

Legislative Counsel Bureau

Regionalizing the Mental Health System in Nevada: Considerations and Options



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**REGIONALIZING THE MENTAL HEALTH SYSTEM IN NEVADA:
CONSIDERATIONS AND POLICY OPTIONS**

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TABLE OF CONTENTS

	<u>Page</u>
Regionalizing the Mental Health System in Nevada: Considerations and Policy Options	1
Legislative Charge	1
Executive Summary	2
Introduction.....	3
I. Key Issues to Consider	7
Access to Behavioral Health Care in Nevada.....	7
Behavioral Health Workforce.....	7
Health Insurance, the Affordable Care Act, and Implications for Mental Health in Nevada	15
➤ Insurance Coverage	16
➤ Medicaid Expansion	16
➤ Young Adult Coverage.....	17
Barriers to Accessing Behavioral Health Services and Treatment	18
Limitations of Insurance Coverage	18
Ensuring the Continuum of Care: Youth Transitioning to Adult Behavioral Health Services.....	19
A Changing Environment: Policy and Program Changes as a Result of the ACA.....	20
Behavioral Health Providers Pre- and Post-ACA	20
Changes to the Medicaid State Plan	20
Mental Health and Medicaid Managed Care	21
Impact of the ACA on the State’s Behavioral Health Budgets	22
➤ Reduced General Fund Appropriations due to Increased Medicaid Reimbursements	22
➤ Reduced Medication Expenditures	22

➤ Reduced General Fund Appropriations for the SAPTA Budget Due to Increased Medicaid Billing by Providers	23
➤ Transfer of State Resources from Civil Psychiatric Services to Forensic Competency Services	24
Relationship Between the Mental Health Care System and Other Systems.....	26
Mental Health and Public Health	26
Mental Health and the Criminal Justice System.....	27
➤ Crisis Intervention Training	28
➤ Mobile Outreach Safety Team	28
➤ Forensic Assessment Services Triage Team.....	29
➤ Mental Health Court.....	29
➤ Assisted Outpatient Treatment	29
➤ Stepping Up Initiative	30
Housing for Individuals With Mental Illness	30
Recent Expansion of State Funding to Address Behavioral Health in Nevada.....	30
Moonlighting and Residency Programs Through the University of Nevada, Reno, School of Medicine	31
Social Workers in Schools Grant Program.....	32
Statewide Psychiatric Medical Director.....	32
Mental Health Court Caseload Increases	33
Stein Hospital.....	33
Weighted Caseloads in Rural and Frontier Counties	34
Western Interstate Commission for Higher Education—Psychology Internship and Psychiatric Nursing Slots.....	34
II. Defining Behavioral Health Care Regions	34
Patterns of Accessing Care	35

Key Observations on Patterns of Accessing Behavioral Health Care in Nevada	38
Current Behavioral Health Collaboration and Care Coordination Structures	39
Children’s Mental Health Consortia (NRS 433B.333)	39
Behavioral Health Coordinators.....	39
Community Mental Health Programs (Chapter 433C of NRS)	40
Nevada Early Intervention Services System	41
Local Health Authorities	41
Potential Options for Defining Behavioral Health Care Regions in Nevada	44
Traditional Regional Structure in Nevada: One Rural/Frontier Region and Two Urban Regions	44
Regions Based on Current Care Access Patterns and Areas of Natural Alignment	44
Expansion of Existing Regions to Include Natural Alignment.....	44
Addressing Rural and Frontier Counties	45
Estimating the Cost of Administering the Regional Structure(s)	46
III. Regionalized Behavioral Health Governance Models	47
Summary of Select State Governance Models	48
Governance Model Discussed at the Southern Nevada Forum	52
Public Policy Options	53
Conclusion.....	56
IV. Appendices	57

REGIONALIZING THE MENTAL HEALTH SYSTEM IN NEVADA: CONSIDERATIONS AND POLICY OPTIONS

Legislative Charge

At its April 4, 2016, meeting, the Legislative Commission directed the Legislative Counsel Bureau (LCB) to study factors that may influence regionalizing the behavioral health system in Nevada. Commission members requested LCB staff to work with the Department of Health and Human Services (DHHS), local government entities, and community advocates to report on:

1. Issues the Legislature may wish to consider in proposing legislation to regionalize mental health in Nevada; and
2. Examples of states that have regionalized their mental health system, including successful and unsuccessful strategies and the advantages and disadvantages of transitioning to a regionalized behavioral health system.

Commission members clarified that the resulting LCB report should build on, rather than duplicate, the work of the Governor's Behavioral Health and Wellness Council, which studied mental health governance systems, among other issues. In addition, upon signing Executive Order 2016-07 in March 2016, which concluded the Council's work, Governor Brian Sandoval directed the DHHS to work with the Interim Legislative Committee on Health Care and the LCB to "evaluate implementing 'a local/regional governance model of administration'" in preparation for the 2017 Legislative Session.¹

Disclaimer

The LCB is a nonpartisan agency; as such, LCB staff neither advocate for nor against any issue, position, or ideology. The purpose of this report is to present information in an unbiased manner to better assist legislators in making informed decisions regarding the subjects addressed herein.

¹ State of Nevada, Executive Order 2016-07, 10 March 2016, gov.nv.gov/News-and-Media/Executive-Orders/2016/EO_2016-07-Concluding-the-Governor_s-Behavior-Health-and-Wellness-Council/.

Executive Summary

Across the nation, the mode of governance for behavioral health systems varies significantly. In many ways, each state's behavioral health governance structure is unique. As policymakers consider transitioning the behavioral health system in Nevada from a governance and service delivery structure centralized at the State level to a more regionalized system, it is important to define the objectives for doing so. It is also important to consider how such a change might build on the strengths and reduce the weaknesses of the existing system, and what it might cost to transition to and maintain a more regionalized system.

Although some steps have been taken to improve behavioral health care in Nevada, many challenges remain. As the State population grew steadily in recent years, the behavioral health system lagged; funding fluctuated and decreased during the recession. Recent improvements to the system have been fueled primarily by behavioral health crises. Mental health advocates and professionals acknowledge that comprehensive improvements and reforms are still necessary to strengthen mental health care in Nevada. Currently, Nevada's mental health system ranks 51st overall, 48th in youth mental health care, and 51st in terms of adult mental health care and access to mental health care, according to a review of state mental health systems by Mental Health America. The report, *The State of Mental Health in America 2017*, evaluated states on a variety of factors that are essential for developing and maintaining a mental health system that adequately meets the needs of the population. While the analysis does not consider each state's governance structure, it does provide a baseline understanding of the status and quality of the existing system compared to others. According to the report, major factors influencing Nevada's low ranking include the availability of behavioral health care providers; access to, quality, and cost of health insurance; access to behavioral health treatment; and high rates of substance abuse.²

The objectives for considering regionalization of behavioral health governance in Nevada may include involving local stakeholders in the identification of key behavioral health issues and development of priorities; developing community-based resources and services; and improving access to care. This study outlines numerous issues and key factors to consider as policymakers weigh whether to regionalize the behavioral health system and the type or style of regional governance that might be most effective in Nevada. It is organized into three broad sections:

1. Key issues to consider, including:
 - a. Access to behavioral health care, including data regarding the behavioral health workforce, health insurance coverage, and barriers to accessing services and treatment;
 - b. Policy and program changes as a result of the Patient Protection and Affordable Care Act (ACA) of 2010 and the impact of the ACA on the State budget;

² Nguyen, Theresa, and Kelly Davis, *The State of Mental Health in America 2017*, Mental Health America, 2016, <http://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Full.pdf>.

- c. The relationship between the mental health care system and other systems; and
 - d. The recent expansions of State funding to address behavioral health in Nevada;
2. An analysis of patterns demonstrating how Nevadans currently access behavioral health care and a discussion of existing behavioral health collaborations and coordination arrangements that may be refined to provide regional boundaries; and
 3. A brief summary of select states that have regionalized behavioral health governance, a model of regional governance proposed by participants at the Southern Nevada Forum, and policy options recommended by stakeholders throughout the course of this study.

In addition, it is important to consider the costs associated with transitioning to a more regionalized system of behavioral health care. These costs—and the ongoing cost of operating a regional system—will depend on how policymakers approach regionalization in Nevada. However, without a clear description of what a regionalized behavioral health system might look like in Nevada, the associated costs cannot be quantified. Therefore, while policymakers may wish to keep cost considerations in mind while deliberating this issue, this report does not provide cost estimates.

Introduction

Nearly one in five adults in Nevada (18.5 percent) had a mental illness in 2014, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services.³ Of those individuals, more than 4 percent had a serious mental illness—which includes certain mental disorders that result in substantial impairment in carrying out major life activities.⁴ In addition, approximately 26,000 Nevada adolescents between the ages of 12 and 17, or 11.6 percent of all adolescents per year, reported at least one major depressive episode in 2013 and 2014.⁵ Nearly 70 percent did not receive treatment for depression, while approximately 30 percent did.⁶ Suicide is also a considerable issue in Nevada, and especially so for youth. In 2014, nearly 18 percent of Nevada youth seriously considered suicide; nearly 16 percent made a plan, and approximately

³ “Mental illness” is defined by SAMHSA as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. See SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014, Table 68, www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeNevada2014.pdf.

⁴ SAMHSA, *Behavioral Health Barometer: Nevada, 2015*, HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: SAMHSA, 2015, www.samhsa.gov/data/sites/default/files/2015_Nevada_BHBarometer.pdf.

⁵ “Major depressive episode” is defined as a period of at least two weeks in which a person experiences a majority of symptoms of depression.

⁶ SAMHSA, *Behavioral Health Barometer: Nevada, 2015*, HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: SAMHSA, 2015, www.samhsa.gov/data/sites/default/files/2015_Nevada_BHBarometer.pdf.

10 percent attempted suicide. Suicide is the second leading cause of death for Nevadans between the ages of 15 and 34 and the 8th leading cause of death statewide.⁷

Currently, the behavioral health system in Nevada is centralized at the State level. Policy development, oversight, service administration and provision, and funding are provided by the State. The Commission on Behavioral Health, established in 1975 by *Nevada Revised Statutes* (NRS) 433.314, guides policy and provides system oversight. This ten-member body also is responsible for reviewing programs and finances and reporting improvements in the quality of behavioral health care to the Governor and Legislature. According to its bylaws, the Commission takes the lead in strategic planning for the DHHS and promotes and assures the protection of the rights of all clients in the behavioral health system.⁸ However, advocates note that the Commission's structure, available resources, and authority to review only public facilities, limits its ability to function as envisioned in statute, as well as its ability to improve the behavioral health care system. See Appendix C for the Commission's establishing statute, bylaws, and most recent annual report summarizing successes, opportunities for improvement, and recommendations regarding the behavioral health and intellectual and developmental health systems.

The DHHS directly provides behavioral health care services in three administrative regions: (1) Clark County; (2) Washoe County; and (3) rural and frontier Nevada. The Division of Public and Behavioral Health (DPBH), DHHS, administers adult behavioral health services in all three regions. Children's behavioral health care is administered by the Division of Child and Family Services (DCFS), DHHS, in Clark and Washoe Counties and by the DPBH in rural and frontier Nevada. In addition, the DPBH provides forensic mental health services statewide through two maximum-security facilities: Lakes Crossing in northern Nevada and Stein Hospital in southern Nevada. While much of the capacity for forensic behavioral health is in the north, the majority of the need for such services remains in southern Nevada. Behavioral health care funding is provided through a mix of Medicaid funds, State General Fund appropriations, and federal grants.

In recent years, a couple of regionally organized behavioral health entities have been established to address mental health issues in Nevada. The exact functions of the Children's Mental Health Consortia and regional behavioral health coordinators differ, but both groups aim to improve mental health by developing regional priorities, improving communication, promoting collaboration, and addressing behavioral health care needs in their geographic areas. In addition, Chapter 433C ("Community Mental Health Programs") of NRS provides the statutory authority and structure for individual counties or groups of counties to establish a locally controlled "community mental health program," but this option has never been used.

⁷ Nevada's Office of Suicide Prevention, DPBH, DHHS, *Youth Suicide Prevention in Nevada*, 18 May 2016, www.leg.state.nv.us/App/InterimCommittee/REL/Document/6623.

⁸ Nevada's Commission on Behavioral Health, DPBH, DHHS, *Bylaws*, September 2013, <http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Boards/xxx/Bylaws-9-13.pdf>.

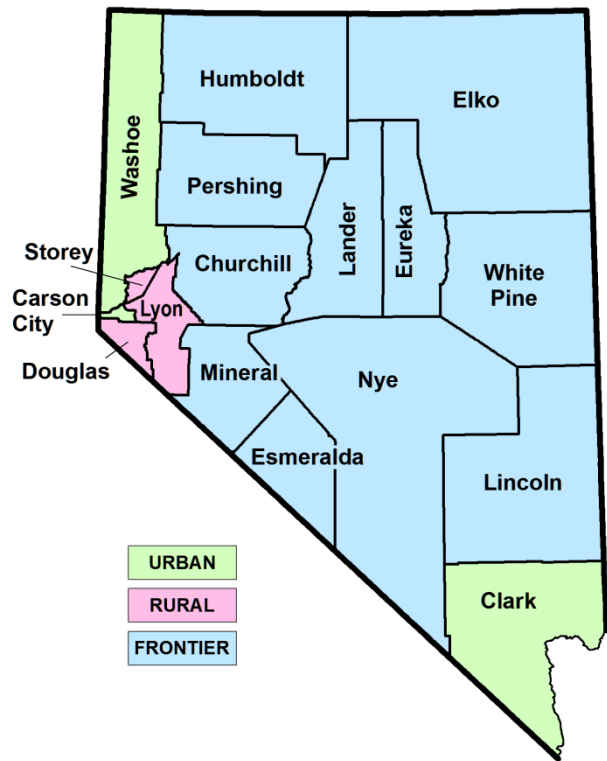
According to *Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers* by the Kenny C. Guinn Center for Policy Priorities, Nevada, Idaho, North Dakota, and South Carolina all rely on a similarly centralized behavioral health system in which the state directly operates community-based programs. A majority of states (31) have state-centered models in which the state contracts with community-based programs to provide services. In contrast, 15 states have a more “regional” approach, in which the state provides funding to local authorities to operate directly or contract with other entities to provide behavioral health services.⁹

In evaluating the behavioral health system in Nevada, it is important to consider the State’s unique qualities. Of particular concern is the geographic distribution of the population, which significantly affects access to behavioral health care. Specifically, while the State spans approximately 110,000 square miles, 90.5 percent of its 2.9 million residents live in only three counties (Carson City, Clark County, and Washoe County). These urban counties comprise a mere 13 percent of the State’s land mass. In contrast, the remaining 9.5 percent of Nevadans reside in rural and frontier Nevada, which covers an area of more than 95,000 square miles. For the purposes of this analysis, counties with a population of less than seven people per square mile are considered frontier regions. Counties with a population density greater than seven people per square mile, but not defined as a metropolitan statistical area, are considered rural regions. As can be seen from the table and map below, the majority of the geographic land mass of the State of Nevada is considered frontier.

⁹ Kenny C. Guinn Center for Policy Priorities, *Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers*, 1 December 2014, guinncenter.org/wp-content/uploads/2014/12/Guinn-Center-Mental-Health-Governance-Report-Dec_2014.pdf.

Figure 1: Nevada Population and Land Area by County

County	2015 Population	Land Area (square miles)	Persons per square Mile
URBAN COUNTIES			
Carson City	54,521	144	378.6
Clark	2,114,801	7,911	267.3
Washoe	446,903	6,343	70.5
RURAL COUNTIES			
Douglas	47,710	710	67.2
Lyon	52,585	1,994	26.4
Storey	3,987	264	15.1
FRONTIER COUNTIES			
Churchill	24,200	4,929	4.9
Elko	51,935	17,182	3.0
Esmeralda	829	3,589	0.2
Eureka	2,016	4,176	0.5
Humboldt	17,019	9,648	1.8
Lander	5,903	5,494	1.1
Lincoln	5,036	10,635	0.5
Mineral	4,478	3,757	1.2
Nye	42,477	18,147	2.3
Pershing	6,634	6,009	1.1
White Pine	9,811	8,877	1.1
Total All Counties	2,890,845	109,806	26.3



Source: United States Census Bureau, August 2016.

Providing behavioral health services across such an expansive territory presents a unique set of challenges and raises numerous issues which must be considered in determining how best to meet the State's behavioral health care needs. This report provides an overview of various issues the Legislature may wish to consider as it deliberates on whether to regionalize the mental health care system.

I. KEY ISSUES TO CONSIDER

Access to Behavioral Health Care in Nevada

Access to care is critical for people with mental illness and other behavioral health conditions. In considering whether and how to regionalize behavioral health care in Nevada, it is important to understand factors that influence access to care, including: (1) the availability and distribution of behavioral health care providers; and (2) health insurance coverage and changes in coverage following implementation of the ACA. It is also important to be aware of barriers that continue to impede access to behavioral health care services.

Behavioral Health Workforce

Nevada faces a severe shortage of behavioral health care providers. Compared to other states nationwide, Nevada ranks at or near the bottom in terms of the number of licensed mental health providers per 100,000 population.

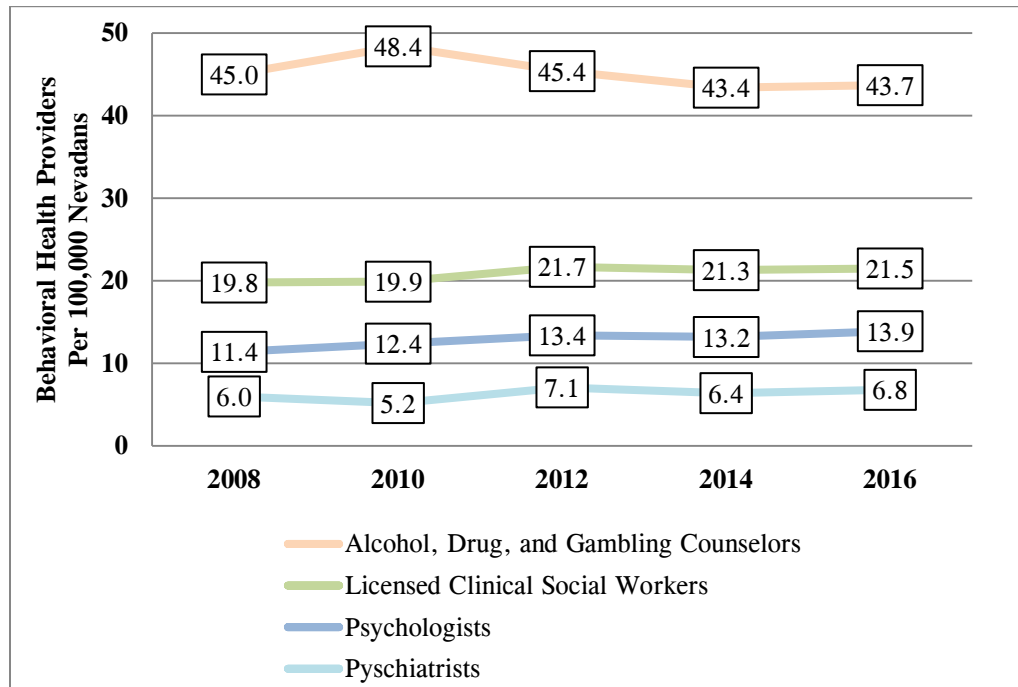
Figure 2: Licensed Behavioral Health Professionals per 100,000 Population in Nevada and the United States¹⁰

Licensed Health Professional	Nevada Rank	Professionals per 100,000 Residents	
		Nevada	United States
Physicians in Psychiatry	47	6.7	12.3
Psychologists	48	13.5	65
Counselors	51	50.4	181
Social Workers	50	88.7	169

Although the SAMHSA projects the behavioral health workforce to be one of the fastest growing across the nation, Nevada's workforce has experienced only modest growth in recent years.

¹⁰ Marchand, Christopher, et al. *Health Workforce Supply in Nevada: 2016 Edition*, Office of Statewide Initiatives, University of Nevada School of Medicine, March 2016, [med.unr.edu/Documents/unsom/statewide/reports/HWIN_Supply_Report-Final-March_2016%20\(2\).pdf](http://med.unr.edu/Documents/unsom/statewide/reports/HWIN_Supply_Report-Final-March_2016%20(2).pdf).

Figure 3: Select Behavioral Health Providers per 100,000 Nevadans, 2008 to 2016



Source: Marchand, Christopher, et al. *Health Workforce Supply in Nevada: 2016 Edition*, Office of Statewide Initiatives, University of Nevada School of Medicine, March 2016, [med.unr.edu/Documents/unsom/statewide/reports/HWIN_Supply_Report-Final-March_2016%20\(2\).pdf](http://med.unr.edu/Documents/unsom/statewide/reports/HWIN_Supply_Report-Final-March_2016%20(2).pdf), and correspondence with John Packham and M. Tabor Griswold, Office of Statewide Initiatives, UNSOM.

Figure 4: Licensed Mental and Behavioral Health Professionals in Nevada

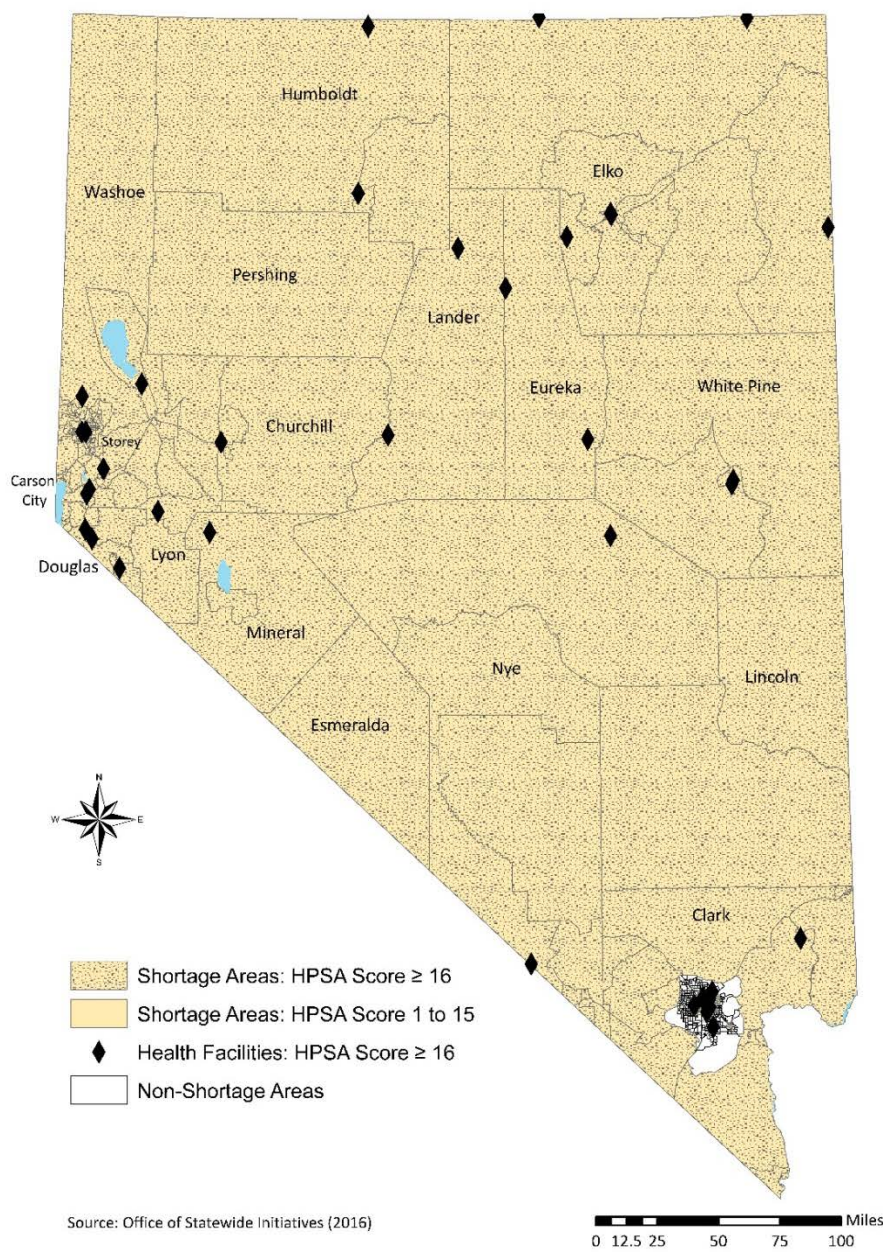
Licensed Health Professionals	2008	2010	2012	2014	2016	Change
Number						
Alcohol, Drug, and Gambling Counselors	1,233	1,306	1,263	1,277	1,224	-9
Clinical Professional Counselors	-	28	47	-	99	71
Licensed Clinical Social Workers	543	537	596	602	698	155
Marriage and Family Therapists	-	635	669	-	734	99
Psychiatrists	169	138	195	180	190	21
Psychologists	311	334	368	373	390	79
Number per 100,000 Population						
Alcohol, Drug, and Gambling Counselors	45.0	48.4	45.8	43.4	43.7	-1.3
Clinical Professional Counselors	-	12.7	20.4	-	35.3	22.6
Licensed Clinical Social Workers	19.8	19.9	21.7	21.3	21.5	1.7
Marriage and Family Therapists	-	23.5	24.3	-	26.2	2.7
Psychiatrists	6.0	5.2	7.1	6.4	6.8	0.8
Psychologists	11.4	12.4	13.4	13.2	13.9	2.5

Source: Marchand, Christopher, et al. *Health Workforce Supply in Nevada: 2016 Edition*, Office of Statewide Initiatives, University of Nevada School of Medicine, March 2016, [med.unr.edu/Documents/unsom/statewide/reports/HWIN_Supply_Report-Final-March_2016%20\(2\).pdf](http://med.unr.edu/Documents/unsom/statewide/reports/HWIN_Supply_Report-Final-March_2016%20(2).pdf).

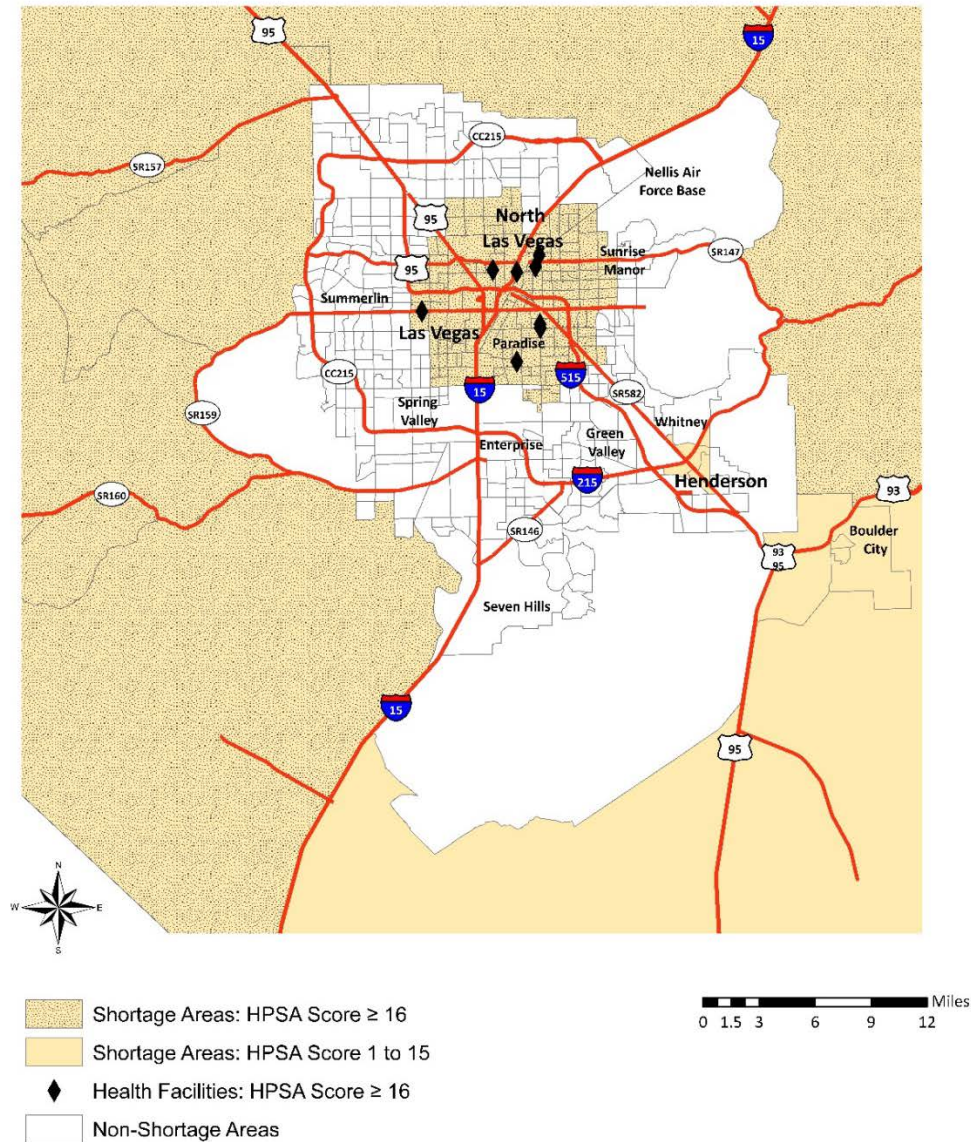
Behavioral health providers are also poorly distributed throughout Nevada. The entire population of 16 of the State's 17 counties lived in a region designated by the federal government as having a shortage of mental health professionals in 2016. This represents 1.5 million Nevadans—more than half (53.3 percent) of the State population—including all residents of rural and frontier regions, as well as Carson City and Washoe County. One-third of the population of Clark County lives in communities considered Mental Health Professional Shortage Areas as well.¹¹

¹¹ “Current and Projected Health Workforce Supply and Demand in Nevada,” John Packham and Tabor Griswold, Office of Statewide Initiatives, UNSOM, 24 February 2016, <https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/2723>.

Map 1: Mental Health Professional Shortage Areas in Nevada—2016

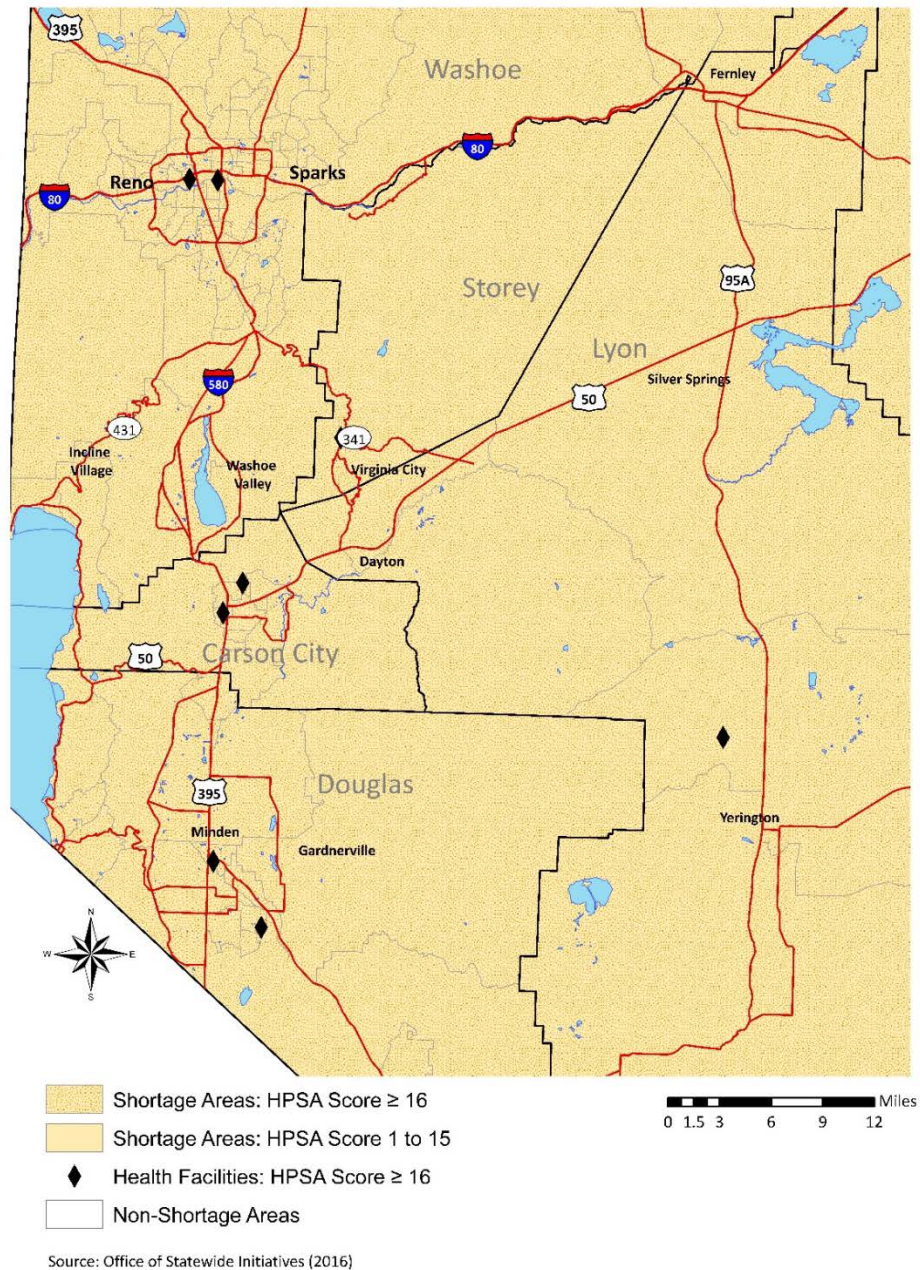


**Map 2: Mental Health Professional Shortage Areas
in Metropolitan Clark County—2016**



Source: Office of Statewide Initiatives (2016)

**Map 3: Mental Health Professional Shortage Areas
in Metropolitan Northern Nevada—2016**



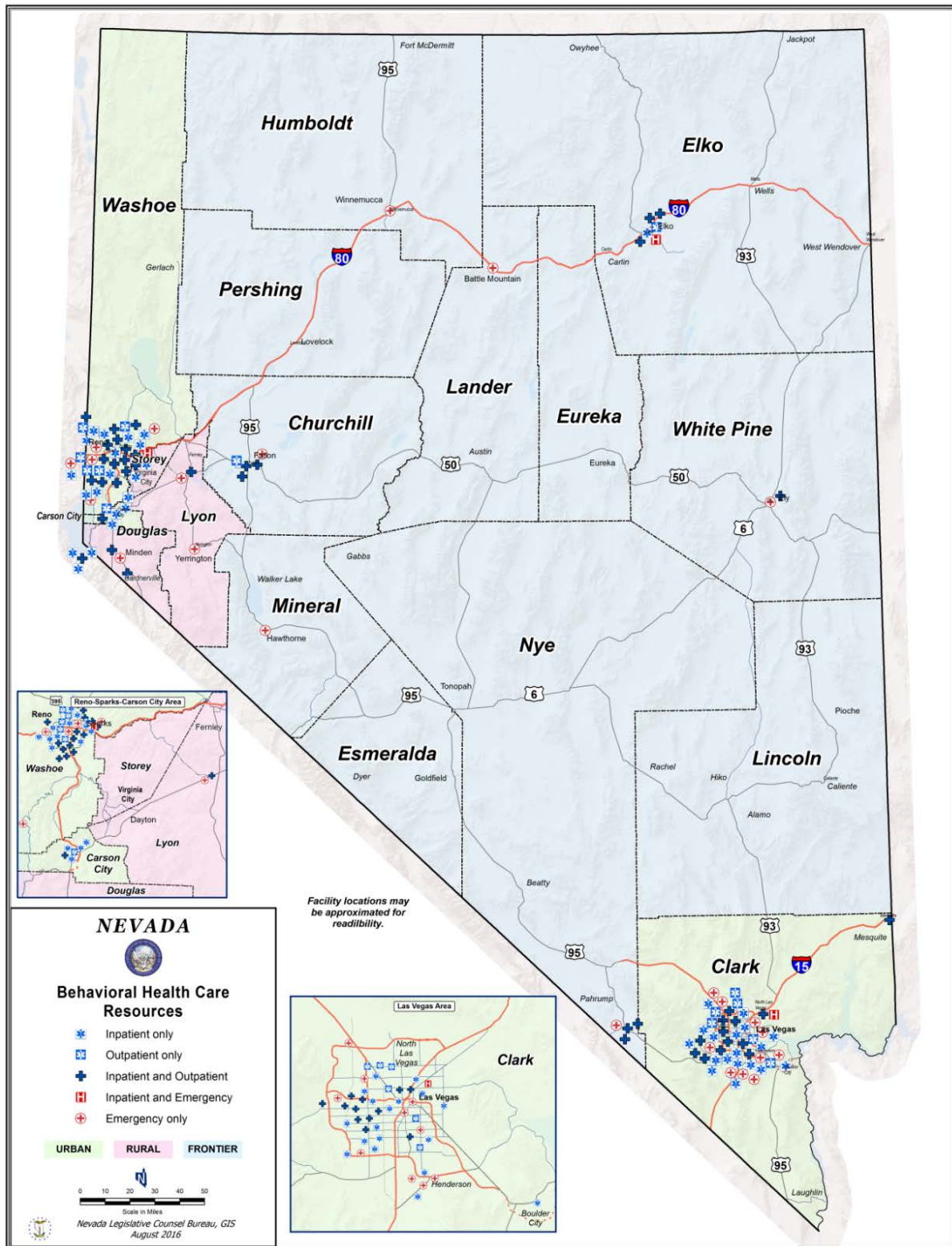
The DPBH historically has been responsible for providing behavioral health care services in rural and frontier regions of the State. While Carson City, Clark County, and Washoe County have seen an increase in the number of private community providers, rural counties and, specifically, frontier counties have not experienced the same growth in the number of community behavioral health providers. The State continues to serve as the primary provider for behavioral health services in 14 rural and frontier counties and has established 12 behavioral health clinics and 4 satellite clinics in the following areas: Battle Mountain

(Lander), Carson City (Carson City), Dayton (Lyon), Elko (Elko), Ely (White Pine), Fallon (Churchill), Fernley (Lyon), Gardnerville (Douglas), Hawthorne (Mineral), Lovelock (Pershing), Pahrump (Nye), Panaca (Lincoln), Silver Springs (Lyon), Tonopah (Nye), Winnemucca (Humboldt), and Yerington (Lyon). Clinics are generally open from 8 a.m. to 5 p.m., Monday through Friday, although some provide services outside of regular business hours. Each clinic is staffed by at least one permanent clinician—who may be a licensed psychologist, clinical social worker, marriage and family therapist, or clinical professional counselor. Satellite clinics in Hawthorne, Lovelock, Panaca, and Tonopah are staffed by licensed clinicians who travel from “parent” clinics in Yerington, Winnemucca, Ely, and Pahrump, respectively, to deliver care on certain days of the week or every other week. Satellite sites also are staffed by a permanent support mental health technician.¹²

As is evident in Map 4, behavioral health care providers are located primarily in Clark and Washoe Counties. This map includes the top ten most utilized behavioral health care programs and facilities for each Medicaid fee-for-service, Medicaid Managed Care Organizations, State-funded facilities, and substance abuse treatment facilities between 2009 and 2015. Due to data limitations, the map does not provide a comprehensive depiction of service providers, but it does offer a baseline of the availability and geographic distribution of mental health care facilities in Nevada, specifically in the rural and frontier regions of the State. Outpatient facility data is extremely limited in this dataset. See Appendix B for more information on the data used in this study, as well as data limitations.

