Children's Mental Health in Nevada– a Vision for the Future

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Introduction

There is no lack of passion or drive among Nevadans who want to improve the state of children's mental health. Mental health professionals, advocates, and program administrators operate in an environment of resource scarcity and disjointed systems. Because there is no single cure-all, it can be disconcerting to those involved about what steps to take to improve our persistently low national ranking.

Mental wellness for our children is meeting developmental and emotional milestones, learning age proper social skills, and cultivating appropriate coping skills when problems arise. Mental illness for our children means that there are obstacles or unformed ways in which children behave or handle their emotions. Specific disorders under the umbrella of children's mental health are as diverse as the issues that may arise under physical health. The causes are vast, ranging from a child's neurochemistry, genetics, brain structure, exposure to trauma or loss, injury, or illness. Additionally, the age of onset of mental or behavioral health challenges can happen at any time. Interventions must match this wide source of contributing factors in both treatment and prevention efforts.

State Numbers

Mental Health America's 2018 *State of Mental Health* ranked Nevada as 51st for prevalence of mental illness and access to appropriate mental health care for our youth (2018). Other studies provide more detail on the prevalence of youth mental illness and a lack of access to care in Nevada. For example, the most recent Nevada Youth Risk Behavior Survey (YBRS) found that one out of every three middle school students 11 – 14 years old reported feeling sad or hopeless. The study also found that from 2015 to 2017, there was no change in the prevalence of suicidal thoughts among Nevada's middle school students. Nearly half of middle school students reported not receiving the kind of help they needed when they were sad, empty, hopeless, angry, or anxious (Lensch et al., 2018). One in ten high school girls in Nevada reported in 2017 to have attempted suicide and a quarter of middle school girls have seriously thought about killing themselves (YRBS, 2017).

Data also indicates that for the social-emotional measures used in the YBRS, there either has been no change or an increase in traumatic experiences over the past 10 years the survey has been conducted (Questions 24 – 29 in Nevada High School Survey 10-year Trend Analysis Report, 2018). Substance use is usually a predictor to mental illness in adolescents as it can be exhibited as a coping mechanism to deal with their ongoing emotional challenges. Compared to the national averages high school students in Nevada reported using methamphetamines (3.2% - NV; 2.5% - US), synthetic marijuana (7.3% - NV; 6.9% - US), cocaine (5.4% - NV; 4.8% - US), inhalants (7.1% - NV; 6.2% - US), heroin (2.4% - NV; 1.7% - US), and ecstasy (6.1% - NV; 4% - US). A bright spot in the 10-year Trend Analysis is that high school students in Nevada did note a significant decrease in reports of relationship partner violence, bullying behaviors at school, and reported school violence. The work of the legislature, school districts, and activists in passing

much needed and comprehensive safe and respectful school environment programs starting in 2009 are contributing factors to this trend further providing evidence that systemic change can happen.

Behavioral Health Care Matters

The determinants linked to mental health are as diverse as the solutions that are needed to overcome our 51st place ranking. There has been much research connecting childhood mental health to the causes and conditions of trauma, gender, income level, education level, sexual orientation, neighborhood, crime and violence, housing quality, presence of social supports, early childhood education, maternal mental health, ethnoracial health disparities and inequities, among many other factors.

It is estimated that on a national scale, only 40% of students with behavioral healthcare disorders graduate high school (U.S. Department of Education, 2001). Untreated behavioral health issues at school not only cause problems for the individual student but can also "derail an entire an entire lesson," according to the Child Mind Institute (Rappaport & Minahan, 2018). Expulsions happen at every level, from preschool to high school because of discriminatory zero-tolerance policies combined with the lack of services and preparation to manage behaviors within the school environment.

