BEHAVIORAL HEALTH SPECIAL POPULATION WORKGROUPS - WHITE PAPERS -

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BEHAVIORAL HEALTH SPECIAL POPULATION WORKGROUPS

WHITE PAPERS

October 1, 2013

ACKNOWLEDGEMENTS

Many individuals contributed to creating the information that has been provided in this report. We truly appreciate all the team leads and workgroups that made this report possible, especially:

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TABLE OF CONTENTS

SUMMARY: SPECIAL POPULATION WORKGROUPS

Keeping with the Public Health Model of examining populations and their needs, and utilizing data to do so, the Nevada Division of Public and Behavioral Health Special Population Workgroups met from approximately November 2012 to April 2013. The primary objective of these workgroups was to determine if needs existed within each population, and if so, what the gaps in service or intervention were, and how much money and/or resources would be required to rectify the needs identified with respect to specific populations. All whitepapers followed a consistent format, including a Purpose, Background, Problem Statement, Proposed Solution and Conclusion.

All told, there were seven workgroups consisting of approximately four to eight members each. Each workgroup met approximately every two to four weeks with their team members. It should be noted that several workgroup team leads resigned their employment with the Division during which time their workgroups were meeting and/or developing their white papers – this included the Workgroup team leads for Homelessness (Ashlynn Martin), Native Americans/Tribes (Joann Flanagan) and Addictions/Co-Occurring Disorders (Tami McKnight). However, several existing team members stepped in admirably and completed the process and submitted their white papers for these groups, including Rob Jones for Homelessness, Dr. Luana Ritch for Native Americans/Tribes and Steve McLaughlin for Addictions and Co-Occurring Disorders. Additionally, with respect to the Adolescents and Young Adult Workgroup, this workgroup identified and addressed three specific needs that necessitated three different whitepapers to address this needs: 1) Transitioning from Adolescent to Adulthood and the Need for Service Continuity, 2) School-Based Health Services, and 3) Out-of-State Psychiatric Residential Treatment Center placements.

It is believed that most, if not all, of the information contained in these white papers can assist the Division of Public and Behavioral Health when it works on completing its next bi-annual budget in approximately one year, for State Fiscal Years (SFYs) 16 and 17. As a result, these groups can reconvene closer to this time as necessary, to assist with this endeavor.

RESPONSIBLE WORKGROUP TEAM LEADS

Special Population Workgroup	Team/Workgroup Leader	Phone Number	Email Address
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WHITEPAPER

RETAINING BEHAVIORALLY COMPLEX ADULTS WITH MENTAL HEALTH NEEDS WITHIN THE STATE OF NEVADA VERSUS OUT OF STATE PLACEMENTS

RETAINING BEHAVIORALLY COMPLEX ADULTS WITH MENTAL HEALTH NEEDS WITHIN THE STATE OF NEVADA VERSUS OUT OF STATE PLACEMENTS

By Lisa Sherych

Purpose:

The purpose of this white paper is to discuss the possible opportunities for supporting behaviorally complex adults who currently are transferred out of state for residential services and supports to stay within Nevada.

Background:

Historically, individuals considered to be behaviorally complex with co-existing mental health support needs have been placed out of state in nursing homes due to either no space availability in Nevada or current providers not being able to provide the level of care for reasons to include reimbursement rates, no specialized training to effectively support the individuals or apprehension surrounding perceived licensing sanctions that could arise with accepting individuals with this required level of support.
Majority of individuals who meet this criterion are located in Southern Nevada and are either patients from a general acute care hospital or individuals with numerous re-admissions with psychiatric hospitals and can't be placed back in the nursing home they have come from.

The tables below summarize the number of individuals specific to this white paper who are in out-of-state placements to include: diagnosis, location, and expenditure costs.

Diagnosis Summary Out of State Nursing Facility Recipients			
Diagnosis	**2010**	**2011**	**2012**
Alzheimer's & Dementias	31	33	36
Depression, Psychosis & MI	20	20	9
Huntington Disease	2	3	1
TBI (*numbers reflect primarily individuals under 22 years of age)	13	12	16
Ventilator Dependent	1	1	0
Autism	0	0	2
Other Medical	13	13	16
Total	**80**	**83**	**80**

Breakdown of Location for Out of State Placements				
	Recipients	**Children (0-21 years)**	**Adults (22-64 Years)**	**Elderly (65 years and older)**
Arizona	10	10	0	0
California	0	0	0	0
Idaho	31	0	16	15
Mass	2	0	2	0
Utah	37	0	22	15
Totals	**80**	**10**	**40**	**30**

Summary of In State Versus Out of State Expenditures						
	Total Expenditures In State	Average # of Recipients per month	Average per month In State	Total Expenditures Out of State	Average # of Recipients per month	Average per month out of state
2010	$156,367,754	2,983	$4,369	$6,311,310	76	$6,928
2011	$167,329,627	3129	$4,457	$7,383,804	83	$7,413
2012	$186,569,709	2,929	$5,311	$7,668,183	80	$8,009

Data: DHCFP Dashboard Data (Uses unduplicated count)

Problem Statement:

Individuals being placed out of state results in higher costs to the state of Nevada, the inability for Nevada to provide oversight to the extent they would if person was residing in state, and also impacts support networks for the individuals and their family/friends. Previous to April 2013, there was no "add on rate" or financial incentive for Nevada nursing home providers to accept individuals considered to be behaviorally complex.

Proposed Solution:

On March 22, 2013 a public hearing was held regarding the Division of Health Care Financing and Policy's proposed change to the Medicaid Manual Chapter 500 concerning a behaviorally complex add-on rate to be approved for a Nevada Medicaid recipient whether placed in or out-of-state, who is identified with a severe medically-based behavior disorder resulting in the Medicaid recipient posing a

danger to self and/or others. The term "medically based behavior disorder" includes mental health diagnoses if the diagnosis substantiates the behavioral manifestations, or if the individual is aggressive for no known reason. The proposed change was approved.

A workgroup incorporating members from the Division of Health Care Financing and Policy, Division of Mental Health/Developmental Services (representatives from Mental Health and Developmental Services), Bureau of Health Care Quality Compliance, and the Nevada Health Care Association has been developed to work on clarifying the add-on rate requirements and correlating implementation needs by the nursing home providers.

Conclusion:

There are currently five Nevada nursing home providers interested in accepting these individuals into their respective programs/services. The Behaviorally Complex Add-On Rate workgroup has and will continue to meet monthly to address the add-on rate requirements, authorization process and correlating implementation needs by the nursing home providers that has included identified training needs for these facilities and staffing; psychotropic medication management; behavioral support plans and oversight and regulatory requirements.

WHITEPAPER

NEVADA NATIVE AMERICANS / TRIBES

NEVADA NATIVE AMERICANS /TRIBES

By Joann Flanagan, M.Ed, LADC and Luana Ritch, Ph.D.

Purpose:

The purpose of this white paper is to address the behavioral health disparities of Nevada's 27 Tribes and urban Native Americans statewide. The proposal is to address the unmet behavioral health needs in collaboration between the Division of Public and Behavioral Health, Nevada's 27 Tribes, Urban Native Americans, and Indian Health Service (IHS). The collaboration will not only enhance current relationships between the 3 entities, but also solidify the working relationship to assist with the emotional, mental, physical healing and wellness of the Native American population in Nevada. The proposed initial objectives is collect behavioral health data to better identify the needs and redirect resources, including federal grant collaboration.

Background:

Indian Health Services (IHS)

The intricacy of IHS and Enrolled/Descendants needs to be explained to appreciate the complexity of accessing and obtaining health care services with IHS. Tribal Clinics and urban clinics. Briefly, Indian Health Service (IHS) is an agency within the Department of Health and Human Services and is the health care provider for American Indians and Alaska Natives. HIS is the primary care health care provider for American Indians and Alaska Natives of 566 federally recognized Tribes in the United States. The provision of health services to members of federally-recognized tribes is based on a special government-to-government relationship between the federal government and Indian Tribes. Therefore, the special interest or race statuses are not applicable. A relationship established in 1787-Article I, Section 8 of the Constitution, and since has been solidified by numerous treaties, laws, Supreme Court decisions and Executive Orders.

Tribal Self-Governance Program (TSGP)

To further exercise the government to government relationship, some tribes elected to participant in the IHS TSGP. Through the TSGP, Tribes have the option to assume IHS program funds and manage them to best fit the needs of their Tribal communities. Tribes participating in the TSGP negotiate with the IHS and take on full funding, control, and accountability for those programs, services, functions, and activities (PSFAs), or portions thereof, that the Tribe chooses to assume.

Participation in the TSGP is one of three ways:

1. Receive health care services directly from the HIS;
2. Contract with the IHS to administer individual programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracts); or

3. Compact with the IHS to assume control over health care programs the IHS would otherwise provide (referred to as Title V Self-Governance Compacts or the TSGP).

Eligibility: Enrolled/Descendance

Eligibility requirements for contract health services (CHS) are in addition to meeting the requirements for direct care services at an IHS or tribal facility. The CHS is not an entitlement program. An individual must meet the eligibility requirements as defined by Federal regulations published in Code of Federal Regulations (CFR), at Title 42, Section 136.21 through 136.25, and Indian Health Services, Part 2, Chapter 3, "Contract Health Services" dated January 5, 1998.

