Clark County Children's Mental Health Consortium

Seventh Annual Plan

Clark County Children's Mental Health Consortium Members:

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Jennifer Bevacqua, Nevada Youth Care Providers Association
Lisa Durette, M.D., American Academy of Child and Adolescent Psychiatry
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July 2008

TABLE OF CONTENTS

Clark County Children's Mental Health Consortium

Seventh Annual Plan

Executive Summary

During Fiscal Year 2007-2008, the Clark County Children's Mental Health Consortium has been working to fulfill the legislative requirement of NRS 433B and to strengthen the local partnership working toward an integrated system of behavioral health care for the children and families in Clark County.

At least 80 individuals, including Consortium members, Clark County stakeholders, providers and parents have actively participated in developing this year's plan.

The Seventh Annual Plan addresses the following areas:

- Provides **updated** information on the needs of Clark County children with the most serious and life-threatening behavioral health problems

- Provides **new** information on needs for improved infrastructure to address the behavioral health needs of Clark County's children.

- **Updates** the information about the behavioral health needs of Clark County's Children in the child welfare system, the juvenile justice system, and the public school system;

- Provides **specific recommendations** to address the CCCMHC's three priority goals for service delivery improvement:

    1. ***To improve public awareness of mental health, reduce stigma, and increase support for behavioral health services and skill building activities that promote behavioral wellness;***

    2. ***To improve access to needed mental health services with initial efforts focusing on improved crisis services and early access to needed intervention;***

    3. ***To improve the infrastructure and coordination across and within systems.***

The following table summarizes the CCCMHC's Seventh Plan Recommendations.

Clark County Children's Mental Health Consortium
Seventh Annual Plan Recommendations

New Funding Recommendations		
Identified Need	**Public Awareness, Early Identification and Prevention**	**Desired Outcome**
Hundreds of at-risk preschoolers in Clark County need preventative services	***Recommend new state funding for CCSD's School-based Early Childhood Program***	Reduce needs for special education and treatment services upon entry into public schools
Elementary School Students with behavioral health problems score below proficiency in academic achievement and are less likely to be promoted	***Recommend funding for early screening and intervention to elementary school students with behavioral health problems***	Early identification and treatment improves academic achievement and reduce the need for later more costly care. Costs for remedial education programs will be reduced
Identified Need	**Improved Access to Behavioral Health Services**	**Desired Outcome**
An estimated 2975 youths in the Clark County Juvenile Justice System with serious emotional disturbance are unserved or underserved	***Recommend DHHS provide funding to expand the Wraparound in Nevada Program to serve an average daily census of 100 youths with serious emotional disturbance from the Clark County Juvenile Justice System***	Youthful offenders will have access to services proven effective in reducing symptoms of mental illness; preventing re-offenses, and improving academic performance Residential treatment and commitment costs will be reduced. Community safety will be enhanced.
Waiting lists for most publicly funded children's behavioral health and social services	***Recommend that the state and county expand programs to fund a sixth Neighborhood Center in metropolitan LV***	Reduction in waiting lists for services. Improved access to community-based services Reduction in utilization of residential care
100 more families each year need services while state/federal funding decreases	***Recommend that the State of Nevada create a dedicated funding source for expansion of family-to-family support services***	Family-to-family support services have been proven to decrease stress on families and improve outcomes for children with SED
Almost 40% of uninsured youths discharged do not get needed aftercare services. Almost 1/3 need emergency services following discharge. Over half are still uninsured after discharge	***Recommend that DCFS expand family-to-family support and provide additional psychiatric services for uninsured youths discharged home from DCFS' Desert Willow Treatment Center***	Improved rates of obtaining needed aftercare services and healthcare coverage. Reduction in recidivism rates and need for emergency services
Clark County's 2008 Child Welfare Service Array Assessment found a lack of support for maintaining children at home and a need for flexible funding	***Recommend that DHHS and Clark County increase flexible funding to provide behavioral health services and supports for children in the child welfare system to remain at home.***	Increase rates of reunification for children placed in the child welfare system; increased ability to maintain children at home. Reduced costs for foster care and other placements.
In 2007, over 1100 youths entered local emergency rooms for behavioral health issues, a 53.1% increase over 2005. Nearly half were suicidal, psychotic or depressed. 52.6% were discharged home with only a referral for treatment.	***Recommend that DHHS increase funding and provider capacity for mobile crisis intervention services to all youths entering emergency rooms for behavioral health issues***	Youths with serious behavioral health needs will have access to services proven effective in preventing emergency room visits and need for hospitalization Emergency rooms will be more available for medical crises, costs to public agencies will be reduced
2008 Child Welfare Service Array Assessment found many families were not able to access these needed services	***Recommend DCFS expand day treatment, family support and home-based services for uninsured families of youths with SED***	Improved ability to maintain children at home and to reunify them after placement in the child welfare system; Reduction in placement costs
Referrals to the CCSD Crisis Team increased 34.2% during the 2007-8 school year. Only 1% recidivated.	***Recommend CCSD provide new funding to expand capacity of their Crisis Intervention Team***	Improved access to a crisis service proven to be effective in improving school performance. Schools will be safer for all students.
Identified Need	**Improved Infrastructure and Coordination**	**Desired Outcome**
Lack of interagency, collaborative system management for Clark County Neighborhood Family Service Centers	***DHHS and Clark County provide funding or redeploy existing resources to phase in an interagency infrastructure to manage the Neighborhood Family Service Centers***	Improved access to services for families with multiple service needs. Reduced costs of service delivery through improved efficiency.
More than half of uninsured youths discharged from Desert Willow were unable to obtain healthcare coverage	***Recommend Medicaid expand eligibility to increase access to aftercare services for uninsured youths discharged from public psychiatric hospitals***	Improved outcomes for youths discharged from public psychiatric hospitals; reduction in need ad state costs for emergency services and repeat hospitalizations
Limited access to aftercare services and ongoing healthcare coverage for uninsured, hospitalized children	***Recommend Medicaid implement a waiver for children with serious emotional disturbance, including those with co-occurring emotional/ substance use.***	Improved outcomes for youths discharged from public psychiatric hospitals; reduction in need and state costs for emergency services and repeat hospitalizations
Large numbers of uninsured youths entering child welfare and juvenile justice	***Recommend Medicaid raise income level for eligibility to average of neighboring states***	Fewer placement in public systems to receive care for behavioral health needs; reduced costs

Clark County Children's Mental Health Consortium
Seventh Annual Plan Recommendations

State Agency Policy Recommendations		
Identified Need	**Public Awareness, Early Identification and Prevention**	**Desired Outcome**
Significantly fewer teens in Clark County Schools were screened for suicide risk this year by the Teen Screen Program	***Recommend Nevada Office of Suicide Prevention expand the number of teens screened in urban Clark County schools***	More teens with depression /suicide risk identified early / referred for services; reduced disruption in school performance/ attendance; fewer attempted /completed suicides
There are no programs to screen and identify teens at risk for suicide and depression in Rural Clark County Schools	***Recommend Nevada Office of Suicide Prevention expand screenings to teens in Rural Clark County schools***	Rural teens with depression/suicide risk identified early; referred for services; reduced disruption in school attendance/ performance; fewer teens attempting/ completing suicides
Only 13% of Medicaid children access behavioral health services while at least 20% are likely to have behavioral health problems	***Recommend DHHS provide support for behavioral health screening/ outreach efforts to children enrolled in Medicaid***	Increased early intervention to Medicaid children with behavioral health problems; reduction in costly out-of-home placements.
Identified Need	**Improved Access to Behavioral Health Services**	**Desired Outcome**
Long lengths of stay in emergency room and pediatric departments *without appropriate treatment* for significant numbers of children needing residential care	***Recommend DHHS facilitate direct access to psychiatric facilities for all youths needing admission by improving medical pre-screening and inpatient capacity***	Youths in crisis will receive more rapid treatment; fewer youths with behavioral health crises admitted to local emergency rooms; emergency rooms more available for medical crises; cost savings for families/agencies
Nearly 40% of youths admitted to local emergency rooms for behavioral health issues were at risk or had attempted suicide	***Recommend DCFS emphasize treatment for suicidal thoughts and gestures in mobile crisis service delivery***	More rapid crisis services for suicidal youths; more youths diverted from emergency room admission; reduced need for hospitalization
In 2007, children enrolled in Medicaid had 40% fewer visits for psychiatric services and psychotherapy as compared to 2005 figures	***Recommend that Medicaid implement steps to recruit and facilitate referrals to more providers of assessment, psychiatric services and psychotherapy***	Increased access to outpatient treatments proven to be effective; reduced need for emergency services /out-of-home placements
Limited availability of some behavioral health services to children at home	***Recommend Medicaid implement steps to recruit more providers of after school day treatment, crisis and home-based services***	Increased ability for children with behavioral health issues to remain at home; reduction in out-of-home placement costs
Identified Need	**Improved Infrastructure and Coordination**	**Desired Outcome**
Lack of specific financing and administrative plan for implement system management for Neighborhood Family Service Centers	****Recommend DHHS and Clark County identify a lead entity and financing plan for implementing the Neighborhood Family Service Center Infrastructure***	Create and implement specific implementation plan with timelines and accountable parties; more efficient and effective neighborhood-based service delivery for youth and families
2008 Child Welfare Service Array Assessment found these services are needed but difficult for families to access	***Recommend DHHS/ Clark County expand Neighborhood Centers to include Housing, Medicaid, Welfare and Private Providers***	Increased ability for children in the Child Welfare System to remain at home; reduction in out-of-home and foster care placement costs
2008 UNLV System of Care Workforce Assessment identified lack of agency support for System of Care Practices	***Recommend DHHS/ Clark County revise Neighborhood Centers Agreement to ensure adherence to System of Care Principles***	Increased adherence to System of Care Principles at Neighborhood Centers; improved outcomes for youth with multiple problems
1000 more youths with behavioral healthcare needs entered juvenile justice system in 2007, no increase in community services residential placements at all time high	***Recommend DHHS provide incentives for behavioral health providers to implement proven programs for juvenile justice youths***	Increased accessibility to services proven effective with juvenile offenders, reduction in need for out-of-home and out-of-community placements, decrease in placement costs
More than 50% of uninsured youths discharged from Desert Willow lack healthcare coverage	****Recommend DHHS streamline Medicaid application process for uninsured youths exiting Desert Willow Treatment Center***	Quicker access to healthcare coverage for needed aftercare services; better continuity of care; decreased need for emergency services
Stakeholder survey identified the need to remove fiscal barriers and develop a grievance procedure for difficult cases	****Recommend DHHS assess and reform the financing system for public children's behavioral health services***	Children with SED will have better access to all services needed to achieve successful outcomes at home, in school and in the community
Medicaid behavioral health services data provides information on the needs of children with emotional problems in Clark County	***Recommend DHCFP provide quarterly reports to the CCCMHC on utilization and outcomes of Medicaid Behavioral Health Services (Fee-for-Service, HMO, Checkup)***	Improved availability to assess the needs of the target population, improved ability to develop a plan for service delivery enhancements.
2008 UNLV Workforce Development Assessment identified need to measure improvements in state's public behavioral health services infrastructure	***Recommend State Children's Behavioral Health Consortium implement an ongoing, statewide method for measuring children's behavioral health system improvements***	Improved ability to assess the strengths and challenges of the infrastructure, improve ability to develop plans for infrastructure improvements

Clark County Children's Mental Health Consortium
Seventh Annual Plan Recommendations

CCCMHC Recommendations		
Identified Need	**Public Awareness, Early Identification and Prevention**	**Desired Outcome**
Need to overcome stigma of children's behavioral health problems and encourage help-seeking behavior	***Recommend CCCMHC continue public awareness activities***	More parents and youth will seek services early when interventions can be most successful
Identified Need	**Improved Access to Behavioral Health Services**	**Desired Outcome**
The majority of youths admitted to emergency rooms using a Legal 2000 procedures arrive via ambulance services	***Recommend CCCMHC implement training to EMS providers in alternatives to the Legal 2000 process for admission to psychiatric facilities***	Reduced unnecessary use of emergency room, law enforcement, and ambulance services; Increased parental involvement in crisis services
CCSD has difficulty linking students in crisis with their private insurance providers in a timely fashion	***Recommend CCCMHC explore strategies with the State Children's Behavioral Health Consortium to increase private insurance providers' capacity for crisis response***	Students in crisis with identified healthcare insurance resources will be able to access immediate service; resulting in better outcomes and less school disruption
Identified Need	**Improved Infrastructure and Coordination**	**Desired Outcome**
There is no lead agency responsible for meeting the behavioral health needs of youths in Clark County Child Welfare and Juvenile Justice Programs	***Recommend CCCMHC facilitate a dialogue between the state and county to identify lead agency for funding behavioral health services to youths in Clark County Child Welfare and Juvenile Justice Systems***	Funding plan to provide services for youths with serious emotional disturbance in the Clark County Child Welfare and Juvenile Justice System
2007 Stakeholder Survey (CSWI) identified the need to remove fiscal barriers and develop a grievance procedure for difficult cases.	***Recommend CCCMHC implement a barrier-busting workgroup***	Enhance effectiveness of program due to involvement by key stakeholders
Need to develop more diverse funding sources to expand wraparound service delivery	***Recommend CCCMHC continue to review and monitor demographics, suicide risk, and outcomes for youths admitted to local emergency rooms for behavioral health problems***	More children with serious emotional disturbance will be able to access wraparound service delivery and achieve success in home, school and community
Need for collaborative programs to address teen suicide prevention	***Recommend CCCMHC continue to serve as the steering committee for the Clark County TeenScreen Program with monthly updates on the progress of the Program***	Enhanced effectiveness of programs due to involvement of key stakeholders
Need to develop more diverse funding sources to expand wraparound service delivery	***Recommend CCCMHC explore community-initiated wraparound with financial support from private businesses***	Greater access to wraparound approach to service delivery; improved clinical and functional outcomes for children and families
CCCMHC Members identified many goals in common with the Juvenile Detention Alternatives Initiative in Clark County	***Recommend CCCMHC collaborate with the Juvenile Detention Alternatives Initiative to plan and implement programs for youths in juvenile justice***	Increased ability to improve community-based service delivery to juvenile offender based on improved collaboration
Limited access to aftercare services and ongoing healthcare coverage for uninsured, hospitalized children	***Recommend CCCMHC monitor the aftercare plans semi-annually for youths discharged from Desert Willow Treatment Center***	Identification and removal of barriers to aftercare services and healthcare coverage
2008 UNLV Workforce Assessment identified need for cross-agency training in evidence-based, behavioral health practices	***Recommend CCCMHC members collaborate to provide at least one cross-agency training per year in a selected evidence-based behavioral health care practice***	More successful implementation of evidence-based behavioral health services, better clinical and functional outcomes for children and families
2008 UNLV Workforce Assessment identified need for public behavioral health service providers to be trained in system of care principles and evidence-base practices	***Recommend CCCMHC encourage local university programs to incorporate system of care principles and evidence-based practices into their curricula***	Improved competence of public behavioral health service providers; more successful implementation of proven principles and practices; better outcomes for youth and families

Clark County Children's Mental Health Consortium
Seventh Annual Plan Recommendations

Local Agency and Provider Recommendations		
Identified Need	**Public Awareness, Early Identification and Prevention**	**Desired Outcome**
Number of youths screened by the TeenScreen Program is significantly lower than in previous years	***Recommend Clark County School District provide training to school administrators and deans on early screening and intervention methods for children with behavioral health issues***	Increased ability to identify and provide early treatment for youths at risk for depression and/or suicide; reduced disruption in school attendance and performance; decreases in teen suicide attempts and completions.
Over half of teens eligible for behavioral health screening were never screened due to lack of consent from parents or caregivers	***Recommend Clark County TeenScreen Program in conjunction with the Clark County School District provide education to parents on the importance of early screening and intervention for youths at risk for suicide***	Increased numbers of youth can receive screening for depression and/or suicide; improved ability to identify and provide early treatment; fewer youths experience disruptions in school performance/attendance; decreases in teen suicide attempts and completions.
Identified Need	**Improved Access to Behavioral Health Services**	**Desired Outcome**
88.6% of aftercare plans for uninsured youths included only medication and psychotherapy; only 17.9% of families of uninsured youth received family support post-discharge	***Recommend DCFS' Desert Willow Treatment Center provide education and resource materials to staff and families on effective types of aftercare services***	Improved ability to develop aftercare plans that sustain treatment gains; decreased need for readmission or emergency services following discharge; reduced costs for repeated hospitalizations or emergency services
Identified Need	**Improved Infrastructure and Coordination**	**Desired Outcome**
2008 UNLV Workforce Needs Assessment identified the need and desire for training in system of care principles and practices among public behavioral health service providers	***Recommend that staff in all local child-serving agencies receive training on system of care principles and practices in partnership with families***	Improved competence of public behavioral health service providers in proven (system of care) practices for youth with SED; improved ability to implement such practices; improved clinical and functional outcomes for youths and their families
2008 UNLV Workforce Needs Assessment identified the lack of policies and procedures as a barrier to success implementation of system of care principles and practices among public behavioral health care providers	***Recommend all local providers of public behavioral health services adopt policies and administrative procedures consistent with system of care philosophy and practices***	Improved ability for public behavioral health care providers to implement proven (system of care) practices for youths with SED; improved clinical and functional outcomes for youths and their families
2008 UNLV Workforce Needs Assessment identified the need for incentives and reward to staff using proven system of care principles in their practice	***Recommend that all local providers of behavioral health care give incentives and rewards to staff for practice consistent with system of care principles and practices***	Enhanced motivation for public behavioral health service provider staff to implement practices consistent with proven system or care principles; improved clinical and functional outcomes for youths with SED and their families; better retention and satisfaction of staff

*Recommendations carried forward from the CCCMHC's Sixth Annual Plan, 2007.

INTRODUCTION AND OVERVIEW

The Clark County Children's Mental Health Consortium has been meeting and working to fulfill the legislative requirements of **NRS 433B and to strengthen the local partnership working toward creating an integrated system of behavioral health care** for the children and families of Clark County.

The Seventh Annual Plan addresses the following areas:

- Provides **updated** information on Clark County children's needs for crisis intervention (response and stabilization);

- Provides **updated** information on the needs of Clark County's uninsured children hospitalized in state facilities;

- Provides **new** information on needs for improved infrastructure to address the behavioral health needs of Clark County's children;

- **Updates** the information about the behavioral health needs of Clark County children in the child welfare system, the juvenile justice system, and the public school system;

- Provides **specific recommendations** to address CCCMHC's three priority goals for service delivery improvement:

    1. ***To improve public awareness of mental health, reduce stigma, and increase support for behavioral health services and skill building activities that promote behavioral wellness;***

    2. ***To improve access to needed mental health services with initial efforts focusing on improved crisis services and early access to needed intervention (response and stabilization);***

    3. ***To improve the infrastructure and coordination across and within systems.***

ACTIVITIES & ACCOMPLISHMENTS OF THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Over the last twelve months since the submission of the Sixth Annual Plan, the members of the Clark County Children's Mental Health Consortium have met eight times. At least 26 workgroup meetings have also been convened to address the goals set by the CCCMHC.

A total of 71 community stakeholders have participated in these workgroups, including Consortium members, private providers, family members, and state and local agency representatives. The Workgroup Charters and Participants are shown in **Appendix A**.

For the past three years, the CCCMHC has set three overarching goals for improvement of behavioral health service delivery for Clark County's children. The CCCMHC requested new funding for specific activities needed to accomplish these goals and developed state agency and local action steps directed toward accomplishing these goals.

The funding requests and action steps accomplished this year are shown below with a check mark[1]:

1. <u>To improve public awareness of and support for behavioral health services and skill building activities that promote behavioral wellness</u>

✓ **1.1 Recommend CCCMHC continue to implement and expand its multimedia public education campaign in collaboration the State Department of Health and Human Services and the Southern Nevada Health District.**

✓ ***1.2 Recommend CCCMHC continue to serve as the steering committee for the SAMHSA-funded Youth Suicide Prevention Project.**

✓ **1.3 Recommend CCCMHC and Youth Suicide Prevention Project explore use of TeenScreen with middle school students.**

2. <u>To improve access to needed mental health services with initial efforts focusing on improved crisis services and early treatment.</u>

2.1 Recommend that DHHS seek $298,000 in new funding to sustain the early access program for young children developed by the Safe Schools, Healthy Students Grant.

[1] For more detailed information on the implementation status of the CCCMHC's goals and recommendations, see Appendix B.

2.2 Develop school-community linkage for early access to community services through strengthening school student intervention teams.

2.3 Link student intervention teams with the Neighborhood Family Service Centers.

***2.4 Recommend that DHHS seek $100,000 in new funding to sustain short-term flexible services to public school students in crisis. These funds have been previously provided by the Safe Schools Healthy Students Grant. In the future, these funds should be administered by and deployed through the Neighborhood Family Service Centers.**

2.5 Streamline medical clearance process for youths requiring emergency admission to psychiatric hospitals.

✓ ***2.6 Recommend CCCMHC continue to review and monitor demographics, suicide risk, and outcomes for youths with behavioral health disorders requiring emergency room admissions.**

✓ **2.7 Target mobile crisis intervention services to Central Las Vegas.**

2.8 Facilitate training to EMS personnel in alternatives to the Legal 2000 procedure.

3. <u>To improve the infrastructure and coordination across and within systems.</u>

3.1 Streamline and expedite Medicaid application process for uninsured youths exiting Desert Willow Treatment Center

***3.2 Expand Medicaid Eligibility to increase access to aftercare services for uninsured youths with serious emotional disturbance exiting Desert Willow Treatment Center.**

✓ ***3.3 Provide family support and additional psychiatric services for uninsured youths discharged home from Desert Willow Treatment Center**

✓ ***3.4 CCCMHC continue to monitor aftercare services and outcomes for uninsured youths served by Desert Willow Treatment Center**

✓ **3.5 Collaborate with the Department of Family Services in conducting a behavioral health service array assessment**

3.6 Conduct a needs assessment to identify those children with behavioral health problems involved in the child welfare system but remaining at home.

***3.7 Recommend that DHHS seek $1,858,900 in new funding for expansion of the Wraparound in Nevada Program (WIN) to provide intensive, community based services to an average daily census of 100 Clark County juvenile offenders.**

3.8 Develop alternative to fee-for-service Medicaid funding for expansion of family support services.

3.9 DHHS and Clark County implement Cross-system professional development for child-serving staff.

3.10 CCCMHC explore community-initiated wraparound in partnership with private businesses.

3.11 CCCMHC implement a barrier-busting workgroup.

3.12 CCCMHC facilitate a dialogue between the state and county to (a) clarify the responsibility for delivery of the needed behavioral health services to youths in the Clark County Child Welfare and Juvenile Justice Systems; and (b) to determine what data are needed to justify funding for these services.

✓ **3.13 DHHS initiate assessment and reform of the financing system for publicly funded, community-based children's behavioral health services.**

***3.14 DHHS and Clark County identify a lead entity and financing plan for implementing the Neighborhood Service Center Infrastructure, with input from CCCMHC and other stakeholders.**

***3.15 DHHS and Clark County provide $821,053 to support a jointly-funded, collaborative infrastructure for the Neighborhood Family Service Centers.**

***3.16 Recommend that the state and county seek funding to expand service capacity in order to staff a sixth Neighborhood Family Service Center.**

***Recommendations carried forward from last year's Plan.**

Other significant accomplishments of the Clark County Children's Mental Health Consortium in fiscal year 2006-2007 were:

- ✓ ***The CCCMHC expanded its public education campaign designed to:***
  1) ***increase public awareness about the prevalence and signs of children's mental health problems; and***
  2) ***encourage parents and youth to engage in early help-seeking behavior as needed.***[2]

- ✓ ***In collaboration with the Nevada Office of Suicide Prevention and the Southern Nevada Health District, the CCCMHC produced a third public service announcement which was aired through 55 local movie theaters***

- ✓ ***The CCCMHC disseminated its nationally recognized public service announcements for use in Northern Nevada and other states.***

- ✓ ***The Consortium provided training to local primary care physicians and pediatricians on screening children for behavioral health issues and suicide risk.***

- ✓ ***The Consortium distributed both English and Spanish brochures and other materials to parents and teachers through hospital emergency rooms, fire departments, schools, and the local TeenScreen Program.***

- ✓ ***The Consortium sponsored activities to promote National Children's Mental Health Awareness Day, which included assemblies at a local high school to raise awareness of behavioral health issues and distribution of public awareness materials through the media, the press, and the schools.***

- ✓ ***The Consortium served a steering committee to support the implementation of the Garrett Lee Smith Youth Suicide Grant awarded to in October, 2005.***[3]

- ✓ ***The CCCMHC supported ongoing expansion and evaluation of the Center for Health and Learning's local Columbia TeenScreen Program, recognized by President Bush's Freedom Commission as a promising practice for the prevention of youth suicide.***[4]

- ✓ ***The Consortium collaborated with Southern Nevada Health District to monitor youths admitted to local emergency rooms for behavioral health problems.***

- ✓ ***The Consortium facilitated the development of interagency protocols designed to ease the transition back into the community for youths discharged from psychiatric hospitals.***

- ✓ ***The Consortium continued to support the Children's Mental Health State Infrastructure Grant Project through participation in surveys, committees and stakeholder's meetings.***

- ✓ ***The Consortium facilitated stakeholder input into Medicaid Policy Changes required by the Nevada Division of Health Care Financing and Policy.***

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[2] For a detailed description of the 2007-8 Public Education Campaign, see Appendix D

[3] For a complete description of the Garrett Lee Smith Youth Suicide Prevention Project, see Appendix H .

METHODS FOR ASSESSING CHILDREN'S NEEDS

Over the past three years, the CCCMHC has developed a consistent method for assessing the behavioral health needs of children in the Clark County jurisdiction. First, the CCCMHC has adopted ongoing indicators of need to assess and monitor on an annual basis. Secondly, the CCCMHC has collected data to address these indicators from the data sets provided by member agencies of the Consortium. Specific recommendations have been developed to address each of the areas of need, including service delivery models and funding strategies. Included with the recommendations to address each area of need are the intended outcomes to benefit children, families, and the community

This year, the CCCMHC has assessed and provided recommendations to address the following areas of need for children's behavioral health services in Clark County:

1. ***Needs of all community children for crisis intervention services***

2. ***Needs for treatment of children in the public school system***

3. ***Needs for prevention/screening of children in the public school system***

4. ***Needs for children in the Medicaid System***

5. ***Needs for aftercare of uninsured Children with a history of psychiatric Hospitalization***

6. ***Needs for treatment of Children in the Child Welfare system***

7. ***Need for treatment of Youths in the Juvenile Justice System***

8. ***Need for family support services for families with children who have serious emotional disturbance***

9. ***Need for infrastructure to support a System of Care, Neighborhood-based, Wraparound approach to Service Delivery***

Through collaboration with its member organizations, the CCCMHC has developed standardized needs assessment indicators and data-gathering protocols for each target population described above. These standardized indicators and protocols will allow the CCCMHC to address the needs of each population on an annual basis as well as annually monitoring the community's progress in meeting these needs through service delivery improvements. For a complete description of the needs assessment indicators and data-gathering protocols for each target population, please see **Appendix C**.

CHILDREN'S NEED FOR BEHAVIORAL HEALTHCARE SERVICES

Nationally, the Surgeon General's Office highlighted the need to improve behavioral health services for children in its National Action Agenda published in 2001.[5] Whereas the U.S. Department of Health and Human Services has reported that 2/3 of children with ***any*** diagnosable disorder are not getting needed treatment, the Surgeon General's Report focused on 10% of all children who have the most serious behavioral health problems, estimating that as many as 80% were not receiving needed treatment.[6]

Figure One. The U.S. Department of Health & Human Services Substance Abuse and Mental Health Services Administration reports that at any given time, one in every five young people is suffering from a mental health problem. Two-thirds are not getting the help they need. Photo taken from the Public Service Announcement produced by the Consortium entitled "Who Can You Talk To?"

Earlier studies by the CCCMHC have confirmed that Clark County's children face the same plight as other children with behavioral health problems across the country. Moreover, the rapid population growth in Clark County presents additional challenges in meeting the needs of these children.

The Surgeon General's National Action Agenda highlights the fact that there is no primary behavioral health system for children. Where services may exist for children, they are fragmented and very difficult for families to navigate. Families of youth with behavioral health disorders face a daunting task in obtaining needed services for their children. In one study, 48% of parents reported they had to quit work to care for their children, and 27% indicated that their employment had been terminated because of work interruptions due to care responsibilities.[7]

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[5] U.S. Surgeon General National Action Agenda for Children's Mental Health. Washington, DC. Government Printing Office, 2001.

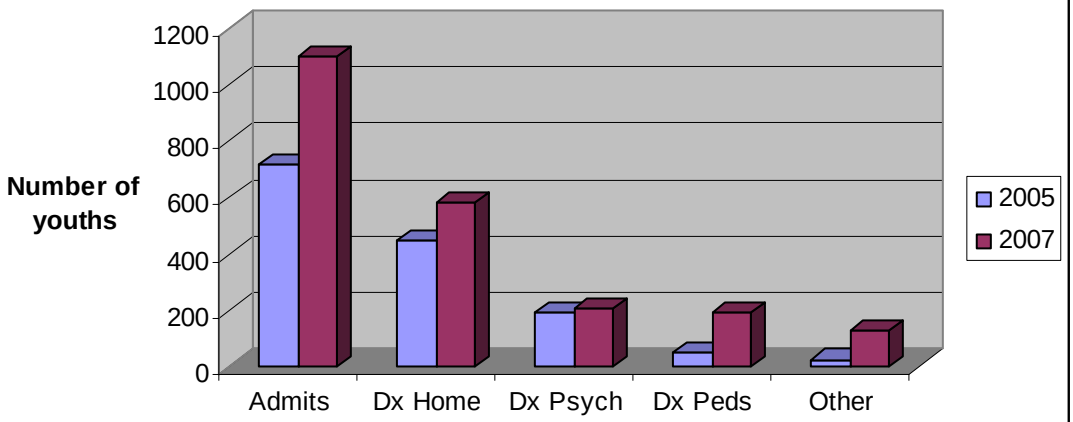
[6] http://www.mentalhealth.org

[7] Rosenzweig, J. et al. (2004). On the job strategies for taking care of business…and family. *Focal Point* 18(1), p. 5. Retrieved April 2006, from http://www.rtc.pdx.edu/pgPubsScript.php.

CRISIS INTERVENTION NEEDS

- **In 2007, 1103 youths entered local emergency rooms for behavioral health problems.[8] This is a 53.1% increase over 2005 admissions.**
- **It is estimated that at least 1088 youths with behavioral health problems will enter local emergency rooms in 2008.**
- **The majority of these youths (58.9%) are older adolescents 15-17 years old but over one-third are youths aged 10-14 years.**
- **Almost 40% had threatened or attempted suicide.**
- **100% receive an assessment of their mental health disorder**
- **52.6 % of youths seen in emergency rooms were discharged home without any immediate treatment**

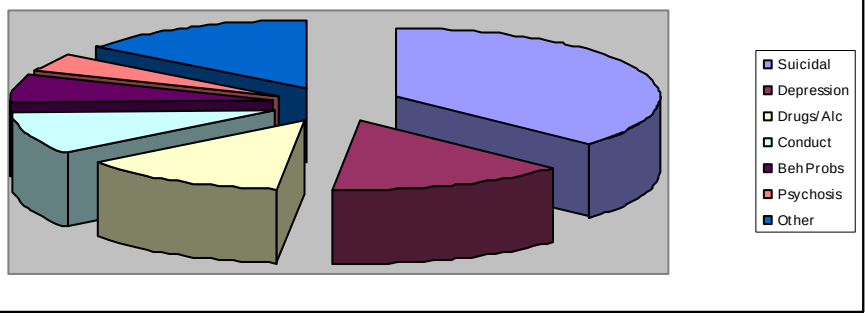
Figure 2. 2005/2007 Clark County Youth Behavioral Health Emergency Room Admissions by Discharge Disposition



- **Over 25% of youths admitted were uninsured and one-third were on Medicaid**
- **Lengths of Stay in emergency rooms were twice as long for uninsured youths as for those with Medicaid or commercial insurance benefits**
- **Nearly 200 children were admitted to UMC's pediatric unit in 2007 for lack of any appropriate inpatient placement, almost 300% more than those admitted in 2005.**
- **Nearly half of youths discharged home were suicidal, psychotic or depressed at the time of their admission to the emergency room**

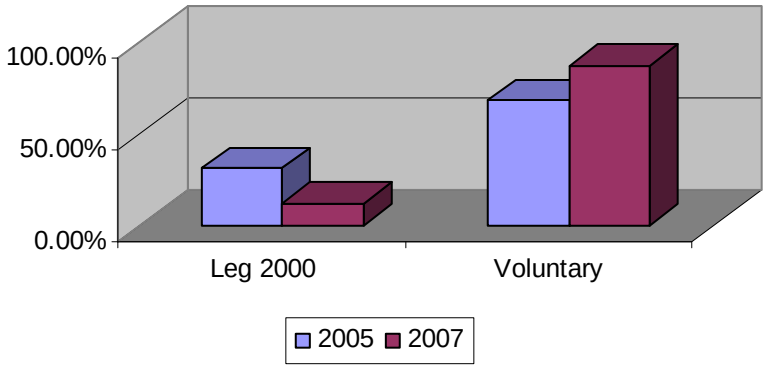
[8] For more information on 2007-8 Clark County Pediatric Behavioral Health Emergency Room Admissions, see Appendix F.

Figure 3. 2007 Youth Behavioral Health Emergency Room Admissions by Diagnosis



- **The number of youths being transported to local emergency rooms via legal 2000s has decreased from 31.6% in 2006 to 16.5% in 2007 due to training efforts by schools and police departments.**

Figure 4. 2005/2007 Clark County Youth Behavioral Health Emergency Room Admissions by Legal Status.



