The Nevada System of Care
for Youth with Serious Emotional Disorders
Clark County

An Initial Review of Readiness

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The Nevada System of Care for Youth with Serious Emotional Disorders[1] *Clark County*

An Initial Review of Readiness

Lenore B. Behar, Ph.D. & William M. Hydaker, MA

Introduction

The Plan for the Nevada System of Care for Youth with Serious Emotional Disorders

In September 2015, the State of Nevada entered into a four-year cooperative agreement with the Child, Adolescent and Family Branch, Center for Mental Health Services, in the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The State of Nevada, through its Division of Child and Family Services (DCFS), as part of the Nevada Department of Health and Human Services (DHHS) has developed a very sophisticated plan designed to focus on children and youth, from birth to 21, with serious emotional disturbances (SED) and their families to improve outcomes for them and to fully implement systems of care values and practices for them across the state. This plan has a strong foundation to establish a system of care throughout the state, as it is grounded in the Nevada Revised Statute (NRS) 433, which mandates any county with a population of 100,000 or more must establish a Mental Health Consortia. "The consortium is mandated to include partners from the local, county and regional level including school districts chamber of commerce and business community, state agencies, juvenile probation, mental health care, foster care provider, a parent or guardian of a child with emotional disturbance, substance abuse agencies, advocates and provider organizations." Given Nevada's vast geographic area, NRS 433 required that three consortia be created to cover the entire state, in Washoe County (Reno/Tahoe), Clark County (Las Vegas and surrounding area), and Rural Nevada (15 counties in rural/frontier Nevada). DCFS provides the leadership in the development of Nevada's Mental Health System of Care (SOC).

To address implementation of systems of care statewide, the State of Nevada has developed *Children's Mental Health 10-year Strategic Plans* specific to these three consortia. The focus of the plans is on prevention, treatment, and family and youth engagement, with access to quality and comprehensive behavioral supports. An important first step has been the adoption statewide of the Children's Uniform Mental Health Assessment (CUMHA), a standardized intake tool for continuity throughout the state.

For the cooperative agreement, the State of Nevada DCFS developed a plan, which builds on the foundation set by NRS 433. The plan has five ambitious goals, which are derived from SAMHSA's *Theory of Change*, and propose to:

1. *Generate support among families and youth, decision policy makers at state and local levels,*

[1] This report was prepared for the Nevada Division of Child and Family Services (DCFS). Funds for this assessment come from the federal cooperative agreement. #SM062468. The material in this section was derived from the Nevada DCFS application for funding and subsequent materials to describe implementation plans.

providers, managed care organizations and other leaders to support expansion of the SOC approach, including transitioning DCFS from a direct care provider to an agency that primarily provides planning, provider certification, utilization management, oversight and quality assurance.

2. *Maximize public and private funding at the state and local levels to provide a SOC with accountability, efficiency, and effective statewide funding sources, utilizing blended funding sources and repurposing state and local funds spent on inpatient services for use on community-based services.*
3. *Implement workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to provide effective services and supports consistent with the system of care approach*
4. *Expand evidence-based services and supports in Nevada based on the SOC approach, creating a delivery model focused on First Episode Psychosis (FEP) and peer-to-peer, family- to-family, and child-centered care ensuring linguistically and culturally responsive service.*
5. *Establish an on-going locus of management and accountability for systems of care to ensure accountable, reliable, responsible, evidence and data-based decision making to improve child and family outcomes and to provide transparency at all levels.*

As part of the implementation strategies, the Nevada Division of Child and Family Services (DCFS) has committed to doing readiness assessments across the state, in each of the three consortia, using the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS). The purpose of this assessment is to determine the readiness status to implement/expand the system of care, so that implementation can be based on the identified strengths and weaknesses of the current community systems, as perceived by the stakeholders. This assessment will provide a benchmark in each consortium for the development of the system of care, providing guidance for planning and implementation. Such information can be particularly useful, as it clearly sets the direction, as well as establishing a baseline against which to measure progress over time. Further, the information about readiness, areas of strength and areas of weakness will provide Nevada DCFS guidance on the training and technical assistance needs of each site, addressing their priorities of "collaboration with stakeholders, consumers and community partners and rigorous evaluation and quality assurance."

The System of Care Readiness and Implementation Measurement Scale (SOC-RIMS)[2]

The original instrument to measure community readiness was developed in 2008 in a national study by Behar & Hydaker (2008; 2009). The Child, Adolescent and Family Branch[3] funded this study to further the understanding of the community and systems factors that underlie the concept of community readiness. The national study used a web-based method of collecting data as developed by Concept Systems, Inc. CS Global© system[4] which allowed for data analysis using multidimensional scaling and cluster analyses and resulted in a detailed, empirically-based description of community readiness. The study produced 109 action statements, which the

[2] Formerly called the Community Readiness Assessment Scale (CRAS).

[3] The study to define community readiness was completed under Contract 280-03-4200, Task Order Number 280-03-4200, funded by the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. The contents of this document do not necessarily reflect the views or policies of the funding agency and should not be regarded as such. A full report of the findings is available at www.lenorebehar.com See also Behar & Hydaker (2009).

[4] Concept mapping analysis and results were conducted using The Concept System© software: Copyright 2004-2007; all rights reserved. Concept Systems Inc.

participants indicated were essential characteristics of a system of care and these were arranged in eight clusters. Following the collection of data from 530 respondents from 24 different federally funded system of care sites, an item analysis yielded 68 items (Rosas, Behar & Hydaker, 2013), producing the revised and refined version of the SOC-RIMS. The revised SOC-RIMS (SOC-RIMS-R) of 68 items can be seen in Appendix A. The 68 statements have been organized into six components, representing essential components of a system of care, to include

- Committed Stakeholders
- Commitment to Family & Youth Partnerships
- Evaluation
- Community Involvement
- Understanding Comprehensive Service Needs
- Shared Goals across Stakeholders

The original 109 action statements, reduced to 68 items in the revised version, form the System of Care Readiness and Implementation Measurement Scale, Revised (SOC-RIMS-R). The six components are consistent with system of care principles and policies promulgated by the Child, Adolescent and Family Branch of the Center for Mental Health Services. The components are similar to the concepts that are a part of technical assistance and training for system of care development. The components are also similar to the common factors that others have identified in reviews of systems of care sites. Hodges, Ferreira, Israel, and Mazza, (2007a, 2007b) used intensive case studies over a six-year period to identify factors that contribute positively to the development of systems of care, to include: shared values, willingness to change, shared accountability, delegation of authority, strategic use of resources, family empowerment, and information-based decisions. Over the past six years, researchers at the University of South Florida (Friedman, Greenbaum, Kutash, Boothroyd & Wang, 2009; Boothroyd, Greenbaum, Wang, Kutash & Friedman, 2011) have developed a survey instrument based on a conceptual model of 14 factors, built upon the nine factors developed by Behar, Friedman & Lynn (2005). Behar et al. used a case study method of nine successful sites and identified nine important factors, to include: transformational leadership, strong foundation of values and principles, a clear description of the local population, a clear and widely held theory of change, an implementation plan, family choice and voice, individualized, culturally competent and comprehensive approaches/ interventions, and an effective governance system. The Behar & Hydaker study and the Rosas, Behar & Hydaker study added the element of using measurable/quantifiable concepts to define community readiness, provided new information and validated the earlier findings.

