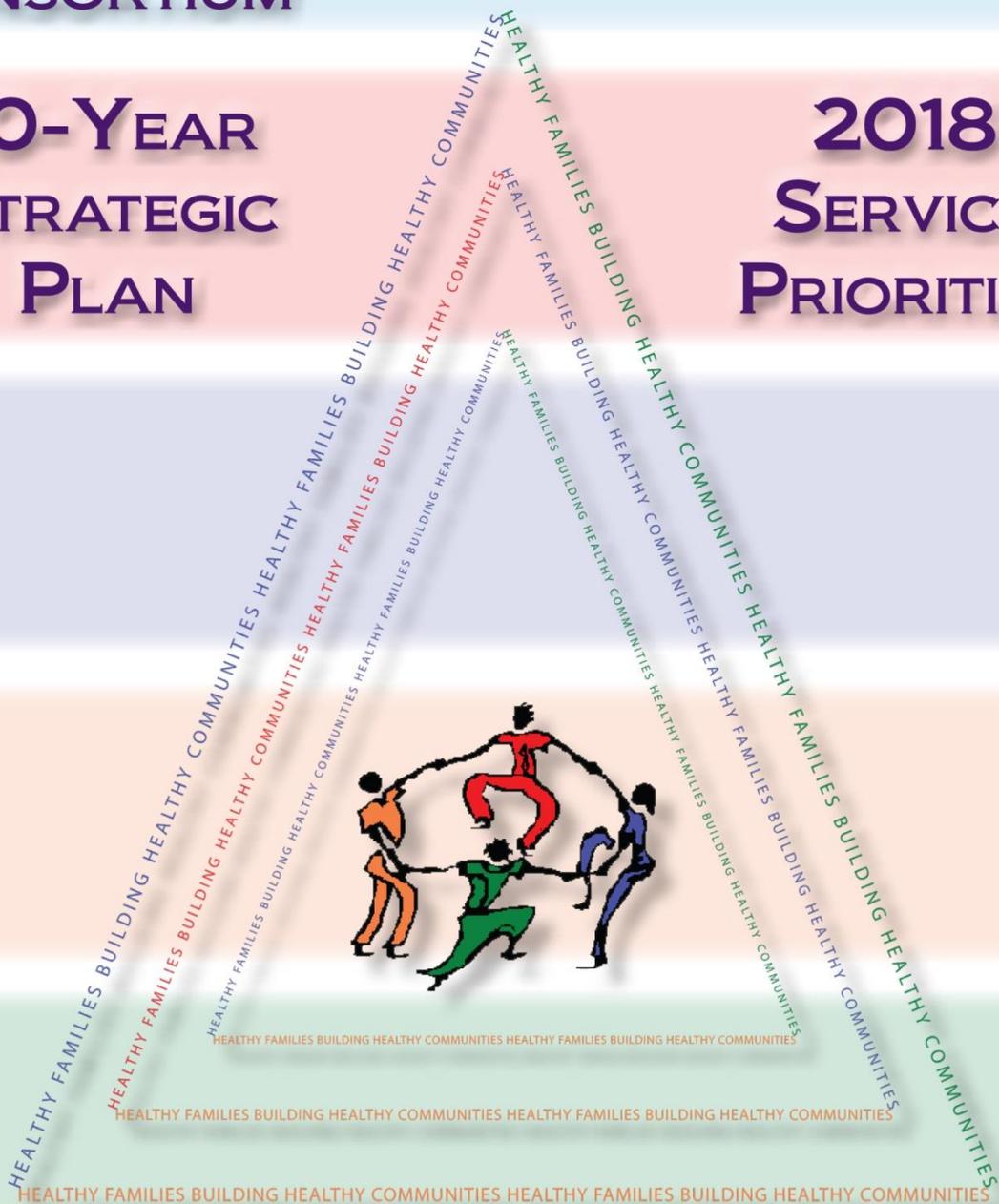


CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

2020 VISION FOR SUCCESS
Children and families in Clark County will have timely access to a comprehensive, coordinated system of behavioral health services and supports.

10-YEAR STRATEGIC PLAN

2018 SERVICE PRIORITIES



Clark County Children's Mental Health Consortium



2018 Service Priorities

Clark County Children's Mental Health Consortium

2018 Service Priorities

I. INTRODUCTION

In its 2018 report, Mental Health America ranked Nevada's behavioral health services for children as 51st in the nation due to the state's disproportionately high prevalence rates of youth mental illness coupled with below average access to health care coverage and needed treatment services (Nguyen et al., 2017). While a January 2017 study directed by the Nevada Legislative Commission pointed out that specific crises have driven some recent improvements to Nevada's behavioral health system, the report acknowledged that comprehensive service delivery reforms are ultimately required to protect and enhance the mental health of all Nevada's citizens, including its young people (Legislative Counsel Bureau Bulletin No.17-6). This most recent legislative study echoed the findings of an earlier state-commissioned report on the status of Nevada's public mental health services which concluded that "Nevada has missed a number of opportunities over the years to strengthen its behavioral health system" and needs "a proactive, strategic plan to implement an integrated system of care approach to behavioral health" (Watson et al, 2013.) This previous report similarly found that Nevada's behavioral health system has perpetually focused on responding to adults with mental health crises, rather than investing its resources in prevention and early intervention for children and youth.

