Clark County Mental Health Consortium

Second Annual Plan

Clark County Children's Mental Health Consortium Members:

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

January 2003

Table of Contents

Introduction…….….. 1

Report of Progress Since the First Annual Report…….……... 1

Expanded and Updated Assessment of Need……...…… 4

Summary of Need for Behavioral Health Services……... 7

How Well Need is Met……..…… 7

System Barriers and Challenges……...…… 10

Eligibility for Services…….…… 11

Methods for Obtaining Services……...…… 11

Process forObtaining Services…….…… 12

Methods for Obtaining Additional Money…… 12

Involvement of Family Members in the Treatment of Children……... 12

Conclusion……...….. 13

Goals for Children's Behavioral Healthcare Services in Clark County...……. 14

Legislative Action Steps……... 14

State Department and Division Action Steps…….…….. 15

Community Action Steps……..…… 16

Appendix A…….….. 18

Appendix B……..…. 21

Clark County Consortium
Second Annual Plan for Mental Health Services

INTRODUCTION

The Clark County Children's Mental Health Consortium approved their First Annual Plan on August 15, 2002. Since that time, the Consortium has met monthly for the remainder of 2002 (e.g., a total of four full meetings). During the first eight months of 2002 the Consortium formed, enacted by-laws, developed procedures, formed work groups, conducted an assessment of the needs for behavioral health services for children and families in the jurisdiction, and developed a plan for improving these in the jurisdiction. The initial plan included seven local actions steps and recommendations for the Nevada Legislature and State Departments and Divisions. During the next four months the Clark County Consortium:

- strengthened the Consortium by adding new membership
- presented the plan and recommendations to two legislative committees
- made progress on all seven of the local action steps
- worked with State Departments and Divisions to address recommendations
- further assessed the need for behavioral health services and found it to be slightly greater than first reported
- fine-tuned the initial recommendations and action steps based on further assessment and analysis
- prioritized improvements in behavioral health services for children in the juvenile justice and family support systems.

REPORT OF PROGRESS SINCE THE FIRST ANNUAL REPORT

Strengthened Consortium by Adding New Membership. In September 2002, the Consortium reviewed its membership and determined that to represent the county more effectively Jan Biggerstaff of CASA, Shelia Parks of Child Welfare Advocates, and Pauline Kennedy of the Foster Parent Association should be added to the membership. The Consortium made recommendations for these new appointments in 2003 to Mr. Edward Cotton, DCFS Administrator. The Consortium began the process of developing its Second Annual Plan.

Presented Findings to Legislative Committees. In August 2002, the Consortium presented its recommendations of the First Annual Plan to the Legislative Committee on Children, Youth and Families (LCCYF), chaired by Assemblywoman Buckley. The LCCYF voted to include a statement in their report to the legislature generally supporting the work of each mental health consortium and the recommendations included in their First Annual Plans. The LCCYF also voted to include specific statements into the report expressing the Committee's support of the recommendations from all three consortia to maintain funding for services to children with severe emotional disturbance in the child welfare system, which was provided under Assembly Bill 1. In addition, the LCCYF voted to include a statement in their report expressing support for expanding the funding to additional children in the Child Welfare and Juvenile Justice systems.

In September, the Consortium presented the recommendation of its First Annual Plan to the Legislative Health Care Committee's Subcommittee on Mental Health Issues chaired by Senator

Townsend. Senator Townsend is also a member of President Bush's Freedom Commission on Mental Health. The Subcommittee supported many of the Consortium's legislative recommendations.

Progress on Local Action *Steps*

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

a. The Consortium has supported the development of DCFS's five Neighborhood Care Centers, and the expansion of these five centers to include Clark County Juvenile Justice and Child and Family Services programs.
b. The Consortium has developed five common geographical boundaries for Clark County and DCFS staff and are working with the School District to do the same.
c. Plans are underway to locate County and State child welfare, juvenile justice, and mental health staff in the same locations in two of the regions in the next two months.
d. An interagency coordinating mechanism to plan and oversee this coordination has been implemented and is called the Neighborhood Center Administrative Team.