¹² LCB staff correspondence with Rural Clinics and Community Health Services, DPBH, DHHS.

Map 4: Mental Health and Substance Use Care Facilities in Nevada



Sources: DPBH and the Division of Health Care Financing and Policy (DHCFP), DHHS. Note that outpatient facility data is extremely limited in this dataset. Please see Appendix B for more information on the limitations of the data provided.

The sheer dearth of mental health providers and the geographic distribution of services across the State has serious implications, especially for those living in rural and frontier Nevada. Time spent traveling to and from behavioral health care appointments is costly for many Nevadans, who not only incur travel time, but must often take time off work and away from other productive activities in order to access care. As a result, many individuals, especially the severely mentally ill and those who do not have access to transportation, may not be able to access behavioral health care—or may do so infrequently or only in a crisis situation.

Health Insurance, the Affordable Care Act, and Implications for Mental Health in Nevada

Lack of insurance and cost of care often are cited as barriers to accessing appropriate care. Health insurance is invaluable for people who suffer from mental illness because it helps cover the cost of mental health care, increasing the likelihood that they receive treatment.¹³

The health insurance environment in Nevada has changed significantly as a result of the implementation of the ACA, which not only expanded health insurance coverage, but also led to various policy and program changes.

The ACA led to increased health insurance coverage by:

- Requiring most individuals to have health insurance;
- Requiring or providing incentives to certain employers to provide health insurance or cover the costs for employees;
- Creating health insurance exchanges, or marketplaces, where individuals and small businesses can purchase health insurance;
- Requiring health insurance plans to cover young adults, through their parents' health care plans, up to the age of 26; and
- Requiring states to expand Medicaid to cover people with incomes up to 133 percent of the federal poverty guidelines. However, the U.S. Supreme Court struck down this requirement, and Medicaid expansion became voluntary.¹⁴ Nevada voluntarily expanded Medicaid coverage to all Nevadans under age 65 whose family income is at or below 133 percent of federal poverty guidelines, effective January 1, 2014.

¹³ Rowan, Kathleen, et al. *Access and Cost Barriers to Mental Health Care by Insurance Status, 1999 to 2010*, Health Affairs (Project Hope), 2016, www.ncbi.nlm.nih.gov/pmc/articles/PMC4236908/.

¹⁴ Initially, the ACA required states to expand Medicaid, but in June 2012, the Supreme Court found this requirement unconstitutionally coercive of states, effectively making Medicaid expansion voluntary.

Provisions of the law that specifically affect mental health include those that require certain health insurance plans to:

- Cover treatment for preexisting conditions, including mental health and substance use disorders;
- Include mental and behavioral health services as one of ten required essential health benefits, or categories of services, that health insurance plans must cover; and
- Cover mental health and addiction services at parity with medical and surgical benefits.

In addition, Medicaid coverage for the newly eligible population also must include the ten essential health benefits, including coverage for mental and behavioral health services.

These requirements increase health insurance coverage for Nevadans living with mental illness, who previously may not have been able to obtain health insurance or whose insurance may not have covered mental and behavioral health services, to the same extent as other medical services. The effect of a few of these changes in Nevada are discussed in greater detail below, as are the implications for behavioral health.

➤ **Insurance Coverage**

From 2013 to 2015, the rate of uninsured Nevadans declined from 19 to 11 percent. In 2015, an estimated 46 percent of the population was covered by employer-based health insurance, 17 percent was covered by Medicaid and the Children's Health Insurance Program (CHIP), and 13 percent by Medicare. However, even with improvements in coverage, Nevada's uninsured rate is still higher than the national average of 9 percent.¹⁵

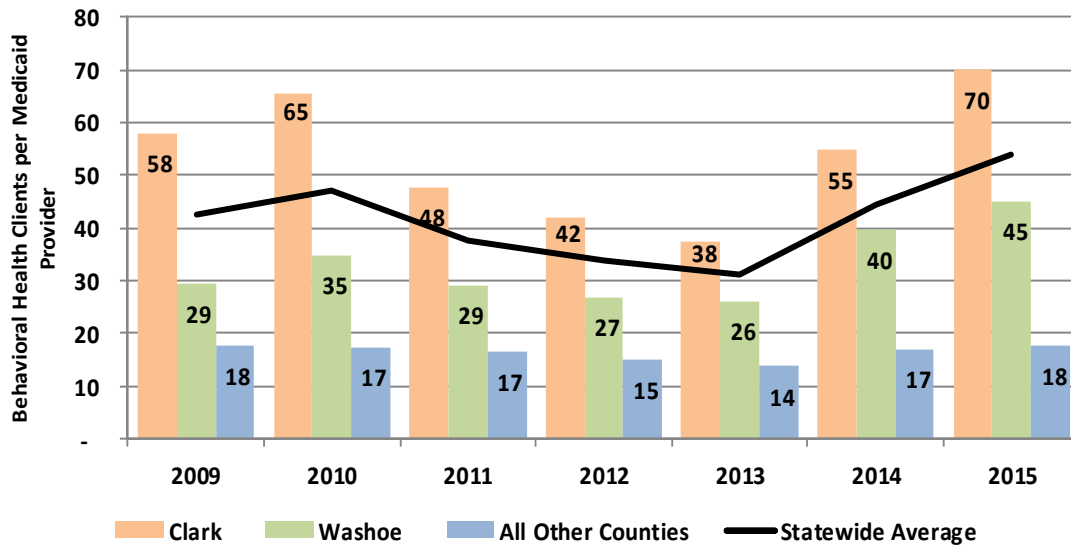
➤ **Medicaid Expansion**

With the expansion of Medicaid, the number of Nevadans covered by the public health insurance program nearly doubled from 320,000 in 2014 to approximately 627,000 in August 2016. The number of behavioral health providers accepting Medicaid patients, however, has not kept pace with the increased demand for service. Provider participation increased 93 percent between 2009 and 2015; however, the number of Medicaid participants requiring behavioral health care services increased 144 percent over the same period. While more Nevadans have insurance, access to care remains a challenge.¹⁶

¹⁵ State Health Facts, *Health Insurance Coverage of the Total Population: 2015*, The Henry J. Kaiser Family Foundation, kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

¹⁶ DPBH and DHCFF, DHHS, August 2016.

Figure 5: Nevada Behavioral Health Clients per Medicaid Provider, 2009 - 2015



Source: DPBH and DHCFP, DHHS, August 2016

➤ Young Adult Coverage

Mental disorders are common among teens and young adults and most begin in childhood or adolescence, according to the National Institute of Mental Health. Nationwide, approximately one in every five youth, ages 13 to 18, will have a seriously debilitating mental disorder during their lifetime.¹⁷ In addition, one-half of the youth and young adults living with a mental health condition develop the condition by age 14 and three-quarters by age 24. Research indicates that despite the prevalence of mental health conditions in adolescents and young adults, the vast majority lack screening, diagnosis, and access to treatment.¹⁸

The ACA provision allowing young adults to remain on their parents' health insurance until age 26 has increased coverage for youth generally and for those with mental illness. According to a Centers for Disease Control and Prevention (CDC) National Health Interview Survey, prior to the ACA, the uninsured rate among individuals ages 19 to 25 was 34 percent; in 2014, it was 20 percent.¹⁹ In Nevada, an estimated 33,000 young adults

¹⁷ *Any Disorder Among Children*, National Institute of Mental Health, National Institutes of Health, U.S. Department of Health and Human Services, www.nimh.nih.gov/health/statistics/prevalence/file_148474.pdf.

¹⁸ *Mental Health Facts: Children & Teens*, National Alliance on Mental Illness, <http://www.nami.org/getattachment/Learn-More/Mental-Health-by-the-Numbers/childrenmhfacts.pdf>.

¹⁹ Cohen, Robin A., and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2015*, National Center for Health Statistics, CDC, U.S. Department of Health and Human Services, August 2015, <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf>.

gained or kept health insurance coverage because of this provision.²⁰ In addition, a SAMHSA report found that following implementation of the ACA, mental health treatment for young adults ages 18 to 25 with possible mental health or substance use disorders increased by 5.3 percent, compared to a similar group of people ages 26 to 35.²¹

Barriers to Accessing Behavioral Health Services and Treatment

Limitations of Insurance Coverage

Barriers to behavioral health care exist, even for those who have health insurance. For example, individuals with mental illness or substance use disorders often face challenges finding in-network behavioral health providers due to the shortage of qualified professionals, inadequate provider networks, and lack of provider participation in health plans. Difficulty locating a provider can delay access to care and necessary treatment.

These challenges affect those who have private insurance and those who have Medicaid. However, Medicaid has and continues to see low rates of provider participation, largely due to complex program requirements, payment delays, and low reimbursement rates. Studies show that psychiatrists accept Medicaid and Medicare patients at a significantly lower rate than physicians in other specialties. Research and experience in Nevada also demonstrate that increasing reimbursement rates has a direct effect on provider participation in Medicaid. For example, in 2014, the DHCFP raised the rate for Medicaid inpatient mental health treatment from \$460 to \$944 per day, and provider participation increased. Between 2014 and the spring of 2016, the number of inpatient psychiatric beds in Nevada increased by approximately 18 percent, according to the Nevada Hospital Association.

Individuals with mental illness also experience a high rate of authorization request denials for treatment; high out-of-pocket costs for psychiatric prescription medications, if they are covered at all; and high copays, deductibles, and coinsurance rates. Choosing the most appropriate health insurance plan also poses a challenge, as sufficient information is not always available to assist with this decision.²²

²⁰ *State-Level Estimates of Gains in Insurance Coverage Among Young Adults*, U.S. Department of Health and Human Services, June 2012, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/state-level-estimates-of-gains-in-insurance-coverage-among-young-adults/index.html>.

²¹ Saloner, Brendan, and Benjamin Lê Cook, *An ACA Provision Increased Treatment for Young Adults With Possible Mental Illnesses Relative to Comparison Group*, *Health Affairs* 33, No. 8 (2014): 1425-1434, <http://content.healthaffairs.org/content/33/8/1425.full.pdf>.

²² Honberg, Ron, et al. *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care*, National Alliance on Mental Illness, April 2015, <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf>

Ensuring the Continuum of Care: Behavioral Health Services for Children and Youth Transitioning to Adult Behavioral Health Services

In addition to the previously described barriers to accessing care, young adults also must navigate the bifurcated State systems of behavioral health care for children and adults. Transitioning between services provided to youth by the DCFS and those provided to adults by the DPBH can be challenging. In the past, a lack of coordination between these systems and a lack of insurance coverage resulted in an unsuccessful transition between services provided by the DCFS and those provided by the DPBH for some youth.

The transition between behavioral health care systems can be especially difficult for vulnerable youth such as those exiting the foster care system. Youth in the child welfare system are much more likely to have mental health disorders than the general population. Studies suggest up to 80 percent of children in foster care have mental health disorders, compared to approximately 20 percent of their peers who are not in the system.²³ For this reason, it is important that a continuum of care exists for children aging out of foster care.. In Nevada, between 2009 and 2016, 67 percent of the 690 youth who aged out of foster care enrolled in Medicaid. Approximately 42 percent of those enrolled in Medicaid received services from State behavioral health or substance abuse prevention and treatment providers. However, it is unclear how many of the remaining 58 percent: (1) need behavioral health or substance abuse services; and/or (2) receive those services in the community. The question remains as to whether these young adults are receiving needed services.

Recognizing the challenge of ensuring a continuum of behavioral health care for youth transitioning to adult services, the Southern Nevada Adult Mental Health Services (SNAMHS) developed in November 2015 the Young Adults in Transition program, which provides case management and helps youth connect with the services they need. For detailed information about the Young Adults in Transition program, see Appendix D.

In addition, in 2015, the DHHS was awarded a four-year, \$11 million grant from SAMHSA as part of its continuing efforts to improve children's behavioral health services in Nevada. The System of Care grant aims to increase access to behavioral health assessment and care coordination services, increase the availability of emergency response services, and expand the behavioral health provider network. Through the grant, the DCFS will become a principal authority on children's behavioral health care in Nevada and transition from a provider of direct services to a more administrative role, planning, assisting with provider enrollment, providing technical assistance and training, and ensuring continuous quality improvement. The grant's strategic plan was developed collaboratively by the Children's Mental Health Consortia and the Commission on Behavioral Health.

²³ *Mental Health and Foster Care*, National Conference of State Legislatures, May 2016, <http://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx>.

A Changing Environment: Policy and Program Changes as a Result of the ACA

As possible regionalization of the behavioral health system is considered, it is important to understand other changes occurring in health insurance and care delivery as a result of the ACA.

Behavioral Health Providers Pre- and Post-ACA

As more people have obtained health insurance coverage, the location at which people receive services has shifted. For example, prior to the ACA, the DPBH provided behavioral health services to individuals who were underinsured, uninsured, or covered by Medicaid or private insurance. Of individuals receiving inpatient treatment from the DPBH (generally those with severe mental illness), 70 percent had health insurance coverage. Following implementation of the ACA, the portion of individuals with health insurance coverage receiving inpatient care at DPBH facilities declined to 50 percent, and the portion of uninsured individuals receiving care at the DPBH increased. It appears that a greater portion of individuals who have health insurance coverage are receiving treatment from community providers rather than from DPBH facilities.²⁴

According to the DPBH, State-funded facilities saw a decrease of approximately 5,450 clients with severe emotional disturbances and severe mental illness between Fiscal Year (FY) 2014 and FY 2016. However, it is unclear whether these individuals are now receiving services from community providers or whether they are no longer receiving services, as such data was not available.

Changes to the Medicaid State Plan

The guidelines for the administration of Medicaid and CHIP are outlined in a State plan. Changes to State Medicaid policies or operations must be approved by the Centers for Medicare and Medicaid Services (CMS) through a State plan amendment (SPA). In order to conform with the ACA, Nevada made several changes to its State plan, many of which directly impact mental health care or access to care by the mentally ill. These proposed changes relate to behavioral health professionals; revise behaviorally complex add-on tier rates; update certain behavioral health definitions and classifications; revise psychiatric and substance abuse services rates for critical access hospitals, general acute hospitals, and freestanding psychiatric hospitals; and eliminate the option for newly eligible recipients, with a serious mental illness, to disenroll from Medicaid managed care plans. For a complete list of Medicaid SPAs, please see <https://www.Medicaid.gov>.

²⁴ Due to data limitations, LCB staff was unable to verify that severely mentally ill—those who were served by DPBH facilities in greater proportion prior to the ACA—are now being served by private providers in the community. The following questions remain unanswered: (1) whether the severely mentally ill are receiving outpatient treatment services; and (2) once severely mentally ill individuals are discharged from inpatient or emergency room facilities, how they are accessing outpatient services.

Mental Health and Medicaid Managed Care

In Nevada, as Medicaid expanded to cover more low-income adults, additional emphasis was placed on improving quality and efficiency, and managed care became the expectation for how care would be provided to the newly eligible population—including those with severe mental, intellectual, or physical disabilities. Managed care is a health care delivery system established to control costs, monitor utilization, and improve the quality of care. Nevada contracts with managed care organizations (MCOs) to deliver health care services to Medicaid beneficiaries in Clark and Washoe Counties.

Approximately 61 percent of the traditional Medicaid population and 83 percent of newly eligible adults are enrolled in managed care in Nevada.²⁵ The remaining portion of the Medicaid population receive care through the fee-for-service (FFS) delivery system. The FFS population includes beneficiaries who are disabled, elderly, and those who live in rural and frontier areas. Currently, beneficiaries with severe mental illness who qualify for traditional Medicaid may opt out of the managed care system. However, newly eligible adult beneficiaries do not have this option.

Managed care organizations contain costs by, among other things, contracting with providers who offer services at a discounted rate, monitoring services delivered by network providers (called “utilization review”), limiting tests and medications that are considered excessive, and requiring prior authorization to see specialists or to receive certain treatments or medications. Disability advocates indicate that the restraints MCOs use often conflict with the distinct needs of individuals with severe disabilities.

However, at the same time, MCOs are in a unique position to help address patients known as “super utilizers”—those who frequently use the emergency department and whose hospital admissions may be avoided through early intervention and primary care. According to the DHCFP, MCOs in Nevada are using a host of services and programs to address members’ physical, social, and behavioral health needs. They are working to improve access to care through telemedicine, mobile medical centers, and convenient outpatient clinics; by co-locating behavioral health providers with primary care providers; and by establishing medical homes. In certain instances, health care providers receive incentive payments for meeting or exceeding specified quality, service, and utilization goals. Recognizing the effect social needs have on the prevalence of acute episodes and readmissions, MCOs are beginning to provide services such as targeted case management, home visits by community health workers and other providers, transitional housing, and behavioral health group homes, among other things.

²⁵ *Medicaid Chart Pack: September 2016*, DHHS Director’s Office, September 2016 <http://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Reports/MedicaidChartPack.pdf>.

Impact of the ACA on the State's Behavioral Health Budgets

The ACA and Nevada's decision to expand Medicaid significantly affected the State budget over the last several years. Impacts on behavioral health budgets include: reduced General Fund appropriations as a result of increased Medicaid reimbursements for patients treated at Northern Nevada Adult Mental Health Services (NNAMHS) and SNAMHS; reduced medication expenditures as more patients obtain insurance with prescription coverage; reduced General Fund appropriations for the Substance Abuse Prevention and Treatment Agency (SAPTA) as a result of training health care providers to bill Medicaid for services; and a shift in inpatient mental health resources from civil psychiatric services to forensic psychiatric services. Each budgetary change is described briefly below.

➤ Reduced General Fund Appropriations due to Increased Medicaid Reimbursements

The 2013 Legislature approved General Fund appropriations for the behavioral health budgets totaling \$240.7 million, representing a decrease of 9.6 percent compared to appropriations of \$266.2 million approved for the 2011–2013 Biennium. The majority of this \$25.5 million decrease was attributable to the expansion of Medicaid eligibility. It was anticipated the need for General Fund appropriations would be offset by an increase in Medicaid reimbursements from Medicaid managed care payers for both inpatient and outpatient services. General Fund appropriations remained relatively flat in the current biennium as the 2015 Legislature approved \$243.3 million in State funding over the 2015–2017 Biennium for the behavioral health budgets.

➤ Reduced Medication Expenditures

Total General Fund appropriations budgeted to cover medication expenditures for the NNAMHS and SNAMHS budgets consistently decreased over the last several years as a result of increased insurance coverage following implementation of the ACA and the expansion of Medicaid. Figure 6 compares the legislatively approved medication expenditures to actual medication expenditures between FY 2013 and FY 2016. Between FY 2013 and FY 2016, authorized medication expenditures for the two budgets combined decreased by 72.8 percent. Actual medication expenditures for the combined budgets decreased by 94.9 percent over the same period. In FY 2016, the medication surplus for the two budgets combined was \$3.7 million, representing 83.6 percent of the legislatively approved amount for that fiscal year.

Figure 6: Medication Expenditures—NNAMHS and SNAMHS Budgets Combined

Medication Expenditures	Legislatively Approved	Actual Expenditures	Medication Surplus
<i>NNAMHS & SNAMHS Combined</i>			
FY 2013	\$16,477,728	\$14,277,319	\$2,200,409
FY 2014	\$13,456,993	\$8,402,909	\$5,054,084
FY 2015	\$11,132,883	\$4,309,392	\$6,823,491
FY 2016	\$4,478,314	\$734,179	\$3,744,135
Total NNAMHS & SNAMHS Combined	\$45,545,918	\$27,723,798	\$17,822,120

Source: Fiscal Analysis Division, LCB; figures are based on legislatively approved budgets and financial information recorded in the State's accounting system.

The DPBH indicated the decrease in medication expenditures correlates with the decrease in caseloads at both facilities as individuals are increasingly covered by insurance (or Medicaid) and are using community providers to fill their medication needs.

➤ **Reduced General Fund Appropriations for the SAPTA Budget Due to Increased Medicaid Billing by Providers**

The 2013 Legislature approved the Governor's recommendation for a 31.3 percent reduction in General Fund appropriations in the FY 2014 legislatively approved budget for SAPTA as compared to the amount approved for FY 2013. The reduction was approved on the premise that SAPTA service providers would be required to bill Medicaid directly for services provided to newly eligible Medicaid clients, rather than rely on General Fund reimbursement.

The table below demonstrates changes in the legislatively approved General Fund appropriation funding levels for this budget.

Figure 7: SAPTA Budget – Legislatively Approved General Fund Appropriations

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
General Fund Appropriations	\$9,532,651	\$6,548,626	\$6,247,823	\$6,507,758	\$6,521,470
Percent Change From Prior Year		-31.30%	-4.59%	4.16%	0.21%

Source: Fiscal Analysis Division, LCB; figures are based on legislatively approved budgets and financial information recorded in the State’s accounting system.

➤ **Transfer of State Resources from Civil Psychiatric Inpatient Services to Forensic Competency Services**

In Nevada, civil psychiatric inpatient mental health services generally involves an involuntary emergency or court-ordered admission to a mental health facility pursuant to certain provisions of Chapter 433A (“Admission to Mental Health Facilities or Programs of Community-Based or Outpatient Services; Hospitalization”) of NRS. For involuntary treatment a persons must be determined to be a danger to themselves or others.

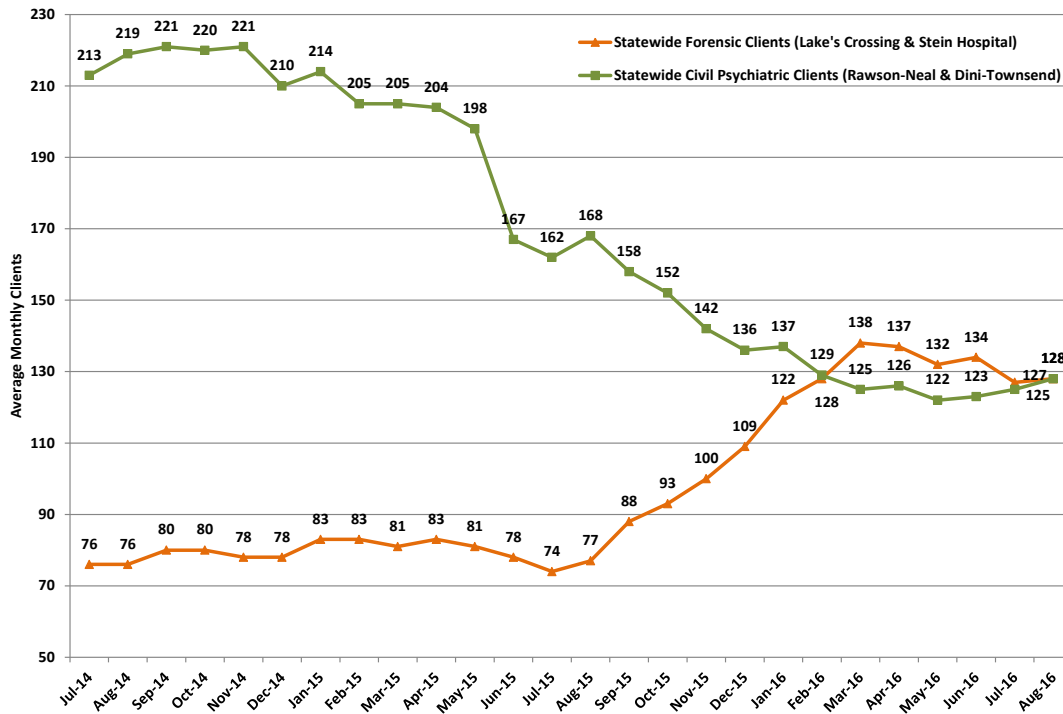
Forensic mental health services in Nevada are provided to individuals referred from the court system for evaluation to determine their capacity for restoration of legal competency to stand trial and for treatment of individuals adjudicated Not Guilty by Reason of Insanity (NGRI) so that they may return safely to the community.

In July 2014, CMS agreed to Nevada’s request to increase the Medicaid reimbursement rate for civil psychiatric inpatient mental health treatment from \$460 per day to \$944 per day. This rate increase led private-sector community providers to enter the market to provide inpatient psychiatric services to Medicaid clients. According to the Nevada Hospital Association, the number of inpatient psychiatric beds available across the State increased by approximately 18 percent, from 1,224 psychiatric beds in 2014 to 1,444 in the spring of 2016. The Nevada Hospital Association indicated that a new private psychiatric hospital under development in Reno and several hospitals in Las Vegas which have plans to expand their current capacity will increase the number of inpatient psychiatric beds in Nevada by 150 to 200 by the end of 2017.

While the influx of private community providers occurred in urban areas of both northern and southern Nevada, the impact was especially dramatic in the south. According to the DPBH, emergency departments once flooded with patients in need of behavioral health services are now receiving services from community providers willing to assist Medicaid clients. The SNAMHS has seen a dramatic reduction in the number of both inpatient and outpatient clients with Medicaid as community providers have stepped in to provide services to these patients. This influx of community providers led to a corresponding decrease in demand for State-provided civil psychiatric services at a time when the State

was under mounting pressure to decrease wait times for admission to forensic facilities. As a result, the State has been able to shift staff and capacity (beds) from civil psychiatric services to forensic services.

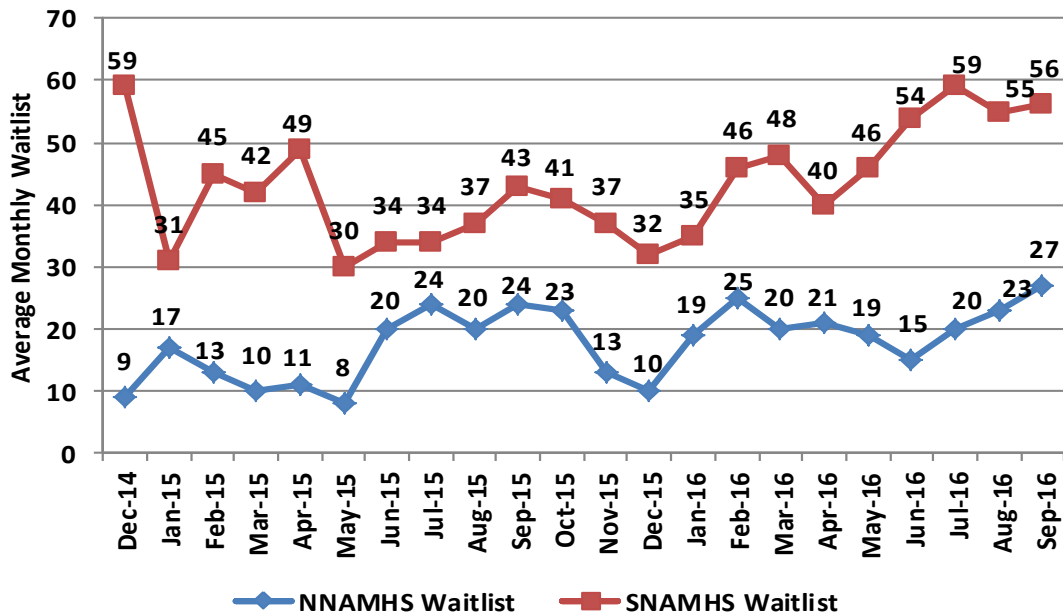
Figure 8: Statewide Average Monthly Clients by Psychiatric Facility Type



Source: Director's Office, DHHS, Facilities Chart Pack, September 2016.

Statistics from the DPBH demonstrate that, since October 2014, the SNAMHS has experienced a 47.7 percent decrease in the number of patients utilizing civil psychiatric services at Rawson-Neal Psychiatric Hospital, as displayed in Figure 8. However, in recent months, the waitlist for civil psychiatric services at both State hospitals combined increased from the previous low of 38 individuals in May 2015 to 78 individuals in August 2016.

Figure 9: Average Monthly Waitlist for State-Provided Civil Psychiatric Services



Source: Director's Office, DHHS, Facilities Chart Pack, October 2016.

The ACA has had a substantial impact on the way the State funds behavioral health services. As certain services transitioned from being covered by the State General Fund to Medicaid or private insurers, the State has been able to increase investments in other behavioral health care services.

Relationship Between the Mental Health Care System and Other Systems

Also important to consider when evaluating whether to regionalize behavioral health care governance and services in Nevada, are the relationships between the behavioral health system, public health, criminal justice, and housing. Lack of access to behavioral health care services and treatment can lead to involvement with the criminal justice system, homelessness, substance use/abuse, early onset of chronic disease, and premature death. People with mental illnesses are more likely to experience poor health, be admitted to an emergency department, and have high rates of chronic disease. They are more likely to cycle in and out of the criminal justice system and often face challenges finding and maintaining safe, affordable housing. State and local governmental entities in Nevada increasingly are recognizing that failing to treat mental illness carries high costs for both the individual and the State as a whole and are working collaboratively across systems to improve services and limit costs.

Mental Health and Public Health

Studies demonstrate a strong link between mental illness, mental health, and physical health—especially chronic disease. According to the CDC, extensive evidence highlights the association between mental illness and chronic diseases, such as arthritis, asthma,

cancer, cardiovascular disease, diabetes, epilepsy, and obesity. In addition, intentional and unintentional injury rates for people with a history of mental illness are between two and six times higher than that of the general population.²⁶ While certain mental illnesses are related to risky behaviors that contribute to chronic disease, evidence also indicates positive mental health is associated with better health outcomes.²⁷

In 1999, the Office of the Surgeon General released a report calling for a broad public health approach to mental illness, concluding that mental disorders are among the most prevalent and costly conditions in the United States, and that effective treatment can reduce their prevalence and negative effect on other health conditions.²⁸ The author of the report emphasized that there is “no scientific reason to differentiate between mental health and other kinds of health. Mental illnesses are physical illnesses.”²⁹

Since then, public health agencies have been working to incorporate mental health promotion into chronic disease prevention efforts, including conducting surveillance and research to improve the evidence base on mental health. In Nevada, the former Health Division and Division of Mental Health and Developmental Services merged to form the DPBH in 2013. The mission of the DPBH is to “protect, promote, and improve the physical and behavioral health of the people of Nevada.”

Mental Health and the Criminal Justice System

People with mental illness disproportionately interact with the criminal justice system. According to a national study by the Bureau of Justice Statistics, U.S. Department of Justice, an estimated 56 percent of state prisoners and 64 percent of jail inmates have a mental health disorder.³⁰ In the Clark County Detention Center, approximately one-third of inmates are on psychotropic medication, and in Washoe County, approximately one-quarter of inmates take medication for mental health disorders.³¹ Nationwide, the criminal justice system houses

²⁶ Centers for Disease Control and Prevention, *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011–2015*, Atlanta: U.S. Department of Health and Human Services; 2011, http://www.narmh.org/News/CDC_MH_Action_Plan_FINAL8-3-12.pdf.

²⁷ Perry, Geraldine S., Letitia R. Presley-Cantrell, and Satvinder Dhingra, “Addressing Mental Health Promotion in Chronic Disease Prevention and Health Promotion,” *American Journal of Public Health*, December 2010; 100(12): 2337-2339, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2978190/>.

²⁸ *Mental Health: A Report of the Surgeon General*, National Institute of Mental Health, Center for Mental Health Services, Office of the Surgeon General, U.S. Public Health Service, 1999, <https://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>.

²⁹ Hegner, Richard E., *Applying Science to Public Policy: The Context of the Surgeon General’s Report on Mental Health*, National Health Policy Forum, March 2000, http://www.nhpf.org/library/background-papers/BP_SGMH_3-00.pdf.

³⁰ James, Doris J., and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Bureau of Justice Statistics, September 2006, <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

³¹ LCB staff correspondence with the Las Vegas Metropolitan Police Department and with the Washoe County Sheriff’s Office, August 2016.

significantly more people with mental illness than hospitals.³² Incarcerating individuals with mental illness is costly, not only for the criminal justice system, as these individuals often have higher health care costs and recidivism rates, but also for the individual and society as a whole. Incarceration negatively affects quality of life and an individual's ability to be a productive member of society.³³

In rural and frontier Nevada, individuals with mental illness present unique challenges for limited health care and law enforcement resources. Often, the only option available to law enforcement in these counties is placing a person with mental illness in custody or in a local hospital emergency department until an inpatient bed is available in an urban area. This process generally occurs through an involuntary civil commitment and consumes hospital and law enforcement resources. Rural and frontier law enforcement also reports that people with mental illness who are transported to an urban hospital often return to the community without resolution, after significant law enforcement resources are expended.

Both State and local governments in Nevada are working to address this issue by implementing programs and policies to divert people with mental illness from the criminal justice system and reduce the number of mentally ill individuals who are incarcerated. Programs focus on better meeting the needs of people with mental illness by connecting them with community resources and treatment options. While urban areas generally have more resources, rural and frontier areas also are working to implement some of the programs described below.

