Clark County Children's Mental Health Consortium

Sixth Annual Plan

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Sixth Annual Plan

Executive Summary

During Fiscal Year 2006-2007, 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 Sixth 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 Sixth Plan Recommendations.

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

Children with Serious and Life-Threatening Behavioral Health Problems[1]		
Identified Need	**New Funding Actions**	**Desired Outcome**
Large numbers of children identified by public schools with crisis service needs and no payment resources	***DHHS sustain $100,000 flexible funding pool developed by the Safe Schools, Healthy Students Initiative.***[2]	Improve safety at high risk public schools More rapid treatment for students with the most serious behavioral health needs
50% rate of success obtaining ongoing healthcare coverage for uninsured, hospitalized children	***DHHS fund $140,656 per year for family support and additional psychiatric services for the uninsured population***	Improve rates of healthcare coverage; improve access to aftercare; reduce recidivism
2975 county youths in the juvenile justice systems with serious emotional disturbance that are unserved or underserved	***DHHS fund $1,858,900 to expand the Wraparound In Nevada Program (WIN) to serve an average daily census of 100 youths from the Juvenile Justice System***	Increase services to youths with SED in the JJ System reduce residential care; improve school functioning; reduce recidivism
Increase in number of families requesting services and decrease in state/federal funding available	***DHHS to develop a stable funding source for Family Support Services***	Families of children with serious emotional disturbance will access needed support. Fewer children will need out of home care, reducing costs to public systems
Identified Need	**State Agency Actions**	**Desired Outcome**
Two-thirds of youths admitted to local emergency rooms for behavioral health problems reside in Central Las Vegas	***DHHS to target mobile crisis intervention services to Central Las Vegas***	Youths with serious behavioral health needs will have access to services proven effective in preventing emergency room visits and need for hospitalization
In 2007, the number entering emergency rooms for behavioral health crises is projected to increase by 40.8% from 2005 to exceed 1000 youths	***DHHS to streamline medical clearance process for youths requiring emergency psychiatric hospitalization for behavioral health disorders***	Emergency rooms will be more available for medical crises, costs to public agencies will be reduced
A 2007 survey of families reported that obtaining aftercare for hospitalized youths was complicated by Medicaid application procedures	***Streamline and expedite Medicaid application process for uninsured youths exiting Desert Willow Treatment Center.***	Reduce unnecessary use of emergency room services Reduce the rate of psychiatric hospitalization for children
39.7% of uninsured children hospitalized in the State Mental Health System are unable to access needed aftercare services	***Expand Medicaid eligibility to increase access to aftercare services for hospitalized, uninsured youth with serious emotional disturbance.***	Improve access to aftercare services Reduce need for emergency services Reduce recidivism rates
Identified Need	**CCCMHC Actions**	**Desired Outcome**
The majority of youths admitted to emergency rooms using a Legal 2000 procedures arrive via ambulance services	***CCCMHC to facilitate training to EMS personnel in alternatives to the Legal 2000 Procedure with youths who have behavioral health crises.***	Reduce unnecessary use of emergency room, law enforcement, and ambulance services; Increased parental involvement in crisis services
Long lengths of stay in emergency room and pediatric departments *without appropriate treatment* for significant numbers of children needing residential care	***CCCMHC to review and monitor the demographics, suicide risk, and outcomes for youths with behavioral disorders requiring emergency room admissions***	Identify unmet needs for this population Develop recommendations for meeting the needs of this population
Limited access to aftercare services and ongoing healthcare coverage for uninsured, hospitalized children	***CCCMHC to continue to monitor aftercare services and outcomes for uninsured youth exiting Desert Willow Treatment Center***	Identify barriers to aftercare services and healthcare coverage; Remove identified barriers
Lack of needs assessment data to determine whether children with serious emotional disturbance in foster care are receiving all needed services	***CCCMHC to collaborate with the Department of Family Services in conducting a service array assessment for children involved in the Child Welfare System***	Identify specific gaps in service for children with serious emotional disturbance in foster care.
Lack of updated needs assessment data as a comparison to the CCCMHC survey conducted in 2002-3	***CCCMHC to identify needs of children with behavioral health problems involve in child welfare but remaining at home***	Update the service needs for children involved in the Child Welfare System but remaining at home.
An estimated 2975 youths in the Clark County Juvenile Justice System with serious emotional disturbance are receiving NO services	***CCCMHC to facilitate state-county dialogue to identify lead agency for funding behavioral health to Juvenile Justice Youths***	Develop a funding plan to provide services for youths with serious emotional disturbance in the Clark County Juvenile Justice System

[1] These children are multi-agency involved and need intensive integrated treatment and support.

[2] Recommendation carried forward from last year's Fifth Annual Plan.

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

Children with Emerging Behavioral Health Problems[3]		
Identified Need	**New Funding Actions**	**Desired Outcome**
A 52% increase in children at risk for serious emotional disturbance served this year using Safe Schools Grant Funds	***Develop a stable funding source to maintain the early access program for young children developed by the Safe Schools, Healthy Students Grant ($298,000/yr)***	Reduce needs for special education and treatment services upon entry into public schools
Lack of collaborative system management for Neighborhood Family Service Centers	***DHHS and Clark County fund $821,053 a collaborative infrastructure for the Neighborhood Family Service Centers***	Improve quality and access to services, including integrated front-end services, improved interagency service coordination; Increase efficiency of planning and resource allocation.
Waiting lists for most publicly funded children's behavioral health and social services	***DHHS and Clark County expand service capacity in order to staff a sixth Neighborhood Family Service Center***	Reduce waiting lists for services Improve access to community-based services Reduce utilization of residential care
Identified Need	**State Agency Actions**	**Desired Outcome**
Lack of specific financing and administrative plan for implementing system management for Neighborhood Family Service Centers	***CCCMHC, and other key state and local decision-makers identify a lead administrative entity and financing plan for implementing Neighborhood Family Service Center Collaborative Infrastructure***	Create specific implementation plan with timelines and accountable parties
	DHHS and Clark County to implement cross-system professional development for public and private child-serving staff and families	
High rates of completed suicide for middle school students	***Office of Suicide Prevention to Suicide Prevention Project to explore use of TeenScreen Program with Middle School Students***	School students w/suicide risk and other behavioral health problems will be identified earlier and receive access to needed services; suicide rates will be reduced
Survey of community infrastructure identifies fiscal policies and inadequate fiscal monitoring as barriers to implementing wraparound model of service delivery	***Nevada Children's Behavioral Health Consortium to initiate assessment and reform of the financing system for community-based behavioral health services***	Children with serious emotional disturbance in the Wraparound in Nevada Program will have access to all of the services needed to achieve successful outcomes at home, school, and community
Elementary School Students with behavioral health problems are significantly more likely to score below proficiency in achievement and matriculation rates as compared to peers	***CCSD to develop school-community linkage for early access to services by strengthening student intervention teams***	Students with behavioral health problems will achieve higher success rates in academic achievement
Identified Need	**CCCMHC Actions**	**Desired Outcome**
Need to overcome stigma of children's behavioral health problems and encourage help-seeking behavior	***CCCMHC to continue public awareness activities***	More parents and youth will seek services early when interventions can be most successful
Need for collaborative programs to address teen suicide prevention	***CCCMHC serve as steering committee for implementation of the SAMHSA-funded GLS Youth Suicide Project***	Enhance effectiveness of program due to involvement by key stakeholders
Stakeholder survey identified the need to remove fiscal barriers and develop a grievance procedure for difficult cases	***CCCMHC to implement a barrier-busting workgroup***	
Need to develop more diverse funding sources to expand wraparound service delivery	***CCCMHC to explore community-initiated wraparound with financial support from private businesses***	More children with serious emotional disturbance will be able to access wraparound service delivery and achieve success in home, school and community
Elementary School Students with behavioral health problems are significantly more likely to score below proficiency in achievement and matriculation rates as compared to peers	***CCCMHC to develop linkage between student intervention teams and neighborhood centers***	School children with behavioral health problems will access needed services and achieve better success in schools. Costs for remedial education programs will be reduced

[3] These children need early access and treatment targeted to specific symptoms and behavioral health problems.

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 Sixth 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 Fifth Annual Plan, the members of the Clark County Children's Mental Health Consortium have met **nine** times. At least **26** workgroup meetings have also been convened to address the goals set by the CCCMHC.

A total of 55 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 two 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[4]:

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:

✓ ***1.1 DHHS to provide funding to expand depression screenings in high schools and add parent advocate to the screening program*** *– - accomplished.*

1.2 Nevada Department of Health and Human Services to provide funding to sustain the early access program developed by the Safe Schools, Healthy Students Grant- *– not accomplished.*

2. To improve access to needed mental health services with initial efforts focusing on improved crisis services and early access to needed interventions:

✓ ***2.1 New funding to implement mobile crisis response & stabilization services—****a pilot program was included in the 2007-8 Legislatively approved Department of Health and Human Services Budget*

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

✓ ***2.2 CCCMHC to review and support of strategies for reducing the use of Legal 2000s for hospitalizing youths with behavioral health problems--*** *was accomplished through training to school personnel and police.*

✓ ***2.3 CCCMHC to review and monitor outcomes for youths with behavioral health disorders requiring emergency room admissions*** *was accomplished through a collaboration with the Southern Nevada Health District.*

✓ ***2.4 Sustained funding for district-wide and school-based crisis services developed by the Safe Schools, Healthy Students Initiative*** *included in the 2007-8 Clark County School District Budget*

2.5 Maintenance of $100,000 flexible funding pool for short-term services to school students in crisis was *not funded.*

2.6 DHHS to recruit Medicaid providers of mobile crisis intervention services and link services to the Neighborhood Service Centers--*not accomplished.*

2.7 New funding for Wraparound services to reach youths in the juvenile justice system *– not accomplished.*

2.8 New funding for family support and psychiatric services to uninsured, hospitalized youths upon discharge *– not accomplished.*

2.9 Medicaid to explore strategies to expand eligibility for needed aftercare services—*not accomplished.*

✓ ***2.10 CCCMHC to monitor aftercare services and ongoing healthcare coverage for uninsured, hospitalized children—****a 2007 survey of families provides new information.*

2.11 Nevada Department of Health and Human Services and Clark County to expand service capacity to staff a sixth Neighborhood Service Center---*not accomplished.*

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

3.1.1 CCCMHC and key local and state decision-makers to identify a financing plan for Implementing a Neighborhood Service Center Collaborative Infrastructure*-- not accomplished.*

3.1.2 New funding to implement a collaborative infrastructure for the Neighborhood Service Centers—*not accomplished*

✓ ***3.3 CCCMHC to serve as the steering committee for implementation of the SAMHSA-funded Youth Suicide Initiative*** *– accomplished.*

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.***[5]

- ✓ ***In collaboration with the Nevada Office of Suicide Prevention and the Southern Nevada Health District, the CCCMHC produced two public service announcements which were aired through local television and movie theaters.***

- ✓ ***The Consortium 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. Nearly 50 primary care physicians were provided with materials and consultation as requested.***

- ✓ ***The Consortium translated its brochure on signs and symptoms of children's behavioral health problems into Spanish and 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 a press conference, 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.***[6]

- ✓ ***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.***[7]

- ✓ ***The Consortium collaborated with the Southern Nevada Health District to develop and implement an ongoing tracking system to monitor youths admitted to local emergency rooms for behavioral health problems.***

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

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[5] For a detailed description of the 2006-7 Public Education Campaign, see Appendix D

[6] 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 two 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 aftercare of uninsured children with a history of psychiatric hospitalization***

5. ***Needs for intensive treatment of children in the Child Welfare system***

6. ***Need for intensive treatment of youths in the Juvenile Justice System***

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

8. ***Need for system of care infrastructure development***

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.[8] 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.[9]

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.

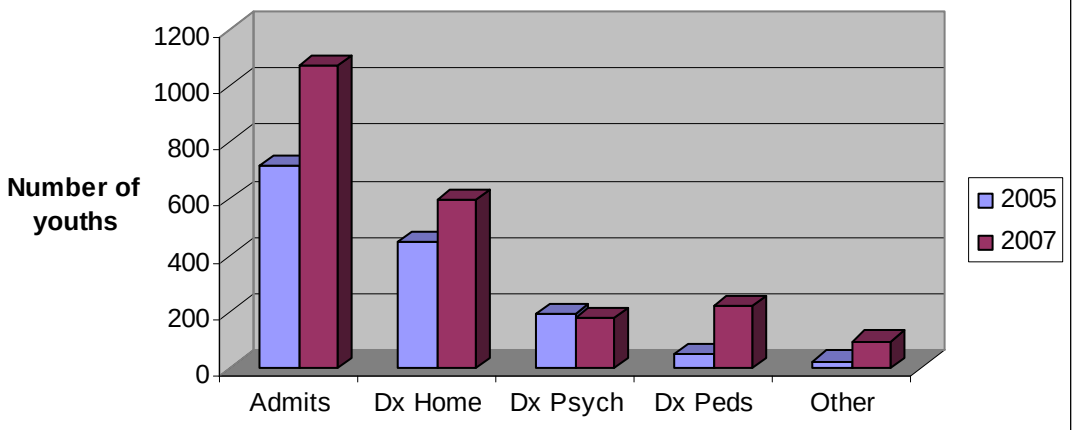
[8] U.S. Surgeon General National Action Agenda for Children's Mental Health. Washington, DC. Government Printing Office, 2001.
[9] http://www.mentalhealth.org

CRISIS INTERVENTION NEEDS

What are the needs of Clark County's children for behavioral health crisis services and how well are these needs being met?