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

a. Working with State Departments and Divisions, staff and families from Clark County have implemented a common level of care determination process and tool for children 5 to 18 (Child and Adolescent Level of Care Utilization System).
b. Agencies in Clark County have implemented a common early intervention screening and assessment tool and protocol for children 0 to 5 (Ages and Stages).
c. Agencies in Clark County have implemented a common mental health screening and assessment tool and protocol for children 5 to 18 (Mental Health Screening Tool).
d. Committees are currently working on common intake, referral, release of information, and assessment formats and systems.

Local Action Step Three. *Develop a written brochure of how to recognize the early signs of emotional disturbance in children and how to access behavioral healthcare services in Clark County.*

a. Since October, a workgroup chaired by Mark Disselkoen of BADA has been reviewing existing materials and developing a strategy for providing new materials. Parents are participating in this effort.

Local Action Step Four. *Commit as agency members of the Consortium to offer flexible hours for services to better meet families' needs.*

a. The plans for co-locating staff include strategies for improved coverage and expanded hours of operation.
b. The plans also mean people can call one number for access to services.
c. Clark County Department Family Services has implemented weekend visits for parents of children in out of home care to make this more accessible.

Local Action Step Five. *Work together as a Consortium to identify funding for mobile crisis teams and a 24-hour children's help line that can provide support to families and foster caregivers and reduce the need for out-of-home care.*

a. The Consortium reviewed the model of Mobile Crisis Services developed by DCFS's Neighborhood Care Center Project.
b. The Consortium supported the implementation of this model. The funding for this was insufficient to cover the full cost and was only available for one year. Providers were not willing develop these services without a longer term commitment and full funding.
c. The Consortium submitted this model to Senator Townsend for potential funding.

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

a. Clark County Department of Family Services is hiring bilingual staff for the hotline.
b. Clark County Department of Family Services is developing a limited English proficiency plan and will share this with the full Consortium.
c. Division of Child and Family Services has hired bilingual staff at all five Neighborhood Centers.

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

a. Initial cross training in the level of care determination system was provided for Clark County and DCFS child welfare and juvenile justice staff.
b. This training will be provided for other Consortium member agencies in January 2003.
c. A cross agency training team including families, county and state staff has been formed to address this action item.

Worked With Departments and Divisions to Address Recommendations.

Staff and family members from Clark County have worked with six state wide committees to develop plans to add additional services and supports, develop a universal level of care system for Medicaid, determine appropriate rates for services, develop a common model of behavioral health services, and develop methodology for determining criteria for early access to services.

In November 2002, the Consortium discussed the Medicaid Program, reviewed the relevant recommendations in its First Annual Plan, and identified barriers to improving access to Medicaid's behavioral healthcare programs for children in public systems. In December 2002, a letter was sent to Mr. Willden asking for assistance in overcoming these barriers.

Over the past eight months, the Consortium has been active in the implementation of the Division of Child and Family Service's SED Services Project funded by Assembly Bill 1. A separate report on the progress and impact of this pilot will be developed in late January 2003 for the Legislative Committee on Children, Youth and Families.

EXPANDED AND UPDATED ASSESSMENT OF NEED

In October 2002, the Consortium began to discuss the next annual plan. It was decided to get a larger sample of children and youth from the Clark County Family Services and Juvenile Justice programs. It was also decided to gather information on risk and protective factors for these children. To meet this goal an additional 44 youth were screened in Clark County Juvenile Justice Services and 30 children in Clark County Children and Family Services.

The updated assessment more clearly documents the unmet need for children in public systems in Clark County. Figure One shows that over 60% of the children in the public child welfare and juvenile justice systems are not receiving the behavioral health services they need and that over 28.5% of the children with severe emotional disorders in these systems are receiving no behavioral health services at all. The figure shows that DCFS with the Neighborhood Care Project and Children's Behavioral Health Services is meeting a larger proportion of the need than Clark County Children and Families Services, Clark County Juvenile Services, and DCFS Youth Parole[1].

Level of Mental Health Need Met from Clark CALOCUS Screening

	Receiving Appropriate Level of Services	Under Served	Children with SED receiving no Services
All	38.9%	61.1%	28.5%
CC DFS	30.0%	70.0%	43.8%
DCFS	53.3%	46.7%	13.0%
CC JJS	29.8%	69.2%	27.1%
Parole	42.6%	57.4%	30.0%

Figure One uses the data from the Child and Adolescent Level of Care Utilization System Screening of 618 children and youth in the Child Welfare and Juvenile Justice Systems in Clark County compared to the Types and amounts of services received to determine how well the need is being met for children and youth in these public systems.