- **Crisis Intervention Training (CIT)**—This program provides law enforcement and emergency responders with 40 hours of comprehensive training on how to interact with people who may have severe mental illness or intellectual disabilities. Participants learn about crisis management and emergency admission to a mental health facility. The training stresses the importance of the partnership between law enforcement and first responders, mental health professionals, and other social service providers and educates participants about community resources for individuals with mental illness. More than 1,430 officers with the Las Vegas Metropolitan Police Department (LVMPD) and 375 officers in Washoe County have received CIT training.³⁴ In addition, Washoe County's CIT program has hosted officers and first responders from throughout northern Nevada.
- **Mobile Outreach Safety Team (MOST)**—This program pairs a behavioral health care provider with a law enforcement officer to visit adults in the community who are at risk of incarceration or hospitalization because they struggle with behavioral health issues or

³² Torrey, E. Fuller, et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, Treatment Advocacy Center, and National Sheriffs' Association, May 2010, http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

³³ Kim, KiDeuk, Miriam Becker-Cohen, and Maria Serakos, *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis*, Urban Institute, March 2015, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf>.

³⁴ LCB staff correspondence with local government entities, August, 2016.

substance use disorders. The program aims to connect such people with appropriate community services before they experience a crisis that could lead to hospitalization or arrest by providing immediate intervention, assessment, de-escalation, and referral to outpatient services. The Mobile Outreach Safety Team is currently being implemented in Carson City, Las Vegas, Washoe County, and in rural and frontier counties including Churchill, Douglas, and Lyon Counties. Nearly all jurisdictions have expressed a desire to implement or expand their MOST programs but have been unable to do so due to limited resources.

- **Forensic Assessment Services Triage Team (FASTT)**—The FASTT program aims to connect people with needed treatment and resources to end the revolving cycle of arrest. It relies on collaboration between law enforcement and community behavioral health providers to prevent arrest and adjudication. Multidisciplinary teams work together to screen inmates for behavioral health concerns, assess needs for service planning, and develop a release plan. The Forensic Assessment Services Triage Team is currently being implemented in Carson City and Douglas and Lyon Counties.
- **Mental Health Court**—This specialty court is a multijurisdictional, community-based program that provides court supervision and services to mentally ill offenders. Mental Health Court focuses on mental health treatment and compliance to improve quality of life, reduce recidivism, and increase community safety and awareness through the cooperation of State, county, and local nonprofit service agencies. More than 300 individuals were participating in Mental Health Courts as of August 2016. Participants are provided supportive services such as basic skills training, case management for court compliance activities, medication management, supervision, and transportation, and some are provided housing. Most participants do not have natural support systems, have a history of homelessness, have little to no employment options, experience co-occurring disorders, and are in need of significant rehabilitation.

Existing mental health courts include those in the Clark Region, Washoe Region, and Western Region (Churchill, Lyon, and Mineral Counties). The Washoe Region also has a Family Mental Health Court. In addition, a new Mental Health Court was added to provide services to the Northern Region (Elko, Humboldt, and Pershing Counties) in FY 2016.

- **Assisted Outpatient Treatment (AOT)**—Established in Clark County in 2013, AOT provides court-ordered, community-based outpatient treatment for individuals diagnosed with severe and persistent mental illness and who have a recent, repeated history of medication noncompliance and/or incarceration. Participants are required by the court to follow treatment plans developed with their health care providers. The program serves approximately 80 patients and has effectively reduced hospitalization, arrest, and incarceration. In addition, AOT programs have been shown to reduce homelessness and victimization and prevent violence associated with mental illness.

- **Stepping Up Initiative**—A national program led by the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Foundation, the Stepping Up Initiative aims to reduce the number of adults with mental illness and co-occurring disorders in jails. The Initiative enlists diverse partners to build on and scale up innovative and evidence-based practices across the nation. Its three main components are: (1) spreading a call to action; (2) providing technical assistance; and (3) hosting a national summit for participating counties. In Nevada, Carson City and Churchill, Clark, Douglas, Lyon, and Washoe Counties are currently taking part in the initiative.

Housing for Individuals With Mental Illness

Having a safe place to live, as well as access to services to live as independently as possible, is key for people with mental illness. Housing—and especially supportive housing—can help reduce the use of homeless shelters, hospitals, emergency departments, jails and prisons, and the associated public costs.³⁵ However, for many people with mental illness, finding and maintaining appropriate housing can pose a serious challenge. Nationally, 20 percent of people experiencing homelessness have a severe mental illness, according to the Substance Abuse and Mental Health Services Administration.³⁶

In Nevada, a handful of housing assistance options are available for vulnerable populations. While not necessarily specific to people with mental illness, housing options include long-term, in-home care; intensive supportive living arrangements; supportive living contracts; transitional housing; group homes; shelter plus care homes; and others. Housing options in northern Nevada are more limited than in southern Nevada, and very few exist in rural and frontier Nevada. A few small, nonprofit organizations provide limited housing allotments specifically for people with severe mental illness. In addition, the NNAMHS and SNAMHS have designated housing slots for individuals enrolled in Mental Health Court—NNAMHS provides housing support for approximately 52 percent of its 200 Mental Health Court participants, and SNAMHS provides housing support for 100 percent of its 75 Mental Health Court participants.

Recent Expansion of State Funding to Address Behavioral Health in Nevada

During the 2015 Legislative Session, the Legislature approved numerous budgetary enhancements for behavioral health care in Nevada. Several of the funding recommendations were proposed by the Governor’s Behavioral Health and Wellness Council and included in the *Executive Budget*. The 20-member Council, established by Governor Sandoval through executive order on December 13, 2013, was tasked with identifying ways to improve and strengthen the delivery of services to individuals with behavioral health issues. It was created

³⁵ *Supportive Housing for People with Mental Illness: Regaining a Life in the Community*, National Governor’s Association: Center for Best Practices, September 2007, <http://housingtaskforce.org/resources/Supportive+Housing+for+People+with+Mental+Illness.pdf>.

³⁶ Karaim, Reed, “People with Mental Illness,” *National Public Radio*, 2002, <http://www.npr.org/news/specials/housingfirst/whoneeds/mentallyill.html>.

on the heels of high-profile incidents that precipitated demand for increased investment in behavioral health programs: During the summer of 2013, severe overcrowding of individuals experiencing mental health issues in southern Nevada emergency rooms received widespread media attention. On June 21, 2013, the Clark County Public Defender's Office filed its second lawsuit in five years regarding extended wait times for admission to Lake's Crossing, which at the time, was the only forensic facility in the State. On September 10, 2013, a class action lawsuit filed by the City of San Francisco accused the State of busing mentally ill patients from the Rawson-Neal Psychiatric Hospital in Las Vegas to California.

A summary and brief description of each of the more substantial behavioral health budget enhancements approved during the 2015 Legislative Session follow.

Figure 10: Behavioral Health Budget Enhancements for the 2015-2017 Biennium

Infrastructure Enhancements	FY 2016	FY 2017	2015-17 Biennium Total
Moonlighting Program Expansion at NNAHMS	\$200,750	\$200,750	\$401,500
Residency Program Expansion at SNAMHS	\$345,024	\$345,024	\$690,048
Social Workers in Schools Grant Program, Department of Education	\$5,594,400	\$11,188,800	\$16,783,200
Statewide Psychiatric Director	\$243,270	\$242,647	\$485,917
Mental Health Court Caseload Increases at SNAMHS	\$889,808	\$889,808	\$1,779,616
Mental Health Court Caseload Increases at NNAHMS	\$185	\$17,102	\$17,287
Stein Hospital Re-Opening	\$5,392,158	\$7,087,606	\$12,479,764
Weighted Caseloads in Rural Counties	\$896,007	\$934,419	\$1,830,426
WICHE - Psychology Internships and Nursing Slots	\$218,996	\$49,994	\$268,990
Total	\$13,780,598	\$20,956,150	\$34,736,748

Source: Fiscal Analysis Division, LCB; figures are based on legislatively approved budgets and financial information recorded in the State's accounting system.

Moonlighting and Residency Programs Through the University of Nevada, Reno, School of Medicine

The 2015 Legislature approved \$690,048 in General Fund appropriations over the 2015–2017 Biennium to increase funding for an estimated 15 to 17 contracted psychiatric residents per year from the University of Nevada, Reno, School of Medicine (UNR) to the SNAMHS. The 2015 Legislature also approved \$401,500 in General Fund appropriations over the 2015–2017 Biennium to increase funding for psychiatric residents from UNR to provide moonlighting coverage—psychiatric coverage outside of regular operating hours including after business hours, on weekends and holidays, and on-call coverage—to the NNAHMS.

The DPBH indicates psychiatrist recruitment is one of its biggest challenges and that the UNR psychiatric residency and child and adolescent fellowship programs are valuable recruitment tools. Over the past ten years, 50 physicians have graduated from these programs,

and half remained in the State.³⁷ These programs not only provide training for residents, but also deliver much needed clinical psychiatric services to Nevadans. In addition, having residents provide moonlighting coverage helps meet operational demands and furnishes training opportunities for residents. After-hours coverage is critical to maintaining CMS certification and accreditation by the Joint Commission. Additionally, the Governor's Behavioral Health and Wellness Council recommended creating additional residency slots.

Social Workers in Schools Grant Program

The 2015 Legislature approved \$5.6 million and \$11.2 million in FY 2016 and FY 2017, respectively, for a new grant program within Nevada's Department of Education to provide contract funding to school districts and charter schools for social workers or other licensed mental health workers in schools. The program operates as a block grant to local school districts based on needs identified through a health screening survey. The survey presents data on student risk and protective factors, mental health, school safety, connectedness, and school climate (including discipline, bullying, and other forms of victimization).

In FY 2016, 161 behavioral health care provider positions were awarded based on school need. Due to the shortage in behavioral health care providers in Nevada, recruiting providers proved challenging. However, 153 providers ultimately were contracted or hired by 84 schools representing 12 school districts.³⁸

Statewide Psychiatric Medical Director

The 2015 Legislature approved \$485,917 in General Fund appropriations over the 2015–2017 Biennium to hire a Statewide Psychiatric Medical Director. The primary duties of this position include oversight of all psychiatric services provided by the SNAMHS, the NNAMHS, rural clinics, Lake's Crossing, and Stein Hospital. Other duties include coordinating with executive committees, providing expert testimony and consultative services, collaborating with law enforcement and correctional agencies, and recruiting medical staff for all behavioral health agencies.

According to the DPBH, the Statewide Psychiatric Medical Director must be a board certified psychiatrist eligible for licensure in Nevada and, at the time of appointment, possess the following qualifications: a Nevada medical license, Drug Enforcement Administration certification, State Board of Pharmacy license, and cardiopulmonary resuscitation (CPR) certification. The Director also must have experience in administrative psychiatry and

³⁷ Griswold, Tabor, and John Packham, *UNSOM Health Policy Report, Nevada Residency and Fellowship Training Outcomes – 2006 to 2015: Key Findings from the Annual UNSOM Graduate Medical Education Exit Survey, July 2015*, Office of Statewide Initiatives, UNSOM, July 2015, http://med.unr.edu/Documents/unsom/statewide/reports/UNSOM_GME_Exit_Survey_Results_2006_to_2015_-_July_27_2015_FINAL_VERSION.pdf.

³⁸ Rindels, Michelle, "Nevada hiring army of social workers to fight school bullying," *Reno Gazette-Journal*, 10 May 2016, <http://www.rgj.com/story/news/2016/05/08/nevada-hiring-army-social-workers-fight-school-bullying/84119162/>.

testifying to facts in legislative and legal hearings. The Statewide Psychiatric Medical Director position was filled on August 3, 2015.

Mental Health Court Caseload Increases

The 2015 Legislature approved \$1.8 million in General Fund appropriations over the 2015–2017 Biennium to meet projected caseload growth needs for clients in the southern Nevada Mental Health Court program. The 2015 Legislature also approved \$17,287 over the 2015–2017 Biennium to fund one new part-time psychiatric caseworker and associated costs, beginning in March 2017, to meet projected caseload growth needs and reduce staffing ratios for service coordination in the northern Nevada Mental Health Court program.

Differences in funding are due, in part, to the fact that Mental Health Court programs vary substantially by region. Participants in the southern Nevada Mental Health Court program primarily face felony charges and have a long history of criminal justice involvement. It is a three-year program, and the majority of participants require housing and supportive services in conjunction with intensive case management and programming. In contrast, the northern Nevada Mental Health Court program primarily serves individuals with misdemeanors and gross misdemeanors. The program typically is completed in 12 months; approximately one-half (48 percent) of participants receive only case management services and do not require housing assistance.

The Governor’s Behavioral Health and Wellness Council proposed expanding existing programs such as Mental Health Courts because providing high-intensity services and safe, stable housing to the heaviest users of the most expensive forms of care (correctional facilities and emergency rooms) can dramatically improve results at a lower cost.

Stein Hospital

The 2015 Legislature approved \$12.5 million in General Fund appropriations over the 2015–2017 Biennium to fund 91.51 new State positions, contract staff, and operating costs related to the reopening of the Stein Hospital on the SNAMHS campus as a forensic psychiatric facility. Forensic facilities provide mental health services in a maximum security environment to mentally disordered offenders referred from the court system, with the goal of restoring their competency.

Previously, Lake’s Crossing, located in northern Nevada, was the only forensic facility in the State. The majority of patients requiring forensic services were from southern Nevada and regularly transported to northern Nevada. The renovation of Stein Hospital added 47 forensic beds in the Las Vegas valley, providing forensic capacity in southern Nevada for the first time in State history.

Weighted Caseloads in Rural and Frontier Counties

The 2015 Legislature approved General Fund appropriations of \$1.8 million over the 2015–2017 Biennium to fund ten case managers, five mental health counselor contract positions, and two new State clinical social worker positions in rural and frontier counties to reduce caseload staffing ratios. The positions were approved to implement a policy change to the way caseload ratios are calculated for clients in rural and frontier counties. The policy change applies weighted ratios based on client acuity (or required level of care) for outpatient counseling. According to the DPBH, individuals with more serious mental illnesses require more time and may be weighted to equal two or more individuals with less severe and less intense needs.

The positions were intended to decrease caseloads from a weighted ratio of one mental health counselor to 77 patients (1:77) to a weighted ratio of 1:67, nearing the DPBH's target weighted caseload of 1:65. Using weighted caseload ratios is intended to better serve existing clients. According to the DPBH, the additional staff will significantly decrease the number of clients a therapist is expected to serve at any one time and improve the Division's ability to meet clients' clinical needs.

Western Interstate Commission for Higher Education—Psychology Internship and Psychiatric Nursing Slots

The 2015 Legislature approved \$150,000 in FY 2016 to fund four new doctoral psychology internship slots in the SNAMHS, the NNAMHS, the Carson Mental Health Center, and Lake's Crossing to help reduce the State's shortage of psychologists. In addition, the 2015 Legislature approved \$118,990 over the 2015–2017 Biennium to fund 17 new post-graduate psychiatric nurse slots. Funding provided coursework for psychiatric nurse credentialing and competencies enabling ten participants to become certified in psychiatric medication management. In addition, seven registered nurse slots were funded to allow participants to become Advanced Practice Registered Nurses and to test for national certification as psychiatric mental health nurse practitioners.

II. DEFINING BEHAVIORAL HEALTH CARE REGIONS

If the behavioral health care system in Nevada is regionalized, the regions must be thoughtfully defined, keeping in mind the issues already discussed in this report, including:

- State geography and population distribution;
- Supply of behavioral health care providers;
- Location of behavioral health services throughout the State; and

- Health insurance coverage and how coverage drives where care is obtained—whether at State operated entities (NNAMHS, SNAMHS, or rural clinics) or community providers.

It also is important to understand where Nevadans currently access care and why they access care in certain locations. While this study examines the former, it does not attempt to explain the reasons patients access care outside of their home county. In defining behavioral health care regions, it also is helpful to evaluate how and where existing entities are collaborating on behavioral health issues to provide possible examples or models for regional alignment for the behavioral health system.

Patterns of Accessing Care

Where do Nevadans receive behavioral health care? Although the shortage of behavioral health providers is a statewide issue, the vast majority of providers are located in urban areas. Residents of urban communities overwhelmingly access care within their community, but where do the 275,000 residents of rural and frontier Nevada—who are spread out over more than 95,000 square miles—go for behavioral health care?

The tables that follow answer part of this question by depicting the home zip code of patients who receive services from State-funded behavioral health facilities, Medicaid FFS providers, and Medicaid MCOs. This data provides some insight into where patients access behavioral health care services, compared to where they reside, and how far they travel for treatment.

However, the data has a few limitations: (1) each behavioral health provider (i.e., Medicaid FFS, Medicaid MCOs, and the State) provided data for only the top ten programs or facilities; (2) each facility or program funded by Medicaid FFS or MCOs only includes patient data for the top 20 zip codes, which may account for a range of 59 to 93 percent of total patients, thus totals do not reflect the true total number of admissions; and (3) outpatient data was provided only for State-funded behavioral health facilities (neither Medicaid FFS nor MCOs provided this information). While the data assists in depicting where individuals from different regions access services, a more complete dataset—as well as information on why patients access care in specific locations—may expand on the key findings derived from this analysis.

Figure 11: Behavioral Health Emergency Room and Inpatient Treatment Facilities, Regional Access

Patient County of Residence	FACILITY LOCATION BY COUNTY											
	Carson City	Churchill	Clark	Douglas	Elko	Humboldt	Lyon	Nye	Pershing	Washoe	White Pine	All Counties
Carson City	1,337	7	-	17	12	1	2	-	-	445	-	1,821
Churchill	17	602	-	1	-	1	-	-	1	208	-	830
Clark	-	-	91,214	1	2	2	1	34	1	63	3	91,321
Douglas	258	4	-	227	-	-	2	-	-	18	-	509
Elko	-	4	-	-	908	1	-	-	-	-	3	916
Esmeralda	-	-	-	-	-	-	-	-	-	-	-	-
Eureka	-	-	-	-	4	-	-	-	-	-	-	4
Humboldt	-	-	-	-	5	207	-	-	2	55	1	270
Lander	-	2	-	1	9	-	-	-	-	-	-	12
Lincoln	-	-	-	-	-	-	-	-	-	-	-	-
Lyon	346	85	-	2	1	-	163	-	-	651	-	1,248
Mineral	-	25	-	-	-	-	7	-	-	9	-	41
Nye	-	3	100	-	-	-	-	1,053	-	-	3	1,159
Pershing	-	-	-	-	-	10	-	-	131	-	-	141
Storey	-	-	-	-	-	-	-	-	-	-	-	-
Washoe	142	53	121	2	36	9	4	-	1	25,362	2	25,732
White Pine	-	-	-	-	7	-	-	-	-	-	223	230
Total	2,100	785	91,435	251	984	231	179	1,087	136	26,811	235	124,234

LEGEND	
	County Residents Using Same County Facilities
	Areas of Natural Alignment

Note: The table above includes all encounters at State-funded mental health inpatient facilities between 2009 and 2015, encounters at inpatient or emergency room facilities for patients residing in the top 20 zip codes funded by Medicaid FFS between 2014 and 2015, and encounters at inpatient or emergency room facilities for patients residing in the top 20 zip codes funded by Medicaid MCOs between 2009 and 2015. See Appendix B for more information.

Figure 12: Behavioral Health Outpatient Treatment Facilities, Regional Access

Patient County of Residence	FACILITY LOCATION BY COUNTY											
	Carson City	Churchill	Clark	Douglas	Elko	Humboldt	Lyon	Nye	Pershing	Washoe	White Pine	All Counties
Carson City	1,636	7	-	76	1	-	35	-	-	1	1	1,757
Churchill	7	488	-	-	1	-	5	-	-	-	2	503
Clark	-	-	11,409	-	-	-	-	-	-	-	-	11,409
Douglas	70	1	-	1,010	1	-	3	-	-	-	-	1,085
Elko	-	-	-	-	451	-	1	-	-	-	7	459
Esmeralda	-	-	-	-	-	-	-	-	-	-	-	-
Eureka	-	-	-	-	2	-	-	-	-	-	7	9
Humboldt	-	-	-	-	1	-	-	-	-	-	-	1
Lander	-	-	-	-	-	-	-	1	-	-	-	1
Lincoln	-	-	-	-	-	-	-	-	-	-	-	-
Lyon	114	51	-	13	-	-	434	-	-	-	-	612
Mineral	2	2	-	-	-	-	-	-	-	-	-	4
Nye	-	3	-	-	-	-	-	862	-	-	2	867
Pershing	-	3	-	2	1	-	-	-	-	-	-	6
Storey	4	-	-	-	-	-	2	-	-	-	-	6
Washoe	-	-	-	-	-	-	-	-	-	8,220	-	8,220
White Pine	2	1	-	-	3	-	-	-	-	-	394	400
Total	1,835	556	11,409	1,101	461	-	480	863	-	8,221	413	25,339

LEGEND	
	County Residents Using Same County Facilities
	Areas of Natural Alignment

Note: The table above includes all encounters at State-funded mental health outpatient facilities between 2009 and 2015. Neither Medicaid FFS or Medicaid MCOs provided outpatient data. See Appendix B for more information.

Source: DPBH and DHCFFP, DHHS, August 2016.

Since Figure 12 does not include outpatient behavioral health data for Medicaid patients, it is unclear how many Medicaid patients who receive inpatient or emergency care ultimately receive outpatient care and whether they travel to another county or remain in their home county for such care. In considering the regionalization of behavioral health governance and services, it is important to try to determine where residents receive outpatient treatment by obtaining additional data from the DHCFFP.

Key Observations on Patterns of Accessing Behavioral Health Care in Nevada

- **The vast majority of individuals seeking behavioral health care receive services in their home county**, as indicated by the data cells shaded in pink in Figures 11 and 12 (on pages 36 and 37, respectively). This is true for most counties and especially so in urban areas. Based on this dataset, it also appears that individuals are more likely to stay in their home county for outpatient treatment than for inpatient and emergency behavioral health services.
- **Not all Nevadans receive behavioral health care in their home county.** For example, Figure 11 on page 36 shows that of the 1,821 behavioral health emergency room and inpatient encounters involving residents of Carson City, 1,337 occurred in Carson City; 7 occurred in Churchill County; 17 in Douglas County; 12 in Elko County; 1 in Humboldt County; 2 in Lyon County; and 445 in Washoe County. All 4 of the behavioral health emergency room and inpatient encounters involving residents of Eureka County occurred in Elko County, as did the majority (9 out of 12) of such encounters involving residents of Lander County.
- **Residents from certain counties receive behavioral health services from facilities in neighboring counties**, as indicated by the data cells shaded in green. For example, the first column in Figure 11 on page 36 shows that a large number or portion of behavioral health emergency and inpatient encounters which occur at facilities in Carson City involve residents from Douglas, Lyon, and Washoe Counties. A similar trend is evident, though to a lesser degree, in travel for outpatient behavioral health services; however, the trend is somewhat less clear due to the limited dataset.
- **Areas of natural regional alignment exist in travel to behavioral health care treatment.** The data show three natural regions within which residents currently travel to receive care.
 - o Northern Nevada: Residents of Carson City and Douglas, Lyon, and Washoe Counties receive emergency, inpatient, and outpatient treatment from facilities in these counties. Residents of Churchill and Mineral Counties travel to these counties to receive services as well.
 - o Southern Nevada: Residents of Nye County travel to Clark County for emergency and inpatient behavioral health services.
 - o Northeastern Nevada: Residents of Elko, Eureka, and Lander Counties all primarily receive emergency and inpatient behavioral health services from facilities in Elko County.
 - o Out-of-State: Although not included in Figures 11 and 12 (on pages 36 and 37, respectively), it is important to note that residents in certain parts of the State receive services across state lines. In 2014 and 2015, at least 8 behavioral health encounters

involving residents of Elko County occurred in Salt Lake City, Utah, and at least 167 behavioral health encounters involving residents of Clark County occurred in Bullhead City, Arizona.³⁹

Current Behavioral Health Collaboration and Care Coordination Structures

In recent years, a few regionally organized entities have been established to address behavioral health issues in Nevada. In contemplating a shift to a regionalized system, it may be helpful to review these organizations, should they offer insight into defining regions or provide a foundation on which to build a more comprehensive regional structure. Each entity's structure and purpose is described briefly below and summarized in Figure 13 on page 42.

Children's Mental Health Consortia (NRS 433B.333)

In 2001, the Legislature established three regional mental health consortia, one each in: (1) Clark County; (2) Washoe County; and (3) rural and frontier Nevada (the remaining 15 counties). Each entity is tasked with developing a regional, long-term strategic plan for the delivery of mental health services to children with mental health disorders. The consortia are required to submit to the Director of the DHHS and the Commission on Behavioral Health a list of service priorities necessary to implement their long-term strategic plans, the cost to provide those services, and revisions to their plans on or before January 31 of each even-numbered year. In odd-numbered years, each consortium must submit a status report on and any revisions to the long-term strategic plan.

The consortia may participate in activities to implement the provisions of their strategic plan, improve the provision of mental health services to children with emotional disturbance and their families, and coordinate with the DHHS to avoid duplication of services. To this end, the DPBH established the Nevada Mental Health Consortium to facilitate communication and collaboration between the State and regional consortia, provide children and their families a system of care that offers access to behavioral health treatment that meets their needs in the least restrictive environment, and develop financing to support quality care. See Appendix E for each consortium's most recent policy priorities.

Behavioral Health Coordinators

In 2015, the DPBH awarded subgrants to fund a behavioral health coordinator in three regions of the State: (1) Clark County; (2) the "Quad County Region," which includes Carson City and Churchill, Douglas, and Lyon Counties; and (3) Washoe County. The DPBH is planning to issue additional grants to the Elko County area and other regions of the State. Funding is provided through the federal Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants.

³⁹ DPBH and DHCFF, DHHS, August 2016.

The Behavioral Health Coordinator's role, in addition to other responsibilities, is to:

- Coordinate and maximize the integration and cooperation of mental health and substance abuse programs and services across State, county, and community organizations;
- Identify community needs, evaluate the quality of behavioral health services, resolve problems, and develop plans and objectives;
- Convene meetings with behavioral health service providers and participate in the development, selection, and implementation of long-range plans for behavioral health services; and
- Develop cooperative working relationships with law enforcement agencies, social services, advocacy organizations, mental health and substance abuse providers, and other agency and community partners.

Each behavioral health coordinator's responsibilities are slightly different, enabling coordinators to better identify and address regional priorities and community needs. See Appendix F for additional information on coordinators' activities and accomplishments to date.

Community Mental Health Programs (Chapter 433C of NRS)

Established in 1965, Chapter 433C of NRS creates the statutory authority and structure for individual counties or groups of counties to develop a locally controlled "community mental health program." Each program is required to have a county mental health advisory board, which is responsible for:

- Reviewing and evaluating community needs, services, facilities, and problems related to mental health and intellectual disabilities;
- Advising and making recommendations to the board of county commissioners about services and facilities for individuals with mental illness and intellectual disabilities; and
- Acting in a general advisory capacity on these topics.

In addition, the DPBH is responsible for establishing the Nevada Conference of County Community Mental Health Programs, to serve as a forum for discussion on rules for implementing community mental health programs, coordinating and integrating county and State services, and other matters. However, to date, no county has established a community mental health program pursuant to this statutory authority. See Appendix G for the full text of Chapter 433C of NRS.

Nevada Early Intervention Services System

One example of a regionalized health program in Nevada, though unrelated to behavioral health care, is Nevada Early Intervention Services (NEIS). Located within the Aging and Disability Services Division, DHHS, NEIS provides services to children with developmental delays or disabilities from birth to 3 years of age. Services must be provided in the home or a home-like setting, which means services need to be available in rural and frontier Nevada, as well as in urban areas. Nevada Early Intervention Services is organized into three regions: (1) the northeast region, which has offices in the cities of Elko, Ely, and Winnemucca and serves families in Elko, Eureka, Humboldt, Lander, upper Nye, Pershing, and White Pine Counties; (2) the northwest region, which has offices in Carson City and Reno and serves families in Carson City and Churchill, Douglas, Lyon, Mineral, Storey, and Washoe Counties; and (3) the southern region, which has offices in Las Vegas and serves urban and rural Clark County, as well as lower Esmeralda, Lincoln, and lower Nye Counties.

Local Health Authorities

Local public health authorities also are organized regionally. Chapter 439 (“Administration of Public Health”) of NRS provides a statutory structure for individual cities and counties to establish a board of health and for groups of cities and counties to create local health districts, governed by a district board of health. Two local health districts currently exist, and the local health authority in Carson City provides some regional public health services.

Health Districts

- **Southern Nevada Health District** has jurisdiction over public health matters in all of Clark County and was established by Clark County, Boulder City, Henderson, Las Vegas, Mesquite, and North Las Vegas.
- **Washoe County Health District** has jurisdiction over all public health matters in Washoe County and was established by Washoe County, Reno, and Sparks.⁴⁰

Local Health Authorities

- **Carson City Health and Human Services** is the local health authority for Carson City and has been delegated authority by the Chief Medical Officer to provide certain services in Douglas, Lyon, and Storey Counties.⁴¹

⁴⁰ “About the Washoe County Health District,” Washoe County, Nevada, 2016, https://www.washoecounty.us/health/about_us/index.php.

⁴¹ LCB staff correspondence with Carson City Health and Human Services.

In addition, under the direction of the State Board of Health, the DPBH serves as the health authority in areas of the State not governed by a health district or local health authority. The State Board of Health also has ultimate authority in non-administrative health matters and over district, county, and city health boards.

These entities not only provide different examples of regionalization, they may also offer a foundation upon which to build a regional system and are summarized in Figure 13.

Figure 13: Behavioral Health Entities and Examples of Regional Organization

Entity	Regional Structure	Establishing Authority
Commission on Behavioral Health	Single, centralized entity associated with the DHHS.	NRS 433.314
Children’s Mental Health Consortia	Regions: • Clark County • Washoe County • Rural and Frontier Counties All regional consortia report to the centralized Nevada Mental Health Consortium within the DPBH.	NRS 433B.333
Behavioral Health Coordinators	Regions: • Clark County • Washoe County • “Quad County Region”: includes Carson City and Churchill, Douglas, and Lyon Counties • Future region: Elko County Regions do not currently cover the entire State.	DPBH subgrant using the Community Mental Health Services block grant and the Substance Abuse Prevention and Treatment block grant.

Figure 13: Behavioral Health Entities and Examples of Regional Organization (continued)

Entity	Regional Structure	Establishing Authority
Community Mental Health Programs	Single counties or groups of counties are authorized to establish a locally-controlled “community mental health program.” The DPBH would establish a conference of such programs to improve communication, coordination, and integration across the State. To date, no county has established such a program.	Chapter 433C of NRS
Nevada Early Intervention Services System	Regions: • Northeast: Elko, Eureka, Humboldt, Lander, upper Nye, Pershing, and White Pine Counties. Regional offices are located in Elko, Ely, and Winnemucca. • Northwest: Carson City and Churchill, Douglas, Lyon, Mineral, Storey, and Washoe Counties. Regional offices are located in Reno and Carson City. • Southern: Clark, Esmeralda, Lincoln, and lower Nye Counties. Regional offices are in Las Vegas.	Federal Individuals with Disabilities Education Improvement Act of 2004, Public Law 108-446
Local Health Authorities	Health Districts • Southern Nevada Health District: Clark County, Boulder City, Henderson, Las Vegas, Mesquite, and North Las Vegas. • Washoe County Health District: Washoe County, Reno, and Sparks. Local Health Authority • Carson City Health and Human Services: Carson City; provides certain services to Douglas, Lyon, and Storey Counties.	Chapter 439 of NRS

Potential Options for Defining Behavioral Health Care Regions in Nevada

When evaluating options for defining behavioral health care regions, it is important to consider all of the factors previously discussed and to ensure residents of rural and frontier Nevada have access to services. The following analysis examines a variety of possible options for regionalization and identifies key issues that must be considered when making such decisions.

Traditional Regional Structure in Nevada: One Rural/Frontier Region and Two Urban Regions

Nevada is commonly split into three regions: (1) Clark County; (2) Washoe County; and (3) rural and frontier counties. This arrangement, however, is difficult for providing or administering behavioral health care services because rural and frontier Nevada spans 95,000 square miles, contains 275,000 people, and has very few behavioral health services. In addition, common patterns of access show that residents of rural and frontier areas often travel to urban areas or out of state for behavioral health services.

Regions Based on Current Care Access Patterns and Areas of Natural Alignment

Patterns of travel to behavioral health treatment clearly reveal three areas of natural alignment, including:

1. Northwest region: Carson City and Churchill, Douglas, Lyon, Mineral, and Washoe Counties;
2. Northeast region: Elko, Eureka, Lander, and potentially White Pine Counties; and
3. South region: Clark and Nye Counties.

However, this option fails to include Esmeralda, Humboldt, Lincoln, Pershing, and Storey Counties. Nor does it account for the size of Nye County and the travel that would be required from northern parts of the county to access services in Clark County.

Expansion of Existing Regions to Include Natural Alignment

Another option is to overlap regions of natural alignment with behavioral health coordinator regions. In this scenario, the “Quad County” (Carson City and Churchill, Douglas, and Lyon Counties) behavioral health coordinator region remains intact. However, based on the natural alignment demonstrated in Figure 11 on page 36, Mineral and Storey Counties are included with the Quad County region, creating a “Northwestern” region. Another area of natural alignment appears between Elko, Eureka, and Lander Counties. In addition, given that residents of White Pine County who do not receive treatment in their home county receive services in Elko County, White Pine is included in the “Northeastern” region. Clark County has its own behavioral health coordinator and is naturally aligned with Nye County, whose

residents travel to Clark County for services. However, based on the size and location of Nye County, it may be helpful to divide it into upper and lower sections.

1. **Northwestern Region(s): Carson City and Churchill, Douglas, Lyon, Mineral, Storey, and Washoe Counties**—The Quad County behavioral health coordinator region remains intact and is joined by Mineral, Storey, and Washoe Counties due to proximity and natural alignment. This region is relatively large and may benefit from being divided into two regions. For example, Humboldt, Pershing, and Washoe Counties might form a region separate from the Quad County region plus Mineral and Storey Counties.
2. **Northeastern Region: Elko, Eureka, Lander, and White Pine Counties**—This area of natural alignment, based on current patterns of access to care, is maintained. The DHHS is planning a future behavioral health coordinator in Elko County and may wish to consider including neighboring counties to increase regional coordination, similar to the Quad County region.
3. **Southern Region: Clark, lower Nye, and Lincoln Counties**—Clark County is joined by lower Nye County due to its size and proximity to services. Lincoln County joins this region with a very small population and, according to data provided in Figures 11 and 12 (on pages 36 and 37, respectively), with very few residents who require behavioral health services, at least between the years 2009 and 2015. It may be worth considering dividing Lincoln County into upper and lower sections and including only lower Lincoln County in this region due to its proximity to Clark County.
4. **Remaining Counties**—This regional arrangement does not include Esmeralda, Humboldt, upper Nye, or Pershing Counties, which do not appear to demonstrate areas of natural alignment for services and which are not included in existing behavioral health coordinator regions.

Addressing Rural and Frontier Counties

As is evident in the options above, the difficulty in trying to create effective and responsive regions lies in the vast geographic expanse that encompasses sparsely populated rural and frontier counties of the State. The frontier counties not included in regions outlined above have few, if any, behavioral health care facilities or providers. These counties do not demonstrate areas of natural alignment in terms of where residents access care, nor do they currently have a regional behavioral health coordinator.

One regional model that accounts for all 17 counties, including all rural and frontier counties, is NEIS. Because this program must provide services either in the home or in a home-like setting, regions have been designed to strategically maximize efficiency and minimize travel. The NEIS regions geographically are quite large and, if this approach is used to regionalize behavioral health care governance and service delivery, there may be concerns regarding whether such expansive regions impede the ability of individual communities to provide

effective input regarding local needs. Creation of smaller sub-regions within large geographic regions may ensure that local input is heard.

