

Rural Children's Mental Health Consortium (RCMHC)
Strategic Ten-Year Plan



Table of Contents

Executive Summary.....3

Background.....4
Rural Children’s Mental Health Consortium
Mission, Vision, and Achievements
Plan Development Process
Systems of Care

Childhood Mental Health Plan.....8
Assessment of Need from Prevention to Intensive Treatment
Documentation of the Number of Children Who are not Receiving Services
Obstacles to Providing to Services to Children not Receiving Services
Methods for Overcoming Obstacles
Eligibility for Services
Methods for Accessing Services

Children and Family Mental Health Challenges.....11
School-Based Mental Health
Child Welfare
Juvenile Justice and Mental Health
Infant Mental Health and Early Intervention
Substance Abuse Prevention and Treatment
Suicide Prevention and Survival and Crisis Assessment
At-Risk/Multiple Risk: Co-morbidity; Complex Family

Logic Model Approach.....15
Definition
Evidence Based Practice
Services to be Provided
Priorities of Services for Plan Implementation
Manner in which Family Members will be Involved
Allocation of Costs
Methods to Obtain Additional Funding: Costs and Funding Sources
Logic Model Application including: Goals, Objectives, Strategies, and
Activities.....18

Appendices.....22
Appendix A—Rural Nevada Demographic Characteristics and Epidemiological
Data
Appendix B—*Infant Mental Health White Paper*
Appendix C—Children in State Custody by County and Age, Rural Regions
Appendix D—Nevada PEP, Statewide Family Network Principles
Appendix E—References

Executive Summary

As Nevada's Rural Region looks into the future, a marked need for mental health services for children and their families becomes apparent in the next decade. The Rural Children's Mental Health Consortium (RCMHC) Strategic Ten-Year Plan is a roadmap for children's mental health services in Nevada's Rural Region that supports individual rural communities through connectivity, collaboration, and advocacy. Systems of Care development occurs through a deliberate process of integrating technical assistance into funding oversight that will help rural communities effectively meet their mental health needs. This process will translate research into evidence-based interventions through grassroots and self-directed practices. Moreover, Systems of Care values and principles will be utilized when working with children that have mental health and behavioral disorders. These values recognize an individual's needs, strengths, and family culture by means of serving children within their own community.

School-based mental health services are the most appropriate method for targeting and expanding children's mental health system in Nevada's Rural Region during the next ten years. The American Academy of Pediatrics (2004) has developed policy and support of school-based mental health services, which has improved access to, diagnosis of, and treatment for mental health problems in children. Preventive strategies will focus on building upon community strengths to establish a child- and family-centered, problem-focused approach. A first tier mental health service can be incorporated into health curricula, behavior management, and discipline plans ultimately building early identification, violence prevention within a supportive environment.

Diversity encompasses values, beliefs, and practices that are different or perceived as different from one's own. Supporting diversity is an integral part of the RCMHC mission. Every child and family is unique, thus mental health practices must be judiciously applied in terms of individual elements and variables. The RCMHC supports a System of Care that strives towards unity in practices and principles.

There comes a time when a call is opportune and urgent in the life trajectory of the individual child. In Nevada's Rural Region, that time is now. The can-do spirit and rural sense of rugged individuality in Nevada's Rural Region are two of our greatest natural resources. We must use those assets to the benefit of the mental health needs of children and their families.

Background

Legislative Mandates

The Nevada Rural Children's Mental Health Consortium (RCMHC) was established under Nevada Revised Statute (NRS) 433B.333. The Consortium is comprised of a coalition of professionals, policy makers, agency personnel, community representatives, volunteers and concerned citizens, advocates, family members, and youth. Since 2002, the Consortium has developed and submitted plans to the Nevada Department of Health and Human Services for the provision of services to emotionally disturbed children in the rural Nevada. During the 75th Regular Session of the Nevada Legislature, 2009, Senate Bill 131 was recorded into statute to expand the consortia membership, to authorize one legislative measure per regular session, and to further require each regional Consortium to develop long-term strategic plans for the provision of mental health services to children with emotional disturbance.

Mission, Vision, Achievements

NRS 433b.335 Recommended plans for provision of services to children with emotional disturbance: Preparation by consortia; requirements; submission to Department.

1. Each mental health consortium established pursuant to [NRS 433b.333](#) shall prepare and submit to the Director a long-term strategic plan for the provision of mental health services to children with emotional disturbance in the jurisdiction of the consortium. A plan submitted pursuant to this section is valid for 10 years after the date of submission, and each consortium shall submit a new plan upon its expiration.
2. In preparing the long-term strategic plan pursuant to subsection 1, each mental health consortium must be guided by the following principles:
 - a. 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.
 - b. 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.
 - c. The system of mental health services should be community-based and flexible, with accountability and the focus of the services at the local level.
 - d. The system of mental health services should provide timely access to a comprehensive array of cost-effective mental health services.
 - e. 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.
 - f. Comprehensive mental health services should be made available in the least restrictive but clinically appropriate environment.
 - g. The family of a child with an emotional disturbance should be eligible to receive mental health services from the system.