Seven out of every ten children in the juvenile justice system have a diagnosable behavioral healthcare condition (National Center for Mental Health and Juvenile Justice, 2013). Child involvement in the justice system predicts adult involvement in the justice system (Bernburg & Krohn, 2003). Our adult jail and prison population is a result of decades of mental health stigma, criminalization of those living with mental illness, and inattention to mental health prevention and treatment. By changing how we address children's mental health now, we are creating a more just society for the future.

The Children's Advocacy Alliance was founded 20 years ago and the picture of children's mental health in Nevada seems like a mirror of today. The headlines *Area social services face unclear future* (Przybys, 1998) and *More mental health care coverage urged; insurers cite costs* (Vogel, 1998) could easily run again in today's news. During testimony for the 1998 Legislative Interim Subcommittee on Health Care, it was brought up that the prisons are the largest treatment centers in the state, that mandating mental health care as essential benefits would cause premiums to skyrocket, and that there are not enough providers in the state to meet the growing need. Twenty years later, our justice system and institutional care acts as the largest caretaker of those living with mental illness, and complete health insurance coverage and access is still a struggle for mental health services.

There are plenty of specific data points on children's mental health that can corroborate our current situation. Over the years, many reports have detailed the gaps, goals, and objectives to achieve optimal mental wellness for children. The Clark County, Washoe County, and Rural Children's Mental Health Consortia (NRS Chapter 433B); the Commission on Behavioral Health (NRS Chapter 433); the Governor's Behavioral Health and Wellness Council, also known as the Dvoskin Council named after chair Dr. Joel Dvoskin (NV Executive Order 2013-26), the Regional

Behavioral Health Policy Boards, the Governor's School Safety Taskforce, and many stakeholders at community advocacy groups have been working on the issues of children's mental health for years. Las Vegas Sun reporter, Jackie Valley, noted in her 2015 series on children's mental health that the 2013 Dvoskin Council found, "Nevada invests very little in prevention and early intervention for children and teens." These multijurisdictional and interprofessional groups know that children in Nevada do not have adequate access to preventative wellness programs, early intervention initiatives, and treatment. Picking one approach, one solution, or one policy recommendation will always set an inadequate table that will not result in any meaningful progress.

Assessment as the First Step to Intervention

Early screenings and comprehensive assessments of children and families is the first step in accurately measuring the need in our state. Early screenings and assessments are a form of prevention; discovering early signs of mental illness or behavioral health challenges is the best prevention against acute episodes. The fear of exploring the universal adoption of mental health assessments is that we will find more children who need mental/behavioral health care while there are still not enough providers. This could lead to waitlists for services, children going untreated, and other possibly devastating consequences. Children experiencing behavioral health issues will continue to do so whether they are screened. The real issue comes down to whether we want to know how big of a responsibility we must take on. It only furthers and enables mental health stigma to allow universal screening for scoliosis, hearing, and vision in our schools but not behavioral health. It is recommended to amend NRS 392.420 which relates to the Health and Safety of students in the school system, to include the requirement of use of an evidence-based behavioral health screening assessment protocol.

Empowering Professionals with State-Endorsed Education

The Nevada Department of Education currently houses the Office of Early Learning and Development which is geared towards the coordination and collaboration of professionals who work with children from birth through 3rd grade. Additionally, the Division of Child and Family Services has a consulting service for early childhood facilities who might have children with behavioral healthcare problems. There have been pilot projects to support the technical assistance and evaluation of early childhood education centers through the Quality Rating & Improvement System, the Preschool Development Grant program, and State-sponsored Pre-Kindergarten. Children can and do have significant mental health problems such as anxiety, depression, and conduct disorders (Zero to Three DC: 0-5, 2016). Early Childhood facilities and education centers need to have resources available to them to have behavioral healthcare experts advise and plan with the educators and families on how to address issues that may arise in these spaces (Duran et al., 2013). High-quality early childhood mental health consultation is also paramount in the reduction of childcare expulsions which only add to individual and family trauma exacerbating already present behavioral health issues (Carlson et al., 2012). Nevada's professional development to early childhood education facilities on behavioral health interventions needs to be supported and expanded. It is recommended that all the early childhood mental health technical assistance

and professional development programs within state across departments be consolidated and further supported to provide high-quality resources to early childhood facilities.

