Clark County Mental Health Consortium

First Annual Plan

August 2002

Clark County Consortium
First Annual Plan for Mental Health Services

Summary of Need for Behavioral Health Services[1]

- Clark County has a need for a capacity to provide behavioral health services to over 8100 children within the Medicaid, juvenile justice, and child welfare systems at any point in time. Of these children there is a need to be able to provide individualized and coordinated services for over 4000 of these children.
- A large proportion (over 75%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need some level of mental health services.
- Parents and staff throughout the jurisdiction rated early access to services before problems become severe as the most important aspect of a mental health system. This would to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice).
- The best outcomes for children and families are achieved through a comprehensive array of flexible and community-based supports that help children and youth be included in their communities.
- To support children with mental health disorders at home and in their communities, families, teachers, social workers, and juvenile justice staff need information, education, and support to understand the special needs of these children, and to work through the challenges of raising and supporting these children and youth.
- Families need services that are customized to work for them. This means they are accessible in time and place to match the schedules and needs of families. It means that there is no wrong door and that services are coordinated across agencies to meet family's needs. It means the services are sensitive to and match the culture and language of the family.
- To make the system responsive and effective for families there is a need for consumer involvement at all levels of decision-making, evaluation and implementation of the system of care. Parents of children who have severe emotional disorders can be very effective supports and advocates for other parents.

How Well Need Is Met

- Of the more than 5000 children in the AFDC Medicaid population who need mental health services in Clark County less than 28.7% are receiving them.
- Of the 544 children screened in the Child Welfare and Juvenile Justice system only 46.8% are receiving mental health services at the level of their need.
- Over 70% of children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services

results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise require these services.

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[1] The terms Behavioral Healthcare Services and Mental Health Services are used interchangeably in this document and include services to address substance abuse disorders.

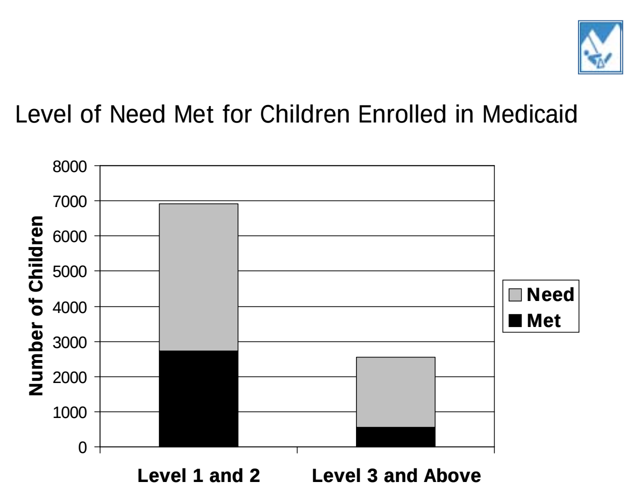


Figure 14

- The current system greatly overuses residential services to address mental health needs. The lack of an individualized family centered approach to supporting children results in 86.3% of the funding being spent on high cost residential care for less than 5% of the children who need services.

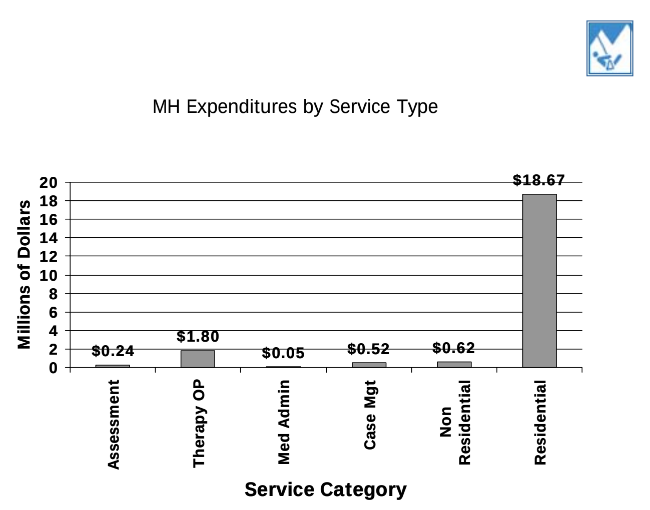


Figure 18

- Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services.

- Families and providers report long waiting times and lack of flexibility from the managed care and public system providers. Interviews with staff and families documented waiting of

10 weeks and longer in all programs and presumptive waiting lists because of the impression that services were not available or accessible.

- Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.

System Barriers and Challenges. Through the initial focus groups with families and staff it become quite apparent that there are a significant number of system barriers and challenges that prevent or make it difficult for staff and agencies to provide good services for children and families.

Eligibility for Services. The current system of eligibility is one of the primary system characteristics that causes the fragmented and discontinuous system. The multiple forms of eligibility, different benefit packages, different providers, and eligibility processes of the different agencies and public programs are a maze that few parents can successfully navigate. The very limited availability of targeted case management and limited funding for parent to parent advocacy and support make this problem even worse.

Methods for Obtaining Services. There are multiple ways for children and families to obtain services. Parents can go directly to providers and use private insurance, public insurance or pay directly for the services. Individualized and coordinated services are often expensive and not covered by private insurance. This means that parents of children with severe emotional disorders often do not have financial resources to pay for the services their children need without going through public systems. This forces many children into the child welfare and juvenile justice systems to obtain services.

Process for Obtaining Services. Children access services through the provider that receives funding for the services (e.g., their own physician, psychologist, managed care provider, or public system service coordinator). Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system. Best practice ratings ranked collaboration and integrated of services as one of the highest priorities but one that was most often not met. The managed care provider and all of the public systems triage initial intakes and focus services on children with the most intense needs.

Methods for Obtaining Additional Money. Nevada has one of the fastest growing populations in the country, but funding for children's behavioral health services has shown little increase in the past ten years. The new funding through AB-1 to fund individualized services for 327 children in the child welfare system will be a great help if it is not a victim of funding cuts to balance the budget. There are ways in which the funding within the current system could be used more effectively but this can only happen if the state level Departments and Divisions with support from the State Legislature work together to form a less fragmented system that is flexible to meet the needs of children and families. There is a description of multiple other ways to help provide services and supports for children in the supplement to this report. Members of the

Clark County Mental Health Consortium are working to secure this support for children and families.

Projections and Costs of Implementing Recommendations. The figure below shows the costs of providing the recommended mental health services for the children in the public systems. The first column shows the unmet need. The second shows the potential savings by providing community based alternatives to highly restrictive residential care. The third column shows the new funding from the AB1 legislation that will address this need. The fourth column shows the amount of additional funding needed. The fifth column estimates the amount of this money that would be recaptured as federal participation in Medicaid. The sixth column shows the additional dollars need in state match for this Medicaid funding. And the final column shows the additional funds from state or county budgets required to meet the need. Note that the Medicaid match is not included in the last column.

Estimated Cost to Meet Need for Clark

	Unmet Need	Savings from ResCare	AB1	Remain Need	Federal Medicaid	State Medicaid Match	State/ County Funds
CPS	$1,908	$260	0	$1,649	$173	$173	$1,302
DCFS	$6,456	$2,282	$4,092	$82	$30	$30	$23
Probation	$8,874	$3,038	0	$5,836	$630	$630	$4,575
Parole	$976	$411	0	$565	$41	$41	$482

Reported in thousands of dollars

Figure 25

Goals for Behavioral Healthcare Services in Clark County

1. Develop a coordinated and integrated behavioral health system for children and families in Nevada that is seamless and easy to access. Build-on the strengths of local communities by implementing locally controlled systems of care.

2. Implement a system of services and supports that is customized to meet the needs of families not focused on agencies and providers. Provide early access to behavioral health services for children and families so families can raise their own children. Implement a consistent, collaborative and family-centered approach that provides consistent support and growth for Nevada children and families.

3. Support the development and expansion of human resources so that we can use the resources of our local communities and grow them to better meet the needs of our local children and families. Support families and staff to succeed by giving them information, education and support.

4. Expand consumer involvement at all levels of decision-making around services and supports for children and families. (See Supplement for more information on these goals.)

Legislative Action Steps

1. Provide DCFS in Clark County with the flexibility to expand targeted case management and other related programs between funding cycles to meet the needs of all eligible children identified by Medicaid. Encourage the Department of Human Resources to use Medicaid revenues and savings from reductions in residential care to fund the expansion. Provide a legislative letter of intent allowing the agency to submit such expansion requests to the Interim Finance Committee.

2. Continue the funding for the 327 SED children in foster care in need of behavioral healthcare services and expand the funding to include those additional children involved in Child Welfare (Level 2 and above on CALOCUS) identified by the Consortiums as underserved. (See Figure 25) Provide funding for services to all children involved in Juvenile Justice (Level 2 and above on the CALOCUS) who are underserved as identified by the Consortium. (See Figure 25).

3. Urge the Department of Human Resources to mandate consumer involvement in all of the interagency groups identified by the Consortium (see Supplement) and provide $25,000 in funding for participation (child care stipends and travel) by Clark County consumers.

4. If State revenues allow, consider funding through DCFS a 24-hour, 7-day/week family support hotline and mobile crisis services for Clark County.

State Department and Division Action Steps

1. Change the Medicaid program to expand the number of providers of direct services to children with behavioral healthcare needs by establishing specialty clinics that are designed to provide outpatient services as well as care coordination, family support and preventative services.

2. Facilitate access to Medicaid services through a single level of care determination that allows the child to obtain a flexible array of services based on the child's level of need.

4. Improve the standards for Medicaid providers of behavioral healthcare services and apply these standards across fee for service and managed care programs. At a minimum, require all providers to deliver services where the family needs them, using flexible

hours, using bilingual and bicultural staff, and providing one-stop service sites for a range of services.

5. Improve the cost effectiveness of behavioral healthcare services provided by public funding and reduce the over utilization of residential care through service delivery driven by a single plan of care and aggressively monitored by targeted case managers who are available to all severely emotionally disturbed children receiving public assistance.

6. Expand targeted case management programs in DCFS to provide the aggressive monitoring, plan of care development and coordination of services required by Medicaid to achieve the goals noted in #4.

7. Reorganize state budgets to unify funding streams for behavioral healthcare services that can be locally monitored and controlled by collaborative bodies such as the Consortium.

8. Maintain funding and support for a system of neighborhood based, multi-agency, integrated service sites for the provision of mental health, child welfare, juvenile justice and substance abuse services and support for a management structure to oversee such a system.

9. Expand the Medicaid program to cover family-to-family support services and mobile crisis services and adopt rate-setting methodologies to incentivise providers to develop these services.

10. Encourage Medicaid, MHDS, and DCFS and County agencies to develop coordinated management information systems to track behavioral healthcare utilization, outcomes and spending patterns.

11. Recommend that MHDS, DCFS, Clark County and Medicaid collaborate to develop an integrated program to serve youth through age 21 and focus these efforts toward developing a comprehensive and integrated plan to support youth in the child welfare and juvenile justice systems in their transition from childhood to adulthood.

12. Provide the same service array for children enrolled in Nevada Checkup as is provided for Medicaid eligible children. Ensure children with behavioral healthcare needs have early access to services under both the managed care and fee for service plans.

13. Ensure participation of the Clark County Consortium in allocating discretionary funding administered by the Department of Human Resources for preventative and early intervention services for vulnerable children.

14. Recommend that the Department of Human Resources adopt the goals of the Clark County Consortium as its vision for children's services in Nevada (see Supplement).

Community Action Steps

1. Create common geographical service areas across public agencies in Clark County and develop integrated service sites that are convenient for families. Use the Consortium to develop other coordinating mechanisms between public agencies, community organizations and families.

2. Establish interagency protocols to implement a universal, family-friendly process for intake, assessment and information sharing so that consortium agencies use a common assessment tool, intake form and universal authorization for information release.

3. Develop a written brochure of how to recognize the early signs of emotional disturbance in children and how to access behavioral healthcare services in Clark County.

4. Commit as agency members of the Consortium of offer flexible hours for services to better meet families needs.

5. Work together as a Consortium to identify funding for mobile crisis teams and a 24-hour, 7-day/week hot line that can provide support to families and foster caregivers and reduce the need for out-of-home care.

6. Develop a collaborative plan for active recruitment, training and retention of bi-lingual and culturally diverse staff of agencies represented on the Consortium.

7. Coordinate resources to provide mandatory and regular cross training to the staff of agencies represented on the Consortium and to the staff of other Clark County child serving organizations in the following areas: (1) goals and services of each organization and/or provider; (2) how to recognize the early signs of emotional and substance abuse problems in children; (3) how to access behavioral healthcare services for children; and (4) how to partner with parents in all aspects of service delivery.

Supplement to the Clark County Consortium Annual Plan
Table of Contents

Development of the Consortium

NRS 433B.333 (commonly referred to as AB-1) established Mental Health Consortia in each of three jurisdictions in Nevada. These Mental Health Consortia cover Clark County, Washoe County, and the rest of the state (Rural Jurisdiction). The functions of the Mental Health Consortia are to: assess the need for behavioral health (mental health and substance abuse) services for children in the jurisdiction, assess how well the current system is meeting this need, develop an annual plan on how the need can be better met, and report this information to the Legislative Committee on Children and Youth on a regular basis. The Mental Health Consortium for the Clark County Jurisdiction was formed in January 2002 and met seven times from January through June 14, 2002. The Consortium organized into three work groups to do the initial work of the Consortium and these workgroups met a total of 17 times during the period.

