NEVADA CHILDREN’S MENTAL HEALTH REPORT CARD

Overall Grade D+
What is Child Mental Health and Why Is It Important?

According to the Centers for Disease Control and Prevention⁴, child mental health is a collective measure of a child's ability to achieve developmental and emotional milestones and learn how to (a) prosocially interact with others and (b) cope with day-to-day struggles. Disruptions in child mental health, which often depend on a variety of interpersonal and environmental factors, can lead to poorer health outcomes and quality of life for children. This is often due to the development of functional impairments that ultimately affect children in many aspects of their life such as in the home, at school, and within communities. Importantly, these impairments do not just affect children during childhood. Functional impairment during development can result in the development of impairments during adulthood.

What are Childhood Mental Health Disorders?

Serious changes in child mental health present in many forms, one of which includes the development of mental health disorders. Mental health disorders in childhood are typically chronic health conditions characterized by substantial changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day. Examples of behavioral, emotional, and developmental mental health disorders include, but are not limited to, depression, anxiety, ASD/autism, ADD/ADHD, and others. The diagnosis of a particular mental health disorder may occur when these changes interfere with a child’s ability to learn, play, interact with others, and/or cope with stressors of daily life. It is important to understand that not all children who experience disruptions in mental health have, or are diagnosed with, mental health disorders. Similarly, those children with mental health disorders may exhibit varying levels of functioning, learning, and coping ability.⁵

Child Mental Health in America: Prevalence and Trends

Mental health disorders are becoming increasingly more common among America's youth. More common conditions include ADHD, which is estimated to be prevalent among about 10% of America's children between the ages of 2 and 17.⁶ Behavior problems are estimated to be experienced by around 7-15% of America's children between the ages of 3 and 17.² Collectively, behavior, emotional, and developmental health conditions are shown to occur more commonly with one another (also known as comorbidity). Furthermore, diagnosis rates of anxiety and depression have increased over time. These conditions tend to be diagnosed in later years whereas behavioral disorders tend to be diagnosed between the ages of 6 and 11.² Lastly, there are apparent differences in treatment rates. Treatment for depression and anxiety are provided in nearly 80% and 60% of cases, respectively. However, treatment for behavioral disorders are estimated to be provided in only 50% of cases.²

Though mental health disorders affect all children, evidence suggests that disparities in diagnosis and access to care exist. Black and American children are significantly less likely to have access to youth mental health care services, specialty outpatient services, and school-based services.⁷ The use of emergency department mental health services for Black and African American children is much higher compared to White children.² Similar patterns of limited access to child mental health care services are observed among Asian American and Latinx/Hispanic children.⁸ Disparities have also been noted in identification and diagnosis patterns. Children from historically minoritized groups are more likely than White peers to have their mental health distress attributed to poor behavior and poor parenting. In many cases, their symptoms are criminalized leading to early and ongoing interactions with the criminal justice system.⁹ Gender and sexual orientation are also contributing factors to prevalence of mental health disorders. Disparities can be noted in treatment access and options for female and LGBTQIA+ youth.¹³ In early childhood, boys are more likely than girls to have an identified mental health disorder.¹⁴ However, emerging research suggests internalizing disorders are often missed in girls until symptoms are very severe.¹⁵ Youth who are a part of the LGBTQIA+ report increased taxation on their mental health and are at higher risk for mental health distress and have lower access to services to mitigate this distress.¹⁶ Living in poverty has also been identified as an indicator of disparate access to mental health care. More than 1 in 5 children living below the federal poverty level have at least one documented mental health disorder.¹⁷ Access to health insurance, child mental health workforce availability and quality, and health care infrastructure each play a critical role in determining treatment for these children.¹⁸ For many youth in poverty, accessing the care to mitigate their symptoms and promote optimal development is difficult.

Mental Health Among Nevada's Youth

Childhood mental health is a severe health problem in Nevada. Mental Health America (MHA) recently ranked Nevada as the worst state (compared to 49 other states and Washington D.C.) in America for youth mental health in both 2021⁷ and 2020⁶. The number of child mental health care service providers and facilities are severely limited⁷,⁸ and many children and their families are not receiving access to the child mental health resources they need⁹. Despite any improvements, the struggle to keep up with the mental health needs of Nevada’s children remains the same.

*Data included in this Report Card does not reflect the current COVID-19 Pandemic.

