Clark County Mental Health Consortium

Third Annual Plan

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Clark County Consortium
Third Annual Plan for Mental Health Services

INTRODUCTION AND OVERVIEW

The Clark County Children's Mental Health Consortium has been meeting and working to fulfill the legislative requirements of NRS 433B and to strengthen the local partnership working toward creating an integrated system of behavioral health care for the children and families of Clark County.

The Third Annual Plan addresses the following areas:

- Updates the information about how well need is met in the child welfare and juvenile justice systems,
- Provides new information on the mental health characteristics and needs of the general school population in Clark County,
- Uses assessments from all three systems to develop a comprehensive model of behavioral health services within Clark County,
- Reports on an assessment of the system and organizational structure to support an integrated system of care, and
- Makes five major recommendations to address the unmet mental health needs in Clark County which include:

    1. Expansion of behavioral wellness activities for Clark County's elementary school children,
    2. Development of an integrated targeted early response system within the schools,
    3. Expansion of intensive intervention services for children with SED in the child welfare system,
    4. Provisions of intensive interventions for youth with SED throughout the juvenile justice system, and
    5. Improvement of the necessary system infrastructure to support community-wide behavioral health services.

UPDATE ON THE ACTIVITIES OF THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Over the last eighteen months since the submission of the Second Annual Plan, the Clark County

Children's Mental Health Consortium has met ten times. At least nine meetings of various workgroups have also been convened to conduct the business of the Consortium.

The Consortium has focused on the following activities: informing legislative committees, agency staff, and state and local groups of the findings of the first two reports, implementing local action steps, working with State Departments and Divisions to address the action steps of the Second Annual Plan, and further assessing the need for behavioral health services and how well it is met within the child welfare and juvenile justice systems.

The Consortium has made progress toward completion of all seven local action steps and has supported the completion of many state and legislative action steps recommended in the 2002 and 2003 Annual Plans[1].

Significant accomplishments of the Clark County Children's Mental Health Consortium are:

- The Consortium supported the development and implementation of the Safe Schools Healthy Students Initiative.
- The Consortium supported the development and implementation of the Child Welfare Kinship Care Grant.
- The Consortium strengthened the Neighborhood Care Center Service Delivery System.
- The Consortium conducted a large assessment of the need for behavioral health services within the Clark County School District.
- The Consortium developed a vision and plan for meeting the health needs of students within the Clark County School District.
- The Consortium reviewed the recommendations of 12 Commissions studying Nevada's Juvenile Justice System to update the assessment of the mental health needs of this population.

METHODS FOR ASSESSING CHILDREN'S AND SYSTEM NEEDS

For the Third Annual Plan, the Consortium coordinated assessment activities in five areas which include:

1. **Assessing how the AB-1 funding impacted the needs of abused/neglected children in the state foster care system.** During the past 18 months, the Wraparound in Nevada (WIN) project began for children in the child welfare system, which created wraparound services for 223 children and youth in Clark County. DCFS completed an evaluation of this effort that looks at the impact these services have had on individual children and youth within the DCFS foster care system and how these services have impacted the overall need for services for children and youth within this population[2].

2. **Updating the assessments of need for abused/neglected children in the Clark County child welfare system.** The consortium updated the information from the second annual plan

[1] See Appendix A for a complete progress report on all of last year's goals and objectives.
[2] The method for this assessment is included in Appendix B.

on the need for services for children receiving child protective services or emergency shelter care in the County.

3. **Expanding the assessment of need for youth in the juvenile justice system.** The juvenile justice assessment reviewed the testimony given to the Nevada Mental Health Plan Implementation Commission and eleven reports related to the Nevada and Clark County Juvenile Justice System and updated information on mental health services.[3]

4. **Conducting a new assessment of the needs for behavioral health services for children in the Clark County School system.** A sample of 2097 children in the elementary schools were selected and screened for signs, symptoms, and risk factors for behavioral health problems. Of these, 427 had positive screens and each of these children was further assessed using the Child and Adolescent level of Care Utilization System (CALOCUS).[4] The CALOCUS describes the level of mental health need. This was compared to the current level of service to determine how well need is met. Focus groups with teachers and counselors provided additional information on needs and barriers to effective services for these children.

5. **Conducting an assessment of the necessary organizational and system structure for supporting individualized behavioral health services.** Recent research has demonstrated the importance and impact of system structure and support on the quality and impact of behavioral health services. The consortium completed a three-part assessment on the current status and needs for infrastructure in Clark County. The details of this assessment are included in Appendix E.

CHILDREN'S NEED FOR BEHAVIORAL HEALTHCARE SERVICES

The combined and updated assessment of need identified the following:

1. **All school children need access to screening and universal behavioral health promotion activities.** The findings from the assessments in each system point to the need to develop a system that supports children and families in a way to avoid entrance into public service systems, such as: child welfare, juvenile justice and special education. By providing public education environments that support wellness through behavioral health promotion activities, many children could avoid deeper involvement in the system. A comprehensive behavioral health system must include behavioral health promotion for all school children. Currently 80.7% of children in the school system need only this level of support. If offered to more students, up to 90% of school children could avoid the need for mental health services. Nevada ranks as the state with the fifth highest rate of teenage suicide in the country. Behavioral health promotion activities need to include early screening for behavioral health problems and risk of suicide in the teen years.

2. **19.3% of all elementary school students need some level of behavioral health services and 6.0% need intense integrated services.** The results of the assessment process for the Clark County School District are shown in Figure One. Based on the screening and

[3] See Appendix C for details of this assessment process.
[4] The details and expanded results of this assessment are included in Appendix D of this report.

assessment the level of need was determined for six levels of the CALOCUS. 80.7% of the children scored at the zero level indicating that they only need health promotion support. 13.3% of the children were assessed to need level one through three services which are targeted interventions. 6.0% of the children were assessed at levels four through six which require intense and coordinated services.

3. **85.3% of abused/neglected children need some level of behavioral health services and 40% need intensive levels of community-based supports.** The Clark County Children's Mental Health Consortium conducted a needs assessment of this population for their 2002 and 2003 Annual Plans.

4. **79% of the juvenile offenders need some level of behavioral health services and 54% need intensive levels of community-based services.** The Clark County Children's Mental Health Consortium conducted a needs assessment of this population for their 2002 and 2003 Annual Plans.

5. **An integrated infrastructure is needed to support effective and accessible behavioral health service delivery.** This infrastructure should include: public engagement and outreach, system management, integrated access, collaborative service processes, utilization management, workforce development, integrated financing, and ongoing utilization focused evaluation.

Need for Services for Elementary School Children

CALOCUS Level / Description		Percent	Number	Needs
Negative on MH Screen		79.6%	103,573	Health Promotion
Zero	No Mental Health Need	1.1%	1429	
One	Resiliency/Health Mgt	6.2%	8057	Early Access Intervention
Two	Outpatient Services	2.4%	3119	
Three	Intensive Outpatient	4.6%	5978	
Four	Intensive Integrated	3.0%	3899	Intense Need
Five	Non-Secure 24 Hr	2.2%	2859	
Six	Secure 24 Hr	0.8%	1040	

Figure One Level of Need. Figure one shows the results of the assessment of the need for behavioral health services for children in the Elementary grades of the Clark County School system. 2097 children in 17 schools were screened for signs, symptoms and risk factors for behavioral health needs. 427 of these children had positive screens. These children were assessed using the Child and Adolescent Level of Care Utilization System to determine current level of behavioral health need. The table above shows the six levels of the CALOCUS, the percentage of children who scored at each level and the number of children that projects for the school district for each level.

HOW WELL CHILDREN'S NEEDS ARE MET

For Children in Foster Care. The Wraparound in Nevada (WIN) program, funded through AB1 has had a significant impact on how well the need is met for children in the DCFS child welfare system.

- The number of children and youth with severe emotional disorders who are receiving no services has decreased from 13.0% to 2.4%.
- The proportion of children and youth who are underserved has decreased from 46.1% to 11.9%.
- Children and youth are showing significantly more and faster improvement in mental health symptoms compare to services provided last year.
- Children and youth are living in less restrictive settings and moving to stable living environments at sooner.
- Children and youth are attending school more often, having fewer disciplinary reports, and making better grades.
- The overall quality of services as measured by the Wraparound Fidelity Index (Bruns, 2004; Suter et al 2002) has improved but has not reached the level correlated with positive research outcomes.

For Children in Clark County Child Welfare Services. An updated assessment shows little change in how well the needs for children in Clark County child welfare have been met. These are abused or neglected children who are in emergency shelter care or receiving in-home child protective services to support their safety.

- Within Clark County Department of Family Services, 75% of children with need for mental health service are underserved
- For those children with SED, 36.4% are receiving no behavioral health services.

For Youth in the Juvenile Justice System. Several reports have supplemented the assessments done by the Clark County Consortium in defining how well the behavioral health needs for youth in the juvenile justice is met.

- Within the juvenile justice system, 71.1% of youth with a need for mental health services are underserved
- In the juvenile justice system, 36.7% of youth with SED are receiving no behavioral health services.

For Children in the Clark County School System. The assessment of the elementary school children in the Clark County School District documented that although there is less need for behavioral health services for the general population of children than for those in the child welfare and juvenile justice systems, the children who do need services are less likely to get them.

- The universal behavioral health promotion proven useful in avoiding many behavioral health services is provided for **less than 10% of children** within the school system.
- Of the **9,097 children** within Clark County elementary schools who need targeted early intervention school based intervention level of behavioral health care, **69% are receiving no services**.

- Of the **7,797** children within the Clark County elementary schools who need intensive integrated services, **62% are receiving no school services** or identified community-based services.
- Teachers report that the level of behavior and mental health problems within their classrooms has increased over the past five years and that these problems are impacting the quality of instruction for all children.

	Receiving Appropriate Level of Services	Under Served	Children with SED receiving no Services
Clark County School	17.4%	82.6%	62.9%
Clark County Child Welfare	30.0%	70.0%	43.8%
DCFS Child Welfare	88.1%	11.9%	2.4%
Juvenile Justice	28.9%	71.1%	36.7%

Figure Two uses the data from the Child and Adolescent Level of Care Utilization System Screening of 2715 children and youth in the child welfare, juvenile justice and school 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.

ASSESSMENT OF SYSTEM NEEDS

Research has highlighted the role of organizational characteristics in delivering effective services (Glisson & Himmelgarn, 1998; Glisson & James, 2002). Such research shows that the success of innovation in working with children and families requires attention to the organizational context in which services are delivered. First, programs serving children with behavioral health needs must attend to organizational factors predictive of successful systems approaches for children with complex needs. These factors include flexible structures, supervisors and program heads who can perform multiple roles, constructive cultures, and positive work attitudes (Glisson & James, 2002). Second, organizational structures must be engineered to overcome the well-heralded "science to service" gap wherein promising or efficacious treatments are not able to be translated effectively into community-based settings (see, e.g., Kazdin & Weisz, 1998; NIMH, 2001; Weisz et al., 2003).

For the Third Annual Report, a system and infrastructure assessment was done through a three-stage process to identify needed organizational supports, the current level of support and prioritize areas of need. The system and infrastructure assessment was done through a three-stage process. First, the consortia reviewed the testimony and reports presented to the legislative committees and mental health consortia to identify the priority areas of need from consumers, providers, community representatives, and local and national content experts. The topics that related to system organization and the policy and funding context were sorted into eleven content areas. These were organized into a Community Team Assessment of State Support (Rast, 2003).

These assessments were completed by a sample of consortia members including representatives from each child serving agency, family members, providers, and community representatives. In the third step consortia members from each of the child serving agencies, consumers and providers completed two validated organizational and policy and funding assessments (Walker, Koroloff, and Schutte, 2003). These assessments rated the current level of performance and the priority for improvement in each area. These were then analyzed to identify the priority areas for infrastructure need and improvement .

The State of Nevada used this information to develop a proposal for an infrastructure building grant from the Substance Abuse and Mental Health Services Administration. During the past 10 years the funding invested in children's mental health services in Nevada has increased from $6.5 to over $35 million. This funding includes: Medicaid, mental health state and block grant funds, education state and student services, substance abuse state and block grant, juvenile justice state, child welfare state, IV-E, IV-B, ASFA funds, TANF, local funds and four federal grants. While service funding has increased by more than 530% the amount of infrastructure has increased by less than 200%. In addition, the number of programs and funding streams supporting mental health services has quadrupled resulting in expanding fragmentation of the service system. Even with the rapid expansion of funding to meet the behavioral health needs of children and families (maybe as a direct result of this expansion) the current situation in Nevada mirrors the results found throughout the nation by the President's New Freedom Commission.

> Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.
>
> Michael F. Hogan, Ph.D. 2003
> Chairman, President's New Freedom Commission on Mental Health

The Clark County Consortium prioritized the findings from the assessments and identified five priority areas for infrastructure development. These include:

- Develop a partnership across service systems and with family members to create a shared vision and integrated plan for behavioral health services for children and families across all child-serving agencies in Nevada.
- Implement flexible fiscal policies that promote individualized behavioral health services and supports. Current funding strategies create barriers to getting the right services to many children.
- Develop a public engagement campaign to reduce stigma and build public support for behavioral wellness. The stigma of behavioral health disorders keeps many families from seeking services until the problems become severe. This stigma also decreases the chances of children being successful in our schools and communities.

- Shift the focus to prioritizing early identification and easy access to services before problems become severe. Currently services are focused on the most restrictive services for the children and youth with the most severe problems.
- Produce good, consistent data on the outcomes, quality and cost benefit of behavioral health services across systems.

ELIGIBILITY FOR BEHAVIORAL HEALTHCARE SERVICES

The current system of eligibility is one of the primary system characteristics that cause 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. The addition of the WIN care coordinators has significantly improved this for children and youth in the DCFS child welfare system,[5] but this is not available for most children.

METHODS FOR OBTAINING BEHAVIORAL HEALTHCARE 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. For the past two years efforts have been underway to redesign the public health insurance programs funded through Medicaid. Although it is unclear if the changes that were recommended that would improve access and flexibility of services are still part of this proposal, changes to the Medicaid benefits and process for authorizing services are clearly needed. 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 BEHAVIORAL HEALTHCARE 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 had shown little increase in the past twelve years until the new funding through AB-1 funded individualized services for 327 children in the child welfare system. This has helped this population of children but not others. 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

[5] See Appendix B for a report on the WIN Project.

form a less fragmented system that is flexible to meet the needs of children and families. Members of the Clark County Mental Health Consortium are working to secure this support for children and families.

VISION FOR AN INTEGRATED BEHAVIORAL HEALTH SYSTEM

The vision for the integrated system is shown in Figure 3. The base of the system is behavioral health promotion for all children. This comes from parents, early education and care providers, school environments, and health providers. The role of the system is to provide public engagement and special supports to these individuals to give them the knowledge and resources to provide activities and environments that promote behavioral wellness. This would be sufficient for more than 80% of all children, and if provided consistently, should reduce the number of children who need intervention services.

The second level of the system is for targeted early access and intervention services. Within the school system this would include a range of group and individual services. Outside the school system this would include a basic benefit of early intervention and intervention services.

The third level of the system is for children who have more intensive needs that require coordination across entities. This is the level of service that is provided through WIN.

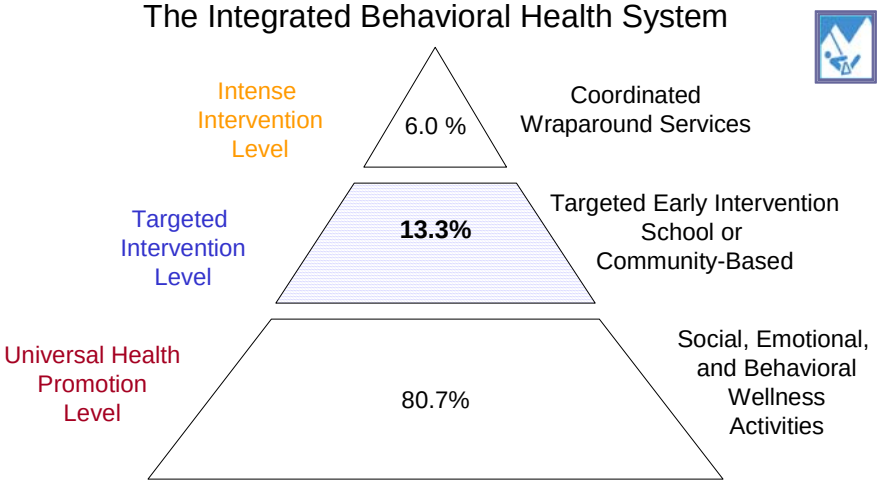

Figure Three New Picture of School-Community Interaction. This diagram shows the community strategy to address the mental health needs of children in the public school system in Clark County. For all students the strategy will be to provide supplemental classroom supports to teachers to create classroom activities and environments that promote social and emotional development and behavioral wellness. For 13.3% of the children there will be additional in school supports that will provide targeted early intervention within the school environment. For those 6% of the students with the most intense needs, services will be a combined effort of the schools and outside providers.

RECOMMENDATIONS

The recommendations describe the prioritized next steps to move toward the vision of the integrated system of behavioral health care in Clark County. Recommendation one focuses on steps to improve the universal health promotion level by implementing early screening for behavioral health problems and supports for teachers and classrooms to improve the learning environment through behavioral health promotion activities. Recommendation two focuses on ways to improve the targeted early intervention response of the system through the school system. Recommendations three and four focus on improving the intense intervention response of the system for children with SED in the juvenile justice and child welfare systems. Recommendation five focuses on improving the necessary system infrastructure to support community-wide behavioral health services.

1. Expand behavioral health promotion activities throughout the elementary schools in Clark County.

2. Implement a systematic approach to targeted early intervention for children with behavioral health problems in the Clark County School District.

3. Expand intervention services for children in the child welfare system by funding WIN (Wraparound) services for an additional 150 children and youth with SED in the Clark County Department of Family Services system. Services should be provided to abused/ neglected children with SED as early as possible without regard to Medicaid eligibility.

