's children are uninsured (U.S. Census Bureau, 2009). Of these uninsured children, at least 22,000 likely suffer from behavioral health problems. State mental health services have the capacity to serve less than 2% of these young people, and other services with sliding fee scales are extremely limited (Daneshvary, 2008).

The Nevada Division of Health care Financing and Policy offers three programs for children who live in poverty and those with disabilities, including fee-for-service Medicaid, managed care Medicaid, and the Nevada Check-Up Program. Children with behavioral health problems must frequently move from program to program due to eligibility and income criteria, complicating access and continuity of care. Nevada's income criterion for Medicaid is one of the most restrictive in the nation and there are no waiver programs for children with behavioral health problems. Recent changes at the federal level have also limited access to behavioral health services known to be effective such as family-to-family support and therapeutic foster care. Enrollment in Nevada Check-Up has been steadily decreasing over the last year, suggesting that more and more children are lacking coverage.

Abuse and Neglect

Some of the most vulnerable Clark County children are those involved in the child welfare system. These children are at high risk for health, mental health and developmental problems. For children placed in foster care, the trauma of separation from their families and the experience of multiple placements itself increase their vulnerability and compound pre-existing behavioral health problems. Furthermore, many parents experience multiple stressors that lead to involvement with the child welfare system. Many of these parents need their own mental health services and supports, and approximately three-fourths need services to address substance abuse problems (McCarthy et al. 2003). Infants and toddlers experience the highest rates of maltreatment in Clark County. Young children are profoundly affected by exposure to abuse and separation from their families when placed in foster care. Problems not addressed during the earliest years of childhood can become more severe and set the stage for problems later in life (Silver et al, 1999). These young children often wait to receive mental health and early education services through the Divisions of Child and Family Services and Health.

Categorical Service System

Although Clark County has many excellent behavioral health providers and programs, children can only access certain programs depending on their health care coverage, referral point, or living situation. For example, children removed from their home by the child welfare or juvenile justice systems can access the most restrictive and least effective treatment through residential care, but cannot receive more effective community and home-based interventions while living with their family. There are significant gaps in the service array, resulting in an overreliance on more intrusive treatments such as medication and inpatient care (Wilson, 2009). Like thousands across the country, Clark County families have

been forced to relinquish custody or have their child arrested in order to gain access to needed services for their children (U.S. General Accounting Office, 2003).

Laws and Regulations

There are relatively few state laws and regulations that address the behavioral health needs of Clark County's children. **Nevada Revised Statutes 433a and 433b** allow the Nevada Division of Mental Health and Developmental Services and the Division of Child and Family Services to provide treatment to children with emotional problems in Clark County. However, these statutes provide little guidance in establishing standards to ensure that programs and services meet the needs of Clark County's children and families. The Division of Health Care Policy and Financing funds mental health services to the largest number of Clark County children and their families through its Medicaid and Nevada Check-up Programs. There is no clearly defined relationship in the law between these Divisions and the services they provide.

The **Nevada Commission on Mental Health and Developmental Services** has the authority to set policy and regulations to ensure “the adequate development and administration of programs for individuals with mental illness and related conditions, including services to prevent mental illness...” However, the scope of the Commission's authority over non-state providers of mental health care is unclear in the law. Historically, the Commission has adopted few policies and regulations specific to children's mental health care. The Commission also has no authority over the biennial budget development process of the state agencies it regulates.

Lacking a clearly defined mental health authority for children, local agencies such as the Clark County School District, the Clark County Department of Family Services, and the Clark County Department of Juvenile Justice Services have become de facto providers of mental health care to address the service needs of their children and youth. This has resulted in a complex framework of standards and practices that are often duplicative and uncoordinated. Families are often caught in the middle of a morass of uncoordinated treatment plans and interventions.

At the federal level, the **Americans with Disabilities Act** provides certain rights for children with disabling mental health conditions. Children with serious emotional disturbance have the civil right to receive services in the most integrated setting appropriate to their needs. Furthermore, they have the human right to be raised in their families and communities, with their individual needs guiding the service array provided. The **Olmstead Decision** of 1999 clearly applies to children with serious

emotional disturbance who are “stuck” in emergency rooms and inpatient settings because community-based services and supports are unavailable (Bazelon Center for Mental Health Law, 2001). Children placed in foster care or juvenile justice settings in order to access needed services are segregated needlessly and experience discrimination that is unambiguously in violation of ADA. In a study by the National Alliance for the Mentally Ill, one in five families of children with serious emotional disturbance were told to give up custody of their children to the state, and 36% were told to have their child arrested.

The Olmstead Decision calls for planning to address the needs of individuals with disabilities. The CCCMHC's planning efforts seek to address the principles embodied in the ADA and the Olmstead Decision. The values and principles guiding our planning efforts will help alleviate discriminatory conditions for children with serious emotional disturbance.

Rosie D. v. Romney was a class action lawsuit brought under the EPSDT provisions of the Medicaid Act to compel Massachusetts to provide intensive home-based mental health services that would enable children with serious emotional disturbance to receive treatment and support in their homes. The court found that Massachusetts violated the provisions of the act even though it offered other services to these children. The decision was based on compelling arguments documenting the effectiveness of intensive home-based services and other supports and the failure of Massachusetts to make these services universally available to all children with serious emotional disturbance in the Medicaid system. The court ordered a remedial plan for Massachusetts that included the requirement for improved mental health screening procedures by primary care providers; more standardized mental health assessments; and provision of medically-necessary, intensive home-based behavioral health services. Based on this landmark decision, Massachusetts is reforming their children's behavioral health system to provide an integrated and coordinated approach to treatment planning and service delivery using the wraparound approach. Massachusetts has also adopted improved guidelines for behavioral health screening of children in the Medicaid system using evidence-based tools and processes. The CCCMHC is advocating for many of the same reforms necessitated by this legal action. In addition to better outcomes for children with serious emotional disturbance and families, these reforms can reduce the likelihood of time-consuming and costly litigation against our state and local governments.

In 2003, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) issued a “call to action” concerning the **use of restraint and seclusion** with mentally ill adults and children with serious emotional disturbance. SAMHSA cited years of research showing that physical force, mobilization, and isolation are dehumanizing. They concluded that “seclusion and restraint should no longer be viewed as treatment options but rather as treatment failures because they risk lives and inflict emotional and physical trauma. Seclusion and restraint should be a safety measure of the very last resort, used only when all other options have failed.” (SAMHSA, 2006). Since that time, successful alternatives to restraint and seclusion have been developed in treatment facilities, but these inhumane practices are still occurring in other systems, including juvenile justice facilities and special education settings. A recent investigation by the U.S. Government Accountability Office found hundreds of allegations that children have been abused, and some even died, as a result of misuses of restraint and seclusion in public and private schools, often at the hands of untrained staff, prompting the introduction of federal legislation to address this problem. Nevada has already taken important steps to monitor the use of restraint and seclusion in treatment facilities and public schools.

The goals of our plan are directed toward a behavioral health system that minimizes the needs for such intrusive methods by providing effective services and supports before emergency situations arise where restraint and seclusion may be necessary. Also included in our plan are strategies to ensure that community providers and agencies participate in a coordinated process to improve workforce competency through the implementation of evidence-based and promising practices that reduce the need for restraint and seclusion.



My experience is that those that need the most help are unable to get it.

--provider

2009 Community Input Survey

2

ACHIEVING THE GOALS: NEEDS, BARRIERS AND STRATEGIES

This 10-Year Strategic Plan is based on our review of national, state and local data which identify the needs, barriers and available strategies for achieving our six goals for the year 2020.

Since its creation in 2001, the CCCMHC has conducted many studies that shed light on the behavioral health care needs of our community's children. We have utilized many of these studies to develop the goals, objectives and strategies. CCCMHC members and other interested stakeholders, families, and providers have also reviewed numerous local and state needs assessments commissioned by local, state, and federal agencies. In October 2009, the CCCMHC conducted a comprehensive community input survey of 105 families, caseworkers and providers to identify specific service gaps and barriers.

In this section, we have identified the specific needs, barriers and strategies for each of the six goals we hope to achieve. In this manner, we have tailored our plan to match the unique strengths and challenges in Clark County.

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

Current Needs and Barriers

Across the nation, too many children with serious emotional disturbance spend far too much time in institutional settings where they are alienated from their peers, their families, their culture, and their community. The American Disabilities Act mandates that these children receive services in the most integrated setting appropriate to their needs (Bazelon Center for Mental Health Law, 2001). Clark County children with serious emotional disturbance are too often sent to out-of-state or out-of-community placements in spite of the fact there is little evidence that these children benefit from such settings (U.S. Surgeon General, 1999, Hoagwood et al., 2002).

Lack of a single locus of accountability for care management and the difficulty of accessing individualized services and supports perpetuate this tragedy facing so many families. The U.S. Department of Health and Human

Services has shown that children with serious emotional disturbance can thrive in their home community when providers and agencies work in partnership with families to provide intensive supports and services (U.S. Substance Abuse and Mental Health Services Administration, 2009). Data from the national system of care program demonstrate that school attendance and achievement, depression and anxiety, suicide attempts, and overall behavioral and emotional health can improve significantly for those youths with the most serious impairments.

Clark County's children with serious emotional disturbance need (1) care management coordinated across agencies and providers; (2) home and community-based services that are responsive to the individual needs of the child and family; and (3) Continuous eligibility for services regardless of payer source.

DCFS Capacity for Intensive Care Management to Youths with SED

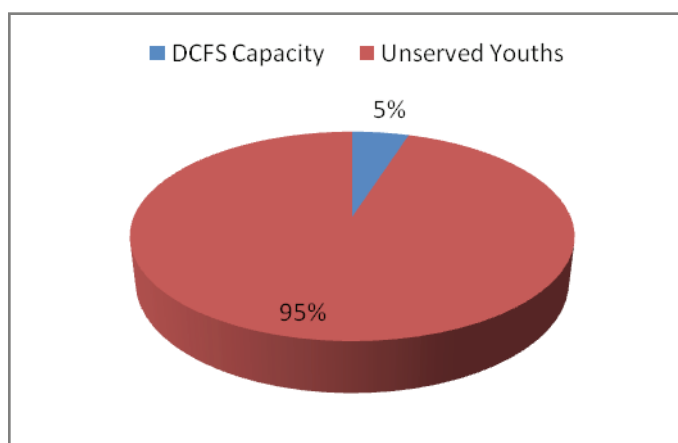


Figure 4. Division of Child and Family Services' Capacity to provide Intensive Care management to Clark County Youths with SED.

Coordinated Care Management

Although one-third of the public children's behavioral health care dollars in Clark County are spent on some type of care management, these efforts are duplicative across agencies, inconsistent and fail to target those youths with the most serious and complex needs (Pires, 2009). Consequently, less than 5% of the estimated 36,942 children with serious emotional disturbance have access to an effective and intensive model of care management such as wraparound. The capacity to provide intensive care management services is particularly limited for those children who lack health care coverage. Of the estimated 117,599 uninsured children in Clark County, over 7050 suffer from serious emotional disturbance and desperately need intensive, effective care management services. Clark County families, caseworkers and providers have rated our current system as failing to provide coordinated care plans for children with serious emotional disturbance (See Appendix A).

Children with SED in Child Welfare

Children with serious emotional disturbance who are involved in the child welfare and juvenile justice systems have some of the greatest needs for coordinated care management and other supports. Consistent with national data, it is estimated that about 1,400 children involved in the child welfare system suffer from serious emotional disturbance and need intensive levels of community-based supports. While approximately half of these children have access to care management through the Wraparound in Nevada Program, children may lose their Medicaid coverage when they are returned home or adopted, resulting in a service disruption. The Child Welfare League of America has emphasized that appropriate mental health services and supports for abused/neglected children can only be provided through collaborations which involve public mental health, health, Medicaid, court and school systems, providers families and other caregivers. Continuous eligibility for services regardless of the child's placement and easy access to specialized services at key transition points are essential in facilitating positive outcomes for these children (McCarthy et al., 2003).

