Supplement to the Rural Consortium Annual Plan
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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 Rural Jurisdiction was formed in January 2002 and met seven times from January through June 19, 2002. The Consortium organized into three work groups to do the initial work of the Consortium and these workgroups met a total of 21 times during the period.

The Rural 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 20, 2002 so that it could be submitted in time for the next legislative session. 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 membership of the Rural Mental Health Consortium are:

Name	Representing	Office
Ruth Aberasturi	Carson City School District	Chair
George Flamer	Rural Clinics MHDS	Work Group Chair
Tom Hughes	Child Advocate	
Marla Morris[1]	DCFS	Secretary
Robert Queryrel	DHCFP (Medicaid)	
Larry Robb	DCFS Elko	
Fernando Serrano	Juvenile Probation Humboldt	Work Group Chair
John Simms	Juvenile Probation Carson City	
Kathy Taitano	Parent	
Lorraine Vasquez	Foster Parent	Vice Chair
Joanna Wilson	School Board	Work Group Chair

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[1] Marla Morris is a nonvoting member of the consortium

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 group 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 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 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.

The plan that was developed involved the input and work of hundreds of staff and families across the jurisdiction. Fernando Serrano from the Humboldt juvenile probation office chaired the committee for gathering information for the annual plan assessment and was very effective in getting input from the rural juvenile justice and rural school systems and staff. George Flamer from the Carson City office for MHDS rural clinics chaired the workgroup on implementing the SED pilot project and screening of the children and youth in the child welfare system. He was effective in getting input from the rural mental health system and staff. Larry Robb coordinated efforts to screen the children and youth and get input and data from the Elko region of DCFS. Joanna Wilson chaired the workgroup to develop by-laws. Ruth Aberasturi,, chaired the committee and organized meetings.

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).

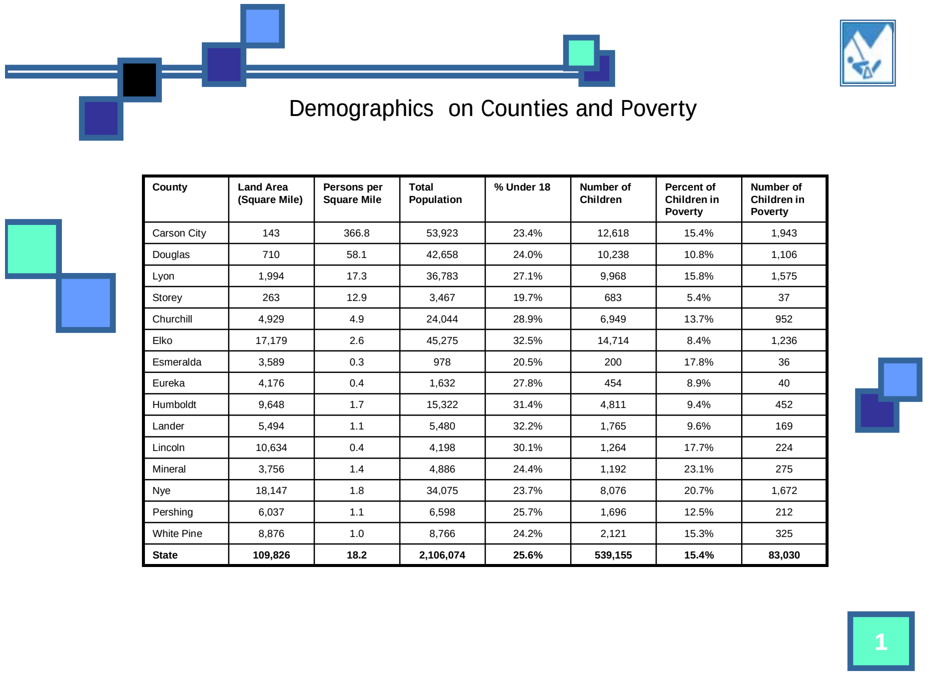
Questions and General Process for Determining Need. The first step in the process of developing the assessment plan was to clarify the questions to be answered. The first set of questions related to the need for mental health services. These asked which children need mental health services, what services 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.

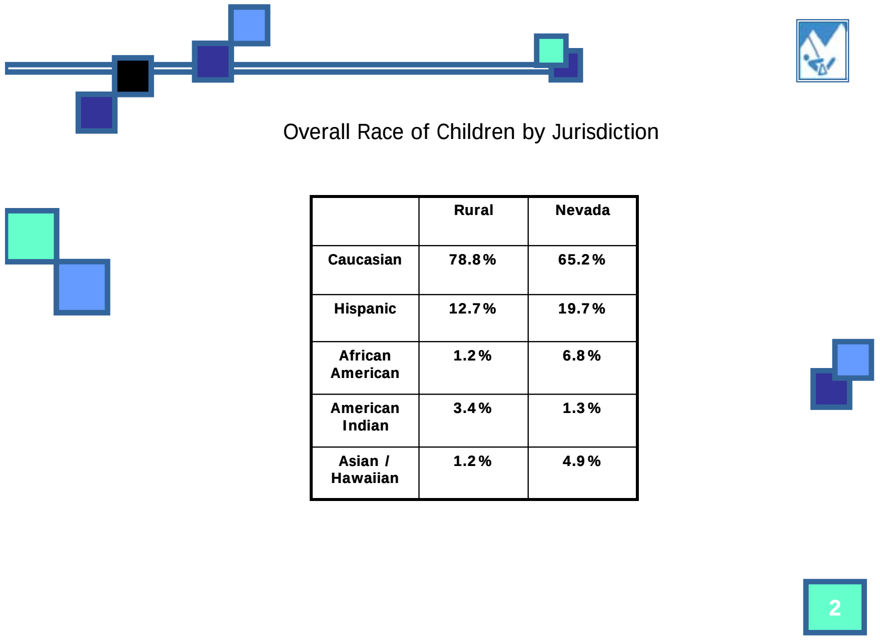
What services and supports do parents need to be able to raise their own special needs children successfully? A primary goal of services for children is to help parents and other family members to support their own children. Families have the most impact on the development and safety of children and 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



