Nevada Child & Adolescent State Infrastructure Grant (CA-SIG)

Statewide System of Care Questionnaire

(Data Collection Period July-August 2009)

<u>In Collaboration with:</u>

State of Nevada Department of Health & Human Services:

Division of Child and Family Services

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Executive Summary

Overview

As part of the Statewide System of Care transformation initiative, the Division of Child and Family Services (DCFS) and the University of Nevada Las Vegas, in collaboration with system partners, conducted a statewide *Workforce Development and Cultural Competency Needs Assessment* in the fall of 2007. The overarching purpose of the needs assessment was to gather critical information about the children's behavioral health workforce system in the state of Nevada in order to improve outcomes for children and families by developing an infrastructure to better coordinate services. Specifically, the needs assessment was designed to provide vital information and data useful in supporting the work and activities associated with system transformation efforts. In short, the needs assessment aimed to measure workforce members' perceptions of how children's mental health transformation efforts can be advanced by addressing critical workforce issues.

Although the original intent was to implement a full second *Workforce Development and Cultural Competency Needs Assessment* in 2009, the project director of the Nevada Child and Adolescent State Infrastructure Grant limited the scope of the evaluation to the collection of just the *System of Care Questionnaire* for 2009 because of limited evaluation resources.

Salient Findings

The majority of the workforce reflected in this report serves children who reside in Clark County. The sample comprises professionals who work in the areas of child welfare, mental health, juvenile justice, substance abuse and education; with significantly more substance abuse workers represented in the 2009 assessment than there were in the 2007 assessment. Many of the respondents are case managers or therapists/clinicians but the sample also included nearly 40% managers/administrators. Nearly half of the respondents possess graduate degrees and the majority are licensed practitioners. In both the 2007 and the 2009 assessments, a third of the sample report being in their current positions for only 1-3 years (this is especially the case with the child welfare workforce) but 68% and 54% of the workforce in 2009 and 2007, respectively have been in the field of social services for more than 10 years.

Multiple System of Care indicators were captured in the 2007 and the 2009 assessments but given the comprehensive efforts of the Nevada CA-SIG in workforce development (especially training) post 2007, two important discoveries are highlighted in this summary: (1) System of Care training; and (2) System of Care adherence. In 2007 (baseline measure) half of the workforce (n = 239) sampled reported that their System of Care involvement had only been for less than three years. Also, more than half of the sample reported never having been trained in System of Care. In 2009 only one-third of the sampled workforce (n = 232) reported that their System of Care involvement was less

than three years and during the repeat measurement period, less than half of the workforce reported having never been trained in System of Care. It should be noted that those workforce members who work in children's mental health are most likely to have received System of Care training. Conversely, a significant majority of those workforce members who report receiving no training in System of Care comprise the child welfare and juvenile justice staff.

In terms of the extent to which System of Care is being implemented in the workplace and the community, in 2007 only two areas of strength could be identified: (1) effective collaboration at the child and family level; and (2) efficiency in service provisions. In 2009, the workforce noted more areas of strength. Improvements from baseline to the repeat measurement period were noted in: (1) communication and information dissemination; (2) cultural competency; and (3) organizational support. Like the findings concerning System of Care training, it is the mental health workforce (versus the child welfare and juvenile justice) that reports the highest System of Care adherence scores.

The way in which a workforce member perceives and experiences the System of Care in Nevada differs somewhat based on his/her socio-demographic characteristics. For example, it is the Washoe County workers' (as opposed to the Clark and Rural County workers) perception that there is more community support for System of Care in their area. This is also true with respect to family advocacy and support; whereby, the Washoe County workforce reports higher levels of activities than do the Clark County workforce members. In terms of communication and information dissemination, the Washoe and the Clark County workforce perceive this aspect of the Nevada System of Care more favorably than do the Rural County workforce.

Clinicians/therapists are less likely than any other position type (including administrators) to have a perception that community supports are adequate. Moreover, workers who have been in their positions 7-9 years perceive greater collaboration at the system level than do those who have been in their positions more than 10 years. Likewise, it seems that those workers who have been in their positions for only 3-5 years perceive there to be higher levels of efficiency in service provisions than workers who have been on the job for long periods of time (more than 5 years).

In short, from the baseline to the follow-up measurement period tremendous strides have been made in System of Care training and adherence. Where the opportunities for growth still remain appear to be in the child welfare and juvenile justice systems and among those workforce members who have longer job tenures. Nonetheless, the vast workforce development work that took place from the baseline to the follow-up measurement period has yielded significant gains in the areas of collaboration at the child and family level, efficiency in service provisions, communication and information dissemination, cultural competency, and organizational support.

Chapter One: History and Background

2007 Workforce Development and Cultural Competency Needs Assessment

As part of the Statewide System of Care transformation initiative, the Division of Child and Family Services (DCFS) and the University of Nevada Las Vegas, in collaboration with system partners, conducted a statewide Workforce Development and Cultural Competency Needs Assessment in the fall of 2007. The overarching purpose of the needs assessment was to gather critical information about the children's behavioral health workforce system in the state of Nevada in order to improve outcomes for children and families by developing an infrastructure to better coordinate services. Specifically, the needs assessment was designed to provide vital information and data useful in supporting the work and activities associated with system transformation efforts. In short, the needs assessment aimed to measure workforce members' perceptions of how children's mental health transformation efforts can be advanced by addressing critical workforce issues.

2007 Instrumentation

Three evaluation methods were used in collecting the 2007 needs assessment data.

1. ***Survey*** which included five system-readiness tools in which the workforce (Division of Child and Family Services, Partner and Provider) staff and supervisors participated. The five readiness tools were:
    a. Socio-demographic Questionnaire;
    b. System of Care (SOC) Questionnaire by James Cook (University of North Carolina)
    c. Organizational Social Context (OSC) Measurement System by Charles Glisson and Tony Hemmelgarn (University of Tennessee);
    d. Evidence-Based Practice Attitude Scale (EBPAS) by Gregory Aarons (San Diego State University)
    e. Minnesota Organizational Self Assessment by the Minnesota Department of Human Services (relating to cultural competence).
2. ***Focus groups*** in which workforce staff participated.
3. ***One-on-One interviews*** in which workforce supervisors, managers and formal and informal leaders participated.

2009 Follow-Up Measure Regarding System of Care

Although the original intent was to implement a full second *Workforce Development and Cultural Competency Needs Assessment* in 2009, the scope of the evaluation had to be limited to the collection of just the System of Care Questionnaire for 2009 because evaluation resources had been exhausted.

Chapter Two: Conceptual Approach & Review of Selected Literature

The Role of a System of Care (SOC)

There is a national effort to address system transformation through the implementation of a service philosophy called System of Care (SOC). A System of Care aims at creating an overall structure of practices in order to facilitate effective delivery of services (Huang, Stroul, Friedman, Mrazek, Friesen, Pires & Mayberg, 2005). Moreover, in November of 2007 the Nevada Children's Behavioral Health Consortium approved a definition of System of Care that is intended to act as a framework for this group's planning and decision making process (Appendix A). Additionally, this group is currently engaged in efforts to have child serving agencies, organizations and service providers officially commit to the System of Care philosophy of service delivery (Appendix B).

According to Huang et al. (2005), "core values and principles guide service delivery to children and families" (p. 616). To this effect, the System of Care model defines principles to guide the organizational structure of an integrated service delivery system. These System of Care principles include three major elements or core values, which are:

1. A System of Care should be child-centered and family driven, with the needs of the child and family dictating the types and mix of services provided;
2. A System of Care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level;
3. A System of Care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

A System of Care approach provides service and support requirements for families from a holistic standpoint and thus, is non-categorical. A System of Care crosses agency and program boundaries and adopts a population focus across systems (Pires, 2002). For example, a System of Care approach bridges the gap between professional service providers and families, in addition to the gaps between agencies (Huang et al. 2005). Optimally, a single plan of care is developed that reflects the unique needs of the child.

Children and youth who have emotional disturbances have specific needs in many areas of their lives such as their homes, schools, and their communities. Assuring quality outcomes for these children and families requires the integration of the various community based child-serving systems to collaborate effectively and in an integrated way. The basic premise of providing care in this way is to redirect resources from institutional levels of care and to put them into local programs of care and support, as well as improving service planning, delivery and evaluation across departments (Pires, 2002).

Thus, a System of Care promotes a service delivery system, including mandated child-serving agencies, private service providers as well as informal resources available within the community, as well as the organization of these systems.

Chapter Three: 2007 System of Care Questionnaire Findings

Half of the 2007 sample (N = 239) reported their involvement with System of Care initiatives to be less than three years. Additionally, more than half of the workforce reported having never been trained in the implementation of System of Care, and more than 80% of the workforce want more training in System of Care.

In using a "moderate level of agreement" as the threshold by which to assess the extent to which the workforce felt as though the principles and practices of System of Care were being implemented in their workplace, five implementation areas were worthy of attention: (1) community support, (2) communication and information dissemination, (3) collaboration at the system level, (4) clarity of mission and purpose and (5) availability and use of community-based services. Conversely, the workforce identified its strengths with respect to the implementation of System of Care to be in two areas: (1) effective collaboration at the child and family team level; and (2) efficiency in service provisions.

More Context for the System of Care Findings

In analyzing the effects of socio-demographics (i.e., workforce profile) on System of Care findings a one-way analysis of variance was used. Salient findings include the following:

- ***Caseload Size***. Respondents with a caseload size exceeding 40 had significantly lower means on several of the System of Care adherence and implementation scales including: organizational support, communication and information dissemination, efficiency in service provision, family focused service provision, and collaboration. Similarly, those workers with caseload sizes of 20 plus have significantly low mean scores on System of Care practices and principles.
- ***Location.*** Clark and Washoe Counties were significantly higher than the rural counties for "Organizational Support" and "Collaboration," but there was no significant variation between Clark and Washoe Counties.
- ***Position Type***. Supervisors were more likely to agree than the caseworkers that there is collaboration, high degree of family advocacy and support and efficiency in service delivery. Likewise therapists were more likely than case managers to report higher degrees of organizational support.
- ***Area of Employment.*** For both Mental Health and Child Welfare, "family focused service" was significantly higher than Juvenile Justice. Organizational Support was significantly higher for Mental Health than Child Welfare.
- ***Years in Social Services.*** Decision-making was significantly higher for those working 1 to 3 years than all the other categories. In other words, workforce members who have been in the field for the shortest amount of time are more likely than those with a longer tenure to perceive that decision making is shared among parents, workers, leadership, staff and among child and family serving agencies.

Chapter Four: Methodology

2009 System of Care Questionnaire Participants

As the 2007 needs assessment planning process unfolded, it became clear that to capture the critical data elements of what was being considered "workforce", a broader view than that of the Division of Child and Family Services line-level workers would be required. Thus, "workforce" was defined as the following:

1. A cross-system approach that included partner (e.g., child welfare, juvenile justice, school district, state-funded service providers) and provider agencies (e.g., therapeutic foster care agencies and/or clinical staff representatives from various provider network agencies, private-practice clinicians).
2. A cross-position approach that included line-level workers, supervisors, administrators/leadership.

Thus, the 2009 System of Care Questionnaire sampling frames consisted of:

1. Division of Child and Family Services staff, supervisors and managers;
2. Partner agencies staff, supervisors, and managers (e.g., child welfare, juvenile justice, school district, state-funded service providers);
3. Provider agencies staff, supervisors, and managers (e.g., therapeutic foster care agencies and/or clinical staff representatives from various provider network agencies, private-practice clinicians); and
4. Leadership Groups (e.g., child and family-serving agencies administrators, community advocacy groups, political representatives).

Sampling Frames

The University of Nevada, Las Vegas Research/Evaluation Staff obtained sampling frames from the Child and Adolescent State Infrastructure Grant (CA-SIG) Workgroup team and e-mailed recruitment invitations to workforce members to participate in the on-line System of Care Questionnaire. These developed sampling frames consisted of the following:

Clark County Sampling Frame

- Division of Child and Family Services sampling frame consisted of over 200 staff, supervisors, and managers.
- Partner/Provider sampling frame consisted of over 700 staff, supervisors, and formal and informal leaders.

Carson City Sampling Frame

- Division of Child and Family Services sampling frame consisted of over 30 staff, supervisors, and managers.
- Partner/Provider sampling frame consisted of over 30 staff, supervisors and formal and informal leaders.

Reno Sampling Frame

- Division of Child and Family Services sampling frame consisted of over 50 staff, supervisors, and managers.
- Partner/Provider sampling frame consisted of over 200 staff, supervisors and formal and informal leaders.

Elko and other Rural areas Sampling Frames

- Division of Child and Family Services sampling frame consisted of over 20 staff, supervisors and managers.
- Partner/Provider sampling frame consisted of over 20 staff, supervisors and formal and informal leaders.

Instrumentation

Survey research via an on-line link was the evaluation method used to collect demographic information and the System of Care Questionnaire data.

Instrumentation: Socio-Demographic Questionnaire

The Socio-Demographic Questionnaire consists of 16 questions that survey important respondent profile information and takes approximately five minutes to complete (Appendix C). All questions were asked in a multiple choice format where respondents checked the box next to the most accurate response. For instance, participants were asked to identify their Race/Ethnicity from a list: Black, Hispanic, White, Asian/Pacific Islander, Native American, or other. Where the 'other' response was an option, it appeared as "Other: (Specify)_________", and participants would fill in the blank. In addition to gathering age, gender, and race/ethnicity, the Socio-Demographic Questionnaire also gathered: area of employment, position in current agency, bilingualism, type of residence, educational background, practitioner license type, years at agency, and years in current position.

Instrumentation: System of Care (SOC) Questionnaire

The System of Care (SOC) questionnaire was developed to measure respondents' perception of the extent to which System of Care practices and principles are adhered to and implemented in agency settings (Appendix D). The questionnaire is comprised of 70 questions and takes approximately 20 minutes to complete. The questions utilized a five point Likert scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly agree with a Don't Know (DK) option. The System of Care (SOC) questionnaire uses seven subscales to assess the following aspects of a System of Care:

- Organizational Support Subscale
- Community Support Subscale
- Family Advocacy Support Subscale
- Communication and Information Dissemination Subscale
- Inter agency Collaboration Subscale
    - The Decision Making
    - Collaboration at the Systems Level
    - Collaboration at the Child and Family Team Level
    - Efficiency in Service Provision
- Membership Subscale

- Clarity of Mission or Purpose Subscale
    - Mission
    - Community-Based Services
    - Family Focused Service Provision
    - Cultural Competence
- The Family-Focused Service Provision Subscale
- The Cultural Competence Subscale

<u>Data Collection</u>

Before any data was collected, participants were emailed an invitation asking if they would be willing to participate in completing the System of Care Questionnaire on-line. The emailed invitation and an attached informed consent discussed the methods employed to safeguard the participants' confidentiality and identity during their participation in the survey as well as providing some detail about the purpose, use, and history of the System of Care Questionnaire. There was an additional attachment that described Nevada's definition of System of Care. If participants were interested in completing the on-line survey, they clicked on the supplied link which opened up the survey on their computer's web browser.

In keeping with the requirements of the University of Nevada Las Vegas's Institutional Review Board and observing human subject protection and safety protocol, the following themes were continually reinforced in the invitation and informed consent:

- Participation was voluntary and all individual quantitative survey responses would be kept confidential.
- No identifiable information would be used in report writing as well as data would be presented in aggregate form, emergent trends and common themes methods.
- UNLV Research/Evaluation staff proctored the data collection area at all times and was available to answer any questions and field any concerns voiced by the participants.

<u>Respondent Sampling Frames</u>

A total of 232 surveys were collected from the following areas:

- 147 from Clark County
- 53 from Washoe County
- 32 from the rural counties

<u>Analysis</u>

Analysis: Demographic Questionnaire

A statistical profile of the respondents' socio-demographic characteristics was created by computing descriptive statistics (frequencies and percents) for the 16 items of the survey. A second analysis was performed that delineated the respondents by mental health, child welfare and juvenile justice.

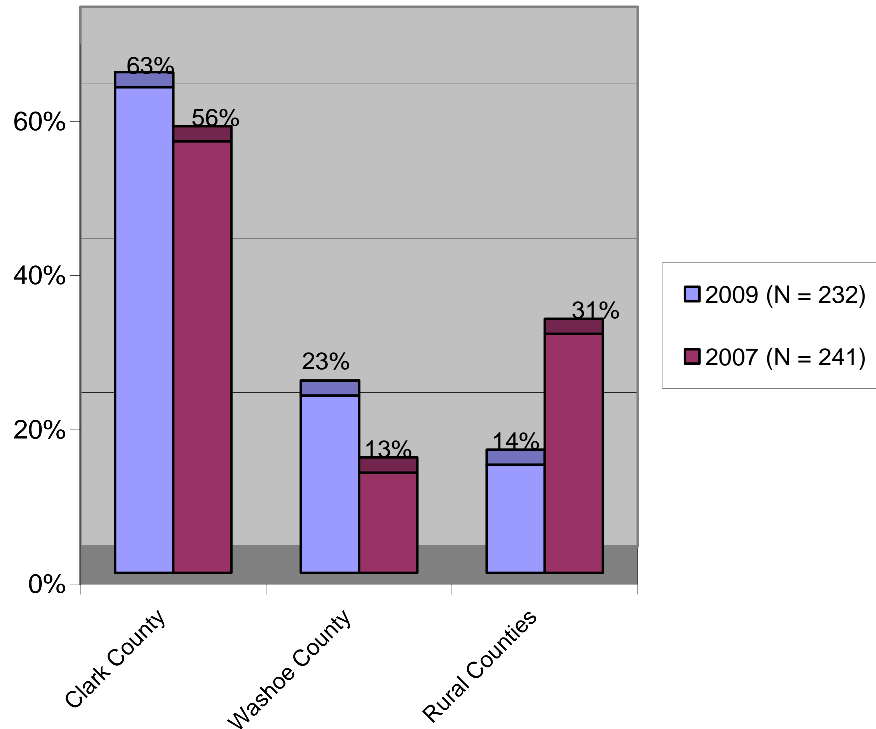
Analysis: System of Care Questionnaire

The first part of this survey consisted of 13 subscales (already noted in the instrumentation section of this chapter) of which a mean score was computed for each subscale. The second part of this survey was an informational questionnaire. The items in this section were computed using descriptive statistics (frequencies and percents). A second analysis was performed where the appropriate means and frequencies were further delineated by respondent type (mental health, child welfare, and juvenile justice). Analyzing the effects of demographics on the scales generated from the System of Care Questionnaire required a measure that could accept both ordinal and categorical variables. We selected a measure that is fairly robust and relatively easy to understand. For this reason, a one-way analysis of variance with a Bonforanni Post Hoc analysis was used. From this a significant variation between categories could be determined, and in most cases which differences between categories were significant. This approach is very broad, and it allowed a focus on comparisons of interest.

Chapter Five: Demographic Findings

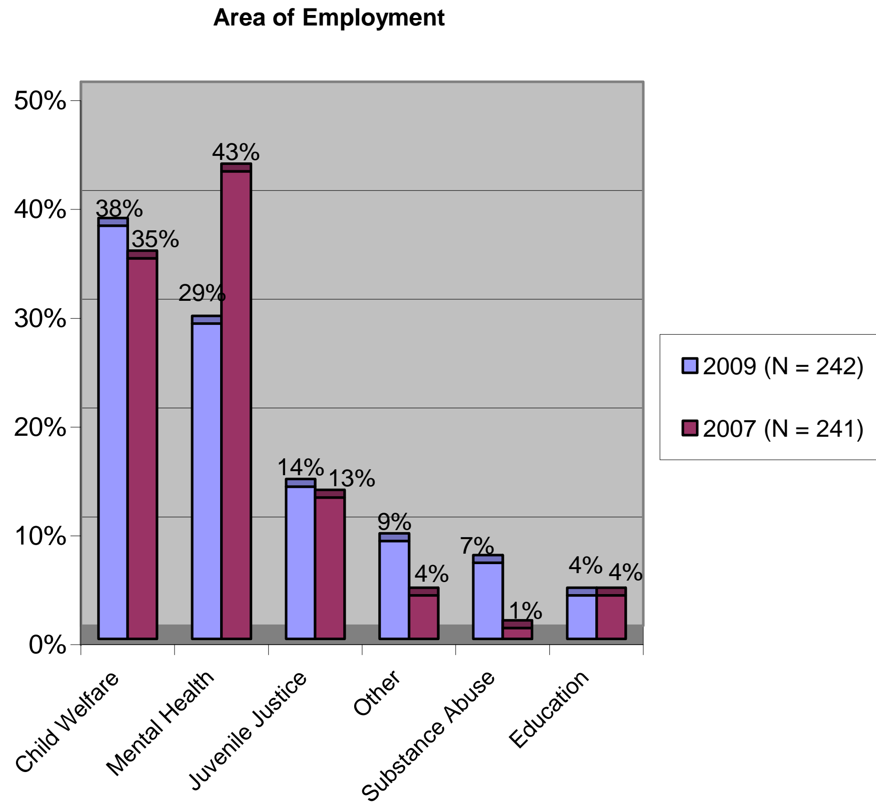
Socio-Demographic Questionnaire

What area best describes where the population is that you serve?



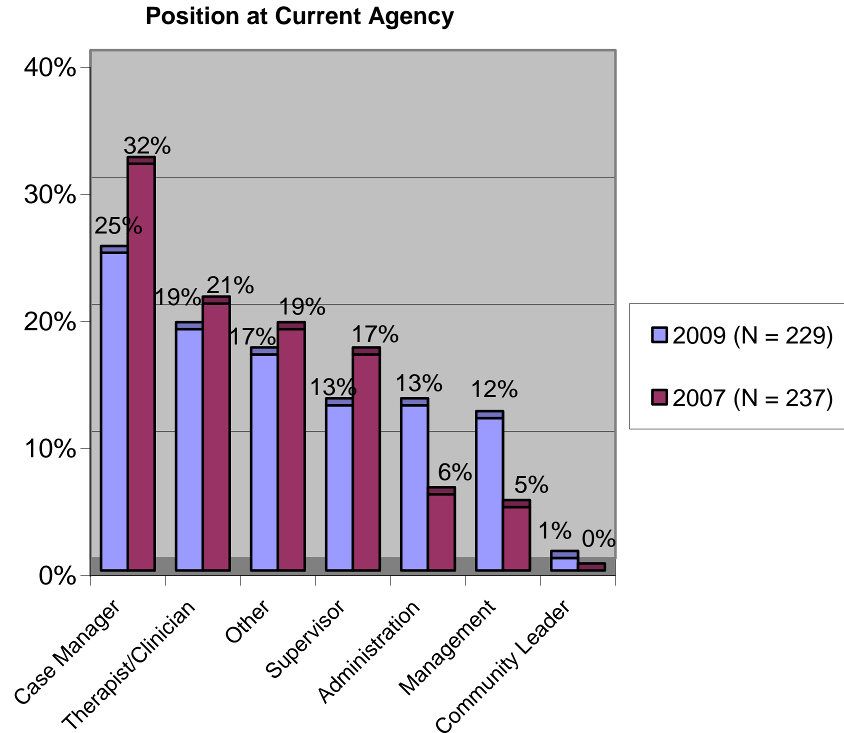
Sixty-three percent (63%) of the respondents from the 2009 sample serve children and adolescents in Clark County (N = 147); this was the highest occurrence. Twenty-three percent (23%) reported that the population they serve is in Washoe County (N = 53) and 14% noted their clients as living in rural counties (N = 32). Data is provided from the 2007 baseline as reference throughout the demographic section.