The Clark County Children's Mental Health Consortium's **10-Year Strategic Plan** (2010) provides the vision, goals and strategies to implement a **system of care approach** that can overcome the identified challenges by producing cost-effective outcomes for children with behavioral health needs (Stroul, 2014). The CCCMHC **10-Year Strategic Plan** represents a commitment to all our community's children who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic. The Plan is based on a set of values and principles that promote a system of care that is community-based, family-driven and culturally competent. Using a public health approach and a neighborhood-based model of service delivery, the plan sets forth the following long-term goals for Clark County by the year 2020.

10-Year Plan Goals

- 1. Children with serious emotional disturbance and their families will thrive at home, at school and in the community with intensive supports and services.**
- 2. Children with behavioral health needs and their families will access a comprehensive array of effective services when and where needed.**
- 3. Families seeking assistance will find an organized pathway to information, referral, assessment and crisis intervention coordinated across agencies and providers.**
- 4. The system will be managed at the local level through a partnership of families, providers and stakeholders committed to community-based, family-driven, and culturally competent services.**
- 5. County-wide programs will be available to facilitate all children's healthy social and emotional development, identify behavioral health issues as early as possible, and assist all families in caring for their children.**
- 6. Heightened public awareness of children's behavioral health needs will reduce stigma, empower families to seek early assistance and mobilize community support for system enhancements.**

Working in partnership with the State Children's Behavioral Health Consortium and the two, other regional consortia, the Clark County Children' Mental Health Consortium calls for parents, policymakers and professionals to come together and take **immediate** action to support a change in approach to children's behavioral health service delivery. This report identifies **four priorities for Fiscal Years 2020-2021**, as well as specific services necessary to produce the most immediate, cost-effective system improvements. These priorities serve as building blocks for the CCCMHC's **10-Year Strategic Plan**, which has been submitted to the Director of the Department of Health and Human Services and the Commission on Behavioral Health.

Clark County Children with Behavioral Health Needs

Clark County's children with behavioral health needs share many of the same characteristics and challenges of children with behavioral health needs across the U.S. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) identifies those with behavioral health needs as having a mental and/or substance abuse disorder that may be recurrent and often serious but treatable (2013). The most recent national studies have confirmed that between 13-20 percent of American children aged 5-18 years have experienced a behavioral health disorder within the past year, and over 1 in 5 adolescents have suffered severe impairment as a result of these disorders (SAMHSA, 2013). By the time U.S. children reach adulthood, approximately one-half have experienced a behavioral health need at some point in their young lives (SAMHSA, 2013). Underscoring the notion that mental disorders begin early in life, these studies have found that symptoms of anxiety disorders began by age 6, behavior disorders (such as ADHD or conduct disorder) by age 11, mood disorders by age 13, and substance use disorders by age 15. The percentage of teenagers suffering from mental disorders is even higher than the most frequent major medical conditions of adolescence (Merikangas et al., 2010). Even children younger than five years of age may exhibit serious emotional and behavioral problems, with one national study estimating a prevalence rate of 10-14% in this population (Brauner, 2006). In Clark County, studies have suggested that 19.3% of elementary school children have behavioral health care needs and over 30% of adolescents self-reported significant levels of anxiety or depression (CCCMHC, 2010). In 2015, almost eighteen percent of Clark County's public middle school students seriously thought about killing themselves, almost 40% had used marijuana, and over 9% had attempted suicide (Lensch et al., 2016). Some children and youth have greater needs for behavioral health care than others. National studies have found that at least 50% of children and youth in child welfare and approximately 70% of youth in the juvenile justice system have significant mental health disorders (Stagman et al., 2010, SAMHSA, 2013). Local surveys conducted by the Consortium have confirmed that Clark County children in the child welfare and juvenile justice systems also experience a greater need for behavioral health care (CCCMHC, 2010).

Although federal and state definitions vary, children with serious emotional disturbance (SED) generally experience symptoms of a diagnosable mental, behavioral, or emotional disorder in the past year which significantly impairs their ability to function at home, in school, or in the community. Depending on the specific definition, regional and national studies suggest that between 6 and 10 percent of U.S. children exhibited signs of SED yearly (SAMHSA, 2013, Williams et al., 2017). With local studies showing at least 6 percent of early elementary school children exhibit signs of SED, it is reasonable to project prevalence rates for all Clark County children and youth with this condition will match the national data (CCCMHC, 2010).