The new assessment also looked at the risk and protective factors that are known to impact how well children do in school, grow to be independent and productive adults, and avoid school failure, substance abuse, juvenile crime and violence. Assessment of the presence of these factors was a part of the screening for the 74 children and youth that were added to the sample for this report. Figure Two shows the risk factors for these children. For youth in the juvenile justice system unsatisfactory school attendance and performance were the two highest rated risk factors. This points to the need to partner with schools in the process of ensuring emotional

[1] More detail on this assessment is included in Appendix A of this report.

health and success for these children and youth. In addition to the history of abuse and neglect the risk factors for the children in the child welfare system are highest for parental substance abuse and unemployment. Thus to support healthy families in Clark County, we must support the parents of our children to find and keep good jobs and provide needed behavioral health services for them. In the surveys reported in the first annual report, family support was rated as the fourth most important service but most parents who needed support were not receiving them.

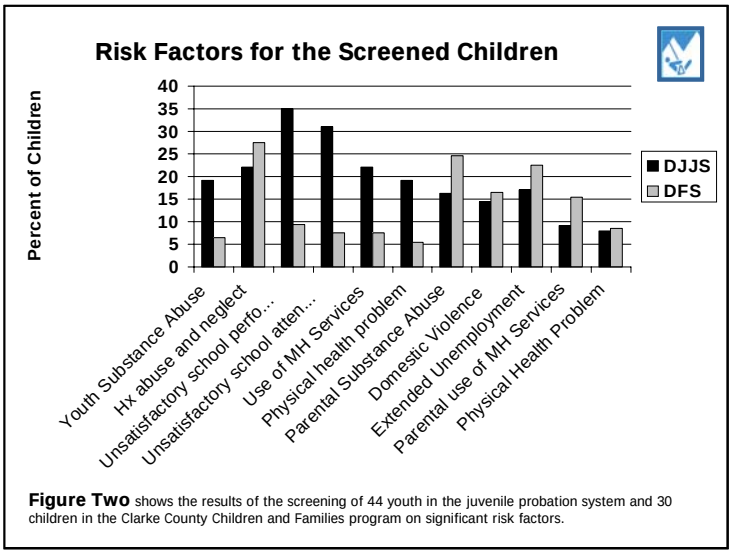

Figure Two shows the results of the screening of 44 youth in the juvenile probation system and 30 children in the Clarke County Children and Families program on significant risk factors.

Figure Three shows the results of the assessment of protective factors. The scale is rated from "no" the protective factor is not present for this child to "sometimes" to "yes" it is present. The results show that only the availability of health insurance rates above sometimes and that for the other four protective factors the results are below that overall. Families with young children are more likely to seek assistance than families with youth in the juvenile justice system. Overall this data reaffirms the need to focus attention on strengthening families through strengths based approaches that have been shown to be successful in engaging almost all families.

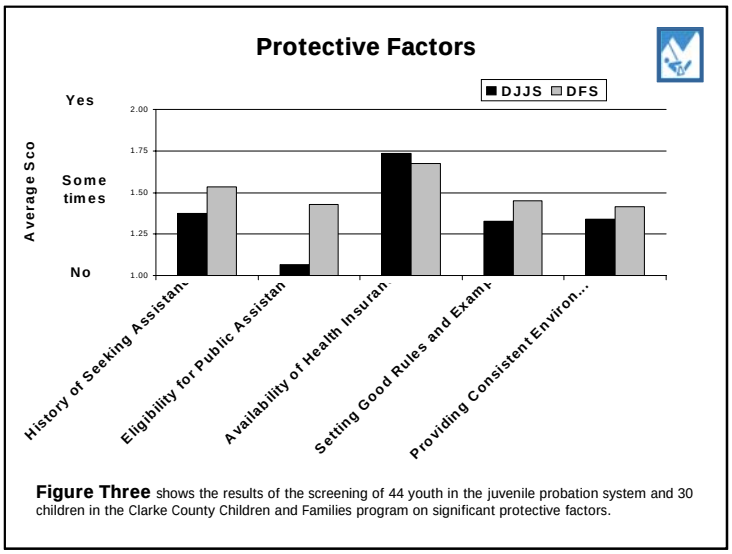

Figure Three shows the results of the screening of 44 youth in the juvenile probation system and 30 children in the Clarke County Children and Families program on significant protective factors.

