

Nevada

UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/01/2019 6.16.45 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State SAPT DUNS Number

Number 625364849

Expiration Date 7/1/2025

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Nevada Division of Public and Behavioral Health

Organizational Unit Nevada Department of Health and Human Services

Mailing Address 4150 Technology Way, Suite 300

City Carson City

Zip Code 89706

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Stephanie

Last Name Woodard

Agency Name Division of Public and Behavioral Health

Mailing Address 4126 Technology Way Suite 200

City Carson City

Zip Code 89706

Telephone (775)684-2211

Fax

Email Address swoodard@health.nv.gov

State CMHS DUNS Number

Number 625364849

Expiration Date 7/1/2025

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Nevada Division of Public and Behavioral Health

Organizational Unit Nevada Department of Health and Human Services

Mailing Address 4150 Technology Way, Suite 300

City Carson City

Zip Code 89706

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Stephanie

Last Name Woodard

Agency Name Division of Public and Behavioral Health

Mailing Address 4126 Technology Way Suite 200

City Carson City

Zip Code 89706

Telephone 775-684-2211

Fax 775-684-4211

Email Address swoodard@health.nv.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

_____ ¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
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13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Title

Organization

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Planning Steps

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NEVADA'S ORGANIZATIONAL CAPACITY

Division Of Public And Behavioral Health

The Nevada Division of Public and Behavioral Health (DPBH) is part of the Department of Health and Human Services (DHHS), under the Executive Branch of the State of Nevada. DPBH is comprised of the former Health Division and of the former Division of Mental Health and Developmental Services.

As authorized by Nevada Revised Statute (NRS) 433.316, DPBH serves as the state's Public Health Authority and Mental Health Commissioner. The DHHS director appoints both the Single State Authority (SSA) for substance abuse and the Single Mental Health Authority (SMHA); currently, a DHHS Senior Advisor on Behavioral Health serves as both the SSA and the SMHA. This executive staff provides oversight and quality assurance to behavioral health providers statewide; designs, plans, funds, and implements systems of care, including behavioral health prevention, early intervention, treatment and recovery support services; establishes funding priorities for behavioral health services and supports through close collaboration with communities and stakeholders; evaluates outcomes of behavioral health interventions; and guides policy and financing options across DHHS.

DPBH is organized into five branches, each overseen by a Deputy Administrator: a) Administrative Services, b) Bureau of Behavioral Health Wellness and Prevention, c) Clinical Services, d) Community Services, and e) Regulatory and Planning Services:

Administrative Services

- Administration - Executive Team
- Administrative Services
- Fiscal
- Human Resources
- Office of Informatics and Technology
- Revenue Management Unit

Bureau of Behavioral Health Wellness and Prevention

- Behavioral Health Services Planning
- Human Immunodeficiency Virus (HIV) Prevention
- Ryan White Part B Programs and Services
- Substance Abuse Prevention and Treatment Agency (SAPTA)

Clinical Services

- Administrative - Clinical Services
- Lake's Crossing Center (LCC)
- Northern Nevada Adult Mental Health Services (NNAMHS)
- Southern Nevada Adult Mental Health Services (SNAMHS)

Community Services

- Administrative – Community Services
- Bureau of Child, Family, & Community Wellness
- Office of Analytics
- Office of Public Health Informatics and Epidemiology
- Rural Clinics (RCs)

Regulatory and Planning Services

- Administrative - Regulatory and Planning Services
- Behavioral Health
- Bureau of Health Care Quality & Compliance
- Bureau of Health Protection and Preparedness
- Environmental Health Program
- Primary Care Office

Advisory Groups

The SSA/SMHA relies on the oversight and direction of stakeholders in several child and adult advisory groups:

Behavioral Health Planning Advisory Council (BHPAC): The BHPAC was created in 2013 by an Executive Order of the Governor with the goal of serving as an advocate for individuals experiencing chronic mental illnesses, children and youth experiencing serious emotional disturbances, and other individuals experiencing mental illnesses or emotional problems, substance use disorders, and co-occurring disorders. The members of BHPAC work in a variety of ways to: improve the way services are provided to individuals, to help bring more money into the state system, to promote awareness of mental health issues; and to provide education and training opportunities. BHPAC has three federal mandates:

1. Review the Combined Health Block Grant Plan and make recommendations.
2. Serve as an advocacy group for adults with serious mental illness, children with severe emotional disturbance, individuals with other mental health conditions or emotional problems; and people with co-occurring substance-related and mental health disorders.
3. Monitor; review; and evaluate; not less than once each year, the allocation and

adequacy of behavioral health services within the state.

Children’s Behavioral Health Consortium: As established in NRS 433B.333 & 433B.335, the statewide Children’s Behavioral Health Consortium provides Nevada’s children and their families with timely access to an array of behavioral health treatment services delivered through a system of care (SOC) that supports their needs in the least restrictive environment.

Commission on Behavioral Health (CBH): CBH is a 10-member legislatively (NRS 433.314) created body and appointed by the Governor. CBH establishes and sets policies to ensure adequate development and administration of services and to provide programmatic and financial oversight of Nevada’s public system of integrated care and treatment of adults and children with mental health disorders, intellectual disorders, substance-related disorders or co-occurring substance-related and mental health disorders, and developmental disabilities-related conditions. DPBH and the Division of Child and Family Services (DCFS) administer the service delivery system. CBH also promotes and assures the protection of the rights of all people in the system.

Multidisciplinary Prevention Advisory Committee (MPAC): MPAC provides ongoing advice and guidance to SAPTA and makes policy recommendations as related to grants or to SAPTA. The committee was originally authorized under the State Incentive Grant in 2002 and was re-authorized under the Strategic Prevention Framework Partnerships for Success Grant in 2013. MPAC is a freestanding committee that was designed to:

- Monitor progress toward objectives;
- Create a comprehensive statewide prevention strategy;
- Maximize all available alcohol, tobacco, and other drug prevention and resources;
- Remove state barriers to enhancing the delivery of effective local substance abuse prevention services;
- Ensure prevention services are culturally relevant and target populations of need;
- Develop shared responsibility among state and local governmental units; and
- Promote the prevention and treatment of alcohol and other drug use.

Regional Behavioral Health Policy Boards (RBHPB): The 2017 Nevada Legislature (Assembly Bill 366) initially created four behavioral health regions (BHR) in the state and created a RBHPB for each of those regions. Just recently, the 2019 Nevada Legislature (Assembly Bill 76) added a fifth BHR and reconfigured the regional assignments:

- Clark – newly created and consists of only Clark County (Las Vegas area);
- Northern – consists of five counties: Carson City, Churchill, Douglas, Lyon, and Storey;
- Rural – consists of six counties: Elko, Eureka, Humboldt, Lander, Pershing, and White Pine;
- Southern – consists of four counties: Esmeralda, Lincoln, Mineral, and Nye; and
- Washoe - consists of only Washoe County (Reno area).

Each RBHPB consists of 13 members and advises DPBH on matters pertaining to the behavioral health needs of adults and children in each region. This includes identifying potential problems with proposed policy changes and service delivery, identifying gaps in services, and making recommendations for service enhancements and allocation of funds.

Regional Mental Health Consortia are tasked with developing a long-term strategic plan for the provision of mental health services to children in their jurisdiction. The strategic plan is submitted to the Director of DHHS. Each even-numbered year, the consortia submit a list of service-priorities in order to implement the long-term strategic plan with an itemized cost to provide the services and to recommend any revisions to the plan. On odd-numbered years, the consortia submit a status report on the long-term strategic plan and on any revisions that were made to the plan.

SAPTA Advisory Board (SAB): SAB serves in an advisory capacity to the SAPTA Bureau Chief and to the SSA. SAB ensures the availability and accessibility of treatment and prevention services within the state. SAB consists of 15 members who serve for 2-year terms; the members are chosen from SAPTA-funded prevention and treatment programs. The chairperson is elected by the membership and serves as the chief executive of the board and provides general supervision, direction, and control of affairs of the board. The SAB meets at least quarterly, and the chairperson presides at all meetings.

OVERVIEW OF THE ADULT MENTAL HEALTH SYSTEM AND SYSTEM ORGANIZATION

Clinical Services

Nevada's adult mental health clinical services are organized into three regions: Northern, Southern, and Rural. Four agencies deliver mental health care in these regions: LCC, NNAMHS, SNAMHS, and RCs.

Northern Region

LCC is a maximum-security psychiatric facility providing comprehensive forensic mental health services. The agency provides evaluation and/or treatment for court-ordered individuals to restore them to legal competency. Located on the DPBH Campus in Sparks, LCC is Nevada's only facility for this purpose. As such, the agency serves people from throughout the state. On the regional level, LCC also provides outpatient evaluations of legal competency, risk assessments, and recommendations for treatment for individuals living in the northern rural counties and in Washoe County.

NNAMHS is a comprehensive, community-based behavioral health agency for adults; the agency is fully accredited by The Joint Commission and is certified by the Centers for Medicare and Medicaid Services (CMMS). Services are provided on a sliding fee scale, and the agency accepts private insurance; Medicaid; and Medicare.

Southern Region

SNAMHS provides mental health services for adults living in Clark County and for adults, children, and adolescents living in four surrounding rural counties that may be closer geographically to this agency than to a rural mental health center. The agency also provides services for the adult forensic population. The main campus is co-located with the state hospital for children and adolescents and with the southern facility for

individuals who have intellectual disabilities. SNAMHS has five regional behavioral health clinics; three are urban and two are rural. SNAMHS is fully accredited by The Joint Commission and is certified by CMMS.

Rural Region

RCs are facilities located in areas not designated as an urban area by the Bureau of the Census, where medical services are provided by licensed physician assistants or by advanced practice registered nurses who are under the supervision of licensed physicians (NRS 449.0175). RCs provide a full array of outpatient behavioral health services for adults and children in 16 clinics in 12 counties situated in the rural and frontier areas of the state between Clark and Washoe counties. These centers provide comprehensive services to severely emotionally disturbed (SED) children and adolescents, as well as adults with serious mental illness, and most of the RCs provide crisis service during business hours.

In the more remote areas of the state (Hawthorne, Lovelock, Tonopah, and Panaca) where therapists are not frequently available on site, medical staffs of Board-Certified Psychiatrists and Advanced Practice Nurses provide a variety of health care services through the use of telehealth, which is audiovisual communication technology. Medical staff from different offices also use telehealth for hard to treat cases.

RCs also house the Community Health Nursing (CHN) program in 14 rural and frontier communities. The CHN program provides public health nursing, preventative health care, early detection of threats to public health, disaster response, and education. Services include adult and child immunizations, well child examinations, chronic disease education, lead testing, family planning, cancer screenings, and the identification and treatment of communicable diseases including sexually transmitted infections, HIV, and tuberculosis (TB).

DPBH provides mental health and co-occurring mental health and substance-related disorders treatment to adults in the two most populated counties of the state, Clark (the greater Las Vegas area) and Washoe (the Reno/Sparks area). The division's RCs provide mental health services to adults and children in all the other counties. Services are provided for people who qualify regardless of their ability to pay.

In general, services include: assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy (family, group, and individual), outpatient, intensive outpatient, partial hospitalization, medication management, medication training and support, and case management. In addition, DPBH provides a number of specialty services:

- **Assertive Community Treatment (ACT):** These specialized, mobile, multidisciplinary teams provide intensive, integrated, community-based mental health services where and when they are needed. ACT teams serve individuals with serious mental illnesses who tend to have significant thought disorders, higher rates of substance-related disorders, histories of victimization and trauma, repeated hospitalizations, heightened arrests and incarcerations, homelessness, and additional functional challenges related to the lack of supportive social relationships and the lack of employment. Services are personalized, and care is comprehensive and not time limited.

- **Assisted Outpatient Treatment (AOT):** AOT provides involuntary court-ordered, community-based outpatient treatment for individuals who are diagnosed with severe and persistent mental health conditions and who have a recent, repeated history of medication noncompliance and/or incarceration.
- **Certified Community Behavioral Health Clinics (CCBHC):** These organizations are designed to improve the behavioral health outcomes for targeted populations through innovation and transformation of the primary and behavioral health care delivery systems. CCBHCs serve the 'whole person' by offering person-centered and family-centered care. These community-based clinics serve: 1) Adults with serious mental illnesses; 2) Children with serious emotional disturbances and their families; 3) Individuals with severe substance-related disorders; and 4) Individuals with mild to moderate co-occurring mental health and substance-related disorders. CCBHCs provide: crisis services; outpatient primary care screening and monitoring; outpatient mental health and substance-related disorder screening, assessment, diagnosis, risk assessment, and treatment; targeted case management; peer support; family support and counseling; and psychiatric rehabilitation services. The CCBHCs serve any eligible individual in need of care regardless of the person's ability to pay for the service. There are currently three CCBHCs in Nevada, and seven agencies are in the process of becoming certified as CCBHCs.
- **Crisis Intervention Teams (CIT):** These teams provide crisis intervention services for individuals with behavioral health disorders; they create connections between law enforcement, mental health providers, and ERs. The CITs also provide a 40-hour training for professionals who are interested in working with this population.
- **Forensic Assessment Service Triage Teams:** These jail-based multi-disciplinary teams are comprised of staff from social service agencies, mental health agencies, and substance-related treatment agencies. Services include behavioral health screenings, criminogenic risk/needs screenings and assessments, educational groups, medical referrals, case management, and peer recovery supports. The services are provided while the individuals are incarcerated and as they re-enter the community.
- **Forensic Mental Health Services:** Clinicians provide maximum-security inpatient treatment of people who are mentally disordered and who are involved in the criminal justice system. Services also include outpatient evaluations of competence.
- **Intensive Service Coordination (ISC):** This is an increased level of service coordination for individuals who are diagnosed with mental illnesses and who have felony legal involvement. Individuals are referred by the judicial system or by agency programs. ISC assists high-need individuals in getting services necessary to live in the community and to understand and comply with their court orders.
- **Juvenile Justice Assessment Services Triage Teams:** These county-based teams provide an early mental health diversion program for youth involved in the criminal justice system. The teams consist of juvenile probation officers, mental health providers, and the juveniles and their families.
- **Mental Health Court:** This specialty court is a multijurisdictional, community-based program that provides court supervision and services to justice-involved individuals who have mental illnesses. The program provides participants with behavioral health treatment and supportive services such as basic skills training, case management for court compliance activities, medication management, supervision, transportation, and housing.
- **Mobile Crisis and Outreach Services:** Clinicians provide evaluations within hospital emergency departments or provide psychiatric services to people who are homeless, have mental illnesses, and who are involved with law enforcement.

- **Mobile Crises Response Teams:** These youth-specific teams support youth and their families in behavioral and mental health crisis situations and help them find community services. The teams are designed to reduce hospital emergency room (ER) visits due to a psychiatric crisis and to reduce psychiatric hospitalizations by providing immediate support and crisis interventions, short-term stabilization, and case management services. Interventions are provided in the community, in the home, and through mobile consultation.
- **Mobile Outreach Safety Teams:** These county-based teams provide psychiatric services to individuals who have mental illnesses and who are homeless and to individuals who have mental illnesses and who are involved with law enforcement. Depending on the county, the teams are composed of a mental health clinician, a law enforcement deputy, and a social services case manager. Also depending on the county, the teams respond to law enforcement calls; psychiatric emergencies; and community referrals. They also provide community outreach and maintenance check-ups for individuals who have received previous contacts with the team.
- **Outpatient Psychiatric Services:** These services include ongoing psychiatric care for individuals with mental health diagnoses, such as depressive disorders; bipolar disorders; anxiety disorders; schizophrenia; and post-traumatic stress disorder. Services include pharmacy services and medication monitoring.
- **Psychiatric Assessment Services:** These services include intake and screening for all psychiatric services and initial assessment and referrals to an outpatient program or to a stabilization unit.
- **Residential Support:** This service includes a range of community housing and assisted living options for individuals with serious mental health disorders. Alternative living arrangements include: family group homes, supported living apartments, substance-related disorder treatment facilities, Housing & Urban Development programs, and specialized rehabilitation homes.
- **Senior Mental Health Outreach Program:** This program provides case management and outreach to older adults with diagnosed mental disorders.
- **Service Coordination:** This service assists individuals to obtain benefits and services throughout the community. Services include coaching and other supports designed to keep the individuals engaged in treatment and in recovery.
- **Telehealth:** This is a telecommunications system that facilitates the provision of health care services from a health care provider at one location to a recipient at a different location through the use of information and audiovisual communication technology. The system is used for professional consultations, office visits, office psychiatry services, and a limited number of other medical services.

OVERVIEW OF THE SUBSTANCE USE DISORDER SYSTEM

Substance Abuse Prevention and Treatment Agency

The Substance Abuse Prevention and Treatment Agency (SAPTA) is part of the Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the DPBH. Pursuant to NRS 458.025 and the Nevada Administrative Code (NAC) 458, SAPTA has the regulatory authority to govern the substance-related prevention and treatment programs and services. As such, SAPTA serves as the SSA for the Federal Substance Abuse Prevention and Treatment Block Grant. The role of the SSA with respect to the delivery of substance use disorder services includes: 1) formulation and implementation of a

state plan for prevention, early intervention, treatment, and recovery support; 2) statewide coordination and distribution of all state and federal funding (tax dollars, general fund, and grants) for community-based public and nonprofit organizations; 3) development and publication of standards for certification, such as the requirement that certified programs adopt evidenced-based programs and practices; and 4) certification of facilities, programs, and services.

Certification of Alcohol and Other Drug Abuse Programs

The State of Nevada has a comprehensive process to oversee the statewide substance use prevention and treatment programs. Programs receiving any state or federal funding through DPBH must be certified by the division as required in NRS 458/NAC 458, which relates to operational; personnel; programmatic; and clinical services. In addition, Medicaid Chapter 400 requires any programs seeking reimbursement for substance use treatment and/or co-occurring treatment under Provider Type 17-215 be certified through SAPTA under NAC 458 and Division Criteria established through NAC 458. SAPTA, through its contractor, the University of Nevada, Reno Center for the Application of Substance Abuse Technologies (CASAT) certifies the coalitions, prevention, and treatment programs based on the types of services they provide.

Adult Substance Use Treatment Services:

- **Level 0.5: Early Intervention**
- **Level 1: Outpatient**
- **Level 2.1: Intensive Outpatient**
- **Level 2.5: Partial Hospitalization**
- **Level 3.1: Clinically Managed Low Intensity Residential**
- **Level 1-WM: Ambulatory Withdrawal Management**
- **Level 3.2-WM: Clinically Managed Residential Withdrawal Management** – Per additional Division Criteria, this level requires: 1) during intake, a blood alcohol content (BAC) and/or urine screen must be administered and 2) the person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff with a nursing license or physician's license or by a SAPTA-certified detoxification technician. **This level of service exceeds ASAM requirements.**
- **Level 3.5: Clinically Managed High-Intensity Residential** – Per additional Division Criteria, this service level includes no less than 25 hours per week of structured interventions. A minimum of 7 hours of structured activities must be provided on each day. A minimum of 10 hours of clinical counseling services must be provided each week. **This level of service exceeds ASAM requirements.**
- **Level 3.7: Medically Monitored Intensive Inpatient**
- **Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management** – Per additional Division Criteria, this level requires: 1) during intake, a blood alcohol content (BAC) and/or urine screen must be administered and 2) the person's vital signs must be monitored at least once every two hours during the person's waking hours by a staff with a nursing license, physician's license, or SAPTA detoxification technician certificate. **This level of service exceeds ASAM requirements.**
- **Office-Based Opioid Treatment: Level 1: Outpatient**
- **Office-Based Opioid Treatment: Level 2.1: Intensive Outpatient**
- **Integrated Opioid Treatment and Recovery Services:** There are two options for certification under this designation, and the provider can only be certified for one of the options: Option 1: Opioid Treatment Program – Uses methadone and other FDA

approved medications for the treatment of an opioid use disorder; Option 2: MAT Program - Uses a minimum two of the three FDA approved medications for an opioid use disorder. The provider shall also have a formal written care coordination plan with an opioid treatment program that utilizes methadone.

- **Opioid Treatment** (Level 1: Outpatient and Level 1: Withdrawal Management)

Adolescent Substance Use Treatment Services:

- **Level 0.5: Early Intervention**
- **Level 1: Outpatient**
- **Level 2.1: Intensive Outpatient**
- **Level 2.5: Partial Hospitalization**
- **Level 3.1: Clinically Managed Low-Intensity Residential**
- **Level 1-WM: Ambulatory Withdrawal Management**
- **Level 3.2-WM: Clinically Managed Residential Withdrawal Management** – Per additional Division Criteria, this level requires: 1) during intake, a blood alcohol content (BAC) and/or urine screen must be administered and 2) the person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff with a nursing license, physician license, or SAPTA detoxification technician certificate. This level of service exceeds ASAM requirements.
- **Level 3.5: Clinically Managed Medium-Intensity Residential** – Per additional Division Criteria, this service level includes no less than 25 hours per week of structured interventions. A minimum of 7 hours of structured activities must be provided on each day. A minimum of 10 hours of clinical counseling services must be provided each week. This level of service exceeds ASAM requirements.
- **Level 3.7: Medically Monitored High-Intensity Inpatient**
- **Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management** – Per additional Division Criteria, this level requires: 1) during intake, a blood alcohol content (BAC) and/or urine screen must be administered and 2) the person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff with a nursing license, physician license, or SAPTA detoxification technician certificate. This level of service exceeds ASAM requirements.
- **Office-Based Opioid Treatment: Level 1: Outpatient**
- **Office-Based Opioid Treatment: Level 2.1: Intensive Outpatient**
- **Opioid Treatment** (includes Level 1: Outpatient and Level 1: Withdrawal Management)

Division Criteria Services

- **Civil Protective Custody (CPC) (alcohol) (NRS 458.270)** – These programs provide intoxication management services for persons taken into CPC by a peace officer for being under the influence of alcohol in a public place and unable to provide for the health or safety of self or others. CPC is not provided in a jail. The CPC facility must be a provider that is SAPTA-certified for Withdrawal Management: Level 3.2 WM Clinically Managed Residential Withdrawal Management or Level 3.7 WM Medically Monitored Inpatient Withdrawal Management. Required Services: 1) During intake, a BAC and/or urine screen will be administered; 2) At the earliest practical time, the person's family or next of kin must be advised they are in CPC if they can be located; 3) The person's vital signs must be monitored at least once every two hours during the person's waking hours by a staff with a nursing license, physician license, or SAPTA detoxification technician certificate; 4) Prior to

discharge, a good faith effort must be made to advise the person of his/her treatment options, and if the person was taken into custody for a public offense, the person must be remanded to the custody of the apprehending peace officer upon release from the withdrawal management unit. ((NRS 458.270 (4)); and 5) The person may not be required against his or her will to remain in a licensed facility or detention facility longer than 48 hours. (NRS 458.270 (3)).

- **Civil Protective Custody (CPC) (controlled substance) (NRS 458.175)** – These programs provide intoxication management for persons taken into CPC by a peace officer for being unlawfully under the influence of drugs in a public place and unable to provide for the health or safety of self or others (NRS 458.175). CPC is not provided in a jail. The CPC facility must be a provider that is SAPTA certified for Withdrawal Management: Level 3.2 WM Clinically Managed Residential Withdrawal Management or Level 3.7 WM Medically Monitored Inpatient Withdrawal Management. Required services: 1) during intake, a BAC and/or urine screen will be administered; 2) the person’s vital signs must be monitored at least once every two hours during the person’s waking hours by a staff with a nursing license, physician license, or SAPTA detoxification technician certificate; and 3) upon release from the withdrawal management unit, the person must immediately be remanded to the custody of the apprehending peace officer.
- **Co-Occurring Disorder Certification and Service Endorsements (Adult and Adolescent)** - Providers with Service Endorsements are certified for specific treatment levels of service and receive an endorsement for Co-Occurring Disorder services based on the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Rating Scale. The DDCAT is an evidence-based benchmark instrument for measuring a provider’s capacity to deliver integrated services for persons with co-occurring mental health and substance use disorders. SAPTA uses the DDCAT to certify programs as Co-Occurring Capable or Co-Occurring Enhanced. Currently, 14 programs are certified as Co-Occurring Enhanced, and 100 programs are certified as Co-Occurring Disorder Capable.
- **Drug Court Service (Adult and Adolescent)** - Provides general assessment and referral for adult clients referred from local and state courts/municipalities related to alcohol and other drug violations. The program complies with all applicable provisions of NAC 458.
- **Evaluation Center** – These programs determine whether a person is appropriate for substance use treatment per ASAM criteria. The program complies with all applicable provisions of NAC 458.
- **Transitional Housing (Adult and Adolescent)** - Services consist of a supportive living environment for individuals who are receiving substance-related treatment in an SAPTA-certified Intensive Outpatient, or Outpatient program and who are without appropriate living alternatives. Individuals admitted to Transitional Housing services must be concurrently admitted to a Level 1 Outpatient program or to a Level 2.1 Intensive Outpatient program, per an assessment.

Administrative Programs

Programs receiving SAPTA funding, both directly and indirectly, are required to participate in compliance monitoring. This function is regulatory in nature and focuses on administrative, programming, and fiscal activities of a program. Local subrecipient programs receiving funding via their coalition are monitored by the coalition. In turn, the coalitions are monitored by SAPTA. The coalitions are also mandated to participate in any evaluation process that is required by their funding sources. The coalitions and the

sub-recipients must comply with all evaluation requirements set forth by both the state and the federal evaluators.

Certified, Funded, Programs

SAPTA currently certifies and funds 23 agencies for a total of 59 *adult* substance use treatment programs and a total of 21 certified *adolescent* substance use treatment programs.

Certified, Non-Funded, Programs

With the exception of Driving Under the Influence (DUI) Evaluation Centers and Opioid Treatment Programs, certification is optional for programs not receiving SAPTA funding or not billing Medicaid under Provider Type 17. DUI Evaluation Centers located within counties with populations of 100,000 or more and Opioid Treatment Programs are not funded by SAPTA but must be certified. Agencies that are not funded often choose to become certified in order to obtain Medicaid, to meet third-party requirements, to better compete for grants, or to meet the requirements from drug courts and other types of courts that will only work with certified providers even though certification for those programs is not required in statute and regulations. SAPTA currently certifies, but does not fund, 72 agencies for a total of 102 *adult* substance use treatment programs and a total of 23 *adolescent* substance use treatment programs.

Licensure of Alcohol and Drug Treatment Facilities

In addition to certification, any residential substance use treatment program (regardless of funding source) is required by NRS/NAC 449 to be licensed as an Alcohol and Drug Treatment Facility. Pursuant to NAC 449, licensed residential substance use treatment facilities are overseen by the Nevada Bureau of Health Care Quality and Compliance (HCQC), which focuses on the health and safety aspects of licensing. Under NAC 449, programs using methadone for the treatment of an opioid use disorder must be licensed as a Narcotic Treatment Program by HCQC and must be certified by SAPTA as Ambulatory Withdrawal Management and Level 1 Outpatient. CASAT and HCQC work closely together to provide oversight and quality improvement of certified and licensed programs.

Program Funding

State General Funds - Financing behavioral health services in Nevada depends on state general fund revenue with contributions from grants and Medicaid. Each service system has its own budget established within the state system. The Division of Health Care Financing and Policy (DHCFP), also known as Nevada Medicaid, operates Medicaid Fee-For-Service (rural Nevada); the Managed Care Organizations (MCO) (urban Nevada); and the Care Management Organization (CMO) for patient centered care in rural Nevada. The prioritization of projects and funding is based on the Governor's performance-based budgeting, state strategic and need based plans, as approved by the Nevada State Legislature. With the cross-over of systems and supports, Nevada is better able to utilize the sources of funding and resources more effectively.

State General fund dollars are primarily used for funding infrastructure to expand services, prevention and treatment services, services for justice involved individuals, the re-entry population, and individuals/families with social services referrals in the state of Nevada.

Substance Abuse Block Grant – Collaboration with our state Medicaid agency resulted in the addition of Medicaid coverage of substance use disorder services effective January 2014. This has offset the need for general fund and block grant funding for treatment services provided in the Medicaid-approved model. Medicaid generously worked with SAPTA to develop a Provider Type 17 agency model that resulted in all nineteen providers being able to bill and be reimbursed by Medicaid.

In response to the changing needs of the treatment delivery system, SAPTA is shifting its block grant funding previously needed for treatment that Medicaid normally pays for such as outpatient and intensive outpatient to enhancing “gap” service. Some of these gap services include residential, transitional care, targeted case management, recovery-oriented systems of care, and expanding access to recovery support services for adolescents and adults.

State Targeted Response Grant - In April 2017, Nevada was awarded a State Targeted Response (STR) to the Opioid Crisis Grant. The STR is designed to address the opioid crisis: by increasing access to treatment; by reducing unmet treatment needs; and by reducing opioid overdose-related deaths through the provision of prevention, treatment, and recovery services. As a STR Grantee, the State of Nevada has expanded access to treatment and recovery services and has implemented a service model that was designed: to provide evidence-based treatment interventions, including medication and psychosocial interventions; to increase the availability of opioid use disorder (OUD) treatment; to reduce opioid-related overdose deaths, based on interventions developed in collaboration with DHHS; and to improve retention in care. Specifically, STR has allowed Nevada to establish a hybrid system of coordinated care for OUD in order to increase the availability, utilization, and efficacy of MAT and to provide pathways to evidence-based recovery and support services by establishing an Integrated Opioid Treatment and Recovery Center’s (IOTRC) System for Nevada residents with OUD. STR grants were awarded in November 2017. Three providers were funded under STR.

State Opioid Response Grant - In October of 2018, Nevada was awarded a State Opioid Response Grant (SOR). Activities and services will build on the work accomplished during the 2017-2018 funding cycle that established three Integrated IOTRCs across the State of Nevada. The SOR program aims to address the opioid crisis by increasing access to MAT using the three FDA-approved medications for the treatment of opioid use disorder; reducing unmet treatment need; and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for opioid use disorder. As a SOR Grantee, the State of Nevada is expanding availability of MAT services and will provide supportive services in collaboration with SAPTA-certified behavioral health providers, CCBHCs, and the IOTRCs (when geographically able) in an effort to provide integrated primary and behavioral health care for adults and adolescents with opioid use disorder. Focus areas for the SOR funding include outpatient clinical treatment and recovery services, MAT expansion for SAPTA-certified providers, tribal treatment and recovery services, criminal justice treatment and recovery services, peer recovery support services, community preparedness planning for tribal communities, mobile opioid recovery outreach teams, and neonatal abstinence

syndrome prevention and wrap around treatment and recovery support services. Approximately 22 providers are being funded under the SOR with an implementation date of July 1, 2019. Additional negotiations are ongoing which may result in additional funded providers.

Service Expansion

Nevada's behavioral health services have been evolving considerably since the expansion of Medicaid in 2014 under the Affordable Care Act (ACA). Prior to 2014, the majority of behavioral health care services for individuals in poverty, who were otherwise not eligible for Medicaid, were primarily served within the state system. After Nevada expanded Medicaid, under Governor Brian Sandoval, the numbers of individuals covered by Medicaid benefits grew exponentially from 351,315 in 2013 to 655,366 in 2018. At the same time, Nevada expanded substance use treatment benefits through an integrated behavioral health clinic model to provide substance-related and/or co-occurring conditions treatment for outpatient and inpatient clients using ASAM as the framework for assessment and for matching multidimensional severity and level of function with type and intensity of service.

In addition, Nevada participated in the 223 Demonstration Program to develop and implement CCBHC's. Under the demonstration program, Nevada has three active CCBHC's: New Frontier Treatment Center in Fallon, Nevada (rural); Vitality Unlimited in Elko, Nevada (rural); and Bridge Counseling in Las Vegas, Nevada (urban). The implementation of CCBHC's has expanded accessibility, availability, and the scope of services available in the communities with CCBHC's. Further, under the demonstration program, CCBHC's expanded the scope of community based behavioral health agencies to include non-state plan services, such as chronic disease self-management; supported employment; and targeted case management for individuals with primary substance-related disorders. The CCBHC's also expanded their scope of services to allow them to provide state plan services in an integrated setting to include: MAT; ambulatory withdrawal management; primary care services; 24/7 crisis intervention, which includes mobile crisis; psychiatric rehabilitation services, such as basic skills training and psychosocial rehabilitation; Assertive Community Services; and family-to-family peer interventions.

Communities in which CCBHC's operate have benefited from greater access to behavioral health and primary care services including a reduction in the number of unnecessary episodes of care in the emergency departments. As such, the CCBHC's have become essential safety-net behavioral health services providers in Nevada. While the demonstration program is set to end in July of 2019, Nevada has been working with the Division of Health Policy and Finance in order to develop a 1915(b4) expansion in order to continue services for CCBHCs. The state is in the process of adding additional seven community providers statewide.

SAPTA Substance-Related Disorder Specialty Populations

SAPTA has a Special Populations Plan that specifically addresses the needs of four specialty populations: 1) adolescents; 2) women who are pregnant and parenting; 3) people with TB, HIV, and acquired immunodeficiency syndrome (AIDS); and 4) people who are injection drug users. SAPTA also provides for the special needs of people who are involved in the criminal justice system.

Adolescents: Considerations for this specialty population include: Gender, ethnicity, disability status, stage of readiness for change, sexual orientation, cultural background, cognitive and social-emotional development issues resulting from the adolescent's substance use, and the role of the family as it relates to sustaining the adolescent's continued substance use. Additional areas of concern are: how to provide necessary services for adolescents in rural or frontier areas where limited accessibility presents a significant obstacle to treatment access, how to best serve those who are involved in the criminal-justice system, and how to provide age-appropriate detention programming.

Women who are pregnant and parenting: Primary medical services for this population include: prenatal intake; prenatal follow-up; labor/delivery with prenatal care; postpartum follow-up; neonatal follow-up and nutritional considerations; primary pediatric care for their children, including immunizations; and TB, HIV, and AIDS services. Therapeutic interventions are provided for children of women in treatment to address the children's developmental needs and to address any issues resulting from sexual abuse, physical abuse, and/or neglect. Psychosocial services include trauma counseling for women who have experienced sexual or physical abuse, mental health counseling for all family members, and general family services including assisting the women to plan for reunification with their other children. Additional services include: case management, child care, housing assistance, home management training, transportation, life skills training, parenting training, vocational training and job-skill development, education programs, and legal assistance.

People with TB, HIV, and AIDS: Services for people with TB include: counseling the individual with respect to TB; testing to determine whether the individual has been infected with TB; and either providing medical evaluation and treatment, or referring the individual to other medical providers for the services. Services for people with HIV and AIDS include: on-site pre- and posttest test counseling, testing to confirm the presence of the disease, tests to diagnose the extent of immune system deficiency, and tests to provide information on appropriate therapeutic measures for preventing and treating conditions arising from the disease. SAPTA, in conjunction with state-wide agency-funded substance-related treatment programs, provides HIV and AIDS services through arrangements with the Southern Nevada Health District and the Nevada State Health Division Bureau of Child, Family, and Community Wellness.

People who are injection drug users: Services for this population include: comprehensive substance-related treatment; on-going and continuing care with community providers; medication assisted treatment for individuals with opioid disorders; recovery supports, such as housing assistance; legal resource access; vocational and job-skill building; and outreach services that adhere to the National Institute of Drug Abuse's Community Based Outreach Model, which is used to identify potential and to provide them with risk-reduction interventions.

People who are involved in the criminal justice system: SAPTA provides a variety of residential and transitional living programs for people re-entering society from prison or jail. Transitional services include but are not limited to: cognitive-behavioral therapy, mental health counseling, trauma informed care, peer support services, skills training, and vocational services and job training. The agency also funds drug court programs which provide a sentencing alternative of treatment combined with supervision for people living with serious substance-related disorders.

Substance Use Prevention

SAPTA is responsible for prevention services and is responsible for ensuring the state uses a variety of evidence-based programs, policies, and practices in their prevention efforts. Nevada Administrative Code (NAC) 458 identifies three areas relating to the use of alcohol and other drugs: a) Prevention Programs, b) Coalition Programs, and c) Administrative Programs.

Prevention Programs

SAPTA currently approves six strategies to prevent the initial onset of substance-related disorders and to eliminate or reduce the harmful effects of alcohol, tobacco, and other drugs in individuals, families, and communities. The methods are recognized by SAMHSA's Center for Substance Abuse Prevention (CSAP), and all SAPTA-funded prevention programs use a structure that is based on one or more of these strategies: a) Information Dissemination, b) Education, c) Alternatives, d) Problem Identification and Referral, e) Community-Based Process, and f) Environmental:

- a) **Information Dissemination:** This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, and other drug use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. The method is characterized by one-way communication from the source to the audience, with limited contact between the two.
- b) **Education:** This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this method are intended to affect critical life and social skills, including decision-making; refusal skills; critical analysis (e.g., of media messages); and systematic judgment abilities.
- c) **Alternatives:** This strategy provides for the participation of target populations in activities that decrease alcohol, tobacco, and other drug use. The assumption is constructive and healthy activities offset the attraction to, or otherwise meet, the needs usually filled by alcohol and other drugs and would, therefore, minimize or obviate resort to the latter.
- d) **Problem Identification and Referral:** This strategy identifies those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those individuals who have used illicit drugs for the first time. The intent is to assess if the behavior of these individuals can be reversed through education. This strategy does not include any activity designed to determine if a person needs treatment.
- e) **Community-Based Process:** This strategy aims to improve the community's ability to more effectively provide prevention services for alcohol, tobacco, and other substance-related disorders. Activities in this strategy include: organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking.
- f) **Environmental:** This strategy influences the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs in the general population. This is achieved by establishing or changing written and unwritten community standards, codes, and attitudes. This method is divided into two subcategories to permit distinction

between activities: a) legal and regulatory initiatives and b) service and action-oriented initiatives.

Prevention Classifications

The prevention interventions are divided into five classifications based on the service delivery method and on the targeted population:

- **Universal:** Targets the general public or a whole population group that has not been identified on the basis of individual risk.
- **Universal Direct:** Directly serves an identifiable group of people who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
- **Universal Indirect:** Supports population-based programs and environmental strategies (e.g., establishing pertinent policies and modifying advertising practices) and could include interventions involving programs and policies implemented by coalitions.
- **Selective:** Targets subsets of the total population deemed to be at risk for a substance-related disorders by virtue of their membership in a particular population segment (e.g., children of parents with substance-related disorders, students who are failing academically, or students who dropout). Risk groups may be identified on the basis of biological; psychological; social; or environmental risk factors known to be associated with substance misuse, and targeted subgroups may be defined by age; gender; family history; place of residence, such as high drug-use or low income neighborhoods; and victimization by physical and/or sexual abuse. Selective prevention strategies target the entire subgroup regardless of the degree of risk of any individual within the group. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for a substance-related disorders than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup (e.g., children of parents who have substance-related disorders).
- **Indicated:** Identifies individuals who are exhibiting early signs of a substance-related disorder or other problem behaviors associated with a substance-related disorder (e.g., falling grades and consumption of alcohol and other gateway drugs) and targets them with special programs. These interventions are designed to prevent the onset of a substance related disorder for individuals who do not meet the DSM-5 criteria for a substance use disorder.

Prevention Coalitions

There are 10 substance abuse prevention coalitions that serve all 17 counties in the state. Each coalition must have a board of directors, and the board must be broadly representative of the community and geographic area to be served. The coalitions are funded by Nevada's State General Fund through SAPTA and by discretionary grants from SAMHSA's CSAP. SAPTA oversees the coalitions to ensure they implement evidence-based prevention strategies as recommended by the federal and state governments.

The coalitions are restricted from providing direct services. However, they act as pass-through entities to fund the prevention services at the community level. This restriction is to ensure there will be no conflict of interest between the coalitions as funding/oversight organizations and the direct service providers in their communities. The coalitions provide environmental strategies; information dissemination; and community-based strategies, which include developing needs assessments; coordinating data collection; developing comprehensive community prevention plans; implementing the plans; and evaluating outcomes.

OVERVIEW OF THE CHILDREN'S MENTAL HEALTH SYSTEM AND SYSTEM ORGANIZATION

Nevada's children's behavioral health system encompasses the emotional, mental, physical, and social well-being of children from infancy through adolescence. Nevada incorporates a system of care (SOC) approach to children's mental health that guides the method in which services are delivered. The SOC is designed to meet the multiple and changing needs of families, children, and youth through a strength-based, family-driven, comprehensive, integrated, and coordinated continuum of services and supports. Oversight of children's mental health is statutorily mandated through NRS Chapter 433 (state agencies only) and NRS 433B for Clark, Washoe, and Rural Children's Mental Health Consortiums.

Division of Children and Family Services

DCFS is responsible for the operation of state-funded children's outpatient community mental health programs, residential programs, juvenile justice programs, and foster care programs. As legislated by NRS 433, the division is responsible for planning; administration; policy setting; monitoring; and budget development of all state-operated children's mental health programs in Washoe and Clark Counties. The DCFS Administrator coordinates the administration of children's behavioral health services with the SSA and the SMHA. In addition, the DCFS administration is also directly involved in decisions regarding agency structure; staffing; program administration; and budget development.

DCFS receives oversight and direction through stakeholder and advisory groups: The Nevada Commission on Behavioral Health, the statewide Children's Behavioral Health Consortium and the Regional Mental Health Consortia. The Regional Consortia are required by statute and offer recommendations on the children's behavioral health service-array to the Nevada Commission on Behavioral Health and to the legislature. These consortia are supported by staff from DCFS' Planning and Evaluation Unit (PEU) and by staff from the SOC grant.

DCFS recently re-organized in order to reduce compartmentalization of services and staff and to improve the way the division provides integrated care to youth. Formerly, DCFS was organized around Children's Mental Health, Child Welfare Services, and Juvenile Justice Services. Under the new structure, DCFS's three areas of focus include: 1) Community-Based (nonresidential) Services; 2) Residential Services; and 3) Quality and Oversight.

Nevada is currently wrapping up a four-year SAMHSA SOC Expansion Grant, which is a

complement to the previous two SOC grants DCFS was awarded. The division and its grant partner Nevada Parents Encouraging Parents – Statewide Family Network (which offers training, resources, and support to parents who have children with disabilities ages 0-26), share responsibility for implementing the grant. The grant expands the SOC for youth identified as SED. Within Quality & Oversight, PEU and SOC grant-staff provide numerous trainings for providers; facilitate the implementation of evidence-based practices; and provide quality assurance activities.

DCFS staff also collaborate with Nevada’s CCBHCs on training related to children’s services; provide consultation to childcare centers, foster care providers, and juvenile justice facilities; and provide input in numerous statewide initiatives to improve access to services for youth.

Other initiatives include collaborating with other Nevada divisions to determine the state’s role in assuring, providing, funding, and regulating behavioral health services to promote community integration; workforce development and training; and state planning for integrating physical and behavioral health including the division’s recent Human Resources and Services Administration Pediatric Mental Health Access grant award.

Children’s Community-Based And Residential Services

DCFS is a direct service provider and serves children and families who have fee-for-service Medicaid, have certain managed care Medicaid coverage, are uninsured, or are underinsured. DCFS provides services in the two urban areas of the state, a) Reno area (Northern Nevada) and b) Las Vegas area (Southern Nevada). In Las Vegas, DCFS has four neighborhood care centers, plus the various care facilities. Services for children in rural Nevada are provided by DPBH. Depending on the region, DCFS provides the following community-based services:

- **Adolescent Treatment Center:** This highly structured community treatment facility provides round-the-clock care; psychiatric evaluation and medication management; individual, family, and group therapy; psychological assessment and evaluation; nursing care; and emergency evaluation and stabilization. Education is provided on-site through Washoe County School District.
- **Caliente Youth Center:** This is a secure facility for male and female youth who are committed to DCFS by the juvenile court. The center follows a criminogenic model that targets the individuals’ crime-producing needs in order to improve treatment outcomes and to reduce the risk of recidivism. Upon successful completion of the programming within the center, youth are released back into the community with supervision and case management services provided by Youth Parole. Youth committed for mental health treatment are placed directly on parole and receive treatment and case management services based on their identified needs.
- **Desert Willow Treatment Center:** This center provides intensive mental health services in a secure environment with both an acute care unit and a residential treatment unit. The acute care unit serves children with critical mental health conditions and provides short-term psychiatric, diagnostic, and stabilization services. The residential unit provides longer-term care to youth who cannot currently be served with community-based programming.
- **Early Childhood Mental Health Services:** These services are for children between birth and six years of age who have emotional disturbances or who may be at high-risk for developing emotional and behavioral disturbances and the associated developmental delays. The goals of services are to strengthen parent-

child relationships, support the family's capacity to care for their children, and enhance the child's social and emotional functioning. Services include: behavioral and psychological assessments; psychiatric services; family, individual, and group therapies and behavioral management; day treatment; clinical case management; in-home crisis intervention; childcare and pre-school consultation, outreach, parent training; and consultation to other child-serving providers.

- **Family Learning Homes:** These highly structured community treatment homes provide round-the-clock care; individual, family, and group therapy; behavior management; care coordination; psychological and psychiatric assessment and evaluation; and parent training.
- **Mobile Crisis Response Teams:** These teams provide information, crisis response (at any location), and stabilization services to children and adolescents in the community up to age 18. The teams also provide up to 45 days of in-home stabilization services following a crisis response, and families are linked to their current provider or connected to new long-term services and supports.
- **Nevada Youth Training Center:** This is a staff-secure facility for male youth who are committed to DCFS by the juvenile court. The program follows a criminogenic model that targets the individuals' crime-producing needs in order to improve treatment outcomes and to reduce the risk of recidivism. Upon successful completion of the program, youth are released back into the community with supervision and case management services provided by youth parole. Youth committed for mental health treatment are placed directly on parole and receive treatment and case management services based on their identified needs.
- **Oasis On-Campus Treatment Homes:** These highly structured community treatment homes provide round-the-clock care, mental health assessment, psychiatric assessment and evaluation, psychoeducation, and mental health rehabilitation services to children and their families.
- **Outpatient Mental Health Services:** These community-based, family-oriented, mental health services are for children from 6 through 17 years of age. They include: clinical case management; psychiatric services; psychological assessment and evaluation; individual, family, and group therapies and behavioral management; care coordination with other child serving entities involved with the child and family; and 24-hour on-call emergency professional coverage.
- **RAISE Up Nevada:** This First Episode Psychosis program is based on the Recovery After Initial Schizophrenic Episode (RAISE) model. The program assists individuals experiencing psychosis by emphasizing a comprehensive initial evaluation at the earliest point after their symptoms appear and through treatments which include: medication, psychosocial therapies, and supportive services that address the multiple problems associated with these illnesses.
- **Specialized Foster Care:** Pursuant to NRS 424.041-424.043, DCFS is authorized to act as the oversight body over specialized foster care. Specialized foster care is an "advanced" version of traditional foster care that targets youth who: have behavioral or mental health needs that cannot be met in traditional family foster care; are struggling to maintain placement in traditional family foster care due to behavioral and emotional needs; have disrupted from a placement due to behavioral and mental health needs; and/or are returning or stepping down from a higher level of care. With specialized foster care, staff provide foster parents with additional training, support, and consultation in order to provide specialized care and support to high-needs youth. Like other programs within a system of care approach, a fundamental assumption of treatment foster care is that the most effective treatment environment for a youth is his/her home, community, and

school. Within this model, foster parents pay close attention to the youth's behavior on a daily basis and are in close communication with other members of the youth's treatment team in order to provide individualized, coordinated treatment.

- **Summit View Youth Center:** This is a maximum-security facility for male youth who are involved in the juvenile justice system. The program follows a criminogenic model that targets the individuals' crime-producing needs in order to improve outcomes and to reduce the risk of recidivism. The center also includes an education program that is provided on-site through the Clark County School District.
- **Wraparound in Nevada (WIN):** WIN is an ecologically based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professionals, and cross-system supports. WIN mobilizes resources and talents from a variety of sources resulting in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies. WIN in Northern Nevada and Rural Nevada includes both High Fidelity Wraparound services and FOCUS. FOCUS is an intermediate care coordination model that supports youth and their families who do not rise to the intensive WIN level of care but who are multi-system involved, at risk of deeper system involvement, and whose challenges exceed the resources of a single organization.

NEVADA'S DIVERSE POPULATIONS

The State of Nevada works continuously to address the needs of diverse populations. During the 2005 legislative session, the Nevada State Legislature created the Office of Minority Health with passage of Assembly Bill 580. Included in the bill was the creation of an Advisory Committee, composed of nine members reflecting the ethnic and geographical diversity of the state. During the 2017 legislative session, AB 141 was passed broadening the entities' title to the Nevada Office of Minority Health and Equity (NOMHE) and revising the definition of "minority" to include members of the LGBTQ community and people who are disabled. Pursuant to NRS 232.474, NOMHE provides an organized statewide focus serving to:

- Identify, assess, and analyze issues related to the health status of minority populations and to communicate this information where needed;
- Participate in, and lead when appropriate, the development of minority needs assessments; service strategies; and the collection of minority health data;
- Provide reference and resource information on minority health issues;
- Engage internal and external entities to support initiatives that address specific minority health needs, including target health care program resources to meet these needs;
- Monitor programs, policies, and procedures for inclusiveness and responsiveness to minority health needs; and
- Facilitate the development and implementation of research and scientific investigations to produce minority-specific findings.

All DHHS agencies are expected to abide by the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in order to advance and sustain culturally and linguistically appropriate services. Further, all funded providers are required to comply with the requirements of the Civil Rights Act of 1964, as

amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and with any relevant program-specific regulations, and shall not discriminate against any employee or offer for employment because of race; national origin; creed; color; sex; religion; age; disability; or handicap condition (including AIDS and AIDS-related conditions).

Further, DHHS has established a statewide Special Populations & Health Disparities Quality Improvement Team. The team consists of eight workgroups that study the needs and service gaps of individuals in special populations:

- Adolescents and young adults
- Criminal justice-involved persons
- Homeless people
- LGBTQ people
- Native American and Hispanic/Latino people
- Older adults
- People with co-occurring mental health and substance-related disorders
- Veterans, active duty military, and their families

In keeping with SAMHSA's guiding principles, DHHS holds that recovery is culturally based and influenced and that services should be culturally grounded, attuned, sensitive, congruent, and personalized to meet each individual's unique needs. To this end, the agency includes representatives from diverse populations on its various advisory councils; includes racial and minority data sections in all of its needs assessments and gaps analysis; and conducts surveys to measure staffs' cultural competence in the ability to understand, communicate with, and effectively interact with people across cultures. The state has specific agencies dedicated to serving people who are LGBTQ in both the northern and southern parts of the state.

DHHS provides all surveys in English and Spanish and provides surveys in other languages, as requested. In addition, the division offers consumer advocates to assist individuals in navigating the system. Many of the consumer advocates are peers with similar diversity and backgrounds as the people they assist.

Finally, DHHS partners with the 27 American Indian Tribes within the State of Nevada through a Tribal Consultation Process Agreement. This coordination establishes and strengthens ties and relationships with the tribal governments as well as provides education and outreach and notifies the tribes of funding opportunities. A network of liaisons represents each division within DHHS; the group meets on a quarterly basis. Tribal mental health and substance-related disorder services are provided by Indian Health Services and Medicaid.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁶ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

FFY 2020–2021 BLOCK GRANT APPLICATION
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (MHBG)
PLAN AND REPORT

Section III. BEHAVIORAL HEALTH ASSESSMENT AND PLAN

B. Planning Steps

Step 2: Unmet Service Needs and Critical Gaps within Nevada’s Current System

Submitted by:

NEVADA DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
BUREAU of BEHAVIORAL HEALTH WELLNESS AND PREVENTION

FFY 2020-2021 Community Mental Health Services Block Grant (MHBG)

STEP 2: Identify the Unmet Service Needs and Critical Gaps within Nevada's Current System

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NEVADA'S

BEHAVIORAL HEALTH COMMUNITY INTEGRATION

STRATEGIC PLAN, July 2018 ¹

EXECUTIVE SUMMARY

In 2016, the Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) began to develop a strategic plan that would assure, provide, regulate, and fund behavioral health services for individuals with behavioral health related disabilities in Nevada. This process culminated in completion of a framework to further *Olmstead Plan development* in the State. The State of Nevada Aging and Disability Services Division (ADSD) has traditionally been the lead entity for implementing the plan. Following discussions with key stakeholders in Nevada, a decision was made to integrate behavioral and mental health into the evolving *Olmstead Plan framework*.

SAMHSA approved a technical assistance (TA) request from DPBH and Bureau of Behavioral Health Wellness and Prevention (BBHWP) to support State staff by increasing understanding of the Olmstead decision and its implications for state action and creating a framework for Olmstead Plan development in the State. As part of this TA, DPBH utilized the *Community Integration Self-Assessment (CISA)* tool to conduct self-assessment of its current performance related to the degree of behavioral and mental health community integration. Data were collected from a number of public and state sources to inform the assessment.

Department of Health & Human Services Strategic Framework for Community

INTEGRATION

The State of Nevada has elected to combine community integration efforts into the updated State Olmstead plan to serve as the Department of Health and Human Services (DHHS) Strategic Framework for Community Integration.

¹ Nevada's Behavioral Health Community Integration Strategic Plan, July 2018. Prepared by: Social Entrepreneurs, Inc.

MISSION

The mission of the DHHS Strategic Framework is to ensure that Nevadans have the opportunity to achieve optimal quality of life in the community of their choice.

VISION

The vision is that Nevadans, regardless of age or ability will enjoy a meaningful life led with dignity and self-determination.

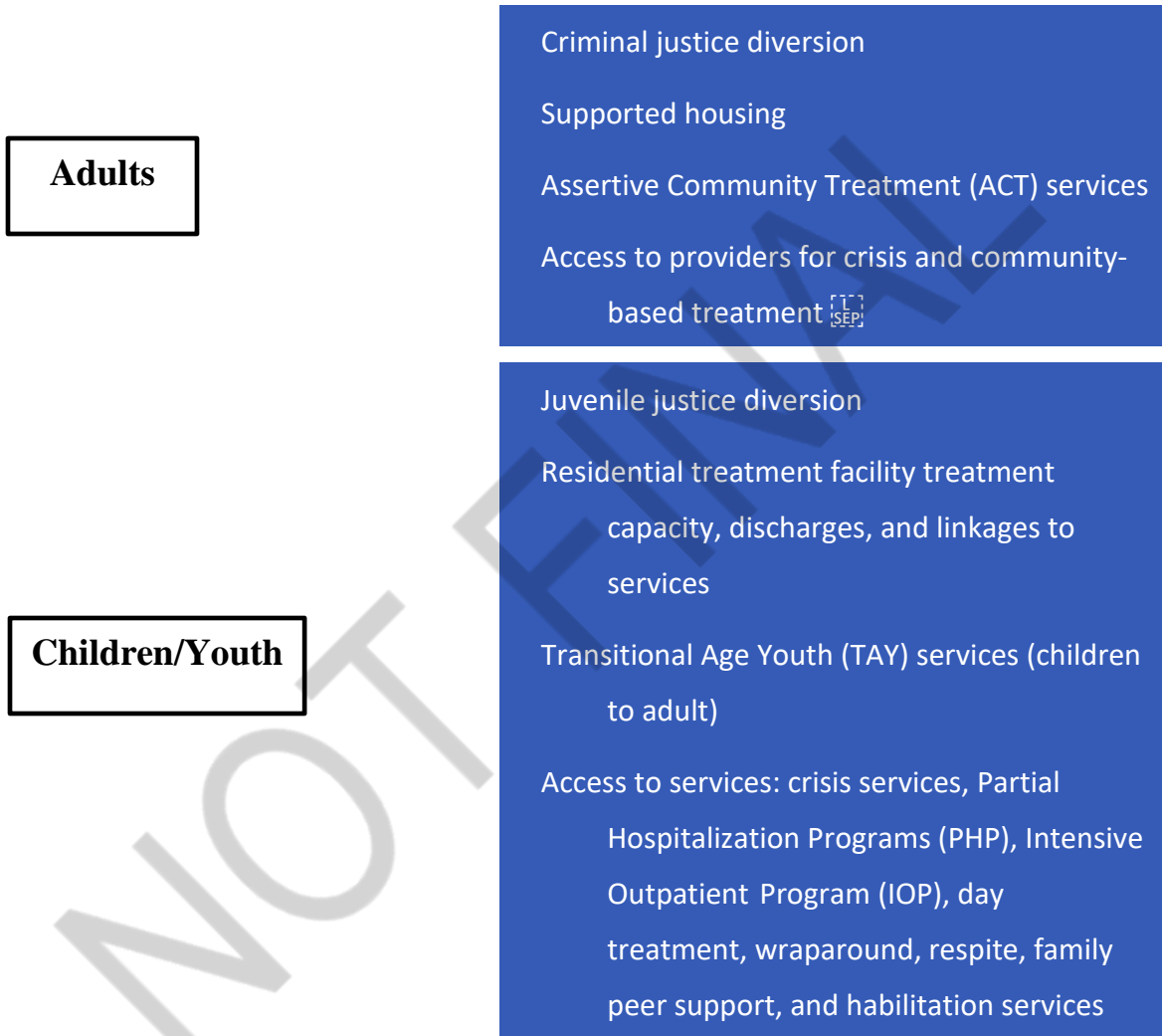
GUIDING PRINCIPLES

The DHHS Strategic Framework has adopted the following guiding principles:

- Independence: People should have options and the ability to select how they live.
- Access: People's needs are identified and met quickly.
- Dignity: People are viewed and respected as human beings.
- Integration: People can live, work, and play as part of their community.
- Quality: Services and supports achieve desired outcomes.
- Sustainability: Services and supports can be delivered over the long term so individuals can be self-sufficient.

PRIORITIES

After reviewing results of the self-assessment, a planning body prioritized categories for adults and children/youth that guided development of the strategic plan:



SYSTEM GOALS and STRATEGIES

Following determination of priority categories, planning members next identified three system goals with specific strategies to address the needs of adult and children/youth populations. A range of specific strategies was developed to assist in achieving these system goals, which can be reviewed in the full document included in the Appendix for this application (Title: Nevada's Behavioral Health Community Integration Strategic Plan, July 2018. Prepared by: Social Entrepreneurs, Inc.).

SYSTEM GOAL 1: Ensure there is a continuum of high-quality recovery support and care to achieve and maintain stability.

SYSTEM GOAL 2: Ensure individuals have access to appropriate, timely services in the most integrated setting based on a self-determination plan.

SYSTEM GOAL 3: Ensure a system that prevents inappropriate incarceration, hospitalization, institutionalization, or placement.

BACKGROUND

Since the *1999 Olmstead decision*, Nevada has made significant progress to ensure that persons with disabilities are able to live in the community setting of their choice. Nevada developed a statewide plan to address the need for community supports for people with disabilities who are in segregated settings and to prevent future unnecessary segregation. The *10-year Olmstead plan* was approved by the Legislature in 2003 and expired in 2013.

Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) recently created a framework to *further Olmstead Plan development* in the state. The State of Nevada Aging and Disability Services Division (ADSD) is the lead entity for implementation of the plan. Following discussions with key stakeholders in Nevada, a decision was made *to integrate behavioral health into the evolving Olmstead Plan framework*. This decision was informed by notable data points, including:

- In 2015, the prevalence rate of adults age 18 or older with a serious mental illness (SMI) was 4.3 percent or 91,893 individuals, slightly higher than the U.S. rate of 4.0 percent. *
- 28,589 persons were served by State Mental Health Agencies (SMHA) in Nevada during 2015 which equates to 31 percent of the adult population with SMI.**

Interest by the Department of Justice (DOJ) has elevated *Olmstead implementation as a priority nationally, and statewide within Nevada*. The DOJ conducts investigations to determine why people are institutionalized, and if institutionalization is needed, whether they are receiving adequate and appropriate care to ensure timely return to and integration back within the community. The DOJ approach includes examining discharge planning, as well as community capacity to ensure

adequate and appropriate services and supports are available within an integrated setting.***

* Substance Abuse and Mental Health Services Administration (SAMHSA). 2015. Serious Mental Illness in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2014 and 2015.

** Center for Mental Health Services (CMHS) Uniform Reporting System. 2015. Total Clients Served by SMHA System.

*** Ted Lutterman. Development of a Community Integration Self-Assessment (CISA) tool for State Governments. November 14-15, 2016.

MISSION

The State of Nevada has elected to integrate community integration efforts into the updated State Olmstead plan to serve as the Department of Health and Human Services (DHHS) Strategic Framework for Community Integration. The mission, vision, and guiding principles in the State's Olmstead plan align well with the behavioral health system and have been adopted in the Community Integration Strategic Plan. This collaborative effort has resulted in one unified comprehensive Olmstead/community integration plan for Nevada.

The mission of the DHHS Strategic Framework is to ensure that Nevadans have the opportunity to achieve optimal quality of life in the community of their choice.

SUBSTANCE USE, MENTAL HEALTH, AND SUICIDE IN NEVADA²

2018 NEEDS ASSESSMENT

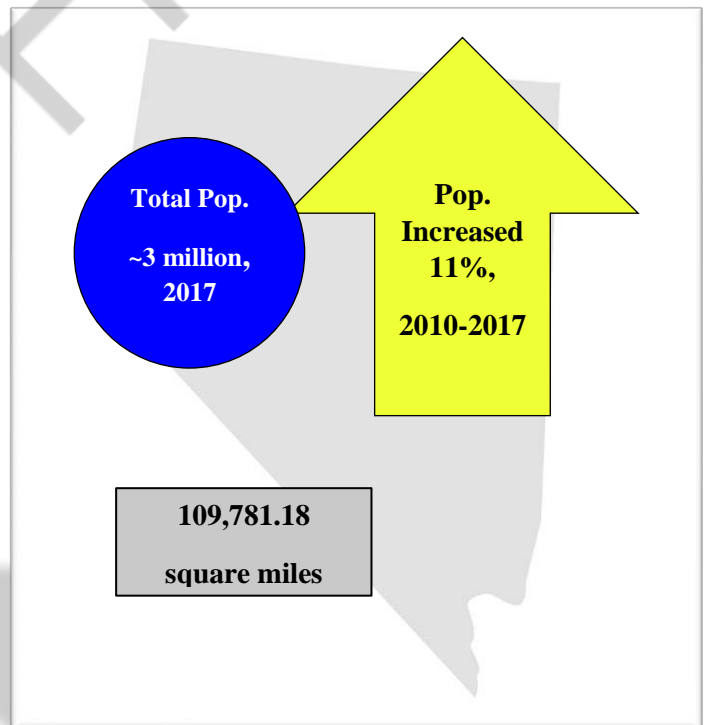
Bureau, Behavioral Health Wellness and Prevention (BBHWP)

Substance Abuse Prevention and Treatment Agency (SAPTA)

THE STATE OF NEVADA: AT A GLANCE

Nevada’s population and geography create unique challenges for service delivery and mental health systems of care. A primary consideration is the number of people; the state has experienced considerable **population growth** since 2010, and total population approached **3 million** in April 2017. The majority of the state’s population is in Clark County, followed by Washoe County and Carson City. Nevada has **19 incorporated municipalities (cities)** and 20 federally recognized tribes composed of **27 separate reservations, bands, colonies and community councils** (First Nation's Focus: Tribal News of Nevada and the Eastern Sierra, 2018).

Data from the most recent U.S. Census shows that among Nevada’s population, roughly one in four people is age 18 or younger. The population of people age 65 and up was 16% in 2017 and is predicted to increase in future years. Roughly 14% of people are in poverty, with rates higher among children and families of young children. Most of Nevada’s population has an education of high school graduate or higher. Nearly one in five people were born in a country other than the U.S., and nearly one in three households



² Substance Use, Mental Health, and Suicide in Nevada, 2018 Needs Assessment, Nevada Substance Abuse Prevention and Treatment Agency – SAPTA, October 2018.

(30%) speak a language other than English at home.

Racially

The majority of the population is White (68%); 9% is Black/African American, 9% is another race (not specified), 8% is Asian, 5% is two or more races, 1% is American Indian, and 1% is Native Hawaiian or Pacific Islander

Ethnically

- 29% (any race) Hispanic/Latino
- 49% White alone, not Hispanic or Latino

By Age

- 23% Age 18 or Younger
- 16% Age 65 or Older

By Circumstances that May Impact Health Care Access

- 13% lack health insurance
- 13% have a disability
- 8% are veterans
- 30% speak a language other than English at home

(Source: United States Census Bureau, 2017)

NOT FINAL

TARGET POPULATIONS

Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED)

Serious mental illness in adults (SMI) and serious emotional disturbance in children (SED) are accompanied by significant functional impairment and represent debilitating conditions that are costly in terms of human suffering and societal economic burden. In the United States, the societal economic burden for schizophrenia alone was estimated at \$155.7 billion for the year 2013, and that burden included additional excess costs that were associated with unemployment, productivity loss for family members due to caregiving, and direct health care costs (Cloutier et al., 2016). It is important to emphasize that this estimate of economic burden pertains to just one of the disorders included within the serious mental illness diagnosis. Early intervention services may provide one avenue to mitigate the magnitude of human suffering and the extent of economic burden of schizophrenia (Mihalopoulos et al., 2009), as well as for other serious mental disorders. Providing intervention services to individuals during the early stages of SMI and SED, and extending those early interventions throughout the State, including to Nevada's rural and remote frontier regions, were adopted as strategic priorities during the previous biennium and for the next budget period.

Expected Rates of Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED): Identifying populations at risk for mental disorders, in general, and for specific categories of mental disorders, in particular, requires consideration of estimates of prevalence and incidence, as well as ages at which disorders first appear. *Prevalence rates* provide the proportion of individuals in a specific population who have a particular disease or characteristic during a specified period of time. *Incidence rates* provide the proportion of new cases of illness within a specific population during a specific period of time. The difference between the two rates is that prevalence rates include both pre-existing cases and new cases, while incidence rates include only new cases. Incidence rates are uniquely informative for early intervention treatment approaches because of the need to identify and enroll individuals at the first onset of their illness. *Age of onset distributions* provide ranges of chronological ages within which most cases of an illness are first diagnosed. The three types of estimates provide information that is essential for planning effective community outreach strategies to identify individuals for recruitment and enrollment in intervention services for serious mental illness and serious emotional disturbance.

Nevada Public Health and Treatment of Mental Illness in Populations: The following needs assessment was conducted by the Bureau of Behavioral Health Wellness and Prevention within the Nevada Division of Public and Behavioral Health. A wide range of information sources was examined for the purpose of identifying service needs and gaps in Nevada's current behavioral and mental health system, with a focus on the following vulnerable populations:

- Children with serious emotional disturbance (SED) and their families
- Adults with serious mental illness (SMI)
- Older Adults with serious mental illness (SMI)
- Individuals with SMI or SED in the rural and homeless populations
- Individuals who have an Early Serious Mental Illness (ESMI) (10 percent MHBG set aside)

Inclusion of mental health within public health science and practice is increasingly recognized as having potential to advance both disciplines (Galea, 2015; Sallis, Owen and Fotheringham 2000; Williams, Chapman and Lando 2005). The State of Nevada is developing this paradigm for its population of individuals with SMI and SED through strategic program planning and evaluation that are data-driven, population-based and community-targeted. The recent needs assessment was conducted within that integrative framework. *Community psychiatric epidemiology and behavioral health data* were reviewed to distinguish the prevalence of mental disorders in Nevada and nationwide. When available, county-level prevalence rates were considered to reveal subsets of the State’s population with particular needs. *Rates of persons served by the State’s current behavioral and mental health system* were then evaluated within the context of the prevalence rates reported for the United States as a whole and for Nevada and its individual counties. *Billing data for hospital emergency room visits related to mental health conditions* were additionally considered as indicators of SMI and SED that were either untreated or ineffectively managed. The combined findings indicate the presence of unmet service needs and gaps within Nevada’s current behavioral and mental health system, and this information shaped the strategic priorities that were adopted for the next biennium. A summary of these findings is provided for the targeted populations, as well as a discussion of their significance for Nevada’s current and future public and mental health system.

- **CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)**

Rates of Serious Emotional Disturbance (SED) in Nevada’s Children: An estimated 6,204 children ages 0-17 in Nevada were diagnosed with serious emotional disturbance (SED) during 2016-2017, with 3,133 identified by Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Clinics (RC). An additional 3,071 children ages 0-17 who were diagnosed with SED were identified by the community providers receiving Medicaid reimbursement for services. In 2014-2015, the years for which the most recent National Survey on Drug Use and Health (NSDUH) are available, Nevada’s annual average percentage of major depressive episode (MDE) among adolescents aged 12-17 was similar to the corresponding national average percentage. An estimated annual average of approximately 31,000 adolescents aged 12-17 (13.9% of all adolescents) in 2014-2015 had experienced a Major Depressive Disorder (MDE) in the previous 12 months. The annual average percentage in 2014-2015 was higher than the annual average percentage in 2011-2012.

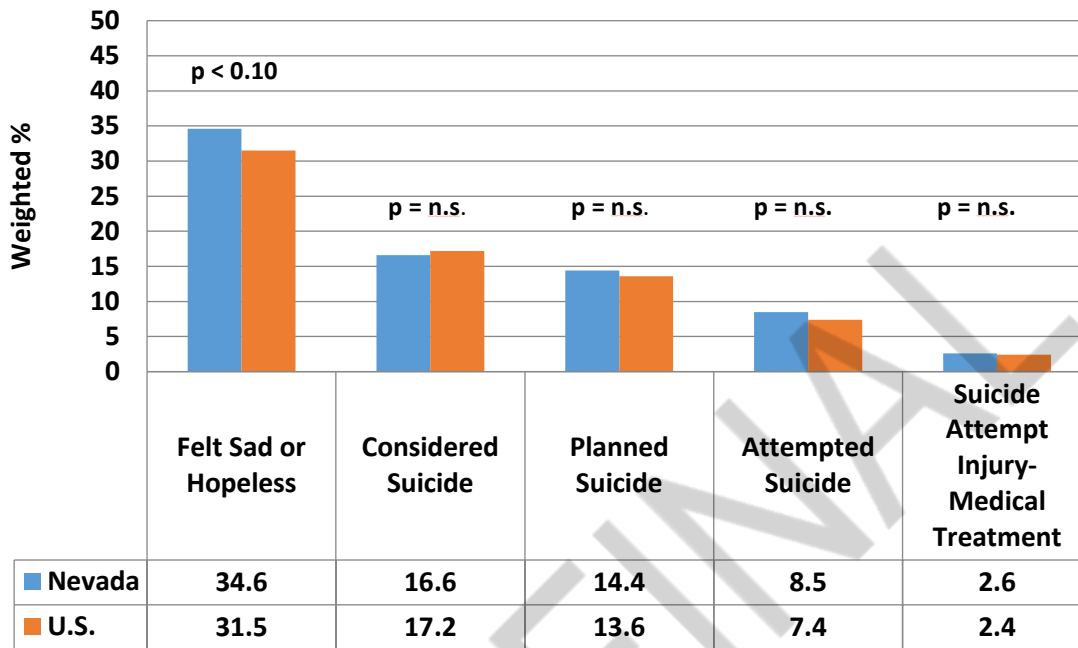
Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12-17 in Nevada and the United States: 2011-2012 to 2014-2015				
Years	2011-2012	2012-2013	2013-2014	2014-2015
Nevada	8.5%	9.6%	11.6%	13.9%
United States	8.7%	9.9%	11.0%	11.9%

Source: Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, Volume 4*. Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

Rates of Health Risk Behaviors in Nevada's Youth, 2017: The *Youth Risk Behavior Surveillance System (YRBSS)* monitors health behaviors among youth and young adults to evaluate the success of public health efforts directed to protect and enhance the well being of these individuals nationwide. *YRBSS* includes the school-based survey, the *Youth Risk Behavior Survey (YRBS)*, which is conducted by the Centers for Disease Control and Prevention (CDC) and state and local education and health agencies to collect population-based data on health behaviors of interest. This section summarizes findings concerning the emotional health of Nevada's youth who were surveyed for the *2017 YRBS* from February to May, 2017. All Nevada school districts agreed to participate in the *2017 High School YRBS* and only three schools did not participate (involving 77 potential participants). **Overall, 5,336 youth from 98 schools completed the survey.** Overall response rates (a combination of school and student participation) were generally higher in the school districts with *Passive Parental Permission* (students take permission form home and return it only if their parent or guardian does not want them to participate in the survey) than with *Active Parental Permission* (students must return a signed permission form indicating their parent or guardian's approval for participation in the survey)

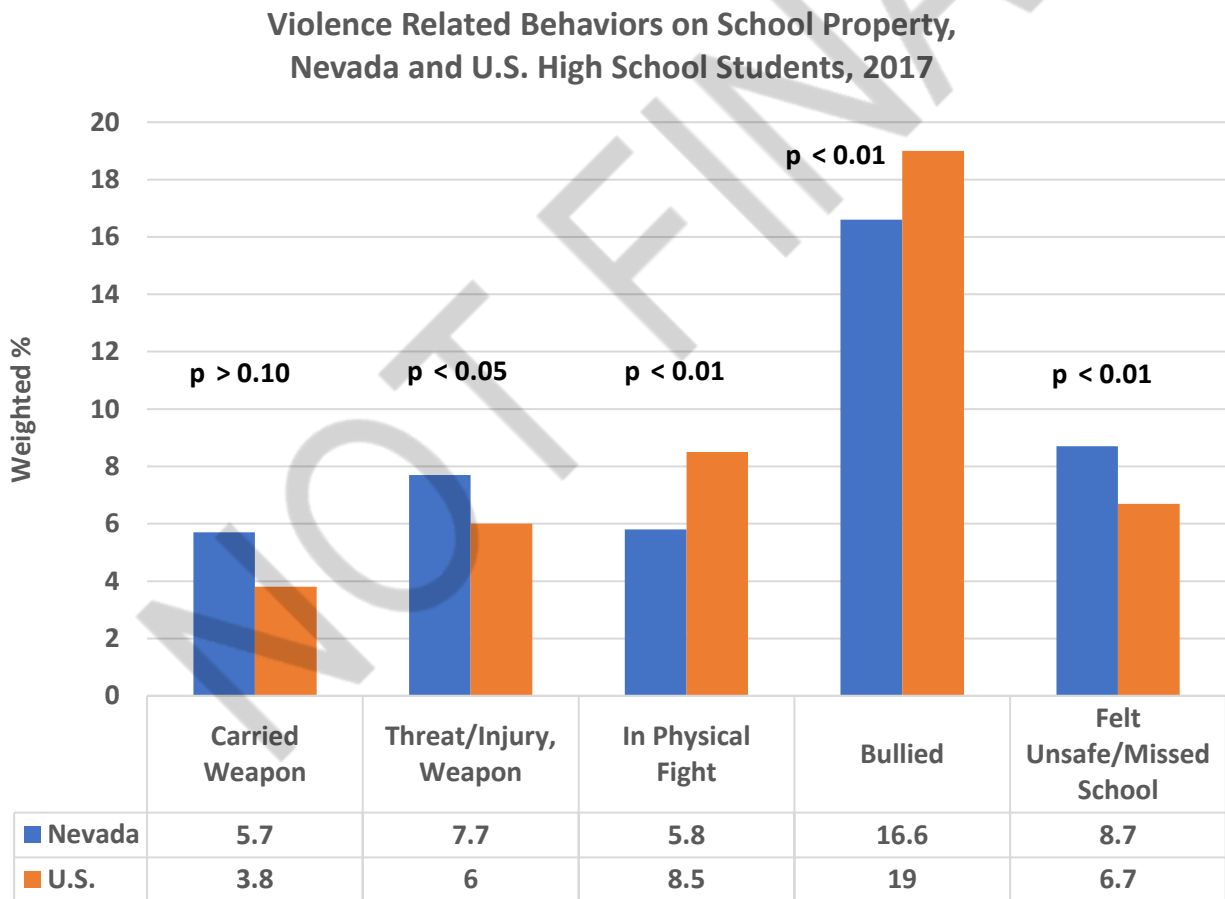
Emotional Health Profile of Nevada's Youth, 2017: The emotional health profile identified for Nevada's youth during 2017 indicated that more than one third (34.6%) had experienced noteworthy *psychological distress* during the prior twelve months, including the hallmark symptoms of depression with reduced functioning (Lensch, Martin, Zhang et al., *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.*) Defined as sadness and hopelessness that occurred almost every day for two weeks or more in a row and that interfered with their usual activities, an elevated number of Nevada's high school students endorsed having experienced this emotional disturbance compared to their age peers nationwide. The difference reached trend statistical significance. This same survey found that only one fourth of Nevada's youth reported reliably receiving help (most of the time or always) for their struggles with disturbed mood.

Mental Health Risk Behaviors, Nevada and U.S. High School Students, 2017



Source: Lensch, Martin, Zhang et al., 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

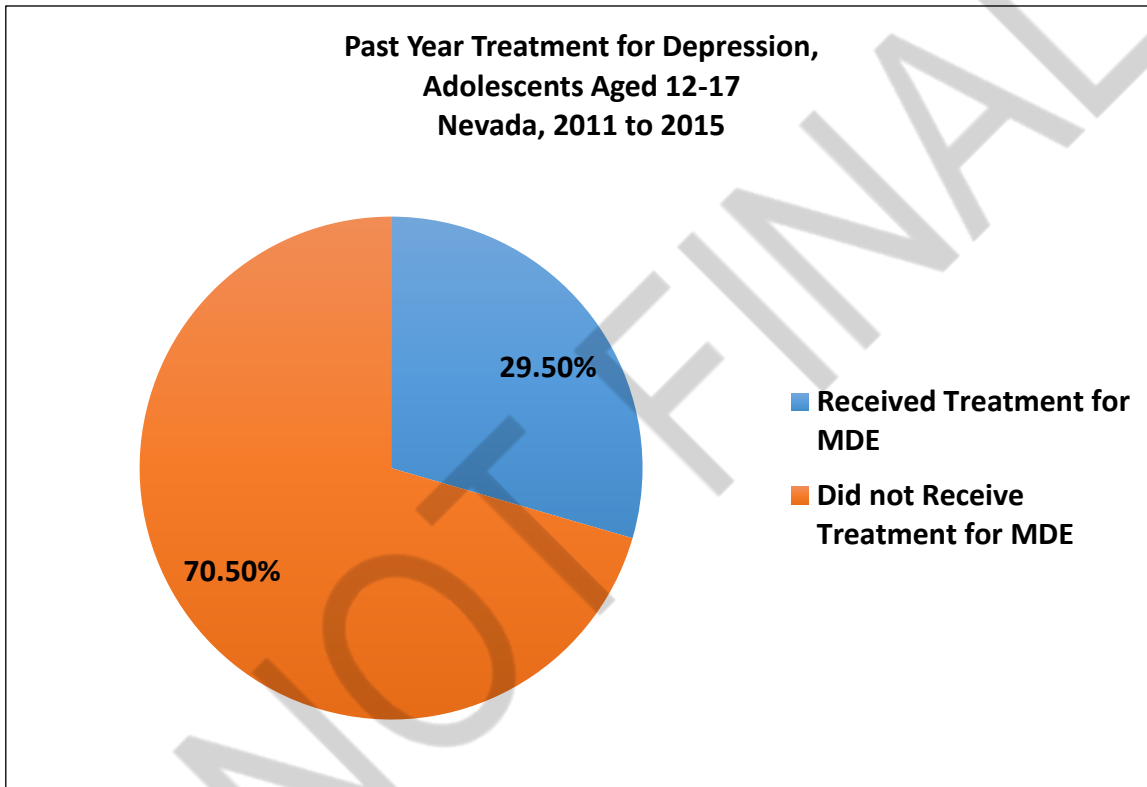
Violence Related Behaviors on School Property in Nevada’s Youth, 2017: Further challenges to the psychological well being of young Nevadans were reflected in the 18% who acknowledged deliberate self injuries, such as cutting or burning themselves on purpose without the intent to die, and the 30% who reported having lived with someone who was depressed, mentally ill or suicidal (Lensch, Martin, Zhang, et al., 2017). Experiencing *violence related behaviors on school property* were additional stressors for Nevada’s youth. Significantly more high school students in Nevada, compared with their age peers nationwide, reported having been threatened or injured on school property, during the past year, with a weapon such as a gun, knife or club. And significantly more students in Nevada, compared with their peers nationwide, reported not going to school during the past 30 days because they felt unsafe at school or on their way to or from school.



Source: Lensch, Martin, Zhang et al., 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.

Summary: Results from recent national health surveys (NSDUH, 2017; YRBS, 2017) suggest that the health and well being are compromised for a significant proportion of Nevada's children and adolescents. Indicators of recent *psychological distress* included mood disturbance and reduced role functioning, suicide-related behaviors, and behaviors involving self harm without the intent to die. Experiencing *violence related interactions on school property* were additional recent stressors for a significant number of Nevada's youth. To achieve an optimal public health response to these health issues, it is important to consider that these data points were likely driven by the presence of more than one population (or cause) of health disturbance. For example, it is possible that some of those adolescents were experiencing challenging life circumstances that produced strong psychological adjustment reactions (mood disturbance, suicidal thoughts and behaviors, deliberate self harm), which waxed and peaked and then subsequently resolved successfully. It is also likely that other adolescents, who carry different constitutional pre-dispositions (or diatheses), were experiencing the early stages of an emerging serious mental illness (SMI) or psychosis, which in the absence of optimal interventions may progress to a chronic illness end state. For these reasons, the State will continue to fund mental health related programs that are provided by the Nevada Division of Child and Family Services (DCFS) and through statewide school-based mental health services.

Treatment for Depression Among Nevada’s Adolescents with Major Depressive Episode, Aged 12-17: The most recent available data reported by the National Surveys on Drug Use and Health (NSDUH) indicate that approximately 31,000 adolescents aged 12-17 in Nevada (13.9% of all adolescents in the state), per year in 2014-2015, had experienced at least one Major Depressive Episode (MDE) during the year before being surveyed. Nevada’s percentage of adolescents experiencing MDE was similar to the national percentage. Importantly, as shown in the chart below, only one-third of Nevada’s adolescents with MDE reported having received treatment for depression (29.5%), which was similar to the annual national average (38.9%) for the same period (2011 to 2015).



Source: SAMHSA, Center for Behavioral Health and Quality, NSDUH, 2011-2015

- **ADULTS WITH SERIOUS MENTAL ILLNESS (SMI) ***

Rates of Serious Mental Illness (SMI) Among Nevada’s Adults Aged 18 and Older:

An estimated 16,371 adults in Nevada were diagnosed with serious mental illness (SMI) during 2016-2017, with 8,581 identified by the State’s mental health agencies— Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Clinics (RC). An additional 7,790 individuals were identified with SMI by providers in the community that were receiving Medicaid reimbursement for services. In 2014-2015, the years for which the most recent National Survey on Drug Use and Health (NSDUH) are available, Nevada’s annual average percentage of past year serious mental illness (SMI) among adults aged 18 or older was similar to the corresponding national average percentage. An estimated annual average of approximately 95,000 adults aged 18 or older (4.4% of all adults) in 2014-2015 had SMI in the past year. The annual average percentage in 2014-2015 was not significantly different from the annual average percentage in 2011-2012.

Past Year Serious Mental Illness (SMI) Among Adults, Aged 18 or Older, in Nevada and the United States: 2011-2012 to 2014-2015				
Years	2011-2012	2012-2013	2013-2014	2014-2015
Nevada	3.9%	4.1%	4.3%	4.4%
United States	4.0%	4.1%	4.2%	4.1%

Source: Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, Volume 4*. Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

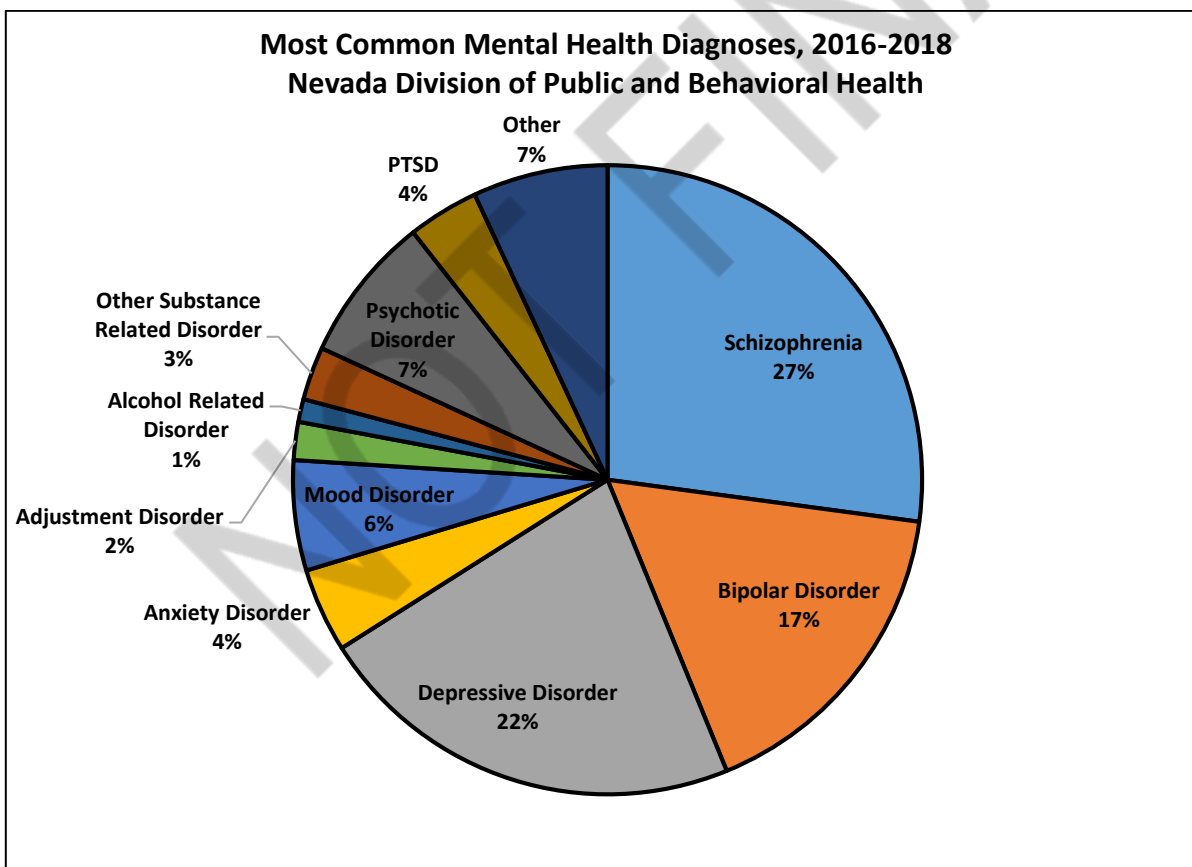
Expected Rates of Specific Serious Mental Disorder—Schizophrenia, Non-affective Psychosis (NAP) and Bipolar Disorder—Among Adults, Aged 18 and Older:

The median rate of new cases of *schizophrenia* each year, or incidence, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007). The estimated lifetime prevalence rates for schizophrenia and schizophreniform disorders range from 0.3-1.6% per 1,000 population (Kessler et al., 2005c). The lifetime prevalence rate for the broader category of *non-affective psychosis (NAP)* is estimated at approximately twice the rate for schizophrenia and schizophreniform disorder (Kessler et al., 2005c). Non-affective psychosis (NAP) has been examined systematically in at least one large-scale community epidemiology survey (Kendler et al., 1996), in which a probability subsample received an initial screen for psychotic symptoms, and detailed follow up interviews that were conducted by mental health professionals of *one-third of the initial participants* based on their responses to the screen. Clinician defined diagnoses of non-affective psychosis in that study resulted in lifetime prevalence rates of 0.2% for narrowly-defined NAP and 0.7% for broadly-defined NAP. Clinical validity was additionally examined, with the clinician defined diagnoses determined to be predictive of clinical characteristics (hospitalization,

medication, illness duration, thought disorder) and levels of social functioning (chronic impairment, low income, unemployment, urban residence, and marital status of single, divorced or separated). The lifetime prevalence rates for **bipolar disorder (BPD)**, estimated from a nationally representative community survey of United States households, indicate average (standard deviation) rates of 1.0% (13.2) for **Bipolar I**; 1.1% (10.6) for **Bipolar II**; and 2.4% (23.3) for **Subthreshold Bipolar Disorder** (Merikangas et al., 2007). Twelve-month prevalence rates estimated from the same survey included: 0.6% (9.2) for **Bipolar I**; 0.8% (9.9) for **Bipolar II**; and 1.4% (15.4) for **Subthreshold Bipolar Disorder**.

Most Common Mental Health Diagnoses by Nevada Mental Health System, 2016-2018:

The Division of Public and Behavioral Health (DPBH or Division) is the largest provider of mental health services in Nevada. During 2016-2018, the most recent period for which data are available, Division provided mental health services to 79,633 adults in Nevada. As reflected in the chart below, the diagnoses most commonly assigned to residents receiving services were schizophrenia, psychotic disorder and mood disorders, including Bipolar and Depressive. Alcohol and other substance related disorders, adjustment disorder, and anxiety disorders, including post-traumatic stress disorder, were the least frequently diagnosed.



Source: Department of Health and Human Services/Office of Analytics

[NOTE: Only primary diagnoses were included in this analysis. Only ICD 9 Codes 290-319 and ICD10 Codes F01-F99 were considered in this analysis.]

Suicide-Related Behaviors and Suicide Deaths Among Nevada Residents

Rates of Suicide Ideation Among Nevada’s Adults Aged 18 and Older: The most recent available data from the National Surveys on Drug Use and Health (2015 NSDUH) indicate that approximately 96,000 adults aged 18 or older (4.4% of all adults) in 2014-2015 had serious thoughts of suicide during the year before participating in the survey. Nevada’s annual average percentage of adults with prior year thoughts of suicide was similar to the national percentage. The table below presents the range of estimates over a 5-year period for serious thoughts of suicide among adults in Nevada and the United States. The annual average percentage for 2014-2015 was not significantly different from the annual average for 2011-2012.

Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older, Nevada and United States: Annual Averages, 2011-2012 to 2014-2015				
Years	2011-2012	2012-2013	2013-2014	2014-2015
Nevada	3.8%	3.8%	4.4%	4.4%
United States	3.8%	3.9%	3.9%	4.0%

Source: Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, Volume 4. Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System.* HHS Publication No. SMA-17-Baro-16-States-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017

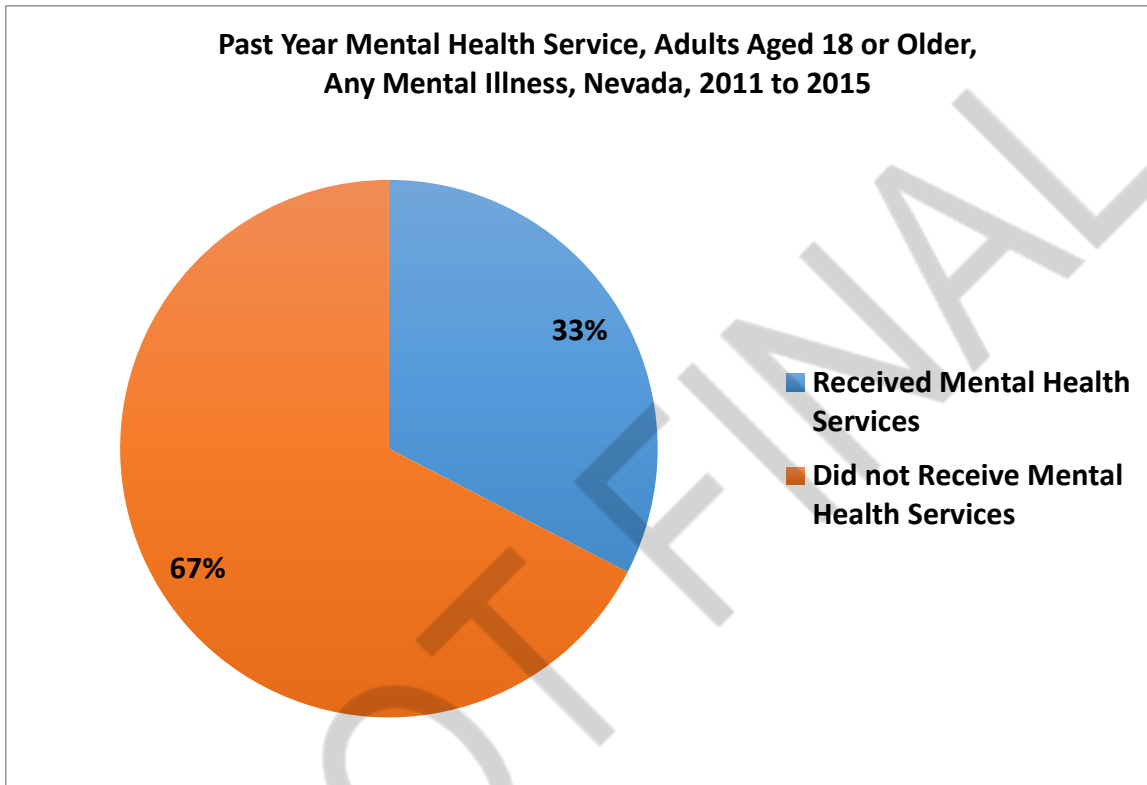
Rates of Suicide Deaths Among Nevada’s Residents, 2017: Nevada continues to rank among the states with the highest rates of suicide deaths nationwide. Regional rates indicate the highest number of deaths per population occur in Nevada’s rural and frontier counties. During 2017, 627 Nevada residents took their own life, a rate that represented 20.25 deaths per 100,000 population (Data from CDC, 2017: www.afsp.org/statistics). Overall, suicide is the 8th leading cause of death in Nevada, with differences observed in ranking by age: 2nd leading cause of death by ages 15-34; 3rd leading cause by ages 35-44; 4th leading cause by ages 45-54; 8th leading cause by ages 55-64; 13th leading cause by ages 65 and older (Data from CDC, 2017: www.afsp.org/statistics). The economic burden of death by suicide in Nevada has been estimated at \$1,084,351 per death (Data from CDC, 2017: www.afsp.org/statistics). The table below presents the suicide rates for Nevada residents by region for 2016, which is the most recent year for which such data are available. Death rates due to homicide and all cause mortality by region are included as points of reference.

Mortality Rates by Cause of Death in Nevada by Region of Residence, 2016					
Cause of Death	Number of Deaths per 100,000 Population				
	Rural and Frontier Counties	Carson City	Clark County	Washoe County	Nevada
Suicide, Intentional Self Harm	27.4	27.9	18.2	26.6	20.6
Homicide, Assault	3.6	—	8.5	3.5	7.1
Total Mortality —All Causes	795.2	921.9	776.4	875.5	796.3

Source: Drawn from Table 4.27, Griswold et al., 2019 and unpublished data of Nevada Division of Public and Behavioral Health.

Note: All rates are age-adjusted. Some data were suppressed due to small numbers.

Mental Health Service Use Among Nevada’s Adults Aged 18 or Older with Any Mental Illness (AMI), 2011 – 2015: The most recent available data reported by the National Surveys on Drug Use and Health (NSDUH) indicate that approximately 117,000 adults aged 18 or older with Any Mental Illness (AMI) in Nevada (32.6% of all adults in with AMI), from 2011 to 2015 received mental health services in the previous year. Nevada’s annual average of past year mental health service use among adults aged 18 or older with any mental illness (AMI) was lower than the corresponding national annual average percentage (42.9%).



Source: SAMHSA, Center for Behavioral Health and Quality, NSDUH, 2011-2015

ACCESS TO MENTAL HEALTH SERVICES IN NEVADA

SERIOUS EMOTIONAL DISTURBANCE (SED) and SERIOUS MENTAL ILLNESS (SMI)

SERVICE PENETRATION RATES

Access to Services for Nevada’s Children with Serious Emotional Disturbance (SED)

Based on the National Outcomes Measures (NOMS) for 2016 - 2017, an estimated 3,133 children aged 0-17 with serious emotional disturbance (SED) were served by the Nevada Division of Child and Family Services (DCFS) and Rural Clinics within Division of Public and Behavioral Health (DPBH). Service penetration rates (proportions of target populations served) are presented below for Nevada’s children with SED and the national rates are provided as comparisons. For both age groups, 0-12 years and 13-17 years, service penetration rates were lower for Nevada’s children served by its state mental health agencies, compared to the rates nationwide. An additional 3,071 children aged 0-17 with serious emotional disturbance were served by community providers receiving Medicaid reimbursement, which resulted in a penetration rate (4.5) that is within the range of those associated with Nevada’s Division of Child and Family Services (DCFS) and Division of Public and Behavioral Health (DPBH) Rural Clinics.

Children with SED served by Nevada Division of Child and Family Services by Age, 2016						
Age (years)	Total Served				Penetration Rates (per 1,000 population)	
	Nevada		US			
	n	%	n	%	State	US
0-12 yrs	1,476	12.6%	745,340	15.1%	3.0	14.1
13-17 yrs	1,657	14.1%	615,386	12.4%	8.8	29.5

Source: 2017 SAMHSA Uniform Reporting System (URS) – Nevada

Access to Services for Nevada’s Adults with Serious Mental Illness (SMI)

Based on the National Outcomes Measures (NOMS) for 2016 - 2017, an estimated 8,581 adults with serious mental illness (SMI) were served by Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Clinics (RC). Service penetration rates are presented below for Nevada’s adults aged 18 to 75 and over, and the national rates are provided as a comparison. For all age categories, penetration rates were consistently lower for adults with SMI who were served by the State’s mental health agencies (NNAMHS, SNAMHS and Rural Clinics), compared to the nation as a whole. An additional 7,790 adults with serious mental illness (SMI) were served by community providers receiving Medicaid reimbursement for services, which resulted in a range of penetration rates of 1.1 to 4.1 that was similar to that obtained for the State’s mental health agencies.

Adults with SMI served by Nevada’s State Mental Health Agencies by Age, 2017						
Division of Public and Behavioral Health NNAMHS, SNAMHS and Rural Clinics						
Age (years)	Total Served				Penetration Rates (per 1,000 population)	
	Nevada		US		State	US
	n	%	n	%		
18-20	306	2.6%	209,367	4.2%	3.2	16.4
21-24	454	3.9%	264,501	5.3%	3.0	14.6
25-44	3,335	28.5%	1,510,821	30.5%	4.1	16.8
45-64	3,965	33.8%	1,366,284	27.6%	5.2	16.2
65-74	466	4.0%	172,350	3.5%	1.7	6.0
75 and over	55	0.5%	60,226	1.2%	0.3	3.2

Source: 2017 SAMHSA Uniform Reporting System (URS) – Nevada.

STATEWIDE SHORTAGE OF MENTAL HEALTH PROFESSIONALS

Almost all of Nevada qualifies as a mental health professional shortage area (Health Resources and Services Administration, HRSA), with the only exception being Las Vegas in Clark County (Griswold et al., 2019, *Map 5.3*, p. 144). The State’s geography and its low population density in rural and frontier counties amplify the challenges associated with this critical health care shortage. **The current population of Nevada is 3,034,392** (Source: Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018. U.S. Census Bureau, Population Division, Release Date, December 2018), and **the State’s land mass encompasses 109,286 square miles**. Ninety percent (90.5%) of the State’s population lives in its three urban counties—Clark County in southern Nevada, and Carson City and Washoe County in northwestern Nevada. The remaining 9.5% of Nevada’s residents, an estimated 288,744 individuals, lives in the fourteen rural and frontier counties, which span 87% of the State’s land area and cover 95,431 square miles (Griswold et al., 2017). The current average population density is 27.8 people per square mile, although the variation is considerable with 0.3 persons per square mile in Esmeralda County to 392.5 persons per square mile in the State Capital in Carson City (Griswold et al., 2019). **Map 1** below illustrates the vast areas that must be traveled for some Nevada residents to reach either of the two urban counties in southern and northern Nevada or the three rural counties clustered in the mid-western corner of the State.

Geography and social factors drive the mental health outcomes for many Nevadans and this circumstance is highlighted in the summary of the State’s mental health specialty care that was

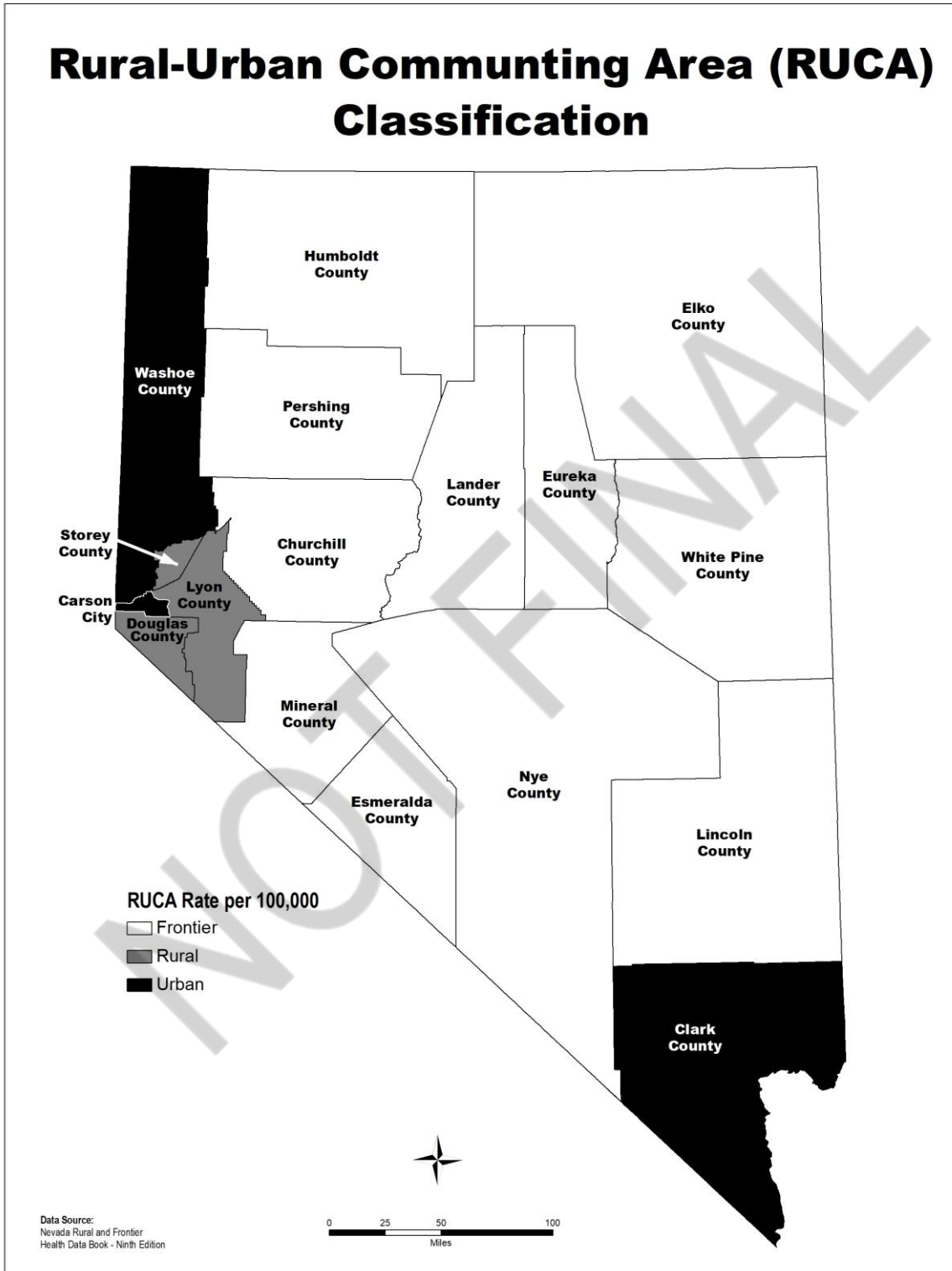
offered by Griswold et al., in their most recent **Nevada Rural and Frontier Health Data Book – Ninth Edition**, January 2019:

- In 2018, there were 239 licensed psychiatrists in the State— 236 reside in urban Nevada and only 3 psychiatrists reside in a rural or frontier county (**Map 2**).
- In 2018, there were 405 licensed psychologists in Nevada, including 10 in rural and frontier counties (**Map 3**).
- In 2018, there were 818 licensed clinical social workers (LCSWs) in Nevada, including 50 LCSWs in rural and frontier counties — the average for rural and frontier counties is 17.4 LCSWs per 100,000 population, as compared to 28.2 in urban counties (**Map 4**).

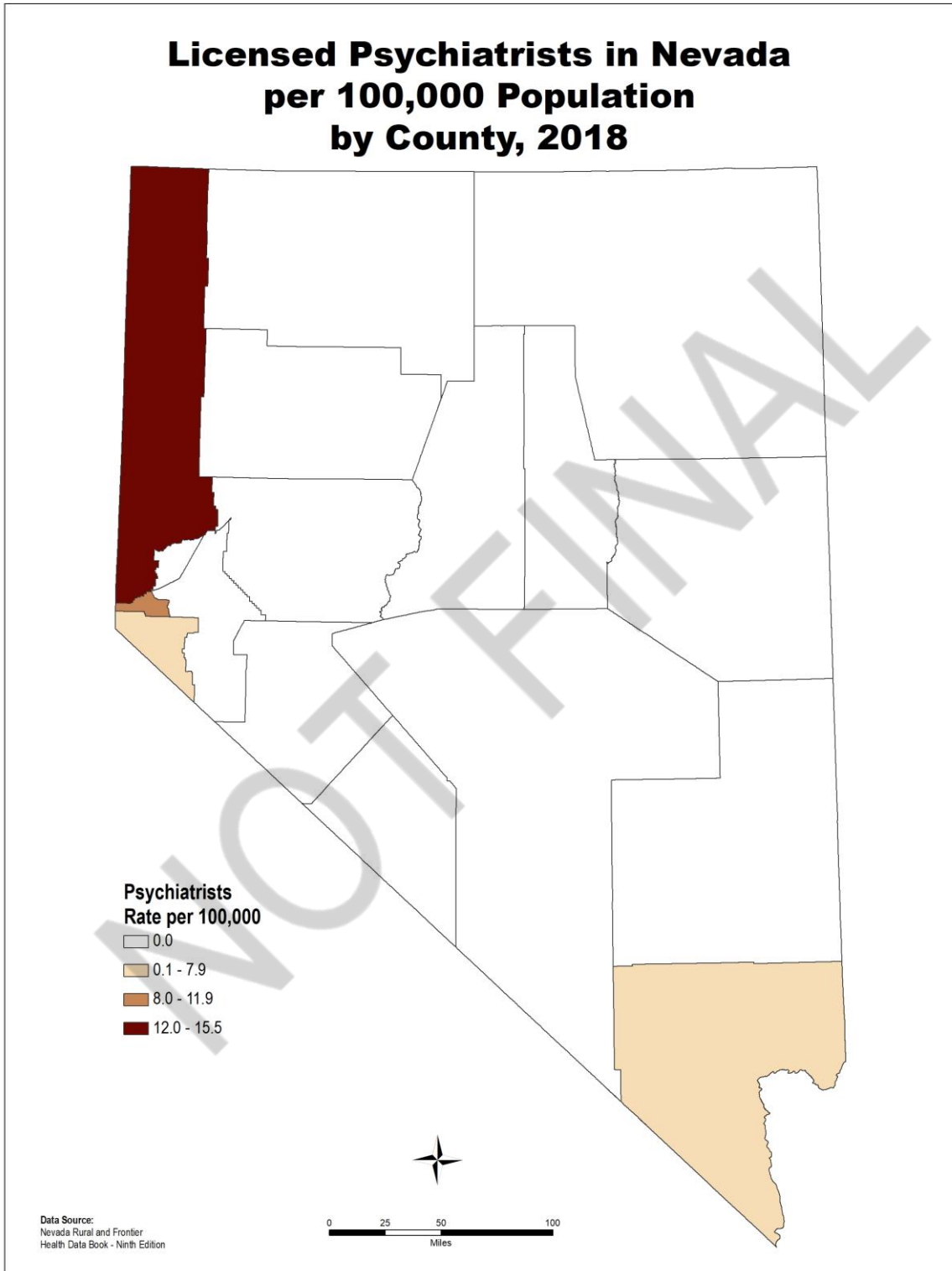
Maps 2-4 below reveal the scarcity of Nevada’s mental health professionals by specialty care who held current licenses in 2018 that were recognized by the State of Nevada Boards of Examiners for their respective disciplines, including psychiatry, psychology and social work. The low rates of these specialty care professionals across Nevada, especially in the rural and frontier counties, underscore the limitations in access to services for the State’s residents.

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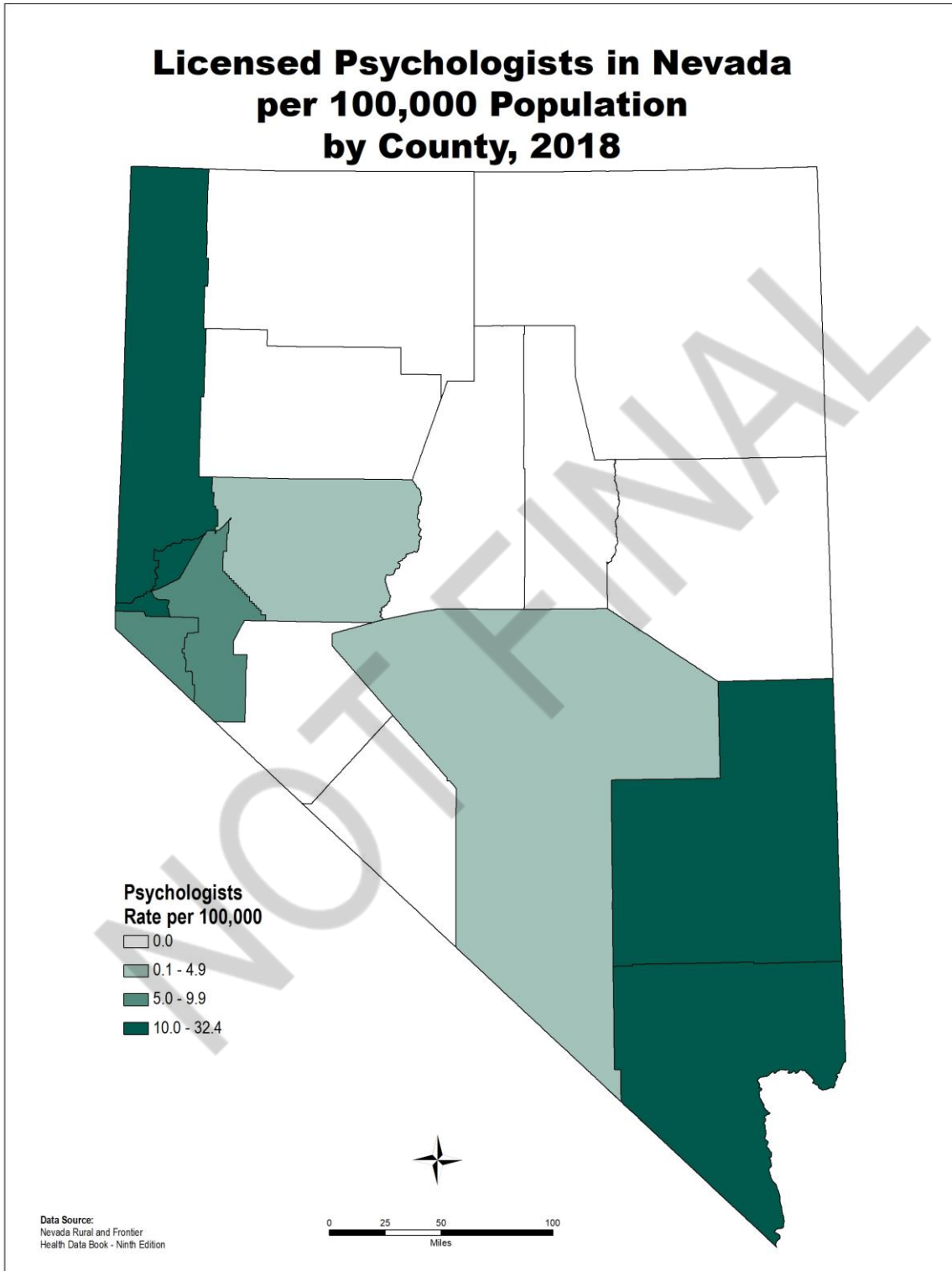
Map 1:



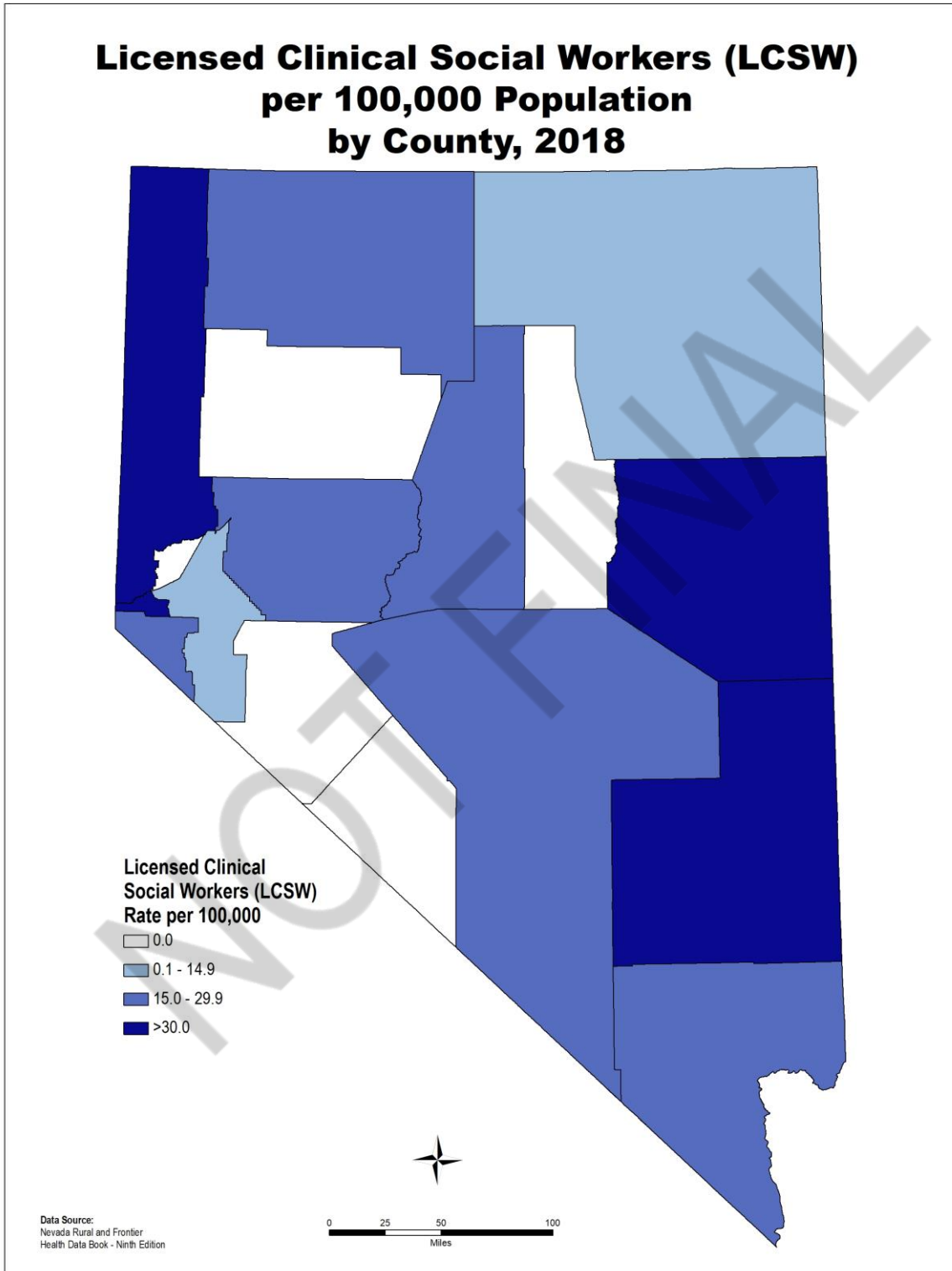
Map 2:



Map 3:



Map 4:



- **OLDER ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)**

Access to Mental Health Services for Nevada’s Residents with SMI, Aged 65 and older:

Based on the National Outcomes Measures (NOMS) for 2016 - 2017, an estimated 521 adults with serious mental illness (SMI) were served by Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Clinics (RC). Service penetration rates were 1.7 for the age category 65-74 years and 0.3 for the age category 75 years and over. An additional 482 adults with serious mental illness (SMI) were served by community providers receiving Medicaid reimbursement, which was associated with a penetration rate of 1.1. (Source: 2017 SAMHSA Uniform Reporting System (URS) – Nevada.)

- **INDIVIDUALS WITH ANY MENTAL ILLNESS (AMI) OR SERIOUS MENTAL ILLNESS (SMI) BY REGION ACROSS NEVADA**

The table below shows the proportions of the State’s population that report having a diagnosis of either any mental illness (AMI) or serious mental illness (SMI) by region. Across regions of the State, approximately 19% of Nevadans reported having an AMI and about 5% reported having an SMI. As shown in **Maps 2-4** above, the statewide shortage of mental health professionals is most marked in Nevada’s rural and frontier counties:

- 3 licensed psychiatrists reside in a rural or frontier county;
- 10 licensed psychologists live in a rural or frontier county;
- 50 licensed clinical social workers (LCSW) live in a rural or frontier county.

Self-Reported Mental Illness Among Population Aged 12 and Over, Nevada by Region, 2017					
Mental Illness	Percent of Population Aged 12 and Over				
	Rural and Frontier Counties	West Counties	Clark County	Washoe County	Nevada
Any Mental Illness, Aged 18 and Older	19.2	17.9	17.6	19.6	18.1
Serious Mental Illness, Aged 18 and Older	4.6	4.3	4.4	5.1	4.5

Source: Drawn from Table 4.10, Griswold et al., 2019 and U.S. Department of Health and Human Services.

