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Ramona W. Denby

University of Nevada, Las Vegas, ramona.denby@unlv.edu

Sandra D. Owens

University of Nevada, Las Vegas, sandra.owens@unlv.edu

Sarah Kern

Lincy Institute

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How are the Children: Challenges and Opportunities in Improving Children's Mental Health

RAMONA W. DENBY, PH.D.
SANDRA OWENS, PH.D.
SARAH KERN, B.A., MSW CANDIDATE

Abstract

The mental health of children is critical to their growth and development, but when their well-being is considered, discussions more often gravitate toward physical health, nutrition, education, parental influences, and living conditions. While these all represent important indicators of well-being, discussions also need to consider the importance of children's mental and behavioral health. In this brief we explore the status of Southern Nevada's children as it relates to mental health outcomes. Like physical health, good mental health is paramount to children's overall functioning and maturation. Frequently when a child experiences mental and behavioral health challenges, signs and symptoms manifest in the home, community, and school. Using a secondary analysis of multiple primary datasets, including the National Survey of Children's Health; Mental Illness Surveillance among Children in the United States; and the Mental Health National Outcome Measure, we analyze the mental health status of children in Southern Nevada. In doing so we provide an overview of services, access, and the implications of the Affordable Care Act. Outcomes are considered in relation to peer states as well as national indicators. This brief provides implications for strengthening the overall mental health service infrastructure, service delivery, and community capacity so that children will experience optimal mental health outcomes.

Overview of Children's Mental Health

Defining mental health has become an ongoing process, often thwarted by controversy and disagreement among practitioners and scientists alike. Nonetheless, the U. S. Surgeon General has defined children's mental disorders as "serious deviations from expected cognitive, social, and emotional development" (U.S. Department of Health and Human Services Health Resources and Services

Administration – USDHHS Administration, Maternal and Child Health Bureau, 1999, p. 123). The surveillance of children's mental health is often conducted by various federal agencies who maintain reporting systems and who issue regular reports that enable a snapshot of conditions and in some instances a longitudinal assessment of conditions. For example, the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report* reported that 8% of U.S. adolescents 12–17 years of age experience unhealthy days (about 14 days or fewer per month) (CDC, 2013). Moreover, researchers

at the National Institute of Mental Health estimated that 1 in 5 U. S. children exhibit symptoms and conditions that meet the criteria for a diagnosis of a mental disorder (Merikangas, Avenevoli, Costello, Koretz, & Kessler, 2009).

Some of the most prevalent children's mental health and behavioral disorders include Attention Deficit and Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder, which often produce problems in peer and family relationships, school and community. Parents and caregivers are the primary observers of children's mental and behavioral health, particularly in home settings. Nationally, about 9% of parents of children age 3–17 report that their child has been diagnosed with ADHD and about 5% of parents indicate that their children have a history of conduct disorders (CDC, 2013). Additionally, although mood and anxiety disorders comprise numerous categories and diagnoses, approximately 4% of parents report that their children have been formally diagnosed with depression, and this number rises significantly when self-reports of depression are considered. With respect to self-reports, adolescents 12–17 years of age place "lifetime" and "past year" depression experiences at 13% and 8% respectively (CDC, 2013). The prevalence of anxiety disorders among children is slightly higher than such mood disorders as depression. For example, it is estimated that 5% of children 3–17 suffer from anxiety disorders (CDC, 2013). As for alcohol abuse, the CDC reports that in 2010–2011, 4% of U.S. adolescents were dependent on or abused alcohol during the previous year. Children's daily function and activities in their local community often enable formal observers (e.g., health care providers, law enforcement, school officials), and informal observers (e.g., neighbors, friends, social, and recreational peers) to become aware of their general mental health functioning. Aside from parents and other caregivers, school officials, especially teachers, are reliable observers of children's mental and behavior condition. Locally, it is estimated that 10% of Clark County

elementary school children need mental health treatment but 70% of them do not receive it (Clark County Children's Mental Health Consortium [CCCMHC], 2010). Additionally, 30% of Clark County public high school children report depressive symptoms (CCCMHC, 2010).

