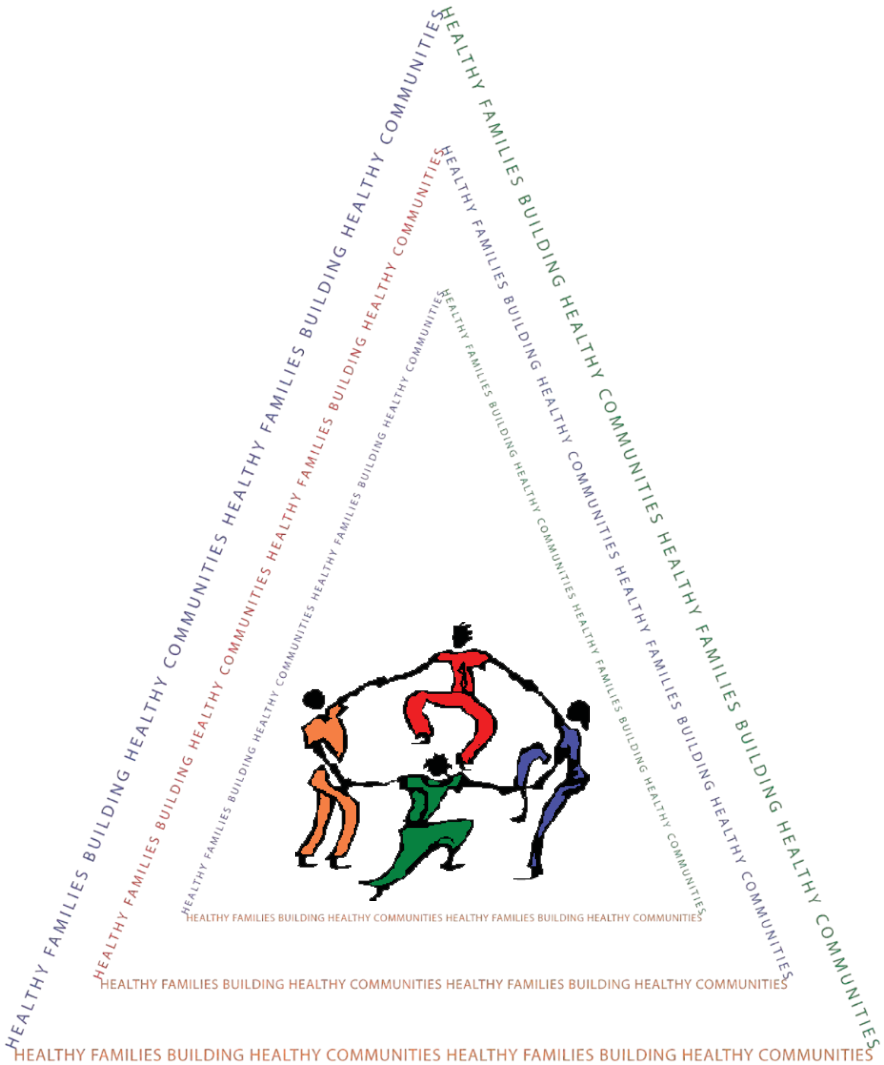
# CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

## 10-YEAR STRATEGIC PLAN

### 2030 VISION FOR SUCCESS

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



# 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 youth 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 conditions become severe and chronic. The Clark County Children's Mental Health Consortium has recognized that the extreme challenges faced by children with behavioral health needs and their families can only be overcome by strategic and sustained planning efforts to develop a more effective system of care for these children.

Nevada has consistently ranked 51st for youth mental health access and services in national reports. Though some improvements have been made since 2010, these changes have not be significant enough to increase our ranking and meet the threshold achieved by other states. To help provide Nevada's youth and families with the high quality care and timely access to services they deserve, the Clark County Children's Mental Health Consortium has updated its 10-Year Strategic Plan to guide future program and service implementation. This plan is based on a set of values and principles that promote a system of care that is community-based, family-driven, and culturally competent. Using a public health approach and working with families and community partners, the Clark County Children's Mental Health Consortium will work to achieve the following long-term goals for Clark County by the year 2030.

## *GOALS*

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

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

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

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

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

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

# Table of Contents


EXECUTIVE SUMMARY ..... 1

2030 GOALS, OBJECTIVES, and STRATEGIES ..... 3

INTRODUCTION ..... 8

**Overview** ..... 8

**Vision and Goals** ..... 9

**Values and Attributes of the Nevada Children's Behavioral Health Consortium** ..... 10

**Public Health Approach to the System of Care** ..... 11

**Prevalence of Mental Health Problems** ..... 12

**Factors Affecting the Mental Health of Clark County's YOUTH** ..... 13

**Laws and Regulations Regarding Youth Mental and Behavioral Health** ..... 14

ACHIEVING THE GOALS ..... 17

**GOAL 1: ADDRESSING THE HIGHEST NEED** - Youth with serious emotional disturbance, including those with the highest need, and their families, will thrive at home, school, and in the community with intensive supports and services ..... 17

*Objective 1.1: Reduce barriers across systems to accessing intensive care management services, implementing a wraparound approach to services for youth.* ..... 17

*Objective 1.2: Reduce the reliance on out-of-state and out-of-community placements for services or treatment of youth with serious emotional disturbance.* ..... 18

*Objective 1.3: Increase the types of support services available (e.g. respite, specialized childcare) and capacity for current treatment services (e.g. location and number of providers) for youth and their families.* ..... 19

*Objective 1.4: Increase the availability of peer support services - both family-to-family and youth-to-youth.* ..... 20

*Objective 1.5: Increase services and supports for families of youth with co-occurring intellectual/ developmental disabilities and mental and behavioral health needs.* ..... 21

**GOAL 2: COMPREHENSIVE SERVICE ARRAY FOR ALL - *Families of youth with any mental and behavioral health needs will have timely access to a comprehensive array of high-quality services when and where needed.*** ..... 22

*Objective 2.1: Increase utilization of high quality, evidence-based and promising practice service models to match community needs.* ..... 22

*Objective 2.2: Increase the capacity and access to provide home and community based services to youth and their families.* ..... 22

*Objective 2.3: Support efforts to assist families in obtaining healthcare coverage.* ..... 24

*Objective 2.4: Increase access to mental and behavioral health services to youth through partnerships between schools and public/private services across the community.* ..... 24

*Objective 2.5: Expand the capacity for community-based substance use programs for youth.* ..... 25

*Objective 2.6: Expand capacity to provide psychological and psychiatric assessments and psychotherapeutic services.* ..... 25

*Objective 2.7: Re-establish neighborhood-based resource centers.* ..... 26

**GOAL 3: NO WRONG DOOR TO SERVICES - *Organized pathways to information, referral, assessment, and crisis intervention – coordinated across agencies and providers – will be available for families.*** ..... 26

*Objective 3.1: Establish a centralized hub for information and service entry for youth and families in need of mental and behavioral health services.* ..... 27

*Objective 3.2: Expand access to mobile crisis services (especially DCFS Mobile Crisis Response Team) as the first line*

*of crisis intervention to ensure the needs of ALL youth are met.* ..... 27

*Objective 3.3: Improve policies and regulations regarding involuntary legal holds for youth.* ..... 27

*Objective 3.4: Encourage the adoption of interagency protocols to streamline procedures and reduce unnecessary burden on families accessing services.* ..... 28

*Objective 3.5: Promote effective implementation of community-based strategies to coordinate services across providers within urban and rural Clark County areas that are geographically accessible for families.* ..... 28

**GOAL 4: PREVENTION and EARLY INTERVENTION IN MENTAL HEALTH - *Programs and services will be available to facilitate the social and emotional development of all youth, identify mental and behavioral health issues as early as possible, and assist families in caring for their youth.*** ..... 28

*Objective 4.1: Increase implementation and availability of evidence-based strategies for the early identification of mental and behavioral health needs for all youth.* ..... 29

*Objective 4.2: Provide training and education, which is up-to-date and culturally competent, about youth mental and behavioral health to families and people working with youth.* ..... 29

*Objective 4.3: Expand implementation of universal programs for youth to promote social emotional skills and positive behavioral supports across settings.* ..... 30

**GOAL 5: RAISE AWARENESS and SUPPORT FOR MENTAL HEALTH - *Increased public awareness of the behavioral health needs of youth will reduce stigma, empower families to seek early assistance, and mobilize community support for system enhancements.*** ..... 31

*Objective 5.1: Increase awareness of youth mental and behavioral health information to members of the general community.* ..... 31

*Objective 5.2: Expand youth mental and behavioral health awareness and suicide prevention in schools and community-based programs.* ..... 31

*Objective 5.3: Support advocacy efforts to make youth mental and behavioral health a priority for local, state, and federal policymakers.* ..... 31

**GOAL 6: LOCALLY MANAGED SYSTEM OF CARE - *A partnership of families, providers, and stakeholders committed to community-based, family driven, and culturally competent services will collaborate to manage this system of care effectively at the local level.*** ..... 32

*Objective 6.1: Strengthen the role of state and local children's mental health consortia.* ..... 32

*Objective 6.2: Support the Nevada System of Care to promote the growth and sustainability of locally managed organizational structures.* ..... 32

*Objective 6.3: Facilitate cross-agency training and workforce development activities, in the foundational areas of: (1) behavioral health screening, (2) principles and approaches of the system of care, (3) High Fidelity Wraparound, and (4) evidence-based practices at the local level.* ..... 33

*Objective 6.4: Ensure accountability of the Nevada System of Care through consistent information-sharing to CCCMHC.* ..... 34

REFERENCES ..... 35

ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM ..... 39

APPENDIX A: NEVADA SYSTEM OF CARE GLOSSARY ..... 40

APPENDIX B. 2019 CLARK COUNTY MENTAL HEALTH NEEDS ASSESSMENT RESULTS ..... 49

**KEY INFORMANT INTERVIEW SUMMARIES** ..... 49

Common Mental and Behavioral Health Issues ..... 49

Current Services and Resources ..... 50

Barriers to Service Delivery ..... 50

Recommendations for Improvement from Stakeholders ..... 52

**PARENT FOCUS GROUP SUMMARIES** ..... 53
Accessibility of Mental and Behavioral Health Services and Treatment ..... 53
Quality of Mental and Behavioral Health Services and Resources ..... 53
Recommendations from Parents ..... 55
**2019 COMMUNITY INPUT SURVEY** ..... 56
APPENDIX C: CCCMHC MEDICAID RFP RECOMMENDATIONS ..... 68

# 2030 GOALS, OBJECTIVES, and STRATEGIES

| **GOAL 1: *ADDRESSING THE HIGHEST NEEDS***<br>**Youth with serious emotional disturbance, including those with the highest need, and their families, will thrive at home, school, and in the community with intensive supports and services.** | |
|---|---|
| **Objective** | **Strategies** |
| **1.1** - Reduce barriers across systems to accessing intensive care management services, implementing a wraparound approach to services for youth. | **1.** Blend/braid existing and redirected funding from state and county service systems.<br><br>**2.** Implement a care management entity focused on strength-based, individualized care.<br>● Design this system to reduce the use of institutional-based care, while providing more services in the home and community.<br>● Incorporate family inclusion in treatment programs.<br><br>**3.** Expand intensive case management to reach all youth with serious emotional disturbance that are involved in multiple state and county service systems.<br>● Support collaboration among child welfare, education, juvenile justice, and mental health in service delivery. |
| **1.2** – Reduce the reliance on out-of-state and out-of-community placements for services or treatment of youth with serious emotional disturbance. | **1.** Facilitate the development and implementation of a community-wide interagency process for reviewing out-of-state and out-of-community placements, with the authority to implement recommendations.<br><br>**2.** Obtain a dedicated funding stream to ensure flexible funding and financial supports will be available to children with serious emotional disturbance and their families to prevent out-of-home placement.<br>● Expand flexible funding allocated to DCFS or the county to help families of children with serious emotional disturbance pay for supports and services not covered by a payer source.<br><br>**3.** Build capacity for appropriate levels of treatment to accommodate youth transitioning out of RTC. |
| **1.3** – Increase the types of support services available and capacity for current treatment services for youth and their families. | **1.** Focus expansion of services for those who are: (a) at risk for hospitalization or placement in child welfare or juvenile justice; and (b) uninsured and underinsured who need such services to prevent higher levels of care.<br>● Increase capacity for family support services such as respite and specialized childcare.<br><br>**2.** Expand access to services and network capacity by increasing the number of providers qualified to treat youth throughout Clark County, especially in underserved areas.<br>● Include unique and expanded methods for transportation for youth and their families to and from services. |
| **1.4** – Increase the availability of peer support services – both family-to-family and youth-to-youth. | **1.** Expand family and youth peer-support services through innovative Medicaid programs, and blended/braided funding.<br>● Ensure inclusion of these support services within the Medicaid State Plan. |
| **1.5** – Increase services and supports for families of youth with co-occurring intellectual/developmental disabilities and mental and behavioral health needs. | **1.** Establish a single accountable agency to serve youth with co-occurring developmental disabilities and mental and behavioral health needs.<br><br>**2.** Evaluate Medicaid guidelines and criteria to prevent exclusion of youth with co-occurring needs from receiving needed services based on a particular diagnosis. |

| GOAL 2: *COMPREHENSIVE SERVICE ARRAY FOR ALL*<br>**Families of youth with *any* mental and behavioral health needs will have timely access to a comprehensive array of high-quality services when and where needed.** | |
|---|---|
| **Objective** | **Strategies** |
| **2.1 –** Increase utilization of high quality, evidence-based and promising practice service models to match community needs. | **1.** Standardize reimbursement incentives statewide for public and private insurers.<br>● Re-structure Medicaid rates to provide incentives for evidence-based and promising practice models.<br><br>**2.** Support increased training and workforce development on high quality service models.<br>● Work with licensing boards to provide CEUs for providers offering certain evidence-based practices. |
| **2.2 –** Increase the capacity and access to provide home and community based services to youth and their families. | **1.** Redeploy funds from higher levels of care (intensive services and supports) to help sustain and expand community-based services.<br>● Encourage a tax or fee to expand financial supports and services for youth with mental and behavioral health needs.<br><br>**2.** Increase network capacity to help expand community-based services.<br>● Advocate for a state subsidy for providers working with youth in rural areas of Clark County. |
| **2.3 –** Support efforts to assist families in obtaining health care coverage. | **1.** Expand insurance coverage for uninsured and underinsured youth.<br><br>**2.** Strengthen outreach efforts to increase the number of youth/families enrolled in Medicaid/Nevada Check-Up.<br><br>**3.** Advocate for and support requirements for standardizing mental and behavioral health services covered across health care insurance resources |
| **2.4 –** Increase access to mental and behavioral health services to youth through partnerships between schools and public/private services across the community. | **1.** Expand capacity for school and community-based services to prevent depression and youth suicide.<br><br>**2.** Develop neighborhood-based, school-linked provider network to address mental and behavioral health needs. |
| **2.5 –** Expand the capacity for community-based substance use programs for youth. | **1.** Blend/braid funding to expand substance use services for youth.<br><br>**2.** Promote collaboration between Medicaid, SAPTA, and other funding sources to provide appropriate services for youth in need of both substance use and mental and behavioral health services.<br>● Encourage cross-training between agencies to ensure effective treatment for youth. |
| **2.6 –** Expand capacity to provide psychological and psychiatric assessments and psychotherapeutic services. | **1.** Utilize private and public insurance resources to improve the quality and accessibility of psychological and psychiatric assessments and services. |
| **2.7 -** Re-establish neighborhood- based resource centers. | **1.** Encourage a collaborative, inter-agency process to secure sustainable funding and infrastructure for neighborhood-based resource centers in Clark County.<br><br>**2.** Expand behavioral health care services at The Harbor to increase access to community-based locations. |

| GOAL 3: *NO WRONG DOOR TO SERVICES*<br>**Organized pathways to information, referral, assessment, and crisis intervention – coordinated across agencies and providers – will be available for families.** | |
|---|---|
| **Objective** | **Strategies** |
| **3.1 –** Establish a centralized hub for information and service entry for youth and families in need of mental and behavioral health services. | **1.** Redeploy cost savings from intensive services and supports provided by the state and county agencies to support local management of a coordinated information and referral system for all youth.<br><br>**2.** Make information and resources readily available to families via online access (e.g. website, newsletters, blogs, etc.), a statewide phone number, and/or text line.<br>● Encourage regular maintenance of available resources to ensure information provided to families is accurate and up-to-date.<br><br>**3.** Provide a single point of contact that families can easily access to receive information and enter into a service delivery system.<br>● Ensure initial contact is with a live person. |
| **3.2 –** Expand access to mobile crisis services (esp. DCFS Mobile Crisis Response Team) as the first line of crisis intervention to ensure the needs of all youth are met. | **1.** Expand access to MCRT services for more youth.<br>● Increase access for transitional age youth.<br>● Expand services to meet the needs of youth with intellectual/developmental disabilities and substance use.<br><br>**2.** Secure increased and sustainable funding for mobile crisis services from Medicaid.<br><br>**3.** Increase awareness of mobile crisis among families and community organizations.<br>● Expand partnerships between mobile crisis, local and state agencies, schools, mental and behavioral health providers, community organizations, and businesses. |
| **3.3 –** Improve policies and regulations to regarding involuntary legal holds for youth. | **1.** Provide education for families and providers about emergency care services available in the community and families' rights in accessing them.<br><br>**2.** Provide recommendations for the development and implementation of current and future statutes affecting youth mental and behavioral health and families' access to services.<br>● This includes, but is not limited to AB378 and SB 204 passed during the 80th Session of the Nevada Legislature in 2019. |
| **3.4 –** Encourage the adoption of interagency protocols to streamline procedures (e.g. intake, assessments, and service planning) to reduce unnecessary burden on families accessing services. | **1.** Promote information-sharing practices between providers and across agencies to ensure a continuity of care for youth and families.<br><br>**2.** Develop effective intake and service planning procedures that can be easily adapted by multiple providers for community-wide implementation.<br><br>**3.** Encourage all mental and behavioral health providers to accept completed assessments from other agencies.<br>● Accept MCRT assessments at all mental and behavioral health agencies.<br>● Establish protocols for publicly funded providers to use evidence-based national assessment tools. |
| **3.5 –** Promote effective implementation of community-based strategies to coordinate services across providers within urban and rural Clark County areas that are geographically accessible for families. | **1.** Explore the feasibility and effectiveness of electronic options for service delivery and care coordination.<br><br>**2.** Increase mental and behavioral health providers in high-need neighborhoods.<br>● Encourage providers and agencies to share office and clinic space in multiple locations for greater presence in more neighborhoods.<br>● Expand capacity for in-home services. |

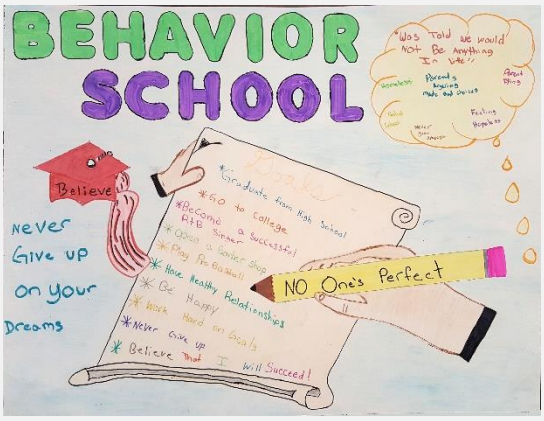
| GOAL 4: *PREVENTION and EARLY INTERVENTION IN MENTAL HEALTH*<br>**Programs and services will be available to facilitate the social and emotional development of all youth, identify mental and behavioral health issues as early as possible, and assist families in caring for their youth.** | |
|---|---|
| **Objective** | **Strategies** |
| 4.1 Increase implementation and availability of evidence-based strategies for the early identification of mental and behavioral health needs for all youth. | **1.** Pediatricians and primary care physicians will use standardized behavioral health screenings as part of Medicaid EPSDT and other well-child check-ups.<br><br>**2.** Assist local child welfare and juvenile justice agencies to implement universal screening mechanisms for behavioral health issues and suicide risk.<br><br>**3.** Expand implementation of effective school-based depression and suicide prevention screening models for middle and high school students. |
| 4.2 Provide training and education, which is up-to-date and culturally competent, about youth mental and behavioral health to families and people working with youth. | **1.** Implement evidence-based prevention programs for bullying prevention, social/life skills training, and positive behavioral supports in schools by (a) inventorying current programs, and (b) progressively expanding successful programs.<br><br>**2.** Provide education and support to parents of at-risk pre-kindergarteners at local elementary schools using an evidence-based model.<br><br>**3.** In alignment with Nevada statutes, progressively develop and implement a comprehensive plan for training school personnel in early identification and intervention for behavioral health issues, depression, and suicide prevention.<br><br>**4.** Ensure access to effective, low cost parent training and education programs for families at neighborhood-based urban and rural locations across the county.<br><br>**5.** Partner with the Nevada Office of Suicide Prevention to train child welfare caseworkers and probation/parole officers in the early identification of youth with behavioral health issues and suicide risk. |
| 4.3 Expand implementation of universal programs for youth to promote social emotional skills and positive behavioral supports across settings. | **1.** Increase availability of evidence-based early childhood programs in school and community-based settings.<br><br>**2.** Increase availability of evidence-based programs for transition-age youth.<br><br>3. Secure increased and sustainable funding for mental health professionals in schools to implement universal prevention programs. |

| GOAL 5: *RAISE AWARENESS and SUPPORT FOR MENTAL HEALTH*<br>**Increased public awareness of the behavioral health needs of children and youth will reduce stigma, empower families to seek early assistance, and mobilize community support for system enhancements.** | |
|---|---|
| **Objective** | **Strategies** |
| 5.1 Increase awareness of youth mental and behavioral health information to members of the general community. | **1.** Expand state and/or local funding for continued public awareness activities.<br><br>**2.** Support the development and dissemination of mental and behavioral health awareness information to youth and families at primary care settings. |
| 5.2 Expand youth mental and behavioral health awareness and suicide prevention in schools and community-based programs. | **1.** Partner with the Nevada Department of Education to expand training on mental health awareness and suicide prevention in curriculum standards.<br><br>**2.** Provide annual professional development and training opportunities in youth mental and behavioral health in Clark County.<br><br>**3.** Encourage consistent delivery of suicide prevention programs with outcome measures and accountability across all public, private, and charter schools in Clark County. |
| 5.3 Support advocacy efforts to make youth mental and behavioral health a priority for local, state, and federal policymakers. | **1.** Promote opportunities for advocacy during Nevada Legislative Sessions and Interim Committee Hearings.<br><br>**2.** Provide accurate and up-to-date information on youth mental and behavioral health in Clark County to community members and advocates that is easily accessible. |

| GOAL 6: *LOCALLY MANAGED SYSTEM OF CARE*<br>**A partnership of families, providers, and stakeholders committed to community-based, family driven, and culturally competent services will collaborate to manage this system of care effectively at the local level.** | |
|---|---|
| **Objective** | **Strategies** |
| **6.1** Strengthen the role of state and local children's mental health consortia. | **1.** Re-establish the CCCMHC designated bill for each Nevada legislative session.<br><br>**2.** Support legislation to include the state consortium as a subcommittee of the Mental Health Commission. |
| **6.2** Support the Nevada System of Care to promote the growth and sustainability of locally managed organizational structures. | **1.** Develop and implement a plan for local system management.<br>● Establish a formal relationship between CCCMHC and a system management entity<br>● Establish the role of the local system management entity in providing integrated case management, crisis intervention, provider networks, and intake/referral.<br><br>**2.** Ensure Clark County's interests are represented in the Nevada System of Care.<br>● Include CCCMHC members and/or other Clark County stakeholders in NV System of Care meetings to hold SOC accountable to its principles.<br><br>**3.** Encourage providers to participate in Nevada System of Care enrollment.<br>● Promote the development and adoption of performance-based contracts for all mental and behavioral health providers. |
| **6.3** Facilitate cross-agency training and workforce development activities, in the foundational areas of behavioral health screening, principles and approaches of the system of care, wraparound, and evidence-based practices at the local level. | **1.** Partner with the Statewide Family Network provide training and professional development opportunities to mental and behavioral health professionals in Clark County. |
| **6.4** Ensure accountability of the Nevada System of Care through annual reporting of process and outcome measures to CCCMHC. | **1.** Support a statewide system for measuring process improvements and youth mental and behavioral health outcomes.<br>● Encourage the utilization of standardized metrics for youth outcomes by all mental and behavioral health providers.<br><br>**2.** Encourage annual reporting of process improvements and youth outcomes to CCCMHC by local and statewide systems including, but not limited to:<br>● Nevada Medicaid<br>● Nevada System of Care<br>● Managed Care Organizations<br>● Psychiatric Hospitals |


***Two of Eleven Winners of the CCCMHC 2016 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*



# 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 presents a vision for the future of mental and behavioral health services for youth and their families in Clark County.

The Centers for Disease Control and Prevention (CDC) acknowledges the difficulties many families face when seeking to get access to timely and appropriate care. Though as many as 20% of children (under age 18) may have a diagnosable mental, emotional, or behavioral health need, only 1 in 5 of those children actually receive the care they truly need (CDC, 2019). Additionally, families are faced with difficulties navigating insurance, high costs of services, and the physical and emotional effort needed to ensure their child is able to access care. Caregiver strain among parents – the observable and emotional impact of caring for a youth with mental and behavioral health challenges (Mendenhall and Mount, 2011) – increases with the level of care their child needs (Green, et al., 2019). Parents, especially women, in the workforce are more impacted by their caregiver role of youth with mental and behavioral health needs. When faced with work-life conflict experienced while caring for their child, women are more likely than men to quit their jobs, retire early, and involuntarily reduce their workload (Brannan et al., 2017). When parents are forced to stop working, the overall household income is reduced by as much as half. This places serious economic burden on the family, putting a strain on the family dynamic as a whole.

Across the nation, a variety of funding sources and complex funding mechanisms support the delivery of children's behavioral health services in communities like Clark County. Children's behavioral health care funding is minuscule as compared to total healthcare spending, disproportionately small as compared to adult mental health funding, and discordant with best practices favoring community-based care over residential treatment. The statewide budget for all mental health care has decreased 16% since 2016, dropping by more than $25 million in that time (NV DHHS, 2017).

It has been shown that overall youth wellbeing is linked to public mental health spending levels, and that youth needing behavioral health services can need up to five times more money than other youth to obtain those services (Pires et al., 2013). 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.
- Recommendations for the allocation and management of costs associated with providing mental and behavioral health services.

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

## Vision and Goals

The Clark County Children's Mental Health Consortium Vision for 2030:

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

In order to realize the vision, this plan is designed to accomplish the following goals:

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

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

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

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

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

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

**Guiding Philosophy for the System of Care**

The Clark County Children's Mental Health Consortium supports a system of care philosophy of service delivery. Updated in 2010, a system of care is defined as:

> *A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
> (Stroul, Blau, and Friedman, 2010)

Core values of a system of care specify that services should be:

1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided,
2) Community-based, with the focus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level, and
3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.
   (Stroul, et al., 2015)

To support these values, thirteen distinct principles guide the System of Care philosophy. When implemented thoroughly, these principles illustrate the ideal system of care for youth mental and behavioral health services (Stroul, Blau, and Friedman, 2010).

## Guiding Principles of the System of Care Philosophy

1) Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.

2) Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.

3) Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.

4) Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

5) Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

6) Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.

7) Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

8) Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.

9) Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

10) Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

11) Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

12) Protect the rights of children and families and promote effective advocacy efforts.

13) Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

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

In concert with the nationally recognized guiding philosophy of the system of care, the CCCMHC embraces the values and attributes of the Nevada Children's Behavioral Health Consortium. The Clark County Consortium works to align the missions and priorities of the state consortium and the other two regional consortia: Washoe County, and the Rural Consortium. The values and attributes listed below fuses the guiding principles of the System of Care with consortia priorities for addressing the unique needs of Nevada's youth.

**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 that 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.

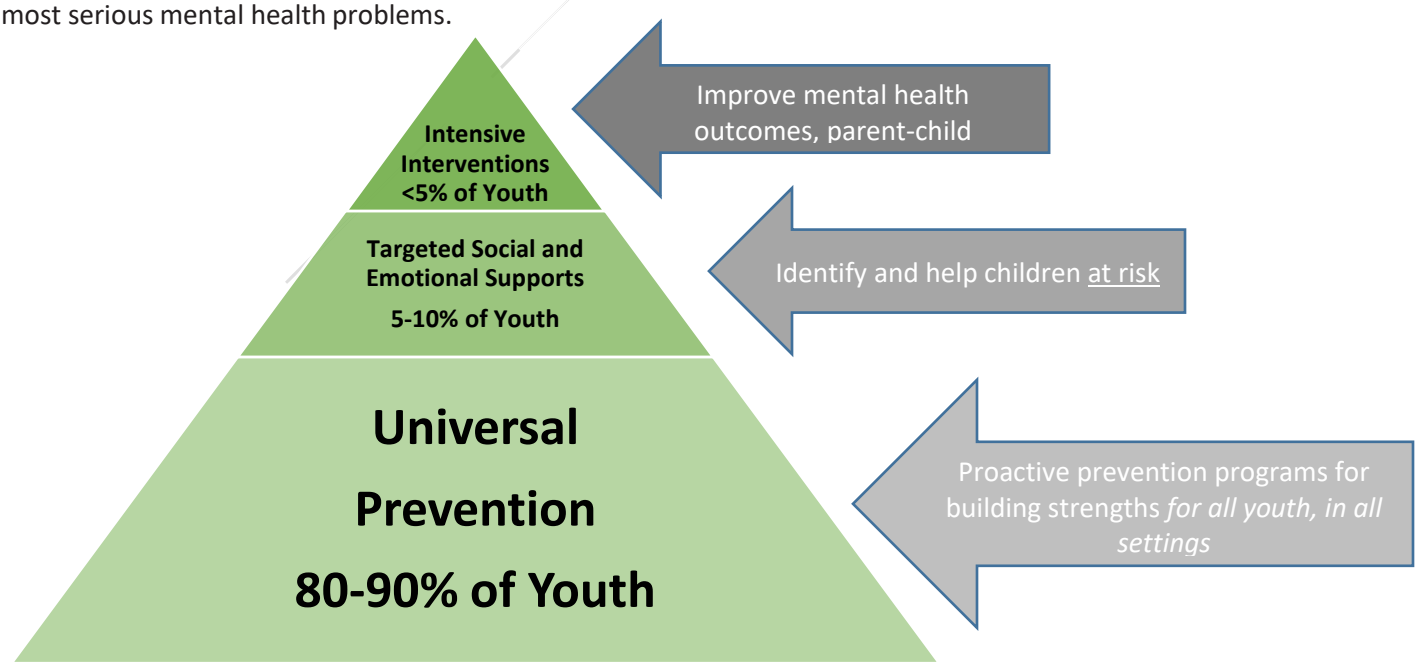
**Outcomes, Evaluation, and Quality Improvement:** Outcomes are evaluated at the individual, agency, and system levels to measure the quality of care. Results from evaluation and quality improvement processes are used to make decisions and to guide policymaking. Evaluation and quality improvement activities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

- 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.

## Public Health Approach to the System of Care

The Clark County Children's Mental Health Consortium supports 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 Surgeon General, National Prevention Council, and Health and Medicine Division of the National Academies of Science, Engineering, and Medicine have recognized mental and emotional well-being as an important priority area for shifting the nation's focus from sickness and disease to prevention and wellness (US DHHS. 2015).

The public health model has a broad and more balanced approach to delivery of services that 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.




Public health approach to youth mental health. *Adapted from: http://www.plaiconsulting.com/what-is-pbs.html*

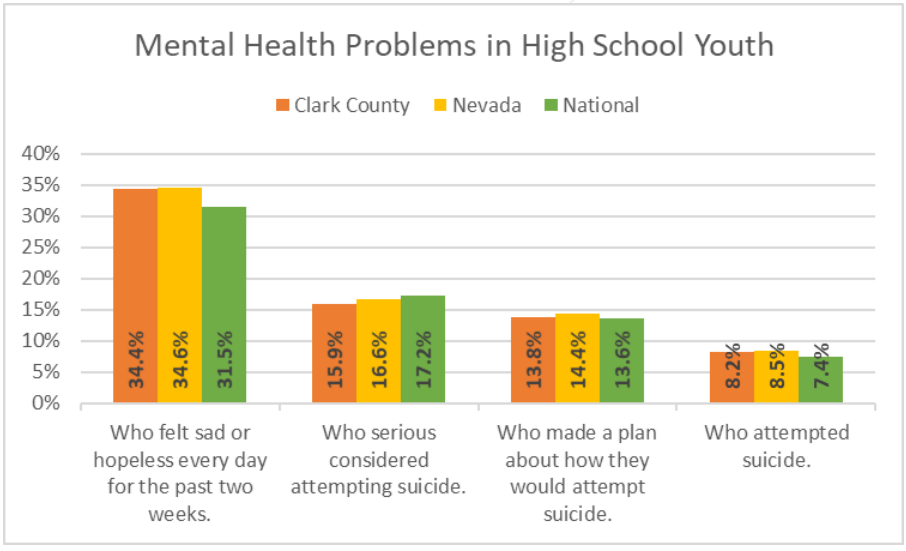
The values of a public health approach are consistent with systems of care philosophy of family-driven, community based, and culturally competent services that are the foundation of the guiding principles for this plan. Both focus on all the needs of the child and family, and require cross-agency collaboration 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.

## Prevalence of Mental Health Problems

A youth's mental health consists of thoughts, feelings, and behaviors that determine whether that individual can cope with stress, relate to others, make appropriate choices, and learn effectively. Like physical health, mental health is important at every stage of a person's life. Unlike physical problems, mental health problems can't always be seen, but the symptoms can be recognized. Nevada has consistently ranked 51st for youth mental health access and services in national reports. Mental Health America has found 61.4% of Nevada youth with major depressive episodes have not received the mental health treatment they need (Mental Health America, 2020); this is much higher than the national average. In the 2016-2017 National Survey of Children's Health, nearly half (47.1%) of the youth who needed mental health services had difficulty getting those services (US Department of Health and Human Services, 2018). Nevada also ranks 11th in the nation for suicide, and adolescent suicide rates are consistently higher than the national rate (CDC WISQARS, 2018; CDC Wonder Online Database, 2018; Drapeau and McIntosh, 2018).

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

About 35,000 Nevada youth (15.6%) were reported to have experienced a major depressive episode in 2018, representing a steady increase since 2011 to a rate that is significantly higher than the national average (SAMHSA, 2018). Additionally, the Nevada Office of Suicide Prevention reports suicide is the second leading cause of death for 8-17-year-olds in the state. The most recent Youth Risk Behavior Survey (YRBS) found that 31% of Clark County public middle school students thought about suicide and 8% actually attempted to kill themselves (Lensch et al., 2017). The Clark County School District (CCSD) has reported that the documented number of students demonstrating suicidal thoughts rose 32% over the last year, and school psychologists are seeing younger and younger students with suicide ideation. According to the Office of Suicide Prevention, the Clark County Coroner reported 12 completed suicides for youth 17 years and younger and 13 suicides for 18 and 19 year olds who could be still in high school. As of January 17, 2019, there have been 19 youth below age 18 lost to suicide during the 2018 calendar year. There were more youth suicides in Clark County in 2018 than in the whole state of Nevada during 2017 (for ages 17 years and below).




*Source: Lensch et al., 2018; CDC, 2018.*

Estimates of the prevalence of mental health problems are much higher for children involved with child welfare and juvenile justice. Nationally, at least 50% of children and youth in child welfare and approximately 70% of youth in the juvenile justice system have significant mental health disorders (Stagman et al., 2010; SAMHSA, 2013). Locally, it is estimated that more than 70% of youth involved in the Clark County juvenile justice system have behavior health disorders

and 60% of those with behavioral health disorders have a co-occurring substance use disorder (CCCMHC, 2018).
A tremendous amount of local, state, and federal dollars are spent each year to address the negative consequences of not providing youth with early access to services and supports---through the schools, the child welfare system, the juvenile justice system, and the adult mental health and prison systems. Parents of children with serious mental health needs often struggle to get services for their child as soon as they know something is wrong. Clark County needs to improve early access to services and to assist families and communities in providing children with environments that support positive emotional and social development. Investing in this "front-end" approach will ultimately free up resources to expand and improve services for children at all levels of need.

## Factors Affecting the Mental Health of Clark County's YOUTH

Nevada's youth are rated the 5th most vulnerable in the nation, with the highest rate of homeless youth, 5th highest rate of overweight and obese youth, and 3rd highest rate of youth without a high school diploma (WalletHub, 2019). Research has shown that there are a number of factors which increase the risk for children's mental health problems (Allen et al., 2014). 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. Of Clark County's 19,000 foreign born children, just over one quarter of them are not US Citizens (US Census, 2019). An increasing number of undocumented immigrants do not have medical insurance, earn lower wages, and might lack the knowledge and support to access behavioral health resources for their children. The current shortage of youth mental health professionals in Clark County is exacerbated for these families, who may require interpreters and other social supports to be able to fully care for their youth. As the most diverse county in the state, it is imperative that mental and behavioral health providers are trained in culturally competent practices and make the effort to familiarize themselves with the unique needs of the communities they serve.

***2nd Place Winner of the CCCMHC 2018 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*

**Poverty and Homelessness**

The impact of poverty and youth can be consequential in a developing mind and body, therefore youth facing poverty and homelessness are at higher risk for needing mental health related services (Bassuk, Richard, and Tsertsvadze, 2015). Approximately 21% of all children in Nevada under the age of 18 live in households below the federal poverty level, and that number has continued to increase (CAA and NICRP, 2018). Last year, 14.9% of U.S. households with children, including 12.8% of Clark County households were food insecure (Three Square, 2019; USDA, 2019). More than 65% of Clark County School District students currently qualify for free and reduced lunch assistance. Nevada currently ranks 4th in the nation for the population of homeless youth and unaccompanied homeless youth, and 1st in the nation for unsheltered, unaccompanied homeless youth (CAA and NICRP, 2018). The Clark County School District identified 14,659 students as homeless during the 2017 – 2018 school year, including students who are living in shelters, and in unstable housing situations (NPHY, 2018). Nevada needs to prioritize strategies that reduce poverty and increase housing stability. Simultaneously, services such as universal screening, access to treatment, and support for parents are a current critical need for families facing these challenges (Bassuk, Richard, and Tsertsvadze, 2015).

**Health Care Coverage**

The Affordable Care Act, passed in 2013, has helped expand health insurance coverage to children across the state and country. The number of uninsured children in Clark County has decreased since the passage of the Affordable Care Act in 2013 (U.S. Census Bureau, 2019). The number of uninsured children has fallen from 75,840 in 2013 to 40,128 children in 2017 (U.S. Census Bureau SAHIE, 2019). Despite expansions to Nevada's Medicaid programs, Nevada has cut its mental health funding by more than 28% since 2009, and has one of the lowest rates per capita of mental health funding in the nation (CCCMHC, 2019). Mental Health America reports that 64% of the youth who experienced a major depressive episode in the past year received no treatment, including more than 3,000 youth with serious emotional disturbance who are covered by Medicaid (CCCMHC, 2019).

**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 alone increases vulnerability and compounds pre-existing behavioral health problems. Youth experiencing chronic, toxic stress are more likely to misuse substances, develop mental health conditions, and need more costly healthcare services throughout their lifespan (CDC, 2015).

**Categorical Service System**
Although Clark County has some excellent behavioral health providers and programs, children can only access certain programs depending on their health care coverage, referral point, or living situation. Parents are sometimes faced with the difficult choice of surrendering their child to child welfare or calling the police on their child so the youth can enter the juvenile justice system in order to obtain the care they need. This does not align with the best practice for a quality mental and behavioral health system, which prioritizes providing the least restrictive and most effective treatment for all levels of care. To prevent families from being forced to relinquish custody of their child in order for them to receive the high-intensity services they need, Nevada passed AB 387 during the 2019 Legislative Session, which creates a taskforce to explore other pathways for families seeking services (described in detail below). Families need to be able to access quality services at home and should not have to consider relinquishing their rights in exchange for care.

## Laws and Regulations Regarding Youth Mental and Behavioral Health

### *Federal Regulations*
In order to eliminate discriminatory conditions for all youth and their families, including those with serious emotional disturbance, the CCCMHC's planning efforts continue to seek to address the principles embodied in the ADA and the Olmstead Decision.

At the federal level, the **Americans with Disabilities Act** provides certain rights for children with disablingmental 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 Mental 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.

In 2010, the federal government passed the Affordable Care Act to provide comprehensive health care reform. This law allowed for the expansion of Medicaid coverage in Nevada and the creation of a state-based health insurance marketplace. The intent of this reform was to make health insurance more affordable and accessible. Some of the changes most relevant to improving mental and behavioral health services to youth include:

- Allowing youth to remain covered by a parent's insurance plan until the age of 26
- Prohibiting insurance companies from denying or increasing the cost of coverage due to pre-existing conditions
- Guaranteeing mental and behavioral health services are covered in all plans

### *Nevada State Regulations*
In order to adequately address the needs of youth and families in Nevada, it is important to understand state laws and regulations regarding mental and behavioral health. The Nevada Revised Statutes 433a and 433b allows 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

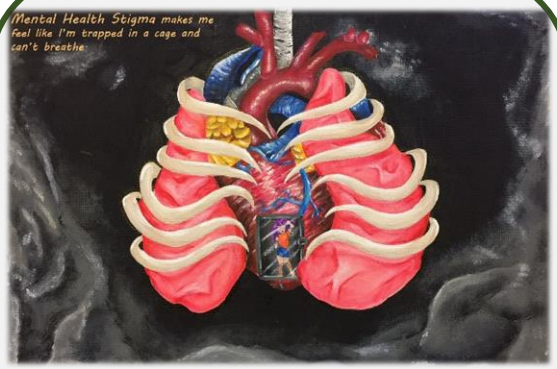
between these Divisions and the services they provide. Lacking a clearly defined mental health authority for children, services accessed through publically funded entities are often uncoordinated and may be duplicative. Unfortunately, families involved in these systems are often unsure how to navigate the system through the confusion to obtain the best care for their youth.

Over the past 10 years, there have been several new laws and regulations that address the behavioral health needs of Clark County's children. During each legislative session, CCCMHC has worked diligently to advocate for policies that will better serve youth with mental and behavioral health needs and their families. Bi-annual status reports and service priorities have been provided to state legislators with recommendations for policy change to improve service access and delivery. Below are highlights of some of the most recent changes to state policy affecting families of youth with mental and behavioral health needs.

**SB 515:** In 2015, the Nevada State Legislature passed this act to provide additional funding for basic supports in schools. In addition to funding more special education units in all school districts in the state, this bill also authorized funding for school social workers and other mental health providers to be placed in schools. Assigning more mental health professionals to schools helps to increase youth access to services, and provide additional resources for the early identification and prevention on mental and behavioral health challenges among students.

**SB 89:** In 2019, more legislation was passed to enhance mental and behavioral health resources in schools. This bill required existing data collection efforts to include disaggregated data for certain student populations so that additional supports could be provided to students with high need. Additionally, it promoted coordination between multiple state efforts to establish and maintain safe and respectful learning environments, including methods to:

1) Engage parents and guardians
2) Assess social, emotional, and academic development of students
3) Screen, monitor, and implement interventions for the social, emotional, and academic development of students




***1st Place Winner of the CCCMHC 2018 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*

**SB 204:** Passed during the 2019 legislative session, this bill mandates a policy for prevention of suicide for all private and public schools that serve grades 7 through 12 in Nevada. Schools must adopt a model and a plan to address the needs of students which scientific research deems high risk for suicide. Their model must address a response to crisis, emergency, or suicide at the school. School personnel who interact with students daily must be trained to identify warning signs of suicide and how to make referrals. Failure to adopt a policy for prevention of suicide could result in the revoking of a license to operate a school. The selected policy will go under review every 5 years. Section 10 makes the implementation of this bill optional in the policy for private schools. Future implementation must take into account the diverse population and needs throughout the state. Procedures within schools should highlight suicide warning signs for students with disabilities, mental illness, or substance use disorders that differ from the general student population; cultural competency must also be considered when training school personnel of suicide warning signs.

**SB 424:** Also passed in 2019, this bill creates an appeal process to the Division of Public and Behavioral Health if a recipient of community-based living arrangement services or providers feel as though services are not a good match for client needs. Current services are based on service treatment plan hours, which may not always be enough. The appeals process would consider the types of services that would apply and ensure the right for the client to take part in an appeal process to keep the client in control. This bill especially benefits families with children living in group homes or other community-based living arrangements will have an opportunity to give their input on the child's treatment. Adding an appeals process will help to maximize a client's individual care based on assessment, rather than contract. To ensure equitable benefit, it is recommended the appeals process include guidelines on what services match best with client populations, factoring in cultural and religious values of the family; it should also include translators and advocates who can help the youth and their family fully understand the appeals process.

**AB 387:** In 2019, Nevada State Legislature approved this bill, which creates a taskforce to explore other pathways for families on the verge of seeking services for their child with mental illness or serious emotional disturbances through relinquishment of custody to the Department of Family Services, despite the absence of abuse or neglect. If successful, this taskforce will determine a pathway for children to receive mental and behavioral health services currently not available to them without parents relinquishing custody of the child to the county or state. This aligns with CCCMHC's objective to reduce the number of out-of-community placements and provides a platform for the Consortium's recommendations regarding this matter to be heard.

**AB 378:** Another bill passed in 2019, AB 378, clarifies that a facility or hospital may accept for emergency admission to evaluate, observe, or treat any person deemed to be a threat to him or herself or others for whom a proper application has been made, regardless of whether a parent or legal guardian has consented to the admission. CCCMHC has great concerns regarding the implementation of this policy and its potential negative impacts on youth and their families. The consequences of transporting a youth from a familiar environment, such as school, to an unfamiliar environment, such as emergency room or psychiatric hospital, without the presence of a parent could be traumatic. In such procedures, parents may be the last to know when their child has been admitted for evaluation. This delay of notification could mean longer separation of the youth from their families, increasing the negative effect on their mental health.

# ACHIEVING THE GOALS

This 10-Year Strategic Plan is based on our review of national, state and local data that identify the needs, barriers and available strategies for achieving our six goals for the year 2030.

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. During the spring and summer of 2019, CCCMHC conducted a community needs assessment by distributing a community input survey of families, community members, and service providers to identify specific service gaps and barriers, and conducted parent focus groups and key stakeholder interviews with service providing agencies (Appendix B).

In this section, we have identified the specific needs, barriers, objectives, 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 of the mental and behavioral health landscape in Clark County.

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

Youth with serious emotional disturbance (SED) are among those with the highest need for mental and behavioral services, AND face the most challenges when trying to access the intensive care they and their families need for appropriate and effective treatment in Clark County. Regional and national studies suggest that between 6 and 10 percent of youth in the United States exhibited signs of SED (SAMHSA, 2013; Williams et al., 2017). The American Disabilities Act mandates that youth with SED receive services in the most integrated setting appropriate to their needs (Bazelon Center for Mental Health Law, 2001). To best address the needs of youth with SED and their families in the mental and behavioral health service delivery system of Clark County, CCCMHC supports the proliferation of High Fidelity Wraparound. Targeted case management utilizing family-team models in which youth and family members are included in decision-making is key to ensuring the most positive outcomes. Additionally, emphasis should be placed on the implementation of evidence-based practices, including all activities outlined in the Nevada System of Care Toolkit. To fully achieve this goal, CCCMHC has developed five objectives under which work towards ensuring appropriate intensive services and supports can be accomplished.

### *Objective 1.1: Reduce barriers across systems to accessing intensive care management services, implementing a wraparound approach to services for youth.*

A long history of research has shown that children with serious emotional disturbance (SED) can thrive in their home community when providers and agencies work in partnership with families to provide intensive supports and services (ISMICC, 2017). In 2017, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) published a report detailing current needs, best practices, and recommendations for enhancing coordination across federal agencies to improve service access and delivery of care for those with SED and their families. ISMICC acknowledges that although effective treatment models exist for youth with SED, only a small percentage of those in need of these services actually receive them. National data shows that ONLY 7% OR LESS of youth with SED that need the following services are able to receive them:

- Therapeutic foster care (1.5%)
- Multi-systemic therapy (3.6%)
- Functional family therapy (6.9%)
- Family psychoeducation (1.9%)

*(Source: ISMICC, 2017)*

Barriers to accessing services also exist for youth with SED in the child welfare and juvenile justice systems.

*Youth with SED in Child Welfare*

Research has found that as many as 70% of children in the child welfare system are diagnosed with a mental/behavioral

health or substance use condition (Kretschmar et al, 2014). In 2019, 779 children (up from 614 in 2018) involved in the child welfare system in Clark County were classified with serious emotional disturbance, needing intensive levels of community-based supports (L. Linning, personal communication, January 7, 2020). 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 that involve public mental health, health, Medicaid, court and school systems, providers, families and other caregivers. Youth with SED in the child welfare system have access to care management through the Wraparound in Nevada Program, however their access to care may change when they return home or are adopted due to a change in their insurance coverage. Unfortunately, this may result in a service disruption. Youth with SED transitioning out of the child welfare system should be able to retain the appropriate level of care or have a transition period if a change in providers is needed due to changes in insurance. Families should be assured proper continuity of care in order for the youth to have the best outcomes.

*Youth with SED in Juvenile Justice.*

Though research has shown that as many as one-third of youth involved in child welfare were also involved in the juvenile justice system, there is little evidence they receive the treatment needed while in the system (Stout and Kennedy, 2016; Stroul et al., 2008). Additionally, approximately 70% of youth in the juvenile justice system have some type of mental or behavioral health need (Stout and Kennedy, 2016); using this calculation, almost 3,500 of the 4,960 youth in secure detention or correctional care during federal fiscal year 2018 were in need of mental or behavioral health services (ART, 2019). To help combat this issue, programs have been established in the community to divert youth with mental and behavioral health needs to treatment rather than detention. For instance, the DCFS Mobile Crisis Response Team (MCRT) has contributed to increased diversion of youth from the juvenile justice system by attending to youth in crisis in a timely manner, reducing escalation and decreasing the risk of youth becoming violent. In addition, the establishment of The Harbor in 2016 has helped divert by providing an option for officers to take youth to access treatment and community-based services rather than detention. Youth brought to The Harbor are assessed to determine immediate need and are provided services to address their individual and family needs. Over 11,000 youth have interacted with The Harbor at either their Mojave or Charleston location since 2016. Approximately 60% of these youth are male, and over 70% are either Hispanic (45%) or African American/Black (28%). The most common offenses include possession of drugs or paraphernalia, battery, domestic violence, or fighting. The figure below provides a breakdown of youth served by each Harbor location between October 2016 and November 2019.

| REFERRALS | MOJAVE | CHARLESTON | TOTAL |
|---|---|---|---|
| **Total Law Enforcement Drop-Offs** | **1,250** | **81** | **1,331** |
| Las Vegas Metro Police Department | 919 | 43 | 962 |
| Clark County School District | 229 | 37 | 266 |
| Henderson Police Department | 36 | 0 | 36 |
| North Las Vegas | 55 | 1 | 56 |
| City of Las Vegas Dept. of Public Safety | 6 | 0 | 6 |
| Nevada Highway Patrol | 1 | 0 | 1 |
| City Marshal's Unit | 3 | 0 | 3 |
| Clark County Park Police | 1 | 0 | 1 |
| **Agency Referrals (CCSD, DFS, DCFS)** | **436** | **693** | **1,129** |
| **Battery (Domestic Violence)** | **240** | **146** | **386** |
| **Citations** | **4,084** | **1,355** | **5,439** |
| **Family/Youth Walk-Ins** | **2,046** | **806** | **2,852** |
| **School Justice Partnership Warnings** | **1** | **3** | **4** |
| **TOTAL YOUTH SERVED** | **8,057** | **3,084** | **11,141** |

*Source: Lemos, 2019*

Overall, youth with SED and their families need access to case management services in order to obtain the appropriate services. It is imperative that Clark County improves access to these services, provides continuity of care for youth engaged with different social systems.

### *Objective 1.2: Reduce the reliance on out-of-state and out-of-community placements for services or treatment of youth with serious emotional disturbance.*

It is best practice to serve youth in the least restrictive setting as it has better long-term outcomes for youth and is less expensive than residential treatment. As seen in the figure below, in FY19, millions of dollars were still spent on youth residential treatment (see Figure below). Youth and families need access to community-based services in order to obtain the appropriate treatment for mental and behavioral health needs. Without access to treatment and support services, youth needs escalate and then might require placement in a residential facility. It is imperative that quality community based resources are accessible to families in help avoid the need for higher levels of care when possible.

| Residential Treatment Center (RTC) Placements of Nevada Children Placements for Children | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | In-State Nevada RTC Patients | | | | Out of State RTC Patients | | | |
| FY19 | Children Placed | % of plcmts. | Total Monthly Cost | Avg. Cost/ Child | Children Placed | % of plcmts. | Total Monthly Cost | Avg. Cost/ Child |
| July | **99** | 43.4% | $979,956.00 | $9,898.55 | **129** | 56.6% | $1,409,609.89 | $10,927.21 |
| August | **106** | 45.3% | $1,062,081.16 | $10,019.63 | **128** | 54.7% | $1,226,972.49 | $9,585.72 |
| September | **99** | 47.8% | $1,048,743.00 | $10,593.36 | **108** | 52.2% | $1,139,180.23 | $10,547.97 |
| October | **113** | 50.0% | $1,224,076.91 | $10,832.54 | **113** | 50.0% | $1,167,197.99 | $10,329.19 |
| November | **111** | 49.3% | $1,159,920.96 | $10,449.74 | **114** | 50.7% | $1,170,165.17 | $10,264.61 |
| December | **125** | 52.5% | $1,319,507.40 | $10,556.06 | **113** | 47.5% | $1,239,381.97 | $10,967.98 |
| January | **120** | 50.8% | $1,264,355.60 | $10,536.30 | **116** | 49.2% | $1,235,159.33 | $10,647.93 |
| February | **113** | 50.0% | $1,075,045.40 | $9,513.68 | **113** | 50.0% | $1,114,516.44 | $9,862.98 |
| March | **115** | 50.0% | $1,161,651.68 | $10,101.32 | **115** | 50.0% | $1,267,057.08 | $11,017.89 |
| April | **129** | 51.4% | $1,283,358.80 | $9,948.52 | **122** | 48.6% | $1,347,359.00 | $11,043.93 |
| May | **133** | 53.4% | $1,457,650.00 | $10,959.77 | **116** | 46.6% | $1,324,567.20 | $11,418.68 |
| June | **147** | 55.7% | $1,456,485.12 | $9,908.06 | **117** | 44.3% | $1,317,877.60 | $11,263.91 |
| | | | **$14,492,832.03** | **$10,276.46** | | | **$14,959,044.39** | **$10,656.50** |

*Source: Nevada Department of Health and Human Services, 2019*

While it is best practice to try to place youth in the least restrictive setting, there are times when youth needs these services to improve. When that is the case, it is imperative that best practices are utilized which includes supporting youth and family connectedness through the process, engaging the family as a part of the treatment process, and creating a transition plan to obtain outpatient support services so their stay in these restrictive facilities is minimized. While it can be challenging to maintain family engagement while youth are in residential care due to specific visitation hours, time of family therapy, and transportation, this can be an even larger barrier when youth are placed out of state. While there have been modest improvements in the number of children placed in out-of-state care during that time, there were 44.3% of youth placed outside of Nevada for residential treatment in June 2019, removing them from their family, friends, and other social support networks. Youth are placed in locations all over the county including Utah, Missouri, Tennessee, and as far as Georgia. Even for youth that are place in Utah, being out of state places a huge burden on the family as it can make visitation limited or non-existent until they are sent home. Using data recent data from a report on DWTC, in SFY17, youth had an average length of stay of 154.3 days and the longest stay recorded as 411 days. Similarly, in SFY18 youth had an average length of stay of 158.2 days and the longest recorded stay as 350 days. It is likely that the average length of stay is similar for those in out of state placement meaning that youth on average may not see their family for over 5 months, especially given that families on Medicaid are low income and may not have the means to travel for visitation (DWTC, 2018). If the average number of days are similar both in state and out of state, youth are separated from their families for an average of five months while in care. This is not best practice. In the instances when residential treatment is the best option for the youth, having in-state options provides better access for the family, and should better facilitate transitions to community-based services. The Building Bridges Initiative provides best practice guidelines and standards that should be used to create residential and community based services and supports are family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes (Building Bridges, 2019).

