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

2019 Status Report

CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM
2019 STATUS REPORT ON THE 10-YEAR STRATEGIC PLAN
EXECUTIVE SUMMARY

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

Approximately 10-12% of children and adolescents experience serious emotional disturbance (SED) symptoms each year; this includes significant impairment in their ability to function at home, in school, and in the community (SAMHSA, 2013). At least 50% of children and youth in child welfare and approximately 70% of youth in the juvenile justice system have significant mental health disorders (Stagman et al., 2010; SAMHSA, 2013).

The 2019 Annual Report of Mental Health America ranked Nevada as the worst state (51st) in providing access to behavioral health care for its youth (Mental Health America, 2019). In Nevada, 15.7% of all adolescents aged 12-17 experienced a Major Depressive episode in 2015-2016. This was approximately a 12% rate increase from the previous year. Of those about 29% received treatment (SAMHSA, 2017). According to the most recent Youth Risk Behaviors Survey (YRBS), nearly 30% of middle school students age 11-14 in Clark County reported that they felt sad or hopeless almost daily for two or more weeks in a row. Among Clark County middle school students, 21% had seriously considered killing themselves. The percentage of high school students in Clark County who had considered suicide was an average of 16% (21% for girls) (YRBS, 2017). Eight percent of those 11-18 year olds surveyed reported having actually attempted suicide in the previous 12 months (YRBS, 2017). Twenty eight percent of public middle school students in Clark County report having tried alcohol and 9% have used marijuana.

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

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

TABLE 1. YEAR 9 REPORT
10-YEAR STRATEGIC PLAN

Strategic Plan Goals for 2020	Objectives at least partially achieved
1. Coordinated services & supports for youth with SED	33%
2. Comprehensive service array for all youth with behavioral health needs	50%
3. Organized pathway to information, assessment, referral & crisis response	40%
4. Local system management involving families, providers & stakeholders	75%
5. Preventative programs promoting social-emotional development	90%
6. Heightened public awareness of children's behavioral health needs	67%

SHORT-TERM SERVICE PRIORITIES OF THE CCCMHC

The CCCMHC's ***2018 Service Priorities Report*** identified recommended actions for the upcoming biennium to achieve the most short-term, cost-effective system improvements while serving as building blocks for the ***10-Year Strategic Plan.*** This report outlines the current status of these priorities.

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

CURRENT STATUS: *Minimal Progress*

- **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.
- **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.
- **Recommend Medicaid adjust 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.
- 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 plans to include these services in their benefit packages.**
- **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.

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

CURRENT STATUS: *Some Progress*

- **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.
- **Recommend 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**.**
- **Sustain funding for Family Peer Support** to enhance outcomes and reduce psychiatric hospital readmissions for youths served by mobile crisis intervention.
- **In order to support the program and provide timely access to needed services, develop a mechanism for providing** presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

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

CURRENT STATUS: *No Progress*

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

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

CURRENT STATUS: Minimal Progress

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

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CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM
2019 STATUS REPORT ON THE 10-YEAR STRATEGIC PLAN

I. INTRODUCTION

Clark County's children with behavioral health needs share many of the same characteristics and challenges of children with behavioral health needs across the country. 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). 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). Approximately 20% of adolescents aged 13-18, and 13% of children aged 8-13 experience a severe mental disorder at some point in their life (NAMI, 2015). 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. Often functioning is severely impaired 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 (SAMHSA, 2013).

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). Studies have found that symptoms of anxiety disorders begin by age 6 years, behavior disorders (such as ADHD or conduct disorder) by age 11 years, mood disorders by age 13 years, and substance use disorders by age 15 years. Even though 50% of all lifetime cases of mental illness begin by age 14 years, the average delay for intervention is 8-10 years (NAMI, 2015). Thirty seven percent of students with a behavioral health condition age 14 years and older drop out of school—the highest dropout rate of any disability group. National studies show that suicide is the third leading cause of death in youth and young adults ages 10-24 years. Ninety percent of those who die by suicide had an underlying mental illness (Shaffer & Craft, 1999). The most prevalent lifetime disorders among suicidal adolescents are depression, followed by impulse control disorders, substance abuse, psychosis, and anxiety (Nock, et al., 2013). In 2017, 21% of Clark County's public middle school students seriously thought about killing themselves and 8% had attempted suicide (Lensch et al., 2017). Studies have indicated that children in the child welfare and juvenile justice systems have behavioral health disorders and have experienced significant trauma at higher rates than their peers.

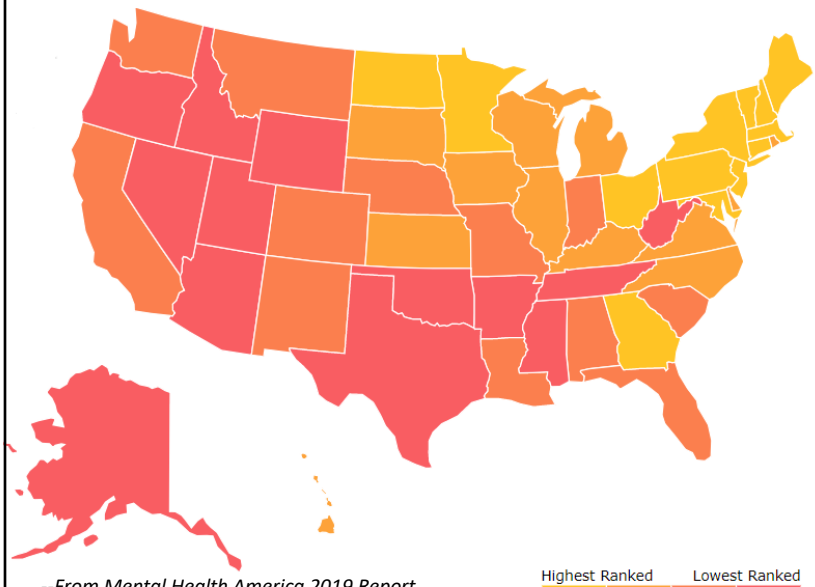
In Clark County, studies have suggested that 19.3% of elementary school children have behavioral health care needs and nearly 35% of adolescents self-reported feeling consistently sad or hopeless (CCCMHC, 2010). Local surveys conducted by the Consortium have confirmed that Clark County children in the child welfare and juvenile justice systems also experience a greater need for behavioral health care (CCCMHC, 2010).

With local studies showing at least 6% 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).

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 who identified with behavioral health disorders were not receiving any special services or treatment (CCCMHC, 2010). **Regardless of family income, 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% 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).

Figure 1. (below) represents Mental Health America's 2019 report ranking 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., 2018). 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 also 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

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



--From Mental Health America 2019 Report

implement an integrated system of care approach to behavioral health" (Watson et al, 2013). 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. The CCCMHC's **10-Year Strategic Plan** and updates of the plan's priorities have been submitted to the Director of the Department of Health and Human Services and the Commission on Behavioral Health since the plan was created in 2010. The plan is due to be updated for 2020-2030.

In 2018, the CCCMHC identified ***four priorities*** that would result in the most short-term, cost-effective improvements in the system while serving as building blocks for the long-term plan (CCCMHC, *2018 Service Priorities*). ***Section II*** of this report provides a description of current progress toward implementing these priorities. ***Section III*** describes any revisions to the primary objectives of the 10-Year Strategic Plan. ***Section IV*** provides a status report on each of the Plan's Phase 1, 2, and 3 Objectives targeted for completion by January 31, 2020.

II. STATUS OF THE CCCMHC'S 2018 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). Nevada youth exhibit disproportionately higher levels of mental illness and substance abuse than other states and struggle to find appropriate services and supports (Nyugen et al., 2018). For example, the number of 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 and 11.2 % of Nevada's children with private insurance lack coverage for comprehensive mental health services. (Nguyen et al., 2018). 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).

Figure 2 (below) shows a comparison between youth placed in out-of-state versus in-state residential treatment between September 2017 and August 2018. While there are been modest improvement in the number of children placed in out-of-state care during that time, there were still more than 50% of youth placed outside of Nevada for residential treatment as of August 2018, removing them from their family, friends, and other social support networks. Additionally, although the monthly cost of out-of-state placements decreased during this time period, the total 12-month cost was over $7,000,000 more than what Nevada paid for in-state RTC during the same time frame. Residential treatment in Southern Nevada is available at Desert Willow Treatment Center (DWTC), which has the ability to provide 12 residential beds (not for acute care) at one time. During SFY17, DWTC served 44 youth with an average length of stay of 154.3 days and the longest stay recorded as 411 days. As of July 31, 2018, DWTC had served 29 youth during SFY18 with an average length of stay of 158.2 days and the longest recorded stay as 350 days (DWTC, 2018). When examining the justification for increasing the availability of residential treatment, it is not only important to look at the fiscal cost but also the access the youth has to their family. 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 5 months while in care. This is not best practice.