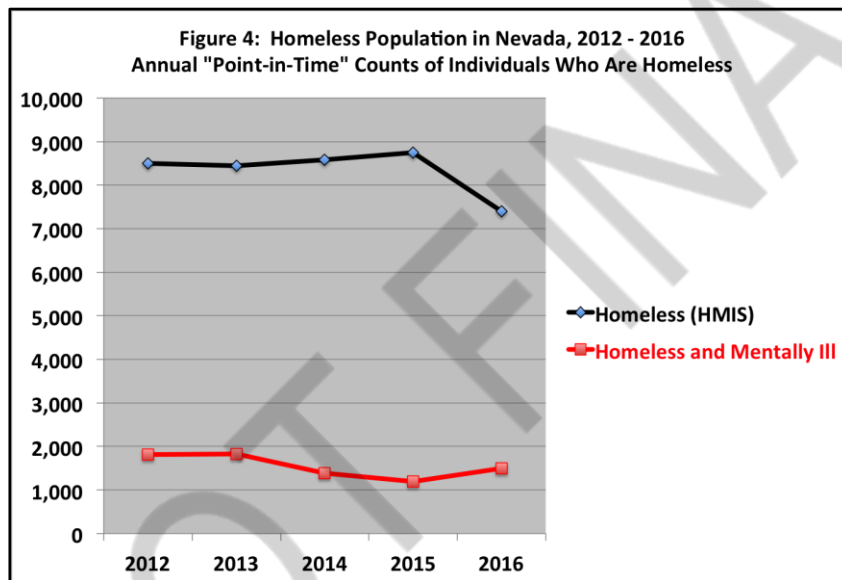
- **INDIVIDUALS WITH SMI OR SED WHO ARE HOMELESS**

Three sources of information were available to the State regarding the number of individuals with mental illness who are also experiencing homelessness in Nevada. It is unclear how much overlap exists between these databases, and each supplies a slightly different perspective about this population possibly due to ascertainment bias. The summaries provided for the first two data sources, the Homeless Management Information System (HMIS) Tracking and the *Point-In-Time Counts*, were drawn from the 2017 Situational Analysis, which was prepared by Social Entrepreneurs, Inc, for Nevada Substance Abuse Prevention and Treatment Agency (SAPTA). The third data source is the Nevada 2017 Mental Health National Outcomes Measures (NOMs), 2017 SAMHSA Uniform Reporting System (URS) Output Tables.

The Homeless Management Information System (HMIS) provides tracking information regarding the number of individuals in Nevada who are homeless, and the proportion of those who also report experiencing a mental health condition. In 2016, data maintained in the Homeless Management Information System (HMIS) indicated 7,398 individuals who were homeless in Nevada. Within this group, 1,495 (or 20%) reported current serious mental illness (SMI), current

substance use disorder, or a current comorbid SMI and substance use disorder (*Nevada Substance Abuse Prevention and Treatment Agency – SAPTA, 2018 Needs Assessment, October 2018*).

A second source of information is the *Point-In-Time* Counts that are supported by the United States Department of Housing and Urban Development (HUD), and conducted by Continuums of Care (CoCs). *Point-in-Time* Counts provide information regarding population trends over time, although it is recognized they capture only a limited portion of the number of persons who are homeless. For example, CoCs are instructed to collect data for one point in time during a specific week and month of the year, such as the last week of January 2016. However, the value of these captures can be seen in the trends identified in the figure below, which presents results of the Annual “*Point-in-Time*” Counts from 2012 to 2016.



Source: *Office of Public Health Informatics and Epidemiology, Nevada Division of Public and Behavioral Health; and Social Entrepreneurs Inc. (SEI) (2017)*.

The final source of information concerning Nevada’s population of individuals with mental illness who are also experiencing homelessness is the Nevada 2017 Mental Health National Outcomes Measures (NOMs) (SAMHSA Uniform Reporting System). Of the total number of 23,945 individuals who were served by the State Mental Health Authority during 2016, an estimated 1,896 (8%) were homeless or living in shelters at the time they were receiving mental health services.

- **INDIVIDUALS WITH EARLY SERIOUS MENTAL ILLNESS (ESMI)
(10 percent MHBG set aside)**

CLINICAL STAGING:

EARLY INTERVENTIONS FOR ESMI AND FIRST EPISODE OF PSYCHOSIS

Expected Rates of Early Stage Serious Mental Illness and First Episode of Psychosis:

Identifying populations at risk for mental disorders, in general, and for specific categories of mental disorders, in particular, requires consideration of estimates of prevalence and incidence, as well as ages at which disorders first appear. *Prevalence rates* provide the proportion of individuals in a specific population who have a particular disease or characteristic during a specified period of time. *Incidence rates* provide the proportion of new cases of illness within a specific population during a specific period of time. The difference between the two rates is that prevalence rates include both pre-existing cases and new cases, while incidence rates include only new cases. Incidence rates are uniquely informative for early intervention treatment approaches because of the need to identify and enroll individuals at the first onset of their illness. *Age of onset distributions* provide ranges of chronological ages within which most cases of an illness are first diagnosed. The three types of estimates provide information that is essential for planning effective community outreach strategies to identify individuals for recruitment and enrollment in intervention services for early stage serious mental illness and first episode of psychosis.

The *median rate of new cases (or incidence)* each year for schizophrenia, one of the principal psychotic disorders, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 years (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). The age range for capturing cases of first episode of psychosis therefore extends from middle adolescence and early adulthood through middle adulthood. Based on these findings, the anticipated incidence rate of schizophrenia for Nevada was estimated as **307 new cases during each fiscal year**, as follows:

$$(2,022,031) (15.2/100,000) = 307.4.$$

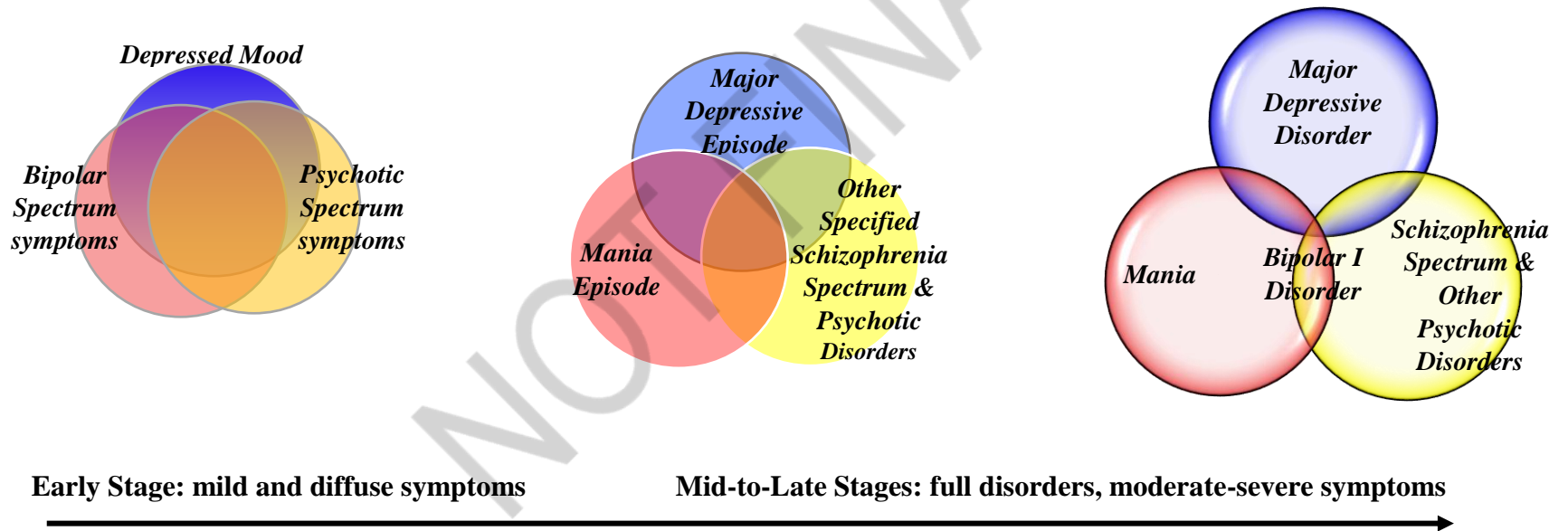
The State does not collect information regarding the rate of new cases of mental disorders per year, so this estimate was determined using the best available information, including the following:

- (1) Population estimates for 2018 (as of July 1) for Nevada residents ages 14 to 64: **2,022,031** (Source: U.S. Census Bureau, Population Division (Release Date: June 2019).
- (2) Selection of the age range for population estimation was informed by age of onset distributions for schizophrenia described above.
- (3) Median incidence of schizophrenia of 15.2/100,000 persons determined by McGrath et al. (2008).

Early Interventions for Early Stage Serious Mental Illness: The psychoses and other serious mental illnesses include significant functional impairment and represent debilitating conditions that are costly in terms of human suffering and societal economic burden. Regarding the latter, the United States societal economic burden of schizophrenia was estimated at \$155.7 billion for the year 2013, and included additional excess costs associated with unemployment, productivity loss due to caregiving, and direct health care costs (Cloutier et al., 2016). Early intervention services for these illnesses may provide an avenue to mitigate the magnitude of suffering and the extent of economic burden (Mihalopoulos et al., 2009). Early treatment for early stage illness may be beneficial by reducing the **duration of untreated illness**, a factor known to be associated with treatment response and clinical course of psychotic disorders (Addington et al., 2015; Kane et al., 2016). The figure shown below (adapted from McGorry et al., 2010) illustrates the idea of chronic *serious mental illness (SMI)* as a dynamic process that evolves over time, and that begins as a diffuse constellation of features, characteristics and mild symptoms, and gradually becomes more severe and coherent within syndrome and disorder boundaries.

The objective of providing early interventions for individuals who are at risk for developing severe mental illness has a long history in the fields of psychiatry and psychopathology. It received renewed focus and vitality from the success achieved recently by the National Institute of Mental Health's (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) initiative (Heinssen, Goldstein and Azrin, 2014). In a comparison of comprehensive and usual community care for first episode psychosis, Kane et al. (2016) demonstrated the feasibility of implementing a comprehensive recovery-oriented, evidence-based intervention for first-episode psychosis that was carried out in community health clinics in the United States. Importantly, greater improvements in clinical and functional outcomes were observed for participants who received this comprehensive, multidisciplinary, team-based treatment. **Statewide implementation of evidence-based early interventions for individuals with early stage serious mental illness, including first episode of psychosis, is a strategic priority for Nevada's mental health system during the next biennium.**

Figure 5: The Trajectory of Serious Mental Illness (SMI) as a Dynamic, Emerging Process
(adapted from McGorry et al., 2010)



MENTAL HEALTH in NEVADA, 2019
UNMET SERVICE NEEDS and CRITICAL GAPS
NEVADA'S MENTAL HEALTH SYSTEM
TARGET POPULATIONS

SUMMARY and RECOMMENDATIONS

Analysis of the combined findings from multiple State and public databases and scientific publications provide guideposts for building a coherent public health model that includes treatment of serious mental illness for Nevada residents. Key findings, conclusions and recommendations are summarized below within the context of the indicators of unmet mental health needs in the target populations and the system goals and programmatic priorities developed through the State's Behavioral Health Community Integration Strategic Plan, July 2018.

SYSTEM GOALS

- System Goal 1: Ensure there is a continuum of high-quality recovery support and care to achieve and maintain stability.
- System Goal 2: Ensure individuals have access to appropriate, timely services in the most integrated setting based on self-determination plan.
- System Goal 3: Ensure a system that prevents inappropriate incarceration, hospitalization, institutionalization, or placement.

INDICATORS of UNMET MENTAL HEALTH NEEDS in TARGET POPULATIONS

Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED)

Nevada's children and adolescents experienced significant psychological distress and violence related experiences in 2017.

- An estimated 8% – 13% of children and adolescents, in Nevada and nationwide, experienced serious emotional disturbance (SED) involving major depressive disorder (National Survey on Drug Use and Health, NSDUH 2017). For Nevada, an annual average of approximately 31,000 adolescents experienced a major depressive episode in 2014-2015 (most recent data).
- More than one third (34.6%) of Nevada's adolescents reported the hallmark symptoms of depression (depressed mood and reduced functioning almost every day for two weeks), during the year before the survey in 2017 (Nevada Youth Risk Behavior Survey (YRBS 2017).
- One-fifth (18%) of Nevada's adolescents acknowledged deliberate acts of self harm, such as cutting or burning themselves, without the intent to die (YRBS 2017).
- Thirty percent (30%) of Nevada's adolescents reported having lived with someone who was depressed, mentally ill or suicidal (YRBS 2017).
- Significantly more adolescents in Nevada reported experiencing violence related behaviors on school property, compared to their peers nationwide (p-values < 0.05); including:

- having been threatened or injured with a weapon such as a gun, knife or club (past year);
- not going to school because they felt unsafe at school or on their way to or from school (past month).

Nevada continues to rank among the states with the highest rates of suicide deaths nationwide. Regional rates indicate the highest number of deaths per population occur in Nevada’s rural and frontier counties.

- In 2017, 627 Nevada residents took their own life, a rate that represented 20.25 deaths per 100,000 population (Data from CDC, 2017: www.afsp.org/statistics).
- Overall, suicide is the 8th leading cause of death in Nevada, with differences observed in ranking by age:
 - 2nd leading cause of death by ages 15-34;
 - 3rd leading cause by ages 35-44;
 - 4th leading cause by ages 45-54;
 - 8th leading cause by ages 55-64;
 - 13th leading cause by ages 65 and older
 (Data from CDC, 2017: www.afsp.org/statistics).
- Up to 17% of Nevada’s adolescents reported having considered, planned or attempted suicide in 2017 (YRBS 2017).
- The economic burden of death by suicide in Nevada has been estimated at \$1,084,351 per death (Data from CDC, 2017: www.afsp.org/statistics).

Access to mental health services is limited for Nevada’s children with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

- Penetration rates for mental health services provided to Nevada residents with SED and SMI are consistently lower than the rates observed nationwide (2017 SAMHSA Uniform Reporting System (URS) – Nevada), and vary by age category and apply to services provided by State’s mental health agencies (Northern Nevada Adult Mental Health Services, NNAMHS, Southern Nevada Adult Mental Health Services, SNAMHS, and Rural Clinics, RC) and by community providers receiving Medicaid reimbursement:
 - Range of services penetration rates for SED: Nevada (3.0 to 8.9); U.S. (3.2 to 16.8)
 - Range of services penetration rates for SMI: Nevada (3.0 to 8.9); U.S. (3.2 to 16.8)
- Only one third (30%) of Nevada’s adolescents with major depressive episode (MDE) reported having received treatment for depression (NSDUH, 2011-2015).
- Shortage of Mental Health Professionals: Almost all of Nevada qualifies as a mental health shortage area:
 - In 2018, there were 239 licensed psychiatrists in Nevada — 236 reside in urban Nevada and only 3 psychiatrists reside in a rural or frontier county.
 - In 2018, there were 405 licensed psychologists in Nevada, including 10 in rural and frontier counties.

- In 2018, there were 818 licensed clinical social workers (LCSWs) in Nevada, including 50 LCSWs in rural and frontier counties — the average for rural and frontier counties is 17.4 LCSWs per 100,000 population, as compared to 28.2 in urban counties.

PROGRAMMATIC PRIORITIES for TARGET POPULATIONS:

The following Priority Areas pertain to the unmet behavioral and mental health needs that were identified for the Target Populations and have been adopted for development and implementation during the next biennium:

- Statewide expansion of early intervention services for individuals with early stage serious mental illness (ESMI), including first episode of psychosis (FEP).
- Specific Priorities to Address the Behavioral Health Needs of Children and Youth
 - Juvenile justice diversion
 - Residential treatment facility treatment capacity, discharges, and linkages to services
 - Transitional Age Youth (TAY) services (children to adult)
 - Access to Services: crisis services, Partial Hospitalization Programs (PHP), Intensive Outpatient Program (IOP), day treatment, wraparound, respite, family peer support, and habilitation services.
- Specific Priorities to Address the Behavioral Health Needs of Adults
 - Criminal justice diversion
 - Supported housing
 - Assertive Community Treatment (ACT) services
 - Access to providers for crisis and community-based treatment
- Expand uncompensated care in Nevada to provide for individuals who have barriers to accessing mental health and substance abuse treatment.
- Development of workforce of mental health professionals.

REFERENCES

Step 2:

Unmet Service Needs and Critical Gaps within Nevada's Current Behavioral Health System

Addington J, Heinssen R (2012): Prediction and prevention of psychosis in youth at clinical high risk. *Annual Review of Clinical Psychology*; 8:269-289.

Addington J, Heinssen R, Robinson DG, Schooler NR, Marcy P, Brunette MF, Correll CU, Estroff S, Mueser KT, Penn D, Robinson JA, Rosenheck RA, Azrin ST, Goldstein AB, Severe J, Kane JM (2015): Duration of untreated psychosis in community treatment settings in the United States. *Psychiatric Services*; 66(7):753-756.

Birchwood M, MacMillan JF (1993): Early intervention in schizophrenia. *Australian and New Zealand Journal of Psychiatry*; 27:374-378.

Birchwood M, Todd P, Jackson C (1998): Early intervention in psychosis: The critical period hypothesis. *British Journal of Psychiatry*; 172(33):53-59.

Center for Behavioral Health Statistics and Quality (2016): Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from <http://www.samhsa.gov/data/>

Cloutier M, Aigbogun MS, Guerin A, Nitulescu R, Ramanakumar AV, Kamet SA, DeLucia M, Duffy R, Legacy SN, Henderson C, Francois C, Wu E (2016): The economic burden of schizophrenia in the United States in 2013. *The Journal of Clinical Psychiatry*; 77(6):764-771.

First MB, Spitzer RL, Gibbon M, Williams JBW (2002): Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP). New York, NY: New York State Psychiatric Institute, Biometrics Research.

Galea S (2015): Public Health and the Prevention of Mental Illness in Populations: Dean's Note. Boston University School of Public Health, <https://www.bu.edu/sph/2015/02/22/public-health-and-the-prevention-of-mental-illness-in-populations/>.

Griswold T, Packham J, Etchegoyhen L, Marchand C (January 2015): Nevada Rural and Frontier Data Book – Seventh Edition, January 2015. Nevada State Office of Rural Health, Office of Statewide Initiatives, University of Nevada, Reno, School of Medicine, www.med.unr.edu/statewide

Griswold T, Packham J, Gunawan A, Etchegoyhen L, Jorgensen T, Marchand C (January 2017): Nevada Rural and Frontier Data Book – Eighth Edition, January 2017. Nevada State Office of Rural Health, Office of Statewide Initiatives, University of Nevada, Reno, School of Medicine, www.med.unr.edu/statewide

Griswold T, Packham J, Etchegoyhen L, Marchand C (January 2019): Nevada Rural and Frontier Data Book – Ninth Edition, January 2019. Nevada State Office of Rural Health, Office of

Statewide Initiatives, University of Nevada, Reno, School of Medicine,
www.med.unr.edu/statewide

Harris and Jeste, 1988): Late-onset schizophrenia: an overview. *Schizophrenia Bulletin*; 14(1): 39-45.

Heinssen R, Goldstein AB, and Azrin ST (2014): Evidence-based treatments for first episode psychosis: Components of coordinated specialty care. Recovery after an initial schizophrenia episode. Bethesda, MD: National Institute of Mental Health.

Howard R, Rabins PV, Seeman MV, Jeste DV, and the International Late-Onset Schizophrenia Group (2000): Late-onset schizophrenia and very-late-onset schizophrenia-like psychosis: an international consensus. *American Journal of Psychiatry*; 157(2):172-178.

Kane JM, Robinson DG, Schooler NR, et al. (2016): Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry*; 173(4):362-372.

Kendler KS, Gallagher TJ, Abelson JM, et al. (1996): Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample: The National Comorbidity Survey. *Archives of General Psychiatry*; 53(11):1022-1031.

Kessler RC, Aguilar-Gaxiola S, Alonso J, Chatterji S, Ling S, Ormel J, Ustun TB, Wang PS (2009): The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiol Psichiatr Soc.*; 18(1):23-33.

Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB (2007a): Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*; 20:359-364.

Kessler RC, Angermeyer M, Anthony JC, et al. (2007b): Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*; 6:168-176.

Kessler RC, Avenevoli S, Costell J, Green JG, Gruber MJ, McLaughlin KA, Petukhova M, Sampson NA, Zaslavsky AM, Merikangas KR (2012): Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*; 69(4):381-389.

Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE (2005a): Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*; 62:593-602.

Kessler RC, Chiu WT, Demler O, Walters EE (2005b): Prevalence, severity and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*; 62:617-627.

Kessler RC, Birnbaum H, Demler O, Falloon IRH, Gagnon E, Guyer M, Howes MJ, Kendler KS, SHI L, Walters E, Wu EQ (2005c): The prevalence and correlates of non-affective psychosis in the National Comorbidity Survey Replication (NCS-R). *Biological Psychiatry*; 58(8):668-676.

Lensch T, Baxa A, Zhang F, Gay C, Larson S, Clements-Nolle K, Yang W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada Reno. *2015 Nevada High School Youth Risk Behavior Survey (YRBS)*.

Lensch T, Baxa A, Zhang F, Gay C, Larson S, Clements-Nolle K, Yang W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada Reno. *2015 Nevada Middle School Youth Risk Behavior Survey (YRBS)*.

Lensch T, Martin HK, Zhang F, et al., *2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report*.

Maglione JE, Thomas SE, Jeste DV (2014): Late-onset schizophrenia: Do recent studies support categorizing LOS as a subtype of schizophrenia? *Current Opinion of Psychiatry*; 27(3):173-178.

McGorry PD, Edwards J, Mihalopoulos C, Harrigan SM, Jackson HJ (1996): EPPIC: An evolving system of early detection and optimal management. *Schizophrenia Bulletin*; 22(2): 305-326.

McGorry PD, Nelson B, Goldstone S, Yung A (2010): Clinical staging: A heuristic and practical strategy for new research and better health and social outcomes for psychotic and related mood disorders. *Canadian Journal of Psychiatry*; 55(8):486-497.

McGrath et al. (2008): Schizophrenia: A concise overview of incidence, prevalence and mortality. *Epidemiologic Reviews*; 30:67-76.

Mihalopoulos C, Harris M, Henry L, Harrigan S, McGorry P (2009): Is early intervention in psychosis cost-effective over the long term? *Schizophrenia Bulletin*; 35(5):909-918.

Nevada State Demographer's Office (2014). Nevada Department of Taxation. Population Statistics and Reports. Available from: [https://tax.nv.gov/Publications/Population Statistics and Reports/](https://tax.nv.gov/Publications/Population%20Statistics%20and%20Reports/)

Nevada State Demographer's Office (2016). Nevada Department of Taxation. Population Statistics and Reports. Available from: [https://tax.nv.gov/Publications/Population Statistics and Reports/](https://tax.nv.gov/Publications/Population%20Statistics%20and%20Reports/)

Sallis JF, Owen N, Fotheringham MJ (2000): Behavioral epidemiology: A systematic framework to classify phases of research on health promotion and disease prevention. *Annals of Behavioral Medicine*, 22(4):294-298.

SAMHSA, Uniform Reporting System (URS) Output Tables – Nevada. Accessed June, 2017: <https://www.samhsa.gov/data/sites/default/files/Nevada-2016.pdf>

Social Entrepreneurs Inc. (SEI) (2017): 2017 Situational Analysis, Substance Abuse and Prevention and Treatment Agency (SAPTA), Bureau of Behavioral Health Wellness and Prevention, Division of Public And Behavioral Health, Nevada Department of Health and Human Services, June 2017.

http://dpbh.nv.gov/uploadedFiles/dpbhgov/content/Programs/ClinicalSAPTA/SAPTA%20Situational%20Analysis_Final.pdf

Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, 2015*. HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nevada, Volume 4*. Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

Substance Abuse Prevention and Treatment Agency (SAPTA) (June 2017): [2016 Epidemiologic Profile](#). Office of Public Health Informatics and Epidemiology (OPHIE), Division of Public and Behavioral Health, Nevada Department of Health and Human Services.

The WHO World Mental Health Consortium (2004): Prevalence, severity, and unmet need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. *JAMA*; 291:2581-2590.

United States Census Bureau, Population Division (Release Date: June 2017): Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016.

U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2018. Source: U.S. Census Bureau, Population Division. Release Date: June 2019. (Accessed July 16, 2019)

Williams SM, Chapman D, Lando J (September 2, 2005): The role of public health in mental health promotion. *MMWR. Morbidity and Mortality Weekly Reports*. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a1.htm>

Youth Risk Behavior Surveillance System, 2015 High School Youth Risk Behavior Survey. Accessed from [Application URL](#) on June 5, 2017:

<https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=G&OUT=0&SID=HS&QID=QQ&LID=NV&YID=2015&LID2=XX&YID2=2015&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FIL=I1&FPL=P1&PV=&TST=True&C1=NV2015&C2=XX2015&QP=G&DP=1&VA=CI&CS=N&SYID=&EYID=&SC=DEFAULT&SO=ASC>

Youth Risk Behavior Surveillance System, 2015 Middle School Youth Risk Behavior Survey. Accessed from [Application URL](#) on June 5, 2017:

<https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=G&OUT=0&SID=HS&QID=QQ&LID=NV&YID=2015&LID2=XX&YID2=2015&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FIL=I1&FPL=P1&PV=&TST=True&C1=NV2015&C2=XX2015&QP=G&DP=1&VA=CI&CS=N&SYID=&EYID=&SC=DEFAULT&SO=ASC>

FFY 2020-2021 BLOCK GRANT APPLICATION
SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
(SABG)
PLAN AND REPORT

Section III. BEHAVIORAL HEALTH ASSESSMENT AND PLAN

B. Planning Steps

Step 2: Unmet Service Needs and Critical Gaps in Nevada's Current System

Submitted by:

Nevada Department Of Health & Human Services
Division Of Public And Behavioral Health
Bureau Of Behavioral Health Wellness And Prevention

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Introduction and Purpose

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of Nevada's Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH). SAPTA plans, funds, and coordinates statewide substance abuse service delivery. While SAPTA is not responsible for direct service delivery, it distributes state and federal grant funding, creates and implements statewide plans for substance abuse services, and develops standards for certification of programs and services.

In 2017, SAPTA updated its strategic plan with a focus on promoting healthy behaviors and reducing the impact of substance use and co-occurring disorders for Nevada's residents and communities. The following vision and the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) core concepts were adopted in the plan.

SAPTA plans, funds, and coordinates Nevada's statewide substance use disorder service delivery system, which is the primary focus of this regional capacity assessment effort. SAPTA's key roles include distributing funds (tax dollars, general fund, and grants), creating and implementing statewide plans for substance use disorder services, and developing standards for certification of programs and services.

In 2019, as part of an effort to understand current statewide and regional capacity for Substance Use Disorder (SUD) prevention and treatment services and establish priorities to build future capacity, SAPTA conducted a system-wide assessment using the CAST. Social Entrepreneurs, Inc. (SEI) was engaged by the state to facilitate completion of the CAST at the regional level, in collaboration with Nevada's Regional Behavioral Health Coordinators (RBHCs).

State Regulations

According to Nevada Revised Statutes (NRS 458.025), the Division of Public and Behavioral Health (DPBH):

(a) Shall formulate and operate a comprehensive state plan for alcohol and drug abuse programs which must include:

(1) A survey of the need for prevention and treatment of alcohol and drug abuse, including a survey of the treatment providers needed to provide services and a plan for the development and distribution of services and programs throughout this State.

(2) A plan for programs to educate the public in the problems of the abuse of alcohol and other drugs.

(3) A survey of the need for persons who have professional training in fields of health and other persons involved in the prevention of alcohol and drug abuse and in the treatment and recovery of alcohol and drug abusers, and a plan to provide the necessary treatment.¹

NRS 458.025 goes on to require that, “In developing and revising the state plan, the Division shall consider, without limitation, the amount of money available from the Federal Government for alcohol and drug abuse programs and the conditions attached to the acceptance of that money, and the limitations of legislative appropriations for alcohol and drug abuse programs.”

Any specifics within the state plan will also be compliant with the Nevada Administrative Code, specifically those provisions in Chapter 458 regarding the Abuse of Alcohol and Drugs.

Federal Block Grants

The Nevada Division of Public and Behavioral Health (DPBH) is the Single State Authority (SSA) for federal grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of the DPBH, SAPTA administers programs and activities that provide community-based prevention and treatment through the Substance Abuse Prevention and Treatment Block Grant - referred to as SABG by SAMHSA and SAPT by DPBH (Nevada Division of Public and Behavioral Health (DPBH), n.d.). Note that “prevention and treatment” is used throughout this document to summarize a broad continuum of approaches including outreach, prevention, (early) intervention, treatment, and recovery.

SABG has identified target populations and service areas to include:

SABG Targeted Populations and Services				
Pregnant women and women with dependent children	Persons who inject drugs	Tuberculosis Screening and Intervention	Early intervention services for people with HIV/AIDS	Primary prevention services (at 20% or more)

¹ Retrieved on October 17, 2016 from: <https://www.leg.state.nv.us/nrs/NRS-458.html>

Nevada's Behavioral Health, Wellness and Prevention Program, within the Division of Public and Behavioral Health (DPBH) is comprised of HIV/AIDS Prevention, Ryan White Part B, Substance Abuse Prevention and Treatment Agency (SAPTA), and Behavioral Health Services Planning efforts. **The mission of SAPTA is to promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's people and communities.**

SAMSHA Strategic Plan FY 2019-2023 has identified five priority areas which include

1. Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services.
2. Addressing Serious Mental Illness and Serious Emotional Disturbances.
3. Advancing Prevention, Treatment, and Recovery Support Services for Substance Use.
4. Improving Data Collection, Analysis, Dissemination, and Program and Policy Evaluation.
5. Strengthening Health Practitioner Training and Education.

SAMHSA's work is guided by five core principles that are being infused throughout the Agency's activities. The five core principles are

1. Supporting the adoption of evidence-based practices.
2. Increasing access to the full continuum of services for mental and substance use disorders.
3. Engaging in outreach to clinicians, grantees, patients, and the American public.
4. Collecting, analyzing, and disseminating data to inform policies, programs, and practices.
5. Recognizing that the availability of mental health and substance use disorder services are integral to everyone's health.

Critical Issues and Gaps

Contextual and Environmental Issues

(Nevada Substance Abuse Prevention and Treatment Prevention Agency-SAPTA 2018 Needs Assessment)

- Widespread availability and use of a number of extremely harmful and addictive substances, including methamphetamine and opioids
- Cultural norms that support excessive drinking, smoking, and cannabis/marijuana
- Following a national trend, increased pressure on systems through a growing population of older adults with complex needs
- Following a national trend, increased pressure on systems from adolescents and young adults with mental health concerns
- Limited opportunities for adequate housing, worsened by rising housing costs
- Limited or no infrastructure for public transportation within many areas of the state

- Stigma associated with behavioral health that impacts access and connection to treatment

Capacity to Serve People with Behavioral Health Needs

(Nevada Substance Abuse Prevention and Treatment Prevention Agency-SAPTA 2018 Needs Assessment)

- Lack of in-state residential care, especially for adolescents for both substance use and mental health.
- Severe shortages in the workforce in nearly all needed behavioral health professions
- Limited number of providers that have cultural competence to serve the community
- An emerging system for care that is fragile; aspects that have the potential to expand availability of care are in the process of development, and not firmly established
- Competition rather than collaboration among service providers in some of the most populated areas of the state
- Challenges in addressing questions of unmet need; data systems are emerging to better answer these questions but currently much of the information available is qualitative
- Populations (geographies and specific subgroups) that are underserved, including but not limited to incarcerated (and recently released people), homeless people, and adolescents
- Progress slow when it comes to the availability of integrated care
- Progress slow to spread use of trauma-informed care
- Limited adoption of evidence-based practices (EBP)

The Assets and “Bright Spots”

(Nevada Substance Abuse Prevention and Treatment Prevention Agency-SAPTA 2018 Needs Assessment)

- Engaged and responsive providers across the state; a committed group of leaders (both formal and informal) working to address the most challenging problems of behavioral health
- Institutions that are establishing a reputation for “being able to help” - regardless of the challenges that individuals face with insurance or circumstance
- Strengthened and emerging partnerships between health, law enforcement, and others
- Innovative problem solving within organizations creating programs to serve more people, provide better services, or both, including rural Nevada
- Formal networks and collaborations working effectively together to find solutions and improve care across agency and geographic boundaries (Prevention Coalitions, Behavioral Health Boards, and Children’s Mental Health Consortia, etc.)
- Expansion of harm reduction activities that help people to be as safe and as well as possible until they are able to initiate help for substance use disorders (e.g. Naloxone distribution, needle exchanges, etc.)
- Promising developments have been made in telehealth – overcoming some of the barriers that have been in place for many years

- Improved collective capacity around crisis response, through crisis intervention teams and other multi-disciplinary teams
- Improvements to health information technology and infrastructure
- Many schools and community-based organizations using evidence-based programs for prevention
- Developments in process to better serve pregnant women who may have a substance use disorder and improving capacity to help newborns through the Plan of Safe Care
- Increased number of peer recovery supports – both people who have been trained as peer supports, and use of peer supports in Nevada
- Progress in implementing Nevada’s hybrid “hub and spoke” model for treatment of opioid use disorders through Integrated Opioid Treatment and Recovery Centers (IOTRCs); this includes expansion of availability of Medication Assisted Treatment (MAT)
- Medicaid expansion, providing opportunities for more people to access care
- Community responses to crises – people coming together across boundaries to help – especially to support children and youth
- Effective specialty courts that are able to connect people to pathways and services (that would be difficult to access otherwise)
- Increased public and professional awareness about substance use and mental health disorders – an important step in reducing stigma
- Outreach to provide technical assistance and capacity building to providers, especially to treat and address opioid use disorders
- Improving resources for people who are incarcerated to address mental illness and substance use disorders
- Available care for co-occurring disorders due to implementation of DDCAT for certification.

CAST (Calculating for an Adequate System Tool)

In January 2019, to prepare an updated plan for SAPTA, each region in Nevada was asked to participate in the CAST (Calculating for an Adequate System Tool). CAST produces community-specific assessments of the capacity of the components of a community substance abuse care system. CAST generates recommendations by the application of social and community determinants of health as risk coefficients to each estimate of component need. CAST can assist public health practitioners in evaluation and improvement of the capacity of community-based, substance abuse care systems. By using recommendations for component needs across the continuum of care, community leaders can use CAST to prioritize resource allocation more effectively and efficiently.

The CAST is based on an expansion of the widely accepted Substance Abuse and Mental Health Services (SAMHSA) continuum of care. In addition, the following were added: category, referral, to the continuum-of-care model to more fully depict a local system of care. The 5 categories along the continuum that is used for CAST were promotion, prevention, referral, treatment, and recovery.

CAST utilizes social determinants of health, population and demographic data, and community resource availability to estimate

1. *Hospitalization Risk Score*: the likelihood that the region's hospitalization rate for substance abuse disorders (SUDs) will be above the national median hospitalization rate for SUDs .
2. *Regional Usage Rates of Commonly Misused Substances*: the number of individuals within the region that will misuse substances within a given year.
3. *Community Capacity Calculator*: the region's capacity to address and combat substance misuse via Promotion, Prevention, Referral, Treatment, and Recovery activities and resources. The Calculator uses algorithms to estimate need for core components of the SUD prevention and treatment continuum in a region.

Summary of Priorities for Action

Following a facilitated review and discussion of each region's CAST results, including an analysis of the region's social characteristics, risk score, and unmet need analysis in the context of planning efforts already underway, up to five priorities were identified for each region by their respective RBH Coordinators in consultation with the region's Behavioral Health Policy Board and stakeholders.

Following a facilitated review and discussion of each region's CAST results, including an analysis of the region's social characteristics, risk score, and unmet need analysis in the context of planning efforts already underway, up to five priorities were identified for each region by their respective RBH Coordinators in consultation with the region's Behavioral Health Policy Board and stakeholders.

The most frequently identified needs and priorities for action across all regions fall into the treatment category.

Treatment

1. Increase availability of short- and long-term residential inpatient treatment |CC, N, W|
2. Increase number of psychiatrists and psychologists listed as specializing in substance abuse and addition issues |CC, N, W|
3. Increase outpatient treatment by leveraging technology and offering more options for treating co-occurring disorders |R|

4. Increase availability of crisis stabilization and outpatient detoxification services |W|

Prevention

1. Expand prescription drug disposal locations and events to communities that do not have them |SR|
2. Increase prevention programming in schools |W|

Promotion

1. Increase advocacy events to promote substance misuse education |SR|
2. Increase marketing advertisements placed across all media |CC, N, SR|

Recovery

1. Increase the availability of transportation vouchers and services for people seeking treatment |R, SR|
2. Increase the number of housing assistance supports available |R|

Referral

1. Increase the number of case managers available to assist with care coordination |W|

Other

2. Increase mental health training for law enforcement, in conjunction w/ administering Naloxone |SR|

CC= Clark County | N= Northern | R= Rural | SR= Southern | W= Washoe

Substance Misuse and Substance Use Disorders: Definitions and Statistics

Definition: A substance use disorder (SUD) occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), a diagnosis of a substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Nevada's rate of SUD is 6.6% compared to the national rate of 8.4%.

(Substance Abuse and Mental Health Services Administration, 2017)

(National Surveys on Drug Use and Health: Model-Based Estimated Totals, 2017)

Persistent and Emerging Issues: Substances of Public Health Concern

Tobacco / Nicotine and Vaping

Tobacco contributes to numerous diseases including cancer, heart disease, stroke, and diabetes. Despite declines in smoking over the last few decades, it is responsible for millions of premature deaths nationwide. According to a report by the U.S. Surgeon General, if current trends continue, 5.6 million U.S. youth who are currently younger than 18 will die prematurely from smoking (*Department of Health and Human Services, 2014*).

A related risk is vaping. While rates of smoking have declined among youth, vaping is on the rise. Recently published studies suggest that vaping has considerable negative health effects that were previously unknown (Desert Research Institute, 2018) and, that vaping is an “epidemic” among youth, having been marketed in flavors and in packaging that make vaping devices easy to hide from parents and teachers (*Stein, 2018*). Vaping can include nicotine, other liquid drugs, or, chemicals that are simply “flavored.”

- Rates of adult smoking are higher in Nevada than the nation.
- Nearly one in four Nevada high school youth (23.9%) “had ever” smoked a cigarette. Twelve percent (12%) had smoked in the previous 30 days (*2017 Youth Risk Behavior Survey (YRBS)*)
- Among Nevada’s high school youth, 42% “had ever” tried vaping, and 15% had used electronic vapor products 30 days before the survey (*2017 Youth Risk Behavior Survey YRBS*).
- Poisoning from nicotine affects a small portion of children. It should be noted that nicotine is highly toxic in large doses, and therefore a risk to young children (*American Academy of Pediatrics, 2017*). Liquid nicotine (used for some vaping devices) poses risk due to its concentration.

Cannabis / Marijuana

Legalization of recreational cannabis / marijuana has been a factor in increased use in Nevada. Many are concerned about youth access and increased use among young people.

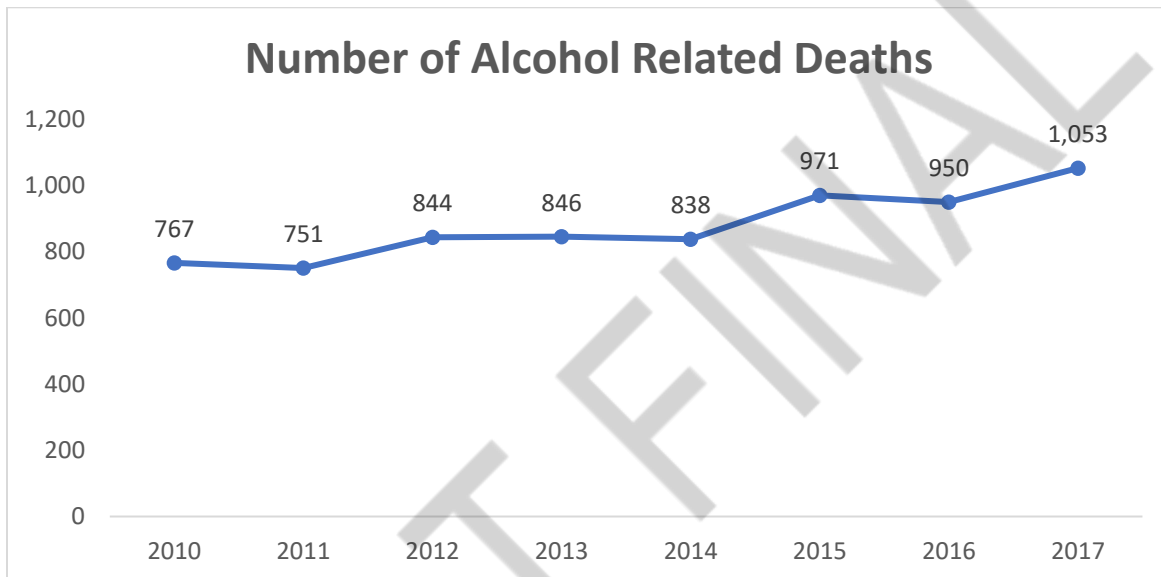
- Rates of cannabis / marijuana have increased in recent years. Among Nevada’s high school youth, 37% “had ever” used marijuana, and nearly one in five (19.5%) had used marijuana in the past 30 days. (*2017 Youth Risk Behavior Survey (YRBS)*)

Alcohol

The availability of alcohol, along with its addictive properties, makes it one of the most significant concerns from a public health perspective (*Jaffee, 2016*).

- Among Nevada’s high school youth, 60.6% “had ever” drank alcohol; more than one in four (26.5%) had at least one drink of alcohol in the past 30 days, and 3.1% had more than 10 drinks in the past 30 days. (*2017 Youth Risk Behavior Survey (YRBS)*)

The number of alcohol related deaths in Nevada climbed in recent years, with more than 1,000 in 2017.



(*DHHS Office of Analytics, 2018*)

Synthetic Marijuana or “Spice”

Synthetic marijuana, (often called “spice” or K2) uses synthetic (man-made) chemicals that are added to plant material to be smoked or sold as liquids to be vaporized. These products may also be known as herbal or liquid incense. They are marketed as safe alternatives to cannabis but are in fact very dangerous due to their unpredictability in chemical content and dosage (*National Institute on Drug Abuse, 2018*).

Methamphetamine

Methamphetamine is a powerful, highly addictive stimulant that has numerous adverse effects including addiction, anxiety, confusion, mood disturbance, and violent behavior.

People using methamphetamine may also display psychotic features such as hallucinations and delusions (*National Institute on Drug Abuse: Advancing Addiction Science, 2013*). Methamphetamine addiction takes a particular toll on children when parents or caregivers are addicted.

- Providers in Nevada are concerned about a resurgence in methamphetamine. This is confirmed with data. According to a recent report, Nevada's death rate from methamphetamines was highest in the U.S. (*Associated Press, 2018*).
- Methamphetamine may also be contaminated with other drugs like fentanyl, contributing to deaths (*Sewall, 2018*).
- Among Nevada's middle school youth, 1.7% reported using methamphetamines; while, among Nevada's high school youth, 3.3% reported having ever used methamphetamine

(2017 Youth Risk Behavior Survey (YRBS))

Opioids: Prescriptions, Heroin and Fentanyl

The Opioid Crisis is Evolving:

- Nevada HIDTA has classified heroin, fentanyl, and methamphetamines as three of the top threats in 2018 (Nevada HIDTA, 2018)
- Fentanyl is 50-100 times more potent than heroin
- Can be mixed into drug supply (pills, heroin, methamphetamine)

2017 Overdose Deaths

- Washoe County: 21 fentanyl-related deaths
 - 89 methamphetamine-related deaths
- Clark County: 42 fentanyl-related deaths
 - 222 methamphetamine-related deaths

The Controlled Substance Abuse Prevention Act (AB 474) passed unanimously during the 2017 Nevada Legislative Session to combat controlled substances II, III, IV abuse, misuse and diversion and became effective on January 1, 2018. This bill included several major provisions including prescribing protocols, continuing education, overdose reporting and occupational licensing board regulations.

Even though Nevada continues to experience an opioid crisis the table below shows decrease in prescribed opiates.

**Opioid Prescription Counts and Rates
per 100 Population by Month, January 2017- December 2018**



Among Nevada’s high school youth, 14.8% had taken prescription pain medicine without a prescription or not as prescribed. (2017 Youth Risk Behavior Survey (YRBS))

Among Nevada’s high school youth, 2.6% reported having used heroin 2017 Youth Risk Behavior Survey (YRBS)

Ecstasy, Molly/MDMA, LSD, Ketamine, Cocaine and Other Drugs

Many other illegal substances are available and used by adults and youth in Nevada. The percentage of Nevadans reporting that they are current users of “other illegal drugs” was up slightly in 2016 to 1.5% of the adult population (DHHS Office of Analytics, 2018).

Dangerous Combinations

When substances (including prescriptions) are combined, there is often amplified risk of complications, including overdose and accidents that can result in death. For example:

- In a recent data collection effort by Trac B, testing of methamphetamine and heroin revealed contamination with fentanyl (increasing risk of overdose and death).
- In a study of recent drug-related deaths in Washoe County, more than one substance was frequent within the detailed cause of death (*Join Together Northern Nevada, 2016*).
- In the same study, a large portion of drug-related deaths were due to blunt traumatic force, asphyxia, drowning, firearms, hanging, hypothermia, or motor vehicle accidents. Those cases had substances in their system at the time of death. (*Join Together Northern Nevada, 2016*).
- Contamination of drugs with other substances is often unknown to the user and causes heightened risk of complications or even death.

Nevada's Opioid and Benzodiazepine Overdose Deaths

Opioid-Related Overdose Deaths, State of Nevada Residents, 2010-2018*

Year	Opioid-Related Overdose Deaths	Crude Rates	Percent Change	Benzodiazepine Related Overdose Deaths	Opioid and Benzodiazepine Related Overdose Deaths
2010	437	16.2		161	139
2011	460	16.9	5%	166	143
2012	437	15.9	-6%	162	140
2013	396	14.1	-11%	126	106
2014	365	12.8	-9%	125	109
2015	409	14.1	10%	130	117
2016	393	13.3	-6%	155	126
2017	401	13.4	1%	123	106
2018*	346	11.4	-15%	137	110
Percent Change 2010-2018*			-29%		

Rates are per 100,000 State of Nevada Population.

Each year:

- Roughly 85% of all benzodiazepine-related overdose deaths also involve opioids.
- Roughly 30% of all opioid-related overdose deaths also involve benzodiazepines.

[A Closer Look at Behavioral Health: People in Nevada](#)

Children and Adolescents

Children and adolescents are a critical population to serve. Even the youngest children may experience mental health concerns. Adolescents are also at risk for mental health issues and substance misuse.

Population

- Nearly one in four Nevadans is age 18 or younger (23%).
- There are approximately 686,550 children and youth in Nevada.

Substance Use Disorder

Many adolescents seek substances to self-medicate. Services that can help address both mental health issues and substance use are often more effective than those that work on only one issue.

Rates of substance use through time vary depending on the specific substance. Of note, 14.8% of high school students in Nevada took prescription pain medication without a prescription or not as prescribed 19.5% had used cannabis/marijuana, and 26.5% had used alcohol in the past 30 days before being surveyed (*2017 Youth Risk Behavior Survey (YRBS)*).

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the prevention/programming available. It is not intended as a comprehensive list of programs in Nevada.

- Signs of Suicide (SOS) Training
- Healthy Schools Healthy Students (Grant Funded Programs)
- Healthy Schools Grant Funding
- State Funding for Social Workers in Schools
- Community-Driven Programs: Big Brothers Big Sisters, Court Appointed Special Advocates (CASA), Boys and Girls Club, etc.
- Multi-Tiered Support Systems through Schools
- Evidence-Based Prevention Programs Provided through Schools
- ARISE Program (see text box)
- Play by the Rules
- JJAST Program: Juvenile Justice Assessment Screening Triage Team (Carson City Probation)
- Leadership and Resiliency Wilderness Program (Carson City Probation)
- Nevada Partners (Las Vegas) – Multiple Programs
- Nevada PEP
- National Alliance on Mental Illness

Transition Age Youth

Adults of all ages make up the largest proportion of the population. A specific subset of this population, transition age youth (TAY) (often defined as those age 18-25) is highlighted for numerous reasons. Transition age youth may be at higher risk for substance use and first experiences of mental illness. Further, while they may have existing or newly emerging needs, they have typically left childhood homes – and aged out of systems that serve children and youth. They face a complex service system that is often not well-equipped to meet their needs.

Population

- Young adults or transition age youth (ages 18-25) make up about 9% of the population.

Critical Issues and Needs

- Mental health, substance misuse, and co-occurring disorders are a major public health concern for transition age youth.
- Proximity and availability of drugs, alcohol, and gambling likely contribute to rates of substance use in Nevada.
- Improvements to insurance access have been made through Medicaid expansion. However, especially for those who may have trouble navigating an insurance system and set of providers, finding services can be difficult or impossible without assistance.
- The limited availability of livable and decent housing impact peoples' ability—especially transition age youth—to find appropriate living situations.
- Transportation for services including assessments and treatment are barriers for many, including those with the highest needs.

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

- Nevada's Integrated Opioid Treatment and Recovery Centers (IOTRCs)
- Federally Qualified Health Clinics (FQHCs)
- National Alliance on Mental Illness (NAMI) works in many ways across Nevada, including programming, advocacy, and support around mental illness
- SAPTA Certified Programs (including both funded and non-funded partners)
- Nevada has several Certified Community Behavioral Health Clinics (CCBHC)

Adults (Ages 26-64)

Population

Adults (26-64) make up more than half of the total population in Nevada.

- Adults ages 26-34 make up about 13% of the population
- Adults ages 35-55 make up 25% of the population
- Adults ages 55-64 make up 25% of the 13% of the population

Substance Use Disorder

- Between 2011 and 2017, on average, 7.5% of Nevada adults used marijuana or hashish in the last 30 days. Marijuana use has increased consistently since 2014 and is expected to increase as marijuana was legalized in Nevada in 2017. Of Nevadans surveyed, 0.7% (on average) used painkillers to get high in the last 30 days and 1.1% used other illegal drugs to get high in the last 30 days. (*Behavioral Risk Factor Surveillance System (BRFSS)*).
- Men who are considered heavy drinkers has significantly decrease from 2011 to 2017, by a percent change of 22%. For men, heavy drinking is defined by consuming more than two alcoholic beverages per day. (*Behavioral Risk Factor Surveillance System (BRFSS)*).
- Women who are considered heavy drinkers has remain steady from 2011 to 2017, at 5.6%. For women, heavy drinking is defined by consuming more than one alcoholic beverage per day. (*Behavioral Risk Factor Surveillance System (BRFSS)*).
- Binge drinking is defined in men as having five or more alcoholic beverages on an occasion. Binge drinking has decreased from 2011 to 2017 but is not significant (95% confidence interval). Nevada men reported the lowest binge drinking percentage, 20.0%, in 2016. (*Behavioral Risk Factor Surveillance System (BRFSS)*).
- Binge drinking is defined in women as having four or more alcoholic beverages on an occasion. Nevada women reported the highest binge drinking percentage in 2011, at 13.2%. In 2017, 11.0% of Nevada women reported binge drinking, which is not a significant (95% confidence interval) decrease since 2011. (*Behavioral Risk Factor Surveillance System (BRFSS)*).

Critical Issues and Needs

- Mental health, substance misuse, and co-occurring disorders are a major public health concern for adults.
- Proximity and availability of drugs, alcohol, and gambling likely contribute to rates of substance use in Nevada.
- Improvements to insurance access have been made through Medicaid expansion. However, especially for those who may have trouble navigating an insurance system and set of providers, finding services can be difficult or impossible without assistance.
- The limited availability of affordable housing impacts peoples' ability to regain health and wellness.
- Transportation for services including assessments and treatment are barriers for many, including those with the highest needs.

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

- Nevada's FQHCs provide care, including integrated primary and behavioral health care.
- Medicaid expansion has allowed many more adults in Nevada to have insurance coverage, which allows use of both public and private providers that accept Medicaid
- State and community settings that promote integration are available for adults.
- The state's opioid response – including expanding availability of naloxone, stands to help all Nevadans, including adults who have been particularly at risk of overdose deaths.

Older Adults and Seniors

Older adults are experiencing substance use or mental health disorders at higher rates than in previous years. Both the rates of mental health and substance use appear to have increased within this population, and the total number of older adults (aging of the baby boomer generation) set the stage for systems that are not ready to address these issues.

Population

- About 16% of Nevada's population is 65 and older.

- The population of older adults is expected to increase dramatically, as the “baby boomer” generation continues to age.
- Older adults are more likely to have a disability compared to the population as a whole; more than one in three older adults lives with a disability (Aging and Disability Services Division, Commission on Aging, 2016).

Substance Use Disorder

- National data suggests that substance use is a growing issue among older adults, with predictions of higher numbers and rates of older adults with a substance use disorder. (Mattson, Lipari, Hays, & Van Horn, 2017).
- Older adults may be particularly at risk for opioid use disorder, as increased age often comes with painful and chronic conditions. Among older adults with opioid use disorder (OUD) may also be difficult to diagnose, with symptoms similar to depression, delirium, and depression (Tilly, Skowronski, & Ruiz, 2017).
- Additionally, accumulated experiences of trauma, isolation, or loss of loved ones can cause emotional pain, worsening existing mental health concerns or substance use disorders.

Critical Issues and Needs

- In 2016, the 65-74 age group had a significant increase in deaths from previous years and in 2017, had the most alcohol and/or drug-related deaths of any age group with 1,275 deaths reported. This was followed by 55-64 age group with 1,057 drug and alcohol-related deaths.
- While the population of seniors has increased, funding for needed services has not kept pace (Aging and Disability Services Division, Commission on Aging, 2016).
- Older adults on fixed incomes are more likely to be negatively affected by rising rental costs in Nevada.
- Issues of behavioral health can be difficult to talk about with older adults – stigma and fear is often a barrier.
- Many caregivers (e.g. staff in nursing facilities, etc.) do not have adequate training to manage the array of mental and behavioral health issues. Early intervention is key; however, problems often are not addressed until a person is in crisis.
- Isolation and poverty can worsen symptoms of disease. Many older adults are without enough supportive connections.

Notable Resources for this Age Group

Programs that were named by key informants are shown to highlight some of the resources in place. This list is intended to provide visibility to some of the programming available. It is not intended as a comprehensive list of programs in Nevada.

- Crisis intervention training can be useful for people working with older adults. More people with training is needed.
- Senior centers provide a place for connection and engagement with older adults that may otherwise be isolated.
- A number of programs are available statewide. Those offered by aging and disability services (Nevada DHHS <http://adsd.nv.gov/Programs/Seniors/Seniors/>).
- The University of Nevada, Reno, Sanford Center on Aging, Geriatric Medication Management Program for individuals over 60 provides individuals with a comprehensive medication evaluation by a geriatric pharmacist – who then works with caregivers and prescribing physicians to recommend changes and address any potential safety concerns.

Racial and Ethnic Minorities

Risk behaviors, disease, injury, and even mortality can be the effects or outcomes of social and institutional inequities, as well as differences in living conditions. Reviewing data by race and ethnicity is one step within a larger set of activities that can help to identify levers for equity (Bay Area Regional Health Inequities Initiative, n.d.).

Population

- Racially, 9% are Black/African American, 9% some other race, 8% are Asian, 5% two or more races, 1% American Indian, 1% Native Hawaiian or Pacific Islander.
- Ethnically, 29% identify as Hispanic/Latino.
- Linguistically, 30% of households speak a language other than English at home.
- Nearly one in five, or 19.3% of Nevada's population was born in another country. A portion of this group is undocumented.
- Hawaiian and Pacific Islanders (42.5%) and "Other" (40.3%) (Kaiser Family Foundation, 2016).
- 52.1% of American Indian adults reported that their mental health was "not good" between 1 and 30 days (past month). Among all states in the nation, this was the highest percentage recorded.

Substance Use Disorder

- The White non-Hispanic population has had a significantly higher increase in alcohol and drug-related deaths since 2014. While Native American deaths increased in 2011 and 2016, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size.
- In 2019, the White non-Hispanic population admissions has been at a significantly high rate of 64% of total number of admissions followed by Hispanic Origin Not Specified Unknown at 12% and Black/African at 10%.
- In 2018, the White population had been 59% of total admissions, followed by Black/African at 14% followed by Hispanic Origin Not Specified Unknown at 11%.
- Primary substance use has been identified as methamphetamine in 2019 and 2018 followed by alcohol related disorders or other/unknown.

(DHHS Office of Analytics 2019)

Critical Issues and Needs

- People of color are disproportionately receiving (Medicaid) in Nevada. In 2017, of the 36% of people on Medicaid, 20% were Black, 33% Hispanic, and 10% “other.” *(DHHS Office of Analytics, 2018)*. Considering that many providers don’t accept Medicaid, people of color may be less likely to get behavioral health services.
- Nationally, and likely in Nevada, people of color use substances at similar rates compared to the rest of the population, but are disproportionately incarcerated for drug-related crimes *(Rosenberg, Groves, & Blankenship, 2017)*.
- Nationally, and likely in Nevada, people of color have poorer health outcomes compared to whites *(McGuire & Miranda, 2008)*. Disparities are caused by system problems and inequalities.
- Language can also be a barrier to service. Support in Spanish is most commonly needed. Among interviewees, the ability to provide services in Spanish were noted as a gap.
- People who are undocumented have access to very public resources. Further, family members of people who are undocumented may not seek out help because they are concerned about the risk of identifying others. Key informants were concerned that people, including youth and children, were not able to get help out of fear for risk of deportation for themselves or family members.

LGBTQ²

People who identify as lesbian, gay, bisexual, or transgender (LGBT) often face social stigma, discrimination, and other challenges not encountered by people who identify as heterosexual. They also face a greater risk of harassment and violence. As a result of these and other stressors, sexual minorities are at increased risk for various behavioral health issues (*National Institute on Drug Abuse, n.d.*).

Population

Statistics to estimate the population of people who are lesbian, gay, bi-sexual, transgender are drawn from national data.

- 4.5% LGBTQ
- Younger people (millennials) account for rise in LGBTQ percentage
- 5.1% of women identify as LGBT, compared with 3.9% of men

Substance Use Disorders

- A Youth Risk Behavior Survey (YRBS) study of risk behaviors among Nevada's youth showed that teens who were LGBTQ were statistically more likely to use substances than their heterosexual peers.
- In 2015 researchers in Nevada compared the YRBS data between youth identifying as heterosexual and youth identifying as LGB. In numerous behaviors measured, the LGB had risk behaviors statistically higher than the group identifying as heterosexual. (Lensch, et al., 2015).
- 41.5% of students (LGB) had seriously considered attempting suicide (during the 12 months before the survey). This was three times the rate among the students identifying as heterosexual (13.9%) (Lensch, et al., 2015).

Critical Issues and Needs

- While statistical data is not collected, several interviewees noted the challenges that adults and youth can face in finding community support, including but not limited to providers that had the training and competence to serve LGBTQ individuals. These challenges can be more extreme in Nevada's rural and frontier communities.

² LGBTQ stands for lesbian, bisexual, transgender, and questioning. The acronym is sometimes expanded to include AI, for asexual and intersex. The acronym appears differently within this section, as different sources refer to different terms.

