The Honorable Governor Steve Sisolak
Office of the Governor
101 North Carson Street, Suite 1
Carson City, Nevada 89701

June 23, 2022

Dear Governor Sisolak,

In accordance with NRS 433.14, the State of Nevada's Commission on Behavioral Health has prepared an update of Nevada's ranking in the areas of mental and behavioral health along with a summary of the annual reports of the Regional Behavioral Health Policy Boards and Children's Mental Health Consortia. While we are beginning to emerge as a nation, as you and every Nevadan are aware, the COVID-19 pandemic continues to have a profound impact. For Nevada's citizens, both young and old, it has fostered an environment where grief, isolation, loss, and fear has elicited mental health conditions or exacerbated existing ones.

While there is much to be hopeful about in our continued fight against COVID-19, we surmise that the overall ramifications of the pandemic will be long-lasting and will be evidenced by increases in the mental and behavioral health needs of Nevada's citizens. For this reason, the role and work of this Commission, Regional Behavioral Health Policy Boards, and the Children's Mental Health Consortia are vitally important. As you consider programming and critical next steps in the State's ongoing role in the provision of mental and behavioral health services, our hope is that the work summarized here will help guide future decision-making, particularly as critical funding decisions are made.

The COVID-19 pandemic and subsequent shutdowns have been associated with significant increases in mental health symptoms for Americans. CDC data shows younger adults, minorities, essential workers, and unpaid adult caregivers reported having experienced increased substance use and elevated suicidal ideation. While the long-term impact of COVID-19 on mental health remains unknown, it is unlikely that Nevada is fully prepared to address any increase in service demand that is likely to come as a result. Even prior to the COVID-19 pandemic, Nevada consistently ranked poorly with regards to prevalence of mental illness and corresponding access to care. In fact, Mental Health America (https://mhanational.org/) ranks states according to prevalence of mental illness and access to care (higher rankings indicating higher prevalence and lower access to care). In 2022, Nevada again ranked 51st overall, and received an improved ranking of 40th for adults, up from 47th in 2021, but remained with no improvement at 51st for youth. The 2022 MHA report highlighted Nevada as one of three states with the largest improvement ranking (46th to 39th) for youth with private insurance that did not cover mental or emotional problems, a decrease from 12.6%-7.1%. While this is welcome news and its evidence that mental health services are continuing to gain in recognition with insurers, access to care remains a significant challenge in all regions of our state. The data collected for the purpose of these rankings is varied, and comes from a variety of public sources, including from the Nevada Division of Child and Family Services (DCFS) and the Nevada Division of Public Behavioral Health (DPBH). Adult mental health indicators contributing to the ranking include the following: adults with Any Mental Illness (AMI); adults with substance use disorder in the past year; adults with serious thoughts of suicide; adults with AMI who are uninsured; adults with AMI who did not receive treatment; adults with AMI reporting unmet need; and adults with disability who could not see a doctor due to costs. Youth mental

health indicators contributing to the ranking also include the following: youth with at least one Major Depressive Episode (MDE) in the past year; youth with substance use disorder in the past year; youth with severe MDE; youth with MDE who did not receive mental health services; youth with severe MDE who received some consistent treatment; and students identified with emotional disturbance for an Individualized Education Program (IEP). Ultimately, the rankings again demonstrate a great need in Nevada to address the mental and behavioral health needs of its population, and more specifically to address critical access to care issues.

Collectively, the Commission, the Regional Behavioral Health Policy Boards, and Children's Mental Health Consortia are all acutely aware of the challenges documented by Mental Health America regarding the state of mental healthcare in Nevada. The reports of the Nevada Regional Behavioral Health Policy Boards and the Children Mental Health Consortia's address both prevalence of mental health disorders as well as access to care in their annual reports and strategic plans. Further, they address the State's need to focus and prioritize the development of a skilled, qualified mental and behavioral health workforce, which includes ensuring Medicaid reimbursement rates are reasonable and encourage provider participation; ensuring adequate crisis response in urban, rural, and frontier areas of the State; increasing access to supportive services, which includes addressing housing, transportation, and the development of competent, reimbursable paraprofessional programs and services, like those that could be offered by community health workers.

Adult Behavioral Health

Northern Region:

NORTHERN REGION PRIORITIES, STRATEGIES, AND RECOMMENDATIONS SUMMARY

The following priorities are presented to include underlying needs and gaps, strategies utilized by the Northern Board, and recommendations from the Northern Board for forward progress.