Area of employment



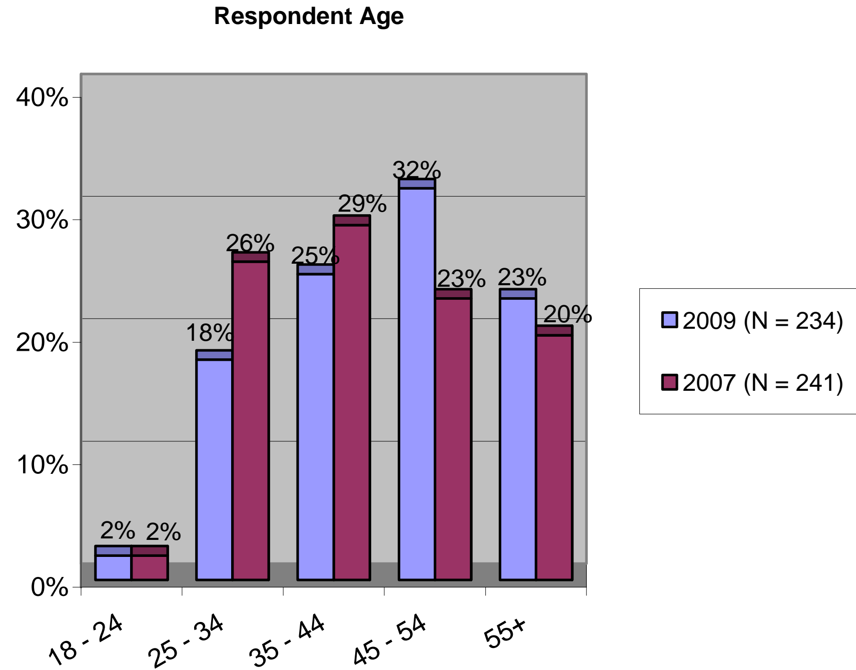
From the 2009 sample, 38% of the respondents indicated that they work in the area of child welfare (N = 96), followed by 29% that work in mental health (N = 75). Fourteen percent (14%) indicated that they work in the area of juvenile justice (N = 36), 7% indicated substance abuse, 4% indicated education (N = 9), and 9% reported some "other" area (N = 23). These other areas include family advocacy/family support organizations (N = 10), developmental services (N = 3), non-profits (N = 2), public health (N = 1), suicide prevention (N = 1), Division of Welfare (N = 1), and domestic violence (N = 1).

Position at current agency



Many of the 2009 survey respondents (25%) indicated that they are employed as case managers (N = 58) with their current agencies. This was followed by 19% who are therapists or clinicians (N = 43). Thirteen percent (13%) are in administration (N = 29), another 13% report that they are supervisors (N = 30), and 12% indicate management (N = 28). One percent (1%) report that they are community leaders (N = 2). Seventeen percent (17%) indicated that they are employed in some "other" area (N = 39) that includes juvenile probation (N = 6), advocate/family member (N = 4), family support (N = 4), mental health technician (N = 2), placement specialist (N = 2), mental health technician (N = 2), commission member (N = 2), program coordinator (N = 2), physician (N =2), "adolescent counselor", "analyst", "child development", "foster care liaison", "foster care licensing", "line staff", "nursing supervisor", "social worker", and "technical assistance".

Respondent Age

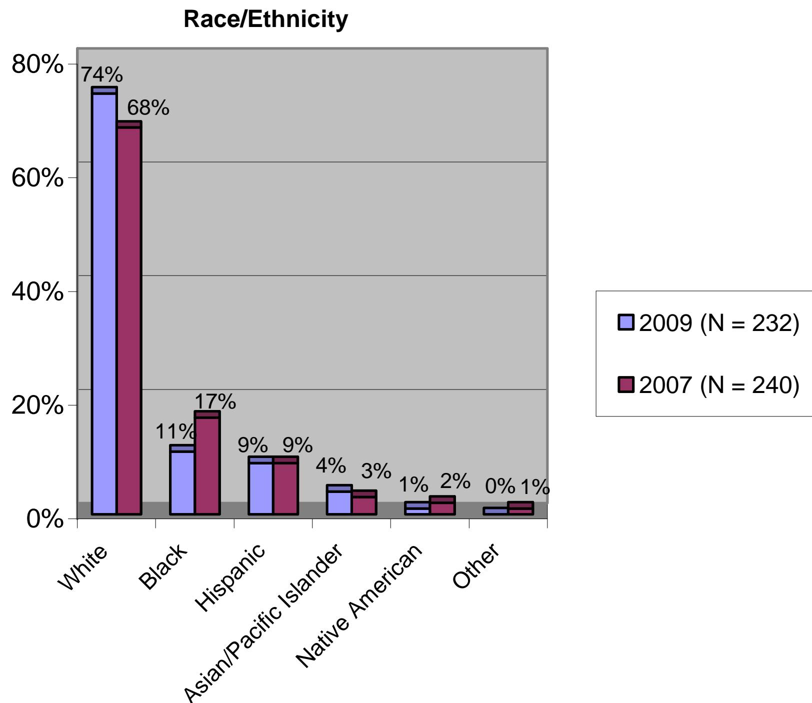


Thirty two percent (32%) of the 2009 respondents indicated that they are between the ages of 45 and 54 (N = 74). This was the highest occurrence. Twenty five percent (25%) are between the ages of 35 and 44 (N = 59) and 23% are in the upper age stratum which is age 55+ (N = 53). Eighteen percent (18%) of the respondents are between the ages of 25 and 34 (N = 43), and 2% (N = 5) are in the lowest age stratum (18 – 24).

Gender:

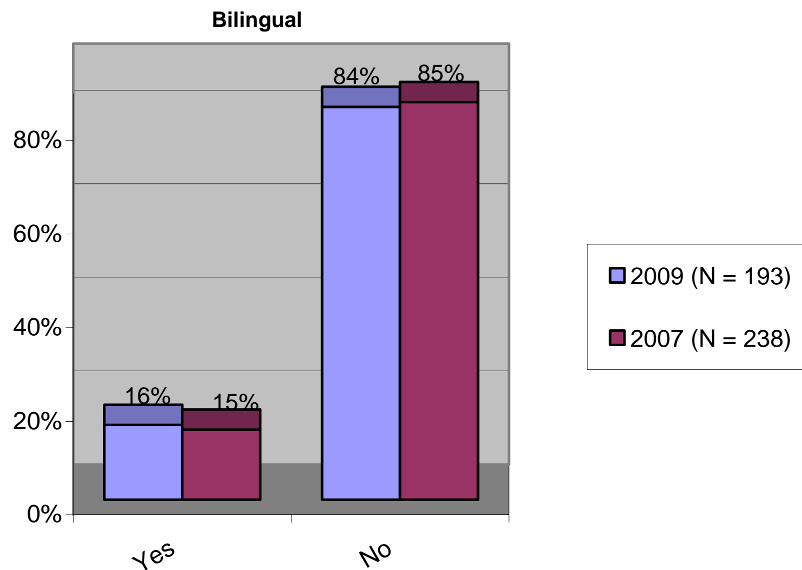
- 24% male (N = 58)
- 76% female (N = 181)

Race/Ethnicity



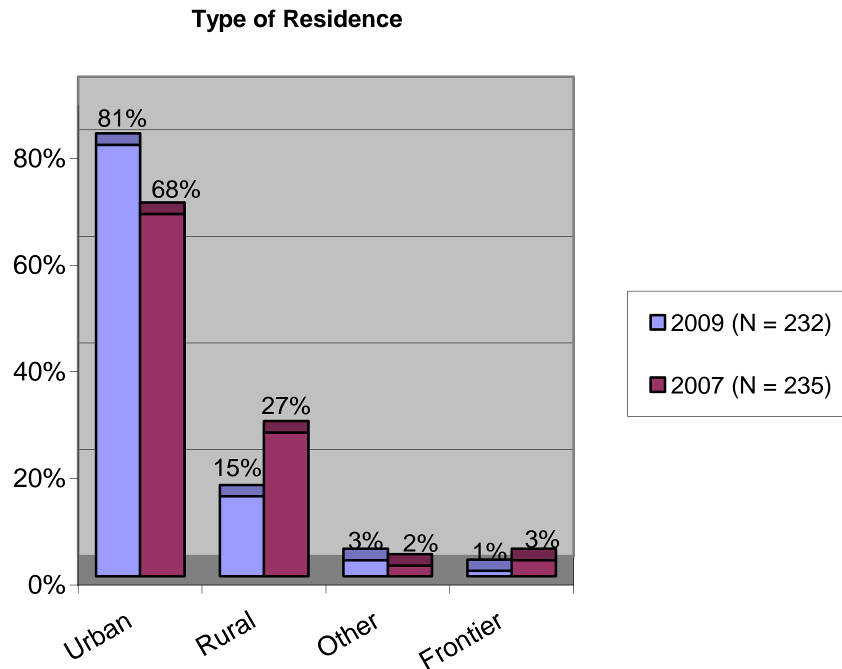
Seventy-four percent (74%) of the 2009 respondents indicated that they are white (N = 172). Eleven percent (11%) are Black (N = 26), while 9 percent are Hispanic (N = 20), 4% are Asian or Pacific Islander (N = 10), and 1% are Native American (N = 3).

Language



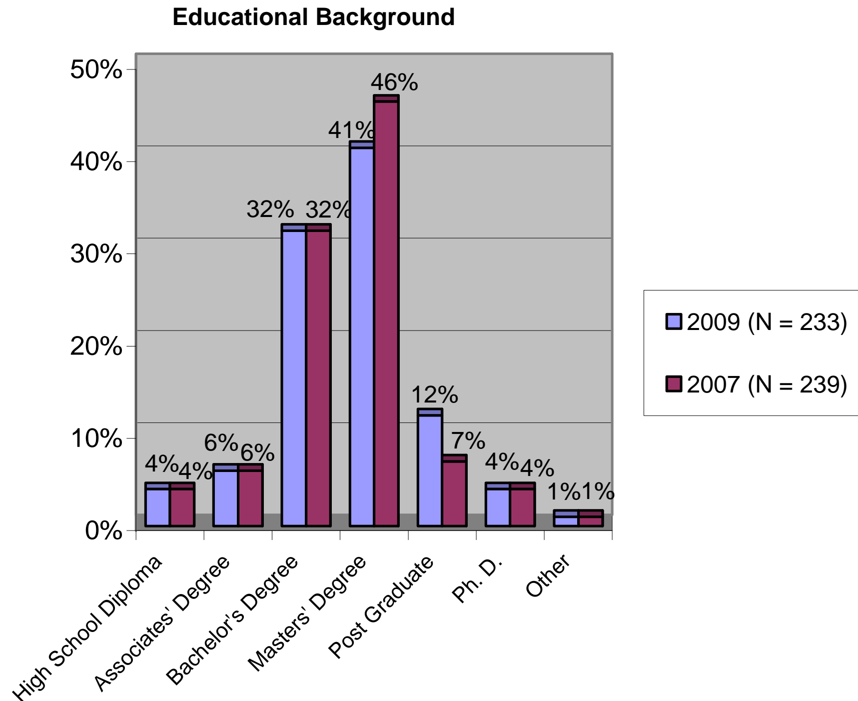
For the 2009 sample, 16% of the respondents indicated that they are bilingual. This represents 30 of the 193 members that answered this question. Respondents were asked to define which languages they could speak fluently. Six languages other than English were mentioned, however, Japanese, Italian, Russian, and Serbian were each only mentioned once. Spanish was mentioned by 15 respondents (67% of the subset that indicated fluency in a second language) and French mentioned by 3 respondents (14% of the subset who indicated fluency in a second language). All 30 of the respondents who indicated that they are fluent in a language other than English reported that they use their bilingual skills in their workplace. Fifty three percent (53%) noted that they use their bilingual skills for translation services (N = 16) and another 53% reported using them for interpreter services (N = 16). Twenty-seven (27) respondents indicated that they use Spanish for bilingual services at the place of employment. Other languages mentioned were Tagalog, with French and Russian mentioned by one respondent each.

Type of Residence



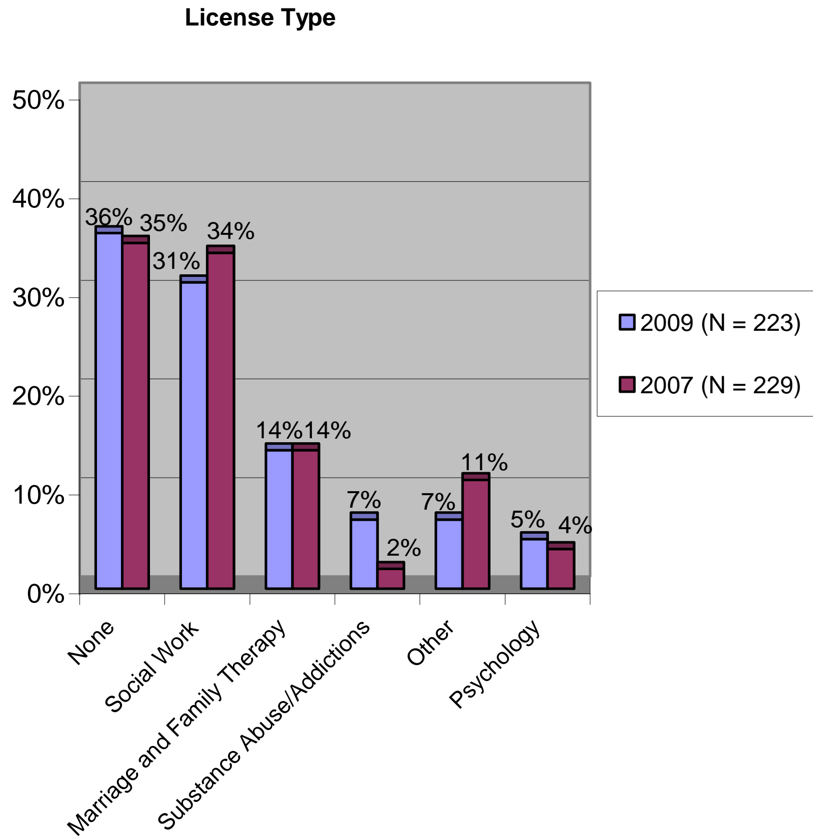
A predominance of the 2009 respondents (81%) indicated that they live in an urban residence (N = 188), while 15% live in a rural residence (N = 34), 1% live in a frontier residence (N = 3) and 3% live in some "other" type of residence (N = 7).

Educational Background



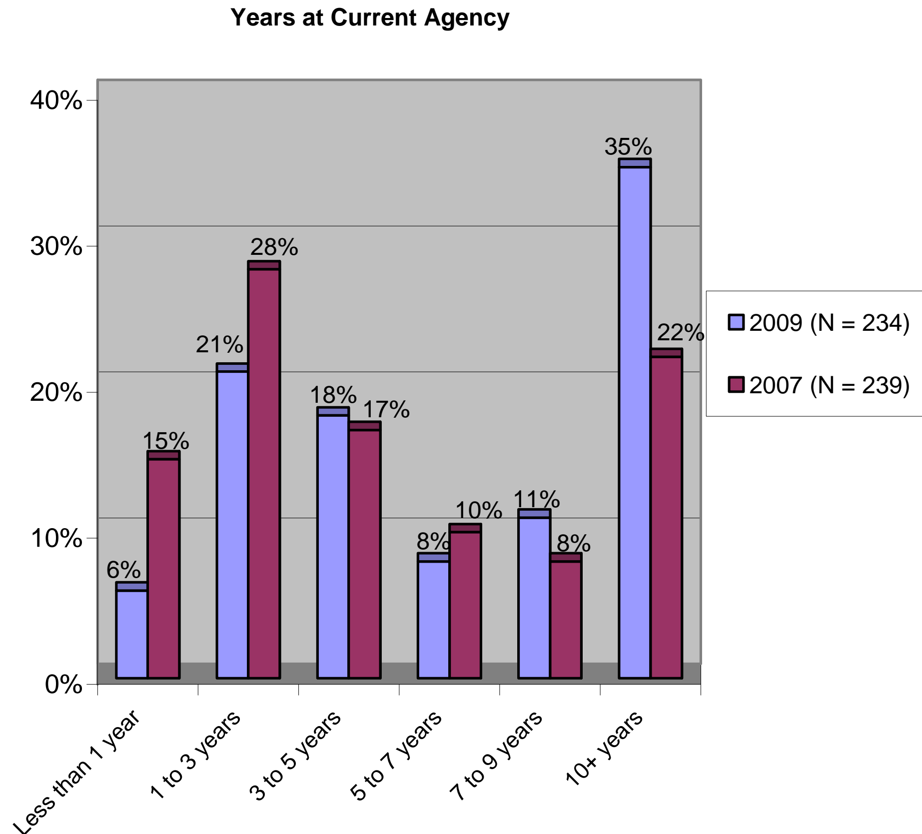
Most of the 2009 respondents (41%) indicated that they have earned a Masters' degree (N = 95). This was followed by 32% who have attained a Bachelors' degree (N = 75). Twelve percent (12%) have earned a post graduate degree (N = 27) and 6% have earned an Associates' degree (N = 14). Four percent (4%) have a PhD (N = 10), another 4% have a high school diploma (N = 10), and 1% indicated that they have some "other" (N = 2) degree that includes two respondents with medical degrees.

Practitioner License Type



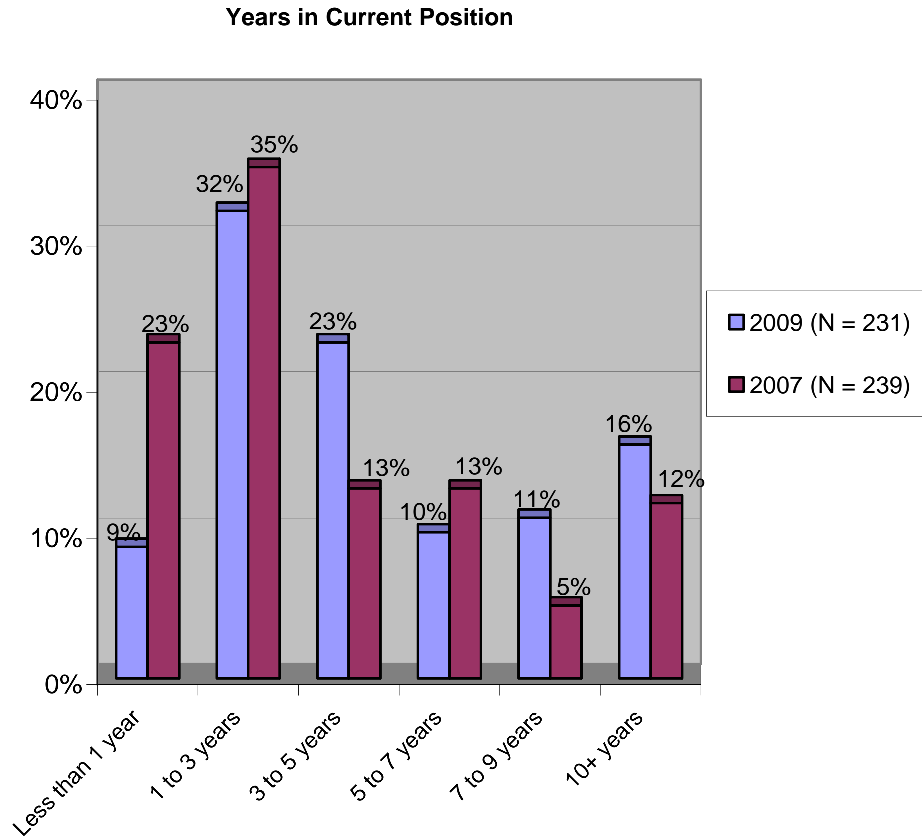
Thirty-six percent (36%) of the 2009 respondents do not have any kind of license (N = 87), while 31% indicated that they have a social work license (N = 73). Fourteen percent (14%) have a marriage and family therapy license (N = 33), while 7% have a substance abuse license (N = 19) and 5% have a psychology license (N = 11). Seven percent (7%, N = 18) indicated that they have some other type of license that includes nursing (N = 3), education (N = 2), MD (N = 2), "clinical professional counselor" (N = 3), "administration", "art therapy", "certified mental health technician", "occupational therapist", and "law enforcement".

Years at Current Agency



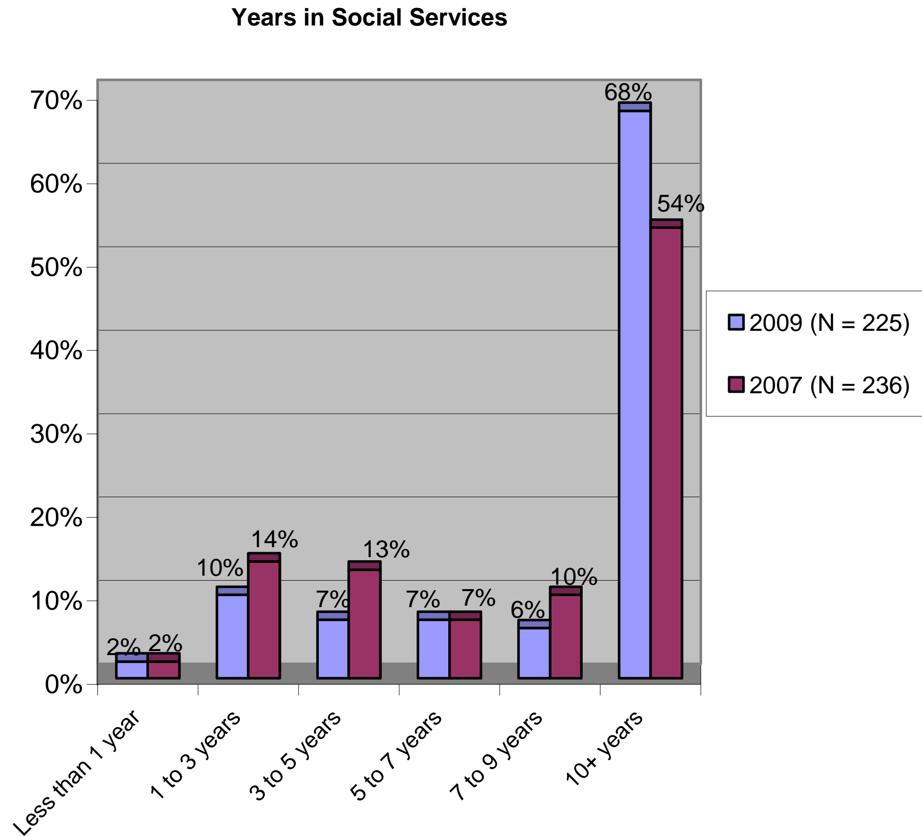
Thirty five percent (35%) of the 2009 respondents have been with their current agencies for ten (10) years or longer (N = 84); this was the highest occurrence. Twenty one percent (21%) have been with their agencies one (1) to three (3) years (N = 50), followed by 18% who have been with their agencies for three (3) to five (5) years (N = 42). Eleven percent (11%) have been with their current agencies between (7) and nine (9) years (N = 25), 8% between five (5) and seven (7) years (N = 19), and 6% have been with their current agency for less than a year (N = 14).

Years in Current Position



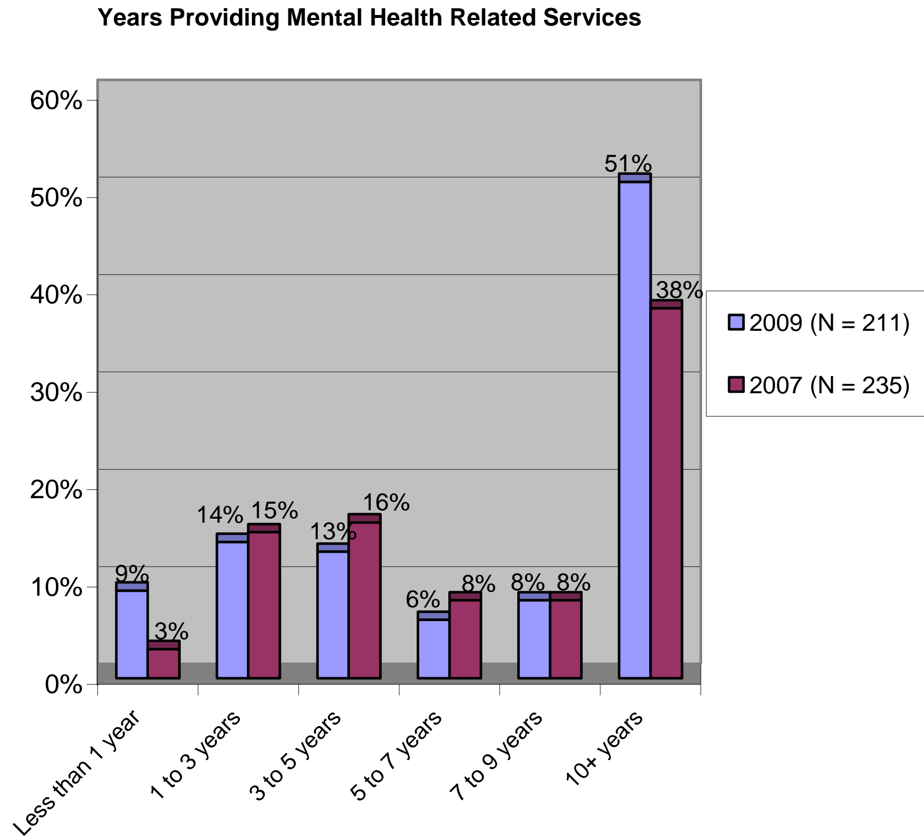
Almost a third (32%) of the 2009 respondents indicated that they have been at their current positions for one (1) to three (3) years (N = 73); this was followed by 23% who have been at their current position for three (3) to five (5) years (N = 53). Sixteen percent (16%) have been at their current position for more than ten (10) years (N = 36), 11% have been at their current position for seven (7) to nine (9) years (N = 25), and 10% have been at their current position for five (5) to seven (7) years (N = 24). Nine percent (9%) report having been at their position less than a year (N = 20).