The Clark County Jurisdiction Mental Health Consortium had one organizational meeting to review the goals of AB-1 and to set goals for the Consortium in January 2002. Additional members were recruited and the Consortium began work in February 2002. It was decided to develop the first annual plan by June 15, 2002 so that it could be submitted in time for the next legislative session. The membership of the Clark County Mental Health Consortium are:

Name	Representing	Office
Deanne Blazzard	Foster Care and adoption Association	
Maria Canfield	Bureau of Alcohol and Drug Abuse	
Tom Criste	Nevada Youth Care Providers	
Adrienne Cox	Clark County Dept of Juvenile Justice Services	
Fernando Guzman	District Court	
Jane Horner	Grandparents as Parents	
Susan Klein-Rothschild	Clark County Dept of Family Services	
Kathryn Landreth	Las Vegas Police Department	Chair
Linda Ley	Court Appointed Special Advocate	
Hilary Westrom	Children’s Advocacy Alliance	
Fran Marshall	Andre Agassi Charitable Foundation	
Juanita Matz	Parent of SED Child	
Kathey Maxfield	Community Representative	
Patty Miller	HCFA and Medicaid Policy	
Christa Peterson	Division of Child and Family Services	Secretary
Brad Reitz	Clark County Schools	
Jessica Reyes	Youth Representative	
Karen Taycher	Nevada Parents Encouraging Parents	Vice Chair
Betty Turner	Clark County Housing Authority	

The Consortium decided to organize into three workgroups to accomplish the initial tasks outlined by the legislature through AB-1. The members of the Consortium committed to monthly meetings for the first six months with additional work groups meetings each month to accomplish the work defined by the AB-1 legislation The first work group is the executive committee who recruited membership, developed by-laws, implemented a process for electing officers, and are developing plans to communicate and collaborate with other collaborative groups within the jurisdiction.

The second work group was tasked with developing the plan to implement the phase-in of the mental health services (commonly called the SED initiative) funded through AB-1. This has included developing a plan for prioritizing children to receive initial and phase-in services, developing a service process model, coordinating training for staff, and developing a plan to evaluate the impact of the services.

The third work coordinated the efforts to gather the information needed for the annual plan. This began by developing an evaluation and assessment plan. Focus groups with staff and family representatives identified important issues for the assessment. The work group identified a process and strategy for screening children and youth within the public systems (child welfare and juvenile justice) to determine their need for mental health services and supports. A process was developed to assess the need for children who are covered by public health insurance, and surveys were developed to elicit information, perceptions, and priorities from a diverse groups of individuals within the jurisdiction.

The Mental Health Consortium held discussions during the first two meetings about their roles and how they wanted to go about developing the annual plan. Clearly this was a large and important task. It was also one added to the full time jobs of all consortium members with no release from other duties. Consortium members prioritized their work based on these factors and identified and completed the following steps to develop the first annual plan and report.

1. The Mental Health Consortium reviewed the requirements of the legislation for the annual plan and report.

2. The Mental Health Consortium discussed the importance of considering the behavioral health (both mental health and substance abuse) needs of all of the children and their families in the jurisdiction.

3. The Mental Health Consortium decided that in the first year the annual plan would focus on children with public insurance (Medicaid and Nevada Check-Up) and those within the child welfare, juvenile justice, and public mental health systems. The Mental Health Consortium knew that there is a great need outside those systems and are committed to addressing this more fully in the second annual report and plan.

4. The Mental Health Consortium gathered information on children with public insurance.

5. The Mental Health Consortium screened children within the child welfare and juvenile parole systems to determine their need for mental health services and the current level of that service.

6. The Mental Health Consortium did focus groups and surveys with parents, youth, provider staff, and managers to determine need and to evaluate the current system.

7. The Mental Health Consortium used the information the gathered to quantify the amount and types of need.

8. The Mental Health Consortium used the data the gathered to evaluate how well the current system is meeting that need.

9. The Mental Health Consortium assessed how the structure and process of the current system impacts access, utilization, impact, and cost benefit of the services provided.

10. The Mental Health Consortium identified ways to increase funding and resources.

11. The Mental Health Consortium developed a set of recommendations for what can be done at the local level, the help needed from State Departments and Divisions, and from the Nevada Legislature.

Relationship to Other Collaborative Efforts

The Mental Health Consortium is only one of several collaborative bodies within the community who are working to coordinate and improve services for children with multi-agency needs. To avoid duplication and fragmentation each of these bodies must know about the work of the others and they should be combined or have specific communication processes so that work and plans are coordinated. This process began with a community assessment of other collaborative bodies. The first workgroup developed a list of other groups and presented this to the Consortium. The list was expanded and the work group determined the membership and functions of each of the other groups. This was followed by the development of a cross walk that shows the overlap of these groups by primary function. Common members were identified and they began to report on the activities of the other groups to the Consortium and of the Consortium to the other groups. It was noted that some of the groups are working on overlapping plans and one of the recommendations from the Consortium to the Legislative Committee and the State Departments and Divisions is that the work of these groups should be coordinated and where possible combined.

Children's Block Grant Commission

Title XX, funds private non-profit social services agencies that support economic self-sufficiency, prevent dependency and assist children to prevent from abuse and neglect. Provides funding for direct services as well as technical assistance. Under the provisions of Title XX of the Social Security Act, states are awarded block grants to fund qualifying social service programs. The Social Services Block Grant is designed to enable each state to furnish social services best suited to the needs of the individuals residing in the state. In fiscal year 2002, 26 nonprofit organizations, 3 county entities and 4 State divisions within the Nevada Department of Human Resources were funded to provide community-based services. Funding for the non-state Title XX allocation is awarded on a competitive basis for a two-year period. The Department of Human Resources' Block Grant Commission is responsible for reviewing applications for non-state Title XX funding and providing the Department with funding recommendations.

Children's Justice Task Force

Nevada Children's Justice Association State Task Force Is funded by a federal grant: Children's Justice Act Grants to States Under the Child Abuse Prevention and Treatment Act, as amended. The mission is to review and evaluate and make recommendations that improve the investigative, administrative and judicial handling of child abuse cases and to support and promote related activities. The goals are to promote:

- Improvement of the investigative, administrative and judicial handling of child abuse and neglect cases;
- Development of experiential, model and demonstration programs; and
- Reformation of state laws ordinances, regulations, protocols and investigative procedures to provide protection of children from abuse, while insuring fairness to all affected persons.

Statewide there are twenty multidisciplinary members who are professionals with knowledge and experience related to the criminal justice system and issues of child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment related fatalities.

Children's Trust Fund

Committee for the Protection of Children. Funds programs in the area of preventing child abuse and neglect throughout the state.

Consortiums (North, South, and Rural)

NRS 433B establishes a consortium in each region whose population is 1000,000 or more; and in the region consisting of all counties whose population is less than 100,000. A consortium has been created for Washoe County and one for the Rural Region. Their duties are stated in NRS 433B and include (1) reporting to the Legislative Committee on Children, Youth and Families; and (2) developing an annual plan for the provisions of mental health services to emotionally disturbed children in the jurisdiction of the consortium. The Washoe County Consortium has the same required membership as the Clark County Consortium; the Rural Consortium's required membership is very similar. Both groups have expanded their memberships from those required by NRS 433B.

Disabilities Task Force – SB513

In order to address the needs of all people with disabilities across Nevada, a Disability Task Force was created by the passage of Assembly Bill (AB) 513 during the 2001 Nevada Legislative Session. Funds were allocated by this bill to develop long-term strategic plans for four areas of concern including:

1. *services and supports for senior citizens,*
2. *rural health care services,*
3. *provider rates issues and,*
4. *services and supports for persons with disabilities including those with autism.*

A steering committee was formed to address all four of the above issues by providing coordination and information sharing with:

1. *The Department of Human Resoruces Director, Michael Willden*
2. *Legislative Interim Study Committee on Disabilities, Nevada Senator Dina Titus, Chair*
3. *Task Force for the Fund for a Healthy Nevada*
4. *Legislative Interim Committee on Health Care, Nevada Senator Ray Rawson*

The Disability Task Force considers services and supports for children and adults, including seniors. Many of the services and supports for adults with disabilities are similar to the needs of some seniors.

The chairman for the Disabilities Task Force is *Brian Lahren, Ph.D., Executive Director, Washoe ARC.* The Disabilities Task Force is divided into two major subcommittees, one for children and one for adults. Further subcommittees were set up to address children and adult issues. Members of the disability committee and its subcommittees provide unique knowledge of disability issues in Nevada. With input from Nevadans with disabilities, a strategic plan will be developed to ensure the availability and accessibility of a continuum of services for persons with disabilities so that they may lead active and independent lives within their community.

All Task Force committee meetings provide opportunities for public comment. You can appear before a committee in person or provide your input via mail or email. If you would like to attend or follow the task force meetings of the Strategic Health Care Plan (AB 513), please check the on-line calendar for dates, agendas and minutes at *www.hr.state.nv.us.shcp/shcp.htm.*

Juvenile Justice Commission Work Study Group

The Nevada Juvenile Justice Commission was created pursuant to the federal Juvenile Justice and Delinquency Prevention Act (JJDPA) of 1974, codified at 42 U.S.C. 5633. It operates under the auspices of a 1994 Executive Order of the Governor or the State of Nevada and is staffed by employees of the Division of Child and Family Services in the Department of Human Resources in Carson City. The federal Act is particularly concerned with four "core requirements": (1) De-institutionalization of status offenders; (2) sight and sound separation for accused and adjudicated juvenile offenders from incarcerated adults; (3) jail and lockup removal from adult jails for detained juveniles; and (4) disproportionate minority confinement (DMC) – requiring that states determine whether minorities are over-represented in confinement and if so, that demonstrable efforts are made to reduce the situation. A final requirement is the Native American pass-through to tribal entities to address juvenile programs.

As a State Advisory Group under the JJDPA, the Commission serves to advise the Governor and other State policy makers on juvenile justice delinquency and prevention matters and to make recommendations concerning the expenditure of certain federal funds. The federal grant programs the Commission oversees include the following: Formula Subgrant distributed to counties to promote compliance with the core requirements of the JJDPA discussed above; Title V grants for prevention programs; Enforcing Underage Drinking Laws subgrants; Juvenile

Accountability Incentive Block Grants to implement accountability based programs, including support for drug courts, restitution programs, substance abuse treatment programs and gender specific programs; Challenge Grants for projects where funding is otherwise limited, including mental health care and intensive aftercare programs.

Members of the Commission are appointed by the Governor to four-year terms which may be renewed. There are currently 25 members from throughout the State, who represent diverse backgrounds, including law enforcement, business, education, juvenile justice, the legal system and Native Americans. There are also several youth members, including the current chair, Nicole Young, a 20-year-old student at University of Nevada at Reno.

The Work Study Group (WSG) of the Nevada Juvenile Justice Commission is composed of members and non-members of the Commission who have particular expertise in juvenile justice matters. They represent rural and urban Nevada and include juvenile and family court judges, juvenile justice program administrators and State officials. The WSG takes its direction from the Juvenile Justice Commission, usually an assignment to study a specific issue. Most recently, it prepared a top to bottom assessment of Nevada's current juvenile justice system and outlined areas of greatest need. Mental health and substance abuse treatment were at the top of the list in the recent WSG report which the Commission forwarded to the Office of the Governor.

Medicaid Managed Care Workgroup

The Managed Care Workgroup was created in 2001 by the DCFS Administrator to look at strategies for managing higher levels of care provided to foster children by DCFS. Carl Valentine was retained as a consultant and facilitator. Membership included representatives of DCFS, representatives of the Mental Health Planning Advisory Council, Nevada's Health Care, Financing and Policy Division, Washoe and Clark Counties and Nevada PEP. Jerry Clark was the DCFS staff person in charge. The outcome of the workgroup was the Level of Care Program Reform Proposal.

Medicaid Task Force to Develop Standardized Components/Formats for Assessment Plans

The subcommittee is tasked with developing standardization in clinical documentation and establishing criteria for various levels of care currently being reimbursed under mental health rehabilitation services. This includes admission, discharge, length of stay and exclusionary criteria.

Mental Health Commission

The commission on Mental Health and Developmental Services is a legislatively created body designed to provide policy guidance to the mental health, mental retardation, and related conditions facilities for adults and children administered by state agencies in Nevada through the Division of Child and Family Services (DCFS). It is also designed to promote client rights for all clients of such treatment facilities.

Mandate	Established: NRS 232.303 Duties/powers: NRS 433.314, NRS 433.316
Chair	Fran Brown, MSN, MSEd, RN Community College of Southern Nevada 702-651-5683

Mental Health Commission Advisory Group (North and South)

The MHDS Commission has created advisory boards in Washoe and Clark Counties and makes appointments to these boards from stakeholders in the community. The boards serve to provide information to the Commission regarding service needs, public input, and other issues pertaining to mental health.