Family Support Specialists Provide Encouragement to Families

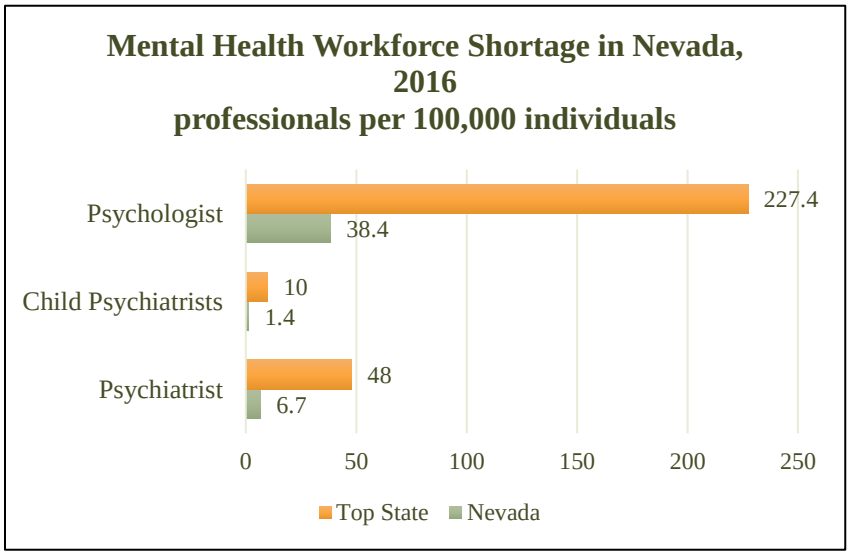
Utilizing peers as paraprofessional behavioral health leaders in their communities is a well-researched and evidence-based practice. A laser focused effort needs to be made on the terms and definitions so that each peer-type support specialist group has self-determination within their field. Community Health Workers (CHWs) are a peer-type support specialist that are geared toward the medical and health fields, peer recovery support specialists are to focus on adult substance use disorders, and family peer support specialists are there to help parents and caregivers raise their children with behavioral health care needs. Each of these peer-type support specialists are important but each should have an independent operation and recognition by Medicaid as viable providers eligible for reimbursement for their services. It is recommended that Family Peer Support Specialists are codified as professional providers upon attainment of a Certified Parent Support Provider national certification – the model of the Community Health Workers and Community Health Worker Pool should be explored as a model.

Licensure Portability Specialist Can Achieve Fairness

It is no secret that Nevada's licensing boards have been seen my many as a barrier to providing enough qualified behavioral health professionals in this state (Ableser 2016; Snyder 2018). Governor Sandoval even called the state of licensing boards, "frustrating [and] exhausting." The 2015 Legislative Session, through AB 89, created a broad legislative intent to promote licensure reciprocity agreements for veterans, spouses of veterans, and spouses of active duty military (NRS 622.500-530). The same sense of urgency that has been called upon in the past to create flexibility in teacher licensure needs to be used for behavioral healthcare professionals (Delaney, 2018). Governor Sandoval introduced SB 69 during the 2017 Legislative Session to institute some of these reforms – and every opportunity should be taken to further reform occupational licensing boards in the future. It is recommended that the Department of Health and Human Services establish a licensure portability specialist to streamline licensing of behavioral health professionals. The legislature needs to endorse licensure reciprocity and portability as a foundation or all behavioral health professionals. The legislature should direct each licensing board to sign onto joint agreements of reciprocity or endorse national certifications as acceptable for licensure in Nevada for National Certified Counselors, Agreement of Reciprocity of the Association of State and Provincial Psychology Boards, and the Psychology Interjurisdictional Compact.