- LGBT individuals may encounter or experience the “double or dual stigma” especially when someone seeks treatment. Often termed “minority stress,” disparities in the LGBTQ community stem from a variety of factors including social stigma, discrimination, prejudice, denial of civil and human rights, abuse, harassment, victimization, social exclusion and family rejection” (National Alliance on Mental Illness, 2018).
- Services and resources that are competent to help people with diverse needs are lacking. This problem is exacerbated by a general shortage of behavioral health care providers in the state. People in rural and frontier areas, including youth and teens, may find it very difficult to find the support within small communities.

Women who are Pregnant and Women with Dependent Children

Women who are pregnant or parenting infants and who also have mental illness, substance use disorders, or both, or those that have children in the home, are an important focus for treatment. Both mothers and the children may require special assistance and approaches for care.

Population

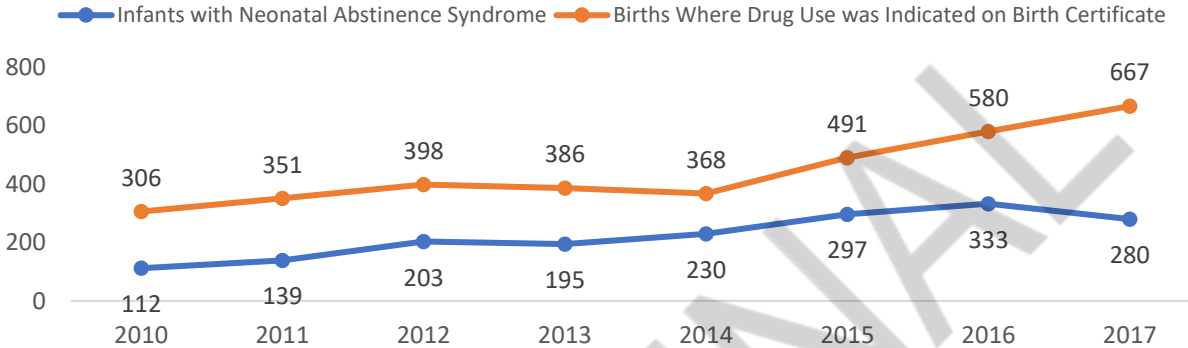
- Each year in Nevada there are roughly 36,000 births (36,260 in 2016).
- In Nevada there are 663,212 children under 18 in households.
 - 88% live with a biological, step, or adopted parent.
 - 7% live with a grandparent.
 - 3% live with other relatives.
 - 2% are in foster care or are otherwise unrelated to the householder.
 - 27.4% lived in households with supplemental security income, cash public income, food stamps/SNAP benefits (US Census, 2016).

Substance Use Disorder

- Data suggests that only a portion of mothers who need treatment get it. In 2017, 213 pregnant women passed through substance abuse centers in Nevada that were publicly funded through SAPTA. (Note that this data reflects only a portion of those receiving services). The total number of those in need, versus those receiving services, is not available.
- In 2017, 667 substance exposed infants were born in Nevada. The number of substance exposed infants born in Nevada has increased each year since 2014.
- National rates of opioid use disorder are increasing among reproductive-aged and pregnant women, and opioid use during pregnancy is associated with adverse maternal

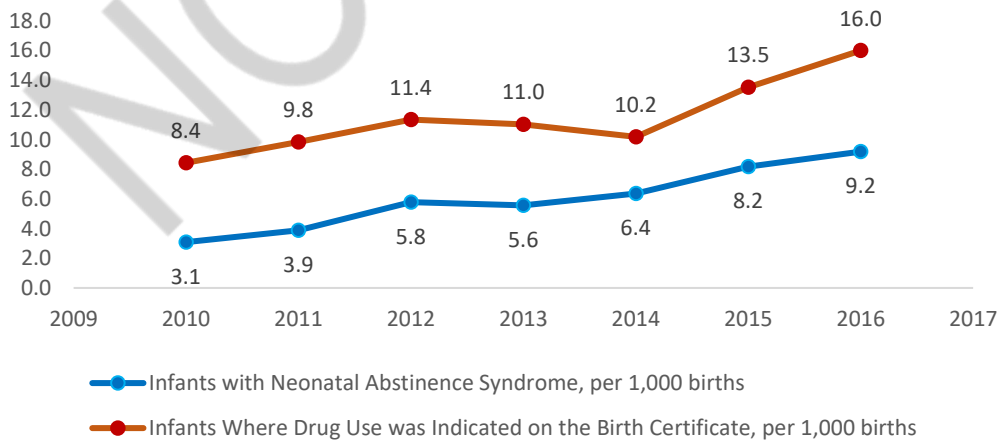
and neonatal outcomes. Increasing trends might represent actual increases in prevalence or improved screening and diagnosis. Diagnostic procedures differ by state, and states with enhanced procedures for identifying infants with neonatal abstinence syndrome might ascertain more cases of maternal opioid use disorder. (SAPTA Needs Assessment 2018)

Births and Drug Use



- Preliminary data for 2017 appears to indicate a continued upward trend for drug use identified on the birth certificate, and a slight decline for neonatal abstinence syndrome. (SAPTA Needs Assessment 2018)

Infants with Neonatal Abstinence Syndrome and Drug Use Indicated on Birth Certificate, Per 1,000 Births



Critical Issues and Needs

- Many pregnant women do not get the treatment they need for mental health, substance use disorder, or both. These issues, untreated, leave both mothers and children at risk.
- When women have substance use disorder, they may avoid sharing this information over fear of reporting and involvement of outside authorities.
- When women have children and are seeking treatment, they may need specialized care including arrangements with or for their children. The programs in Nevada able to provide these services exist, but are limited; especially in rural or frontier areas. There are also limited programs available for active users.
- Women experiencing domestic violence may have difficulty accessing shelter if they are active users – this gap was noted by key informant interviews.
- Many resources exist, but providers and the public may not know how to access them. [Substance Use During Pregnancy Provider Toolkit](#)
- The [Sober Moms Healthy Babies](#) (SMHB) website is part of an effort launched by Maternal and Child Health (MCH) Programs and SAPTA. The SMHB website focuses on preventing substance misuse during pregnancy and providing women, their families, and providers information on resources and treatment options.
- Perinatal Addiction Treatment Network Coordinator.

Additional Populations that May be at Particular Risk, be Underserved, or Hard to Serve

Many other sub-populations are important for focus and priority. These sub-populations may be at higher risk for health issues, be difficult to serve through traditional treatment services, or require specialized services.

Persons Who Inject Drugs (PWID)

Population

- The population of people injecting drugs is difficult to estimate. A national study in 2014 estimated the lifetime PWID comprised 2.6% of the U.S. population ages 13 and older (Lansky, et al., 2014).
- Among Nevada’s high school youth, 2.6% reported having “ever injected” any illegal drugs.
- Disparities were noted among youth by race and ethnicity: nearly one in ten high school students who are American Indian (9.9%) reported having ever injected illegal drugs. The rate was also especially high among high school students who are Native Hawaiian

and Pacific Islander (6.9%). The rates of injection were lowest among students who were Hispanic (2.2%) and White (2.2%).

Critical Issues and Needs

- Injection drug use is a route of transmission of blood-borne infections including but not limited to HIV, hepatitis, and the bacteria that cause heart infections (Centers for Disease Control and Prevention, 2018).
- Nationally, among people 18-29, Hepatitis C infection rose by 400% between 2004 and 2014, and admission for opioid injection rose 622% (Centers for Disease Control and Prevention, 2018).
- Harm reduction strategies that reduce risk-injection behaviors are available and effective in reducing disease transmission. However, these services are not widely understood or available in all areas of the state.

Tuberculosis (TB)

Population

- In FFY 2017 TB incidence in Nevada is currently measured for active TB disease only. Estimates on the prevalence of LTBI need to be established for Nevada. Nationally, the Centers for Disease Control and Prevention estimates LTBI prevalence in the U.S. population as 13 million.

Critical Issues

- The CDC in *Trends in Tuberculosis, 2017*, reports the breakdown of TB disease cases involving substance abuse to be 8.9% reported excessive alcohol use, 6.7% reported using non-injectable drugs, and 1.2% reported using injectable drugs.
- In Nevada, 2017, 80 cases of TB disease were reported and of these 8% reported excessive alcohol use and 6% reported drug use (injectable or non-injectable).
- In Nevada, 2018, of the 69 cases of TB disease reported 13% reported excessive alcohol use and 3% reported drug use.
- These statistics emphasize the need for individuals residing in Nevada with substance abuse or with a history of substance abuse to receive TB screening, education, and linkage to care with emphasis on completion of LTBI treatment.

People who are Incarcerated or Leaving Detention

Population

- Prison admission is up 6% from 2008 at 6,011 individuals in 2017.
- Female prison admission is up 39% over the last decade at 991 individuals in 2017.
- Number of offenders admitted with mental health needs is up 35% at 1,751 in 2017.
- Between 2005 and 2015, the incarcerated population increased 13.3%. (State Of Nevada Department of Corrections, Fiscal Years 2014 and 2015).
- In addition to people in Nevada's prisons, people are held in local jails and other facilities. Youth may also be held in special detention centers.

Critical Issues and Needs

- Possession offenses make up nearly one third of drug admissions: Trafficking 27%, Possession, 32%, Sale 33%, Other 8%. (*Crime and Justice Institute 2017*)
- 1 in 10 admissions have no prior felony convictions. (*Crime and Justice Institute 2017*)
- A portion of the incarcerated population may have mental health, substance use disorder, or both (co-occurring disorders). Resources to help are limited within these settings, in part due to concerns about safety.
- Many programs are making their way into Nevada's prisons to help people with recovery. Mental health groups (through NAMI), Crisis Intervention Training, and groups for Substance Use are being piloted in some prisons. As part of Nevada's opioid response, a project is also in place to pilot implantable medication assisted treatment for people incarcerated.
- Upon release or probation, housing and other services can be particularly hard to find for people who have been incarcerated. Even with efforts to connect people to housing and resources through a discharge plan, housing may be extremely difficult, with homelessness and recidivism results from limited housing options.
- For people within (or leaving detention,) appropriate supports are often not available to address complications of substance use disorders (e.g. detox, withdrawal, etc.).
- A recent study comparing re-arrests in Washoe County among those that participated in specialty courts vs. non-specialty courts showed promising results, with a lower percentage re-arrested during the time period reviewed (*Morgan & Popovich, 2018*). While preliminary, these data suggest that Nevada's specialty courts reduce recidivism.

People who are Homeless

Population

- Nevada's population of people who are homeless is large relative to the population size. Point in time counts in January 2017 revealed that there were 7,281 homeless individuals and the time of the count.
- In 2016, data maintained in the Homeless Management Information System showed 7,398 people homeless in Nevada. Within this group, 1,495, or 20%, had a mental illness.
- A portion of the population that is homeless has serious mental illness, substance use disorder, or both.

Critical Issues and Needs

- Mental illness, for some, can have "cascading effects," contributing to precarious housing or no housing. People who are homeless and that have a mental illness, substance abuse, or co-occurring disorder are at risk for escalating and advancing health problems.
- Trauma experienced before (and during) homelessness can be a factor that exacerbates mental illness, substance use, or both (Substance Abuse and Mental Health Services Administration, 2013) (Substance Abuse and Mental Health Services Administration, 2016).
- People who are homeless may have particular challenges in navigating health services, including insurance, that is available to them.

Veterans

Population

- In Nevada there are an estimated 216,275 veterans.

Critical Issues and Needs

- Veterans are at considerably higher risk for suicide. In a special report that reviewed data between 2010 and 2014, 22% of Nevada's suicide deaths were veterans (Interagency Council on Veterans Affairs, 2017).
- Veterans may experience increased stigma that impacts the ability to access treatment for mental health, substance use, or both. (Interagency Council on Veterans Affairs, 2017).

- In a national study, 18.5% of veterans who served in Afghanistan or Iraq currently have post-traumatic stress disorder or depression, and 19.5% report experiencing a traumatic brain injury while deployed. Yet, only a portion of those who need help receive it, and the adequacy of care is often insufficient (*Tanielian, et al., 2008*).

HIV

The RWPB works in tandem with the HIVPP to ensure individuals highest at-risk for HIV are targeted for HIV testing. HIV positive individuals who are having difficulty accessing services (i.e., core and supportive) are linked into comprehensive medical/non-medical case management services and other ancillary services. Utilizing high impact prevention (HIP) and evidence-based intervention strategies, our sub-recipients/providers work with their clients to overcome barriers to accessing HIV testing, care, and treatment.

- Anti-Retroviral Treatment and Access to Services (ARTAS) is a HIP intervention designed to link individuals, including those with substance use disorder, who have recently been diagnosed with HIV to medical care.
- ARTAS is an individual-level, multi-session, time-limited intervention to link recently diagnosed persons with HIV to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the linkage coordinator.
- According to the State of Nevada, Office of Public Health Informatics and Epidemiology (OPHIE) HIV Surveillance Program in 2016 reported that 90% of new HIV infections in the State of Nevada comes from Clark County (Las Vegas, NV).
- The SAPTA HIV Test Counseling program in Southern Nevada has a close partnership with the Southern Nevada Health District to offer RAPID ART (Rapid Antiretroviral Therapy [ART] Program Initiative for HIV Diagnoses) to provide immediate Antiretroviral Therapy (ART) to all HIV-infected patients.
- The RAPID ART program extends the concept of universal ART to include immediate linkage to HIV care and initiation of ART through two (2) different reactive rapid HIV fingerstick antibody tests.
- Data from the CDC and WHO showed immediate ART initiation decrease the median time to virologic suppression by removing obstacles to HIV care.

**Emergency Room Visits and Inpatient Admissions for Substance-Related Disorders
only/and Alcohol-Related Disorders
HIV Incidence and Prevalence Among Nevada Residents, FFY 2017**

HIV Incidence		
Indicator	Individuals	Total Visits
Substance and alcohol use	118	243
Substance use	113	235
Total Newly Diagnosed HIV FFY 2017	499	

HIV Prevalence		
Indicator	Individuals	Total Visits
Substance and alcohol use	1,019	2,603
Substance use	991	2,469
Total Newly Diagnosed HIV FFY 2017	11,633	

ICD-10-CM codes used: F10 (alcohol-related disorders), F11-F19 (substance-related disorders).

HIV Incidence is number of newly diagnosed HIV/AIDS individuals during FFY 2017 (October 1, 2016 through September 30, 2017).

HIV Prevalence is number of persons living with HIV/AIDS (PLWH) in Nevada as of September 30, 2017.

Regional Focus

Assembly Bill (AB) 366 passed in 2017 and introduced the development of behavioral health policy boards. Through this bill, Nevada is divided into 4 regions. A policy board was identified for each region, to consist of 13 members (Flood, Gutman, Saunders, & Leslie, 2018). A breakout by these regions is provided to help support clarification of needs.

Southern Nevada (Clark County, Nye County and Esmeralda Counties) Region

Description

The Southern Nevada region holds the largest population compared to other regions. It includes the greater Las Vegas area within Clark County as well as Nye and Esmeralda Counties, which have small populations and are considered frontier counties. (Note: As of the time frame of this publication, the rural counties of the southern region were being established as a separate region but had not been broken out to date).



Population

	Population	Percentage Under 18	Percentage 65 and Older
Clark County	2,204,079	23%	14%
Esmeralda County	850	15%	33%
Nye County	44,202	17%	30%
Total	2,249,131		

Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Clark County	Esmeralda County	Nye County	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.3	4.9	4.6	3.1	4.5
Adult Smoking	16%	21%	19%	14%	16%
Excessive Drinking	17%	16%	17%	13%	18%
Alcohol-Impaired Deaths	32%	20%	29%	13%	32%
Mental Health Providers	570:1	790:0	740:1	330:1	540:1
Violent Crime	706	207	366	62	616
Social Associations	3.4	0.0	6.1	22.1	4.2
Drug Overdose Deaths	21	ND	33	10	21

(Robert Wood Johnson Foundation, 2018)

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, or reports.

- **System Instability.** Recent program closures and threats of closures leave people without resources and challenge those trying to make referrals and placements. This is worsened by the sudden nature of many of these changes – there is a lack of trust in the systems that are in place locally to provide services.
- **Complex Systems to Navigate.** The system for assistance and treatment is complex and difficult to navigate.
- **High Turnover.** Providers are changing all the time – which impacts the relationships that can enhance collaboration and communication within and among the organizations providing services.
- **Transportation.** Transportation is often an issue for people with limited means – even short mileage distances can be impossible in southern Nevada without a car during summer months due to high temperatures. In the frontier areas of this county, travel time is long and trips to get people to appropriate care is expensive.
- **Workforce Shortages.** There are not enough providers to meet the needs, especially in rural areas.
- **Cultural and Linguistic Competency.** The ability to serve a diverse population – racially, ethnically, linguistically, and for people who are LGBT – are limited.
- **Lack of Detox Facilities.** Treatment often does not involve detox, and, when people are not in a monitored environment they go back to using.

- **Stigma.** People are often afraid to be labeled on health records, or, even among family members.

Opportunities

The following list of opportunities is not comprehensive but highlights some of key priorities identified by key informants, focus groups, or existing documents.

- Continue work to address the disconnection within the system through communication and collaboration.
- Consider system changes (structures, incentives, funding) that can improve referral and collaboration, toward a recovery-oriented system of care.
- Continue to encourage innovations and collaborations “that work” – regardless of the geographic boundaries that have been established.
- Build upon and share harm reduction strategies across providers and with other areas of the state.
- Continue to support and strengthen the providers that have a reputation for collaboration, results, and high-quality services.

Washoe Region

Description

The Washoe County region includes Reno and Sparks, the second largest metropolitan area in Nevada.

Population

	Population	Percentage Under 18	Percentage 65 and Older
Washoe County	460,587	22%	16%
Total			



Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is compared to the nation’s top performers in these indicators, as well as to the state as a whole.

	Washoe County	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.6	3.1	4.5
Adult Smoking	15%	14%	16%
Excessive Drinking	21%	13%	18%
Alcohol-Impaired Deaths	37%	13%	32%
Mental Health Providers	350:1	330:1	540:1
Violent Crime	372	62	616
Social Associations	5.8	22.1	4.2
Drug Overdose Deaths	21	10	21

(Robert Wood Johnson Foundation, 2018)

NOT FINAL

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, or reports.

- **Housing Costs.** Recent rises to housing costs impact people with limited income. Those who are working through treatment and recovery, or those with mental illness, may have particular challenges in finding and maintain affordable and decent housing.
- **Lack of Detoxification (Detox) Services.** Additional services for detox were noted as a gap, keeping people from using the treatment services available.
- **Complex and Confusing System to Navigate.** One of the key issues is navigation of managed care organizations (MCOs). Determining how to use and access these services is difficult for those who are suffering from mental illness, substance use, or co-occurring disorders, those who are homeless, or because of other circumstances, have very little understanding – and therefore limited access – to the services that are available.
- **Wait Time for Services.** Programs and services can have considerable wait times for patients or there can be other barriers to accessing available services within the community.
- **Lack of Providers.** There is a lack of providers available to meet the needs of the population. Those who are qualified and interested in serving people with addiction disorders are not common, and this contributes to barriers to access.
- **Affordability.** Many programs have costs associated, including those with sliding scale fees. Even discounted medicine can be out of reach – with the example of some of the medications recommended for medication assisted treatment.

Opportunities

- Continue to build partnerships between law enforcement, treatment and recovery, and public health.
- Expand and enhance programs that have a reputation within the community positive outcomes.
- Expand Crisis Intervention Teams (MOST, FAST).
- Enhance the ability for people to access preventative services and supports.
- Continue work in schools that provides youth and families with social and emotional learning supports.
- Continue to develop collaborative approaches to serving the community including in service of those with the most challenging needs.

Northern Nevada Rural Region

Description

The Northern Nevada rural region includes Carson City, Storey, Lyon, Douglas, Churchill, and Mineral Counties.

Population

	Population	Percentage Under 18	Percentage 65 and Older
Carson City	54,745	20%	20%
Churchill	24,230	23%	19%
Douglas	48,309	17%	27%
Lyon	54,122	22%	21%
Mineral	4,457	19%	24%
Storey	4,006	12%	30%
Total	189,869		



Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is shown compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Carson	Churchill	Douglas	Lyon	Mineral	Storey	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.1	4.4	3.9	4.5	5.0	3.9	3.1	4.5
Adult Smoking	18%	18%	14%	21%	20%	15%	14%	16%

	Carson	Churchill	Douglas	Lyon	Mineral	Storey	Top US Performers	Nevada
Excessive Drinking	15%	17%	19%	18%	16%	20%	13%	18%
Alcohol-Impaired Deaths	25%	29%	29%	52%	18%	67%	13%	32%
Mental Health Providers	460:1	600:1	890:1	670:1	1,110:1	1,010:1	1:330	540:1
Violent Crime	257	187	138	273	193	954	62	616
Social Associations	9.0	10.7	7.8	5.9	4.5	2.5	22.1	4.2
Drug Overdose Deaths	32	28	22	18	21	ND	10	21

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, and reports.

- **Housing.** There is an insufficient amount of affordable housing to cover the needs of the area. The high cost of housing is a challenge for those already living close to poverty and deters new professionals from moving to the area.
- **Families Face Separation for Treatment.** When youth need treatment out of the area, families can have difficulty staying connected and providing the support the child needs.
- **Lack of “Upstream” Support.** Lack of appropriate prevention and intervention results in overuse of Emergency Departments, Emergency Services, Law Enforcement) as well as poor outcomes for individuals involved.
- **Over-Prescribing.** Key informants identified concerns about doctors that over-prescribe; they were uncertain if new laws had yet had an impact.
- **Service for Co-Occurring Disorders.** Few services are available for people with co-occurring disorders.
- **In-Region Resources.** Key informants noted that it may not be possible for their county to have every support needed, but, if treatment was nearby – especially residential, it would reduce barriers to treatment.

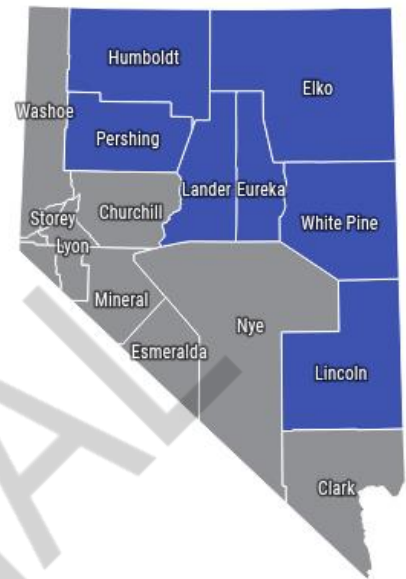
Opportunities

The following list of opportunities is not comprehensive but highlights some of key priorities identified by key informants, focus groups, or existing documents.

- Continued development and expansion of crisis intervention teams.
- Crisis intervention training for personnel at schools and those working with older adults.
- Continued professional development of the workforce on crisis intervention.
- Support and mechanism for transportation within and especially between counties.
- Continued partnerships within and among counties, including law enforcement, social work, county and city governments, schools, and treatment providers.
- Additional supports to help people that don't qualify for Medicaid but don't get paid enough for insurance (when it is not available through employers).
- Support to shelter people who are homeless – many communities do not have a shelter, and while numbers are small, there is nowhere for people to go.
- Expand the initial successes of telehealth, including telehealth that has taken place in jails.
- Continue to provide opportunities for rural communities to address workforce shortages through innovations in telehealth, remote (higher education), and supports for recruitment.

Frontier Nevada Region

This region is the largest in terms of square miles. Counties include Humboldt, Pershing, Lander, Eureka, Elko, White Pine, and Lincoln.



Population

	<i>Population</i>	<i>Percentage Under 18</i>	<i>Percentage 65 and Older</i>
Elko	52,649	28%	11%
Eureka	1,961	23%	17%
Humboldt	16,826	27%	13%
Lander	5,693	26%	15%
Pershing	6,508	16%	16%
White Pine	9,592	20%	17%
Total	93,229		

Selected Behavioral Health Indicators

Several county-level indicators are presented below. These indicators can be used to see areas of strength as well as priorities for attention. County data is compared to the nation's top performers in these indicators, as well as to the state as a whole.

	Elko	Eureka	Humboldt	Lander	Lincoln	Pershing	White Pine	Top US Performers	Nevada
Poor Mental Health Days (Average Number in past 30 Days)	4.0	3.9	4.1	4.1	4.1	4.0	4.3	3.1	4.5
Adult Smoking	18%	16%	18%	16%	16%	18%	20%	14%	16%

	Elko	Eureka	Humboldt	Lander	Lincoln	Pershing	White Pine	Top US Performers	Nevada
Excessive Drinking	23%	21%	23%	22%	20%	22%	21%	13%	18%
Alcohol-Impaired Deaths	31%	21%	32%	27%	47%	44%	19%	13%	32%
Mental Health Providers	1,680:1	ND	990:1	1,900:1	1,690:1	2,190:1	320:1	330:1	540:1
Violent Crime	371	359	335	674	44	841	338	62	616
Social Associations	5.4	0.0	12.3	11.9	4.0	4.5	3.1	22.1	4.2
Drug Overdose Deaths	12	ND	ND	ND	ND	ND	ND	10	21

Highlighted Issues for Attention

The following list of issues is not comprehensive but highlights some of the pressing concerns identified by key informants, focus groups, or reports.

- **Linguistic and cultural barriers to treatment.** There is one Spanish speaking provider in the Elko area making it difficult for Spanish speakers to receive treatment in their native language. Members of the tribal community are able to seek services through Indian Health Services, but specific tribal providers are available only on the colony.
- **Workforce shortages.** There are not enough providers to meet needs within communities. This includes residential and outpatient services.
- **Transportation (within and out of county).** For many, treatment has to take place out of the area. However, there is no longer a Greyhound Bus service for Interstate 80. When the person is involved with courts or law enforcement, they may be able to be transported by a deputy, but this means days that staff have to be out of the area.
- **Families Face Separation.** People have trouble accessing child care and related services. These problems are exacerbated for people who are faced with a choice between leaving the county for treatment, and staying to care for family. Women don't want to leave their children to go into treatment unless they have proper supports, as they are afraid they will not regain custody.

- **Documentation.** People who are undocumented are not able to be served through most programs.
- **Lack of “Upstream” Support.** Families may struggle with food, shelter, and bills. Attention and funding for substance use doesn’t address the preventative and protective factors.
- **Child Abuse and Neglect.** The impact of substance misuse within communities affects children.
- **Over-Prescribing.** Key informants identified concerns about doctors that over-prescribe; they were uncertain if new laws had yet had an impact.
- **Costs.** Some programs have a charitable fund to help people with financial barriers – however cost (and inadequacy of insurance) was noted as a critical barrier to receiving needed services.

Opportunities

The following list of opportunities is not comprehensive but highlights some key priorities identified by key informants, focus groups, or existing documents.

- Funding and support for higher levels of care within frontier areas.
- Support and mechanism for transportation within and especially between counties.
- Additional supports to help people that don’t qualify for Medicaid but don’t get paid enough for insurance (when it is not available through employers).
- Develop triage or 24-hour stabilization services (like Mallory Center in Carson City).
- Flexible funding for frontier communities to be able to address specific barriers.
- Revisit funding formula to provide more funding to rural communities.
- Support to shelter people who are homeless – many communities do not have a shelter, and while numbers are small, there is nowhere for people to go.
- Expand the initial successes of telehealth, including telehealth that has taken place in jails.
- Continue to provide opportunities for rural communities to address workforce shortages through innovations in telehealth, remote (higher education), and supports for recruitment.
- Support and build community programs that are currently serving the community well and that have a positive reputation for helping people.

Prevention and Treatment Goals, Objectives and Strategies

Workforce Development (SAP, SAT, MHS)

The Bureau of Behavioral Health Wellness and Prevention works with the Center for the Application of Substance Abuse Technologies (CASAT) to increase and expand training for workforce development in Nevada. Trainings are for mental health, treatment and/or prevention topics such as peer recovery support services, evidence based practices, co-occurring treatment, telehealth, trauma informed care, cultural diversity and special services for vulnerable populations such as adolescents. CASAT trainings are in the following formats: face-to-face workshops, self-paced and online courses, webinars, via tele-health, compressed video workshops, technical assistance, and via online video library. CASAT staff apply continuing education hours (CEU's) approval from appropriate licensing boards in Nevada. Currently, all CASAT sponsored workshops are approved by the following Nevada State Boards: Alcohol, Drug, and Gambling Counselors; Marriage and Family Therapists and Clinical Professional Counselors; Nursing; and Social Workers. Other national and state continuing education provider ships held by CASAT include: the National Board for Certified Counselors (NBCC); the National Association of Alcohol and Drug Abuse Counselors (NAADAC); California Association of Alcohol and Drug Abuse Counselors; California Association of Alcohol and Drug Educators; and California Board of Behavioral Science (this board licenses marriage and family counselors and clinical social workers).

Additionally, in an ongoing effort to address substance use prevention and treatment in the Silver State, Governor Steve Sisolak and the Department of Health and Human Services have continued a recovery Friendly Workplace Program to reduce the stigma of substance use and encourage workplaces to support treatment and recovery. This program encourages business owners to educate their staff on substance use and recovery; to develop policies and procedures to support recovery of an employee; and support employees who are caring for a family member in recovery. The program is designed to give business owners free resources — including training, policy guidance, and technical assistance — to become a recovery-friendly workplace.

BHWP continues to target Opioid Use Disorders through continued education and training. BHWP is working in tandem with CASAT to bring in the American Society of Addiction Medicine (ASAM) Treatment of Opioid Use Disorder course curriculum to Nevada. The ASAM course covers all medications and treatments for opioid use disorder, and it provides the required education needed to obtain the waiver to prescribe buprenorphine. The course is 8 hours; 4 hours of online learning followed by 4 hours of interactive learning. This training will

further develop knowledge and skills necessary to continue the treatment and education of treating opioid use disorders in Nevada.

Program Evaluation and Certifications (SAP, SAT, MHS)

The Bureau of Behavioral Health Wellness and Prevention contracts with the Center for the Application of Substance Abuse Technologies (CASAT) to continue with the established certification process, expand certification to identify specialty endorsements and increase quality oversight and monitoring. These services are used to create and sustain high quality services for treatment and prevention and ensure that all facilities are evaluated on a regular basis.

CASAT is currently working on expanding Division Criteria for certifications to include endorsements for women's services, medication assisted treatment and create a new certification for Supportive Housing. The Supportive Housing certification is the first step in addressing a reoccurring critical issue and needs for all Nevada's priority populations in all regions.

CASAT will also be developing an online tool for treatment location, to reflect certification status, accreditation and quality. This online tool will help the community locate a provider and assess quality based on patient satisfaction and the CASAT clinical monitor.

The State of Nevada has a comprehensive process to oversee substance use prevention and treatment programs statewide. Substance use prevention and treatment programs receiving any state or federal dollars through the Division of Public and Behavioral Health must be certified by the Division as required in Nevada Revised Statutes and Nevada Administrative Code NRS/NAC 458. Additionally, residential substance use treatment programs are required by NRS/NAC 449 to be licensed as an Alcohol and Drug Treatment Facility. NAC 458 focuses on operational, personnel, programmatic and clinical services and NAC 449 focuses on health and safety of facilities. NAC 449 Licensing is overseen by Health Care Quality and Compliance (HCQC). Substance Abuse Prevention and Treatment Agency (SAPTA) serves at the Signal State Authority (SSA) related to Block Grant Funding, its contractor the Center for the Application of Substance Abuse Technologies (CASAT) and HCQC work closely together related to oversight and quality improvement of certified and licensed programs. Medicaid Chapter 400 also requires any programs seeking reimbursement for substance use treatment or co-occurring treatment be certified through SAPTA/CASAT under NAC 458.

NAC 458 through Division Criteria has adopted ASAM Criteria as the mechanism to certify programs by ASAM levels of care. SAPTA contracts with CASAT to certify the following levels of care, Level 0.5, Level 1, Level 2.1, Level 2.5, Transitional Housing, Level 3.1, Level 3.5, Level 3.2WM, Level 3.5, Level 3.7 and Level 3.7WM. SAPTA also certifies programs as Co-Occurring Capable or Enhanced utilizing the Dual Diagnosis Capability in Addiction Toolkit (DDCAT). This is for both adolescent and adults. Additionally, Division Criteria provides additional requirements that are state specific and go beyond what ASAM requires. Examples of this are related to residential treatment levels, 3.2 Withdrawal Management, 3.5 and 3.7 Withdrawal Management. These enhancements include a minimum number of clinical hours in a residential program as well as a minimum number of hours of structured activities per the week as ASAM does not provide this detail for any levels above 3.1. There are also additional requirements for Withdrawal Management programs related to health and safety such as the number of times vitals need to be taken which is at least every 2 waking hours in a given day.

The quality improvement and clinical oversight process through certification is extensive. SAPTA Certified programs must develop comprehensive policies and procedures guiding the administrative and clinical implementation practices of the program. Staff must also be trained in these policies with evidence of competency through the programs continuous quality improvement plan. Additionally, SAPTA certified programs must provide screening and a comprehensive biopsychosocial that reviews medical, legal, family/social supports, substance use, employment/academic and psychiatric history. Additionally, a DSM 5 Diagnosis must be completed with specific criteria met for diagnosis with client centered examples for each criterion. An ASAM comprehensive 6-Dimensional Assessment also must be completed including each dimension by severity with an overall risk rating. These three components are utilized to discuss treatment recommendations with the client. It is essential that clients have input to treatment options and are fully involved in the direction of their care.

Utilization management is a key feature of the SAPTA certification process. Certified programs are required to document continued service criteria per ASAM Criteria requirements as clinically indicated rather than a periodic timeframe such as every 30 days. Clinical records are reviewed to determine if the client is meeting continued service criteria in real time and assure that services are either increased based on client's needs or reduced. Transfer criteria is also reviewed if the client needs to move from a lower level of care to a higher or from a higher level of care to a lower level of care. If the client has successfully moved through the continuum of care from highest level based on client centered needs to the lowest, typically Level 1, the clinical record must reflect the client has met the criteria for discharge. Discharge planning is a critical phase of treatment as well and SAPTA certification reviews that robust

discharge planning is taking place including the client completing a continuing care plan prior to discharge. Peer Support Specialist are utilized to provide support in the discharge planning and helps to insure the clients are being connected to outside supports prior to discharge.

It is critical that individual treatment plans reflect the needs identified in the assessment process with client feedback and participation. Treatment plans should reflect the client centered needs of the client related to substance use, mental health, legal, family, social, employment/academic and psychiatric at a minimum. SAPTA certification process reviews treatment plans to assure that they're congruence with issues identified through the assessment process.

Ongoing progress notes are reviewed to assure that the client's care is being managed in real time and relevant to the client's individual needs. The Golden Thread of clinical documentation is reviewed to assure that screening connects to the assessment, the assessment connects to treatment planning and that progress notes reflect the ongoing care of the client.

Division Criteria also has adopted the Dual Diagnosis Capacity Toolkit (DDCAT) to measure the level of integration SAPTA certified programs are at. Program at a minimum, per Nevada Medicaid Chapter 400, must be Co-Occurring Capable.

Care Coordination is critical related to client care. The follow regulations describes the specific requirements. Additionally, the DDCAT has extensive requirements related to care coordination.

NAC 458.0262 "Coordination of care" defined. ([NRS 458.025](#)) "Coordination of care" means the exchange of information between two or more parties providing a necessary service to a client to ensure that:

1. The client receives such service; and
2. The efforts of the parties are coordinated with one another in providing service to the client.

(Added to NAC by Bur. of Alcohol and Drug Abuse by R100-98, eff. 11-3-98; A by Bd. of Health by R120-04, 10-5-2004)

NAC 458.246 Provision of services to clients. ([NRS 439.200](#), [458.025](#)) The operator of a treatment program shall:

5. Provide, when appropriate, a referral to, and coordination of care with, any other provider of a service related to the treatment of a substance-related or mental health disorder

to address any identified problems of a client which cannot be resolved by a service provided by the treatment program.

NAC 458.272 Records regarding clients. ([NRS 439.200](#), [458.025](#), [458.055](#)) The operator of a treatment program shall:

2.

(i) Any additional information that should be taken into consideration during the planning of treatment, determination of appropriate referrals and determination of any need for coordination of care.

Capacity and Waitlist Monitoring (SAT, MHS)

The Bureau of Behavioral Health Wellness and Prevention is working with Nevada's Office of Public Health Informatics and Epidemiology (OPHIE) program to implement an online system to track and monitor waitlist and capacity with treatment providers. This system will ensure the state has an accurate system to monitor provider capacity and waitlists with real time information and easily accessible to hospitals and crisis services. The state has purchased an online bed registry and referral system; OpenBeds. OpenBeds is a system used to identify, unify, and track all behavioral health treatment and support resources in a single network. It facilitates rapid, digital referrals and fosters collaboration among mental health, substance use, social service and medical providers, which drives better patient treatment outcomes. In partnership with SAPTA, OPHIE is in the process of developing an implementation timeline and plan with treatment providers and hospitals. OpenBeds will be a valuable resource used to refer individuals to treatment through an online system.

Funding will also be provided to Crisis Services of Nevada's Substance Use Hotline. Crisis Support Services of Nevada provides 24/7, free, confidential, and caring support to people in crisis. The hotline is available 365 days a year, seven days a week to anyone experiencing personal crisis across Nevada. Last year, more than 67,000 individuals were served through the hotline, text line and in-person advocacy services. Crisis services of Nevada will also use OpenBeds to facilitate referrals.

The State requires all funding programs to provide priority treatment services to Pregnant Women (PW) and Pregnant Women and Women with Dependent Children (PWWDC). Although the Bureau of Behavioral Health Wellness and Prevention only has jurisdiction over programs that receive funding, every effort is made to encourage non-funded entities to follow the same best practice. All providers who treat PW and PWWDC are required to immediately contact the State for assistance if they are unable to place a PW or PWWDC,

offer interim services, and they cannot locate another facility available. This information is collected and managed by the State program. Both the State and Community Providers will use OpenBeds to facilitate referrals.

Adolescent Services (SAT, MHS)

Nevada Revised Statute (NRS) 458.125 requests the state to seek proposals for the continuation and/or expansion of services in Nevada to support adolescents and transitional age youth who need services. Services include, but are not limited to residential, outpatient, transitional, and evaluation services. The Bureau of Behavioral Health Wellness also intends to support the services for adolescents through educating the workforce, engage in school-based services and collaborate with child and family services. The focuses will help ensure adolescents in Nevada have access to high quality inpatient and outpatient SAT/MH treatment in state.

Pregnant Women (SAT)

The State requires all funding programs to provide priority treatment services to Pregnant Women (PW) and Pregnant Women and Women with Dependent Children (PWWDC). Although the Bureau of Behavioral Health Wellness and Prevention only has jurisdiction over programs that receive funding, every effort is made to encourage non-funded entities to follow the same best practice.

Nevada recently hired a Perinatal Substance Use Treatment Network Coordinator that will work with providers over the next couple of years to ensure they are meet the minimum required performance to serve pregnant women. She will perform site visits/monitors, review policy, provide technical assistance and assist in the development of new Division Criteria that will serve as a certification endorsement to providers who meet the minimum required performance to serve pregnant women. Certification will continue at 6 months to 2 years intervals depending on a facilities certification score.

Behavioral Health Wellness and Prevention works with Maternal and Child and Adolescent Health on its outreach efforts for PW and PWWDC. Past outreach efforts have primarily focused on bilingual radio and television commercials and advertisements. The State intends to increase its outreach efforts by targeting PW and PWWDC through an upcoming social media campaign platform, stickers, and magnetic bumper stickers.

The state is also working with partners to develop SBIRT and Methods of Treatment trainings, create a Perinatal Quality Collaborative, implement the CARA Plan of Care Act, and support the development of a toolkit for PW and PWWDC which will serve as a guide for parents and caregivers who have babies born with neonatal abstinence syndrome (NAS).

The goal of these services in Nevada is to ensure pregnant women seeking services are appropriately evaluated, practitioners are well educated about treatment options and to provide a toolkit for Sober Moms, Health Babies, ASTHO Omni.

IVDU/HIV/TB Risk (SAT)

Nevada's Office of HIV (NOH) within the Division of Public and Behavioral Health (DPBH) manages the state's Ryan White Part B (RWPB) and HIV Prevention Programs' (HIVPP). RWPB provides medical services, medications, and other ancillary services to Nevadans living with HIV. HIVPP staff coordinates HIV prevention strategies in collaboration with the local health authorities, HIV Prevention Planning Groups, HIV-infected and affected communities, state and local HIV prevention providers, and interested citizens to improve HIV prevention in Nevada. The HIVPP also oversees the Substance Abuse Prevention & Treatment Agency (SAPTA) HIV testing program since 2016.

In FFY 2016, SAPTA and NOH collaborated and developed the SAPTA HIV Testing Program, to assist SAPTA certified residential and/or transitional treatment facilities in offering rapid HIV testing at treatment locations statewide. Substance abuse counselors were trained to conduct rapid HIV testing at treatment location utilizing an "Opt-out" HIV testing model, where clients are offered a rapid HIV test. This follows the Centers for Disease Control and Prevention (CDC) recommendations for opt-out strategy.

Year 1 FFY17 (2016 – 2017)

1600 Rapid HIV Test with 11 Newly Diagnosed Confirmatory Positive.

Year 2 FFY18 (2017-2018)

2,873 Rapid HIV Test with 16 Newly Diagnosed Confirmatory Positive.

The SAPTA HIV Testing Program meets the SAMHSA early intervention services requirements by requiring HIV test counselors to make immediate referrals to the local health authority or community health nursing office for all new HIV positive clients. Please see the follow incidence and prevalence data as they relate to substance users.

The RWPB works in tandem with the HIVPP to ensure individuals highest at-risk for HIV are targeted for HIV testing. HIV positive individuals who are having difficulty accessing services (i.e., core and supportive) are linked into comprehensive medical/non-medical case management services and other ancillary services. Utilizing high impact prevention (HIP) and

evidence-based intervention strategies, our sub-recipients/providers work with their clients to overcome barriers to accessing HIV testing, care, and treatment.

Goal five (5) of the *Nevada Substance Abuse Prevention & Treatment Agency Strategic Plan 2017-2020* is to, “Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.” This goal is addressed with the partnership with the NOH to develop the SAPTA HIV Testing Program.

In the *Nevada Integrated HIV Prevention and Care Plan 2017-2021*, drug users (intravenous drug user and Substance Users/Abusers) co-infected with HIV are a growing priority population based on current epidemiological data. The SAPTA HIV testing program addressed this priority population by conducting targeted rapid HIV testing with Nevada’s two (2) Harm Reduction programs. Northern Nevada HOPES, “Change Point” and Southern Nevada “TracB Exchange” are Nevada’s syringe exchange programs. Beside syringe exchange and rapid HIV testing, they also offer counseling, testing for sexually transmitted diseases (i.e., STI, STD, Hepatitis, and Tuberculosis).

Some of the success stories from the SAPTA HIV testing program include, 27 newly infected HIV-positive (HIV+) individuals linked into medical care. SAPTA HIV Test counselors has also shared that their clients have been receptive to HIV testing, and learning risk reduction strategies, which enhanced the rapport between the counselor and client.

Tuberculosis (TB)

The Nevada Division of Public and Behavioral Health (DPBH) Tuberculosis (TB) Program was established to identify, control, and prevent tuberculosis in Nevada with the goal of tuberculosis elimination. The major duties of the DPBH TB program are identifying individuals with active tuberculosis disease (TB disease) and latent tuberculosis infection (LTBI), ensuring access to care for individuals with TB disease treatment and LTBI treatment, providing education on TB disease and LTBI to all stakeholders including the public, and conducting surveillance and epidemiologic studies of TB disease in Nevada. Recently, the DPBH TB program has partnered with the Nevada Bureau of Behavioral Health Wellness and Prevention (BBHWP) to provide TB education, identification, and treatment to a specific targeted population in Nevada, individuals with substance abuse or with a history of substance abuse, through the Substance Abuse Treatment and Prevention Block Grant (SAPT BG). The SAPT BG enables subgranted community partners identified by the DPBH TB program to conduct these activities in their local communities of Clark County, Washoe County, and Carson City. The numerous rural Nevada counties receive SAPT BG funded services through a separate collaboration between BBHWP and the Nevada Community Health Services.

The DPBH TB program's subgranted community partners have successfully met the goals of screening all individuals housed within inpatient substance abuse treatment facilities and have met the goals of diagnosing and counseling any positive LTBI cases. [Notable: Active TB cases have not been identified under this collaborative effort between BBHWP and DPBH TB since 2017; per Nevada law, all active cases of TB must be reported to the local health department and managed clinically and otherwise by the local health department.] The DPBH TB program believes emphasis should also be placed on individuals not residing in inpatient facilities. These individuals may encounter greater barriers to accessing care, socially and financially. As of June 2019, through the SAPT BG, the program has not met the activity goal of providing TB screening, education, diagnosis and treatment to individuals with substance abuse or with a history of substance abuse not affiliated with an inpatient program or facility. These individuals are equally at risk of progression from LTBI into active TB disease so identification is imperative. The challenge lies in efficiently managing DPBH TB program and subgrantee resources to provide this needed service. The DPBH TB program desires to increase their subgranted community partners' knowledge of a basic TB screening process to identify those at higher risk and requiring subsequent medical evaluation and testing. In this manner, larger numbers of individuals can be served and identified as needing linkage to care for both TB medical services and substance abuse treatment services or social services. In the future, the DPBH TB will work with subgranted partners to identify populations and geographic areas within their respective communities that demonstrate a higher prevalence of individuals with substance abuse and develop a plan for effectively accessing these populations for general TB screening and education without creating a negative stigma.

To assist with the goal of increasing TB activities in out-patient populations, the additional activity of delivering TB education to providers, staff, and outreach workers is essential. Properly informed medical and social services personnel, can be very effective. Training this service base will increase the capacity and efficiency of the program to provide TB screenings and linkage to care in the out-patient, as well as inpatient, populations. Furthermore, increasing knowledge of the TB disease process within this provider and service base will most likely result in increased acceptance of LTBI treatment. Increasing LTBI treatment and completion will reduce likelihood of progression to active TB disease and thus decreasing incidence in Nevada.

Behavioral Health Wellness and Prevention works with the NOH and TB programs to ensure the public, treatment providers and the public are aware of the risks of TB and HIV through IVDU. In addition to the previously listed services, BHWP will provide funding to our HIV

program to create a media campaign to disseminate materials that will provide education and training to provider staff and clients about the risks of HIV through IVDU.

Sustain Families and Support Reunification During Treatment (SAT)

Recovery-oriented care and recovery support systems assist individuals with SUDs. Recovery includes comprehensive treatment within four dimensions:

1. Health: Managing Disease or Symptoms and holistic healthy choices (mental/physical).
2. Home: Stable living environment
3. Purpose: Establishing sense of self, security and independence both personally and financially.
4. Community: Forming relationship with other (social/personal)

Recovery is a process and is supported by several aspects of life which includes self-exploration and building healthy relationships. It often involves family members who offer hope to individuals suffering from disease. Often times family members feel a multitude of different emotions which are not limited to: guilt, shame, sadness, and anger. Resilience and boundaries in recovery is an important aspect as is the support of family, friends and peers.

Nevada providers are currently working with Family Drug Court programs and the Division of Child and Family Services to reconnect children and families back together after in-patient treatment. Nevada lacks facilities that offer services that sustain families and supports reunification during treatment. Typically, we see that reunification doesn't happen until after inpatient treatment. Programs offer transitional living environments for patients as part of the continuum of care rarely offer those services with reunification for children or family members. Recognizing that being reintegrated into the family can have significant barriers and triggers, especially when spouses and children may also be active drug users, there is domestic violence present in the home, and other unhealthy family dynamics, BHWP intends to expand services to the entire family system and a portion of that care may be needed in a controlled environment. The state will support an increase in treatment capacity for families to stay together during treatment and/or reunification during recovery. First, facilities will be evaluated to determine their current capacity and ability to reunify and serve families during treatment. Providers who meet the minimum capacity requirements will have an opportunity to expand services/space based on the data.

Increase the Prevention Set-Aside to 25% (SAP)

Behavioral Health Wellness and Prevention intends on increasing funding for primary prevention activities from 20% to 25% for primary prevention activities to allow state general

fund dollars to focus on tertiary prevention. Prevention activities will be implemented based on data driven decision through the Statewide Epidemiology Workgroup and the Multidisciplinary Prevention Advisory Committee (MPAC).

Expand Uncompensated Care (SAT, MHS)

Nevada was fortunate to be selected to participate in the 223 Demonstration program to develop and implement Certified Community Behavioral Health Clinics (CCBHC's). Under the demonstration, Nevada has three active CCBHC's: New Frontier Treatment Center in Fallon, Nevada (rural), Vitality Unlimited in Elko, Nevada (rural), and Bridge Counseling in Las Vegas Nevada (urban). The implementation of CCBHC's has expanded accessibility, availability and the scope of services available in the communities with CCBHC's. Under the Demonstration Program, CCBHC's expanded the scope of community based behavioral health agencies to include non-state plan services, such as chronic disease self-management, supported employment, and targeted case management for individuals with primary substance use disorders. In addition, CCBHC's in Nevada also have an expanded scope allowing them to provide state plan services in an integrated setting. This expanded scope includes Medication Assisted Treatment (MAT) and ambulatory withdrawal management, primary care services, 24/7 crisis intervention including mobile crisis, psychiatric rehabilitation services such as Basic Skills Training and Psychosocial Rehabilitation, Assertive Community Services, and family to family peer interventions.

Communities in which CCBHC's operate have benefited from greater access to behavioral health and primary care services including reduced unnecessary episodes of care in the emergency departments. CCBHC's have become essential safety-net behavioral health services providers in Nevada. While the demonstration program is set to end in July of 2019, Nevada is creating a State Plan Amendment for CCBHC's. CCBHC's are included in Governor Sisolak's budget for the 2020-2022 biennium budget for Medicaid.

Through a competitive Request for Application Process using Community Mental Health Services Block Grant funding, Nevada is currently providing training and technical assistance support an additional six providers in working towards meeting certification criteria. These non-profit agencies include outpatient behavioral health providers: Quest Counseling in Reno, Nevada (urban), Carson Community Counseling Center in Carson City, Nevada (rural), Rural Nevada Counseling in Silver Springs, Nevada (rural), and Bridge Counseling in Las Vegas, Nevada (urban). We have also included two Federally Qualified Health Centers: Northern Nevada Hopes in Reno, Nevada (urban) and FirstMed in Las Vegas, Nevada (urban). Vitality

Unlimited in Carson City, Nevada (rural) was awarded the SAMHSA CCBHC Expansion Grant and is included in the additional seven CCBHC's in the demonstration expansion.

Certified Community Behavioral Health Clinics (CCBHC) provide the needed framework to evolve the behavioral health system in Nevada, by increasing access to high-quality, coordinated care in communities, reforming the payment structure, and providing oversight and evaluation of outcomes.

States including Nevada are increasingly exploring new partnerships, funding strategies and policy innovations in their efforts to build their SUD service system capacity. As the need for SUD treatment grows, primary care clinics (PCCs) and Federally Qualified Health Centers (FQHCs) are partnering with traditional treatment providers to play an important role in capacity expansion efforts related to SUD care as they invest in new ways to deliver care in places where treatment options are in short supply (e.g. utilizing technology such as telehealth and telepsychiatry to enhance care for those with difficulty accessing care). By providing much needed SUD services to their patients, these primary care health centers are rising to the challenge associated with the dramatic increase in the prevalence of SUD and Opioid Use Disorders (OUD) over the past decade.

In both rural and urban communities in Nevada, scarcity of high-level professionals is one issue impacting the availability of services. This shortage is across every category of health care professional, but the lack of psychologists and psychiatrists is especially apparent. As new integrated care models are developed that provide better services for people who receive public benefits, a qualified and professional workforce is needed.

Given that treatment access is, in part, a function of affordability and availability, and availability is a function of provider capacity, transportation, and use of technology, it is important to identify solutions that take the sum of those elements into account when considering the best approach for expanding treatment services at every level of care. State partnerships are needed that include SAPTA, Medicaid and Nevada's health plans to ensure that reimbursement structures and policies don't unnecessarily limit options for consumers with provisions and riders that may affect eligibility and coverage conditions, including preexisting condition riders and lifetime limit clauses.

Behavioral Health Wellness and Prevention will continue to work with its state partners to identify solutions for treatment access and provider compensation. Continued funding is available for individuals who have barriers to accessing MH/SAT services. These services are covered by the SABG and MHBG's which leaves state general funds available for special projects and building capacity for services in Nevada's communities. BHWP is currently expanding the CCBHC program from 3 providers to 10. With this new clinic model, individuals

with a co-occurring disorder will have increased access to MH/SAT and limited medical services.

Outpatient detoxification and other needed core SUD crisis services include: mobile crisis services, 24/7 crisis hotlines, warm lines, and peer crisis services. Detoxification (detox) services are an important component in the treatment of SUDs, often serving as a gateway to longer term treatment. Detox includes a set of interventions designed to manage acute intoxication and withdrawal while minimizing the medical complications and/or physical harm caused by withdrawals from substance abuse. This process consists of three components: evaluation, stabilization, and fostering patient entry into substance abuse treatment. A successful detoxification program can be partly measured by the progression from detox to entry into and compliance with substance abuse treatment.

Over the next biennium, BHWP would like to expand funding to two new providers who have become a CCBHC that have not received SAT/MH funding in the past. Additionally, BHWP would like to create one crisis stabilization center and/or outpatient detox facility in both the North and South.

Definitions

Any mental illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet DSM-IV criteria. Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI.

https://www.samhsa.gov/data/sites/default/files/Nevada_BHBarometer_Volume_4.pdf

Behavioral Health: Refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA).

Benzodiazepines are a class of drugs primarily used for treating anxiety, but they also are effective in treating several other conditions. Familiar names include Valium and Xanax. They are some of the most commonly prescribed medications in the United

States. <https://www.webmd.com/mental-health/addiction/benzodiazepine-abuse#1>

Co-Occurring Disorder: People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated.

CCBHC: Certified Community Behavioral Health Clinics. CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing or contracting with partner organizations to provide different types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

Crude death rates equal the total number of deaths during a specific year for a given cause of death (i.e. heroin overdose), divided by the population and multiplied by 100,000.

DPBH: Division of Public and Behavioral Health.

Fentanyl is an extremely potent synthetic opioid. It can be prescribed for pain but is also a common contaminant in unregulated drugs. 50 times stronger than heroin, is responsible for a growing number of overdose deaths each year. Typically manufactured as a white powder, it can be mixed into other drugs such as heroin and cocaine without the user knowing, but with extreme consequences. <http://www.latimes.com/health/la-me-ln-fentanyl-test-strips-20180531-story.html>

NAC: Nevada Administrative Code.

NRS: Nevada Revised Statutes.

Person-and Family-centered Planning: According to SAMHSA, “Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible.”

Prevalence: is a measure of disease that allows us to determine a person's likelihood of having a disease. Therefore, the number of prevalent cases is the total number of cases of disease existing in a population.

Recovery Oriented System of Care (ROSC): a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SABG: Substance Abuse Block Grant. Federal grant administered by SAPTA.

SAMHSA: Substance Abuse and Mental Health Services Administration.

SAPT Grant: Substance Abuse Prevention and Treatment Grant. See SABG.

SAPTA: Nevada’s Substance Abuse and Treatment Agency.

SED: Serious emotionally disturbed.

SSA: Single state agencies (SSAs) and state mental health agencies (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. (Substance Abuse and Mental Health Services Administration., 2015).

Suicidal Ideation: While the definition of suicide is well understood, several other important concepts are important to share. First suicidal ideation means thinking or planning about

suicide. Among individuals it can be a passing thought, or part of a plan. Ideation does not include the final act of suicide (Pederson, 2018).

Suicidal Contagion: Another important concept in understanding suicide trends, especially among youth, is suicide contagion. Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors (U.S. Health and Human Services, 2014).

Serious mental illness (SMI) is defined as a diagnosable mental, behavioral or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to cause serious functional impairment in an individual's major life activities (going to work, school, interacting with family, etc.).

Serious emotional disturbance (SED) has been defined historically by the Substance Abuse and Mental Health Services Administration (SAMHSA) and released as a Federal Register notice. The SAMHSA definition was crafted in order to inform state block grant allocations for community mental health services provided to children with an SED and adults with a serious mental illness (SMI). <https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactChildSED-2016.pdf>.

Substance Use Disorder (SUD): According to SAMHSA, substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Suicide contagion: Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors (U.S. Health and Human Services, 2014).

Trauma-Informed Approach: According to SAMHSA, a trauma-informed approach is, "A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization" (Substance Abuse and Mental Health Services Administration, 2015).

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?
Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

The Division of Public and Behavioral Health (DBPH) and the Office of Analytics, under the Department of Health and Human Services (DHHS), has experience in data collection and performance measurement as demonstrated by several SAMHSA-funded projects, including the State Incentive Grant (SIG), Strategic Prevention Framework State Incentive Grant (SPF-SIG), the State Epidemiological Outcomes Workgroup (SEOW) and the CABHI Program. Nevada has a current state system that is able to report data at the client, program, provider, provider type, and funding level. The state's data collecting and reporting system for substance abuse and mental health is part of a larger system that include the Division of Child and Family Services (DCFS), the Division of Aging and Disability (ADSD), the Division of Health Care Financing and Policy (DHCFP – Medicaid), and Division of Welfare and Supportive Services (DWSS). The state is able to collect and report on measures at the individual client level, which includes diagnosis, clients served, while also protecting and not making client-identification available. Nevada has been collecting client-level data and working to improve and expand the ability to ensure validity, reliability, and continuity with data collection and evaluation measures.

Data Collection, Management, Analysis and Reporting

SAPTA is planning on onboarding the Web Infrastructure for Treatment Services (WITS) system to includes the acquisition of WITS and Clics (automated certification processes) data management systems. A major advantage of adopting WITS is the system's robust data collection capability. The adoption of WITS will enable the state to better collect and analyze uniform Treatments Episodes and Data Set (TEDS) data. Poor infrastructure related to the collection of this data, and data sharing, presents a barrier to comprehensive data collection and analysis. Internal analysis of complete TEDS and other data related to OUD in Nevada will allow the DPBH to better inform and evaluate programming.

WITS facilitates cooperation and collaboration among providers by enabling the sharing of client services information via the web, and includes robust billing capabilities and an integrated contract management module allowing for multiple forms of provider management and billing between the government entity and its community of providers. DPBH has signed data sharing agreements with the Board of Pharmacy for access to PMP data and with multiple law enforcement agencies for data related to substance use and mental illness in the criminal justice system. The addition of WITS is a logical next step to streamline treatment and recovery services, while improving data collection and management simultaneously.

In addition, SAPTA-funded treatment providers throughout Nevada collect client-level data at intake and throughout the course of treatment. Comprehensive information regarding the client's background, drug use, social situation, mental health and housing is exported for further analysis and generates a TEDS (Treatment Episode Data Set) report. Providers of substance abuse prevention and treatment services submit data to the state utilizing the state's Secure File Transfer Protocol (SFTP). This data is then compiled, tested, validated and submitted by the state's Data Analyst through the secure, web-based interface provided by SAMHSA, on a monthly basis. Providers use AWARDS, Methasoft, eClinicalWorks, AVATAR, NHIPPS and other

EHRs capable of providing all Government Performance Results Act (GPRA) performance measures: abstinence from use, housing status, employment status, criminal justice system involvement, access to services, retention in services, and social connectedness.