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About CAA

Making a Difference in a Child’s Life

Children’s Advocacy Alliance (CAA) is an independent voice dedicated to achieving public policy wins in the areas of child safety, health and school readiness. CAA creates lasting change by tackling the biggest issues that kids and families face in Nevada.

Serving as a leading advocate for children in Nevada since 1998, the CAA is comprised of community leaders dedicated to improving the lives of children and families. To achieve our goals, CAA:

» Brings people together to build consensus around priorities and to leverage our collective strength towards real reform;
» Collects, analyzes and shares research and information with people who make decisions impacting Nevada’s children and families; and
» Builds public will through education, outreach and advocacy to solve expansive and chronic problems facing kids and families.

When we come together to face the biggest issues for kids and families, we can create more and longer-lasting change. By pooling our resources to put government on the side of Nevada’s children, we can make a bigger difference together than we could have done alone.

How You Can Help:

Become a friend of CAA by supporting our work on the issues you care most about, like ensuring our kids are safe from abuse and neglect, that every child enters school ready to learn, and that all of our kids are healthy. We share your passion for change, and by joining our team, you’ll see your investments go further and reach more kids. With advocacy:

Go online at www.caanv.org and click “donate” to make a contribution today.

The CAA is a 501(c)3 nonprofit organization – all donations and contributions to CAA may be tax deductible. Please contact your financial advisor for additional information.

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Children’s Advocacy Alliance
www.caanv.org
702.228.1869

Las Vegas
528 S. Eastern #151
Las Vegas, NV 89119
DEPRESSION (PREVALENCE AND SEVERITY): B+

Current estimates of the prevalence of depression among Nevada’s youth are varied. The National Survey of Children’s Health (NSCH) suggests that Nevada ranks in the top 15 states with a low average parent-reported rate of depression and depression severity in youth between the ages of 3 and 17.12 Nevada is ranked 7th based on parent-reported prevalence of depression among children, yielding an A grade.12 The state is also ranked 3rd based on depression of mild severity and 14th based on depression of moderate/severe severity,12 earning Nevada an A+ and a B grade, respectively. However, prevalence estimates suggest an increase in the number of depressed youth from 2016 to 2019 with indications that thousands of children are newly affected and that nearly 3% of children experience the condition.10 11 12 While NSCH parent-reported survey data is helpful, it is likely that it is not characterizing the full mental health picture of depression among Nevada’s youth.

Consider Mental Health America (MHA) ranking Nevada 39th with more than 15% of Nevada’s youth experiencing at least one major depressive episode in the past year7, earning the state a D- grade. While this may seem like a steep improvement from Nevada’s F grade ranking as 47th in 20208, Nevada’s rate of youth experiencing major depressive episodes in the past year has actually increased. This increase is merely being clouded by a much more dramatic national increase in the number of depressive episodes in the past year7.

Fortunately, the reported proportion of Nevada’s youth experiencing severe major depressive episodes has decreased from 13.2% in 20208 to 11.8% in 20217. Despite this decrease shifting Nevada from the position as the 51st state in 20208 to the 39th state in 20217, these rates suggest that Nevada’s youth is still suffering from severe major depression at rates higher than the national average. At best, this earns Nevada a D- grade.

ADOLESCENT SUBSTANCE USE DISORDERS: F

Substance use disorder is a diagnosable mental health condition that affects a child’s brain and behavior.18 Ultimately, substance use disorder can interfere with a child’s proper development and functioning, which puts children at higher risk for developing mental health conditions.19 Furthermore, children with existing mental health challenges, such as ADHD, are also at higher risk for developing substance use disorder.20 This makes substance abuse disorder a quality indicator for mental health among children.

Nevada’s yearly rates of youth experiencing substance use disorder have not decreased enough to help Nevada earn a more improved ranking. In 2020, an estimated 5.2% of Nevada’s youth experienced substance use disorder9. These rates lowered to about 5.09% in 20217. However, Nevada’s state ranking moved from 43 to 477 8. This maintains Nevada’s F grade in terms of youth who experience substance abuse disorders in the state.

