Legislative Committee on Children, Youth and Families

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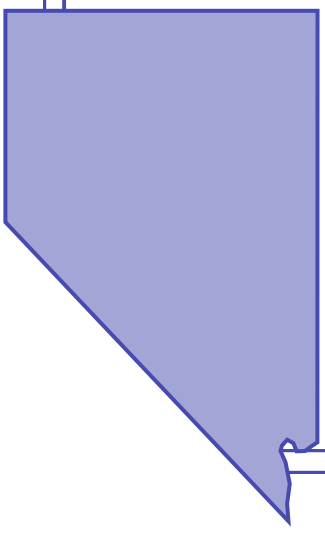

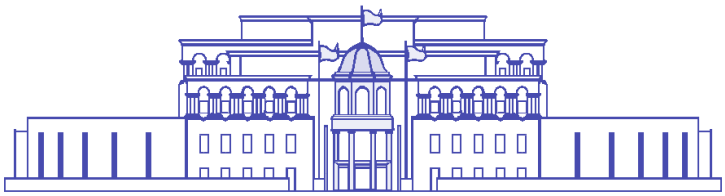

BULLETIN 03-15

LEGISLATIVE COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

Nevada Revised Statutes 218.53723

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LEGISLATIVE COUNSEL BUREAU STAFF

Fiscal Analysis Division:
Larry L. Peri, Senior Program Analyst
Mark W. Stevens, Fiscal Analyst
Sherie Silva, Secretary
(775-684-6821)

Research Division:
Allison Combs, Principal Research Analyst
(775-684-6825)

Legal Division:
Leslie K. Hamner, Principal Deputy Legislative Counsel
(775-684-6830)

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SUMMARY OF RECOMMENDATIONS

NEVADA LEGISLATIVE COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

(Nevada Revised Statutes 218.5372 – 218.53727)

This summary presents the recommendations approved by the Legislative Committee on Children, Youth and Families. The Committee submits the following proposals for consideration by the 72nd Session of the Nevada Legislature. Bill draft requests will be provided in this report under Appendix I.

FUTURE FUNDING OF THE PROVISION OF CHILD WELFARE SERVICES

1. Draft legislation necessary to implement the plan for funding the provision of child welfare services in this state in counties whose populations are 100,000 or more. The plan will address the fiscal responsibility of the state and each county for such services, including any increases in the costs of providing the services. The plan includes a "swap" between the state and Clark and Washoe Counties of child welfare costs and Medicaid long-term care county match costs. (**-- BDR 687**)

MODIFICATIONS TO THE JUDICIAL SYSTEM

2. Draft legislation authorizing a court to grant a permanent guardianship in a proceeding held pursuant to Chapter 432B of NRS (Protection of Children from Abuse and Neglect). **(--BDR 688)**

3. Draft legislation to amend NRS 432B.430 to provide that once a petition is filed proceedings are open to the general public unless the judge or master determines that the hearing should be closed in the best interest of the child. (**-- BDR 689**)

ASSISTANCE TO YOUTH "AGING OUT" OF FOSTER CARE

4. Draft legislation to allow DCFS to continue to provide services to foster care children up to and including age 21 under certain circumstances. (**-- BDR 690**)

5. Draft legislation requiring the Director of the Department of Human Resources to include in the State Plan for Medicaid a provision that specifies young people between the ages of 18 and 21 years who were in foster care on their 18th birthday are eligible for Medicaid coverage, to the extent authorized pursuant to federal law. (**-- BDR 691**)

CHILD WELFARE INVESTIGATIONS

6. Draft legislation to require agencies that provide child welfare services to ensure that children under three years of age who are reported as possible victims of child abuse or neglect are examined by a medical professional who is trained in diagnosing child abuse and neglect. (-- **BDR 692**)

7. Send a letter to the Division of Child and Family Services (DCFS) urging the division to develop regulations and hold related hearings on the issue of requiring that all child protective services employees and employees of agencies that provide child welfare services and their supervisors receive mandatory training and demonstrate competence in using standardized safety assessment protocol. Ask that a written report on the progress of modifying the regulations be provided to the Senate Committee on Human Resources and Facilities, the Assembly Committee on Health and Human Services, and the Legislative Committee on Children, Youth and Families prior to the 2003 Legislative Session.

MENTAL HEALTH CONSORTIA RECOMMENDATIONS

8. Include a statement in the final report urging the Administrator of DCFS to include a representative of the Welfare Division on the mental health consortia.

9. Draft legislation amending NRS 433B.335 to change the deadline for each consortium to submit the annual plan to the Committee on Children, Youth and Families from January 15 to August 15. (-- **BDR 693**)

10. Include a statement in the report expressing the Committee's support of the recommendation from the three mental health consortia to maintain funding for services to severely emotionally disturbed children in the child welfare system, which was provided under Assembly Bill 1 (Chapter 1, *Statutes of Nevada, Seventeenth Special Session, 2001*), contingent upon a review of the amount of funding necessary to provide these services. Include in the statement the Committee's support for expanding mental health service accessibility by allowing master's level professionals to become Medicaid providers.

11. Include a statement in the report expressing support for expanding the funding of mental health services to additional children in the child welfare and juvenile justice systems identified as underserved, contingent upon a review of the amount of funding necessary to provide these services.

12. Include a statement in the report generally supporting the work of the three Mental Health Consortia and the recommendations presented in their first annual plans.

ASSISTANCE FOR FOSTER CARE PROVIDERS

13. Include a statement in the report encouraging DCFS to work with the Foster Care and Adoption Association of Nevada (FCAAN) to explore methods of increasing the number of providers of respite care.

14. Send a letter to Governor Kenny C. Guinn urging the inclusion of an increase in The Executive Budget for the 2003-05 biennium for DCFS to fund foster parent respite care to allow foster parents 14 days of respite per fiscal year at a rate of $30 a day for ages 1 through 12 years and $35 a day for ages 13 through 18 years. In addition, urge the Governor to include authorization in the budget to use these funds for hourly respite (or part of the day or evening) instead of requiring an overnight respite placement.

15. Include a statement in the final report recognizing the need for resources (such as an ombudsman) to assist foster parents with problems and concerns while working within the foster care system. Encourage exploration of potential solutions to this problem, if necessary, in the future.

16. Include a statement in the report recognizing the cost of raising a child, as reflected in the USDA's 2001 Annual Report on Expenditures on Children by Families, and encouraging DCFS, the Department of Human Resources, the Office of the Governor, and the Legislature to consider these average costs when determining the reimbursement rates each biennium. In addition, recommend that the Legislature, the Department of Human Resources, and the Office of the Governor support raising the foster care reimbursement rate in rural Nevada and in Clark County to $30 per day.

17. Draft legislation allowing employees of DCFS and county child welfare agencies to become foster parents for children who have not been on their caseload in the past three years and who are not currently on their caseload. Retain current authorization for an employee to provide services to any child pursuant to a court order or upon referral of appropriate law enforcement officials for emergency care. **(-- BDR 690)**

KINSHIP CARE ISSUES

18. Include a statement in the final report supporting the areas of improvement for kinship care and child welfare in general identified through the course of the study by David Love, Executive Director of Bethel Renaissance Aging Council, and the Intergenerational Community Navigator Project for Grandparents Raising their Grandchildren Support Group.

    In addition, as part of the statement, include encouragement for the DCFS and the Welfare Division to review these issues and, based upon the review, report any recommendations for legislation deemed necessary to implement improvements to the child welfare system to the Committee. Finally, include as part of the statement, support for restoration and continuation of the funding for the Kinship Care program, as authorized by the 2001 Legislature.

REPORT TO THE 72ND SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

REPORT TO THE 72nd SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

I. INTRODUCTION

The Legislative Committee on Children, Youth and Families, in compliance with *Nevada Revised Statutes* (NRS) 218.5372 through 218.53727, is responsible for studying and commenting on a broad range of issues relating to the provision of child welfare services in Nevada. The Committee was created in 2001 under Assembly Bill 1 (Chapter 1, *Statutes of Nevada* 2001 Special Session), which provided for the integration of child welfare services in Clark and Washoe Counties. One of the Committee's primary responsibilities is to oversee this integration. The Committee is scheduled to sunset on June 30, 2005.

The Committee held a total of six meetings, including a work session, during the course of the study. All meetings were open to the public and conducted through simultaneous videoconferences between legislative meeting rooms at the Grant Sawyer State Office Building in Las Vegas and the Legislative Building in Carson City.

During the course of this interim study, the Committee received regular updates from representatives of the state's Division of Child and Family Services (DCFS) and child welfare agencies in Clark and Washoe Counties on the progress of ending bifurcation between the state and the two counties. In addition, the Committee closely monitored the progress on developing a plan for future funding of the child welfare system in Nevada, as required by Section 132 of Assembly Bill 1. The Committee also received testimony from governmental representatives, child advocates, representatives of foster care providers, and licensed social workers on the methods of improving the child welfare system throughout the state. The minutes from each meeting are available through the Legislative Counsel Bureau's Research Library and through the Legislature's web site at www.leg.state.nv.us.

During its last two meetings, the Committee adopted 18 recommendations, including eight recommendations for bill drafts, for consideration by the 2003 Legislature. The recommendations address the future funding of the provision of child welfare services; procedures for granting permanent guardianships and opening certain hearings to the public; assistance to youth "aging out" of foster care; improvements in procedures governing child welfare investigations; mental health services provided to children in the child welfare system; and assistance for foster care providers and grandparents raising grandchildren.

Assemblywoman Barbara E. Buckley served as the chairwoman of the Committee, and Senator Valerie Wiener served as the vice-chairwoman. Other legislative members of the Committee during the 2001-02 interim included:

Senator Joseph M. Neal, Jr.
Senator Bernice Mathews
Senator Raymond D. Rawson
Senator Maurice Washington
Assemblyman John C. Carpenter
Assemblyman Joseph E. Dini, Jr.
Assemblywoman Ellen M. Koivisto
Assemblywoman Sheila Leslie

Legislative Counsel Bureau staff services were provided by:

Mark W. Stevens, Fiscal Analyst
Larry L. Peri, Senior Program Analyst
Allison Combs, Principal Research Analyst
Leslie K. Hamner, Principal Deputy Legislative Counsel
Sherie Silva, Secretary

II. REVIEW OF COMMITTEE FUNCTIONS

The primary responsibilities of the Committee are established pursuant to NRS 218.53727, which directs the Committee to study and comment on the following issues relating to the child welfare system in Nevada:

- Programs for the provision of child welfare services;
- Licensing and reimbursement of providers of foster care;
- Mental health services; and
- Compliance with federal requirements, such as those under the Adoption and Safe Families Act of 1997.

In addition, Section 131 of Assembly Bill 1 imposes on the Committee the responsibility for monitoring the transfer of duties relating to the provision of child welfare services from DCFS to the agencies in Clark and Washoe Counties that will provide these services under the integrated system required by the legislation. As part of this responsibility, the Committee also was required to review the future funding plan for child welfare services developed by DCFS in consultation with the two counties and report the plan to the Nevada Legislature's Interim Finance Committee and to the Governor by November 15, 2002.

III. BACKGROUND ON ASSEMBLY BILL 1 (2001) AND THE RELATED FUNDING FOR INTEGRATED CHILD WELFARE SYSTEMS

In 1999, the Nevada Legislature created an interim subcommittee to examine the bifurcation of child welfare functions between the state and Clark and Washoe Counties, and to determine the most appropriate manner in which to integrate the system (Assembly Concurrent Resolution No. 53, File No. 141, *Statutes of Nevada 1999*). During the course of its study, the ACR 53

Subcommittee found that children were not served well by the bifurcated system. Children under the age of three years were moved to a new foster home on an average of 3.5 times in six months, and older children were moved more frequently.

At the conclusion of its study, the Subcommittee recommended transferring foster care, adoption, and other related services from the state to Clark and Washoe Counties to streamline services and eliminate the fragmentation. The Subcommittee also recommended funding be approved for more than 300 severely emotionally disturbed (SED) children in foster care who were not receiving needed services. Details of the Subcommittee's work, findings and recommendations are available in its 2001 report to the Legislature (Bulletin 01-13).

During the 2001 Special Session, the Legislature adopted the Subcommittee's recommendation to end bifurcation and passed Assembly Bill 1 to transfer the state's responsibility for "back-end services," including foster care, adoption, and other related services, to Clark and Washoe Counties (counties whose population is 100,000 or more). The two counties retain their current responsibility for all "front-end services," including investigations of child abuse and neglect, emergency shelter care, and short-term foster care. The functions and responsibilities in Nevada's other counties remain with the state. Assembly Bill 1 also includes personnel provisions necessary to address the transfer of employees from the state to Clark and Washoe Counties.

Additionally, Assembly Bill 1 establishes three mental health consortia in Clark and Washoe Counties and in the region consisting of all counties whose population is less than 100,000. On or before January 1 of each year, each mental health consortium shall prepare a recommended plan for the provision of mental health services to emotionally disturbed children in its jurisdiction. The plan must include, among other items: (1) an assessment of the need for mental health services in the jurisdiction; (2) a description of the types of services to be offered to emotionally disturbed children; (3) criteria for eligibility for those services; and (4) the mechanisms to manage the money provided for those services.

A. Summary of Funding Approved for Assembly Bill 1 in 2001

At the close of the 2001 Special Session, Washoe County anticipated taking over the responsibility for case management in April 2002, and Clark County's anticipated date for taking over this responsibility was January 1, 2003. The Legislature appropriated the following amounts for child welfare services and improved services to severely emotionally disturbed children within the child welfare system. These amounts were recommended by the Governor and included in The Executive Budget for the 2001-03 biennium.

- **"One-Shot" Appropriations - $5.2 million** for the 2001-03 biennium in one-time General Fund appropriations for transition costs relating to computers, SACWIS/UNITY compliance, equipment, employee leave "buyouts," and vehicles;

- **Ongoing Appropriations - $1 million** in FY 2002 and **$5.6 million** in FY 2003 in ongoing General Fund appropriations for the integration effort, which includes

$1.6 million over the biennium for services to the children with SED. The appropriation is in addition to the amount budgeted for the Division of Child and Family Services (DCFS) to provide child welfare services in Clark and Washoe Counties until the integration. (For FY 2003, the combined General Fund appropriation in the DCFS budget, separate from A.B. 1, for services in Clark and Washoe Counties is approximately $18.2 million.) The state planned to transfer ongoing funding to the counties throughout the course of the 2001-03 biennium as DCFS staff moved to the counties and responsibility for child welfare services transferred from the state to the counties.

For additional information on the amounts appropriated for Assembly Bill 1, see Appendix B.

B. Overview of Funding Changes and Delays in Integration During the 2001-03 Biennium

During the 2001-03 biennium, Nevada began to experience an unforeseen budget crisis. Estimates of the potential budget shortfall for the 2001-03 biennium ranged from approximately $294 million to $333 million, which can be attributed in part to shortfalls in revenue and the distributive school account, higher-than-budgeted expenses in Medicaid, and an 80 percent increase in the Temporary Assistance for Needy Families (TANF) caseload. In response, Governor Kenny Guinn developed a plan to address the shortfall, which includes a three percent reduction of the General Fund appropriations to state agencies and deferment of certain one-time expenditures.

Following is an outline of the effects on the child welfare integration effort resulting from the Governor's plan to address the budget shortfall, as of January 2003.

- **Integration in Washoe County** - Because its work toward integration is largely complete, Washoe County was not affected by the budgetary reductions. The first staff transfer occurred on schedule in April 2002, and the remaining staff and responsibilities are scheduled to transfer in January 2003.

- **Integration in Clark County** - Originally, a total of 144 state positions were scheduled to transfer in various phases to Clark County, with the transfers starting in October 2002. The start of the transfers was delayed until July 2003. In addition, only 7 of the 35 new Clark County positions included for the integration effort by the Legislature were scheduled to be released prior to June 30, 2003. The money appropriated for the conversion from FamilyTracs to UNITY and some of the costs associated with the "co-location" effort were not affected.

  As a result of the budgetary changes, Clark County will not assume case management responsibilities until at least July 2003, instead of January 2003 as originally proposed, and integration of child welfare services in Clark County has been delayed.

Summary of General Fund Appropriation Changes: *Reduction in ongoing General Fund appropriations for 2001-03 biennium from approximately $2.6 million (includes salaries and operating costs) to $373,000, which is an 86 percent reduction.*

- **Statewide Mental Health SED Services** – In April 2002, a DCFS pilot project was started to provide services to 32 SED children. Originally, services were to be provided to approximately 327 SED children during the 2001-03 biennium. Under the budgetary changes, the staggered start-up dates for SED children were delayed from November 2002 through June 2003 to January 2003 through June 2003. Under the revised plan, a total of 213 SED children would begin receiving services by June 30, 2003, instead of the original 327 children.

  Summary of General Fund Appropriation Changes: *Reduction in ongoing General Fund appropriations for the 2001-03 biennium from approximately $1.6 million to $1.1 million, which is a 31.3 percent reduction.*

- **"One-Shot" Appropriations** – Clark County was allocated $3.1 million of the $5.2 million in one-time General Fund appropriations. The $3.1 million allocation was reduced to $2.1 million. The funding for the conversion from FamilyTracs to UNITY was not affected by the reduction. The funds reserved for reversion were originally appropriated for items such as cars, office equipment, and computers that will be needed once Clark County assumes responsibility for all child welfare services (now scheduled to begin in July 2003).

- **Oversight/Regulatory Role of DCFS and Services in Rural Nevada** – The DCFS continues to provide an oversight/regulatory role throughout the state, including in Clark and Washoe Counties, under the integrated system. The DCFS also continues to provide all services in rural Nevada. Of the 18 positions approved for the regulatory/oversight role, only 9 positions were scheduled to be released in Fiscal Year 2003, with starting dates in October 2002 and January 2003. In addition, the 2 new state positions approved for the SACWIS compliance effort were reduced to 0. Finally, the 10 new positions approved to enhance services in rural Nevada were reduced to 5 positions, which were scheduled to start in October 2002.

  Summary of General Fund Appropriation Changes: *Reduction in ongoing General Fund appropriations for the 2001-03 biennium from approximately $1 million to $324,000, which is a 67.6 percent reduction.*

IV. FINAL RECOMMENDATIONS OF THE COMMITTEE

At its work session in August 2002, the Committee adopted 18 recommendations, including eight recommendations for bill drafts, for consideration by the 2003 Legislature.

A. Future Funding of the Provision of Child Welfare Services

Assembly Bill 1 requires DCFS, in consultation with Clark and Washoe Counties, to develop a plan for funding the provision of child welfare services in Nevada and submit the plan to the Committee by September 15, 2002. The Committee must submit the plan, with any revisions, to the Interim Finance Committee and the Governor on or before November 15, 2002.

On October 21, 2002, representatives of DCFS, Clark County and Washoe County presented *Nevada's Integrated Child Welfare System: Future Funding Plan,* to the Legislative Committee on Children, Youth and Families. A copy of the plan (without attachments) is provided under Appendix C of this report. Copies of the complete document are available through DCFS. Based upon the presentation and the plan approved by the Committee, the members voted to have a bill drafted to:

> **Recommendation No. 1 - Implement the plan for funding the provision of child welfare services in this state in counties whose populations are 100,000 or more. The plan will address the fiscal responsibility of the state and each county for such services, including any increases in the costs of providing the services. The plan includes a "swap" between the state and Clark and Washoe Counties of child welfare costs and Medicaid long-term care county match costs. (-- BDR 687)**

Following is an overview of the future funding plan, as presented to and approved by the Committee, with modifications, on October 21, 2002.

Assumptions for Estimating Costs

To develop the estimated costs for the integrated child welfare system in the future, assumptions were made by DCFS and the two counties concerning the definitions of "front-end services" (Child Protective Services) and "back-end services" (Child Welfare Services), staff-to-caseload ratio standards, caseload projections for placement services, projections for adoption subsidy caseloads, reimbursement rates for family foster care, and the amount of respite care for foster care providers. In addition, for purposes of the future funding plan, the rate of Federal Financial Participation (FFP) for the 2003-05 biennium is assumed to be 32.7 percent in Washoe County and 36 percent in Clark County.

The details of these assumptions are provided under Appendix C.

Estimated Costs for Integrated Services in FY 2004 and FY 2005

Following are the costs for Fiscal Year 2003 and the estimated costs for future child welfare services ("Back-End Services" such as foster care and adoptions) in Clark and Washoe Counties, as presented by DCFS in October 2002. (These costs do not include child protective services or other "Front-End Services," which are currently provided by the two counties.) These numbers were derived from county and DCFS estimates for future costs. The funding for SED children within the child welfare system is included in the total amounts below, and is estimated at $6.1 million in each year of the 2003-05 biennium.

- **Total FY 2003 (current) – Total of $75.9 million**, of which $35 million represents state General Funds. (Includes $33.6 million in state General Funds for the current DCFS child welfare budget, plus $1.4 million in state General Funds for the SED services.)

- **Total FY 2004 – Total of $95.3 million**, of which $52.6 million represents state General Funds. (Includes $48.4 million in state General Funds for the ongoing child welfare budget for DCFS and Clark and Washoe Counties, plus $4.2 million in state General Funds for the SED services.)

- **Total FY 2005 – Total of $100.8 million**, of which $56.2 million represents state General Funds. (Includes $52 million in state General Funds for the ongoing child welfare budget for DCFS and Clark and Washoe Counties, plus $4.2 million in state General Funds for the SED services.)

Appendix D provides a breakdown of these estimated costs prepared by DCFS in October 2002.

Future Funding Plan Approved by the Committee

The presentation to the Committee offered three alternative plans for future funding. The DCFS recommended implementing the "swap" (explained in more detail below) and sharing the remaining costs between the state and the individual county at a constant rate. Based upon information presented by DCFS, Clark County and Washoe County, the Committee approved that recommendation, with some modifications, and requested a bill draft to implement the plan. Following are the primary components of the chosen option:

- **"Swap" –** Under a complex agreement implemented in 1989, counties in Nevada provide to the state the non-federal share of costs for individuals in long-term care who have incomes between 156 percent and 300 percent of the Supplemental Security Income (SSI) limit (income between $851 and $1,635 per month). The state is currently responsible for individuals in long-term care with monthly incomes at or below 156 percent of the SSI limit, or $851 per month.

  Under the proposed future funding plan for child welfare services, the state will assume responsibility for the costs of the Medicaid long-term care programs in Clark and Washoe Counties, and the two counties will assume responsibility for all "back-end" costs

relating to salaries, benefits, and operating, which are now the state's responsibility (a "swap"). Based upon projections, the estimated value of the "swap" in FY 2004 is approximately $15.3 million for Clark County and $4.6 million for Washoe County.

- **Funding the Remaining Costs After the "Swap"** – In the future, the state and the two counties will share the remaining costs (primarily placement costs) for child welfare, but Clark County and Washoe County are on different schedules for assuming shared costs. As proposed, the two counties and the state will share the costs in the same proportions as the respective county and state now devote to those costs. The most recent calculations estimate Washoe County will pay approximately 50 percent of the shared costs and Clark County will pay approximately 54 percent.

  Under the modified funding option approved by the Committee, Washoe County and the state start sharing the remaining costs at the beginning of the 2003-05 biennium. Clark County will not assume shared costs until 18 months after the beginning of the transfer of responsibilities and state employees to the county, thus allowing Clark County sufficient experience with the integrated system before a final evaluation of costs. Until that time, the state retains responsibility for the remaining "back-end" costs in Clark County. Under the Governor's plan to address the budgetary problems, the transition of responsibilities and staff is now scheduled to begin in July 2003.

