

2020-2029



Washoe County

Washoe County
Children's Mental
Health Consortium

Long-Term Plan

Executive Summary

The Nevada Revised Statutes (NRS) [433B.333 & .335](#) established and charged the Washoe County Children’s Mental Health Consortium (WCCMHC) to develop a long-term strategic plan for children’s mental health in the geographic region of Washoe County. For 17 years the WCCMHC has advocated for the safety and well-being of Washoe County Youth and Families in all areas of their lives. In this past decade, the Consortium has encouraged, advocated for, and supported a myriad of activities across multiple agencies, touching the lives and improving the well-being of youth and families in Washoe County. The thoughtful, comprehensive nature of the first [10 Year Plan](#) provides the Consortium a foundation upon which to launch the plan for the next 10 years of goal driven and data supported activity. As such, the WCCMHC designed the goals and objectives of this long-term plan to build upon the foundation and successes of the Consortium’s past activities and the Nevada System of Care (SOC) while expanding strategies to specifically focus on healthy youth development, resilience, positive community supports and relationships, and community protective factors.

Our vision for children, youth, and families in Washoe County is:

Equitable access to compassionate and comprehensive mental health services and supports within our community.

The goals of the long-term plan are:



1 Increase access to compassionate care in the least restrictive environment.



2 Decrease and/or buffer children and youth’s exposure to toxic stress.



3 Increase child, youth, and family access to positive community-based experiences.

Table of Contents

Executive Summary	1
Introduction	3
Vision and Mission	3
Background	4
Development of the Report	6
Guiding Principles	7
Key Partnerships	8
Community Strengths	8
Summary of Literature	10
System of Care (SOC)	10
Adverse Childhood Experiences (ACEs)	11
Toxic Stress	13
Social Determinants of Health	14
National CLAS Standards & Health Equity	15
Incarcerated Youth	16
Children, Youth, and Families in Washoe County	16
Population	16
Adverse Childhood Experiences (ACEs)	17
Poverty	19
Health Insurance	20
Serious Emotional Disturbance/Mental Health	21
Out-of-State Placements	22
Addiction	23
Suicide	25
School Success	27
Child Abuse and Neglect	27
Housing	28
Youth and Homelessness	28
Workforce	29
Priorities in Washoe County	31
Goals, Objectives, and Strategies	32
Increase access to compassionate care in the least restrictive environment.	33
Decrease and/or buffer children and youth’s exposure to toxic stress.	36
Increase child, youth, and family access to positive community-based experiences.	40
Implementation Plan	41
Conclusion	42
References and Resources	42

Introduction

In order to assess, develop, and support a behavioral health system of care for Nevada’s youth and families, the Nevada Revised Statutes ([NRS 433B.333-339](#)) established mental health consortia in three jurisdictions in Nevada: Clark County, Washoe County, and the remaining rural counties. The functions of the consortia are to assess current behavioral health services for youth in each jurisdiction and develop a plan that will identify gaps and areas in need of improvement. The Washoe County Children’s Mental Health Consortium (WCCMHC) is the designated consortium for the geographic area of Washoe County and is comprised of committed professionals, agency personnel, community representatives, parents, foster parents, youth, community business representatives, and advocates who come together to support youth and families in Washoe County with behavioral health needs.

In accordance with NRS 433B.335, the WCCMHC presents the following long-term strategic plan (2020-2029). The plan begins with a statement of the vision and mission for the next 10 years. Then, it provides a background that describes contextual considerations for the plan, a brief description of children and their families in Washoe County, and a description of the long-term goals with short-term objectives and activities. This plan is a result of a collaborative process with WCCMHC members, guests, and partners.

Vision and Mission

Our vision for children, youth, and families in Washoe County is:

Equitable access to compassionate and comprehensive mental health services and supports within our community.

Our mission is to:

Advocate on behalf of children, youth, and their families in Washoe County who require timely access to an array of behavioral health treatment services and supports.

Background

For 17 years the WCCMHC has advocated for the safety and well-being of Washoe County Youth and Families in all areas of their lives. This long-term plan, submitted in 2020, marks the culmination of 10 years of concerted efforts to achieve the goals established in our first 10-year plan. As the membership of the Consortium evolved and changed over this past decade, a few key consistent members kept the identified goals and outcomes as the foundation of our activities. With each new Chair and each new funding year, the WCCMHC explored ways to adapt and achieve our goals, all while keeping the framework of the System of Care at the center. In its first 10- year plan, the Consortium asserted a “Call to Action,” documenting a commitment to work towards the following Goals:

1. Families will be partners in every aspect of our system of care.
2. Our locally managed system of care will be upheld by our strong collaborative base.
3. We will embrace a family-centered culture of care that is seamless and easy to access.
4. We will facilitate the development, growth, and best use of our local resources.

The Consortium set about activities tied to the above goals intending that, “by 2020, families in Washoe County would be supported by: preventative services to facilitate healthy social and emotional development in all children, universal screening to identify children with behavioral health issues as early as possible, education and support to assist all families in caring for their children; and be able to remain intact and thrive here as they are embraced with the help they need, in their neighborhoods and on their terms.”

“Through my participation in WCCMHC, and its workgroups, I have seen the commitment and effort of the people involved result in making progress with trying to assess the need for mental health services in the community, identifying barriers to accessing the services. WCCMHC has made efforts to reach out to community partners and involve them; making resources known to the youth in the community. The Website is an effective tool for this. We need to continue to involve families, make it easy for youth and families to access care, facilitate the use of our community resources.”

** Consortium member*

In this past decade, the Consortium has encouraged, advocated for, and supported a myriad of activities across multiple agencies, touching the lives and improving the well-being of youth and families in Washoe County. Some of the highlights in the past decade include:

- Successful MOU among partner agencies to expand Wraparound services for 40 children in the community (2013 Annual Report page 1);
- In the 2012-2013 School Year 81 of 102 schools carried the Positive Behavioral Interventions and Supports designation;
- Created and updated an Access to Care Guide;
- Monitored placements of youth;
- Created the Home in Nevada (HINT) model, implemented as a collaborative effort in 2018;
- Create opportunities for families to receive training, information, and support in advocating for themselves;
- Supported the development of the Mobile Crisis Response Team, which started in October of 2014;
- Multiple initiatives over the years have sought to strengthen youth awareness of depression, anxiety, suicide prevention, and bullying;
- Expansion of school-based suicide screening year over year;
- Provision of workshops to homeless youth and tangible resources including bus passes and backpacks;
- The creation and funding of the Access to Care Scholarship Fund;
- Supported delivery of an ethics training for clinicians reflecting the values and principles of our System of Care;
- Development of a website to promote communication and access to information for youth, families, caregivers, and providers.

The thoughtful, comprehensive nature of the first [10 Year Plan](#) provides the Consortium a foundation upon which to launch the plan for the next 10 years of goal driven and data supported activity.

The foundational themes carried into this new 10 Year Plan allow for Consortium activities to:

- Continue to strengthen family voice so that youth and families can advocate for their self-identified needs
- Continue to encourage family participation in policy evaluation, revision, and decision making

- Continuing to strive for greater cultural sensitivity
- Continue to support training opportunities for professionals and caregivers in our community
- Continue to strengthen the Consortium and community agencies’ relationship with Washoe County School District to support school district-based programming so youth can develop pro-social skills while remaining in their home school and family setting

The Consortium has been an advocate for, supportive of, and witness to tremendous gains for children and families in our community. There is still much work to be done. In recent years, the Consortium has developed a list of data sets with ongoing presentations from community partners. As we move into the next decade, the Consortium is committed to data driven decision making and advocacy for youth and families in our community.

Development of the Report

During the calendar years of 2018 and 2019, the Consortium engaged in regular “data presentations” from local child-serving organizations and researchers on the needs and services for children and youth in Washoe County. Following each data presentation, Consortium members and guests discussed implications of the information presented. Additionally, the Consortium utilized public meetings to brainstorm and discuss possible priority areas, current strategies, and areas of need. The goals and objectives presented in this report are derived from the collection of those discussions, data, other community reports, and literature on best practices in child development and mental health.

Additionally, the Consortium commends the work and accomplishments of the Nevada System of Care (Nevada SOC). At the time of this report, the Nevada SOC is continuing its implementation in key areas of developing a “no wrong door” system for children, youth, and families to access assessment, services, and supports; establishing an evidence-supported “tiered care coordination model” to coordinate services at varying levels of intensity to meet the unique needs of the families; implementing a “provider designation system” to expand a broad array of services and supports which includes provider training infrastructure; and, developing the Nevada Division of Child and Family Services (DCFS) as the lead state entity for the provision of children’s mental health services setting forth policies and standards in accordance with SOC values and principles. Moving forward, the Consortium will remain an active stakeholder in the Nevada SOC and will continuously provide input, feedback, and support in the ongoing development and institutionalization of a SOC in the state.

Our mission continues:

The Consortium actively supports Nevada’s System of Care values and is interested in improving the quality, quantity, and accessibility of mental health services for children, youth, and their families.

As such, the Consortium designed the goals and objectives of this long-term plan to build upon the foundation and successes of the Nevada SOC while expanding strategies to specifically focus on healthy youth development, resilience, positive community supports and relationships, and community protective factors.

Guiding Principles

Per the Nevada Revised Statutes [433B.335](#), the principles guiding the development of this long-term plan are:

- The system of mental health services set forth in the plan should be centered on children with emotional disturbance and their families, with the needs and strengths of those children and their families dictating the types and mix of services provided.
- The families of children with emotional disturbance, including, without limitation, foster parents, should be active participants in all aspects of planning, selecting and delivering mental health services at the local level.
- The system of mental health services should be community-based and flexible, with accountability and the focus of the services at the local level.
- The system of mental health services should provide timely access to a comprehensive array of cost-effective mental health services.
- Children and their families who are in need of mental health services should be identified as early as possible through screening, assessment processes, treatment and systems of support.
- Comprehensive mental health services should be made available in the least restrictive but clinically appropriate environment.
- The family of a child with an emotional disturbance should be eligible to receive mental health services from the system.

- Mental health services should be provided to children with emotional disturbance in a sensitive manner that is responsive to cultural and gender-based differences and the special needs of the children.

Key Partnerships

The WCCMHC believes the health and well-being of children, youth, and their families in Washoe County is contingent upon the overall health and well-being of Nevada’s citizens. As such, in addition to its membership, the Consortium recognizes the unique contributions of other key groups in overall system-wide change in Nevada and considers partnership with such groups a priority in overall implementation of the plan. The list below includes, but is not limited to, key partnerships that contributed to the development of this long-term plan and are necessary for the implementation of the long-term plan (see more on implementation at the end of this document):

- Nevada Commission on Behavioral Health
- Department of Health and Human Services
- Nevada PEP
- Statewide Children’s Behavioral Health Consortium
- Rural Children’s Mental Health Consortium
- Clark County Children’s Mental Health Consortium
- Nevada State Office of Suicide Prevention
- Nevada System of Care
- Behavioral Health Policy Boards
- Truckee Meadows Regional Planning Agency
- Managed Care Organizations
- Public and private mental health providers
- Washoe County based child serving systems (i.e. schools, child welfare, juvenile justice)
- Community-based organizations

Community Strengths

The communities in Washoe County vary widely with regard to socioeconomic status, access to affordable housing, access to supportive resources including quality day care and public transit, and reasonable access to behavioral health resources. There are multiple existing strengths across the County upon which the WCCMHC can build while simultaneously creating new

collaborative partnerships with non-profit agencies, for profit agencies, small businesses, and government funded programs and services.

