

DHCFP Public Workshop  
5-12-15  
NGA Behavioral Health Screening for Youth

1. Introductions
2. Power Point presentation by Alexis Tucey (DCHFP Behavioral Health Program Specialist) introduced the program, crisis concept moving from crisis treatment to prevention and early intervention.
3. Discussion: Consequences of untreated behavioral health issues in youth - suicide or attempts; poor school performance; involvement with criminal justice; severe disease, high health care costs
4. Prevention and Early Intervention: How do we identify Rising Risk?
5. Treatment:
  - Long delays between first onset and when people seek treatment or receive treatment;
  - 20% of children with mental disorders receive services;
  - New service delivery model focused on rising risk and preventative care
6. Discussion: Screening Areas; need a comprehensive tool that captures:
  - mental health;
  - trauma;
  - suicide; and
  - substance abuse
7. Nevada Mental Health Issues: Study found that in the past 12 months, 31.7% of high school students experienced depression.
8. Screening Discussion:
  - Screening Tools
  - Patient Health Questionnaires
  - Strength and Difficulties Questions
  - MacArthur Foundation on depression
9. Trauma screening: Adverse childhood events ACE); the higher the score the higher the probability for various health problems. Trauma screening tools - ACE' CTSQ
10. Substance Abuse Screening Tools:
  - SBIRT
  - NIDAMED
  - CAGE AID
  - DAST - 10

11. Suicide screening: 90% of children who commit have mental disorders
  - Signs of suicide SOS
  - SAFE-T
  - C-SSRS
  - SBQ-R
12. 7<sup>th</sup> grade Mandate Proposal:
  - Removes stigma
  - 4 part BH screening prior to school entry
  - Require proof of completion align with TDAP immunization requirement = Immunization rates increased with implementation of mandates for immunizations
13. Medicaid Transformation
  - Allow same day billing for EPSDT and BH screening
  - Add non-traditional providers that can bill for BH screening
  - New designation for youth that allows preventative services for youth identified as Rising Risk
  - Incentivize referral for services and comprehensive exams
14. Rising Risk Designation: Outline the paper screening which generates in person screening, or emergency services initiated. If in person screening identifies concerns then assessment is required.  
Areas of intervention:
  1. Preventative services;
  2. Refer for treatment if diagnosis exists
15. Provider Type Expansion, including:
  - JJ officers
  - truancy officers
  - probation officers
  - school counselors
  - school social workers.
  - Community Health Workers
  - child care providers
  - private and charter school staff
  - peers
16. Review of handout listing various screening tools available
17. Questions and Concerns

Mary Wherry (DPBH): Does the state have a specific tool that has been identified?

A: No, we are looking.

Mary Wherry: There is a need for a tool or a database to be able to have a more organized and not disjointed approach to the screenings. Issues to consider: stigma, parental denial, .....

Dr. Green (DPBH): We are looking for a tool and exploring options that can be utilized- thus the need for the workshop.

Mary Wherry: Recommend tools used at EI, CHN's, Safety net providers....

Alexis Tucey (DHCFP): CASI and Locus will be used.

Mary Wherry: questions about modifying the tools that are used via EPSDT

Dr Green: suggested that we aren't ready to modify until we define the tool

Joe Haas: rising risk, suggests a pilot approach to the 7th graders to see how they do with any specific tool, prior to implementation and to evaluate percent of children who respond with risk. ASSIS can provide symptomatic approach.

Charlene Howard: logistics, is this instrument going to be completed by 7th graders? and in school?

Alexis Tucey: We don't yet know which tools we are using.

Dr. Green: flow sheet in the presentation page 19 shows paper and then in-person screening. Need to determine if self-assessment triggers an assisted in-person screen, allied health professional, or Psychologist, Community health worker to do initial screen, peers- looking at many options for gathering info.

Amber Reid (Washoe Schools): How long are we looking for the screening to take? Are we worrying about languages and culturally sensitivity?

Dr. Green: How can we streamline the tool? The school district is concerned about time aware from schoolwork. We are open to looking at alternatives that get them quickly screened and into services. Training might be the answer. We will definitely be culturally sensitive and linguistically appropriate, and we may be challenged by that.

Nancy Hook: Have we looked at the tools and the research to screen out some of the tools?

Dr. Green: Yes we have. This rising risk population is not traditionally identified by the tools available, and CMS is excited about the possibility. We are identifying a tool that hasn't been in place. Three ACES is a determining factor however it must be able to identify higher risk to no risk.

Las Vegas

Devon Brooks: We aren't sure which tool and how often are we supposed to use them. Psychologist on staff is limited in time and so we want to be able to have enough time to do this properly.

Alexis Tucey: screening at one time during entry to 7th grade, initially, and then triage based on scoring of the tool.

Dr. Green: If you were entering into a psychiatric facility, that would opt you out of this tool. This is screening of others who might have a symptom or diagnosis. How do we get

coverage for a child without diagnosis? We went to Washington D.C., and told them we wanted to identify the rising risk not already diagnosed as having a mental health issues, behavioral health or substance abuse issues with rising risks.

Devon Brooks: You mentioned without a diagnosis, can we provide a service without a diagnosis?

Dr. Green: Non-traditional resources, peer-to-peer, and others to get coverage, Traditionally, uncovered service that would prevent them from getting down stream to require high level interventions,

Devon Brooks: These are issues that exist that haven't been dealt with- kudos

Dr. Green: We need that support.

Sue Proder (Mohave Youth Services): Youth screening tool, consider when behaviors are more prominent like prom, finals, etc- abbreviated screening when stressor exists? Using the same tool?