SUMMARY OF NEED FOR BEHAVIORAL HEALTH SERVICES

- Clark County has a need for a capacity to provide behavioral health services to over 8250 children within the Medicaid, juvenile justice, and child welfare systems at any point in time. Of these children there is a need to be able to provide individualized and coordinated services for over 4200 of these children.
- A large proportion (over 65%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need some level of mental health services.
- Parents and staff throughout the jurisdiction rated early access to services before problems become severe as the most important aspect of a mental health system. This would to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice).
- The best outcomes for children and families are achieved through a comprehensive array of flexible and community-based supports that help children and youth to be included in their communities.
- To support children with mental health disorders at home and in their communities, families, teachers, social workers, and juvenile justice staff need information, education, and support to understand the special needs of these children, and to work through the challenges of raising and supporting these children and youth.
- Families need services that are customized to work for them. This means they are accessible in time and place to match the schedules and needs of families. It means that there is no wrong door and that services are coordinated across agencies to meet family's needs. It means the services are sensitive to and match the culture and language of the family.
- To make the system responsive and effective for families there is a need for consumer involvement at all levels of decision-making, evaluation and implementation of the system of care. Parents of children who have severe emotional disorders can be very effective supports and advocates for other parents.

HOW WELL NEED IS MET

- Of the more than 5000 children in the AFDC Medicaid population who need mental health services in Clark County, less than 28.7% are receiving them.
- Of the 618 children screened in the Child Welfare and Juvenile Justice system, only 38.9% are receiving mental health services at the level of their need.
- Over 70% of children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise require these services.

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 Four shows the summary data for this comparison. Of the 7000 children who are estimated to need behavioral health services only 2700 are actually receiving them. Of the 2500 who are estimated to need behavioral health services at higher levels of care only 560 are receiving them.

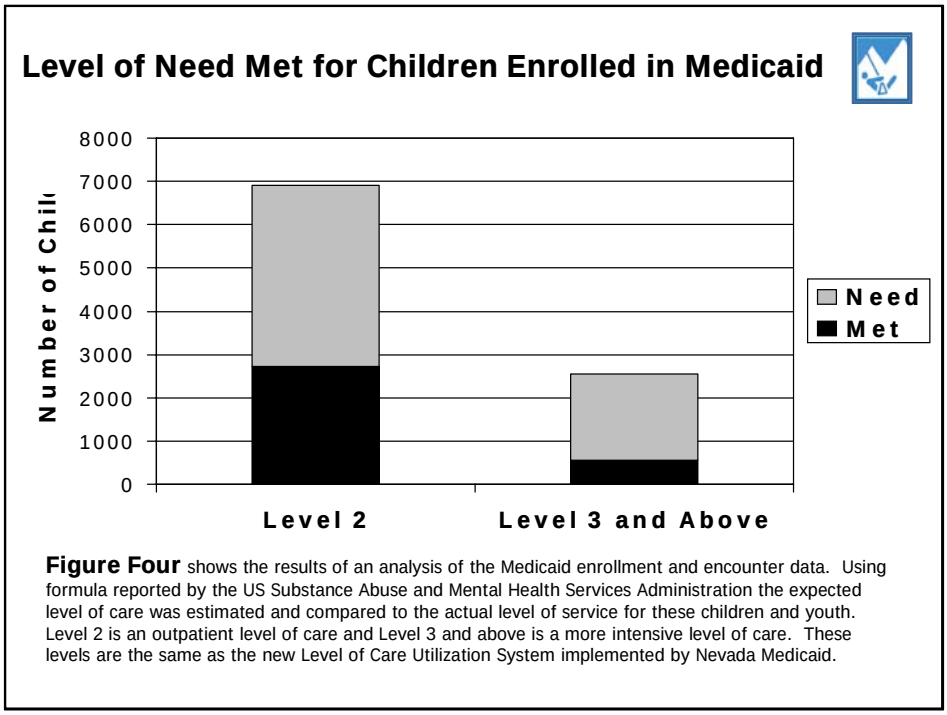

Figure Four shows the results of an analysis of the Medicaid enrollment and encounter data. Using formula reported by the US Substance Abuse and Mental Health Services Administration the expected level of care was estimated and compared to the actual level of service for these children and youth. Level 2 is an outpatient level of care and Level 3 and above is a more intensive level of care. These levels are the same as the new Level of Care Utilization System implemented by Nevada Medicaid.