Whereas children's behavioral health disorders are highly treatable and even sometimes preventable, studies have found long delays, even decades between onset of symptoms and identification and treatment of the disorder (SAMHSA, 2007; SAMHSA, 2013). Similar to national studies showing that 75% to 80% of children and youth in need do not receive mental health services (Stagman et al, 2010), a Clark County study showed that 70% of elementary school children identified with behavioral health disorders were not receiving any special services or treatment (CCCMHC, 2010). **Whether rich or poor, insured or uninsured, the families of children with serious behavioral health disorders struggle to find appropriate services, often turning to the public systems that provide children's mental health care.** Like others across the nation, many Clark County families have been forced to relinquish custody to child welfare or juvenile justice in order to access services and supports for their children (U.S. General Accounting Office, 2003). National studies have shown that privately-insured families with children in need of mental health care face significantly greater financial barriers than families with children without mental health needs (Stagman et al., 2010). Seventy-nine percent of children with private health insurance and 73 percent with public health insurance have unmet mental health needs (Stagman et al., 2010). Even when children with SED receive treatment, only a fraction can access the wraparound care coordination, family peer support and other innovative services proven effective in meeting their needs (Pires et al., 2013).



In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008).

II. PRIORITIES

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

Justification

In order to improve the condition of Nevada’s children with behavioral health needs, the CCCMHC’s first priority is **to re-structure the public children’s behavioral health financing and delivery system in order to ensure quality, accountability, and positive outcomes for Clark County’s children and families.** In addition to critical service gaps, federal and state studies have suggested that the system of behavioral health services in Clark County is complex and difficult to navigate (CCCMHC, 2010). Even though Nevada youth exhibit disproportionately higher levels of mental illness and substance abuse than other states, they struggle to find appropriate services and supports (Nyugen et al., 2017). For example, Nevada adolescents experiencing depression increased significantly between 2011 and 2015 to a level significantly higher than the national average, while only 29.5% of these youth received treatment for their illness (SAMHSA, 2017).

Nevada’s youth access state-supported community mental health programs at a rate four times lower than that of other states, while proportionately more of the state’s children with private insurance lack coverage for mental or emotional problems (Nguyen et al., 2017). Only 35.3% of state mental health expenditures are devoted to community-based care as compared to 75% of expenditures for other states across the U.S (SAMHSA, 2017 NOMS). In January 2017, community organizations convened a *Youth and Family Mental Health Summit* in Las Vegas designed to promote consumer engagement in improving mental health care. Nearly half of the seventy-five participants identified better access to affordable mental health services for children and families as a top priority for the Las Vegas community (Nevada Division of Child and Family Services, 2017).

A 2014 study commissioned by the Governor’s Council on Behavioral Health & Wellness concluded that the current governance structure of the state’s public mental health system has contributed to a lack or responsiveness to community needs (Brune et al., 2014). As a consequence of these systemic problems, Nevada youths with serious emotional disturbance or other disabilities continue to be unnecessarily placed in out-of-state institutions (Valley, 2015).

The CCCMHC has developed five specific recommendations to address this priority in large part because youth with serious emotional disturbance have a right to receive community-based services under the U.S. Supreme Court’s Olmstead Decision (CCCMHC, 2010). First, CCCMHC recommends that Nevada implement local system management of all publicly funded children’s behavioral health services in Clark County, including those administered by the Division of Child and Family Services and the Division of Health Care Financing and Policy. Nevada law already specifies that “the system of mental health services [for children] should be community-based and flexible, with accountability and focus of the services at the local level” (NRS 433B). In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local level to manage system of behavioral health care (Stroul et al., 2014). The 2017 Nevada Legislature recognized the importance of local input into the governance of mental health service systems by creating regional mental health boards across the state.

Fig 1. Out-of-State Residential Treatment Center Placements for Children

Month	Children Placed	Total Monthly Cost	Cost per month per child
Sept 2016	253	\$2,576,307	\$10,183
Oct 2016	244	\$2,543,695	\$10,425
Nov 2016	233	\$2,322,678	\$9,969
Dec 2016	228	\$2,195,004	\$9,670
Jan 2017	212	\$2,149,367	\$10,139
Feb 2017	211	\$1,925,319	\$9,125
Mar 2017	210	\$2,072,920	\$9,871
Apr 2017	203	\$2,059,664	\$10,146
May 2017	208	\$2,053,197	\$9,871
June 2017	213	\$2,017,427	\$9,471
July 2017	207	\$2,116,713	\$10,226
Aug 2017	209	\$2,035,405	\$9,739
Sept 2017	192	\$1,943,103	\$10,120

Under local systems management, the CCCMHC has developed a second recommendation to redeploy Medicaid and other funding that will support a single, accountable entity in Clark County that adheres to the

System of Care philosophy (Stroul et al., 2008) and uses an evidence-based wraparound approach (Bruns et al, 2010) to coordinate the care for youth with serious emotional disturbance. The federal government has reported that less than 10% of Nevada children with serious emotional disturbance have access to the state mental health wraparound care management at a penetration rate of less than half the average of other states (CMS, 2013). The report commissioned by the Governor’s Council on Behavioral Health and Wellness described the benefits of integrating funding and the effective use of care coordinating organizations in producing effective service outcomes (Brune et al., 2014). 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 & 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).