Another option for rural and frontier Nevada may be to focus efforts on developing behavioral health services. New and existing programs could be leveraged to improve access to care in these areas. For example, the University of Nevada, Las Vegas, School of Medicine is planning to integrate various initiatives to provide care to rural and frontier areas in its new curriculum and programs. Other institutions within the Nevada System of Higher Education (NSHE) may be willing to collaborate as well. Telemedicine also holds promise to increase access to care in rural and frontier Nevada, as long as appropriate infrastructure is available. Alternatively, resources could be targeted to expand the services provided at rural health clinics and federally qualified health centers in rural and frontier Nevada to establish a baseline of behavioral health care services in these areas.

Estimating the Cost of Administering the Regional Structure(s)

Estimating the cost of establishing and operating a regional behavioral health care system is nearly impossible without additional information. Details such as the number of regions, the structure of each regional entity and its scope of work, among other things, are necessary to accurately estimate potential costs. Below is a list of factors that may influence the cost of administering a regionalized behavioral health system:

- Number of regions and coordinating bodies;
- Number of members in each entity;
- Member compensation, if any;
- Degree of formalization of each coordinating body (e.g., being subject to the Open Meeting Law or receiving compensation);
- Meeting location and frequency (e.g., in person or via video conference technology);
- Meeting length (i.e., single or multiday meetings);
- Reimbursement of travel, transportation, and per diem costs to attend meetings;
- Access to facilities for meeting spaces and the cost for such space;
- Staff support for the operations of each body;
- Use of contractors—committee roles and responsibilities will dictate whether contractors are needed;

- Availability of existing infrastructure to facilitate a regional model (e.g., office space for support staff); and
- Expenses such as supplies, postage, and miscellaneous operating expenses.

In considering whether and how to regionalize the behavioral health system in Nevada, it is important to keep these potential costs in mind. In addition to the cost of administering a regional structure, it is also important to consider how regionalization might affect the cost of providing or expanding the direct provision of behavioral health care services, how services would be funded, and any other effects regionalization might have on State supported DHHS budgets.

III. REGIONALIZED BEHAVIORAL HEALTH GOVERNANCE MODELS

In response to the federal Community Mental Health Act of 1963, many states began developing comprehensive community-based mental health centers, transferring funding to local authorities, and supporting the development of community-based services. Over time, many states shifted the responsibility of providing behavioral health care services to local communities and established community-based service delivery systems. The DPBH's *2013 Gaps Analysis of Behavioral Health Services – Update* highlights these trends in contrast to Nevada, where the State continues to serve as the sole provider of public behavioral health services.⁴² If the Legislature's goal is to implement a comprehensive regionalized behavioral health system, it is essential to develop strong community-based behavioral health services in Nevada.

Today, many states have a regionalized system of behavioral health governance. However, the definition of “regionalization”—what it means and looks like—varies. In some states, a local government or regional entity is responsible for nearly everything related to behavioral health care, while in others, regional bodies primarily provide input and develop behavioral health priorities that are responsive to community needs. While some states rely on existing government entities, such as counties, to govern behavioral health care, other states develop specific authorities and governmental or quasi-governmental structures.

The most comprehensive form of regionalization exists in states in which the regional or county entity is responsible for nearly all financial and administrative behavioral health activities, such as identifying needs, developing priorities, directing funding, and contracting for or directly delivering services. In this type of governance structure, the state's role is generally to transmit funds to the regional entities and provide oversight, support, and statewide standards.

⁴² Watson, Lisa, and Kelly Marschall, *2013 Gaps Analysis of Behavioral Health Services – Update*, DPBH, DHHS, 2013, <http://www.leg.state.nv.us/interim/77th2013/Committee/StatCom/HealthCare/Other/5-February-2014/Agenda5.pdf>.

The models discussed below vary in governance structure, specific responsibilities, and involvement in the delivery of direct services. Each was chosen to display a different approach to regionalization. This section also includes the description of a structure for a potential regional governing body in Nevada, as presented by certain participants in the Southern Nevada Forum.

Summary of Select State Governance Models

In California, individual counties or groups of counties have broad discretion for administering the behavioral health system, including developing program budgets and priorities, determining how to fund and provide services to specific populations, and delivering services—either directly through county-employed providers at county-owned or operated facilities or by contracting with providers and facilities. Counties also are responsible for contracting with Medicaid MCOs and other providers for non-Medicaid services. County boards of supervisors oversee local mental health programs with assistance from mental health advisory boards. This level of decentralization results in wide variation in the type, quality, and quantity of services provided. At the state level, the Mental Health Services Division within the Department of Health Care Services is responsible for shaping the mental health delivery structure through statute and for providing oversight of the system.

Since California passed the Short-Doyle Act in 1957, counties have maintained primary responsibility for delivering behavioral health services, with state oversight. This Act improved the ability of local governments to deliver community-based behavioral health services by providing matching state funds for these programs. In 1991, the state's Realignment Act gave counties greater control over their behavioral health programs, modified state-county funding ratios, and allowed for more stable streams of revenue derived from taxes and vehicle registration fees. Public spending on mental health services in California currently is comprised of a mix of state, federal, and county funds, with counties administering approximately 90 percent of behavioral health care funding.

In Massachusetts, the Department of Mental Health (DMH) is organized into five geographic areas, which recognize and respond to the unique characteristics of each community. Each area has its own administrative structure and staff, including a full-time medical director, a part-time child psychiatrist, a director of community services, a director of child/adolescent services, and a director of quality management. The areas are further divided into 28 local service sites throughout the state. Site offices provide case management and work with an integrated system of state- and vendor-operated mental health services to provide care. At the state level, the DMH Central Office sets and monitors DMH policies and standards, provides service and program planning, and oversees fiscal, legal, and personnel tasks.

Funding is allocated by the DMH to the five geographic areas from state appropriations, a trust fund, and a federal block grant. These funds cover expenditures for both state-operated and contracted services, such as state hospitals, community mental health centers, and contracted

adult and adolescent inpatient units. Funding also commissions contracted service providers to manage a community-based system that serves and supports approximately 19,000 patients.

In Ohio, the Department of Mental Health and Addiction Services (OhioMHAS) manages the behavioral health care system, which includes 51 regional community mental health boards—most of which are known as Alcohol, Drug Addiction, and Mental Health Services Boards. While some boards represent a single county, others represent multiple counties. The boards are responsible for planning, funding, monitoring, and evaluating each county’s mental health and addiction recovery services. Rather than directly providing services, the boards contract with public, private, and nonprofit providers.

State statute governs board composition, size, and requirements and stipulates that each board must include a clinician, consumer, and family member with knowledge of mental health and addiction services. Boards receive funding from Medicaid, the state, and grant funds. Counties also can approve local property taxes in addition to state funds. General guidelines for distributing funds are provided by the Ohio General Assembly, and OhioMHAS operates within those guidelines to direct and establish priorities to provide effective and sustainable services. In addition, OhioMHAS sponsors a Behavioral Health Leadership Group, which meets quarterly to facilitate communication throughout the state.

In Michigan, 46 Community Mental Health Services Programs (CMHs) coordinate mental health services. The CMHs have evolved over time and may take one of three forms: (1) CMH Agency, formed by one or more counties, as a county entity with county employees; (2) CMH Authority, a nonprofit formed by one or more counties as a separate entity from the county—CMH Authorities may own property and enter into contracts, and employees are not county employees—or (3) CMH Organization, formed by two or more counties or one county and an institute of higher education—organizations are separate bodies from counties, and they may own property and enter into contracts. A 12-member board governs all of these entities; county commissioners appoint CMH Agency and Authority boards or the county Chief Executive Officer and CMH Organization boards have equal representation from each governing body. The CMHs can deliver services directly or oversee a network of private service providers. The programs are responsible for assessing and responding to community needs; making sure providers act in accordance with standards of care; accepting and resolving grievances, appeals, and complaints; and providing certain public services, prevention, and education. The CMHs are independent entities under State supervision. The State manages contracts with the programs, requires fiscal and performance audits, and reviews mandatory annual reports outlining all of the services and support activities provided to consumers.

Across Michigan, federal, state, and local funds support behavioral health services. The behavioral health budget is divided into three categories: (1) traditional Medicaid; (2) Healthy Michigan Plan (the ACA Medicaid expansion population); and (3) non-Medicaid behavioral health and state psychiatric hospitals. The State is financially liable for 90 percent of the annual “net cost” of a CMH, and the local county is liable for the remaining 10 percent. The “net cost” includes CMH expenditures that are approved and eligible for state financial

support and not paid for by the federal or state government or other reimbursement from individuals and insurers who are obligated to pay the cost of services. The local match changes based on the availability of local and state funds, and the state match is subject to the legislative appropriation designated to support the CMHs.

The State of Nebraska is divided into six regions, or Regional Behavioral Health Authorities, which contract with the Division of Behavioral Health within the Department of Health and Human Services (DHHS) to plan and implement non-Medicaid behavioral health services. The regions in turn contract with local providers for an array of services and support including inpatient, outpatient, and emergency services, as well as community mental health and substance use disorder services. While most services are purchased from providers within the region, services may be purchased from providers in other regions, if necessary. Each region is staffed by an administrator and “system coordinators” (i.e., for emergency, youth, prevention, housing, and consumer systems) and other personnel and is governed by a board comprised of one county commissioner from each of the counties within the region. Regions are allocated funds based on a formula consistent with census and poverty level. Community-based mental health and substance use disorder services are funded through state general fund appropriations, federal block grants, federal discretionary grants, a local county match (\$1 dollar for every \$3 received), health care cash funds, and housing-related assistance funds.

At the state level, the Division of Behavioral Health directly operates three public psychiatric hospitals and provides funding, oversight, and technical assistance to the behavioral health regions. The Division prioritizes funds after assessing for gaps in services and directly contracts for services such as those with the federally recognized tribes, Interchurch Ministries, and others. In addition, two advisory committees—on mental health services and substance abuse prevention and treatment services—meet quarterly and advise the Division in their respective areas. While the advisory committees are separate in statute, the committees meet jointly to ensure co-occurring and complex issues are addressed.

In North Dakota, behavioral health services are provided primarily by the state. With a relatively small population and large geographic rural and frontier areas, North Dakota faces many of the same behavioral health care challenges as Nevada. Most of the state is federally designated as having a shortage of mental health professionals, the majority of the population lives in urban counties, and 36 of the state’s 53 counties are considered frontier.

However, behavioral health care services are provided on a more regional basis in North Dakota. Eight regional human service centers provide co-located community-based mental health services, substance abuse treatment, disability services, vocational rehabilitation, and other human services to a designated multicounty area, either directly or through contracts with providers. Regional human service centers are state agencies, funded by state and federal funds, and operated by regionally located state employees under the leadership of the Department of Human Services (DHS). The Behavioral Health Division within the DHS provides leadership for the planning, development, and oversight of the state’s behavioral health system. It works with stakeholders to improve access to behavioral health services,

address workforce needs, develop policies, and ensure quality services are available. The Behavioral Health Division also licenses the regional human service centers. Separately, the Field Services Division within the DHS functions as the service delivery system, providing behavioral health and other human services at the regional service centers and the state hospital.

While behavioral health resources are relatively scarce in North Dakota, leaving the state to provide many of these services, there is a relatively high level of access to care compared to other states, according to Mental Health America's ranking of state mental health systems.

In Washington State, the Behavioral Health Administration (BHA) within the Department of Social and Health Services (DSHS) provides prevention, intervention, inpatient, outpatient, and recovery services to people with mental illness and substance use disorders, using state and federal funds. The BHA operates three state psychiatric hospitals and the Division of Behavioral Health and Recovery within the BHA licenses, certifies, and regulates programs and agencies that provide behavioral health services.⁴³

In 2015, the Washington State Legislature authorized the DSHS to establish regional Behavioral Health Organizations (BHOs) to purchase and administer regional, publicly funded behavioral health services through managed care contracts. The BHOs operate within state-designated Regional Service Areas (RSAs), which encompass a single county or multiple contiguous counties, contain at least 60,000 Medicaid recipients, include an adequate supply of health care providers, and reflect natural referral patterns for both behavioral and physical health. The BHOs also are aligned contractually and geographically with the state's Medicaid managed care contracts.⁴⁴

The BHOs assumed responsibility for providing behavioral health services in nine RSAs in April 2016. Counties in one RSA chose not to create a BHO and instead have the state contract with managed care organizations to purchase and administer combined physical and behavioral health services.

In transitioning to this system, the DSHS indicated it anticipates increased access to publicly funded, community-based behavioral health care as a result of larger provider networks, as well as more effective management of financial resources.⁴⁵

The Division of Behavioral Health and Recovery partners with the Washington State Behavioral Health Advisory Council on issues related to behavioral health. The Council reviews state plans, annually monitors and evaluates the adequacy of mental health services,

⁴³ Reyes, Carla, *Behavioral Health Administration: Strategic Plan 2015-2017*, BHA, DSHS, March 2016, <https://www.dshs.wa.gov/sites/default/files/SESA/spmrw/documents/current/Strategic%20Plans/BHA.pdf>.

⁴⁴ *Overview: Integrating Washington State's Behavioral Health System*, DSHS, March 2016, https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/BHO_Overview.pdf.

⁴⁵ Ibid.

studies programs and services, identifies gaps in the service system, and solicits feedback on mental health issues in the state.⁴⁶

Governance Model Discussed at the Southern Nevada Forum

Proposed by certain participants at the Southern Nevada Forum, this model would divide the State into three or four regions, including: (1) Southern Nevada (Clark, Lincoln, and Nye Counties); (2) Northern Nevada (Carson, Douglas, and Washoe Counties); and (3) one or two rural regions, depending on the number of people accessing services and available service locations.

Each region would have its own mental health authority, consisting of two groups, or tiers, of stakeholders.

- **Tier I** would consist of behavioral health care experts, including academics and providers, as well as representatives of law enforcement, the criminal justice system, public health, housing, community nonprofits, and for-profit organizations. This group would be responsible for identifying community needs and defining regional behavioral health priorities.
- **Tier II** would consist of State and local policymakers—including State legislators who represent the region, county commissioners, and other local policymakers. This group would be responsible for translating the priorities outlined by the group of experts in Tier I into policy recommendations and budget requests. This group would also make decisions on how to prioritize recommendations to maximize resources and the impact on behavioral health.

The two-tiered regional behavioral health authorities would each submit base/partial biennial budgets to the DHHS, with flexibility to address emerging issues that require immediate action. Funding would be allocated by the Nevada Legislature to the DHHS and distributed to each regional mental health authority based on factors such as regional population, policy recommendations and budget requests, use of evidence-based programs, and improvements in regional behavioral health services. According to proponents, the goal of such a structure is to create a system that is more responsive to emerging needs. Rather than relying on the two-year biennial budget process, regional mental health authorities would be able to request additional funds from the DHHS throughout the biennium.

Regional authorities could be public bodies, subject to the Open Meeting Law, or government-sanctioned nonprofit entities established in such a way to provide an open, inclusive, and transparent way for regional behavioral health policy to be discussed, developed, and administered. Regional mental health authorities would provide

⁴⁶ “Behavioral Health Advisory Council,” DSHS, 2016, <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/behavioral-health-advisory-council>.

services directly or contract with community-based or private entities for provision of services. Regional authorities also would be represented on appropriate local health district boards.

In this model, the State would distribute funds to regional mental health authorities. It also would be responsible for providing oversight of regional mental health authorities, setting standards, monitoring performance through assessments, and ensuring operations occur in an open, transparent manner. In addition, the State's role may vary by region. For example, the State may continue to provide services directly in rural areas or for specific "carve out" populations or services. The State's role in each region would be developed jointly by the regional authority and the DHHS.

Public Policy Options

As with many complex systems, it is difficult to decide where to dedicate efforts and limited resources to effectuate improvements and change. However, during the course of this study, various stakeholders presented policy options that may be beneficial in future deliberations on regionalizing behavioral health care in Nevada and in informing improvements to the behavioral health care system. Following is a brief summary of options presented by stakeholders.

To involve local stakeholders in the identification of key behavioral health issues and development of priorities, policymakers may wish to consider:

- Establishing boundaries for behavioral health regions and designating or developing entities within each region to provide input, feedback, and other consultation;
- Increasing the number of behavioral health program coordinators to ensure that all communities in the State have a coordinator; and
- Revising the duties and responsibilities of the Commission on Behavioral Health to increase communication and coordination with regional entities to improve the responsiveness of State policies and programs to meet specific regional needs. In order to help improve the Commission's ability to respond to concerns, stakeholders recommended expanding the Commission's authority to review findings of investigations of complaints about the treatment of individuals with mental illness, intellectual disabilities, substance use disorders, co-occurring disorders, or related conditions to include private facilities. The Commission already has the authority to review findings of investigations about the treatment of these individuals in public facilities, pursuant to subsection 3 of NRS 433.316; and
- Incorporating the Commission on Behavioral Health, or its duties and responsibilities, in to the State Board of Health to enhance communication and coordination with regional entities to improve the responsiveness of State policies and programs to meet regional needs. Such

integration would be another step toward integrating physical and behavioral health in Nevada.

To develop community-based resources and services, policymakers may wish to consider:

- Collaborating with rural hospitals, rural health clinics, and licensed medical providers who practice primarily in rural areas of the State to develop a plan to expand behavioral health care services provided at existing health care facilities in rural and frontier Nevada;
- Increasing the use of telemedicine to improve access to behavioral health care services across the State, especially in rural and frontier Nevada;
- Requesting the DHHS evaluate whether and how Medicaid funding could be used to help support behavioral health services offered by community-based providers;
- Working with behavioral health professional licensing boards, NSHE institutions, private institutions of higher education, and other stakeholders to create a comprehensive behavioral health workforce development plan to improve the workforce and increase behavioral health services in every region of the State in order to support the decentralization of service delivery. Specific activities might include:
 - o Reviewing health professional scopes of practice, health professional licensing board licensure application and renewal processes, and options for recognizing national accreditations and expanding reciprocal licensing or endorsement opportunities, while maintaining quality standards and patient safety; and
 - o Establishing policy and funding priorities for new or expanding health professional education programs at institutions of higher education that focus on increasing access in underserved areas of the State; and
- Expanding the capacity of community health centers (CHCs)—private, nonprofit organizations that provide primary health care services to residents of specific, medically underserved areas—to increase provision of behavioral health services by:
 - o Expanding the list of billable providers for Prospective Payment System reimbursement—a Medicare payment structure based on a predetermined fixed amount—to include additional qualified behavioral health providers (e.g., Marriage and Family Therapists or Licensed Professional Counselors);
 - o Providing additional resources for both operational support and capital;
 - o Improving access to specialty behavioral health services needed by CHC patients with significant behavioral health issues (e.g., through co-location of services, closer physical proximity, or streamlined referrals); and

- o Increasing access to supportive housing services.

To **further study behavioral health regionalization and develop policy options in Nevada**, the Legislature may consider: (1) creating a subcommittee of the Legislative Commission; (2) establishing an interim study committee through legislation; or (3) delegating specific responsibility to existing legislative entities, Executive Branch agencies, and public institutions of higher education. Public entities with responsibility for health care strategic planning and oversight or professional development include:

- Legislative Committee on Health Care (NRS 439B.200);
- Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs (NRS 218E.750);
- Legislative Committee on Child Welfare and Juvenile Justice (NRS 218E.705);
- Division of Public and Behavioral Health, DHHS;
 - o Office of Health Planning and Primary Care;
- Department of Employment, Training and Rehabilitation;
 - o Governor's Workforce Development Board; and
- NSHE institutions, including:
 - o University of Nevada, Reno, School of Medicine;
 - Office of Statewide Initiatives;
 - ❖ Health Workforce Research and Policy Program;
 - ❖ Medical Education Council of Nevada;
 - ❖ Nevada State Office of Rural Health; and
 - ❖ Project ECHO; and
 - o University of Nevada, Las Vegas, School of Medicine.

Conclusion

The issues, examples, and options described in this study serve as catalysts for discussion among diverse policymakers and stakeholders to inform deliberations related to decentralizing mental health care governance and services in Nevada. Numerous factors that may influence such deliberations must be considered, including: access to behavioral health care across the State; the status of private and public health care insurance coverage; the effect of the ACA on health insurance coverage and health care providers; the vast geographic expanse that encompasses sparsely populated rural and frontier counties of the State; collaboration among stakeholders within the State; and the costs associated with transitioning to and maintaining a more regional behavioral health system. Considering these issues collectively will help inform future efforts to improve the quality, accessibility, effectiveness, and efficiency of the mental health care system in Nevada.

IV. APPENDICES

	<u>Pages</u>
Appendix A	
Abbreviations	57
Appendix B	
Data Summary and Limitations.....	61
Appendix C	
Commission on Behavioral Health	67
C.1 – Establishing Statute: Nevada Revised Statutes 433.314 Through 433.327	69
C.2 – Bylaws	73
C.3 – 2016 Letter to the Governor (annual report)	81
Appendix D	
Young Adults in Transition	101
Appendix E	
Children’s Mental Health Consortia Policy Priorities	105
E.1 – Clark County Children’s Mental Health Consortium	107
E.2 – Rural Nevada Children’s Mental Health Consortium	129
E.3 – Washoe County Children’s Mental Health Consortium	149
Appendix F	
Regional Behavioral Health Coordinators	161
Appendix G	
Community Mental Health Programs.....	167

APPENDIX A

Abbreviations

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Abbreviations

ACA	Affordable Care Act
AOT	Assisted Outpatient Treatment
CCSS	Clark County Social Services
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CIT	Crisis Intervention Training
CMS	Centers for Medicare and Medicaid Services
DHHS	Department of Health and Human Services
DCFS	Division of Child and Family Services
DHCFP	Division of Health Care Financing and Policy
DPBH	Division of Public and Behavioral Health
FASTT	Forensic Assessment Services Triage Team
FFS	Fee-for-service
FY	Fiscal Year
LCB	Legislative Counsel Bureau
MCO	Managed care organization
MOST	Mobile Outreach Safety Team
NEIS	Nevada Early Intervention Services
NRS	<i>Nevada Revised Statutes</i>
NSHE	Nevada System of Higher Education
NNAMHS	Northern Nevada Adult Mental Health Services
OML	Open meeting law

SNAMHS	Southern Nevada Adult Mental Health Services
SPA	State Plan Amendment (Medicaid)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPTA	Substance Abuse Prevention and Treatment Agency
UNSOM	University of Nevada, Reno, School of Medicine

APPENDIX B

Data Summary and Limitations

APPENDIX B

Data Summary and Limitations

The Legislative Counsel Bureau (LCB) solicited data from the Department of Health and Human Services (DHHS) for portions of this report. Three divisions provided data, including the Division of Public and Behavioral Health (DPBH), the Division of Health Care Financing and Policy (DHCFP), and the Division of Child and Family Services (DCFS).

The data offer information on the status of mental health and the mental health system in Nevada. However, certain datasets contain limitations that constrain the ability to make definitive conclusions. It is important to keep these limitations in mind when interpreting the data provided; notes regarding such limitations are included throughout the body of the report. If the Legislature decides to consider regionalization, it may be helpful to pursue and analyze a more expansive data set.

This Appendix provides summaries of the datasets provided by the DHHS, as well as a discussion of data limitations.

Map 4 (Mental Health and Substance Use Care Facilities in Nevada)

Map 4 was created using data from the DPBH and the DHFCP regarding the locations in which individuals access mental health and substance use services in Nevada, including data from State funded substance abuse treatment facilities, State funded behavioral health inpatient and outpatient programs, and Medicaid. However, there are several limitations to this dataset.

First, the only outpatient behavioral health facilities represented are those from State funded facilities at Northern Nevada Adult Mental Health Services, Southern Nevada Adult Mental Health Services, and rural clinics. Community outpatient behavioral health facilities are not included in this dataset.

Second, Medicaid fee-for-service (FFS) and Medicaid managed care organizations (MCOs) only provided inpatient and emergency room data.

Third, all data providers, including State funded services, Medicaid FFS, and Medicaid MCOs provided information for only the top ten programs or facilities in Clark County, Washoe County, and rural and frontier regions of the State. Therefore, this map does not represent a comprehensive list of behavioral health facilities in Nevada. It does, however, provide a baseline of the availability of mental health care facilities in Nevada. In addition, this dataset represents facilities accessed by patients between the years of 2009 and 2015—including facilities that are no longer open. When possible, LCB staff attempted to eliminate these facilities from the map.

Figure 5 (Nevada Behavioral Health Clients per Medicaid Provider, 2009–2015)

The DPBH and DHCFP provided data related to access to behavioral health care for Medicaid recipients from 2009 to 2015, including the number of behavioral health professionals providing services to Medicaid beneficiaries and the total number of Medicaid beneficiaries receiving behavioral health care services by region. Using this data, LCB staff created Figure 5 to demonstrate the increase in the number of both Medicaid behavioral health providers and clients statewide. The LCB is not aware of any significant limitations to this dataset.

Ensuring the Continuum of Care: Youth Transitioning to Adult Behavioral Health Services (page 18)

The DPBH, DHCFP, and DCFS provided data related to Nevada foster children who were 18 years of age or older when they exited the foster care system between January 1, 2009, and July 7, 2016. This data was used to calculate the number of former foster youth enrolled in Medicaid who accessed care at State behavioral health or substance abuse prevention and treatment providers, with the goal of determining whether former foster youth—who are more likely to experience mental health disorders—access behavioral health services after leaving the child welfare system. While the data demonstrates that some former foster youth are accessing behavioral health care services at State funded facilities, it does not include information about youth who receive services from community providers not funded by the State or Medicaid providers at non-State facilities. The data does, however, provide a baseline indication of the portion of former foster youth who access behavioral health care services.

Figure 11 (Behavioral Health Emergency Room and Inpatient Treatment Facilities, Regional Access) and Figure 12 (Behavioral Health Outpatient Treatment Facilities, Regional Access)

The DPBH and DHCFP provided data related to where individuals receive behavioral health care services. State funded behavioral health facilities, Medicaid FFS, and Medicaid MCOs provided the home zip code of patients, compared to the location in which they received services, in order to determine where patients access behavioral health care services. This data has several limitations, some of which were previously discussed in relation to Map 4 (Mental Health and Substance Use Care Facilities in Nevada).

First, each data provider (i.e., Medicaid FFS and MCOs) and State funded facilities provided information only for their top ten programs or facilities. Second, data for each facility or program funded by Medicaid only includes patient encounters for the top 20 zip codes, meaning totals do not reflect 100 percent of all admissions. Third, the use of patient encounters does not provide insight as to whether the same patients access facilities multiple times. Fourth, neither Medicaid FFS nor Medicaid MCOs provided outpatient data. Finally, data were provided for different time periods by different sources. State funded behavioral health services and Medicaid MCOs provided data for 2009 through 2015, while

Medicaid FFS provided data for 2014 through 2015. While the data helps identify where individuals from different regions of the State access services, a more complete dataset may help improve and expand upon the findings derived from this analysis.

APPENDIX C

Commission on Behavioral Health

APPENDIX C

Commission on Behavioral Health

C.1 – Establishing Statute: *Nevada Revised Statutes 433.314 Through 433.327*

NRS 433.314 Duties. The Commission shall:

1. Establish policies to ensure adequate development and administration of services for persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders, including services to prevent mental illness, intellectual disabilities and related conditions, substance use disorders and co-occurring disorders, and services provided without admission to a facility or institution;
2. Set policies for the care and treatment of persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders provided by all state agencies;
3. Review the programs and finances of the Division; and
4. Report at the beginning of each year to the Governor and at the beginning of each odd-numbered year to the Legislature on the quality of the care and treatment provided for persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders in this State and on any progress made toward improving the quality of that care and treatment.

(Added to NRS by [1975, 1593](#); A [1985, 2265](#); [1999, 2591](#); [2009, 662](#); [2013, 664](#), [3005](#))

NRS 433.316 Powers. The Commission may:

1. Collect and disseminate information pertaining to mental health, intellectual disabilities and related conditions, substance use disorders and co-occurring disorders.
2. Request legislation pertaining to mental health, intellectual disabilities and related conditions, substance use disorders and co-occurring disorders.
3. Review findings of investigations of complaints about the care of any person in a public facility for the treatment of persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders.
4. Accept, as authorized by the Legislature, gifts and grants of money and property.
5. Take appropriate steps to increase the availability of and to enhance the quality of the care and treatment of persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders provided through private nonprofit organizations, governmental entities, hospitals and clinics.
6. Promote programs for the treatment of persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders and participate in and promote the development of facilities for training persons to provide services for persons with mental

illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders.

7. Create a plan to coordinate the services for the treatment of persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders provided in this State and to provide continuity in the care and treatment provided.

8. Establish and maintain an appropriate program which provides information to the general public concerning mental illness, intellectual disabilities and related conditions, substance use disorders and co-occurring disorders and consider ways to involve the general public in the decisions concerning the policy on mental illness, intellectual disabilities and related conditions, substance use disorders and co-occurring disorders.

9. Compile statistics on mental illness and study the cause, pathology and prevention of that illness.

10. Establish programs to prevent or postpone the commitment of residents of this State to facilities for the treatment of persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders.

11. Evaluate the future needs of this State concerning the treatment of mental illness, intellectual disabilities and related conditions, substance use disorders and co-occurring disorders and develop ways to improve the treatment already provided.

12. Take any other action necessary to promote mental health in this State.

(Added to NRS by [1985, 2263](#); A [1999, 2592](#); [2009, 663](#); [2013, 665](#), [3006](#))

NRS 433.317 Appointment of subcommittee on the mental health of children; duties; compensation to extent of available funding.

1. The Commission shall appoint a subcommittee on the mental health of children to review the findings and recommendations of each mental health consortium submitted pursuant to [NRS 433B.335](#) and to create a statewide plan for the provision of mental health services to children.

2. The members of the subcommittee appointed pursuant to this section serve at the pleasure of the Commission. The members serve without compensation, except that each member is entitled, while engaged in the business of the subcommittee, to the per diem allowance and travel expenses provided for state officers and employees generally if funding is available for this purpose.

(Added to NRS by [2009, 662](#))

NRS 433.318 Appointment of subcommittee or advisory committee; member qualifications; duties; compensation to extent of available funding.

1. The Commission may appoint a subcommittee or an advisory committee composed of members who have experience and knowledge of matters relating to persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders and who, to the extent practicable, represent the ethnic and geographic diversity of this State.

2. A subcommittee or advisory committee appointed pursuant to this section shall consider specific issues and advise the Commission on matters related to the duties of the Commission.

3. The members of a subcommittee or advisory committee appointed pursuant to this section serve at the pleasure of the Commission. The members serve without compensation, except that each member is entitled, while engaged in the business of the subcommittee or advisory committee, to the per diem allowance and travel expenses provided for state officers and employees generally if funding is available for this purpose.

(Added to NRS by [2009, 662](#); A [2013, 665, 3007](#))

NRS 433.324 Regulations.

1. The State Board of Health shall adopt regulations:

(a) For the care and treatment of persons with mental illness, persons with substance use disorders or persons with co-occurring disorders by all state agencies and facilities, and their referral to private facilities;

(b) To ensure continuity in the care and treatment provided to persons with mental illness, persons with substance use disorders or persons with co-occurring disorders in this State; and

(c) Necessary for the proper and efficient operation of the facilities of the Division.

2. The State Board of Health may adopt regulations to promote programs relating to mental health, substance use disorders and co-occurring disorders.

(Added to NRS by [1975, 1594](#); A [1985, 368, 2265](#); [1999, 2592](#); [2009, 664](#); [2013, 666, 3007](#))

NRS 433.325 Inspection of facility. The Commission or its designated agent may inspect any state facility providing services for persons with mental illness, persons with intellectual disabilities and persons with related conditions, persons with substance use disorders or persons with co-occurring disorders to determine if the facility is in compliance with the provisions of this title and any regulations adopted pursuant thereto.

(Added to NRS by [1985, 2263](#); A [1993, 2715](#); [1999, 2593](#); [2009, 664](#); [2013, 666, 3007](#))

NRS 433.327 Right of certain employees of Department to submit information or requests to Commission or appear before Commission. Every employee of the Division, and every person employed by the Division of Child and Family Services of the Department pursuant to [chapter 433B](#) of NRS is entitled to submit written information or requests directly to the Commission or its individual members, or appear before it with its permission, but the Commission shall not interfere with the procedures for resolving the grievances of employees in the classified service of the State.

(Added to NRS by [1985, 2263](#); A [1993, 2716](#))

APPENDIX C

Commission on Behavioral Health

C.2 – Bylaws

NEVADA COMMISSION ON BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES BYLAWS

***Updated
September
2013***

Article I: Name and Mission

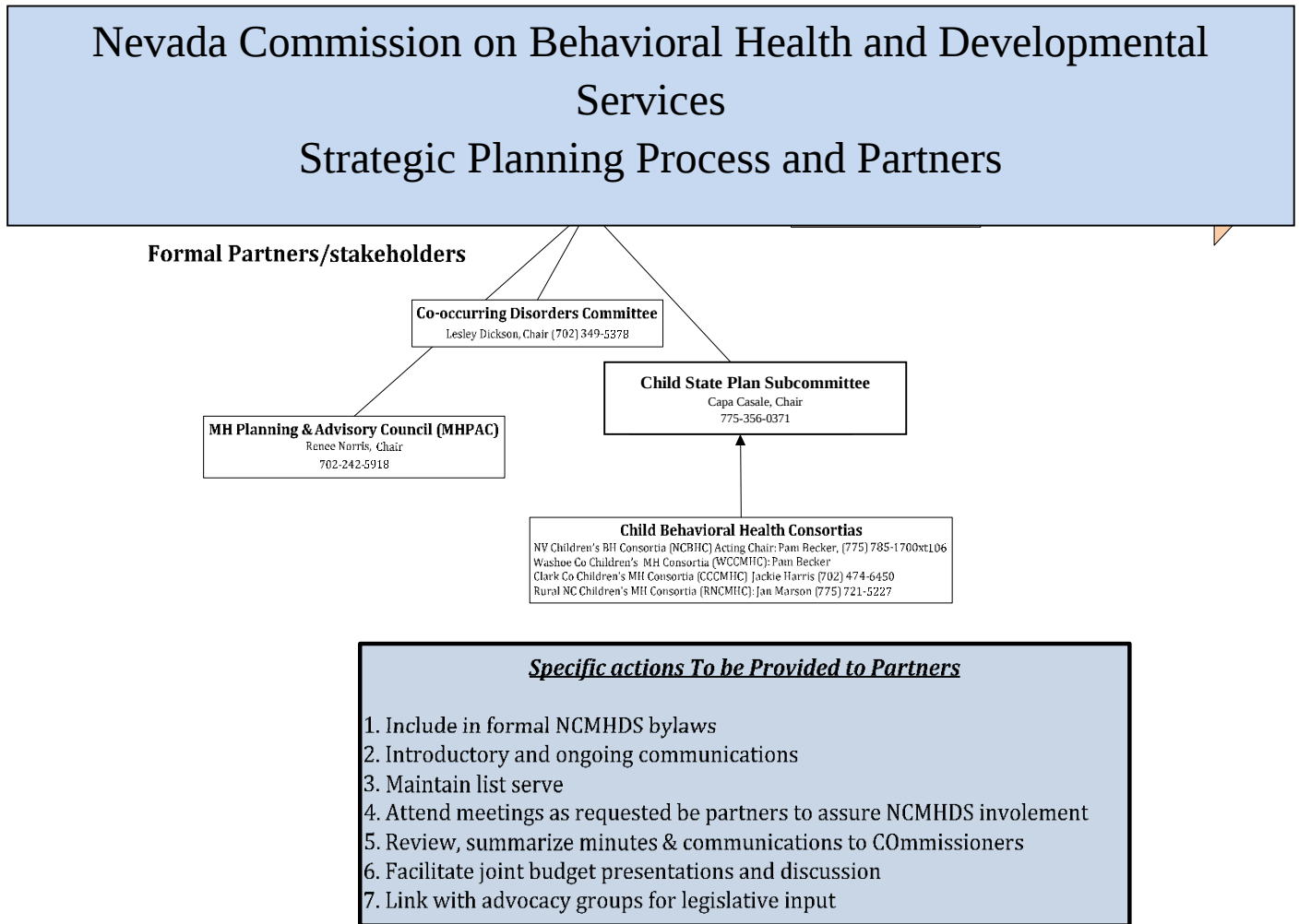
1. Name. This Commission shall be the Nevada Commission on Behavioral Health and Developmental Services.