4. Expand intensive interventions for youth in the juvenile justice services by :
   a. providing funding for a pilot project for 100 youth in the Clark County Juvenile Justice system with severe emotional disorders. This would require the addition of eight wraparound facilitators and the behavioral health services these youth and their families need. It is recommended that this pilot be done in one or two of the Neighborhood Care Centers in Clark County.
   b. Provide funding for telehealth psychiatric services in the three Nevada juvenile training facilities (CYC, NYTC, and Summit View).
   c. Fund mobile crisis intervention services for youth with behavioral health problems that are at risk for entering juvenile justice system.

5. Strengthen the organizational and systems infrastructure by:
   a. Developing in partnership with family members a common shared vision and integrated plan for behavioral health services for children and families across all child serving agencies in Nevada.
   b. Implementing flexible fiscal policies that promote individualized behavioral health services and supports.
   c. Developing a public engagement campaign to reduce stigma and build public support for behavioral wellness.
   d. Prioritizing early identification and easy access to services before problems become severe.
   e. Requiring and gathering consistent and useful data to assess the impact of services.

PLAN FOR ADDRESSING SCHOOL MENTAL HEALTH NEEDS

Through the process of completing the school assessment for this report and developing the new pilot project for the Safe Schools/Healthy Students initiative the Clark County School District in conjunction with the Clark County Consortium has developed a plan to address the mental health needs of the children within the district. The Consortium supports this plan because the school is a central part of all children's lives and the focus on promotion should have a positive impact on all children while the focus on targeted intervention should better meet the needs of children and families while effectively and cost efficiently integrating school and community resources to meet the mental health needs of these children. The primary goal of the plan is to remove barriers to academic achievement. The objectives are:

- Support for teachers and classrooms to provide improved learning environments
- Early identification of social-emotional and behavioral needs of elementary school-aged children
- Increased access to student intervention services (classroom modeling/small group and individual counseling)
- Seamless delivery of services
- Connect to parents of children with needs
- Establish linkages to community services

The plan is to add 50 additional positions to provide support for teachers and to manage the Student Intervention Teams (SIT) that will provide the targeted early intervention response for 5000 elementary school children across the district. The positions will be filled by a combination of School Psychologists, Social Workers, and contract positions at a cost of $2,700,000. To support the behavioral health promotion activities in the classrooms, $75,000 of instructional supplies will be purchased and distributed among all employees using a library style system. To support 2500 hours of teacher involvement in training and planning activities there is a need for $100,000 in extra duty pay. The total cost of this plan is $2,875,000. Of this amount it is estimated that a portion could be recovered through increased federal participation.

PLAN FOR ADDRESSING CHILD WELFARE MENTAL HEALTH NEEDS

The initiation of the WIN program has resulted in providing the needed behavioral health services for almost all children and youth in the foster care system. This has resulted in significant improvement in outcomes for these children in terms of moving to less restrictive living environments, length of time in custody, improved mental health, school performance, and decreased delinquency. Children and youth in the front end of the child welfare system, however, can not access these services and there is not enough capacity in the current WIN program to expand past the children in the foster care system. The plan is to add the capacity to the WIN program to serve 150 children and their families in the Clark County Children Division of Family Services. Services would be provided by WIN care coordinators located in the neighborhood care centers in the five regions of the County and at the emergency shelter facility. The assessment identifies 99 children with SED that need an intensive level of services who are currently receiving no services. To meet the needs of these children through WIN would cost $1,840,311. Of this amount, it is estimated that $276,046 could be recovered through increased federal participation.

PLAN FOR ADDRESSING JUVENILE JUSTICE MENTAL HEALTH NEEDS

The assessment of needs identified 763 youth within the juvenile justice system who need intensive levels of behavioral health services who are not receiving them. The plan is to implement a pilot project through two of the neighborhood care centers to provide WIN services for 100 of these youth. To meet the needs of these children through WIN would cost $1,858,900. Of this amount it is estimated that $278,835 could be recovered through increased federal participation.

Youth in the three youth correction centers (Caliente, Summit View, and Elko) do not have access to needed behavioral health services. The Clark County Consortium supports the expansion of telehealth service to these facilities to address this need.

Mobile Crisis Intervention Services are needed for the youth with mental health disorders who are at risk for entering the juvenile justice system. Mobile Crisis Services are best deployed through the five neighborhood care centers in Las Vegas. The Consortium had adopted a model of mobile crisis intervention that provides immediate care from qualified mental health professionals and paraprofessionals to a youth having a psychiatric emergency. Available between the hours of 8 a.m. and midnight, trained staff screen for emergencies by telephone, provide crisis triage, and dispatch a 2 person intervention team. Home-based or community-based crisis intervention averaging up to six hours in duration is provided to support the youth's caregiver and decrease the likelihood of hospitalization or out-of-home care. To meet this need for 200 youths per year would cost $124,800[6].

PLAN FOR ORGANIZATIONAL AND SYSTEM INFRASTRUCTURE NEEDS. The current Nevada system has many good programs and initiatives, but these are fragmented and sometimes duplicative. Developing a common vision and integrated plan for a behavioral health system will increase cross agency communication and focus efforts on common barriers. It will decrease fragmentation and build off the strengths of the individual partners in the effort. The common vision and plan will create the blend needed to support the public engagement and sustainability goals. This will concurrently set the framework for the developing organizational climate that has been demonstrated to be the most predictive feature of improved outcomes for children and families (Glisson & Himmelgarn, 1998). One recommendation of the previous consortium reports is to strengthen and streamline interagency coordination and funding mechanisms to address many of the organizational structure issues predictive of improved outcomes for children and families. The redesigned behavioral health financing plan is one strategy that would provide flexibility and incentives to shift the focus of funding from traditional and residential services to science-based community approaches. Communication and public engagement campaigns would build public support and common commitment.

Area One. Developing in partnership with family members a common shared vision and integrated plan for behavioral health services for children and families across all child-serving agencies in Nevada. This should begin by inviting all of the different groups who are working

[6] Cost estimate is based on an hourly rate of $104 per hour and an intervention episode of six hours. Hourly rate based on the Nevada Provider Rates Task Force Strategic Plan for Phase II Services, August 15, 2002.

on some aspects of behavioral health services for children (see supplement to first annual report for a partial list) to a facilitated two day retreat to develop this vision, then requesting public comment, and finalizing this in legislation. We recommend that this be co-hosted by the Mental Health Commission, the Legislative Committee on Children and Families, and the Nevada Mental Health Plan Implementation Commission.

Area Two. Implementing flexible fiscal policies that promote individualized behavioral health services and supports. The work of the Health Care Authority to redesign the behavioral health benefit engaged from all state agencies and consumers in the process. The goals and plans developed through this group would address many of the system needs for an array of services that can be individualized to address the individualized needs of children and families and to make mental health services more accessible to children and families throughout the state. The plan developed in partnership with these stakeholders groups should be implemented.

Area Three. Developing a public engagement campaign to reduce stigma and build public support for behavioral wellness. One of significant barrier to early access to behavioral health services is the stigma attached to mental illness. A public engagement campaign could help public and family understanding mental health as one component of overall health.

Area Four. Prioritizing early identification and easy access to services before problems become severe. The development of the suicide prevention and school based behavioral health promotion programs set a clear priority on early identification and easy access to services. This is the first step in changing the focus of the system from triaging the most severe levels of disorder to building emotional and behavioral wellness for our children and thus our society.

Area Five. Requiring and gathering consistent and useful data to assess the impact of services. One of the problems with accurately accessing the need for behavioral health services and how well that need is met is the lack of outcome, services and costs, and process data to make these determinations. The Clark County Consortium has used federal grant funds to perform specific assessments of the need within the county and the outcomes of the WIN project. To sustain the development of data driven decision making for the Consortium, agencies and divisions and for the Legislature, there is a need for common measures of outcomes, services and costs, and process measures of fidelity and quality for behavioral health services across all programs that are collected and used. A letter of intent to create and provide the necessary resources should be developed.

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Appendix A

CCCMH Consortium Progress Toward Action Steps

Below are the Action Steps from the 2002 and 2003 Clark County Children's Mental Health Consortium's Annual Plans. Progress toward Action Steps is shown in bold.

LEGISLATIVE ACTION STEPS

Legislative Action Step 1 *provides 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.*

Legislative Action Step 2 *continues the funding for the 327 children with severe emotional disorders (SED) who are in child welfare custody.*

> **As recommended by the Consortium in their Second Annual Plan, the Legislature funded the full implementation of the WIN Program (Wraparound in Nevada). The WIN Program provides intensive community-based services using a wraparound model to at least 327 children in foster care (statewide) with serious emotional disturbance.**

Legislative Action Step 3 *provides 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 eight wraparound facilitators and enough funding to cover the behavioral health services these children need.*

Legislative Action Step 4 *provides 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 eight wraparound facilitators and enough funding to cover the behavioral health services these children need.*

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

> **Goal 1.3 of Nevada's Strategic Plan for People with Disabilities mandates that "Boards, Commissions and decision-making bodies where actions substantially impact the lives of adults and children with disabilities (include the paragraph of informed adults with disabilities and their families)."**
>
> **Through the Children's Mental Health Services Block Grant, DCFS has provided funding to support the Clark County Children's Mental Health Consortium.**

Legislative Action Step 6 *provides funding through DCFS for a 24-hour, 7-day/week mobile crisis services for Clark County. (2002 Plan)*

STATE DEPARTMENT AND DIVISION ACTION STEPS

State Action Step 1 *recommends that the Department of Human Resources adopt the goals of the Clark County Consortium as its vision for children's services in Nevada.*

State Action Step 2 *changes 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.*

> **In collaboration with the Division of Mental Health and Developmental Services and the Division of Child and Family Services, Nevada Medicaid has developed the Behavioral Health Redesign Proposal. If funded, this proposal will expand providers and facilitate access to behavioral healthcare.**

State Action Step 3 *improves the standards for Medicaid providers of behavioral healthcare services and applies 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.*

State Action Step 4 *expands the Medicaid program to cover family-to-family support services and mobile crisis services for children and adopt rate-setting methodologies to incentivise providers to develop these services.*

State Action Step 5 *encourages Medicaid, MHDS, and DCFS and County agencies to develop coordinated management information systems to track behavioral healthcare utilization, outcomes, and spending patterns.*

State Action Step 6 *recommends 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.*

State Action Step 7 *improves 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.*

State Action Step 8 *expands 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.*

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

State Action Step 10 *maintains 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.*

State Action Step 11 *provides 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.*

State Action Step 12 *ensures 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.*

State Action Step 13 *builds on existing funding resources within the Department of Human Resources to provide a cross systems family support hotline in Clark County.*

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, Clark County Family Services, and Nevada Division of Health 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. **As of July 2004, County and State child welfare, juvenile justice, and mental health staff will be co-located at three neighborhood sites in West Las Vegas, Central Las Vegas, and Henderson.**
d. **An interagency coordinating mechanism to plan and oversee this coordination has been implemented and is called the Neighborhood Center Administrative Team with local leaders from the Clark County Departments of Family Services and Juvenile Justice, Clark County School District, and Nevada Division of Health and Division of Child and Family Services.**
e. **The Neighborhood Center Administrative Team has formed a midlevel management structure and is strengthening the effectiveness of its neighborhood-based, interagency teams in reducing out-of-home placements of children with special needs.**
f. **As recommended by the Consortium in the First Annual Plan, the 2003 State Legislature provided funding for continuation of the Neighborhood Care Center Project.**
g. **The Consortium is supporting a federal grant to the Clark County Department of Family Services for expansion of family support services at these neighborhood**

sites. This five-year, $500,000/year Kinship Care Grant will implement and evaluate family support services for kin caregivers of abused/neglected children.

h. **The Consortium is working with the Clark County School District to implement a grant awarded September 1, 2003. This Safe Schools/Healthy Students Initiative grant provides $1.9 million for three years to help link schools to neighborhood-based early intervention, family support, and treatment services. School Intervention teams will link with the Neighborhood Care Centers.**

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). This tool is now being used by all DCFS Mental Health Programs.**
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. **The CCMHC has developed a draft brochure for parents and consumers that will be available by September 2004.**

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 supports the implementation of this model.**

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.**
d. **NV PEP provides bilingual family support services through the Neighborhood Care 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. **Cross-training in the level of care determination system is ongoing for Clark County, DCFS, and Departments of Juvenile Justice and Family Services.**
b. **A cross agency training team including families, county and state staff has been formed to address this action item.**
c. **The Clark County Department of Family Services has provided cross-training in the system of care and wraparound approach through its Kinship Care Grant.**
d. **DCFS and NV PEP staff provides regular training in children's mental health issues to the Las Vegas Metropolitan Police Department and the Public Defender's Office.**

APPENDIX B

Impact of the Wraparound in Nevada (WIN) Program

Project WIN is using wraparound to engage families and natural supports in a strengths-based process to plan and implement services and supports for children and youth with severe emotional disorders. Wraparound is a promising practice that has been used widely across North America with very positive outcomes but has not been clearly documented as an evidenced based practice. DCFS has embraced wraparound as a process and will use this pilot evaluation findings to verify and document the efficacy and cost impact of the process in order to establish clear quality guidelines and performance indicators to ensure the quality of the Wraparound Service Model. In addition, DCFS will use the evaluation process to develop utilization review processes to ensure that children and youth get the services and supports they need but do not receive unneeded or excessive services.

IMPACT ON ACCESS TO SERVICES

The assessment of how well the need for services is met was updated from the 2002 assessment based on the new capacity created through the AB-1 funding. The table below shows the numbers and calculations. The first line shows the percent of children within the DCFS child welfare system that need Levels 2, 3 and higher levels of care. The AB-1 funding addressed the intense needs of children with SED and this need is largely met. The proposed behavioral health redesign could address the need for the children who need Level 2 services.

	Level 2	Level 3	Level 4+	Total
Percent who need this level of care	12.6	9.2	32.1	
Number who need this level of care (2002)	235	171	598	1004
Numbers served in 2002	135	280	211	
Number who need this level of care (2003)	231	169	588	988
Added capacity in 2003		-111[1]	356	
2003 number served	135	169	567	871

[1] The change in the number of Level 3 services provided reflects the change from a service to a service coordination model for CCS staff within DCFS. The loss of Level 3 services is correlated to the gain of the same amount of Level 4 services.

The table below summarizes how well the need is met in terms of the number of children who are receiving less services than they need and those children with SED who are receiving no services at all.

	2002		2003	
	Percent	Number	Percent	Number
Total Children		1863		1833
Underserved	46.1	859	13	115
Unserved SED	11.9	92	2.4	18

EVALUATION OF EFFECTIVENESS WITH INDIVIDUAL CHILDREN

This study compares the impact of these service approaches on child and family outcomes and costs to youth receiving traditional services that is currently available. Data has been collected in the following areas: child symptoms and diagnosis, child social functioning, substance use, school attendance and performance, delinquency, juvenile justice involvement, restrictiveness and stability of the child's living arrangements, and the costs and services of the approaches.

Components: the study consists of five primary parts:

1. Child and Family Outcomes Study
2. Process and Quality Assessment
3. Services and Costs Study
4. Implications for Quality Management and Funding
5. Implications for Social Work Curriculum

Child and Family Outcome Study. This study examines the impact of services on child clinical and functional status and family life. Data is collected in the following areas: child symptoms and diagnosis, child social functioning, substance use, school attendance and performance, delinquency, juvenile justice involvement, restrictiveness and stability of the child's living arrangements, development of natural supports, impact on family quality of life and ability of the family to meet the needs of the child or youth. This evaluation component follows children and families through the service process for at least six months post discharge from services.

Process and Quality Assessment. The process and quality assessment compares the service process of each child and family served to established performance indicators for wraparound. This process provides descriptive and supervisory information that will aid in developing and ensuring high fidelity wraparound process for the children and youth assigned to the wraparound group and a comparison of the differences with the process for the children receiving the traditional mental health services.

Services and Costs Study. The services and costs study compares the services, supports and costs for children and youth in the wraparound service model and traditional service model

groups. The comparison of the types and amounts of paid services and natural supports for each child in each group is demonstrated. In addition, the outcomes and risk factors for the children and youth will be used to predict future costs of effective services in each of the two groups.

Implications for Quality Management and Funding. The findings from the program will be analyzed and presented to DCFS, Medicaid, DMH, the three Mental Health Consortia, the Legislative Committee on Children and Youth, and the Nevada Legislature to be used to guide future planning and funding decisions. In addition, the findings will be used to determine and test strategies in the implementation of the program for staff training and development, utilization review and quality management. Appendix B suggests recommended practice and system improvements.

Outcomes

The youth enrolled in the pilot project began receiving WIN services 15 to 19 months ago. Data on outcomes is gathered at baseline, three months, six months, and every six months afterwards. Data has been collected on 30 of the 33 youth through the 12-month period. Data collection for the youth receiving traditional mental health services began from June to October 2002. Data have been collected through the 12-month interval for 29 of the 32 youth assigned to the traditional services group. Data collection for the youth enrolled after the pilot phase began in May 2003 and the end of the first six-month interval will be in March 2004[2] and the first comparison of this data will be completed in March 2004 and included in the next report.

One of the primary outcomes of concern was the use of higher levels of care. The Consortia's initial needs assessments found that more than 86% of the public mental health funding was being spent on less than 5% of the youth. One of the primary objectives of WIN is to provide needed community based supports so youth can remain in their home communities with family and in community activities and schools. The process of partnering with family members to determine the strengths, needs, and culture of the child and family has helped to find the people and resources necessary to get youth into lower levels of care. In fact, 11 of the 30 youth in the WIN group have moved from higher levels of care back into the homes of family and friends. This compares to only 5 of 29 of the youth receiving traditional services. The figure on the next page shows a comparison of the two groups. The graph on the right shows the average level of care for the two groups at intake, six months, and 12 months[3]. The level of care is based on the Restrictiveness of Living Environments Scale (ROLES) assessment instrument. Level 1 is a homelike setting with parents, adoptive parents, or other family. Level 2 is foster care. Level 3 is specialized or therapeutic foster care. Level 4 is nonsecure group homes. Level 5 is secure group homes. Level 6 is residential facilities and Level 7 is inpatient hospitalization or detention. The figure shows that the average level of care has decreased steadily for the youth in WIN but has remained constant for the youth receiving traditional services.

