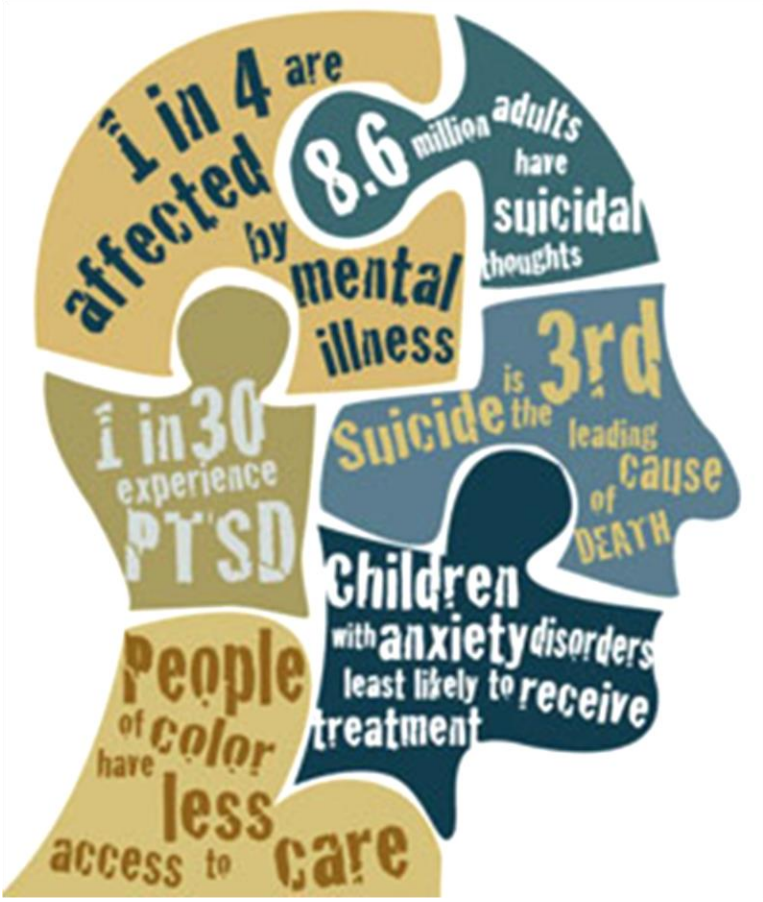
Nevada Department of
Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

2013

Gaps Analysis of Behavioral Health Services -- Update



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Acknowledgements

This report was developed by Social Entrepreneurs, Inc. under contract by the Nevada Primary Care Office in the Division of Public and Behavioral Health. The following individuals guided the planning and execution of the project:

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The following are greatly acknowledged for sharing their time and expertise as key informants.

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Executive Summary

Nevada is one of three states in the United States (US) that operates the public behavioral health system for its vulnerable residents. In 2013, the Mental Health and Developmental Services Division merged with the State Health Division to become the Division of Public and Behavioral Health (DPBH). As a result, behavioral health services throughout the State of Nevada are undergoing significant change.

The integration of public and behavioral health is aligned with recent research on brain development. New information from the fields of neuroscience and behavioral medicine has dramatically advanced understanding of mental functioning. The public health approach to behavioral health considers those advances and:

- Recognizes the interrelatedness of behavioral health and physical health,
- Focuses on prevention and promotes behavioral health across the lifespan,
- Identifies risks that may contribute to illness or disability, as well as protective factors that protect against the development of illness or disability and/or limit its severity,
- Provides people with the knowledge and skills to maintain optimal health and wellbeing, and
- Brings together individuals, communities and a variety of systems (health, human services, schools, etc.) to work collaboratively toward better behavioral health for all.[1]

The purpose of this report is to forward the efforts of the state as it implements an integrated public and behavioral health system of care. The report identifies gaps in the current service delivery system and promotes strategies that build upon a public health approach to the prevention, intervention and treatment of behavioral health conditions.

Context of the Report

From March through August 2013, the State of Nevada faced a number of difficult circumstances surrounding the operations of publicly supported behavioral health services throughout the state. These circumstances included allegations of improper discharge practices, excessively long wait times for clients at the state operated forensic facility, and infractions within state psychiatric facilities that could jeopardize their Center for Medicare & Medicaid Services (CMS) certification.

[1] The Center for Disease Control and Prevention, www.cdc.gov.

These situations have resulted in multiple investigations and state-requested examinations to explore the challenges facing the Division and its operations. While this report was commissioned prior to the unfolding of a behavioral health crisis across the state, the circumstances surrounding the crisis offered a unique and unprecedented opportunity to examine complex issues facing the system from a variety of perspectives. As such, this report is written within the context of a system in constant flux, facing significant scrutiny, and yet in the process of reform.

Current Service System

The current behavioral health system in Nevada is comprised of federal, state and local resources with a variety of funding sources, priorities and mandates. Services throughout the state differ based on target population, geographic region and funding source. As a result, there are often different challenges for persons seeking behavioral health assistance based on what services are available and where they are seeking services.

The most significant primary provider for public behavioral health services is DPBH. Within the Division, there are four service delivery systems operated to protect, promote and improve the physical and behavioral health of the people in Nevada. These systems include Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), Rural Counseling and Supportive Services (RCSS), and Lake's Crossing Forensic Facility.

- NNAMHS is located in Sparks, Nevada, and is a comprehensive, community-based, behavioral health system for adult consumers. Inpatient services are provided through Dini-Townsend psychiatric hospital, located on the same campus as the central NNAMHS site. Numerous outpatient services are available which include the Washoe Community Mental Health Center, Outpatient Pharmacy, Program of Assertive Community Treatment (PACT), Psychosocial Rehabilitation Program (PRP), Consumer Peer Counseling, and Service Coordinator Services.
- SNAMHS provides both inpatient and outpatient services for adults living in Clark County and in surrounding counties that may be closer geographically to this agency rather than to a rural behavioral health center. Inpatient services are provided through the Rawson-Neal psychiatric hospital on the central SNAMHS campus. SNAMHS has eight behavioral health clinics serving the community and rural southern Nevada. SNAMHS provides: Inpatient Services, Mobile Crisis, Outpatient Counseling, Service Coordination, Intensive Service Coordination, Medication Clinic, Residential Support Programs, Mental Health Court, and Programs for Assertive Community Treatment (PACT) Teams.

- RCSS has seven full service clinics, five partial service clinics, and one limited service clinic that provide behavioral health services to both adults and children in the rural areas of the state considered to be every county with the exception of Washoe County, Clark County, Lincoln County and parts of Nye County. Satellite Clinics provide all services offered by RCSS. Sub-satellite clinics offer many of the same services with itinerant Clinics providing services less frequently. RCSS is the only service system within DPBH to provide services to children and adolescents.
- Lake's Crossing is a forensic facility that provides services aimed at determining the legal competency of an individual to stand trial and restoration of legal competency for trial purposes. Adult forensic services include clinical assessment, forensic evaluation and short or long-term treatment for both pretrial detainees and jail/prison inmates.

Financing behavioral health services through DPBH relies primarily upon state general fund revenue with contribution from grants, and Medicaid insurance coverage. Each service system, as described above, has its own budget established within the state system, creating inflexibility to meet the needs of the system as a whole. This is compounded by the lack of sufficient resources allocated to meet behavioral health needs across the state. This issue could be further impacted in the event that SNAMHS and/or NNAMHS loses CMS certification, placing Medicaid reimbursements at risk. The ongoing crisis leaves the Division in a difficult position as it implements integration of behavioral health into a public health model of care, and prepares for the implementation of the Affordable Care Act (ACA) in 2014.

Nevada has missed a number of opportunities over the years to strengthen its behavioral health system in response to previous reforms. These opportunities go back to the adoption of the Community Mental Health Act of 1963 (CMHA), some 50 years ago. Since adoption of the CMHA, other states shifted funding to local communities and divested their control in providing behavioral health services. Nevada continued to be the primary source for behavioral health care for low-income adults throughout the state and low-income children in rural areas of the state.

> *"Officials have known about solutions for decades, economic recessions and budgetary constraints have kept them from fully and consistently implementing mental health programming."*
>
> The Las Vegas Sun, August 2013

To better understand how this difference in approach may have affected the development of a comprehensive behavioral health system of care, a review of the Kaiser

report, "Learning From History: Deinstitutionalization of People with Mental Illness As Precursor to Long-Term Care Reform," specified circumstances that have had a negative impact on the success of de-institutionalizing mentally ill persons. Those circumstances include:

- Housing: People with serious mental illness were moved to settings that were ill-equipped and poorly supported to meet their needs.
- Essential services: The supports needed to successfully live independently in the community were not available or provided.
- Outcomes: Mental health systems continued to measure success by effort, such as bed days, instead of measuring the effect of services such as quality of life indicators.
- Resources:
    - State funds previously used for state institutions were not reinvested in community programs.
    - Federal funds for the community mental health centers program did not adequately address need.
    - Third-party health insurance policies and public programs, such as Medicare, limited coverage for the treatment of mental illness.

Many of these circumstances have and continue to exist within Nevada. As specified in a 1979 review of the history of Nevada's mental health system "three characteristics of Nevada's system are: (1) marked fluctuations in service capacity; (2) a lack of public supervision or independent professional review of mental health programs; and (3) absence of long-term planning. (Pillard, 1979) These issues remain. A proactive strategic plan to establish a comprehensive and integrated public and behavioral health system of care is critical to preventing behavioral health care needs from escalating and placing additional burdens upon the state of Nevada.

In examining the current service delivery system this report relied upon quantitative variables to establish who is being served and where gaps exist, and qualitative information to identify why gaps exist.

Profile of Behavioral Health Consumers Accessing Care through DPBH

Age of Behavioral Health Consumers

In Nevada, the largest category of consumers accessing care through DPBH is between the ages of 25-44, representing 38% of the service population. This is followed by consumers between the ages of 45-65, representing 35% of the service population. While persons age 25-64 make up slightly more than half of the state's population, they represent almost two-thirds of the persons served by Nevada's public behavioral health services. The system serves significantly fewer very young (children up to age 12) and older adults (65+) compared to the population distribution of persons in the state. Although DPBH is not the primary agent responsible for providing services to children and adolescents, it will ultimately bear the burden of treating these individuals in the event that early prevention and intervention services are not adequate.

It should be noted that the US averages figures used throughout this document were established based on data compiled by the National Research Institute (NRI). NRI collects this information from State Mental Health Agencies (SMHA), all of which do not collect and report information in the same manner. Nevada is one of at least 9 states that do not report service or expenditure data for community programs supported by Medicaid revenues. At the time in which this report was being developed, the number of Medicaid recipients provided services through non-DPBH service outlets was not available.

Penetration rates, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) is the "percentage of members using behavioral health services." This variable is commonly used to assess access to services. Penetration rates were only available for DPBH and a limited DCFS clientele. These rates were compared against 2012 US averages to indicate if Nevada was reaching subsets of people in a manner better, worse, or consistent with US averages.

As Figure 1 demonstrates, Nevada's public behavioral health system is reaching approximately one for every two people served on average nationally who require behavioral health services. The most pronounced deficiencies pertain to the following age groups:

- Nevada served one child age 0-12, for every four served nationally
- Nevada served one adolescent age 13-17, for every four served nationally
- Nevada served on older adult age 75 and over, for every twelve served nationally

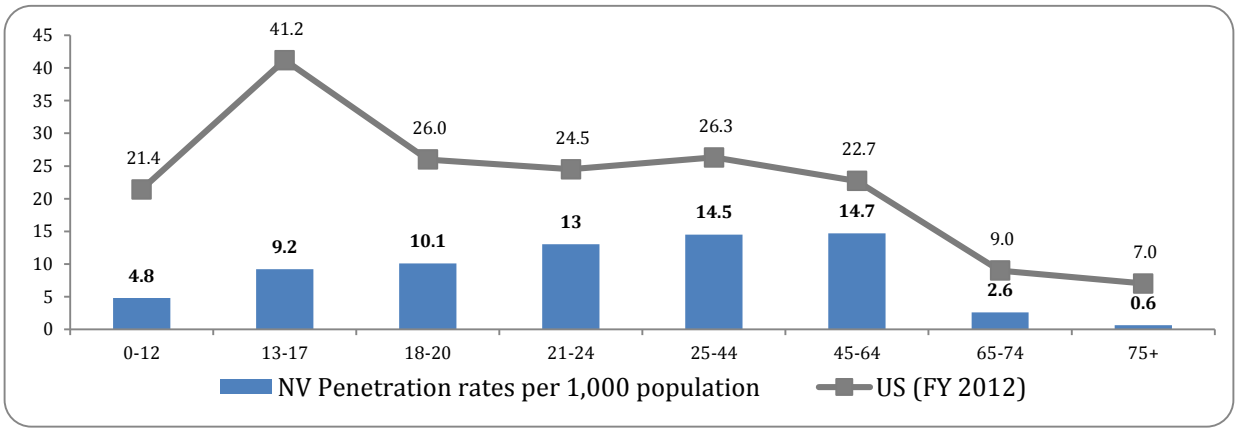


Figure 1: Penetration Rates by Age Group

Whereas other states appear to be focused on early intervention and prevention, Nevada appears to respond more to crisis in adulthood.

Race of Behavioral Health Consumers

While the vast majority of consumers served through DPBH reflect the racial demographics of the state, there are variances particular to the Asian and African-American populations. In Nevada, Asians represent 7.2% of the overall population in Nevada, but only 1.9% of the service population. In contrast, African-Americans represent 8.1% of the population, but account for 12.6% of the service population. While 26.5% of the population of Nevada is Hispanic, they represent 12.5% of those served. National penetration rates for services to the Hispanic population are 18.3 per 1,000 people in the population, but Nevada reaches only 4.9 per 1,000.

Unmet Need

Beyond understanding the consumer base of clients accessing DPBH services, a review of estimated need and actual DPBH usage data was conducted to establish an approximation of unmet need in services to children and adults as well as within each region of the state.

- Children's Services: The Department of Children and Family Services (DCFS) is responsible for providing behavioral health services to children and adolescents in Washoe and Clark County, while DPBH is responsible for providing services in the rural areas of the state. In Fiscal Year (FY) 2011-2012, there were a total of 12,399 children in the state that were Medicaid eligible and estimated to have a serious emotional disturbance (SED). Of that total, the state provided services to 3,989 in FY 2011-12, representing 32% of the estimated need. The number of Medicaid eligible children who accessed services through non-DPBH providers is unknown

so that subpopulation was not available. For that reason, the 32% is considered an estimate of potential unmet need in this report.
    - DCFS's service population totaled 10,991, of which 2,927 were served, representing approximately 27% of the estimated need.
    - DPBH's service population totaled 1,408, of which 931 were served, representing approximately 66% of the estimated need. A total of 477 (34%) children were estimated to be in need of but not receiving services in FY 2011-12.

- Adult Services: There were a total of 88,956 adults in the state of Nevada that were Medicaid eligible and considered to have any mental illness or a severe mental illness (AMI/SMI). Of that total, DPBH provided services to 25,522 in FY 2011-12, representing 29% of the total of those estimated to be in need. Medicaid eligible adults who accessed services through non-DPBH providers were not included in this calculation as the information was not available. For that reason, the 29% is also considered an estimate of potential unmet need in this report.
    - Urban North: When considering the urban part of northern Nevada, Washoe County, the estimated total adults in need were 14,239. DPBH provided services to 5,785 adults in FY 2011-2012, representing 41% of those estimated to be in need.
    - Urban South: When considering the urban part of southern Nevada, considered to be Clark County, the adult population in need was estimated to be 63,767. Of that total, DPBH provided services to 15,203 adults in FY 2011-12, representing 24% of those estimated to be in need.
    - Rural: For rural Nevada, considered to be all counties except Washoe County and Clark County, the estimated adult population in need for FY 2011-12 was 10,950. DPBH provided services to 4,534, representing 41% of adults in need.

Gaps in Services

While statistics were combined with existing publications to identify **what** gaps exist in the public behavioral health system, information gathered through key informant interviews and consumer surveys was used to explain **why** gaps in services exist. Representatives from DBPH indicated that data collection has not been uniform throughout or between complimentary systems, making data analysis challenging.

Insufficient service options identified include inpatient and outpatient treatment statewide, co-occurring disorder services for substance abusing mentally ill consumers, substance abuse services for all populations, lack of youth services, lack of housing, care management and wrap-around services to help those getting better to maintain stability, and workforce concerns related to morale, compensation, recruitment and retention.

Quantitative and qualitative data indicates:

- Services are currently reaching people in their middle stages of life, with insufficient resources for prevention or early intervention. Investing early and often is a proven technique in service delivery both in terms of costs and outcomes. "Intervening at the first sign of symptoms offers the best opportunity to make a significant, positive difference in both immediate and long-term outcomes for people affected by mental health issues."[2] As such, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has designated prevention as their first strategic priority (Steve Vetzner, 2013).

- Services are not sufficient to meet the needs of people later in life. Attention should be paid to identifying and engaging older Nevadans who require behavioral support services. Older adults require different treatment responses and supports such as transportation, home-based treatment options, and specialized outreach efforts (Services W. S., 2013).

- A culturally competent framework to provide services to Nevada's growing minority population is needed. Particular interest should be paid to the over-representation of African-American males in the service system, exploring the link between this dynamic and their over-representation in the criminal justice system. As identified in the report: Prevalence of Mental Illness in the Criminal Justice System, "mentally ill individuals of African American origin were over-represented among the CCDC detainees with mental illness while all other racial/ethnic minorities were underrepresented. The rate of detained African Americans with mental illness was 20.8% at CCDC in 2011, which significantly exceeded their overall rate of less than 11% among the residents of Clark County."

- Insufficient penetration rates are most pronounced in the southern region of the state, as indicated by statistics that reveal only approximately 24% of people

[2] Retrieved from: http://www.sfgate.com/opinion/openforum/article/Mental-health-prevention-a-wise-investment-4028399.php

eligible and needing assistance are being served by DPBH. Identifying the differences between the regions in service populations, resources, and service deployment is critical for understanding and addressing this reality.

- Treatment is a critical component of the continuum of care. To encourage the use of services and minimize stigma, treatment should be available in the community in the least restrictive environment possible. In addition to psychiatric management, behavioral health treatment should include: counseling, medication management, and linking individuals to other wrap-around services necessary for them to remain stable. While DPBH has worked to make community-based treatment more widely available, they lack sufficient funds to meet existing demand.

- The system of care should be strengthened to promote community-based organizations and include: inpatient, partial hospitalization, intensive outpatient, outpatient, residential, adult day treatment, and mobile therapy options. Specialized treatment facilities for youth with substance abuse disorders are needed, and should include peer-supportive counseling to prevent relapse and develop strategies for drug-free living.

- Discharge planning should consider housing, medication, and basic needs at a minimum. No persons should be discharged to another level of care or from a facility without a safe, stable environment to go to with assistance in making the transition. Housing gaps include:
    - long term transitional housing
    - services for persons who are mentally ill and developmentally delayed
    - resources for persons who are under the age of 60 but experiencing mental illness and dementia
    - violent individuals with a mental illness
    - sex offenders
    - persons with co-existing medical and mental health and/or intellectually delayed

Both quantitative and qualitative data support the conclusion that Nevada's system is crisis response driven. While efforts are currently underway to build a continuum of care with an emphasis on community-based services, without sufficient resources, these efforts will not be fully realized.

Recommendations

Nevada has an opportunity to implement a behavioral health system that is community-based, comprehensive and efficient. The gaps analysis is intended to assist the state in understanding gaps and taking steps to address them. To do so, three focus areas are recommended.

1. Ensure accountability, credibility and high quality services.
2. Develop community and state capacity to implement no wrong door
3. Establish a vision and plan for the system of care and secure the resources necessary to implement the plan

> *"There is a consequence for our whole community when people need services and can't get them. We have an opportunity to intervene early in the process and provide services or we can leave it unaddressed and that portion of the populations is less happy, less productive and possibly dangerous. We do no kindness by letting folks suffer with their mental illness."*
>
> Key Informant Comment

Strategies from research, key informants and best practices are provided for each focus area. Each is designed to address one or more of the gaps, unmet needs and/or weaknesses or threats from the situational analysis.

With leadership, vision, resources and a strategic approach, Nevada has an opportunity to leverage the lessons learned by other states and to seize the moment to implement a public health model for community-based services through the integration of the Division of Public and Behavioral Health and the implementation of the Affordable Care Act.

Introduction

Behavioral health services throughout the State of Nevada are undergoing significant change. What used to be the Nevada Division of Mental Health and Developmental Services (MHDS) is in the process of integrating within the Nevada State Health Division (NSHD), creating a Division of Public and Behavioral Health (DPBH). Included in this change is the merger of MHDS and the Substance Abuse Prevention and Treatment Agency (SAPTA) into a behavioral health system. Part of this transition to a more comprehensive "system of care" strategy includes the completion of a gaps analysis. The Substance Abuse and Mental Health Services Administration (SAMHSA) suggests identification of unmet needs and service gaps as part of a "strategic prevention framework."[3] The framework relies upon a five-step planning process that consists of:

1. Completion of a Comprehensive Needs Assessment
2. Identification of Unmet Needs and Service Gaps
3. Development of a Strategic Plan
4. Implementation of Effective Community Prevention Programs, Policies and Practices; and
5. Evaluation of Outcomes

[3] Retrieved from: http://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf.

In recent years, new information from the fields of neuroscience and behavioral medicine has dramatically advanced understanding of mental functioning. Increasingly, it is becoming clear that mental functioning has a physiological underpinning, and is fundamentally interconnected with physical and social functioning and health outcomes.[4] The integration of public and behavioral health aligns with research on brain development. The public health approach to mental health:

- Recognizes the interrelatedness of mental health and physical health,
- Focuses on prevention and promotes mental health across the lifespan,
- Identifies risks that may contribute to illness or disability, as well as protective factors that protect against the development of illness or disability and/or limit its severity,
- Provides people with the knowledge and skills to maintain optimal health and well-being, and
- Brings together individuals, communities and a variety of systems (health, human services, schools, etc.) to work collaboratively toward better mental health for all.[5]

The purpose of this gaps analysis is to forward the efforts of the state to implement a system of care as Nevada integrates Public and Behavioral Health by identifying gaps in the service delivery system. To accomplish that, the gaps analysis includes a comprehensive mapping and analysis of behavioral health services in Nevada using the strategic prevention framework. The report summarizes:

- The current behavioral health service delivery system at the state and local level,
- Unmet needs related to behavioral health, and
- Opportunities and recommendations for systems improvement.

Figure 2: Strategic Prevention Framework Components

[4]The World Health Organization, The World Health Report 2001, Mental Health: New Understanding, New Hope, 2001.
[5] The Center for Disease Control and Prevention, www.cdc.gov.

Methods of the Study

Conducting a gaps analysis is simplified within a defined system of stable service delivery components where consistent and reliable longitudinal data are available for analysis. In those circumstances, the system at the point in time of the analysis is compared to the defined system as planned or intended and the variance between the two systems and the outcomes sought versus achieved are used to identify gaps. Unfortunately, these circumstances did not exist during the development of this report.

Because of this, the report relies upon a variety of resources to assess gaps in Nevada's behavioral health system. Resources used to complete the gaps analysis included qualitative data such as gathering the perspectives of system stakeholders and consumers, a review of public documents, and a literature review of papers and studies specific to Nevada's system. Quantitative data such as state demographics, estimated need and DPBH penetration statistics, as well as comparisons of national behavioral health statistics was analyzed. The combination of qualitative and quantitative data was used to complete the gaps analysis.

Qualitative Data Collection Efforts

Key informant interviews, group meeting participation, and consumer surveys were used to gather input from consumers, behavioral health professionals, local and state program administrators, school counselors, law enforcement, emergency health providers, and other stakeholders to discern the resources in use and the gaps related to behavioral health in their area of concern.

- Key Informant Interviews: Social Entrepreneurs, Inc. (SEI) worked with the staff of the DPBH to identify key informants to interview. From May through September 2013, 19 key informant interviews were conducted by phone or in person. The results of these interviews were woven throughout the report with direct quotes found in quotations. A summary of the key informant questions can be found in the Appendices.
- Media Scan: A number of interviews and reports relevant to the gaps analysis were published in print and media during the period in which the gaps analysis was completed. SEI reviewed media reports, including interviews, and used the results to validate themes identified by key informant interviews. A summarized table of this media scan can be found in the Appendix of this report.
- Group Meeting Participation: SEI attended two meetings with the Division's behavioral health quality assurance team, comprised of content experts in a variety of areas including criminal justice, veterans, youth, homeless services, etc.

Information was collected during these meetings to track issues and system-change strategies as they were planned statewide.

- Consumer Survey: To inquire about program services availability, use of, barriers, and gaps, SEI worked with 19 provider agencies throughout the state to distribute consumer surveys to their clients. There were a total of 339 surveys collected in both English and Spanish representing clients in the north, south and rural areas of Nevada. The survey questions are included in the Appendices.

Quantitative Data Collection Efforts

Quantitative data such as census data, estimated Medicaid population information, service provider capacity, and DPBH service utilization rates were collected and analyzed. Research from US sources was utilized to approximate unmet needs.

- Demographic Profile of DPBH Consumers and Penetration Rates: This information was derived from the 2012 Uniform Reporting System (URS) by SAMHSA Center for Mental Health Services (CMHS). CMHS operates the only program in the nation that focuses on the development of data standards that provide the basis for uniform, comparable, high-quality statistics on mental health services, making it a model in the health care statistics field. Despite the reliability of the URS data, it should be noted that the data collected by CMHS is provided by each individual state. Nevada's Penetration Rates information does not include services to Medicaid recipients that accessed care through non-DPBH providers, whereas other states may have included this information in data provided to CMHS which was aggregated to establish US averages. For that reason, the comparison between Nevada and the US average only considers those known and reported by DPBH or DCFS.
- Census Data: Population estimates from the 2010 US Census were used to describe Nevada's current population.
- Prevalence Rates: The prevalence rates were based on national studies of the prevalence of adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The prevalence rates, separated by age, were applied to the population statistics for each county in Nevada. Because the public mental health system is intended to serve those persons who have low resources, the prevalence rates were applied to the estimated Medicaid eligible population for the State of Nevada.
- Utilization Statistics: Utilization statistics for services provided by what was known formerly as MHDS, from the state AVATAR database, were provided by staff of DPBH. Utilization statistics for services provided to children through the

Department of Children and Family Services (DCFS) came from an internally developed state report titled: "Descriptive Summary of Children's Mental Health Services – Fiscal Year 2012."

Public Document Review

Public documents such as the "Consultation Report on Rawson-Neal Psychiatric Hospital," "Nevada Division of Mental Health and Developmental Services Needs Assessment 2012," and the "Joint Federal Mental Health and Substance Abuse Block Grant Application 2013" were reviewed and information was leveraged to assist in the development of this report. A bibliography of all reports reviewed is provided in the Appendices. Additionally, a broad based internet scan for research, state reports, and US publications was conducted to trace the history of mental health in the US and in Nevada, to identify alternative approaches and best practices in providing mental health services and to put Nevada's system in context with other states in the US.

Study Limitations

The quantitative data used for analysis in this report includes information that was available at the time of development. Information that was not available, but that would have provided a more comprehensive picture of the gaps in the service spectrum, includes Medicaid eligible service recipient information for those who accessed care through non-DPBH providers.

Context of the Study

This study took place during a significant time of transition and turmoil within the State of Nevada related to behavioral health. The state was preparing for integration efforts across multiple state departments and hosting the biennial legislative session tasked with budget passage. Additionally, the state became the target of public scrutiny as a result of a number of issues related to the care and treatment of behavioral health clients.