Figure Five shows how well the behavioral health need is being met for children in different eligibility criteria. Children who are enrolled in the child welfare or foster care system are much more likely to get Level II services and these children plus those children with disabilities are much more likely to get Level III and higher services if they need them. Children in public custody are more than three times as likely to get behavioral health services as those who are not. The barriers to service described in a later section prevent many families from getting the services and supports they need for their children and themselves and may force children into the custody of the state.

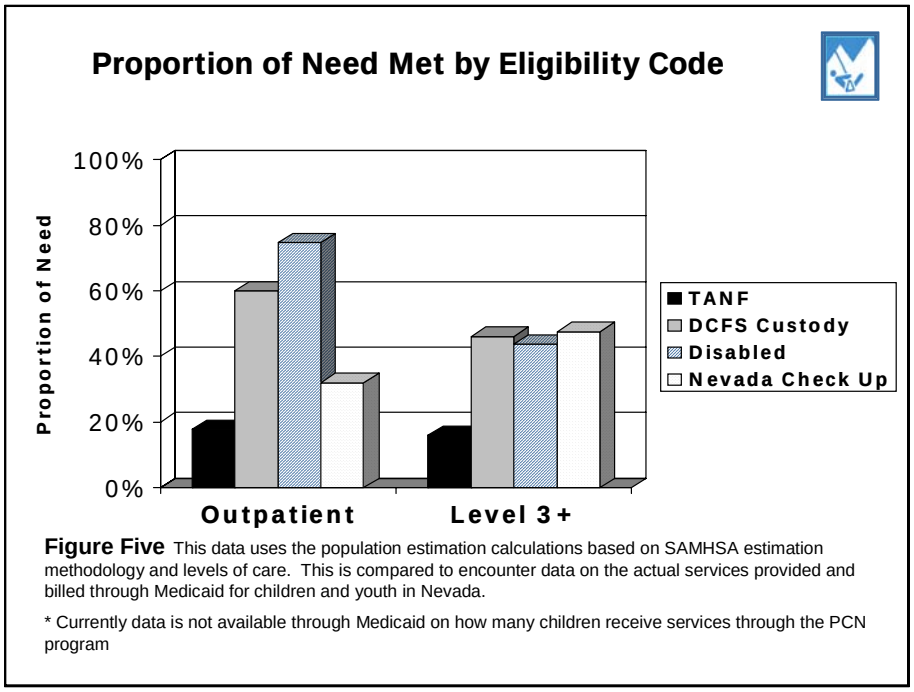

Figure Five This data uses the population estimation calculations based on SAMHSA estimation methodology and levels of care. This is compared to encounter data on the actual services provided and billed through Medicaid for children and youth in Nevada.

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

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

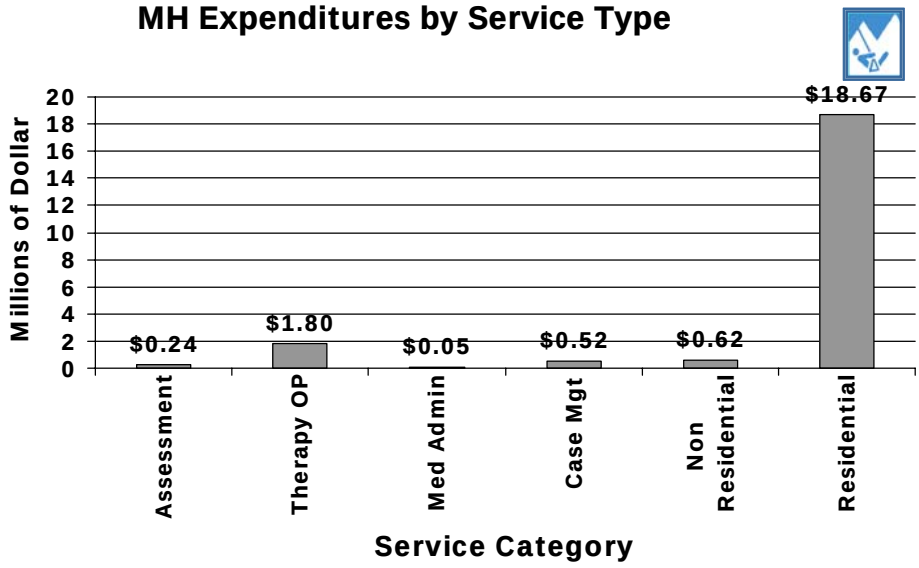

Figure Six shows the amount of money that has been spent through Medicaid on different types of behavioral health services. This data was drawn from the encounter data for Medicaid.

- Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services.
- Families and providers report long waiting times and lack of flexibility from the managed care and public system providers. Interviews with staff and families documented waiting of 10 weeks and longer in all programs and presumptive waiting lists because of the impression that services were not available or accessible.
- Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.

SYSTEM BARRIERS AND CHALLENGES

Through the initial focus groups with families and staff it become quite apparent that there are a significant number of system barriers and challenges that prevent or make it difficult for staff and agencies to provide good services for children and families. Specific Barriers were cited by the staff interviewed for this report. They include:

Problems Cited by the Juvenile Justice Staff in Accessing Services

- **213 Criteria** - This refers to the difficulty experienced in attempting to access State services for delinquent youth covered under AB 213. AB 213 was intended to meet the needs of youth with chronic psychological/psychiatric disorders who are also in need of correctional placement because of their delinquent behavior. The criteria for youth to be accepted for services via AB 213 are vague and subject to interpretation, leading to delays and frustration on everyone's part.
- **Payment sources and limitations on services -** Difficulties are frequently encountered when attempting to identify what insurance coverage/resources the family has or is eligible for with regards to obtaining mental health services; and even when properly identified, many have "limitations" that prohibit or impede delivery of services to delinquent youth.
- **Change in programs and eligibility change medications and services -** If the youth's insurance coverage changes, this often results in "Starting over", rather than continuing with services that have been established. Also, if a youth moves from one program to another, his/her eligibility to receive services may change (e.g., A youth in custody at Clark County Juvenile Justice Services' Detention Center is not Medicaid-eligible, but may become eligible if placed into a community-based group home.
- **Families as a barrier** – staff noted that many times they could not engage the families of children in the juvenile justice system in the process and that youth often went back to the environments that caused the problem in the first place.

Problems Cited by the Family Services Staff in Accessing Services

- **Lack of family support and prevention services** – Easily accessible, no-/low-cost community-based children's programs (e.g. recreational) and family support services are needed to enable families to pursue activities that support their children's normal development. While existing early intervention programs are good, additional services are needed to meet the need. These support services should be individualized and build on a family's resources.
- **Lack of appropriate services –** Both traditional (e.g. outpatient therapy, medication) and nontraditional (e.g. respite, daycare, after school programs, day treatment) services are often unavailable or have long waiting lists.
- **Lack of assistance to help families navigate service systems** – Finding available services and determining how to access these services is challenging to families, as well as new child welfare staff. High caseloads also leave child welfare staff with less time to guide families to needed services. A single point of entry that could link families to services or service coordinator positions would ensure families are linked with needed services.
- **Access to services is eligibility-driven** – Too often eligibility criteria for services and financial assistance prevent children and their parents from accessing services early, often resulting in crises and a need for higher levels of care. At times, children moving from higher to lower levels of care become financially ineligible for needed services, making it difficult to successfully keep children in lower levels of care. Additionally, eligibility requirements do not make services available to some needy children, e.g. undocumented youth.

ELIGIBILITY FOR SERVICES

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

METHODS FOR OBTAINING SERVICES

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

PROCESS FOR OBTAINING SERVICES

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

METHODS FOR OBTAINING ADDITIONAL MONEY

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

Projections and Costs of Implementing Recommendations. The figure below shows the costs of providing the recommended mental health services for the children in the public systems. The first column shows the unmet need. The second shows the potential savings by providing community based alternatives to highly restrictive residential care. The third column shows the new funding from the AB1 legislation that will address this need. The fourth column shows the amount of additional funding needed. The fifth column estimates the amount of this money that

would be recaptured as federal participation in Medicaid. The sixth column shows the additional dollars need in state match for this Medicaid funding. And the final column shows the additional funds from state or county budgets required to meet the need. Note that the Medicaid match is not included in the last column.