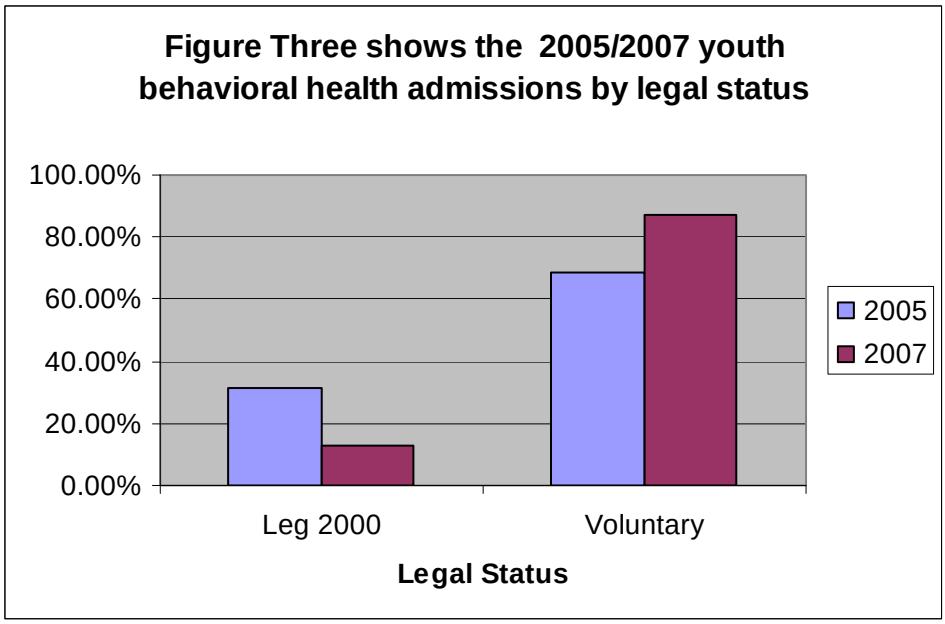
- **It is estimated that the number of children entering emergency rooms for serious, life-threatening behavioral health problems will increase this year by 49% over 2005 estimates to exceed 1000 youths**
- **The majority of these youths (57.7%) are adolescents 15-17 years old.**
- **Three-fourths of these youths reside in the central Las Vegas area.**
- **100% receive an assessment of their mental health disorder through the services of Montevista Hospital and Spring Mountain Treatment Center**
- **An estimated 55.9% will be discharged home in 2007 without any immediate treatment**
- ***Nearly one-third of these youths are uninsured and one-third are on Medicaid (HMOs and Fee for Service)***
- **As many as 218 children may be admitted to UMC's pediatric unit in 2007 for lack of any appropriate inpatient placement, nearly 419% more than those admitted in 2005.[10]**

Figure Two shows 2005/2007 Clark County youth behavioral health emergency room admissions by discharge disposition



[10] For more information on 2007 youth behavioral health admissions, see Appendix F

- **The number of youths being transported to local emergency rooms via legal 2000s has decreased from 31.6% in 2006 to 12.4% in 2007 due to training efforts by schools and police departments.**



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?

- **Increasing numbers of youths in public schools need immediate Crisis Services. During the 2006-7 school year, CCSD provided mental health assessment, crisis response or short-term services to 1273 students, a 45% increase over the previous school year[11]**

- **19.3% of all elementary school students need some level of behavioral health services and 6.0% need intense integrated services.** Of the estimated 28,070 children within the public elementary schools *this school year* who need early

[11] Data provided by the Clark County School District's Safe Schools Healthy Students Initiative, see Appendix I

access to behavioral health interventions, **69% or 19,368 children are receiving no school or known identified community-based services**.[12]

- ***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.***[13]

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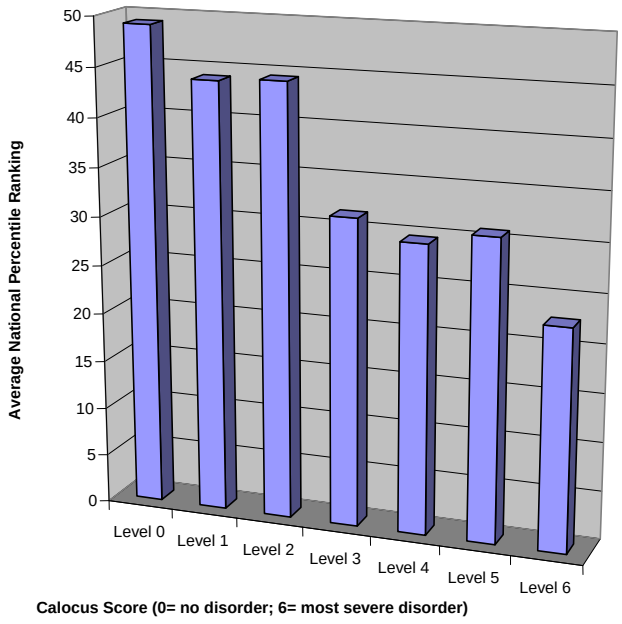
Figure Four shows the current average academic achievement rankings for Clark County Elementary School Students identified with behavioral health disorders in 2004 by level of severity.



- ***29.3% of Nevada high school students have felt sad or hopeless for a period of more than 2 weeks***

- ***27.8% of high school students self-reported depression of a magnitude sufficient to impact completion of daily tasks in the previous 12 months.***

- ***Nationally, 14-year-olds have the highest rates of completed suicide among youths 11-18 years.***

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[12] Prevalence estimates based on Clark County School District 2006-7 official enrollment figures and a study conducted for the Clark County Children's Mental Health Consortium Third Annual Plan, 2003.

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

- ***11.9% of Clark County 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 similar to last year's (14%) and somewhat lower than the national average for Columbia TeenScreen (17%).***

- ***An estimated 41% of those identified at risk of suicide received no known follow-up services. This is a slight improvement over last year (48%).***

- ***56% of those students eligible for the TeenScreen Program in 2006-7 were never screened due to lack of permission from parents. This refusal rate is significantly higher than in the 2005-6 school year when the refusal rate was 15.9% and slightly lower than the national average for TeenScreen Programs.***

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?[14]

- ***Of an estimated 247 children admitted to Desert Willow Treatment Center in 2006, 118 were uninsured or underinsured.***

- ***39.3% of the youths did not receive all the services recommended at discharge. There is no change in this figure since 2006.*** Aftercare services are designed to support the child to function adequately at home, at school and in the community.

- ***35.7% needed emergency or residential services following discharge, as compared to 31.6% in 2006.*** Children with serious behavioral health problems are likely to need re-hospitalization or other emergency services on a recurring basis.

- ***50% of uninsured youths obtained insurance coverage following discharge, a significant increase from 2006 (34.2%)*** With benefits, these children are much more likely to receive the services and supports needed for their families to maintain them at home.

- ***Nonetheless,, families reported that obtaining aftercare for their youth was complicated by Medicaid procedures, difficulty accessing psychiatric services, and unavailability of in-home services and supports.***

NEEDS OF CHILD WELFARE CHILDREN

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

[14] See Appendix G

- **Previous studies by the CCCMHC[15] have indicated that 85.3% of abused/neglected children need some level of behavioral health services and 40% need intensive levels of community-based supports**. These prevalence rates are consistent with national prevalence figures for abused/neglected children.

- **Based on the estimates shown above, 1836 children in foster care need behavioral health services and 861 suffer from serious emotional disturbance and need intensive levels of community-based supports**

- In 2006, over 97% of children with serious emotional disturbance in ***foster care*** received intensive service coordination through DCFS and Mojave Mental Health Services. However, It is **not** known whether all of these children received the full array of direct services they need. Placement disruptions continue to occur with these youths.

- It is estimated that 70% of children ***involved in the child welfare system but remaining at home*** are underserved and 43.8% of these children with SED are receiving no behavioral health services

Over the past two years, the Clark County Child Welfare Services has experienced a tremendous growth in the number of children requiring their services. The expansion of the WIN Program over the last two years has helped meet the needs of this growing population.

Unmet Needs in Public Systems

	Receiving Appropriate Level of Services	Under Served	Children with SED receiving no Services
Clark County School	17.4%	82.6%	62.9%
Clark County Child Welfare	30.0%	70.0%	43.8%
DCFS Child Welfare	88.1%	11.9%	2.1%
Juvenile Justice	28.9%	71.1%	36.7%

Figure Five **uses the data from the Child and Adolescent Level of Care Utilization System Screening of 2715 children and youth in the child welfare, juvenile justice and school systems in Clark County compared to the types and amounts of services received to determine how well the need is being met for children and youth in these public systems.[19]**

[15] Clark County Children's Mental Health Services 2nd Annual Plan, 2003

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 the juvenile offenders are estimated to have a diagnosable disorder and need some level of behavioral health services.**[16] 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.

- **In 2006, 54% or 8114 of Clark County's Juvenile Offenders are estimated to have serious behavioral health problems and need intensive levels of community-based services**.

- **In 2006, 19.8% or 2975 of ALL offenders have serious emotional disturbance and are receiving no services.**

The juvenile justice population has remained steady over the last two years with approximately 15,000 youths served each year as a result of one or more offenses. No new community-based behavioral health services have been implemented this year to address the ongoing needs of these youths.

Youths involved with the juvenile justice system who are residing in the community have difficulty accessing appropriate mental health services though the Neighborhood Family Service Centers due to high-risk behaviors and co-occurring substance abuse problems. Additionally, there are no services designed to provide wraparound service coordination to juvenile offenders with serious behavioral health problems.

NEEDS OF CHILDREN IN THE MEDICAID SYSTEM

The needs of children in the Medicaid System were extensively studied by the CCCMHC in 2002 and 2003. The results of these needs assessments are published in the CCCMHC's First and Second Annual Plans. Many of the recommendations made by the CCCMHC were incorporated in the Medicaid Behavioral Health Redesign Plan. The 2005 Legislature authorized funding for the Nevada Division of Healthcare Financing and Policy begin implementing its Behavioral Health Redesign Plan. Significant changes in Medicaid funding and policy for behavioral health services were implemented in January 2006. The CCCMHC has been unable to obtain quantitative data from Medicaid to assess the progress of the Behavioral Health Redesign in meeting the needs of Clark County's Medicaid Children. However, the CCCMHC continues to receive qualitative feedback from parents that the Medicaid System present barriers to accessing the services needed for their children who suffer from serious emotional disturbance.

[16] These figures are based on a 2003 CCCMHC study published in the Third Annual Plan

The Behavioral Health Redesign Plan has recently undergone changes as a result of feedback from the U.S. Center for Medicare/Medicaid Services. The CCCMHC would like to partner with the Nevada Division of Healthcare Financing and Policy to develop strategies for (1) evaluating the impact of these changes; (2) advocating for further reforms to improve access to behavioral healthcare services.

NEEDS OF FAMILIES WHO HAVE CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

- **Over the past two years, there has been an increase of over 200 families per year requesting support from Nevada Parents Encouraging Parents.**

- **State and federal funding for family support services in Clark County has been reduced in 2007 by 50% over 2004 funding levels.** Medicaid and discretionary grant funding is no longer available to provide these services.

- **77% of referrals for family support services originate from mental health facilities, individual professionals, school personnel and other community child-serving agencies.** Community professionals rely on these services to complement their treatment of youths with serious emotional disturbance.

- **Family-to-family support services has been shown to improve child and family functioning.** Data from local and national programs suggest family-to-family support is a best practices strategies for treating youths with serious emotional disturbance.

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[17] 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**

[17] 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.

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 children and for youths in the juvenile justice system.

While there have 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

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.

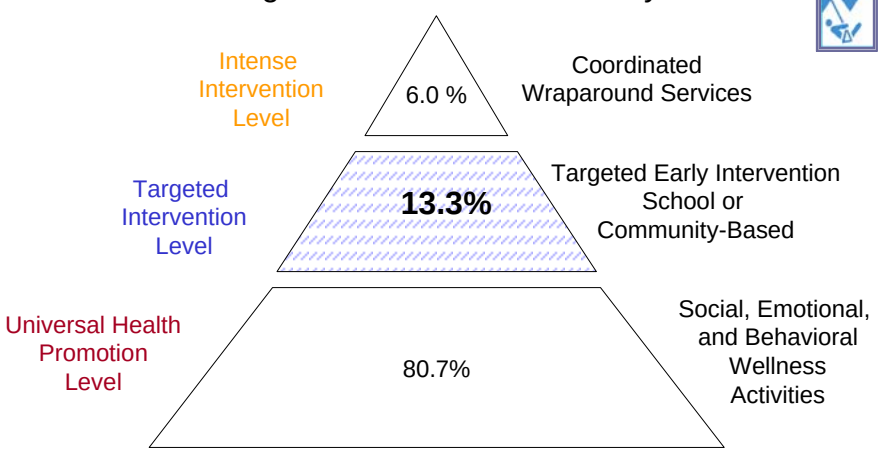


Figure Six **New Picture of School – Community Interaction.** This diagram shows the community strategy to address the mental health needs of children in the public school system in Clark County. For all students, the strategy will be to provide supplemental classroom supports to teachers to create classroom 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.

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 eligibility requirements, multiple service delivery locations, and inconsistent expectations in fragmented local social service systems."[18]

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.[19]

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

[18] 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

[19] 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

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:[20]

- 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.

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

Figure Seven shows a proposed integrated service delivery infrastructure for the Neighborhood Family Service Centers.

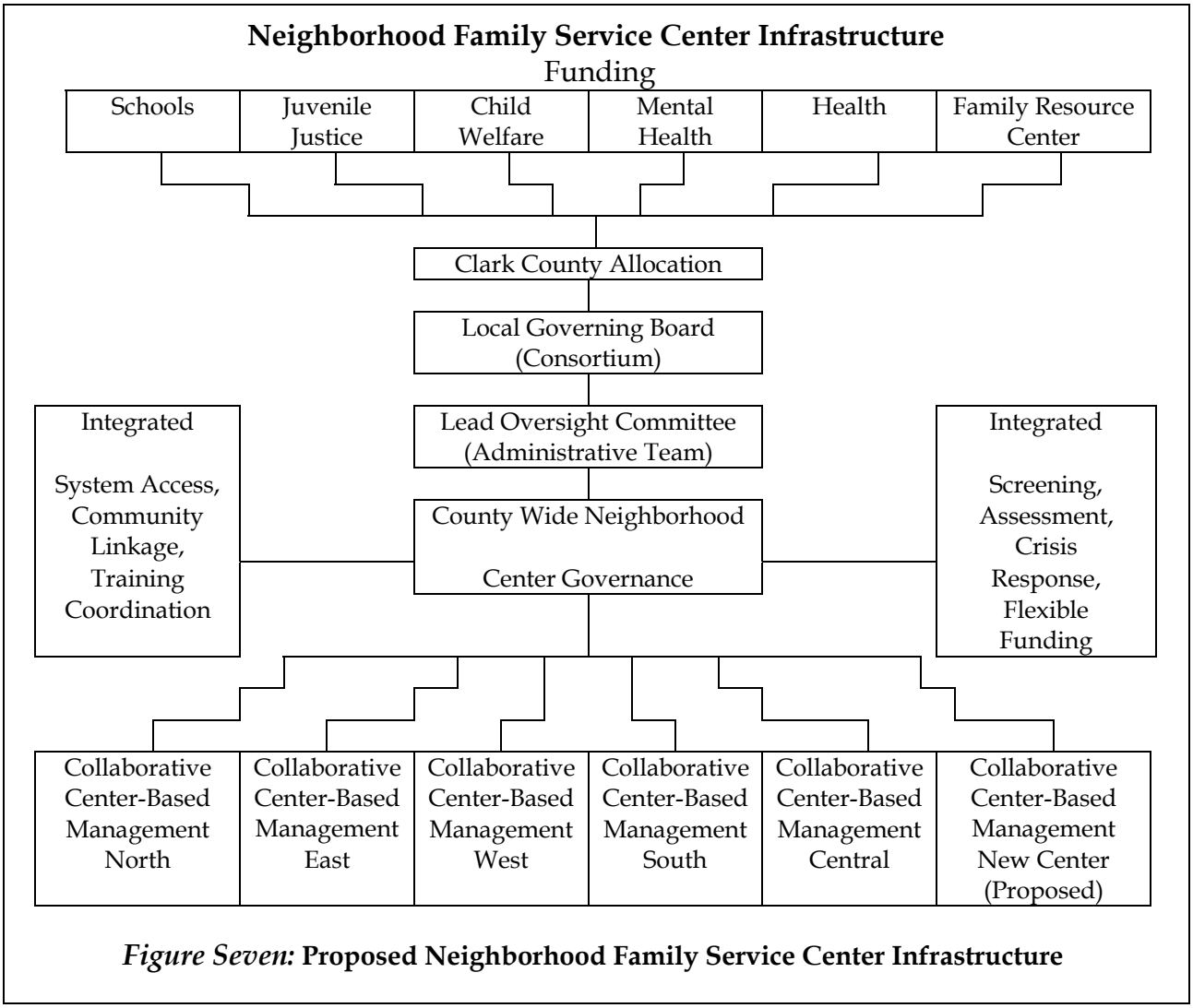


Figure Seven: **Proposed Neighborhood Family Service Center Infrastructure**

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 values upon which the Neighborhood Centers were established.