Integration Efforts

Integration of Mental Health and Developmental Services (MHDS) and the Health Division into the Division of Public and Behavioral Health (DPBH) became official on July 1, 2013. However, the development of a cohesive and integrated system is currently a work in progress. While the name of the Division has changed, uniform policies and procedures do not exist system wide, staffing resources and service provision continue to function in silos, and data to quantify services provided and identify ongoing need are not reliably captured.

2013-2015 Legislative Session

While efforts to integrate had been initiated, the resources necessary to fully launch integration required passage of the 2013-2015 budget by a legislature that was in session from February to June 2013. The required presence of Division leadership during the legislative session further impacted the ability to move forward with implementation. In addition, regulations that require separate budgets for SNAMHS, NNAMHS and RCSS created inflexibility to meet the changing needs of the system as a whole.

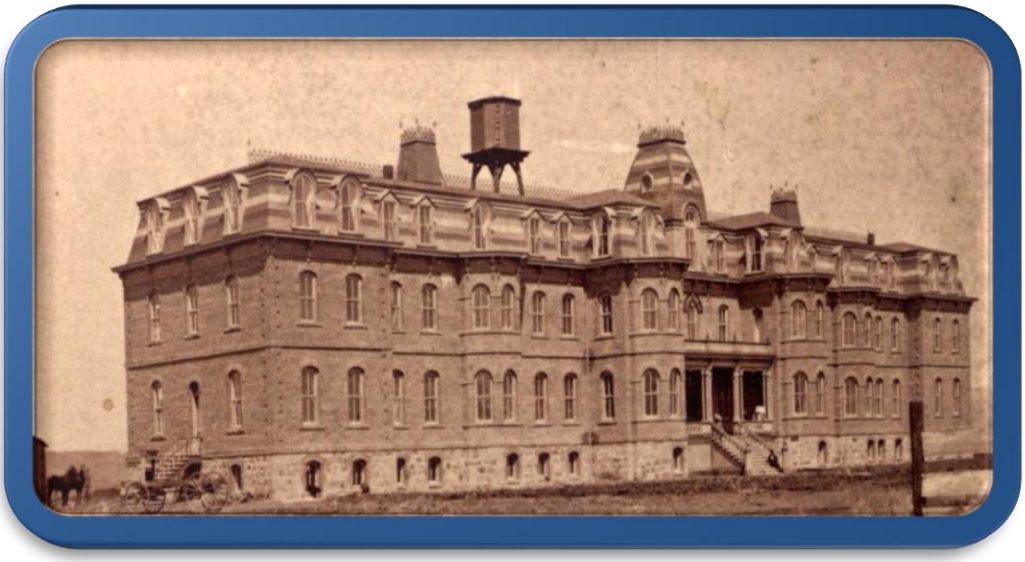
Public Scrutiny

Beginning in March 2013, and current through the publication of this report, the State of Nevada has faced a number of difficult circumstances surrounding the operations of publicly supported behavioral health services throughout the state. These circumstances included allegations of improper discharge practices, excessively long wait times for clients at the state operated forensic facility, and infractions within state psychiatric facilities that could jeopardize CMS certification. These situations have resulted in multiple investigations and state-requested examinations to explore the challenges facing the Division and its service operations. Included in the Appendix of this report is a sample of news articles that were published during this timeframe.

> *"Over the years, the state's mental health system has reflected the same cycle endured by mental health patients themselves, oscillating between making progress and receding into crisis.*
>
> Las Vegas Sun, August 2013

Each one of these situations influenced the other, culminating in a behavioral health crisis that continues to unfold. While this report was commissioned prior to the unfolding of this crisis, the circumstances did offered a unique and unprecedented opportunity to examine complex issues facing the system from a variety of perspectives. As such, this report is written within the context of a system in constant flux, facing significant scrutiny, and yet ready for reform.

The following section of this report provides a historical context with detail of missed opportunities and strategies other states have employed, as well as lessons learned over the past 50 years. This current challenges facing the system, coupled with the integration of the Division of Public and Behavioral Health and the implementation of the Affordable Care Act provides an opportunity for systems reform for Nevada.



1882: Nevada's First State Asylum

Historical Context

Nevada is one of only three states in the nation that serves as the sole source provider for public behavioral health services. The other two states are Alaska and South Carolina. Historically, this had a tremendous impact on the method of service delivery and influenced how systems change efforts are addressed. Many of the current issues plaguing the system have their roots in past policies and practices.

The following info graphic provides a snapshot of major milestones within the behavioral health system in Nevada spanning the last five decades, beginning with the adoption of the Community Mental Health Act of 1963 (CMHA), which de-institutionalized mental health care.

50 Year Retrospective of Behavioral Health in Nevada 1963 – 2013

For comparison purposes, a similar timeline for the state of California can be found in Appendix 1.4.

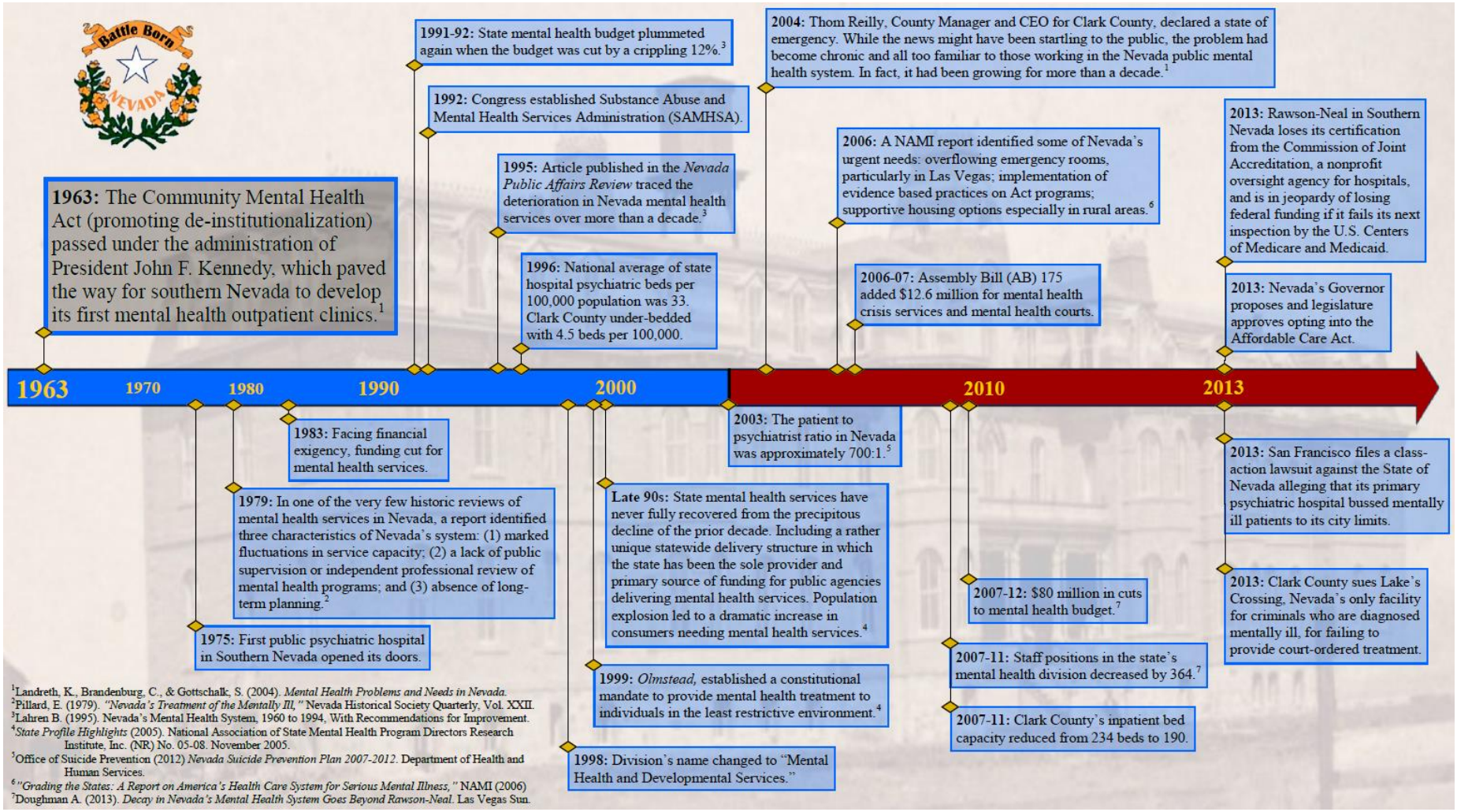


Figure 3: 50 Year Retrospective of Behavioral Health in Nevada 1963-2013

Over the past 50 years, many states ceased to serve as the primary provider of behavioral health services for persons without insurance. Rather, they responded to the CMHA by shifting funding to local jurisdictions, supporting community-based services, and over time, closing institutions due to a lack of demand. See Appendix 1.4 for an info graphic that illustrates how a state neighboring Nevada took a different path following the adoption of the CMHA of 1963, with different results.

While many states now have a community-based service delivery system, it took time to develop with lessons learned along the way. As noted by the Kaiser Family Foundation:

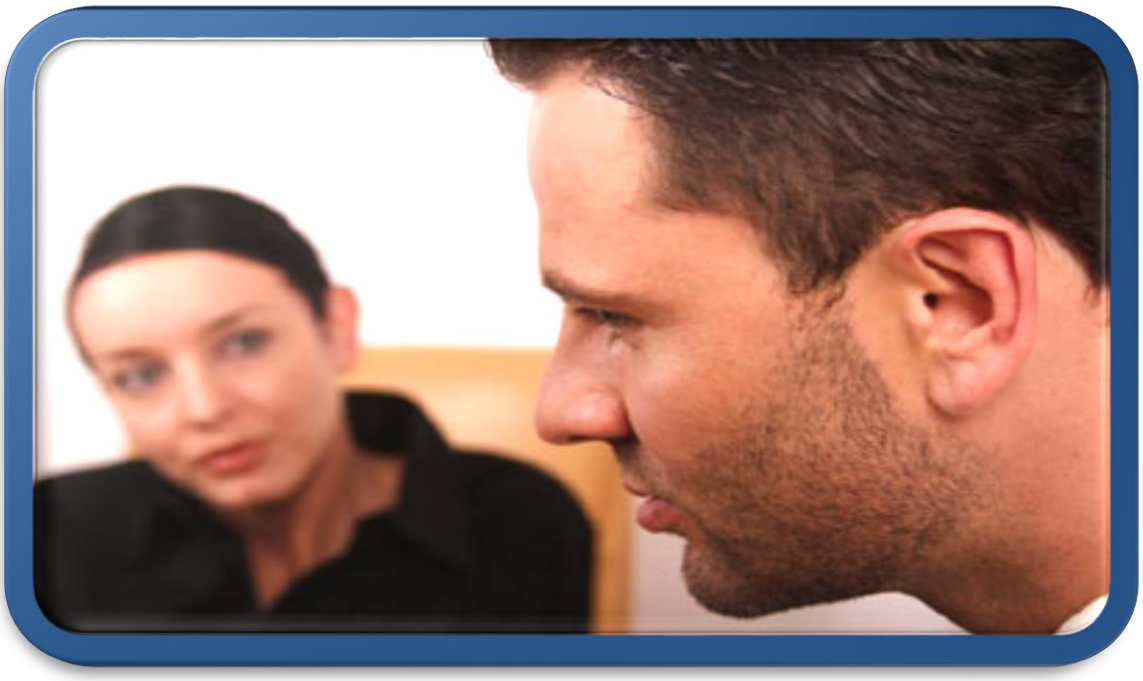
> *"The history of deinstitutionalization falls into several stages as policies and objectives have changed over time. The early focus was on moving individuals out of state public mental hospitals and from 1955 to 1980, the resident population in those facilities fell from 559,000 to 154,000. Only later was there a focus on improving and expanding the range of services and supports for those now in the community, in recognition that medical treatment was insufficient to ensure community tenure. In the 1990's whole institutions began to close in significant numbers and there was a greater emphasis on rights that secured community integration – such as access to housing and jobs (pg.1)."*

As noted in the Kaiser report, "Learning From History: Deinstitutionalization of People with Mental Illness As Precursor to Long-Term Care Reform," many systems made a number of mistakes that impacted their success in de-institutionalizing mentally ill persons. The description of those mistakes is informative for Nevada, as the state is challenged by many of the same issues:

- Housing: People with serious mental illness were moved to settings that were ill-equipped and poorly supported to meet their needs.
- Essential services: The array of supports needed to successfully live independently in the community was not available or provided.
- Outcomes: Mental health systems continued to measure success by effort, such as bed days, instead of measuring the effect of services such as quality of life indicators.
- Resources:
    - State funds previously used for state institutions were not reinvested in community programs.
    - Federal funds for the community mental health centers program did not adequately address need.

- Third-party health insurance policies and public programs, such as Medicare, limited coverage for the treatment of mental illness.

With leadership, vision, resources and a strategic approach, Nevada has an opportunity to leverage the lessons learned by other states and to seize the moment to implement a public health model for community-based services through the integration of the Division of Public and Behavioral Health and the implementation of the Affordable Care Act.



Current Service System

The behavioral health system in Nevada is comprised of federal, state and local resources that operate under a variety of funding sources, priorities and mandates. Services throughout the state differ based on target population, geographic region and funding source. As a result, there are often different challenges for persons seeking behavioral health assistance based on services available and where they are sought. The system is most developed in the urban areas of northern and southern Nevada, although more linkages exist between urban and rural areas than in the past.

The system relies on a variety of providers. For the purpose of this report, they are divided into three categories: 1) primary service providers, 2) secondary service providers, and 3) linkage and coordination efforts. The following section summarizes each category. A more comprehensive description can be found in the Appendices.

Primary Providers

The primary providers of behavioral health services in Nevada include the public behavioral health system as operated by DPBH, non-profit/community-based organizations, private practitioners and psychiatric hospitals, and federally qualified health centers.

Division of Public and Behavioral Health (DPBH)

The most significant primary provider for public behavioral health services is DPBH. Within the Division, there are four service delivery systems operated to protect, promote and improve the physical and behavioral health of the people in Nevada. These systems include Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), Rural Counseling and Supportive Services (RCSS), and Lake's Crossing Forensic Facility.

- NNAMHS is located in Sparks, Nevada, and is a comprehensive, community-based, behavioral health system for adult consumers. Inpatient services are provided through Dini-Townsend psychiatric hospital, located on the same campus as the central NNAMHS site. Numerous outpatient services are available which include the Washoe Community Mental Health Center, Outpatient Pharmacy, Program of Assertive Community Treatment (PACT), Psychosocial Rehabilitation Program (PRP), Consumer Peer Counseling, and Service Coordinator Services.
- SNAMHS provides both inpatient and outpatient services for adults living in Clark County and in surrounding counties that may be closer geographically to this agency rather than to a rural behavioral health center. Inpatient services are provided through the Rawson-Neal psychiatric hospital on the central SNAMHS campus. SNAMHS has eight behavioral health clinics serving the community and rural southern Nevada. SNAMHS provides: Inpatient Services, Mobile Crisis, Outpatient Counseling, Service Coordination, Intensive Service Coordination, Medication Clinic, Residential Support Programs, Mental Health Court, and Programs for Assertive Community Treatment (PACT) Teams.
- RCSS has seven full service clinics, five partial service clinics, and one limited service clinic that provide behavioral health services to both adults and children in the rural areas of the state considered to be every county with the exception of Washoe County, Clark County, Lincoln County and parts of Nye County. Satellite Clinics provide all services offered by RCSS. Sub-satellite clinics offer many of the same services with itinerant Clinics providing services less frequently. RCSS is the only service system within DPBH to provide services to children and adolescents.
- Lake's Crossing is a forensic facility that provides services aimed at determining the legal competency of an individual to stand trial and restoration of legal competency for trial purposes. Adult forensic services include clinical assessment, forensic evaluation and short or long-term treatment for both pretrial detainees and jail/prison inmates.

Nevada Substance Abuse Prevention and Treatment Agency (SAPTA)

SAPTA currently funds private, non-profit treatment organizations and government agencies statewide to provide the substance abuse related services and treatment levels of care. In state fiscal year 2012-2013, SAPTA funded 22 treatment organizations providing services in 68 locations throughout Nevada. Together, these providers had 11,907 treatment admissions. Services consist of intervention, comprehensive evaluation, detoxification, residential, outpatient, intensive outpatient, and transitional housing services for adults and adolescents, and opioid maintenance treatment for adults.

Non-Profit Community-based Organizations

Community-based organizations provide behavioral health, substance abuse and co-occurring disorder counseling and supportive services. Community-based organizations throughout the state vary in target population, approach, location, and accessibility. These services are primarily grant funded and more prevalent in urban areas. There are great differences in the sophistication and the capacity of these providers throughout the state.

Private Psychiatric Providers

Private practitioners and psychiatric hospitals are concentrated primarily in Washoe and Clark Counties. Access to these services often depends upon medical insurance. Throughout rural Nevada, there is a significant shortage of mental health professionals.

Federally Qualified Health Centers (FQHC)

FQHCs provide services in the most medically underserved areas and/or to the most medically underserved populations. Nevada is host to a total of 31 FQHC clinics of which only two offer behavioral health services.

Secondary Providers

Beyond the primary providers, there are also demands placed on a number of other systems throughout Nevada that respond to persons with behavioral health issues. Secondary providers such as specialty courts, emergency transport, hospital emergency rooms, county law enforcement, primary care practitioners and rural community health and social service centers often provide services when needed. While many do not see themselves as providers of behavioral health services and are not equipped to fully address the behavioral health

> *"Over 13 percent of those with behavioral health disorders receive treatment outside the health care system entirely, such as through human services programs or the voluntary support network of self-help groups and organizations".*
>
> (Garfield, 2011)

problems they encounter, they are part of a continuum of services providing access to care.

A secondary provider that has been impacted most significantly by the behavioral health needs of its service population is the criminal justice system, including juvenile, state and federal correctional facilities. As stated in the report, "Mental Illness and the Criminal Justice System: Clark County, Nevada:"

> "It has become increasingly commonplace for mentally ill individuals exhibiting troublesome behaviors to be sentenced to criminal custody rather than receive placement in psychiatric institutions. Unfortunately, the public and media frequently regard jails and prisons, rather than psychiatric facilities, as the *de facto* institutions responsible for the care of people with mental illness" (pg.3). One explanation routinely offered for this dynamic involves the confluence of deinstitutionalization efforts with the lack of supportive community-based resources.

Linkages and Coordination Efforts

Nevada has numerous boards, commissions, collaboratives, and workgroups across the state that seek to address systems improvement for consumers accessing behavioral health services. These entities establish linkages and promote coordination critical to an effective continuum of care. Because of the integration within the Division, some of these entities are also in a state of transition.

Formal state-driven efforts have included the Commission on Mental Health and Developmental Services, the Nevada Children's Behavioral Health Consortium, the Nevada Mental Health Planning Advisory Council, the Multidisciplinary Prevention Advisory Committee (MPAC), the Substance Abuse Prevention and Treatment Agency (SAPTA) Advisory Board, and SAPTA Community-based Coalitions.

Another example of a state-driven effort to create linkages within the Division includes the 2012 establishment of a statewide Quality Improvement Team (QIT). The team identified special populations such as veterans, youth, and persons involved in the criminal justice system, and met regularly to identify special needs and resources requiring coordination. In 2013, the QIT established workgroups for each special population area and published white papers to capture and transfer knowledge throughout the system.

Local efforts to coordinate services exist regionally and throughout the state in the form of coalitions, work groups, task forces and alliances. For the most part, they are population specific and designed to identify ways to serve consumers in a more comprehensive, coordinated manner. Some seek to implement evidence-based solutions to address community problems. The results of these efforts can be seen in the development of new community-based resources including community response teams, diversion programs, and multidisciplinary transition teams. These efforts exist on a continuum of formality, ranging from partnerships generated from formal operational agreements to ad hoc working groups collaborating on short-term issues.

> *"There are models of partnerships between law enforcement, courts, the state and social services all across the state that have worked to the benefit of the client. These are not always formalized, are often person or relationship dependent and can quickly evaporate when a person change position, a crisis occurs, or one agency stops participating."*
>
> Key Informant

The effectiveness of these collaborations varies. Several key informants describe that linkages throughout the system on behalf of behavioral health consumers are largely dependent upon the personal relationship created between people working within the system.

This complex system of primary and secondary service providers, supported by state and local coordination efforts, serve a growing population of people needing behavioral health services. While the service population has grown, the availability of qualified staff, sufficient facilities, and resources to support community-based services is insufficient to meet the demand, resulting in overcrowded emergency rooms, jails filled with mentally ill persons, and long waiting lists for all types of services.

Financing Behavioral Health Services

Financing behavioral health services through DPBH relies upon three funding streams which include:

1. General Fund Revenues currently makes up the largest portion of funding to support public behavioral health services.
2. Grants both large and small make up another source of funding to support public behavioral health services throughout the state. The largest of these grants is the Mental Health Block Grant.
3. Public Insurance Products such as Medicare and Medicaid are the smallest contributor to funding services in their current formation.

Expenditures related to behavioral health within the Department of Health and Human Services (DHHS) are separated into five categories: Director's Office, Aging and Disability Services Division (ADSD), Division of Health Care Financing and Policy (DHCFP), Division of Public and Behavioral Health (DPBH), and Division of Child and Family Services (DCFS).

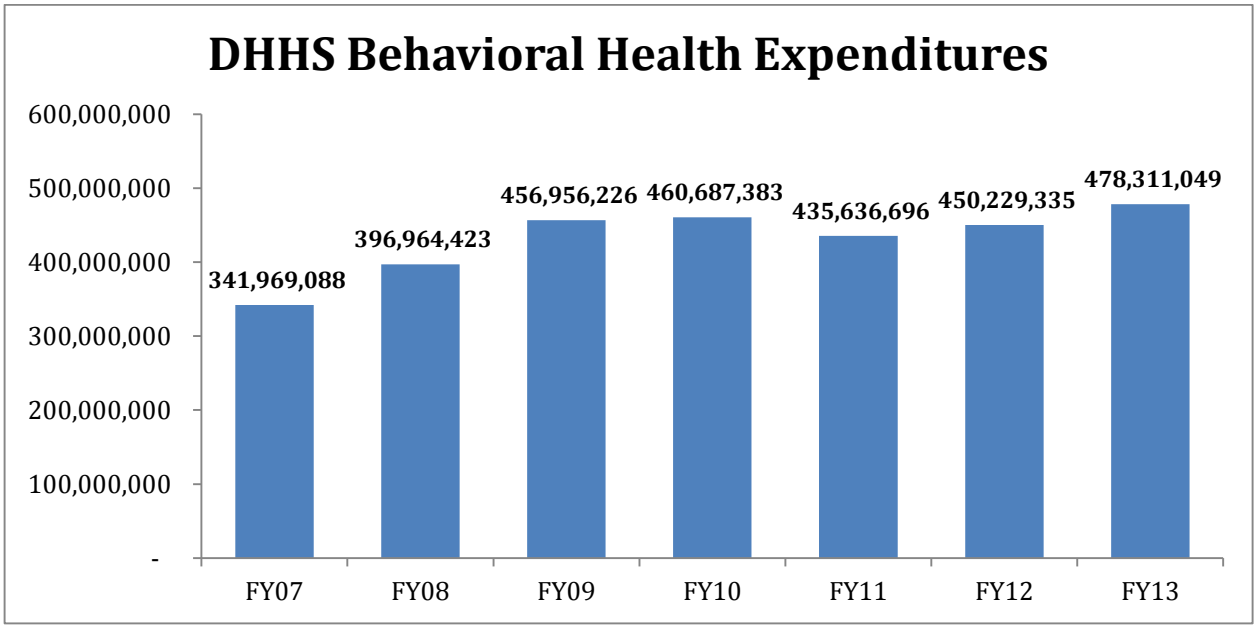


Figure 4: DHHS Combined Spending

Expenditures increased from $341,969,088 in fiscal year 2007 (FY07) to $478,311,049 in FY13. Some programs and agencies have moved from one Division to another during this time period. Current expenditures planned are described by category:

Director's Office

The Director's Office allocates funding for behavioral health services for the following programs:

- Positive Behavior Supports
- Problem Gambling
- Suicide Prevention
- 2-1-1[6]

[6] Estimated based on 4.5% of 2-1-1 calls relating to behavioral health issues including drug, alcohol, and tobacco use.

Aging and Disability Services Division

ADSD behavioral health funding is allocated for the following programs:

- Youth Intensive Support Services (YISS)--Provides intensive support services to children/youth and their families. The significant behavioral challenges include court involvement, conduct issues, frequent and/or intensive aggression, property destruction, self-harm, sexual offenses, and mental health issues.
- Intermediate Care Facility (ICF/ID)--Provides support services recipients who are 18 years and older and have significant medical and/or behavioral support needs, and who require active treatment designed to teach or maintain skills necessary to promote functional status and level of independence.[7]
- Senior and Disability Rx--Psychotropic Medication includes state cost for Part D and Gap coverage.

Division of Health Care Financing and Policy

The Division of Health Care Financing and Policy budget provides funding for:

- Medical--Includes Psychiatric, Inpatient (Provider Type (PT) 013), Mental Health, Outpatient (PT 014), Psychologist (PT 026), Targeted Case Management (PT 054), Mental Health Rehab Svc/Residential (PT 061), Residential Treatment Center (PT 063), Mental Health Rehab Svc/Non-Residential (PT 082), Hospital, Inpatient (PT 011 with Psych/Detox Revenue Codes), and Physician, M.D., Osteopath (PT 020 with Behavioral Health/Mental Health Specialties).
- Pharmacy--Includes Antianxiety Agents, Antidepressants, Antipsychotics/Antimanic Agents, Hypnotics, ADHD/Anti-Narcolepsy/Anti-Obesity/Anorex, Psychotherapeutic and Neurological Agent, and Anticonvulsants.[8]
- Health Plan of Nevada (HPN) – Medical
- Health Plan of Nevada (HPN) – Pharmacy
- Amerigroup – Medical
- Amerigroup – Pharmacy

Division of Child and Family Services

Spending from DCFS is provided to the following programs:

[7] Currently the number of dually diagnosed residents, an intellectual disability and Mental health diagnosis stands at 39 out of 48, or 81.25%.

[8] Anticonvulsants are usually used to treat a seizure disorder, but are often used as adjunctive behavior treatments

- Children's Mental Health--Includes Southern Nevada Child and Adolescent Services (SNCAS, BA 3646), Wraparound in Nevada (BA 3278), and Northern Nevada Child and Adolescent Services (NNCAS, BA 3281)
- Victims of Domestic Violence--Domestic Violence Grants (Cat. 10, BA 3181)
- Child, Youth and Family Admin.--BA 3145 including mental health related positions, Community Mental Health Grants (CMHS, Cat. 14/15), Mental Health Placements (Cat. 16), Victims of Crime Grant (Cat. 20), and Meth Grant (Cat. 25)
- Rural Child Welfare--BA 3229 including Intensive Family Services mental health positions, med/health contracts and med rehab/ Res. TX (Cat 13), Youth Parole Residential Treatment (Cat. 14), and Mental Health Placements (Cat 16)
- Youth Parole Services--BA 3263 including Youth Parole mental health positions, Community Reintegration/Residential Treatment (Cat. 36), and Residential Treatment (Cat. 36)
- Community Juvenile Justice--BA 1383 Cat. 20 Community Corrections Block Grant
- Caliente Youth Center--BA 3179 including mental health positions and Medical/Psychiatrist/Psychologist contracts (Cat. 04/08)
- Nevada Youth Training Center--BA 3259 including mental health positions and Medical/Psychiatrist/Psychologist Contracts (Cat. 04)

Division of Public and Behavioral Health

DPBH provides spending for the following:

- Southern Nevada Adult Mental Health Services (SNAMHS)
- Northern Nevada Adult Mental Health Services (NNAMHS)
- Rural Clinics
- Lake's Crossing Center
- Substance Abuse Prevention and Treatment Agency (SAPTA)
- Mental Health Information Technology[9]
- Mental Health Administration
- Alcohol Tax Program[10]

Financial investments made to support DPBH behavioral health services from 2007-2013 are provided in the table that follows.

