Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grant (CA-SIG)

FINAL EVALUATION REPORT

Nevada State Infrastructure Grant
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Completed by:

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Section A: Governance Structure

Member Category	Number of Members	Activity *(Indicate all that apply)* G=Governance PD=Policy Development I=Implementation SD=Service Delivery E=Evaluation	Area of Expertise *(Indicate all that apply)* MH=Mental Health SA=Substance Abuse FN=Finance ED=Education JJ=Juvenile Justice CW=Child Welfare MD=Medicaid O=Other (specify)	Level of Participation *(Indicate level for each activity)* 1=Low Involvement 2=Moderate Involvement 3=High Involvement	Paid or Volunteer Staff P=Paid V=Volunteer
Grant Project Staff	7	PD,I , E	MH, CW	3	P
State/Tribal Agency	200	G, PD, I, SD	MH, SA, FN, ED, JJ, CW, MD	3	P
Family Members	15	G, I	MH, SA, ED, JJ, CW	2	V, P
Youth	0	-	-	-	-
Community Members	0	-	-	-	-
Service Providers	40	G, I, SD	MH, SA, FN, ED, JJ, CW, MD	2	P
Other (specify) Local SOC	100	I, SD	MH, SA, FN, ED, JJ, CW, MD	2	P

Section B: Family, Youth, and Community Member Involvement

(B1) The CA-SIG project made it possible to include family, youth, and community members in planning, policy, and service delivery and work towards creating "Nevada's System of Care". A few of the statewide outcomes include: (a) One Northern parent who was receiving services was mentored in system level participation on the Washoe Consortium. She subsequently became a member of Nevada Children's Behavioral Health Consortium(NCBHC) and now is the Chairperson of the NCBHC; (b) Nineteen parents and one youth statewide attended the

System of Care (SOC) Training and seven attended an additional one day training to become SOC trainers; (c) Seventeen parents attended the NCBHC for a two day organizational restructuring and financing strategies meeting; (d) Nevada PEP signed on the agreement by all the stakeholders for the SOC Principles for the State of NV. (e) Nevada PEP, with stakeholder involvement, created the Parent's Quick Guide to Wraparound; (f) Nevada PEP, with stakeholder involvement, created the Parent's Guide to Wraparound Training Curriculum; (g) Nevada PEP has presented the training for parents at each Neighborhood Family Service Center; (h) Parents/family members have been involved in producing anti stigma PSA's with the Office of Suicide Prevention in conjunction with the Clark County Children's Mental Health Consortium (CCCMHC), to run on TV, in movie theaters and online; (i) Family members have been involved with Children Mental Health Awareness Day activities, locally and nationally; (j) Family members have volunteered statewide to do health fairs, wellness fairs, and school fairs to bring information to other families and professionals; and (k) Parents/families were participants in the Nevada Children's Behavioral Health Policy and Legislation, Collaboration and Strategic Planning Workgroups.

(B2) In spring 2009 an assessment of Nevada's children's behavioral health stakeholder groups took place. The stakeholder assessment involved (n = 66) general respondents and (n =13) parents/family respondents representing all regions of the State of Nevada. Most of the respondents were members of the Nevada Children's Behavioral Health Consortium or they were active in a Consortium workgroup. Most of the respondents participate in System of Care transformation work on a monthly basis. Parents expressed that they are active members of a collaborative that is transforming Nevada's System of Care but that each member of the collaborative does not have an equal "voice."

The stakeholder assessment revealed that parents were most satisfied with their participation in system transformation, and they felt as though they were helping to improve the lives of children and families. Although a moderate level of satisfaction was found, parents were somewhat more satisfied with their regional consortium and the Nevada Children's Behavioral Health Consortium's progress in implementing their goals than were the general stakeholders.

Section C: Evidence-Based Models and Practices (EBPs)

(C1) In order to improve treatment, service provision and supports for children and youth with co-occurring mental health and substance abuse disorders and their families through evidence-based activities, the Nevada CA-SIG undertook two comprehensive statewide assessments of the Nevada children's behavioral health workforce. First, the objectives of the *Statewide Workforce & Cultural Competency Needs Assessment* were: (1) determine workforce capacity, (2) determine workforce capacity to implement evidence based practice, (3) assess workforce current level of cultural competency, and (4) assess organizational climate and readiness for evidence based practice and culturally-specific model implementation. Second, the *Co-occurring Disorders Study* was conducted by a multidisciplinary research team from the University of Nevada Las Vegas (UNLV) in collaboration with local community partners and was partially supported (financially) by the Nevada CA-SIG grant. The project involved a needs assessment of service providers.