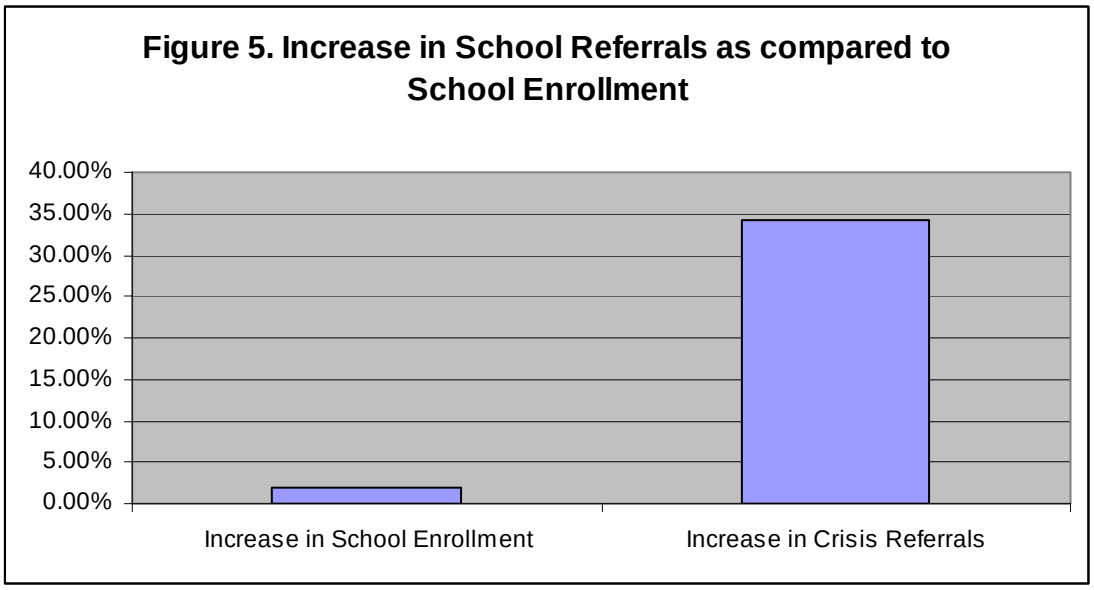
University Medical Center and Sunrise Hospital Emergency Department Staff have consistently identified the need for emergency room diversion and specialized residential care as top priorities for this population. Emergency room personnel noted that emergency room services for this population places an unnecessary burden on already busy emergency room departments without providing any benefits to the children seen.

NEEDS OF PUBLIC SCHOOL CHILDREN

What are the behavioral health needs for children in public schools and how well are these needs being met?

Students in Crisis

During the 2007-8 school year, CCSD provided mental health assessment and crisis response services to at least 267 students, a 34.2% increase over the previous school year as compared to a 3% increase in school enrollment.[9]



- **Referrals to the CCSD Crisis Team for suicide ideation more than doubled between 2006-7 and the 2007-8 school years. More students in elementary and middle school are being referred for suicide ideation.[10]**

- **Recidivism rates for crisis services are less than 1% and the majority of youths served exhibited improvements in classroom engagement, grades and attendance.**

- **Clark County School District Social Workers also received hundreds of requests for mental health services from students, especially from those students already receiving special education services.**

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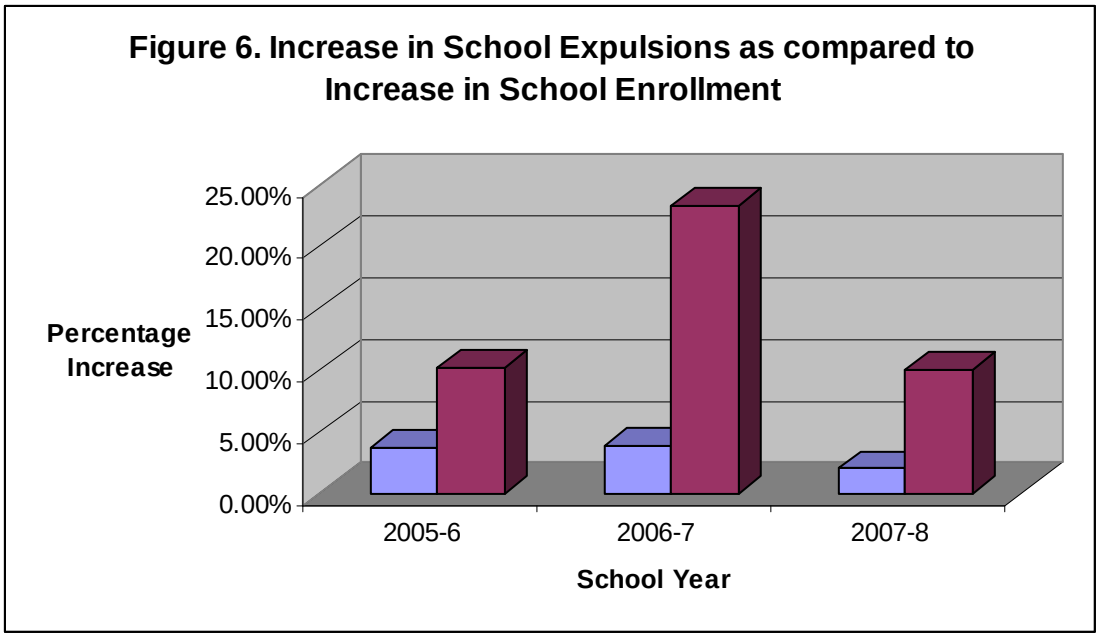
[9] For more information on crisis services provided by the Clark County School District, see Appendix I.
[10] Research suggests that early suicide risk increase with exposure to abuse, household substance abuse and violence. Dube, SR et al. (2001) Childhood abuse, household dysfunctions and the risk of attempted suicide; Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association. 286*(24), 3126-7.

- **School Expulsions have increased disproportionate to school enrollment in recent years. In the 2007-8 school year, there were 4607 student expulsions, with an estimated 24.3% for substance abuse problems.**



- **Clark County School District staff identified a need for additional capacity to provide crisis services and more responsive private insurance providers for immediate linkage to counseling and treatment.**

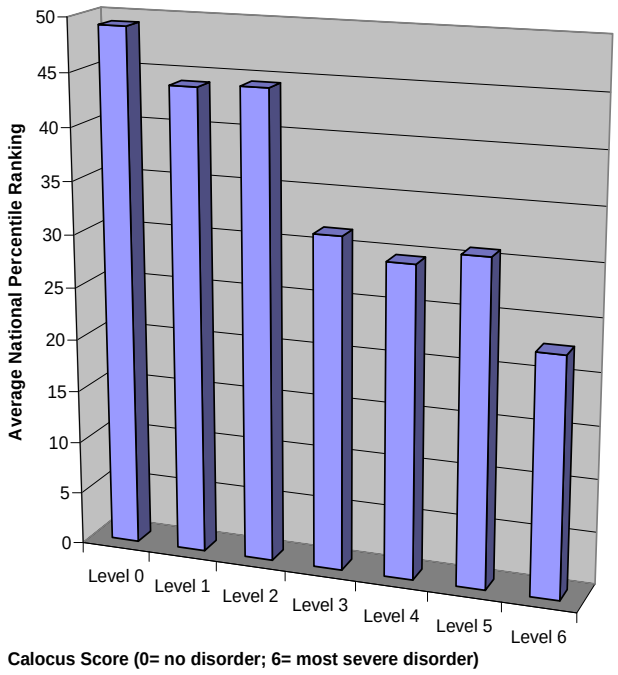
Elementary School Students

- **19.3% of all elementary school students need some level of behavioral health services and 6.0% need intense integrated services.** Of the estimated **28,184** children within the public elementary schools *this school year* who need early access to behavioral health interventions, **69% or 19,447 children are receiving no school or known identified community-based services**.[11]

[11] Prevalence estimates based on Clark County School District 2007-8 official enrollment figures and a study conducted for the Clark County Children's Mental Health Consortium Third Annual Plan, 2003.

- ***A 2007 follow-up study of a sample of 450 elementary school students identified with behavioral health problems three years ago shows they are now significantly more likely to score below proficiency in achievement and matriculation rates as compared to their peers.***[12]

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



- **CCSD provided mental health services to 198 preschoolers and their families through the Safe Schools, Healthy Students Grant during the 2007-78 school year with a sub grant to the Division of Child and Family Services, Early Childhood Mental Health Services. This program improves young children's social skills, decreases problem behaviors and reduces family stress levels as children enter elementary school.**

[12] For more information on this study, please see Appendix E

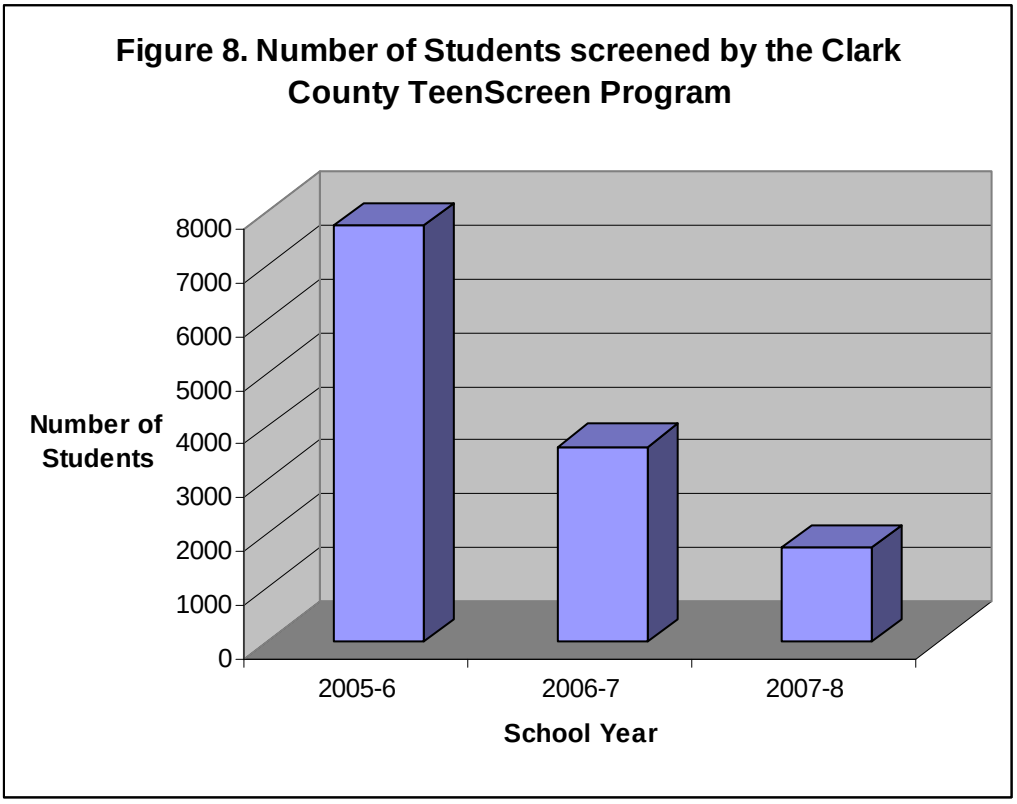
High School Students

- **26.1% of Nevada high school students reported that they felt so sad or hopeless for a period of more than 2 weeks in a row that they stopped doing usual activities** [13]

- **14.2% self-reported that they had seriously considered suicide and thought about a plan**

- **3.3% self-reported that they had caused significant self-injury by attempting suicide**

- **Unfortunately, Less than 2000 local high school students were screened for depression by the Clark County TeenScreen Program during the 2007-8 school year. This is significantly lower than in the past two years.**

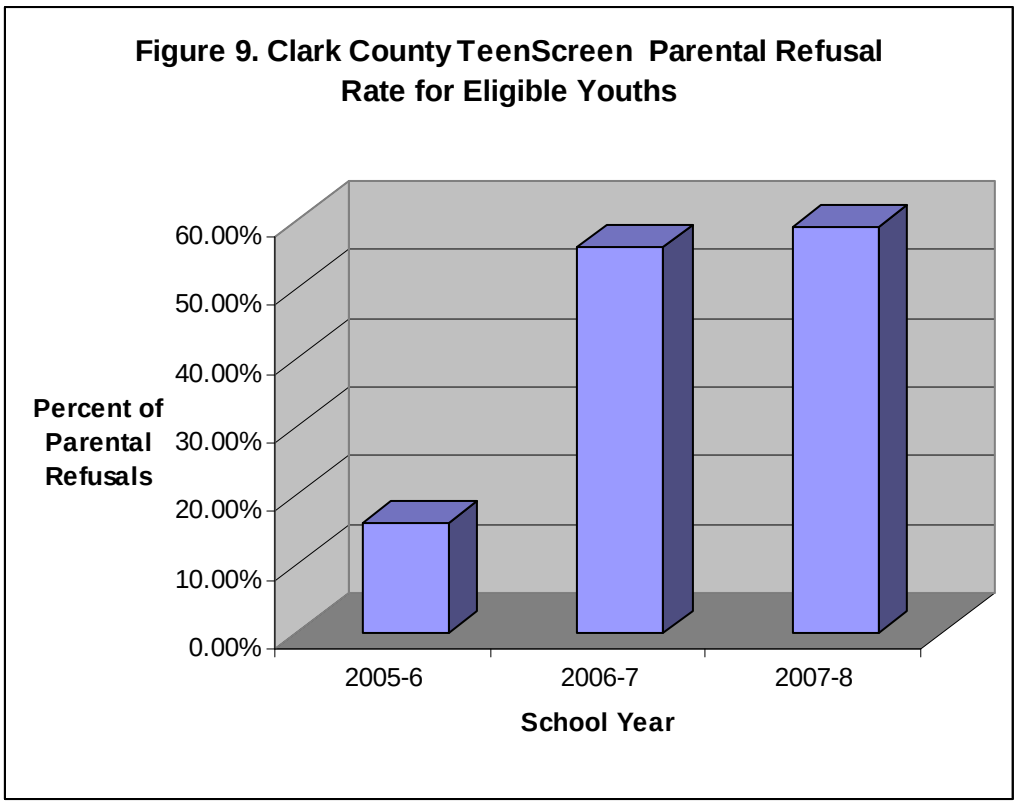


- **6.6% of high school students screened during the 2006-7 school years were identified as at risk of suicide due to clinically significant levels of depression. This identification rate is significantly lower than local screening results in previous years and also significantly lower than the national average for the Columbia TeenScreen Program. The average identification rate nationally for Columbia TeenScreen is 15-17%.**

[13] 2007 Nevada Youth Behavior Risk Survey. In Eaten, D.K. et al., Youth Risk Behavior Surveillance—United States, 2007. *MMWR Surveillance Summaries*, **57, *pp. 1-131.* http://www.cdc.gov.**

- **At least 92% of those identified at risk of suicide by the Clark County TeenScreen Program received follow-up services. This is a significant increase over last year (52%).**

- **59% of those students eligible for the TeenScreen Program in 2007-8 were never screened due to lack of permission from parents. This refusal rate is similar to the local refusal rate during the 2006-7 school year and the National TeenScreen rate, but significantly higher than in the 2005-6 school year when the refusal rate was 15.9%.**



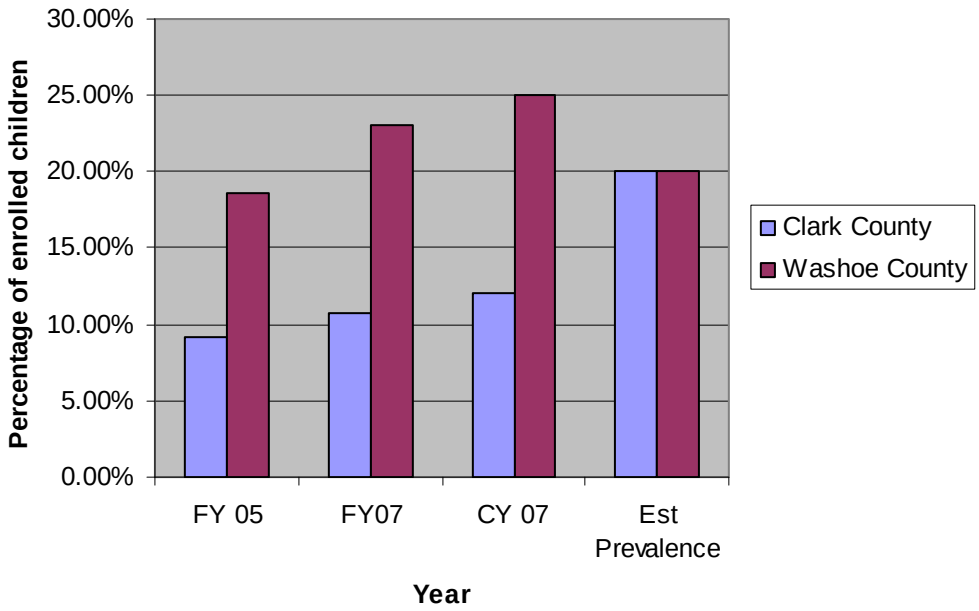
NEEDS OF CHILDREN IN THE FEE-FOR-SERVICE MEDICAID SYSTEM

- **In 2007, there were nearly 21,000 children in the fee-for-service Medicaid system. Those children covered by Medicaid have increased 13% since Fiscal Year 2005.**

- **The percentage of Medicaid children accessing behavioral health services increased to 12% in 2007. This is a 30% increase over Fiscal Year 2005, but still less than half the rate found in Washoe County (25%)**

- **It is estimated at least 20% of Medicaid children have a diagnosable behavioral health disorder and may need services.[14]**

Figure 10. Percentage of Fee-for Service Medicaid Children Accessing Behavioral Health Services



- **In 2007, there was a 44% increase in the number of Medicaid children accessing outpatient behavioral health services.**

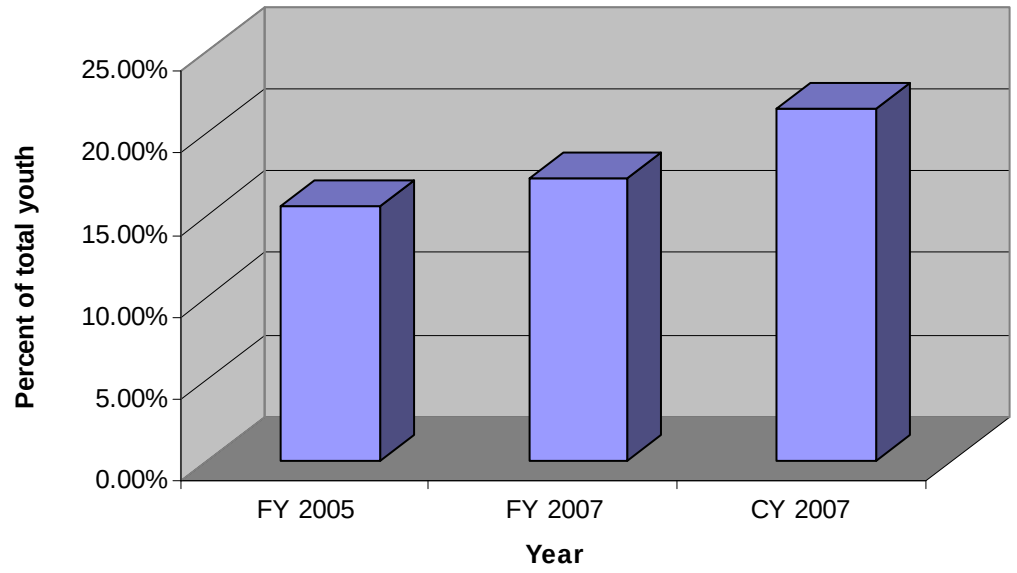
- **However, the number of visits per child for traditional outpatient mental health services (assessment, psychiatric services, and psychotherapy) decreased in 2007 by 40% over fiscal year 2005 levels. In 2007, each child received an average of 15.7 visits.**

- **In contrast, the average billed hours per patient for mental health rehabilitative outpatient services increased by 569% over fiscal year 2005 levels.**

[14]U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. http://www.mentalhealth.org.

- **In 2007, the greatest increases were found in psychosocial and skills training services provided to children in treatment homes, not in those children remaining at home.**
- **In 2007, 32% of Medicaid Children accessing behavioral health services were served in Treatment Homes. There was a slight increase (9%) in those placed and in the length of stay (14%) as compared to fiscal year 2005.**
- **In 2007 there were 551 admissions to inpatient care, with no significant improvements in admissions per 1000 children enrolled in Medicaid, but a slight decrease in lengths of stay to an average of 14 days as compared to Fiscal Year 2005.**
- **In 2007, readmission rates increased substantially, with 21.5% of youths being readmitted within 60 days and 31.5% being readmitted after 365 days. These readmission rates are twice as high as expected if adequate community services are available.[15]**

Figure 11. Percentage of Clark County Fee-for-Service Medicaid Youths readmitted to Inpatient Services after 60 days



- **There were no overall increases in admissions of lengths of stay to residential services, but out of state residential placements more than doubled from fiscal year 2005 to calendar year 2007.**

[15] Salzberg, Les First Health Corporation. *Personal Communication*, 2008.

NEEDS OF UNINSURED CHILDREN IN STATE FACILITIES

What are the needs of children requiring hospitalization in the State Mental Health System and how are these needs being met?[16]

- **Of an estimated 300 children admitted to Desert Willow Treatment Center in Fiscal Year 2007-8, an estimated 157 youths were uninsured or underinsured and an estimated 133 were fee-for service Medicaid.**
- **63.0% of the youth received all of the services recommended at discharge this year as compared to 60.7% in Fiscal Year 2006-7.**
- **However, 88.6% of the aftercare plans for the uninsured youths included only two behavioral health services: outpatient therapy and psychiatric support. Only 11.4% included other types of behavioral health services or supports.**
- **Although not part of their aftercare plans, 17.9% of the uninsured youths' families had received or were receiving family-to-family support services.**
- **32.1% needed emergency or unplanned residential services following discharge, as compared to 34.5% in Fiscal Year 2006-7.**
- **42.9% of uninsured youths obtained insurance coverage following discharge, slightly fewer than in Fiscal Year 2006-7 (48.3%)**
- **Families reported that the primary barrier to obtaining aftercare services was failure of insurance to cover needed services.**

NEEDS OF CHILD WELFARE CHILDREN

What are the needs of children in the Child Welfare System and how well are these needs being met?

- **Previous studies by the CCCMHC have indicated that 85.3% of abused/neglected children in Clark County need some level of behavioral health services. In 2007, it is estimated that 3099 children involved in the child welfare system need these services.**
- **It is estimated that in 2007, 40% or 1453 abused/neglected children had serious emotional disturbance and needed intensive levels of community-based supports.**
- **A comprehensive child welfare service array assessment completed in March, 2008**[17] **concluded that the need for mental health and family support services by children involved in the child welfare system far exceeded the availability of these services in Clark County.**
- **The assessment also suggested that lack of availability was a significant barrier to children referred for home-based mental health services and after-school day treatment.**
- **According to the assessment, families do not have the necessary flexible funding and other supports necessary to maintain their children at home or sustain a successful reunification following foster care.**

[16] See Appendix G

[17] Applied Analysis (2008) Service Array Needs Assessment. Clark County, Nevada.

NEEDS OF JUVENILE JUSTICE CHILDREN

What are the needs of the juvenile justice population and how well are these needs being met?

- **In Clark County, 79% of juvenile offenders are estimated to have a diagnosable disorder and need some level of behavioral health services. The U.S. Office of Juvenile Justice and Delinquency Prevention estimates that nationally, about 60% of youths involved with juvenile justice have a diagnosable disorder.**

- **Only one-third of youths with behavioral health problems entering the juvenile justice system have received prior treatment in the community**

- **54% of juvenile offenders in Clark County are estimated to have serious behavioral health problems. Due to increasing referrals to the juvenile justice system, there were 1000 more youths entering the system with behavioral health needs in 2007, with no increase in behavioral health service capacity.**

- **There are more juvenile justice youths in out-of-community placements than in any previous year.**

- **Youths with behavioral health disorders are as likely to commit serious crimes as others entering the system but do not necessarily get the treatment needed to reduce recidivism.**

- **Youths involved with the juvenile justice system who are residing in the community have difficulty accessing appropriate mental health services through the Neighborhood Family Service Centers due to high-risk behaviors and co-occurring substance abuse problems. Programs for co-occurring disorders have just begun to be implemented in the community and access is limited.**

NEEDS OF FAMILIES WHO HAVE CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

- **Over the past year, there has been an increase of over 100 families requesting support from Nevada Parents Encouraging Parents.**

- **Unfortunately, State funding for family support services was reduced in 2007 by 50% over 2004 funding levels when federal grant funds ended.**

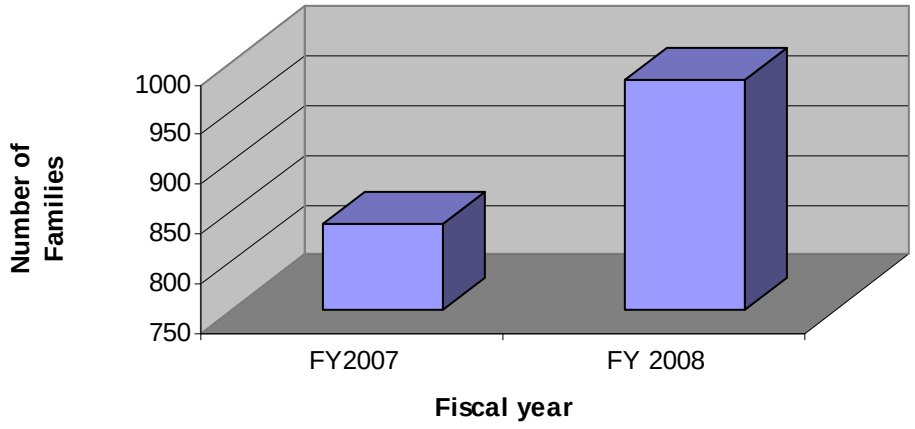
- **82% of referrals for family support services originate from mental health facilities, individual professionals, school personnel and other community child-serving agencies.**

- **70% of parents surveyed reported that services were improved for their child as a result of family-to-family support from Nevada PEP.**

- **82% of parents surveyed reported that family-to-family services by Nevada Parents Encouraging Parents helped strengthen their family.**

- **Research has shown that family-to-family support services has been shown to improve child and family functioning.**

Figure 12. Number of Parents requesting Family-to-Family Support Services



NEEDS FOR LOCAL SYSTEM OF CARE INFRASTRUCTURE DEVELOPMENT

In the CCCMHC's Fifth Annual Plan, a model and funding recommendations for supporting Neighborhood Family Service Center infrastructure were developed. The following needs for administrative infrastructure were identified:

- **There is a need for staff support to the local interagency team administering the Neighborhood Family Service Centers**
- **There is a need for a mechanism or authority to pool resources to support essential Neighborhood Center functions**
- **The physical facilities management of all centers needs to be provided by a single agency or organization**
- **There is a need for integrated funding to develop a single access point, family support function and crisis management function**
- **There is a need for resources to support an interagency tracking and evaluation system**
- **There is a need to pool funding for integrated school linkages, volunteer programs, public awareness programs, and cross-system professional development**

The CCCMHC supports Wraparound as the preferred service coordination model for youths with serious emotional disturbance served by the Neighborhood Family Service Centers. This year's needs assessment has identified the following infrastructure supports[18] that that are critical for successful implementation of Wraparound Services in Clark County:

- **Stronger youth voice in policy, planning and service delivery**
- **Removal of fiscal barriers to implementing successful wraparound plans**
- **Implementation of cost-sharing vs. cost-shifting strategies**
- **Better fiscal monitoring of services and supports to youths receiving wraparound**
- **Improved Crisis Response**
- **Implementation of grievance procedures**

[18] The CCCMHC conducted a formal infrastructure assessment in collaboration with the National Wraparound Initiative using the Community Supports for Wraparound Inventory. See Appendix J for a full report on this assessment.

The Clark County Children's Mental Health Consortium supports a local systems of care philosophy of service delivery. A "Systems of Care" philosophy crosses agency and program boundaries, and approaches the services and support requirement of families holistically (Pires, 2002). In 2007, the Division of Child and Family Services, through its Child and Adolescent State Infrastructure Grant, funded the University of Nevada to complete a comprehensive workforce needs assessment in partnership with the state and regional consortia. The following were identified as workforce needs to implement practices consistent with a system of care philosophy[19]:

- **Stakeholders and staff need more training in systems of care and evidence-based practices was needed**

- **Large caseloads and staff turnover were barriers to improving competency in system of care practices**

- **Factors such as community support, agency support, and additional provider resources were necessary to enhance the effectiveness of the workforce in delivering services consistent with system of care principles and practices**

[19] UNLV School of Social Work Evaluation Team. (2008). *Workforce Development and Cultural Competency Needs Assessment: Baseline Findings (Data Collection Period September - November 2007).* University of Nevada Las Vegas, School of Social Work

ELIGIBILITY FOR BEHAVIORAL HEALTHCARE SERVICES

The current system of eligibility is one of the primary system characteristics that cause the fragmented and discontinuous system. The multiple forms of eligibility, different benefit packages, different providers, and eligibility processes of the different agencies and public programs are a maze that few parents can successfully navigate. The very limited availability of crisis intervention and stabilization services, targeted case management and family-to-family support services make this problem even worse.

The expansion of wraparound facilitators for child welfare children and parental custody, Medicaid-eligible children has significantly improved care coordination for these populations, but this service is not yet available for many uninsured/underinsured children and for youths in the juvenile justice system.

While there has been progress for some children (e.g., children being reunited with families and youth transitioning out of foster care), the overall perception is that eligibility has not improved and access barriers are one of the primary challenges of the current system.

METHODS FOR OBTAINING BEHAVIORAL HEALTHCARE SERVICES

There are multiple ways for children and families to obtain services. Parents can go directly to providers and use private insurance, public insurance or pay directly for the services. Individualized and coordinated services are often expensive and not covered by private insurance. For the past two years efforts have been underway to redesign the public health insurance programs funded through Medicaid. It is unclear if the recommended changes in the redesign are sufficient to improve access and flexibility of services. Nonetheless, it is clear that significant changes to the Medicaid benefits and process for authorizing services are necessary before the desired improvements to access and flexibility of services can be achieved.

The current methods of access mean that parents of children with serious behavioral health problems often do not have financial resources to pay for the services their children need without going through public systems. This forces many children into the child welfare and juvenile justice systems to obtain services.

PROCESS FOR OBTAINING BEHAVIORAL HEALTHCARE SERVICES

Children access services through the provider that receives funding for the services (e.g., their own physician, psychologist, managed care provider, or public system service coordinator). Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system. Best practice ratings ranked collaboration and integrated services as one of the highest priorities but one that was most often not met.

Although the Medicaid managed care provider and all of the public systems triage initial intakes and focus services on children with the most intense needs, the process for obtaining services remains lengthy and confusing for families and clinicians.

Case Example: ***A single mother struggles with services for her two children. One of the children has depression and ADHD, the other child has early mood disorder which may progress to bipolar disorder. Their mother has had intermittent periods of employment and unemployment. The medical coverage for the siblings has vacillated between fee-for-service Medicaid and HMO Medicaid. They did very well on a combination of medications and regular psychotherapy. Their mother went from receiving many negative calls from the school and the children from frequent Required Parent Conferences, to weeks without negative feedback. Then, the mother opened her own business lost HMO driven Medicaid and was placed on full state Medicaid. Shortly thereafter, the children became out of control AND one was expelled from school - all because mother's new Medicaid benefits were unable to cover the medications and psychotherapy which HAD been covered by the HMO driven Medicaid - a treatment plan on which both children had been extremely stable. The daughter, who has depression, had begun to express suicidal ideations and felt increasingly irritable and sad due to the 3 months during which she was unable to obtain medications - the same medications which she had been taking while being covered under the HMO Medicaid Program.***

METHODS FOR OBTAINING ADDITIONAL MONEY

Nevada has one of the fastest growing populations in the country, but funding for children's behavioral health services had shown little increase in the past. The Wraparound in Nevada (WIN) Program has expanded individualized services for over 300 children in the Clark County foster care system. The program as helped this specific population of children but not other vulnerable children. There are ways in which the funding within the current system could be used more effectively but this can only happen if the state level Departments and Divisions with support from the State Legislature work together to form a less fragmented system that is flexible to meet the needs of children and families. Members of the Clark County Children's Mental Health Consortium are working to secure this support for children and families.

Funding strategies should add on the need for more direct, community-based mental health funds that are specifically targeted towards children with severe emotional and behavioral challenges. Incentives are needed to recruit and retain additional licensed providers skilled in providing science and evidence-based practices specifically for children.

VISION FOR AN INTEGRATED BEHAVIORAL HEALTH SYSTEM

Public Health Approach to Behavioral Health Services System

The Clark County Children's Mental Health Consortium supports an integrated, public health approach to behavioral health service delivery. The vision for the integrated system is shown in Figure Four. The base of the system is behavioral health promotion for all children. Behavioral health promotion originates from parents, early education and care providers, school environments, and health providers. The role of the system is to provide public engagement and special supports to these individuals to give them the knowledge and resources to provide activities and environments that promote behavioral wellness. Behavioral health promotion activities would be sufficient to avoid the need for mental health treatment for more than 80% of all children, and if provided consistently, should reduce the number of children who need intervention services.