Figure Eight. **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 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.

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

***3.8 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.**

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

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

3.11 CCCMHC explore community-initiated wraparound in partnership with private businesses

3.12 CCCMHC implement a barrier-busting workgroup.

3.13 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.

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

***3.15 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.**

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

***3.17 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.**

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:

Mike Bernstein	Southern Nevada Health District
Ann Polakowski	Division of Child and Family Services
TJ Rosenberg	Nevada Parents Encouraging Parents
Lynda Tanner-Delgado	Montevista Hospital
Tammi Ewing	Spring Mountain Treatment Center
Dale Matteson	Matteson Media Inc.
Jodi Tyson	Office of Suicide Prevention
Robert Borders	Clark County School District
Linda Flatt	Office of Suicide Prevention
Cheryl Murphy	Bipolar Support Alliance
Neha Mehta, M.D.	Sunrise Hospital
Lisa Durette, M.D.	Child and Adolescent Psychiatrist
Hilary Westrom	Children's Advocacy Alliance
Andrea Sundberg	S.A.F.E. House
Yolena Yekta	Our Kids Home
Suzanne Orlando	Our Kids Home
Stephen Dubrofsky	Our Kids Home
Susan Sernoe	Clark County School District
Tom Cook	Montevista Hospital
Natalie Filipic	Nevada Parents Encouraging Parents
Gary Waters	Center for Health and Learning
Donna Wilburn	Nevada Association of Marriage/ Family Therapists
Tim Boylan	Clark County Juvenile Justice Services
Barbara Ludwig	Columbia TeenScreen Program
Jackie Harris	Bridge Counseling

Anita Post	Nevada Parents Encouraging Parents
Rosemary Virtuoso	Clark County School District
Kitty Hardy	Clark County Department of Family Services
Sharelle Bates	Office of Suicide Prevention
Jennifer Personius-Zipoy	University of Nevada Las Vegas
Cynthia Escamilla	Nevada Parents Encouraging Parents
Michele Howser	Girls and Boys Town
Amanda Haboush	University of Nevada Las Vegas
Beth Marek	Clark County Juvenile Justice Services
Eric Skansgaard	Division of Mental Health and Developmental Services
Tammi S. Roitman	Clark County School District
Kelli Slater	Spring Mountain Treatment Center
Tom Criste	Clark County Department of Family Services
Karen Taycher	Nevada Parents Encouraging Parents
Thomas Morton	Clark County Department of Family Services
Scott Reynolds	Clark County School District
James R. Osti	Southern Nevada Health District
Viki Kinnikin	Mojave Mental Health Services
Fritz Reese	Clark County Juvenile Justice Services
Sandal Kelly	First Health
Lien Bragg	Clark County Department of Family Services
Janelle Kraft	Las Vegas Metropolitan Police Department
Russell diBartolo	Safe Schools Healthy Students Initiative
Leslie Nix Fuentes	Clark County School District
Rebecca McCollom	Nevada Parents Encouraging Parents
Joann Griffen	Grandparent
Theresa Brooks	Nevada Parents Encouraging Parents
Anne-Marie Abruscato	Mojave Mental Health Services
Nancy Harpin	University Medical Center
Linda Santangelo	Desert Willow Treatment Center

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 recognize the importance of the mental health of children and reduce the stigma of using mental health services

Action Step 1. Develop and implement strategies for dissemination brochure and information from Annual Plans

Action Step 2. Develop speaking points for community presentations.

Action Step 3. Reproduce executive summary of each Annual Plan

Action Step 4. Hold a press conference to disseminate findings of Annual Plan

Action Step 5. Survey Providers listed in CCCMHC Brochure and solicit feedback.

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

Action Step 1. Engage school officials in a collaborative process to improve school-based services (Counseling, Safe School Program, and Nursing)

Action Step 2. Provide findings of Annual Plan to CCSD Board of Trustees

Action Step 3. Engage consumers, agencies and local businesses to support CCMHC.

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. Identify and describe existing crisis services and develop a flow chart for accessing these services

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.

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.

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. Determine legislative reporting responsibilities of the CCCMHC in collaboration with other local consortia.

Appendix B
Clark County Children's Mental Health Consortium
Status Review of Annual Plan Recommendations 2002-2006

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
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 serve 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 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
2002 2003 2004 2005 2006	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

Plan Year	*Request/ Recommendation*	*Identified Need*	*Data Source*	*Status*
2002 2003 2004 2005 2006	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 room diversion	Focus Groups with staff from Clark County Juvenile Probation and Clark County Child Protective Services Parent Survey from 2002 plan #youths with bh problems admitted to emergency rooms	Pilot project funded by 2007 Legislature
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's 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	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 services	School district data from Safe Schools Healthy Students Grant Initiative	Not implemented—no funding

Plan Year	*Request/ Recommendation*	*Identified Need*	*Data Source*	*Status*
2006	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 survey of parents	Not 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	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	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	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

Appendix C

Clark County Children's Mental Health Consortium
Ongoing Needs Assessment 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)* *%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* *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.* ***Follow-up on elementary school students identified by the 2004 CCCMHC needs assessment***
Children in the Public School System	*TeenScreen Report*	*# Children engaged in TeenScreen* *# Children screened positive* *#Children served, unserved, underserved* *Satisfaction with services*
Children with serious behavioral health crises	*Self-report by Hospitals*	*#Children admitted to hospital emergency rooms for suicide attempts; other mental health problems; disposition types; %legal 2000s; lengths of stay by payor source*
Uninsured children hospitalized in the state inpatient facility	Survey of youths discharged from DWTC	*#uninsured youths admitted to inpatient care needing aftercare services*
Children with serious emotional disturbance in public systems	Stakeholder Surveys: UNLV and Wraparound	*Extent to which the state infrastructure supports the development of services consistent with system of care principles* ***Extent to which local/state infrastructure supports Wraparound. Assessment of system support for wraparound in Clark County in six areas:*** ***(1) Community Partnership;*** ***(2)Collaborative Action;*** ***(3)Fiscal Policies and Sustainability;*** ***(4)Access to needed supports and services;*** ***(5)Human Resource Development and Support;*** ***(6) Accountability***
Children with Serious Emotional Disturbance in family care	Family survey; Provider Survey	*#of families needing family support services* *#of families receiving family support services* *#of families which could be served by current providers*

Appendix D

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

Over the past two 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.

Led by Hilary Westrom, CCCMHC Vice-Chair, the Workgroup on Public Awareness and Behavioral Wellness has set two 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 is producing a series of public service announcements that began airing on television and radio. 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.

An evaluation has been conducted to assess the effectiveness of this initial media campaign. Over 100 call-in responses to the commercial have been tracked and approximately 82 callers were linked with services and/or sent information about children's mental health. Call-in responses to the commercial originated from zip codes throughout Clark County. Caregivers asked for assistance with children ranging from 2 through 15 years of age and with behavioral health problems which included anger, tantrums, stealing, runaway behavior, school issues, depression, attentional problems, insomnia, autism, substance abuse, and bipolar disorder. A questionnaire has been sent to callers to evaluate the effectiveness of the public service announcement and the helpfulness of the information/assistance provided. The results of this specific analysis are being compiled as the questionnaires are returned .

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?" began airing on cable television stations and in local movie theaters. On television, the PSA is airing 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 is also showing 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. The Workgroup members are working with the National Anti-Stigma Campaign to track visits to their website (www.whatadifference.org, referred to in the PSA) as a result of people in Nevada seeing it.

Both 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.

In conjunction with the media campaign that began in December, the Consortium 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. To date, nearly 50 physicians have expressed interest in the public education campaign and have been sent materials.

The CCCMHC celebrated National Children's Mental Health Awareness Day with a press conference held at a local high school to highlight the value of early identification and treatment in promoting school success. A parent of a teen with serious emotional disturbance spoke about the challenges faced by high school students with behavioral health problems, and the potential for success if treatment is available. A school counselor, school health teacher, school psychologist and principal also discussed the value of early screening and treatment. CCCMHC members presented new local data collected to demonstrate the link between behavioral health and school achievement and the CCCMHC's ongoing media campaign.

The CCCMHC's Public Education Campaign is being supported by funding provided through the Nevada Division of Child and Family Services and the Nevada Office of Suicide Prevention. The Consortium is also seeking funding from local businesses and other private foundations to support this campaign. The Workgroup will submit a grant proposal to the American Psychiatric Foundation. The Workgroup has been exploring the possibility of partnering with private industry to support the campaign. At least one major corporation has expressed interest in partnering with the CCMHC in its public education campaign.

A public education toolkit will be developed in the coming year to disseminate to other jurisdictions in the state.

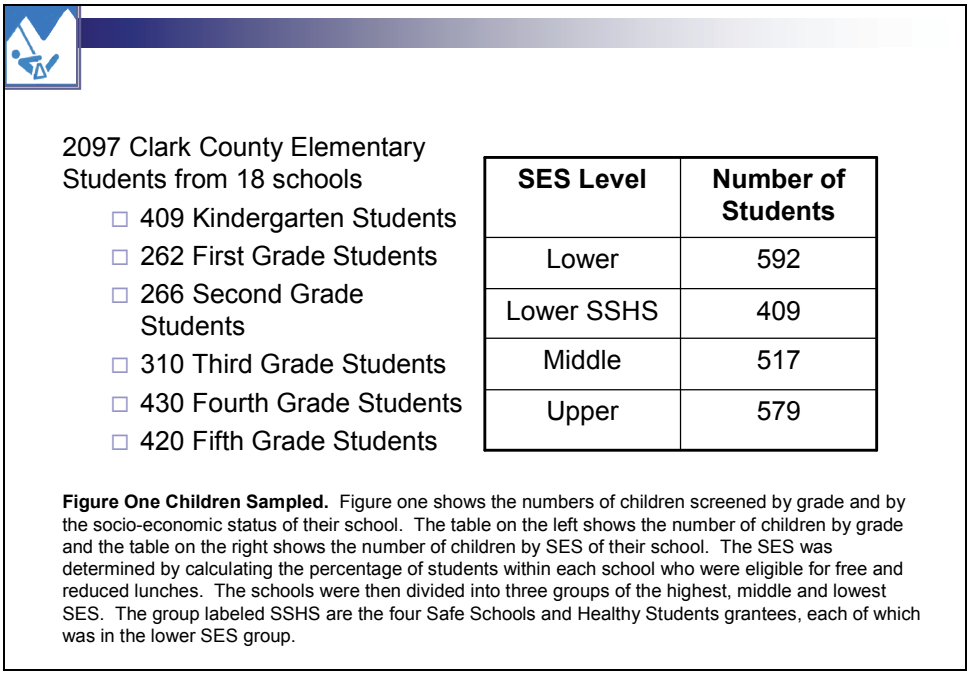
Appendix E

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.



2097 Clark County Elementary Students from 18 schools

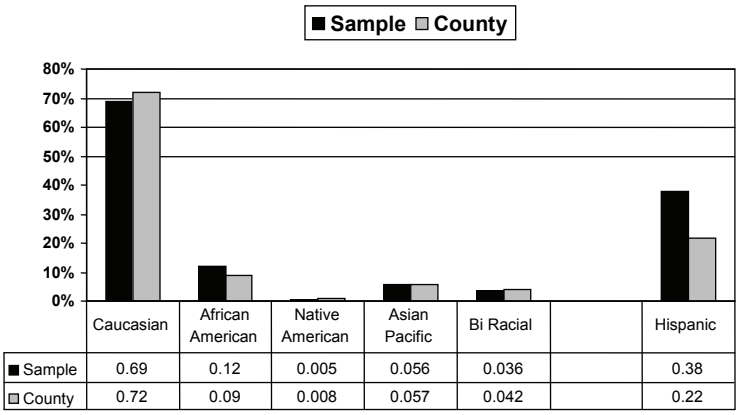
- 409 Kindergarten Students
- 262 First Grade Students
- 266 Second Grade Students
- 310 Third Grade Students
- 430 Fourth Grade Students
- 420 Fifth Grade Students

SES Level	Number of Students
Lower	592
Lower SSHS	409
Middle	517
Upper	579

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 Two. Ethnicity of Sample. Figure two 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.***

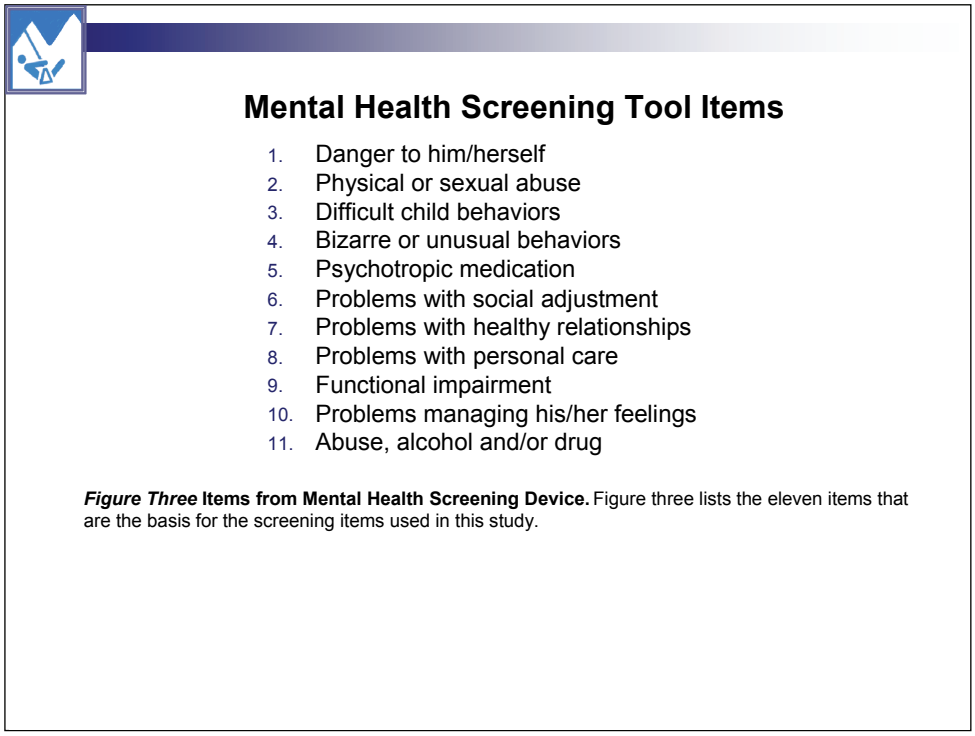


***Figure Three* Items from Mental Health Screening Device.** Figure three lists the eleven items that are the basis for the screening items used in this study.