Mandate	MHDS Commission
Northern Chair	Henry Watanabe, M.D. UNR Department of Psychiatry 775-784-4917
Southern Chair	Janyce Benson New Horizons Academy 702-876-1181

Mental Health Planning and Advisory Council

Public Law 102-321 is designed to assist states to establish, implement, and expand an organized, community-based system of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Federal block grant funds are provided under this law to enable states to meet this goal through the Center for Mental Health Services (CMHS), which is an agency of the Substance Abuse and Mental Health Services Administration (SAMHSA). Additionally, this law mandates that stakeholders, including mental health consumers, their family members, and parents of children with SED must be involved in mental health planning efforts related to the block grant through membership in planning advisory councils (PACs). To this end, the State of Nevada Mental Health Planning Advisory Council (MHPAC) was established in 1989. PACs have three federally mandated duties:

- To review the Mental Health Block Grant Plan and to make recommendations.
- To serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses.
- To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

Federal Law -	Public Law 99-660 (1986) Public Law 101-639 Public Law 102-321
Chair	Alyce Thomas-Thrash, MSW, MSEd Mental Health Association of Southern Nevada 702-822-2739

Southern Nevada Coalition for Mental Health (formerly Southern Nevada Sheriff's Task Group)

Sheriff Keller formed the Sheriff's Task Force on Mental Health in March of 2001 to address the needs of the acutely mentally ill in Southern Nevada who were coming into contact with local law enforcement. As the definition of unmet needs for mental health consumers expanded beyond the criminal justice system, the task force took on greater membership and eventually changed its name to the Southern Nevada Coalition for Mental Health.

Participants number over 60, and include representatives of diverse government, nonprofit, medical agencies along with academic faculty and advocacy groups. Representatives from most local police forces and correctional facilities regularly participate. In addition, representatives of area hospitals, the State mental health agencies, private service providers and ambulance companies participate. State, local and county governments are also represented. NAMI of Nevada participates as do a number of mental health consumers and mental health advocates. Other participants include local charitable organizations who respond to the needs of the indigent and UNLV faculty who have expertise in issues relating to mental illness and homelessness.

The goals of the Coalition include the following:

- Improving law enforcement and criminal justice system response to the acutely mentally ill both in the community and within correctional facilities
- Improving access to mental health services for all consumers, including emergency care, residential treatment and case management
- Creation of a crisis triage center to address the needs of the acutely mentally ill and those individuals with dual diagnosis in need of attention
- Improving community outreach to individuals in need of mental health services who are not currently being served

Title IV-B, Subpart II, Promoting Safe and Stable Families Steering Committee

Structure: The Family Preservation and Support Act (1993) created new federal legislation which provided funding for five (5) years to strengthen, reform and better coordinate state service delivery systems. Federal dollars were made available in 1994 to develop five-year plans. During the first year, FY 1995-96, DCFS and the Steering Committee conducted an extensive needs assessment and planning process (which included a provider survey, the results of community I, and an evaluation of the CPS system) to write the five-year plan. In the second year, FY 1996-1997, the Steering Committee provided funding, oversight and technical assistance to three (3) community-based consortia located in northern, southern and rural Nevada as they implemented regional needs assessments. During the third year of funding, FY 1997-1998, the Committee continued to guide the community consortia as they performed the following activities: capacity-building, direct service implementation designed to preserve and support families while developing an improved child welfare service delivery system, process evaluation, identification of benchmarks, and development of outcomes to be measured.

In 1998, Title IV-B was reauthorized to include these changes: 1) the name change from Family Preservation and Support Program to Promoting Safe and Stable Families, 2) fund allocation to "direct services" in four (4) program areas, and 3) exclusion of "planning and coordination" from the definition of direct services. Of the funding block for each state, 20% of the total must be allocated to each of the following four (4) program areas: 1) 20% for Family Support (Prevention and Support Services); 2) 20% for Family Preservation; 3) 20% for Time-Limited Reunification Services; and 4) 20% for Adoption Promotion and Support Services. Changes in Title IV-B tie in to other federal changes, which limit children's time in foster care to no more than twelve (12) months or no more than fifteen (15) of the last twenty-two (22) months. As a consequence, the consortia infrastructure is no longer funded. Title IV-B funds are now directed to direct services programs across the state focusing on the required program areas (listed above).

While the Division of Child and Family Services is responsible for the administration of Nevada's Title IV-B program, planning is guided by the statewide Title IV-B Steering Committee. The Nevada Title IV-B Steering Committee is the advisory body for the Nevada Promoting Safe and Stable Families Program. (previously, the Family Preservation and Support Act). The purpose of the Committee is to provide advice and make recommendations to the Division of Child and Family Services regarding child welfare programs and services. Members of the Steering Committee serve as proposal reviewers during the grant funding process. The Evaluation Subcommittee reviews the evaluation results (as provided by the contract evaluators) and makes recommendations for future grant funding based on the results.

The Title IV-B Steering Committee has met quarterly for more than six (6) years (since September 1994) to work together to define and address the needs of children and families in Nevada. Committee members and the coordinator have been involved in Title IV-B planning and implementation since its inception and actively support other family and child services initiatives in Nevada. There are currently thirteen (13) Steering Committee members who represent state and county agencies, organizations and initiatives serving children and families. Specifically, Committee membership includes representatives of the following agencies, initiatives, or entities: 1) Family Resource Centers (FRCs); 2) State and County CPS; 3) Bureau of Indian Affairs (BIA); 4) Nevada State Welfare (TANF); 5) Nevada Maternal and Child Health (MCH); 6) Family Voices; 7) Nevada P.E.P.; 8) Citizens for Disability Rights and Education (C.A.D.R.E.); 9) Foster Parents of Southern Nevada; and 10) one individual who is both a foster and an adoptive parent. Five (5) DCFS program specialists also staff the Committee.

Title IV-B, Subpart II Promoting Safe and Stable Families Was reauthorized in 1998 to allocate federal funds for direct services in four (4) program areas. Of the funding block 20% of the total must be allocated to each of the 4 program areas: 1) Family Prevention and Support Services; 2) Family Preservation; 3) Time-limited Reunification Services; and Adoption Promotion and Support Services. While the Division of Child and Family Services (DCFS) is responsible for administration of Nevada's Title IV-B program, planning is guided by a statewide Title IV-B Steering Committee. The purpose of the committee is to advise and make recommendations to DCFS regarding child welfare programs and services. Members of the Steering Committee serve as reviewers during the grant funding process. The evaluation subcommittee reviews the evaluation results from the contract evaluators and makes recommendations for future grant funding based on the results. There are currently thirteen (13) steering committee members who represent state and county agencies, organizations and initiatives serving children and families.

	Area of Concern	Needs Assessment	Planning	Policy Recommends	Policy and Regs Authority	Evaluation	Advocacy	Funding Recommends	Service Coordination
1. Children's Block Grant Commission	Poor families & children at risk of abuse/neglect							X	
2. Children's Justice Task Force	Child Abuse & Neglect	X	X	X		X			X
3. Children's Trust Fund	Child Abuse & Neglect							X	
4. Consortiums (North, South and Rural)	Mental Health	X	X					X	
5. Disabilities Task Force SB513	Rural Health, Developmental Disabilities, Seniors		X	X					
6. Juvenile Justice Commission Work Study Group	Juvenile Justice	X	X	X				X	
7. Medicaid Managed Care Work Group	Mental Health		X	X					X
8. Medicaid Task Force	Develop Standardized Components/Formats		X	X					X
9. Mental Health Commission	Mental Health		X		X	X			
10. Mental Health Commission Advisory Group	Mental Health	X					X		
11. Mental Health Planning and Advisory Council	Mental Health		X					X	
12. Southern Nevada Coalition for Mental Health	Mental Health						X		X
13. Title IV-B Steering Committee	Child Abuse and Neglect		X					X	

Assessment and Findings of Need

Purposes and Priorities of the Assessment. As consortia members began to discuss the initial annual plan it became clear that there was a need to gather information to define the current status of mental health services for children in the jurisdiction. The first step was to review the requirements for the assessment in the enabling legislation for the Mental Health Consortium. This called for:

- an assessment of the need for mental health services in the jurisdiction of the Consortium;
- a description of the types of services to be offered to emotionally disturbed children based on the amount of money available to pay the costs of such mental health services within the jurisdiction of the Consortium;
- criteria for eligibility for those services;
- a description of the manner in which those services may be obtained by eligible children;
- the manner in which the costs for those services will be allocated;
- the mechanisms to manage the money provided for those services;
- documentation of the number of emotionally disturbed children who are not currently being provided services,
- the costs to provide services to those children,
- the obstacles to providing services to those children and recommendations for removing those obstacles;
- methods for obtaining additional money and services for emotionally disturbed children from private and public entities; and
- the manner in which family members of eligible children and other persons may be involved in the treatment of the children.

The Mental Health Consortium saw their responsibility for the mental health needs of all children in the jurisdiction but the first priority was to children that were involved with state and county public systems. The annual report work group conducted an assessment of the child welfare, juvenile justice and education programs within the jurisdiction and determined that there was currently no common way to determine need for behavioral health services. This assessment also showed that none of the agencies monitored the need for mental health services in any systematic way, and that clearly there was a very large unmet need for behavioral health services and supports for children in systems. As the process to develop the first annual plan for the Mental Health Consortia began, the need of these children was not known. Although the Mental Health Consortium has a high priority to address the mental health needs of all children and their families within the jurisdiction, it was decided to focus on the children in the public systems for the first year. The primary responsibility of the public system is for children who are in the custody of the state or are receiving services through state funded programs. This includes children in the child welfare and juvenile justice systems, children receiving services through the public mental health system, and children and their families covered by public health insurance (Medicaid and Nevada Check-Up).

Questions and General Process for Determining Need. The first step in the process of developing the assessment plan was to clarify the questions to be answered. The first set of questions related to the need for mental health services. These asked which children need mental health services, what services do they need, what do their families need, and what are the characteristics of these services that make them accessible, useful, and effective for the children and families?

Who are the children who need mental health services and support? The first question was to determine which children need behavioral health services (mental health and substance abuse). The work group decided to focus on two concurrent strategies to get this overall information. The first was to look at the children of the jurisdiction who are covered by public insurance (Medicaid and Nevada Check-Up) and to use population estimation strategies to determine the expected level of need for services and supports for these children. The second was to directly assess the need for services of children and youth in the child welfare and juvenile justice systems through a screening process. Through these two strategies the work group was able to specify who and how many children within these groups need behavioral health services.

What services and supports do they need? The second step was to determine what services these children and youth need. Three concurrent strategies were proposed to address this question. The population estimation studies that served as the basis for projecting how many children need services also project the levels and types of services to be expected. The screening tool (CALOCUS) used to identify children and youth with mental health needs is a level of care determination tool and was specifically developed to identify the level of needed service for each of the children and youth screened. The third strategy was to survey youth, families, providers, and managers within the jurisdiction and ask them to identify and prioritize the services that are most important to support children with behavioral health needs. Through these surveys respondents were also asked to identify the characteristics of services and supports that are important to facilitate access, utilization and effectiveness of the services and supports.

What services and supports do parents need to be able to raise their own special needs children successfully? A primary goal of services for children is to help parents and other family members to support their own children. Families have the most impact on the development and safety of children and are the long term support system for most children and youth. An effective system provides supports to keep children out of public care by supporting parents and other family members. Through the surveys youth, families, providers, and managers within the jurisdiction were asked to identify and prioritize the services and supports that are most important to help parents and other family members support children with behavioral health needs. Through these surveys respondents were also asked to identify the characteristics of services and supports that are important to facilitate access, utilization and effectiveness of the services and supports.

Assessment of Need Using Population Estimation. The first method used to determine need was to use population estimation of the children covered by Medicaid. The first step in this process was to determine the current population demographics of children in the jurisdiction. Data was obtained from the 2000 US census with the 2001 growth estimators. Figure 1 shows the data for Clark County and the State of Nevada. This data provides a one-shot look at the number of children in the various public programs in Clark County.

Children in Clark County

Total Number of Children (<18)	374,951
Children in Poverty (100%)	61,492
Child Welfare (non custodial)	1491
County Child Welfare	502
Custodial Child Welfare	1608
Juvenile Probation	2800
Juvenile Parole	505

Figure 1

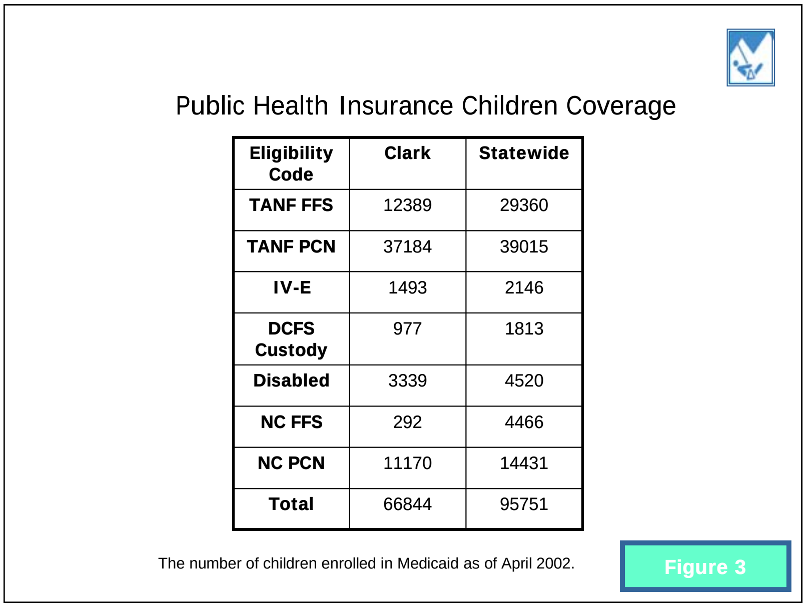
Figure 2 shows the race of these children. The data in figures one and two will be used in later sections of the assessment to compare population data to the number of children enrolled in public systems and receiving public insurance.