The findings of the national study to define community readiness in 2008 and the subsequent refinement in 2013 can be useful to communities as they plan to develop systems of care, whether they are at the stage of writing an application for funding, in the early stages of implementation or at later stages if needed. The components that resulted from the study define the essential elements of system development. Within those components, there are specific action steps (statements) that guide what needs to be done. The action steps are rated for how important they are to the successful implementation of a system of care. The action steps are also rated for how difficult they are to implement. The revised SOC-RIMS has excellent psychometric properties, with a reliability score of .92 and validity scores from .89-.98, depending on the method. This empirically-based assessment strategy allows a large number of community stakeholders to rate their own readiness to develop a system of care (Rosas, Behar, &

Hydaker, 2013). The input can be analyzed quickly to provide a status report on a community's readiness. This assessment of the community can be done face-to-face, in a group or individually via a web-based program. Once the community stakeholders assess their readiness, the resulting information of their strengths and weaknesses should provide direction for their implementation efforts. A follow-up rating after 12-14 months would reflect their progress.

A Study of Readiness for the Nevada System of Care in Clark County

In July 2016, as part of the Nevada System of Care Project, Clark County was the first of the three consortia to complete the study of community readiness. Clark County is the largest county in Nevada and the 13th largest county in the US. Covering an area about the size as New Jersey. Clark County has a population of 2,028,000 million and its largest city is Las Vegas. As noted above, the purpose of this assessment is to determine the current readiness status, so that planning can be based on the identified strengths and weaknesses of the current community system, as perceived by the stakeholders. This assessment represents a benchmark for the development of the system of care, providing guidance for planning and implementation and providing guidance for technical assistance and training.

Participants in the Study

In Clark County, the SOC-RIMS-R was administered during July and August 2016, using the revised versions of the SOC-RIMS-R in both English and Spanish. On August 19 the decision was made to end the data collection phase. There were 26 people that responded to the survey. Of these, 22 met the criteria for inclusion in the data analysis. One individual did not answer a sufficient number of questions (66%), two individuals marked every item as "not being ready at all," and the last respondent marked every item as "totally in place." These responses were omitted from the data analysis because they reflected a bias rather than an appraisal of readiness. The size of the group is sufficient for this methodology (Kane & Trochim, 2007). Also Trochim (1993), in summarizing 38 projects, reported an average of approximately 14 raters in each project. By comparison to other system of care communities that have been studied, the number of respondents from Clark County is in the average range.

A description of the 26 respondents' roles in the project is

- 17 Parent or caregivers of children with special needs
- 2 Community service providers
- 3 Supervisors/Administrators
- 1 Interested community member
- 1 System of care project leadership/management team/governing council
- 2 Other (Youth Facilitator, Commission for Public and Behavioral Health)

Ethnic Identity was listed as

- 11 Caucasian
- 3 African American
- 12 Hispanic/Latino

The goal of the project leaders was to involve a broad range of respondents in terms of roles in the community. From the above descriptors it appears that they were very successful in

involving a range of community partners, including a good representation of parents, and diverse ethnicity.

Using the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS-R)
The participants in this study were asked to rate community readiness using the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS-R) which was derived from the data collected in the earlier national study (2008) to define community readiness and refined in a subsequent item analysis in 2013. The 68 items on the scale were to be rated on a five-point scale with a score of 1 being "least ready" and a score of 5 being "most ready."

The Findings of the Readiness Study for the Nevada System of Care in Clark County
There are five sets of findings for this study:

- A readiness score
- Ratings of items independent of components
- A comparison of the ratings of items for Readiness with Importance and Difficulty of Implementation that was determined in the earlier study
- Ratings of items within components
- A comparison of the rankings of components for Readiness with Importance and Difficulty of Implementation that was determined in the earlier study

The Readiness Score: The Readiness score is calculated to reflect the average score for all items. These items were rated on a scale of 1 – 5, with 1 being the "least ready" and 5 being the "most ready." The Readiness score for all 15 participants from Clark County is **3.45** out of a possible 5.00. The range of scores for the 37 funded sites studied in 2009 - 2015 was 2.58 – 4.06, with the average being 3.379. Clark County's score is in the above average range and falling within the first standard deviation above the mean. For the 37 sites assessed, the average time period from funding to using the SOC-RIMS for a community assessment is 12 months, so most sites were essentially in their second year. The Nevada sites, funded in September 2015, completed the community assessment during the tenth-eleventh month of their first year, a comparable time period to other newly funded sites.

In addition to the comparison with other sites, a good use for the Readiness score will be to compare this average with a follow-up rating for this site to see if overall Readiness improves, that is, if progress is made. There is every reason to assume that these scores will improve over time, as implementation proceeds.

*Results of the Ratings of Items Independent of Components***:** There are two ways to present the ratings of the items, without considering the components in which they are arranged. The first way to present the ratings independently of the components is to present the absolute ratings, and the list of items by ranking is presented in Appendix B. Those items that the participants rated as "most ready" and those that they rated as "least ready" are presented in Tables 1 and 2. The second way is to present the participants' ratings of the most ready and least ready items adjusted for Importance and Difficulty of Implementation (Figures 1 and 2). Both the Importance ratings and the Difficulty of Implementation ratings were determined in the original national study.

Absolute Ratings: Tables 1 and 2 below present the items rated as "most ready" and the items rated as "least ready" by the participants from Clark County. The number of items presented in all tables is determined by the statistical breaks in the data.