***Objective 1.3: Increase the types of support services available (e.g. respite, specialized childcare) and capacity for current treatment services (e.g. location and number of providers) for youth and their families.***

*Individualized Services and Supports to Youth and Families*

Clark County is lacking in many types of services that go beyond traditional clinic-based interventions to support youth with SED in their homes, at school, and in other community settings. Youth with SED 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

In Spring 2019, the CCCMHC surveyed over 100 families, caseworkers, and providers as part of the Clark County Mental Health (CCMH) Needs Assessment (Appendix B). Respondents identified five community-based supports most needed for children with serious emotional disturbance, including: respite care, specialized childcare, financial support, day treatment mental health, and transition living and housing support. Only a small percentage of families caring for youth with SED are currently receiving these types of services.

**Intensive Services and Supports Most in Need of Expansion**

- Respite Care
- Specialized Child Care
- Financial Support
- Day Treatment Mental Health
- Transitional Living and Housing Support

*Source: 2019 Clark County Community Input Survey*

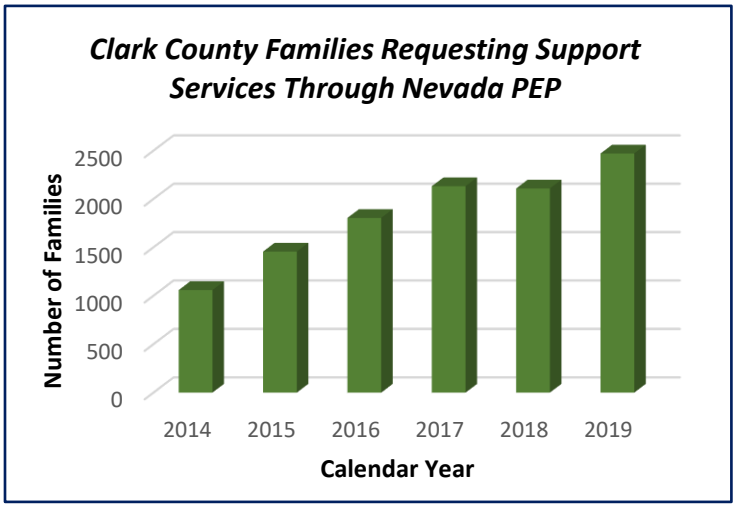
*Continuous Eligibility for Services*

Another barrier families face is that once treatment may be secured, transitioning to a different level of care can be burdensome. 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 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 transitioning back into the family's care. This regressive system not only penalizes families who want to care for their children, it traumatizes the most vulnerable of our youth by separating them from their caregivers in order to receive services. It is imperative that insurance providers, especially those serving the most vulnerable families. To address this issue, it is important for insurance companies, managed care organizations, service providers, and state agencies to work together and provide a system in which continuity of care is prioritized for the effective care of youth and support for families.

### *Objective 1.4: Increase the availability of peer support services - both family-to-family and youth-to-youth.*

*Family-to-Family Support Services*

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

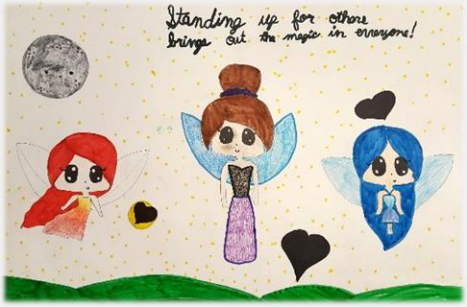



Nevada PEP currently provides family peer support services for families who have children with mental health needs. Families are referred by DCFS programs, schools, and community organizations. During 2019, PEP provided family peer support services to 2,471 families of youth with SED in Clark County (see figure below). Families who contact Nevada PEP for support receive individualized and unique support

to meet their needs which may include informational and educational support; instructional and skills development support; emotional and affirmation support; instrumental support and referral; advocacy support; and leadership skill building at child and family level as well as at system levels. Nevada PEP has partnered with DCFS's Mobile Crisis Response Team, serving 429 Clark County families with youth in crisis in 2019 and 432 in 2018. In a 2018 PEP survey of family satisfaction with services, 96% of parents reported that their understanding of the system improved, 94% acquired or improved skills, 90% reported better services for their child, and 94% reported that NV PEP help strengthen their family. While Nevada PEP continues to increase the number of families served, more families in Clark County need access to family peer support.

*Peer-to-Peer Support Services*

Peer-to-peer support encourages youth with previous lived experience of mental and behavioral health challenges to create a community of healing with other youth currently experiencing those same challenges. During the 2019 CCMH Needs Assessment, just over 55% of survey participants indicated that the need for peer support services were not currently being met (Appendix B). In Clark County, there are currently limited options for peer-to-peer support, especially outside of the school system. During the 2019-2020 school year, middle and high schools located in the City of Henderson began training students and staff to implement Hope Squad – a school-based peer support team where members are trained to recognize students at risk of mental health needs, provide friendship, identify suicide warning signs, and seek help from adults (Hope Squad, 2018). Individual schools touched by suicide have also developed their own peer-to-peer supports in collaboration with community-based non-profits, like the Brookie Foundation. However, these programs are only available for students enrolled in participating schools, and similar supports are not widely accessible for other youth in the community. More youth peer support services should be available throughout Clark County to help create a comprehensive community of support that empowers youth to help each other.




***One of Eleven Winners of the CCCMHC 2016 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*

### *Objective 1.5: Increase services and supports for families of youth with co-occurring intellectual/ developmental disabilities and mental and behavioral health needs.*

Youth with co-occurring intellectual/ developmental disabilities and mental and behavioral health needs unfortunately struggle to access essential supports. Not only is their distress not understood, categorical funding structures often prevent the ability to access appropriate treatment which can escalate behaviors. This leaves youth at high risk for foster care, juvenile detention, long-term confinement, as well as medically preventable acute psychiatric inpatient and emergency room treatment. Children and youth with IDD experience serious trauma at rates far higher than their peers, including bullying, teasing, and physical, emotional and sexual abuse, which often does not receive needed attention (Henderson-Smith & Jacobstein, 2015)

During the 2019 CCMH Needs Assessment (Appendix B), multiple services providers – including DCFS Mobile Crisis – reported struggling to find appropriate placements and/or services for youth with co-occurring developmental disabilities and behavioral health needs. To gain the outcomes necessary for Nevada's youth with co-occurring disorders they must receive intensive care coordination using a wraparound model in conjunction with family peer support that results in diversion from the use of long-term residential care. To address these needs, DCFS has developed a statewide task force consisting of several divisions, agencies, and community partners. This attempt for collaboration resulted in broad recommendations for improving services for youth with co-occurring needs that have not yet been implemented. Changes in policies and practices are needed immediately in Clark County to ensure that families and youth with co-occurring conditions can access the appropriate treatment.

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

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, 2013). One major challenge of Clark County's behavioral health system is adhering to this key principle of systems of care. Key areas of concern related to Nevada's ability to provide a comprehensive array of services were identified by in a 2019 Clark County Mental Health (CCMHC) Needs Assessment (Appendix B).To provide a framework for the implementation of an efficient service array, CCCMHC has developed seven objectives that will help to increase access to high quality, evidence-based programs and services for youth and families.

**Significant Barriers Preventing Access to Services**

- Long Waiting Lists
- Inadequate Number of Providers
- Time-limited Placements and Services
- Lack of Transportation Resources
- Access Based on Family's Ability to Pay/Medical Coverage
- Low Reimbursement Rates for Providers

*Source: 2019 CCMH Needs Assessment*

### *Objective 2.1: Increase utilization of high quality, evidence-based and promising practice service models to match community needs.*

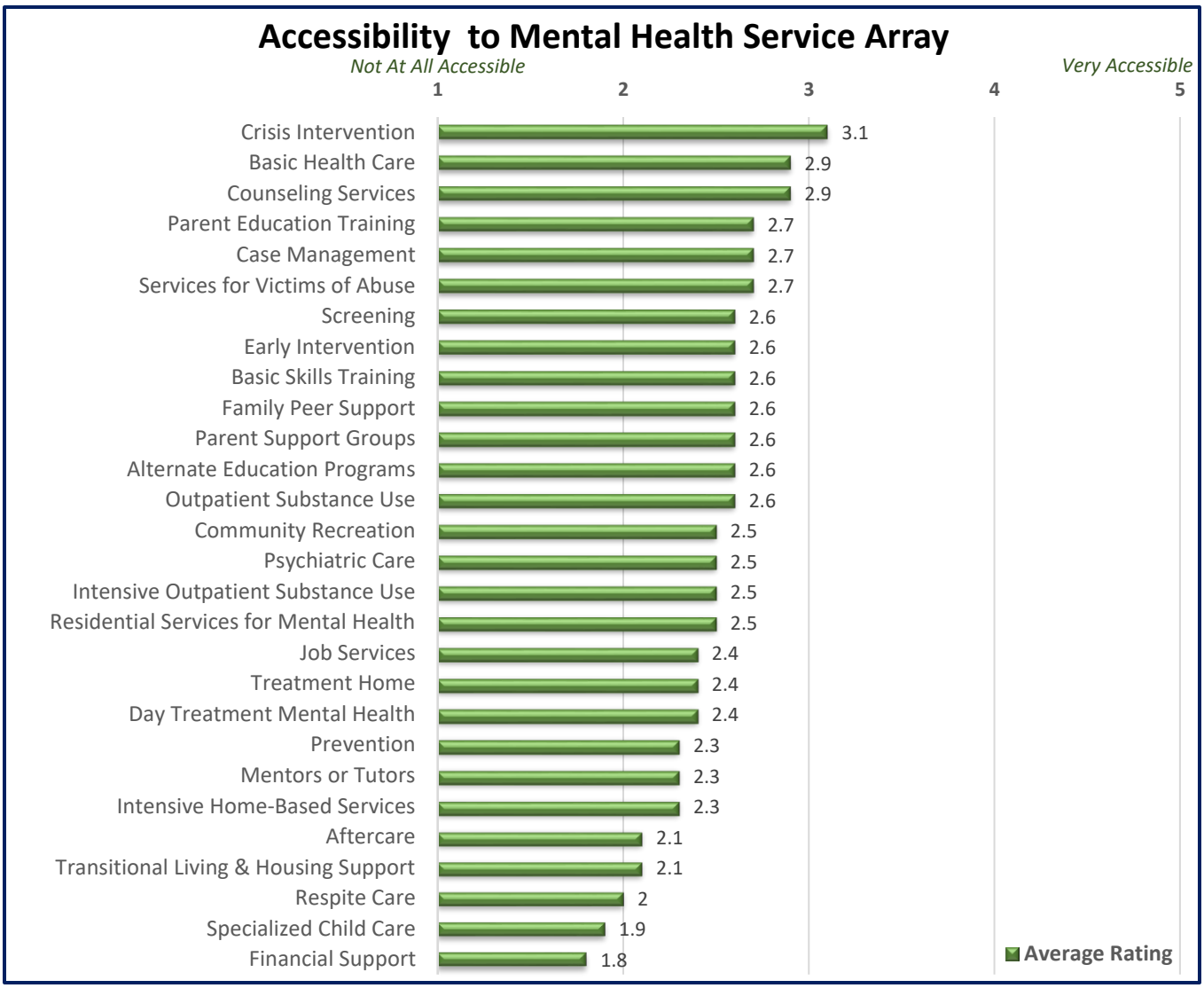
As previously stated, as many as 4 in 5 youth with mental and behavioral health needs are unable to get the care they need (CDC, 2019). To increase the impact of the practices and services that are currently available, CCCMHC encourages the use of evidence-based programs. The Center for Health Care Strategies has profiled successful demonstration projects that use integrated care management entities such as Wraparound Milwaukee, producing positive outcomes while reducing utilization and costs for long-term residential care (Bruns et al., 2010; Simons et al., 2014). Results from the Centers for Medicare and Medicaid Services' Psychiatric Residential Treatment Facility Waiver Demonstration Project also showed the value of integrated case management in achieving better outcomes for children and families at a significant cost-savings (Pires et al., 2013). The Harvard Business Review has also described the value of integrated care from both a business and client outcome perspective (Porter et al., 2013). By integrating behavioral health services with primary care, families are able to access a more comprehensive service array, supporting the unique and pervasive needs of youth and their families. It is imperative that our provider community is using evidenced-based and promising practice approaches for youth with mental health needs to ensure the best outcomes are achieved.

### *Objective 2.2: Increase the capacity and access to provide home and community based services to youth and their families.*


***3rd Place Winner of the CCCMHC 2019 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*

The 2019 CCMH Needs Assessment (Appendix B) surveyed over 100 community members and service providers to learn more about gaps and barriers in the local service array for youth with behavioral health needs. Results of this survey highlight the overall challenges families face in accessing services for their children. Of the 28 service types for youth and their families, the top three most accessible services identified were crisis intervention (3.1), basic health care (2.9), and counseling services (2.9). Respite care (2.0), specialized childcare (1.9), and financial support (1.8) were rated as the three least accessible services. The figure on the next page provides a breakdown of the accessibility ratings for all 28 community services.

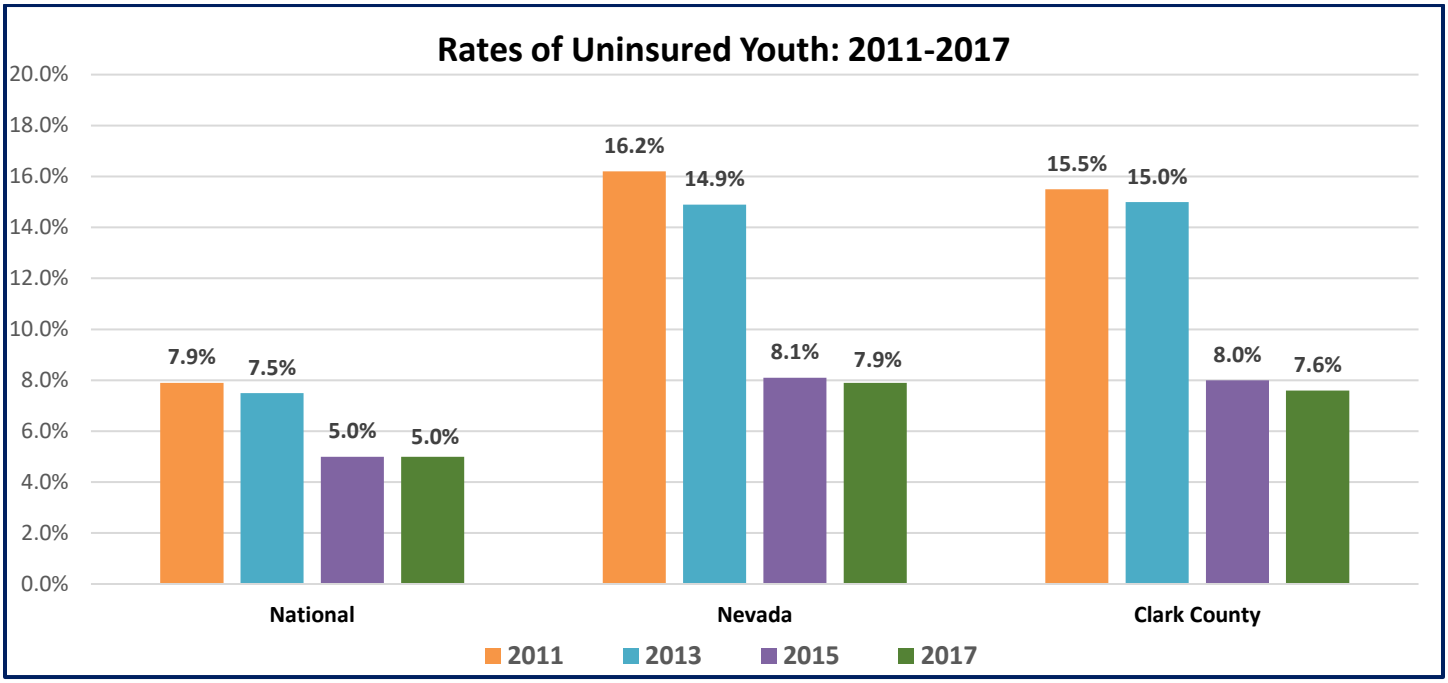



*Scale: 1=Service not at all accessible to 5=Service is very accessible*. *Source: 2019 Clark County Community Input Survey*

As part of the 2019 CCMH Needs Assessment, interviews were also conducted with community service providers and focus groups were conducted with parents of youth with mental and behavioral health needs. During this process, key stakeholders identified barriers that significantly prevent access to mental and behavioral health services. Insurance coverage, affordability of services, and reimbursement rates were noted as three main financial barriers to an effective and efficient system of care within the community. Simply having insurance coverage does not guarantee access to needed mental and behavioral health services, especially for families who may be struggling financially. The low reimbursement rates for services exacerbates network adequacy issues described by assessment participants. These low rates discourage providers from offering needed services, or accepting certain types of insurance plans. This makes it even more difficult to find a provider who (a) provides the services families need at an affordable rate and (b) are qualified to work with young children, especially those under the age of six. There were also issues specific to Medicaid coverage related to autism services mentioned by participants. Reports of youth on the autism spectrum being denied coverage for mental health services were prevalent. Additionally, as youth on the spectrum grow into adolescence, services they have relied on during childhood – especially applied behavior analysis (ABA) – are no longer available or no longer covered by insurance. Lastly, both community members and service providers described the lack of timely and affordable transportation as the most significant environmental barrier to accessing services in the community. Reliable transportation is needed for youth and their families to get to and from services in the community, which are often not located within the same geographic area of the Las Vegas valley. Transportation is an even bigger challenge for those living in rural areas of the county, where providers are sparse, who will often need to drive far distances to obtain services. Addressing these barriers will help to increase access for families and allow for more Clark County youth with mental and behavioral health needs and their families to receive the help they need.

### *Objective 2.3: Support efforts to assist families in obtaining healthcare coverage.*

Since the implementation of the Affordable Care Act in 2010, the number of uninsured youth in Clark County has decreased significantly. In Nevada, 10% of children who are Hispanic are uninsured, which, despite continuous improvements from previous years, is still 3% higher than the national average for that ethnic group (Kids Count, 2018). The table below provides a comparison between Clark County, the state of Nevada, and national average for rates of uninsured youth under age 19.




*Source: US Census Bureau, 2019b*

By assisting families in obtaining insurance coverage, more youth will be able to access the community-based services that will help treat their mental and behavioral health needs. The Statewide Family Network, organized by Nevada PEP, provides education for families about educational and treatment opportunities for youth with mental and behavioral health needs. Collaboration between the Statewide Family Network, community-based providers, state/county agencies, and the Division of Healthcare Financing and Policy would help to create a robust resource for ensuring insurance coverage for all Clark County youth.

### *Objective 2.4: Increase access to mental and behavioral health services to youth through partnerships between schools and public/private services across the community.*

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. The Clark County School District Mental Health Transition Team (MHTT) works to facilitate communication and support for students transitioning from local hospitals and treatment centers back into school. As part of their role, MHTT collaborates with individual schools, families, and community mental health providers to provide the following services:

- Help parents with community resource referrals.
- Facilitate communication among hospitals, parents, and schools.
- Review hospital discharge information for recommendations to schools.
- Provide consultative support to schools for reentry planning for all students.
- Train school team members on Reentry Plan development.
  *Source: CCSD, n.d.*

During the 2018-2019 school year, MHTT worked 1,358 youth transitioning from hospitals and treatment centers back

into school (special education (26%), section 504 (6%), and general education (68%)) (CCSD, 2019). The four most common mental or behavioral health diagnoses for all students interacting with MHTT were: major depressive disorder (54.4%), mood disorders (22.0%), bipolar disorder (9.7%), and ADD/ADHD (4.5%) (CCSD, 2019). Of the 353 students provided special education services, the most common need presented was serious emotional disturbance (39.3%), followed by any type of specific learning disability (26.3%), some other health impairment (19.8%), and autism (7.7%). Even though school social workers, as well as school psychologists and school counselors, are working with more students each year, they face challenges in linking students to timely and effective services. For this reason, it is important to expand the capacity of community-based services, so that students identified by schools can receive a continuum of care in and out of school.

Another point of concern is the need for afterschool and out-of-school time (OST) programs to accept youth with mental and behavioral health needs and ensure a safe and inclusive environment. Currently, many youth with mental and behavioral health needs are restricted from participating in these programs or are asked to leave programs due to behavioral management challenges. While some afterschool and OST programs in the community have expressed an interest in providing the necessary training to their staff, programs face challenges paying for staff time to attend trainings and have issues with high turnover rates. High turnover makes it very difficult to ensure that all staff receive the proper training and experience to successfully work with youth living with mental and behavioral health challenges. The overall lack of options in the community for afterschool and OST care for youth places a significant burden on all families and prevention youth from accessing potentially beneficial programming.

### *Objective 2.5: Expand the capacity for community-based substance use programs for youth.*

Previous research has found that youth with SED have increased rates of co-occurring physical health conditions, including obesity and asthma (Pastor and Ruben, 2011; Goodwin et al., 2014). A local needs assessment conducted in 2015 revealed many youth populations in Nevada are in need of substance use services, including: unaccompanied minors, youth experiencing homelessness, LGBTQIA youth, and those with co-occurring disorders (Christiansen, 2015). These youth often escalate in behaviors and historically have been placed in facilities outside Nevada and thus great distances from their home, family, and community. Nevada lacks appropriate facilities for these youth and services in the community are inadequate to meet their needs and/or there are delays in receiving services. In fact, it was found that only five percent of service providers in Nevada treat youth for *both* mental health and substance use (Christiansen, 2015). A Mental Health America (MHA) report published in 2019 found that 4.13% of youth in the nation experienced a substance use disorder within the previous year (MHA, 2019). According to this same report, Nevada is one of thirteen states that has the most youth reporting heroin and cocaine use as well as alcohol dependence that caused severe impairment and distress. These youth are overly represented in the juvenile justice population as well and thus present unique challenges. Increasing the number of providers and community-based services that have the capacity and qualifications to treat substance use along with other mental health needs will help to prevent escalation on both fronts.

### *Objective 2.6: Expand capacity to provide psychological and psychiatric assessments and psychotherapeutic services.*

During the key stakeholder interviews conducted as part of the 2019 CCMH Needs Assessment (Appendix B), many providers acknowledged the challenges families face when seeking the proper assessments for their youth. There are few professionals in Clark County available to conduct assessments with youth in order to provide a formal diagnosis to access care. Additionally, navigating the complexities of what types of tests and services a family's insurance plan will cover (or not) increases frustration. Without a diagnosis (specifically SED), it is very difficult for families to get Medicaid Fee-For-Services; and many have found it difficult to obtain an SED diagnosis from certain managed care providers. Without *any* specific diagnosis, getting a referral for a specialist, like a neuropsychologist, or access to treatment is near impossible.

Focus groups conducted with parents during the same needs assessment revealed additional challenges in accessing these services (Appendix B). Parents reported their frustration with inconvenient times that the limited number of available services are offered. Specifically, it is difficult to find a provider that will accept an appointment outside of Monday through Friday during "regular" business hours; this means the only way to make sure their child receives the service they need is to pull them out of school and/or take off from work. This jeopardizes academic and economic stability for both parent

and child. Agencies and community organizations should explore the feasibility of flexible operating hours and recruiting additional providers qualified to work with youth to help reduce this burden and prevent families from having to choose between getting their child the help they need, and being present at work/school.

### *Objective 2.7: Re-establish neighborhood-based resource centers.*

CCCMHC supports a neighborhood-based model of service delivery, formerly established as Neighborhood Family Service Centers in Clark County. This model uses a wraparound process for delivery of care management and intensive supports to youth with serious emotional disturbance and their families. To do this, multiple agencies were co-located within a single building or building complex, encouraging inter-agency staff communication and collaboration to help serve all of a family's needs. Though these centers had been successful in increasing access to services, continuity of care, and diverting youth from hospitalization and out-of-community placement, these centers have all closed in Clark County. Changes in agency administrators lessened commitment to the model of these service centers, and reallocated funding for neighborhood centers to other projects. CCCMHC advocates that efforts to re-establish these centers should be made in order to increase access to care for youth and families.

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

Currently, youth and families seeking mental and behavioral health services in Clark County face challenges accessing resources and navigating the multiple systems of care. A No Wrong Door (NWD) system model is promoted by the federal Medicaid agency, noting that the implementation of this system will help states reduce duplication of services and informational processes, thereby increasing effectiveness and reducing the burden on families in need of these services and information (Medicaid, n.d.). The Nevada DCFS System of Care is working on incorporating this NWD model into their service implementation, creating a platform for collaboration with other agencies, community service providers, and subject matter experts like CCCMHC to develop a more efficient and effective mental and behavioral health system.

However, it is important to note that "No Wrong Door" does not mean establishing a "single door;" families should be able to enter the service delivery system through multiple entry points and obtain the same results, that are tailored to the individual needs of their family. The NWD system model provided by Medicaid emphasizes the four primary functions of a properly executed system:

1) Public outreach and coordination with key referral sources
2) Person-centered counseling
3) Streamlined access to public long term services and supports programs
4) State governance and administration


A fully implemented NWD system in the community would ensure that any family reaching out for help will get access to exactly what they need, regardless of where they go or who they call. While a centralized source for information (digital or physical) would be of great help, a more effective practice would for each request for help be accompanied by a warm hand-off to an appropriate service provider to address that family's needs.

To support the implementation and expansion of this model, CCCMHC has developed five objectives to address different aspects of service access along the spectrum of mental and behavioral health needs of youth and their families.

### *Objective 3.1: Establish a centralized hub for information and service entry for youth and families in need of mental and behavioral health services.*

Obtaining proper care begins with receiving accurate information. Clark County currently has many sources of information that families can turn to regarding available mental and behavioral health services. Unfortunately, it may be difficult for some families to determine which of that information is up-to-date or applicable to their unique situation. During the 2019 CCMH Needs Assessment (Appendix B), parents participating in focus groups described the challenges they have experienced in obtaining information and services from a centralized and convenient location. Also, over 60% of community members and service providers responding to the Community Input Survey of the needs assessment reported the unmet need of being able to get all needs met from one location without complications. Parents (62.9%) also indicated that the need of having service providers coordinate across multiple agencies was either not met, or mostly not met.