Demographics on Counties and Poverty

County	Land Area (Square Mile)	Persons per Square Mile	Total Population	% Under 18	Number of Children	Percent of Children in Poverty	Number of Children in Poverty
Carson City	143	366.8	53,923	23.4%	12,618	15.4%	1,943
Douglas	710	58.1	42,658	24.0%	10,238	10.8%	1,106
Lyon	1,994	17.3	36,783	27.1%	9,968	15.8%	1,575
Storey	263	12.9	3,467	19.7%	683	5.4%	37
Churchill	4,929	4.9	24,044	28.9%	6,949	13.7%	952
Elko	17,179	2.6	45,275	32.5%	14,714	8.4%	1,236
Esmeralda	3,589	0.3	978	20.5%	200	17.8%	36
Eureka	4,176	0.4	1,632	27.8%	454	8.9%	40
Humboldt	9,648	1.7	15,322	31.4%	4,811	9.4%	452
Lander	5,494	1.1	5,480	32.2%	1,765	9.6%	169
Lincoln	10,634	0.4	4,198	30.1%	1,264	17.7%	224
Mineral	3,756	1.4	4,886	24.4%	1,192	23.1%	275
Nye	18,147	1.8	34,075	23.7%	8,076	20.7%	1,672
Pershing	6,037	1.1	6,598	25.7%	1,696	12.5%	212
White Pine	8,876	1.0	8,766	24.2%	2,121	15.3%	325
State	**109,826**	**18.2**	**2,106,074**	**25.6%**	**539,155**	**15.4%**	**83,030**



Overall Race of Children by Jurisdiction

	Rural	Nevada
Caucasian	**78.8%**	**65.2%**
Hispanic	**12.7%**	**19.7%**
African American	**1.2%**	**6.8%**
American Indian	**3.4%**	**1.3%**
Asian / Hawaiian	**1.2%**	**4.9%**

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 200 US census with the 2001 growth estimators. Figure One shows the data for the seventeen counties in Nevada. This data provides an estimate of the number of children who should be enrolled in the Medicaid and Nevada Check-Up systems. Figure Two 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.

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 Three shows the number of children covered by each of these programs.

Public Health Insurance Children Coverage

Eligibility Code	Rural	Statewide
TANF FFS	8771	29360
TANF PCN	99	39015
IV-E	308	2146
DCFS Custody	317	1813
Disabled	503	4520
NC FFS	4126	4466
NC PCN	34	14431
Total	14158	95751

This analysis shows the number of children enrolled in Medicaid as of April 2002.

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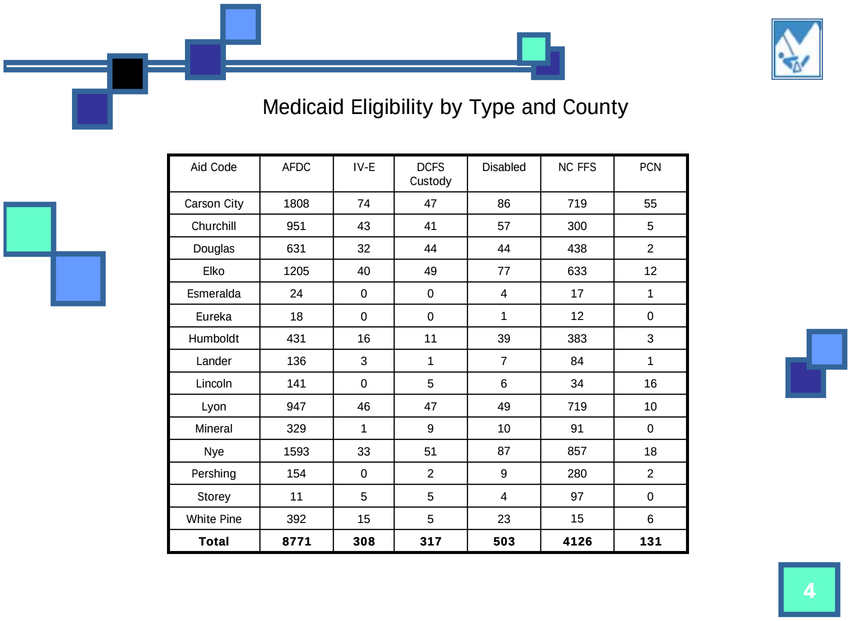
It is important to separate these different eligibility codes to understand how the benefits become fragmented for children and families. The first two codes in Figure Three are TANF FFS and TANF PCN. These categories represent the children and families that become eligible for Medicaid related to the 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



Medicaid Eligibility by Type and County

Aid Code	AFDC	IV-E	DCFS Custody	Disabled	NC FFS	PCN
Carson City	1808	74	47	86	719	55
Churchill	951	43	41	57	300	5
Douglas	631	32	44	44	438	2
Elko	1205	40	49	77	633	12
Esmeralda	24	0	0	4	17	1
Eureka	18	0	0	1	12	0
Humboldt	431	16	11	39	383	3
Lander	136	3	1	7	84	1
Lincoln	141	0	5	6	34	16
Lyon	947	46	47	49	719	10
Mineral	329	1	9	10	91	0
Nye	1593	33	51	87	857	18
Pershing	154	0	2	9	280	2
Storey	11	5	5	4	97	0
White Pine	392	15	5	23	15	6
Total	**8771**	**308**	**317**	**503**	**4126**	**131**

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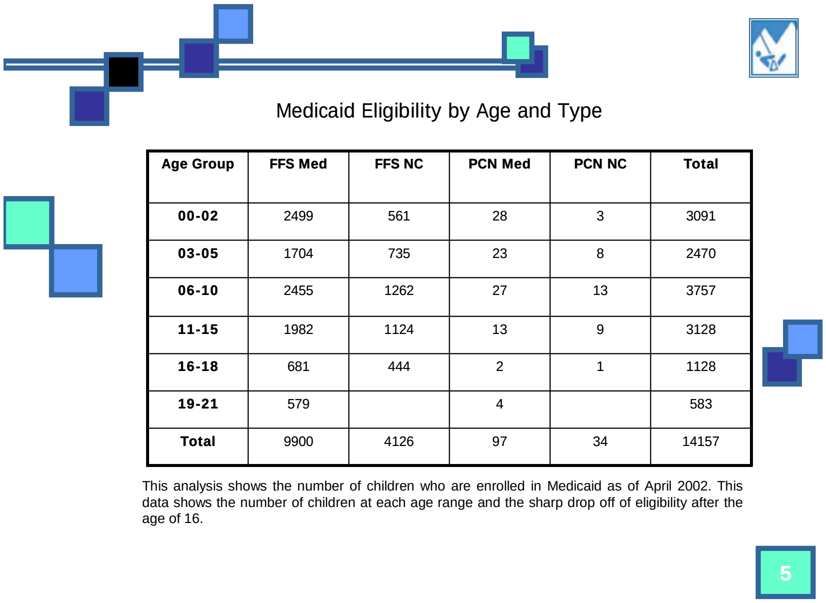
may lose their public insurance. This may be replaced by private insurance through a new job or the family may become uninsured depending on the type of income the family has received. The benefits and providers in the public sector are often different from those providing Medicaid services. The Nevada 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 Four shows the same data broken down by county in the rural jurisdiction. The numbers of children in the two Managed Care programs from the rural counties is small and the benefits are similar. For these reasons the two programs have been combined in this figure.