There are five eligibility requirements, which must be met by each person needing and applying for CHS assistance. The eligibility requirements are:

1. An individual is of Indian and/or Alaska Native descent as evidenced by one or more of the factors: Meaning an individual must be of Indian descent and belong to the Indian community which may be verified by tribal descendancy or census number. An individual must be a member, enrolled or otherwise, or an Indian or Alaska Native Tribe or Group under Federal supervision; Is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post partum (usually 6 weeks); or Is a non-Indian member of an eligible Indian's household and the medical officer in charge services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard;

2. An individual resides within his/her Tribal Contract Health Service Delivery Area (CHSDA). The Tribal CHSDA encompasses the Reservation, trust land, and the counties that border the reservation. Resides on tax-exempt land or owns restricted property;

3. Notification and authorization of approval for payment. An individual must be authorized by CHS authorizing official for the payment of services;

4. CHS funds are limited to the medical or dental services considered medically necessary and listed within the established Area IHS medical/dental priorities. An individual medical need at the time of services must be within the Priorities or Care (medical priorities) being funded at that time;

5. An individual must apply for and use all alternate resources that are available and accessible, such as Medicare A and B, state Medicaid, state or other federal health program, private insurance, etc; and

6. The IHS is the "payer of last resort" of persons defined as eligible for CHS, notwithstanding any state or local law or regulation to the contrary. Citation CFR at Title 42 §136.61.

Native American Health Disparities

Native Americans continue to experience significant rates of diabetes, mental health disorders, substance abuse disorders, cardiovascular disease, pneumonia, influenza, and injuries. Native Americans

are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than other Americans, including white and minority populations. As a result of these increased mortality rates, the life expectancy for Native Americans is 71 years of age, nearly five years less than the rest of the U.S. population.

Behavioral Health Disparities

Native Americans are at a higher risk for mental health disorders than other racial and ethnic groups in the United States, and are consistently overrepresented among high-need populations for mental health services. Surgeon General reported that this over representation might be attributed to the high rates of homelessness, incarceration, alcohol and drug abuse, and stress and trauma in Native American populations. Further indicated that the U.S. mental health system is not well equipped to meet these needs; specifically that IHS, due to both budget constraints and personnel problems, is mostly limited to basic psychiatric emergency care. IHS lacks in providing quality, ongoing psychiatric care. Instead, IHS approach is one of responding to immediate mental health crises and stabilizing patients until their next episodes. The most significant mental health concerns today are substance abuse, depression, anxiety, violence, and suicide. Of these, substance abuse, notably alcoholism, has been the most visible health disorder crisis, while depression is emerging as a dominant concern. These two illnesses are often a consequence of isolation on distant reservations, pervasive poverty, hopelessness, and intergenerational trauma, including the historic attempts by the federal government to forcibly assimilate tribes.

Alcohol abuse is widespread in Native American communities. Native Americans use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups. Consequently, their age-adjusted alcohol-related mortality rate is 5.3 times greater than that of the general population. Despite a significant demand for mental health services, there are approximately 101 mental health professionals available per 100,000 Native Americans, compared with 173 mental health personnel per 100,000 whites. With a greater need for mental health specialists, but fewer available for treatment, Native Americans frequently do not receive the necessary care for substance abuse, depression, anxiety, suicide ideations, and other mental health conditions.

Nevada has 27 federally recognized Tribes, including Washoe, Paiute, and Shoshones. Additionally, numerous other American Indians and Alaska Natives reside in Nevada's urban communities or within the Washoe, Paiute, and Shoshones reservations. Together, American Indians and Alaska Natives comprise approximately 2% of Nevada's population.

Problem Statement:

Nevada Data

Currently, Nevada Health Division Data and Nevada's 27 Tribes have limited and/or dated information to report accurate data. However, the consensus amongst Nevada Tribes, urban Native American, I.H.S. and the Nevada Division of Public and Behavioral Health is Nevada's 27 Tribes and urban Native

American health disparities are consistent with the national Native American health disparities as well as unmet needs identified and to be identified. National data from the US Office of Minority Health for 2008, states the percent of serious mental illness for this population is 5.3%, compared to the White (non-Hispanic) population of 3.1%. Similar disparities exist for other mental health concerns, such as depression, anxiety disorders, and post-traumatic stress disorder.

In a sample of 4,070 individuals diagnosed with a mental illness during FY2012 for Nevada provided by the Indian Health Service reflects 51% of this population was under the age of 40 at the time of their first mental health visit of the year, 56% were female, 5% had a diagnosis of post-traumatic stress disorder, including very young children and adolescents.

Affordable Care Act (ACA)

Indian Health Care Improvement Act (IHCIA) was initiated in 1976 and renewed in 2010. The ACA permanently reauthorized the IHCIA and authorized new programs within the IHS. The Affordable Care Act authorized the following new programs: expands IHS services, including Mental and Behavioral Health treatment and prevention. Nevada's approval of the Medicaid Expansion affords the Nevada Tribes increased access to the Medicaid services, allowing Tribal Clinics reimbursement capabilities. Those needing services, state can assist in addressing the needs of on-going behavioral health needs and definitely provide care to those not enrolled or not eligible for contract. In consulting with IHS. and tribal behavioral health providers, longer term intensive outpatient counseling is lacking. Additionally, ACA Medicaid Expansion will allow more Native Americans to access state mental health and substance abuse services.

Proposed Solution/Conclusion:

Short-term (Implementation by July 1, 2014)

- ✓ To collaboratively provide at least annual opportunities in services training on Native American Cultural Competency and Nevada Division of Public and Behavioral Health service delivery system services statewide to a variety of disciplines, agencies, and Tribal Health Clinics and Urban Health Clinics.

Long Term (Implementation by December 31, 2013)

Provide staff support for on-going inter-disciplinary policy development suggestion to administrators regarding mental health and substance abuse issues of Nevada's 27 Tribes American Indian/Alaska Natives in Nevada

- ✓ Study the mental health and substance abuse service needs of to assist in project and program evaluation; and to study and refine data collection system to more fully track needs and service; and
- ✓ To research funding opportunities to enhance the short and long-term recommendations.

WHITEPAPER

MILITARY SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

MILITARY SERVICE MEMBERS, VETERANS, AND THEIR FAMILIES

By Luana Ritch, Ph.D.

Purpose:

As stated in Nevada's Green Zone Initiative, the goal of the Wellness Sector is to assure "Service members, veterans, their families, and the families of the fallen have access to healthcare, mental health services, prevention services, benefit information, wellness programs, and community supports." The Division of Public and Behavioral Health's programs are critical to creating an environment where this goal can be achieved.

Background:

The nation, and Nevada, is entering a second decade of war in response to attacks of terrorism. The needs of military families are evident to elected leaders, policy makers, and broader communities, even though the percentage of Nevadans that have served, been injured, or lost a loved one is small compared to past wars. Part of this awareness comes from media coverage of obstacles faced by returning service members in finding employment, healthcare, and education programs. The challenges for veterans from these most recent wars are great with hardship, illness, and injury experienced disproportionately to non-veterans. In addition, the challenges of recent veterans have increased awareness of society's treatment of veterans from past wars, especially Vietnam Veterans. The on-going mental and physical health needs of older veterans add to the need for community action exponentially. The Green Zone Initiative is Nevada's coordinated planning and action initiative to address identified needs of this population to thrive in Nevada.

Problem Statement:

There are an estimated 234,081 veterans residing in Nevada of all ages and eras of service, representing 12% of the population compared to the lower estimated rate for the United States of 10%. Veterans represent a distinct population with health risks and injury risks higher than the general population. In a study of veteran suicide mortality from 2008-2010 in Nevada, veteran suicide death rates were 46 per 100,000 population compared to 19 per 100,000 for the population as a whole. Recent national studies have shown veterans experience accidental deaths, mental health and substance abuse disorders, and chronic diseases at higher rates than non-veterans do. A current on-going survey of individuals receiving mental health services from Division programs indicates that approximately 6% have served in the military. These individuals have lower percentages of employment and school attendance and higher percentages of on-going encounters with law enforcement.

In spite of having this identified population with higher health risks and poorer health outcomes, Division programs have, for the most part, not given attention or service coordination to military service members, veterans, their families, and families of the fallen.

Proposed Solutions:

A. Commit to and participate in the Green Zone Initiative as the lead state agency for the Wellness Sector to implement recommended strategies including the following to improve the health status of this population in culturally sensitive ways, acknowledging a unique military culture.

Green Zone Initiative Wellness Recommendations:

1. Veterans Suicide Task Force: Nevada should address the need for better coordination between agencies through the creation of a veterans' suicide task force, sponsored by the Department of Health and Human Services and the Nevada Department of Veterans Services, and made up of members of the statewide veteran and mental health communities.

2. Coordinate with the Nevada Department of Veterans Services to collaborate with other state and local entities, and with the US Department of Veterans Affairs in providing access to all benefits and services for which a veteran, or family member, is eligible.

3. Veterans should be identified through an online self-identification mechanism, the Veterans Driver's License, a VA "Request of Names and Addresses," and through self-identification on all state forms.

4. Advertise in Various Channels: To build the bridge to other generations, NDVS should use direct mail, eNewsletters, newspaper, and develop a quarterly magazine. Include information promoting wellness in each modality.

5. Develop a Hard Copy Benefits Guide: When all of the benefits are identified, NDVS should publish a print edition of the benefits guide (while a soft copy would be available online), so that all state locations can disseminate them to veterans who might be using their services.

6. Collaborate with Community-Based Organizations for outreach, physical and behavioral health education/prevention services to service members, veterans, and their families, and families of the fallen.