Years in Social Services Field



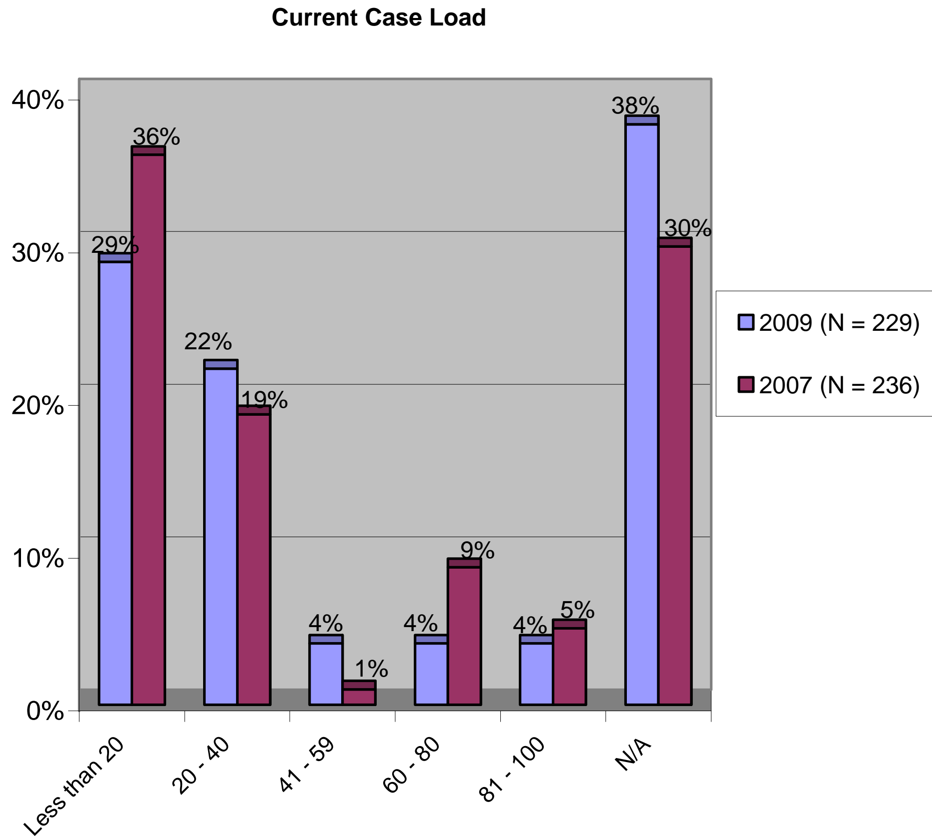
Approximately two-thirds (68%) of the 2009 respondents have spent ten (10) years or longer in the field of social services (N = 154). This was the highest occurrence. Ten percent (10%) have been in the field for one (1) to three (3) years (N = 23), 7% have been in the social services field for three (3) to five (5) years (N = 15), followed by another 7% that have been in the field for five (5) to seven (7) years (N = 16). Six percent (6%) have been in the field of social services for seven (7) to nine (9) years (N = 13), and only 2% have been in the field for less than a year (N = 4).

Years Provided Children's Mental Health Related Services



Respondents were asked to quantify how many years they had provided children's mental health related services. The highest occurrence for 2009 was the 51% who had been doing so for ten (10) years or longer (N = 108). Fourteen percent (14%) have been doing so for one (1) to three (3) years (N = 29), followed by 13% who have been doing so for three (3) to five (5) years. Nine percent (9%) have been doing so for less than a year (N = 18), 8% have been doing so for seven (7) to nine (9) years (N = 16), while 6% for five (5) to seven (7) years (N = 18).

Current Case Load



Respondents were asked to quantify their current case load and for more than a third (38%) this was not applicable (N = 88). However, 29% indicated that their case load was less than 20 (N = 66), while 22% have a caseload of between 20 and 40 clients (N = 51). Four percent (4%) have a caseload of between 41 and 59 clients (N = 8), another 4% have 60 to 80 clients (N = 8), and another 4% have 81 to 100 clients (N = 8).

Demographic Questionnaire by Respondent Type

From the 2009 sample, 38% of the respondents indicated that they work in the area of child welfare (N = 96) and 29% work in mental health (N = 75). Fourteen percent (14%) indicated that they work in the area of juvenile justice (N = 36), 7% indicated substance abuse, 4% indicated education (N = 9), and 9% reported some other area (N = 23). These other areas include family advocacy/family support organizations (N = 10), developmental services (N = 3), non-profits (N = 2), public health (N = 1), suicide prevention (N = 1), Division of Welfare (N = 1), and domestic violence (N = 1). In the following section the data will be displayed by the three main groups; child welfare, mental health and juvenile justice.

Respondent Location

Location	2009 (N = 193)				2007 (N = 218)		
	Child Welfare (N = 91)	Mental Health (N =70)	Juvenile Justice (N = 32)		Child Welfare (N = 85)	Mental Health (N = 102)	Juvenile Justice (N = 31)
Clark County	65%	61%	88%		59%	57%	48%
Washoe County	26%	21%	3%		9%	21%	3%
Rural	9%	17%	9%		32%	23%	48%
Total	100%	100%	100%		100%	100%	100%

When looking at the 2009 respondents that work in child welfare, 65% (N = 59) are from Clark County, 26% (N = 24) are from Washoe County, and 9% (N = 8) are from the rural counties. Among mental health workers 61% (N = 43) are from Clark County, 21% (N = 15) are from Washoe County, and 17% (N = 12) are from the rural counties. Eighty-eight percent (88%) of the juvenile justice workers are from Clark County (N = 28), and 9% are from the rural counties (N = 3). Three percent (3%) of the juvenile justice workers are from Washoe County; this represents only one (1) respondent. Again, as in the previous section, data from the 2007 baseline is provided as reference.

Position at Current Agency

Position	2009 (N = 191)				2007 (N = 216)		
	Child Welfare (N = 91)	Mental Health (N = 70)	Juvenile Justice (N = 30)		Child Welfare (N = 84)	Mental Health (N = 101)	Juvenile Justice (N = 31)
Case Manager	**53%**	**4%**	**13%**		**50%**	**18%**	39%
Supervisor	**12%**	**16%**	**17%**		**18%**	**16%**	16%
Administration	**7%**	**11%**	**13%**		**7%**	**2%**	3%
Therapist/Clinician	**3%**	**46%**	**13%**		**5%**	**43%**	7%
Management	**6%**	**14%**	**13%**		**4%**	**7%**	7%
Community Leader	**1%**	**0%**	**0%**		**1%**	**0%**	0%
Other	**19%**	**9%**	**30%**		**16%**	**15%**	29%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the positions from the 2009 sample in which child welfare workers are employed at their current agencies, 53% (N = 48) are working as case managers. This is the highest occurrence for child welfare workers and is followed by 12% (N = 11) who are currently employed as supervisors at their current agencies. Among other positions held by child welfare workers, 7% (N = 6) are administrators, 3% (N = 4) are therapists/clinicians (N = 3), 6% are in management (N = 5), 1% define themselves as community leaders (N = 1), and 19% (N = 17) work in some other position.

Among those working in mental health, most (46%) are working as therapist/clinicians (N = 32). This was followed by 16% who are supervisors (N = 11) and 14% who are working in management (N = 10). Eleven percent (11%) identify themselves as administrators (N = 8), 4% as case managers (N = 3), and 9% reported some “other” position (N = 6).

Seventeen percent (17%) of the juvenile justice workers are currently working as supervisors (N = 12). This was followed by 13% (N = 4) who are administrators, another 13% who are case managers (N = 4), another 13% who are therapists/clinicians (N = 4), and another 13% who are managers (N = 4). Thirty percent (30%) of the juvenile justice respondents identify their position as “other” (N = 9).

Respondent Age

Age	2009 (N = 195)				2007 (N = 219)		
	Child Welfare (N = 92)	Mental Health (N = 71)	Juvenile Justice (N = 32)		Child Welfare (N = 85)	Mental Health (N = 103)	Juvenile Justice (N = 31)
18 - 24	**2%**	**4%**	**0%**		**2%**	**0%**	10%
25 - 34	**33%**	**6%**	**25%**		**32%**	**25%**	29%
35 - 44	**28%**	**27%**	**16%**		**34%**	**21%**	36%
45 - 54	**23%**	**32%**	**41%**		**21%**	**26%**	10%
55 and older	**14%**	**31%**	**19%**		**11%**	**27%**	16%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Among child welfare workers from the 2009 sample, about a third (33%, N = 30) indicated that they are between the ages of 25 and 34, and 28% (N = 26) are between the ages of 35 and 44. Twenty-three (23%) percent (N = 21) are between the ages of 45 and 54. Fourteen percent (14%, N = 13) are in the oldest age strata (55 +), and 2% (N = 2) are in the youngest age strata (18 – 24).

Among mental health workers, about a third (32%, N = 23) indicated that they are between the ages of 35 and 44, and another third (31%, N = 22) are 55 or older. Twenty-seven (27%) percent are between the ages of 35 and 44 (N = 19), 6%, (N = 4) are between the ages of 25 and 34, and 4% (N = 3) are in the youngest age strata (18 – 24).

Among those who work in juvenile justice, most (41%, N = 13) are between the ages of 45 and 54. Twenty-five percent (25%, N = 8) are between the age of 25 and 34 and 16% are between the ages of 35 and 54 (N = 4). None of the juvenile justice workers are in the youngest age strata, and 19% (N = 6) are 55 or older.

Gender

Gender	2009 (N = 192)				2007 (N = 217)		
	Child Welfare (N = 90)	Mental Health (N = 71)	Juvenile Justice (N = 31)		Child Welfare (N = 84)	Mental Health (N = 103)	Juvenile Justice (N = 30)
Female	81%	77%	52%		87%	75%	40%
Male	19%	23%	48%		13%	25%	60%
Total	100%	100%	100%		100%	100%	100%

Most (81%) of the 2009 child welfare workers are female which represents 73 respondents; 19% (N = 17) are male. Seventy-seven percent (77%) of the mental health workers (N = 55) are female and 23% (N = 16) are male. Among juvenile justice workers, most (52%) are male (N = 16) and 48% (N = 15) are female.

Race/Ethnicity

Race/Ethnicity	2009 (N = 194)				2007 (N = 218)		
	Child Welfare (N = 92)	Mental Health (N = 71)	Juvenile Justice (N = 31)		Child Welfare (N = 85)	Mental Health (N = 102)	Juvenile Justice (N = 31)
Black	12%	14%	10%		22%	10%	23%
Hispanic	10%	7%	13%		8%	8%	7%
White	70%	79%	58%		60%	78%	68%
Asian/Pacific Islander	5%	0%	16%		4%	4%	0%
Native American	2%	0%	3%		5%	0%	3%
Other	1%	0%	0%		1%	1%	0%
Total	100%	100%	100%		100%	100%	100%

For 2009, in all three employment areas a preponderance of the respondents indicated that they are white; 70% child welfare (N = 64), 79% mental health (N = 56), and 58% juvenile justice (N = 18). Twelve percent (12%, N = 11) of the mental health workers reported that they are black, as are 14% (N = 10) of the mental health workers, and 10% (N = 3) of the juvenile justice workers. Ten percent (10%, N = 7) of the child welfare workers are Hispanic, as are 7% (N = 5) of the mental health workers, and 13% of the juvenile justice workers (N = 4). Five percent (5%) of child welfare workers are Asian/Pacific Islanders (N = 5) as are 16% of juvenile justice workers (N = 5). Two percent (2%) of child welfare workers reported that they are Native American (N = 2) as did 3% of juvenile justice workers (N = 1). One percent (N = 1) of child welfare workers indicated that they are some "other" race/ethnicity.

Language

Are you Bilingual?	2009 (N = 162)			2007 (N = 216)		
	Child Welfare (N = 90)	Mental Health (N = 71)	Juvenile Justice (N = 31)	Child Welfare (N = 84)	Mental Health (N = 103)	Juvenile Justice (N = 30)
Yes	**15%**	**16%**	**21%**	**13%**	**16%**	16%
No	**85%**	**84%**	**79%**	**87%**	**84%**	84%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The incidence of bilingual respondents from the 2009 respondents ranges from 15% among child welfare workers (N = 11), 16% among mental health workers (N = 9), and 21% among juvenile justice workers (N = 6). Respondents were also asked to define which languages they could speak fluently. Spanish was the language other than English that was mentioned most often. Among the bilingual child welfare workers, 45% (N = 5) of those that reported they were bilingual indicated they are fluent in Spanish, and one worker each noted they are fluent in Swedish, Japanese, and Serbian. Among the bilingual mental health workers 33% (N = 3) of those that reported they are bilingual indicated they are fluent in Spanish, another 33% (N = 3) indicated being fluent in French, and one worker indicated being fluent in Russian. When looking at the data for the bilingual juvenile justice workers, 50% (N = 3) of those that reported they were bilingual indicated they are fluent in Spanish, and one worker each reported they are fluent in Italian and Portuguese.

All (100%) of the child welfare (N = 11), mental health (N = 9), and juvenile justice workers (N = 6) who indicated that they were bilingual use their bilingual skills in the workplace. Of the 11 bilingual child welfare workers, eight (73%) use their bilingual skills for translation and all (100%) use their bilingual skills for interpreter services. Among the nine mental health workers who use their bilingual skills in the workplace, seven (78%) use their skills for translation and five (56%) use their bilingual skills for interpreter services. Among the six bilingual juvenile justice workers who use their skills in the workplace, five (83%) use their skills for translation and three (50%) use them for interpreter services.

Type of Residence

Residence	2009 (N = 193)			2007 (N = 213)		
	Child Welfare (N = 91)	Mental Health (N = 71)	Juvenile Justice (N = 31)	Child Welfare (N = 82)	Mental Health (N = 101)	Juvenile Justice (N = 30)
Urban	**87%**	**79%**	**77%**	**76%**	**75%**	47%
Rural	**10%**	**16%**	**20%**	**22%**	**20%**	50%
Frontier	**1%**	**1%**	**0%**	**1%**	**4%**	0%
Other	**2%**	**4%**	**3%**	**1%**	**1%**	3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

When looking at the residence types of the child welfare workers in the 2009 sample, 87% (N = 79) live in an urban residence, 10% (N = 9) live in a rural residence and 1% (N = 1) live in a frontier residence. Among the mental health workers, 79% (N = 56) live in an urban residence, 16% (N = 11) live in a rural residence, and 1% (N = 1) live in a frontier residence. Among the juvenile justice workers, 77% (N = 24) live in an urban residence and 20% (N = 6) live in a rural residence.

Educational Background

Education	2009 (N = 192)			2007 (N = 213)		
	Child Welfare (N = 92)	Mental Health (N = 69)	Juvenile Justice (N = 31)	Child Welfare (N = 82)	Mental Health (N = 101)	Juvenile Justice (N = 30)
HS Diploma	**0%**	**7%**	**3%**	1%	1%	17%
Associates' Degree	**3%**	**3%**	**7%**	7%	4%	13%
Bachelor's Degree	**57%**	**3%**	**45%**	42%	20%	53%
Master's Degree	**34%**	**55%**	**36%**	45%	59%	17%
Post Graduate	**4%**	**22%**	**7%**	4%	7%	0%
Ph.D.	**2%**	**10%**	**3%**	1%	9%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

From the 2009 sample, the highest occurrence of educational level among child welfare and juvenile justice workers is a bachelor's degree held by 57% (N = 52) of child welfare workers and 45% (N = 14) of juvenile justice workers. Among mental health workers, most (55%, N = 38) have earned a master' degree as the highest level of education.

When looking at the rest of the child welfare workers, 34% (N = 31) have a bachelor's degree, 4% (N = 4) have done some post graduate work, 3% have an associates' degree (N = 3), and 2% have earned a Ph.D. (N = 2).

When looking at the mental health workers who do not have a master's degree, 22% (N = 15) have completed some post graduate work, and 10% (N = 7) have a Ph.D., which is the highest occurrence for a Ph.D. Seven percent (7%, N = 5) have a high school diploma as the highest level of education attained, 3% have earned a bachelor's degree (N = 2), and another 3% have earned an associates' degree (N = 2).

Among the juvenile justice workers who have a degree other than a bachelors degree, 36% have a master's degree (N = 11), 7% have completed some post graduate work (N = 2), and another 7% have earned an associates' degree (N = 2). One respondent (3%) has a high school diploma as the highest level of education attained, and another has a PhD.

Practitioner License Type

License Type	2009 (N = 206)				2007 (N = 211)		
	Child Welfare (N = 93)	Mental Health (N = 82)	Juvenile Justice (N = 32)		Child Welfare (N = 79)	Mental Health (N = 105)	Juvenile Justice (N = 27)
Psychology	3%	6%	3%		1%	7%	0%
Social Work	47%	28%	16%		57%	30%	4%
Marriage/Family Therapy	5%	27%	16%		3%	27%	0%
Substance Abuse/Addictions	1%	10%	13%		0%	4%	7%
Other	8%	11%	3%		5%	7%	15%
None	37%	18%	50%		34%	26%	74%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

For the 2009 respondents, a majority (47%) of the child welfare workers (N = 43) have a social work license, while 37% (N = 34) do not have any practitioner license. Five percent (5%, N = 5) have marriage/family therapy licenses, 3% have a psychology licenses (N = 3), and 8% some "other" type of license (N = 7).

Many (28%) of the mental health workers have a social work license (N = 23). This is followed by 27% (N = 22) who have a marriage/family therapy license and 18% who do not have any practitioners license (N = 15). In addition, 11% have some "other" type of license (N = 9) and 6% (N = 6) of the mental health workers have a psychology license.

Most (50%) of the juvenile justice workers (N = 16) do not have any type of practitioners license. Sixteen percent (16%, N = 5) have a social work license and another 16% have a marriage and family license (N = 5). Thirteen percent (13%, N = 4) have a substance abuse license, 3% (N = 1) have a social work license, and another 3% (N = 1) have some "other" type of license.

Years at Current Agency

Years at Current Agency	2009 (N = 195)				2007 (N = 217)		
	Child Welfare (N = 93)	Mental Health (N = 82)	Juvenile Justice (N = 32)		Child Welfare (N = 83)	Mental Health (N = 103)	Juvenile Justice (N = 31)
Less than 1 year	9%	3%	6%		16%	13%	13%
1 – 3 years	29%	15%	19%		32%	28%	29%
3 – 5 years	16%	24%	16%		10%	19%	26%
5 – 7 years	11%	7%	3%		10%	12%	6%
7 – 9 years	4%	11%	28%		10%	12%	6%
10 years or longer	30%	39%	28%		22%	24%	23%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Among the child welfare workers from the 2009 sample, the highest occurrence is the 30% who have been at their current agency for 10 years or longer (N = 28). This was followed by 29% of child welfare workers who have been with their current agency for one (1) to three (3) years (N = 27). Sixteen percent (16%, N = 15) of child welfare workers have been with their current agencies for three (3) to five (5) years, 11% have been with their current agency five (5) to seven (7) years (N = 10), 9% have been with their current agency for less than a year (N = 8), and 4% have been with their current agency seven (7) to nine (9) years (N = 4).

When looking at the data for the mental health workers, 39% (N = 28) have been with their current agencies for 10 years or longer; this was the highest occurrence. The lowest occurrence was the 3% (N = 2) who had been with their current agency for less than a year. In addition, 24% of the mental health workers have been at their current agencies three (3) to five (5) years (N = 17) and 15% (N = 24) have been at their current position for one (1) to three (3) years. Among the other categories, 11% (N = 8) of the mental health workers have been with their current agencies for seven (7) to nine (9) years, and 7% (N = 5) have been there for five (5) to seven (7) years.

Among the juvenile justice workers, 29% (N = 9) have been at their current agencies for one (1) to three (3) years. This was the highest occurrence. In addition, 26% (N = 8) have been there for one (1) to three (3) years and 23% (N = 7) have been with their current agencies for 10 years or longer. Thirteen percent (N = 4) have been with their current agencies for less than a year, 6% (N = 2) have been there for five (5) to seven (7) years, and 3% (N = 1) for seven (7) to nine (9) years.

Years in Current Position

Years in Current Position	2009 (N = 192)				2007 (N = 217)		
	Child Welfare (N = 92)	Mental Health (N = 69)	Juvenile Justice (N = 31)		Child Welfare (N = 83)	Mental Health (N = 103)	Juvenile Justice (N = 31)
Less than 1 year	13%	3%	10%		34%	17%	16%
1 – 3 years	45%	19%	29%		33%	38%	42%
3 – 5 years	14%	38%	19%		10%	16%	16%
5 – 7 years	10%	10%	10%		11%	15%	7%
7 – 9 years	6%	12%	26%		6%	3%	0%
10 years or longer	12%	19%	6%		7%	12%	19%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Among the child welfare workers in 2009, the highest occurrence is the 45% (N = 41) who have been in their current position for one (1) to three (3) years. This was followed by 14% who have been in their current position for three (3) to five (5) years (N = 13), 13% who have been in their current position for less than a year (N = 12), and 12% who have been in their current position 10 years or longer (N = 11). Ten percent (10%, N = 9) have been in their current position five (5) to seven (7) years and 6% for seven (7) to nine (9) years (N = 6).

When looking at the data for the mental health workers, 38% have been in their current position for three (3) to five (5) years (N = 26). This was the highest occurrence. Nineteen percent (19%, N = 13) have been in their current position one (1) to three (3) years and another 19% have been in their current position for 10 years or longer (N = 13). Twelve percent (12%, N = 8) have been in their current position for seven (7) to nine (9) years, while 10% have been in their current position for five (5) to seven (7) years (N = 7), and 3% have been in their current position for less than a year (N = 2)

Among the juvenile justice workers, 29% (N = 9) have been in their current position for one (1) to three (3) years. This was the highest occurrence. This was followed by 26% (N = 8) of the juvenile justice workers who have been in their current positions for seven (7) to nine (9) years. Nineteen percent (19%, N = 6) of the juvenile justice workers have been employed in their current positions for three (3) to five (5) years, 10% have been in their current position for less than one year (N = 3), and another 10% have been in their position for five (5) to seven (7) years (N = 3). The lowest occurrence was the 6% of juvenile justice workers who have been in their current positions for 10 or more years (N = 2).

Years in Social Service Field

Years in Social Services	2009 (N = 188)				2007 (N = 216)		
	Child Welfare (N = 92)	Mental Health (N = 68)	Juvenile Justice (N = 28)		Child Welfare (N = 84)	Mental Health (N = 101)	Juvenile Justice (N = 31)
Less than 1 year	2%	2%	4%		2%	1%	7%
1 – 3 years	15%	4%	11%		18%	9%	19%
3 – 5 years	10%	2%	7%		16%	11%	13%
5 – 7 years	13%	2%	4%		8%	3%	16%
7 – 9 years	7%	6%	7%		16%	10%	3%
10 years or longer	53%	85%	68%		41%	66%	42%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at those employed in child welfare from the 2009 sample, the largest occurrence (53%) is the 49 respondents who have been in the social service field for 10 years or longer. In addition, 15% of the child welfare workers have been in the field for one (1) to three (3) years (N = 14). Thirteen percent (13%, N = 12) have been in the field for five (5) to seven (7) years, while 10% have been in the field three (3) to five (5) years (N = 9). Seven percent (N = 6) of the child welfare workers have been employed in the field for three (3) to five (5) years and 2% (N = 2) have been in the field for less than a year.

Among the mental health workers, the largest percentage (85%, N = 58) have been in the field for 10 years or longer, 6% (N = 4) for seven (7) to nine (9) years, and 4% (N = 3) for one (1) to three (3) years. Two percent (2%, N = 1) of the mental health workers have been in the field for three (3) to five (5) years, another 2% (N = 1) for five (5) to seven (7) years, and another 2% (N =1) for less than a year.

Among the juvenile justice workers, again, most (68%) have been in the field for 10 years or longer (N = 19), this is followed by 11% (N = 3) who have been in the field for one (1) to three (3) years, 7% for three (3) to five (5) years (N = 2), and another 7% (N = 2) for seven (7) to nine (9) years. Four percent (4%, N = 1) of the juvenile justice workers have been in the field for five (5) to seven (7) years, while another 4% have been in the field for less than a year (N = 1).