Overall Race of Children

	Clark	Nevada
Caucasian	60.2%	65.2%
Hispanic	22.0%	19.7%
African American	9.1%	6.8%
American Indian	0.8%	1.3%
Asian / Hawaiian	5.8%	4.9%

Figure 2

Nevada has four separate public insurance programs for children. These are fee for service Medicaid, fee for service Nevada Check-up (CHIP Program), managed care Medicaid and managed care fee for service. The benefits, providers, and payment systems are different for each of these programs. For this reason the estimation analysis was done for each of the four groups separately. In addition there are additional eligibility (AID) codes that determine eligibility for Medicaid or Nevada Check-Up. Figure 3 shows the number of children covered by each of these programs In Clark County and Statewide.



Public Health Insurance Children Coverage

Eligibility Code	Clark	Statewide
TANF FFS	12389	29360
TANF PCN	37184	39015
IV-E	1493	2146
DCFS Custody	977	1813
Disabled	3339	4520
NC FFS	292	4466
NC PCN	11170	14431
Total	66844	95751

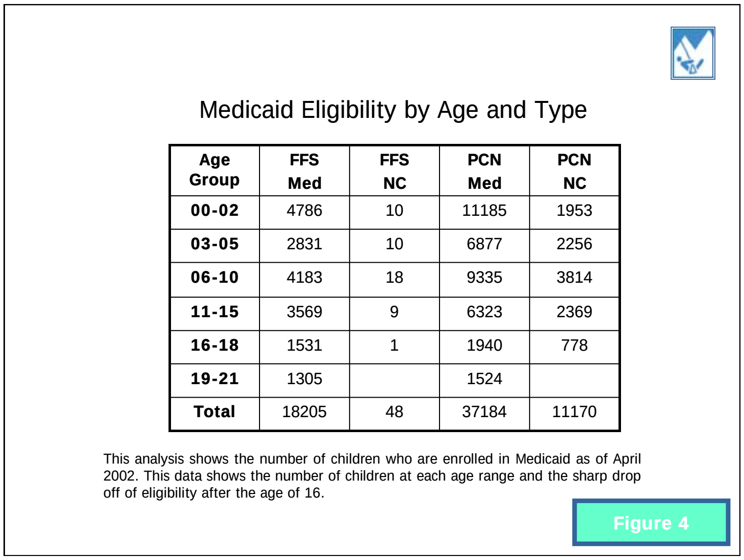
The number of children enrolled in Medicaid as of April 2002.

Figure 3

It is important to separate these different eligibility codes to understand how the benefits become fragmented for children and families. The first two codes in Figure 3 are TANF FFS and TANF PCN. These categories represent the children and families that become eligible for Medicaid related to the Temporary Assistance to Needy Families program. The fee-for-service (FFS) program is primarily for children in the rural parts of the state and the managed care (PCN) program is for children in the two urban counties). As the financial status of the family changes children and families may lose their public insurance. This may be replaced by private insurance through a new job or the family may become uninsured depending on the type of income the family has received. The benefits and providers in the public sector are often different from those providing Medicaid services. The Nevada Check-Up program is for children and families who earn too much money to be eligible for Medicaid but who are still uninsured. The mental health benefit is significantly less than for Medicaid and excludes most mental health services. Thus as a child moves from one Medicaid program to another, even with no change in need for mental health services, the services he or she receives can change dramatically.

The IV-E eligibility is for children in poverty who are in foster care. Once these children leave foster care and return to family they might transfer back to TANF eligibility or may no longer be eligible. The DCFS custody category is for children who are in the care of the state but who are not financially eligible for Medicaid. When they leave state custody they will lose their public insurance. This often means that while in custody a child receives services but as he or she transitions back into the home environment services are lost. This set of conditions results in children staying in custody or restrictive residential facilities for longer than they might other wise need to avoid losing services. The disability code is for children with significant physical and developmental disabilities. Some states use this code for children with severe emotional disorders but this rarely occurs in Nevada.

Figure 4 shows the number of children enrolled in public insurance programs in Clark County by age and eligibility code. The data show that there are about there are almost 18,000 children aged 0 through 2 enrolled or about 6000 at each year. For 3- through 5-year-olds this drops to 4000, for 6- to 10-year-olds it drops to 3500, for 11- through 15-year-olds it drops to 2500, for 16- through 18-year-olds it drops to 1300 and for 19- to 21-year-olds it decreases to 943. This is important because transition out of foster care and into adult hood are some of the highest risk times and many of these youth and young adults end up in highly restrictive behavioral health or detention facilities.



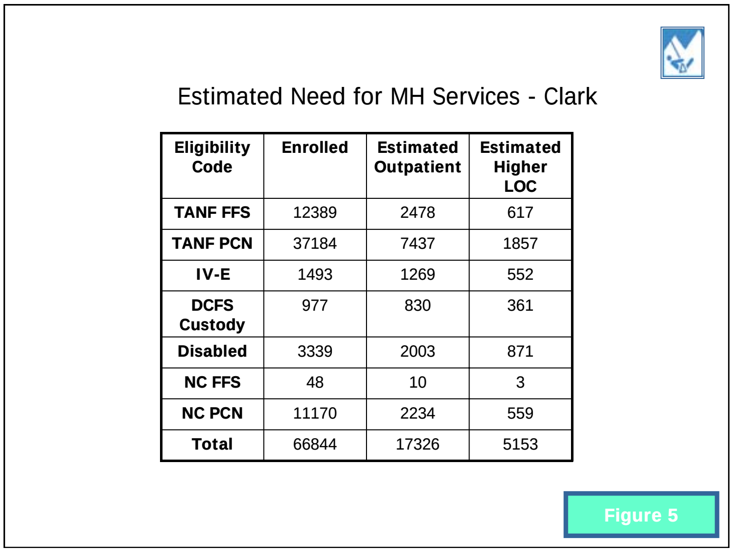
Medicaid Eligibility by Age and Type

Age Group	FFS Med	FFS NC	PCN Med	PCN NC
00-02	4786	10	11185	1953
03-05	2831	10	6877	2256
06-10	4183	18	9335	3814
11-15	3569	9	6323	2369
16-18	1531	1	1940	778
19-21	1305		1524	
Total	18205	48	37184	11170

This analysis shows the number of children who are enrolled in Medicaid as of April 2002. This data shows the number of children at each age range and the sharp drop off of eligibility after the age of 16.

Figure 4

Using estimation methodology reported by SAMHSA the number of children who should need behavioral health services were estimated from these totals. Through this methodology risk factors and demographics of the children are compared to population samples in which the amount of needed mental health services has been determined by taking samples of children and assessing the need of individual children. Figure 5 shows this estimation for children in the public insurance system in Clark County.



Estimated Need for MH Services - Clark

Eligibility Code	Enrolled	Estimated Outpatient	Estimated Higher LOC
TANF FFS	12389	2478	617
TANF PCN	37184	7437	1857
IV-E	1493	1269	552
DCFS Custody	977	830	361
Disabled	3339	2003	871
NC FFS	48	10	3
NC PCN	11170	2234	559
Total	66844	17326	5153

Figure 5

The data in Figure 5 show that at any point in time about 17,326 children and youth in the Clark County jurisdiction are in need of behavioral health services and of these 5153 need coordinated and individualized services and supports at a Level III or above. At these levels services become more complex and more coordinated. The use of case management begins at this level and the use of child and family teams to develop individualized services also begins. Figure 5 shows a break down of this need by eligibility code.

Assessment of Need Using Screening Methodology. The second assessment to determine the number of children needing behavioral health services was done by screening a large sample of the children who are in the child welfare and juvenile justice systems. This process began by determining which children to screen. It was decided to screen most of the children in the foster care system and a sample of the children in the juvenile parole systems. This decision was made for two reasons. The county child welfare, juvenile probation and juvenile parole systems were sampled to determine the need for behavioral health services because it is sufficient to sample the children in these programs. One of the goals of the assessment was to determine which children in the foster care population should be the first to receive the new services funded through AB-1. Thus screening most of these children allowed for the screening data to be used for prioritizing which children would get the services first. Based on this rationale 544 children were screened in the Clark County Jurisdiction. This included 373 children from DCFS, 21 from Clark County Child Protective Services, 89 from Clark County Juvenile Probation, and 61 from youth parole.

When a child or youth needs mental health services, there has been no standardized way to link the presenting symptoms to a needed level of care. This has been true even though state Medicaid plans, managed care financing, and numerous law suits all are based on a level of care determination. The American Academy of Child and Adolescent Psychiatry in collaboration with the American Association of Community Psychiatrists, developed the Child and Adolescent Level of Care Utilization System (CALOCUS) to address these needs. The underlying structure of the CALOCUS is derived from the Level of Care Utilization System for Adults (LOCUS) developed by the American Association of Community Psychiatrists. The CALOCUS differs from the LOCUS because it takes into account the importance of the parents and care giving support system for children and adolescents. It also has the ability to consider developmental disorders.

The CALOCUS links a clinical assessment with standardized levels of care. It measures clinical severity and service factors that have standardized anchor points. The CALOCUS dimensional rating system operationalizes the factors into six dimensions: risk of harm, functional status, co-morbidity, recovery environment, resiliency and treatment history, and acceptance and engagement.

The levels of the CALOCUS are organized in a unique way. The focus is on the level of resource intensity, which is more flexibly defined in order to meet the unique needs of each child, adolescent, and family. Each level of care is defined by a combination of service variables: residential facilities, clinical services, support services, crisis services, and prevention services. The levels contain many of the same elements and higher levels of care are defined in terms of how much support and how many resources a child and family may need not in terms of the restrictiveness of the services provided. In the CALOCUS there are seven levels of care:

Level 0: Basic Services: This is a basic package of prevention and health maintenance service that are available to everyone in the population being served, whether or not they need mental health care.

Level 1: Recovery Maintenance and Health Management. This level of service is usually reserved for those stepping down from higher levels of care who need minimal system involvement to maintain their current level of function or need brief intervention to return to their previous level of functioning. Examples of this level of service are children or adolescents who only need ongoing medication services for a chronic condition or brief crisis counseling.

Level 2: Outpatient services. This level of care most closely resembles traditional office based practice and requires limited use of community based services.

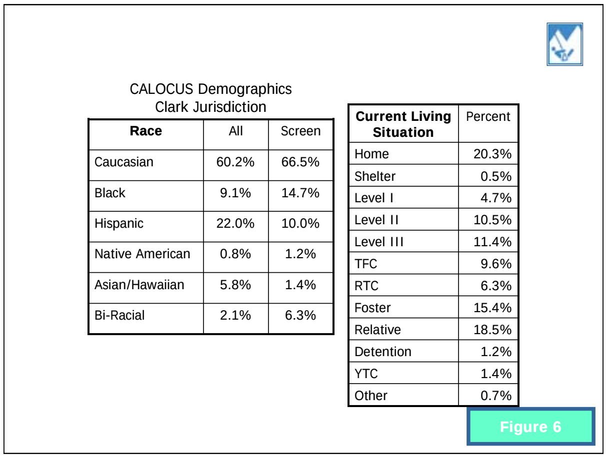
Level 3: Intensive Outpatient services. At this level services begin to become more complex and more coordinated. The use of case management begins at this level. The use of child and family teams to develop Individualized Services (wraparound) plans also begins, using mostly informal community supports such as church or self-help groups and “Big Brothers/Big Sisters.” This level requires more frequent contact between providers of care and the youth and his family as the severity of disturbance increases.

Level 4: Intensive Integrated Services Without 24-Hour Psychiatric Monitoring. This level of care requires increased intensity of services necessary for the “Multi-system, multi-problem: child or adolescent requiring more extensive collaboration between the increased number of providers and agencies. A more elaborate Wraparound plan is also required, using an increased number of informal supports. Additional supports may include respite, homemaking services or paid mentors. In more traditional systems, this level of service is often provided in a day treatment or a partial hospitalization setting. Active case management is essential at this level of care.

Level 5: Non-secure, 24 hour, services with psychiatric monitoring. Traditionally, this level of care is provided in group homes or other unlocked residential facilitate, but may be provided in foster care and even family homes if the level of wraparound services in the community is extraordinarily high. In either case, a complex array of services should be in place around the child and a higher level of care coordination is needed in order to manage the child’s multiple needs.

Level 6: Secure, 24-hour, services with psychiatric management. Most commonly, these services are provided in inpatient psychiatric settings or highly programmed residential facilities. If security needs could be met through the wraparound process, then this level of intensity of service could also be provided in a community setting. Case management remains essential to make sure that the time each child spends at this level of care is held to the minimum required for optimal care and that the transition to lower levels of care are smooth.

Testing of the CALOCUS in a variety of settings has been done to establish both the reliability and validity of the tool and process. These studies were funded in part by the Center for Mental Health Services[1]. The results of these studies indicate that the CALOCUS can be used reliably by psychiatrists and case manager level staff, even with brief training. The general trend is that subscale scores for child psychiatrists were more consistent, but the composite scores balance out the inconsistencies for the non-psychiatrists providing an extremely reliable summary score even for case workers with less extensive training.