Mission:

The Rural Children’s Mental Health Consortium advocates for the continuum of accessible community-based mental health services for families, children, and adolescents in Nevada’s Rural Region.

Vision:

Through a process of a reflection and deliberation, the Rural Children’s Mental Health Consortium developed a vision that incorporates connectivity, collaboration, and advocacy.

Connectivity- Facilitating grassroots efforts for evidence-based family-centered approaches to children’s mental and behavioral health concerns.

Collaboration- Developing public-private partnerships to promote and implement *System-of-Care* principles.

Advocacy- Serving as a voice for rural communities in the legislative and policy-making processes.

ACHIEVEMENTS

Received statutory ability to propose biannual Bill Draft Requests.

Created annual plans and provided recommendations with respect to services and needs of rural communities.

Surveyed the state of mental health services in rural Nevada public schools.

Established legislative voice by testifying on behalf of Nevada’s Rural Region families and community stakeholders.

Organized and implemented trainings and focus groups conducted by members of the Consortium.



Assessed existing mental health services and current needs with regards to rural communities.

Developed relationships & resource coordination in the Rural Nevada Region.

Utilized trained clinicians in the DC: 0-3R model (Diagnostic Classification of Mental Health and Developmental Disorders of infancy and early childhood).

Promoted parent involvement on various levels of planning & policy-making.

Plan and Development Process

In a series of workgroup meetings with community partners and stakeholders across Nevada’s Rural Region, the RCMHC identified community needs and resources, discussed local strengths and barriers, and invited partners and stakeholders to contribute to the development of this plan. The Consortium Chair, Jan Marson, met individually with Nevada Statewide Coalition Partnership Rural County Directors and attended community meetings to receive collaboration and input on the plan and to discover the provision and need of rural mental health services. Specifically, the Consortium identified Lovelock as an area of focus due to a partnership with a former RCMHC member, Richard Tree. The Lovelock community demonstrated the can-do rural Nevada attitude through high levels of community involvement and a strong school system. The RCMHC met over a period of several months to organize, create, and revise the strategic plan. In this planning process, the Consortium selected the Logic Model for the construction of the plan.

Systems of Care

All Consortium activities and plans are dedicated to the Systems of Care principles outlined by Nevada Children’s Behavioral Health Consortium, which has formally endorsed and committed itself to Nevada’s System of Care philosophy and attributes. Multi-systemic solutions must be considered at this critical crossroads for children and families living in Nevada’s Rural Region with emotional and behavior health concerns. Children that have been identified, or are already at-risk for mental health disorders, may be best served through individualized care plans that are delivered by a core entity and supported through various funding streams.

Childhood Mental Health Plan

In order to meet the mental health needs of Nevada's children, stakeholders must further develop a referral program and increase access. The Consortium advocates for a coordinated and integrated Systems of Care that includes screening and referral to assessment; planning and coordination; and access to indicated mental health levels of care. Child mental health and well being can be promoted through surveillance, prevention, and early intervention across Systems of Care. Systems of Care must include but should not be limited to: early intervention, education, child welfare; juvenile justice and any child that has been identified at-risk or in possible need of mental health services.

Assessment of Need from Prevention to Intensive Treatment

According to the US Surgeon General's report on children's mental health (2001), 20% of children are in need of mental health interventions with 5% suffering from extreme functional impairment. Areas of concern include: (a) school-based services, (b) child welfare services, (c) juvenile justice and mental health services, (d) infant mental health services, (e) substance abuse prevention and treatment services, (f) suicide prevention and survival and crisis assessment services, and (g) the diverse and complex needs of co-morbid conditions and at-risk children from multi-problem families.

Documentation of the Number of Children Who are not Receiving Services

Although we do not have complete and accurate figures regarding the number of children who are not receiving services, using the US Surgeon General's mental health statistics, Nevada's average could be estimated from 5% to 20% in any rural community. Given information regarding Nevada's children, the available data indicates that children's mental health services are limited in Nevada's Rural Region.

Obstacles to Providing Services to Children not Receiving Services

- Distance and time between communities to access services.
- Limited milieu of services in rural communities.
- Workforce in-service for new employment opportunities.
- Variability of complex cases and low incidence diagnoses.
- Lack of awareness and motivation to obtain mental health services.
- Socioeconomic resource issues related to time, transportation, and financial capability.

Methods for Overcoming Obstacles

- Harnessing grassroots spirit of rural and frontier communities.
- Understanding rural communities from their unique perspective.
- Creating multidisciplinary assessment and planning.
- Implementing competency-based approaches to workforce training and development.
- Developing alliances with state universities and colleges to include collaboration and connectivity.
- Considering and supporting best practice and evidenced-based approaches through a partnership between higher education and rural community stakeholders.
- Regulating stable and integrated funding streams and the reallocation of resources and authority through an advisory board.
- Improving linkages to natural supports within communities.
- Integrating regional care in collaboration with state authority such as Child Welfare and/or Juvenile Justice services.