It has been estimated that \$247 billion is spent annually in the U.S. in response to children's mental health disorders (CDC, 2013). In 2010 it was estimated that in Clark County alone there were 118,830 children with behavioral health problems, and among them 38,942 suffered serious emotional disturbances (CCCMHC, 2010). The consequences of mental disorders in children are felt by the children, families, and communities. However, mental disorders are treatable and preventable and when adequate investments and collective community responses are in operation, children's psychological and emotional well-being are greatly improved. Proven approaches both from a treatment and policy perspective exist and when implemented, children's home, community and school-life are enhanced (Cooper & Stagman, 2010; The National Academies, 2009). In this issue brief we examine plausible children's mental health policy, service, and research directions for Southern Nevada. Recommendations are based on a critical review of the mental health experiences of Nevada children in comparison with children who reside in peer states. Based on a brief analysis of Nevada's mental health service system, we provide a discussion of steps and strategies that can be implemented to strengthen the community infrastructure with the goal of supporting children and families.

Comparison with Peer States

As a point of comparison to Nevada we examined the mental health service delivery systems of Arizona, Colorado and Florida. The rationale for selecting these three states is because Phoenix, Denver, and Orlando are peer cities to Las Vegas. They are considered peer cities to Las Vegas for multiple reasons but largely because of similar economic

drivers, urban population sizes, and the emergence of medical and health education structures that support mental health workforce development and service delivery. When comparing the service and delivery of children’s mental health services in Nevada to the situation in other states, including Arizona, Colorado, and Florida, it is evident that there is room for improvement in this area across the nation. Despite relatively low rates of mental health disorders experienced by some of Nevada’s most vulnerable children, there is a wide discrepancy in the number of these youths who are accessing services (Data Resource Center for Child and Adolescent Health, 2007d). Furthermore, while the data suggest that Nevada’s mental health consumers are relatively satisfied with the services received when compared with other states, there is a need to extend these services to more children and families who can benefit from treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011a, 2011b, 2011c, 2011d.)

Prevalence of Mental Health Disorders and Treatment

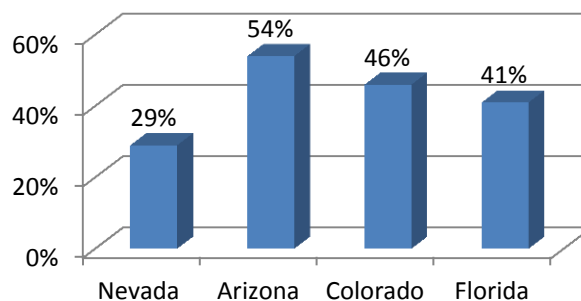
The Data Resource Center for Child and Adolescent Health reported that approximately 8% of Nevada children with special health care needs possessed an emotional, behavioral, or developmental disorder as of 2007. This contrasts with a rate of 10% in Arizona, 10% in Colorado, and 11% in Florida. Depression is one of the most highly represented conditions with prevalence rates among youths with special health care needs ranging from a low of 10% in Colorado and a high of 14% in Nevada (Data Resource Center for Child and Adolescent Health, 2010a, 2010b, 2010c, 2010d). Despite the smaller proportion of children with overall mental health conditions, Nevada children suffer from higher rates of depression. Furthermore, Nevada’s children tend to access services at a much lower rate than those in other states. While 54% of Arizona children with an emotional, behavioral, or developmental condition reported receiving counseling or treatment in the previous year, only 29% of

Nevada children received similar services (Data Resource Center, 2007a, 2007d)(see Table 1). This contrasts with Colorado’s rate of 46% and Florida’s rate of 41%, revealing a need for increased services in Nevada aimed at improving the mental health and well-being of its children (Data Resource Center, 2007b, 2010c).

Adolescent Substance Abuse and Dependence

While children’s mental health needs alone represent an important challenge, it is important to recognize that emotional disorders often co-occur with other behavioral disorders, including substance abuse and dependence. In the U.S., an average of 7.5% of children served by their State Mental Health Authority meet both the criteria for Severe Emotional Disturbance as well as a substance abuse diagnosis (SAMHSA, 2011a). These rates are even higher for Nevada (8%), Florida (10%), and Colorado (12%), while Arizona’s rate falls below the national average at 5% (SAMHSA, 2011a, 2011b, 2011c, 2011d). Furthermore, an increasing number of adolescents across these states regularly engage in binge drinking, ranging from 9% in Florida and 11% in Nevada to 12% in both Colorado and Arizona (U.S. DHHS, 2009a, 2009b, 2009c, 2009d). Despite these staggering statistics,