1. **Regional Board infrastructure development -** Several areas have been identified where additional infrastructure could lead to greater efficiency as the Northern region works to develop a more sophisticated behavioral health system.

   Strategies: Explore Regional Behavioral Health Authorities **–** In May 2022, the Northern Board established a formal multidisciplinary subcommittee to explore concepts for regional behavioral health authorities and models to increase system efficiency/ The Northern Board developed and submitted a concept paper for Regional Behavioral Health Authorities to DHHS to express their intent. (Please see the Northern Region's white paper of Behavioral Health Authorities at https://nvbh.org/northern-behavioral-health-region/). Sustain Board Support Positions – advocate for sustainable funding for Regional Behavioral Health Coordinator and regional data analyst positions. These positions provide the support necessary for the Board to fulfill duties described in NRS 433.4295. Implement Northern Region Behavioral Health Emergency Operations Plan (BHEOP) – Support local emergency management agencies in formally adopting the regional BHEOP approved by the Board in early 2021. Implement after-actions identified in 2022 regional BHEOP tabletop exercise, including expanding awareness to psychological first aid training.

2. **Affordable and supportive housing and other social determinants of health -** The region's communities are experiencing many individuals who have behavioral health issues and are homeless. These individuals with complex needs deteriorate on the street or become stuck in hospitals or jails for long periods of time with no safe discharge plan available. In addition, the board sees a gap in resources to address social determinants of health. There is no supportive housing aligned with best practice for residents with mental health issues in the region.

   Strategies: The Board established a formal subcommittee to address affordable and supportive housing solutions in January 2022. The Northern Region Behavioral Health Housing Subcommittee established the following recommendations that were adopted formally by the Northern Regional Behavioral Health Policy Board on May 5, 2022 : Advocate for the State to fund regional housing assessments and systems modeling by organizations such as Corporation for Supportive Housing, recommend the Nevada Division of Housing consider equitable distribution of the $500 million Home Means Nevada Housing initiative dedicated to supportive housing to create opportunities for all five behavioral health regions, advocate for sustainable supportive housing, support State and local agencies in the development of 1915i and other applicable home and community-based programs to encourage people-centered services.

3. **Behavioral health workforce with capability to treat adults and youth -** The Northern Region faces significant barriers caused by a lack of behavioral health workforce and difficulties that behavioral health professionals encounter in becoming in-network providers for insurance reimbursement. This gap impedes timely access to treatment and prevents providers from expanding quality services. In addition, the Northern Board recognizes that the community health worker (CHW) and peer recovery support specialists (PRSS) are underutilized in the behavioral health workforce pipeline.

   Strategies: The Northern Board supports a tiered approach for a calibrated mental health system that includes a robust relationship between clinicians, CHWs and PRSSs. Following this model, the Northern Board has been exploring strategies to increase the clinical workforce and expand use of CHWs and PRSSs to bridge the gaps caused by lack of clinical providers. Recommendations: Support local agencies facilitating CHW and PRSS workforce development, expand Medicaid reimbursement to include all behavioral health clinicians as community health worker supervisors, provide incentives for providers in rural areas, evaluate network adequacy and efficiency for insurance company credentialing, support family caregivers through access to reimbursement, respite services, and training across the lifespan.

4. **Development of a sustainable regional crisis response system that integrates existing local crisis stabilization, jail diversion and reentry resources (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center) -** The Northern Region has made significant progress in addressing gaps in crisis response services through the following community-based crisis stabilization, jail diversion and reentry programs: Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, and Carson Tahoe's Mallory Crisis Center. (Please see https://nvbh.org/education/ for more information on these programs.) In addition, there is a need to coordinate local infrastructure into the state crisis response system with the implementation of the 988 system.

   Strategies: While progress is being made in obtaining sustainable funding for these programs, the Northern Board continues to hold this as a priority until long term program sustainability is achieved. The Board wrote a position statement on behalf of the region's crisis response system which can be found here on the Statewide Regional Behavioral Health Policy Board's website: https://nvbh.org/northern-behavioral-health-region/. In addition, the Northern Board recommends developing sustainable Medicaid reimbursement rate and other funding sources to

sustain Assertive Community Treatment (ACT) and First Episode Psychosis (FEP) programs, develop 988 infrastructure in coordination with local agencies. Further, the Board supports Certified Community Behavioral Health Centers (CCBHCs) in providing full range of services in coordination with communities.