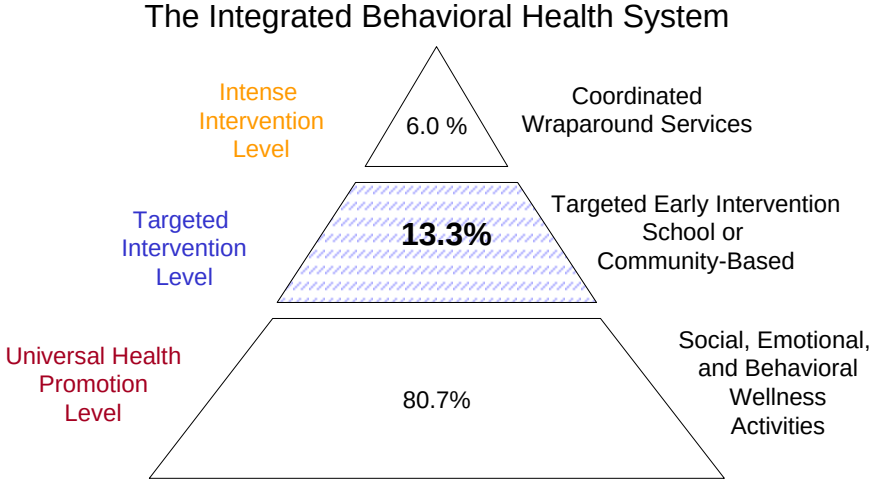


Figure 13. New Picture of School – Community Interaction. This diagram shows the community strategy to address the mental health needs of children in the public school system in Clark County. For all students, the strategy will be to provide supplemental classroom supports to teachers to create classroom activities and environments that promote social and emotional development and behavioral wellness. For 13.3% of the children, there will be additional in school supports that will provide targeted early intervention within the school environment. For those 6% of the students with the most intense needs, services will be a combined effort of the schools and outside providers.

The second level of the system is for targeted early access and intervention (response and stabilization) services. Within the school system this would include a range of group and individual services. Outside the school system this would include linkage with Neighborhood Family Service Centers for services such as family support, mobile crisis, and early childhood services.

The third level of the system is for children who have more intensive needs that require coordination across entities. This is the level of service that is provided through programs such as Wraparound In Nevada (WIN).

An integrated infrastructure is needed to support this model of effective and accessible behavioral health service delivery. This infrastructure should include: public engagement and outreach, system management, integrated access, collaborative service processes, utilization management, workforce development, integrated financing, and ongoing utilization focused evaluation.

System of Care Philosophy and Values for Behavioral Health Service Delivery

The Clark County Children's Mental Health Consortium supports a local systems of care philosophy of service delivery. A "Systems of Care" philosophy crosses agency and program boundaries, and approaches the services and support requirement of families holistically.[20] A system of care is a "comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families."[21] Core values of a system of care specify that services should be community based, child center and family focused, and culturally competent. The guiding principles of the system of care philosophy dictate that service should be:

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

Neighborhood-based Model for Behavioral Health Service Delivery

The Clark County Children's Mental Health Consortium supports a neighborhood-based approach to integrated service delivery The **Neighborhood Family Service Center** service delivery model has been adopted in Clark County to provide the infrastructure to support effective, integrated service delivery. The purpose of the Neighborhood Family Service Centers is to provide: (1) one stop service centers for families in the communities where they live; and (2) collaborative, integrated services for families accessing services across multiple public child serving agencies. Neighborhood Family Service Centers target children and families who need public behavioral health and other social services.

The Child Welfare League of America and the Robert Wood Johnson Foundation have identified the lack of interagency and cross-agency coordination and communication as the most troubling barrier in providing quality care for these vulnerable children and families. These families typically have multiple and complex needs, yet face "daunting economic challenges and must navigate a maze of

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[20] Pires, S.A. Building Systems of Care (2002). Washington, DC: National Technical Assistance Center for Children's Mental Health.

[21] Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

eligibility requirements, multiple service delivery locations, and inconsistent expectations in fragmented local social service systems."[22]

The Clark County Neighborhood Family Service Center model offers a local blueprint for integrating systems of care as advocated by the Child Welfare League and the Robert Wood Johnson Foundation.[23]

The current five Neighborhood Family Service Centers include the following partners:

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

The Centers are administered by the Neighborhood Family Service Centers' **Administrative Team** comprised of the Deputy Administrator of the Division of Child and Family Services, the Director of the Department of Family Services, the Director of the Department of Juvenile Justice Services, the Program Manager of Nevada Early Intervention Services, Grants Manager for Family Resource Centers, the Clark County School District Executive Director of Special Education and Support Services, and Executive Director of Nevada Parents Encouraging Parents.

Neighborhood Family Service Centers have the potential to provide the following support for children and families who rely on public behavioral health and social services:

- Integrated system entry/access
- Integrated Screening and Assessment
- Integrated Outreach and Referral
- Integrated Crisis Management at the Service Delivery and Systems Level
- Family and Youth Involvement in planning, management, and monitoring
- Interagency tracking and evaluation
- School Linkage
- Community Linkage, i.e., partnership-building, volunteers, public awareness
- Flexibility and resources to add more centers.

In order to provide these critical functions, Neighborhood Family Service Centers need the following administrative components:[24]

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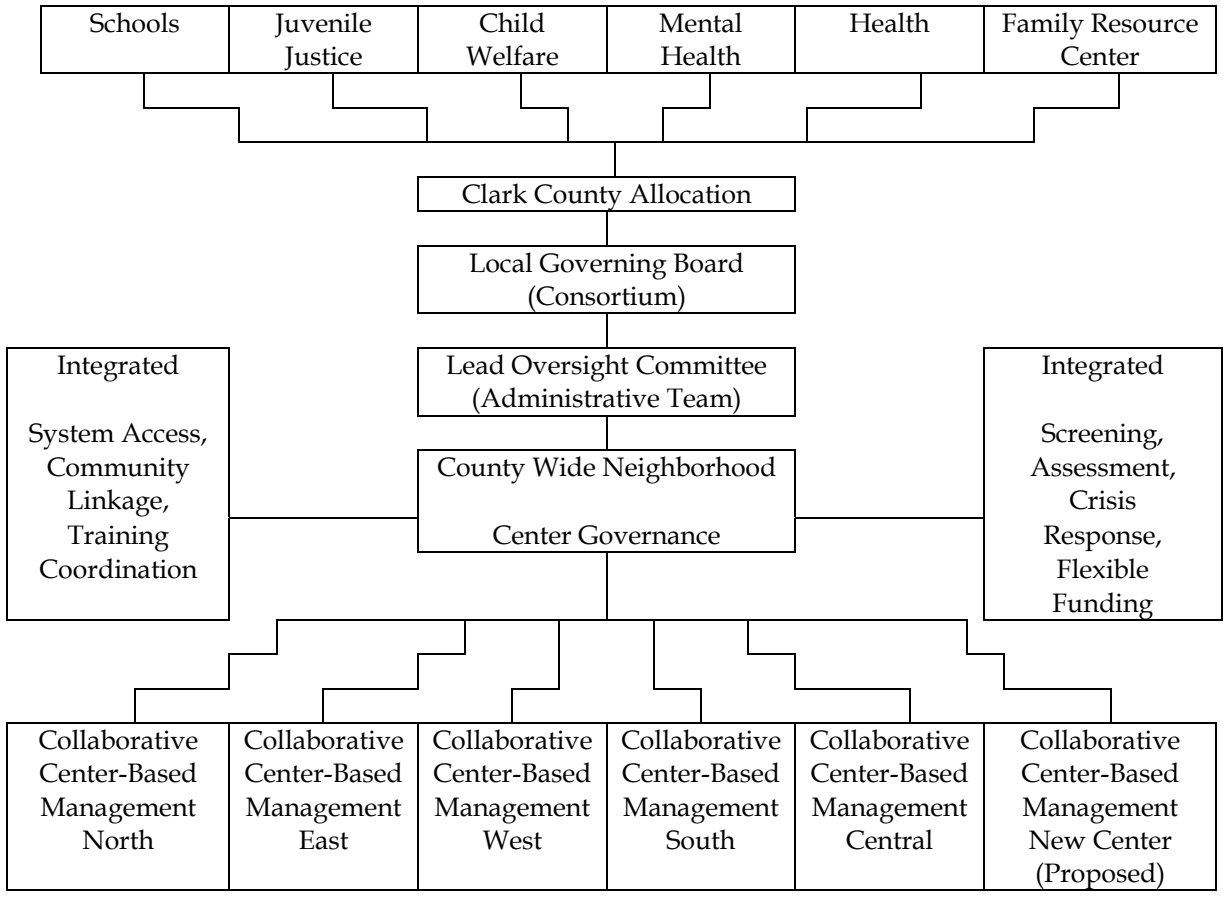
[22] Hornberger, S., Martin, T. & Collins, J. Integrating Systems of Care: Improving quality of Care for the Most Vulnerable Children and Families. Washington, DC: CWLA Press, 2006

[23] Hornberger, S., Martin, T. & Collins, J. Integrating Systems of Care: Improving quality of Care for the Most Vulnerable Children and Families. Washington, DC: CWLA Press, 2006

- Integrated training for staff, stakeholders, and families
- Formal and locally-based collaborative governance at the policy and financing level established by legislation, executive order, or memorandum of agreement
- Governance includes authority to manage and allocate shared resources
- Financing structure that allows for pooled resources to support collaborative functions
- Governance Structure assumes shared liability across systems for a defined target population
- Day-to-Day management of the collaborative process at each Neighborhood Family Service Center, including the management of the physical facilities
- Integrated case coordination for the target population (Triage and Wraparound)
- There is no integrated funding to develop community and school linkages, volunteer programs, or public awareness programs.

Figure 14. **Proposed Neighborhood Family Service Center Infrastructure Funding**



[24] Pires, S.A. Building Systems of Care: A Primer. Washington DC: National Technical Assistance for Children's Mental Health, 2002

The proposed structure would be governed by a local board or administrative team. While each agency partner would retain their own service providers and budget, some funds would be pooled for key collaborative functions. Countywide collaborative governance would include an executive director, quality assurance and fiscal/grants management staff, and resources for interagency training coordination. Each center would require a collaborative governance structure to include a center manager and to provide integrated system access, community linkage, and integrated screening assessment for multi-agency-involved youth.

Other collaborative functions supported by joint funding would include: integrated crisis response and an integrated flexible funding pool.

At the youth and family level, the Neighborhood Family Service Centers use a Wraparound model of interagency coordination as the infrastructure to deliver appropriate services. The Wraparound Model is consistent with the system of care values upon which the Neighborhood Centers were established.

Figure Fifteen. Levels of Integrated Infrastructure for Neighborhood-based, System of Care Service delivery

RECOMMENDATIONS

The Surgeon General's Office identified at least three priorities for improving the nation's behavioral health services for children: (1) the need to promote more public awareness of children's behavioral health issues, (2) the need to increase early identification and treatment services; and (3) the need to improve coordination of services for children with behavioral health needs.

The CCCMHC has followed the U.S. Surgeon General's lead and set three overarching goals for improvement of behavioral health service delivery for Clark County's children. The goals are listed below with specific recommendations for this year's plan:

1. <u>To improve public awareness of and support for behavioral health services and skill building activities that promote behavioral wellness</u>

***1.1** Recommend CCCMHC continue public awareness activities.*

***1.2** Recommend ongoing funding for the SSHS Early Childhood Program.*

1.3 Provide funding for early screening and intervention to elementary school students with behavioral health problems.

1.4 Recommend Nevada Office of Suicide Prevention implement strategies to expand the number of youths screened in urban Clark County Schools.

1.5 Recommend Nevada Office of Suicide Prevention expand screenings to rural Clark County Schools

1.6 Recommend that Medicaid support behavioral health screening and outreach efforts to children enrolled in Medicaid.

1.7 Recommend Clark County School District provide training to school administrators and deans on early screening and intervention methods for children with behavioral health problems.

1.8 Recommend that the Clark County TeenScreen Program in conjunction with the Nevada Office of Suicide Prevention provide education to parents on the importance of early screening and intervention for youths at risk for suicide

**Recommendations in italics carried forward from last year's Plan.*

2. <u>To improve access to needed mental health services with initial efforts focusing on improved crisis services and early treatment.</u>

**2.1 Recommend provide funding to expand the Wraparound in Nevada Program to serve an average daily census of 100 youths in the Clark County Juvenile Justice System.*

**2.2 Recommend that the state and county expand programs to fund a sixth Neighborhood Center*

**2.3 Recommend that the State of Nevada create a dedicated funding source for expansion of family-to-family support services.*

**2.4 Recommend that the Department of Health and Human Services and Clark County increase flexible funding to provide behavioral health services and supports for children in the child welfare system to remain at home.*

** 2.5 Recommend the Nevada Division of Child and Family Services expand family support and provide additional psychiatric services for uninsured youths discharged home from Desert Willow Treatment Center*

2.6 Recommend CCCMHC implement training to EMS personnel in alternatives to the Legal 2000 procedure.

2.7 Recommend the Nevada Division of Child and Family Services increase funding and provider capacity for mobile crisis intervention services to serve all youths entering emergency rooms for behavioral health issues.

2.8 Recommend that the Nevada Department of Health and Human Services facilitate direct access for youths needing admission to psychiatric facilities by improving medical pre-screening and expanding inpatient capacity.

2.9 Recommend that the Division of Child and Family Services emphasize treatment for suicidal thoughts and gestures in mobile crisis service delivery.

2.10 Recommend Clark County School District provide additional funding to expand capacity of the CCSD Crisis Intervention Program

2.11 Recommend that Medicaid implement steps to recruit and facilitate to more providers of assessment, psychiatric services and psychotherapy.

2.12 Recommend that Medicaid implement steps to recruit more providers of after school day treatment, crisis services and home-based rehabilitative services.

**Recommendations in italics carried forward from last year's Plan.*

2.13 Recommend that Desert Willow Treatment Center provide education and resource materials to staff and families on the types of aftercare services effective in supporting youths after hospitalization.

2.14 Recommend that the Nevada Division of Child and Family Services expand day treatment, family support and home-based services for uninsured families of youths with serious emotional disturbance to maintain youths at home and/or facilitate reunification of youths and families after discharge from residential care.

2.15 Recommend CCCMHC explore strategies with the State Children's Behavioral Health Consortium to ensure that private insurance providers have capacity for crisis response to youths with behavioral health problems.

3. <u>To improve the infrastructure and coordination across and within systems.</u>

***3.1** *Recommend CCCMHC continue to review and monitor demographics, suicide risk, and outcomes for youths with behavioral health disorders requiring emergency room admissions*

***3.2** *Recommend the Nevada Division of Healthcare Financing and Policy expand Medicaid Eligibility to increase access to aftercare services for hospitalized youths with serious emotional disturbance*

***3.3** *Recommend that the Nevada Division of Healthcare Financing and Policy streamline and expedite Medicaid application process for uninsured youths exiting Desert Willow Treatment Center*

***3.4** *Recommend CCCMHC explore community-initiated wraparound in partnership with private businesses*

***3.5** *Recommend DHHS initiate assessment and reform of the financing system for publicly funded, community-based children's behavioral health services*

***3.6** *DHHS and Clark County identify a lead entity and financing plan for implementing the Neighborhood Service Center Infrastructure, with input from CCCMHC and other stakeholders.*

***3.7** *DHHS and Clark County provide $821,053 to fund a collaborative infrastructure for the Neighborhood Family Service Centers.*

***3.8** *CCCMHC implement a barrier-busting Workgroup*

**Recommendations in italics carried forward from last year's Plan.*

*3.9 *CCCMHC facilitate a dialogue between the state and county to (a) clarify the responsibility for delivery of the needed behavioral health services to youths in the Clark County Child Welfare and Juvenile Justice Systems; and (b) to determine what data are needed to justify funding for these services.*

3.10 Recommend CCCMHC collaborate with the Juvenile Detention Alternative Initiative to plan and implement community-based programs for youths in the juvenile justice system

3.11 Recommend CCCMHC continue to serve as the steering committee for the Clark County TeenScreen Program and that the program provide monthly updates on its recruitment, screening, and intervention activities

3.12 Recommend that the Division of Healthcare Financing and Policy provide quarterly reports on the utilization and outcomes of behavioral health services, including the utilization of psychotropic medications, for Medicaid children. Also recommend that the Division of Healthcare Financing and Policy more information specific to distinct groups within fee-for-service Medicaid (children in custody, disabled children), Managed Care Medicaid,

3.13 Recommend that Medicaid implement a waiver for children with serious emotional disturbance, to include those with co-occurring disorders

3.14 Recommend that the Nevada Division of Healthcare Financing and Policy raise the income level for Medicaid eligibility from 100% poverty to the average level used in neighboring states (Arizona, Utah, and California.

3.15 Recommend that Desert Willow provide semi-annual reports to the CCCMHC on the aftercare plans for youths discharged from the facility.

3.16 Recommend that the Department of Health and Human Services and Clark County provide incentives to providers to implement programs that have been proven effective with youths in the juvenile justice systems, especially Multisystemic Therapy, Multidimensional Treatment Foster Care, and Functional Family Therapy.

3.17 Recommend that the Department of Health and Human Services and Clark County review and revise the state-county inter-local agreement governing the Neighborhood Centers to ensure adherence to system of care principles and practices.

**Recommendations in italics carried forward from last year's Plan.*

3.18 Recommend that Neighborhood Centers expand to include staff from housing programs, Medicaid, Welfare, and private providers*

3.19 Recommend that staff in all local child-serving agencies receive training in system of care principles and practices with parents involved in implementing and participating in the training.

3.20 Recommend that the State Children's Behavioral Health Consortium implement an ongoing method for measuring system change throughout the state.

3.21 Recommend that members of the local consortium collaborate to provide at least one cross-agency training in a selected evidence-based practice.

3.22 Recommend that local agencies providing public behavioral health services adopt policies and administrative procedures consistent with system of care philosophy and practices.

2.23 Recommend that the CCCMHC encourage local university programs to incorporate system of care principles and evidence-based practices into their curricula.

2.24 Recommend that local public behavioral health care providers give incentives and rewards to staff for practice consistent with system of care principles.

**Recommendations in italics carried forward from last year's Plan.*

Appendix A

Workgroup Participants and Charters

Workgroup Participants

During the 2006-2007 fiscal year, three standing workgroups met to address the overarching goals of the Consortium. Each workgroup included at least three members of the Consortium. Many other individuals participated in the Workgroups and helped to achieve the goals set forth in the workgroup charters.

The CCCMHC extends its appreciation to the following 55 CCCMHC members and other individuals who participated in workgroup activities during the 2006-2007 fiscal year:

Public Awareness and Behavioral Wellness Workgroup

Bernstein	Mike	Southern Nevada Health District
Bueno	Gabriel	
Durette	Lisa	Child and Adolescent Psychiatry
Escamilla	Cynthia	Nevada Parents Encouraging Parents
Ewing	Tammi	Spring Mountain Treatment Center
Flatt	Linda	Office of Suicide Prevention
Hardy	Kitty	Clark County Family Services
Ludwig	Barbara	Consultant
Matteson	Dale	Matteson Media
May	Gordon	Youth Advocate Programs
Miller	Karen	Parent
Mosley	Natesha	Youth Advocate Programs
Peterson	Christa	Consultant
Polakowski	Ann	Division of Child and Family Services
Romo	Adam	Matteson Media
Rosenberg	TJ	Nevada Parents Encouraging Parents
Sernoe	Susie	Clark County School District
Tanner-Delgado	Lynda	Montevista Hospital
Tyson	Jodi	Office of Suicide Prevention
Westrom	Hilary	Children's Advocacy
Wilburn	Donna	Nevada Association of Marriage/Family Therapists
Windle	Linda	Nevada Parents Encouraging Parents

Crisis Services and Early Intervention Workgroup

Adler	Richard	
Barclay	Beverly	Rural Clinics
Bergdale	Sommer	Desert Willow Treatment Center
Bernstein	Mike	Southern Nevada Health District
Boylan	Tim	Clark County Juvenile Justice Services

Cromwell	Sandra	Division of Child and Family Services
Dunn	Rawl	Odyssey
Escamilla	Cynthia	Nevada Parents Encouraging Parents
Espinosa	Eugene	Rural Clinics
Ewing	Tammi	Spring Mountain Treatment Center
Flatt	Linda	Office of Suicide Prevention
Habash	Amanda	University of Nevada, Las Vegas
Hardy	Kitty	Clark County Family Services
Harpin	Nancy	University Medical Center
Harris	Jackie	Bridge Counseling
Hastings	Karen	Spring Mountain Treatment Center
Hummel	Arlene	Clark County School District
Joyce	Cheryl	Miley Achievement Center
Kameda	Wendy	Clark County Legal Services
Ludwig	Barbara	Consultant
Macaluso	Deanna	Nevada Parents Encouraging Parents
Madajski	Katherine	Miley Achievement Center
McClain	Fran	Division of Child and Family Services
McCollom	Rebecca	Nevada Parents Encouraging Parents
Merrifield	Patricia	Division of Child and Family Services
Miller	Karen	Parent
Moulton	Deborah	Clark County Family Services
Newbern-Johnson	Meambi	Clark County Family Services
Peterson	Christa	Consultant
Post	Anita	Nevada Parents Encouraging Parents
Richards	Shannon	Attorney General's Office
Rojas	Jhosmara	Desert Willow Treatment Center
Rosenberg	TJ	Nevada Parents Encouraging Parents
Santangelo	Linda	Division of Child and Family Services
Savage	Lynda	Clark County Family Services
Sernoe	Susie	Clark County School District
Tanner-Delgado	Lynda	Montevista Hospital
Teel	Barbara	Spring Mountain Treatment Center
Tyson	Jodi	Office of Suicide Prevention
Virtuoso	Rosemary	Clark County School District
White	Ava	Odyssey
Windle	Lynne	Nevada Parents Encouraging Parents
Wright	Cheryl	Clark County Juvenile Justice Services
Young	Renee	Parent

Infrastructure and Coordination Workgroup

Abruscato	Anne-Marie	Mojave Mental Health Services
Carrell	Derrick	Communities in Schools
Davidson	Ron	Department of Family Services
Escamilla	Cynthia	Nevada Parents Encouraging Parents

Espinosa	Eugene	Rural Clinics
Ewing	Tammi	Spring Mountain Treatment Center
Feher	Ann	Clark County Juvenile Justice Services
Feng	Jing	Southern Nevada Health District
Flatt	Linda	Office of Suicide Prevention
Franzen-Weiss	Marjorie	Health Division
Ghertner	Stuart	Southern Nevada Adult Mental Health Services
Kelly	Sandal	First Health
Kinnikin	Viki	Mojave
Kraft	Janelle	Las Vegas Metropolitan Police Department
Ludwig	Barbara	Consultant
Merrifield	Patricia	Division of Child and Family Services
Miller	Karen	Parent
Newbern-Johnson	Meambi	Clark County Family Services
Noonan	Pam	Montevista Hospital
Osti	James	Southern Nevada Health District
Peterson	Christa	Consultant
Polakowski	Ann	Division of Child and Family Services
Reese	Fritz	Clark County Juvenile Justice Services
Reynolds	Scott	Clark County School District
Rosenberg	TJ	Nevada Parents Encouraging Parents
Sernoe	Susie	Clark County School District
Sirkin	Nancy	Division of Child and Family Services
Tanner-Delgado	Lynda	Montevista Hospital
Taycher	Karen	Nevada Parents Encouraging Parents
Teel	Barbara	Spring Mountain Treatment Center
Townsend	Cherie	Clark County Juvenile Justice Services
Wagner	Cheryl	Clark County School District
Westrom	Hilary	Children's Advocacy Alliance
Wetzel	Lisa	Division of Child and Family Services
Wright	Cheryl	Clark County Juvenile Justice Services

Workgroup Charters

The **Charter** for each of the three standing workgroups is shown below:

Workgroup #1 Public Awareness and Behavioral Wellness

Workgroup#1 will focus on improving public awareness of and support for behavioral health services and skill building activities that promote behavioral wellness

Goal 1. **Develop and implement strategies to help the public recognize the importance of the mental health of children and reduce the stigma of using mental health services**

Action Step 1. Update CCCMHC Brochure and implement strategies for targeted dissemination of brochure to (a) Primary Care Providers; (b) First Responders; and (c) Schools.

Action Step 2. Disseminate Annual Plan information to public and stakeholders (a) Hold a press conference to disseminate findings of Sixth Annual Plan; and (b) Implement strategies for Annual Plan Dissemination to stakeholders.

Action Step 3. Continue Public Awareness Media Campaign (a) Adopt a slogan for the campaign; (b) Collaborate with the Southern Nevada Health District and the Youth Suicide Prevention Initiative to produce and disseminate a public service announcement focused on youth suicide; (c) Develop community support for ongoing dissemination of public service announcements through media outlets; (d) Disseminate public service announcements in the schools and on educational TV; and (e) Evaluate the effectiveness of the media campaign.

Goal 2. **Build Awareness and engage community stakeholders in strengthening the systems for meeting the emotional and behavioral needs of children**

Action Step 1. Provide training on behavioral health screening to primary care providers

Action Step 2. Explore a partnership with the PTA to develop community forums promoting public awareness.

Workgroup #2 Crisis Services and Early Intervention

Workgroup #2 will focus on improving access to needed mental health services with initial efforts focusing on improved crisis services and early intervention.

Goal 1. Improve access to existing crisis services through increased coordination and consumer awareness.

Action Step 1. ***Facilitate training to EMS personnel in alternative to the Legal 2000 procedure with youths who have behavioral health crises.***

Action Step 2. Develop a resource directory or website to educate consumers and providers about crisis services.

Action Step 3. Facilitate communication and information sharing between child-serving agencies with clients in crisis through court orders or other agreements.

Action Step 4. Develop interagency staffing committee to overcome barriers to crisis services in the most difficult cases or when demands for crisis services exceed capacity (e.g. hospital or RTC beds).

Goal 2. Improve early access to services through increasing the number and type of providers of these services.

Action Step 1. Work with Nevada Medicaid to identify and engage potential providers of crisis intervention services.

Action Step 2. Develop strategies for increasing the number of psychiatric services providers, to include the training of nurse practitioners.

Action Step 3. Support the Clark County School District in implementing a school-based early access model, utilizing walk-in counselors, nurses, and/or other school personnel.

Action Step 4. ***Monitor the implementation, evaluation and sustainability of the Garrett Lee Smith Youth Suicide Prevention Initiative.***

Goal 3. Explore use of wraparound with juvenile probation and youth parole populations in Clark County

Action Step 1. Monitor the current utilization of and unmet need for wraparound with the juvenile probation and youth parole population.

Workgroup #3 Infrastructure and Coordination

Workgroup #3 will focus on Improving the infrastructure and coordination across and within systems.

Goal 1. Improve the state infrastructure for children's mental health services.

Action Step. 1. Provide local representation and input for state infrastructure project workgroups and action teams.

Action Step 2. Provide reports and updates to the CCCMHC on activities related to the State Infrastructure project.

Goal 2. Provide meaningful needs assessment information for effective annual planning by the CCCMHC

Action Step 1. Develop and prioritize performance indicators for annual needs assessment.

Action Step 2. Review and evaluate assessment tools and strategies utilized by the CCCMHC and its member organizations.

Action Step 3. Develop and implement strategies to obtain needs assessment information.

Action Step 4 Collaborate with DFS in conducting a service array assessment for children involved in the Child Welfare System.

Goal 3. Increase the CCCMHC's effectiveness in facilitating local improvements in children's mental health service delivery.

Action Step 1. Review recommendations from the CCCMHC's annual plans and update progress toward implementing these recommendations.

Action Step 2. Identify barriers to fully implementing recommendations made by the CCCMHC's annual plans.

Action Step 3. Develop and implement marketing strategies to help gain external support for implementing CCCMHC recommendations.

Action Step 4. Identify other organizations and groups who support the implementation of the CCCMHC's recommendations.

Action Step 5. Develop and implement communication strategies with other local groups/organizations with similar goals to the CCCMHC.

Action Step 6. Develop proposed legislative changes to improve the effectiveness of The Consortium's planning efforts.

Appendix B

Clark County Children's Mental Health Consortium
Status Review of Annual Plan Recommendations 2002-2007
New Funding Requests

Plan Year	*Request/ Recommendation*	*Identified Need*	*Data Source*	*Status*
2002 2003	Expand Medicaid-funded targeted case management to all eligible recipients (TANF) with SED	#Medicaid children needing outpatient and intensive services; # unserved, underserved. %DHHS funding spend on residential vs. community services	Estimation w/Medicaid Encounter Data Medicaid Claims Database	Legislature funded expansion in 2005.All TANF recipients are eligible but there are waiting lists (only 2 providers-DCFS and Mojave).
2002 2003	Develop Specialty Mental Health Clinics	#Medicaid children needing outpatient and intensive services; # unserved, underserved	Estimation w/Medicaid Encounter Data	Funded by 2005 Legislature; implemented 1/06; Federal CMS denied parts of new policy 12/06
2002 2003	Expand Medicaid to provide family-to- support services	Most highly rated services/support Availability of services/support	Consortia Parent Survey	Funded by 2005 Legislature, implemented in 1/06; now discontinued as CMS denied this part of new policy 12/06
2002 2003	Improve Standards for Medicaid Providers	Most highly rated services/support Availability of services/support	Consortia Parent Surveys	Some improvements made in Medicaid Policy 1/06
2002 2003	Provide same service array for Medicaid and Nevada Checkup	Most highly rated services/support Availability of services/support	Consortia-led focus groups with parents/staff	Not implemented
2003	Continue and expand WIN program to all children involved (informally or formally) in Child Welfare	#children in public are needing outpatient and intensive services (CPS, Foster Care, JJ) # unserved, underserved	Consortia Screenings of population sample with MHST and CALOCUS	WIN was expanded by 2005 Legislature; still not available to those under Child Welfare supervision but placed with families.
2002	Expand WIN to all children with SED in the Juvenile Justice Systems	#children in public care needing outpatient and intensive services (CPS, Foster Care, JJ) # unserved, underserved	Consortia screenings with MHST and CALOCUS (CASII) using population sample	Not implemented—no funding
2002 2003	Mandate and fund consumer involvement		Consortia Parent Surveys	Partially implemented through federal grants and a small amount of state funding (DCFS)by 2005 Legislature
2002 2003	Support Neighborhood-Based Services	Most highly rated services/supports Availability of highly rated services/supports	Consortia Parent Surveys	5 Centers were funded by 2003 Legislature; Expanded in 2005

Plan Year	*Request/ Recommendation*	*Identified Need*	*Data Source*	*Status*
2002 2003	Involve Consortia in decisions about discretionary prevention/early intervention funds (Title XX, IVB-Part 2)	Most highly rated barriers/challenges	Consortia-led focus groups with Parents/Staff	Not implemented
2002 2003	Reorganize state budgets to unify funding streams for behavioral healthcare services that can be locally monitored and controlled by collaborative bodies such as the CCCMHC	Most highly rated barriers/challenges	Consortia-led focus groups with Parents/staff	Not implemented
2002 2003	Develop coordinated management information systems – Medicaid/MHDS/DCFS	Most highly rated barriers/challenges	Consortia-led focus groups with Parent/Staff	Not implemented
2002	Improve services for CW and JJ Children 18-21 years through integrated local planning	Most highly rated barriers/challenges	Consortia-led focus groups with parents/staff	Not implemented
2002 2003	Facilitate access to services through a Level of Service System consistent for both HMO and Fee-for-Service Medicaid	Most highly rated barriers/challenges	Consortia-led focus groups with parents/staff	Implemented by Medicaid in 2006
2003	Build on existing funding resources in DHHS to implement a cross-systems family support hotline in Clark County	Need for early access regardless of eligibility status Need for family support services Need for single point of entry	Focus Groups with staff from Clark County Juvenile Probation and Clark County Child Protective Services Parent Survey from 2002 plan	2005 Legislature funded pilot program for 2-1-1 information system and the program expanded in 2007
2002 2003 2004 2005 2006 2007	Provide funding for services for a pilot project to implement school-based wraparound for 100 youth in Clark County Juvenile Probation Provide $1,858,900 in funding	Expanded Consortia assessment of youth in juvenile probation services with SED	Consortia screen of youths in juvenile probation services using MHST and CALOCUS	Not implemented—no funding
2003	Provide funding for wraparound for 100 (parental custody) children involved in the child welfare system to divert them from custody	Expanded Consortia assessment of children involved with child protective services	Consortia screening of youth involved with Child Protective Services using MHST and CALOUS	Not implemented--WIN Program expanded by 2005 Legislature but children must be in foster care
2002 2003 2004 2005 2006 2007	Provide funding through DCFS for a 24-hour, 7-day per week mobile crisis services Provide $986,400 per year in funding for services	Need for early access regardless of eligibility status Need for family support services Need for single point of entry Need for emergency	Focus Groups with staff from Clark County Juvenile Probation and Clark County Child Protective Services	Pilot project funded by 2007 Legislature, implementation deferred by 2008 Special Legislative Session

Plan Year	*Request/ Recommendation*	*Identified Need*	*Data Source*	*Status*
		room diversion	Parent Survey from 2002 plan #youths with bh problems admitted to emergency rooms	
2004	Expand behavioral health promotion activities throughout elementary schools in Clark County	# Clark County elementary school children needing behavioral health promotion activities	Consortium screening of 2100 Clark County elementary school children Focus groups with school counselors	Not implemented
2004 2005	Implement school-based targeted early intervention for elementary school students with behavioral health problems	#Clark County elementary school children needing early intervention for behavioral health problems	Consortium screening of 2100 Clark County elementary school children Focus groups with school counselors	Not implemented—no funding
2004	Provide funding for telehealth psychiatric services at state correctional facilities (i.e. Elko, Caliente, and Summit View)	Need for infrastructure enhancements in: family partnerships, flexible funding policies, public engagement, early identification services, data gathering strategies	Clark County Consortium assessment using Standardized infrastructure Survey of parents, providers and stakeholders	2005 Legislature funded equipment for telehealth services
2004	Strengthen DCFS' infrastructure to support implementation of family –driven, individualized services			DCFS received a 5-year, 3.7 million dollar Grant from SAMHSA, 2004.
2004 2005	Implement the Nevada State Infrastructure Project to address organization and system infrastructure needs	Need for infrastructure enhancements identified in 3rd Plan	Consortium Infrastructure Survey of parents, stakeholders, and providers	See above
2006	Recommend $1,300,000 in funding to sustain school district crisis intervention services developed by grant initiative	Large numbers of youths with behavioral health crises during school hours	School district data from crisis response team	Pending implementation by Clark County School District
2006 2007	Recommend DHHS provide $100,000 in flexible funding to provide short-term treatment to public school youths in crises who have no payment resources	Large numbers of children identified by public schools with crisis service needs and no payment resources; Waiting lists for state	School district data from Safe Schools Healthy Students Grant Initiative	Not implemented—no funding