Proposed Budget: (does not include personnel)

Item	Expense per Unit	Subtotal/Total
In-State Travel		
Quarterly 2 day to Las Vegas	$660	$2,640.00
1 Day Events/2 times per year	$660	$1,320.00
		Subtotal: $3,960.00
Out of State Conference	$2,500	Subtotal: $2,500.00
		Total Travel: $6,460.00
Out-Reach Materials		
Newspaper Insert (Vet Day)	$15,000	
GZI website posters/wallet cards	$5,000	**Total Out-Reach: $20,000.00**
Equipment/Technology		
Laptop Computer	$3,500	$3,500
Micro-portable projector	$500	$500
Data Plan	$40/month	$480
All-in-One Printer	$130	$130
		Total Equipment: $4,610.00
Misc. Operating	$25/month	**Total Misc. Operating: $300.00**
Program Cost 1st Year		**Program Cost 1st Year: $31,370.00**
Program Cost 2nd Year		**Program Cost 2nd Year: $22,240.00**

Conclusion:

Military service often results in an increased individual risk for a wide variety of health conditions including mental health conditions that extends to the veteran or service member, their families, and the families of those who died in such service. This represents a significant segment of the state's population and requires innovative methods, coordination, collaboration and understanding to improve health status and reduce risk. Addressing the needs of Nevada's military population also helps to improve the health status of the overall population.

WHITEPAPER

HOMELESS INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS IN NEVADA

HOMELESS INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS IN NEVADA

By Rob Jones, MA, LMFT

Purpose:

Individuals who are chronically homeless and who have substance use and/or mental disorders are arguably the most vulnerable of homeless subpopulations. Yet this population is also among the most difficult for public and private agencies to provide services to. This is due in part to the struggles homeless individuals have with mental disorders, substance use, and co-occurring mental and substance use disorders. Due to these struggles, chronically homeless individuals often resist, or even avoid, service attempts. It is the goal of the Division of Public and Behavioral Health to identify and provide outreach, housing options, treatment and recovery to individuals who are homeless and who have behavioral health needs.

Background:

The 2013 Nevada statewide Point in Time count on homelessness revealed there are 6,896 homeless individuals in Clark County, 746 homeless individuals in Washoe County, and 180 homeless individuals in rural Nevada.

According to SAMHSA, studies show co-occurring rates in the homeless population as high as 23% for lifetime prevalence. That number is probably high for a point-in-time comparison. The Department of Health and Human Services estimates that 25% – 30% of all homeless persons have a mental health condition, and half of those also have co-occurring conditions. That equates to 12.5% – 15% of the overall homeless population.

If the middle average between 12.5% and 23% (i.e., 17.75%) is used as our indicator, the approximate number of homeless individuals with co-occurring substance use and mental disorders in Nevada for 2013 comes to 1224 individuals in Clark County, 132 individuals in Washoe County, and 32 individuals in rural Nevada. For the entire State of Nevada, the estimated number of homeless individuals with co-occurring substance use and mental disorders equals approximately 1388.

According to SAMSHA, individuals who are homeless with co-occurring disorders are more likely to have life-threatening health conditions and live in life threatening situations. One fifth of men and one third of women who are homeless with a co-occurring disorder also have port traumatic stress disorder (SAMSHA Publications, TIP 55 “Behavioral Health Services for People Who Are Homeless” p.7).

The Implementation of the Homeless Emergency Assistance and Rapid Transition to Housing Acts of 2009 (HEARTH Act) changed the focus of homelessness from addressing the needs of homeless people in emergency or transitional shelters to assisting people to quickly regain stability in permanent housing

after experiencing a housing crisis and/or homelessness. The priorities of homeless programs have changed to include factors such as:

- Shortening the period of homelessness for people living in shelters, cars, or other situations not meant for human habitation;
- Decreasing the length of stay in an emergency shelters;
- Providing permanent housing for individuals and families defined as homeless (i.e., rapid re-housing) and including essential services, such as case management, housing search, and placement;
- Providing financial assistance to households at imminent risk of homelessness.

Nevada's 2010-2014 Consolidated Plan addressing the State's housing and community development needs established 19 priorities to guide funding decisions. Each priority is equally important to ensure quality of life for households with low-incomes. Priorities are developed through a public participation and planning process that includes input from the non-entitlement jurisdictions in Nevada, other vital stakeholders, and the citizenry. Priorities 6 – 11 are of significance to this paper:

Priority 6: Continue to support agencies operating emergency shelters and provide assistance to people who are homeless.
Priority 7**:** Support efforts to create additional transitional and permanent supportive housing.
Priority 8**:** Continue to provide financial support to assist those in imminent danger of becoming homeless.
Priority 9: Increase and preserve the supply of affordable housing available to people who are elderly, disabled, or have large families.
Priority 10: Improve housing accessibility and safety (existing and new).
Priority 11: Improve access to services for people with special needs.

The first step towards healing for these individuals may be access to medical care and a safe and healthy place to live (SAMSHA TIP 55, "Behavioral Health Services for People Who Are Homeless" p. 7). This subpopulation is also more likely to have immediate life-threatening health conditions and to live in life-threatening situations. They have high rates of HIV/AIDS, hepatitis C, cardiovascular conditions, dental problems, asthma, diabetes, and other medical conditions (SAMSHA TIP 55, "Behavioral Health Services for People Who Are Homeless" p. 13).

Currently Nevada State Division of Public and Behavioral Health have HUD Shelter Plus Care (SPC) and other (SLA) funds that provide housing to homeless individuals diagnosed as SMI/SED. Southern Nevada Adult Mental Health Services' (SNAHMS) SPC grant provides 201 beds of which 199 are currently used, and the 1 Pathways Grant (which used to be run by the Salvation Army) that provides 55 beds of which all 55 are currently available. Northern Nevada Adult Mental Health Services (NNAMHS) SPC 1 & 2 Grants currently provide 63 beds, and they have four open beds for single individuals. Rural Services Mental Health (RSMH) SPC grant provides 24 beds, with 1 opening available.

Problem Statement:

Lack of funding for supportive services in housing programs continues to be a barrier for the State, especially in rural Nevada. To address the very complex issues facing chronically homeless individuals and families, providers need to build capacity to deliver both intensive and regular case management and supportive (SLA) services. This is vital to ensure the long-term housing success of chronically homeless individuals. The current lack of resources regarding these services makes it difficult to end chronic homelessness in Nevada.

A barrier in addressing homelessness in Nevada continues to be the lack of current state-of-the–art statewide initiatives to address and end homelessness. Continuums and communities work at local levels to address this important issue and are showing some success. However implementing a statewide initiative that includes high-ranking state and local representatives would help to address the many challenges faced by local communities to address and end homelessness in Nevada.

According to the 2012 MHDS Needs Assessment, many communities indicated that the priorities in their area were addressing:

1. Households at imminent risk of becoming homeless.
2. Homeless individuals living in someone else's home or who are living in motels.
3. Individuals otherwise precariously housed.

Agencies felt that a better use of limited resources was to help stabilized program participants so that they don't become homeless, with the hope that other resources (such as funding provided through the HUD Continuum of Care process) will be available to help homeless households.

Proposed Solutions:

1. The State of Nevada needs develop strategies associated with addressing the needs of individuals who experience chronic homelessness. This would require the Governor to re-establish the State Interagency Council on Homelessness. The Council will then need to update the State's plan to end homelessness and to be aggressively active in developing statewide policies and procedures toward this endeavor. The United States Interagency Council on Homeless web site states: "Every State and territory has been encouraged by the United States Interagency Council to establish by Governor's Executive Order or legislative authority a State Interagency Council on Homelessness with representation at the Cabinet level from the mainstream income support, health care, behavioral health, human services, Veterans, housing, corrections, transportation, education, and labor departments and agencies." There would be costs related to upper management time spent during the meetings, travel expenses for in person meetings, and related issues. Estimated travel costs: approximately $5,000 annually.

2. Community and state agencies need greater involvement and participation in State wide consortium/continuum meetings at least quarterly to discuss, evaluate and report on the

implementation of statewide initiatives, goals and objectives regarding services and activities to end homelessness, including supporting the reinstatement of the Governor's Interagency Council on Homelessness. Meetings can be organized to begin in October 2013. There would be costs related to state staff time spent during the meetings and related assignments/tasks. Estimated travel costs: approximately $5,000 annually.

3. Data obtained from the homeless point-in-time counts and the Homeless Management Information System database need to be used by state and local agencies to demonstrate the homeless and under-housed needs in Nevada. This can be implemented beginning October 2013. There would be costs related to state staff time spent during the meetings and related assignments/tasks. Also, state and community agencies who provide shelter and housing for homeless individuals/families need to convert their database system to the HMIS (Clarity) database system in order to ensure statewide epidemiological data is accurate for reports to the state executive and legislative branches as well as to potential grant funders. There will be costs associated with converting database systems to HMIS. Costs are unknown at this time. Implementation timeframes depends on associated funding resources.

4. State agencies and community partners need to collaborate to accomplish strategic outreach endeavors. A major focus of this outreach should be with individuals identified as having a co-occurring disorder who are scheduled for discharge from correctional facilities and psychiatric hospitals and who would be homeless upon discharged without case management assistance to address their housing and treatment needs. The major proponents of this endeavor need to be Peer to Peer Navigators and case managers (psychiatric case workers) who are eligible for Medicaid reimbursement. Most likely, these services will be provided through the Division of Public and Behavioral Health (DPBH), SAPTA Providers or County employees. This endeavor has recently begun to be implemented on a small scale in Reno and Carson City.

