Advocating, Collaborating & Connecting Children's Mental Health in Rural Nevada

RURAL CHILDREN'S MENTAL HEALTH CONSORTIUM

Annual Progress Report for Ten-Year Strategic Plan

2018 STATUS UPDATE

INTRODUCTION

In order to assess, develop and support a Behavioral Health System of Care for Nevada's youth and families, the Nevada Revised Statute (NRS 433B) established Mental Health Consortia in three jurisdictions in Nevada; Clark County, Washoe County and Rural Areas. The functions of the Consortia are to assess the current behavioral health services for youth, in each jurisdiction and develop a plan that will identify gaps and areas in need of improvement. The Rural Children's Mental Health Consortium (RCMHC) is comprised of committed professionals, agency personnel, community representatives, parents, foster parents, youth, community business representatives, representatives from the Department of Education, and advocates who come together to support youth and families in Rural Nevada with behavioral health needs. Using a set of values and principles which promote a system of care that is community-based, family driven & youth guided and culturally competent, the following status report identifies 7 goals that are the focus for developing an integrated system of care.

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OUR MISSION

Advocating, Collaborating & Connecting Children's Mental Health in Rural Nevada

The Rural Children's Mental Health Consortium is driven by a vision which includes a "System of Care" approach to serving youth and their families with an overarching focus on prevention and intervention. The intent of prevention and intervention programs is to move to a proactive system. Engaging individuals, before the development of serious emotional disturbance or to alleviate the need for extended mental health treatment, by facilitating access to services and supports at the earliest signs of mental health concerns. These principles influence and are infused into the consortium's ideas, efforts, and work in order to develop, support and improve behavioral health throughout Rural Nevada.

TEN YEAR PLAN GOALS

The goals of the RCMHC Ten Year Plan have been slightly modified over the last few years. With the vision of a unified system of care, a new goal, supporting the system of care design, was created-#3. With the creation of goal #3, several of the other goals were collapsed and included in the System of Care goal. The RCMHC has 7 main goals identified for the 2018 status report. Moving forward, these 7 goals will be the on-going focus for the RCMHC's Ten Year Plan.

Goal #1- Address Work Force Development to Provide Mental Health Professionals to Rural Nevada

Goal #2- Promote Appropriate Mental Health Providers to Public Schools

Goal #3- Support a System of Care Designed for Nevada's Rural Region

Goal #4- Promote Adequate Technology to Support the Use of Telehealth Services in Nevada's Rural Regions

Goal #5- Create a Rural Children's Mobile Crisis Response Team (RMCRT)

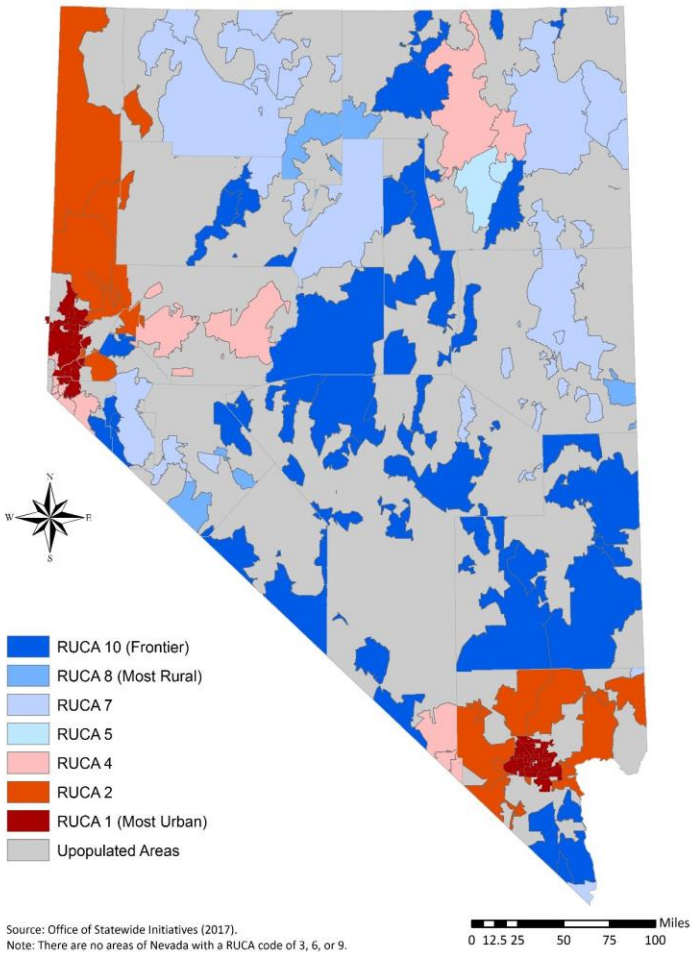
Goal #6- Promote Prevention and Intervention: Addressing Behavioral Health Issues Early

Goal #7- Increase Transitional Support to Youth Receiving Treatment in Inpatient & Residential Treatment Centers, Especially Those Out-of-State Through Increased Local Service Array

BACKGROUND

The Rural Children's Mental Health Consortium has been tasked with addressing children's mental health needs across fifteen large and diverse counties in Nevada. This includes the urban county of Carson; the three rural counties of Douglas, Lyon, and Storey; and the eleven frontier counties with a population density of seven or less persons per square mile of Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, and White Pine counties. Collectively, the rural and frontier counties of Nevada account for approximately 9.7% of the state's population, spread across an expansive 87% of the state's land mass. (Nevada Rural and Frontier Health Data Book, 2017).

Map 2: Nevada Population by Rural-Urban Commuting Areas (RUCA)



Source: Office of Statewide Initiatives (2017).
Note: There are no areas of Nevada with a RUCA code of 3, 6, or 9.

The predominate issues impacting children's mental health in Rural Nevada are complex and intensified by two primary challenges: limited access to services due to geographic distance and insufficient provider availability. In 2014, the current data from the Nevada Rural and Frontier Health Data Book for 2017 reports the total number of children ages 17 and under living in Nevada has rose to 693,021, increasing the need for more mental health services not only in Rural and Frontier areas but Statewide. (Nevada Rural and Frontier Health Data Book, 2017).

In Rural Nevada, it remains that 100% of the population resides in a mental health professional shortage area (Nevada Rural and Frontier Health Data Book, 2017). This is evident in the charts below that depict only 1 psychiatrist residing in Rural Nevada. Not only is there a mental health workforce shortage, but there has also been a decline in providers from 2008-2016 (Nevada Rural and Frontier Health Data Book, 2017) resulting in workforce development and training as a priority for the Consortium. The charts below provide the detailed number of various mental health professionals in Rural Nevada and how they are dispersed by County:

Table 5.19: Licensed Alcohol, Drug and Gambling Counselors in Nevada by County — 2008 to 2016

Region/County	Licensed Alcohol, Drug and Gambling Counselors					
	Number		Change — 2008 to 2016		Number per 100,000 Population	
	2008	2016	Number	Percent	2008	2016
Rural and Frontier						
Churchill County	39	32	-7	-17.9	144.5	123.5
Douglas County	30	21	-9	-30.0	57.5	43.9
Elko County	88	21	-67	-76.1	174.0	37.8
Esmeralda County	1	0	-1	-100.0	80.6	0.0
Eureka County	0	0	0	0.0	0.0	0.0
Humboldt County	9	12	3	33.3	50.0	64.9
Lander County	2	3	1	50.0	34.0	44.3
Lincoln County	1	2	1	100.0	23.0	38.9
Lyon County	31	30	-1	-3.2	55.5	55.3
Mineral County	1	0	-1	-100.0	22.7	0.0
Nye County	16	9	-7	-43.8	33.8	19.9
Pershing County	2	3	1	50.0	27.8	42.6
Storey County	2	2	0	0.0	45.6	49.4
White Pine County	4	5	1	25.0	41.3	48.2
Region Subtotal	226	140	-86	-38.1	78.0	48.8
Urban						
Carson City	62	57	-5	-8.1	107.6	103.3
Clark County	619	731	112	18.1	31.5	35.0
Washoe County	326	296	-30	-9.2	76.9	65.7
Region Subtotal	1,007	1,084	77	7.6	41.1	41.5
Nevada — Total	1,233	1,224	-9	-0.7	45.0	42.1

Source: Nevada State Board of Examiners for Alcohol, Drug and Gambling Counselors (2008, 2016).