[2] This includes the youth who began receiving services through October 2003. Following this cycle, new data will be available on a cohort on a monthly basis.

[3] It has been over 18 months for more than half of the youth in the wraparound group and that data is also included in this graph.

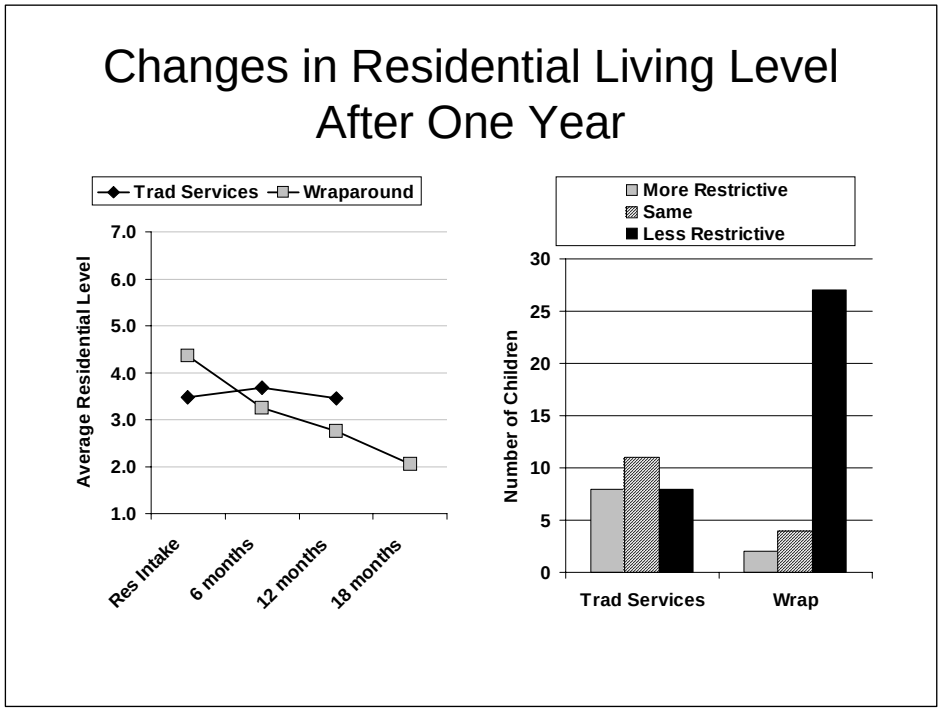


Figure One Impact on Residential Living Level

The graph on the right side shows the number of youth who have moved to lower levels of care (gray columns), stayed at the same level (striped columns) or moved to lower levels of care (black columns). The data show that the youth in the traditional services group have moved in equal numbers to higher and lower levels of care and most have stayed at the same level. These are the youth in the program who have the most severe levels of mental health need. Clearly the current services are not meeting their needs. On the other hand only two youth in the WIN group moved to higher levels of care and over 80% of these youth have moved to lower levels of care.

The second significant outcome measure is the change in emotional and mental health. This is measured with the Child and Adolescent Functional Assessment Scale (CAFAS), widely used tool to measure the impact of mental illness on functioning level of children and youth. This assessment is completed every six months for all children and youth receiving services at DCFS. The lower the score the lower the amount of impact and seriousness of the mental illness. Scores below 50 are considered to be in the normal range. Scores over 90 show marked or severe impairment. Figure Two shows the average CAFAS scores for the youth in the wraparound and in the traditional services group. The graph shows that the two groups had very similar scores at intake. After six months the scores of the wraparound group had decreased an average of 25 points. The scores for the traditional services group rose slightly at each interval.

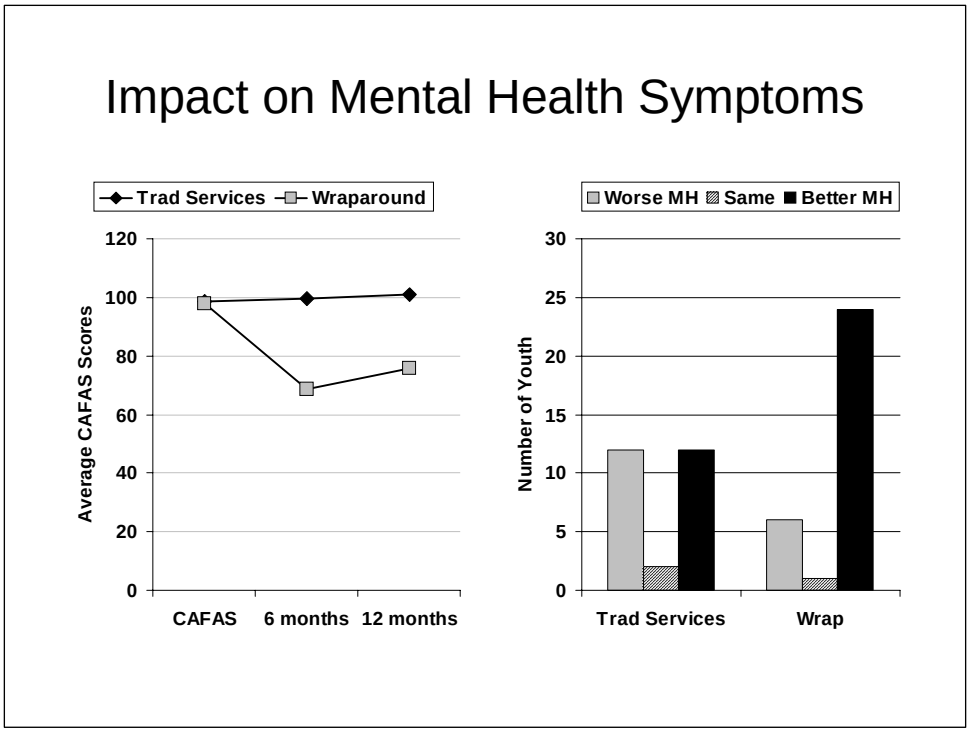


Figure Two Impact on Mental Health Symptoms

The graph on the right side of Figure Two above shows the number of youth whose scores increased (worsened), stayed the same, or decreased (got better). The results show that about equal numbers of the youth receiving traditional services got better and worse. On the other hand over 75% of the youth receiving WIN services had decreased scores.

School performance is the final measure on outcomes. Data is taken on absences, disciplinary actions and average grade point. The data shows improvement for both school attendance and disciplinary actions for the WIN group. Figure Three shows the data for the grade point average (GPA). The figure on the left shows the average GPA for the two groups. These started out about the same and were still similar after six months. After one year, however the GPA for the WIN youth had increased significantly while the GPA for the youth receiving traditional services had decreased. Anecdotal reports suggest that as the family bonds improved and needs were met, youth became more motivated and less distracted. The graph on the right side of figure three shows the number of youth with increasing as decreasing GPA. This shows that twice as many youth in traditional services had deteriorating grades as improving grades while 60% of the youth in WIN had improved grades.

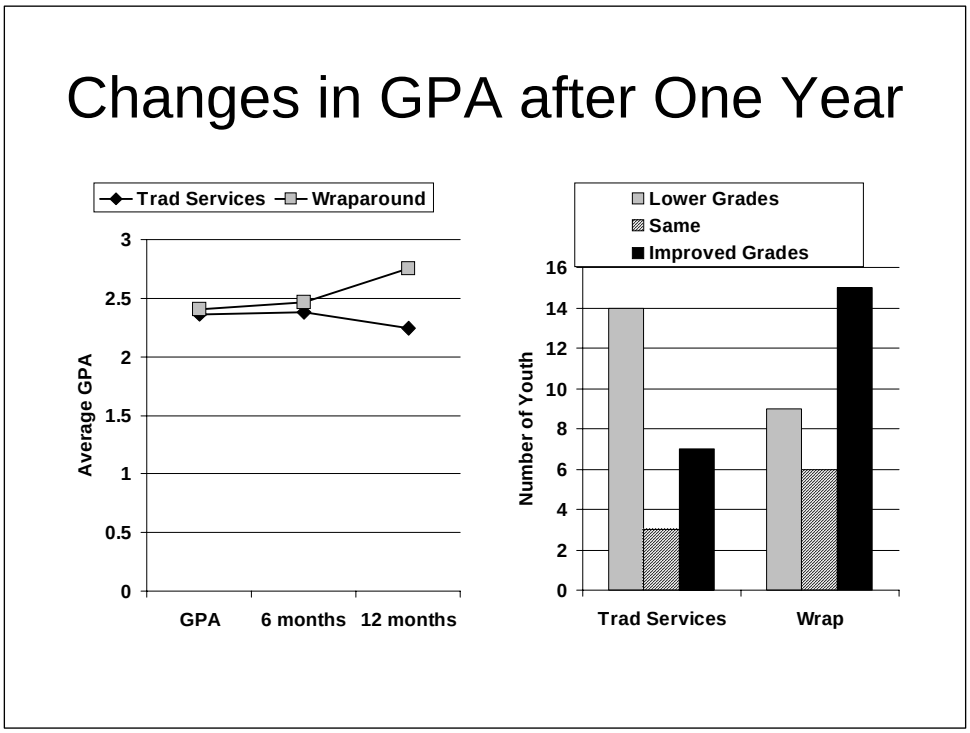


Figure Three Changes in GPA

Costs and Services

Reports on services and costs are more difficult because the primary source of data is the billing database from Medicaid which has a nine to twelve month lag from the time services are provided until they can be monitored. Also, the recent change in Medicaid Management Information System (MMIS) has made the necessary data less available. To address this problem, DCFS has implemented two data collection methods to gather information on services provided and costs incurred. The first is a survey process in which the staff working with the youth report on a monthly basis the services scheduled to be implemented and the amount of services provided. These service commitments and provision logs were set for implementation in December 2003 but were delayed due to the holidays and began in January 2004. With the collection of this information, DCFS will have quarterly data on costs and services for each youth[4]. This same methodology will be implemented as part of the evaluation protocols for the youth in the traditional services group. Results from a survey to determine the amount of services in January 2004 revealed the information in the table on the next page.

This table summarizes the types and amounts of services received by youth in the WIN program in January 2004. Of the 229 active cases, the table reflects how many received each of the services and supports. All of the active cases were receiving wraparound facilitation (targeted

[4] The data for these forms is completed as part of the 90-day reviews. To gather this data more frequently would be a documentation burden on staff and would detract from service delivery.

case management) and just over half were receiving individual therapy. 102 of the 229 youth were receiving medication management services. The fourth most frequent service that was provided to the youth was natural supports. This is the part of the planning process in which friends and family take an active roll in providing the supports that make up the treatment plan. This is a critical part of wraparound process because these are the individuals that will be there for the youth and family after formal services end. These are the individuals who will prevent much of the recidivism and future problems. The right hand column of the table shows the average number of episodes of the service youth received. Case management and natural supports provided more than 11 contacts per month.

Services and Supports Provided for WIN Youth In January 2004					
	NORTH	**RURAL**	**SOUTH**	**TOTAL**	**AVG/ CHILD**
Individual Therapy	29	23	77	129	3.3
In Home Family Therapy	3	3	22	28	4.3
Group Therapy	15	6	27	48	6.3
Targeted Case Management	39	37	153	229	11.5
Rehabilitative Skills Training (Ind)	3	10	30	43	5.6
Rehabilitative Skills Training (Group)	6	10	24	40	7.9
Medication Mgt	20	15	67	102	1.4
Evaluation	16	20	51	87	1.3
Respite	8	3	19	30	2.7
Family to Family Support Services	3	0	10	13	3.8
Placement Prevention Costs	0	2	5	7	1.3
FREE Natural Supports	15	28	56	99	7.2
Rehabilitative Partial Care	9	2	25	36	11.1
Average Number of Different Types of Service Per Client	**4.25**	**4.29**	**3.69**	**4.07**	

Table Five Services and Supports Provided for WIN Youth

For the youth in the pilot group and the matched group receiving traditional services, the amount of services and the cost of these services were calculated using two interrelated processes. The Medicaid database was used to identify the services and supports that had been billed between intake and June 2003. The billing logs for DCFS staff were reviewed through the end of the year and the service and support information was combined to form an estimate of the amount of services and the costs of these services for each youth. These were then averaged for the two groups in the graph in Figure Five.

The total annualized cost per youth calculated on this basis was $24,112 at intake and remained about the same at one year for the youth receiving traditional services (most of this money is

spent on residential treatment. For the youth in the WIN group the twelve months cost an average of $17, 274. One of the primary reasons was the work of the wraparound facilitators who discovered the available natural supports and engaged them in this process. This led to these youth moving to lowered levels of residential care.

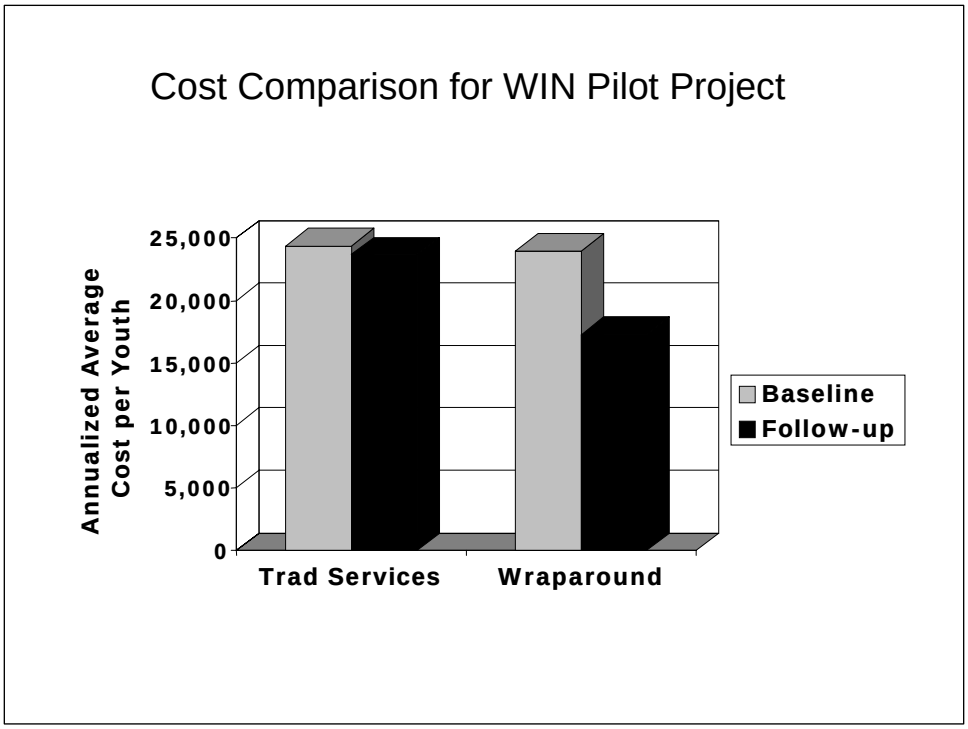


Figure Four Cost Comparison of Wraparound to Traditional Services

Appendix C
Assessment of Need for Behavioral Health Services
Juvenile Justice

Introduction

The assessment of the juvenile justice system for youth in Clark County had two goals. The first was to provide data for DCFS and Clark County to develop a plan for improving behavioral health services for youth in juvenile justice. The second was to provide the Clark County Consortium with an understanding of how well the behavioral health needs of youth in the juvenile justice system are met.

The Nevada Juvenile Justice system has been under great pressure for the past fifteen years. A 1992 national assessment described a Nevada Juvenile Justice system that was overcrowded, had few effective alternatives to containment and disparate commitment practices. Since 1990 the number of youth and youth in Nevada has increased from 344,000 to over 632,000 as Nevada has been one the fastest growing population in the country. With the growth in population has come an increase in diversity and the proportion of the population that is Asian and Hispanic has doubled during that same time. At the same time the stresses on families have increased resulting in increased risk factors and decreased parental supports for youth and youth. Concurrently the Nevada economy has not kept pace with the growing population resulting in proportionately fewer resources for the juvenile justice system to address these increasing problems.

In 1997 the Nevada Legislature responded to a juvenile justice system in crisis through short-term measures and long-term planning. That legislative session provided mechanisms and funding for immediate short-term relief for overcrowding and expanded community-based alternatives to commitment. In addition, the Legislature funded two interim study committees to develop a comprehensive strategy for improving the quality and range of service for the juvenile justice system. These committees identified high rates of mental illness and substance abuse among the youth in the juvenile justice system and recommended a Community Approach that focused on early access, family support and integrated services across systems.

In 2001 the Nevada Legislature began to address the increasing behavioral health needs for youth by forming Mental Health Consortia and funding expanded mental health services for youth in the foster care system. The legislature charged the Mental Health Consortia with doing an annual assessment of the needs for behavioral health services for the youth and youth within the jurisdiction of the Consortium and how well these needs are met. In addition, the consortia were charged with the task of developing a plan to meet the unmet need.

In Clark County the first annual plan focused on youth and youth in the child welfare system. The second plan included an assessment of need for youth in the juvenile justice system. The third annual plan will focus on developing plans for youth in juvenile justice and youth in elementary school. This appendix describes the assessment process to determine the need for the youth in the juvenile justice system. The assessment plan had two parts: a review of a series of assessments of the juvenile justice system and an assessment of a sample of youth for how well their behavioral health needs are met. This information was combined with stakeholder feedback

to develop a set of recommendations and a plan to improve behavioral health services for youth in juvenile justice.

