Rural Children's Mental Health Consortium

Long-Term Strategic Plan | 2020-2029

Executive Summary

The Nevada Revised Statutes (NRS) 433B.333 &. 335 established and charged the Rural Children's Mental Health Consortium (RCMHC) to develop a long-term strategic plan for children's mental health in the rural and frontier counties of the state. A comprehensive system of care offering an array of prevention, intervention, and treatment options for children, youth, and families/caregivers is critical to the health and well-being of Nevada families. Currently, Nevada ranks 51st place in Mental Health America's (MHA) state rankings for youth mental health indicating that youth in Nevada have a higher prevalence of mental illness with lower rates of access to care (MHA, 2019). In the rural and frontier counties of the state, 100% of the population resides in a designated mental health professional shortage area (Griswold, Packham, Etchegoyhen, Young, & Friend, 2019). This long-term strategic plan builds upon the accomplishments of the previous plan, the strengths of the rural and frontier areas of the state, identified needs, and evidence-based approaches in children's mental health. The following briefly summarizes the vision, mission, goals, and key strategies of the long-term plan.

Vision: Youth in rural and frontier Nevada are healthy and well with unhindered access to care.

Mission: To advance an integrated system in which youth and their families/caregivers with mental health needs are accepted in their communities, feel meaningfully connected to services and supports in the least restrictive environment, and experience equity in opportunities to access care.

5 Goals:

1. Expand and sustain the Nevada System of Care to rural and frontier Nevada.
2. Increase access to mental and behavioral health care.
3. Increase access to treatment in the least restrictive environment.
4. Increase health promotion, prevention, and early identification activities.
5. Develop, strengthen, and implement statewide policies and administrative practices that increase equity in access to mental and behavioral health care for youth and families.

6 Strategies:

1. Community Discussion
2. Communications.
3. Training.
4. Data collection and reporting.
5. Key partner development and collaboration.
6. Policy and administrative practice influence.

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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 Rural Children's Mental Health Consortium (RCMHC) is the designated consortium for the rural region of the state 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 rural and frontier Nevada with behavioral health needs. Of the three designated consortia, the RCMHC covers the largest geographic region of the state. This includes Carson City (a consolidated municipality), 3 rural counties (Douglas, Lyon, and Storey), and 11 frontier counties (Humbolt, Elko, Pershing, Churchill, Lander, Eureka, White Pine, Lincoln, Nye, Esmeralda, and Mineral) (Griswold, Packham, Etchegoyhen, Young, & Friend, 2019).

In accordance with NRS 433B.335, the RCMHC 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 rural and frontier Nevada, and a description of the long-term goals with short-term objectives, deliverables, and strategies. This plan is a result of a collaborative process with RCMHC members, guests, and partners.

Vision and Mission

The 10-year vision for the Rural Children's Mental Health Consortium is that:

> Youth in rural and frontier Nevada are healthy and well with unhindered access to care.

Our mission in achieving the above-stated vision is:

> To advance an integrated system in which youth and their families/caregivers with mental health needs are accepted in their communities, feel meaningfully connected to services and supports in the least restrictive environment, and experience equity in opportunities to access care.

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.

Background

The long-term plan for children's mental health in rural and frontier Nevada was developed from a grassroots perspective, utilizing intensive input from community and Consortium members. Members reviewed and discussed data compiled by Consortium members and developed goals accordingly. The goals and objectives included in this plan were derived from the stakeholder input and are informed by successes and ongoing needs from the prior long-term plan, activities of the Nevada System of Care, and literature related to children's mental health. The following summarizes contextual factors that influenced the development of this plan and will continue through implementation of the plan.

Stakeholder Input

During 2018 and 2019, the RCMHC facilitated two "Community Discussion" events in Winnemucca (2018) and Tonopah (2019). The purpose of the events was to:

- Increase stakeholder awareness of current activities across rural and frontier Nevada addressing children's mental health.
- Increase perception of the RCMHC as a "hub" of information and resources across the state.
- Increase number of RCMHC members.
- Increase RCMHC membership to include child serving systems.
- Engage in planning efforts for new 10-year plan for RCMHC.

As a result of the events, the RCMHC collected direct input from stakeholders on their perceived needs as they related to children's mental health, community strengths to build upon, and barriers to services. This input is summarized below and informed the development of the vision, goals, objectives, and strategies included in this long-term plan.