Creating an easily accessible location for information about available services, educational opportunities, resources, and other relevant information will make it easier for families to obtain the information they need and determine the next steps for accessing care. By ensuring that families have the option for initial contact on this platform with a live person, it will reduce the burden currently placed on families to determine what services are needed, who the eligible providers are, and contact each of them separately. For ease of use, information and resources should be readily available to families via online access, such as a website, newsletters, or blogs as well as a statewide phone number and text line for those with limited internet access. While the state does currently have Nevada 2-1-1, this system has proven to be an inadequate resource for connecting families with accurate information and services. Multiple attempts by CCCMHC to work with 2-1-1 administrators to improve the effectiveness of this service has gone unanswered.

### *Objective 3.2: Expand access to mobile crisis services (especially DCFS Mobile Crisis Response Team) as the first line of crisis intervention to ensure the needs of ALL youth are met.*

Based on the recommendation of CCCMHC and supported by Healthy Nevada funds, DCFS implemented the Mobile Crisis Response Team Program (MCRT) in Clark County as a pilot project in January 2014 and significantly expanded in October 2014 with the same funding source. Active participation from CCCMHC members during the development of the program helped to guide the effective implementation of MCRT as it exists today. Currently, MCRT serves youth in the greater Las Vegas area that are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, depression, anxiety, or any other situation the family self-defines as a crisis. In October 2016, the Mobile Crisis Response Program in Clark County began offering services 24 hours per day, 7 days per week. The program also placed a full-time crisis team at the Harbor Juvenile Assessment Center on North Pecos Road in Las Vegas, where staff collaborates with other agency professionals to serve children and families in need of behavioral health services and other supports. Since its inception, MCRT has received 11,716 calls, resulting in 6,778 assessments of youth. During the 2019 fiscal year, the majority of calls came from emergency departments or families, however, 88.9% of youth served by the program were diverted from psychiatric hospitalization. After initial evaluation or discharge from stabilization services, 70% percent of families served were referred for additional mental health and/or community support services (11% declined additional services; for 0.2% of families, no additional services were necessary). The youth served through MCRT have shown significant improvement in functioning and 94% of parents/guardians report being satisfied with the program. Increased and sustained funding is a priority to help ensure that MCRT can expand its services to more youth throughout urban and rural Clark County.

### *Objective 3.3: Improve policies and regulations regarding involuntary legal holds for youth.*

One charge of CCCMHC is to review and address policies and regulations that affect youth with mental and behavioral health needs and their families. Recent legislation has brought the issue of involuntary legal holds for youth to the forefront of the conversation about school-linked services and emergency care. AB378, passed during the 80th session of the Nevada Legislature in 2019, standardized the process for involuntary legal holds initiated within schools. To ensure that the rights of youth and families are respected, CCCMHC and community partners will provide recommendations for the development and implementation of current and future statutes. Working with the Statewide Family Network, CCCMHC will promote education for families and providers about emergency care services available in the community, as well as families' rights in accessing them. Additionally, CCCMHC will work to provide education for families and providers

about emergency care services available in the community and families' rights in accessing them.

***Objective 3.4: Encourage the adoption of interagency protocols to streamline procedures and reduce unnecessary burden on families accessing services.***

Of the currently available programs in the community, DCFS Mobile Crisis Resource Trams (MCRT) was mentioned most often in 2019 interviews with service providers as an effective service for youth and families. However, each mention of MCRT was accompanied by a recommendation that its service be extended to children covered by all types of insurance, and not allow individual managed care organizations to deny MCRT services to their clients. However, MCRT has experienced challenges in facilitating inpatient services for some youth depending on the insurance provider. Some providers required their own assessments for youth served by the MCRT in order to admit the youth which delays the access to treatment and puts an unnecessary burden on youth and families. In 2018, more than 200 families requesting services were turned away from the program due to the inability to partner with their managed care provider to access needed services. The CCCMHC continues to recommend that DHHS develop interagency protocols and policies with hospitals and managed care providers to ensure 24-7 access to DCFS's mobile crisis intervention services and seamless transition to appropriate inpatient or community-based care for all uninsured, privately and publicly insured youth, including those enrolled in Medicaid or other managed care programs.


***2nd Place Winner of the CCCMHC 2019 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*

***Objective 3.5: Promote effective implementation of community-based strategies to coordinate services across providers within urban and rural Clark County areas that are geographically accessible for families.***

During the 2019 CCMH Needs Assessment, many interviewees reported the need for high-intensity services, such as respite for families, day treatment, and acute and sub-acute care for inpatient and outpatient needs. Transportation was mentioned repeatedly as one of the biggest barriers for families to maintain consistent participation in services and programs, even when those programs are offered for free. Some organizations do provide bus passes to families enrolled in programs, or (in rare cases) offer staff assistance in helping families to attend services. While there are multiple health transportation companies, many have strict parameters regarding who they are allowed to transport and for what reason. Transportation issues are exacerbated when trying to serve families in outlying, rural communities within Clark County. Overall, these stakeholders spoke to the purpose of many community-based services in diverting youth with mental and behavioral health needs from escalation and hospital admission, noting that current programs succeed in this effort but are not able to accommodate the overwhelming number of youth in the community who still need help.

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

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. For the average youth, symptoms typically precede a serious disorder by about two to four years (Denby, 2013). In order to decrease the number of youth in need of mental and behavioral health services, the most effective strategy is to promote evidence-based early identification practices and expand the capacity of community providers to carry them

out. To assist in this effort, CCCMHC has developed three objectives focusing on prevention strategies.

### *Objective 4.1: Increase implementation and availability of evidence-based strategies for the early identification of mental and behavioral health needs for all youth.*

Through a public health approach, children with risk factors for mental health problems can be identified early through screening and public education. Over the last decade, research has highlighted the importance of detecting early warning signs and utilizing trauma-informed approaches to screening and care (Goldman, et al., 2016). Research into Adverse Childhood Experiences (ACEs) shows the need for comprehensive approaches to addressing mental and behavioral health needs, taking into account personal, familial, environmental, and systemic factors that may negatively affect youth throughout their lives (CDC, 2015).

In its 2017 report to Congress, SAMHSA's Interdepartmental Serious Mental Illness Coordinating Committee recommended that screening for early signs of serious emotional disturbance should take place in a wide range of settings to effectively enhance access to early intervention and recovery. In Nevada, there have been recent efforts to implement wide scale screening activities in schools. School-based screening has been shown effective in identifying teens with mental health problems and linking them with needed services (Husky et al., 2011). Even more important, screening for depression coupled with suicide awareness training can reduce the incidence of suicide attempts in adolescents (Azeltine et al., 2004). Unfortunately, current screening practices in schools were difficult due to the availability of staff to perform the screening, time to connect youth in need to appropriate services, as well as, an inadequate number of community-based providers to which students could be referred for additional services.

Screening practices should also be a regular practice by primary care providers as they have the opportunity to assess youth from a very early age. For youth on Medicaid, screening is a required part of the EPSDT well check. **In 2006, 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.

Clark County needs to dedicate more resources in order for not only schools but other appropriate locations to offer screening and referral services for youth and families while simultaneously building the capacity within the community to offer high-quality, affordable, and timely services to youth who screen positive for mental and behavioral health needs.

### *Objective 4.2: Provide training and education, which is up-to-date and culturally competent, about youth mental and behavioral health to families and people working with youth.*

Families can 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. However, 45.3% of parents and community members, along with 50.0% of service providers, reported that parent education and training is not accessible in response to the 2019 Community Input Survey (Appendix B). Currently, Nevada PEP provides multiple opportunities for parent education through the Statewide Family Network. PEP also helps to facilitate the trainings provided by the Nevada System of Care to ensure that families' perspectives are included, along with culturally appropriate standards. Additional educational opportunities in schools will help to engage more youth and families in learning about important topics. One strategy to accomplish this is by implementing evidence-based programs for bullying prevention, social/life skills training, and positive behavioral supports through sustainable education funding. By partnering with schools, training and support can be more accessible for families, and will help families and other professionals working with youth identify the needs

before their challenges escalate. Since most youth spend the majority of their weekday hours in school, surrounding them with properly trained adults could help to prevent the onset of crises or development of behavioral challenges. This could be accomplished through a comprehensive plan for training school personnel in early identification and intervention for behavioral health issues, depression, and suicide prevention.

CCCMHC supports training opportunities and professional development for mental and behavioral health service providers, healthcare administrators, and agency leadership. Starting in 2018, the CCCMHC Public Awareness and Behavioral Wellness workgroup has organized an Annual Southern Nevada Summit on Children's Mental Health. This summit offers professionals and community stakeholders the ability to learn about the most salient youth mental and behavioral health topics from subject matter experts. While this summit continues to grow each year, it is imperative for additional educational opportunities to be available for professionals to build their competencies in youth mental and behavioral health. Higher education institutions offering clinical programs must assess the content of their training programs to ensure a balance of education in youth and adult issues. The future workforce of Clark County can only be expected to increase services for youth if they are afforded the opportunity to hone their skills during initial training programs.

### *Objective 4.3: Expand implementation of universal programs for youth to promote social emotional skills and positive behavioral supports across settings.*

Since children spend a significant amount of time in schools, programming within schools that promote social emotion development would be extremely beneficial. Positive Behavioral Interventions and Supports (PBIS) is an evidence-based three-tiered framework implemented within schools to improve academic, social, and emotional outcomes for students. The PBIS Project within the Clark County School District (CCSD) continues to grow. Moreover, CCSD is now officially endorsing a Multi-Tiered System of Supports (MTSS) framework for schools to progressively address the academic, behavioral/social, and basic mental health needs of all students. The following are just some examples of recent advances within the Clark County public schools:

- 83 CCSD schools participated in PBIS pilot project (2018-20219 school year)
- 110 CCSD elementary schools implemented the Sanford Harmony Social Emotional Learning Program in 2019
- Support plan implemented for specialized programs serving students with disabilities and SED (2018-20219 school year)

Also, a new safety-reporting program began in the fall of 2017, SafeVoice. SafeVoice is an anonymous tip report system with live response 24/7/365. SafeVoice (SV) includes and goes beyond bullying to create an anonymous way to also report threats of school violence and friends at risk of suicide, self-harm, drugs and more. Since its initial roll out, 6,976 tips were reported to the system; of those, 837 were specifically related to concerns of suicide (41.2%), self-harm (31.4%), depression (21.7%), or anxiety (5.6%).


Additionally, CCSD has incorporated the Signs of Suicide (SOS) Educational Program into its eighth and ninth grade health class curriculum. During the 2017-2018 school year 44,535 students participated in the lessons. The SOS Program is a valuable addition to the Clark County School District's Health Curriculum and research studies have suggested that the SOS Education Program can be effective in reducing suicide risk when paired with the SOS Screening Program (SOS Signs of Suicide, 2016). The Nevada Institute for Children's Research and Policy conducted an evaluation of suicide prevention program implementation in Clark County schools in 2019. A little more than half of the schools surveyed (57.4%) reported at least one potential barrier that would impede the implementation of a suicide prevention program at their school. The most common barriers reported were related to staffing issues as a primary hindrance, especially a lack of on-site school mental health professionals, high staff turnover, and not having staff that are trained to deliver such a program.

Ultimately, these beneficial programs serve to create a community of positive supports and resilience for youth in Clark

County. However, access to these programs are mostly limited to public and charter schools operated by CCSD. While efforts are being made to expand implementation to schools outside the purview of CCSD, it is equally as important to explore the implementation of community-based programs available to all youth residing in Clark County. This will help to ensure equitable access for all families to the benefits of evidence-based prevention and strength-building programs.

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


CCCMHC's Public Awareness and Behavioral Wellness Workgroup that works towards informing community members and service providers about the most up-to-date information regarding youth mental and behavioral health. Through the efforts of this workgroup, CCCMHC provides regular training and professional development opportunities, and organizes an annual contest for youth to encourage involvement in community awareness efforts. To bolster existing efforts and encourage increased participation from community members and service providers, CCCMHC has determined three primary objectives for increasing mental and behavioral health awareness.

### *Objective 5.1: Increase awareness of youth mental and behavioral health information to members of the general community.*

Mental health stigma persists in the community and has been identified by parent and provider stakeholders as a major factor impacting service utilization. During interviews with parents, many expressed feelings of embarrassment or shame when receiving a mental or behavioral health diagnosis for their child. Misconceptions that the child's condition is the fault of bad parenting or bad genes fuel these feelings and discourage some parents from openly sharing their stories and seeking support. 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 relevance for the families of our communities. CCCMHC will support families and youth who can share their own stories and assist in the development and field testing of these materials.

### *Objective 5.2: Expand youth mental and behavioral health awareness and suicide prevention in schools and community-based programs.*

One important goal of 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. CCCMHC's Public Awareness and Behavioral Health Workgroup coordinate activities to promote mental and behavioral health awareness in the community with the assistance of a small budget from the state. The workgroup maintains a website (www.CCCMHC.org) to use for promoting awareness of children's behavioral health needs and services, organizes an annual summit on children's mental health, and organizes a contest where Clark County youth submit original artwork about the importance of mental health awareness and suicide prevention. To increase participation awareness activities, CCCMHC will seek to help facilitate more programs in schools and encourage interaction from rural and under-represented communities.

### *Objective 5.3: Support advocacy efforts to make youth mental and behavioral health a priority for local, state, and federal policymakers.*

The World Health Organization lists mental illness as the single most common cause of disability in young people worldwide. Despite this fact, Nevada currently ranks 50$^{th}$ in the nation for public health funding, with an average of $46 per person (America's Health Rankings, 2020). This contributes to Mental Health America's ranking of Nevada as 51$^{st}$ for children's mental and behavioral health services (MHA, 2019). All children have the right to live healthy lives and deserve

access to appropriate and effective mental health care. CCCMHC encourages ongoing advocacy efforts within the state to educate policymakers about the importance of investing in youth mental and behavioral health. Over the past ten years, these efforts have resulted in the dramatic policy changes and adoption of legislation discussed earlier in this plan; however, there are still many improvements that can be made.

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

CCCMHC consists of a partnership of public agencies, providers, and families that has worked collaboratively in an effort to improve the system of behavioral health services. A comprehensive system of service delivery, information dissemination, evidence-based programs for prevention and treatment, family training and support, and youth input, has been shown to be both cost-effective and best practice for ensuring positive outcomes (Hamilton, et al., 2017). Four objectives have been developed to guide this partnership in the management of complex systems of care so that they work efficiently and effectively to meet the needs of all youth and their families.

### *Objective 6.1: Strengthen the role of state and local children's mental health consortia.*

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.


***1st Place Winner of the CCCMHC 2019 Youth Poster Contest***

*See all winning artwork at www.cccmhc.org.*

In this plan, CCCMHC's capacity will be strengthened to play a key role in overseeing a 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. CCCMHC will work with state and local governments to identify funds that can be redirected, 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.

### *Objective 6.2: Support the Nevada System of Care to promote the growth and sustainability of locally managed organizational structures.*

The concept and philosophy of systems of care has become increasingly more prevalent in communities across the country since its inception in the mid 1980's. Investment in a system of care has been shown to reduce utilization of higher levels of care, inpatient services, emergency room visits, and out of state placements. States utilizing this approach often were able to allocate funds to provide care locally in the families' community. In addition to utilizing funds more effectively, more intervention services can be in place. A system of care is a spectrum of effective, community-based services and supports for youth with or at-risk for mental and behavioral health challenges and their families. It is organized into a

coordinated network that builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them to function better at home, in school, in the community, and throughout life.

The Nevada System of Care (NVSOC) consists of a broad array of both behavioral health and support services aligned with the guiding principles and philosophies of systems of care. These services include both home and community based treatment, as well as out of home treatment services that are provided when necessary. NVSOC operates under three core values:

- Family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.
- Community-based, with the focus of services, as well as the system management, existing within a supportive, adaptable framework of organizations, processes, and relationships at the community level.

To help support these efforts, CCCMHC works closely with NVSOC to act as a conduit for families' voices and needs, while providing feedback on training content and service delivery. Moving forward, continued partnership is essential to the growth of both funding and services for the System of Care through advocacy efforts spearheaded by the Consortium.

### *Objective 6.3: Facilitate cross-agency training and workforce development activities, in the foundational areas of: (1) behavioral health screening, (2) principles and approaches of the system of care, (3) High Fidelity Wraparound, and (4) evidence-based practices at the local level.*

Workforce development is key to building the capacity of state agencies and community organizations to accommodate all of the youth with mental and behavioral health needs and their families in Clark County. New providers entering the community must be informed about the foundational areas of systems of care and qualified to implement evidence-based practices. Training and professional development for service providers must also include families' voices and concerns so that the unique needs of the community can be addressed. One effective way to do this is to collaborate with community organizations that already provide training in these and other relevant topics, and support their efforts to reach more professionals in the community. One such organization doing this work throughout the state is Nevada PEP.

An essential partner of DCFS and the Nevada System of Care is the Statewide Family Network. Nevada PEP is the federally designated agency in Nevada charged with ensuring the inclusion of families in the development of children's mental health practices and policies. As source of education, Nevada PEP empowers parents and other caregivers to be full participants in decision-making at the service delivery level, encouraging meaningful involvement at the system level in developing policies as well as planning, implementing, and evaluating new programs and services. Through its partnership with DCFS, the Statewide Family Network lends the unique perspective of the family to cross-agency staff and provider training. During the first two Annual Summits on Children's Mental Health, members of the Statewide Family Network led presentations and panels on culturally and linguistically appropriate standards of care, youth experience utilizing community mental and behavioral health services, and the importance of patient and family-driven care. Additionally, Nevada PEP facilitates partnership between parents and professionals to provide these trainings together statewide, strengthening families' role in Nevada's overall mental and behavioral health workforce development.

### *Objective 6.4: Ensure accountability of the Nevada System of Care through consistent information-sharing to CCCMHC.*

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. Through DCFS, 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-Focused 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. This 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.


As the subject matter experts regarding children's mental health, CCCMHC encourages information-sharing with state and local agencies so that Consortium members can contribute their knowledge and expertise for system improvement. By reviewing data collected by the Nevada SOC and other mental and behavioral health programs in the county, CCCMHC can provide comprehensive recommendations that includes multiple perspectives from members that represent professional and community stakeholder interests.

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# 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

**Dan Musgrove, Chair**
Strategies 360
*Business Community Representative*

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

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

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

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

**Rebecca Cruz-Nañez**
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*Health District Representative*

**Dana DiPalma**
Las Vegas Metropolitan Police Department
*Metropolitan Policy Representative*

**Richard Egan**
Nevada Office of Suicide Prevention
*Community Representative*

**Char Frost**
United Citizens Foundation
*Parent Representative*

**Jackie Harris**
Creative Solutions Counseling Center
*Substance Abuse Service Providers Representative*

**Timothy Jeider**
Jeider Limited
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**Heather Lazarakis**
NV Division of Health Care Financing and Policy
*Medicaid Services Representative*

**Cesar Lemos**
The Harbor
*Juvenile Justice Representative*

**Lisa Linning**
Clark County Department of Family Services
*Child Welfare Representative*

**Karen Taycher**
Nevada Parents Encouraging Parents
*Parent Representative*

**Robert Weires**
CCSD Psychological Services
*Clark County School District Representative*


## ACKNOWLEDGEMENTS

The development of this 10 Year Strategic Plan would not have been possible without the participation and support of the members of the Clark County Children's Mental Health Consortium, and the many additional family members, community providers and other stakeholders who participated via workgroup, stakeholder interview, or survey over the last six months. These individuals have worked tirelessly to identify the needs of our community and craft solutions that will help us meet our goals.

In addition, Karen Taycher of Nevada Parents Encouraging Parents was instrumental in this process as chair of the planning workgroup, as well as the staff from the Nevada Institute for Children's Research and Policy, consultant to the CCCMHC, and the administrative support of Salwa Phillips, Division of Child and Family Services.

Financial support for the planning process and preparation of this report was provided through the annual Clark County Children's Mental Health Consortium state funds through the Division of Child and Family Services.



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# APPENDIX A: NEVADA SYSTEM OF CARE GLOSSARY
## Division of Child And Family Services
## Children's Mental Health Programs

# GLOSSARY OF TERMS

**Instructions:** This glossary includes definitions of terms which are used in many, if not most, of DCFS Children's Mental Health (CMH) policies. As such, they are considered "universal" to the services provided in DCFS CMH programs. This glossary shall be revised and distributed by the CMH Policy Development Coordinator as warranted based on the process of updating and revising policies and procedures, program needs, and services offered in DCFS.

1. Assessment
   A process used to answer a referral question, solve a problem, or arrive at a decision by using tools. An assessment may include, but is not limited to, a clinical interview, a bio-psychosocial history, a mental status examination, a care management assessment, and/or behavioral observations, which may result in a diagnosis and recommendations for treatment and/or services. An assessment also includes a Targeted Case Management Assessment (TCMA) for PT54 (please see MSM 2500).

2. Basic Skills Training (BST) Services
   Interventions designed to reduce cognitive and behavioral impairments and restore the child/youth to their highest level of functioning. BST services help children/youth acquire constructive cognitive and behavioral skills to include basic living and self-care skills, social skills, communication skills, parent training, organization and time management skills, and transitional living skills. Services may be provided by a Qualified Behavioral Aide (QBA), a Qualified Mental Health Associate (QMHA), or a Qualified Mental Health Professional (QMHP).

3. Care Coordination Plan (CCP)
   A written individualized plan developed jointly in a Child and Family Team that specifies the goals, objectives and actions to address the medical, social, educational, and other services needed by the child/youth, including activities such as ensuring the active participation of the child/youth and working with child/youth or the legally responsible person and others to develop the goals and identify a course of action to respond to the assessed needs. The CCP is the planning document used for Targeted Case Management (TCM) services.

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

5. Child and Family Team (CFT)
   A family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child/youth and family. The team consists of the child/youth (as developmentally appropriate), parents, and service professionals and may also consist of family members, care providers, and other individuals identified as being integral to the child's environment of mental health rehabilitation. (Source: MSM Chapter 400).

6. Children's Uniform Mental Health Assessment (CUMHA)
   A bio-psychosocial assessment tool used to evaluate a child's/youth's mental health status, symptoms, and needs. It is conducted by a QMHP who solicits and explores, with the child/youth and family's information about strengths and needs as these pertain to the major physical, psychological, and social issues of the child/youth and family. The CUMHA provides a format for obtaining a comprehensive assessment of a child's/youth's and family's history and current functioning. This assessment, combined with the clinical judgment of the QMHP, leads to a DSM or DC:0-5 diagnosis and establishes the basis for the treatment planning process, including treatment goals and services needed to help the child/youth and family resolve or ameliorate symptoms and improve functioning.

7. Child/Youth

A child/youth who seeks, on his/her own or another's initiative, and can benefit from care and treatment by DCFS. In DCFS CMH policies, the terms "patient", "child" and/or "youth" are used interchangeably.

8. Child/Youth Right(s)
   Includes, without limitation, all rights provided to a child/youth pursuant to NRS 433.456 to 433.536, inclusive, and any regulations adopted pursuant thereto.

9. Code of Federal Regulations (CFR)
   The codification of the general and permanent rules and regulations (sometimes called administrative law) which are published in the Federal Register by the executive departments of the federal government of the United States. The CFR's are noted as chapter, then section. For example, the CFR for the Health Insurance Portability Act (HIPAA) is located in Chapter 45 of the CFR in sections 160, 162, and 165; therefore, HIPAA CFR's are written as 45 CFR § 160, 162, and 164. The symbol "§" is used in referencing laws and regulations and means "section".

10. Confidentiality
    Pertains to all safeguards required to protect all information which concerns a child/youth and any other information which may not be disclosed by any party pursuant to federal and state law…including by not limited to NRS 422 and 42 CFR 431 (MSM 100).

11. Continuous Quality Improvement
    An ongoing effort to improve products, services, or processes. These efforts can seek "incremental" improvement over time or "breakthrough" improvement all at once.

12. Critical Incident
    Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a child/youth, DCFS staff or stakeholder and which results or may result in a major disruption to a program or any event which may have a negative impact on DCFS.

13. DCFS or Division
    Division of Child and Family Services.

14. DCFS Residential Programs
    Oasis On–Campus Treatment Homes (OCTH), Family Learning Homes (FLH), and Adolescent Treatment Center (ATC), which provide residential treatment home care. Also includes Desert Willow Treatment Center (DWTC), which provides acute psychiatric care as well as Residential Treatment Care (RTC).

15. DCFS Staff
    Means a mental health counselor, clinical social worker, licensed psychologist, psychiatric caseworker, psychiatric nurse, treatment home provider, treatment home supervisor, mental health technician, psychiatrist, clinical program manager, clinical program planner, LPN/RN, developmental specialist or public service intern who assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral and mental health needs. DCFS staff also includes fiscal and administrative staff.

16. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5)
    A developmentally based diagnostic manual, published by Zero to Three, that provides clinical criteria for categorizing mental health and developmental disorders in infants and toddlers. It is organized into a five-part axis system.

17. Diagnostic and Statistical Manual of Mental Disorders (DSM)
    The manual which provides the standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). (Retrieved from: http://www.psych.org/practice/dsm; 06-04-14)

18. Electronic Signature
    An electronic indication of intent to agree to or approve the contents of a document. More specifically, the U.S. Federal ESIGN Act defines an electronic signature as an "electronic sound, symbol, or process attached to or logically

associated with a contract or other record and executed or adopted by a person with the intent to sign the record." All information entered into myAvatar by DCFS staff is considered "signed" by the DCFS staff who entered the information by virtue of this definition.

19. Emancipated Minor
    A legal status conferred upon children/youth who have not yet attained the age of legal competency as defined by state law but are entitled to be treated as if they had such status by virtue of assuming adult responsibilities, such as self-support, marriage, or procreation. In addition, a child/youth may be legally emancipated through a court order. Unless specifically indicated otherwise, an emancipated minor has the same rights, privileges, and responsibilities as an adult.

20. Emergency
    A situation during which, within a reasonable degree of medical certainty, a delay in the initiation of emergency medical care or treatment would endanger the health of an individual (NRS 433.484).

21. Expressed Consent
    Means the child/youth or legally responsible person has specifically consented, in writing, to the treatment or intervention. As a practice issue, expressed consent cannot occur without first obtaining and documenting informed consent.

22. Facility
    Pursuant to NRS 433B.110, the Nevada Youth Hospital (i.e., Desert Willow Treatment Center)**,** the Adolescent Treatment Center (ATC), Northern Nevada Child and Adolescent Services (NNACS), and Southern Nevada Child and Adolescent Services (SNCAS).

23. False Claims Act
    Allows that any person or entity that knowingly submits a false or fraudulent claim for payment, knowingly uses a false record or statement to obtain payment on a false claim or conspires to defraud the United States Government by getting a false claim paid is liable for significant penalties and fines.

24. Family
    An individual who is a LRI (Legally Responsible Individual) for a child/youth. Family for children and youth may also include siblings and/or other individuals identified by the legal guardian as integral in their home/community environment or mental health stabilization. (MSM 400 Addendum, January 2018)

25. Fictive Kin
    A person not related by birth or marriage who has a significant emotional and positive relationship with the child/youth. These persons may include foster parents, friends, neighbors, school teachers, clergy, etc.

26. Fraud
    Knowingly and willfully attempting to falsely obtain money from any health care benefit program. Fraud is distinguished from abuse in that there is clear evidence that the acts were committed knowingly, willfully, and intentionally or with reckless disregard. Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2).