Table 1. Children with emotional, behavioral, or developmental conditions who received mental health treatment or counseling in the past year



the data reveals a gap in services for youths with substance abuse issues. According to the 2003-2006 NSDUH, of the 199,000 adolescents in Nevada, approximately 13,000 did not receive treatment needed for alcohol-related issues in the previous year (USDHHS, 2009d). In Arizona, 31,000 of the state's 511,000 adolescents needed but did not receive similar services (USDHHS, 2009a). Colorado failed to meet this need for 27,000 of its 389,000 adolescents (USDHHS, 2009b). Among Florida's population of 1,391,000 adolescents, 70,000 were also in need of alcohol-related treatment but did not receive it (USDHHS, 2009c). As alarming as these numbers are, we speculate about the extent to which they are conservative estimates given that a number of adolescents who suffer from substance abuse disorders are not readily identified unless they are already in services for mental health disorders. Nonetheless, these staggering statistics reveal a failure by the states to meet the treatment needs of their youths in this area.

Consumer Perceptions of Care

It is also important to note the consumers' perceptions of treatment when assessing the quality of care. In 2011 SAMHSA compiled the results of surveys completed by consumers of state-administered mental health services in all states.

The measures were broken into several categories, including access to services, general satisfaction with care, participation in treatment planning, positivity about outcome, improved social connectedness from services, improved functioning from services, and cultural sensitivity of providers. Among children and family consumers, the surveys revealed that Florida performed better than the other three states in all of the areas except *cultural sensitivity of providers* and *improved social connectedness* (SAMHSA, 2011a, 2011b, 2011c, 2011d)(see Table 2). Positivity regarding Nevada's services consistently fell close behind Florida's, including 81.5% of consumers reporting positivity about outcomes of services, a higher rate than the U.S. average of 64.6% (SAMHSA, 2011c, 2011d). Nevada's child and family consumers also reported satisfaction with care, with 95.8% of users rating this measure positively (SAMHSA, 2011d). Nevada also performed better than all three other states on the cultural sensitivity measure and improved social connectedness as a result of services, reporting higher outcomes than the U.S. average (SAMHSA, 2011a, 2011b, 2011c, 2011d). Arizona and Colorado reported measures below Florida and Nevada in the areas of positivity about outcomes, access to services, and general satisfaction with care (SAMHSA, 2011a, 2011b, 2011c, 2011d).

Table 2. Consumer Ratings of Adequacy of Care

Mental Health Outcome Measures (NOMS) Uniform Reporting System	U.S. (%)	Nevada (%)	Arizona (%)	Colorado (%)	Florida (%)
Access to Services	85.20	92.30	83.40	84.90	95.40
General Satisfaction with Care	83.80	95.80	81.60	85.40	96.00
Participation in Treatment Planning	86.80	91.80	93.80	91.20	95.00
Positivity about Outcome	64.60	81.50	63.10	62.50	83.00
Improved Social Connectedness	85.30	95.80	88.90	85.00	94.90
Improved Functioning	66.80	82.40	65.60	64.30	85.00
Cultural Sensitivity of Providers	92.50	97.90	96.40	96.60	92.60

Reductions in Funding for Mental Health Services

While child and family consumers of mental health services in Nevada have rated their satisfaction on a few measures higher than the U.S. average, there remains a gap in services for many, including those with co-occurring substance abuse issues. Many states have reduced expenditures for mental health from 2009–2011; Arizona and Nevada sustained some of the largest cuts, cutting state mental health budgets by 23% and 17% respectively, with Colorado trailing behind with a 7% decrease while Florida’s mental health budget sustained a meager increase of 0.2% (National Alliance on Mental Illness [NAMI], 2011). These reductions were sustained at a time when an average of 15%–38% of the State Mental Health Authority’s client population within these states consisted of adolescents who were directly affected by the reductions in expenditures (U.S. Department of Health and Human Services [USDHHS], 2009a, 2009b, 2009c, 2009d). The impact on the adult mental health population in Nevada was greater than that on the children; however, by increasing expenditures overall for mental health services, Nevada providers can focus on meeting the needs of undeserved children and adults.