Incentivize Professionals to Practice in Shortage Areas

The University of Nevada's School of Medicine produced a *Health Workforce Supply in Nevada 2017 Edition* report which indicated that there were only 190 psychiatrists and 390 psychologists in this state.



This data indicates that we just simply do not have enough licensed professionals in this state that would even be able to serve every child who needed help. If we increase access to care without increasing the number of qualified mental health providers, then caseloads will increase. What can be done to educate, expand, retain, and attract qualified behavioral and mental health professionals to work in Nevada? It is recommended that the State provide a stipend, student loan forgiveness, or other incentive to behavioral health clinicians to practice in Nevada's least-served communities. It is recommended that tele-supervision from qualified licensed professionals be adequate and acceptable for clinical hours requested by the various licensing boards; this modernization will allow our rural and frontier schools more options for bringing clinicians into their schools.

Decrease Utilization of Emergency Rooms

When families utilize the hospital emergency rooms as the first source of mental health care for their child during a crisis, the psychological needs of the child are not met. Through long wait times, insufficient pediatric expertise onsite, and inappropriate or nonexistent risk-reduction interventions, the emergency room can make a mental health crisis worse (Cooper & Masi, 2007). That is why investment in Mobile Crisis Response Teams is vital. These are specialized, interdisciplinary teams that are community-based provide family-driven, immediate response to children and youth in crisis.

Similar to AB 549 from the 2005 legislature, a direct appropriation to Mobile Crisis Response in Clark County, Washoe County, and Rural/Frontier Nevada should be made.

Vigilant Focus on Medicaid Reimbursement Rate Reform

We all agree there is a problem in the state when we are confronted with our low rankings, our lack of providers, and the abundance of anecdotal evidence of financially-strapped behavioral healthcare practices. Reimbursements should be adequate to community providers so that they continue to offer services and are able to compensate professionals at a rate that keep them practicing in our state. Fee-for-service Medicaid reimbursement rates for behavioral health care for children can be modified with greater ease than the reimbursement rates from Medicaid

managed care organizations. All reimbursement rates regardless of Medicaid type should be high enough in order to retain and grow the provider community in our State. Assembly Bill 108 of 2017 required the Division of Health Care Financing and Policy to perform a periodic review of reimbursement rates to ensure that they were in alignment with the cost of business and cost of living increases, but we can go further. Reimbursement rates only apply to those in enrolled in fee-for-service. For those in managed care, the reimbursement model is privately negotiated through a contract between the State and the Managed Care Organizations. To determine the adequacy of reimbursement for providers in an MCO, those contracts need external review.

Medicaid is not a program set in stone – it should be flexible to respond to the needs to Nevadans who depend on it as their source of health care coverage. Every option to increase coverage of children who have behavioral healthcare needs must be explored by Nevada Medicaid. There have been numerous recommendations from the community on how DHCFP can leverage Medicaid funds to positively affect the state of children's mental health. In terms of focusing funding towards prevention It is recommended to use increased reimbursement in fee-for-service and managed care as a financial incentive to behavioral health providers to serve enough children Nevada rather than placing them in out-of-state treatment centers. Medicaid needs to expand the use of community- and home-based services rather than institutional care. Endorse State Plan Amendments to expand scopes of care so that children and families can have increased choice and services at various levels of intensity.

Conclusion

Confronting complex behavioral health challenges in children and youth within a system that spans various levels of potential intervention can seem daunting. Families, schools, pediatricians, the justice systems, educational policy, insurance carriers, and economic environments all play a part in the outcome of a child's wellbeing. All child-serving agencies and organizations need to continue to be at the table. But this table also needs to be fully set with a variety of options, strategies, and authorities so that the community leaders can implement change. A public health approach to addressing the children's mental health is necessary in the state. This approach comes with an understanding of the full systems view of mental health and wellness. Anyone can be affected by mental illness. Our state's overall quality of life will not improve if we do not reduce the barriers faced by children, adolescents, and families in overcoming their behavioral health care challenges. .

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