Youth with SED in Juvenile Justice

Over half of the approximately 15,000 youths involved yearly with the juvenile justice system are estimated to have a serious behavioral health problem (Stroul et al., 2008, CCCMHC, 2002). Few youths involved in juvenile justice are able to access intensive service coordination or other community-based supports currently available through the Division of Child and Family Services and the Nevada Medicaid Program. Consequently, there were more of these youths in out-of-community placement in 2008 than in any other year. Clark County youths with serious behavioral health disorders are just as likely to commit serious crimes as others entering the juvenile justice system but often do not necessarily get the clinical treatment that will be effective in reducing recidivism. Nationally recognized programs such as Wraparound Milwaukee are producing positive outcomes for these youth such as improved school performance, reduced recidivism, and per capita cost savings (Pires, 2009).

Youth with SED in Fee-for-Service Medicaid

In 2009, there were approximately 23,000 Clark County children in the fee-for-service Medicaid system (First Health Services, 2010). It is estimated that more than half of these children were involved in the child welfare or juvenile justice system while the remainder were children with disabling conditions, including serious emotional disturbance (Nevada Division of Health care Financing and Policy, 2008). The percentage of these children accessing behavioral health services increased to 12% in 2007, but was still less than half the rate found in Washoe County

(25%). Unfortunately, the increase in access to services was primarily targeted toward children in out-of-home placements, with little additional services to families caring for their own children.

The investment of Medicaid in these additional services and supports has failed to yield the desired outcomes for Clark County's children and families. Over 40% of Clark County's public behavioral health care dollars were spent on residential care, which has not been shown effective in improving the long-term outcomes for children with serious emotional disturbance, especially without follow-up services. Readmission rates for youths receiving residential services under Fee-for-Service Medicaid have been increasing since 2006 to 11.7%, while the percentage of these youths accessing follow-up services within 90 days has decreased significantly to 12.8%.

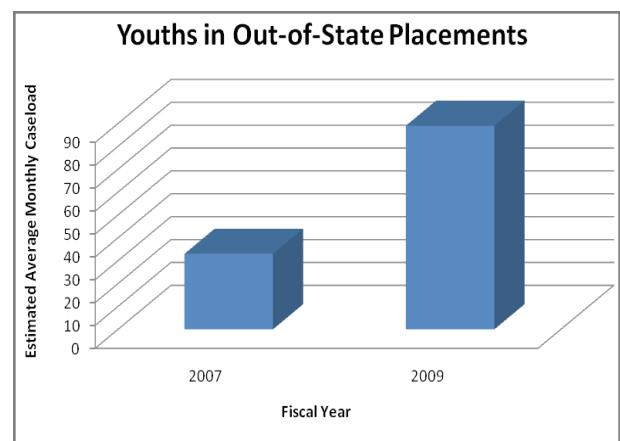


Figure 5. Estimated average monthly caseload of Clark County Youths in Out-of-State Placements funded by fee for service Medicaid.

The number of Clark County Children in out of state placements more than doubled in the past two years. In Fiscal Year 2009, there were an estimated monthly average of 89 Clark County children in out-of-state placements and at least another 100 in out-of-community placements.

Individualized Services and Supports to Youth and Families

Our community is lacking in many types of formal services that go beyond traditional clinic-based interventions to support children with serious emotional disturbance in their homes, at school, and in other community settings. Children with serious emotional disturbance will function more successfully in Clark County when the system strengthens its use of informal supports that are unique to each family's faith, culture and neighborhood.

Family-to-family support services are particularly effective in improving outcomes for children with serious emotional disturbance and their families (Stroul et al, 2008). Families who have long been blamed for their children's emotional disorders are finally supported as key partners in their

child’s treatment process.

The need for these services and supports for Clark County’s children has been documented in a number of studies over the past four years. The 2008 Clark County Child Welfare Service Array Assessment concluded that the need for mental health and family support services on behalf of children in the system far exceeded the availability of these services in Clark County. This needs assessment specifically identified a lack of available home-based services and after-school day treatment for children with behavioral health care needs involved in child welfare. Most importantly, the Clark County assessment found that families do not have access to the necessary flexible funding and other financial supports necessary to maintain their children at home or sustain a successful reunification following foster care (Applied Analysis, 2008).

An audit of the child welfare system commissioned by the Nevada Legislature (Nevada Institute for Children’s Research and Policy, 2008) found that families involved in the child welfare system were twice as likely to be offered services ONLY once their children were removed from their care.

In October 2009, the CCCMHC surveyed over 100 families, caseworkers, and providers. Respondents identified five community-based supports most needed for children with serious emotional disturbance, including: financial supports, respite care, specialized child care, home-based counseling, mentors, family-to-family support. Only a small percentage of families caring for their children with serious emotional disturbance are currently receiving these types of services.

Intensive Services and Supports Most in Need of Expansion

- ▲ Financial Supports
- ▲ Respite Care
- ▲ Specialized Child Care
- ▲ Family-to-Family Support
- ▲ Home-based Counseling

-- From 2009 Clark County Community Input Survey

Family-to-Family Support Services

Nevada Parents Encouraging Parents is the only organization in Clark County currently providing family-to-family support services. In spite of yearly increases in the number of requests for these services from families of children with serious emotional disturbance, state funding has not increased over the last five years. 82% of families requesting these services do so at the

recommendation of the child’s school, behavioral health care provider, or another child-serving agency. National research supports the effectiveness of family-to-family support in promoting better services, increasing family satisfaction with services, and improving family and child functioning (Burns et al., 2002). Studies conducted in Clark County through the federally funded Neighborhood Care Center Project also suggested that family-to-family support services resulted 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).

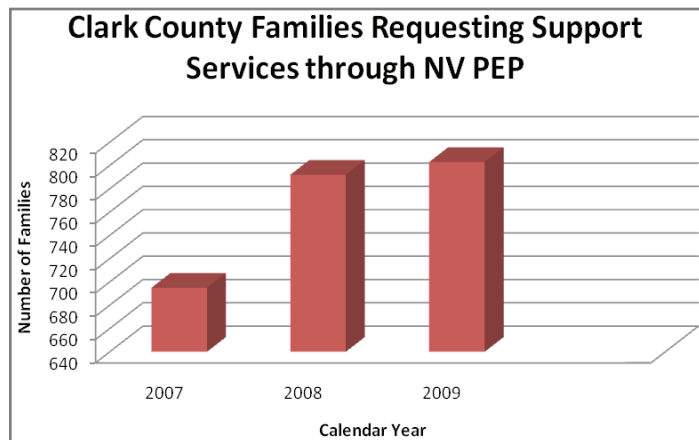


Figure 6. Number of families requesting support services through Nevada Parents Encouraging Parents

In a 2009 PEP survey of family satisfaction with services, 95% of parents reported that their understanding of the system improved, 96% acquired or improved skills, 98% reported better services for their child, and 96% reported that NV PEP help strengthen their family

Uninsured youths with SED

The CCCMHC has surveyed over 150 families of youths hospitalized at the Division of Child and Family Services’ Desert Willow Treatment Center(See Appendix B). These youths were covered by medicaid while hospitalized. Over the last four years, less than 50% of uninsured families were able to obtain healthcare coverage to support aftercare services for their children following discharge. Both insured and uninsured families identified the need for additional, family support groups, parent education, and home-based counseling to be successful in caring for their children at home..

Continuous eligibility for services regardless of payer source.

The families of children with serious emotional disturbance face extreme economic challenges in providing needed care for their children with serious emotional disturbance. For example, services and supports accessible through one payer source, such as Fee-for-Service Medicaid, may be not available when

the family is covered by private insurance. The inability to blend payer sources and assure continuity in services and supports is one of six top barriers identified by Clark County families, caseworkers and providers in a 2009 survey (See Appendix A). The cohesion and trust established in the child and family team is undermined when service providers or programs change. The system works against families and community-based care by providing Medicaid eligibility once children are removed from the home, but withdrawing these benefits when the child is ready to go home. This regressive system not only penalizes families who want to care for their children, it traumatizes the most vulnerable of our youths by separating them from their caregivers in order to receive services.

Strategies to Meet Needs and Overcome Barriers

The plan includes several strategies designed to improve care management, develop services and supports, and re-structure financing arrangements to better meet the needs of Clark County's children with serious emotional disturbance and their families. The CCCMHC will work with the Department of Health and Human Services to re-structure the delivery of intensive care management, targeting those children with the most serious and complex needs while assuring the delivery of services through a consistent, effective model such as wraparound. The CCCMHC supports a system where each child and family has a single plan of care that is supported by the resources of collaborating agencies, providers, and other community supports. Care management will only be effective with one entity accountable for ensuring that the model and intensity are cost-effective and produce the desired outcomes.

Cost savings from decreased utilization of residential care and more efficient service coordination will facilitate the expansion of those community-based supports and services essential to maintaining these youths in their family and home community. The CCCMHC will advocate for a tax to create a dedicated funding source for family-to-family support services, while working with the Nevada Division of Health Care Financing and Policy to expand Medicaid eligibility for children with serious emotional disturbance and create innovative Medicaid programs to support continuous eligibility and the expansion of home and community-based services. These strategies will work together synergistically to create a behavioral health care "home" for children with serious emotional disturbance and their families.

The CCCMHC will continue to support and strengthen our local, neighborhood based, barrier-busting teams. These teams were established through a memorandum of understanding and meet regularly to support those youths

who are at the greatest risk for out-of-community and out-of-state placements.

The Role of Family Involvement

Since its creation in 1992, Nevada Parents Encouraging Parents has been intimately involved in virtually all of Clark County's efforts to implement a family-driven, individualized, and culturally competent system of care for the state's children with serious emotional disturbance. Nevada PEP has made it possible for parents of children with SED to find their voice, to have a say about their needs, the needs of their children, and the needs of the community. Nevada PEP helps families care for their own children through information, referral, training, and individualized family-to-family support services.

The CCCMHC will continue to partner with Nevada PEP to ensure that family voices are heard and incorporated into the care management and service delivery process to improve intensive services and supports for children with serious emotional disturbance, including the expansion of family-to-family support services.

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

Current Needs and Barriers

Research has shown that early identification and treatment improves outcomes for children with behavioral health problems. Sadly, a national survey has shown long delays, even decades, between the onset of emotional problems and the initiation of treatment (U.S. Substance Abuse and Mental Health Services Administration, 2007).

The majority of lifetime mental illnesses begin in youth and half of all diagnosable lifetime cases of mental illness begin by age 14. If left untreated, childhood disorders may intensify and persist, often leading to a downward spiral of school failure, juvenile justice involvement, substance abuse, poor employment opportunities and poverty in adulthood. (U.S. Substance Abuse and Mental Health Service Administration, 2007) Longitudinal studies by the CCCMHC have shown that almost 70% of Clark County elementary school children with behavioral health problems are not identified and treated, leading to poor academic achievement and failure to move from grade to grade with their peers (CCCMHC Plan, 2008) Nationally, only 50% of adolescent with serious emotional disturbances finish high school, and individuals who first exhibit symptoms of mental health disorders in childhood tend to consume a disproportionate amount of health care services as adults (Substance Abuse and Mental Health Services Administration, 2007).