- **One-Time Reconciliation of Costs** – The state and each county will have an opportunity to evaluate their respective costs and ensure that the percentages utilized in the funding formula reflect actual experience. For Washoe County, the reconciliation would occur at the end of the 2003-05 biennium. For Clark County, the final reconciliation is estimated to occur after the 2005-07 biennium, assuming full integration occurs at some point during the 2003-05 biennium.

B. Modifications to the Judicial System

During the course of the study, members of the judiciary identified two issues for further review by the committee: procedures for establishing permanent guardianships and opening certain hearings to the general public. The Honorable Gerald W. Hardcastle from the Family Division of the Eighth Judicial District Court in Clark County and the Honorable Deborah Schumacher from the Second Judicial District Court in Washoe County participated extensively in the Committee's discussions of these issues. The testimony of the judges is included in the minutes of the February 14, 2002 and the June 28, 2002 meetings, which are available on the Legislature's website at www.leg.state.nv.us and through the Research Library.

Permanent Guardianships

In Nevada, the statutory provisions governing the establishment of a guardianship of a minor are under Chapter 159 of NRS. There is no mechanism under Chapter 432B of NRS, which governs child abuse and neglect hearings, to establish a permanent guardianship. Thus, to establish such a guardianship for an abused or neglected child, an individual seeking the

guardianship must start new proceedings separate from the child abuse and neglect proceedings. In Clark County, this change typically involves starting the guardianship proceedings with a new judge who is unfamiliar with the child's abuse and neglect proceedings.

Testimony indicated that authorizing the court responsible for the child abuse and neglect proceedings to establish a permanent guardianship would provide for a more streamlined system and benefit the child involved. As a result, the Committee voted to adopt the following recommendation:

Recommendation No. 2 - Draft legislation authorizing a court to grant a permanent guardianship in a proceeding held pursuant to Chapter 432B of NRS (Protection of Children from Abuse and Neglect). (-- BDR 688)

Open Hearings

Under existing law, court proceedings involving child abuse and neglect cases are open only to "those persons having a direct interest in the case, as ordered by the judge or master" (NRS 432B.430). In a white paper prepared for the consideration of the Committee, *The Case for Open Dependency Hearings* (Appendix E), Judge Hardcastle noted that the benefits of presumptively opening these types of proceedings to the public include the following:

- Making judges, caseworkers and lawyers exercise greater care and professionalism;
- Disseminating information critical to good government;
- Educating the public about child welfare; and
- Developing and expressing community norms regarding child welfare.

An additional benefit identified in presumptively opening the hearings, as presented in testimony and Judge Hardcastle's paper, include enhancing the ability of the press to act as a "watchdog." However, concerns were raised during the testimony for the need to protect the children involved from undue embarrassment, particularly when the proceedings are still in the preliminary stages of determining whether the allegations of abuse and neglect can be substantiated.

The white paper submitted by Judge Hardcastle (Appendix E) includes more detail on the arguments in favor of and against opening hearings, as well as information on the experience of other states.

After lengthy debate, the Committee voted to adopt the following recommendation:

Recommendation No. 3 - Draft legislation to amend NRS 432B.430 to provide that once a petition is filed, proceedings are open to the general public unless the judge or master determines that the hearing should be closed in the best interest of the child. (-- BDR 689)

C. Assistance to Youth "Aging Out" of Foster Care

A continuing issue discussed by the Committee during the course of the study was the need to provide assistance to youth as they leave the foster care system. The issue was also a concern for the A.C.R. 53 Subcommittee and the 2001 Legislature, which passed Assembly Bill 94 (Chapter 603, *Statutes of Nevada*) to provide a mechanism of funding assistance to these youth.

Assembly Bill 94 authorizes county recorders to charge additional fees for various services and to deposit those additional fees with the State Treasurer for credit to an account to assist persons formerly in foster care. The account is administered by DCFS and is to be used to assist persons in making the transition from foster care to economic self-sufficiency. In Fiscal Year 2002, $678,582 was deposited into the account. As of January 2003, the account balance was approximately $1.1 million. There have been no expenditures to date.

A second source of revenue received by DCFS to assist in the transition to independence for youths starting at the age of 15 years is the federal Independent Living or "Chaffee" grant. Nevada received approximately $500,000 in Fiscal Year 2001 under this grant, with $129,450 required from the state in matching funds. The funds are used to provide services to youths 15 years of age and older who are in foster care and are expected to be in custody until the age of 18 years. This number includes approximately 400 youth in state custody and 30 youth in tribal custody in Fiscal Year 2001. An additional $114,500 is set aside under the grant to provide assistance to youths who are between the ages of 18 and 20 years who have left foster care and are in need of room, board or services.

During the 2001-02 interim, DCFS finalized the regulations governing the operation of the Account to Assist Persons Formerly in Foster Care (NRS 423.137). Under the regulations, DCFS, Clark County Child Welfare Services, and the Washoe County Department of Social Services can establish self-sufficient programs to assist former foster youth to attain economic self-sufficiency by providing goods and services, including job training, housing assistance, case management and medical insurance. The funds from the Account to Assist Persons Formerly in Foster Care and from the federal Chaffee grant may be used for this purpose and distributed quarterly to each agency with a self-sufficiency program.

Authorization for DCFS to Continue to Provide Certain Services

The A.C.R. 53 Subcommittee submitted a bill to the 2001 Legislature authorizing DCFS to enter into agreements with children 18 through 20 years of age to continue to receive maintenance and special services if the child is enrolled as a student at a university, college, trade school or technical school. Assembly Bill 342 failed to pass the 2001 Legislature. The estimated fiscal impact of the bill was $489,846 ($400,248 in General Funds and $89,598 in federal funds) for Fiscal Year 2002 and $1,099,238 ($896,357 in General Funds and $202,881 in federal funds) in Fiscal Year 2003, with ongoing costs of $1.3 million in future years.

The Committee on Children, Youth and Families received testimony that the need for DCFS and the court to stay involved in the lives of foster youth past the age of 18 years has not changed. Therefore, the Committee voted to adopt the following recommendation:

Recommendation No. 4 - Draft legislation to allow DCFS to continue to provide services to foster care children up to and including age 21 under certain circumstances. (-- BDR 690)

Eligibility for Medicaid Coverage

The A.C.R. 53 Subcommittee also submitted a resolution for the consideration of the 2001 Legislature urging the Department of Human Resources to review the federal Foster Care Independence Act of 1999 to determine the feasibility of amending the State Plan for Medicaid to create a new Medicaid eligibility group for young adults who have "aged out" of foster care. The Foster Care Independence Act of 1999 authorized states to extend Medicaid to 18, 19, and 20-year-olds who have left foster care.

Although the Legislature adopted Assembly Concurrent Resolution No. 10 (File No. 83, *Statutes of Nevada 2001*), the Committee was unable to determine whether the Department of Human Resources had conducted any feasibility review, as urged by the resolution. Therefore, the Committee voted to adopt the following recommendation:

Recommendation No. 5 - Draft legislation requiring the Director of the Department of Human Resources to include in the State Plan for Medicaid a provision that specifies young people between the ages of 18 and 21 years who were in foster care on their 18th birthday are eligible for Medicaid coverage, to the extent authorized pursuant to federal law. (-- BDR 691)

D. Child Welfare Investigations

To improve the procedures governing child welfare investigations, DCFS submitted two recommendations for the Committee's consideration governing the protocol for examining possible victims of child abuse or neglect and the need to ensure employee competence in using standardized safety assessment protocol.

Use of Trained Medical Professionals

The Division of Child and Family Services recommended that the Committee request a bill to require agencies that provide child welfare services to establish protocol for ensuring children under three years of age who are reported as possible child abuse or neglect victims are examined by a physician who is trained in diagnosing such abuse or neglect.

In support of the recommendation, DCFS noted the following:

- Improved access to medical services for diagnosing and treating child abuse and neglect is needed;

- A network of physician specialists is also needed;
- Children are being seen by physicians who are not trained to identify child abuse and neglect, and as a result, children may be subject to further abuse; and
- Social workers are not experts at identifying the causes of injuries to small children.

Finally, DCFS noted that federal funds might be available under the Victims of Crime Act to pay for any fiscal impact associated with the implementation of the recommendation. Based upon the information provided, the Committee voted to approve the following recommendation:

Recommendation No. 6 - Draft legislation to require agencies that provide child welfare services to ensure that children under three years of age who are reported as possible victims of child abuse or neglect are examined by a medical professional who is trained in diagnosing child abuse and neglect. (-- BDR 692)

Standardized Safety Assessment Protocol

The DCFS also noted the need to ensure that all child protective services employees, as well as employees of agencies providing child welfare services, demonstrate competence in using standardized safety assessment protocol. Unlike some states, Nevada does not legislatively require a standardized safety assessment or employee competence with such an assessment. Concern was expressed in testimony that some employees may view the safety assessment as an administrative requirement, rather than a key thought process for making decisions on a child's safety, for which all employees should receive training and a competency certification. Testimony from DCFS also emphasized the need for standardized protocol specifying the "red flags" and subsequent required actions when "red flags" occur.

Committee members expressed concern for trying to "legislate" competency and questioned whether existing training should be addressed before resorting to a bill draft request. Members endorsed the idea that agencies throughout the state should work together to develop a common framework for safety assessments, and voted to approve the following recommendation:

Recommendation No. 7 - Send a letter to DCFS urging the Division to develop regulations and hold related hearings on the issue of requiring that all child protective services employees and employees of agencies that provide child welfare services and their supervisors receive mandatory training and demonstrate competence in using standardized safety assessment protocol. Ask that a written report on the progress of modifying the regulations be provided to the Senate Committee on Human Resources and Facilities, the Assembly Committee on Health and Human Services, and the Legislative Committee on Children, Youth and Families prior to the 2003 Legislative Session.

A copy of the letter sent to DCFS is included as Appendix F.

E. Mental Health Consortia Recommendations

As noted previously, in addition to providing for the integration of child welfare services, Assembly Bill 1 also created three mental health consortia: one in Clark County, one in Washoe County, and one to represent the remainder of the state. Each consortium must prepare a plan for the provision of mental health services to emotionally disturbed children within its jurisdiction. The plan must include, among other items: (1) an assessment of the need for mental health services in the jurisdiction; (2) a description of the types of services to be offered to emotionally disturbed children; (3) criteria for eligibility for those services; and (4) the mechanisms to manage the money provided for those services.

Each consortium includes representatives of the following agencies: DCFS, the agency providing child welfare services in the area, the Division of Health Care Financing and Policy, the county board of trustees of the school districts, the local juvenile probation departments, and the local chambers of commerce or business community. Also included are a private provider of mental health care, a provider of foster care, and a parent of an emotionally disturbed child (NRS 433B.333).

By statute, the plans must be prepared by January 1 annually, and submitted to the Department of Human Resources and the Committee by January 15th, with quarterly progress reports to the Committee throughout the year. However, in their first year of operation, the timing of the appointments to and the initiation of the work of the consortia rendered the January deadlines impracticable.

The Committee monitored the work of the consortia and received updates on their progress throughout the course of the study; drafts of the first annual plans were submitted to the Department of Human Resources and the Committee in June 2002. Revised documents were subsequently submitted in August 2002. Copies of the extensive plans are available through the Division of Child and Family Services. The complete plans are also available in the Research Library of the Legislative Counsel Bureau as exhibits to the August 28, 2002 meeting of the Committee. The executive summaries of the three plans are provided under Appendix G.

Recommended Changes in the Operation of the Consortia

In testimony, one of the consortium's members noted that it would be helpful to have participation in the consortium discussions from a representative of the State Welfare Division within the Department of Human Resources. Because the Administrator of DCFS currently has the discretion to appoint additional members to each consortium, the Committee voted to adopt the following statement in its report:

Recommendation No. 8 - Include a statement in the final report urging the Administrator of DCFS to include a representative of the Welfare Division on the mental health consortia.

In recognition of the difficulty in complying with the January deadlines for completion and submission of the annual plans, the Committee adopted the following recommendation for legislation to change the deadlines:

Recommendation No. 9 - Draft legislation amending NRS 433B.335 to change the deadline for each consortium to submit the annual plan to the Committee from January 15 to August 15. (-- BDR 693)

Support for the Recommendations of the Consortia

Generally, each plan and the recommended "action steps" are unique to the area the consortium represents, but one of the "action steps" for the Legislature was recommended by all three consortia: maintain the funding for services to SED youth that was allocated under Assembly Bill 1. Although the estimates for continuing these services in future years were not yet available, the Committee strongly supported this recommendation and voted to include a statement of its support in the report.

Many of the recommended "action steps" from the consortia focused on the administration of Medicaid by the Division of Health Care Financing and Policy, Department of Human Resources. During the work session, the Committee identified and discussed one of the "action steps" designed to expand the number of mental health providers. Specifically, the Washoe County Mental Health Consortium identified the need for a greater network of master's level professionals to become Medicaid providers to expand mental health service accessibility to children and adolescents, particularly with alcohol and other drug related problems. Testimony from the department indicated that this proposal was under active review and changes may be forthcoming. The Committee voted to include a statement of its support for this "action step" in its report.

In summary, following is the recommendation approved by the Committee:

Recommendation No. 10 – Include a statement in the report expressing the Committee's support of the recommendation from the three mental health consortia to maintain funding for services to severely emotionally disturbed children in the child welfare system, which was provided under Assembly Bill 1, contingent upon a review of the amount of funding necessary to provide these services.

Include in the statement the Committee's support for expanding mental health service accessibility by allowing master's level professionals to become Medicaid providers.

An additional "action step" that was included in the consortium reports for Clark County and Rural Nevada was to expand the funding of mental health services to additional children in the child welfare and juvenile justice systems identified as underserved. At the time of the work session, the number of underserved children in the child welfare and juvenile justice

systems and the costs for providing the services were not available. However, the Committee members expressed their support for expanded funding with the following recommendation:

Recommendation No. 11 - Include a statement in the report expressing support for expanding the funding of mental health services to additional children in the child welfare and juvenile justice systems identified as underserved, contingent upon a review of the amount of funding necessary to provide these services.

Finally, the Committee members voted to recognize and express their support for the work of each consortium with the following recommendation:

Recommendation No. 12 - Include a statement in the report generally supporting the work of the three Mental Health Consortia and the recommendations presented in their first annual plans.

F. Assistance for Foster Care and Respite Care Providers

As part of its review of the effort to integrate child welfare services, Committee members examined services and financial support available for foster care providers. Representatives of foster care providers and individual foster parents frequently participated in the discussions. Prior to the work session, the Foster Care and Adoption Association of Nevada (FCAAN) submitted several recommendations for the Committee's consideration. Many of these recommendations were adopted, with some modifications.

Respite Care Providers

The FCAAN noted the need for an increased number of respite care providers and suggested legislation authorizing the Department of Human Resources to develop a program for licensing or certifying this type of provider in order to create a "pool" of reliable providers. However, concern was expressed for both the cost of such a program and for the possibility that respite care providers may choose not to go through the time-consuming hurdles of licensure, thus decreasing the number of available providers. Therefore, the Committee voted to adopt the following recommendation in recognition of the need to actively pursue additional respite care providers:

Recommendation No. 13 - Include a statement in the report encouraging DCFS to work with FCAAN to explore methods of increasing the number of providers of respite care.

In addition, FCAAN recommended increasing the reimbursement rate for respite care providers, which has not been increased since the program was created. Currently, the respite care rate is $15 per day for children 0 to 13 years of age and $20 a day for children 13 years of age and older. Under its recommendation, FCAAN proposed to increase the rate to $30 a day for children 0 through 12 years of age and to $35 a day for children 13 years of age and older.

Further, FCAAN suggested that the Legislature provide funding to allow foster parents 14 days of respite care each fiscal year at the increased rate, and to allow flexibility to access these funds for hourly respite care instead of limiting the funds for overnight respite.

At the time of its work session, the Committee did not have estimates on the potential fiscal impact of the recommendation, but voted to support the identified need for enhanced respite care services with the following recommendation:

> **Recommendation No. 14 - Send a letter to Governor Kenny C. Guinn urging the inclusion of an increase in The Executive Budget for the 2003-05 biennium for DCFS to fund foster parent respite care to allow foster parents 14 days of respite per fiscal year at a rate of $30 a day for ages 1 through 12 years and $35 a day for ages 13 through 18 years. In addition, urge the Governor to include authorization in the budget to use these funds for hourly respite (or part of the day or evening) instead of requiring an overnight respite placement.**

A copy of the letter to Governor Guinn is included under Appendix H.

Coordinating Assistance for Foster Care Providers

In its recommendations, FCAAN identified the need for a person or office in Nevada specifically designated to assist foster care providers in navigating through the complicated foster care system. As noted by FCAAN, foster care providers have no one to help settle grievances, complaints or concerns. At the time of the work session, the FCAAN was in the process of developing a proposal for a "buddy and liaison program" supported by volunteers.

To provide needed assistance to foster care providers, FCAAN recommended the creation of an ombudsman position within the Department of Human Resources. No estimates were available at the time of the work session concerning the cost of establishing such an office. Although Committee members supported the concept, concern was expressed for the cost of the proposal in light of the budgetary constraints facing the 2003 Legislature. The Committee voted to adopt the following recommendation:

> **Recommendation 15 - Include a statement in the final report recognizing the need for resources (such as an ombudsman) to assist foster parents with problems and concerns while working within the foster care system. Encourage exploration of potential solutions to this problem, if necessary, in the future.**

Guidelines for Determining Reimbursement Rates for Foster Care

At its June 2002 meeting, the Committee discussed a recommendation from FCAAN's representative, Deanne Blazzard, to utilize federal data prepared annually on the cost of raising a child when determining reimbursement rates for foster care providers. Some states utilize data prepared by the United States Department of Agriculture (USDA) on the average annual cost to raise a child in determining foster care rates. In Kentucky, for example, state

statute requires a comparison of the reimbursement rates paid to foster parents with the Expenditures on Children by Families Annual Report prepared by the United States Department of Agriculture. To the extent funding is available, reimbursement rates paid to foster parents must be increased on an annual basis to reflect cost of living increases. (*Kentucky Revised Statutes* 605.120)

For 2001, the USDA's estimated annual expenditure on a child by a middle-income family in the western region of the United States ($39,600 to $66,600 pre-tax income) was as follows:

- For a child 0 through 2 years of age: $9,840 (including $530 for health care), which is an estimated $28.24 per day;

- For a child 9 years of age: $10,170 (including $630 for health care), which is an estimated $28.90 per day; and

- For a child 16 years of age: $11,100 (including $670 for health care), which is an estimated $31.53 per day.

In 2001, the Nevada Legislature increased foster care rates, which include clothing allowances and school supplies, paid to foster parents for children 0 through 11 years of age from $13.28 per day to $19.50 per day (46.8 percent increase). The rate for children 12 years and older increased from $16.33 per day to $22.50 per day (37.8 percent increase).

The Committee members discussed the varying rates of reimbursement in the state for foster care providers. Prior to the enactment of Assembly Bill 1, Washoe County paid its foster care providers a rate of $44 per day in an effort to reflect the market rate for childcare services and promote the retention of foster families. To prevent the loss of foster care services in Washoe County, Assembly Bill 1 included funding for Washoe County to pay a lower reimbursement rate of $30 a day after the first 90 days of foster care. The county continues to fund the first 90 days of foster care at a rate of $40 a day. Foster care providers in the remainder of the state are reimbursed at the 2001 legislatively approved rates.

Testimony from representatives of Washoe County during the interim advocated the continuation of the $30 a day rate as a means both to retain foster care providers and to provide higher quality of care, which would result in fewer children advancing to higher, and more costly, levels of care. During the discussions of this issue, Committee members advocated pursuing increased rates for foster care providers throughout the state to the equivalent of the rates in Washoe County in future years. The Committee members also encouraged DCFS and Washoe County to work together in a pilot program or study to monitor the levels of foster care to determine if the $30 a day rate actually resulted in a reduction of the use of higher, more costly levels of care.

Expressing concern for mandating the state to follow out-of-state indices, but supporting the need for annual increases for foster care providers to reflect the current economic conditions, the Committee voted to adopt the following recommendation:

Recommendation No. 16 - Include a statement in the report recognizing the cost of raising a child, as reflected in the USDA's 2001 Annual Report on Expenditures on Children by Families, and encouraging DCFS, the Department of Human Resources, the Office of the Governor, and the Legislature to consider these average costs when determining the reimbursement rates each biennium.

In addition, recommend that the Legislature, the Department of Human Resources, and the Office of the Governor support raising the foster care reimbursement rate in rural Nevada and in Clark County to $30 per day.

Expanding the Pool of Available Foster Care Providers

The FCAAN also noted that employees of child welfare agencies, who have exhibited a tremendous dedication to children through their chosen careers, represent a tremendous untapped resource for foster care providers. However, due to existing restrictions, these individuals are not eligible to become foster care providers. Under NRS 432.030, no employee of an agency that provides child welfare services may provide maintenance and special services for any child, except as otherwise provided by specific statute or:

- Upon the request of a child whom the agency which provides child welfare services determines to be emancipated;
- Pursuant to court order or request; or
- Upon referral of appropriate law enforcement officials for emergency care.

Concern was expressed by DCFS for the potential of conflicts of interest if employees seek to become foster care providers for children on their own caseload. To avoid these concerns, but to enable employees to become foster care providers under appropriate circumstances, the Committee voted to adopt the following recommendation:

Recommendation No. 17 - Draft legislation allowing employees of DCFS and county child welfare agencies to become foster parents for children who have not been on their caseload in the past three years and who are not currently on their caseload. Retain current authorization for an employee to provide services to any child pursuant to a court order or upon referral of appropriate law enforcement officials for emergency care. (-- BDR 690)

G. Kinship Care Issues

Kinship care is an ongoing issue from the A.C.R. 53 interim study and the 2001 Legislature. Kinship care involves a living arrangement in which a family member (frequently a grandparent) or someone else emotionally close to a child accepts primary responsibility for raising the child. The 2001 Legislature approved Assembly Bill 15 (Chapter 326, *Statutes of Nevada 2001*), which established a program administered by the Department of Human Resources to provide assistance to kinship care providers. For the operation of the program, the Legislature authorized federal TANF (Temporary Assistance for Needy Families) funds

of approximately $860,000 in Fiscal Year 2002 and approximately $2.3 million in Fiscal Year 2003.

The Committee requested updates on the operation of the program during the course of the study. In April 2002, the Welfare Division, which oversees the program, reported that the program paid a monthly stipend of $534 for children 0 to 12 years of age and $616 for children 13 years of age and older. These amounts represent 90 percent of the current foster care rate. The division testified that, as of March 2002, fewer children than anticipated were participating in the program. Committee members encouraged the division to promote the program more aggressively, as many Nevada grandparents and other kinship care providers would certainly seek assistance from the program if they knew of its existence.

Based upon a slow start-up and the need to transfer TANF funds to other TANF programs, the Welfare Division reduced the program's funding for Fiscal Year 2002 to approximately $427,000. In Fiscal Year 2003, as of January 2003, the $2.3 million authorized for the program had not been reduced. However, the Division did reduce the monthly stipends in order for projected expenditures to remain within the $2.3 million budgeted. Under the reduced amounts, instead of receiving 90 percent of the foster care rate for each child in a multiple child household, kinship care providers received 90 percent for the first child but only $100 for each additional child.

During the course of the study, David Love, Executive Director of Bethel Renaissance Aging Council, and the Intergenerational Community Navigator Project for Grandparents Raising their Grandchildren Support Group, submitted the following general recommendations for the Committee's consideration:

- Improve distribution of kinship care information and referral.

- Make special needs provider services available to strengthen the whole family in the health and wellness area. The special needs area is very important to grandparents raising grandchildren.

- Deal with the issue of teen responsibility for successful fathering. There is a need to focus within the family focus centers on providing courses to some of the parents of the children being raised by the grandparents.