Based on 2018 data derived from the National Survey on Drug Use and Health (NSDUH), the Nevada Medical Center (NMC) reports three indicators for substance abuse among Nevada’s youth between the ages of 12 and 1713. While the number of youth experiencing alcohol use disorder has decreased since prior years, the prevalence rates for illicit drug use disorder and any substance abuse disorders have increased13. For alcohol use disorder, Nevada earns a state ranking of 3613, a notable improvement from recent years, and a D grade. The rate of illicit drug use disorder among youth increased from 4.2% in prior years to 4.7% in 201813. This earns Nevada a ranking of 5013 and an F- grade. Similarly, the rate of any substance use disorders among youth has increased.13 This earns Nevada a ranking of 4913, a setback compared to recent years, and an F- grade.
DEVELOPMENTAL DISORDERS (PREVALENCE AND SEVERITY): B

In recent years, the NSCH reports that the suspected prevalence of Autism or Autism Spectrum Disorder (ASD) among Nevada’s youth between the ages of 3 and 17 has increased from 2.7% in 2016\(^{10}\) to 3.1% in 2019\(^{12}\). This increase in prevalence is accompanied with a reduction in Nevada’s ranking from 23 to 32\(^{10}\)\(^{11}\)\(^ {12}\), yielding a shift from a C+ grade to a D+ grade. Parent-reported rates of Autism/ASD severity have also increased with a .4% increase in moderate/severe Autism/ASD and a .7% increase in mild Autism/ASD\(^{10}\)\(^ {11}\)\(^ {12}\). In 2019, the number of children affected by mild Autism/ASD was higher than the number of children affected by moderate/severe Autism/ASD\(^{12}\). These rate increases are paralleled by rankings that have worsened over the years from 29 in 2016\(^{10}\) to 33 in 2019\(^ {12}\). This earns Nevada a D+ grade.

Attention-Deficit Disorder (ADD) and Attention-Deficit/Hyperactivity Disorder (ADHD) is less prevalent among youth in the state of Nevada compared to other states. The NSCH ranked Nevada as the number 1 state in 2019 using estimates suggesting only 6.2% of Nevada’s youth are suspected to have ADD/ADHD\(^ {12}\). However, when examining severity, Nevada is ranked as 3\(^ {12}\). This lowered ranking can be attributed to a greater number of reported youth experiencing moderate/severe ADD/ADHD compared to mild ADD/ADHD in the state. Regardless, both rankings earn Nevada an A+ grade.

SUICIDE: B -

Suicide is the global leading cause of death in childhood and adolescence.\(^ {22}\) Suicide is linked to mental health disorders including, but not limited to, depression, substance abuse disorder, anxiety, eating disorders, and personality disorders.\(^ {22}\) Any child with a mental health disorder is identified as having a 47-74% risk of suicide\(^ {22}\). Affective disorders, such as depression, are closely linked to substance use disorders, which are closely linked to suicide.\(^ {22}\) Thus, the mental health comorbidities associated with suicide are of serious concern, making it a clearly appropriate mental health indicator for children.

Data suggests that Nevada is faced with a significantly reduced burden of suicidality among the state’s youth between the ages of 0 and 19 when compared to most other states\(^ {13}\), earning Nevada an improved ranking of 26\(^ {13}\) and a C grade. However, ongoing trends based on data from the Youth Risk Behavior Surveillance System (YRBSS) indicate increasing numbers of Nevada youth between the ages of 13 and 17 that are (a) seriously considering suicide and (b) attempting suicide.\(^ {13}\) Despite earning the rankings of 21 (C+ grade) and 9 (A- grade), respectively, worsening trends\(^ {13}\) in these categories suggest that the matter of suicide prevention should continue to be prioritized and taken seriously in the state.
INFANT AND EARLY CHILDHOOD MENTAL HEALTH: C

Infant and early childhood mental health pertains to the ability of children from birth to 5 or 6 years to form relationships, experience and regulate emotion, and learn new things from their environment. Indicators of poor mental health in infancy and early childhood include, but are not limited to, experiencing problems associated with feeding, gastric disturbance, anxiety and tension, and failures in reaching developmental milestones or experiencing contentment. Mental health problems in infancy and early childhood put the child at significantly higher risk for poorer mental health and developmental health outcomes in the future.