5. Developed cross system linkages and use of Continuum of Care Point in Time interview data so that case managers can determine the best fit for employment in regard to education level of homeless persons, proximity and availability to transportation, and employment with some benefits. This can be implemented immediately with no cost increase.

6. Case management, which is often intensive in the beginning, is essential in addressing the individual's manifold needs and preventing them from becoming lost in the maze of community services. These individuals often need assistance with such tasks as arranging transportation, obtaining appropriate clothing for interviews, ensuring follow-through on referrals, understanding the instructions provided by other agencies, and assembling appropriate information and credentials needed by other community programs (SAMSHA Publications, TIP 55 "Behavioral Health Services for People Who Are Homeless", p.7). More case managers will need to be hired on state, county and community provider levels in order to have a large scale impact on ending homelessness for individuals with behavioral health problems in Nevada. It

will involve intensive case management at least for the first three to six months after the individual is discharged from jail or the hospital.

7. Housing access is the bull work of recovery for these individuals. Case managers need to work closely with their local HUD Continuum of Care and Housing Authority to advocate for prioritization of these individuals in governmental subsidized housing. This can be implemented immediately with no cost increase.

8. Income stability through access to Federal or local income benefits is a crucial ingredient in helping these individuals integrate into the social mainstream. Behavioral health provider case managers and peer to peer navigators need to engage and enroll these individuals in Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP). Case management referral and linkage activities are covered Medicaid reimbursable expenses for qualified case managers (QMHA's). This can be partially implemented immediately. However full implementation would require hiring more case managers to provide intensive case management. Intensive case management requires case managers to carry smaller case loads – approximately 15 to 20 cases instead of the normal caseload of 35 or more cases.

9. Supportive employment will assist these individuals to access, obtain, and maintain employment as a primary method to prevent or end homelessness (SAMSHA TIP 55, "Behavioral Health Services for People Who Are Homeless", p. 41). State agencies and community partners need to increase collaboration to provide assistance with encouraging these individuals to engage in supportive and competitive employment endeavors. This will include case management referrals and linkages to the State of Nevada Departments of Vocational Rehabilitation and Employment, Training and Rehabilitation. No costs associated with this solution.

10. State agencies and community partners need to collaborate in providing wrap around services that include the utilization of Supportive Living Arrangement (SLA) providers who can assist the individual with learning daily living and household maintenance skills. Currently only Nevada State Mental Health Agencies pay for these services. This MH state budget item will need to be increased at least 2-3 times more than what it is currently budgeted. Mental Health SLA provider capacity in the rural areas is also non-existent and will need to be developed.

11. State agencies and community partners need to collaborate with providing these individuals with opportunities to participate in evidence based co-occurring substance use and mental health treatment. Treatment modalities should include, but not be limited to, Trauma Focused Cognitive Behavioral Therapy (TFCBT). Individual and group treatment is Medicaid reimbursable for qualified providers. One time cost for state wide training to providers: approximately $10,000.

12. State agencies and community partners need to collaborate with providing opportunities for these individuals to participate in evidence based Basic Skills Training (BST) and Psycho-social Rehabilitation (PSR) programs. One such model already implemented at SNAHMS, NNAMHS, and RSMH is called "Illness, Management and Recovery" (IMR). BST and PSR services are Medicaid reimbursable costs by qualified providers. No costs are associated with this solution.

13. Developed a state wide Peer-to-Peer program to assist individuals who are homeless with co-occurring disorders with identifying and accessing housing, recovery support services, social mainstream benefits, and personal network development. Training peer mentors will cost the state approximately $6,000 - $10.000 a year for the first few years and then tapering off to less in the following years. The services provided by the peer navigators may be Medicaid reimbursable. This solution is already in the process of occurring.

14. The Division of Public and Behavioral Health has formulated an interagency workgroup to assist with the submission (through SAPTA) of the SAMSHA CABHI (Cooperative Agreement to Benefit Homeless Individuals for States) grant worth up to $711,818 each year for three years. It is designed to create an integrated system of care and treatment for individuals who are homeless and who have a co-occurring disorder. The grant was submitted to SAMSHA on May 28, 2013. The anticipated impact is permanent housing coupled with case management and co-occurring substance use and mental health treatment for a minimum of 100-120 individuals a year.

Cost and Projected Time for Implementation:

Clark County: A low estimate of homeless individuals with a mental disorder is approximately 1,724 individuals (6,896 homeless individuals times 25% who have a mental disorder = 1,724). New staff required to accommodate these individuals is outlined below.

Description	Pay Grade	Step	FTE	Salary	Benefits	Individual Cost	Total
Clinical Program Manager I	**39**	**5**	**1.00**	**62,345**	**21,143**	**83,488**	**83,488**
Psychiatric Case Worker II	**33**	**5**	**80.00**	**47,880**	**18,185**	**66,065**	**5,285,200**
Sr. Psychiatrist (Range C) (EA)	**99**	**5**	**5.00**	**170,445**	**39,999**	**210,444**	**1,052,220**
Psychiatric Nurse 2	**39**	**5**	**8.00**	**62,345**	**21,143**	**83,488**	**667,904**
Psychiatric Nurse 3	**41**	**5**	**1.00**	**68,220**	**22,343**	**90,563**	**90,563**
Mental Health Counselor II	**37**	**5**	**4.00**	**57,034**	**20,056**	**77,090**	**308,360**
Administrative Assistant III	**27**	**5**	**1.00**	**37,118**	**15,983**	**53,101**	**53,101**
Administrative Assistant II	**25**	**5**	**2.00**	**34,180**	**15,386**	**49,566**	**99,132**
Consumer Services Assistants	**20**	**5**	**3.00**	**28,126**	**14,122**	**42,248**	**126,744**
						Total:	**$7,766,712**

The program would also need an increase in state funded Supported Living Arrangement (SLA) as outlined below:

- SLA (rent, utilities & personal needs) average = $1,031 per month times twelve months times 1,724 individuals = $21,329,328
- SLA (provider direct services @ $18.86 times 35 hours a month times twelve months times 1,724 individuals = $ 13,656,149
- Total increase in SLA funding needed: $34,985,477
- Total funding increase needed for SNAHMS: $42,752,189

Washoe County: A low estimate of homeless individuals with a mental disorder is approximately 187 individuals (746 homeless individuals times 25% who have a mental disorder = 187). New staff required to accommodate these individuals is outlined below.

Description	Pay Grade	Step	FTE	Salary	Benefits	Individual Cost	Total
Psychiatric Case Worker II	**33**	**5**	**5.50**	**47,880**	**18,185**	**66,065**	**363,358**
Sr. Psychiatrist (Range C) (EA)	**99**	**5**	**1.00**	**170,445**	**39,999**	**210,444**	**210,444**
Psychiatric Nurse II	**39**	**5**	**2.00**	**62,345**	**21,143**	**83,488**	**166,976**
Voc Rehab Specialist	**33**	**5**	**2.50**	**47,880**	**18,185**	**66,065**	**165,163**
Mental Health Counselor II	**37**	**5**	**2.00**	**57,034**	**20,056**	**77,090**	**154,180**
Mental Health Counselor III	**39**	**5**	**3.5**	**62,345**	**21,143**	**83,488**	**292,208**
Mental Health Tech. IV	**27**	**5**	**2**	**37,118**	**15,983**	**53,101**	**106,202**
Family Service Assistant	**27**	**5**	**1.5**	**37,118**	**15,983**	**53,101**	**79,652**

Total: $1,538,183

The program would also need an increase in state funded Supported Living Arrangement (SLA) as outlined below:

- SLA (rent, utilities & personal needs) average = $1,031 per month times twelve months times 187 individuals = $2,313,564
- SLA (provider direct services @ $18.86 times 35 hours a month times twelve months times 187 individuals = $1,481,264
- Total increase in SLA funding needed: $3,794,828
- Total funding increase needed for NNAMHS: $5,333,011

Rural Nevada: A low estimate of homeless individuals with a mental disorder is approximately 45 individuals (180 homeless individuals times 25% who have a mental disorder = 45).

Description	Pay Grade	Step	FTE	Salary	Benefits	Individual Cost	Total
Psychiatric Case Worker II	**33**	**5**	**2.50**	**47,880**	**18,185**	**66,065**	**165,163**
Mental Health Counselor II	**37**	**5**	**1.00**	**57,034**	**20,056**	**77,090**	**77,090**
Psychiatric Nurse 2	**39**	**5**	**0.50**	**31,173**	**10,572**	**41,744**	**41,744**
Administrative Assistant II	**25**	**5**	**0.5**	**17,090**	**7,693**	**24,783**	**24,783**

Total: $308,780

The program would also need an increase in state funded Supported Living Arrangement (SLA) as outlined below:

- SLA (rent, utilities & personal needs) average = $1,031 per month times twelve months times 45 individuals = $556,740
- SLA (provider direct services @ $18.86 times 35 hours a month times twelve months times 45 individuals = $356,454
- Total increase in SLA funding needed: $913,194
- Total funding increase needed for Rural Mental Health: $1,221,974

Total funding increase needed for the Division of Public and Behavioral Health to provide services to individuals who are homeless and have a behavioral health disorder: $49,307,240.
Estimated time for implementation is October 2015.

Conclusion:

Although community and state agencies have provided housing and behavioral health (substance use and mental health) services for homeless individuals for years, it has not been done so in an integrated and collaborative fashion. The integration of Nevada State's Divisions of Public Health and Mental Health has created an opportunity for new and innovative ways to provide services and treatment through integrated, collaborative partnerships within and between state and community providers. This is especially needed to effectively end homelessness and provide sustained recovery for individuals who are homeless and who have co-occurring substance use and mental disorders.