2. Mission. The Nevada Commission is a 10-member legislatively created body designed to provide policy guidance and oversight of Nevada’s public system of integrated care and treatment of adults and children with mental health, substance abuse, and developmental disabilities/related conditions. The service delivery system is administered by state agencies in Nevada through the Division of Public and Behavioral Health and the Division of Child and Family Services. The Commission also promotes and assures the protection of the rights of all clients in this system.

3. Commission shall undertake and maintain a lead role in providing strategic planning to the Department of Health & Human Services (DHHS). The strategic planning process is outlined using Figure 1 below. The NCDPBH ongoing planning process will collect information from these specific organizations;

- a. Mental Health Planning & Advisory Council (Section 1914(c) of the Public Health Service Act)
- b. Co-Occurring Disorders Committee (SB2)
- c. Nevada Child Behavioral Health Consortia (SB 131)

Figure 1.



Article II: Powers and Duties

1. The Commission shall provide all advisory and oversight duties as assigned to it via Nevada Revised Statutes 433.

Article III: Membership

1. The Commission shall maintain membership as assigned to it via Nevada Revised Statutes 232.361

2. Absences

- a. Two absences from regularly scheduled meetings within a calendar year without sufficient or overriding reason will be considered unexcused absences and may constitute grounds for removal from membership.
- b. At each regularly scheduled meeting, absences will be noted and indications of excused or unexcused will be noted.
- c. The Chair will determine if the absences are excused or unexcused at the time of the next scheduled meeting. An excused absence includes, but is not limited to, an unexpected occurrence or emergency with health, family, or employment that would prevent the member from attending the meeting. An unexcused absence includes, but is not limited to, lack of communication (no contact) with the NCDPBH Chair, or Administrative Assistant.
- d. Unless an absence is the result of an emergency or unexpected occurrence, members who cannot attend a regularly scheduled meeting must give written prior notice (letter, memo, or e-mail) to the MHPAC Chair, Vice Chair, or Administrative Assistant within 24 hours prior to the meeting. Failure to do so will result in an unexcused absence.

3. Removal from Membership

- a. When a member has a second (2rd) unexcused absence within a calendar year, the Chair will send a notification letter to the member that the Commission intends to take action at the next scheduled meeting.
- b. At that meeting, the member will have an opportunity to refute the action or the Commission will proceed with the removal process.
- c. The removal process shall be a simple majority vote to recommend the removal to the Governor for action.

Article IV: Officers

1. Officers of the Commission shall be a Chairperson, Vice-Chairperson, and Past Chairperson.

2. The Chairperson and Vice-Chairperson of the Commission shall be elected at the Commission's first annual meeting of all even numbered years. Chairperson and Vice Chairperson shall hold office to be elected for 2 year terms or until they shall file a

resignation in writing. A member of the Commission may serve not more than two consecutive terms in an office.

3. The Commission officers shall have the following duties:

- a. The Chairperson shall preside at all meetings of the Commission. He shall determine the agenda for all regular meetings. Such duties and authority as are herein conferred upon him and as shall be entrusted to him from time to time by the Commission.
- b. The Vice-Chairperson shall preside at meetings of the Commission in the absence of the Chairperson. He shall perform such other duties as are herein conferred upon him and as may be assigned to him by the Chairperson of the Commission.
- c. The Past-Chairperson shall preside at meetings of the Commission in the absence of the Chairperson and Vice Chairperson. He shall perform such other duties as are herein conferred upon him and as may be assigned to him by the Chairperson of the Commission.

Article V: Meetings

1. A special meeting of the Commission may be called by the Chairperson, or in the event of his absence, by the Vice-Chairperson.

2. The full Commission must meet at the call of the chair at least 6 times, but not more than 12 times per year. The Commission must meet face to face twice annually; the Commission will utilize video and teleconferencing for the remainder of the meetings. This does not include subcommittee meetings.

3. A majority of the members of the Commission constitutes a quorum and is required to transact any business of the Commission.

4. The Chair in consultation Administrators of the Nevada Division of Public and Behavioral Health and the Division of Child and Family Services shall prepare all written agendas. Any other person desiring to place an item on the agenda or make a presentation to the Commission shall provide this information to the Chairperson or the Administrator not later than 10 days before a Commission meeting. Any Commissioner shall submit an agenda item through the Chair or the Administrator.

5. The vote of the majority of the Commission members present at a meeting at which a quorum is present shall be an act of the Commission. In the event of a tie vote, the Chairperson or Vice Chairperson shall break the tie.

6. Minutes of each open meeting shall be provided using existing staff at the respective agency that is hosting that particular meeting, either DCFS or DPBH. All minutes shall be furnished to all Commission members.

Article VI: Committees

1. Standing Subcommittees. The Commission shall have two standing subcommittees. These standing subcommittees shall meet during publicly posted meetings. Minutes of all subcommittee meetings shall be taken by a member of DPBH and Developmental Services staff designated by the DPBH Administrator. The minutes shall be furnished to all Commission members.

2. Standing subcommittees are authorized to make decisions concerning the affairs of the Commission in the interim between regularly called meetings. Actions taken by these Subcommittees must be reported to all members of the Commission at the next regularly called meeting.

a. Strategic Planning & Bylaws. Provides oversight to the Commissions ongoing strategic planning process, and updates bylaws annually.

b. Children's Statewide Behavioral Health Planning. This subcommittee meets to specifically provide compliance with Senate Bill 31 (2009), which requires the Commission annually analyze regional reports, to be consolidated by the Commission for transmission to the Legislature.

3. The Chairperson may designate other temporary committees and project assignments as deemed advisable. The committees shall have such powers and authority as the Commission shall entrust to them. Each committee shall consist of at least one Commission member who shall be appointed thereto by the Chairman and such other persons as shall be selected by the committee chairperson. The Commission Chairperson shall be an ex officio member of each committee.

4. A majority of the members of a committee shall constitute a quorum for the transaction of business at any committee meeting.

5. The vote of a majority of committee members present a committee meeting at which a quorum is present shall be an act of the committee.

Article VII: Rules of Order

1. The most recent edition of Roberts' Rule of Order shall govern the Commission in all cases to which they are applicable and in which they are not inconsistent with these Bylaws.

2. In compliance with Nevada's Open Meeting Law, Chapter 241 of NRS, a staff person designated by the Administrator(s) of DPBH and DCFS shall be responsible for posting the agendas for the Commission meetings three (3) days prior to each scheduled meeting.

3. New Commissioners shall participate in new member orientation prior to their first formal meeting.

Article VIII: Amendments

1. These bylaws may be amended at any time a vote of a majority of the whole Commission at any meeting of the Commission if the following conditions are first met:
2. Any proposed amendment shall be presented at least 5 (five) calendar days before the meeting when the amendment is to be voted upon;
3. These bylaws were amended September 20, 2013 and remain in effect until amended or repealed as provided in Article VII.

APPENDIX C

Commission on Behavioral Health

C.3 – 2016 Letter to the Governor (annual report)



STATE OF NEVADA
COMMISSION ON BEHAVIORAL HEALTH
4126 Technology Way, Suite 201
Carson City, Nevada 89706
Phone (775) 684-5943 • Fax (775) 684-5966

BRIAN SANDOVAL
Governor

VALERIE KINNIKIN
Chair

Governor Brian Sandoval
Office of the Governor
101 North Carson Street, Suite 1
Carson City, Nevada 89701
January 29, 2016

Dear Governor Sandoval:

The State of Nevada Commission on Behavioral Health is a 10-member, legislatively created body designed to provide policy guidance and oversight of Nevada's public system of integrated care and treatment of adults and children with mental health, substance abuse, and intellectual/developmental disabilities and related conditions.

The Commission establishes policies to ensure adequate development and administration of services for persons with mental illnesses¹ and reports to the Governor and Legislature on the quality of care and treatment provided for persons with mental illness, intellectual/developmental disabilities or related conditions and co-occurring disorders in this State and on any progress made toward improving the quality of that care and treatment.²

The Commission is charged with sending you a report in January of each year. This letter is intended to fulfill that obligation. Our last report in January of 2015 resulted in dialogue with your office and with several legislators. It is our hope that this year's report will have a similar response.

Since the time of our 2015 report, the State of Nevada has continued to move toward providing the most comprehensive and effective services possible to the citizens of Nevada. It is our hope that the Commission can continue to be an entity to drive forth these statewide efforts. This 2016 report includes successes and opportunities for improvement within Children's Behavioral Health Services, Adult Behavioral Health Services, Workforce Development, Intellectual/Developmental Services and Substance Abuse Treatment/Prevention Services. Recommendations regarding the opportunities for improvement will accompany each section.

¹ Nevada Revised Statutes (NRS) Chapter 433.314 Sec. 1.

² NRS 433.314 Sec. 5.

ITEM #1: Children's Behavioral Health Services

According to the 2016 report on youth from The State of Mental Health in America, Nevada was ranked 45th in the nation for states with the highest prevalence of mental illness and the lowest rates of access to care.

The Division of Children and Family Services (DCFS) is responsible for providing behavioral health services to children and adolescents in Washoe and Clark County, while the Division of Public and Behavioral Health (DPBH) is responsible for providing services in the rural areas of the state.

Currently, the juvenile justice system in Washoe County serves as a portal for the treatment placements of a significant number of youth with serious emotional disturbance. Because most of these children are not clients of the state mental health system, juvenile justice has become a parallel mental health system for the most impaired youth in the State. Youth who are treated by private providers or who are not served at all, commit crimes and are placed in detention which allows them to obtain Medicaid. Based on the risk that these youth pose to the community or themselves, they are often placed in residential treatment centers, most of which are out of state. The State funds these placement through Medicaid yet in most cases does not have the resources to provide case management for these children with the highest level of need. This curious state of affairs is driven by a lack of intensive community based services, no state run residential treatment beds in the north, and the absence of service coordination at the state level.

To improve upon this service gap, DCFS has been working toward expanding preventative services, developing an organized delivery system, strengthening LOCAL systems and restructuring funding and Medicaid policies to produce positive outcomes for youth.

In the fall of 2015 the State of Nevada/DCFS were awarded a System of Care Implementation (SOC) Grant. This was a part of an ongoing process that stakeholders have been involved in for several years.

The concept and philosophy of SOC has become increasingly more prevalent in communities across the country since its inception in the mid 1980's. Investment in SOC has been shown to reduce utilization of higher levels of care, inpatient services, emergency room visits, and out of state placements. States utilizing this approach often were able to allocate funds to provide care locally in the families' community. In addition to utilizing funds more effectively, more intervention services can be in place.

Coming together as a statewide effort, the Nevada Children's System of Care Behavioral Health Subcommittee, which includes the regional consortia and other key stakeholders have been examining commonalities across the regional strategic plans, developing statewide logic models and taking other steps toward the shift to a System of Care.

The Nevada System of Care Implementation Grant is summarized in four broad goals. These goals will also serve as the organizing framework from which activities and planned, implemented and evaluated. The goals are;

1. Generate support among families and youth, providers, and decision policy makers at state and local levels, to support expansion of the SOC approach, transition the Division of Child and Family Services, Children's Mental Health from a direct care provider to an agency that primarily provides planning, provider enrollment, utilization management through an assessment center, technical assistance and training, continuous quality improvement.
2. Maximize public and private funding at the state and local levels to provide a SOC with accountability, efficiency and effective statewide funding sources.
3. Implement workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to provide effective services and support consistent with the SOC approach.
4. Establish an on-going locus of management and accountability for SOC to ensure accountable, reliable, responsible, evidence and data-based decision making to improve child and family outcomes and to provide transparency at all levels.

Over the past year, DCFS has also been successful with increasing the capacity to divert youth in crisis from costly emergency rooms, inpatient care and juvenile detention due to the expansion of DCFS's Mobile Crisis Intervention Program (MCRT). The hospital diversion rate has been reduced by 91.3% in the south.

Recommendation: Review Medicaid rates for children's behavioral health services to determine if inadequate provider reimbursement contributes to lack of capacity and access for children and families.

- Medicaid eligible children face long waits for many behavioral health services and have difficulty finding qualified providers.

Recommendation: Expand and streamline the Mobile Crisis Intervention Program (MCRT): Although this program has been very successful, many children assessed by the DCFS teams and referred for hospitalization of other types of care, face delays in receiving services due to additional assessments required by the hospitals or managed care providers.

- Develop interagency protocols and policies to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior.

- Develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

Recommendation: Enhance intensive community based services, state run residential treatment beds and service coordination for youth.

ITEM #2: Adult Behavioral Health Services

Over the last several years, it was apparent that Nevada was in need of additional placements for the forensic population. In answer to this need, Stein Hospital was opened in Las Vegas in November 2015. Currently, 30 of the 47 beds are being utilized. It is anticipated that Stein hospital will reach maximum capacity by February 2016. Current projections suggest that Nevada will need to continue to plan for even further expansion in this area. Additionally, the case law 7 day requirement for admission into forensic placement presents difficulties that need to be addressed, even with the addition of Stein Hospital.

Within the inpatient psychiatric hospitals, DPBH has embarked on a multi-year effort to reduce the utilization of seclusion and restraints. DPBH has provided and will continue to provide all of its direct care staff members *Conflict Prevention and Response Training* (CPART) during new employee orientation. CPART is an approved, evidence-based curriculum of de-escalation techniques and increasingly intrusive/restrictive intervention procedures used by trained staff to re-establish and/or maintain safety in the presence of threatening or dangerous behavior. In addition, the hospitals have begun to introduce seclusion and restraint prevention tools such as positive behavioral support plans and sensory/comfort rooms that promote de-escalation and allow consumers to develop distress tolerance and self-soothing skills.

From October 2014 through September 2015, DPBH inpatient psychiatric hospitals had a seclusion rate of 0.50 per 1,000 patient hours, more than the national average of 0.38. For that same time period, DPBH inpatient psychiatric hospitals had a restraint rate of 0.48 per 1,000 patient hours, below the national average of 0.57.

A successful outpatient program, Assisted Outpatient Treatment (AOT) became operationalized in March 2014 by Southern Nevada Adult Mental Health Services (SNAMHS). The intent of AOT is to support individuals who have demonstrated a history of non-compliance with mental health treatment through multiple hospitalizations and/or arrests through a civil commitment and wrap around services in an outpatient setting. AOT has been adopted by many states, and it utilizes the PACT (program for assertive treatment) model for services. Family court has jurisdiction over the civil commitment, and the court orders are valid for six months with the ability to re-petition if needed to continue stability. The budgeted caseload is 12:1 with an overall caseload of 75. The current program is running at 80+. The team is comprised of a psychiatrist, psychiatrist nurses, psychologist, clinical social worker, substance abuse counselor, psychiatrist case workers, and is provided oversight by a mental health counselor. AOT

provides wrap around services including intensive service coordination, counseling, substance abuse counseling, residential support, medication management, integrated medical care, peer support services and daily living skills. Individuals either graduate or are terminated from AOT through the court process, and then they are transitioned over to the Supportive Outpatient Treatment (SOT) team.

When individuals have graduated or terminated from AOT, they are then supported through wrap around services of SOT. Originally when individuals were stepping down from AOT, they were again becoming "lost" within the system. Individuals who had graduated from AOT were asking to go back. This brought attention to a gap in our system of what was missing and how to fix it. Essentially, SOT is AOT without the civil commitment component. SOT provides wrap around services including intensive service coordination, counseling, substance abuse counseling, residential support, medication management, integrated medical care, peer support services and daily living skills. The average caseload is 15:1. Individuals stay with the SOT team and this becomes their "home pod" unless they demonstrate non-compliance or the need for civil commitment for AOT again.

The Mobile Outreach Safety Team (MOST) is statewide but the programming implementation is different based upon the region and the community's needs. The concept and goal of MOST is to provide field services intervention and de-escalation for individuals who are experiencing crisis in the community. In Washoe and Douglas Counties, staff ride along with officers from the Sheriff's department and provide de-escalation and intervention for individuals. Some individuals are able to be diverted to alternative placements such as outpatient services, sobering units or local hospitals instead of jail. For individuals where it is appropriate, they might be placed on a Legal 2000 if they are a danger to themselves or others. The cost advantage to MOST is that individuals are linked to the appropriate resources and services in a swifter manner, and it reduces the amount of arrests and recidivisms for individuals who do not necessarily need to be in jail. In Clark County, MOST is sub-granted from the State to Clark County Social Services (CCSS). CCSS and Metro police department provide home visits follow up through referrals based on individuals who were placed on a Legal 2000 through the police department. If individuals agree to services, then they are provided with three months of case management and linkage to services and support through a treatment plan. This program methodology was designed and approved due to the size of the county, police department, and the limitations of human resources to replicate the Washoe model. The post intervention after the Legal 2000 provides supportive services to reduce recidivism and additional hospitalizations and/or arrests for individuals.

Crisis Intervention Training (CIT) is a national model that has been adopted statewide and has been fully integrated with Washoe, Clark and Douglas counties in cooperation of the police/sheriff departments and DPBH. The rural areas are expanding their training cooperation efforts with the smaller counties, and have recently hired two new mental health counselors to launch the programming.

Peer support services are supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a national evidence-based model. DPBH has integrated peer supporters throughout many of the outpatient programs. As SAMHSA describes, peers support services are “delivered by individuals who have common life experiences, giving a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience...research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community.” (<http://www.samhsa.gov/recovery/peer-support-social-inclusion>)

Recommendation: Support the streamlining and expansions of the forensic, seclusion and restraint and jail diversion programs.

- Monitor and facilitate the means to provide an adequate number of forensic beds.
- Support the examination of forensic case law that contains a 7 day admission requirement, which may create unreasonable demands on the forensic system and not align with standards that are practical for Nevada.
- Provide training for inpatient psychiatric hospital staff in effort to drastically reduce the use of seclusion and restraints within the treatment realm.
- Expand the AOT program with a second AOT team in the south (Capacity is 75 participants and the program is currently serving 80) and the establishment of a team in the north and rural areas.
- Expand the SOT program in the south to compliment the growth of the AOT program and establish AOT programs in both the north and the rurals.
- Although the MOST and CIT programs are established statewide, the expansion of the programs in all areas would increase the positive dynamics for both the early intervention and post intervention components that empower the individuals to help them stabilize.

ITEM #3: Workforce Development

Over the past year, there has been several exciting developments that will positively impact the growth of Nevada’s healthcare workforce. Roseman University of Health Sciences, (a private, not for profit, school started in Henderson, Nevada) is opening an accredited MD granting medical School in Las Vegas. This program will complement their existing programs in pharmacology, nursing and orthodontics. Roseman University programs embed students within the community with the goal of keeping their graduates practicing in Nevada. The University of Nevada, Las Vegas is also opening a school of medicine, offering an innovative curriculum for Nevada’s future physicians. In addition, several of the state’s major hospital systems have announced plans to start new residency programs with emphasis on primary care and psychiatry.

The Division of Public and Behavioral Health (DPBH), in partnership with Western Interstate Commission for Higher Education's (WICHE's) Mental Health Program and the Nevada WICHE program, developed a psychology internship program named The Nevada Psychology Internship Consortium (NV-PIC). This program consists of four partner agencies within the Division: Lake's Crossing, NNAMHS, SNAMHS, and Rural Community Health Services (RCHS). The NV-PIC welcomed its inaugural cohort of four interns in August, 2015 to begin their yearlong training program. Since that time NV-PIC has applied for and been granted membership to the national internship organizing body APPIC. NV-PIC faculty are currently completing the self-study for national accreditation with the American Psychological Association (APA) with plans to submit in December, 2015. If granted membership, NV-PIC will become the second accredited internship program in the state. NV-PIC is currently reviewing applications from 50 applicants for next year's cohort, which will include a 5th intern position (for SNAMHS/Stein Hospital).

The Division of Public and Behavioral Health (DPBH) has also worked with WICHE to provide tuition assistance for current Registered Nurses (RNs) to become Advanced Practitioners of Nursing (APNs) and also for current APNs to go back to school to specialize in psychiatry.

As Nevada continues to move toward improvement in workforce development, it is important to recognize where we stand in relation to the rest of the nation when it comes to the availability of healthcare providers. According to the latest data available, the following rankings (per 100,000 population) display a baseline for improvement.

- Active Physicians – **47th** (2014)
- Total Active Patient Care Physicians – **49th** (2014)
- Active Primary Care Physicians – **48th** (2014)
- Registered Nurses – **51st** (2014)
- Advanced Practitioners of Nursing – **51st** (2014)
- Psychiatrists – **47th** (2014)
- Psychologists – **41st** (2014)
- Counselors – **51st** (2014)
- Social Workers – **50th** (2014)

Another aspect of the workforce development issue for consideration is the continuing need for the state of Nevada to offer wages that are competitive across state agencies as well as with other states. For example, it would be beneficial for people employed in the forensic mental health facilities to have the same financial opportunities as those employed by corrections. This would encourage more stability in the workforce.

In addition to strengthening the workforce through competitive wages, Nevada must also examine and restructure the Medicaid reimbursement rates available to our healthcare providers. This will ensure access to healthcare for Nevada's most needy citizens where currently, some vital services are in danger of being discontinued. One example of this risk for reduced services is manifesting itself at Mojave Mental Health in Reno. Due to

low Medicaid reimbursement rates for physicians, Mojave is considering offering an extremely reduced amount of services to children and the Intellectually Disabled population to specialize in adults diagnosed with Serious Mental Illness (SMI). This specialization would allow them to stay afloat financially.

Nevada Medicaid has been reimbursing for Peer Support Services since 2005 as individual providers. In the 78th Legislative Session, legislation passed to create Peer Support Agencies to allow for a new delivery model in order to allow for certification of Peer Supporters. Certification of providers allows for consistency of application of standards for quality of care across the state, consistency of care from a national perspective and an increase in ethical standards. Nevada has worked diligently to develop the evidence-based model as supported under SAMHSA, the state requires assistance on workforce development to promote the model throughout the community.

Recommendation: Support and expand programs that create incentives and opportunity for provider education and establishment within the state of Nevada by allocating funds from the next Biennial budget for program creation and preservation.

- Continue and expand the medical programs and residency opportunities for physicians.
- Expand programs that grant tuition assistance for nurses as well as other disciplines.
- Continue and expand internships and fellowships for psychologists as well as establish more available positions for Psychological Assistants.

Research has shown that psychologists and other healthcare providers are most likely to begin their careers in the geographic area where they complete their training. Psychologists are required to complete a yearlong internship in order to complete their doctorate degree, which is typically the last year of their training program. Currently, Nevada only has one nationally accredited internship program in the state (the VA in Reno). This means that historically the majority of psychology students from UNR and UNLV had to leave the state to complete their training at an accredited internship, thereby reducing the probability of them beginning their professional careers in the state. The lack of accredited internships in Nevada also results in a reduced ability to recruit early career psychologists trained in other states. The stipends for the four NV-PIC interns are paid for by funding from Nevada WICHE. This funding is provided for at least the 2015-2017 biennium to help NV-PIC launch its first two cohorts. Long-term funding for the program is still needed. With long-term funding NV-PIC would be able to sustain its current cohort class and potentially expand to offer even more internship slots each year.

An additional consideration for the recruitment and retention of psychologists is the need for dedicated Psychological Assistant positions. In Nevada, after a person completes their internship and doctorate degree they are required to register with the Nevada Board of Psychological Examiners as a Psychological Assistant for one year, which requires them to practice under the license of a psychologist. Currently, there are very few dedicated Psychological Assistant positions within DPBH or elsewhere in the state. The creation of dedicated Psychological Assistant positions, which would be one year terminal positions, would help ensure that NV-PIC and other state internship programs could retain successful interns by promoting them into a Psychological Assistant position in support of their last year of training before becoming independently licensed to practice as a psychologist in Nevada.

- Continue statewide workforce development programs for evidence-based Peer Support programs.

Recommendation: Examine and support the long-term funding of the NV-PIC, as well as the creation of dedicated Psychological Assistant positions.

Recommendation: Examine and support the adjustment of wages to be competitive across state agencies and with other states. It is recommended that funds are allocated in the next Biennial budget to create a competitive environment that attracts and retains a qualified workforce.

Recommendation: Examine and Support the adjustment of Medicaid reimbursement rates for Nevada's healthcare providers.

Recommendation: Create opportunities that will increase the number of certified mental health professionals that specialize in treatment for children and youth.

ITEM #4: Intellectual/Developmental Services

Aging and Disability Services Division (ADSD) is responsible for providing integrated services statewide for individuals across the lifespan with an intellectual/developmental disability or a related condition.

Additionally, Aging and Disability Services Division supports three regional centers assisting individuals with intellectual/developmental disabilities or with a related condition. Sierra Regional (SRC), Rural Regional Center (RRC) and Desert Regional Center (DRC) provide assistance to individuals and their family's to live as independently as possible in their community. The service supports include the following: Service Coordination, Respite, Family Support, Jobs and Day Training Programs, Habilitative Services including residential supports. Desert Regional Center includes an intermediary care facility to assist individuals unable to live within their local community due to health care needs, intense behavioral issue or personal choice.

In June, the 2015 Legislature approved the establishment of two pilot programs specific to providing treatment for children with intellectual disabilities and a behavioral health need. The programs will be located in Washoe County and Clark County focusing on providing community based treatment. The programs will enhance Nevada's ability to support children with intense behavioral needs in their own community avoiding out of state placement.

Over the past year, Aging and Disability Services Division has worked to provide training on Person Centered Thinking to all staff within the division. Using an evidenced based program, the division continues to work toward building a service system prepared to meet the needs of individuals living with an intellectual disability or a related condition across the lifespan through assisting the individuals and their family's to live and work in the least restrictive setting.

Developmental Services is participating in the National Core Indicators which will provide data on performance measures specific to quality measures and may be compared to 48 other participating states. The independent surveys will provide value data for assessing the health of the service system.

Aging and Disability Services Division in collaboration with Vocational Rehabilitation and the Governor's Council on Developmental Disabilities completed a strategic plan on Integrated Employment in July 2015. The plan provides strategies for transforming the service delivery system to provide support for individuals to obtain and retain competitive employment.

Statewide training for Aging and Disability Services Division staff, sister agency staff, community partners and other interested parties on Person Centered Thinking will continue on an ongoing basis. The division invested on developing a train the trainer model for the evidence based practice and will be available on a quarterly basis.

Developmental Services increased their ability to assist individuals with behavioral issues to live in the least restrictive setting by providing training and support for Safety Care. Safety Care provides techniques and processes to assist staff to focus on behavioral interventions in a less intrusive manner.

Recommendation: Increase availability of funding to support habilitative services for individuals to live and work in the least restrictive setting within their community.

Recommendation: Ensure availability of appropriate mental health services, especially community based psychiatric services, for children with special needs.

Recommendation: Establish a Medicaid rate for children with intellectual/developmental conditions which takes into account the additional time needed by the professional to address the individual's condition and support needs.

Recommendation: Support the growing need for innovative mental health delivery systems for older adults. Nevada has one of the highest suicide rates in the country for individuals over the age of 65. Nevada must address the need for specialized training for all professionals working in the field to learn the signs and symptoms of depression in seniors especially as they relate to age related conditions.

Recommendation: Address the issue of discrimination by mental health providers towards individuals with intellectual/developmental conditions. Psychiatric care for this population has reached a crisis level with many providers unwilling to continue to service the population. Medicaid reimbursement for the actual time needed to address the individual's needs would enhance the availability to obtain healthcare.

ITEM #5: Substance Abuse Treatment/Prevention Services

According to SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH) an estimated 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.2 million adults (8.4%) had a substance use disorder. Of these, 7.9 or million people or 39.1% of those with a substance use disorder had both a mental health disorder and substance use disorder, also known as co-occurring mental and substance use disorders. (Source: <http://www.samhsa.gov/disorders>)

In Nevada in 2015, only 6% of clients treated within the Bureau of Behavioral Health, Wellness and Prevention (BBHWP) funded and certified programs were identified as having a co-occurring disorder, which is many times less than the national average. It is presumed that Nevada's lower numbers of co-occurring clients represents an issue of under identification and relate to program capacity and ability to identify and treat clients with co-occurring disorders.

Despite the intersection of substance use and mental health disorders in the individual client, traditionally treatment services for substance use disorders and treatment for mental health disorders have been conducted separately and with little coordination between the two. In 2007, the Nevada Legislature allocated additional funds to treat clients through the BBHWP funded providers. This was a strong acknowledgment of the need to address co-occurring issues comprehensively. However, since 2008, those funds have been cut by more than half to under \$500,000 per year due to overall state budget cuts.

The Division of Public and Behavioral Health (DPBH) and the BBHWP recognize the need to elevate the issue of access to treatment for those with co-occurring disorders. At this point in time, all of the treatment providers funded and certified by BBHWP are certified to provide various levels of care for those with substance use disorders. In addition, all providers are recognized as "Co-occurring Capable," which means that their programs and clinicians are able to recognize a possible mental health disorder and refer that client to external and appropriate mental health services.

However, only one BBHWP funded and certified provider is “Co-occurring Enhanced,” meaning that provider is able to treat (in-house with their own clinical staff) clients who present with co-occurring disorders. The lack of Co-occurring Enhanced providers in the BBHWP programs creates a bifurcated system of care for those with co-occurring disorders and, bottom line, creates barriers to access to comprehensive systems of care for substance use and mental health disorders.

To remedy this access problem, the Bureau is embarking on a project in which all BBHWP funded and certified providers will be given the opportunity to become Co-occurring Enhanced providers. This will be accomplished through training on a tool entitled the Dual Diagnosis Capability in Addiction Treatment (DDCAT). BBHWP team members in collaboration with the UNR based Center for the Application of Substance Abuse Technologies (CASAT) will provide on-site training and certification to all BBHWP funded and certified providers in 2016 in order to enable those providers to become Co-occurring Enhanced. This opportunity will also be offered to all State of Nevada run mental health providers.

The outcome of this project will be the increased capacity of the BBHWP funded and certified system of care, as well as the State Mental Health system, to identify and effectively treat clients with co-occurring disorders. Barriers to access will be decreased. In addition, clients will be able to access care in a “one stop shop” as opposed to being seen by two or more providers in what often amounts to fragmented episodes of care for that client.

Recommendations: Even though the DPBH and BBHWP are working to upgrade provider capacity to treat clients with co-occurring disorders, more funding is needed to help providers meet the need. It is recommended that funds are allocated in the next Biennial budget for workforce development and to fund programs to improve their ability to hire clinicians who can identify and treat co-occurring disorders. In addition, it is recommended that Medicaid policies are examined to ensure that providers who are Co-occurring Enhanced are able to be reimbursed adequately for services rendered to clients with co-occurring disorders.

In closing, thank you for taking time to consider our concerns and if you or staff have any questions, we welcome discussion.

Sincerely,

Nevada Commission on Behavioral Health

Chair: Valerie Kinnikin, LCSW (Representing Social Workers)

Larry Nussbaum, M.D. (Representing Psychiatrists)

Marcia Cohen, APRN (Representing General Public – MH)

Pamela Johnson, RN (Representing Registered Nurses)

Paula Squitieri, Ph.D. (Representing Psychologists)

Thomas Hunt, MD (Representing Physicians)
Capa Casale, MFT (Representing Marriage and Family Therapists)
Barbara Jackson (Representing Consumers)

Pc: Nevada State Senate
Nevada State Assembly
Nevada Behavioral Health and Wellness Council
Richard Whitley, Director, Department of Health and Human Services
Jane Gruner, Administrator, Division of Aging and Disability Services
Cody Phinney, Administrator, Division of Public and Behavioral Health
Tracey Green, M.D., State Health Officer
Kirsten Coulombe, Administrator, Division of Child and Family Services
Nevada Children's Mental Health Consortia
Nevada Behavioral Health Planning and Advisory Council (BHPAC)

APPENDIX

Recommendation Summary

ITEM #1: Children’s Behavioral Health Services

Recommendation: Review Medicaid rates for children’s behavioral health services to determine if inadequate provider reimbursement contributes to lack of capacity and access for children and families.

- Medicaid eligible children face long waits for many behavioral health services or have difficulty finding qualified providers.

Recommendation: Expand and streamline the Mobile Crisis Intervention Program (MCRT): Although this program has been very successful, many children assessed by the DCFS teams and referred for hospitalization of other types of care, face delays in receiving services due to additional assessments required by the hospitals or managed care providers.

- Develop interagency protocols and policies to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior.
- Develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services.

Recommendation: Enhance intensive community based services, state run residential treatment beds and service coordination for youth.

ITEM #2: Adult Behavioral Health Services

Recommendation: Support the streamlining and expansions of the forensic, seclusion and restraint and jail diversion programs.

- Monitor and facilitate the means to provide an adequate number of forensic beds.
- Support the examination of forensic case law that contains a 7 day admission requirement, which may create unreasonable demands on the forensic system and not align with standards that are practical for Nevada.
- Provide training for inpatient psychiatric hospital staff in effort to drastically reduce the use of seclusion and restraints within the treatment realm.
- Expand the AOT program with a second AOT team in the south (Capacity is 75 participants and the program is currently serving 80) and the establishment of a team in the north and rural areas.

- Expand the SOT program in the south to compliment the growth of the AOT program and establish AOT programs in both the north and the rural areas.
- Although the MOST and CIT programs are established statewide, the expansion of the programs in all areas would increase the positive dynamics for both the early intervention and post intervention components that empower the individuals to help them stabilize.

ITEM #3: Workforce Development

Recommendation: Support and expand programs that create incentives and opportunity for provider education and establishment within the state of Nevada by allocating funds from the next Biennial budget for program creation and preservation.

- Continue and expand the medical programs and residency opportunities for physicians.
- Expand programs that grant tuition assistance for nurses as well as other disciplines.
- Continue and expand internships and fellowships for psychologists as well as establish more available positions for Psychological Assistants.

Research has shown that psychologists and other healthcare providers are most likely to begin their careers in the geographic area where they complete their training. Psychologists are required to complete a yearlong internship in order to complete their doctorate degree, which is typically the last year of their training program. Currently, Nevada only has one nationally accredited internship program in the state (the VA in Reno). This means that historically the majority of psychology students from UNR and UNLV had to leave the state to complete their training at an accredited internship, thereby reducing the probability of them beginning their professional careers in the state. The lack of accredited internships in Nevada also results in a reduced ability to recruit early career psychologists trained in other states. The stipends for the four NV-PIC interns are paid for by funding from Nevada WICHE. This funding is provided for at least the 2015-2017 biennium to help NV-PIC launch its first two cohorts. Long-term funding for the program is still needed. With long-term funding NV-PIC would be able to sustain its current cohort class and potentially expand to offer even more internship slots each year.

An additional consideration for the recruitment and retention of psychologists is the need for dedicated Psychological Assistant positions. In Nevada, after a person completes their internship and doctorate degree they are required to register with the Nevada Board of Psychological Examiners as a Psychological Assistant for one year, which requires them to practice under the license of a

psychologist. Currently, there are very few dedicated Psychological Assistant positions within DPBH or elsewhere in the state. The creation of dedicated Psychological Assistant positions, which would be one year terminal positions, would help ensure that NV-PIC and other state internship programs could retain successful interns by promoting them into a Psychological Assistant position in support of their last year of training before becoming independently licensed to practice as a psychologist in Nevada.

Recommendation: Examine and support the long-term funding of the NV-PIC, as well as the creation of dedicated Psychological Assistant positions.

Recommendation: Examine and support the adjustment of wages to be competitive across state agencies and with other states. It is recommended that funds are allocated in the next Biennial budget to create a competitive environment that attracts and retains a qualified workforce.

Recommendation: Examine and Support the adjustment of Medicaid reimbursement rates for Nevada's healthcare providers.

Recommendation: Create opportunities that will increase the number of certified mental health professionals that specialize in treatment for children and youth.