Figure Five shows the number of children enrolled in public enrolled in public insurance programs in the rural areas by age and eligibility code. The data show that there are about 1000 children of each age (e.g., 1000 five year olds) until the age of sixteen. There are only half as many 16 and 17 year old youth and 25% as many 19 and 20 year old young adults. 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. This may be from a lack of behavioral health supports.



Medicaid Eligibility by Age and Type

Age Group	FFS Med	FFS NC	PCN Med	PCN NC	Total
00-02	2499	561	28	3	3091
03-05	1704	735	23	8	2470
06-10	2455	1262	27	13	3757
11-15	1982	1124	13	9	3128
16-18	681	444	2	1	1128
19-21	579		4		583
Total	9900	4126	97	34	14157

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.

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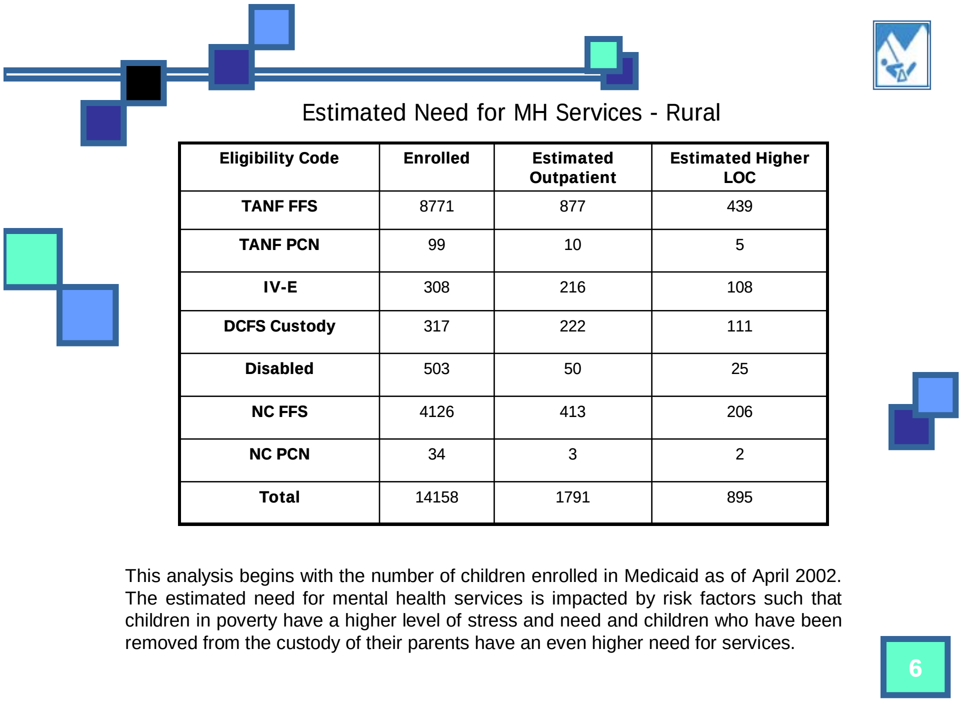
Using estimation methodology reported by SAMHSA the number of children who should need behavioral health services were estimated from these totals. Through this methodology risk factors and demographics of the children are compared to population samples in which the amount of needed mental health services has been determined by taking samples of children and assessing the need of individual children. Figure Six shows this estimation for children in the fee for service Medicaid program in Nevada.



Estimated Need for MH Services - Rural

Eligibility Code	Enrolled	Estimated Outpatient	Estimated Higher LOC
TANF FFS	8771	877	439
TANF PCN	99	10	5
IV-E	308	216	108
DCFS Custody	317	222	111
Disabled	503	50	25
NC FFS	4126	413	206
NC PCN	34	3	2
Total	14158	1791	895

This analysis begins with the number of children enrolled in Medicaid as of April 2002. The estimated need for mental health services is impacted by risk factors such that children in poverty have a higher level of stress and need and children who have been removed from the custody of their parents have an even higher need for services.

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The data in Figure Six show that at any point in time about 1791 children and youth in the rural jurisdiction are in need of behavioral health services and of these 895 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 Six 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 juvenile parole system was sampled to determine the need for behavioral health services because it is sufficient to sample the children in the program. 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 248 children were screened in the Rural Jurisdiction. This included 81 children from the DCFS Carson City region, 76 from DCFS Elko region, 59 from the DCFS Fallon region, and 32 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 O: 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[2]. 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.

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[2] 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 Seven 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 248 children and youth. About 46% of the children are living at home or with a relative. The rest are in out of home placements and 18% of these are in higher levels of care.

CALOCUS Demographics
Rural Jurisdiction

Race	All	Screen
Caucasian	81.6%	82.4%
Hispanic	11.0%	4.3%
African American	1.3%	6.6%
Native American	3.3%	0.9%
Asian Hawaiian	1.1%	0.1%
Bi-Racial	2.7%	5.7%

Current Living Situation	Percent
Home	30.8%
Shelter	0.9%
Level I	1.4%
Level II	7.9%
Level III	4.2%
TFC	1.9%
RTC	0.0%
Foster	30.4%
Relative	15.9%
Detention	0.5%
YTC	4.2%
Other	1.9%