- Provide an Intergenerational Navigator Program, as they do in Ohio, to help grandparents through the child welfare system, be it legal or financial. Many times grandparents need financial support in order to get through the legal system.

- Provide financial support for kinship care initiatives for health and fitness.

- Provide legal help and court involvement for a grandparent when a parent does not want to give the grandparent authority to make decisions about medical treatment. If the

grandparent decides to stay out of the state foster care system and take informal custody of the grandchild on his or her own, they will not qualify for foster care assistance.

- Provide childcare services such as day care, nursery school, babysitting, as well as respite care on a sliding price scale, based on the ability to pay, in order to provide grandparents some relief from caring for children 24 hours a day, 30 days a month.

- Address problems with medical care and insurance assistance, which are very important, since early periodic diagnosis will allow for mental health treatment follow-up, as well as make available physicians who may opt out of the Medicare payment system. Grandparents might be receiving benefits, but they cannot find a physician who will provide mental health services through the Medicare system.

- Facilitate relationships with parents of grandchildren. An important aspect for grandparents is dealing with the parents of their grandchildren, so there needs to be group interaction, as well as some counseling, in the family focus centers to assist with solutions for grandparents, as well as the parents of the children.

- Better usage of the family focus centers in follow-up of children who are 18 years old and opting out of the system, but would like to continue their education. This past June, three good students graduated from high school, but they were not given any advice or financial assistance in order to continue their education.

The Committee generally supported the recommendations for improving the services for kinship care and child welfare, as identified by Mr. Love, and encouraged the responsible agencies to review thoroughly the recommendations and bring any necessary legislation to the attention of Committee. In addition, the Committee also voiced strong concern for the reduction of kinship care funds in Fiscal Year 2002 and advocated restoration and continuation of the funding, as authorized by the 2001 Legislature.

Following is the recommendation approved by the Committee with regard to kinship care issues:

Recommendation No. 18 - Include a statement in the final report supporting the areas of improvement for kinship care, and child welfare in general, identified through the course of the study by David Love, Executive Director of Bethel Renaissance Aging Council, and the Intergenerational Community Navigator Project for Grandparents Raising their Grandchildren Support Group.

In addition, as part of the statement, include encouragement for the DCFS and the Welfare Division to review these issues and, based upon the review, report any recommendations for legislation deemed necessary to implement improvements to the child welfare system to the Committee. Finally, include as part of the statement, support for restoration and continuation of the funding for the Kinship Care program, as authorized by the 2001 Legislature.

V. CONCLUSION

Under Assembly Bill 1, the Committee is scheduled to "sunset" in 2005. Until that time, the Committee will continue the work started this interim to identify areas for improvement in the system throughout the state and recommend changes to address the needs of the children. The development of the plan for the future funding of the integrated system is one of the primary hurdles remaining for the 2003 Legislature, and the intense work of the Committee and the agencies involved in the integration during the interim provides the necessary foundation for the Legislature's difficult task of forging the appropriate plan.

APPENDICES

VI. APPENDICES

APPENDIX A

Nevada Revised Statutes 218.53723
Legislative Committee on Children, Youth and Families

LEGISLATIVE COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

REVISER'S NOTE.

Ch. 1, Stats. 2001 Special Session, the source of NRS 218.5372 to 218.53727, inclusive, contains the following provisions not included in NRS:

"Sec. 131. The legislative committee on children, youth and families established pursuant to section 37 of this act [NRS 218.53723] shall monitor the transfer of duties relating to the provision of child welfare services from the division of child and family services of the department of human resources to each agency which provides child welfare services in a county whose population is 100,000 or more, including, without limitation, the fiscal effects resulting from the transfer of such duties.

Sec. 132. 1. The division of child and family services of the department of human resources, in consultation with each agency which provides child welfare services in a county whose population is 100,000 or more, shall develop a plan for funding the provision of child welfare services in this state. The plan must address the fiscal responsibility of the state and each such county for any increases in the costs of providing those services. The division of child and family services shall submit the plan to the legislative committee on children, youth and families established pursuant to section 37 of this act [NRS 218.53723] on or before September 15, 2002, for its review.

2. The legislative committee on children, youth and families may revise the plan submitted by the division of child and family services pursuant to subsection 1 as it deems necessary and shall submit the plan, including any necessary revisions, to the governor and the interim finance committee on or before November 15, 2002.

Sec. 135. Notwithstanding the amendatory provisions of this act, the division of child and family services of the department of human resources shall, except as otherwise provided in NRS 432B.325, provide child welfare services in a county whose population is 100,000 or more as necessary until the division and the board of county commissioners of the county agree that an agency in the county is fully capable of providing child welfare services. Any dispute regarding the capability of the agency to provide child welfare services must be determined by the governor."

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States ⇐ 45.
WESTLAW Topic No. 360.
C.J.S. States §§ 79 to 80, 82, 136.

NRS 218.5372 "Committee" defined. [Effective through June 30, 2005.] As used in NRS 218.5372 to 218.53727, inclusive, "committee" means the legislative committee on children, youth and families.

(Added to NRS by 2001 Special Session, 19)

NRS 218.53723 Creation; membership; chairman and vice chairman; vacancies. [Effective through June 30, 2005.]

1. There is hereby established a legislative committee on children, youth and families consisting of:

(a) Five members appointed by the majority leader of the senate, at least two of whom were members of the committee on finance during the immediately preceding legislative session; and

(b) Five members appointed by the speaker of the assembly, at least two of whom were members of the committee on ways and means during the immediately preceding legislative session.

2. The members of the committee shall elect a chairman and vice chairman from among their members. The chairman must be elected from one house of the legislature and the vice chairman from the other house. After the initial election of a chairman and vice chairman, each of those officers holds office for a term of 2 years commencing on July 1 of each odd-numbered year. If a vacancy occurs in the chairmanship or vice chairmanship, the members of the committee shall elect a replacement for the remainder of the unexpired term.

3. Any member of the committee who is not a candidate for reelection or who is defeated for reelection continues to serve until the convening of the next session of the legislature.

4. Vacancies on the committee must be filled in the same manner as the original appointments.

(Added to NRS by 2001 Special Session, 19)

NRS 218.53725 Meetings; regulations; quorum; compensation. [Effective through June 30, 2005.]

1. The members of the committee shall meet throughout each year at the times and places specified by a call of the chairman or a majority of the committee.

2. The director of the legislative counsel bureau or his designee shall act as the nonvoting recording secretary.

3. The committee shall prescribe regulations for its own management and government.

4. Except as otherwise provided in subsection 5, six voting members of the committee constitute a quorum.

5. Any recommended legislation proposed by the committee must be approved by a majority of the members of the senate and by a majority of the members of the assembly appointed to the committee.

6. Except during a regular or special session of the legislature, the members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session, the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207 for each day or portion of a day of attendance at a meeting of the committee and while engaged in the business of the committee. The salaries and expenses paid pursuant to this subsection and the expenses of the committee must be paid from the legislative fund.

(Added to NRS by 2001 Special Session, 19)

NRS 218.53727 Duties. [Effective through June 30, 2005.] The committee shall:

1. Study and comment upon issues related to the provision of child welfare services within this state, including, without limitation:

(a) Programs for the provision of child welfare services;

(b) Licensing and reimbursement of providers of foster care;

(c) Mental health services; and

(d) Compliance with federal requirements.

2. Receive progress reports and testimony from the division of child and family services of the department of human resources on the activities of each mental health consortium established pursuant to NRS 433B.333.

3. Conduct investigations and hold hearings in connection with its powers pursuant to this section.

4. Request that the legislative counsel bureau assist in the study of issues related to the provision of child welfare services within this state.

5. Make recommendations to the legislature concerning the manner in which the provision of child welfare services within this state may be improved.

(Added to NRS by 2001 Special Session, 19)

NRS CROSS REFERENCES.

Administration of welfare programs, NRS ch. 422

Foster homes for children, NRS ch. 424

Mental health of children, NRS ch. 433B

Protection of children from abuse and neglect, NRS ch. 432B

Public services for children, NRS ch 432

APPENDIX B

Summary of Funding Approved under
Assembly Bill 1 (2001 Special Session)

CHILD WELFARE INTEGRATION

Assembly Bill 1 - 2001 Special Session

ONE-TIME GF APPROPRIATION - Section 136

Division of Child and Family Services

	FY 2002	FY 2003
Regulatory Oversight		
Equipment/Computer Hardware		$51,776
Rural Matchup		
Equipment/Computer Hardware		$26,463
Sick Leave, Annual Leave & Retirement Buyout		$1,093,841
Project Manager and Cost Allocation Manager		$222,017
SACWIS/UNITY Compliance		$422,856
DCFS - Total One-Time Appropriation		**$1,816,953**

Clark County

Salary Costs		$275,698
Reverse Interface for Data System		$1,399,832
Transition Manager		$194,674
Computer Software and Hardware		$349,420
Equipment and Vehicles		$889,441
Clark County - Total One-Time Appropriation		**$3,109,065**

Washoe County

Transition Manager/Human Services Consultant		$120,143
Computer Software and Hardware		$21,645
Equipment and Vehicles		$99,054
Washoe County - Total One-Time Appropriation		**$240,842**

Grand Total - One-Time GF Appropriation **$5,166,860**

ONGOING GF APPROPRIATION - Section 137

Division of Child and Family Services

Regulatory Oversight				
Salary Costs		$93,696		$424,375
Travel and Operating Costs		$16,784		$62,963
Subtotal		$110,480		$487,338

		FY 2002		FY 2003
Statewide MH-SED Contract Services		$168,579		$1,447,486
Rural Matchup				
Salary Costs		$69,774		$279,097
Travel and Operating Costs		$10,267		$32,263
Subtotal		$80,041		$311,360
SACWIS/UNITY Compliance				
Salary, Travel and Operating Costs		$108,534		$123,193
EDP System Charges		$123,227		$125,447
Subtotal		$231,761		$248,640
DCFS - Total Ongoing Appropriation		**$590,861**		**$2,494,824**

Clark County

Salary Costs		$187,343		$1,856,565
Operating Costs		$92,209		$446,328
Clark County - Total Ongoing Appropriation		**$279,552**		**$2,302,893**

Washoe County

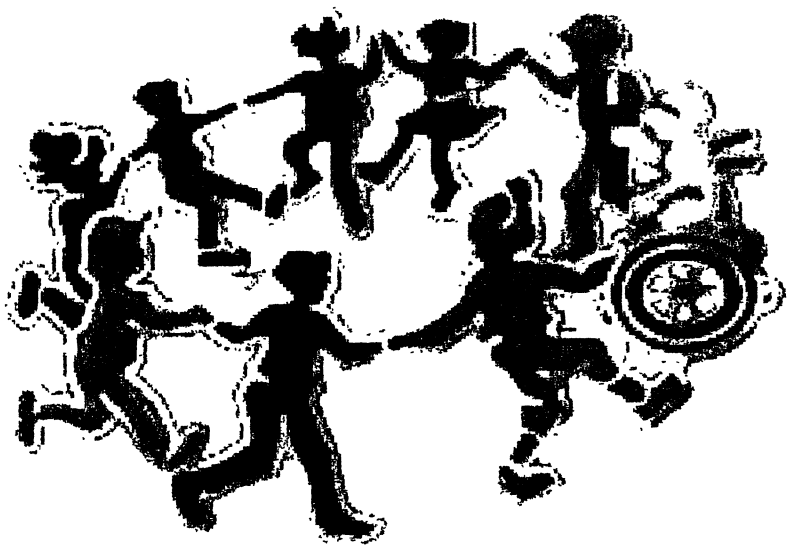
Salary Costs		$60,358		$304,592
Operating and Contract Services		$84,726		$517,301
Washoe County - Total Ongoing Appropriation		**$145,084**		**$821,893**

Grand Total - Ongoing GF Appropriation		**$1,015,497**		**$5,619,610**

APPENDIX C

Nevada's Integrated Child Welfare System: Future Funding Plan

Nevada's Integrated Child Welfare System



Future Funding Plan

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Appendices

Introduction

Every child deserves a safe and permanent family. This was the underlying message sent by Congress in 1997 when it passed the Adoption and Safe Families Act (ASFA), the first major reform of Federal child welfare policy since 1980. ASFA was a bipartisan action intended to ensure that children's safety would be of paramount concern when family preservation or reunification is pursued and to promote adoption of children who cannot return safely to their own homes. It attempted to strike a delicate balance between the child's urgent need for safety and permanency, and agency and court efforts to help parents overcome the problems that result in child maltreatment or make their home unsafe for their child.

ASFA legislation was adopted by the 1999 Nevada Legislature along with ACR 53 directing the Legislative Commission to conduct an interim study of the integration of state and local child welfare systems in this state. ACR 53 recognized that it was necessary to develop a more efficient system that would provide placement stability and continuity for children of this state who are in need of protection. It also recognized that the current bifurcated system caused children to remain in the system for a longer period of time.

As its primary recommendation, the Legislative Commission's Subcommittee on the Study of the Integration of State and Local Child Welfare Systems (ACR 53 Subcommittee) voted unanimously to introduce legislation to integrate Nevada's child welfare system by transferring certain responsibilities from the Division of Child and Family Services (DCFS) to counties whose population is 100,000 or more. This recommendation was based upon a service delivery model entitled "Nevada's Integration Child Welfare System: The Next Step" prepared by Dr. Thom Reilly for the ACR 53 Subcommittee. Under this model, case management functions for foster care and adoptions, family preservation, centralized intake, family foster care and emergency care, foster care/group home licensing, eligibility, and foster care recruitment would transfer. The Division of Child and Family Services would assume a new role of policy development, program monitoring, technical assistance, administering money granted from the federal and state government and would continue to administer child protective services and child welfare services in Rural Nevada.

Foster children spend far too long waiting, deprived of the permanent and stable homes necessary for their healthy development. Dr. Reilly's model stresses the need for one agency to be responsible for children and families requiring child welfare services to ensure that permanency planning can begin as soon as it is identified that children and their families are having difficulties that require intervention by the child welfare system. Early permanency planning allows the case manager to focus on efforts to ensure that a child can be protected within his or her own home, or through reunification with their rehabilitated parents. When the biological parents are unable to provide a safe, stable and nurturing home, adoption is generally considered the optimal form of permanency.

Assembly Bill 1, as passed by the 17th Special Legislative Session, redefines "child welfare services" to include protective services, foster care services, and services related to adoption. It permits the transfer of child welfare services from the Division of Child and Family Services to a county whose population is 100,000 or more. This legislation also recognizes that the State and counties have a shared fiscal responsibility for the costs of providing child welfare services and must be committed to ensuring,

through negotiation in good faith, future maintenance of their efforts in providing those services and to equitably sharing future costs for providing those services.

Section 132 of AB1 requires the Division of Child and Family Services, in consultation with each agency, to develop a plan for funding the provision of child welfare services in this state. The plan must address the fiscal responsibility of the State and each such county for any increases in the costs of providing those services. The Division is required to submit the plan to the Legislative Committee on Children, Youth and Families on or before September 15, 2002 for its review.

The Division and Washoe and Clark counties have worked to develop a future funding plan that addresses the costs of providing child welfare services in SFY 04 and 05, proposes funding for the upcoming biennium, and recommends additional considerations for future biennium. This plan was developed under the basic principle that the purpose of integration is to improve the delivery of services, not to shift financial responsibility in either direction.

Estimating Costs

In developing estimates of the costs of providing for child welfare services in State Fiscal Years 2004 and 2005, a number of basic assumptions had to be agreed upon. Those assumptions include:

- The definition of front-end/back-end services;
- Staff to caseload ratio standards;
- Placement services (foster care/higher levels of care) caseload projections;
- Adoption subsidy caseload projections;
- Family foster care reimbursement rate; and
- Respite care.

Definition of Front-End/Back-End Services

Child protective services (referred to as the "front end services") include:

- Preventative Services
- Investigations of abuse and neglect
- Family Assessments
- Emergency shelter care and/or short-term foster care
- In-home services

Child welfare services (referred to as the "back end services") include:

- Placement services (family foster care, higher levels of care)
- Case management for foster care and adoptions
- Independent living services
- Family preservation
- Family foster home/group foster home licensing

Staff to Caseload Ratio Standards

Included in the recommendations approved by the ACR 53 Subcommittee, the Subcommittee recommended lower caseload ratios for foster care case management at 1 staff to 28 children. This staff to caseload ratio standard was used in estimating the need for additional foster care case management staff in State Fiscal Years 2004 and 2005.

Standards were not adopted for adoption case management. The staff to caseload ratio used in estimating the need for additional adoption case management staff in State Fiscal Years 2004 and 2005 for special needs adoptions was 1 staff to 35 children, and 1 staff to 53 children for non-special needs.

Placement Services Caseload Projections

Historically, broader economic, social and political realities have affected the welfare of families and children. Those factors impact the overall functioning and well being of families, and consistently play a key role in the extent to which child abuse and neglect occur and foster care is needed. Many of the stresses that have historically been associated with increased risk of child maltreatment and the need to provide placement services to children characterize the current economic and social environment. These

factors include poverty, homelessness, adolescent parenthood, parental substance abuse and the effects of HIV/AIDS.

Since 1990, the number of children placed in placement services nationwide has increased from 405,700 in 1990 to 588,000 today, or roughly 31%. In Nevada, for that same time period, children requiring placement services have increased from 1,536 to 2,373, or roughly 35% *(as shown in Table 1).*

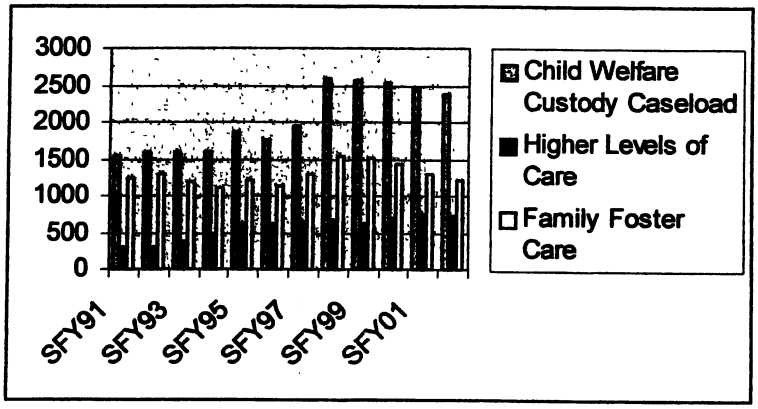

Table 1
Division of Child and Family Services
Child Welfare Caseloads
State Fiscal Years 1991-2002

Additionally, children coming into the system today are significantly different from the children we saw five years ago, with a growing number of seriously handicapped infants at one end of the spectrum and a increasing number of emotionally disabled teenagers at the other end. This is evidenced by the increasing number of children requiring higher levels of care.

Although Nevada has experienced roughly a 9% decrease in the Child Welfare Custody Caseload over the past five years, there has been a recent increase in the number of children coming into the front-end of the system. Clark County experienced a 57% increase in the number of cases sent to the State for foster care services between January and April 2002. Washoe County experienced similar increases, estimating a 15% increase in the number of investigations in the year ending June 30, 2002 than had occurred in the previous year. This change in activity made projecting placement service caseloads for the upcoming biennium very difficult.

At its June 28, 2002 meeting, the Committee on Children, Youth and Families voted unanimously to utilize the current caseload figures adjusted by the population growth for the 0 to 18 year in each county and that they be adjusted at six-month increments according to actual caseload growth.

Table 2 shows the ASRHO estimates provided by the State Demographer, Jeff Hardcastle.

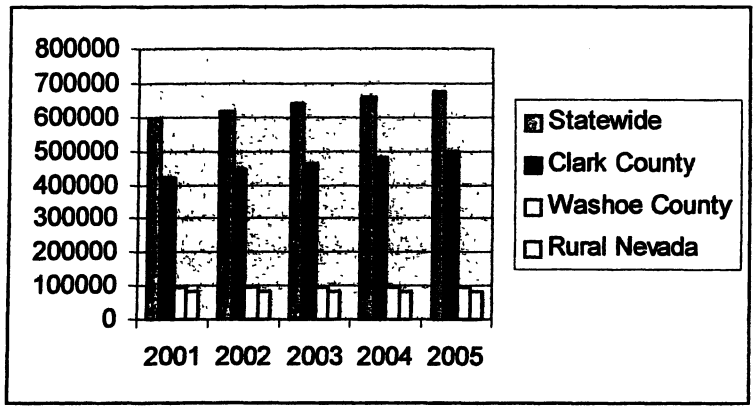

Table 2
Population Characteristics
2001 – 2005
Cohorts 0 – 19 Years of Age

Based upon Mr. Hardcastle's projections, the following growth rates were used for estimating placement services caseloads in State Fiscal Years 2004 and 2005.

	SFY04	SFY05
Clark County	3.87%	3.31%
Washoe County	1.39%	1.27%
Rural Nevada	0	0

Adoption Subsidy Caseload Projections

Since ASFA's enactment, the number of adoptions of children in foster care has increased dramatically. Between 1998 and 1999, the number of finalized adoptions of children in foster care increased 28% nationwide (U.S. Department of Health and Human Services, 2000a). As shown in Table 3, the trend for the number of adoptions finalized in Nevada for the past three years has been approximately 18% growth per year. The trend for the adoption subsidy eligible caseload continues to grow an average of 19 – 20% a year.

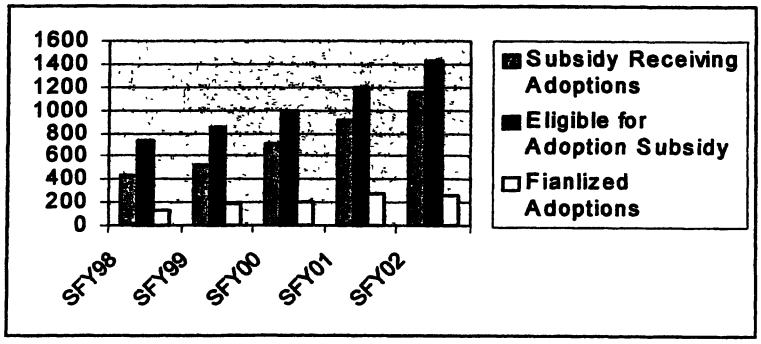

Table 3
Division of Child and Family Services
Adoption Subsidy Caseload Comparison
State Fiscal Years 1998 - 2002

The 20% growth rate in eligible for adoption subsidy was used for estimating adoption subsidy caseloads in State Fiscal Years 2004 and 2005.

Family Foster Care Reimbursement Rate

In an attempt to address the wide disparity in payments for foster care reimbursements throughout the State, the ACR 53 Subcommittee recommended changes in the reimbursement rates for regular family foster care. With the passage of AB1, the following reimbursement rates were established:

- Washoe County: After the first 90 days, decrease the $40 per day rate paid in Washoe County to $30 per day.

- Clark County/Rural Nevada: Increase daily rate for 0 – 12 years from $12 per day to $19.50 per day and for 13 – 18 years from $14.40 per day to $22.50 per day.

At its June 28, 2002 meeting, the Committee on Children, Youth and Families voted unanimously to support the continuation of these rates, with the understanding that Washoe County and the Division of Child and Family Services explore ways to pay for the continuation of the higher rate through a pilot project involving possible reductions in higher levels of care costs. These reimbursement rates were used for estimating the foster care placement costs in State Fiscal Years 2004 and 2005.