Table 1
Most Ready Items

#	Statement	Score
42	Families are willing to take on a lead role in taking the vision to reality.	4.62
32	There is a commitment to measurement of progress and outcomes.	4.50
59	There is a fully functioning advisory board or other group that represents key program partners, families, and youth.	4.33
17	There is a strong family organization with resources to fully participate.	4.06
27	A family organization was developed before funding.	4.00
46	Families have been at the table throughout the visioning process.	4.00
24	Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.	3.94
12	There is a felt need for services within the community by the stakeholders.	3.94
33	There is a mechanism for communicating to the community the goals and the progress toward those goals in developing a system of care.	3.94
31	The agency that received the funds has a history of positive audits and has disclosed any fiduciary or subcontracted agent that will manage funds.	3.93
35	There is a commitment from leadership at major child serving systems that a family-driven, youth-guided system of care is essential to success.	3.89
58	There is a commitment to ensure that cultural and linguistic competence is represented in both conceptualization and implementation of all activities.	3.88

The scores for the high-ranking items are quite high. It is unusual for items to be scored near or above 4.00 in a newly funded site. Half of the highest items were rated at 4.00 or higher and the remaining half was very close to 4.00. The Clark County site received the highest ratings on items that reflect the involvement of families and the coordination and integration of community services. This high level of ratings regarding family participation is unusual in newly funded sites. Family participation is one of the major principles of system of care development and usually is a focus and challenge that is not easy to achieve. Of the 12 items ranked highest, eight of them (67%) involve the role of the family in systems development and the remaining six address commitment to coordination, communication and culturally responsive services. It appears that the requirement for integrated services across child-serving agencies and the priority role of families delineated in the Nevada Revised Statute (NRS 433B) has had an impact on the organization and delivery of services and has provided an important foundation for system of care development.

Table 2
Least Ready Items

#	Statement	Score
60	The community has dedicated sufficient resources to support cultural and linguistic proficiency.	3.00
62	The community is being made aware of the potential services in order to be willing to support additional funding.	2.94
19	Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2.88
65	There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.	2.88
56	The school district and medical professionals are in the collaborative agreement.	2.83
26	There has been a comprehensive assessment within the community of where the gaps are in terms of resources.	2.71
5	Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.	2.69
4	There are well trained, culturally competent, flexible personnel working in the system.	2.67
57	There is a governance body that is powerful and independent of any specific provider in the community.	2.62
18	Community organizations such as faith-based groups have participated in the planning process.	2.38

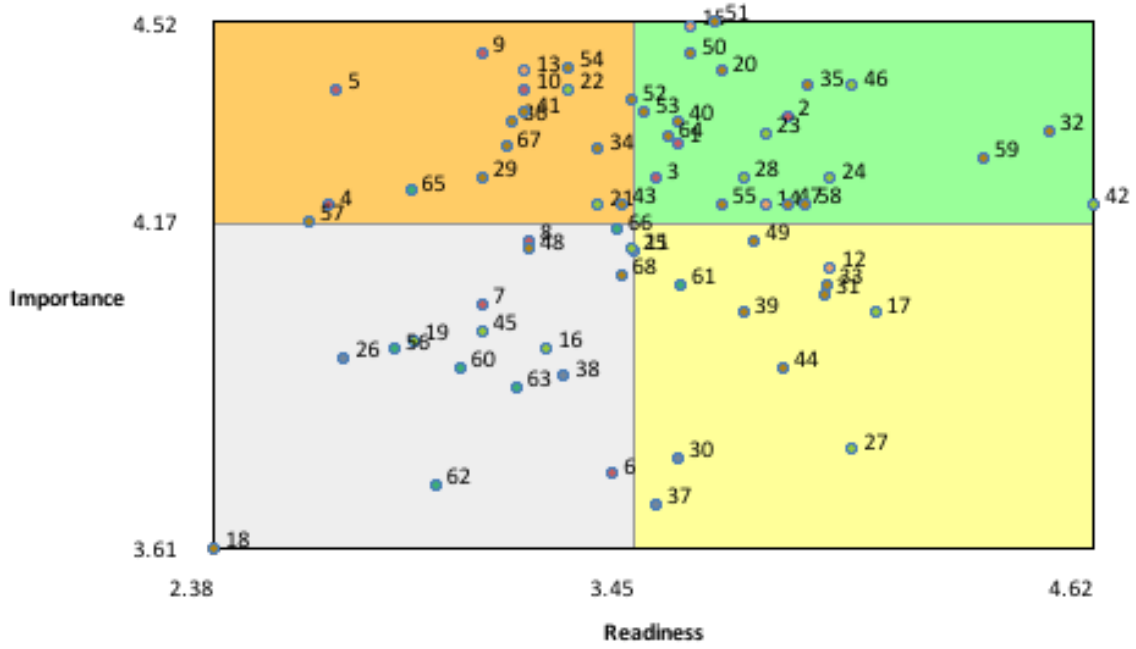
The majority of low ranking items fall into areas that delineate next steps. The low-ranking items involve facets of the system of care that are not typically seen in early stages of implementation but would be expected in graduated SOC communities. The lowest ranked items address issues that will take substantial collaboration and cooperation to implement, such as understanding the system of care principles, blended or braided funding and conducting a needs assessment. Low rankings offer clear guidance as to what needs to be addressed to develop a system of care. Items for which they are unready provide direction for the next level of work.

Comparison of the Ratings of items for Readiness with Importance and Difficulty of Implementation: To understand the comparison of the ratings of items for Readiness with Importance and Difficulty, it is important to understand the national study of readiness completed in 2008. The study is discussed briefly above on pages 5-7 and references for further information are provided in the footnote on page 5 and in the Reference section. In this study, 223 experts in systems of care identified 109 characteristics considered essential to the development of a system of care. These 109 items became the System of Care Readiness and Implementation Measurement Scale (SOC-RIMS). The expert panel also rated each item on a

five-point scale as to its importance in developing a system of care and then re-rated the 109 items in terms of difficulty to implement. In 2015, based on an item analysis, the SOC-RIMS-R was reduced to the 68 most powerful items, with excellent reliability and validity scores.