Table 5.23: Licensed Psychologists in Nevada by County — 2008 to 2016

Region/County	Licensed Psychologists					
	Number		Change — 2008 to 2016		Number per 100,000 Population	
	2008	2016	Number	Percent	2008	2016
Rural and Frontier						
Churchill County	3	1	-2	-66.7	11.1	3.9
Douglas County	5	5	0	0.0	9.6	10.4
Elko County	4	0	-4	-100.0	7.9	0.0
Esmeralda County	0	0	0	0.0	0.0	0.0
Eureka County	0	0	0	0.0	0.0	0.0
Humboldt County	3	0	-3	-100.0	16.7	0.0
Lander County	0	0	0	0.0	0.0	0.0
Lincoln County	0	0	0	0.0	0.0	0.0
Lyon County	2	4	2	100.0	3.6	7.4
Mineral County	0	0	0	0.0	0.0	0.0
Nye County	2	2	0	0.0	4.2	4.4
Pershing County	0	0	0	0.0	0.0	0.0
Storey County	2	0	-2	-100.0	45.6	0.0
White Pine County	0	0	0	0.0	0.0	0.0
Region Subtotal	21	12	-9	-42.9	7.3	4.2
Urban						
Carson City	24	17	-7	-29.2	41.7	30.8
Clark County	147	215	68	46.3	7.5	10.3
Washoe County	119	146	27	22.7	28.1	32.4
Region Subtotal	290	378	88	30.3	11.8	14.5
Nevada — Total	311	390	79	25.4	11.4	13.4

Source: Nevada State Board of Psychological Examiners (2008, 2016).

Table 5.24: Licensed Social Workers in Nevada by County — 2016

Region/County	Licensed Social Workers			
	Licensed Social Workers (LSWs)	Licensed Associates in Social Work (LASWs)	Licensed Clinical Social Workers (LCSWs)	Licensed Independent Social Workers (LISWs)
Rural and Frontier				
Churchill County	17	0	4	0
Douglas County	2	0	8	0
Elko County	30	2	6	0
Esmeralda County	0	0	0	0
Eureka County	0	0	0	0
Humboldt County	8	0	4	0
Lander County	0	0	2	0
Lincoln County	1	0	3	0
Lyon County	14	1	6	0
Mineral County	0	0	0	0
Nye County	8	0	5	0
Pershing County	2	0	0	0
Storey County	0	0	0	0
White Pine County	4	0	3	0
Region Subtotal	86	3	41	0
Urban				
Carson City	74	3	30	0
Clark County	723	42	459	7
Washoe County	357	9	168	5
Region Subtotal	1,154	54	657	12
Nevada — Total	1,240	57	698	12

Source: State of Nevada Board of Examiners for Social Workers (2016).

Table 5.22: Licensed Psychiatrists in Nevada by County — 2006 to 2016

Region/County	Licensed Psychiatrists					
	Number		Change — 2006 to 2016		Number per 100,000 Population	
	2006	2016	Number	Percent	2006	2016
Rural and Frontier						
Churchill County	0	0	0	0.0	0.0	0.0
Douglas County	3	1	-2	-66.7	6.0	2.1
Elko County	0	0	0	0.0	0.0	0.0
Esmeralda County	0	0	0	0.0	0.0	0.0
Eureka County	0	0	0	0.0	0.0	0.0
Humboldt County	0	0	0	0.0	0.0	0.0
Lander County	0	0	0	0.0	0.0	0.0
Lincoln County	0	0	0	0.0	0.0	0.0
Lyon County	0	0	0	0.0	0.0	0.0
Mineral County	0	0	0	0.0	0.0	0.0
Nye County	0	0	0	0.0	0.0	0.0
Pershing County	0	0	0	0.0	0.0	0.0
Storey County	0	0	0	0.0	0.0	0.0
White Pine County	0	0	0	0.0	0.0	0.0
Region Subtotal	3	1	-2	-66.7	1.1	0.1
Urban						
Carson City	5	4	-1	-20.0	8.8	7.3
Clark County	97	120	23	23.7	5.4	5.6
Washoe County	47	65	18	38.3	11.8	11.8
Region Subtotal	149	189	40	26.8	6.6	7.1
Nevada — Total	152	190	38	25.0	6.0	6.8

Source: Nevada State Board of Medical Examiners (2006, 2016).

Table 5.20: Licensed Marriage and Family Therapists (MFTs) in Nevada by County — 2010 to 2016

Region/County	Marriage and Family Therapists					
	Number		Change — 2010 to 2016		Number per 100,000 Population	
	2010	2016	Number	Percent	2010	2016
Rural and Frontier						
Churchill County	6	5	-1	-16.7	22.2	19.3
Douglas County	22	23	1	4.5	42.2	48.0
Elko County	3	3	0	0.0	5.9	5.4
Esmeralda County	0	0	0	0.0	0.0	0.0
Eureka County	0	0	0	0.0	0.0	0.0
Humboldt County	3	3	0	0.0	16.7	16.2
Lander County	0	0	0	0.0	0.0	0.0
Lincoln County	1	0	-1	-100.0	23.0	0.0
Lyon County	5	8	3	60.0	9.0	14.8
Mineral County	1	0	-1	-100.0	22.7	0.0
Nye County	3	4	1	33.3	6.3	8.8
Pershing County	0	0	0	0.0	0.0	0.0
Storey County	1	0	-1	-100.0	22.8	0.0
White Pine County	1	1	0	0.0	10.3	9.6
Region Subtotal	46	47	1	2.2	18.1	16.4
Urban						
Carson City	20	20	0	0.0	34.7	36.3
Clark County	335	398	63	18.8	17.0	19.1
Washoe County	234	269	35	15.0	55.2	59.7
Region Subtotal	589	687	98	16.6	25.9	26.3
Nevada — Total	635	734	99	15.6	24.0	25.2

Source: Nevada State Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors (2010, 2016).

Table 5.21: Licensed Clinical Professional Counselors in Nevada by County — 2010 to 2016

Region/County	Licensed Clinical Professional Counselors					
	Number		Change — 2010 to 2016		Number per 100,000 Population	
	2010	2016	Number	Percent	2010	2016
Rural and Frontier						
Churchill County	0	0	0	0.0	0.0	0.0
Douglas County	1	4	3	300.0	2.1	8.4
Elko County	2	4	2	100.0	4.1	7.2
Esmeralda County	0	0	0	0.0	0.0	0.0
Eureka County	0	0	0	0.0	0.0	0.0
Humboldt County	0	0	0	0.0	0.0	0.0
Lander County	0	0	0	0.0	0.0	0.0
Lincoln County	0	0	0	0.0	0.0	0.0
Lyon County	2	1	-1	-50.0	3.8	1.8
Mineral County	0	0	0	0.0	0.0	0.0
Nye County	0	1	1	100.0	0.0	2.2
Pershing County	0	0	0	0.0	0.0	0.0
Storey County	0	0	0	0.0	0.0	0.0
White Pine County	0	0	0	0.0	0.0	0.0
Region Subtotal	5	10	5	100.0	1.8	3.5
Urban						
Carson City	0	0	0	0.0	0.0	0.0
Clark County	15	71	56	373.3	0.8	3.4
Washoe County	8	18	10	125.0	1.9	4.0
Region Subtotal	23	89	66	287.0	0.9	3.4
Nevada — Total	28	99	71	253.6	1.0	3.4

Source: Nevada State Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors (2010, 2016).