Also at the June 28, 2002 Subcommittee meeting, Assemblyman Joe Dini requested information regarding the USDA guideline on the cost of raising a child. Based upon the 2001 Annual Report on Expenditures on Children by Families, the estimated annual average child-rearing expenditures, overall United States, for a two-child family with 2001 before-tax income between $39,100 and $65,800 ($52,100 average) is as follows:

Age of Child	Husband-wife households
0 - 2 including Health Care Costs	9,030
0 - 2 excluding Health Care Costs	8,420
3 - 5 including Health Care Costs	9,260
3 - 5 excluding Health Care Costs	8,680
6 - 8 including Health Care Costs	9,260
6 - 8 excluding Health Care Costs	8,600
9 - 11 including Health Care Costs	9,190
9 - 11 excluding Health Care Costs	8,470
12 - 14 including Health Care Costs	9,940
12 - 14 excluding Health Care Costs	9,220
15 - 17 including Health Care Costs	10,140
15 - 17 excluding Health Care Costs	9,370

A copy of the complete 2001 Annual Report on Expenditures on Children by Families is provided in the Appendices.

Respite Care

Planned respite care provides caregivers a much needed break from the 24-hour a day responsibility of care. It is an opportunity for family members to rest, re-group, re-vitalize, and gives the child in respite care a chance to experience different activities while receiving consistent care.

While most parents are able to leave their children with a relative or a friend/neighbor to take an afternoon off to regroup or enjoy a night out, it is more difficult for foster parents. In Nevada, respite care providers are required to undergo background investigations.

Both the State and counties recognize the importance of respite care programs and agree that the current program offered by the State is inadequate. However, much discussion has centered on the number of respite care days to provide. Washoe County feels that increased respite care could increase the retention of foster parents and reduce the incident of abuse and neglect in foster care. The Division is concerned with the psychological impact on the foster child when his or her "family" takes vacations without them. As a compromise, it was agreed that seven days per year, per child, would be used for estimating respite care costs in State Fiscal Years 2004 and 2005.

Funding Considerations

Federal Funding Participation

In it's final report, the ACR 53 Subcommittee anticipated that a considerable amount of potential federal funding would be available to offset increased costs associated with integration. The State and counties have been working to find means of increasing the level of federal reimbursement. A number of new circumstances have added complexity to this effort. Some of those circumstances include:

- The ASFA legislation, in addition to its permanency focus, placed more requirements on states to show that a child was eligible for Title IV-E, the principal federal funding source for foster care. If courts do not issue orders with the proper wording within specified time frames, the child is not eligible and, in some instances, cannot be eligible for as long as he or she remains in care. These changes have already shown a negative impact on the Division's Title IV-E penetration rate.

- Beginning October 1, 2002, an additional requirement is placed on the eligibility determination. Whereas up to this point the caseworker and other administrative costs for children who were in ineligible facilities, e.g., unlicensed relative homes or large public institutions such as Child Haven, were eligible for federal reimbursement if the child was determined to be Title IV-E eligible. This will no longer be the case.

- The significant increase in the TANF caseloads is making less TANF available for child welfare purposes.

While both the State and counties are working to adjust to the new circumstances, it is too early to say what the impact of those efforts will be. The safest assumptions around federal funding levels will be the most conservative ones. For purposes of estimating the funding in State Fiscal Years 2004 and 2005, Washoe County estimates a 32.7% federal reimbursement rate, and Clark County estimates a 36% federal reimbursement rate.

Funding Options

Five possible ongoing funding options were considered. Those options include:

1. State only with county maintenance of effort – Under this option the State would be responsible for supporting all of the costs of child welfare with the counties continuing to pay the level of costs they have historically paid (front-end costs), with two limitations. The first limitation would be a maintenance of effort (MOE) amount which represented each county's current share of the costs of delivering child welfare services and which the counties would be required to maintain in all future years. The second would be the level of state appropriation for child welfare services.
2. County only with state maintenance of effort – The county would be responsible for supporting all of the costs of child welfare with the State continuing to pay the level of costs they have historically paid (the back end costs). This is the reverse of the State only option. Under this scenario, the State's share of costs would be limited to the current level of expenditure, while the

counties would be required to finance all increases that occurred. This includes increases in caseloads, increases in costs and reductions in federal revenue. The reverse is also true. If caseloads decreased or if the federal share of costs rose, the counties would receive all of the benefit.

3. County block grant – The Block Grant option envisions each county receiving an allocation from the State for funding of its child welfare services. This may take either of two forms. First, federal funds could be incorporated into the block grant and the counties would not benefit from any increase in federal funding or suffer from a decrease. Second, the federal funds could be left outside of the block grant and increases or decreases in those funds would increase or decrease the amount actually available to the counties.

4. State/County sharing with constant rate – Under this option, all costs of services, regardless of who performed the case management function or what service was provided, would be shared between the counties and the State at a constant rate. That rate could include the federal share, or it could represent the relative contribution of the State and counties of the non-federal share of the costs. This would be limited to the appropriated amount.

5. State/County sharing with variable rate – Under this option, the costs of services are shared by the State and counties in varying degrees, depending upon which services are being provided. Services the State wishes to encourage are reimbursed at a higher rate, while services that the State wishes to see used only as a last resort are reimbursed at a lower rate. Again, this would be limited to the amount appropriated.

Funding Swap

Three possible funding swaps in county and State financial responsibilities were reviewed, as follows:

1. Medicaid Long Term Care County Match Program – The Department of Human Resources, Division of Health Care Financing and Policy (formerly under the Welfare Division) entered into an Interlocal Agreement with the seventeen Nevada counties in 1989 in an effort to bring additional Medicaid dollars to Nevada for long term care. DHR is the designated "single state agency" responsible for medical assistance provided in Nevada under authority of Title XIX of the Social Security Act. HCFP is responsible for implementing the state plan under Title XIX.

   With the implementation of the Interlocal Agreement, HCFP is authorized to provide the administrative services necessary to implement the program of medical assistance to those individuals who meet financial and medical eligibility criteria, and the County to provide the non-federal share to the Division for medical, administrative and transaction costs incurred as a result of this medical assistance program. HCFP has agreed to determine eligibility based on criteria established and set forth in the Title XIX state plan. The criteria includes, but is not limited to, length of stay in the facility, level of care, age and disability determination, resources and net countable income, which is not more than 300 percent of the supplemental security income federal benefit (SSI/FBR) rate.

   For SFY02, under the County Match Program the County was responsible for the non-federal Medicaid expenditures for qualified persons whose net countable income was > $851, or 156 percent of the SSI, and < $1,635, or 300 percent of the SSI. A summary of the costs of the

County Match Program for SFY 1988 through 2002, as well as the projected costs through SFY2010 for Washoe and Clark counties, has been included in the Appendices.

2. District Court Costs – Currently, the State is responsible for the payment of district court judges' salaries pursuant to NRS 3.030. All operating and capital costs are the responsibility of the counties.

3. Ad Valorem Tax Swap – The State and counties may agree to allow the counties to retain a portion of the $.15 tax levied for the payment of the bond indebtedness.

For purposes of estimating the funding in State Fiscal Years 2004 and 2005, the State and counties agree that the Medicaid Long Term Care County Match Program is the most viable swap for consideration to offset some of the costs. It was further agreed that the swap would first apply to salaries, operating costs, county indirect cost pools (including agency legal counsel costs), and any residual would then be applied toward placement costs. Clark County would prefer that the residual be applied to costs not directly related to case load growth, such as family preservation services, transportation, drug testing, placement prevention, emergency shelter, contract services, independent living and adoption foster care recruitment.

Estimated Costs for State Fiscal Years 2004 and 2005

Table 4 shows a summary of the total cost of providing child welfare back-end services in State Fiscal Years 2004 and 2005. Detailed estimates of the back-end costs have been provided in the Appendices.

	Washoe County		Clark County		Division of Child and Family Services	
	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2004	Fiscal Year 2005
REVENUES:						
State General Funds	8,358,110	9,137,133	22,307,121	24,621,847	17,774,617	18,330,416
Federal Title IV-B	90,000	90,000	85,075	85,075	978,938	978,938
Chafee	20,000	20,000	31,508	31,508		
CCDF					616,861	624,577
Cost of Care					300,000	300,000
Federal Title IV-E	2,713,454	3,010,582	6,820,499	7,791,236	9,124,105	9,140,360
Post Adoption Fees			28,410	28,410		
Federal Title XIX – Medicaid	922,235	992,327	2,902,558	3,113,785	7,477,561	7,749,485
Federal Title XX	20,000	20,000	1,314,103	1,314,103	3,505,920	3,505,920
Transfer from TANF	430,000	430,000	1,503,392	1,503,392	1,698,541	1,698,541
Other Funding					271,501	271,501
Total Revenues	**$ 12,553,799**	**$ 13,700,042**	**$ 34,992,666**	**$ 38,489,357**	**$ 41,748,044**	**$ 42,599,738**
EXPENDITURES:						
Salaries/Benefits	4,165,906	4,545,156	13,806,287	14,855,093	11,052,410	11,112,563
Travel	75,209	77,465	219,745	234,093	275,286	286,770
Operating Expenses	306,928	316,022	601,972	620,031	812,400	814,097
Rental			1,119,168	1,152,743		
Equipment	38,144	39,288			4,316	28,101
Specialized Training	3,380	3,380	17,306	18,436	1,116,049	1,116,049
Background Investigations	10,000	10,300	25,979	27,675	21,673	21,673
Information Systems	29,713	30,605	185,125	197,213	4,742,579	4,573,010
Training	12,085	12,447	25,094	25,094	11,624	11,624
Client Evaluation					1,238	1,238
Utilities					76,675	76,675
Legal Counsel to Agency	229,224	239,163	744,610	801,498	246,235	246,235
Indirect Costs	718,713	740,275	1,580,362	1,645,492	147,487	147,487
Emergency Shelter	426,833	439,638	1,615,349	1,720,822	52,000	52,000
Higher Levels of Care					19,740,867	20,458,467
Substitute Foster Care	3,241,705	3,283,368	6,435,908	6,656,441	1,827,750	1,827,750
Adoption Services	2,732,104	3,383,231	7,551,891	9,410,813	910,967	1,046,783
Non-Title XIX					476,524	547,252
Family Preservation Services	22,472	23,146	124,480	132,608		
Transportation (Client Travel)	41,653	42,903	85,111	90,668	28,748	28,748
Day Care					1,343	1,343
Independent Living	22,660	23,340	33,758	35,962		
Respite Care	62,170	62,969	123,428	127,658	8,548	8,548
Drug Testing	30,900	31,827	50,000	50,000	4,110	4,110
Placement Prevention	309,000	318,270	505,098	538,078	81,900	81,900
Adoption/Foster Care Recruitment	50,000	51,500	66,995	71,369	58,184	58,184
Foster Home Insurance					1,268	1,268
Funeral Expenses					1,000	1,000
Foster Care Liability	25,000	25,750	75,000	77,570	46,863	46,863
Total Expenditures	**$ 12,553,799**	**$ 13,700,042**	**$ 34,992,666**	**$ 38,489,357**	**$ 41,748,044**	**$ 42,599,738**

Recommendation for Funding Costs for Providing Child Welfare Services

There are several points on which the State and counties agree. Most importantly, all agree that one component of the future funding should involve a swap between child welfare costs and Medicaid Long Term Care County Match costs, with the swap being implemented in a hierarchical manner. Additionally, the State and counties agree that the "State/County sharing with a constant rate funding" formula option is the best ongoing option to implement. However, the difference in child welfare integration progress makes it very difficult to agree to a single future funding solution for the upcoming biennium. Washoe County has gained experience in providing back-end services with the pilot program and the transfer of some of the services in April 2002, and will gain additional experience when the remaining services transfer in January 2003. Clark County on the other hand did not participate in the pilot program and the State made the decision to delay child welfare integration in Clark County due to economic reasons. This means that Clark County will have no actual experience in providing back-end services entering the upcoming biennium. Therefore, the State and counties have agreed to present three funding alternatives to the Committee for consideration. Those alternatives include:

- Implementation of the swap in both counties with fiscal responsibility remaining separated into front-end and back-end costs. Any back-end costs not covered by the swap would remain the responsibility of the State.
- Implementation of the swap in both counties, funding the remainder of the costs through the "State/County sharing with a constant rate" funding formula.
- Implementation of the swap in both counties in the 2003-2005 biennium with Washoe County funding the remainder of the costs through the "State/County sharing with a constant rate" funding formula and Clark County back-end costs remaining the responsibility of the State. In the 2005-2007 biennium, following the achievement of mutually agreed to milestones, Clark County and the State would assume shared fiscal responsibility for child welfare services.

Tables 5 and 6 show the costs during the upcoming biennium if the first alternative is adopted. Clark County supports this option based upon the following factors:

- The State has deferred child welfare integration in Clark County until the end of the fiscal year, therefore the county will have no actual experience in providing foster care and adoption related services upon which to make long-term decisions.
- The complexity of the program revenue structure, including federal funding, requires some actual program experience to evaluate the sufficiency of on-going funding.
- Major programmatic milestones have not been accomplished which are necessary to enter into a shared funding plan.
- Clark County is in the process of implementing multiple program changes. The impact of these changes is not fully realized.
- Clark County is in the process of making programmatic changes to the County's public emergency management shelter, which the timing of those changes is difficult to anticipate in structuring a shared cost formula in the next biennium.

Issues surrounding this option include:

- While the integration effort will bring the casework decision-making into the hands of a single agency, this alternative retains the current bifurcation on the fiscal side. For any costs which are

not covered by the swap, there will continue to need to be bookkeeping procedures to determine what costs are front-end and what are back-end.

- All casework decisions will be made by county workers, including decision for which the county bears no responsibility for the costs. The State will be responsible for costs with no say in which service is provided.
- The county could shift costs to the State which would normally be borne by the county.

Table 5
Clark County
Separate Responsibility for Front-end and Back-end Costs

Cost Type	Costs	Federal Share of Costs	Net Costs Pre-swap	Costs Assumed by County through Swap	Net County Share (including Swap)	Net State Share
SFY04: SWAP=$15,372,139						
Salaries/Benefits Front End	9,353,274	1,870,655	7,482,619		7,482,619	
Salaries/Benefits Back End	13,806,287	4,295,551	9,510,736	9,510,736	9,510,736	
Operating/Indirect Front End	2,726,007	545,201	2,180,806		2,180,806	
Operating/Indirect Back End	4,519,361	1,129,840	3,389,521	3,389,521	3,389,521	
Purchase Placement Front End	8,244,448	2,473,334	5,771,114		5,771,114	
Purchase Placement Back End	15,603,148	6,616,257	8,986,891	2,471,882	2,471,882	6,515,009
Other Placement/Other Front	92,700	23,175	69,525		69,525	
Other Placement/Other Back	1,063,871	643,897	419,974	-	-	419,974
Totals	**$55,409,096**	**$17,597,911**	**$37,811,185**	**$15,372,139**	**$30,876,202**	**$ 6,934,983**
SFY05: SWAP = $16,716,639						
Salaries/Benefits Front End	10,067,864	2,013,573	8,054,291		8,054,291	
Salaries/Benefits Back End	14,855,093	4,557,753	10,297,340	10,297,340	10,297,340	
Operating/Indirect Front End	4,758,546	951,709	3,806,837		3,806,837	
Operating/Indirect Back End	4,722,275	1,180,569	3,541,706	3,541,706	3,541,706	
Purchase Placement Front End	8,820,217	2,646,065	6,174,152		6,174,152	
Purchase Placement Back End	17,788,076	7,465,777	10,322,299	2,877,593	2,877,593	7,444,706
Other Placement/Other Front	95,481	23,870	71,611		71,611	
Other Placement/Other Back	1,123,914	663,410	460,504			460,504
Totals	**$62,231,466**	**$19,502,726**	**$42,728,740**	**$16,716,639**	**$34,823,530**	**$ 7,905,210**

Table 6 Washoe County Separate Responsibility for Front-end and Back-end Costs						
Cost Type	**Costs**	**Federal Share of Costs**	**Net Costs Pre-swap**	**Costs Assumed by County through Swap**	**Net County Share (including Swap)**	**Net State Share**
SFY04: SWAP=$4,649,028						
Salaries/Benefits Front End	7,571,570	1,514,314	6,057,256		6,057,256	
Salaries/Benefits Back End	4,165,906	1,481,723	2,684,183	2,684,183	2,684,183	
Operating/Indirect Front End	1,618,745	323,749	1,294,996		1,294,996	
Operating/Indirect Back End	1,423,396	359,711	1,063,685	1,063,685	1,063,685	
Purchase Placement Front End	3,148,716	944,615	2,204,101		2,204,101	
Purchase Placement Back End	6,400,641	2,145,100	4,255,541	901,160	901,160	3,354,381
Other Placement/Other Front	786,302	196,576	589,727		589,727	
Other Placement/Other Back	563,854	209,156	354,698			354,698
Totals	**$25,679,130**	**$ 7,174,943**	**$18,504,187**	**$ 4,649,028**	**$14,795,108**	**$ 3,709,079**
SFY05: SWAP = $4,953,575						
Salaries/Benefits Front End	8,228,404	1,645,681	6,582,723		6,582,723	
Salaries/Benefits Back End	4,545,156	1,572,743	2,972,413	2,972,413	2,972,413	
Operating/Indirect Front End	1,679,6741	335,935	1,343,739		1,343,739	
Operating/Indirect Back End	1,468,946	370,642	1,098,304	1,098,304	1,098,304	
Purchase Placement Front End	3,296,177	988,853	2,307,324		2,307,324	
Purchase Placement Back End	7,106,236	2,405,613	4,700,623	882,858	882,858	3,817,765
Other Placement/Other Front	809,891	213,356	596,535		596,535	
Other Placement/Other Back	579,704	213,911	365,793			365,793
Totals	**$27,714,188**	**$ 7,746,734**	**$19,967,454**	**$ 4,953,575**	**$15,783,896**	**$ 4,183,558**

Tables 7 and 8 show the costs during the upcoming biennium if the second alternative is adopted. The results represent calculations of the current relative shares of costs borne by the counties and State after the swap is taken into account. These calculations show Clark County currently bearing 55 percent of the after-swap costs, and Washoe County at 50 percent.

Both Washoe County and the State support this option for the 2003-2005 biennium and Clark County supports achieving this through an incremental approach in the 2005-2007 biennium. Implementing a funding formula in which the State and county both share in all costs is important for the reason that both will be making decision which have some impact on all types of costs. The county's decisions will largely be case-specific or will represent procedures governing the handling of individual cases. The State's decisions will involve policies which govern both the structure of services and the handling of individual cases. If either agency is permitted to make those decisions without sharing the costs, the decisions themselves are likely to be different than if the agency has to bear part of the burden.

Additionally, both Washoe County and the State support a one-time "trueup" at the end of the 2003-2005 biennium and Clark County at the end of the 2005-2007 biennium to ensure that the percentages utilized in the funding formula reflect actual experience and the growth of the County Match program has not significantly outpaced the growth of child welfare.

Clark County support utilizing an incremental approach to implementing this option for the following reasons:

- No opportunity to learn from experience – Since child welfare integration in Clark County has been delayed, the county will have no actual experience in providing foster care and adoption related services upon which to make long term funding decisions.
- No opportunity to connect program and funding – Many programmatic decisions related to child welfare integration may not be made and the County and/or State may not be prepared for the integration. The County is in the process of implementing multiple program changes. The impact of these changes is not fully realized.
- No time to consider Child Haven Programmatic Changes – Clark County is in the process of making programmatic changes at Child Haven. There are political considerations and the County needs time to address these concerns in a thoughtful manner to meet community needs. Funding issues may overwhelm programmatic considerations.
- Commitments not made or met – Agreements and decisions could be made that are not met. There are fiscal and other risks for all involved entities.

Table 7
Clark County
State/County Sharing with a Consistent Rate

Cost Type	Costs	Federal Share of Costs	Net Costs Pre-swap	Costs Assumed by County through Swap	Net County Share (including Swap)	Net State Share
SFY04: SWAP=$15,372,139						
Salaries/Benefits Front End	9,353,274	1,870,655	7,482,619		7,482,619	
Salaries/Benefits Back End	13,806,287	4,295,551	9,510,736	9,510,736	9,510,736	
Operating/Indirect Front End	2,726,007	545,201	2,180,806		2,180,806	
Operating/Indirect Back End	4,519,361	1,129,840	3,389,521	3,389,521	3,389,521	
Purchase Placement Front End	8,244,448	2,473,334	5,771,114		3,146,253	2,624,861
Purchase Placement Back End	15,603,148	6,616,257	8,986,891	2,471,882	4,899,406	4,087,485
Other Placement/Other Front	92,700	23,175	69,525		37,903	31,622
Other Placement/Other Back	1,063,871	643,897	419,974	-	228,958	191,016
Totals	**$55,409,096**	**$17,597,911**	**$37,811,185**	**$15,372,139**	**$30,876,202**	**$ 6,934,983**
SFY05:						
Salaries/Benefits Front End	10,067,864	2,013,573	8,054,291		8,054,291	
Salaries/Benefits Back End	14,855,093	4,557,753	10,297,340		10,297,340	
Operating/Indirect Front End	4,758,546	951,709	3,806,837		3,806,837	
Operating/Indirect Back End	4,722,275	1,180,569	3,541,706		3,541,706	
Purchase Placement Front End	8,820,217	2,646,065	6,174,152		3,365,978	2,808,174
Purchase Placement Back End	17,788,076	7,465,777	10,322,299		5,627,434	4,694,865
Other Placement/Other Front	95,481	23,870	71,611		39,040	32,571
Other Placement/Other Back	1,123,914	663,410	460,504		251,054	209,450
Totals	**$62,231,466**	**$19,502,726**	**$42,728,740**		**$34,983,681**	**$ 7,745,059**

Table 8 Washoe County State/County Sharing with a Consistent Rate						
Cost Type	**Costs**	**Federal Share of Costs**	**Net Costs Pre-swap**	**Costs Assumed by County through Swap**	**Net County Share (including Swap)**	**Net State Share**
SFY04: SWAP=$4,649,028						
Salaries/Benefits Front End	7,571,570	1,514,314	6,057,256		6,057,256	
Salaries/Benefits Back End	4,165,906	1,481,723	2,684,183	2,684,183	2,684,183	
Operating/Indirect Front End	1,618,745	323,749	1,294,996		1,294,996	
Operating/Indirect Back End	1,423,396	359,711	1,063,685	1,063,685	1,063,685	
Purchase Placement Front End	3,148,716	944,615	2,204,101		1,099,953	1,104,148
Purchase Placement Back End	6,400,641	2,145,100	4,255,541	901,160	2,123,721	2,131,820
Other Placement/Other Front	786,302	196,576	589,727		294,302	295,424
Other Placement/Other Back	563,854	209,156	354,698		177,011	177,687
Totals	**$25,679,130**	**$ 7,174,943**	**$18,504,187**	**$ 4,649,028**	**$14,795,108**	**$ 3,709,079**
SFY05:						
Salaries/Benefits Front End	8,228,404	1,645,681	6,582,723		6,582,723	
Salaries/Benefits Back End	4,545,156	1,572,743	2,972,413		2,972,413	
Operating/Indirect Front End	1,679,674	335,935	1,343,739		1,343,739	
Operating/Indirect Back End	1,468,946	370,642	1,098,304		1,098,304	
Purchase Placement Front End	3,296,177	988,853	2,307,324		1,151,466	1,155,858
Purchase Placement Back End	7,106,236	2,405,613	4,700,623		2,345,838	2,354,785
Other Placement/Other Front	809,891	213,356	596,535		297,700	298,835
Other Placement/Other Back	579,704	213,911	365,793		182,548	183,245
Totals	**$27,714,188**	**$ 7,746,734**	**$19,967,454**		**$15,974,732**	**$ 3,992,722**

It should be noted that there is an assumption here that the State will maintain responsibility for higher levels of care through SFY05. However, in some future year it is anticipated that higher levels of care will become the responsibility of the counties. At that time, the relative State and county proportions will need to be recalculated, with the higher levels of care costs being assigned to the State.