WHITEPAPER

ADOLESCENTS AND YOUNG ADULTS: TRANSITIONING FROM ADOLESCENCE TO ADULTHOOD AND THE NEED FOR SERVICE CONTINUITY

TRANSITIONING FROM ADOLESCENT TO ADULTHOOD AND THE NEED FOR SERVICE CONTINUITY

By Rob Jones, MA, LMFT

Purpose:

It is the goal of the Division of Public and Behavioral Health (DPBH) to provide a seamless transition of service delivery for adolescents who are transferred into adult services.

Background:

According to the final report from the 2012 Olmstead Initiative for Returning Individuals from Out-Of-State Placements, Nevada's systems for child mental health and adult mental health are separate and disconnected, making transitions and planning difficult for youth and their families as well as the professionals on both sides of the divide.

Problem Statement:

One of the major barriers to providing service continuity to individuals during this stage of life is the current practice of segmenting Nevada's mental health services into child/adolescent and adult service systems. Many adolescents who complete treatment and/or who have reached the end of their youth treatment options (due to aging out of foster care by virtue of entering adulthood but still require mental health services) lack adequate access to services due to:

1. A bifurcated system in which there is no clear process for coordination between children and adult services.
2. The transfer process is not always understood or followed by the referring or accepting agencies.

A disruption in service prompted solely by a change in age forces the individual to cease services initiated when they were an adolescent and seek those appropriate in the adult system. This disruption is abrupt and problematic for several reasons:

1. In the AVATAR system when an adolescent turns eighteen years old and wishes to continue mental health services, he/she has to be closed out of the "youth" episode and opened up again in the "adult episode". AVATAR is currently not set up to track the number of adolescents who transfer to adult services. There is also a break in record keeping continuity with the closing of the "youth" episode and the opening of the "adult" episode.
2. Existing therapeutic relationships are often forced to end. This is especially true in Clark and Washoe Counties where the youth transfers from getting mental health services from DCFS to SNAHMS, NNAMHS, or Mojave Mental Health Adult Services. Disruptions such as these can be very stressful, and service disruption can lead to service loss.

3. The individual often lacks the know-how to set up an appointment to get into adult services.
4. Adult services and children's services look very different.
5. Child mental health services are more intensive than adult services.

Proposed Solutions:

1. Revise AVATAR so that when an adolescent transitions into adult services there is a way to also transition the records and be able to tack the individual for data collection purposes.

2. Create "transition" therapy groups to help prepare the adolescent for adulthood and navigating adult systems of care and assistance. In Reno, Mojave Mental Health's Transition to Independence Program (TIP) serves young adults ages 17 – 22 in a group setting and utilizes the book entitled, *"Transition of Young Adults with Emotional or Behavioral Difficulties"*. Preliminary data shows that this is a successful program as it utilizes a 12-week workshop format to address topics of relevance of youth transitioning out of children's services. Feedback from participants has been extremely positive. Nevada DPBHS needs to collaborate with Mojave Mental Health with getting their permission to implement this program in all DPBHS' outpatient centers. There should be no cost involved with this solution.

3. Beginning at about age 17 ½ of the youth, case management services need to be increased to assist with SSI/ SSDI application, Section 8 housing options, and supportive living arrangement (SLA) planning. Case management services also need to provide referrals and linkages to Vocational Rehabilitation, DETR, Medicaid, TANF, SNAP (food stamps), etc. Intensive case management requires lower case loads in order to effectively carry out intensive case management functions. As a result, more case management positions will need to be created. Cost increase is unknown at this time. Since this only involves the rural centers, and the numbers will be relatively small, current case managers should be able to cover this solution. In Clark and Washoe Counties where DCFS treats adolescents in greater volume, DCFS may need to increase their number of mental health case managers.

4. Begin utilizing the Individual Placement & Support (IPS) model. It has been extensively researched and found to be much more effective than traditional approaches such as day treatment, sheltered employment, and conventional vocational rehabilitation services. Sites that converted to supported employment experienced nearly a threefold increase in the rate of competitive employment. States have relied on Medicaid to help finance IPS-model supported employment, often braiding Medicaid with other funding sources to pay for different components of the EBP. Many states use Medicaid rehabilitative services ("the rehab option") to finance some components, although job placement and coaching are excluded from payment under the rehab option. The Medicaid 1915(c) and 1915(i) home and community-based services (HCBS) programs can cover long-term employment support, and can also cover job placement and coa**c**hing if vocational rehabilitation funds are unavailable. States have also used the flexibility of managed care programs to incorporate supported employment into their menu of

covered Medicaid services. This solution probably needs to be done through private providers. The State may need to encourage private providers to develop this as a new service.

Cost and Projected Time for Implementation:

No new costs. Implementation time estimated for January, 2014.

Conclusion:

Adolescents transitioning from youth to adult mental health programs often get disconnected and discouraged due to an inadequate transfer process. This white paper outlines a few ways that could help alleviate, if not eradicate, the problem.

WHITEPAPER

ADOLESCENTS AND YOUNG ADULTS: SCHOOL BASED HEALTH CENTERS

ADOLESCENTS AND YOUNG ADULTS: SCHOOL BASED HEALTH CENTERS

By Rob Jones, MA, LMFT

Purpose:

Although school-based health centers (SBHCs) began in the United State in 1969, Nevada began its first school-based health center in 2001. SBHC growth in numbers in Nevada has been slow and regionalized to only Clark County. It is the goal of the Division of Public and Behavioral Health (DPBH) to collaborate with school districts to increase the number of SBHC's throughout Nevada. In order to accomplish this, SBHCs will need to seek multiple funding sources and become financially sustainable by billing Medicaid and private insurance.

Background:

Data shows that SBHCs help decrease absenteeism, reduce unnecessary and costly emergency room visits, and ensure quality and cost-effective care for children and adolescents.

SBHCs help integrate primary and behavioral health services for children while providing a new access point. Currently there are more than 1,800 centers nationwide serving more than 1.8 million children.

A public opinion survey of 600 Clark County registered voters found that 63% thought public schools should be responsible for dealing with the behavioral health needs of their students. Children most frequently needing assistance were those with Attention Deficit Hyperactivity Disorder and depression (MHDS 2012 Needs Assessment).

Over half of high school students with a mental disorder drop out of high school—the highest dropout rate of any disability group. Schools are influential forces in the development of both pro-social and problem behaviors. They also provide opportunities for prevention and treatment. Limited access to behavioral health care increases the likelihood that untreated behavioral concerns will emerge in schools and communities.

Schools provide a unique opportunity to reach adolescents. SBHCs provide convenient access to comprehensive primary and preventative physical and behavioral health services for students to meet their physical and emotional needs. They provide preventative care, health education, and behavioral health services that promote wellness and address risky behaviors that can lead to school failure. The scopes of service can include, but are not limited to, preventative and primary care medical treatment, and mental health/substance abuse treatment, intervention and education.

There are currently 12 SBHCs in Nevada. They are all located in Clark County. They vary in location from elementary schools, middle schools and high schools. Some even provide services to individuals in the

community. However none of the 12 SBHCs are comprehensive with offering all available services on site – especially mental health services. One Clark County SBHC, Foundation for Positively Kids, received a $408,672 grant from HRSA in 2012 to expand the services currently being provided to become a comprehensive medical home.

Problem Statement:

Most SBHCs are dependent on funding from state (76%) and/or local governments (37%) for their operations. Half of the existing programs receive some support from private foundations. Only 23% of centers are sponsored by (and only 28% are even eligible for) funding under section 330 of the Public Health Service Act, a major federal funding source directed at providing primary health care for the nation's underserved populations. Today, many SBHCs are not being opened or are struggling to remain open due to slashed state, city, and county budgets, insufficient long-term funding from public health dollars and revenue from patient reimbursement and decreasing insurance coverage among the school-aged population. This is also the case in Nevada.

Proposed Solutions:

1. Nevada needs to provide assistance with helping Nevada's SBHCs to be able to offer comprehensive services – including mental health services. SBHC's are an option in communities to increase access to health care and are a gateway for providing access to mental health services, especially for pre-teens and adolescents.

2. The Division of Public and Behavioral Health (DPBH) has awarded three planning grants to Nevada organizations to develop new or enhance existing comprehensive school-based health centers (SBHCs). Approximately 19,000 students from three Nevada counties - Clark, Lyon and Washoe - stand to benefit from the grants. Grant monies will also be used to enhance school emergency preparedness. Grant recipients – the Nevada Board of Regents, Community Health Alliance Foundation, and Healthy Communities Coalition -- identify main schools for the SBHCs, and arrange for several "feeder schools" to participate.

3. DPBH is in the process of applying for HRSA "Access Point" grants that can be used to develop SBHCs. They are also pursuing SBHC funding through the Robert Wood Foundation and the Kellogg Foundation.

4. Nevada's SBHCs need to establish long-term financial sustainability by billing Medicaid and private insurance. Part of the difficulty with becoming a Medicaid provider is setting up the SBHC to provide comprehensive services so it can become a comprehensive medical home. To this end, the DPBH is working with Medicaid to assist SBHCs with becoming a provider type 17 for reimbursement. Medicaid would like for the DPBH to audit and certify that SBHCs interested in being a provider type 17 are following the NV SBHC standards that have been developed.