INVOLVEMENT OF FAMILY MEMBERS IN THE TREATMENT OF CHILDREN

The data gathered for the First Annual Plan highlight the need for family involvement at all levels of decision-making, evaluation and implementation of the system of care. Additionally, the updated assessment data gathered for this Second Annual Plan highlight the importance of family support services in addressing specific family risk factors for each target population and building on family strengths to overcome barriers to effective treatment of children.

Estimated Cost to Meet Need for Clark

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

Figure Seven shows estimates of how much funding it will take to meet the need of all children with behavioral health needs in Clark County. This is reported in thousands of dollars and assumes full funding for the 327 children through AB-1.

* Portions of this need can be paid through private insurance if the policies allow for community-based alternatives to hospital care

CONCLUSION

The new data that have been gathered for this second report supports all of the findings and priorities of the first report and determines that the need for behavioral health services is even greater than had been first reported. Based on the assessment and discussions of the Consortium and cross consortia discussions with the Washoe and Rural Consortia, the Clark County Consortium developed a vision of what the behavioral health system for children and families should be in Nevada. This is expressed in terms of the four goals listed below. From these goals the Consortium developed a set of priority recommendations for actions to be taken by the Nevada Legislature and the Nevada State Departments and Divisions to support movement towards these goals. In addition, the Clark County Consortium has developed a set of action steps that can be accomplished at a local level to move toward these goals. To provide good emotional health for children and families requires a partnership effort between families, local agencies and providers, state departments and divisions, and the Nevada Legislature. We believe progress has been made towards these goals in the past year but that there is still a long way to go. We are committed to this effort and are encouraged that we have good partners in the state administration and legislature.

GOALS FOR CHILDREN'S BEHAVIORAL HEALTHCARE SERVICES IN CLARK COUNTY

1. 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. 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. 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. Consumer involvement at all levels of decision-making around services and supports for children and families.

LEGISLATIVE ACTION STEPS

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

2. Continue the funding for the 327 children with severe emotional disorders (SED) who are in child welfare custody.

3. Provide funding for services for a pilot project for school based wraparound for 100 youth in the Juvenile Justice System who have severe emotional disorders. This would require the addition of 8 wraparound facilitators and enough funding to cover the behavioral health services these children need.[2]

4. Provide funding for services for a pilot project for wraparound for 100 children in the child welfare system who have severe emotional disorders to divert them from custody and out of home placement. This would require the addition of 8 wraparound facilitators and enough funding to cover the behavioral health services these children need.[2]

[2] This is a new action step

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

6. Provide funding through DCFS for a 24-hour, 7-day/week mobile crisis services for Clark County.[2]

STATE DEPARTMENT AND DIVISION ACTION STEPS

1. Recommend that the Department of Human Resources adopt the goals of the Clark County Consortium as its vision for children's services in Nevada.

2. Change the Medicaid program to expand the number of providers of direct services to children with behavioral healthcare needs by establishing specialty clinics that are designed to provide outpatient services as well as care coordination, family support and preventative services. Facilitate access to Medicaid services through a single level of care determination that allows the child to obtain a flexible array of services based on the child's level of need.

3. Improve the standards for Medicaid providers of behavioral healthcare services and apply these standards across fee for service and managed care programs. At a minimum, require all providers to deliver services where the family needs them, using flexible hours, using bilingual and bicultural staff, and providing one-stop service sites for a range of services.

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

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

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

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

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

[2] This is a new action step

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

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

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

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

13. Build on existing funding resources within the Department of Human Resources to provide a cross systems family support hotline in Clark County.[2]

COMMUNITY ACTION STEPS

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

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

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

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

5. Work together as a Consortium to developed a plan, identify funding, and implement mobile crisis teams.

6. Work together as a Consortium to developed a plan, identify funding, and implement a 24-hour children's help line that can provide support to families and foster caregivers and reduce the need for out-of-home care.

[2] This is a new action step

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

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

Appendix A
Summary of Additional Assessment

The Clark County Consortium decided to expand the sample of children who were assessed for need for mental health services and this need was compared to the current level of services. An additional 30 children were assessed from the Clark County Children and Family Services and 44 additional youth were assessed from the Clark County Department of Juvenile Justice Services. This assessment had four parts. First the staff were trained to assess the Level of Care needed by each child and youth through the Child and Adolescent Level of Care Utilization System. They then assessed children and youth that were selected through a random selection process. The third step was to complete a risk and protective factor assessment for each of the children. Finally the staff were interviewed through a focus group to determine what is working to support children and families today, what is needed, what are barriers to service, and recommendations they have for improving the Clark County system of care.