5. **Increase access to treatment in all levels of care -** Stakeholders in the region identified lack of insurance as a barrier for access to behavioral health care. Furthermore, there is significant concern about access to care for youth and adults who have insurance. While there is no quantitative data on this, there are many stakeholder reports of struggling to obtain outpatient appointments for youth and adults. They also report not having adequate access to intensive outpatient treatment for youth and inpatient treatment for youth as many youths are waiting in hospitals for acute psychiatric treatment. Notable gaps in the region are the lack of intensive in-home services, crisis stabilization centers, and respite care for youth.

   Strategies: In exploring access to care issues for individuals who are under-insured or lack insurance, the Northern Board identified some opportunities to connect uninsured individuals with care, including the youth trauma recovery grant and the region's Certified Community Behavioral Health Centers (CCBHCs). The Northern Board is planning to continue to learn more about the topic including solutions for underinsured individuals and increasing use of CCBHCs. The Northern Board is also interested in exploring other models of care including peer drop-in centers, living room models, respite care, and community support centers.

6. **Develop services to support continuity of care (i.e., continuation of medication/ service connection with community health worker) -** For years, stakeholders in the Northern Region have identified issues with continuity of care across the continuum. There are barriers in linkages to care that include lack of formalized referral systems, lack of coordination and communication, and limited provider capacity.

   Strategies: The Northern Board is very interested in utilizing community health workers to address challenges in continuity of care for individuals with behavioral health issues. The Board recommends formal agreements between CHWs and various existing programs such as Nevada Healthlink, OpenBeds, and hospitals. The Northern Board also plans to identify other strategies, such as peers, to support discharge planning and continuity of care in the region and investigate structural solutions to strengthen warm hand offs.

Rural Region:

Recommendations to the Commission on Behavioral Health:

I. Increase investments in Nevada Medicaid reimbursement for behavioral health services.

   Ongoing business closures and other restrictions related to controlling the spread of COVID-19 in Nevada heavily impacted state budgets, the need for behavioral health services by Nevadans covered by Medicaid have been more dire than ever. Improving investments in these services now may help to mitigate more long-term negative effects to population mental health and substance use outcomes across the state in the wake of the COVID-19 pandemic.

II. Increase resources and program choices to address the needs of high-risk populations, including youth, the elderly, and ethnic or racial minority groups. Specific populations had been seeing greater issues related to behavioral health in Nevada previous to the COVID-19 pandemic, much of which has been exacerbated during the pandemic response. These groups include the elderly, children, adolescents, and young adults of all racial or ethnic groups, as well as BIPOC communities specifically. Programs and policies to address these needs must focus on being culturally competent (or moreover, culturally respectful) and age appropriate (including use of technology).

III. Support programs that assist and support service members, veterans, and their families (SMVF) in a way that is competent to military culture.

IV. Support programs and funding that would increase the number of behavioral health providers across the state of Nevada.

V. Support behavioral health transportation solutions and pilot programs.

Data Highlights:

- All counties in the Rural Region have inadequate local availability of licensed Alcohol and Drug Counselors, Clinical Alcohol and Drug Counselors, and Certified Problem Gambling Counselors.
- All counties in the Rural Region have inadequate local availability of Licensed Marriage and Family Therapists and Licensed Clinical Professional Counselors.
- There are no licensed psychiatrists located in any counties included in the Rural Region.
- There is only one licensed psychologist located within the Rural Region, in Elko County.
- There are 29 Licensed Clinical Social Workers located within the Rural Region; 20 of which are in Elko County.

Behavioral health concerns related to COVID-19:

- Increased mental health crisis in hospital emergency departments.
- Increased alcohol and substance use
- Increased intentional overdoses.
- Increased stress and burnout in front-line workers
- Increased depression and suicidality among youth
- Increased isolation among home-bound and geographically isolated persons.

Clark County Region:

This summary has been prepared with data from 2021 provided by the Clark Regional Behavioral Health Policy Board (CRBHPB). The data collection period covers January through December 2021.

Due to the continued impact of COVID-19, the Board met virtually five times through web-based video conferencing, with additional accessibility through teleconferencing, in compliance with NRS to accomplish its mission this year. Accordingly, the Board has also determined to continue video and teleconferencing until further notice.

The COVID-19 public health crisis and interrelated events resulted in the Board maintaining its previous top four priorities from those identified in 2021 and emphasizing recovery. However, for 2022, the Board also voted to add a fifth priority to address behavioral health and wrap-around services for individuals experiencing homelessness.