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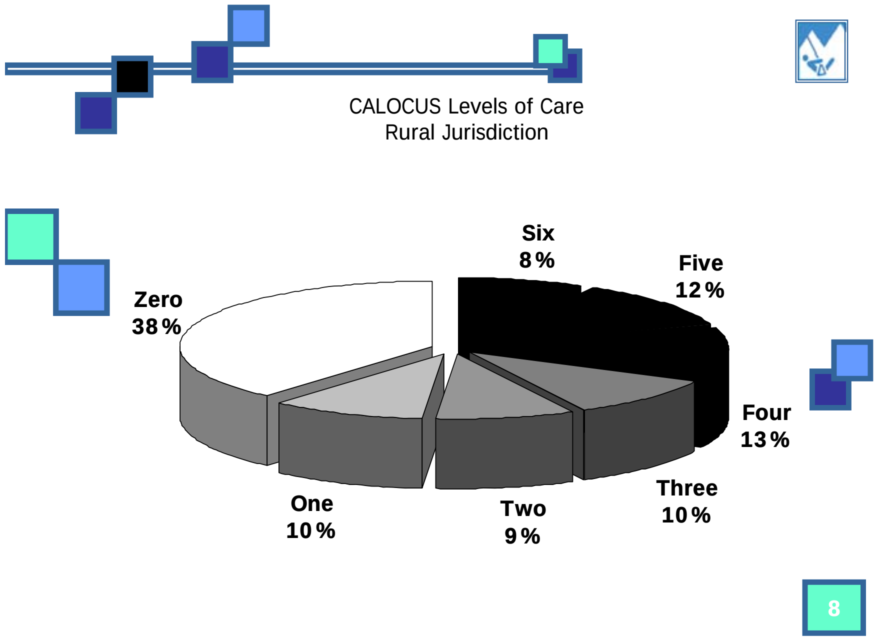
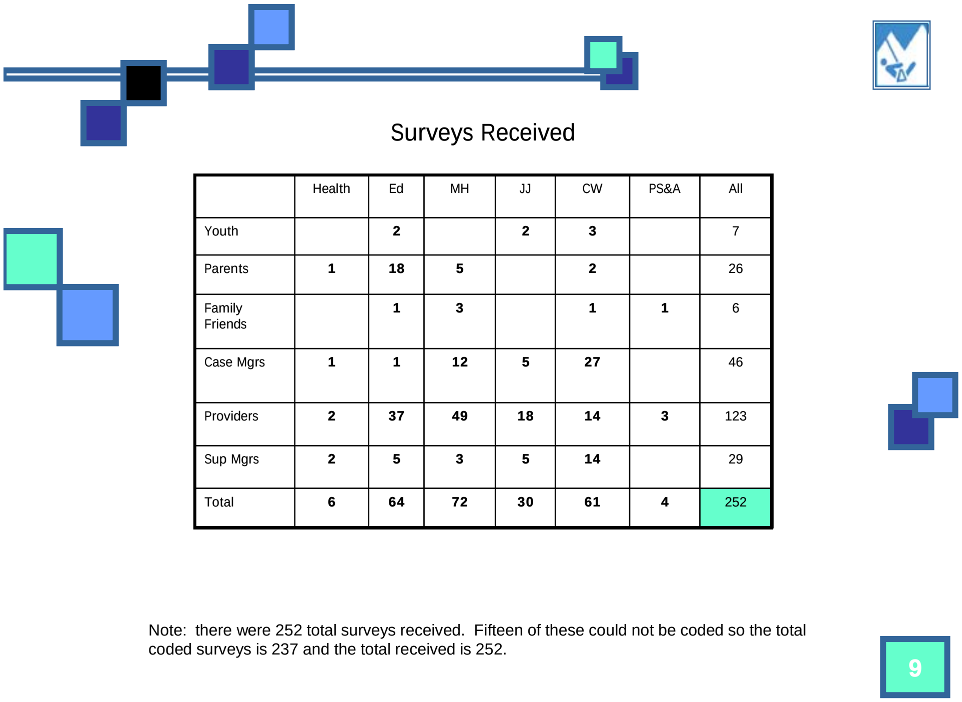
Figure Eight shows the results of the CALOCUS screening. The screening is scored in the seven levels of needed service and support. The first two levels (Levels zero and one) predict no need for behavioral health services. These children should get the kinds of supports and services offered to all children 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. Table Four shows the results of the screening in graphic form. Figure Eight shows the screening data by level and program. The data show that about half of the children (48%) need no behavioral health services. The 52% of the children and youth in the child welfare and juvenile parole systems who do need behavioral health care is a higher proportion of these children than estimated in the last section. The screening also found that 43% 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.


CALOCUS Levels of Care
Rural Jurisdiction

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 53%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 43% 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 Nine shows the numbers of people by role and system that completed the surveys. There were 7 youth, 26 parents and foster parents who completed the surveys. In addition, extended family members and friends were two 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.

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

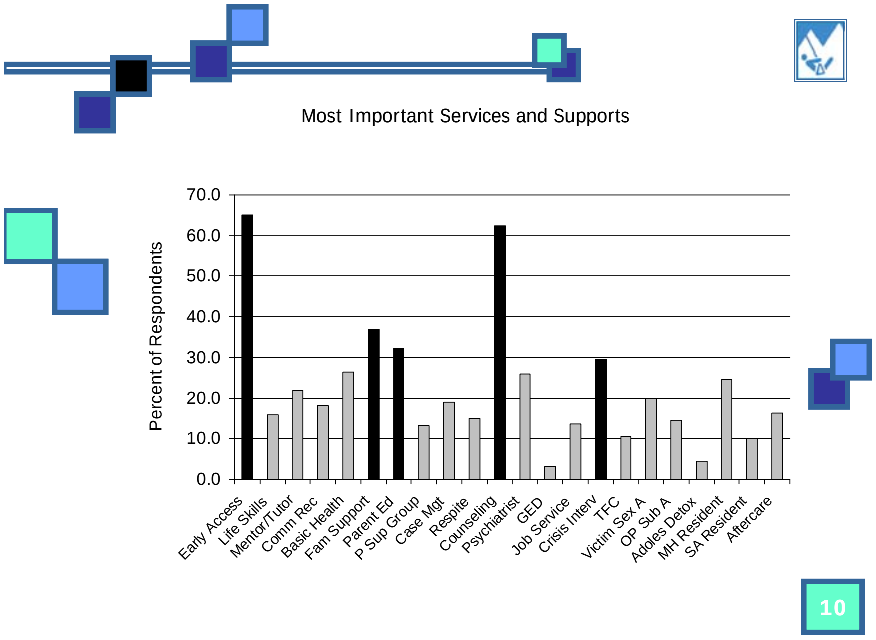


Surveys Received

	Health	Ed	MH	JJ	CW	PS&A	All
Youth		**2**		**2**	**3**		7
Parents	**1**	**18**	**5**		**2**		26
Family Friends		**1**	**3**		**1**	**1**	6
Case Mgrs	**1**	**1**	**12**	**5**	**27**		46
Providers	**2**	**37**	**49**	**18**	**14**	**3**	123
Sup Mgrs	**2**	**5**	**3**	**5**	**14**		29
Total	**6**	**64**	**72**	**30**	**61**	**4**	252

Note: there were 252 total surveys received. Fifteen of these could not be coded so the total coded surveys is 237 and the total received is 252.

their communities. From the focus groups twenty two potential services and supports were identified. Figure Ten 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 chart shows the ten services and supports that had the highest priority. The highest rated service was early access to services before problems become severe. A very close second was for counseling and therapy. The third and fourth priorities were for supports for families 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.