Eligibility for Services

This is an area that should be in alignment with the no-wrong door mindset. Despite the various eligibility requirements, in Nevada's Rural Region it would be beneficial if system partners could utilize points of entry and connections as opportunities to help caregivers locate and access appropriate and indicated services and supports. Public and private funding streams have diverse and complex individual variations in eligibility, service authorization processes, diagnostic criteria, and covered benefits. Limited consistency or parity exists in accessing children's mental health services in Nevada's Rural Region. High rates of unemployment as well as large numbers of uninsured and underinsured also affect eligibility criteria. Additionally, services in rural areas are limited, and system barriers such as incarceration and reintegration into the community from residential treatment may affect eligibility status. Complex referral and intake processes and possible wait-lists are additional factors.

Methods for Accessing Services

- Promoting the "no wrong door" mindset - where system partners help families locate and access needed mental health services, regardless of which agency is contacted first.
- Building consideration of comprehensive mental health screenings that target children and adolescents involved in Child Welfare, Juvenile Justice, Nevada Tribes, and Hispanic communities.
- Developing access and delivery of services utilizing rural school systems.

RCMHC Ten-Year Strategic Plan

- Strengthening connections with caregivers via the internet and/or other technologies including social networking and Geo-Mapping as a method of screening, assessment, and referral that is interactive and family driven.
- Improving mental health access for frontier children and their families.
- Developing new venues for collaboration, allowing Nevada's rural region to access comprehensive assessment and intervention services.
- Building redundancy into children's mental health surveillance and screening initiatives.
- Collaborating with universities and colleges.
- Coordinating a Rural Children's Mental Health Institute.
- Expanding the availability of services that are responsive during critical windows of opportunity.

Children and Family Mental Health Challenges and Contexts

School-Based

Most students need school-based support for their physical and emotional development. As a result, schools are on the front lines of providing child and adolescent preventive mental health services. School-Based Systems of Care (School Based Health Centers) is anticipated to have the potential to provide rural children with consistent and cost-effective primary, secondary, and tertiary preventive services and programs. Furthermore, the National Assembly on School Based Health Care's (NASBHC) has a focused mission on uniting education and health for success in the classroom and in life. It is an indisputable fact: a healthy child is a teachable child.

Freudenburg and Ruglis (2007) assert that rarely has a single problem as high school drop-out rates contributed to so many adverse social, economic, and health conditions. Nevada's adolescents deserve a concerted community effort to improve school completion rates and thus give young people a gateway to lifetime health and success. School Based Health Centers address physical, emotional, and behavioral health issues and foster learning readiness and academic achievement. Opening school doors to health care creates pathways to children's educational achievement and lifelong well being.

Child Welfare

Among the various safety, well being, and permanency challenges that Child Welfare workers face in Nevada's Rural Region is the balance of keeping children in their communities, maintaining sibling groups, placing foster children with culturally relevant foster families, continuing biological family visits, and linking foster children to appropriate mental health services when necessary. In Nevada's Rural Region, specialized mental health services are extremely limited, which results in children with serious emotional disturbances often having to be relocated and/or travel to urban areas to receive adequate care. Consequently, when children are relocated out of their communities, they are frequently separated from their siblings, and parental visits become problematic due to distances between rural communities.

Child Welfare workers in Nevada's Rural Region spend large amounts of time trying to locate mental health therapists and/or other mental health resources who can meet the specialized needs of children in foster care.

Juvenile Justice and Mental Health

Mental health services provided to detained and incarcerated children are expensive. There are time and logistical factors that must be considered in obtaining mental health services for children and youth that are involved in the Juvenile Justice system. According to Federal guidelines, Medicaid funding may not be used to cover medical services provided to detained or incarcerated persons. As a result, mental health services are primarily financed through State and County general funds and other grants. Consequently, many Juvenile Justice systems are unable to provide essential and adequate mental health services.

Additionally, because of limited outpatient mental health services throughout the Rural Region, many children with untreated emotional disturbances find themselves detained and/or incarcerated. Families may have a sense of helplessness and hopelessness when faced with the Juvenile Justice system. Moreover, system needs can be divided into service and motivation. Service includes training and motivation includes helping families understand the importance of mental health. Many juvenile justice systems lack a seamless approach for the continuum of care for mental health services. Often children come from in-patient mental health placements without follow-up and care plans. These children are considered high maintenance and concern. Issues remain with regards to funding as well as finding providers to go into juvenile detention facilities to provide care. The evaluations that are needed and indicated are often costly yet necessary for placement planning (i.e. residential treatment). In conclusion, there needs to be a smooth transition from private providers to Systems of Care.

Infant Mental Health and Early Intervention

State and Federal initiatives, laws, and policy have had a history of supporting services for infants. The idea of early identification, intervention, and prevention of developmental and mental health problems may be the most effective and timely application of limited resources; unfortunately, Nevada Early Intervention Services does not serve at-risk infants and toddlers at this time. Infants from multi-risk families that are

involved with the child welfare system are facing complex challenges during critical developmental periods. The 24 months of infancy is the critical time in growth and development that underlies future capacities and function. The primacy of infancy is a vast opportunity for potentially charting future life trajectories. Developmental outcomes of infants at environmental risk are of utmost social priority. Capitalizing upon a child's resilience and the power of a self-organizing, family-centered approach is a sound and effective strategy.