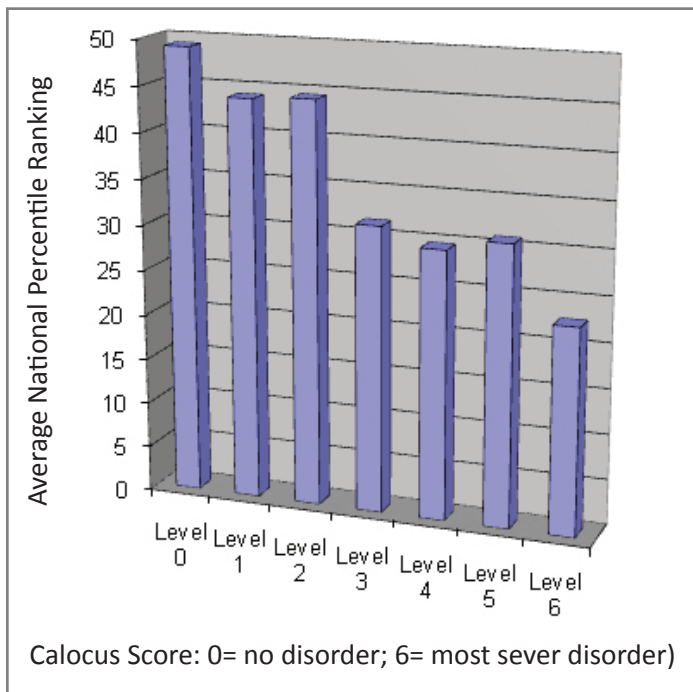


Figure 7. 2007 Academic Achievement Ranking for Clark County Elementary School Students Identified in 2004 with Behavioral Health Disorders by Level of Severity

One key principle of an effective system of care is the development of a comprehensive array of services and supports, including both clinical services and natural supports (Pires, 2002). The greatest challenge of Clark County's behavioral health system is adhering to this key principle of systems of care (University of Nevada Las Vegas, 2009).

Key areas of concern related to Nevada's ability to provide a comprehensive array of services were identified in a 2009 UNLV survey of Clark County stakeholders as:

2009 UNLV survey of Clark County stakeholders

- ▲ Inadequate number of providers
- ▲ Lack of timely access to services for children and adolescents in parental custody
- ▲ Lack of engagement of the private providers to expand the array of evidence-based services
- ▲ Lack of availability of specialty services for specific disorders/disabilities
- ▲ Unavailability of services in the family's primary language
- ▲ Lack of services for children and adolescents with co-occurring and dually-diagnosed disorders

Specific Service Gaps

The majority of children involved in child welfare and juvenile justice suffer from behavioral health problems, but relatively few are receiving the treatment they need in a timely manner. According to the Child Welfare League of America, these children need timely access to assessment, crisis intervention, and neighborhood and home-based behavioral health services to support the child and the family. One national study found that only 25% of children in the child welfare system received needed mental health treatment. In Nevada, a legislatively commissioned performance audit of the child welfare system found that nearly 40% of children reviewed needed additional mental health services. The audit found significant gaps in mental health and substance abuse services for children, as well as services for youths transitioning to adulthood. The 2008 Clark County Child Welfare Service Array Assessment found significant gaps in the mental health service array for children in the system with behavioral health problems. In particular, day treatment, crisis intervention services, and transition services were most in need. In 2009, the United States Department of Health and Human Services conducted a Child and Family Services Review of the Nevada Child Welfare System. The Review concluded that service array is a major challenge for the Nevada Child Welfare System, with major gaps in substance abuse and quality mental health services.

Even though youths often enter the juvenile justice system in order to obtain needed mental health services, there is little evidence they receive the treatment needed while in the system (Stroul et al., 2008).

The CCCMHC surveyed over 100 providers, caseworkers and families to learn more about gaps and barriers in the local service array for children with behavioral health problems. The findings of this 2009 survey highlight the overall challenges families face in accessing services for their children. Of the 29 service types for children and their families shown in Figure 9, **only four services**--outpatient counseling services, family-to-family support services, parent education and services to abuse victims were rated as more than moderately accessible. All other services were rated as less than moderately accessible. Prevention services, mentors or tutors, respite care, specialized child care, and financial support were rated as the least accessible services.

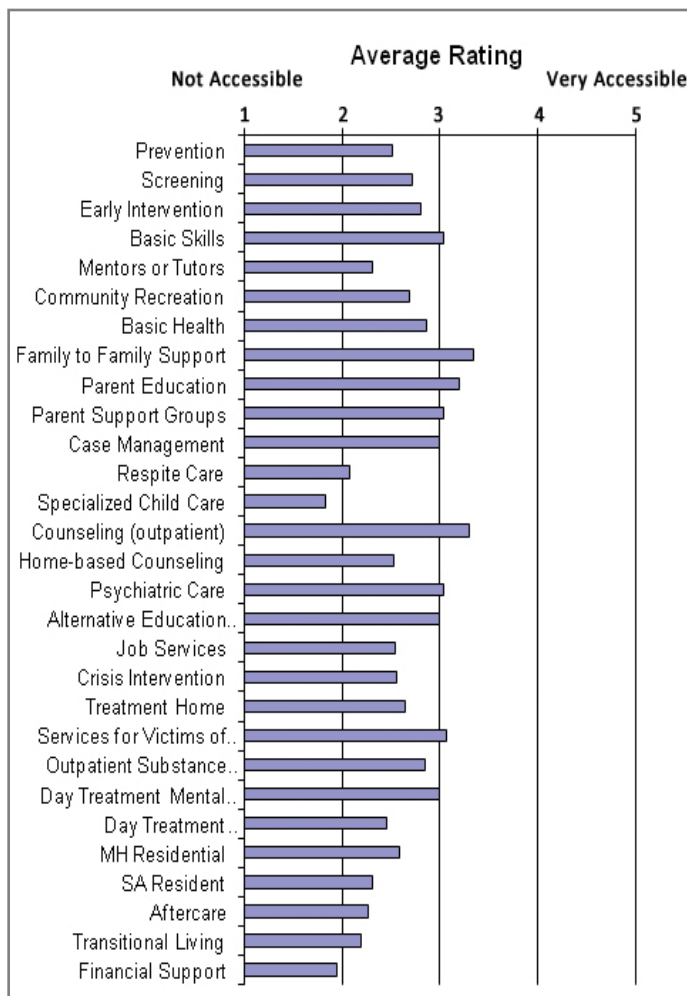


Figure 8 Average ratings of service accessibility by respondents on the 2009 CCCMHC Community Input Survey.

Providers, caseworkers, and families also identified services most in need of expansion in Clark County. Many of these services are needed for youths with serious emotional disturbance and some of these services need expansion to reach all children with identified behavioral health problems. However, prevention services targeted toward ALL children and families in Clark County were rated as the top priority for expansion.

Top Ten Services Most in Need of Expansion

- Prevention
- Mentors and Tutors
- Financial Supports
- Respite Care
- Specialized Child Care
- Basic Health Care
- Screening
- Home-Based Counseling
- Family-to-Family Support
- Early Intervention with Young Children

-- From 2009 Clark County Community Input Survey

Finally, the 2009 Community Input Survey asked participants to identify significant barriers providing the needed services.

The top seven barriers and challenges were:

- ▲ Complex paperwork with multiple providers takes too much time away from children and families
- ▲ Lack of flexible resources and funds to keep children at home and in the community
- ▲ Long waiting lists or insufficient numbers of providers for some services
- ▲ Time limited placements or services create lack of consistency and permanency
- ▲ Transportation resources to help families get to services are hard to arrange
- ▲ Access to services is based on the family’s ability to pay or medical coverage and not the child’s needs
- ▲ Third Party (including Medicaid) reimbursement rates are too low for providers to expand needed services

School-based and School-linked Services

Schools find themselves in the position of providing a wide range of mental health services to their students. With community collaboration and support, schools can be extremely successful in implementing early identification and intervention strategies for behavioral health issues. In one national survey, one-fifth of students received some sort of school-supported mental health services during the school year (U.S. Substance Abuse and Mental Health Services Administration, 2007). It is the expectation of Clark County residents that schools address important behavioral health issues. A public opinion survey of 600 Clark County Registered Voters found that 63% thought public schools should be responsible for dealing with the behavioral health needs of their students (Superintendent’s Education Network, 2008).

During the 2008-2009 school year, over 40% of the students referred to school social workers needed assistance with behavioral health problems. Children most frequently needing assistance were those with Attention Deficit Hyperactivity Disorder and Depression. Even though these school social workers, as well as school psychologists and school counselors are receiving these types of referrals, they face challenges in linking these students to timely and effective services. According to a recent study, Clark County’s schools are currently underutilizing these personnel and funding to leverage

much needed school-based services and supports (Pires, 2009). Although few behavioral health support services exist in the Clark County's public schools, the school district has implemented a model of crisis intervention services for youths with serious behavioral disorders. With a 1% recidivism rate, the program improves classroom engagement, grades and attendance. School administrators implement crisis plans to ensure high risk youths are identified and referred for services. If only these students could be identified earlier and treated before crisis services become necessary.

Strategies to meet Needs and Overcome Barriers

Building a comprehensive array of behavioral health services will require that public agencies, private providers and families work together in an ongoing effort to identify needs, best practices, financing opportunities and workforce challenges so that the diverse and individualized needs of Clark County's children with behavioral health disorders can be met.

Evidence-based and promising practice service models to match community need will be identified in partnership with the consortium, providers and insurers. The CCCMHC will work with public and private insurers to provide reimbursement incentives to providers who successfully implement the evidence-based or promising practices that meet the community's need. Outreach efforts to enroll more children in public insurance programs will be initiated with the support of DHHS. Public insurance plans will expand their options for families to purchase coverage for their children with behavioral health needs. In partnership with DHHS, the consortium will develop and implement cross-agency funding plans to offer school-based services as well as substance abuse services to children with behavioral health needs. The CCCMHC will support a partnership between Medicaid and the schools to leverage existing public education funding to expand school-based programs through student intervention teams and positive behavioral support programs. Neighborhood Centers will be strengthened to help schools develop linkages with service providers as well as informal supports for children with behavioral health needs and their families. In other communities, it is estimated that 70% to 80% of identified children can access behavioral health services through their school system. Currently, there are over 1,500 school-based health clinics across the nation funded by federal, state and private sources to provide services include mental health assessment and intervention (Grantmakers in Health, 2008) Expansion of school-based health centers is another potential strategy to improve early identification and promote timely access to community-based behavioral health services.

Role of Family Involvement

Responsibility for children's mental health care is shared across multiple systems, including schools, primary health care, juvenile justice, child welfare, and substance abuse providers. The *first* system, however, is the family (U.S. Surgeon General, 2001). Families' role in the mental health treatment of their children has dramatically changed over the last 25 years. While families were initially excluded from treatment, national policy and best practice now dictate they should be full partners in their children's care.

Unfortunately, parents lack information regarding community resources and best practices for children's mental health care. Successfully involving families in the development of a comprehensive service array requires the existence of decision making mechanisms and processes that include them as equal, informed, and empowered participants. Parents and other caregivers should not only be full participants in decision making at the service delivery level with respect to their own child. In addition, they should have meaningful involvement at the system level in developing policies, and planning, implementing and evaluating new programs and services.

Nevada PEP is federally funded and designated as the Statewide Family Network and Parent Center. In this role, PEP will continue to help keep families informed about the educational and treatment options for their children with behavioral health needs. PEP will also continue its pivotal role in planning for service array improvements by conducting regular surveys and focus groups with families and youth to get information on current service gaps, barriers and strengths of the behavioral health system in Clark County.

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

Needs and Barriers

One of the biggest challenges in Clark County is the lack of a primary behavioral health system for children. Like other communities across the nation, services that do exist are fragmented and difficult for families to navigate (U.S. Surgeon General, 2001). Children may access behavioral health services through a number of entry points, including the education, public mental health, juvenile justice, or child welfare system. Depending on the entry point, families may or may not find the services they need for their child (Farmer et al, 2003). The CCCMHC is committed to a system of care philosophy which crosses agency and program boundaries to reach out to families in a holistic manner. Families with the

courage to step forward and seek assistance for a struggling child need an organized pathway to information, referral, intake, and especially crisis intervention. An organized gateway to care does not necessarily mean there is just one place to go to enter the system of care. The agencies and providers in our community need to work together in an effort to help families navigate to the right program or service to meet their unique and individualized needs.

Families, caseworkers and providers have rated our current system as failing to provide families with an organized pathway to services (See Appendix A). The burden of complex and duplicative paperwork when families seek assistance was also found to be one of the top seven barriers to providing effective behavioral health services in Clark County. Although the 2-1-1 phone system developed by DHHS is an important first step in providing an organized pathway to care, it lacks the capacity to identify, prioritize and respond to family's needs for mental health services and supports.

One of the most important functions of an organized pathway to care is providing families with easy access to crisis intervention and stabilization services. Without easy access to crisis intervention and stabilization services, families in Clark County are forced to utilize local emergency rooms to obtain behavioral health care for their children.