Method

Report Review. Since 1992 at least a dozen different assessments and plans have been developed for the juvenile justice system in Nevada. The consortium committee reviewed these reports and summarized six of them in this report. This information was used to develop the plan in the last section of this appendix. The reports that were reviewed are listed in Figure One.

Figure One
Materials Review for 3rd Annual Report for Clark MH Consortium

- Nevada's Community Approach to Juvenile and Family Justice (Nevada Juvenile Justice Commission Work Study Group) October 1996
- Handle with Care – Serving the Mental Health Needs of Young Offenders (Coalition for Juvenile Justice) November 2000
- Study of the System of Juvenile Justice in Nevada (Report of Legislative Commission ACR 13) Jan 2001
- An Assessment of the Nevada Juvenile Justice System Final Report (National Center for Juvenile Justice) April 2001
- Fundamental Review Committee Report March 2002
- Report of the Mental Health Consortium for Clark County July 2002
- Findings of the Investigation of the Nevada Youth Training Center at Elko, Nevada (Assistant US Attorney General) November 2002
- Report of the Mental Health Consortium for Clark County January 2003
- Clark County Department of Juvenile Justice and Services Incarcerated Youth Facility Comparison Report August 2003
- Governors Summit Report September 2003
- MOU between US and State of Nevada Feb 2004

Sample Population. The assessment to determine the number of youth needing behavioral health services was done by screening a sample of the youth who are in the juvenile justice systems. This process began by determining which youth to screen. The county juvenile probation and DCFS juvenile parole systems were sampled to determine the need for behavioral health services because it is sufficient to sample the youth in these programs. Based on this rationale 129 youth from Clark County Juvenile Probation, and 61 from youth parole were assessed. They were selected through a stratified sample in which each population was grouped into the various programs and then every third youth was selected at random from the lists.

Assessment Tools. The assessment was done through screening all youth with the Mental Health Screening Device (MHSD), assessing the level of need for all youth who score positive on the screen using the Child and Adolescent Level of Care Utilization System (CALOCUS), and then comparing the identified level of need to the current level of services. The Mental Health Screening Device is an 11-item screen that is completed by juvenile justice staff to identify youth with emotional or behavioral symptoms or risk factors that may indicate a need for mental health services. The worker completes the tool for each of the students in the class. Each item is scored on a two point scale yes (which includes suspected) or no. A yes score on any item is considered a positive screen. In addition, an 11-item risk factor and 5-item protective factor assessment was completed for each youth.

Each of the youth who received a positive screen was then assessed using the CALOCUS. 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. 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 youth 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.

For each of the youth who were assessed on the CALOCUS, the juvenile justice worker identified current services using a survey form. The form listed current behavioral health based services, identified current medications, and asked if the counselors knew of out of school services the youth were receiving. In addition, to the scores on the screening and CALOCUS assessments, workers and supervisors were asked to provide supplemental information about the needs of their youth and to give recommendations for how they might be better served. This information was provided through survey questions with each assessment and focus groups for each participating worker and supervisor.

Data Analysis. The raw data from the MHSD and CALOCUS were entered and the determination of positive screens and calculation of level of care were checked through the computer program. The data was then analyzed. For the MHSD an item analysis identified the prevalence of the eleven items. The CALOCUS data was analyzed in terms of the need at each level. The expected levels of care were then compared to level of services received. Once these analyses had been completed and reviewed by juvenile justice staff.

Results

Summary of Reports:

Work Study Group of the Nevada Juvenile Justice Commission, October 1996.

In early 1995 the Nevada Juvenile Justice Commission responded to local and national concerns about the state of juvenile justice by appointing a work study group to undertake a comprehensive examination of the Nevada Juvenile Justice System. The group was comprised of key stakeholders throughout the State and included the Governor's office, the State Assembly, Judges from the Family Court, Nevada Association of Counties, and leaders from State and County Juvenile Justice and Child Welfare agencies. The group adopted a consensus decision making model and an impartial facilitator and was able to develop a concept and vision of the system that they labeled, the Community Approach to Juvenile and Family Justice. Figure Two summarizes the major points of this work.

Figure Two
Nevada's Community Approach to Juvenile and Family Justice

Work Study Group of Nevada Juvenile Justice Commission
October 1996
Major Findings

- Juvenile Justice should be integrated into the larger continuum serving children and families using "***The Community Approach"***
- Justice for youth necessarily involves justice for families. Family well-being may be the key to avoiding delinquency.
- The front end of the continuum suggests significant neighborhood development of supports that aid youth competency and strengthen families.
- Prevention is the lynch-pin of "***The Community Approach"*** building wellness and enhancing skills.
- When prevention is not sufficient, case management is required to create a "seamless" experience for families.
- Even prevention and case management will not be enough for some youth and Nevada needs a system of graduated sanctions.
- Serving Nevada's children, youth and families will require a good deal of resource sharing and swapping. ***The Community Approach*** recognizes the collective value of stable families and encourages the sharing of resources (fiscal, staff, facility, and ideological) between communities, agencies and governments as a practice toward achieving jointly held goals.

Coalition for Juvenile Justice, November 2000. In November 2000, the Coalition for Juvenile Justice published their sixteenth annual report to the President, Congress and the Administrator of the Office of Juvenile Justice and Delinquency Prevention (OJJDP). This report was title Handle with Care and focused on serving the mental health needs of young offenders. The report summarized national data on prevalence and impact of mental illness among the juvenile justice population. The overarching recommendation of the report is that youth and families should have access to high quality, integrated mental health and juvenile justice services, appropriate to their needs which should encompass: prevention programs, screening and assessment opportunities, community-based intervention and treatment programs that address and take into consideration the many factors related to mental health disorder; and institutional care and aftercare that provides appropriate treatment for youth who must be confined for their own safety and for public safety reasons. Some of the primary findings from the report are summarized in Figure Three.

Figure Three
Handle with Care - Serving the Mental Health Needs of Young Offenders

The Coalition for Juvenile Justice's 2000 Annual Report
November 2000
Major Findings

- Between 50 to 77 percent of incarcerated youth have diagnosable mental health disorders and are likely without service to become more vulnerable, volatile and dangerous to them selves and others
- At least half the youth with mental illness in the juvenile justice system also have a co-occurring substance abuse disorder. In effect what many of the adolescents are doing is self medicating for untreated mental health problems
- Youth suicide in juvenile detention and corrections facilities occurs four time more often than youth suicide in the general public and up to 19 percent of youth involved in the juvenile justice system may be suicidal
- Youth of color, particularly males frequently are misdiagnosed or not diagnosed at all
- Early screening often means that a youth can be diverted into a safer and more appropriate mental health setting.
- Every day, inside locked juvenile justice facilities, youth with mental illness are being neglected, mishandled, even abused

ACR 13 Subcommittee of the Legislative Commission of the Nevada Legislature, January 2001. In 1999 the Nevada Legislature adopted ACR 13 which directed the Legislative Commission to continue study of the juvenile justice system. A subcommittee of eight legislators and three nonvoting advisory members was established. The subcommittee held four public hearings and conducted a public work session. They reviewed expert and public testimony and correspondence and developed set of sixteen recommendations which are shown in Figure Four.

Figure Four
Recommendations from the ACR13 Legislative Commission

ACR 13 Subcommittee of the Legislative Commission of the Nevada Legislature
January 2001
Recommendations

- Need to continue refinement of placement instruments
- Need to continue creation of additional intermediate sanctions and interventions
- Continue assessment of substance abuse treatment programs
- Progress on implementation and evaluation of placement instrument and performance based standards
- Longitudinal study of diversion, intervention and aftercare programs
- Continue the evaluation of youth gang problems and youth gang involvement
- Analyze availability of alternative education programs
- Create statutory legislative committee on juvenile justice
- Issues to be studied by proposed statutory legislative committee on juvenile justice
- Implement performance based standards
- Expand governor's juvenile justice commission
- Review of transfer statues regarding certification of juvenile offenders to adult status
- Reporting of national center for juvenile justice study results
- Study of minority overrepresentation in the juvenile justice system
- Amend Nevada Revised statutes 62.180 regarding detention homes
- Amend chapter 210 of Nevada Revised Statutes regarding parole violators

National Center for Juvenile Justice, April 2001. In 1992, the National Council on Crime and Delinquency (NCCD) prepared a report delineating the challenges faced by the juvenile justice system in Nevada. Eight years later, DCFS asked the National Council of Juvenile and Family Court Judges to revisit the NCCD assessment to provide an update on progress made and challenges remaining within the juvenile justice system. The report noted that even though there have been many stresses on the system, much progress has been made. The report attributes much of the success to the strong collaboration among various levels of stakeholders in the system. The report also cites many remaining challenges. The assessment was based on a comparative analysis of current Nevada Juvenile Justice System to 1992 system. Over 100 stakeholders were interviewed and the assessment team reviewed documentation and data. They assessed the overall system and evaluated current conditions relative to cultural needs, gender specific needs, special populations, mental health and substance abuse needs. The assessment examined system and infrastructure supports and did projections of future need. Figure Five summarizes the assessment results related to behavioral health and Figure Six summarizes behavioral health related recommendations.

Figure Five
Assessment of Nevada Juvenile Justice System

National Center for Juvenile Justice
April 2001
Findings Related to Behavioral Health

- Proportion of detained youth with mental health diagnosis over 50% which is a substantial increase from 1992
- Overcrowding is a problem at detention facilities that is made worse by high percentage of youth with mental health and substance abuse challenges
- Through the CCPBG, Nevada has implemented an impressive range of community-based alternatives to commitment in Clark County which has kept a lid on commitments
- In 1997 15% of the juvenile offenders in Nevada were in custody for substance abuse offences
- Despite some improvements, there is still no comprehensive range of substance abuse service at all levels of the juvenile justice system
- In 1997, the state implemented a standardized assessment process that is very thorough and is conducted jointly by a parole counselor and a mental health counselor
- The opening of Dessert Willow in 1998 provides mental health and sex offender treatment in secure and semi-secure settings
- There is a growing need for mental health services among youth in the juvenile justice system

Figure Six
Recommendations from Assessment of Nevada Juvenile Justice System

National Center for Juvenile Justice
April 2001
Recommendations

- Clark county should promptly expand alternative to commitment including suitable residential alternatives and wraparound services to keep mentally ill juveniles out of detention
- Youth correctional services should develop specialized programs specially designed for girls with serious substance abuse problems.
- The state should carefully assess the extent of substance abuse problems among committed youth
- The state should initiate a careful assessment of current substance abuse services and determine how well they meet current needs
- The state should carefully track the short and long term outcomes for substance abuse treatment
- There is a shortage of mental health and sexual offender residential placements
- The challenges presented by youth with alcohol, drug, and mental health disorders are such to suggest the need for a statewide training conference or summit specifically intended to produce workable state and regional plans for addressing this growing problem.

Governor's Fundamental Review Committee from the Juvenile Justice Commission, March 2002. In September 2001 the Governor directed the work study group (WSG) of the Juvenile Justice Commission to provide a report to the Governor's Fundamental Review Committee on the status of the juvenile justice system in Nevada. The WSG was asked to do the following: (1) present an overview of the system; (2) identify any structural problems; (3) identify service shortfalls and/or overlaps; (4) recommend potential statutory changes; (5) articulate budgetary implications; and (6) recommend personnel and/or administrative changes that should be considered during the next legislative session. The work study group was created by the Commission and includes: District Court judges, juvenile probation officers and State juvenile justice professionals. This was part of an ongoing process begun by the legislature in 1997 to respond to a juvenile justice system in crisis. Among the options considered was the "Ohio Plan" model which provides financial incentives to local governments for keeping youthful offenders in community-based programs rather than in state institutions. While analyzing the data, it was determined that Nevada's statewide commitment rate for male offenders had been significantly

reduced as a result of the Community Corrections Partnership Block Grant (CCPBG) and the Transitional Community Reintegration Program (TCRP) which were implemented in the fall of 1997. The report summarizes the problems:

> Funding deficiencies in Nevada have led to gaps, and sometimes substantial absences, of critical juvenile services. This has been particularly true in the areas of mental health and substance abuse. Perhaps the single most pressing need in the system is the need for enhanced mental health services available to youth and their families in the area of assessment and referral, and both outpatient and residential treatment. This need is apparent throughout the public systems that serve youth in Nevada – beginning with pre-school, foster care, and the school system. For example, it is estimated that approximately 30% of all youth in foster care suffer from serious emotional disorders (SED). Such a condition, if untreated, leads to behavioral problems in school, high risk for school failure, and the problems that attend school failure including, school dropout or expulsion and delinquency. Once these youth come in contact with the juvenile justice system, they stay in the system longer and require mental health treatment not generally available.

The report includes a set of necessary actions that are included in Figure Seven and a recommendation to call a Governor's Summit. "Development of a comprehensive continuum of services at both the county and State level is critical to address the needs of Nevada's youth and families who are within the scope of the juvenile justice system. Specific emphasis should be placed on programs for mental health, substance abuse, education, minority youth, and adolescent females. This collaboration can be spearheaded through the calling of a Governor's Juvenile Justice Summit to develop the necessary strategies and plans to address the continuum of needs."

Figure Seven
Necessary Actions from Fundamental Review

Governor's Fundamental Review Committee from the Juvenile Justice Commission March 2002.

Necessary Actions

- The counties and the State must expand community-based and correctional services for juvenile populations with substance abuse and mental health problems.
- Program resources must be developed which can effectively treat delinquency, mental illness and substance abuse. Specialized programs of this nature would reduce the need to transfer youths among different programs, thereby preventing the trauma often associated with program change and, in all probability, decrease costs.
- Resources must be developed to provide intensive services addressing substance abuse and mental health issues for youth in the juvenile justice system. Programs would involve a community approach to implement what works best in Nevada.
- New initiatives should specifically address minority overrepresentation and gender specific issues.
- Local and State entities must work in a collaborative effort to develop specific guidelines and outcome measures, including a professional evaluation of the process and outcome of programs and services provided.
- The utilization of the Juvenile Accountability Incentive Block Grant program is a means to begin implementation of these actions.

Governors Summit on Juvenile Justice, September 2003. In response to the recommendations of the fundamental Review Committee, Nevada hosted a Governor's Summit on Juvenile Justice:

Building an Alliance for Nevada's Youth for two days in September 2003. Over 100 key stakeholders were invited to the event because they were leaders in their area of expertise and senior administrators capable of committing resources to the final recommendations put forward by the Summit Focus Groups. The Steering Committee divided the group of invited participants into five focus groups including participants from as many agencies as possible to provide strong interagency contact and cross fertilization. The groups met for three sessions over the two days to raise consciousness, identify current gaps, develop collaborative possibilities to fill gaps, and develop individual agency possibilities to fill the gaps. Figure Eight summarizes some of the key needs and ideas to address the needs that were related to behavioral health.

Figure Eight

Mental Health and Substance Abuse Disorders Among Young Offenders

Governors Summit on Juvenile Justice

September 2003

Needs

- Service Delivery Gaps including limited integrated service coordination, services for co-occurring disorders, diagnosticians, bilingual staff, and transportation
- Need affordable services for youth and families
- Need for early identification and intervention including universal screening and consistent assessment
- Fragmented services and communication between systems and providers
- More effective early identification and intervention through a universal screening process, parent support, stronger partnerships and going where the kids are
- Geographical barriers to services and coordination of services
- Little focus on the family as a system and in engaging families in the process
- Cultural/language barriers
- Lack of appropriate substance abuse placements and aftercare for adolescents

Ideas to Address Needs

- Specific action items to improve collaboration for early identification and early access to services
- MH Consortia and District Judges Association should organize the collaborations and specific strategies to improve collaboration
- Explore integrated case management systems
- Adopt ICM model and complete recommendations for 2005 legislature
- Explore options to shift funds from expensive back end to front end
- Develop plan to fill gaps in the continuum of services

Assessment Results. The assessment results for the risk and protective factors assessments are shown in Figures Nine and Ten. Figure nine shows the ratings for the 44 youth from the juvenile probation system and an additional 30 children from the county child welfare system. The results show that for youth in the juvenile justice system 35% are having unsatisfactory school performance and 31% are not attending school regularly. 19% report substance abuse, 23% a history of abuse or neglect, 22% a history of mental health services.

Figure Nine Risk Factors for the Screened Children

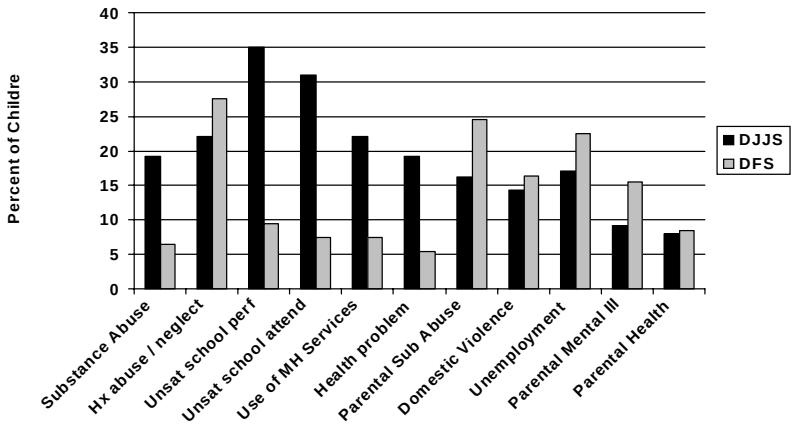


Figure Nine shows the results of the screening of 44 youth in the juvenile probation system and 30 children in the Clark County Children and Families program on significant risk factors. The black columns show the percent of the juvenile justice sample that scored positive on that risk factor. The gray columns show the percent of children in the Clark County child welfare system.

Figure Ten shows the results of the protective factor assessment for the same youth. Most of the youth have health insurance but less than a third have good support or consistent rules in their home environments.