Assessment results revealed a workforce whose evidence-based practice (EBP) readiness scores differed by their caseload size (clinicians and workers with caseloads higher than 20 did not express enthusiasm and willingness to use evidence-based practices), location and position type (Clark County workforce members were more likely to have divergent attitudes about EBP, EBP openness scores were highest for mental health professionals and workforce members who are therapists had significantly higher affirmative EBP attitudes that those who were case managers), and years in the field (openness toward EBP was higher for those workforce members who had only been in the field 1 to 3 years). Additionally, in the co-occurring disorders assessment, most workforce members stressed the importance of treating mental health and substance abuse problems at the same time but several indicated that they were not qualified to deliver such treatment. The workforce competency test score results (using the TIP-42) revealed an average score of 63% (out of 100%) suggesting a low competency level. As a result of these findings and other considerations, a comprehensive workforce development and training plan was developed and implemented. The trainings are described below in sub-section C3.

(C2) The Nevada Youth and Families WIN Study is the first federally funded (NIMH), controlled study of the impact of the wraparound process for youth with intensive mental health needs. As such, it is intended to evaluate outcomes of wraparound implemented with full fidelity to the wraparound service model. The initiation of this study coincided with the start up of the Nevada CA-SIG grant and was supported by CA-SIG efforts.

Early study results led to significant concerns about wraparound fidelity. These results suggested the need for significant professional development supports for staff persons implementing wraparound to achieve fidelity that will lead to positive outcomes. Based in part on these results, Wraparound in Nevada (WIN) and Children's Clinical Services (CCS) supervisors created a professional development plan. As part of this plan, extensive training was provided for Nevada wraparound trainers as well as training for supervisors and coaches on directive supervision and certification procedures. Highlights of this training were: (1) Providing expert in-vivo coaching; (2) providing strengths-based feedback; (3) conducting document reviews; (4) preparing staff for direct coaching activities; (5) providing group coaching; (6) retention of staff through better coaching; and (7) providing shadowing experiences.

Final wraparound study results will be disseminated in spring 2010 but the infrastructure, training protocols and workforce development activities that developed under the Nevada CA-SIG grant as a result of early study findings remain in place and will be sustained.

(C3) Many statewide trainings to include promising and evidence based practices were implemented with guidance presented in the *Workforce Development and Cultural Competency Statewide Needs Assessment* and the Co-Occurring Disorders Assessment. These training included: (a) American Academy of Child and Adolescent Psychiatry provided Technical Training and Consultation on the Early Childhood Service Intensity Instrument (ECSII); (b) On average, 2 statewide trainings per year over the 5 years were provided by DCFS staff on the Child and Adolescent Service Intensity Instrument (CASII). The CASII is designed to help determine the intensity of services needed for a child served in a mental health system of care; (c) On average, 2 statewide trainings were provided by DCFS staff on the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS is the gold standard for assessing a youth's