Access and Services

The Affordable Care Act’s Impact on Mental Health Services

The Patient Protection and Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in a generation. It affects mental health access for one third of those who are currently covered in the individual market who have no coverage for substance use disorder services, and the nearly 20% who have no coverage for mental health services, including outpatient therapy visits and inpatient crisis intervention and stabilization (Beronio, Po, Skopec, & Glied, 2013). Additionally, it provides mental health access

to the 47.5 million Americans who lack health insurance coverage altogether, and 25% of these uninsured individuals have a mental health condition or substance use disorder or both (USDHHS, 2013). Therefore, according to the U.S. Department of Health and Human Services, (Beronio et al., 2013) the estimated effect on improved access to mental health services can be described as follows:

First, treatment for mental health and substance use disorders is a benefit category covered as part of the package of Essential Health Benefits available to all Americans in non-grandfathered plans in the individual and small group markets as of January 1, 2014. This ensures that about 3.9 million people currently covered in the individual market and 1.2 million covered in small group plans will gain either mental health or substance use disorder coverage or both. Second, Americans accessing coverage through non-grandfathered plans will now be able to count on mental health and substance use disorder coverage that is comparable to their general medical and surgical coverage. Under this approach, 7.1 million Americans currently covered in the individual market and 23.3 million current enrollees in small group plans will also receive the benefit of having mental health and substance use disorder benefits that are subject to the federal parity law. Finally, the Affordable Care Act will expand insurance coverage to a projected 27 million previously uninsured Americans through access to private health insurance in the individual and small group markets, the Marketplaces, and via Medicaid. Essential health benefits, including mental health and substance use disorder services subject to parity requirements, will be available to this newly covered population (Beronio et al., 2013).

To summarize, beginning in 2014, through the Affordable Care Act, 32.1 million Americans will be afforded mental health and/or substance use disorder benefits coverage that complies with federal parity requirements. And an additional 30.4 million Americans who currently have some level of mental health and substance abuse benefits

will in 2014 benefit from the federal parity protections. Thus, as a result of the Affordable Care Act, and building on the structure of the Mental Health Parity and Addiction Equity Act, over 62 million Americans will have improved access to mental health and substance use disorder treatment and prevention services. This historic initiative promises increased access to a continuum of services that are essential to good mental and behavioral health for children, their families and their communities.

Nevada's State Mental Health Services System

A mental health planning and advisory council exists in every state and U.S. territory as a result of federal law first enacted in 1986 that requires states and territories to perform mental health planning initiatives in order to receive federal Community Mental Health Services Block Grant (MHBG) funds. The grants are used by states to help build and support the community-based public mental health system for adults with serious mental illness (SMI) and children with severe emotional disturbance (SED). In 2011, the U. S. Substance Abuse and Mental Health Services Administration (SAMHSA) made sweeping changes to its MHBG through which Nevada receives funds for public mental health programs. The changes made were in response to the passage of the Patient Protection and Affordable Care Act in March of 2010. Along with these significant changes, SAMHSA established the Strategic Prevention Framework. This five-step planning process requires states to assess the strengths and needs of their service system based on epidemiological data; identify unmet needs and service gaps and begin building the prevention capacity of the plan; develop a strategic plan; implement effective community prevention programs, policies and practices; and evaluate outcomes (USDHHS SAMHSA, 2011).

The Patient Protection and Affordable Care Act open enrollment began on October 1, 2013, for coverage through the Health

Insurance Marketplace (also called Exchanges). Whether individuals are uninsured or if they want to explore new options, the Marketplace will provide more choice and control over health (and mental health) insurance options. Using a single universal application, individuals will also be able to learn whether they qualify for financial assistance such as a new kind of tax credit that lowers their monthly premiums. Consumers in every state will have access to a Marketplace, but each state can choose how it will operate. In anticipation of this expanded coverage, Nevada is working diligently to bring significant changes to the delivery of its mental health system.