Figure 2. Residential Treatment Center (RTC) Placements of Nevada Children Placements for Children							
	In-State Nevada RTC Patients			Out of State RTC Patients			Out of State
Year/Month 2017	Children Placed	% of plcmts.	Total Monthly Cost	Children Placed	% of plcmts.	Total Monthly Cost	Difference in Cost
September	**94**	32.5%	$921,952.06	**195**	67.5%	$1,975,577.57	$1,053,625.51
October	**105**	34.5%	$1,054,873.81	**199**	65.5%	$2,058,378.25	$1,003,504.44
November	**100**	33.7%	$989,296.18	**197**	66.3%	$1,977,631.97	$988,335.79
December	**109**	36.1%	$1,085,538.06	**193**	63.9%	$2,034,128.40	$948,590.34
2018							
January	**108**	37.2%	$1,093,669.16	**182**	62.8%	$1,983,437.28	$889,768.12
February	**97**	35.0%	$781,402.00	**180**	65.0%	$1,726,239.14	$944,837.14
March	**106**	37.9%	$1,027,939.00	**174**	62.1%	$1,804,439.47	$776,500.47
April	**115**	41.2%	$1,087,304.00	**164**	58.8%	$507,975.09	-$579,328.91
May	**120**	44.8%	$1,223,017.00	**148**	55.2%	$1,635,258.40	$412,241.40
June	**106**	43.1%	$1,049,032.00	**140**	56.9%	$1,421,138.19	$372,106,.19
July	**99**	43.4%	$979,956.00	**129**	56.6%	$1,409,609.89	$429,653.89
August	**94**	43.1%	$859,432.00	**124**	56.9%	$1,187,382.18	$327,950.18
Total 12 Months Cost			**$12,153,411.27**			**$19,721,195.83**	$7,567,784.56

Source: Nevada Department of Health & Human Services, 2018

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 of responsiveness to community needs (Brune et al., 2014). Because of these systemic problems, Nevada youths with serious emotional disturbance or other disabilities continue to be unnecessarily placed in costly out-of-state institutions (see Figure 2). 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 systems 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 behavioral health policy boards across the state.

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).

Recommended Action Steps

- 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)
- 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.
- 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)
- 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)
- 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.

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). A Mental Health America 2019 report ranked Nevada 32nd in mental health workforce availability, with a ratio of 580 Nevadans to every 1 mental health provider. As recently as 2016, studies showed as many as 700,000 Clark County residents living in a mental health professional shortage area as 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.

CURRENT STATUS: Minimal Progress

The Nevada Division of Child and Family Services (DCFS) has coordinated efforts between the Commission on Behavioral Health and the three regional consortia via a joint subcommittee established in 2012 to address the governance for children's behavioral health service delivery as well as the restructuring of policy and financing strategies. Members of the CCCMHC participate in workgroups of the subcommittee and give voice to the behavioral health needs of children in Clark County. The subcommittee, known as the System of Care Subcommittee, oversees the goals and activities of System of Care Expansion and Sustainability Grant that DCFS was awarded in October 2015 from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. With support from this project, the subcommittee has a strategic action plan that integrates services for children with serious emotional disturbance under a system of care overseen by DCFS. The grant is in its final year and ends September 30, 2019. During the 4-year grant project, DCFS and its system partners including the Nevada Division of Health Care Financing and Policy have worked together in efforts to develop plans to restructure the policies and funding for children's behavioral health services. Amendments to the State Medicaid Plan are needed that will allow blending and braiding of all federal and state funding available for children's behavioral health services. The System of Care efforts have determined that the Medicaid reform should include the addition of needed services such as: family peer support, mentoring, mental health consultation, mobile crisis intervention, and respite care for children with behavioral health needs. Concerning rates for providers, Assembly Bill 108 of the 2017 Legislature required a review of rates to determine if they were adequate.

As part of the grant's strategic plan, DCFS has provided access to training in evidence-based practices, including Together Facing the Challenge (a therapeutic foster care model), System of Care Overview, High-Fidelity Wraparound, Trauma-Informed Care, Parent-Child Interaction Therapy, Family Checkup and Everyday Parenting, and Working with LGBTQ+ youth. DCFS has made many of these trainings available through the Center for Applied Substance Abuse Technologies (CASAT) website. The grant has also facilitated the development and training of providers across the state in using the Child and Adolescent Needs and Strengths (CANS) tool and the collaborative case planning process resulting from it. The CANS tool is part of a comprehensive assessment that will eventually be used statewide by behavioral healthcare providers who receive Medicaid reimbursement. Recognizing that this is widely

used across the country, Medicaid is proposing to transition to this tool as a measure of service intensity by 2020. This will result in behavioral health providers and families collaborating in their youth's care through a strength-based process and experiencing smooth transitions between providers and levels of care.

DCFS has worked with stakeholders to developing quality standards for providers of children's behavioral health services that reflect nationally recognized system of care values and principles. Through the System of Care Workforce Development Workgroup, efforts were made to collaborate with the three behavioral health licensing boards to explore barriers to licensing, credentialing and retention of providers. Lack of an adequate number of appropriately trained and licensed behavioral health workforce remains a challenge in Nevada especially outside the two major urban areas. Lack of access to care is one of several factors responsible for Nevada ranking 51st in the nation for children's behavioral health care.

The Southern Nevada Regional Behavioral Health Policy Board created through NRS 433.429 advises the Department of Health and Human Services and the Commission on Behavioral Health concerning redundant, conflicting or obsolete federal, state and local laws and regulations that relate to behavioral health. This board has agreed to largely defer to the CCCMHC for matters related to the behavioral health of children and youth in Clark County. The creation of this board as well as the CCCMHC provides for local influence and guidance related to children's behavioral health matters in Clark County.

Next Steps

Plans are being proposed to designate DCFS as the children's mental health authority under the auspices of the Division of Public and Behavioral Health which is the Single State Agency for Nevada. This would impact any agency who receives public funding for behavioral health care for children. DCFS would also become a Care Management Entity (CME) for youth who are Medicaid eligible and have complex behavioral health needs and would benefit from wraparound and care coordination. Under this plan DCFS would oversee the system of care for youth with Serious Emotional Disturbance (SED). This includes screening, assessment, referral, care management, utilization management, provider enrollment, quality oversight, training and technical assistance. This approach has been shown to improve outcomes, system efficiencies, and increased resiliency for families across the country.

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 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).

Recommended Action Steps

- 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
- 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**.**
- Sustain funding for Family Peer Support to enhance outcomes and reduce psychiatric hospital readmissions for youths served by mobile crisis intervention.
- In order to support the program and provide timely access to needed services, develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

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).

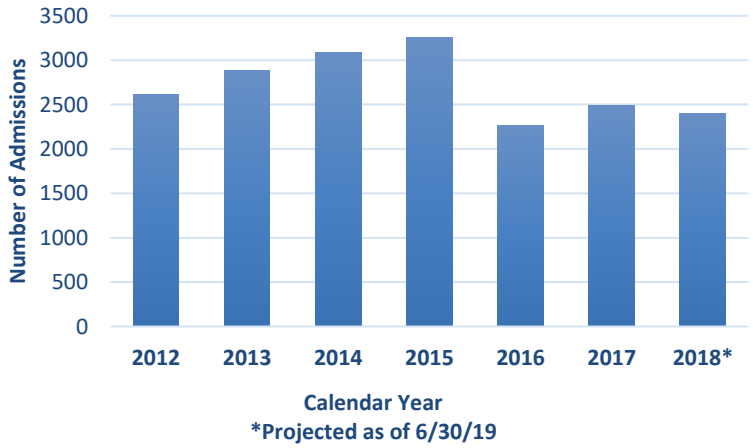
Children seen in emergency rooms are often admitted to psychiatric inpatient care. In 2013 Clark County psychiatric hospitals admitted more than 7,200 children, a 45% increase over 2009 (Valley, 2015). Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric 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).

CURRENT STATUS: Some Progress

Supported by Healthy Nevada funds, DCFS implemented the Mobile Crisis Response Team Program (MCRT) in Clark County as a pilot project in January 2014 and significantly expanded in October 2014 with the same funding source. Currently, the DCFS Mobile Crisis Response Team (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. Through its System of Care Expansion and Sustainability Grant from by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, DCFS has been funding a rural Mobile Crisis Response Team program that provides services to the rural areas of Clark County. The rural MCRT team will be sustainable through the Division of Public and Behavioral Health when the grant ends.