Community Organizations

There are multiple well-established community organizations that are constantly striving to expand services and resources to underserved and outlying zip codes. Quest Counseling, Northern Nevada HOPES, Renown Hospital, and The Children’s Cabinet are examples of agencies that have expanded scope of services in order to meet the behavioral health needs of broader populations in Washoe County. Most recently, the Eddy House launched an overnight emergency shelter for youth ages 18-24 years old with an option for housing stabilization support. County funded agencies, including Washoe County Department of Juvenile Services, Washoe County School District, Washoe County Health Department, and Washoe County Human Services Agency, and State funded programs within Washoe County, including Northern Nevada Child and Adolescent Services and the Youth Parole Bureau continue to search for effective ways to collaborate with community agencies for the benefit of youth and families. Washoe County’s Mobile Crisis Response Teams (MCRT) and Mobile Outreach Safety Teams (MOST) continue to refine and expand their availability for youth and adults in crisis. Additionally, the Northern Nevada Foodbank has implemented partnerships across the county resulting in a network of resources to strengthen food security.

Coalitions, Training, and Education

In addition to the monthly WCCMHC meetings, Washoe County has multiple collaborative meetings that occur regularly in an effort to share resources and information and increase the quality of our local best practices in mental health. These various coalitions form and adapt in response to the changing needs of our community. Examples include the Adolescent Task Force and SAFE Kids, which meet regularly to evaluate the status of various mental and physical health needs of youth in our community; The Northern Nevada Behavioral Health Coalition meets regularly to share updates on available resources and to track pending and ongoing legislative issues; and Join Together Northern Nevada implements a community-wide substance abuse prevention plan. Our region has several key organizations that strive to offer training for mental health professionals across multiple disciplines on a variety of topics. These key organizations include the Center for the Application of Substance Abuse Technologies, The Nevada Coalition of Systemic Counseling, Mental Health Peer Connections, Nevada SOC, and UNR’s Grand Rounds. Washoe County also has a thriving library system with multiple branches in neighborhoods throughout our community. The library system offers many free resources for families including access to educational materials and tutoring services.

Summary of Literature

In addition to data compiled from existing reports, the Consortium relied on information from key sources of evidence and literature in the development of this long-term plan. The following summarizes the literature that informed the Consortium’s goals, objectives, and activities.

System of Care (SOC)

A “[system of care](#)” is an evidence-based framework that focuses on the governance and service delivery infrastructure of children’s mental health services according to a set of values and principles. As such, the Consortium has adopted the following core values and guiding principles in the development and implementation of this long-term strategic plan.

Values and Principles for the System of Care

Core Values

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

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services should be sensitive and responsive to cultural differences and special needs.

Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.) Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health. As included in Pires, S. (2002). *Building systems of care: A primer*. Retrieved from: https://gucchd.georgetown.edu/products/PRIMER_CompleteBook.pdf

At the time of this report, the Nevada Division of Child and Family Services (DCFS) recently concluded a four-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of that grant was to implement and expand the SOC in Washoe and Clark Counties. At the conclusion of the grant, an infrastructure had been developed and proposed to facilitate an assessment process utilizing the [Child and Adolescent Needs and Strengths \(CANS\)](#) as a universal assessment tool; implement a tiered care coordination model to include high fidelity wraparound services, and the development of a provider enrollment system. The WCCMHC applauds the accomplishments of the Nevada SOC and intends to coordinate goals and activities of the Consortium with the Nevada SOC's ongoing implementation.

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences are the experiences of children 0-17 that could be perceived as traumatic or otherwise inducing a chronic stress or toxic stress response. These negative experiences, which include direct stressors such as exposure to violence, neglect, and abuse and indirect stressors related to family members such as severe mental health conditions including suicide, incarceration, and substance use, have been found to be directly correlated to negative outcomes in adult life ([Centers for Disease Control, 2019](#)). ACEs cause a disruption in the ability to cope and navigate, particularly for youth with Serious Emotional Disturbance (SED). Researchers are increasingly finding that unmitigated toxic stress can have an impact on a child's developing brain.

“Multiple, chronic or persistent stress can impact a child’s developing brain and has been linked in numerous studies to a variety of high-risk behaviors, chronic diseases and negative health outcomes in adulthood such as smoking, diabetes and heart disease. For example, having an ACE score of 4 increases a person’s risk of emphysema or chronic bronchitis by 400 percent and suicide by 1200 percent.”

* [ACEs Resource Packet: Adverse Childhood Experiences \(ACEs\) Basics](#)

The Data Resource Center for Child & Adolescent Health explains that, though stress is a normal response to a variety of challenges a child may face, if the stress is not effectively managed and mitigated, the potential for physical and psychological impacts increase. The Consortium is particularly interested in research indicating that the impact of ACEs and associated chronic or toxic stress can be managed and reduced through opportunities to develop and increase a child and family's resilience.

“[P]eople can be extremely resilient in the face of adversity when provided with protective relationships, skills and experiences. Research has shown that resilience – which can be learned - can mitigate the impact of ACEs and produce better health and educational outcomes. At the heart of resiliency is the need to cultivate healthy social- emotional development in children and families. This includes both intrapersonal skills – self- regulation, self- reflection, creating and nurturing sense of self and confidence – and interpersonal skills – establishing safe, stable and nurturing relationships.”

* [ACEs Resource Packet: Adverse Childhood Experiences \(ACEs\) Basics](#)

The image below describes strategies with specific approaches recommended for preventing ACEs. While the recommendations informed the goals and activities of this long-term plan, further data collection and analysis is needed to better understand the prevalence of ACEs for Washoe County youth. Thus, the strategies will be consistently reviewed by the WCCMHC for future consideration.

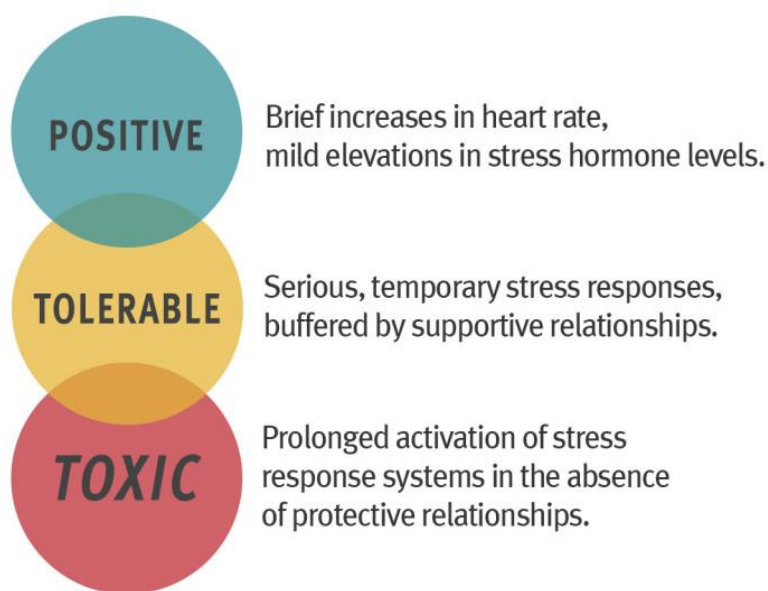
- Strengthen economic supports to families**
 - Strengthening household financial security
 - Family-friendly work policies
- Change social norms to support parents and positive parenting**
 - Public engagement and enhancement campaigns
 - Legislative approaches to reduce corporal punishment
- Provide quality care and education early in life**
 - Preschool enrichment with family engagement
 - Improved quality of child care through licensing and accreditation
- Enhance parenting skills to promote healthy child development**
 - Early childhood home visitation
 - Parenting skill and family relationship approaches
- Intervene to lessen harms and prevent future risk**
 - Enhanced primary care
 - Behavioral parent training programs
 - Treatment to lessen harms of abuse and neglect exposure
 - Treatment to prevent problem behavior and later involvement in violence

Source: Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html>

Toxic Stress

Toxic Stress is the “prolonged activation of stress response systems in the absence of protective relationships” ([Harvard University Center on the Developing Child, n.d.](#)). Research has linked the impact of toxic stress changes in the development and “architecture” of the brain to long-term damaging effects on health and well-being ([Harvard University Center on the Developing Child, n.d.](#)). Sources or types of toxic stress include: deep poverty, community violence, substance abuse, and/or mental illness ([Harvard University Center on the Developing Child, 2017](#)).

The Center on the Developing Child at Harvard University explains that not all stress is damaging and distinguishes between three different types of stress: positive, tolerable, and toxic (see figure below) and the damaging effects of toxic stress are unique to the individual’s own biological response systems.



Source: Harvard Center on the Developing Child, [Toxic Stress](#)

For the purposes of its planning and action, the WCCMHC is particularly interested in working with children, youth, families, caregivers, and child-serving organizations to build a community-wide network of supports and protective factors to diminish the effects of toxic stress. In doing so, the “[3 Principles to Improve Outcomes for Children and Families](#)” have been integrated into the goals and objectives of this plan. In short, the principles recommend policies and services that aim to: 1. Support responsive relationships for children and adults, 2. Strengthen core life skills, and 3. Reduce sources of stress in the lives of children and families. In doing so

communities can contribute to the healthy development and academic achievement for children and youth.

Social Determinants of Health

The Social Determinants of Health (SDOH) are environmental factors that impact the health, mental health, and well-being of individuals and communities ([World Health Organization & Calouste Gulbenkian Foundation, 2014](#)). Factors such as poverty, safety, housing, and access to food are all determinants of one's health. In fact, it is the SDOH that lead to unfair or unequal access to healthcare; resulting in disproportionate health outcomes for historically marginalized communities and for those from a low socioeconomic background ([Health People, n.d.](#)). These factors are rooted in institutional systems that *are possible* to change.

“By applying what we know about SDOH, we can not only improve individual and population health but also advance health equity.”

**[Centers for Disease Control, 2018](#).*

Collecting local data on SDOH while implementing resources to mitigate the impact of SDOH carries the potential to increase access to health care and improve long-term health outcomes. For example, after finding that lack of access to transportation resulted in missed healthcare visits in the United States, Lyft, a national ride-share company, partnered with the University of Southern California to offer free rides to seniors for a designated period of time. As a result of the program, seniors utilized Lyft for doctors' visits, fitness programs, and social activities ([Center for Open Data Enterprise \(2019\)](#)). This is an example of how SDOH data can inform local interventions to improve access to health care and improve overall well-being.

In a report from the [Center for Open Data Enterprise \(2019\)](#), the federal Health and Human Services Assistant Secretary for Health stated “America yearns for a new approach to healthcare, and addressing the social determinants of health must be a foundational principle of that approach” (p. 2). SDOH centers the child and youth's environment as a critical factor in promoting their health and well-being; this includes their home, schools, and neighborhoods ([Health People, n.d.](#)). Strategies informed by the SDOH approach are comprehensive (focused on the whole population), aim to address the lifespan, focus on strategies that are universal and proportionate to need, and cross-sector collaboration ([World Health Organization & Calouste Gulbenkian Foundation, 2014](#)). It is noted that “universal and proportionate to need” includes the recognition of inequity as a result of historical oppression and racism. Additionally, SDOH focus during early childhood years includes interventions that benefit mothers such as

increasing opportunities for better employment and higher levels of income; whereas, strategies focused on adolescent years include focus on school success, employment, income, positive community participation and mitigation of risk factors ([World Health Organization & Calouste Gulbenkian Foundation, 2014](#)).

National CLAS Standards & Health Equity

The 15 national standards for Culturally and Linguistically Appropriate Services (CLAS) “are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations ...” ([U.S. Department of Health and Human Services, Office of Minority Health, 2013](#)). The CLAS standards take a social justice perspective in creating a system of health care and services that respects and responds to the unique cultural and linguistic needs of the population served. The standards are in direct response to a history of discrimination that resulted in lack of access to care and the provision of inadequate and unequal care. Thus, in the development of a long-term plan for children’s mental health, the WCCMHC seeks to focus on equity in access to quality mental health care with attention to populations that have been historically marginalized and suffer disparities in their health outcomes. One such strategy is the use of peer delivered services (youth peer support and family support).

“Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make.”

([Robert Wood Johnson Foundation, n.d.](#))

As the SDOH and other research have explained, health is impacted by social conditions that shape an individual’s access to quality health care and positive community experiences. Thus, the WCCMHC aims for “health equity” by increasing access to mental health care for all children, youth, and their families. There is a growing trend amongst health care organizations to create “Health Equity Action Plans” that specify organization-level strategies to achieve equity. Building such plans at the community-level requires improving cross-sector data collection, accurately report health care disparities, utilize storytelling as a strategy to bring attention to the impact of institutional factors that result in unequal access to mental health care, review and modify hiring practices, and accountability for addressing disparate outcomes ([Los Angeles County Health Agency, 2019](#)).

Incarcerated Youth

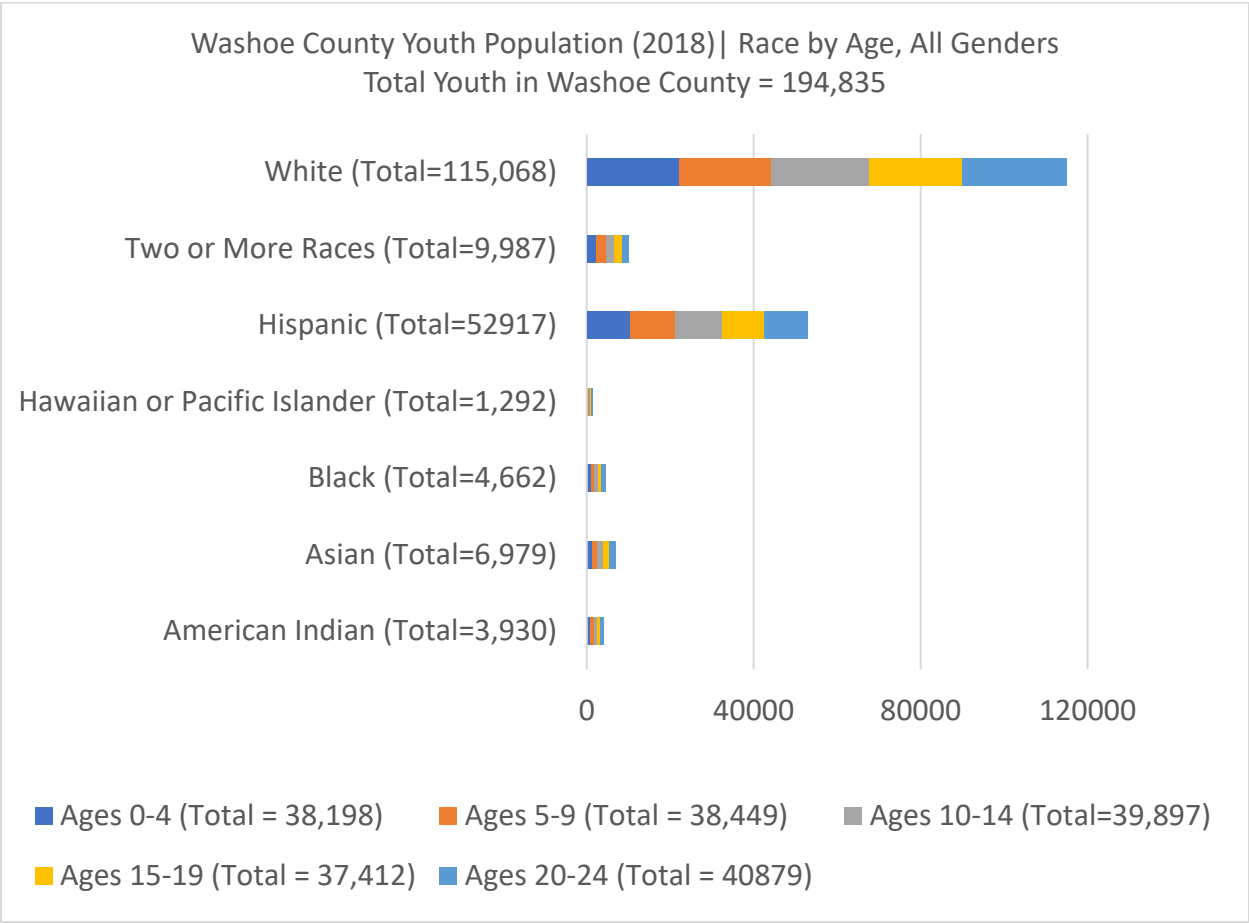
Among incarcerated youth, it is estimated that 50-70% meet criteria for a mental health disorder and there are higher rates of ACEs among youth involved in the juvenile justice system (Clements-Nolle & Waddington, 2019). In their analysis of ACE scores among Washoe County youth in detention, Clements-Nolle and Waddington (2019) found high levels of internal resilience reduced psychological distress due to ACE exposure. The authors suggest that interventions that aim to develop internal resilience carry the potential to moderate or buffer the impact of ACEs on psychological distress for youth involved in the juvenile justice system.

Disrupting the pipeline to juvenile justice by diverting youth with mental health concerns to appropriate community-based services carries the potential to reduce the economic burden of youth confinement. In their analysis of state expenditures for youth confinement, the Justice Policy Institute (JPI) found that “the average costs of the most expensive confinement option for a young person was \$407.58 per day, \$36,682 per three months, \$73,364 per six months, and \$148,767 per year” (2014, p. 3). In Washoe County, families incur a cost of \$30/day for their child in detention and if they refuse to pick up their child after the child is authorized for release, then the cost increases to \$100.75 per day ([Washoe County Department of Juvenile Services, n.d.](#)). JPI’s list of recommendations to reduce the costs of confinement includes shifting services for treatment to community-based options. Community-based treatment not only offers treatment in the least restrictive setting, but it carries the potential to decrease costs for the public as well as for the families of the youth. JPI also recommends improving system capacities to measure recidivism and track positive outcomes. Thus, a community-wide approach to serving youth’s mental health needs outside the walls of confinement would require community-wide collaboration on data collection, tracking, and monitoring of outcomes for the youth and their families.

Children, Youth, and Families in Washoe County

Population

Washoe County, Nevada is one of 17 counties in the State of Nevada. As the 2nd most populated county in the state, the “total population in Washoe County is projected to grow from 464,523 in 2018 to 558,746 in 2038. This represents an average annual growth rate of 0.93 percent” ([Truckee Meadows Regional Planning Agency, 2018](#), p. 4). Currently, approximately 22% of the population is under age 18 and 6% of the population is under age 5 ([U.S. Census, 2019](#)). The following chart depicts the number of youths in Washoe County by age and race.



* United States Census Bureau (2019-12-08). Population Estimates - Detail (1980 - Current): Population Estimates, State: Nevada, Age: Age 0 to 4, Age 5 to 9, Age 10 to 14, Age 15 to 19, Age 20 to 24, Gender: All. <https://doi.org/10.6068/DP1701BE8470266>

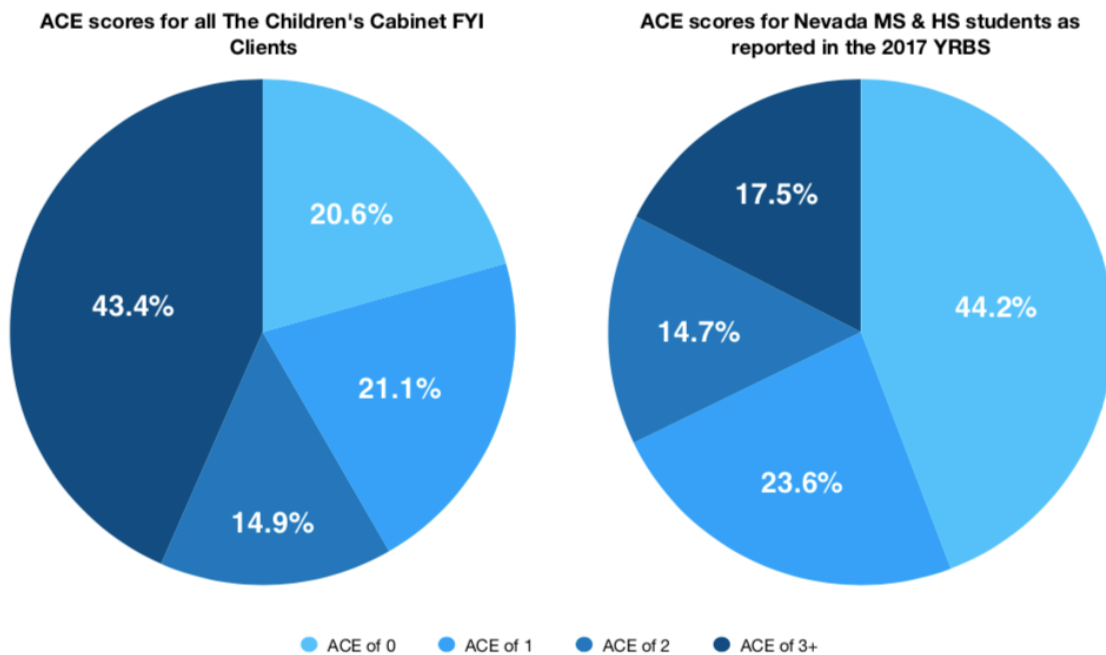
The [Nevada Kids Count \(2017\)](#) reports that the largest increases in the projected number of youth under age 18 in the state by race are African Americans (projected to increase 7.8% by 2022) and Asian/Pacific Islander youth (projected to increase by 4.9% by 2022).

Adverse Childhood Experiences (ACEs)

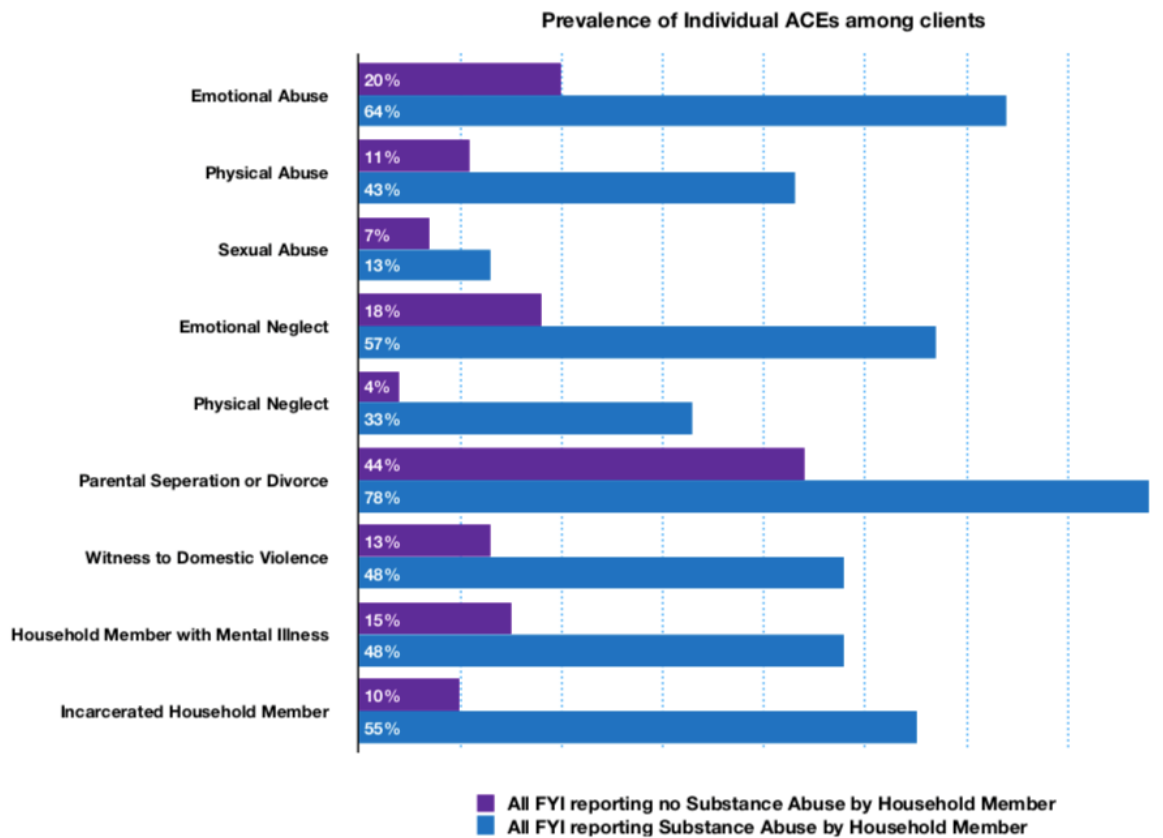
At the time of this report, collection of ACEs data is a relatively new initiative undertaken by a few organizations in Washoe County. ACEs are also included in the Nevada Youth Risk Behavior Survey (YRBS) data collection and analysis process. As depicted below, the 2017 YRBS reported that over half of middle school and high school students had 1 or more ACEs. In a presentation to the WCCMHC, Dr. Kristen Clements-Nolle reported that there was a high number of youth who reported “never/rarely” receiving help when they felt sad, empty, hopeless, or anxious. Additionally, Dr. Clements-Nolle reported that the number of ACEs a youth has is significantly