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***.

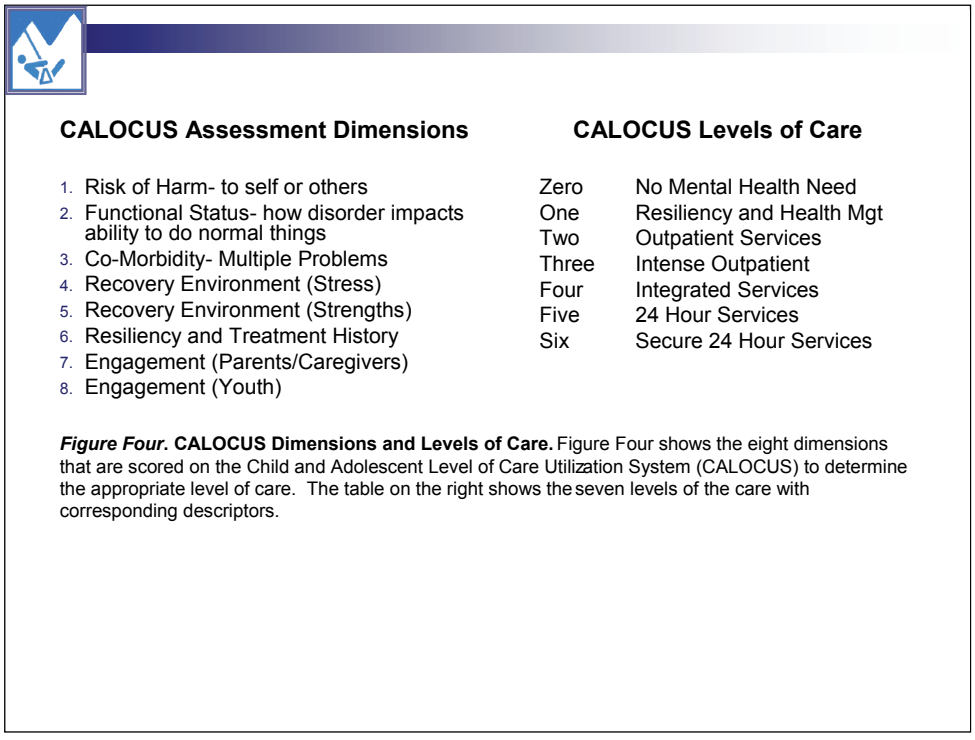


***Figure Four*. CALOCUS Dimensions and Levels of Care.** Figure Four shows the eight dimensions that are scored on the Child and Adolescent Level of Care Utilization System (CALOCUS) to determine the appropriate level of care. The table on the right shows the seven levels of the care with corresponding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

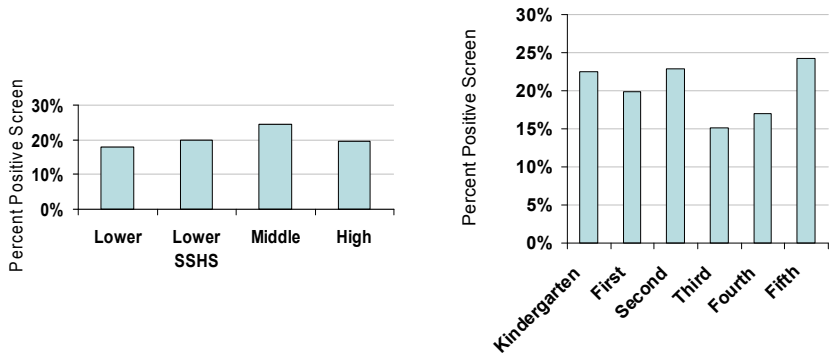


Figure Five Mental Health Screens by socio-economic status and grade. The left side of Figure Five shows the percentage of children with positive screens from the three levels of socio-economic status and the four Safe Schools Health Students (grantees) who were all in the lower socioeconomic status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

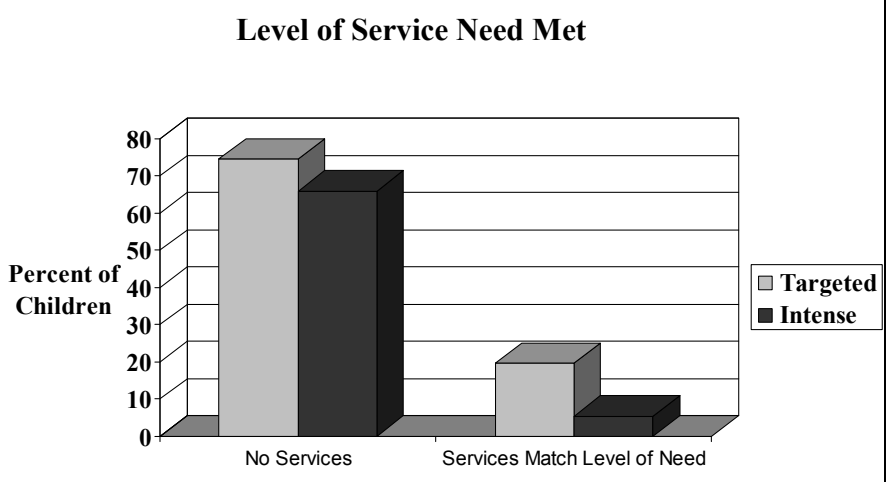


Figure Six Level of Need Met. Figure Six shows the existing level of services for the children assessed in 2004 with targeted and intense needs. The first set of columns show that over 60% of the children with intense needs and over 70% of the children with early access needs are currently receiving 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.

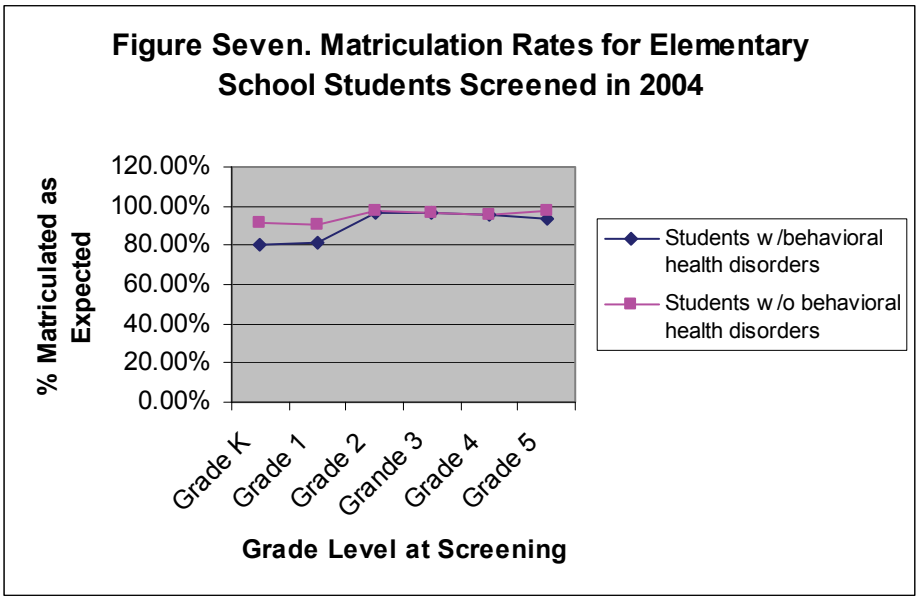
Methods

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.

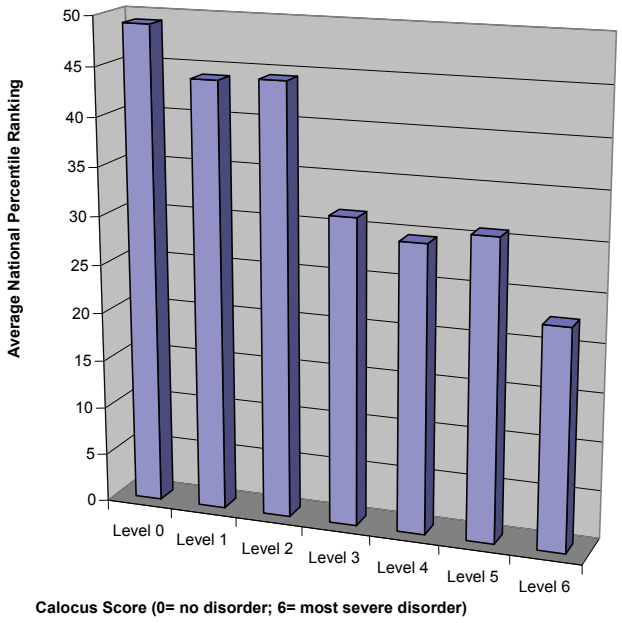
Results

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 CALOCUS 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

Purpose of the Survey. 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.

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.

In the 2006 Plan, the CCCMHC recommended that the Legislature fund mobile crisis intervention and stabilization services to provide alternative treatment to these youth. The CCCMHC also recommended that a monthly tracking system be established to monitor youth psychiatric emergency room admissions.

Survey Methods.

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.

Emergency Room Managers were asked to provide the total number of admissions for youths with behavioral health problems for calendar year 2007. Youth identified are those for whom a behavioral health problem is the primary reason for admission to the emergency room. An electronic tracking form was developed by Mr. Osti and provided to the hospitals monthly for completion. With the assistance of the emergency room managers and their staff, standardized definitions were created for several other data elements and these elements were included in the reporting format. 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

A copy of the tracking form and categories for each indicator are shown in Table 1.

Data were gathered for the period between January 1, 2007 and June 30, 2007. These data were annualized and compared to last year's estimates wherever possible.

Survey Results:

Data were available for the period from January 1, 2007 until June 30 2007. There were a total of 545 admissions reported by four local hospitals: Sunrise Medical, University Medical Center, Spring Valley Hospital and Valley Hospital.

More detailed information was available for 535 (98%) of the admissions that originated from Sunrise Medical and University Medical Center. Figure 1 shows the projected number of admissions for 2007 based on the actual admissions reported by the two largest hospitals. Annual estimates for 2005 are also shown on Figure One. Based on the available data, there is a 49% increase projected in the admissions between 2005 and 2007.

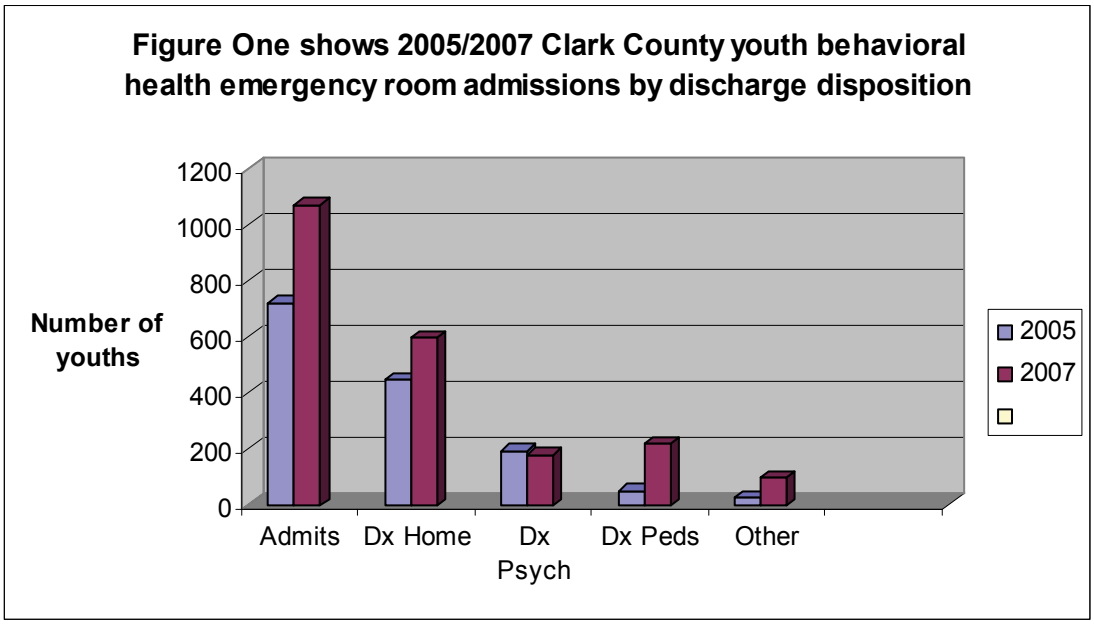


Figure 1 shows the total number and disposition of youths admitted to two local emergency rooms for behavioral health problems. These numbers represent annual estimates based on actual data for 11 months of 2005 (January-November 2005) and actual data for 6 months of 2007 (January 1-June 30). The disposition 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.

Figure 1 illustrates that there is 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 is projected that 218 youths will require inpatient pediatric services in 2007, a **419% 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.

In last year's 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 an project 12% 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 **55%** of the 2007 youth admissions via the Legal 2000 Procedure were initiated by emergency transport agencies, the CCCMHC will assist these agencies in training their personnel in alternatives to the Procedure.