The National Center for Children in Poverty has identified youth emergency room visits for behavioral health care as a national problem. Over the past decade, child mental health-related visits to hospital emergency rooms have significantly increased across the United States and are symptomatic of the lack of community-based crisis services for children and youth with behavioral health disorders (Cooper et al., 2007).

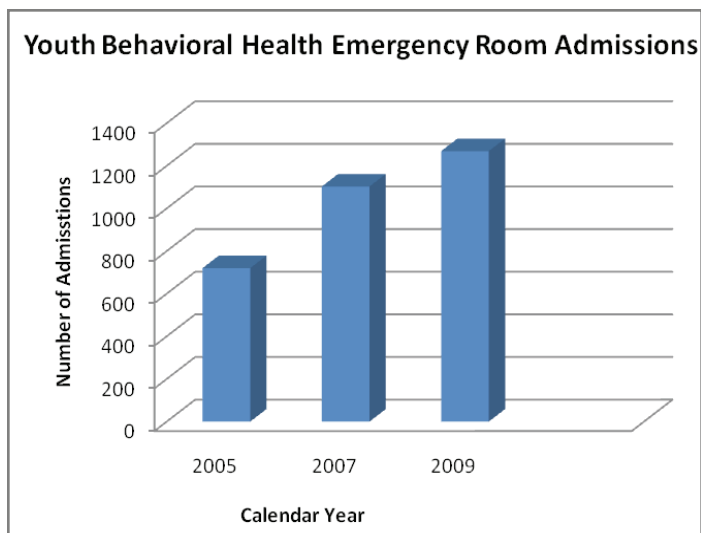


Figure 9. Clark County Youth Emergency Room Admissions for Behavioral Health Problems.

The CCCMHC has been monitoring admissions of youths to local emergency rooms for behavioral health problems. The number of youths entering emergency rooms for behavioral health problems has nearly doubled in the last 4 years. Of 1300 youths seen in 2009, it is estimated that almost 40% have threatened or attempted suicide. Over half of all youths admitted were discharged home without any immediate treatment. Nearly half of youths discharged home without immediate treatment were suicidal, psychotic or depressed. Although the majority of youths seen are typically 15-17 years of age, over one-third are younger children (10-14 years). Hundreds of children seen in emergency rooms have been warehoused in University Medical Center's pediatric unit sometimes for months while waiting for appropriate care. Some of Clark County's most vulnerable children spend the most time in local emergency rooms waiting for appropriate treatment or referral to behavioral health services. Lengths of stay for uninsured youths were twice as long as lengths of stay for Medicaid and commercially insured youths (CCCMHC Plan, 2008). Our families and stakeholders have joined a chorus of national experts in concluding that these emergency room admissions unnecessarily burden already overwhelmed emergency room departments without providing any benefits to the children seen (Cooper et al., 2007).

Strategies to Meet Needs and Overcome Barriers

It is essential that agencies pool resources to develop an organized pathway to information, referral, intake, and crisis intervention for Clark County's families. The CCCMHC will work with DHHS to strengthen the 2-1-1 system or develop a 1-800 number to provide information and referral to families seeking assistance, while identifying and prioritizing services for those families who need public support. Mobile crisis intervention is a strategy that has been proven effective for reducing emergency room visits and the need for psychiatric hospitalization (Pires, 2009). The CCCMHC will work with DHHS to develop a cross-agency funding plan for these services. School-based crisis intervention efforts should be linked with community-wide crisis intervention and stabilization teams. Public and private providers of children's behavioral health services will adopt standardized intake and service planning protocols to eliminate duplicative paperwork for families as they access new services and supports. Neighborhood Centers will coordinate intake, crisis intervention, service planning and service delivery processes across public and private providers in their geographic areas.

The Role of Family Involvement

As our community's system entry process is being improved, there is always a need for families to help each other in navigating the pathway to care. PEP will work

closely with the system management entity to engage families seeking assistance and improve the likelihood that they will follow through in accessing treatment for their children. By speaking the language that parents understand, PEP will work cooperatively with the information and referral system to help parents overcome the barriers they may face in linking with needed services. The family organization also plays an important role in the process of continuous quality improvement by gathering important information from parents and other caregivers about the effectiveness of the information and referral system.

GOAL 4. Local System Management

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.

Current Needs and Barriers

Nevada law specifies that “the system of mental health services should be community-based and flexible, with accountability and focus of the services at the local level.” (NRS 433B). Our county needs local system management to ensure that services and supports are responsive to the community’s values, needs, and diversity. Like other communities across the nation, Clark County’s families, providers and stakeholders have long embraced system of principles and philosophy, but these principles have not been embedded in formal management mechanisms (Cooper et al., 2008). Now is the time to recognize that our traditional system’s structure is woefully inadequate in achieving the outcomes we want for children and families. Successful outcomes with children and families are based on creating a partnership between families and stakeholders to manage a system that institutionalizes rather than undermines the values we believe in.

Planning, policy, governance and financing through the local system structure must support: (1) Services that are neighborhood-based; (2) Services that are individualized to each child and family; (2) Families that are participants in all aspects of service planning, selection and delivery, (3) Allocation of service funding that is flexible and locally accountable; (4) Agency collaboration in all aspects of workforce development, service planning and implementation; and (5) Information sharing that is used to continuously evaluate outcomes and improve service delivery.

Clark County families and stakeholders rated the extent to which the local infrastructure supports the values and principles of systems of care in a 2009 survey (UNLV, 2009). Consistent with national findings (Cooper et al., 2008), there is substantial room for growth and

improvement in creating a more family-centered approach to service delivery and care through increased family and youth involvement in the local infrastructure. Although progress has been made in giving families a “voice” in the system management, the stakeholder survey called for additional strategies to create and strengthen family and youth “voice” in policy and practice.

System of Care Report Card—Clark County’s Adherence to System of Care Principles

Strengths-based	C
Family and Youth Driven	D
Outcomes Evaluation and Quality Improvement	D
Integrated and Coordinated Service Delivery	D
Work force Practices	D
Comprehensive Array of Services	F

From 2009 UNLV Stakeholder Survey

For the past 10 years, we have been committed to a wraparound model of care management and service delivery for children with serious emotional disturbance and their families. Led by the Division of Child and Family Services, hundreds of youth receive care management and other supports yearly through this approach. Wraparound can only be effective when the community infrastructure supports the values and principles of Wraparound (Walker et al, 2003). Although we have made a huge investment in the development and implementation of this promising practice in our community, its effectiveness is challenged by the flaws in system management and structure. Inflexible fiscal policies and the lack of cost-sharing strategies have been identified as top barriers to fully implementing effective wraparound (See Appendix D).

Ensuring Quality of Care Across the United States, there have been significant advances in the development of evidence-based and promising practices to address children’s behavioral health problems. In spite of Nevada’s efforts to encourage the use of evidence-based practices over the last five years, there is little evidence that these practices have yet been broadly incorporated into the service array for Clark County’s children (Pires, 2009). Through the Division of Child and Family Services, what has been accomplished is better awareness of the value of evidence-based practice and training of many providers on specific evidence-based models such as Parent-Child Interaction Therapy, Trauma-Focus Cognitive-Behavioral Therapy, Motivational Interviewing, and Positive Behavioral Supports.

However, implementation of evidence-based practice is a complex, ongoing process rather than a time-limited training event. In partnership with families, providers and stakeholders, our community must first identify specific evidence-based treatments that match community needs and evaluate “practice-based evidence” that does not meet rigorous research standard but holds promise for desired outcomes. Changes in practitioner skill level, organizational capacity to sustain training and coaching, and promotion of an organizational culture that will be accountable for practice fidelity will require time to mature (Stroul et al., 2008). Unless our public agencies, families, and service providers are fully engaged in the process, implementation will not be successful on any useful scale. Our plan recommends a process to implement and sustain evidence-based practices that is embedded in our local management system and supported by technical assistance and financial incentives provided by the designated children’s mental health authority.

Clark County development of evidence-based practices will only be effective if tailored to the cultural diversity and norms of our community. Cultural adaptation of evidence-based and promising practice models will be required to achieve relevancy and acceptance by our predominant racial and ethnic groups as well as other locally underserved populations (U.S. Substance Abuse and Mental Health Administration, 2007).

Children’s behavioral health services are currently administered by a variety of state and local agencies, creating a major impediment to the development of universal standards of care and accountability mechanisms for providers and service organizations. Failure to develop and implement community-wide performance and outcome measures for our providers across all systems has resulted in serious concerns about the quality of behavioral health care in Clark County. Services must be guided by standards for access, quality of care and performance measures of service delivery and outcomes to reduce inappropriate and ineffective care and produce data for continuous quality improvement.

Strategies to Meet Needs and Overcome Barriers

In communities across the nation, outcomes for children and families have been improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008). The Clark County Children’s Mental Health Consortium has a partnership of public agencies, providers and families that has worked for the last 9 years in an effort to improve the system of behavioral health services. Studies have shown that these partnerships play a critical role in ensuring that the management of the local system actualizes the system

of care principles of community based, family-driven and culturally competent services (Hodges et al, 2007).

In this plan, the CCCMHC’s capacity will be strengthened to play a key role in overseeing the local management entity. This entity will provide a locus of accountability for care management and services to children with serious emotional disturbance. The system management entity will also have the capacity to provide referral and linkage to all children with behavioral health problems. The regional systems management entity will provide cross-agency including the training in behavioral health screening, systems of care, wraparound, and evidence-based practices. The systems management entity will be financially supported to maintain an infrastructure for the Neighborhood Centers.

CCCMHC will work with state and local governments to identify funds that can be re-directed, and blended/braided to provide the financial support for a collaborative regional management structure.

The local systems management entity will implement mechanisms for measuring process improvements and outcomes for children with behavioral health needs and their families in Clark County. In partnership with the state children’s mental health authority, the local systems management entity will implement provider standards for access, quality of care, and accountability for performance measures. Provider performance, payments and outcomes will be linked to facilitate high quality and family-responsive services.

Role of Family Involvement

Over the last 20 Years, there has been growing recognition of the critical role that families play in developing systems of care for children with serious emotional disturbance. When family-run organizations are full partners in systems of care, they make critical contributions to improving quality at both the service and system levels. In 2003, the President’ New Freedom Commission recognized the effectiveness of family involvement and insisted that families “must stand at the center of the system of care.” (Stroul et al, 2008). A recent survey found that family organizations are playing a major role in most states and communities through the provision of children’s mental health services through direct family contact and policy advocacy at the local, state, and federal level (Hoagwood et al, 2008). Recognizing this, the U.S. Substance Abuse and Mental Health Services Administration has funded a system of Statewide Family Networks across the United States with access to best practice and technical assistance from national experts. PEP has served as Nevada’s Statewide Family Network for over eight years. Families must have an equal voice in all aspects of local

system management, including service planning, policy development, and evaluation. Although family members already participate in some systems management through their membership on the consortium, the barrier-busting teams, and the management teams of certain agencies, their voice needs to be strengthened (UNLV, 2009). The CCCMHC also supports the Statewide Family Network in its efforts to expand families' role in providing cross-agency staff and provider training and orientation.

GOAL 5. Prevention and Screening County-wide programs will 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.

Current Needs and Barriers

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. More importantly, proactive effects to address children's mental health result in better outcomes for children and families (U.S. Substance Abuse and Mental Health Services Administration, 2007). Without a doubt, our community recognizes that prevention is a key element of the public health approach to children's mental health. The public health approach recognizes that it is inherently more cost effective to promote the mental health for all children and prevent mental illness before it begins. ***Prevention services were rated as the top priority for expansion in a 2009 survey of over 100 Clark County families, caseworkers, and providers.*** Risk factors for mental health problems can now be pinpointed during the toddler years. These risk factors are often compounded by lack of parenting skills and negative school experiences, making it imperative to start prevention programs as early as possible (Webster-Stratton et al., 2001). Family-focused, evidence-based programs implemented with fidelity can have a profound effect on parenting behavior and the developmental trajectories of children whose life course is threatened by multiple risk factors. Prevention efforts in the early childhood years have demonstrated both short-term and long-term effectiveness in contributing to the overall mental well being of children, as well as in reducing later costs of delinquency, substance abuse,

health-risk sexual behaviors and school failure. Some interventions that occur early in life may continue to produce benefits throughout a child's lifetime (U.S. Substance Abuse and Mental Health Services Administration, 2007).