Dr. Green: We haven't thought about high risk situations as we were looking at those with risks, however we need to look at those in response to a high risk situation which is different than those we have intended to screen.

Charlene Frost (NVPEP): Are these the only screening tools that we are looking at or are we looking at those that work with the ACES.

Dr. Green: No, if ACES is not on the list we wanted it to be.

Julia Peek: We intended to use the ACES.

Dr. Green: ACES for sure--these are supplemental.

Charlene Frost- ACES was designed for adults over 18 yrs, are you going to reframe- might be shocking for 7th graders.

Dr. Green: CMS has some adaptations of the ACES. We will post to the website those that are adolescent-appropriate.

Julia Peek: A physician

Kelly Wooldridge (DCFS): Many states are using ACES and there are adaptations for younger kids and adolescents

Sherry Wright: Dept. of JJ uses MAYSI 2, and it works well with that population.

Kelly Wooldridge: MAYSI 2 is specific for JJ population.

Dr. Megan Freedman: DCFS- might be downstream, we ask about abuse and neglect; how is mandatory reporting handled?

Dr. Green: We will be training for mandated reporters. With identification of SED kids, trauma and unstable home environment, screeners will be trained prior to implementation. We don't have enough providers for SED kids now; how do we enhance reimbursement to those who screen mentally, psychological issues?---great point.

Reno: nothing

Elko: nothing

Dr. Green: Can I ask if anyone is familiar with these screens---hates or loves them---with adolescents?

Sally Jost: Las Vegas uses BESS in the school-setting and there are pluses and minuses. There is a computer based product. It did require parents and to be sat down.

Dr. Green: How long?

Sally Jost: It didn't even take an entire period in a middle school classroom. Parental consents were problematic, about 30% being done. We have more information on this.

Dr. Green: Anyone else?

Dr. Megan Freeman: CRS-R is not recommended.

Joe Haas: UNR's Dept of Public Health is using ACES for kids in their system. It went well-- looked at role of trauma in their system. It seems that trauma is related to risks and delinquent behavior, we didn't use it as a clinical tool- but we could pull out data suggesting the number of ACES going up is correlated to the number of adverse behaviors and risk goes up.

Dr. Green: Did you assess children? If so, what modified version did you use?

Joe Haas: Yes; could we get together to discuss?

Chris Empey (WCSS): Contracted licensed providers implemented screening for 11 year olds and up and used the BECK inventory, life event check list and the DSM V cross cut measure; for trauma use UCLA PTSD reaction index; have used a strength assessment tool.

Dr. Green: Common themes are noted. We need to place a positive approach like strengths rather than negative.

Julia Peek: We have been looking at *Strengths and Weaknesses*.

Kelly Wooldridge: Child and adolescent strengths used as an outcome measure---does anyone have experience with that? It is free, so we were looking at that.

Alexis Tukey: Any other feedback with any of the tools?

S. Wright: we have used several tools with JJ population, but MAZI was most helpful.

Dr. Green: Who is providing the screenings in which settings?

S. Wright: All youth take the MAYSI via computer, if score is significant they follow-up with a clinician.

Dr. Green: What is the process? Who gets the results?

S. Wright: The therapist checks the printout for screens to see if they need follow up.

Dr Green: Which level needs follow up?

S. Wright: For LCSWs and MFTs, we have a clinical division and no diagnosis is required. Most of the kids we see have a diagnosis.

Dr. Green: It would be nice to look at low risk, undiagnosed kids to see if there is a score correlation with those kids.

Empy: At Kids Kottage, staff implements the screenings, like those with HS Diploma in school working on a BA; Dr. Carter-Hargroie, PhD.

Joe Haas: In Washoe County, we use a paper test. When they score high, there is a list of follow-up questions and then they may be referred to a higher level using the MAYSI. It's not as robust as the ACES.

Dr. Green: Is there a self assessment on the computer?

Joe Haas: It's on paper. ACES & MAYSI are on the computer; use to refer to therapist for intervention. It doesn't drive diagnosis. It does relate to their behavior.

Dr. Green: Are there some that are scored low and not referred (MAYSI)?

Joe Haas: Yes, about 80% are being seen by therapist; 60-70% have a mental health diagnosis.

Dr. Green: It would be interesting to look at lower scores and compare to outcomes. (KID outcomes)

Alexis Tucey: Anything else, regarding tools, any information to be shared?

Dr. Green: If someone is shy, please send positive and negative comments. We want all feedback. We believe this is a great venture for our state and our state's children. We are focusing on treatment next. Which services should we cover? Non-traditional providers. Look at services that are not currently reimbursed or are underutilized. We hope to have a vibrant meeting. We would appreciate your input.

Devon Brooks: This is an important meeting, with regards to working with those kids with no diagnosis. Their self-esteem is low and services for low education and being bullied, dealing with financial issues, cultural issues. There is a component we need to focus on-

nutrition is a big focus too. I'm glad that we are able to talk about this, especially for those kids with adults dying young, and there are no services reimbursed

Dr. Green: Self esteem building, aftercare, boys and girls club. Can we enhance their social and home environments? How can we prevent future issues and crisis? Next meeting, we will discuss services.

Alexis: We are looking at CMS guidance for our next steps. At [DFCHP.gov](http://DFCHP.gov) there is a link for NGA for behavioral health youth previous public meeting info email: [NGABHyouth@dncfp.nv.gov](mailto:NGABHyouth@dncfp.nv.gov)

Julia Peek: Health Leads' website has great information.

Alexis Tucey: Our third meeting will address treatment, non-traditional services. It will be in approximately 30 days. Keep it in mind, and if you have feedback we want to hear from you. Go to our email or website.