The Clark Regional Policy Board continues to embrace a data-driven approach to identifying the region's behavioral health needs and system gaps. In a review of the data, workforce-related issues, with cluster aspects of recruitment and retention, significantly influence the first three priorities. This is unchanged from their previous report and is consistent with public comments of stakeholders statewide made during regular Commission Meetings. Therefore, the Board and the Commission on Behavioral Health believe the below identified recommendations are a top priority for the Clark region:

- Mental health oversight agency and workforce development issues.
- Dedicated funding for crisis services for children and adults.

- Residential treatment services for youth.
- Increasing collaboration on the spectrum of substance misuse and its relation to mental health.
- Identify wrap-around services for individuals experiencing homelessness and mental health crisis.

Clark County represents the largest county by population in Nevada. Therefore, the following data was collected and analyzed to understand better the impact of the priority recommendations submitted by the Board:

- Clark County population 2,226,715
- Approximately 73% of the whole state of Nevada
- 15.1% of the population is 65 and over
- 56% of the population is an ethnic minority
- Young adults and children make up almost half the entire population
- An estimated 20% of the population experience ten or more poor mental health days and categorize themselves as having unfavorable mental health
- Significant increase in unintentional or undetermined overdose-related deaths for youth under eighteen followed closely by young adults.
- Significant need for inpatient and outpatient beds that are left unmet
- Clark County, on average, has 21 child and adolescent psychiatrists per 100,00; the national average is 89.
- Alcohol and substance misuse continue to rise
- Clark County coroner data attributes 219 deaths to fentanyl overdose

Workforce Development for prevention and intervention services for youth and adults continues to be a priority for Southern Nevada, as it remains below the national average of providers per capita. The Board recommended the following:

- DHHS and DPBH review the allocation of funds to meet the identified needs for the Clark Region.
- Address the region's counselor-to-patient ratio by attracting counselors from out of state.
- Mainstream the application process for a behavioral health professional to become licensed.
- Review the Medicaid reimbursement rate and processing time to align with more competitive states.
- Add incentives for providers who serve high-risk populations and utilize peer support specialists.

The need for continued and expanded crisis services in Clark remains a priority. The Board, encouraged by the Commission on Behavioral Health, supports increasing the community's access to and availability of comprehensive crisis support, especially for those efforts that reduce over-reliance on emergency rooms, hospitals, and the criminal justice system. Still, in Clark County, only one mobile crisis unit exists, which serves only one zip code located in Downtown Las Vegas and responds to thousands of calls annually. In addition, the Department of Health & Human Services Division of Child & Family Services provides one mobile crisis team (MCRT) for youth and families in crisis.

The Board identified the Crisis Now model, which utilizes a non-hospital like an environment to provide urgent behavioral health services, as an evidenced-based good practice to serve the community better. This model creates a home-like environment for individuals that need services that are not restrictive and provides clinical and medical services with added peer specialists. The Crisis Now model, in conjunction with the Crisis Intervention Team (CIT) model, can safely and effectively provide needed crisis services that divert an individual from emergency rooms, hospital admissions, and jails.

The Board, DHHS, and DPBH should review, develop, and implement a plan for working with community partners to model Crisis Now services. Crisis services with adequately trained staff and good options for behavioral health treatment and follow-up can reduce the number of emergency room visits. The average number of patients waiting in emergency rooms for Behavioral Health Services continues to rise yearly. In 2021 data from the U.S. Labor Statistics rated Nevada second in the nation for the highest number of workers quitting jobs. Many health care professionals are experiencing high burnout and long hours with little incentives. Other professions have offered remote work, but this is not the case

for in-person medical staff. The shortage of staff and increased emergency rooms can leave a patient not receiving adequate behavioral health care or limited options for follow-up. Crisis care can help an individual get on the right track while in crisis.

Regarding residential treatment services for youth, there is little change concerning data and costs associated with the placement of youth into treatment centers. In the 2021 report, a 12-month analysis revealed over $7,000,000 was spent on out-of-state placements despite a decrease in the monthly cost of treatment. This amount was more than what Nevada paid for in-state residential treatment during the same reporting period. Part of the Clark County Children's Mental Health Consortium's 10-year plan calls for reducing the reliance on out-of-state and out-of-community placements for services or treatment of youth with Serious Emotional Disturbance (SED). Compounding the ability of the CCCMHC to reach this goal is the fact that the Clark County Department of Family Services is experiencing staff reductions while encountering children and families with higher needs of care. This has resulted in children not having the support or services available to provide services adequately.