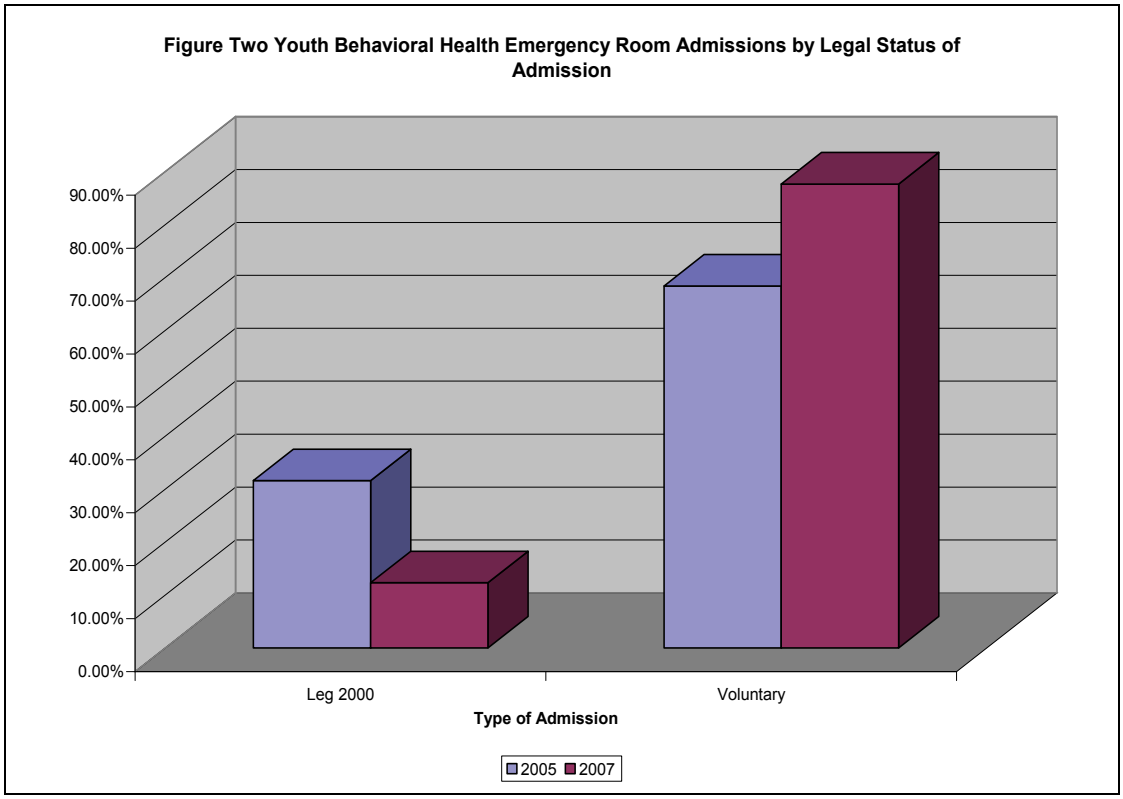


Figure 2 shows the percentage of youth behavioral health emergency rooms admissions made using the Legal 2000 Procedure as compared to those admissions that involved voluntary consent (by parent or guardian). 2005 estimates are based on 11 months of data from the two larges local hospital. 2007 estimates are based on the first 6 months of data from the same hospitals.

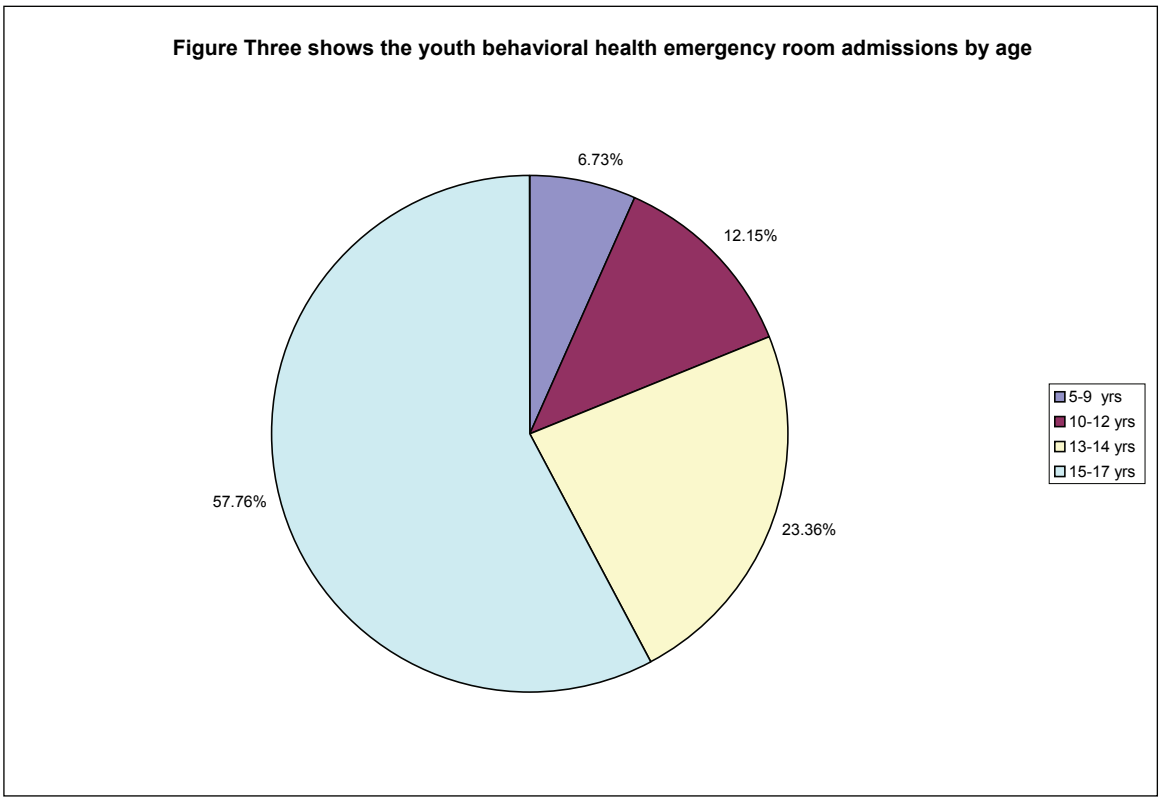


Figure 3 shows the distribution of youth behavioral health admissions by age based on the first sixth months of 2007. More than half of the admissions are teens 15-17 years old.

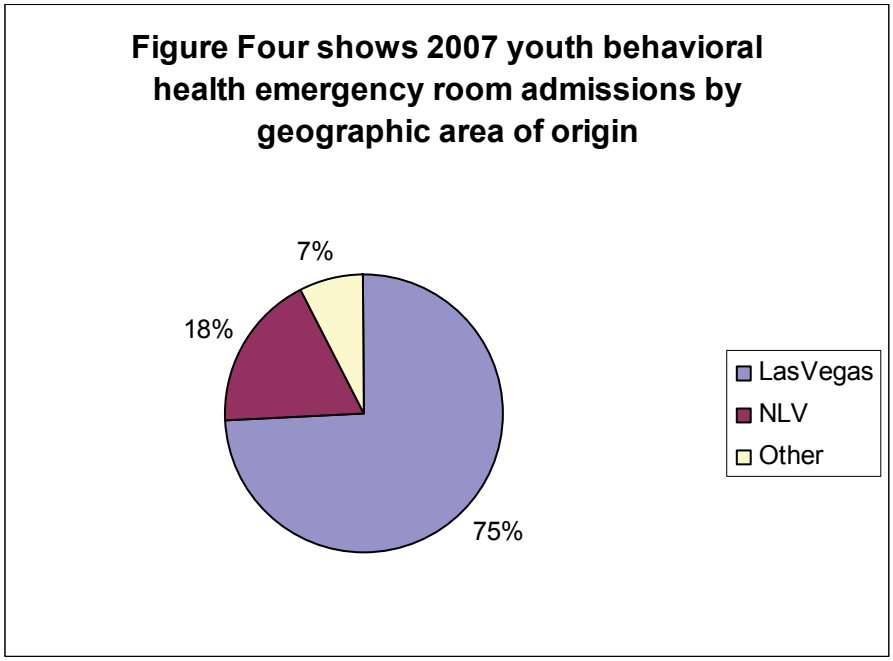


Figure 4 shows the percentage of youth behavioral health admissions based on the geographic Area of origin. The majority of the youth originate from the central area of Clark County (Las Vegas) and North Las Vegas.

The 2007 Legislature funded a pilot project to implement a mobile crisis intervention and stabilization program in Clark County to provide services to the types of youths admitted to local emergency rooms for behavioral health problems. The monthly tracking system implemented by the CCCMHC in collaboration with the Southern Nevada Health District provides information to guide the development of this new program. As shown in Figure 3, a majority of youths admitted to local emergency rooms with behavioral health problems are 15-17 years of age. As shown in Figure 4, most of these youths originate from central Clark County, which consists of the city of Las Vegas and portions of North Las Vegas. As mobile crisis services are implemented, it will be important to design programming that will be effective in reaching this age range and geographic area. The CCCMHC has developed a recommended model of mobile crisis intervention services. Detailed information on this model can be found in the *Clark CCCMHC Fifth Annual Plan*, 2006.

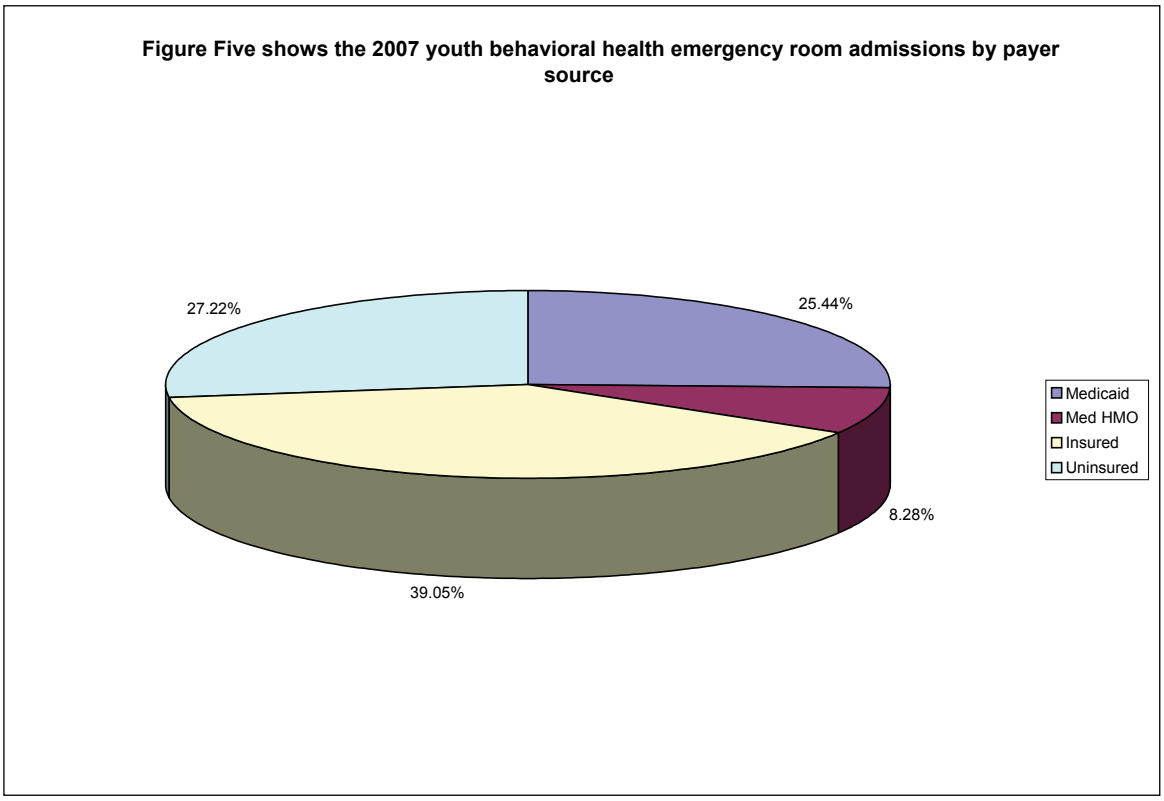


Figure 5 shows the percentage of youth behavioral health admissions by payer source based on the first six months of 2007. About one-third of the admissions represent uninsured youths and about one-third are covered by Medicaid (fee-for-service or HMO). Data from the 2005 survey suggested that uninsured and Medicaid youths stayed in emergency rooms significantly longer than those youths with commercial insurance. 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.

PEDIATRIC PSYCHIATRIC TRACKING FORM

YEAR-TO-DATE SUMMARY

Facility: Las Vegas Metropolitan Area Report

MONTH: January - June YR: 2007

PEDIATRIC PSYCHIATRIC Spreadsheet Data Summary

STATS	
Total Hours	13933.25
Total Days	580.55
Total patients	535.00
Hours/Patient	26.04

Homeless	Number	Percent
Homeless	0	**NONE**
ZipCode	532	99.44%
Unknown	3	0.56%
Total	535	100.00%

ZipCode Analysis	Number	Percent
Out of Country	0	**NONE**
Out of State	5	0.93%
NV Outside Area	7	1.31%
Clark County	3	0.56%
Boulder City	1	0.19%
Henderson	18	3.36%
North Las Vegas	98	18.32%
Las Vegas	397	74.21%
Unknown	6	1.12%
Total	535	100.00%

Type	Number	Percent
Adult	0	**NONE**
Pediatric	169	100.00%
Voluntary	0	**NONE**
Unknown	0	**NONE**
Total	169	100.00%

Legal 2000	NUMBER	PERCENT
(Y) YES	66	12.34%
(N) NO	469	87.66%
(U) UNKNOWN	0	**NONE**
Total	535	100.00%

Arrival	Number	Percent
Walk In	170	31.78%
EMS	298	55.70%
CIT	0	**NONE**
Police Not CIT	27	5.05%
Unknown	40	7.48%
	535	100.00%

Hospital Disposition	Number	Percent
(AP) Admitted Psychiatric	0	**NONE**
(AM) Admitted Medical	1	0.19%
(P) Admitted PEDS	109	20.37%
(NA) Not Admitted	425	79.44%
Total	535	100.00%

AGE	Number	Percent
1-4	0	**NONE**
5-9	36	6.73%
10-12	65	12.15%
13-14	125	23.36%
15-17	309	57.76%
18-Above	0	**NONE**
Total	535	100.00%

Post Hospital Disposition	Number	Percent
(D) Desert Willow	43	8.04%
(H) Home	299	55.89%
(J) Juvenile Detention	21	3.93%
(M) Monte Vista	62	11.59%
(O) Other	24	4.49%
(S) Spring Mountain	75	14.02%
(U) Unknown	11	2.06%
(NA) Not Applicable	0	**NONE**
Total	535	100.00%

Payor Source	Number	Percent
Medicaid	130	24.30%
Commercial	162	30.28%
Champus	1	0.19%
HMO	61	11.40%
Managed Medicaid	40	7.48%
Self-Pay	141	26.36%
Total	535	100.00%

Pediatric Psychiatric Tracking Spreadsheet

Original 12/07/2006 Revised 03/09/2007

Table 1

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 provides short-term hospitalization and residential care to youths with the most serious and life-threatening conditions. Nearly 40% 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."