day-to-day functioning across critical life domains and for determining whether a youth's functioning improves over time; (d) Nevada Building System of Care Training- 88 participants and 27 trainers, currently being sustained by two active training groups in Northern/Rural Nevada and Southern Nevada. To date three official trainings have taken place. One at the Washoe County Children's Behavioral Health Consortium monthly meeting; one for administrators at the Washoe County School District; and a third one at the University of Nevada Reno- Family First conference; (e) Parent Child Interaction Therapy (PCIT) is highly structured evidence based treatment model involving both parent and child ages 4-12. The goal of PCIT is to change negative parent-child interaction patterns in abusive or traumatic events. The CA-SIG project provided a three phase training model to DCFS staff and community partners in collaboration with the University of Oklahoma Health Sciences Center. Eight clinicians statewide were trained. Four of the eight participants were trained to become trainers. The CA-SIG project also allowed for six complete PCIT therapy rooms, five in the Southern region and 1 in the Northern region to be set up as permanent occupants in order to utilize the therapy effectively and sustain the practice over time with Nevada's children and families; (f) Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment approach shown to help children, adolescents, and their caretakers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse and other traumatic events. Two trainings took place. Each contained two training sites, one in the southern part of the state and one in the northern part of the state. The first training (Phase I) was for Masters level clinical supervisors. The second training (Phase II) was for clinicians in the agencies where the supervisors where trained. In total DCFS trained a total of 121 participants. All these participants were required to sign a commitment to participate in consultation calls for up to 6 months with a TF-CBT expert within a group and complete the course of treatment with 4-6 cases over this time; (g) Motivational Interview (MI) training was implemented in May 2008 in collaboration with the Center for the Application of Substance Abuse Technologies (CASAT) through their 2009 Spring Academy, Prevention and Treatment Exchange in Reno, Nevada. The CA-SIG project was able to support 24 statewide behavioral health participants. MI is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. In order to sustain this training beyond our federal grant end date, each agency that participated was asked to send one participant to become a statewide trainer and participate in statewide workforce development training initiatives; (h) The CA-SIG project worked in consultation with Zero to Three (ZTT) and Dr. Karen Frankel, University of Colorado, School of Health Sciences to support a Training of Trainers (TOT) model to build workforce capacity to support the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R) as the diagnostic classification through which young children with mental health needs are identified and diagnosed. In Northern Nevada, the Revised Edition (DC:0-3R) Training of Trainers process has had active involvement from the start from DCFS and community partners, with representation from Northern Nevada Child and Adolescent Services- Early Childhood Mental Health Services, Washoe County Department of Social Services, Nevada Early Intervention Services, DCFS-Carson City, and Koinonia Family Services. In 2009 alone, the training team conducted two 2-Day Intensive Trainings in Washoe County, there were approximately 90 participants, with representation from community mental health agencies, social services, University of NV Reno-School of Medicine, the Bureau of Disability Adjudication, Nevada Early Intervention Services, Nevada Disability Advocacy & Law Center, and private mental

health providers. Additionally, half-day Awareness trainings on the DC:0-3R were provided to the Sierra Association of Foster Families, Washoe County Department of Social Services, the Bureau of Disability Adjudication, Community Services Agency-Head Start, one Awareness training for Koinonia Family Services staff and one for Koinonia Foster parents, and four Awareness trainings with Court Appointed Special Advocates (CASA). The Northern Nevada training team brought increasing community awareness to the mental health needs of children birth through four years old with over 300 participants in Awareness training in the last year. In Southern Nevada in the last year there were two trainings conducted at the Neighborhood Family Service Centers in Las Vegas, Nevada. Over 75 people attended the trainings to include participants from WestCare, Eagle Quest, the Division of Child and Family Services, Majestic Health, Crest Point Counseling, Nevada Early Intervention Services, Amerigroup Inc. Nevada HOPE Counseling, Bridge Counseling Associates, Head Start of Clark County, Nevada Cooperative Extension, East Central Family Services, and SAFY of Nevada.

Section D: Culturally and Linguistically Competent Policies and Procedures

(D1) One of the major goals of the statewide *Workforce Development and Cultural Competency Needs Assessment* was to ascertain the developmental level of the workforce with respect to culturally and linguistically competent practice. Four different types of workforce members were examined: DCFS staff, DCFS partners (including child welfare, juvenile justice and school officials), provider agencies (including substance abuse providers) and children's behavioral health community leaders. The Minnesota Department of Human Services (2004) *Organizational Self-Assessment* tool was used to identify workforce strengths and areas in need of development concerning cultural and linguistic competence. The cultural competence tool measured: service delivery, human resource practices, governance, administration and policy and organizational culture.

The workforce assessment and the stakeholder assessment revealed that efforts to effectively hire and retain a culturally and demographically diverse workforce are inadequate. Also, these assessments concluded that the cultural and linguistic needs of staff, youth and families are not adequately met.

The findings of these assessments along with other recommendations were given to system leadership. As a result, the CA-SIG project was involved in significant program and policy developments as described below in sub-sections D2 and D3.