Adjusted Ratings: There are two comparisons to present the adjusted ratings, which are the respondents' ratings adjusted for the national study's findings of which items are most important and which are most difficult to implement. The first comparison addresses the items rated highest and lowest on Readiness, compared to the ratings on Importance (Figure 1). The second comparison addresses the items rated highest and lowest on Readiness, compared to the ratings on Difficulty of Implementation (Figure 2). This information is presented in focus zone maps. The maps below display the Readiness ratings of the statements compared with the Importance ratings of those statements (Figure 1) and the Difficulty of Implementation ratings of those statements (Figure 2). The numbers on the maps are the statement numbers from the SOC-RIMS-R. In Figure 1, the upper right quadrant (green) contains those statements rated highest on both Readiness and Importance; this quadrant reflects the best amount of readiness in relation to Importance and the area where the easiest work might be. The lower right quadrant (yellow) contains those items on which there are high ratings of Readiness, even though they were not considered to be among the most important statements. The lower left quadrant (gray) contains those items, which were rated as less important and for which there is less readiness. These are items to be addressed in the future. The upper left quadrant (orange) contains those items that are most important and for which the community is least ready. These items represent the most important next steps, together with the upper right quadrant. The items in the upper right quadrant may require less effort to complete, as more has already taken place with these tasks.

Figure 1
A Focus Zone of the Ratings for Importance



There are many items for which the stakeholders rate Clark County as ready or moving toward being ready. These are the items displayed in Figure 1 on the right side of the Focus Zone map.

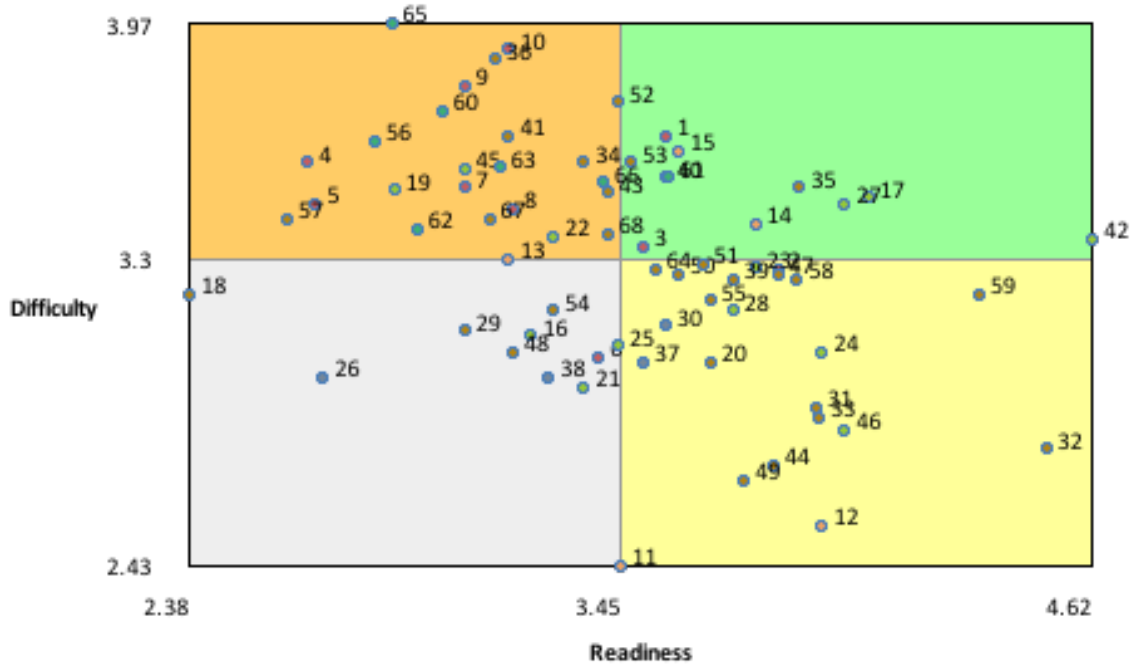
The items in the green and orange quadrants were rated in the national study as being the most important to the development of a system of care. As examples, items #32 and, #59 are rated both highest on Readiness and highest on Importance and item #42 is rated high on readiness and moderately high on Importance.. These are the items that appear in Table 1 as the highest rated items, also matched for being the most important items. These items read,

- There is a fully functioning advisory board or other group that represents key program partners, families, and youth. (#59)
- There is a commitment to measurement of progress and outcomes. (#32)
- Families are willing to take on a lead role in taking the vision to reality. (#42)

The participants in the national study considered these items very important. They both are important to the foundation on which to build a system of care. And Clark County has done well with developing an advisory board with parent and youth representation and making a commitment to measuring progress. To further explain Figure 1, item #18 is rated as the least ready but also the least important item. This item reads, "Community organizations such as faith-based groups have participated in the planning process."

The items in the green quadrant will need more work for the site to be completely ready, but there is a foundation of progress on which to build. Additional work on these items may be relatively easy, given the momentum already in place and similarly, for the items in the yellow quadrant. The most important items, rated as less ready, are in the orange quadrant and some of these items are hovering around the middle, indicating that they are almost at the point of moving into the green area.

Figure 2
A Focus Zone of the Ratings for Difficulty of Implementation



The display of items rated for Readiness and Difficulty of Implementation shows that few items are rated at a high level of the "most ready" and "most difficult" items. Although there are some

items in the green quadrant, they hover toward the middle rather than at the right margin, indicating that they need much more work. The strongest items in the most difficult and most ready quadrant are items #42, #17, and # 27. Items read,

- Families are willing to take on a lead role in taking the vision to reality. (#42)
- There is a strong family organization with resources to fully participate. (#17)
- A family organization was developed before funding. (#27)

As the project in Clark County moves forward, the areas on the right side of the map should continue to be addressed, as there is progress with these and ongoing effort will be needed to maintain and increase that progress. The next emphasis should be on the items in the orange zone that are most important and are currently rated as less ready.

Results of the Rating Process for the Ranking of Items within Components: The discussion above used the ratings of the items, independent of the components. The revised version of the SOC-RIMS has six components. An analysis of how Clark County respondents ranked the items within components is presented in Table 3 below, focusing on the items that were rated as "most ready" and those that were rated as "least ready." The presentation of four items for each of six components includes 24 items, that is, 35% of the total 68 items.

Table 3
Ranking of Items within Components by Clark County

Shared Goals across Stakeholders

Most Ready

2 The collaborative is actively involved in developing the approach, strategies, goals, and outcomes.

1 Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.

Least Ready

5 Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.

4 There are well trained, culturally competent, flexible personnel working in the system.

Commitment to Family & Youth Partnerships

Most Ready

42 Families are willing to take on a lead role in taking the vision to reality.

17 There is a strong family organization with resources to fully participate.

Least Ready

45 There is a plan for substantial financial support for family involvement, controlled by families being served.

19 Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.