A demonstration project conducted by the Clark County School district identified and provided preventative services to 198 at-risk preschoolers during the 2007-8 school year in collaboration with the Nevada Division of Child and Family Services. The program improved young children's social skills, decreased problem behaviors, and reduced family stress levels as children entered elementary school (Clark County School District, (2008).

When measured across all age groups, mental illnesses are the leading causes of disability worldwide. The costs are staggering. Currently, the United States spends more than \$45 billion per year for children's mental health services and it is estimated that the overall costs across social systems is as much as \$247 billion (National Research Council, 2009). The prevention of even a small percentage of behavioral health problems will result in substantial cost savings and improve quality of life for children, families and communities. Without such programs, our community will continue to pay a heavy personal and financial toll that will affect the workforce as well as the education, child welfare, and juvenile justice systems. There is great promise for the future of our county's children's behavioral health system if we redeploy some of our resources for prevention programs. We will select programs that best match the risks and priority needs of our county's children.



Examples of the cost benefits of Prevention Programs

<u>Program</u>	<u>Population</u>	<u>Benefits</u>	<u>Costs</u>	<u>Benefits minus Costs</u>
School-based Life Skills Training	All Elementary School Students	\$746	\$29	\$717
Strengthening Families Program	Parents of 10-14 year olds	\$6656	\$851	\$5805

From Aos et al. (2004) Benefits and Costs of Prevention and Early Intervention Programs. Olympia, WA: Washington State Institute for Public Policy.

Screening

Because the early signs of children's behavioral health problems are often not identified and addressed, the average diagnosis usually occurs 10 years or more after the onset of symptoms. Missing early symptoms can result in disorders that create a lifetime of disability or tragically result in suicide (TeenScreen, 2009). The need for behavioral health screening begins in early childhood. It is estimated that less than one percent of young children with emotional behavioral problems are identified (Conroy et al., 2004).

Although screening should be provided across the age span from infancy to adolescence, it becomes even more critical as children enter adolescence. Adolescents' developing brains, coupled with hormonal changes, make them more prone to depression and more likely to engage in risky and thrill-seeking behaviors than either younger children or adults (Schwarz, 2009). Youth Suicide is the third leading cause of death for Nevada youth, ages 10-24 years. Our youths have a suicide rate well above the national average (Nevada Office of Suicide Prevention, 2009).

In 2009, results of the Youth Behavioral Risk Survey suggested that 31% of Clark County high school students experienced feelings of sadness and hopelessness significant enough to affect daily activities for at least two weeks during the school year. Over 17% of Nevada high school students and 23.3% of middle school students self-reported that they had seriously considered suicide. At least 14 percent of both group also had a suicide plan (Clark County School District, 2009).

In Clark County, the CCCMHC has found that referrals to school psychologists for suicidal behavior rose 137% during the 2008-9 year. Suicide ideation referrals are the most frequent at the middle school level and more students in elementary school are being identified at risk for suicide (See Appendix G). Community failure to address adverse family circumstances such as abuse, household substance abuse and domestic violence may be contributing to this increased early suicide risk (Dube, 2001).

Although the Institute of Medicine, U.S. Prevention Services Task Force, the American Academy of Pediatrics, and the American Academy of Child Psychiatry support adolescent screening, fewer than one-third of primary care providers routinely screen their patients for mental illness (TeenScreen, 2009). The Congressional Omnibus Budget Reconciliation Act of 1989 clarified the requirement for mental health screening as part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program Reimbursement for screenings

Need for Behavioral Health Screenings

- ▲ Suicide is the third leading cause of death for Nevada youth
- ▲ All but one of Clark County's 2008 completed youth suicides talked about hurting themselves before their death
- ▲ 23.3% of Clark County's middle school students seriously considered suicide in 2009
- ▲ 14.2% of Clark County's high school and middle school students also had a specific suicide plan.

From Nevada Office of Suicide Prevention, Nevada Institute for Children's Research & Policy, Clark County Child Death Review, and Clark County School District, 2009.

is a significant barrier to the use of evidence-based screening tools. Only Massachusetts (as a result of the Rosie D Lawsuit) requires a standardized mental health assessment using evidence-based screens and reimburses doctors for this service at the rate of \$9.73 per screening session (TeenScreen, 2009).

The CCCMHC is committed to expanding the use of proven school-based suicide awareness programs and screening models such as Columbia TeenScreen. These programs can result in early identification of behavioral health disorders that lead to suicidal behavior in adolescents. In 2007, 92% of adolescents identified through school-based screening in Clark County were successfully linked to treatment. Such programs have been supported over the last three years by federal funds administered by the Nevada Office of Suicide Prevention. Unfortunately, only a few thousand of nearly 90,000 public high school students have been screened over the past two years.

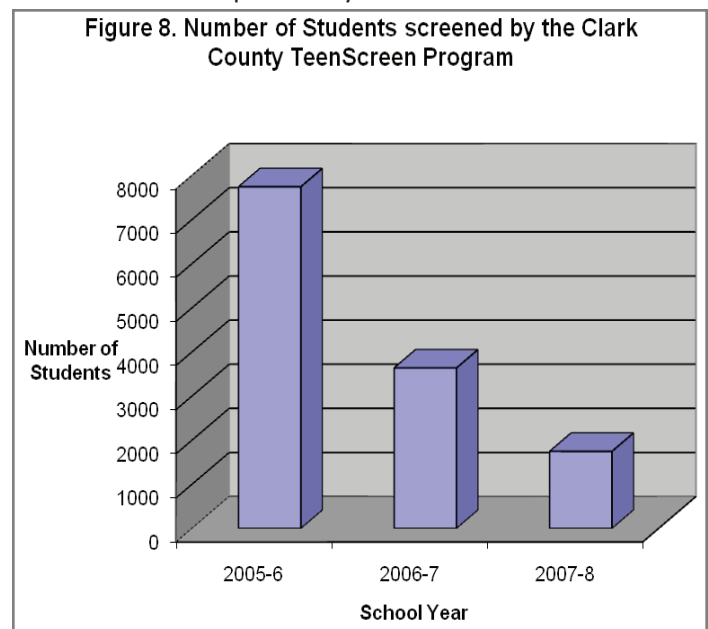


Figure 11. Number of Clark County public school students screened for behavioral health problems

Substance abuse accounts for nearly a quarter of increasing numbers of school expulsions and is another issue that can be addressed by screening programs.

Child Welfare and Juvenile Justice

Clark County's juvenile justice and child welfare systems recognize the importance of screening incoming youths for behavioral health problems. Limited time at initial referral and limited resources have prevented these agencies from developing comprehensive screening programs. Consequently, these systems are not able to identify all of the children with mental health needs upon entry into the system.

Though the cost-effectiveness of prevention and screening programs has been well documented, public behavioral health care systems are not investing sufficient funds to develop and implement these services (Pires, 2009).

Strategies to Meet Needs and Overcome Barriers

School-Based Screening and Prevention Schools provide an ideal location for implementing the screening and prevention programs that are critical for a successful public health approach. An advantage to school-based interventions is that they have the potential to address the underlying causes of many behavior problems in children while also supporting academic achievement (Hoagwood et al., 2007). Schools offer a strategic time for early interventions because this time can be stressful for both families and children. Nationally more than 52 million students attend more than 114,000 schools and another 6 million adult work at those schools. Based on these national estimates, almost one-fifth of Clark County's entire population passes through our public schools on any given weekday. These members of our community represent all economic, geographic, racial and cultural groups. The CCCMHC is supporting the development of school-wide programs for bullying prevention and social/life skills training. The 10-year plan recommends that the Clark County School District also focus on the development of universal positive behavioral supports programs in elementary schools.

Promoting Alternative Thinking Strategies (PATHS) is an example of a proven school-based program for promoting emotional and social health and reducing aggression and acting-out behavior in children ages 5 to 12 years. It can be implemented by teachers and counselors. It includes lesson plans, materials and instructions for teaching students about self-control, social skills, positive peer interactions, and problem-solving in social situations.

From SAMHSA. Promotion & Prevention in Mental Health, 2007.

Our consortium will continue its successful partnership with the Nevada Office of Suicide Prevention to support the schools in implementing comprehensive suicide prevention programs which include: suicide awareness and gatekeeper training to school personnel, and behavioral screening using the evidence-based programs such as TeenScreen, and school-based crisis intervention services.

Parent Education Programs

Families will be successfully engaged in prevention programs when they are offered in environments that fit within the normal routine, such as community, school and primary care settings. We will accelerate our efforts to strengthen families by addressing the protective factors known to be responsible for child well-being (U.S. Dept. of Health and Human Services, 2009). Following a needs assessment, we will partner with Nevada PEP, family resource centers and other parent education programs to address these protective strategies:

Protective Strategies for Parenting Programs

- ▲ Nurturing and Attachment --Building a close bond helps parents better understand, respond to, and communicate with their children
- ▲ Knowledge of Parenting and Child Development-Knowing what to look for at each age and how to help their child learn.
- ▲ Parental Resilience—Recognizing the signs of stress and enhancing problem solving and coping skills
- ▲ Social Connections-- Parents building an extensive network of family, friends and neighbors
- ▲ Concrete supports—Caregivers with access to financial, housing and other concrete resources and services that help them meet their basic needs

Screening in Primary Care Settings

A great majority of children and youth see a physician at least once a year, which provides the opportunity to conduct evidence-based screening programs that will result in better early identification of behavioral health needs (TeenScreen, 2009). The CCCMHC will build partnerships with primary care clinics to increase the use of evidence-based, behavioral health screening tools. In collaboration with the Nevada Office of Suicide Prevention, the CCCMHC has already developed and piloted a training curriculum for primary care providers (See Appendix F). One physician trained through our

program testified to its efficacy at a Congressional Briefing in Washington, DC. The CCCMHC will support efforts to expand the training and work with the Nevada Health Division and the Division of Health Care Financing and Policy to promote the use of standardized tools.

Screening in Juvenile Justice and Child Welfare Settings

The CCCMHC will work with the Nevada Office of Suicide Prevention to improve identification of youths with behavioral health needs through (1) Training of caseworkers and probation officers and (2) More effective and comprehensive screening programs. The CCCMHC will support the Clark County Department of Family Services in implementing the Child Welfare League of America’s recommendation for a mental health substance use/abuse screening within 24 hours of out-of-home placement (Child Welfare League of America, 2003).

Role of Family Involvement

Parents and other caregivers are a child’s first and foremost teachers. Prevention programs that address issues of families increase the potential of positive outcomes. Family members and caregivers should be equal partners, along with school and community leaders in selecting, implementing, evaluating and sustaining prevention programs. School settings present a key opportunity to reach out to families because the social and emotional skills taught by these programs have a positive impact on academic achievement. Primary health care also offers great potential to involve families in mental health prevention, as well as screening and early intervention.

Nevada Parents Encouraging Parents and individual family organizations can play a key role in conducting outreach to the parents of children who are at risk for behavioral health problems. In partnership with the Nevada Office of Suicide Prevention, Nevada PEP will develop better parent-to-parent engagement strategies to inform families about the benefits of screening, and obtain their consent for screening.

GOAL 6. Public Awareness

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

Current Needs and Barriers

One of the key barriers in improving children’s early access to behavioral health services is the stigma associated with children’s behavioral health problems. A large national survey has recently confirmed that both adults and teenagers have less understanding and more negative perceptions of youths with behavioral health problems

such as attention deficit disorder and depression, as opposed to those with physical health problems, such as asthma (Walker et al., 2008). Other studies have shown that children with serious mental health disorders are not well understood or accepted by their communities and families continue to be falsely blamed for their children’s behavioral health issues (Pescosolido et al., 2007). Parents are less likely to allow their children to play with others that have been identified with behavioral health needs, contributing to the social isolation of these children and their families.