Furthermore, federal and state reports continue to highlight Nevada’s need for a more substantial workforce trained to provide quality behavioral health services to children (Dvoskin, 2014). Nevada ranks 50th among states in the number of psychiatrists per capita,

with over 700,000 Clark County residents living in mental health professional shortage areas identified by SAMHSA (Packham et al., 2016). With an extreme shortage of child psychiatrists in Southern Nevada, families face especially long waitlists, short medical appointments and few alternatives for accessing needed care for their children with behavioral health needs (Valley, 2015). Given this workforce shortage, the CCCMHC has developed a third recommendation that Medicaid should include an evaluation of reimbursement rates for existing mental health services in their regular rate reviews mandated by the 2017 Nevada Legislature to determine if inadequate reimbursement adds to the difficulty in recruiting providers.

As a fourth action step to facilitate effective local service delivery, the CCCMHC also recommends that both traditional health care providers and care management entities have the ability to provide innovative services such as family peer support, mentoring, mental health consultation, and respite care, under health care coverage policies or flexible funding strategies. These strategies are currently underutilized in public children’s behavioral care systems in spite of their demonstrated effectiveness in improving outcomes and reducing costs of services (Pires et al., 2013). In order to improve the quality of children’s behavioral health care, the CCCMHC has made a fifth recommendation to develop statewide standards that require all providers receiving Medicaid or other public funding as reimbursement to utilize family-driven, individualized, evidence-based interventions. As a model, Nevada can utilize the process developed for Substance Abuse and Treatment Agency (SAPTA) providers.

Traevon’s Story*

Traevon is a 15-year-old youth with multiple diagnoses including depression and anxiety. Traevon’s family has been seeking help in the community for some time, but work and transportation issues have made it difficult for him to attend his therapy appointments. Recently, Traevon’s behavior led to multiple suspensions from school. Following these suspensions, Traevon’s mother, Dorothy, began missing a lot of work because Traevon resisted returning to school and she feared that he wanted to hurt himself. Her reduced hours also sent the family into a financial crisis; they worried they would be evicted and also might lose Dorothy’s employer-provided health insurance. Dorothy also began considering residential treatment as an option for Traevon because he was spiraling downward, and she didn’t know how else to help him. This family could benefit from community-based services that are close to the family’s home and intensive care coordination that would help address the needs of the entire family, such as Wraparound in Nevada (WIN) Program.

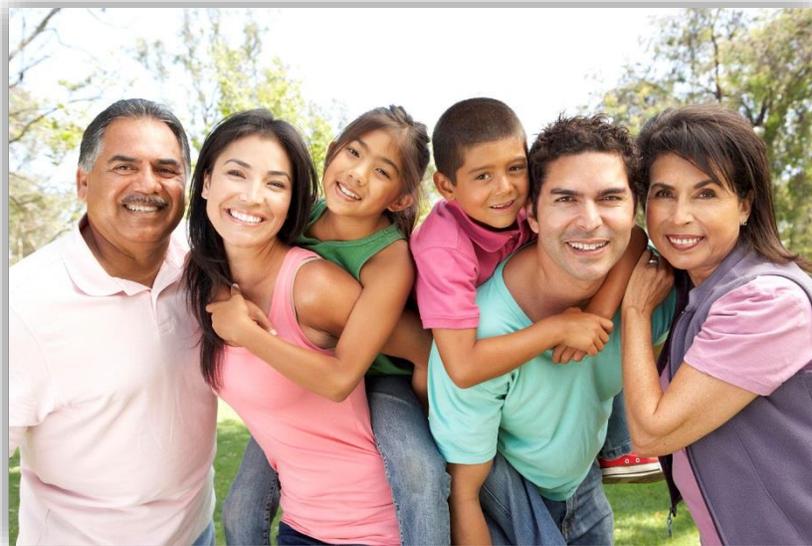
**Not the child’s actual name*

Recommendations

- A. Implement a model of integrated, local system management of all publicly funded children’s behavioral health services in Clark County with oversight by the CCCMHC in coordination with the regional mental health boards. (Revised 2017)
- B. Re-structure Medicaid policies and funding to support a single, accountable entity in Clark County that uses a wraparound approach to manage the care for youth with serious emotional disturbance. Blend/braid Medicaid and other public resources, allowing flexibility in the care management entity’s use of the funding to implement individualized services and supports that strengthen the family, reduce the need for out-of-home placement, and demonstrate and report positive outcomes for each youth.
- C. Recommend that Medicaid adjust its rates for children’s behavioral health services following the review mandated by AB 108 of the 2017 Legislature if inadequate provider reimbursement contributes to lack of capacity and access for children and families. (revised 2017)
- D. Include the following as essential health benefits to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, Health Insurance Exchanges and other publicly subsidized health coverage plans: family peer support, mentoring, mental health consultation, mobile crisis intervention, and respite care. Encourage private health insurance plans to include these services in their benefit packages. (Revised 2017)
- E. Develop and implement a statewide, universal set of quality standards that require those children’s behavioral health providers who receive Medicaid or other public funding as reimbursement for their services to utilize family-driven, individualized, evidence-based treatment interventions.