[9] Since budget accounts 3164 and 3168 provided services to both mental health and developmental services accounts, some of the costs in those budget accounts were adjusted based on an FTE allocation and some were excluded because they were not mental health related.
[10] Transfers from BA 3168, Cat. 19 to DCFS budgets accounts have been excluded.

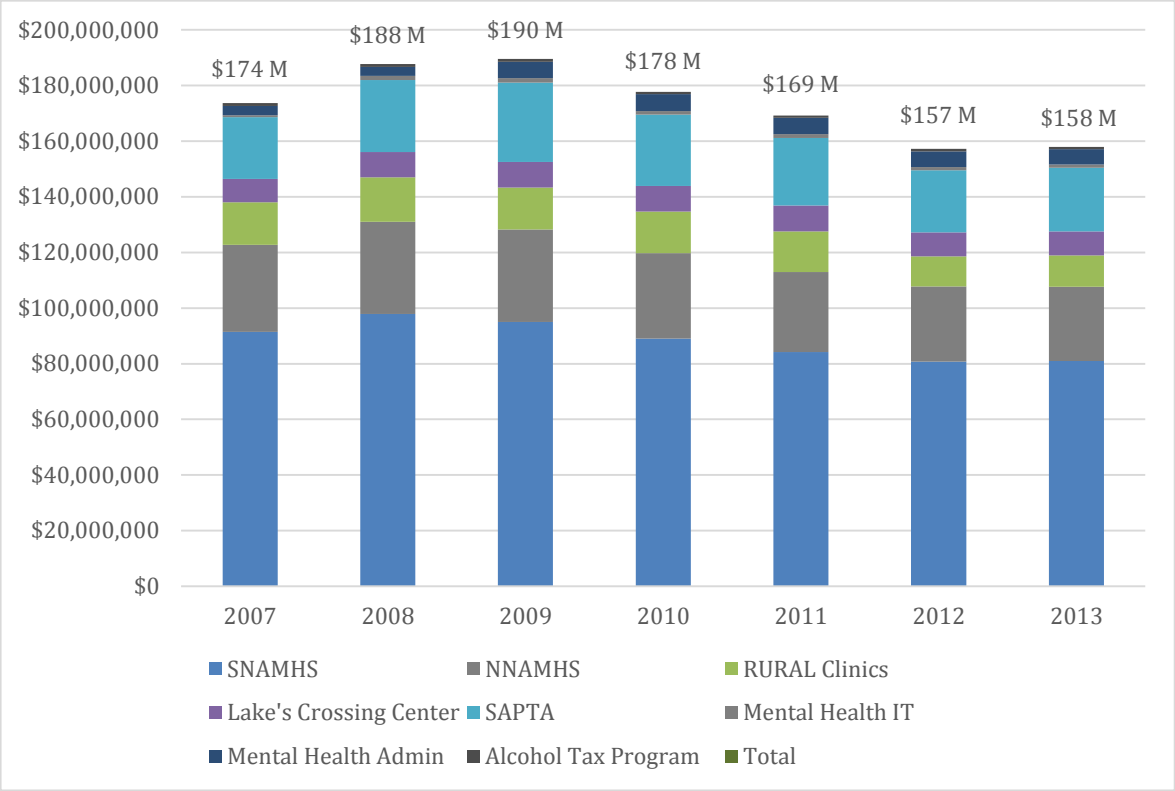


Figure 5: DPBH Expenditures FY 2007-2013

Expenditures from DPBH have been on a steady decline since FY09 with a slight increase in FY13. The largest decline was in FY12 with a $10,980,906 or 6.5% decrease.

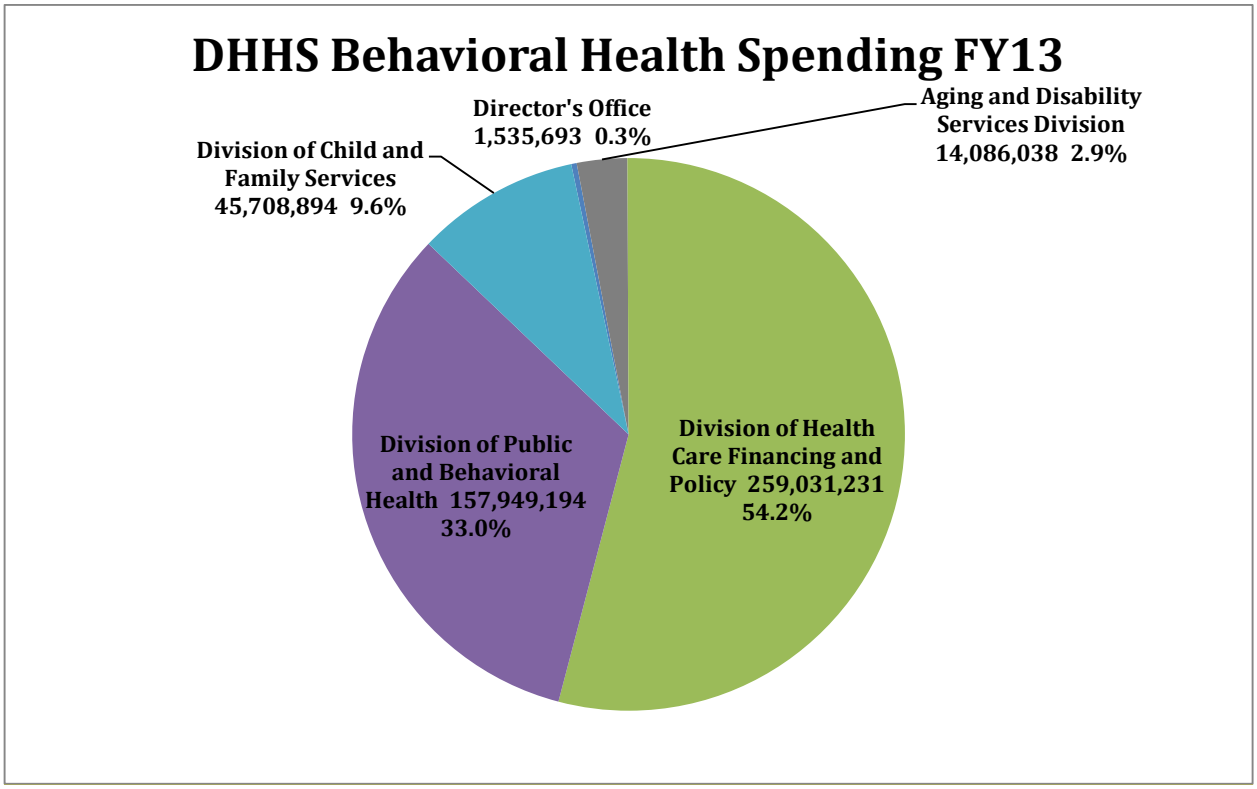


Figure 6: Spending for FY13

Spending in FY13 is broken out by the five divisions with DHCFP making up more than half the expenditures with 54.2%. DPBH makes up the next largest group with 33.0% followed by DCFS at 9.6%, ADSD at 2.9%, and the Director's Office at 0.3%.

As noted in Nevada's MHDS 2012 Needs Assessment, Nevada ranked fifth of all states with the greatest proportion of cuts to behavioral health from FY 2009 to 2012 (McKnight, 2012). These cuts were also referenced in Nevada's 2013 Joint Block Grant Application:

> "MHDS suffered a total budget decrease of 12.5% for the 2011 through 2013 biennium and a 13.9% overall decrease in the General Fund appropriations. This has resulted in a loss of approximately 150 positions Division-wide. The eliminations occurred in agency programs in the north and south and in the inpatient and outpatient treatment centers. The elimination of these positions impacted services provided to Nevada's consumers statewide and in all regions for MHDS, Division of Child and Family Services (DCFS) and the Substance Abuse Prevention and Treatment Agency (SAPTA). The cuts have raised concerns regarding meeting client needs" (Block Grant Division of Mental Health and

Developmental Services Substance Abuse Prevention and Treatment Agency, 2013).

During the most current legislative session, Governor Sandoval requested and the legislature approved a series of new funds to support additional staff within DPBH as well as additional services for consumers such as comfort rooms, additional civil and forensic beds, housing for Nevadans leaving jails and prisons, and the requirement of treatment for co-occurring disorders. While these additional investments are welcome enhancements, they are not tied to a comprehensive strategic plan to confront and address some of the structural flaws within the existing service delivery model such as insufficient resources to fill position, professional staff, lack of community-based programming, lack of housing, and transportation barriers.

A proactive, strategic plan to implement an integrated system of care approach to behavioral health is not in place. Without this type of vision, investments will continue to be targeted to confront crises, and will likely achieve only short-term gains.

Profile of Behavioral Health Consumers

This section explores the profile of consumers who accessed DPBH services based on age, gender and race. Additionally, age and race are cross-tabulated to establish a more comprehensive picture of the profile of current DPBH consumers. The demographic profile of DPBH consumers is important to understand compared to the demographics of the state. Comparing these two data sets shows where subpopulations are either underrepresented or over-represented in services.

Additionally, penetration rates for DPBH identifies how well the State of Nevada is doing in reaching consumers in need of behavioral health services. Penetration rates particular to demographic profiles are compared against 2012 national averages to determine if Nevada is reaching subsets of people in a manner better, worse, or consistent with national averages. This variable is commonly used to assess access to services.

Age

In Nevada, the largest category of DPBH consumers accessing care is between the ages of 25-44, representing 38% of the service population. This is followed by DPBH consumers between the ages of 45-65, representing 35% of the service population.

The chart below demonstrates the age distribution of DPBH consumers accessing behavioral health care compared to the age demographic profile of the state.

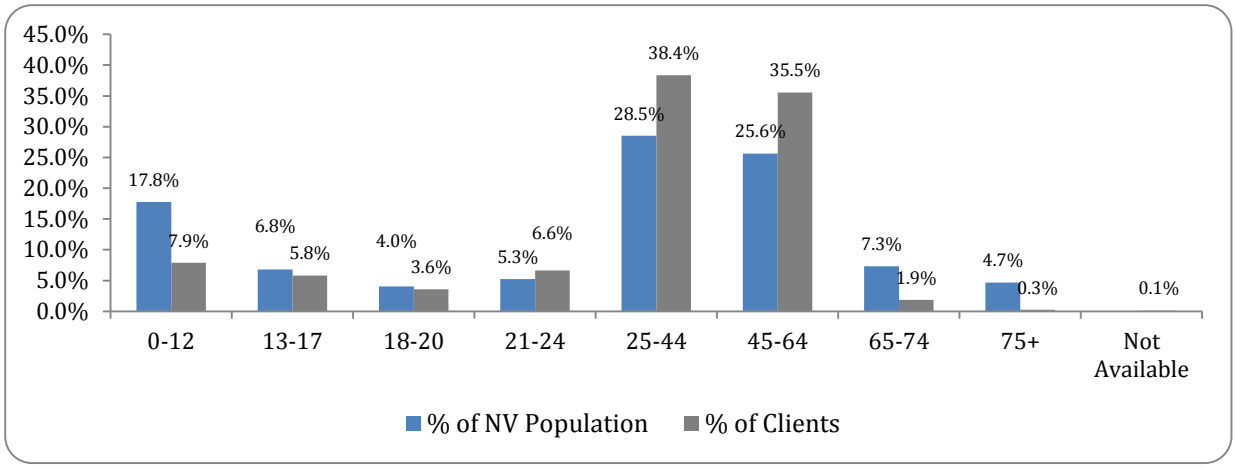


Figure 7: Age of Clients Accessing DPBH Services Compared to Statewide Population Statistics

This chart demonstrates that while persons between the ages of 25-64 make up slightly more than half of the state's population, they represent almost two-thirds of the persons served in DPBH. The system, including DCFS and DPBH, serves significantly fewer very young children (up to age 12) and older adults (65+) compared to the population distribution of persons in the state.

Figure 8 demonstrates how Nevada compares to the national averaged efforts in reaching individuals throughout the lifespan. On average, the national average is to reach consumers ages 13-17 with a penetration rate of 41.2 per 1,000 people in the population, in contrast to Nevada, which has a penetration rate of 9.2 per 1,000 between the ages of 13-17.

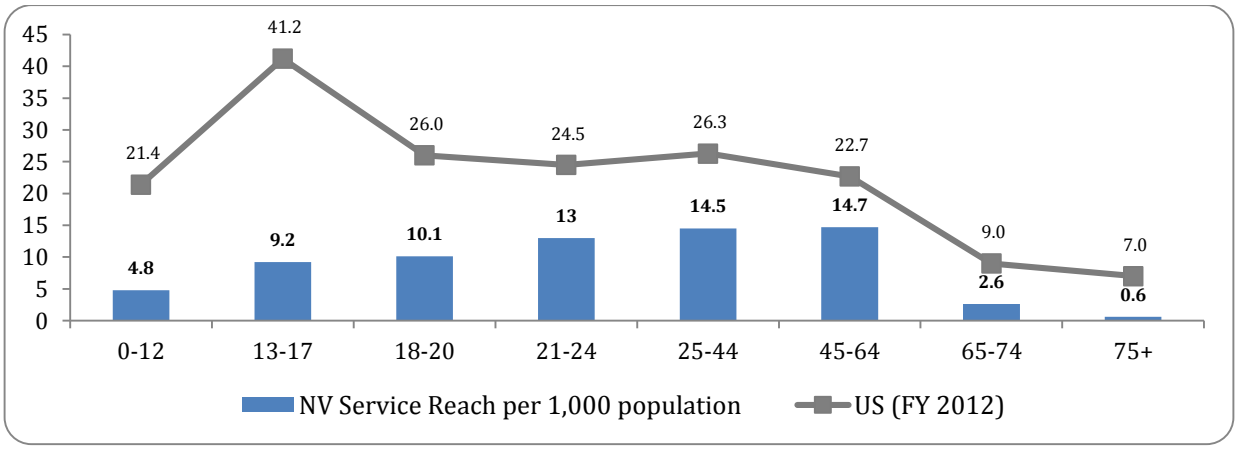


Figure 8: Penetration Rates by Age

Nevada serves one child (ages 0-12) for every four, on average, served nationally and one senior (ages 75+) to every 12 served nationally.

For all age ranges, Nevada fails to reach the same amount of consumers as national averages. The following represents the ratio of penetration between Nevada and national averages (Nevada: National).

Ages	Ages	Ages	Ages
0-12 Ratio (1:4)	18-20 Ratio (1:3)	25-44 Ratio (1:2)	65-74 Ratio (1:3)
13-17 Ratio (1:4)	21-24 Ratio (1:2)	45-64 Ratio (1:2)	75+ Ratio (1:12)

Figure 9: Ratio by Age Nevada: National

Because penetration rates are an indication of access, low penetration rates in Nevada indicate a deficiency of service options including outreach, assessment and treatment. This appears to be particularly true in relationship to services for the very young. Whereas other states appear to be focused on early intervention and prevention, Nevada appears to respond more to crisis in adulthood. Intervening earlier in the life span may result in fewer persons requiring intervention and treatment later in life, which would be a less costly and more effective service delivery system. "Intervening at the first sign of symptoms offers the best opportunity to make a significant, positive difference in both immediate and long-term outcomes for people affected by mental health issues."[11] As such, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has designated prevention as their first strategic priority (Steve Vetzner, 2013).

While DPBH is not the primary agent responsible for providing services to children and adolescents, it will ultimately bear the burden of treating these individuals in the event that early prevention and intervention services are not adequate.

[11] Retrieved from: http://www.sfgate.com/opinion/openforum/article/Mental-health-prevention-a-wise-investment-4028399.php

Gender

Figure 10demonstrates the gender distribution of consumers accessing DPBH services for FY 2011-12. Female consumers make up the largest demographic of individuals accessing care, representing 53% of the service population. Male consumers represent the remaining 47% of the service population.

Figure 11 shows the gender distribution of consumers accessing behavioral health care compared to the demographic of the state.

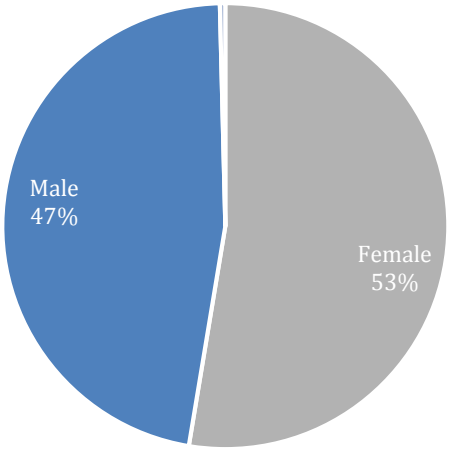


Figure 10: Gender of DPBH Clients FY 2011-12

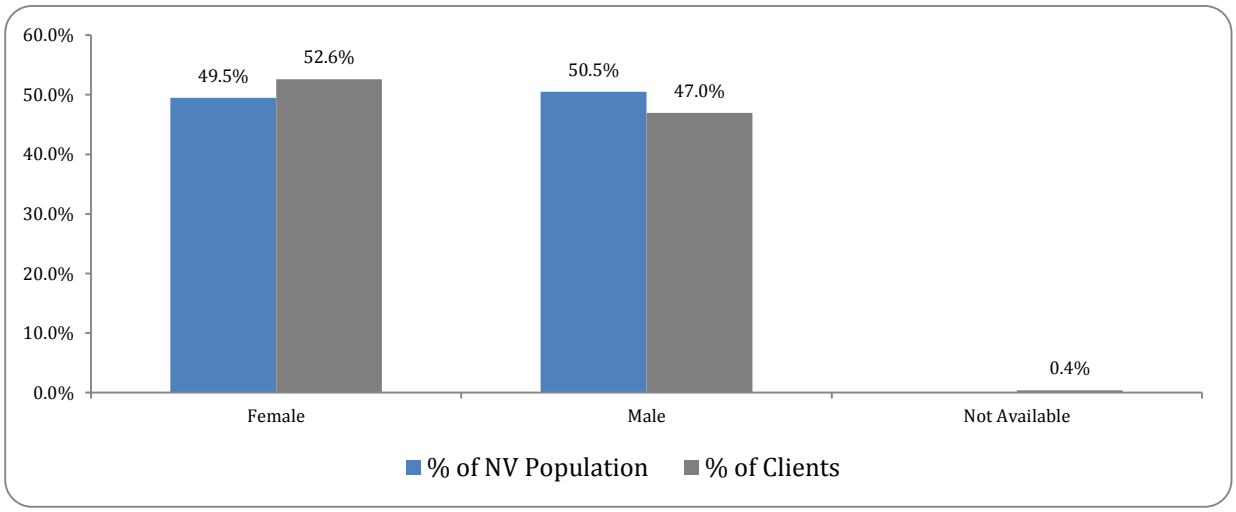


Figure 11: Gender of Clients Accessing DPBH Services Compared to Statewide Population Statistics

While there are fewer females than males in Nevada, more females use DPBH services. This is consistent with national trends which identify females as accessing behavioral health services with slightly more frequency than men (Center for Mental Health Services, NASMHPD Research Institute, Inc., 2012).

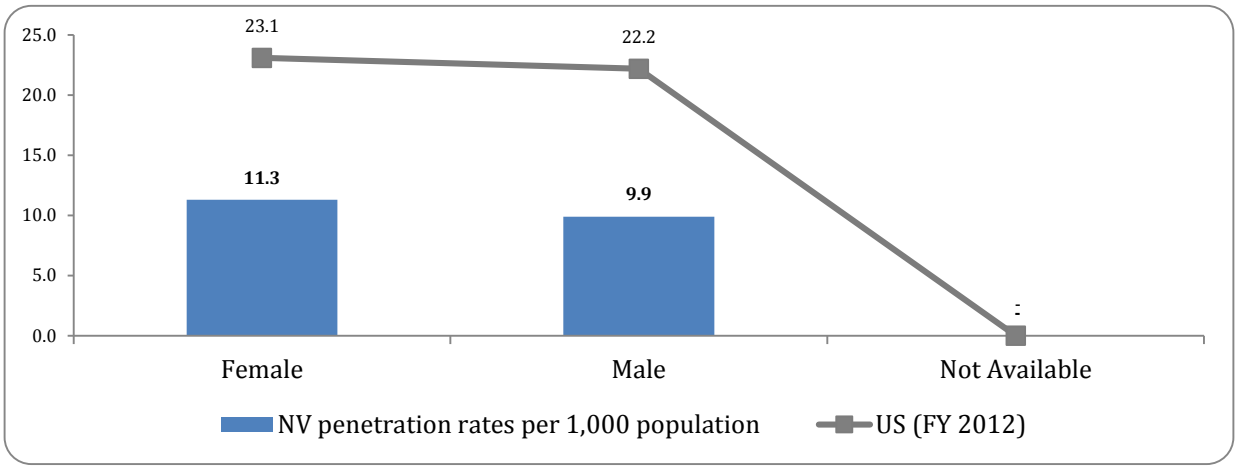


Figure 12: Penetration Rates by Gender

Nationally averaged penetration rates for females account for 23.1 persons per 1,000 people in the population, compared to 11.3 persons in Nevada. Nationally averaged penetration rates for services to men, (22.1 per 1,000) also exceed Nevada's rate of 9.9 per 1,000. Again, this data is limited by the lack of data on those Medicaid eligible served outside of DPBH and that every state reports differently and it is not possible to determine whether those served include Medicaid eligible accessing services through non DPBH services.

Race & Ethnicity

Figure 13 shows the racial distribution of DPBH consumers accessing services for FY 2011-12. White consumers represent the largest demographic accessing care, representing 64% of those served.

Figure 14 demonstrates the racial distribution of consumers accessing behavioral health compared to the racial demographic of the state.

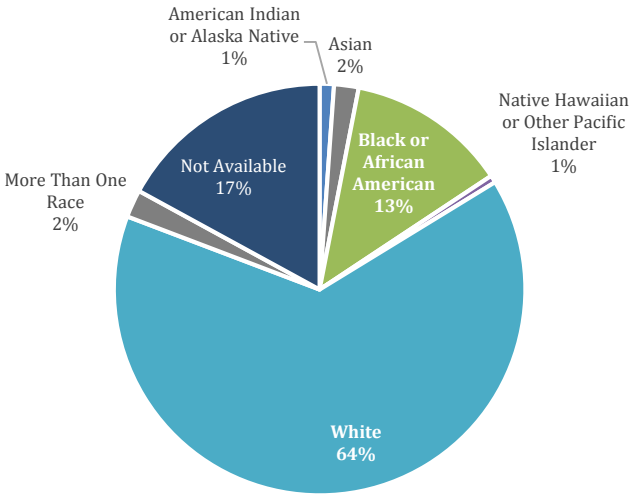


Figure 13: Race of DPBH Clients FY 2011-2012

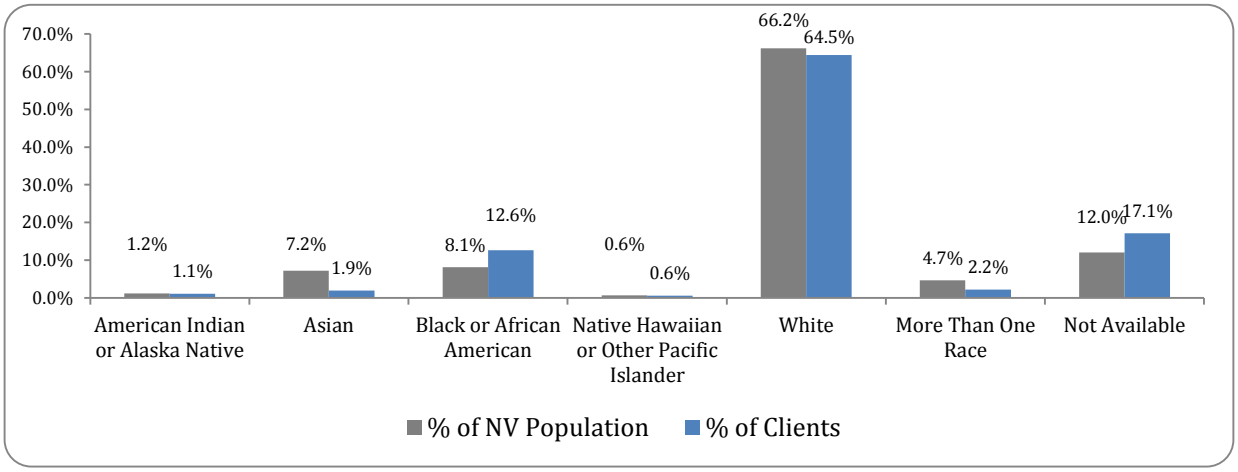


Figure 14: Race of Clients Accessing DPBH Services Compared to Statewide Population Statistics

While the vast majority of consumers served reflect the racial demographics of the state, there are variances particular to the Asian and African-American populations served. In Nevada, Asians represent 7.2% of the overall population in Nevada, but only 1.9% of the service population. In contrast, African-Americans represent 8.1% of the population in Nevada, but account for 12.6% of the service population.

The table that follows demonstrates how Nevada compares to the national average in reaching consumers according to race. It demonstrates that in every racial category, Nevada lags behind in reach when compared to national averages.

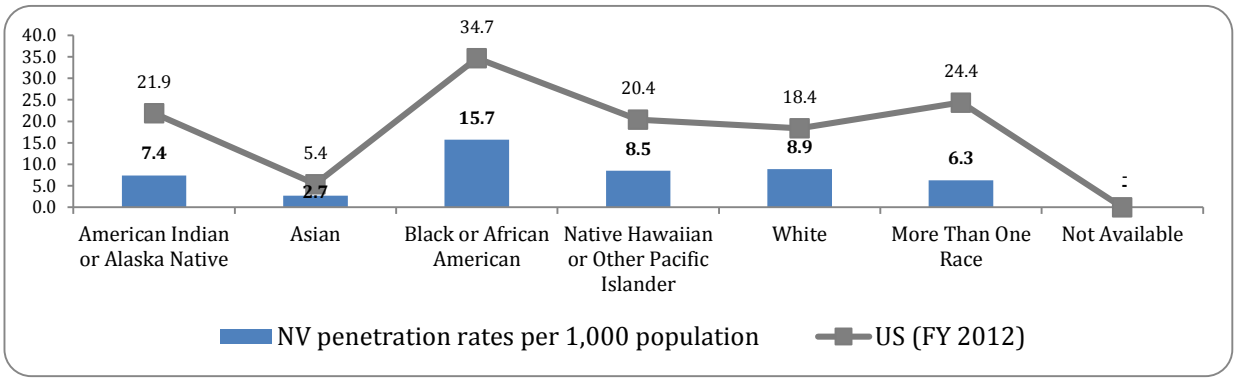


Figure 15: Penetration Rates by Race

The following represents the ratio of penetration between Nevada and national averages (Nevada: Nation).

American Indian or Alaskan Native Ratio (1:3)	Black or African American Ratio (1:2)	White Ratio (1:2)
Asian Ratio (1:2)	Native Hawaiian or Other Pacific Islander Ratio (1:2)	More than one Race Ratio (1:4)

Figure 16: Ratio by Race Nevada: National

On average, Nevada continues to serve one individual for every two served nationally. This dynamic is most pronounced among American Indian / Alaskan Native populations as well as amongst those of more than one racial heritage.

Ethnic Considerations

While 26.5% of the population of Nevada is Hispanic/Latino, they represent 12.5% of those served, as identified below in Figure 16.