Years Provided Children's Mental Health Related Services

Years Providing Mental Health Services	2009 (N = 174)			2007 (N = 214)		
	Child Welfare (N = 79)	Mental Health (N = 67)	Juvenile Justice (N = 28)	Child Welfare (N = 82)	Mental Health (N = 101)	Juvenile Justice (N = 31)
Less than 1 year	15%	1%	7%	1%	3%	10%
1 – 3 years	19%	10%	11%	26%	10%	13%
3 – 5 years	16%	10%	7%	6%	23%	16%
5 – 7 years	6%	4%	0%	7%	9%	6%
7 – 9 years	9%	7%	11%	9%	8%	6%
10 years or longer	34%	66%	64%	22%	47%	42%
None	-	-	-	29%	0%	6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

When looking at the 2009 data for those employed in child welfare, the highest occurrence was the 34% (N = 27) who indicated that they have 10 years or more providing children's mental health related services. This was followed by 19% (N = 15) who have one (1) to three (3) years experience providing children's mental health related services, followed by 16% who have done so for three (3) to five (5) years (N = 13). Fifteen (15%, N = 12) have done so for less than a year, 9% for seven (7) to nine (9) years (N = 7), and 6% for five (5) to seven (7) years (N = 5).

Among the mental health workers, the highest occurrence is the 66% (N = 44) who have been providing children's mental health related services for 10 years or longer. This was followed by 10% who have been providing children's mental health related services for three (3) to five (5) years (N = 7), and another 10% who have provided such for one (1) to three (3) years (N = 7). In addition, 7% (N = 10) have been providing children's mental health related services for seven (7) to nine (9) years (N = 5), 4% for five (5) to seven (7) years (N = 3), and 1% that have done so for less than one year (N = 1).

Among the juvenile justice workers, the highest occurrence is the 64% who have been providing children's mental health related services for longer than 10 years (N = 18). This was followed by the 11% who have been doing the same for seven (7) to nine (9) years (N = 3), followed by another 11% who have done so for one (1) to three (3) years (N = 3). In addition, 7% have been delivering children's mental health related services for less than a year (N = 2) with another 7% doing so for three (3) to five (5) years.

Current Case Load

Current Case Load	2009 (N = 191)				2007 (N = 214)		
	Child Welfare (N = 92)	Mental Health (N = 68)	Juvenile Justice (N = 31)		Child Welfare (N = 83)	Mental Health (N = 100)	Juvenile Justice (N = 31)
Less than 20	36%	32%	19%		28%	48%	36%
20 – 40	27%	27%	19%		26%	15%	16%
41 – 59	3%	3%	0%		2%	0%	3%
60 – 80	1%	7%	3%		7%	8%	23%
81 – 100	1%	3%	7%		1%	3%	10%
N/A	32%	28%	52%		36%	25%	13%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Respondents from the 2009 sample were asked to quantify their current case load. For 32% of the child welfare workers this was not applicable (N = 29), as it was not applicable for 28% of the mental health workers (N = 19), and 52% of the juvenile justice workers (N = 16). Among the child welfare workers who do have a case load, the highest occurrence was the 36% who have a case load of less than 20 (N = 33). In addition, 27% of the child welfare workers have a case load of 20 to 40 (N = 25), 3% have a case load of 41 to 59 clients (N = 3), 1% have 60 to 80 clients (N = 1) and another 1% have a case load between 81 and 100 (N = 1).

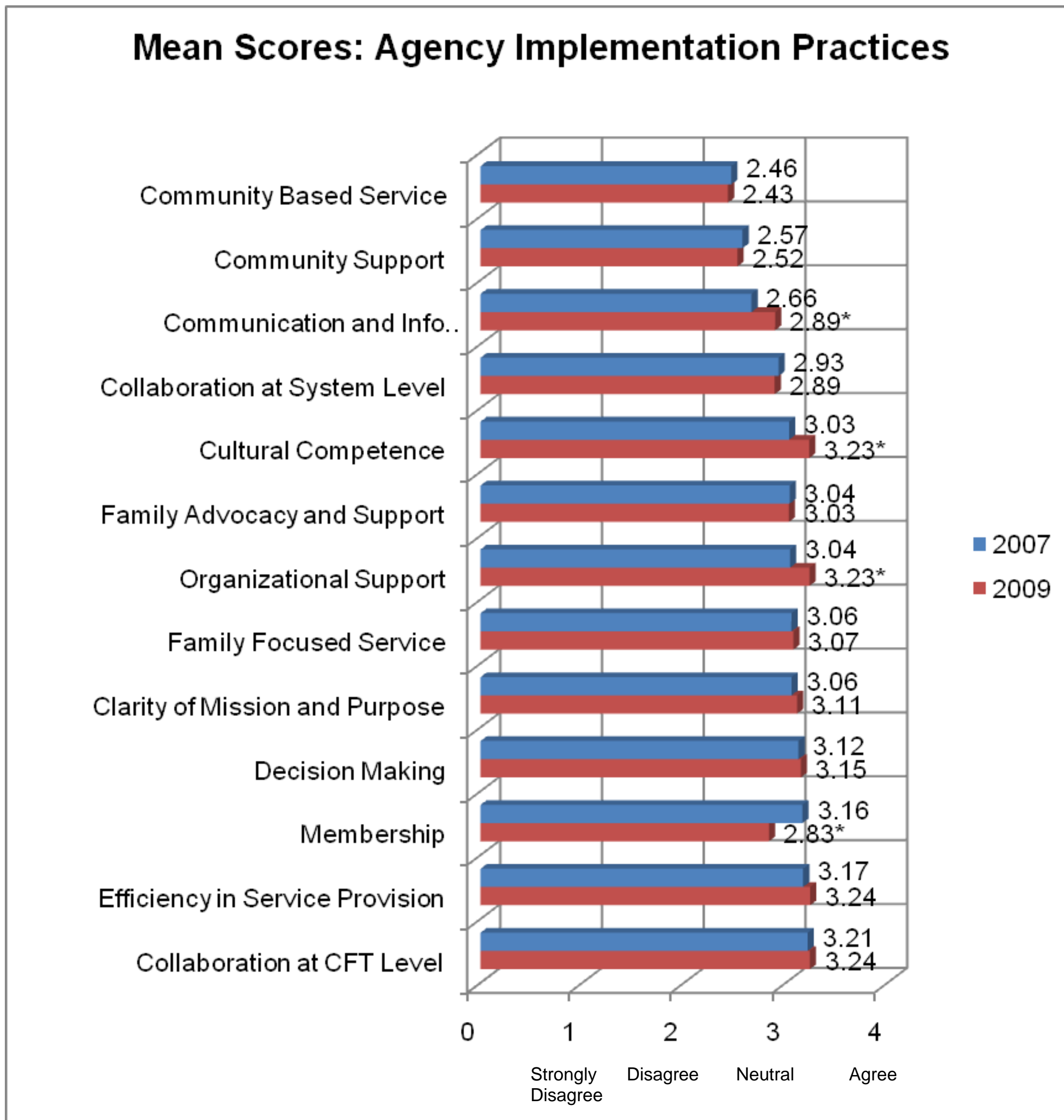
Among the mental health workers who have a case load, the highest occurrence is the 32% who reported having less than 20 in their case loads (N = 22). In addition, 27% have a case load of 20 to 40 (N = 18), while 7% have 60 to 80 (N = 5), 3% have 41 to 59 (N = 2), and another 3% (N = 2) have a case load of 81 to 100.

When looking at the data for the juvenile justice workers who have a case load, the highest occurrence was shared among two categories; 19% have a case load of less than 20 (N = 6) and another 19% have 20 to 40 (N = 6). In addition, 7% (N = 2) have a case load of 81 – 100, while 3% (N = 1) have 60 to 80 in their case loads.

Demographic Questionnaire: Data Trend Summary & Salient Issues

The majority of the workforce reflected in this report serves children who reside in Clark County. The sample comprises professionals who work in the areas of child welfare, mental health, juvenile justice, substance abuse and education; with significantly more substance abuse workers represented in the 2009 assessment than there were in the 2007 assessment. Many of the respondents are case managers or therapists/clinicians but the sample also included nearly 40% managers/administrators. Nearly half of the respondents possess graduate degrees and the majority are licensed practitioners. In both the 2007 and the 2009 assessments, a third of the sample report being in their current positions for only 1-3 years (this is especially the case with the child welfare workforce) but 68% and 54% of the workforce in 2009 and 2007, respectively have been in the field of social services for more than 10 years.

System of Care Questionnaire



*indicates 2009 mean scores that are significantly different than 2007.

The graph above shows the mean scores of the 13 System of Care (SOC) subscales. They are displayed in rank order from the 2007 baseline, lowest to highest. The respondents were asked to agree or disagree with a series of statements using a scale of one (1) to five (5) where one (1) meant "strongly disagree" and five (5) meant "strongly agree".

An independent-samples t-test was conducted to compare the mean scores from the two time periods. The differences from four of the subscales were found to be significantly different. The "Communication and information dissemination" subscale, which is

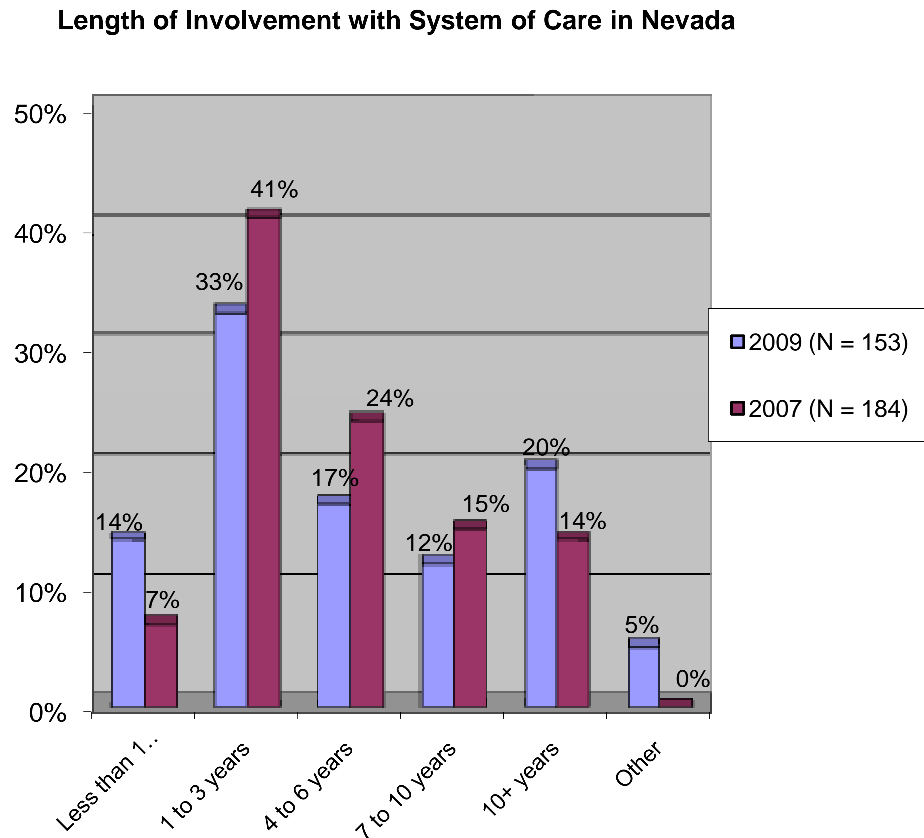
comprised of five items, produced a mean of 2.89 (SD = .82) in 2009, compared to a 2007 mean of 2.66 (SD = 1.00). This increase is statistically significant at the $p<.05$ level [t (281.44) = -2.17, p=.03]. Additionally, the “Cultural Competence” subscale, which is comprised of six items, produced a 2009 mean score of 3.23 (SD = .71) which is higher than the 2007 mean of 3.03 (SD = .81). This increase is statistically significant at the $p<.05$ level [t (295) = -2.21, p=.03]. Similarly, the “Organizational Support” subscale, which consists of seven items, produced a mean score of 3.23, which is higher than the 2007 mean score of 3.04. This increase is statistically significant at the $p<.01$ level [t (367) = -2.71, p=.007]. Lastly, the “Membership” subscale, which is comprised of four items, produced a mean score of 2.83 (SD = .84) which is lower than the 2007 mean score of 3.16 (SD = .79). This decrease is statistically significant at the $p<.01$ level [t (246.33) = 3.59, p=.00].

Statistically significant differences were not found for the remaining nine subscales. Of these, the lowest mean score from 2009 for any of the sub- scales was 2.43 which was obtained for the “Community-Based Service” scale which is comprised of four items. This was also the lowest mean score for the 2007 baseline findings (M = 2.46).

This was followed by “Community Support,” which consists of four items and produced a mean score of 2.52, which is slightly lower that the 2007 mean of 2.57. The “Collaboration at System Level” sub-scale consists of six items and had a mean score of 2.89, which is slightly lower than the 2007 mean score of 2.93. The “Family and Advocacy Support” sub-scale is comprised of six items and the mean obtained for this scale was 3.03, which is slightly lower than the 2007 mean of 3.04. The “Family-focused service” subscale, which is comprised of five items, had a mean of 3.05, which is slightly higher than the 2007 mean of 3.06. The “Clarity of mission or purpose” subscale consists of seven items and produced a mean of 3.11, which is slightly higher than the 2007 mean of 3.06).

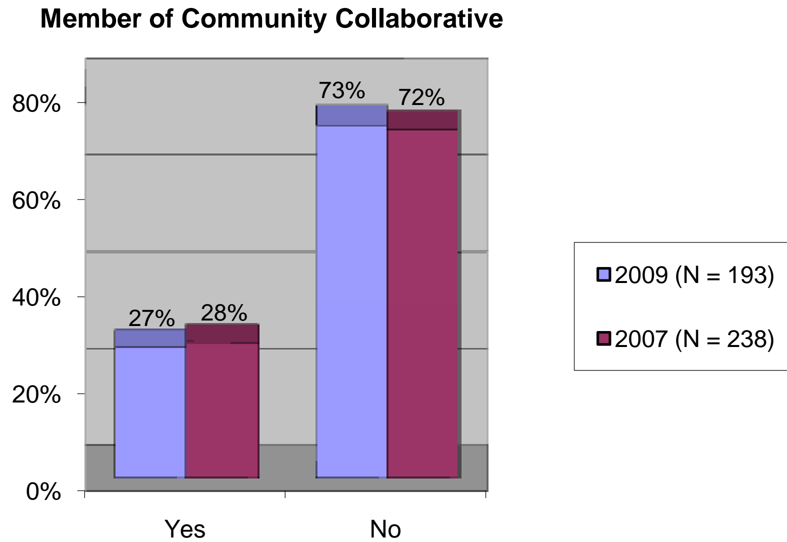
The mean for “Decision Making,” which consists of five items, was 3.15; this was slightly higher than the 2007 mean of 3.12. This was followed by the mean for “Efficiency in Service Provision” which produced a mean score of 3.24 and consists of five items. This is slightly higher than the 2007 mean which was 3.17. The highest mean score obtained, 3.24, was calculated for the seven item “Collaboration at the Child and Family Team Level” scale. This was also the highest mean score for the 2007 baseline findings (M = 3.21).

Length of Time Involved with System of Care in Nevada



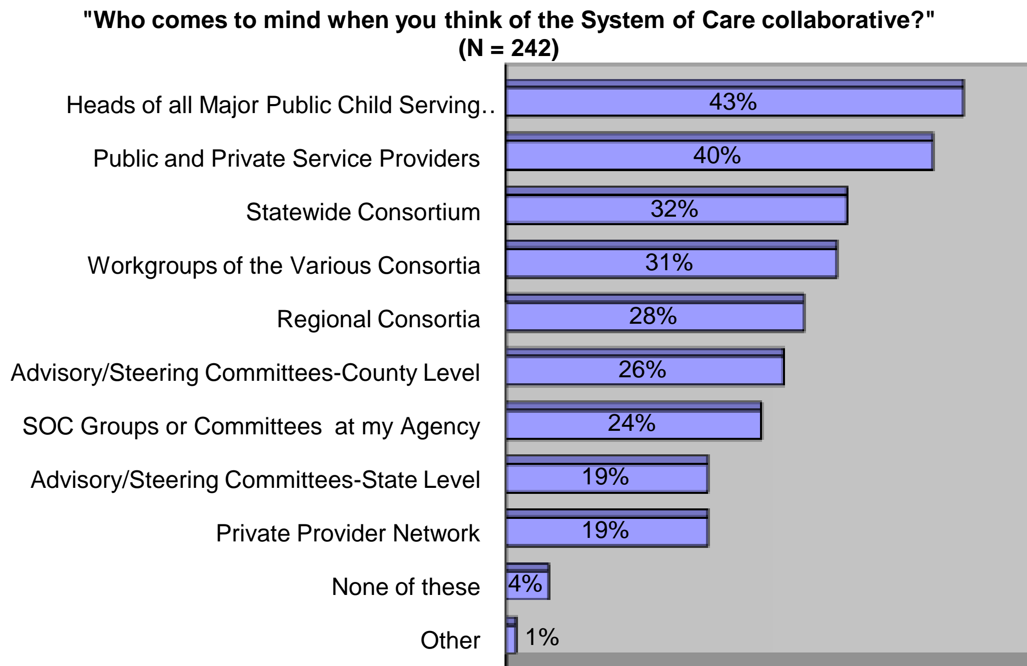
Respondents from the 2009 sample were asked to quantify the length of time that they had been involved with the System of Care in Nevada. The highest occurrence was the 33% who have been involved with the System of Care for one (1) to three (3) years (N = 51); this was followed by 20% who have been involved with the System of Care for 10 years or longer (N = 30). In addition, 17% of the respondents have been involved with the System of Care in Nevada for four (4) to six (6) years (N = 26), 14% for less than one year (N = 21), and 12% have been involved for seven (7) to 10 years (N = 18). Five percent (5%) of the respondents indicated some "other" response which was comprised of five individuals who were not sure if they were involved in Nevada's System of Care, and two people who were not involved at all.

Member of the Community Collaborative



For 2009, 27% are members of the Community Collaborative and 73% are not.

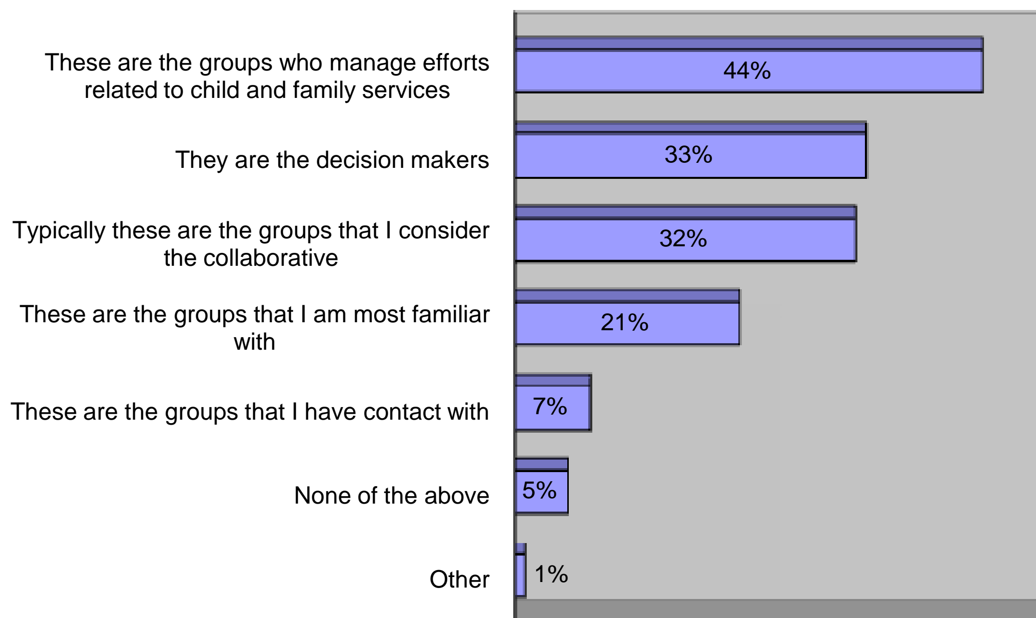
Collaboration Membership



For the 2009 follow data collection point, respondents were asked, "Who comes to mind when you think of the System of Care collaborative?" Participants were given the option of choosing more than one answer and this question was not asked of the 2007 cohort. A majority of the 2009 respondents (43%, N = 104) indicated that the "heads of all the

major public child and family serving agencies" comprised the System of Care collaborative. This was followed by 40% who reported that a "combination of public and private service providers" were members of the System of Care collaborative (N = 96), 32% indicating the "statewide consortium" (N = 78), 31% noting "workgroups of the various consortia" (N = 74), and 28% indicating the "regional consortia" (N = 68). Additionally, 26% of participants noted that "advisory or steering committees at the county level" are members of the System of Care collaborative (N = 62), as is "groups or committees in charge of System of Care planning at my place of employment" (24%, N = 59), "advisory or steering committees at the state level" (19%, N = 46), and another 19% noting "the private provider network" (N = 45). Four percent (4%) of respondents indicated that none of the choices provided were members of the System of Care collaborative, and two individuals noted that there were other entities involved such as an "adhoc group of providers" and the "mental health commission." One individual noted that they had never heard of System of Care.

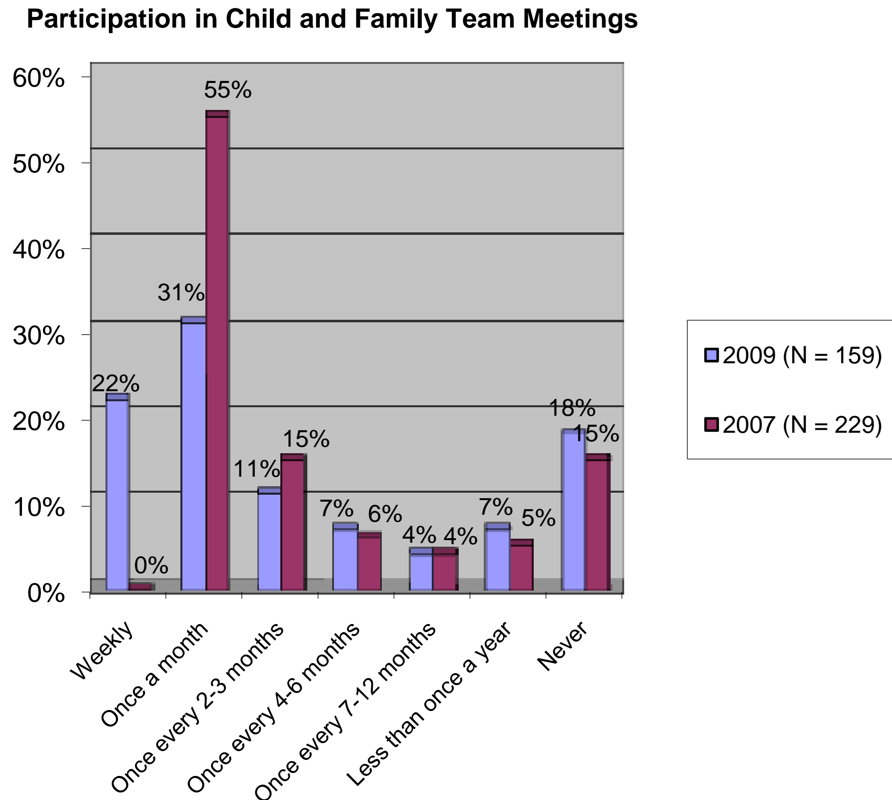
Collaboration Membership – Continued



Participants from the 2009 cohort were asked, "Why do you regard these groups as the System of Care collaborative?" Again as in the previous question, participants were given the option of choosing more than one answer and this question was not asked of the 2007 cohort. A majority of the 2009 respondents (44%, N = 107) indicated that they regard these groups as the System of Care collaborative because "for the most part these are the groups/entities who organize and manage efforts related to child and family type of services." A third (33%) of the respondents perceive these groups as the System of Care collaborative because "they are the decision makers" (N = 79), while another third (32%) perceive that "typically these are the groups that I consider the collaborative" (N = 78).