The DCFS utilizes AVATAR and has a statewide *Planning and Evaluation Unit* that utilizes existing data collection and analysis methods to obtain information on factors collected as part of the Uniform Reporting System for SAMHSA's Community Mental Health Block Grant. In addition, this Unit works to develop and implement statewide policies for children's mental health as well as monitors residential provider's implementation of policies required by licensing bodies. The Planning and Evaluation Unit collects data from residential providers in the community concerning client demographics, length of stay, medication management, crisis management, suicide attempts, discharge and departure conditions and trauma informed training of staff.

Nevada Statewide HMIS / MyAVATAR Database Integration - Through the strategic prevention enhancement project funded by SAMHSA in 2010, DBPH developed a comprehensive data warehouse system to incorporate the MHIS system data and generate user reports from it. The infrastructure enhancement created a 'common data communication model' to enhance coordination across database systems. Nevada has designed the Application Program Interface (API) communication platform to overcome barriers to quality data collection, analysis, and reporting. Historically, there have been challenges with non-integration among data systems, which have resulted in discrepancies with data reporting. The first phase of the API project involved the development of the communication platform. The API is a published specification outlining the types of initial data and formats that can be exchanged between systems. The second phase involved the development and maintenance of the API within the Clarity Human Services application. The Clarity Human Services application, which is utilized by the Nevada Statewide HMIS, is an exceptionally user-friendly, highly intuitive, and state of the art client management system that enables integration among and between infrastructures. The Clarity Human Services application instigated and facilitated the type of quality data collection, analysis, and reporting necessary to reach the DPBH goals. DPBH requires all partners funded by the Block Grant to utilize the HMIS.

The goal of the initial infrastructure expansion project was to use data to improve the efficacy of coordinated and targeted service delivery efforts by integrating data systems used by stakeholders in the community. Bridging the gap between them prevented duplication of client data and eliminated duplicate data entry efforts; increased coordination of service delivery between agencies and departments that use multiple data systems; provided longitudinal data analysis and performance measurement across multiple departments previously operating within their respective silos; reported performance and client outcomes across integrated systems; increased coordination between Departments and Agencies; streamlined application and referral processes; and developed and enhanced partnerships between public health and housing systems.

This quality communication platform provides comprehensive support for activities that unite public health and housing services, streamlined application and enrollment processes, as well as

those activities that foster the planning, development, and maintenance of recovery-oriented services. The updated performance measurement plan takes API from a substantial improvement in integration and process improvement to a vehicle for providing service to chronically homeless persons through the SOAR benefits specialists. The homeless population is a high utilizer of mental health and substance abuse services.

Office of Public Health Informatics and Epidemiology

The Office of Analytics along with the Office of Public Health Informatics and Epidemiology (OPHIE) records and analyzes reportable disease information, conducts interviews with infected individuals and their contacts, refers individuals for medical treatment, analyzes data from disease investigations, identifies risk factors, provides education and recommendations on disease prevention, and works in conjunction with appropriate agencies to enforce communicable disease laws. Reporting data includes, but is not limited to, vital statistics, morbidity, cancer, demographics, infection disease, sentinel event, and psychology. This includes a Health Statistics Portal. OPHIE also identifies and manages reportable diseases and Nevada Core Health Indicators. The OPHIE houses over 60 public and behavioral health datasets, including communicable disease (HIV, STD, TB, and others) registries, births, deaths, fetal deaths, abortions, marriages, divorces, cancer, mental health, substance use prevention and treatment, the Behavioral Risk Factor Surveillance Survey, Youth Risk Behavior Surveillance Survey, and others. Common elements between databases enable matching or linking of these databases in order to provide newly accessible and standardized information for analytical and programmatic purposes. Extracted databases derived from each database and linked databases are available for statistical data analysis. Analyses are compiled in a variety of reports, which are posted on the DPBH website, making the data available for program evaluation and planning and policy development.

Center for Health Information Analysis (CHIA)

Nevada implements data measures to improve quality of health, but also to evaluate cost savings from reduced use of inpatient psychiatric hospitalization, emergency rooms, residential treatment, and group care. Through the Center for Health Information Analysis for Nevada (CHIA), CHIA provides information on over 250 Nevada Healthcare facilities that submit summary utilization and financial data per state regulation. After all of the facilities have submitted their quarterly data, CHIA aggregates and formats the data. These include acute hospitals, non-acute hospitals, ambulatory surgical centers, skilled nursing/intermediate care facilities, imaging facilities and hospices. This includes, but is not limited to, emergency department admissions by diagnosis, psychiatric in-patient hospital admission, and residential treatment center out of state placement.

Medicaid Data Collection

The Division of Health Care Financing and Policy (DHCFP) [Nevada Medicaid] – provides baseline

data and updates insurance information to ensure that there is no duplication of services; or care being provided for Medicaid eligible recipients. DHHS is able to capture billing date for the managed care organizations (MCOs) that serve both Clark and Washoe County Medicaid recipients; Fee-For-Service (FFS) recipients in rural and frontier Nevada; and Care Management Organization (CMO) information for FFS recipients with identified chronic conditions. This data can capture client level data, provider, type of service provided, and demographics.

(SPARS)

Nevada utilizes the SPARS client-level measures for providing direct services at baseline, 6-month follow up and at discharge. Nevada ensures that data is entered into the SPARS web system with seven days of data collection. Specific information will be detailed in the reporting: mental illness symptomatology; employment; education; crime and/or criminal justice; housing; access; age; gender; race; and ethnicity; rate of re-admission to psychiatric hospitals; social support; and client perception of care. Nevada has been expanding use of process and outcome evaluation to guide the development of behavioral health services and the system of care. The Nevada system of care is built on: formative implementation evaluation to monitor the process and success of initiating plans and programs, strengths, needs, culture and gaps analysis to determine how well the current system is addressing the needs of children and families in Nevada. Process and fidelity assessments are used to determine if services and system development meet performance standards and expectations. Outcome evaluation is used to determine the effectiveness and cost impact of the services we provide.

Data Measure DCFS Collects

Admissions and Discharges	Social Connectedness and Functioning (NOMS)	Consumer Survey	Trauma History
Age (birthdate)	Substance Abuse	CBCL	Danger to others
Gender	Diagnosis	BERS	Fire setting &
Race	SED	SDQ	Developmental History
Ethnicity	SED & Dual	Youth Self Report	Psychiatric history
Service Setting	Living Situation	Referrals to PEP	Treatment history
Zip Code	Juvenile justice (arrests)	Disposition	Sexual history
Funding Source	Expulsions	Client Satisfaction (POT)	Child & family team
Custody Status	Suspensions	Client Satisfaction - DC	Substance Abuse history
Legal Status (Prob/Parole)	Entering Stabilization	ER Visits	Mental health status
Special Ed Status	Stabilization sessions	Psychiatric Admissions	Medications
Language	CAFAS	Outpatient MH	PECFAS
LOS – IP	CASII & ESCII	Behavioral Symptomology	Access to firearms
Readmissions at 30 &	CAT	Self-Harm Factors	Global Assessment

Data-driven Quality Improvement

To ensure continually quality improvement and integrity of the data, DHHS data and evaluation teams verify and ensure that data are synthesized, analyzed, reviewed, and reported on a quarterly basis, with the priority of assessing 1) a) the progress of the state on the development of a plan; b) sustaining and expanding partnerships; c) developing streamlines applications; d) implementing and expanding the peer navigation network; e) the individuals serviced are transitioning to independence; f) disparities in service access; g) disparities in service use; and h) client outcomes change over time. In addition, DPBH focuses on access to care and if Nevada is improving in mental health or substance abuse.

Draft Measures for Client Level Data

DCFS, SAPTA, DPBH and the Office of Analytics can currently collect and report on proposed client level data, without client identifying information, on the following measures:

11. Reduced Morbidity (Abstinence from Alcohol Use)

Employment

Attendance

21. Housing.

The other proposed measures have some variability between organizations and their current collection. There are some proposed measure that are not currently collected or reported on at all.

Barriers to Expanding Client Level Data

To meet the on-going needs of quality data collection to promote health surveillance, Nevada is prepared to evaluate current data collections platforms and augment data collection efforts. DHHS has evaluated the current data collection systems strengths and barriers to expanding CLD to address the proposed measures. The evaluation of current data collection systems identified several barriers that would need to be addressed in order for Nevada to expand CLD to meet specific data reporting requirements. These barriers are not insurmountable but present some challenges to the current data collection methods. One such barrier is whether measures are “Self-Reported” or have to be verified or attained from another source. For example, “Percentage of individuals 12 or older who used any tobacco product in the past 30 days” or “Number of DWI and DUI arrests”. If self-report is acceptable method of gathering this type of data, these CLD elements could be easily captured in our systems.

Intervals of frequency may also pose difficult to meet if the requirements within the data collection timeline do not match with the intervals of interaction with clients. For example, some medication clinic patients may only be seen every 90 days. If some of the data required to collect is needed every 30 days, we may not be able to easily capture the data. Another concern regarding frequency of data collection is the potential for clients to decline providing data if they must be asked certain questions as part of each clinical interface. Client level data needs to be

relevant to clients in order for us to be able to request that they provide data on an on-going basis.

The acceptable methods of data collection and data entry may pose some challenges for implementation. We are currently exploring platforms that would allow clients to use technology-based questionnaires that would import data directly into our EHR. If the demands of data collection and entry fall to staff, it may strain already limited resources of staff time. While Nevada has internal expertise to augment our existing EHR to capture needed data, the degree to which our EHR's would need to be changed may present financial barriers to implementation. Significant resources would need to be allocated to create, test, and maintain these data tables and ensure data quality was maintained.

Nevada will look forward to collaborating with SAMHSA as these CLD elements are explored further. We are confident that any additional data elements required for reporting by SAMHSA will be meaningful and assist us in monitoring quality and measure outcomes of clients and the timeline to implement additional CLD elements will be collaborative and well-planned.

NOT FINAL

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Workforce Development
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, ESMI, PWID

Goal of the priority area:

To increase and expand the workforce in Nevada for substance use, mental health and prevention. To provide employers with tools to create a recovery friendly workforce.

Objective:

To provide training opportunities for individuals in the field for treatment and/or prevention.

Strategies to attain the objective:

Use MHBG and SABG funds to partner with the Center for the Application of Substance Abuse Technologies to create and host in-person, online and self-passed learning opportunities.

Priority #: 2
Priority Area: Certifications
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, ESMI, PWID

Goal of the priority area:

To continue with the established certification process, expand certification to identify specialty endorsements and increase quality oversight and monitoring.

Objective:

To create and sustain high quality services for treatment and prevention. To ensure all facilities are evaluated on a regular basis for fidelity and clinical appropriateness.

Strategies to attain the objective:

Use MHBG and SABG funds to partner with the Center for the Application of Substance Abuse Technologies (CASAT) to continue and expand the certification process. CASAT currently certifies and monitors all co-occurring treatment facilities and prevention providers. SABG and MHBG funds will be used to maintain current certification and expand certification to include an endorsement for women's services, medication assisted treatment and create a new certification for supportive housing services.

Develop an online tool for treatment location, to display results from the patient satisfaction survey's and TEDS data. This online tool will help the community locate a provider and assess quality based on patient satisfaction and the CASAT clinical monitor.

Priority #: 3
Priority Area: Capacity and waitlist monitoring
Priority Type: SAT, MHS
Population(s): SMI, SED, PWWDC, ESMI, PWID

Goal of the priority area:

To implement an online system to track and monitor waitlist and capacity with treatment providers.

Objective:

To ensure the state has an accurate system to monitor provider capacity and waitlists with real time information and easily accessible to hospitals and crisis services.

Strategies to attain the objective:

The state has purchased an online bed registry and referral system. Once implemented with treatment providers, hospitals will be able to refer individuals to treatment through the online system. Providers will be responsible to update and maintain the system with real time information. Funding will be provided to Crisis Services of Nevada for the substance use hotline where they will also have access to the system to facilitate referrals.

Priority #: 4

Priority Area: Adolescent services

Priority Type: SAT, MHS

Population(s): SED

Goal of the priority area:

To increase services for adolescents through increasing the workforce, engage in school-based services and collaborate with child and family services.

Objective:

To ensure adolescents in Nevada have access to high quality in patient and out patient SAT/MH treatment in state.

Strategies to attain the objective:

Work with the local university's to create pathways for professional development through fellowships. Fund providers who have the capacity to engage with the school districts to allow therapists to delivery services in the school setting, and continue to fund services through child and family services for children with SED.

Priority #: 5

Priority Area: Pregnant women

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

To ensure pregnant women seeking services are appropriately evaluated, practitioners are well educated about treatment options and provide a toolkit for mothers.

Objective:

To increase knowledge and resources for medical professionals, families, and pregnant women regarding treatment options and treatment facilities.

Strategies to attain the objective:

Training will be provided to professional to complete the SBIRT, support development for a toolkit and methods of treatment.

Priority #: 6

Priority Area: IVDU/HIV Risk

Priority Type: SAT

Population(s): EIS/HIV

Goal of the priority area:

Provide opioid use education via ASAM

Objective:

To ensure the public, treatment providers and the public are aware of the risks of HIV through IVDU.

Strategies to attain the objective:

Provide funding to our HIV program to create a media campaign to disseminate materials.

Priority #: 7

Priority Area: Sustain families and support reunification during treatment.

Priority Type: SAT

Population(s):

Goal of the priority area:

To increase capacity for families to stay together during treatment and/or reunification during recovery.

Objective:

To ensure families are able to stay together during treatment and/or be reunified during recovery.

Strategies to attain the objective:

Evaluate capacity in current treatment facilities for their ability to serve families during treatment, use TEDS data to determine need and work with providers to expand services based on the data.

Priority #: 8

Priority Area: Increase the prevention set aside to 25%

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To increase funding for primary prevention activities.

Objective:

To increase funding for primary prevention activities to allow state general fund dollars to focus on tertiary prevention.

Strategies to attain the objective:

Implement prevention activities based on data driven decision through the SEOW and the MPAC.

Priority #: 9

Priority Area: Assertive Community Treatment

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Increase ACT teams in Nevada.

Objective:

To provide a team-based treatment model that provides multidisciplinary, flexible treatment and support to individuals with SMI 24/7.

Strategies to attain the objective:

Work with the Community Behavioral Health Clinics to stand-up their ACT teams, provide training, monitoring and technical assistance to ensure fidelity.

Priority #: 10

Priority Area: Expand uncompensated care

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID

Goal of the priority area:

Expand uncompensated care to new providers.

Objective:

To provide funding for individuals who have barriers to accessing MH/SAT services. Nevada is currently expanding the CCBHC program from 3 providers to 10. With this new clinic model, individuals with a co-occurring disorder will have increased access to MH/SAT and limited medical services.

Strategies to attain the objective:

Expand funding to two new providers who have become a CCBHC that have not received SAT/MH funding in the past.

Priority #: 11

Priority Area: Early Serious Mental Illness

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Increase the ESMI program from one provider in the rural area to three total providers adding two in the urban areas.

Objective:

To train providers in the urban areas to provide early identification and treatment to individuals with ESMI.

Strategies to attain the objective:

A competitive funding announcement will be released soliciting providers to participate in the ESMI program. Funding will go to community providers to ensure individuals continuity of care as they transition from adolescence to adulthood without having to find a new treatment provider. Collaboration with child and family services, state MH providers and the community providers selected to implement ESMI services to ensure access to care.

Priority #: 12

Priority Area: Synar

Priority Type:

Population(s): PP

Goal of the priority area:

Compliance with Synar

Objective:

To ensure compliance with Synar and to reduce the retail violation rate of tobacco sales to individuals under the age of 18.

Strategies to attain the objective:

Create a Synar position to increase subject matter expertise, increase efforts to reduce the retail violation rate through merchant education, increase funding to prevention coalitions to address tobacco use among youth with the increase in prevention set aside from 20% to 25%.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$11,050,876		\$0	\$0	\$2,721,523	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$850,067		\$0	\$0	\$0	\$0	\$0
b. All Other	\$10,200,809		\$0	\$0	\$2,721,523	\$0	\$0
2. Primary Prevention	\$4,250,337		\$0	\$0	\$1,942,674	\$0	\$0
a. Substance Abuse Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$425,034		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$425,034		\$0	\$0	\$0	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$850,067		\$0	\$0	\$0	\$0	\$0
10. Total	\$17,001,348	\$0	\$0	\$0	\$4,664,197	\$0	\$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

NOT FINAL

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention [†]		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$727,866	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$0	\$0	\$0
7. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$6,186,861	\$0	\$0	\$0	\$0	\$0
9. Administration (Excluding Program and Provider Level)***		\$363,933	\$0	\$0	\$0	\$0	\$0
10. Total	\$0	\$7,278,660	\$0	\$0	\$0	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

NOT FINAL

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	5000	209
2. Women with Dependent Children	33000	3767
3. Individuals with a co-occurring M/SUD	6000	1277
4. Persons who inject drugs	17000	1553
5. Persons experiencing homelessness	1501	577

Please provide an explanation for any data cells for which the state does not have a data source.

*Women with Dependent Children: Women of child-bearing age (15-44 years) were counted. **20% of the homeless population has SU and/or MH problems: 20% * 7,544 (Homeless in 2017) = 1,501 <https://www.usich.gov/homelessness-statistics/nv> From NSDUH 2017: Estimated in need: Number of Pregnant Women, Women of Child-Bearing Age, Individuals with Co-Occurring SA & MH and Persons who Inject Drugs <https://pdas.samhsa.gov/#/survey/NSDUH-2017-DS0001> From TEDS 2017: Number in Treatment: <https://pdas.samhsa.gov/#/survey/TEDS-A-2017-DS0001> OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$11,050,876
2 . Primary Substance Abuse Prevention	\$4,250,337
3 . Early Intervention Services for HIV**	\$425,034
4 . Tuberculosis Services	\$425,034
5 . Administration (SSA Level Only)	\$850,067
6. Total	\$17,001,348

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

NOT FINAL

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Strategy	A	B
	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	\$4,531
	Selective	\$44,431
	Indicated	\$703,642
	Unspecified	\$1,806
	Total	\$754,410
2. Education	Universal	\$360,400
	Selective	\$123,567
	Indicated	\$197,590
	Unspecified	\$6,230
	Total	\$687,787
3. Alternatives	Universal	\$272,892
	Selective	\$39,721
	Indicated	\$103,814
	Unspecified	\$111,448
	Total	\$527,875
4. Problem Identification and Referral	Universal	\$68,114
	Selective	\$61,229
	Indicated	\$27,761
	Unspecified	\$71,543
	Total	\$228,647
	Universal	\$711,991

5. Community-Based Process	Selective	\$31,863
	Indicated	\$413,115
	Unspecified	\$63,880
	Total	\$1,220,849
6. Environmental	Universal	\$83,006
	Selective	\$4,357
	Indicated	\$134,839
	Unspecified	\$64,347
	Total	\$286,549
7. Section 1926 Tobacco	Universal	\$296,563
	Selective	\$0
	Indicated	\$81,000
	Unspecified	\$0
	Total	\$377,563
8. Other	Universal	\$130,878
	Selective	\$0
	Indicated	\$35,779
	Unspecified	\$0
	Total	\$166,657
Total Prevention Expenditures		\$4,250,337
Total SABG Award*		\$17,001,348
Planned Primary Prevention Percentage		25.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	\$1,928,375
Universal Indirect	\$319,254
Selective	\$305,168
Indicated	\$1,697,540
Column Total	\$4,250,337
Total SABG Award*	\$17,001,348
Planned Primary Prevention Percentage	25.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

NOT FINAL

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input checked="" type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

NOT FINAL

Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	\$445,080		
2. Infrastructure Support	\$300,000		
3. Partnerships, community outreach, and needs assessment	\$100,000	\$75,500	
4. Planning Council Activities (MHBG required, SABG optional)	\$25,000	\$25,000	
5. Quality Assurance and Improvement	\$61,178	\$147,754	
6. Research and Evaluation	\$33,408	\$35,000	
7. Training and Education	\$387,558	\$304,510	
8. Total	\$1,352,224	\$587,764	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019

MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	\$19,000
2. Infrastructure Support	\$475,318
3. Partnerships, community outreach, and needs assessment	\$120,000
4. Planning Council Activities (MHBG required, SABG optional)	\$10,000
5. Quality Assurance and Improvement	\$950,171
6. Research and Evaluation	\$50,000
7. Training and Education	\$677,000
8. Total	\$2,301,489

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Footnotes:

Non Direct allocations are as follows:

Information Systems: Avatar licensing for EHR

Infrastructure Support: Contract with Dr. Ryst (Works with EHR system Development),, Crisis Services of Nevada and NAMI

Partnerships, Community Outreach and Needs Assessment: Laptops, Staff Travel, and Marketing

Planning Council Activities: Behavioral Health BPAC Advisory Board support (Fringe; travel)

Quality Assurance and Improvement: Certification and Reviews for Supportive Housing, CCBHC review and support and Telemedicine program (Nevada ECHO)

Research and Evaluation: Performance measurement and research done by provider.

Training and Education: Ongoing training needs

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²² Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.²⁷ Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³⁰ Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁶ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.³⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²² BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.
Nevada was selected as a demonstration state for the Certified Community Behavioral Health Clinics (CCBHC). Nevada is in the process of expanding the number of CCBHCs from 3 clinics to 10. These clinics provide behavioral health services and some primary health screenings. Two of the new CCBHCs are also Federal Qualified Health Centers (FQHC) that will provide both behavioral health and primary health services.
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.
The CCBHC's provide services and supports for individuals with co-occurring disorders and their families. The CCBHCs have established a perspective payment rates under Medicaid. The CCBHCs are licensed by the Bureau of Health Care Quality and Compliance.
3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? Yes No
b) and Medicaid? Yes No
4. Who is responsible for monitoring access to M/SUD services by the QHP?
The CCBHC's are monitored as a Medicaid provider type, licensed under the Bureau of Health Care Quality and Compliance and receive ongoing certification monitoring through the Center for Application of Substance Abuse Technologies CASAT). They are required to submit performance measure data.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes No
6. Do the M/SUD providers screen and refer for:
 - a) Prevention and wellness education Yes No
 - b) Health risks such as
 - ii) heart disease Yes No
 - iii) hypertension Yes No

- iv) high cholesterol Yes No
- v) diabetes Yes No
- c) Recovery supports Yes No
- 7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes No
- 8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes No
- 9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? Individuals who live in rural and frontier areas of Nevada often struggle with access to services. Nevada experiences a shortage with licensed professionals.
- 10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for [Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)⁴⁵.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁴⁷. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁴⁸. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
 - a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:



Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵³ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)⁵⁵ was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁴⁹ United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵⁰ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵¹ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? Yes No
2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) Leadership support, including investment of human and financial resources.
 - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) Use of financial and non-financial incentives for providers or consumers.
 - d) Provider involvement in planning value-based purchasing.
 - e) Use of accurate and reliable measures of quality in payment arrangements.
 - f) Quality measures focus on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (**RAISE**) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? Yes No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

CLINICAL STAGING:

EARLY INTERVENTIONS for ESMI and FIRST EPISODE of PSYCHOSIS

Expected Rates of Early Stage Serious Mental Illness and First Episode of Psychosis:

Identifying populations at risk for mental disorders, in general, and for specific categories of mental disorders, in particular, requires consideration of estimates of prevalence and incidence, as well as ages at which disorders first appear. Prevalence rates provide the proportion of individuals in a specific population who have a particular disease or characteristic during a specified period of time. Incidence rates provide the proportion of new cases of illness within a specific population during a specific period of time. The difference between the two rates is that prevalence rates include both pre-existing cases and new cases, while incidence rates include only new cases. Incidence rates are uniquely informative for early intervention treatment approaches because of the need to identify and enroll individuals at the first onset of their illness. Age of onset distributions provide ranges of chronological ages within which most cases of an illness are first diagnosed. The three types of estimates provide information that is essential for planning effective

community outreach strategies to identify individuals for recruitment and enrollment in intervention services for early stage serious mental illness and first episode of psychosis.

The median rate of new cases (or incidence) each year for schizophrenia, one of the principal psychotic disorders, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 years (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). The age range for capturing cases of first episode of psychosis therefore extends from middle adolescence and early adulthood through middle adulthood. Based on these findings, the anticipated incidence rate of schizophrenia for Nevada was estimated as 307 new cases during each fiscal year, as follows:

$$(2,022,031) (15.2/100,000) = 307.4.$$

The State does not collect information regarding the rate of new cases of mental disorders per year, so this estimate was determined using the best available information, including the following:

- (1) Population estimates for 2018 (as of July 1) for Nevada residents ages 14 to 64: 2,022,031 (Source: U.S. Census Bureau, Population Division (Release Date: June 2019).
- (2) Selection of the age range for population estimation was informed by age of onset distributions for schizophrenia described above.
- (3) Median incidence of schizophrenia of 15.2/100,000 persons determined by McGrath et al. (2008).

Differential diagnoses for sub-populations with emergent Serious Mental Illness (ESMI):

The emotional health profile identified for Nevada's youth during 2017 indicated that more than one third (34.6%) had experienced noteworthy psychological distress during the prior twelve months, including the hallmark symptoms of depression with reduced functioning (Lensch, Martin, Zhang et al., 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report.) Defined as sadness and hopelessness that occurred almost every day for two weeks or more in a row and that interfered with their usual activities, an elevated number of Nevada's high school students endorsed having experienced this emotional disturbance compared to their age peers nationwide. The difference reached trend statistical significance. This same survey found that only one fourth of Nevada's youth reported having received help reliably (most of the time or always) for their experiences of disturbed mood.

Further challenges to the psychological well being of young Nevadans were reflected in the 18% who acknowledged deliberate self injuries, such as cutting or burning themselves on purpose without the intent to die, and the 30% who reported having lived with someone who was depressed, mentally ill or suicidal (Lensch, Martin, Zhang et al., 2017). Experiencing violence related behaviors on school property were additional stressors for Nevada's youth. Significantly more high school students in Nevada reported having been threatened or injured during the past year with a weapon on school property, such as a gun, knife or club. And significantly more students in Nevada, compared with their age peers nationwide, reported not going to school during the past 30 days because they felt unsafe at school or on their way to or from school.

It is likely that some of these adolescents experienced challenging life circumstances that produced strong adjustment reactions (mood disturbance, suicidal thoughts and behaviors, deliberate self harm), which peaked and then resolved successfully. It is also probable that other adolescents were experiencing the early stages of a first episode of psychosis (FEP) or an emerging serious mental illness (SMI), which in the absence of optimal interventions may progress to chronic and debilitating illnesses. As such, the year 2017 may have represented a critical period for a subset of Nevada's youth, and thereby afforded an opportunity for early interventions. The figure below (adapted from McGorry et al., 2010) illustrates the idea of chronic serious mental illness (SMI) as a dynamic process that evolves over time, and that begins as a diffuse constellation of features, characteristics and mild symptoms, which gradually cohere within syndromal boundaries. The objective of providing early interventions for individuals who are at risk for developing severe mental illness has a long history in the fields of psychiatry and psychopathology. It received renewed focus and vitality from the success achieved recently by the National Institute of Mental Health's (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) initiative (Heinssen, Goldstein and Azrin, 2014). In a comparison of comprehensive and usual community care for first episode psychosis, Kane et al. (2016) demonstrated the feasibility of implementing a comprehensive recovery-oriented, evidence-based intervention for first-episode psychosis that was carried out in community health clinics in the United States. Importantly, greater improvements in clinical and functional outcomes were observed for participants who received this comprehensive, multidisciplinary, team-based treatment.

The psychoses and other serious mental illnesses that include significant functional impairment represent debilitating conditions that are costly in terms of human suffering and societal economic burden. Regarding the latter, the United States societal economic burden of schizophrenia was estimated at \$155.7 billion for the year 2013, and included additional excess costs associated with unemployment, productivity loss due to caregiving, and direct health care costs (Cloutier et al., 2016). Early intervention services may provide an avenue to mitigate the magnitude of suffering and the extent of economic burden (Mihalopoulos et al., 2009). Early interventions for early serious mental illness (ESMI) may be beneficial by reducing the duration of untreated illness, a factor known to be associated with treatment response and clinical course of psychotic disorders (Addington et al., 2015; Kane et al., 2016). Statewide implementation of evidence-based early interventions for individuals with early stage serious mental illness is a strategic priority for Nevada's mental health system during the next biennium.

Figure 5: The Trajectory of Serious Mental Illness (SMI) as a Dynamic, Emerging Process (adapted from McGorry et al., 2010)

Early Stage: mild, non-specific symptoms Mid-to-Late Stages: full disorders, moderate-severe symptoms

Access to Services for Nevada's Residents with Early Serious Mental Illness (SMI) and First Episode Psychosis (FEP)

Historical Overview of First Episode of Psychosis Services in Nevada: 2015-2017:

In July 2015, Nevada introduced a newly established service of early interventions for residents experiencing a first episode of psychosis (FEP). This service was supported with the 10 percent MHBG set aside and sub-contracted through Nevada Division of Child and Family Services to private sector entities, including The Children's Cabinet and its community partners. This new service offered interventions for individuals diagnosed with FEP in the urban counties of Washoe and Clark in northern and southern Nevada. Known as Enliven, the service involved a team-based, multi-component approach that included intensive case management, education and supported employment services, pharmacotherapy and medication management by psychiatrists, and psychotherapy for patients and family members. An array of social supports services was also provided, including housing assistance, access to food banks, and financial, transportation and clothing assistance. During that initial period of program development, Enliven included a number of key components from the coordinated specialty care model developed by the National Institute of Mental Health (NIMH) through the RAISE (Recovery After an Initial Schizophrenia Episode) initiative (Heinssen R, Goldstein AB, and Azrin ST, 2014). The table below shows the number of individuals served by Enliven beginning with its inception in July 2015 and through May 2017.

Number of Nevada Residents Served by Enliven, 2015-2017

Northern Nevada, Washoe County Nevada Residents Served

(n)

Brief Contact 25

Screening and Evaluation:

Pending

Referred Out

0

43

Excluded (Did not meet criteria) 0

Active Cases of FEP 31

Southern Nevada, Clark County Nevada Residents Served

(n)

Brief Contact 5

Screening and Evaluation:

Pending

Referred Out

6

0

Excluded (Did not meet criteria) 6

Active Cases of FEP 9

Source: Enliven Service, The Children's Cabinet, Nevada Division of Child and Family Services, May 18, 2017

RECENT ADVANCES

FIRST EPISODE OF PSYCHOSIS SERVICES IN NEVADA, 2018-2019

Major Milestones and Program Achievements, 2018-2019: The Nevada State Early Treatment Program for individuals who are experiencing a first episode of psychosis (FEP) and who live within the State's rural and frontier counties was launched within the past calendar year. During February 2019, this early treatment program began to accept referrals within two of our rural and frontier behavioral health regions across northern Nevada. As of July, 2019, enrollment includes 6 active cases and 1 inactive case. This follows a readiness assessment and vetting of the non-profit community provider home site, Carson Tahoe Behavioral Health Services and Hospital, which is located physically in Carson City. The plan is for this program to take referrals and provide treatment for individuals experiencing FEP from Carson City, which is the State

Capital, and the counties of Storey, Churchill, Mineral, Lyon, Douglas, Pershing, Humboldt, Lander, Eureka, White Pine and Elko. Collectively, these two behavioral health regions have approximately 100,000 population. Using the McGrath et al. (2008) estimates, we can therefore anticipate approximately 15 new cases (or incidence) of FEP each year within this geographic area.

We selected NAVIGATE, the coordinated specialty care (CSC) Early Treatment Program as the evidence-based practice for FEP in Nevada, and have been working closely with Susan Gingerich, Coordinator for the national NAVIGATE Training Team. Based in Philadelphia, Susan travelled to Nevada in June (2018) and provided a general audience session for our statewide community of mental health professionals. This informational session lasted more than three hours and included an overview of the NIMH supported RAISE model and initiative, as well as a presentation of the clinical data reported by John Kane and his collaborators, which demonstrate the feasibility and efficacy of NAVIGATE for community mental health clinics. This general audience session was followed by a half-day of pre-training orientation by Susan for a smaller group that included the Director of Clinical Services and clinical staff of Carson Tahoe Behavioral Health Services and Hospital.

A surprising and welcome outcome of these readiness and preparatory activities was the high level of excitement expressed by our professional mental health community about the early treatment program for ESMI. Importantly, several of our Nevada State Legislators also expressed interest and strong support.

The next series of trainings were provided by the entire NAVIGATE Training Team, which travelled to Nevada during January 2019. Similarly to our pre-training orientation in June (2018), Susan Gingerich again provided a general audience session for our statewide community of mental health professionals and other interested individuals. Again, this general audience presentation was well attended and participants were highly enthusiastic about their experience. The remainder of the 2.5 day training conference focused on the separate NAVIGATE early treatment components and included didactic presentations and break-out sessions on individual psychotherapy, supported employment and education, family education, and pharmacotherapy and primary care coordination. The backgrounds of the Training Team and brief descriptions of the NAVIGATE early treatment components are provided below:

1. Psychotherapy based on Individual Resilience Training (IRT), an evidence-based, manualized psychosocial treatment program. Training for this component was provided by Piper Meyer-Kalos, Ph.D., Licensed Psychologist, who is Executive Director for the Minnesota Center for Chemical and Mental Health (MNCAMH). Dr. Meyer-Kalos specializes in working with persons with serious mental illness and first episode of psychosis. Since 2009, Dr. Meyer-Kalos has been part of the psychosocial development team of the RAISE project and has co-lead the development of the individual therapy component (IRT).
 2. Supported Employment and Education (SEE) Services assist in a recovering person's return or initial entry to work or educational settings and facilitate achievement of expected vocational and educational roles. SEE specialty staff aim to integrate vocational and mental health services and to function as a CSC Team liaison with educators and employers. Training for this component was provided by Shirley M. Glynn, Ph.D., Licensed Clinical Psychologist and faculty member of the UCLA Department of Psychiatry and Biobehavioral Sciences. Dr. Glynn's clinical and psychosocial research has focused on the importance of the family environment in recovery from psychiatric illnesses such as schizophrenia and bipolar illness. Dr. Glynn conducted much of the SEE training for the NAVIGATE component of the NIMH-supported RAISE project.
 3. Family Education Program teaches relatives and other supporting individuals about psychosis and its treatment with the aim of strengthening their ability to help in patients' recovery. The foundation of this treatment component includes recognition that an initial episode can have a devastating effect on a patient's relatives and other close relationships. Moreover, family relationships present complexities that impact treatment outcomes in significant ways. The research literature is clear about the relationship between family conflict and worse clinical outcomes for patients, but the research is also informative about the association between family members' involvement in patients' care and better outcomes. The goals of family education and support efforts include reducing the burden on patients' relatives and helping those relatives acquire the knowledge and interpersonal skills needed to adapt to their new circumstances and to support patients' recovery. Training for this component was provided by Susan Gingerich, MSW, who is the National Training Coordinator for the NAVIGATE First Episode of Psychosis Early Treatment Program. Susan has worked with individuals with serious mental illness and their families for over 30 years, and has been providing training and consultation for mental health professionals for the past 20 years. She has worked with the NAVIGATE early treatment program since it began and has over 5 years of experience working with multiple NAVIGATE sites across the United States.
 4. Evidence-based Pharmacotherapy and Primary Care Coordination. The regimen of pharmacotherapy and primary care coordination that was developed for the NAVIGATE first episode of psychosis treatment program typically begins with a low dose of a single antipsychotic medication and includes monitoring for signs and symptoms of psychopathology, side effects and attitudes about medication at each visit. Emphasis is given to cardio-metabolic risk factors (smoking, weight gain, hypertension, dyslipidemia and pre-diabetes). Prescribers maintain close contact with primary care providers to assure optimal medical monitoring and intervention for risk related to cardiovascular disease and diabetes. Training for this component was provided by Delbert G. Robinson, M.D., who served as the Chair of the NAVIGATE Psychopharmacological Treatment Committee in the NIMH RAISE project. Since 1986, Dr. Robinson has been an integral part of the ongoing program of clinical research at The Zucker Hillside Hospital through investigations of the psychobiology of patients experiencing their first episode of psychosis and studies of pharmacotherapy treatment. With John M. Kane, M.D., Dr. Robinson reported one of the earliest demonstrations of the effectiveness of maintenance antipsychotic medication for the prevention of relapse in first episode of psychosis patients.
- Planned Expansion of First Episode of Psychosis Services Statewide, FFY 2020-2021: Nevada will be expanding services statewide during FFY 2020-2021. It is anticipated that two additional first episode of psychosis programs will be implemented beginning in January 2020.

Data Collection and Reporting, FFY 2020-2021: The eLoicModel or eLogic is being implemented for the data collection and reporting about the newly launched early treatment program for first episode of psychosis at Carson Tahoe Behavioral Health Services and Hospital.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

In addition to the newly established service of early interventions for individuals with first episode of psychosis (FEP), the state currently supports the following evidence-based programs for the treatment of serious mental illness (SMI):

- Assisted Outpatient Treatment (AOT): Also known as involuntary civil commitment, AOT delivers comprehensive community-based treatment to individuals with persistent and serious mental illness. Individuals receiving AOT services participate in a civil court process. To receive AOT services, individuals must have a history of non-compliance with voluntary treatment for their mental health issues, as well as have failed attempts in less restrictive treatment programs. Goals of the involuntary civil commitment AOT program include: preventing harmful outcomes, such as illness relapse that results in hospitalization, incarceration or trauma; supporting individuals in maintaining stability and achieving personal goals; assisting individuals to attain positive relationships with family, friends and other social supports. AOT services include intensive case management; psychiatric services; medication management and support; life skills, job, and vocational support and development; peer and professionally led recovery groups; and financial assistance and housing support.

- Clinical Program for Assertive Community Treatment (PACT): PACT involves a multi-disciplinary team that delivers comprehensive, intensive and integrated care for individuals with serious and persistent mental health disorders. This program is designed to support individuals with serious mental illness in their efforts to live within their community.

Although not included in SAMHSA's National Registry of Evidence-Based Programs and Practices (<https://www.samhsa.gov/data/evidence-based-programs-nrepp>), community outreach and crisis intervention services are supported by the state through the following program:

- Mobile Outreach Safety Team (MOST): The MOST program is a partnership between public mental health providers and local law enforcement agencies that works to identify individuals who are better served by direct mental health services instead of the criminal justice system.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.
See answer #2 above.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?
See answer #2 above. NAVIGATE early treatment program for Early Psychosis.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.
See answer #2 above.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Schizophrenia, Schizoaffective Disorder, Schizophreniform, Brief Psychotic Disorder, and Psychotic Disorder NOS

Please indicate areas of technical assistance needed related to this section.

Need assistance to develop data capture for ESMI served in private provider, community agencies, that is compatible with the procedures used to collect data for SAMHSA URS output tables.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? Yes No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
State has created person-centered planning trainings that are available to all state employees and community providers.
4. Describe the person-centered planning process in your state.
Service plans are created and implemented to provide support around an individuals needs using a team approach that includes the individual, their support system and service providers.
Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes No

3. Does the state have any activities related to this section that you would like to highlight?

The State has assurances in all sub grants that include the federal program requirements as listed in sections A, and G below. These policies are reviewed on a regular basis to include changes and all recipients of funds are required to abide by them. Technical assistance is provided ongoing to providers through provider calls, monitors, site visits, monthly requests for reimbursement reviews, and occasionally formal audits as needed or required by law.

Assurances

As a condition of receiving subgranted funds from the Nevada State Division of Public and Behavioral Health, the Subgrantee agrees to the following conditions:

1. Grant funds may not be used for other than the awarded purpose. In the event Subgrantee expenditures do not comply with this condition, that portion not in compliance must be refunded to the Division.
2. To submit reimbursement requests only for expenditures approved in the spending plan. Any additional expenditure beyond what is allowable based on approved categorical budget amounts, without prior written approval by the Division, may result in

denial of reimbursement.

3. Approval of subgrant budget by the Division constitutes prior approval for the expenditure of funds for specified purposes included in this budget. Unless otherwise stated in the Scope of Work the transfer of funds between budgeted categories without written prior approval from the Division is not allowed under the terms of this subgrant. Requests to revise approved budgeted amounts must be made in writing and provide sufficient narrative detail to determine justification.

4. Recipients of subgrants are required to maintain subgrant accounting records, identifiable by subgrant number. Such records shall be maintained in accordance with the following:

a. Records may be destroyed not less than three years (unless otherwise stipulated) after the final report has been submitted if written approval has been requested and received from the Administrative Services Officer (ASO) of the Division. Records may be destroyed by the Subgrantee five (5) calendar years after the final financial and narrative reports have been submitted to the Division.

b. In all cases an overriding requirement exists to retain records until resolution of any audit questions relating to individual subgrants.

Subgrant accounting records are considered to be all records relating to the expenditure and reimbursement of funds awarded under this subgrant award. Records required for retention include all accounting records and related original and supporting documents that substantiate costs charged to the subgrant activity.

5. To disclose any existing or potential conflicts of interest relative to the performance of services resulting from this subgrant award. The Division reserves the right to disqualify any subgrantee on the grounds of actual or apparent conflict of interest. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of funding.

6. To comply with the requirements of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and any relevant program-specific regulations, and shall not discriminate against any employee or offeror for employment because of race, national origin, creed, color, sex, religion, age, disability or handicap condition (including AIDS and AIDS-related conditions).

7. To comply with the Americans with Disability Act of 1990, P.L. 101-136, 42 U.S.C. 12101, as amended, and regulations adopted thereunder contained in 28 C.F.R. 26.101-36.999 inclusive and any relevant program-specific regulations

8. To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. 160, 162 and 164, as amended. If the subgrant award includes functions or activities that involve the use or disclosure of protected health information (PHI) then the subgrantee agrees to enter into a Business Associate Agreement with the Division as required by 45 C.F.R. 164.504(e). If PHI will not be disclosed then a Confidentiality Agreement will be entered into.

9. Subgrantee certifies, by signing this notice of subgrant award, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pr. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal Register (pp. 19150-19211). This provision shall be required of every subgrantee receiving any payment in whole or in part from federal funds.

10. Sub-grantee agrees to comply with the requirements of the Title XII Public Law 103-227, the "PRO-KIDS Act of 1994," smoking may not be permitted in any portion of any indoor facility owned or regularly used for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans and loan guarantees, and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

11. Whether expressly prohibited by federal, state, or local law, or otherwise, that no funding associated with this subgrant will be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose the following:

- a. Any federal, state, county or local agency, legislature, commission, council, or board;
- b. Any federal, state, county or local legislator, commission member, council member, board member, or other elected official; or
- c. Any officer or employee of any federal, state, county or local agency, legislature, commission, council or board.

12. Division subgrants are subject to inspection and audit by representative of the Division, Nevada Department of Health and Human Services, the State Department of Administration, the Audit Division of the Legislative Counsel Bureau or other appropriate state or federal agencies to:

- a. Verify financial transactions and determine whether funds were used in accordance with applicable laws, regulations and

procedures;

- b. Ascertain whether policies, plans and procedures are being followed;
- c. Provide management with objective and systematic appraisals of financial and administrative controls, including information as to whether operations are carried out effectively, efficiently and economically; and
- d. Determine reliability of financial aspects of the conduct of the project.

13. Any audit of Subgrantee's expenditures will be performed in accordance with generally accepted government auditing standards to determine there is proper accounting for and use of subgrant funds. It is the policy of the Division, as well as federal requirement as specified in the Office of Management and Budget (2 CFR § 200.501(a)), revised December 26, 2013, that each grantee annually expending \$750,000 or more in federal funds have an annual audit prepared by an independent auditor in accordance with the terms and requirements of the appropriate circular. A COPY OF THE FINAL AUDIT REPORT MUST BE SENT TO:

Nevada State Division of Public and Behavioral Health
Attn: Contract Unit
4150 Technology Way, Suite 300
Carson City, NV 89706-2009

This copy of the final audit must be sent to the Division within nine (9) months of the close of the subgrantee's fiscal year. To acknowledge this requirement, Section E of this notice of subgrant award must be completed.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
BUREAU OF BEHAVIORAL HEALTH WELLNESS AND PREVENTION
NOTICE OF SUBGRANT

SECTION G

In addition to the Division of Public and Behavioral Health Sub-grant Grant Assurances, the sub-grantee and all organizations or individuals to whom the sub-grantee passes through funding (subrecipients) must be in compliance with all applicable rules, federal and state laws, regulations, requirements, guidelines, and policies and procedures. The terms and conditions of this State award flow down to the sub-grantee and to subrecipients unless a particular section specifically indicate otherwise.

GENERAL REQUIREMENTS

Applicability: This section is applicable to all sub-grantees who receive funding from the Division of Public and Behavioral Health through the Bureau of Behavioral Health Wellness and Prevention. The sub-grantee agrees to abide by and remain in compliance with the following:

1. 2 CFR 200 -Uniform Requirements, Cost Principles and Audit Requirements for Federal Awards
2. 45 CFR 96 - Block Grants as it applies to the subrecipient and per Division policy.
3. 42 CFR 54 and 42 CFR 54A Charitable Choice Regulations Applicable to States Receiving Substance Abuse Prevention & Treatment Block Grants & / or Projects for Assistance in Transition from Homelessness
4. NRS 218G - Legislative Audits
5. NRS 458 - Abuse of Alcohol & Drugs
6. NRS 616 A through D Industrial Insurance
7. GAAP - Generally Accepted Accounting Principles and/or GAGAS Generally Accepted Government Auditing Standards
8. GSA - General Services Administration for guidelines for travel
9. The Division of Public and Behavioral Health, Bureau of Behavioral Health Wellness and Prevention Policies and guidelines.
10. State Licensure and certification
 - a. The Sub-grantee is required to be in compliance with all State licensure and/or certification requirements.
 - b. The Sub-grantee's Certification must be current and fees paid prior to release of certificate in order to receive funding from the Division. Sub-grants cannot be issued unless certifications are current.

11. The Sub-grantee's commercial general or professional liability insurance shall be on an occurrence basis and shall be at least as broad as ISO 1996 form CG 00 01 (or a substitute form providing equivalent coverage); and shall cover liability arising from premises, operations, independent Sub-grantees, completed operations, personal injury, products, civil lawsuits, Title VII actions, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).
12. To the fullest extent permitted by law, Sub-grantee shall indemnify, hold harmless and defend, not excluding the State's right to participate, the State from and against all liability, claims, actions, damages, losses, and expenses, including, without limitation, reasonable attorneys' fees and costs, arising out of any alleged negligent or willful acts or omissions of Sub-grantee, its officers, employees and agents.
13. The sub-grantee shall provide proof of workers' compensation insurance as required by Chapters 616A through 616D inclusive Nevada Revised Statutes at the time of their certification.
14. The sub-grantee agrees to be a "tobacco, alcohol, and other drug free" environment in which the use of tobacco products, alcohol, and illegal drugs will not be allowed;
15. The sub-grantee will report within 24 hours the occurrence of an incident, following Division policy, which may cause imminent danger to the health or safety of the clients, participants, staff of the program, or a visitor to the program, per NAC 458.153 3(e).
16. The sub-grantee is required maintain a Central Repository for Nevada Records of Criminal History and FBI background checks every 3 to 5 years were conducted on all staff, volunteers, and consultants occupying clinical and supportive roles, if the sub-grantee serves minors with funds awarded through this sub-grant.
17. Application to 211
o As of October 1, 2017, the Sub-grantee will be required to submit an application to register with the Nevada 211 system.
18. The Sub-grantee agrees to fully cooperate with all Bureau of Behavioral Health Wellness and Prevention sponsored studies including, but not limited to, utilization management reviews, program compliance monitoring, reporting requirements, complaint investigations, and evaluation studies.
19. The Sub-grantee must be enrolled in System Award Management (SAM) as required by the Federal Funding Accountability and Transparency Act.
20. The Sub-grantee acknowledges that to better address the needs of Nevada, funds identified in this sub-grant may be reallocated if ANY terms of the sub-grant are not met, including failure to meet the scope of work. The Division may reallocate funds to other programs to ensure that gaps in service are addressed.
21. The Sub-grantee acknowledges that if the scope of work is NOT being met, the Sub-grantee will be provided a chance to develop an action plan on how the scope of work will be met and technical assistance will be provided by Division staff or specified sub-contractor. The Sub-grantee will have 60 days to improve the scope of work and carry out the approved action plan. If performance has not improved, the Division will provide a written notice identifying the reduction of funds and the necessary steps.
22. "The Sub-grantees will NOT expend Division funds, including Federal Substance Abuse Prevention and Treatment and Community Mental Health services Block Grant Funds for any of the following purposes:
- To purchase or improve land: purchase, construct, or permanently improve, other than minor remodeling, any building or other facility; or purchase major medical equipment.
 - To purchase equipment over \$1,000 without approval from the Division.
 - To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
 - To provide in-patient hospital services.
 - To make payments to intended recipients of health services.
 - To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstrated needle exchange program would be effective in reducing drug abuse and there is no substantial risk that the public will become infected with the etiologic agent for AIDS.
 - To provide treatment services in penal or correctional institutions of the State.
23. Failure to meet any condition listed within the sub-grant award may result in withholding reimbursement payments, disqualification of future funding, and/or termination of current funding.

Audit Requirements

The following program Audit Requirements are for non-federal entities who do not meet the single audit requirement of 2 CFR Part 200, Subpart F-Audit requirements:

24. For sub-grantees of the program who expend less than \$750,000 during the non-federal entity's fiscal year in federal and state awards are required to report all organizational fiscal activities annually in the form of a Year-End Financial Report.

25. For sub-grantees of the program who expend \$750,000 or more during the fiscal year in federal and state awards are required to have a Limited Scope Audit conducted for that year. The Limited Scope Audit must be for the same organizational unit and fiscal year that meets the requirements of the Division Audit policy.

Year-End Financial Report

26. The non-federal entity must prepare financial statements that reflect its financial position, results of operations or changes in net assets, and, where appropriate, cash flows for the fiscal year.

27. The non-federal entity financial statements may also include departments, agencies, and other organizational units.

28. Year-End Financial Report must be signed by the CEO or Chairman of the Board.

29. The Year-End Financial Report must identify all organizational revenues and expenditures by funding source and show any balance forward onto the new fiscal year as applicable.

30. The Year-End Financial Report must include a schedule of expenditures of federal and State awards. At a minimum, the schedule must:

- a. List individual federal and State programs by agency and provide the applicable federal agency name.
- b. Include the name of the pass-through entity (State Program).
- c. Must identify the CFDA number as applicable to the federal awards or other identifying number when the CFDA information is not available.
- d. Include the total amount provided to the non-federal entity from each federal and State program.

31. The Year-End Financial Report must be submitted to the Division 90 days after fiscal year end at the following address.

Behavioral Health, Prevention and Treatment
Attn: Management Oversight Team
4126 Technology Way, Second Floor
Carson City, NV 89706

Limited Scope Audits

32. The auditor must:

- a. Perform an audit of the financial statement(s) for the federal program in accordance with GAGAS;
- b. Obtain an understanding of internal controls and perform tests of internal controls over the federal program consistent with the requirements for a federal program;
- c. Perform procedures to determine whether the auditee has complied with federal and State statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on the federal program consistent with the requirements of federal program;
- d. Follow up on prior audit findings, perform procedures to assess the reasonableness of the summary schedule of prior audit findings prepared by the auditee in accordance with the requirements of 2 CFR Part 200, §200.511 Audit findings follow-up, and report, as a current year audit finding, when the auditor concludes that the summary schedule of prior audit findings materially misrepresents the status of any prior audit finding;
- e. And, report any audit findings consistent with the requirements of 2 CFR Part 200, §200.516 Audit findings.

33. The auditor's report(s) may be in the form of either combined or separate reports and may be organized differently from the manner presented in this section.

34. The auditor's report(s) must state that the audit was conducted in accordance with this part and include the following:

- a. An opinion as to whether the financial statement(s) of the federal program is presented fairly in all material respects in accordance with the stated accounting policies;
- b. A report on internal control related to the federal program, which must describe the scope of testing of internal control and the results of the tests;
- c. A report on compliance which includes an opinion as to whether the auditee complied with laws, regulations, and the terms and conditions of the awards which could have a direct and material effect on the program; and
- d. A schedule of findings and questioned costs for the federal program that includes a summary of the auditor's results relative to the federal program in a format consistent with 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(1), and findings and questioned costs consistent with the requirements of 2 CFR Part 200, §200.515 Audit reporting, paragraph (d)(3).

35. The Limited Scope Audit Report must be submitted to the Division within the earlier of 30 calendar days after receipt of the

auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or Federal holiday, the reporting package is due the next business day. The Audit Report must be sent to:

Behavioral Health, Prevention and Treatment
Attn: Management Oversight Team
4126 Technology Way, Second Floor
Carson City, NV 89706

Amendments

36. The Division of Public and Behavioral Health policy is to allow no more than 10% flexibility within the approved Scope of Work budget line items. Notification of such modifications must be communicated in writing to the Bureau of Behavioral Health Wellness and Prevention prior to submitting any request for reimbursement for the period in which the modification affects. Notification may be made via e-mail.

37. For any budgetary changes that are in excess of 10% of the total award, an official amendment is required. Requests for such amendments must be made to the Bureau of Behavioral Health Wellness and Prevention in writing.

38. Any expenses that are incurred in relation to a budgetary amendment without prior approval are unallowable.

39. Any significant changes to the Scope of Work over the course of the budget period will require an amendment. The assigned program analyst can provide guidance and approve all Scope of Work amendments.

40. The Sub-grantee acknowledges that requests to revise the approved sub-grant must be made in writing using the appropriate forms and provide sufficient narrative detail to determine justification.

41. Final changes to the approved sub-grant that will result in an amendment must be received 60 days prior to the end of the sub-grant period (no later than April 30 for State funded grants and July 31 for federal funded grants). Amendment requests received after the 60 day deadline will be denied.

Remedies for Noncompliance

42. The Division reserves the right to hold reimbursement under this sub-grant until any delinquent requests, forms, reports, and expenditure documentation are submitted to and approved by the Division.

SUBSTANCE USE TREATMENT SERVICES

Applicability

This section applies to all sub-grants that support direct services to persons being treated for substance use.

1. The Sub-grantee, as applicable, if identifying as Faith-Based Organizations must comply with 42 USC § 300x-65 and 42 CFR part 54 (42 CFR §§ 54.8(c) (4) and 54.8(b)), Charitable Choice provisions and regulations.

a. The Sub-grantee must post a notice to advise all clients and potential clients that if the client objects to the religious character of the Sub-grantee's organization as applicable.

b. The client has the right to be referred to another Division funded provider that is not faith-based or that has a different religious orientation.

2. Priority Groups – The sub-grantee agrees to prioritize admission to treatment, except for Civil Protective Custody Services, for priority populations in the following order:

- a. Pregnant injecting drug users;
- b. Pregnant substance abusers;
- c. Injection drug users;
- d. Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
- e. All others.

3. The sub-grantee agrees to report within 24 hours to the Bureau of Behavioral Health Wellness and Prevention when any level of service reaches 90% capacity or greater in accord with the Division's Wait List and Capacity Management policy.

4. A sub-grantee who provides residential services agrees to report bed capacity in the HavBed system or a successor system for residential services daily in accord with the Division's Wait List and Capacity Management policy.

5. Programs will make continuing education in alcohol and other drug treatment available to all employees who provide services.
6. The sub-grantee must post a notice, where clients, visitors, and persons requesting services may easily view it, that no persons may be denied services due to inability to pay. This notice may stipulate that the organization is authorized to deny services to those who are able to pay but refuse to do so.
7. The sub-grantee is required to implement the National Institute of Drug Abuse (NIDA) 13 principles of treatment.
8. The sub-grantee is required to participate, if selected to be reviewed by the Nevada Alliance for Addictive Disorders, Advocacy, Prevention and Treatment Services (AADAPTS) annual peer review process.

Capacity of treatment for intravenous substance abusers

9. A sub-grantee must admit an individual who requests and needs treatment for intravenous drug use to a treatment program. If unable to provide services, the sub-grantee must contact the Bureau of Behavioral Health and Wellness according to the Division's Capacity Management and Wait List policy.
10. The sub-grantee who treats persons who inject drugs agrees to carry out activities to encourage individuals in need of treatment for injection drug use to undergo such treatment. The sub-grantee must use outreach models that are scientifically sound or an alternate outreach method that is reasonably expected to be effective and has been approved by the Bureau of Behavioral Health Wellness and Prevention. All outreach activities will be reported to the Division quarterly. The model shall require that outreach efforts include the following at a minimum:
 - a. Selecting, training and supervising outreach workers;
 - b. Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2;
 - c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
 - d. Recommend steps that can be taken to ensure that HIV transmission does not occur; and
 - e. Encouraging entry into treatment.

Treatment services for pregnant women (45 CFR § 96.131)

11. All sub-grantees who treat women agree to provide immediate comprehensive treatment services to pregnant women, or if the sub-grantee is unable to do so, the sub-grantee must immediately contact the Bureau of Behavioral Health Wellness and Prevention in accord to the Divisions Capacity Management and Wait List policy.
12. Sub-grantees who do not treat women and who receive a request for treatment services from a pregnant woman must provide a referral to an appropriate treatment provider within 48 hours of the request for services and must immediately notify the Bureau of Behavioral Health Wellness and Prevention of the need for such services.
13. Sub-grantees who provide services to women agree to publicize the availability of services to women in priority populations and the admission priority granted to pregnant women. The publication of services for women in priority populations may be achieved by means of street outreach programs, ongoing public service announcements, regular advertisements, posters placed in target areas, and frequent notification of availability of such treatment services distributed to the network of community based organizations, health care providers, and social services agencies.

Records

14. All sub-grantees will have in effect a system to protect from inappropriate disclosure of client records, compliant with all applicable State and federal laws and regulations, including 42 CFR, Part 2.
15. The system to protect confidentiality shall include, but not be limited to, the following provisions:
 - a. Employee education about the confidentiality requirements, to be provided annually;
 - b. Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.

Reporting

16. The sub-grantee is required to submit monthly Treatment Episode Data Set (TEDS) admissions files and TEDS discharges files in accordance with current block grant requirements. The sub-grantee is also required to submit any other reporting as defined and requested by the Bureau of Behavioral Health Wellness and Prevention.
17. The sub-grantee agrees to participate in reporting all required data and information through the authorized Bureau of Behavioral Health Wellness and Prevention data reporting system and to the evaluation team as required; or, if applicable, another qualified Electronic Health Record (EHR) reporting system.

Fee for Service requirements

18. Sub-grantees that have been awarded a fee for service sub-grant must comply with the Division's Utilization Management policy and the following billing and eligibility rules for claims processing.