CALOCUS Demographics
Clark Jurisdiction

Race	All	Screen
Caucasian	60.2%	66.5%
Black	9.1%	14.7%
Hispanic	22.0%	10.0%
Native American	0.8%	1.2%
Asian/Hawaiian	5.8%	1.4%
Bi-Racial	2.1%	6.3%

Current Living Situation	Percent
Home	20.3%
Shelter	0.5%
Level I	4.7%
Level II	10.5%
Level III	11.4%
TFC	9.6%
RTC	6.3%
Foster	15.4%
Relative	18.5%
Detention	1.2%
YTC	1.4%
Other	0.7%

Figure 6

Figure 6 shows the ethnicity and current living situation of the children screened. The table on the left shows the ethnicity of all children in the Rural Jurisdiction and compares that to the ethnicity of the children screened. The proportion of Hispanic and Native American children that become part of the child welfare system is much lower than the population numbers and this is reflected in the screening data. The column on the right shows the current living situation of the 544 children and youth. About 39% of the children are living at home or with a relative. The rest are in out of home placements and 29% of these are in higher levels of care.

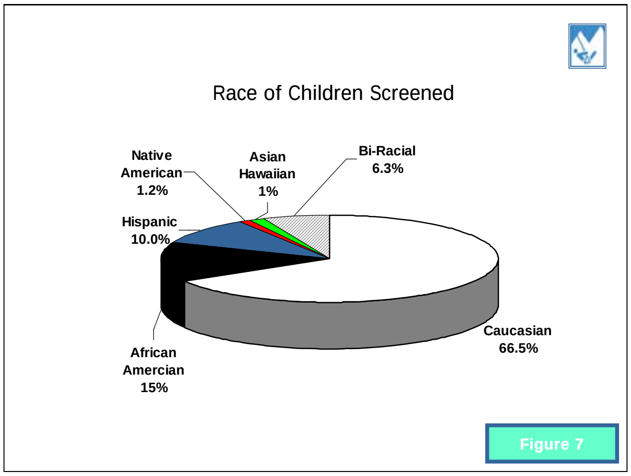


Figure 7

Figure 7 shows the data on the race of the children and youth in a pie chart format.

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[1] Fallon, T., Pumariega, A., et. Al. (2001) "Child and Adolescent Level of Care Utilization System for Psychiatric and Addiction Services". Report to the AACAP Council.

Figure 8 shows the results of the CALOCUS screening. The screening is scored in the seven levels of needed service and support. The first two levels (Levels zero and one) predict no need for behavioral health services. These children should get the kinds of supports and services offered to all children through their homes, schools, and community. Level Two shows a need for an out patient level of service. Level Three and above show a need for higher levels of care. Figure 9 shows the screening data by level and program. The data show that about one third of the children (32.5%) need no behavioral health services. The screening also found that 50% of the children and youth within the child welfare and juvenile justice systems need a higher level of care. This data is slightly higher than what would be estimated by the national estimation data. The reason for this becomes clear in the next section. The findings in that section show that most of the children who need behavioral health services do not get them when they need them. The services are provided only after the need reaches severe levels.

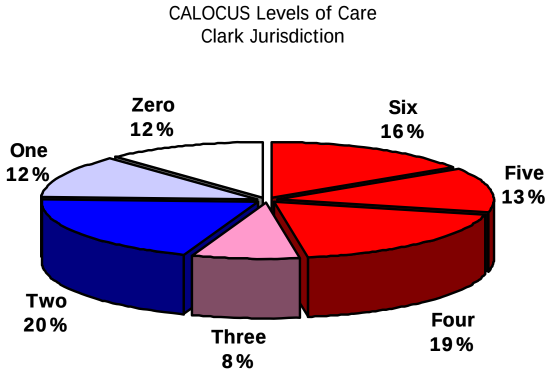


Figure 8

Levels of Care by System

	All	DCFS	CPS	Probation	Parole
Six	15.8%	11.5%	33.3%	21.3%	9.8%
Five	12.7%	7.5%	9.5%	18.0%	27.9%
Four	18.9%	20.6%	4.8%	10.1%	23.0%
Three	8.1%	3.5%	4.8%	16.9%	4.9%
Two	20.2%	10.2%	9.5%	11.2%	14.8%
One	12.3%	14.2%	28.6%	12.4%	13.1%

Figure 9

Assessment of the Types and Levels of Services Needed. The population estimation and CALOCUS assessment processes identified the level of need for service in terms of both the percentage of children and the level of service the children with public insurance and within the public systems need. These findings show that about 20% of the children in the public health insurance program and 67% of the children who are in the public child welfare and juvenile justice systems need some form of mental health services. They also show that of these children about half of the children who need services that are not in the public system need individualized and coordinated services and that about 50% of the children who need services after they have entered the system need this level of care.

The final assessment of need was done through a series of focus groups and a survey with families and staff. Figure 10 shows the numbers of people by role and system that completed the surveys. There were 10 youth, 35 parents and foster parents who completed the surveys. In addition, extended family members and friends were six of the others. The surveys came from staff in the schools, special education, mental health, juvenile justice, parent support and advocacy, health and substance abuse. The surveys came from case mangers, providers, supervisor, and managers.

Surveys Received

	Ed	Sp Ed	MH	CW	JJ	PSA	Other	All
Youth	2	0	0	5	1	0	2	10
Parent	7	2	4	13	6	2	1	35
Case Mgr	1	1	9	16	5	0	2	34
Provider	11	12	19	13	17	5	7	84
Sup Mgr	15	7	5	5	11	2	6	51
Other	1	2	2	3	2	0	19	29
Total	37	24	39	55	42	9	37	243

Note: there were 243 total surveys received. Nineteen of these could not be coded so the total coded surveys is 224 and the total received is 243.

Figure 10

The first survey question asked respondents to identify the services children with mental health or behavioral disorders and their families need to live successfully in their communities. From the focus groups twenty nine potential services and supports were identified. Figure 11 shows the results of this question of the survey. Each participant was asked to select the five most important services and supports. The data is reported in terms of how many participants selected each of the services and supports. The highest rated service was early intervention services and the second was early access to services before problems become severe. The third rated priority was for counseling and therapy. The fourth priority was for supports for families

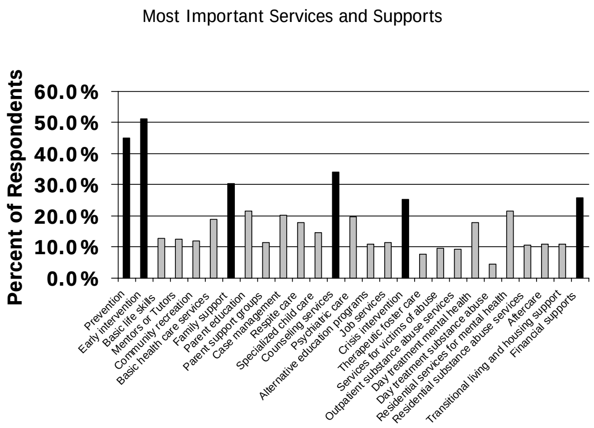


Figure 11

so they would be better prepared to support the special needs of their children with emotional and behavioral challenges. Crisis intervention was the fifth choice and flexible financial supports was the sixth priority.

The service priority data was analyzed by role and services system to see if different types of respondents had different priorities. Figure 12 shows the results of the analysis. The table on the top of Figure 12 shows the data sorted by role. All groups rated early access to early intervention services as their top two choices except the case managers who choose counseling over early intervention. The table at the bottom of Figure 12 shows the rankings by system. Interestingly the education and special education respondents rated family support as their second or third choice although the mental health, juvenile justice, and child welfare staff rated it as no higher than fifth.

Service and Support Priority by Role and System

	All	Parent	Case Mgr	Provider	Sup Mgrs	
Early intervention	51%	50.6%	37.9%	59.3%	56.0%	
Prevention	45%	41.7%	44.8%	39.1%	53.9%	
Counseling	34%	23.8%	44.8%	39.1%	36.6%	
Family support	30%	35.7%	13.8%	37.9%	30.2%	
Financial Support	26%	20.8%	34.5%	22.7%	25.9%	
Crisis Intervene	25%	17.9%	41.4%	17.7%	36.6%	
	All	Ed	Special Ed	MH	Juvenile Justice	Child Welfare
Early intervention	51%	58%	60%	51%	50%	49%
Prevention	45%	56%	37%	41%	50%	46%
Counseling	34%	26%	32%	46%	41%	29%
Family support	30%	44%	46%	26%	22%	29%
Financial Support	26%	20%	23%	26%	24%	30%
Crisis Intervene	25%	15%	14%	33%	19%	32%

Figure 12

The second survey question addressed important characteristics of programs. During the focus groups and discussions prior to the assessment it become clear that just having a service available does not mean it would be used or that it would be effective. Thus an assessment of program characteristics examined what programs must do to be used and be successful. Figure 13 shows the results of this part of the survey. Respondents rated being able to go one place and get what they needed as the most preferred characteristic. Families reported incredible difficulty in finding what they needed to support their children. They found that most agencies offered a few programs but had to go from place to place. Families thought they would be much more successful if they could go to one place in their local community and find almost all of the resources they would need to raise their own children. Similar to this was the need to have providers come to families. Flexibility in the hours and places of services was the second most important characteristic. Families and staff talked about the need for providers and agencies to work together as the third highest rated characteristic. The assessment of needs point to the importance of integrated and coordinated services.

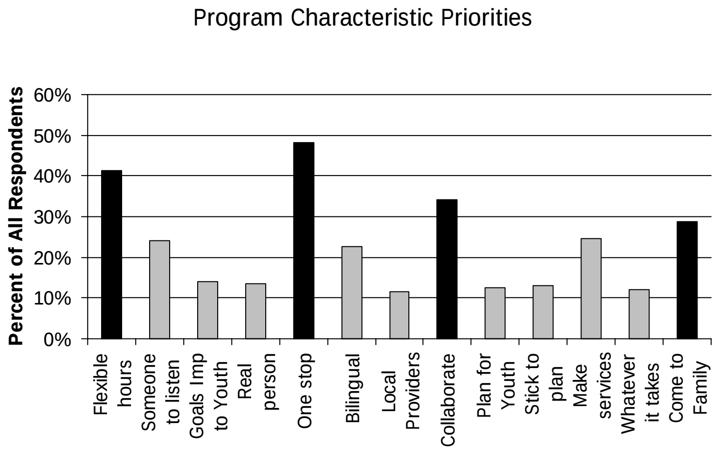


Figure 13

Summary of Need for Behavioral Health Services.

- A large proportion (over 67.5%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need mental health services and over 50% need individualized, integrated and coordinated mental health services.
- The highest rated need area is for early intervention and early access to services before problems become severe to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice).
- To get the best outcomes for children and avoid restrictive and costly inpatient and long term residential care, there is a need for a comprehensive array of flexible and community-based supports for children and for their families.

- The families, teachers, social workers, and juvenile justice staff who work with children with mental health disorders need information and education to understand the special needs of these children, how they can effectively support these children, how to access needed services and supports, and support to work through the challenges of raising and supporting a child with special needs.

- Families need services that are customized to work for them. This means they are accessible in time and place to match the schedules and needs of families. It means that there is no wrong door and that services are coordinated across agencies to meet families needs. It means the services are sensitive to and match the culture and language of the family. It means the services focus on partnering with families to find ways that work for them.

Assessment and Findings of How Well Need is Being Met

There are four basic questions that were addressed for this section of the annual report. How many of the children identified to be in need of behavioral health services are receiving services, are they receiving services at the level they need, do these services meet criteria for best practices, and do they match up to the important program characteristics?

1. ***Are the children who need mental health services and support receiving these services and supports?*** During the first part of the assessment the work group determined how many children covered by public insurance (Medicaid and Nevada Check-Up) and how many of the children and youth in the child welfare and juvenile justice systems needed services. To answer this question, Medicaid service records were reviewed to determine how many children were receiving mental health services. Then the services and supports for the children and youth who were screened through the CALOCUS were reviewed.
2. ***Are the services and supports they receiving matching to what they need?*** To answer this second question the Medicaid data and the service records for the children and youth screened through the CALOCUS were compared to the level of needed services determined through the first part of the assessment.
3. ***Do the services and supports meet standards for best practice?*** A separate part of the survey asked respondents to rate how well current services and programs were meeting 25 best practice service practices. It is known that these service practices impact access, utilization and outcomes from services and supports.
4. ***Do the service and supports match the prioritized characteristics for programs?*** The survey asked the respondents to rate how well the current system was meeting the prioritized program characteristics.

Comparisons to Level of Need to Level of Care. Encounter data for the Medicaid programs was obtained for 2001. This data was analyzed and used to determine how many children were receiving behavioral health services. This was compared to the number of children projected to need behavioral health services. Figure 14 shows the summary data for this comparison. Of the 7000 children who are estimated to need behavioral health services, only 2700 are actually receiving them. Of the 2500 who are estimated to need behavioral health services at higher levels of care, only 560 are receiving them.