Figure Ten Protective Factors for the Screened Children

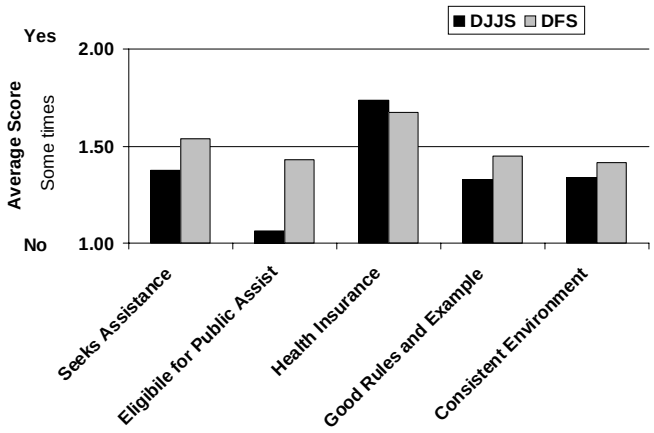


Figure Ten shows the results of the screening of 44 youth in the juvenile probation system and 30 children in the Clark County Children and Families program on significant protective factors. The black columns show the percent of the juvenile justice sample that scored positive on that protective factor. The gray columns show the percent of children in the Clark County child welfare system.

Figure Eleven shows the overall results for the CALOCUS assessment. The table on the left shows the CALOCUS level in the left hand column and the descriptor for each level in the next column. The table on the right shows the percentage of the youth assessed who scored at each level of need separated by juvenile probation and parole. The results suggest that 63% of the

youth in juvenile probation and 61% of the youth in Juvenile parole meet the criteria for severe emotional disturbance and that an additional 28% of the juvenile probation youth and an addition 28% of the youth in juvenile probation need behavioral health services.

Figure Eleven – Levels of Behavioral Health Need

CALOCUS Levels of Care	
Six	Secure 24 Hour Services
Five	24 Hour Services
Four	Integrated Services
Three	Intense Outpatient
Two	Outpatient Services
One	Resiliency and Health Mgt
Zero	No Mental Health Need

	DJJS	Parole
Six	23%	10%
Five	16%	28%
Four	14%	23%
Three	16%	5%
Two	12%	15%
One	12%	13%
Zero	7%	7%

Figure Eleven Levels of Behavioral Health Need. Figure eleven shows the results of the CALOCUS assessments for youth in the juvenile justice system in Clark County. The table on the left shows the seven levels of the CALOCUS. The table on the right shows the percentage of youth who scored at each level for Clark County Probation and DCFS Parole youth.

The next step in the assessment process was to compare the current level of services to the level of services indicated by the CALOCUS assessment. The staff first listed all of the current special services the youth is receiving including those provided by outside agencies and individuals. This was compared to the levels of need for the individual youth. Figure Twelve shows a summary of the results of this phase of the assessment.

Figure Eleven shows the current level of services for the youth assessed with targeted and intense needs. For this analysis the youth were separated into two groups. Youth who scored at levels 1 through 3 on the CALOCUS were placed in the targeted early access group. Students who scored at levels 4 through 6 were placed in the intense needs group. The first set of columns compares the percentage of the youth at the two levels that have been identified for special education. The second set of columns show that over 60% of the youth with intense needs and over 70% of the youth with early access needs are currently receiving no services. The final set of columns show that 18% of the youth with early access needs are receiving the right level of services compared to less than 5% of the youth with intense needs. The results were shared with the staff and their supervisors who made recommendations for how to meet this need and barriers that need to be overcome.

Figure Twelve - How Well Are Behavioral Health Needs Met**?**

	Receiving Appropriate Level of Services	Under Served	Children with SED receiving no Services
Clark Probation	**29.8%**	**69.2%**	**27.1%**
Clark Parole	**42.6%**	**57.4%**	**30.0%**

Figure Twelve Behavioral Health Need Met. Figure Thirteen combines the data from the Child and Adolescent Level of Care Utilization System Screening and the service utilization assessment to determine how well the level of need is met. The second row shows data for youth in the Clark County Juvenile Probation system. The third row shows data for youth in the DCFS juvenile parole system. The second column shows the percentage of the youth who were receiving a level of services that met or exceeded the level predicted by the CALOCUS. The third column shows the percentage who were underserved. The final column shows the percentage of youth who meet the SED criteria who are receiving no services. The percentage of youth with SED is determined by levels 4 through 6 of the CALOCUS.

Based on these findings from the review and the assessment of how well need is met within the system, a schematic of the proposed juvenile justice system was developed that included prevention, early intervention, and coordination of intense services.

Figure Thirteen A Balanced Juvenile Justice System

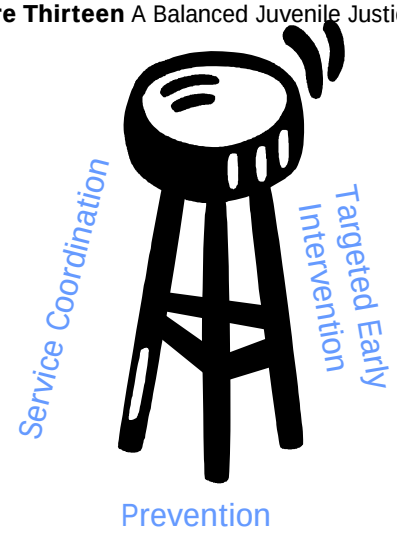


Figure Thirteen A Balanced Juvenile Justice System. This is a schematic of the view of a balanced or community approach to addressing the behavioral health needs of children and families. The system is based on the three legs of prevention, early intervention and coordinated intense services.

Recommendations

To address the need to implement the Community Approach for a Juvenile Justice System the Clark County Mental Health Consortium developed the following five recommendations:

1. Expand behavioral health promotion activities throughout the elementary schools in Clark County.

2. Implement a systematic approach to targeted early intervention for children with behavioral health problems in the Clark County School District.

3. Expand intervention services for children in the child welfare system by funding WIN (Wraparound) services for an additional 150 children and youth with SED in the Clark County Department of Family Services system. Services should be provided to abused/neglected children with SED as early as possible without regard to Medicaid eligibility.

4. Expand intensive interventions for youth in the juvenile justice services by :
    a. Providing funding for a pilot project for 100 youth in the Clark County Juvenile Justice system with severe emotional disorders. This would require the addition of eight wraparound facilitators and the behavioral health services these youth and their families need. It is recommended that this pilot be done in one or two of the Neighborhood Care Centers in Clark County.
    b. Provide funding for telehealth psychiatric services in the three Nevada juvenile training facilities (CYC, NYTC, and Summit View).
    c. Fund mobile crisis intervention services for youth with behavioral health problems that are at risk for entering juvenile justice system.

5. Strengthen the organizational and systems infrastructure by:
    a. Developing in partnership with family members a common shared vision and integrated plan for behavioral health services for children and families across all child serving agencies in Nevada.
    b. Implementing flexible fiscal policies that promote individualized behavioral health services and supports.
    c. Developing a public engagement campaign to reduce stigma and build public support for behavioral wellness.
    d. Prioritizing early identification and easy access to services before problems become severe.
    e. Requiring and gathering consistent and useful data to assess the impact of services.

PLAN FOR ADDRESSING JUVENILE JUSTICE MENTAL HEALTH NEEDS. The assessment of needs identified 763 youth within the juvenile justice system who need intensive levels of behavioral health services who are not receiving them. The plan is to implement a pilot project through two of the neighborhood care centers to provide WIN services for 100 of these youth. **To meet the needs of these children through WIN would cost $1,858,900. Of this amount it is estimated that $278,835 could be recovered through increased federal participation.**

Youth in the three youth correction centers (Caliente, Summit View, and Elko) do not have access to needed behavioral health services. **The Clark County Consortium supports the expansion of telehealth service to these facilities to address this need.**

Mobile Crisis Intervention Services are needed for the youth with mental health disorders who are at risk for entering the juvenile justice system. Mobile Crisis Services are best deployed through the five neighborhood care centers in Las Vegas. The Consortium had adopted a model of mobile crisis intervention that provides immediate care from qualified mental health professionals and paraprofessionals to a youth having a psychiatric emergency. Available between the hours of 8 a.m. and midnight, trained staff screen for emergencies by telephone, provide crisis triage, and dispatch a two-person intervention team. Home-based or community-based crisis intervention averaging up to six hours in duration is provided to support the youth's caregiver and decrease the likelihood of hospitalization or out-of-home care. **To meet this need for 200 youths per year would cost $124,800.**

Appendix D
Assessment of Need for Behavioral Health Services
Clark County Schools

Introduction

The Clark County elementary school assessment was done for two overarching goals. The first was to provide data for the school district to plan improvements in school based services. The second was to provide the Clark County Consortium with an understanding of how well the behavioral health needs of children in the general population are met. The two goals were addressed collaboratively by the Clark County school district and the Clark County Mental Health Consortium of which the Clark County School district is a member.

Multiple factors have placed pressure on the Clark County School systems' ability to promote optimal academic performance from students. Clark County has been one of the fastest growing urban populations in the country for over a decade. The number of students in the school district has increased from $156,348 to $268,357 since 1994 (CCSD Budget and Statistical Report 2003-2004 Fiscal Year). With the growth in population has come an increase in diversity and students with English as a second language. At the same time the stresses on families have increased resulting in increased risk factors and decreased parental supports for children. Within the schools children are having more and more severe emotional and behavioral challenges and these are occurring at younger and younger ages. Concurrently the Nevada economy has not kept pace with the growing population and needs resulting in proportionately fewer resources for schools to address these increasing problems.

In 2001 the Nevada Legislature began to address the increasing behavioral health needs for children by forming Mental Health Consortia and funding expanded mental health services for children in the foster care system. The legislature charged the Mental Health Consortia with doing an annual assessment of the needs for behavioral health services for the children and youth within the jurisdiction of the Consortium and how well these needs are met. In addition, the consortia were charged with the task of developing a plan to meet the unmet need.

The first two annual plans focused on the needs of children and youth in the child welfare and juvenile justice systems. Each of these assessments identified early access as a priority need. The Clark County Consortium identified that the base for early access and intervention should be though the medical home and educational setting for the child and family. To better assess the need of the general population and to develop an integrated vision of how early access would operate in Clark County, the Consortium focused the year three assessment on the school population.

The plan was to screen and assess a sample of students to determine need for behavioral health services and compare this to the current level of services to determine how well need is met. With a total school population of over 265,000 students, it was decided to focus the assessment on one segment of the school population. The elementary grades were selected because it is easier to get quality screening data, early access should begin during these grades, and follow-up assessments over time could be used to assess the overall impact of changes in the system.

The information from the screening and assessment will be augmented with information on current challenges and recommendations from focus groups with teachers and counselors. All of the information will then be used to develop a vision of a System of Care that includes early and targeted access for children through the school system.

Method

Sample Population. To select the sample population for the assessment, a stratified sampling process was developed that identified geographic and socio economic groupings within the school district. There are 129,958 students in the elementary grades (K-5) of the Clark County school system. The goal was to take a sample of 1.5% or 1950 students. The Clark County school district is organized into five geographic regions. The schools can be classified as high, medium, or low socio-economic status based on the percentage of students within the school who qualify for free and reduced lunches. Three schools representing the three socio-economic levels were selected from each of the five regions. In addition, Clark County has four elementary schools that are participating in a federal Department of Education Safe Schools Health Students grant. These schools were included in the assessment to provide a baseline assessment for the impact of this program. In each of the selected schools one class was selected for each grade K-5. All of the students in that class were selected to participate. One of the nineteen selected schools had administrative turnover during the time of the screening and assessment and did not complete the process.

2097 Clark County Elementary Students from 18 schools

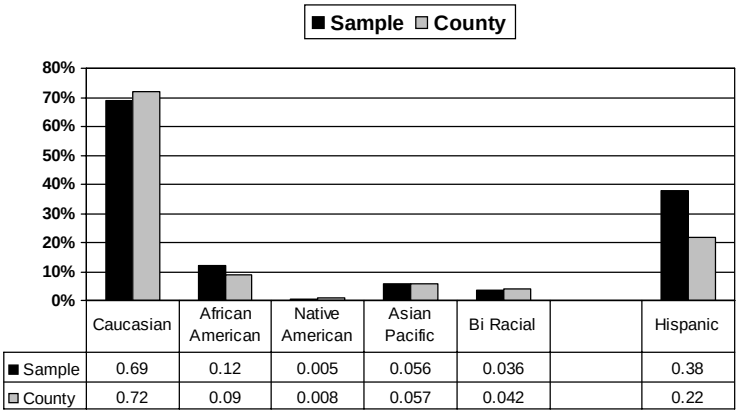
- 409 Kindergarten Students
- 262 First Grade Students
- 266 Second Grade Students
- 310 Third Grade Students
- 430 Fourth Grade Students
- 420 Fifth Grade Students

SES Level	Number of Students
Lower	592
Lower SSHS	409
Middle	517
Upper	579

Figure One Children Sampled. Figure one shows the numbers of children screened by grade and by the socio-economic status of their school. The table on the left shows the number of children by grade and the table on the right shows the number of children by SES of their school. The SES was determined by calculating the percentage of students within each school who were eligible for free and reduced lunches. The schools were then divided into three groups of the highest, middle and lowest SES. The group labeled SSHS are the four Safe Schools and Healthy Students grantees, each of which was in the lower SES group.

Figure One shows the number of children screened by grade and socio-economic status of the school. The table on the left shows that 2097 total children were screened with exceeded the goal of 1950 by 147 students. The difference in the numbers per grade is partially explained by the difference in class size. Earlier grades have smaller class sizes. Kindergarten classes meet for a half day so the increased number of kindergarten students relates to the fact that each

kindergarten teacher has two classes and both were screened. The table on the right shows the number of students by social-economic status of the schools.



	Caucasian	African American	Native American	Asian Pacific	Bi Racial		Hispanic
Sample	0.69	0.12	0.005	0.056	0.036		0.38
County	0.72	0.09	0.008	0.057	0.042		0.22

Figure Two Ethnicity of Sample. Figure two shows a comparison of the ethnicity of the sample of children screened with the general population of Clark County from census records. The five sets of columns on the left side of this graph show the self reported races of the children and general population. The columns on the right show the percentage of children and population who were reported to also be of Hispanic origin.

Figure Two shows the racial distribution of the sample compared to the general population of Clark County. The sample is within the expected variation of population figures. The one difference that stands out is the percentage of students identified as Hispanic. This is a secondary rating and the difference may be related to the data sources. The population data comes from official census data which would be self report. The sample data comes from teacher report. It may also be that there is this much difference between adults and children's populations in Clark County.

Assessment Tools. The assessment was done through screening all children with the Mental Health Screening Device (MHSD), assessing the level of need for all children who score positive on the screen using the Child and Adolescent Level of Care Utilization System (CALOCUS), and then comparing the identified level of need to the current level of services. The Mental Health Screening Device is an 11-item screen that is completed by teachers to identify students with emotional or behavioral symptoms or risk factors that may indicate a need for mental health services. Figure Three lists the eleven general items from the tool. The teacher completes the tool for each of the students in the class. Each item is scored on a two point scale yes (which includes suspected) or no. A yes score on any item is considered a positive screen.

Each of the children who received a positive screen was then assessed by a school counselor using the CALOCUS. 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. 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.

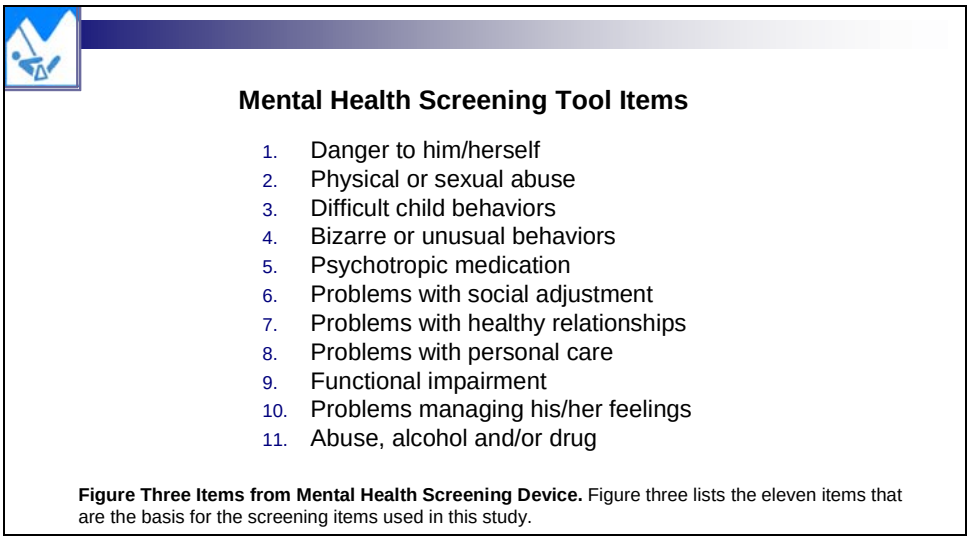


Figure Three Items from Mental Health Screening Device. Figure three lists the eleven items that are the basis for the screening items used in this study.

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 (see the table to the left of Figure Four).

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. 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 which are listed on the right side of Figure Four.

For each of the children who were assessed on the CALOCUS, the counselors identified current services using a survey form. The form identified students in special education; listed current school based services, identified current medications, and asked if the counselors knew of out of school services the children were receiving.

In addition, to the scores on the screening and CALOCUS assessments, teachers and counselors were asked to provide supplemental information about the needs of their students and to give recommendations for how children might be better served. This information was provided through survey questions with each assessment and focus groups for each participating teacher and counselor. In addition, a second focus group was done for the counselors to have them review and comment on the assessment findings.