related to suicide behaviors; cumulative trauma is more harmful than single incidents; ongoing verbal abuse is more harmful than sexual abuse; and that youth who identify as LGBTQ+ and have ACEs have increased suicide ideation. In a discussion following the presentation, it was recommended that strategies promoting early identification and access are important and the middle school population would be a good target population. It was also recommended that implementing strategies to increase protective factors such as school connectedness, peer support, and access to caring adults can buffer exposure to ACEs. The implication of the data and the discussion determined that reducing or buffering exposure to ACEs could reduce suicide behaviors.

The Children’s Cabinet, a primary child and youth serving organization in the community, reported that over 40% of the clients served in their Family and Youth Intervention programs had an ACE score of 3 or more. This indicates that while youth already involved in organizational services may have higher ACE scores, there is still a large number of youths who have at least 1 ACE and may or may not be involved in services.



As depicted below, parental separation or divorce, emotional abuse, and substance abuse by a household member were the most common ACEs reported by the youth in the Children’s Cabinet programs. Additionally, 86% of youth that reported substance abuse by a household member had an ACE score of 3 or more.



As of June 30, 2018, there were 2,546 offenders convicted in Washoe County and incarcerated by the Nevada Department of corrections who reported having children ([Nevada Kids Count, 2017](#)):

- 578 reported having 1 child
- 479 reported having 2 children
- 294 reported having 3 children
- 162 reported having 4 children
- 67 reported having 5 children
- 59 reported having 6 or more children

Poverty

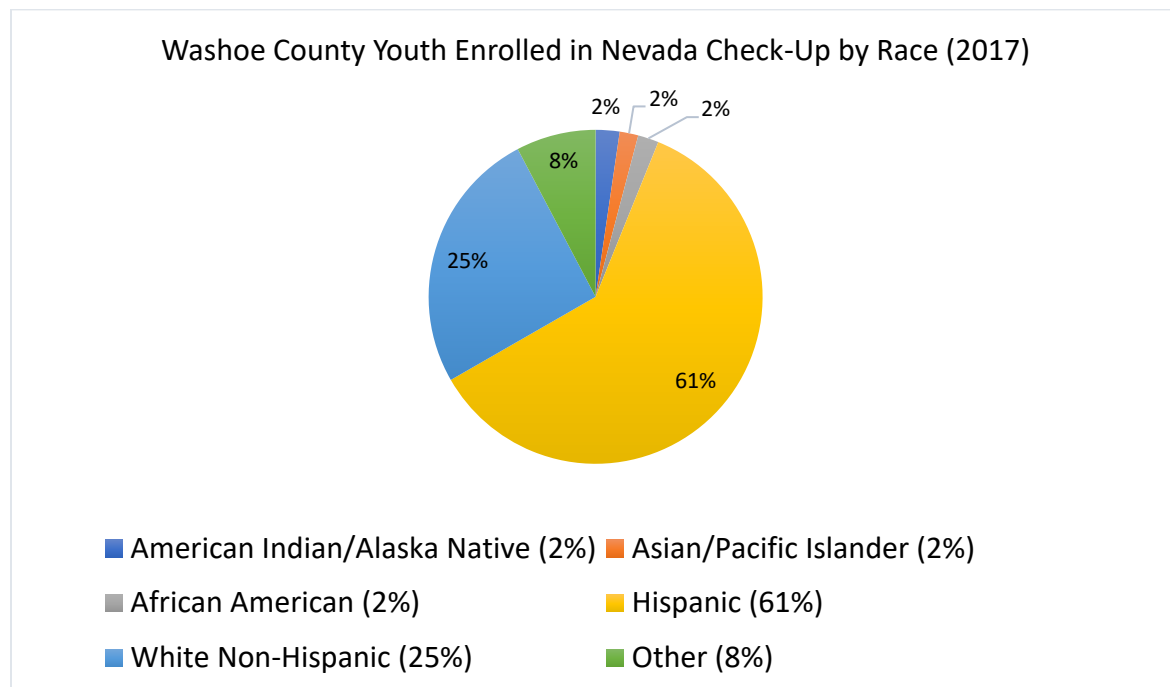
Overall, 16% of children under 18 in Washoe County live at or below poverty level. Approximately 10% of the population lives in poverty ([U.S. Census Bureau, 2019](#)). The [Washoe County Community Health Needs Assessment \(2018\)](#) reported that, in Washoe County, African Americans comprise one of the smallest proportions of the population, yet they represent the highest proportion of people living below poverty. In 2019, there were 7,356 youth under age

19 who were uninsured and 77,138 Washoe County residents enrolled in Medicaid in 2018 ([Nevada Office of Statewide Initiatives, n.d.](#)).

Among middle school students responding to the Nevada Youth Risk Behavior Survey (YRBS), 32.3% qualified for or received free and reduced lunch at school; 55.6% of those students are Black, 52.3% are Hispanic/Latino, and 40.3% are American Indian/Alaska Native ([Nevada Middle School YRBS, 2017](#)). Among high school students responding to the YRBS, 32.7% qualified for or received free and reduced lunch at school; 44.7% of those students are Black, 55% are Hispanic/Latino, and 47.8% are American Indian/Alaska Native ([Nevada High School YRBS, 2017](#)).

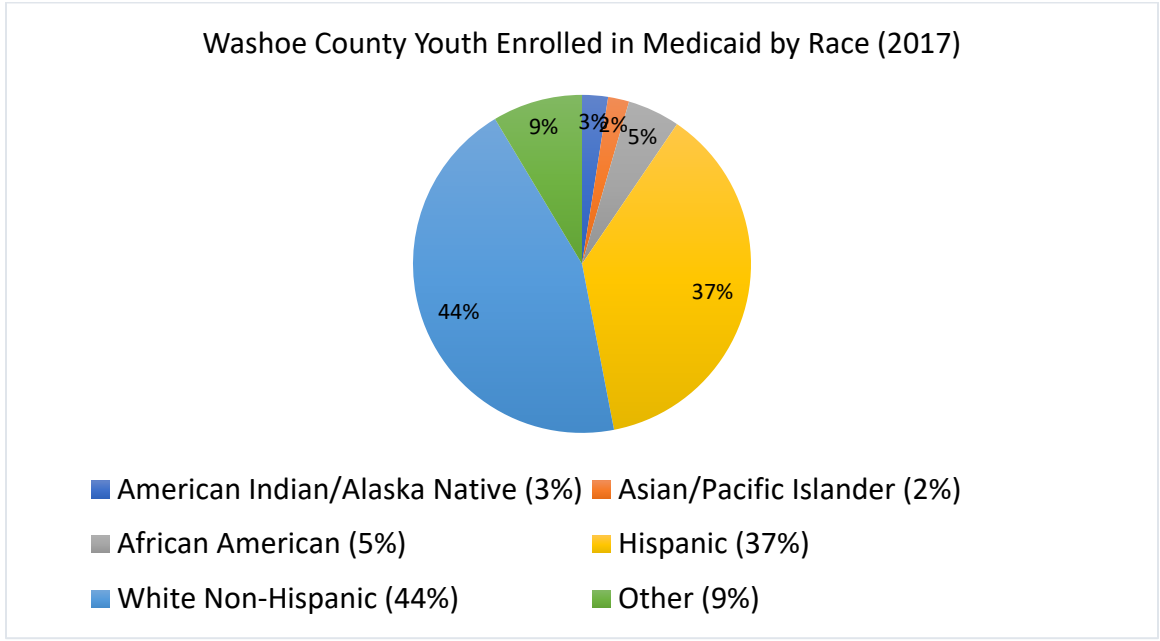
Health Insurance

Nevada Check Up and Medicaid are the primary sources of insurance for children in Nevada whose families have low-income. Nevada Check Up is the public health program that covers children, birth to 18, whose families have an income that is too high to qualify for Medicaid, but too low to afford private health insurance. In January, 2017, there was a total of 4,328 Washoe County youth under 18 enrolled in Nevada Check Up ([Nevada Kids County, 2017](#)). The image below describes the number of youth enrolled in Nevada Check-Up by race.



In January, 2017, there was a total of 33,959 Washoe County youth under 18 enrolled in Nevada Medicaid ([Nevada Kids County, 2017](#)). The image below describes the number of youth enrolled in Medicaid by race.

Washoe County Youth Enrolled in Medicaid by Race (2017)



In 2016, there were 5,787 (5.8%) youth ages 17 and under in Washoe County who were uninsured (Nevada Kids Count, 2017).

Serious Emotional Disturbance/Mental Health

In a study of national and state-level prevalence of mental health disorders among children, it is estimated that prevalence of children having at least 1 mental health disorder is 16.5%, nationally, and that nearly 50% of those children do not receive needed treatment (Whitney & Person, 2019). In 2017, there were 256 youth in Washoe County with an emotional disturbance at a rate of 4 per 1,000 enrolled students ([Nevada Office of Statewide Initiatives, n.d.](#)). In 2017, there were 613 youth ages 17 and under who received mental health services from the Division of Child and Family Services ([Nevada Kids Count, 2017](#)). In 2017, there were 3,354 youth under 17, statewide, who received mental health services from the Division of Child and Family services with the largest proportions of those youth being white (68%), Hispanic origin (34.5%), and African American (21%) (Nevada Kids Count, 2017). In 2016, there were 273 Washoe County youth enrolled in special education with “emotional disturbance” as their primary disability category (Nevada Kids Count, 2017).