Projected Costs

This priority may be implemented through the redeployment of resources currently dedicated to the management of the system and through blending and braiding local, state and federal funds from those agencies currently providing children’s behavioral health services.



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

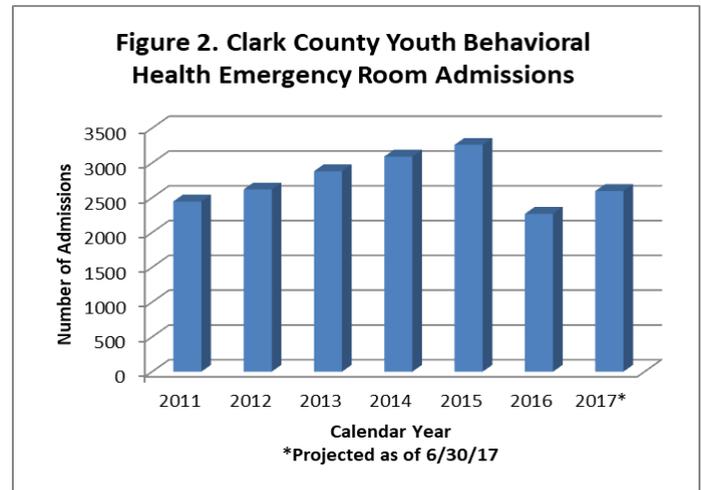
Justification

The second priority of the CCCMHC is to **provide mobile crisis intervention and stabilization services for all Clark County youths in crisis**. Without easy access to crisis intervention and stabilization services in the past, families in Clark County have been forced to utilize local emergency rooms in order to obtain behavioral health care for their children. The National Center for Children in Poverty first identified youth emergency room visits for behavioral health care as a serious problem across the United States (Cooper, 2007). A more recent national study of children's behavioral health services utilization in the Medicaid program showed that eligible adolescents still use disproportionately more services--particularly facility-based care—when there is a lack of more cost-effective approaches such as mobile crisis intervention services (Pires et al., 2013).

Until 2016, child mental health-related visits to hospital emergency rooms increased steadily every year in Clark County. Nearly half of youths admitted were discharged home without immediate treatment, still showing signs of suicidal ideation, psychosis, or depression (CCCMHC, 2010). The medical director of University Medical Center's Pediatric Emergency Room called the situation a "health crisis of unbelievable proportions," noting that mental-health related visits to his facility had tripled over the past decade while the county population has increased by only 25% (Valley, 2015).

Children seen in emergency rooms are often admitted to psychiatric inpatient care. In 2013 Clark County psychiatric hospitals admitted more than 7,200 children, a 45% increase over 2009 (Valley, 2015). Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric hospitalization for youths in successful programs implemented across New Jersey, in Milwaukee, Wisconsin and in Seattle, Washington (AHRQ, 2013). Based on the success of other states and communities, DCFS implemented a mobile crisis team pilot program in January 2014, expanding the services in October 2014 after the Governor's Council on Behavioral Health & Wellness successfully advocated for additional funding (Dvoskin, 2014)

The DCFS Mobile Crisis Response Team (MCRT) currently 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 and substance abuse problems. The Las Vegas MCRT received 1,856 calls in 2017, providing services to nearly 1200 youth and families during this time period. Telephone response and face-to-face intake assessments take place 24 hours/7 days per week in an emergency room department or a private residence. However, the MCRT also frequently responds on-site to referrals from the Clark County School District and the Department of Juvenile Justice. *A total of 86.7% of youths served by the program were diverted from psychiatric hospitalization. Moreover, youth psychiatric admissions to local emergency rooms dramatically decreased during calendar year 2016 and remained lower during the first six months of 2017 (Figure 2), in spite of yearly increases in population (Greenway, 2017).* Ninety five percent of the families served were referred for additional mental health and/or community support services. The Mobile Crisis Team has partnered closely with Nevada PEP, immediately linking families for the support needed to keep the child at home whenever possible. The youth served through the MCRT have shown significant improvement in functioning and 90% of parents'/guardian's report being satisfied with the program.

Youth in crisis and their families have benefited from this evidence-based program without regard to referral or payment source, including the uninsured as well as those with fee-for-service Medicaid, private insurance and Medicaid managed care coverage. However, the MCRT has experienced challenges in facilitating inpatient

services and other types of intensive care needed for some youths covered by managed care and private insurance. There are local psychiatric hospitals and managed care providers who have required their own assessments for youths served by the MCRT, delaying the necessary linkages to appropriate services and increasing the length of emergency room stays for these youth and families. In 2017, nearly 150 families requesting services were turned away from the program in 2017 due to the inability to partner with their managed care or private insurance providers to access needed inpatient or other intensive services. The MCRT also struggles to find appropriate placements and/or services for youth for co-occurring developmental disabilities and behavioral health needs. The CCCMHC is recommending 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 youths, including those enrolled in Medicaid or other managed care programs.

