

***The Nevada System of Care for Youth
with Serious Emotional Disorders
An Initial Review of Readiness
across Three Sites***

***Lenore B. Behar, Ph.D. Child & Family Program
Strategies***

***William M. Hydaker, M.A. Hydaker Community
Consulting***

December 2016

*The Nevada System of Care
for Youth with Serious Emotional Disorders¹*

Three Site Summary

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).

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

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.

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.”

Three Site Summary

In July 2016, as part of the Nevada System of Care Project, the three consortia worked to complete the study of community readiness. Clark County, the largest county in Nevada, and the 13th largest county in the country, covering an area about the size as New Jersey with a population of 2,028,000, was the first of the three consortia to complete the study of community readiness. Rural Nevada, comprised of 15 counties and encompassing a large geographic area of the state’s 110,567 square miles and sparsely populated, was the second of the three consortia to complete the study of community readiness. Washoe County is located along the eastern slopes of the Sierra Madre Mountains in northwestern Nevada and borders on California and Oregon. Washoe County encompasses a large geographic area of 6,600 square miles with a population of approximately 435,000 and was the third of the three consortia to complete the study of community readiness.

The purpose of these three assessments was to determine the current readiness status, so that planning can be based on the identified strengths and weaknesses of each of the three current community systems, as perceived by their stakeholders. These assessments represent a benchmark for the development of the system of care, providing guidance for planning and implementation and providing guidance for technical assistance and training.

The information provided below summarizes the data from these three sites and provides a sense readiness to implement a system of care across the State of Nevada in this initial year of implementation.

Participants in the Study

Across the three consortia, 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. There was a total of 104 respondents.

A description of the 104 respondents’ roles in the project is

- 23 Parents
- 1 Youth (age 10 – 18)
- 29 Mental Health Service Providers
- 17 Community Service Providers
- 1 Educator (college level)
- 13 Supervisors/Administrators

- 1 Member of a Faith Community
- 2 Interested Community Members
- 1 System of Care Project Leadership
- 5 System of Care Staff
- 7 Other (Youth Facilitator, Commission for Public and Behavioral Health, Early Intervention Provider, Non-profit Management Consultant, Treatment Home Provider, Specialized Foster Care Provider and a Police Administrator
- 4 No Information

Ethnic Identity was listed as

- 72 Caucasians
- 5 African American
- 19 Hispanic/Latino
- 1 Native American
- 2 Asian American
- 1 Other
- 3 No Information

Of the 104 people who responded to the survey, 89 met the criteria for inclusion in the data analysis. Seven individuals did not answer a sufficient number of questions (66%) and eight individuals marked a sufficient number of items the same, indicating a failure to discriminate or a bias, rather than an appraisal of readiness. These responses were omitted from the data analysis.

Note that there were no parents in the rural sample and there were nearly 3 times the number of parents in the Clark County vs. Washoe samples. Clark County was relatively rich with parents as compared to the others. Interestingly, there were no mental health service providers in the Clark County sample.

The Findings of the Readiness Study for the Nevada System of Care in Rural Nevada

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 Rural Nevada is **2.72**; for the 47 participants from Washoe County is **2.85** and for all 15 participants from Clark County is **3.45** out of a possible 5.00. The average of the three scores is **3.01**. The range of scores for the 37 funded sites studied in 2009 - 2015 was 2.58 – 4.06, with the average being 3.379. Nevada’s overall score is in the low average range and falls in the first standard deviation below 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 at the beginning of 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.

The Ranking of Components: Table 1 below reflects the scores across the three sites by components. These components are like domains or clusters within the SOC-RIMS-R, that is items that “go together.”

Table 1

Components	Rural	Washoe	Clark
Understanding Comprehensive Service Needs	3.29	3.08	3.58
Shared Goals across Stakeholders	2.99	3.03	3.54
Evaluation	2.82	2.70	3.26
Committed Stakeholders	2.49	2.66	3.21
Community Involvement	2.44	2.68	3.10
Commitment to Family & Youth Partnerships	2.25	2.64	3.63

The Areas of Greatest Readiness: The scores for components vary across the three sites, with scores from Clark County being consistently higher. Clark County scored highest on Commitment to Family & Youth Partnerships a score not often seen in developing sites. However, across the three sites, the components that received the highest scores are Understanding Comprehensive Service Needs and Shared Goals across Stakeholders. The scores for these two components across the three sites represent a good start on building a system of care, that is, building on strengths. Clark County is consistently strong, but the other two are not far behind. These top two component areas need to be strengthened over time for complete systems of care to be in place.

The Areas of Least Readiness: Clark County does much better than the other two sites across all components. Within each site, the components that receive the lowest scores are Committed Stakeholders and Community Involvement. Commitment to Family & Youth Partnerships is the lowest scoring component for Washoe County and the Rural sites. (Appendix A shows the items within these components.) As noted above, all components need attention over time to achieve systems of care. The areas that need the most attention are a sustained focus on greater community involvement, committed stakeholders and stronger commitments to family and youth partnerships.

Appendix A

Items by Component

Committed Stakeholders

- 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.
- 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.
- 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.
- 8 Key budget staff is working with partners on funding issues, requirements, restrictions, and how to resolve the issues.
- 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.
- 9 The community partners understand and accept the concept of permanent system change as the end goal.
- 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.
- 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 and Youth Partnerships

- 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.
- 27 A family organization was developed before funding.
- 46 Families have been at the table throughout the visioning process.
- 24 Training has been provided to parents to help them feel more confident advocating for themselves and others in the community.
- 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.
- 28 Family members and youth are active members of a community system of care initiative.
- 25 There is a dedicated amount in the budget to go to the family organization.
- 21 The community can show specific ways that family members and youth participate in decision-making for their individual service plans.

- 22 There is active participation from families, youth and front-line workers from public and private sectors in the implementation of the system.
- 16 Representatives of the community's different cultures have been involved from the early planning stages forward.
- 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.

#

Community Involvement

- 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.
- 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.
- 60 The community has dedicated sufficient resources to support cultural and linguistic proficiency.
- 62 The community is being made aware of the potential services in order to be willing to support additional funding.
- 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.