As reported by parents in the 2018-2019 NSCH, an estimated 3% of Nevada’s children between the ages of 3 and 5 years of age currently have anxiety problems. Nevada is ranked 38th in the nation in this category, earning the state a D+ grade. Furthermore, 7.8% of Nevada’s children in the 3-5 age category currently have behavior or conduct problems, positioning Nevada as the 46th state and earning Nevada an F grade. 86.3% children aged 0-5 years are estimated to have breastfed or been fed breastmilk, which earns Nevada a B grade for its state ranking of 14. Parent-reported data also suggests that about 8% of children between the ages of 0 and 5 years old have experienced frequent or chronic difficulty with digesting food in the past 12 months. This earns Nevada a ranking of 20 and a grade of B-. Lastly, data indicates that only 86% of young children in Nevada between the ages of 6 months and 5 years are “flourishing” as indicated by the NSCH’s standard for young children’s overall social and emotional development. This measure indicates the infant or child’s ability to smile and laugh, be affectionate towards others, demonstrate resilience, and show interest in their environment and learning new things. This earns Nevada a ranking of 17 and a B grade. Compiling the findings from these rankings, Nevada is demonstrating some promise but has clear areas for growth.

EMOTIONAL DISTURBANCE: F +

Emotional disturbance (ED) is a condition among school-aged children that interferes with their ability to learn, develop, and reach important milestones. Children with ED typically suffer from 1 of 6 types of disturbance: anxiety disorders, conduct disorders, psychotic disorders, eating disorders, Bipolar Disorder and Obsessive-Compulsive Disorder (OCD). ED also interferes with children’s ability to maintain appropriate and satisfactory social relationships. Individualized Education Programs, or IEPs, are considered a critical step in ensuring children with emotional disturbance are provided with the resources and support they need to have a quality education. Without these resources, children may be faced with severe consequences including, but not limited to, early encounters with the juvenile justice system, an inability to obtain work as an adult, having difficulty with maintaining healthy social relationships, and struggling with low academic achievement. Thus, it is imperative that students with ED are identified as having the condition so they can be provided with an IEP.

Nationally, less than 1% of America’s children have been identified as having an ED for an IEP. However, estimates suggest that this number should be around 8%. The state of Nevada ranked 43 in 2020 and 2021 for the number of students who have been identified as having an ED for an IEP in the state, which earns Nevada an F+ grade. Nevada’s 2021 prevalence estimate for students identified as having an ED for an IEP is ~4.5%.
JUVENILE JUSTICE: F-

The strength of the association between juvenile justice and child mental health is overwhelming. A wide range of evidence suggests that anywhere from 65% to 70% of Juvenile Justice youth in juvenile detention centers have "diagnosable mental illnesses." Of the many juvenile incarcerations that occur in a given day, estimates suggest that nearly 2,000 of those incarcerations can be clearly attributed to a lack of community child mental health services.

Based on data from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Nevada ranks as one of the worst states in the country with the highest rates of juveniles arrested for aggravated assault (ranked 51), robbery (ranked 48), drug abuse (ranked 48), and weapons (ranked 46). This earns Nevada an F-grade in the first 3 categories and an F grade in the weapons category. Nevada ranks 25 in juvenile arrests for larceny, earning the state a C grade in this fifth category. These findings suggest Nevada's juvenile population is encountering the juvenile justice system in much greater numbers compared to most other states in the country.

*These rates are based on data from individual states that vary dramatically in reporting coverage that ranges anywhere from 0-100%. 14 states (including D.C.) have reporting coverage at 75% or less. Nevada is one of the best reporting states with 96% reporting coverage.

ACCESS TO MENTAL/BEHAVIORAL CARE: F

Nearly every indicator pertaining to access to mental/behavioral care services in this category earns the state of Nevada an F-grade. The 2018-2019 National Survey of Children's Health ranks Nevada as the 50th state with less than 40% of children between the ages of 3 and 17 obtaining treatment or counseling for a mental/behavioral condition. This indicator includes parent-reported information suggesting that their child has been diagnosed with a mental/behavioral condition including anxiety, depression, or behavior/conduct problems. Nevada was recently ranked by MHA as the worst state in the nation with an estimated 71% of youth who experience major depressive episodes and do not receive some form of a mental health treatment. The state received the same ranking for the mere 14% of youth who experience severe major depressive episodes and have been able to receive some form of consistent treatment of at least 7 to 25 visits in a year. This indicates that close to 90% of Nevada's youth suffering from severe major depressive episodes, which can be life-threatening, are not receiving at least some form of consistent treatment.