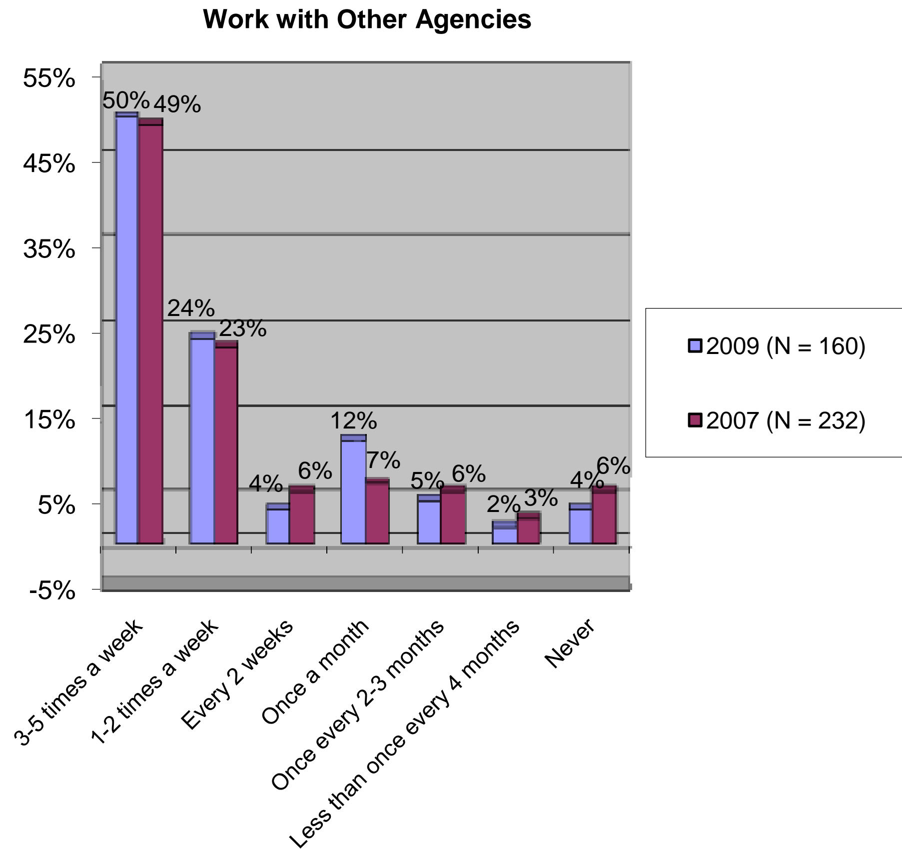
This was followed by 21% who perceived “these groups are the ones I am most familiar with” (N = 50) and 7% who note that “these are the groups that I have contact with” (N = 17). Five percent (5%) of the respondents chose the “none of the above” category (N = 13), while 3 respondents (1%) chose the “other” category. Responses to the “other” category included: “System of Care not relevant to their position”; and “providers should be involved but it is only department head and management that meets.”

Frequency of Participation in Child and Family Team Meetings



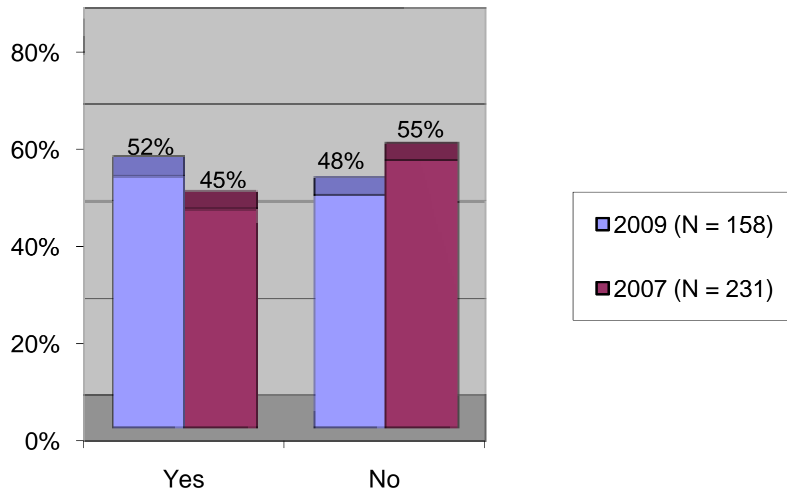
From the 2009 respondents, 31% reported that they participate once a month in child and family team meetings (N = 49). This was the highest occurrence. This was followed by 22% percent that reported they participate weekly (N = 35), while 18% of the indicated that they never participate in child and family team meetings (N = 29). Eleven percent (11%) participate in child and family team meetings once every two (2) or three (3) months (N = 17), 7% participate once every four (4) to six (6) months (N = 11), and another 7% participate less than once a year (N = 11). The lowest incidence was the 4% who participate in these meetings once every seven (7) to 12 months (N = 7).

Frequency of Working with Other Agencies Serving Children and Families



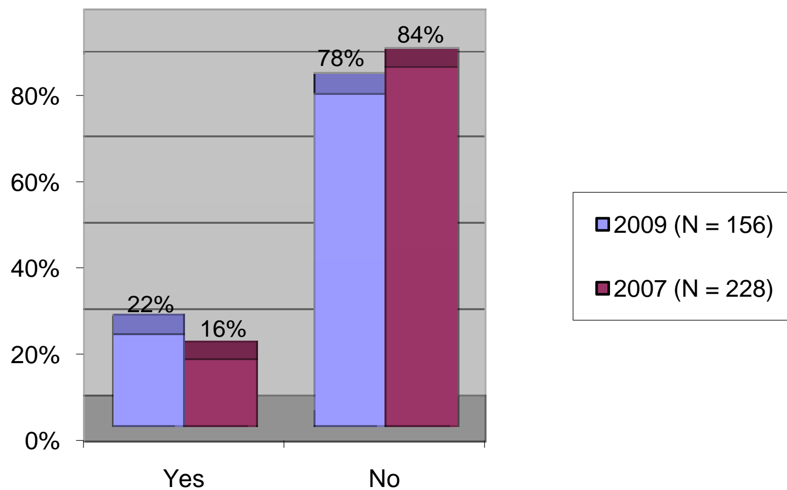
In 2009, most of the respondents (50%) reported that they work with other agencies three (3) to five (5) times weekly (N = 80). This was the highest occurrence. Six percent (6%) never work with other agencies (N = 14). Among the other categories, 24% work with other agencies once (1) or twice (2) a week (N = 38), 12% do so once a month (N = 19), 5% once every two (2) or three (3) months (N = 8), 4% every two (2) weeks (N = 6), and 2% work with other agencies less than once (1) every four (4) months (N = 3). This was the lowest occurrence.

Received Training in the System of Care principles



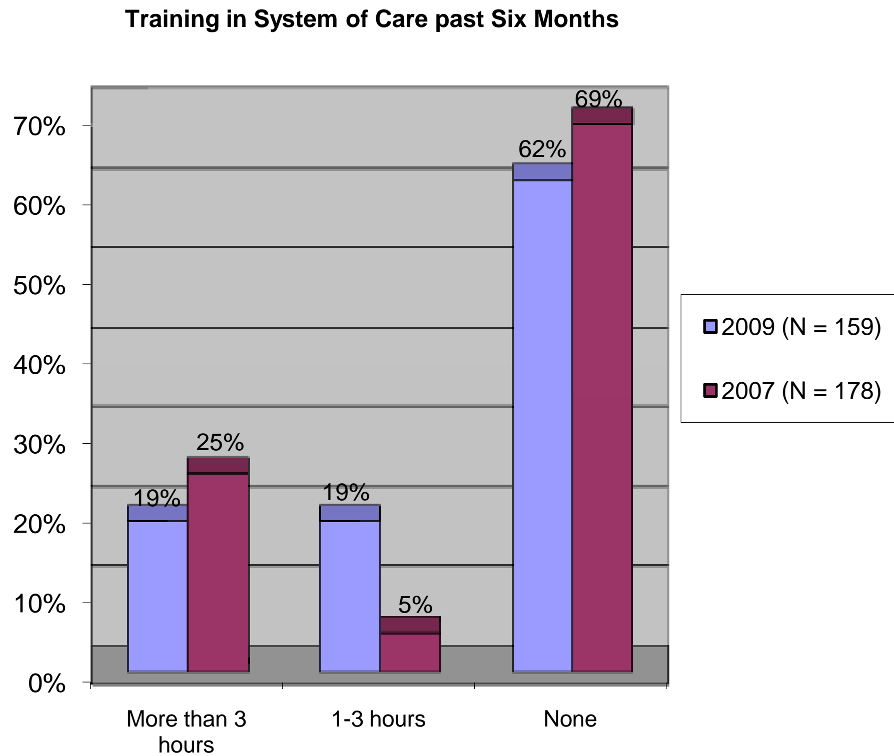
- 52% of the respondents indicated that they *have* received training in the System of Care principles (N = 82).
- 48 % of the respondents indicated that they *have not* received training in the System of Care principles (N = 76).

Regularly Attend System of Care Workshops/Training



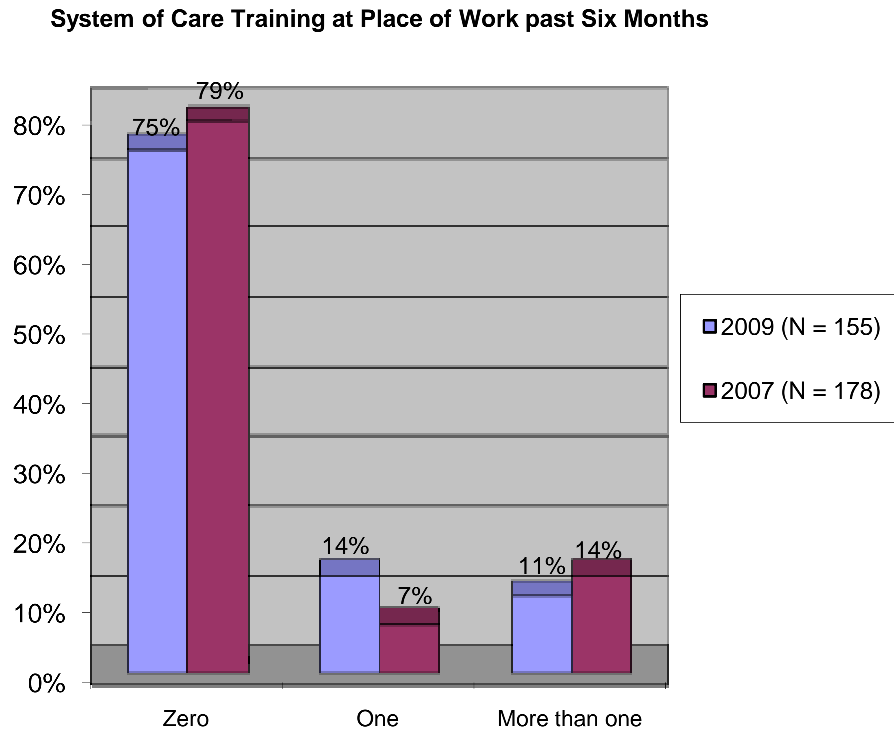
- 22% of the respondents *regularly attend* System of Care workshops and training (N = 34).
- 78% of the respondents *do not regularly attend* System of Care workshops and training (N = 122).

Number of Hours Spent in System of Care Training in the Past Six Months



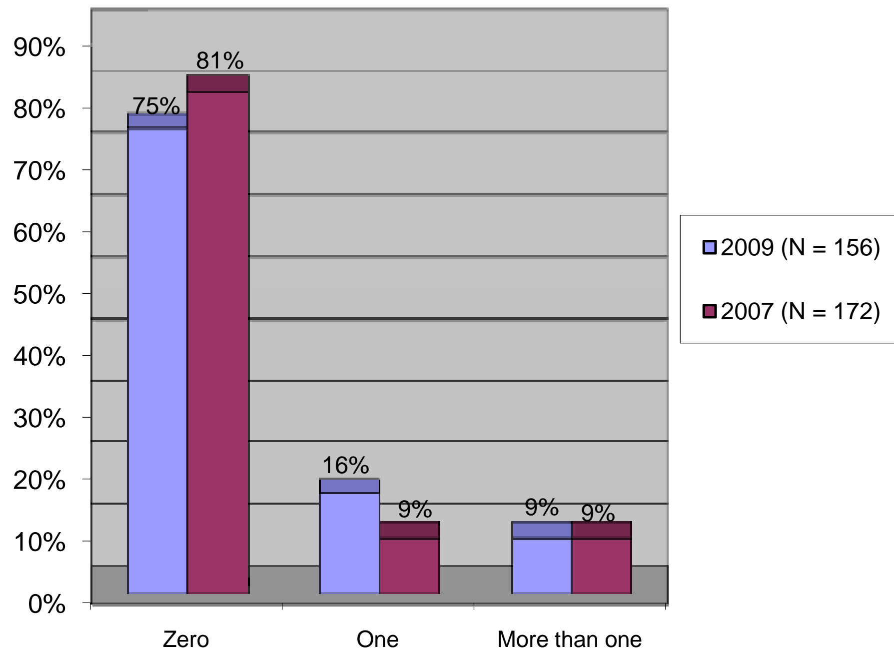
Most of the respondents (62%) reported that they have not spent any hours in System of Care training during the past six months (N = 98). Nineteen percent (19%) have spent more than three (3) hours in the past six months in System of Care training (N = 30), while 19% have spent between one (1) and three (3) hours in System of Care training in the past three months (N = 31).

Number of System of Care Training Sessions at the Workplace Attended in Last Six Months



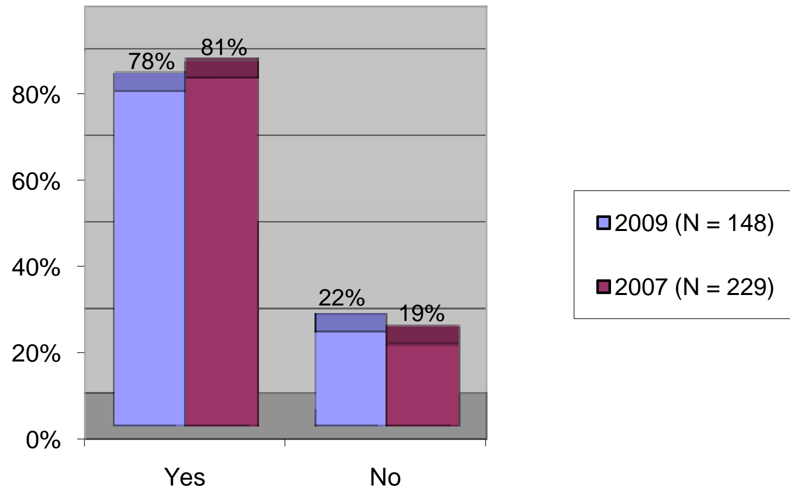
When asked to quantify the number of training sessions at the respondents workplace that have been attended in the last six months, a preponderance (75%) of the 2009 cohort indicated that they have not attended any training sessions in their workplace in the last six months (N = 116). Among those that have attended a System of Care training session in their workplace in the past six months, 14% have attended one (1) training session (N = 22) and 11% have attended more than one (N = 17).

Number of System of Care Training Sessions outside the Workplace Attended in Last Six Months



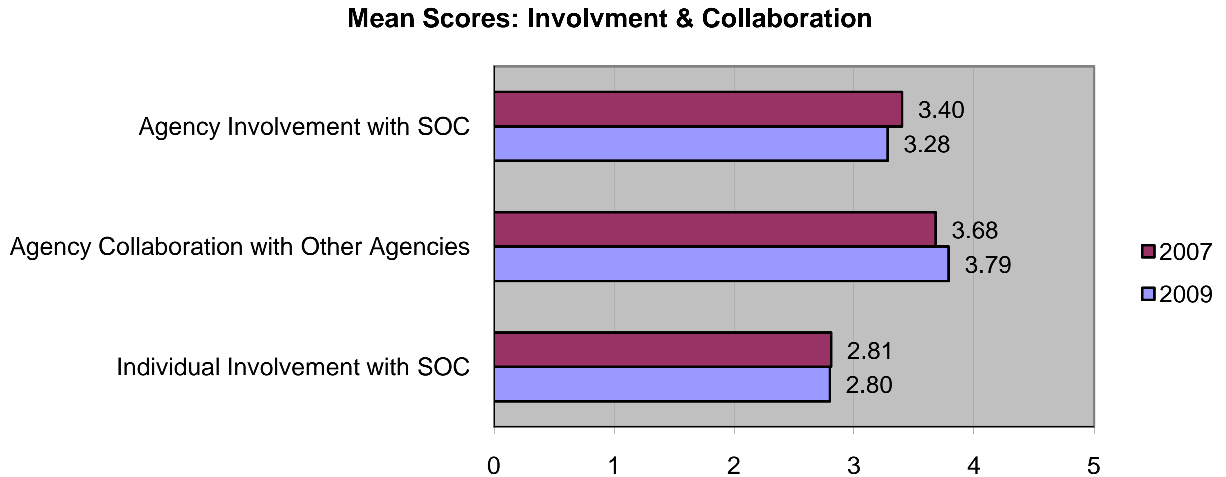
When asked to quantify the number of training sessions held outside of the respondents workplace that have been attended in the last six months, a preponderance (75%) of the 2009 respondents indicated that they have not attended any training sessions held outside of their workplace in the last six months (N = 117). Among those that have attended a System of Care training session outside of their workplace in the past six months, 16% have attended one (1) training session (N = 25) and an additional 9% have attended more than one (N = 14).

Desire More Opportunities to Learn About System of Care and How to Work According to the Principles



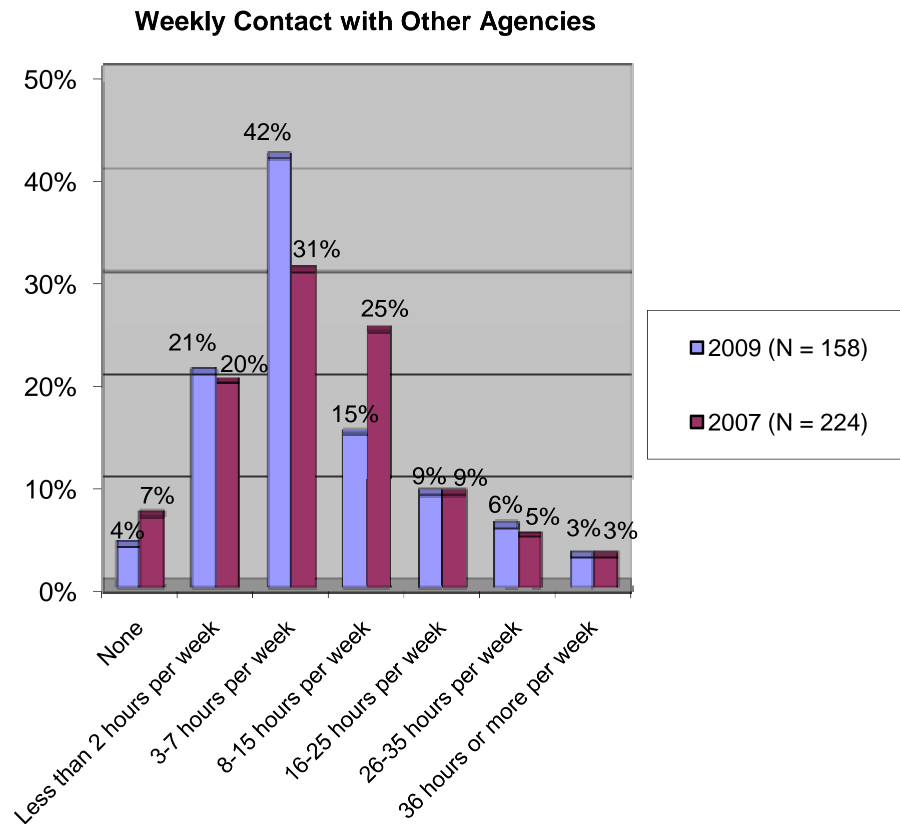
- 78% of the respondents indicated that they *desire* more System of Care training opportunities (N = 115).
- 22% of the respondents indicated that they *do not desire* additional System of Care training opportunities (N = 33).

Agency and Individual Involvement & Collaboration with System of Care



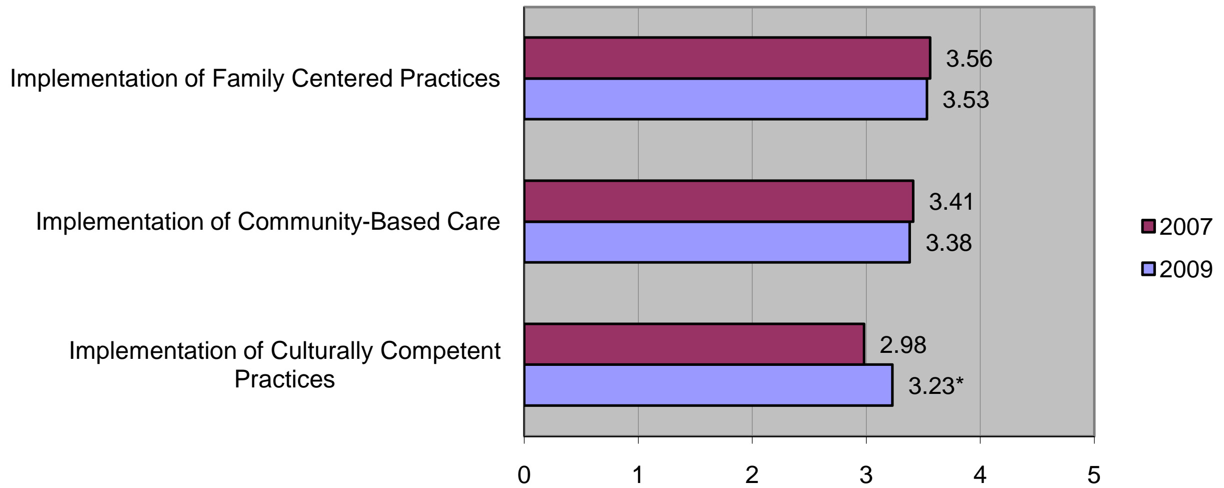
The graph above shows the mean scores for respondents who were asked to rate their level of involvement and their agency's level of involvement with the System of Care. A five point scale was used where one (1) meant "uninvolved" or "no collaboration" and five (5) meant "very involved" or a "strong collaboration". The highest mean score for 2009 (3.79) was produced when respondents were asked to rate their agency's level of collaboration with other agencies. The mean score for individual involvement with System of Care is 2.80 and the mean score for agency level of involvement with the System of Care is 3.28. An independent-samples t-test was conducted to compare the mean scores from 2009 and the 2007 baseline and no significant differences were found.

Weekly Contact with Other Agencies



For the 2009 sample, 42% of the respondents have three (3) to seven (7) hours of weekly contact with other agencies that provide services to the children or families that they serve (N = 67). This was the highest incidence. This was followed by 21% that have less than two (2) hours of weekly contact (N = 34), while 15% have eight (8) to fifteen (15) hours of weekly contact (N = 24). Nine percent (9%) have 16 to 25 hours of contact weekly with other agencies (N = 16), 6% have 26 to 35 hours of weekly contact (N = 9), and 4% have no weekly contact (N = 6). Three percent (3%) reported that they have 36 hours or more of weekly with other agencies (N = 4). This was the lowest incidence.

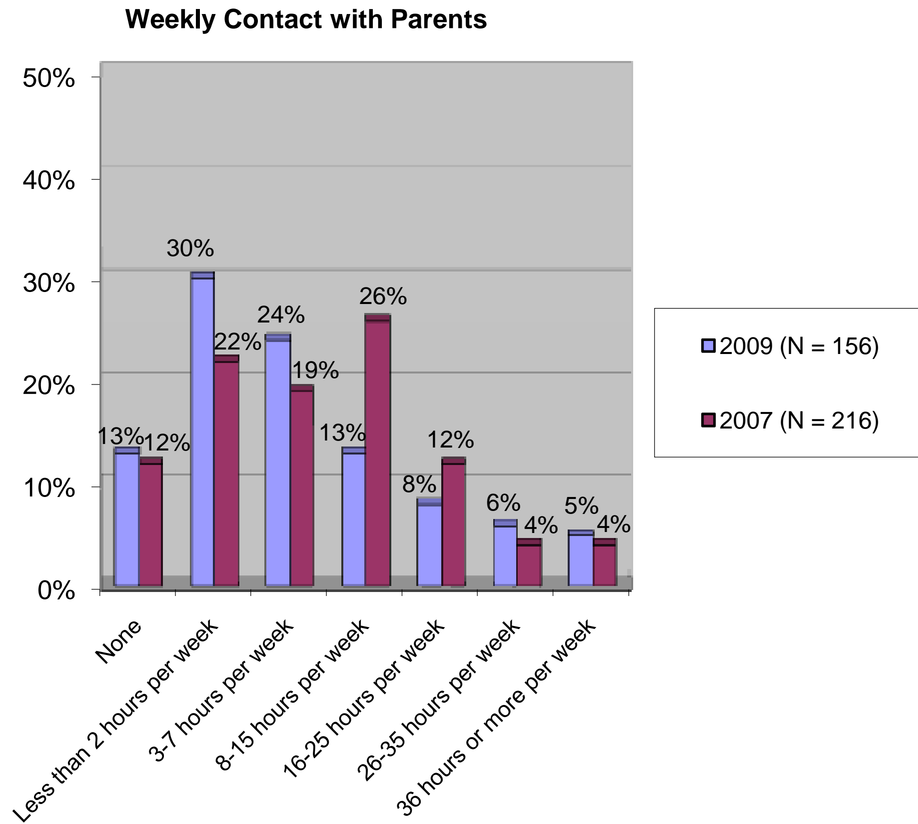
Agency Implementation Practices



*indicates 2009 mean scores that are significantly different than 2007.