Vision Development

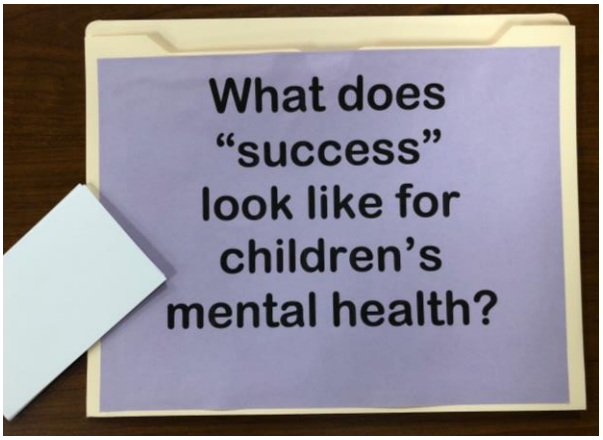
The above stated vision for the long-term planned was derived from stakeholder input. During the "Community Discussion" event in Tonopah (2019), stakeholders participated in an interactive discussion about their vision for healthy children and families in rural and frontier Nevada. Participants were asked to enter words or phrases to describe their vision into a mobile application that immediately produced results. The results were displayed "live" and informed participants' ongoing contribution to the activity. Participants repeated words they agreed with or felt strongly about. The image below represents the participants responses. The larger the word, the more frequently it was entered.

The results were immediately discussed by the participants, allowing more opportunity to elaborate on their vision. As depicted in the image above, the most common words that

participants used to describe their vision of health children, youth and their families/caregivers were:

1. **Happy/Happiness:** Participants described the importance of community members feeling happy or experiencing happiness and that this is an indicator of reduced stress with access to resources.
2. **Connection**: For their vision, participants described children, youth, and their families/caregivers as feeling connected to their community; connected to one another; and connected to services and supports.
3. **No judgment:** Participants described a vision in which children, youth, and their families/caregivers gain access to opportunities that are unique to their needs and strengths without experiencing judgement, barriers, or discrimination.

Also informing the vision, participants in the Winnemucca (2018) described "success" as:



- "Unhindered access to services."
- Prevention
- Early intervention
- Affordable
- "Feeling normal & that others aren t always making fun of them."
- Reduced stigma
- Latino families have same access to service.
- Access to services regardless of location.
- Services are available when they are needed.
- Care is provided by highly trained, compassionate providers.

Assets and Strengths in Rural and Frontier Nevada

In the development of this long-term plan, the RCMHC recognized the need to continue expanding and enhancing successes of the prior long-term plan and general strengths in rural and frontier Nevada. In doing so, the RCMHC "Community Discussion" events asked stakeholders for their perception of the strengths and assets in their local communities. The following lists and describes some of that input:

- There is a sense of community
- Community coalitions are effective at facilitating collaboration/partnerships
- Youth are involved
- Local providers are compassionate
- Mental Health First Aid programs
- Safe Talk programs

- Family/peer groups & training
- Social Workers in schools
- Signs of Suicide (SOS) & other training programs
- Juvenile justice systems' assessment and diversion programs

Nevada continues to fund the Rural Mobile Crisis Response Team. This program facilitates a quick entry point into mental health services for youth and families. The addition of a Crisis Case Manager to the Team has improved services to families and the Case Manager helps the family navigate barriers to mental health services and helps find resources in the family's home communities. Continued funding for this vital program is needed as well as marketing to let families know there are resources that can help.

Federal and State funding continues to support Certified Community Behavioral Health Clinics (CCBHC's). There are now several CCBHC's in rural communities. The clinics provide an array of services including immediate mental health assistance, case management, outpatient services, mediation clinics and crisis intervention. These Clinics are vital in providing community-based services to rural youth and families.

Telehealth has become a viable option for rural families. Numerous providers such as Pacific Behavioral Health, United Citizens Foundation, Your Choice Behavioral Health and Virtual Nevada serve rural families through telehealth. Part of the success of these services has been possible through Nevada Medicaid's approval for payment of telehealth services. In addition, insurance providers are recognizing telehealth as a reimbursable service and many of the providers take Fee For Service Medicaid. The Nevada Department of Health and Human Services, Division of Public and Behavioral Health (DPBH), Rural Clinics program continues to partner with telehealth providers, allowing them to utilize office space and technology when there is none available in remote communities. This allows families more treatment options.

Funding for school social workers and programs like Project Aware has been successful in helping identify yearly signs of mental health distress in school aged youth. School based social workers have been able to provide valuable preventive services, early identification of mental health symptoms and linkage to community services. The RCMHC commends the partnership between the Nevada Department of Health and Human Services and the Department of Education in the ongoing development of options to expand and sustain school-based mental health services.

The RCMHC Community Discussion Events, Community Coalitions, and the Behavioral Health Policy Boards have been instrumental in helping break down silos in rural communities. Communities and counties are coming together to work towards an improved mental health system for Rural and frontier Nevada. NAMI of Western Nevada has also been implemental in providing training and support for families who are caring for a child with a mental illness.