ACKNOWLEDGEMENT

In pursuit of advocating, collaborating and connecting children's mental health in Rural Nevada, the Rural Children's Mental Health Consortium would like to note the significant progress which has been made over the past year. RCMHC experienced several barriers in 2017, including having vacant officer positions and experiencing a decline in membership. Despite these barriers, rural community partners, agency personnel, foster parents, parent partners and DCFS have stepped up to ensure a strong consortium moving forward. We would like to extend sincere gratitude to all those who have helped and continue to passionately work to realize this purpose.

THE FOLLOWING RECOMMENDATIONS ARE RESPECTFULLY SUBMITTED

Given the unique challenges of Rural Nevada, the Consortium proposes rather than simply replicating an "urban" children's mental health model in Rural Nevada, efforts should target the unique barriers of Rural Nevada in order to create a sustainable and accountable System of Care tailored to rural youth and families.

GOAL #1- ADDRESS WORK FORCE DEVELOPMENT TO PROVIDE MENTAL HEALTH PROFESSIONALS TO RURAL NEVADA

SUCCESSES

Over the past year, large advances have been made toward the goal of "growing our own" providers for the development of a stable workforce; one that is skilled and responsive to the needs of rural communities. The dedicated leadership and staff of the University of Nevada, Reno, School of Social Work have been instrumental in this effort. In 2016, they expanded the capacity of the social work program to increase professional output by admitting and thus graduating student cohorts from one time each year (Fall semester) to three times each year (Fall, Spring, and Summer semester). They began an online Masters of Social Work degree in the fall semester of 2016. The online Master's Program successfully graduated twenty students, in December 2017, with 7 of the graduates being from rural areas. Through a secured grant, UNR was also able to offer a number of $10,000 stipends for students to pursue social work education. Seventeen of the 20 graduates, from the online program, received the stipend. The stipend required internships be completed in a behavioral health setting, which included Youth in Transition as part of the population served. In addition, there is approximately 90 online students, in their foundation or concentration year, that will be entering field placements this next year. The development of multiple tracks and the online MSW program are expected to provide additional avenues for members of rural communities to expand the number of mental health professionals at the regional and community level.

Advances have also been made within Peer Programing and accessible education. A Peer-to-Peer certification curriculum was developed and the para-professionals have been very successful in the urban areas, with efforts being made to provide services statewide.

Expanding the workforce also requires ongoing and specialized training in order to meet the unique needs of youth and families in rural and frontier areas. The Division of Child and Family Services (DCFS) and Rural Clinics through the Division of Public and Behavioral Health (DPBH) have worked cooperatively, along with the University to provide training opportunities to rural community members. Trainings have been offered at rural sites, via telehealth and through webinars to help with travel expenses and busy schedules. The DCFS System of Care Grant, in coordination with the Rural Mobile Crisis Response Team has also been able to provide youth specific trainings in rural areas. State agencies, such as DCFS and Nevada Early Intervention Services (NEIS,) provided the facility and technology in five rural communities that allowed trainings such as Motivational Interviewing and LGTBQ to be broadcast across Nevada. The Center for the Application of Substance Abuse Technology (CASAT), through UNR is also offering a variety of trainings via webinar and the UNR School of Social Work developed a "Saturday Series" set of trainings with several of them being youth and family focused. The Office of Suicide Prevention and the Nevada National Alliance on Mental Illness

(NAMI) also focused on providing educational opportunities for rural areas. The collective efforts of these entities have allowed rural communities more access to educational opportunities, which results in a more skilled rural workforce and a collaborative system of care for youth and families.

RECOMMENDATIONS:

- Continue supporting "growing our own" rural providers for the development of a stable workforce that is skilled and responsive to the needs youth and families within their communities.
    - *Coordinate with System of Care partners and other training agencies to ensure that rural communities are aware of educational opportunities, in their area.*
    - *Create a unified statewide technology system that can be utilized by all State agencies in order to ensure training opportunities are easily accessible. Currently State Agencies utilize different technology systems which makes it very challenging to coordinate trainings in the rural areas.*
- Pursue legislative changes that require reasonable and transparent state licensure reciprocity for mental health providers in order to expand the available workforce.
    - *The mental health provider shortage in Rural Nevada could be partially relieved by utilizing licensed out-of-state providers. It is expected that Rural Nevadan's would benefit from mental health licensure boards that acknowledge the credentialing processes of other states, cooperate with other licensing boards, and have transparent requirements for reciprocity to facilitate potential workforce expansion.*
- Conduct targeted focused groups with behavioral health providers to survey and gather information on issues impacting decreasing mental health workforce in Rural Nevada.
- Work with university partners to identify workforce needs and develop solutions to meeting those needs through direct and internet accessible education, outreach, and training.
    - *The grant, through UNR School of Social Work, that provided the $10,000 stipends for eligible students, has closed. Supporting university programs in securing additional grant monies, in order to be able to offer educational stipends for people interested in pursuing a degree in the Behavioral Health Field, would help with student enrollment rates.*
- Increase opportunities for rural clinical mental health internship to allow mental health interns to learn, practice, and stay in Rural Nevada.
    - *By increasing the number of board approved clinical mental health internship sites in Rural Nevada, the ability of Rural Nevada to "grow our own" would be significantly impacted. Too often rural practitioners, such as psychologists, leave*

to pursue an internship and never return. The Department of Education is in the process of having all school districts become clinical internship sites.

- *Additionally, the approval for all disciplines, to allow off-site clinical supervision, through telehealth, would provide more flexible and accessible professional licensure.*
- *Provide the ability to partner with the universities to offer school based field practicums allowing students more learning opportunity specifically in the Rural Communities.*
- *Having the School Social Work Program continue to work with WICHE in the development of dedicated stipends for rural school based practitioners.*

GOAL #2 PROVIDE APPROPRIATE MENTAL HEALTH PROVIDERS TO PUBLIC SCHOOLS

SUCCESSES

Significant progress has been made over the course of the past biennium in regards to the provision of appropriate mental health services in schools. In January 2015, Governor Sandoval announced the creation of the Office for a Safe and Respectful Learning Environment (OSRLE) and included in his budget requests $32 million in state block grants to put social workers and other licensed mental health workers in schools. The legislature approved the creation of the new office within the Nevada Department of Education and ultimately appropriated approximately $17 million under Senate Bill 515 for the Social Workers in Schools (SWxS) Grant.

Application for a SWxS professional required participation in the Nevada School Climate/Social Emotional Learning (NVSCSEL) survey, which was developed in partnership with the American Institutes for Research (AIR) for the purposes of determining need according to scores on school climate and social emotional learning constructs. The state's two largest school districts each utilize their own school climate survey for the purposes of application for SWxS professionals; AIR developed metrics for the comparison and alignment of the data. These surveys continue to provide insight statewide regarding the needs of schools as well as the impact of increased supports.

Funding for the SWxS state block grant was maintained during the 79th (2017) Session of the Nevada Legislature for the coming biennium. The program is currently funding 230 positions in 11 school districts and 7 charter academies statewide, with over 200 schools receiving at least one SWxS funded professional. These additional supports have been vital in providing not just the necessary day to day non-academic supports in schools but also when communities face tragedies with broad reaching effects, including the events of One October in Clark County as well as several community tragedies in our rural and frontier school districts.

One of the most exciting elements coming out of the SWxS program this year has been the expansion of collaboration with University Schools of Social Work in Nevada. The program offers MSW students the opportunity to complete their field practicum in a school setting, which not only benefits the school and community in which they serve but also acts as a strong effort in workforce development.

When applications for the 17-18 school year were received, all previously funded schools requested that they be able to maintain their SWxSs funded position for the coming school year, with many principals begging the department to not take their social worker or other licensed mental health worker away. As funding for each year of the biennium was flat, priority was given to maintaining those positions. However, there were an additional 190 new schools that submitted applications to request a SWxS funded professional. As efforts to identify and braid additional funding sources for these in demand services find success, the increased capacity in workforce that these partnerships with the universities provide will become even more vital.