Shared Knowledge & Experience

Most Ready

12 There is a felt need for services within the community by the stakeholders.

14 The applicant fully understands the magnitude of the evaluation component and the importance of data driven services.

Least Ready

11 The community has identified a population of initial focus for its system transformation efforts.

13 The community understands that the cooperative agreement is not primarily a granting of money, but is a partnership with the federal government to accomplish the federal program goals.

Community Involvement

Most Ready

61 There is a clear understanding with local community organizations and municipalities of where the community is with a vision of where they want to be within a given period of time.

66 An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.

Least Ready

65 There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.

56 The school district and medical professionals are in the collaborative agreement.

Evaluation

Most Ready

30 There are partnerships with colleges and universities for research and/or evaluation purposes.

37 The collaborative has validated a needs assessment.

Least Ready

38 There has been a study that provides insight into the barriers to change within the community.

26 There has been a comprehensive assessment within the community of where the gaps are in terms of resources.

Understanding Comprehensive Service Needs

Most Ready

32 There is a commitment to measurement of progress and outcomes.

59 There is a fully functioning advisory board or other group that represents key program partners, families, and youth.

Least Ready

57 There is a governance body that is powerful and independent of any specific provider in the community.

18 Community organizations such as faith-based groups have participated in the planning process.

Results of the Rankings of Components for Readiness: The six domains were determined in the item analysis, which produced the SOC-RIMS-R of 68 items. In Clark County, the rankings for Readiness provide information about the ranking of the components, indicating the strongest to the weakest. Table 4 presents this ranking.

Table 4
Ranking of Components

Commitment to Family & Youth Partnerships	3.63
Understanding Comprehensive Service Needs	3.58
Shared Goals across Stakeholders	3.54
Evaluation	3.26
Committed Stakeholders	3.21
Community Involvement	3.10

When considering the most ready areas, it appears that the respondents in Clark County have rated their site highly on Commitment to Family & Youth Partnerships and Understanding Comprehensive Service Needs. When considering the least ready area, the component Community Involvement is the area where most work is needed. However, it should be noted that three of the domains are scored quite high and the remaining three are respectably scored, indicating a good foundation on which to build a system of care.

Discussion

In September 2015, the State of Nevada received a four-year implementation grant from the Child, Adolescent and Family Branch, Center for Mental Health Services, in the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a integrated systems of care for children, from birth to 21, with serious emotional disturbance (SED) and their families. The State of Nevada, through its Division of Child and Family Services (DCFS), as part of the Nevada Department of Health and Human Services (DHHS) has developed a very sophisticated plan designed to focus on children and youth, from birth to 21, with serious emotional disturbances (SED) and their families to improve outcomes for them and to fully implement systems of care values and practices for them across the state. The proposed plan to develop systems of care throughout the state is based on a good foundation derived from Nevada state law. The Nevada Revised Statute (NRS) 433 mandates any county with a population of 100,000 or more must establish a Mental Health Consortia. "The consortium is mandated to include partners from the local, county and regional level including school districts chamber of commerce and business community, state agencies, juvenile probation, mental health care, foster care provider, a parent or guardian of a child with emotional disturbance, substance abuse agencies, advocates and provider organizations." Given Nevada's vast geographic area, NRS 433 requires that three consortia be created to cover the entire state, in Washoe County (Reno/Tahoe), Clark County (Las Vegas and surrounding area), and Rural Nevada (15 counties in rural/frontier Nevada). DCFS provides the leadership in the development of Nevada's Mental Health System of Care (SOC).

In the first year of implementation, Nevada DCFS committed to doing readiness assessments in all three consortia, using the revised System of Care Readiness and Implementation Measurement Scale (SOC-RIMS-R). The purpose of this assessment is to determine the readiness status to implement/expand the system of care, so that implementation can be based on the identified strengths and weaknesses of the current community systems, as perceived by the stakeholders. This assessment will provide a benchmark in each consortium for the development

of the system of care, providing guidance for planning and implementation. Such information can be particularly useful, as it clearly sets the direction, as well as establishing a baseline against which to measure progress over time. Further, the information about readiness, areas of strength and areas of weakness will provide Nevada DCFS guidance on the training and technical assistance needs of each site, addressing their priorities of "collaboration with stakeholders, consumers and community partners and rigorous evaluation and quality assurance." They asked their stakeholders to complete the System of Care Readiness and Implementation Scale (SOC-RIMS-R) developed by Behar and Hydaker (2009) in July-August 2016.

Clark County was the first of the three consortia to complete data collection for the study of community readiness, administering the SOC-RIMS-R during July and August 2016. There were 26 people that responded to the survey. Of these, 22 met the criteria for inclusion in the data analysis. One individual did not answer a sufficient number of questions (66%) and three other individuals were omitted from the data analysis because the responses reflected a bias rather than an appraisal of readiness.

The Readiness score is calculated to reflect the average score for all items. These items were rated on a scale of 1 – 5, with 1 being the "least ready" and 5 being the "most ready." The Readiness score for all participants from Clark County is **3.45,** with 5.00 being the most ready. This average is based upon the ratings by the 22 participants for each of the 68 items. The range of scores for the 37 newly funded sites studied in 2009-2015 was 2.58 – 4.06, with the average being 3.379. Clark County's score is in the above average range, falling within the first standard deviation above the mean. For the 37 sites assessed, the average time period from funding to doing an initial community readiness assessment is 12 months. Clark County is within this time frame. The respondents from Clark County gave a very positive rating to the current foundation on which to build a system of care.

It will be helpful to look at the areas that the respondents rated as "most ready," and "least ready" as this information can help shape next steps for Clark County. This information is found in Tables 1, 2, and 3.

Focusing on the statements reflecting accomplishments, which are presented in Table 1, the respondents rate Clark County highest, that is "most ready," on the following 12 items:

- Families are willing to take on a lead role in taking the vision to reality.
- There is a commitment to measurement of progress and outcomes.
- There is a fully functioning advisory board or other group that represents key program partners, families, and youth.
- There is a strong family organization with resources to fully participate.
- A family organization was developed before funding.
- Families have been at the table throughout the visioning process.
- Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.
- There is a felt need for services within the community by the stakeholders.