Additionally, the Nevada Department of Health and Human Services, Division of Child and Family Services (DCFS) has successfully continued to apply and receive grants to support youth mental health in rural and frontier Nevada. Recently they received two grants targeted for rural and frontier Nevada youth and families: The Pediatric Mental Health Care Access Program which supports pediatricians, practicing in rural and frontier Nevada, to identify, treat and make referrals for early intervention of mental health symptoms. The other grant is another System of Care Expansion grant designed to expand the Nevada System of Care (hereinafter "Nevada SOC") to rural and frontier Nevada.

Barriers, Gaps, and Priorities in Rural and Frontier Nevada

Collectively, the rural and frontier counties of Nevada account for approximately 9.5% of the state's population and is spread across an expansive 86.9% of the state's land mass (Griswold, Packham, Etchegoyhen, Young, & Friend, 2019). The predominate issues impacting mental health in rural and frontier Nevada are complex and intensified by two primary challenges: limited access to services due to geographic distance and insufficient provider availability. In rural and frontier Nevada, it remains that 100% of the population resides in a mental health professional shortage area (Griswold, Packham, Etchegoyhen, Young, & Friend, 2019). The Northern Nevada Behavioral Health Policy Board (2019) identified gaps and needs for the northern region of the state (not including Washoe County). The following lists some of those identified gaps and needs as they relate to children's mental health (p.24-29):

- 24/7 youth behavioral health crisis response
- Sustainable funding and expansion of youth mental health diversion programs
- Identification and funding for evidence-based youth treatment and interventions for juvenile justice diversion
- Behavioral health professionals capable of treating youth
- Lack of clinical internship sites
- Options for non-emergency behavioral health transport for mental health crisis holds
- Need for crisis triage centers in strategic locations in rural counties allowing individuals to stay in their communities, reduce unnecessary long-distance travel, and reduce pressure on urban counties

In the development of a strategic plan to integrate behavioral health into the Olmstead Plan framework, the following priorities related to youth were established (Nevada Division of Public and Behavioral Health, 2018, p. 3).

- Juvenile justice diversion
- Residential treatment facility capacity, discharges, and linkages to services,
- Transitional age youth services
- Access to services: crisis services, partial hospitalization, intensive outpatient, day treatment, wraparound, respite, family peer support, and habilitation services

During the "Community Discussion" event in Tonopah (2019), stakeholders participated in a discussion to recommend priorities for the RCMHC long-term plan. The top 3 areas of need identified by the participants were:

- Increase early detection and treatment in schools
- Family support and education
- Transportation services.

During the discussion, participants also indicated that families and youth often don't know where to go to get help and that they do not have quick access to quality care.

Key Partnerships

Nevada's vast rural and frontier space with 3 urban centers is united in its understanding of the needs and opportunities for children's mental and behavioral health across the state. As such, the RCMHC does not and will not operate in a vacuum or with a "rural only" approach. System-wide changes require collaboration with the Washoe and Clark children's mental health consortia, the Statewide Mental Health Consortium, and the Nevada Behavioral Health Policy Boards. Our goals and strategies are aligned with our key partners and we intend to leverage resources while maximizing impact through collaborative efforts. In doing so, we will be able to advocate for the needs of Nevada's rural and frontier communities while improving the state's overall system of services and supports for children, youth, and families/caregivers.

Data Collection

The RCMHC notes the difficulty in gathering comprehensive and informative data to describe the needs of children and their families across the rural and frontier regions of the state. The Nevada Department of Health and Human Services is commended for making great strides in compiling and making data publicly available. There remains a need for the "translation" of this data to useable baseline and outcome measures. Data is still compartmentalized to specific Divisions and programs and requires extensive expert research resources to manage and interpret for an overall understanding of children's mental and behavioral health needs and outcomes. Thus, the data included in this report is a snapshot of readily available information, but is missing comprehensive interpretation. The RCMHC is intentionally noting this challenge *as a need* to be addressed in the long-term plan with associated objectives related to gathering more data to better describe and measure the needs of children, youth, and families in rural and frontier Nevada. This effort has already begun with the RCMHC collaboration with the University of Nevada Reno, School of Medicine, Office of Statewide Initiatives (the entity responsible for the publication of the *Nevada Rural and Frontier Health Data Book).*

Children's Mental Health in Rural and Frontier Nevada

Nevada ranked 51st place in Mental Health America's (MHA) state rankings for youth mental health indicating that youth in Nevada have a higher prevalence of mental illness with lower rates of access to care (MHA, 2019). "The problem is particularly severe in the state's rural and frontier counties, where the burden of ensuring that people in need of acute mental health care receive treatment often falls on the shoulders of rural emergency rooms and law enforcement" (Messerly, 2018). Resources in rural communities are depleted with extensive waits in emergency departments and lack of transportation for individuals needing psychiatric hospitalization. In addition to the lack of services, the UNLV Center for Health Information Analysis (CHIA) reports from 2009-2013 emergency departments and in-patient psychiatric hospitals in Nevada showed an astonishing increase in admissions due to behavioral health crises. Mood disorders, including major depression, dysthymic disorder and bipolar disorder are the third most common cause of hospitalization in the U.S. for both youth and adults (Weir, et al., 2011). And 37% of students with a mental health condition age 14-21 have the highest education dropout rate of any disability group (DOE, 2014). Alcohol-related disorders and mood disorders were two of the most common conditions that showed a major increase between 1997 and 2009 for uninsured hospitals stays.