RECOMMENDATIONS

- Continue work toward expanding approved clinical internship sites to include school settings in order to both draw professionals to the field as well as to increase the qualifications of school based providers.
    - *The BOESW has approved school districts as a clinical internship site and ongoing efforts to convert that application to a standardized form for use by all school districts is expected to be completed in the spring of 2018, with clinical internships in schools beginning in the 18-19 school year.*
- Work with appropriate state agencies and stakeholders to support and advocate for the expansion of school based services that are allowable under the state's Medicaid plan, in order to increase sustainability.
    - *Ongoing collaboration with DHCFP has resulted in a plan for NDE to become an approved biller of Medicaid, with the goal of having that system in place for the beginning of the 18-19 school year.*
- Continue to support workforce development efforts across a broad range of areas, including provision of an online school social work course such that rural school based providers have access to the increased training, as well as efforts to streamline and clarify the process for granting reciprocal licenses across all behavioral health fields in Nevada.
    - *A flowchart that identifies the necessary steps for becoming a licensed social worker in the state as well as those required to receive the endorsement as a school social worker has been developed in partnership with the BOESW and the Office for Educator Licensure. Draft language for an endorsement as a licensed mental health provider has been presented to the Commission on Professional Standards,*

so that non-social work licensed mental health providers may be hired as employees by school districts.

- In accordance with high levels of feedback from key district level stakeholders, advocate for the expansion of the SWxS grant program to allow for district level hiring as well as the provision of benefits for SWxS grant professionals.
    - *The ability for school districts to hire their SWxS funded professionals was approved by the Legislature in 2017, which also gives districts the ability to provide benefits if they have additional funding available. Work to identify other funding sources, including Medicaid, Title IV-A, and federal grants, continues in an effort to help districts have access to funding which will allow them to extend benefits, as the level of funding provided by the state is inadequate to do so.*

GOAL #3 PROMOTE AND SUPPORT A SYSTEM OF CARE DESIGNED FOR NEVADA'S RURAL REGION.

SUCCESSES

The System of Care is an array of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families. It is organized into a coordinated network that builds meaningful partnerships with families and youth. A System of Care includes behavioral health services that are youth guided/family driven, delivered in a manner that is culturally competent, community supportive, and strength based. This System of Care is designed to help youth function better at home, in school, in the community, and throughout life. The Consortium supports a statewide System of Care that is flexible enough to be adapted to meet the needs of both urban and rural Nevada. Given the unique challenges of Rural Nevada, simply replicating an "urban" model for System of Care would not be effective. Creating a model that targets the distinctive barriers of Rural Nevada, in order to build a sustainable and accountable System of Care that fits rural and frontier communities, is the ultimate goal.

The Consortium also recognizes the unique needs and cultural considerations of Nevada's tribes and seeks to build a stronger partnership to support healthy outcomes for all children. Youth who reside on the reservation are often limited in the spectrum of behavioral health care services they receive. In 2017, through the System of Care Grant, 9 Culturally and Linguistically Appropriate Services (CLAS) trainings were offered statewide. In addition, in coordination with Rural Clinics, the System of Care offered a LGBTQ training that was broadcast from Carson City to 4 rural communities including Elko, Pahrump, Ely and Winnemucca. The classes were free to all attendees.

The progress over the last year to help reduce the silo effect, identify duplication of services and work towards a continuity of care have been commendable. DCFS (Division of Child and Family Services), DPBH (Department of Public and Behavioral Health) and DHCFP (Division of Health Care Financing and Policy), all contributing agencies to the provision of mental health services to rural youth, have worked together in helping to break down barriers to services in Rural Nevada. For example, although the DCFS System of Care Grant is specific to Washoe and Clark Counties, the grant management team has worked collaboratively to include rural partners, resulting in the quest for a cohesive system of care for youth, across Nevada, achievable. The System of Care Grant funds both the Rural Mobile Crisis Response Team and the Rural Youth in Transition Program through Pacific Behavioral Health. Rural community partners participate and are invited to attend the monthly System of Care Subcommittee meetings. In addition, the grant allowed scholarships for rural providers to attend national trainings focused on moving all of Nevada towards a unified System of Care.

Another combined effort was the successful opening of two rural Certified Community Behavioral Health Clinics (CCBHC); Vitality Unlimited in Elko and New Frontier Treatment Center in Fallon. The CCBHC's aim to serve any individual in need of care, regardless of ability to pay. The CCBHC focuses on the 'whole person' by offering person-centered and family-centered care. The following populations are served:

- Adults with serious mental illness (SMI)
- Children with serious emotional disturbance (SED)
- Individuals with severe substance use disorders
- Individuals with mild or moderate mental illness and substance abuse disorders

CCBHC's provide outpatient behavioral health services and primary care screenings and monitoring for children, adults and families with the goals to provide:

- Community-based mental and substance use disorder services.
- Combined behavioral health and physical health care with no wrong door entry to services.
- Evidence-based practices.
- Improved access to high-quality care.
- Care coordination and case management to address all needs of the individual.
- Better overall health outcomes.

From June 2017 to November 2017 the Vitality Unlimited CCBHC has served 73 rural youth and the New Frontier Treatment Center CCBHC has served 32 rural youth. The clinics are currently funded through a grant under DPBH.

The Office of Suicide Prevention (OSP) in collaboration with the Nevada Coalition for Suicide Prevention, has trained over 16,000 Nevadans (381 rural community members) in suicide intervention and alertness training and has brought Suicide Awareness to tens of thousands of our states population through media and news outlets, reducing the stigma and taboo around suicide and help-seeking. Through a Project Aware sub grant, with the Department of Education, OSP's Youth Mental Health Coordinator supported rural YMHFA trainers in training 611 first aiders in rural Nevada communities during 2017. In addition, Nevada hosted a third Train the Trainer event in September 2017 with 9 new trainers representing multiple rural counties.

The Juvenile Justice system has seen an increase in referrals for substance abuse related offences and domestic violence violations that can be directly linked to behavioral health illness in youth. State funding has allowed for mental health evaluations for these youth, resulting in the system becoming better equipped at identifying youth with mental health issues. The Rural Mobile Crisis Response Team has been able to intervene when a youth is flagged for suicidal or homicidal ideation. Many of the Juvenile Detention Centers in Rural Nevada are set up with telehealth so that crisis evaluations can be done in a timely manner. Despite these advancements, there still remains a disconnect in being able to access mental health services for those youth involved in the justice system, both at state and county levels.

The Regional Behavioral Health Coordinators have been active in the Washoe and Northern Rural (Carson, Lyon, Douglas, Churchill, Story, and Mineral Counties) regions, for the past several years, however they have been primarily focused on the adult population. This year, Regional Behavioral Health Coordinator positions were created in Clark County, and in the other rural counties (Lander, Humboldt, Pershing, Elko, White Pine, and Eureka), and another position is currently being developed for Nye and Esmerelda Counties. Regional Behavioral Health Coordinators can assist communities and stakeholders in coordinating and developing youth behavioral health resources within and between regions as well, as these positions focus on client, community, and policy areas of behavioral health across the life span. On the client level, the behavioral health coordinator participates on multi-disciplinary teams and works with communities to develop plans for children and families in with chronic behavioral health needs who are often in crisis. At the community level, this position can support communities in identifying behavioral health gaps and organizing to develop behavioral health initiatives and programs. Other coordination duties at the community level include facilitating communication between local, regional, and state stakeholders, and assisting in delivering behavioral health trainings to increased public awareness of behavioral health and to enhance community provider response to individuals in crisis.

Currently, this goal is striving to be addressed through organizations such as, Nevada PEP whom served 261 families in 2017. They hosted 30 workshops and webinars with 79 rural participants covering topics such as Positive Behavior Interventions, IEPs, Bullying and

Attention Deficit Hyperactivity Disorder.A Peer-to-Peer certification curriculum is now available that provides training in both behavioral health and substance use areas for Peer-to-Peer specialists over 18.