Most Important Services and Supports

The service priority data was analyzed by role and services system to see if different types of respondents had different priorities. Figure Eleven shows the results of the analysis. The table on the top of Figure Eleven shows the data sorted by role. All groups rated early access to services and counseling as their top two choices although supervisors and managers ranked counseling as most important. Parents ranked psychiatrists and medication management as their fourth choice although it was not an overall top five choice. The table at the bottom of Figure Eleven shows the rankings by system.

Service and Support Priority by Role and System

	All	Parent	Case Mgr	Provider	Sup Mgr
Prevention	65.3%	67.3%	71.7%	64.6%	64.5%
Counseling	62.7%	43.3%	62.8%	63.7%	76.6%
Family Support	37.1%	28.8%	47.1%	34.5%	44.4%
Parent Education	32.2%	43.3%	29.1%	33.6%	36.3%
Crisis Intervention	29.6%	19.2%	31.4%	32.7%	36.3%
Medication Mgt	26.0%	38.5%	26.9%	23.9%	32.3%
	All	**School**	**M Health**	**J Justice**	**C Welfare**
Prevention	65.3%	67.3%	71.7%	64.6%	64.5%
Counseling	62.7%	43.3%	62.8%	63.7%	76.6%
Family Support	37.1%	28.8%	47.1%	34.5%	44.4%
Parent Education	32.2%	43.3%	29.1%	33.6%	36.3%
Crisis Intervention	29.6%	19.2%	31.4%	32.7%	36.3%
Medication Mgt	26.0%	38.5%	26.9%	23.9%	32.3%

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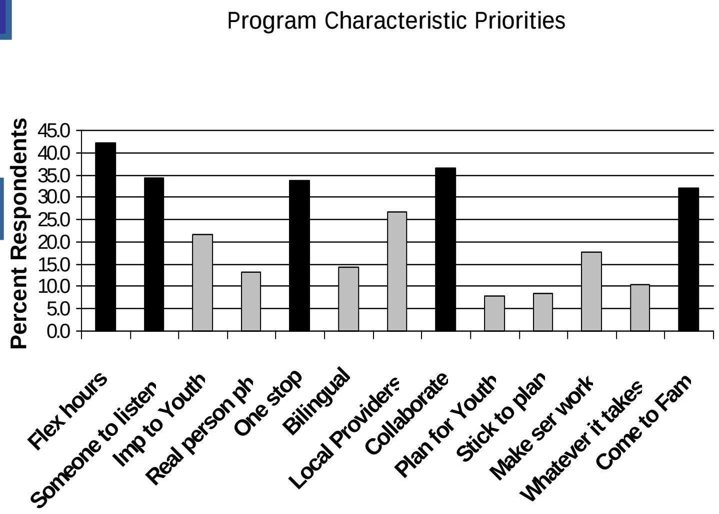
The second survey question addressed important characteristics of programs. During the focus groups and discussions prior to the assessment it become clear that just having a service available does not mean it would be used or that it would be effective. Thus an assessment of program characteristics examined what programs must do to be used and be successful. Figure Twelve shows the results of this part of the survey. Flexibility in the hours and places of services was the most important characteristic. Families and staff talked about the need for providers and agencies to work together. The assessment of needs point to the importance of integrated and coordinated services and this is repeated in the second priority for program characteristic. Respondents rated being able to go one place and get what they needed as the third most important characteristic of good programs and services. 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. They also talked someone to listen to the needs of the youth and having providers in and from the local communities.



Summary of Need for Behavioral Health Services.

- A large proportion (over 53%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need mental health services and over 43% need individualized, integrated and coordinated mental health services.
- 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). The second highest priority was counseling services.
- 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 counseling, early response, mobile crisis response, mentors, respite care, and integrated case management to coordinate and link services.
- 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

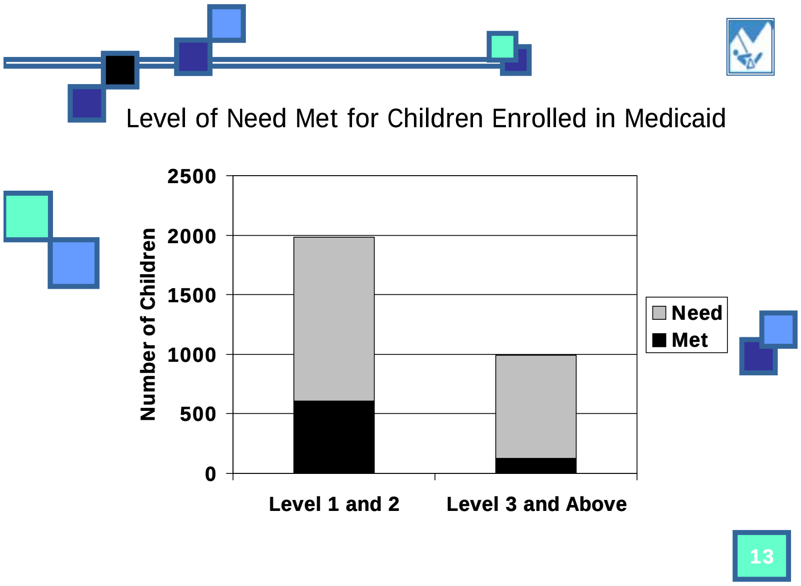
these children, how to access needed services and supports, and support to work through the challenges of raising and supporting a child with special needs.