The Clark Regional Behavioral Health Policy Board and the Clark County Children's Mental Health Consortium, supported by the Commission, suggest creating more intensive community-based services to enhance the existing system of care. While the ideal situation is for a child(ren) to remain with families and caregivers, increased collaboration and funding options for local and state services will need to align with the severe needs of children who require a higher level of care to stay safe to themselves and within their community.

The National Institute on Drug Abuse recognizes that about half of individuals who develop substance abuse disorders are also diagnosed with mental disorders and vice versa. As such, the Board understands and acknowledges the need to address substance abuse and misuse to address behavioral health concerns more effectively, as these issues are often co-occurring. Therefore, the Commission encourages the Board's desire to build bridges connecting prevention, treatment, and recovery providers to mental health professionals to create innovative solutions and system change.

The Clark Regional Behavioral Health Policy Board, supported by the Commission, supports efforts to improve public education and awareness of substance misuse and prevention. Due to prejudice or discrimination, many individuals are unwilling to seek mental health and substance misuse treatment. Breaking down biases through education encourages individuals to meet with health care professionals and openly discuss treatment options, recovery support, and connections to services. In addition to a treatment option, prevention has long-lasting economic benefits and averts injuries, disabilities, and deaths caused by misuse. The U.S. Surgeon General's office reports that evidence-based intervention returns $58 for every $1 spent.

The return on investment could have significant implications for public safety and criminal justice system costs. In a 2021 study by Applied Analysis, the increased demands of the growing community and the lack of available beds for both substance abuse and mental health issues are bombarding the system. On average, the Clark County Detention Center (CCDC) processes 70,000 inmates yearly, with 30 percent of that population experiencing a mental health need. In conjunction with substance misuse, the large volume of inmates makes it nearly impossible to provide comprehensive treatment while in custody. Identifying issues while in custody may be the only opportunity for linking someone to a diversion program that would better suit their needs versus imprisonment. Often, individuals serve their time and are released with little understanding of an action plan, therefore having a higher likelihood of repeating the cycle. The Board will continue monitoring public health trends like this to make effective current and relevant recommendations.

Workforce Recommendations

The Commission is thankful for Governor Sisolak's attendance of the Healthcare Provider Summit on April 19, 2022. It was a great opportunity to meet with so many colleagues in the behavioral health field to discuss life and our work through the pandemic. It was heartening to hear how we were able to get through the pandemic together and explore ways to improve access to behavioral health services in our state.

One theme that was often heard during the summit was that there is a need to increase and build our behavioral health workforce and specifically licensed providers that are regulated by several different licensing boards. Each discipline (psychologists, nurses, social workers, marriage & family therapists, clinical professional counselors, and drug & Alcohol counselors) is working under their own board of examiners. It has been proposed in that these boards unite under a single board – this suggestion is alluring, but likely introduces several complications. Another solution that is more feasible is the boards aligning their guidelines to make the licensing of new providers more streamlined. If the process for licensure is easier to navigate Nevada is more likely to attract providers to our state. One example we heard during the summit is that a licensed nurse from out of state can apply for a temporary license in Nevada and be approved to work within just a few days – the same process for a licensed marriage and family therapist from out of state can take 3 months or more. Nevada's various boards of examiners should be sharing strategies to encourage and develop a licensed behavioral health workforce. The biggest opportunities we see for collaborating amongst the boards are in the areas of license reciprocity with providers moving to Nevada from out of state and supervision on new professionals seeking licensure in Nevada.

Regarding reciprocity – Nevada will continue to struggle with behavioral health workforce unless we make the process easier for fully licensed and experienced providers moving from out of state to obtain a license in Nevada. In this area it appears that the Board of Nursing in Nevada has been the most successful in providing out of state applicants a "temporary" license to practice in Nevada in just a few days until background checks and other administrative processes are cleared for full licensure in Nevada. Other state boards should look towards the nursing boards policies in this area. Additionally, there are several interstate compacts for licensing reciprocity in various behavioral health fields that Nevada should consider joining to increase the number of providers licensed in the state for behavioral health services.