(D2 and D3) The following documents/plans/policies/procedures/educational information were developed during the course of the CA-SIG project: (a) An outline for the development of the Nevada Cultural Competence Plan; (b) Language Access to Children's Mental Health – the overarching plan to guide the Mental Health Managers to develop language access services across the state of Nevada; (c) A charter for the Children's Mental Health Managers - workgroup to develop a language access services plan; (d) Rural Region Language Assistance Plan; (e) The Rural Region Language Assistance Plan was submitted to the Office for Civil Rights; (f) Communication plan for translation of vital documents; (g) A discrimination policy; (h) Rural Region Policy and Procedures for implementation of Language access services; (i) Rural Region Policy statement for language access services; (j) Establishing linkages with Tribal Nations – a

draft plan of action to connect with tribes; (k) Multicultural charter for a Statewide Diversity Committee; and (l) What is Cultural Competency in Nevada – brief.

Section E: Building an Effective Workforce

(E1) 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 baseline *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.

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.

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.

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 here: (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.

In short, from the baseline to the follow-up measurement period tremendous strides have been made in System of Care training and adherence. These positive results are in large part related to the workforce programming that was planned and implemented between the baseline assessment (2007) and the repeat measure (2009). The outcomes include the following: (a) A workforce development strategic guide was developed; and (b) Many statewide trainings to include promising and evidence based practices were implemented including:

- American Academy of Child and Adolescent Psychiatry provided Technical Training and Consultation on the Early Childhood Service Intensity Instrument (ECSII).
- On average, 2 statewide trainings per year over the 5 years were provided by DCFS staff on the Child and Adolescent Service Intensity Instrument (CASII). The CASII is designed to help determine the intensity of services needed for a child served in a mental health system of care.
- On average, 2 statewide trainings were provided by DCFS staff on the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS is the gold standard for assessing a youth's day-to-day functioning across critical life domains and for determining whether a youth's functioning improves over time.
- Nevada Building System of Care Training- 88 participants and 27 trainers, currently being sustained by two active training groups in Northern/Rural Nevada and Southern Nevada. To date three official trainings have taken place. One at the Washoe County Children's Behavioral Health Consortium monthly meeting; one for administrators at the Washoe County School District; and a third one at the University of Nevada Reno-Family First conference.
- Parent Child Interaction Therapy (PCIT) is highly structured evidence based treatment model involving both parent and child ages 4-12. The goal of PCIT is to change negative parent-child interaction patterns often resulting from abusive or traumatic events. The CA-SIG project provided a three phase training model to DCFS staff and community partners in collaboration with the University of Oklahoma Health Sciences Center. Eight clinicians statewide were trained. Four of the eight participants were trained to become

trainers. The CA-SIG project also allowed for six complete PCIT therapy rooms, five in southern Nevada and one in northern Nevada to be set up as permanent sites; in order to utilize the therapy effectively and sustain the practice over time with Nevada's children and families.

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- Motivational Interview (MI) training was implemented in May 2008 in collaboration with the Center for the Application of Substance Abuse Technologies (CASAT) through their 2009 Spring Academy, Prevention and Treatment Exchange in Reno, Nevada. The CA-SIG project was able to support 24 statewide behavioral health participants. MI is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. In order to sustain this training beyond our federal grant end date, each agency that participated was asked to send one participant to become a statewide trainer and participate in statewide workforce development training initiatives.

Section F - Statewide Adoption of Local Grant Practices, Section G -Inter-Agency Collaboration with Existing Service Delivery Systems and Section H - Coordinating Project w/ Relevant Federal Funding State

In order to measure how effective the Nevada CA-SIG grant efforts were at statewide adoption of local grant practices, building and strengthening inter-agency collaborations, and coordinating with other federally funded grant projects, a spring 2009 assessment of Nevada's children's behavioral health stakeholder groups took place. The stakeholder assessment involved (n = 66) respondents representing all regions of the State of Nevada. Demographic information about the stakeholders as well as their opinions about the implementation of System of Care in Nevada, stakeholder involvement in the work of system change and stakeholder satisfaction was obtained. Stakeholders involved in this assessment for the most part were individuals affiliated with the Nevada Children's Behavioral Health Consortium and Consortium workgroups. The respondents represented the fields of mental health, child welfare, juvenile justice, health, substance abuse and Medicaid and they were affiliated with public agencies, although there was a modest representation of private agencies as well. Over half of the sample reported participating in System of Care transformation efforts at least on a monthly basis. More than a third of the rural respondents indicated that they were active participants in their regional consortium while the percent who were involved in the Washoe region is about 23% and in Clark County 20%. About equally divided, 41% of the respondents resided in Clark County and 40% were from Washoe County. The rural regions of the state accounted for about 19% of the sample. Respondents were