- There is a mechanism for communicating to the community the goals and the progress toward those goals in developing a system of care.
- The agency that received the funds has a history of positive audits and has disclosed any fiduciary or subcontracted agent that will manage funds.
- There is a commitment from leadership at major child serving systems that a family-driven, youth-guided system of care is essential to success.
- There is a commitment to ensure that cultural and linguistic competence is represented in both conceptualization and implementation of all activities.

The Clark County site received the highest ratings on items that reflect the involvement of families and the coordination and integration of community services. This high level of ratings regarding family participation is unusual in newly funded sites. Family participation is one of the major principles of system of care development and usually is a focus and challenge that is not easy to achieve. Of the 12 items ranked highest, eight of them (67%) involve the role of the family in systems development and the remaining six address commitment to coordination, communication and culturally responsive services. It appears that the requirement for integrated services across child-serving agencies and the priority role of families delineated in the Nevada Revised Statute (NRS 433B) has had an impact on the organization and delivery of services and has provided an important foundation for system of care development.

The action steps presented in Table 2 that are rated as "least ready" should be addressed in Clark County. These issues are important to the development of systems of care and will have to be reviewed given the history of the county. The need to focus on these activities is clear. These include the following items:

- The community has dedicated sufficient resources to support cultural and linguistic proficiency.
- The community is being made aware of the potential services in order to be willing to support additional funding.
- Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.
- There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.
- The school district and medical professionals are in the collaborative agreement.
- There has been a comprehensive assessment within the community of where the gaps are in terms of resources.
- Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.
- There are well trained, culturally competent, flexible personnel working in the system.
- There is a governance body that is powerful and independent of any specific provider in the community.

- Community organizations such as faith-based groups have participated in the planning process.

The majority of low ranking items fall into areas that delineate next steps. The low-ranking items involve facets of the system of care that are not typically seen in early stages of implementation but would be expected in graduated SOC communities. The lowest ranked items address issues that will take substantial collaboration and cooperation to implement, such as understanding the system of care principles, blended or braided funding and conducting a needs assessment. Low rankings offer clear guidance as to what needs to be addressed to develop a system of care. Items for which they are unready provide direction for the next level of work. Considering the lowest scores, the majority of these items reflects concerns about leadership and shared goals. The items, for which they are unready, provide direction for future work, work that would re-create the system developed earlier.

Table 3, on pages 13-14, organizes the "most ready" and "least ready" items by components, offering the possibility of the Clark County Consortium establishing six committees to address the six components. Alternatively, this table offers an organizational structure for building on the strengths and addressing the areas that need more work.

In the national study, where the items for the System of Care Readiness and Implementation Measurement Scale were established, these items were also rated in terms of Importance and Difficulty of Implementation. Figure 1 displays the Most Ready and Least Ready items relative to Importance and Figure 2 displays the Most Ready and Least Ready items relative to Difficulty of Implementation. The areas of greatest strength for Clark County are those that involve commitment to family and youth partnerships, the stakeholders' understanding of service needs, and shared goals across stakeholders. Involvement of the broader community, for example the medical community and the school systems, is an area that needs stronger attention.

Overall, the results of the initial readiness assessment of the Clark County community are quite positive. The respondents' ratings indicate that there is a strong foundation on which to build a system of care.

In addition to using the information from the System of Care Readiness and Implementation Measurement Scale for planning action steps, the information provided by the readiness assessment can serve as the basis for the development of a logic model, a strategic plan, and a technical assistance plan. The information obtained through the community assessment is good information to use for these purposes, as it reflects the views of the community stakeholders, in this case, the consistent views of the stakeholders. The logic model, the strategic plan, and the technical assistance plan by necessity are usually done by smaller groups and then shared with larger groups. For the members of the larger group to be able to identify the input of the broader community in these entities, reflects the importance of their voices and that the reality of the community, as they see it, has been taken seriously. Lastly, a follow-up rating after 12-18 months, using the same rating scale would reflect progress in addressing areas of relative weakness and provide an update on "next steps."

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Appendix A

System of Care Readiness and Implementation Measurement Scale

Revised Version

System of Care Readiness and Implementation Measurement Scale-R[5]

Lenore Behar, Ph.D. & William M. Hydaker, MA

Please rate each item in terms of how ready your community is to implement a system of care, that is, how much your community has accomplished for each item. A rating of 1 indicates "least ready" and a rating of 5 indicates "most ready."

1	Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	☐1☐2 ☐3 ☐4 ☐5
2	The collaborative is actively involved in developing the approach, strategies, goals, and outcomes.	☐1☐2 ☐3 ☐4 ☐5
3	There is training and support to help teach and educate families and professionals how to work together and respect and value each other's expertise.	☐1☐2 ☐3 ☐4 ☐5
4	There are well trained, culturally competent, flexible personnel working in the system.	☐1☐2 ☐3 ☐4 ☐5
5	Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.	☐1☐2 ☐3 ☐4 ☐5
6	Key family contacts and youth leaders have been identified prior to the application submission so that the groups are ready to roll once the funding is received.	☐1☐2 ☐3 ☐4 ☐5
7	The community is being provided with examples of what following the values and principles of the system of care looks like in order to understand what a shift in thinking and practice it is from how they currently serve children and families.	☐1☐2 ☐3 ☐4 ☐5
8	Key budget staff is working with partners on funding issues, requirements, restrictions, and how to resolve the issues	☐1☐2 ☐3 ☐4 ☐5
9	The community partners understand and accept the concept of permanent system change as the end goal.	☐1☐2 ☐3 ☐4 ☐5
10	The community partners have a willingness to share resources: knowledge, staff, dollars, understanding that it is through joint investment that joint success is achieved.	☐1☐2 ☐3 ☐4 ☐5