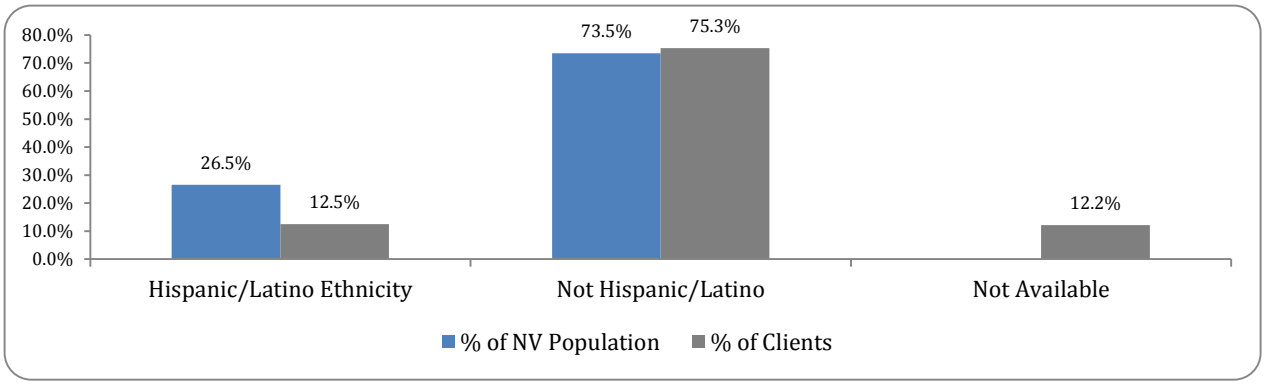


Figure 17: Ethnicity of Clients Accessing DPBH Services Compared to Statewide Population Statistics

Figure 18 reveals that while national penetration rates for services to the Hispanic population are 18.3 per 1,000 people in the population, Nevada reaches only 4.9 per 1,000. This is the most pronounced gap in penetration rates identified among racial/ethnic groups when compared to national averages.

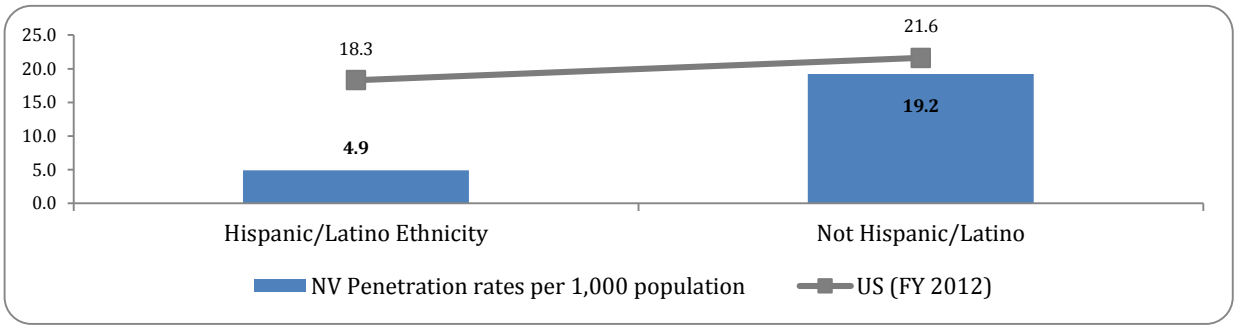


Figure 18: Penetration Rates by Ethnicity

Nevada's lack of resources, compounded with language barriers and lack of bilingual professionals likely accounts for this disparity.

Cross-Tabulation

To further understand the profile of DPBH behavioral health consumers, cross-tabulations of the following were calculated Race/Age, Ethnicity/Age, Race/Gender and Ethnicity/Gender. These provide a picture of how target populations of consumers access DPBH behavioral healthcare system and help identify underserved groups in need of outreach. The following is a narrative summation of what the cross-tabulation analysis reveal. All charts associated with the analysis can be found in the Appendix of this report.

Race/Age

Cross-tabulations reveal that in most categories there is little difference between when White, African American/Black, and American Indians/Alaska Native DPBH consumers access services based on age. Approximately 15-19% of the behavioral health consumer base between these three racial groups access services prior to the age of 18. Approximately 9-12% access services in early adulthood, between the ages of 18-24. The largest age range of consumers makes up the two age categories 25-44 (36-37%) and 45-64 (32-38%). A very small portion of the population age 65 and over are accessing care at all, accounting for just 1-2% of the total service population.

Cross-tabulations of race and age demographics reveal the following variances within particular racial groups:

- Asian consumers tend to access the bulk of services between the ages of 25-44, accounting for 49% of the consumer base within that racial category. Additionally, this population has a very low percentage (10%) of consumers accessing services prior to the age of 18.
- Native Hawaiian/Other Pacific Islander consumers have the largest percentage of all racial groups accessing services prior to the age of 18, with 29% of their consumer base within this age category. 11% of their consumer base is between the ages of 18-24, and 42% is between the ages of 25-44. This racial group has the smallest population of consumers within the 45-64 age range, making up just 18% of the consumer base within their racial category.

Ethnicity/Age

26% of the Hispanic DPBH consumer base access services prior to the age of 18. Only 12% access services in early adulthood, between the ages of 18-24, while 38% access services between the ages of 25-44. Hispanic consumers between the ages of 45-64 make

up 23% of their consumer population, and only 1% of their consumer base is over the age of 65.

Race & Ethnicity/Gender

Cross-tabulations of race/ethnicity and gender demographics reveal the following variances within particular groups:

- African American/Black DPBH consumers are the only racial group in which men access services more frequently than their female counterparts.
- Hispanic DPBH consumers access services equally amongst gender categories, with both men and women each accounting for 50% of consumers within their ethnic category.

Gaps Analysis

This section compares information about the prevalence of serious emotional disturbance (SED) among children, and any mental illness (AMI) and serious mental illness (SMI) among adults against the numbers of individuals currently being served by DPBH to develop an approximation of unmet need. Additionally, results of a survey which aimed to identify how people access services, their satisfaction with services received and identification of gaps in the service delivery model is presented.

This information helps define **what** gaps exist in the public mental health system. The situational analysis component of this report will seek to explain **why** these gaps exist.

Estimated Unmet Need

A multi-step formula was used to establish an estimate of unmet need related to behavioral health services.

Step 1: To identify the population in Nevada that need behavioral health support and are eligible to receive it through public provisions, the following formula was used:

(2010 CENSUS DATA **X** % OF POPULATION ELIGIBLE FOR MEDICAID IN NEVADA) **X** ESTIMATED % OF PEOPLE CONSIDERED SED/AMI/SMI **=** PEOPLE IN NEVADA NEEDING **AND** ELIGIBLE FOR PUBLIC MENTAL HEALTH SERVICES

This component of the analysis took into consideration the following:

- 2010 Census Data: Population statistics were taken from the 2010 US Census data.
- Percentage of Population Eligible for Medicaid in Nevada:
    - Estimated Medicaid eligible population of children: The estimated Medicaid eligible population for children was taken from the, "Medicaid Facts Sheet for Nevada – September 2012," produced by the American Academy of Pediatrics in conjunction with the Children's Hospital Association.
    - Estimated Medicaid eligible population of adults: The US average of the Medicaid enrollees (16%) was applied to population statistics to determine the Medicaid eligible population. This information comes from a memorandum by the Public Consulting Group (PCG) to the State of Nevada Department of Health and Human Services titled: "An Overview of Nevada's Publicly-Subsidized Health Coverage Programs," produced on August 4, 2011.
- Percentage of People Suffering from SED/AMI/SMI:
    - SED prevalence rate: Estimates of the number of children suffering from serious emotional disturbances (SED) vary widely. A 5% prevalence rate was used for the purpose of this analysis based on an expanded literature review conducted by Brauner and Stephens in their article, "Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorders: Challenges and Recommendations." In this article, the authors provided a range of 5% to 26% based on their review of 10 studies conducted around the issue (Brauner & Stephens, 2006). The 5% prevalence rate is also referenced in the MHDS Needs Assessment 2012 Report (pg. 55).
    - AMI/SMI prevalence rates: Estimated prevalence rates for adults suffering from any mental illness (AMI) or severe mental illness (SMI) were taken from the, "State Estimates of Substance Use and Mental Disorders from the 2009-2010 US Surveys on Drug Use and Health Report," produced by the US Department of Health and Human Services, Substance Abuse and Mental

Health Services Administration, Center for Behavioral Health Statistics and Quality (Services S. A., 2012).

Step 2: To identify the unmet need of people in Nevada that required behavioral health services and were eligible to receive them through public provision, yet did not, the following formula was used:

PEOPLE IN NEVADA NEEDING **AND** ELIGIBLE FOR PUBLIC BEHAVIORAL HEALTH SERVICES **−** NUMBER OF PEOPLE WHO ACCESSED PUBLIC BEHAVIORAL HEALTH SERVICES **=** PEOPLE IN NEVADA NEEDING **AND** ELIGIBLE FOR PUBLIC BEHAVIORAL HEALTH SERVICES BUT NOT RECEIVING THEM FROM DPBH (POTENTIAL UNMET NEED)

This component of the analysis took into consideration the following:

- DPBH (known as MHDS during the time of data collection) Service Utilization Statistics: This information was obtained directly from Division staff.
- DCFS Service Utilization Statistics: This information was taken from DCFS Descriptive Summary of Children's Mental Health Services – Fiscal Year 2012 (Services, 2012).

Information that was not available for inclusion:

- Information that was not available for inclusion in this analysis was service utilization statistics for Medicaid recipients who accessed behavioral health care through non DPBH providers. Had this information been available, it would have been included in the total number of people who accessed public behavioral health services, and thus would have inevitably lowered the number that is represented as unmet need.

Estimated Unmet Need for Children Requiring Behavioral Health 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 DPBH is responsible for providing services in the rural areas of the state.

In Fiscal Year (FY) 2011-2012, there were a total of 12,399 children in the state that were Medicaid eligible and estimated to have a serious emotional disturbance (SED). Of that total, the state provided services to 3,989 in FY 2011-12, representing 32% of the estimated need.

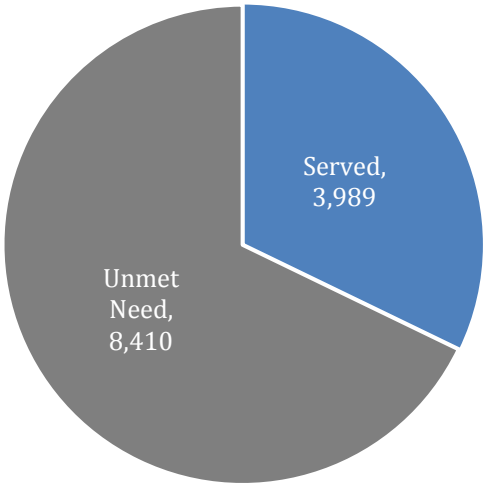


Figure 19: Children Served by State vs. Unmet Need in Nevada

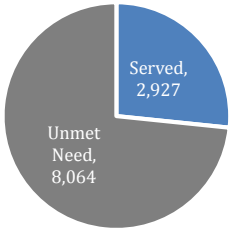


Figure 20: Children served by DCFS vs. Unmet Need

DCFS's service population totaled 10,991, of which 2,927 were served, representing approximately 27% of the estimated need.

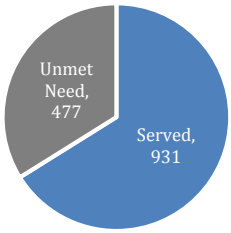


Figure 21: Children served by DPBH vs. Unmet Need

DPBH's service population totaled 1,408, of which 931 were served, representing approximately 66% of the estimated need. A total of 477 (34%) children were estimated to be in need of but not receiving services in FY 2011-12.

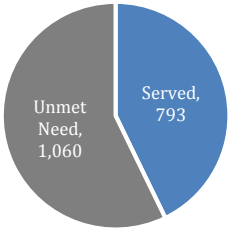


Figure 22: Children Served vs. Unmet Need in Washoe County

Urban North

When considering the urban part of northern Nevada alone, considered to be Washoe County, the total service population is estimated to be 1,853. Of that, DCFS provided services to 793 in FY 2011-12, or 43% of those in need.

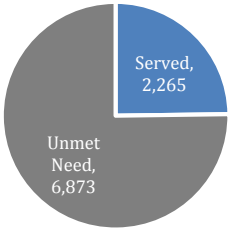


Figure 23: Children Served vs. Unmet Need in Clark County

Urban South

In urban southern Nevada, considered to be Clark County, the total service population is estimated to be 9,138. Of that, DCFS provided services to 2,265 in FY 2011-12, representing 25% of children estimated to be in need.

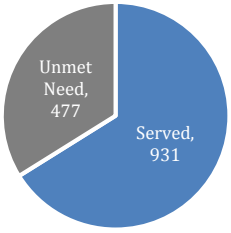


Figure 24: Children Served vs. Unmet Need in Rural Nevada

Rural

For all counties except Washoe and Clark, the total service population is estimated to be 1,408. Of that, DPBH provided services to 931 in FY 2011-12 or 66% of children estimated to be in need.

Combined, 8,410 children were estimated to need but not receive services in FY 2011-12. The tables that follow provide detail on those numbers.

Children's Mental Health Prevalence, Utilization and Unmet Need

Region/County	2010 Census Data (Age 0-17)[12]	Medicaid Eligible Population (37.36%)[13]	Medicaid Eligible SED Population (based on 5% Prevalence Rate)[14]	Total Served by State DCFS[15]	Total Served by State MH Authority[16]	Total Child Medicaid Recipients served by Non-DPBH Provider	Total Children Served Statewide	Estimated Unserved Medicaid Eligible Population
Rural and Frontier								
Churchill	6,128	2,289	114	0	75	Unknown	75	**39**
Douglas	9,128	3,410	171	0	84	Unknown	84	**87**
Elko	14,306	5,345	267	0	123	Unknown	123	**144**
Esmeralda	144	54	3	0		Unknown	0	**3**
Eureka	475	177	9	0		Unknown	0	**9**
Humboldt	4,522	1,689	84	0	102	Unknown	102	**-18**
Lander	1,573	588	29	0	31	Unknown	31	**-2**
Lincoln	1,336	499	25	0	18	Unknown	18	**7**
Lyon	12,524	4,679	234	0	191	Unknown	191	**43**
Mineral	842	315	16	0	16	Unknown	16	**0**
Nye	8,622	3,221	161	0	45	Unknown	45	**116**
Pershing	1,247	466	23	0	25	Unknown	25	**-2**
Storey	631	236	12	0		Unknown	0	**12**
White Pine	2,170	811	41	0	81	Unknown	81	**-40**
Carson City	11,741	4,386	219	0	140	Unknown	140	**79**
Regional Subtotal	75,389	28,165	1,408	0	931	Unknown	931	**477**
Northern								
Washoe	99,179	37,053	1,853	793	0	Unknown	793	**1,060**
Northern Subtotal	99,179	37,053	1,853	793	0	Unknown	793	**1,060**
Southern								
Clark County	489,207	182,768	9,138	2,134	131	Unknown	2,265	**6,873**
Southern Subtotal	489,207	182,768	9,138	2,134	131	Unknown	2,265	**6,873**
Nevada - Total	**663,775**	**247,986**	**12,399**	**2,927**	**1,062**	Unknown	**3,989**	**8,410**

12 Population statistics were taken from the *Nevada Rural and Frontier Health Data Book – 2013 Edition* using the 2010 Census data.

13 The estimated Medicaid eligible population for children was determined by statistics provided in the Medicaid Facts Sheet for Nevada – September 2012, produced by the American Academy of Pediatrics in conjunction with the Children's Hospital Association.

14 5% prevalence rate identified by Brauner and Stephens in their article: Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorders: Challenges and Recommendations Public Health Reports, Volume 121, pp 301-310. That 5% was applied to the Medicaid eligible population statistic to identify the consumer base for State Behavioral Health Services.

15 Utilization data was taken from the Division of Child and Family Services: Descriptive Summary of Children's Mental Health Services Fiscal Year 2012 Report.

16 Utilization data was provided by Sean Dodge, Psy.D., Lead Clinical Psychologist for Public and Behavioral Health Rural Counseling and Supportive Services. The data represents utilization for FY 2011-12.

Estimated Unmet Need for Adults Requiring Behavioral Health Care

Public behavioral health services to adults, age 18 and over, are provided through the following service agencies:

- Northern Nevada Adult Mental Health Services (NNAMHS)
- Southern Nevada Adult Mental Health Services (SNAMHS)
- Rural Counseling and Supportive Services (RCSS) sites

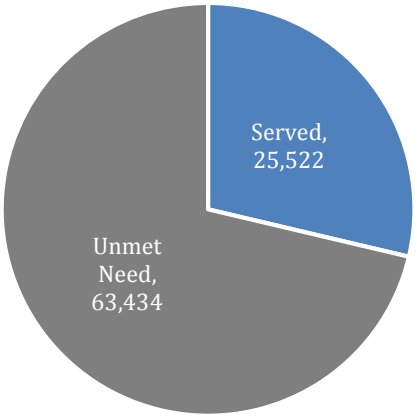


Figure 25: Adults Served by DPBH vs. Unmet Need in Nevada

There are a total of 88,956 adults in the state of Nevada that are Medicaid eligible and are considered to have any mental illness or a severe mental illness. This is considered the service population that DPBH is responsible to serve. Of that total, DPBH provided services to 25,522 in FY 2011-12, representing 29% of the total of those estimated to be in need. Over 60,000 adults were estimated to be in need, but it is unknown what number received services in FY 2011-12. The tables that follow provide detail on those numbers.

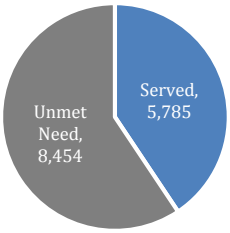


Figure 26: **Adults Served vs. Unmet Need in Washoe County**

Urban North

When considering the urban part of northern Nevada, Washoe County, the estimated total adults in need were 14,239. DPBH provided services to 5,785 adults in need in FY 2011-12, or 41% of those estimated to be in need.

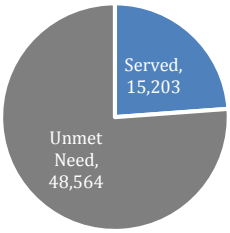


Figure 27: **Adults Served vs. Unmet Need in Clark County**

Urban South

When considering the urban part of southern Nevada, considered to be Clark County, the adult population in need was estimated to be 63,767. Of that total, DPBH provided services to 15,203 adults in FY 2011-12, representing 24% of the total estimated to be in need.

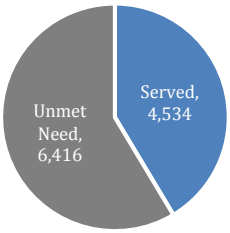


Figure 28: **Adults Served vs. Unmet Need in Rural Nevada**

Rural

For rural Nevada, considered to be all counties except Washoe County and Clark County, the estimated adult population in need for FY 2011-12 was 10,950. DPBH provided services to 4,534, representing 41% of adults in need.

Adult Mental Health Prevalence, Utilization and Unmet Need

Region/County	2010 Census Data[17] 18-64	65+	Medicaid Eligible Population (16%)[18]	SMI Population (based on 5.29% Prevalence Rate)[19]	AMI Population (based on 21.96% Prevalence Rate)	Total Adults Served by State MH Authority[20]	Total Adult Medicaid Recipients served by Non-DPBH Provider	Potential Unserved Population (SMI/AMI)
Rural and Frontier								
Churchill	14,652	3,742	2,943	156	646	**449**	Unknown	**353**
Douglas	27,877	9,323	5,952	315	1,307	**486**	Unknown	**1,136**
Elko	30,886	4,072	5,593	296	1,228	**487**	Unknown	**1,037**
Esmeralda	428	195	100	5	22	**0**	Unknown	**27**
Eureka	1,239	222	234	12	51	**0**	Unknown	**64**
Humboldt	10,489	2,079	2,011	106	442	**421**	Unknown	**127**
Lander	3,570	623	671	35	147	**121**	Unknown	**62**
Lincoln	2,982	1,367	696	37	153	**59**	Unknown	**131**
Lyon	30,477	8,081	6,169	326	1,355	**778**	Unknown	**903**
Mineral	2,708	1,008	595	31	131	**104**	Unknown	**58**
Nye	24,045	11,143	5,630	298	1,236	**606**	Unknown	**928**
Pershing	4,528	729	841	44	185	**78**	Unknown	**151**
Storey	2,494	671	506	27	111	**0**	Unknown	**138**
White Pine	6,398	1,442	1,254	66	275	**245**	Unknown	**97**
Carson City	34,261	9,415	6,988	370	1,535	**700**	Unknown	**1,204**
Regional Subtotal	197,034	54,112	40,183	2,126	8,824	**4,534**	Unknown	**6,416**
Northern								
Washoe	273,032	53,550	52,253	2,764	11,475	**5,785**	Unknown	**8,454**
Northern Subtotal	273,032	53,550	52,253	2,764	11,475	**5,785**	Unknown	**8,454**
Southern								
Clark County	1,250,003	212,545	234,008	12,379	51,388	**15,203**	Unknown	**48,564**
Southern Subtotal	1,250,003	212,545	234,008	12,379	51,388	**15,203**	Unknown	**48,564**
Nevada - Total	**1,720,069**	**320,207**	**326,444**	**107,931**	**448,045**	**25,522**	**Unknown**	**63,434**

17 Population statistics were taken from the *Nevada Rural and Frontier Health Data Book – 2013 Edition* using the 2010 Census data.

18 16% Medicaid Eligible statistic was identified in a memo produced by Public Consulting Firm PCG to the State of Nevada Department of Health and Human Services titled: An Overview of Nevada's Publicly-Subsidized Health Coverage Programs produced on August 4, 2011.

19 SMI/AMI Prevalence determined by the US Survey on Drug Use and Health (NSDUH) available at: http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsae2010/NSDUHsaeCh6-2010.htm

20 Utilization data was provided by Sean Dodge, Psy.D., Lead Clinical Psychologist for Public and Behavioral Health Rural Counseling and Supportive Services. The data represents utilization for FY 2011-12.

Consumer Surveys

Surveys were distributed throughout the state to social service providers that did not provide behavioral health services. Providers included food pantries, family resource centers and health and human service organizations. A total of 339 individuals completed the survey. The demographics of the survey respondents are found in the following tables.

Gender (n=334)	Number	Percent
Male	185	55.4%
Female	149	44.6%

Figure 29: Consumer Survey Gender Breakout

More males filled out the survey compared to females with 185 men (55.4%) and 149 women (44.6%).

Age (n=333)	Number	Percent
0-12	0	0.0%
13-17	2	0.6%
18-20	5	1.5%
21-24	11	3.3%
25-44	98	29.4%
45-64	124	37.2%
65-74	39	11.7%
75+	54	16.2%

Figure 30: Consumer Survey Age Breakout

The majority of respondents were adults between the ages of 25 to 64 (222 of 333 or 66.6%). This corresponds with the ages of persons most frequently served by DPBH. Two respondents were under the age of 18 (0.6%) and 16 were young adults between the ages of 18 and 24 (4.8%). There were 93 respondents over the age of 65 (27.9%).

Race/Ethnicity (n=331)	Number	Percent
White	225	68.0%
Hispanic	33	10.0%
Black/African American	40	12.1%
American Indian/Alaskan	10	3.0%

Race/Ethnicity (n=331)	Number	Percent
Pacific Islander	3	0.9%
Asian	7	2.1%
Mixed Race	13	3.9%

Figure 31: Consumer Survey Race/Ethnicity Breakout

Out of 331 survey respondents who indicated race, 225 were White (68%) while the most underrepresented were Pacific Islanders with three respondents or 0.9%. African American/ Black respondents made up 12.1% of the survey respondents (40 of 331) while Hispanics represented 10% (33). American Indian/Alaska, Pacific Islander, Asian, and Mixed Race made up 10% or 33 of the surveys.

County (n=330)	Number	Percent
Carson City	13	3.9%
Churchill	15	4.5%
Clark	104	31.5%
Douglas	0	0.0%
Elko	2	0.7%
Esmeralda	0	0.0%
Eureka	0	0.0%
Humboldt	0	0.0%
Lander	0	0.0%
Lincoln	0	0.0%
Lyon	12	3.6%
Mineral	0	0.0%
Nye	0	0.0%
Pershing	0	0.0%
Storey	2	0.6%
Washoe	182	55.2%
White Pine	0	0.0%

Figure 32: Consumer Survey Region Breakout

The majority of survey respondents were from Washoe or Clark County with 182 of 330 from Washoe (55.2%) and 104 from Clark (31.5%). Forty-four respondents were from Carson City, Churchill, Elko, Lyon, or Storey Counties (13.3%). Douglas, Esmeralda,

Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, and White Pine Counties did not return any surveys.

Types of Services Used	Yes	Percentage Yes	No	Percentage No
Inpatient Care -- Hospitalization	80	27.8%	208	72.2%
Outpatient Care -- Community-Based Services	97	35.1%	179	64.9%
Psychiatry -- Access to a Therapist	77	27.6%	202	72.4%
Medication Management -- Use of Prescription Psychotropics	70	25.6%	203	74.4%
Support Group Participation	57	21.3%	210	78.7%
Dual Diagnosis Services	41	15.6%	221	84.4%
Case Management -- Support services to help with ancillary needs (goals establishment linkage to other services, etc.)	71	26.7%	195	73.3%

Figure 33: Consumer Survey - Services Used

Question six on the survey asked respondents if they have used any of the listed services. A majority of the services were not utilized by the respondents while the most utilized service was Outpatient Care with 35.1% or 97 respondents. The least utilized was Dual Diagnosis Services with 41 or 15.6% of respondents indicating they had used that service.

Degree to Which their Need Was Met	Always met my needs	Usually met my needs	Sometimes met my needs	Never met my needs
Inpatient Care -- Hospitalization (n=60)	46.7%	18.3%	26.7%	8.3%
Outpatient Care -- Community-Based Services (n=69)	33.3%	29.0%	29.0%	8.7%
Psychiatry -- Access to a Therapist (n=55)	30.9%	18.2%	32.7%	18.2%
Medication Management -- Use of Prescription Psychotropics (n=57)	45.6%	19.3%	17.5%	17.5%
Support Group Participation (n=40)	32.5%	32.5%	20.0%	15.0%
Dual Diagnosis Services (n=24)	50.0%	4.2%	12.5%	33.3%

Case Management -- Support services to help with ancillary needs (goals establishment linkage to other services, etc.) (n=48)	33.3%	29.2%	22.9%	14.6%

Figure 34: Consumer Survey - Needs Met

For those who had received services, respondents were asked to indicate the degree to which their needs were met. No clear patterns of satisfaction in having needs met were evident, but Inpatient Care, Medication Management, and Dual Diagnosis Services rated the highest in needs met. At the same time, Dual Diagnosis Services also rated the highest in never having needs met. More than half of those respondents who answered the question indicated "always" or "usually" to indicate the services met their needs. Psychiatry or access to a therapist was the lone exception with more than 50% indicating the service never or sometimes met their needs.