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 in assessing the aftercare needs of uninsured and underinsured youths requiring hospitalization for their serious emotional disturbance. A survey was developed and administered in April, 2006 to assess families' access to needed aftercare services following discharge from Desert Willow Treatment Center. The results of the 2006 survey are reported in the CCCMHC's Fifth Annual Plan. In 2007, the survey was replicated to assess any changes in the aftercare needs for this population.

Survey Methods

Approximately 250 youths are hospitalized annually at Desert Willow Treatment Center. Of these youths 59% are typically "family of one" cases. A total of 61 "family of one" youths were discharged from Desert Willow Treatment Center between July, 2006 and March , 2007. These youths were selected as the target population for the survey.

During April, 2007, a family member was hired to administer the six-item telephone survey of aftercare services. The family member successfully contacted the parent or legal custodian of 29 of the 61 "family of one" youths in the sample. The family member completed the survey instrument with each family in a telephone interview. Families were asked to rate each item on a five-point scale. Families were also asked to provide open-ended comments in response to each item. 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. There were no significant differences in the distribution of respondents by Center Unit between the 2006 and 2007 surveys.

TABLE ONE. PARTICIPANTS BY PROGRAM UNIT

Survey Year		2006	Survey	2007	Survey
		Frequency	Percent	Frequency	Percent
	AAP	17	**44.7**	10	**34.5**
DWTC	CAP	6	**15.8**	8	**27.6**
Unit	RTC1	7	**18.4**	5	**17.2**
	RTC2	6	**15.8**	6	**20.7**
	SATP	2	**5.3**	0	**0**
	Total	38	**100.0**	29	**100.0**

Table 2 shows the lengths of stay for the youths of families participating in the survey. There were no significant differences in the distribution of lengths of stay for respondents between the 2006 and 2007 surveys.

TABLE TWO. PARTICIPANTS BY LENGTHS OF STAY

Survey Year		2006	Survey	2007	Survey
		Frequency	Percent	Frequency	Percent
Length of Stay	< 1 MO	13	**34.2**	13	**44.8**
	1-3 MO	17	**44.7**	6	**20.7**
	3-6 MO	4	**10.5**	7	**24.1**
	6-9 MO	3	**7.9**	2	**6.9**
	9-12 MO	1	**2.6**	1	**3.4**
	Total	38	**100.0**	29	**100.0**

Table 3 shows the responses for each of the six items on the survey. The response patterns are similar for both years. Seventy-two percent of the parents reported that their child was doing well after discharge, slightly higher than the previous year. However, similar to the 2006 Survey, **about 1/3 of the parents** reported that their child needed residential or

emergency services following discharge. **Approximately 75%** of the 2007 Survey Respondents reported satisfaction with the after care services, up slightly from the 2006 Survey.

There were significant differences in the responses to Item #3 between the 2006 and the 2007 Survey. This difference is attributed to a large number of the respondents who did not know whether their child was receiving all of the services recommended at discharge. There was a difference approaching statistical significance for Item #6 between the 2006 and the 2007 Survey. In the 2007 Survey, a **larger percentage of parents (48%)** reported having insurance and/or Medicaid coverage after discharge.

TABLE THREE. RESPONSES FOR EACH SURVEY QUESTION

1. HOW IS YOU CHILD DOING SINCE HE/SHE WAS DISCHARGED?

Survey Year		2006 Survey		2007 Survey	
		Frequency	Percent	Frequency	Percent
Parent Rating	POOR	7	**18.4**	7	**24.1**
	FAIR	8	**21.1**	1	**3.4**
	GOOD	7	**18.4**	6	**20.7**
	VERY GOOD	9	**23.7**	7	**24.1**
	EXCELLENT	7	**18.4**	8	**27.6**
	Total	38	**100.0**	29	**100.0**

2. SINCE DISCHARGE, HAS YOUR CHILD NEEDED ANY EMERGENCY OR RESIDENTIAL SERVICES?

Survey Year		2006 Survey		2007 Survey	
		Frequency	Percent	Frequency	Percent
	No response	0	**0**	1	**3.4**
Parent Response	YES	12	**31.6**	10	**34.5**
	NO	25	**65.8**	18	**62.1**
	Total	38	**100.0**	29	**100.0**

TABLE THREE. RESPONSES FOR EACH SURVEY QUESTION (CONT'D)

3. IS YOUR CHILD RECEIVING (HAS RECEIVED) ALL SERVICES RECOMMENDED AT DC FROM DWTC?

Survey Year		2006 Survey		2007 Survey	
		Frequency	Percent	Frequency	Percent
	No response	0	**0**	1	**3.4**
Parent Response	YES	23	**60.5**	17	**58.6**
	NO	15	**39.5**	3	**10.3**
	Don't Know	0	**0**	8	**27.6**
	Total	38	**100.0**	29	**100.0**

4. HOW WOULD YOU RATE THE SERVICES THAT YOUR CHILD IS NOW RECEIVING?

Survey Year		2006 Survey		2007 Survey	
		Frequency	Percent	Frequency	Percent
	No response	0	**0**	1	**3.4**
Parent Rating	POOR	4	**10.5**	1	**3.4**
	FAIR	1	**2.6**	3	**10.3**
	GOOD	6	**15.8**	8	**27.6**
	VERY GOOD	7	**18.4**	6	**20.7**
	EXCELLENT	11	**28.9**	8	**27.6**
	NA	9	**23.7**	2	**6.9**
	Total	38	**100.0**	29	**100.0**

TABLE THREE. RESPONSES FOR EACH SURVEY QUESTION (CONT'D)

5. HAVE YOU APPLIED FOR MEDICAID AND/OR OTHER INSURANCE SINCE YOUR CHILD'S DC FM DWTC?

Survey Year		2006 Survey Frequency	2006 Survey Percent	2007 Survey Frequency	2007 Survey Percent
	No response	0	**0**	1	**3.4**
Parent Response	YES	14	**36.8**	13	**44.8**
	NO	24	**63.2**	15	**51.7**
	Total	38	**100.0**	29	**100.0**

6. DO YOU CURRENTLY HAVE MEDICAID AND/OR OTHER INSURANCE COVERAGE?

Survey Year		2006 Survey Frequency	2006 Survey Percent	2007 Survey Frequency	2007 Survey Percent
	No Response	0	**0**	1	**3.4**
Parent Response	YES	13	**34.2**	14	**48.3**
	NO	25	**65.8**	14	**48.3**
	Total	38	**100.0**	29	**100.0**

Below are some of the characteristic open-ended comments provided by survey respondents by Program Unit:

** Needs help getting Medicaid-understanding the process*
** Medicaid process is too long, involved and complicated. Mom feels son should not have been released but was because insurance ran out. Can't apply for Medicaid until family of one runs out.*
**Lapse in Medicaid coverage/Admission to Copper Hills in approx. 3 mo after release from DWTC-Placed by Probation Officer in Copper Hills for being violent to family. member. Mom hopes he goes in DWTC to ease transition.*
**Mom is upset because she has to go down to Medicaid to complete entire app. process again.*
**Service received at DWTC were great! They were compassionate and nice.*
**In home counseling for family. Clear steps for help to address situations after leaving hosp.*
**Parents would like help in the home.*

**More support after release w/school district & with transitioning from hospital to home setting.*
**Had services come into home to help w/transition. Counseling for parents/therapy in home.*

Survey Conclusions

Over 70% of families reported that their youths were functioning at a good to excellent level. In spite of these positive outcomes, over one-third of the youths still required emergency services during the aftercare period. Similar to the results of the 2006 Survey, Nearly 40% of families in the 2007 Survey reported that they were not able to access all the needed aftercare services or did not know what services were needed. This result was in part due to the fact that many children were residing with parents or guardians following discharge who had not been involved in the discharge planning. Although there was an increase in the percentage of families with health insurance following discharge, slightly more than half still were without coverage.

In 2006, lack of insurance benefits was often cited by the families as a barrier to receiving needed aftercare services. Families also requested advocates to help find and access needed services and benefits. In 2007, families noted the complexities and delays in Medicaid application procedures as a major barrier in getting timely services. Families noted that continuity in psychiatric services and medication monitoring were the biggest problem following discharge. Families also noted that managing their child at home was a major challenge and that more home-based services are needed to make the transition successful.

Appendix H

Youth Suicide Prevention Program Update 2006-2007

OFFICE OF SUICIDE PREVENTION

Youth Suicide Prevention Program Update 2006-2007

CCCMHC 6th Annual Plan **Submitted June 1, 2007**

2005 Youth Suicide Data at a Glance

- 69 young people between 6-29 years of age died by suicide in Clark County
- 54 of those deaths were male
- 29.3% of Nevada high school students have felt sad or hopeless for a period of more than 2 weeks
- 12.5% of Nevada high school students have attempted suicide in the past 12 months
- 3.8% of students who attempted suicide reported being seen by a doctor or nurse for their injuries
- The most prevalent method of suicide among youth continues to reflect their access to firearms

Statistics are provided from the following sources: Clark County Coroners Office, Nevada Dept. of Education, and the Center for Disease Control and Prevention's 2005 Youth Risk Behavior Survey

Inside this update:

CCCMHC Workgroup Provides Program Steering and Involvement

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 of this 3 year funding project.

Two major impacts have been the addition of a funded parent/family support component, and the emergence of a separate sub-group meeting regularly with the Clark County School District's student/family support services such as: school nursing, counseling, social work, psychology, and the Student Threat Assessment and Crisis Evaluation Team.

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.

Monthly meetings with CCSD services have been beneficial; these meetings have increased open communication about program authority, program objectives and target audiences. Representatives from other community-based suicide prevention programs also attend this meeting so that all programs can work together and support each others' efforts without concern of duplication or competition.

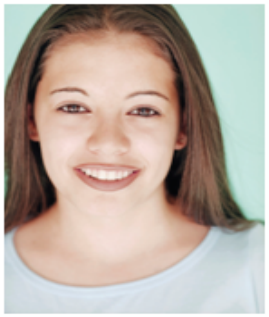
The workgroup has also been instrumental in determining evaluation objectives to measure the success of these new collaborations.

Partnerships Will Play Key Role in Program Sustainability

Legacy Wheel courtesy of: www.promoteprevent.org

Nevada was one of the first recipients of Garrett Lee Smith Memorial Act grant funds. Since the original grants were awarded, only one additional cohort of state grants has been released due to federal shortfalls. This means that Nevada must be prepared to sustain program components and partnerships without this funding mechanism. Sustainability will be a key term during the third and final year of funding. The national Suicide Prevention Resource Center will assist Nevada in developing a sustainability plan over the next year.

The CCCMHC and workgroups, sub-grantees, and the Nevada Coalition for Suicide Prevention will take part in the development and implementation of a sustainability plan. Part of the sustainability of this program will be to encourage it's growth through adoption and implementation in other communities across the state. To ensure that all communities have a program road map for implementation and sustainability, the Project Coordinator in the Office of Suicide Prevention, will be producing a comprehensive Youth Suicide Prevention Program tool kit.



Participants of the Applied Suicide Intervention Skills Training had this to say about their experience:

"The values clarification and exploration session was very valuable!"

- December 2006

"For me, the [intervention] model itself helped me feel more prepared to help someone at risk of suicide."

- December 2006

More people will feel prepared to help if they have this training!"

- February 2007

"What I liked most about the program was the comfort level and knowledge of the trainers."

- February 2007

"I felt better prepared in this training because of the time that was spent going through the model and role playing."

- February 2007

TeenScreen Data Results

3635 students in 10 high schools were offered a mental health screening through the Center for Health and Learning's Teen Screen program. 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.

TeenScreen Participation:

1610 parents consented to their child's participation; 114 families have consented to further services from the Center for Health and Learning or accepted referrals to recommended community services.

TeenScreen Results:

193 students were determined to be a current suicide risk;

no students were determined to be in such risk after the clinical interview, that they were determined to need transport for emergency services.

TeenScreen Follow-Up:

78 students/families are receiving multi-level care;

CHL staff spend an average of 12 hours per month with each student/family receiving on-going counseling services.

Gatekeeper Training Results

The Office of Suicide Prevention hosted a 16 hour Community Core Competency Training in Las Vegas in May, 2006, which 20 clinicians, agency supervisors, and program staff attended. The National Suicide Prevention Resource Center provided the curriculum and 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:

Suicide Prevention Awareness (1-2 hrs) = 110 participants;

Nevada Gatekeeper Training (2-4 hrs) = 31 participants;

Nevada Gatekeeper Training for Trainers = 30 participants;

ASIST (16 hrs) = 119 participants.

Geographic Locations:

159 of the 290 persons trained in 2006-2007 grant year were in the Southern Nevada area;

100 participants were from the rural areas in Northeast, NV.

Training Events:

OSP staff provided the curriculum and/or instruction for 8 of the 9 training events.

Anti-Stigma Media Campaign Results

Phase One of Three of the Anti-Stigma Media Campaign 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 One broadcast dates:

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.

Phase One broadcasts were aired on:

Fox 5, CBS 8, & eight cable channels (AEN, LIFETIME, FX, TBSC, TNT, USA, CRT, ENT).

Phase One generated increased call volume to the DCFS Neighborhood Family Service Center:

Nearly 100 calls from parents requesting more information, referrals and services;

Calls from parents were in regards to children ranging in ages from 2 years to 15 years;

More than 30 callers requested services or specific referrals through a DCFS Intake Coordinator.