There are complex difficulties present in the health care and health insurance systems that present families with significant challenges and prevent children from receiving the mental/behavioral health care they need. While affordability of insurance and the matter of ensuring every child has access to health services is an issue of utmost importance, there are children who are covered by private insurance that do not have access to care for mental or emotional problems. In Nevada, 12.6% of children who are covered by private insurance do not have coverage for mental or emotional health problems. This earns Nevada a ranking of 45 and an F grade. The NSCH gives Nevada a ranking of 39 based on a parent-reported rate of health insurance always providing the services and benefits that are necessary to meet their child's mental health needs only 43% of the time. This earns Nevada a D+ grade.

Unfortunately, Nevada's low rates of children with mental/behavioral conditions receiving services to treat and manage those conditions is paralleled by the diminished number of healthcare professionals available to provide those services in the state. Though reliable ranking data is not readily available for child mental health care workforce availability, Nevada is given a 2021 ranking of 32 for general mental health care workforce availability. This earns Nevada a D+ grade. Estimates provided by 2015 data from the CDC suggest the possibility that Nevada may have an even worse mental health care environment for children.
DISPARITIES: C

Existing trends suggest the presence of age, gender, racial/ethnic, and socioeconomic mental health disparities among Nevada’s children. Though this is not an exhaustive description of the child mental health disparities that may exist in the state, this section provides novel information that can be utilized to educate the community and guide efforts to reduce these disparities. We place emphasis on the prevalence of ADD/ADHD and behavioral or conduct disorders and mental health treatment service utilization for grading purposes. Our data sources do not provide information on sexual orientation or gender identity outside of male/female categorization.

The prevalence of diagnosed ADD/ADHD among children in Nevada varies by gender and race. 9.8% of male children have an ADD/ADHD diagnosis while 2.4% of female children have the same diagnosis. Nevada ranks at 7 for a lower prevalence of diagnosed males, but ranks at 1 for the lowest state-wide prevalence of diagnosed females. This earns Nevada a A grade and an A+ grade respectively. In regards to race, the prevalence of diagnosed ADD/ADHD among Hispanic, Other non-Hispanic, and Black non-Hispanic children is much lower than the prevalence of diagnosed ADD/ADHD among White children, ranking Nevada as 10th, 8th, 23rd, and 27th, respectively. These rankings earn the grades of A-, A-, C+, and C, respectively. Though more information is needed to make informed conclusions, the variations in the rankings indicate a likely presence of disparity.

The prevalence of behavioral/conduct disorders vary by age, gender, and race. Nevada currently ranks at 11, earning Nevada a B+ grade, based on parent-reported data suggesting their child between the ages of 3 and 17 has behavioral or conduct problems. These problems are most common among children in the 3-5 and 6-11 age groups. Nevada has a poor parent-reported prevalence ranking of 46, earning an F grade, for behavioral or conduct problems among 3-5 year olds. In contrast, Nevada is ranked at 13 for parent-reported prevalence behavioral or conduct problems in the 6-11 age groups. This earns a B+ grade. Children in the 12-17 age group earn Nevada a ranking of 4. While males experience behavioral or conduct problems at nearly twice the rate of females, Nevada ranks at 11 for females and 21 for females, earning B+ and C+ grades, respectively. In regards to race, Nevada ranks at 41, earning a rank of F+, for behavioral or conduct problems among White, non-Hispanic children. However, the state ranks at 12 (B+ grade), 13 (B+ grade), and 17 (B grade) for non-Hispanic Black, Hispanic, and Other non-Hispanic children, respectively. This indicates a disparity between White non-Hispanic children and all other racial/ethnic categories despite the fact that Black non-Hispanic children experience the greatest proportional burden of behavioral or conduct disorders when compared to all other racial groups in the state.

Evidence suggests the mental health treatment service utilization decreases as children age while racial and gender differences tend to permeate. Parent-reported data from the 2018-2019 NSCH provides data consistent with this finding as children in the 12-17 age range are receiving treatment or counseling services for their diagnosed mental/behavioral condition at a low rate of only 36.6% compared to diagnosed children in the 6-11 age range receiving treatment at a rate of 54.8%. In addition to an age disparity, there is a stark gender disparity with female diagnosed children accessing mental health treatment at a significantly higher rate (44.1%) compared to male diagnosed children (34.1%).
DISPARITIES (cont): C

Despite there being no significant racial/ethnic data available for this indicator, we observe a socioeconomic disparity for mental health treatment service utilization. Those diagnosed children in families with a household income of 100-199% of the Federal Poverty Line (FPL) receive mental health treatment services at a rate of 30.2%\(^\text{12}\). However, those diagnosed children in families with a household income of 200-399% of the FPL receive treatment at a rate of 50.0%\(^\text{12}\). The trend of increasing treatment utilization with increased household income among diagnosed children increases with an estimated 61.4% of children utilizing treatment in households that have an income of 400% of the FPL or greater\(^\text{12}\).