Some of the figures in the following description were used in the main body of the report. For this reason the figure numbers from the main text are used here unless the figure is new to the Appendix.

The figure below shows the total sample of children from the two assessments by race and current living condition. The all column for race shows the overall race of children in the county. The screened column shows the percentage for the 618 children screened.

CALOCUS Demographics
Clark Jurisdiction

Race	All	Screen
Caucasian	60.2%	63.2%
Black	9.1%	16.7%
Hispanic	22.0%	9.9%
Native American	0.8%	0.9%
Asian	5.8%	1.2%
Bi-Racial	2.1%	8.1%

Current Living Situation	Percent
Home	28.2%
Shelter	1.1%
Group Foster	21.3%
Therapeutic Foster	7.9%
Residential	6.4%
Foster	12.2%
Relative	18.3%
Detention	1.6%
Youth Training Center (Corrections)	2.3%
Other	0.7%

Figure Eight shows the race and current living situation the 618 children and youth screened in phases one and two of this assessment.

The figure below shows the scores on the CALOCUS for all of the children screened. The scores of Level 3 and above refer to children who would score in the severe range of emotional disorders.

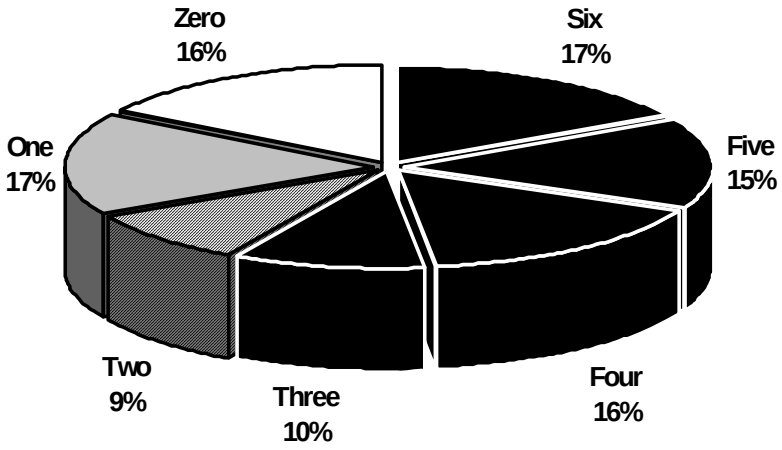

Figure Nine shows the percentage of the 618 children who were screened using the CALOCUS who need each of the seven levels of care.

The figure below shows the level of need for each of the different agencies. More information on the CALOCUS is available in Appendix B.

Levels of Care by System

	All	DFS	DCFS	DJJS	Parole
Six	17%	23%	12%	23%	10%
Five	15%	10%	8%	16%	28%
Four	16%	7%	21%	14%	23%
Three	10%	13%	3%	16%	5%
Two	9%	0%	10%	12%	15%
One	17%	30%	14%	12%	13%
Zero	16%	17%	32%	7%	7%

Figure Ten shows level of care determination for all of the children screened in each system.

The figure below shows how well this need is being met. This figure shows that over 60% of the children in the public child welfare and juvenile justice systems are not receiving the behavioral health services they need and that over 28.5% of the children with severe emotional disorders in these systems are receiving no behavioral health services at all. The figure shows that DCFS with the Neighborhood Care Project and Children's Behavioral Health Services is meeting a larger proportion of the need.

Level of Mental Health Need Met from Clark CALOCUS Screening

	Receiving Appropriate Level of Services	Under Served	Children with SED receiving no Services
All	38.9%	61.1%	28.5%
CC DFS	30.0%	70.0%	43.8%
DCFS	53.3%	46.7%	13.0%
CC JJS	29.8%	69.2%	27.1%
Parole	42.6%	57.4%	30.0%

Figure One uses the data from the Child and Adolescent Level of Care Utilization System Screening of 618 children and youth in the Child Welfare and Juvenile Justice Systems in Clark County compared to the Types and amounts of services received to determine how well the need is being met for children and youth in these public systems.

Appendix B

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: Nonsecure, 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[3]. 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.

[3] 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.