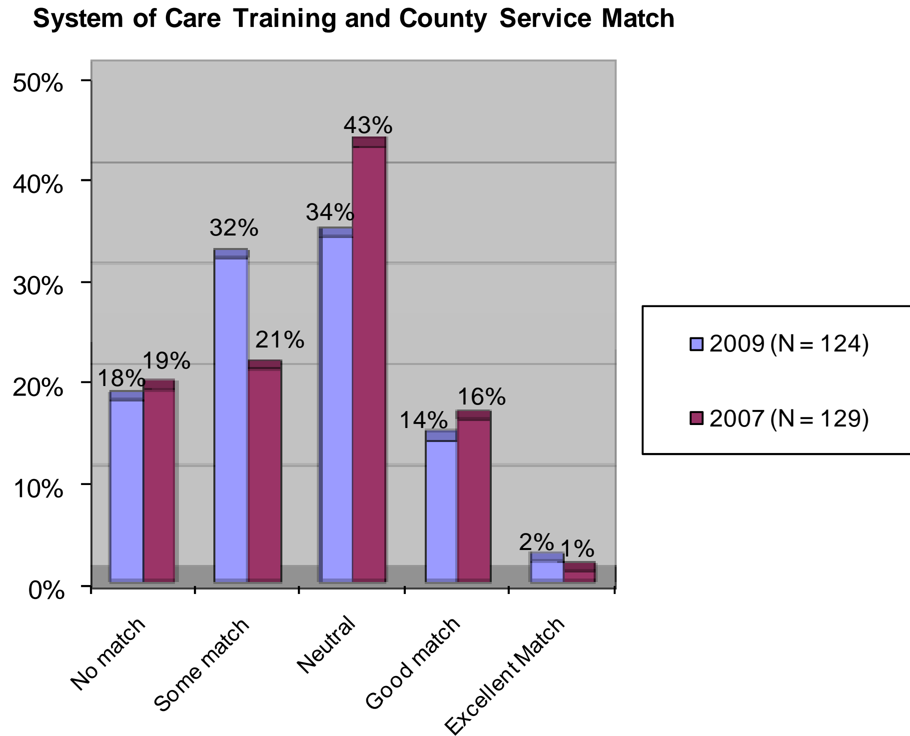
Mean scores were computed for the agency's implementation practices in three areas. Respondents used a scale where one (1) meant "poor" or "don't" use and five (5) meant "excellent". From the 2009 cohort, the highest mean score (3.53) was produced when rating the agency on its implementation of family-centered practices, followed by 3.41 for agency implementation of community-based care. An independent-samples t-test was conducted to compare theses mean scores to the 2007 baseline and no significant differences were found. However, there was a significant difference found at the $p<.05$ [$t(386) = -2.07$, $p=.04$] when comparing the 2009 mean score of 3.23 for the implementation of culturally competent care to the 2007 mean score of 2.98.

Weekly Contact with Parents of Families You Are Working With



From the 2009 sample, thirty percent (30%) of the respondents indicated that they have less than two (2) hours per week of contact with parents of the children with whom they work (N = 46). This was the highest occurrence. This was followed by 24% having between three (3) and seven (7) hours per week of contact with parents (N = 38), 13% having between eight (8) and 15 hours of weekly contact (N = 40), while another 13% having no contact with parents. Additionally, 8% have between 16 and 25 hours of weekly contact with parents (N = 13), 6% have between 26 to 35 hours (N = 10), and 5% have more 36 hours or more a week of contact with the parents of the children with whom they work (N = 8).

If you have had System of Care training, how well does the system of service in your county match the principles learned in training?



In the last question on the System of Care questionnaire respondents were asked to indicate how well the system of services in their county matches the principles learned about in the System of Care training. About a third (34%) elected to remain neutral on this question (N = 56). Half (50%) responded negatively (N = 62), of these 18% reported that there was no match (N = 22) and 32% indicated that there was only some match (N = 40). Among those that responded positively (16%, N = 20), 14% indicated that there was a good match (N = 17) and 2% reported that the match was excellent (N = 3).

System of Care Questionnaire by Respondent Type

Mean Scores: Agency Implementation Practices by Respondent Type

Item	2009				2007			
	Mean All	Mean Child Welfare	Mean Mental Health	Mean Juvenile Justice	Mean All	Mean Child Welfare	Mean Mental Health	Mean Juvenile Justice
Community-based Service	**2.43**	2.44	2.45	2.43	**2.46**	2.55	2.34	2.85
Community support	**2.52**	2.54	2.43	2.57	**2.57**	2.57	2.59	2.47
Membership	**2.83***	2.88	2.72	3.02	**3.16**	3.29	3.13	3.05
Communication and Information Dissemination	**2.89***	2.82	2.91	2.84	**2.66**	2.71	2.61	2.85
Collaboration at System Level	**2.89**	2.95	2.80	2.95	**2.93**	3.09	2.91	2.90
Family Advocacy and Support	**3.03**	2.99	3.14	2.84	**3.04**	3.04	3.08	2.77
Family-focused Service	**3.07**	3.02	3.07	3.17	**3.06**	3.09	3.09	2.83
Clarity of Mission or Purpose	**3.11**	3.10	3.11	3.12	**3.06**	3.13	3.04	2.94
Decision Making	**3.15**	3.05	3.12	3.16	**3.12**	3.26	3.08	3.00
Organizational Support	**3.23***	3.17	3.25	3.30	**3.04**	2.91	3.14	3.03
Cultural Competence	**3.23***	3.10	3.36	3.24	**3.03**	3.15	2.97	2.87
Collaboration at the Child & Family Team Level	**3.24**	3.29	3.25	3.22	**3.21**	3.33	3.21	2.91
Efficiency in Service Provision	**3.24**	3.20	3.27	3.06	**3.17**	3.18	3.25	3.06

The table above shows the mean scores of the 13 System of Care subscales in rank order of from the 2009 cohort, lowest to highest. The respondents were asked to agree or disagree with a series of statements using a scale of one (1) to five (5) where one (1) meant "strongly disagree" and five (5) meant "strongly agree". As previously noted, four of the means from the subscales were found to be statistically significant when comparing the means between the two different time periods, and these are noted with an asterisk (*) above. As in the previous sections of this report, data is provided from the 2007 baseline as reference.

The lowest overall mean score for any of the 2009 subscales was 2.43 which was obtained for the "Community-Based Service" scale. When looking at the data by the employment groups the means scores were 2.44 for the child welfare workers, 2.45 for the mental health workers, and 2.43 for the juvenile justice workers.

"Community Support" consists of four (4) items and produced a mean score of 2.52. The highest mean score produced among the levels of respondent types was the 2.57 mean

score produced by the juvenile justice workers. The child welfare workers produced a mean score of 2.54, while the mental health workers produced a mean score of 2.43.

The "Membership" subscale is a four (4) item scale that produced a mean score of 2.83. The highest mean score for this sub-scale was produced by the juvenile justice workers (3.02). The mean scores for the child welfare workers was 2.88 and mental health workers was 2.72.

"Communication and Information Dissemination" produced a mean of 2.89 and is a five (5) item scale. When looking at the data by the employment groups, the highest mean score was produced by the mental health workers (2.91). Among the other employment groups, the mean score for juvenile justice workers was 2.84 and the mean score for the child welfare workers was 2.82.

The mean score among all employee types for "Collaboration at the System Level" which consists of six (6) items was 2.89. When looking at the data by the employment type, the highest mean was produced by the child welfare workers (3.08). The mean scores for the mental health workers (2.98) and the juvenile justice workers (2.95) were very similar.

The "Family and Advocacy Support" sub-scale is comprised of six (6) items and the mean obtained for this scale was 3.03. The highest mean score among the types of employees was the 3.14 produced by the mental health workers. The means for the other employment groups were 2.99 for child welfare workers and 2.84 for juvenile justice workers.

"Family-focused service" had an overall mean of 3.05, while the juvenile justice workers produced a mean score of 3.17. This was followed by the mental health workers who produced a mean score of 3.07 and finally the child welfare workers who produced a mean score of 3.02.

When looking at the "Clarity of Mission or Purpose" sub-scale which consists of seven (7) items, a mean of 3.11 was produced among all respondents. When looking at the data among the groups of employment, the highest mean score obtained was from the juvenile workers (3.12). Among the other employment groups, the mean score for the mental health workers (3.11) was very similar to the juvenile justice workers (3.10).

The mean score for "Decision Making" among all participants was 3.15. When looking at the mean scores by employment group, the mean score for the juvenile justice workers was 3.16. This was the highest mean score, while the mean score for the mental health workers was 3.12 and the mean score for the child welfare workers was 3.05.

The "Organizational Support" subscale consists of seven (7) items and produced a mean score of 3.23 among all respondents. When looking at the data by the respondent type, the highest mean score was produced by the juvenile justice workers (M = 3.30). This was followed by 3.25 for the mental health workers and 3.17 for the child welfare workers.

The "Cultural Competence" sub-scale produced an overall mean score of 3.23. When looking at the data by the sub-groups, the mental health workers produced the highest mean score of 3.36, which was followed by the juvenile justice workers who produced a mean score of 3.10, and finally the child welfare workers who produced a mean score of 2.98.

Survey wide, the highest mean score obtained, 3.24, was calculated for the seven (7) item "Collaboration at the Child and Family Team Level" scale. When looking at the data from the employment groups, the highest mean score was produced by the child welfare workers (3.29) followed by a mean score of 3.25 obtained from the mental health workers, and a mean score of 3.22 from the juvenile justice workers.

The "Efficiency in Service Provision" scale also produced a mean score of 3.24. For this item the mental health workers produced a mean score 3.27. This was followed by a mean score of 3.20 for the child welfare workers and 3.06 for the juvenile justice workers.

Length of Time Involved with System of Care in Nevada

Time Involved with System of Care	2009 (N = 133)				2007 (N = 147)		
	Child Welfare (N = 57)	Mental Health (N = 56)	Juvenile Justice (N = 20)		Child Welfare (N = 66)	Mental Health (N = 73)	Juvenile Justice (N = 8)
Less than 1 year	19%	7%	15%		5%	7%	8%
1 to 3 years	33%	34%	30%		46%	36%	33%
4 to 6 years	25%	14%	15%		24%	26%	8%
7 to 10 years	3%	16%	15%		6%	19%	25%
10+ years	16%	23%	20%		11%	12%	25%
Not Involved	4%	5%	5%		8%	0%	0%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Respondents were asked to quantify the length of time that they had been involved with the System of Care in Nevada. From the 2009 cohort, when looking at the child welfare workers, the highest occurrence was the 33% (N = 19) who have been involved with System of Care for one (1) to three (3) years. This was followed by 25% (N = 14) who have been involved with System of Care in Nevada for four (4) to six (6) years, and 19% (N = 11) who have been involved for less than one year. In addition, 16% (N = 9) have been involved for 10 years or longer, while 3% percent (N = 2) note that they are not involved in these efforts, and another 3% report that they have been involved with System of Care in Nevada for seven (7) to 10 years (N = 2).

Among the mental health workers, the highest occurrence was the 34% (N = 19) who have been involved with System of Care in Nevada for one (1) to three (3) years. This was followed by 23% (N = 13) who have been involved for longer than 10 years, 16% (N = 9) who have been involved for seven (7) to 10 years, and 14% (N = 8) who have been involved for four (4) to six (6) years. Additionally, 7% (N = 4) have been involved for less than a year while 5% (N = 3) claim to not be involved at all.

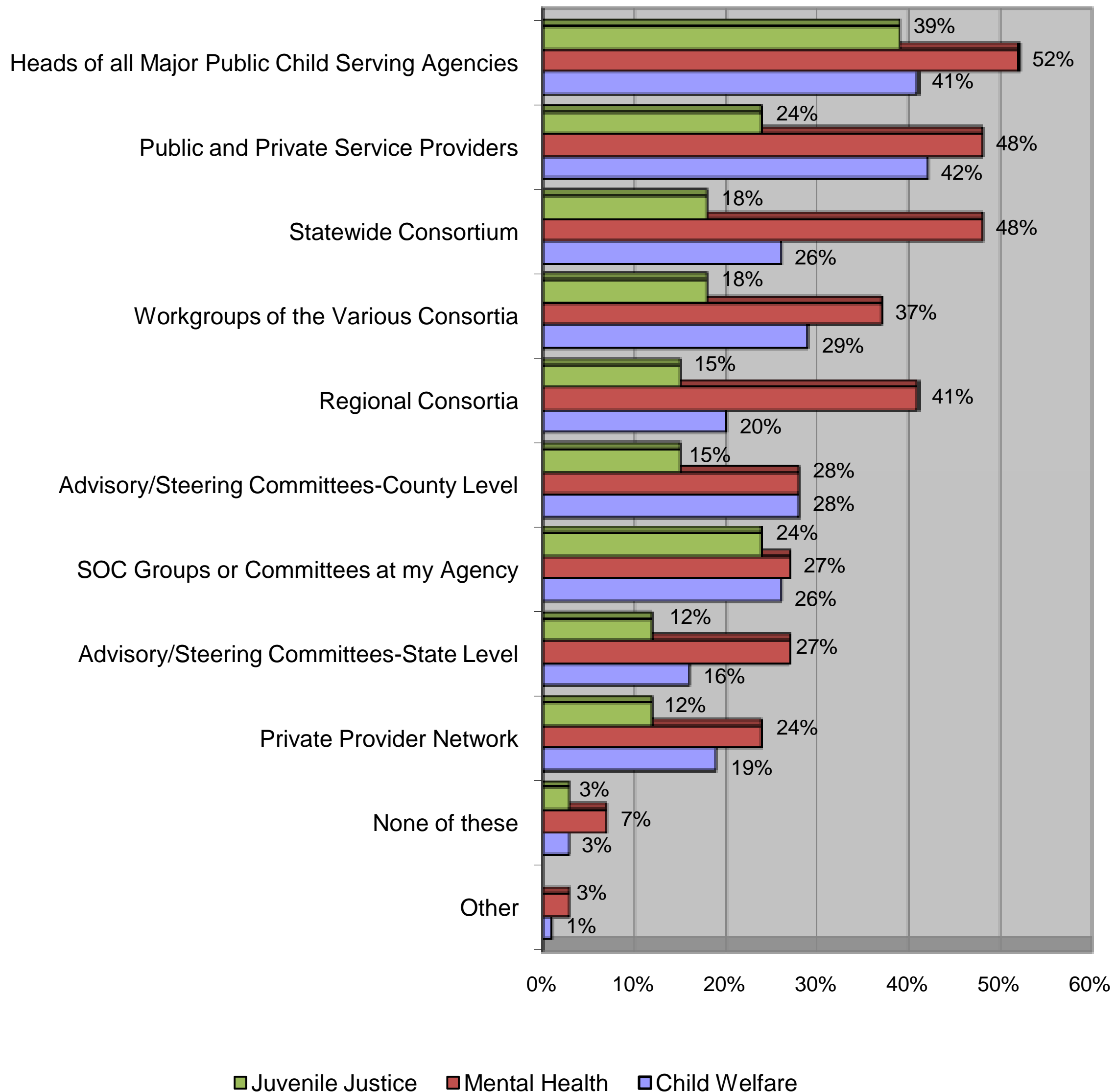
Among the juvenile justice workers, 15% have been involved with System of Care in Nevada for seven (7) to 10 years, another 15% reporting four (4) to six (6) years, and another 15% noting less than a year (N = 3). The highest occurrence among the juvenile justice workers is the 30% (N = 6) who have been involved with System of Care in Nevada for one (1) to three (3) years, followed by 20% at the other end of the spectrum noting being involved for 10 years or more (N = 4).

Member of the Community Collaborative

Member of Community Collaborative	2009 (N = 137)				2007 (N = 202)		
	Child Welfare (N = 57)	Mental Health (N = 56)	Juvenile Justice (N = 20)		Child Welfare (N = 66)	Mental Health (N = 73)	Juvenile Justice (N = 8)
Yes	15%	36%	5%		35%	23%	17%
No	85%	64%	95%		65%	77%	83%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

For 2009, mental health workers were more likely than other employee types to report being a member of the Community Collaborative. Thirty-six percent (36%, N = 20) of the mental health workers are a member of the Community Collaborative, as are 15 % (N = 9) of the child welfare workers, and 5% (N = 1) of the juvenile justice workers.

Collaboration Membership



For the 2009 follow-up data collection point, respondents were asked, "Who comes to mind when you think of the System of Care collaborative?" Participants were given the option of choosing more than one answer and this question was not asked of the 2007 cohort. When looking at the data from the employment groups, more than half (52%, N = 37) of the mental health workers indicated that the "heads of all the major public child and family serving agencies" comprised the System of Care collaborative, as did 41% of the child welfare workers (N = 38), and more than a third (39%) of the juvenile justice workers (N = 13).

Almost half (48%, N = 34) of the mental health workers reported that a "combination of public and private service providers" were members of the System of Care collaboration, as did 42% of the child welfare workers (N = 39), and a quarter (24%, N = 8) of the

juvenile justice workers. Forty-eight percent (48%, N = 34) of the mental health workers noted that the "statewide consortium" were members of the System of Care collaboration, followed by 26% of child welfare workers (N = 24), and 18% of the juvenile justice workers (N = 6).

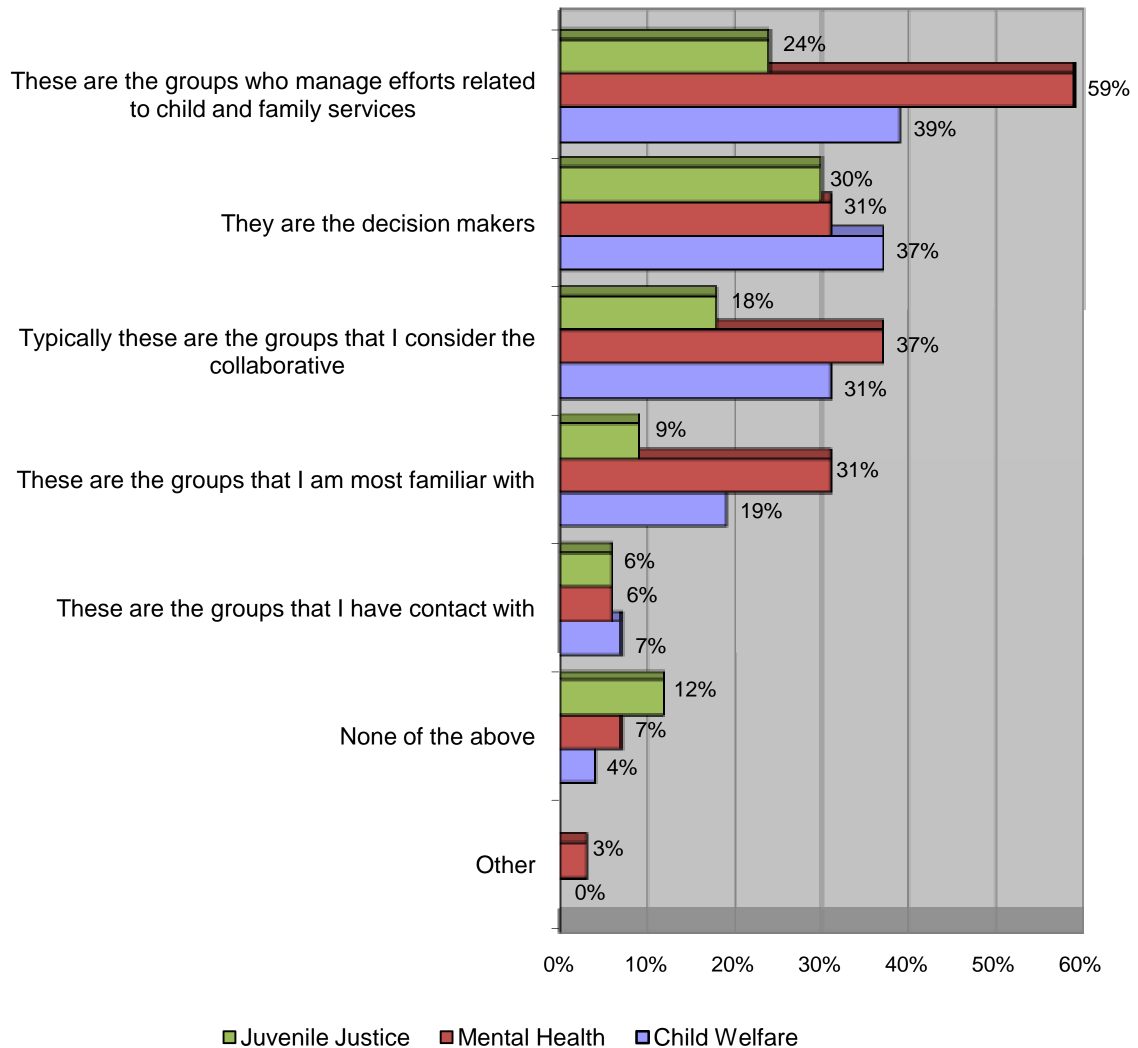
Thirty-seven percent (37%, N = 26) of the mental health workers perceive the "workgroups of the various consortia" as members of the System of Care collaboration, as does 29% of the child welfare workers (N = 27), followed by 18% of the juvenile justice workers (N = 6). Forty-one percent (41%, N = 29) of the mental health workers indicated that the "regional consortia" is part of the collaboration, as does 20% of the child welfare workers (N = 19) and 15% of the juvenile justice workers (N = 5).

Additionally, 28% of participants noted that "advisory or steering committees at the county level" are members of the System of Care collaborative (N = 20), as did another 28% of from the child welfare workers (N = 26) and 15% of the juvenile justice workers (N = 5). Just over a quarter (27%, N = 19) of the mental health workers reported that "groups or committees in charge of System of Care planning at my place of employment" are members of the collaborative, along with 26% of the child welfare workers (N = 24) and 24% of the juvenile justice workers (N = 8).

Over a quarter of the mental health workers (27%, N = 19) report that "advisory or steering committees at the state level" are members of the System of Care collaborative, as did 16% of the child welfare workers (N = 15) and 12% of the juvenile justice workers (N = 4). Similarly, about a quarter of the mental health workers (24%, N = 17) note "the private provider network" as members of the collaborative, along with 19% of the child welfare workers (N = 18) and 12% of the juvenile justice workers (N = 4).

Seven percent (7%, N = 5) of the mental health workers indicated that none of the choices provided were members of the System of Care collaborative, as did 3% of the child welfare workers (N = 3) and 3% of the juvenile justice workers (N = 1). Three percent (3%, N = 2) of the mental health workers reported that there were other entities involved as did 1% of the child welfare workers (N = 1)

Collaboration Membership – Continued



Participants from the 2009 cohort were asked, "Why do you regard these groups as the System of Care collaborative?" Again as in the previous question, participants were given the option of choosing more than one answer and this question was not asked of the 2007 cohort. When looking at the data from the employment groups, over half (59%, N = 42) of the mental health workers indicated that they regard these groups as the System of Care collaborative because "for the most part these are the groups/entities who organize and manage efforts related to child and family type of services." This was also the case for as 39% of the child welfare workers (N = 36), and 24% of the juvenile justice workers (N = 8).

More than a third (37%, N = 34) of the child welfare workers perceive these groups as the System of Care collaborative because "they are the decision makers," as does 31% of the mental health workers (N = 22) and 30% of the juvenile justice workers (N = 10). More

than a third of the mental health workers (37%, N = 26) perceive that "typically these are the groups that I consider the collaborative," as does 31% of the child welfare workers (N = 29) and 18% of the juvenile justice workers (N = 6).

Thirty-one percent (31%, N = 22) of the mental health workers perceive these groups as the System of Care collaborative because "these groups are the ones I am most familiar with," as does 19% of the child welfare workers (N = 18) and 9% of the juvenile justice workers (N = 3). Seven percent (7%, N = 6) of the child welfare workers note that "these are the groups that I have contact with," as does 6% of the mental health workers (N = 4) and 6% of the juvenile justice workers (N = 2).