The Las Vegas MCRT received 2,112 calls in 2018, providing services to 1,159 youth and families during this time period in various locations including emergency departments, schools, and private residences. *A total of 85% of youths served by the program were diverted from psychiatric hospitalization.* After initial evaluation or discharge from stabilization services, 85% percent of families served were referred for additional mental health and/or community support services (7.9% declined additional services; for 2.3% of families, no additional services were necessary). Of the remaining 953 calls where services were not provided, only 2 were not served due to the response team not being available. The majority of calls requested information only (641), in which support or a referral for services to a new provider was given over the phone; followed by calls where MCRT did not mobilize (217) where either the police was called, the youth was taken to an emergency room, the crisis was abated, or no services were needed; and incomplete responses (99) in which the family declined MCRT services en route or on scene. 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 MCRT have shown significant improvement in functioning and 94% of parents/guardians report being satisfied with the program.

Figure 3. Clark County Youth Behavioral Health Emergency Room Admissions



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, 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 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 MCRT also struggles to find appropriate placements and/or services for youth for co-occurring developmental disabilities and behavioral health needs. 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 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.

Next Steps

Given the success of DCFS's MCRT it is imperative that there is a stabilized funding source to full staff this program and meet the needs of the children and families in the community. In addition, it is imperative that all managed care plans work with DCFS's MCRT to ensure that children are receiving access to care in a timely manner. It is recommended that the state's MCRT Program be designated a provider under each managed care plan to avoid any barriers to receiving service from their team or the denial of services resulting from their consultation. 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.

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 DCFS, 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. 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).

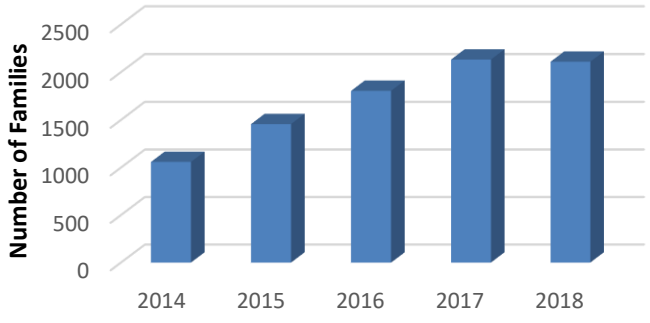
Recommended Action Steps

- Expand funding to provide family peer support for Clark County youths with serious emotional disturbance at risk for long-term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization and referred from the CCSD Mental Health Transition Team.
- 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 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.

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 (2018), PEP provided family peer support services to 2,109 families of youth with serious

emotional disturbance in Clark County (see Figure 4). 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 and 734 in 2018. Funding for family peer support should be sustained in the next biennial budget to keep pace with the growing MCRT program.

Figure 4. Clark County Families Requesting Support Services Through Nevada PEP



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. Although the CCCMHC recommended that intensive family peer support be incorporated into the pilot project for such youths authorized by Assembly Bill 307, and that recommendation was accepted by DHHS Director Whitley, there was no follow through by Nevada's Aging, Disability, and Services Division.

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.

CURRENT STATUS: No Progress

Due to reported budgetary restrictions, no additional general fund monies have been proposed by DHHS for family peer support. Plans are to include this service under the proposed State Plan Amendment. Meanwhile, considerations are being made to obtain funding through other grants such as Victims of Crime. Other funding sources that can be considered include the Fund for a Healthy Nevada as well as through the Office of Community Partnerships and Grants. At this time, the Certified Community Behavioral Health Center (CCBHC) model is the only funded model of care in Medicaid that reimburses for Family to Family Self-Help/Peer Services. However, it is uncertain whether or not these services are being provided.

Regarding NRS 435.035 authorized by Assembly Bill 307 of the 2015 Legislature, no additional funding has been requested for the pilot project through the Aging and Disability Services Division (ADSD). A report to the Legislative Council Bureau dated June 2018 indicated that six children had participated in the pilot program at Desert Regional Center. Family Peer Support was not provided to these families.

Next Steps

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. ADSD Service Coordinators should be trained in wraparound model and family peer support should be securely funded for all youth with SED and co-occurring disorders. The return on investment would be reflected in a decrease in costly out of home placements and less separation and strain on families.

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.

Recommended Action Steps

- 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)
- 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)

About 35,000 Nevada youth (15.6%) 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, 2018). The Nevada Office of Suicide Prevention reports suicide is the second leading cause of death for 8-17-year-olds in the state. A 2017 survey 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 suicide in Clark County in 2018 than in the whole state of Nevada during 2017 (for ages 17 years and below).

CURRENT STATUS: Minimal Progress

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 of Children's Research and Policy in the UNLV School of Community Health Sciences is assessing the current use of and ability to expand the Signs of Suicide (SOS) curriculum to all public and private middle and high schools. Information gathered by this evaluation will also help the Nevada Office of Suicide Prevention secure resources and materials for schools to enhance their implementation of the SOS program to fidelity. Additionally, the results of this survey will provide context for school administrators and policymakers to better understand the needs of southern Nevada schools for preventing youth suicide.

Regarding screening, 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.

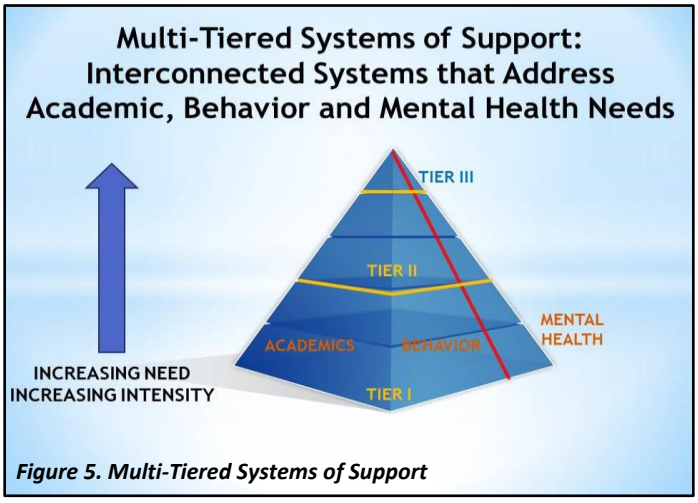


Figure 5. Multi-Tiered Systems of Support

The Nevada Legislature has authorized over $11,000,000 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 using strength-based, evidence-based programs and best practices. With these funds, the Clark County School District has approximately 170 Safe School Professional positions to help provide basic mental health services in the schools. Of those 170 positions, approximately 100 Safe School Professionals are Licensed Social Workers or Licensed Clinical Social Workers. Other Safe School Professionals include but are not limited to Marriage and Family Therapists (MFTs) and Clinical Professional Counselors (CPCs). These providers are participating in training in order to become trainers in the Nevada Child and Adolescent Needs and Strengths (Nevada CANS)

assessment tool. As of December 2018, approximately 50 Safe School Professionals have been trained in this instrument.

In the aftermath of the 1 October Tragedy in Las Vegas, Nevada, the Clark County School District obtained a Project SERV (School Emergency Response to Violence) grant through the United States Department of Education to help the district with recovery efforts within the educational community. The grant funds have been used to bring professional development to staff members related to recognizing the impact of trauma on students and steps toward relieving mental health symptoms associated with trauma. As of December 2018, 35 Licensed Clinical Social Workers within the district have been trained under the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back models for spring 2019 implementation in 35 district schools. Additionally, approximately 1,000 school staff members, including teachers, and other related service providers (e.g., counselors, school psychologists, etc.) have been trained in related Trauma 101 practices.

Another service related to this priority is the Clark County School District's collaboration with the United Citizens Foundation for the operation of school-based health centers. Initially partially supported by a sub-grant through the System of Care grant, the centers offer health, medical, and mental health services. The centers are currently located in 4 elementary schools as well as 4 high schools and served 285 students during the 2017-2018 school year. CCSD also participates in an interagency collaboration agreement with Juvenile Justice Services (JJS), the Department of Family Services (DFS), the Division and Child and Family services (DCFS), and other local partners for the operation of the Harbor Juvenile Assessment Centers. Two locations are currently active, with CCSD providing 2 full-time staff members and 2 part-time staff members.