In this time of scarce resources, it is more critical than ever that early intervention services be appropriate, meaningful, and client-centered. An integrated early intervention practice model would consider culture, class, and diversity within the contexts of discovering the strengths and capacities to supporting the emergence of the individual development of the infant. The early interventionist is well positioned to cross the boundaries within the context and focus on the infant to build healthy alliances with diverse families.

Substance Abuse Prevention and Treatment

The Substance Abuse Prevention Treatment Agency (SAPTA) is part of the Nevada Division of Mental Health and Developmental Services (MHDS). SAPTA, in compliance with the Program Operating Access Standard and the Federal Block Grant, is increasing access to treatment by improving: (a) service efficiency, (b) quality of care, (c) care coordination, and (d) outcome measurement via on-going treatment, certification, and fiscal monitoring.

The services available in Nevada's Rural Region must be strengthened by increasing the number of clinicians who specialize in treating adolescents in the continuum of care (prevention, outpatient, residential, and support) system. There is a need for clinicians trained in assessment and treatment of adolescents with co-occurring conditions. Financial support for program development and increasing the qualified workforce, as well as developing informal and formal community supports is an indicated need.

Challenges include client issues of retention (treatment completion); clinical engagement (client non-participation in treatment); cultural differences (social stigma associated with substance abuse treatment and/or social acceptance of alcohol and drug

abuse); low community awareness; underfunded school systems (cannot address substance abuse in student population); lack of transportation to and from services; and feasibility of servicing small populations.

Suicide Prevention and Survival and Crisis Assessment

The RCMHC encourages Nevada's System of Care to strengthen the State's ability to recognize and respond to crisis situations throughout the Rural Region. The RCMHC encourages public and private agencies dedicated to the care and well being of children to increase their knowledge and awareness of crisis situations. The Consortium supports these agencies to develop comprehensive policies and procedures designed to identify and respond to a variety of crisis situations (viz. crisis triage, response, and ongoing crisis management). The RCMHC will partner with Nevada's System of Care to help meet the crisis needs of children and families throughout the State of Nevada.

At-Risk/Multiple Risk: Co-morbidity; Complex Family

The impacts of multiple at-risk factors, the high rate of co-morbidity of health conditions and the complex family problems must be considered throughout the process and levels of care in addressing child mental health and developmental issues.

Logic Model Approach

The Logic Model Approach was selected by members because it provides stakeholders with a roadmap describing the sequence of activities needed to bring about necessary change for effective program planning and evaluation (W. K. Kellogg Foundation, 2004).

Definition

A logic model is an action-oriented tool for programming, planning, and evaluation. It is important to pose relevant questions that can direct planning and evidence-based practice by establishing priority indicators. The long-term impact of this process is twofold. First, it will improve mental health status for rural children and families; and second, will increase mental health efficacy and efficiency across Systems of Care.

Evidence-Based Practice

The RCMHC Strategic Plan adheres to the definition of evidenced-based practices (EPB) as defined as follows:

EBP is the integration of the best available research with clinical expertise in the context of individual characteristics, culture, and preferences (American Psychological Association, 2005). Sackett and colleagues (2000) described the purpose of EBP as promoting effective psychological practice and enhancing public health through empirically supported principles of psychological assessment, formulation and planning, therapeutic relationships, and intervention. EBP improves functional outcomes and the well being of children and their families.

A comprehensive array of accessible and affordable services is the long-term goal for rural children's mental health. To achieve this goal, supportive policy development and a stable and sustained financial system and workforce must be developed. Furthermore, evidenced-based interventions are a high priority concern for the provision of mental health services to Nevada's rural children with emotional disturbance.

Services Provided

The RCMHC advocates that provision of children's mental health services are provided in accordance with System of Care principles that include evidence-based, empirical, and promising practices. The continuum of care includes prevention, early

identification and screening, comprehensive assessment and intervention as well as case coordination and continuing care. Challenging areas include that Nevada's Rural Region has a limited number of providers, programs, and community and agency awareness and resources to adequately address the mental health needs of children and youth.

An important goal for Nevada's System of Care is to employ a universal set of screening and assessment tools that can identify children and youth who are eligible for services. It is imperative that children remain with their families when clinically appropriate and/ or safe. Another concern is that children remain in their communities, at the least restrict level of care that facilitates recovery and wellness. Family support services must be provided throughout the continuum of care from prevention through residential and aftercare services. Community based mental health services are vital and should be family-centered.

Nevada's System of Care should be encouraged to provide services that are responsive to the unique culture of each child, and their family. Regards of the child's custody status, the system must be navigable and provide easy access to a comprehensive array of preventive, early intervention and intervention services to meet the needs of children, youth, and their families in a timely manner.

Priorities of Services for Plan Implementation

- Children involved with Child Welfare and/or Juvenile Justice.
- Youth transitioning to higher education, employment, and independent lives.
- Infant mental health and school-based services.
- Children with prenatal drug and/or alcohol exposure.
- Children and their families with drug and/or alcohol exposure
- Nevada Hispanic and Native American communities.