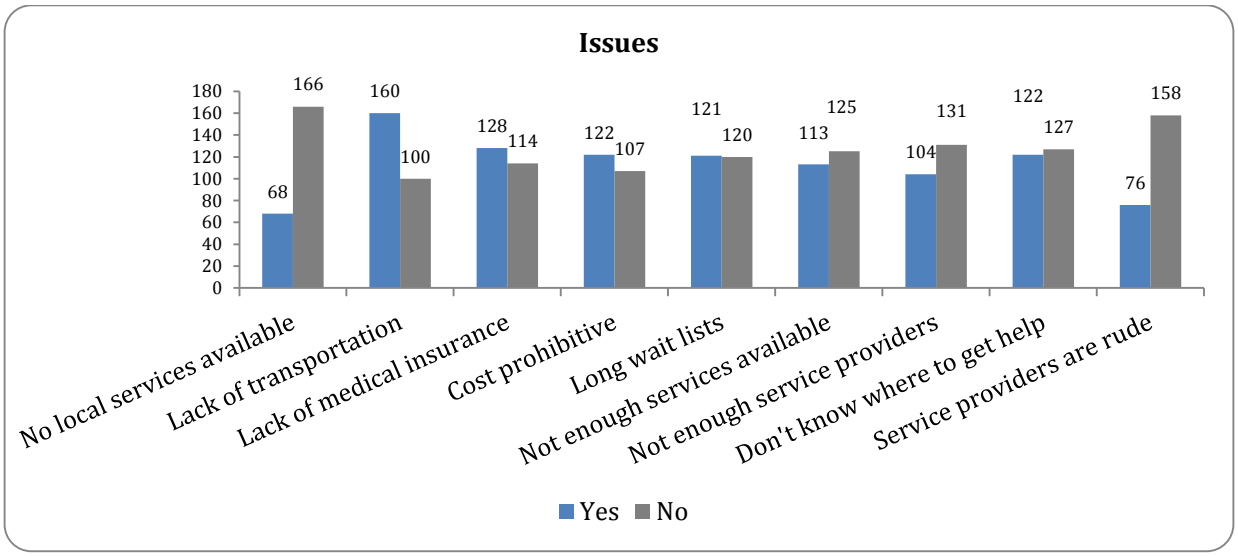


Figure 35: List of Issues

Respondents were given a list and asked to indicate whether the issue was a concern or barrier for them. Lack of transportation received the highest number of responses (160). Lack of medical insurance, costs of services, long waiting lists and not knowing where to get help were also rated as high concerns. In addition, not enough services available and not enough service providers each were cited by more than 100 respondents as a concern.

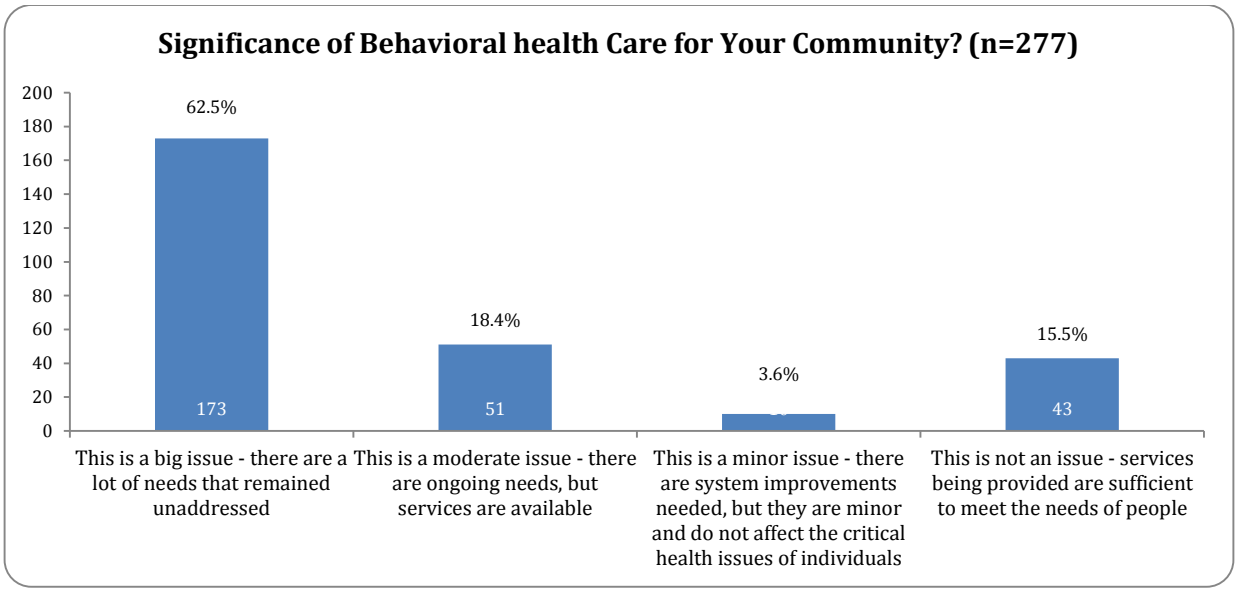


Figure 36: Significance of Behavioral Health Care for Your Community

62% of those who responded indicated that behavioral health concerns were a big issue in their community with a lot of needs that remain unaddressed.

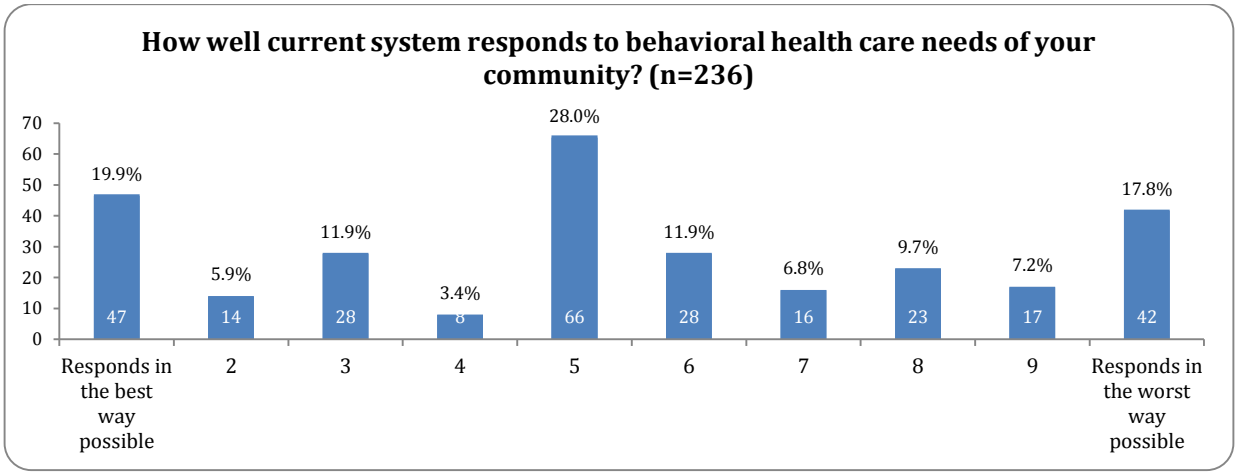


Figure 37: Response to Behavioral Health Care Needs

Respondents varied in how well they rated the current system in responding to the behavioral health care needs of the community.

Respondents were asked to list other issues they felt were important to understand. From the open-ended responses, the following issues were listed most frequently.

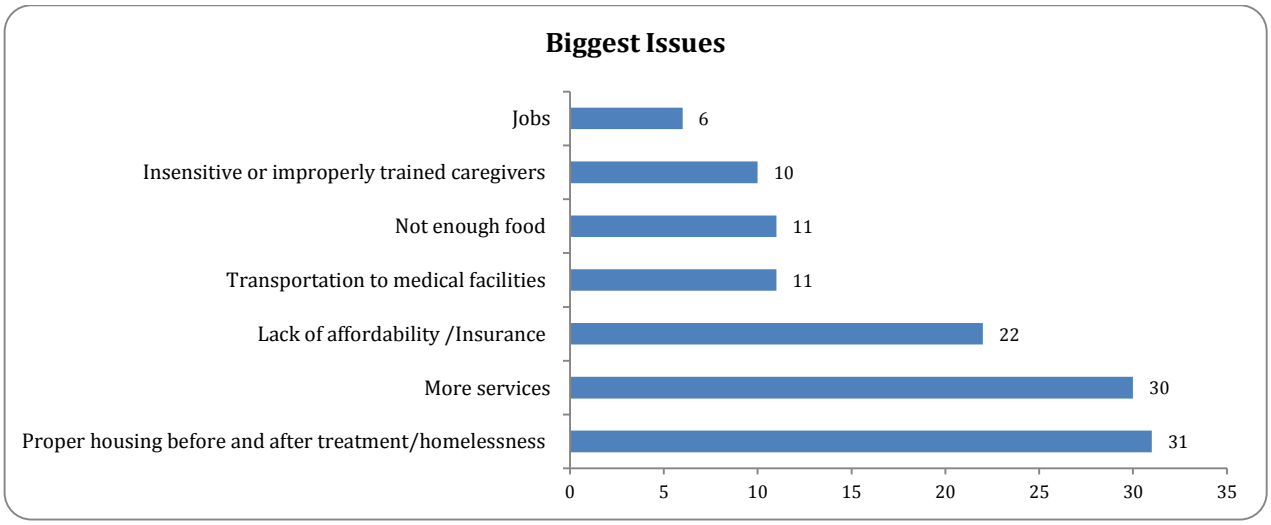


Figure 38: Biggest Issues

The surveys received from Nevadans validate that housing, lack of services, lack of providers, and transportation for access to services are the biggest challenges they face. They also show that people view behavioral health concerns as a large problem in their communities and they don't feel the problem is being addressed. When they were the recipient of services, they indicated that services met their needs, with the exception of access to psychiatry or a therapist. This is supported by the key informant results found in the next section.

Summary

The profile of behavioral health consumers in Nevada, where they are served, and trends of service penetration, when compared to national averages, indicate that Nevada's current system and approach to providing behavioral health services does not meet the needs of Nevadans, with a pronounced deficiency in Southern Nevada. Nevadans of all ages, both genders, and all racial and ethnic considerations are underserved. It is estimated that over 8,000 children and more than 60,000 adults in Nevada need but are not able to receive behavioral health care.

Data indicates:

- Services are currently reaching people in their middle stages of life, with insufficient resources for prevention or early intervention. "Intervening at the first sign of symptoms offers the best opportunity to make a significant, positive difference in both immediate and long-term outcomes for people affected by mental health issues."[21] As such, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has designated prevention as their first strategic priority (Steve Vetzner, 2013).
- Services are not sufficient to meet the needs of people later in life. Attention should be paid to identifying and engaging older Nevadans who require behavioral support services. Older adults require different treatment responses and supports such as transportation, home-based treatment options, and specialized outreach efforts (Services W. S., 2013).
- A culturally competent framework to provide services to Nevada's growing minority population is needed.
    - Particular interest should be paid to the over-representation of African-American males in the service system, exploring the link between this dynamic and their over-representation in the criminal justice system. As identified in the report: "Prevalence of Mental Illness in the Criminal Justice System", "mentally ill individuals of African American origin were over-represented among the CCDC detainees with mental illness while all other racial/ethnic minorities were underrepresented. The rate of detained African Americans with mental illness was 20.8% at CCDC in 2011, which significantly exceeded their overall rate of less than 11% among the residents of Clark County."
    - Hispanics/Latinos are significantly underrepresented in service delivery. Attention should be paid to how to reach this population.
- Insufficient penetration is most pronounced in the southern region of the state, as indicated by statistics that reveal only 24% of people eligible and needing assistance are being served. Identifying the differences between the regions in service populations, resources, and service deployment is critical for understanding and addressing this reality.

[21] Retrieved from: http://www.sfgate.com/opinion/openforum/article/Mental-health-prevention-a-wise-investment-4028399.php

Situational Assessment

With a clear understanding of **what** gaps exist within the behavioral health system of care, a situational assessment was conducted to explore **why** the gaps exist and to identify opportunities to leverage existing strengths within the system. The following section provides a situational assessment using the strengths, weaknesses, opportunities and threats (SWOT) method. This is followed by a summary of the findings related to that assessment. Throughout this entire section of the report, the analysis is largely shared in the words of key informants.

SWOT Analysis

The SWOT method of analysis identified the following aspects affecting the Division:

- Strengths: the assets, resources, or capabilities that have the greatest positive impact on the success of the organization and its ability to achieve its mission.
- Weaknesses: the aspects of the organization that are considered to be important internal weaknesses– deficiencies in resource or capabilities, or other liabilities, that hinder the ability of the organization to achieve its mission.

- Opportunities: the external factors that offer a genuine opportunity to benefit the organization. This may include environmental factors that allow the organization to expand its services, or apply its capabilities to benefit a different part of the community.
- Threats: the external conditions, trends, and other forces that are at least moderately likely to hurt the organization in some manner if not addressed.

Information was compiled by qualitative data collection methods and themes were identified. The areas noted by multiple stakeholders as strengths, weaknesses, opportunities or threats are highlighted under the appropriate area below.

Strengths

Innovative Practices

Research and key informants indicate there are a number of innovative practices that are occurring at varying stages across the state. Some projects cited by key informant include, "the Health Home Pilot Project, the Community Health Worker Program, Project Echo, Community Triage Centers and WHAM[22] to name a few." There are a subset of practices that have had a measurable impact on mental health services and should be understood as they present opportunities for state-wide implementation. Each of the following was identified as system strengths by a number of key informants. Descriptions of services were obtained from public sources.

Mental Health Court

Mental Health Court is a collaborative effort between DPBH and the criminal justice system. This program provides the opportunity for people with misdemeanor and minor felony criminal charges who would benefit from psychiatric treatment to be diverted from the standard criminal justice system if they participate in treatment. It is a service coordination model with a caseload of 25 consumers per coordinator, ensuring

[22] WHAM stands for Whole Health Action Management (WHAM), the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) new peer support curriculum. According to SAMHSA, WHAM is designed to train "peers teaching skills to better self-manage chronic physical health conditions and mental illnesses and addictions to achieve whole health and resiliency."

consumers obtain benefits, comply with court ordered treatment, medication and substance abuse recovery.

Mobile Crisis Team (MCT) in Las Vegas at SNAMHS

This specialized unit works with Las Vegas area hospital emergency departments. The Team is comprised of Licensed Clinical Social Workers (LCSWs) who travel to local emergency rooms to evaluate patients on involuntary holds and, when feasible, develop safe discharge plans to allow the ER to discharge the person back to the community. This service averts unnecessary psychiatric hospitalizations, saves ER personnel time and reduces the numbers of psychiatric patients in the ER.

Mobile Outreach Safety Team (MOST) at NNAMHS

This is a specialized program, staffed with two Licensed Clinical Social Workers (LCSWs, in collaboration with local law enforcement agencies (Reno, Sparks, Washoe County) to offer psychiatric services to the homeless mentally ill and those with mental illness who bring themselves to the attention of law enforcement. This helps prevent increasing numbers of persons with mental illnesses from being incarcerated and assists with enrolling them in appropriate services. Also noted was the "Crossroads Program," which provides long-term housing and support for persons considered, "frequent flyers" that are identified by the MOST team.

Project for Assistance in Transition from Homelessness (PATH)

This program targets homeless, or those at risk of becoming homeless. Individuals access mental health services, apply for housing assistance, and/or maintain current housing. This program is funded through a grant from SAMHSA. DPBH contracts with three private providers throughout the state to meet the program objectives.

Telemedicine Services

Teleconferencing therapy, psychiatric consults and medication management at RCSS have been implemented since 2011, to better serve people in frontier and rural Nevada who have limited access to services and face transportation barriers. This pilot project included purchasing and installing equipment in remote locations and hospitals across Nevada to connect consumers to providers. One key informant described equipment placed at China Springs. "Now we don't need to discharge children with mental health issues as they can have psychiatric care there and their families can come see them."

Evidence-based Practices

DPBH has implemented the Program for Assertive Community Treatment (PACT) in northern and southern Nevada that provides intensive support to people with mental illness who have a history of high use of emergency, hospital and law enforcement services. The teams work in an interdisciplinary manner to support consumers living in the community, adherence to their medication regime and employment rehabilitation. Key informants noted repeatedly the implementation of evidence-based practices within DPBH as a strength.

DCFS currently implements the following best practice approaches in their deployment of behavioral health services to children and adolescents:

- Trauma-Focused Cognitive Behavioral Therapy
- Parent-Child Interaction Therapy
- Motivational Interviewing
- Dialectical Behavior Therapy
- Aggression Replacement Training
- Positive Behavioral Supports
- Wraparound

Resource Development

Leadership has charged the staff of DPBH with securing grants for additional resources. They have supported grant writing training for staff to better position the Division to secure new sources of funding. One state employee noted, "We have written more grants in the last 60 days than I can remember in the past 10 years."

These efforts have financially strengthened the system. Nevada recently received notice that the state is likely to be awarded a new Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant, which will include capacity building and supports including treatment for homeless individuals. The state was awarded an expansion of the Maternal, Infant and Early Childhood Home Visiting Program grant, which provides prevention and early intervention services to at risk families. In addition, the state received a technical assistance award to implement a PEER counseling project. These projects help augment the system of care currently in place. The state is also awaiting word on other grants submitted.

Additional revenue development activities have centered on how to draw down additional federal funding for existing services rendered. Staff at SAPTA-funded programs have been trained on how to bill Medicaid to increase reimbursement for services.

New funding was approved during the 2013 legislative session and the Interim Finance Committee to expand or reconfigure existing services to include:

- 11 new full time positions and 12 new contract positions for SNAMHS
- SNAMHS renovation of building 3A for 21 Civil Psychiatric beds
- 5 new comfort rooms at Rawson-Neal
- SNAMHS Drop-In Center opened September 23rd
- 42 forensic beds and 16 civil beds in building 3 at SNAMHS
- 20 new full time positions at Lake's Crossing
- 10 new Forensic Psych beds at Lake's Crossing
- New Behavioral Health Center opened July 2013; expanded hours pending staff coverage

Quality of Care

Key informants noted that the following enhance the quality of services provided:

- "The state formulary provides good coverage for services/medications."
- "Outpatient and group services are delivered well by qualified staff."
- "System of care principles and values are embraced by system partners that serve children.
- "Staff of DPBH are passionate, dedicated and talented."
- "Use of evidence-based practices," within DPBH was also acknowledged by key informants.

Regardless of region, key informants indicated that,

- "State behavioral health staff reach out to homeless shelters, jails, social services, any place where mentally ill people are,"
- "This is more effective than when the client has to go to the state to access services."
- There is acknowledgement that, "this has happened much more frequently lately," with the state acting in a, "flexible," "nimble way," to reduce barriers to services.

- The Division has, "a good training series that orients staff" to evidence-based services.
- One key informant noted that, "therapists are unbelievably good." and
- "Medications are good." and
- "Use of state of the art evidence-based practices, are in place."

Statewide Collaboration

Parts of the system in northern and southern Nevada were described as:

- [Its] "Working much better these days between jail, cop on the street, public defender and court."
- "There is good cooperation with the pharmacy board."
- "Parole and probation are much more collaborative now. "

Weaknesses/Gaps

Key informants identified a number of weaknesses that need to be addressed to strengthen the system.

Workforce

Key informants noted that there, "are not sufficient staff resources." "Psychiatrists are difficult to recruit and retain and quality psychiatrists even more difficult."

- "Morale" at DPBH has been impacted by the continual, "flood of surveyors, inspectors, reporters and requests for public information."
- "The volume of consumers in southern Nevada means training is less of a priority than in other parts of the state because of the size of caseloads and the backlog in paperwork."
- In addition, "compensation" and
- The "credibility of the system" were both cited as barriers to recruiting a highly qualified workforce to fill positions.
- Psychiatric coverage was described as "spotty" throughout the state. "There are some areas with no psychiatrists at all."

- "Child psychiatrists" were also identified as a gap by key informants.
- The rural telemedicine mental health project was seen as, "a strength" but key informants noted that, "psychiatrists often combat burnout by feeling satisfaction in patients outcomes but, the program is structured to use psychiatrists for consults but transfer the case to Rural Clinics which is frustrating for the psychiatrists participating in the program."

This perspective is supported by statistics derived from the, "Nevada Rural and Frontier Health Data Book - 2013 Edition," which depicts every county in Nevada, with the exception of Clark, having a shortage of mental health professionals (pg.177-179).

Provider Network

Nevada's system of community-based providers is, "actually weaker than it was prior to the recession." Key informants noted that,

- "A number of nonprofits have ceased operation" and/or, "eliminated essential community services."
- The "private mental health provider community hasn't evolved like other states" because of the state operated system.
- So, community-based clinics and services, "haven't emerged to extend the safety net" of services.
- Formal systems, "aren't in place to ensure reliability of practice" across the continuum of services.
- "Referral relationships are dependent on knowing the right person to reach, reaching them and hoping they have a resource."

Resources

Key informants noted a lack of capacity and long waiting lists for all services across the system of care including:

Outpatient Services

- "Individual counseling" is a gap because, "A lot of folks [clinicians] don't believe in individual therapy."
- "Long term safe, outpatient civil commitment with wrap around services."
- "Outpatient for those who don't need the same level of support."
- "Peer support groups"
- "Youth and transgender options"

Inpatient Services

- "Forensic inpatient beds for those who have not been deemed competent."
- Residential services for:
  - Co-occurring disorder services
  - Mental health and substance abuse services for juveniles
  - Substance abuse treatment beds statewide
- In southern Nevada, "people are sent to the emergency room for medical clearance before they can be admitted to the hospital, rather than clearing them medically at Rawson-Neal."
- As stated earlier in this report, there are primary, secondary, and linkage agencies that play a role in the deployment of behavioral health care. Some of those partners, outside of the state operated system pose challenges to the system. For example, in northern Nevada, there were a number of stories of persons who "were a danger to themselves or others, picked up by the police, taken for a 72-hour hold and then discharged when they clearly weren't safe to return home."[23]
- Even the most sophisticated service providers describe the, "impossibility of getting an involuntary commitment in northern Nevada."

> *"Nevada currently has one of the most restrictive civil commitment laws in the country. The state forces individuals to deteriorate to the point of dangerousness before help can be provided. In Nevada, there are almost ten seriously mentally ill persons in jails and prisons for every one person in a hospital."*
>
> Testimony provided in favor of AB 287, April 8, 2013 by Kristina Ragosta, Esq., Treatment Advocacy Center

Culturally Competent Services

- There were gaps in efficacy of the providers within the state to provide culturally and linguistically appropriate services for special populations with Latinos and transgender individuals identified as two particular populations that are underserved.

Supportive Services

- Transportation was identified as a challenge along the continuum of services.
- "Lack of transportation to access services," coupled with, "costly" transportation options to, "transport persons from rural or southern Nevada to northern Nevada to access Lake's Crossing," which was noted more than once as a weakness.

[23] See section of the report which describes the passage of AB 287, which could help address this issue.

- "There is a lack of supportive housing for those who can't live independently but don't need to be locked up."
- "Affording safety and security with some supervision but without confinement is what is most often needed but lacking."
- "Resources that include some supervision but that are less intensively supervised are needed" at all levels.
- "Housing resources" were identified in all regions as a gap.
- Often, "housing with some level of support or supervision" was identified as a gap. The housing gaps noted include:
    - long term transitional housing,
    - services for persons who are mentally ill and developmentally delayed.
    - resources for persons who are under the age of 60 but experiencing mental illness and dementia
    - violent individuals, including sex offenders
    - persons with co-existing medical and mental health and/or intellectual challenges

Wrap-around Care

- "There is a lack of resources to provide structure for those in need."
- "Most acute cases need support to remember to take medication, to check in, to ensure they are managing finances, that they are connected to supports."
- "For those in mental health court, for a year, they receive intensive support. Once they are discharged, that support often ends."

Competing Priorities

Key informants noted a number of policies have been recently established or modified. Additionally, investigations and information requests have required attention and focus that can at times divert attention from daily responsibilities. Key informants from DPBH noted it is challenging to implement changes:

- "when also responding to investigations, an incessant number of public information requests,"
- "the need to respond to law suits regarding waiting lists" or discharge practices and federal" inspections of its residential mental health facilities."

Opportunities

There are a number of developments in process or planned that provide opportunities to strengthen Nevada's system of care.

Consolidation of Public and Behavioral Health

Consolidation of health, substance abuse and mental health was seen as an opportunity by many key informants:

- "It will integrate public and behavioral health services by leveraging existing capacity." Implementing a patient-centered system of care for prevention, early intervention and access to treatment will greatly strengthen the system of care.
- This provides an opportunity to, "foster collaboration" and,
- "Allow the system to meet the needs" of persons with both behavioral health and/or health problems, including mental illness, substance abuse disorders and chronic diseases, such as hypertension, diabetes and kidney disease.

Under this public health model of delivering behavioral health services, DPBH has the opportunity to focus more on data-driven, population-based needs and service opportunities. Key informants referenced a number of positive changes underway related to the merger. They include:

- "training SAPTA providers to bill Medicaid,"
- "out-posting staff in emergency rooms to provide access to behavioral health assessments,"
- "implementing telemedicine resources and equipment in rural Nevada" to give access to psychiatric consultations therapy and medication management,
- "implementing a system of care including shared policies and procedures Division-wide," and
- "pursuing new grants to bring resources to Nevada" to meet gaps in services.

System of Care

Establishment of and, "consistently applied" statewide systems are planned as of July 1, 2013. In addition, a number of changes can positively impact the system of care:

> *"The Division leadership has a clear vision of the importance of addressing basic needs to have any chance of stabilizing and providing holistic care."*

- "Full implementation of AVATAR," the management information system designed to ensure uniform data collection across the state.
- Statewide policies and procedures for NNAMHS, SNAMHS, and RSCC. "Outpatient mental health services are being standardized across the state."
- "The new outpatient service delivery model is based on overlapping, blending and coordinating efforts with multiple service agencies."
- Implementation of Quality Improvement Programs. A focus on, "meeting accreditation standards is an opportunity statewide" and at the time of investigations had been extended to Lake's Crossing and RCSS.
- Investments are currently being made to expand urgent care and medical clearance practices. In order to more effectively manage the flow of individuals seeking psychiatric services, "SNAMHS facility is co-locating a walk-in clinic to provide medical clearance and behavioral health services."
- "Northern Nevada Adult Mental Health facility is expanding medical clearance hours."
- "The Division is expanding mental health court diversion programs" for consumers in the criminal justice system whose charges are due to their mental illness.
- Nevada may be awarded the Cooperative Agreements to Benefit Homeless Individuals for States (CABHI) grant. The grant will enhance or develop the infrastructure and treatment service system to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services with permanent supportive housing and peer supports to the homeless population.
- The CABHI grant proposal also included funding for a data patch to link data across management information systems (MIS) within DPBH.
- Emergence of Nevada's Green Zone Initiative for veterans was cited by several key informants. Within Nevada's state government, the Green Zone Initiative will provide an interagency approach to veteran education, employment, and wellness benefits. Access to behavioral health services is a key focus of the Initiative.

The Affordable Care Act (ACA)

Key informants noted:

- The ACA could, "save the state substantial General Fund dollars for pharmacy expenditures, outpatient services, and substance abuse prevention and treatment."
- "Medicaid can be billed for more of the services currently provided."
- In addition, there is a greater focus and coverage for prevention and wellness services. However, "the system must meet CMS standards to bill Medicaid" and recent events indicate, "problems in doing so."
- "Certification is the priority."
- The ACA is intended to improve access to quality care and needed health services. "Better access, improved coverage, and support for prevention" all provide an opportunity to, "achieve better health outcomes, higher quality of care, and, critical to the health of Nevadans, a reduction in health disparities."

New Regulations

The passage of AB 287 impacting Nevada's law on Civil Commitments was identified by key informants as a real opportunity. The bill would create a system of "outpatient civil commitment" for mentally ill patients with a history of repeat interactions with law enforcement. It allows judges to consider a doctor's recommendation for treatment and order that offenders be compliant with doctors' orders, which may include medication management.

Threats

Threats are conditions external to DPBH that may impact its ability to achieve its mission. The following threats were identified that pose challenges to the system if not adequately addressed.

Credibility

Given the media attention, the investigations and the problems with data and documentation, key informants noted a number of threats:

- "Loss of accreditation,"
- "Certification,"
- "Media attention," and
- "Ongoing investigations make it difficult to promote positive changes and threaten existing resources. "

> *"Multiple data systems including home grown systems are a problem in quantifying actual need. Everyone has to use the same forms, the same processes, the same criteria and the same data system (Avatar). This has not been the case."*

They also threaten to, "divert the focus of DPBH efforts" on integrating into a public health model, with a comprehensive community-based service delivery system.

Loss of Funding

While additional investments were made during and after the 2013 legislative session, Nevada:

- "Stands to lose millions of dollars in funding" should lawsuits move forward or
- "Medical reimbursements be denied,"
- Inability to bill Medicaid due to the "patient dumping" scandal and the recent audits by CMS is a concern.