Plan Year	*Request/ Recommendation*	*Identified Need*	*Data Source*	*Status*
		services		
2006 2007	Recommend DHHS provide $140,656 per year in funding for family-to-family support and psychiatric services for uninsured youths upon discharge from state inpatient hospitalization	Low success rate in obtaining healthcare coverage for aftercare services for uninsured youths discharged from state inpatient hospitalization	Results of 2006, 2007 survey of parents	Some family-to-family support services redeployed from Neighborhood Centers to Desert Willow Treatment Center in 2008
2006 2007	Expand Medicaid Eligibility to increase access to aftercare services for uninsured youths exiting DCFS' Desert Willow Treatment Center	Less than one-half of uninsured youths obtain healthcare coverage after exiting Desert Willow Treatment Center	Results of 2006,2007 survey of parents	No implemented – no funding
2006	Recommend DHHS provide $40,000 in funding to expand depression screenings from 10 schools to 20 schools	High rates of suicide ideation and attempts in public high school students screened	Data collected by Clark County TeenScreen Program	Pending implementation through Garrett Lee Smith Grant Funds(temporary)
2006 2007	Recommend DHHS fund $298,000 to sustain the early access program for young children developed by the Safe Schools Grant (ends 7/07)	Large numbers of young children at risk for serious behavioral health problems and juvenile delinquency	Data collected by the Safe Schools Healthy Students Initiative	Not implemented—no funding
2006 2007	Recommend DHHS and Clark County provide $821,053 in funding for infrastructure to support the Neighborhood Centers.	Lack of collaborative system management for Neighborhood Centers	Focus group of Consortium members and stakeholders	Not implemented—no funding
2006 2007	Recommend funding for DHHS and Clark County to expand service capacity by opening a sixth Neighborhood Center	Waiting lists for most public funded children's behavioral health and social services	Review of waiting lists and residential care utilization	Not implemented—no funding
2007	Develop alternative to fee-for-service Medicaid funding for expansion of family-to-family support services	100 new families of youths with serious emotional disturbance request family-to-family support services each year	Review of referral data from Nevada Parents Encouraging parents	Not implemented—no funding

Appendix C

Seventh Annual Plan
Performance Indicators

Target Population	Data Source	Needs Indicator
Children in the Child Welfare and Juvenile Justice Systems	Self-report by Agencies	• *% children in public care needing outpatient and intensive services (CPS, Foster Care, JJ); and* • *% served, underserved, unserved.*
Children in the Medicaid System	Medicaid Database	• *Inpatient vs. community-based service utilization by Medicaid HMO, Fee-for-Service, and Checkup Clients;* • *Utilization of residential treatment center bed days(in-state and out-of-state) by various types of Medicaid recipients;* • *Utilization of Medicaid services by zip code, age, ethnicity, gender, length of stay, co-morbidity, and custody stratus;* • *Data on Medicaid Behavioral Health Denials, and Appeals; and* • *Utilization of multiple aid codes by recipients.*
Children in the Public School System	CCSD database	• *# students identified w/emotional/behavioral disorders by the district-wide crisis intervention team;* • *# expulsions/substance abuse expulsions; and* • *Referrals to school social workers.*
Children in the Public School System	Office of Suicide Prevention	• *# Children engaged in TeenScreen;* • *# Children screened positive;* • *# Children linked with services; and* • *Proportion of eligible children screened.*
Children with serious behavioral health crises	Self-report by Hospitals through Southern Nevada Health District	• *#Children admitted to hospital emergency rooms for behavioral health issues;* • *Diagnosis and presenting problems;* • *Disposition of admitted youths;* • *% legal 2000s;* • *Lengths of stay by payer source; and* • *Youth Behavior Risk Survey.*
Uninsured children hospitalized in the state inpatient facility	Survey of youths discharged from DWTC	• *# uninsured youths admitted to inpatient care needing aftercare services;* • *# youths receiving needed aftercare services;* • *barriers to receiving needed aftercare services;* • *# youths needing emergency services post-discharge; and* • *# Youth with healthcare coverage post-discharge.*
Children with serious emotional disturbance in public systems	Stakeholder Surveys: UNLV and Wraparound	• *Extent to which the state and local infrastructure support the development of services consistent with system of care principles and the wraparound approach.*
Children with Serious Emotional Disturbance	Family survey; Provider Survey	• *# of families needing family-to-family support services;* • *# of families receiving family-to-family support services; and* • *Types of referrals for family-to-family support services.*

Appendix D

Clark County Children's Mental Health Consortium Public Education Campaign Update

Over the past three years, the CCCMHC has been working to increase public awareness of children's mental health problems and to gain community support in building a service delivery system that every child in need can access. Nevada's Child and Adolescent State Infrastructure Project is supporting the efforts of the local Consortium to develop a model for a statewide public education campaign.

One of the key barriers in improving children's behavioral health services is the stigma associated with children's behavioral health problems. A large survey recently conducted nationally by Harris Interactive in collaboration with the Portland State University Children's Mental Health Research and Training Center has confirmed that both adults and teenagers have less understanding and more negative perceptions of youths with behavioral health problems as opposed to those with physical health problems.

The Consortium has established a Workgroup to implement a public education campaign in Clark County. The Workgroup's key partners in the campaign are Nevada's Garrett Lee Smith Youth Suicide Prevention Project and the State Office of Suicide Prevention; the Southern Nevada Health District; and the Division of Child and Family Services. Other Workgroup participants include representatives from Nevada Parents Encouraging Parents, the Clark County School District, local chapter of the American Academy of Child and Adolescent Psychiatry, other local mental health providers, and the Children's Advocacy Alliance. Chaired by Mike Bernstein of the Southern Nevada Health District, the Workgroup on Public Awareness and Behavioral Wellness has been working to achieve the two primary goals of the Public Education Campaign: (1) to increase public awareness about the prevalence and signs of children's mental health problems; and (2) to encourage parents and youth to engage in early help-seeking behavior as needed.

The Workgroup has developed a brochure to help parents recognize the signs of mental health problems and know how and where to ask for help. The brochure is available in English and Spanish and has been distributed to parents through the school district, health district, local hospitals, and fire departments.

With the assistance of Matteson Media, Inc., the Consortium Workgroup has produced a series of public service announcements which have aired on television and in local movie theaters. The stakeholders on this Workgroup actively participate in the development of the public service announcements. In addition, focus groups of parents and/or youth involved in behavioral health issues are being utilized to develop the scripts and the messages for these public service announcements.

During Fiscal Year 2006-7, the Workgroup began implementing several important components of its multifaceted social marketing plan. In December, 2006, the first public service announcement was produced, edited, finalized and distributed to several local television stations for airing. This PSA was targeted toward caregivers of children with suspected behavioral health problems. The 30-second commercial was aired during the last week of December, 2006 (12/25-12/31/06) and the second week of January, 2007 (1/8/07-1/14/07)on the following television

stations: Fox 5 TV – 60 spots over the two weeks; CBS TV 8 – 75 spots over the two weeks; eight Cable Stations (AEN, LIFETIME, FX, TBSC, TNT, USA, CRT and ENT) for a total of 218 spots over the two weeks. A news story on the public education campaign was also aired on a local television station (Channel Five) on January 11, 2007. Karen Taycher, a representative of Parents Encouraging Parents, Hilary Westrom, a children's advocate, and a parent of two seriously emotionally disturbed young children were interviewed as part of the story.

The second public service announcement was targeted toward youths with suspected behavioral health problems and their peers. Its goal is to reduce the stigma of mental health problems among teens and encourage teens to support each other in getting help for these problems. A subcommittee of the Workgroup convened a focus group of youths to review and finalize the script and storyboard. In May, 2007, the second public service announcement was filmed at a local high school. In June, 2007 this youth-targeted PSA entitled "Who can you talk to?" was aired on cable television stations and in local movie theaters. On television, the PSA was aired on the CW Network (Ch 6) and KVMY (12) from June 25 – July 14, 2007. On Cox Cable the PSA airs on Nickelodeon (23), BET (27), Spike TV (29), MTV (37), MTV2 (38), Comedy central (56), Family (59), Cartoon Network (65) and Toon Disney (69) from June 25 – July21, 2007. The PSA was also shown on 81 screens at 5 Movie Theatres (Colonnade 14, Orleans 18, Sunset Station 13, Texas Station 18, Village Square 18) around the valley prior to every feature from June 29 – August 23, 2007.

During Fiscal Year 2007-8, a third public service announcement was developed to address the issue of suicide prevention with teens as the primary target audience. Youths were utilized to develop the theme and storyboard, the script, and as actors in this PSA entitled "You don't need to be an expert to prevent a suicide, just be a friend." Representatives of the National Resource Center for Suicide Prevention also provided technical assistance in developing this public service announcement. Production of the PSA was completed in June, 2008, with the assistance of Matteson Media, Inc., Palm Mortuary, and the Las Vegas Academy. The PSA will be shown from July 4 – August 4, 2008 in 55 local movie theaters across Clark County and on youth-oriented cable television stations July 7 – August 4, 2008.

All three public service announcements can be viewed on the Southern Nevada Health District's Website: **http://www.gethealthyclarkcounty.org/injury_prev/mental_health.html.**

The CCCMHC has received national recognition from the U.S. Substance Abuse and Mental Health Services Administration for the media campaign and the public service announcements. The public service announcements have been shared with programs in Florida and with the Washoe County Mental Health Consortium, who received a grant to air the second PSA in Reno movie theaters during the month of December, 2007.

Last year, the CCCMHC contacted 800 local primary care physicians and pediatricians in January, 2007 to offer brochures for parents, posters for use in their clinics, and referral information. This year, the CCMCHC provided training to primary care physicians on screening children for behavioral health issues and suicide risk. A program entitled "Adolescent Depression and Suicidality" was presented to 53 pediatricians and other health care professionals on January 26, 2008 through the Sunrise Hospital's Continuing Medical Education Department.

The workgroup is also moving forward with its initiative to promote universal behavioral health care screening by primary care physicians. The workgroup has retained Barbara Ludwig, Consultant to assist with this effort. Through the efforts of Dr. Lisa Durette and Tammi Ewing, Spring Mountain Treatment Center, and Barbara Ludwig, Consultant, a curriculum for didactic physician training has been developed and local child and adolescent psychiatrists are being

recruited to assist in the training. As part of this initiative, the CCCMHC will offer on-site training and technical assistance to local physicians as they implement standardized behavioral health screening tools in their pediatric clinics. The workgroup is also working with the Medicaid EPSDT Screening Program on this effort.

The Clark County Children's Mental Health Consortium sponsored a celebration of National Children's Mental Health Awareness Day at Las Vegas High School. In partnership with the student council, two back-to-back assemblies were held for the 3300 students enrolled at the school. The goal of the event was to promote the following message to high school students: 1. Every child's mental health is important; 2. Many children have mental health problems; 3. These problems are real, painful, and can be severe; 4. Mental Health problems should be identified and treated as early as possible; 5. Caring families and communities working together can help

Speakers at the assembly included CCCMHC Chair Scott Reynolds, Executive Director for Student Support Services at the Clark County School District, and Kendall Tenney, News Anchor for Channel 3 KVBC Television in Las Vegas. In addition to live presentations by Mr. Reynolds and Mr. Tenney, Howie Mandel provided information about the importance of mental health via video clips provided by SAMSHA's Caring for Every Child's Mental Health Campaign. In order to heighten the awareness of the prevalence of behavioral health issues, 20% of the students in each assembly wore bright green t-shirts. Kendall Tenney facilitated a mental health awareness "quiz" with door prizes for the participating students. School social workers and counselors were available during the assembly and at least one student came forward during the assembly to seek help for his depression. A news story about the event was published in Las Vegas' major Hispanic newspaper, *El Mundo Las Vegas.*

During the coming year, the CCCMHC will continue its public education campaign and develop partnerships with public television and private businesses to continue to disseminate the public service announcements that have been produced. Additionally, the CCCMHC will explore methods for evaluating the impact of the campaign in partnership with the Nevada Office of Suicide Prevention, the Southern Nevada Health District, and the University of Nevada, Las Vegas.

Appendix E

Elementary School Students with Behavioral Health Problems Three Year Follow-Up Study

Summary of 2004 Survey

Sample Population

In 2004, an assessment was conducted to determine the behavioral health needs of Clark County's elementary school students and to estimate how well these needs were being met. A stratified sample of 2097 students was selected from the 129,958 students in the elementary grades (K-5) of the Clark County School District. The sample was selected to approximate the socioeconomic, geographic, and ethnic diversity of the total population. The goal was to take a sample of 1.5% or 1950 students. Schools were classified as high, medium, or low socio-economic status based on the percentage of students within the school who qualify for free and reduced lunches. Three schools representing the three socio-economic levels were selected from each of five geographic regions that make up the Clark County School District. In addition, Clark County had four elementary schools that were participating in a federal Department of Education Safe Schools Health Students grant. These schools were included in the assessment to provide a baseline assessment for the impact of this program. In each of the selected schools, one class was selected for each grade K-5. All of the students in that class were selected to participate. One of the nineteen selected schools had administrative turnover during the time of the screening and assessment and did not complete the process.

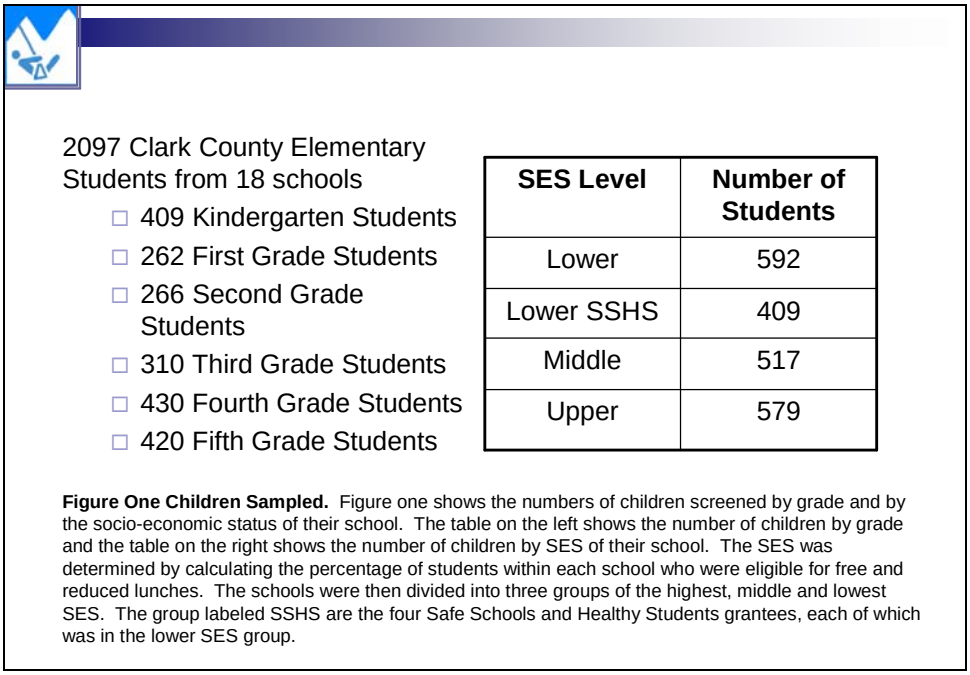
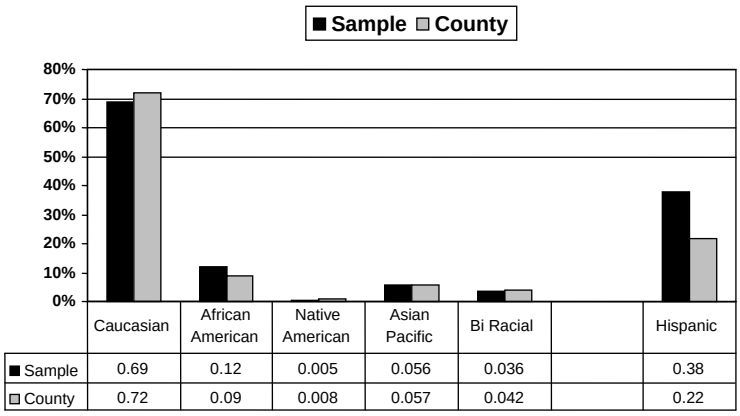


Figure One Children Sampled. Figure one shows the numbers of children screened by grade and by the socio-economic status of their school. The table on the left shows the number of children by grade and the table on the right shows the number of children by SES of their school. The SES was determined by calculating the percentage of students within each school who were eligible for free and reduced lunches. The schools were then divided into three groups of the highest, middle and lowest SES. The group labeled SSHS are the four Safe Schools and Healthy Students grantees, each of which was in the lower SES group.

Figure One shows the number of children screened by grade and socio-economic status of the school. The difference in the numbers per grade is partially explained by the

difference in class size. Earlier grades have smaller class sizes. Kindergarten classes meet for a half day so the increased number of kindergarten students relates to the fact that each kindergarten teacher has two classes and both were screened. The table on the right shows the number of students by social-economic status of the schools.



	Caucasian	African American	Native American	Asian Pacific	Bi Racial		Hispanic
Sample	0.69	0.12	0.005	0.056	0.036		0.38
County	0.72	0.09	0.008	0.057	0.042		0.22

Figure 2. Ethnicity of Sample. Figure 2 shows a comparison of the ethnicity of the sample of children screened with the general population of Clark County from census records. The five sets of columns on the left side of this graph show the self reported races of the children and general population. The columns on the right show the percentage of children and population who were reported to also be of Hispanic origin.

Figure Two shows the racial distribution of the sample compared to the general population of Clark County. The sample is within the expected variation of population figures. The one difference that stands out is the percentage of students identified as Hispanic. This is a secondary rating and the difference may be related to the data sources. The population data comes from official census data which would be self report. The sample data comes from teacher report.

Methods

2097 Students were selected to participate in the 2004 survey. The survey consisted of a two-tiered assessment: First, the student's primary teacher completed the 11-item Mental Health Screening Tool (MHST) on each student. MHST items are shown in ***Figure Three.***

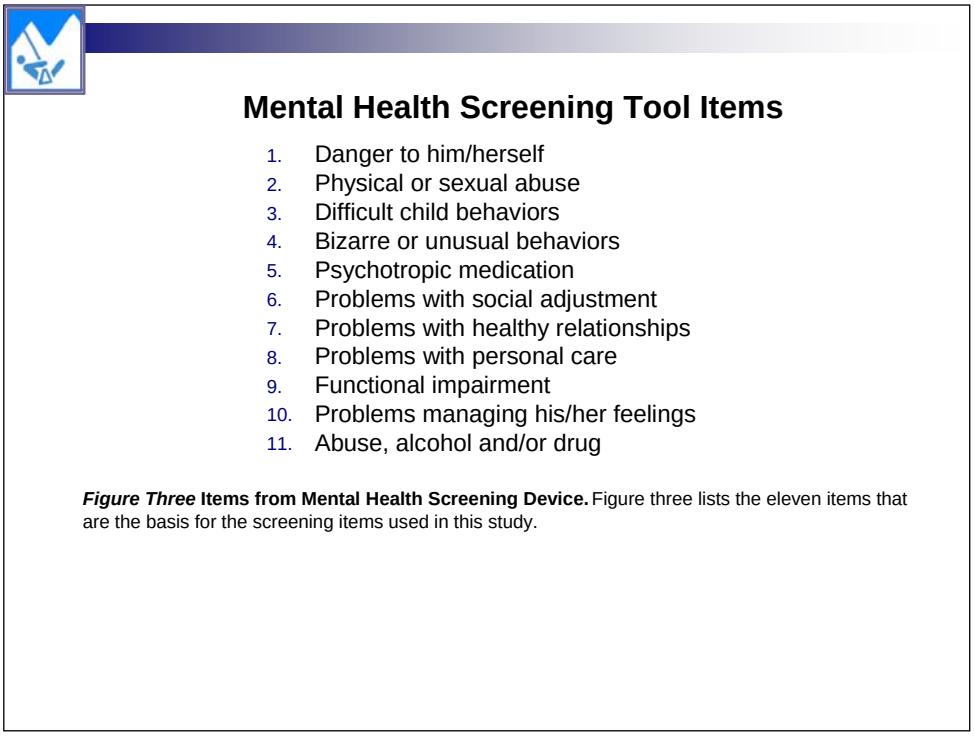


***Figure Three* Items from Mental Health Screening Device.** Figure three lists the eleven items that are the basis for the screening items used in this study.

Secondly, the school counselor assessed the level of service need using the Child and Adolescent Level of Care Utilization System (CALOCUS) for all students who scored positive on the Mental Health Screening Tool. The dimension and service need levels are shown in ***Figure Four***.

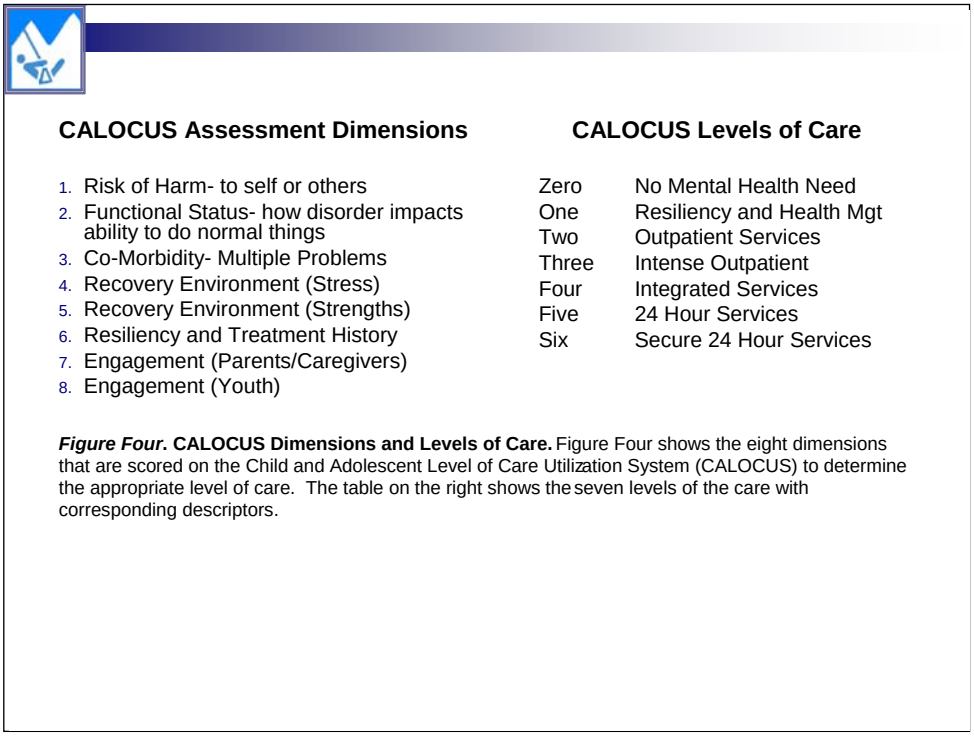


***Figure Four*. CALOCUS Dimensions and Levels of Care.** Figure Four shows the eight dimensions that are scored on the Child and Adolescent Level of Care Utilization System (CALOCUS) to determine the appropriate level of care. The table on the right shows the seven levels of the care with corresponding descriptors.

For each of the children who were assessed on the CALOCUS, the counselors also identified current services using a survey form. The current service need was compared to the level of service need identified by the CALOCUS for each child.

Results

The survey identified 19.3% of the students with some level of behavioral health problems and 6% with problems serious enough to warrant intensive levels of service. ***Figure Five*** shows the percentage of positive screens by the socio-economic status of the schools (left graph) and grade (right graph).

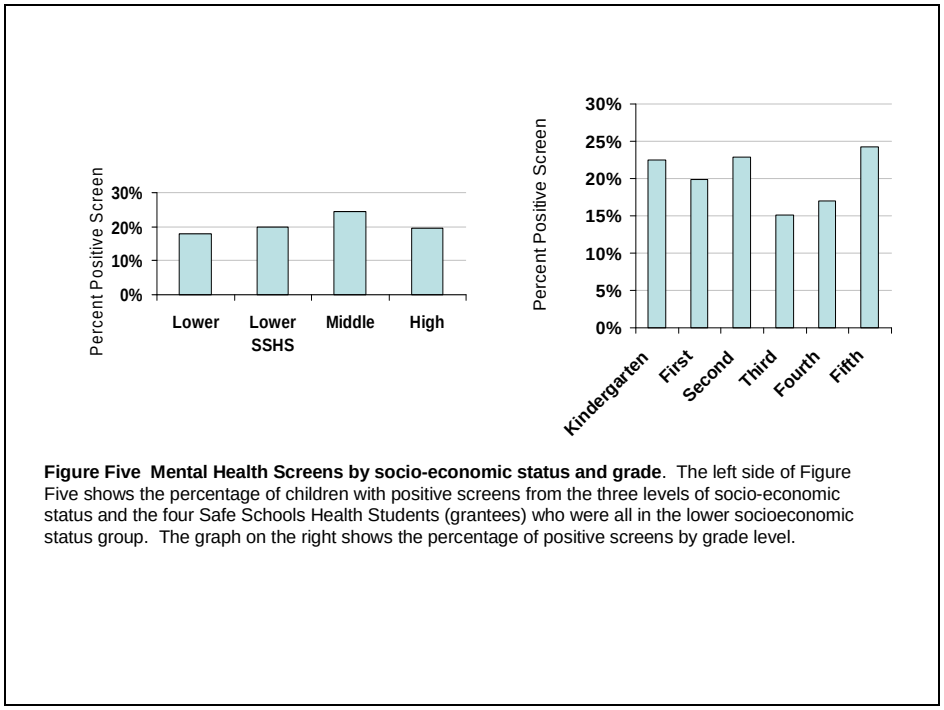


Figure Five Mental Health Screens by socio-economic status and grade. The left side of Figure Five shows the percentage of children with positive screens from the three levels of socio-economic status and the four Safe Schools Health Students (grantees) who were all in the lower socioeconomic status group. The graph on the right shows the percentage of positive screens by grade level.

At least 60% of the students with behavioral health service needs were receiving no known services. ***Figure Six*** shows the existing levels of services for children assessed with moderate and intense needs.

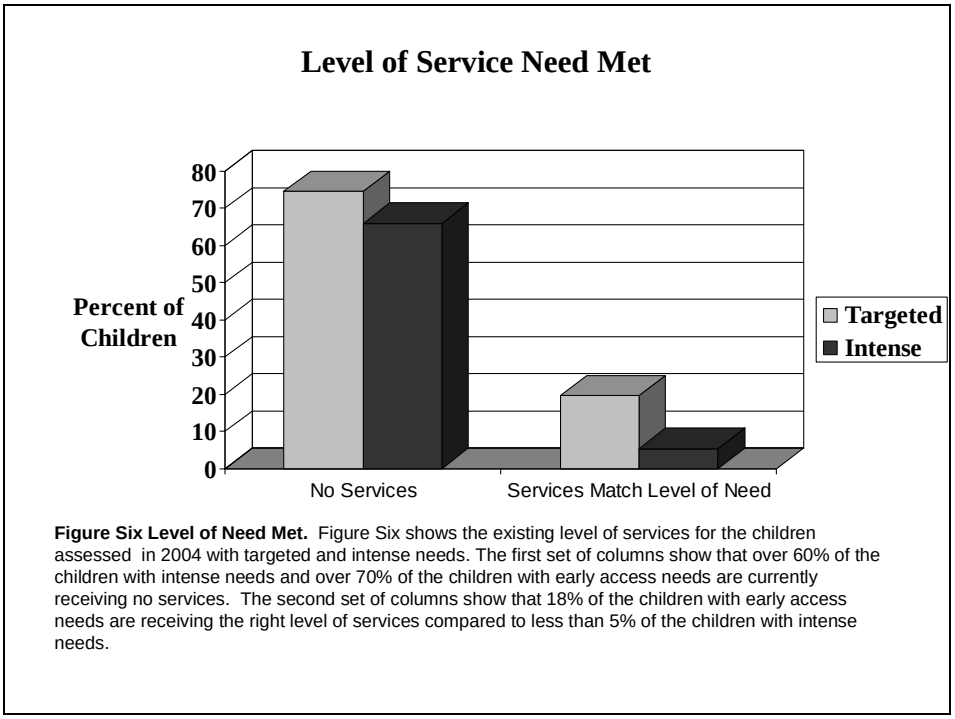


Figure Six Level of Need Met. Figure Six shows the existing level of services for the children assessed in 2004 with targeted and intense needs. The first set of columns show that over 60% of the children with intense needs and over 70% of the children with early access needs are currently receiving no services. The second set of columns show that 18% of the children with early access needs are receiving the right level of services compared to less than 5% of the children with intense needs.

The information from the surveys was provided to the school counselors in an effort to assist students in obtaining the needed services for those children identified. The information was also used to develop a model for earlier and more effective service delivery to these children. Unfortunately, the model developed for targeted and intense interventions to elementary school children was not implemented as recommended by the Clark County Children's Mental Health Consortium. For more detailed information on the 2004 Survey, please see the CCCMHC's Third Annual Plan (2004).

2007 Follow-up Study

Sample Population

In 2007, the Clark County Children's Mental Health Consortium collaborated with the Clark County School District to conduct a preliminary follow-up study of the 2097 children surveyed in 2004. The District was able to identify 1700 of the original sample enrolled during the 2006-7 school year. 250 of the original 427 students identified with behavioral health problems were still enrolled in the district.

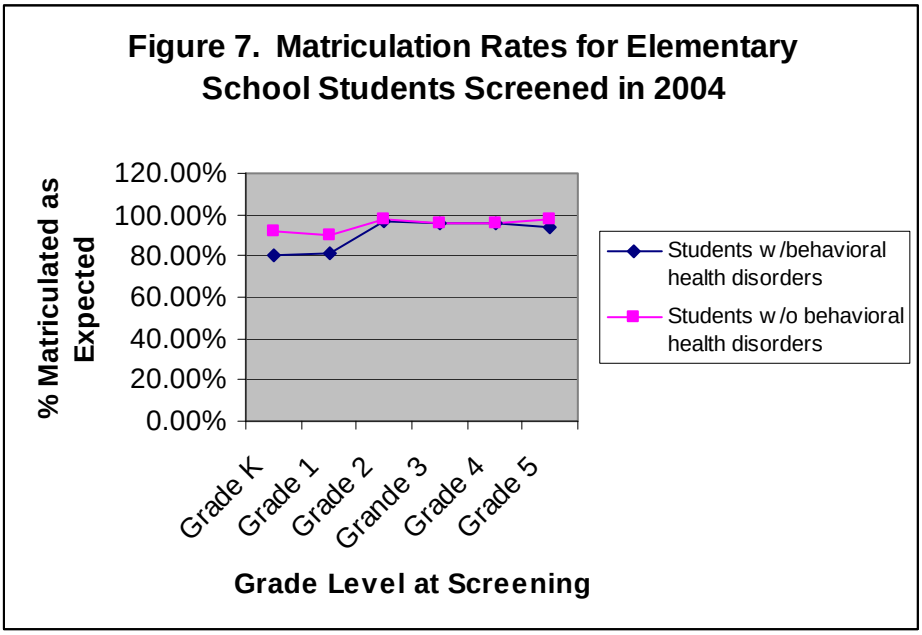
Methods

The records of all 1700 students from the original sample were examined to determine whether the children identified with behavioral health problems in 2004 were more likely to be receiving special education services in 2007 than the rest of the remaining

sample of students. Matriculation rates and scores on national achievement testing for the original student sample were also examined and compared.

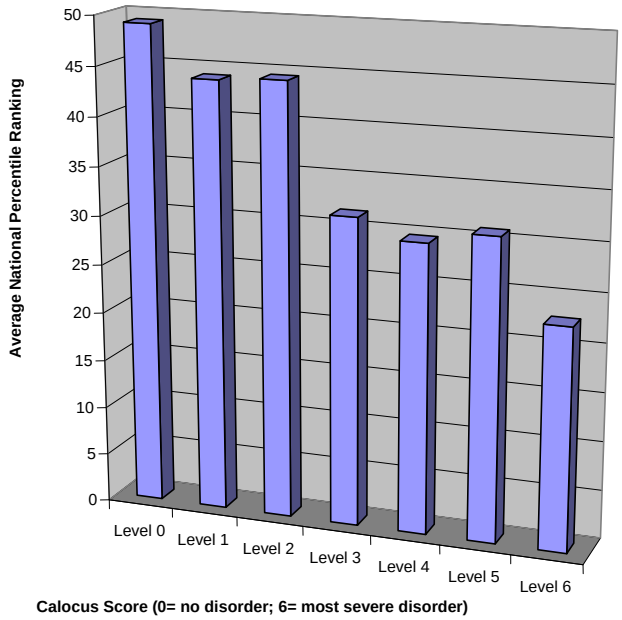
Results

The analysis revealed no differences in special education eligibility between those students identified with behavioral health problems and those in the overall sample. Students identified with behavioral health problems were no more likely to be receiving special education services than the overall sample. Less than 10% of the children identified in 2004 are currently getting special education services through the school district. This was an unexpected finding, suggesting that the children with behavioral health problems were still being included in regular classroom programs, either because their behaviors had improved, or because special education services were not an appropriate option to address their behaviors.