Manner in which Family Members will be Involved

The intention is for the family voice to be integrated into all policy, programming, and activities of the RCMHC. In fact, a parent of an emotionally disturbed child is an appointed member on the RCMHC. Parents are invited to attend all meetings and workgroups either in person or through telephone conferences. Nevada's System of Care includes parents, family members, and youth in all aspects of planning, service provision, management, and oversight.

RCMHC will continue to partner with Nevada Statewide Family Network (Nevada PEP). Nevada PEP is an integral component of the System of Care principles. Nevada PEP assures that family voices are heard and incorporated into the child and family team process, and the individual service coordination, planning, and implementation. Nevada PEP provides leadership through activities at all levels that encourage System of Care principles including family-driven, child-centered and strength-based service planning and delivery. As a Systems partner, PEP provides the parent perspective to all other agencies to ensure the system is functioning in the best interests of the child and their family.

Allocation of Costs

The impact of national health reform is the great unknown, but it could be a period of increased opportunity. Children with mental health concerns are involved in various systems; therefore, costs must be equally distributed across systems, agencies, and child serving organizations. Pursuant to the request for an itemized list of costs to provide services to address the mental health needs of children living in Nevada's Rural Region, the RCMHC is in a position to address the allocation of costs. There is a sense that in this time of uncertainty, it may be perceived as an opportunity to allow for higher levels of organization, integration, and improved delivery system.

That being said, there is a need for a clear governance structure that is accountable for System of Care direct services and fiscal responsibility. Funding must to be flexible and allow for rapid response as well as emerging knowledge about behavioral health issues and research-informed practices.

Methods to Obtain Additional Funding: Costs and Funding Sources

- Increase parity of mental health services for children and families in Nevada's Rural Region.
- Blend, braid, and pool funding so that children and youth with behavioral health needs and their families have access to a full array of services and supports.
- Develop Children's Mental Health Trust to provide long-term stability in times of economic downturns.
- Seek grants and sub-grants on the community level.
- Develop locally controlled, evidence-based projects.
- Partner with higher education and Nevada Early Intervention Services (NEIS).

RCMHC Ten-Year Strategic Plan

- Better identify needs through multidisciplinary approaches and collaborations with caregivers and local team members to more effectively utilize resources.
- Consider capitation rates and intervention algorithms.

Logic Model Goals

Goal 1: Determine and promote awareness of the specific challenges families of children with mental health and behavioral disorders face in Nevada’s Rural Region.

1. Establish and maintain connection through community outreach.
2. Advocate for specific mental health services on three levels: community, county, and state coalitions.
3. Promote improvement of mental health services by assisting communities’ advocacy within internal state agencies.
4. Identify stakeholders who are in a position to facilitate changes in each community.

Activities and Strategies	Progress
Begin dialog with community stakeholders and meet with Nevada Coalition leaders, visit regions, and attend community meetings and forums to establish communication as a means of advocacy and awareness.	During the Fall 2009 period, met with 7 Directors for Rural Coalition Partners, 52 Nevada Rural Region Partners, 12, parents and 3 youth with mental health concerns, and attended 5 community meetings with Nevada’s Rural Region.
Develop a contact list of Rural Region stakeholders.	Began October 2009; on going
Translate RCMHC brochure into Spanish.	Pending
Develop a RCMHC interactive exhibit at The Kid’s Talking Wall at the Carson Mall	2010/2011
Meet/communicate with each Rural Mental Health Clinic to develop or enhance existing resource lists for children in their respective communities.	On going
Provide training in play therapy to at least one therapist in each Rural Clinic.	Proposed 2010

Goal 2: Promote the mutual sharing of regional resources to improve mental health services for families of children with mental illness and behavioral disorders in Nevada’s Rural Region.

1. Encourage Memorandums of Understanding (MOU) or informal agreements.
2. Promote flexibility and access to needed services within catchment areas, inter-state, inter-county, and inter-coalition boundaries.
3. Support the establishment of an annual Nevada Rural Region mental health summit to include stakeholder, families, youth, and all interested parties.
4. Develop ongoing ties with individuals in the community who can assist with logistics for on-site visits and meetings.
5. Utilize PSAs, local newspapers, and community settings to post

RCMHC Ten-Year Strategic Plan

RCMHC meeting agendas.

Activities and Strategies	Progress
Develop RCMHC website.	Proposed
Engage Nevada Tribal stakeholders; facilitate development of a consortium and participate on statewide level of policy and funding.	12/09 RCMHC member met with Inter-Tribal Council of Nevada and the Indian Health Board of Nevada.

Goal 3: Promote and support the use of technology to enhance mental health services for families of children with mental health and behavioral disorders in Nevada’s Rural Region.

1. Promote telemedicine including telephone and video conferencing.
2. Create website for contacts, information, electronic record, and links.