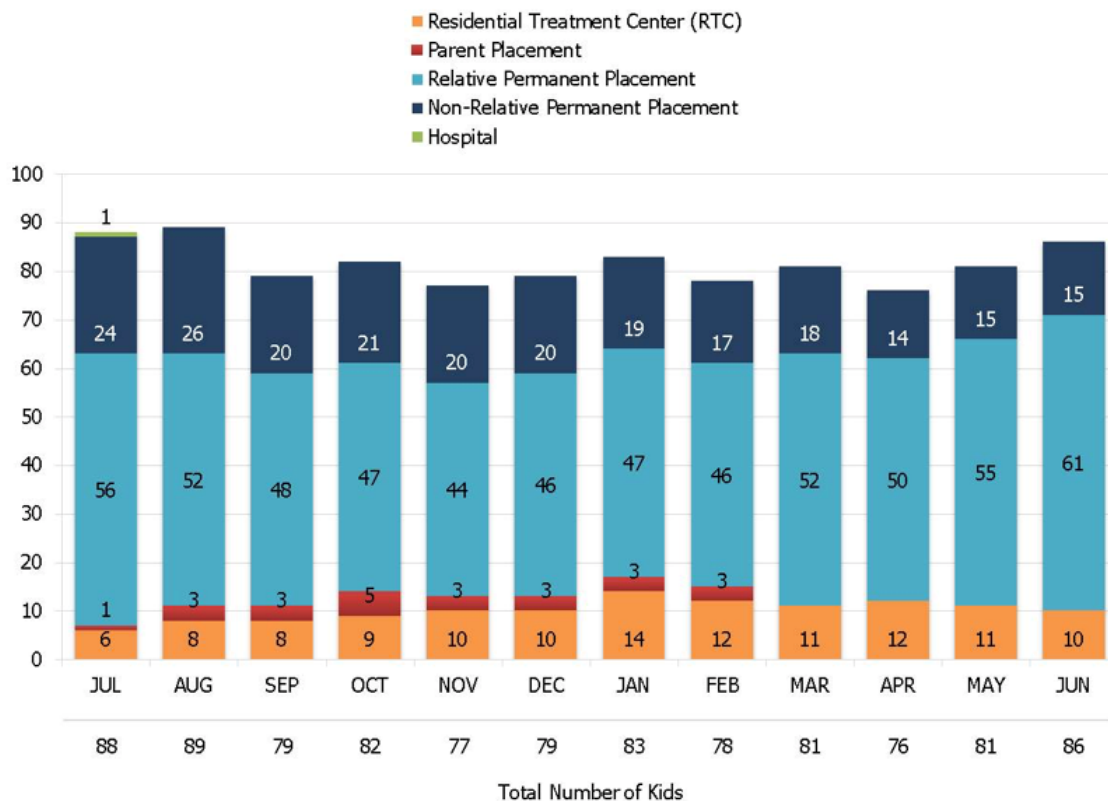
At the time of this report, Washoe County experiences a lack of appropriate short-term psychiatric stabilization “beds” for youth and coordinated step down services prior to discharge. Youth are currently stabilizing in shelters, juvenile detention, and/or foster homes. There is a need to create and expand services to offer youth a secure and safe place for short-

term crisis stabilization. There is also a need to expand service coordination programs to implement intensive and community-based care plans to support youth returning to their families or to support referral to long-term residential treatment.

Out-of-State Placements

In 2019, there were 55 Washoe County youth ages 10-17 who were enrolled in Medicaid that received treatment from facilities outside of Nevada (Division of Health Care Financing and Policy, 2020). Additionally, the Washoe County Human Services Agency (2019) reports the following for children in the child welfare system who had to be placed out of the state for more than 15 days (please note that not all out-of-state placements are treatment related):

FY 2019 OUT-OF-STATE PLACEMENTS >15 DAYS



As reported above, an average of 82 children in the child welfare system are placed out of the state per month for reasons that extend beyond children’s mental health (i.e. relative placement). Of those youth, an average of 10 are placed in residential treatment centers per month. The average age of the youth placed in residential treatment centers is 15 (Washoe County Human Services Agency, 2019). In describing the primary reasons for out of state residential treatment, the Washoe County Human Services reports a lack of community-based options for inpatient and intensive outpatient services.

“Prevention is key to maintaining children in their community. Washoe County is in need of Intensive Outpatient Programs (IOP) that provide intensive, short-term services for children ages 6-18. An increase in local IOPs would allow youth to be immersed in services in their own community and increase the availability of natural supports for the youth and family, and potentially decrease the rate of entry into foster care. Additionally, Washoe County is in need of an increase in therapeutic foster homes to allow for children with more significant behavioral or emotional needs to remain in a family setting.”

**[Washoe County Human Services Agency, 2019](#)*

Addiction

The members and guests of the WCCMHC identified substance use and abuse as a top priority for the Consortium. Substance use disorders among parents and among adolescents continue to be a challenge for our community and an increasing number of Washoe County residents report needing, but not receiving treatment for both alcohol and illicit drug use. Adding to past and current challenges in Northern Nevada with high rates of alcohol and methamphetamine abuse, the nation’s opioid crisis has also hit Nevada with increases in opioid use and subsequent increases in overdose deaths. Prevent Child Abuse America describes the relationship between parental alcohol or other drug problems and child maltreatment as becoming increasingly evident. State child welfare records indicate that substance abuse is one of the top two problems exhibited by families in 81% of reported cases (*Prevent Child Abuse America, 2017*). Opioids are an emerging concern in Washoe County ([DPBH, 2017](#); [McIntyre, E.n.d.](#)). In 2016, there were 408 opioid-related overdose deaths in Nevada—a rate of 13.3 deaths per 100,000 persons and equal to the national rate. Nevada saw a decrease in overdose deaths from 2011 to 2014, followed by an uptick in 2015 that continued into 2016. From 2011 to 2016, the number of heroin-related deaths has doubled from 40 to 86 deaths, while deaths related to prescription opioids has been steadily decreasing from 362 to 275 deaths. In 2015, Nevada providers wrote 83.0 opioid prescriptions per 100 persons (2.4 million prescriptions). In the same year, the average U.S. rate was 70 opioid prescriptions per 100 persons ([IMS Health, 2016](#)).

One local substance abuse treatment center for adolescents, Quest Counseling, reports 688 youth, ages 13-22 were diagnosed with a substance use disorder in 2019. More specifically,

- 483 diagnosed with Cannabis Use Disorder
- 226 diagnosed with Alcohol Use Disorder
- 70 diagnosed with tobacco/nicotine use disorder
- 30 diagnosed with amphetamine use disorder
- 19 diagnosed with cocaine use disorder
- 9 diagnosed with stimulant use disorder
- 17 diagnosed with opioid use disorder
- 12 diagnosed with sedative, hypnotic, or anxiolytic use disorder
- 9 diagnosed with hallucinogen use disorder

Further, Quest Counseling reports concern with the rising accessibility of cannabis to teens. This increased access is resulting in an increase in use, varied routes of administration (THC pens, Dabs/wax, edibles, plant), as well as the high potency/THC level of the substance. There is a growing concern and need to monitor data trends on the number of youths who experience psychotic episodes and gastrointestinal issues (i.e. Cannabinoid Hyperemesis Syndrome) related to chronic, severe cannabis use. Additional data to monitor amongst this population is Tobacco/Nicotine Use Disorder as it may currently be underrepresented as clinicians were initially unsure of code/diagnose kids who were vaping, even though they probably met criteria for a use disorder.

In Washoe County, we have a gap in substance use treatment for teens: we have outpatient options, but higher levels of care, such as intensive outpatient (IOP), partial hospitalization programs (PHP), and in-state residential services are minimally available. One barrier, for example, to providing IOP is that it is difficult for providers to get reimbursement from insurance.

Additionally, transportation to services is a major challenge for youth trying to access treatment. The bus system is difficult to navigate and bus lines don't adequately reach populations outside the Reno metro area (i.e. Cold Springs, Sun Valley, only one stop in Stead, minimal lines South of town). Many youth in need of substance abuse treatment do not have a driver's license or access to a vehicle and it is difficult for working parents to bring their kids to treatment.

Suicide

The members and guests of the WCCMHC identified the elimination of suicide as a top priority for the Consortium.

“Over the past decade, we have seen stigma around mental health and suicide reduced; we have mandated suicide prevention awareness and education, and we have more behavioral health and healthcare providers trained in screening and suicide intervention. Yet, we are seeing our youth rates increase. We must increase connectedness, creativity and innovation as we continue our work in the next decade.”

**Youth rates have increased from 0.9 in 2008 to 3.8 in 2018.*

*Source: Nevada Office of Suicide Prevention

In Washoe County, there were 4 youth who died by suicide during the fiscal year 2019 (Washoe County Human Services Agency, 2019). Among middle school students who participated in the YRBS, 21.3% reported ever seriously considered killing themselves; 28.6% were female, 29.8% of those youth are American Indian/Alaska Native, 22.4% of those students are Black, 21.4% are Hispanic/Latino, 24.4% are “other/multiple” races, 20.9% are White, and 17.5% are Asian ([Nevada Middle School YRBS, 2017](#)). Among high school students who participated in the YRBS, 21.3% reported ever seriously considered attempting suicide; 23.3% were female, 28.8% of those youth are Black, 16.5% are Hispanic/Latino, 29.6% are “other/multiple” races, and 19.9% are White ([Nevada Middle School YRBS, 2017](#)).

According to a report to [Congress on behalf of the Congressional Black Caucus \(2019\)](#), the suicide death rate among Black youth is increasing faster than any other racial/ethnic group and Black youth under age 13 are twice as likely to die by suicide compared to their white peers.

“Black adolescents are significantly less likely to receive care for depression – a major risk factor for suicide – with pervasive structural inequities, social determinants of health, stigma and mistrust of healthcare providers creating daunting barriers to treatment” (p. 5).

The Children’s Cabinet, a local non-profit organization that provides a wide range of services for children, youth, and their families/caregivers, operates the nationally recognized “Signs of

Suicide” screen service for middle school and high school youth in the Washoe County School District. Results of the screening are not diagnostic but indicate the presence or absence of symptoms that are consistent or inconsistent with depression or suicide. As the lead agency, The Children’s Cabinet collaborates with staff at Washoe County School District, Washoe County Health Department, and community volunteers to implement each screen. The table below describes the number of screenings conducted across Washoe County Schools and the results of those screenings. Results are described as:

	2016 2017	2017 2018	2018 2019
6th Grade			
Number of Screening Sites (Schools)	5	2	6
Number of Students Screened	187	128	173
Number of Students Positive	21	32	48
Percentage of Positive Screens	11%	25%	28%
7th Grade			
Number of Screening Sites (Schools)	14	14	16
Number of Students Screened	839	1,244	1090
Number of Students Positive	213	263	343
Percentage of Positive Screens	25%	21%	31%
8th Grade			
Number of Screening Sites (Schools)	4	3	2
Number of Students Screened	406	335	100
Number of Students Positive	59	63	26
Percentage of Positive Screens	15%	19%	26%
High School			
Number of Screening Sites (Schools)	2	3	4
Number of Students Screened	16	53	44
Number of Students Positive	9	19	12
Percentage of Positive Screens	56%	36%	27%
TOTAL			
Number of Screening Sites (Schools)	25	22	28
Number of Students Screened	1,448	1,760	1407
Number of Students Positive	302	344	429
Percentage of Positive Screens	21%	21%	30%

Source: Children’s Cabinet (2019). *Signs of Suicide: Screening and assessment data 2016-2019.*

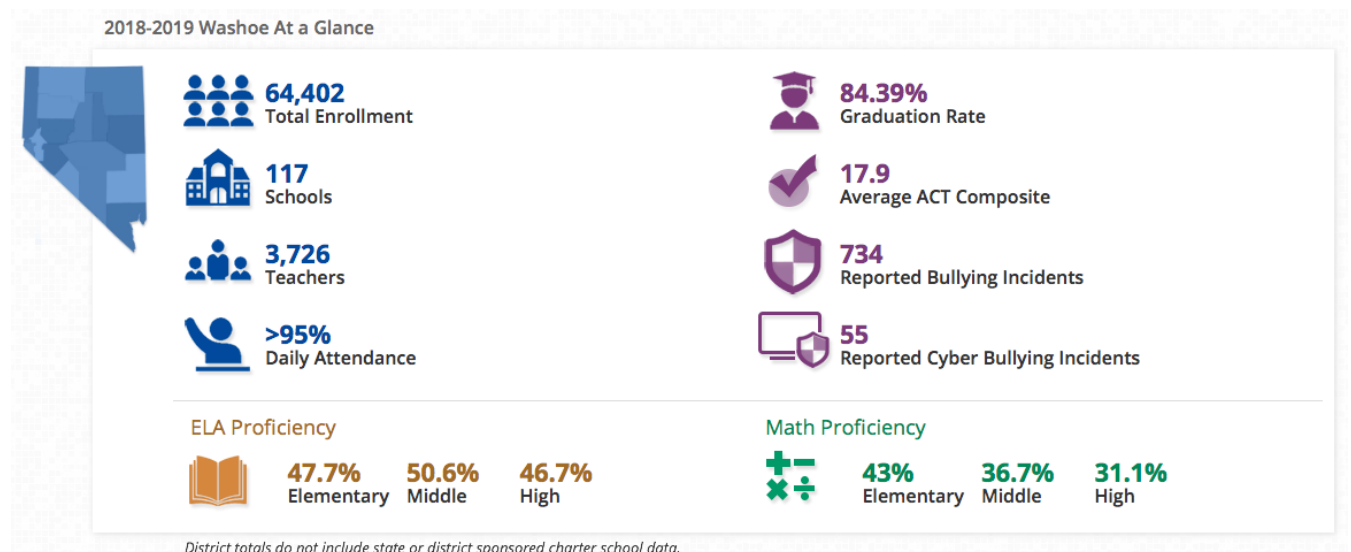
As reported above, of the over 1,400 students screened under the Signs of Suicide program in 2019, nearly 430 students resulted in a positive screen (30%).