There were, however, significant differences in the matriculation rates of the students originally identified with behavioral health problems. In particular, Kindergarten and 1st Grade Children with behavioral health problems (i.e. scoring 1+ on the CALOCUS in 2004) were significantly more likely to be matriculating at a lower rate than those without a CLOCUS score. ***Figure Seven*** shows the matriculation rates by grade level for those children identified with behavioral health problems and without identified problems.

***Figure Eight*. Academic Achievement Rankings for Elementary School Students Screened for Behavioral Health Disorders in 2004**



There were also significant differences in the achievement scores of students identified with behavioral health problems as compared to the rest of the sample. Students who received 1+ CALOCUS rating were **17.3**% more likely to score in the bottom 2 quartiles on state student achievement tests than their counterparts who did not receive a CALOCUS rating. ***Figure Eight*** shows that average national percentile ranking of students by the level of their CALOCUS score. The average is computed across math, reading and language arts rankings. The higher the CALOCUS score a student received in 2004, the lower their future achievement test NPR. Students who received the highest CALOCUS rating (6) in 2004 scored an average of 26.38 NPRs (more than one quartile) lower than those students who did not receive a CALOCUS rating.

Discussion

The original study and follow-up of elementary school children with identified behavioral health problems highlights the relationship between behavioral health and school achievement. The study suggests that elementary school children with behavioral health problems perform more poorly in school and receive relative few services to help them overcome these performance problems. The Clark County Children's Mental Health Consortium is committed to a service delivery model that facilitates early access to targeted interventions for these elementary school children.

Appendix F

Survey of Youth Behavioral Health Emergency Room Admissions

Background Information. As part of the needs assessment for last year's Annual Plan, information was gathered from the emergency room departments of the two largest hospitals in Clark County serving the pediatric population. Emergency Room Managers from University Medical Center and from Sunrise Children's Hospital provided quantitative and qualitative data on youths admitted to emergency rooms for serious and life-threatening behavioral health problems. In 2005, an estimated 720 of these youths were admitted to the two largest local emergency rooms Admitting problems for these youths included: suicidal ideation, conduct disorder, depression, suicide attempts, acute anxiety, and psychosis.

In 2006, the CCCMHC's Workgroup on Infrastructure and Coordination received feedback from the emergency room managers, law enforcement representatives, psychiatric hospital staff, and stakeholders which suggested that an increasing number of youths in Clark County are being admitted to emergency rooms for serious behavioral health problems.

Emergency room personnel suggested the youths admitted for behavioral health problems expended relatively more emergency room resources than other emergency room admissions. Additionally, emergency room services for these youths did NOT result in better access to needed behavioral health services.

As part of the CCCMHC's 2006 needs assessment, the Workgroup on Infrastructure and Coordination gathered information on youth admissions from the emergency room departments of the two largest hospitals in Clark County serving the pediatric population.

Emergency Room Managers from University Medical Center and from Sunrise Children's Hospital provided quantitative and qualitative data on youths admitted to emergency rooms for serious and life-threatening behavioral health problems. In 2005, an estimated 720 of these youths were admitted to the two largest local emergency rooms. Admitting problems for these youths included: suicidal ideation, conduct disorder, depression, suicide attempts, acute anxiety, and psychosis.

As a results of this examination of youth behavioral health emergency room admissions, the CCCMHC: (1) Recommended that the Legislature fund mobile crisis intervention and stabilization services to provide alternative treatment to these youth; (2) Developed a model of service delivery for mobile crisis intervention services; and (3) Recommended that a monthly tracking system be established to monitor youth psychiatric emergency room admissions.[25]

With the assistance of Jim Osti of the Southern Nevada Health District, a comprehensive system was developed to track youth admissions to local emergency rooms for behavioral health problems on a monthly basis. The system was implemented in January, 2007. At least eight local hospitals agreed to participate in the tracking program. Additionally, the 2007 Nevada Legislature approved funding to implement mobile crisis intervention services as a pilot project in Central Las Vegas. The project was originally due for implementation in October 2007. The Division of Child and Family Services began developing policies and procedures for the program consistent with the model created by the CCCMHC. A state budget crisis during fiscal year 2007-8 has deferred any implementation indefinitely. Nonetheless, the CCCMHC Workgroup

[25] Clark County Children's Mental Health Consortium (2006). *Fifth Annual Plan.* Carson City, NV: Nevada Division of Child and Family Services

on Infrastructure has continued to work with Mr. Osti to track youth admissions and to gather more information for planning and needs assessment.

2007 Survey Methods.

Emergency Room Managers continued to submit data in the tracking system developed by Mr. Osti for all of calendar year 2007. Managers were asked to provide the total number of admissions for youths with behavioral health problems each month. Youth identified are those for whom a behavioral health problem is the primary reason for admission to the emergency room. Emergency Room Managers used an electronic tracking form was to complete and submit the data to Mr. Osti on a monthly basis. The data elements included the following:

1. Total number of admissions
2. Total days/hours of emergency services
3. Hospital and post-hospital disposition
4. Legal Status of admission (i.e., legal 2000 or voluntary)
5. Payer Source
6. Zip Code of Origin for each Admission
7. Mode of Arrival to Emergency Room (i.e., police, ambulance, walk-in)
8. Age of youth

Data were gathered for the period between January 1, 2007 and December 31, 2007.

2007 Survey Results and Conclusions:

Data are available for the period from January 1, 2007 until December 31, 2007. There were a total of 1103 admissions reported by seven local hospitals: Sunrise Medical, University Medical Center, Spring Valley Hospital, Desert Springs, Summerlin Hospital, Valley Hospital and Boulder City Hospital. Youth emergency room admissions for behavioral health problems increased 53.1% between 2005 and 2007.

Figure 1 shows the age breakdown for the 2007 admissions. The majority of youths were older adolescents (15-17 years old) but over one-third are youths aged 10-14 years. The Clark County School District has reported increasing crisis referrals for this age group during school hours.

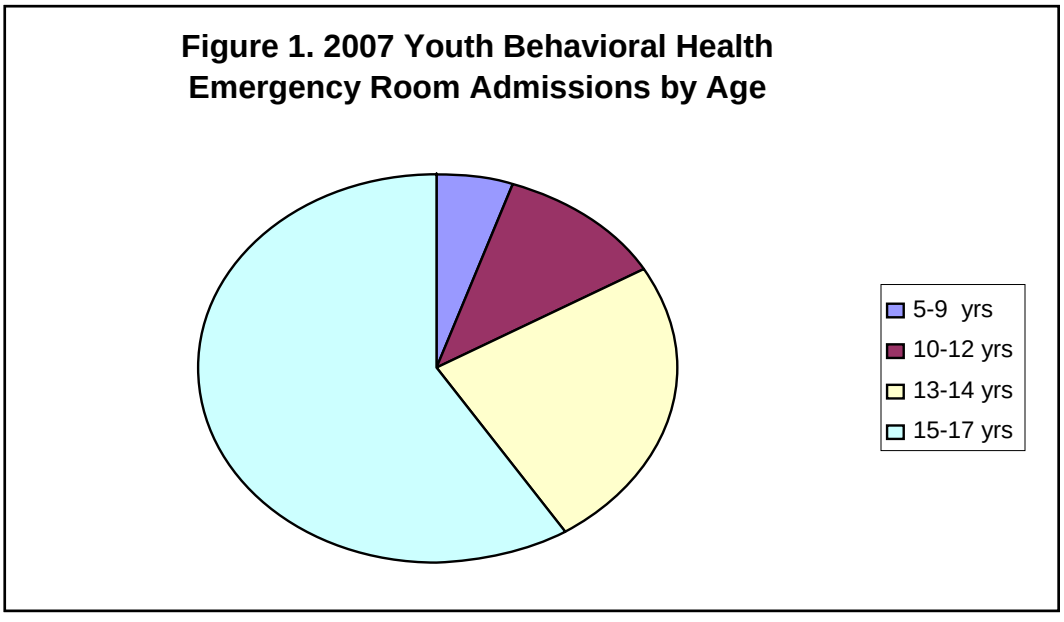


Figure 2 illustrates the geographic breakdown of addresses for youths admitted. Two-thirds of the youths originate from the central area of Clark County (Las Vegas) and North Las Vegas. Although it is important to ensure that any mobile crisis intervention team can effectively respond to this geographic area, the CCCMHC has recommended that mobile crisis intervention services should be accessible to the entire Las Vegas Metropolitan area.

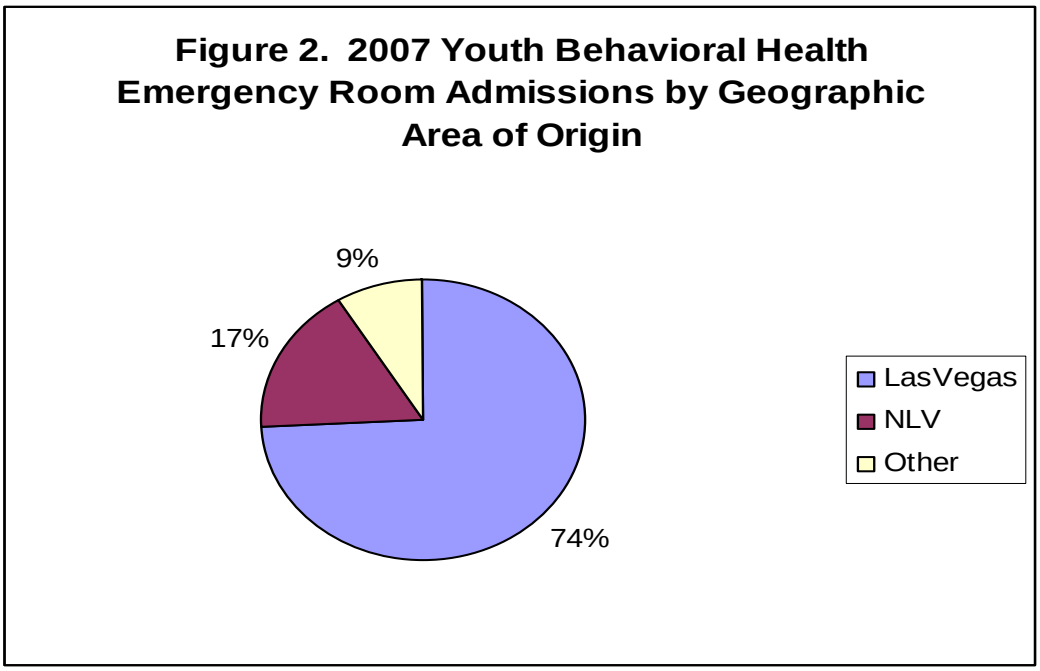
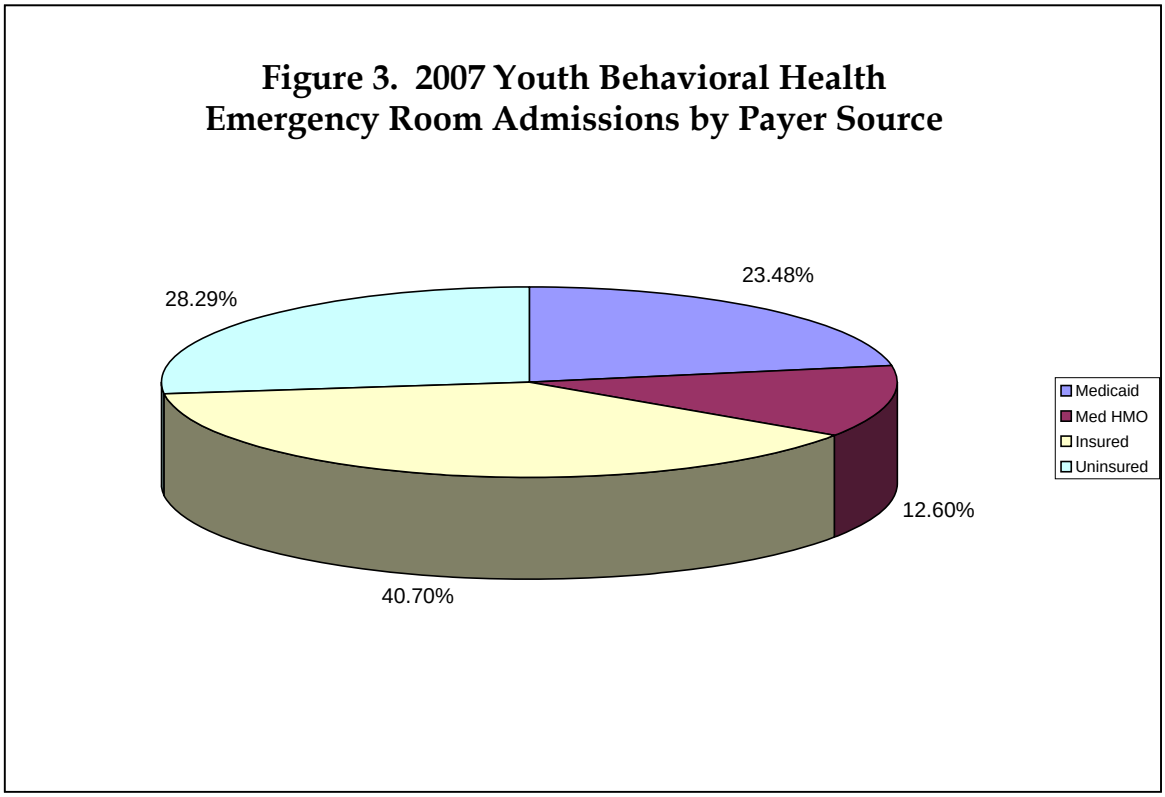
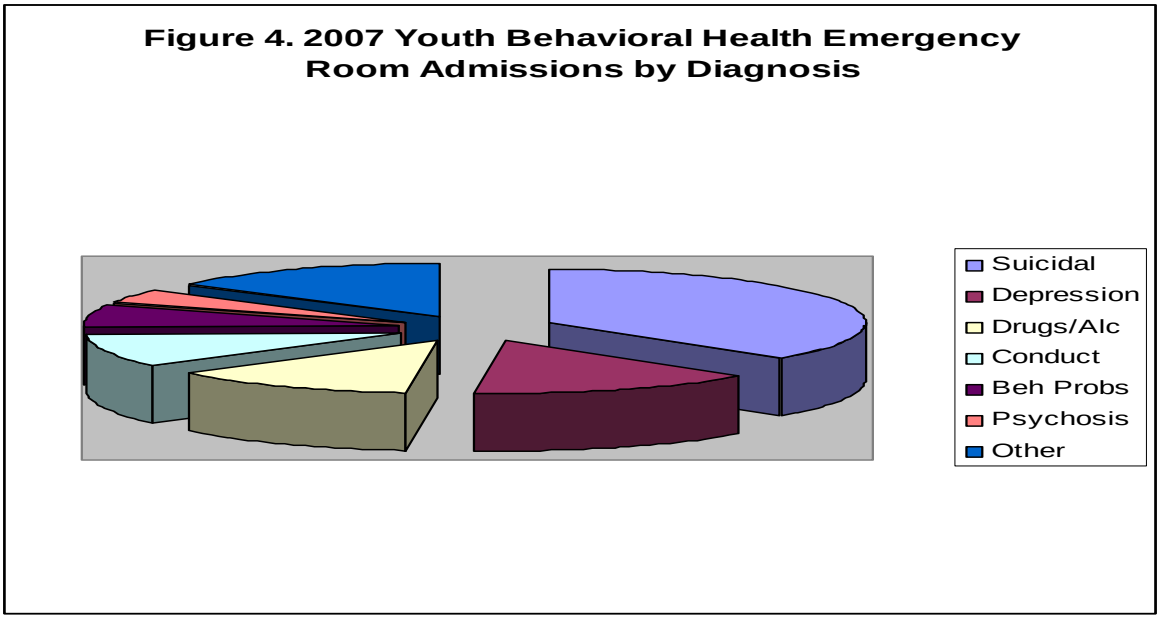


Figure 3 shows the payer source for the 2007 admissions. Over 25% of the youths admitted were uninsured and one-third were covered by Medicaid.

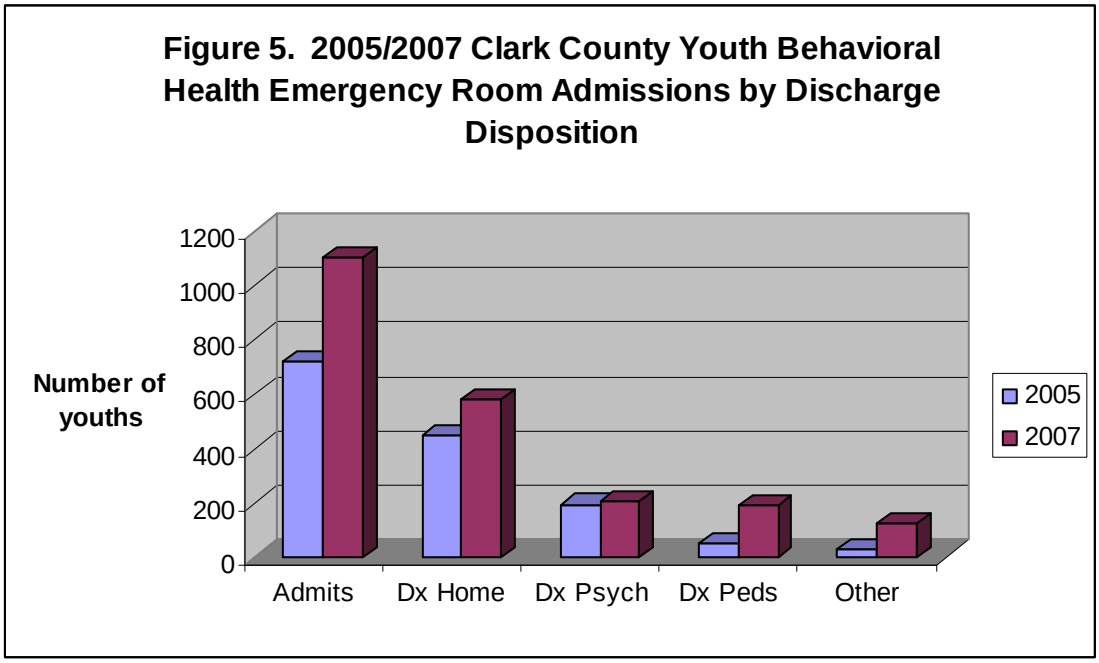


An analysis was completed on the primary presenting problems at the time of admission (See Figure 4). Thirty-seven percent of the admissions were youth with suicide attempts or suicide ideation. Depression and substance abuse were the other top reasons for admissions.



Any mobile crisis intervention program that is implemented must include professional staff trained to assess and de-escalate suicide risk.

Figure 5 shows the total number and disposition of youths admitted to two local emergency rooms for behavioral health problems. These numbers represent annual estimates based on actual data for 11 months of 2005 (January-November 2005) and actual data for 6 months of 2007 (January 1-June 30). The disposition categories are: Dx Home=discharged home; Dx Psych=discharged to psychiatric hospital; Dx Peds=discharged from emergency room to hospital pediatric unit; Other=includes discharged to juvenile detention or unknown.

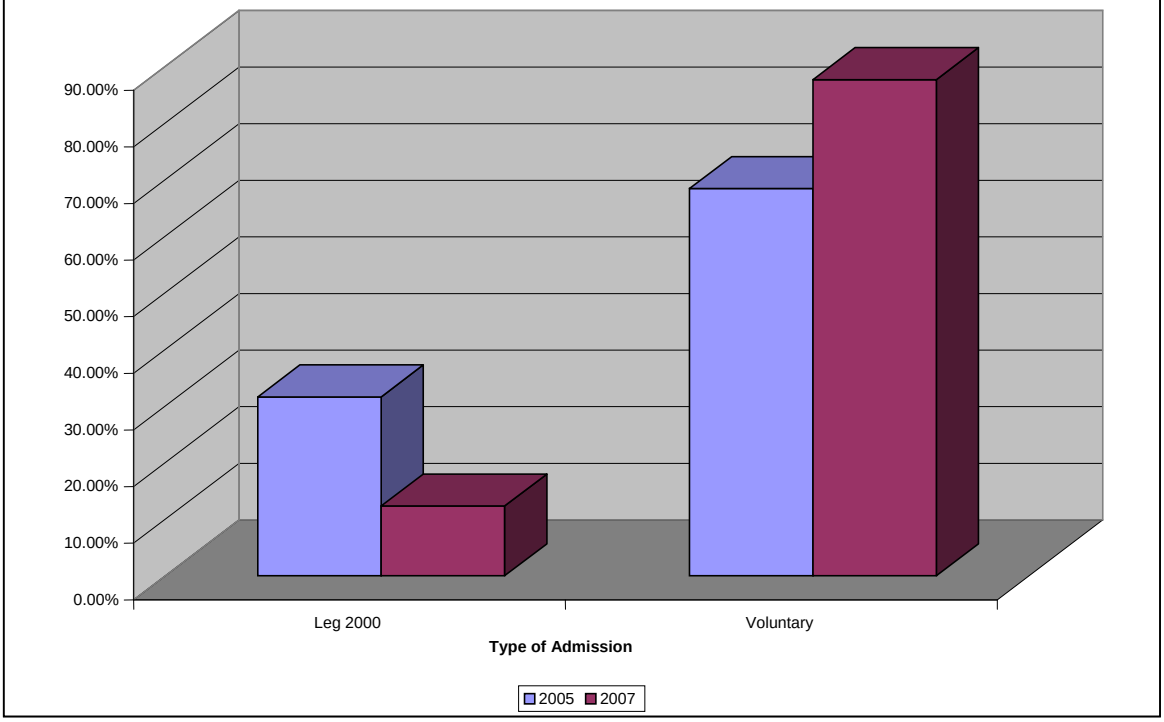


There were a total of 53.1% of youths admitted that were discharge home without any immediate treatment. Nearly half of youths discharged home were suicidal, psychotic or depressed at the time of their admission the emergency room. The ability to provide immediate services to these youths through a mobile crisis intervention team may have prevented further difficulties in maintaining these youths at home.

There was a disproportionate increase in the number of youths admitted to the hospitals' pediatric units upon discharge from emergency room services. Whereas there were an estimated 52 youths admitted to inpatient pediatric care in 2005, it there were 193 youths requiring inpatient pediatric services in 2007, a **269% increase**. Feedback from emergency room staff suggests that the inability to secure psychiatric hospital, residential placement, or other intensive services for these youths necessitated their admission to the pediatric unit for safety and security purposes. Although psychiatric consultation was available on these units, emergency room staff indicated that appropriate services were NOT available for these youths. The CCCMHC will continue to monitor youth behavioral health admissions in the coming year.

Figure 6 shows the percentage of youth behavioral health emergency rooms admissions made using the Legal 2000 Procedure as compared to those admissions that involved voluntary consent (by parent or guardian). 2005 estimates are based on 11 months of data from the two larges local hospital. 2007 estimates are based on the first 6 months of data from the same hospitals.

Figure 6. 2007 Youth Behavioral Health Emergency Room Admissions by Legal Status



In the 2006 Plan, the CCCMHC recommended that efforts be initiated to reduce the utilization of the Legal 2000 Procedure to admit youths with behavioral health problems to local emergency rooms. The Legal 2000 Procedure allows medical professionals, law enforcement, or other emergency service personnel to transport and hold a youth in the emergency room without parental consent. The CCCMHC encouraged agencies to train their personnel in alternative strategies to the Legal 2000 Procedure, including the engagement and involvement of parents and family whenever possible. As shown in Figure 2, the percentage of admissions using the Legal 2000 Procedures decreased from 34% in 2004 to 16.5% in 2007. Clark County School District, Clark County Fire Department and the Las Vegas Metropolitan Police Department reported systematic efforts to train their personnel in alternative to the Legal 2000 as recommended by the CCCMHC. Since **57.7%** of the 2007 youth admissions via the Legal 2000 Procedure were initiated by emergency transport agencies, there is still a need to assist these agencies in training their personnel in alternatives to emergency room transport.

Lengths of stay in emergency rooms are shown in Table 1. The average length of stay for all 2007 youth behavioral health admissions was 23.5 hours. Lengths of stay were twice as long for uninsured youths as for those with Medicaid or commercial insurance benefits.

Uninsured youth have limited access to psychiatric inpatient or outpatient care. One goal of effective crisis intervention services is to reduce or eliminate stays in local emergency rooms for these youths. Other community programs such as Wraparound Milwaukee have found mobile crisis intervention services to be effective in meeting such a goal.

Table 1. 2007 Youth Behavioral Health Emergency Room Admissions
Average Lengths of Stay by Payer Source

Payer Source	Average Length of Stay
Champus	18.2 hours
Commercial Insurance	18.7 hours
Health Maintenance Organizations	12.7 hours
Managed Medicaid	20.2 hours
Medicaid Fee-for-Service	22.3 hours
Uninsured	35.3 hours
Unknown	7.9 hours
All Admissions	23.5 hours

Appendix G

Survey of Aftercare Needs for Youths served by Desert Willow Treatment Center

Purpose of the Survey

Children with serious behavioral health problems often require hospitalization in order to prevent harm to self or others, and to reduce acute symptoms resulting from conditions such as schizophrenia, post-traumatic stress disorder, and bipolar disorder. Desert Willow Treatment Center (DWTC) provides short-term hospitalization and residential care to youths with the most serious and life-threatening conditions. Approximately one-half of youths served by DWTC are uninsured or underinsured at the time of hospitalization. Medicaid subsidizes the care of these youths while in the hospital under a benefit called "family of one." DWTC also serves youths covered by Fee-for-Service Medicaid.

Aftercare services are one of the factors associated with successful outcomes for hospitalized youths with serious behavioral health problems. CCCMHC members reported anecdotally that some families' members experience difficulty in accessing aftercare services following their youth's hospitalization. Uninsured and underinsured families are typically referred to DCFS programs at the Neighborhood Centers for aftercare services. However, DCFS does not provide a full range of aftercare services. For example, DCFS does not directly provide day treatment services for these youths, but may refer to private providers in the community.

In 2006, the CCCMHC collaborated with Desert Willow Treatment Center to develop an annual survey for assessing the aftercare needs of uninsured and underinsured youths requiring hospitalization for their serious emotional disturbance. A survey was first administered in April, 2006 and April, 2007. The results of the 2006 and 2007 surveys are reported in the CCCMHC's Fifth and Sixth Annual Plans, respectively.

In April, 2008, CCCMHC members met with Desert Willow Treatment Center Staff and revised the survey. There were a number of families surveyed in 2007 who were not sure what their aftercare plans had recommended, and so they had difficulty responding as to whether the plan had been fully implemented. The revised survey prompted families on the services listed in their youth's aftercare plans, and asked for specific information on implementation and/or barriers to implementation for each service. In addition to sampling the "Family of One" or uninsured youths, a sample of Fee-for-Service Medicaid youths were also selected as a second group to be surveyed. The revised survey was then administered in May and June 2008.

Survey Methods

Approximately 300 youths were hospitalized in Fiscal Year 2007-8 at Desert Willow Treatment Center. Of these youths, 51.5% of the youths were "family of one" cases. There were also 43.7% of the youths served who were covered by Fee-for-Service Medicaid. Uninsured youths covered by "Family of One" Medicaid and youths covered by Fee-for-Service Medicaid were selected as the target population for the survey. Only those youths discharged for more than 30 days were selected as subjects for the survey. There were approximately 114 such youths in the "family of one" group and 94 youths in the Fee-for-Service Medicaid group.

During May, 2008, a family member was hired as the surveyor to administer the twelve-item telephone survey of aftercare services. The surveyor successfully contacted the parent or legal custodian of 28 of the 114 "family of one" youths in the sample and 17 of the 94 youths in the Fee-for-Service Medicaid sample. The surveyor completed the survey instrument with each family in a telephone interview. A copy of the survey is included at the end of this report. Attempts to contact the remaining families were unsuccessful.

Survey Results

Table 1 shows the distribution of the survey respondents by Desert Willow Treatment Center Unit for each year the survey was conducted and by each group surveyed in 2008. There were more youths surveyed from the Adolescent Acute Unit (AAP) and fewer youth surveyed from the Children's Acute Unit (CAP) and the Residential Treatment Units (RTC) in 2008 as compared to previous years.

Table 1. Percentage of Participants in Each Group by Program Unit

	Percentage of Youths Family of One (Uninsured)			FFS Medicaid
DWTC Unit	**FY2006**	**FY2007**	**FY2008**	**FY2008**
AAP	44.7	34.5	57.1	29.4
CAP	15.8	27.6	17.9	35.3
RTC	39.5	37.9	25.0	35.3
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**

Table 2 shows the lengths of stay for the youths of families participating in the survey. There were fewer youths with lengths of stays greater than six months in the 2008 sample as compared to the 2007 sample. There were more youths that were served for less than 30 days in the 2008 sample as compared to previous years.

Table 2. Percentage of Participants in Each Group By Length of Stay

Length of Stay	Percentage of Youth Family of One (Uninsured)			FFS Medicaid
	FY2006	**FY2007**	**FY2008**	**FY2008**
< 1 month	34.2	44.8	53.6	58.8
1-3 months	44.7	20.7	21.4	29.4
3-6 months	10.5	24.1	21.4	5.9
6-9 months	7.9	6.9	3.6	5.9
9-12 months	2.6	3.34	-0-	-0-
Group Total	**100.0**	**100.0**	**100.0**	**100.0**

Comparison of Results for Uninsured Youths 2006-2008

Figure 1 shows the percentage of uninsured youths receiving all recommended after care services for each year of the survey. 63% of youths surveyed in 2008 received all recommended aftercare services, somewhat more than in 2006 and 2007. *However, the survey question was modified in 2008 so any comparisons should be made with caution.*

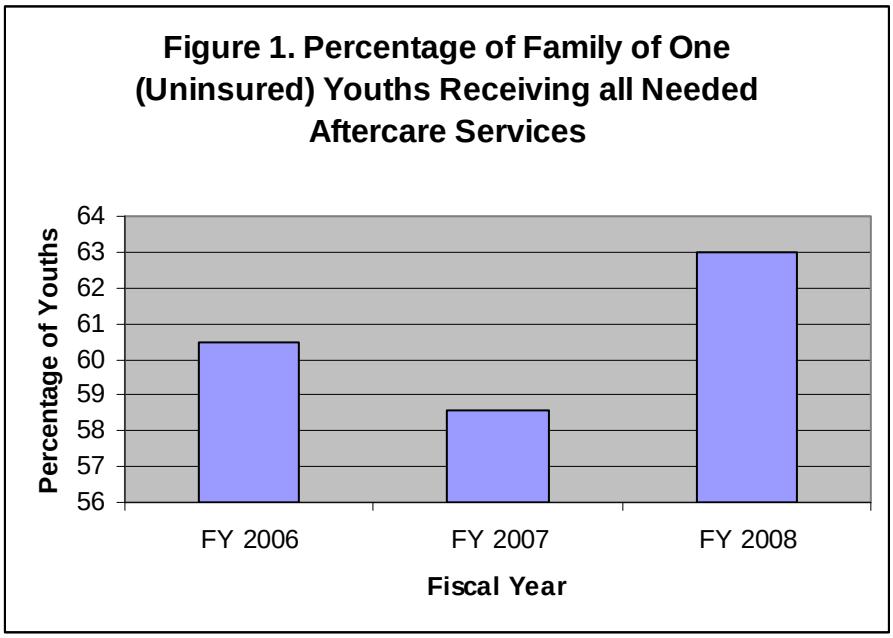


Table 3 shows the percentage of uninsured youths who required emergency or unplanned residential services following discharge. **About one-third of uninsured youths** required these emergency or residential services post-discharge across all three years.

Table 3. Percentage Family of One (Uninsured) Youth's Utilization of Emergency or Unplanned Residential Services Post-Discharge			
	Percentage of Youth		
Utilized Emergency Services	**FY2006**	**FY 2007**	**FY2008**
Yes	31.6	34.5	32.1
No	65.8	62.1	67.9

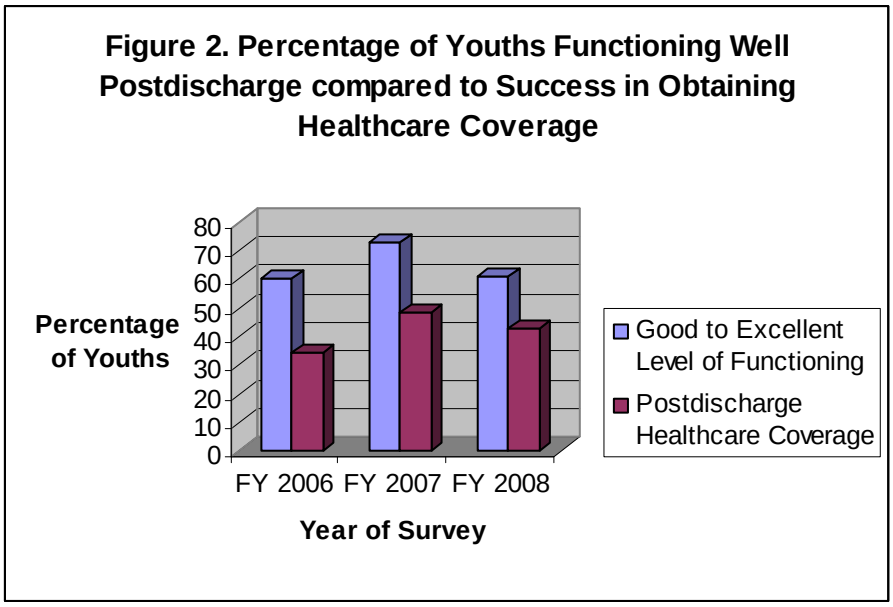
Table 4 shows the parent's report on the uninsured youths' level of functioning. 60.7% of parents reported that their youths were functioning well in the 2008 survey, significantly fewer than in 2007 and similar to the results found in 2006. More youths were functioning at the "fair" or "poor" levels in 2008 than in previous years. Only 14.3% of youths were functioning at an "excellent" level.