Cost and Projected Time for Implementation:

Costs are undetermined at this time. Implementation is estimated for July 2015,

Conclusion:

Although SBHCs began in Nevada in 2001, their growth in numbers has been slow and regionalized to only Clark County. The State of Nevada needs to continue collaborating with the school districts across Nevada to bring school-based health centers that provide comprehensive services (including mental health services) to the entire State. This will require increased allocation of State revenues targeted to this end, as well as an increase in aggressive pursuit of government and private grants. Nevada will need to assist SBHC's in providing comprehensive services that are eligible for reimbursement through Medicaid and private insurance.

WHITEPAPER

ADOLESCENTS AND YOUNG ADULTS: OUT-OF-STATE RESIDENTIAL PLACEMENTS

ADOLESCENTS AND YOUNG ADULTS: OUT-OF-STATE RESIDENTIAL PLACEMENTS

By Rob Jones, MA, LMFT

Purpose:

It is the goal of the state of Nevada to provide the necessary services to meet the special needs of children, adolescents, and young adults with behavioral difficulties so that placement in out-of-state residential facilities is not necessary. The state of Nevada has attempted to address the issue of adolescents and young adults being placed in out-of-state residential facility for years. The reasons for out-of-state residential placements are complex. To fix this situation it will require restructuring in-state behavioral health services in an effort to prevent these occurrences and to ensure successful community integration upon returning from out-of-state placements. It will also require the allocation of more state funds toward creating, expanding, and sustaining these services.

Background:

In Nevada it is not uncommon for families to give up custody of their children to the child welfare system or have their children arrested in order to access mental health care. National Alliance on Mental Illness (NAMI) reports that approximately one in five families of children with a diagnosis of Severely Mentally Disturbed (SED) have been told to give up custody of their child to the state or turn their children over to the juvenile justice system to get help.

According to Mr. Richard Whitley's testimony before this year's Nevada State Legislature, there are approximately 225 Nevada children, adolescents and young adults who are Medicaid recipients and who are receiving specialized services in out-of-state residential facilities. Mr. Whitley further stated the two primary reasons for these out-of-state placements are violence and sexual aggressiveness.

In general, a youth may be placed in an out-of-state facility because the youth has failed at least two placements within the state, the youth has a combination of diagnoses that cannot be treated in Nevada, the youth has been adjudicated as a female sex offender, or the youth is sexually aggressive.
Over 40% of Clark County's public behavioral health care dollars are spent on residential care. This has not been shown to be effective with improving the long-term outcomes for children with SED, especially without follow-up services. Readmission rates for youths receiving residential services under Fee-For-Service Medicaid have been increasing since 2006 while the percentage of these youths accessing follow-up services within 90 days has decreased.

Nevada has an Out-of-State Placement Workgroup. Members of this Workgroup consist of representatives each with a specialization unique to the diagnosis and placement of Nevada youth in out-of-state facilities. These members include staff from DCFS' Children's Mental Health, DCFS' Family Programs Office, DCFS Rural Child Welfare, Washoe County Department of Social Services, Clark County

Department of Family Services and Juvenile Justice, as well as support from management, legal and fiscal representatives, as needed. Children are placed in out-of-state placements when in-state services are not available to meet their needs and/or intensive community-based services are unavailable or unaffordable. The Out-of-State Placement Workgroup meets periodically. The workgroup recognizes that, in most cases, it is preferable to keep children in their home state and to facilitate permanency in a healthy environment. The workgroup remains committed to ensuring that when out-of-state placement is the only alternative for a Nevada youth, the facility meets all of the state and federal requirements.

Over the past two decades, two major federal initiatives have addressed the needs of children and youth with significant mental health conditions: SAMSHA's "Children Mental Health Initiative" (CMHI) and CMS' "Psychiatric Residential Treatment Facility" (PRTF) Demonstration Program. The CMHI program promotes a coordinated, community-based approach to care for children and adolescents with serious mental health challenges and their families. The PRTF Demonstration Program was designed to determine the effectiveness of community-based services for youth who are in, or at risk of entering, a PTRF. Results from these programs have consistently found that the implementation of home and community-based services for this population has made significant improvement in the quality of life for these children, youth, and family (Joint CMCS and SAMSHA Information Bulletin, May 7, 2013).

Problem Statement:

The final report from the 2012 Olmstead Initiative for Returning Individuals from Out-Of-State Placements identified specific themes regarding youths placed out of state:

1. Youths are placed out-of-state due to insufficient community services.
2. Need for increased capacity to serve children with the proper intensity.
3. Need for improvement in the continuum of care.
4. Services are fragmented.
5. There is a need for an integrated, collaborative, accountable and uniform system of care.

Wraparound services are unavailable to meet the current need. Some of the reasons for this are:

1. Nevada has critical shortages of licensed professionals who have specialized training in treating children.
2. Lack of adequate funding for critical staff positions – especially case managers needed for referrals, linkage, and liaison to professional and non-professional community supports.
3. For Rural Services Mental Health's child and adolescent therapists, caseloads are too high. Adolescents with SED require more intensive involvement of energy and time for the clinician who navigates between the adolescent, parents/family, schools, child welfare and/or probation/parole department. It is very difficult for the clinician to invest the time and energy required with their current standard required caseload of 75.
4. Psychosocial rehabilitation (PSR) and Basic Skills Training (BST) services provided by private agencies often last in business a short time and leave individuals without continued care. Two reasons for this are that owners/managers of these agencies do not engage in a strong business

model that keeps them financially afloat and their difficulty with navigating Medicaid regulations for reimbursement.

5. Medicaid pre-authorizations (PARs) are tedious and time consuming while reimbursement for services rendered is so low that it may not cover the cost of the service provided.

Residential facilities located in Nevada do not have the specialized programs and trained staff to provide services to children, adolescents and young adults who are placed out of state. Two examples of needed specialized treatment programs for children, adolescents or young adults who:

1. Demonstrate sexual aggressiveness.
2. Demonstrate severe difficulties surrounding poor impulse control resulting in severe aggressive behaviors.

Laws regulating residential facilities are too restrictive and require them to have "lock down" capabilities similar to those of inpatient psychiatric facilities.

Proposed Solutions:

1. In order to keep adolescents and young adults in community settings and out of out-of-state residential facilities, family support services must be provided throughout the continuum of care from prevention through residential and aftercare services. One effort to accomplish this is DCFS' nationally recognized "promising practice" program, Wraparound in Nevada (WIN), provides intensive community-based services to children and adolescents with severe emotional disturbances and who are in child welfare custody. In addition to addressing mental health needs, services support the achievement of permanency for these youth through reunification with their families, guardianship with relatives, adoption or successful emancipation in all three regions statewide. Mental health care for these youth is essential to the success of achieving permanent placements. These services need to be expanded throughout Nevada - especially for youths not yet involved with child welfare and/or juvenile probation/parole. There are currently approximately 65 psychiatric caseworkers (including supervisors) in Washoe and Clark County, and another five in the rural counties of Elko, Ely, Fallon, Winnemucca, and Pahrump, who are providing targeted case management utilizing the Wraparound model.

2. Specialized Alternatives for Families and Youth (SAFY) of America in Las Vegas offers a broad continuum of services for youth and families in the child welfare and juvenile justice systems. In 2012, their comprehensive services improved the lives of at-risk children and families including early intervention and prevention services, home and community-based interventions, out-of-home placements, reunification and aftercare services. SAFY of America is a national leader in developing and utilizing evidence based programs and strategies proven effective in reducing recidivism, substance abuse and/or anti-social behavior. Other agencies that provide similar services in Nevada include Boys Town, Eagle Quest, and Maple Star. The State of Nevada needs to collaborate with these agencies to expand services throughout Nevada.

3. Family support services must be provided throughout the continuum of care from prevention through residential and aftercare services. Two examples of this currently being done on a limited scale in Nevada are:

    a. Nevada Parents Encouraging Parents (PEP) is a nationally recognized parent organization that contracts with DCFS to provide family-to-family support for families served through DCFS' Children's Mental Health Services. Nevada PEP also receives a sub-grant from DCFS to support family participation in the system of care as trainers, trainees, members of or participants on boards, commissions and DCFS management teams, and to provide information and referrals to other parents. The Nevada PEP Program needs to expand in scope throughout Nevada. They will need state and/or grant funding for this to occur.

    b. Neighborhood Family Service Centers in the Las Vegas area are considered a best practice program. These centers, originally funded by a SAMHSA System of Care Grant, provide a broad array of comprehensive services to children, adolescents, and families, and enhance the existing local interagency service system by developing interagency collaboration, known as Neighborhood Review Teams, at neighborhood sites. The Neighborhood Review Teams are striving to prevent unnecessary out-of-community and out-of-state placements of children. Teams assist with the reintegration of youth that are returning from out-of-state placements. Neighborhood Review Teams collect data on each child and youth presented to determine if their efforts are working. Top-level managers from the major youth-serving public agencies comprise a Clark County Review Team, which addresses barriers that the Neighborhood Review Teams are unable to resolve. Neighborhood Family Service Centers need to expand throughout Nevada. To succeed with this, there may need to be a statewide program manager (or three regional program managers) to coordinate its development and growth and to ensure its sustainability. State and/or grant funding will need to be designated for this.

4. Community-based services for children and families, particularly for children with SED, can be accessed through 1915(c) HCBS Medicaid waivers, which are designed to help states develop community long-term services and supports that help Medicaid beneficiaries avoid institutional placement. HCBS for children with SED often include wraparound services in recognition of their unique and complex needs.