Staffing Shortages

Key informants noted that, "many upper level professionals are turning over because of morale, pay, and the current environment."

- The dual pressures of, "providing high quality services while doing so in a more efficient manner" has led to some of the staff turnover.
- Multiple key informants noted turn-over, stating "when staff leaves, it is often difficult to find replacements and positions go unfilled," for extended periods of time.
- As one key informant noted, "state services are so underfunded. How are we going to recruit and retain talent?"

Housing

Housing is considered a critical component that is, "a gap for many" of the DPBH consumers. Key informants noted that,

- "Not in my back yard (NIMBY) syndrome" is a challenge to addressing the housing needs of all types of consumers within the system.

- "Locating a place to provide housing" for vulnerable populations often results in a public outcry within neighborhoods.
- This makes it, "difficult for public officials to approve zoning or permits for group housing options."
- In addition, the oversight of group housing was questioned by several key informants, one described, "Cases of fraud and the inability of the state to invest resources to prevent fraud."

Substance Abuse Services

One key informant raised a number of issues related to, "the provision of substance abuse treatment services," and concerns of how the state may not be doing enough to provide adequate services according to federal regulations.

Other Concerns

Another concern expressed was specific to the merger of mental health and substance abuse services. As one key informant put it:

"Issues have, "been raised repeatedly in open meetings" but have not received the scrutiny of the "patient dumping" crisis. These issues threaten to be the next wave of criticisms to be leveled against the Division".

- "I worry that instead of fully integrating substance abuse and mental health that the good parts of mental health will feel the impact."
- Another asked, "How is integration between substance abuse and mental health going to look or is substance abuse going to be forgotten?"
- Key informants noted that, "there are so many changes happening at lightning speed, something is bound to fail."
- Another stated, "I worry about the Affordable Care Act and its impact on the system when new consumers now have a payer source, are there sufficient providers and how will it impact the Division's bottom line?"

Summary

The key informant interviews indicate a number of strengths, weaknesses, opportunities and threats that DPBH should consider as it plans for the future. The steps taken by DPBH to this point are seen as positive and the leadership and the staff are considered by many to be strengths. The weaknesses identified are known to DPBH and steps have been taken to begin to address the needs. However, without sufficient resources, a true continuum of care that addresses the gaps in services identified by key informants can't be put in place.

One key informant claimed. "While changes are planned, and many changes had been made, the system at this point in time, "is inadequate."

Insufficient System of Care

According to one key informant, Nevada's behavioral health system, "doesn't meet minimum needs. We do what we can but we lack sufficient resources, infrastructure and supports to truly help everyone who needs help."

Key informants note that access to services depends on geographic location and what mental state a person is in when presenting for care. Some described the criminal justice system as, "the main referral source" or portal for accessing the state behavioral health system, saying, "For those who haven't committed a crime, it is difficult to access services." As one key informant put it, "You have to be homicidal, suicidal or out of meds to be seen. The wait list at some clinics is between 60 and 90 days for an appointment. Your only option is to walk in and wait all day."

According to one key informant, "[the system] historically has not focused on prevention or early intervention but on treating those in crisis which is a costly and more harmful approach to care."

Key informants described that some even have a "bad outcome after getting to the right door." One noted that, "the front door is broken." Community-based organizations question whether, "The state people understand how difficult it is to get mental health services." One noted that, "the greatest challenges and variances occur when someone needs hospitalization." Another stated, "There are no resources in rural Nevada and people often end up in the emergency room, in jail, or being transported to Reno in handcuffs, in the back of a squad car, or by helicopter."

"The legislative Interim Finance Committee approved $2.1 million in emergency mental health funding…after spending hours criticizing Nevada's inadequate treatment of mentally ill residents and visitors. Legislators said the state of Nevada's mental health system appears to have reached crisis levels. Failures in the system, they said, have led to overcrowding in emergency rooms, backlogs and delays in jails, loss of accreditation for one major state hospital, difficulties in recruiting quality staff because of pay that's not competitive, and inefficient, expensive practices of moving mentally-ill inmates between Southern and Northern Nevada

Las Vegas Review Journal
August 6, 2013

One key informant said, [In northern Nevada] "even trying to get someone into the hospital that is clearly in need is a challenge."

Another noted, "At NNAMHS, the barriers from the inside are horrendous. One person can erect a barrier, by not asking an evaluation using the right questions." That being said, "The system in Northern Nevada is leaps and bounds ahead of the rest of the state. In southern Nevada, the volume is so much greater, it is constantly crisis driven and the lack of beds leads to premature discharges, with a push to get folks out of a bed as soon as possible." Another key informant stated that, "southern Nevada is a magnet for people from out of state who get into trouble, spend all their money and then are stranded here after a long weekend of drinking or worse." A number expressed the opinion that, "The demand in the south is greater and harder to serve."

Accountability and Credibility

Key informants within the state system indicated that uniform systems including policies, procedures and data collection were not employed across the three regions in Nevada but were being implemented beginning in July. For the first time, "all agencies will use the same paperwork and processes." Prior to July 2013, NNAMHS, SNAMHS and RSCC all had, "their own processes and paperwork systems."

The National Alliance on Mental Illness gave Nevada a "D" grade on report cards in 2006 and in 2009.

"In a state with high rates of severe depression and other serious mental illnesses — as well as suicides — a strong commitment is needed to restore and expand the mental health safety net," the 2009 report said. "Without one, Nevada will find its emergency rooms and criminal justice system overwhelmed — and costs being shifted to other sectors of state and local government."

Las Vegas Review Journal, April 14, 2013

Data collection also varied by region with, "multiple management information systems in use" but not applied in a consistent manner. In addition, some clinicians were described as, "creating and keeping their own spreadsheets" to track data they felt they needed. There was "little confidence" from key informants within the state in the, "quality or accuracy of data" that had been collected. Waiting list data was an example provided multiple times as something that, "should be, but isn't known." As one state key informant noted, "we have a credibility problem." This alluded to data but also to the investigations, documentation problems and

resulting impact on accreditation and certification. Key informants from the state readily identified, "conditional problems that need to be addressed."

Leadership

Leadership at DPBH is viewed by external stakeholders as being, "data driven, outcome oriented," and "wanting to use evidence-based approaches" and "promoting outreach to communities to increase access services. Sentiments ranged from, "cautiously optimistic" to "enthusiastic" about the leadership of DPBH and the, "changes they plan and have already made." Leadership within the Division is doing what it can to strengthen the existing system and to improve outcomes but, "don't have the resources to be successful." "They are seeking resources when possible and trying to use resources more wisely." However, at this time, the system is, "woefully inadequate."

Collaboration and Coordination with State, Regional & Local Partners

In addition, key informants identified a need for collaboration. One noted that, "essential collaboration across systems is relationship based." Another said that in term of collaboration, "This is worse in Southern Nevada. The system is far too person dependent." As one key informant stated, "there are models of partnerships between law enforcement, courts, the state and social services all across the state that have worked to the benefit of the client. These are not always formalized, are often person or relationship dependent and can quickly evaporate when a person changes position, a crisis occurs, or one agency stops participating."

This is a critical issue as, "persons with behavioral health needs don't only impact the mental health system." Rather, they often are also, "accessing local health and human resources," and "are involved in the criminal justice system" and may be "accessing health care through local emergency rooms or clinics." Linkages, collaboration and transitions between systems, "aren't institutionalized in a way that affords consumers 'no wrong door' for accessing services." Several key informants noted, "We need no wrong door." One said "the client doesn't care if you work for the state or the county, they just know they need help and aren't getting it," and "

> *"The counties need to be at the table with the state and have an honest conversation about roles and responsibilities. That hasn't happened because the state often doesn't show up at local meetings and the county, "is afraid if they dip their toe in the swimming pool to try and solve an issue they will end up owning the pool."*

One key informant noted that, "the largest gap continues to be persons coming out of prison as the Department of Corrections provides its own mental health services but is less concerned about what happens when that person returns to the community." There is "less collaboration with the non-psychiatric community and substance abuse providers and mental health." There are plans to strengthen this collaboration within DPBH but that coordination of services is not fully in place.

One key informant was "positive about the changes underway within DPBH but assert that policies and procedures, collaboration and linkages, are not enough to make behavioral health services available, accessible and sufficient" to meet Nevada's needs. Without a "fundamental financial investment in services and supports" at the community and state level, "the system may improve but will never be able to meet the needs."

There are opportunities to collaborate with the counties and coalitions and task forces to extend the safety net of services in Nevada. Restoring credibility by attaining federal certification and national accreditation of services, partnering to create a "no wrong door" approach to services and securing resources should all be priorities for DPBH.

Recommendations

Nevada has an opportunity to implement a behavioral health system that is community-based, comprehensive and efficient. The gaps analysis is intended to assist the state in understanding gaps and taking steps to address them. To do so, the following three focus areas are recommended. The strategies listed below the focus areas come from research, key informants and best practices. Each is designed to address one or more of the gaps, unmet needs and/or the weaknesses or threats from the situational analysis.

Ensure Accountability, Credibility and High Quality Services:

- Ensure that policies and procedures are clearly articulated and understood across the state. From the point of first contact on, processes for assessment, referral, admission, treatment, discharge planning and transition should be clear, coherent and consistently implemented.
- Ensure that outcome-based, measurable criteria are in place to document and later describe those receiving services, what the service delivery cycle entailed, how waiting lists and discharges were managed and the outcome of services.

- Collect and report data uniformly across services and within DPBH using one shared data system. Use data to make decisions about how future resources are allocated.
- Establish performance-based targets of penetration rates for all levels of care, by region, provided by both the state and community-based providers.
- Implement the recommendations from the consultation report on the Rawson-Neal Psychiatric Hospital system-wide, as appropriate, with a focus on the ten recommendations provided.
- Ensure that substance abuse services meet the regulations and standards that apply to them.
- Seek accreditation and certification to demonstrate credibility and quality.

1. **Develop Community and State Capacity to Implement No Wrong Door.**
   - Educate the public about the value of identifying and seeking care for behavioral health issues before a person escalates to the point of criminal justice involvement. Work to reduce the stigma related to mental illness and confront individuals' desires to, "solve it on my own."
   - Ensure that the community is aware of services and how to access them and that services are accessible, available and supportive in every community.
   - Identify and engage community partners throughout the state to include county commissioners, county social service agencies, and county and city managers.
   - Define with community partners' roles and responsibilities to collaborate, coordinate and care for Nevadans in need of behavioral health prevention, intervention and treatment.
   - Define a shared approach to building the capacity of community-based organizations to provide services to people in need in their communities.
   - Create a plan to build the capacity for services focused on prevention and early intervention and for culturally appropriate services for special populations.
   - Support the development and enhancement of behavioral health services for children ages 0-17 and those ages 65+.
   - Promote a culture of shared ownership with regional, county and local partners where all staff promotes collaboration, coordination and communication with counties and community-based agencies and between public health workers and behavioral health staff.

- Develop and formalize partnerships that effectively facilitate referrals and transitions across systems so that there truly is no wrong door or point of contact within the Division and throughout Nevada.
- Provide cross-training between behavioral health and public health staff to maximize resources and advance knowledge of all services within all programs and staff of DPBH.
- Promote recruitment and retention, and publicize loan repayor programs to retain professionals who receive their education and training within Nevada.
- Use technology to provide training and promote evidence-based practices within the system of care.

2. **Establish a vision and plan for the system of care and secure the resources necessary to implement the plan.**
   - Define the system of care essential for Nevada including sufficient providers, substance abuse and co-occurring disorder services, housing, transportation, wrap around support and case management. (Note: a description of the components can be found at the end of this section.)
   - Convene state, county and local providers to define roles and responsibilities for each component of the system of care.
   - Quantify the funds needed, based on target penetration rates to meet demand and identify all funding sources at the federal, state and county level that can be accessed to support the system of care.
   - Transition some state services to local communities as possible and appropriate and reallocate funding to support the system of care.
   - Pursue a diversified funding approach with all partners (hospitals, law enforcement, state, county and other) to support the system of care including:
     - Continue to pursue new grants to support components needed to implement the system of care.
     - Leverage federal dollars and matching funding programs.
     - Establish systems to obtain reimbursement for services.
     - Request revisions to regulations to maximize flexibility and efficiency in how state funding can be allocated and reallocated based on demand and need for services, deploying state resources in a strategic manner.
     - Evaluate feasibility of a dedicated funding stream to support behavioral health services.

    - Invest additional resources in prevention and intervention as available from treatment savings.
- Evaluate the system of care based on outcomes and indicators agreed to by all parties.

When designing a system of care, a number of specific components are needed and detailed below.

Prevention/Education:

Implement high-impact prevention and use combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas. Include screening and assessment to identify concerns early and provide needed support. Link with other formal systems to help identify and address behaviors that may be an indication of a concern such as school expulsions. Design an education and prevention program to confront myths about behavioral health, explain the signs of mental illness and substance abuse and inform the public on how they can help persons at risk.

Identification, Outreach and Access:

Build on the MOST and MCT team concepts to develop identification mechanisms that will establish linkages with community-based entities (including group homes, churches, police, emergency rooms, inpatient facilities, pharmacists, primary care physicians, public housing facilities, senior centers, child care settings, etc.) capable of identifying and referring people in need of services prior to law enforcement involvement.

Incorporate mental health screenings in health check-ups, with referral to a behavioral health assessment for follow-up. Design effective outreach to engage individuals in their own environments including school, work, home, or other settings including health care.

Convene a planning team comprised of state, county and local health and human service providers to map an effective process for identification, outreach, and access that defines roles, responsibilities, and agreements between state and local government and that identifies local access points based on the capacity of local providers and service delivery systems.

Assessment and Evaluation:

Identify resources and approved assessment processes that are appropriate to the person's culture and level of acculturation, and utilize assessment tools that are valid and

reliable. Establish standards for access to assessment that promote prevention and intervention rather than delaying access until an individual reaches crisis status.

Behavioral Health Treatment:

Treatment is a critical component of the continuum of care. To encourage the use of services and to minimize stigma, treatment should be available and provided within an individual's community, in the least restrictive environment possible. In addition to psychiatric management, behavioral health treatment should include: counseling, medication management, and linking individuals to other wrap around services necessary for them to remain stable.

The system of care should be strengthened to promote community-based organizations and include: inpatient, partial hospitalization, intensive outpatient, outpatient, residential, adult day treatment, and mobile therapy options. Specialized treatment facilities for youth with substance abuse disorders are needed, and should include peer-supportive counseling to prevent relapse and develop strategies for drug-free living.

Discharge planning should consider housing, medication and basic needs at a minimum. No persons should be discharged to another level of care or from a facility without a safe, stable environment to go to with assistance in making the transition.

Housing:

Any system of care for persons with behavioral health needs must emphasize safe and stable environments. Affordable housing should be made available for low-income individuals and families. It should also include an appropriate range of supportive housing options.

Clustered apartments such as those implemented through the Crossroads program should be replicated to provide services and supports in a cost efficient manner. A variety of more structured residential settings are needed for a small number of more seriously disabled individuals who require a greater degree of attention, supervision or structure. This may include housing specific for subpopulations such as persons with dementia under the age of 60, youth with a behavioral health disorder and other disability, and adults in need of structure and support in order to remain independent.

Coordination with Health Care:

Create systems and linkages to ensure a high level of integration of physical and behavioral health care, using a public health model approach to a continuum of care. Ensure individuals are connected to both medical and behavioral health services, and

facilitate the coordination of care. This includes ensuring primary care practitioners are skilled in identifying behavioral health and substance abuse problems and in making referrals for treatment and ensuring that treatment is available at the time of the referral.

Care Management:
Care management should be available to the most severely impacted consumers to ensure they receive the services they need. Depending on individual needs and preferences, care managers could be a single person or a team who assumes responsibility for maintaining a long-term, caring and supportive relationship with the individual. All care managers should be trained in behavioral health and be skilled in working within behavioral health, public health and human service systems.

Crisis Response Service:
Ensure crisis assistance is in place to immediately respond to persons in crisis and members of their support system and is available 24-hours a day, 7 days a week. This can be done by building upon programs that are working in both northern and southern Nevada including the MOST teams and the MCT teams. These services could be replicated in some manner in the other counties in Nevada.

Protection and Advocacy:
Persons with behavioral health/substance abuse problems are particularly at-risk as victims of violence or abuse, but may be afraid or unable to report crime and abuse. They also may have difficulty caring for themselves. Law enforcement, social service providers and emergency responders should be linked to crisis intervention teams to identify and provide protection for vulnerable populations.

The following secondary components are also essential to supporting a system of care and can be provided by community-based organizations on a community by community basis.

Peer Support:
Peers are one of the most influential groups for people with behavioral health issues and provide a "non-treatment" approach most persons prefer. Faith-based groups, community organizations, veteran groups, senior centers and other informal support systems can help identify at-risk children and adults and help them maintain their treatment.

Social Rehabilitation:
Social rehabilitation services help consumers gain or regain practical skills needed to live and socialize in the community. Activities should be age and culturally appropriate and

tailored to individual needs and preferences. Social rehabilitation should include assistance in developing interpersonal relationships and leisure time activities/interests that provide a sense of participation in a community. Employment and volunteer opportunities should be available through community-based organizations for those who choose and are able to work or volunteer in the community.

Summary

Nevada has an opportunity to strengthen the behavioral health system by taking a public health approach to behavioral health. As research indicates, this opportunity would advance the field of practice, build on brain development research, and create community-based solutions to prevent crises and:

- Recognize the interrelatedness of behavioral health and physical health,
- Focus on prevention and promotes behavioral health across the lifespan,
- Identify risks that contribute to illness or disability and in some cases protect against the development of illness or disability or limit the severity,
- Provide Nevadans with the knowledge and skills to maintain optimal health and wellbeing, and
- Bring together individuals, communities and the systems throughout the state to work collaboratively toward better behavioral health for all.

This would strengthen the current service delivery system and promote strategies that build upon a public health approach to the prevention, intervention and treatment of behavioral health conditions. The integration of the Division, awareness of the scope of the problem, and the implementation of the ACA, make this an opportune time to build the system of care that Nevadans need.

Appendix

Appendix 1.1: Key Informant Interview Questions

- Please describe your target population, geographic area served, any mandates and the services you offer related to persons with mental health concerns in Nevada. Location, Priority Populations, Services Offered
- Describe the steps your organization has in place to assess and admit people for services? How are they referred to you? List major referral sources
- What is the average length of stay or service cycle?
- Do you discharge plan with consumers? How does that work?
- Do you have data you could provide on number of admissions, length of stay, number of discharges and where consumers are discharged to?
- What are the major challenges when discharge planning?
- What resources are available and what resources are not available but needed for mental health?
- How do you educate the public about the services available through your organization?
- Is your organization engaged in any public awareness campaigns around mental health issues? Anti-stigma campaigns, outreach to specific populations, etc.
- How does your agency collaborate with mental health, substance abuse, and or other agencies to meet the needs of consumers? Is there a process for interagency collaboration? Which agencies participate? Who should be at the table but isn't?
- Are there opportunities for improving collaboration?
- What are areas of ongoing strengths within the mental health system of care in Nevada?
- What do you anticipate as possible challenges related to the reorganization of the Mental Health services system within Nevada?
- What opportunities or concerns do you think the Affordable Care Act will have on mental health services/systems in Nevada?
- What are the most critical issues that Nevada needs to address to meet the mental health needs of its population?
- Where do gaps exist within the system, and how do those gaps affect the end user? Are there any gaps that are particularly pronounced based on region?
- What are the major barriers to accessing services within the mental health system? Geographic isolation, service provider capacity, transportation, etc.

- Who needs mental health services and does not receive them? What are the consequences of people needing services and not receiving them? To themselves as well as within the context of the community
- What policy level changes are needed to improve the mental health system at the local, regional and/or state level?
- What practical changes are needed to improve the mental health system and promote wellness and recovery for consumers at the local, state and regional level?
- If you had a wish list, what other changes would you like to see happen?

Appendix 1.2(a): Consumer Survey Questionnaire (English)

People can get counseling, treatment or medicine for many different reasons, such as:

- For feeling depressed, anxious, or "stressed out"
- Personal problems (like when a loved one dies or when there are problems at work)
- Family problems (like marriage problems or when parents and children have trouble getting along)
- Needing help with drug or alcohol use
- For mental or emotional illness

Any of these reasons can lead to someone needing behavioral health care. We are collecting information to help the state understand what kind of behavioral health care services are needed to support Nevada residents. We are also trying to identify what prevents people who need assistance from getting the help they require.

Respondent Profile Questions

1. ***What is your gender?
   - ☐ Male
   - ☐ Female

2. ***What is your age?
   - ☐ 0-12
   - ☐ 13-17
   - ☐ 18-20
   - ☐ 21-24
   - ☐ 25-44
   - ☐ 45-64
   - ☐ 65-74
   - ☐ 75+

3. ***What is your race/ethnicity?
   - ☐ White
   - ☐ Hispanic
   - ☐ Black/African American
   - ☐ American Indian/Alaskan
   - ☐ Pacific Islander
   - ☐ Asian
   - ☐ Mixed Race
   - ☐ Other

4. ***What county do you live in?
   - ☐ Carson City
   - ☐ Churchill
   - ☐ Clark
   - ☐ Douglas
   - ☐ Elko
   - ☐ Esmeralda
   - ☐ Eureka
   - ☐ Humboldt
   - ☐ Lander
   - ☐ Lincoln
   - ☐ Lyon
   - ☐ Mineral
   - ☐ Nye
   - ☐ Pershing
   - ☐ Storey
   - ☐ Washoe
   - ☐ White Pine

5. ***Which of the following best describes you?
   - ☐ Current behavioral health care client
   - ☐ Former behavioral health care client
   - ☐ Friend/family member of someone who has received behavioral health care services
   - ☐ Parent of a child currently receiving behavioral health care services
   - ☐ Parent of a child formerly receiving behavioral health care services
   - ☐ Someone in need of behavioral health care services but not currently receiving them
   - ☐ Someone in recovery
   - ☐ Not sure

6. * There are a variety of behavioral health care services that can be provided to help people live a meaningful life. Please indicate which of the following type of services you or someone you know have used and the extent to which it served your/their needs.**

Type of Services Used	Have you used this service?		If you answered yes, please indicate to what extent you believe the level of care received was sufficient to meet the need?			
	No	Yes	Always met my needs	Usually met my needs	Sometimes met my needs	Never met my needs
Inpatient Care – Hospitalization						
Outpatient Care – Community-Based Services						
Psychiatry – Access to a therapist						
Medication Management – Use of Prescription Psychotropics						
Support Group Participation						
Dual Diagnosis Services						
Case Management – Support Services to help with ancillary needs (goals establishment, linkage to other services, etc.)						

7. * There are a number of reasons that people may not receive the assistance they need. We want to understand why people who need services may not be able to access care. Please indicate which of the following you believe prevents you or other people from accessing services and the severity of the issue.**

Barriers to Services	Is this an issue?		If you answered yes, please indicate to what extent you believe this issue prevents you/others from accessing care.			
	No	Yes	Big Problem	Medium Problem	Little Problem	Isolated Issue
No local services available						
Lack of transportation						
Lack of medical insurance						
Cost prohibitive						
Long wait lists						
Not enough services available						
Not enough service providers						

8. * How significant of an issue is behavioral health care for your community?**

- ☐ This is a big issue – there are a lot of needs that remain unaddressed
- ☐ This is a moderate issue – there are ongoing needs, but services are available
- ☐ This is a minor issue – there are system improvements needed, but they are minor and do not affect the critical health issues of individuals
- ☐ This is not an issue – services being provided are sufficient to meet the needs of people.

9. * On a scale of 1-10, how well do you think the current system responds to the behavioral health care needs of your community?**

☐ 1 – Responds in the best way possible	☐ 6
☐ 2	☐ 7
☐ 3	☐ 8
☐ 4	☐ 9
☐ 5	☐ 10- Responds in the worst way possible

10. ***What do you think the state should focus on to address the behavioral health care needs of your community? Please list them in order of importance.

Most important issue to address gaps in services:

Second most important issue to address gaps in services:

Third most important issue to address gaps in services:

Thank you for taking the time to complete this survey. Your input is valuable and appreciated!

Appendix 1.2(b): Consumer Survey Questionnaire (Spanish)

Las personas pueden recibir servicios de consejería, tratamiento o medicamentos por varias razones, tales como"

- Depresión, Ansiedad, Estrés
- Problemas personales (la muerte de un ser querido o problemas en el trabajo)
- Problemas familiares (de matrimonio, o cuando los padres y los hijos tienen problemas llevándose bien)
- Problemas con el uso de alcohol y drogas
- Enfermedades mentales o emocionales

Cualquiera de estas razones puede llevar a alguien a necesitar cuidado de salud del comportamiento Estamos recopilando información para ayudar al estado a entender qué tipo de servicios de salud del comportamiento son necesarios para apoyar a los residentes de Nevada. También estamos tratando de identificar qué es lo que impide que las personas reciban la ayuda que necesitan.

c preguntas sobre el perfil del participante

11. * ¿Cuál es su género?**

- ☐ Masculino
- ☐ Femenino

12. * ¿Cuál es su edad?**

- ☐ 0-12
- ☐ 13-17
- ☐ 18-20
- ☐ 21-24
- ☐ 25-44
- ☐ 45-64
- ☐ 65-74
- ☐ 75+

13. * ¿Cuál es su raza/etnicidad?**

- ☐ Blanco
- ☐ Hispano
- ☐ Afro- Americano
- ☐ Indio Americano/Alaska
- ☐ Islas del Pacifico
- ☐ Asia
- ☐ Raza Mixta
- ☐ Otro

14. * ¿En cuál condado vive?**

- ☐ Carson City
- ☐ Churchill
- ☐ Clark
- ☐ Douglas
- ☐ Elko
- ☐ Esmeralda
- ☐ Eureka
- ☐ Humboldt
- ☐ Lander
- ☐ Lincoln
- ☐ Lyon
- ☐ Mineral
- ☐ Nye
- ☐ Pershing
- ☐ Storey
- ☐ Washoe
- ☐ White Pine

15. * ¿Cuál de las siguientes situaciones es la que mejor lo describe?**

- ☐ Cliente actual de cuidados de salud del comportamiento
- ☐ Ex cliente de cuidados de salud del comportamiento
- ☐ Amigo/familiar de alguien que ha recibido servicios de cuidado de salud del comportamiento
- ☐ Padre de un niño que actualmente recibe servicios de cuidado de salud del comportamiento
- ☐ Padre de un niño que recibió servicios de cuidado de salud del comportamiento
- ☐ Persona con necesidad de servicios de cuidado de salud del comportamiento pero que no los recibe actualmente
- ☐ Persona en recuperación
- ☐ No estoy seguro / No Aplicable

16. ***Hay una variedad de servicios de cuidado de salud del comportamiento que pueden proporcionarse para ayudar a las personas a tener una vida significativa. Por favor indique cuál de los siguientes servicios ha utilizado usted o alguien que usted conoce y el grado al que sirvió a sus necesidades.

Tipo de Servicio	¿Utilizó usted este servicio?		Si contestó sí, indique en qué medida cree que el nivel de atención que recibió fue suficiente para satisfacer sus necesidades			
	No	Si	Siempre	Usualmente	Algunas veces	Nunca
Paciente Interno – Hospitalización						
Paciente Externo – Servicios a través de la comunidad						
Psiquiatría – Acceso a terapeuta						
Administración de Medicamentos – Uso de prescripciones Psicotrópicos						
Participación en Grupos de Apoyo						
Servicios de Diagnóstico						
Manejo de caso – Servicios de apoyo para ayudar con necesidades auxiliares (establecimiento de metas, vinculación con otros servicios, etc.)						