[5] Formerly the Community Readiness Assessment Scale

11	The community has identified a population of initial focus for its system transformation efforts.	☐1☐2 ☐3 ☐4 ☐5
12	There is a felt need for services within the community by the stakeholders.	☐1☐2 ☐3 ☐4 ☐5
13	The community understands that the cooperative agreement is not primarily a granting of money, but is a partnership with the federal government to accomplish the federal program goals.	☐1☐2 ☐3 ☐4 ☐5
14	The applicant fully understands the magnitude of the evaluation component and the importance of data driven services.	☐1☐2 ☐3 ☐4 ☐5
15	There is a commitment from key community stakeholders - people with the ability to influence attitudes and actions of others such as elected officials, community leaders, and other respected individuals.	☐1☐2 ☐3 ☐4 ☐5
16	Representatives of the community's different cultures have been involved from the early planning stages forward.	☐1☐2 ☐3 ☐4 ☐5
17	There is a strong family organization with resources to fully participate.	☐1☐2 ☐3 ☐4 ☐5
18	Community organizations such as faith-based groups have participated in the planning process.	☐1☐2 ☐3 ☐4 ☐5
19	Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	☐1☐2 ☐3 ☐4 ☐5
20	There are strong relationships and commitments to collaboration among community partners.	☐1☐2 ☐3 ☐4 ☐5
21	The community can show specific ways that family members and youth participate in decision-making for their individual service plans.	☐1☐2 ☐3 ☐4 ☐5
22	There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.	☐1☐2 ☐3 ☐4 ☐5
23	Project leaders have identified youth and family members who with support and training, if necessary, can articulate and advocate using their stories and voice.	☐1☐2 ☐3 ☐4 ☐5
24	Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.	☐1☐2 ☐3 ☐4 ☐5
25	There is a dedicated amount in the budget to go to the family organization.	☐1☐2 ☐3 ☐4 ☐5

26	There has been a comprehensive assessment within the community of where the gaps are in terms of resources.	☐1☐2 ☐3 ☐4 ☐5
27	A family organization was developed before funding.	☐1☐2 ☐3 ☐4 ☐5
28	Family members and youth are active members of a community system of care initiative.	☐1☐2 ☐3 ☐4 ☐5
29	The child serving agency stakeholders have bought into the systems of care and wraparound concepts.	☐1☐2 ☐3 ☐4 ☐5
30	There are partnerships with colleges and universities for research and/or evaluation purposes.	☐1☐2 ☐3 ☐4 ☐5
31	The agency that received the funds has a history of positive audits and has disclosed any fiduciary or subcontracted agent that will manage funds.	☐1☐2 ☐3 ☐4 ☐5
32	There is a commitment to measurement of progress and outcomes.	☐1☐2 ☐3 ☐4 ☐5
33	There is a mechanism for communicating to the community the goals and the progress toward those goals in developing a system of care.	☐1☐2 ☐3 ☐4 ☐5
34	The stakeholders share power and decision-making.	☐1☐2 ☐3 ☐4 ☐5
35	There is a commitment from leadership at major child serving systems that a family-driven, youth-guided system of care is essential to success.	☐1☐2 ☐3 ☐4 ☐5
36	State and/or county support is available - not only to support the proposed service delivery changes, but to support/allow flexibility for larger system change initiatives (proposed changes in funding structure, for example).	☐1☐2 ☐3 ☐4 ☐5
37	The collaborative has validated a needs assessment.	☐1☐2 ☐3 ☐4 ☐5
38	There has been a study that provides insight into the barriers to change within the community.	☐1☐2 ☐3 ☐4 ☐5
39	A strong collaborative team is in place, ideally with some past history and prior success on earlier projects that involve system change.	☐1☐2 ☐3 ☐4 ☐5
40	There is accountability within the collaborative body for follow through and commitment from the boards that control them.	☐1☐2 ☐3 ☐4 ☐5
41	There is a strong trusting working relationship among all collaborating parties.	☐1☐2 ☐3 ☐4 ☐5

42	Families are willing to take on a lead role in taking the vision to reality.	☐1☐2 ☐3 ☐4 ☐5
43	There is a well-defined, clear, and articulated decision-making structure.	☐1☐2 ☐3 ☐4 ☐5
44	The staff and the community partners have a demonstrated knowledge of characteristics of the population to be served.	☐1☐2 ☐3 ☐4 ☐5
45	There is a plan for substantial financial support for family involvement, controlled by families being served.	☐1☐2 ☐3 ☐4 ☐5
46	Families have been at the table throughout the visioning process.	☐1☐2 ☐3 ☐4 ☐5
47	The community partners are willing to have open discussions and come to agreement on what some of the barriers and obstacles are to making the changes necessary to have a system of care.	☐1☐2 ☐3 ☐4 ☐5
48	There is an understanding of community assets that can be used in building the system.	☐1☐2 ☐3 ☐4 ☐5
49	There is agreement to have family advocates on staff.	☐1☐2 ☐3 ☐4 ☐5
50	There is a commitment from policy makers, community leaders, partners, and staff to the system of care values and principles	☐1☐2 ☐3 ☐4 ☐5
51	Sustainability of services is part of the discussions from the beginning, not waiting until the end of the funding period.	☐1☐2 ☐3 ☐4 ☐5
52	Leaders are willing to be challenged and are able to experience discomfort when it comes to movement and change.	☐1☐2 ☐3 ☐4 ☐5
53	There is a consensus among system leadership about the role of a cooperative agreement.	☐1☐2 ☐3 ☐4 ☐5
54	There is a willingness to work in a fair, inclusive, and open manner.	☐1☐2 ☐3 ☐4 ☐5
55	Infrastructure is in place to ensure implementation of major system of care values such as collaboration.	☐1☐2 ☐3 ☐4 ☐5
56	The school district and medical professionals are in the collaborative agreement.	☐1☐2 ☐3 ☐4 ☐5

57	There is a governance body that is powerful and independent of any specific provider in the community.	☐1☐2 ☐3 ☐4 ☐5
58	There is a commitment to ensure that cultural and linguistic competence is represented in both conceptualization and implementation of all activities.	☐1☐2 ☐3 ☐4 ☐5
59	There is a fully functioning advisory board or other group that represents key program partners, families, and youth.	☐1☐2 ☐3 ☐4 ☐5
60	The community has dedicated sufficient resources to support cultural and linguistic proficiency.	☐1☐2 ☐3 ☐4 ☐5
61	There is a clear understanding with local community organizations and municipalities of where the community is with a vision of where they want to be within a given period of time.	☐1☐2 ☐3 ☐4 ☐5
62	The community is being made aware of the potential services in order to be willing to support additional funding.	☐1☐2 ☐3 ☐4 ☐5
63	There are plans to develop a method of sharing real time, useful information to identify important system trends and to provide information necessary for data based decision-making.	☐1☐2 ☐3 ☐4 ☐5
64	Services are being designed to be customer driven and strength and solution focused.	☐1☐2 ☐3 ☐4 ☐5
65	There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.	☐1☐2 ☐3 ☐4 ☐5
66	An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.	☐1☐2 ☐3 ☐4 ☐5
67	There is an agreement to share information across child-serving systems.	☐1☐2 ☐3 ☐4 ☐5
68	There is an understanding of and buy-in of the use of the research to help address what is working and what can be improved at in the community.	☐1☐2 ☐3 ☐4 ☐5