In addition, CCSD works directly with the Nevada Department of Education to provide additional training and supports to 30 low-performing "Partnership" schools. Training and supports include but are not limited to Positive Behavioral Interventions and supports (PBIS). A newer partnership involves CCSD working with Invo Healthcare and Progressus Therapy to bring licensed mental health providers and their services directly into school campuses. This "Impact" Program is currently being piloted at 3 schools, an elementary school, middle school and a high school.

CCSD also serves as a significant referral source for the Mobile Crisis Response Team (MCRT), Division of Child and Family Services. Active collaboration between the district's Mental Health Transition Team (MHTT) and 5 local hospitals help facilitate the return of students to CCSD schools.

Next Steps

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. Additional Safe School Professionals will be trained to use the Nevada CANS through spring of 2019. Plans should be identified for systemic implementation of the Nevada CANS for universal screening or targeted assessments within the district. The district should utilize Project SERV funds to continue all trainings related to trauma and behavioral health and establish resources for implementation beyond the grant.

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

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

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

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

Phase 1/2/3 Objectives and Strategies

Objective 1.1 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.

Indicators: *Number of youths receiving intensive case management, improved outcomes*

CURRENT STATUS: Minimal progress

The Department is proposing to designate DCFS as the children's mental health authority under the Division of Public and Behavioral Health the designated Single State Agency for Nevada as delegated by the Nevada Department of Health and Human Services. This specific children's designation would impact any agency who receives public funding for behavioral health care for children. This proposal is considered by stakeholders to be the core strategy for implementing the Nevada System of Care and does not aim to replace any responsibility of the single state authority for adult mental health currently held by DPBH. DCFS would also become a Care Management Entity (CME) for youth who have complex behavioral health needs and would benefit from Wraparound care coordination. Under this plan DCFS would oversee the system of care for youth with Serious Emotional Disturbance (SED). This includes screening, assessment, referral, care management, utilization management, provider enrollment, quality oversight, training and technical assistance. This approach yields improved outcomes, system efficiencies, and increased resiliency for families. SAMHSA (2017) describes state mental health authorities as being responsible for monitoring the flow of public funds from the federal and state sources to counties, cities and directly to providers. Additionally, SAMHSA notes that state mental health authorities typically set policy and regulations that govern service provision in accordance with federal and state laws.

It is proposed that as the delegated authority for children's mental health, DCFS would provide leadership in the development and implementation of the system of care with specific attention to the needs and priorities of children, youth and families. Core tasks associated with being mandated

as the children's mental health authority include implementing evidence-based practices, involving stakeholders in strategic planning, developing standards of practice, creating incentives, maximizing funding and fiscal planning, quality assurance, utilization management, and developing the workforce.

Objective 1.2 With active participation from Clark County Management, CCSD Student Services, the Eighth Judicial Court, family members, and other stakeholders, the Nevada Department of Health and Human Services will facilitate the development and implementation of a community-wide, interagency process for reviewing and reducing out-of-state and out-of-community placements of children with serious emotional disturbance.

Indicators: *Adherence to MOU; Decrease in Out-of-State and Out-of-Community Placements, increase in number of children staffed by the teams*

CURRENT STATUS: No progress

No MOUs have been developed, however a MOU between related state and county agencies may be a result of the taskforce described in Objective 1.6.

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

Indicators: Increase in number of children served, increased family satisfaction, improved family functioning

CURRENT STATUS: Minimal progress

Medicaid recipients are currently eligible to receive psychotherapy in their home or in the community. There is a billing code designated for this service. Few providers utilize this option due to travel time and other considerations such as confidentiality. Through the System of Care Expansion Grant two providers across the state recently have agreed to provide in-home therapeutic services to children who are fee for service Medicaid recipients, in Clark County the provider is United Citizens Foundation. This service has just begun therefore outcome data are not yet available.

As the criteria for Wraparound eligibility are made clearer, only the highest need youth and families are served through the high fidelity DCFS program. Therefore, it is likely that more families can now be served through Wraparound and the FOCUS model of care coordination, thus increasing capacity.

Objective 1.4 Establish tax or fee to expand financial supports for youths with serious emotional disturbance.

Indicators: Increase in number of children receiving financial supports. Increased satisfaction of families and improved family functioning.

CURRENT STATUS: No progress

DCFS administers a Placement Prevention Fund that children's mental health staff can access if the child and family team or the staff feel that one of the families they are working with need assistance. This assistance comes in the form of providing monies for rent, food, and clothing for SED youth and their families. This assistance has helped prevent more expensive out-of-home placements and disruptions for families. The amount budgeted for Fiscal Year 2018 as well as the current fiscal year is $27,377. This same amount has been allocated in the biennial budget request that is going to the legislature in February. Last fiscal year 265 families were assisted statewide with these funds. The funds are not adequate for the all the needs of this population, but development of a Medicaid waiver may increase the amount of families who can receive assistance.

Objective 1.5 Expand family peer support services through innovative Medicaid programs, blended/braided funding.

Indicators: *Increase in funding for family peer support services, increase in families served*

CURRENT STATUS: No progress

DCFS is currently contracting with Nevada PEP for Family Peer Support Services statewide. The DCFS System of Care strategic plan has identified goals and objectives to increase family support in Nevada. Recommendations include adopting a national certification for family peer support providers, developing a training curriculum, standards and an enrollment process. These services are also recommended to be reimbursable by Medicaid through the State Plan Amendment process.

Objective 1.6 Strengthen partnerships between DCFS, DPBH, and other agencies to improve services to children with co-occurring developmental disabilities and behavioral health problems

Indicators: *Improved Memorandums of Understanding*

CURRENT STATUS: No progress

DCFS is developing a taskforce to address the needs of children who have been determined to have an Intellectual Developmental Disorder, a Developmental Disability, as well as behavioral health needs. These children 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. These youth are overly represented in the juvenile justice population as well and thus present unique challenges. The taskforce has grown out of a workgroup of the System of Care Subcommittee that focused on special populations of youth. The initial meeting is scheduled for early 2019. The taskforce will meet as often as deemed necessary and its' membership consists of several divisions, agencies and community partners including: Deputy Administrators from DCFS, Aging and Disability Services Division (ADSD), Division of Healthcare Financing and Policy (DHCFP), and the Division of Public and Behavioral Health (DPBH), Nevada PEP and parent representatives, child welfare agencies, children's mental health staff, regional center staff and community providers, juvenile justice, a Judicial District Court-Juvenile Division judge, a Deputy Attorney General, and DCFS Youth Parole. The taskforce is expected to develop a Memorandum of Understanding between these entities in order to improve collaboration, service delivery and

outcomes to these youth. Assuring High Fidelity Wraparound is serving the top 5% of the population of SED youth will increase capacity and possibly prevent the need for higher levels of care. The plans for DCFS to utilize the FOCUS model of case management for the remaining SED youth, will likely improve families getting assistance prior to escalating to higher levels of care. The FOCUS model is being obtained through the National Wraparound Implementation Center (NWIC).

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

Phase 1/2/3 Objectives and Strategies

Objective 2.1 Identify evidence-based and promising practice models for most needed services. (a) Re-structure Medicaid rates to provide incentives for these practices; and (b) Standardize reimbursement incentives statewide for public and private insurers.

Indicators: *Public and private insurer reimbursement rates for Evidence-Based and Promising Practices*

CURRENT STATUS: No progress

As previously mentioned in Objective 1.1, it is proposed that as the delegated authority for children's mental health, DCFS would provide leadership in the development and implementation of the system of care with specific attention to the needs and priorities of children, youth and families. Core tasks associated with the mandate to be the children's mental health authority include implementing evidence-based practices, involving stakeholders in strategic planning, developing standards of practice, creating incentives, maximizing funding and fiscal planning, quality assurance, utilization management, and developing the workforce. Currently the proposal extends only to providers who accept public funding. DCFS would have no authority for behavioral health provided under private insurances although it is hoped that the standards of practice could apply to them and that their providers would see the benefit of engaging in training and delivery of therapeutic practices that have demonstrated positive outcomes. Currently there are no financial incentives available offered by private or public insurers for appropriate use of evidence-based models and Promising Practices.

DCFS has provided numerous trainings in evidence-based practices for children through both local trainers as well as providing access to nationally recognized experts. A gap analysis was conducted under the System of Care Expansion Grant in order to identify what needs exist across the state. This information is considered when trainings are developed.

Objective 2.2 Increase the capacity to provide home and community-based services to uninsured and underinsured children by redeploying funds from higher levels of care and expanding insurance coverage.