asked for their perspectives on how well Nevada is implementing System of Care principles throughout its work in children's behavioral health. In a ranking of the six subscales that comprise the Nevada System of Care principles, the *strength-based, family-driven* and *outcome/accountability* principles ranked the highest. The respondents felt that Nevada is least successful in adhering to practice principles related to the establishment of a *comprehensive service array.* No regional differences were discernable in opinions about the implementation of System of Care principles. In ranking the elements that define the stakeholder process and how stakeholders were involved in the work of system change, statewide the respondents felt that certain aspects of the *decision making process* (e.g., flexibility, participation, inclusiveness) were the strongest collaborative elements. On the other hand, respondents felt that the *creation and coordination of partnerships between substance abuse and mental health* was the weakest element in the stakeholder process as it relates to the work of system change. In terms of stakeholder satisfaction, respondents were most satisfied with their participation in system transformation because they felt that they were helping to improve the lives of children and families. Also, in Washoe County the respondents had a sense that they were valued and important members of the collaborative. When stakeholders expressed dissatisfaction, it was because they felt as though the Nevada Children's Behavioral Health Consortium was not making progress in the implementation of its goals (this was the sentiment expressed especially by respondents who resided in Clark and Washoe counties). In the rural areas, dissatisfaction was expressed by respondents who felt the regional consortium was not making progress towards the implementation of its goals.

Coordination with substance abuse partners has been one of the Nevada CA-SIG's greatest efforts since learning from the baseline workforce assessment findings that the integration of substance abuse and mental health services was lacking. The most significant mental health and substance abuse coordination activities included: Senate Bill No. 131 which expands the mandated membership of each mental health consortium to include a representative of an agency which provides services for the treatment and prevention of substance abuse; the Bureau Chief of the Substance Abuse Prevention and Treatment Agency is now actively involved in the Consortium; there is active membership on all regional Consortia of substance abuse prevention and treatment providers. In addition, the chair of the Clark County Children's Mental Health Consortium is the Director of a Substance Abuse Treatment Agency in Clark County, Nevada, Bridge Counseling; the Chair of Nevada's Commission on Mental Health and Developmental Services is a local Substance Abuse Prevention Provider and Director of Join Together Northern Nevada. He has a two year term commitment; with the partnerships created through the CA-SIG project, Nevada's Statewide Family Network (Nevada PEP) has reported increased involvement with local and statewide substance abuse prevention and treatment agencies when working with families in the community; through a collaborative effort with Nevada's Division of Health Care Financing and Policy the CA-SIG project was able to assist one of 3 substance abuse treatment providers in providing billable services for Medicaid eligible substance abuse treatment clients with co-occurring disorders; A Children's Uniform Mental Health Assessment (Long Version and Crisis Version) was created to use across all children's behavioral health entities. This assessment was specifically revised to add Substance Abuse questions. This Assessment is currently being implemented across children's behavioral health agencies statewide; and the CA-SIG team held regularly scheduled team meetings. The Substance Abuse Prevention and

Treatment Agency in the last year of the grant were active participants in these meetings. The Bureau Chief specifically appointed a member of their Treatment Team to the CA-SIG team.

The Nevada CA-SIG will continue to utilize what was learned from the assessment of its stakeholder groups in order to improve adoption of grant practices statewide, coordination, inter-agency collaboration. Currently, coordination and collaborations takes place under the Children's Mental Health Services Block Grant, the Garrett Lee Smith Memorial Grant Funds for Youth and Tribal Communities, and several local and federal grant proposals in the areas of children's behavioral health.