ITEM #4: Intellectual/Developmental Services

Recommendation: Increase availability of funding to support habilitative services for individuals to live and work in the least restrictive setting within their community.

Recommendation: Ensure availability of appropriate mental health services, especially community based psychiatric services, for children with special needs.

Recommendation: Establish a Medicaid rate for children with intellectual/developmental conditions which takes into account the additional time needed by the professional to address the individual's condition and support needs.

Recommendation: Support the growing need for innovative mental health delivery systems for older adults. Nevada has one of the highest suicide rates in the country for individuals over the age of 65. Nevada must address the need for specialized training for all professionals working in the field to learn the signs and symptoms of depression in seniors especially as they relate to age related conditions.

Recommendation: Address the issue of discrimination by mental health providers towards individuals with intellectual/developmental conditions. Psychiatric care for this population has reached a crisis level with many providers unwilling to continue to service the population. Medicaid reimbursement for the actual time needed to address the individual's needs would enhance the availability to obtain healthcare.

ITEM #5: Substance Abuse Treatment/Prevention Services

Recommendations: Even though the DPBH and BBHWP are working to upgrade provider capacity to treat clients with co-occurring disorders, more funding is needed to help providers meet the need. It is recommended that funds are allocated in the next Biennial budget for workforce development and to fund programs to improve their ability to hire clinicians who can identify and treat co-occurring disorders. In addition, it is recommended that Medicaid policies are examined to ensure that providers who are Co-occurring Enhanced are able to be reimbursed adequately for services rendered to clients with co-occurring disorders.

APPENDIX D

Young Adults in Transition

APPENDIX D

Young Adults in Transition

In November 2015, Southern Nevada Adult Mental Health Services (SNAMHS) implemented the Young Adults in Transition program to assist young adults ages 18 to 25 as they transition from receiving children's services through the Division of Child and Family Service (DCFS), Department of Health and Human Services (DHHS), to adult services provided by SNAMHS and the Division of Public and Behavioral Health (DPBH), DHHS. Young Adults in Transition is designed to engage young adults at intake or as soon as they are referred to SNAMHS. The program works with other units within SNAMHS, including the Mental Health Court and Assisted Outpatient Treatment.

Young Adults in Transition serves as a mentorship program and safe space for youth to explore options and maneuver through institutions that help serve their needs. Services are tailored to encourage every participant to share ideas with staff and explore their hopes for their future. Staff members help young adults understand the steps necessary to meet their goals. Initial priorities may include obtaining identification, food stamps, or placement in group housing. Overall, however, the program aims to help young adults take steps toward independence and participation in a healthy lifestyle of their choosing.

In addition, Young Adults in Transition encourages personal growth through education or employment as a core element of success. Participants are encouraged early in the program to express their hopes, dreams, and desires; identify what life might look like if they were living independent of social assistance systems; and make personal choices to enhance their lives. Young Adults in Transition staff help participants learn basic skills such as maintaining personal hygiene, budgeting, and effectively interacting with others—whether socially or in a structured environment such as employment.

A full-time Young Adults in Transition case manager works closely with program participants and arranges group outings to community events. Such events assist with the development of relationships, trust building skills, and appropriate social interactions. In February 2016, Young Adults in Transition opened a drop-in center, where young adults can relax, use a computer, or talk to staff more informally.¹

In Fiscal Year (FY) 2015, the program served an average of 7 young people each month. This number increased to 12 in FY 2016 and 13 as of August of FY 2017.²

¹ LCB staff correspondence with SNAMHS, 2016.

² *Behavioral Health Chart Pack*, Director's Office, DHHS, 25 October 2016, <http://dhhs.nv.gov/uploadedFiles/dhhsnv.gov/content/Reports/BehavioralHealthChartPack.pdf>.

APPENDIX E

Children's Mental Health Consortia Policy Priorities

APPENDIX E

Children's Mental Health Consortia Policy Priorities

E.1 – Clark County Children's Mental Health Consortium

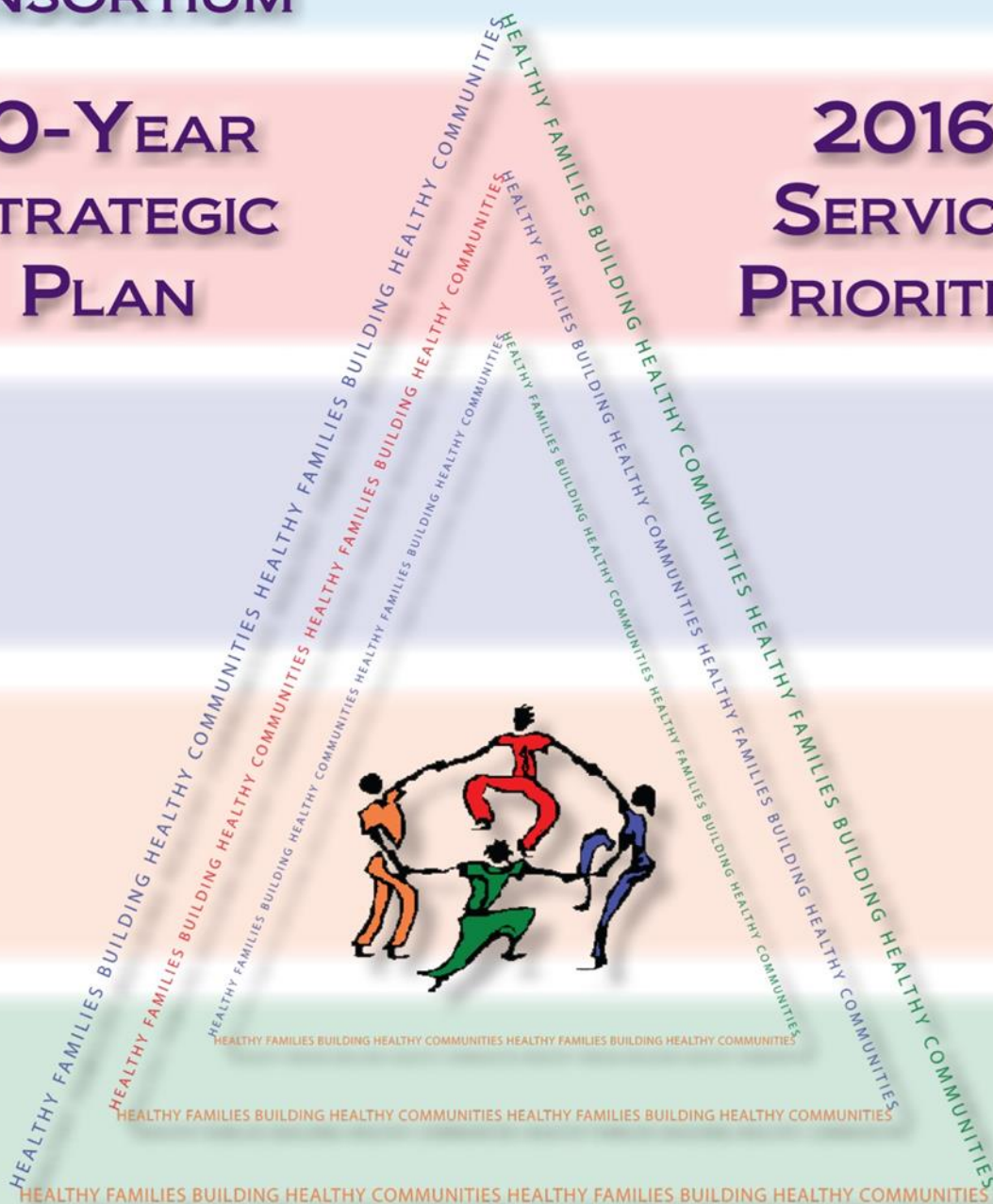
CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

2020 VISION FOR SUCCESS

Children and families in Clark County will have timely access to a comprehensive, coordinated system of behavioral health services and supports.

10-YEAR STRATEGIC PLAN

2016 SERVICE PRIORITIES



CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

2016 SERVICE PRIORITIES

Clark County Children's Mental Health Consortium

2016 Priorities

INTRODUCTION

In December 2015, 200 family members, providers, and other stakeholders attended a Community Forum at UNLV to discuss the mental health of Clark County's children. After a panel discussion and audience input, they reached a consensus that Nevada needs to reform its service delivery system for children with behavioral health needs (Valley, 2015). The voices at the Community Forum echoed the findings of a state-commissioned report on the status of Nevada's public mental health services which concluded that "Nevada has missed a number of opportunities over the years to strengthen its behavioral health system" and needs "a proactive, strategic plan to implement an integrated system of care approach to behavioral health" (Watson et al, 2013.) The report found that Nevada's behavioral health system has focused on responding to adults with mental health crises, rather than investing its resources in prevention and early intervention for children and youth. The U.S. Substance Abuse and Mental Health Services Administration has provided data to suggest that in recent years, Nevada has increased the percentage of state spending on inpatient hospitalization and centralized administration while decreasing its funding on community-based services for individuals with behavioral health needs (SAMHSA, 2013). In spite of disproportionately high levels of teen suicide and depression, UNLV's Lincy Institute has shown that Nevada lags significantly behind neighboring states in providing adequate funding for children's mental health services that will strengthen families and help youths with mental health needs succeed at home, in school and in their community (Denby, 2013).

The Clark County Children's Mental Health Consortium's **10-Year Strategic Plan**(2010) provides the vision, goals and strategies to implement an integrated system of care approach that will overcome the challenges identified by the Community Forum participants and by recent local, state, and national studies. The CCCMHC **10-Year Strategic Plan** represents a commitment to all our community's children who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic. The Plan is based on a set of values and principles that promote a system of care that is community-based, family-driven and culturally competent. Using a public health approach and a neighborhood-based model of service delivery, the plan sets forth the following long-term goals for Clark County by the year 2020.

10-Year Plan Goals

- 1. Children with serious emotional disturbance and their families will thrive at home, at school and in the community with intensive supports and services.***
- 2. Children with behavioral health needs and their families will access a comprehensive array of effective services when and where needed.***
- 3. Families seeking assistance will find an organized pathway to information, referral, assessment and crisis intervention coordinated across agencies and providers.***
- 4. The system will be managed at the local level through a partnership of families, providers and stakeholders committed to community-based, family-driven, and culturally competent services.***
- 5. County-wide programs will be available to facilitate all children's healthy social and emotional development, identify behavioral health issues as early as possible, and assist all families in caring for their children.***
- 6. Heightened public awareness of children's behavioral health needs will reduce stigma, empower families to seek early assistance and mobilize community support for system enhancements.***

Working in partnership with the State Children's Behavioral Health Consortium and the two other regional consortia, the Clark County Children' Mental Health Consortium calls for parents, policymakers and professionals to come together and take immediate action to support a change in approach to children's behavioral health

service delivery. This report identifies **four priorities for Fiscal Years 2017-2018**, as well as specific services necessary to produce the most immediate, cost-effective system improvements. These priorities serve as building blocks for the CCCMHC's **10-Year Strategic Plan**, which has been submitted to the Director of the Department of Health and Human Services and the Commission on Behavioral Health.

Clark County Children with Behavioral Health Needs

Clark County's children with behavioral health needs share many of the same characteristics and challenges of children with behavioral health needs across the U.S. The most recent national studies have confirmed that between 13-20 percent of American children aged 5-18 years have experienced a behavioral health disorder within the past year, and over 1 in 5 adolescents have suffered severe impairment as a result of these disorders (SAMHSA, 2013). By the time U.S. children reach adulthood, approximately one-half have experienced a behavioral health need at some point in their young lives (SAMHSA, 2013). Underscoring the notion that mental disorders begin early in life, these studies have found that symptoms of anxiety disorders began by age 6, behavior disorders (such as ADHD or conduct disorder) by age 11, mood disorders by age 13, and substance use disorders by age 15. The percentage of teenagers suffering from mental disorders is even higher than the most frequent major medical conditions of adolescence (Merikangas et al., 2010). Even children younger than five years of age may exhibit serious emotional and behavioral problems, with one national study estimating a prevalence rate of 10-14% in this population (Brauner, 2006). In Clark County, studies have suggested that 19.3% of elementary school children have behavioral health care needs and over 30% of adolescents self-reported significant levels of anxiety or depression (CCCMHC, 2010). In 2013, almost twenty percent of Clark County's public middle school students seriously thought about killing themselves, more than 30% had used alcohol or illegal drugs, and over 11% had attempted suicide (Frankenberger et al., 2014). Some children and youth have greater needs for behavioral health care than others. National studies have found that at least 50% of children and youth in child welfare and approximately 70% of youth in the juvenile justice system have significant mental health disorders (Stagman et al., 2010, SAMHSA, 2013). Local surveys conducted by the Consortium have confirmed that Clark County children in the child welfare and juvenile justice systems also experience a greater need for behavioral health care (CCCMHC, 2010).

Children with serious emotional disturbance (SED) experience symptoms that significantly impair their ability to function at home, in school and in the community. The most recent studies suggest that 10-12 percent of U.S. children exhibited signs of SED in the past year (SAMHSA, 2013). With local studies showing at least 6 percent of early elementary school children exhibit signs of SED, it is reasonable to project prevalence rates for all Clark County children and youth with this condition will match the national data (CCCMHC, 2010).

*Whereas children's behavioral health disorders are highly treatable and even sometimes preventable, studies have found long delays, even decades between onset of symptoms and identification and treatment of the disorder (SAMHSA, 2007; SAMHSA, 2013). Similar to national studies showing that 75% to 80% of children and youth in need do not receive mental health services (Stagman et al, 2010), a Clark County study showed that 70% of elementary school children identified with behavioral health disorders were not receiving any special services or treatment (CCCMHC, 2010). **Whether rich or poor, insured or uninsured, the families of children with serious behavioral health disorders struggle to find appropriate services, often turning to the public systems that provide children's mental health care.** Like others across the nation, many Clark County families have been forced to relinquish custody to child welfare or juvenile justice in order to access services and supports for their children (U.S. General Accounting Office, 2003). National studies have shown that privately-insured families with children in need of mental health care face significantly greater financial barriers than families with children without mental health needs (Stagman et al., 2010). Seventy-nine percent of children with private health insurance and 73 percent with public health insurance have unmet mental health needs (Stagman et al., 2010). Even when children with SED receive treatment, only a fraction can access the wraparound care coordination, family-to-family peer support and other innovative services proven effective in meeting their needs (Pires et al., 2013).*



In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008).

PRIORITIES

Priority 1. Re-structure the public children's behavioral health financing and delivery system to ensure quality, accountability, and positive outcomes for Clark County's children and families.

2017-2018 Programs/Services:

Justification:

In order to improve the condition of Nevada's children with behavioral health needs, the CCCMHC's first priority is **to re-structure the public children's behavioral health financing and delivery system in order to ensure quality, accountability, and positive outcomes for Clark County's children and families.** In addition to critical service gaps, federal and state studies have suggested that the system of behavioral health services in Clark County is complex and difficult to navigate (CCCMHC, 2010). The UNLV Lincy Institute found a wide discrepancy in the number of youths able to access services in Nevada as compared to neighboring states. While 54% of Arizona's children and 46% of Colorado's children with emotional, behavioral or developmental needs received counseling or treatment, only 29% of Nevada's children with these special needs received comparable services (Denby et al., 2013). Another study found Nevada's adolescents accessed outpatient treatment at a rate lower than 45 other states (SAMHSA, 2013; Mental Health American, 2016). The most recent study of Nevada's system found large disparities in access to public behavioral health programs for minority groups such as Hispanics and Asians (Watson et al., 2013). A 2014 study commissioned by the Governor's Council on Behavioral Health & Wellness concluded that the current governance structure of the state's public mental health system has led to a lack of coordination between agencies and poor responsiveness to community needs (Brune et al., 2014). As a consequence of these systemic problems, Nevada youths with serious emotional disturbance or other disabilities continue to be unnecessarily placed in out-of-state institutions (Valley, 2015).

To address this priority, the CCCMHC recommends that Nevada implement local system management of all publicly funded children's behavioral health services in Clark County, including those administered by the Division of Child and Family Services and the Division of Health Care Financing and Policy. Nevada law already specifies that "the system

of mental health services [for children] should be community-based and flexible, with accountability and focus of the services at the local level" (NRS 433B). In communities across the U.S., outcomes for children and families have improved by creating partnerships at the local level to manage the system of behavioral health care (Stroul et al., 2008). A recent report on Nevada's behavioral health programs recommended more locally-driven, community-based services to address difficulties in service access and outcomes (Watson et al, 2013). The Southern Nevada Health Forum has been advocating for local governance of Nevada's Public Mental Health System for the past two years.

Fig 1. Children in Medicaid Out-of-State Placements

Month	Children Placed	Total Mo Cost	Cost/Mo/child
Oct 2014	249	\$2,446,189.50	\$9,824.05
Nov 2014	243	\$2,389,709.45	\$9,834.20
Dec 2014	235	\$2,376,544.62	\$10,112.96
Jan 2015	225	\$2,287,021.77	\$10,164.54
Feb 2015	225	\$2,020,606.91	\$8,980.48
Mar 2015	230	\$2,307,873.35	\$10,034.23
Apr 2015	231	\$2,209,525.04	\$9,565.04
May 2015	226	\$2,215,472.20	\$9,802.97
Jun 2015	238	\$2,176,245.01	\$9,143.89
Jul 2015	220	\$2,265,612.53	\$10,298.24
Aug 2015	230	\$2,259,816.75	\$9,825.29
Sep 2015	233	\$2,225,401.25	\$9,551.08

Under local systems management, the CCCMHC recommends redeployment of Medicaid and other funding to support a single, accountable entity in Clark County that adheres to the System of Care philosophy (Stroul et al., 2008) and uses an evidence-based wraparound approach (Bruns et al, 2010) to coordinate the care for youth with serious emotional disturbance. The federal government has reported that less than 10% of Nevada children with serious emotional disturbance have access to the state mental

health wraparound care management at a penetration rate of less than half the average of other states (CMHS, 2013). A 2009 state-commissioned report found that approximately one-third of public children's behavioral health care dollars in Clark County were spent on some type of care management, but that these efforts were duplicative, inconsistent, and failed to target those youths with the most serious and complex needs (Pires, 2009). A report commissioned by the Governor's Council on Behavioral Health and Wellness described the benefits of integrating funding and the effective use of care coordinating organizations in producing effective service outcomes (Brune et al., 2014). The Center for Health Care Strategies has profiled successful demonstration projects that use integrated care management entities such as Wraparound Milwaukee, producing positive outcomes while reducing utilization and costs for long-term residential care (Bruns et al., 2010; Simon et al., 2014). Results from the Centers for Medicare & Medicaid Services' Psychiatric Residential Treatment Facility Waiver Demonstration Project also showed the value of integrated case management in achieving better outcomes for children and families at a significant cost-savings (Pires et al., 2013).

Furthermore, federal and state reports continue to highlight the need for a more substantial workforce in Nevada trained to provide quality behavioral health services to children (Denby, 2013;

Dvoskin, 2014; SAMHSA, 2013). For example, the shortage of child psychiatrists in Southern Nevada results in families facing long waitlists, short medical appointments and few alternatives for accessing needed care for their children with behavioral health needs (Valley, 2015). Given the workforce shortage, existing Medicaid reimbursement rates should also be examined to determine if they incentivize local providers to expand their capacity to serve this vulnerable population.

To facilitate the effectiveness of local service delivery, the CCCMHC also recommends that both traditional health care providers and care management entities have the ability to provide innovative services such as family-to-family peer support, mentoring, mental health consultation, and respite care, under health care coverage policies or flexible funding strategies. These strategies are currently underutilized in public children's behavioral care systems in spite of their demonstrated effectiveness in improving outcomes and reducing costs of services (Pires et al., 2013). In order to improve the quality of children's behavioral health care, the CCCMHC has made a fourth recommendation to develop statewide standards that require all providers who receive Medicaid or other public funding as reimbursement to utilize family-driven, individualized, evidence-based treatment interventions. As a model, Nevada can utilize the process developed for its SAPTA providers.

Matthew's Story

Matthew is a 10-year old boy with multiple mental health diagnoses including Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. Matthew lives with his mother, Sarah, who is parenting Matthew and his two siblings on her own. Matthew has been receiving therapy for two years and is seeing a psychiatrist for medication management. Neither of these services is provided in the community where his family lives, so his mother has to remove him from school early once a week to take a bus across the Las Vegas Valley for therapy, rearranging her work schedule to accommodate these appointments as well. She then has to pick up her other children at an after school program upon her return to their community and go home to cook dinner and do homework. Sarah has no family in the community and feels uncomfortable leaving Matthew in the care of friends because his behavior can sometimes be unpredictable and explosive. The school calls her at work at least twice a week to complain about Matthew's behavior. Respite and other supportive services are not available in the healthcare plan from her work. Sarah is becoming increasingly stressed, isolated, and experiences frequent feelings of hopelessness but has no access to respite services which would give her a much needed break and a chance to "recharge". Accessing targeted case management (Wraparound in Nevada) would provide the family with a wraparound facilitator who could help her coordinate services, including respite, and help the family recognize and develop natural supports in the community.

**Not the child's actual name.*

Recommendations:

- A. Develop and implement a plan for integrated, local system management of all publicly funded children's behavioral health services in Clark County.
- B. Re-structure Medicaid policies and funding to support a single, accountable entity in Clark County that uses a wraparound approach to manage the care for youth with serious emotional disturbance. Blend/braid Medicaid and other public resources system, allowing flexibility in the care management entity's use of the funding to implement individualized services and supports that strengthen the family, reduce the need for out-of-home placement, and facilitate positive outcomes for each youth.
- C. Include the following as essential health benefits to be covered for children with serious emotional disturbance under benchmark plans for Medicaid, Health Insurance Exchanges and other publicly subsidized health coverage plans: family-to-family peer support, mentoring, mental health consultation, mobile crisis intervention, and respite care.
- D. Develop and implement a statewide, universal set of quality standards that require those children's behavioral health providers who receive Medicaid or other public funding as reimbursement for their services to utilize family-driven, individualized, evidence-based treatment interventions.
- E. Review Medicaid rates for children's behavioral health services to determine if inadequate provider reimbursement contributes to lack of capacity and access for children and families. **(new)**

Projected Costs:

This priority may be implemented through the redeployment of resources currently dedicated to the management of the system and through blending and braiding state and federal funds from those agencies currently providing children's behavioral health services.



Priority 2. Provide mobile crisis intervention and stabilization services to Clark County youths in crisis.

2017-2018 Programs/Services:

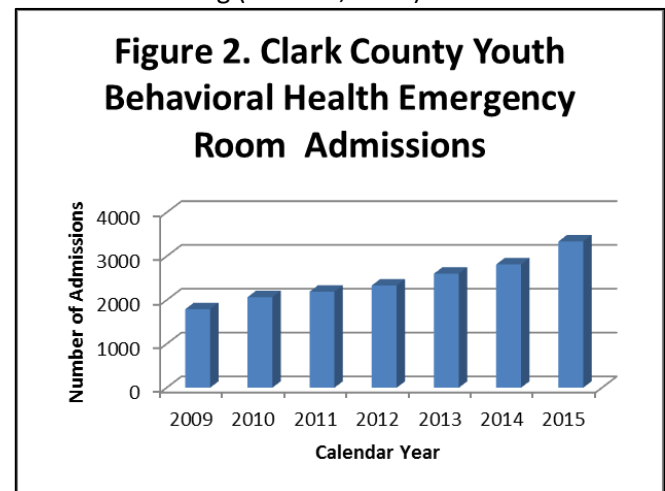
Justification:

The second priority of the CCCMHC is to **provide mobile crisis intervention and stabilization services for all Clark County youths in crisis**. Without easy access to crisis intervention and stabilization services in the past, families in Clark County have been forced to utilize local emergency rooms in order to obtain behavioral health care for their children. The National Center for Children in Poverty first identified youth emergency room visits for behavioral health care as a serious problem across the United States (Cooper, 2007). A recent national study of children's behavioral health services utilization in the Medicaid program showed that eligible adolescents still use disproportionately more services--particularly facility-based care--due to the lack of more cost-effective approaches such as mobile crisis intervention services (Pires et al., 2013).

Child mental health-related visits to hospital emergency rooms have increased steadily in Clark County over the past five years. Depression, Anxiety, Conduct Disorder and Alcohol Abuse represent the most predominant diagnoses upon admission to local emergency rooms (Greenway, 2015). From earlier studies, it is estimated that almost 40% of these youths have been admitted to emergency rooms due to suicide attempts or threats. Nearly half of youths admitted are discharged home without immediate treatment, still showing signs of suicidal ideation, psychosis, or depression (CCCMHC, 2010). The medical director of University Medical Center's Pediatric Emergency Room has called the situation a "health crisis of unbelievable proportions," noting that mental-health related visits to his facility have tripled over the past decade while the county population has increased by only 25% (Valley, 2015).

Children seen in emergency rooms are often admitted to psychiatric inpatient care. In 2013 Clark County psychiatric hospitals admitted more than 7,200 children, a 45% increase over 2009 (Valley, 2015). Mobile crisis intervention services have reduced the costs and utilization of inpatient psychiatric hospitalization for youths with complex behavioral health care needs in programs implemented across New Jersey, in Milwaukee,

Wisconsin and in Seattle, Washington (AHRQ, 2013). Based on the success of other states and communities, DCFS implemented a mobile crisis team pilot program in January 2014, expanding the services in October 2014 after the Governor's Council on Behavioral Health & Wellness successfully advocated for additional funding (Dvoskin, 2014).



The DCFS Mobile Crisis Response Team (MCRT) currently serves youth in the greater Las Vegas area that are experiencing a mental health crisis such as suicidal ideation or behavior, homicidal ideation or behavior, acute psychosis, extreme parent/child conflict, difficulty adjusting to a serious peer relational issue such as bullying, or any other serious mental health problem. The ultimate goal of MCRT services is to divert youth from psychiatric hospitalization whenever possible. The Las Vegas MCRT received 990 calls during 2015 and provided services to 675 youth and families in response to these calls. Suicide ideation represents the most common reason for calls to the program. Most intake assessments take place in an emergency room department or a private residence. However, the MCRT frequently responds directly to referrals from the Clark County School District and the Department of Juvenile Justice. A total of 88% of youths served were diverted from psychiatric hospitalization. Ninety five percent of the families served were referred for additional mental health and/or community support services. The Mobile Crisis Team has partnered closely with Nevada

PEP, immediately linking families for the support needed to keep the child at home whenever possible. As more youth in crisis are referred to the MCRT, additional funding will be needed for family support through Nevada PEP. The youth served through the MCRT have shown significant improvement in functioning and 93% of parents/guardians report being satisfied with the program.

In spite of their success, the MCRT has experienced challenges in facilitating inpatient services and other types of intensive care needed for some youths served by the program. The MCRT struggles to find appropriate placements and/or services for youth for co-occurring developmental disabilities and behavioral health needs. Additional assessments required by the hospitals or managed care providers have also caused delays in linking many other youth to needed services, increasing the length of emergency room stays for these youth and families.

The CCCMHC is recommending that DCFS develop interagency protocols and policies with hospitals and managed care providers to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior.

Over the past year, the Nevada Department of Health and Human Services implemented a program that allows hospitals to determine presumptive Medicaid eligibility for their patients. The Nevada Department of Health and Human Services should explore the expansion of presumptive eligibility to all youths requiring the services of DCFS Mobile Crisis Intervention program. This strategy would result in less reliance on emergency room services and more rapid access to community-based providers, while creating a stable funding source for the program.

David's Story*

David is a 13-year old boy diagnosed with multiple mental health disorders who has a history of multiple acute psychiatric hospitalizations. David struggles with behavior at school, at home and in the community but has an especially hard time controlling his impulsivity and aggressive outbursts in the school setting. David's mother is able to manage his behaviors at home but even after placement in a specialized school setting, David is often in trouble at school. On one occasion, he became physically violent with another student and afterwards told school staff that "he didn't want to live anymore." David was transported to the local hospital emergency room, where the staff contacted the DCFS Mobile Crisis Response Team (MCRT). The immediate situation was addressed, Mom agreed to work with MCRT and their assessment indicated that David could return home that night, which avoided another acute psychiatric hospital admission. MCRT developed a safety plan with mom and set a follow-up home appointment for the following day. After a month of intensive services with MCRT, the family was transitioned to more traditional therapy services and referred to the Wraparound in Nevada program. Over a year later, David's school behaviors are better, the family is participating in therapy, his medication is stable, and the family is preparing to graduate from Wraparound. *Not the child's actual name

Recommendations:

- A. Provide ongoing funding for DCFS to maintain an evidence-based mobile crisis intervention program with fidelity that meets the needs of Clark County youth experiencing severe psychiatric crises
- B. Develop interagency protocols and policies with hospitals and managed care providers to facilitate the seamless transition to appropriate inpatient or community-based care for all uninsured as well as privately and publicly insured youths admitted to emergency rooms with severe psychiatric crises, including those with suicidal behavior. (new)
- C. Expand funding for Family-to-Family Peer Support to enhance outcomes and reduce recidivism for youths served by mobile crisis intervention.
- D. In order to support the program and provide timely access to needed services, develop a mechanism for providing presumptive Medicaid eligibility to appropriate youths referred for crisis intervention services. (new)

Projected Costs:

\$2,055,000 per year for 1500 youths. Projected costs are based on an average of 10 hours of mobile crisis intervention per youth and family at the Medicaid rate of \$137.00 per hour.

Priority 3. Expand access to family-to-family peer support services for the families of Clark County's children at risk for long-term institutional placement.

2017-2018 Programs/Services:

Justification:

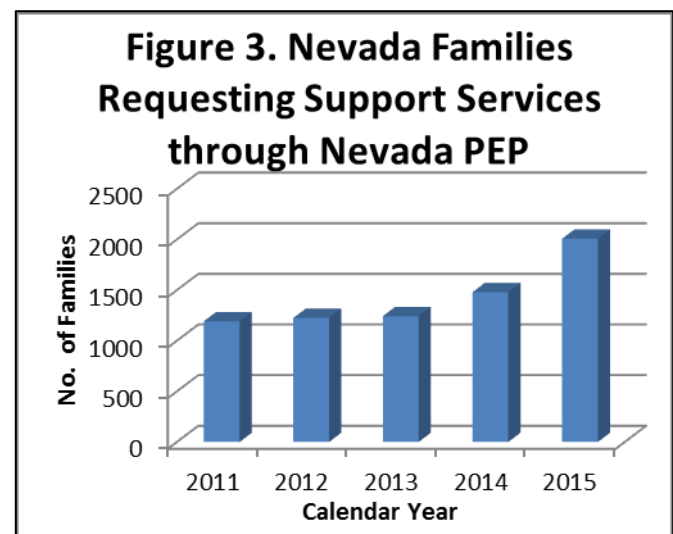
As a third priority, the CCCMHC recommends that **Nevada expand access to family-to-family peer support services for the families of Clark county's children at risk for long-term residential placements.** Youths with these co-occurring disorders are disproportionately represented among large numbers of Nevada youth currently being placed in out-of-state residential institutions.

Family-to-family peer support services have been shown effective in improving outcomes for such youths with serious emotional disturbance and their families (Stroul et al., 2008). Studies conducted in Clark County through the federally funded Neighborhood Care Center Project also suggested that family-to-family peer support services can result in an increase in stable, community-based placements; improvement in school grades and attendance; and improvement in the child's clinical symptoms (Nevada Division of Child and Family Services, 2005).

A national study of children's behavioral health services utilization in the Medicaid Program found that one percent or fewer eligible children with behavioral health needs were receiving nontraditional services such as family-to-family peer support, in spite of a mounting body of evidence demonstrating the cost effectiveness of this approach (Pires et al., 2013). Such findings suggest a lack of access to family-to-family peer support services; even while more and more Nevada families of children with serious emotional disturbance request this program through Nevada PEP each year (see Figure 3). Because family-to-family peer support services can help reduce reliance on expensive, restrictive residential treatment, the Centers for Medicare & Medicaid Services issued a bulletin in May 2013 recommending that states provide funding for family-to-family peer support as part of their benefit plan for children with significant mental health conditions (CMS, 2013). The Governor's Council on Behavioral Health & Wellness also recommended expansion of family-to-family peer support programs in its 2014 report (Dvoskin, 2014).

Nevada PEP currently provides family-to-family peer support services for families who have

children with mental health needs. Families are referred by DCFS programs, schools, and community organizations. Over the last year PEP provided family-to-family peer support services to 1,129 families of youth with serious emotional disturbance in Clark County. Families who contact Nevada PEP for support receive individualized and unique support to meet their needs which may include: Informational and educational support; Instructional and skills development support; Emotional and affirmation support; Instrumental support and referral; Advocacy support; and Leadership skill building at child and family level as well as at system levels.



Nevada PEP has partnered in the development and implementation of DCFS's Mobile Crisis Response Team, serving 327 Clark County families referred by MCRT in 2015. The funding approved in June 2014 by the Interim Finance Committee to expand DCFS's mobile crisis intervention services also included a small amount of funding to add additional family-to-family peer support services for youths identified by the mobile crisis teams, with the intent of reducing the number of youths at risk for long term institutional placement. This new funding for family-to-family peer support included in the FY 16-17 Governor's Biennial Budget Request should be sustained in the next biennium to keep pace with the growing need.

The 2013 Pires et al. study also found that behavioral health expenses for children in Medicaid with a developmental disability were more than double those for other children, pointing to the need for alternative approaches such as family-to-family peer support for this population. At least 24 Clark County youths with co-occurring developmental disabilities and behavioral health needs have been served by the Mobile Crisis Response Team over the past year. Linking these youths to community-based services creates one of the greatest challenges for the MCRT. Family-to-family peer support can improve outcomes for these children, representing a critical component of any care coordination plan. The CCCMHC recommends that intensive family-to-family peer support be incorporated into the pilot project for such youths authorized by Assembly Bill 307 of the 2015 Nevada Legislature.

Additional funding for family-to-family peer support is also desperately needed to provide services

to the large numbers of youths at risk for long-term psychiatric residential treatment identified each year by the Clark County School District's Mental Health Transition Team. Created in 2014, this team develops school-based aftercare for youths discharged from psychiatric hospitals. In the 2014-15 academic year, the team provided aftercare support to 1485 youths transitioning back to their home schools after hospital stays. During the first half of this school year, the team has already served 773 youths. The majority of youth identified by the team lack special education supports and suffers from depression, bipolar disorders, or other serious mood disorders. While the Mental Health Transition Team connects youth with needed services as they return to school, the families also need support to care for these high-risk youths at home. Almost 200 youths identified by the CCSD Team have already had at least two psychiatric hospitalizations so far this year.

Jenna's Story*

Jenna is a 12-year old girl with co-occurring mental health and developmental disabilities. Jenna's family had accessed multiple services over the years, all with various levels of what mom termed "very limited success or failure." Jenna's behaviors at school had escalated with no clear indication of what was triggering the behaviors. Although mom was often able to redirect Jenna, there had been some instances when that was not possible. In these instances, Jenna had run from the home and the police had been called for assistance. The private acute psychiatric hospitals in the area would not accept Jenna because of her developmental disability and mom often felt her only choice was to take Jenna to the emergency room for assistance and then to Desert Willow Treatment Center if there was a bed available. Jenna had been placed in long term residential placement in the past for a period of 6 months which mom felt had little lasting effect. The CCSD Mental Health Transition Team assisted when her daughter was discharged from a short stay at Desert Willow Treatment Center. As part of that transition, the family was referred to Nevada PEP for family support. The parents received family-to-family peer support from their Nevada PEP Family Specialist and learned about options for different resources in the community. Mom has also accessed Nevada PEP for Positive Behavior Interventions trainings and support groups to meet other family members who were experiencing similar issues. Mom feels better equipped now and has not had to call the police or go to the emergency room for assistance in four months.