Stakeholder Input

During the Consortium s 2nd Community Discussion Event stakeholders and attendees were asked to identify barriers they see in their communities when it comes to mental health services. Not surprisingly, the barriers were very similar which included: cost of services, navigating insurance providers, poverty, no follow up care, families not knowing how to access services, proximity of services, and transportation. Also, important to note, is the consensus that many services are lacking family involvement and peer supports. These barriers accumulate, resulting in families not reaching out for services because the mental health system in rural and frontier Nevada is so difficult to navigate. For example:

- A rural sheriff deputy had to transport a suicidal youth and her mother to the closest psychiatric hospital which was 4 hours away. Besides the family having to ride in the back of a sheriff vehicle, this arrangement left the rural community down a deputy for 9 hours and it also left the mother in Reno with no resources and no way home.
- In a rural hospital, a child was suicidal and needed transportation to a psychiatric hospital, which was hundreds of miles away. The family did not have the means or the funds to drive their child to the psychiatric hospital. Because of this, the hospital called Child Protective Services and made a report of medical neglect due to the family's "failure to provide transportation" for their child.

- A youth, who had been in acute psychiatric hospitals several times, needed longer-term residential treatment. The family worked with a psychiatric case manager to help find residential treatment that would take their insurance and had openings. Even with the case manager helping the family, it took 8 weeks to find a residential placement for the youth and the placement ended up being out-of-state. During the 8 weeks of trying to find placement for this youth, the family had no options but to try and maintain their child in their home. The mother had to quit her job to stay with the youth and their other children went to live with relatives to ensure their safety while the family exhausted every effort to find their child treatment.

Mental health is important for individual, family and community health, well-being and productivity. It is unacceptable that rural mental health concerns have not been adequately addressed and that accessible services are scant. With half of all chronic mental illness beginning by age 14, three quarters by age 24, and with suicide as the 2nd leading cause of death among people ages 10-34; the consequences of not funding mental services for youth and adults in rural and frontier Nevada will result in the continuation of our residents, living with mental illness, to be overlooked and disregarded (NAMI, 2019). Children and families in rural and frontier Nevada deserve the same treatment opportunities as those in Nevada's urban cities, with funding to support programs they can quickly access in their home communities.

Children in Rural and Frontier Nevada

There are approximately, 77,025 children and youth age 19 and under residing in rural and frontier Nevada (Nevada Kids Count, 2019). The largest percentage of rural and frontier children ages 9 or younger reside in Humbolt County (15%) and the largest percent of youth ages 10-19 reside in Lincoln county (14%) (Nevada State Health Needs Assessment, 2019). As Nevada's population is projected to grow, the percentage of the population comprising individuals from historically marginalized populations is also expected to grow – this trend is already visible in Nevada schools with over 50% of students enrolled in Nevada's urban counties representing a historically marginalized group (Nevada State Health Needs Assessment, 2019). This trend is also expected in some of Nevada's rural and frontier regions. Importantly, the *Nevada Health Needs Assessment* (2019) reports that one of the most critical health disparities in health outcomes is socioeconomic status (i.e. education, employment, and income) and that socioeconomic status is a strong predictor of health. Essentially, poverty is a "critical risk factor" for mental and behavioral health disorders among children and youth and, nationally, 20% of children under age 18 live below the federal poverty line with poverty (Yoshikawa, Aber, & Beardslee, 2012, p. 272). Additionally, given that "many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live," the following data aims to describe those conditions for children, youth, families/caregivers in rural and frontier Nevada (WHO, 2014, p. 8).