Additionally, Nevada's Chapter 400 defines the role of the "Peer specialist" in terms of their role, expectations and reimbursement rates, this has been approved for many years in Nevada making it a reimbursable service. In 2015 the Peer to Peer Agency was adopted into legislation and the Bureau of Health Care Quality and Compliance oversees this group. There is also additional work being done to expand the roles of people with lived experience in Medicaid funded services. The Department of Health Care Financing and Policy Behavioral Health Unit will be looking at "re-defining" the peer to peer qualifications to align with upcoming changes if needed.

RECOMMENDATIONS

- Identify and support entities to expand the availability of services for system involved youth including specialized youth specific training.
    - *Support the expansion of Family Peer Support as recommended by the Nevada Commission on Behavioral Health Children's System of Care Subcommittee to adopt the National Certification for Parent Support Providers and include Family Peer Support as a reimbursable Medicaid service.*
    - *Advocate for continued training efforts by the Office of Suicide Prevention in helping educate rural communities about suicide awareness, reduce the stigma associated with seeking help and mentor new trainers to maintain fidelity of the YMHFA curriculum.*
- Divert Juvenile Justice referrals where mental health issues are predominant and ensure mental health needs can be addressed for those that cannot be diverted out of the juvenile justice system.
    - *Especially concerning for rural youth is the limited number of child psychiatrists that can conduct evaluations for the Court and help guide necessary interventions. To further complicate the issue, youth in custody lose their Medicaid coverage and this can make it challenging to pay for medications, doctor's appointments for medication management, or ongoing therapeutic interventions during incarceration. The average length of stay in our detention facility is less than two weeks. Advocating for a change in laws regarding Medicaid, to allow for short-term periods of incarceration without disrupting coverage and allow Medicaid to be accessed during the time of incarceration.*
    - *There are also extreme limitations for In-State residential treatment; often requiring a youth be placed hundreds or even thousands of miles from their family if residential treatment is required. This can create a disconnect for the families in trying to be involved in treatment and planning for the youth's return home.*

Having more In-State residential treatment options would allow more engagement opportunities for families and improve the outcome of a youth's rehabilitation.

- *Support looking at changing the eligibility requirements that if a court has jurisdiction, prior to a youths 18th birthday, the youth could continue with Medicaid as long as the youth is under court jurisdiction. The language that allows for it at a state level could be utilized at the county level as well. At a state level, if a youth is committed to DHHS/DCFS for correctional care, Medicaid can be accessed after a youth turns 18 but, for rural counties, the eligibility is not the same. Changing the language could eliminate the challenge that when the youth is close to their 18th birthday, the program may have to release them due to not being eligible for Medicaid through the county past their 18th birthday.*

- Identify and provide services to tribal youth to help broaden the spectrum of behavioral health treatment available.
  - *Support research and data gathering to identify and target the needs to tribal youth and families.*
  - *Support strengthening of existing programs through collaboration and partnership.*
  - *Advocate for sustainable programs models for long term effectiveness.*
  - *In general, continue to offer trainings throughout Rural Nevada on cultural diversity. More specific, coordinate with tribal liaisons to have them train rural communities on respecting and responding to the uniqueness of tribal cultures.*
  - *Promote the understanding that each tribal community is an entity in itself. Not all functions under the Tribal Council ensure continuity of care across tribes. Ongoing collaboration is essential to help ensure Tribal Liaisons are representing and including all individual tribal communities in their efforts.*
- Identify and support access to internship training sites whose instruction includes child and adolescence service located within rural communities to encourage sustainable workforce development to serve youth.
  - *Workforce in Nevada's rural region serving youth could be increased by availability of community based internship opportunities. The expectation would be that by "growing our own" professionals they might learn, stay, and practice in their home community.*
  - *Having State Licensing Boards approve video supervision would allow opportunities for internships, in rural communities where there is not access to a supervisor in their discipline, to still be able learn and practice in their home community.*
- Support regional entities who coordinate community resource linkage, align efforts, and leverage existing local services in order to assist youth with behavioral health challenges in their home communities.
  - *Within Rural Nevada Communities, there is often a lack of a regional leadership authority to adequately support "grass roots" regional/community based collaborations. Supporting our rural coalitions increases the ability to find novel*

solutions to serving youth within their home community through leveraging existing resources and capitalizing on regionally centered assets.
    - *The Rural Regional Coordinators are working to increase their participation in youth behavioral health in their regions, and intend to support community organization and development of youth behavioral health resources, initiatives, and programs to address community gaps in the rural counties.*
- Create and utilize unified statewide assessment and data collection tools for youth.
    - *Progress has been made in presenting the Nevada Child and Adolescent Needs Screening as a statewide assessment tool. Multiple rural providers and state agencies have been trained in the Nevada Child and Adolescent Needs Screening (CANS) with many providers becoming certified as trainers. Training and free certification has been offered to Rural providers through DCFS.*

GOAL #4 PROMOTE ADEQUATE TECHNOLOGY TO SUPPORT TELEHEALTH SERVICES IN NEVADA'S RURAL REGIONS

SUCCESSES

The expanded use of technology in the rural region has offered a cost-effective opportunity to enhance services for rural families of children with behavioral health issues. Telehealth allowed for access to specialized providers that are not present in Rural Nevada, maximizing the productivity of those professionals by eliminating long travel times to reach remote rural locations, and allowed for children and families to receive care in their home communities.

The enhancement and development of telemedicine services is a statewide goal that is identified in the Nevada System of Care Strategies. In Rural Nevada, the Department of Public Behavioral Health has been using telehealth through different means including Project ECHO through the University of Nevada School of Medicine, Vsee, Zoom and Polycom. Nevada Medicaid Services Chapter 3400 allows mental health professionals to bill for telehealth services.

Rural Mental Health Clinics have been working on improvements to their broadband systems in order to increase the quality of telehealth for children and adults. The hope is that this increase in bandwidth will give each clinic enough capacity to double the current strength or possibly allow two telehealth sessions to occur at once. Telehealth training for providers has also been offered by CASAT and Rural Clinics.

In cooperation with the Nevada Rural Hospital Partners, Rural Mobile Crisis Response Team has developed a program offering emergency telehealth to rural hospitals for assessments, prior to being transported to psychiatric inpatient hospitals. New mental health providers, such as West Care, have expanded into Rural Nevada to provide telehealth for insured consumers.

RECOMMENDATIONS

- Advocate for appropriate bandwidth and up-to-date equipment for delivery of telehealth services to Rural Nevada locations.
    - *Cost of access is still the primary problem in Rural Nevada due to lack of affordable bandwidth. For Rural Mental Health Clinics, the primary provider for telehealth services to Rural Nevada, all updates are funded through general funds which allows limited improvements.*
    - *Equipment, that meets current industry standards, in order to support efficient service delivery to rural youth and families, needs to be made available.*
- Support grant funding opportunities to improve service delivery to rural and frontier communities via Telehealth.
- Partner with rural locations to utilize already established tele-health rooms which will allow private providers the opportunity to provide tele-health services. Collaborating with Medicaid to identify a fee that can be collected, for the originating site, should also be explored. In addition, Medicaid changes that will allow clients to be able to receive services in their homes should also be explored.
- Stay up-to-date on National Telehealth initiatives.

GOAL #5- CREATE A RURAL CHILDREN'S MOBILE CRISIS RESPONSE TEAM

SUCCESSES

The Rural Mobile Crisis Response Team (RMCRT) serves a key function in the system of care by providing community-based services that youth can access wherever he/she is experiencing a crisis, such as at home, at school, or in a hospital emergency department. This program is essential for rural youth experiencing a crisis because waitlists, for youth to see providers, are common and can be several months long. RMCRT, through a DCFS System Of Care Sub-Grant, has been able to provide quality behavioral health services, sometimes to very remote areas, while connecting the family with resources in their home communities. This has been possible by using evidence based tools, quality program design, and building Statewide partnerships.