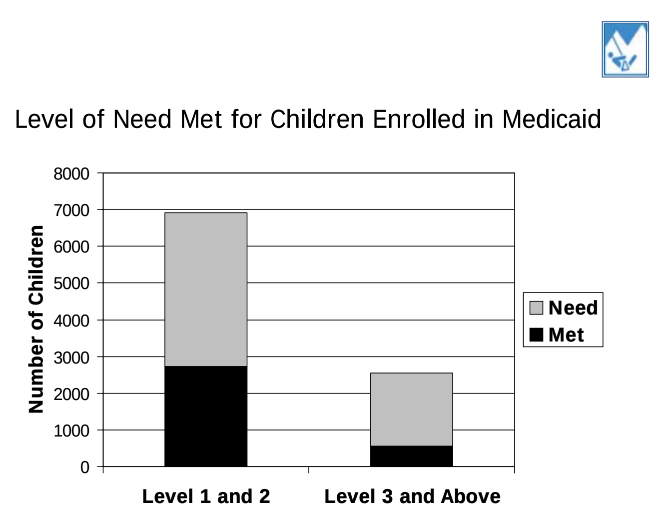
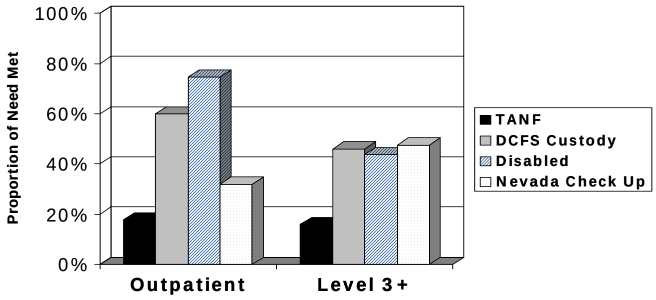


Figure 14

Figure 15 shows how well the behavioral health need is being met for children in different eligibility criteria. Children who are enrolled in the child welfare or foster care system are much more likely to get Level I and II services and these children plus those children with disabilities are much more likely to get Level II and higher services if they need them. Children in public custody are more than three times as likely to get behavioral health services as those who are not.

Proportion of Need Met by Eligibility Code



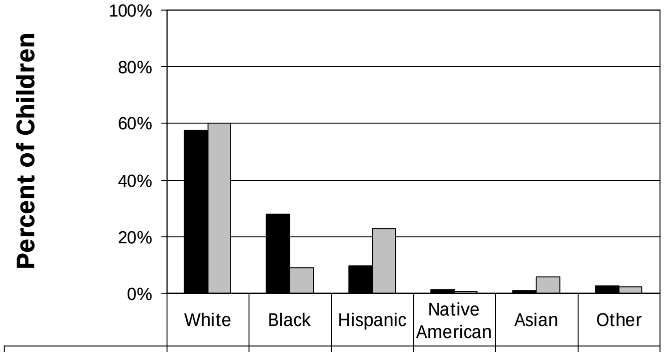
This data uses the population estimation calculations based on SAMHSA estimation methodology and levels of care. This is compared to encounter data on the actual services provided and billed through Medicaid for children and youth in Nevada.

* Currently data is not available through Medicaid on how many children receive services through the PCN program

Figure 15

Figure 16 shows a comparison of the race of children in the general population of children in Clark County to those receiving Medicaid mental health services. African American children are much more likely to receive mental health services and Hispanic and Asian children are less likely to receive these services.

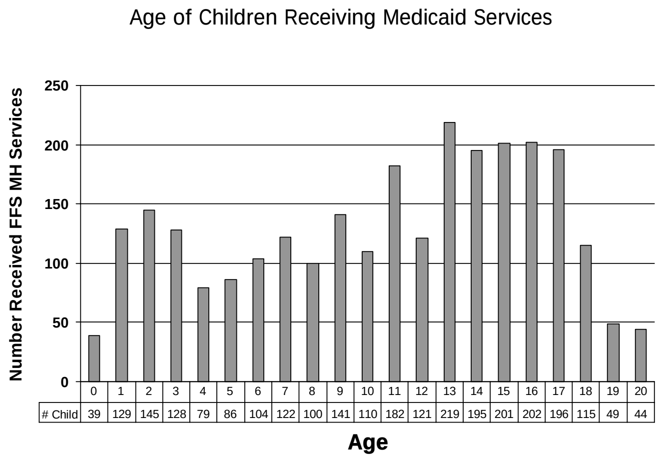
Race of Children Receiving Services



	White	Black	Hispanic	Native American	Asian	Other
■ Receive Services	57.7%	27.9%	9.6%	1.3%	0.9%	2.5%
▨ Population	60.2%	9.1%	22.9%	0.8%	5.8%	2.1%

Figure 16

Figure 17 shows the age of the children receiving Medicaid funded behavioral health services. There is a sharp decrease in utilization of behavioral health services after a youth becomes eighteen years old to the point that less than 20% of the young adults 19 and 20 years of age are receiving services compared to sixteen-year-old youth. It is interesting to note that even though the children enrolled show a decrease from age two, teenage children are receiving the most services. This matches the overall concern that early intervention and early access services are not available.



This data is for 2001

Figure 17

Figure 18 shows how much money was spent on Medicaid mental health services by service type. In the Clark County jurisdiction over $21.9 million was spent through Medicaid on children’s mental health services. Of this amount over 84% or $18.6 million were spent on residential services. Figure 19 shows these expenditures broken out by procedure code.

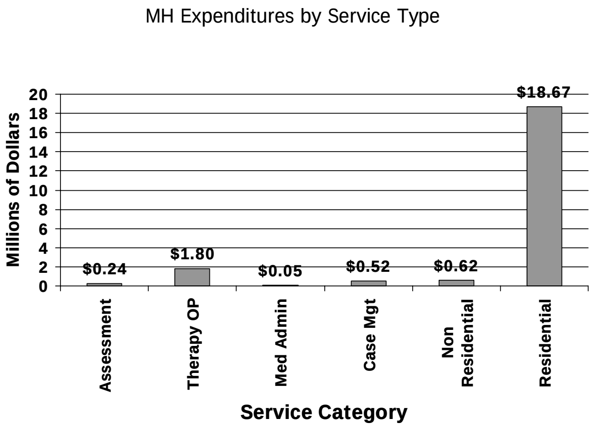
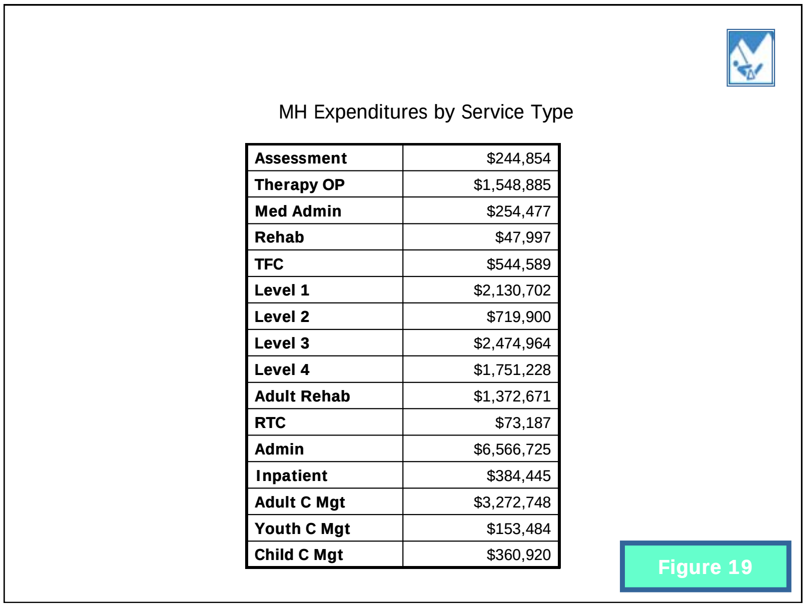


Figure 18

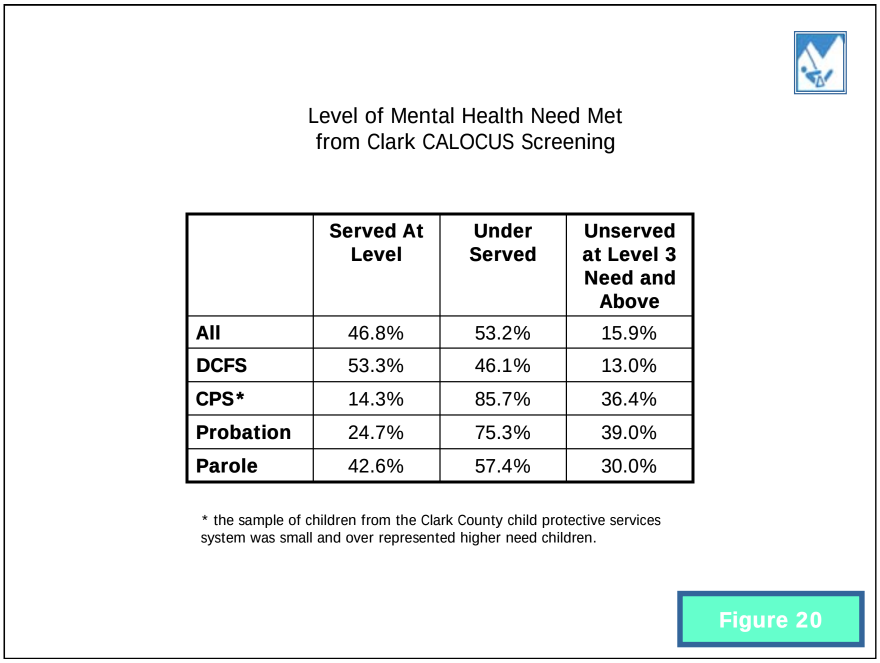


MH Expenditures by Service Type

Assessment	$244,854
Therapy OP	$1,548,885
Med Admin	$254,477
Rehab	$47,997
TFC	$544,589
Level 1	$2,130,702
Level 2	$719,900
Level 3	$2,474,964
Level 4	$1,751,228
Adult Rehab	$1,372,671
RTC	$73,187
Admin	$6,566,725
Inpatient	$384,445
Adult C Mgt	$3,272,748
Youth C Mgt	$153,484
Child C Mgt	$360,920

Figure 19

The second assessment of need assessed how well behavioral health needs were met for the 544 children and youth who had been screened using the CALOCUS. The services that these children and youth are receiving was recorded and compared to the predicted level of care. Figure 20 shows a summary of this assessment. Only 46.8% of the children in these public programs were receiving the services and supports at a level that was equal to their need. This included the children who did not need services. Of the children who had higher levels of care needs, more than 15% were receiving no behavioral health services at all.



Level of Mental Health Need Met
from Clark CALOCUS Screening

	Served At Level	**Under Served**	**Unserved at Level 3 Need and Above**
All	46.8%	53.2%	15.9%
DCFS	53.3%	46.1%	13.0%
CPS*	14.3%	85.7%	36.4%
Probation	24.7%	75.3%	39.0%
Parole	42.6%	57.4%	30.0%

* the sample of children from the Clark County child protective services system was small and over represented higher need children.

Figure 20

On the survey respondents rated the accessibility of the services and supports listed. Figure 21 shows the ratings for how accessible the priority services are. The question was of the children who need a service how many receive that service. The overall ratings found that none of the priority services were rated at even the middle “some” value. In a system that is meeting the needs of children and families you would expect most of these to be rated in the “most” range. The overall ratings found that counseling services were the most accessible and that early access was least accessible. Figure 22 shows this rating of accessibility by role and system.

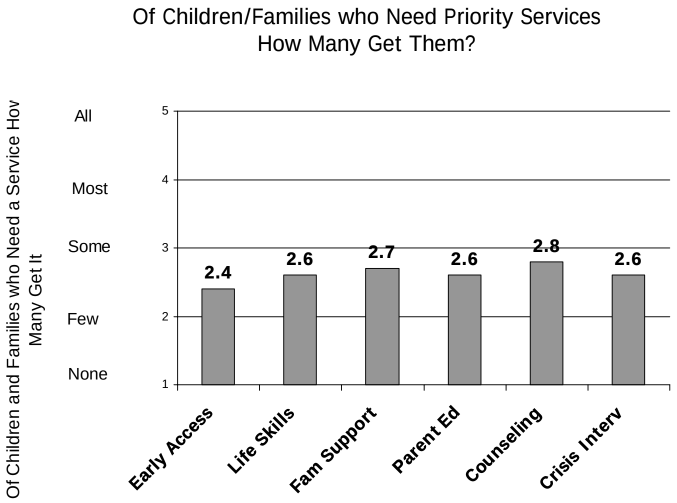

Of Children/Families who Need Priority Services
How Many Get Them?

Figure 21

Service and Support Priority by Role and System

	All	Parent	Case Mgr	Provider	Sup Mgrs	
Early intervention	2.4	2.0	2.3	2.5	2.4	
Prevention	2.2	1.7	1.8	2.1	2.3	
Counseling	2.9	2.8	3.0	2.9	2.6	
Family support	2.6	2.6	2.3	2.7	2.5	
Financial Support	2.1	1.6	2.0	2.1	2.0	
Crisis Intervene	2.5	2.5	2.3	2.5	2.4	
	All	Ed	Special Ed	MH	Juvenile Justice	Child Welfare
Early intervention	2.4	2.4	2.5	2.5	2.2	2.4
Prevention	2.2	2.3	2.2	2.0	2.0	2.2
Counseling	2.9	2.9	2.4	2.9	2.9	3.2
Family support	2.6	2.7	2.4	2.7	2.3	2.6
Financial Support	2.1	2.2	2.3	1.8	1.7	2.2
Crisis Intervene	2.5	2.9	2.2	2.3	2.1	2.5

Figure 22

The next section of the survey asked respondents to rate how well the current system is meeting best practice standards for behavioral health service practices. The respondents rated the 25 items on a scale that included met, mostly met, mostly unmet, and unmet. Figure 23 shows the results of this section of the surveys for the seven items that were rated as the most met and the four items that were listed as the least met.