Clark County families must overcome this stigma faced across the nation as their “last hill to climb” in the struggle to obtain services for their children. The negative perceptions of mental health disorders and services often keep parents from seeking treatment even after their children have been identified and referred. (Gould, 2009) With the support of federal funding through the Office of Suicide Prevention and the Nevada Division of Child and Family Services, the CCCMHC developed a nationally recognized public education campaign over the last three years aimed at increasing public awareness of the prevalence of children’s behavioral health problems and encouraging both parents and youth to seek help for these problems. Unfortunately, none of the systems providing behavioral health care have sustained funding for ongoing public awareness about children’s mental health needs.

Strategies to Meet Needs and Overcome Barriers

The goal of the CCCMHC is to heighten community awareness of the behavioral health needs of our county’s children so that families will be empowered and supported in seeking assistance for their children’s behavioral health needs. This plan recommends that state and local funds are allocated for public service announcements, school-based activities for students and parents, and dissemination of print brochures including and not limited to schools, medical clinics, libraries, recreation centers. In partnership with the Nevada Department of Education, the CCCMHC will work to strengthen high school and middle school curriculum requirements to teach about mental health awareness and suicide prevention. Through partnerships with professional associations and the Southern Nevada Health District, the CCCMHC will encourage all primary care facilities to provide information to parents on the importance of children’s behavioral health and warning signs of behavioral health problems through print and electronic means.

The Role of Family Involvement

Families who have successfully accessed services for their children play a key role in helping other parents to

overcome the stigma of children's behavioral health needs and reach out for assistance. The success of media and print materials is based on their relevancy for the families of our communities. The CCCMHC will support families and youth who can share their own stories and assist in the development and field testing of these materials.

Nevada Parents Encouraging Parents has played a key role in the success of our consortium's public awareness activities through technical assistance, focus groups and other partnerships designed to enhance the effectiveness of our communication strategies. The CCCMHC will continue to partner parent with PEP through its federally funded Statewide Parent Network. in developing public awareness campaigns.



There needs to be more programs that are cost effective and easily accessible for parents.

--parent

Community Input Survey



LOCAL SERVICE DELIVERY

Services, Eligibility and Access.

The Clark County Children’s Mental Health Consortium supports an integrated, **Public Health Approach** to behavioral health service delivery. The public health approach requires a local service delivery model that integrates universal services designed to promote the behavioral health of all children, targeted intervention for early identification and treatment of emerging behavioral health problems, and intensive services and supports for youths with the serious behavioral health problems. The goals of this 10-year plan will be realized when local system planning, management and services integrate these three strategies. More children will be served, the need for costly deep-end services will be reduced, and there will be significant improvements in the well-being of all of our children.

The Clark County Children’s Mental Health Consortium supports a **Systems of Care Philosophy** of service delivery. The public health approach will be implemented consistent with this philosophy. A “Systems of Care” philosophy crosses agency and program boundaries, and approaches the services and support requirement of families holistically (Pires, 2002). A system of care is defined as a “comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families,” (Pires, 2002). Core values of a system of care specify that services should be community based, child centered and family focused, and culturally competent.

Our consortium also supports a neighborhood-based model of service delivery. The **Neighborhood Family Service Center** model has been adopted in Clark County to provide the infrastructure for supporting accessible service delivery. At the youth and family level, the Neighborhood Family Service Centers use a Wraparound Process for the delivery of care management and intensive supports to children with serious emotional disturbance and their families. The **wraparound process** has been shown to produce effective outcomes for these children, especially when the local system management supports its principles.

The base of our local service delivery system is the promotion of behavioral health. Behavioral health promotion includes public awareness, prevention, and screening strategies targeted to all children and families. The role of the system is to provide public engagement and special supports to individuals such as parents, teachers, child care providers and health care providers to give them the knowledge and resources to promote behavioral wellness. Universal behavioral health promotion activities will be sufficient to avoid the need for mental health treatment for more than 80% of all children, and if provided consistently, should reduce the number of children who need intervention services.

Through a 1-800 number or the 2-1-1 system, all Clark County families will have access to information about children’s behavioral health and available services. Prevention and screening services will be available to all families.

The second level of the system is for targeted early access and intervention. Within the school system this would include a range of school-based group, individual or family services for the most common problems and school-supported linkages with community providers for all other identified problems. Outside the school system, Neighborhood Family Service Centers will provide access to mobile crisis services, standardized intake/assessment family supports, provider networks, informal supports and early childhood services.

Children who are identified with behavioral health needs will access services provided at the schools or providers who are linked with schools and/or neighborhood centers. These school-linked and neighborhood based provider networks will accept both private and public third party reimbursement for services so that all families have equal access and continuity of care.

The third level of the system is for children who have more intensive needs that require coordination across entities. This is the level of service that is provided through programs such as Wraparound In Nevada (WIN). Care management will be coordinated by a single management entity and provided at Neighborhood Center locations. Children who are at risk for serious emotional disturbance will be assessed through a standardized process overseen by the local management system and offered through the Neighborhood Centers. Children with serious emotional disturbance will receive only one care manager who is responsible for coordinating all of the services for the children and families.

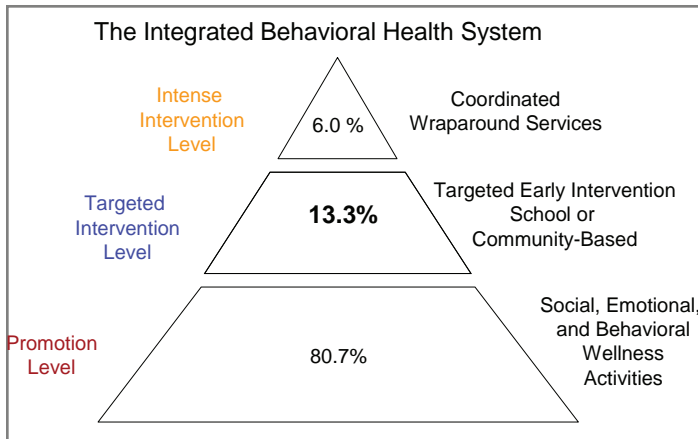


Figure 12. Clark County Service Delivery Approach. This diagram shows the community strategy to address the mental health needs of children in Clark County. For all children the strategy will be to provide community and school supports that promote social and emotional development and behavioral wellness. For 13.3% of the children, there will be additional in school based and neighborhood targeted early intervention. For those 6% of the students with the most intense needs, services will be coordinated through a collaborative care management entity.

Management Mechanisms

Local system management must be strengthened to support this model of effective and accessible behavioral health service delivery so that the three strategies of the public health approach (universal, targeted and intensive) are incorporated into the system. The local system management must develop infrastructure for the following functions: outreach and screening to at-risk populations, information and referral to prevention and targeted intervention services; formal linkage of providers with schools and neighborhood centers; standardized intake/assessment; mobile crisis services; family support; and development of informal support networks and volunteer resources.

In order to implement service delivery that is community-based, family-driven and culturally competent, a partnership of families, child-serving agencies and other stakeholders such as the CCCMHC must oversee the local management system. Oversight by a partnership of families, child-serving agencies and other stakeholders will increase the likelihood that system management will develop policies, services, and funding strategies that support neighborhood-based services, encourage family participation in all aspects of service planning, selection and delivery, and promote agency collaboration in the development, coordination and implementation of services and supports. The local management system must also have the resources to use information across the system to continuously evaluate outcomes and improve service delivery.

The local system management structure must have the ability to develop and monitor a new system of care management for children with serious emotional



disturbance and their families as recommended in this plan. The management system must have the resources and authority to blend/braid a variety of public and private funding sources, including: Medicaid, Federal Block Grant Funding, State Children’s Mental Health Funding, state and local child welfare and juvenile justice funding. The management system must have the flexibility to

redeploy these resources for new and different services and supports in order to meet the changing needs of our community’s children.

It is essential that the CCCMHC collaborate with the Nevada Department of Health and Human Services, the Mental Health Commission, and the Nevada Children’s Behavioral Health Consortium to gain support for a local management system with these characteristics. The CCCMHC supports the efforts of these organizations to strengthen the infrastructure for children’s mental health at the state level. The development of 1-800 information and referral systems, provider networks, utilization management and overall monitoring of the system may be standardized across regions through a statewide administrative services organization. Nonetheless, the local system management structure must have the ability to work closely together with such an organization to tailor these processes for the individual needs of our community.

Allocation of Costs

The CCCMC’s 10-year plan includes many strategies to leverage existing state and local funds to increase federal dollars, re-direct expenditures from deep-end programs to more effective, community-based services, and develop new funding sources through special fees and taxes. There are also opportunities for cost savings by reducing inefficiencies and eliminating duplicative services and structures. For example, re-structuring Medicaid’s system of intensive care management will not only result in opportunities to redeploy funding,

it will result in reduced expenditures for residential treatment and better outcomes for our children and families.

The ultimate goal is a cost allocation plan that provides adequate funding at all levels of the system. We hope to achieve a system where costs are allocated in the manner consistent with the public health approach and illustrated below:

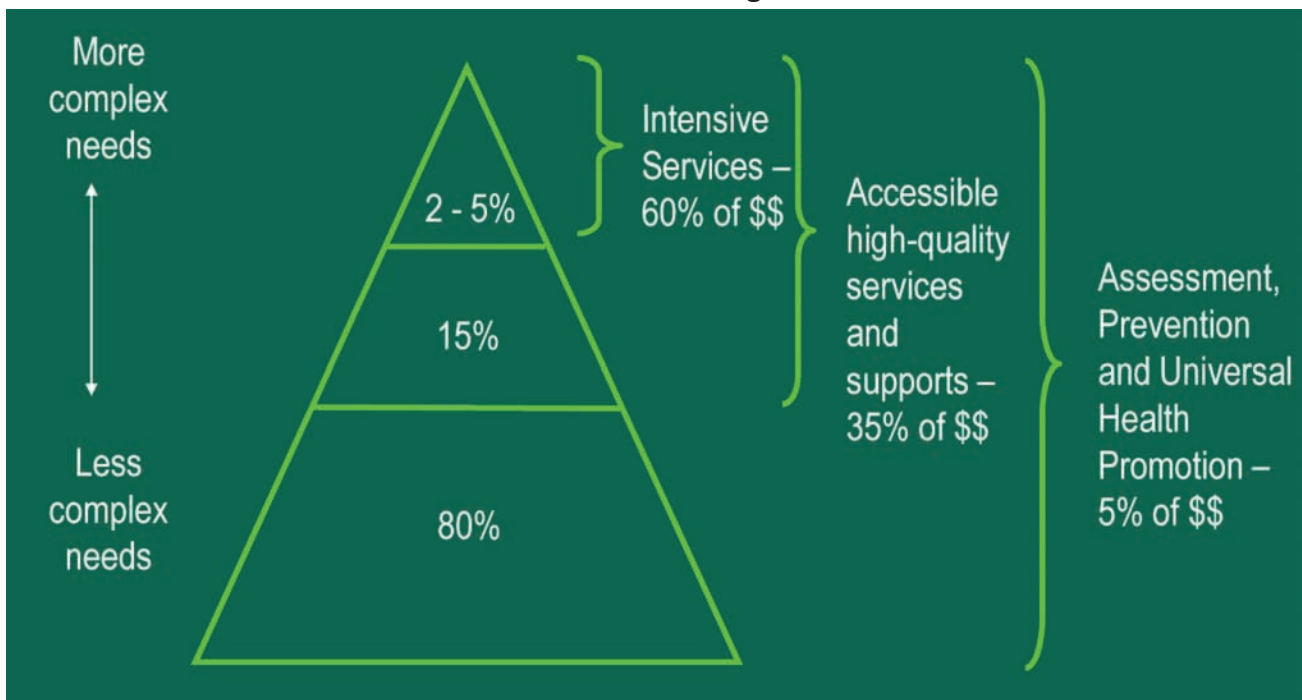


You have to know what's out there or have a place to go to find referrals.