Activities and Strategies	Progress
Support and encourage the system partners to develop strategies of interacting with tech-friendly parents to developmentally screen and support children and their families.	Proposed
Model team meeting and multidisciplinary planning and collaboration opportunities.	On going
Pursue collaboration with other entities that are on a similar pathway to determine how the Consortium can be helpful.	Proposed

Goal 4: Investigate potential delivery of mental health services to families of children age 0-3 with possible mental health and behavioral disorders in Nevada’s Rural Region.

1. Work with systems of care partners to explore potential funding sources.
2. Encourage systems partners to coordinate with other early childhood providers and community stakeholders.
3. Collaborate with Systems partners to identify possible funding sources.

Activities and Strategies	Progress
Determine efficacy of the integration and application of early intervention and infant mental health services through defining focused question and conducting an evidence-based literature review and summarized in a position paper.	Completed Fall 2009
Encourage and support the development of the DIR/ Floortime Approach in	Ongoing

RCMHC Ten-Year Strategic Plan

<p>organizing and providing multidisciplinary services. Establish plan for rollout of model and training opportunities. Establish transdisciplinary group of stakeholders with emphasis on the University of Reno (UNR) Departments of Speech Language Pathology and Audiology, Education, the School of Medicine, NV University Center for Excellence in Education and Disabilities (NV-UCED), UNR University Center for Autism and Neurodevelopment (UCAN), and Nevada Early Intervention Services (NEIS).</p>	
<p>Support the effort of the development of a Behavioral Health Community Network to support children in need that are eligible or receiving NEIS. Encourage partnerships with non-profits to support infant mental health services. Further utilize the DC: 0-3 for identified target groups.</p>	<p>Proposed 2010</p>
<p>Explore training needs for delivery services for the birth to three populations in collaboration with NEIS.</p>	<p>Proposed 2010</p>

Goal 5: Encourage mental health services to the families of children and adolescents in Juvenile Justice detention facilities in Nevada’s Rural Region.

1. Support the development of interagency agreements; provide needed mental health assessment and treatment for the provision of mental health services to families of children and adolescents in the Juvenile Justice system.
2. Encourage the investigation of ways to initiate mental health services to the families of children and families in the Juvenile Justice system that are underinsured or are not eligible for Medicaid.

Activities and Strategies	Progress
<p>Facilitate communication between Rural Mental Health /Clinics and local probation agencies in the Rural Region.</p>	<p>Carson City has received a grant to provide mental health services in the facility. Every facility does do a screening according to Federal requirements. Ongoing</p>
<p>Advocate for increased services for the youth in the custody of local probation</p>	<p>Proposed</p>

RCMHC Ten-Year Strategic Plan

detention facilities.	
Promote the need for transition plans for adolescents to promote safe, healthy and functional outcomes into adulthood.	Proposed

Goal 6: Explore the potential for mental health service provisions in public schools in Nevada’s Rural Region.

1. Encourage smooth reintegration of students transitioning out of Residential Treatment Center (RTC) placements and/or acute psychiatric facility reentering the school systems through Memorandums of Understanding for continuing care plans, discharge summaries and investigate potential barriers.
2. Promote ongoing discussions between family, youth, service providers and stakeholders about information sharing related to children and adolescents From mental health placements; explore the use of a universal release of information.
3. Explore and promote applications of school-based mental health services for children and families in the Rural Region.

Activities and Strategies	Progress
Help determine efficacy of school-based mental health services through defining focused question and conducting an evidence-based literature review and summarized in a position paper.	Focused question and literature review completed Fall 2009.
Promote the potential for Carson City and Lovelock to develop pilot sites for school-based mental health services.	Proposed
Explore the use of the Teen Screen to identify youth with mental and substance abuse issues and suicidal tendencies.	Proposed
Support efforts to develop a workgroup to explore, plan and discuss strategies for developing school-based mental health services in the Rural Region.	Proposed

Appendix A—Rural Nevada Demographic Characteristics and Epidemiological Data

Population Characteristics	Carson City	Churchill	Douglas	Elko	Esmeralda	Eureka	Humboldt	Lander	Lincoln	Lyon	Mineral	Nye	Pershing	Storey	White Pine
U. S. 2008 Census estimate	54,867	24,896	45,180	47,071	677	1,628	17,763	5,086	4,898	53,022	4,684	44,375	6,291	4,341	9,199
Children under 5 years	3,731	1,793	1,988	3,437	13	105	1,297	314	216	3,606	206	2,308	265	183	497
Children under 18 years	12,620	6,747	8,314	12,992	105	357	4,868	1,399	1,014	12,832	956	9,009	1,259	831	1,859
School District															
# of students (DOE '07-'08)	8,225	4,409	6,818	9,811	77	236	3,394	1,273	953	9,275	624	6,532	722	428	1,443
# of emotionally handicapped #	31	18	17	11	1	0	25	2	4	38	4	46	1	6	10
SpEd & Behavior	1,078/100	650/30	60	1,215/105	1	0	25	15	30	1,217/169	25-30	1,135	24	20	155/30
#emotional/behavior only	270	30	240	unknown	6-10	13	50	15	est. 80	8	30	unknown	70	5-6	20
Rural Mental Health (Average pediatric cases, 12/01/08-11/30/09)	82	28	12	13	0	0	21	10	5	44	5	14	4	0	18
SAPTA Services Available	X	X	X	XX			X			X	X	XX	X	X	
Children Living in Poverty U.S. 2008 Census estimate	1867	906	794	1430	18	14	703	183	158	1644	197	1443	239	53	269
Native American Children U.S. 2008 Census estimate	393	445	186	904	9	4	352	98	24	346	200	197	66	16	97
Hispanic Children U.S. 2008 Census estimate	3287	906	948	3680	15	20	1708	331	68	2548	138	1431	302	87	283
Vulnerable and at-risk children & **families** A guesstimate based on U.S. Surgeon General's(2001) estimate of prevalence of 5% high need and 20 % some need of mental health supports and services.	631	338	416	650	6	18	244	70	511	642	48	451	63	42	93
	2524	1350	1663	2599	21	72	974	280	203	2567	192	1802	252	167	372