At the time of this report, there is no dedicated school-based Safe Voice program professional housed within Washoe County School District.

School Success

The Annie E. Casey Foundation has ranked Nevada 47th in the nation for overall child well-being. The state ranks 45th in the nation for children ages 3 and 4 not attending school with 63% of those children are not attending. In Nevada, the number of high school students graduating on time is 81%.

The following describes youth in Washoe County School District.



Source: [Washoe County School District Accountability Report 2018-2019](#).

In 2017, the high school dropout rate for Washoe County was 2.4%, below the state average of 3.2% ([Nevada Kids Count, 2017](#)).

Child Abuse and Neglect

As depicted in the chart below, there was 6,568 referrals or reports made to the Washoe County Human Services Agency for possible child abuse or neglect in fiscal year 2019 (Washoe County Human Services, 2019). This number is down from the previous 4 years. In general, approximately 70% of those referrals are information only, 30% are assigned for investigation indicating a higher level of concern, and approximately 3% are referred “Differential Response”

indicating a family may need support but the concern does not warrant an investigation.

REFERRALS AND INVESTIGATIONS

	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
TOTAL NEW REFERRALS	7,423	100%	7,436	100%	7,070	100%	6,943	100%	6,568	100%
▶ INFORMATION ONLY	5,147	69%	5,130	69%	4,884	69%	4,782	69%	4,480	68%
▶ INVESTIGATIONS	2,041	28%	2,049	28%	1,957	28%	1,950	28%	1,936	29%
▶ DIFFERENTIAL RESPONSE	235	3%	257	3%	229	3%	211	3%	152	3%

Source: Washoe County Human Services Agency (2019). *Data Book*. p. 3

During the fiscal year 2019, 224 child removals by the Washoe County Human Services agency were drug and alcohol related. Of those, 6 removals were due to parental Opioid use (Washoe County Human Services Agency, 2019).

Housing

Affordable housing is when a household pays no more than 30% of their housing costs ([Truckee Meadows Regional Planning Agency – Regional Strategy for Affordable Housing, 2019](#)). At the time of this report, the average rent in the Truckee Meadows region is \$1,480; home values have doubled with the average home sale price is \$360,000; with a median income of \$67,000 “incomes throughout the region have not kept pace with home prices”; 38% of Truckee Meadows residents have to pay too much of their income on their housing costs; and there has been an increase renters to 44% of households (Truckee Meadows Regional Planning Agency – Regional Strategy for Affordable Housing, 2019, p. 12-13). The [Washoe County Community Health Needs Assessment \(2018\)](#) reported that 20.5% of survey respondents indicated having difficulty paying for housing in the past 12 months and 18.7% reported having difficulties paying utilities.

Youth and Homelessness

As described above, the cost of housing in the region has been on the rise and not affordable for many in Washoe County. The Washoe County Health 2018 Community Health Improvement Plan report described the impact of the housing prices on youth who are homeless:

“The lack of a social safety net and funding for homeless programs continues to be an on-going issue to adequately meet the needs of youth experiencing homelessness. For example, as youth ages out of institutions like foster care, limited resources are available to prepare them for the transition to adulthood. The causes and solutions of youth homeless are unique; however, if interventions are effectively implemented, chronic homelessness can be prevented. Evidence suggests 85% of youth experiencing homelessness won’t experience chronic homelessness if interventions are provided before the critical age of 25. To address youth homelessness in Washoe County, the Youth Homelessness Roadmap was developed and then endorsed by the Reno Area Alliance for the Homeless (RAAH) Leadership council. Youth and young adults need stable housing, supportive connections to caring adults, and access to mainstream services that will place them on a path to long-term success. The RAAH Youth Homeless committee is working to implement the roadmap which includes strategies such as establishing a 24-hour drop in center, identifying a data collection tool, and increasing the amount of supportive transitional and workforce housing.”

In 2017, there were 2,259 Washoe County School District students who qualified for the Children in Transition program; students who “lack a fixed, regular, and adequate nighttime residency” (Washoe County Community Health Needs Assessment, 2018, p. 50). Additionally, the Children’s Cabinet Safe Place Hotline, designed to be an immediate response to Homeless, Runaway, and At-Risk youth received 136 calls in the 2019 calendar year. Of those requests for help, 80 youth under 18 received face-to-face services at a designated Safe Place site within Washoe County. All youth were offered immediate crisis shelter, and 60 youth accepted that offer of emergency shelter.

Workforce

Historically, Nevada has struggled to identify adequate resources and community-based solutions to appropriately respond to our behavioral health needs due to a variety of factors. Lack of funding has often been cited as a top limitation to providing adequate services to our most vulnerable populations, with the per capita funding of mental health services averaging \$89.41, far short of the national average of \$131 per capita ([NRI, n.d.](#)). In 2016, 100 percent of the population in Washoe County resided in a mental health care professional shortage area ([Nevada Office of Statewide Initiatives, n.d.](#)). In 2017, there were 399 licensed inpatient

psychiatric beds at a rate of 90.6 per 1,000 population ([Nevada Office of Statewide Initiatives, n.d.](#)). The following summarizes the current number and rates of mental health professionals in Washoe County for 2018. At the time of this report, it is not known how many of the following professionals specialize in services for children and youth.

Specialist	Number	Rate per 100,000
Psychiatrist (MD and DO)	71	15.5
Psychologist	146	31.7
Clinical Social Workers	190	41.4
Marriage and Family Therapists	287	62.6
Alcohol, Drug, & Gambling Counselors	182	42.1
Clinical Professional Counselors	35	7.6
Social Workers	427	93.1
Licensed Applied Behavior Analyst	3	NA
Licensed Behavior Analyst	37	NA

Source: [Nevada Office of Statewide Initiatives, n.d.](#)

Priorities in Washoe County

The Consortium is acutely aware of the compartmentalized collection of local needs assessments, statement of priorities, and collective action strategies. Thus, efforts to break down such silos or “pockets” of activity, the Consortium has reviewed, considered, and integrated findings from existing reports, stated priority areas of other key partners, and recommendations from national sources. The following briefly summarizes some of those priority areas by group and/or report (full source details are included at the end of this document).

Source	Priorities/Strategies/Findings
Washoe County Community Health Needs Assessment (2018-2020)	Healthy topic priority ranking: <ol style="list-style-type: none"> 1. Access to health 2. Mental health 3. Social determinants 4. Crime & Violent-related behaviors 5. Physical activity, nutrition, & weight
Washoe County Health District, Community Health Improvement Plan, 2018	Focus areas of priority: <ol style="list-style-type: none"> 1. Housing 2. Behavioral health 3. Nutrition/Physical activity
Nevada Kids Count, 2017	Recommendations to improve well-being of Nevada’s Children: <ol style="list-style-type: none"> 1. Diversify the economy to create more, higher-paying jobs 2. Develop teams of parents, teachers, and schools to encourage student success 3. Encourage political leaders not to rollback health insurance coverage
Nevada Youth Risk Behavior Survey	<ul style="list-style-type: none"> • Suicide rates are high, but consistent across the state. • There are sub-populations that are emerging with concerns (i.e. LGBTQ+, military families, and ACE scores) • There is an overall decline in substance abuse, but trends in marijuana use should be monitored. • There are no declines in mental health indicators. • There are no declines in sexual health indicators.
Washoe County School District Annual Accountability Report, 2018-2019	<ul style="list-style-type: none"> • 64,402 students are enrolled in 117 schools. • Graduation rate = 84.39% • Reported bullying incidents = 734 • Reported cyber bullying = 55

Source	Priorities/Strategies/Findings
Substance Abuse Prevention & Treatment Agency, 2019 Epidemiologic Profile	<ul style="list-style-type: none"> • Female high school students are more likely to feel sad or hopeless, consider suicide, or purposely hurt themselves compared to males. • Males high school students are more likely to report current use of smokeless tobacco compared to females. • Females are more likely to report having drunk alcohol that was given to them by someone else.
Truckee Meadows Regional Planning Agency – Regional Strategy for Affordable Housing (2019)	<p>Increase affordable housing in the region:</p> <ul style="list-style-type: none"> • Build capacity to provide and maintain diverse supply of housing at different price points • Increase available resources for affordable housing • Reduce costs of housing development • Foster community support for housing affordability
Annie E. Casey Foundation	<p>Recommended strategies:</p> <ul style="list-style-type: none"> • Use data to develop and invest in policies such as expanding Medicaid access, invest in education, and economic tools such as federal and state earned income tax credits and child tax credit programs. • Address racial and ethnic inequity • U.S. Census – Count all kids.
Wojcik, O. (2020). Robert Wood Johnson Foundation.	<p>Research informed recommended community-wide strategies:</p> <ol style="list-style-type: none"> 1. Let a shared vision guide the way forward 2. Use big data locally 3. Practice resiliency 4. Foster radical collaboration 5. Lift up marginalized communities

Goals, Objectives, and Strategies

In order to reach the goals and objectives described below, the WCCMHC will provide leadership and facilitate collaboration across key state departments and divisions, community-based organizations and stakeholders in order to align resources, reduce barriers to care, and build ample capacity to meet the need. The following goals, objectives, and activities build upon the strengths and needs described above while integrating recommendations from the literature and other key groups. Additionally, activities within each objective include further examining the situation (i.e. need vs. capacity), identifying gaps, and implementing activities accordingly.



1

Increase access to compassionate care in the least restrictive environment.

In a joint Centers for Medicare and Medicaid Services (CMCS) and Substance Abuse and Mental Health Services Administration (SAMHSA) bulletin, it was reported that an array of home and community based supports make it possible for “children with complex mental health needs – many of whom have traditionally been served in restrictive settings like residential treatment centers, group homes and psychiatric hospitals – to live in community settings and participate fully in family and community life” ([Mann & Hyde, 2013](#)). The WCCMHC added the term “compassionate care” in this goal to emphasize the importance of the humanity underlying the needs of children and families and the importance of providers – at all points of contact with children and families – place compassion at the forefront of their interactions.

Objective 1A: Expand early identification and assessment services.