- 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

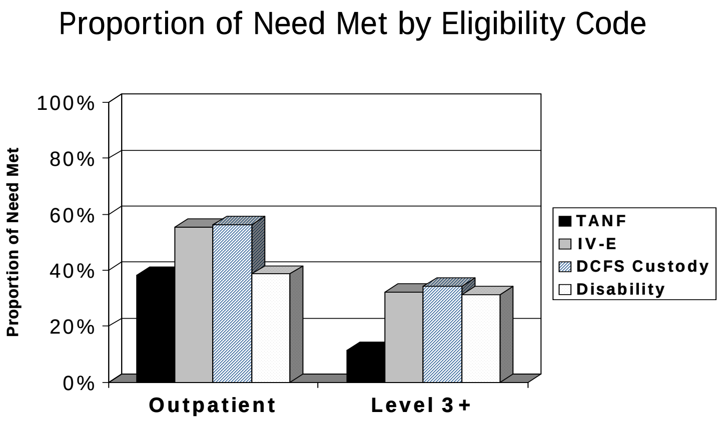
There are four basic questions that were addressed for this section of the annual report. How many of the children identified to be in need of behavioral health services are receiving services, are they receiving services at the level they need, do these services meet criteria for best practices, and 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 Thirteen shows the summary data for this comparison. Of the 1970 children who are estimated to need behavioral health services only 611 are actually receiving them. Of the 990 who are estimated to need behavioral health services at higher levels of care only 123 are receiving them.

Figure fourteen shows how well the behavioral health need is being met for children in different eligibility criteria. Children with identified disabilities are most likely to get behavioral health services if they need them. Children in public custody are more than twice as likely to get behavioral health services as those who are not.



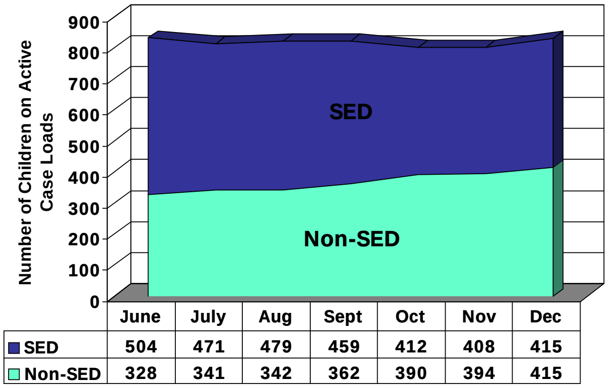
This data uses the population estimation calculations based on SAMHSA estimation methodology and levels of care. This is compared to encounter data on the actual services provided and billed through Medicaid for children and youth in Nevada.

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

14

Rural clinics provide behavioral health services for children and youth. They provide services to children and youth who are enrolled in Medicaid and to children and youth who are not. Figure Fifteen shows how many children were served each month through the rural mental health clinics for the last 6 months of 2001. Clearly the rural clinics are the primary providers of children's mental health services in rural Nevada. Figure fifteen shows how many children are served and the proportion of these children who meet the SED criteria. It is clear that these clinics are forced to triage and work with only the more severe children because of very limited resources to serve children and youth.

Children Receiving Services in Rural MHDS Clinics



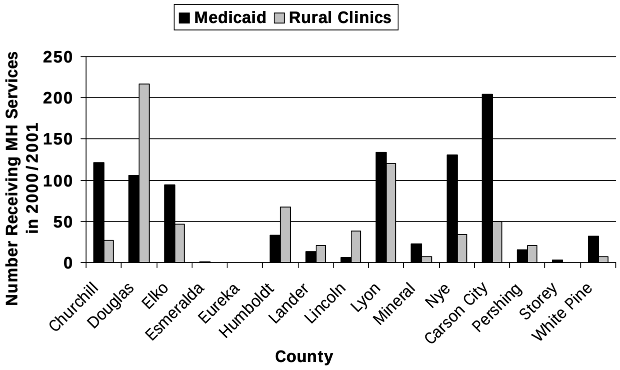
	June	July	Aug	Sept	Oct	Nov	Dec
■ SED	504	471	479	459	412	408	415
■ Non-SED	328	341	342	362	390	394	415

This data is for the last six months of 2001

15

Figure sixteen shows the number of children with SED who received services through the rural mental health clinics and the number of children who billed Medicaid mental health services by county. The rural mental health clinics data is reported by where the services were provided. The Medicaid data reports the home county for the child. Clearly children in the rural jurisdiction must travel outside their home counties to get services.

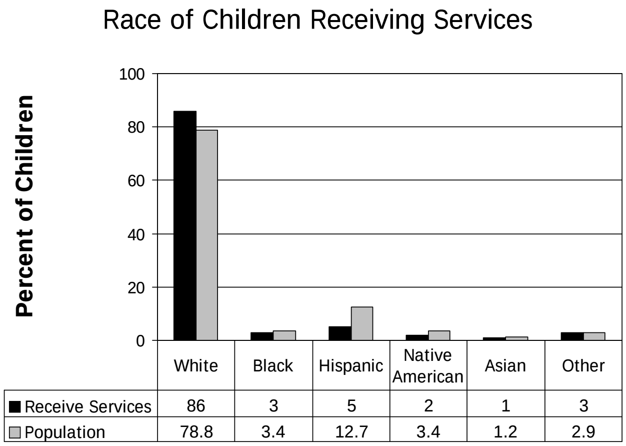
Children Receiving MH Services by County



This data is for 2001

16

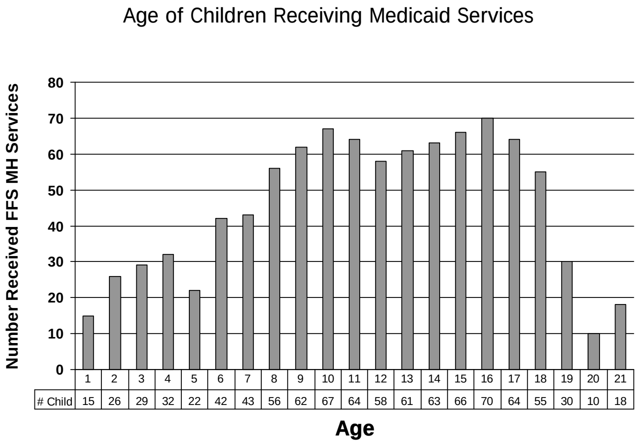
Figure seventeen shows a comparison of the race of children in the rural population to those receiving Medicaid mental health services. African American and Caucasian children are more likely to receive mental health services and Hispanic and Native American children are less likely to receive these services.



	White	Black	Hispanic	Native American	Asian	Other
■ Receive Services	86	3	5	2	1	3
▨ Population	78.8	3.4	12.7	3.4	1.2	2.9

17

Figure eighteen 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 seventeen 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.