5. Section 1915(i) state plan amendment (SPA) provides an opportunity for states to amend their state Medicaid plans to offer intensive home and community-based behavioral health services that were previously provided through 1915(c) HCBS waivers programs. Intensive care coordination, respite, parent and youth support partners, and other services can be offered under 1915(i) and serve children and youth with significant mental health conditions. Under 1915(i) states may not waive the requirement to provide services statewide, nor can they limit the number of participants in the state who may receive the service if they meet the population definition. Unlike the 1915(c) waiver program, the 1915(i) delinks the provision of services with

participants meeting an institutional level of care. In order to target the initiative and limit costs, states may identify a specific population and establish additional needs-based criteria. Nevada Division of Public and Behavioral Health needs to collaborate with their state Medicaid Division to explore whether the 1915(i) is a viable option to bring to Nevada.

6. Memorandums of Understanding (MOUs) need to be implemented between state agencies and the out-of-state residential facilities outlining guarantees for appropriate case management discharge planning and the transition process of adolescents and young adults from the residential facilities back into their communities. Discharge planning must involve, at a minimum, the appropriate residential facility staff, involved Nevada governmental agency staff, and the family. The use of video-conference equipment would greatly enhance this process.

7. Nevada needs to conduct a statewide review of all out-of-state residential supports and develop a plan to develop specialized services within Nevada communities to serve this population (Final report from the 2012 Olmstead Initiative for Returning Individuals from Out-Of-State Placements).

8. Nevada needs to develop in-state specialized residential facility capacity for the adolescents and young adults with special needs who are sent out of state. For example, West Hill Hospital in Reno is part of a conglomerate of mental health facilities throughout the United States. Its parent company is Universal Health Services, Inc. Several of West Hills' sister companies located in other states are the facilities that Nevada sends adolescents and young adults to in order to receive specialized residential treatment. Typically, West Hills Hospital has been running at around 50% capacity. Nevada should consider engaging in discussions with West Hills and Universal Health Services about subcontracting the non-utilized portion of West Hills hospital to the sister residential facility that provides specialized service to our out-of–state adolescents and young adults who have the highest percentage of special needs (i.e., violence and/or sexual aggression). This would become into a win-win situation in that:

9. Sub solutions
    a. West Hills will bring in revenue from subcontracting out their non utilized portion of the hospital.
    b. The out-of-state facility would continue to provide services and not lose revenue from the adolescents and young adults leaving the facility to receive services back in Nevada. This would be especially true if Nevada made a very clear proclamation that its goal is to build the infrastructure necessary to provide specialized residential services in Nevada.
    c. It would keep the adolescent and young adult in Nevada closer to his/her natural supports.
    d. It would make multi-agency collaboration easier in the endeavor of providing coinciding services and treatment with both the family and the individual.
    e. It would assist with seamless discharge planning and the transition process back into the community with appropriate wrap around services.
    f. It would generate revenue in jobs, etc., and keep Medicaid dollars in Nevada.

g. It would create new University of Reno School of Medicine resident placements for specialties in psychiatry and neurology.

10. Collaborate with Nevada Medicaid to increase service/treatment delivery reimbursement rates for adolescents and young adults with special behavioral challenges. Treatment programs that provide services to these individuals are more intense and costly to run.

11. Nevada laws with regard to residential treatment facilities need to be revised to be similar to those in Utah, Idaho and Texas (where Nevada sends the majority of out-of-state residential placements).

Cost Analysis and Timeline for Implementation:

Costs are for new staff needed to address the above state solutions that would involve the thirteen rural mental health centers managed by Rural Services Mental Health and the five rural mental health centers managed by Southern Nevada Adult Mental Health Services - for a total of eighteen Division of public and Behavioral Health run rural mental health centers scattered across Nevada.

Description	Pay Grade	Step	FTE	Salary	Benefits	Individual Cost	Total
Psychiatric Case Worker II	**33**	**5**	**18.00**	**47,880**	**18,185**	**66,065**	**1,189,170**
Mental Health Counselor II	**37**	**5**	**18.00**	**57,034**	**20,056**	**77,090**	**1,387,620**
Psychiatric Nurse 2	**39**	**5**	**9.00**	**62,345**	**21,143**	**83,488**	**751,392**
Sr. Psychiatrist (Range C) (EA)	**99**	**5**	**3.00**	**170,445**	**39,999**	**210,444**	**631,332**
Administrative Assistant II	**25**	**5**	**6.00**	**34,180**	**15,386**	**49,566**	**297,396**

Total: $4,256,910

Estimated time for implementation is October 2015.

Conclusion:

It is possible to significantly lower the numbers of adolescents and young adults placed in out-of-state residential facilities. It will require increasing the use of intensive family services, wrap-around services, and community/peer supports. This will mean funding through state and/or grant dollars more professional staff (i.e., therapists and case managers who specialize in treatment and services to adolescents and young adults). It also requires Nevada to create incentives to entice companies who provide these specialized residential programs in other states to begin providing them in Nevada.

WHITEPAPER

CRIMINAL JUSTICE / CO-OCCURRING DISORDERS

CRIMINAL JUSTICE / CO-OCCURRING DISORDERS

By Sharon Dollarhide, MSW, LCSW

Purpose:

In 2013 in Nevada, there is little argument that the legacy of deinstitutionalization has failed. Moving the severely mentally ill out of the state hospital and into the community has led to a crisis of epic proportions. The severely mentally ill have disproportionately ended up homeless, cycling through the legal system, abusing psychoactive substances, and/or utilizing emergency services at alarming rates. This issue is well documented in the research compiled by Dr Ihsan Azzam, Nevada State Office of Epidemiology, *The Prevalence of Mental Illness in the Criminal Justice System (see attached)*.

Nationally and locally, we have shifted the problems of mental hospitals to the streets and jails – instead of being in hospitals, the mentally ill are in jail. This process of indirect cost shifting may have led to a form of "re-institutionalization" through the increased use of jail detention for those with mental disorders deemed unmanageable and noncompliant.

For the past several decades the mental health system has adopted a principle that the mentally ill should be treated "in the least restrictive environment." While this emphasis on individual freedom, self-determination, autonomy, and dignity has benefitted a large number of mentally ill, for a substantial minority the "least restrictive environment" equates to a cardboard box, a jail cell, a soup kitchen, and/or a terror-filled, unsafe environment.

At this point the state of Nevada is willing to admit that deinstitutionalization has failed and it has committed to fix the situation. The mentally ill offender population is a priority consideration. The state is committed to building on and expanding its existing continuum of care, including: Crisis Intervention Team (CIT) trained emergency responders, Mobile Outreach Safety Team (MOST), Mental Health Courts (in Washoe County, Carson City, and southern Nevada), jail and prison reentry efforts in Washoe County and Carson City, and modified Forensic Assertive Community Treatment (FACT) teams, to improve personal and community safety, reduce recidivism, and improve quality of life for the mentally ill.

Background:

A comprehensive mental health prevalence study by the Department of Justice found that approximately 70,000 adults with mental illness enter U.S. jails each year, and approximately 75 percent of these individuals suffered from co-occurring disorders (GAINS Ctr. 2001). Complicating their situation, many mentally ill offenders display multiple health problems, experience financial instability, exhibit transient behavior, and engage in high risk behaviors. This population has poorer outcomes in the community and is more likely to be homeless, relapse to substance abuse, be hospitalized, engage in criminal behavior, be treatment and medication non-compliant, engage in violence and/or suicide, and

have complicating health issues. These factors pose a threat to personal and community safety, as well as burdening limited state and local resources.

It is widely recognized that jails and prisons have, by default, become the largest psychiatric institutions in many communities. This is often the case because behavioral health centers are inaccessible in the community and this is cited as a factor responsible for people recycling through the legal system. Criminalization hypothesis states that because of deinstitutionalization, shorter inpatient hospital stays, and stricter criteria for civil commitment without an adequate match in mental health spending, the criminal justice system became responsible for controlling individuals with mental illness.

Nevada's high prevalence of untreated mental illness and substance abuse has created a population whose illegal activity and mental health and substance abuse disorders lead to a cycle of homelessness, petty criminal activity, and incarceration. At the same time, Nevada's treatment resources have been unable to meet the demand.

Problem Statement:

As documented by Dr. Ihsan Azzam, Nevada State Office of Epidemiology, *The Prevalence of Mental Illness in the Criminal Justice System (see attached)*, the mentally ill are housed in local jails at a rate of anywhere between 10.3% in Clark County Detention Center (CCDC) to 22.8% in Carson City County Jail (CCCJ). Mental health and criminal justice data available from 2011 was cross-matched and analyzed at the Nevada State Health Division in order to assess prevalence of mental illness in the criminal justice system.

It is also estimated that approximately 75% of these mentally ill offenders have a co-occurring substance use disorder. Data compiled by Washoe County Mental Health Court from 2007 – 2011 report an average rate of 86% of participants with a co-occurring substance use disorder.

Existing Resources

Under provisions set forth in NRS 176A and AB 175, efforts to expand supervision and services to mentally ill offenders were initiated. Since 2005, there has been a concerted effort to address the unique issues facing this special population throughout Nevada. Mental Health Courts now exist in Washoe County, Clark County, Carson City, and Douglas County. Throughout the state, additional services have been implemented to address the needs of mentally ill offenders. These programs and services are listed on an attachment in the appendix. These services offer a continuum of care based on where a mentally ill individual "intercepts" with the legal system.

Utilizing "The Sequential Intercept Model," developed by the SAMHSA GAINS Center, this workgroup identified services provided within each region, from the pre-arrest to post-release phases of intervention.