Activities

- 1A.1 Implement information dissemination activities and provider training on the basic structure and procedures of the Nevada SOC “No Wrong Door” model.
- 1A.2 Support the implementation of the Child and Adolescent Needs and Strengths (CANS) tool as a universal assessment tool in Washoe County.
- 1A.3 Identify, examine, and make recommendations on the use of other screening tools to assess for social determinants and adverse childhood experiences.
- 1A.4 Support the implementation of “Family Engagement Specialist” positions within DCFS to provide families and community partners guidance in accessing mental health resources.
- 1A.5 In order to promote continuity in mental health care from adolescence to adulthood, advocate for the dedication of a “Navigator” position within DHHS to guide youth through their transition of services.

Objective 1B: Expand crisis and stabilization services to prevent out-of-home placements.

Activities

- 1B.1 Develop at least 16 community-based “beds” and services that offer short-term psychiatric stabilization services with linkage to community-based services (including school-based supports).
- 1B.2 Implement an “urgent assessment and stabilization” system of services and supports for youth who are at risk of out-of-home placement.
- 1B.3 Support the Nevada SOC in expanding high fidelity wraparound to meet demand. This includes, but is not limited to, conducting an analysis of workforce recruitment and retention and a planned response to workforce needs.
- 1B.4 Support the Nevada SOC implementation of a “Tiered Care Coordination Model.”
- 1B.5 Develop community-based partners to fill gaps and expand capacity to meet a full service array accessible to children, youth, and families/caregivers.
- 1B.6 Develop policy and coordinate system-level partners to expand the Washoe County children’s Mobile Crisis Response Team services to 24 hours per day, 7 days per week.

Objective 1C: Expand access to an array of evidence-based substance abuse and mental health services on a continuum from prevention to recovery.

Activities

- 1C.1 Support the addition of a position within the state’s Office of Suicide Prevention dedicated to supporting youth and assisting families to keep their youth safe during and after treatment for suicide ideation and attempts.
- 1C.2 Expand funding to support Signs of Suicide (SOS) screenings for all 7th grade students in Washoe County.
- 1C.3 Develop policy and coordinate system-level partners to assess the need and develop safe and affordable respite care for non-foster care children with Severe Emotional Disturbance, autism, physical disability, and high-risk behavior.
- 1C.4 Develop policy and coordinate system-level partners to:
 - a. Assess the need and develop treatment options for youth with co-occurring substance abuse and mental health treatment needs.
 - b. Assess the need and develop Intensive Outpatient Services (IOP) for addiction and mental health services (i.e. step-down services following inpatient treatment).

- c. Assess the need and develop services for children, who are affected by parental substance use, to access assessment and supportive services.

Objective 1D: Increase racial, linguistic, and cultural equity in access to services and supports.

Activities

- 1D.1 Consortia members will obtain and/or participate in technical assistance and “toolkit” options for the development of health equity plans.
- 1D.2 Consortia members will pilot the development and implementation of health equity plans.
- 1D.3 Scaling this strategy will be assessed following pilot testing and capacity development.
- 1D.4 Commit to further analyzing the mental health needs of youth in Washoe County according to race and ethnicity.
- 1D.5 Commit to expanding the number of People of Color who are Consortium members and/or who attend Consortium meetings.

Objective 1E: Expand workforce to meet demand.

Activities

- 1E.1 Gather data and develop an inventory of fiscal sources, services, and supports for children’s mental health.
- 1E.2 Determine county-level capacity to meet demand for services and make recommendations.
- 1E.3 Support and disseminate Nevada SOC and other state or local training opportunities; implement WCCMHC sponsored training according to identified gaps.
- 1E.4 Assess Medicaid reimbursement rates as they impact provider incentive to provide Medicaid-funded services.
- 1E.5 Recruit and retain child psychiatrists.
- 1E.6 Recruit and retain crisis services professionals.
- 1E.7 Develop options for public-private partnerships to expand access to crisis services and treatment options.
- 1E.8 Implement information dissemination activities and provider training on the basic structure and procedures of the Nevada SOC “Provider Designation System.”

Objective 1F: Expand and sustain school-based services and supports.

Activities

- 1F.1 Develop policy and coordinate system-level partners to conduct a review of resources allocated to the “Safe Voice” program in Washoe County and expand resources to support Washoe County School District staff and their coverage of the Safe Voice hotline (i.e. dedicated positions, provide pay for on-call staff).
- 1F.2 Develop policy and coordinate system-level partners to integrate Counselors, Safe School Professionals, and other school-based personnel into the community-based crisis response and stabilization service system.

Objective 1G: Coordinate key system contacts and partnerships.

Activities

- 1G.1 Identify and recommend policies that mandate and sustain youth and family linkage between primary care providers and external services and supports.
- 1G.2 Identify and/or develop a practice with dedicated staffing to support the transition and care coordination of youth who experience a disruption and/or delay in any type of services.
- 1G.3 Facilitate the designation of Department of Health and Human Services “Division Liaisons” to streamline effective collaboration and problem-solving strategies specific to youth in Washoe County.



2 Decrease and/or buffer children and youth’s exposure to toxic stress.

As described above, prolonged exposure to stress changes the architecture of the brain impacting the overall health, well-being, and academic achievement for children and youth. Creating a community environment that promotes positive and responsive relationships, strengthens core life skills, and reduces sources of stress are recommended strategies for decreasing and/or buffering the impact of toxic stress ([Harvard University, Center on the Developing Child, 2017](#))

Objective 2A: Develop and implement responsive relationship *policies*.

Responsive relationships have been found to buffer exposure to toxic stress and are “[serve and return](#)” interactions between children/youth and caring adults.

Activities

- 2A.1 Identify existing state, county, and organization-based policies and services that buffer the disruption of critical relationships with caregivers such as housing support, childcare options, respite services, juvenile detention, out-of-home treatment, and child welfare system involvement.
- 2A.2 Determine gaps in system and organizational level services and supports that promote responsive relationships.
- 2A.3 Develop, recommend, and advocate for the implementation of funding and policies to address such gaps. Such policies may include, but are not limited to:
 - a. Funding for the expansion of parent and caregiver support services (i.e. respite and family peer support).
 - b. Funding for the expansion of family peer support services.
 - c. Policies that mandate and fund ongoing connection to existing responsive relationships in the event a child/youth is placed in out-of-home care.
 - d. Funding for the expansion of services to develop responsive relationships for youth who are homeless and/or are otherwise disconnected or disrupted from such relationships.
 - e. Funding and policies to strengthen the workforce in order to reduce turnover that disrupts responsive long-term relationships. This may include training, modification of hiring practices, and programs to address burn-out and compassion fatigue.

Objective 2B: Develop and implement policies that support evidence-based services and supports that develop core life skills.

Core life skills are “executive function and self-regulation” skills that are learned over time and help children, youth, and adults adapt to changing situations, navigate life demands, and develop health relationships.

Activities

- 2B.1 Identify existing state, county, and organization-based policies and services that explicitly focus on self-regulation and executive function skills.
- 2B.2 Determine gaps in system and organizational level services and supports that develop core life skills.
- 2B.3 Develop, recommend, and advocate for the implementation of funding and policies to address such gaps. Such policies may include, but are not limited to:
 - a. Policies that mandate the provision of service programs that focus on self-regulation and executive function skills.
 - b. Policies that mandate the inclusion of adults in core life skill development.
 - c. Policies that fund and mandate core life skill development within early learning programs and school settings.
 - d. Explore, develop, and support evidence-based practices that focus on the development of “core life skills.”
 - e. Explore, develop, and support integration of health information in schools.

Objective 2C: Develop and implement *policies* that decrease sources of toxic stress.

“When parents can meet their families’ essential needs, teachers and caseworkers have effective training and manageable class sizes/caseloads, and policies and programs are structured and delivered in ways that reduce stress rather than amplify it, families are better able to take advantage of community services that support healthy child development” (Harvard University Center on the Developing Child, 2017, p. 6).

Activities

- 2C.1 Gather data and develop an inventory of sources, services, and supports that buffer the exposure to toxic stress.
- 2C.2 Determine gaps in system and organizational level services and supports that develop core life skills.
- 2C.3 Develop a community-based lecture series for youth, families/caregivers, and providers with the opportunity for providers to obtain continuing education units.
- 2C.4 Develop, recommend, and advocate for the implementation of funding and policies to address sources of toxic stress and/or buffer exposure. Such policies may include, but are not limited to:
 - a. Policies and funding to expand funding for services and supports that mitigate sources of stress including, but not limited to, food security, access to medical care, access to mental and behavioral health treatment, emergency hardship supports, access to quality and affordable housing.
 - b. Strengthen child-serving organization-level policies and administrative practices to eliminate punitive practices while streamlining assessment and care coordination practices.
 - c. Policies and funding that mandate and support stopgap and transition services to mitigate impact of unplanned changes in service type and availability.
 - d. Policies that mandate “frontline” organizations and service providers (i.e. primary care providers) to routinely ask about and respond to a family’s major stressors in all assessment and treatment services.
 - e. Policies and funding that mandate and support the development of inclusive and equitable service environments.
 - f. Policies and funding that supports the workforce to manage their own levels of stress, particularly in crisis-oriented services such as the Mobile Crisis Response Teams (i.e. case load reduction programs, training, quality supervision, adequate release time, etc.).
 - g. Policies and funding that incentivize workforce development and retention in high-need and crisis-oriented services and supports.
 - h. Policies and funding to expand and sustain school-based screening and access to follow-up care.
 - i. Policies and funding to expand and sustain school-based violence prevention and intervention services such bullying.
 - j. Policies that mandate youth and family linkage between school-based Individual Education Plans (IEP) to external services and supports.



3

Increase child, youth, and family access to positive community-based experiences.

There is a need to “revitalize high-poverty communities – transforming them into places of opportunity...” ([Annie E. Casey Foundation, 2019](#)). The WCCMHC recognizes the needs of children, youth, and their families are centered within a community context. A context focused on opportunity, connection, and positive interactions carries the potential to reduce or buffer the impact of oppression, poverty, isolation, loneliness, addiction, and mental health needs. Additionally, the impact of suicide on youth and their families is considered a priority for the WCCMHC.

Objective 3A: Inform and support implementation of standards of quality care in accordance with the SOC values and principles, reducing toxic stress, and preventing ACEs.

Activities

- 3A.1 Support implementation of NV SOC “Provider Designation System”
- 3A.2 Support the development of DCFS as the “lead” organization for children’s mental health (NV SOC).
- 3A.3 Coordinate local agency ACEs studies, monitor, and develop responses to continuing ACEs research.

Objective 3B: Develop, implement, and sustain services and supports that decrease impact of effects of isolation, loneliness, and loss of connection on youth.

Activities

- 3B.1 Expand funding and implementation of suicide postvention services and supports.
- 3B.2 Develop and implement a “zero suicide” initiative.
- 3B.3 Examine and implement “screen time” services and supports.
- 3B.4 Examine credit recovery programs for young adults and parents.
- 3B.5 Develop partnerships with vocational rehabilitation/employment services to create “access to work” resources.

Implementation Plan

The implementation of the long-term strategic plan will be facilitated by the WCCMHC with specific services, supports, and strategies delivered by key partners, peer support systems, and child-serving organizations. The Consortium will continue to meet regularly with the goals and strategies contained in this plan serving as the guide for meeting agendas. The WCCMHC may develop sub-committees, as appropriate, to implement the plan. On an annual basis, the WCCMHC will develop a report summarizing its primary accomplishments according to the plan's goals and objectives, will update such goals and objectives, and will identify data needs and benchmarks to measure outcomes.

On an annual basis, the WCCMHC will develop a budget--aligned with the goals, objectives, and key strategies-- in accordance with the state allocation of funds (\$15,000 annually at the time of this report). Budget items may include but are not limited to: youth/family/caregiver participation incentives, development and/or maintenance of communication materials (i.e. website), experts/researchers to collect and analyze data, experts/researchers to recommend and prepare model policies, training events, and community events.