Risks

Whichever alternative is chosen for the upcoming biennium, there are risks to be faced. There are at least four which bear serious discussion:

1) The risk that the growth rate in the County Match program could outpace the growth in child welfare expenses for salaries and operating;
2) The risk that one party or another will face unexpected costs under the funding formula;
3) The risk that more children will be placed into out-of-home care if the counties do not share in the costs of those placements;
4) The risk that fewer federal funds will be available than have been projected; and,
5) The risk that sufficient funds will not be appropriated.

While the swap costs are made equal in SFY04, Medicaid is growing at a much faster pace than child welfare. The State could potentially be taking on a much larger cost than the counties.

The second of these risks represents Clark County's concerns about the funding formula and; the second the State's concerns about maintaining a fiscal bifurcation; and the third is a serious concern under either scenario. The risk that one party will face unexpected costs if it is forced to participate in the funding formula is one that has no solution. Clark County faces a higher risk of unexpected costs given the deferral of child welfare integration because the county will have no actual experience in providing foster care and adoption related services upon which to make long-term decisions. Because prediction of the future, particularly in the midst of an organizational change like integration, is always subject to error and even to serious miscalculation no one can honestly say that the risk does not exist or is even inconsequential. One can, however, say that there is also a chance that the costs will be lower than expected. There is a risk and it may be large, but that is all the more reason to ensure that it is shared.

The same is not true of the risk that more children will be placed into out-of-home care if the counties do not share in the costs of that care. If county caseworkers are deciding which children should be placed into care and which should remain in their own homes and if the county has the sole decision-making on where to deploy its resources for eligibility determination and even for casework services, the fiscal structure will almost certainly have some impact on those decisions.

The goal of the funding formula is to make those decisions as fiscally neutral as possible. Making a decision to defer the funding formula and maintaining a fiscal bifurcation while removing the programmatic bifurcation may impact what happens to children and families, as well as the burdens placed on the State and county budgets.

The last of these risks applies to all scenarios. The so-called penetration rate, i.e., the percentage of children in out-of-home care who are eligible for Title IV-E has been dropping recently. In addition, there is a federal policy change about to take effect which will drop it further, and the inclusion for the first time of Clark County's population residing in Child Haven may further depress that rate. Each of these means a potential loss in federal funds.

This is not the entire story. A recent review of Title IV-E cases has suggested there may also be opportunities for making some children eligible who have up to this time been considered ineligible. It is not known, however, what the final result will be or even how much the State and county agencies can impact it. All parties need to be prepared for the possibility that the actual amount of federal funds received will be smaller than what has been projected here.

APPENDIX D

Estimated Future Costs for Integrated Child Welfare System

AB1 FUNDING

Child Welfare Ongoing Budget Summary(Back-End Costs Only)

	FY03 Total	FY04	Change FY04/FY03	% Change	FY05	Change FY05/FY03	% Change
General Funds	33,612,539	48,439,848	14,827,309	44.11%	52,089,397	18,476,858	54.97%
Federal Funds	37,194,435	40,203,242	3,008,807	8.09%	42,048,321	4,853,886	13.05%
Other	2,720,761	651,419	(2,069,342)	-76.06%	651,419	(2,069,342)	-76.06%
	73,527,735	89,294,509	15,766,774	21.44%	94,789,137	21,261,402	28.92%

Statewide MH-SED Services

	FY03 Total	FY04	Change FY04/FY03	% Change	FY05	Change FY05/FY03	% Change
General Funds	1,447,486	4,157,331	2,709,845	187.21%	4,157,331	2,709,845	187.21%
Federal Funds	969,790	1,939,864	970,074	100.03%	1,939,864	970,074	100.03%
Other							
	2,417,276	6,097,195	3,679,919	152.23%	6,097,195	3,679,919	60.35%

TOTAL AB1

	FY03 Total	FY04	Change FY04/FY03	% Change	FY05	Change FY05/FY03	% Change
General Funds	35,060,025	52,597,179	17,537,154	50.02%	56,246,728	21,186,703	60.43%
Federal Funds	38,164,225	42,143,106	3,978,881	10.43%	43,988,185	5,823,960	15.26%
Other	2,720,761	651,419	(2,069,342)	-76.06%	651,419	(2,069,342)	-76.06%
	75,945,011	95,391,704	19,446,693	25.61%	100,886,332	24,941,321	32.84%

APPENDIX E

The Case for Open Dependency Hearings

The Case for Open Dependency Hearings

Prepared by:
Honorable Gerald W. Hardcastle
District Court Judge
Eighth Judicial District Court
Family Division - Juvenile

May 2002

Proposed Legislation

That NRS 432B.430, which presently reads:

Except as otherwise provided in NRS 432B.457, only those persons having a direct interest in the case, as ordered by the judge or master, may be admitted to any proceeding held pursuant to NRS 432B.410 to 432B.590, inclusive.

Be amended to read:

1. All proceedings pursuant to this chapter must be open to the general public unless the judge, or in the case of a reference, the referee, upon his own motion or the motion of another person, determines that all or part of the proceedings must be closed to the general public because such closure is in the best interests of the child. If the judge or the referee determines that all or part of the proceedings must be closed to the general public, the general public must be excluded and only those having a direct interest in the case may be admitted, as ordered by the judge or referee.

2. In determining whether to close the proceedings, the judge or referee shall consider:

1. ***The child's maturity or state of mental health,***
2. ***The child's age,***
3. ***The potential that an open hearing will have for embarrassment of the child,***
4. ***The desires of the child,***
5. ***The interests of parents and relatives,***
6. ***The type of proceeding,***
7. ***The type of access requested by the public or press, and***
8. ***Any other factor relevant to the child's best interests.***

In the event that the judge or referee determines to close the hearing, the judge or referee shall be required to make specific findings as to why closing the hearing is in the child's best interest.

Table of Contents

THE CASE FOR OPEN DEPENDENCY HEARINGS

Children can rarely tell their own stories and do not make their own laws. It is important to inject their voices into the public arena.[1]

This paper proposes that juvenile abuse and neglect (dependency) proceedings under NRS, Chapter 432B should be presumptively open to the public and the press. However, upon making specific findings, the Juvenile Court Judge may close any dependency proceeding.[2]

Present statute

NRS 432B.430 provides:

"Except as otherwise provided in NRS 432B.457, only those persons having a direct interest in the case, as ordered by the judge or master , may be admitted to any proceeding held pursuant to NRS 432B.410 to 432B.590 inclusive."

The clear language of NRS 432B.430 prohibits the public or the press from attending abuse and neglect proceedings. No known decision has been found in Nevada or any other jurisdiction which would extend the concept of "direct interest in the case" to include the public or press.[3]

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[1]E. Bazelon, *Public Access to Juvenile and Family Court: Should Courtroom Doors Be Open or Closed?*, 1999 YALE L. & POL'Y REV. 155, 181 (1999).

[2]A related issue concerns the confidentiality of abuse and neglect reports and records. Generally, these records are of two types. First, there are the investigative records and reports of child protective services. Second, there are the court records and reports regarding cases before the Juvenile Court. This paper makes no request or recommendation relative to either class of record.

[3] Several states have statutes which allow admission to dependency hearing of persons who have a direct interest in the case or *in the work of the court.* Such language has been construed as allowing the press access to juvenile proceedings. *See, e.g., In re* R.L.K., Jr., 269 N.W.2d 367 (Minn. 1978); *In re* L., 546 P.2d 153 (Or. Ct. App. 1976).

While Nevada does not permit public access to dependency proceedings, there are presently 17 states that allow either the press or public, or both, access to such proceedings. The states are Arizona, Arkansas, Colorado, Florida, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Nebraska, New York, North Carolina, Ohio, Oregon, Texas, and Washington.[4] Not all statutes allow unfettered access by the press and public. Some limit access to the press and exclude the public. Some create a presumption that hearings are closed and allow the Juvenile Court Judge to open the hearings to the press or public while others create a presumption that the hearings are open and require special findings by the Judge to close the hearing from the press or public.

Brief history of confidentiality

In her Note, Bazelon[5] provides a brief outline of the history of confidentiality in juvenile court proceedings. She concludes that "Policies of non-disclosure for minors originated because the founders of the juvenile court at the turn of the century believed that confidentiality was critical to rehabilitation and treatment."[6] Congress reinforced the concept of confidentiality in the 1974 Child Abuse Prevention and Treatment Act [hereinafter CAPTA]. Following CAPTA's guidelines, states enacted statutes that "strictly protected the confidentiality of child protection proceedings and child welfare agency records."[7]

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[4]H.S. Schellhas, *Children in the Law Issue: Contributors Open Child Protection Proceedings in Minnesota*, 26 WM. MITCHELL L. REV. 631, 670 (2000).

[5]Bazelon, *supra* note 1, at 155-159.

[6]*Id.* at 155.

[7]*Id.* at 156.

CAPTA guidelines were viewed as excessively restrictive. For example, police, doctors and treatment providers were seemingly denied access to abuse and neglect records. As a result, federal law was modified to allow police, doctors and counselors access to child welfare agency files.[8] In 1996, CAPTA was amended to allow limited disclosure of child welfare agency files to child abuse and fatality citizen review boards. It also allows disclosure of findings when a child dies or nearly dies as the result of abuse.[9]

The relaxing of federal CAPTA requirements has caused states to reexamine their position relative to accessing abuse and neglect proceedings and records. For example, California follows the CAPTA guidelines and its abuse and neglect proceedings remain closed. New York, however, has greatly expanded public and press access to dependency proceedings. New York creates a presumption that all Family Court proceedings (including dependency proceedings) should be open absent a *compelling* reason and the Judge is required to make specific findings in the event the Judge orders the hearing closed.[10]

The question has risen whether states may expand openness of dependency proceedings beyond that authorized by federal CAPTA law. The answer was provided when Minnesota decided to form a pilot project to determine if dependency and termination of parental rights proceedings should be open. The concern was that if the federal government viewed openness of such proceedings as a violation of federal law,

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[8]*Id.* at 157.

[9]*Id.* at 176.

[10]N.Y. Ct. R. 205.4 (b).

certain child welfare funding might be withheld or denied. However, Minnesota received a letter from the federal Health and Human Services that federal funding was not in jeopardy as the result of opening such proceedings.[11]

The Reasons and Arguments For Open Hearings

It does not require cited support for the fundamental proposition of American government that operation of government and courts should be open. Denying access of the public and press to courts has always been tricky business. Great pride is taken in the openness with which courts conduct the business of law. Perhaps, the last bastion of confidentiality relative to court proceedings is the juvenile dependency proceeding. In Nevada, even juvenile delinquency proceedings and termination of parental rights actions are open.

Initially, within the American frame of government, the burden is on those seeking to deny access to courts to justify such denial. As a Legislature, the appropriate question is not whether these hearings should remain closed but whether the public's right to access should continue to be denied. Fundamental principles of American government, not the least of which is free press, puts a great burden on those requiring that hearings be closed.

There are those who believe that allowing the public and press access to abuse and neglect proceedings will be, in fact, beneficial. The benefits include (1) making judges, caseworkers, and lawyers exercise greater care and professionalism, (2) disseminating

[11]Schellhas, *supra* note 4, at 663.

information critical to good government, (3) educating the public about child welfare, and (4) developing and expressing community norms regarding child welfare.[12]

Within those perceived benefits there is much rhetoric in the literature. For example, Bazelon states, "If the court's rehabilitation and treatment missions still have meaning, then there is a gap between internal systemic norms and the public's perception of how the system should function."[13] That gap is closed by allowing the public and press access to dependency proceedings.

Besides individual authored opinions, the literature contains two examples that give credence to openness in abuse and neglect proceedings. The first is the statement of a Symposium Panel on the Future of Access to the Family Court. The Panel concluded:

> "The recently enacted rule opening family courts to the press and public is a significant first step towards educating and reforming instead of naming and blaming. With this redefined role, the press can act not only as a 'watchdog,' but also as a 'fly on the wall.' And the new stories that are told, as well as the new laws that are eventually changed because of the telling of these stories, will inure to the benefit of children and families throughout the state."[14]

Second, consideration is given to the experience of Judge Heidi S. Schellhas, a Minnesota Juvenile Court Judge. She was engaged in a three year pilot project to open dependency proceedings, called child protection proceedings, in her court. Her experience made her a firm proponent of open proceedings.

Regarding the unfair impact of closed hearings, she states:

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[12]Bazelon, *supra* note 1, at 177.

[13]*Id.* at 181.

[14]J.L. Rosato, *Symposium: Panel III: Secrecy and the Juvenile Justice System: The Future of Access to the Family Court: Beyond Naming and Blaming*, 9 J.L. & POL'Y 149, 167 (2000).

"Keeping the courtroom doors closed to the public in child protection proceedings is one of the many hidden cruelties in child-rearing. We become part of the problem, rather than part of the solution, when we perpetuate family secrets about abuse and neglect."[15]

Also:

"My experience suggested that secrecy did not protect the children, but rather served only to protect stakeholders in the system and parents accused of child abuse and neglect."[16]

Finally:

"An injustice committed in private is a very different thing than an injustice committed under the watchful eye of even one disinterested observer."[17]

In examining the benefits of open hearing, Judge Schellhas found three benefits to open dependency hearings. First, she concluded that open hearings serve the best interests of children who are the subject of the proceedings. Second, open proceedings led to increased participation by witnesses and a more accurate picture of the child's circumstances. Finally, open hearings provide a monitoring mechanism for the public and the child welfare system.[18]

Perhaps most important, Judge Schellhas did not find reason to favor closed hearings. She concluded that after 17 months under the pilot project, none of the opponents' concerns had come to fruition.[19] Further, "[t]he greatest fear - that troubled

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[15]Schellhas, *supra* note 4, at 663.

[16]*Id.* at 633.

[17]*Id.* at 669.

[18]*Id.* at 666.

[19]*Id.* at 671.

children would be victimized and embarrassed by sensationalized news media coverage and community scorn - has yet to be realized."[20]

The Reasons and Arguments for Closed Hearings

While the clear national trend is to open dependency hearings, there are those who decry that opening such proceedings is bad policy. Their argument is in part historical. The Juvenile Court was founded to provide a more paternalistic alternative to the adult criminal justice system. Juvenile Courts were to be informal, flexible, and kind. The concept of a kindly judge sitting down informally with a wayward child was the model. Essentially, Juvenile Court was not about law but about parenting. The feeling was that openness would hinder the task of helping children.[21] It is also noted that in spite of the fact that the Juvenile Court process has undergone much change and is now dramatically more formalized, closed hearings and confidentiality of records still remains the general but diminishing rule.

A strong opponent to opening dependency hearings is Professor William Wesley Patton of the Whittier Law School. His essential argument is that opening dependency proceedings will "re-victimize" children without substantially increasing the public's understanding of the child welfare system or making government more accountable.[22]

Professor Patton's argument can be broken down into three lesser premises. First, opening hearings will "re-victimize" children. Arguably, identifying children of abuse

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[20]*Id.* at 665.

[21]Bazelon, *supra* note 1, at 170.

[22]W.W. Patton, *Pandora's Box: Opening Child Protection Cases to the Press and the Public*, 27 WHITTIER L. REV. 181 (2000).

and neglect by name or picture may subject them to public comment, good and bad. Clearly, identifying children by name and picture will expose them to the public. Public reaction and the impact that such reaction would have upon children has not been documented or examined to this writer's knowledge. Patton presumes that the impact is fundamentally harmful but the argument can equally be made that the support of the community for an identified victim can be beneficial. Realistically, it must be remembered that in many cases, the public knows about many cases of abuse or neglect since parents or others often go to the press. Closing Juvenile Court hearings does not prevent exposure.

Patton's second premises is that opening abuse and neglect hearings does not increase the public's understanding of the child welfare system. This argument essentially is that the media is not interested in the daily work of Juvenile Court and that the reporting of the unusual or sensational distorts the public's view of the child welfare process. He concludes:

"The press' selective reporting has given the public an extremely skewed view of the legal process, and has led the public and legislature to pass unwise systemic modifications of the criminal, delinquency, and dependency systems."[23]

Further, he quotes Michigan Juvenile Court Judge Donald Owens as stating,

"[O]ther than notorious cases, like babies found in dumpsters, the public and the media just don't follow child protection . . . . So the practical effect of [open hearings] hasn't been all that great."[24]

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[23]*Id.* at 186.

[24]*Id.* at 193.

The third lesser premise of Patton's argument is that opening abuse and neglect hearings will not result in beneficial changes in support of the child welfare system. In that regard, he states:

"Esther Wattenberg, one of the five members of the Minnesota Supreme Court's Task Force on Foster Care and Adoption, stated that 'media scrutiny in Michigan did not bring a wave of child protection reforms, primarily because such reform is 'costly' and the public's response to funding systemic improvements such as lower caseloads, training, and family services has been 'No, thank you.' Ms. Wattenberg further noted that 'there is not a shred of evidence to support these assumptions' that press and public access to dependency hearings will improve the quality of judging, advocacy, child welfare work, or reduce the overloaded system."[25]

Professor Patton's cynical view of open hearings and the role of the media leads one to conclude that the media serves no role in forming public opinion. The reality is that the press very frequently reports on the child welfare system. However, present reporting is distorted because of closed hearings and other confidentiality requirements. Further, child welfare agencies are restrained from making their case for increased funding or services to the public because of such requirements. In the battle for public and private funding, the child welfare community is the only community that is restrained from making its case openly and publicly. As noted in the introduction, children cannot tell their stories or make their own laws. A way must be found to inject their voices into the public debate over child welfare services and other issues relative to child welfare.

Requested Statutory Changes

Opening dependency hearings is serious business. Caution is warranted. It must be acknowledged that abused and neglected children have a greater access to privacy than the general public and even than delinquency children. The issue is how to balance the

[25] *Id.* at 194.

best interests of the child *as an abuse or neglect victim* with the public's right to information along with the benefits that open hearings provide. No statute gives an absolute right to public access in all abuse or neglect hearings.

It is respectfully asserted that an appropriate statute should provide a presumption in favor of open courtrooms, i.e., "Proceedings under NRS, Chapter 432B shall be open unless. . ." The next obligation is to define the exceptions. Those exceptions should be based upon defining circumstances wherein the privacy interests *of the child* deserve protection.

The literature and some case law have attempted to define those factors the Court should consider in determining whether dependency proceedings should be closed when presumed opened. Essentially, the factors are common sense elements addressing circumstances where public disclosure may have a unique detrimental impact on the child either because of the needs of the child or the nature of the abuse or neglect.

The factors commonly identified include:

1. The child's age,
2. The child's maturity or state of mental health,
3. The potential that an open hearing will have for embarrassment,
4. Desires of the child,
5. Interests of the parents and relatives,
6. Type of proceeding (for example, sexual abuse may be more sensitive than other abuse or neglect), and
7. Type of access requested by media.

In this author's opinion, the Legislature should not limit consideration only to these factors but also provide a provision that the Court may consider other relevant factors.

Finally, the statute should contain a provision that in the event that the Court determines to close the hearing, specific findings are required. This will insure that the Legislature's policy of open hearings is followed.

Conclusion

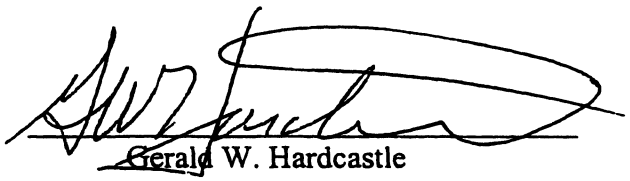
It is a matter of degree. Closing all abuse or neglect hearings to the public and the press simply goes too far. Likewise, opening all such hearings to the press and public fails to recognize that some children deserve privacy. To date, Nevada law follows the extreme by closing hearings that ought to be open. It is patently offensive to cornerstones of American philosophy to grant universally closed hearings in any matter. The public has a right to know what occurs in its courts, even and especially, its Juvenile Courts. Secrets serve the interests of perpetrators, not victims. Secrets serve the interests of failure, not success. Accordingly, while there are exceptional cases where a child's right to privacy through a closed hearing ought to be respected, those exceptions should not be the rule.

Further, while Professor Patton asserts that open hearings will not result in either good legislation or increased public attention on child welfare, I disagree. Keeping proceedings secret will certainly not encourage good legislation or provide public support. It is true that opening hearings may not immediately result in a public or private outpouring of support, financial or otherwise. However, access to what is going on in abuse and neglect will enable the public to understand the importance of what we do in child welfare and enable child welfare services to compete for support rather than operate

in a vacuum. It will enable the public to become educated about the impact of child abuse and neglect by putting faces on the victims.

Mostly, opening hearings will serve children, not harm them. If allowed to do so, we in child welfare can make a solid case for greater support for abused and neglected children. Secrecy isolates the issues between a couple of judges dealing with a couple of agencies. It should be public and it should be personal. Sadly, one of my expressions from the bench is "I wish the public could see what I see here." My hope is that the public can.

Respectfully,



Gerald W. Hardcastle
District Court Judge
Family Division - Juvenile
Eighth Judicial District Court

APPENDIX F

Letter to the Division of Child and Family Services
Regarding Standardized Safety Assessment Protocol

BARBARA E. BUCKLEY
ASSEMBLYWOMAN
District No. 8

MAJORITY FLOOR LEADER

COMMITTEES:
Vice-Chair
Commerce and Labor

Member
Elections, Procedures, and Ethics
Judiciary

State of Nevada Assembly

Seventy-First Session

DISTRICT OFFICE:
5442 Holbrook Drive
Las Vegas, Nevada 89103-2439
(702) 222-9901

LEGISLATIVE BUILDING:
401 S Carson Street
Carson City, Nevada 89701-4747
Office: (775) 684-8537
Fax No.: (775) 684-8522

December 5, 2002

Edward E. Cotton, Administrator
Division of Child and Family Services
Department of Human Resources
711 East Fifth Street
Carson City, Nevada 89701-5092

Dear Mr. Cotton:

As Chairwoman of the Legislative Committee on Children, Youth and Families, I am writing to you on behalf of its members to urge the Division of Child and Family Services (Division) to ensure that all of its Child Protective Services employees and employees of agencies that provide child welfare services, including supervisors, demonstrate competence in using standardized safety assessment protocol. In addition, training in this protocol should be required for all such employees and supervisors. As you are aware, the Committee approved a recommendation at its August 28, 2002 work session to encourage the Division to ensure such competence, and to support the development of any related regulations deemed necessary to carry out this goal.

Based upon the testimony during the meeting, it is our understanding that Nevada does not currently have a standardized safety assessment, which would evaluate a child's situation for any dangers or possible dangers that need to be controlled immediately. As you noted in your testimony, such an assessment should not be the perfunctory act of simply filling out a form, and should involve much thought and evaluation to ensure a child's immediate safety. During the meeting, representatives of both Clark and Washoe Counties volunteered to assist in the development of a standardized safety assessment and any necessary regulations, and the Committee supports and encourages such a collaborative effort.

It is probable that additional funding will be needed to pay for costs associated with the training of employees to ensure competence in the protocol. I understand that federal Title IV-E funds may be available for this purpose, and encourage the Division to seek all available federal funding.

Finally, as part of this recommendation, the members requested that the Division provide a written report on the progress of adopting and implementing the regulations to the Legislative Committee on Children, Youth and Families and two standing committees: the Senate Committee on Human Resources and Facilities and the Assembly Committee on Health and Human Services. The members and I look forward to reviewing the Division's report prior to the 2003 Legislative Session.

Thank you for your assistance throughout the course of the Committee's work. The members and I look forward to working with you and your staff on the important issues involving the safety and health of Nevada's children during the 2003 Legislative Session.