27. General Consent
    A one-time agency and child/youth, family executed agreement to provide and receive services. The child/youth may provide consent only if they are a legally emancipated minor. (NRS 129.030)

28. Goal
    A component of Individualized Treatment Plans (ITP) (MSM 400) and/or a component of a Care Coordination Plan (CCP) (MSM 2500). Goals are outcome driven. Goals are created during the treatment/rehabilitation and/or service planning process and must include the involvement and agreement of the child/youth and their legally responsible person or individual/family. Treatment/rehabilitation goals and/or case management service goals are written statements that specify anticipated treatment/rehabilitation and/or service outcomes and provide indicators of treatment/rehabilitation and/or case management success. Goals must be specific, measurable (observable), achievable, realistic, and time limited. Goals must clearly address specific behaviors and/or problems or case

management service needs and they must evolve in conjunction with the child's/youth's functional progress and/or service needs resolution. (MSM Addendum, January 2018)

29. Grievance or Complaint
    An allegation by a child/youth or legally responsible person/family about a violation of basic rights or an expression of dissatisfaction about agency services, programs, policies, or staff, respectively.

30. Health Information Portability and Accountability Act (HIPAA)
    A federal law passed in 1996 which requires that all HIPAA covered businesses, such as DCFS, develop safeguards which prevent unauthorized access to Protected Health Information (PHI). PHI includes demographic information such as the child's/youth's name, date of birth, diagnoses, addresses, and all information pertaining to the child's/youth's health and payment records.

31. Hospital
    An establishment for the diagnosis, care, and treatment of human illness, including care available 24 hours each day from persons licensed to practice professional nursing who are under the direction of a physician, services of a medical laboratory, and medical, radiological, dietary, and pharmaceutical services (NRS 449.012).

32. Imminent
    About to happen, impending (Webster's II New Riverside Dictionary, Revised Edition, 1996).

33. Incident
    An unusual or significant event that disrupts or adversely affects the course of treatment or care of a child/youth.

34. Incident Report
    A report to be completed by DCFS staff whenever an incident occurs involving a child/youth, DCFS staff, or stakeholder in a DCFS facility (i.e., DWTC, ATC, NNCAS, or SNCAS). *Also refer to definition for Reportable Incident and Critical Incident*.

35. Individualized Treatment Plan
    A comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services, to include Rehabilitative Mental Health (RMH) and Outpatient Mental Health (OMH) services. A Treatment Plan is person-centered, rehabilitative, and recovery oriented. The treatment plan addresses individualized goals and objectives. (MSM 400, December 2018)

36. Informed Consent
    Requires that the person whose consent is sought be adequately informed as to the nature and consequences of the procedure; the reasonable risks, benefits and purposes of the procedure; and alternative procedures available. (MSM 400 Addendum, January 2018). Informed consent is a process of communication between a child, youth, and family/legally responsible person and DCFS staff which results in the child/youth's family/legally responsible person's authorization or agreement to undergo a specific intervention. Informed consent requires DCFS staff to disclose the child's/youth's diagnosis (if known), the nature and purpose of a proposed treatment or intervention, the risks and benefits associated with the proposed treatment or intervention, alternatives (regardless of their cost or the extent to which treatment options are covered by health insurance), the risks and benefits of alternatives treatments or interventions, and the risks and benefits of not receiving or undergoing treatment or interventions (American Medical Association, 2013).

37. Legally Responsible Individual
    Individuals who are legally responsible to provide medical support, including: spouses of recipients, legal guardians, and parents of minors, including: stepparents, foster parents and adoptive parents. (MSM 400 Addendum, January 2018). The term "legally responsible individual" is used interchangeably with the term "legally responsible person/family" in CMH policies.

38. Medical Assessment
    A medical evaluation to determine if a child/youth has any medical conditions impacting his or her psychiatric presentation or any medical concerns or communicable diseases that need to be addressed. Timelines to complete a

medical assessment for DCFS residential treatment home programs are within 30 days of admission and for DWTC the timeline is within 7 days of admission. Procedures may differ according to specific program guidelines.

39. Medical Director/Medical Supervisor
"Medical director" means the medical officer in charge of any division mental health program. (NRS 433.134). A physician licensed to practice in the State of Nevada with at least two years of experience in a mental health treatment setting who has the competency to oversee and evaluate a comprehensive mental health treatment program, including rehabilitation services and medication management to individuals who are diagnosed with severe emotional disturbance or serious mental illness, may be considered to meet the qualifications of a Medical Director or Medical Supervisor. (MSM 400)

40. Medical Necessity
A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat, or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury, or disability (MSM 103.1).

41. Medical Record
The collection of all documentation regarding a child's/youth's mental health treatment and services. The record is a legal document and provides the foundation for managing and tracking the provision and quality of services. The medical record is a hybrid system at DCFS with some of its contents maintained in the myAvatar information management system and some of its contents maintained as a hard copy.

42. Medical Supervision
Medicaid Supervision is provided by a board-certified psychiatrist. It is the documented oversight which determines the medical appropriateness of the mental health program and services covered in MSM 400. Medical supervision must be documented at minimum, annually and always when determined medically appropriate based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication. Medical supervision may be secured through a current written agreement, job description, or similar type of binding document. Behavioral Health Community Networks (BHCN) and all inpatient mental health services are required to have medical supervision (MSM 403.2A, 1)

43. Medication
A drug prescribed only for the purpose of controlling or preventing a specific condition or symptom.

44. Medication Management
A psychiatric service which provides medical oversight of a child's/youth's medication regimen for the purpose of rapid symptom reduction, to maintain improvement in a chronic recurrent disorder or to prevent or reduce the chances of relapse or reoccurrence. Medication management services are provided by a psychiatrist or physician licensed to practice in the State of Nevada (see DCFS Federally approved Cost Allocation Plan, 2013).

45. Mental Health Professional
A person professionally qualified in the field of mental health, pursuant to NRS 433B.090, as well as a person professionally qualified in the field of psychiatric mental health.

46. Mental Health Therapies
The treatment of psychological, emotional, or behavioral disorders or maladjustments by a Qualified Mental Health Professional. They include, in combination or alone, family therapy, group therapy, and/or individual therapy.

47. Mental Illness
"Mental illness" means a clinically significant disorder of thought, mood, perception, orientation, memory or behavior which seriously limits the capacity of a person to function in the primary aspects of daily living, including, without limitation, personal relations, living arrangements, employment and recreation. The term does not include other mental disorders that result in diminished capacity, including, without limitation, epilepsy, intellectual disability, dementia, delirium, brief periods of intoxication caused by alcohol or drugs or dependence upon or addiction to alcohol or drugs. (NRS 433.164)

48. Mental Status Examination

A structured way of observing and describing a child or youth's current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment (Trzepacz and Baker, 1993).

49. myAvatar
    The collection of interdisciplinary data relating to a child's/youth's treatment and the Health Insurance Portability and Accountability Act (HIPAA) electronic billing information management system that supports the mental health services provided by DCFS programs.

50. Objective
    Benchmarks to measure progress towards treatment and/or rehabilitation goals. Objectives specify the steps that must be taken/achieved in order to reach treatment and/or rehabilitation goals. Objectives must be specific, measurable (observable), achievable, realistic, and time-limited. Objectives must clearly address specific behaviors and/or problems, and they must evolve in conjunction with the child's/youth's functional progress. (MSM Addendum, January 2018)

51. Off Label
    A medication prescribed by a physician for conditions other than those indicated and approved by the United States Food and Drug Administration (FDA)

52. Outcome
    An event, occurrence, or condition after services have been provided.

53. Patient
    A person who is admitted to a medical facility for the purpose of treatment; resides in a medical facility; or receives treatment from a provider of health care (NRS 439.810). In DCFS CMH policies, the terms "patient" and "child/youth" are used interchangeably.

54. Performance Evaluation
    Pursuant to NAC 284.194, the overall rating of an employee's efficiency, character, and conduct, which is included in a report on performance.

55. Performance and Quality Improvement (PQI)
    The complete process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions. PQI is not a time-limited project or initiative. It is the ongoing process by which a system makes decisions, evaluates its progress, and implements program improvement.

56. Person-Centered Treatment Planning
    Joint planning with a recipient and their family (when appropriate) of treatment services and interventions for the amelioration of symptoms of mental health needs which prohibit effective functioning. Recipient and family involvement in treatment planning must be documented on the Treatment Plan and/or Rehabilitation Plan, when the plan is reviewed every 90 days and at any time the plan is revised. (MSM Addendum, Section P, page 2; April 2019)

57. Person Legally Responsible for the Psychiatric Care of the Child (PLR)
    A person, appointed by the court, who is legally responsible for the psychiatric care of a child who is in the custody of an agency that provides child welfare services and is responsible for the procurement and oversight of all psychiatric care for the child and shall make decisions relating to the psychiatric care and related treatment of the child, including, without limitation, the approval of all psychiatric services, psychiatric treatment, and psychotropic medication that may be administered to the child. (NRS 432B.4686)

58. Privacy
    Means those health care protections monitored and enforced by the federal Office for Civil Rights (OCR), including:
    - the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information;
    - the HIPAA Security Rule, which sets national standards for the security of electronic protected health information;

•the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and,
•the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

Privacy recognizes that the child, youth and family/legally responsible person has a right and role in the collection, maintenance, use and disposition of their health care information (U.S. Department of Health and Human Services, 2013). *Also refer to definition for HIPAA, #33 above.*

59. Provider
A person who has applied to participate or who participates in the plan as a provider of goods or services; a private insurance carrier, health care cooperative or alliance, HMO, insurer, organization, entity, association, affiliation, or person who contracts to provide or provides goods or services that are reimbursed by or are a required benefit of the plan. (MSM 400 Addendum, January 2018).
In DCFS CMH programs, a provider includes a mental health counselor, clinical social worker, licensed psychologist, psychiatric caseworker, psychiatric nurse, treatment home provider, mental health technician, psychiatrist, developmental specialist or public service intern who assesses, plans, implements, coordinates, monitors and evaluates options to meet a child's/youth's or families' mental health needs. (MSM 400).

60. Provider of Healthcare
A physician, nurse, or physician assistant licensed in accordance with state law (NRS 441A.334).

61. Protected Health Information (PHI)
Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any form or medium.

62. Psychiatric Hospital
A hospital for the diagnosis, care, and treatment of mental illness which provides 24-hour residential care (NRS 449.0165).

63. Psychiatric Services
Includes psychiatric evaluation, therapy and medication management services to children and adolescents (Source: DCFS Federally Approved Cost Allocation Plan, 2013).

64. Psychotropic Medication
Medication, the prescribed intent of which is to affect or alter thought processes, mood, or behavior, including, but not limited to, antipsychotic, antidepressant, anxiolytic, and mood stabilizing medications. The classification of a medication depends on the causes of illness or symptoms.

65. Qualified Behavioral Aide (QBA)
A person who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by the overseeing Clinical Supervisor to provide RMH services. These services must be provided under direct contract with a Behavioral Health Community Network (BHCN) or Independent RMH provider. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services under the Clinical Supervision of a QMHP and the Direct Supervision of a QMHP or QMHA. QBAs must also have experience and/or training in service provision to people diagnosed with mental and/or behavioral health disorders, must be cleared through a Federal Bureau of Investigation (FBI) background check, and comply with ongoing trainings as required by Medicaid.

66. Qualified Mental Health Associate (QMHA)
A person who meets the documented minimum qualifications as defined by MSM 400, Section 403.3, A, 1 through 5.

67. Qualified Mental Health Professional (QMHP)
A mental health practitioner as defined by MSM Chapter 400, Section 403.3 Provider Qualifications – Outpatient Mental Health Services.

68. Quality Assurance

A structured internal monitoring and evaluation process designed to improve quality of care. Quality assurance involves the identification of quality of care criteria, which establishes the indicators for program measurement and needed improvements.

69. Recovery
A process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:
    - Health—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
    - Home—having a stable and safe place to live.
    - Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
    - Community—having relationships and social networks that provide support, friendship, love, and hope. (SAMHSA, May 2019)

70. Reportable Incident
Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a child/youth, DCFS staff, or stakeholder. It is also an event or situation which could have or has had a negative impact on the mental and/or physical wellbeing of a child/youth, DCFS staff member, or stakeholder in the short or long term.

71. Seven Rights of Medication Management
Standards for safe medication management – the right patient, right medication, right dose, right route, right time, right to refuse, and the right to be educated; any violation of these rights by DCFS staff is required to be reported as a medication error on an incident report.

72. Severe Emotional Disturbance (SED)
Children/youth determined SED are children and youth up to age 18 who currently or at any time during the past year (continuous 12-month period) have a:
    a) Diagnosable mental or behavioral disorder or diagnostic criteria that meet the coding and definition criteria specified in the current ICD (excluding substance abuse or addictive disorders, irreversible dementias, intellectual disability, developmental disorders and Z codes, unless they co-occur with a serious mental disorder that meets ICD criteria); and, have a
    b) Functional impairment which substantially interferes with or limits the child/youth from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent and persistent features are included, however may vary in term of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

    SED determinations are made by a QMHP within the scope of their practice under state law and expertise. (MSM Addendum, Section S, Page 3, April 2017).

72. Targeted Case Management (TCM)
TCM is an optional service that refers to the identification of a target group for whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination thereof. These services are defined as services which assist an individual, eligible under the plan, in gaining access to needed medical, social, educational and other services. The intent of these services is to allow States to reach beyond the usual bounds of the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of the Medicaid recipient. (MSM Addendum, Section T, page 4, April 2017).

73. Treatment
Any combination of procedures or activities for the mental health of children, of whatever level of intensity and whatever duration, ranging from occasional counseling sessions to full-time admission to a residential facility. (NRS 433B.100)

# APPENDIX B. 2019 CLARK COUNTY MENTAL HEALTH NEEDS ASSESSMENT RESULTS

## KEY INFORMANT INTERVIEW SUMMARIES

To better understand the current experiences and needs of mental and behavioral health service providers in Clark County, the Nevada Institute for Children's Research and Policy (NICRP) conducted semi-structured interviews with nine community organizations and agencies. Interviews were conducted from June through October, 2019 and included representatives from:

- The Harbor
- Boys Town Behavioral Health Clinic
- DCFS - Mobile Crisis
- CCSD – Psychological Services
- Clark County Department of Family Services
- Specialized Alternatives for Family and Youth (SAFY)
- DCFS - Early Childhood Mental Health
- The PRACTICE at UNLV
- DCFS - Wraparound in Nevada (WIN)

**Common Mental and Behavioral Health Issues**

Surprisingly, many organizations reported more youth coming in for services to address behavioral issues or undiagnosed intellectual disabilities, rather than mental health concerns. Though this may be the issue identified at intake, it is imperative that thorough investigation of the potential underlying causes for behavioral problems are conducted by providers to ensure accurate and effective treatment. Among mental health symptoms and disorders discussed, the most commonly seen by interviewed organizations were anxiety, depression, and suicidal ideation and behaviors. Experiences of trauma, especially during early childhood, were also reported by organizations as a significant contributing factor in both mental and behavioral issues presenting in the youth they serve. When describing the behavioral health issues for which families are seeking services, the most commonly reported include:

- Parental/child conflict
- Conduct disorders
- Bullying
- Aggression
- School-related issues (truancy, classroom behavior, absenteeism)

These behaviors were sometimes attributed to youth making "poor decisions" and in need of education and training on anger management or emotion regulation; or sometimes as a result of insufficient familial supports, whether by a lack of time spent with parents, being in an unstable household, or other settings not controlled by the family.

Additionally, organizations were asked whether they noticed any patterns in behavior within certain demographic groups amongst their clients. Though not all organizations provided a racial breakdown for the children they served, two that did were The Harbor (a deferral program to prevent youth from entering the juvenile justice system) and the Division of Family Service, Child Welfare office.

| | THE HARBOR | DFS – CHILD WELFARE | MCRT |
|---|---|---|---|
| **GENDER** | 38% female | 49% male | 55.8% female |
| **HISPANIC** | 45% | 24% | 38.1% |
| **AFRICAN-AMERICAN** | 30% | 34% | 22.5% |
| **CAUCASIAN** | 20% | 51% | 62.9% |

Multiple organizations reported an increase in the number of parent calls and community referrals for children at younger ages than previously seen, including for issues such as oppositional or aggressive behaviors, attachment disorders, and suicidal ideation. Some organizations reported receiving behavioral calls from parents stem from children who "aren't listening" or are not following rules, but that many times children are labeled as "oppositional" for their behavior problems, when there is an undiagnosed mental health or intellectual issue. When asked about common mental health issues seen by interviewed organizations, the most often reported included:

- Depression
- Autism
- ADHD
- Trauma
- Intellectual disabilities
- Suicidal ideation and behaviors

In youngest children: selective mutism, separation issues, tick disorders. While all organizations reported overall low recidivism rates, each had their own stories of challenging individual cases in which a child or family needed multiple sessions or referrals due to their need for higher complexity care. Two major factors that contributed to the need for repeat visits from families were: (1) difficulties navigating insurance to be able to cover necessary care during initial visits, and (2) lack of parent/family participation in treatment sessions with the child when needed. However, it is important to note that families' individual time constraints, work responsibilities, and other factors may play a role in a youth's inability to continue needed treatment. Providers should assess the individual needs of families to be able to meet them where they are at, and be willing to change modalities in order to do so.

**Current Services and Resources**

All organizations were asked about the community services they provide and most often refer out to, as well as the services that are most needed by the families they work with. Of the currently available programs in the community, Mobile Crisis was mentioned most often as an effective service for youth and families. However, each mention of Mobile Crisis was accompanied by a recommendation that its service be extended to children covered by all types of insurance, and not allow individual managed care organizations to deny Mobile Crisis service to their clients. Additionally, many organizations reported the need for high-intensity services, such as respite for families, day treatment, and acute and sub-acute care for inpatient and outpatient needs. Overall, organizations spoke to the purpose of many community-based services in diverting youth with mental and behavioral health needs from escalation and hospital admission, noting that current programs succeed in this effort but are not able to accommodate the overwhelming number of youth in the community who still need help.

*Mobile Crisis.* Every organization interviewed mentioned the introduction and recent expansion of the Mobile Crisis Response Team (MCRT) as one of the most significant resources in the community that supports children's mental and behavioral health. As previously mentioned, certain insurance regulations prohibit some youth from being able to access MCRT services, leaving families confused and frustrated. More about this is provided in the "Barriers to Service Delivery" section below.

*Emergency and Crisis Intervention.* In addition to MCRTs, many organizations implement their own crisis intervention protocols to address emergency situations when a youth presents as a danger to themselves or others. Organizations that operate 24 hours a day, such as The Harbor, have found it difficult to get other agencies to commit their staff to working on a 24-hour schedule. Parents seeking help during off-hours have reported waiting in hospital emergency departments for hours, while both parents and providers request a 24/7 number for help with de-escalating youth crisis situations available for ALL youth. Additionally, some organizations reported that once parents are connected with a helping agency, the onus is then put on the family to be proactive and follow up with providers and insurance companies to ensure the child in need gets all of the appropriate services. This makes it difficult for families to obtain the most effective services, since families may not be aware of all of the available options, or be inhibited from accessing services due to competing priorities within the home.

*Help-Seeking Behaviors.* Organization representatives were also asked to provide their opinions as to why some youth do not seek mental or behavioral healthcare when needed, and what strategies could be employed to encourage more help-seeking behavior when appropriate. Stigma about mental health, intellectual disability, and suicide were identified as the top reasons that youth and their families avoid or delay seeking care. Familial and cultural differences were also noted, with some organizations describing a lack of awareness or understanding about infant and/or child mental health, disagreement between parents about the need for services, and identifying emotional issues as simply "bad behavior" as other reasons help is not sought. Lastly, organizations that work with undocumented individuals and families have noted that there is much fear among that population of seeking services, especially those provided by government organizations, and worries of deportation or separation from their families. To encourage help-seeking, many organizations recommended increasing community education and awareness of children's mental health as a treatable medical issue and integrating mental/behavioral health services into primary care settings.

**Barriers to Service Delivery**

The most frequently mentioned barrier to service delivery and effective care was the way in which insurance plans

are not structured in the most beneficial way for the child or family. Navigating insurance for families was mentioned to be particularly difficult in situations when a mobile crisis response was needed. Though Mobile Crisis services are available 24 hours a day, 7 days a week, children covered by certain managed care organizations (MCO) were not allowed to utilize those services and were instead informed their insurance would only cover services provided directly by their MCO. Many organizations that refer to Mobile Crisis or rely on their services as part of a crisis intervention procedure expressed frustration with this policy and how the process of enforcing this makes it feel as though "knowing what insurance the [child] has is more important that helping the kid."

*Insurance and Affordability:* Multiple facets of health insurance were brought up in interviews as barriers to providing services needed by children in the community. Providers relayed many stories of families attempting to navigate their insurance plans, only to be confused by conflicting answers provided to them by customer service representatives (CSRs), or given incorrect information by CSRs who were not familiar with recent changes to Medicaid codes/coverage. Additionally, some families with private insurance plans were finding it difficult to get high intensity services, since their plans would not pay at parity with Medicaid reimbursement rates. This led to an uncommon, but still traumatic, practice of parents being advised they may need to relinquish custody of their child to the state so that Medicaid would be able to pay for the necessary treatments.

*Medicaid-specific Issues:* Many organizations reported issues with the way Medicaid covers services for very young children in need of mental or behavioral health care. One organization noted that Medicaid claim reviewers are often not pediatric specialists, and therefore do not understand what services are age appropriate. This may be a contributing factor to the reports of difficulty getting Medicaid to cover services such as psychosocial rehabilitation, or Autism Spectrum Disorder (ASD) services once youth have grown into adolescence. Additionally, changes to Medicaid codes have required repeated staff trainings on proper billing and coding procedures, taking time away from service delivery and client interaction.

*Reimbursement Rates:* Multiple organizations noted the low Medicaid reimbursement rates for children's mental and behavioral health services, with some pointing out that Nevada might have some of the lowest rates in the country. This makes it difficult to recruit and retain high quality service providers to work within the state, especially in rural communities. This has also made it difficult for some organizations to find psychiatrists for their patients that will accept private insurance; they will accept Medicaid (due to the higher reimbursement rate) or cash payments, but will turn privately insured patients away. Recommendations for improving inadequate reimbursement rates and infrastructure include:

- Create reimbursement structures for stepping up/down from RTC care to make it easier for out-of-state RTC facilities to work with NV.
- Offer salaries that are more competitive for school mental health professionals, especially school psychologists.
- Offer an endorsement for providers certified to work with young patients, enabling them to get higher reimbursement rates for the extra training and time it takes to work in early childhood.

Additionally, it is important to encourage providers to offer as many preventive services as possible for families. This could potentially divert the need for residential treatment, reducing the number of youth placed in out-of-community care.

*Network Inadequacy:* All organizations mentioned a severe shortage in high quality, specialized mental and behavioral health service providers in the community. While almost all agreed that the currently available services do well to address the needs in the community, the organizations that refer to these services feel they are overwhelming them with new clients and are confronted with month or yearlong wait times before new referrals can be accepted. The amount of need in the community is more than the capacity of what current service delivery agencies are able to provide. Psychosocial rehabilitation (PSR) and basic skills training (BST) providers were mentioned specifically as in high-demand, along with ASD screening, and professionals qualified to work with children under the age of six.

*Environmental Challenges:* Transportation was mentioned repeatedly as one of the biggest barriers for families to maintain consistent participation in services and programs, even when those programs are offered for free. Some

organizations do provide bus passes to families enrolled in programs, or (in rare cases) offer staff assistance in helping families to attend services. While there are outside transportation companies, many have strict parameters regarding who they are allowed to transport and for what reason. Transportation issues are exacerbated when trying to serve families in outlying, rural communities within Clark County. While each organization does they best to accommodate and assist families with their transportation issues, many of these are not sustainable long-term.

### Recommendations for Improvement from Stakeholders

Though many barriers and challenges exist in meeting the mental and behavioral health needs of children in Clark County, many organizations look to larger cultural shifts as the means to improving service delivery for the community. Overall, "taking politics out of the whole process," breaking down the walls of the silos that various agencies have placed themselves in, and addressing "Nevada's general attitude" about the need for individual communities to figure things out for themselves were discussed. Community education and collaboration are key strategies from all organizations that were recommended to help raise the effectiveness of current efforts and programs. Ultimately, all organizations requested that service providers, advocacy groups, educators, policymakers, and any community member with a stake in the mental health of children "stop admiring the problem" and start taking action to make lasting, positive change.

*CCCMHC Priorities.* Organizations were asked what CCCMHC should prioritize over the next ten years that would impact and help children's mental health. While every organization responded with some sort of request for increased funding, more specific strategies included:

- Downsizing priorities and identifying the main targets that are realistic.
- Basic supports for Tier 1 in schools, such as social emotional learning, screening, and specialized programs.
- Helping MCRT be allowed to serve everyone.
- Provide a buffer between what insurance covers and does not cover.
- Explore alternative treatment sources to medication and advancements in that area.
- More oversight that will help ensure access to services by finding a statewide or county authority willing to address the issue; working with the insurance exchange and MCOs.
- Curriculum based training for anyone working with kids in child welfare, including: cultural competency, trauma-informed care.
- A dedicated school for recovering students.
- Support a professional association and/or multidisciplinary collaboration for licensed professionals in the state.
- Building an infrastructure for a Center of Excellence (similar to the UNLV School of Medicine)
- Increase services for rural and undocumented families.

*Recommendations for Southern Nevada.* Organizations were also asked what members of the general community can and should do to help improve children's mental health. Again, in addition to increased and sustained funding sources, their recommendations include:

- More mentorship programs for youth, with more adult volunteers.
- Implement and expand evidence-based practices to get good, high-quality services.
- Educate the judicial system and CASAs about children's mental health.
- Help kids foster healthy relationships by providing support that families need to help them raise their children.
- Address dual diagnosis to help youth (and their parents) to get off drugs.
- Provide more mid-level services, and facilities that are able to provide longer term care (3-6 months).
- Provide access to IDD care for kids, where in-state hospitals are not allowed to deny a NV resident youth or youth with an IQ less than 70 from RTC.
- Educate more politicians and encourage bipartisan support.
- Improve the culture of schools by engaging with leadership.
- Increase the number of Spanish-speaking professionals in the mental/behavioral health professions.

## PARENT FOCUS GROUP SUMMARIES

### Accessibility of Mental and Behavioral Health Services and Treatment

Many parents described their experiences looking for mental and behavioral health treatment for their child as "difficult" and complicated, especially when seeking referrals to specialist services. One parent related their experience in seeking a referral of psychiatric services for their child, and their inability to get assistance from their primary care provider, judicial system, and hospital staff:

> *[Medicaid] were sending us to [MCO] who basically said, 'we are the therapy, you don't need a psychiatrist...if after two or three years we haven't fixed it, maybe we'll give you a referral.' I've tried to get a referral through the court, through the primary physician. I tried to go directly to the insurance and accessing actual psychological care was beyond anything I could do without being able to pay out of pocket...One of the psych hospitals...didn't have any information to give me. They only wanted to know is do I prefer in-state or out-of-state care...I just need to check boxes and it was 'Your problem will go away, and aren't you happy that you aren't a mom six months, a year, or whatever, because I'm sure you need a break too.'*

Other challenges experienced by parents in trying to access treatment for children included long wait times to receive an Autism diagnosis, ABA therapy, Basic Skills Training, and Psychosocial Rehabilitation. Many parents reported their frustration with inconvenient times that these services are offered - Monday through Friday during "regular" business hours - and that the only way to make sure their child receives the service they need is to pull them out of school and take off from work. This jeopardizes academic and economic stability for both parent and child. Additionally, navigating the complexities of what types of treatment and services each family's insurance plan will cover (or not) increases frustration. Without a diagnosis (specifically SED), it is very difficult for families to get Medicaid Fee-for-Service; and many have found it difficult to obtain an SED diagnosis from HBI. Without *any* specific diagnosis, getting a referral for a specialist, like a neuropsychologist, or access to treatment is near impossible. Parents noted that these challenges lead to practices in which providers and families sometimes choose a diagnosis that is the *"best fit"* for the child, just so that they can access some kind of services.