Twelve percent (12%, N = 4) of the juvenile justice workers chose the "none of the above" category, as did 7% of the mental health workers (N = 5) and 4% of the child welfare workers (N = 4). Three percent (3%, N = 2) of the mental health workers chose the "other" category.

Frequency of Participation in Child and Family Team Meetings

Participation in Child and Family Team Meetings	2009 (N = 139)				2007 (N = 213)		
	Child Welfare (N = 62)	Mental Health (N = 57)	Juvenile Justice (N = 20)		Child Welfare (N = 83)	Mental Health (N = 99)	Juvenile Justice (N = 31)
Weekly	27%	25%	10%		-	-	-
Once a Month	31%	35%	25%		52%	63%	32%
Once every 2 -3 Months	8%	16%	0%		18%	11%	23%
Once every 4 -6 Months	8%	7%	10%		6%	5%	10%
Once every 7 -12 Months	7%	2%	5%		6%	2%	3%
Less than once a year	7%	5%	15%		6%	5%	3%
Never	13%	11%	35%		12%	14%	29%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the frequency that child welfare workers participate in child and family team meetings from 2009, the highest occurrence is the 31% who participate once monthly (N = 20). This is followed by 25% (N = 14) who participate in the meetings weekly. Sixteen percent (16%, N = 9) participate in the meetings once every two (2) or three (3) months, and 11% (N = 10) never participate in child and family team meetings. In the remaining frequency categories, 7% (N = 4) report participating in child and family team meetings once every four (4) to six (6) months, 5% (N = 3) participate less than once per year, and 2% (N = 1) report participating once every seven (7) to 12 months.

Among the mental health workers, the highest occurrence was the 35% (N = 20) who participate in the meetings once monthly. This is followed by 25% (N = 14) who participate in child and family team meetings on a weekly basis. Sixteen percent (16%, N = 9) of the mental health workers participate once every two (2) or three (3) months, and 11% (N = 6) never participate in the meetings. In the other remaining categories, 7% (N = 4) participate in the child and family team meetings once every four (4) to six (6)

months, 5% (N = 3) participate less than once per year, and 2% (N = 1) once every seven (7) to 12 months.

When looking at the juvenile justice workers, a little more than a third (35%) never participate in the meetings (N = 7), followed by 25% that participate once monthly (N = 5). Fifteen percent (15%, N = 3) attend the meetings less than once per year, 10% participate weekly (N = 2), another 10% do so once every four (4) to six (6) months (N = 2), and one person noted (5%) that they participate once every seven (7) to 12 months.

Frequency of Working with Other Agencies Serving Children and Families

Working with Other Agencies	2009 (N = 140)				2007 (N = 215)		
	Child Welfare (N = 63)	Mental Health (N = 57)	Juvenile Justice (N = 20)		Child Welfare (N = 84)	Mental Health (N = 100)	Juvenile Justice (N = 31)
3-5 times a week	60%	58%	25%		54%	47%	39%
1-2 times a week	16%	25%	35%		21%	24%	26%
Every 2 weeks	5%	0%	0%		6%	7%	0%
Once a month	10%	12%	15%		11%	4%	7%
Once every 2-3 months	3%	2%	10%		4%	8%	3%
Less than once every 4 months	2%	2%	5%		2%	3%	10%
Never	5%	2%	10%		2%	7%	16%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the data from the 2009 child welfare workers, more than half (60%) reported that they work with other agencies serving children and families three (3) to five (5) times weekly (N = 38). This is followed by 16% (N = 10) who work with other agencies one (1) or two (2) times weekly and 10% (N = 6) who do so once a month. Five percent (5%, N = 3) work with other agencies once every two (2) weeks, while another 5% (N = 3) never work with other agencies. Three percent (3%, N = 2) work with other agencies once every two (2) or three (3) months, and 2% (N = 1) do so once every four (4) months.

Among the mental health workers, 58% (N = 33) work with other agencies three (3) to five (5) times weekly. This is followed by 25% who work with other agencies once or twice weekly (N = 14), and 12% (N = 7) who do so once a month. Two percent (2%, N = 1) work with other agencies that provide services to children and families once every two (2) or three (3) months, another 2% (N = 1) do so once every four (4) months, and an additional 2% (N = 1) never work with other agencies.

Among the juvenile justice workers, 35% (N = 7) work with other agencies once or twice a week. This is followed by 25% (N = 5) who do the same three (3) to five (5) times weekly, and 15% (N = 3) who do once a month. Ten percent (10%, N = 2) work with other agencies once every two (2) or three (3) months, while another 10% (N = 2) never work with other agencies. One individual (5%) works with other agencies less than once every four (4) months.

Received Training in System of Care Principles

Training in System of Care Principles	2009 (N = 138)				2007 (N = 213)		
	Child Welfare (N = 63)	Mental Health (N = 56)	Juvenile Justice (N = 19)		Child Welfare (N = 83)	Mental Health (N = 100)	Juvenile Justice (N = 30)
Yes	46%	61%	42%		43%	56%	17%
No	54%	39%	58%		57%	44%	83%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Those who work in mental health are the most likely to have received training in System of Care principles. Sixty-one percent (61%) of the mental health workers (N = 34) indicated that they have received such training. Among the child welfare workers, 46% (N = 29) have received training in System of Care principles, and 42% (N = 8) of the juvenile justice workers have received the same.

Regularly Attend System of Care Workshops & Training

Training in System of Care Principles	2009 (N = 136)				2007 (N = 210)		
	Child Welfare (N = 61)	Mental Health (N = 55)	Juvenile Justice (N = 20)		Child Welfare (N = 80)	Mental Health (N = 99)	Juvenile Justice (N = 31)
Yes	16%	20%	15%		16%	17%	10%
No	84%	80%	85%		84%	83%	90%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Regardless of the area of employment, most of the respondents do not regularly attend System of Care workshops and training. Among the child welfare workers only 16% reported attending such (N = 10), as did 20% of the mental health workers (N = 11). Only three (7%) juvenile justice workers reported regularly attending System of Care workshops and training.

Number of Hours Spent in System of Care Training in the Past Six Months

System of Care Training Hours in the Past Six Months	2009 (N = 139)				2007 (N = 164)		
	Child Welfare (N = 63)	Mental Health (N = 57)	Juvenile Justice (N = 20)		Child Welfare (N = 84)	Mental Health (N = 100)	Juvenile Justice (N = 31)
7+ hours	8%	11%	0%		24%	18%	25%
4 – 6 hours	8%	4%	5%		2%	6%	5%
1 – 3 hours	19%	25%	15%		8%	4%	5%
None	65%	61%	80%		67%	72%	65%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the child welfare workers in 2009, most (65%) have not spent any hours in System of Care training in the past six months (N = 41). Among those that did, 19% trained for one (1) to three (3) hours (N = 12), 8% did so four (4) to six (6) hours (N = 5), and another 8% attended seven (7) hours or more (N = 5). Most (61%) of the mental

health workers also did not receive any System of Care training in the past six months (N = 34). Of the 36% who did, 25% received one (1) to three (3) hours (N = 14), 11% received more than seven (7) hours (N = 8), and 4% received four (4) to six (6) hours (N = 2). Additionally, most of the juvenile justice workers did not receive any System of Care training in the past six months (N = 16). Of those that did, three respondents (15%) received one (1) to three (3) hours of training, and one person (5%) received four (4) to six (6) hours of training.

Number of System of Care Training Hours at the Workplace Attended in the Last Six Months

System of Care Training at the Workplace in the Last Six Months	2009 (N = 139)				2007 (N = 70)		
	Child Welfare (N = 60)	Mental Health (N = 54)	Juvenile Justice (N = 20)		Child Welfare (N = 13)	Mental Health (N = 56)	Juvenile Justice (N = 1)
More than One	15%	9%	5%		77%	12%	100%
One	8%	20%	10%		23%	12%	0%
Zero	77%	71%	85%		0%	75%	0%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the 2009 data for the child welfare workers, 77% reported that they had not received any hours of System of Care training in their workplaces during the past six months (N = 46). Fifteen percent (15%) of the child welfare workers had received more than one training (N = 9), and 8% had received one (1) training regarding System of Care in their workplaces (N = 5).

Among mental health workers, most (71%, N = 40) reported that they had not received any hours of System of Care training in their workplaces during the past six months. Twenty percent (20%) of the mental health workers had received one (1) training (N = 11), and 9% had received more than one training regarding System of Care in their workplaces (N = 5).

Most (85%) juvenile justice workers reported that they had not received any hours of System of Care training in their workplaces during the past six months. Ten percent (10%) of the juvenile justice workers had received one (1) training (N = 2), and 5% had received more than one training regarding System of Care in their workplaces (N = 1).

Number of System of Care Training Hours Outside of the Workplace Attended in the Last Six Months

System of Care Training Outside the Workplace in the Last Six Months	2009 (N = 139)				2007 (N = 70)		
	Child Welfare (N = 60)	Mental Health (N = 56)	Juvenile Justice (N = 20)		Child Welfare (N = 74)	Mental Health (N = 56)	Juvenile Justice (N = 4)
More than One	8%	7%	5%		10%	9%	25%
One	10%	18%	5%		8%	11%	25%
Zero	82%	75%	90%		82%	80%	50%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the 2009 data for the child welfare workers, 82% reported that they had not received any hours of System of Care training outside their workplaces during the past six months (N = 49). Ten percent (10%) of the child welfare workers had received one (1) training (N = 6), and 8% had received more than one training regarding System of Care outside their workplaces (N = 5).

Among mental health workers, most (75%, N = 42) reported that they had not received any hours of System of Care training outside their workplaces during the past six months. Eighteen percent (18%) of the mental health workers had received one (1) training (N = 10), and 7% had received more than one training regarding System of Care outside their workplaces (N = 4).

Most (90%) juvenile justice workers reported that they had not received any hours of System of Care training outside their workplaces during the past six months. One worker (5%) had received one training (N = 2), and another worker (5%) had received more than one training regarding System of Care outside their workplaces (N = 1).

Desire More System of Care Training

Training in System of Care Principles	2009 (N = 130)				2007 (N = 211)		
	Child Welfare (N = 59)	Mental Health (N = 55)	Juvenile Justice (N = 16)		Child Welfare (N = 80)	Mental Health (N = 100)	Juvenile Justice (N = 31)
Yes	80%	73%	75%		88%	73%	87%
No	20%	27%	25%		12%	27%	13%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

Most respondents indicated that they want more opportunities to learn about System of Care and how to work according to the principles. Eighty percent (80%) of the child welfare workers (N = 47), 73% of the mental health workers (N = 40) and 75% of the juvenile justice workers (N = 12) want additional training opportunities.

Agency and Individual Involvement & Collaboration with System of Care

Mean Scores: Involvement and Collaboration

Item	2009					2007			
	Mean All	Mean Child Welfare	Mean Mental Health	Mean Juvenile Justice		Mean All	Mean Child Welfare	Mean Mental Health	Mean Juvenile Justice
Individual involvement with System of Care	**2.80**	2.53	3.21	2.26		**2.81**	2.65	3.12	2.32
Agency collaboration with other agencies	**3.79**	3.70	3.98	3.63		**3.68**	3.66	3.79	3.23
Agency involvement with System of Care	**3.28**	3.14	3.60	3.05		**3.40**	3.37	3.65	2.72

The table above shows the mean scores for respondents who were asked to rate their level of involvement, their agency's level of involvement, and collaboration with the System of Care. A five point scale was used where one (1) meant "uninvolved" or "no collaboration" and five (5) meant "very involved" or a "strong collaboration".

The highest mean score (3.79) was produced when respondents were asked to rate their agency's level of collaboration with other agencies. The highest mean produced among the subgroups is 3.98 by the mental health workers. The mean score for agency collaboration with System of Care among child welfare workers was 3.70, while the mean score for juvenile justice workers was 3.63.

The mean score for agency involvement with the System of Care among all respondents is 3.28. The mean score for the mental health workers when rating their agency's involvement with the System of Care is 3.6, while the mean was 3.14 among the child welfare workers and 3.05 for the juvenile justice workers.

When rating individual involvement with the System of Care, the mean score was 2.80. Among the subsets, mental health workers produced a mean score of 3.21, child welfare workers produced a mean of 2.53, and juvenile justice workers produced a mean of 2.26.

Weekly Contact with Other Agencies

Weekly Contact with Other Agencies	2009 (N = 138)				2007 (N = 207)		
	Child Welfare (N = 63)	Mental Health (N = 57)	Juvenile Justice (N = 20)		Child Welfare (N = 79)	Mental Health (N = 98)	Juvenile Justice (N = 30)
None	3%	4%	11%		4%	7%	17%
Less than 2 hours per week	19%	14%	42%		10%	24%	27%
3-7 hours per week	37%	55%	32%		32%	34%	20%
8-15 hours per week	19%	14%	11%		32%	21%	23%
16-25 hours per week	11%	9%	5%		11%	8%	7%
26-35 hours per week	10%	2%	0%		8%	3%	7%
36 hours or more per week	2%	2%	0%		4%	3%	0%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the 2009 data for the child welfare workers, 37% of the respondents have three (3) to seven (7) hours of weekly contact with other agencies that provide services to the children or families that they serve (N = 23). This was the highest incidence. This was followed by 19% that have less than two (2) hours of weekly contact (N = 12), while another 19% have eight (8) to 15 hours of weekly contact (N = 12). Eleven percent (11%) have 16 to 25 hours of contact weekly with other agencies (N = 7), 10% have 26 to 35 hours of weekly contact (N = 6), and 3% have no weekly contact (N = 2). One respondent (2%) reported that they have 36 hours or more of weekly with other agencies (N = 1).

The findings for the mental health workers are somewhat similar. Fifty-five percent (55%) of the respondents have three (3) to seven (7) hours of weekly contact with other agencies that provide services to the children or families that they serve (N = 31). This was followed by 14% that have less than two (2) hours of weekly contact (N = 8), while another 14% have eight (8) to 15 hours of weekly contact (N = 8). Nine percent (9%) have 16 to 25 hours of contact weekly with other agencies (N = 5), while 4% have no weekly contact (N = 2). The lowest incidence was shared between two categories; one respondent (2%) noted they have 26 to 35 hours of weekly contact, and another (2%) noted they have 36 hours or more of weekly contact.

Among the juvenile justice workers, 42% reported having less than two (2) hours of weekly contact with other agencies that provide services to the children or families that they serve (N = 8). This was followed by 32% that have three (3) to seven (7) hours of weekly contact (N = 6), 11% have eight (8) to 15 hours of weekly contact (N = 2), while another 11% have no weekly contact (N = 2). The lowest incidence was the one respondent (5%) that reported to have 16 to 25 hours of contact weekly with other agencies.

Agency Implementation Practices

Mean Scores: Agency Implementation Practices

Item	2009					2007			
	Mean All	Mean Child Welfare	Mean Mental Health	Mean Juvenile Justice		Mean All	Mean Child Welfare	Mean Mental Health	Mean Juvenile Justice
Implementation of family-centered practices	**3.53**	3.41	3.74	3.47		**3.56**	3.52	3.77	2.97
Implementation of community-based care	**3.38**	3.10	3.65	3.37		**3.41**	3.40	3.57	2.93
Implementation of culturally competent practices	**3.23***	2.98	3.44	3.42		**2.98**	2.88	3.11	2.60

*indicates 2009 mean scores that are significantly different than 2007.

Mean scores were computed for the agency's implementation practices in three areas. Respondents used a scale where one (1) meant "poor" or "don't" use and five (5) meant "excellent".

Overall, the highest mean score (3.53) was produced when rating the agency on its implementation of family-centered practices. Among the sub groups the highest mean score for this item was 3.74 as rated by the mental health workers. The juvenile justice workers rated their agencies implementation of family centered practices with a mean of 3.47, while the mean for the child welfare workers for this item was 3.41.

Agency implementation of community-based care produced an overall mean score of 3.38. The highest mean among the groups of employees was the 3.65 as rated by the mental health workers. The mean score for juvenile justice workers on this item was 3.37 and the mean for the child welfare workers was 3.10.

When rating their agency's implementation of culturally-based care, a mean score of 3.23 was produced survey wide. Among the groups of workers, the highest mean was again produced by the mental health workers (3.44). The mean score for juvenile justice workers was 3.42, and for child welfare workers it was 2.98.

Weekly Contact with Parents of Families You Are Working With

Weekly Contact with Parents	2009 (N = 137)				2007 (N = 198)		
	Child Welfare (N = 62)	Mental Health (N = 56)	Juvenile Justice (N = 19)		Child Welfare (N = 75)	Mental Health (N = 95)	Juvenile Justice (N = 28)
None	13%	7%	21%		15%	13%	11%
Less than 2 hours per week	29%	27%	42%		16%	18%	39%
3-7 hours per week	16%	36%	26%		16%	23%	11%
8-15 hours per week	18%	11%	11%		32%	26%	14%
16-25 hours per week	10%	9%	0%		16%	12%	11%
26-35 hours per week	8%	7%	0%		1%	5%	7%
36 hours or more per week	7%	4%	0%		4%	3%	7%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

When looking at the 2009 data from the child welfare workers, almost a third (29%) spend two (2) hours or less with weekly contact with parents of the families they are working with (N = 18); this was the highest occurrence. This was followed by 18% that have eight (8) to 15 hours of weekly contact (N = 11), 16% that have three (3) to seven (7) hours of weekly contact (N = 10), while 13% have no weekly contact (N = 8). Ten percent (10%) have 16 to 25 hours of weekly contact (N = 6), followed by 8% that have 26 to 35 hours of weekly contact. The lowest incidence was the 7% of child welfare workers that have more than 36 hours of weekly contact with parents (N = 4).

Among the mental health workers, more than a third (36%) spend three (3) to seven (7) hours of weekly contact with parents of families they are working with (N = 20). This was followed by 27% that spend less than two (2) hours per week (N = 15), 11% that have eight (8) to 15 hours of weekly contact (N = 6), and 9% that have 16 to 25 hours of weekly contact (N = 5). Seven percent (7%) have 26 to 35 hours of weekly contact, while another 7% have no weekly contact (N = 4), and 4% that have more than 36 hours of weekly contact with parents (N = 2).

When looking at the data for juvenile justice workers, 42% spend two (2) hours or less with weekly contact with parents of the families they are working with (N = 8). This was followed by 26% that have three (3) to eight (8) hours of weekly contact (N = 5), while 21% have no weekly contact (N = 4), and 11% have eight (8) to 15 hours of weekly contact with parents (N = 2).

If you have had System of Care training, how well does the system of service in your county match the principles learned in training?

Weekly Contact with Parents	2009 (N = 70)				2007 (N = 82)		
	Child Welfare (N = 29)	Mental Health (N = 33)	Juvenile Justice (N = 8)		Child Welfare (N = 29)	Mental Health (N = 48)	Juvenile Justice (N = 5)
No Match	3%	3%	0%		3%	8%	0%
Some Match	48%	30%	63%		28%	21%	20%
Neutral	35%	46%	25%		31%	56%	80%
Good Match	14%	15%	0%		35%	15%	0%
Excellent Match	0%	6%	13%		3%	0%	0%
Total	**100%**	**100%**	**100%**		**100%**	**100%**	**100%**

In the last question on the System of Care questionnaire, respondents were asked to indicate how well the system of services in their county matches the principles learned about in the System of Care training. The data reported in the chart above is only for those respondents who in an earlier question indicate that they had been trained in System of Care principles.

When looking at the responses obtained from the 2009 subset, child welfare workers who had earlier indicated that they received System of Care training (N = 34), the highest occurrence was the 48% (N = 14) who thought that the match between the System of Care services in their county and principles learned in System of Care training were somewhat matched. Thirty-five percent (N = 10) remained neutral on this question, while 14% (N = 4) thought there was a good match, and 3% thought there was no match at all.

When looking at the responses obtained from the mental health workers (N = 29) who had earlier indicated that they received training in System of Care principles, 46% (N = 15) remained neutral on this question. Thirty percent (30%, N = 10) described the match between service and System of Care principles as "some match", while 15% (N = 15) described the match as good. At the opposite sides of the continuum, 6% thought there was an excellent match (N = 2), while one person (3%) thought there was no match between service and System of Care principles.

When looking at the responses obtained from the juvenile justice workers (N = 8) who had earlier indicated that they received training in System of Care principles, 63% (N = 5) described the match between service and System of Care principles as "some match". Twenty-five percent (25%, N = 2) remained neutral on this question, and one person (13%) thought there was an excellent match between service and System of Care principles.

System of Care Questionnaire: Data Trend Summary & Salient Issues

In 2007 (baseline measure) half of the workforce (n = 239) sampled reported that their System of Care involvement had only been for less than three years. Also, more than half of the sample reported never having been trained in System of Care. In 2009 only one-third of the sampled workforce (n = 232) reported that their System of Care involvement was less than three years and during the repeat measurement period, less than half of the workforce reported having never been trained in System of Care. It should be noted that those workforce members who work in children's mental health are most likely to have received System of Care training. Conversely, a significant majority of those workforce members who report receiving no training in System of Care comprise the child welfare and juvenile justice staff.

In terms of the extent to which System of Care is being implemented in the workplace and the community, in 2007 only two areas of strength could be identified: (1) effective collaboration at the child and family level; and (2) efficiency in service provisions. In 2009, the workforce noted more areas of strength. Improvements from baseline to the repeat measurement period were noted in: (1) communication and information dissemination; (2) cultural competency; and (3) organizational support. Like the findings concerning System of Care training, it is the mental health workforce (versus the child welfare and juvenile justice) that reports the highest System of Care adherence scores.

Chapter Seven: System of Care Questionnaire Significant Mean Differences

When analyzing the effects of demographics on the scales generated from the System of Care Questionnaire, significant findings emerged.

Analysis of Variance: Significant by Location

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences High Category	Low Category	Difference	Sig.	Statistically Significant in 2007
Community Support	.003	Washoe	Clark	.45119	.002	No
		Washoe	Rural	.48214	.031	No
Family Advocacy & Support	.005	Washoe	Clark	.36911	.009	No
Communication & Information Dissemination	.001	Washoe	Rural	.91176	.001	No
		Clark	Rural	.57143	.022	No

The mean for Washoe County on the "Community Support" scale (M = 2.88) was significantly higher than the means for Clark (M = 2.42) and the rural counties (M = 2.39). This means that respondents in Washoe County perceived that there was more "Community Support" around System of Care than respondents in Clark and the rural counties. Additionally, the mean score for the "Family Advocacy and Support" scale was significantly higher in Washoe (M = 3.27) versus Clark County (M = 2.90). That is, respondents in Washoe county were more likely to perceive greater levels of "Family Advocacy and Support" in their community than respondents in Clark County. Lastly, means for Washoe (M = 3.21) and Clark Counties (M = 2.87) were significantly higher for the "Communication and Information Dissemination" scale than the rural counties (M = 2.30). In other words, respondents in the rural counties did not perceive the "Communication and Information Dissemination" efforts regarding System of Care as positively as respondents in Washoe and Clark counties.

Analysis of Variance: Significant by Position Type

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences			Sig.	Statistically Significant in 2007
		High Category	Low Category	Difference		
Community Support*	.054	Other	Therapist/ Clinician	.67199	.026	No
Communication & Information Dissemination	.001	Administration	Therapist/ Clinician	.80991	.016	No
		Other	Therapist/ Clinician	.95241	.001	No

* Nearly significant

The "Communication and Information Dissemination" subscale varied significantly by two position types, and "Community Support" was nearly significant. When it came to perceptions of "Community Support" for System of Care, therapists/clinicians (M = 2.20) perceived there to be less than those that chose the category "other" (M = 2.87) for their position type. Additionally, therapists/clinicians (M = 2.43) did not perceive the efforts around "Communication and Information Dissemination" regarding System of Care as positively as administrators (M = 3.24) and those that chose "other" (M = 3.38).

Analysis of Variance: Significant by Years in Position

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences			Sig.	Statistically Significant in 2007
		High Category	Low Category	Difference		
Collaboration at the System Level	.033	7 to 9 years	10+ years	.58877	.022	No
Efficiency in Service Provision	.047	N/A	N/A	N/A	N/A	No
Cultural Competence	.044	N/A	N/A	N/A	N/A	No

Three scales varied significantly across the categories of years in position. However, "Efficiency in Service Provision" and "Cultural Competence" showed no significant category-to-category relationships with a post-hoc analysis. "Collaboration at System the Level" was significantly higher for the seven (7) to nine (9) years category (M = 3.29) than for the 10 or more years category (M = 2.70). In other words, those respondents that have been in their current position from seven (7) to nine (9) years perceive greater "Collaboration at the System Level " taking place around System of Care practices than those that have been in their current position for 10 or more years.