CALOCUS Assessment Dimensions

1. Risk of Harm- to self or others
2. Functional Status- how disorder impacts ability to do normal things
3. Co-Morbidity- Multiple Problems
4. Recovery Environment (Stress)
5. Recovery Environment (Strengths)
6. Resiliency and Treatment History
7. Engagement (Parents/Caregivers)
8. Engagement (Youth)

CALOCUS Levels of Care

Zero	No Mental Health Need
One	Resiliency and Health Mgt
Two	Outpatient Services
Three	Intense Outpatient
Four	Integrated Services
Five	24 Hour Services
Six	Secure 24 Hour Services

Figure Four CALOCUS Dimensions and Levels of Care. Figure Four shows the eight dimensions that are scored on the Child and Adolescent Level of Care Utilization System (CALOCUS) to determine the appropriate level of care. The table on the right shows the seven levels of the care with corresponding descriptors.

Assessment Process. Figure Five shows a schematic of the assessment process. The preparation phase began with development of the protocols for the assessment. The sample of classrooms to be assessed were selected which led to identification of the teachers and counselors to be involved. The teachers and counselors who screened and assessed the students were trained to use the tools. During this training initial focus groups with these staff were used to identify primary challenges and needs and to begin to identify recommendations for next steps.

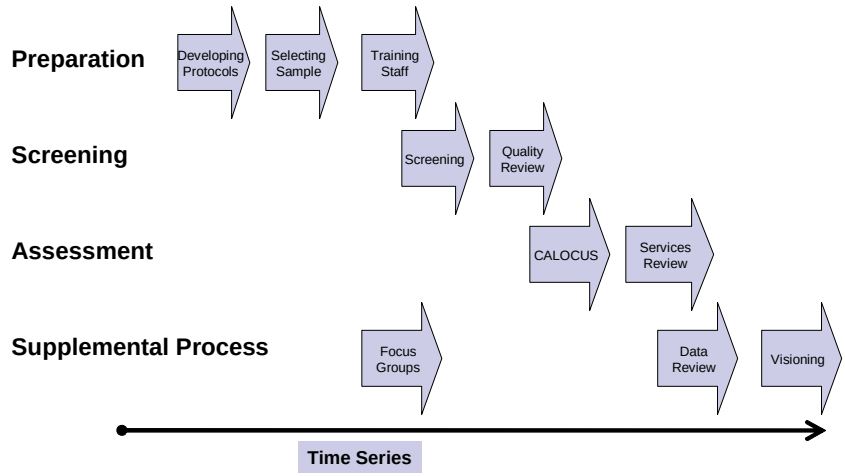


Figure 5 Assessment Process. Figure Five shows a schematic of the assessment process. The first phase of the assessment was to prepare for the assessment by developing the protocols, selecting the sample of children to be screened and training the staff. In the second phase classroom teachers screened each child in their call and these were checked by school counselors. In the third phase the school counselors assessed the level of need and current services for each child. Supplemental focus groups and data review by the counselors helped to inform the overall process that ended with school district visioning of how to meet the need identified in the assessment.

During screening, the primary teacher for each identified child completed the 11-item screening of that child. This included a section to respond to special concerns that could be added to the

screening and recommendations for needed services. The teachers were supported by the school counselor for their school. The counselors then reviewed each of the screens and worked with teachers to ensure that each screen was accurate.

In the next phase the school counselor completed the CALOCUS for each of the students who had a positive screen. In addition, to scoring the eight CALOCUS items the counselor recorded if the child was current enrolled in special education, currently receiving psychotropic medication, identified any current school-based services, and recorded any outside behavioral health services the child was receiving.

The data forms were submitted to the external evaluator who entered all of the information into a data base and completed the first draft of the data analysis. This information was presented back to the counselors for comment. These comments become part of the report and paired with the assessment and focus group results served as a basis for a visioning process for the school district.

Data Analysis. The demographic data for the sample were compared to the expected sample to determine comparability. The data from the 2097 screens and 427 assessments were entered into an Excel workbook along with general demographic information about each student. The raw data from the MHSD and CALOCUS were entered and the determination of positive screens and calculation of level of care were checked through the computer program. The data was then analyzed. For the MHSD an item analysis identified the prevalence of the 11 items. The CALOCUS data was analyzed in terms of the need at each level and the relative need by grade, socio-economic status of the schools, and region of the school district. The expected levels of care were then compared to special education status, medications, and level of services received. Once these analyses had been completed and reviewed by school personnel, the need and how well the need is met was projected to the entire population of elementary students in Clark County.

Results

The comparison of the sample population to the overall population of students suggested that the sample could be used to predict results for the entire population of elementary students in Clark County. The comparison of grade, race, socio-economic status of the schools and region were within the bounds of comparability. There were two aspects of the sample that raised some concern. With the addition of the four safe school health students grantees to the overall sample the proportion of the sample that was lower socio economic status was larger than for the other two groups. For this reason the analysis of the data was done separately for the four groups (e.g., low, medium high and SSHS schools). The data from the four groups were consistent and this suggested that the addition of these schools did not compromise the sample. The second concern was the over representation of Hispanic students compared to the census data. The overall ethnicity data was very representative of the census data and the assumption is that the difference in reporting mechanisms accounts for this difference. It is the impression of the school staff that the assessment percentages are closer to the actual population than the census data.

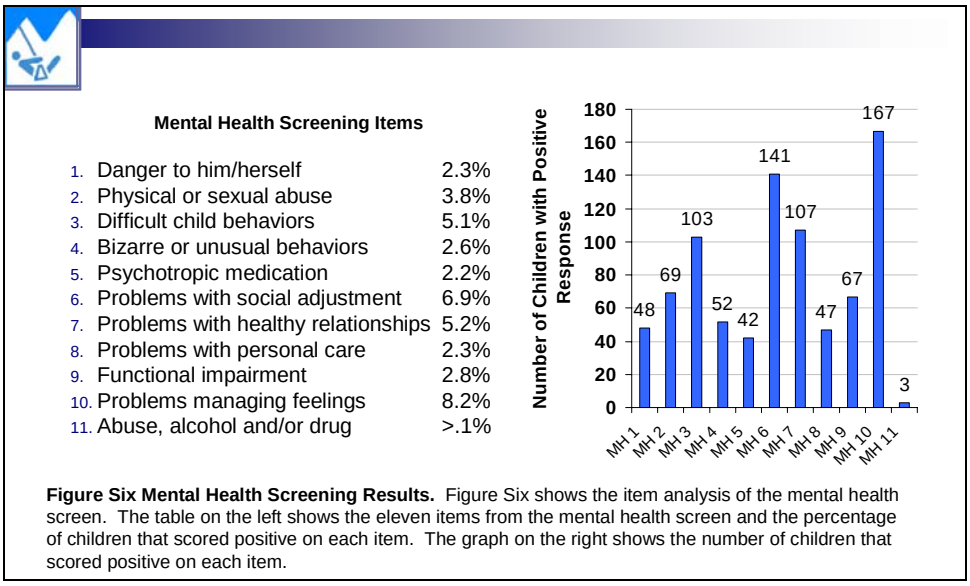


Figure Six Mental Health Screening Results. Figure Six shows the item analysis of the mental health screen. The table on the left shows the eleven items from the mental health screen and the percentage of children that scored positive on each item. The graph on the right shows the number of children that scored positive on each item.

The first stage of the determination of need was completed through the screening process. 427 children scored positive for at least one item on the mental health screening device. This represents 20.4% of the students. Figure Six shows the item analysis of the screen. The table on the left shows the eleven mental health screening items and the percentage of children that scored positive for each of these items. The right side of Figure Six shows the number of children that scored positive for each of the 11 items. The item that is scored positive most often is Item 10, managing feelings, which was scored positive for 8.2% of the children. The second through fourth most frequently scored items are social adjustment – 6.9%, health relationships – 5.2%, and behavior problems – 5.1%.

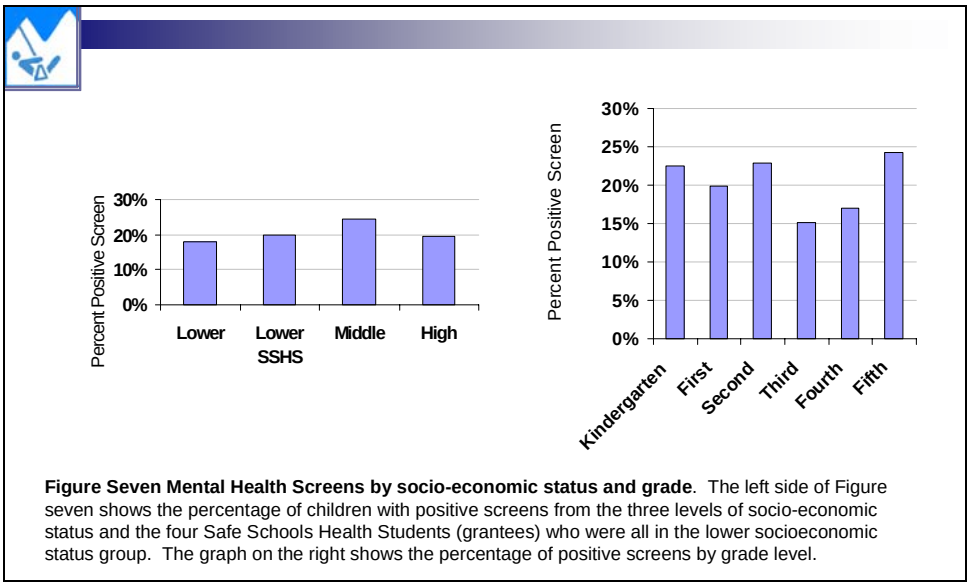
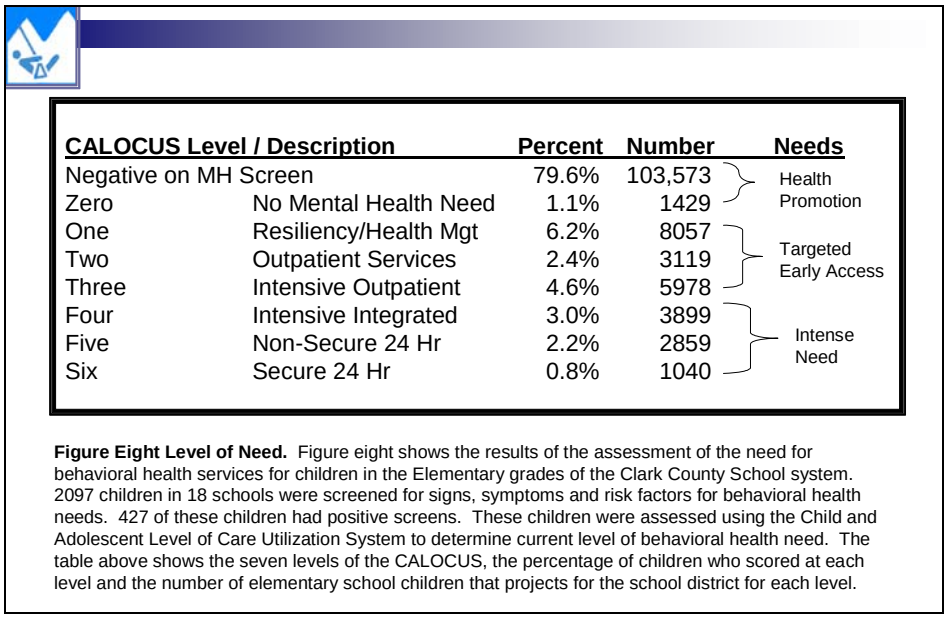


Figure Seven Mental Health Screens by socio-economic status and grade. The left side of Figure seven shows the percentage of children with positive screens from the three levels of socio-economic status and the four Safe Schools Health Students (grantees) who were all in the lower socioeconomic status group. The graph on the right shows the percentage of positive screens by grade level.

Figure Seven shows the percentage of positive screens by the socio-economic status of the schools (left graph) and grade (right graph). The data on the right shows the percentage of positive screens for the students at the four types of schools. The lower SSHS refers to the four

Safe Schools and Health Students grantees. This data is presented separately to evaluate if adding these schools to the sample biased the overall sample. It is interesting to note that the middle socio-economic schools had the highest rating of positive screens. The right side of Figure Seven shows the percentage by grade. The fact that the percentage of positive screens for kindergarten is the second highest of the grades suggests the need for mental health supports from the beginning of a child's academic career.

The next step in the assessment process was to complete CALOCUS assessments for each child that had a positive screen. This was done by the school counselors assigned to the student's school. Most of these assessments were done with assistance from the student's primary teacher. Of the 20.4% of the students who had positive screens, 1.1% had negative assessments indicating no need for additional services. this means that the percentage of children who would benefit from some level of services or support is 19.3%. This level of support is predicted by the other six levels of the CALOCUS.



CALOCUS Level / Description		Percent	Number	Needs
Negative on MH Screen		79.6%	103,573	Health Promotion
Zero	No Mental Health Need	1.1%	1429	
One	Resiliency/Health Mgt	6.2%	8057	Targeted Early Access
Two	Outpatient Services	2.4%	3119	
Three	Intensive Outpatient	4.6%	5978	
Four	Intensive Integrated	3.0%	3899	Intense Need
Five	Non-Secure 24 Hr	2.2%	2859	
Six	Secure 24 Hr	0.8%	1040	

Figure Eight Level of Need. Figure eight shows the results of the assessment of the need for behavioral health services for children in the Elementary grades of the Clark County School system. 2097 children in 18 schools were screened for signs, symptoms and risk factors for behavioral health needs. 427 of these children had positive screens. These children were assessed using the Child and Adolescent Level of Care Utilization System to determine current level of behavioral health need. The table above shows the seven levels of the CALOCUS, the percentage of children who scored at each level and the number of elementary school children that projects for the school district for each level.

Figure Eight shows the overall results for the CALOCUS assessment. The table shows the CALOCUS level in the left hand column and the descriptor for each level in the next column. The percentage of the total population of the 2097 children that were screened is in the next column. This percentage is projected to the total number of children in the elementary grades for Clark County in the fourth column. The fifth column lists the level of need in terms of the model developed through the visioning process. this will be described in the discussion section of this paper.

The CALOCUS is based on eight dimensions that impact the need for services. Figure Nine shows an analysis of these eight dimensions for the 427 children that were assessed with the CALOCUS. Each dimension is scored on a four-point scale denoting the level of impact of that item (e.g., no impact, mild impact, moderate impact or severe impact). The figure shows the percentage of children that scored at each of these four levels of severity. For example, the first dimension is risk of harm. 212 of the 427 children (49.7%) scored no risk of harm,

141 (33.0%) scored mild risk of harm, 47 (11.0%) scored moderate risk of harm, and 27 (6.3%) scored severe risk of harm. The dimensions with the largest percentages of children scoring at the moderate and severe ranges were environmental stresses and lack of strengths in the home environments.

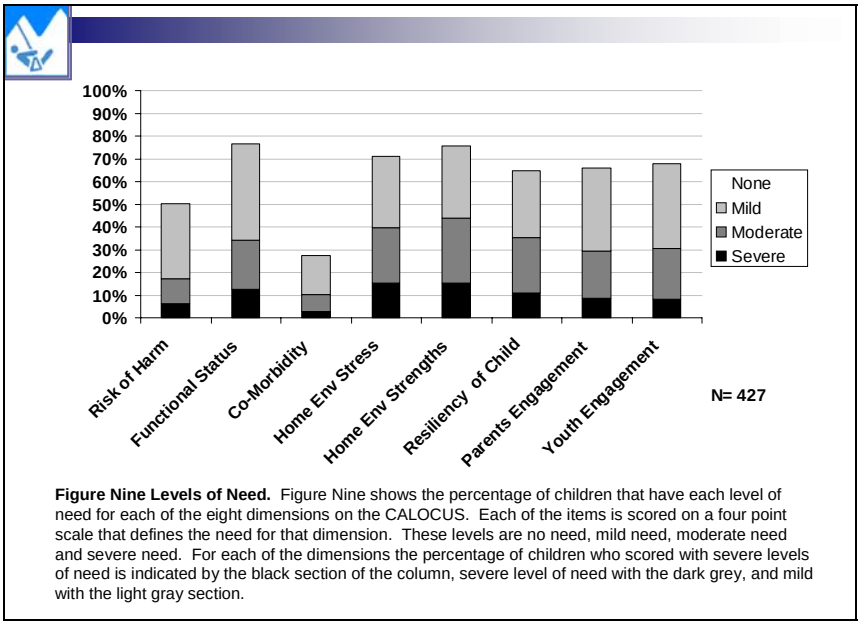


Figure Nine Levels of Need. Figure Nine shows the percentage of children that have each level of need for each of the eight dimensions on the CALOCUS. Each of the items is scored on a four point scale that defines the need for that dimension. These levels are no need, mild need, moderate need and severe need. For each of the dimensions the percentage of children who scored with severe levels of need is indicated by the black section of the column, severe level of need with the dark grey, and mild with the light gray section.

Figure Ten shows the percentage of children scoring at the targeted (Levels 1-3) and intense (Levels 4-6) levels of need by grade. The light gray columns show the percentage of all students who would benefit from early access and targeted services and the black columns show the percentage of students who need intense services. The percentage of children entering school who need intense services is about 7%. This decreases to 5% by the third grade but has increased back to almost 8% by the fifth grade.

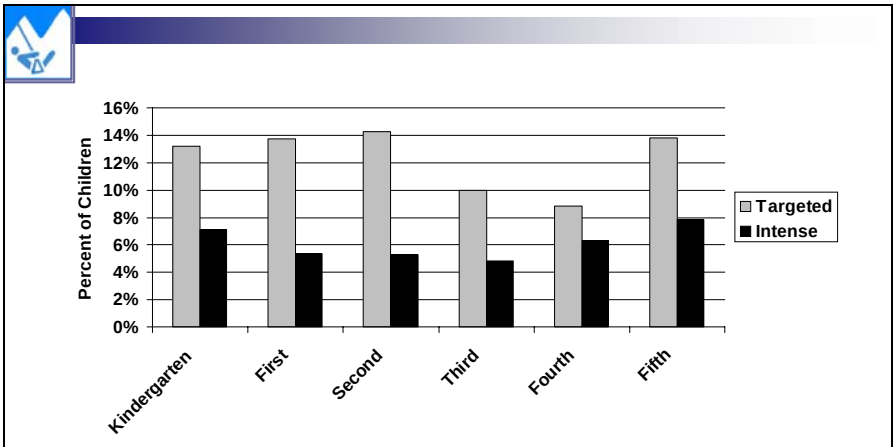


Figure Ten Level of Service Need. Figure Ten coverts the CALOCUS levels to the levels based on the intervention model developed in the visioning process by grade. The visioning process developed three overall levels of behavioral health support and services for the integrated school system of care. At the first level all students would benefit from behavioral health promotion and prevention activities that will be incorporated into the regular classroom experience. At the second level school staff will offer early access and targeted interventions for children who have some but not severe needs (this corresponds to levels 1 through 3 on the CALOCUS. At the highest level intense and coordinated services will be provided by external mental health professionals in collaboration with school teams.