Uninsured youths comprise a disproportionately high number (40%) of those receiving services from the MCRT. The Nevada Department of Health and Human Services should explore the expansion of presumptive eligibility to all youths requiring the services of DCFS Mobile Crisis Intervention program. This strategy would result in less reliance on emergency room services and more rapid access to community-based providers, while creating a stable funding source for the program.

Linda's Story*

Linda is a 13-year-old girl who experiences problems both at home and in school. Recently, Linda has been spending a lot of time alone and is becoming increasingly isolated from peers and her family. Linda's dad and stepmother increasingly worry about Linda's safety. Also, Linda has become very belligerent with her stepmother, recently physically attacking her during a disagreement that prompted a call to the police. After threatening to hurt herself when the police visited her home, Linda was transported to the emergency room(ER) for evaluation. The hospital called DCFS's Mobile Crisis Response Team (MCRT). The MCRT referred Linda and her family to their Medicaid Managed Care (MCO) insurance because the MCO contracts with a behavioral healthcare organization (BHO) that provides its own crisis services, refusing to accept MCRT assessments or partner with DCFS in providing services. The BHO crisis services was not able to respond for more than 24 hours, forcing Linda to remain hospitalized in the ER while waiting for their evaluation. Had the family been able to access DCFS's MCRT, they would have avoided a protracted wait for services and unnecessary ER expenses.

**not the child's actual name*

Recommendations

- A. Provide stable funding for DCFS to maintain an evidence-based mobile crisis intervention program with fidelity that meets the needs of Clark County youth experiencing severe psychiatric crises
- B. Recommend that DHHS develop interagency protocols and policies to ensure 24-7 access to evidence-based mobile crisis intervention services and seamless transition to appropriate inpatient or community-based care for all uninsured, privately insured and publicly insured youths with severe psychiatric crises, including those enrolled in Medicaid or other managed care programs. (Revised 2017)
- C. Sustain funding for Family Peer Support to enhance outcomes and reduce psychiatric hospital readmissions for youths served by mobile crisis intervention. (Revised 2017)
- D. In order to support the program and provide timely access to needed services, develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

Projected Costs

Funding for existing program costs should be shifted to state general fund and/or Medicaid to ensure program stability.

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

Justification

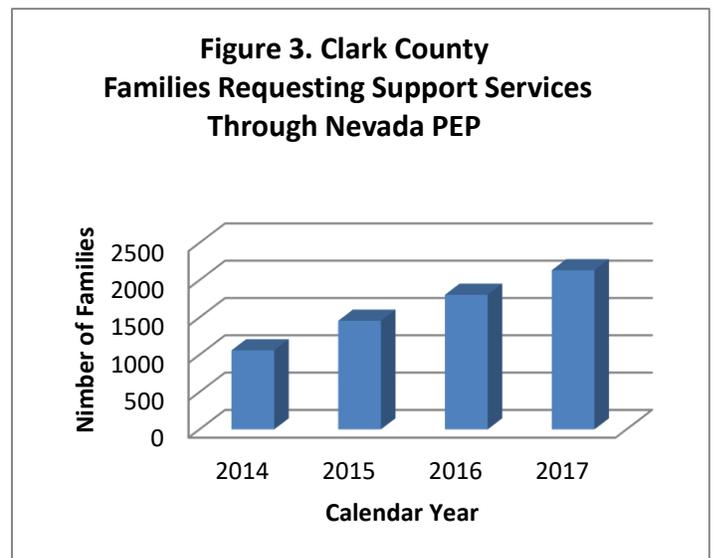
As a third priority, the CCCMHC recommends that **Nevada expand access to family peer support services for the families of Clark county’s children at risk for long-term residential placements.** In particular, the CCCMHC recommends funding to implement a pilot project for 200 youths with serious emotional disturbance identified by the Clark County School District’s Mental Health Transition Team who have required multiple acute psychiatric hospitalizations, as well as an additional 50 youths with co-occurring developmental disabilities and mental health needs identified through the AB 307 Project who are at risk for long-term residential care. Youths with these co-occurring disorders are disproportionately represented among large numbers of Nevada youth currently being placed in out-of-state residential institutions.

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

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, even while more and more Nevada families of children with serious emotional disturbance request this program through Nevada PEP each year (see Figure 4). Because family peer support services can help reduce reliance on expensive, restrictive residential treatment, the Centers for Medicare & 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 & Wellness

also recommended expansion of family peer support programs in its 2014 report (Dvoskin, 2014).

Nevada PEP currently provides family peer support services for families who have children with mental health needs. Families are referred by DCFS programs, schools, and community organizations. Over the last year, PEP provided family peer support services to 2,132 Clark County families of youth with serious emotional disturbance in Clark County. 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 507 Clark County families with youth in crisis in 2017. Funding for family peer support should be sustained in the next biennial budget to keep pace with the growing MCRT program.