Washoe County

Services identified for this region include: over 300 Crisis Intervention Team (CIT) trained police officers and first responders, Mobile Outreach Safety Team (MOST), various specialty courts (Mental Health Court with 238 current participants), investigators for special populations at the Public Defenders's Office, specialty unit at State of Nevada Parole & Probation Office in Reno, Forensic Mental Health Team (jail reentry in collaboration with Washoe County Detention Center, Public Defender's Office, Parole & Probation, and Northern Nevada Adult Mental Health Services), and Criminal Justice Advisory Sub-Committee for Mental Illness (CJAC).

Clark County

Services identified within this region include: Clark County Mental Health Court and various specialty courts; residential and intensive outpatient, outpatient, and group treatment for COD; mental health services for incarcerated individuals at CCDC and Las Vegas Jail; peer training for clients leaving incarceration; NAMI; Crisis Intervention Team (CIT) training; wrap-around services – employment assessment, training & placement, housing, residential, inpatient/outpatient mental health services, peer coaching, veteran's services, housing and reentry services for incarcerated women, and intensive mental health case management.

Rural Nevada

Services identified in this region include: Forensic Assessment Triage Team (FASTT), Mental Health Court, Drug Court, Carson City Jail psychologist, and Crisis Intervention Team (CIT) trained officers.

Statewide

Services identified for the state include: Lakes Crossing Center. This facility provides inpatient evaluation and treatment of competency to stand trial, commitment for individuals who have been found Not Guilty by Reason of Insanity (NGRI), commitment for individuals who have been unable to attain competency (category A felonies and some category B felonies (and considered to be high risk), outpatient evaluations and treatment of competency to stand trial, and Conditional Release programs for those committed after an NGRI or incompetency finding.

No response from Department of Corrections was received, despite numerous attempts.

Unmet Needs

- Housing and wrap-around services, especially for the hard to serve/high users of services, are lacking
- Accountability to keep mentally ill involved in treatment (outpatient civil commitment – AB 287 Senator Hardy)
- Resources to work with mentally ill offenders who have traumatic brain injury, dementia and/or other major debilitating health issues are lacking/non-existent
- Mental Health Court within Nevada vary from jurisdiction to jurisdiction. No standardized statewide procedure exists.

- Offenders exiting prisons/jails have difficulty reinstating Medicaid, food stamp, TANF, and/or disability benefits. Mentally ill offenders frequently do not have benefits due to inability to follow through with agency procedures due to homelessness and/or illness acuity.
- Civil commitment and/or Legal 2000 laws are too strict (look at Ohio - unable to care for self).
- No systematic prison reentry procedure or communication from DOC and Parole Board.
- No residential COD treatment for individual with severe mental illness (SMI) in northern Nevada.
- Northern Nevada Adult Mental Health Services campus lacks safety and security precautions to work with offenders with a history of violence and sexual offenses.
- MHDS has no trained/certified clinicians to treat individuals convicted of sexual offenses.
- No routine screenings or evaluations are done to evaluate for risk of violence.
- No systematic way to collect data and performance measures for this population.
- Providing assessment, evaluation, and treatment of mentally ill offenders with history of violence and/or sexual offenses increases the risk to agency staff and consumers. Community mental health agencies are underprepared to provide safe and secure services.
- Currently, there is no easy way to collect data on performance measures: # hospital days, # jail days, # days clean and sober, recidivism rates and/or quality of life measures.

Proposed Solutions:

Designate a statewide manager for Forensic Mental Health to provide for coordinated, collaborative, and evidence-based assessment and treatment of mentally ill offenders in Nevada. Responsible Party – MHDS. Cost is dependent upon job classification. Clinical Program Manager II salary range – $61,950.96 – 93,187.44, pay grade 42/Clinical Program Manager III salary range - $66,001.68 – 99,681.42, pay grade 44.

This position would be responsible for planning for and coordinating statewide forensic mental health services.

a. Inpatient
   Lakes Crossing
   Conditional Release Program
b. Outpatient
   Mental Health Courts/Specialty Court Programs
   Prison Reentry (including special conditions of Parole Board) Programs
   Jail Reentry Programs
   Mobile Outreach Programs
   Crisis Intervention Team

This position would also be responsible for communicating and with existing community agencies and criminal justice/mental health collaborations (i.e. – Washoe County Criminal Justice Advisory Committee).

In addition, this position would work closely with agency statisticians to develop a data collection mechanism that would allow for research and analysis. With this process in place, the agency would be better able to identify successful/unsuccessful treatment efforts, gaps in services, and future areas for program development.

Conclusion:

In the 1960s and 1970s several hundred thousand mentally ill nationwide were released from psychiatric hospitals. This well-intentioned deinstitutionalization was prompted by patients' rights advocates who discovered gross violations and abuses in institutions. There was great hope that severe mental illness would be radically reduced and perhaps eliminated through the use of new psychotropic medications, adequate community mental health funding, and a standard for treatment in the "lease restrictive environment."

However, in reality the deinstitutionalization movement amounted to the wholesale dumping of the mentally ill into communities that were ill prepared to provide for them. The inadequate care was exacerbated by increased unemployment, cuts in state/federal funding, and hard economic times. In fact, community treatment for the deinstitutionalized mentally ill never materialized. Having rights but no resources was a cruel joke played on the mentally ill.

The result of our abandoned commitment has led to the inundation of our city streets with the mentally ill. Because of a lack of services, many decompensated mentally ill are homeless, have drifted into the criminal justice system, and/or have resorted to self-medicating via drugs and alcohol addiction. Removing the mentally ill from jail should be one of the most important priorities for society.

The first step to realizing this goal will be to establish a permanent, long-term commitment to providing humane care for the chronically mentally ill, while eliminating the tendency to criminalize mental illnesses. Nevada must continue to work toward viable solutions: providing 24-hour crisis intervention, training officers to recognize mental illness, developing alternative sentencing for the mentally ill, increasing intensive case management services, continuing collaboration between criminal justice, public, substance use and mental health systems, and providing secure, structured residential facilities.

WHITEPAPER

ENHANCEMENT OF CLINICAL AND TRANSITIONAL SERVICES FOR OFFENDERS WITH CO-OCCURRING DISORDERS

ENHANCEMENT OF CLINICAL AND TRANSITIONAL SERVICES FOR OFFENDERS WITH CO-OCCURRING DISORDERS

By Steve McLaughlin, MA, LADC

Purpose/Background:

There exists amongst the criminal justice population a high number of individuals diagnosed with co-occurring mental health and substance use disorders (COD). In fact, it is estimated that individuals with COD are three to five times higher to be incarcerated than the general population. Compared to offenders who do not suffer with COD, these individuals are arrested more often, incarcerated for longer periods of time, lack access to treatment, are discharged without adequate reentry planning, and re-arrested at higher rates. Besides enhanced clinical services, the most important treatment components needed to effectively treat the COD forensic population at the point of release is transitional or reentry services, particularly supportive housing. Due to a system failure within the treatment community and a lack of quality reentry services there currently is an extreme lack of transitional and clinical services in Nevada that are needed to treat this underserved population. Using a combination of state and community resources, the strategy proposed in this paper links and expands existing clinical resources and increases the amount of transitional housing beds to treat offenders with COD.

Problem Statement:

Individuals with co-occurring mental health and substance use disorders (COD) are disproportionately represented in the Nevada's criminal justice system. In the jails alone data indicates Nevada's criminal justice are forced to become crisis or treatment centers for individuals with mental illness and or COD as 16.85% of offenders detained in the Washoe County Jail and 22.8% of offenders detained in the Carson City Jail, and 10.3% of offenders detained in 2011 had been treated for a mental illness at some point. In regards to the prison system, Nevada's prison population has been among the fastest growing in the nation and by 2017 is expected to increase by 61% due to the high number of COD offenders expected to come in contact with the criminal system

The fact that Nevada of our jails and prisons are forced to house and treat the COD offender is only part of the issue; the other part is adequately treating offenders once they are released into the community. When offenders are released the responsibility to stop the cycle of recidivism and treat COD issues is passed on to the community providers. This places a substantial burden on the treatment system as the reentry needs of the COD offender go beyond the clinical and transitional services that are currently available within the community. In addition, Nevada's behavioral health system has been disjointed with the individual treatment entities operating in silos resulting in an extreme void of transitional and clinical services that are needed to treat this underserved population. As a result, offenders have a difficult time obtaining crucial services upon reentry making re-arrest and relapse more likely.

Offenders suffering with COD are at their most vulnerable when they are reentering the community. Therefore, it is imperative that the community have the proper resources available to adequately address the needs of the offender. Clinical strategies shown to be effective in treating the offender reentering the community include transitional housing, residential treatment (step down from prison or jail), individual and group intensive outpatient and services targeting basic cognitive, communication and social skills, anger management. While these programs exist in Nevada, waiting lists, poor coordination, and lack of enhanced programming presents a barrier to the returning offender.

Proposed Solutions:

The strategy proposed here includes a 150 bed increase to the transitional housing beds within the community. Several studies have supported the long-term efficacy of transitional housing and continued clinical intervention in the reduction of recidivism and relapse and other positive post incarceration outcomes. Transitional housing is considered to be a basic need one that is needed prior to the continuation or onset of clinical intervention. Clinical services will be enhanced by leveraging existing services and providing funding to community providers to increase treatment capacity for individual and group counseling services and medical detoxification if relapse occurs for up to 150 offenders.

Conclusion:

It is projected that by increasing clinical and transitional service options returning offenders will have increased access to crucial services needed to make an easy transition into the community and reduce recidivism. Additionally, by increasing access to clinical and recovery services Nevada will be taking the first step in establishing both an integrated treatment system and a recovery oriented system of care.

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