Section I: Financing Strategies

(I1) The most significant financing strategies included the following:

- The Children's Mental Health Block Grant provided braided funding to enhance Workforce Development Initiatives statewide.
- The Nevada Children's Behavioral Health Consortium (NCBHC) was created as an overarching body over the CA-SIG project and advisory body regarding Children's Behavioral Health Services throughout Nevada. The NCBHC was the overarching body of the CA-SIG project and advisory body for Children's Behavioral Health in Nevada but also was the coordinating body of the three regional Consortia. Senate Bill No. 131 passed in the 2009 Legislative session and it requires Nevada's three regional children's mental health consortia to develop long-term strategic ten year plans for their geographic areas. These long-term strategic plans must include needs assessments and the strategies and goals of the consortium for meeting the needs of children with emotional disturbances and their families. This bill further requires each consortium to submit their plans to the Director of the Department of Health and Human Services and the Commission on Mental Health and Developmental Services. In even-numbered years any revisions to the long-term strategic plan and a prioritized list of services and costs necessary to implement the plan will be submitted. In odd-numbered years (Legislative session years), each consortium must submit a report regarding the status of their long-term strategic plan and a recommended plan for the provision of mental health services to children with emotional disturbances within the jurisdiction of the consortium to the Department of Health and Human Services. In addition, the bill requiring a strategic ten year plan also expands the mandated membership of each mental health consortium to include a representative of an agency which provides services for the treatment and prevention of substance abuse, a significant accomplishment for the CA-SIG infrastructure efforts. The consortia always extended an open invitation to substance abuse treatment and prevention providers, but their membership and participation was never in the statute that governs the consortia. In addition, Senate Bill 79, section 16 was also passed this last legislative session, which states that the Commission on Mental Health and Developmental Services shall appoint a subcommittee on the mental health of children to review the findings and recommendations of each mental health consortium submitted pursuant to NRS 433B.335 and to create a statewide plan for the provision of mental health services to children. Again, a significant achievement for Nevada's

children, which in turn substantiates all the great work the Consortia have done, which was all supported by the CA-SIG project.

- LSM Government Financial Management, Inc. was contracted by DCFS to conduct a statewide Children's Behavioral Health Services financing assessment, using the Self Assessment and Planning Guide, from the University of South Florida Research and Training Center for Children's Mental Health. The goal of the contract was to identify, collect and document current spending and utilization patterns across government agencies and stakeholder entities. The project was completed in September 2009 with a presentation to the NVCBHC and facilitation of their strategic planning. This project was also enhanced by Ms. Sheila Pires, from Human Services Collaborative in Washington D.C. LSM Government Financial Management, Inc and Ms. Sheila Pires worked together on this project in order to guide Nevada's System of Care Initiative.
- In September 2009, based on all the work that has been done under the CA-SIG project, in conjunction with the results from the Financing Assessment, Ms Sheila Pires led a Strategic Planning two day meeting in Las Vegas, Nevada. The meeting was attended by over 40 statewide stakeholders, families, and community members. The meeting produced a new organizational structure recommendation for children's behavioral health services in Nevada. This recommendation will be presented to administrative and legislative decision-makers.

Section J: Sustainability

The CA-SIG has asked for a no cost extension to fund the four Consortia through the 2010 fiscal year in order for them to complete their legislatively mandated 10 year strategic plans. The Division of Child and Family Services strongly believes that continued support of Nevada's children mental health consortia in the development of these mandated plans will further sustain the work of the CA-SIG initiatives and improve services to Nevada's behaviorally challenged children. It is the logical and necessary next step in the evolution of system of care in Nevada. The goals and accomplishments of the CA-SIG provide the groundwork and guidance for the creation of these plans by regional stakeholders. The statewide consortium in collaboration with the Commission on Mental Health and Developmental Services has committed to developing a statewide strategic plan which will incorporate statewide goals and the regional plans. The ten year strategic plans will sustain the work of the CA-SIG post grant funding and are the necessary and critical next step in infrastructure development and sustainability of the system of care in Nevada. Upon completion, Nevada is hopeful that there will be some legislatively approved funding to implement the recommendations created by these ten year strategic plans. In addition, the Community Mental Health Block Grant (CMHS Block Grant) continues to provide funding to the Statewide Family Network agency, NV PEP. The CA-SIG Project Director and support staff positions have ended, but the staff was able to be sustained, meaning that all their knowledge and expertise will still be able to be utilized when continuing to move forward with Nevada's System of Care initiative. The Child and Adolescent Psychiatry Fellowship funds were braided with CMHS Block Grant funds for the past several years in anticipation of sustaining at least a part-time fellowship after the CA-SIG project has sunsetted. A significant amount of the workforce training activities will be sustained through the train-the-trainer efforts that have been put into place during the past five years.