Analysis of Variance: Significant by Years at Agency

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences				Statistically Significant in 2007
		High Category	Low Category	Difference	Sig.	
Community Support	.043	N/A	N/A	N/A	N/A	Yes
Efficiency in Service Provision	.018	3 to 5 years	10+ years	.46693	.033	No
Community-Based Services*	.056	N/A	N/A	N/A	N/A	No

* Nearly significant

Three scales varied significantly across the categories of years at agency. However, "Community Support" and "Community-Base Services" showed no significant category-to-category relationships with a post-hoc analysis. For the "Efficiency in Service Provision" scale, the three (3) to five (5) years category was significantly higher (M = 3.49) than the 10 or more years category (M = 3.02). In other words, those workers who have worked at their agency from three (3) to five (5) years are more apt to perceive "Efficiency in Service Provision" around System of Care practices more satisfactory than workers who have been with their agency for five (5) to nine (9) years.

Analysis of Variance: Significant by Education

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences				Statistically Significant in 2007
		High Category	Low Category	Difference	Sig.	
Communication and Information Dissemination	.003	High School Diploma	Bachelor's Degree	1.05342	.015	No
		Associates' Degree	Bachelor's Degree	.87246	.032	Yes

"Communication and Information Dissemination" was significantly higher for those with a high school diploma (M = 3.71) and associates' degree (M = 3.53) than for those with a bachelor's degree (M = 2.66). In other words, those with a bachelor's degree did not perceive the efforts around "Communication and Information Dissemination" regarding System of Care as positively as those with an Associates' degree or less.

Analysis of Variance: Significant by Race/Ethnicity

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences			Sig.	Statistically Significant in 2007
		High Category	Low Category	Difference		
Community-Based Services	.002	Black	Hispanic	.32112	.032	Yes
		Black	White	1.05093	.001	No

The "Community-Based Services" scale was significantly higher for Black respondents (M = 3.38) than for Hispanic (M = 2.48) and White (M = 2.32) respondents. This means that Black respondents perceived "Community-Based Services" around System of Care practices as adequate or at least at an acceptable level more often than Hispanic and White respondents.

Analysis of Variance: Significant by Years in Social Services

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences			Sig.	Statistically Significant in 2007
		High Category	Low Category	Difference		
Community-Based Services*	.059	N/A	N/A	N/A	N/A	Yes

* Nearly significant

The "Community-Based Services" scale varied significantly across categories, but a post-hoc analysis showed no significant category-to-category relationships.

Analysis of Variance: Significant by Age

Scale	ANOVA Sig.	Post-Hoc Analysis: Significant Differences			Sig.	Statistically Significant in 2007
		High Category	Low Category	Difference		
Family Advocacy and Support	.050	N/A	N/A	N/A	N/A	No
Clarity of Mission and Purpose	.041	N/A	N/A	N/A	N/A	No

The "Family Advocacy and Support" and "Clarity of Mission and Purpose" scales varied significantly across categories, but a post-hoc analysis showed no significant category-to-category relationships.

Significant Mean Differences: Data Trend Summary & Salient Issues

The way in which a workforce member perceives and experiences the System of Care in Nevada differs somewhat based on his/her socio-demographic characteristics. For example, it is the Washoe County workers' (as opposed to the Clark and Rural County workers) perception that there is more community support for System of Care in their area. This is also true with respect to family advocacy and support; whereby, the Washoe County workforce reports higher levels of activities than do the Clark County workforce members. In terms of communication and information dissemination, the Washoe and the Clark County workforce perceive this aspect of the Nevada System of Care more favorably than do the Rural County workforce.

Clinicians/therapists are less likely than any other position type (including administrators) to have a perception that community supports are adequate. Moreover, workers who have been in their positions 7-9 years perceive greater collaboration at the system level than do those who have been in their positions more than 10 years. Likewise, it seems that those workers who have been in their positions for only 3-5 years perceive there to be higher levels of efficiency in service provisions than workers who have been on the job for long periods of time (more than 5 years).

References

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Appendices

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Appendix A

NEVADA CHILDREN'S BEHAVIORAL HEALTH CONSORTIUM

"Building Nevada's System of Care for Children and Their Families"

Membership:

- Clark County Children's Mental Health Consortium
- Clark County Children's Mental Health Consortium Family Member
- Rural Mental Health Consortium
- Rural Mental Health Consortium/Family Member
- Washoe County Children's Mental Health Consortium
- Washoe County Children's Mental Health Consortium Family Member
- Division of Child and Family Services
- Division of Health Care Financing & Policy
- Division of Health
- Division of Mental Health & Developmental Services
- Washoe County Dept. of Social Services
- Clark County Dept. of Family Services
- Nevada Youth Care Providers
- Nevada Parents Encouraging Parents
- Substance Abuse Prevention and Treatment Agency
- Substance abuse provider
- Behavioral Health Strategies
- Family and Juvenile Courts
- Clark County School District
- Washoe County School District
- Clark County Dept. of Juvenile Justice
- Washoe County Dept. of Juvenile Services
- Inter-Tribal Council

NEVADA'S SYSTEM OF CARE

Nevada's System of Care meets the multiple and changing needs of families, children, and youth through a comprehensive, integrated, and coordinated continuum of services and supports.

Definitions:

Family – can be defined in a myriad of ways such as: adult(s), children, and youth in a parenting relationship; legal guardians; adoptive relationship; substitute or foster care; or emancipated youth. Throughout this document the word family will be used in place of any specific situation.

Comprehensive – a full array and timely access to services that families, children and youth need

Integrated – the elimination of service delivery silos

Coordinated – agencies working together to ensure services are seamless

Philosophy:

System of care is not a program — it is how care is delivered whether voluntarily or involuntarily; directly or indirectly. System of Care is a committed and sustainable approach to services that values and responds to the importance of family, school and community, that seeks to promote the full potential of every child, youth and family member by addressing their individual physical, emotional, intellectual, educational, cultural and social needs while balancing risks that may be identified for the child, youth and/or family.

Attributes:

Family Driven: Families have a key-decision role in the care of their own children as well as in policies and procedures governing care for all children in their own community, state, and tribe. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; and determining the effectiveness of all efforts to promote the mental health and wellbeing of children and youth.

Youth Guided/Youth Directed/Youth Driven: Recognizes that youth must be heard and listened to but that in order for their full, authentic involvement we must provide them with tools and opportunities to participate in the process.

Strengths-based: Recognizes and builds upon each family's unique strengths which are the cornerstone for immediate and future success.

Comprehensive array of Traditional and Non-traditional Services: Includes the full range of services and supports from public and private agencies, and the community. Non-traditional services can include, but are not limited to, recreation, faith-based, and the performing arts. These services must be accessible in a timely and meaningful manner to support positive outcomes for families.

Common Intake and Assessment: Commitment by all partners to the collection of common information that with proper consent can be shared across systems.

Outcomes, Evaluation, and Quality Improvement: Outcomes are evaluated at the individual, agency, and system levels to measure the quality of care. Results from evaluation and quality improvement processes are used to make decisions and to guide policy making. Evaluation and quality improvement activities include:

- How to best meet the needs of children, youth and families;
- Determining if services and supports are working and used;

- Determining the cost of services and supports
- Assessing the need for additional resources and services;
- Providing feedback to those who provide services and information; and,
- Continually assessing the system of care's capacity to respond to feedback and implement change.

Evaluation and quality improvement aids in building a system of care by examining what we are doing and how we can do it better. The results of all evaluations and quality improvement activities are provided to families, system partners and community stakeholders.

Workforce Practices: Provides state-of-the art and effective organizational supports to workforce development initiatives and continuous improvement processes in service development and delivery. State of the art workforce development practices include an organizational culture which supports worker well-being, evidence based practice in recruitment, retention, and selection strategies, clinical supervision programs, mentoring, evaluation and goal setting, team building, organizational culture change management, and other related initiatives. The intention is to facilitate family and youth choice in achieving positive outcomes for children and families, and to support the service delivery system.

Culturally and Linguistically Competent/Responsive: Recognizes that every family has individual cultural values. Services are responsive with an awareness and respect of the importance of values, beliefs, traditions, customs, and parenting styles of families. Services also take into account the varying linguistic needs of individuals who speak different languages, have varying literacy skills, and who need a variety of communication formats.

Community-based Services and Supports: Afford families early intervention and services in the communities where they live. Such services and supports allow families to remain intact **and** recognizes that children, youth and families thrive in the context of their homes, communities and schools.

RESOURCES

Tips and Additional Talking Points:

Youth Guided/Youth Directed/Youth Driven: The process from youth guided to youth driven is a continuum to engage youth with the final goal of authentic youth involvement. At this point in time we

must begin by implementing youth guided policies with the goal of moving these policies through youth directed to youth driven. When we have reached youth driven policies they will include policies such as: youth setting agendas and calling meetings; youth informing the public about current policies and having a position platform; and youth being able to function as self advocates and peer advocates in the policy making process.

Strengths-based: A recognition that type and context of strengths can vary from family to family. A request for information and/or services can be the starting point for dealing with strengths in some families.

Common shared information: This attribute is an essential component of a seamless system to expedite services to a family.

Workforce practices: The success of this attribute lies in building the infrastructure needed to ensure that we have the right people with the right skills doing the right things at the right times. Workforce practices which build the needed infrastructure include: evaluation and goal setting, supervision, mentoring/coaching, professional development (of which training is one service component), recruitment, retention, selection, performance appraisals, developing teams and delegating authority for decision making to teams, workforce performance, organizational readiness and culture change management, etc. These work force development elements will build our infrastructure to support our workforce in moving the system forward toward improved services, including a better and broader service array, and improved outcomes for children and families.

Community based: By offering a wide range of community-based services we are promoting safety, permanency and well being of children, youth and families.

Performance and Quality Improvement: This process commits us to "continuous quality improvement' in Nevada's System of Care.

The following references provide additional information on System of Care, Family-Driven Care, and Youth Guided, Directed and Driven Care.

Pires, S.A. (2002). *Building systems of care: A primer*. Washington, DC: Human Service Collaborative.

Working Definition and tools: www.ffcmh.org/systems_whatis.htm

Webinar and supporting documents – follow links under Defining Family Driven Care to: View the PowerPoint slides for the Webinar; View the definition of family-driven care; Read the story "Journey to Family-Driven Policy;" or post a message to the discussion board: www.tapartnership.org/advisors/family/the_family_page.asp

Achieving the Promise: Report of the President's Commission on Mental Health Web site: www.mentalhealthcommission.gov/reports/FinalReport/toc.html

McCarthy, J., Marshall, A., Collins, J., Arganza, G., Deserly, K. & Milon, J. (2003) A family's guide to the child welfare system from www.tapartnership.org/advisors/ChildWelfare/resources/AFamilysGuideFINAL%20WEB%20VERSION.pdf

Substance Abuse and Mental Health Service Administration System of Care Web site: www.systemsofcare.samhsa.gov

Appendix B

NEVADA CHILDREN'S BEHAVIORAL HEALTH CONSORTIUM

"Building Nevada's System of Care for Children and Their Families"

I, ______________________________, commit to Nevada's System of Care (NV SOC) Philosophy and the attributes that further explain the philosophy.

I understand that by committing to NV SOC that:

- In my leadership role I will pass along the NV SOC and its attributes to all that I lead.
- I will expect that everyone working for me will read and understand the NV SOC and its attributes.
- I expect that all the people working for me will pass this information to everyone in my agency and or business.
- I will expect that everyone incorporate the NV SOC and its attributes into our business model.

I understand that by committing to NV SOC and its attributes I can:

- Request assistance in training my staff
- Review the NV SOC and its attributes on a regular basis and make suggestions for changes based on actual experiences in implementing the philosophy and attributes

This document was signed on _______________________

By: ____

Representing: ______________________________________

Appendix C – Demographic Questionnaire

Child and Adolescent Mental Health and
Substance Abuse Infrastructure Grant

This questionnaire is for demographic purposes only and will not be used to identify you or your individual responses on the surveys that you complete.

1. Which category best describes your area of employment? You may select more than one:

   □ Child Welfare □ Juvenile Justice
   □ Mental Health □ Substance Abuse
   □ Education
   □ Other: (specify) ____
   □ Other: (specify) ____

2. Which category best describes your position in your current agency?

   □ Case Manager □ Supervisor □ Administration
   □ Therapist/ Clinician □ Management □ Community Leader
   □ Other: (specify) ____
   □ Other: (specify) ____

3. Age:

   □ 18 – 24 □ 35 – 44 □ 55+
   □ 25 – 34 □ 45 – 54

4. Gender:

   □ Male □ Female

5. Race/ Ethnicity: You may select more than one.

   □ Black □ Hispanic □ White
   □ Asian/ Pacific Islander □ Native American
   □ Other: (specify) ____________________________

6. Are you Bilingual?

   □ Yes □ No

7. What language(s) do you speak fluently?

□ English □ Spanish □ French

□ Japanese □ Chinese: (specify type) ______________________

□ Native American: (specify type) ___________________________

□ Other Language: (specify type) ____________________________

8. Do you use your bilingual skills in your workplace?

□ Yes □ No

If yes, for Translation Services ______ Interpreter Services ________

What is the language that you use for bilingual services at your place of employment? ____

9. Type of Residence:

□ Urban □ Rural □ Frontier □ Other

10. Educational Background:

□ High School Diploma □ Masters' Degree

□ Associates' Degree □ Post Graduate

□ Bachelor's Degree □ Ph.D.

□ Other: (specify) ____

11. Practitioner License Type:

□ Psychology □ Other: (specify) ________________

□ Social Work □ None

□ Marriage and Family Therapy

□ Substance Abuse/Addictions

12. How many years have you been at your current agency?

□ Less than 1 year □ 5 to 7 years

□ 1 to 3 years □ 7 to 9 years

□ 3 to 5 years □ 10 + years

13. How many years have you worked in your current position?

□ Less than 1 year □ 5 to 7 years

□ 1 to 3 years □ 7 to 9 years

□ 3 to 5 years □ 10 + years

14. How many years have you worked in the social services field?

□ Less than 1 year	□ 5 to 7 years
□ 1 to 3 years	□ 7 to 9 years
□ 3 to 5 years	□ 10 + years

15. How many years have you provided children's mental health or children's mental health related services?

□ Less than 1 year	□ 5 to 7 years
□ 1 to 3 years	□ 7 to 9 years
□ 3 to 5 years	□ 10 + years
□ None	

16. What is your current case load size?

□ Less than 20	□ 41-59	□ N/A
□ 20 – 40	□ 60 – 80	□ 80 – 100

Child and Adolescent Mental Health and Substance Abuse Infrastructure Grant Workforce Development and Cultural Competency Needs Assessment

System of Care Questionnaire

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System of Care (SOC) Questionnaire

System of Care (SOC) is a service philosophy that has been adopted by child- and family-serving agencies throughout the state of Nevada for over a decade. The System of Care model defines principles to guide the organizational structure of an integrated service delivery system. This questionnaire is designed to gather your feedback and thoughts about the performance of the SOC structure in your county.

Please answer the following questions using the scale below. **Please answer the items in regards to the services for children and their families currently provided in your county unless otherwise specified**. We realize that not everyone will be knowledgeable of every one of the key areas covered in the assessment. If you find that you cannot answer some of the questions, you may answer **"Don't Know."** We would appreciate it, however, if you would provide your candid opinion about the areas and issues with which you are familiar.

IMPORTANT NOTE: The term "community collaborative" refers to the core group of leaders/administrators from public child and family serving agencies (e.g., mental health, child welfare, juvenile justice, school district) and their parent partners (e.g., Nevada Parents Encouraging Parents) who meet regularly to plan "cross-system" work.

If you do not know how to respond to the item, please answer the item with "DK".

1	2	3	4	5	DK
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know

Organizational Support

1. _____Supervisors in my agency/organization encourage staff to be involved in System of Care activities.
2. _____I am so burdened with my other responsibilities that I have little time or energy left to contribute to the System of Care.
3. _____I have clear personal performance goals regarding my contributions to the System of Care.
4. _____The System of Care has taken up so much of my time that I am falling behind with my other "primary" work responsibilities.
5. _____The details of assigned responsibilities concerning the System of Care are well explained to staff in my agency.
6. _____My supervisor has thoroughly explained to me my responsibilities to the System of Care.
7. _____A positive annual evaluation depends on my involvement in the System of Care.

Community Support

1. _____The community provides support for the development of the System of Care.
2. _____The community provides adequate funding for the System of Care.
3. _____People in the community make an effort to learn about the System of Care.
4. _____Nontraditional agencies or support groups are willing to participate in the System of Care.

Family Advocacy and Support

1. _____When necessary, service providers make it easy for families to move from one service provider to another.
2. _____Families and service providers are given ample opportunities to learn about each other's resources and capabilities.
3. _____Families feel that their input is welcome.
4. _____Service providers take families' input seriously.
5. _____My agency provides flexible funding to help families receive the services they need.
6. _____The agencies are willing to be flexible scheduling meetings so families and informal supports can attend.

Communication and Information Dissemination

1. _____My agency regularly receives useful information about the System of Care from our System of Care management.
2. _____I receive timely news and information about the System of Care from our System of Care management.
3. _____I regularly receive the minutes of each Collaborative meeting.
4. _____Our Collaborative effectively uses timely notices and written agendas.
5. _____There are adequate opportunities for my concerns to be heard and fed back to our System of Care management.

Interagency Collaboration

Collaboration Membership: Who comes to mind when you think of the System of Care "collaborative" (check all that apply)

1. _____Regional Consortia
2. _____Statewide Consortium
3. _____Workgroups of the various consortia
4. _____Groups or committees in charge of System of Care planning at my place of employment
5. _____Advisory or steering committees at the county level
6. _____ Advisory or steering committees at the state level
7. _____The heads of all the major public child and family serving agencies (e.g. children's mental health, child welfare, juvenile justice, education)
8. _____The private provider network
9. _____Combination of public and private service providers
10. _____None of the above
11. _____Other, please specify:____

Collaboration Membership (continued): Why do you regard these groups as the System of Care "collaborative" (check all that apply)

12. _____They are the decision makers
13. _____Typically these are the groups/entities that most would consider to be the "collaborative"
14. _____For the most part these are the groups/entities who organize and manage efforts related to child and family type of services
15. _____These are the only groups/entities that I have contact with
16. _____These are the groups/entities that I am most familiar with
17. _____None of the above
18. _____Other, please specify:____

Decision Making

19. _____The leaders of the System of Care encourage all members, even those with different opinions, to participate in decision-making about planning and policies.
20. _____The different members of the Collaborative work together in effective decision making.
21. _____The child and family serving agencies make effective joint decisions through interagency collaboration.
22. _____Parents are equal partners with providers in deciding what services are available in the community.
23. _____Decisions made by the Collaborative reflect the consensus of the group members.

Collaboration at the Systems Level

24. _____The system of services for children and families is well coordinated and agencies collaborate well.
25. _____The system of services for children and families has become better coordinated and has shown greater collaboration over the past few months.
26. _____Providers who serve children and families often ignore the concerns and input of other agencies or professionals.
27. _____Providers who serve children are able to function together as a unit to create a System of Care.
28. _____When agencies have conflicts, they are able to resolve them in a way consistent with the System of Care principles.
29. _____My agency contributes to an interagency pool of flexible funds for children and their families.

Collaboration at the Child and Family Team Level

30. _____When service providers have children and families with multiple needs, multiple agencies are regularly involved.
31. _____Development of a multi-agency plan is standard for children and families with multiple needs.
32. _____Service providers follow through on commitments made at Child and Family Team Meetings.
33. _____Agencies are flexible in their processes and criteria so that children and family needs are met.
34. _____Agencies collaborate in financing services for individual children and families.
35. _____There is a high level of coordination between service providers who serve children.
36. _____Plans for children and families with multiple needs regularly include informal community resources.

Efficiency in Service Provision

37. _____Service agencies dealing with children and families work hard to eliminate ineffective procedures and improve their efficiency.
38. _____Service agencies have developed interagency agreements to avoid needless duplication of effort.
39. _____Different service providers are able to work together so that services are delivered in an organized, complementary and effective manner.
40. _____While collaboration among service providers takes more time and effort, it helps us better serve children and their families.
41. ______Agencies are able to work together to meet clients' needs in a timely manner.

Membership

1. _____The System of Care has successfully recruited people from diverse constituencies to help meet the needs of children and families.
2. _____We have consistent and meaningful parent participation in the System of Care.
3. _____The membership of our Collaborative reflects the cultural diversity of the community.
4. _____The primary agencies that serve children with special needs and their families are represented on our Collaborative.

Clarity of Mission or Purpose

Mission

1. _____I have a clear picture of how the System of Care is developing, who is responsible for the different components, and who is actually in charge.
2. _____Our Collaborative is floundering, experiencing frequent switches in direction or confusion about what the team should do next.
3. _____I feel that our Collaborative has a clear vision and is progressing steadily towards its goals.
4. _____I feel that I need a clearer explanation of my role in the System of Care.
5. _____In the System of Care, we know which roles belong to one agency, which roles are shared, and how the different roles interact.
6. _____The System of Care helps our agency develop directions and vision about where we are headed.
7. _____I have a clear picture of what the System of Care should look like.

Community-based services

8. _____In this community children and families have easy access to the services they need.
9. _____Regardless of the agency that first makes contact with a child or family, clients usually receive the appropriate service without unnecessary delays.
10. _____Service providers make it a priority to serve children in their own homes and communities to the greatest extent possible.
11. _____The child and family services in this community are comprehensive.

Family-focused service provision

12. _____We give first priority to being the family's advocate, someone on their side.
13. _____Program staff do not support family-empowerment or advocacy viewpoints very strongly.
14. _____Staff make the major decisions about treatment plans for children.
15. _____Families have the primary role in choosing what services they receive.
16. _____Services for children and their families are tailored to meet their individual needs.

Cultural Competence

17. _____Providers who serve children and families are aware of how mental health/illness is perceived by different cultures in our community.
18. _____Service providers understand and utilize the informal/formal helping networks in the different communities they serve.
19. _____There have been adequate opportunities for service providers to learn how to operate in a culturally appropriate manner.
20. _____Collaboration between service providers involves citizens from different cultural groups or communities.
21. _____Service providers work collaboratively with individuals/organizations that provide support or services to different cultures.
22. _____Services are provided with respect to the cultural values of children and their families.

INFORMATIONAL QUESTIONNAIRE

1. Length of involvement in the System of Care here in Nevada? ___________________

2. Are you a member of the Community Collaborative? _______

3. How often do you participate in child and family team meetings?
   A. Weekly
   B. Once a month
   C. Once every 2-3 months
   D. Once every 4-6 months
   E. Once every 7-12 months
   F. Less than once a year
   G. Never

4. How often do you work with other agencies in serving children and families?
   A. 3-5 times a week
   B. 1-2 times a week
   C. Every 2 weeks
   D. Once a month
   E. Once every 2-3 months
   F. Less than once every 4 months
   G. Never

5. I have received training in the SOC principles? Yes No

6. I regularly attend the System of Care workshops/training offered by my community? Yes No

7. Number of hours spent in System of Care training in last 6 months_________

8. Number of System of Care training sessions in your place of work attended in last 6 months_____

9. Number of System of Care training sessions outside of your place of work attended in last 6 months_______

10. I desire more opportunities to learn about the System of Care and how to do work according to the principles. Yes No

11. Please rate your <u>individual</u> level of involvement in the System of Care

1	2	3	4	5
uninvolved				very involved

12. Please rate your <u>agency's</u> level of collaboration with other agencies

1	2	3	4	5
no collaboration				strong collaboration

13. Please rate your agency's level of involvement in the System of Care

1	2	3	4	5
uninvolved				very involved

14. How much weekly contact do you have with other agencies? _______________hours

15. How would you rate your agency on its implementation of family-centered practices?

1	2	3	4	5
Poor/Don't use				Excellent

16. How would you rate your agency on its implementation of community-based care?

1	2	3	4	5
Poor/Don't use				Excellent

17. How would you rate your agency on its implementation of culturally competent practices?

1	2	3	4	5
Poor/Don't use				Excellent

18. How much weekly contact do you have with parents of the children with whom you work?
______hours

19. If you have received training in the SOC, please indicate how well the system of services in your county matches the
principles you learned about in the training.

1	2	3	4	5
No match				Excellent Match