Nevada Department of Education, *Enrollment by School and County 2007-2008*

Nevada Division of Mental Health and Developmental Services, *Staff Time Productivity Report*

U. S. Census Bureau (n.d.). *Nevada Quick Facts*. Retrieved on January 10, 2010 from <http://quickfacts.census.gov/qfd/states/32/321001.html>

*Note that in Washoe County, the Reno/Sparks Indian Colony, and the Nevada Urban Indian Tribe and in Clark County, the Moapa Tribe and the Las Vegas Indian Center may prefer to be recognized and included with the Nevada Rural Region structure.

Appendix B—*Infant Mental Health White Paper*

The following white paper will introduce the evidence for achieving unity in principles and practice in an early intervention application of an integrated model of infant mental health.

Early intervention and infant mental health practice have the common child-centered focus that looks at the individual infant's biological and genetic makeup. These unique patterns of interactive and emotional function can determine the extent to which the child masters or fails to develop core learning and emotional capacities (Greenspan and Wieder, 2006). Foley and Hochman (2006) discuss the nature of infant development and derailment and the centrality of the family and relationships. The parent-practitioner relationship is a reflection of the of the parent-child relationship. Moreover, in early intervention practices, the action is in the interaction and very much in the present moment. Envisioning this new unity of practice, an integrated model will strive to embrace complexity and require a System of Care that is equally comprehensive and possess the following characteristics (Foley and Hochman, 2006):

- A Holistic and Synergistic Frame of Reference
- A Broad Vision of the Scope of Intervention
- A Family-Centered and Relationship-Based Approach
- A Multi, Cross-Disciplinary Team Model of Staffing

Federal and state initiatives, laws and policy have had a history of supporting services for infants. The idea of early identification, intervention, and prevention of developmental and mental health problems may be the most effective and timely application of limited resources; unfortunately, Nevada Early Intervention Services does not serve at-risk infants and toddlers. Infants from multi-risk families that are involved in child welfare programs are facing complex challenges during critical developmental periods. The 24 months of infancy is the critical time in growth and development that underlies future capacities and function. The primacy of infancy is a vast opportunity for potential and the charting of life's trajectories. Developmental outcomes of infants at environmental risk are a social priority. Capitalizing upon a child's resilience and the power of a self-organizing family-centered approach is a sound and effective strategy.

Transdisciplinary work requires that one does not go beyond the scope of practice and competence. There is opportunity to support and develop evidenced-based interventions in building capacity by partnering with community partners in the service of the birth to three populations. Collaboration across Systems of Care requires sensitivity and awareness of the unique language, culture, and goals of stakeholders as well as the meaningful expansion of infant mental health knowledge across and within disciplines (Zeanah, 2009).

RCMHC Ten-Year Strategic Plan

In this time of scarce resources, it is more critical than ever that early intervention services be appropriate, meaningful, and client-centered. An integrated early intervention practice model would consider culture, class, and diversity within the contexts of discovering the strengths and capacities to supporting the emergence of the individual development of the infant. The early interventionist is well positioned to cross the boundaries within the context and focus on the infant to build healthy alliances with diverse families.

The Medicaid Chapter 400 services allow for the provision of mental health services to children in the form of Behavioral Health Networks that are comprised of groups of individual mental health providers under the medical direction of a child psychiatrist or pediatrician. The services of Marriage and Family Therapists as well as graduate clinicians working on clinical hours are Medicaid reimbursable. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: DC: 0-3R (Zero to Three, 2005) is the gold standard for working with infants and toddlers in mental health and complements the comprehensive developmental approach to assessment and intervention that is core to the provision of early intervention services in our State of Nevada.

The evidence supports home-visits within universally preventive interventions that includes screening, selective, and indicated preventive measures directed towards high-risk children and families (Ammaniti, Speranza, Tambelli, & Muscetta, et al, 2006, Law, 2009). Research supports the recognition of subthreshold symptomatology as there is a notion of the continuum of function (Struner, Albus, Thomas, & Howard, 2007) and that the development of indicated preventive mental health interventions may deter, diffuse, and prevent the expression of mental health and developmental disorders.