For older diagnosed adolescents, Nevada earns a ranking of 51\(^\text{12}\) and an F- grade. The younger group earns Nevada a ranking of 16\(^\text{12}\) and a B grade. Nevada has a ranking of 50\(^\text{12}\) for diagnosed males who utilize mental health treatment, earning the state an F- grade. Nevada has a ranking of 45\(^\text{12}\) and earns an F grade for diagnosed females who utilize mental health services. The presence of a socioeconomic disparity pertaining to utilization of mental health treatment services among diagnosed children in Nevada is exemplified by the dramatic changes in grades from F to D+ to B- as household income groups increase. Of 29 states included in the data report, Nevada ranks at 25\(^\text{12}\) for treatment utilization among households with an income between 100-199% of the FPL, yielding an F grade***. The ranking for the 200-399% of the FPL level is 30\(^\text{12}\) out of 46 states, yielding a D+ grade***. Of all states, Nevada ranks at 20\(^\text{12}\) for households with an income of 400% of the FPL or greater. This earns Nevada a B- grade.

*Cases where rankings do not dramatically differ do not indicate the absence of disparity. Instead, disparity may be greater in other states, thus minimizing the perceived disparity in the state of Nevada as demonstrated by the ranking system. Another possibility is the inadequate rates of diagnosis that the state may experience due to healthcare access issues relating to child mental health care treatment and services.

**The grading for this category is not the same as prior categories. Reference the “grading methodology” section for a more thorough explanation of the grading assignment process for this category.

***To adjust for missing data from many states, the grade is obtained by performing a mean imputation and applying it to the numerical ranking system used throughout the report card.
Recommendations to Improve Nevada’s Grades

1) Increase access to child mental/behavioral health services.
   - Improve the spectrum of wrap-around services available in Nevada.
     - Wrap-around services are services that are provided with a family-based and needs-based approach in a variety of facilities within the healthcare continuum.  
     - Wrap-around service facilities should specialize in families with mild mental health disorders.
     - Wrap-around service facilities should prioritize outpatient mental healthcare for children and families.
   - Policy makers should focus on funding and supporting these facilities.  
   - Increase the resources (facilities, programs, funding, etc.) available to those children with severe mental health disorders as these resources are almost non-existent within the community.

2) Increase the number of licensed child mental health professionals in the community.
   - Increase the number and diversity of training programs (e.g., residencies, internships, and postdoctoral fellowships) for infant, early childhood, child and adolescent mental and behavioral health providers and clinical professionals.
   - Develop and implement a plan to incentivize child mental and behavioral health practitioners through tuition assistantships, paid internships/post doctoral fellowships, and student loan forgiveness programs in rural and high-needs areas.

3) Provide universal screening for behavioral and emotional health throughout childhood.
   - Prioritize early intervention starting in infancy and continuing throughout childhood to prevent the onset and worsening of behavioral and emotional mental health conditions.
   - Utilize pediatric offices and child care facilities for screening that will support identification of behavioral and emotional risk in infancy and early childhood.
   - Engage local communities, child care centers, and schools with the universal screening process to target children of all ages.
Recommendations to Improve Nevada’s Grades

4) Examine implicit bias and school discipline practices.
   - Encourage positive, restorative, and healing-centered approaches to mitigate student emotional distress.\textsuperscript{26}
     
     • Utilize multi-tiered systems offering universal supports for youth with low levels of mental health distress.\textsuperscript{25} \textsuperscript{26}
     
     • This should also be accompanied with practices to reduce the criminalization of behaviors that may be associated with mental or behavioral health disorders.\textsuperscript{23} \textsuperscript{26}

5. Place focus on parent education and developing family support programs within the community.\textsuperscript{25}

6. Ensure children and families have access to health care coverage that provides them with the coverage they need to obtain mental and behavioral health treatment and services.
   
   - Provide health care coverage that offers a wider range of mental health supports to children and their families.
References


Children’s Advocacy Alliance
an independent voice for Nevada’s children
www.caanv.org