17. ***Hay un número de razones por las que la gente no puede recibir la asistencia que necesita. Queremos entender por qué las personas no pueden acceder esa atención. Por favor, indique cuál de las siguientes razones usted cree que sea la que impide que usted u otras personas tengan acceso a los servicios y la gravedad del problema.

Barreras a los Servicios	¿Es esto un problema?		Si contesto que si, por favor indique hasta qué punto usted cree que este problema le impida a usted y a otras personas tener acceso a servicios.			
	No	Si	Gran Problema	Problema no tan Grande	Problema Pequeño	Problema Aislado
No hay servicios locales disponibles						
Falta de transportación						
Falta de seguro médico						
Costo muy elevado						
Largas listas de espera						
No hay suficientes servicios disponibles						
No hay suficientes proveedores						

18. * ¿Qué tan importante es para su comunidad el problema del cuidado de la salud del comportamiento?**

☐ Es un gran problema –hay muchas necesidades que se mantienen sin resolver

☐ Es un problema moderado - existen necesidades pero hay servicios disponibles

☐ Es un problema mínimo - se necesitan mejoras en el sistema, pero son menores y no afectan los problemas críticos de salud de las personas

☐ No es un problema – los servicios proporcionados son suficientes para atender las necesidades de las personas.

19. *¿En la escala de 1-10, qué tan bien cree usted que el sistema actual responde a las necesidades de cuidado de salud del comportamiento de su comunidad?**

☐ 1 – Responde de la mejor manera posible	☐ 6
☐ 2	☐ 7
☐ 3	☐ 8
☐ 4	☐ 9
☐ 5	☐ 10- Responde de la peor manera posible

20. *¿En qué cree usted que el estado deba enfocarse para atender las necesidades del cuidado de salud del comportamiento de su comunidad? Por favor enumérelos por orden de importancia.**

Problema más importante para resolver la falta de servicios:

Segundo problema más importante para resolver la falta de servicios:

Tercer problema más importante para resolver la falta de servicios:

Gracias por tomarse el tiempo de completar esta encuesta. ¡Valoramos y apreciamos su opinión!

Por favor, devuelva esta encuesta a la persona que venga con su próxima entrega.

Appendix 1.3: Expanded Service System Description

The behavioral health system in Nevada is comprised of federal, state and local resources with a variety of funding sources, priorities and mandates. Services throughout the state differ based on target population, geographic region and funding source. As a result, there are often different challenges for persons seeking behavioral health assistance based on what services are available and where they are seeking services. The system is most developed in urban areas comprised of northern and southern Nevada, although more linkages exist between urban and rural areas than ever before.

Beyond the formal, known systems, there are also behavioral health demands placed on a number of other systems throughout Nevada that respond to persons with behavioral health issues. While not primary behavioral health providers, these systems must be considered when identifying where gaps in services exist. Providers such as emergency transport, hospital emergency rooms, county law enforcement, primary care practitioners and rural community health and social service centers often provide behavioral health services when needed. While many do not see themselves as a provider of behavioral health services and are not equipped to address the behavioral health problems they encounter, they are part of a continuum of services that provides access to care.

Primary Behavioral Health Providers

The primary providers of behavioral health services in Nevada include the public behavioral health system as operated by the Nevada Division of Public and Behavioral Health (DPBH), non-profit/community-based organizations, private practitioners and psychiatric hospitals, and federally qualified health centers.

Nevada Division of Public and Behavioral Health

DPBH, formerly known as Mental Health and Developmental Services (MHDS), provides the majority of behavioral health services throughout the state. Within the Division, a number of agencies and service sites exist that provide behavioral health and substance abuse treatment to children, families, and adults. Those agencies are listed below.

Southern Nevada Adult Mental Health Services (SNAMHS) has clinics and locations in various communities within Clark County and a centralized inpatient hospital. The variety of community-based clinics offers easy access throughout Clark County. SNAMHS is licensed by the State of Nevada. The facility is certified by the Centers for Medicare and Medicaid Services (CMS) and was accredited by the Joint Commission until July 2013. SNAMHS provides both inpatient and outpatient services for people living in Clark County and persons living in surrounding counties that may be closer geographically to this agency rather than to a rural behavioral health center. SNAMHS has eight behavioral health clinics serving the community and rural southern Nevada. SNAMHS provides: Inpatient Services, Mobile Crisis, Outpatient Counseling, Service Coordination, Intensive Service Coordination, Medication Clinic, Residential Support Programs, Mental Health Court, and Programs for Assertive Community Treatment (PACT) Teams.

Rawson-Neal Psychiatric Hospital is a state hospital operated by SNAMHS which was established to diagnose, treat and reintroduce behavioral health patients into the community. The facility opened in 2006 and is licensed to serve 289 adult suffering from severe mental illness. It currently is budgeted to serve 190 individuals. In 2013, the budget was expanded to add 21 beds to building 3A of the facility.

Northern Nevada Adult Mental Health Services (NNAMHS) occupies part of 92 acres deeded to the State in the 1800's for the benefit of the mentally ill and developmentally disabled. Located adjacent to the Truckee River in Sparks Nevada, it shares grounds with Lake's Crossing Center, the State Forensic Hospital, and Sierra Regional Center, the treatment center for the developmentally disabled.

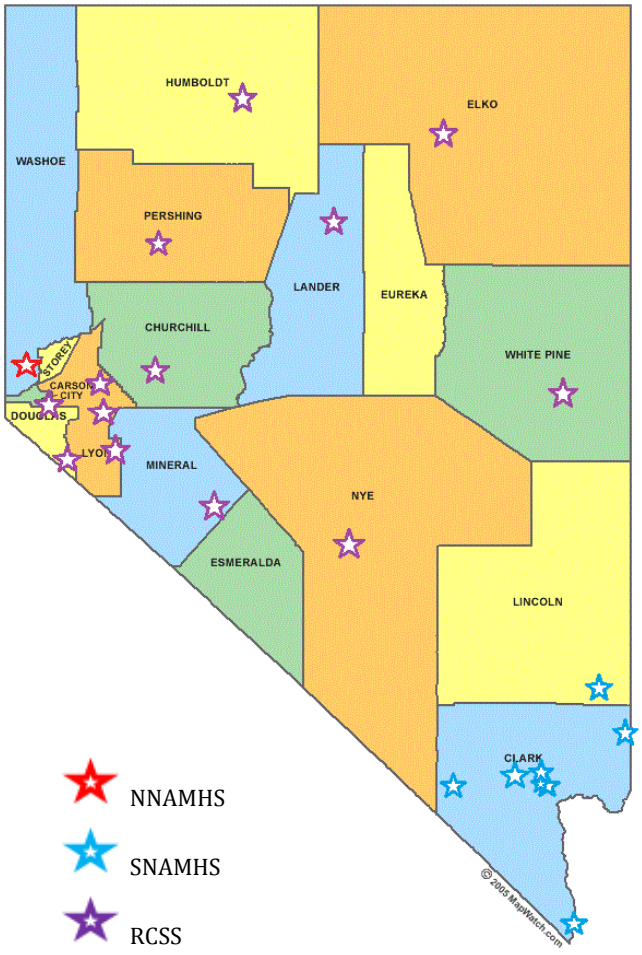


Figure 39: DPBH Behavioral Health Service Location

In recent years NNAMHS has developed from the only state hospital in Nevada to a comprehensive, community-based, behavioral health system supported by an acute care psychiatric inpatient hospital. The agency is fully licensed and is certified by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Centers for Medicare & Medicaid Services (CMS). Its primary service area is northern Nevada. Numerous outpatient services are available that include the Washoe Community Mental Health Center, Outpatient Pharmacy, Program of Assertive Community Treatment (PACT), Psychosocial Rehabilitation Program (PRP), Consumer Peer Counseling, and Service Coordinator Services.

Dini-Townsend Hospital is a state psychiatric in-patient facility operated by NNAMHS. The facility opened in 2001 and has the capacity to serve 70 adults suffering from severe mental illness. It currently is budgeted to serve 30 individuals. In addition, there are 2 (10 bed) annexes at Dini-Townsend that are used for Lake's Crossing consumers.

Lake's Crossing is a forensic facility that provides services focusing on determining the legal competency of an individual to stand trial and restoration of legal competency for trial purposes. Forensic services include clinical assessment, forensic evaluation and short or long-term treatment for both pretrial detainees and jail/prison inmates. Lake's Crossing is not certified through the Centers for Medicare and Medicaid Services, and is not accredited. The facility has the capacity to serve 66 individuals waiting to stand trial.

Rural Counseling and Supportive Services (RCSS) is the one agency within the DPBH that provides outpatient services/programs throughout rural Nevada. Today RCSS has seven full service clinics, five partial service clinics, and one limited service clinic that provide behavioral health services to more than 4,577 consumers throughout the 76,391 square miles of Nevada with the exception of Washoe County, Clark County, Lincoln County and parts of Nye County. Satellite Clinics provide all services offered by RCSS. Sub-satellite clinics offer many of the same services with itinerant Clinics providing services less frequently. Rural Counseling and Supportive Services Centers continue to provide a comprehensive array of services to the seriously mentally ill (SMI adult) and seriously emotionally disturbed (SED children) populations.

The table that follows provides a summary of individuals served by NNAMHS, SNAMHS and RCSS in Nevada in FY 2011-12.

SERVICE TYPE	SNAMHS	NNAMHS	RURAL CLINICS NORTH	RURAL CLINICS SOUTH	STATEWIDE
Outpatient Counseling	5,506	2,673	4,463	1,246	**13,888**
Med Clinic	11,712	4,778	2,290	638	**19,418**
Service Coordination	1,227	1,392	762	361	**3,742**
PACT	138	96	-	-	**234**
Mental Health Court	113	311	52	-	**476**
Inpatient Treatment	5,005	1,337	-	-	**6,342**

Figure 40: Individuals Provided Behavioral Health Services by DPBH as MHDS (2011-12)

Nevada Substance Abuse Prevention and Treatment Agency (SAPTA) – SAPTA currently funds private, non-profit treatment organizations and government agencies statewide to provide the substance abuse related services and treatment levels of care. In state fiscal year 2012-2013, SAPTA funded 22 treatment organizations providing services in 68 locations throughout Nevada. Together, these providers had 11,907 treatment admissions. Services consist of intervention, comprehensive evaluation, detoxification, residential, outpatient, intensive outpatient, and transitional housing services for adults and adolescents, and opioid maintenance treatment for adults.

In state fiscal year 2013, SAPTA supported services including 2,162 detoxification admissions, 2,205 residential treatment admissions, 6,259 outpatient, and 1,281 intensive outpatient admissions. Adolescents accounted for 9.6% of total admissions. There were 1,077 individuals needing treatment that had to wait for admission an average of 17 days (Agency, 2013).

Battle Mountain	**Dayton**	**Fallon**
• Vitality Unlimited Cottonwood Counseling • New Frontier • American Comprehensive Counseling Center • Cinper Evaluation Center • Community Counseling Center-CC • John Glen Evaluation Center	• Lyon Council on AOD	• New Frontier
	Elko	**Fernley**
	• New Frontier • Vitality Unlimited	• Lyon Council on AOD
		Gardnerville
	Ely	• Tahoe Youth & Family Svs.
	• New Frontier	**Hawthorne**
		• New Frontier

Henderson	Las Vegas (Cont.)	Reno
• ABC Therapy • Choices Group, Inc • Family & Child Treatment (FACT) • Henderson Assessment Center • Mission Treatment Centers, Inc. • Westcare Nevada Inc	• New Beginnings Counseling Center • Restoration Counseling Service • Solutions Recovery, Inc. • WestCare Nevada (3)	• Bristlecone Family Resources • Center for Behavioral Health • Family Counseling Services of No. NV • Footprints • Vitality Unlimited • Lynne Daus Evaluation Center • Nevada Urban Indians • Northern Nevada Evaluation Center • Quest Counseling and Consulting, Inc. • Reno Sparks Tribal Health Center • Ridge House (The) • Silver State Substance Abuse Evaluations • Step 1, Inc. • Step 2, Inc. • WestCare Nevada Reno Community Triage Center
Incline Village	**Laughlin**	**S. Lake Tahoe**
• Sierra Recovery Center	• Community Counseling Center	• Sierra Recovery Center
Las Vegas	**Lovelock**	**Silver Springs**
• ABC Therapy • Adelson Clinic • B.D.D. Counseling • Bridge Counseling Associates • Center for Addiction Medicine • Center for Behavioral Health • Choices Group, Inc. • Clark County Court Education Program • Community Counseling Center • Family & Child Treatment (FACT) • Help of Southern Nevada • Las Vegas Indian Center, Inc. • Las Vegas Municipal Court • Las Vegas Recovery Center • LRS Systems, Ltd. • Mesa Family Counseling • Mission Treatment Centers, Inc. • Nevada Homes for Youth • Nevada Treatment Center	• New Frontier	• Lyon Council on AOD
	Mesquite/Moapa	**Sparks**
	• Mesquite Mental Health Center • Moapa Mental Health Center • WestCare Nevada Inc. - Harris Springs	• Evergreen Evaluation and Education Center • Life Change Center
	North Las Vegas	**Tonopah**
	• Center for Behavioral Health (2) • Family & Child Treatment (FACT) • North Las Vegas Municipal Court • Options Diversionary Program • Salvation Army	• New Frontier
	Owyhee	**Virginia City**
	• Shoshone Paiute Tribes of Duck Valley Reservation	• Lyon Council on AOD (Community Chest)
	Pahrump	**West Wendover**
	• Community Counseling Center • WestCare Nevada	• New Frontier
	Pioche	
	• New Frontier	
Winnemucca	**Yerington**	
• New Frontier • Vitality Unlimited Silver Sage	• Lyon Council on AOD	

Figure 41: SAPTA Services Sites

Nevada Division of Children and Family Services

The Division of Children and Family Services (DCFS) provides a broad range of services through State-operated, community-based behavioral health centers and community providers. These centers are organized within Northern Nevada Child and Adolescent Services (NNACS) and the Southern Nevada Child and Adolescent Services (SNACS) agencies. Services consist of comprehensive evaluation, community-based individual, group, and family therapy, medication management, clinical and intensive targeted case management, and early childhood behavioral health services. Additionally, DCFS provides treatment homes, residential treatment and psychiatric hospitalization to children and adolescents needing intensive behavioral health support. Services provided are primarily to children and adolescents residing in the Northern and Southern part of the state as DPBH provides behavioral health services to this population in the rural areas. The only exception is the WIN home-based model which provides services statewide.

Below is a summary of children/adolescents served by DCFS in FY 2011-12.

SERVICE TYPE	NNCAS	SNCAS	RURAL	STATEWIDE
Early Childhood MH Services (0-6)	238	803		**1,041**
Community-Based Outpatient Services	362	862		**1,224**
WIN Wraparound Services	182	267	96	**545**
Treatment Homes	112	49	-	**158**
Residential Treatment Care	-	102	-	**102**
Psychiatric Hospitals		182	-	**182**

Figure 42: Individuals Provided Behavioral Health Services by DCFS (FY2011-12)

Non-profit and Private Practice Providers

Non-profit and private practice behavioral health providers throughout the state vary in their approach, location, and accessibility. A sample of this community is provided below to provide a general understanding of the varying types, organizational structures, and service provision that exist in Nevada. The extent to which these services are available depend upon the medical coverage that individuals hold.

Northern Region

- Northern Nevada HOPES is a non-profit community health center. In addition to primary care, the organization also provides behavioral health services in their

community health center located in downtown Reno, NV. Services provided include behavioral health and substance abuse counseling, individual and group therapy.

- Behavioral Health Services (BHS), a division of Carson Tahoe Health, provides a diagnosis/multi-disciplinary team approach to treating seniors, adults, adolescents and children experiencing behavioral and addictive disorders. It provides a broad range of inpatient and outpatient services that includes individual, group and family counseling, support groups, medical model detox services, and a 14-21 day addictive disorders rehabilitation program. BHS has two locations both situated in Carson City, one providing inpatient care and the other providing outpatient care.
- HealTherapy of Nevada provides non-traditional behavioral health services utilizing horses with children, adolescents and adults. The program has two locations in northern Nevada, one in Carson City and the other in Reno. Staff of the program includes a psychiatrist, licensed clinicians, family resource specialists, and therapeutic equestrian instructors.

Southern Region

- Heads Up Guidance and Wellness Centers of Nevada provide community-based health care focused on the behavioral health needs of traditionally underserved populations. Therapists and clinicians assist individuals, couples, children and families providing basic skills training, psychosocial rehabilitation, mental emotional release therapy, play therapy, neuro-linguisitic programming, hypnotherapy, medication management, and group therapy/day treatment. Services are provided at their Las Vegas location.
- Compass Behavioral Health provides behavioral health and prevention/early intervention services to young children and adolescents in the Las Vegas area. Services include basic skills training, psychosocial rehabilitation services, individual therapy, play therapy, and group therapy.
- Nevada Behavioral Solutions provides comprehensive treatment for the child, adolescent, and adult with behavioral and emotional problems. Services are available in three locations including Las Vegas, North Las Vegas, and Pahrump and include psychosocial rehabilitation, psychiatry, therapy, basic skills training, and a day treatment progressive behavioral program.
- Liaison Behavioral Health and Community Outreach: provides behavioral healthcare to adolescents and adults. Services are offered through their office

located in Henderson, NV and include residential treatment foster care, individual and family counseling, group counseling, rehabilitative treatment (psycho-social rehabilitation & basic skills training), anger management (individual & group), stress management, and HIV/STI support groups & education.

Rural Region:

- Alliance Family Services (AFS), Inc. offers outpatient healthcare services to children, adolescents, and adults. Services include diagnostic evaluations, consultations, medication management, individual, couples and family counseling. Services are provided out of their clinic in Fernley, Nevada.

Statewide Resources:

- Mojave Mental Health Services is a clinical practice out of the University of Nevada School Of Medicine. There are two clinics in Las Vegas and one in Reno. Services vary by site, and include medication management, therapy, day treatment and targeted case management for children, adolescents and adults.
- WestCare provides a wide spectrum of health and human services in both residential and outpatient environments. Services include substance abuse and addiction treatment, homeless and runaway shelters, vocational counseling and behavioral health programs. These services are available to adults, children, adolescents, and families. WestCare is host to multiple locations throughout Nevada offering different service options.

It is important to note, that while services such as these exist, that the workforce to support these types of service delivery is deficit in most parts of the state. As the following map shows, the State of Nevada suffers from a significant shortage of behavioral health providers in all counties except Clark. The map is taken from the, "Nevada Rural and Frontier Health Data Book - 2013 Edition," that depicts every county in Nevada except Clark with a shortage of mental health professionals (pg.177-179).

Figure 43: Mental Health Provider Shortage Area

Psychiatric Care Hospitals

The following table represents the facilities across the state that provide acute psychiatric care, including care capacity.

REGION	FACILITY	NUMBER OF PSYCHIATRIC HOSPITAL BEDS
Rural		
Carson City	Carson Tahoe Regional Medical Center	**46**
Henderson	Seven Hills Behavioral Institute	**94**
Northern		
Reno	Willow Springs Center	**116**
Reno	BHC West Hills Hospital	**95**
Sparks	Northern Nevada Medical Center	**21**
Southern		
Las Vegas	Spring Mountain Sahara	**30**
Las Vegas	Spring Mountain Treatment Center	**82**
Las Vegas	Red Rock Behavioral Hospital	**28**
Las Vegas	Desert Willow Treatment Center	**58**
Las Vegas	Monte Vista Hospital	**162**
Las Vegas	North Vista Hospital	**60**

Figure 44: Hospitals Providing Psychiatric Care (Office of Public Health Informatics and Epidemiology, 2013)

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) provide services in the most medically underserved areas and/or to the most medically underserved populations. They are intended to increase access to care by providing low to no cost services and will often provide transportation and translation supports to consumers. Nevada is host to a total of 31 FQHCs, of which only 2 offer behavioral health services.

HAWC Community Health Centers provide behavioral health services through their two clinic sites located in Virginia City and Reno. Services provided include behavioral health evaluation, diagnosis, therapy and case management. In 2011, HAWC provided behavioral health service to 231 consumers (UDS Summary Report 2011, 2013).

Secondary Behavioral Health Providers

Beyond the primary behavioral health providers outlined above, there are a number of other systems that come into contact with people requiring behavioral health intervention. These systems, while not intentionally designed to deal with the complex issues surrounding behavioral healthcare, are increasingly being tasked with serving this vulnerable population.

Veteran's Administration Services

The Veteran's Administration plays a key role in providing mental health services in Nevada. For those in northern Nevada, the VA Sierra Nevada Health Care System (VASNHCS) provides alcohol and drug treatment and other mental health services to veterans. Special services not available within VASNHCS are supported through referrals to community hospitals and VA medical centers in San Francisco and Palo Alto. Mental health care is also available through community clinics such as the VA Sierra Foothills Outpatient Clinic in Auburn, the VA Carson Valley Outpatient Clinic in Minden, and the VA Lahontan Valley Outpatient Clinic in Fallon.

For those in the southern part of the state, the VA Southern Nevada Healthcare System (VASNHS) provides health care and mental health services. The system includes a community-based outpatient clinic in Pahrump, as well as a federal medical center as part of a VA/Department of Defense (VA/DoD) joint venture that is a US model for sharing agreements. Finally veterans who meet the definition of homeless defined in The McKinney Homeless Assistance Act may apply for VASH vouchers that provide shelter for those with mental illnesses, substance abuse, or physical disabilities. These vouchers are often distributed from HUD through local nonprofits in communities across the state.

Specialty Courts

Nevada has 46 specialty court programs: 29 urban and 17 rural programs. These 46 programs include 17 adult drug courts including, diversion and child support, 3 family drug courts, 3 mental health courts, 6 juvenile drug courts, 2 prison re-entry courts, 6 DUI courts, 5 hybrid DUI/drug courts, 1 prostitution prevention court, 1 veterans treatment court, and 2 habitual offender courts. They are located all across the state and organized into regions including Eastern, Central, Clark, 5th Judicial, Washoe and Western Region.

Mental Health Courts

The Washoe County Mental Health Court was the first in the state, hearing its first case in November 2001. In 2012, the Washoe County Mental Health Court served a total of 199 new participant admissions.

The Clark Region Mental Health Court was established in December 2003. Of all the Mental Health Courts located throughout the state, this is the only program to host a competency court, used to determine whether an individual will be held against their will. Located within the Eighth Judicial District, this Mental Health Court served a total of 31 new participant admissions in 2012.

The Carson City Mental Health Court, established in 2005, handles misdemeanor cases as well as felony cases transferred from the First Judicial District Court. In 2012, the Carson City Mental Health Court served a total of 30 new participant admissions.

Department of Corrections Services

The Nevada Department of Corrections plays a crucial, yet unofficial role in addressing behavioral health needs in the state. The Department recognizes behavioral health problems as an everyday challenge to new and current inmates, and recognizes its role in a Nevada Revised Statute that states: "The goal of Mental Health services in the Department is to provide for the detection, diagnosis, treatment, and referral of inmates with mental health problems, and to provide a supportive environment during all stages of each inmate's period of incarceration."

The Department of Corrections is composed of 10 conservation camps, 7 correctional facilities, 1 restitution center and 1 transitional center. Each major institution provides behavioral health services by licensed health professionals while other campuses provide varying degrees of treatment services.

Northern Nevada Correctional Center hosts the Regional Medical Facility for the Nevada Department of Corrections. This facility provides in-patient medical and behavioral health services. In addition there is the Medical Intermediate Care and Structured Care Units for inmates whose medical and behavioral health situations are stable but who require additional staff monitoring.

Southern Desert Correctional Center offers the most programs of any of the facilities in Nevada to include: anger management, stress management, fitness and wellness,

Inside/Out Dads, domestic violence, Toastmasters, gang awareness, conflict resolution, victim empathy, commitment to change, SOS Help for Emotions, Thinking for Change, relationships, sex offender treatment, stress and anxiety management. Additionally, Southern Desert offers "New Beginnings" a re-entry program, forklift certification and OSHA certification in cooperation with the local Teamsters Union. SDCC offers "TRUST" a therapeutic community and "Re-Entry," a unit to prepare inmates for reintegration back into the community.

FACILITY	INMATE POPULATION	LICENSED MEDICAL STAFF	TREATMENT SERVICES
Conservation Camps			
Carlin Conservation Camp	150		•
Ely Conservation Camp	150		•
Humboldt Conservation Camp	152		•
Jean Conservation Camp	240	•	•
Pinoche Conservation Camp	196-238		•
Stewart Conservation Camp	360		•
Three Lakes Valley Boot Camp	75		
Three Lakes Valley Conservation Camp	192		
Tonopah Conservation Camp	152		•
Wells Conservation Camp	150		•
Correctional Facilities			
Ely State Prison	1150	•	•
Florence McClure Women's Correctional Center	950		•
High Desert State Prison	4176		•
Lovelock Correctional Center	1680	•	•
Northern Nevada Correctional Center	1619	•	•
Southern Desert Correctional Center	2149	•	•
Warm Springs Correctional Center	532	•	•
Other			
Northern Nevada Restitution Center	103		•
Casa Grande Transitional Center	400		•

Figure 45: Department of Corrections Service Population & Behavioral Health Services

A Statewide Prisoner Reentry Coalition exists in Nevada to identify challenges for inmates who are released from prison with substance abuse and mental health disorders, which may have gone undiagnosed or untreated.

School Based Services

Many school districts employ school psychologists and school counselors to provide a variety of services to their student population which include academic counseling, special education assessments and supports, as well as behavioral health interventions. The degree to which behavioral health counseling occurs is dependent upon the staffing resources, community resources, and the needs of each school districts' student population. Some innovative practices occurring at school sites around the provision of behavioral health services include:

School Based Health Centers (SBCHs) are designed to provide health education, preventative care, and comprehensive physical and behavioral health care services for students on the school campus. There are 12 SBHCs in Nevada, all of which are located in Clark County. While none of the sites currently offer comprehensive on-site services, with a pronounced deficit related to the provision of behavioral health care, there is an acknowledgment of this and efforts being made to address it.

Lyon County School District – There is a cooperative agreement between Lyon County School District and Silver Springs Mental Health Center to provide behavioral health outreach services in four Dayton area schools.

White Pine County School District – There is a cooperative agreement between White Pine County School District and Ely Mental Health Center to provide group counseling sessions at school sites. A psychologist from Ely Mental Health co-facilitates with school

site counselors weekly group counseling sessions with students and the counselors refer to the behavioral health center for ongoing care and treatment of the students who present with behavioral health needs.

Hospitals and Emergency Medical Facilities

Hospitals and emergency medical facilities have increasingly become a place where people with behavioral health issues are accessing care. The lack of adequate community-based resources to serve people with behavioral health issues will continue to exacerbate this issue.

> *"Due to a lack of available alternatives, 79 percent of hospital emergency departments report having to "board" psychiatric patients who are in crisis and in need of inpatient care, sometimes for eight hours or longer."*
>
> (SAMHSA, 2009)

According to a report by the Nevada Disability Advocacy & Law Center, "Individuals on involuntary mental health holds wait on average four days in hospital emergency rooms because state law requires they must be medically screened. The state psychiatric hospital, administered by Southern Nevada Adult Mental Health Services, does not have the equipment or personnel to conduct such screenings. While individuals are being held in community hospital emergency rooms, they receive little to no psychiatric care." (Nevada Disability Advocacy & Law Center, 2005)

Linkages and Coordination

State Driven Efforts

Nevada is host to numerous boards, commissions, collaboratives, and workgroups across the state charged with addressing systems improvement for consumers accessing behavioral health services. These entities are tasked with establishing linkages and coordination that is critical to an effective continuum of care.

Formal Boards, Committees & Coalitions

Some Commissions will be reorganized as part of the integration of DPBH. Commission prior to July 1, 2013 included the following.