Regarding supervision – there are two opportunities in Nevada to improve access to new providers seeking high quality supervision towards licensure. First is to standardize the training/process to become a supervisor in a given discipline. This process is often convoluted or daunting to professionals that would otherwise qualify to supervise state interns, but do not do so because the process is confusing. In this area the board of examiners for drug and alcohol counselors seems to be most successful in offering a standardized training program through state sponsored CASAT to meet the qualifications to supervise interns in Nevada. Other state boards should consider a standardized and easily accessible training to certify supervisors in their discipline.

Another innovative suggestion not mentioned in the recap is the use of Telesupervision. There are advantages that the Telesupervision Services may provide. Our State Licensing Boards are the appropriate regulators to oversee and develop these services. All around the world, Telesupervision services are being developed and implemented.

Telesupervision, also known as e-supervision, is defined as the use of video conferencing technologies to supervise graduate students or assistants remotely. Supervisors can utilize video conferencing technologies to meet with students to discuss their objectives, assignments, and caseload, and to provide necessary and timely feedback for effective supervision.

What we have learned from the delivery and productivity of telehealth services during the pandemic shows the viability of telehealth services and the opportunity to develop high-quality Telesupervision in our state. Many states face similar challenges, and have developed or are developing Telesupervision, and they are able to eliminate the logistical problems and hardships that limit the development of high-quality providers and services.

The advantages of Telehealth and Telemedicine can be realized with Telesupervision. The Boards can develop protocols to establish clear expectations and goals for Telesupervision and tailor these as each Board determines appropriate and consistent with their professional standards. They can embed Telesupervision into a sound supervisory model to develop high quality training and services. They can formulate plans to manage technical problems. The supervisors in our state will be able to use technology in supervision once the policies and procedures are in place for ethical practice of tele-psychology and digital communications. Telesupervision offers an opportunity to overcome distance, access and time and develop high quality supervision and support the development of our provider workforce.

https://telehealth.org/telesupervision
https://pubmed.ncbi.nlm.nih.gov/30589439
https://psycnet.apa.org/fulltext/2020-39749-016.pdf

Substance Abuse and Gambling in Nevada

In relation to Nevada's substance abuse concerns, there is an overarching need for increased need for qualified professionals to increase capacity and quality of services. The COVID-19 pandemic stressed an already overwhelmed and understaffed behavioral health field, including substance abuse treatment providers. The recent passing of SB69 in the 81st legislative session will assist with ensuring that Peer Recovery Support Specialists are adequately trained and able to provide quality services. Also, adding substance misuse prevention education curriculum to schools will help to educate young Nevada's about the dangers of substance use earlier in life.

Mental Health America ranks states on a basis on 15 criteria which includes but is not limited to: Adults with Substance Use Disorder in the Past Year and Youth with Substance Use Disorder in the Past Year. While the above measures are not a complete picture of the mental health system, they do provide a strong foundation for understanding the prevalence of mental health concerns, as well as issues of access to insurance and treatment, particularly as that access varies among the states. Related to adults in the reports through Mental health America, Nevada Ranks 40th, up two spots since last year. However, Nevada remains 51st when it comes to youth meeting the listed criteria. Nevada also remains ranked 51st overall regarding mental health care in the United States. Specifically in relation to substance use, Nevada ranks 45th for adults with substance use disorder in the past year, a regression from 40th last year, for youth Nevada declined to 49th from 47th the previous year.

The Clark County Regional Behavioral Health Policy Board highlights a priority of increasing collaboration on the spectrum of substance misuse and its relation to mental health. To create change around behavioral health and improve the lives of Clark County residents. substance misuse and abuse must be part of the discussion. The state must work to build a bridge that connects prevention, treatment, and recovery providers to mental health professionals to create innovative solutions and systems change. The Clark County Regional Behavioral Health Policy Board recommends supporting efforts to improve public education and awareness for substance misuse prevention and breaking down biases through education. Prevention has long-lasting economic benefits and averts injuries, disabilities, and deaths caused by misuse.

The Northern Regional Behavioral Health Policy Board highlights increasing workforce. Nevada faces significant barriers caused by a lack of behavioral health workforce and difficulties that behavioral health professionals encounter in becoming in-network providers for insurance reimbursement. The Northern Regional Behavioral Health Policy Board recommends:

- Increase reimbursement rates for all behavioral health professions where there is a low ratio of active providers to population to attract more to the workforce,
- Develop and expand additional incentives for practitioners providing services in rural counties. (e.g., Expand application time window and streamline process to complete HRSA loan forgiveness application as a provider agency and provider; provide housing stipends, etcetera)
- Support policy change by the Department of Insurance that simplifies the insurance paneling process for behavioral health clinicians.