- a. The service must be delivered at a Division certified facility.
- b. The certifications must cover the service levels under which the qualified service was delivered.
- c. The service must be provided by an appropriately licensed/certified staff member.
- d. The service delivered must be a Division qualified service which is NOT reimbursable by Medicaid or other third party insurance carrier.
- e. The rate of reimbursement will be based on the Division approved rates (available upon request).
- f. The sub-grantee agrees to accept the Division reimbursement rate as full payment for any program eligible services provided.
- g. The Sub-grantee is responsible for ensuring that all third party liabilities are billed and collected from the third party payers and are NOT billed to the Division.
- h. Division funds will NOT be used to fund the services for self-pay clients or clients who elect not to use their insurance coverages. This includes clients that elect not sign up for insurance under the Affordable Care Act or clients that have existing insurance and choose not to use their insurance for treatment services. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.
- i. Division funds will NOT be used to reimburse Medicare claims.
- j. Division funds will NOT be used to reimburse claims for which the client is pending eligible for insurance coverage.
- k. Division funds will NOT be used to reimburse for claims denied by Medicaid or other insurance carriers unless the claim was denied as "not a covered benefit".
 - a. Claims denied as "not a covered benefit" and billed to the Division must have the accompanying denial attached in order to guarantee payment.
- l. Division funds will NOT be used to cover any unpaid costs that Medicaid and/or other insurance carriers may not reimburse (i.e. copayments, deductibles).
- m. The Sub-grantee agrees to use Division funds as the "payer of last resort" for all services provided to clients. If an undue barrier to treatment exist, a written request to the Division may be submitted for review and some services may be covered upon written permission from the Division.

19. The Sub-grantee must establish policies, procedures, and the systems for eligibility determination, billing, and collection to:
- a. Ensure that all eligible clients are insured and/or enrolled in Medicaid in accord with the Affordable Care Act.
 - b. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical assistance, any grant program, any private health insurance, or any other benefit program; and secure from client's payment for services in accordance with their ability to pay.
 - c. And prohibits billing the Division for a service that is covered by Medicaid or any other insurance carrier. In certain circumstances and upon written request to the Division, some services may be covered if an undue barrier to treatment exists.
- Billing the Division

Fee for Services only:

20. The sub-grantee agrees to submit a monthly billing invoice, along with back-up documentation via the Secure File Transfer Protocol (SFTP) site to the Division; the Sub-grantee agrees to notify the treatment analyst once the invoice has been posted to the SFTP site.
21. Upon official written notification from the Bureau of Behavioral Health Wellness and Prevention, prior authorizations will be required for all residential and transitional housing services being billed to the Division.
22. The Sub-grantee agrees to include an explanation of benefits for all charges requested for services that have been denied by Medicaid or any other third-party payer due to non-coverage of that benefit.
23. The Sub-grantee understands that charges greater than 90 days from the date of service will be considered stale dated and may not be paid.
24. The Sub-grantee understands that quarterly Medicaid audits will be conducted by Division and recouping of funds may occur.
25. The Sub-grantee understands that they are required to produce an invoice that breaks out the total number of services provided by level of care and CPT or HCPCS code. The invoice must, at a minimum meet the following conditions.
- a. The invoice must contain, company information (Name, address, City, State and Zip), Date, unique Invoice #, vendor #, PA or HD#.
 - b. The invoice must contain contact name, phone number, e-mail and identify the invoice period.
 - c. The invoice must contain: Billed To: The Division of Public and Behavioral Health, 4126 Technology Way, Suite 200, Carson City, NV 89706.
 - d. The invoice must show the total number of services by CPT or HCPCS code, the rate being charged, the total amount charged to that CPT or HCPCS code line and summarize the totals by level of care.
 - e. The invoice must also show the total number of services provided, the total number of unique clients served for the invoice and the total amount charged to the invoice.
 - f. The invoice must be signed and dated by the organizations fiscal officer and include the following certification, "By submitting this invoice, we certify that all billing is correct and no Medicaid or other insurance eligible services have been charged to this

invoice."
PREVENTION SERVICES

Applicability

This section is only applicable to primary prevention coalitions and programs.

1. The sub-grantee will implement the Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework Planning Process.
2. If the sub-grantee is a certified prevention coalition, it will solicit representatives from local substance abuse prevention programs and treatment providers to become coalition members and assist with efforts to implement the CSAP's Strategic Prevention Framework Planning Process.
3. The sub-grantee representatives are required to attend prevention training as listed below if applicable to provide prevention services:
 - a. All fulltime staff must annually complete a minimum of twenty (20) hours of prevention training.
 - b. All part-time staff must annually complete a minimum for ten (10) hours of prevention training.
 - c. Participate in the implementation of evidence-based prevention programs, strategies, policies, and practices, and use the Prevention Program Operating and Access Standards as the basis for program, workforce, and agency development.

REQUESTS FOR REIMBURSEMENTS (All non-fee for service sub-grants):

1. A Request for Reimbursement is due, at a minimum, on a monthly basis, based on the terms of the sub-grant agreement, no later than the 15th of the month. If there has been no fiscal activity in a given month, a Request for Reimbursement claiming zero dollars is required to be submitted for the month.
2. Reimbursement is based on actual expenditures incurred during the period being reported.
3. Requests for advance of payment will not be considered or allowed by the Division.
4. Reimbursement must be submitted with all Division required supporting back up documentation. The Division has the authority to ask for additional supporting documentation at any time and the information must be provided to Division staff within 10 business days of the request.
5. Payment will not be processed without all programmatic reporting being current.
6. Reimbursement may only be claimed for allowable expenditures approved within the sub-grant award.
7. The sub-grantee is required to submit a complete financial accounting of all expenditures to the Division within 30 days of the CLOSE OF THE SUB-GRANT PERIOD. All remaining balances of a federally funded sub-grant revert back to the Division 30 days after the close of the sub-grant period.
8. The Request for reimbursement to close the State Fiscal Year (SFY) is due at a minimum of 25 days after the close of the SFY which occurs on June 30. All remaining balances of the State funded sub-grants revert back to the State after the close of the SFY.
9. The sub-grantee must retain copies of approved travel requests and claims, consultant invoices, payroll register indicating title, receipts for goods purchased, and any other relevant source documentation in support of reimbursement requests for a period of three years from the date of submission of the State's final financial expenditure report submitted to the governing federal agency.

The sub-grantee agrees that any failure to meet any of the conditions listed within the above Program Requirements may result in the withholding of reimbursement for payment, termination of current contract and/or the disqualification of future funding.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁶ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The State of Nevada meets with the tribes quarterly each year. Those meetings are held in January, April, July, and October.
2. What specific concerns were raised during the consultation session(s) noted above?

The tribes drive the agenda of the meetings based on concerns they are experiencing in their communities. The recent meetings have included discussions regarding tele-pharmacy, child welfare, Medicaid billing and reimbursement for specific services, care for behavioral health services, the insurance exchange, dental health services, substance abuse treatment and prevention and aged and elder services.

The tribes are focused on being a partner with the State in the continuum of care affecting their vulnerable populations and are participating in the Tribal Consultations as a means to that end.
3. Does the state have any activities related to this section that you would like to highlight?

The State of Nevada, in the 2019 Legislative Session, passed a law that is modeled after the New Mexico State-Tribal Consultation Act of 2009 which promotes increased cooperation and collaboration between the State and federally recognized tribes. The bill passed and was signed by Governor Sisolak with sixteen Assemblymen joining in the effort. The Nevada bill calls for

 - Government to government relations between a state agency and a tribe
 - Promotes positive government to government relations between a state agency and a tribe
 - Promotes cultural competency in providing effective services to Indian tribes
 - Tribes will be consulted in developing the policy as it relates to this chapter
 - A state agency will make a reasonable effort to collaborate with Indian tribes in developing the policy as it relates to programs of the state agency that directly affect Indian tribes
 - Each state agency who regularly interacts with an Indian tribe shall designate a tribal liaison who reports directly to the head of the agency...

- Ensure that training is provided to the staff of the state agency pursuant to section 2 of section 7 of this act...
- A process to ensure that if a representative of an Indian tribe contacts a state entity on tribal business, there is a process for response which includes the head of the state agency
- At least once each year the Governor shall meet with the leaders of the Indian tribes in a state-tribal summit to address matters of mutual concern
- All heads of a state agency and state agency managers and employees will have ongoing communication and shall complete a training provided by the Division of Human Resource Management of the Department of Administration, in consultation with the Commission which must include:
 - a. Promotion of effective communication
 - b. Development of positive relations
 - c. Cultural competency

- On or before July 1 of each year, each state agency that communicates with Indian tribes shall submit a report to the Commission on the activities... The report must include:
 - a. Name and contact information of each person in the state agency who is responsible for developing and implementing programs that directly affect Indian tribes
 - b. Any action taken or planned under this act
 - c. Training taken, employees and managers
 - d. Description of current and planned programs affecting Indian tribes...

With the passage of this legislation, Nevada has taken a step forward in the goal of there being a partnership between the state agencies who work with Indian tribes on programs impacting the continuum of care for Nevada's Native American populations.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - a) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) Intervening variables (including risk and protective factors)
 - d) Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

School Climate Surveys where they exist.
Clark County Coroners report.

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

Data collected from the needs assessment dive decisions regarding areas of SU focus, geographical areas and population. Based on the data that is collected from the sources identified above and local data (if available), each coalition creates a Community Coalition Prevention Plan (CCPP) every three years. This allows the coalitions to identify their greatest needs, set priorities, and allot their fiscal resources to address those needs. This is accomplished through environmental strategies and primary prevention programs. SAPTA also uses the data collected in the sources above to create and update its strategic plan. SAPTA recently conducted a situational analysis and strategic plan to assist in developing key strategies over the next 5 years. Whenever new reports are generated related to mental health, substance use prevention, and treatment across the state SAPTA reviews the data and attempts to utilize it in planning for the future and reports are shared with all partners. We utilize data from results of the various state surveys, data from billing codes, and any other sources available throughout the State which provides insight into the issues affecting consumers. These plans include the 3 consortium plans, and individual agency plans within the Division of Public and Behavioral Health which all utilize consumer input and stakeholder feedback prior to being published.

If no, (please explain) how SABG funds are allocated:

Our state is very unique in how it has coalitions representing all counties that utilize the strategic prevention framework and are highly trained in that model. The coalition structure is such that there is representation from a minimal of 12 sectors of participants in each community, and all communities are represented in a lead from the middle framework which helps partners feel they are a part of the whole process. This avoids a top down approach, or a bottom up approach but a true partnership between the communities and the State. Coalitions provide sub grants to various community partners through an open bid process to ensure the prevention priorities are implemented well and that the experts from the proper sectors are utilized. For example, if a media campaign is needed then they partner with a local or national media company that meets their needs. Furthermore, if educational materials are needed to run groups such as parenting classes, or refusal skills training, then coalitions partner with the right community experts to provide the training and can provide funding to purchase necessary curriculum materials. The coalitions ensure that services span the whole state and are tailored to the needs of the individual community but also align with state priorities and that duplication of services are not occurring with the same funding sources and same community.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

Our State requires certification for funding, and funding they must have one prevention specialist. The state encourages all prevention providers to have more than one staff member certified in prevention. This certification started in 2016. Many of the providers sought national prevention certifications previously.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

Our State has ongoing communication with providers through monthly provider calls, and a state liaison to the providers that can be contacted for technical assistance needs. When training needs are identified the State works with providers to try and find solutions, and at times hosts collaborative training's for state staff and community prevention partners. Attempts are made whenever possible to communicate trainings that are being held that will be mutually beneficial and can serve the needs of all who participate in the field. Also, the coalitions provide information to the State regarding training's they are holding and invite state staff to participate when appropriate.

SAPTA has relied on the CAPT West RET along with the Center for the Application of Substance Abuse Technologies (CASAT) and Community Anti-Drug Coalitions of America (CADCA) to provide training and technical assistance to SAPTA staff as well as all of the state's prevention workforce. All of these entities offer live trainings, webinars, and conferences. SAPTA makes every effort to notify prevention and treatment providers of any pertinent training opportunities of which it becomes aware.

A top priority for SAPTA is the continuous education on substance abuse prevention. In support of this priority, the Center for Application of Substance Abuse Technologies (CASAT) offers workshops and trainings on substance abuse for prevention professionals, Coalitions and, in its advisory capacity the SEW, MPAC, and the SAPTA Advisory Board, meet and offer recommendations on the types of trainings needed to further SAPTA's goals and objectives. This supports the updating of the partners with evidence-based practices and the workforce trends in substance abuse. CASAT offers many training sessions during each year.

In addition, the Nevada Prevention Resource Center (NPRC - CASAT Clearinghouse) will serve as an information clearinghouse to SAPTA and the 12 community coalitions. The Crisis Call Center will provide training and continuing education to those taking calls regarding substance abuse issues through the Nevada 211 system, as part as information and crisis management. The Nevada Statewide Partnership, which is the "coalition of coalitions" made up of the Executive Directors of the 12 funded coalitions, will also offer training sessions to coalition staff and board members. Nevada will create a competency-based statewide training designed to increase professional and volunteer ability to impact community substance and abuse and related risk and protective

factors.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

Our State has a request for qualification application. In the application are agency capacity questions including policies and procedures for managing funds properly, maintaining the proper staffing ratios needed to manage projects, and demonstrating an understanding of the federal rules and regulations. There have been times in the past where agencies struggled to maintain the proper capacity to perform duties of the grants and requirements of the projects and have closed their doors. This typically happened after many supportive interactions with the State providing technical assistance as well as peers providing supportive services. Most State partners are willing to mentor other providers as needed to help them be successful as Nevada struggles with keeping professionals of all backgrounds in the workforce.

Most of the twelve coalitions have served their community for many years and have a keen sense of their community's challenges. During the economic downturn, several of the rural and frontier communities were greatly affected. Unemployment in some counties was as high as 20%, and the ability to buy food for families was on the decline. In response to this turn of events, several of the coalitions applied for grants from other sources such as the FDA in an effort to expand their reach and available resources. Because of the leadership of these coalitions, food banks and thrift stores were created. Some of the communities experienced an increase in mental health and crime related issues. The Coalitions began to broaden their membership to include businesses, schools, law enforcement, physicians, and dentists to assist their underserved. In addition, some coalitions have now expanded through other grant resources to include assisting with mental health capacity building and have increased their partnerships with the schools to build referral systems and decrease mental health stigma. This broadened approach allows for a coordinated, focused, intentional response to community challenges. With the funding and technical assistance from the Bureau of Behavioral Health Wellness and Prevention the coalitions will continue to grow their organizations.

The issue of workforce development has been a challenge for the Bureau for many years. Workforce development is a topic of concern from every state agency and community agency that provides care. One of the goals in the Bureau's Strategic Plan is to engage with educational partners including higher education and secondary education partners to create a pipeline of qualified workforce to address community needs. Building capacity in the workforce is mentioned in most strategic meetings across the state and is being addressed on a continual basis until there is no longer a shortage in professionals. With Nevada's growing population and increased need, based on population growth it is unlikely the need will go away soon.

NOT FINAL

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Evidence-Based Work Group Policy and Guidelines Overview

The Nevada Evidence-Based Work Group's purpose is to assist prevention specialists and coalitions with identifying research- and evidence-based strategies and programs (EBP) that are grounded in prevention science and, if implemented with fidelity and are culturally relevant, can achieve measurable outcomes and move the needle on curbing and addressing substance misuse and abuse.

Mission Statement: Assist Nevada communities in selecting best fit evidence-based substance misuse and abuse prevention strategies and programs for their unique community to address identified needs.

The Evidence-Based Work Group's purpose is to assist SAPTA staff and community coalitions with identifying evidence-based strategies or programs that are grounded in prevention research and, if implemented with fidelity and are culturally relevant, can achieve measurable outcomes and move the needle on curbing and addressing substance use and abuse.

The EBP Work Group will focus its efforts on evidence-based activities which include:

1. Defining levels of evidence to allow state leaders to distinguish proven programs from those that have not been evaluated or have not been shown to be consistently effective or consistently effective in the Nevada environment
2. Maintaining a list of evidence-based programs including those funded by the state to help SAPTA manage available resources strategically
3. Comparing program costs and benefits allowing policymakers to weigh the costs of public programs against the outcomes and economic returns they deliver
4. Reviewing outcome evaluations of provisionally approved or funded programs including their implementation fidelity to help policymakers identify which investments are generating positive results and use this information to better prioritize and direct funding

NOT FINAL

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:

Health Fairs-Nevada's rural and frontier regions rely on these types of community gatherings to get the word out about substance abuse and underage drinking.

 - Printed Material-When coalitions make presentations to parents, bartenders, or students, often they take home printed materials with information and phone numbers or referrals for future reference.
 - PSA Development- PSA's are a part of coalitions regular operation. Many new PSA's are being developed to address marijuana use and build traffic to sites like knowmj.org where people can learn more about marijuana, and coalition prevention work including the harmful effects of various substances. Other uses are when coalitions want to announce their events to draw community members to attend.
 - Speaking Engagements Email requests- Because the coalitions have a long history of serving their communities, they are often called upon to make presentations to the public or speak at conferences and events about strategies and the latest trends in use and prevention efforts.
 - Coalitions are frequently called upon to provide information to legislative bodies who use the information to make informed decisions about issues facing their community.
 - Social Media Dissemination- All of the coalitions have websites and most have Facebook pages or Twitter accounts. These social media outlets help to attract youth to their activities and mission. This is also true for the State partners including Maternal and Child Health which promotes the website sobermomshealthybabies.org, and the Department of

Health and Human Services Tobacco Prevention and Control Program which both provide appropriate prevention information.

b) Education:

Education for Youth Groups-Presentations to youth K-12 related to substance abuse. Many coalitions engage youth to conduct peer-to-peer educational presentations.

- Education to parents-Coalition staff or guest speakers from the community present to parents at high schools. In this way, parents are engaged in the prevention process and can reinforce and support information youth are receiving regarding substance use and abuse.
- Education and information to medical providers- Multiple resources are available to help providers do a better job at detecting and making referrals to the proper places. Prevention partners come together to ensure resources are shared and utilized by providers.
- Education to Treatment and Prevention providers on addiction- In an effort to assist prevention and treatment providers with information to hone their skills or keeping abreast of current trends.
- Education to bartenders and servers on the importance of carding their customers before serving them alcohol to reduce underage drinking. Additional focus is placed on responsible beverage service to address binge-drinking and other hazards such as alcohol poisoning.
- Education to tobacco sales merchants about carding customers before selling.
- Education to Marijuana dispensaries about the laws associated with sales. Focus is also placed on harm to minors, and assistance given to help avoid access to minors.

c) Alternatives:

Recovery picnic which is held every September in northern Nevada in an effort to normalize the decision to be drug-free and support those in recovery.

- Safe and Sober graduation parties are held in many of Nevada's high schools. Block grant funds are often combined with the Safe and Sober organizations throughout the state to offer a safe, drug-free graduation experience.
- Block Grant funds are utilized to form and support youth prevention clubs in middle and high schools across the state. These groups offer youth a safe, constructive and meaningful way to spend their time.

d) Problem Identification and Referral:

Most of the coalitions in the state fund direct service programs that address high risk youth (incarcerated, on probation, or whose parents are incarcerated). In some of the counties, Signs of Suicide (SOS) is being conducted as well as Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) where there are increases in number of referrals to services taking place across the State, and an annual increase in trainers who help communities know signs and symptoms and make referrals to triage centers to get people the proper help. Some communities are mapping out their resources and deliberately creating a formalized triage process that all community partners can follow giving it a no wrong door approach.

e) Community-Based Processes:

. This is the most powerful strategy used in Nevada and it begins within the twelve community coalitions. Attending the coalition meetings, one sees members of the community from all walks of life and business including the 12 sectors from the SPF SIG model. Included, but not limited to, are food banks, domestic violence agencies, law enforcement, farmers, ranchers, health care providers of mental health as well as medicine, tribal entities, government agencies, schools, students, youth, parents, and clergy all working together to improve their community. Again, with the various sectors working together and seeking to solve problems as a group rather than in silo's they are able to close the service gaps more efficiently.

The Statewide partnership and a select few coalitions are tasked with mentoring new and existing coalitions to improve their practices, and build capacity to serve their perspective communities better which includes sharing experiences, managing grants, building lasting relationships with community members, understanding reporting, evaluation, community outreach techniques and following proper state processes.

f) Environmental:

Service and Actions oriented Initiatives:

- RX Round-ups which are held semi-annually. These events highlight the issue of availability to youth of prescription medication for non-medical purposes, as well as bring awareness to misuse/abuse of these medications.
- Block Grant funds are utilized to form and support youth prevention clubs in middle and high schools across the state. These groups are working towards shifting social norms regarding drug use among youth.
- Media campaigns which focus:
 - o On the need to limit the over-prescribing of opioids
 - o Locking up prescriptions from youth
 - o Dangers of second hand smoke especially around children
 - o Governor's campaign to improve birth outcomes
 - o Substance use including Marijuana, alcohol, and Opioids.

Legal and regulatory initiatives:

- Quarterly compliance checks especially during Reno's Pub Crawls. These checks spread the word that the community will

not tolerate underage drinking and/or misuse of alcohol.

- Working with Nevada's legislators and local city councils to inform policies.
- Coalition Youth participate in legislation days and attend hearings on important issues that affect youth in Nevada related to substance use and mental health, and offer their voice and are heard. Typically, when youth speak the adults listen.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

Our state has a no supplanting requirement in place for all sub recipients. While braiding is encouraged for sustainability purposes it is to be done within the proper parameters that avoid duplication of efforts or supplanting. There are two federal substance abuse-related grants DPBH oversees (Block, and PFS) and two state grants awarded to the prevention coalitions, and monitored by SAPTA. Each funding source has its priorities, thus complimenting or enhancing the other funding streams. The Coalitions report on each grant's quarterly activities separately, to maintain separate scopes of work and avoid any supplanting of funds. Additionally, a monitor is conducted annually to include a fiscal review to ensure all sources are accounted for separately as well as whether each is complying with federal and state regulations.

NOT FINAL

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan Nevada developed an EBP workgroup 2018-2019.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use
- Perception of harm

- c) Disapproval of use
- d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e) Other (please describe):

NOT FINAL

Footnotes:

NOT FINAL

**Substance Abuse
Prevention and Treatment
Agency
Bureau of Behavioral Health,
Wellness and Prevention
Strategic Plan
2017-2020**

Nevada Division of Public and Behavioral Health

Acknowledgements

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Name	Position	Organization
Michelle Berry	Project Manager	Center for the Application of Substance Abuse Technology
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Kendra Furlong	Health Program Specialist II	Nevada Bureau of Public and Behavioral Health, Behavioral Health, Wellness and Prevention
James Kuzhippala	Health Program Specialist	Office of Public Health Informatics and Epidemiology
Linda Lang	Director	Nevada Statewide Coalition Partnership
Barry Lovgren	Public	Private Citizen
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Julia Peek	Deputy Administrator	Division of Public and Behavioral Health
Karen Taycher	Executive Director	Nevada PEP
Stephanie Woodard	Senior Advisor on Behavioral Health State of Nevada	Department of Health and Human Services



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Executive Summary

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of the Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH). SAPTA plans, funds, and coordinates statewide substance abuse service delivery.¹ SAPTA's key roles include distributing funding (tax dollars, general fund, and grants), creating and implementing statewide plans for substance abuse services, and developing standards for certification of programs and services.

In January 2017, a Steering Committee was convened to develop a strategic plan to both guide SAPTA's efforts and to fully align with state and federal regulations. This Strategic Plan documents a path to administer funding and coordinate substance use disorder services between 2017 and 2020. The plan was informed by a situational analysis based on community input, epidemiological data, key informant interviews, and other sources. Both critical issues identified by stakeholders and strategic initiatives identified in the Substance Abuse Block Grant (SABG) were used in the identification of plan goals and strategies.

The mission, or core purpose for this plan, is to promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's residents and communities. The vision is that Nevadans are healthy and resilient and able to fully participate in their communities.

The Steering Committee drafted six values to guide both the planning process and its implementation, and, developed five goals and 12 objectives to guide its work between June 2017 and June 2020. Strategies were also identified to help launch implementation. Note that while goals and objectives are intended to stay fixed during the plan term, strategies may need to be adjusted to reflect the most current situations at the federal, state, and local levels.

Regular use, review, and updates to the public are critical to the success of this plan.

¹ Many of the statutes and regulations refer to substance abuse; however, goals and strategies reflect the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) language. The DSM no longer uses the terms substance abuse and substance dependence.

Goal 1	
Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.	
Objectives	Objective 1.1: By August 30, 2018, attain compliance with federal and state regulations.
	Objective 1.2: By June 30, 2018, structure the Bureau for effective planning and administration.
	Objective 1.3: By December 31, 2018, establish practices to increase accountability and transparency in alignment with the values described in this plan.
	Objective 1.4: By March 31, 2018, develop protocols that provide for consistent affordable billing by the funded treatment programs for the uninsured and the underinsured.
Goal 2	
Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.	
Objectives	Objective 2.1: By December 2018, reduce service gaps.
	Objective 2.2: By December 2019, increase the capacity of local communities.
Goal 3	
Sustain and strengthen evidence-based practices and promote a competent workforce.	
Objectives	Objective 3.1: By December 2018, increase the use of evidence-based practices.
	Objective 3.2: By December 2020, increase the competency of the workforce.
Goal 4	
Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.	
Objectives	Objective 4.1: By December 2018, improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information.
	Objective 4.2: By December 2019, improve intercommunication between the Bureau, the public, and its partners.
Goal 5	
Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.	
Objectives	Objective 5.1: By December 2018, improve access to timely and appropriate treatment and care.
	Objective 5.2: By December 2018, increase collaboration among funded providers.

The plan will be reviewed at least annually by the Behavioral Health Planning and Advisory Council (BHPAC) or its successor and the Bureau to evaluate progress towards completion of goals, as well as the feasibility of strategies.

Introduction and Purpose

Nevada's Substance Abuse Prevention and Treatment Agency (SAPTA) is part of Nevada's Bureau of Behavioral Health Wellness and Prevention (BBHWP) within the Division of Public and Behavioral Health (DPBH). SAPTA plans, funds, and coordinates statewide substance abuse service delivery.² While SAPTA is not responsible for direct service delivery, it distributes state and federal grant funding, creates and implements statewide plans for substance abuse services, and develops standards for certification of programs and services.

Because the last SAPTA Strategic Plan was completed in 2007, the Bureau recognized the need for a new plan to guide its efforts and to fully align with state and federal regulations.

State Regulations

According to Nevada Revised Statutes (NRS 458.025), the Division of Public and Behavioral Health (DPBH):

(a) Shall formulate and operate a comprehensive state plan for alcohol and drug abuse programs which must include:

(1) A survey of the need for prevention and treatment of alcohol and drug abuse, including a survey of the treatment providers needed to provide services and a plan for the development and distribution of services and programs throughout this State.

(2) A plan for programs to educate the public in the problems of the abuse of alcohol and other drugs.

(3) A survey of the need for persons who have professional training in fields of health and other persons involved in the prevention of alcohol and drug abuse and in the treatment and recovery of alcohol and drug abusers, and a plan to provide the necessary treatment.³

NRS 458.025 goes on to require that, "In developing and revising the state plan, the Division shall consider, without limitation, the amount of money available from the Federal Government for alcohol and drug abuse programs and the conditions attached to the acceptance of that money, and the limitations of legislative appropriations for alcohol and drug abuse programs."

² Many of the statutes and regulations refer to substance abuse; however, goals and strategies reflect the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) language. The DSM no longer uses the terms substance abuse and substance dependence.

³ Retrieved on October 17, 2016 from: <https://www.leg.state.nv.us/nrs/NRS-458.html>

Any specifics within the state plan will also be compliant with the Nevada Administrative Code, specifically those provisions in Chapter 458 regarding the Abuse of Alcohol and Drugs.

Federal Block Grants

The Nevada Division of Public and Behavioral Health (DPBH) is the Single State Authority (SSA) for federal grants issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). As part of the DPBH, SAPTA administers programs and activities that provide community-based prevention and treatment through the Substance Abuse Prevention and Treatment Block Grant - referred to as SABG by SAMHSA and SAPT by DPBH (Nevada Division of Public and Behavioral Health (DPBH), n.d.). Note that “prevention and treatment” is used throughout this document to summarize a broad continuum of approaches including outreach, prevention, (early) intervention, treatment, and recovery.

The SABG program, mandated by Congress, provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity. Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services. (Substance Abuse and Mental Health Administration, 2016).

SABG has identified target populations and service areas to include:

SABG Targeted Populations and Services				
Pregnant women and women with dependent children	Persons who inject drugs	People with tuberculosis	Early intervention services for people with HIV/AIDS	Primary prevention services (at 20% or more)

Primary prevention strategies are used for those who are not in need of treatment. The requirement for the SABG allotment towards prevention strategies is “no less than 20%” (Substance Abuse and Mental Health Services Administration, 2015).

Plan Creation

A Steering Committee consisting of diverse stakeholders from the community, professional organizations, and advisory boards and councils was convened to guide the development of this plan. A situational analysis was conducted to develop critical issues and goals. Additional input from public town hall meetings helped to prioritize needs and provide feedback on draft goals.

This Strategic Plan creates a comprehensive path forward from 2017-2020 for SAPTA to best administer funding and coordinate substance use disorder services. It facilitates compliance with state and federal requirements while bolstering its own organizational cohesion, strengthening collaboration with other state entities, and directing services to those populations most at risk.

Organization of this Document

This strategic plan contains the following sections:

Methods and Approach

This section outlines the methods and approach to the strategic planning process.

Situational Analysis Summary

This section summarizes the Situational Analysis, describing the regulatory framework for the plan. It also identifies needs, strengths, and potential areas for focus both within SAPTA as an organization and within Nevada’s communities.

Plan Framework

This section describes the mission, vision, and values that articulate SAPTA’s philosophy.

Critical Issues and Goals

This section outlines the priorities established in light of the situational analysis.

Strategic Plan Goals and Strategies

This section details the goals and strategies as well as an implementation timeline. It also identifies potential parties responsible for accomplishing these goals.

Management and Evaluation of the Plan

This section explains how SAPTA plans to measure and monitor accomplishments.

Methods and Approach

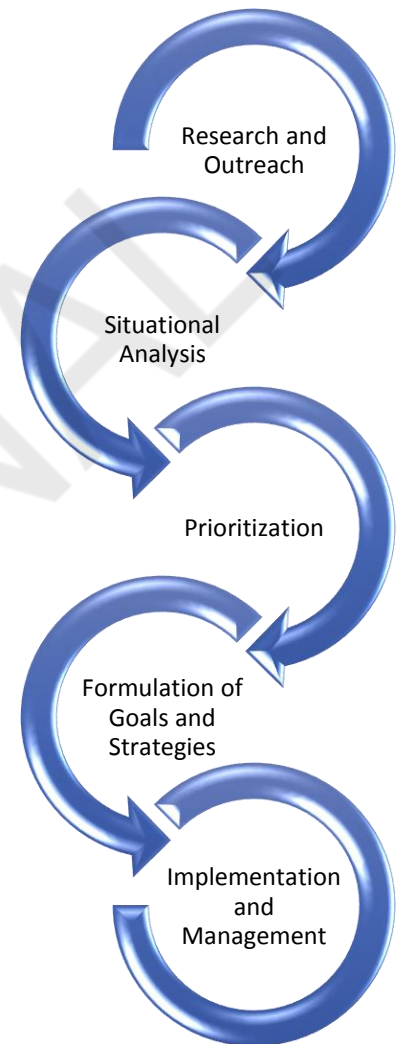
To arrive at the Strategic Plan, Focused Strategic Thinking (FST) was employed. FST is a process for thinking about and planning for the future of an organization that is simple, structured, participative, efficient, and effective. The process involves developing and implementing a strategy and requires three activities – strategic thinking, strategic planning, and strategic management. In practice, the model calls for understanding the situation and then planning the strategy, its implementation, and control. The strategy links leadership’s understanding of the organization today with where it wants, can, and should be at some point in the future (Ginter, Duncan, & Swayne, 2013).

Additionally, SAMHSA’s Strategic Prevention Framework (SPF), designed to answer the following questions, was also incorporated in the approach (Substance Abuse and Mental Health Services Administration, 2016).

1. What is the problem and how can I learn more? (Situational Analysis)
2. What do I have to work with? (Situational Analysis)
3. What should I do and how should I do it? (Strategic Plan)
4. How can I put my plan into action? (Strategic Plan)
5. Is my plan succeeding? (Strategic Plan)

The Steering Committee agreed to use consensus based decision-making in developing the strategic plan, but reserved the option of taking decisions to a vote if the group became deadlocked on an issue. Consensus based decision-making is an inclusive, participatory, and collaborative approach to making decisions that seeks the entire group’s agreement before moving forward with a proposal (Seeds for Change, 2010).

In the first phase, the Steering Committee established a mission, vision, and values for SAPTA’s Strategic Plan. Additionally, a consulting firm under contract with SAPTA conducted research



and outreach to explore and confirm the most pressing needs facing SAPTA using the regulatory framework provided by the Code of Federal Regulations (CFR), the SABG, Nevada Administrative Code (NAC), and Nevada Revised Statutes (NRS). The results of this research produced the situational analysis. The Steering Committee used the situational analysis and its expertise to develop a S.W.O.T. and identify critical issues. It is important to note that not all data for a complete needs assessment was available, and these limitations were detailed in the Situational Analysis.



Next, with additional input from the general public via Town Hall Meetings, the Steering Committee determined priorities based on the situational analysis. These priorities were used to formulate goals and strategies to guide SAPTA over the next three years. Again, public input on drafted goals and strategies was solicited. Finally, the Steering Committee decided how the plan would be implemented and managed in the coming years.

Situational Analysis (Summary)

Overview

Both quantitative and qualitative data were used to develop the situational analysis. Data from multiple sources, including data systems, reports, and publications, were compiled to answer key questions about service availability, utilization, needs, and gaps. It is important to note that the Situational Analysis was created without a comprehensive needs assessment as defined by CFR 96.133. However, to help identify and clarify the most important assets and issues related to substance use disorder outreach, intervention, prevention, treatment, and recovery, the consulting firm that facilitated the planning process interviewed stakeholders across the state, completed a S.W.O.T. analysis with Steering Committee Members, and conducted Town Hall Meetings in Las Vegas, Carson City, and Elko. This section provides a high-level overview of the situational analysis. The complete version can be accessed in the Appendix of this plan.

Summary

Nevada's population is growing and much of the data available indicates that more resources and better outcomes are needed to address prevention and treatment of substance misuse. The current system of care appears overly reliant on emergency rooms and criminal justice settings to identify and engage individuals with substance use and mental health needs. Wait lists for services are long. Additionally, uncertainty about the Affordable Care Act (ACA) could impact already threatened provider groups struggling with workforce issues. Solutions are needed to provide access, expand the workforce, and support prevention, outreach, intervention, and effective treatment and recovery. Disproportionate representation of people with mental illness and substance issues in the criminal justice system points to lost opportunities to reach people early and intervene before additional adverse events impact their lives.

In 2017, Nevada's top needs align well with SAMHSA's strategic initiatives. Several highlights are provided below.

Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

- **Focus on high risk populations.** Key informants identified subpopulations that may have limited access and exposure to resources available for prevention and treatment. These include people speaking a language other than English, youth, and people that are lesbian, gay, bisexual, transgender and questioning (LGBTQ). Data shows that transition-age youth are particularly at risk for substance misuse in Nevada. The rate of older adults with

dependence on opioids has also increased in recent years, pointing to the importance of surveillance to identify emerging populations and develop targeted prevention efforts.

Strategic Initiative #2: Health Care and Health Systems Integration

- **Integrate behavioral health with health promotion and health care delivery.** Continued attention and work to collaborate across behavioral health systems is important to achieve the long-term goal of successful integration. Data from the situational analysis suggests that stronger support for people with co-occurring disorders should remain a priority in Nevada. Cross-sector training and education are also promising approaches to better align and integrate best practices throughout Nevada.

Strategic Initiative #3: Trauma and Justice

- **Reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.** Data from the situational analysis indicates considerable gains are possible through attention to trauma. The state is engaged in several innovative programs around the justice system, which may shed light on additional needs and opportunities. Work through local corrections (jails) and hospitals is an important short-term strategy to address the current situation. It is important to strengthen behavioral health systems so that people are interfacing with appropriate treatment and care. Finally, ‘upstream’ prevention efforts, for example focusing on reducing adverse childhood experiences and the impact of community trauma, can play an important role in addressing the root causes of some mental health and substance use disorders.

Strategic Initiative #4: Person-centered Planning and Recovery Supports

- **Partner with people in recovery from mental and substance use disorders and their family members to guide the behavioral health systems and promote individual, program, and system-level approaches that foster health and resilience.** Assistance with navigation and advocacy were identified as important workforce needs. Families and peers, with training and support, are an under-utilized asset. Housing and transportation are two important needs that were identified as barriers to treatment, treatment outcomes, or both. Several specific services—such as residential treatment—were identified as inadequate to meet community demand. Wraparound or continuum-of-care approaches were identified as solutions to improve outcomes for those with complex needs.

Strategic Initiative #5: Health Information Technology

- **Ensure that the behavioral health systems, including community providers, patients, peers, and prevention specialists can fully participate with the healthcare delivery system in the adoption of health information technology (Health IT).** Nevada has made many

advancements in this regard, including expansion of electronic health records and improvements to data systems. Development of specific data, enhanced communication between state and community groups, and enhanced capacity to analyze and use data to improve outcomes, were key themes identified through this analysis.

Strategic Initiative #6: Workforce Development

- **Support active strategies to strengthen and expand the behavioral health workforce.** Nevada continues to face shortages of providers. Continued efforts to address reciprocity, compensation, and training/licensure issues are needed. Other opportunities include leveraging the planning and activities that are taking place at the state to address issues of reimbursement and payment for providers.

Additionally, a summary of what is working, needs and issues, emerging issues, and opportunities identified through the situational analysis is provided in the following tables.

<i>What's Working Well</i>	
	<i>Examples and Support for Finding</i>
Improvements to Nevada's Behavioral Health System	➤ Nevada has successfully applied for many grants that are helping to improve behavioral health systems. For example, Certified Community Behavioral Health Clinics (CCBHC) and the State Targeted Response (STR) to the Opioid Crisis grant will expand resources available within the state. Other programs like Community Health Workers provide an example of a grant-funded resource that helped connect hard to reach populations with resources. Interviewees for this report recognized progress toward a recovery-oriented system of care, including integration, inclusion, and person-centered care.
Use of Evidence-Based Practices (EBP)	➤ Many systems and organizations use EBP. There is interest in continuing or strengthening existing models and practices and promoting training so more people can benefit across systems and settings.
Local Coordination for Prevention	<ul style="list-style-type: none"> ➤ Coalitions are locally driven and relevant within their communities. They provide information about emerging issues across providers, systems, and geographies. ➤ Coalitions that have successfully engaged local youth and school districts have high quality prevention efforts in their communities. ➤ Behavioral health data has been prepared and presented at the coalition-level to direct prevention and treatment sources and identify areas of unmet need.
Substance Misuse Decreasing for Many	➤ Data from surveys (e.g. National Survey on Drug Use and Health or "NSDUH" and Youth Risk Behavior Survey or "YRBS") show that for many substances and among many populations, Nevada's rates of misuse are decreasing. Significant decreases in use were observed among high school youth between 2013 and 2015 for 'ever smoking cigarettes,' 'currently used tobacco,' 'drank first alcohol

What's Working Well

Examples and Support for Finding

Substances and Populations	before 13,' 'ever used cocaine,' 'ever used inhalants,' 'ever used methamphetamine,' 'ever used [methylenedioxy-methamphetamine, known as] MDMA, 'and 'ever used synthetic marijuana.'
Insurance Coverage	<ul style="list-style-type: none"> ➔ Since Medicaid expansion in Nevada in 2013, the rate of people covered by Medicaid has increased dramatically, providing a source of insurance. Further, the Mental Health Parity Addiction Equity Act has helped to ensure people get the treatment they need. ➔ SAPTA is in the process of revising policies to provide treatment by functioning as a safety-net for claims that are denied by Medicaid.
State-level Improvements	<ul style="list-style-type: none"> ➔ Administrative longevity and restructuring has started to improve the operations at the state level, including improvements to the certification system.

Issues and Challenges

Examples and Support for Finding

System Challenges	<ul style="list-style-type: none"> ➔ Emergency rooms have shown dramatic increases for behavioral health needs in recent years. Key informants also identified that jails are in contact with more people for behavioral health issues. The reasons are not fully clear. Some believe that access to insurance has driven these increases. Others are concerned that the shift to community-based providers has resulted in new access gaps. ➔ Services are not well-known within the community. Online resource directories are not always up to date. Even when people know of services, they often need help navigating and advocating for services. This includes people seeking care for the first time, exiting institutions, and transitioning from treatment. Transitions from higher to lower levels of treatment were identified by key informants as contributing to higher rates of relapse and higher costs due to recurring need for more intensive services. Besides affecting community members, this information gap also affects providers' ability to refer. ➔ Rates of diagnosis and treatment for co-occurring disorders are lower in Nevada compared to the rest of nation. Integrated care is a best practice, and differences between Nevada and the nation for diagnosis and treatment point to the potential for improvement in this area. ➔ There are long wait times for people seeking services within their communities. A lack of services to meet demand, especially residential programs, was noted as a key challenge across the state.
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Issues and Challenges

Examples and Support for Finding

	<ul style="list-style-type: none"> ➤ Providers struggle to collaborate to provide the best care to community members, and seek to better understand resources that are available and reliable within their community to improve collaboration. ➤ Compliance with federal block grant requirements and federal and state regulations is lacking. Examples given include the lack of outreach to intravenous drug users (IVDU), the lack of a capacity management system, the lack of a needs assessment that meets federal requirements, and insufficient referrals to pregnant women, among others. ➤ There is a struggle to align across state systems, divisions, and bureaus. Additionally, a lack of institutional knowledge and lack of subject matter expertise create barriers for providers and prevention professionals to effectively interact with the state.
<p>Substance Misuse Is Elevated for Many Substances and Populations</p>	<ul style="list-style-type: none"> ➤ Rates of substance misuse including dependency are higher among many populations within Nevada compared to the nation. ➤ Survey data shows that many people needing treatment do not get the care they need. ➤ Admissions for substance abuse treatment in Nevada in 2014 were for a variety of substances including alcohol, methamphetamines, heroin, marijuana/hashish, and other opiates/synthetic opiates. ➤ Hundreds of Nevadans die each year from drug and alcohol related illness and injury.
<p>Workforce Shortages</p>	<ul style="list-style-type: none"> ➤ A lack of providers across the state contributes to people needing services and not receiving them. This is a challenge for both consumers and providers. ➤ Compensation for licensed professionals was identified as inadequate to attract and retain the workforce at the level needed. Additionally, professionals, especially in rural areas, experience a high level of 'burnout.' ➤ While many grants have been successfully obtained, these programs, (e.g. Community Case Managers funded through Cooperative Agreement to Benefit Homeless Individuals or "CABHI") will end when grant funding ends. Resources to sustainably build and fund the workforce is lacking. ➤ Funding for case managers and other positions in corrections and state systems has been limited, but these professionals are important to making systems more effective and navigable. ➤ More outreach and services are needed in languages other than English and that are culturally competent.

Issues and Challenges

Examples and Support for Finding

	<ul style="list-style-type: none"> ➤ Many people with behavioral health problems are found in local jails. Education and resources on substance abuse treatment and recovery is important for those professionals working in jails. ➤ Training is needed for people that regularly encounter substance misuse, including nurses, first responders, and other professionals. They may not recognize the signs and symptoms, know how to treat an overdose, or to whom they should refer.
Service Gaps	<ul style="list-style-type: none"> ➤ People needing support for substance use may also have other major unmet needs including housing and transportation. These issues impact their ability to access and have successful outcomes from treatment and for recovery. ➤ Insurance requirements can create problems with continuity of care and individualization of care. ➤ It is difficult to provide the appropriate level of care to individuals seeking help at any point from early intervention to appropriate treatment to recovery services. There are basic barriers to entry into the system, like having an address and transportation issues that prevent people from getting to the care they need. Additionally, services are sometimes simply unavailable. For example, youth whose parents are in treatment require supports and would benefit from early intervention and prevention services.
Data Issues	<ul style="list-style-type: none"> ➤ Data systems are imperfect, and there are still gaps in terms of data available for prevention, planning, and treatment. This includes coordination for individuals (e.g. case management systems), surveillance data (e.g. waiting lists for treatment and recovery), comparable data across communities, and support for monitoring and evaluation. ➤ Data on treatment and recovery is also in need of development (or made more accessible) to answer questions about the use of evidence-based practices, person-centered care, etc. ➤ Some data requests are often duplicative or not coordinated. For providers, this results in time lost that could be spent with clients. For prevention, this limits responsiveness to emerging situations. ➤ For both prevention and treatment, enhanced two-way communication with the state to discuss the data available would support evaluation, reporting, and funding.

Threats and Emerging Issues

Examples and Support for Finding

Policy Changes	<ul style="list-style-type: none"> ➔ The ACA has contributed many improvements to Nevada’s system for care. Loss of the ACA without a replacement could have major consequences for programs that have been planned and developed leveraging provisions of the ACA. ➔ Legalization of marijuana, both medical and recreational, may have an impact on behavioral health and substance misuse in the state.
Emerging Substance Issues	<ul style="list-style-type: none"> ➔ Substance misuse has increased among specific populations including youth, pregnant women, and older adults. ➔ Vaping and e-cigarettes have emerged among youth populations as a new issue. Rates of marijuana use also increased between 2013 and 2015. More than one in 10 middle school youth reported currently drinking alcohol, and 3.8% reported currently using marijuana. ➔ Several concerning patterns of misuse that mirror national trends include increased opioid addiction and children born with Neonatal Abstinence Syndrome (NAS). The severe consequences of opioid misuse have made it a priority for Nevada.
Funding	<ul style="list-style-type: none"> ➔ Many key informants are concerned that funding is not adequate to address and sustain system needs in Nevada. ➔ Information about funding opportunities and assistance to seek these opportunities are unavailable in a timely manner.

Opportunities

Examples and Support for Finding

Engage in Effective Planning	<ul style="list-style-type: none"> ➔ Many states are innovating, including Nevada. Nevada can learn from other states’ efforts to improve policies, systems, and practices toward improved behavioral health outcomes. Nevada also needs to share best practices and highlight innovative programs implemented in the state. ➔ The strategic prevention framework, public health model, and collective impact framework can be leveraged to strengthen Nevada’s planning efforts. ➔ Continued integration of substance outreach, prevention, intervention, treatment, and recovery with mental health provides an opportunity to better serve Nevadans.
Build Sustainability	<ul style="list-style-type: none"> ➔ Outreach indicated a willingness by providers to work with limited resources and collaborate to better serve communities. The state can help to increase this capacity by creating greater transparency related to funding that would allow for

Opportunities

Examples and Support for Finding

	<p>a clearer picture of the funding available and the identification of effective collaborations.</p> <ul style="list-style-type: none"> ➔ Sustainability planning for programs and services provides an opportunity to stabilize systems. ➔ The work of other planning processes, for example Olmstead Planning and <i>Nevada's No Wrong Door</i>, can be leveraged to support better outcomes for people seeking services. Additionally, there are existing collaborative processes and systems (e.g., among the coalitions, Nevada 2-1-1, etc.) that could be leveraged and built upon.
<p>Enhance Communication, Relationships, and Collaboration</p>	<ul style="list-style-type: none"> ➔ SAPTA could serve as the high-level coordinator of services and oversight, working to integrate and consolidate community services and improve access to the system. Data is an important tool for communication, and the state can work to improve existing data collection systems, enhance capacity to report on both services provided and service outcomes, and strengthen two-way communication with local and regional partners. ➔ Improvements to functionality and better coordination of advisory boards holds the potential to improve communication and transparency. ➔ There are many opportunities for the state to work more closely and collaboratively within communities. ➔ Providers' collaboration could be incentivized. Additionally, it could be facilitated with better information (e.g., a comprehensive directory of providers) and formal opportunities to work together toward shared goals.
<p>Regional and Local Control</p>	<ul style="list-style-type: none"> ➔ Town Hall participants and key informants indicated that a "one size fits all" approach may not take into account the distinct needs of different communities. There may be an opportunity to create greater regional and local control. Doing so would allow communities to better address the needs of specific populations and geographies, assist with training the workforce, and develop effective programs.
<p>Develop the Workforce</p>	<ul style="list-style-type: none"> ➔ Cross-systems expertise can increase training and educational opportunities. Educational institutions can be engaged to create better programs, the use of "force multipliers" (e.g., first responders, law enforcement, etc.) can be increased, and masters-level providers can supervise workers with less education to better meet demand.

Opportunities

Examples and Support for Finding

Expand Knowledge
and Practice of
Effective Services

- ➔ Key informants identified many practices that hold promise for improved outcomes, including:
 - Targeted outreach and messaging for prevention
 - Assistance with navigation and coordination for services
 - Interventions that utilize family members and peer support
 - Medication-assisted treatment (MAT), including walk-in clinics
 - Trauma-informed approaches to care
 - Cognitive behavioral therapy and related practices
 - Best practices for working with people recovering from opioid addiction
 - Supportive transitions through a continuum of treatment services
- ➔ Providers are very interested in learning more and using the best tools. SAPTA can help to support widespread use of effective practices and a shared vocabulary, helping to ensure training and support by reducing financial and geographic barriers.

Plan Framework

This section describes the components that serve as the basis for SAPTA's Strategic Plan. The vision statement gives a compelling view of the type of future that the plan seeks to create for the clients and communities being served. The mission statement clearly and succinctly describes the fundamental purpose for the plan's existence, while the concepts and values are used for all decision-making related to the plan.

Together, the mission, vision, concepts, and values guide SAPTA's philosophy for implementing its strategic plan.

Mission

The mission of this plan is to promote healthy behaviors and reduce the impact of substance use and co-occurring disorders for Nevada's people and communities.

Vision

Nevadans are healthy and resilient and able to fully participate in their communities.

SAMHSA's Core Concepts

Behavioral health is essential to health.
Prevention works.
Treatment is effective.
People recover from mental and substance use disorders.

Values

Data driven decision-making. We strive to develop and use data as a primary foundation for all planning and decision-making.

Comprehensive, coordinated, and integrated services. We believe that outcomes are strengthened through community-based mental health and substance use disorder outreach, prevention, intervention, treatment, and recovery services, creating a recovery-oriented system of care that addresses people's comprehensive needs and uses evidence-based and trauma-informed care consistently.

Affordable and timely care that meets state quality assurance standards. We believe that people have a right to access care that meets state quality assurance standards and receive respectful substance abuse services in a timely manner, regardless of ability to pay.

Culturally and linguistically appropriate services. We believe that substance abuse outreach, prevention, intervention, treatment, and recovery services should be respectful of and responsive to cultural and linguistic needs, as established by the culturally and linguistically appropriate service (CLAS) standards developed by the U.S. Department of Health and Human Services. We embrace principles of equal access and non-discriminatory practices in service delivery. We strive to incorporate cultural and linguistic competence into policy making, infrastructure, and practice.

Well-trained and incentivized workforce sufficient to meet community needs. We believe that an educated, trained, and appropriately compensated workforce can provide the best care for the people of Nevada. Additionally, we recognize that there must be enough providers to meet community needs.

Accountable to the people who are served, local communities, and the public. We include opportunities for public engagement in planning and decision-making and promote access to information through transparency in all processes.

Critical Issues and Goals

This section outlines the critical issues and the corresponding goals established by the Steering Committee and the public.

Based on the evidence presented in the situational analysis, the Steering Committee, webinar participants, and Town Hall participants established five critical issues and developed goals to address each one.

Critical Issue #1: State Capacity

A critical issue is the state's capacity to assess need, manage available resources, report on utilization and outcomes, and comply with federal regulations and federal grant requirements. This issue contributes to lack of integration as specified in statute and has the potential to impact much-needed funding. The capacity gap includes the need for state-level subject matter expertise, knowledge capture, and the transfer of institutional knowledge.



Goal #1:

Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.

Critical Issue #2: Service Gaps

A critical issue is the gap in services needed for prevention, outreach, intervention, treatment, and recovery in Nevada, including (but not limited to):

- a. Lack of wraparound services
- b. Lack of person-centered planning and recovery supports
- c. Services for adolescents
- d. Services to address needs in justice systems



Goal #2:

Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.

Critical Issue #3: Strong, Sustainable Resources for Evidence-Based and Integrated Approaches

A critical issue is the need to sustain and strengthen evidence-based practices and promote a competent workforce to implement evidence-based practices. Promote cross-system, integrated approaches, and cross-agency initiatives.



Goal #3:

Sustain and strengthen evidence-based practices and promote a competent workforce.

Critical Issue #4: Public Education and Information

A critical issue is insufficient public education and information that addresses stigma and promotes the availability of resources to allow for better navigation of the system.



Goal #4:

Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.

Critical Issue #5: Fragmented Systems

A critical issue is the lack of consistent eligibility assessment and referral within the state and community-based service delivery system that creates silos and obstacles for an effective system of referral and care for people needing treatment and recovery.



Goal #5:

Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.

Goals, Objectives, and Strategies

This section presents each goal and its subsequent objectives and strategies for completion that were articulated as a result of the priorities set by the Steering Committee and the public. Note that strategies may need to be modified during the life of the plan to best address current situations.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 1.1: By August 30, 2018, attain compliance with federal and state regulations.	1.1.1 Ensure Nevada is fully compliant with all federal mandates designated in the Code of Federal Regulations as well as substance abuse federal block grants (SABG). <ul style="list-style-type: none"> Comply with federal law for content of SAPT Block Grant application by August 2017 Comply with federal law for eligibility for SAPT Block Grant funding by August 2018 	Ongoing	Bureau staff with technical assistance.
	1.1.2 Complete a statewide needs assessment that meets all state and federal standards.	Every other year	Bureau staff to lead; suggest building on Situational Analysis document with additional data (See the Situational Analysis for documentation of needs as well a list of other information needed).
	1.1.3 Develop and implement a quality assurance system to ensure compliance with federal and state regulations.	Ongoing	Bureau staff, with guidance from SAMHSA technical assistance providers.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 1.2: By June 30, 2018, structure the Bureau for effective planning and administration.	1.2.1 Define the focus and purpose of the Bureau.	One time; review when there are changes to regulations	Bureau staff; consider both existing mandates as well as the emerging changes at the federal level.
	1.2.2 Clearly identify the Bureau's capabilities and essential functions via an internal assessment.	Every other year and on an "as needed" basis	Bureau staff; consider use of a TA provider to map functions, capabilities, and, recommendations.
	1.2.3 Develop and implement a plan for the recruitment and retention of qualified staff.	As determined by plan	Bureau staff, working with state HR to develop and document the plan.
	1.2.4 Review policies and statutes to strengthen prevention, outreach, intervention, treatment, and recovery systems, including a review rules of practice.	Every other year or as needed	A workgroup facilitated by Bureau staff, engaging knowledgeable experts in these areas.
	1.2.5 Develop a system to capture and transfer institutional knowledge.	Ongoing	Bureau staff. Review, update, and compile policies and practices with necessary updates. Allocate hours for keeping this information up to date, organized, and accessible.
	1.2.6 Identify any outstanding funding needs and identify plans to address them (e.g. through fiscal leveraging, new grant applications, etc.)	After completion of 1.1-1.5	Bureau staff.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 1.3: By December 31, 2018, establish practices to increase accountability and transparency in alignment with the values described in this plan.	1.3.1 Implement an integrated and streamlined approach for the collection, analysis, interpretation, and use of data. <ul style="list-style-type: none"> Identify redundancies and issues within existing systems and make plans to address. Review existing questions to ensure that high quality and useful information is being collected. 	Ongoing	Bureau staff with guidance and coordination from Office of Public Health Informatics and Epidemiology (OPHIE). Any additions of 'new data' from providers should be considered with the context that multiple data-systems are already required and are cumbersome. Improving efficiency should be part of this work.
	1.3.2 Increase opportunities for public involvement and public oversight.	Ongoing; track activities each month	Use workgroups or subcommittees to address specific aspects and have these groups shape future plans.
	1.3.3 Increase transparency and improve communication by sharing accurate epidemiological information with the public and the Bureau's partners.	Ongoing; track activities each month	Continue to work with OPHIE to analyze and share data.
	1.3.4 Assure collaboration with other state agencies.	Ongoing; track activities each month	Bureau staff with technical assistance.
Objective 1.4: By March 31, 2018, develop protocols that provide for consistent affordable billing by the	1.4.1 Review billing and collection protocols for funded treatment programs.	One time and as needed	Bureau staff with technical assistance.
	1.4.2 Clarify billing and collection protocols for funded treatment programs.	Every five years or as needed	Bureau staff with technical assistance.

Goal #1: Strengthen and enhance the Bureau's infrastructure to manage, lead, and sustain effective behavioral health promotion, programs, and strategies.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
funded treatment programs for the uninsured and the underinsured.	1.4.3 Publicize billing and collection protocols for funded treatment programs.	Ongoing; track activities each month	Bureau staff with technical assistance. Work with coalitions and funded treatment providers to publicize.
	1.4.4. Develop systems to enforce the requirement that funded partners meet grant assurances.	One time and as needed	Bureau staff working with other state agencies as well as with funded partners.

Goal #2: Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 2.1: By December 2018, reduce service gaps.	2.1.1 Leverage the coalition assessment process to identify and document local and regional service needs and gaps and potential resources to best address those gaps.	Every other year	In alignment with timing for coalition assessments.
	2.1.2 Evaluate existing strategic frameworks for planning, including the Strategic Prevention Framework and the Integrated Block Grant Planning Framework, to identify applicable aspects of these frameworks and leverage coalition knowledge and processes for specific communities.	Every five years	Bureau staff with input from coalition leadership.

Goal #2: Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 2.2: By December 2019, increase the capacity of local communities.	2.2.1 Determine which aspects of local infrastructure can be enhanced in order to address service gaps.	Every other year	Bureau staff to support local leadership.
	2.2.2 Distribute data to community stakeholders to inform local and regional planning.	Quarterly	Bureau staff in partnership with OPHIE and the Statewide Epidemiological Workgroup (SEW).
	2.2.3 Facilitate public and private partnerships to increase the impact of services.	Ongoing	Bureau staff working to support public and private partnerships.
	2.2.4 Establish a continuum of resources that includes Medicaid, block grant funding, and other resources to best serve the needs of each community.	One time; update only as needed	Bureau staff working together with other state partners.
	2.2.5 Use data to inform and drive policy and practice changes. For example: <ul style="list-style-type: none"> Assess number of providers to treat the number of patients/clients. Assess the number of patients with diagnosis that needs treatment. Recommend funding and policy changes to address data issues. Review national and regional research that can help address behavioral health needs and issues. Identify and recommend policies to improve the state's system of care. See Situational Analysis for additional data gaps. 	Ongoing	Bureau staff working with OPHIE, SEW, and in communication with local leaders.
	2.2.6 Encourage and support Medicaid to provide sufficient technical assistance to providers.	Ongoing	Bureau staff working together with other state partners.

Goal #2: Build the capacity of local communities to provide the services to address their specific needs based on data-driven priorities.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
	2.2.7 Create a training and technical assistance system that is community-driven. Identify the training and technical assistance needs of providers to address the specific needs of their service populations. (Related to 2.3.3)	Ongoing	Bureau staff working together with other state partners and local leaders to design, implement and maintain a strategic and responsive system for TA.