Table 4. Percentage Family of One (Uninsured) Youth's Level Functioning Post-Discharge			
	Percentage of Youths at Each Level		
Level of Functioning	**FY2006**	**FY 2007**	**FY2008**
Poor	18.4	24.1	28.6
Fair	21.1	3.4	10.7
Good	18.4	20.7	25.0
Very	23.7	24.1	21.4
Excellent	18.4	27.6	14.3
Good or Above	60.5	72.4	60.7

Table 5 shows the percentage of uninsured youths in the with healthcare coverage post-discharge. 42.9% of these youths had obtained healthcare coverage at the time of the 2008 survey, while slightly more youths (48.3%) had coverage in 2007 and significantly fewer had coverage in 2006.

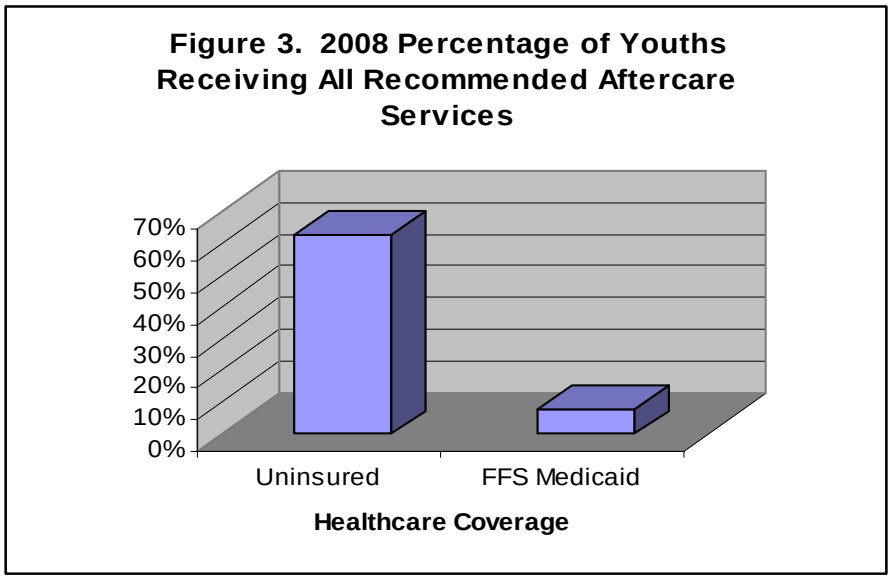
Table 5. Percentage of Family of One (Uninsured) Youths with Healthcare Coverage Post-Discharge			
	Percentage of Youth		
Healthcare Coverage	**FY2006**	**FY2007**	**FY2008**
Yes	34.2	48.3	42.9
No	65.8	48.3	53.6
Don't Know	0	3.4	3.6

Figure 2 shows the relationship between post-discharge functioning and healthcare coverage for uninsured youths across the three years of the survey It appears that healthcare coverage may be related to better outcomes for youths or that other factors covarying with healthcare coverage (such as parent employment and stability) may contribute to the relationship between healthcare coverage and post-discharge functioning.

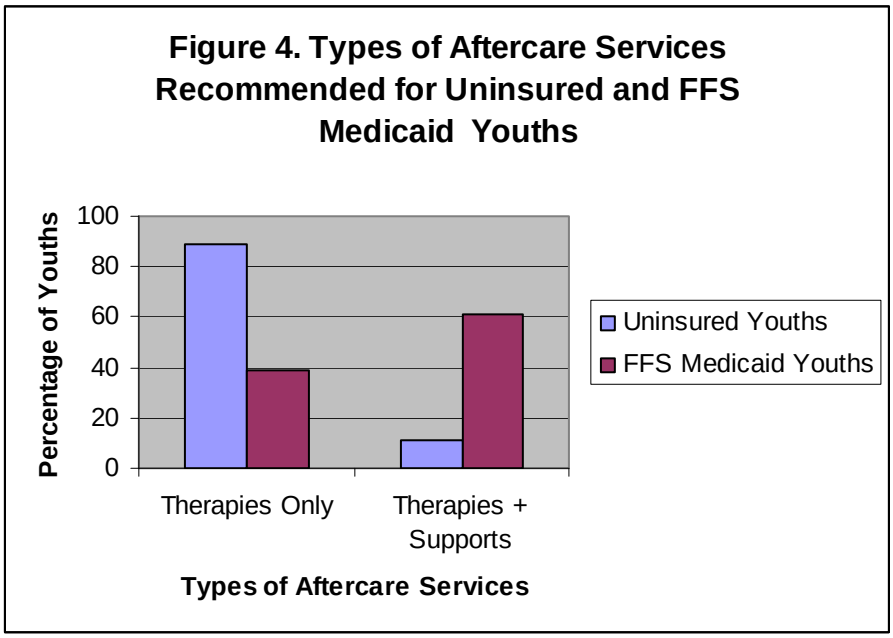


Comparison of Results for Uninsured and Fee-for-Service Medicaid Youths

Figure 3 shows a comparison of the percentage of youths who received all recommended aftercare services in the Family of One (uninsured) Group and the Fee-for-Service Medicaid Group. Only 7.7% of youths in the FFS Medicaid Group received all recommended services as compared to 63% in the Uninsured Group.



However, it is important to note that the aftercare plans of FFS Medicaid Youths included many more services and supports than the plans for the Uninsured Youths. **Figure 4** shows a comparison of the types of services included in the aftercare plans for each group.



Almost 90% of the aftercare plans for the uninsured youths listed only psychiatric care and psychotherapy as recommended care. Only 11.4% of these plans included other services and supports. Only about 17% of the families of uninsured youths had received family-to-family support services. Aftercare plans for uninsured youths may have been developed based on limited availability of services for this population rather than based on specific needs of the youth. Families surveyed were unaware of all aftercare service options.

Table 6 shows a comparison of post-discharge functioning for the Family of One (Uninsured) Group as compared to the Fee-for-Service Medicaid Group. Somewhat fewer
Youths in the FFS Medicaid Group were reportedly functioning well following discharge.

Table 6. Percentage Family of One (Uninsured) Youth's Level Functioning Post-Discharge		
	Percentage of Youths at Each Level	
Level of Functioning	**Family of One (Uninsured)**	**Fee-for-Service Medicaid**
Poor	28.6	29.4
Fair	10.7	17.6
Good	25.0	17.6
Very	21.4	23.5
Excellent	14.3	11.8
Good or Above	60.7	52.9

Table 7 shows a comparison of the utilization of post-discharge emergency and unplanned residential services by the two groups. Approximately one-third of each group utilized emergency or unplanned residential services.

Table 7. Comparison of Youths' Utilization of Emergency or Unplanned Residential Services Post-Discharge by Healthcare Coverage Group		
	Percentage of Youth	
Utilized Emergency Services	Family of One (Uninsured)	Fee-for-Service Medicaid
Yes	32.1	31.3
No	67.9	68.8

Satisfaction with and Barriers to Services

Parents in the Family of One (Uninsured) Group and the FFS Medicaid Group both rated the specific aftercare services that the youth received following discharge. **Table 8** shows a comparison of the service ratings.

Table 8. Comparison of Aftercare Service Ratings by Health care Coverage Group		
	Percentage of All Received Services	
Service Rating	Uninsured Youth	FFS Medicaid
Poor	2.6	9.4
Fair	2.6	9.4
Good	17.9	12.5
Very Good	35.9	18.7
Excellent	41.0	50.00
Good or Above	94.9	81.2

A total of 39 received aftercare services were rated by the 17 parents survey from the FFS Medicaid Group. A total of 32 received aftercare services were rated by the 28 parents surveyed from the Family of One (Uninsured) Group. Service ratings were significantly higher for the Family of One (Uninsured) Group. However, it is important to keep in mind the differences in the types and range of services recommended (and received) by each group (See Figure 4).

For the Uninsured Group of Youths, extraneous factors such as family relocation, caregiver changes and the youth aging out of the system were the most frequently cited barriers to receiving recommended services. The second most frequently cited barrier was lack of insurance coverage.

For the Fee-for-Service Medicaid Group of Youths, lack of insurance coverage for the recommended services was the most frequently cited barrier to receiving the specific services. This finding deserves more study, since many of the recommended services that were not received appear to those typically covered by Medicaid.

Survey Conclusions

Even though about sixty percent of families of youth discharged from DWTC in 2008 reported that their youths were functioning at a good to excellent level, over one-third of the youths still required emergency services during the aftercare period. Similar to the results of the 2007 Survey, nearly 40% of families of uninsured youths in the 2008 survey reported that they were not able to access all the needed aftercare services. More than half of the youths were still without healthcare coverage following discharge. Examination of the findings of the survey over the last three years suggested that having healthcare coverage appeared to be related to positive post-discharge functioning.

Even those families of youths with FFS Medicaid coverage reported challenges in receiving the recommended aftercare services and these youths did not appear to be functioning as well as the Family of One (Uninsured) Group. This finding deserves further study.

One of the unexpected findings was the difference between the aftercare plans for Family of One (Uninsured) Youths and FFS Medicaid Youths. Most of the aftercare plans for the uninsured youths listed only psychiatric care and psychotherapy as aftercare services. Parents surveyed were unaware of other aftercare service options. Both parents and staff should receive training in the most effective aftercare services for the types of youths being served. FFS Medicaid Youths' aftercare plans more frequently listed additional services and supports for aftercare. Another surprising finding was that very few FFS Medicaid Youths accessed all recommended aftercare services.

Only about 17% of families surveyed had received family-to-family support services and none of the plans listed this as a recommended service. More family-to-family support services should be made available to both groups of youths.

DESERT WILLOW TREATMENT CENTER
Aftercare Services Survey

*Unit:*_____ *Respondent :* ☐ *Parent* ☐*Legal Custodian*

Date of Discharge: _____ *Date of Survey:*_____

Patient length of stay: ☐ *Less than a month* ☐ *3 Months* ☐ *6 Months*

☐ *9 Months* ☐ *12 Months*

The purpose of the survey is to find out how your child is doing since being discharged from DWTC and to find out if you have been able to access the services needed to care for your child at home.

1. Please tell me how your child is doing since being discharged from DWTC?

1. Poor ___ 2. Fair___ 3. Good___ 4 Very Good___ 5. Excellent_____

Comments: _____

2. Please tell me how your child is doing:

a) At home_____

b) At school_____

c) In the community_____

3. Since discharge, has your child needed any emergency or other unplanned residential services?

Yes ____ No ____

If yes, please tell me about the services your child has received:_____

_____

4. Your discharge plan listed the following recommended aftercare services for your child. Please tell me which services your child has received or is receiving? If your child is receiving or has received the service, how would you rate the service? (1. Poor; 2. Fair; 3. Good; 4. Very good; 5. Excellent) If not receiving the service, please tell me for what reason(s) from the list below. Other reasons?

Recommended service	Has been received? (y/n)	Reasons for not receiving Code all from list below	Service Rating
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Please tell me what other services your child is receiving or needs to receive in order to function well at home and in the community. Please tell me if your child has received or is receiving the service? If your child is receiving the service, how would you rate the service? (1. Poor; 2. Fair; 3. Good; 4. Very good; 5. Excellent). If your child is not receiving the service, please tell me for what reason(s) from the list below? Other reasons?

Other services needed	Has been received? (y/n)	Reasons for not receiving Code all from list below	Service Rating
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Barriers to service code list:

1. My child refused to participate
2. I felt my child didn't need service (use only for #4)
3. The provider couldn't start services when we needed them
4. The location of the services wasn't convenient for us
5. The services weren't available at a time convenient for us
6. We couldn't afford the fee or co-pay for the services
7. We had difficulty communicating with the provider
8. The paper work needed to apply for services was too confusing
9. We didn't find the service available in the community
10. My insurance company (or Medicaid) wouldn't pay for the service
11. I am still on a waiting list for the service
12. Other(list)_____

6. **Have you received or are you receiving Family Support Services from Nevada Parents Encouraging Parents?**

   Yes_____ No_____

7. **Have you applied for Medicaid and/or other insurance since your child's discharge from DWTC**?

   Yes _____ No_____

8. **If yes, what type of coverage? _____What date did you apply?_____**

10. **Do your currently have Medicaid and/or other insurance coverage?**

    Yes _____ No _____

11. **If so, what type of coverage? _____ Effective date:_____**

12. **If not, what is keeping you from obtaining Medicaid and/or other insurance coverage?**

    _____

    _____

13. **What else would you like to tell me about your child and his aftercare services?**

    _____

    _____

Appendix H

Garrett Lee Smith Memorial Act Grant – Youth Suicide Prevention Program

Nevada Department of Health and Human Services - Office of Suicide Prevention
Project Update for 7/1/07-6/30/2008
For the Clark County Mental Health Consortium
July 1, 2008

Nevada's Youth Suicide Prevention Program has the management and leadership of two important groups: an Administration Committee consisting of representatives from the Nevada Department of Health and Human Services and the Division of Children and Family Services, and a locally driven program implementation and guidance workgroup consisting of parents, youth services, mental health professionals, and sub-grantees. The Office of Suicide Prevention and local sub-grantees also work together to implement enhance their program components and services. These services include:

- Supporting Nevada's comprehensive statewide Suicide Prevention State Plan through the advancement of priorities and goals addressing suicide prevention among youth populations, and enhancing collaborative partnerships with traditional and non-traditional partners;

- Developing, producing, and disseminating an anti-stigma campaign in three phases which will work to de-stigmatize help-seeking behaviors of parents and children regarding mental health issues of young children and adolescents;

- Incorporating the current TeenScreen program as a component of a more comprehensive effort to educate students about mental health, assess the mental health status of students through voluntary screening activities, and offer multiple gatekeeper training opportunities to adult caregivers who encircle youth;

- Providing multiple trainings for adult caregivers utilizing nationally recognized gatekeeper training programs. Recognizing the expertise of professional development training staff at the Office of Suicide Prevention who have been trained as trainers to provide a myriad of gatekeeper programs to support the available time, resources, professional skills, and interests of the participating groups and agencies.

- Participating in the national cross site evaluation as well as several locally driven evaluation projects currently under development. Final evaluation system will monitor the implementation of the project, the process and quality of services, and the outcomes and costs of services to drive decision making to support good outcomes for youth and their families.

The Clark County Children's Mental Health Consortium's Workgroup on Crisis Services and Early Identification has been instrumental in providing community-based steering to the efforts of the Garrett Lee Smith Memorial Act grant for youth suicide prevention. This workgroup was not founded as an oversight committee for the Nevada GLS grant, but it was a natural connection for the committee's objectives to enhance crisis services and support new and innovative methods of early identification in children's mental illness and suicide prevention. The number of participants regularly attending the workgroup has increased since providing this valuable

community-based program steering. The workgroup has contributed to the success of the program in Year 2 and 3 of this 3 year funding project.

The addition of a funded parent/family support component has been a good start to improved community resource linkage. Nevada PEP was awarded a sub-grant this year to coordinate a more comprehensive support mechanism for family systems when a child has been identified as being at risk for suicide or is otherwise in crisis and in need of support. The Center for Health and Learning, which is charged with risk screening, provides referrals to PEP of parents who consent to additional support services post-screening. Parents have a variety of options for support services from Nevada PEP, with the underlying theory that when parents are also supported, retention rate of children in mental health services will increase.

General Suicide Data for Nevada Youth

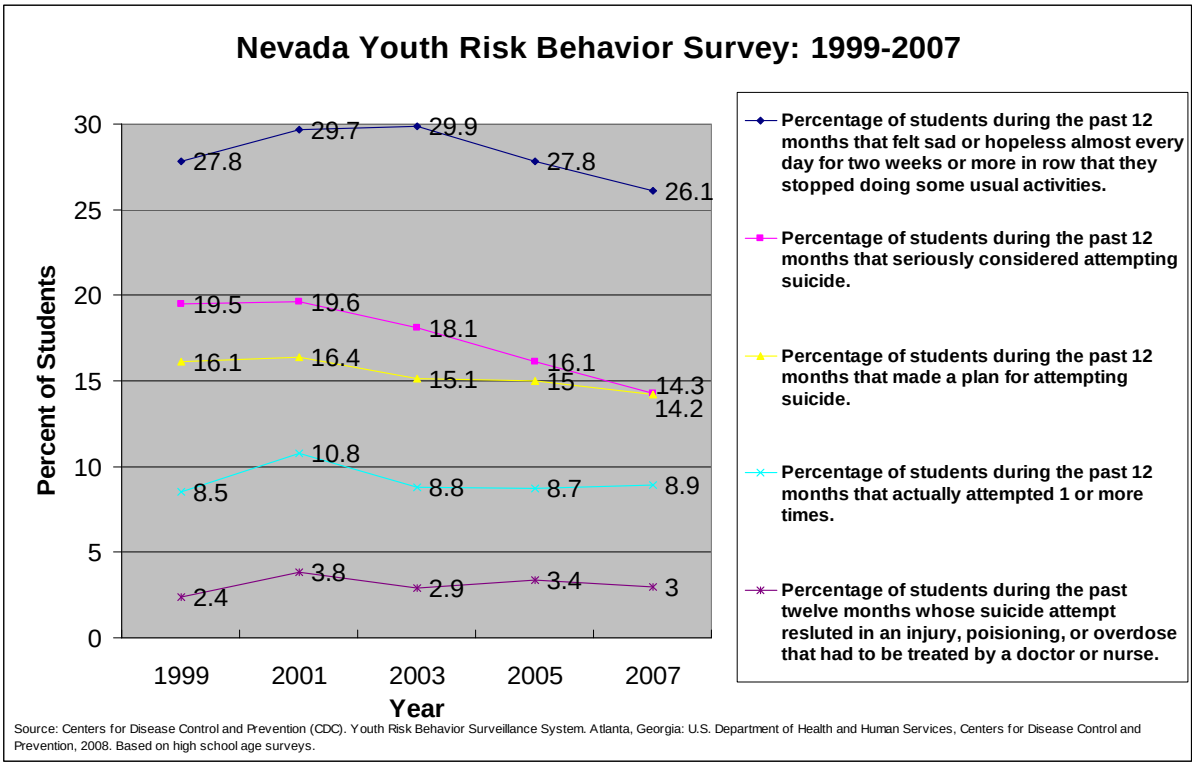
→ If one looks at youth ages 10-24, Nevada has the tenth highest rates in the nation with 10.68, well above the national average of 7.04. Suicide was the 2nd leading cause of death of children and young adults aged 15-24 years and the 3rd leading cause of death for children ages 10-14 in 2005. (WISQARS, 2008)

→ While 60% of suicide deaths of youth ages 10-24 occurred in Clark County, rates are higher in Washoe and highest in the rural counties. For all ages, Clark County rates were 16.4, Washoe rates were 19.1 and all other counties combined were 27.8 (Nevada State Health Division, 2004).

→ The 2007 Youth Risk Behavior Surveys found that 26.1% of Nevada high school students reported depression of a magnitude sufficient to impact completion of daily tasks at some point in the previous 12 months (Nevada Dept. of Education, 2008). This same research found 14.3% of high school students had seriously considered attempting suicide, 14.2% have made a suicide plan, 8.9.0% actually attempted suicide, and 37% that did attempt required medical attention following that suicide attempt. In 2007, 4.3% of Nevada teen girls and 2.2% of teen boys attempted and had to be treated by a doctor or nurse after the attempt.

→ The majority of youth suicide victims are Caucasian (61.4%) which is higher than the proportion of the youth population (49.6%). Tribes in Nevada are also affected by suicide. Based on WISQARS data, 7 deaths occurred in Nevada among American Indian/Alaska Natives (AI/AN) ages 10 to 24 during years 1999-2004. While the number of deaths is small and caution must be exercised when drawing conclusions, the crude rate and age-adjusted rate for Nevada AI/ANs is 25% higher than the all Nevada rate for the same age group.

→ The most current Kids Count report for Nevada shows that of all violent deaths, 52.8% were due to suicide or homicide versus 48.1% to accidents (Kids Count, 2007).



Source: Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance System. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008. Based on high school age surveys.

TeenScreen Program Data Results

TeenScreen originated at Columbia University in New York. As a TeenScreen site, specific protocols safeguard confidential student health information and increase student and family access to needed to mental health services outside of the school district. Clark County School District provides a critical partnership with TeenScreen, by providing immediate support plans and services to back-up TeenScreen in the event that students are determined to be in imminent danger.

4296 students in 13 high schools and a Fire-setters program run by the juvenile justice were offered mental health screening through the Center for Health and Learning's Teen Screen program originated at Columbia University. Forty percent of those offered screening, a total of 1746 students, received the mental health screening. Mental health screening is only performed with an active consent by the individual's parent/guardian. Approximately 8.9% of those screened (157 students) were determined to be a current suicide risk. This is a decrease compared to the previous year's screening results where almost 12% of those screened were determined to be a current suicide risk. Current inquiries are being conducted to attempt to account for this change. For those who at risk, a rigorous follow-up procedure is followed to ensure that the individuals have access to services and all individuals screened positive received a list of community referral sources for treatment. The majority of those screened positive, over 90%, seek treatment within 48 hours from the Center for Health and Learning.

Early Identification Referral Form

Table A. details information regarding youth that have been identified at risk for suicidal behavior. The Aggregated number refers to all sites in the cross site evaluation. The data presented was last updated September 2007. New screening data for the Fall of 2007 should be available shortly. All the youth who have been identified at risk have participated in the Screening activities offered by the Center for Health and Learning at their high school. There is a very small percentage of youth who have been identified through working with the child welfare and juvenile justice facilities. Youth who are identified at risk are assessed to need mental health services approximately 50% of the time. However, youth can also be referred for academic tutoring, medical care, or some individuals may already be receiving treatment. There are also instances where the initial screening may be inaccurate and the youth is not currently in need of a referral for any service.

Table A. Youth Identified At-Risk

Garrett Lee Smith Suicide Prevention Cross-site Evaluation State/Tribal Performance Indicators 4 Quarter 2007 Report-- State of Nevada*				
Indicator	**Current Score**	**Percent**	**Aggregated**	**Aggregated %**
Client Level Outcomes				
Number of youth Identified at risk	157		1420	
Total number of youth referred to mental health services	84	53.5%	706	50%
Total number of youth referred to non-mental health services	35	22.3%	218	15%
Total number of youth receiving mental health services	77	91.7%	327	46%
Total number that have no access due to lack of capacity at agency	0	0%	0	0%
Total number of youth referred for social supports in non-mental health services	20	54.1%	161	77%

Table B below details demographic information regarding the population screened and identified at risk (screened positive). The sample screened includes slightly more females compared to males, and the majority was White followed by Hispanic, Black/African American, Asian, Pacific Islander, and lastly American Indian or Alaska Native. It is important to understand that in order to be screened parents must give their permission. It may be important to reach out to the different populations in various ways in order to be able to screen these children.

Of those who screened positive, there were more females identified, and the majority of individuals were of White and Hispanic background. Of those who were screened positive and referred for mental health services, within three months 88.0% received a mental health assessment, 1.2% received family therapy, 2.4% received other services, and 8.4% did not receive service. For those who did not receive service, this meant that either no action was taken following the referral, an appointment was made but the youth did not attend, or the youth was wait-listed for at least 3-months. The Center for Health and Learning has been able to accommodate most individuals and has offered treatment at no cost for individuals who have screened positive.

Table. B At-risk Youth Characteristics

	Screened Positive	Screened*
Average Age	15(n=156)	
Gender	(n=156)	(n=1567)
Male	39.1%	45.2%
Female	60.9%	54.8%
Transgender	0.0%	0.0%
Race/Ethnicity	(n=157)	(n=1573)
American Indian or Alaska Native	0.0%	0.2%
Asian	3.2%	3.2%
Black or African American	9.6%	9.9%
Hispanic/Latino	49.7%	28.5%
Native Hawaiian or Other Pacific Islander	0.0%	0.8%
White	57.3%	44.8%
Individual reporting on races not included above	1.3%	1.3%

* Age not reported on EIRF Aggregate form.

The Center has implemented a fee-for-service schedule and is now collecting fees. Insurance reimbursement was on track for implementation in March 2008. The Center for Health and Learning is assuming the cost of this service to get insurance credentials in place to collect insurance reimbursement for clients. This is a substantial step toward sustainability.

The Center for Health and Learning is building a direct referral system with the3 fire-setters program that will enable a more rapid response for screening and counseling services for youth and families the fire-setter programs refers to the Center. The direct referral program has been in place about a month – and provides for direct referral of a youth and their family apart from participation in the standard fire-setter program. Some of the referrals so far have included extensive and complex court or juvenile justice involvement. The fire-setter program provides the referral directly and is well aware of who they are.

Office of Suicide Prevention Community Training

The Office of Suicide Prevention offers a menu of training options for the community and agency staff development. Four main training programs offer varied training lengths and focuses in order to target audiences with appropriate training for their interests and skill levels.

Training Program Data:

The Office of Suicide Prevention trained 1,930 community gatekeepers in 2007-2008 of which 95% were from Clark County and 947 were directly related to the Garrett Lee Smith Youth Suicide Prevention Program in Clark County. A sample of individuals receiving gatekeeper training are asked to complete a Training Exit Survey to evaluate the training program. Over the past year 315 trained individuals have completed this survey. The majority of individuals attended training in order to increase the general awareness and knowledge of suicide for themselves and other, identify youth who might be at risk for suicide, make referrals for at risk youth, provide direct service to youth and/or families, and some attended training to train other staff members and/or learn how to screen youth for suicidal behaviors.

Overall, the trainings received an average rating of 3.7 on a 4 point scale with 4 being extremely satisfied. This indicates that individuals were satisfied with the training provided. Individuals

also indicated that the training increased knowledge about suicide prevention, was practical to work and daily life, and indicated that they will use the information in the training and they feel more prepared to help with youth suicide in the community.

Training Events:
The Office of Suicide Prevention partnered with the Nevada Coalition for Suicide Prevention to host five 16 hour Applied Suicide Intervention Skills Trainings – four in Las Vegas and one in Pyramid Lake—with 114 participants total. Other trainings included:

Suicide Prevention Awareness (1-2 hrs) = 979 participants;

Nevada Gatekeeper Training (2-4 hrs) = 322 participants;

Nevada Gatekeeper Training for Trainers = 38 participants;

Postvention = 104 participants;

Conferences = 487 participants.

Geographic Locations:
1,829 of the 1,930 persons trained in 2007-2008 grant year were in the Southern Nevada area; and101 participants were from the tribal communities/rural areas and Northern Nevada.

Anti-stigma Media Campaign

All three phases of the Anti-stigma media campaign have now been produced and the final phase is currently being aired.

Phase One was parent-focused and aired 12/25/2007 thru 12/31/2007 and again 1/8/2007 thru 1/14/2007. The spot aired a total of 218 air times. It was produced to target moms with children between the ages of 8-18 years. Major themes of the commercial emphasize that 1 in 5 children have a mental health issue and that having a child with mental health challenges does not assume bad parenting, but that as good parents seeking help for your child's mental health is as important as seeking help for their physical health.

Phase Two was youth focused with "Who Can You Talk To?" This phase of the campaign focuses on teens suffering in silence. The campaign attempts to "normalize" youth mental health issues by interjecting factual information such that one in five young people have a mental health condition that can be positively impacted with help from formal and informal resources. This spot aired on TV from June 25, 2007 – July 23, 2007 and in the theatres from June 29, 2007 – August 23, 2007. This spot was also aired in Washoe County through the Washoe County Children's Mental Health Consortium over Winter Break in 5 Washoe County Theatre Complex's (58 screens) from December 21, 2007 through January 3, 2008.

Phase Three focused on breaking the stigma of helping while also identifying some warning signs with "Just Be a Friend." Airing began July 4th through September 4th with showings in the 4 movie theatre complexes. Television airing will be from June 30th-July 13th, 2008, depending on funding on MTV, MTV2, TOON TV, VH1, and NICK –TV at NITE (155 spots in total). To view these public messages, visit the Southern Nevada Health District at: www.gethealthyclarkcounty.org/injury_prev/mental_health.html.

Next Steps

The Office of Suicide Prevention has submitted a grant to SAMHSA for the funding period of 2009-2012. If funded, the Youth Suicide Prevention Program will continue in Clark County while expanding in a greater capacity to Washoe and rural counties.

As for the current grant cycle, we are working to address any concerns shown in our data and finalize current programs. We are examining the changes in numbers screened from previous years as well as the drop in "true positives" on the screening tool. Anti-stigma campaign partners are working towards a toolkit and protocol for other Nevada communities to access one or all public awareness spots. We are also exploring other materials that will tie the spots together cohesively to spread the anti-stigma message.

To enhance gatekeeper training in Nevada, the Office of Suicide Prevention is seeking to expand the number of Applied Suicide Intervention Skills Training (ASIST) trainers. This two day program is in high demand with a constant waiting list. To make this more accessible, we need to increase our qualified trainers. We are partnering with the Nevada Coalition for Suicide Prevention to accomplish this.

Appendix I

Clark County School District
Department of Student Threat Evaluation and Crisis Response Annual Update: Blueprint for Change

Introduction, Purpose, and Prologue

Schools are meant to safe places where students can learn, teachers can teach and administrators can be viewed as the instructional leader of his/her school. That is why we in education got into the field, to teach and be positive role models for our students. This Blueprint has identified key areas of strengths and challenges that have been experienced in dealing with the five year in directing the Department of Student Threat Evaluation and Crisis Response and administering the Safe Schools/Healthy Students grant.

The purpose of this document is to illuminate the presenting issues that face the Clark County School district. It highlights the services offered by the district's Department of Student Threat Evaluation and Crisis Response (DOSTECR). It is organized in a fashion that discussed school violence, the historical changes within the district and the inception of the department, reviews data highlighting its accomplishments, analyses the presenting challenges, and offers a Blueprint for Change using the Logic Model.

Times have changed. Society has changed. Family dynamics has changed. We as educators must change to realistically respond to the type of students entering our system, the challenges that students bring to their learning environment as well as the demands placed on teacher's and administrators today. Statistics continue to reflect that the schools are still one the safest environments that students can be in, however, one act of violence is too much and there is enough violence occurring in the schools to warrant a high level of concern from all stakeholders, parents, educators, law enforcement as well as the community in general.

Candidly speaking, violence is a societal problem, not an educational problem. The education environment is just a microcosm of society in general. The **expression**…"It takes a whole village to raise a child" is an absolute truism. In the **Nevada 2007 High School Youth Risk Behavior Survey Study**, results identified some areas of concern for educators as well as the communities at large. The trend has not changed when compared to 2005 youth risk survey data. (See attached) They are as follows:

- **26 %** Students do not feel accepted at school always or most of the time
- **7 %** Students carrying a weapon on school property within the last 30 days
- **26 %** Students had feelings of sadness or hopeless in past year that they stopped doing activities
- **14.3 %**Students thinking seriously about attempting suicide in the last 12 months
- **14.2 %** Students making a plan about how they would attempt suicide
- **8.9 %** Students actually attempting suicide in the last 12 months

It has also been established that past behavior is a good predictor of future behavior and that risk factors that may be identified as early as kindergarten can lead to violent and aggressive behaviors later in life. Given these data points from the state survey one can generalize that

student population (150,000 middle/high school students) figures that currently exist in CCSD, conceivably 38,000 students do not feel accepted, approximately 10,500 students could have brought a weapon on campus, 39,000 felt sad or hopeless, 21,000 contemplated suicide, the same number had a plan and 13,350 students attempted suicide**. Although these figures are only speculative and are generalized based on the percentages of students responding to the Nevada Risk Survey, we must walk away with a sense of concern as to the state of affairs of student mental health, the sense of violence and security or lack thereof that they are feeling within these times.**

Nevertheless, the need for action and renewed commitment from the community–at-large as well as those of us in education to do what is necessary to stem what appears to be increasing at an alarming rate.

Although not exhaustive, researchers have attempted to identify various causes of violent behavior, both against other persons and self that falls into the some of the following categories:

- Change in traditional family structures
- Lack of positive role models in developmental years
- Adult parental role models who demonstrate inadequate parenting skills
- Lack of adequate supervision during developmental years
- Lack of success in school and academic failure
- Media and its focus violence and instant gratification
- Desensitization of violence portrayed in video games

To give a more local perspective, there are additional data generated by the Clark County Schools that provides another reason for concern regarding the mental health aspects of students and their parents. In 2007, CCSD randomly sampled 2097 Child Sample of Clark County elementary students from 18 schools from ages of 5years to 12 years. The sampling took into account SES, gender, grade, etc. Twenty percent (20%) of the students sampled were judged by teachers to have difficulties in the following (See attached.):

1. Danger to him/herself
2. Difficult child behaviors
3. Problems with social adjustment
4. Problems with healthy relationships

Conclusions drawn from these data indicate as compared to same aged peers that if these areas remain unaddressed a child's chances of success in the areas of academic achievement and healthy social development are greatly decreased. Additionally, unmet social-emotional and behavioral needs of students result in costly correctional and mental health interventions. Implications from this study are:

- ***Children with behavioral health problems in Clark County Elementary Schools are lagging significantly behind their peers in state achievement testing and matriculation rates (moving up to their next grade level).***
- ***A 2007 follow-up of students identified with behavioral health problems three years ago, shows they are now significantly more likely to score below proficiency in achievement as compared to their peers.***
- ***Less than 10% of these children are currently getting special education services through the school district.***

These data are critical in the fact that at the elementary level the students are impacted by mental health issues complicating their behavioral performance in the classroom (difficulty with behaviors, social relationships, and social adjustment.) These are the same students who find themselves in the later grades struggling behaviorally and academically.

Mental health issues impact not only a students ability to manage themselves within the school environment behaviorally and socially (impacting the environmental feelings of safety and control), these students do not do well academically and do not progress/graduate to their next grade level as their same age peers. Not only is this an issue impacting the classroom and school climate, it is an academic problem impacting CCSD. These problems that imminent from the community, begin to emerge in the elementary schools as behavior and learning problems of students who have minimal resources and skills to manage challenging situations with many elevating to the level of violence.