The Washoe Regional Behavioral Health Policy Board highlights equitable focus on substance misuse. While it is generally known and accepted that behavioral health encompasses mental health and substance misuse, there has been some concern expressed that the focus of programs, funding, and policy might be inequitable between the two. Understanding that the two are often co-occurring, the Washoe Regional Behavioral Health Policy Board realized a need to work to ensure inclusion and collaboration of all sectors of behavioral health. The Board views the passage of SB69 as successful completion of this priority area, however, will continue its support of the inclusion of and focus on substance abuse issues within the region.

To be noted the Washoe Regional Behavioral Health Policy Board reported on the methamphetamine and stimulant surveillance 20202, in which methamphetamine related deaths in Nevada per 100,000residents rose from 4.4 in 2011, to 13.7 in 2020. The Board also reported on the Opioid surveillance reporting in Nevada opioid related emergency department encounters increased by 96% from 2010 to 2020 and deaths increased by 24% in the same timeframe.

The Rural Regional Behavioral Health Policy Board reiterated workforce development and improved reimbursement as common priorities. Some ideas presented to bolster workforce in behavioral health include:

- Tuition reimbursement for providers serving within designated provider shortage areas;
- Tuition reimbursement or scholarship opportunities for new providers serving disadvantaged populations, including persons of lower socio-economic status and/or persons of color who are underserved in their respective communities;
- Increased reimbursement for behavioral health services, particularly for persons covered by Nevada Medicaid in Fee-For-Service areas, specifically rural and frontier Nevada;
- incentives for providers specializing in the treatment of children, the elderly, and other high-risk populations; and
- support policy changes that expand the ability of interns to access completely remote supervision, expansion of the number of internship sites available, and to expedite licensure processes.

A unique priority for the Rural Board is transportation: while transportation to and from all types of treatment has been a priority of the Board in previous years, the situation has remained dire for many communities. Unfortunately, other efforts to improve transportation to and home from services has largely proved fruitless; these options are either cost prohibitive or not realistic for consumers or are cost prohibitive for potential transportation providers. The Rural RBHPB prioritizes both novel and evidence-based practices in resolving transportation challenges, so long as proposed solutions are centered around the needs of user.

In relation to Problem gambling services in Nevada, recently the Reno Center for Problem Gambling closed, leaving one less facility where individuals can receive treatment for program gambling assistance, fortunately clients were able to be absorbed by other community partners. The pandemic affected gambling throughout the state and Problem gambling providers saw a slight decline in service requests over the last two year, however, are anticipating an increase in services as gaming establishments are open and individuals are returning to old behaviors. According to UNLV's report on problem gambling a total of 364 Nevada residents received problem gambling services in FY2021. In FY21, there was a 23% decline in outpatient enrollments and a 33% decline in residential enrollments. The ongoing Covid-19 pandemic has severely impacted programs. All clinics quickly adapted to the crisis and began offering telehealth services in addition to face-to-face services to support their clients' needs, but they continue to face challenges. On average, the treatment population are single white men, around 45 years old. The treatment population is not representative of the overall Nevada population and tends to be more white, less educated, with lower household income. Most of the treatment population seeking services have a DSM-5 score indicating severe gambling disorder and are seeking treatment for the first time. Around 40% of clients who were discharged in FY21 were discharged after successfully completing 75% of their treatment goals, which is a good indicator of the effectiveness of Nevada's treatment system as well as the positive post-treatment follow up.

Children's Behavioral Health

In October 2021, the US Surgeon General declared a State of Emergency in child and adolescent mental health. Between March and October 2020, the percentage of emergency department visits nationwide for children ages 5-11 rose 24% and for children 12-17 rose 34%. There was a greater than 50% increase in suspected suicide attempts amongst girls aged 12-17 presenting to the emergency department in early 2021 compared to 2019.

These above numbers represent national trends. These concerns are heightened in our state, which sadly consistently is ranked 51st in children's mental health metrics by Mental Health America (mhnational.org). The core areas in which our state struggles include access to care and fiscal support/insurance coverage for necessary care. These issues are addressed by our state's three regional children's mental health consortia annual reports, highlights of which are summarized below.

Clark County Region:

Clark County's regional group identifies four priority areas: mobile crisis intervention services, expansion of family peer to peer support, implementation of the Building Bridges model to support transition of youth back to our community from higher level of care treatment facilities, and an expanded service/care array to mitigate the need for crisis care. Projected costs and specific details for these recommendations are found within the ten-year plan report submitted by the Clark County Children's Mental Health Consortium.