Office of Suicide Prevention
Department of Health and Human Services

We're on the web!
Suicideprevention.nv.gov

Nevada Office of Suicide Prevention Releases First Statewide Prevention Strategy

The Office of Suicide Prevention in collaboration with many professional groups, coalitions, consortiums and communities, has developed Nevada's first comprehensive State Suicide Prevention Plan. The recently released Nevada Suicide Prevention Plan outlines specific goals and objectives in youth suicide prevention within the next five years. The document, now available on the OSP website as a electronic download, is an important step in understanding the direction in which prevention programs and community efforts are encouraged to take in order to enhance local capacity to address the needs for prevention, intervention and postvention throughout the state. Priority one for all populations in the state includes gatekeeper and intervention skills training for all public health and social service delivery systems. You can download a PDF version of the Nevada State Suicide Prevention Plan by visiting: suicideprevention.nv.gov

Southern Nevada Campaign Addresses Stigma as a Barrier to Mental Health & Help-Seeking

In an effort to address both real and perceived stigma associated with mental illnesses endured by those seeking help for themselves or their loved ones, the Southern Nevada Health District embarked on the development, production and broadcast of a three phase stigma reduction campaign. SNHD has collaborated with the Clark County Children's Mental Health Consortium's Public Information Committee and the Division for Child and Family Services State Infrastructure Grant, as well as the Office of Suicide Prevention to share campaign costs, ideas, and to attract focus group participants through their association with partner agencies. Phase one of the campaign aired in late December 2006 and early January 2007. The campaign generated local news stories about children's mental health and community

resources. The commercials also catalyst more than 100 calls for information and help from parents in need of mental health services for their children and support for them as parents. While some families were referred for private care, about 35 families received at least one mental health related service from a Neighborhood Care Center.

Phase two 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. Production and broadcast of the Phase two campaign is slated for spring and summer of 2007. Catch the commercial this summer at a movie theater near you!

To view these public messages, visit the Southern Nevada Health District at: www.gethealthyclarkcounty.org/

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Appendix I
Clark County Children's Mental Health Consortium
Report on the Safe Schools, Healthy Students Initiative

INTRODUCTION

In 2001, the Nevada State Legislature passed Assembly Bill 1, which amends Chapter 433B of the Nevada Revised Statutes. This bill established a mental health consortium in every county with a population of 100,000. In Clark County, a twelve-member Mental Health Consortium began its work by submitting a grant proposal to the U.S Departments of Education, Justice, and Health and Human Services to establish a 'Safe Schools/Healthy Students' Program. The program is administered by the Clark County School District under the guidance of the present Southern Nevada Children's Mental Health Consortium. In late 2003, the three-year grant was awarded and the program is about to embark upon its fourth year of activities under a no-cost extension.

PROGRAM THEORY, GOALS AND OBJECTIVES

The program theory is that if a complete system for assuring safe schools and coordinating delivery is designed and implemented, then comprehensive and effective services may be delivered to students and families who need those services. In this way schools will become safer and students in schools will be healthier, thus helping schools to meet the goals of their School Improvement Programs and allowing students to profit more fully from their educational experiences.

The goal of the project is to:
Develop and implement a comprehensive, sustainable system of prevention, assessment, intervention and treatment programs and services to enhance the safe and healthy development and learning of children, youth, and families.

This goal is approached through working toward objectives under seven related elements of the program, including activities to:

- create and maintain safe school environments so that acts of violence by students will be reduced, and students parents and staff will perceive schools as safe and secure learning environments.
- prevent and reduce substance and drug and alcohol use in schools.
- implement a system that identifies children, youth, and families who are in need of preventive and/or treatment intervention services, provides timely access for each of the identified youth or family

members to appropriate, affordable mental health services within the school or community, and ensures that students identified as threats to self or others receive mental health assessments and appropriate treatment and services.

- implement a system that identifies pre-school children from high-risk families who are in need of services for psychosocial or emotional development problems, supports family members and childcare providers of pre-school children with psychosocial and emotional development problems, and, provides effective intervention and treatment services for identified pre-school children.
- modify/design and implement safe school policies through the school improvement process Provide recommendations for district-wide safe school policies.
- develop a plan to sustain safe school environments and an integrated mental health services delivery system.

PROGRAM MANAGEMENT AND SERVICE DELIVERY

The Clark County School District [CCSD] *Safe Schools/Healthy Students Initiative* is conducted under the auspices of the District's Department of Student Threat Evaluation and Crisis Response [STECR]. The program is overseen by the STECR Director and managed by an SS/HS Program Coordinator. Program staff consists of three school-based Student Success Advocates, five licensed counselors, six psychologists, and a team of seven counselors and psychologists who specialize in pre-school and early childhood issues. A number of CCSD licensed mental health staff persons, teachers, school police officers and other staff provide in-kind or volunteer services as part of Threat Assessment/Crisis Response Teams or school-based prevention or intervention programs. A key aspect of the SS/HS Mental Health Service Delivery System is a network of community-based agencies and CCSD agencies and departments who provide mental health, social and other support services for those students and families who may not be appropriately assisted by SS/HS licensed staff or other CCSD personnel.

The SS/HS Program provides threat assessment/crisis response and follow-up services to all schools in the district and offers mental health and other support services to students and families at eight at-risk schools in two administrative regions.

Each Threat Assessment Teams consist of SS/HS-based counselors and psychologists, with support by other CCSD personnel. A student identified as being in crisis or as posing a threat to others is immediately evaluated by a SS/HS Threat Assessment Team and a treatment and follow-up plan is developed and implemented for psychiatric, psychological, counseling, mental health and/or substance abuse treatment services for the student and family. These services may be provided by SS/HS staff, other CCSD personnel or by community-based agencies under contract with SS/HS.

Under the grant, the SS/HS Program has established a Mental Health Service Delivery System at eight schools identified as in need of mental health services and/or at-risk for violence, drug use or student safety. Student Success Advocates are assigned to these schools, as are specific SS/HS licensed staff members. The SS/HS Initiative provides programs for violence and substance use prevention, early intervention and treatment in eight at-risk schools. These schools include four elementary schools, two middle schools and two high schools. The major focus is to identify high-needs and/or at-risk students and families and on to provide them with appropriate programs and services.

The SS/HS Early Childhood Mental Health Service Delivery System is offered in conjunction with the State of Nevada Department of Child and Family Services. This program offers services to families and pre-school children within the zoning areas of the program schools. Services include provided parent-infant home visiting, mental health counseling, and prevention and counseling groups in the areas of parenting, social skills, and child care.

PERFORMANCE

Since its inception in 2003, the SS/HS Program has provided effective mental health and other support services to a number of students and their families. Each year has seen significant increases in the number of programs offered and individuals served. An unprecedented cooperative system of service delivery has been developed with public agencies and other community-based services with the guidance of the Southern Nevada Children's Mental Health Consortium.

- **Levels of Service**

During the past school year, the SS/HS Program provided services and referrals, as follows:

Table 1. Number of Individuals Served, 2006 - 2007

	Threat Assess. Response Services	**Mental Health Services**	**Support/ Referral Services**	**Family Counseling & Resource Coord.**	**Prevention/ Counseling Groups**	**Student Social Skills Groups**	**Parenting Groups**
Threat Assess-ment Teams	199						
Licensed Staff & SSAs		330	365		156		
Early Childhood Program Staff				431		1,034	256
					Total All Programs		**2,615**
					Individuals		*960*
					Groups		*1,446*

- **Student Performance Indicators**

Pre- and post service changes in academic performance, attendance and number of disciplinary incidents, as recorded in CCSD databases, were analyzed for a sample of students served by the program. It should be noted that each of the students had experienced poor grades, and exhibited significant negative behaviors prior to inclusion in the SS/HS Program. This information shows that the students have reversed or at least checked those trends.

Table 2. Student Performance Indicators

	Improved	**Same**	**Lower**
GRADES	52%	43%	5%
ATENDANCE	51%	40%	9%
SCHOOL BEHAVIOR	**64%**	**30%**	**6%**
NO. OF DISCIP-LINARY INCIDENTS	**Fewer**	**Same**	**More**
	72%	22%	6%

Appendix J

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

Clark County Children's Mental Health Consortium

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Introduction

In last year's Plan, the CCCMHC developed a model and funding recommendations for supporting Neighborhood Family Service Center infrastructure development. An administrative structure and funding levels were recommended to support the implementation of a system of care model at the Centers. As part of the development of a system of care model in Clark County, the CCCMHC has remained committed to the Wraparound Process as the preferred service coordination model for youths with serious emotional disturbance served by the Neighborhood Family Services Centers.

In the Sixth Annual Plan, the CCCMHC examined the need to expand capacity to provide wraparound to underserved youths in the juvenile justice and child welfare systems.
The CCCMHC also examined the need to enhance the system infrastructure to support high quality wraparound programs.

To assess systems level implementation quality, the 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)[1], 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:

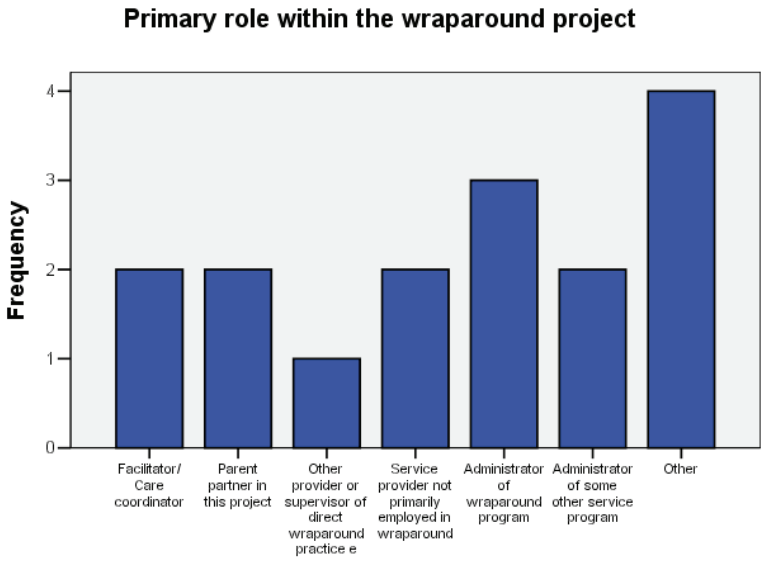
1. Community partnership
2. Collaborative action
3. Fiscal policies
4. Service array
5. Human resource development, and
6. Accountability

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

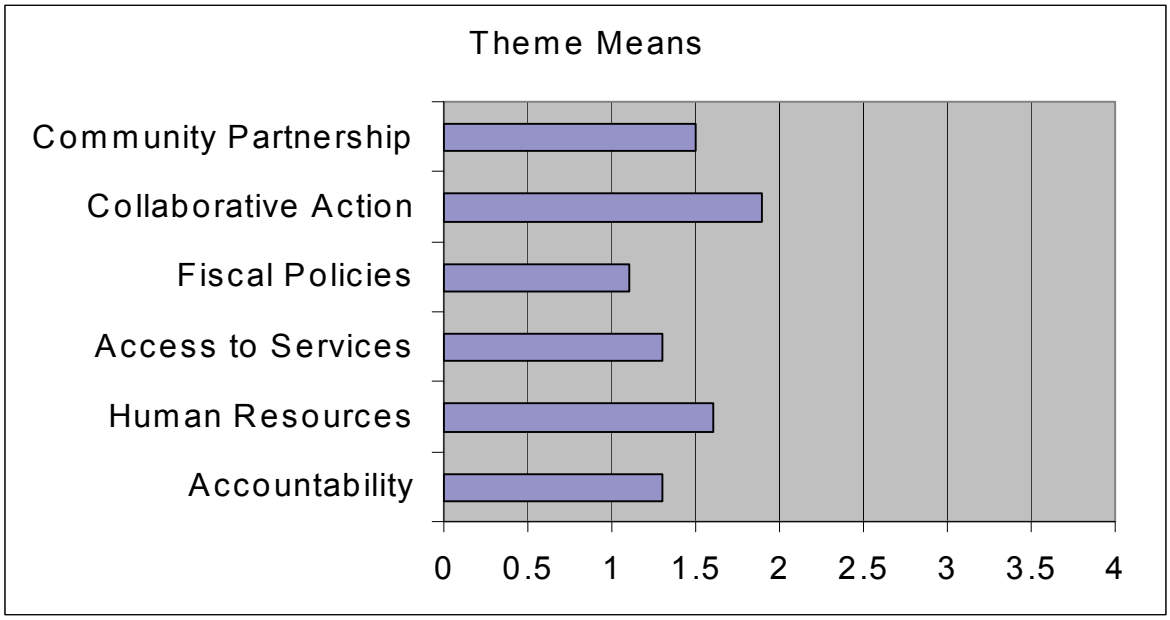
Respondents complete the 40 items by rating the development of supports in their community or program on a 5 point scale, 0 being "least developed" and 4 being "fully developed". In Clark County, 26 stakeholders were identified and invited to complete the CSWI. These stakeholders were sent a link to a web survey version of the CSWI. Of the 28 nominated respondents, 16 completed the CSWI, 5 were not reached or did not respond, and 7 declined.

Results

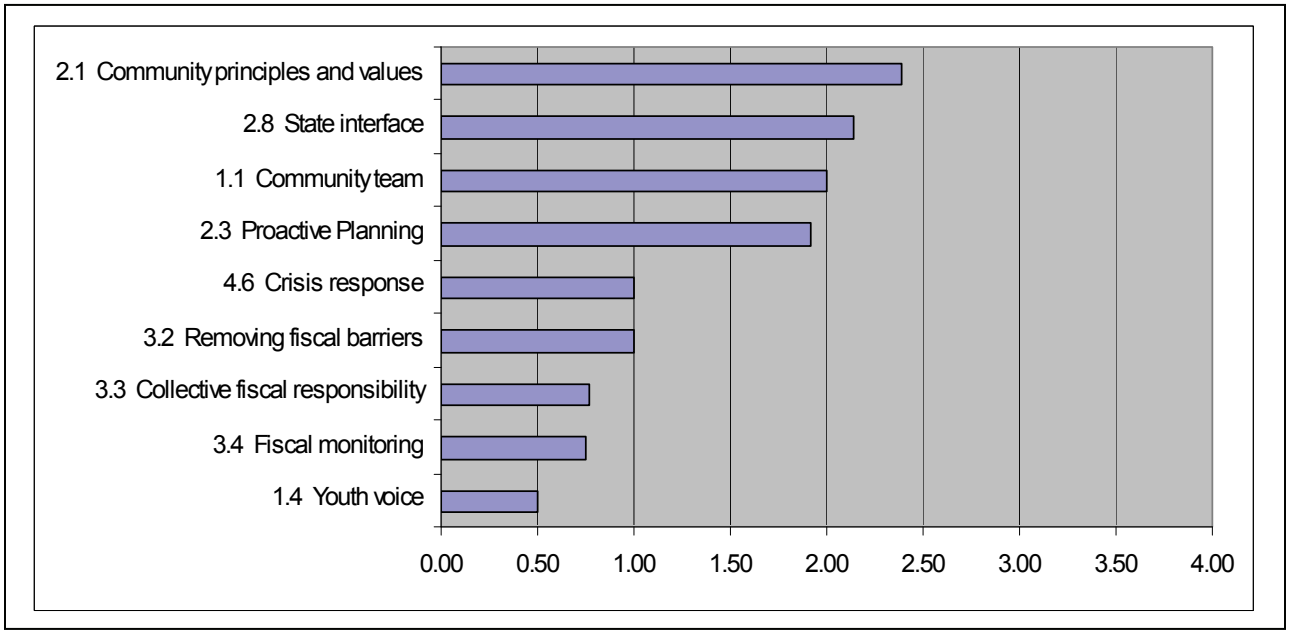
Respondents. The 16 respondents reported having a wide variety of experience in wraparound, often having different roles over time. The majority of respondents (n = 11) reported having managerial or administrative experience. Others reported having experience as a professional on a team (n = 9), or a trainer or consultant (n = 6). Respondents were asked to pick one role, and answer according to that role. These roles were distributed fairly evenly between Wraparound Facilitators and Parent Partners (n=4), other providers (n=3), and administrators (n=5). (Four respondents were classified as "other," including trainers and supervisors). The mean total years involved in wraparound was 9 years (SD = 6.30). See graph below for primary roles in wraparound project.