Sincerely,

Barbara E. Buckley
Nevada State Assembly

cc: Members of the Committee
Mike Willden, Director, Department of Human Resources

I:\ONGOING\Committees\Children, Youth & Families\Correspondence\Cotton_CommitteeRecs_LLP.AC.ss.doc

APPENDIX G

Executive Summaries from the Mental Health Consortia Plans
for Clark County, Washoe County and Rural Nevada

Clark County Consortium
First Annual Plan for Mental Health Services
Executive Summary

NRS 433B.333 established Mental Health Consortia in each of three jurisdictions in Nevada. These Mental Health Consortia cover Clark County, Washoe County, and the rest of the state (Rural Jurisdiction). The functions of the Mental Health Consortia are to assess the need for behavioral health (mental health and substance abuse) services for children in the jurisdiction, assess how well the current system is meeting this need, develop an annual plan on how the need can be better met, and report this information to the Legislative Committee on Children and Youth on a regular basis. [1] The Mental Health Consortium for Clark County was formed in January 2002 and met seven times from January through June 14, 2002. Six of these meetings were held in tandem with the local child welfare integration advisory committee meeting. The Consortium organized into three work groups to do the initial work of the Consortium and these workgroups met a total of 19 times during the period.

As consortia members began to discuss the initial annual plan, it became clear that there was a need to gather information to define the current status of mental health services for children in the jurisdiction. The first step was to review the requirements for the assessment in the enabling legislation for the Mental Health Consortium. This called for: an assessment of the need for mental health services in the jurisdiction of the Consortium; a description of the types of services to be offered to emotionally disturbed children based on the amount of money available to pay the costs of such mental health services within the jurisdiction of the Consortium; criteria for eligibility for those services; a description of the manner in which those services may be obtained by eligible children; the manner in which the costs for those services will be allocated; the mechanisms to manage the money provided for those services; documentation of the number of emotionally disturbed children who are not currently being provided services, the costs to provide services to those children, the obstacles to providing services to those children and recommendations for removing those obstacles; methods for obtaining additional money and services for emotionally disturbed children from private and public entities; and the manner in which family members of eligible children and other persons may be involved in the treatment of the children.

Summary of Need for Behavioral Health Services.

- A large proportion (over 75%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need individualized, integrated and coordinated mental health services.

[1] The Legislative mandate for the Mental Health Consortia can be found in Appendix A of this document.

- The highest rated need area is for early access to services before problems become severe to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice).
- To get the best outcomes for children and avoid restrictive and costly inpatient and long term residential care, there is a need for a comprehensive array of flexible and community-based supports for children and for their families. This would include a mobile crisis response, mentors, respite care, integrated case management to coordinate and link services, and community recreation programs that have the necessary support to include children with emotional and behavioral challenges safely.
- The families, teachers, social workers, and juvenile justice staff who work with children with mental health disorders need information and education to understand the special needs of these children, how they can effectively support these children, how to access needed services and supports, and support to work through the challenges of raising and supporting a child with special needs.
- Families need services that are customized to work for them. This means they are accessible in time and place to match the schedules and needs of families. It means that there is no wrong door and that services are coordinated across agencies to meet families needs. It means the services are sensitive to and match the culture and language of the family. It means the services focus on partnering with families to find ways that work for them.

Overall Findings About How Well Need is Met

- Of the 544 children screened only 46.8% are receiving mental health services at the level of their need.
- Most children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise.
- Most parents, family members, and staff who need information and support to know how to support their own children are not accessing these services. In addition, family members who need treatment to assist their children are generally not able to access these services.
- Proportionately more children are accessing services through fee for service Medicaid than through the managed care plans and are receiving many more community-based services.
- Families and providers report long waiting times and lack of flexibility from the managed care and public system providers. Interviews with staff and families documented waiting of 10 weeks and longer in all programs and presumptive waiting lists because of the impression that services were not available or accessible.
- Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.

How Well is Need Met for FFS Medicaid Children?

	Needed Capacity for Outpatient	Needed Capacity for Higher Levels of Care	Children Receiving Outpatient Level	Children Receiving Higher Levels of Care
Clark	3640	1820	1833	512
Washoe	1948	974	831	241
Rural	1980	990	611	123
State	7568	3784	3275	876

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

Appendix J MHC Annual Report

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Level of Mental Health Need Met

	Served At Level	Under Served	No Services Need Higher Levels of Care
All	46.8%	53.2%	15.9%
DCFS	53.3%	46.1%	13.0%
CPS*	14.3%	85.7%	36.4%
Probation	24.7%	75.3%	39.0%
Parole	42.6%	57.4%	30.0%

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

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- The current system greatly overuses residential services to address mental health needs. The lack of an individualized family centered approach to supporting children results in 86.3% of the funding being spent on high cost residential care for less than 5% of the children who need services.
- Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families

who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services.

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

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

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

Process for Obtaining Services. Children access services through the provider that receives funding for the services. This means their own physician, psychologist, managed care provider, or public system service coordinator. Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system. Best practice ratings ranked collaboration and 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. Access to other systems and services is determined by the initial intake agency unless the child and family change systems in which case services and supports are generally started over.

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

Goal One - A Comprehensive and Integrated Behavioral Health System

Community Action Steps:

1. The Mental Health Consortium should have regular coordination meetings to maintain the momentum created through the jurisdiction assessment and development of the annual plan to continually address ways agencies and organization can better work together for children and families. This work should focus on coordination of existing resources and funds to expand capacity and decrease duplication and fragmentation of services.
2. The Mental Health Consortium should establish interagency protocols and or memoranda of understanding that form agreements on how the agencies communicate, share information, provide training, coordinate case management and develop and implement plans to engage parents.
3. There are many community resources (e.g., boys and girls clubs, churches, scouts, United Way) that could provide support for children with special needs if they were part of a united community approach and support to handle the special challenges involved. The Mental Health Consortium should recruit additional membership that can engage and commit local informal resources to the efforts of building an integrated community approach to supporting children and families.
4. The Mental Health Consortium should develop and implement a common assessment instrument, intake process, uniform release of confidentiality, and develop and implement protocols for sharing information and protecting confidentiality that can be used agency to agency, and allow parents share this information agency to agency without needing to redo assessments and intake forms.

State Department and Division Action Steps:

1. Change the Medicaid program to simplify access to services, expand the number of private providers of Medicaid service, provide equitable services for all children eligible for the program, provide community-based alternatives to expensive residential care at all levels of service, decrease the requirements to change providers when moving from aid code to aid code, and provide Medicaid eligibility to all children with severe emotional disorders.

2. There is overlap in intake, assessment, utilization review, administrative functions, and supervision that could be reduced through an integrated approach to the provision of mental health. State agencies should partner with local Consortium agencies to develop common systems that go across agencies.
3. The state should focus efforts to develop a comprehensive and integrated plan to support youth in the child welfare and juvenile justice systems in their transition from childhood to adulthood. Changes in status that restrict eligibility for services and supports and building mandated bridges between child and adult systems should be part of this plan.

State Legislature Action Steps:

1. The state legislature should support changes in the Medicaid program to simplify access to services, expand access to flexible community-based services, expand the number of private providers of Medicaid service, provide equitable assessment for eligibility for the program, provide aggressive case management and quality management reduce the use of expensive and restrictive forms of service, decrease the requirements to change providers when moving from program to program, and provide Medicaid benefits to all children with severe emotional disorders
2. Increase state funding for child/adolescent mental health services and develop an ongoing commitment to increase the funding for children's mental health to match the population growth of children in the state. This year's priority should be to maintain the funding for the AB-1 mental health initiative and target new money to support children in the juvenile justice system.
3. The State Legislature should review the many community "collaboration" and coordination groups and their mandates and streamline the process and groups. In the future, new groups should only be established after reviewing if current groups are already doing similar or the same work.

Goal Two - Services Individualized to Family Needs

Community Action Steps:

1. The Mental Health Consortium should serve as a focal point to continually find and address ways to increase coordination and collaboration among local agencies, community organizations, and families.
2. The agencies should work to create similar geographical service areas and work to make the linkages between the agencies clear when we serve different geographic areas. The Mental Health Consortium agencies should commit to improving access for families by creating integrated services sites throughout communities that are close to families.
3. The Mental Health Consortium should develop written guidance on where and how to access counseling and other mental health services.
4. Community agencies should work together to have counselors and interventionists work in the school along side teachers to provide integrated

plans within the school day and to coordinate with out of school programs (wraparound approach) and develop in and after school programs.

5. The Mental Health Consortium agencies and organizations should commit to offering flexible hours for services to better meet families needs.
6. All public agencies focus on high-end kids. The Mental Health Consortium agencies and organizations should commit to creating a focal point in the community where families could get access to more behavioral health and related services before problems become severe.
7. The Mental Health Consortium agencies and organizations should work together to develop mobile crisis teams that can provide support to families and foster care staff so they would be more willing to keep kids in their homes.

State Department and Division Action Steps:

1. State divisions and departments should work together to create funding streams that can be controlled by local collaborative bodies to meet the needs of local jurisdictions. This should include plans for early intervention, serving children and families with cross agency needs, and human resource development.
2. State divisions and departments should work together to create a universal crisis phone service (211) that could be tied to local crisis response plans.
3. Redirecting some of the current prevention and early intervention funds through mental health, substance abuse, child welfare and juvenile justice into an integrated early access program could save significant money in the high-end usage of mental health services down the road.
4. The county Social Service, Juvenile Justice, and Special Education programs are providing services to children eligible for Medicaid, but are not receiving full federal participation for these expenditures. An integrated system to provide and bill for these services could expand the total amount of money available without increasing local or state expenditures.
5. State divisions and departments should examine funding streams and rules to increase in-home and in-community services and supports for children and families.

State Legislature Action Steps:

1. The state legislature should examine ways to make it easier for information about children and families to be shared while maintaining family control over their own information and maintaining confidentiality.
2. Provide more flexibility to move appropriated funds between budget lines where program need dictates.

Goal Three - Improve Human Resources Support for Children and Families

Community Action Steps:

1. The Mental Health Consortium should adopt a model of family-centered service and provide training across community agencies and organizations.
2. Consortium and agency staff should receive mandatory and frequent cross-training that describes the social mandates, rules and goals of all public agencies and descriptions of the services offered by all local providers.
3. The Mental Health Consortium should coordinate and co-sponsor community training and awareness programs to make families and providers more aware of early signs of mental health and substance abuse problems and how to access services.
4. Local members of the Mental Health Consortium should develop a plan and actively promote the education and recruitment of bi-lingual and culturally diverse staff. This will include direct recruitment of already qualified individuals and support and recruitment for the education of culturally diverse and bilingual individuals (especially those from the local community).
5. The Mental Health Consortium agencies and organizations should develop and implement a plan to coordinate and provide training and support for staff in working together and meeting the needs of children with severe emotional disturbances and their families.
6. The Mental Health Consortium should coordinate and develop a model of interagency coordination for case management of multi-system youth that is family-centered.

State Department and Division Action Steps:

1. A comprehensive online information resource about services and where and how to access services (and could go across disabilities and family needs) should be developed that has an 800 number that would be staffed 24 hours per day.
2. A cross department and division effort should be made at the state level to support community cross agency initiatives to increase bilingual and culturally diverse staff and professional resources.
3. A cross department and division effort should partner with local communities and develop a strong utilization review and monitoring processes for an integrated system to allow expansion of the use of other professionals (e.g., marriage and family therapists, master level psychologists and social workers) and create roles for paraprofessionals that would expand capacity and reduce overall rates.
4. A cross collaboratives task force should be created to develop specific plans for coordination of case management efforts.

State Legislature Action Steps:

1. The state legislature should develop support and funding incentives for local efforts to increase bilingual and culturally diverse staff and professional resources.

Goal Four - Expand Consumer Involvement

Community Action Steps:

1. The local Mental Health Consortia agencies can adopt a model family-centered service and provide training across community in this service process.
2. The local Mental Health Consortium can develop a common assessment instrument and work together to form a one-stop process for accessing services.
3. The local Mental Health Consortium can work together to provide integrated services throughout communities that are close to families.
4. The local Mental Health Consortium can have regular coordination meetings and work to engage and support expanded parent involvement in these meetings.
5. The local agencies can work together to develop a universal intake form that parents can take agency to agency and establish interagency protocols (how to communicate, share information, provide training, coordinate case management and plans to engage parents) that form a more integrated and easy to access system.
6. They can also provide training for Consortium and agency staff about how to partner with parents.

State Department and Division Action Steps:

1. State divisions and departments funding pubic programs for children can adopt more flexible funding regulations that support providing more services in-home and in the community services and support individualizing services and supports to match family needs and what works for them
2. State divisions and departments can support family to family advocacy within the mental health system, do social marketing to improve support for these activities in local communities, and create paraprofessional job classes for families to provide support to other families.
3. State divisions and departments work across division and department to support coordinated information systems for agencies

State Legislature Action Steps:

1. The State Legislature could mandate parental involvement in policymaking and provide funding for parent support and advocacy positions to work with families.
2. Legislation should be based that mandates consumer (parents, foster parents, and youth) involvement in policy making that impacts programs meant to serve them.

Washoe County Consortium
First Annual Plan for Mental Health Services
Executive Summary

NRS 433B.333 established mental health consortia in each of three jurisdictions in Nevada. These Mental Health Consortia cover Clark County, Washoe County, and the rest of the state (Rural Jurisdiction). The functions of the Mental Health Consortia are to assess the need for behavioral health (mental health and substance abuse) services for children in the jurisdiction, assess how well the current system is meeting this need, develop an annual plan on how the need can be better met, and report this information to the Legislative Committee on Children and Youth on a regular basis. [1] The Mental Health Consortium for Washoe County was formed in December 2001 and met seven times from January through June 19, 2002. The consortium organized into three work groups to do the initial work of the consortium and these workgroups met a total of 17 times during the period.

The Washoe Mental Health Consortium took on the additional task to develop a funding proposal to submit to the Substance Abuse and Mental Health Service Administration to obtain a six year federal grant worth more than $7.5 million to fund the development of a comprehensive system of care for Washoe County.

Summary of Need for Behavioral Health Services.

- A large proportion (over 65%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need mental health services and over 40% need individualized, integrated and coordinated mental health services.
- The highest rated need area is for counseling services. The second highest priority was early access to services before problems become severe to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice).
- To get the best outcomes for children and avoid restrictive and costly inpatient and long term residential care, there is a need for a comprehensive array of flexible and community-based supports for children and their families. This would include mobile crisis response, mentors, respite care, integrated case management to coordinate and link services, and community recreation programs that have the necessary support to include children with emotional and behavioral challenges safely.
- The families, teachers, social workers, and juvenile justice staff who work with children with mental health disorders need information and education to understand the special needs of these children, how they can effectively support these children, how to access needed services and supports, and support to work through the challenges of raising and supporting a child with special needs.

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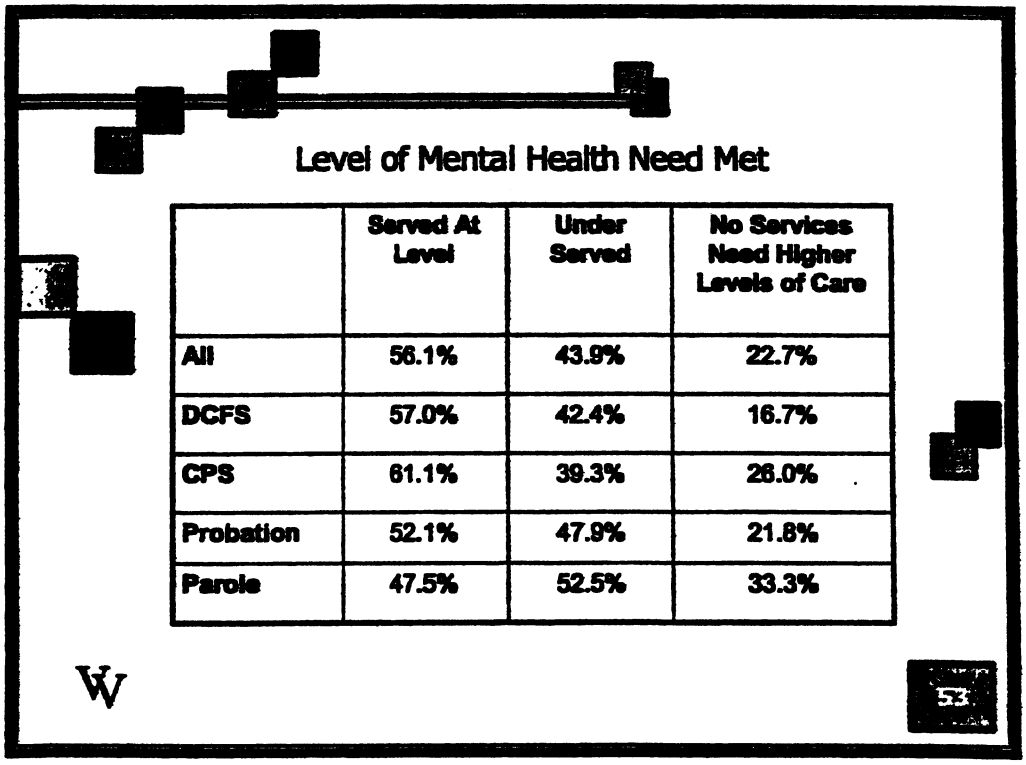
[1] The Legislative mandate for the Mental Health Consortia can be found in Appendix A of this document

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

Overall Findings About How Well Need is Met

- Of the children screened only 56.1% are receiving mental health services at the level of their need. Although counseling was rated as the most accessible service, it was still rated as accessible for just "some" of the children who need it.
- Most children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise.



	Served At Level	Under Served	No Services Need Higher Levels of Care
All	56.1%	43.9%	22.7%
DCFS	57.0%	42.4%	16.7%
CPS	61.1%	39.3%	26.0%
Probation	52.1%	47.9%	21.8%
Parole	47.5%	52.5%	33.3%

- Most parents, family members, and staff who need information and support to know how to support their own children are not accessing these services. In addition, family members who need treatment to assist their children are generally not able to access these services.

- Proportionately more children are accessing services through fee for service Medicaid than through the managed care plans and are receiving many more community-based services.
- Families and providers report long waiting times and lack of flexibility from the managed care and public system providers. Interviews with staff and families documented waiting of 10 weeks and longer in all programs and presumptive waiting lists because of the impression that services were not available or accessible.
- Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.
- The current system greatly overuses residential services to address mental health needs. The lack of an individualized family centered approach to supporting children results in 86.3% of the funding being spent on high cost residential care for less than 5% of the children who need services.
- Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services.

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

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

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

Process for Obtaining Services. Children access services through the provider that receives funding for the services. This means their own physician, psychologist, managed care provider, or public system service coordinator. Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system.

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

Action Plan Goals. The Washoe County Mental Health Consortium developed four primary goals for the first annual mental health plan for the Legislative Committee on Children and Families. These four goals are the areas that have been prioritized as most important for the next phase of building a strong system of care for children and families within the Washoe County Jurisdiction. The plan is developed at three levels. We know that any plan to successfully support children with severe emotional disorders within our community must be a partnership. It must be a partnership between the service providers and the children and families they serve. Through such a partnership families can learn to support their own children successfully and for the long run. It is a partnership between the different public agencies, private agencies and community leaders that provide services and supports for children and families within our community. One clear message of the current assessment is that the system is currently dangerously fragmented and the lack of coordinated and individualized services and supports for our children and families is rapidly pushing more and more children and youth to lifetimes of dependency on our public systems. It also requires a partnership between the local community, state departments and divisions, and the state legislature. We hope to set a common vision for the future of a system of care for our children and families and develop a common and reasonable plan for how to make it happen. It will not happen if we continue to develop programs, regulations, and legislation one piece at a time. All of these need to be a collective effort and each decision evaluated for its impact on the future vision of how we want our communities to take care of themselves. (A more detailed description of the Action Plan is located on Page 36).

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

State Legislature Action Steps:

1. The state legislature should support changes in the Medicaid program to simplify access to services, expand access to flexible community-based services, expand the number of private providers of Medicaid service, provide equitable assessment for eligibility for the program, provide aggressive case management and quality management reduce the use of expensive and restrictive forms of service, decrease the requirements to change providers when moving from program to program, and provide Medicaid benefits to all children with severe emotional disorders
2. Increase state funding for counseling services to eliminate the waiting list for state child/adolescent mental health services and develop an ongoing commitment to increase the funding for children's mental health to match the population growth of children in the state. This year's priority should be to maintain the funding for the AB-1 mental health initiative and target new money to support children with mental health needs in the juvenile justice system.
3. The State Legislature should review the many community "collaboration" and coordination groups and their mandates and streamline the process and groups. In the future new groups should only be established after reviewing if current groups are already doing similar or the same work.

State Department and Division Action Steps:

1. Change the Medicaid program to simplify access to services, expand the number of private providers of Medicaid service, provide equitable services for all children eligible for the program, provide community-based alternatives to expensive residential care at all levels of service, decrease the requirements to change providers when moving from aid code to aid code, and provide Medicaid eligibility to all children with severe emotional disorders.
2. There is overlap in eligibility functions, and supervision that could be reduced through an integrated approach to the provision of mental health. State agencies should partner with local consortium agencies to develop common systems that go across agencies.
3. The state should focus efforts to develop a comprehensive and integrated plan to support youth in the child welfare and juvenile justice systems in their transition from childhood to adulthood. Changes in status that restrict eligibility for services and supports and building mandated bridges between child and adult systems should be part of this plan.

Local Community Action Steps:

1. The mental health consortium will continue to have regular coordination meetings to maintain the momentum created through the jurisdiction assessment and

development of the annual plan to continually address ways agencies and organization can better work together for children and families. This work should focus on coordination of existing resources and funds to expand capacity and decrease duplication and fragmentation of services.

2. The mental health consortium will develop and establish interagency protocols and or memoranda of understanding that form agreements on how the agencies communicate, share information, provide training, coordinate case management and develop and implement plans to engage parents.
3. There are many community resources (e.g., parent organizations, boys and girls clubs, churches, scouts, united way) that could provide support for children with special needs if they were part of a united community approach and support to handle the special challenges involved. The mental health consortium will recruit additional membership that can engage and commit local informal resources to the efforts of building an integrated community approach to supporting children and families.
4. The mental health consortium will develop protocol for the use of a common assessment instrument, intake process, uniform release of confidentiality, and develop and implement protocols for sharing information and protecting confidentiality that can be used agency to agency, and allow parents to share this information agency to agency without needing to redo assessments and intake forms.

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

State Legislature Action Steps:

1. The state legislature should examine ways to make it easier for information about children and families to be shared while maintaining family control over their own information and maintaining confidentiality.
2. Provide more flexibility to move appropriated funds between budget lines where program need dictates.

State Department and Division Action Steps:

1. State Department and Divisions should work together to create funding streams that can be controlled by local collaborative bodies to meet the needs of local jurisdictions. This should include plans for early intervention, serving children and families with cross agency needs, and human resource development.
2. State Department and Divisions should work together to create a universal crisis phone service (211) that could be tied to local crisis response plans.

3. Redirecting some of the current prevention and early intervention funds through mental health, substance abuse, child welfare and juvenile justice into an integrated early access program could save significant money in the high end usage of mental health services down the road.
4. The county social service, juvenile justice, and special education programs are providing services to children eligible for Medicaid but are not receiving full federal participation for these expenditures. An integrated system to provide and bill for these services could expand the total amount of money available without increasing local or state expenditures.
5. State Department and Divisions should examine funding streams and rules to increase in-home and in-community services and supports for children and families.