Recently, in March 2008, focus groups were held within the schools to further investigate the students' perception of causes of violence among high school teenagers. (See attached.) These students define the following as the presenting issues:

- Peer pressure
- Self esteem issues
- Home and family factors (lack of parent involvement, disconnect from schools, lack of strategies for conflict resolution)
- Easy access to guns and weapons
- Lack of real consequences
- Lack of meaningful options
- Excessive media attention causing desensitization to violence

These issues may be some of the same reasons why the students in the 2007 *Nevada Youth Risk Behavior Scale* are finding answers through less effective means and feeling less protected from a perceived unsafe, non-supportive, or violent environment.

With these facts in mind, this Blueprint will attempt to address the resenting issues as they impact the students in the Clark County School District. The department history, accomplishments, and challenges will be addressed. An analysis will be presented offering the key issues and presenting problems. With this analysis, a Blueprint using the Logic Model for structure will provide the future direction in addressing the issues and meeting these goals.

Department History

One cannot begin to describe a department's blueprint future without first establishing its past. The seeds of this department first took root in a previous department when one of the most significant school shootings of this era took place in 1999, Columbine. Given the significant nature of that event and the emotional fulfillment that was immediately transmitted by the media after the event became the impetus for creating a "think tank" of clinically talented school psychologists from the Department of Psychological Services to come together to look at the school shooting tragedies in more clinical/developmental terms. It became quite obvious by review previous school shooting events where targeted violence either resulted in death or serious injury, that there were motivational factors involved that had significant emotional indicators that needed to be more clinically explored. From that group experience a

developmental matrix was developed that established certain developmental delays or needs that were present that may be a causative factor in their decision to commit violence to themselves or others. Through their efforts a school psychologist was identified from that pool of school psychologists to specialize in what is now referred to as "threat assessment." In the next couple of years the Department of Psychological Services identified a larger team of school psychologists, nurses and other practitioners to be one of the first school districts in the nation to be personally trained by The U.S. Secret Service in the area of "Threat Assessment."

Forward three years and through the financial support provided through the Safe Schools Healthy Students three year grant (extended to five years) which was a community (Clark County Children's Mental Health Consortium) effort born through mental health needs in the community that had long been ignored, the Department of Student Threat Evaluation and Crisis Response" was established. Today, the department provides full time threat evaluation services to the school district as well as the provision of crisis response services to schools that experience critical events which require district level support and services.

Department Accomplishments

1. Threat Evaluation and Crisis Response

The CCSD Department of Student Threat Evaluation and Crisis Response (DOSTECR) was established in Fall 2003 to address the problem of violence in schools and to assist students and families who were either perpetrators or victims of violent action. DOSTECR, by way of prevention efforts, created and maintains quick response Threat Evaluation Teams that respond to requests for assistance from school administrators who believe that a student may pose a physical threat to himself or others. These teams consist of licensed school psychologists and counselors, a school police officer, and administrative and support staff.

Upon receiving a call, intake information is received and a DOSTECR licensed staff person is assigned. During this intake process, it is also determined whether a team be sent to a site to evaluate and/or manage the threat or crisis. A complete evaluation is conducted which is consistent with progressive practice in threat assessment.
Although not exhaustive, students who pose threats usually have a history that includes the following:

Personal Characteristics and Support System

- Self-centered view of the world
- Weak or no bonding with others, including family members
- Lack of resiliency
- Lack of trust in others
- No one to talk to about problems

School and Community

- Lack of engagement in classroom/campus or with peers
- Conflicts with school staff and/or other students
- Culture of bullying/violence at school
- Victim or perpetrator of bullying at school
- High incidence of violence in the community

Family

- Inadequate supervision or boundaries
- Ineffective parenting

- Abuse or neglect by parents, other family members
- Family instability (divorce, separation, absent parent, marital problems, substance/alcohol abuse)
- Domestic violence
- History of parental incarceration/criminal activity

Violence/Violent Images

- Exposure to violent media images, including TV news and programs, movies, video games

Upon acceptance of a threat or crisis case by DOSTECR, licensed staff complete an assessment and determine an action plan. They may either make a referral to an appropriate CCSD or community agency or work directly with a student, and family in some cases, to provide mitigation of the risk factors. Approaches may include providing stabilization and modification of individual, family, organizational and/or community situations through individual or group interventions. Counselors are assigned to each student to establish regular contact and to monitor school-based activity.

2005 – 2008: Number and Nature of Calls Regarding Student Threats/Crises. From January 2005 to February 2008, DOSTECR has received 1,098 calls for assistance from school administrators regarding student threats [81%] or crises [19%]. 38% of the calls concerned elementary school students, 36%, middle school students, and 26%, high school students. The highest percentage of calls concerned students in the fifth, seventh or eighth grades – students in the last grades of the elementary or middle school levels. During this time, there were only eight repeat cases, or less than .07%.

These cases involved either verbal or written threats to use a gun or other weapon to harm self, other students, school staff or property. In some cases, there were vague threats to do harm.

Of all calls received, it was determined that 72% posed a threat. Students deemed to be moderate, high, or imminent risk receive direct intervention by DOSTECR counseling staff. The average length of treatment was 43 weeks. On average, students met 72% of their treatment goals, and those who have not attained their goals continue to be monitored or treated.

Reason for Threat or Crisis Calls to DOSTECR 2005-2008			
	Number	**%**	**Repeat Calls**
Student Threat	891	81%	8
Boys		*87%*	
Girls		*13%*	
Student Crisis/Suicide Ideation	207	19%	0
Boys		*37%*	
Girls		*63%*	
Totals	**1,098**		
Grade Level			
First	22	2%	
Second	52	5%	
Third	72	7%	
Fourth	105	10%	
Fifth	147	14%	
Elementary Totals	***398***	***38%***	
Sixth	87	8%	
Seventh	134	13%	
Eighth	159	15%	
Middle School Totals	***380***	***36%***	
Ninth	10	10%	
Tenth	79	7%	
Eleventh	51	5%	
Twelfth	38	4%	
High School Totals	***278***	***26%***	
Grade Not Reported	42		

Imminent Threats. The most serious threat cases are adjudged to be either "High Risk" or "Imminent Risk," and require immediate and intensive intervention. These are defined as follows:

High Risk for Targeted Violence: Evidence of violence potential that poses potential for imminent harm that does not warrant immediate arrest or hospitalization.

Imminent Risk for Targeted Violence: Evidence of high violence potential that shows imminent risk of potential harm that warrants immediate arrest or hospitalization.

During 2005 – 2008, only 39 (4%) of the 1,098 cases were adjudged to be either at the high or imminent risk level. These 39 cases represented 33 schools. The greatest incidence occurred at the high school level (46%) and at the middle school level (41%). Students who were adjudged to be in these more serious categories were usually in the first grades of the middle school or high school level, i.e., sixth and ninth grades. This is different from students who were categorized as no threat, low or moderate threat where the highest percentage of calls concerned students in the fifth, seventh or eighth grades.

High or Imminent Risk Threat Cases 2005-2008			
	Number	**%**	**Repeat Calls**
Student Threat	39	81%	0
Boys	34	*87%*	
Girls	5	*13%*	
Grade Level			
Third	2	5%	
Fourth	1	3%	
Fifth	2	5%	
Elementary Totals	***5***	***13%***	
Sixth	10	26%	
Seventh	3	8%	
Eighth	3	8%	
Middle School Totals	***16***		
Ninth	8	21%	
Tenth	3	8%	
Eleventh	4	10%	
Twelfth	3	8%	
High School Totals	***18***		

2007- 2008 Referrals. From August 2007 to March 2008, there have been 201 referrals to DOSTECR regarding student threat, crisis, or suicide ideation. 126 (63%) of these referrals were threat evaluation cases and 75 (37%) were crisis/suicide ideation cases. It should be noted that for those cases that DOSTECR intervened in regards to suicide or suicide ideation, no students committed suicide.

Of these referrals, 37% concerned high school students, 35%, middle school students, and 28%, elementary school students. As compared to the overall 2005-2008 numbers, this shows a trend toward more high school threat referrals, 37% vs. 26%, and fewer elementary school referrals, 28% vs. 38%. The middle school referrals stayed constant at 35% -36%. (See table.).

Threat/Crisis Cases by Grade Level, 2007-2008			
	Number	**%**	**Repeat Calls**
Student Threat	126	63%	2
Student Crisis/ Suicide Ideation	75	*37%*	0
Grade Level			
Kindergarten	4	2%	
First	2	1%	
Second	5	2%	
Third	9	4%	
Fourth	20	10%	
Fifth	16	8%	
Elementary Totals	***56***	***28%***	
Sixth	16	8%	
Seventh	23	11%	
Eighth	32	16%	
Middle School Totals	***71***	***35%***	
Ninth	34	17%	
Tenth	18	9%	
Eleventh	12	6%	
Twelfth	11	5%	
High School Totals	***75***	***37%***	

2007 – 2008 School Related Outcomes. In addition to determining whether students repeated threats, information regarding classroom/campus engagement, grades, and attendance was collected before and after intervention by DOSTECR. For students for whom SASI information is available, 80% showed improved classroom or campus engagement as indicated by reduced number of disciplinary incidents, 50% improved in grades, and 59% improved in attendance. There were two repeat incidents of students who made threats against others or who were referred for suicide ideation.

2007 – 2008 Student Performance Indicators	**Number**	**Improved**	***%***	**Same**	***%***	**Worse**	***%***
Classroom/Campus Engagement	188	150	*80%*	31	*16%*	7	*4%*
Grades	183	91	*50%*	80	*44%*	12	*7%*
Attendance	187	111	*59%*	57	*30%*	19	*10%*

2. Crisis Response Planning and Preparation

Crisis Response Drills. The purpose of the drills is to assist the schools in conducting student and staff evacuation from school facilities according to CCSD policies and procedures, and reducing the elapsed time for complete evacuation. It also gives an excellent training opportunity to directly interact with students, students, and administrators. Drill activity is reviewed, analyzed through video taping, and presented to staff as a formative training exercise to illustrate those areas that were considered strength areas and those areas that require some refinement.

From November 2006 to March 2008, the DOSTECR Crisis Response Team conducted crisis response drills in 93 CCSD high schools and middle schools with a total student population

of 133,637. These included 27 high schools with populations ranging from 200 to 3,268 students, 48 middle schools with student populations ranging from 540 to 2,200 and 17 elementary schools with an average size of 673 students.

These data reflect that more than 40% of the total populations of students have practiced in an evacuation drill under the supervision of the DOSTECR staff. All secondary schools have had at least one formal observation by the DOSTECR staff. Recognizing that first responders typically are on the scene of an event within the first 20 minutes, the educator is as the 9/11 Commission Reports establishes, is the first initial first responder. Administrators are typically able to evacuate their students to their evacuation site between 8 to 21 minutes.

A weighted rubric reviewed schools level of performance prioritizing essential issues as sweeping, intra- and inter-communication skill, and overall evacuation procedures. On this rubric, 29 schools (32%) received a perfect score defining them as consistently exemplary. On the weighted rubric, 30 schools or 29% demonstrated consistently satisfactory with some exemplary standards met. Thirty-two (32) school met standards, but some with inconsistent levels.

A correlation analysis of the data was computed. Data reflects that at the larger (population) schools, the lower the scores on the rubric. It is obvious that the larger schools have more complications to deal with, size of student population, larger physical plant to sweep, larger staff, and possibly longer routes because of the size of the physical plant.

Therefore, the evacuation drills will continue to be conducted to assist sites in enhancing their sweeping techniques, the movement of students to the evacuation/reunification site, and the management of the students as they exit. The rubric allows for formative teaching for specific site improvement as well as overall district wide needs via item analysis. These data assist in planning for training to improve levels of competency.

*Survey*s completed after a crisis evacuation drill furthermore fine tune the needs of schools regarding crisis response. With random sampling, data was obtained. (See attached.)

Staff surveys obtained from CCSD FADA department reflects the following:

- 87.5-88.9% strongly agreed or agreed felt that the drill at their respective site helped better their understanding
- 86.1-90.6 strongly agree or agree at their respective sites felt sufficiently trained to respond to an emergency like today's drill
- 78.1-80.6 strongly agree or agree that their school is adequately prepared

Student surveys obtained by DOSTECR after each drill randomly sampling 10% of the student population reflect the following:

High School:

- 77.1 % felt well prepared or prepared if a crisis were to occur at their site
- 72.9% felt well satisfied or satisfied regarding the steps their school has taken to provide a safe environment
- 87.5 % felt that it was very important or important in having crisis drills

Middle School:

- 79.6 % felt well prepared or prepared if a crisis were to occur at their site
- 77.8% felt well satisfied or satisfied regarding the steps their school has taken to provide a safe environment

- 93.4 % felt that it was very important or important in having crisis drills

Administrator surveys post-drill support from DOSTECR has also been obtained. The following results were obtained: (Scale 1-5, 5 significant)

- 80% scored 4s-5s and felt the constructive recommendations/directions were helpful
- 80% scored 4s-5s and felt that the information given in the pre-drill meeting enhanced the drill process
- 100% scored 4s-5s and felt that the school based training/conferencing and technical support was helpful in the development of their Crisis Response Plans
- 100% (gave 4s and 5s) felt that provided essential information in preparing for an evacuation drill

Randomly sampled surveys obtained from two entities (FADA and DOSTECR) reflect that the drill experience enhances the staff and students' sense of preparedness. Staff and students recognize the importance of having the drills. The practice underscores that the administration is taking steps to increase response preparedness. Not only are the drills important to crisis response and management, but also the use of surveying as a tool to capture perceptions and needs for further training and practice. Administration feel that the support provided before, during and after the evacuation drill was valuable giving them essential information and assistance thereby enhancing the process.

3. Education and Training

One priority of DOSTECR department is to enhance the practices of site based staff district-wide as they deal with issues that surround student safety and student violence towards self and others.

In response to the many inquiries in dealing with students with suicide ideation, the department has formulated a Suicide Assessment Protocol. This is a comprehensive approach to dealing with students and their parents. Interviews, decision making triage tool, necessary paperwork and recommended interventions and resources are included. All school counselors (600), school psychologists (200), school nurses (200), and school social workers (8) have been trained.

Pre-training surveys conducted prior to the Suicide Protocol Training reflected that 63% of the participants (counselors, psychologists, and nurses) had conducted five (5) or less suicide interviews in their career. Seventy% (70) rated their current skills as limited to very limited.

A satellite DOSTECR office was set up at a high site with an inordinate amount (5) of completed suicides within a brief time. A total of 49 students were serviced all of whom were undetected until the DOSTECR program was introduced to the site and the SOS (signs of Suicide) presented in the critical classes.

Participation in the Coroner's Children's Death indicated that eleven (11) students committed suicide last year. That equates to approximately one per month. DOSTECR has a one hundred (100) % per cent success rate when the department can intervene.

Training has also been provided and supported for schools in the area of Natural Helpers (a program enhancing the peer support system within the school), SOS (Signs of Suicide, a program designed to address symptoms and actions), Blueprint for Anti-bulling Program (a program to assist schools in a system-wide approach to bullying) as well as a night-time Violence Prevention Program directed to students (who are within the Education Services

System), who along with their parents are taught more effective problem solving approaches in dealing with day to day issues.

Training has also occurred in the Crisis Response realm. DOSTECR has devised an Evacuation Drill Rubric as well as an Evacuation Drill-Phase Two Rubric to assist schools in operationalizing their Crisis Plan though an evacuation process. The rubric has standardized a standard of practice that allows for a consistent approach district-wide in dealing with a crisis event. Pre-drill training is offered to sites prior to the drill to assist sites in reviewing routes, sweeping techniques and communication. Post-drill meetings provide critical feedback using the rubric standards. Administrative training is also provided through the CPD leadership process to initiate new administrators in the process of developing a crisis plan that will address the unique needs of their site while staying within the parameters of the crisis template.

Therefore, three basic areas, Threat Evaluation, and Crisis Response, Crisis Response Planning and Preparation and Training and Education are the three areas of emphasis within the department.

Analysis of Data Directing of Future Challenges

A review of the final reports reflects that year by year there is an increase in the referral sent to DOSTECR. It appears that as the program provides service intervention to sites and administration, there is an increase of referrals from that site. Student threats continue to be the most requested. The highest percentage of referrals to DOSTECR comes from threat assessments. It is possible with these situation that site administration find themselves in a position whereby they feel they can not take a chance on guessing whether a student who states a threat may truly pose one.

It appears that the community is more vigilant regarding these issues, possibly because of media exposure but also the sense of vulnerability that their students as well as staff perceive during this day and age. Very interestingly however, for whatever the reason for the increase, there has become a reliance by administrations and divisions that the action plan and follow-up monitoring services is a crucial element that typically can not be duplicated at the school providing the student with the ongoing connection with a significant adult (DOSTECR counselor). Not only are the students' progress monitored for forward movement as well as therapeutic service intervention, there is a case management function that serves as the glue in ensuring that the needed community services *are* being provided as determined by the Threat or Suicide Assessment and dictated in the Action Plan. This singular connected adult assisting in merging services is critical, (Systems of Care).

Data have shown a distinct pattern throughout the course of DOSTECR's presence. There are distinct referral patterns with regards to grades. Fifth, eighth and lastly seventh grades represent the highest portion referrals with respect to threat assessments. The bulk of these students are moving from one educational level to another, i.e., elementary to junior or junior to high school. It is possible may be reacting to a variety of potential issues: sense of power over the "establishment" and the desire to press the limits or standards, or possibly the fear of moving up to an unknown educational level which can present additional challenges that the student feels there are not capable of managing.

Middle school continues to maintain the bulk of referrals as compared to elementary and high school grades. It is here that movement between classes, less structure during down time, the exposure to different teacher and subjects with a variety of expectations, the initiation of experience of a social life, can complicate a student's life. School climate issues become have more of an impact on a student's life as they age from the more cocoon-existence in the primary grades. Additional system issues can become more obvious to a student. By sheer numbers, these system problems may not be as evident to the teaching and support staff. DOSTECR has found that in many cases, bullying and intimidation are pervasive issues that either go un-noticed because of the subtleties or are ignored because of the many priorities placed upon staff. There is the greatest percentage of high and imminent case at the high school level. These are the students who need to be monitored and who potential to pose a threat, have the means and wherewithal to do so. Research with these types of students reflect that frequent interactions with the students in their life, in some cases, interrupts the "unhealthy thinking" that goes on when students are considering violence. They require increased supervision on the part of the school staff, the strongest adherence to the DOSTECR Action Plan and more frequent, invasive monitoring and intervention by the DOSTECR staff.

A part of the increased numbers includes the referrals regarding suicide ideation. DOSTECR has seen a dramatic increase in the need for consultation. This fact is more than likely due to the Suicide Protocol trainings. Unfortunately, Nevada has been rated from rankings of one to four in student suicides nationally. In the past, students are sent home. Staff at schools are now taking a more proactive approach in dealing with the student by introducing the Suicide Screener or Comprehensive Protocol. There appears to be a greater awareness of the issue among staff as well as students (self referrals and other student referrals), HOWEVER, there still need to be more done. An informal count of the Coroner's case count for the review reflects fewer students this year as compared to last. Unfortunately, some of the names were unknown by staff reflecting the student did not pursue assistance nor let people know. The Legal 2000 process continues to be an issue. There are some instances in which there is no other option than to pursue this approach. However, it appears that within these instances it is more of staff not knowing a more effective method in dealing with the parent and the student. In those instances that DOSTECR is able to intervene to offer assistance to the parent regarding legal rights, transportation issues and follow-up services, more effective intervention does occur. It appears that in the first responder (not CCSD licensed staff), the Legal 2000 process becomes the avenue of choice possibly because it is all that is known or for sheer convenience. Local research completed on data provided by two local hospitals and one short term care mental health facility reflects that most students are sent home rather than admitted once they are taken to the hospital. This means that the parent and student still must pursue agency counseling for support while in crisis. In essence, the family has been put into more crises, after waiting for the emergency room appointment and recommendations; they are in the same position as they were before they left the school with their child in crisis. More work needs to occur in this area. This is clearly a community-wide issue that requires community-wide resolution.

With regards to imminent need referrals, both threat and suicide ideation, immediate direct intervention continues to be problematic. Hospitalization is only one answer in the continuum of services and the most restrictive. Typically, it is viewed as the first option, before addressing the lesser restrictive options. A key option in the continuum is the possibility of using respite services in which a family has time to separate from the student and regroup allowing for a different perspective from all parties and then address the specific issue of intervention. There

are a couple of community agencies that can offer a reduced time frame (although this is not their primary function). An issue that is connected with the respite option however, is dealing with runners (students who run away from the facility). Beyond the hospital placement, no agency is set up for runners.

It is always the preferable route to provide an immediate appointment for a family in crisis with a student. Often time appointments can NOT be obtained, despite agreements.
The mental health care system itself is on overload and overbooked. There is a paucity of non-English providers in the community. A myriad of issues are present for those families who are illegal.

Community challenges also surface with regards to overall coordination of service delivery. Many of these families require more than supporting agencies to assist them. Communication between these providers typically does not occur in a seamless fashion. Consequently, service delivery can be disjointed, held up, or non-existent due to paperwork "glitches."

DOSTECR often finds that treatment does not include the interaction or communication with school involvement. When serious changes occur in behavior or management, there needs to be an automatic conduit between the schools and the providing agency. Problems occur because the CCSD does not meet their authorization to release information. It is also evident that releases are made too quickly, that there is little, if any follow-up, and that monitoring does not occur. These issues *can* be accomplished with a family who is astute to know that there needs to be a collaborative effort and that when services need to continue. *However*, most families who require these supports are at best in crisis themselves and unable to rally their energies to maintain the required elements to keep things going (confirming and going to appointments, getting transportation, making sure the school is contacted, contacting the school re the provider, etc.) At worst, there are families, who need a full service system of care and support, working on their own basic needs, and mental health issue become last, even if they are a priority.

When these issues are complicated by a community provider system that does not communicate well among itself, does not have a common paperwork system, has limited resources to obtain on-going monitoring of current patients, let alone those who have been release for day program, major dysfunction can and does occur within the system. These issues have been addressed at length in the Clark County Children's Mental Health Consortium.

The systemic problems are occurring within a community that is typically working from pay check to paycheck and on a 24/7 work schedule. Many families are working for their families to maintain basic needs, shelter, and food. Issues such as mental health, resiliency, etc, have not yet been mastered by parents, let alone bestowed upon their children. It is always the preferable route in attempting to provide an immediate appointment for a family in crisis with a student. Often times these can NOT be obtained, despite agreements. The mental health care system itself is on overload and overbooked. There is a paucity of non-English provided. A myriad of issues are present for those families who are illegal.

The Challenges of Mental Health in the Schools within the Context of the Las Vegas Community

- The requests for threat assessments are increasing at a significant rate.

- The request for assistance and consultation for suicide ideation and students in crisis are increasing at a significant rate.
- The on-going therapeutic service provided after the assessment process and the completion of the Action Plan is the most effective method in making a change in the student's and family's life and reducing recidivism.
- These issues impact schools, at all levels, from elementary, to middle to high school.
- Students at the early primary grades with unchecked mental health have proven by CCSD research to have more behavioral problems, social skill difficulties and do not matriculate to their next grades as compared to their same aged peers.
- Last elementary (5^{th} grade) and 8^{th} grade demonstrate the highest needs for referrals. Middle schools overall have the highest rate for school community issues and threat assessment requests.
- High school students are referred the most for suicide ideation.
- High school students have the highest percentage of high or imminent level of risk classification.
- Although there are spikes in threat referrals in grade 5 and 8 and spike in the suicide ideation in high school, there is an increased prominence in the elementary grades. That is, more threat referrals and suicide ideations referrals are occurring in the primary grade.
- There continues to be an over-reliance on the Legal 200 process by non-professional entities when lesser supports would be more appropriate.
- Although community providers want to provide assistance, there is paucity in available resources. Typically when a connection occurs, it is because there was a personal alliance or relationship between the CCSD provider and the community provider.
- The community is lacking a system in which the neediest of cases are staffed in a multidisciplinary venue which would include the schools to allow for a more comprehensive approach.
- More resources that can provide immediate therapeutic intervention to imminent need cases must be made available.
- Since community by-in to children's mental health needs is less than overwhelming, there needs to a be a strong legislative campaign incorporating entities such as Juvenile Court (Judge Voy), Family Services, DCFS and CCSD to enlighten our legislators to the issues that currently are presented to the therapeutic community. The acceleration in statistics reflects a slope that is only increasing, not decreasing.
- School safety continues to be a challenge. The use of training and practice through the evacuation drills allows sites to operationalize their plan. Surveys reflect that practice enhances the staff and students' knowledge of crisis response.

A Blueprint for Change: Community-wide Practices, School-based Practices and Department Training and Practices

Recognizing that student violence and the preparation and response to crisis can not happen in a vacuum but within the confines of the district as a subsection but within the community as a whole, overall strategies, that is a blueprint must be devised to incorporate essential elements, resources, activities and stakeholders. These will be defined in the forthcoming.

ELEMENTS

1. Enhance Safe School Environments
2. Enhance and Maintain School *and* Community Prevention and Intervention/Treatment Services
3. Promote Safe School Policies and Public Reform

The ***Logic Model*** will define the elements providing a direction and strategic planning to address the aforementioned issues.

Element 1. Enhance Safe School Environments

Objectives:

1. Improve the quality of site based Crisis Plan (CP) development annually
2. Improve the operationalization of the CP
3. Increase site based staffs' knowledge of safety procedures
4. Increase staff and students' perception of their school as a safe environment
5. Institute the Fusion Document within CCSD.
6. Collaborate with CCSD departments involved with the compilation of the CCSD Priority Capabilities Target Analysis

Obj.	Activities (Numbers Related to Objectives)	Schedule/Resources (Personnel, Funding Source, Other Depts.)	Measures/Indicators/ Products/Reports	Data Source
1.	Enhance Crisis Plan yearly to include effective practices.	8/08 to 9/09 DOSTECR staff Collaboration with Facilities, School Police, etc. as needed With initiation of REMS grant, expert Michael Dorn	Analysis of exceptional Crisis Plans Review of well-defined explanation Review of graphic or pictures	CCSD Crisis Plans
2.	Enhance the Evacuation Drill process to incorporate stages of challenges depending upon the site's prowess.	8/08 to 9/09 DOSTECR crisis staff	Analysis of rubric of sites who performed at an exemplary level Review of video tapes	Review of Crisis Evacuation Drill data
3.	Expand the drill rubric structure to include graduated phases of skill difficulty, including tabletop exercises.	8/08-9/09 DOSTECR staff To be used with sites capable of "managing" a more challenging evacuation event (will be determined by '07-'08 data)	Completion of rubric "post-evacuation" to review strengths/ use of good judgment, and areas in need of improvement Post evacuation interview with site administration as to their perspective, recommendations for improvement	Post-drill Surveys from sites Post evacuation interview with site administration as to their perspective, recommendations for improvement
4.	Provide trainer of trainer (TOT) programs for administrators to educate their staffs on more effective/efficient processes.	08-12/08 REMS grant specialist in collaboration with DOSTECR staff	School Safety Facility Checklist	Post training administration surveys Student surveys regarding site safety
5.	Yearly complete a safety check around physical plant to determine any areas that would promote unsafe/unsupervised environments and provide improvement to that area.	11/08-9/09 DOSTECR staff with site based administration Collaboration with REMS experts	TOT ppts. and exercises	Staff surveys regarding procedures and perception of safety of site

Element 1. Enhance Safe School Environments, *continued*

Obj.	**Activities** (Numbers Related to Objectives)	**Schedule/Resources** (Personnel, Funding Source, Other Depts.)	**Measures/Indicators/ Products/Reports**	**Data Source**
6.	Create Fusion Document. Provide training to all CCSD administration on the use of the Fusion Document. Meet with all administration to review the purpose and process of the Fusion Document.	5/08-12/08 DOSTECR administration with Legal Office will present to all administration	Gather data regarding usefulness of Fusion Document Determine any outcomes changes after six months of use.	Discussion with Fusion Center who receive calls using the document Survey administrators who use the Fusion Document
7.	Reconvene all department membership to review and operationalize CCSD Priority Capabilities target areas.	1/09-2/09 DOSTECR will reconvene forum of participants (administrators from School Police, Facilities, Maintenance, Risk Management, etc.) to review status, needs and devise an action plan for completion	Revised Priority Capability Target Analysis Cost analysis of recommendations Action Plan for future planning	Meeting Notes and recommendations

Element 2. Enhance and Maintain School *and* Community Prevention and Intervention/Treatment Services

Objectives:

1. Provide appropriate prevention & intervention services regarding school violence, suicide ideation, and student crises.
2. Provide Threat Evaluation to referred students who pose a threat to school safety.
3. Enhance the Threat Assessment (TA) Protocol to optimize the evaluative process.
4. Enhance the Suicide Assessment Protocol (SP) to optimize the process.
5. Incorporate more advanced levels of training regarding mental health issues to CCSD providers (counselors, psychologists, nurses, etc.).

Obj.	**Activities** (Numbers Related to Objectives)	**Resources (**Personnel, Funding Source, Other Depts.)	**Measures/Indicators/ Products/Reports**	**Data Source**
1.	Meet with middle school administrators regarding prevention services and programs tailored to the needs of their schools. Introduce programs for elementary and middle schools students on topics of system-wide intimidation/bullying control, Natural Helpers, middle school SOS (Signs of suicide) program. Introduce prevention programs such as Love and Logic, Guiding Good Choices and Emotional Intelligence at primary grade levels. *Planning and Collaboration* Meet with stakeholders interested in respite intervention; set up protocol. With DCFC, facilitate collaborations with NCCs and Desert Willow to encourage personal knowledge between staffs. Investigate bilingual, mental health supports. Meet with MFT Association to solicit their assistance in imminent need cases. Meet with union/association health providers (Culinary, HBI, etc.) to solicit support for imminent cases with insurance.	Administration that have already used the same programs. Early primary site staff Summer 2008 DOSTECR staff	Set up a template allowing for a blueprint approach for each school site to meet their unique needs. Process will include needs assessment, focus groups of parents, students and staff, delineation of goals, set up of goals, timelines, resources, products/outcomes (similar to Logic Model). Set up MOUs (memorandums of understanding Organize a list of readily available resources for imminent need cases Decipher union/provider guidelines to assist parents in navigating the systems	Site administration interviews Surveys District templates for MOUs

Element 2. Enhance and Maintain School *and* Community Prevention and Intervention/Treatment Services, *continued*

Obj.	**Activities (Numbers Related to Objectives)**	**Resources (Personnel, Funding Source, Other Depts)**	**Measures/Indicators/ Products/Reports**	***Data Source***
2.	Maintain on-call Threat Evaluation Teams to respond to calls from site administrators.	Ongoing. Threat Evaluation Teams	Annual Report regarding number of calls, disposition of cases, parental and administrators' evaluation of services.	*Threat Assessment Database* Parent surveys post referral regarding supports obtained. Follow-up phone interview with parents regarding the process.
3.	Review Threat Assessment (TA) protocol with focused look at analysis of data and the reasonableness of the Action Plan recommendations. Promote TA protocol to all CCSD Education Services administrators.	Summer '08 DOSTECR psychologists 8-08 DOSTECR administration to returning administrators	Revised TA protocol Adendas, hand outs	TA protocol
4.	Review SP with a focus on the use of resources and the Legal 2000 process. Meet with those who complete the Legal 2000 process to obtain feedback on its use and provide training where areas of emphasis or misinterpretation are needed.	8/08 -5/09 DOSTECR staff Meet with Judge Voy, writer of the Legal 2000 process Train School Police, new licensed psychologists, nurses, counselors and social workers	9/-08-12/08 Review data from emergency room admissions Review School Police documentation on each Legal 2000 case	Interview of participants to obtain suggestions for enhancements Monitor future Legal 2000 caseload data
5.	Analyze and update prior training packages. Provide training in the Suicide Protocol (SP) Process, "in loco parentis", and liability issues to all administrative staff, especially newly appointed leaders. Provide more advanced levels of training as to complete and monitor an Action Plan, navigate the mental health system for resources and to assist administration is dealing with licensed staff as they work though the process to seasoned administration through CPD Pathlore process. Widen the audience of DOSTECR's Violence Prevention Program (VPP) by providing training and information to all Education Services Administrators.	8/08-12/08 DOSTECR staff 8-08-10/08 DOSTECR staff Meet with new Education Services Directors	Analyze surveys to enhance training. Obtain feedback on enhancing the referral process Feedback on enhancing the referral process	Training surveys Feedback on enhancing the SP referral process. Survey data obtained from parents who participated Survey data obtained from students who participated

Element 3. Promote Safe School Policies and Public Reform

Objectives

1. Incorporate defined approach to school safety into the School Improvement Plans.
2. Develop draft and final children's mental health program for Clark County and Nevada.