The 2013 Pires et al. study also found that behavioral health expenses for children in Medicaid with a developmental disability were more than double those for other children, pointing to the need for alternative approaches such as family peer support for this population. Many Clark County youths with co-occurring

developmental disabilities and behavioral health needs have been served by the Mobile Crisis Response Team over the past year. Linking these youths to community-based services creates one of the greatest challenges for the MCRT. Family peer support can improve outcomes for these children, representing a critical component of any care coordination program. The CCCMHC recommends that intensive family peer support be incorporated into the pilot project for such youths authorized by Assembly Bill 307 of the 2015 Nevada Legislature. In order for this project to be implemented as intended by the legislation, more youth with co-occurring disorders must receive intensive care coordination using a wraparound model in conjunction with family peer support that results in diversion from long-term residential care and placement at home whenever possible.

Additional funding for family peer support is also desperately needed to provide services to the large

numbers of youths at risk for both acute and long-term psychiatric residential treatment being identified each year by the Clark County School District's Mental Health Transition Team. Created in 2014, this team facilitates the development of school-based aftercare support to youths discharged from local psychiatric hospitals. Each academic year, this team provides aftercare support to nearly 1500 youths transitioning back to their home schools after hospital stays. The majority of youths identified by the team lack special education supports and suffer from depression, bipolar disorders, or other serious mood disorders. While the Mental Health Transition Team connects the youth with needed services as they return to school, the families of these youths also need support to provide care for these youths at home. Over 200 of the youths served by the CCSD Team experienced *at least three* psychiatric hospitalizations during academic year 2016-2017.

Juan's Story*

Juan is an 11-year-old boy with co-occurring mental health and intellectual disability. Juan's mother has been receiving some case management and a respite voucher from Desert Regional Center. Even though her son is diagnosed with anxiety and acts out when frustrated, he has not received mental health care because of his intellectual disability. Juan's mother has two other children, with no family or social network to depend on. Recently, the police were called after an incident at school, and Juan was given a citation to appear in court. Juan's mother was terrified that they were going to send her son to a residential facility. Luckily, he was diverted from juvenile court to The Harbor where DCFS's MCRT became involved, referring mother to Nevada PEP for family peer support services. At PEP, a Family Specialist provided multiple resources to help Juan's mother address his mental health needs. Mother became involved with a family support group which has decreased her isolation and introduced her to positive behavior management techniques. Unique and ongoing challenges are common for children that have a co-occurring mental health diagnosis and intellectual disabilities; they need consistent community-based services and their families must have access to the family support so critical for successfully raising their children at home

**Not the child's actual name*

Recommendations

- A. Expand funding to provide family peer support for Clark County youths with serious emotional disturbance at risk for long-term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization and referred from the CCSD Mental Health Transition Team.
- B. Recommend that the pilot project established under Assembly Bill 307 of the 2015 Nevada Legislature should be: (1) implemented as the law intended; and (2) provide an intensive level of family peer support for at least 50 Clark County youth with intellectual/developmental disabilities or related conditions who are also diagnosed with behavioral health needs in an effort to prevent long-term institutional placement. The Legislative Committee on Health Care should review the project's outcomes and make recommendations for the 2019 Legislative Session. (revised 2017)

Projected Costs

\$600,000 per year for Program A (200 youths) and **\$150,000 per year** for Program B (50 youths). Costs based on Nevada PEP cost per family of \$3,000 for 75 hours of family peer support.

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

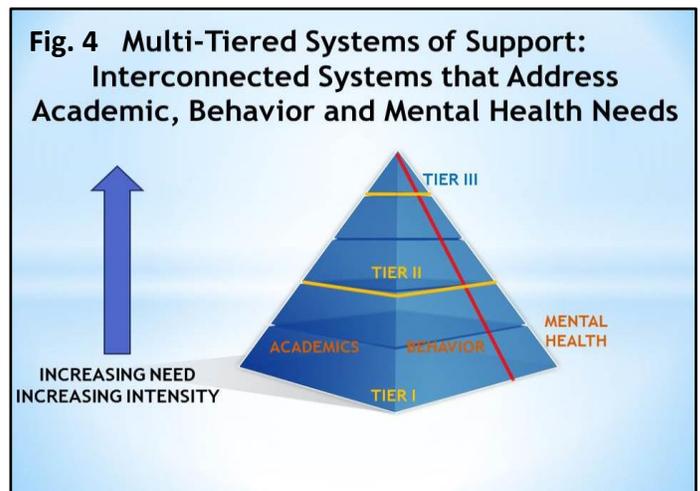
Justification

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

About 31,000 Nevada youth (13.9%) have experienced a major depressive episode in the past year, representing a steady increase since 2011 to a rate that is significantly higher than the national average (SAMHSA, 2017). The Nevada Office of Suicide Prevention reports that suicide is the second leading cause of death for 15-24 year-olds in the state. A 2015 survey found that 17.5% of Clark County high school students thought about suicide and 9.2% actually attempted to kill themselves (Lensch et al., 2016). The Clark County School District 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. The county coroner’s office has

indicated that the number of children and teens completing suicide has also increased steadily, from eight deaths in 2014 to fifteen deaths in 2016 (Pak-Harvey, 2017).