Local Community Action Steps:

1. The mental health consortium will strive to serve as a focal point to continually find and address ways to increase coordination and collaboration among local agencies, community organizations, and families.
2. The mental health consortium agencies will commit to improving access for families by creating integrated services sites throughout the community that are close to families.
3. The mental health consortium will develop written guidance on where and how to access counseling and other mental health services.
4. Community agencies will strive to have counselors and interventionists work in the school along side teachers to provide integrated plans within the school day and to coordinate with out of school programs (wraparound approach) as well as develop in and after school programs.
5. The mental health consortium agencies and organizations commit to offering flexible hours for services to better meet families needs.
6. The mental health consortium agencies and organizations will commit to creating a focal point in the community where families could get access to more behavioral health and related services before problems become severe.
7. The mental health consortium agencies and organizations will work together to develop mobile crisis teams that can provide support to families and foster care staff so they would be more willing to keep kids in their homes.

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

State Legislature Action Steps:

1. The state legislature should develop support and funding incentives for local efforts to increase bilingual and culturally diverse staff and professional resources.

State Department and Division Action Steps:

1. A cross department and division effort should be made at the state level to support community cross agency initiatives to increase bilingual and culturally diverse staff and professional resources.
2. A cross department and division effort should partner with local communities and develop a strong utilization review and monitoring processes for an integrated system to allow expansion of the use of other professionals (e.g., marriage and family therapists, master level psychologists and social workers) and create roles for paraprofessionals that would expand capacity and reduce overall rates
3. A cross-collaborative task force should be created to develop specific plans for coordination of case management efforts

Local Community Action Steps:

1. The mental health consortium continues to research how to adopt a model family-centered service and provide training across community agencies and organizations.
2. Consortium and agency staff will receive frequent cross-training that describes the social mandates, rules and goals of all public agencies and descriptions of the services offered by all local providers.
3. The mental health consortium will coordinate and co-sponsor community training and awareness programs to make families and providers more aware of early signs of mental health and substance abuse problems and how to access services.

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

State Legislature Action Steps:

1. The State Legislature should mandate parental involvement in policy making and provide funding for parent support and advocacy positions to work with families. Legislation should mandate consumer (parents, foster parents, and youth) involvement in policy making that impacts programs meant to serve them.
2. Legislature should encourage State Department of Personnel to create paraprofessional job classifications.

State Department and Division Action Steps:

1. State Department & Division's funding public programs for children should adopt more flexible funding regulations that support providing more services in-home and in the community services, support individualizing services, supports to match family needs and what works for them.
2. Support family to family advocacy within the mental health system and do social marketing to improve support for these activities including the creating para professional job classes.

3. Work across division and department to support coordinated information systems for agencies.

Local Community Action Steps:

1. Mental health consortium members have agreed to pilot the use of a common assessment instrument
2. The mental health consortium wrote a grant to support an integrated, family-centered system of care and to provide training throughout the community.
3. In the service delivery model proposed in the grant agencies commit to work together to provide integrated services throughout community that are close to families and to coordinate services.
4. Develop a universal intake form that parents can take agency to agency
5. Establish interagency protocols (how communicate, share information, provide training, coordinate case management and plans to engage parents).
6. Provide training for consortium and agency staff about how to partner with parents.

Rural Mental Health Consortium
First Annual Plan for Mental Health Services
Executive Summary

NRS 433B.333 established Mental Health Consortia in each of three jurisdictions in Nevada. These Mental Health Consortia cover Clark County, Washoe County, and the rest of the state (Rural Jurisdiction). The functions of the Mental Health Consortia are to assess the need for behavioral health (mental health and substance abuse) services for children in the jurisdiction, assess how well the current system is meeting this need, develop an annual plan on how the need can be better met, and report this information to the Legislative Committee on Children and Youth on a regular basis. [1] The Mental Health Consortium for the Rural Jurisdiction was formed in January 2002 and met seven times from January through June 19, 2002. The Consortium organized into three work groups to do the initial work of the Consortium and these workgroups met a total of 21 times during the period.

Summary of Need for Behavioral Health Services.

- A large proportion (over 53%) of the children in child protective services, child welfare, juvenile probation and juvenile parole need mental health services and over 43% need individualized, integrated and coordinated mental health services.
- The highest rated need area is for early access to services before problems become severe to help parents raise their own children successfully and avoid entering public systems (e.g., child welfare and juvenile justice). The second highest priority was for counseling services.
- To get the best outcomes for children and avoid restrictive and costly inpatient and long term residential care, there is a need for a comprehensive array of flexible and community-based supports for children and for their families. This would include available and local counseling, a mobile crisis response, mentors, respite care, and integrated case management to coordinate and link services.
- The families, teachers, social workers, and juvenile justice staff who work with children with mental health disorders need information and education to understand the special needs of these children, how they can effectively support these children, how to access needed services and supports, and support to work through the challenges of raising and supporting a child with special needs.
- Families need services that are customized to work for them. This means they are accessible in time and place to match the schedules and needs of families. It means that there is no wrong door and that services are coordinated across agencies to meet families needs. It means the services are sensitive to and match the culture and language of the family. It means the services focus on partnering with families to find ways that work for them.

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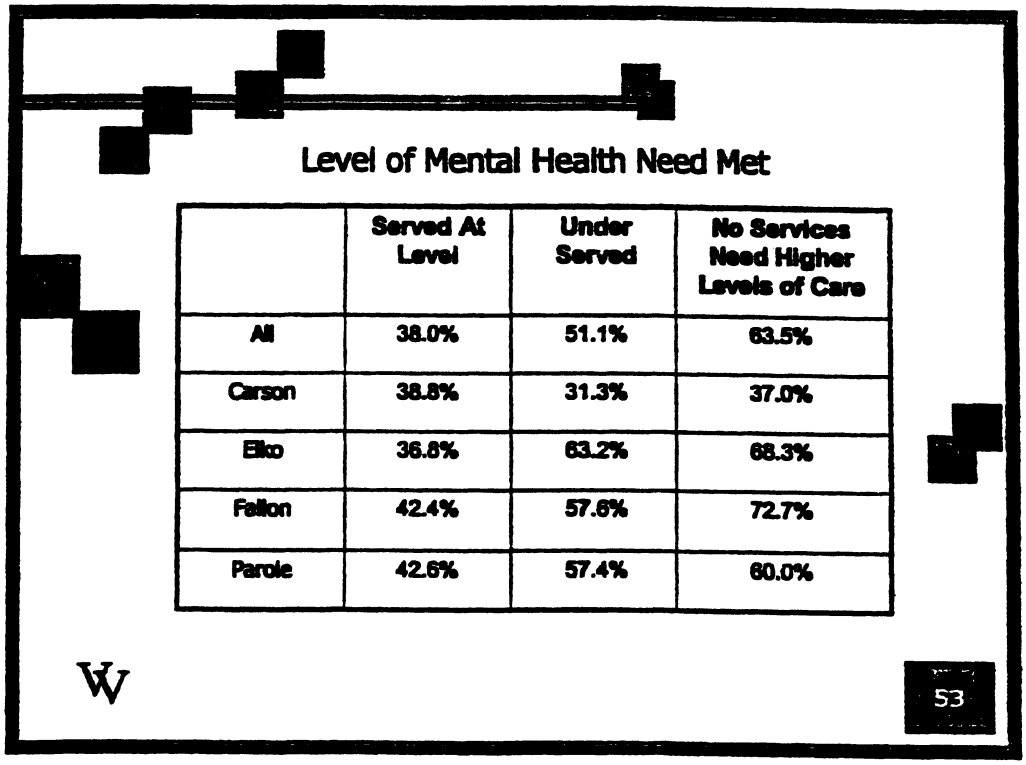
[1] The Legislative mandate for the Mental Health Consortia can be found in Appendix A of this document.

Overall Findings About How Well Need is Met

- Of the 248 children screened only 38% are receiving mental health services at the level of their need. Although counseling was rated as the most accessible service, it was still rated as accessible for just "some" of the children who need it. In fact there are whole counties in the rural jurisdiction that do not have available counseling services that can be purchased through Medicaid due to lack of Medicaid providers or access to services due to travel distance.
- Most children who need early access to mental health services are not able to access them. It is the impression of families and providers that lack of early access to services results in many children entering public systems (e.g., child welfare and juvenile justice) who would not otherwise.



	Served At Level	Under Served	No Services Need Higher Levels of Care
All	38.0%	51.1%	63.5%
Carson	38.8%	31.3%	37.0%
Elko	36.6%	63.2%	68.3%
Fallon	42.4%	57.6%	72.7%
Parole	42.6%	57.4%	60.0%

- Most parents, family members, and staff who need information and support to know how to support their own children are not accessing these services. In addition, family members who need treatment to assist their children are generally not able to access these services.
- Proportionately more children are accessing services through fee for service Medicaid than through the managed care plans and are receiving many more community-based services.
- Families and providers report long waiting times and lack of flexibility from the managed care and public system providers. Interviews with staff and families documented waiting of 10 weeks and longer in all programs and presumptive waiting lists because of the impression that services were not available or accessible.

- Ratings on best practices show that individualization based on culture does not occur and that the lack of bilingual and culturally diverse providers and staff limits access for many Hispanic children who need services.
- The current system greatly overuses residential services to address mental health needs. The lack of an individualized family centered approach to supporting children results in 86.3% of the funding being spent on high cost residential care for less than 5% of the children who need services.
- Ratings on best practice find that current services and supports are not provided on schedules and in locations that are easily accessible for many children and families who need them and that failure to tailor programs to the needs and what works for families is a barrier to services for many families who need the services.

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

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

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

Process for Obtaining Services. Children access services through the provider that receives funding for the services. This means their own physician, psychologist, managed care provider, or public system service coordinator. Each of these systems has different eligibility requirements and offers a different array of services. Thus the same child with the same presenting problems and same family-support system may get significantly different services based on where they enter the system.

Methods for Obtaining Additional Money. Nevada has one of the fastest growing populations in the country, but funding for children's behavioral health services has shown little increase in the past ten years. The new funding through AB-1 to fund

individualized services for 327 children in the child welfare system will be a great help if it is not a victim of funding cuts to balance the budget. There are ways in which the funding within the current system could be used more effectively but this can only happen if the state level Departments and Divisions with support from the State Legislature work together to form a less fragmented system that is flexible to meet the needs of children and families.

Action Plan Goals. The Rural Jurisdiction Mental Health Consortium developed four primary goals for the first annual mental health plan for the Legislative Committee on Children and Families. These four goals are the areas that have been prioritized as most important for the next phase of building a strong system of care for children and families within the Rural Jurisdiction Jurisdiction. The plan is developed at three levels. We know that any plan to successfully support children with severe emotional disorders within our community must be a partnership. It must be a partnership between the service providers and the children and families they serve. Through such a partnership families can learn to support their won children successfully and for the long run. It is a partnership between the different public agencies, private agencies and community leaders that provide services and supports for children and families within our community. One clear message of the current assessment is that the system is currently dangerously fragmented and the lack of coordinated and individualized services and supports for our children and families is rapidly pushing more and more children and youth to lifetimes of dependency on our public systems. It also requires a partnership between the local community, state departments and divisions, and the state legislature. We hope to set a common vision for the future of a system of care for our children and families and develop a common and reasonable plan for how to make it happen. It will not happen if we continue to develop programs, regulations, and legislation one piece at a time. All of these need to be a collective effort and each decision evaluated for its impact on the future vision of how we want our communities to take care of themselves.

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

State Legislature Action Steps:

1. The state legislature should support changes in the Medicaid program to simplify access to services, expand access to flexible community-based services, expand the number of private providers of Medicaid service, provide equitable assessment for eligibility for the program, provide aggressive case management and quality management, reduce the use of expensive and restrictive forms of service, decrease the requirements to change providers when moving from program to program, and provide Medicaid benefits to all children with severe emotional disorders

2. Increase state funding for counseling services to eliminate the waiting list for state child/adolescent mental health services and develop an ongoing commitment to increase the funding for children's mental health to match the population growth of children in the state. This year's priority should be to maintain the funding for the AB-1 mental health initiative and target new money to support children with mental health needs in both the public mental health and the juvenile justice systems.
3. The State Legislature should review the many community "collaboration" and coordination groups and their mandates and streamline the process and groups. In the future, new groups should only be established after reviewing if current groups are already doing similar or the same work.

State Department and Division Action Steps:

1. Change the Medicaid program to simplify access to services, expand the number of private providers of Medicaid service, provide equitable services for all children eligible for the program, provide community-based alternatives to expensive residential care at all levels of service, decrease the requirements to change providers when moving from aid code to aid code, and provide Medicaid eligibility to all children with severe emotional disorders.
2. There is overlap in eligibility functions, and supervision that could be reduced through an integrated approach to the provision of mental health. State agencies should partner with local Consortium agencies to develop common systems that go across agencies.
3. The state should focus efforts to develop a comprehensive and integrated plan to support youth in the child welfare and juvenile justice systems in their transition from childhood to adulthood. Changes in status that restrict eligibility for services and supports and building mandated bridges between child and adult systems should be part of this plan.

Community Action Steps:

1. The Mental Health Consortium will continue to have regular coordination meetings to maintain the momentum created through the jurisdiction assessment and development of the annual plan to continually address ways agencies and organization can better work together for children and families. This work should focus on coordination of existing resources and funds to expand capacity and decrease duplication and fragmentation of services.
2. The Mental Health Consortium will develop and establish interagency protocols and or memoranda of understanding that form agreements on how the agencies communicate, share information, provide training, coordinate case management and develop and implement plans to engage parents.
3. There are many community resources (e.g., parent organizations, boys and girls clubs, churches, scouts, United Way) that could provide support for children with special needs if they were part of a united community approach and support to handle the special challenges involved. The Mental Health Consortium will recruit

additional membership that can engage and commit local informal resources to the efforts of building an integrated community approach to supporting children and families.

4. The Mental Health Consortium will develop and protocol for the use of a common assessment instrument, intake process, uniform release of confidentiality, and develop and implement protocols for sharing information and protecting confidentiality that can be used agency to agency, and allow parents share this information agency to agency without needing to redo assessments and intake forms.

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

State Legislature Action Steps:

1. The state legislature should examine ways to make it easier for information about children and families to be shared while maintaining family control over their own information and maintaining confidentiality.
2. Provide more flexibility to move appropriated funds between budget lines where program need dictates.

State Department and Division Action Steps:

1. State department and divisions should work together to create funding streams that can be controlled by local collaborative bodies to meet the needs of local jurisdictions. This should include plans for early intervention, serving children and families with cross agency needs, and human resource development.
2. State department and divisions should work together to create a universal crisis phone service (211) that could be tied to local crisis response plans.
3. Redirecting some of the current prevention and early intervention funds through mental health, substance abuse, child welfare and juvenile justice into an integrated early access program could save significant money in the high end usage of mental health services down the road.
4. The county Social Service, Juvenile Justice, and Special Education programs are providing services to children eligible for Medicaid, but are not receiving full federal participation for these expenditures. An integrated system to provide and bill for these services could expand the total amount of money available without increasing local or state expenditures.
5. State department and divisions should examine funding streams and rules to increase in-home and in-community services and supports for children and families.

Community Action Steps:

1. The Mental Health Consortium will strive to serve as a focal point to continually find and address ways to increase coordination and collaboration among local agencies, community organizations, and families.
2. The Mental Health Consortium agencies will commit to improving access for families by creating integrated services sites throughout the community that are close to families.
3. The Mental Health Consortium will develop written guidance on where and how to access counseling and other mental health services.
4. Community agencies will strive to have programs that work within the school day and to coordinate with out of school programs (wraparound approach) and develop in and after school programs.
5. The Mental Health Consortium agencies and organizations will explore feasibility to offering flexible hours for services to better meet families needs.
6. The Mental Health Consortium agencies and organizations will commit to creating a focal point in the community where families could get access to more behavioral health and related services before problems become severe.
7. The Mental Health Consortium agencies and organizations will work together to develop mobile crisis teams that can provide support to families and foster care staff so they would be more willing to keep kids in their homes.

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

State Legislature Action Steps:

1. The state legislature should develop support and funding incentives for local efforts to increase bilingual and culturally diverse staff and professional resources.

State Department and Division Action Steps:

1. A cross department and division effort should be made at the state level to support community cross agency initiatives to increase bilingual and culturally diverse staff and professional resources.
2. A cross department and division effort should partner with local communities and develop a strong utilization review and monitoring processes for an integrated system to allow expansion of the use of other professionals (e.g., marriage and family therapists, master level psychologists and social workers) and create roles for paraprofessionals that would expand capacity and reduce overall rates
3. A cross collaboratives task force should be created to develop specific plans for coordination of case management efforts.

Community Action Steps:

1. The Mental Health Consortium continues to research how to adopt a model family-centered service and provide training across community agencies and organizations.
2. Consortium and agency staff should receive mandatory and frequent cross-training that describes the social mandates, rules and goals of all public agencies and descriptions of the services offered by all local providers.
3. The Mental Health Consortium should coordinate and co-sponsor community training and awareness programs to make families and providers more aware of early signs of mental health and substance abuse problems and how to access services.

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

State Legislature Action Steps:

1. The State Legislature should mandate parental involvement in policy making and provide funding for parent support and advocacy positions to work with families. Legislation should be based that mandates consumer (parents, foster parents, and youth) involvement in policy making that impacts programs meant to serve them.
2. Legislature should encourage State Department of Personnel to create paraprofessional job classifications.

State Department and Division Action Steps:

1. State Department & Division funding public programs for children should adopt more flexible funding regulations that support providing more services in-home and in the community, services and support individualizing services and supports to match family needs and what works for them. Support family to family advocacy within the mental health system and do social marketing improve support for these activities including creating paraprofessional job classes. Work across division and department to support coordinated information systems for agencies.

Local Community Action Steps:

1. Mental Health Consortium members have agreed to pilot the use of a common assessment instrument.
2. Develop a universal intake form that parents can take agency to agency
3. Establish interagency protocols (how to communicate, share information, provide training, coordinate case management and plans to engage parents)
4. Provide training for Consortium and agency staff in how to partner with parents.

APPENDIX H

Letter to Governor Kenny C. Guinn
Regarding Funding for Respite Care

BARBARA E. BUCKLEY
ASSEMBLYWOMAN
District No 8

MAJORITY FLOOR LEADER

COMMITTEES:
Vice-Chair
Commerce and Labor

Member
Elections Procedures and Ethics
Judiciary

State of Nevada Assembly

Seventy-First Session

DISTRICT OFFICE
5442 Holbrook Drive
Las Vegas, Nevada 89103-2439
(702) 222-9901

LEGISLATIVE BUILDING.
401 S Carson Street
Carson City, Nevada 89701-4747
Office (775) 684-8537
Fax No.: (775) 684-8522

December 5, 2002

The Honorable Kenny C. Guinn
Governor of Nevada
Office of the Governor
101 North Carson Street, Suite 1
Carson City, Nevada 89701

Dear Governor Guinn:

As Chairwoman of the Committee on Children, Youth and Families, I am writing on its behalf to urge you to consider including increased funding and flexibility for respite care for foster parents in The Executive Budget for the 2003-05 biennium. As you are aware, foster parents provide an invaluable service to the state that enables children to live in loving environments. Foster parents also save the state money by avoiding more expensive higher levels of care.

At its August 28, 2002 meeting, the Committee considered a request from the Foster Care and Adoption Association of Nevada (FCAAN) asking that the state fund 14 days of respite care per fiscal year at a rate of $30 a day for ages 0 through 12 years and $35 a day for ages 13 through 18. The FCAAN also requested authorization to use funds for respite care on an hourly, instead of a daily or overnight, basis to allow foster parents more flexibility. Testifying in support of the FCAAN recommendations, Deanne Blazzard noted that during the 2001 Session, the Legislature and the Governor's Office supported a much-needed and appreciated increase in the foster care rate. However, the respite care rate has never been increased. Currently, the rate is $15 a day for children 0 through 12 years of age and $20 a day for children 13 years and older, and is minimally funded at approximately $38,000 in Fiscal Year 2003.

As you are aware, respite care is a small component of the funding needed for quality child welfare in Nevada. However, the members of the Committee strongly support the work of Nevada's foster care parents, without whom the child welfare system in Nevada could not

function. The state should do everything feasible to support and assist the parents, and the Committee voted unanimously to forward FCAAN's request to your attention.

The members of the Committee and I look forward to working with you in the future on the funding of child welfare for the upcoming biennium, and strongly urge you and your staff to examine FCAAN's request for an increase and flexibility in the funds for respite care. Thank you for your consideration and for your continued support of the effort to improve Nevada's child welfare system.

Sincerely,

Barbara E. Buckley
Nevada State Assembly

cc: Members of the Committee
Mike Willden, Director, Department of Human Resources
Edward E. Cotton, Administrator, Division of Child and Family Services
Deanne Blazzard, FCAAN

APPENDIX I

Suggested Legislation

SUGGESTED LEGISLATION

BILL DRAFT REQUESTS

SUMMARY—Provides that proceedings concerning abuse or neglect of children are presumptively open to public. (BDR 38-689)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State: No.

AN ACT relating to the protection of children; providing that proceedings concerning the abuse or neglect of children are presumptively open to the public; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 432B.430 is hereby amended to read as follows:

432B.430 ***1. Except as otherwise provided in NRS 432B.457 and subsection 3, any proceeding held pursuant to NRS 432B.410 to 432B.590, inclusive, must be open to the general public unless the judge or master, upon his own motion or upon the motion of another person, determines that all or part of the proceeding must be closed to the general public because such closure is in the best interests of the child who is the subject of the proceeding. In determining whether closing all or part of the proceeding is in the best interests of the child***

who is the subject of the proceeding, the judge or master must consider and give due weight to the desires of that child.

2. If the judge or master determines pursuant to subsection 1 that all or part of a proceeding must be closed to the general public:

(a) The judge or master must make specific findings of fact to support such a determination; and

(b) Except as otherwise provided in NRS 432B.457, ***the general public must be excluded and*** only those persons having a direct interest in the case, as ordered by the judge or master, may be admitted to ~~[any]~~ ***the*** proceeding.

3. In conducting a proceeding held pursuant to NRS 432B.410 to 432B.590, inclusive ~~[.]~~, ***a judge or master shall keep information confidential to the extent necessary to obtain federal funds in the maximum amount available to this state.***

ASSEMBLY BILL NO. 25–COMMITTEE ON HEALTH AND HUMAN SERVICES

(ON BEHALF OF LEGISLATIVE COMMITTEE ON CHILDREN, YOUTH AND FAMILIES)

PREFILED JANUARY 29, 2003

Referred to Committee on Health and Human Services

SUMMARY—Makes various changes concerning provision of public services for children. (BDR 38-690)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State: Yes.

~

EXPLANATION – Matter in *bolded italics* is new, matter between brackets [~~omitted material~~] is material to be omitted

AN ACT relating to children; authorizing an agency which provides child welfare services to enter into agreements with certain persons for the provision of maintenance and other services; authorizing an employee of such an agency to provide maintenance and special services to certain children under certain circumstances; providing a penalty; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 432 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A child may enter into an agreement with an agency which provides child welfare services to continue to receive maintenance and special services if the child is enrolled as a student at a university, college, trade school or technical school. Such an agreement must be approved by a court.

2. At intervals specified in the agreement by the agency which provides child welfare services, the child must submit to the agency which provides child welfare services documentation evidencing his enrollment as a student at a university, college, trade school or technical school.

3. The term of any agreement entered into pursuant to subsection 1 must not extend beyond the 22nd birthday of the child.

4. Subject to the approval of the court, the agreement may be terminated by:

(a) Mutual agreement; or

(b) The agency which provides child welfare services if the child fails to comply with any term or condition in the agreement.

5. As used in this section:

(a) "Child" means a person who is 18 years of age or older but less than 22 years of age.

(b) "Court" has the meaning ascribed to it in NRS 432B.050.

Sec. 2. NRS 432.010 is hereby amended to read as follows:

432.010 As used in this chapter, except as otherwise defined by specific statute or unless the context otherwise requires:

1. "Administrator" means the Administrator of the Division.