The next step in the assessment process was to compare the current level of services to the level of services indicated by the CALOCUS assessment. The counselors first determined if the children being assessed were enrolled in special education. Then they listed all of the current special services the child is receiving including those provided by outside agencies and individuals. This was compared to the levels of need for the individual children. Figure Eleven shows a summary of the results of this phase of the assessment.

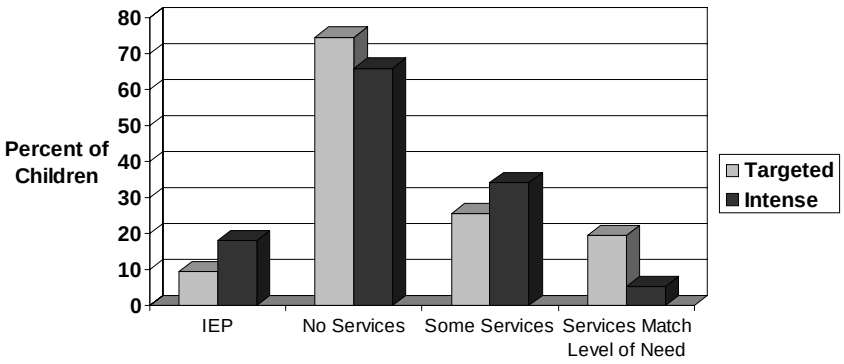


Figure Eleven Level of Need Met. Figure Eleven shows the current level of services for the children assessed with targeted and intense needs. The first set of columns compares the percentage of the children at the two levels who have been identified for special education. The second set of columns show that over 60% of the children with intense needs and over 70% of the children with early access needs are currently receiving no services. The final set of columns show that 18% of the children with early access needs are receiving the right level of services compared to less than 5% of the children with intense needs.

Figure Eleven shows the current level of services for the children assessed with targeted and intense needs. For this analysis the children were separated into two groups. Children who scored at Levels 1 through 3 on the CALOCUS were placed in the targeted early access group. Students who scored at Levels 4 through 6 were placed in the intense needs group. The first set of columns compares the percentage of the children at the two levels who have been identified for special education. The second set of columns show that over 60% of the children with intense needs and over 70% of the children with early access needs are currently receiving no services. The final set of columns show that 18% of the children with early access needs are receiving the right level of services compared to less than 5% of the children with intense needs.

The above results were shared with the counselors who had been part of the process and school administrators. This helped to inform the last part of the process which was developing a vision for the integrated system is shown in Figure Twelve. The base of the system is behavioral health promotion for all children. This comes from parents, early education and care providers, school environments, and health providers. The role of the system is to provide public engagement and special supports to these individuals to give them the knowledge and resources to provide activities and environments that promote behavioral wellness. This would be sufficient for more than 80% of all children, and if provided consistently, should reduce the number of children who need intervention services.

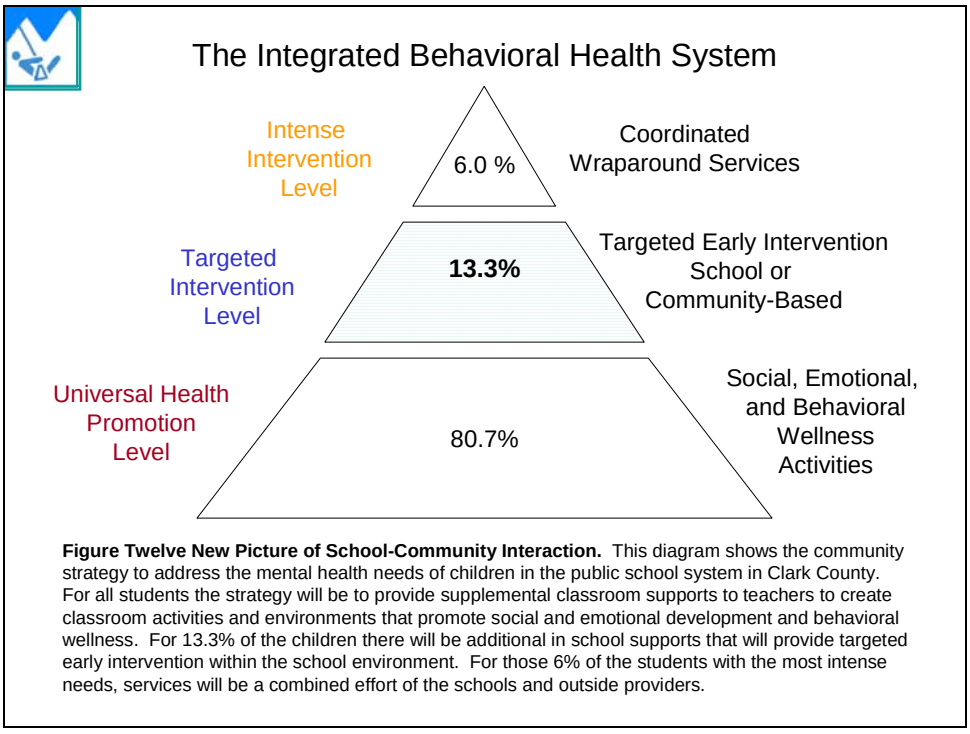


Figure Twelve New Picture of School-Community Interaction. This diagram shows the community strategy to address the mental health needs of children in the public school system in Clark County. For all students the strategy will be to provide supplemental classroom supports to teachers to create classroom activities and environments that promote social and emotional development and behavioral wellness. For 13.3% of the children there will be additional in school supports that will provide targeted early intervention within the school environment. For those 6% of the students with the most intense needs, services will be a combined effort of the schools and outside providers.

The second level of the system is for targeted early access and intervention services. Within the school system this would include a range of group and individual services. Outside the school system this would include a basic benefit of early intervention and intervention services. The third level of the system is for children who have more intensive needs that require coordination across entities. This is the level of service that is provided through WIN.

Through the process of completing the school assessment for this report and developing the new pilot project for the Safe Schools/Healthy Students initiative the Clark County School District in conjunction with the Clark County Consortium has developed a plan to address the mental health needs of the children within the district. The Consortium supports this plan because the school is a central part of all children's lives and the focus on promotion should have a positive impact on all children while the focus on targeted intervention should better meet the needs of children and families while effectively and cost efficiently integrating school and community resources to meet the mental health needs of these children. The primary goal of the plan is to remove barriers to academic achievement. The objectives are:

- Support for teachers and classrooms to provide improved learning environments
- Early identification of social-emotional and behavioral needs of elementary school-aged children
- Increased access to student intervention services (classroom modeling/small group and individual counseling)
- Seamless delivery of services
- Connect to parents of children with needs
- Establish linkages to community services

The plan is to add 50 additional positions to provide support for teachers and to manage the Student Intervention Teams (SIT) that will provide the targeted early intervention response for 5000 elementary school children across the district. The positions will be filled by a combination of School Psychologists, Social Workers, and contract positions at a cost of $2,700,000. To support the behavioral health promotion activities in the classrooms, $75,000 of instructional supplies will be purchased and distributed among all employees using a library style system. To support 2500 hours of teacher involvement in training and planning activities there is a need for $100,000 in extra duty pay. The total cost of this plan is $2,875,000. Of this amount it is estimated that a portion could be recovered through increased federal participation.

Appendix E
Assessment of Infrastructure
Clark County Mental Health Consortium

Introduction

Research has highlighted the role of organizational characteristics in delivering effective services (Glisson & Himmelgarn, 1998; Glisson & James, 2002). Such research shows that the success of innovation in working with children and families requires attention to the organizational context in which services are delivered. First, programs serving children with behavioral health needs must attend to organizational factors predictive of successful systems approaches for children with complex needs. These factors include flexible structures, supervisors and program heads who can perform multiple roles, constructive cultures, and positive work attitudes (Glisson & James, 2002). Second, organizational structures must be engineered to overcome the well-heralded "science to service" gap wherein promising or efficacious treatments are not able to be translated effectively into community-based settings (see, e.g., Kazdin & Weisz, 1998; NIMH, 2001; Weisz et al., 2001, 2002).

For the third annual report a system and infrastructure assessment was done through a three stage process to identify needed organizational supports, the current level of support and prioritize areas of need. The State of Nevada used this information to develop a proposal for an infrastructure building grant from the Substance Abuse and Mental Health Services Administration. The Clark County Mental Health Consortium used this information to assess the current infrastructure and develop recommendations and plans to improve the infrastructure to support the developing system of care.

During the past 10 years the funding invested in children's mental health services in Nevada has increased from $6.5 to over $35 million. This funding includes: Medicaid, mental health state and block grant funds, education state and student services, substance abuse state and block grant, juvenile justice state, child welfare state, IV-E, IV-B, ASFA funds, TANF, local funds and four federal grants. While service funding has increased by more than 530% the amount of infrastructure has increased by less than 200%. In addition, the number of programs and funding streams supporting mental health services has quadrupled resulting in expanding fragmentation of the service system. Even with the rapid expansion of funding to meet the behavioral health needs of children and families (maybe as a direct result of this expansion) the current situation in Nevada mirrors the results found throughout the nation by the President's New Freedom Commission.

> Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.
>
> Michael F. Hogan, Ph.D. 2003
> Chairman, President's New Freedom Commission on Mental Health

Method

The system and infrastructure assessment was done through a three stage process. First, the consortia reviewed the testimony and reports presented to the legislative committees and mental health consortia to identify the priority areas of need from consumers, providers, community representatives, and local and national content experts. The topics that related to system organization and the policy and funding context were sorted into eleven content areas. These were organized into a Community Team Assessment of State Support (Rast, 2003). These assessments were completed by a sample of consortia members including representatives from each child serving agency, family members, providers, and community representatives.

The eleven areas of the assessment are:

Area One: State organization staff will meet the system of care values in their work and promote these values within their organizations.

Area Two: State agencies will work with state organizations to foster and expand cross organization collaboration and help government to better support System of Care development in communities.

Area Three: State organizations will have expectations for local incorporation of System of Care and Wraparound values and processes.

Area Four: State agency leaders will partner with communities, be responsive to their needs, and focus their state work to make systems of care work in communities.

Area Five: State agency leaders will support parent and youth involvement and partner with parents and youth in all phases of system of care work.

Area Six: State agency leaders will have representative membership of culturally diverse groups and embrace and support the cultural diversity that is Nevada.

Area Seven: State agency leaders will listen to and understand the strengths, needs, and culture of the communities, and use this information in decision making, planning and implementation of support for communities.

Area Eight: State agencies will engage in ongoing planning to improve state support of local system of care development that is responsive to these issues in their state work. This will include developing and changing state mandates, policies, and procedures to be responsive to the needs of communities.

Area Nine: State agency efforts will focus on improving the quality of local wraparound process and the supporting local systems of care through quality management strategies, training, technical assistance, and other options as defined by the planning process.

Area Ten: State agencies will support outcome and process measurement at the state and local level and base decisions on what works and produces good outcomes.

Area Eleven: State agencies will support changes in funding needed to successfully support local Systems of Care and Wraparound.

In the third step, consortia members from each of the child serving agencies, consumers and providers completed two validated organizational and policy and funding assessments (Walker, Koroloff, and Schutte, 2003). The Assessment of Organizational Supports (AOS) for ISP assesses the necessary conditions at the organizational level. Each section of the AOS focuses on one of the conditions listed at the organizational level. Respondents rate the extent to which the feature is in place, and the level of priority assigned to improvement of this feature.

As is the case with the other assessments, the AOS is not intended to provide a rating or grade to agencies. Instead, the purpose of the AOS is to provide data that can help agencies clarify their understanding of the conditions that are necessary for local implementation, the extent to which these conditions are in place, and the priorities for action to improve implementation. Local decision makers may decide that, in their particular context, certain features are not good indices of a given condition, or even that certain conditions are not truly necessary. Discussions of such possibilities can help decision makers further develop their understanding of the goals and strategies for local implementation.

Like the AOS, the Assessment of the Policy and Funding Context (APFC) for ISP uses an "upward" assessment strategy. Respondents to this system-level assessment included the managers, supervisors, and/or administrators in lead and partner agencies. Each section of this assessment focuses on one of the conditions listed at the system. For each condition, the APFC lists a series of features that index the extent to which the condition is in place. Individuals completing the assessment provide two ratings for each feature. The respondent is asked to rate the extent to which the feature is in place, and the level of priority she or he assigns to improvement of this feature.

Results

Consortium Assessment of State Support for Wraparound and Systems of Care. The results of the consortium assessment of state support is reported in the eleven area of the assessment in terms of identified strengths and needs.

Area One: State organization staff will meet the system of care values in their work and promote these values within their organizations.
Strengths:

- Northern Nevada has started the Wraparound in Nevada for children with SED in state custody.
- A new Administrator was hired to oversee DCFS.
- Funds were allocated by the Legislature that provided funding to hire new staff at NNC&AS. This allowed NNC&AS to implement a wraparound service delivery system.
- Neighborhood Care Centers have been established.

- Reunification Services have been added to many child welfare cases.
- Additional funding sources have been identified for the extra needs of children.
- Merging of the County and state agencies.
- Assessment of needs and gaps.
- Actual implementation of Neighborhood Care Center approach.
- Increase in use of wraparound services offering these services to children earlier in the process.
- Historically the state may not have been oriented to this value but leadership clearly is included families to a greater degree.
- More family involvement and interagency involvement at all levels.
- Safe school, healthy students initiative and legislative support for project to fund services for 300 plus SED children in DCFS.
- State workers are collaborating better with outside agencies.

Needs:

- Wraparound services need to be extended to include children with SED who are not in state custody.
- Need to make a case for additional funding to support widening the wraparound system of care to serve more families.
- Care values need to be clear and concise and all community agencies need a list of these care values. There needs to be more of an opportunity for training for professions and youth care providers to ensure that goals are shared and being met for children and families in care. High caseworker turnover continues to be a problem, not allowing for consistent care for children and families. Increased communication between state agencies, staff, and providers.
- Increase and expand services and access to services.
- Strengthen coordination and collaboration bodies such as CRT.
- More flexible funding and support for informal and out-of-the box supports.
- Coordination between mental health providers, state providers, and the private and Medicaid HMO.
- Use the wraparound process in providing for all families.

Area Two: The state agencies will work with state organizations to foster and expand cross organization collaboration and help government to better support System of Care development in communities.

Strengths:

- The organizations that are members of the Washoe County Mental Health Consortium continue to work together to build the foundation of the System of Care.
- Even though there has not been much change in the last year things will be changing in the near future. The federal review of DCFS that was just completed will drive the change.
- The work of the Legislative Commission developing the state's mental health plan will give its support for change.
- In the best interest of children, the state and county have worked collaboratively to merge the two existing child welfare agencies to provide coordinated care for families.

- Involvement of diverse community based members of the consortium.
- This appears to have been a weakness recognized and addressed over the past years.
- Included nonstate agencies.
- Co-located with the county and other agencies.
- Created meetings and committees where more agencies are heard and involved.

Needs:

- There needs to be a way for different services to share funds, resources, information and policies to aid families of children with SED getting the services and tools their children need to have a successful life.
- Departments must stop seeing themselves as silos offering services but as part of a system.
- A system where a family comes in at any point seeking assistance and expects agency people to hear their story and understand they have many needs. And that the person hearing their story will help them with their entire needs not just one.
- New Medicaid changes have brought about a trend where stable, long-term placements of youth are being disrupted, as youth no longer qualify for the level of care that their current placement provides. In some instances, sibling groups are separated.
- Unknown whether state agencies has worked with other state teams and organizations have more interagency agreements and policies.

Area Three: State organizations will have expectations for local incorporation of System of Care and Wraparound values and processes.

Strengths:

- New leadership at DCFS has raised expectations of the agency's workforce. This new leadership provides a vision that is inclusive not exclusive.
- A positive step for developing one-stop and integrated service approaches for children and families has been seen through merging state and county services and in the development of Neighborhood Care Centers.
- Programming has been implemented.
- This is clearly a focus.
- Expectation of system of care and wraparound values are priority.
- With the WIN program and CCS there is more expectation across the program.
- Neighborhood care centers .
- They are working better with the county to co-locate the NCC.

Needs:

- State organizations expect private nonprofits to incorporate systems of care into their practices but do so as unfunded mandates. Because they hold the purse strings they expect much more from community groups then they do from themselves.
- Need a more coordinated approach in addressing the needs of children and families.
- There is often a lack of communication between providers and state organization staff.
- Needs to be expectation across agency with integration and CPS child welfare.
- Change needed for our community to see and recognize improvements.
- Be firm in the approach to change this system (not wishy-washy).

Area Four: State agency leaders will partner with communities, be responsive to their needs, and focus their state work to make systems of care work in communities.

Strengths:

- The Health Care Financing & Policy Division is in the process of a behavioral health redesign plan that will expand services/providers and allow more services at an early point (early intervention).
- The state's Mental Health Plan has incorporated this concept.
- The federal review of DCFS required them to develop a program improvement plan. In developing this plan DCFS brought many state stakeholders together and all agreed this is needed.
- There has been more access to different funding sources over the past year. Caseworkers have a better knowledge of these funding sources and have been active in accessing money for youth.
- This has been brought up to committees for solutions and active efforts are ongoing.
- There have been several assessments to identify the needs.