NAME_____

PROJECT SITE/COUNTY_____

Appendix B

System of Care Readiness and Implementation Measurement Scale

Items Ranked by Score

Clark County, Nevada

#	Statement	Score
42	Families are willing to take on a lead role in taking the vision to reality.	4.62
32	There is a commitment to measurement of progress and outcomes.	4.50
59	There is a fully functioning advisory board or other group that represents key program partners, families, and youth.	4.33
17	There is a strong family organization with resources to fully participate.	4.06
27	A family organization was developed before funding.	4.00
46	Families have been at the table throughout the visioning process.	4.00
24	Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.	3.94
12	There is a felt need for services within the community by the stakeholders.	3.94
33	There is a mechanism for communicating to the community the goals and the progress toward those goals in developing a system of care.	3.94
31	The agency that received the funds has a history of positive audits and has disclosed any fiduciary or subcontracted agent that will manage funds.	3.93
35	There is a commitment from leadership at major child serving systems that a family-driven, youth-guided system of care is essential to success.	3.89
58	There is a commitment to ensure that cultural and linguistic competence is represented in both conceptualization and implementation of all activities.	3.88
2	The collaborative is actively involved in developing the approach, strategies, goals, and outcomes.	3.83
47	The community partners are willing to have open discussions and come to agreement on what some of the barriers and obstacles are to making the changes necessary to have a system of care.	3.83
44	The staff and the community partners have a demonstrated knowledge of characteristics of the population to be served.	3.82
23	Project leaders have identified youth and family members who with support and training, if necessary, can articulate and advocate using their stories and voice.	3.78
14	The applicant fully understands the magnitude of the evaluation component and the importance of data driven services.	3.78
49	There is agreement to have family advocates on staff.	3.75
28	Family members and youth are active members of a community system of care initiative.	3.72
39	A strong collaborative team is in place, ideally with some past history and prior success on earlier projects that involve system change.	3.72
55	Infrastructure is in place to ensure implementation of major system of care values such as collaboration.	3.67
20	There are strong relationships and commitments to collaboration among community partners.	3.67

51	Sustainability of services is part of the discussions from the beginning, not waiting until the end of the funding period.	3.65
15	There is a commitment from key community stakeholders - people with the ability to influence attitudes and actions of others such as elected officials, community leaders, and other respected individuals.	3.59
50	There is a commitment from policy makers, community leaders, partners, and staff to the system of care values and principles	3.59
1	Families are provided with support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	3.56
61	There is a clear understanding with local community organizations and municipalities of where the community is with a vision of where they want to be within a given period of time.	3.56
30	There are partnerships with colleges and universities for research and/or evaluation purposes.	3.56
40	There is accountability within the collaborative body for follow through and commitment from the boards that control them.	3.56
64	Services are being designed to be customer driven and strength and solution focused.	3.53
3	There is training and support to help teach and educate families and professionals how to work together and respect and value each other's expertise.	3.50
37	The collaborative has validated a needs assessment.	3.50
53	There is a consensus among system leadership about the role of a cooperative agreement.	3.47
25	There is a dedicated amount in the budget to go to the family organization.	3.44
11	The community has identified a population of initial focus for its system transformation efforts.	3.44
52	Leaders are willing to be challenged and are able to experience discomfort when it comes to movement and change.	3.44
43	There is a well-defined, clear, and articulated decision-making structure.	3.41
68	There is an understanding of and buy-in of the use of the research to help address what is working and what can be improved at in the community.	3.41
66	An advisory or leadership board has been established that has at least 1/3 parent participation and they have input on the design and implementation of the project.	3.40
6	Key family contacts and youth leaders have been identified prior to the application submission so that the groups are ready to roll once the funding is received.	3.39
21	The community can show specific ways that family members and youth participate in decision-making for their individual service plans.	3.35
34	The stakeholders share power and decision-making.	3.35

22	There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.	3.28
54	There is a willingness to work in a fair, inclusive, and open manner.	3.28
38	There has been a study that provides insight into the barriers to change within the community.	3.27
16	Representatives of the community's different cultures have been involved from the early planning stages forward.	3.22
8	Key budget staff is working with partners on funding issues, requirements, restrictions, and how to resolve the issues.	3.18
48	There is an understanding of community assets that can be used in building the system.	3.18
10	The community partners have a willingness to share resources: knowledge, staff, dollars, understanding that it is through joint investment that joint success is achieved.	3.17
13	The community understands that the cooperative agreement is not primarily a granting of money, but is a partnership with the federal government to accomplish the federal program goals.	3.17
41	There is a strong trusting working relationship among all collaborating parties.	3.17
63	There are plans to develop a method of sharing real time, useful information to identify important system trends and to provide information necessary for data based decision-making.	3.14
36	State and/or county support is available - not only to support the proposed service delivery changes, but to support/allow flexibility for larger system change initiatives (proposed changes in funding structure, for example).	3.13
67	There is an agreement to share information across child-serving systems.	3.12
9	The community partners understand and accept the concept of permanent system change as the end goal.	3.06
7	The community is being provided with examples of what following the values and principles of the system of care looks like in order to understand what a shift in thinking and practice it is from how they currently serve children and families.	3.06
45	There is a plan for substantial financial support for family involvement, controlled by families being served.	3.06
29	The child serving agency stakeholders have bought into the systems of care and wraparound concepts.	3.06
60	The community has dedicated sufficient resources to support cultural and linguistic proficiency.	3.00
62	The community is being made aware of the potential services in order to be willing to support additional funding.	2.94
19	Young people are being provided support and training so that they can participate fully and comfortably in system of care planning, implementation oversight, and evaluation.	2.88

65	There is an understanding of blended or braided funding and the willingness among the community agencies to share resources.	2.88
56	The school district and medical professionals are in the collaborative agreement.	2.83
26	There has been a comprehensive assessment within the community of where the gaps are in terms of resources.	2.71
5	Everyone--community partners, leaders, families, and youth--understands the principles on which the new system will be built and share the same values.	2.69
4	There are well trained, culturally competent, flexible personnel working in the system.	2.67
57	There is a governance body that is powerful and independent of any specific provider in the community.	2.62
18	Community organizations such as faith-based groups have participated in the planning process.	2.38