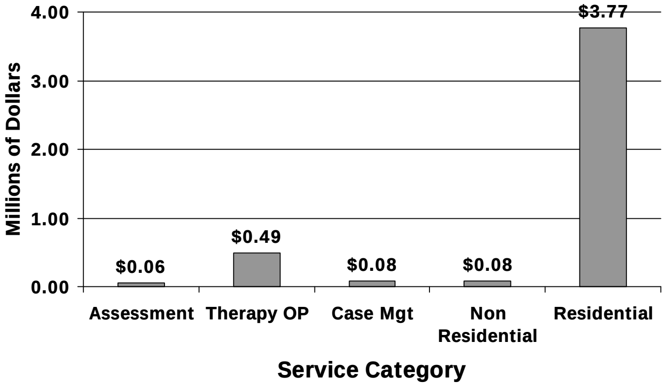
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
# Child	15	26	29	32	22	42	43	56	62	67	64	58	61	63	66	70	64	55	30	10	18

This data is for 2001

18

Figure nineteen shows how much money was spent on Medicaid mental health services by service type. In the rural jurisdiction over $4.48 million was spent through Medicaid on children's mental health services. Of this amount over 84% or $3.77 million were spent on residential services. Figure twenty shows these expenditures broken out by procedure code.

MH Expenditures by Service Type



19

MH Expenditures by Service Type

Assessment	**$63,092**
Therapy OP	**$486,028**
Med Admin	**$4,096**
Rehab	**$76,709**
TFC	**$363,931**
Level 1	**$129,178**
Level 2	**$746,879**
Level 3	**$220,320**
Level 4	**$188,072**
Adult Rehab	**$6,094**
RTC	**$1,513,452**
Admin	**$88,020**
Inpatient	**$518,377**
Adult C Mgt	**$15,075**
Youth C Mgt	**$19,263**
Child C Mgt	**$41,446**

20

The second assessment of need assessed how well behavioral health needs were met for the 248 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 twenty one shows a summary of this assessment. Only 42.6% 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 30% of the children who did not need services. Of the children who had higher levels of care needs, more than 63% were receiving no behavioral health services at all. Figure twenty one also shows how well the need is being met in the individual regions and juvenile probation in the rural jurisdiction. There is a stark contrast between the area that was served by the old Northern region (the counties close to Carson City) and the rest of the rural region.

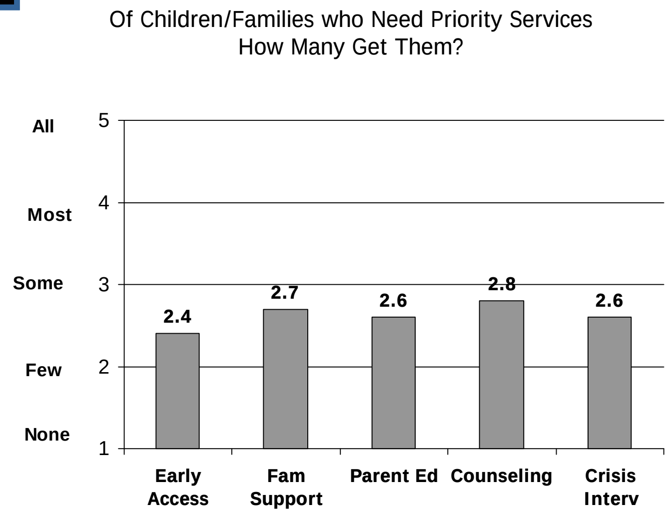
Level of Mental Health Need Met
from Rural CALOCUS Screening

	Served At Level	Under Served	Unserved Level 3 and Above
All	42.6%	57.4%	63.5%
Carson	55.4%	44.6%	37.0%
Elko	36.8%	63.2%	68.3%
Fallon	42.4%	57.6%	72.7%
Parole	42.6%	57.4%	60.0%

21

In Carson City, Douglas, Lyon , and Story counties 55.4% of the children who need mental health services are receiving them at the level identified by the CALOCUS and 63% of the children who need higher levels of care are receiving at least some mental health services. Although the 44.6% that need mental health services and the 37% who need higher levels of care but are receiving no services is a significant amount of unmet need, it is much better than the other areas of the rural jurisdiction.

On the survey respondents rated the accessibility of the services and supports listed. Figure twenty two 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 only counseling 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 and financial supports to pay for the services and supports children and families need were least accessible.


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

22

Figure twenty three shows this rating of accessibility by role and system. Overall providers found services to be more accessible and parent found them to be less

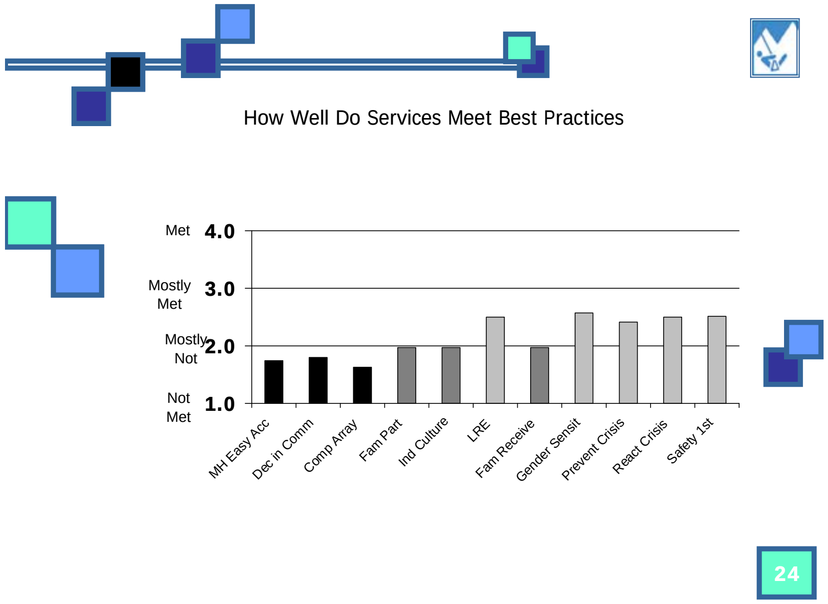
Service and Support Access by Role and System