Indicators*: Annual increase in funding/number of children and families receiving behavioral health services.*

CURRENT STATUS: Minimal progress

As of July 2018, the System of Care Expansion Grant had served over 600 children and families. One of the goals of the grant is to increase home and community-based services. Funding has been provided for programs that help meet some of the needs for children and families in the two urban areas of the state as well as funding mobile crisis response in the rural areas of Nevada.

Through the Affordable Care Act, significantly more Clark County youths have coverage that provide access to services however waiting times are often long before appointments and there are limited numbers of providers overall.

Objective 2.3 Strengthen outreach programs to assist families in obtaining healthcare coverage.

Indicators: *Increase in families enrolled in Medicaid/NV Check-up; decrease in uninsured.*

CURRENT STATUS: Substantial progress

As of 2017 approximately 7% of children ages 0-18 were uninsured in Nevada. Clark County has the highest percentage of minority uninsured and/or underinsured adolescent populations.

Nevada has numerous navigators, called Certified Application Connectors, who assist families in obtaining healthcare coverage either through enrolling in Medicaid /Nevada Check-Up or by applying for coverage during the open enrollment period for the Exchange under the Affordable Care Act. Other efforts include increasing awareness of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that is available to Medicaid and Nevada Check-Up recipients. According to data provided by the DHHS Office of Analytics, in June of 2018 in Clark County a little over 8000 children with SED received behavioral health services from either Fee for Service Medicaid providers or through one of the three Managed Care Medicaid companies. Data is not available for those receiving services utilizing their private insurance benefits.

Nevada has participated in the National Governors Association (NGA) Learning Network on Improving Quality and Access to Care in Maternal and Child Health since February 2016. The project aims to increase access to health insurance coverage and medical care for adolescents aged 15 – 18 years. The project also seeks to increase the number of youths receiving at least one yearly medical visit and increase recognition that this could often be accomplished during required sports physicals. The goal is that the percentage of youths receiving yearly visits will increase from 67% to nearly 80% by 2020. Efforts include: continuing efforts by the Division of Health Care Finance and Policy (DHCFP, or Medicaid) and the Division of Welfare and Supportive Services (DWSS) to connect people to health insurance coverage statewide, including possible policy changes to adopt the Children's Health Insurance Program Reauthorization Act (CHIPRA) amendment; developing flyers to increase awareness of health insurance coverage and work with the Nevada Department of Education on strategies for distribution in schools. Additionally, Nevada PEP distributes insurance enrollment information through their social media postings as well as through their electronic newsletter that reaches over 17,000 Nevadans.

Objective 2.4 Leverage school funding to implement school-based services for ADHD and Depression. Develop neighborhood-based, school-linked provider network for other behavioral health issues in collaboration with the system management entity.

Indicators: *Proportion of schools offering each type of services; number of children served; achievement levels of children completing the programs.*

CURRENT STATUS: No progress

Activities associated with this objective have not been a focus of CCSD since the previous status report, therefore no progress has been made.

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

Indicators: *Increase in funding levels*

CURRENT STATUS: Minimal progress

According to the 2019 Mental Health America 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. Rates are higher among special populations such as LGBTQ youth. The Certified Community Behavioral Health Center model provides an avenue for substance use treatment for youth since the facilities serve anyone, any age regardless of insurance status and provides crisis services, screening, assessment, diagnosis and risk assessment, outpatient behavioral health and substance use services, treatment planning as well as family support and targeted case management. The CCBHC may collaborate with other organizations if there is a service that is unavailable at the CCBHC. This model is funded through June 30, 2019. It is not clear if there will be additional funds available.

Objective 2.6 Expand capacity and improve quality for psychological and psychiatric assessments and service through private and public insurance resources.

Indicators: *Increase the proportion of children enrolled in public/private insurance programs that access behavioral health services*

CURRENT STATUS: No progress

Over the past two years the behavioral health licensing boards have been working to streamline efforts to increase their response to applications for licensure and processes related to reciprocity. This is a work in progress, but all the boards appear to be working together to increase quality providers in the community. To ensure that progress continues, this process should be monitored, and the boards should be asked to provide regular updates. There are very few child and adolescent psychiatrists in Nevada as a whole and particularly in the rural and frontier regions of the state.

As noted elsewhere in this report, the number of uninsured youths has decreased with the advent of the Affordable Care Act. Information on the number of resources/providers for behavioral health care through private insurance is not readily available. According to the DHHS Office of Analytics, as

of June 2018, the number of children in Clark County covered by Medicaid (both Fee for Service as well as the Managed care companies) was 247,748. This includes both those considered SED and Non-SED. Of the nearly 11,000 youth covered by Medicaid determined to have Serious Emotional Disturbance, approximately 8,000 of those youth received behavioral health services either through an MCO or a Fee for Service provider. This indicates nearly 3,000 youth with SED did not receive services during the timeframe of the data collection (Office of Analytics, 2018). The number of providers who accept Medicaid clients is insufficient for the needs of the population. Families complain of long waiting periods in order to get services leading to delays which can exacerbate conditions resulting in treatment being provided in emergency rooms or higher levels of care at a higher cost.

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

Phase 1/2/3 Objectives and Strategies

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

Indicators: *Numbers and types of calls to 1-800 number*

CURRENT STATUS: No progress

Nevada 2-1-1 was implemented in February of 2006 to provide free connection to critical health and human services information about local community resources. This service is available in a single statewide location that can be accessed via voice, text, and online. Although this system has been running for 13 years, the services provided are often inadequate and not kept up to date. The call center staff are not trained on all service areas therefore do not always know the appropriate referral sources, especially for behavioral health care needs, and the information available on the site is often out of date and incomplete. A well-functioning system that assists families in finding the appropriate services is needed and it is important that this service is different than a mere directory. The system has been operated by the Financial Guidance Center for the past 4 years and the website has gone through many revisions. Currently the home page of the website has a feature to assist families in searching for mental health resources. The mental health page includes several main topics including counseling, assessment, and emergency services. However, this page needs major revisions in order to meet the needs of the community. For example, there is a heading to find counseling for a child, adolescent or young adult, but the description indicates services start at age 8 when in reality services are needed for children at younger ages. Additionally, the search function is difficult to use. Nevada needs a system that will provide accurate, complete, and current services available in local communities with regard to mental and behavioral health needs.

Objective 3.2 Implement a cross-agency program of mobile crisis intervention services that will be available to divert youths in crisis from costly emergency rooms, inpatient care and juvenile detention by: (a) Re-structuring Medicaid's Mobile Crisis and Stabilization Policies to increase provider capacity; (b) Blending/braiding existing funds to implement a cross-agency contract for mobile crisis program for Medicaid, Child Welfare and Juvenile Justice involved youths; and (c) Expanding crisis intervention to all youths in crisis, including privately insured and uninsured.

Indicators: *Decrease in youths accessing emergency rooms for psychiatric problems; decrease in inpatient psychiatric bed utilization*

CURRENT STATUS: Some progress

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, where staff collaborates with other agency professionals to serve children and families in need of behavioral health services and other supports. ***The Las Vegas MCRT received 2,112 calls in 2018, providing services to 1,159 youth and families during this time period in various locations including emergency departments, schools, and private residences.*** Of the remaining 953 calls where services were not provided, only 2 were not served due to the response team not being available. The majority of calls requested information only (641), in which support or a referral for services to a new provider was given over the phone; followed by calls where MCRT did not mobilize (217) where either the police was called, the youth was taken to an emergency room, the crisis was abated, or no services were needed; and incomplete responses (99) in which the family declined MCRT services en route or on scene. ***A total of 85% of youths served by the program were diverted from psychiatric hospitalization.*** Youth in crisis and their families have benefited, including the uninsured, those with fee-for-service Medicaid, private insurance and Medicaid managed care coverage.

However, 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. This is reflected in the trend of emergency room admissions over the past few years (figure 3), wherein there has been a sharp decrease in the number of youth admissions once MCRT expanded their services in 2016, but has remained steady from 2017 to 2018.

Additionally, The Harbor continues to provide services to youth and families as a juvenile assessment center devoted to diminishing the number of youth in the juvenile justice system through early identification of risk and with early intervention. Ongoing expansion plans have been supported by multiple agencies, including: Clark County Juvenile Justice Probation Services, Clark County Department of Family Services, DCFS Mobile Crisis/Mental Health, Clark County School District, medical professionals, Southern Nevada Adult Mental Health Services, and the Nevada Division of Welfare and Supportive Services.