Needs:

- Some administrators within the Dept. of Human Resources see value in the items discussed above but the Director must articulate a vision and expectations for all administrators under his purview and hold them accountable.
- There remains a lack of resources and funding for families in crisis. There are a lack of emergency placements for youth and lengthy waiting lists for emergency services for families.
- Expand number of partners and involve more community representatives.
- Communities need to be defined on a much smaller scale.
- Flexible funding at local level is needed.
- We need to be able to figure out how to make it accessible for families.
- Need crisis unit.
- We need more private providers and a wider array of services to choose from.

Area Five: State agency leaders will support parent and youth involvement and partner with parents and youth in all phases of system of care work.

Strengths:

- Whenever the state legislature forms a board, council, or task force, they mandate consumers have membership.
- There appears to be an emphasis on including all major steak holders in the process of developing policies to benefit children and families at committee meeting and public forums.
- Do not see that much has been done in this regard.
- Greater parental support.
- Parents are involved at all levels of all committees and boards including foster parents.
- Parents and youth participate at some level.

- The state has come a long way since we reviewed this grant (they are very pleasant to work with now).

Needs:

- Funding is limited to support family involvement.
- Most of the meetings are scheduled during the day and there are insufficient funds to reimburse a consumer (someone working outside of state/county or nonprofit sector jobs) for time spent away from their job. In some cases there are funds to pay for childcare, per diem and mileage/travel costs. There does not appear to be a movement to change meetings to the evening hours.
- The move towards neighborhood care centers is a family friendly first step in enlisting family and youth involvement, however, there remains a lack of funding to assist families with their basic needs and therapeutic services needed to maintain or reunify families.
- Preventative services and education need to be more readily available to parents and children in order to prevent a family crisis and ultimately placement disruption.
- Establish plan of action to address this.
- Need to create times for convenience of more family and youth involvement.
- More parent sand more youth need to be involved at all levels of decision making.
- Keep up the hard work and work to get other agencies to buy in.

Area Six: State agency leaders will have representative membership of culturally diverse groups and embrace and support the cultural diversity that is Nevada.

Strengths:

- The people who came together to create the state's Oral Health Plan, the Mental Health Plan, and the Program Improvement Plan (PIP [DCFS]) have incorporated this need into each plan. There have also been suggestions for actions steps to ensure culturally diverse groups are included.
- Some reaching out has taken place.
- Outreach in areas where groups would be Spanish speaking service providers and Spanish materials.
- Cultural diversity is part of the team.
- Our state has worked very hard to overcome our problems with cultural diversity and they have tried to get our Indian tribe engaged in the system of care effort.

Needs:

- Better internal communication at the state level so not only the groups mentioned above are aware of this issue but of all the issues highlighted in this survey.
- Need to be more diligent and persistent in getting more culturally diverse groups involved.
- Continued effort to ensure diverse representation.
- Need more cultural awareness.
- Try to be more embracing of cultural diversity.

Area Seven: State agency leaders will listen to and understand the strengths, needs, and culture of the communities, and use this information in decision making, planning and implementation of support for communities.

Strengths:

- The federal review of DCFS did what no one else has been able to do. Specifically their report says reviewing Nevada was like reviewing three different states. The issue is now on the table, the cone of silence has been lifted. We are here to serve Nevadans not just those with the most money/political clout.
- The Bureau of Drug Abuse (BADA) distributes funding through community coalitions who review proposals and recommend funding.
- Positive efforts to assess and or identify needs strengths are ongoing.
- Neighborhood councils at each site are available to listen to the community.
- Child welfare integration, study of mental health needs in the CCSD elementary schools.
- The state has tried very hard to engage our Indian tribes.

Needs:

- Overarching policies that speak to fair and equitable treatment of Nevadans and then the delivery of services can be personalized to meet the needs of individual communities.
- Continued assessment of community needs by visiting with local and private practitioners.
- Need more manpower for outreach.
- We need more training in effective ways to engage different cultures and respect their differences.

Area Eight: State agencies will engage in ongoing planning to improve state support of local system of care development that is responsive to these issues in their state work. This will include developing and changing state mandates, policies, and procedures to be responsive to the needs of communities.

Strengths:

- The points in this area were identified by community stakeholders brought together by DCFS in April 2004 to assist in the development of a program improvement plan (PIP).
- Legislature provides opportunity for community representatives to provide input before passing laws and/or mandates.
- There has been a significant focus on identifying and addressing barriers.
- Having barriers recorded by parent organization and reviewed by management team, to come up with solutions.
- Our policies and procedures are better written to meet these goals.

Needs:

- The communication loop needs to be closed. Often people are asked to engage in dialogue about community needs but a summary and next steps are not communicated to this same group.
- Policies and procedures need to be tested before being activated to ensure they are workable and not academic exercises. What sounds like a good procedure may not be practical under real-life conditions.

- Need ongoing site level barrier reporting and responses.
- Need a loop of feedback to families.
- State directors and administrators could better communicate developing and changing policies and procedures.
- Use more often in practice.

Area Nine: State agency efforts will focus on improving the quality of local Wraparound process and the supporting local systems of care through quality management strategies, training, technical assistance, and other options as defined by the planning process.

Strengths:

- The communication loop needs to be closed. Often people are asked to engage in dialogue about community needs but a summary and next steps are not communicated to this same group. Policies and procedures need to be tested before being activated to ensure they are workable and not academic exercises. What sounds like a good procedure may not be practical under real-life conditions.
- Efforts to address this goal seem to be occurring.
- Wraparound and child and family team being done.
- They have been willing to work with other agencies to share the lessons learned.

Needs:

- Funding needs to continue to counties to assist with child welfare. State needs to assist private providers and nonprofit personnel with TA and training opportunities in wraparound services and best practices as they begin providing services.
- Need to make such efforts more readily known.
- Local decision making ability.
- Need to keep it local and consistent.
- Clark County needs to continue to stand up and be heard.
- Continue working with county and other agencies.

Area Ten: State agencies will support outcome and process measurement at the state and local level and base decisions on what works and produces good outcomes.

Strengths:

- The Bureau of Alcohol and Drugs has moved to this type of system in regards to funding of programs.
- Not ware of any specific examples.
- A strength of leadership is the full embrace of outcome measurement.
- Collecting data and getting reports to legislature.
- Our state is very good at data and results.

Needs:

- Need to pull funding from organizations that do not produce results after having been given training and time to improve but fail to make the necessary improvements. State tends to hold community organizations to a higher standing than they themselves can

attain yet they do not seem to have consequences. This will change now that DCFS has had a federal review.
- Need to get data to families about what is working.
- More emphasis on process measurement.
- Need to communicate results in simpler forms to more people.

Area Eleven: State agencies will support changes in funding needed to successfully support local Systems of Care and Wraparound

Strengths:

- Various state plans have incorporated wording that will have agency heads look at these issues.
- Nevada's fiscal climate makes the issue of pooling funds a necessity.
- There are currently agency administrators that are willing to consider pooling of funds.
- The state Child Care Program has been a leader in identifying and expending discretionary funds to support projects that further the childcare workforce and children and families receiving subsidies.
- Within the constraints of a political environment leadership works to improve resources.

Needs:

- The state needs to seek TA on successful models for pooling information.
- The legislature needs to understand that successful programs still require funding.
- Historically when they hear that a program has had a cost savings they look to pull funding.
- A wraparound system of care for children has shown that children need less restrictive levels of care but these funds need to be transferred to the early intervention programs not taken away.
- Consistent voice as to the unmet needs strong public education and partnership to educate decision makers on needs.
- Need to know how to make funding accessible.
- More flexibility in funding.

Overall State Assessment

Needs:

- Northern Nevada needs to extend the Wraparound services to children with SED not in state custody through establishing Neighborhood Care Centers modeled after the ones in Southern Nevada.
- State administrators within the Department of Human Resources need to take time to meet together to map out the services they provide and see that they provide services from birth to death. With this realization comes the opportunity to look at services on a continuum and not from a silo perspective. By looking at services along a continuum planning for services and funding to transition children and families along the continuum can take place. The state can be the model for wraparound services.

- Education of the community to be able to access resources. Better communication between state organization staff and providers. More opportunities for training for professionals and families.
- Expansion of service delivery to all clients. Possibly development of substance abuse specific counseling and other services.
- Institute clear referral procedures. Develop methods for early identification of SED. Promote timely collaborative response.
- Continue to educate public and decision makers on needs of youth and families and the justification for financial resource increase.
- Family support, respite, pooled funding, and informal supports.
- Mobile crisis unit, more local providers of services, more involvement in policy and procedural changes.
- Keep working with other agencies.

Local Commitments:

- All members of the Washoe County Mental Health Consortium (i.e. DCFS, CPS, CBS, Washoe County School District, Juvenile Justice, etc.) are committed to seeing the system change where a pooling of finances and resources are used to enhance services to families with children with SED.
- Share information with local community groups, such as the Mental Health Consortia, so they can help to champion the changes being made at the state level.
- Merging the county and state agencies. Lobbying for more funding sources for children, families, and youth exiting care. Clarifying roles and functions of professionals and families involved in the child welfare system. Better coordination of services for children and families.
- Use consortium to focus on and implement some of the identified action steps of the mental health plan.
- Support flexible hours access by different cultures convenience for families.
- Ask families what they need and want. Help them achieve their goals.
- Involvement of parent and youth.
- Develop a better array of services to meet the diverse needs of our community.

Commitment Support:

- We need state organizations to continue to be committed to establishing a system of care in Nevada that pools resources and finances.
- A willingness to share information and answer questions that are raised in a consistent manner. Keeping people outside the state agencies in the loop when changes are made.
- Collaboration, Education, Team Approach, and Clear and Concise Communication.
- continued communication collaboration with and support between the whole spectrum of public and private entities.
- Follow through on agreed upon action steps beyond identification of needs. Provide leadership for consortiums and action plans.
- Staff and funding.
- The commitment of local community organizations is strong.

Assessment of Organizational and System Infrastructure. These assessments rated the current level of performance and the priority for improvement in each area. These were then analyzed to identify the priority areas for infrastructure need and improvement and are show in the table below:

Table One Prioritized Infrastructure Need	Rating	Priority
for a common shared vision and integrated plan for BH services for children and families	0.82	1.89
for increased support of family and youth involvement in system level decision making	0.69	1.62
for increased support for cultural diversity in system level decision making	0.71	1.65
for flexible fiscal policies that promote individualized services and supports	0.57	1.77
for integrated responsibility to meet the needs for children and families at the local level	0.77	1.75
for ongoing interagency problem solving at the local and state system level	0.84	1.67
for a public engagement to reduce stigma and build public support for behavioral wellness	0.54	1.82
to develop and support an integrated continuum of science based services and supports	1.08	1.8
for early identification and easy access to services before problems become severe	0.46	1.84
to support increased family-centered service coordination through the wraparound process	0.79	1.76
to recruit staff and providers to meet the needs of the children and families	0.81	1.71
to develop the cultural proficiency in the services and workforce to meet the needs of children and families	0.72	1.66
to ensure that providers of service are updated on science based practice	0.93	1.61
for consistent and useful data to assess the impact of services and supports	0.44	1.78
for data to monitor and continually improve the quality and fidelity of service process	1.22	1.67

Table One shows the 15 areas of infrastructure development with the highest priority ratings. The first column describes the need, the second shows the average rating of current performance in which 2 is met, 1 is partially met, and 0 is not met. The third column shows the priority for change in which 2 is high, 1 is moderate, and 0 is low.

This information was first used by DCFS to develop a grant proposal to fund infrastructure development through a grant from the Substance Abuse and Mental Health Services Administration. This NEVADA SIG (state infrastructure grant) proposal provided the opportunity for Nevada to develop the needed system level infrastructure to support the funding and values commitment made by state administration, legislature and community groups

(Consortia) to develop an integrated behavioral health system that builds on the values of the system of care. It has five primary goals and related objectives:

Goal One: Nevada will develop a common vision and plan for developing an integrated and comprehensive behavioral health system across agencies

1.1: Prepare the state consortia to develop a comprehensive and integrated plan.
1.2: Implement a feedback - communication process for community input and feedback.
1.3: Identify gaps and duplication in Nevada's behavioral health services for children.
1.4: Assess Nevada's behavioral health services funding streams and resources.
1.5: Develop a long range plan to build an integrated and comprehensive behavioral health system for children and families in Nevada.
1.6: Ensure that the integrated system of services and supports can be sustained.

Goal Two: Nevada will strengthen and streamline the interagency coordination and funding mechanisms needed to support the developing System of Care

2.1: Complete and implement the behavioral health system redesign financing plan.
2.2: Support the continued development of the mental health consortia.
2.3: Grant responsibility and flexibility to local consortia to develop effective science-based services and supports that fit their jurisdiction.
2.4: Develop and implement an ongoing process for the local and state consortia to review and correct system challenges and barriers to effective integrated services.
2.5: Develop and implement a system of communication to support the integrated behavioral health system.
2.6: Develop and implement a public engagement campaign.

Goal Three: Nevada will develop the needed service and provider infrastructure to implement the integrated and comprehensive behavioral health system

3.1: Support the development of the community-based infrastructure needed to provide the identified continuum of services and supports.
3.2: Develop and implement a universal screening process for young children and youth.
3.3: Implement a comprehensive suicide prevention program for youth.
3.4: Improve access to rural services.
3.5: Improve the cultural proficiency of services and supports.
3.6: Support the expansion of family to family supports.
3.7: Expand access to fidelity wraparound process (integrated service coordination).

Goal Four: Nevada will develop the infrastructure to support continuing development of the workforce for the integrated and comprehensive behavioral health system

4.1: Provide resources and incentives to continually update behavioral health staff in science based practices.
4.2: Expand capacity and infrastructure support for a high fidelity wraparound process.
4.3: Improve cultural proficiency of workforce.
4.4: Develop and implement a system of strengths based professional development.

Goal Five: Nevada will strengthen the state level infrastructure for performance management and quality improvement efforts

5.1: Through policy and funding arrangements Nevada will require sufficient and consistent data to monitor outcomes for all behavioral health services.
5.2: Through policy and funding arrangements Nevada will require sufficient and consistent data to monitor behavioral health service process, quality and costs.
5.3: Use the outcome, process and cost data to assess the relative impact of different services and programs and to make decisions about future system development.
5.4: Make evaluation data available for use by consumers and stakeholders.
5.5: Disseminate lessons learned from the project within and outside the state.

The Clark County Consortia reviewed the Nevada SIG and the findings from the assessments and identified five areas of infrastructure development that should be the priority areas for development. These include:

- Developing in partnership with family members a common shared vision and integrated plan for BH services for children and families across all child serving agencies in Nevada.
- Implementing flexible fiscal policies that promote individualized behavioral health services and supports.
- Developing a public engagement campaign to reduce stigma and build public support for behavioral wellness.
- Prioritizing early identification and easy access to services before problems become severe.
- Requiring and gathering consistent and useful data to assess the impact of service.

PLAN FOR ORGANIZATIONAL AND SYSTEM INFRASTRUCTURE NEEDS. The current Nevada system has many good programs and initiatives, but these are fragmented and sometimes duplicative. Developing a common vision and integrated plan for a behavioral health system will increase cross agency communication and focus efforts on common barriers. It will decrease fragmentation and build off the strengths of the individual partners in the effort. The common vision and plan will create the blend needed to support the public engagement and sustainability goals. This will concurrently set the framework for the developing organizational climate that has been demonstrated to be the most predictive feature of improved outcomes for children and families (Glisson & Himmelgarn, 1998). One recommendation of the previous consortium reports is to strengthen and streamline interagency coordination and funding mechanisms to address many of the organizational structure issues predictive of improved outcomes for children and families. The redesigned behavioral health financing plan is one strategy that would provide flexibility and incentives to shift the focus of funding from traditional and residential services to science-based community approaches. Communication and public engagement campaigns would build public support and common commitment.

Area One. Developing in partnership with family members a common shared vision and integrated plan for behavioral health services for children and families across all child-serving agencies in Nevada. This should begin by inviting all of the different groups who are working on some aspects of behavioral health services for children (see supplement to first annual report for

a partial list) to a facilitated two day retreat to develop this vision, then requesting public comment, and finalizing this in legislation. We recommend that this be co-hosted by the Mental Health Commission, the Legislative Committee on Children and Families, and the Nevada Mental Health Plan Implementation Commission.

Area Two. Implementing flexible fiscal policies that promote individualized behavioral health services and supports. The work of the Health Care Authority to redesign the behavioral health benefit engaged from all state agencies and consumers in the process. The goals and plans developed through this group would address many of the system needs for an array of services that can be individualized to address the individualized needs of children and families and to make mental health services more accessible to children and families throughout the state. The plan developed in partnership with these stakeholders groups should be implemented.

Area Three. Developing a public engagement campaign to reduce stigma and build public support for behavioral wellness. One of significant barrier to early access to behavioral health services is the stigma attached to mental illness. A public engagement campaign could help public and family understanding mental health as one component of overall health.

Area Four. Prioritizing early identification and easy access to services before problems become severe. The development of the suicide prevention and school based behavioral health promotion programs set a clear priority on early identification and easy access to services. This is the first step in changing the focus of the system from triaging the most severe levels of disorder to building emotional and behavioral wellness for our children and thus our society.

Area Five. Requiring and gathering consistent and useful data to assess the impact of services. One of the problems with accurately accessing the need for behavioral health services and how well that need is met is the lack of outcome, services and costs, and process data to make these determinations. The Clark County Consortium has used federal grant funds to perform specific assessments of the need within the county and the outcomes of the WIN project. To sustain the development of data driven decision making for the Consortium, agencies, and divisions and for the Legislature, there is a need for common measures of outcomes, services and costs, and process measures of fidelity and quality for behavioral health services across all programs that are collected and used. A letter of intent to create and provide the necessary resources should be developed.