The State of Nevada, Department of Health and Human Services (DHHS), which oversees the Division of Public and Behavioral Health (DPBH), began planning for health care reform by creating two separate teams. These teams have reviewed the legislation, ensured that coordinated planning and implementation efforts occurred throughout state government, and provided high-level policy advice to Nevada Governor Brian Sandoval (McKnight, 2012). The Health Care Reform Policy Planning Group has been responsible for the development of high-level policies, whereas the Health Care Reform Implementation Working Group has examined the intricacies of the legislation and the effects of legislation on state policies and procedures regarding Medicaid (McKnight, 2012). The DPBH is also working with the Division of Health Care Financing and Policy (DHCFP), the State of Nevada's Medicaid agency, to ensure ready access to mental health services, as more people will become eligible for Medicaid services because of the Patient Protection and Affordable Care Act (McKnight, 2012).

As mentioned at the beginning of this section, in order to receive Community Mental Health Services Block Grant funds states are required by federal law to perform ongoing planning initiatives to help build and support community-based systems for adults with SMI and children with SED. Thus, as more

children and adults are insured in Nevada, the role of the state mental health services system will likewise expand to keep pace with the growing demand for services. As of July 1, 2013, the DPBH released its Behavioral Health Strategic Plan (July 2013–June 2015) and changed its infrastructure to be integrated into public health. Other divisions under the oversight of the Nevada DHHS, including the Divisions of Child & Family Services, Aging & Disability Services, Welfare & Supportive Services, and Health Care Financing & Policy will work in unison with the new Division of Public and Behavioral Health to help Nevada prepare for and implement health care reform and concomitantly mental health care reform in Nevada. There are historic experiences of fragmented care, disconnects between child and family services, and eligibility requirements. It is anticipated that some of these barriers to access will be eliminated as future planning coincides with future expansion of coverage via the Affordable Care Act.

Our Investment

Strengthening Children and Families

Nevada's children and families experience difficulty in accessing adequate behavioral health resources, with many people reporting that services are fragmented and complex, making the system difficult to navigate (CCCMHC, 2010). In order to ensure that the most vulnerable children receive the services they need to maximize their chances for success, the system must be simplified, with behavioral health providers collaborating to provide a consistent level of care. A child should receive adequate, culturally competent services regardless of his or her entry point into the system (CCCMHC, 2010). Families need to be viewed as partners in treatment planning and implementation, reinforcing skills and techniques applied in therapy in the home. By adhering to a "system of care" approach as advocated by SAMHSA's Comprehensive Community Mental Health Services Program for Children and Their Families, children receive

coordinated services, with their families "at the center of the decision-making process" (Clay, 2009, p.1). Nevada has adopted the system-of-care approach, and its efforts are visible. Given the anticipated expansion of mental health coverage for many local children, the state is poised to increase its efforts to advance service.

In addition to increasing access and improving delivery of intensive behavioral health services, it is equally important to focus on improving preventative efforts. It is estimated that for the average youth, symptoms typically precede a disorder by about 2 to 4 years (The National Academies of Science, 2009). During this time symptoms can become more intense and debilitating, often requiring more restrictive, costly treatment. By expanding early intervention programs through school-based and community screenings, mental health problems can be identified when symptoms first appear, allowing the child to receive timely and adequate treatment and increasing the likelihood of restoring an optimal level of functioning (CCMHC, 2010). Gains have been made in expanding these screening efforts in Nevada through the passage of Assembly Bill 386 (2013), which established a pilot program for school-based mental health screenings in two schools across the state, one in Clark County and one in Washoe County. In these selected schools, students whose parents sign a permission form will be screened for potential mental disorders. Schools will assist parents of students whose scores indicate possible emotional disturbances in obtaining necessary mental health services and other supports (A.B. 386, 2013). There is an estimated local cost of \$890,000 between both Clark and Washoe counties, but there is no funding from the Department of Education allocated to this bill (Nevada Legislative Council Bureau, 2013). While this program represents a positive step forward in implementing preventative behavioral health services for adolescents, any substantial impact will require an expansion of the program to more schools and a greater fiscal investment. To ensure that children receive

adequate and timely treatment of behavioral health issues, it is necessary to advocate for greater investment in screening programs designed to detect symptoms before they manifest in greater behavioral, social, and physical problems.