Nevada County	Children under 18 Years Nevada State Demographics Projections (2017) Nevada Kids Count p7-8	% NV	Est. % Children under 18 years in Poverty (2016) US average 19.5%		Est. Single Women/Children Dependents US 35.7% NV 31% (NV Health Needs Assessment,2019)	16.5% at least one dx mental health disorder At least 50% receiving no treatment. (Whitney & Peterson, 2019)
Carson (Urban)	12,271	1.9%	20.1 %	2,196	36.0%	2,025 1,013
Churchill (Frontier)	5,986	0.9%	20.7%	1,127	55.8%	988 494
Douglas (Rural)	8,364	1.6%	15.4%	1,263	22.4%	1,380 690
Elko (Frontier)	11,303	1.8%	13.1%	1,851	36.9%	1,865 933
Esmerelda (Frontier)	89 <0.1%		20.2%	25	50%	15 7
Eureka (Frontier)	359	0.1%	10.0%	750	NA	59 30
Humboldt (Frontier)	4,296	0.6%	16.3%	43	31.7%	709 355
Lander (Frontier)	1,426	0.2%	14.0%	208	68.9%	235 118
Lincoln (Frontier)	870	0.2%	18.1%	200	50.0%	144 72
Lyon (Rural)	11,728 1.8%		19.7%	2,214	37.4%	1,935 966
Mineral (Frontier)	903	0.2%	27.8%	226	46.2%	149 75
Nye (Frontier)	8,081	1.5%	25.9%	1,866	46.7%	1,333 667
Pershing (Frontier)	1,087	0.2%	19.3%	220	68.6%	179 90
Storey (Rural)	525	0.1%	13.8%	69	NA	87 44
White Pine (Frontier)	1,941	0.3%	19.5% 382		45.1%	320 160
Clark (Urban)	536,774	73.4%	20.7% 103,069		33.4%	88,568 44,284
Washoe (Urban)	105,634	15.2%	16.7% 16,300		22.6%	17,430 8,715

Prevalence rates for mental health disorders and mental health care access described above were calculated from a study published in the Journal of American Medical Association, Pediatrics (Whitney & Peterson, 2019). The 16.5% prevalence and the evidence suggest that the rate of not receiving care in children with mental health disorders is 53.2 -72.2%. Therefore, our model with 50% estimates not receiving any services for treatable mental health conditions is conservative as social determinants may be less favorable and access less available in the Nevada rural and frontier regions.

Additionally, mental health services for families living in Nevada are fragmented and often focus on controlling symptoms rather than focusing on life course functioning. Nevertheless, initiatives that assist systems of care coordination have demonstrated a reduction of mental health-related burdens across multiple domains (Whitney & Peterson, 2019). The following describes youth in Nevada as they interact with specific systems (i.e. juvenile justice and school).

Nevada County	Children under 18 Years Nevada State Demographics Projections (2017) Nevada Kids Count p7-8	% NV	Youth ages 10-17 years	Referred to Juvenile Court 2017	Incidents of Violence in Schools 2016-2017 - suspensions - expulsions	Incidents of Bullying Reported and Determined
Carson (Urban)	12,271	1.9%	10,792	680	81	39/25
Churchill (Frontier)	5,986	0.9%	3,816	572	121	22/17
Douglas (Rural)	8,364	1.6%	9,427	290	6	64/38
Elko (Frontier)	11,303	1.8%	9,720	681	13	65/25
Esmerelda (Frontier)	89	<0.1%	NA	0	0	0
Eureka (Frontier)	359	0.1%	301	6	0	0
Humboldt (Frontier)	4,296	0.6%	3,527	299	75	27/10
Lander (Frontier)	1,426	0.2%	979	87	4	41/27
Lincoln (Frontier)	870	0.2%	1,040	10	2	6/0
Lyon (Rural)	11,728	1.8%	7,979	860	94	92/42
Mineral (Frontier)	903	0.2%	591	13	0	-/16
Nye (Frontier)	8,081	1.5%	8,047	313	245	154/143
Pershing (Frontier)	1,087	0.2%	1,332	119	11	3/0
Storey (Rural)	525	0.1%	504	10	2	3/2
White Pine (Frontier)	1,941	0.3%	1,357	86	17	14/14

Nevada County	Children under 18 Years Nevada State Demographics Projections (2017) Nevada Kids Count p7-8 % NV	Total Public School Enrollment (not including charter)	Individual Education Plans (IEPs) 2016-2017	Free and Reduced Lunch (FRL)	Graduation Rates by School District 2016-2017 p. 67
Carson (Urban)	12,271 1.9%	7,815	1,104	4,049 (51.8%)	83.9%
Churchill (Frontier)	5,986 0.9%	3,196	485	1,579 (49.4%)	73.3%
Douglas (Rural)	8,364 1.6%	5,932	872	1,822 (30.7%)	87.5%
Elko (Frontier)	11,303 1.8%	9,907	1,222	3,314 (33.5%)	88.5%
Esmerelda (Frontier)	89 <0.1%	75	10	41 (54.7%)	--
Eureka (Frontier)	359 0.1%	276	26	63 (22.8%)	100%
Humboldt (Frontier)	4,296 0.6%	3,399	496	1,588 (46.7%)	89.5%
Lander (Frontier)	1,426 0.2%	1,004	123	250 (24.9%)	92.3%
Lincoln (Frontier)	870 0.2%	1,085	169	507 (46.7%)	86.1%
Lyon (Rural)	11,728 1.8%	8,348	984	4,626 (55.4%)	83.6%
Mineral (Frontier)	903 0.2%	518	83	265 (51.2%)	84.4%
Nye (Frontier)	8,081 1.5%	5,032	781	3,254 (64.7%)	79.3%
Pershing (Frontier)	1,087 0.2%	627	89	214 (34.1%)	100%
Storey (Rural)	525 0.1%	425	73	121 (28.5%)	90.6%
White Pine (Frontier)	1,941 0.3%	1,390	209	507 (36.5%)	69.9%