**Not the child's actual name*

Recommendations:

- A. Expand funding to provide family-to-family peer support for Clark County youths with serious emotional disturbance at risk for long-term residential treatment by implementing a pilot project for 200 youths discharged from psychiatric hospitalization and referred from the CCSD Mental Health Transition Team.
- B. As part of the pilot project established under Assembly Bill 307 of the 2015 Nevada Legislature, provide an intensive level of family-to-family peer support for at least 50 Clark County youth with intellectual/developmental disabilities or related conditions who are also diagnosed with behavioral health needs in an effort to prevent long-term institutional placement. (revised)

Projected Costs:

\$600,000 per year for Program A (200 youths) and **\$150,000 per year** for Program B (50 youths). Costs based on Nevada PEP cost per family of \$3,000 for 75 hours of family-to-family peer support.

Priority 4. Develop partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health care needs.

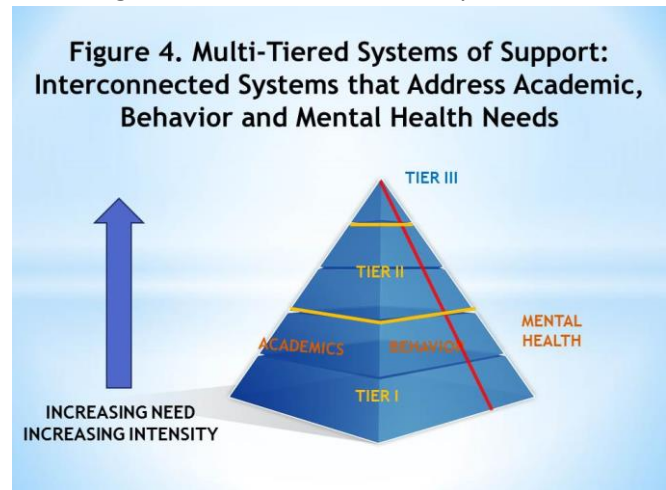
2017-2018 Programs/Services:

Justification:

The Consortium's fourth priority is to: **Develop partnerships between schools and behavioral health providers in order to implement school-based and school-linked interventions for children identified with behavioral health care needs.** As with physical illnesses, prevention and early intervention for behavioral health problems will reduce costs to public agencies for later, more intensive, and long-term treatment (SAMHSA, 2007). For the average youth, symptoms typically precede a serious disorder by about two to four years (Denby, 2013). Screening can help identify and link youth early with services before symptoms become so intense and debilitating that they require more restrictive, costly care. Although screening should be provided across the age range, it becomes even more critical as children enter adolescence and become more prone to depression and high-risk behaviors (Schwarz, 2009). School-based screening has been shown effective in identifying teens with mental health problems and linking them with needed services (Husky et al., 2011). Even more important, screening for depression coupled with suicide awareness training can reduce the incidence of suicide attempts in adolescents (Azeltine et al., 2004).

Clark County public and private schools have experienced some success in implementing school-based screening programs to identify students with mental health needs and provide them with assistance in obtaining treatment services (CCCMHC, 2010). Between 2011 and 2013, CCSD screened over 17,000 adolescents using the evidence-based Signs of Suicide program. Recognizing the importance of school-based screening approaches, the 2013 Nevada Legislature approved Assembly Bill 386 mandating that Clark and Washoe County School Districts implement and evaluate a school-based program in partnership with community stakeholders to provide students with general behavioral health screenings. In 2014, CCSD implemented a pilot program of general mental health screening for middle school children in response to the Legislative mandate. In spite of the

success of both of these screening programs, substantial funding and a more efficient process must be developed before CCSD can initiate wide-scale screening efforts across all community schools.



Screening is one of the steps in actualizing the Clark County School District's preferred approach of building a multi-tiered system of supports that includes selective mental health services interconnected with the District's system of academic supports (See Figure 4.). In this system, preventative behavioral health supports can be initially developed and provided to all students through social-emotional learning programs, while students identified with behavioral health needs, in part through screening, can receive early intervention or intensive support.

Currently, the Nevada Department of Health and Human Services (DHHS) is not providing any funding for school-based screening efforts in Clark County. The CCCMHC recommends that DHHS's Office of Suicide Prevention conduct a survey of Clark County public, private and charter schools to determine the extent to which they have implemented mental health screening programs. DHHS should also provide funding support to implement an evidence-based model of school-based mental health and suicide prevention screening that is cost-effective, utilizes parental consent, and includes procedures and resources to link identified students with needed services.

Sally's Story*

Sally is a 16-year old sophomore attending school in Clark County. Sally's mom and dad had noticed that she had been sad and withdrawn lately, but thought it was just a typical adolescent phase. They tried to talk to her and get her to open up but Sally said that they were making a big deal out of nothing and that she was fine. Later that week, mom received a consent request for a school-wide screening activity, which she signed for Sally to participate. During the screening, Sally was found to be at risk for attempting suicide. Sally talked with the school counselor and shared that she was feeling very depressed and angry over a recent breakup with her boyfriend. The counselor immediately called Sally's parents and a decision was made to have Sally assessed that same day at an acute psychiatric hospital. Sally was admitted for a short stay and discharged. Sally's parents followed through with all of the hospital's recommendations, started family counseling and got Sally involved in a positive youth group. Sally's parents feel that the screening not only saved their daughter's life, but also led them to counseling and has opened lines of communication among all of them.

**Not the child's actual name*

Recommendations:

- A. Assist the Nevada Office of Suicide Prevention to obtain resources in order to conduct a comprehensive survey of Clark County public, charter, and private schools that will determine the degree to which mental health and/or suicide prevention screening has been implemented. (new)
- B. DHHS initiatives for mental health and/or suicide prevention screening should support the implementation of an effective model of school-based mental health and suicide prevention screening that is: (1) Evidence-based; (2) Cost-effective; (3) Utilizes active parental consent; and (4) Includes procedures and enhanced resources to link identified students with needed services. (new)

Projected Costs:

The Nevada Departments of Education and Department of Health and Human Services should evaluate current funding sources for school-based social climate and mental health programs in order to redeploy a portion of the funding toward screening programs for Clark County schools.



ABOUT THE CLARK COUNTY CHILDREN'S MENTAL HEALTH CONSORTIUM

Current Membership

Janelle Kraft-Pearce, Chairperson

Las Vegas Metropolitan Police Department

Dan Musgrove, Vice Chairperson

Business Community Representative

Mike Bernstein

Southern Nevada Health District

Jennifer Bevacqua

Nevada Youth Care Providers Association

Leslie Brown

Nevada Division of Aging and Disabilities Services

Lisa Durette, M.D.

American Academy of Child & Adolescent Psychiatry

Richard Egan

Nevada Office of Suicide Prevention

Charlene Frost

Parent Representative

Jacqueline Harris

Provider of Substance Abuse Services

Amanda Haboush-Deloye, Ph.D.

Nevada Institute for Children's Research & Policy

Terri Keener

Clark County Family Services

Heather Lazarakis

Nevada Division of Health Care Financing & Policy

Karen Miller

Parent Representative

Karen Taycher

Nevada Parents Encouraging Parents

Robert Weires

Clark County School District

Kelly Wooldridge

Nevada Division of Child & Family Services

Cheri Wright

Clark County Juvenile Justice Services

Mission

The Consortium was created by the passage of Assembly Bill 1 of the 2001 Special Session of the Nevada Legislature to study the mental health needs of all children in Clark County and to develop recommendations for service delivery reform. The Consortium is required to conduct a needs assessment and submit a 10-Year Strategic Plan and Annual Reports to the Commission on Behavioral Health and the Nevada Department of Health and Human Services. Required membership and activities for the Consortium are described in Nevada Revised Statutes 433B.333-335.

The CCCMHC's 10-Year Strategic Plan

Is available on the DCFS website at:
http://www.dcf.state.nv.us/DCFS_ChildMentalHealth_CCCMHC.htm.

Acknowledgements

The Clark County Children's Mental Health Consortium would like to acknowledge the financial and technical support provided by Nevada PEP in order to complete this report. Special thanks to the Nevada Division of Child and Family Services for providing administrative support for the meetings of the consortium and to Dr. Christa Peterson for preparing the report.

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The CCCMHC 10-Year Strategic Plan represents a commitment to all our community's children who deserve the supports necessary for optimal mental health and social-emotional development, early access to treatment when problems arise, and intensive interventions when behavioral health problems become severe and chronic.

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APPENDIX E

Children's Mental Health Consortia Policy Priorities

E.2 – Rural Nevada Children's Mental Health Consortium

Nevada Rural Children's Mental Health Consortium

Annual Progress Report for Ten-Year Strategic
Plan

1/1/2016

Nevada Rural Children's Mental Health Consortium
(RCMHC)

Annual Progress Report for
Ten-Year Strategic Plan

Introduction

The Rural Children's Mental Health Consortium (RCMHC) is comprised of committed professionals, agency personnel, community representatives, parents, community business representatives, representatives from the Department of Education, and advocates who come together to support children, youth and families in Rural Nevada with emotional and behavioral health needs.

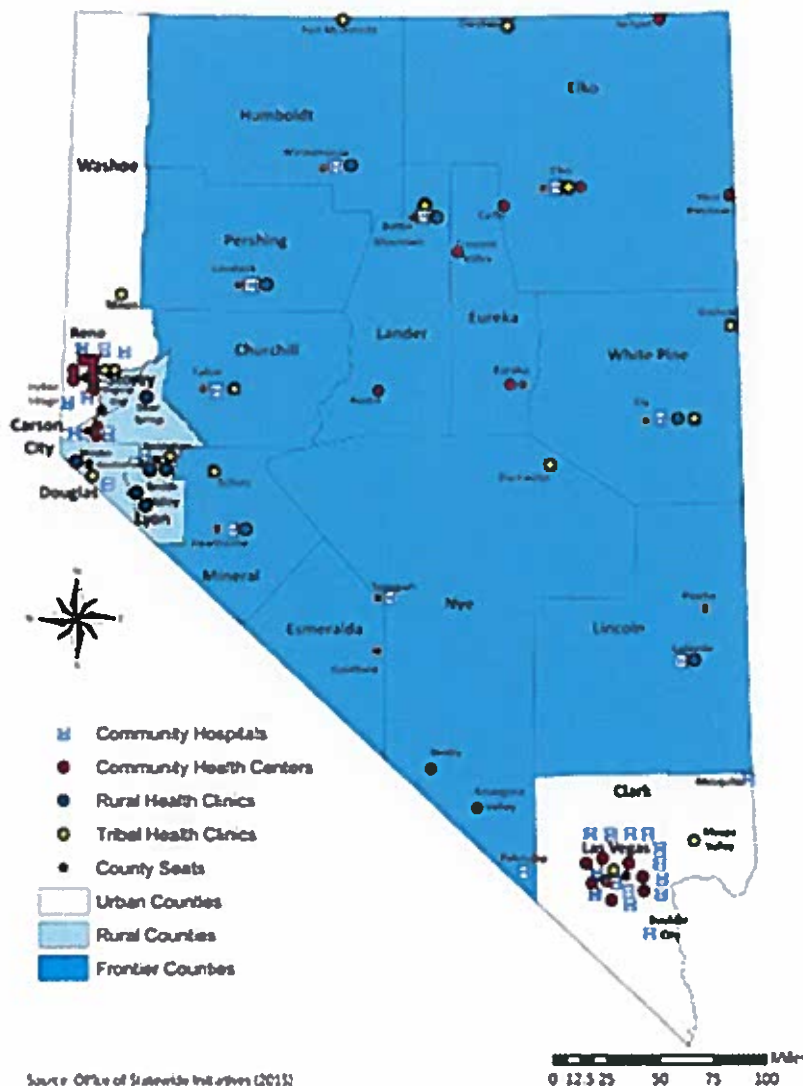
The mission statement is:

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

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

Background

The Rural Children's Mental Health Consortium has been tasked with addressing children's mental health needs across fifteen large and diverse counties of Nevada. This includes the urban county of Carson; the three rural counties of Douglas, Lyon, and Storey; and the eleven frontier counties with a population density of seven or less persons per square mile of Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, and White Pine Counties. Collectively, the rural and frontier counties of Nevada account for approximately 12.1% of the state's population spread across an expansive 87% of the state's land mass (Nevada Rural and Frontier Health Data Book, 2015).



The predominate issues impacting children's mental health in Rural Nevada are complex and intensified by two primary challenges: limited access to services due to geographic distance and insufficient provider availability. As of 2014, from the total of approximately 676,000 children ages 17 and under living in Nevada, 72,000 lived in the region served by the RCMHC (Nevada State Demographer's Office, 2014). Currently, the primary

providers of children's mental health service in Rural Nevada are the Behavioral Health Rural Clinics. These clinics are frequently the only provider of mental health services in the region and provide mental health services to the entire spectrum of the population in which they are located. They expand access through the use of tele-health and are essential community partners in their respective rural communities. Given the unique challenges of Rural Nevada, the Consortium proposes that rather than simply replicating an "urban" children's mental health model in Rural Nevada, that efforts target the unique barriers of Rural Nevada in order to create a sustainable and accountable system of mental health care that fits the rural setting.

Acknowledgement

In pursuit of this ambitious objective, the Rural Children's Mental Health Consortium would like to note the significant progress which has been made over the past year and extend sincere gratitude to all those who have helped and continue to passionately work to realize this purpose.

The following recommendations are respectfully submitted for consideration.

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

Over the past year, large advances have been made toward the goal of “growing our own” rural providers for the development of a stable workforce that is skilled and responsive to the needs of their communities. The dedicated leadership and staff of the University of Nevada, Reno, School of Social Work have been instrumental in this effort. They are actively in the process of expanding the capacity of the social work program to increase professional output. In addition, they have secured a grant offering a number of \$10,000 stipends for students to pursue social work education. Of exceptional note, they are in the final stages of developing an online program for the Masters of Social Work (MSW) degree, expected to begin in the fall of 2017. The online MSW program will provide an additional avenue for members of rural communities to expand the number of mental health professionals at the regional and community level.

Nonetheless, in Rural Nevada, it remains that 100% of the population resides in a mental health professional shortage area (Nevada Rural and Frontier Health Data Book, 2015). The chart below provides the detailed number of various mental health professionals in Rural Nevada and how they are dispersed by County.

County	Licensed Social Workers	Licensed Clinical Social Workers	Psychiatrists	Licensed Psychologists	Licensed Clinical Professional Counselors	Licensed Alcohol, Drug & Gambling Counselors	Licensed Marriage & Family Therapists
Churchill County	16	7	0	2	0	37	6
Douglas County	1	8	1	5	2	22	23
Elko County	29	6	0	0	2	23	3
Esmeralda County	0	0	0	0	0	0	0
Eureka County	0	0	0	0	0	0	0
Humboldt County	4	3	0	1	0	11	2

Lander County	0	2	0	0	0	5	0
Lincoln County	1	4	0	0	0	2	1
Lyon County	9	3	0	5	3	32	7
Mineral County	0	0	0	0	0	0	1
Nye County	11	6	1	3	1	16	3
Pershing County	2	0	0	0	0	4	0
Storey County	0	0	0	0	0	3	2
White Pine County	4	3	0	1	0	3	1
Carson City	70	0	3	18	0	50	22
Total	147	42	5	35	8	208	71

(Rural and Frontier Health Data Book, 2015)

Recommendations

- Support “growing our own” rural providers for the development of a stable workforce that is skilled and responsive to the needs of their communities.
- Address mental health licensure by requiring reasonable and transparent licensure reciprocity for mental health providers in order to expand the available workforce.

The mental health provider shortage in Rural Nevada could be partially relieved by utilizing licensed out of state providers. It is expected that Rural Nevada’s would benefit from mental health licensure boards that acknowledge the credentialing processes of other states, cooperate with other licensing boards, and have transparent requirements for reciprocity to facilitate potential workforce expansion.

- Provide adequate mental health providers with culturally and linguistically appropriate service (CLAS) standards to Tribal populations.
- Improve clinical mental health internship process in Rural Nevada to build work force and provide for the retention of mental health providers.

By increasing the number of board approved clinical mental health internship sites in Rural Nevada, the ability of Rural Nevada to “grow our own” would be significantly impacted. Too often rural practitioners, such as psychologists, leave to pursue an internship and never return. Additionally, clinical mental health internships could benefit from mental health licensure board expansion of the definition of clinical services to include the role of preventative intervention to engage individuals before the development of serious mental illness or serious emotional disturbance.

- Adopt a standard of certification with accountability acknowledged by the State for paraprofessionals working in children’s mental health.

Ensure quality and continuity of care among non-traditional support personnel through quality training and oversight.

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

In January 2015 Governor Sandoval announced the creation of the Office for Safe and Respectful Learning Environments, including \$32 million in grants to put social workers and other licensed mental health providers in schools. The legislature approved the creation of the new office within the Nevada Department of Education and approximately \$17 million as part of SB 515, with slightly over \$5 million granted the first year and the remainder of the funding pending approval from the Interim Finance Committee in June 2016.

Additionally, a workforce development workgroup was formed to begin to identify and address barriers and incentives to being able hire social workers for school-based settings. Through the efforts of that group, progress in several areas has been made, with plans for continued efforts moving in to 2016.

In January of 2016, the Office for a Safe and Respectful Learning Environment in the Nevada Department of Education awarded \$5.6 million in grants to hire more than 160 social workers and mental health professionals in Nevada schools. Students had been surveyed on the health of their school climate, and

awards were based in part on which schools needed the most intervention. Eleven districts and six charter schools received funding.

Recommendations

- While the funds granted through SB 515 are for contract positions, two of the major barriers to being able to hire social workers in schools exist in the Nevada Administrative Code regarding the requirements for an endorsement to serve as a school social worker (see NAC 391.320). The workforce development workgroup was able to bring a proposed revision before the Commission on Professional Standards in November of 2015, which, if approved, will address these barriers. The first barrier within NAC 391.320 as it is currently written is the requirement that an applicant has had a practicum within a school setting; the proposed revision expands that language to include work equivalency in providing direct services to children and adolescents and their families.
- The second barrier that the proposed revisions seek to address is the need for a current license from the Nevada Board of Examiners for Social Work, by inserting language that allows for the holding of an equivalent license from another state as long as the licensing from Nevada is granted within a year, as a condition of continued employment.
- One of the major incentives identified by the workforce development workgroup for drawing mental health providers to work in school settings is the potential for schools to serve as sites for clinical internships. However, barriers to accomplishing that goal exist within the policies and requirements for clinical internships of several of the state professional licensing boards. The workforce development workgroup is working in concert with the Governor's office to seek creative solutions to those barriers in order to facilitate the development of highly qualified mental health providers who work in Nevada's schools.

- Identify new barriers as they arise, then support, advocate, and assist in the navigation of solving issues to overcome placing social workers in the schools. For example, internal district policies, liability insurance, benefits etc.

Goal #3 Promote and Support Greater Use of Technology to Enhance Mental Health in Nevada's Rural Region.

The expanded use of technology in the rural region offers a cost effective opportunity to enhance services for rural families of children with mental health and behavioral disorders. It allows for access to specialized providers that are not present in Rural Nevada, maximizes the productivity of those professionals by eliminating long travel times to reach remote rural locations, and removes the need for families to travel to receive care.

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

Rural Mental Health Clinics have been working on improvements to their broadband systems in order to increase the quality of telehealth for children and adults. All Rural Mental Health Clinic locations will be upgraded from 1.5 Mbps to at least 3 Mbps, with one clinic upgrading to 6 Mbps, by the end of this fiscal year. The hope is that this increase in bandwidth will give each clinic enough capacity to double the current strength or possibly allow two telehealth sessions to occur at once.

Emergency telehealth is being used in several rural hospitals and jails for intake assessments, prior to being transported to psychiatric inpatient hospitals. New mental health providers, such as West Care, are also expanding into Rural Nevada to provide telehealth for insured consumers.

Recommendations

- Provide appropriate bandwidth and equipment for delivery of telehealth services to Rural Nevada locations. Cost of access is still the primary problem in Rural Nevada due to lack of affordable bandwidth. For Rural Mental Health Clinics, all updates are funded through general funds which allows limited improvements. Potential grant funds are being looked at to help supplement the cost of improvements.
- Find alternative solutions to address bandwidth usage at each rural site during telehealth services due to impact on quality that depends on how other people at the site are using the connection at the time.
- Explore the possibility and logistics of using the VSee program for telehealth in Rural Nevada. VSee is a video conferencing, HIPAA compliant, free downloadable program.

Goal #4 Create a Rural Children's Mobile Crisis Response Team (MCRT):

Through the System of Care expansion grant, Rural Nevada has been sub granted \$135,000.00 to implement a MCRT. Under the Division of Child & Family Services (DCFS), Washoe and Clark counties currently have Mobile Crisis Response programs. The sub grant for Rural Nevada is a four year grant for one mobile crisis unit which consists of a mental health professional and a case manager. The Department of Public and Behavioral Health's Rural Children's Program Coordinator is currently working with Washoe County's MCRT programmers and other administrators on a scope of work. In addition to the scope of work, strategic planning for a roll-out of this program that will best serve all of Rural Nevada's children and families is actively being designed. DCFS has offered to provide partnering and training for the Rural MCRT including evidence based Motivational Interviewing, Brief Solution Focused Therapy, mentoring through Washoe and Clark County's MCRT's, coordination with their biostatistician, and telehealth training for all entities.

Additionally, the office for a Safe and Respectful Learning Environment in the Nevada Department of Education is in the process of forming a multiagency partnership and hiring three positions to support children and youth. These personnel would provide leadership to social workers in schools, coordinate training, and assist in appropriate intervention for students in crisis.

Recommendations

- Support implementation of MCRTs in Rural Nevada.
- Seek stakeholder input to determine most effective way to utilize the sub grant funds for maximized impact.
- Support design of a program that can be self-sustained after the four year sub grant is exhausted.

Goal #5 Promote Prevention and Intervention: Addressing Behavioral Health Issues Early---At a Point Before Escalation to the Level of a Behavioral Health Diagnosis.

Optimal mental health in childhood means reaching developmental and emotional milestones, acquiring healthy social skills, and learning how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. The Rural Children's Mental Health Consortium supports greater focus on prevention rather than crisis response alone. The consortium recognizes the need to place a primary emphasis on prevention and not simply focus on what to do after someone is in crisis; this requires addressing the mental-health concerns, bullying, trauma, and other risk factors that often precede mental health concerns.

The Nevada Division of Health Care Financing and Policy was selected to receive technical support from the National Governor's Association on a Medicaid transformation project addressing the behavioral health needs of children in Nevada. A proactive program is being designed to identify the "rising risk" youth in Nevada and provide this group with services that would enable them to cope with traumatic experiences and situations, with the goal of positioning their lives in a positive trajectory. The vision is to act early, in order to reduce behavioral health diagnoses and to decreased costs associated with high-level

behavioral health services in inpatient psychiatric hospital, residential treatment center, and emergency room settings in Nevada.

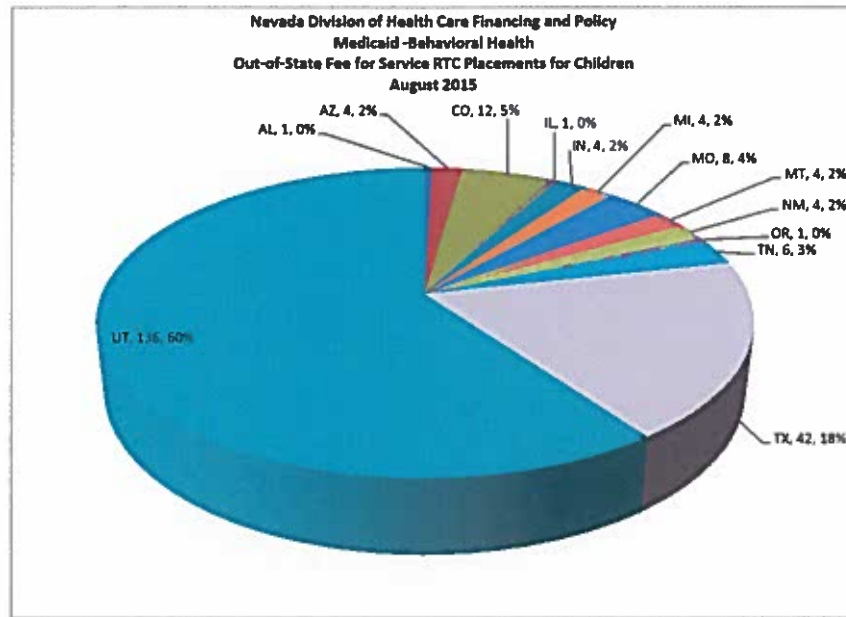
Recommendations

- Support and promote statewide screening of all children in Nevada prior to entry into the 7th grade and provide appropriate services.
- Support five year demonstration to evaluate and determine the effectiveness of reducing behavioral health diagnoses and decreasing costs associated with high-level behavioral health needs.

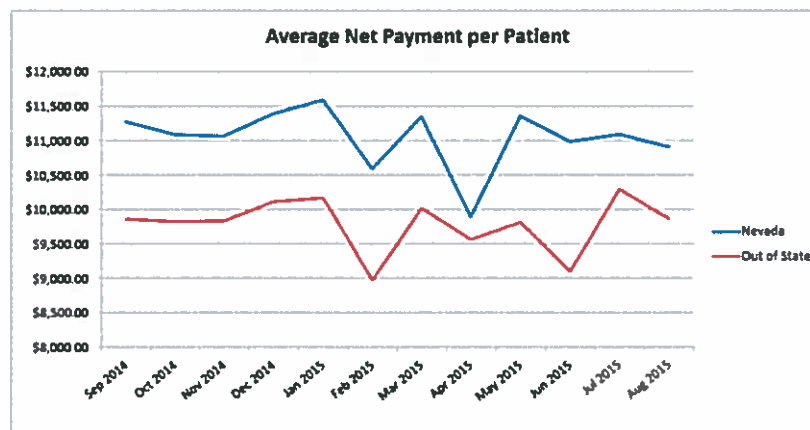
Goal #6- Increase Transitional Support to Youth Receiving Treatment in Inpatient & Residential Treatment Centers, Especially Those Out-of-State Through Increased Local Service Array

The Rural Children's Mental Health Consortium recognizes the significant issues surrounding youth who are placed in intensive inpatient care and out of state residential treatment care. As of August 2015, a total of 227 Nevadan children were in Out-of-State placement (Nevada Department of Health Care Financing and Policy, 2015). In 2015, the top three diagnoses of these youth were Episodic Mood Disorder NOS, Bipolar Disorder NOS, and Posttraumatic Stress Disorder (Nevada Department of Health Care Financing and Policy, 2015).

The graph below captures the location by state of the 227 children in out-of-state fee for service residential treatment center placement as of August 2015 (Nevada Department of Health Care Financing and Policy, 2015).



The graph below captures the financial discrepancy in cost between in-state residential treatment center placement vs. of out-of-state residential treatment center placement of patients from Nevada, from September 2014 to August 2015 (Nevada Department of Health Care Financing and Policy, 2015).



Recognizing this level of intensive care, it is important to address the concerns surrounding these youth as they transition back into the community. In response, the Rural Children's Mental Health Consortium participated with multiple agencies in June of 2015 to provide a free workshop facilitated by Dr. Rusty Clark, Ph.D, at the University of Nevada, Reno. The purpose of this workshop was to describe the

Transition to Independence Process (TIP) model that prepares and supports youth and young adults with emotional and behavioral difficulties (EBD) as they move into employment, educational opportunities, independent living situations, increased personal effectiveness/wellbeing, and increased community involvement. The TIP model is an evidence-supported practice that affords mental health providers in Nevada the possibilities of demonstrating real-life outcomes among youth and young adults with EBD.

Recommendation

- Support the development of services that facilitate smooth reintegration of youth coming out of residential treatment center placements and/or psychiatric residential treatment facilities as they reenter the community, school and family through strengthening discharge planning, case management and coordination of appropriate supports with State agencies, school districts, families, and community providers.
- Support the increase of community based service array to support children, youth, and their families with emotional and behavioral health difficulties.
- Advocate for the decreased need for out-of-state placement.

Goal #7- Create a Unifying Mental Health Authority for Nevada Children's Mental Health

Currently, Nevada lacks a state level mental health authority. While DCFS (the Division of Child and Family Services), DPBH (the Department of Public and Behavioral Health) and DHCFP (the Division of Health Care Financing and Policy) all contribute to the provision of mental health services to children and youth in Nevada, there is no clearly defined relationship in law (Needs Assessment, Environmental Scan & Gaps Analysis Developed for the State of Nevada and Lyon, Nye, and Washoe Counties, 2014).

Recommendation

- Advocate for the creation of a unifying entity with regional representation and the ability to set practice standards, conduct quality assurance, and improve state-wide planning in order to:

- Reduce duplication of services
- Reduce siloed efforts
- Adequately support “grass roots” regional/community based collaborations
- Provide continuity of screening and assessment tools specific to youth
- Support development of and promote existing “regional grass roots collaborative efforts” to expand community based wraparound type services through leveraging existing resources and capitalizing on regionally centered assets.

Goal #8- Identify and Provide Services to Tribal Children and Youth to Support Social, Mental, and Behavioral Health Needs.

Children who reside on the reservation are often limited in the spectrum of health care services they receive. Data is currently being gathered to provide information on gaps and needs of the Pyramid Lake Tribal population with assistance from the University of Nevada, Reno, School of Social Work. The Consortium recognizes the unique needs and cultural considerations of each of Nevada’s Tribes and seeks to build a stronger partnership to support healthy outcomes for all children.

Recommendations:

- Support research and data gathering to identify and target the needs to Tribal children and youth.
- Support strengthening of existing programs through collaboration and partnership.
- Support early intervention for improved outcome.
- Advocate for sustainable programs models for long term effectiveness.

In Conclusion

The Rural Children’s Mental Health Consortium thanks the many community partners that contributed to this report and looks forward to continuing these efforts to build a stronger system of care for Nevada’s children with mental health needs.

Resources

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APPENDIX E

Children's Mental Health Consortia Policy Priorities

E.3 – Washoe County Children's Mental Health Consortium

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017



The Washoe County Children's Mental Health Consortium (WCCMHC) was formed in 2002 to fulfill the legislative requirements of NRS 433B and to strengthen the local partnership working toward creating an integrated system of behavioral health care for children and families of Washoe County. NRS 433B established Mental Health Consortia in each of three jurisdictions in Nevada. The functions of the Consortia are to assess the need for behavioral health services for children, assess how well the current system is meeting the need in the community and develop an annual plan on how the need can be better met.

The Washoe County Consortium continues to focus our efforts on the four goals listed below. The annual plan will outline progress made over the past year and goals going forward in 2016-17.

PRIORITIES OF SERVICES NECESSARY TO IMPLEMENT 10-YEAR PLAN

The Consortium formed four workgroups to address 4 prioritized goals presented in the initial plan, '2020 Vision' *A Call to Action, Ten Year Plan for Children's Mental Health: January 2010 – December 2020*.

GOAL 1: Serve Youth in Their Home Communities - Enhance Washoe County's capacity to provide community-based, wraparound treatment and care to serve youth locally in a manner that supports safety, stability, and permanency.



Mobile Crisis Response Teams and program expansion in Washoe County:

Mobile crisis services are dedicated to the goal of helping children or youth remain in the least restrictive setting possible, preferably a family or relative home. Mobile Crisis Response Teams (MCRT) serve a key function in the System of Care by providing community based services that the youth can access wherever the youth experiences crisis and regardless of ability to pay or insurance type. The ultimate goal of MCRT is to divert youth from psychiatric hospitalization.

In the 2015-16 annual plan, WCCMHC requested funding for the MCRT program to expand to Washoe County. The request was fulfilled with support received from the State of Nevada Governor's Advisory

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

Council on Behavioral Health and Wellness. The Division of Child and Family Services originally employed eight professionals: four Psychiatric Caseworkers and four Mental Health Counselors to provide Mobile Crisis response services in Washoe County. In October, 2015, MCRT was able to add a Clinical Program Manager and Administrative Assistant. The program formally rolled out on October 13th, 2014. As of September 30, 2015, MCRT received 366 phone calls and responded to 173 crises in the community. Of the 173 responses, 143 resulted in hospital diversion which is a rate of 82.7%.

Statewide since program inception, 1,437 calls have been received by Mobile Crisis Response Teams, resulting in 793 hospital diversions which is a rate of 87%.

As the data reflects, since program inception in both Washoe and Clark Counties, a significant diversion rate has been achieved. The WCCMHC supports the expansion of Mobile Crisis Response Teams under the System of Care Grant administered by DCFS and the strategic plan to segway crisis response to intensive wraparound services for SED children requiring this level of intensive case management services. Linking children to comprehensive mental and behavioral health services is key in reducing the high rate of children whose emotional disturbance is undetected or unnoticed and therefore, untreated in our community.

As Mobile Crisis continues to partner with and educate key community stakeholders, it is anticipated that program utilization will continue to increase and the most appropriate as well as the least restrictive services will be utilized within the community. The youth can remain in the community, thus reducing the need for costly out-of-state residential treatment center placement.

Offer full continuum of care in children's mental and behavioral health services in Washoe County:

In the 2015-16 annual plan, WCCMHC identified a need in Washoe County to expand local residential treatment options for children and youth. The lack of community-based residential treatment options led to children being sent out of state to access Residential Treatment Facilities (RTC) to get medically recommended stabilization and treatment.

Although the Governor's Council and state officials changed the regulations for RTC allowing for growth of such facilities in Nevada, no agencies or corporations elected to expand or start RTC facilities in Nevada. Therefore, no progress has occurred toward this goal to-date.

The WCCMHC continues to recommend that a concerted effort be made to recruit RTC providers and funding strategies be analyzed and examined to attract RTC providers to Nevada. The Consortium supports efforts such as private-public partnerships to make this goal a reality and to better serve our children and youth in their home community. Local services would also allow for more direct family involvement and empower families to participate in treatment planning and oversight of the individualized and culturally appropriate plan. Local services would also allow for reduced loss of Washoe County school credits and tighter, more efficient transitions and access to identified wraparound services such as linkage to informal supports and other community-based services.

Lack of linking case management services to children sent out-of-state to Residential Treatment Facilities:

This priority issue under Goal 1 continues to be an area where improvement can be made. A percentage of children sent to RTC facilities are not connected to any state or county entity for mental and behavioral health services prior to going into crisis. According to the DHCFP website, as of July, 2015, there were 215 Medicaid Fee-For-Service covered children statewide in out-of-state RTC placements. This number only includes children on Fee-For-Service Medicaid and does not reflect managed care, uninsured or other

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

insured families. The highest number of FFS covered children in RTC placement in 2014 was in August where reports indicate 249 children were in RTC out-of-state placements. It is unclear how many of these child placements could have been diverted to community-based services if a procedural protocol was in place to link children rising to this level of treatment need to appropriate assessment, utilization review and MCRT and wraparound intensive case management services in Washoe County PRIOR to sending them out of state. Because some medical professionals are not familiar with local mental and behavioral health resources, they may consider out-of-state RTC placement prematurely which leads to undue family disruption and difficulty with child reintegration back to their local community.

Out of State (OOS) placement reports for RTC's:

https://dhcfp.nv.gov/BehavioralHealth/BH_OOS.htm

Overall Behavioral Health 'Report Card' for FY 15 that covers all BH programs:

<https://dhcfp.nv.gov/BehavioralHealth/Reports/BH%20Report%20Card%2010-15.pdf>

Expand Wraparound Intensive Case Management Services to parental custody children and youth:

DCFS has implemented statewide wraparound services for youth in parental custody that also have involvement with other service systems. WCCMHC is recommending that this effort be expanded to parental custody children and youth that do not have involvement with other service systems but are presenting as high risk for out of state placement due to severity of behavioral health need. The point at which the linkage could occur for FFS or managed care insured would be through our Medicaid partner/ fiscal agent-provider at which time they receive the request for out of state placement by the referring psychiatrist/medical professional. The case manager would review with the parents or caregivers efforts made to this point to access community assistance and assure that all local behavioral provider agencies have been considered. If it is determined that out-of-state placement is the level of care required, then the wraparound case manager would provide assistance with admission, monthly treatment reviews, discharge planning including coordination of resources prior to the child's return from out-of-state placement.