Goal #3: Sustain and strengthen evidence-based practices and promote a competent workforce.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 3.1: By December 2018, increase the use of evidence-based practices.	3.1.1 Utilize the agency certification process to embed evidence-based practices in service provision.	One-time to set up; review annually	Bureau staff.
	3.1.2 Strengthen the linkage between the agency certification process and funding allocation.	One-time to set up; review annually	Bureau staff.
	3.1.3 Utilize public-private partnerships to increase resources at the federal, state, and local levels to encourage use of evidence-based practices.	Ongoing	Bureau staff working with other state partners, as well as local leaders, to strengthen EBP.
Objective 3.2: By December 2020, increase the competency of the workforce.	3.2.1 Promote training and technical assistance opportunities, in partnership with other state and community entities.	Ongoing	Bureau staff working with other state and community entities.

Goal #3: Sustain and strengthen evidence-based practices and promote a competent workforce.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
	3.2.2 Utilize public-private partnerships to increase workforce development resources at the federal, state, and local levels. Include Nevada's system of higher education as a partner in this work. (See 2.3.5)	Ongoing	Bureau staff working with other partners, including other state and local partners. Note that placements are also needed and other partners may need to be engaged to accomplish this task.
	3.2.3 Identify common concerns and recommendations for improving credentialing, certification, and other factors related to workforce. Provide information and recommendations for consideration to credentialing and advisory boards.	Work to begin as soon as possible with preparation for 2019 legislative session	Bureau staff to support workgroup meetings and communications centered on consensus of concerns and recommendations for improvement.
	3.2.4 Engage with educational partners including higher education (Nevada System of Higher Education) and secondary education partners to create a pipeline of qualified workforce that addresses community needs.	Ongoing	Bureau staff working to engage education partners in workgroups. Note that other partners may also be needed to support placements of qualified personnel into the workforce.

Goal #4: Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 4.1: By December 2018, improve the accessibility and dissemination of prevention, outreach, intervention, treatment, and recovery information.	4.1.1 Provide adequate public information and education about the admission priorities and availability of treatment for all federal and state priority populations at Bureau-funded treatment programs.	Ongoing	Bureau staff working with funded partners.
	4.1.2 Require Bureau-funded providers to provide up-to-date information to 2-1-1 about access and availability of services.	Ongoing	Bureau staff working with funded partners and Nevada 2-1-1.
	4.1.3 Create linkages between state systems to ensure seamless access to information (e.g. provide 2-1-1 with HavBed to improve referral services).	Ongoing (and after completion of 4.1.2)	Bureau staff working with 2-1-1.
	4.1.4 Increase publicity and visibility for the Bureau itself, including promoting its role in funding local education efforts.	Ongoing	Bureau staff working with funded partners and other state agencies.
	4.1.5 Share up-to-date state-funded prevention, outreach, intervention, treatment, and recovery resources with other public and private entities that offer information and referral services that meet Culturally and Linguistically Appropriate Service (CLAS) Standards.	Quarterly	Bureau staff working with funded partners and other state agencies.
	4.1.6 Develop a communications plan and engage partners in sharing up-to-date messaging and information.	One time, with updates as needed	Bureau staff with technical assistance.
	4.1.7 Assure educational and informational materials meet Culturally and Linguistically Appropriate Service (CLAS) Standards.	Every five years or as needed	Bureau staff with technical assistance.

Goal #4: Improve behavioral health care and wellness through relevant, timely, and accessible education, training, and information.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 4.2: By December 2019, improve intercommunication between the Bureau, the public, and its partners.	4.2.1 Improve public feedback mechanisms to allow the public to communicate with Bureau about service quality and service needs.	Ongoing	Bureau staff.
	4.2.2 Provide support for coalitions and other funded providers to maintain up-to-date information resources on their websites.	Ongoing	Bureau staff working with funded partners.
	4.2.3 Support local and regional communities to conduct outreach to and engage individuals and their families in recovery in accordance with the values of the plan.	Ongoing	Bureau staff working with funded partners and other state agencies.
	4.2.4 Support targeted trainings to build the public's knowledge-base in relationship to effective prevention, outreach, intervention, treatment, and recovery.	Ongoing	Bureau staff working with funded partners and other community leaders.

Goal #5: Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
Objective 5.1: By December 2018, improve access to timely and appropriate treatment and care.	5.1.1 Implement and track a quality assurance system, including capacity management and waitlist.	One-time to establish system; ongoing	Bureau staff with technical assistance.

Goal #5: Improve state and local cross-organizational collaboration to provide a system of effective and inclusive prevention, outreach, intervention, treatment, and recovery services.			
Objective	Strategy	Timeline or Frequency	Responsible Parties and Potential Partners
	5.1.2 Report annually on quality assurance system, including capacity management and waitlist, specifically addressing priority populations.	Annually and as needed	Bureau staff.
	5.1.3 Incorporate consumer and community voices into planning, implementation, and evaluation of services.	Ongoing	Bureau staff with technical assistance.
	5.1.4 Support and facilitate screening and referral for substance use and co-occurring disorders within the Bureau's network and develop partnerships outside of the network for referrals.	Ongoing	Bureau staff working with funded partners as well as non-funded providers.
Objective 5.2: By December 2018, increase collaboration among funded providers.	5.2.1 Require funded programs to demonstrate participation and engagement in local collaborative partnerships.	Ongoing	Bureau staff working with funded partners.
	5.2.2 Encourage certified programs to participate and engage in local collaborative partnerships.	Ongoing	Bureau staff working with non-funded partners through the certification process.

Management and Evaluation of the Plan

This Strategic Plan was developed to drive change within the Bureau while simultaneously offering flexible strategies to create adaptability and ensure goal fulfillment. The plan may also be used to inform SAPTA's annual budget.

The plan will be reviewed annually by the Behavioral Health Planning and Advisory Council (BHPAC) or its successor and the Bureau to evaluate progress towards completion of goals, as well as the feasibility of strategies. Additionally, this annual review will be used to scan the internal and external environment for potential changes. In the case that there are considerable changes, the plan will be updated to reflect changes and adapt accordingly.

Additionally, it is important to review data as part of updating the plan. Trends in the situational analysis can be updated annually, and new data elements are likely to be available through system improvements. Monitoring community needs and resources is critical for ensuring the plan remains relevant and for meeting federal requirements for a comprehensive needs assessment.

Updates on progress and changes to the plan resulting from these annual reviews will be communicated to the public via the Bureau of Behavioral Health, Wellness and Prevention page on the DPBH website.

If you have any feedback on this plan or would like to offer suggestions or improvements, please email: Julia Peek, Deputy Administrator at jpeek@health.nv.gov or Kyle Devine, Bureau Chief at kdevine@health.nv.gov.

Glossary of Terms

Behavioral Health: Refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and recovery support (SAMHSA).

CCBHC: Certified Community Behavioral Health Clinics. CCBHCs were created through Section 223 of the Protecting Access to Medicare Act (PAMA). CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing or contracting with partner organizations to provide different types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

CFR: Code of Federal Regulations.

Charitable Choice: Provisions of the SAMHSA Charitable Choice regulations are designed to strengthen the capacity of faith-based and other neighborhood organizations to deliver services effectively to those in need and provide people with a choice of SAMHSA-supported substance use prevention and treatment programs. Provisions also ensure that funding administered by SAMHSA is accomplished without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries.

Co-Occurring Disorder: People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis. Substance use disorder. A substance use disorder includes. Alcohol or drug abuse (Behavioral Health Evolution, n.d.).

DPBH: Division of Public and Behavioral Health

Evidence-Based Practice: A working definition for evidence-based practices has been included from SAMHSA and meets the following criteria:

- The intervention is included in a federal registry of evidence-based interventions, such as the National Registry of Evidence-based Programs and Practices (NREPP) OR
- The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal OR
- The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which must be followed. These guidelines require interventions to be:
 - ✓ Based on a theory of change that is documented in a clear logic or conceptual mode AND
 - ✓ Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals AND
 - ✓ Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects AND
 - ✓ Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

FST: Focused Strategic Thinking. Method of strategic planning employed to create this plan.

NRS: Nevada Revised Statutes

NAC: Nevada Administrative Code

OPHIE: Office of Public Health Informatics and Epidemiology

Person-and Family-centered Planning: According to SAMHSA, “Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible.”

Recovery: SAMHSA has established a working definition of recovery that defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-

based clinical treatment and recovery support services for all populations. SAMHSA has delineated four major dimensions that support a life in recovery:

Health—overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being

Home—having a stable and safe place to live

Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society

Community—having relationships and social networks that provide support, friendship, love, and hope

Recovery-Oriented System of Care (ROSC): a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SABG: Substance Abuse Block Grant. Federal grant administered by SAPTA.

SAMHSA: Substance Abuse and Mental Health Services Administration.

SAPT Grant: Substance Abuse Prevention and Treatment Grant. See SABG.

SAPTA: Nevada’s Substance Abuse and Treatment Agency.

Serious Mental Illness (SMI): Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment. In 2014, there were an estimated 9.8 million adults (4.1%) ages 18 and up with a serious mental illness in the past year. People with serious mental illness are more likely to be unemployed, arrested, and/or face inadequate housing compared to those without mental illness (Substance Abuse and Mental Health Services Administration., 2015).

Serious Emotional Disturbance (SED): Serious emotional disturbance. The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional

impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A Centers for Disease Control and Prevention (CDC) review of population-level information found that estimates of the number of children with a mental disorder range from 13 to 20%, but current national surveys do not have an indicator of SED (Substance Abuse and Mental Health Services Administration., 2015).

Substance Use Disorder (SUD): The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. (Substance Abuse and Mental Health Services Administration., 2015).

SPF: "SAMHSA's Strategic Prevention Framework (SPF) is a planning process for preventing substance use and misuse. The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive process for addressing the substance misuse and related behavioral health problems facing their communities. The effectiveness of the SPF begins with a clear understanding of community needs and involves community members in all stages of the planning process" (Substance Abuse and Mental Health Services Administration, 2016).

SSA: Single state agencies (SSAs) and state mental health agencies (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. (Substance Abuse and Mental Health Services Administration., 2015).

Trauma-Informed Approach: According to SAMHSA, "A program, organization, or system that is trauma-informed: realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization" (Substance Abuse and Mental Health Services Administration, 2015).

Bibliography

- Behavioral Health Evolution. (n.d.). *What are Co-Occurring Disorders?* Retrieved from http://www.bhevolution.org/public/cooccurring_overview.page
- Ginter, P., Duncan, W., & Swayne, L. (2013). *Strategic Management of Health Care Organizations* (7th ed.). San Francisco, California: John Wiley & Sons/ Jossey-Bass Publishers.
- Nevada Division of Public and Behavioral Health (DPBH). (n.d.). *SUBSTANCE ABUSE PREVENTION AND TREATMENT AGENCY (SAPTA)*. Retrieved from http://dphh.nv.gov/Programs/ClinicalSAPTA/Home_-_SAPTA/
- Seeds for Change. (2010). *Consensus Decision Making: A Short Guide*. Retrieved 2017, from Seeds for Change: <http://www.seedsforchange.org.uk/shortconsensus>
- State of Nevada. (2011). *SAPTA Policy Manual*.
- Substance Abuse and Mental Health Administration. (2016, December 6). *Substance Abuse and Mental Health Block Grants*. Retrieved from <http://www.samhsa.gov/grants/block-grants>
- Substance Abuse and Mental Health Services Administration. (2015, August 14). *National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint*. Retrieved from <https://www.samhsa.gov/nctic/trauma-interventions>
- Substance Abuse and Mental Health Services Administration. (2015, February 2). *What is the Substance Abuse Prevention and Treatment Block Grant?* Retrieved February 2017, from Substance Abuse and Mental Health Services Administration: <https://www.samhsa.gov/grants/block-grants/sabg>
- Substance Abuse and Mental Health Services Administration. (2016, June 22). *Apply the Strategic Prevention Framework*. Retrieved October 2017, from <https://www.samhsa.gov/capt/applying-strategic-prevention-framework>
- Substance Abuse and Mental Health Services Administration. (2015). *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2013*. *HHS Pub*. Rockville, MD: Substance Abuse and Mental Health Services Administration

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?
 - a) Physical Health Yes No
 - b) Mental Health Yes No
 - c) Rehabilitation services Yes No
 - d) Employment services Yes No
 - e) Housing services Yes No
 - f) Educational Services Yes No
 - g) Substance misuse prevention and SUD treatment services Yes No
 - h) Medical and dental services Yes No
 - i) Support services Yes No
 - j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) Yes No
 - k) Services for persons with co-occurring M/SUDs Yes No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Clarification for letter H- Medical yes and Dental Rehabilitation services

3. Describe your state's case management services
Nevada Medicaid reimburses targeted case management services for individuals with SMI/SED. The CCBHC's offer case management as a core service for individuals with SUD.

4. Describe activities intended to reduce hospitalizations and hospital stays.
Diversion program: FAST

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	95,000 (4.4% all adults)	15.2/100,000
2. Children with SED	31,000 (13.9% all adolescents)	15.2/100,000

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Criterion 2: Mental Health System Data Epidemiology

1. Statewide Prevalence of SMI and SED:

Adults with Serious Mental Illness (SMI):

Nevada's statewide prevalence of serious mental illness (SMI) in adults 18 years or older was estimated based on the most recent and available data from the National Survey on Drug Use and Health (NSDUH, 2017): Nevada's annual average percentage of past year serious mental illness (SMI) among adults aged 18 or older was similar to the corresponding national average percentage. An estimated annual average of approximately 95,000 adults aged 18 or older (4.4% of all adults) in 2014-2015 had SMI during the previous year. The annual average percentage of SMI during 2014-2015 was not significantly different from the annual average percentage in 2011-2012.

Source: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Nevada, Volume 4. Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017

Children with Serious Emotional Disturbance (SED):

Nevada's statewide prevalence of Serious Emotional Disturbance (SED) among adolescents aged 12 to 17 was estimated using the most recent and available data from the National Survey on Drug Use and Health (NSDUH, 2017) and viewing major depressive episode (MDE) as a proxy estimate for SED. Nevada's annual average percentage of major depressive episode (MDE) among adolescents aged 12-17 was similar to the corresponding national average percentage. An estimated annual average of approximately 31,000 adolescents aged 12-17 (13.9% of all adolescents) in 2014-2015 had experienced a Major Depressive Disorder (MDE) in the previous 12 months. Noteworthy, the annual average percentage in 2014-2015 was higher than the annual average percentage in 2011-2012

Source: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Nevada, Volume 4. Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-NV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

2. Statewide Incidence (new cases) per year of SMI and SED:

The median rate of new cases (or incidence) each year for schizophrenia, one of the principal psychotic disorders targeted for funding of early treatment services during the next biennium, is estimated to be 15.2 per 100,000 population (McGrath et al., 2008), and the first episode of psychosis exhibits a peak onset between 15 and 25 years of age (Heinssen et al., 2014; Kessler et al., 2007a; Kessler et al., 2007b). However, approximately 20% of individuals diagnosed with schizophrenia have an onset of their illness after the age of 40 years (Harris and Jeste, 1988; Howard et al., 2000; Maglione et al., 2014). The age range for capturing cases of first episode of psychosis therefore extends from middle adolescence and early adulthood through middle adulthood. Based on these findings, the anticipated incidence rate of schizophrenia for Nevada (statewide) was estimated as 307 new cases during each fiscal year, as follows:

$(2,022,031) (15.2/100,000) = 307.4$.

The State does not collect information regarding the rate of new cases of mental disorders per year, so this estimate was determined using the best available information, including the following:

- (1) Population estimates for 2018 (as of July 1) for Nevada residents ages 14 to 64: 2,022,031 (Source: U.S. Census Bureau, Population Division (Release Date: June 2019).
- (2) Selection of the age range for population estimation was informed by age of onset distributions for schizophrenia described above.
- (3) Median incidence of schizophrenia of 15.2/100,000 persons determined by McGrath et al. (2008).

NOT FINAL

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services Yes No
- b) Educational services, including services provided under IDE Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse prevention and SUD treatment services Yes No
- e) Health and mental health services Yes No
- f) Establishes defined geographic area for the provision of services of such system Yes No

NOT FINAL

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Nevada receives the PATH and CABHI grants to assist in managing the homeless population. These grants allow outreach case workers to serve individuals in the North, South, and rural regions of the State. They make referrals when needed and assist individuals to get care. Medicaid has started to place eligibility workers within local agencies that serve the targeted populations including rural, homeless, and older adults. The workers are able to get necessary services and assistance to families and individuals who are struggling with finances, and mental health or substance use needs.

b. Describe your state's targeted services to the homeless population.

Nevada receives the PATH and CABHI grants to assist in managing the homeless population. These grants allow outreach case workers to serve individuals in the North, South, and rural regions of the State. They make referrals when needed and assist individuals to get care. Medicaid has started to place eligibility workers within local agencies that serve the targeted populations including rural, homeless, and older adults. The workers are able to get necessary services and assistance to families and individuals who are struggling with finances, and mental health or substance use needs.

c. Describe your state's targeted services to the older adult population.

Nevada receives the PATH and CABHI grants to assist in managing the homeless population. These grants allow outreach case workers to serve individuals in the North, South, and rural regions of the State. They make referrals when needed and assist individuals to get care. Medicaid has started to place eligibility workers within local agencies that serve the targeted populations including rural, homeless, and older adults. The workers are able to get necessary services and assistance to families and individuals who are struggling with finances, and mental health or substance use needs.

NOT FINAL

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The State of Nevada State Administrative Manual (SAM) and associated Nevada Revised Statutes and Regulations dictate the general business operations of all State agencies. Routine compliance audits are conducted by both the State Legislative Counsel Bureau and the Department of Administration auditors regularly. Routine revision and review of the agency's internal controls occurs each two-year State Budget cycle. The Division of Public and Behavioral Health (DBPH), which includes both Mental Health and Public Health programs, has an Administration Manual that addresses program integrity in depth. The Bureau of Behavioral Health, Wellness and Prevention is comprised of the Substance Abuse Prevention and Treatment Agency, Mental Health Planning, and the AIDS/HIV programs. The Bureau is working to revise the manual to develop a comprehensive program integrity plan that reflects the integration of the Mental Health and Substance Abuse block grants. Strong internal controls are in place to assure the accountability of all revenue and expenditures, and the state is developing a distribution methodology for funds that are dispersed for prevention, direct services, and treatment related activities to align substance abuse and mental health services. This model will also detail compliance reviews; performance measures; and results will be validated with data based measurements. This will incorporate program integrity measures as standard across all block grant activities.

The Division of Child and Family Services (DCFS) is funded to provide child and adolescent mental health service and provide extensive training for their staff on SMI and SED practices as mentioned in planning step 1. They have a program integrity plan in place for direct service funds for children that are uninsured or underinsured. Nevada is one of only a few states that currently provide State level direct mental health services for children and youth. Nevada will be transitioning through the System of Care Grant to shift these direct services to community providers at a higher rate each year as infrastructure is built and capacity is present to serve the need on a community level.

The Department of Health and Human Services (DHHS) requires each mental health providing agency to employ quality assurance specialists. In support of these specialists, the Statewide Quality Assurance and Performance Improvement (QAPI) Program will develop strategic documents to implement and manage the Quality Assurance Program based on Hospital and Behavioral Health Care Joint Commission (JC) standards and standards outlined by the Centers for Medicaid and Medicare Services (CMS). The existing agencies are working on standardizing information across auditing and fiscal and compliance program monitors throughout the Community Services Section.

Reasonable and Appropriate Disbursement of Funds: The Division of Public and Behavioral Health (DPBH) Administration Manual contains individual policy or procedures that support processes. The Division of Child and Family Services Children's Mental Health program uses the same payment methodologies for Block Grant funds as it does for Medicaid and other guarantors. Currently, DBPH requires all requests for reimbursement are completed by the Agency on a Deposit Receipt form, which is submitted to Central Office, who reviews and approves reimbursement of expenditures and sent for draw down of the federal funds.

The Division of Public and Behavioral Health (DPBH) acts as a pass-through entity and sub-grants the majority of its funding to non-profit and other governmental agencies to provide direct services. The requirements and restrictions of state and federal funding are passed to the providers through sub-grant agreements. Providers are responsible for understanding and complying with federal and state regulations in implementing the program. DBPH is charged with the responsibility of verifying that all the requirements are met by the sub-grantee, including 45 CFR Parts 74 and 96 and OMB Circular A-133.

Funds are awarded on a competitive basis through a Request for Qualifications (RFQ) process. Major RFQs will be issued for treatment and prevention on a three-year cycle. One-year prevention will be issued, the next year treatment will be issued and supplemental Funding Announcements will be issued during the three-year period based on funding and need. Programs which are awarded funding through the RFQ process and subsequent funding announcement will have the opportunity to continue their sub-grant throughout the RFQ period with noncompetitive continuation sub-grants as long as funds are available and the grantee continues to be in compliance of grant requirements.

Assisting Providers with Quality, Practice, Safety, and Compliance Policy Adoptions and Standards: The DPBH Administration Manual contains individual policies or procedures that support block grant processes for providing technical assistance to sub-recipients of the program. All individual policy components for providing technical assistance are being revised.

Programs are also required to have a system to prevent inappropriate disclosure of client records that is in compliance with all applicable state and federal laws and regulations, including 42 Code of Federal Regulations (CFR), Part 2; Health Insurance Portability and Accountability Act (HIPAA). The system shall include, but not be limited to, the following provisions:

- Employee education on the confidentiality requirements.
- Informing employees of the fact that disciplinary action may occur upon inappropriate disclosure.
- In addition, programs funded through coalitions have Program Compliance Monitors. The programs are monitored by the coalition, who will in-turn be monitored by the Division for compliance. Monitor activities determine if a program is meeting the minimum terms and conditions of the sub-grant, state, and federal policies. In general, compliance monitors focus on administrative, programming, and fiscal activities of a program to determine if a program is meeting all requirements. A monitor is regulatory in nature and the purpose of a monitor is to accomplish the following:
 - Ensure the efficient delivery of prevention services to Nevada's population.

- Encourage quality improvement practices.
- Verify that alcohol and drug abuse funds are being used as identified in subgrant award documents.
- Ensure that state and federal funds are used to fund programs in compliance with state and federal requirements and restrictions.
- Identify the need for technical assistance.
- Identify problems or difficulties and develop an agreed upon compliance action plan.
- Programs receiving state and/or federal funding, both directly and indirectly, are required to participate in both the certification and the monitor processes.

Assurance of Appropriate Use of Block Grant Dollars: To ensure the appropriate use of block grant funds for eligible services, clients are assessed at intake and every month thereafter to determine medical need, Medicaid eligibility, private insurance eligibility, or if insurance is lacking. Should the client be found to have private insurance or to be eligible for Medicaid, services are billed to those funding sources and not to the block grant. Each participating agency is required to demonstrate Medicaid billing, and ensure no supplanting of funds.

As an example of success due to the policy changes put in place as a result of the Affordable Care Act and Medicaid Expansion supporting mental health services, the Southern Nevada Adult Mental Health Services program which includes the State hospital reduced outpatient caseloads by 50%, transitioning clients to Medicaid service providers within the local community. When individual clients applying for services meet basic screening requirements, it is the Division of Public and Behavioral Health's policy that the client apply for Medicaid benefits. To ensure that all persons seeking public health, mental health, and developmental services remain eligible for Medicaid, provider staffs are trained in the basic screening requirements to make appropriate referrals. As a contractual requirement, sub-grantees are required to verify whether or not the client has private insurance or Medicaid. Sub-grantees' policies and procedures in addition to client file documentation are monitored to ensure compliance.

On a monthly basis, the state queries the Medicaid eligibility system to identify any clients who may have unreported Medicaid. If Medicaid eligibility is determined, subsequent payments for Medicaid covered services are denied. Sub-grantees submitting claims to the state for those recipients with private insurance coverage are required to submit appropriate documentation to validate that the service is not covered by the insurance carrier. For services provided to an insured client, a claim is generated for each service provided and submitted to the identified insurance plan for payment. Claims resulting in a denial of payment of the service are reviewed. Only those services that are denied because they are not covered by private insurance and/or Medicaid may be subsequently supported with block grant dollars.

Care Coordination

The Division of Public and Behavioral Health has a formal process that ensures ongoing coordination of efforts on behalf of all individuals served who meet the care criteria for a higher intensity of needs. Care coordination includes: facilitation of communication and enrollment between the individual and providers and provisions for continuity of care by creating linkages to and monitoring transitions between intensities of care, thereby ensuring access to medically necessary outpatient and inpatient services.

Quality Assurance Program

In agreement with the Medicaid Services Manual (MSM) chapter 403.2(B)(6), the Division of Public and Behavioral Health maintains a quality assurance program. This program includes publication of an organizational chart, documentation of staff qualifications and competencies through established work performance standards, position descriptions, staff training, clinical philosophies, practices and protocols, and accounting methods.

Organizational Chart

In concurrence with the Medicaid Services Manual (MSM) 403.2(B)(6)(a), the Division of Public and Behavioral Health publishes and maintains an organizational chart that shows lines of authority, including medical, clinical and direct services. This chart can be accessed at the following link: http://dph.nv.gov/About/AdminSvcs/HR/Organizational_Charts/

Staff Qualifications and Documented Competencies

In support of Medicaid Services Manual (MSM) 403.2(B)(6)(b), the Division of Public and Behavioral Health (DPBH) maintains documentation of staff qualifications. Additionally, all employment applicants must pass the minimum qualifications set forth through various job class specifications. Human Resource Management assures that potential employees meet these minimum class specifications and other DPBH established qualification criteria. Job applicants that do not meet minimum qualification criteria are not considered for employment. Additionally, managers and/or supervisors verify potential applicants' resumes, certifications, and/or licensures before offering employment and/or internships. Employee records and competencies are maintained by the Division/Agency human resources departments. Division of Public and Behavioral Health Policy A-5.7 (Provider Enrollment and Quality Assurance) mandates that all professional staff meet Medicaid's provider requirements.

Position Descriptions

Consistent with Medicaid Services Manual 403.2(B)(6)(c), job positions within DPBH are defined by class specifications, essential functions, and work performance standards (WPS). Supervisors are required to review essential functions and WPS with employees. Written position descriptions for all staff providing mental health services are recorded in class specifications, work performance standards and documentation of staff training.

Staff Training

In alignment with Medicaid Services Manual 403.2(B)(6)(d), the Division assures staff are appropriately trained to perform functions within their assigned positions and established WPS. All training is documented and maintained.

Clinical Philosophies, Practices and Protocols

In accordance with Medicaid Services Manual 403.2(B)(6)(e), the Division operates under guiding philosophies and practices which arise from its overall mission:

"It is the mission of the Division of Public and Behavioral Health to protect, promote and improve the physical and behavioral health of the people of Nevada." Guiding philosophies and practices include the following principles and models:

- Client Centered: All services are client-centered. Clients are fully informed about their health information, and participate in all decisions surrounding their health care.
- Biopsychosocial Systems Theory (whole person): All services adhere to a Biopsychosocial (biological, psychological and social factors) systems theory of health care.
- Multidisciplinary Team: All services draw upon the expertise of a variety of support staff, psychiatrists, psychologists, licensed therapists (LCSW, LMFT, and LCPC), advanced practice registered nurses (APRN), psychiatric registered nurses, registered nurses, pre- and post-graduate interns, mental health counselors, case managers (Qualified Mental Health Associates/QMHAs), mental health technicians (Qualified Behavioral Aides/QBAs), and peer supporters/consumer services assistants (CSAs).
- One System of Care: The Division is committed to collaborative and seamless partnerships with diverse public and private health care and community support organizations for successful coordinated and integrated care.
- Service Delivery Model: Within one integrated system of care, the Division of Public and Behavioral Health provides community health nursing, medication clinics, outpatient mental health services, rehabilitative mental health (RMH) services, targeted case management (TCM), and contracted substance abuse and co-occurring disorders treatment provided by the Bureau of Behavioral Health Wellness and Prevention.

Procedures for implementing these philosophies are communicated to staff and providers through the following policies and methods:

- Established Division policies approved by the Commission on Behavioral Health and the following Behavioral Health Outpatient (BHO) policies:
- BHO:003 – Service Delivery Model;
- BHO:005 – Outpatient Mental Health and Rehabilitative Mental Health.

Accounting Methods

Accounting methods used by the Division of Public and Behavioral Health (DPBH) follow administrative guidelines set forth in the Nevada Revised Statutes, the Nevada Administrative Code, the State Administrative Manual, generally accepted auditing standards, and other DPBH policies and directives. Division policies F-1.1 (Medicaid Mental Health Rehabilitative Services Billing and Charting/Documentation Requirements), F-2.3 (Mental Health Cost Report Data and Allocation Methods), and 3.004 (Mental Health billing/Collections Procedures) outline the requirements for DPBH Medicaid and other insurance liability billing.

Staff are responsible for documenting services provided to clients in our centralized electronic health records system (Avatar). Billing is done in accordance with Medicaid and/or other payer source standards and includes reports within the electronic medical system to identify service duplication and other billing errors and to ensure accuracy.

The Division of Public and Behavioral Health makes every effort to ensure that appropriate service prior-authorization approvals are in place before submitting claims to Medicaid's fiscal agent. Administrative and fiscal staff work collaboratively to identify budgeting errors and to develop improvement plans. Billing activities include but are not limited to:

- Collecting credentialing information from new providers prior to the provision of services;
- Completing and submitting enrollment applications to payers for approval;
- Creating billing and license numbers in electronic medical record system (Avatar);
- Verifying the accuracy of service information using cleansing reports (Avatar);
- Assigning coding activity to client and insurance payment as required by Priorities and Performance Based Budget (PPBB);
- Reviewing and verifying weekly deposits made by centers for submission to the Division of Public and Behavioral Health central billing, and posting to individual accounts;
- Reviewing all Medicaid and Medicare payments to identify denials that require resubmission or further research by central billing;
- Assigning activity coding for Medicaid and Medicare payments as required by PPBB; and
- Verifying deposits for accuracy and posting in the electronic medical record system (Avatar).

The State uses most funds to provide services not covered by Medicaid and Managed Care Organization's for the two-year cycle of the Block Grant. This includes expanding agency capacity to serve new client populations, outpatient services, and filling service gaps. The Division of Public and Behavioral Health provides technical assistance to providers when needed. DPBH will work with a sub-grantee to develop a warm and have it implemented by the second year of this funding cycle. The DPBH is also concentrating efforts to improve program performance outcomes and implement evaluation models that will assist in directing future funding.

Footnotes:

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening Yes No
- ii) Education Yes No
- iii) Brief Intervention Yes No
- iv) Assessment Yes No
- v) Detox (inpatient/social) Yes No
- vi) Outpatient Yes No
- vii) Intensive Outpatient Yes No
- viii) Inpatient/Residential Yes No
- ix) Aftercare; Recovery support Yes No

b) Services for special populations:

- Targeted services for veterans? Yes No
- Adolescents? Yes No
- Other Adults? Yes No
- Medication-Assisted Treatment (MAT)? Yes No

NOT FINAL

Criterion 2

NOT FINAL

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, and custody issues? Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The State requires all funding programs, except for all male programs, to provide priority treatment services to Pregnant Women (PW) and Pregnant Women and Women with Dependent Children (PWWDC). Although the Bureau of Behavioral Health Wellness and Prevention only has jurisdiction over programs that receive funding, every effort is made to encourage non-funded entities to follow the same best practice.

Nevada recently hired a Pregnant Women's Treatment Coordinator that will work with providers over the next couple of years to ensure they meet the minimum required performance to serve pregnant women. She will perform site visits/monitors, review policy, provide technical assistance and assist in the development of new Division Criteria that will serve as a certification endorsement to providers who meet the minimum required performance to serve pregnant women. In addition to the new Division Criteria, the State will also offer enhanced rates or a new set of coding that can be used for women's set-aside funding. To qualify for this enhanced funding, providers must serve PW and PWWDC and qualify for the certification enhancement. Certification are performed every 6 months to 2 years depending on a facilities certification score.

Also, site visits are planned and performed quarterly by the State's treatment analysts and program monitors for funded providers are also conducted at a minimum of one time per year. When problems are identified, every attempt is made to correct the issue on site immediately. If time is needed, then a corrective action plan is written and the provider is given a timeline to complete the corrective action. Once completed, the issue is reexamined for compliance on the next site visit or formal program monitor.

Nevada recently moved to an active monitoring system for Capacity Management and Wait List. All providers who treat PW and PWWDC are required to immediately contact the State for assistance if they are unable to place her, offer interim services, and they cannot locate another facility available. This information is collected and managed by the State program. The State is also collecting information on the numbers of PW and PWWDC on a quarterly basis. To increase the number of PW and PWWDC, the Maternal and Child Health program is expanding outreach efforts. The State is also planning to provide a PW and PWWDC tool kit available on the State's website. If data anomalies or direct observations identify any compliance issues, they will be addressed with technical assistance as soon as an issue is identified.

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement Yes No
 - b) 14-120 day performance requirement with provision of interim services Yes No
 - c) Outreach activities Yes No
 - d) Syringe services programs Yes No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Has your state identified a need for any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached Yes No
 - b) Automatic reminder system associated with 14-120 day performance requirement Yes No
 - c) Use of peer recovery supports to maintain contact and support Yes No
 - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? Yes No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The State requires all funding programs, except for all male programs, to provide priority treatment services to Pregnant Women (PW) and Pregnant Women and Women with Dependent Children (PWWDC). Although the Bureau of Behavioral Health Wellness and Prevention only has jurisdiction over programs that receive funding, every effort is made to encourage non-funded entities to follow the same best practice.

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Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD

treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Programs that provide substance use services are required to make Tuberculosis (TB) services available. The State has changed methodology and policy to allow this testing to occur on sight at the substance use treatment provider's facility. This program is managed by the States TB program who also collects all data. Site visits are planned at a minimum of one time per year but are sometimes more frequent. Program monitors for funded providers are also conducted at a minimum of one time per year. When problems are identified, every attempt is made to correct the issue on site immediately. If time is needed then a plan is written and the provider given a timeline to complete the corrective action and communication as to when the action is completed is requested and reviewed again for compliance on the next site visit or formal program monitor. The State's Substance Use Prevention and Treatment program and the TB program will collaborate on this monitoring process.

Early Intervention Services for HIV (for "Designated States" Only)

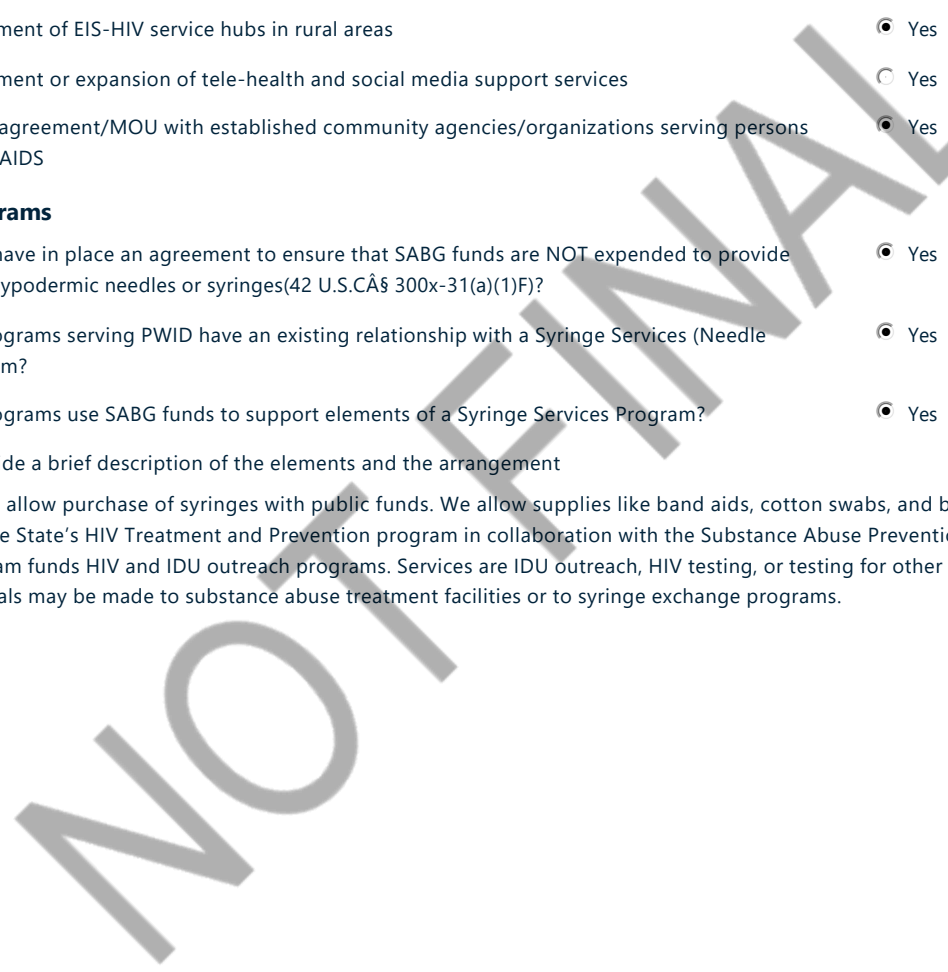
1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas Yes No
 - b) Establishment or expansion of tele-health and social media support services Yes No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.â 300x-31(a)(1)F)? Yes No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No

If yes, please provide a brief description of the elements and the arrangement

Nevada does not allow purchase of syringes with public funds. We allow supplies like band aids, cotton swabs, and bleach. The State, through the State's HIV Treatment and Prevention program in collaboration with the Substance Abuse Prevention and Treatment program funds HIV and IDU outreach programs. Services are IDU outreach, HIV testing, or testing for other STD's as necessary. Referrals may be made to substance abuse treatment facilities or to syringe exchange programs.



Criterion 8,9&10**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? Yes No
2. Has your state identified a need for any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of services for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? Yes No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) An organized referral system to identify alternative providers? Yes No
 - c) A system to maintain a list of referrals made by religious organizations? Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No
 - c) Identify workforce needs to expand service capabilities Yes No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? Yes No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements Yes No
- b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
- c) Updating written procedures which regulate and control access to records Yes No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure Yes No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Approximately four to eight sub-recipients will receive peer review over the grant period.

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan Yes No
- b) Establishment of policies and procedures related to independent peer review Yes No
- c) Development of long-term planning for service revision and expansion to meet the needs of specific populations Yes No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If Yes, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Has your state identified a need for any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? Yes No
 - b) Mental Health TTC? Yes No
 - c) Addiction TTC? Yes No
 - d) State Targeted Response TTC? Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No

c) Coordination of Various Activities and Services

Yes No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

<http://admin.nv.gov/Documents/Policies/Procedures/>

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? Yes No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁵⁸ paper.

⁵⁷ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

⁵⁸ Ibid

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁵⁹

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶⁰

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁵⁹ Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
- b) Required peer accreditation or certification? Yes No
- c) Block grant funding of recovery support services. Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
Consumers and family members are a part of several state coalitions and advisory boards. One example being BHPAC (Behavioral Health Planning Advisory Counsel).

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
Recovery from serious mental illness is not only possible, but for many people living with mental illness today, probable. The notion of recovery involves a variety of perspectives. Recovery is a holistic process that includes traditional elements of physical health, and aspects of recovery extend beyond medication. Recovery from serious mental illness also includes the idea of attaining and maintaining physical health as another cornerstone of wellness. People in recovery make important contributions to their communities. Hope for recovery should be reflected in all treatments, services, and supports.

The recovery journey is unique for each individual. There are several definitions of recovery; some grounded in medical and clinical values, some grounded in context of community and successful living. One of the most important principles of recovery is this: recovery is a process, not an event. The uniqueness and individual nature of recovery must be honored.

For NAMI, recovery is a foundational principle. While serious mental illness impacts individuals in many challenging ways, the concept that all individuals can move towards wellness is paramount. A strengths-based approach is a cornerstone for NAMI initiatives, activities, and efforts. Many, many NAMI members living with mental illness have benefited from the various opportunities within the organization. NAMI has become a vehicle for recovery, and a pathway towards wellness.

Specific NAMI initiatives developed to help the process of recovery are:

The Peer-to-Peer Recovery Education Course: a 9-week, experiential, illness management and wellness educational course taught by people in recovery, for people living with mental illness.

NAMI Connection Support Group - a weekly support group facilitated by and for individuals living with mental illness.

In Our Own Voice: a public awareness project built around a one-hour presentation by a person living with mental illness. An 11-minute video frames the presentation around dark days, acceptance, treatment and medications, and hopes and dreams.

Hearts and Minds: Learn about healthy, accessible and affordable lifestyle changes designed to reduce cardiac risk among people with mental illness.

National Consumer Council: the only nationally convened representative body of persons living with mental illness. The Council serves in an advisory capacity to the NAMI National Board of Directors, and includes subcommittees on the issues of Restraint and Seclusion; Ethics; and Education, Mentoring, and Outreach.

NAMI has peers who serve on the NAMI Nevada and all of the NAMI Affiliates' Board of Directors

Leadership development opportunities are emerging as an important mechanism to help in the recovery process. The Consumer Councils are one important opportunity supported by NAMI. Experiential knowledge is a common theme in both leadership and recovery, and NAMI provides those experiences.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

NAMI Programs that support family members in the recovery process are:

NAMI Family-to-Family – an Evidenced Based Practice, is a 12-class course which teaches family members about mental illnesses

and how to support recovery for their adult loved one living with mental illness.

NAMI Basics – a 6-class course based on NAMI Family-to-Family for parents and caregivers of children or adolescents who have serious emotional disturbances or a diagnosed mental health condition. This course is now in study to become an Evidence Based Practice.

NAMI Homefront – this 6-class course is based on NAMI Family-to-Family and is directed to family members of active service members or veterans living with a mental health conditions.
Leadership development opportunities are emerging as an important mechanism to help in the recovery process.

The Consumer Councils are one important opportunity supported by NAMI. Experiential knowledge is a common theme in both leadership and recovery, and NAMI provides those experiences.

NAMI Nevada has peers who are active members of numerous advisory groups, advocating for the peer perspective on treatment, discharge planning, and other issues related to the behavioral health care system.

In summary, NAMI is dedicated to improving the lives of all those living with mental illnesses. Whether by providing support, education, advocacy, or leadership experiences, all levels of NAMI are working every day to help. Recovery is possible, and people no longer need be defined by their illness, but rather by the goals, hopes, and dreams so vital to each of us.

5. Does the state have any activities that it would like to highlight?

Foundation for Recovery (FFR) is an independent, non profit organization and the only peer-run Recovery Community Organization in the state of Nevada. In the last 12 months, FFR has expanded its services to Northern Nevada by establishing a new location. FFR's mission is to promote the positive impact of addiction recovery in the community and the lives of individuals and families affected by the disease of addiction. The programs, services and partnerships open pathways to recovery by removing social barriers and creating opportunities for those seeking recovery. Some activities within FFR to note are the peer support specialist training, specialized women's services, a Nevada resource directory and a location made available for various support groups to meet.

Nevada's Recovery and Prevention (NRAP), a peer-driven and faculty over seen program, is located on the University of Nevada, Reno campus. NRAP provides a nurturing and affirming environment where students choosing a substance-free lifestyle can successfully pursue academic and professional goals while enhancing their personal resiliency, quality of life, and positive college experiences. It is a place to connect with other students, a place to grow in sobriety, and to thrive as an individual. Through faculty and peer support, NRAP members create a family to assist them during their college career. Some activities within NRAP to note are a collegiate peer mentor training, a on-campus dedicated space for various support groups, events aimed at stigma reduction of celebration of recovery.

Please indicate areas of technical assistance needed related to this section.

N/A

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

- Does the state's Olmstead plan include :
 - Housing services provided. Yes No
 - Home and community based services. Yes No
 - Peer support services. Yes No
 - Employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Since the 1999 Olmstead decision, Nevada has made significant progress to ensure persons with disabilities are able to live in the community setting of their choice. Nevada developed a statewide plan to address the need for community supports for people with disabilities who are in segregated settings and to prevent future unnecessary segregation. The 10-year Olmstead plan was approved by the Legislature in 2003 and expired in 2013.

The Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) recently completed the process of creating a framework to further Olmstead Plan development in the state. The State of Nevada Aging and Disability Services Division (ADSD) is the lead entity for implementation of the plan. As a result of discussions with key stakeholders in Nevada, a decision was made to integrate behavioral health into the evolving Olmstead Plan framework. This decision was informed by notable data points, including:

- In 2015, the prevalence rate of adults age 18 or older with a serious mental illness (SMI) was 4.3 percent or 91,893 individuals, slightly higher than the U.S. rate of 4.0 percent.
- 28,589 persons were served by State Mental Health Agencies (SMHA) in Nevada during 2015 which equates to 31 percent of the adult population with SMI.
- The number of children with serious emotional disorder (SED) increased from 339 children in 2012 to 411 in 2015.
- The number of at-risk populations served by Juvenile Justice and the state foster care system was 8,096 children in 2016. This number has remained nearly constant since 2012.

In 2018, DPBH requested technical assistance from SAMHSA to address Supported Housing and ACT implementation. The TA

addresses three of the four Adult priorities, specifically:

- Design, financing, and delivery of high-quality behavioral health treatment services and supports, including Supported Housing
- Full implementation of high fidelity Assertive Community Treatment (ACT) services statewide
- Establishment of a full, sustainable continuum of care to allow individuals with disabilities related to SMI/SED to be able to have choice in the communities they live and services and supports to allow them to live independently to the greatest extent possible, including access to providers for crisis and community-based treatment

SAMHSA approved the TA request and began working with DPBH on Phase 1 of the request in April 2018 to identify an ACT model that best fits the needs of the state. Included in this phase of the TA is establishment of the infrastructure needed to support statewide implementation of ACT including configuration of the bundled rate for Medicaid services and integration into reimbursement and addressing Medicaid's policy implications for implementation of ACT. SAMHSA will also work with DPBH to provide Supported Housing TA.

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶³ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁶⁴ For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.⁶⁵

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁶⁶ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁵Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? Yes No
 - for youth in foster care? Yes No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The State of Nevada's Division of Child and Family Services (DCFS), as part of the Nevada Department of Health and Human Services (DHHS) provides a wide range of services for children, youth and families in Nevada.

DCFS program areas include Rural Child Welfare, Youth Parole, as well as Children's Mental Health Services. DCFS also provides severely emotionally disturbed children and youth direct services as well as oversight for the programs administered at the state and county level. In recognizing the important role the State has to protect and provide services to Nevada's vulnerable children, the Governor and Legislature passed and enacted Nevada Revised Statute (NRS) 433B to provide additional provisions related to children. NRS 433B mandates that any county, whose population is 100,000 or more establish a Mental Health Consortia. Nevada's vast geographic area required that a consortia be created in Washoe County (Reno/Tahoe), Clark County (Las Vegas and area), and Rural Nevada (15 of 17 Nevada counties in rural/frontier Nevada). Each consortium is mandated to include partners from the local, county and regional level including school districts, chambers of commerce and business community, state agencies, juvenile probation, community behavioral health care providers, foster care providers, a parent of a child with an emotional disturbance, substance abuse agencies, advocates and provider organizations.

DCFS serves as Nevada's Mental Health System of Care (SOC) expert and manages Nevada's Children's Mental Health System of Care Subcommittee as part of the Governor's Wellness and Behavioral Health Council. Nevada is committed to statewide

implementation to create sustainable infrastructure and services as part of the Children's Mental Health Initiative (CHMI). The State of Nevada was recently awarded the Substance Abuse and Mental Health Services Administration System of Care- Expansion and Sustainability Grant for youth with Serious Emotional Disorders. This grant will support efforts to further establish and monitor a comprehensive system of care for seriously emotionally disturbed children, youth and their families as well as young adults, who age out of the foster care system in Nevada. Nevada's focus of the SOC expansion and sustainability is to improve mental health outcomes for children and youth (birth to 21 years of age) with serious emotional disturbances (SED) and their families.

To strengthen Children's Mental Health Services, Nevada's plan focuses on prevention and treatment and builds on SAMHSA's Theory of Change. Nevada shares the fundamental belief that prevention, early intervention and treatment for SED, and appropriate family, peer and support services are essential components of a system of care and impact and improve the quality of life. The Nevada Strategic Priorities, as evidenced through the Clark County, Rural and Washoe County Children's Mental Health Consortium Strategic Plans and the Nevada Children's Mental Health System of Care Subcommittee align and ensure a wide range of activities, programs, results- oriented and evidence-based goals are in the SOC.

DCFS will ensure Nevada's children and families benefit from evidence informed services and supports that are delivered within a SOC framework by assuring coordinated, accessible, community-based, individualized services that are culturally and linguistically competent. DCFS will provide infrastructure and sustainable funding for services by establishing standards, setting policy and monitoring quality of care. This will require programs to integrate mental health, social services, educational, health care, substance abuse, vocational, recreational and juvenile justice services when necessary for each client. Nevada's plan for a SOC is an organizational framework for system reform based on strategic plans of behavioral health initiatives across the State. Nevada's program activities focus on community-based services that are delivered at a local level; family driven and youth guided; culturally and linguistically competent; individualized and strength based; with measures and metrics that ensure the SOC is data driven and accountable.

Nevada's plan emphasizes expansion and adoption of the SOC approach through dissemination of training and knowledge that focuses on capacity building and implementation of programs to ensure SED youth and their families are engaged in effective services and have greater access to innovative and evidence based, trauma informed practices. The Nevada plan incorporates workforce development, governance and accountability for publicly funded children's mental health providers and maintains the safety net for those youth who are uninsured, underinsured, or undocumented. The plan relies heavily on technical assistance, collaboration with stakeholders, consumers and community partners and rigorous evaluation and quality assurance. Statewide adoption of the proposed activities will result in unprecedented changes in how funding is utilized to develop an effective SOC for children's mental health services in Nevada.

Nevada's framework supports SAMHSA's Theory of Change through an expansion and improvement of policy, both administrative and regulatory, focused on the gaps and needs assessments that turn strategic plans into widely adopted action plans. This supports the expansion of services and supports at the community and local levels, based on the SOC philosophy and approach and targets SED youth ages 0-21. Nevada's established teams will utilize evidence-based practices, enhanced youth and family support networks, direct and community service providers to provide training, technical assistance and coaching to ensure continuity and expansion of services.

To enhance the workforce throughout the state, DCFS has collaborated with the University of Nevada, Las Vegas and direct service providers to identify and develop curriculum for behavioral health providers. DCFS will continue to collaborate to align mental health training with community, technical, and the State University system to develop comprehensive programs for training, infrastructure development, and workforce expansion

Innovative programs that have been developed to enhance the System of Care include addressing the need for a system of early mental health identification. The First Episode Psychosis (FEP) model has been developed and is ready to begin serving families in Clark and Washoe Counties. Nevada has also successfully implemented Mobile Crisis Response Teams in northern and southern Nevada. This program has resulted in fewer youth being hospitalized and instead acts as a "no wrong door" avenue to access stabilization and other services at lower levels of care. Further evaluation of these services and outcomes will support the identification of technical assistance and supports needed at all levels of service delivery.

Outreach, collaborative efforts, and support from stakeholders and community partners will ensure backing at all levels of government for the SOC structure. This will facilitate change in financial strategies and result in blended and expanded funding streams.

Monies can be utilized more efficiently since the services will be in place to address the needs of SED youth at less costly lower levels of care. Furthermore, DCFS Children's Mental Health transitioning to the children's mental health authority rather than primarily a direct service provider will allow for more accountability and oversight in the care that children receive from publicly funded community providers. Policy development and procedural changes and the proposed activities in this application will result in a transformation of Nevada's children's mental health services. This will reduce the percentage of children that are provided direct services from DCFS and create a Statewide Children's Mental Health Authority, allowing DCFS to oversee quality improvement and quality evaluation strategies with the support of an outside evaluator to maintain integrity of the data and supports.

Ultimately, the goal is to work to support the SOC through training, evaluation, utilization management, and quality assurance accompanied by widespread dissemination of system of care values and principles which will lead to effective, qualified children's mental health providers in the jurisdictions targeted. Nevada's plan emphasizes dissemination of training and knowledge of system of care and focuses on capacity

building and implementation of programs so that SED youth and their families are engaged in their services and have better access to innovative, culturally and linguistic appropriate services and evidence based, trauma informed practices.

The goals and strategies of the DCFS plan are as follows:

Policy Leadership & Support

Goal 1: Generate support among families and youth, decision policy makers at state and local levels, providers, managed care organizations and other leaders to support expansion of the SOC approach, including transitioning DCFS from a direct care provider to an agency that primarily provides planning, provider certification, utilization management, oversight and quality assurance.

Through existing efforts in Nevada, the project team will continue to reach out to policy leaders at the state and local level to support policies and practices that create a collaborative network of fiscal and program supports for a comprehensive SOC for youth ages 0-21. With competing priorities and limited resources, a SOC framework ensures the system has the ability to address the most disadvantaged in the community. These strategies and goals will work to advance the SOC in Nevada and engage policy makers at all levels.

- Nevada will synthesize the regional strategic plans by incorporating the Clark County Children's Mental Health Consortium, the Washoe County Children's Health Consortium, and the Rural Children's Mental Health Consortium Strategic Plan 10- Year Strategic Plan into one collaborative document building on the strengths, practices and lessons learned in each region (such as telemedicine for rural families) for SOC Statewide Plan.
- Nevada will implement identified strategies into action plans to increase opportunities for home, community and school success for children with disabilities, including those who are at risk for or who have serious emotional disturbances (SED), their families and service providers, through education, encouragement and empowerment activities through a statewide communication plan.
- Nevada will expand existing state and local level youth support systems to more widely incorporate value-based decision making to strengthen capacity of youth leaders to inform policy and practice.
- Nevada will develop memoranda of understanding to promote flexibility and access to needed services and develop a "no wrong door" approach.
- Nevada will implement a Quality Improvement Program (QIP) to ensure all outcomes are evaluated at the individual, agency and system levels to measure the quality of care, access and any potential gaps. Evaluation and grant monitoring efforts will impact decision-making and creation of policy for the SOC.

Develop and Evaluate Blended Funding and Resources State-wide

Goal 2: Maximize public and private funding at the state and local levels to provide a SOC with accountability, efficiency, and effective statewide funding sources, utilizing blended funding sources and repurposing state and local funds spent on inpatient services for use on community-based services.

- Develop and implement a statewide financing plan to blend funds to provide long- term support for the expansion and sustainability of a statewide SOC approach.
- Implement strategies for policy change as identified through statewide strategic plans and priorities to enhance SOC implementation by maximizing existing revenue sources including the Medicaid; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); 1115 waiver, state block grants and general funding, as well as local and regional funding.
- Identify opportunities for new revenue funding sources for SOC implementation, including Medicaid waivers, private and public health insurance, philanthropic foundations, corporate partnerships, social impact bonds, and other grants or collaborative agreements.
- Repurpose funds currently being used for the State Children's Psychiatric Hospital/Residential Treatment Center to expand non-institutional services in the community.

Increase Readiness to Enhance Implementation and Sustain the SOC Framework.

Goal 3: Implement workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to provide effective services and supports consistent with the system of care approach

- Facilitate and expand community infrastructure through service providers as part of implementation strategies to provide technical assistance and education at all levels of care.
- Target the most disadvantaged populations to advance the SOC readiness and development through dissemination of information and publications.
- Provide mobile crisis intervention and stabilization services to youth in crisis at risk for costly acute and long-term placements.
- Enhance partnerships between schools and behavioral health providers to implement school-based and school-linked interventions for children identified with behavioral health needs; and provide preventive services for those identified with high

risk factors.

- Adopt and increase workforce practices that ensure Nevada has the right people, with the right skills, at the right times for evaluation, goal setting, supervision, mentoring/coaching, professional development, training, recruitment, retention, selection, performance appraisals, developing decision making teams, and ensuring organizational readiness. These will build the infrastructure to support Nevada's system moving towards improved services.

Effective Services through Cultural and Linguistic Competence

Goal 4: Expand evidence-based services and supports in Nevada based on the SOC approach, creating a delivery model focused on First Episode Psychosis (FEP) and peer-to-peer, family-to-family, and child-centered care ensuring linguistically and culturally responsive service.

By geographical size, Nevada is the 7th largest state in the nation with a large majority of the state including vast and sparsely populated frontier areas. Although Nevada is not yet a majority-minority state, Nevada has a minority population of 42%. [1] In 2014, 88 percent of the state's population resided in Clark and Washoe Counties. [2] The adoption of linguistically and culturally competent programs promotes family-centered values and decision-making. Services will be responsive with an awareness and respect of values, beliefs, traditions, customs and parenting taking into consideration the specific language, literacy ability, and communication preference of families.

- Establish a culture of collaborative inquiry, shared language and resources for the diverse population in the state of Nevada. Nevada will review all assessment instruments and identify methods and procedures for ensuring that all children will be assessed consistently, regardless of their language, culture, or disabilities, and that the tools provide useful information for fostering development and learning.
- Further enhance the infrastructure to support culturally diverse peer support services for youth and family through training, policy, accountability, and community health services.
- Expand non-traditional services for children with mental health challenges and their families, to include: Behavioral health workers, language services, respite care, family to family support, peer to peer services, transportation and FEP Teams.
- Provide program development, financing and workforce training to expand services and supports for youth transitioning to adulthood.
- Support the implementation of culturally and linguistically competent organizations to serve children, youth and families, by supporting promising practices within communities that address the social-emotional development for youth and young adult populations.

Accountability in Services, Data Collection, Evaluation and Outcomes

Goal 5: Establish an on-going locus of management and accountability for systems of care to ensure accountable, reliable, responsible, evidence and data-based decision making to improve child and family outcomes and to provide transparency at all levels.

- Define and develop effective data measures and key indicators of the children's mental health system to monitor strengths, needs, outcomes, and trends to be used by local and state decision-makers.
- Involve families and youth in developing evaluation plans, gathering and analyzing data, and reporting and disseminating information on a central site to maximize transparency.
- Strengthen collaborative capacity to ensure continuity in reporting to track and monitor outcomes across child serving systems to understand multi-system impacts and identify gaps.
- Identify and increase the use of evidence-based, strength based models and valid measurement tools for child outcomes and provide training for continuity of use.

[1] Healthy People Nevada, 2010-2020

[2] <http://nvdemography.org/wp-content/uploads/2011/05/Clark.pdf>

- Increase the use of technology to support data management, information sharing and coordination of services to ensure continuity and consistency within the SOC at all levels from birth to age 21, including collaborations with school-based programs.

Established Guidelines for Individualized Care Planning: The SOC has established guidelines for individualized care planning for children and youth. Upon entering treatment, each child and their caregiver/family undergo a series of standardized structured intake assessments designed to evaluate their individual needs for clinical care, case management, and family support. Following the assessment period, the case manager convenes a child and family team, which consists of the child, the family, family support specialist, other providers, and any other people chosen by the child and family.

The child and family team then collaborate to produce an integrated Care Coordination Plan that addresses each child and family's unique needs via a series of treatment goals. All team members, as well as the child and family, sign the Care Coordination Plan to indicate that they agree with the course of treatment and are committed to working together to achieve the goals. The Care Coordination Plan is reviewed and updated every 90-days and at discharge. These individualized care planning guidelines will remain in place as the SOC expands to serve more children statewide and will also function as a template for policy as DCFS assumes responsibility for oversight of community providers of mental health/substance use treatment.