--parent

2009 Community Input Survey

Prevalence Triangle



Pires S, 2006 Human Service Collaborative. Washington



PLAN GOALS, OBJECTIVES, STRATEGIES, AND MEASUREMENT INDICATORS

GOAL 1. Intensive Services and Supports. In partnership with families, children with serious emotional disturbance will become successful at home, school and in the community through effective programs of care management, services, and supports.

Objective 1.1 Intensive care management services using a wraparound approach will be provided to all youths identified with serious emotional disturbance involved in the juvenile justice system, the child welfare system, and youths with SED who are struggling in school and early childhood environments. *Strategies:* Re-structure Medicaid targeted case management program to support a single, accountable care management entity. *Indicators:* Numbers of youths receiving intensive care management. Improved outcomes for youths served including: improved school performance, decrease in out-of-home placements and incarceration rates.

Objective 1.2 Neighborhood-based resource teams will reduce the reliance on out of state placements and help identify and overcome barriers in providing community-based services to children with serious emotional disturbance and their families. *Strategies:* Strengthen adherence and commitment to the memorandum of understanding for resource teams. *Indicators:* Adherence to memorandum of understanding; Decrease in out-of-state placements, increase in number of children staffed.

Objective 1.3 Respite care, specialized child care, mentoring, home-based counseling, basic health care, and transitional services (including job services) will be available when needed to all children with serious emotional disturbance, including children at risk for placement in child welfare or juvenile justice. *Strategies:* Medicaid will develop and implement expanded eligibility programs for youths with SED; waivers or other innovative programs(e.g. Katie Beckett) to provide funding. *Indicators:* Increase in number of children served by these programs, increased family satisfaction and improved family functioning.

Objective 1.4 Flexible funding and financial supports will be available to children with serious emotional disturbance and their families to prevent out-of-home placement in the child welfare and/or juvenile justice systems. *Strategies:* CCCMHC will propose legislation to create a state/local tax or fee to fund this service. *Indicator:* Increase in number of children receiving flexible funding/financial supports. Increased satisfaction of families and improved family functioning, decreased numbers of out-of-home placements,

Objective 1.5 Family Driven, family-to-family support services will be available to all children with serious emotional disturbance through blended/braided funding. *Strategies:* Medicaid will develop and implement waivers or other innovative programs to provide funding for family-to-family support services; state/county should consider dedicated funding source such as a special tax or fee to fund this service. *Indicators:* Increase in funding for family-to-family support services; increase in number of families served.

Objective 1.6 Children with co-occurring developmental disabilities and behavior health problems will achieve better outcomes at home, at school and in the community *Strategies:* Improve collaboration between services agencies such as DCFS and MHDS *Indicator:* Improved memoranda of understanding

GOAL 2. Service Array and Accessibility. The Clark County Children’s Behavioral Health System will reduce the long-term and costly effects of untreated children’s behavioral health issues by providing timely access to a comprehensive array of effective services for identified children and their families, regardless of their ability to pay.

Objective 2.1 Public and private insurers will offer reimbursement rate incentives to enhance the array of proven models of community-based, evidenced based services. *Strategies:* Evidence-based and promising practice Service models to match community need will be identified in partnership with the consortium, providers and insurers. *Indicator:* Public and private insurer reimbursement rates for behavioral health services.

Objective 2.2 Increase the capacity to provide home and community-based services to uninsured and underinsured children and their families. *Strategies:* Redeploy funding from higher levels of care to fund community based services, allow families to buy into Medicaid. *Indicators:* Annual increase in state/county funding for services to uninsured/underinsured children and families. Increase in number of children and families served.

Objective 2.3 Medicaid will support outreach efforts to assist families in obtaining health care coverage in Medicaid or Nevada Check-up. *Strategies:* Medicaid will strengthen its outreach efforts by coordinating with health care workers and the Statewide Family Network. *Indicator:* Increase in families enrolled in Medicaid/Nevada Check-up and decrease in the percentage of uninsured children in Clark County.

Objective 2.4 Students will have increased access to behavioral health services through partnerships between schools and community providers focusing on assessment, evidence-based interventions for ADHD and depression, mentoring programs, and linkage to community services. *Strategies:* Schools and Medicaid will develop and implement a braided/blended funding plan for these services. *Indicator:* Proportion of schools offering each type of service. Number of children served. Achievement levels of children served.

Objective 2.5 Expand the capacity for community-based substance abuse programs for youths. *Strategies:* The Department of Health and Human Services will develop and implement a braided/blended financing plan for these services *Indicators:* Increase in amount of funding; increase in numbers of youths served.

Objective 2.6 Public and private insurers will expand their capacity to provide psychological and psychiatric assessments and psychotherapy services. *Strategies:* Request that the Insurance Commission review and standardize rates for professional services across third party payers. *Indicator:* Increase in proportion of children enrolled in public/private insurance programs who access behavioral health services.

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

Objective 3.1 A cross-agency 1-800 or 2-1-1 number will be available for all youths and families requesting behavioral health services to identify and prioritize service needs, and refer families to needed services. *Strategies:* Use blended/braided funding to support a regional system; partner with statewide family network to reach families of children with serious emotional disturbance *Indicator:* Number and type of calls to 1-800 number.

Objective 3.2 A cross-agency program of mobile crisis intervention and stabilization services will be available to divert youths in crisis from costly emergency rooms, inpatient care and juvenile detention. *Strategies:* DHHS will develop a funding plan through Medicaid's already existing program; blend/braid other funds to expand capacity of crisis services to all youths *Indicators:* Decrease in youths accessing emergency rooms; decrease in inpatient psychiatric bed utilization

Objective 3.3 State mental health policy and regulation will support local families, providers and law enforcement in accessing emergency care for children and youth with psychiatric crises. *Strategies:* Mental Health Commission to adopt policy and/or regulation to clarify the procedures for voluntary and involuntary hospitalization of children; CCCMHC to provide training to families, providers and law enforcement on improved policies *Indicator:* Written regulation or policy; number of trainings and participants.

Objective 3.4 Public and private providers of children's behavioral health services will adopt standardized intake and service planning protocols. *Strategies:* The Nevada Children's Behavioral Health Consortium will develop local memoranda of understanding between public and private providers. *Indicators:* Proportion of public and private providers adopting standardized intake and service plan tools.

Objective 3.5 Neighborhood Centers will coordinate intake, crisis intervention, service planning and service delivery processes across public and private providers in their geographic areas. *Strategies:* Redeploy state and county funding to support the local management structure in developing these functions. *Indicators:* Description of activities at neighborhood centers, Number of youths linked with crisis or other services.

GOAL 4. Local System Management. 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

Objective 4.1 The Clark County Children's Mental Health Consortium and the Nevada Children's Behavioral Health Consortium will be strengthened. *Strategies:* State funding will be allocated to sustain the CCCMHC and the NCBHC; Nevada Revised Statutes will be amended to formalize the role of the NCBHC as a subcommittee of the Mental Health Commission; Partnerships to be strengthened with Statewide Family Network *Indicator:* Increased participation by family members and stakeholders; increased funding; amended legislation.

Objective 4.2 The system will be regionally managed by an entity with oversight by the Clark County Children’s Mental Health Consortium and supported by blended/braided public agency funding. *Strategies:* Use Medicaid and state targeted case management and redirected “deep end” expenditures (residential care, detention, group care) to finance the structure; establish formal relationship between CCCMHC and local system management entity. *Indicator:* Identification of funding support, contracts for system management entity; memoranda of understanding.

Objective 4.3 In partnership with the Statewide Family Network, the regional systems management entity will facilitate cross-agency training and other workforce development activities, especially in the areas of behavioral health screening, systems of care, wraparound, and evidence-based practices. *Strategies:* Use Medicaid and state targeted case management and redirected “deep end” expenditures (residential care, detention, group care) to finance the infrastructure to provide these services; partner with local colleges and universities. *Indicators:* Number of annual trainings, number and type of participants.

Objective 4.4 The systems management entity will be financially supported to maintain an infrastructure for the Neighborhood Centers and expand the number of centers based on population growth. *Strategies:* Blend/braid local and state funding to support a single management entity. *Indicator:* Contracts, memoranda of understanding, integrated management structure

Objective 4.5 The systems management entity will provide referral and linkage to all children with behavioral health problems. *Strategies:* Redeploy and leverage deep-end funding to provide resources for this function; develop local partnerships with private insurers and providers. *Indicator:* Number and types of children and families screened, referred, and linked.

Objective 4.6 The systems management entity will provide a single locus of accountability for all intensive care management efforts provided to children with serious emotional disturbances. *Strategies:* Medicaid state plan and policy to be revised; contracts re-written for intensive care management; Funding for intensive care management to be blended/braided. *Indicator:* Increase in blended/braided funding for intensive care management, standardization of service contracts.

Objective 4.7 A statewide system for measuring process improvements and outcomes for children and families will provide yearly measurements of the success of the Clark County system. *Strategies:* State Children’s Behavioral Health Consortium to develop indicators; Department of Health and Human Services to implement policy that requires regular reporting by its agencies, including Medicaid. *Indicator:* Progress toward implementing statewide system.

Objective 4.8 Provider standards and accountability mechanisms will facilitate the delivery of quality care and family-responsive services. *Strategies:* Partner with the state children’s mental health authority to develop and implement agency certification and provider standards for access, quality of care, and performance measures; Link payments to provider performance and outcomes. *Indicators:* Written standards and policies, provider contracts, performance and outcome reports.

GOAL 5. Prevention and Screening. 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.

Objective 5.1 There will be yearly suicide prevention screening programs in Clark County middle schools and high schools, focusing first on the needs of the county’s rural schools, schools with transient populations, and schools with culturally diverse populations. *Strategies:* Medicaid, State and local funds for children’s behavioral health screening will be allocated. *Indicators:* Number and type of students screened yearly; Decrease in number of suicide attempts as reported on Youth Risk Behavior Survey and other available data reports.

Objective 5.2 There will be yearly school-based screening programs offered in early elementary grades for general behavioral health issues. *Strategies:* Medicaid, State and local funds for children’s behavioral health screening will be allocated. *Indicators:* Number of elementary school children screened annually and number linked to services.

Objective 5.3 Pediatricians and primary care physicians will use standardized behavioral health screenings as part of Medicaid EPSDT examinations and other well-child check-ups. *Strategies:* CCCMHC will work with professional associations and third party payers to support the development and dissemination of information. *Indicators:* Proportion of physicians using standardized tool

Objective 5.4 School aged children will participate in school-based bullying prevention, social/life skills training programs, and universal programs of positive behavioral supports. *Strategies:* Funds will be allocated to support training, implementation and follow up. Curriculum standards/regulations include requirements for bullying prevention and social/life skills training. *Indicator:* School Policies and regulations, Schools with programs and number of students participating.

Objective 5.5 Education and support will be available to parents of at-risk pre-kindergartners at local elementary schools using the model developed by the Clark County School District's Safe Schools Initiative. *Strategies:* New state education funding will be allocated. *Indicators:* Number of schools and participants.

Objective 5.6 In partnership with the Office of Suicide Prevention, school personnel will receive training in early screening and intervention for behavioral health issues and suicide prevention. *Strategies:* The Office of Suicide Prevention will provide train the trainer support to local public and private schools. *Indicator:* Proportion and type of staff trained annually.

Objective 5.7 Families will have access to effective, low cost parent training and education programs regularly at neighborhood-based locations across the county. *Strategies:* In partnership with Nevada PEP and family resource centers, CCCMHC will inventory current programs and models and develop strategies to address gaps in service capacity and quality. *Indicator:* Number of sessions and participants annually.

Objective 5.8 Universal behavioral health screening will be available for all youth and families referred to the juvenile justice and child welfare systems. *Strategies:* The Department of Health and Human services will provide technical assistance to local and state agencies to establish universal screening programs. *Indicator:* Proportion of children screened.

Objective 5.9 Increase culturally relevant outreach to at-risk populations and early screening efforts through school-based health clinics, partnerships with primary care clinics, and Nevada PEP. *Strategies:* Medicaid funding through administrative claiming or fee-for-service peer support. *Indicator:* Annual Medicaid expenditures for Clark County outreach and screening.