Geographical distance between families and their providers, as well as between multiple providers that parents may need to bring their child to, can pose a serious barrier to timely and efficient care. Multiple parents mentioned driving to multiple areas of town to visit various specialists, or needing to travel up to 100 miles round trip to visit the only specialist in the area that could provide the treatment their child needed (biofeedback) that was also covered by their insurance; some have even spent up to five hours one-way using public transportation.

Overall, the types of treatment and services that parents most commonly noted were challenging to access included:

- *Respite Services* - Available respite agencies are not taking intakes and not accepting names for their waiting list (because it is too long). Parents are having to rely on Family Medical Leave, if available from their employer.
- *Cognitive Behavioral Therapy* - Parents are frustrated with the push for medication only, even for very young children. For children whose condition is not treatable with medication, parents have experienced providers attempting to provide different diagnoses in order to prescribe medications.
- *Acute Care*- Parents of younger children have been told their child needs to be enrolled in a full time treatment program for addressing issues such as Reactive Attachment Disorder, however, outpatient programs in the community will not accept children that young (9 to 12 years old).
- *Basic Skills Training* - Difficult to find someone certified to provide BST for children. Schools are quick to provide parents with information about what children need, but do not/cannot provide sufficient information for parents to obtain those services.

### Quality of Mental and Behavioral Health Services and Resources

Many parents voiced their concerns about the quality of mental health services and supports available for children in the community, and whether the ones that are currently available are even working in the best interest of the children and their families. For example, multiple parents commented on challenging experiences they had when working with their child's school and school staff to get IEPs, 504s, and positive behavioral supports. Parents noted that some school staff

they encountered have *"written off"* their child as someone with behavior problems, and are faced with multiple RPCs and negative interactions. Additionally, some parents requested more age-appropriate documents and practices in schools for children with IEPs and 504s, with one parent describing their frustration with the implementation of behavior contracts for young children:

> *And I'm like look, he is 6...if the idea behind discipline is to teach, him looking at a tax form is not going to teach him. Show him the happy - sad - angry [faces]; ask him what happened...What preceded the behavior?...They don't have time and they don't care.*

Schools and school police were also described by parents as not wanting to *"deal with"* children with behavioral issues, and use disciplinary practices such as RPCs, suspensions, and police citations to take kids out of the school for a couple of days to give the staff a break. However, this makes maintaining a steady job and work schedule very difficult for parents, exacerbating problems with affording and accessing care.

Parents also remarked about the limited amount of services available for children in the community, and their challenges in finding high quality treatment for the specific needs of their children. One common theme was the need for parents to educate certain providers that have worked with their children (such as ABA therapists and registered behavior technicians) on the unique needs of children with disabilities or intense emotional issues. Parents felt this stemmed from an inadequate amount of training provided to these professionals on best practices for working with young children and special populations. In terms of overall quality and available options, one parent summed up the feelings of the group thusly:

> *They don't have a lot to choose from already and what's available, what takes their insurance or maybe they don't have a car so how close as far as proximity to bus stations, they kind of have to narrow it down to like one or two - and that one or two is really bad, and that's putting it nicely.*

Quality concerns were also brought up in a discussion regarding the use (or lack thereof) of evidence-based practices with youth, specifically in certain inpatient settings. One parent described observing their child's experience at a community psychiatric hospital in which *"all of the children watched Shirley Jackson's <u>The Lottery</u>, followed by <u>Hunger Games</u>...and they play Call of Duty to relax."* Many parents also remarked their frustration with the push to medicate children upon diagnosis, rather than try other types of non-pharmaceutical treatments first.

Parents also noted a lack of cultural sensitivity when interacting with racially mixed families. Multiple parents had children with lighter color skin than they have, and described instances of providers skeptically asking whether they are the child's biological parent or assuming they are a babysitter. One African-American parent remarked, *"I have a child that presents with white privilege. When I'm not standing there, everyone thinks that mom's blond and blue."*

**Recommendations from Parents**

Ultimately, parents were asked to provide recommendations about the types of services and supports their children and families need in the community to help improve mental and behavioral health. Many parents reiterated the needs discussed during previous sections, as well as new ideas that tackle the bigger picture of improving the overall culture and general community perceptions about mental wellbeing. Below is a list of recommendations provided by parents for services that they found to be helpful and/or they feel need to be expanded in some way.

- *Afterschool Care* - After school and out-of-school time care is essential for working parents to ensure that children are in a safe and supervised location. Many children with mental and behavioral health needs are not accepted at these types of programs, or are not properly accommodated to be able to interact with other youth.

- *Advocacy/Lobbying*- Parents were very appreciative of the advocacy work currently undertaken by Nevada PEP and expressed interest in becoming more involved in educating policymakers about these issues.

- *Wraparound Services* - Addressing basic needs, such as shelter, food, and clothing are the primary concern for many parents, making it difficult to juggle a full time job and ensuring children receive all of the care they need.

- *Stigma*- Stigma surrounding mental health and disabilities is still very prevalent in the community and many parents expressed feelings of embarrassment or shame when receiving the diagnosis for their child. Misconceptions that their condition is the fault of bad parenting or bad genes fuel these feelings and discourage some parents from openly sharing their stories and seeking support.

- *Understanding the Unique and Individual Needs of Families*- Each child and family may respond to treatment and interventions in different ways, regardless of the diagnosis. Many parents described instances of their child being *"placed in a box"* without anyone discussing the unique circumstances of the family. In addition, the community overall needs more bilingual services and staff at all level.

- *Consider Environmental Changes to Address Sensory Sensitivities*- Parents requested parks, especially water parks, that are more accessible for children with disabilities - both physical and mental. What many parents would like to see are more places where their child can go to truly enjoy being a kid - not to be excluded from certain activities or be told they are not playing correctly.

- *More School Psychologists*- Parents explained their difficulties in being denied testing or other services, while their child's school was transitioning to a new school psychologist. While some parents suggesting bringing in university interns to help fill the shortage in professionals, others proclaimed they did not want an intern working with their child. All parents agreed that more funding is necessary to provide adequate mental health staffing for schools and the community at large.

## 2019 COMMUNITY INPUT SURVEY

The Clark County Children's Mental Health Consortium conducted a Community Input Survey to learn more about people's experiences accessing and utilizing mental and behavioral health services in Clark County for children and adolescents. Community organizations that provide services and/or works with families who may seek services related to mental and behavioral health were asked to distribute surveys. Surveys were available in English and Spanish and were accessible online and in paper format. A total of 316 survey were collected, and approximately 30% represented family, friends, or general community and 70% represented service providers. Provided below are highlights of the results.

### PROGRAM CHARACTERISTICS THAT NEED IMPROVEMENT

#### 25-35% Parents Say Not Met

- Being able to go to one place and get what you need without a lot of complications
- Having service providers coordinate across multiple agencies and systems
- Having someone to help children and families to achieve their goals for the future.
- Support to provide needed services to children within their own community
- Services available in locations convenient to families (at home, work, school, etc.)
- Youth are active partners in service planning and delivery
- You have a choice of services and supports
- You have access to peer support (Providers-16.9%)

### SIGNIFICANT BARRIERS OR CHALLENGES IN PREVENTING ACCESS TO BEHAVIORAL SERVICES

#### 50% or More Providers Say Very Significant

- There are long waiting lists or not enough providers for children needing some services
- Time-limited placements or services creates lack of consistency and permanency for children
- 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

#### Instances of Larger Differences of Opinions between Parents and Providers

- Complex paperwork with multiple providers takes too much time away from children and families Parent 21.8 Provider 15.7
- Assessments don't identify the individual needs of the child and family Parent 44.4 Provider 24.5

### INACCESSIBLE SERVICES

#### 40%-50% Parents Say Not Accessible

- **Prevention Services:** Providing services for youth and families before challenges arise (provider 21.2)
- **Screening Services:** Activities to identify children and youth who may have behavioral health needs
- **Basic Skills Training:** Teaching about personal care, socialization, communication, organizational skills, time management, and traditional living and life skills (safety, getting ready for school, taking the bus, etc.) (provider 8.9%)
- **Mentors or Tutors:** One-to-one adult role models and supports for youth including help with school work
- **Community Recreation:** A safe environment where children with emotional/behavioral challenges can participate in social, recreational, and sports activities
- **Respite Care:** A place or someone to take care of the child to give both child and parents (caregivers) a break for a specific period of time.
- **Specialized Child Care:** A place or someone to take care of children with emotional and behavioral needs on a regular basis while parents work or have other engagements
- **Job Services:** Services to provide skills training that will help youth find and keep a job.
- **Day Treatment Mental Health:** Specialized programs to provide therapeutic experiences and socialization.
- **Aftercare:** Support to move back into the community from a hospital or residential setting.
- **Transitional Living and Housing Support:** Programs to help youth move from programs to adulthood.

- **Financial support:** Emergency funds to access needed services or medicine.

## DESIRED SERVICE DEVELOPMENT OR ENHANCEMENT

Parents and providers both listed:

- Increase in providers that take insurance,
- respite services,
- bilingual providers (especially Spanish),
- long-term and transitional care services, and
- access to mental health services and supports in schools

Parents expressed several additional services including:

- case management services at public schools to assist with IEPs,
- support learning how to advocate for their child, and
- resources that would help direct them to the correct places to get the support they need.

Providers expressed several additional services including:

- long-term mental health treatment services
- expanded care coordination services
- comprehensive community mental health system
- substance abuse prevention and treatment services initiated at an earlier age (to prevent use and treat youth who are initiating substance use at earlier ages)
- mental health crisis services and mental health aftercare services

## ADDITIONAL COMMENTS

Many parents indicated that while they could access services for their children, they had difficulties for their children with mental and behavioral health care needs at school. Parents also commented that they felt medication was used too quickly. Several providers expressed that more services were needed for youth in crisis, saying:

- the hospital is too overwhelming for children with thoughts of suicide
- mobile crisis services had received very poor feedback from parents
- that they had difficulty when trying to complete the “Legal 2000” process, and
- “NV Medicaid requests proof of multiple failed attempts at a lower service level for kids who we know need immediate residential treatment … unfortunately the message this sends to families is that we need them to go into further crisis before they can access the level of care they truly need.”

**Table 1. Rate How Well the Current Service Systems for Children with Behavioral Health Needs and Their Families Meets Each of the Program Characteristics**

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Programs have flexible hours to be open when people can get there.** | | | | | | |
| Not Met | 10 | 16.7% | 15 | 12.5% | 25 | 13.8% |
| Mostly Not Met | 18 | 30% | 45 | 37.5% | 63 | 35% |
| Mostly Met | 19 | 31.7% | 39 | 32.5% | 58 | 32.2% |
| Met | 13 | 21.7% | 21 | 17.5% | 34 | 18.9% |
| *Total* | 60 | 100% | 120 | 100% | 180 | 100% |
| **Somebody who is there when children and youth need them (not just when they want to talk to youth).** | | | | | | |
| Not Met | 14 | 25% | 17 | 13.9% | 31 | 17.4% |
| Mostly Not Met | 19 | 33.9% | 42 | 34.4% | 61 | 34.3% |
| Mostly Met | 11 | 19.6% | 32 | 26.2% | 43 | 24.2% |
| Met | 12 | 21.4% | 31 | 25.4% | 43 | 24.2% |
| *Total* | 56 | 100% | 122 | 100% | 178 | 100% |
| **Help with things that are important to youth, not just what providers think youth need.** | | | | | | |
| Not Met | 10 | 17.9% | 17 | 14.1% | 27 | 15.3% |
| Mostly Not Met | 22 | 39.9% | 41 | 33.9% | 63 | 52.1% |
| Mostly Met | 7 | 12.5% | 35 | 28.9% | 42 | 23.7% |
| Met | 17 | 30.4% | 28 | 23.1% | 45 | 25.4% |
| *Total* | 56 | 100% | 121 | 100% | 177 | 100% |
| **Having a real person on the phone** | | | | | | |
| Not Met | 9 | 15.8% | 15 | 13.5% | 24 | 14.3% |
| Mostly Not Met | 11 | 19.3% | 22 | 19.8% | 33 | 19.6% |
| Mostly Met | 15 | 26.3% | 40 | 36% | 55 | 32.7% |
| Met | 22 | 38.6% | 34 | 30.6% | 56 | 33.3% |
| *Total* | 57 | 100% | 111 | 100% | 168 | 100% |
| **Being able to go to one place and get what you need without a lot of complications** | | | | | | |
| Not Met | 19 | 32.2% | 38 | 31.7% | 57 | 31.8% |
| Mostly Not Met | 17 | 28.8% | 35 | 29.2% | 52 | 29.1% |
| Mostly Met | 11 | 18.6% | 30 | 25% | 41 | 22.9% |
| Met | 12 | 20.3% | 17 | 14.2% | 29 | 16.2% |
| *Total* | 59 | 100% | 120 | 100% | 179 | 100% |
| **Having providers who use your preferred language** | | | | | | |
| Not Met | 5 | 8.9% | 15 | 13% | 20 | 11.7% |
| Mostly Not Met | 6 | 10.7% | 30 | 26.1% | 36 | 21.1% |
| Mostly Met | 12 | 21.4% | 40 | 34.8% | 52 | 30.4% |
| Met | 33 | 58.9% | 30 | 26.1% | 63 | 36.8% |
| *Total* | 56 | 100% | 115 | 100% | 171 | 100% |
| **Having providers available in your local area** | | | | | | |
| Not Met | 13 | 21.7% | 24 | 19.5% | 37 | 20.2% |
| Mostly Not Met | 14 | 23.3% | 38 | 30.9% | 52 | 28.4% |
| Mostly Met | 17 | 28.3% | 41 | 33.3% | 58 | 31.7% |
| Met | 16 | 26.7% | 20 | 16.3% | 36 | 19.7% |
| *Total* | 60 | 100% | 123 | 100% | 183 | 100% |
| **Having service providers coordinate across multiple agencies and systems** | | | | | | |
| Not Met | 16 | 29.6% | 27 | 22% | 43 | 24.3% |
| Mostly Not Met | 18 | 33.3% | 44 | 35.8% | 62 | 35% |
| Mostly Met | 10 | 18.5% | 28 | 22.8% | 38 | 21.5% |
| Met | 10 | 18.5% | 24 | 19.5% | 34 | 19.2% |
| *Total* | 54 | 100% | 123 | 100% | 177 | 100% |

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Helping children and families develop long term goals for health and success** | | | | | | |
| Not Met | 11 | 18.6% | 28 | 22.8% | 39 | 21.4% |
| Mostly Not Met | 20 | 33.9% | 35 | 28.5% | 55 | 30.2% |
| Mostly Met | 15 | 25.4% | 39 | 31.7% | 54 | 29.7% |
| Met | 13 | 22% | 21 | 17.1% | 34 | 18.7% |
| *Total* | 59 | 100% | 123 | 100% | 182 | 100% |
| **Having someone to help children and families to achieve their goals for the future.** | | | | | | |
| Not Met | 15 | 25.9% | 25 | 20.3% | 40 | 22.1% |
| Mostly Not Met | 17 | 29.3% | 34 | 27.6% | 51 | 28.2% |
| Mostly Met | 13 | 22.4% | 43 | 35% | 56 | 30.9% |
| Met | 13 | 22.4% | 21 | 17.1% | 34 | 18.8% |
| *Total* | 58 | 100% | 123 | 100% | 181 | 100% |
| **Ensuring the services provided meet the individualized needs of children and families** | | | | | | |
| Not Met | 14 | 23.3% | 26 | 20.8% | 40 | 21.6% |
| Mostly Not Met | 18 | 30% | 36 | 28.8% | 54 | 29.2% |
| Mostly Met | 16 | 26.7% | 41 | 32.8% | 57 | 30.8% |
| Met | 12 | 20% | 22 | 17.6% | 34 | 18.4% |
| *Total* | 60 | 100% | 125 | 100% | 185 | 100% |
| **Support to provide needed services to children within their own community** | | | | | | |
| Not Met | 15 | 25.4% | 27 | 21.8% | 42 | 23% |
| Mostly Not Met | 18 | 30.5% | 44 | 35.5% | 62 | 33.9% |
| Mostly Met | 17 | 28.8% | 32 | 25.8% | 49 | 26.8% |
| Met | 9 | 15.3% | 21 | 16.9% | 30 | 16.4% |
| *Total* | 59 | 100% | 124 | 100% | 183 | 100% |
| **Services available in locations convenient to families (at home, work, school, etc.)** | | | | | | |
| Not Met | 17 | 28.3% | 24 | 19.7% | 41 | 22.5% |
| Mostly Not Met | 16 | 26.7% | 51 | 41.8% | 67 | 36.8% |
| Mostly Met | 16 | 26.7% | 31 | 25.4% | 47 | 25.8% |
| Met | 11 | 18.3% | 16 | 13.1% | 27 | 14.8% |
| *Total* | 60 | 100% | 122 | 100% | 182 | 100% |
| **Individualized child and family teams are used to develop and implement a customized service plan** | | | | | | |
| Not Met | 12 | 21.4% | 23 | 18.9% | 35 | 19.7% |
| Mostly Not Met | 20 | 35.7% | 42 | 34.4% | 62 | 34.8% |
| Mostly Met | 16 | 28.6% | 36 | 29.5% | 52 | 29.2% |
| Met | 8 | 14.3% | 21 | 17.2% | 29 | 16.3% |
| *Total* | 56 | 100% | 122 | 100% | 178 | 100% |
| **Families have a primary decision making role in service planning and delivery** | | | | | | |
| Not Met | 13 | 22.4% | 18 | 14.9% | 31 | 17.3% |
| Mostly Not Met | 11 | 19% | 28 | 23.1% | 39 | 21.8% |
| Mostly Met | 18 | 31% | 47 | 38.8% | 65 | 36.3% |
| Met | 16 | 27.6% | 28 | 23.1% | 44 | 24.6% |
| *Total* | 58 | 100% | 121 | 100% | 179 | 100% |
| **Youth are active partners in service planning and delivery** | | | | | | |
| Not Met | 17 | 31.5% | 25 | 21.4% | 42 | 24.6% |
| Mostly Not Met | 14 | 25.9% | 44 | 37.6% | 58 | 33.9% |
| Mostly Met | 12 | 22.2% | 30 | 25.6% | 42 | 24.6% |
| Met | 11 | 20.4% | 18 | 15.4% | 29 | 17% |
| *Total* | 54 | 100% | 117 | 100% | 171 | 100% |
| **Youth strengths and interests are incorporated in service planning and delivery** | | | | | | |
| Not Met | 12 | 21.4% | 20 | 16.3% | 32 | 17.9% |
| Mostly Not Met | 15 | 26.8% | 37 | 30.1% | 52 | 29.1% |
| Mostly Met | 18 | 32.1% | 41 | 33.3% | 59 | 33% |
| Met | 11 | 19.6% | 25 | 20.3% | 36 | 20.1% |
| *Total* | 56 | 100% | 123 | 100% | 179 | 100% |

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **You have a choice of services and supports** | | | | | | |
| Not Met | 15 | 25.9% | 30 | 25.2% | 45 | 25.4% |
| Mostly Not Met | 21 | 36.2% | 38 | 31.9% | 59 | 33.3% |
| Mostly Met | 9 | 15.5% | 31 | 26.1% | 40 | 22.6% |
| Met | 13 | 22.4% | 20 | 16.8% | 33 | 18.6% |
| *Total* | 58 | 100% | 119 | 100% | 177 | 100% |
| **You have access to peer support** | | | | | | |
| Not Met | 20 | 35.1% | 20 | 16.9% | 40 | 22.9% |
| Mostly Not Met | 14 | 24.6% | 43 | 36.4% | 57 | 32.6% |
| Mostly Met | 9 | 15.8% | 30 | 25.4% | 39 | 22.3% |
| Met | 14 | 24.6% | 25 | 21.2% | 39 | 22.3% |
| *Total* | 57 | 100% | 118 | 100% | 175 | 100% |
| **A youth organization exists and supports youth involvement at system and service delivery levels** | | | | | | |
| Not Met | 12 | 23.5% | 26 | 21.5% | 38 | 22.1% |
| Mostly Not Met | 16 | 31.4% | 52 | 43% | 68 | 39.5% |
| Mostly Met | 10 | 19.6% | 26 | 21.5% | 36 | 20.9% |
| Met | 13 | 25.5% | 17 | 14% | 30 | 17.4% |
| *Total* | 51 | 100% | 121 | 100% | 172 | 100% |
| **Providers represent the cultural and linguistic characteristics of the population served** | | | | | | |
| Not Met | 5 | 10% | 19 | 15.6% | 24 | 14% |
| Mostly Not Met | 14 | 28% | 45 | 36.9% | 59 | 34.3% |
| Mostly Met | 14 | 28% | 36 | 29.5% | 50 | 29.1% |
| Met | 17 | 34% | 22 | 18% | 39 | 22.7% |
| *Total* | 50 | 100% | 122 | 100% | 172 | 100% |
| **Providers are trained in cultural and linguistic competence** | | | | | | |
| Not Met | 5 | 10.4% | 19 | 15.7% | 24 | 14.2% |
| Mostly Not Met | 16 | 33.3% | 35 | 28.9% | 51 | 30.2% |
| Mostly Met | 12 | 25% | 40 | 33.1% | 52 | 30.8% |
| Met | 15 | 31.3% | 27 | 22.3% | 42 | 24.9% |
| *Total* | 48 | 100% | 121 | 100% | 169 | 100% |
| **Services and supports are adapted to ensure access and effectiveness for culturally diverse populations** | | | | | | |
| Not Met | 6 | 13.3% | 21 | 17.5% | 27 | 16.4% |
| Mostly Not Met | 15 | 33.3% | 41 | 34.2% | 56 | 33.9% |
| Mostly Met | 11 | 24.4% | 34 | 28.3% | 45 | 27.3% |
| Met | 13 | 28.9% | 24 | 20% | 37 | 22.4% |
| *Total* | 45 | 100% | 120 | 100% | 165 | 100% |
| **Specific strategies are used to reduce racial and ethnic disparities in access to and outcomes of services** | | | | | | |
| Not Met | 9 | 20.9% | 24 | 19.8% | 33 | 20.1% |
| Mostly Not Met | 13 | 30.2% | 39 | 32.2% | 52 | 31.7% |
| Mostly Met | 10 | 23.3% | 34 | 28.1% | 44 | 26.8% |
| Met | 11 | 25.6% | 24 | 19.8% | 35 | 21.3% |
| *Total* | 43 | 100% | 121 | 100% | 164 | 100% |

**Table 2. Please Rate the Significance of Each Barrier or Challenge in Preventing Children or Families from Effectively Getting Behavioral Services**

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Complex paperwork with multiple providers takes too much time away from children and families** | | | | | | |
| 1 (Not at All Significant) | 15 | 26.3% | 7 | 6.4% | 22 | 13.3% |
| 2 | 11 | 19.3% | 11 | 10.1% | 22 | 13.3% |
| 3 | 8 | 14% | 18 | 16.5% | 26 | 15.7% |
| 4 | 9 | 15.8% | 30 | 27.5% | 39 | 23.5% |
| 5 (Very Significant) | 14 | 24.6% | 43 | 39.4% | 57 | 34.3% |
| *Total* | 57 | 100% | 109 | 100% | 166 | 100% |
| **Confidentiality issues make it hard to share or to know when to share information** | | | | | | |
| 1 (Not at All Significant) | 14 | 25.5% | 17 | 15.7% | 31 | 19% |
| 2 | 13 | 23.6% | 25 | 23.1% | 38 | 23.3% |
| 3 | 11 | 20% | 31 | 28.7% | 42 | 25.8% |
| 4 | 5 | 9.1% | 18 | 16.7% | 23 | 14.1% |
| 5 (Very Significant) | 12 | 21.8% | 17 | 15.7% | 29 | 17.8% |
| *Total* | 55 | 100% | 108 | 100% | 163 | 100% |
| **There are long waiting lists or not enough providers for children needing some services** | | | | | | |
| 1 (Not at All Significant) | 13 | 23.6% | 3 | 2.7% | 16 | 9.7% |
| 2 | 3 | 5.5% | 3 | 2.7% | 6 | 3.6% |
| 3 | 3 | 5.5% | 9 | 8.2% | 12 | 7.3% |
| 4 | 3 | 5.5% | 18 | 16.4% | 21 | 12.7% |
| 5 (Very Significant) | 33 | 60% | 77 | 70% | 110 | 66.7% |
| *Total* | 55 | 100% | 110 | 100% | 165 | 100% |
| **Time-limited placements or services creates lack of consistency and permanency for children** | | | | | | |
| 1 (Not at All Significant) | 13 | 25.5% | 4 | 3.8% | 17 | 10.8% |
| 2 | 6 | 11.8% | 6 | 5.7% | 12 | 7.6% |
| 3 | 8 | 15.7% | 14 | 13.2% | 22 | 14% |
| 4 | 3 | 5.9% | 25 | 23.6% | 28 | 17.8% |
| 5 (Very Significant) | 21 | 41.2% | 57 | 53.8% | 78 | 49.7% |
| *Total* | 51 | 100% | 106 | 100% | 157 | 100% |
| **Children are placed in child welfare or juvenile justice custody in order to access services for the child and family** | | | | | | |
| 1 (Not at All Significant) | 13 | 31% | 11 | 11.2% | 24 | 17.1% |
| 2 | 3 | 7.1% | 14 | 14.3% | 17 | 12.1% |
| 3 | 9 | 21.4% | 30 | 30.6% | 39 | 27.9% |
| 4 | 4 | 9.5% | 18 | 18.4% | 22 | 15.7% |
| 5 (Very Significant) | 13 | 31% | 25 | 25.5% | 38 | 27.1% |
| *Total* | 42 | 100% | 98 | 100% | 140 | 100% |
| **Children may be moved from one place to another when a different level of care is needed** | | | | | | |
| 1 (Not at All Significant) | 14 | 28.6% | 7 | 6.9% | 21 | 13.9% |
| 2 | 6 | 12.2% | 8 | 7.8% | 14 | 9.3% |
| 3 | 9 | 18.4% | 31 | 30.4% | 40 | 26.5% |
| 4 | 5 | 10.2% | 24 | 23.5% | 29 | 19.2% |
| 5 (Very Significant) | 15 | 30.6% | 32 | 31.4% | 47 | 31.1% |
| *Total* | 49 | 100% | 102 | 100% | 151 | 100% |
| **Transportation resources to help families get to services are hard to arrange** | | | | | | |
| 1 (Not at All Significant) | 13 | 27.1% | 4 | 3.7% | 17 | 10.9% |
| 2 | 2 | 4.2% | 5 | 4.6% | 7 | 4.5% |
| 3 | 6 | 12.5% | 15 | 13.9% | 21 | 13.5% |
| 4 | 5 | 10.4% | 23 | 21.3% | 28 | 17.9% |
| 5 (Very Significant) | 22 | 45.8% | 61 | 56.5% | 83 | 53.2% |
| *Total* | 48 | 100% | 108 | 100% | 156 | 100% |

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Access to services is based on the family's ability to pay or medical coverage and not the child's needs** | | | | | | |
| 1 (Not at All Significant) | 9 | 17% | 5 | 4.5% | 14 | 8.6% |
| 2 | 3 | 5.7% | 4 | 3.6% | 7 | 4.3% |
| 3 | 5 | 9.4% | 19 | 17.3% | 24 | 14.7% |
| 4 | 6 | 11.3% | 18 | 16.4% | 24 | 14.7% |
| 5 (Very Significant) | 30 | 56.6% | 64 | 58.2% | 94 | 57.7% |
| *Total* | 53 | 100% | 110 | 100% | 163 | 100% |
| **Assessments don't identify the individual needs of the child and family** | | | | | | |
| 1 (Not at All Significant) | 10 | 18.5% | 11 | 10.4% | 21 | 13.1% |
| 2 | 6 | 11.1% | 20 | 18.9% | 26 | 16.3% |
| 3 | 8 | 14.8% | 31 | 29.2% | 39 | 24.4% |
| 4 | 6 | 11.1% | 18 | 17% | 24 | 15% |
| 5 (Very Significant) | 24 | 44.4% | 26 | 24.5% | 50 | 31.3% |
| *Total* | 54 | 100% | 106 | 100% | 160 | 100% |
| **Providers are not trained in the latest, most effective treatment methods** | | | | | | |
| 1 (Not at All Significant) | 17 | 33.3% | 17 | 16.5% | 34 | 22.1% |
| 2 | 2 | 3.9% | 18 | 17.5% | 20 | 13% |
| 3 | 6 | 11.8% | 29 | 28.2% | 35 | 22.7% |
| 4 | 8 | 15.7% | 8 | 7.8% | 16 | 10.4% |
| 5 (Very Significant) | 18 | 35.3% | 31 | 30.1% | 49 | 31.8% |
| *Total* | 51 | 100% | 103 | 100% | 154 | 100% |
| **Third Party (including Medicaid) Reimbursement rates are too low for providers to expand needed services** | | | | | | |
| 1 (Not at All Significant) | 13 | 28.3% | 9 | 9.9% | 22 | 16.1% |
| 2 | 3 | 6.5% | 6 | 6.6% | 9 | 6.6% |
| 3 | 4 | 8.7% | 18 | 19.8% | 22 | 16.1% |
| 4 | 2 | 4.3% | 8 | 8.8% | 10 | 7.3% |
| 5 (Very Significant) | 24 | 52.2% | 50 | 54.9% | 74 | 54% |
| *Total* | 46 | 100% | 91 | 100% | 137 | 100% |

Participants were also given the opportunity to provide information about other barriers they or their clients experience that were not included in the survey. The barriers that parents indicated they experienced the most included:

- a lack of mental health care providers,
- a lack of services for specific age groups, particularly 18 – 24
- long wait times, and
- a lack of support groups for parents – especially during non-work hours.