2. "Agency which provides child welfare services" has the meaning ascribed to it in NRS 432B.030.

3. "Child" means a person ~~[less]~~ *who is:*

(a) Less than 18 years of age ~~[, or if in school,]~~ *; or*

(b) Eighteen years of age or older and is attending high school, until graduation from high school.

4. "Division" means the Division of Child and Family Services of the Department of Human Resources.

5. "Maintenance" means general expenses for care such as board, shelter, clothing, transportation and other necessary or incidental expenses, or any of them, or monetary payments therefor.

6. "Special services" means medical, hospital, psychiatric, surgical or dental services, or any combination thereof.

Sec. 3. NRS 432.030 is hereby amended to read as follows:

432.030 ~~[No]~~

1. Except as otherwise provided in subsection 2, an employee of an agency which provides child welfare services may *, if otherwise qualified,* provide maintenance and special services ~~[for any child except as otherwise provided by specific statute or:~~

~~1. Upon the request of a child whom the agency which provides child welfare services determines to be emancipated;~~

~~2.]~~ *to any child other than a child who:*

(a) Is included as a client in the caseload of the employee at the time of the provision of the maintenance or special services; or

(b) Has been included as a client in the caseload of the employee within the 3 years immediately preceding the provision of the maintenance or special services.

2. An employee of an agency which provides child welfare services may provide maintenance and special services to any child:

(a) Pursuant to court order or request; or

~~[3.]~~ *(b)* Upon referral of appropriate law enforcement officials for emergency care.

Sec. 4. NRS 432.034 is hereby amended to read as follows:

432.034 Written statements of information required from responsible relatives of applicants for or recipients of assistance pursuant to NRS 432.010 to 432.085, inclusive, ***and section 1 of this act*** need not be under oath, but any person who signs such a statement and willfully states therein as true any material matter which he knows to be false is guilty of perjury which is a category D felony and shall be punished as provided in NRS 193.130.

Sec. 5. NRS 432.037 is hereby amended to read as follows:

432.037 1. The Trust Fund for Child Welfare is hereby created. All benefits for survivors or other awards payable to children receiving child welfare services pursuant to NRS 432.010 to 432.085, inclusive, ***and section 1 of this act,*** in a county whose population is less than 100,000 must be deposited in the State Treasury for credit to the Fund.

2. The Division shall:

(a) Keep a separate account for each child who receives money.

(b) Deduct from the account any services to the child provided by public money. Any surplus remaining may be expended for extraordinary items deemed beneficial to the child.

(c) Remit any surplus balance to the parent or legal guardian of the child, or to the child if he is emancipated or has reached the age of 18 years, when the Division is no longer legally responsible for him ~~[.]~~ ***unless the child has entered into an agreement with an agency which provides child welfare services pursuant to section 1 of this act.***

3. The Division shall pay interest to each child's separate account maintained in the Trust Fund for Child Welfare at the end of each interest period. Interest must be paid at a rate equal to the average of the interest rates quoted by at least three banking institutions for interest-bearing savings accounts of $3,000 or less on the first day of each interest period. Interest must be paid on the child's account commencing with the first interest period that the Division is legally responsible for the child. Interest must not be paid for the interest period during which the child ceases to be the legal responsibility of the Division.

4. All benefits for survivors or other awards payable to children receiving child welfare services in a county whose population is 100,000 or more pursuant to NRS 432.010 to 432.085,

inclusive, ***or section 1 of this act,*** must be deposited in the trust fund for child welfare established in the county treasury. A disbursement from the benefits for survivors or other awards of a child which is deposited in the fund may be made to the agency which provides child welfare services for any child welfare services provided to the child with public money.

5. As used in this section, "interest period" means that period not less frequent than quarterly, as determined by the State Treasurer, for which interest must be paid.

Sec. 6. NRS 432.085 is hereby amended to read as follows:

432.085 1. ~~[The]~~ ***Except as otherwise provided in subsection 6, the*** parents of a child placed in the custody of an agency which provides child welfare services pursuant to the provisions of NRS 62.880 or 432.010 to 432.085, inclusive, or chapter 432B of NRS are liable to the agency which provides child welfare services for the cost of maintenance and special services provided to the child.

2. The Division shall establish by regulation reasonable schedules for the repayment of money owed by parents pursuant to subsection 1.

3. An agency which provides child welfare services may waive all or any part of the amount due pursuant to this section if it determines that the parents of the child do not have the ability to pay the amount.

4. If a parent refuses to pay an agency which provides child welfare services for money owed under this section, the agency which provides child welfare services may bring a civil action to recover all money owed with interest thereon at the rate of 7 percent per year commencing 30 days after an itemized statement of the amount owed is submitted to the parents.

5. All money collected pursuant to this section must be deposited:

(a) In a county whose population is less than 100,000, with the State Treasurer for credit to the State Child Welfare Services Account.

(b) In a county whose population is 100,000 or more, with the county treasurer for credit to a fund or account established by the board of county commissioners.

6. The parents of a child who has entered in to an agreement with an agency which provides child welfare services pursuant to section 1 of this act are not liable to the agency which provides child welfare services for the cost of maintenance and special services provided to the child.

Sec. 7. This act becomes effective on July 1, 2003.

ASSEMBLY BILL NO. 5–COMMITTEE ON HEALTH AND HUMAN SERVICES

(ON BEHALF OF LEGISLATIVE COMMITTEE ON CHILDREN, YOUTH AND FAMILIES (NRS 218.53723))

PREFILED JANUARY 27, 2003

Referred to Committee on Health and Human Services

SUMMARY—Requires Director of Department of Human Resources to include in State Plan for Medicaid requirement that young adults who have "aged out" of foster care are eligible for Medicaid. (BDR 38-691)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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EXPLANATION – Matter in *bolded italics* is new, matter between brackets [omitted material] is material to be omitted

AN ACT relating to public welfare; requiring the Director of the Department of Human Resources to include in the State Plan for Medicaid a requirement that young adults who have "aged out" of foster care are eligible for Medicaid; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Director shall include in the State Plan for Medicaid a requirement that an independent foster care adolescent is eligible for Medicaid.

2. As used in this section, "independent foster care adolescent" means:

(a) A person described in 42 U.S.C. § 1396d(w)(1), as that section existed on July 1, 2003; or

(b) If the Director specifies a different category of adolescents in the manner set forth in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII), as that section existed on July 1, 2003, a person who is within such a category.

Sec. 2. NRS 422.240 is hereby amended to read as follows:

422.240 1. Money to carry out the provisions of NRS 422.001 to 422.410, inclusive, *and section 1 of this act,* and 422.580, including, without limitation, any federal money allotted to the State of Nevada pursuant to the program to provide Temporary Assistance for Needy Families and the Program for Child Care and Development, must be provided by appropriation by the Legislature from the State General Fund.

2. Disbursements for the purposes of NRS 422.001 to 422.410, inclusive, *and section 1 of this act,* and 422.580 must be made upon claims duly filed, audited and allowed in the same manner as other money in the State Treasury is disbursed.

Sec. 3. This act becomes effective on July 1, 2003.

Includes Unfunded Mandate - § 2
(Not Requested by Affected Local Government)

SUMMARY—Requires examination by trained provider of health care of each child under age of 3 years who is reported as abused or neglected. (BDR 38-692)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State: Yes.

AN ACT relating to the protection of children; requiring each agency investigating a report of abuse or neglect of a child under the age of 3 years to ensure that a provider of health care trained to recognize child abuse or neglect examines the child; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 432B.160 is hereby amended to read as follows:

432B.160 1. Except as otherwise provided in subsection 2, immunity from civil or criminal liability extends to every person who in good faith:

(a) Makes a report pursuant to NRS 432B.220;

(b) Conducts an interview or allows an interview to be taken pursuant to NRS 432B.270;

(c) Allows or takes photographs or X rays pursuant to NRS 432B.270;

(d) Causes a medical test to be performed pursuant to NRS 432B.270;

(e) ***Examines or requires an examination of a child under the age of 3 years pursuant to subsection 3 of NRS 432B.270;***

(f) Provides a record, or a copy thereof, of a medical test ***or examination*** performed pursuant to NRS 432B.270 to an agency which provides child welfare services to the child, a law enforcement agency that participated in the investigation of the report of abuse or neglect of the child or the prosecuting attorney's office;

~~[(f)]~~ ***(g)*** Holds a child pursuant to NRS 432B.400, takes possession of a child pursuant to NRS 432B.630 or places a child in protective custody pursuant to any provision of this chapter;

~~[(g)]~~ ***(h)*** Performs any act pursuant to subsection 2 of NRS 432B.630;

~~[(h)]~~ ***(i)*** Refers a case or recommends the filing of a petition pursuant to NRS 432B.380; or

~~[(i)]~~ ***(j)*** Participates in a judicial proceeding resulting from a referral or recommendation.

2. The provisions of subsection 1 do not confer any immunity from liability for the negligent performance of any act pursuant to paragraph (b) of subsection 2 of NRS 432B.630.

3. In any proceeding to impose liability against a person for:

(a) Making a report pursuant to NRS 432B.220; or

(b) Performing any act set forth in paragraphs (b) to ~~[(i),]~~ ***(j)*** inclusive, of subsection 1,

FLUSH there is a presumption that the person acted in good faith.

Sec. 2. NRS 432B.270 is hereby amended to read as follows:

432B.270 1. ~~[A]~~ ***Except as otherwise provided in subsection 3, a*** designee of an agency investigating a report of abuse or neglect of a child may, without the consent of and outside the presence of any person responsible for the child's welfare, interview a child concerning any

possible abuse or neglect. The child may be interviewed at any place where he is found. The designee shall, immediately after the conclusion of the interview, if reasonably possible, notify a person responsible for the child's welfare that the child was interviewed, unless the designee determines that such notification would endanger the child.

2. ~~[A]~~ ***Except as otherwise provided in subsection 3, a*** designee of an agency investigating a report of abuse or neglect of a child may, without the consent of the person responsible for a child's welfare:

(a) Take or cause to be taken photographs of the child's body, including the areas of trauma; and

(b) If indicated after consultation with a physician, cause X rays or medical tests to be performed on a child.

3. ***Each agency investigating a report of abuse or neglect of a child under the age of 3 years shall ensure that the child is examined, with or without the consent of the person responsible for the child's welfare, by a provider of health care who is trained to recognize indications of abuse or neglect of children. In addition, a designee of an agency investigating such a report may engage in any activity set forth in subsection 1 or 2.***

4. Upon the taking of any photographs or X rays , or the performance of any medical tests pursuant to subsection 2 ~~[,]~~ ***or 3 or the performance of an examination pursuant to subsection 3,*** the person responsible for the child's welfare must be notified immediately, if reasonably possible, unless the designee ***or agency, if the examination was performed pursuant to subsection 3, or the photograph or X ray was taken or the medical test was performed***

pursuant to an examination conducted pursuant to subsection 3, determines that the notification would endanger the child. The reasonable cost of these photographs, X rays , ~~[or]~~ medical tests ***or examinations*** must be paid by the agency which provides child welfare services if money is not otherwise available.

~~[4.]~~ ***5.*** Any photographs or X rays taken or records of any medical tests performed pursuant to subsection 2 ~~[,]~~ ***or 3,*** or any medical records relating to the examination or treatment of a child pursuant to this section, or copies thereof, must be sent to the agency which provides child welfare services, the law enforcement agency participating in the investigation of the report and the prosecuting attorney's office. Each photograph, X ray, result of a medical test or other medical record:

(a) Must be accompanied by a statement or certificate signed by the custodian of medical records of the health care facility where the photograph or X ray was taken or the treatment, examination or medical test was performed, indicating:

(1) The name of the child;

(2) The name and address of the person who took the photograph or X ray, performed the medical test, or examined or treated the child; and

(3) The date on which the photograph or X ray was taken or the treatment, examination or medical test was performed;

(b) Is admissible in any proceeding relating to the abuse or neglect of the child; and

(c) May be given to the child's parent or guardian if he pays the cost of duplicating them.

~~[5.]~~ *6.* As used in this section, "medical test" means any test performed by or caused to be performed by a provider of health care, including, without limitation, a computerized axial tomography scan and magnetic resonance imaging.

Sec. 3. NRS 432B.290 is hereby amended to read as follows:

432B.290 1. Except as otherwise provided in subsections 2, 5 and 6 and NRS 432B.513, data or information concerning reports and investigations thereof made pursuant to this chapter may be made available only to:

(a) A physician, if the physician has before him a child who he has reasonable cause to believe has been abused or neglected ~~[,]~~ ***, or a provider of health care who is examining a child under the age of 3 years pursuant to subsection 3 of NRS 432B.270 if the provider of health care has reasonable cause to believe the child has been abused or neglected;***

(b) A person authorized to place a child in protective custody, if the person has before him a child who he has reasonable cause to believe has been abused or neglected and the person requires the information to determine whether to place the child in protective custody;

(c) An agency, including, without limitation, an agency in another jurisdiction, responsible for or authorized to undertake the care, treatment or supervision of:

(1) The child; or

(2) The person responsible for the welfare of the child;

(d) A district attorney or other law enforcement officer who requires the information in connection with an investigation or prosecution of the abuse or neglect of a child;

(e) A court, for in camera inspection only, unless the court determines that public disclosure of the information is necessary for the determination of an issue before it;

(f) A person engaged in bona fide research or an audit, but information identifying the subjects of a report must not be made available to him;

(g) The attorney and the guardian ad litem of the child;

(h) A grand jury upon its determination that access to these records is necessary in the conduct of its official business;

(i) A federal, state or local governmental entity, or an agency of such an entity, that needs access to the information to carry out its legal responsibilities to protect children from abuse and neglect;

(j) A person or an organization that has entered into a written agreement with an agency which provides child welfare services to provide assessments or services and that has been trained to make such assessments or provide such services;

(k) A team organized pursuant to NRS 432B.350 for the protection of a child;

(l) A team organized pursuant to NRS 432B.405 to review the death of a child;

(m) A parent or legal guardian of the child and an attorney of a parent or guardian of the child, if the identity of the person responsible for reporting the alleged abuse or neglect of the child to a public agency is kept confidential;

(n) The persons who are the subject of a report;

(o) An agency that is authorized by law to license foster homes or facilities for children or to investigate persons applying for approval to adopt a child, if the agency has before it an application for that license or is investigating an applicant to adopt a child;

(p) Upon written consent of the parent, any officer of this state or a city or county thereof or Legislator authorized, by the agency or department having jurisdiction or by the Legislature, acting within its jurisdiction, to investigate the activities or programs of an agency which provides child welfare services if:

(1) The identity of the person making the report is kept confidential; and

(2) The officer, Legislator or a member of his family is not the person alleged to have committed the abuse or neglect;

(q) The Division of Parole and Probation of the Department of Public Safety for use pursuant to NRS 176.135 in making a presentence investigation and report to the district court or pursuant to NRS 176.151 in making a general investigation and report;

(r) Any person who is required pursuant to NRS 432B.220 to make a report to an agency which provides child welfare services or to a law enforcement agency;

(s) The Rural Advisory Board to Expedite Proceedings for the Placement of Children created pursuant to NRS 432B.602 or a local advisory board to expedite proceedings for the placement of children created pursuant to NRS 432B.604; or

(t) The panel established pursuant to NRS 432B.396 to evaluate agencies which provide child welfare services.

2. Except as otherwise provided in subsection 3, data or information concerning reports and investigations thereof made pursuant to this chapter may be made available to any member of the general public if the child who is the subject of a report dies or is critically injured as a result of alleged abuse or neglect, except that the data or information which may be disclosed is limited to:

(a) The fact that a report of abuse or neglect has been made and, if appropriate, a factual description of the contents of the report;

(b) Whether an investigation has been initiated pursuant to NRS 432B.260 ~~[,]~~ and the result of a completed investigation; and

(c) Such other information as is authorized for disclosure by a court pursuant to subsection 4.

3. An agency which provides child welfare services shall not disclose data or information pursuant to subsection 2 if the agency determines that the disclosure is not in the best interests of the child or if disclosure of the information would adversely affect any pending investigation concerning a report.

4. Upon petition, a court of competent jurisdiction may authorize the disclosure of additional information to the public pursuant to subsection 2 if good cause is shown by the petitioner for the disclosure of the additional information.

5. An agency investigating a report of the abuse or neglect of a child shall, upon request, provide to a person named in the report as allegedly causing the abuse or neglect of the child:

(a) A copy of:

(1) Any statement made in writing to an investigator for the agency by the person named in the report as allegedly causing the abuse or neglect of the child; or

(2) Any recording made by the agency of any statement made orally to an investigator for the agency by the person named in the report as allegedly causing the abuse or neglect of the child; or

(b) A written summary of the allegations made against the person who is named in the report as allegedly causing the abuse or neglect of the child. The summary must not identify the person responsible for reporting the alleged abuse or neglect.

6. An agency which provides child welfare services shall disclose the identity of a person who makes a report or otherwise initiates an investigation pursuant to this chapter if a court, after reviewing the record in camera and determining that there is reason to believe that the person knowingly made a false report, orders the disclosure.

7. Any person, except for:

(a) The subject of a report;

(b) A district attorney or other law enforcement officer initiating legal proceedings; or

(c) An employee of the Division of Parole and Probation of the Department of Public Safety making a presentence investigation and report to the district court pursuant to NRS 176.135 or making a general investigation and report pursuant to NRS 176.151,

FLUSH who is given access, pursuant to subsection 1 or 2, to information identifying the subjects of a report and who makes this information public is guilty of a misdemeanor.

8. The Division of Child and Family Services shall adopt regulations to carry out the provisions of this section.

Sec. 4. The provisions of subsection 1 of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 5. This act becomes effective on July 1, 2003.

ASSEMBLY BILL NO. 6–COMMITTEE ON HEALTH AND HUMAN SERVICES

(ON BEHALF OF LEGISLATIVE COMMITTEE ON CHILDREN, YOUTH AND FAMILIES (NRS 218.53723))

PREFILED JANUARY 27, 2003

Referred to Committee on Health and Human Services

SUMMARY—Changes dates by which mental health consortia are required to prepare recommended plans and submit plans to Department of Human Resources and to Legislative Committee on Children, Youth and Families. (BDR 39-693)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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EXPLANATION – Matter in *bolded italics* is new; matter between brackets [~~omitted material~~] is material to be omitted

AN ACT relating to children; changing the dates by which each mental health consortium is required to prepare a recommended plan for the provision of mental health services to certain children and submit the plan to the Department of Human Resources and to the Legislative Committee on Children, Youth and Families; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 433B.335 is hereby amended to read as follows:

433B.335 1. On or before [~~January~~] ***July*** 1 of each year, each mental health consortium established pursuant to NRS 433B.333 shall prepare a recommended plan for the provision of mental health services to emotionally disturbed children in the jurisdiction of the consortium.

2. In preparing the recommended plan, each mental health consortium must be guided by the following principles:

(a) The system of mental health services set forth in the plan should be centered on emotionally disturbed children and their families, with the needs and strengths of those children and their families dictating the types and mix of services provided.

(b) The families of emotionally disturbed children, including, without limitation, foster parents, should be active participants in all aspects of planning, selecting and delivering mental health services at the local level.

(c) The system of mental health services should be community-based and flexible, with accountability and the focus of the services at the local level.

(d) The system of mental health services should provide timely access to a comprehensive array of cost-effective mental health services.

(e) Children and their families who are in need of mental health services should be identified as early as possible through screening, assessment processes, treatment and systems of support.

(f) Comprehensive mental health services should be made available in the least restrictive but clinically appropriate environment.

(g) The family of an emotionally disturbed child should be eligible to receive mental health services from the system.

(h) Mental health services should be provided to emotionally disturbed children in a sensitive manner that is responsive to cultural and gender-based differences and the special needs of the children.

3. The plan prepared pursuant to this section must include:

(a) An assessment of the need for mental health services in the jurisdiction of the consortium;

(b) A description of the types of services to be offered to emotionally disturbed children based on the amount of money available to pay the costs of such mental health services within the jurisdiction of the consortium;

(c) Criteria for eligibility for those services;

(d) A description of the manner in which those services may be obtained by eligible children;

(e) The manner in which the costs for those services will be allocated;

(f) The mechanisms to manage the money provided for those services;

(g) Documentation of the number of emotionally disturbed children who are not currently being provided services, the costs to provide services to those children, the obstacles to providing

services to those children and recommendations for removing those obstacles;

(h) Methods for obtaining additional money and services for emotionally disturbed children from private and public entities; and

(i) The manner in which family members of eligible children and other persons may be involved in the treatment of the children.

4. On or before ~~[January]~~ ***July*** 15 of each year, each mental health consortium shall submit the recommended plan prepared pursuant to this section to the Department. If the Department disapproves the plan, the Department shall submit the plan to the consortium for revision and resubmission to the Department.

5. On or before ~~[January]~~ ***August*** 15 of each year, each mental health consortium shall submit the recommended plan prepared pursuant to this section ***and, if applicable, the revised plan prepared pursuant to subsection 4,*** to the Legislative Committee on Children, Youth and Families established pursuant to NRS 218.53723 and shall submit progress reports to the Legislative Committee on Children, Youth and Families at the end of each calendar quarter.

Sec. 2. NRS 433B.335 is hereby amended to read as follows:

433B.335 1. On or before ~~[January]~~ ***July*** 1 of each year, each mental health consortium established pursuant to NRS 433B.333 shall prepare a recommended plan for the provision of mental health services to emotionally disturbed children in the jurisdiction of the consortium.

2. In preparing the recommended plan, each mental health consortium must be guided by the following principles:

(a) The system of mental health services set forth in the plan should be centered on emotionally disturbed children and their families, with the needs and strengths of those children and their families dictating the types and mix of services provided.

(b) The families of emotionally disturbed children, including, without limitation, foster parents, should be active participants in all aspects of planning, selecting and delivering mental health services at the local level.

(c) The system of mental health services should be community-based and flexible, with accountability and the focus of the services at the local level.

(d) The system of mental health services should provide timely access to a comprehensive array of cost-effective mental health services.

(e) Children and their families who are in need of mental health services should be identified as early as possible through screening, assessment processes, treatment and systems of support.

(f) Comprehensive mental health services should be made available in the least restrictive but clinically appropriate environment.

(g) The family of an emotionally disturbed child should be eligible to receive mental health services from the system.

(h) Mental health services should be provided to emotionally disturbed children in a sensitive manner that is responsive to cultural and gender-based differences and the special needs of the children.

3. The plan prepared pursuant to this section must include:

(a) An assessment of the need for mental health services in the jurisdiction of the consortium;

(b) A description of the types of services to be offered to emotionally disturbed children based on the amount of money available to pay the costs of such mental health services within the jurisdiction of the consortium;

(c) Criteria for eligibility for those services;

(d) A description of the manner in which those services may be obtained by eligible children;

(e) The manner in which the costs for those services will be allocated;

(f) The mechanisms to manage the money provided for those services;

(g) Documentation of the number of emotionally disturbed children who are not currently being provided services, the costs to provide services to those children, the obstacles to providing services to those children and recommendations for removing those obstacles;

(h) Methods for obtaining additional money and services for emotionally disturbed children from private and public entities; and

(i) The manner in which family members of eligible children and other persons may be involved in the treatment of the children.

4. On or before ~~[January]~~ ***July*** 15 of each year, each mental health consortium shall submit the recommended plan prepared pursuant to this section to the Department. If the Department disapproves the plan, the Department shall submit the plan to the consortium for revision and resubmission to the Department.

Sec. 3. 1. This section and section 1 of this act become effective on October 1, 2003.

2. Section 1 of this act expires by limitation on June 30, 2005.

3. Section 2 of this act becomes effective at 12:01 a.m. on July 1, 2005.