Commission on Mental Health and Developmental Services (Commission on MHDS): The Commission on MHDS is a ten member, legislatively created body, appointed by the Governor and designed to provide policy guidance and oversight of Nevada's public

system of integrated care and treatment of adults and children with behavioral health, substance abuse and developmental disabilities-related conditions. The Commission also promotes and assures the protection of the rights of all consumers in this system and has oversight and accountability function for both MHDS and DCFS.

Local Advisory Boards: The Commission on MHDS has created advisory boards in Washoe and Clark Counties and makes appointments to these boards from stakeholders in the community. The boards serve to provide information to the Commission regarding service needs, public input, and other issues pertaining to mental health.

Nevada Children's Behavioral Health Consortium: The Nevada Children's Behavioral Health Consortium was developed in response to the need for a statewide governance body. The mission of the Consortium is to provide Nevada's children and their families with timely access to an array of behavioral health treatment services and support that meet their needs in the least restrictive environment; and to deliver such services through a system of care. To develop financing strategies to support quality service delivery. To provide a mechanism by which system stakeholders can act in concert to ensure that children's needs are met. The Consortium works as a statewide voice for the common themes articulated by the three regional consortia.

- Washoe County Children's Mental Health Consortium
- Rural Regional Children's Mental Health Consortium
- Clark County Children's Mental Health Consortium

The Nevada Mental Health Planning Advisory Council (MHPAC): Nevada's MHPAC was established in 1989 by an Executive Order of the Governor with the goal of serving as an advocate for individuals experiencing chronic mental illnesses, children and youth experiencing serious emotional disturbances, and other individuals experiencing mental illnesses or emotional problems. The members of the Council work in a variety of ways to improve the way services are provided to consumers, to help bring more money into the State system, to promote awareness of mental health issues, and to provide education and training opportunities. MHPAC has created a Consumer and Family Member Advocacy Committee to assist in their functions. The MHPAC has three federally mandated duties which include; 1) To review the Community Mental Health Block Grant Plan and to make recommendations; 2) To serve as an advocate for adults with Serious Mental Illness (SMI), children with Severe Emotional Disturbance (SED), and other individuals with mental illnesses or emotional problems; and 3) To monitor, review, and evaluate, not less

than once each year, the allocation and adequacy of mental health services within the state.

Prior to July 2013, MHDS was in the processes of "transforming" its Mental Health Planning and Advisory Council (MHPAC) into a Behavioral Health Planning and Advisory Council (BHPAC). In doing so, membership of the Council will be increased to include consumers and family members of substance abuse and co-occurring-related disorders. Populations of persons having substance abuse and co-occurring disorder services will be advocated for and additional services related to these populations will be developed and delivered.

Multidisciplinary Prevention Advisory Committee (MPAC): The MPAC is a volunteer working group responsible for providing strategic and operational guidance to MHDS and SAPTA. The MPAC advises SAPTA in the development and implementation of a comprehensive statewide substance abuse prevention strategy that will optimize all substance abuse prevention funding streams and resources, with specific focus on the utilization of data, state and local level strategic planning, and underage drinking. The MPAC serves as the Policy Consortium under a new federal grant, the Strategic Prevention Framework State Enhancement Grant, and is responsible for grant oversight, input and recommendations on the Capacity Building/Infrastructure Enhancement Plan and the Five-Year Strategic Plan.

Substance Abuse Prevention and Treatment Agency (SAPTA) Advisory Board: The SAPTA Advisory Board serves in an advisory capacity to the Agency Director of SAPTA and the SSA. Its purpose is to ensure the availability and accessibility of treatment and prevention services within the State. It consists of fifteen members who serve for two year terms and are chosen from SAPTA funded prevention and treatment programs. The chairperson is elected by the membership and serves as the chief executive of the Board and provides general supervision, direction and control of affairs of the Board. The Board meets at least quarterly, and the chairperson presides at all meetings.

SAPTA Community-based Coalitions: In state fiscal year 2012, SAPTA funded 11 community-based coalitions and one statewide coalition serving all 17 Nevada counties. By convening key stakeholders, service providers and citizens, each coalition creates comprehensive community prevention plans and implement sustainable prevention efforts. In state fiscal year 2012, the coalitions managed 65 direct service providers who served 27,068 participants with funds from various grants.

Workgroups

In November 2012, MHDS established a statewide Quality Improvement Team in an effort to recognize and improve quality and to work in collaboration as MHDS integrates with the Nevada State Health Division (NSHD). This team consists of individuals from MHDS mental health agencies, SAPTA and the NSHD. The Quality Improvement Team identified special populations with specific needs to be addressed and created work groups for each. The workgroups identified by focus area are:

- Adolescent/Young Adults
- Older Persons
- Race and Ethnic Disparities: Native Americans
- Veterans/Military
- Addictions/Co-occurring Disorders
- Criminal Justice/Law Enforcement
- Homelessness

Each workgroup consists of internal (MHDS and SAPTA) and external (community at large) subject matter experts. The teams were tasked with examining the population being addressed, and identifying the following:

- Data that supports that population's service needs and recommendations
- What specifically is the need?
- What resources already exist?
- What resources need to be developed?
- Is there a cost factor to address the specific needs? If so, what is the approximate amount?
- Reasonable time required for implementation

Local Efforts

There are a number of coordinating efforts occurring between service organizations in an attempt to serve consumers effectively. To establish a comprehensive list of formal and informal coordination efforts would be exhaustive, so a summary list is provided below:

- Operational agreements between state-operated behavioral health agencies and county law enforcement to establish community response teams (CIT, MOST, FACT).

- Operational agreements between state operated behavioral health agencies, law enforcement, community-based providers and court systems to implement diversion programs through Mental Health Courts.
- Working relationships between state operated behavioral health agencies and local private and public hospitals to provide acute behavioral health care.
- Working relationships between counties and private therapists to provide community-based behavioral health care.
- Working relationships between UNR School of Medicine and RSCC to provide telemedicine to remote communities.
- Formal collaboration between rural clinics and juvenile justice programs to integrate behavioral health case management services into discharge planning for youth with behavioral health needs.
- Formal collaboration between rural behavioral health, community coalitions and local school districts to implement an evidence-based behavioral health and suicide screening tool.
- Formal collaboration between DCFS, counties, school districts, and community-based providers to provide wraparound services to children, adolescents and their families throughout the state.

Appendix 1.4: California Mental Health Timeline 1957-2013

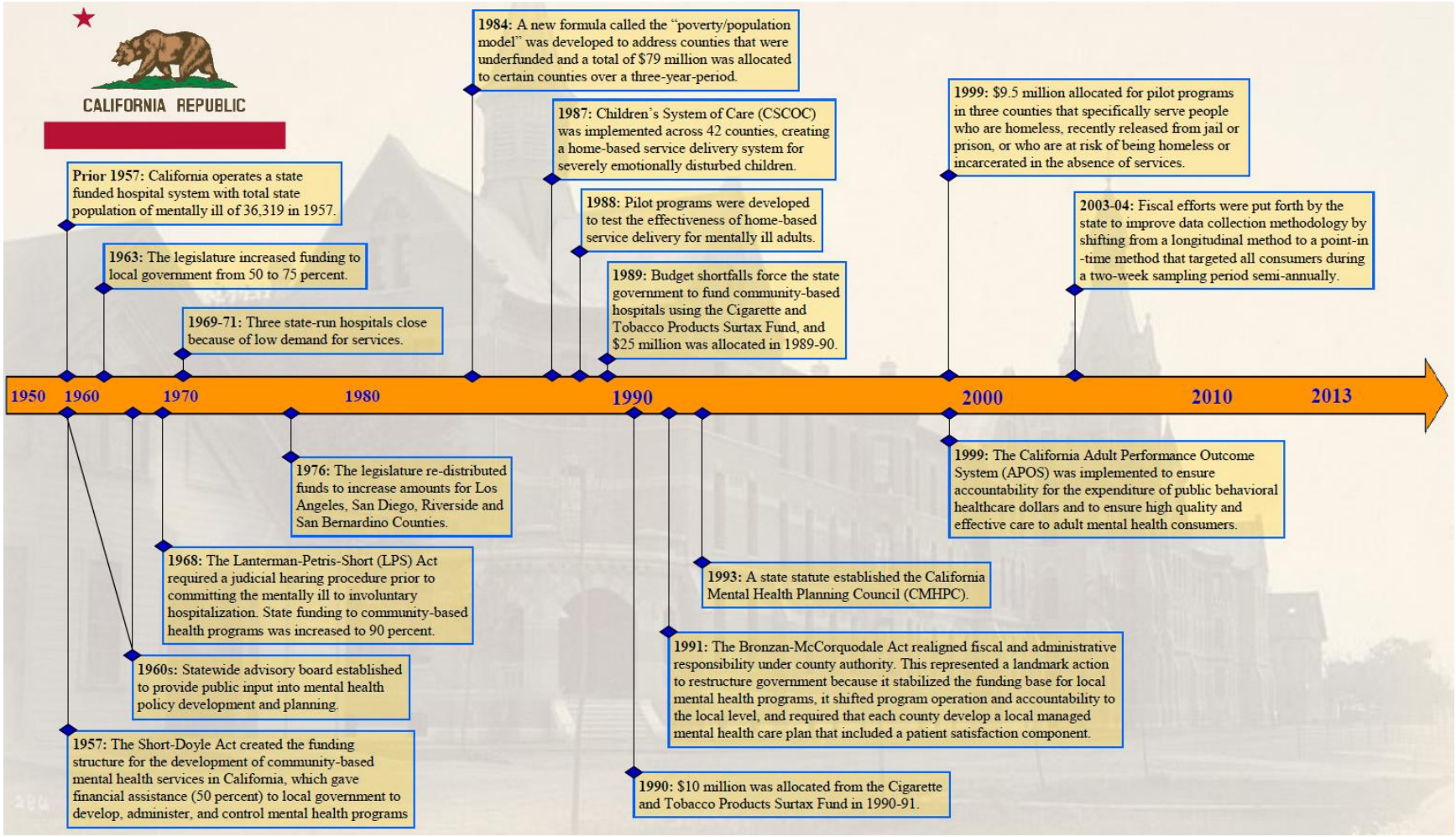


Figure 46: California Mental Health Timeline 1957-2013

Appendix 1.5: Summary of New Articles Published

Beginning in March 2013, a number of events unfolded that significantly impacted the deployment of behavioral health services in the state. Allegations that patients were inappropriately discharged from SNAMHS psychiatric hospital in southern Nevada and bused to California led to a series of investigations, including internal and external audits. Officials in San Francisco formally filed suit against Nevada, while others throughout the state of California threatened to and still may follow their lead. The charges of "patient dumping" highlighted the impact of budget cuts that began in 2007 and contributed to ongoing public scrutiny. While new developments were noted on a weekly if not daily basis, the timeline of events is summarized as follows:

Timing	Event
March 1, 2013	"From a mental hospital in Las Vegas, he's dispatched by bus to Sacramento" is published in the Sacramento Bee, detailing James Flavy Coy Brown's discharge from Southern Nevada Adult Mental Health Services Psychiatric Hospital to the Greyhound Bus Station with a ticket to Sacramento, CA.[24]
April-May 2013	Both Rawson-Neal and Dini-Townsend, inpatient facilities providing psychiatric care, are investigated by the Centers for Medicare and Medicaid Services, (CMS).[25]
April-May 2013	Governor Sandoval's office and the Nevada Department of Health and Human Services request the National Association of State Mental Health Program Directors retain consultants to review conditions at Rawson-Neal Psychiatric Hospital (RNPH) in Las Vegas, examining all areas of hospital policy and practice.[26]
April 2013	Nevada modified policy to transport discharged patients when transporting them out of state.[27]
May 2013	CMS reports structural problems at Rawson-Neal facility. Both Rawson-Neal and Dini-Townsend are cited with a number of deficiencies that could jeopardize Medicare funding.[28]
May 2013	A consultation report on Rawson-Neal Psychiatric Hospital is issued to the state, outlining strengths and 10 recommendations including the need for additional funding for services and staffing.
June 2013	The legislature approves a DHHS budget with a $23.4 million addition to the state's behavioral health system.

[24] Retrieved from http://www.sacbee.com/2013/03/01/5227505/from-a-mental-hospital-in-las.html.

[25] Retrieved from: http://www.10tv.com/content/stories/apexchange/2013/08/23/nv--psychiatric-hospitals.html.

[26] Retrieved from: http://carsonnow.org/story/04/29/2013/nevada-governor-sandoval-says-firings-discipline-action-taken-mental-health-bus-pro.

[27] Retrieved from: http://www.lasvegassun.com/news/2013/apr/24/health-officials-reverse-policy-busing-mentally-il/.

[28] Retrieved from: http://www.sacbee.com/2013/05/09/5406543/federal-probe-cites-major-problems.html.

Timing	Event
July 2013	Southern Nevada Adult Mental Health Services (SNAMHS) relinquishes its accreditation from The Joint Commission on Accreditation of Healthcare Organizations.
August 2013	CMS issues a survey report saying Rawson-Neal was out of compliance with conditions for participating in Medicare, stating, "deficiencies…substantially limit the hospital's capacity to render adequate care to patients" and "adversely affect patient health and safety."
August 2013	The Interim Finance Committee approved $2.1 million to open 22 beds at the Rawson-Neal Facility.
August 2013	The Legislature approved adding 10 beds to Lake's Crossing, which are estimated to be available in November 2013. In August, Nevada's Interim Finance Committee approved $3 million in funding to renovate the Stein Hospital in Las Vegas, adding 58 beds. However, renovations will take until 2015 at which time there will be 42 beds added for patients in legal custody. The others 16 beds would be used as overflow beds for the Rawson-Neal facility.
September 2013	The San Francisco City Attorney files a class-action suit against the State of Nevada, Rawson-Neal Psychiatric Hospital and state mental health administrators.[29]
September 2013	The Clark County Public Defender's office, again sues the state for failing to meet agreed upon time frames for persons being held in detention while waiting for court ordered psychiatric evaluations at Lake's Crossing, the only forensic psychiatric facility in the state for persons who in need of competency evaluation.

[29] Retrieved from http://www.sacbee.com/2013/09/10/5723995/san-francisco-files-class-action.html.

Appendix 1.6: Cross-Tabulation Charts and Graphs

Cross-Tabulation

To further understand the profile of behavioral health consumers, cross-tabulations of the following were calculated Race/Age, Ethnicity/Age, Race/Gender and Ethnicity/Gender. These provide a picture of which target populations of consumers access the behavioral healthcare system and help identify underserved groups in need of outreach. The following is a narrative summation of what the cross-tabulation analysis reveal. All charts associated with the analysis can be found in the Appendix of this report.

When analyzed by race and gender only African American/Black males ages 25-44 access services more frequently than their female counterparts.

Race/Age

This figure groups consumers by category-based on race and age.

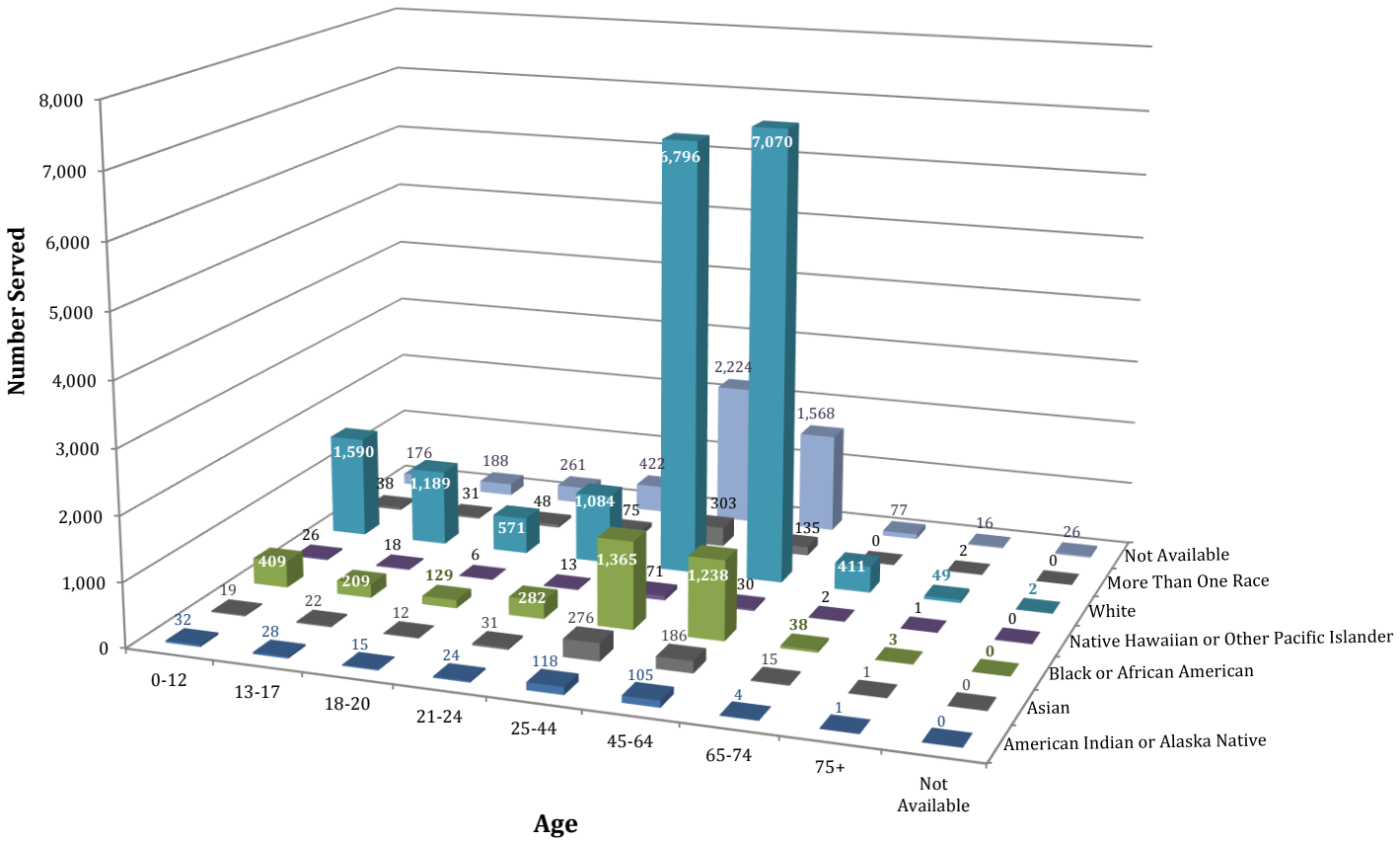


Figure 47: Cross Tabulation of Race and Age of Behavioral Health Consumers

White Consumers

The White population makes up the majority of behavioral health consumers with most between the ages of 45-64, followed closely by ages 25-44. Consistent with known trends, women make up the majority of consumers.

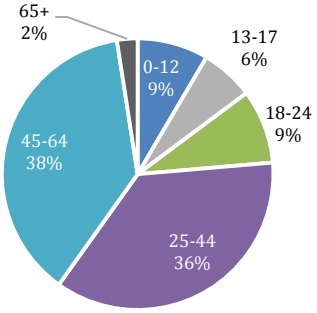


Figure 48: White Population of Behavioral Health Consumers Based on Age

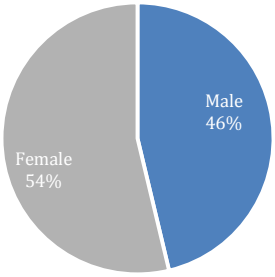


Figure 49: White Population of Behavioral Health Consumers Based on Gender

Black or African American Consumers

For Black or African Americans in Nevada, consumers between the ages of 25-44, followed closely by ages 45-64, most frequently utilize services with men making up the majority.

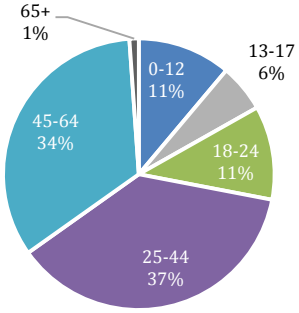


Figure 50: Black Population of Behavioral Health Consumers Based on Age

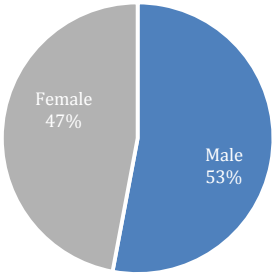


Figure 51: Black or African American Population of Behavioral Health Consumers Based on Gender

Asian Consumers

Asians in Nevada access services most often between the ages of 25-44, followed by the age range 45-64. There is a marked difference between this population and the White and Black/African American groups in that they tend to have lower access levels of services at a very young age. Women make up the majority of consumers.

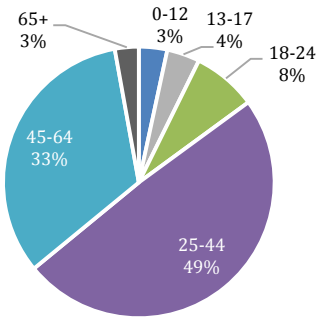


Figure 52: Asian Population of Behavioral Health Consumers Based on Age

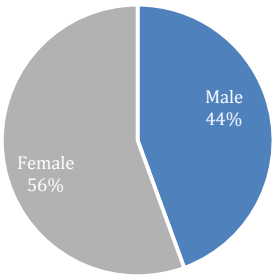


Figure 53: Asian Population of Behavioral Health Consumers Based on Gender

Multi-racial Consumers

Consumers who identify as multi-racial are most often between the ages of 25-44 and female.

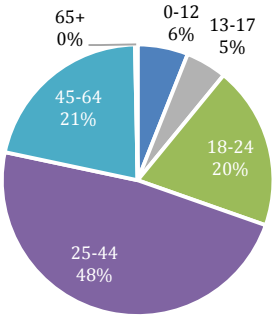


Figure 54: Multi-racial Population of Behavioral Health Consumers Based on Age

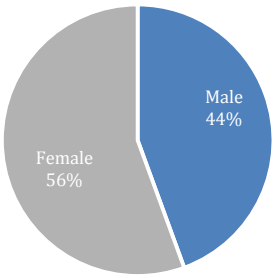


Figure 55: Multi-racial Population of Behavioral Health Consumers Based on Gender

American Indian or Alaska Native Consumers

American Indian or Alaska Native consumers are also most often between the ages of 25-44 and female.

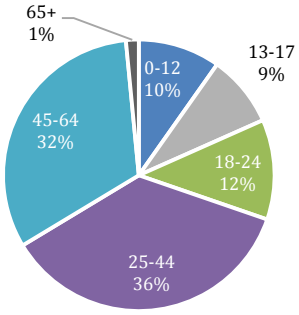


Figure 56: American Population of Behavioral Health Consumers Based on Age

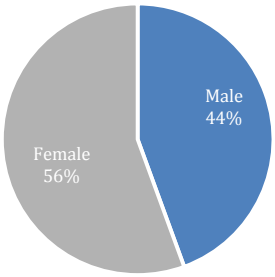


Figure 57: American Indian or Alaska Native Population of Behavioral Health Consumers Based on Gender

Native Hawaiian or Other Pacific Islander Consumers

Native Hawaiian or Other Pacific Islander consumers are also most often female and between the ages of 25-44.

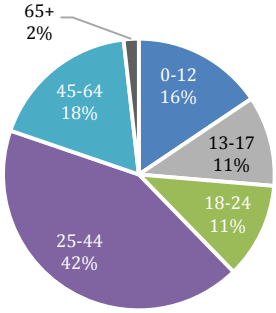


Figure 58: Native Population of Behavioral Health Consumers Based on Age

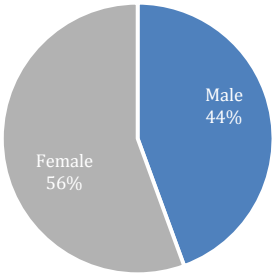


Figure 59: Native Hawaiian or Other Pacific Islander Population of Behavioral Health Consumers Based on Gender

Ethnicity/Age

Figure 61 groups consumers by category based on ethnicity and age.

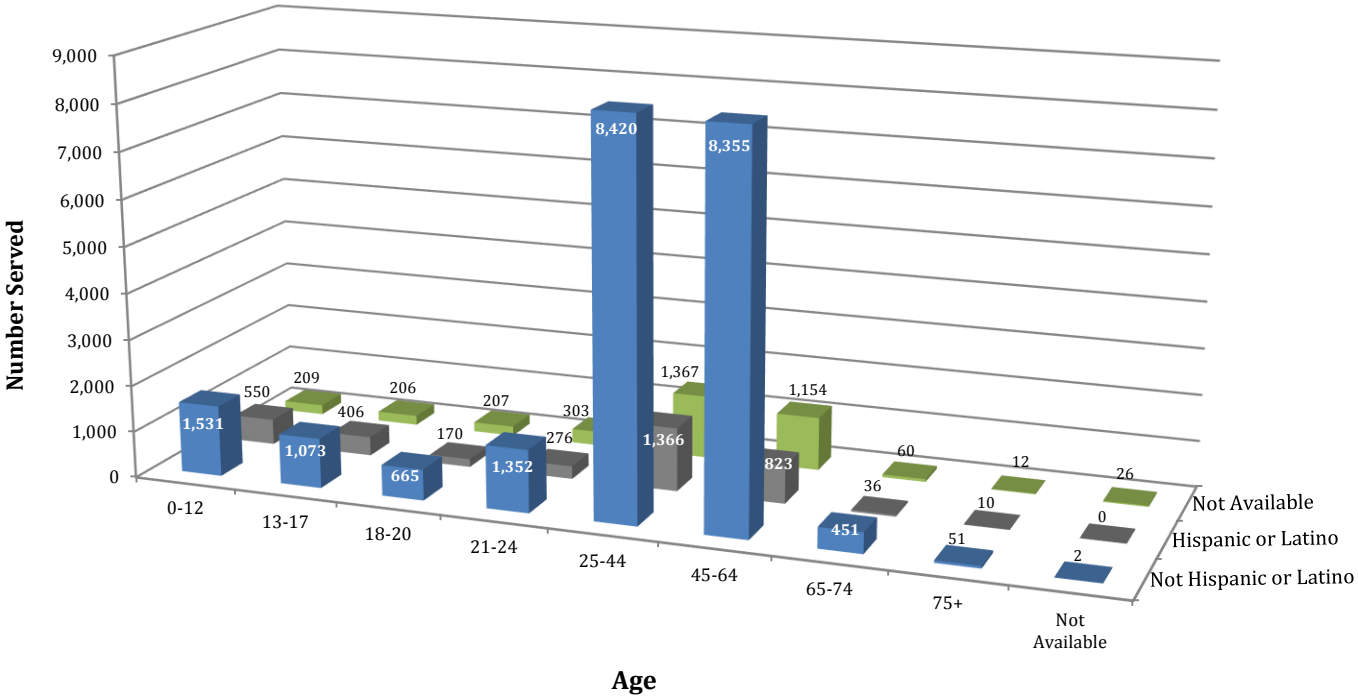


Figure 60: Cross Tabulation of Ethnicity and Age of Behavioral Health Consumer

Hispanic Consumers

The bulk of Hispanic Consumers are between the ages of 25-44, representing 38% of the service population within that ethnic group. Men and women equally access services.

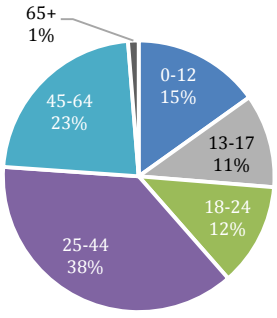


Figure 61: Hispanic Population of Behavioral Health Consumers Based on Age

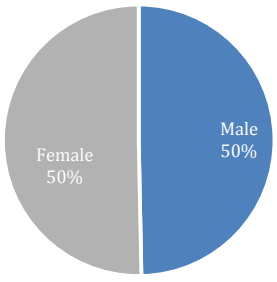


Figure 62: Hispanic Population of Behavioral Health Consumers Based on Gender

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