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

Indicators: *Written regulation or policy and numbers trained*

CURRENT STATUS: No progress

As of yet the Commission has not developed policy or regulations related to hospitalization although it does review all seclusion and restraints from hospitals and facilities statewide. The Northern and Rural Regional Behavioral Health Policy Board is submitting bill drafts to address procedures related to involuntary hospitalizations and proposing to change some of the language in NRS 433.324 related to mental illness, discharge planning, and risk of harm.

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

Indicator: *Proportion of public and private providers adopting standardized tools*

CURRENT STATUS: Some progress

Since 2016, DCFS has been providing training and access to the Nevada Child and Adolescent Needs and Strengths Tool (CANS). The Nevada version of this tool was developed with stakeholders from child serving agencies and interested parties across Nevada. The Nevada CANS initially consisted of two versions, one for younger children and one for older youth. The revised version NV-CANS 2.0 was recently released and it is for all ages with a separate module for younger children as well as modules that are completed depending on whether those particular situations are relevant to the child and family. DCFS has sponsored live trainings with the CANS developers as well as webinars. DCFS System of Care has funded behavioral health professionals across the state becoming certified to use the CANS through successfully training on an online learning platform. Nevada Medicaid will be adopting the CANS as a measure of service intensity for youth in early 2020.

The CANS is a collaborative tool that is used to assist the behavioral health professional in working with the family to decide on the needs that the family consider of primary concern and that they would like to resolve. The strengths of the family are identified through the CANS and are built upon to help resolve the needs. This collaborative service planning process is known as Transformational Collaborative Outcomes Management (TCOM). DCFS is seeking to collaborate with child serving agencies across the system of care to develop TCOM implementation teams and garner commitment from decision makers to utilize this process as well as to develop a shared data platform in order to make transition from one service provider to another more streamlined for families. The initial kickoff meeting had approximately forty supervisors and managers from across the state. Further efforts to enlist support will be taking place throughout 2019 and will also seek to involve the private sector as well as managed care providers.

Objective 3.5 Coordinate intake, crisis intervention, service planning and service delivery across public and private providers at a neighborhood level, beginning with organized information and referral networks.

Indicators: *Description of coordinated system; number of youths linked with crisis or other services*

CURRENT STATUS*: *No progress

Currently DCFS Mobile Crisis Response Teams (MCRT) provides crisis triage and stabilization services as well as referral information. MCRT responds regardless of insurance status except for persons insured with a particular managed care Medicaid who prefers to do their own response. MCRT assists persons in connecting with their provider if they have private coverage once they are stabilized. DCFS hopes to continue to expand these services. There are no other coordinated activities as described in this objective.

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.

Phase 1/2/3 Objectives and Strategies

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

Indicators: *Increased participation; increased funding; amended legislation*

CURRENT STATUS: Some progress

The regional and state consortia have played active roles in the development of the strategic plan for the System of Care Expansion Grant as the core of the Children's System of Care Behavioral Health Subcommittee in conjunction with members of the Behavioral Health Commission. The subcommittee guides the implementation of the grant and the Nevada System of Care and members are involved in all workgroups. The 10-year plans and the priorities of each consortium are considered and align with the goals of the grant. Furthermore, the Regional Policy Boards has agreed to accept the goals of the consortia as well.

Objective 4.2 Develop and implement a plan for local system management by: (a) establishing a formal relationship between CCCMHC and a system management entity; (b) establishing the role of the local system management entity in providing integrated case management, crisis intervention, provider networks, and intake/referral.

Indicators: *Identification of funding support; contracts and/or Memorandums of Understanding*

CURRENT STATUS: No progress

Members of the CCMHC have been involved in the strategic planning for the System of Care as well as providing information to share their goals with the Southern Nevada Regional Behavioral

Health Policy Board so they can be in alignment where children are concerned. DCFS as a care management entity and children's mental health authority are still in the conceptual stages and nothing is formalized at this point. Changes in funding through a state plan amendment as well as a waiver are being considered.

Objective 4.3 develop a partnership between the local system management entity, the CCMHC and the Statewide Family Network to facilitate the implementation of cross-agency training and other workforce development activities.

Indicators: *Number of annual trainings, number and type of participants*

CURRENT STATUS: Substantial progress

Since the Division of Child and Family Services was awarded the System of Care Expansion Grant, there have been efforts to increase trainings available to behavioral health providers and agency partners in the system of care. Initially these trainings were primarily done face to face which limited capacity as well as being inconvenient for providers in the rural areas. The System of Care has since partnered with the Center for Applied Substance Abuse Technology (CASAT) to record these trainings and make them accessible for anyone with access to the internet. Whenever possible, DCFS co-trains with staff from Nevada PEP, the statewide family network partner, in order to add the family perspective. If there are evidence-based trainings that are proprietary and only available from outside trainers or consultants, the grant has funded these trainings across the state whenever possible. Models that have Train the Trainer components are favored due to their ability to be sustained locally. To date, at least 1,454 persons have attended trainings, of course some of these could be the same person attending different trainings. Examples of some of the trainings sponsored during the tenure of the grant as part of workforce development include: Trauma Informed Care, Together Facing the Challenge, Child and Adolescent Needs and Strengths, Transformational Collaborative Outcome Management, Child Parent Psychotherapy, Compassion Fatigue, Cultural and Linguistically Appropriate Services, Wraparound, System of Care Overview, Working with LGBTQ+ Youth. These trainings as part of the workforce development were discussed in meetings concerning the development of the goals of the strategic plan for the System of Care in which several CCMHC members were active participants.

Objective 4.4. The CCCMHC will identify: (1) The full array of services needed to meet the needs of children with serious emotional disturbance; and (2) A local approach to service delivery that is based on proven family-driven, system of care principles.

Indicator: *Integrated management structure; Memorandums of Understanding*

CURRENT STATUS: Minimal progress

As previously stated, members of the CCMHC participate on the workgroups of the System of Care Subcommittee. That group has used information from a Nevada Gaps Analysis and a System of Care Readiness Implementation Survey in order to identify needed children's behavioral health services in Nevada. Funding for some of these services can best be achieved through a Medicaid waiver and amendments to the state's plan. Provider standards have been created in order to ensure that

providers who choose to participate in the System of Care uphold nationally recognized core principles and values.

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.

Indicators*: Increase in number and types of families screened referred and linked with services*

CURRENT STATUS: Some progress

As outlined in the strategic plan for the System of Care grant, DCFS Children's Mental Health continues to plan to eventually provide a limited number of direct services and move to more of an oversight function as well as offer training, care management, and assistance to behavioral health providers who are reimbursed through public funds. The process for this shift into a more regulatory role is in the initial stages of planning. DCFS continues to provide crisis response, assessment, stabilization, and referral as it expands its Mobile Crisis Response Team to be available 24 hours.

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

Indicators*: Increase in blended/braided funding of intensive case management; standardization of service contracts*

CURRENT STATUS: No progress

DCFS is working with DHCFP and DBPH to develop a plan for DCFS to become a care management entity and the Children's Mental Health Authority.

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

Indicator: *Progress toward implementing statewide system*

CURRENT STATUS: Some progress

As previously discussed in Objective 3.4, the Nevada Child and Adolescent Needs and Strengths Tool is going to be adopted by Medicaid as the measure of service intensity for SED youth in early 2020. This tool will provide the ability to streamline referrals as well as transitions between providers and will lead to standardized outcome measures across the state. The use of this tool and its collaborative service planning process (TCOM) will benefit families and provide a common language among service providers. Discussions concerning a shared data platform will also contribute to continuity of care and indicators of performance.

Objective 4.8 Through the local system management entity, develop performance-based contracts with providers linking standards of care, outcomes and reimbursement.

Indicators: *Written standards and policies, provider contracts, performance and outcome reports*

CURRENT STATUS: Some progress

The System of Care Expansion Grant through its workgroups has adopted the SAMHSA System of Care Values and Principles and has incorporated those into its agreements with providers. If DCFS becomes the Children's Mental Health Authority and Care Management Entity as proposed, providers will be held to those standards. Mechanisms for provider enrollment, utilization management and evaluation of outcomes will be created to facilitate holding providers accountable for these standards.

Due to previous concerns about possible abuse of mental health rehabilitative services, Medicaid is implementing a moratorium on new providers while seeking input from stakeholders regarding the possibility of creating and requiring a certification process for individual providers of these services. This will likely create standards for these providers as well.

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

Phase 1/2/3 Objectives and Strategies

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

Indicators: *Number and type of students screened; decrease on YRBS risk indicators*

CURRENT STATUS: Minimal Progress.