Providers reported similar barriers for children and families as parents, including:

- a lack of mental health care providers,
- long wait times,
- few or no services for uninsured or low-income families, and
- a lack of services available outside of working times.

Providers also indicated that other barriers children and families face included:

- a lack of inpatient services,
- a lack of respite services,
- insurance denials, and
- difficulty obtaining approvals from insurance companies for mental or behavioral health needs.

Other barriers providers indicated were provider burnout, low-pay, and a lack of diversity in providers.

**Table 3. Please Rate How Accessible all of the Services are for Children Who Need Them**

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Prevention Services:** Providing services for youth and families before challenges arise | | | | | | |
| 1 (Not at All Accessible) | 22 | 43.1% | 22 | 21.2% | 44 | 28.4% |
| 2 | 16 | 31.4% | 43 | 41.3% | 59 | 38.1% |
| 3 | 5 | 9.8% | 28 | 26.9% | 33 | 21.3% |
| 4 | 2 | 3.9% | 7 | 6.7% | 9 | 5.8% |
| 5 (Very Accessible) | 6 | 11.8% | 4 | 3.8% | 10 | 6.5% |
| *Total* | 51 | 100% | 104 | 100% | 155 | 100% |
| **Screening Services:** Activities to identify children and youth who may have behavioral health needs | | | | | | |
| 1 (Not at All Accessible) | 21 | 39.6% | 16 | 15.5% | 37 | 23.7% |
| 2 | 13 | 24.5% | 34 | 33% | 47 | 30.1% |
| 3 | 8 | 15.1% | 25 | 24.3% | 33 | 21.2% |
| 4 | 5 | 9.4% | 21 | 20.4% | 26 | 16.7% |
| 5 (Very Accessible) | 6 | 11.3% | 7 | 6.8% | 13 | 8.3% |
| *Total* | 53 | 100% | 103 | 100% | 156 | 100% |
| **Early Intervention Services:** Providing support for preschool-aged children and their families before needs become severe | | | | | | |
| 1 (Not at All Accessible) | 13 | 26% | 12 | 12.1% | 25 | 16.8% |
| 2 | 18 | 36% | 39 | 39.4% | 57 | 38.3% |
| 3 | 6 | 12% | 29 | 29.3% | 35 | 23.5% |
| 4 | 3 | 6% | 12 | 12.1% | 15 | 10.1% |
| 5 (Very Accessible) | 10 | 20% | 7 | 7.1% | 17 | 11.4% |
| *Total* | 50 | 100% | 99 | 100% | 149 | 100% |
| **Basic Skills Training:** Teaching about personal care, socialization, communication, organizational skills, time management, and traditional living and life skills (safety, getting ready for school, taking the bus, etc.) | | | | | | |
| 1 (Not at All Accessible) | 18 | 38.3% | 9 | 8.9% | 27 | 18.2% |
| 2 | 15 | 31.9% | 39 | 38.6% | 54 | 36.5% |
| 3 | 3 | 6.4% | 31 | 30.7% | 34 | 23% |
| 4 | 3 | 6.4% | 10 | 9.9% | 13 | 8.8% |
| 5 (Very Accessible) | 8 | 17% | 12 | 11.9% | 20 | 13.5% |
| *Total* | 47 | 100% | 101 | 100% | 148 | 100% |
| **Mentors or Tutors:** One-to-one adult role models and supports for youth including help with school work | | | | | | |
| 1 (Not at All Accessible) | 22 | 43.1% | 25 | 24% | 47 | 30.3% |
| 2 | 16 | 31.4% | 40 | 38.5% | 56 | 36.1% |
| 3 | 4 | 7.8% | 27 | 26% | 31 | 20% |
| 4 | 3 | 5.9% | 5 | 4.8% | 8 | 5.2% |
| 5 (Very Accessible) | 6 | 11.8% | 7 | 6.7% | 13 | 8.4% |
| *Total* | 51 | 100% | 104 | 100% | 155 | 100% |
| **Community Recreation:** A safe environment where children with emotional/behavioral challenges can participate in social, recreational, and sports activities | | | | | | |
| 1 (Not at All Accessible) | 24 | 48% | 17 | 16.2% | 41 | 26.5% |
| 2 | 11 | 22% | 42 | 40% | 53 | 34.2% |
| 3 | 6 | 12% | 20 | 19% | 26 | 16.8% |
| 4 | 3 | 6% | 15 | 14.3% | 18 | 11.6% |
| 5 (Very Accessible) | 6 | 12% | 11 | 10.5% | 17 | 11% |
| *Total* | 50 | 100% | 105 | 100% | 155 | 100% |
| **Basic Health Care Services:** Preventive and basic medical and other health care services. | | | | | | |
| 1 (Not at All Accessible) | 11 | 22% | 9 | 8.8% | 20 | 13.2% |
| 2 | 11 | 22% | 33 | 32.4% | 44 | 28.9% |
| 3 | 7 | 14% | 37 | 36.3% | 44 | 28.9% |
| 4 | 8 | 16% | 15 | 14.7% | 23 | 15.1% |
| 5 (Very Accessible) | 13 | 26% | 8 | 7.8% | 21 | 13.8% |
| *Total* | 50 | 100% | 102 | 100% | 152 | 100% |

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Family Peer Support:** Individualized assistance for families finding information, support, and resources; assistance to advocate, for child and family access to support and services to help with challenges at home, In the community and at school. | | | | | | |
| 1 (Not at All Accessible) | 9 | 16.7% | 17 | 16.5% | 26 | 16.6% |
| 2 | 13 | 24.1% | 37 | 35.9% | 50 | 31.8% |
| 3 | 14 | 25.9% | 27 | 26.2% | 41 | 26.1% |
| 4 | 3 | 5.6% | 14 | 13.6% | 17 | 10.8% |
| 5 (Very Accessible) | 15 | 27.8% | 8 | 7.8% | 23 | 14.6% |
| *Total* | 54 | 100% | 103 | 100% | 157 | 100% |
| **Parent Education Training:** Mentoring for parents in skills to help raise confident, competent, and resilient children and youth. | | | | | | |
| 1 (Not at All Accessible) | 11 | 20.8% | 12 | 11.5% | 23 | 14.6% |
| 2 | 13 | 24.5% | 40 | 38.5% | 53 | 33.8% |
| 3 | 11 | 20.8% | 30 | 28.8% | 41 | 26.1% |
| 4 | 6 | 11.3% | 15 | 14.4% | 21 | 13.4% |
| 5 (Very Accessible) | 12 | 22.6% | 7 | 6.7% | 19 | 12.1% |
| *Total* | 53 | 100% | 104 | 100% | 157 | 100% |
| **Parent Support Groups:** For parents to share lived experience, support each other, explore new parenting strategies, and establish positive family supports. | | | | | | |
| 1 (Not at All Accessible) | 14 | 25.9% | 18 | 17.3% | 32 | 20.3% |
| 2 | 9 | 16.7% | 44 | 42.3% | 53 | 33.5% |
| 3 | 10 | 18.5% | 29 | 27.9% | 39 | 24.7% |
| 4 | 7 | 13% | 8 | 7.7% | 15 | 9.5% |
| 5 (Very Accessible) | 14 | 25.9% | 5 | 4.8% | 19 | 12% |
| *Total* | 54 | 100% | 104 | 100% | 158 | 100% |
| **Case Management:** Individualized help in finding and coordinating services for the child and family. | | | | | | |
| 1 (Not at All Accessible) | 15 | 27.8% | 15 | 14.6% | 30 | 19.1% |
| 2 | 15 | 27.8% | 28 | 27.2% | 43 | 27.4% |
| 3 | 10 | 18.5% | 32 | 31.1% | 42 | 26.8% |
| 4 | 5 | 9.3% | 21 | 20.4% | 26 | 16.6% |
| 5 (Very Accessible) | 9 | 16.7% | 7 | 6.8% | 16 | 10.2% |
| *Total* | 54 | 100% | 103 | 100% | 157 | 100% |
| **Respite Care:** A place or someone to take care of the child to give both child and parents (caregivers) a break for a specific period of time. | | | | | | |
| 1 (Not at All Accessible) | 26 | 57.8% | 34 | 34% | 60 | 41.4% |
| 2 | 11 | 24.4% | 38 | 38% | 49 | 33.8% |
| 3 | 2 | 4.4% | 18 | 18% | 20 | 13.8% |
| 4 | 2 | 4.4% | 7 | 7% | 9 | 6.2% |
| 5 (Very Accessible) | 4 | 8.9% | 3 | 3% | 7 | 4.8% |
| *Total* | 45 | 100% | 100 | 100% | 145 | 100% |
| **Specialized Child Care:** A place or someone to take care of children with emotional and behavioral needs on a regular basis while parents work or have other engagements | | | | | | |
| 1 (Not at All Accessible) | 27 | 58.7% | 42 | 42% | 69 | 47.3% |
| 2 | 10 | 21.7% | 34 | 34% | 44 | 30.1% |
| 3 | 2 | 4.3% | 15 | 15% | 17 | 11.6% |
| 4 | 2 | 4.3% | 7 | 7% | 9 | 6.1% |
| 5 (Very Accessible) | 5 | 10.9% | 2 | 2% | 7 | 4.8% |
| *Total* | 46 | 100% | 100 | 100% | 146 | 100% |
| **Counseling services (outpatient therapy):** Individual, group, anger management, or family counseling. | | | | | | |
| 1 (Not at All Accessible) | 10 | 18.2% | 13 | 12.5% | 23 | 14.5% |
| 2 | 17 | 30.9% | 29 | 27.9% | 46 | 28.9% |
| 3 | 10 | 18.2% | 27 | 26% | 37 | 23.3% |
| 4 | 9 | 16.4% | 22 | 21.2% | 31 | 19.5% |
| 5 (Very Accessible) | 9 | 16.4% | 13 | 12.5% | 22 | 13.8% |
| *Total* | 55 | 100% | 104 | 100% | 159 | 100% |

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Intensive Home-Based Services:** In-home family therapy, behavioral interventions, and relationship building to maintain children at home. | | | | | | |
| 1 (Not at All Accessible) | 15 | 30.6% | 19 | 20% | 34 | 23.6% |
| 2 | 16 | 32.7% | 47 | 49.5% | 63 | 43.8% |
| 3 | 6 | 12.2% | 18 | 18.9% | 24 | 16.7% |
| 4 | 5 | 10.2% | 8 | 8.4% | 13 | 9% |
| 5 (Very Accessible) | 7 | 14.3% | 3 | 3.2% | 10 | 6.9% |
| *Total* | 49 | 100% | 95 | 100% | 144 | 100% |
| **Psychiatric Care:** Prescription and follow-up for medications. | | | | | | |
| 1 (Not at All Accessible) | 6 | 13.3% | 15 | 15.6% | 21 | 14.9% |
| 2 | 18 | 40% | 43 | 44.8% | 61 | 43.3% |
| 3 | 8 | 17.8% | 25 | 26% | 33 | 23.4% |
| 4 | 6 | 13.3% | 10 | 10.4% | 16 | 11.3% |
| 5 (Very Accessible) | 7 | 15.6% | 3 | 3.1% | 10 | 7.1% |
| *Total* | 45 | 100% | 96 | 100% | 141 | 100% |
| **Alternative Education Programs:** Assistance to help youth complete school goals (special school, home school, vocational school, virtual school). | | | | | | |
| 1 (Not at All Accessible) | 12 | 25% | 15 | 14.9% | 27 | 18.1% |
| 2 | 19 | 39.6% | 31 | 30.7% | 50 | 33.6% |
| 3 | 6 | 12.5% | 38 | 37.6% | 44 | 29.5% |
| 4 | 3 | 6.3% | 11 | 10.9% | 14 | 9.4% |
| 5 (Very Accessible) | 8 | 16.7% | 6 | 5.9% | 14 | 9.4% |
| *Total* | 48 | 100% | 101 | 100% | 149 | 100% |
| **Job Services:** Services to provide skills training that will help youth find and keep a job. | | | | | | |
| 1 (Not at All Accessible) | 11 | 31.4% | 16 | 16.5% | 27 | 20.5% |
| 2 | 14 | 40% | 39 | 40.2% | 53 | 40.2% |
| 3 | 5 | 14.3% | 32 | 33% | 37 | 28% |
| 4 | 3 | 8.6% | 5 | 5.2% | 8 | 6.1% |
| 5 (Very Accessible) | 2 | 5.7% | 5 | 5.2% | 7 | 5.3% |
| *Total* | 35 | 100% | 97 | 100% | 132 | 100% |
| **Crisis intervention:** Immediate, individualized support through a crisis, including mobile crisis to the home or school, with the youth and family. | | | | | | |
| 1 (Not at All Accessible) | 11 | 23.4% | 9 | 8.7% | 20 | 13.2% |
| 2 | 10 | 21.3% | 23 | 22.1% | 33 | 21.9% |
| 3 | 5 | 10.6% | 34 | 32.7% | 39 | 25.8% |
| 4 | 6 | 12.8% | 23 | 22.1% | 29 | 19.2% |
| 5 (Very Accessible) | 15 | 31.9% | 15 | 14.4% | 30 | 19.9% |
| *Total* | 47 | 100% | 104 | 100% | 151 | 100% |
| **Treatment home:** Specialized therapeutic home for children with emotional/behavioral challenges that provides supervision and support. | | | | | | |
| 1 (Not at All Accessible) | 9 | 24.3% | 21 | 21.4% | 30 | 22.2% |
| 2 | 14 | 37.8% | 37 | 37.8% | 51 | 37.8% |
| 3 | 6 | 16.2% | 29 | 29.6% | 35 | 25.9% |
| 4 | 4 | 10.8% | 7 | 7.1% | 11 | 8.1% |
| 5 (Very Accessible) | 4 | 10.8% | 4 | 4.1% | 8 | 5.9% |
| *Total* | 37 | 100% | 98 | 100% | 135 | 100% |
| **Services for Victims of Abuse:** Services for youth who are physically, sexually, or emotionally abused. | | | | | | |
| 1 (Not at All Accessible) | 10 | 29.4% | 7 | 7.3% | 17 | 13.1% |
| 2 | 11 | 32.4% | 35 | 36.5% | 46 | 35.4% |
| 3 | 5 | 14.7% | 37 | 38.5% | 42 | 32.3% |
| 4 | 2 | 5.9% | 10 | 10.4% | 12 | 9.2% |
| 5 (Very Accessible) | 6 | 17.6% | 7 | 7.3% | 43 | 10% |
| *Total* | 34 | 100% | 96 | 100% | 130 | 100% |
| | | | | | | |

| | Parents | | Providers | | Total | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Outpatient Substance Use Services:** Services for youth who use drugs or alcohol. | | | | | | |
| 1 (Not at All Accessible) | 9 | 30% | 12 | 12.2% | 21 | 16.4% |
| 2 | 11 | 36.7% | 36 | 36.7% | 47 | 36.7% |
| 3 | 3 | 10% | 29 | 29.6% | 32 | 25% |
| 4 | 4 | 13.3% | 15 | 15.3% | 19 | 14.8% |
| 5 (Very Accessible) | 3 | 10% | 6 | 6.1% | 9 | 7% |
| *Total* | 30 | 100% | 98 | 100% | 128 | 100% |
| **Day Treatment Mental Health:** Specialized programs to provide therapeutic experiences and socialization. | | | | | | |
| 1 (Not at All Accessible) | 16 | 38.1% | 18 | 18.2% | 34 | 24.1% |
| 2 | 14 | 33.3% | 36 | 36.4% | 50 | 35.5% |
| 3 | 3 | 7.1% | 33 | 33.3% | 36 | 25.5% |
| 4 | 2 | 4.8% | 9 | 9.1% | 11 | 7.8% |
| 5 (Very Accessible) | 7 | 16.7% | 3 | 3% | 10 | 7.1% |
| *Total* | 42 | 100% | 99 | 100% | 141 | 100% |
| **Intensive Outpatient Treatment Substance Use:** Daily 3-5 hour programs which can include basic information about alcohol and drugs, support groups, and a relapse prevention training. | | | | | | |
| 1 (Not at All Accessible) | 7 | 25% | 14 | 14.9% | 21 | 17.2% |
| 2 | 12 | 42.9% | 44 | 46.8% | 56 | 45.9% |
| 3 | 3 | 10.7% | 26 | 27.7% | 29 | 23.8% |
| 4 | 2 | 7.1% | 7 | 7.4% | 9 | 7.4% |
| 5 (Very Accessible) | 4 | 14.3% | 3 | 3.2% | 7 | 5.7% |
| *Total* | 28 | 100% | 94 | 100% | 122 | 100% |
| **Residential Services for Mental Health: Short (2 weeks or less) or long term residential treatment hospitalization for youth with mental health needs.** | | | | | | |
| 1 (Not at All Accessible) | 9 | 24.3% | 15 | 15.3% | 24 | 17.8% |
| 2 | 16 | 43.2% | 38 | 38.8% | 54 | 40% |
| 3 | 4 | 10.8% | 28 | 28.6% | 32 | 23.7% |
| 4 | 3 | 8.1% | 13 | 13.3% | 16 | 11.9% |
| 5 (Very Accessible) | 5 | 13.5% | 4 | 4.1% | 9 | 6.7% |
| *Total* | 37 | 100% | 98 | 100% | 135 | 100% |
| **Aftercare:** Support to move back into the community from a hospital or residential setting. | | | | | | |
| 1 (Not at All Accessible) | 14 | 41.2% | 28 | 29.2% | 42 | 32.3% |
| 2 | 11 | 32.4% | 38 | 39.6% | 49 | 37.7% |
| 3 | 3 | 8.8% | 23 | 24% | 26 | 20% |
| 4 | 2 | 5.9% | 4 | 4.2% | 6 | 4.6% |
| 5 (Very Accessible) | 4 | 11.8% | 3 | 3.1% | 7 | 5.4% |
| *Total* | 34 | 100% | 96 | 100% | 130 | 100% |
| **Transitional Living and Housing Support:** Programs to help youth move from programs to adulthood. | | | | | | |
| 1 (Not at All Accessible) | 14 | 40% | 24 | 24.7% | 38 | 28.8% |
| 2 | 14 | 40% | 44 | 45.4% | 58 | 43.9% |
| 3 | 1 | 2.9% | 22 | 22.7% | 23 | 17.4% |
| 4 | 2 | 5.7% | 4 | 4.1% | 6 | 4.5% |
| 5 (Very Accessible) | 4 | 11.4% | 3 | 3.1% | 7 | 5.3% |
| *Total* | 35 | 100% | 97 | 100% | 132 | 100% |
| **Financial support:** Emergency funds to access needed services or medicine. | | | | | | |
| 1 (Not at All Accessible) | 24 | 58.5% | 43 | 43.4% | 67 | 47.9% |
| 2 | 12 | 29.3% | 36 | 36.4% | 48 | 34.3% |
| 3 | 0 | 0% | 15 | 15.2% | 15 | 10.7% |
| 4 | 1 | 2.4% | 3 | 3% | 4 | 2.9% |
| 5 (Very Accessible) | 4 | 9.8% | 2 | 2% | 6 | 4.3% |
| *Total* | 41 | 100% | 99 | 100% | 140 | 100% |

Both parents and providers were asked if there were any additional services that they would like to see developed or expanded. Parents and providers had similar thoughts about what services they would like to see developed or

expanded in Southern Nevada and would like mental health services to be expanded across the board, including providers who accept insurance. Other areas where providers and parents felt services could be expanded included:

- respite services,
- bilingual providers (especially Spanish), and
- long-term and transitional care services.

Providers and parents also felt that access to mental health services and supports in schools are greatly needed in southern Nevada, including adding more:

- safe schools professionals,
- school social workers, and
- school-based providers.

Parents expressed several additional services that would help them get needed care for their children, including:

- case management services at public schools to assist with IEPs,
- support learning how to advocate for their child, and
- resources that would help direct them to the correct places to get the support they need.

One parent said they would like to have bridge services to support higher functioning kids between medical providers, their home, and their child's school.

Providers indicated that mental health crisis services and mental health aftercare services need to be expanded. Providers wanted:

- long-term mental health treatment services
- expanded care coordination services
- comprehensive community mental health system
- substance abuse prevention and treatment services initiated at an earlier age (to prevent use and treat youth who are initiating substance use at earlier ages)

Finally, participants were asked if they had any additional comments to provide. Many parents indicated that while they could access services for their children, they had difficulties for their children with mental and behavioral health care needs at school. Parents also commented that they felt medication was used too quickly.

Several providers expressed that more services were needed for youth in crisis, saying:

- the hospital is too overwhelming for children with thoughts of suicide
- mobile crisis services had received very poor feedback from parents
- that they had difficulty when trying to complete the "Legal 2000" process, and
- "NV Medicaid requests proof of multiple failed attempts at a lower service level for kids who we know need immediate residential treatment … unfortunately the message this sends to families is that we need them to go into further crisis before they can access the level of care they truly need."

Finally, one provider said that they felt the "most effective way to reach children with mental health needs is at school," suggesting that mental health services should be provided to children at school, and aligning with parents' needs for mental and behavioral health care services in school.

# APPENDIX C: CCCMHC MEDICAID RFP RECOMMENDATIONS

Nevada has continuously ranked in the bottom 10 with regards to many children's issues including education, health, family and community, and economic well-being (2018 Kids Count Data Book). A recent report from Mental Health American ranks Nevada 51st in the nation in regards to children's overall mental health.

Policy makers and leaders in the state need to prioritize the well-being of our children. With Medicaid revising the managed care Request for Proposals (RFP), Nevada has an opportunity to increase access specifically to quality mental and behavioral health care options.

The Clark County Children's Mental Health Consortium (CCCMHC), which includes professionals and parents from a variety of disciplines and organizations, has a focus on bettering the services and resources for children's mental health in Clark County, NV. 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.

To best serve children and families, it is imperative that the RFP aligns with current guiding principles of the state's system of care and should reflect the National Standards for culturally and Linguistically Appropriate Services in Health and Health Care (the CLAS Standards). The CCCMHC has compiled a list of suggestions for consideration in the RFP for contracts with managed care organizations (MCOs) operating within the state of Nevada. Below are highlighted recommendations which fall into 6 key areas followed by a more comprehensive list of recommendations for each area.

1) **MANAGED CARE ORGANIZATIONS NEED TO OFFER AN ARRAY OF SERVICES TO MEET THE CURRENT NEEDS OF YOUTH AND FAMILY**

2) **DCFS MOBILE CRISIS RESPONSE TEAMS SHOULD BE CONTRACTED WITH ALL MEDICAID MCOS**

3) **NETWORK ADEQUACY – PROVIDING FAMILIES CHOICES OF ACCESSIBLE CARE OPTIONS**

4) **MANAGED CARE ORGANIZATIONS NEED TO COMMUNICATE SERVICES TO YOUTH AND FAMILIES**

5) **DATA TRANSPARANCY AND COLLECTION OF QUALITY ASSURANCE MEASURES**

6) **ENSURE YOUTH ARE BEING SCREENED AND ASSESSED – SPECIFICALLY AS RELATED TO EPSDT**

The RFP is a critical component to ensure that MCOs are best serving children and families. Please review each of these in detail as inclusion of these recommendations will benefit the most vulnerable children and families in our state

## 1) MANAGED CARE ORGANIZATIONS NEED TO OFFER AN ARRAY OF SERVICES TO MEET THE CURRENT NEEDS OF YOUTH AND FAMILY

Depending on the mental and/or behavioral health condition of the child, different services and different levels of service may be needed at different times. Therefore, a variety of services need to be available to support the youth and their family to obtain positive outcomes.

Studies have been conducted on two major federal programs which serve children with significant mental health conditions, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative (CMHI) which promoted coordinated, community based services, and the Centers for Medicare and Medicaid Services (CMS) Psychiatric Residential Treatment Facility (PRTF) Demonstration Program, which promotes the use of community based services to prevent or reduce time spent in the most restrictive environments, residential treatment facilities.

These programs have obtained very positive results including reduced costs of care, increase in behavioral and emotional strengths, improved clinical and functional outcomes, reduced suicide attempts, improved school attendance and

performance, decreased contacts with law enforcement, more stable living situations, and improved attendance at work for Caregivers.

**Highlighted Recommendations:**

1) The MCO core benefit package for youth with significant mental health conditions needs to include:
    - individual therapy,
    - family therapy,
    - medication management,
    - intensive care coordination (often called wraparound service planning/facilitation),
        - For children with significant behavioral health needs (as determined by state criteria), the MCO shall ensure access to intensive care coordination using a fidelity Wraparound model either through Care Management Entities or through designated fidelity Wraparound health teams that have been trained and certified in a fidelity Wraparound approach.
    - family and youth peer support services from families and youth with lived experience ,
    - intensive in-home and community based services,
    - respite care,
    - mobile crisis response and stabilization, and
    - flex funds.