Objective 5.10 Increase the early identification of youths in the child welfare and juvenile justice systems. *Strategies:* Partner with the Nevada Office of Suicide Prevention to train caseworkers and probation officers; implement more effective and comprehensive screening programs. *Indicators:* Number of children and youth identified and linked with services.

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

Objective 6.1 There will be ongoing public awareness activities in Clark County which include: public service announcements, school-based activities for students and parents, and dissemination of print brochures including and not limited to schools, medical clinics, libraries, recreation centers. *Strategies:* State and local funds for children's mental health will be allocated to fund public awareness activities. *Indicator:* Number, type and outcomes of public awareness activities yearly

Objective 6.2 In partnership with the Nevada Department of Education, high school and middle school curriculum requirements will include training on mental health awareness and suicide prevention. *Strategies:* CCCMHC will review the curriculum and work with the Nevada Department of Education to improve standards. *Indicator:* Nevada Department of Education regulations.

Objective 6.3 All primary care facilities in Clark County will provide information to parents on the importance of children's behavioral health and warning signs of behavioral health problems through print and electronic means. *Strategies:* CCCMHC will work with professional associations, Southern Nevada Health District, and Nevada PEP to support the development and dissemination of information. *Indicator:* Proportion of primary care facilities with available materials.



PRIORITIES AND TIMELINES

Priorities

The CCCMHC's priorities for the next biennium have been identified as immediate actions which will provide the most short-term, cost effective improvements in the system while serving as building blocks for the long term plan. These priorities are:

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.

Identified Needs: Failure of current policy and funding strategies to improve access and quality of services; promote positive outcomes for children with the most serious problems; and strengthen families' ability to care for their children; identified as a top priorities by Clark County's families, caseworkers, and providers.

Desired Outcomes: Fewer children in out-of-home care; policies and standards that promote appropriate community-based care; cost-savings from inefficient and ineffective programs; positive clinical, school, and community outcomes for children.

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

Identified Needs: Increasing numbers of youths in crisis entering local emergency rooms and pediatric hospitals; increasing number of youths in crisis identified during school hours; high readmission rates for psychiatric hospital and other institutional care.

Desired Outcomes: Effective, responsive treatment for youths in crisis and their families; decrease in utilization of local hospitals for youth psychiatric emergencies; decrease in utilization of psychiatric inpatient care and other out-of-home placements; cost savings.

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

Identified Needs: Lack of access to these services for children with serious emotional disturbance who are living with their families; high use of out-of-home placements in the child welfare and/or juvenile justice systems for these children; identified as a priority by Clark County families, caseworkers and providers.

Desired Outcomes: Improvements in home, school, and community functioning for children with serious emotional disturbance; reduction in need for out-of-home placements; reduced costs for foster care and other placements.

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

Identified Needs: Increasing number of families requesting family-to-family each year; identified as a priority by Clark County families, caseworkers and providers

Desired Outcomes: Improved access to services through family support and education; improvements in home, school and community functioning for youths with serious emotional disturbance; decreased stress for families; improvement in families' ability to care for their children.

Expand access to intensive care management using a wraparound model for youths with serious emotional disturbance, including those involved with the juvenile justice system and those living with their families.

Identified Needs: Lack of access to intensive, effective case management, especially for youth in the juvenile justice system and those living at home.

Desired Outcomes: Reduction in symptoms and improved functioning at home, in school and in the community; fewer re-offenses and improved community safety; reduced costs for out-of-home placement and institutional care.

Support early childhood preventative programs that strengthen families' ability to promote the social and emotional development of their children.

Identified Needs: Large numbers of young children with risk factors for behavioral health problems, such as diversity, poverty, maltreatment and homelessness; identified as top priority by Clark County families, caseworkers, and providers

Desired Outcomes: Reduced need for special education and treatment upon entering school; decrease in later involvement with juvenile justice; cost savings to a variety of public systems.

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

Identified Needs: Failure to identify school students with emerging behavioral health needs; lack of access to early treatment for students identified with behavioral health problems; large number of students in crisis

Desired Outcomes: Earlier access to treatment; better academic and social functioning for students identified and treated; improved identification of youths at risk of suicide; reduced need for special education services; cost savings

Timelines

The CCCMHC recognizes that there is a long road ahead to achieve the goals of this 10-Year Strategic Plan. This 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. We cannot continue to operate using a “band-aid” approach to address each service delivery “crisis.” In recognition of the daunting task of implementing this plan, the CCCMHC has developed the following implementation timelines.

Phase 1 - July 1, 2010 - June 30, 2013

Goal 1. Intensive Services and Supports

- 1.1** Re-structure Medicaid Care Targeted Case Management Policies to support a single, accountable care management entity in Clark County. Blend/braid existing funding to implement the care management entity
- 1.2** Strengthen adherence and commitment to local barrier-busting resource teams
- 1.3** Expand Medicaid eligibility to cover home-based counseling and other family supports for youth with serious emotional disturbance who are at risk for rehospitalization or placement in child welfare or juvenile justice
- 1.6** Strengthen partnerships between DCFS, MHDS and other agencies to improve services to children with co-occurring developmental disabilities and behavioral health problems

Goal 2. Comprehensive Service Array

- 2.1** Identify evidence-based and promising practice models for most needed services; Re-structure Medicaid rates to provide incentives for these practices

- 2.3** Strengthen outreach programs to assist families in obtaining healthcare coverage

- 2.6** Expand capacity and improve quality for psychological and psychiatric assessments and service through creation for private and public resources

Goal 3. Organized Pathway to Care

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

- 3.3** Mental Health Commission to adopt policy and/or regulations clarifying procedures for voluntary and involuntary hospitalization of children

- 3.4** Implement memorandum of understanding for standardized intake and service planning protocols across public and private providers

Goal 4. Local Systems Management

- 4.1** Strengthen role of state and local consortia; support legislation to include the state consortium as a subcommittee of the Mental Health Commission

- 4.2** Develop and implement a plan for state and local system management; establish formal relationship between CCCMHC and local system management

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

- 4.6** Re-structure Medicaid targeted case management policies and funding to create regional care management entities under the direction of local system management

- 4.7** Partner with state consortium to develop standardized performance and outcome measures for the local system

Goal 5. Prevention and Screening

- 5.1** Develop and implement effective screening models for middle and high school students through GLS Grant

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

- 5.6** Develop and implement a comprehensive plan for training school personnel in early identification and intervention for behavioral health issues and suicide prevention through the GLS Grant

5.8 Assist local child welfare and juvenile justice agencies to implement universal screening mechanisms for behavioral health issues and suicide risk

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

Goal 6. Public Awareness

6.1 Continue Public Awareness Activities through GLS Grant

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

Phase 2 - July 1, 2013 - June 30 2015

Goal 1. Intensive Services and Supports

1.1 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

1.3 Expand access to most needed intensive services for uninsured and underinsured children with SED through innovative Medicaid programs.

1.5 Expand family-to-family support services through innovative Medicaid programs, blended/braided funding.

Goal 2. Comprehensive Service Array

2.1 Standardize reimbursement incentives statewide for public and private insurers

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

2.5 Expand Medicaid Program and blend/braid funding to expand substance abuse services

Goal 3. Organized Pathway to Care

3.1 Implement 2-1-1 or 800 number for behavioral health system entry

3.2 Expand Mobile Crisis Intervention to all youths in crisis, including privately insured and uninsured

3.4 Enhance Neighborhood Center Infrastructure to provide standardized intake, assessment and crisis management

3.5 Partner with private providers to facilitate information and referral

Goal 4. Local System Management

4.2 Expand role of local system management from care management to management of crisis intervention, provider networks, intake and referral

4.3 Develop and 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

4.4 Enhance neighborhood-center infrastructure to promote the development of informal support networks with churches, community centers, and other organizations

4.8 Local system management entity to develop performance-based contracts with providers linking standards of care, outcomes and reimbursement

Goal 5. Prevention and Screening

5.2 Develop and implement school-based screening programs for elementary school children

5.3 Develop and implement standards and reimbursement incentives for screening in primary care settings

5.4 Education funding will support evidence-based preventative programs for bullying prevention, social/life skills training, and positive behavioral supports in public schools

5.9 Use Medicaid funding and a partnership with Nevada PEP to expand outreach and early screening to at-risk groups through school-based health clinics and primary care clinics

Goal 6 Public Awareness

6.1 Establish ongoing funding source for Public Awareness Activities

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

Phase 3 - July 1, 2015 - January 31, 2020**Goal 1. Intensive Services and Supports**

- 1.1** Expand care management through partnerships with private insurers
- 1.4** Establish tax or fee to expand financial supports for youths with SED
- 1.5** Establish tax or fee to expand family-to-family support services

Goal 2. Comprehensive Service Array

- 2.12** Redeploy public funding from higher levels of care to expand community services for uninsured and underinsured
- 2.2** Expand school-based and school-linked services

Goal 3. Organized Pathway to Care

- 3.4** Expand relationships with private insurers to support standardized information, referral, assessment and crisis intervention services

Goal 4. Local System Management

- 4.4** Expand the number of neighborhood centers
- 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

Goal 5. Prevention and Screening

- 5.1** Sustain universal screening in schools and primary care clinics through blend/braided funding
- 5.4** Education funding will support evidence-based programs for bullying prevention, social/life skills training, and positive behavioral supports in public schools
- 5.5** Education funding will support preventative programs for at-risk young children and their families using the school-based model developed by Clark County's Safe Schools Initiative
- 5.7** Family support and education will be available at neighborhood-based locations across the county through partnerships between Nevada PEP, the family resource centers, and the consortium

Goal 6. Public Awareness

- 6.1** Provide ongoing public awareness activities in the media, in schools, clinics and other community settings



I have seen the inadequacies of the...system. I do hope changes can occur--as our future children are at risk!

--parent

2009 Community Input Survey



ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Mission

The Consortium was created by the passage of Assembly Bill 1 of the 2001 Special Session of the Nevada Legislature to study the mental health needs of all children in Clark County and to develop recommendations for service delivery reform. The Consortium is required to conduct a needs assessment and submit a 10-Year Strategic Plan to the Mental Health and Developmental Services Commission and the Nevada Department of Health and Human Services. Required membership and activities for the Consortium are described in Nevada Revised Statutes 433B.333-335.

Current Membership

Jacqueline Harris, Chair

Bridge Counseling Associates

Cynthia Escamilla, Vice-Chair

Parent Representative

Mike Bernstein

Southern Nevada Health District

Jennifer Bevacqua

Nevada Youth Care Providers Association

Lisa Durette, M.D.

American Academy of Child & Adolescent Psychiatry

Janelle Kraft Pearce

Las Vegas Metropolitan Police

Dee McLellan

Nevada Division of Mental Health & Developmental Svcs.

Patty Merrifield

Nevada Division of Child & Family Services

Karen Miller

Parent Representative

Tom Morton

Clark County Family Services

Fritz Reese

Clark County Juvenile Justice Services

Andreana Robinson

Foster Parent

Palisa Sturgis

Nevada Division of Health Care Financing and Policy

Karen Taycher

Nevada Parents Encouraging Parents

Hilary Westrom

Children's Advocacy Alliance

Kim Wooden

Clark County School District

Recent Activities & Accomplishments

- ▲ Produced and disseminated three public service announcements promoting children's mental health awareness
- ▲ Developed a model of mobile crisis intervention services for diversion of youth psychiatric emergency room admissions
- ▲ Facilitated training to law enforcement personnel to reduce involuntary admissions of youths to psychiatric hospitals
- ▲ Distributed brochures in English and Spanish to educate parents on the signs and symptoms of children's behavioral health problems
- ▲ Provided training to local pediatricians on methods for screening, identification and referral of children with behavioral health problems
- ▲ Facilitated the development of interagency protocols to ease the transition of youth from psychiatric hospitals back to their school environment
- ▲ Served as the steering committee for the Garrett Lee Smith Youth Suicide Prevention Project
- ▲ Developed and implemented an interagency barrier-busting process for youths at risk of out-of-community placement

For more information, contact:

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