	All	Parent	Case Mgr	Provider	Sup Mgr
Prevention	2.4	2.1	2.3	2.5	2.3
Counseling	2.7	2.5	2.8	2.7	2.8
Family Support	2.6	2.6	2.7	2.6	2.8
Parent Education	2.8	2.6	2.7	2.9	2.7
Crisis Intervention	2.6	2.7	2.5	2.6	2.6
Medication Mgt	2.4	1.8	2.3	2.4	2.5
	All	**School**	**M Health**	**J Justice**	**C Welfare**
Prevention	2.4	2.3	2.3	3.0	2.3
Counseling	2.8	2.5	3.1	3.3	2.6
Family Support	2.7	2.5	2.8	3.1	2.6
Parent Education	2.6	2.3	2.5	2.9	2.8
Crisis Intervention	2.6	2.3	3.0	2.5	2.4
Medication Mgt	2.4	1.9	2.5	2.7	2.4

23

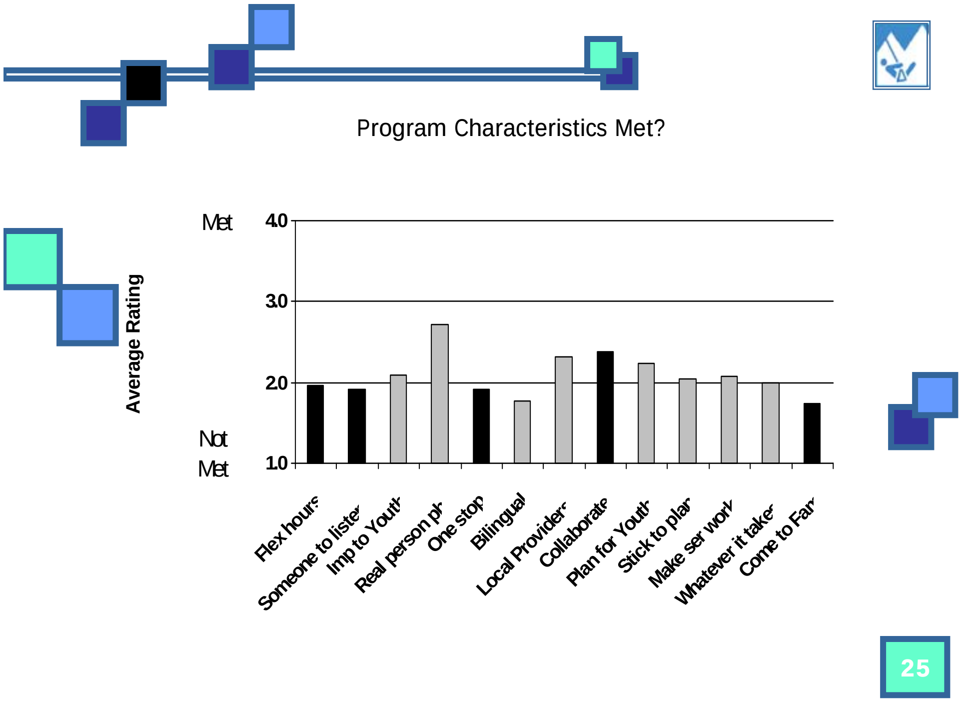
accessible. Juvenile justice staff found them more accessible and school staff found them less accessible.

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 twenty four shows the results of this section of the surveys for the five items that were rated as the most met and the six items that were listed as the least met.



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 six 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. There is a sense that local communities can not control their own services but that state policies and decisions take this choice away from them. 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 twenty five shows the results of this part of the survey. The top five 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.



Overall Findings About How Well Need is Met

- Less than 13% of the children who needed individualized and coordinated services were receiving them. Children in the rural jurisdiction are less than half as likely to get the services they need as children in the other two jurisdictions. Of the children screened only 56.1% 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 just "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.
- The level of mental health services in the rural area is significantly less than in the two urban jurisdictions. Simply having someone who can be paid through Medicaid in a community to provide services is not always true. One of the largest needs is the recruitment and privileging of staff to provide mental health services in the rural areas.

- 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 86.3% 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 nine 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.

- In rural areas there a need (recruitment and retention) for professional staff in a number of disciplines who specialize in children (58.1%)
- Need to open up Medicaid funding to private providers and provide incentives to get them to work in rural areas of need. (55.8%)
- Duplicative and complex paperwork takes too much time away from children and families (54%)
- We need access to flexible resources and dollars for stuff (guardianship, placement prevention) (47.6%)
- To provide individualized services we need a network of services instead of piecemeal development of programs (36.3%)
- Insufficient training and support for staff and professionals to be able to meet the needs of children with more difficult and specialized needs. People do not know what resources are available or how to access them (33.7%)

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.

Children covered through public insurance can access basic assessment, out patient therapy, and medication management through their managed care plan or through qualified physicians and psychologists. A broader array of services can be provided through the managed care plans and by DCFS in the urban jurisdictions and MHDS in the rural jurisdiction. The current benefit for the managed care plans only pays for a portion of the costs of these services and both DCFS and MHDS are significantly understaffed to meet the demand to provide these individualized services.

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 child welfare and 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

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 across the three consortia so each would know what the other was doing and have the benefits of the work and planning of the other. 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 could be shared 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 consortia. There were some differences but 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 there should be four overarching goals for developing the system of behavioral health care for children statewide, but that based on the current strengths, culture and needs of each consortium that the local plans should focus on local needs. 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 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.

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.

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. [3]

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

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[3] Satcher, 1999

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.

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.

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.

1. 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.

2. 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.

3. Children's Trust Fund

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

4. 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.

5. 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:

a) *The Department of Human Resources Director, Michael Wilden,*
b) *Legislative Interim Study Committee on Disabilities, Nevada Senator Dina Titus, Chair*
c) *Task Force for the Fund for a Healthy Nevada*
d) *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.*

6. 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 Sub grant 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 sub grants; 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.

7. 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.

8. 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.

9. 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

10. 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

11. 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

12. Carson City Mental Health Coalition

In 1998 the Carson City Bioard of Supervisors established a community goal to identify available resources for mental health services. It was decided that interested parties should meet and identify the unmet need of the mentally challenged in the community as well as establish beneficial partnerships between respective organizations. A group of professionals from private and public mental health organizations, law enforcement, criminal justice, juvenile and adult probation and local government officials have met regularly to discuss these issues. The mission is to create a sustainable and comprehensive mental health network.

13. 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 fora, 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. Carson City Coalition for Mental Health	Mental Health						X		X
13. Title IV-B Steering Committee	Child Abuse and Neglect		X					X	