The Program began taking calls in November 2016. From November 2016 through September 2017, the Rural Mobile Crisis Response Team (RMCRT) has served 243 youth and families across Rural Nevada. One hundred and twenty-seven of these youths were considered Hospital Diversion calls meaning that Rural Mobile Crisis Response Team was able to stabilize youth and wrap them with services in their own community, preventing unnecessary costly visits to the Emergency Departments. The Hospital Diversion Rate for Rural Mobile Crisis Response Team from November 2016 through September 2017 is 86 percent. Progress for 2017 includes:

- A program design that is tailored to rural youth and families. Because the program links youth and families to the Rural Clinics system, youth and families are connected to local resources, in their home community.
- Awarded funding for the Federal Fiscal Year 2017-18 through a sub grant with the DCFS System of Care Grant.
- RMCRT, in cooperation with the System of Care Trainers, hosted trainings that included Rural Mobile Crisis Staff and 28 Rural Clinics Case Managers. The attendees were trained in the System of Care philosophies, Introduction to Wraparound in Nevada(WIN), Parents Educating Parents (PEP), Culturally and Linguistically Appropriate Services (CLAS), Motivational Interviewing, LGTBQ, and Trauma Informed Care.
- Developed a successful partnership with the North and South Mobile Crisis Response Teams which now includes monthly Statewide Management meetings.
- RMCRT was successful in advocating with the DCFS WIN Program so they can accept the Crisis Assessment Tool (CAT), that is used in the Mobile Crisis Program, in order to streamline the referral process. This helped reduce barriers for referrals to WIN in rural communities.
- Many of the schools, hospitals and Juvenile Detention Centers, in Rural Nevada, are now equipped with the tele-health program that RMCRT uses for interventions, allowing for more efficient response times during crisis calls.
- Developed partnerships with Nevada's inpatient psychiatric hospitals so that a referral from RMCRT is treated as a direct admission for the youth, resulting in a more seamless system of care for the youth.
- Rural Clinics has developed an agreement with the Nevada Rural Hospital Partners wherein, RMCRT is called to assess youth who are in emergency rooms due to a behavioral health crisis, resulting in eliminating unnecessary and costly psychiatric hospitalization for youth who were able to be stabilized in their communities.

RECOMMENDATIONS

- Continue to support crisis services to Nevada rural and frontier youth through the Rural Mobile Crisis Response Team (MCRT) to reduce hospital admissions.
    - *Sustainability for the program, after the grant funding is exhausted, is imperative to continue to meet crisis needs of rural and frontier youth. Advocating to roll RMCRT into a State funded program or seek other funding, will be needed to ensure the services remain focused on Rural youth and families. Part of the success of the program has been being able to utilize Rural Clinics Case Managers which is essential to providing services for youth in their home communities.*

- *Transportation for youth, when hospitalization is required, continues to be a struggle. Families often have to travel hundreds of miles to get to a psychiatric hospital and at times, the youth requires a more secure transport. Finding a solution for more reliable, cost effect transportation is needed.*
- *Addressing the stigma associated with telehealth has been a challenge. Many referral sources are skeptical as to the quality of services that can be provided via telehealth. Increased bandwidth and up-to-date technology, within our State systems, could help alleviate some skepticism and provide more dependable services.*

- Advocate for funding to support sustainability for mobile crisis programing and for the services to remain under providers who are skilled at providing services to rural youth and families.
  - *Moving forward, funding should include the expansion for the program to provide 24 hour/7 day a week services.*
  - *Increasing advertising and marketing in the rural areas will allow for more youth and families to know about the program and how to access mobile crisis services.*

GOAL #6- PROMOTE PREVENTION AND INTERVENTION: ADDRESSING BEHAVIORAL HEALTH ISSUES EARLY

SUCCESSES

Optimal mental health in childhood means reaching developmental and emotional milestones, acquiring healthy social skills, and learning how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. The Rural Children's Mental Health Consortium supports greater focus on prevention rather than crisis response alone, which includes trauma specific services. Individuals impacted by trauma often have severe and persistent mental health and/or substance abuse problems and are frequently the highest users of the system's most costly inpatient, crisis, and residential services. The consortium recognizes the need to place a primary emphasis on prevention and early intervention; not simply focusing on what to do after someone is in crisis. These efforts require addressing mental health symptoms, bullying, trauma, substance abuse, and other risk factors that often precede mental health diagnoses.

One Rural initiative that focuses on early prevention is the Resources for the Early Advancement of Child Health (REACH) program. This pilot program is currently funded by the Children's Health Insurance Program (CHIP), Health Services Initiative (HSI). The implementation of these innovative preventative behavioral health changes supports Nevada children in achieving a physical and emotionally safe environment. REACH Program Approval was received from the Center for Medicare and Medicaid Services on November 23, 2016.

- Currently the REACH pilot program has completed four, six-week sessions with continued success and full participation from children, youth and their parents or legal guardians. Due to the innovative population based component of the program all children and youth are provided preventative services which further promotes no stigma for those that participate in this prevention program.
- There have been two areas of direct increase in pre and post test results that identified an average increase within the post scores by 20 %. This directly provides that the REACH preventative services are providing those at risk a positive intervention per the pre and post outcomes.
- In addition to the increase of children and youth per and post scores the parent/ legal guardian attendance has increased from 20% to the current rate of 80% attendance rate. Also, the parents and legal guardians are requesting further preventative intervention topics to help assist in understanding and focusing on their children's and young adults behavioral heath questions.
- Only 2% of the children and youth attending the REACH program have been referred for further services to an outside behavioral health provider in the local community. These referrals will be monitored and if the children and youth would like to continue to participate in a second sessions while receiving further behavioral health services they are immediately enrolled for supportive intervention.
- In 2017, the REACH Program partnered with local school districts and Carson City School District, Associate Superintendent to coordinate behavioral health intervention collaboration between the REACH program and direct referrals from the school for children and youth needing further behavioral health assistance.

The Consortia supports the Office of Suicide Prevention's (OSP) belief that "everyone has a role to play in suicide prevention and those individuals and groups that address the psychical, emotional, psychological and spiritual needs of individuals and communities must work together if we are to be effective" (State of Nevada, Suicide Prevention Plan 2016). The mission of the Nevada Office of Suicide Prevention (OSP) is to reduce the rates of suicide and suicidal acts in Nevada through statewide collaborative efforts to develop, implement and evaluate a state strategy that advances the goals and objectives of the National Strategy for Suicide Prevention. Over the last year, the persistence and passion of the OSP has resulted in breaking down barriers and building critical relationships with Rural Nevada Schools. The OSP has been actively collaborating with rural school districts in efforts to reduce youth suicides below the national average by 2020.

- School-Based Screening: OSP has helped established sustainable screening programs in Lyon, Nye and Pershing Counties through partnerships with the Children's Cabinet, Community Chest, Healthy Communities Coalition, Nye Community Coalition, and the Frontier Community Coalition. These community

coalitions have been funded and mentored to the point of sustaining their local screening programs annually with their local school districts.
    - OSP is currently working to develop screening programs in Humboldt, Elko and Carson City Counties with the support of Pace and Carson Community Coalitions.
    - In 2016, there were 25 SOS education and/or screening events reaching 6,684 students in Pershing, Humboldt, Elko and Washoe Counties.
    - In 2017, there were 16 SOS education and/or screening events in Pershing, Humboldt and Carson City Counties.