2) MCOs should provide the full range of behavioral health services, including residential treatment services and day treatment programs, or carve out all of behavioral health care services in order to increase continuity of care.
    - If the carve out specifically for residential treatment services remains allowable in the contract, it is recommended that:
        - Families should have a choice to remain in Fee For Service as they exit residential treatment in order to maintain continuity of care.
        - A determination of Serious Emotional Disturbance (SED) should be made by the provider of the parent's choice to ensure the determination is made without bias.

**2) DCFS MOBILE CRISIS RESPONSE TEAMS SHOULD BE CONTRACTED WITH ALL MEDICAID MCOS**

As mentioned in the first recommendation, mobile crisis is an essential service which must be available for youth with significant mental health conditions. These services are intended to de-escalate difficult mental health situations to prevent hospitalization or other restricted environments, as well as identify community based resources to mitigate future crises. The Mobile Crisis Response Team (MCRT) run by the Division of Children and Family Service (DCFS) has been making great strides in diverting youth in crisis from hospitalization. Mobile crisis services provided by DCFS are available 24/7 in Clark County and are provided in any setting where a crisis may be occurring. However, in the few instances where hospitalization cannot be avoided, certain MCOs currently do not accept the MCRT assessments recommending clinical services and hospitalization – insisting the family endure duplicative tests from their contracted providers which delays youth from receiving timely care.

**Highlighted Recommendations:**

1. Managed care providers should be required to contract with the Division of Children and Family Service (DCFS) MCRT to reduce barriers to services and to avoid unnecessary duplicative assessments in the cases were hospitalization cannot be avoided.

**3) NETWORK ADEQUACY – PROVIDING FAMILIES CHOICES OF ACCESSIBLE CARE OPTIONS**

The shortage of youth mental health providers in Southern Nevada is well documented. According to the 2016 – 2017 National Survey of Children's Health, more than half (52.3%) of Nevada's children aged 3 – 17 who received needed mental health care, had difficulties accessing these services (HRSA MCHB, 2018). Accessing care through primary or mental health

care providers is challenging due to shortages of providers in all of Nevada's counties. It is imperative that MCOs ensure which there is an adequate supply of providers to give the family a choice of providers, that are available to serve youth of all ages especially young children, provide services in the preferred language of the family, and are available throughout the county to reduce access barriers.

**Highlighted Recommendations:**

1. The MCO evaluates the sufficiency of the provider network on an ongoing basis and fills the gaps as appropriate. Network sufficiency includes:
    - more than one behavioral health provider network contracted in order to provide choice of providers to parents,
        - *In the same way our state offers multiple MCOs to allow Medicaid enrollees to have a choice of health plans, MCOs that choose to subcontract behavioral health services should do so with more than one organization that manages behavioral health care*
    - geographic sufficiency,
    - an adequate array of home and community-based service providers ***who are experienced in serving children with significant behavioral health needs***,
    - culturally and linguistically diverse providers,
    - substance use disorder treatment providers,
    - providers capable of offering evidence-based practices, such as trauma informed care, and cognitive-behavioral therapy,
    - providers that are available on weekends and after-hours.

2. The MCO develops and submits action plans to address network sufficiency issues, whether geographic or specialty driven, which includes a description of collaborative efforts with local behavioral health and social services authorities.

**4) MANAGED CARE ORGANIZATIONS NEED TO COMMUNICATE SERVICES TO YOUTH AND FAMILIES**

Even when the appropriate services are available to youth and families, without proper communication about benefits and the services available, youth and families still may not access the services they need. Therefore it should be the responsibility of the MCOs to make reasonable efforts to provide information to youth and families as a method to increase access to services.

**Highlighted Recommendations:**

1. The MCO ensures provision of web-based resources for members and their families and providers that include but are not limited to a roster of formal and informal community supports and culturally and ethnically diverse providers by locality.
2. The MCO creates and maintains an up-to-date, user-friendly, online, searchable provider directory that includes but is not limited to:
    a. Provider name, address, telephone and fax numbers, website address, office hours, foreign languages spoken, provider type, area(s) of expertise, practice limitations or age restrictions, geographic area served, disability accessibility, and if accepting new members.
3. The MCO proposes a method to establish and update provider information and expertise including cultural and linguistic competencies and certification in treating co-occurring disorders; reviews the listing monthly and updates it to keep the information current.
4. The MCO develops written member outreach and education materials, which are publicly available for no charge.

**5) DATA TRANSPARANCY AND COLLECTION OF QUALITY ASSURANCE MEASURES**

Data collection is essential for quality monitoring and improvement. To better understand the current state of service delivery among MCOs, more quality-related questions are needed to assess children's mental health services; specifically,

questions regarding access to and satisfaction with service.

**Highlighted Recommendations:**

1. The MCO provides annual reports on the utilization of child behavioral health services and expenditures, broken down by service type, demographics and aid category. All data collected regarding services (number of providers, access to services, quality of services, etc.) should be transparent and available to the public (e.g. data dashboard). Measures to be tracked by the MCO include but are not limited to:
    - o Population served with additional attention to age, race/ethnicity, gender, locality, and involvement in public child-serving systems
    - o Behavioral health service utilization (patterns and cost, attention to outliers, use of home and community versus restrictive services, wait times from date the child called for service and may have been scheduled versus when care was actually received, and treatment satisfaction),
    - o Service quality (use of evidence-based practices, adherence to a family-centered and systems of care approach, inclusion of natural supports in care plans)
    - o Outcomes at the child, program, and system level, to be determined in conjunction with the State, to be reported by the second year of the contract
2. The MCO implements an annual Program Improvement Plan, beginning in the second year of the contract (due by the end of the second year of the contract), focused on an issue related to behavioral health care for youth.
3. The MCO convenes quality improvement teams on a quarterly and as-needed basis that are comprised of MCO staff, youth, family members, representatives from the child welfare system, and other stakeholders, such as the children's mental health consortiums in the state, to focus on network sufficiency and clinical quality, including the use of evidence-based practices; culturally and linguistically competent practices and disparities/disproportionality in access; and access to and appropriateness of care with respect to particular populations of children and youth.

**6) Ensure Youth are being Screened and Assessed – Specifically as related to EPSDT**

Increasing access to mental and behavioral health screening for youth is critical for early identification of conditions which require treatment. Approximately 50% of lifetime mental health conditions begin by age 14 and 75% begin by age 24. Unfortunately, there is often a large delay between the start of the condition and access to an intervention, approximately 11 years. Mental health screenings provide an opportunity for early identification of potential concerns in order to connect youth and families with support services and interventions. These screenings are supposed to be a standard part of the EPSDT visit which is required under Medicaid. It is vital to ensure that these screenings are occurring in order to increase access to services.

**Highlight Recommendation:**

1) The MCO ensures provision and tracking of all EPSDT services including behavioral health screening and that screenings occur according to the state's periodicity schedule.

These recommendations were developed through discussions at open meetings of the consortium. The majority of the language for the recommendations is adapted or taken directly from the Recommended Contract Specifications for System of Care Integration in Managed Care Organizations (MCOs).

Through this revised RFP process, Nevada has a chance to provide better mental and behavioral healthcare services to our most vulnerable youth and families. Our state's future is dependent upon children reaching their full potential in adulthood which means that they should have access to quality mental, behavioral, and physical healthcare, receive a quality education, and have opportunities to make a livable wage. Ultimately, caring for the health of children in Nevada will ensure a successful Nevada in the future.

## COMPREHENSIVE LIST OF CHILDREN'S BEHAVIORAL HEALTH RECOMMENDATIONS FOR MEDICAID MCOS[1]

**Offer an Array of Services to Meet the Current Needs of Youth and Family**

1) The MCO core benefit package for youth with significant mental health conditions needs to include:
    a. individual therapy,
    b. family therapy,
    c. medication management,
    d. intensive care coordination (often called wraparound service planning/facilitation),
        i. For children with significant behavioral health needs (as determined by state criteria), the MCO shall ensure access to intensive care coordination using a fidelity Wraparound model either through Care Management Entities or through designated fidelity Wraparound health teams that have been trained and certified in a fidelity Wraparound approach
        ii. The MCO demonstrates ability to support Care Management Entities (CMEs) or fidelity Wraparound health teams to ensure effective intensive care coordination for particular populations of youth with serious emotional disorders as identified by the state.
        iii. The MCO demonstrates ability to support risk-based case rates for high-utilizing (i.e., outlier) populations of children and youth to include the use of particular evidence-based practices, emerging best practices, and intensive care coordination using fidelity Wraparound
    e. family and youth peer support services from families and youth with lived experience
    f. intensive in-home and community based services,
        i. To encourage providers to offer these services with youth and their family should be billed at enhanced rates.
    g. respite care,
    h. mobile crisis response and stabilization, and
        i. The MCO establishes crisis and stabilization response protocols to facilitate and track timely linkage of youth to available community crisis and stabilization services to reduce/minimize emergency department utilization, reduce placement disruptions, and reduce inpatient psychiatric hospital and residential and group care admissions.
        ii. MCO establishes specialized response for urgent care and out-of-home placement authorizations to ensure rapid assessment and approvals (ideally within 24 hours), in partnership with ER diversion and crisis and stabilization program providers serving as the access point for behavioral health admissions to hospitals.
    i. flex funds.

A standard definition should be required across all MCOs, and specific codes should be established to track these service categories.

A description of each of these services can be found in the Joint CMCS and SAMHSA Informational Bulletin "Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions" which also provides additional details on programmatic outcomes related to these services. This informational bulletin was created specifically to design benefits that would meet the needs of youth with significant mental health conditions.

2) The MCO should include coverage of telebehavioral health capacity for all network providers with clearly defined terms of use
3) At the direction and identification of the state, the MCO partners with local health or child-serving departments and providers to pay for specific evidence-based or promising practices.
4) The MCO assists in identifying instances where private insurance is not covering necessary benefits, such as crisis response and stabilization or intensive in-home services. (If non-Medicaid dollars are included in the MCO payment structure, then the MCO is responsible for serving commercially insured children who need access to a

[1] Information adapted from: Advancing innovations in health care delivery for low-income Americans https://www.chcs.org/media/BH-Integration-Brief_041316.pdf

particular type of service or who exhaust their commercial benefit, with the MCO pursuing third party payment from the commercial insurer.)

5) If the carve out specifically for residential treatment services remains allowable in the contract, it is recommended that:
    a. Families should have a choice to remain in Fee For Service as they exit residential treatment in order to maintain continuity of care.
    b. A determination of Serious Emotional Disturbance (SED) should be made by the provider of the parent's choice to ensure the determination is made without bias.
6) MCO should provide Coordination and Continuity of Care
    a. The MCO develops and maintains a care coordination function that ensures covered behavioral health services are available when and where individuals need them. The MCO ensures the provision of services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care coordination system must have sufficient child trained, licensed mental health professional care managers to respond 24 hours per day, 7 days per week, and 365 days per year to members, their families/caregivers, or other authorized parties calling on behalf of the member.
    b. The MCO makes timely referrals to qualified providers or to care management entities or designated Wraparound health teams as appropriate and as designated by state criteria.
    c. The MCO provides behavioral health consultation to primary care practitioners and early childhood providers (such as Head Start programs) either through its own licensed clinical staff or through designated behavioral health specialty providers.
    d. The MCO provides consultation to primary care physicians and other prescribers on the prescribing of psychotropic medications by a board certified child psychiatrist or advanced practice nurse.
    e. The MCO ensures ongoing availability of behavioral health consultation to child welfare, education/special education, and juvenile justice to support shared responsibility for coordinating health care services for these populations.  The MCO ensures that youth and families continue to receive Medicaid services while transitioning to other insurance coverage for up to 60 days from the date of notification that they are no longer Medicaid-eligible.  The MCO ensures that psychiatric residential treatment facilities and other residential/group care providers are able to provide services in the home and community for youth in their care beginning 90 days prior to discharge and for an additional 90 days after the youth returns to the community to facilitate successful transition.
    f. The MCO ensures the use of a state-determined pass-through case rate or bundled care coordination rate to care management entities or fidelity Wraparound health teams for youth with the most intensive needs, as documented through a clinical review process and criteria designated by the state.
    g. The MCO ensures that every child has an identified primary care physician and oral health care provider. The MCO maintains close collaboration with the state and local mental health and social services authorities, case management providers in local communities, community services organizations, peer support and recovery organizations, behavioral health providers and behavioral health provider associations, advocacy groups, schools, local child welfare agencies, family serving agencies, family members, youth and family peer mentors, and other interested parties, when such parties are working on behalf of member to secure medically necessary behavioral health care for the member.

    The MCO RFP should be written to allow for the flexibility to add and ability to serve all Medicaid-eligible and enrolled children (including SSI, TANF, foster care, and youth in the 1915(i) or 1915(c) as well as additional populations as contracted by the State, and could potentially include funds from the Substance Abuse and Mental Health Block Grants, State General Funds, and other prevention and early intervention funds. This would allow the State to more effectively and efficiently serve youth with complex multi-system needs and assist in avoid duplicative funding and service delivery.

**DCFS MOBILE CRISIS RESPONSE TEAMS SHOULD BE CONTRACTED WITH ALL MEDICAID MCOS.**

1. Managed care providers should be required to contract with the Division of Children and Family Service (DCFS) MCRT to reduce barriers to services and to avoid unnecessary duplicative assessments in the cases were hospitalization cannot be avoided.

**NETWORK ADEQUACY - Provider Management and Maintenance**

1. The MCO uses an efficient and streamlined credentialing process and maintains an up to date database (update requirements are clearly defined) of registered providers approved to deliver services in the public behavioral health system (PBHS).
2. Provider Recruitment:
    1) The MCO evaluates the sufficiency of the provider network on an ongoing basis and fills the gaps as appropriate. Network sufficiency includes:
        i. more than one behavioral health provider network contracted in order to provide choice of providers to parents,
            1. *In the same way our state offers multiple MCOs to allow Medicaid enrollees to have a choice of health plans, MCOs that choose to subcontract behavioral health services should do so with more than one organization that manages behavioral health care*
        ii. geographic sufficiency,
        iii. an adequate array of home and community-based service providers ***who are experienced in serving children with significant behavioral health needs***,
        iv. culturally and linguistically diverse providers,
        v. substance use disorder treatment providers,
        vi. providers capable of offering evidence-based practices, such as trauma informed care, and cognitive-behavioral therapy,
        vii. providers that are available on weekends and after-hours.
    2) Network sufficiency may be evaluated by (but not limited to):
        i. Analyzing MCO data based on density and demographics of membership geography and provider demographics and geography.
        ii. Analyzing MCO data based on complaints regarding access to care.
        iii. Analyzing wait times
        iv. Analyzing MCO data which compares services authorized to services delivered.
        v. Survey methods such as provider self-report or secret shopping surveys to gather information on appointment availability.
        vi. Trending of data to prepare for seasonal variation in utilization.
    3) The MCO reports monthly on provider recruitment activities. The report includes: the type of provider, location, date and type of recruitment activity
    4) The MCO reports quarterly on all providers whose participation status was terminated during the preceding quarter, including the provider's name, address, specialty, and reason for termination.
    5) The MCO develops and submits action plans to address network sufficiency issues, whether geographic or specialty driven, which includes a description of collaborative efforts with local behavioral health and social services authorities.

**Communicate Services to Youth and Families**

**Member and Provider Assistance and Communication**

1. MCO operates a toll-free call center that provides accurate and timely assistance to members and providers on securing appointments, filing grievances and appeals, and other information. Specifically, the MCO's call center:
    - Responds to questions regarding available behavioral health services, requirements to become a provider, procedures for filing a complaint or grievance, and billing information in an accurate and timely manner.
    - Responds to clinical calls, authorizes care, provides appointment assistance, and referrals to single points of access, navigators, family support organizations, and child-serving agencies.
    - Works with individuals and their families/caregivers to obtain eligibility for other necessary services
    - Immediately responds to crisis calls and connects with and transfers member seamlessly to identified crisis and stabilization response systems and hotlines.

- Makes certain that members encounter no barriers to accessing care due to language or other communication barriers; ensures access to TTY and staff who can communicate in the member's spoken language, and/or access to a phone-based translation service.
- Employs clinically competent child trained behavioral health professionals

2. The MCO processes and tracks all written and telephonic grievances and appeals within prescribed timeframes.
3. The MCO processes, investigates, resolves, and tracks all written and telephonic complaints.
4. The MCO conducts retrospective reviews bi-annually of data from grievances and complaints and develops a system level plan to anticipate and proactively prepare for potential system issues that could lead to complaints and/or grievances.
5. The MCO develops and implements an annual disparities plan with specific goals and measurable outcomes that address:
    - Differences in access to and utilization of assessment and treatment services based on ethnicity, race, gender, sexual orientation, social class, and location of its covered members; and the ability of members and families/caretakers to access and use services.
    - The competencies of service system to provide assessment and treatment services to persons from varying cultures, including the fit and relevance of services and service providers to the communities within each region, and strategies to optimally engage members and their family/caregivers in ways that reflect their culture and experiences.

**Provider and Member Relations and Communication:**

6) The MCO responds to provider inquiries within one business day and provides individual technical assistance as needed and as requested by providers within agreed upon time parameters.
7) The MCO maintains staffing capability to provide individualized in-person, telephonic, and web-based training formats as needed and as requested by providers with identified training and technical assistance needs.
8) The MCO develops and maintains a user-friendly website that contains separate sections for providers and members and pages of information which are updated monthly.
9) The MCO develops and maintains a state of the art communication/alert system for providers and members to include:
    i. Telephone, email, mail, internet, and all other forms of communication deemed necessary by the state for information exchange between the MCO, providers, members, local mental health and child welfare authorities, and the public.
    ii. Ability to target messages to specific provider types and specific members
    iii. Use of emerging technologies, including telemedicine, social media, smartphones, and internet, for prevention services, treatment service provision and reminders about services and treatment
    iv. Updates to the public behavioral health system provider directory
    v. Updates of relevant federal and state guidelines for current announcements and transmittals.
10) Through the provider communication system, the website, and written materials, the MCO ensures that providers access a call center if they need immediate assistance and are unable to reach their provider relations representative.
11) The MCO ensures provision of web-based resources for members and their families and providers that include but are not limited to a roster of formal and informal community supports and culturally and ethnically diverse providers by locality.
12) The MCO creates and maintains electronic provider manuals which include information about provider application and credentialing, member referral and authorization process, service delivery requirements, service documentation, and claims/billings requirement

**Member Education**

1) The MCO creates a member handbook that facilitates access to covered services
2) The MCO creates and maintains an up-to-date, user-friendly, online, searchable provider directory that includes but is not limited to:

a. Provider name, address, telephone and fax numbers, website address, office hours, foreign languages spoken, provider type, area(s) of expertise, practice limitations or age restrictions, geographic area served, disability accessibility, and if accepting new members
b. Evidence based and promising programs offered by the provider that are covered by the MCO

3) The MCO proposes a method to establish and update provider information and expertise including cultural and linguistic competencies and certification in treating co-occurring disorders; reviews the listing monthly and updates it to keep the information current.
4) The MCO develops written member outreach and education materials, which are publicly available for no charge.

**DATA TRANSPARANCY AND COLLECTION OF QUALITY ASSURANCE MEASURES**

1. The MCO incentivizes all network providers to demonstrate improved quality and effectiveness of care, including through performance-based contracts.
2. The MCO identifies, tracks and collaborates with mental health, physical health and social services authorities to decrease rates of emergency department, psychiatric inpatient and residential treatment utilization for youth with significant behavioral health needs, including those with a history of high utilization.
3. The MCO convenes quality improvement teams on a quarterly and as-needed basis that are comprised of MCO staff, youth, family members, representatives from the child welfare system, and other stakeholders to focus on network sufficiency and clinical quality, including the use of evidence-based practices; culturally and linguistically competent practices and disparities/disproportionality in access; and access to and appropriateness of care with respect to particular populations of children and youth.
4. The MCO provides annual reports on the utilization of child behavioral health services and expenditures, broken down by service type, demographics and aid category. All data collected regarding services (number of providers, access to services, quality of services, etc.) should be transparent and available to the public (e.g. data dashboard).
    a. Measures to be tracked by the MCO include but are not limited to:
    o Population served (with additional attention to age, race/ethnicity, gender, locality, and involvement in public child-serving systems—child welfare, juvenile justice, etc.)
    o Behavioral health service utilization (patterns and cost, attention to outliers, use of home and community versus restrictive services, patterns by aid category (TANF, SSI, foster care, etc.) and locality; encounter and claims data, wait times from date scheduled versus received care, and treatment satisfaction)
    o Service quality (use of evidence-based practices, adherence to a family-centered and systems of care approach, inclusion of natural supports in care plans)
    o Cost (total, per child served, and for each aid category)
    o Outcomes at the child, program, and system level, to be determined in conjunction with the State, to be reported by the second year of the contract
    o Family, youth and other child serving system (e.g. child welfare) experience of the system

**Management Information System (MIS) requirements to report data include:**

5. The MIS must have interoperability with Health Homes and Care Management Entities to allow care coordinators and case managers in these settings to view all authorizations for enrolled children and youth.
6. Capacity to fully interface the MIS with other child-serving systems (e.g., SACWIS) to allow for open flow and sharing of current information on a regular basis and to ensure multi-system involved youth are receiving appropriate care coordination, services, and supports.
7. The MIS must also be able to produce dashboard reports on child behavioral health service utilization, authorizations, diagnoses, and other child-specific features at the state, regional, and county levels. (Can also require dashboard reports on specific populations such as those in foster care)
8. The MIS should be web-based.
9. MOUs and data sharing agreements, as required, should be fully executed and operational within 6 months of the contract effective date.
10. The software and systems developed and used by the MCO for this contract will remain in and with the State if and when the contract ends and the MCO will provide the state with all necessary data dictionaries, training, etc.

a. For additional examples of MIS system requirements, please refer to p. 48 – 58 of Maryland's RFP http://www.dhmh.state.md.us/procumnt/Documents/OPASS-14-13835-Final.pdf or p. 151 – 156 of Louisiana's RFP http://www.dhh.state.la.us/assets/docs/contracts/BayouHealthPrepaidFINAL72814.pdf).

11. The MCO requires providers in the network to secure and maintain necessary credentials and accreditation status, as applicable, by the appropriate entity.
12. The quality review process and corresponding performance measures should include families and youth and local child-serving authorities such as DCFS and the regional and state children's mental health consortia.
13. The MCO implements an annual Program Improvement Plan, beginning in the second year of the contract (due by the end of the second year of the contract), focused on an issue related to behavioral health care for children/youth. See Wraparound Milwaukee's Program Improvement Plan for 2012 as an example: http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/Wraparound/2012QA-PIP.pdf
14. The MCO has the following staffing Requirements and Expertise to ensure quality of services and collection of applicable data:
    a. Director of Quality Assurance
    b. Psychiatrist who is licensed and certified by the American Board of Psychiatry and Neurology in Child and Adolescent Psychiatry
    c. Compliance staff
    d. Public behavioral health data system development and data analysis staff
    e. Licensed mental health professional with child and adolescent experience to be the designated staff
    f. Member, family, and advocacy organization liaison
    g. Licensed clinical staff to serve as care managers with experience and training in treatment planning for children and adolescents
    h. Dedicated clinical staff to work with local mental health and social services authorities and hospitals to monitor high utilization and at-risk users, including a dedicated team of child- and adolescent-trained clinicians and professionals at all levels of the MCO to focus on child welfare, juvenile justice, Health Home, and other clinically intensive populations
    i. Staff to perform evaluation activities, including those related to members and provider surveys and other proposed evaluation activities
    j. If applicable, special needs coordinators focusing on the following populations:
        i. Youth (16-24) who are transitioning into the adult system to facilitate linkage between child and adult systems and providers,
        ii. Children and youth involved in the child-welfare system,
        iii. Children and youth enrolled in care management entities, health homes or designated fidelity Wraparound health teams.
15. MCO establishes and maintains an advisory board that includes families, youth and young adults, including those with lived experience of public child-serving systems (behavioral health, child welfare, juvenile justice, etc.) and involves families, youth and agency stakeholders at all levels of the organization including in policymaking and operations.

    For additional examples of MCO staffing requirements, please refer to p. 45 – 46 of Maryland's RFP (http://www.dhmh.state.md.us/procumnt/Documents/OPASS-14-13835-Final.pdf).

**Ensure Youth are being Screened and Assessed – Specifically as related to EPSDT**

1) The MCO ensures provision and tracking of all EPSDT services including behavioral health screening and that screenings occur according to the state's periodicity schedule.
2) The MCO uses a standardized tool, such as the Early Childhood Service Intensity Instrument (ECSII) and the Child and Adolescent Service Intensity Instrument (CASII) or state-designated tool, to assist in determining the member's required intensity of service needs and eligibility for services.
3) The MCO ensures a 48-hour response for physical and behavioral health screening for children entering child welfare (or, alternatively, within the timeframes specified in individual state child welfare codes).
4) To ensure strong communication with child welfare, juvenile justice, and other child serving agencies and providers, MCO staff are trained and certified in the use of the Child and Adolescent Needs and Strengths (CANS) tool or other state-designated tool used for utilization management and outcomes tracking.

**Authorizations and Utilization Management**

The MCO ensures authorization for services that are medically necessary, meet quality standards, and are provided in a cost-effective manner.

1) The MCO develops and implements all necessary processes and policies for authorization of services, and monitoring, assessing and promoting effective utilization (see p. 39 of Maryland's RFP for additional authorization details: http://www.dhmh.state.md.us/procumnt/Documents/OPASS-14-13835-Final.pdf).
2) The MCO performs concurrent reviews for member receiving psychiatric inpatient and residential treatment services, including:
    a. Reviewing all psychiatric admissions to acute care hospitals, medically monitored inpatient services, and residential treatment and group care.
    b. Determining continued medical necessity
    c. Reviewing all requests for continued services for medical necessity and effectiveness of the services provided
    d. Denying services that are not effective and offering more effective services
3) The MCO monitors the use of psychotropic medications using the state's guidelines. The MCO issues reports on a regular basis (frequency and specific measures to be determined by the state) and develops a strategy for addressing inappropriate practices with its network providers and implements corrective action plans as needed. Psychotropic medication data should be disaggregated by aid category (TANF, SSI, foster care, etc.).
4) MCO performs independent initial certifications of need and recertification of need for all members seeking admission or who have been admitted to a psychiatric inpatient facility or psychiatric residential treatment facility. The MCO ensures that:
    a. Less restrictive, ambulatory care resources available in the community do not meet the treatment needs of the member;
    b. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and,
    c. The services can reasonably be expected to improve the member's condition or prevent further regression, so that the services will no longer be needed.
5) The MCO conducts an annual utilization review of psychiatric residential treatment facility beds to identify the system and service supports necessary to reduce psychiatric residential treatment facility placements and lengths of stay, focusing on disproportionality issues due to race, ethnicity, gender and geographic limitations.
    a. The MCO partners with all psychiatric residential treatment facilities in the State to maintain a real-time tracking system of bed availability.
6) The MCO sets authorization parameters that promote access to medically necessary care including: no prior authorization for a certain number of initial outpatient visits for particular services (for example, the first 12 outpatient visits to ensure ready access); for youth with significant behavioral health needs served by care management entities or designated fidelity Wraparound teams, the Child and Family Team plan of care determines medical necessity and the MCO monitors outlier utilization. Other services (inpatient, other more intensive, restrictive, and/or expensive services) require prior authorizations with reviews conducted by child-trained clinicians.
7) The MCO provides clear and transparent written information to covered members and network providers on the medical necessity criteria it uses for all covered services, including authorization parameters, initial, concurrent and discharge criteria. The MCO provides training and technical assistance to network providers on the medical necessity criteria.

    Advancing innovations in health care delivery for low-income Americans https://www.chcs.org/media/BH-Integration-Brief_041316.pdf