Building our Mental Health Infrastructure and Workforce

In response to the Patient Protection and Affordable Care Act, Nevada has implemented the Silver State Health Insurance Exchange (see <http://exchange.nv.gov>). Because of health care reform, including Medicaid expansion, more people will become eligible for Medicaid services or other forms of health insurance coverage. This expansion will bring many more children and adults into Nevada's mental health and substance abuse service delivery systems. It is significant that seemingly in anticipation of the implementation of the Affordable Care Act, more facilities have opened or expanded in Nevada, most notably the opening of Desert Hope, a 148-bed private treatment facility in Clark County in January 2013. Additionally Desert Willow Treatment Center will be opening another 8-bed acute adolescent inpatient unit, and will be converting one of its adolescent residential treatment centers into a co-occurring unit for mental health and substance abuse. Also Monte Vista Hospital, announced the opening of 72 additional beds, with 48 devoted to residential youths aged 12–17. These expansions bode well for the increased availability of services and for the increased demand for an expanded mental health workforce in Nevada.

Documenting the Need for an Improved Behavioral Health Workforce

Nevada has not yet sufficiently studied, documented, planned, or budgeted for the recruitment, education and licensing of sufficient numbers of skilled, culturally competent, clinical mental health, substance abuse and co-occurring disorder practitioners. In 2006 the National Alliance

on Mental Illness (NAMI) conducted an extensive analysis of the statewide mental health care system in Nevada and rated it a grade of D. Three years later, in 2009, the grade remained the same. NAMI authors Aron et al. (2009) reported that with Nevada's high rates of severe depression and other serious mental illnesses such as suicides, a strong commitment would be needed to restore the state mental health safety net and expand services. NAMI went on to surmise that without increased capacity for therapy, inpatient staffing, case management, medication, and housing options for the adult mentally ill, Nevada would find its emergency rooms and criminal justice system overwhelmed, with mental health costs being shifted to other sectors of state and local government. NAMI's call for an expanded mental and behavioral health workforce in Nevada was recently echoed in a March 2013 report, commissioned by Nevada Governor Brian Sandoval, on Nevada's primary, dental, technical, and mental health care workforces. The report gathered secondary data about workforce supply and demand among all licensed health professionals in Nevada between 2002 and 2012 (Packham, Griswold, & Marchand, 2013). However, the Health Care Workforce Report 2013 did not gather primary data from the existing workforce regarding the current and projected training and infrastructure needs of the mental and behavioral health and substance use and abuse treatment workforce in Nevada. Additionally, there was a lack of focus on Clark County, the largest county in Nevada, which is anticipated to see the largest growth in demand for an expanded mental and behavioral health workforce because of its population size. However, in anticipation of this foreseeable dramatic increase in mental health care insurance coverage, the Lincy Institute launched a survey in 2013 of Southern Nevada's licensed mental health and substance use and abuse practitioners. The purpose of this study is to assess the clinical mental health workforce, determine the availability and adequacy of mental health services per their perspective and that of their administrators, and to ascertain the present and future training and support

needs of the mental and behavioral health workforce. Additionally, a survey of youth and adult consumers of mental health services will soon be conducted so as to triangulate data from their insider perspectives on the skills, strengths, and weakness of the behavioral health workforce in Southern Nevada. It is anticipated that the findings from these Lincy Institute studies of members, administrators, and consumers of

the mental and behavioral health workforce will help inform and guide university-community partnerships and initiatives and projects that directly enhance and expand the capacity of the mental and behavioral health workforce so as to meet the imminent needs of Southern Nevadans. This brief is the first in a series of mental health reports that will be released in 2013-2014.

Suggested Mental Health Resources and Additional Readings

For Southern Nevada, Clark County, & Rural Areas:

State and Community Mental Health & Developmental Services; Substance Abuse Prevention and Treatment Agency; Family Resource Centers; Housing; Department of Employment, Training and Rehabilitation; and Education [http://mhds.state.nv.us/images/southern nevada clark co and rurals resource handouts 1-2013.pdf](http://mhds.state.nv.us/images/southern_nevada_clark_co_and_rurals_resource_handouts_1-2013.pdf)

For Northern Nevada, Washoe County, & Rural Areas:

State and Community Mental Health & Developmental Services; Substance Abuse Prevention and Treatment Agency; Family Resource Centers; Division of Welfare & Supportive Services; Salvation Army; Housing; Department of Employment Training Rehabilitation; and Education [http://mhds.state.nv.us/images/northern nevada washoe co and rurals resource handouts 1-2013.pdf](http://mhds.state.nv.us/images/northern_nevada_washoe_co_and_rurals_resource_handouts_1-2013.pdf)

Clark County Children's Mental Health Consortium 10-Year Strategic Plan

Written by a committee of stakeholders, family members, and community providers, this plan was developed in 2010 to strengthen behavioral health services provided to emotionally disturbed children and their families. The plan focuses on expanding preventative services, developing an organized delivery system, and strengthening the role of families in establishing treatment plans. To access the full plan, visit the following website: http://www.dcss.state.nv.us/CW_Policies/Consortia/CLARK/CLARK10-YearStrategicPlan.pdf

Ensuring that the Affordable Care Act Serves the American People

The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many provisions of the Affordable Care Act (ACA), the historic healthcare reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance. For up-to-date information on state-based health insurance exchanges, data and fact sheets related to the ACA, and other information related to insurance coverage in America, visit the following website: <http://www.cms.gov/ccio/index.html>

Grading the States: A Report on America's Mental Health Care System for Serious Mental Illness

National Alliance on Mental Illness (NAMI) first publication of this report in 2006 provided a baseline for measuring progress toward the transformation envisioned by the New Freedom Commission. In 2006, the national average was a D grade. Three years later, this second report finds the national average to be stagnant—again a D. Fourteen states have improved their grades since 2006, but not enough to raise the national average. Twelve states have fallen back. Twenty-three states have stayed the same. Oklahoma improved the most, rising from a D to a B; South Carolina fell the farthest, from a B to a D. Overall, the grade distribution for 2009 is 6 Bs; 18 Cs; 21 Ds; and 6 Fs. For the full 204-page report including individual state reports, go to: [http://www.nami.org/gtsTemplate09.cfm?Section=Grading the States 2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459](http://www.nami.org/gtsTemplate09.cfm?Section=Grading%20the%20States%202009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459)

The Mental and Emotional Well-Being of Children: A Portrait of States and the Nation 2007

The National Survey of Children's Health provides information on children's health needs in all 50 states and the District of Columbia. This survey includes information on children's behavioral, developmental, and emotional needs, as well as access to behavioral health services and treatment. <http://www.mchb.hrsa.gov/nsch/07emohealth/state/state.html>

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About the Authors

Dr. Ramona Denby-Brinson is Professor, School of Social Work, and Senior Resident Scholar, The Lincy Institute, at the University of Nevada Las Vegas. Dr. Denby-Brinson completed her Ph.D. in social work at The Ohio State University. Prior to her academic career, Dr. Denby-Brinson worked with children and families in a wide capacity for more than 10 years. Dr. Denby-Brinson conducts research in the areas of child welfare, children's mental health, juvenile justice, and culturally specific service delivery. Her goal is to help practitioners bridge the gap between theory and practice by utilizing science-based interventions to support vulnerable populations.

Dr. Sandra Owens is an Associate Professor in the School of Social Work at the University of Nevada Las Vegas, and is a Hartford Faculty Scholar of Gerontological Social Work. Dr. Owens completed her Ph.D. in Social Welfare at the University of California, Berkeley. Prior to her academic career, Dr. Owens' clinical experience was gained working with children and adults admitted to inpatient psychiatric units in Monte Vista Hospital, Charter Hospital, and Southern NV Adult Mental Health Services. Dr. Owens' research has focused on family caregiving, cross-cultural competency, and the mental health and social functioning of Black, White, and Latino female caregivers of the elderly. Dr. Owens is committed to assisting agencies with meeting their organizational goals and to helping address the myriad problems facing individuals, groups, and communities. Dr. Owens is actively involved in leadership roles in a variety of community organizations, and she recently served as President's Fellow in the cabinet of UNLV President Neal Smatresk.

Ms. Sarah Kern is a graduate research assistant at The Lincy Institute at the University of Nevada Las Vegas. She completed her B.A. in Psychology and is currently working toward her Master's in Social Work at UNLV with a concentration in direct practice. Her interests include child welfare policy and mental health service and delivery.

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4505 S. Maryland Parkway, Box 453067
Las Vegas, NV 89154 (702) 895-0088

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