CSWI Results. Item scores ranged from 0.5 to 2.38 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 1.1 for "Fiscal Policies" to 1.9 for "Collaborative Action." 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 2.38. Two other items showed relative strengths as well. Item 2.8 "State Interface" had a mean of 2.14, and Item 1.1 "Community Team" had a mean of 2.0.

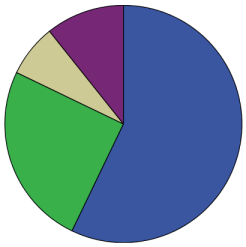


Other items showed **moderate development**. Mean scores for this group ranged from 1.91 to 1.78. Items in this group include 2.3 "Proactive Planning", 1.2 "Empowered Community Team, 2.5 "Partner Agency Staff Preparation", 5.4 "Professional Development", 5.5 "Supervision", 2.7 "Single Plan", and 3.6 "Sustained Funding".

The areas found to be of **least development** had means that ranged from 1.0 to .5. These included items 3.2 "Removing Fiscal Barriers", 4.6 "Crisis Response", 3.3 "Collective Fiscal Responsibility", 3.4 "Fiscal Monitoring", and 1.4 "Youth Voice". Other items that indicate community and system factors that need greater development include 3.1 "Fiscal understanding," 6.7 "Addressing barriers," 6.5 "Grievance procedures," 4.4 "Youth and family choice," 5.6 "Compensation for wraparound staff," and 1.6 "Community stakeholders."

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 very preliminary, given that they are based on the results of only 16 respondent stakeholders. In addition, 12 of the 28 nominated respondents did not complete the CSWI. Moreover, 64% (7 of 11) of nominated respondents who were project staff declined to respond. This creates significant difficulty in interpreting the data



	Responded	16	57.1%
	Declined	7	25.0%
	Bounced	2	7.1%
	No Response	3	57.1%
	Total	28	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 below. 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
2.1	Community principles and values	13	1	4	2.38	0.96
2.8	State interface	14	1	4	2.14	1.03
1.1	Community team	16	1	4	2.00	1.03
2.3	Proactive Planning	12	1	3	1.92	0.79
1.2	Empowered community team	16	1	4	1.88	0.89
2.5	Partner agency staff preparation	13	0	4	1.85	0.99
5.4	Professional development	13	0	4	1.85	1.57
5.5	Supervision	13	0	4	1.85	1.41
2.7	Single plan	14	1	3	1.79	0.80
3.6	Sustained funding	14	0	4	1.79	1.25
1.5	Agency support	16	0	3	1.75	0.86
2.2	High-level leadership	14	0	4	1.71	1.07
4.1	Program access	13	1	4	1.69	0.95
5.1	Wraparound job expectations	12	0	3	1.67	1.23
1.3	Family voice	16	0	3	1.63	1.15
5.3	Caseload sizes	13	0	4	1.62	1.33
2.6	Information sharing	14	0	3	1.57	0.94
2.4	Joint action steps	13	1	3	1.46	0.66
6.2	Range of outcomes	13	0	4	1.46	1.13
5.2	Agency job expectations	12	0	3	1.42	0.90
6.1	Outcomes monitoring	12	0	4	1.42	1.16
6.3	Wraparound quality	13	0	3	1.38	0.96
1.7	Community representativeness	16	0	3	1.38	0.96
6.4	Plan fulfillment	11	0	3	1.36	1.03
3.5	Fiscal flexibility	14	0	4	1.36	1.28
4.5	Service/support quality	12	0	3	1.33	1.07
6.6	Satisfaction monitoring	12	0	3	1.33	0.98
4.3	Building natural and community supports	13	0	3	1.31	0.95
4.2	Service/support availability	13	0	3	1.31	1.11
1.6	Community stakeholders	16	0	3	1.25	0.86
5.6	Compensation for wraparound staff	12	0	2	1.25	0.87
4.4	Choice	13	0	4	1.23	1.30
6.5	Grievance procedure	10	0	3	1.10	1.20
6.7	Addressing barriers	11	0	3	1.09	1.14
3.1	Fiscal understanding	13	0	3	1.08	1.04
3.2	Removing fiscal barriers	11	0	3	1.00	1.10
4.6	Crisis response	13	0	2	1.00	0.71
3.3	Collective fiscal responsibility	13	0	2	0.77	0.83
3.4	Fiscal monitoring	12	0	3	0.75	1.06
1.4	Youth voice	16	0	2	0.50	0.73

Item Results

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	6	37.5			
Midway	6	37.5			
Fairly close to 'most developed'	2	12.5			
Fully developed system	2	12.5			
Total	16	100.0	**1**	**4**	**2.0**

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	37.5			
Midway	7	43.8			
Fairly close to 'most developed'	2	12.5			
Fully developed system	1	6.3			
Total	16	100.0	**1**	**4**	**1.875**

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	18.8			
Small amount of progress has been made	5	31.3			
Midway	3	18.8			
Fairly close to 'most developed'	5	31.3			
Total	16	100.0	**0**	**3**	**1.625**

Item Results

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	10	62.5			
Small amount of progress has been made	4	25.0			
Midway	2	12.5			
Total	16	100.0			
Least developed system support	10	62.5	**0**	**2**	**.5000**

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	6.3			
Small amount of progress has been made	5	31.3			
Midway	7	43.8			
Fairly close to 'most developed'	3	18.8			
Total	16	100.0	**0**	**3**	**1.75**

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	3	18.8			
Small amount of progress has been made	7	43.8			
Midway	5	31.3			
Fairly close to 'most developed'	1	6.3			
Total	16	100.0	**0**	**3**	**1.25**

Item Results

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	25.0			
Small amount of progress has been made	3	18.8			
Midway	8	50.0			
Fairly close to 'most developed'	1	6.3			
Total	16	100.0	**0**	**3**	**1.375**

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	2	15.4			
Midway	6	46.2			
Fairly close to 'most developed'	3	23.1			
Fully developed system	2	15.4			
Total	13	100.0	**1**	**4**	**2.3846**

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	14.3			
Small amount of progress has been made	3	21.4			
Midway	7	50.0			
Fairly close to 'most developed'	1	7.1			
Fully developed system	1	7.1			
Total	14	100.0	**0**	**4**	**1.7143**

Item Results

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	4	33.3			
Midway	5	41.7			
Fairly close to 'most developed'	3	25.0			
Total	12	100.0	**1**	**3**	**1.9167**

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	8	61.5			
Midway	4	30.8			
Fairly close to 'most developed'	1	7.7			
Total	13	100.0	**1**	**3**	**1.4615**

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	7.7			
Small amount of progress has been made	3	23.1			
Midway	7	53.8			
Fairly close to 'most developed'	1	7.7			
Fully developed system	1	7.7			
Total	13	100.0	**0**	**4**	**1.8462**

Item Results

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	7.1			
Small amount of progress has been made	7	50.0			
Midway	3	21.4			
Fairly close to 'most developed'	3	21.4			
Total	14	100.0	**0**	**3**	**1.5714**

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	6	42.9			
Midway	5	35.7			
Fairly close to 'most developed'	3	21.4			
Total	14	100.0	**1**	**3**	**1.7857**

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	5	35.7			
Midway	3	21.4			
Fairly close to 'most developed'	5	35.7			
Fully developed system	1	7.1			
Total	14	100.0	**1**	**4**	**2.1429**

Item Results

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	5	38.5			
Small amount of progress has been made	3	23.1			
Midway	4	30.8			
Fairly close to 'most developed'	1	7.7			
Total	13	100.0	**0**	**3**	**1.0769**

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	5	45.5			
Small amount of progress has been made	2	18.2			
Midway	3	27.3			
Fairly close to 'most developed'	1	9.1			
Total	11	100.0	**0**	**3**	**1.00**

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	6	46.2			
Small amount of progress has been made	4	30.8			
Midway	3	23.1			
Total	13	100.0	**0**	**2**	**.7692**

Item Results

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	7	58.3			
Small amount of progress has been made	2	16.7			
Midway	2	16.7			
Fairly close to 'most developed'	1	8.3			
Total	12	100.0	**0**	**3**	**.7500**

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	4	28.6			
Small amount of progress has been made	5	35.7			
Midway	2	14.3			
Fairly close to 'most developed'	2	14.3			
Fully developed system	1	7.1			
Total	14	100.0	**0**	**4**	**1.3571**

3.6 Sustained 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	2	14.3			
Small amount of progress has been made	4	28.6			
Midway	5	35.7			
Fairly close to 'most developed'	1	7.1			
Fully developed system	2	14.3			
Total	14	100.0	**0**	**4**	**1.7857**

Item Results

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
Small amount of progress has been made	7	53.8			
Midway	4	30.8			
Fairly close to 'most developed'	1	7.7			
Fully developed system	1	7.7			
Total	13	100.0	**1**	**4**	**1.6923**

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	4	30.8			
Small amount of progress has been made	3	23.1			
Midway	4	30.8			
Fairly close to 'most developed'	2	15.4			
Total	13	100.0	**0**	**3**	**1.3077**

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	3	23.1			
Small amount of progress has been made	4	30.8			
Midway	5	38.5			
Fairly close to 'most developed'	1	7.7			
Total	13	100.0	**0**	**3**	**1.3077**

Item Results

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	4	30.8			
Small amount of progress has been made	6	46.2			
Fairly close to 'most developed'	2	15.4			
Fully developed system	1	7.7			
Total	13	100.0	**0**	**4**	**1.2308**

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	3	25.0			
Small amount of progress has been made	4	33.3			
Midway	3	25.0			
Fairly close to 'most developed'	2	16.7			
Total	12	100.0	**0**	**3**	**1.333**

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	3	23.1			
Small amount of progress has been made	7	53.8			
Midway	3	23.1			
Total	13	100.0	**0**	**2**	**1.00**

Item Results

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	3	25.0			
Small amount of progress has been made	2	16.7			
Midway	3	25.0			
Fairly close to 'most developed'	4	33.3			
Total	12	100.0	**0**	**3**	**1.6667**

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	16.7			
Small amount of progress has been made	4	33.3			
Midway	5	41.7			
Fairly close to 'most developed'	1	8.3			
Total	12	100.0	**0**	**3**	**1.4167**

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	23.1			
Small amount of progress has been made	4	30.8			
Midway	2	15.4			
Fairly close to 'most developed'	3	23.1			
Fully developed system	1	7.7			
Total	13	100.0	**0**	**4**	**1.6154**

Item Results

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	23.1			
Small amount of progress has been made	4	30.8			
Midway	1	7.7			
Fairly close to 'most developed'	2	15.4			
Fully developed system	3	23.1			
Total	13	100.0	**0**	**4**	**1.8462**

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	15.4			
Small amount of progress has been made	4	30.8			
Midway	4	30.8			
Fully developed system	3	23.1			
Total	13	100.0	**0**	**4**	**1.8462**

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	3	25.0			
Small amount of progress has been made	3	25.0			
Midway	6	50.0			
Total	12	100.0	**0**	**2**	**1.25**

Item Results

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	16.7			
Small amount of progress has been made	6	50.0			
Midway	2	16.7			
Fairly close to 'most developed'	1	8.3			
Fully developed system	1	8.3			
Total	12	100.0	**0**	**4**	**1.4167**

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	15.4			
Small amount of progress has been made	6	46.2			
Midway	3	23.1			
Fairly close to 'most developed'	1	7.7			
Fully developed system	1	7.7			
Total	13	100.0	**0**	**4**	**1.4615**

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	15.4			
Small amount of progress has been made	6	46.2			
Midway	3	23.1			
Fairly close to 'most developed'	2	15.4			
Total	13	100.0	**0**	**3**	**1.3846**

Item Results

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	18.2			
Small amount of progress has been made	5	45.5			
Midway	2	18.2			
Fairly close to 'most developed'	2	18.2			
Total	11	100.0	**0**	**3**	**1.3636**

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	5	50.0			
Midway	4	40.0			
Fairly close to 'most developed'	1	10.0			
Total	10	100.0	**0**	**3**	**1.100**

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	25.0			
Small amount of progress has been made	3	25.0			
Midway	5	41.7			
Fairly close to 'most developed'	1	8.3			
Total	12	100.0	**0**	**3**	**1.333**

Item Results

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	36.4			
Small amount of progress has been made	4	36.4			
Midway	1	9.1			
Fairly close to 'most developed'	2	18.2			
Total	11	100.0	**0**	**3**	**1.0909**

Theme	Theme sum	Theme mean	Reliability	Items with low agreement
Community Partnership	10.4	1.5	42%, α=.75 (48%, α=.78)**	Youth Voice
Collaborative Action	13.5	1.9	51% α=.82 (57% α=.87)	High level leadership
Fiscal Policies & Sustainability	5.7	1.1	68% α=.93	
Access to Needed Supports/Services	6.2	1.3	63% α=.86 (74% α=.91)	Building natural supports
Human Resources	8.0	1.6	76% α=.93	
Accountability	7.7	1.3	77% α=.96	

**Statistics in parentheses are for themes with problematic item(s)—I.e., those with lower agreement among respondents—from last column removed.