Rural and Frontier Nevada including Carson City (Urban), Kids Count 2017

Children ages 17 and under page 24	70,729
Based on JAMA (2019) Mental Health Diagnosis Prevalence at 16.5% rate **At least 50% untreated**	**16,670** **5,835**
Children ages 17 and under uninsured page 24	5,407
Grandparents living with grandchildren 17 and under page 47	6,394
Grandparents responsible for grandchildren page 47	3,031
Children in foster care page 83	663
Children entering foster care during 2016 page 83	244
Two or more foster placements first year page 83	48
Children leaving foster care during 2016 page 83	273
Finalized adoptions during 2016 page 83	89
Children with at least 1 parent incarcerated page 97	1,565

Child Abuse and Neglect Substantiated Allegations: Rural, Frontier and Carson Counties (2016)

Mental Injury Abuse	2
Mental Injury Neglect	2
Medical Neglect	8
Abandonment	10
Inadequate Supervision	171
Failure to Protect	97
Parental Homicide	2
Inadequate Food	2
Inadequate Shelter	42
Environmental Neglect	93
Educational Neglect	14
Physical Injury Abuse	57
Physical Injury Maltreatment	124

Substance Abuse	1
Substance Misuse	4
Tying Confinement	1
Physical Risk Abuse/Maltreatment	5/118
Burns/Scalds	3
Fractures	4
Bruises, Cuts/Bruises Maltreatment	42/1
Head injury	1
Sexual Abuse	9
Substance Exposed Infant	13

Additionally, in summarizing available statewide data, the Northern Regional Behavioral Health Policy Board (2019), reports that northern Nevada school students experience mental health risk behaviors (middle school) and suicide risk (high school) at higher rates than students statewide. Additionally, middle school and high school youth in northern Nevada who report ever having a drink of alcohol is higher than the statewide percent. Notably, "the most common method for attempted suicide was substance use or drug overdose" (Northern Nevada Behavioral Health Policy Board, 2019, p. 14).

Goals

The World Health Organization (WHO) states that community-level action "provides a platform to develop and improve social norms, values and practices, while encouraging community empowerment and participation" (WHO, 2014, p. 30). The RCMHC is this platform in rural and frontier Nevada. As such, the perspectives and influence of social determinants have been considered in our rural Nevada baseline data and in the development of our goals. Factors such as poverty, food insecurity, single parent homes, and other impacts of adverse social conditions must be considered while promoting well-being and unhindered access -- when combined, should be considered a social justice issue. The needs, gaps, priorities, and strengths described above informed the development of the long-term plan goals.

Thus, the RCMHC will accomplish the above-stated mission by facilitating a network of youth, families, caregivers, providers, and policy-makers who are committed to developing a System of Care in rural and frontier Nevada. We aim to strengthen strategic partnerships, monitor overall progress, provide feedback to key decision makers, inform the alignment of policies and procedures, and advocate on behalf of youth and their families/caregivers. Given this, the RCMHC has established the following goals:

> **Goal 1:** Expand and sustain the Nevada System of Care to rural and frontier Nevada
>
> **Goal 2:** Increase access to mental and behavioral health care.
>
> **Goal 3:** Increase access to treatment in the least restrictive environment.
>
> **Goal 4:** Increase health promotion, prevention, and early identification activities.
>
> **Goal 5:** Develop, strengthen, and implement statewide policies and administrative practices that increase equity in access to mental and behavioral health care for youth and families.

Objectives and Deliverables

The following describes the goals, objectives and deliverables that will guide the Consortium over the next 10 years. A review of accomplishments and benchmarks will be conducted annually with modifications to the goals and objectives as appropriate based on outcomes. The following also links the goals and objectives to key strategies. A list of those strategies with associated process and outcome measures follows this section.

Goal 1: Expand and sustain the Nevada System of Care to rural and frontier Nevada.