The Clark County School District does not yet have a systematic plan for the universal screening of middle and high school students for behavioral/social functioning. However, universal screening is recognized as one of the 7 pillars of a Multi-Tiered System of Support (MTSS) framework, as advocated by the Nevada Department of Education (Integrated Student Supports) and incorporated in the district's endorsed MTSS framework.

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

Indicators: *Number of elementary school children screened annually, and number linked to services*

CURRENT STATUS: Minimal Progress

Lucille Rogers ES is implementing a pilot program for universal screening with the entire student population (i.e., over 900 students) in 2018-2019 to detect behaviorally at-risk students. The instrument being used is the Student Risk Screening Scales which differentiates for internalizing versus externalizing behaviors.

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

Indicators: *Proportion of physicians using standardized tool*

CURRENT STATUS: Some progress

In September of 2018, The Division of Child and Family Services was awarded a five-year grant from the Health Resources and Services Administration (HRSA). The Pediatric Mental Health Care Access Program provides funding to promote behavioral health integration in pediatric primary care by supporting the development of new or the improvement of existing statewide or regional pediatric mental healthcare telehealth access programs. Plans include the development of an online database and expanded communication mechanisms as well as consultation teams and trainings to support primary care providers' knowledge of children's behavioral health. This program hopes to improve access through telehealth to treatment and referral services for children and adolescents with identified behavioral health disorders, conduct training, and provide technical assistance to primary care providers to enable them to conduct early identification, screening, diagnosis, and treatment for children with behavioral health conditions. This project will also capitalize on Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. EPSDT covers regular screening services (checkups) for infants, children and adolescents. These screenings are designed to identify health and developmental issues as early as possible.

DCFS Planning and Evaluation will be responsible for overseeing the data collection and evaluation related to this grant. Relevant indicators will be provided to stakeholders and the Nevada State Consortium that will serve in an advisory role. By achieving the goal of increased physician screening and recognition of existing mental health disorders, families would have greater access to services to address existing issues that may place children at risk of out of home placement. In addition, this grant will increase the service array offered to families; particularly home and community-based services.

Objective 5.4 Through education funding, implement evidence-based preventative programs for bullying prevention, social/life skills training, and positive behavioral supports in public schools by (a) inventorying current programs; and (b) expanding successful programs.

Indicators: *School policies and/or regulations; number of schools with programs and number of students participating*

CURRENT STATUS: Substantial Progress

The Positive Behavioral Interventions and Supports (PBIS) Project within the Clark County School District (CCSD) continues to grow. For the 2018-2019 school year, 83 schools are participating in the pilot project that provides staff training, external coaching and technical support, and program evaluation feedback to school staff.

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. Training with representatives from all CCSD schools is expected to begin in January 2019 and continue through spring 2020. Training will focus on overview of MTSS-Behavior (i.e., fundamental principles and practices associated with PBIS), awareness of implicit bias, promoting positive student engagement practices, better tracking of student behavior with an emphasis on prevention and positive intervention practices, and development of de-escalation skills. CCSD is also continuing to advocate for inclusion of social emotional learning curriculum in Tier I instruction and

services for students. For the 2018-2019 school year, approximately 110 elementary schools are implementing the Sanford Harmony Social Emotional Learning Program, either school-wide or selectively (e.g., for a targeted grade).

For the 2018-2019 school year, the Student Services Division has implemented a new support plan for specialized programs serving students with disabilities identified with serious emotional disturbance. Benefits include licenses for classroom teachers to access LEAPS social emotional learning resources and well as to request assistance (i.e., classroom-based or assistance with an individual student) through the Linking Instructional Needs and Key Supports (LINKS) Program. LINKS also provides district-wide professional learning opportunities for teachers on various topics including trauma-informed care, setting up classrooms, and student/classroom behavior management.

In addition, a new safety reporting program began in the fall of 2018, 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.

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

Indicators: *Number of schools and participants*

CURRENT STATUS: No Progress

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

Indicators: *Proportion and type of staff trained annually*

CURRENT STATUS: **Substantial Progress**

The Clark County School District has well-established policies and procedures pertaining to crisis intervention with students presenting with suicide ideation. First responder responsibilities center on a core "school-based intervention team" composed on school counselors, school nurses, school psychologists, and safe school professionals/social workers. All school-based intervention team members are required to complete training in the district's mental health crisis intervention model and suicide Intervention (SI) Protocol. Courses are also offered for building effective school-based intervention teams. These training are delivered through the Department of Student Threat Evaluation and Crisis Response (DOSTECR) and the Mental Health Transition Team (MHTT), both specialized sub-departments of Psychological Services. Multiple comprehensive and refresher courses for the SI Protocol are offered across the school year. SI Protocol training has also recently expanded to include interested school administrators (i.e., deans, assistant principals, and principals).

For centralized services, district efforts are increasingly focused on developing additional professional learning opportunities that focus on mental health needs of students. Considerations include system expansion of skills-based trainings (e.g., CBITS and Bounce Back; Trauma 101;

Psychological First Aid; positive student engagement practices; behavioral de-escalation skills; self-care by students and staff; etc.

Objective 5.7 Families will have regular access to effective, low cost parent training and education programs at neighborhood-based locations across the county.

Indicators: *Number of sessions and participants annually.*

CURRENT STATUS: Substantial Progress

Nevada PEP provides parent education workshops and webinars for families of children at-risk of and with mental health needs. In 2018, Nevada PEP conducted 22 workshops covering Positive Behavior Interventions, Bullying and Attention Deficit Hyperactivity Disorder, with a total of 211 parents attending the trainings.

Prevent Child Abuse Nevada (PCANV), housed at the Nevada Institute for Children's Research & Policy at UNLV, also provides free trainings to parents and professionals throughout the community. Working with various community partners, PCANV provides trainings in *Recognizing and Reporting Child Maltreatment, Toxic Stress and Child Development,* and how to *Choose your Partner Carefully*. These trainings teach parents, and professionals who work with parents, evidence—based practices on how to identify, report, and prevent child maltreatment in all its forms, as well as provide community-based resources for families and caregivers. In 2018, PCANV conducted 26 trainings with a total of 275 parents in attendance.

The department of Family and Community Engagement Services (FACES) recognizes that family engagement is a partnership recognizing the collaboration between family, school, and community to make sure every single student succeeds. FACES has District-wide Family Engagement Centers (FECs) that provide families the opportunity to improve family capabilities. FECs establish and nurture relationships with one common goal—student achievement. FECs offer parents and families academic support, classes and workshops in a variety of topics, and access to community resources. The FECs are located at nine elementary schools and one middle school and are staffed with two Family Learning Advocates (FLAs). All University of Family Learning workshops and classes are free and open to the community. Free early learning activities are available for young children while their parents/caregivers are in class.

The Clark County Department of Family Services (DFS) provides over 200 parent education programs yearly throughout Clark County to over 3,000 parents, caregivers and youth, using evidence-based curricula such as the Triple P Program for children aged 2-11 years, the Teen Triple P Program, and the Stepping Stones Triple P Program for parents of children with a disability. Families can access the Primary Triple P Program of brief 1-to-1 parenting consultations as well as the group programs. Through their Parenting Project, DFS also provides evidence-based programs for high-risk families, which include: Nurturing Parents and Families for parents of children six months through four years of age, the ABCs of Parenting for parents of children aged 5-10 years, the Nurturing Skills for Families in Substance Abuse Treatment and Recovery, the Baby care Program for expectant and new parents, and the Staying Connected with Your Teen program for parents and youth aged 11-17 years.

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

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

Indicators: *Proportion of youth screened*

CURRENT STATUS: Some progress

The Clark County Department of Juvenile Justice Services utilizes the Massachusetts Youth Screening Instrument (MAYSI-2), a brief screening instrument (52 questions) designed to identify potential mental health needs of adolescents involved in the juvenile justice system. All detained youth receive this screening that uses seven scales to assess substance use, irritability, depression and anxiety, suicidal ideation, somatic complaints, thought disturbances, and trauma. This is also the process at Summit View.

Youth who are seen at The Harbor who present with behavioral health symptoms are screened utilizing the Crisis Assessment Tool (CAT) if they are seen by DCFS Mobile Crisis staff. The CAT allows for the rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community. Additionally, The Harbor has expanded to a second location in order to serve more youth, and has included routine screening for those seen at both locations.

In child welfare, the Nevada Initial Assessment (NIA) is completed upon initial contact with a family. The NIA assesses risk related to abuse and/or neglect as well as strengths and the child's functioning. Youth who are determined to have mental health needs and are going to require a higher level of care placement are assessed for serious emotional disturbance and their strengths and needs through the use of the Child and Adolescent Needs and Strengths tool (CANS). The Division of Child and Family Services provides access to training in the CANS for any behavioral health provider, juvenile justice staff, or child welfare staff who need to utilize the tool to aid in decision making.