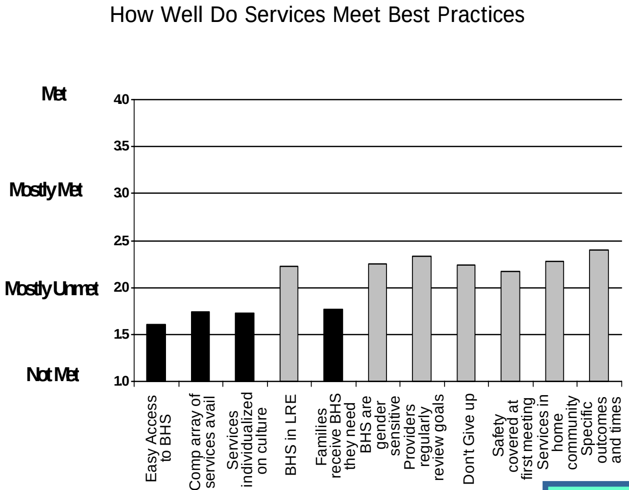


Figure 23

The overall ratings for all of the items are low. In systems that are providing good individualized services that address the needs, culture and strengths of the children and families of the community the ratings should be at or above the mostly met rating. The four areas of greatest weakness are that there is not easy access to behavioral health services. Families report that it is often a monumental effort to get what a child needs. That there is not a comprehensive array of services and that children and families are generally required to fit into existing programs instead of getting what they need. Services and supports are generally not individualized based on the culture of the child and family. Families are not treated as partners in the process and the families of children in service can not get the services they need.

The survey also asked respondents to rate how well the current programs and services are meeting the prioritized program characteristics. Figure 24 shows the results of this part of the survey. The top four prioritized characteristics are shown in black. The least well met of all the prioritized program characteristics is for services to come to families and for the one stop. It is clear from the surveys and the discussions with families and staff that the fragmented and discontinuous system is the most frustrating and the main characteristic of the current system that makes it a failure for so many children and families.

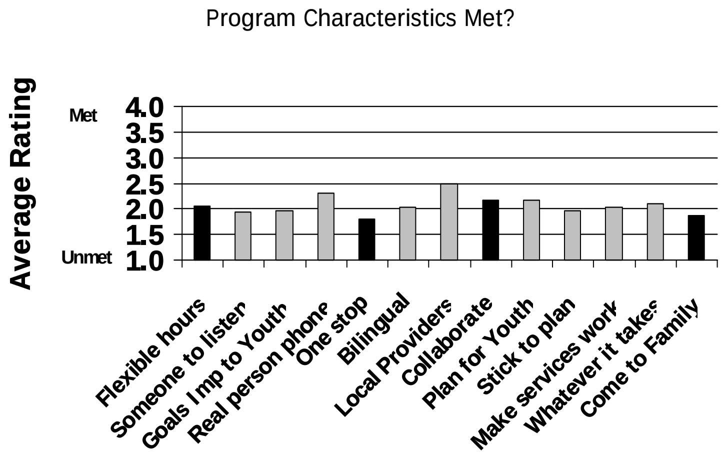

Program Characteristics Met?

Figure 24

Overall Findings About How Well Need Is Met

- More than 15% of the children who needed individualized and coordinated services were receiving no services at all. Of the children screened only 46% are receiving mental health services at the level of their need. Although counseling was rated as the most accessible service, it was still rated as accessible for less than "some" of the children who need it.
- The reason there is a higher proportion of children in the child welfare and juvenile justice system who need services than would be projected is probably the result of unavailability of services. If the services were available the need would decrease and without services the need accelerates as the severity of the need increases until it reaches crisis stages. This causes many of the incidents that place children in the child welfare and juvenile justice systems.
- Most children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise.
- Most parents, family members, and staff who need information and support to know how to support their own children are not accessing these services. In addition, family members who need treatment to assist their children are generally not able to access these services.
- Proportionately more children are accessing services through fee for service Medicaid than through the managed care plans and are receiving many more community-based services.
- Families and providers report long waiting times and lack of flexibility from the managed care and public system providers. Interviews with staff and families documented waiting of 10 weeks and longer in all programs and presumptive waiting lists because of the impression that services were not available or accessible.

- Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.
- The current system greatly overuses residential services to address mental health needs. The lack of an individualized family centered approach to supporting children results in 86% of the funding being spent on high cost residential care for less than 5% of the children who need services.
- Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services.
- If children were to receive the support before they enter the these public systems the level of need would be significantly reduced and estimates suggest that as many as half the children would not never enter either child welfare or juvenile justice.

Assessment of the System Structure

System Barriers and Challenges. Through the initial focus groups with families and staff it become quite apparent that there are a significant number of system barriers and challenges that prevent or make it difficult for staff and agencies to provide good services for children and families. Twenty such system barriers and challenges were identified and then these were prioritized by survey respondents. The system barriers and challenges that respondents rated as most in need of changing are shown below. The proportion of respondents that identified each item as a top three priority is shown at the end of each item.

- Duplicative and complex paperwork takes too much time away from children and families (**44%)**
- To provide individualized services we need a network of services instead of piecemeal development of programs (**44%)**
- Funding eligibility categories force children and families to change providers and come into and out of service (**41%)**
- The current licensing and placement system forces children to be moved and separated from siblings (**36%)**
- We need access to flexible resources and dollars for stuff (guardianship, placement prevention) (**34%)**
- Lack of bilingual services (primarily Spanish) makes it hard to communicate with some families (**27%)**

Eligibility for Services. The current system of eligibility is one of the primary system characteristics that causes the fragmented and discontinuous system. The multiple forms of eligibility, different benefit packages, different providers, and eligibility processes of the different agencies and public programs are a maze that few parents can successfully navigate. The very limited availability of targeted case management and limited funding for parent to parent advocacy and support make this problem even worse.

Currently, children can be eligible for services based on funding source or program. The different forms of eligibility lead to different programs, services and providers based on eligibility and not on the need of the child and family. Many of the eligibility criteria and triage procedures of the agencies result in children not being able to access services until the problems become severe or until something happens that forces the children through the court system. More children receive services following court actions than through early requests. If eligibility and program criteria allowed children easy access to services early when needs are not as great, they would have the most impact and many fewer children would require court orders to enter programs.

Children often change from program to program and their eligibility changes. This results in forced changes in coverage and providers creating discontinuous treatment and even changes in living arrangements. When children are discharged from programs they often lose eligibility for public insurance which creates no support for transition and aftercare causing them to remain in higher levels of care much longer than needed and higher recidivism rates.

Eligibility rules related to SED and managed care create a great amount of confusion and adversely impact both the managed care providers and the public system. Currently the rates for managed care do not include services for children who have a severe emotional disorder (SED). These children have the choice of opting out of the managed care plan and going into fee for service. Many of the services provided by the managed care providers are not eligible for fee-for-service billing. It also requires coordination between the managed care provider and MHDS in the rural areas.

Methods for Obtaining Services. There are multiple ways for children and families to obtain services. Parents can go directly to providers and use private insurance, public insurance or pay directly for the services. Individualized and coordinated services are often expensive and not covered by private insurance. This means that parents of children with severe emotional disorders often do not have financial resources to pay for the services their children need without going through public systems. This forces many children into the child welfare and juvenile justice systems to obtain services. As noted earlier the system structure for eligibility, lack of local flexibility, and requirements for provider privileging that does not support services by paraprofessional and masters level staff results in much of this money paying for the wrong kinds of services and supports.

Special education departments have budgets for children with emotional and behavioral disorders and provide some funding directly for these services both through their programs and through contracted services. These budgets are relatively small and can not meet the need of all students. County probation departments provide some Mental Health Services directly and purchase additional services to supplement.

Process for Obtaining Services.   Children access services through the provider that receives funding for the services. This means their own physician, psychologist, managed care provider, or public system service coordinator. Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system. Best practice ratings ranked collaboration and integration of services as one of the highest priorities but one that was most often not met. The managed care provider and all of the public systems triage initial intakes and focus services on children with the most intense needs.

Access to other systems and services is determined by the initial intake agency unless the child and family change systems in which case services and supports are generally started over.

Methods for Obtaining Additional Money. Nevada has one of the fastest growing populations in the country, but funding for children’s behavioral health services has shown little increase in the past ten years. The new funding through AB-1 to fund individualized services for 327 children in the child welfare system will be a great help if it is not a victim of funding cuts to balance the budget. There are ways in which the funding within the current system could be used more effectively but this can only happen if the state level Departments and Divisions with support from the State Legislature work together to form a less fragmented system that is flexible to meet the needs of children and families. Some of the steps that could be taken to increase the amount and impact of current funding are:

- The very large percent of public Medicaid funding that is used for residential and inpatient services could be redirected to provide a greatly expanded array of community based services.
- The county social service, juvenile justice, and special education programs are providing services to children eligible for Medicaid but are not receiving full federal participation for these expenditures. An integrated system to provide and bill for these services could expand the total amount of money available without increasing local or state expenditures.
- There is overlap in intake, assessment, utilization review, administrative functions, and supervision that could be reduced through an integrated approach to the provision of mental health.
- Redirecting some of the current prevention and early intervention funds through mental health, substance abuse, child welfare and juvenile justice into an integrated early access program could save significant money in the high end usage of mental health services down the road.
- Developing strong utilization review and monitoring processes for an integrated system could allow expansion of the use of other professionals (e.g., marriage and family therapists, master level psychologists and social workers) and create roles for paraprofessionals that would expand capacity and reduce overall rates.
- There are many community resources (e.g., boys and girls clubs, churches, scouts, United Way) that could provide support for children with special needs if they were part of a united community approach and support to handle the special challenges involved.

Manner in Which Family Members Can Be Involved. Family members are the most significant influence on the development, health and safety of children. Supporting parents to be successful in this role should be a primary goal of a good system of care. The parents of children with emotional and behavioral disorders, especially those with severe disorders face incredible challenges to successfully raise their children. Children with severe emotional disorders often disrupt social events and can be dangerous to other children, adults, and the environment around them. For these reasons and because society has often assumed that a child’s behavior problems are the result of some failing on the part of the parents, these families are often isolated from other family, friends and the normal social supports (e.g., churches, recreation and social programs) that are so much a part of other families lives. This social isolation further inhibits the problems these children and families have. A system that tries to treat these children without supporting these needs for the whole family is bound to fail and send more and more children into higher levels of restrictive, expensive and ultimately unsuccessful residential care. A system that partners with the parents to help them succeed in raising this special needs child and finding the ways and resources to build an effective social network of supports will have much better results. The most important ways that parents can be involved is as partners in the services and supports for their own child. Plans that are developed jointly with parents have a much better chance to work.

The second way that families can be involved is helping other families through the process. The experiences of raising a child with special needs gives the parents of that child a special understanding what it is like to deal with the challenges of a special needs child and how to navigate the system. For these reasons parents who have successfully navigated the system are often one of the best supports for other families. They are more effective at engaging parents than professional staff who have not shared the experience of raising a child with SED or navigating the system from the recipients point of view.

The third way families can be involved is at the system level. Having parents and youth involved in planning the systems to provide supports for all families within a jurisdiction can make the plans more useful. Parents understand how different decisions will impact access and impact of the system and this makes the plans work better. Parents and youth can also make quality management and evaluation of the impact of the system more useful and focused on issues that are important. Effective development, fine-tuning, and sustaining of system of care development is aided immensely by involvement of parents and youth at every level of the system.

Goals for Behavioral Healthcare Services in Clark County

During the initial two meetings of each consortium, there were discussions of the advantages and disadvantages of coordinating efforts between the consortia at some level. On the one hand each jurisdiction has unique strengths, culture and needs. On the other hand children and families have similar needs and goals across jurisdictions and best practices suggest similar approaches. In the beginning it was decided to share information with the Rural and Washoe Consortia and use this information to make decisions about how the Clark Jurisdiction Mental Health Consortium would proceed. As the plan to gather information for the assessment unfolded, each consortium decided that it would be beneficial if each consortium used a common process for gathering this information so the information would be comparable statewide. For this reason the assessment and annual plan workgroups shared ideas and development of the assessment tools and methodology. As the results from the assessment phase were tabulated results were shared across consortium. There were some differences but overall children and families had similar needs across jurisdictions and the findings suggested that there were common areas of priority need. Each consortium then discussed development of plans. It was decided that based on the common needs that the overarching goals for the four consortia should be the same, but that based on the current strengths, culture and needs of each consortium that the local plans should focus on local needs. The Mental Health Consortia developed four primary goals for the first annual mental health plan for the Legislative Committee on Children and Families. These four goals are the areas that have been prioritized as most important for the next phase of building a strong system of care for children and families within the State of Nevada.

The plans are developed at three levels. We know that any plan to successfully support children with severe emotional disorders within our community must be a partnership. It must be a partnership between the service providers and the children and families they serve. Through such a partnership families can learn to support their own children successfully and for the long run. It is a partnership between the different public agencies, private agencies and community leaders that provide services and supports for children and families within our community. One clear message of the assessment is that the system is currently dangerously fragmented and the lack of coordinated and individualized services and supports for our children and families is rapidly pushing more and more children and youth to lifetimes of dependency on our public systems. It also requires a partnership between the local community, state departments and divisions, and the state legislature. We hope to set a common vision for the future of a system of care for our children and families and develop a common and reasonable plan for how to make it happen. It will not happen if we continue to develop programs, regulations, and legislation one piece at a time. All of these need to be a collective effort and each decision evaluated for its impact on the future vision of how we want our communities to take care of themselves. The following are the first four goals for our plan:

1. Develop a coordinated and integrated behavioral health system for children and families in Nevada that is seamless and easy to access. Build-on the strengths of local communities by implementing locally controlled systems of care.