Offer full continuum of care in children's mental and behavioral health services in Washoe County:

An area of ongoing need in Nevada identified by the WCCMHC and the Psychiatric Residential Treatment Facility state-wide workgroup is a full continuum of care for children's mental and behavioral health services. With a full continuum of care, children, parents, families, advocates and treatment professionals would have treatment options to address the level of intensity required based on a child's mental and behavioral health assessed need. Matching the child to the appropriate service level may reduce the incident of crisis situations and escalation to higher levels of treatment. Additional service options would also increase available mental health services in the community and therefore improve access to services while decreasing wait list numbers.

Conversely, if a youth does access RTC placement, RTC professionals frequently recommend children transition to a "step down" program prior to returning to their family home. There is currently a lack of providers in Nevada offering partial hospitalization, intensive outpatient and community based residential treatment, which impacts the child's length of stay in out-of-state treatment facilities. Oftentimes, children are returned back home to family that does not feel prepared to provide the needed structure and recommended follow-up care. The results are high recidivism rates and multiple acute hospitalizations.

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

In summary, Washoe County has a large gap between the traditional outpatient level of care (outpatient therapies and routine psychiatric care) and the highest level of care represented by secure residential treatment centers. Efforts to provide intensive outpatient services such as Mobile Crisis and Wraparound services to parental custody youth have been successful; however the capacity is not sufficient to stem the growing tide of out-of-state residential placements. Of particular concern, are youth who are placed by parents directly from the community or via the juvenile justice system. These families, in most cases, are not receiving intensive outpatient services prior to their placement out of state. It is also difficult to access these services upon return from placement. Placement out of the community makes the reintegration into the community all the more difficult and at risk for being unsuccessful.

GOAL 2: Help Families to Help Themselves – The Consortium will promote the coordination of formal and informal strategies and resources that support youth and family autonomy in actively managing and finding solutions to fit their needs.

During the 2015-2016 school year, the WCCMHC continued to support the Signs of Suicide (SOS) screening program in Washoe County School District (WCSD) middle and high schools. WCSD mandated all middle schools offer SOS education and screening. School staff and parents were also offered training as part of this comprehensive screening program.

Accomplishments:

- The Office of Suicide Prevention (OSP) received a sub-grant from Project Aware from the Department of Education to coordinate expansion of Youth Mental Health First Aid (YMHFA) across the state. This included four YMHFA trainers from the Children's Cabinet and one from JTNN, Join Together Northern Nevada.
- All middle school students in Washoe County will be offered screening by the Signs of Suicide screening team (WCSD, Children's Cabinet, West Hills and OSP) in 2015-2016 school year. Presently, 420 students have received training about what to look for and how to help, through the SOS education component, and 111 students were screened. Of those, 22 students screened positive for a mental health concern or suicide risk. These students were then referred to services. Children's Cabinet will continue screening during the second semester.
- Outreach to high school staff and parents continues with Stephanie Brown from West Hills, the Office of Suicide Prevention and the Children's Cabinet to ensure families are increasingly aware of SOS education and screening opportunities; not only to increase understanding of the program but also safety for the students exposed to this empowering opportunity.

The WCCMHC will continue to support the work by community providers and the Office of Suicide Prevention to expand the community and school-based youth suicide prevention program. How this will be accomplished will be determined based on the scope of other recent proposals such as the use of the Child and Adolescent Needs and Strengths (CANS) Tool or other collaborative County-Division sponsored initiatives. WCCMHC would like to see earlier identification and intervention of youth experiencing mental health concerns or thoughts of suicide. We are seeing increases in elementary students' depression and distress. YMHFA and SOS screening programs can play a role in this.

Attempts were made to offer continuing education credits and training opportunities through Parent University, (including making the, "Training Trusted Adults: SOS staff and Parent Education video" available on the WCSD website). However, due to the competing demands of training required by the school district

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

for district personnel, this goal was not achieved. The WCCMHC is recommending that additional representation from Washoe County School District be appointed to the WCCMHC to create more avenues into this system that has a direct impact on children and families and is an opportune venue to share important information to help families educate themselves and become aware of critical resources to eliminate youth suicide.

WCCMHC will continue to support the Trauma-Informed Care training, which is being conducted in Washoe, Clark and Elko County, based on curriculum from the National Child Traumatic Stress Network (NCTSN). Trainings have been conducted with the WCDSS case workers and Foster parents, NEIS Child Development Specialists, child care providers and others. A Training of Trainers has also been conducted to increase the trainer pool statewide. Currently, local trainers are from DCFS, WCDSS, and NV PEP. The curriculum is being modified to create a brief training for parents reunifying with children who were in foster care.

Finally, WCCMHC will continue to support Infant Mental Health efforts in Washoe County. This will include community educational efforts to include school district and Early Intervention programs, the expansion of mental health providers who serve the birth to four year old population, and exploration in the development of a specialty court project based on the Safe Babies Court Initiative developed through the National Zero to Three organization. These approaches will ultimately preserve resources to expand and improve services for children and families across all four original goals.

Medicaid Parent and Consumer Access Guide:

A workgroup of WCCMHC members was formed to develop a guide to assist parents and Medicaid enrollees with how to navigate the Medicaid mental and behavioral health system and to define terminology that parents and consumers may not be familiar with. The guide addresses enrollment, disenrollment, denials and other common terms used by Medicaid and explains options the enrollee has along with contact information needed to resolve issues or answer questions as they arise. The goal is to have the guide available on the DHCFP website as well as children mental health agencies, NV PEP and other sites where Nevada Medicaid is utilized.



GOAL 3: Help Youth Succeed in School -The Consortium will work with community agencies and Washoe County School District (WCSD) to support system-wide implementation of Positive Behavioral Supports so that youth can develop pro-social skills while remaining in their home school and family setting, and the need for more intrusive or aversive interventions will be reduced.

Major changes are underway with the Washoe County School District and how student services are being structured. WCSD will be impacted by the addition of the Nevada Department of Education's Office for a

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

Safe and Respectful Learning Environment and the addition of contracted behavioral health workers. WCCMHC will reach out to the District to see how we can identify common goals and support these efforts going forward.

WCSD continues its implementation of the Social Emotional Learning program. Washoe County was one of eight of the urban school districts in the "Collaborating Districts Initiative" awarded a grant. The focus is SEL implementation and education from a counselor perspective and training teachers. The approach is three pronged: 1) integration within academics; 2) strengthening culture and climate with students, staff and families; and 3) direct instruction.

Another objective of WCCMHC is bullying prevention and response. The WCSD has a mandatory web-based training that all staff must complete accompanied by a quiz for understanding. There is a web-based reporting mechanism for parents /students. Web-based reporting has been low. There is a policy for mandatory investigation of reports of bullying by students with a record kept on the accuser and the accused. There reportedly is a staff reporting and investigation requirement as well.

WCCMHC supports NV PEP in the continuation of their partnership with the WCSD and Parent University to bring trainings to parents and professionals in our community. A previous goal existed for NV PEP to work with the WCSD to post videos on their respective (Parent Portal) websites for SEL and Suicide Prevention education. The goal was to broaden access to parents by partnering with the WCSD and their parent involvement facilitators to explain about the purpose, focus and benefits of Social Emotional Learning for their children in our schools and explore best practices in, "post-vention" for school personnel. Due to the competing demands of training required by the school district for district personnel, this goal did not happen. As a result, the WCCMHC is recommending that additional representation from Washoe County School District be appointed to the WCCMHC to increase the opportunity for collaboration to occur between the WCCMHC and the WCSD as this is an opportune venue to share important children's mental health information and resources and for the consortium to support the school districts vision and goals.

GOAL 4: Support Youth to Succeed as Adults - Develop, fund and implement system-level policies coupled with successful strategies to help youth with mental health needs transition to postsecondary education, employment, and independent lives.

First Lady's Summit:

Workgroup 4 in partnership with the Public and Behavioral Health Division assisted Nevada's First Lady, Kathleen Sandoval, in organizing and presenting the third, "First Lady's Summit on Children's Mental Health". The theme for the summit was "Connecting the Community Dots". 147 people met and discussed 15 grants that impact youth and young adults' birth through 24 years of age. An overview of each grant was given along with the area in the state to be served and the population that will be covered. This Summit provided the first opportunity to have representatives of many state grants in the same room together. Three state initiatives, a new System of Care grant, Medicaid transformation and School Based-Health Centers were also discussed. Networking was another positive outcome of the Summit and participants reported that this was accomplished and beneficial.

Logic Model:

Workgroup 4 took steps to address the goal in the Ten Year Plan by inviting Dr. Hewitt "Rusty" Clark to Washoe County to provide a seminar on the Transition to Independence Process (TIP) Model. Dr. Clark is the Director of the National Network on Youth Transition for Behavioral Health and a Professor Emeritus at

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

the Department of Child & Family Studies, Florida Mental Health Institute in the College of Behavioral and Community Sciences, University of South Florida. Dr. Clark has developed and researched various innovative programs and published extensively, including 5 books and more than 125 professional publications.

The TIP model aims to prepare and support youth and young adults diagnosed with emotional/behavioral difficulties in their movement into adulthood. TIP focuses on securing employment, educational opportunities, establishing a living situation, personal effectiveness/wellbeing, and successful community-life functioning. The TIP model is an evidence-supported practice that has six research studies demonstrating improvements in real-life outcomes.

With the assistance of Jill Manit from the School of Social Work at University of Nevada, Reno, over 125 people were able to attend a seminar facilitated by Dr. Clark about the TIP model at the Joe Crowley Center at UNR at no cost. The Rural Children's Mental Health Consortium provided funding so the seminar could be streamed live on the Internet and others around the state could benefit from Dr. Clark's presentation. In addition to the overview of the TIP model, a panel of representatives from local agencies shared the work currently being accomplished in the community for this young adult population. Refreshments were provided by West Hills Hospital and stipends to youth who attended were provided by The Community Foundation of Western Nevada.

After the seminar, Dr. Clark spent the afternoon and following day visiting local community agencies that serve transition age youth. The visits occurred at The YOU which is an agency that provides "Care and Comfort" services and connections to local service providers to our area's homeless youth. Dr. Clark also visited Mojave Mental Health outpatient agency, Quest House which provides residential substance abuse treatment to teens from all around Nevada; Casa de Vida, an agency which provides residential supports and resources to pregnant teens and The Children's Cabinet, which provides services and resources that address unmet needs through a unique and effective cooperative effort between the private sector and public agencies in Nevada.

Dr. Clark's visit ended with a de-briefing session held at the Northern Nevada Adult Mental Health Campus that was attended by approximately 30 local community professionals. Dr. Clark thanked everyone for their warm welcome and helpfulness, and for providing him with a rich experience including the ability to speak directly to youth during his agency tours. At the conclusion of the de-brief session, those in attendance unanimously agreed that the TIP model would be a beneficial model to improve our current transition age youth service structure in Washoe County.

The Workgroup has received a proposal to implement the TIP model in Washoe County. This proposal has been presented to the Washoe County Consortium for consideration for funding. In addition, Workgroup 4 has provided this information to DCFS and the Nevada Children's Behavioral Health Consortium to consider implementing as part of the System of Care grant.

Youth Voice – Youth Advocacy:

The Youth Move process had some success this past year. A core group of 3 young women attended several WCCMHC workgroup 4 meetings and provided some constructive feedback and ideas for the workgroup to consider when working with transition age youth.

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

At the time of this report, the young man who led the group (Ricardo Saldana-Marquez), obtained full-time employment elsewhere and this has temporarily stalled the group. However, the vision and impetus to continue Youth Move still exists and another venue will be explored to continue this important work.

Summary of WCCMHC Annual Plan Recommendations for 2016-17:

GOAL 1: Serve Youth in their Home Communities

The Consortium recommends the following course of action to address the out-of-state placement of youth with serious emotional disturbance:

1. Establish viable local residential treatment programs for our most challenged youth via aggressive recruitment of private new residential providers, establishing a state run or public/private partnership residential treatment facility in the North.
2. Increase capacity of the Mobile Crisis program to enable the program to serve youth at risk for out-of-home placement as opposed to solely serving youth with imminent suicide risk.
3. Increase the Wraparound in Nevada (WIN) program capacity to serve more youth who are at risk for out-of-home placement. This recommendation aims to reduce out-of-state placements by assuring that community treatment options have been considered first and improve coordination of care and effective discharge planning from out-of-state facilities when youth return to their local community.
4. Create a coordinated unit combining Mobile Crisis and Wraparound approaches to focus exclusively on serving youth at risk for out-of-home placement.
5. Establish DCFS as the mental health authority under the System of Care grant so that a comprehensive oversight program can be developed to monitor treatment utilization and outcomes for these most challenged youth.

GOAL 2: Help Families to Help Themselves

1. Increase early identification of those at risk for suicide or other violence.
2. Support the Trauma-Informed Care Training and Infant Mental Health efforts in Washoe County.
3. Support bullying prevention and response efforts in Washoe County.
4. Develop a guide to assist parents and Medicaid enrollees with how to navigate the Medicaid mental and behavioral health system and to define terminology that parents and consumers may not be familiar with.

Washoe County Children's Mental Health Consortium

Summary of the Annual Plan 2016-2017

GOAL 3: Help Youth Succeed in School

1. The WCCMHC is recommending that additional representation from Washoe County School District be appointed to the WCCMHC to increase the opportunity for collaboration to occur between the WCCMHC and the WCSD, as this is an opportune venue to share important children's mental health information and resources and for the Consortium to support the school district's vision and goals.
2. The WCCMHC recommends exploring additional ways to increase collaboration and participation with the Washoe County School District. Workgroup 3 recommends a review of PBIS efforts to align WCSD and Consortium efforts to help youth succeed in school.

GOAL 4: Support Youth to Succeed as Adults

1. The Consortium supports the implementation of the TIP model in Washoe County. This proposal has been presented to DCFS for consideration for funding and inclusion in the System of Care Implementation Grant Strategic Plan.
2. Support efforts at promoting an Anti-stigma and Suicide Prevention Public Information Campaign recommended by the Governor's Council on Behavioral Health and Wellness. The Office of Suicide Prevention recommends investigating existing national campaigns to promote stigma reduction, recovery and help-seeking.

WCCMHC Requests:

Maintain a more formalized relationship with DHHS and work through the statewide Nevada Children's Behavioral Health Consortium to make formal recommendations on program initiatives and plans for significant change within the children's mental and behavioral health service delivery structure.

Continue to provide funding to the WCCMHC to accomplish the goals set forth in this plan.

IN CONCLUSION

The Washoe County Children's Mental Health Consortium thanks all community partners and Consortia members who participated in the workgroups and contributed to this report. The Consortium looks forward to our ongoing collaboration to build a stronger system of care for Nevada's children and families.

APPENDIX F

Regional Behavioral Health Coordinators

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Regional Behavioral Health Coordinators

As previously indicated, the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services, issued three subgrants to fund regional behavioral health coordinators to solicit local feedback on behavioral health services, convene stakeholders interested in improving the behavioral health care system, and develop cooperative working relationships across systems, agencies, and levels of government. Subgrants were first issued in 2015, and coordinators have engaged in a wide range of activities, which are highlighted below. While the subgrants were set to expire at the end of September 2016, all three are in the process of being extended through September 2017. In addition, the DPBH is working with other counties and regions to create similar positions.

Clark County Behavioral Health Coordinator

Clark County Social Services (CCSS) was awarded a behavioral health coordinator subgrant of \$80,000 for July 1, 2015, through September 30, 2016. Clark County's subgrant is slightly different than the other behavioral health coordinator subgrants in that the scope of work authorizes the coordinator to provide direct services to clients who have substance use disorders, serious mental illness, or serious emotional disturbances. These services may include client screening and assessments, treatment planning and attending treatment team meetings or case conferences, acting as an advocate for the client, and case management services. Clark County Social Services also is authorized to review and evaluate program services and activities to ensure conformance with agency policies, standards, licensing requirements, and community standards of care. In addition, CCSS is authorized to work with a Homeless Management Information System vendor to develop a frequent user identification system to track "super-utilizers," work with contractors to review mental health service gaps in the community, and develop a strategic plan.

As part of its subgrant, in August 2016, Clark County entered into an agreement with Applied Analysis to review behavioral health service gaps in the community and to develop a strategic plan by September 29, 2016. The contract with Applied Analysis includes data analysis, evaluation of the integration and cooperation of mental health and substance abuse treatment programs in the county, evaluation of the responsiveness of behavioral health systems and the quality of behavioral health services, and identification of behavioral health needs. Clark County also entered into an agreement with Community Management Information System vendor Bitfocus Inc. to develop a frequent user identification system to track frequent users of various behavioral health services. A behavioral health coordinator will be hired in the second year of the subgrant and begin providing community mental health service coordination for Clark County.

Partnership Carson City (“Quad County”) Behavioral Health Coordinator

Partnership Carson City was awarded \$80,000 for the subgrant period of October 1, 2015, through September 30, 2016, for the coordination of behavioral health care services in Carson City and Churchill, Douglas, and Lyon Counties. The regional behavioral health coordinator works with stakeholders from community treatment agencies, local government, health and human services, emergency services, law enforcement, hospitals, and State government to coordinate and develop behavioral health services across jurisdictions. The coordinator’s responsibilities include engaging in activities at the individual client level, the community level, and the policy level. A large focus of the coordinator is developing and implementing evidence based crisis management and jail diversion programs with community support.

On the individual client level, the behavioral health coordinator participates on multidisciplinary teams and works with communities to develop stabilization plans for individuals in behavioral health crisis or those identified as super-utilizers. At the community level, the coordinator supports communities in identifying resources and assists with developing plans to address community needs and gaps, as well as in developing and replicating certain behavioral health initiatives and programs. For example, the coordinator helped facilitate community initiatives such as county participation in the national Stepping Up Initiative and the development of county Behavioral Health Task Forces. The coordinator also assisted with implementing the Mobile Outreach Safety Team (MOST), Forensic Assessment Services Triage Team, and Crisis Intervention Training programs in counties throughout the region; helped jurisdictions replicate these programs through educating stakeholders, coordinating resources, problem-solving, and formalizing processes through stakeholder contact; and assisted with various community behavioral health trainings. At the policy level, the coordinator facilitates the Regional Behavioral Health Task Force and advocates for behavioral health policies and initiatives at local, regional, and State levels.

According to the coordinator, feedback from stakeholders in Carson City and Churchill, Douglas, and Lyon Counties reflects motivation to be a part of the regional initiative. The region is informally named the “Quad County Region.”

Washoe County Social Services Behavioral Health Coordinator

Washoe County Social Services was awarded \$150,000 for the subgrant period of October 1, 2015, through September 30, 2016, for the coordination of services in Washoe County. Prior to issuing the subgrant, State funding provided support for a Regional Behavioral Health Program Coordinator in February 2015, although the position currently is included in the subgrant. In addition to other activities, the coordinator worked in collaboration with Catholic Charities, Specialty Courts, Alta Vista Mental Health, and other partners to strengthen and expand the Crossroads transitional housing program providing housing, basic needs, and treatment to people with co-occurring disorders, including rehabilitating cottages and expanding beds on the Northern Nevada Adult Mental Health

Services campus. The coordinator also participates in the Northern Nevada Behavioral Health Task Force, which meets monthly.

During the [One Truckee River](#) initiative, the coordinator led a “social issues” group and continues to work on the following three major priorities that emerged from the initiative’s process:

1. Community case managers to focus on complex needs of the chronically homeless;
2. Same-day access to behavioral health treatment; and
3. Expanded housing options at all levels, including expansion of the Crossroads program.

The coordinator wrote and collaborated on numerous grants to expand the capacity of behavioral health treatment and services for Washoe County residents. Successful or pending grants provide funding for: a pilot project offering mental health care to seniors in crisis in Washoe County; a Young Offenders track and a Human Trafficking track in the Reno Justice Court’s Community Court; a Justice and Mental Health Collaboration Program to strengthen the MOST program; the Sober 24/7 program offering alcohol and drug testing twice daily to assist with jail diversion; and Permanent Supportive Housing, through the U.S. Department of Housing and Urban Development, for 16 families with a disability.

In addition, the coordinator identified the need for a behavioral health annex for the Washoe County Emergency Operations Plan, trained additional county employees in Disaster Mental Health Aid, participated in several new suicide prevention initiatives, and provided presentations on a variety of behavioral health issues to State and community groups. The coordinator also participated in several new community groups to address opioid addiction and collaborated with rural areas on the development of additional behavioral health resources including the opening of a Regional Mental Health Court for rural western counties.

APPENDIX G

Community Mental Health Programs

APPENDIX G

Community Mental Health Programs

Nevada Revised Statutes 433C.110 Through 433C.350

NRS 433C.110 Purposes of chapter. The Legislature declares that the purposes of this chapter are:

1. To encourage and provide financial assistance to counties in the establishment and development of mental health services, including services to persons with intellectual disabilities and persons with related conditions, through locally controlled community mental health programs.

2. To promote the improvement and, if necessary, the expansion of already existing services which help to conserve the mental health of the people of Nevada. It is the intent of this chapter that services to individuals be rendered only upon voluntary application.

(Added to NRS by [1965, 764](#); A [1971, 1019](#); [1975, 1625](#); [1999, 2603](#); [2013, 679](#)) — (Substituted in revision for NRS 436.110)

NRS 433C.120 Definitions. As used in this chapter, unless the context requires otherwise:

1. “County board” means a county mental health advisory board.
2. “County director” means the director of a county program.
3. “County program” means a county community mental health program.
4. “Governing body” means the board of county commissioners.
5. “Service” means a mental health service.

(Added to NRS by [1965, 764](#); A [1971, 1019](#); [1975, 1625](#)) — (Substituted in revision for NRS 436.120)

NRS 433C.130 Responsibility of Department for developing and administering preventive and other services for mental health. The Department is designated as the official state agency responsible for developing and administering preventive and outpatient mental health services. The Department shall function in the following areas:

1. Assisting and consulting with local health authorities, local governments and all law enforcement agencies in this State in providing community mental health services, which services may include prevention, rehabilitation, case finding, diagnosis and treatment of persons with mental illness, and consultation and education for groups and individuals regarding mental health.

2. Coordinating mental health functions with other state agencies.

3. Participating in and promoting the development of facilities for training personnel necessary for implementing such services.

4. Collecting and disseminating information pertaining to mental health.

5. Performing such other acts as are necessary to promote mental health in the State.

(Added to NRS by 1961, 615; A 1963, 936; [1965, 373](#); [1969, 925](#); [2013, 3036](#); [2015, 1817](#)) — (Substituted in revision for NRS 436.123)

NRS 433C.140 Administration by Division; standards and regulations governing county programs. The Division shall, subject to the supervision of the Commission, administer this chapter. The Commission shall adopt guidelines for county programs and regulations necessary thereto, but these standards and regulations must be adopted only after consultation with and approval of the county director of each program being so administered. These standards and regulations must support and maximize local responsibility for and control of county programs within the framework of general guidelines.

(Added to NRS by [1971, 1018](#); A [1973, 1406](#); [1975, 1626](#); [1985, 2274](#)) — (Substituted in revision for NRS 436.125)

NRS 433C.150 Power of county to establish program. The governing body of any county may by ordinance or resolution establish a county community mental health program which may cover the entire area of the county.

(Added to NRS by [1965, 764](#); A [1971, 1019](#); [1975, 1626](#)) — (Substituted in revision for NRS 436.130)

NRS 433C.160 County mental health advisory board: Composition; terms of members.

1. The county program shall have a county mental health advisory board of 7 to 15 members appointed by the governing body. The composition of the county board shall be representative of providers of mental health services, recipients or consumers of mental health services, agencies and occupations having a working involvement with mental health services and the general public, but such representation need not be in any fixed proportion.

2. The term of each member of the advisory board shall be for 3 years, but of the members first appointed approximately one-third shall be appointed for a term of 1 year, one-third for a term of 2 years and one-third for a term of 3 years.

(Added to NRS by [1965, 764](#); A [1971, 1019](#); [1975, 1626](#)) — (Substituted in revision for NRS 436.140)

NRS 433C.170 County board: Duties. The county board shall:

1. Review and evaluate communities' needs, services, facilities and special problems in the fields of mental health and intellectual disabilities and related conditions.

2. Advise the governing body as to programs of community mental health services and facilities and services to persons with intellectual disabilities and persons with related conditions, and, when requested by the governing body, make recommendation regarding the appointment of a county director.

3. After adoption of a program, continue to act in an advisory capacity to the county director.

(Added to NRS by [1965, 765](#); A [1975, 1626](#); [1999, 2604](#); [2013, 679](#)) — (Substituted in revision for NRS 436.150)

NRS 433C.180 County director: Appointment. The county board, with the approval of a majority of the governing body, shall appoint a county director, who must be a person professionally qualified in the field of psychiatric mental health. The choice of appointing a physician or one who is not a physician rests with the county board, and in making such choice the county board shall consider the duties that the county director is expected to perform.

(Added to NRS by [1965, 765](#); A [1971, 1019](#); [1975, 1627](#)) — (Substituted in revision for NRS 436.160)

NRS 433C.190 County director: Duties. The county director shall:

1. Serve as chief executive officer of the county program and be accountable to the county board.

2. Exercise administrative responsibility and authority over the county program and facilities furnished, operated or supported in connection therewith, and over services to persons with intellectual disabilities and persons with related conditions, except as administrative responsibility is otherwise provided for in this title.

3. Recommend to the governing body, after consultation with the county board, the providing of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable to accomplish the purposes of this chapter.

4. Submit an annual report to the governing body reporting all activities of the program, including a financial accounting of expenditures and a forecast of anticipated needs for the ensuing year.

5. Carry on such studies as may be appropriate for the discharge of his or her duties, including the control and prevention of psychiatric disorders and the treatment of intellectual disabilities and related conditions.

(Added to NRS by [1965, 765](#); A [1971, 1020](#); [1975, 1627](#); [1999, 2604](#); [2013, 679](#)) — (Substituted in revision for NRS 436.170)

NRS 433C.200 Establishment of joint community programs by counties. The governing body of any county may by agreement with the governing body or bodies of any other county or counties establish joint community mental health programs.

(Added to NRS by [1965, 765](#); A [1971, 1020](#); [1975, 1627](#)) — (Substituted in revision for NRS 436.180)

NRS 433C.210 Agreement for joint program: Provisions.

1. Any agreement between two or more counties for the establishment of joint county programs shall provide:

(a) That each county shall bear its share of the cost of the joint county program in proportion to the population of each county served.

(b) That the county treasurer of one participating county shall be the custodian of moneys made available for the purposes of such joint program and that the county treasurer may make payments from such moneys upon warrant of the appropriate officer or body of the county for which he or she is county treasurer.

2. Any such agreement may also provide:

(a) For the joint provision and operation of services and facilities or for the provision and operation of services and facilities by one participating county under contract for the other participating counties.

(b) For appointments of members of the board for the joint program by the several participating counties.

(c) That for specified purposes officers and employees of such joint county programs shall be considered to be officers and employees of one participating county only.

(d) For such other matters as are necessary or proper to effectuate the purposes of this chapter.

(Added to NRS by [1965, 765](#); A [1971, 1020](#); [1975, 1627](#)) — (Substituted in revision for NRS 436.190)

NRS 433C.220 Provisions of chapter applicable to joint programs. Unless otherwise expressly provided or required by the context, the provisions of this chapter relating to county community mental health programs and the appointment of county boards or county directors shall apply to joint county programs.

(Added to NRS by [1965, 766](#); A [1971, 1021](#); [1975, 1628](#)) — (Substituted in revision for NRS 436.200)

NRS 433C.230 Contract with hospital, clinic, laboratory or other institution. The county director may, with the approval of a majority of the governing body, contract for services and facilities with any hospital, clinic, laboratory or other similar institution.

(Added to NRS by [1965, 766](#); A [1971, 1021](#); [1975, 1628](#)) — (Substituted in revision for NRS 436.210)

NRS 433C.240 Expenses: Charge against county. The expenses incurred under the provisions of this chapter shall be a charge against the county and shall be audited, levied, collected and paid in the same manner as other charges.

(Added to NRS by [1965, 766](#); A [1971, 1021](#); [1975, 1628](#)) — (Substituted in revision for NRS 436.220)

NRS 433C.250 Legislative appropriations; payment of claims. Except as otherwise provided in this chapter:

1. Funds to carry out the provisions of this chapter shall be provided by direct legislative appropriation from the General Fund. Such funds shall be expended in accordance with the allotment, transfer, work program and budget provisions of [NRS 353.150](#) to [353.246](#), inclusive, and transfers to and from salary allotments, travel allotments, operating expense allotments, equipment allotments, and other allotments shall be allowed and made in accordance with the provisions of [NRS 353.215](#) to [353.225](#), inclusive, and after separate consideration of the merits of each request.

2. All moneys in any fund available to the Division for carrying out the provisions of this chapter shall be paid out on claims approved by the Administrator as other claims against the State are paid.

(Added to NRS by 1961, 616; A 1963, 937; [1965, 374, 769](#); [1969, 925](#); [1971, 1018](#); [1975, 1625](#)) — (Substituted in revision for NRS 436.225)

NRS 433C.260 Reimbursement by State for expenditures by county. Expenditures made by counties for county programs, including services to persons with intellectual disabilities and persons with related conditions, pursuant to this chapter, must be reimbursed by the State pursuant to [NRS 433C.270](#) to [433C.350](#), inclusive.

(Added to NRS by [1965, 766](#); A [1971, 1021](#); [1975, 1628](#); [1999, 2604](#); [2013, 680](#)) — (Substituted in revision for NRS 436.230)

NRS 433C.270 Services included in county program.

1. A service operated within a county program must be directed to at least one of the following mental health areas:

- (a) Mental illness;
- (b) Intellectual disabilities and related conditions;
- (c) Organic brain and other neurological impairment;
- (d) Alcoholism; and
- (e) Drug abuse.

2. A service is any of the following:

- (a) Diagnostic service;
- (b) Emergency service;
- (c) Inpatient service;
- (d) Outpatient or partial hospitalization service;
- (e) Residential, sheltered or protective care service;
- (f) Habilitation or rehabilitation service;
- (g) Prevention, consultation, collaboration, education or information service; and
- (h) Any other service approved by the Division.

(Added to NRS by [1965, 766](#); A [1971, 1021](#); [1975, 1628](#); [1999, 2604](#); [2013, 680](#)) — (Substituted in revision for NRS 436.240)

NRS 433C.280 Eligibility for reimbursement: Requirements. To be eligible for reimbursement a county, or in the case of joint county programs, two or more counties, shall first:

1. Establish one or more of the services provided for in [NRS 433C.270](#). In-service training necessary to providing such services shall be proper items of expenditures subject to state reimbursement.

2. Annually submit to the Administrator a plan for proposed expenditures. The Administrator shall review such plan to determine compliance with standards established in this chapter and fix the amount subject to state reimbursement. Existing services may qualify pursuant to the provisions of this chapter for reimbursement upon determination by the county board that such services shall be subject to and administered under the provisions of this chapter.

(Added to NRS by [1965, 766](#); A [1971, 1022](#); [1975, 1629](#)) — (Substituted in revision for NRS 436.250)

NRS 433C.290 Reimbursement for expenditures for certain items; investigation and audit of expenditures. Expenditures incurred for the items specified in [NRS 433C.270](#) shall be subject to reimbursement in accordance with the regulations of the Division whether incurred by direct or joint operation of such services, by contracting for such services or by other arrangement pursuant to the provisions of this chapter. The Administrator may make such investigations and audits of such expenditures as the Administrator may deem necessary.

(Added to NRS by [1965, 767](#); A [1971, 1022](#); [1975, 1629](#)) — (Substituted in revision for NRS 436.260)

NRS 433C.300 Amount of reimbursement; disbursements through Division.

1. Money provided by direct legislative appropriation for purposes of reimbursement as provided by [NRS 433C.260](#) to [433C.290](#), inclusive, must be allotted to the governing body as follows:

(a) The State shall pay to each county a sum equal to 90 percent of the total proposed expenditures as reflected by the plan of proposed expenditures submitted pursuant to [NRS 433C.280](#) if the county has complied with the provisions of paragraph (b).

(b) Before payment under this subsection, the governing body of a county must submit evidence to the Administrator that 10 percent of the total proposed expenditures have been raised and budgeted by the county for the establishment or maintenance of a county program.

2. All state and federal moneys appropriated or authorized for the promotion of mental health or for services to persons with intellectual disabilities and persons with related conditions in the State of Nevada must be disbursed through the Division in accordance with the provisions of this chapter and rules and regulations adopted in accordance therewith.

(Added to NRS by [1965, 767](#); A [1969, 926](#); [1971, 1022](#); [1975, 1629](#); [1999, 2605](#); [2013, 680](#)) — (Substituted in revision for NRS 436.270)

NRS 433C.310 Reimbursement for joint programs. Where counties have established joint county programs, expenditures subject to reimbursement are the prorated expenditures of such counties as provided by the agreement establishing the joint program.

(Added to NRS by [1965, 767](#); A [1971, 1023](#); [1975, 1630](#)) — (Substituted in revision for NRS 436.280)

NRS 433C.320 Expenditures subject to reimbursement; reimbursement prohibited for certain expenditures.

1. Expenditures subject to reimbursement include:

- (a) Expenditures for the items specified in [NRS 433C.270](#);
- (b) Salaries of personnel;
- (c) Approved facilities and services provided through contract;
- (d) Operation, maintenance and service costs; and
- (e) Such other expenditures as may be approved by the Administrator.

2. Reimbursement may not be made for:

- (a) Expenditures for capital improvements;
- (b) The purchase or construction of buildings;

(c) Compensation to members of a county board, except for actual and necessary expenses incurred in the performance of official duties;

(d) Expenditures for a purpose for which state reimbursement is claimed under any other provision of law;

(e) Expenditures incurred for court procedures under this or any other provision of law; or

(f) The cost of confinement of any person in excess of 90 days in any 1 calendar year.

3. Reimbursement may not be made to any county or counties which employ a physician in the county program who is not a lawful permanent resident of the United States.

(Added to NRS by [1965, 767](#); A [1971, 1023](#); [1973, 10](#); [1975, 1630](#)) — (Substituted in revision for NRS 436.290)

NRS 433C.330 Claims for reimbursement.

1. Claims for state reimbursement shall be made in such form, at such times, and for such periods as the Administrator shall determine.

2. When certified by the Administrator, claims for state reimbursement shall be presented to the State Board of Examiners.

(Added to NRS by [1965, 768](#)) — (Substituted in revision for NRS 436.300)

NRS 433C.340 Fees charged according to ability to pay; limitation. Fees for mental health services, including services to persons with intellectual disabilities and persons with related conditions, rendered pursuant to an approved county plan must be charged in accordance with ability to pay, but not in excess of actual cost.

(Added to NRS by [1965, 768](#); A [1975, 1630](#); [1999, 2605](#); [2013, 681](#)) — (Substituted in revision for NRS 436.310)

NRS 433C.350 Nevada Conference of County Community Mental Health Programs: Establishment; organization; meetings; purposes.

1. There is hereby established the Nevada Conference of County Community Mental Health Programs. The Division shall take appropriate steps to effectuate the establishment of the Conference as provided in this section.

2. The voting membership of the Conference shall consist of the county director of each county program and one member of the county board of each county program to be chosen by such board. The nonvoting membership of the Conference shall consist of the Administrator and such other employees of the Division as the Administrator shall designate, but such employees shall be not less than two nor more than 15 in number.

3. A scheduled meeting of the Conference shall be convened at least once every 6 months. A nonscheduled meeting shall be convened upon the request of two-thirds of the voting membership. Meetings shall be called and chaired by the Administrator or the Administrator's official designee.

4. The Conference may organize itself in such manner and adopt such procedures as it deems appropriate.

5. The purpose of the Conference is to serve as an organized forum for the discussion of the following matters:

(a) Recommendations for rules of the Division to implement this chapter as provided in [NRS 433C.140](#);

(b) Coordination and integration of county program services and state services; and

(c) Such other matters as members may bring before the Conference in connection with county programs or the relationship between county programs and the Division.

6. A resolution, proclamation, recommendation or similar pronouncement of the Conference does not have any legal effect.

(Added to NRS by [1965, 768](#); A [1975, 1631](#)) — (Substituted in revision for NRS 436.320)