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

Indicators: *Annual Medicaid expenditures for Clark County outreach and screening*

CURRENT STATUS: Minimal progress

United Citizen's Foundation has been working with several of the schools and they are enrolled as a Special Clinic with SAPTA certification. As previously mentioned, they are onsite at Hollingsworth

Elementary, Valley High School, Rancho High School and they also have a clinic in North Las Vegas. Under this model, they provide behavioral health services.

Nevada Medicaid program staff is looking at the expansion of the School Based Child Health Services policy. In 2014, CMS reversed their guidance on a school's ability to bill for services outside of an IEP and will allow for reimbursement of services for the general education population. Nevada's Medicaid State Plan currently does not allow for this, but the Division of Health Care Financing and Policy is working with the school districts and CMS to make the necessary changes. This would allow for screenings, behavioral health services, etc. that the school district has the capacity to provide and are covered under our State Plan. Nevada Medicaid is also exploring the possibility of allowing for the billing of school psychologists.

Objective 5.10 Partner with the Nevada Office of Suicide Prevention to train child welfare caseworkers and probation and parole officers in the early identification of youths with behavioral health issues and suicide risk.

Indicators: *Number youths identified and linked with services by trained caseworkers and parole/probation officers*

CURRENT STATUS: Minimal progress

According to the Clark County Department of Juvenile Justice Services, 70% of youth who come in contact with the department meet criteria for at least one mental health disorder and of those youth, 60% have a co-occurring substance use disorder. The department trains all probation officers in Shield of Care, an eight-hour, research-informed curriculum that teaches juvenile justice staff strategies to prevent suicide in correctional facilities. The program emphasizes connection to youth and communication among staff as well as appropriate policies and procedures. It also helps officers to understand risk and protective factors associated with self-harm. In 2018, 130 DCFS Staff and 521 Police Officers were trained in Clark County.

DCFS Youth Parole utilizes Shield of Care in the institutional settings. While specific training in suicide prevention has not formally been offered annually to community-based Youth Parole officers, there are staff members available within DCFS who can provide suicide prevention and awareness. All youth receive a mental health assessment prior to entering the correctional institutions. Summit View utilizes the Massachusetts Youth Screening Instrument (MAYSI-2) described earlier in Objective 5.8 which is also a suicide screening and the SAVRY (Structured Assessment of Violence Risk in Youth). All youth have access to mental health services while incarcerated at Summit View.

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

Phase 1/2/3 Objectives and Strategies

Objective 6.1 Establish state or local funding for Continued Public Awareness Activities

Indicators: *Number, type and outcomes of awareness activities yearly*

CURRENT STATUS: Minimal progress

CCCMHC has supported awareness activities through approximately $3,500 from its yearly budget of state general funds. These activities are coordinated by the CCCMHC's Public Awareness and Behavioral Health Workgroup. The workgroup maintains a website (CCCMHC.org) to use for promoting awareness of children's behavioral health needs and services and providing information. DCFS's System of Care Expansion Grant was also used to create a website and a newsletter promoting SOC principles and practices as well as grant activities. The SOC newsletter reaches approximately 1100 people, Facebook followers and Twitter followers equal nearly 300.

Over the past year, CCCMHC has increased awareness activities by distributing awareness materials through consortium members and partner organizations (500 pens, 500 pins, 500 car magnets, over 500 brochures) and utilized paid social media advertisement which reached over 10,000 people. Annual awareness activities have been centered on the National Children's Mental Health Awareness Day in May which include a mental health symposium, a poster contest for youth to engage in increasing mental health support in the community, and distribution of mental health day yard signs. The 1st Annual Southern Nevada Summit on Children's Mental Health & Injury Prevention took place on May 10 & 11, 2018 at the Cambridge Recreation Center in Las Vegas. Over these two days, five sessions were offered on mental health and injury prevention at no cost to community members and mental health professions. Approximately 50 individuals attended sessions over the 2 days and favorably on the content and the presenters. This event was sponsored by other community partners including the *Nevada Executive Committee to Review the Death of Children*, the *Nevada Coalition for Suicide Prevention*, *Montevista & Red Rock Behavioral Health Hospitals, and the Nevada Office of Suicide Prevention*.

In addition to the symposium, the CCCMHC celebrated Children's Mental Health Awareness Day last year with a community reception open to the public, where winners of the 2018 STOP the Stigma! Youth Poster Contest were announced. Refreshments were provided courtesy of Nevada PEP and Creative Solutions Counseling Center. During the reception, a panel was convened of mental health professionals, parent advocates, and youth to discuss mental health needs and current services in Southern Nevada. This panel solicited ideas from attendees about how to improve the quality and access to mental health services for youth. No evaluations were completed for this session. Finally, over 50 yard signs were distributed to agencies around Southern Nevada that were displayed in May to increase awareness about children's mental health.

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

Indicators: *Nevada Department of Education Regulations*

CURRENT STATUS: No Progress

NRS 389.021 requires the establishment of regulations for study in the prevention of suicide. Nevada Department of Education regulations (NAC 389.455) include the avoidance of self-harm as a requirement of the high school curriculum but do not include mental health awareness and suicide

prevention as required curriculum components. However, the Clark County School District has voluntarily incorporated suicide prevention awareness into its secondary school health classes by requiring the implementation of the Signs of Suicide Educational Program. This program teaches youth to "acknowledge, care, and tell someone" if they or a friend have feelings of depression or thoughts of suicide. Additionally, the Department of Education has partnered with the Office of Suicide Prevention and the school district to bring Safe Talk and Youth Mental Health First Aid training to school staff as well as adults that work with youth in other settings across the state. Training in these areas enable adults to better detect and respond to mental illness in school age children, and to encourage these youths and their families to seek treatment. To determine how this program is being implemented within individual schools in the school district and better understand the needs of schools, CCCMHC - in partnership with the Nevada Office of Suicide Prevention and Nevada Institute for Children's Research & Policy – is conducting an assessment of suicide prevention curriculum use in all schools within Clark County (including private and charter schools). The results of this evaluation will help CCCMHC's future efforts to ensure resource allocation and proper program implementation among CCSD schools.

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

Objective 6.3 CCCMHC will work with professional associations, Southern Nevada Health District, and Nevada PEP to support the development and dissemination of mental health awareness information to parents at primary care settings.

Indicators: *Proportion of primary care facilities with available materials*

CURRENT STATUS*: *Some progress

CCCMHC members conduct ongoing outreach to increase the awareness of children's mental health needs in Clark County. Nevada PEP continues to support the dissemination of suicide prevention awareness brochures and other materials at local health fairs and through media outlets. The Southern Nevada Health District uses its website to promote children's mental health awareness materials produced in collaboration with the CCCMHC. In 2018, the Office of Suicide Prevention in conjunction with the Nevada Coalition for Suicide Prevention directly reached 8,767 community members through 226 separate events in Southern Nevada. Each year, members disseminate the most recent findings of the CCCMHC to local advocacy and professional organizations such as the Nevada Psychological Association and the Children's Advocacy Alliance as well as to local and state policy makers, and members of the judiciary. As previously mentioned in Objective 5.3, DCFS Children's Mental Health has recently been awarded a five-year grant from the Health Resources and Services Administration (HRSA). The Pediatric Mental Health Care Access Program provides funding to promote behavioral health integration in pediatric primary care. Supporting these physicians would increase their awareness and likely lead to them providing more information to parents concerning behavioral health.

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

Current Membership

Dan Musgrove, Chairperson
Business Community Representative

Amanda Haboush-Deloye, Ph.D., Vice-Chairperson
Nevada Institute for Children's Research & Policy

Jennifer Bevacqua
Family Focused Treatment Association

Tonia Kapel
Nevada Division of Aging and Disabilities Services

Richard Egan
Nevada Office of Suicide Prevention

Charlene Frost
Parent Representative

Jacqueline Harris
Private Provider of Behavioral Health Services

Lisa Linning, PhD
Clark County Department of Family Services

Jim Osti
Southern Nevada Health District

Heather Lazarakis
Nevada Division of Health Care Financing & Policy

Karen Taycher
Nevada Parents Encouraging Parents

Robert Weires
Clark County School District

Cesar Lemos
Clark County Department of Juvenile Justice Services

Dana DiPalma
Las Vegas Metropolitan Police

Timothy Jeider
Jeider Limited

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.

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