The school district has incorporated the Signs of Suicide (SOS) Educational Program into its eighth and ninth grade health class curriculum with 48,271 students participating in the lessons during the 2016-2017 school year. While the SOS Program may be a valuable addition to the Clark County School District’s Health Curriculum, its effectiveness in reducing suicide risk has not been shown. 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 Clark County School District successfully conducted suicide risk screening at selected sites prior to 2014, but does not have a comprehensive screening program currently in place. For example, between 2011 and 2013, CCSD screened over 17,000 youths using the SOS screening program.



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

through screening, can receive early intervention or intensive support.

The Nevada Legislature has authorized over 11 million dollars annually for the Department of Education’s “Social Workers in Schools Program” to implement school-based preventative mental health interventions. DOE distributes block grants to school districts and charter schools to provide Tier 1 or Tier 2 mental health interventions to students (See Fig. 5),

using strength-based, evidence-based programs and best practices. With these funds, the Clark County School District has hired 130 social workers and other licensed mental health professionals to implement the desired school-based mental health interventions. The “Social Workers in Schools Program” can also provide the critical funding and personnel resources to implement a comprehensive suicide risk screening program across Clark County schools that links identified students with necessary services and supports.

Maggie’s Story*

Maggie is an 8th grader attending public school in the Clark County School District. Some of Maggie’s teachers felt that lately she had become quieter and more withdrawn, also noticing that she was not turning in homework. At home, Maggie’s parents observed that she was spending more time in her room, but they thought it represented an adolescent phase and nothing serious. Recently, Maggie had a breakup with her boyfriend and was being bullied by some of his friends. One afternoon, her mother came home to find Maggie unresponsive with an empty bottle of a prescription pain medication on the floor and a note. After her mother frantically called 9-1-1, Maggie was transported to the hospital where her stomach was pumped and she was subsequently admitted to an acute psychiatric hospital. If Maggie’s school had a mental health and suicide prevention screening program, it is likely that Maggie’s parents would have been notified of a potential issue and linked to services instead of finding out there was a problem through a suicide note.

**not the child’s actual name*

Recommendations

- A. Recommend the Nevada Office of Suicide Prevention in collaboration with Clark County School District and the Nevada Institute for Children’s Research and Policy, conduct a comprehensive survey of Clark County public, charter, and private schools that will determine the degree to which mental health and/or suicide prevention screening has been implemented. (revised 2017)
- B. The Department of Education Social Workers in Schools Program should support the implementation of an effective model of school-based mental health and suicide prevention screening that is: (1) Evidence-based; (2) Cost-effective; (3) Utilizes active parental consent; and (4) Includes procedures and resources to link identified students with needed services. (revised 2017)

Projected Costs

The Nevada Departments of Education and Department of Health and Human Services should evaluate current funding sources for school-based social climate and mental health programs in order to redeploy a portion of the funding toward screening programs for Clark County schools.

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

In accordance with requirements set forth in Nevada Revised Statutes (NRS) 433B, this section describes the objectives from the *10-Year Strategic Plan* that have been revised by the CCCMHC since the *2017 Status Report*.

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

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

Revised Objective 1.1 Restructure Medicaid policies to support intensive care management using a wraparound approach for children with serious emotional disturbance under a single, accountable, locally managed entity; Blend/braid existing and redirected funding from state and county service systems to: (a) implement the care management entity; and (b) expand intensive case management to reach all youth with serious emotional disturbance that are involved in multiple state and county service systems.

Justification: This objective has been revised to allow flexibility in developing Medicaid policy to support integrated, intensive care management and to clarify the target population for these supports.

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

Original Objective 4.5. Redeploy cost savings from deep-end services to expand role of system management to coordinate information and referral for all children with behavioral health problems.

Revised Objective 4.5 Redeploy cost savings from deep end services (i.e., detention, residential and group care) provided by state and county agencies to support local management of a coordinated information and referral system for all children with behavioral health problems.

Justification: This objective has been revised to clarify the source of funding for a coordinated information and referral system.

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

Revised Objective 4.6 Re-structure Medicaid policies to create and finance a regional intensive care management entity under the direction of local system governance.

Justification: This objective has been revised to allow flexibility to Medicaid in developing policies and funding to support intensive care management.

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

Current Membership

Dan Musgrove, Chairperson

Business Community Representative

Amanda Haboush-Deloye, Vice Chairperson

Nevada Institute for Children's Research & Policy

Jennifer Bevacqua

Nevada Youth Care Providers Association

Richard Egan

Nevada Office of Suicide Prevention

Charlene Frost

Parent Representative

Jacqueline Harris

Provider of Substance Abuse Services

Tonia Kapel

Nevada Division of Aging and Disabilities Services

Terri Keener

Clark County Family Services

Heather Lazarakis

Nevada Division of Health Care Financing & Policy

Jim Osti

Southern Nevada Health District

Cara Paoli

Nevada Division of Child & Family Services

Karen Taycher

Nevada PEP

Robert Weires

Clark County School District

Cheri Wright

Clark County Juvenile Justice Services

Mission

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

The CCCMHC's 10-Year Strategic Plan

is available online at <http://www.cccmhc.org/reports>

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