To achieve unity in principles and practice, the institutional culture needs to have a shift; educate administrators and policy makers on the importance of transdisciplinary work and support through resource allocation and boots on the ground. There has already been an effective partnership between infant mental health and Early Head Start through a 2000 mental health initiative. This collaboration has funded research and program development in aspects of ensuring program guidance, technical assistance, monitoring, and research evaluation to address the needs of infants and families (Chazan-Cohen, Stark, Mann, and Fitzgerald, 2007). Furthermore, in applying an integrated and unified approach within the contexts of the parent-child relationship, the underlying theory to these approaches and the overarching premise of this white paper is demonstrated that relationships organize development.

Submitted by:

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12/8/09

Appendix C—Nevada Rural Region Children in Child Welfare State
Custody by County and Age

Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	18	Total	
County																						
Carson		5	1	1	4	1	3	2	1	2		1	2	1		3	1	4	1	1		34
Churchill		3	3	2	3	5	3	1	3		5	2	2	4		2	3	4	1			46
Clark																		1				1
Douglas	1	1	2	2		2	1			1			1						1			12
Elko		1	7	2	2	3	3	2	3	2	2	3	2	1	5	2	6	4	1			51
Eureka																					1	1
Humboldt	1	4	3	3	3	3	3	2		5	1			2	1	1	2	2				36
Lander	1	1	2	1		2	1	3		3	1	2	1	1					2			21
Lincoln	1		1									1				1						4
Lyon		4	5	5	6	4	3	4	4	3	2	3	3	1	4	1	4	4	4	2		62
Mineral	1	3	1	1	2	3		3	1	1		1	2		1	2						22
Nye			4	7	2	2	1	4	4	7	2	4	2	6	3	4	5	4	4	3		64
Pershing						1	1		3	2		1	3	2	2	1						16
White Pine	2	1	1	3	2	1	1	1		1			1		2	1	1	2			1	21

Grand Total	7	23	30	27	24	27	20	22	19	27	13	18	19	18	18	18	22	28	8	3		391
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Retrieved on December 8, 2009 from UNITY Database

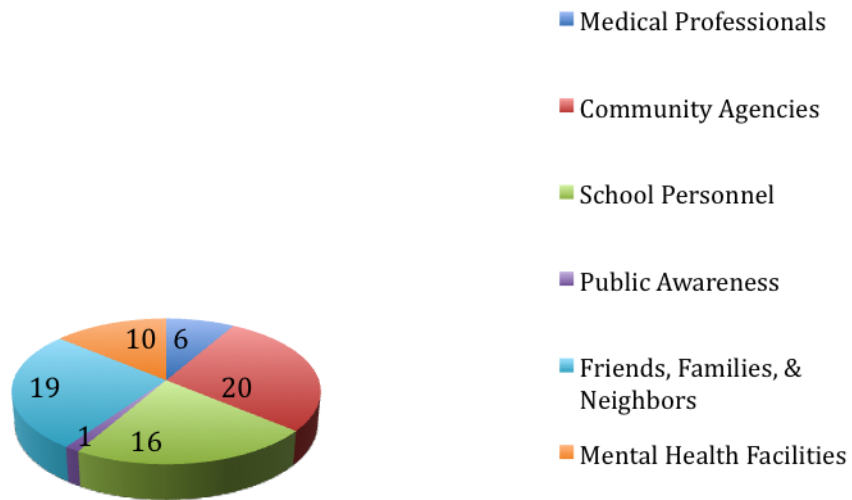
Note: this is a snap shot in time. There is a significant number of youth that will be transitioning to adulthood in the next several years.

Appendix D—Nevada PEP, Statewide Family Network Principles

• Nevada PEP Services Provided, 7/1/08 - 6/30/09	
33	• Child and Family Team Meetings
11	• Home Visits
40	• IEP/School Meetings
705	• Individual Assistance Contacts
131	• Families Served in Rural Counties
72	• New Referrals for Family Support Services

Nevada PEP, Statewide Family Network, serves as the “family voice” for rural communities in the legislative and policy-making process. Nevada PEP is a full system partner that is an essential component of the RCMHC. It has the responsibility of ensuring that family voices are heard and incorporated into the Child/Family Team process and Individual Service Coordination and planning and implementation. As a system partner, PEP brings the parent perspectives to the RCMHC to ensure that the system functions in the best interests of the families and children. Within the RCMHC, PEP promotes the development of public-private partnerships using the Systems of Care principles as a guideline. PEP organized and implemented trainings on IDEA 2004, Systems of Care, Wrap-Around in Nevada, and other PEP agency partners.

Nevada PEP Referrals 7/1/08 - 6/30/09 Rural County Data Family Support Services Only



Appendix E—References

- Nevada Revised Statute (NRS), Chapter 433B, *Additional Provisions Relating to Children*
NRS, Chapter 424, *Foster Homes for Children*
NRS, Chapter 432, *Public Services for Children*
NRS, Chapter 432A, *Services and Facilities for the Care of Children*
NRS, Chapter 432B, *Protection of Children from Abuse and Neglect*
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