Implementation Considerations – Strengths

The WCCMHC acknowledges the ongoing administrative and structural support of DCFS. This support is critical to the implementation success of the long-term plan as DCFS manages the budget, facilitates contracts as determined by the Consortium, provides guidance on public meeting facilitation, and prepares reports as requested. Additionally, the WCCMHC acknowledges that much of its success is contingent upon the active involvement of its members, their respective organizations, and local business support.

The consortium is committed to continuously assessing, evaluating, and monitoring service quality, developing and implementing action steps, and providing community education and advocacy. Data driven recommendations, reports goals, and accomplishments are provided to the Washoe County Regional Policy Board, the NV Children's Behavioral Health Consortium and the State of Nevada Director of Health and Human Services at least annually.

The WCCMHC affirms that youth and families are key partners in the implementation of the long-term plan. As stated by [Nevada PEP](#), "nothing about us without us" is a key factor in the

planning and implementation of the long-term plan. The WCCMHC will not condone or tolerate blaming of families, implication of personal responsibility for the mental health needs of a child, nor suggest that a family, alone, can meet the needs of their child without community support. Likewise, the Consortium will utilize its resources and strategies to support this approach across all child-serving systems and providers.

The WCCMHC considers the Nevada Behavioral Health Policy Boards as key partners in overall system analysis and strengthening through policy development. State administrative and fiscal support for this ongoing partnership, particular to the needs of children’s mental health, is necessary to formalize this partnership.

Implementation Considerations – Potential Barriers

It is acknowledged that direct action is often contingent on time and resources. As the Consortium members and guests are volunteers who are often full-time working parents, professionals, and school-age youth it can be challenging to implement the goals and objectives. Thus, the WCCMHC will utilize its budget to the greatest extent feasible to contract services and develop other supports to overcome such barriers. Annually, the WCCMHC will take stock of the barriers in accordance to goal attainment in order to update strategies and request and/or procure resources appropriately.

Conclusion

The WCCMHC respectfully submits this long-term strategic plan as a roadmap for achieving its vision of children and youth in Washoe County Children, youth, and their families/caregivers having equitable access to compassionate mental health services and supports within their home and community. In collaboration with our partners and building upon our strengths, we aim to further our analysis of the needs, capacity, and evidence-based practices available in Washoe County. This analysis will continuously inform and renew the objectives and activities contained in the plan and will be updated annually.

We are thankful to all the members, guests, parents/caregivers, youth, and partners of the WCCMHC for their input, feedback, and tireless advocacy on behalf of children, youth, and their families/caregivers in Washoe County.

References and Resources

ACEs resource packet: Adverse childhood experiences (ACEs) Basics (n.d.). Johns Hopkins Bloomberg School of Public Health, The Child & Adolescent Health Measurement

Initiative, Academy Health. Retrieved from:

https://www.childhealthdata.org/docs/default-source/cahmi/aces-resource-packet_all-pages_12_06-16112336f3c0266255aab2ff00001023b1.pdf

Annie E. Casey Foundation (2019). *Children living in high-poverty, low-opportunity*. Retrieved from: <https://www.aecf.org/resources/children-living-in-high-poverty-low-opportunity-neighborhoods/>

Annie E. Casey Foundation (2019). *2019 kids count data book: State trends in child well-being*. Retrieved from: <https://www.aecf.org/m/resourcedoc/aecf-2019kidscountdatabook-2019.pdf>

Centers for Disease Control (2019). Preventing adverse childhood experiences (ACEs): Leveraging the best available evidence: <https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf>

Center for Open Data Enterprise (CODE) (2019). *Leveraging data on the social determinants of health*. Retrieved from: <http://reports.opendataenterprise.org/Leveraging-Data-on-SDOH-Summary-Report-FINAL.pdf>

Clements-Nolle, K., Lensch, T., Baxa, A., Gay, C., Larson, S., Yang, W. (2018). Sexual identity, adverse childhood experiences, and suicidal behaviors. *Journal of Adolescent Health*. 62(2). 198-204.

Clements-Nolle, K., Waddington, R. (2019). Adverse Childhood Experiences and psychological distress in juvenile offenders: The protective influence of resilience and youth assets. *Journal of Adolescent Health*. 64. 49-55.

Congressional Black Caucus (2019). *Ring the alarm: The crisis of Black youth suicide in America*. Retrieved from: https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

Harvard University, Center on the Developing Child (2017). *3 Principles to improve outcomes for children and families*. Retrieved from: https://46v5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2017/10/HCDC_3PrinciplesPolicyPractice.pdf

Harvard University, Center on the Developing Child (n.d.). *Toxic stress*. Retrieved from: <https://developingchild.harvard.edu/science/key-concepts/toxic-stress/>

Health People 2020 (n.d.). *Social determinants*. Retrieved from:

<https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants>

Justice Policy Institute (JPI)(2014). *Sticker shock: Calculating the full price tag for youth incarceration*. Retrieved from:

http://www.justicepolicy.org/uploads/justicepolicy/documents/sticker_shock_final_v2.pdf

Los Angeles County Health Agency (2019). *A call to action: Supporting a movement for fair and just health outcomes, action plan 2018-2023*. Retrieved from:

http://publichealth.lacounty.gov/CenterForHealthEquity/PDF/CHEActionPlanFinalDraft_2.15.2019.pdf

Mann, C., Hyde, P. (2013). Coverage of behavioral health services for children, youth, and young adults with significant mental health conditions. *Joint CMCS and SAMHSA Information Bulletin*. Retrieved from:

<https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>

McIntyre, E. (n.d.). *Opioid overdose in Nevada presentation*. Department of Health and Human Services, Division of Public and Behavioral Health. Retrieved from:

<http://dph.nv.gov/uploadedFiles/dphnvgov/content/Programs/ClinicalSAPTA/Docs/Opioid%20Overdose%20PPT-Eric%20McIntyre.pdf>

Nevada Kids County (2017). *Data book 2017: County, regional, and state profiles of child and youth well-being in Nevada*. Retrieved from: <https://www.caanv.org/wp-content/uploads/2018/10/2017-NEVADA-KIDS-COUNT-DATA-BOOK.pdf>

Nevada Youth Risk Behavior Survey (2017). *Washoe County Special Reports (Middle School and High School)*. 2017 reports available from: <https://www.unr.edu/public-health/research-activities/nevada-youth-risk-behavior-survey>

NRI (n.d.). Analytics improving behavioral health. Retrieved from: <http://www.nri-inc.org>

Pires, S. (2002). *Building systems of care: A primer*. Retrieved from:

https://gucchd.georgetown.edu/products/PRIMER_CompleteBook.pdf

Robert Wood Johnson Foundation (n.d.). *Achieving health equity*. Retrieved from:

<https://www.rwjf.org/en/library/features/achieving-health-equity.html>

- State of Nevada, Nevada Department of Health and Human Services, Office of Analytics (2019). *Substance Abuse Prevention and Treatment Agency, 2019 epidemiologic profile, Washoe County behavioral health region*. Retrieved from: http://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Programs/Office_of_Analytics/2019%20Epidemiologic%20Profile%20WASHOE%20FINAL.pdf
- State of Nevada, Division of Public and Behavioral Health (DPBH)(2017). *The scope of opioid use in Nevada, 2016*. Retrieved from: <http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Resources/opioids/Opioid%20Infographic.pdf>
- Sun staff (2018). Advocating for children with special needs and their families. *Las Vegas Sun, Findlay Good Works*. Retrieved from: <https://lasvegassun.com/news/2018/oct/04/advocating-for-children-with-special-needs-and-the/>
- Truckee Meadows Regional Planning Agency (2018). *Regional strategy for affordable housing*. Retrieved from: <http://www.tmrpa.org//files/reports/18-09-12%20WC%20Consensus%20Forecast%202018%20Final%20with%20Appendices.pdf>
- Truckee Meadows Regional Planning Agency (2019). *Regional strategy for affordable housing*. Retrieved from: https://docs.wixstatic.com/ugd/bdff28_8d13137552d04b11bf7d5fa1f50873ed.pdf
- United States Census Bureau (2019). *Quick facts, Washoe County*. Retrieved from: <https://www.census.gov/quickfacts/washoecountynevada>
- University of Nevada Reno, School of Medicine, Office of Statewide Partnerships (n.d.) *Nevada instant atlas*. Retrieved from: <https://med.unr.edu/statewide/instant-atlas/county-data-map>
- Washoe County Department of Juvenile Services (n.d.). *Frequently asked questions*. Retrieved from: <https://www.washoecounty.us/juvenilesvs/fag/index.php>
- Washoe County Health District (2018). *Washoe County community health needs assessment*. Retrieved from: https://www.washoecounty.us/health/files/data-publications-reports/2018-2020%20CHNA_FINAL.pdf
- Whitney, D., Peterson, M. (2019). US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *Journal of American*

Medical Association, Pediatrics. 173(4), p389-391. Retrieved from:

<https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377nevada>

Wojcik, O. (2020). Community health resolutions for a new decade: Five things your community can do to ensure healthier, more equitable 2020s for all. *Culture of Health Blog*, January 21, 2020. Robert Wood Johnson Foundation. Retrieved from: <https://www.rwjf.org/en/blog/2020/01/community-health-resolutions-for-a-new-decade.html>

World Health Organization & Calouste Gulbenkian Foundation (2014). *Social determinants of mental health*. Geneva, World Health Organization. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=83C1F267A130C8F7C4E27A4131653218?sequence=1

THE WASHOE COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

2020 Membership

Jacquelyn Kleinedler, Chair
Children's Cabinet
Non-profit Agency Representative
Dr. Joe Haas, Vice-Chair

Washoe County Juvenile Services
Juvenile Justice Representative
Robin Reedy, Secretary
National Alliance on Mental Illness-Nevada

Parent Advocacy Representative
Chris Empey, Treasurer

Rhonda Lawrence
Northern Nevada Child & Adolescent Services
DCFS Representative

Sara Dearborn
Division of Health Care Financing and Policy
Medicaid Representative

Dr. Brandy Olson
WCSD Psychological Services
Washoe County School District Representative

Stephanie Brown
Willow Springs Center
Business Community Representative

Mala Wheatley
Pacific Behavioral Health
Mental Healthcare Representative

Brinn Wallace
Quest Counseling and Consulting
Substance Abuse Provider Representative

Washoe County Human Services Agency
Child Welfare Representative

Lyn Morales
Nevada PEP
Parent Representative

Steve Reagan
Reagan Home
Foster Care Representative

Dr. Rebecca Arvans
Sierra Regional Center
Aging and Developmental Services Representative

Sandy Arguello
Koinonia Family Services
Group Home Representative

Dr Jose Cucalon
UNR School of Medicine
Primary Healthcare Representative

Misty Allen
Nevada Office of Suicide Prevention
Suicide Prevention Representative

ACKNOWLEDGEMENTS

The development of this 10 Year Strategic Plan would not be possible without the participation and support of the members of the Washoe County Children’s Mental Health Consortium, and the many additional family members, community providers and other stakeholders who participated in workgroups and planning meetings over the past 6 months. These individuals have worked tirelessly to develop a dynamic strategic plan to guide our community for the next decade.

In addition, Jill Manit, Ph.D., MSW, was an invaluable organizer, consultant, and author of this plan without whom, we would not have been successful.

Financial support for the planning process and preparation of this report was provided through the annual Washoe county Children’s Mental Health Consortium state funds through the Division of Child and Family Services.

Meeting Announcements can be found at

<http://dcfs.nv.gov>

Additional information and resources:

<http://wccmhc.com>

Contact us at:

wccmhconsortium@gmail.com