Rural Region:

The Rural Regional report includes updated statistics pertinent to their region. Of significance, 100% of the rural population in Nevada reside in a federally designated health professions shortage area (HPSA). The four priorities identified for 2022 include: creation of a website with up-to-date local resources, promotion of an awareness and de-stigmatizing campaign, support for community-wide early intervention training as well as crisis support, and a push to increase their group's influence on mental health policy creation.

Washoe County Region:

Washoe County's consortia has two legislative recommendations: to fund the infrastructure to support and maintain local programs benefitting youth and families, as well as promotion of programs to respond to the local mental health crisis.

Washoe Regional Behavioral Health Policy Board (WRBHPB) Overview: The Board's efforts were prioritized in the following areas for 2021:

- Crisis Response/Stabilization
- Equitable Response to Substance Misuse
- Behavioral Health Emergency Response

Given the unprecedented and historic times we are living in with the Covid 19 pandemic, the coming year may be dramatically different, and the strategies may pose potential fiscal, programmatic and logistical challenges. The Board continues to note that Nevada remains at the bottom of many national indices for behavioral health care.

1. **Crisis Response**: The WRBHPB recognized the need for crisis response and stabilization in Washoe County, individuals and families experiencing a behavioral health crisis need to be supported by a crisis response system

that provides a continuum of services to stabilize and engage anyone in crisis and provide the appropriate, integrated treatment to address the problem that led to the crisis. A robust crisis response system ensures that every person in crisis receives the right response in the right place every time. A number of developments at the national level and within Nevada were focus around addressing behavioral health crisis and preventing suicides. The implementation of the new 988 as the three-digit call line for anyone experiencing a behavioral health crisis or suicidality. The 988 number will go live across the country on July 16, 2022, which will lead to the development of a crisis response system for Washoe region. The core elements of the crisis response system include a statewide crisis call center to manage the 988 crisis line, deployment and utilization of mobile crisis teams, and physical crisis stabilization centers.

2. **Equitable Focus on Substance Misuse**: The Board recognized that efforts were lacking when addressing citizens with co-occurring disorders (mental health and substance misuse). Mental illness and substance use problems and illnesses seldom occurs in isolation and they frequently accompany each other, as well as substantial number of general medical issues. The Board's contact with community stakeholders has identified and was expressed that the focus of the programs, funding, and policy creates inequity between mental illness and substance use problems. Understanding that the two are often co-occurring, the Board realized a need to work to ensure inclusion and collaboration with all sectors of behavioral health. The Board acknowledge and views the passage of SB69 as a successful completion of this priority area, however the Board will continue its support of the inclusion and focus on substance abuse issues within the region.

3. **Behavioral Health Response**: Before, During, and After a Crisis/Disaster/Health Crisis: The Board recognizes that a robust plan must be in place in order to response to any crisis/disaster. It was determined that there is a lack of coordinated behavioral response and lack of trained providers. It is helpful if county behavioral health agencies pre-identify behavioral health responders from both public and private sectors that have disaster behavioral health qualifications, skill sets and training as part of a regional health coalition. By identifying current capabilities in advance, resources may be assigned that the appropriate level of clinical support and response is provided at the incident site or other community setting. Discussion continues with the County Emergency Manager's office around the inclusion of the draft Washoe County Regional Behavioral Health Emergency Response Plan Annex with the Washoe County Regional Emergency Operations Plan. Resources were provided in order to train groups and individuals in Psychological First Aid with the goal of creating a community response team to activate during a crisis/disaster.

The following are additional areas of discussion by the Board to move to the priority list including diversity and inclusion, mental and behavioral health needs of children, behavioral health workforce and ongoing support of the behavioral health focus of the Community Health Improvement Plan (CHIP).

In summary, all three consortia have similar recommendations: expansion of services as well as expansion of the currently available service array to best support youth and families, to identify issues before they rise to the level of a crisis, and to support crisis services in the community.

In closing, the Commission, the Regional Health Policy Boards, and the Children's Mental Health Consortia remain committed to improving the mental and behavioral health systems in Nevada. We are committed to improving the services that exist and augmenting them to include a more robust system of care that can better meet the needs of all Nevadans. We encourage the State to consider the priorities summarized in this letter and that have been developed to address the mental and behavioral health service needs in our rural, urban, and frontier communities.

Respectfully submitted,

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