2. Implement a system of services and supports that is customized to meet the needs of families not focused on agencies and providers. Provide early access to behavioral health

services for children and families so families can raise their own children. Implement a consistent, collaborative and family-centered approach that provides consistent support and growth for Nevada children and families.

3. Support the development and expansion of human resources so that we can use the resources of our local communities and grow them to better meet the needs of our local children and families. Support families and staff to succeed by giving them information, education and support.

4. Expand consumer involvement at all levels of decision making around services and supports for children and families.

Goal One: A Comprehensive and Integrated Behavioral Health System

Goal: Develop a coordinated and integrated behavioral health system for children and families in Nevada that is seamless and easy to access. Build-on the strengths of local communities by implementing locally controlled systems of care.

Need: A large proportion (over 55%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need individualized, integrated and coordinated mental health services. Children and families need access to a system of behavioral health care that is comprehensive, integrated, and seamless. Resources to support children and families include public and private agencies and insurance

Status: Of the children screened only 43.5% are receiving mental health services at the level of their need. At the same time the current system greatly overuses residential services to address mental health needs. The lack of an individualized family centered approach to supporting children results in 86.3% of the funding being spent on high cost residential care for less than 5% of the children who need services. Best practice ratings ranked collaboration and integrated of services as one of the highest priorities but one that was most often not met. There are several significant contributing factors for this:

1. Current funding practices and eligibility rules are based on funding source and program. The services and providers are generally more dependent on the place the child enters the system (e.g., private provider, school, child welfare, juvenile justice) than the needs of the child. As the needs or program change, this fragmented system results in changes in coverage and providers thus creating discontinuous treatment and even changes in living arrangements.
2. When children are discharged from programs they often lose eligibility for public insurance which creates no support for transition and aftercare, causing them to remain in higher levels of care much longer than needed and higher recidivism rates.
3. Eligibility rules related to SED and managed care create a great amount of confusion and adversely impact both the managed care providers and the public system.
4. Although there are many different resources available to support the emotional growth and health of children, there are few incentives for schools, public and private agencies, and local community “informal” supports to work together. In fact the different

administrative rules, funding requirements and state level micro management of decision making fragment local community efforts to work together.

5. Targeted case management and higher levels of service are only available through DCFS and MHDS and funding for these programs has not been increased to match need or population growth. This means that there are real or presumptive waiting lists in all of the public programs for service coordination forcing children in crisis into higher levels of care.

Goal Two: Services Individualized to Family Needs

Goal: Implement a system of services and supports that is customized to meet the needs of families not focused on agencies and providers. Provide early access to behavioral health services for children and families so families can raise their own children. Implement a consistent, collaborative and family-centered approach that provides consistent support and growth for Nevada children and families.

Need: Families need services that are customized to work for them. This means services that are accessible at the times and places that match the schedules and needs of families. It means that there is no wrong door and that services are coordinated across agencies to meet families needs. It means the services are sensitive to and match the culture and language of the family. It means the services focus on partnering with families to find ways that work for them. The highest rated need area is for early access to services before problems become severe to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice). There is also a high need for early intervention support for high risk families with very young children. These families often end up with multigenerational problems without support to break the cycle.

To get the best outcomes for children and avoid restrictive and costly inpatient and long term residential care, there is a need for a comprehensive array of flexible and community-based supports for children and for their families. This would include a mobile crisis response, mentors, respite care, integrated case management to coordinate and link services, and community recreation programs that have the necessary support to include children with emotional and behavioral challenges safely.

Status: Most children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise. Families and providers report long waiting times and lack of flexibility from the rural mental health centers. Interviews with staff and families documented long waiting periods and presumptive waiting lists because of the impression that services were not available or accessible. Currently children can be eligible for services based on funding source or program. Many children who need services are not able to access them early when they would have the most impact because of eligibility criteria. The managed care provider and all of the public systems triage initial intakes and focus services on children with the most intense needs.

Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services. Children access services through the provider that receives funding for the services. This means their own physician, psychologist, managed care provider, or public system service coordinator. Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system. Access to other systems and services is determined by the initial intake agency unless the child and family change systems in which case services and supports are generally started over.

Goal Three: Improve Human Resources Support for children and Families

Goal: Support the development and expansion of human resources so that we can use the resources of our local communities and grow them to better meet the needs of our local children and families. Support families and staff to succeed by giving them information, education and support.

Need: The families, teachers, social workers, and juvenile justice staff who work with children with mental health disorders need information and education to understand the special needs of these children, how they can effectively support these children, how to access needed services and supports, and support to work through the challenges of raising and supporting a child with special needs. There is a need for culturally diverse and bilingual staff to provide support for children and families.

Status: Most parents, family members, and staff who need information and support to know how to support their own children are not accessing these services. In addition, family members who need treatment to assist their children are generally not able to access these services. Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.

Goal Four: Expand Consumer Involvement

Goal: Expand consumer involvement at all levels of decision making around services and supports for children and families.

Needs: Parents and family members of children who have been in the system are excellent supports for other families. Recognition and support of these families and the organizations that support them can produce a large amount of support.

Status: Parental involvement and advocacy currently occurs on a voluntary basis or through limited grant programs.

Implementation Project for AB-1 Mental Health Services

Overview to Project

Through AB-1 the Nevada Legislature has integrated the child welfare system and increased support for children in the child welfare system. This includes creating funding for 327 behavioral health services slots for children in the ongoing child welfare system who have severe emotional disorders and are currently unserved or receiving inadequate services. The funding for these services begins for 10% of these children in April 2002 and then a phase-in of the other children begins in November 2002. For the first phase it has been decided to identify eight children in the Rural jurisdiction, eight in the Washoe jurisdiction, and eight in each the North and West neighborhood Care Center regions of the Clark jurisdiction. The model that will be used to provide these services will be wraparound. The model is intended to:

- Be family-centered and done in partnership with the significant people for the child
- Be individualized to the specific culture, strengths, and needs of each child and family
- Be provided in the least restrictive and most normalized environment appropriate keeping children at home or in their home communities whenever possible
- Be a collaborative process between the people providing support and services for the child
- Result in a single coordinated approach including a consolidated functional strengths, needs, and culture assessment, single plan of care, and coordinated progress tracking, adapting and reporting. This plan will include and be the safety plan, crisis plan, child welfare case plan, mental health treatment plan, plans for other providers involved with the child, transition plan, and plan for independence for youth.
- Be outcome driven focusing on child safety, permanency, emotional and physical health, developmental progress, and youth and family independence.

To implement the process above resource coordinators have been hired to provide a wraparound process. These resource coordinators and child welfare case workers will need to team to ensure that children and families get what they need while minimizing duplication. There are many roles that staff may play in supporting children with SED in the child welfare system. Who will do any of these roles will be individualized on a case by case basis by the child and family team. This partnership and the model to provide services represent a new approach to providing services for children with severe emotional disturbances within the child welfare system. Vroon VanDenBerg has been hired to provide coaching and training for staff to support this new way of providing services. This document describes how this coaching and training will be provided for the first four “pilot” resource coordinators.

Evaluation Plan for Pilot Project. The research in this proposal will compare the effects of the traditional strategies being used to provide services and placement for children within the foster care system to a wraparound approach. This study will examine the impact of these service approaches on child clinical and functional status and family life. Data will be collected in the following areas: child symptoms and diagnosis; child social functioning; substance use; school attendance and performance; delinquency; juvenile justice involvement; and stability of the child's living arrangements. The research study will include a process evaluation to determine the fidelity of the service process for each child within each group and to identify the service process elements that result in the best outcomes for children and families. The information from this research study will be used to inform the curriculum for social work at UNLV. This proposal is part of a larger study being done as part of a CMHS demonstration project of systems of care and wraparound process services in Nevada. Most of the cost of this study will be paid with federal, state, and local funds through this demonstration project. By combining this study with the federal demonstration project, the State of Nevada, UNLV, Clark and Washoe Counties, DMHS and DCFS will gain valuable information about new service processes while only paying a small fraction of the cost for the research. This research will identify 8 children in each of four sites (two in Las Vegas, one in Reno, and one in Carson City) to receive wraparound services funded through new state legislation. 8 additional children will be identified at each site who will receive current services. These second groups of children will be the "controls" for the "experimental" groups.

The most recent report from the surgeon general on children's mental health issues describes mental health and mental illness as points on a continuum. The report summarizes available research to suggest that one in five children experience signs and symptoms of a diagnosable mental health disorder during the course of a year. In addition, the report found that 5% of all children experience severe functional impairment and that mental disorders and mental health problems appear in families of all social classes and backgrounds. However, the children at greatest risk are those who have certain physical problems, family histories of substance abuse, mental illness, and multigenerational poverty. [2]

National research on foster care and juvenile justice systems show that the majority of the children served in those systems has these risk factors. These prevalence studies have found that 30 to 45% of the children in foster care meet the criteria for severe emotional disturbance. In addition, a total of 75 to 85% of the children in the foster care system have diagnosable emotional disorders. Based on the prevalence studies, approximately 11 to 18% (56,259 to 92,061) of Nevada children would have emotional disturbance, and approximately 5 to 7%, (25,572 to 35,802) would have severe emotional disturbance. More specifically for this proposal the research shows that most of the children within the child welfare system have emotional disorders and a third have severe emotional disorders. DCFS records and estimates suggest that 36.3% of the children within the child welfare system in the Southern region meet the criteria for severe emotional disorders. Similar estimation methodology would predict that clearly an additional 40% of the children would benefit from mental health services. Thus most of these children need concurrent support from child welfare, mental health and educational services. Demonstration work around the country is showing that wraparound is a successful process for providing integrated support for these children. The purpose of this research is to compare the outcomes, service utilization and access, costs, and satisfaction of staff and families in wraparound with families in the traditional service delivery process.

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[2] Satcher, 1999

Methods and Procedures: The evaluation for this study will have five primary parts:

1. Services and Costs Study,
2. Process and Intervention Assessment,
3. Child and Family Outcomes Study,
4. Cross-Sectional Descriptive Study, and
5. Implications for Social Work Curriculum.

A. **Services and Cost Study.** DCFS will track service and placement use and costs to describe the types of services used by children and families, their utilization patterns, and the associated costs. The relationship between service use and outcomes will also be explored. This data will be maintained continually by DCFS. Of interest are the types of services, the combination of services, continuity or gaps in care, and the length of services and placement. Where possible, service data from a variety of agencies representing different service sectors (e.g. mental health, juvenile justice, education, and child welfare) will be integrated. This information will be analyzed with the data collected from children, family members, and service providers to create a comprehensive picture of the services and supports families use.

B. **Process and Intervention Assessment.** The significant questions of this research study involve the comparison of wraparound to traditional services processes. The process and intervention assessment will assess the fidelity of the wraparound process to the values and specifics of the independent variable. In addition, the process and intervention assessment will assess the traditional services to the same standards. This assessment will be used to determine the experimental contrast between the two groups. The process and intervention survey (WIFFI) will be administered through phone and personal interviews with families, youth, and care managers involved in the process. This methodology will give numerical ratings to the different aspects of service process and these will be analyzed with the outcomes for children and families to determine the elements of the process that have the most beneficial impact. The implications from this study will be used to shape the social work curriculum.

C. **Child and Family Outcome Study.** This study will examine the impact of services on child clinical and functional status and family life. Data will be collected in the following areas: child symptoms and diagnosis; child social functioning; substance use; school attendance and performance; delinquency; juvenile justice involvement; and stability of the child's living arrangements. This evaluation component will follow children and families as long as possible to assess long-term impact of the system of care and assess important functional outcomes as children develop toward maturity. Several data collection instruments are used in this phase of the evaluation (*Table 1*). All instruments will be administered at baseline and at all follow-up data collection points.

Table 1: Data Collection Instruments Used in the Child and Family Outcomes Study

Instruments for Caregivers and Staff-as-Caregivers
♦ Child Behavior Checklist (CBCL)
♦ Client Status Report including:
♦ Restrictiveness of Living Environments and Stability Scale, Revised Version (Roles-R)
♦ Education Questionnaire (EQ)
♦ Child and Adolescent Functional Assessment Scale (CAFAS)

D. **The Cross-Sectional Descriptive Study.** These studies involve the collection of demographic and background data on all children and families within the system of care. We will be collecting the following descriptive information: demographic characteristics of children and families, child diagnostic indicators, child and family risk factors, child mental health service and placement history, and family socioeconomic status. These elements, as well as additional elements selected for inclusion within the evaluation, will be collected through the use of the ***Descriptive Information Questionnaire (DIQ)***. The DIQ is administered to caregivers during the normal service intake process. It will cover all the descriptive data needed for the evaluation, except for the diagnostic elements, which will be extracted from the child's record. The DIQ will take approximately 15 minutes to complete.

E. **Implications for Social Work Curriculum.** The research team consists of international experts on child welfare services and placement and wraparound services, the regional administrator for DCFS and faculty from UNLV. Prior to implementation of the study the research group will meet and determine the critical analyzes that have implication on social work services. Through this process the research group will ensure that data is gathered in ways to produce the most usable information. The research group will monitor the process during the study and then at the conclusion of the study complete the analysis and recommendations for implications to social work curriculum. In addition, members of the research group will present at least three times to graduate students in social work during the study to discus the issues and preliminary findings.