Obj.	**Activities** (Numbers Related to Objectives)	**Schedule/Resources (**Personnel, Funding Source, Other Depts.)	**Measures/Indicators/ Products/Reports**	**Data Source**
1.	Review existing policies. Find areas that needs enhancement. Meet with Board of Trustee members (after Division and Instructional Unit Leadership approval) to obtain needs assessment and their analysis and "buy-in" to the issues. Meet with local stakeholders to gain perspective- on issues to incorporate future challenges and subsequent goals	8/08-12/8 DOSTECR Board of Trustee members Clark County Children's' Mental Health Consortium including NV PEP	Analysis of CCSD documents Analysis of large school district documents re mental health supports Review of NASP, ASCA, and etc. position statements re mental health in schools. Analyses of existing data compiled by Consortium in providing "wrap around" services.	NRS regulations CCSD Regulations
2.	Draft policies and define supporting information regarding a children's mental health program for Clark County and Nevada. Meet with local legislators to educate them on the needs.	6/09 DOSTECR staff Children's Mental Health Consortium		Drafts of documents Draft of Consortium documents

This Blueprint has identified through data analysis key areas of strengths and challenges that have been experienced in dealing with the five year in administering the Safe Schools/Healthy Students grant. Although there are many systems in place, roadblock are continually met due to FERPA, differences in authorizations, limited resources impacting personnel availability, incomplete knowledge of first responders in dealing with mental health issues, a legislature that represents a community that does not value the importance of mental health supports for children within this environment. A concerted effort by the CCCMHC, CCSD, and other key agencies, both private and public needs to continue to keep the momentum going. There needs to be investigation into the availability of large grants to provide the seeds for further development and ultimate sustainability.

Recommendations to the 2007-08Consortium

Build a multi-agency group comprised of key stakeholders to review difficult cases that have reached roadblocks, have stalled, or who are locked in a "silo," in which multiple agencies are involved to problem solve and dictate a course of action and responsible manager.

Enhance the "in house"/family preservation model used within the Clark county community offering an ecological approach of within home therapeutic intervention. Linked to this concept is the enhancement of respite intervention for families as a viable alternative to hospitalization when families are in crisis.

Improvement and strengthening the collaboration and participation from Clark County's Family Services Department and Juvenile Justice Services Department as there is frequent interaction with mental health and social system issues.

Expansion of the use of the family advocacy in penetrating these systems.

Improve the bilingual, mental health supports.

Incorporate the private mental health provider sector to solicit their assistance in imminent need cases.

Obtain greater cooperation with protocol with union/association health providers (Culinary, HBI, etc.) to solicit support for imminent cases with insurance.

Appendix J

Assessing Supports for Implementing the Wraparound Process: Results of the Community Supports for Wraparound Inventory

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Full Report ~ Clark County, Nevada
July 2008

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Introduction

In June 2006, Nevada Department of Child and Family Services (DCFS) administrators, along with Wraparound In Nevada (WIN) and Children's Clinical Services (CCS) supervisors and identified quality improvement for the wraparound process as a critical need. Over the course of 6 months, a quality assessment team collected data on wraparound fidelity (using interviews, observations, and document reviews) as well as system-level supports for wraparound implementation. The overall quality assurance effort was intended to achieve several overall goals, such as to:

- Inform high quality practice,
- Create a culture in which data is used to inform decision making,
- Ensure a better understanding of wraparound on the part of families and providers alike, and
- Help "make the case" for better support for wraparound implementation in Nevada.

In 2007, Clark County Children's Mental Health Consortium partnered with researchers at the University of Washington and the Research and Training Center on Children's Mental Health at Portland State University to implement the **Community Supports for Wraparound Inventory** (CSWI). The CSWI is intended for use as both a research and quality improvement tool to measure how well a local system supports the implementation of high quality wraparound.

Methods

The **Community Supports for Wraparound Inventory** (CSWI) is based on the Necessary Conditions for Wraparound described by Walker & Koroloff (2007)[26], and presents 40 community or system variables that support wraparound implementation. The CSWI can be used in several ways: (1) To help researchers determine how much these community support conditions affect fidelity and outcomes of wraparound; (2) To help evaluators understand the system context for wraparound as part of their local evaluation projects; and (3) To help local evaluation groups to assess the supports for wraparound that are (and are not) in place in their community. Using this information, the community partners can make changes and track improvements in community supports over time.

The CSWI is broken down into 40 items, which are grouped within 6 themes:

1. Community partnership
2. Collaborative action
3. Fiscal policies
4. Service array
5. Human resource development, and
6. Accountability

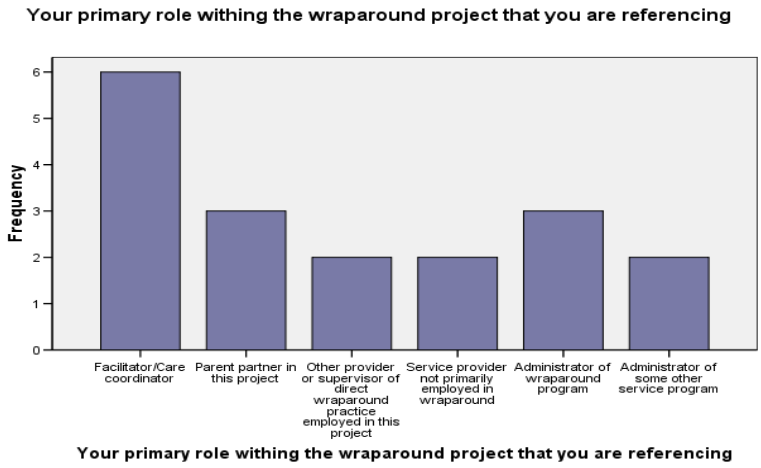
Respondents completed the 40 items by rating the development of supports in their community or program on a 5 point scale, 0 being "least developed" and 4 being "fully developed". In Clark

[26] * Walker & Koroloff (2007). Grounded theory and backward mapping: Exploring the implementation context for wraparound. *Journal of Behavioral Health Services and Research.*

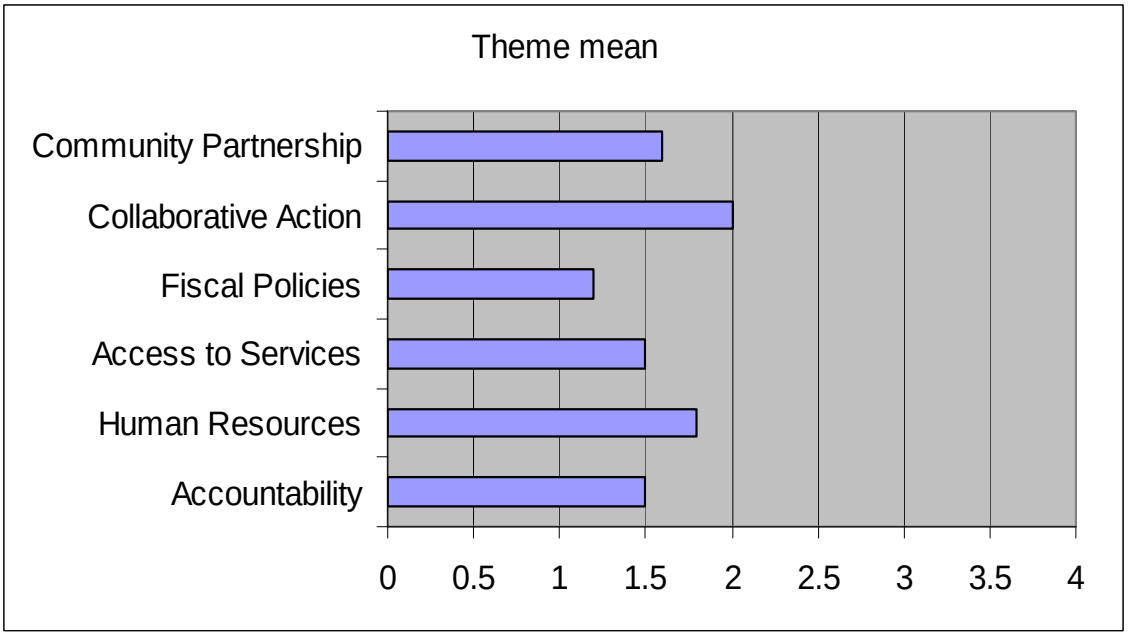
County, 31 stakeholders were identified and invited to complete the CSWI. These stakeholders were sent a link to a web survey version of the CSWI. Of the 31 nominated respondents, 22 completed the CSWI, 5 were not reached or did not respond, and 4 declined.

Results

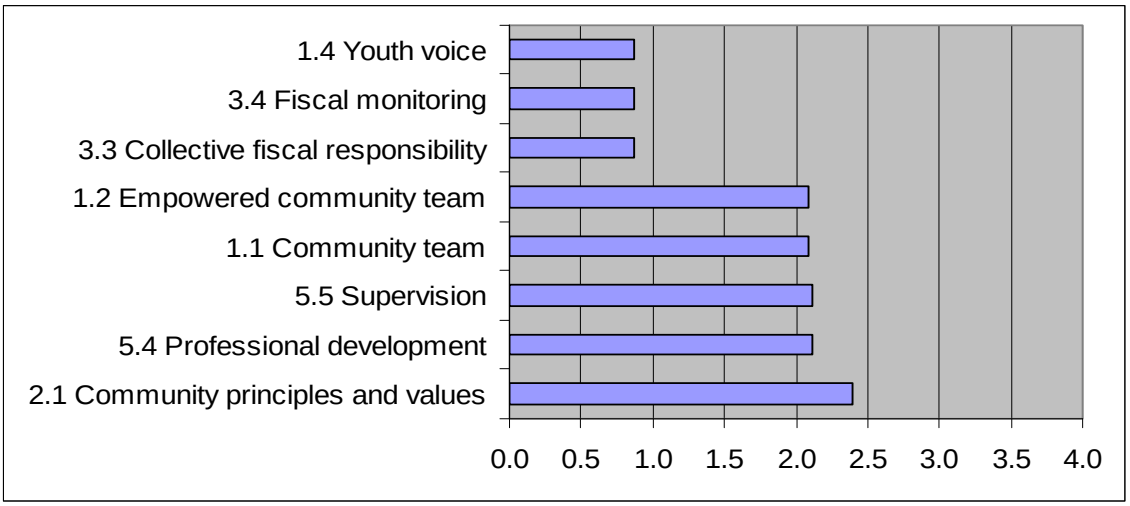
Respondents. The 22 respondents reported having a wide variety of experience in wraparound, often having different roles over time. Many respondents (n = 10) reported having managerial or administrative experience. Others reported having experience as a professional on a team (n = 12), or a trainer or consultant (n = 9). Respondents were asked to pick one role, and answer according to that role. See graph below for primary roles in wraparound project.



CSWI Results. Item scores ranged from 0.86 to 2.4 on the 0-4 scale. The figure below presents mean scores for each of the 6 themes. Mean scores for the 6 themes ranged from 1.2 for "Fiscal Policies" to 1.8 for "Human Resources." Overall, these mean scores are lower than for most communities assessed with the CSWI to date nationally.



Relative strengths and weaknesses. Item 2.1 "Community Principles & Values" showed the highest **relative strength**, with a mean of 2.4.

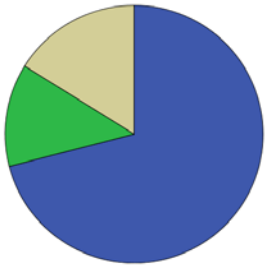


Other items showed **moderate development**. Mean scores for this group ranged from 2.09 to 1.39. The two top items showing moderate development were Item 5.4 "Professional Development", which had a mean of 2.11, and Item 5.5 "Supervision" also had a mean of 2.11. Other items in this group include 1.1 "Community Team", 1.2 "Empowered Community Team, 2.3 "Proactive Planning, 2.8 "State interface", and 2.5 "Partner Agency Staff Preparation".

The areas found to be of **least development** had means that ranged < 1.0. These included items 3.3 "Collective fiscal responsibility", 3.4 "Fiscal Monitoring", and 1.4 "Youth Voice".

Discussion

This narrative is intended to present an overview of results from the Clark County assessment of wraparound supports and infrastructure using the CSWI. The results presented in this summary should be considered somewhat preliminary, given that they are based on the results of only 22 respondent stakeholders. In addition, 9 of the 31 nominated respondents did not complete the CSWI. This creates some difficulty in interpreting the data.



	Responded	22	71%
	Declined	4	13%
	No Answer	5	16%
	Total	31	100.0%

Finally, it should be noted that the discussion presented here about these results are based on the interpretation of data by external evaluators. The ultimate use of the CSWI data will be review, interpretation, and quality improvement planning by local stakeholders.

Results from the CSWI indicate that the areas of greatest strength in Clark County are Community Partnership (except *youth voice*, which scored very low) and Collaborative Activity. In other words, the most positive aspects of community development were based on the foundations of collaboration in Clark County, and the state of Nevada. Scores that are relatively high on these items indicate that agencies agree on the use of the wraparound process, and collaborate toward shared goals. This is a positive finding because research has shown that when agencies have shared commitment to the wraparound process, work satisfaction increases, positive collaborative efforts increase and families and children benefit. These results would also indicate that Clark County is gaining competence in wraparound.

Thus, there are strengths in the stable basic infrastructure for the wraparound program. There are beginning efforts to implement continuous quality improvement strategies and there has been strategic application of training and coaching for provider staff. There is an acceptance of the team approach to implementing services via the wraparound process in ways that are family driven, strength based, family voice and choice based.

Least developed areas are around fiscal policies and sustainability, particularly a lack of funding for support services. A lack of funding for collaborating non-governmental organizations appears to be a barrier. Fiscal policies and practices also present barriers to effective implementation of wraparound. Responses to CSWI items as well as qualitative comments suggest there is inadequate capacity to provide the supportive services necessary for wraparound (therapies, psychiatric services, mentoring, behavioral support services, etc.).

Though high-level commitment to using wraparound is a strength, items pertaining to collaborative action at the ground level represented lower levels of development. This may include across agency collaboration and full understanding of the wraparound process. There may be conflicting philosophies among public agencies or a lack of understanding of what the wraparound process is both in public and private system partner agencies and therefore, inadequate buy-in and support for the process. Getting everyone's buy in to agree to systematic collaborative processes for implementing services is key.

Overall, this presents an overall picture of a community still at the early stages of development, or that is being implemented at a high (i.e., state) level that requires significant attention to bureaucratic issues in order for wraparound to be well supported. Complete results are presented in Appendix A. As mentioned earlier, the ultimate utility of CSWI data in quality improvement will be found in local efforts to review, discuss, and apply these results among stakeholders who know the system well and who have perspectives and authority to make positive changes.

All Results

Item Rank by Mean

Item #	Title	N	Min	Max	Mean	Std. Dev
2.5	Partner agency staff preparation	18	0	4	2.56	.937
2.1	Community principles and values	18	1	4	2.38	.978
5.4	Professional development	18	0	4	2.11	1.40
5.5	Supervision	18	0	4	2.11	1.27
1.1	Community team	22	1	4	2.09	1.02
1.2	Empowered community team	22	1	4	2.09	.92
2.8	State interface	17	1	4	2.05	1.03
2.7	Single plan	19	1	4	1.89	.875
2.2	High-level leadership	19	0	4	1.89	1.15
5.3	Caseload sizes	18	0	4	1.89	1.27
1.5	Agency support	22	0	3	1.86	.83
3.6	Sustained funding	17	0	4	1.82	1.28
5.1	Wraparound job expectations	17	0	4	1.76	1.25
5.2	Agency job expectations	17	0	3	1.76	.97
2.6	Information sharing	19	0	3	1.74	.933
1.3	Family voice	22	0	3	1.73	1.03
4.1	Program access	18	0	4	1.72	1.3
6.2	Range of outcomes	17	0	4	1.64	1.05
6.1	Outcomes monitoring	16	0	4	1.62	1.20
2.4	Joint action steps	17	1	3	1.59	.76
6.3	Wraparound quality	17	0	3	1.58	1.00
1.7	Community representativeness	22	0	3	1.55	.869
6.4	Plan fulfillment	15	0	3	1.53	.99
4.5	Service/support quality	17	0	4	1.52	1.23
4.2	Service/support availability	18	0	4	1.5	1.25
4.4	Choice	18	0	4	1.5	1.38
3.5	Fiscal flexibility	19	0	4	1.47	1.26
5.6	Compensation for wraparound staff	17	0	2	1.41	1.00
6.6	Satisfaction monitoring	15	0	3	1.4	.91
4.3	Building natural and community supports	18	0	3	1.38	.98
6.5	Grievance procedure	14	0	3	1.28	1.20
1.6	Community stakeholders	22	0	3	1.23	.87
4.6	Crisis response	18	0	3	1.22	.878
6.7	Addressing barriers	15	0	3	1.20	1.01
3.1	Fiscal understanding	16	0	3	1.13	1.09
3.2	Removing fiscal barriers	14	0	3	1.07	1.07
2.3	Proactive Planning	17	1	3	1.06	1.15
3.3	Collective fiscal responsibility	16	0	2	.88	.89
3.4	Fiscal monitoring	15	0	3	.87	1.06
1.4	Youth voice	22	0	3	.863	.99

1.1 Community team

There is a formal collaborative structure (e.g., a “community team”) for joint planning and decision-making through which community partners take collective responsibility for development and implementation of wraparound.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	7	31.8			
Midway	9	40.9			
Fairly close to 'most developed'	3	13.6			
Fully developed system	3	13.6			
Total	22	100.0	**1**	**4**	**2.09**

1.2 Empowered community team

The community team includes leaders who are empowered to make decisions and commit resources on behalf of their organization to support the development and implementation of wraparound.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	6	27.3			
Midway	10	45.5			
Fairly close to 'most developed'	4	18.2			
Fully developed system	2	9.1			
Total	22	100.0	**1**	**4**	**2.09**

1.3 Family voice

Families are influential members of the community team and other decision-making entities, and they take active roles in wraparound program planning, implementation oversight, and evaluation. Families are provided with support and training so that they can participate fully and comfortably in these roles.

	Frequency	Percent	Min	Max	Mean
Least developed system support	3	13.6			
Small amount of progress has been made	6	27.3			
Midway	7	31.6			
Fairly close to 'most developed'	6	27.3			
Total	22	100.0	**0**	**3**	**1.73**

1.4 Youth voice

Youth and young adults are influential members of the community team and other decision-making entities, and they take active roles in wraparound program planning, implementation oversight, and evaluation. Young people are provided with support and training so that they can participate fully and comfortably in these roles.

	Frequency	Percent	Min	Max	Mean
Least developed system support	11	50.0			
Small amount of progress has been made	4	18.2			
Midway	6	27.3			
Fairly close to 'most developed'	1	4.5			
Total	22	100.00	**0**	**3**	**.863**

1.5 Agency support

The community team benefits from active collaboration across child-serving agencies. Relevant public agencies (e.g., mental health, child welfare, schools, and courts) and major private provider organizations all participate actively and "buy in" to the wraparound effort.

	Frequency	Percent	Min	Max	Mean
Least developed system support	1	4.5			
Small amount of progress has been made	6	27.3			
Midway	10	45.5			
Fairly close to 'most developed'	5	22.7			
Total	22	100.0	**0**	**3**	**1.86**

1.6 Community stakeholders

The community team includes leaders from the business, service, faith and other sectors, who partner in system design, implementation oversight, and evaluation and provide tangible resources (including human resources such as volunteers).

	Frequency	Percent	Min	Max	Mean
Least developed system support	5	22.7			
Small amount of progress has been made	8	36.4			
Midway	8	36.4			
Fairly close to 'most developed'	1	4.5			
Total	22	100.0	**0**	**3**	**1.23**

1.7 Community representativeness

The membership of the community team reflects the social, cultural, and economic diversity of the community and the families served by wraparound.

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	18.2			
Small amount of progress has been made	5	22.7			
Midway	10	45.5			
Fairly close to 'most developed'	3	13.6			
Total	22	100.0	**0**	**3**	**1.55**

2.1 Community principles and values

Key stakeholders in the wraparound effort have collectively developed and formally ratified statements of mission, principles, and desired outcomes that provide a clear direction for planning, implementation, and joint action.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	3	16.7			
Midway	8	44.4			
Fairly close to 'most developed'	4	22.2			
Fully developed system	3	16.7			
Total	18	100.0	**1**	**4**	**2.38**

2.2 High-level leadership

The system has multiple high level leaders (e.g., senior agency administrators, elected officials, and other influential stakeholders) who understand wraparound and who actively support wraparound development by forging partnerships among agencies and organizations, changing policies, inspiring individual stakeholders, and creating effective fiscal strategies.

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	10.5			
Small amount of progress has been made	5	26.3			
Midway	7	36.8			
Fairly close to 'most developed'	3	15.8			
Fully developed system	2	10.5			
Total	14	100.0	**0**	**4**	**1.89**

2.3 Proactive Planning

The wraparound effort is guided by a plan for joint action that describes the goals of the wraparound effort, the strategies that will be used to achieve the goals, and the roles of specific stakeholders in carrying out the strategies.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	5	29.4			
Midway	6	35.3			
Fairly close to 'most developed'	6	35.3			
Total	17	100.0	**1**	**3**	**1.06**

2.4 Joint action steps

Collaborative and individual agency plans demonstrate specific and tangible collaborative steps (e.g., developing MOUs, contributing resources, revising agency regulations, participating in planning activities) toward achieving joint goals that are central to the wraparound effort.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	10	58.8			
Midway	4	23.5			
Fairly close to 'most developed'	3	17.6			
Total	17	100.0	**1**	**3**	**1.59**

2.5 Partner agency staff preparation

The collaborating agencies take concrete steps to ensure that their staff members are informed about wraparound values and practice. All staff who participate directly in the wraparound effort do so in a manner that is in keeping with wraparound principles, such as collaborative, strengths-based, and respectful of families and youth.

	Frequency	Percent	Min	Max	Mean
Least developed system support	1	5.6			
Small amount of progress has been made	3	16.7			
Midway	9	50.0			
Fairly close to 'most developed'	4	22.2			
Fully developed system	1	5.6			
Total	18	100.0	**0**	**4**	**2.56**

2.6 Information sharing

Information is shared efficiently across systems (or is maintained centrally for the wraparound program) so as to provide the data needed to monitor wraparound quality, plan implementation, costs, and outcomes.

	Frequency	Percent	Min	Max	Mean
Least developed system support	1	5.3			
Small amount of progress has been made	8	42.1			
Midway	5	26.3			
Fairly close to 'most developed'	5	26.3			
Total	19	100.0	**0**	**3**	**1.74**

2.7 Single plan

The wraparound plan is *the* plan of care that structures and coordinates all partner agencies' work with a given child and family. The format and structure for documenting the plan reinforces relevant wraparound principles such as strengths-based, family-driven, and individualized.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	7	36.8			
Midway	8	42.1			
Fairly close to 'most developed'	3	15.8			
Fully developed system	1	5.3			
Total	14	100.0	**1**	**4**	**1.89**

2.8 State interface

The wraparound effort has an active and productive partnership with state agencies. This partnership has been successful in motivating policy and funding changes that support wraparound programs and practice.

	Frequency	Percent	Min	Max	Mean
Small amount of progress has been made	7	41.2			
Midway	3	17.6			
Fairly close to 'most developed'	6	35.3			
Fully developed system	1	5.9			
Total	17	100.0	**1**	**4**	**2.05**

3.1 Fiscal understanding

Agencies and decision makers have access to accurate information about the types and magnitudes of expenditures from all funding streams (e.g., mental health, special education, juvenile justice, developmental disabilities) for services and supports for *all* children with serious and complex needs (regardless of whether or not they are actually enrolled in wraparound).

	Frequency	Percent	Min	Max	Mean
Least developed system support	6	37.5			
Small amount of progress has been made	4	25.0			
Midway	4	25.0			
Fairly close to 'most developed'	2	12.5			
Total	16	100.0	**0**	**3**	**1.13**

3.2 Removing fiscal barriers

The community collaborative has a formalized process for identifying and acting to remedy fiscal policies that impede the implementation of the wraparound program or the fulfillment of wraparound plans. Important changes to fiscal policies have been made

	Frequency	Percent	Min	Max	Mean
Least developed system support	6	42.9			
Small amount of progress has been made	2	14.3			
Midway	5	35.7			
Fairly close to 'most developed'	1	7.1			
Total	14	100.0	**0**	**3**	**1.07**

3.3 Collective fiscal responsibility

Key decision-makers and relevant agencies assume collective fiscal responsibility for children and families participating in wraparound and do not attempt to shift costs to each other or to entities outside of the wraparound effort.

	Frequency	Percent	Min	Max	Mean
Least developed system support	7	43.8			
Small amount of progress has been made	4	25.0			
Midway	5	31.3			
Total	16	100.0	**0**	**2**	**.88**

3.4 Fiscal monitoring

There is a formalized mechanism for reviewing the costs of implementing the wraparound program and wraparound plans. This information is used to clarify/streamline spending policies and to seek ways to become more efficient at providing high-quality wraparound.

	Frequency	Percent	Min	Max	Mean
Least developed system support	8	53.3			
Small amount of progress has been made	2	13.3			
Midway	4	26.7			
Fairly close to 'most developed'	1	6.7			
Total	15	100.0	**0**	**3**	**.87**

3.5 Fiscal flexibility

Funds are available to pay for services and supports, and to fully implement strategies included in individual wraparound plans and safety/crisis plans.

	Frequency	Percent	Min	Max	Mean
Least developed system support	5	26.3			
Small amount of progress has been made	6	31.6			
Midway	3	15.8			
Fairly close to 'most developed'	4	21.1			
Fully developed system	1	5.3			
Total	19	100.0	**0**	**4**	**1.47**

3.6Sustained funding

There is a clear and feasible plan for sustaining fiscal support for the wraparound effort over the long term, and this plan is being fully implemented.

	Frequency	Percent	Min	Max	Mean
Least developed system support	3	17.6			
Small amount of progress has been made	4	23.5			
Midway	5	29.4			
Fairly close to 'most developed'	3	17.6			
Fully developed system	2	11.8			
Total	17	100.0	**0**	**4**	**1.82**

4.1 Program access

Wraparound is adequately available and accessible so that families who can benefit from it are able to participate if they wish.

	Frequency	Percent	Min	Max	Mean
Least developed system support	1	5.6			
Small amount of progress has been made	9	50.0			
Midway	4	22.2			
Fairly close to 'most developed'	2	11.1			
Fully developed system	2	11.1			
Total	18	100.0	**1**	**4**	**1.72**

4.2 Service/support availability

Wraparound teams can readily access (or receive necessary support to create) the services and supports required to fully implement their plans (including services such as respite, in home services, family support, mentoring, etc., that are commonly requested by wraparound teams).

	Frequency	Percent	Min	Max	Mean
Least developed system support	5	27.8			
Small amount of progress has been made	4	22.2			
Midway	5	27.6			
Fairly close to 'most developed'	3	16.7			
Fully developed system	1	5.6			
Total	18	100.0	**0**	**4**	**1.5**

4.3 Building natural and community supports

The wraparound effort devotes resources to and is able to develop connections with organizations in the community and individuals in families' social support networks. Teams, family members, and youths regularly and effectively access these resources to implement individualized strategies contained in wraparound plans.

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	22.2			
Small amount of progress has been made	5	27.8			
Midway	7	38.9			
Fairly close to 'most developed'	2	11.1			
Total	18	100.0	**0**	**3**	**1.38**

4.4 Choice

Children and families have the opportunity to select among service and support options when developing strategies for their wraparound plans (including options that rely on natural or informal supports rather

than formal supports). They are able to choose different providers or strategies if they become dissatisfied.

	Frequency	Percent	Min	Max	Mean
Least developed system support	5	27.8			
Small amount of progress has been made	6	33.3			
Midway	2	11.1			
Fairly close to 'most developed'	3	16.7			
Fully developed system	2	11.1			
Total	18	100.0	**0**	**4**	**1.5**

4.5 Service/support quality

Providers offer high-quality services and supports (e.g., therapies, treatments, in-home services, mentoring) that are "research based" in that they conform to current information about best practices and/or have research or evaluation data demonstrating their effectiveness.

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	23.5			
Small amount of progress has been made	5	29.4			
Midway	4	23.5			
Fairly close to 'most developed'	3	17.6			
Fully developed system	1	5.9			
Total	17	100.0	**0**	**4**	**1.52**

4.6 Crisis response

Necessary support for managing crises and fully implementing teams' safety/crisis plans is available around the clock. The community's crisis response is integrated with and supportive of wraparound crisis and safety plans.

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	22.2			
Small amount of progress has been made	7	38.9			
Midway	6	33.3			
Fairly close to 'most developed'	1	5.6			
Total	18	100.0	**0**	**3**	**1.22**

5.1 Wraparound job expectations

The job expectations (duties and requirements from supervisors) of people with primary roles for carrying out wraparound (e.g., wraparound facilitators, parent partners) affords them adequate time, flexibility, and resources and encourages them to implement high-fidelity wraparound.

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	23.5			
Small amount of progress has been made	2	11.8			
Midway	6	35.3			
Fairly close to 'most developed'	4	23.3			
Fully developed system	1	5.9			
Total	17	100.0	**0**	**4**	**1.76**

5.2 Agency job expectations

The job expectations of people who participate on wraparound teams (e.g., providers and partner agency staff) affords them adequate time, flexibility, and resources to participate fully in team meetings and to carry out their assigned tasks for implementing wraparound plans.

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	11.8			
Small amount of progress has been made	4	23.5			
Midway	7	41.2			
Fairly close to 'most developed'	4	23.5			
Total	17	100.0	**0**	**3**	**1.76**

5.3 Caseload sizes

Caseload sizes for people with primary roles for carrying out wraparound (e.g., wraparound facilitators, parent partners) allow them to consistently and thoroughly complete the activities of the wraparound process.

	Frequency	Percent	Min	Max	Mean
Least developed system support	3	16.7			
Small amount of progress has been made	4	22.2			
Midway	5	27.8			
Fairly close to 'most developed'	4	22.2			
Fully developed system	2	11.1			
Total	18	100.0	**0**	**4**	**1.89**

5.4 Professional development

People with primary roles for carrying out wraparound (e.g., wraparound facilitators, parent partners) receive comprehensive training, shadow experienced workers prior to working independently, and receive ongoing coaching that focuses on systematically developing needed skills.

	Frequency	Percent	Min	Max	Mean
Least developed system support	3	16.7			
Small amount of progress has been made	4	22.2			
Midway	2	11.1			
Fairly close to 'most developed'	6	33.3			
Fully developed system	3	16.7			
Total	18	100.0	**0**	**4**	**2.11**

5.5 Supervision

People with primary roles for carrying out wraparound (e.g., wraparound facilitators, parent partners) receive regular individual and group supervision, and periodic "in-vivo" (observation) supervision from supervisors who are knowledgeable about wraparound and proficient in the skills needed to carry out the wraparound process.

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	11.1			
Small amount of progress has been made	4	22.2			
Midway	5	27.8			
Fairly close to ‘most developed’	4	22.2			
Fully developed system	3	16.7			
Total	18	100.0	**0**	**4**	**2.11**

5.6 Compensation for wraparound staff

Compensation for people with primary roles for carrying out wraparound (e.g., wraparound facilitators, parent partners) reflects their value and encourages staff retention and commitment. These people have opportunities for career advancement based on the skills they acquire with wraparound.

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	23.5			
Small amount of progress has been made	4	23.5			
Midway	7	41.2			
Fairly close to ‘most developed’	2	11.8			
Total	17	100.0	**0**	**2**	**1.41**

6.1 Outcomes monitoring

There is centralized monitoring of relevant outcomes for children, youth, and families in wraparound. This information is used as the basis for funding, policy discussions and strategic planning

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	12.5			
Small amount of progress has been made	7	43.8			
Midway	4	25.0			
Fairly close to 'most developed'	1	6.3			
Fully developed system	2	12.5			
Total	16	100.0	**0**	**4**	**1.62**

6.2 Range of outcomes

The outcomes that are measured include outcomes that are typically important to families and that reflect the values of wraparound (e.g. child and family assets and strengths, caregiver well-being, family/youth empowerment).

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	11.8			
Small amount of progress has been made	6	35.3			
Midway	6	35.3			
Fairly close to 'most developed'	2	11.8			
Fully developed system	1	5.9			
Total	17	100.0	**0**	**4**	**1.64**

6.3 Wraparound quality

There is ongoing collection and review of data on the quality of wraparound provided, including live observation, plan review, and feedback from children and families. The methods used to assess quality are grounded in the principles of wraparound. Data is used as the basis for ongoing quality assurance/improvement.

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	11.8			
Small amount of progress has been made	7	41.2			
Midway	4	23.5			
Fairly close to 'most developed'	4	23.5			
Total	17	100.0	**0**	**3**	**1.58**

6.4 Plan fulfillment

There is centralized monitoring and analysis of the types of services and supports included in wraparound plans, whether or not planned services and supports are provided, and whether or not the goals and needs that appear on wraparound plans are met.

	Frequency	Percent	Min	Max	Mean
Least developed system support	2	13.3			
Small amount of progress has been made	6	40.0			
Midway	4	26.7			
Fairly close to 'most developed'	3	20.0			
Total	15	100.0	**0**	**3**	**1.53**

6.5 Grievance procedure

There is a grievance procedure that is easily accessible to families when they believe that they are not receiving appropriate supports and services or are not being treated in a manner consistent with the wraparound philosophy. Grievances are resolved in a timely manner, and families are in no way penalized for accessing the procedure.

	Frequency	Percent	Min	Max	Mean
Least developed system support	6	42.9			
Midway	6	42.9			
Fairly close to 'most developed'	2	14.3			
Total	14	100.0	**0**	**3**	**1.28**

6.6 Satisfaction monitoring

There is an ongoing process to track satisfaction and buy-in among stakeholder groups, including youth and families and representatives of partner agencies and organizations.

	Frequency	Percent	Min	Max	Mean
Least developed system support	3	20.0			
Small amount of progress has been made	4	26.7			
Midway	7	46.7			
Fairly close to 'most developed'	1	6.7			
Total	15	100.0	**0**	**3**	**1.4**

Coordinated

6.7 Addressing barriers

There is an ongoing, systematic process for identifying and addressing barriers that prevent wraparound teams from doing their work and/or fully implementing their plans. Central barriers have been successfully addressed through this process

	Frequency	Percent	Min	Max	Mean
Least developed system support	4	26.7			
Small amount of progress has been made	6	40.0			
Midway	3	20.0			
Fairly close to 'most developed'	2	13.3			
Total	15	100.0	**0**	**3**	**1.20**