Objectives	Deliverables	Key Strategies (see below)
Objective 1A: Facilitate youth, family, and provider voice through all stages of the expansion and sustainability.	• Annual "Community Discussion" Events • Regular Consortium meetings with dedicated "Youth and Family Voice" agenda items • Consortium member(s) participate in SOC planning activities as appropriate.	1-6
Objective 1B: Establish the RCMHC as a SOC point-of-contact for youth, family, and provider voice.	• Annual "Community Discussion" Events • Regular Consortium meetings with dedicated "Youth and Family Voice" agenda items • Consortium member(s) participate in SOC planning activities as appropriate.	2,4,5,6
Objective 1C: Support statewide implementation of the Child and Adolescent Needs and Strengths (CANS) as a common assessment tool to increase assessment and access to coordinated care.	• Disseminate training and other information as prepared by the Nevada SOC. • Provide feedback to the Nevada SOC on implementation progress, provider needs, and youth and family experiences.	2,3,5,6
Objective 1D: Support Nevada SOC expansion activities including, but not limited to: "No Wrong Door" approach, Tiered Care Coordination, and the SOC Provider Designation System.	• Disseminate training and other information as prepared by the Nevada SOC. • Provide feedback to the Nevada SOC on implementation progress, provider needs, and youth and family experiences. • Consortium member(s) participate in SOC planning activities as appropriate.	1-6

Goal 2: Increase access to mental and behavioral health care.

Objectives	Deliverables	Key Strategies (see below)
Objective 2A: Identify barriers for youth and families in accessing mental and behavioral health care and coordinate appropriate solutions.	• Examine the needs and develop a plan to address barriers in access to care related to transportation. • Facilitate partnerships necessary to institutionalize school social workers and implement services and supports that promote early detection in schools.	1,2,4,5
Objective 2B: Facilitate the development and implementation of a health equity plan in accordance with recommendations from the Substance Abuse and Mental Health Services Administration's (SAMHSA) national standards for culturally and linguistically appropriate services (national CLAS standards).	• Consortia members will obtain and/or participate in technical assistance and "toolkit" options for the development of health equity plans. • Consortia members will pilot the development and implementation of health equity plans. • Scaling this strategy will be assessed following pilot testing and capacity development.	3,4,6
Objective 2C: Facilitate an organized provider continuum with the expansion of services according to the System of Care recommended service array (see Stroul, B., et al., 2015, p. 5).	• Conduct and/or facilitate an in-depth analysis of the current capacity to meet the need and identify gaps in access to treatment, areas in need of enhancement, and new service development opportunities. • Develop and implement a plan to address the identified needs and gaps in access to treatment. • Facilitate the expansion of respite services for families and caregivers, in particular, those who are not eligible for respite services offered by the child welfare system (i.e. non foster care families) including out-of-home care as a respite option. • Facilitate the expansion of family peer support services. • Facilitate the expansion, training, and support of a rural-based workforce.	1-6

Goal 3: Increase access to treatment in least restrictive environment.

Objectives	Deliverables	Key Strategies (see below)
Objective 3A: Divert youth in need of care from juvenile justice systems to community-based care.	• Facilitate the development and implementation of assessment and access to treatment services for all youth in juvenile justice.	3,5,6
Objective 3B: Divert youth in need of care from hospitals or other psychiatric emergency care to community-based care.	• Support the ongoing expansion and promotion of the children's Mobile Crisis Response Teams (MCRT), specifically the expansion of the clinical response service to be offered 24 hours per day/7 days a week. • Develop and disseminate communication material to increase awareness of MCRT. • Partner with the Behavioral Health Policy Boards to institutionalize a process for implementing a common assessment tool for youth in crisis and linking them to treatment options.	3,5,6
Objective 3C: Increase access to an array of transitional services for youth returning to their homes after inpatient care.	• Facilitate the development and implementation of a plan to fill gaps and strengthen existing transitional services and supports.	3,5,6

Goal 4: Increase health promotion, prevention, and early identification activities.

Objectives	Deliverables	Key Strategies (see below)
Objective 4A: Facilitate community-based youth, parent, and caregiver training (in-person and online).	• Develop and implement information activities focused on the availability and confidentiality of telehealth services. • Develop and implement information activities focused availability and confidentiality of school-based care. • Develop and implement information activities focused availability and confidentiality of family peer support services. • Maintain the Rural Children's Mental Health Consortium website as a source of health promotion messages and a schedule of upcoming activities and trainings.	1,2,3,5

Goal 5: Develop, strengthen, and implement statewide policies and administrative practices that strengthen equity in access to mental and behavioral health care for youth and families.