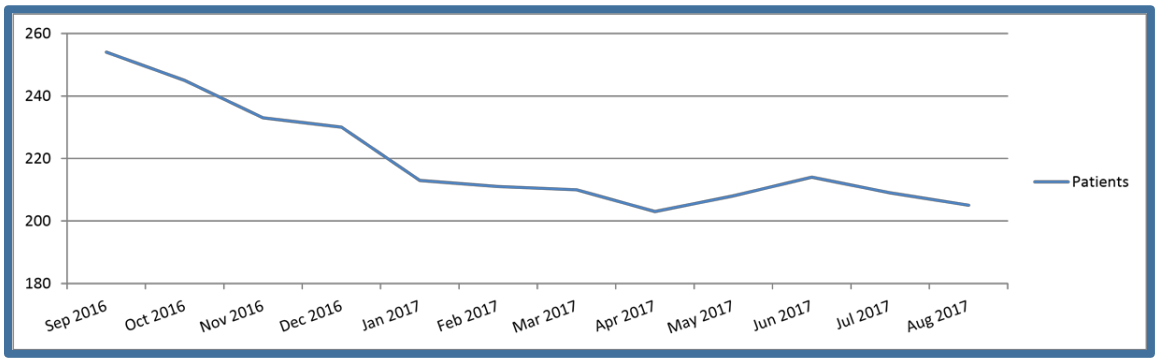
RECOMMENDATIONS

- Support a trauma-informed behavioral health systems and trauma specific services.
    - *A trauma-informed child and family service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.*
- Work with entities to expand piolet programs that have shown success in early prevention for rural youth.
    - *The HSI public health approach allows services to be provided to all children in a targeted area regardless of payer source. The DHCFP will work with current after-school program(s) to determine capacity for providing the services within their current structure or coordinate with community providers who have the capacity to create a collaboration to provide these services. The DHCFP will be working to identify these groups to determine the best model for payment of these programs based on the community infrastructure and capacity.*
    - *The HSI option allows the state to take a population health approach to behavioral health and early intervention for children. HSI also provides the flexibility to pilot the rising-risk concept across children ages 10 through 18 with the goal of being able to demonstrate the effectiveness of early intervention through the use of performance measures. The scope of services will target early intervention and preventive services and mental health resources to prevent the onset of a future behavioral health diagnosis. DHCFP provides assurance that the HSI program will not supplant or match the Children's Health Insurance Program (CHIP).*
- Continue to help reduce stigma associated with children's mental health by developing outreach and activities on May 5th, in support of Children's Mental Health Day.

GOAL #7- INCREASE TRANSITIONAL SUPPORT TO YOUTH RECEIVING TREATMENT IN INPATIENT & RESIDENTIAL TREATMENT CENTERS, ESPECIALLY THOSE OUT-OF-STATE THROUGH INCREASED LOCAL SERVICE ARRAY

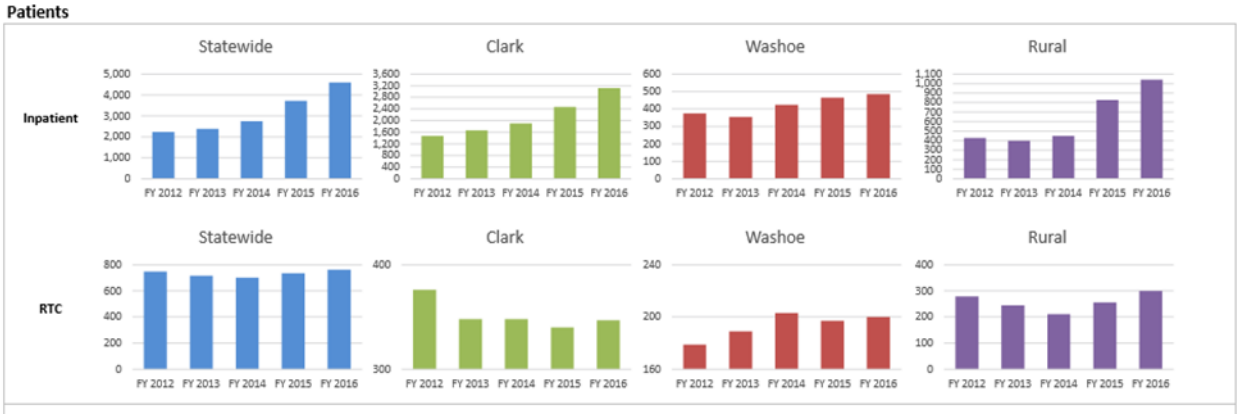
SUCCESSES

The Rural Children's Mental Health Consortium recognizes the significant issues surrounding youth who are placed in intensive inpatient care and out-of-state residential treatment care. The Division of Healthcare Finance and Policy continues to welcome further opportunities for assisting youth with in-state facilities for Residential Treatment Center, insuring that collaboration with the recipient's parents and legal guardians. This will assist in the integration and collaboration of services involving both the families and the children/youth in treatment services. As of August 2017, a total of 205 Nevadan children were in out-of-state placement, down from 245 in 2016 (Nevada Department of Health Care Financing and Policy, 2017). Efforts continue to move forward under this goal however movement has been slow, resulting in an urgency to increase treatment centers and acute hospitals for Nevada's youth. The following data helps provide a clear account of why the Consortium considers the expansion of services a priority.

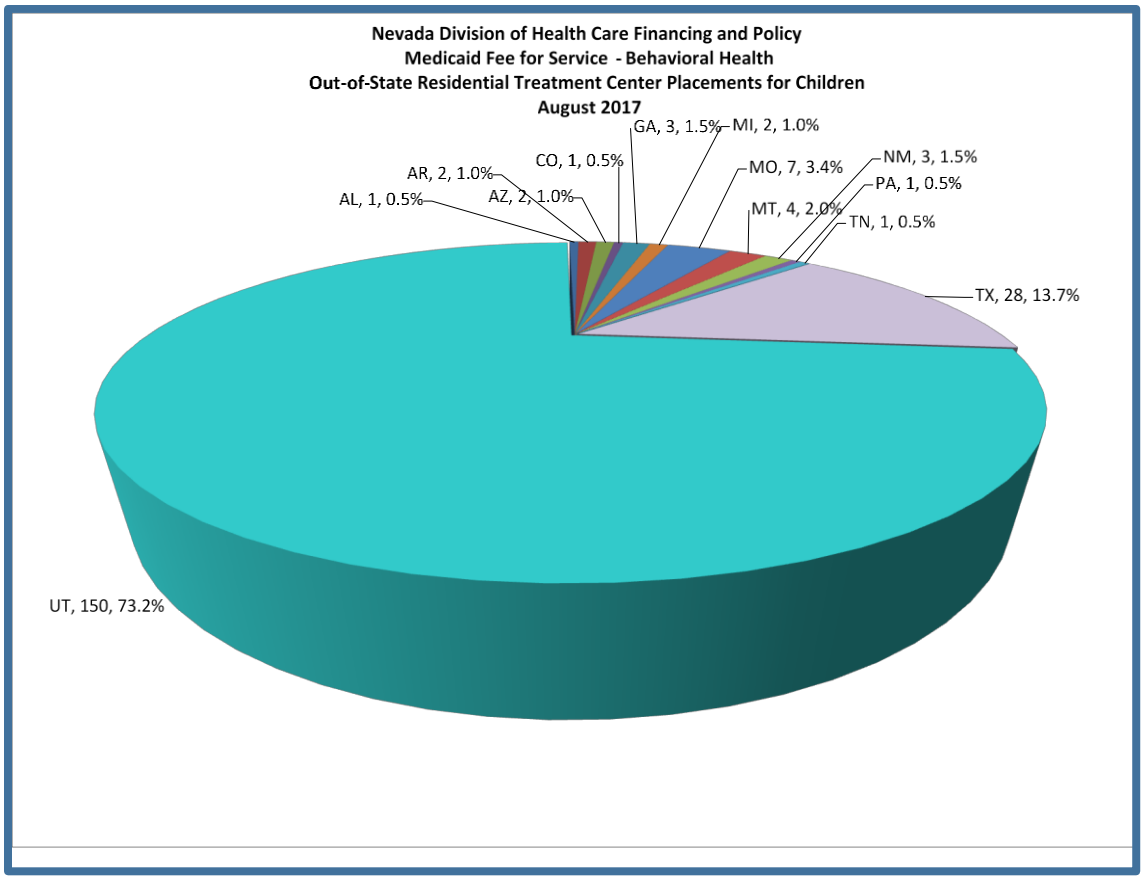


In both 2016 and 2017, the top three diagnoses of these youth were Other Persistent Mood [affective] Disorders, Unspecified Mood [affective] Disorder, and Bipolar Disorder, unspecified (Nevada Department of Health Care Financing and Policy, 2017).

The graph below captures and compares the disproportionate number of Medicaid fee for service inpatient and residential treatment patients from Rural Nevada (approx. 12% of the state population) as compared to Clark and Washoe County for calendar years 2012 through 2016. (Nevada Department of Health Care Financing and Policy, 2016).



The graph below captures the location by state of the 205 children in out-of-state fee for service residential treatment center placement as of August 2017 (Nevada Department of Health Care Financing and Policy, 2017).



Another success has been the continued growth of the Advanced Foster Care Program's (AFCP) which offers services to Rural Nevada youth. The AFCP mission is to provide support for foster parents in specialized foster homes to increase placement stability and permanency for children and youth experiencing a Severe Emotional Disturbance or SED. The AFCP is a specialized foster care program that is part of the Nevada Division of Child and Family Services (DCFS). The program trains, mentors, and coaches foster parents in the home through evidence based practices to support the children in their home who are experiencing mental health issues. The AFCP's goal is to enable the children served in the home to experience a stable life and grow up in a healthy safe environment.

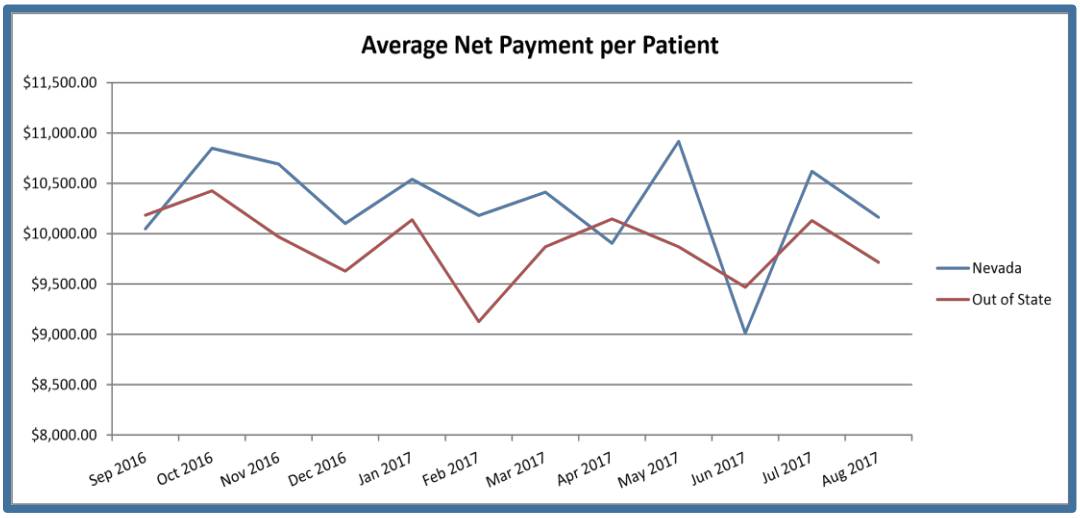
Some of the children that are referred to the program are referred through a social worker who is trying to place a child discharging from a higher level of care. The AFC Program is a good step down from residential to the community because it ensures that foster children with mental health problems are afforded a stable home placement along with the wrap around services (i.e. case worker, WIN, mental health counseling, coaching with the foster parents through the Advanced Foster Care Program, and more) that they need.

2017 also brought the expansion of transitional behavior health providers to rural youth with the addition of Pacific Behavioral Health's Intensive Out-patient program for youth in transition. Pacific Behavioral Health (PBH) mission is ensuring all clients have access to professional community based services, proven treatment methods, and comprehensive service planning. PBH's vision is to integrate behavioral health, mental health and medical health support to provide comprehensive care. Pacific Behavioral Health focuses on providing services to Rural Nevada. The agency provided face-to-face clinical services to approximately 100 clients in Fallon, Fernley, Gardnerville, Silver Springs, Yerington, Dayton, and Carson City in 2017. Telehealth therapy was provided for clients in remote areas like Elko. PBH also started Services for Community Reintegration for Transitional Aged Youth, ages 15-24. The program is grant funded, and enables uninsured youth to access services. The program is currently operated in Carson City. Services for transitional aged youth include all clinical services; services to provide the youth with the skills, preparation, and resources to be able to live independently as well as to guide them towards reaching their goals and encouraging them to be successful. The program offers youth support while they become stable in their independence.

RECOMMENDATIONS

- Support the development of programs that facilitate reintegration of youth transitioning out of residential treatment center placements and/or acute psychiatric facilities as they reenter the community, school and family through strengthening discharge planning, case management and coordination of appropriate supports with state agencies and community providers.

- Encourage development of existing "regional grass roots collaborative efforts" to expand community based wraparound type services through leveraging existing resources and capitalizing on regionally centered assets.
    - *Ensuring there is adequate coverage in each community for Case Management Services would provide intensive wrap around services for youth as well as the family as they are transitioning back into their communities.*
    - *Requirements that outline a family's progress towards being able to provide a healthy environment should be explored as part of the youth's treatment process. This would allow treatment of the family system, not just the youth.*
- Support the increase of community-based service array to support children, youth, and their families with emotional and behavioral health difficulties.
    - *The graph below captures the financial discrepancy in cost between in-state residential treatment center placement vs. out-of-state residential treatment center placement of patients from Nevada, from September 2015 to August 2016 (Nevada Department of Health Care Financing and Policy, 2016).*



1. *The high cost of residential treatment in Nevada continues to be a concern. The DHCFP is working diligently along with other entities to establish more treatment options In-State. Currently they are working on licensing facilities in Douglas County and Mineral County.*

RCMHC SUMMARY OF GENERAL REQUESTS FOR 2018:

There is great appreciation for the successes that have been made over the last year however rural youth and families need so much more than is being offered. Summarizing information from this report, below are specific requests that the Consortium proposes:

1) Funding to create and provide accessible and youth specific training for developing a foundation of skilled mental health providers to be housed in an identified state agency. Online, webinar based trainings including telehealth education could be taped and then leveraged on a platform such as Nvpartnership4training to allow for maximum access. This type of training platform would be able to build quality, community based professionals who are trained in rural specific services for youth and families.
2) Funding of a rural specific children's mental health tribal liaison position designed specifically to build partnerships across tribal and non-tribal entities to improve tribal youth's access to mental health services.
3) Permanent funding of Mobile Crisis services in rural Nevada, housed under DPBH, including additional State positions needed to provide 24-hour coverage to all rural communities.
4) Funding of a rural specific children's mental health juvenile justice liaison to address solutions for mental health services including expansion of Medicaid services for youth who are temporarily detained.
5) Assistance for addressing legislative issues with the professional mental health boards in allowing for more flexible avenues for rural professionals to pursue internship and clinical hours, as well as efforts to streamline and clarify the process for granting reciprocal licenses.
6) Support research study to survey and gather information on issues impacting the decreasing mental health workforce in Rural Nevada.
7) Funding of a consultant to assist the Consortium with reorganizing, planning, data collection, attendance at all workgroups and grant writing.

IN CONCLUSION

The Rural Children's Mental Health Consortium has experienced a great deal of turnover during the previous year and finds itself in an excellent position to become revitalized and recommitted to serving the children and families of our rural communities. We are looking forward to a renewed energy through an expansion of memberships, a change in leadership, and a refocusing of the purpose and goals of the Consortium. Steps are being taken to assure meetings are held at locations, accessible via video, across Rural Nevada as well as ensuring the meetings are held at convenient times for youth and community advocates. With the many successes, for rural children's mental health this year, there are still many challenges ahead, including sustainability of grant funded programs, keeping rural initiatives relevant within our States unique structure, and technological advances.

We are grateful to the many partners that continue to serve our rural communities and anticipate many shared accomplishments and successes in the year to come. RCMHC will continue to represent a commitment to all Rural Nevada's youth who deserve quality and accessible mental health services.

For general questions about this status update, suggestions for progress towards goals or general information, please contact us:

Email: rcmhc.nv@gmail.com

Or call:

Michelle Sandoval, Vice-Chair, RCMHC: 775-738-8021

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