Objectives	Deliverables	Key Strategies (see below)
Objective 4A Advocate for a unified and integrated system for children's mental health.	• Maintain active involvement in the behavioral health policy boards for regions impacting rural and frontier Nevada counties. • Facilitate regular meetings with key decision makers, policy boards, commissions, and workgroups that are integral to policy and administration for	1-6

	children's mental health. Within such meetings, communicate findings from Community Discussions, Youth and Parent Voice, Providers, and priorities. • Examine the impact of the current bifurcated system for the provision of state-funded services on children, youth, and their families/caregivers. • Facilitate and advocate for a system-level response that aligns funding and develop an action plan to address results of the examination.	

Key Strategies

The following list of key strategies cross-cut the goals and action items listed above. The strategies will be implemented each year according to needs identified and resources available and will vary from year-to-year. Progress on the implementation of the strategies with recommended updates to the strategies will be reported on an annual basis.

Strategy	Process Measures	Outcome Measures
1. **Community Discussion Events**: Annually, the Consortium will coordinate the event modeled after previous events. The locations will rotate through rural communities to increase engagement and opportunities to gather and disseminate information.	• Number of events, • Description of events, • Number of attendees, and • Youth and family involvement in planning and implementing events.	• Attendee reported increase of knowledge and awareness, and • Attendee reported satisfaction, attendee reported collaborations.
2. **Communications**: Further develop and maintain Consortium website, hold public meetings according to Nevada Open Meeting laws, implement information campaigns, implement public service messages, engage in social	• Number and types of messages, • Number of individuals exposed to messages, and • Social media and website analytics.	When appropriate, • Recipient reported increase of knowledge and awareness, • Recipient reported satisfaction, • Recipient reported intended action, and

Strategy	Process Measures	Outcome Measures
media communications, conduct individual outreach.		• Service utilization rates.
3. **Training**: Facilitate the delivery of in-person and online trainings for providers, youth, families, and caregivers on topic areas related to the goals and recommended by participants of Community Discussion events.	• Number of trainings, • Description of trainings, • Number of attendees, • Geographic location of attendees, and • Number of training by delivery model (in-person, online).	• Attendee reported increase of knowledge and awareness, • Attendee reported satisfaction, • Attendee reported intended action, and • Overall geographic "reach" of trainings in rural and frontier Nevada.
4. **Data Collection and Reporting:** Conduct ongoing data collection and analysis of to children's mental health needs in rural and frontier Nevada (i.e. understanding youth, family and caregiver needs, analyzing system-level capacity, assessing policy context and needs).	• Number and types of reports/analyses developed, • Action plans developed as a result of reports/analyses, • Description of how, when and audience of disseminated, and • Number and type of events utilized to collaborate on developing the reports and/or collaboration on the response to report findings.	• Extent to which action plans are implemented in accordance with report findings and recommendations.
5. Key Partner Development and Collaboration: Networking and collaborative facilitation with other children's health oriented decision making bodies, service providers, advocacy groups, and youth/family stakeholder groups (i.e. facilitating cross agency partnerships).	• Number and types of collaborative events and meetings coordinated and/or attended by Consortium members, • Youth and family involvement in planning and implementing events, • Number of new Consortium members and guests, and • Number of Consortium members and guests attending meetings	• Extent to which collaborative efforts result in system-level changes that impact stated goals.

Strategy	Process Measures	Outcome Measures
6. **Policy and Administrative Practice Influence:** Engage in policy, regulation, and procedural development activities to provide input, feedback, and recommendations.	• Number and types of policy, regulatory, and/or procedural meetings coordinated or attended by Consortium members, and • Youth and family involvement in the meetings, and • Number and type of changes enacted.	• Changes in access to services, • Changes in support for Consortium recommendations, • Inclusion of youth and family input and policy and administrative practice development.

Implementation

The implementation of the long-term strategic plan will be facilitated by the RCMHC 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 RCMHC may develop sub-committees, as appropriate, to implement the plan. On an annual basis, the RCMHC 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 RCMHC 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 RCMHC acknowledges the ongoing administrative and structural support of the DCFS. This support is critical to the implementation success of the long-term plan as the DCFS manages the budget, facilitates contracts as determined by the Consortium, provides guidance on public meeting facilitation, and prepares reports as requested. Additionally, the RCMHC

acknowledges that much of its success is contingent upon the active involvement of its members, their respective organizations, and local business support.

The RCMHC 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 RCMHC strategies. The RCMHC 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 RCMHC will utilize its resources and strategies to support this approach across all child-serving systems and providers.

The RCMHC 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 RCMHC will utilize its budget to the greatest extent feasible to contract services and develop other supports to overcome such barriers. Annually, the RCMHC 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 RCMHC respectfully submits this long-term strategic plan as a roadmap for achieving its vision of children and youth in Nevada being healthy and well with unhindered access to care. 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 rural and frontier Nevada. 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 RCMHC for their input, feedback, and tireless advocacy on behalf of children, youth, and their families/caregivers in rural and frontier Nevada.

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