The purpose of the Nevada State collaboration is to provide coordinated, accessible, community-based, evidence-informed, individualized services that are culturally and linguistically sensitive through community-based mental health programs, statewide. The importance of and need for increased interagency coordination and a SOC is demonstrated by the gap of mental health services available and/or being utilized by the population aged 0-21. Many children and youth access the mental health system through

various doors including the school system, child welfare, the juvenile justice system, non-profits, pediatrician's offices, and emergency rooms. The continuum of care is currently a fragmented system that poses significant coordination and access of care issues that are funding and policy based, and not family or "person-centered." The systems that serve children, youth and families have become increasingly more complicated, increasing the need for coordination, collaboration and case management to reduce duplication of effort, enhance continuity of care, ensure optimal performance, track outcomes and access across multiple provider systems, and maximize limited fiscal resources.

Training in SOC principles, evidence-based practices, and trauma informed approaches will be enhanced with the implementation of the Nevada SOC and quality improvement measures, which include evaluation and improvement. Nevada will focus on prevention and recovery as well as expansion of innovative programs to improve outcomes for youth experiencing the onset of serious behavioral health disorders, such as programs targeting youth experiencing a first episode of psychosis. Collaborations and coordination with adult-serving agencies will also be a focus to improve transition services for young adults no longer eligible for services through the child-serving system of care. All of these goals focus on a SOC that diverts children and young adults from psychiatric inpatient

and residential treatment facilities, while at the same time achieving positive clinical and functional outcomes through the use of community and direct care service provider supports from family, peer, and community. In addition, Nevada seeks to reduce out-of-home and juvenile correction placements.

Established Collaboration with Child- and Youth-serving Agencies Addressing Behavioral Health: In the state of Nevada, child welfare, juvenile justice, and children's mental health are integrally connected due to the unique structure of its Division of Children and Family Services agency. DCFS has three branches covering the three main child-serving areas of mental health, juvenile justice, and child welfare. The Deputy Administrators overseeing each branch collaborate closely to ensure the service needs of children and adolescents are adequately met, State resources are appropriately allocated, and gaps in the system are addressed. The State is also working closely with the education system to better serve youth who may seek services primarily in a school setting. Planning is actively underway for the creation of school-based health centers, which will provide integrated primary-behavioral healthcare. Additionally, the State-provided Children's Mobile Crisis Response Teams that respond to schools in the Washoe County and Clark County School Districts on a daily or near-daily basis to serve children and adolescents experiencing mental/behavioral health crises at school. DCFS is working actively with the Department of Healthcare Financing and Policy (State Medicaid) to expand the number of providers available for children's mental/behavioral healthcare, including making DCFS a provider for managed care organizations statewide. Finally, DCFS Planning and Evaluation Unit staff provide support and technical assistance including training to Specialized Foster Care providers statewide.

In some of the Southern Nevada DCFS Neighborhood Care Centers and Family Service Centers, Clark County Department of Family Services Child Welfare and Child Protective Services staff are co-located with DCFS programs. This collaboration serves to streamline communication and facilitate services for families. Washoe County Social Services actively collaborates with DCFS in training and initiatives such as Wraparound expansion. Washoe County Social Services and Clark County Department of Family Services are represented on the statewide consortium as well as their local consortia and participate on related workgroups of those consortia.

The following community and state organizations are part of the core that developed the state plans for mental health in Nevada and remain engaged in service delivery and policy development across the state: The Children's Cabinet, Department of Public and Behavioral Health, Department of Employment, Training and Rehabilitation (DETR), Suicide Prevention of Nevada, DCFS, Northern Nevada Adult Mental Health Services, Washoe County School District, University of Nevada School of Medicine, Northern Nevada HOPES, Mojave North, Community Health Alliance, Southern Nevada Adult Mental Health Services, Nevada State Office of Rural Health, Clark County School District, PACT Coalition for Safe and Drug Free, Transparent Mental Health, WestCare Nevada, National Alliance on Mental Illness (NAMI), Rural Nevada Hospital Association, Nevada Healthcare Guidance Program, Rural Community Health Services, Nevada Parents Encouraging Parents (PEP), Aging and Disability Services, Washoe

County Social Services, Clark County Social Services, and the State of Nevada Governor's Behavioral Health and Wellness Council (BHWC) which includes judicial, legislative, law enforcement, community, higher education and private individuals across the State of Nevada. DCFS also worked with SAPTA on developing this joint, integrated Block Grant application.

Tracking and Monitoring Service Utilization, Costs and Outcomes: DCFS Children's Mental Health has a Planning & Evaluation Unit with 11.5 FTE responsible for monitoring service utilization and outcomes across all youth mental/behavioral health programs receiving state funding. This includes monitoring risk measures, admission and discharge conditions as well as policy implementation pertaining to the children and youth in specialized foster care. These providers include privately-operated homes as well as those who are operated by DCFS. Depending upon the program, staff report service utilization and outcome statistics on a quarterly, semi-annual, or annual basis to administrators and other stakeholders. Logic models and evaluation plans guide

data collection and analysis.

In addition, DCFS has a statewide Planning and Evaluation Unit that utilizes existing data collection and analysis methods to obtain information on factors collected as part of the Uniform Reporting System for SAMHSA's Community Mental Health Block Grant. In addition, this Unit works to develop and implement statewide policies for children's mental health as well as monitors residential provider's implementation of policies required by licensing bodies. The Planning and Evaluation Unit collects data from residential providers in the community concerning client demographics, length of stay, medication management, crisis management, suicide attempts, discharge and departure conditions and trauma informed training of staff.

The Division of Health Care Financing and Policy (DHCFP) – Nevada Medicaid – also provides baseline data and updates insurance information to ensure that there is no duplication of services; or care being provided for Medicaid eligible recipients. With the implementation of the SOC Grant, and transition of DCFS from a direct service provider to the children's mental health authority, DCFS will provide oversight and governance to children's mental health providers. Data collection methods, evaluation, and reporting will be developed to be able to report the required performance measures to SAMHSA at all levels throughout the state. Information and feedback available from other state, tribal, and local entities as well as stakeholders and community partners will be utilized in addition to federal government resources and technical assistance. In addition, the State of Nevada will also be incorporating performance measures as part of the National Outcome Measurement Systems (NOMS). Nevada currently gathers client satisfaction surveys.

As part of the Child Outcome Measures for Discretionary Programs, Nevada will utilize the Transformation Accountability (TRAC) client-level measures for providing direct services at baseline, 6-month follow up and at discharge. Nevada is committed to ensuring that data is entered into the Common Data Platform (CDP) web system with seven days of data collection. Specific information will be detailed in the reporting: mental illness symptomatology; employment; education; crime and/or criminal justice; housing; access; age; gender; race; and ethnicity; rate of re-admission to psychiatric hospitals; social support; and client perception of care. Nevada has been expanding use of process and outcome evaluation to guide the development of behavioral health services and the system of care. The Nevada system of care is built on: formative implementation evaluation to monitor the process and success of initiating plans and programs, strengths, needs, culture and gaps analysis to determine how well the current system is addressing the needs of children and families in Nevada. Process and fidelity assessments are used to determine if services and system development meet performance standards and expectations. Outcome evaluation is used to determine the effectiveness and cost impact of the services we provide.

Nevada will establish a data subcommittee to identify and confirm key indicators of system and individual outcomes for children with mental health and address any challenges. This will be done by conducting meetings with child-serving agencies and other stakeholders to identify selected factors for system monitoring. The data subcommittee will identify processes and procedures, with assigned tasks for updating the system and dashboard. The dashboard (data and reports) will be available through the DCFS website. This dashboard will be used to 1) identify a system to share data across state child-serving systems for transparency; 2) implement capacity building technical assistance to cross-system data share; and 3) provide technical assistance to other agencies to support an understanding of the available data and processes for accessing and utilizing the data sources. An important overall guiding principle will be the ability to identify opportunities to reduce policy barriers to information sharing across data management systems and providing the opportunity to use technology to enhance service coordination, data management and system of care activities.

By monitoring the quality and fidelity of the service process in terms of the outcomes it produces, Nevada will focus attention on needs of the children and families. By providing data on needs, gaps, service quality and fidelity, outcomes, and costs to decision makers as part of the ongoing planning process we will achieve better outcomes for children, families, and communities. Evaluation efforts will be centered in the DCFS Planning and Evaluation Unit (PEU). Evaluation staff will work with managers, families, and providers and other stakeholders to develop an integrated data collection plan for measures identified through the system of care. This will build on the data collection that is already ongoing through DCFS staff and the Clark County, Washoe County and Rural Mental Health Consortia. The focus will be for data collection that is integrated within the normal flow of work and documentation and a sampling of this data for verification purposes. Nevada will ensure that information and data is collected by the PEU and provided to the outside evaluator. An outside evaluator with experience in assessing the performance, data measures and compliance with programs will be hired through the MSA process.

Outcomes are evaluated with structured, standardized measures such as the Child and Adolescent Functioning Assessment Scale, Child Behavior Checklist, Crisis Assessment Tool, Strengths and Difficulties Questionnaire, and other well-validated tools. Additionally, client satisfaction is assessed regularly. Program leaders use the results of regular monitoring and reporting to adjust services to best meet the needs of all youth. This includes identifying workforce development initiatives for staff and potential marketing and recruitment strategies for the agency in order to best serve all populations within our state. Depending upon the funding source, Fiscal personnel within DCFS, as well as Nevada Medicaid, monitor expenditures and utilization across the state.

Social workers in schools: The state created a new office at the Department of Education as of October 1st 2015 called the Office of Safe and Respectful Learning Environments. This office coordinates 11 million dollars of annual funding to place professionals in schools to help manage and triage mental health and substance use needs. To date over 120 new professionals have been

placed in schools. This office also works on reducing bullying in schools and conducts training on anti bullying initiatives across the state and works to build capacity to manage mental health referrals in school systems.

Transitioning Child to Adult Behavioral Health Services, including Foster Care: Typically, age 18 is considered the cut-off in the State of Nevada for receiving behavioral health services in the child/adolescent system. In most cases, non-foster youth referred to mental/behavioral health services for the first time between the ages of 18 and 21 would be assisted in transitioning to the adult behavioral health system. If a youth is already receiving services and remains in high school, he/she would continue to be served within the child/adolescent system, unless on a case-by-case basis it was determined that their needs would be better met by the adult system (for example, treatment plan goals would be better addressed by an evidence-based treatment for adults).

When it is time for a non-foster youth to transition from the child to the adult system, one or more staff members working with the youth, which typically includes a case manager, assist the youth in contacting an intake coordinator at the appropriate treatment site in order to set up an initial appointment per Memoranda of Understanding between DCFS and the Division of Public and Behavioral Health, which houses the behavioral health services for adults. The clinician, caseworker, and other staff members from the child/adolescent service system do not terminate services with the youth until they are confident that the transition is successful. When appropriate, peer or family support is engaged to assist with the transition. Youth who meet eligibility criteria for intellectual disability and related conditions would be referred to the appropriate regional centers within the Division of Aging and Disability.

Foster care youth may choose to remain voluntarily in the child welfare system past the age of majority. There are programs related to independent living as well as monetary support for young adults who have been in the foster care system. Collaboration between child and adult serving agencies, regional center services, schools, and vocational rehabilitation services can assist the youth in transition.

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

Nevada's rate of suicide is high and demands continued attention. Yet, it is also notable the gap between the rate in Nevada and for the United States (U.S) overall has narrowed. Rates in Nevada have remained relatively steady since 1999, while the rate for the nation has increased. Nevada has also reduced suicide as a leading cause of death, from being the sixth leading cause to the eighth leading cause of death. Suicide remains the tenth leading cause of death for the nation. Across all states (excluding the District of Columbia), Nevada was the only state with a lower rate in 2014 and 2015 compared to 2005 (WISQARS, 2017). The factors contributing to this difference are not clear and warrant further study. Nevada recognizes the barriers that currently exist to appropriate follow-up care with ever-increasing admissions to emergency departments and mental health hospitals. Exploring effective programs where hospitals follow up with patients after release, ensure the patient is still taking the medication and is connected to outpatient services will help the person stay well. Partners will explore current programs to facilitate patient connection to services within the community which would encourage follow through with discharge plans, reduce return visits to the emergency department, and provide caring outreach post-discharge when risk can be highest. Community programs exist that collaborate with psychiatric hospitals for follow-up such as the Mobile Outreach Safety Team (MOST) team, Crisis Call Center and Division of Child and Family Services (DCFS) Mobile Crisis Response Team. These are all programs that can introduce patients and their families to alternatives which might help avoid visiting an emergency department if services are needed in the future. This proposal will meet individuals recovering from ideation and behaviors through development of a continuity of care pathway that must coordinate within and between systems including health care, public health, law enforcement, and community/family supports. Nevada's proposed goals and objectives will leverage and coordinate existing resources, address unmet needs in our continuity of care and follow-up for treatment and prevention, and establish a sustainable infrastructure to address suicide in our state now and in the future.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? Yes No

If so, please describe the population targeted.

Nevada passed legislation to mandate training in suicide prevention for ALL healthcare providers. This initiative was the #1 priority for Nevada Veterans but will also improve outcomes for older adults as well.

PRIORITY POPULATIONS

Veterans: Nevada's veterans die by suicide 2 to 2.5 times more frequently than their civilian counterparts. Nevada's suicide rate among veterans also appears to be considerably higher than the national rate. For 2015-2016, preliminary data shows the rate for Nevada veterans was 50.3 per 100,000 compared to an estimated 35.3 per 100,000 Nationwide. Factors such as disability, independent living, health, and personal financial concerns may contribute to the high rate of suicide deaths among older veterans (Nevada Office of Public Health Informatics and Epidemiology, 2017). The percentage of veterans with a disability is considerably higher than for non-veterans, and, among disabled veterans, 68% are disabled by a service-connected condition (State of Nevada, 2015).

Across the United States, the proportion of suicide deaths resulting from firearms among veterans is higher than the non-veteran or civilian population (U.S. Department of Veterans Affairs, 2016). From 2010-2014 the majority (70%) of Nevada's veteran suicide deaths were caused by firearms or explosives.

Seniors: Since 2001, seniors in Nevada have died from suicide at substantially high rate, nearly twice the rate seen nationwide. From 1999-2015, the average rate for Nevada was 31.5, compared to 15.3 for the US. In general, the rate of suicide increases throughout the lifespan, with the oldest adults among those most at risk. As with younger adults, those 65 years and older are more likely to have suicidal thoughts if they have depression, other mood disorders, or problems with substance abuse. However, compared to younger cohorts, older adults are more likely to face additional issues which can produce suicidal thoughts, such as ongoing medical conditions, chronic pain, a lack of mobility, or lack of autonomy. Older adults may also be at higher risk of social isolation, undiagnosed depression, or feelings they are a burden (SAMHSA, 2016). These issues point to the need for different strategies and partners to prevent suicide among older adults. As with Nevada's veterans, firearms were used in the majority of deaths among older adults, with firearms/explosives the method of seven out of ten senior suicides from 2010-2015. Poisoning was second most common method among older adults, making up 17% of suicides.

Middle Age Adults: The rate of suicide both nationally and in Nevada is high in middle age. In 2015, the estimated age-adjusted rate for people 55-64 was 29.1, second only to the oldest adults (31.6 for the population 85 and older). In Nevada, people middle age (45-64) are considerably more at risk than younger people including youth. The suicide rate among middle age adults has been increasing nationwide – and a recent study showed while “all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases” (Case & Deaton, 2015). Physical pain, addiction, and declines in mental health, have been hypothesized to contribute to the national increase in suicide observed among this group. A broad number of circumstances may contribute to this rise; however, on the whole, it is reasonable to consider risk factors have increased, while some protective factors have decreased (Keating & Bernstein, 2016). Syndromic surveillance data shows young adult and middle age showing up in EDs with suicide ideation and attempts at higher rates than other ages.

Nevada proposes to use some resources available through this funding opportunity to build capacity and infrastructure related to data collection, specifically concerning suicide. Improvements in data collection related to suicide and suicide attempts would enable DPBH to better determine populations most at risk evaluate the effectiveness of interventions.

Please indicate areas of technical assistance needed related to this section.

N/A

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Nevada Office of Suicide Prevention Action Plan 2017 - 2019

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INTRODUCTION

The Nevada Office of Suicide Prevention (OSP) was created in December 2005 in response to high suicide rates within the state. Since 2005, OSP staff have worked to prevent suicide in Nevada and to support people who have been impacted by a suicide of a friend or family member. OSP is currently housed in the Nevada Department of Health and Human Services (DHHS) Division of Public and Behavioral Health's (DPBH) Bureau of Child, Family, and Community Wellness (BCFCW).

OSP has accomplished numerous goals during its 11-year history. Examples of OSP accomplishments include: sustained implementation of evidence-based practices for screening, including Signs of Suicide middle and high school programs; widespread training of professionals and community members; and development of strong partnerships focused on common goals of prevention. OSP has also successfully obtained grant funding to support suicide prevention in the state.

In October of 2013, OSP began work in collaboration with the Nevada Department of Health and Human Services Director's Office to appoint and establish a statewide Suicide Fatality Review Committee (CRSF) and develop the protocols and tools to establish structure in the first year. Year 2 focused on the actual review process and development of initial recommendations. Although only a few cases are reviewed each year, these are examined in depth to understand the circumstances which led to the suicide fatality and identify areas to improve coordination and communication, as well as potential recommendations for changes to prevent future suicide fatalities. A 2016 report developed by the CRSF illuminated some of the specific issues and concerns for Nevada, and also outlined 12 recommendations. In order to move these recommendations forward, this plan (referred to as the "Action Plan" throughout) was created to guide future work and to serve as a communication tool with stakeholders.

This Action Plan is intended to serve many functions. Most importantly, it will serve as a guide for activities through 2019. The Action Plan incorporates recent developments provided in the National Strategy for Suicide Prevention, including "...a better understanding of how suicide is related to mental illness, substance abuse, trauma, violence, and other related issues; new information on groups that may be at an increased risk for suicidal behaviors; increased knowledge of the types of interventions that may be most effective for suicide prevention; and increased recognition of the importance of implementing suicide prevention efforts in a comprehensive and coordinated way" (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012, p. 11).

The current project moves suicide prevention forward in Nevada by identifying the most urgent and important activities to implement. This project reflects one component of OSP's larger, long term vision to develop:

- a strategic plan which communicates the goals, objectives and strategies to stakeholders across the state;
- a detailed implementation plan resulting in tangible outcomes from activities; and,
- an evaluation plan to measure results.

For every one death by suicide, research shows at least 25 people will attempt suicide, leaving thousands of individuals and their friends and families impacted by suicidal behaviors. Like an iceberg with its mass unseen, those numbers are just the tip of this profound public health problem. Countless others will have such deep depression and despair they contemplate suicide in isolation and do not reach out for help.

(Drapeau & McIntosh, 2016)

OVERVIEW

Suicide impacts individuals, families, friends, and entire communities. Additionally, being a suicide survivor immediately puts a person at-risk for suicide (Centers for Disease Control and Prevention, 2015). From this standpoint, suicide is a critical public health issue, and communities can benefit from a broad range of actions, including reducing factors which put people at risk for suicide, and increasing factors to help protect people from suicidal behavior (Centers for Disease Control and Prevention, n.d.).



Across the United States, suicide rates have increased steadily since 2006, and suicide is the tenth leading cause of death in the nation (Curtin, Warner, & Hedegaard, 2016)

Figure 1: U.S. Suicide Rates



*Age-adjusted rate per 100,000 in 2015

Figure 1 shows the states with the highest suicide rate in darkest colors, and lower rates in lighter colors. Nevada joins several mountain states with high rates of suicide. In 2015, Alaska had the highest age-adjusted rate in the nation (26.8 per 100,000). Washington DC had the lowest age-adjusted rate at less than half the national average of 13.8. Nevada ranked 11th in the nation in 2015 (age adjusted).

This map is courtesy of the *American Foundation for Suicide Prevention, 2015.*

While no exact figures exist, the financial costs of suicide make the economic case for prevention efforts. According to the Centers for Disease Control and Prevention (CDC) in 2015 the average estimated cost of a single suicide is \$1,164,499, which takes into account lost productivity and medical expenses (Centers for Disease Control and Prevention, 2015). Nationally, the CDC estimates the cost of suicide at greater than \$44.6 billion annually. Another study which adjusted for the increased price of healthcare and underreporting of suicides, estimates the actual national cost of suicide is 2.1 times higher at \$93.5 billion (Shepard, Gurewich, Lwin, Reed, Jr., & Silverman, 2015). Using the CDC estimated cost per suicide, which is likely conservative, the 558 suicides in Nevada in 2015 resulted in upward of \$650 million in lost productivity and medical bills. As this single-year estimate illustrates, the financial impact of suicide is staggering.

Nevada's rate of suicide is high and demands continued attention. Yet, it is also notable the gap between the rate in Nevada and for the United States (U.S.) overall has narrowed. Rates in Nevada have remained relatively steady since 1999, while the rate for the nation has increased by 24% (Curtin, Warner, & Hedegaard, 2016).

Nevada has also reduced suicide as a leading cause of death, from being the sixth leading cause to the eighth leading cause of death (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015). Suicide remains the tenth leading cause of death for the nation.



Among all states, Nevada was the *only* state (excluding the District of Columbia) with a lower rate in 2014 and 2015 compared to 2005 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015). The factors contributing to this difference are not clear and warrant further study.

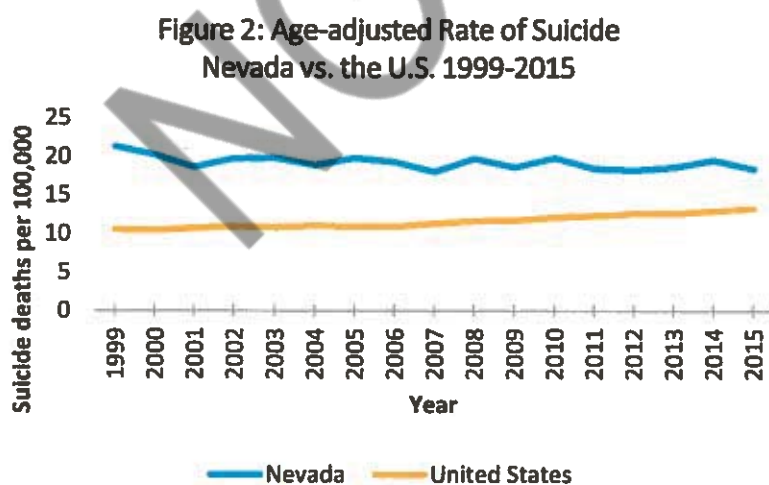


Figure 2 shows rates of suicide death in Nevada compared to the nation. Rates are considerably higher in Nevada than for the U.S. In Nevada, rates have shown variability year to year, with the long-term trend flat (or slightly decreasing), while the rate nationwide has increased.

Data Source: Centers for Disease Control and Prevention; National Center for Injury Prevention and Control, 2017 (Wonder)

Looking More Closely at Suicide in Nevada

Suicide crosses all social, economic, and demographic lines. However, specific groups may be at increased risk. In alignment with this understanding, it is important to identify subgroups which may be at increased risk so prevention efforts can be targeted, relevant, and effective.

PRIORITY POPULATIONS

VETERANS

Nevada's veterans die by suicide 2 to 2.5 times more frequently than their civilian counterparts (Office of Public Health Informatics and Epidemiology, 2016). Nevada's suicide rate among veterans also appears to be considerably higher than the national rate.*

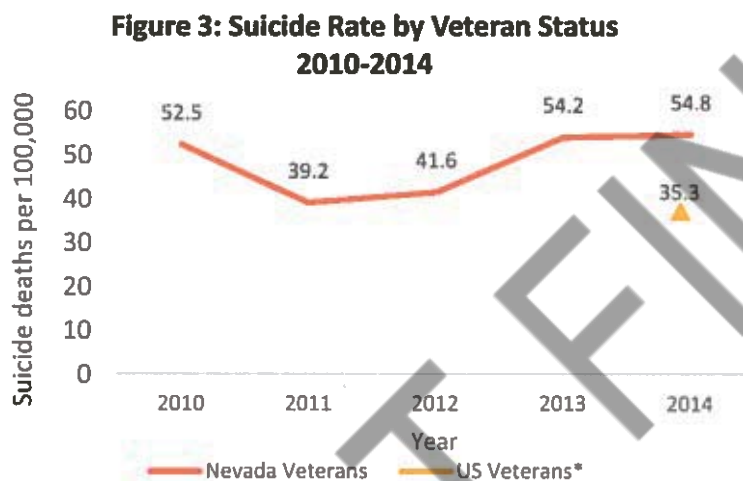


Figure 3 Nevadan Veterans compared to U.S Veterans. In 2014, the rate in Nevada for veterans was 54.8 per 100,000 compared to an estimated 35.3 per 100,000 nationwide.

Data Source: Office of Public Health Informatics and Epidemiology, 2016 and U.S. Department of Veterans Affairs, 2016.

The highest percentage of veteran suicide deaths have occurred among individuals 55 years of age and older (Ritch, 2015). Factors such as disability, independent living, health, and personal financial concerns may contribute to the high rate of suicide deaths among older veterans. The percentage of veterans with a disability is considerably higher than for non-veterans, and among disabled veterans, 68% are disabled by a service-connected condition (Ritch, 2015).

Across the United States, the proportion of suicide deaths resulting from firearms among veterans is higher than the non-veteran or civilian population (U.S. Department of Veterans Affairs, 2016). From 2010-2014 the majority (70%) of Nevada's veteran suicide deaths were caused by firearms or explosives (Ritch, 2015).

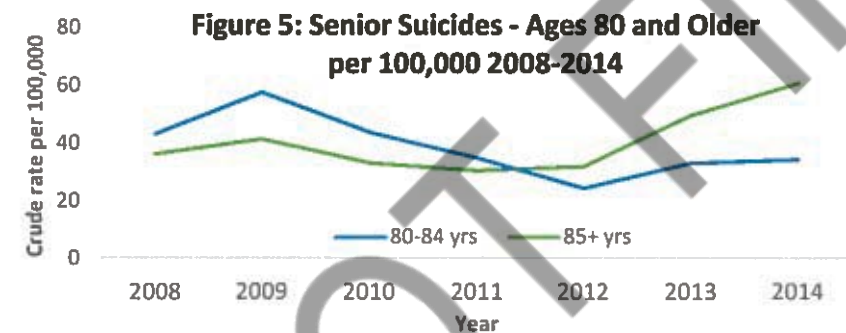
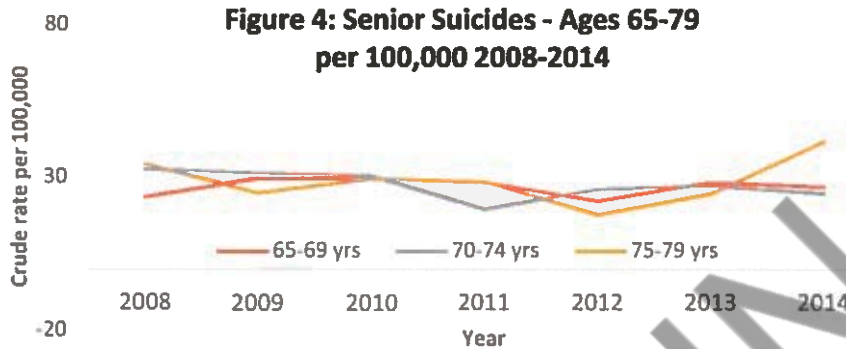
SENIORS

Since 2001, seniors in Nevada have died from suicide at substantially high rates, consistently nearly twice the rates seen nationwide (Centers for Disease Control and Prevention; National Center for Injury Prevention and Control, 2017). From 1999-2015, the average rate for Nevada was 31.5, compared to 15.3 for the United States (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015). Figure 4 shows the suicide trends for

five groups of older adults. In general, the rate of suicide increases throughout the lifespan, with the oldest adults among those most at risk.



Suicide rates for Nevadans age 75 and older have increased since a 2011 low to a high in 2014. Deaths by suicide among the oldest adults, ages 85 and older, also followed an upward trend.



Figures 4 & 5 show the rates of older adult suicides in Nevada from 2008 to 2014. Rates have increased in recent years, and the oldest adults are most at risk of suicide.

Data Source: Centers for Disease Control and Prevention; National Center for Injury Prevention and Control., 2017 (Wonder)

As with younger adults, those 65 years and older are more likely to have suicidal thoughts if they have depression, other mood disorders, or problems with substance abuse. However, compared to younger cohorts, older adults are more likely to face additional issues which can produce suicidal thoughts, such as ongoing medical conditions, chronic pain, a lack of mobility, or lack of autonomy. Older adults may also be at higher risk of social isolation, undiagnosed depression, or feelings they are a burden (SAMHSA, 2016). These issues point to the need for different strategies and partners to prevent suicide among older adults.

As with Nevada’s veterans, firearms were used in the majority of deaths among older adults, with firearms/explosives the method of seven out of ten senior suicides from 2010-2015. Poisoning was second most common method among older adults, making up 17% of suicides (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015).

CHILDREN AND YOUTH

Suicide has been the third leading cause of death for children and young adults, ages 10-24 in the United States and the second leading cause of death for children in Nevada from 2000 to 2014 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015).



Rates of suicide among youth and young adult have varied dramatically, but recently stayed close to the national average. Continued attention on youth and children is critical to progress toward zero suicides.

Figure 6: Nevada Suicide Rates vs. the U.S. for Children and Young Adults Ages 10 to 24

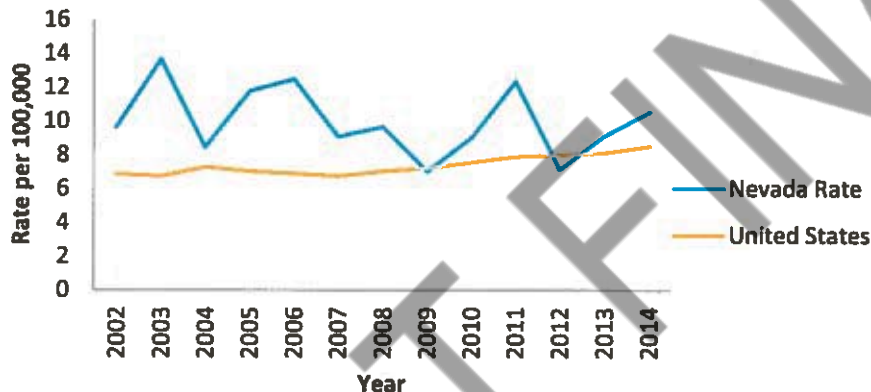


Figure 6 illustrates the rate of suicide among children and young adults, ages 10 to 24 per 100,000 in Nevada compared to the United States.

Data Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015.

Among youth, suicide attempts, ideation, and contagion, are particularly important related issues. Defined by the National Strategy for Suicide Prevention, suicidal behavior is a spectrum of activities related to thoughts and behaviors which include suicidal thinking, suicide attempts, and completed suicide (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012). Suicidal ideation is self-reported thoughts of engaging in suicide-related behavior. A suicidal act (also referred to as suicide attempt) is a potentially self-injurious behavior with evidence the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries. Contagion is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts. A ten-year trend analysis report for the 2015 Youth Risk Behavior Survey conducted by the CDC indicates between 2005 and 2015 the percentage of students in 9th to 12th grade who seriously considered attempting suicide in Nevada increased. Additionally, between 2005 and 2015 more than 11% and up to 14.5% of students report attempting suicide one or more times in the year previous to being surveyed (Lensch, et al., 2015).

As with veterans, firearms play a prominent role in youth suicide; according to the Children's Safety Network, 49% of Nevada's youth suicides in 2008-2012 were committed with a firearm (Children's Safety Network, 2015).

MIDDLE AGE ADULTS

The rate of suicide both in the nation and in Nevada is high for those in the middle age group. In 2015, the estimated age-adjusted rate for people 55-64 was 29.1, second only to the oldest adults (31.6 for the population 85 and older) (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015).

People middle age (45-64) are considerably more at risk than younger people including youth. In general, risk of suicide increases with age.

**Figure 7: Adult Suicide Rates per 100,000
2008-2014 in Nevada**

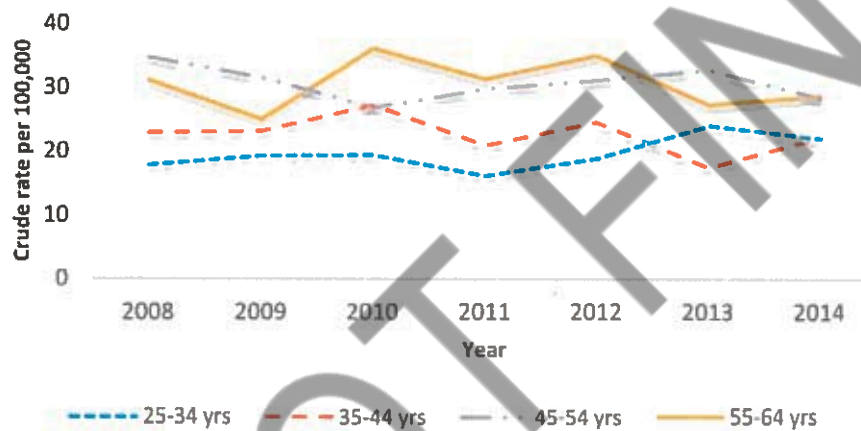


Figure 7 shows among the adult population, rates are highest among middle aged adults, ages 45-64. Data Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2015.

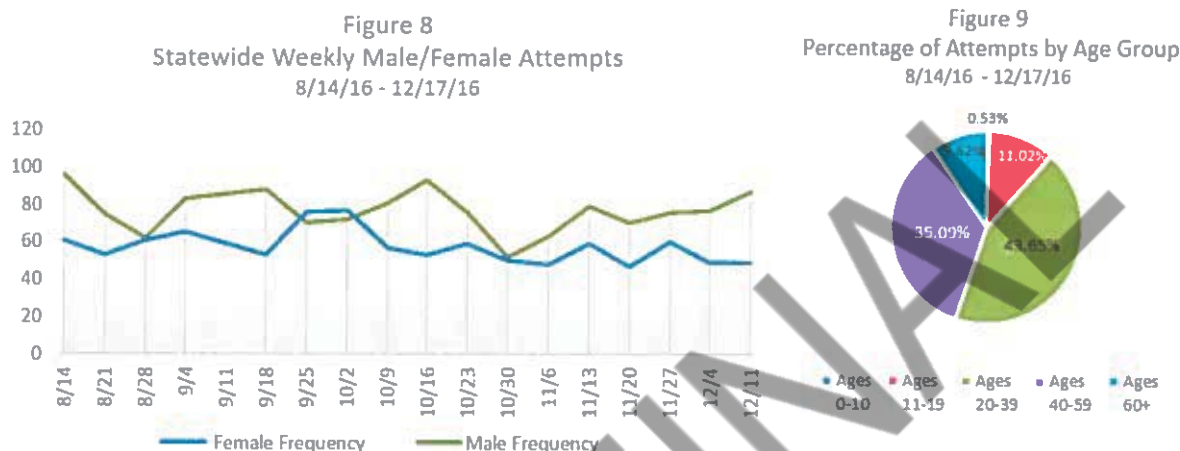
The suicide rate among middle age adults has been increasing nationwide – and a recent study showed while “all education groups saw increases in mortality from suicide and poisonings, and an overall increase in external cause mortality, those with less education saw the most marked increases” (Case & Deaton, 2015, p. 1). Physical pain, addiction, and declines in mental health, have been hypothesized to contribute to the national increase in suicide observed among this group. A broad number of circumstances may contribute to this rise; however, on the whole, it is reasonable to consider risk factors have increased, while some protective factors have decreased (Keating & Bernstein, 2016).

OTHER DEMOGRAPHIC CONSIDERATIONS

Gender

In the U.S., rates of suicide for women have been, and continue to be, lower than the rates for men. However, a recent report showed for females, the age-adjusted suicide rates increased between 1999 and 2014 for all racial and ethnic groups except non-Hispanic Asian or Pacific

Islanders (Curtin, Warner, & Hedegaard, 2016). In Nevada, roughly three out of four deaths by suicide are males (Office of Public Health Informatics and Epidemiology, 2016). Looking at recent suicide attempt data collected from Nevada hospitals, males present at double the rate of females, a trend which should be explored. Nationally, female attempt rates are considerably higher than male attempt rates (Office of Public Health Informatics and Epidemiology, 2016).



Race and Ethnicity

In Nevada, the age-adjusted rates for suicide were highest among people who were white (non-Hispanic) with age-adjusted rates, and were also high among people who were Native American. Suicides occurred within every racial and ethnic group; the issue crosses all racial and ethnic boundaries (Office of Public Health Informatics and Epidemiology, 2016). Opportunities exist to improve prevention using attempt data by race and ethnicity.

Geography

Age-adjusted rates of suicide from 2001-2014 in Nevada's counties varied considerably. Some of the highest average rates were among Nevada's frontier counties including Esmeralda, Nye, Mineral, Humboldt, and White Pine (Office of Public Health Informatics and Epidemiology, 2016). These communities also offer unique opportunities to implement comprehensive suicide prevention initiatives due to connectedness and ability to work across systems.

People in Juvenile and Criminal Justice Systems

Among youth in contact with the juvenile justice system, there is increased risk for suicide ideation and suicidal behaviors. Across the United States, death from suicide is estimated at three times the risk for youth involved with juvenile justice compared to those who are not in the juvenile justice system (National Action Alliance for Suicide Prevention: Youth in Contact with Juvenile Justice System Task Force, 2013). Adults who are incarcerated as well as those recently released are also at high risk (Noonan, Rohloff, & Grinder, 2015). Surveillance systems within and across justice systems offer a key opportunity for prevention.

Other Groups with Higher Risk

In addition to the priority populations identified in this report, many other groups may be at higher risk for suicide compared to the general population. They include people who have witnessed or are bereaved by suicide, people involved with child welfare settings, people who have attempted suicide, people with medical conditions, people with mental or substance use disorders, people who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ), members of the armed forces and their families, and people who have engaged in non-suicidal self-injury (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012).



According to the American Foundation for Suicide Prevention, 90% of people who die by suicide have a mental disorder at the time of their deaths (2017). Biological and psychological treatments can help address the underlying health issues which put people at risk for suicide.

INDIVIDUAL RISK FACTORS

Many factors including issues which are transitory or accumulated over the lifespan can increase the risk of suicidal thoughts and behaviors. Examples include:

- a serious mental illness,
- physical illness,
- alcohol or other abuse,
- a painful loss,
- exposure to violence,
- social isolation, and
- access to lethal means.

FIGURE 10: RISK FACTORS FOR SUICIDE



PROTECTIVE FACTORS

In contrast, protective factors reduce risk of suicide. Protective factors include:

- access to strong social support network,
- effective mental health care,
- connectedness to individuals,
- reduction in access to lethal means,
- family, community, and social institutions, and
- problem solving skills.

ASSESSMENT OF CURRENT SITUATION IN NEVADA

To develop the Action Plan, Office of Suicide Prevention staff assessed strengths, weaknesses, opportunities, and threats. This information was used to help define priorities for action, build on assets and also to address the most critical needs within the state.

STRENGTHS

- Nevada's suicide rate has not increased in recent years, which is in contrast to other western states and the nation as a whole. Prevention efforts can continue to impact and reduce rates toward zero suicides.
- Office of Suicide Prevention staff are experienced and committed to positive change. Strong relationships between OSP and other organizations, coalitions, etc. help to foster broad collaborative action.
- Several evidence-based programs are already in place in Nevada; for example, Signs of Suicide (SOS).
- Through grant funding, relationships across Nevada were formed and have been sustained. These grants also helped to position the state for additional funding for related issues such as mental health services and supports.
- Grant funding also furthered prevention outcomes. A national study showed counties which implemented Garrett Lee Smith (GLS) programming had lower rates of suicide attempts within the target populations (Garraza, Walrath, Goldston, Reid, & McKeon, 2015). Nevada received GLS funds in previous years.
- Prevention efforts in Nevada's diverse communities are increasing and improving.
- Many providers and community members have increased their own skills to recognize when someone is at risk of suicide and are now empowered to offer help.
- During Nevada's 78th (2015) Legislative Session, Assembly Bill (AB) 93 mandated two hours of suicide prevention training for mental and behavioral health providers, and recommended training for other healthcare providers. This system change has helped to move the conversation about suicide prevention to the forefront.

WEAKNESSES

- Funding the Office of Suicide Prevention is becoming more challenging as sources of revenue are declining and competing priorities are increasing. As demand for services

within the state has increased, the resources to meet the need have decreased. Sustainable funding and staffing is critical, including staffing to support growth of relationships within diverse groups and communities (e.g. geography, circumstance, etc.).

- In Nevada, electronic health records (EHR) are not widely utilized or linked, creating a barrier to federal funding streams. This also impacts continuity of services between providers.
- OSP is not as closely linked to some of the other state initiatives working on mental health and behavioral health interventions (e.g. block grant initiatives).
- Many people experiencing problems cannot access services, including those in the public systems like criminal justice, until or unless they are in crisis. Upstream preventions are not adequate and are not currently aligned to the national strategy of providing care in the least restrictive setting.

OPPORTUNITIES

- Efforts mandated by the Clay Hunt Suicide Prevention for American Veterans Act passed by the United States Congress and signed into law in February 2015, may give those on the frontline of Nevada's fight against suicide the ability to steer veterans to the Veterans Administration for preventive services. Opportunities to partner with these federal services may improve care specific to veterans.
- Suicide awareness and screening can take place using the existing healthcare workforce.
- Research can help to inform practice in Nevada. Programs and initiatives showing successes can provide strategic direction. For example, the Suicide Prevention Resource Center (SPRC) has compiled programs which are promising as well evidence-based (Suicide Prevention Resource Center, 2017).
- Collaborative groups working on issues related to mental health, safety, and other community health issues offer an opportunity to further advance suicide prevention.
- The OSP can work strategically and with leaders to reach more people throughout the state. There is broad interest in suicide prevention, and leaders are likely to be interested in learning how they can support it, regardless of sector or role. By working to educate, influence, and collaborate with leaders from healthcare, business, nonprofit organizations, and coalitions, the reach of effective strategies is multiplied considerably.
- The national focus on the Zero Suicide Initiative (National Action Alliance) is proven to be effective in reducing rates within a closed system (e.g. U.S. Air Force) when implemented with fidelity (McKeon, 2013).
- OSP can strengthen the alignment between suicide prevention strategies and state mental and behavioral health initiatives (e.g. block grant initiatives).
- OSP can work to strengthen screening and supports for people of all ages to ensure people get the help they need prior to crisis or emergency.
- OSP can identify and pursue additional funding opportunities such as grants and sub-awards from other programs.

THREATS

- Suicide is a difficult and complex problem without simple solutions. Some of the most straightforward solutions—such as reducing access to means—can be politically difficult, while some of the more universally accepted strategies—such as improved access to high quality mental health services—are costly and difficult to implement.
- Funding for suicide prevention is limited in Nevada. Additional resources are needed to implement recommendations put forward by the Committee to Review Suicide Fatalities.
- Despite having a national strategy in place and considerable attention to suicide at the national level, the rate of suicide has increased considerably between 1999 and 2014. Further research, effective prevention practices, and system changes are still needed to address the complexity of suicide.

STRATEGIC DIRECTION

The mission of the Nevada Office of Suicide Prevention is to reduce the rates of suicide and suicidal acts in Nevada through statewide collaborative efforts to develop, implement and evaluate a state strategy which advances the goals and objectives of the National Strategy for Suicide Prevention.

The vision for Nevada's Suicide Prevention Action Plan is to catalyze collaborative action, improve understanding, and increase wellness in communities across Nevada. This Action Plan is based on the strong belief everyone has a role to play in suicide prevention, and those individuals and groups addressing the physical, emotional, psychological, and spiritual needs of individuals and communities must work together if they are to be effective. Many organizations and agencies working at the state and local level are working to address and prevent suicide. This plan is intended to help connect these efforts, enhance collaboration, and illuminate best practices available for prevention as identified by state and national sources.



All activities in this plan are intended to accomplish a singular outcome: to continue the downward trajectory of Nevada's suicide rate.

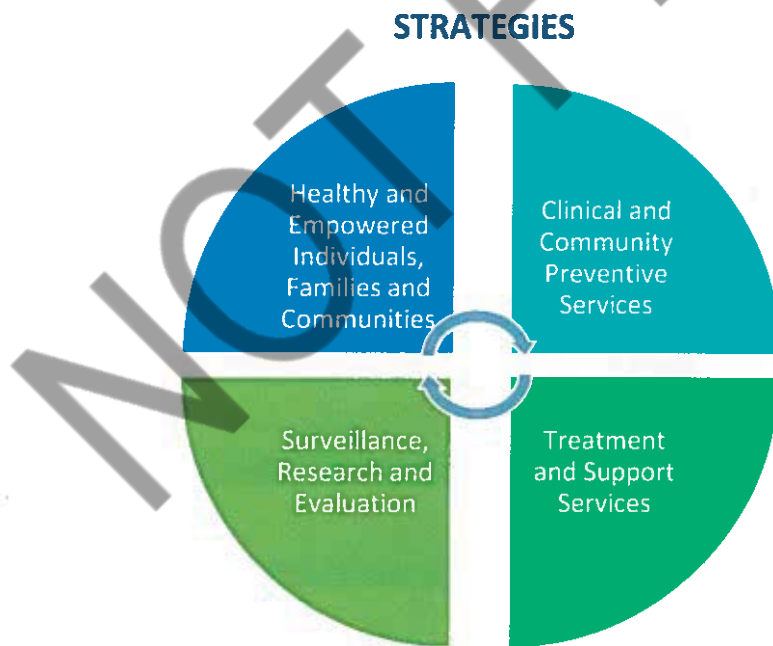
Nevada's leaders are working to address suicide. Governor Sandoval's *Nevada's Strategic Planning Framework* (Sandoval, 2016) identified objectives to reduce suicide among Nevada's veterans, senior citizens, and youth to rates lower than the national average by 2020. In alignment with the framework, four specific populations and targets have been identified for focus.

Figure 11: Governor’s Strategic Framework to Reduce Suicide

Veterans	Older Adults	Youth	Adults
<ul style="list-style-type: none"> • Reduce veteran suicides below the national average by 2020. 	<ul style="list-style-type: none"> • Reduce older adult / senior suicides below the national average by 2020. 	<ul style="list-style-type: none"> • Reduce youth suicides below the national average by 2020. 	<ul style="list-style-type: none"> • Reduce middle-aged adults suicides below the national average by 2020.

APPROACH

Nevada’s Plan is based on research focusing on the unique state, and local needs and circumstances. These findings and recommendations were integrated with the U.S. Department of Health and Human Services’ *National Strategy for Suicide Prevention*. In alignment with the National Strategy for Suicide Prevention, Nevada is working in four related strategic directions.



Strategies are designed to work at multiple levels:

- **Universal strategies** target the entire population.
- **Selective strategies** are appropriate for subgroups which may be at increased risk for suicidal behaviors.

- **Indicated strategies** are designed for individuals identified as having a high risk for suicidal behaviors, including someone who has made a suicide attempt.

STRATEGIC PRIORITIES, STRATEGIES AND ACTION STEPS

This section of the Action Plan synthesizes information about Nevada's four priority areas and target populations, their alignment to national strategies, and shows key action steps. These action steps were developed based on recommendations from the Committee to Review Suicide Fatalities and aligned with the National Strategy (Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.), 2012). They are only the first steps on the longer journey to continue the downward trajectory of Nevada's suicide rate.

Priority 1. Adopt standardized protocols for following up with suicidal patients after discharge from emergency departments (ED) and other hospital settings.

Target Populations. Lifespan (all ages)

Alignment to the National Strategies

- Promote suicide prevention as a core component of healthcare services. National Strategy –Goal 8
- Integrate and coordinate suicide prevention activities across multiple sectors and settings. National Strategy –Goal 1
- Develop and implement protocols for delivering services to individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. National Strategy –Goal 8.2

Action Steps

1. Work to understand existing practices within Nevada hospitals using a survey and additional outreach.
2. Use data from survey (see step 1 above) to assess what is in place and identify system gaps.
3. Share suicide prevention plan and use to engage partners in strong prevention efforts.
4. Support suicide prevention training for healthcare providers by working to build capacity for training and education.
5. Participate in dialogue regarding suicide prevention among all primary care providers.
6. Hold informational interviews with key leaders to understand barriers to patient follow up.
7. Identify any areas of policy or practice where the Office of Suicide Prevention and other state agencies can support improvement.

8. Engage partners to understand the Health Insurance Portability and Accountability Act (HIPAA) as an opportunity, not a barrier, to providing follow up care.
9. Foster and support collaborations between emergency departments and other healthcare providers to deliver services for individuals with suicide risk collaboratively, responsively, and in the least restrictive settings.

Priority 2. Utilize syndromic surveillance (attempt data) and partnerships throughout *Continuity of Care for Suicidality Workgroup* to recognize and monitor trends in real time and develop a system of follow-up care and minimize repeated attempts.

Target Populations. Lifespan (all ages), Veterans

Alignment to the National Strategies

- Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. (National Strategy –Goal 11.3)

Action Steps

1. Continue development and use of syndromic surveillance data.
2. Complete study to understand feasibility of attempt data. Include issues of privacy; permission to collect and identify opportunities to systematically collect and analyze; data sharing.
3. Explore amending legislation to include attempt data collection.
4. Amend existing law to include collection of attempt data.

Priority 3. Enhance data collection to capture information about specific characteristics of the population including veterans, active duty military and families, LGBTQ, and race/ethnicity.

Target Populations. Lifespan (all ages)

Alignment to the National Strategies

- Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. (National Strategy –Goal 11.3)

Action Steps

1. Use National Violent Death Reporting System and Committee to Review Suicide Fatalities data to recognize trends and opportunities.
2. Establish workgroup to advise on reporting military/veteran deaths.
3. Work with coroners' offices to develop protocols for reporting on veteran suicide deaths.

4. Work with coroners' offices and medical examiners across the state to share protocols.
5. Assess challenges and make changes as needed to protocols once established.
6. Continue development of a memorandum of understanding (MOU) being developed with the key partners on the expansion of data use.

Priority 4. Address sustainability of efforts through funding, infrastructure, and system change.

Target Populations. Lifespan (all ages)

Alignment to the National Strategies

- Promote effective programs and practices to increase protection from suicide risk. (National Strategy –Goal 3.1)
- Develop and sustain public-private partnerships to advance suicide prevention. (National Strategy –Goal 1.4)
- Integrate suicide prevention into all relevant healthcare reform efforts. (National Strategy –Goal 1.5)

Action Steps

1. Support expansion of Mobile Crisis Response Teams (Nevada Department of Health and Human Services, Division of Child and Family Services within Washoe, Clark, and Rural Counties).
2. Continue to develop school-based screening capacity across the state.
3. Support development of walk-in crisis centers.
4. Identify barriers to using electronic health records.
5. Provide support for expansion of electronic health records.
6. Share data, plans, and awareness about suicide in Nevada.

Nevada's Guiding Principles for Suicide Prevention Efforts

1. **Our Efforts are Stronger When We Engage Community.** Foster positive dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention;
2. **Equity Must be a Focus.** Address the needs of vulnerable groups; seek to understand the cultural and situational contexts of groups, and seek to eliminate disparities;
3. **Our Outcomes Should be Sustainable.** Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
4. **Our Work Must Address Root Causes.** Promote changes in systems, policies, and environments to facilitate the prevention of suicide and related problems;
5. **Our Work Must be Integrated.** Bring together public health and behavioral health to better address the whole health needs of people;
6. **Addressing Lethal Means is a Critical Lever for Change.** Promote efforts to reduce access to lethal means among individuals with identified suicide risks; and
7. **Our Work is Informed by Data.** Apply the most up-to-date knowledge base for suicide prevention and engage in monitoring and evaluation to understand what works.
8. **Seek out additional grant funds to support suicide prevention.**
 - Adapted for Nevada, based on *2012 National Strategy for Suicide Prevention*

ACKNOWLEDGMENTS

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The Nevada Coalition for Suicide Prevention

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NOT FINAL

REFERENCES

- Action Alliance. (2013). *Need to Know: A Fact Sheet Series on Juvenile Suicide: Juvenile Detention and Secure Care Staff*.
- Administration, S. A. (2015). Behavioral Health Barometer: Nevada, 2015. . *HHS Publication No. SMA-16-Baro-2015-NV*. . Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Allen, M. V. (2016, April). Committee to Review Suicide Fatalities Year 2 Report. Carson City, NV: Nevada Division of Public and Behavioral Health.
- American Foundation for Suicide Prevention. (2015) *Additional Facts About Suicide in the US*. Retrieved from <https://afsp.org/about-suicide/suicide-statistics/>.
- American Foundation for Suicide Prevention. (2017) *Out of the Darkness Walks: Suicide claims more lives than war, murder, and natural disasters combined*. Retrieved from <https://www.theovernight.org/index.cfm?fuseaction=cms.page&id=1034>.
- Case, A., & Deaton, A. (2015). *Rising morbidity and mortality in midlife among white*. odrow Wilson School of Public and International Affairs and Department of Economics, Princeton University.
- Centers for Disease Control and Prevention. (n.d.). *Suicide Prevention: A Public Health Issue*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/asap_suicide_issue2-a.pdf.
- Centers for Disease Control and Prevention. (2011). *State Suicide Prevention Planning Brief*. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/state-suicide-prevention-planning-brief.pdf>.
- Centers for Disease Control and Prevention. (2015, August 28). *Suicide: Consequences*. Retrieved July 31, 2016, from National Center for Injury Prevention and Control, Division of Violence Prevention: <http://www.cdc.gov/violenceprevention/suicide/consequences.html>.
- Centers for Disease Control and Prevention. (2016, August) *Suicide: Risk and Protective Factors*. Retrieved from <https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>.
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2015, January 22). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved August 2, 2016, from www.cdc.gov/injury/wisqars.

- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2017). Wide-ranging ONline Data for Epidemiologic Research (*WONDER*). Retrieved August, 2016 from <http://wonder.cdc.gov>.
- Children's Safety Network. (2015). *2015 Nevada State Fact Sheet*. Retrieved August 2016, from Children's Safety Network: <https://www.childrenssafetynetwork.org/state/nevada>.
- Curtin, S., Warner, M., & Hedegaard, H. (2016, April). Increase in Suicide in the United States, 1999-2014. *National Center for Health Statistics Data Brief No. 241*.
- Curtin, S., Warner, M., & Hedegaard, H. (2016, April). *Suicide rates for females and males by race and ethnicity: United States, 1999 and 2014*. NCHS Health E-Stat. National Center for Health Statistics.
- Department of Children and Families Office of Substance Abuse and Mental Health. (2016). *Florida Suicide Prevention Plan 2016-2020*.
- Drapeau, D.W., & McIntosh, J.L. (2016). *Facts and Statistics*. Retrieved from American Association of Suicidology: <http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870>.
- Christansen, E. (2015). *Nevada Substance Abuse, Mental Health and Suicide Prevention Needs Assessment Report 2015*. Nevada Department of Health and Human Services, Division of Public and Behavioral Health.
- Garraza, L. G., Walrath, C., Goldston, D., Reid, H., & McKeon, R. (2015). Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on Suicide Attempts Among Youths. *JAMA Psychiatry*.
- Keating, D., & Bernstein, L. (2016, April 22). U.S. Suicide Rate Has Risen Sharply in the 21st Century. *Washington Post*.
- Lensch, T., Baxa, A., Zhang, F., Gay, C., Larson, S., Clements-Nolle, K., Yang, W. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. *2015 Nevada High School Youth Risk Behavior Survey (YRBS)*.
- McKeon, R. Substance Abuse and Mental Health Services Administration. (2013). *The National Strategy for Suicide Prevention: Everyone Has a Role (PowerPoint Slides)*. Retrieved from actionallianceforsuicideprevention.org.
- Minnesota Department of Health. (2015). *Minnesota State Suicide Prevention Plan 2015-2020*.
- Montana Department of Public Health and Human Services. (2014). *Strategic Suicide Prevention Plan For Montana 2015*.

- National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task. (2013.) *Need to know: a fact sheet series on juvenile suicide - juvenile detention and secure care staff*. Washington, DC: Author.
- Nevada Service Member, Veterans, and Nevada Service Member, Veterans, and Their Families Public Wellness Projects. (2013). *Strategic Action Plan for Ending Suicide among Veterans, Service Members, and their Families in Nevada*.
- Noonan, M., Rohloff, H., & Grinder, S. (2015). *Mortality in Local Jails and State Prisons, 2000–2013 - Statistical Tables*. U.S. Department of Justice.
- Office of Public Health Informatics and Epidemiology. (2016). Age-Adjusted Rates of Suicide for Nevada Residents by County from 2001 - 2014.
- Office of Public Health Informatics and Epidemiology. (2016). *Emergency Department (ED) Patient Volume for Suicidal Ideation/Attempt Data (unpublished)*.
- Office of Public Health Informatics and Epidemiology. (2016, June). Special Surveillance Report on Veterans Suicide 2010-2014. Carson City, Nevada: Division of Public and Behavioral Health.
- Office of the Surgeon General; National Action Alliance for Suicide Prevention (U.S.). (2012). *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*.
- Ritch, L. (2015, February 27). *Revisiting an Epidemic: Suicide Mortality in Nevada's Military and Veteran Community*. Carson City, NV: Nevada Division of Public and Behavioral Health.
- SAMHSA. (2016). *SAMHSA News: Preventing Suicide Among Seniors*. Retrieved from <http://newsletter.samhsa.gov/2016/02/02/preventing-suicide-among-seniors/>.
- SAMHSA Suicide Prevention Resource Center. (2014). *Suicide Prevention Implementation Academy*.
- Sandoval, B. (2016, April 11) *Generations to Come, Nevada's Strategic Planning Framework*. Retrieved from <http://gov.nv.gov/uploadedFiles/govnv.gov/Content/StrategicPlan/GovernorsPlanningFrameworkFinal.pdf>.
- Shepard, D., Gurewich, D., Lwin, A., Reed, Jr., G., & Silverman, M. (2015, October 29). Suicide and Suicidal Attempts in the United States: Costs and Policy Implications. *Suicide and Life-Threatening Behavior*, 46(3), 352-362. doi:doi:10.1111/sltb.12225.
- Substance Abuse and Mental Health Services Administration. (2014). *Behavioral Health Barometer for Nevada*.
- Suicide Prevention Resource Center. (2017). *Resources and Programs*. Retrieved from <http://www.sprc.org/resources-programs>.

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS, September 2012. Nevada Office of Public Health Informatics and Epidemiology. (2016). *Report of Suicide Rates - 2015 (Preliminary and Subject to Change)*.

U.S. Department of Veterans Affairs. (2016, August 3). *Suicide Among Veterans and Other Americans 2001-2014*. Retrieved August 5, 2016, from Office of Public and Intergovernmental Affairs: <http://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>.

Washington Department of Health . (2016). *Washington State Suicide Prevention Plan* . Retrieved from <http://www.sprc.org/sites/default/files/Washington631-058-SuicidePrevPlan.pdf>.

Wray, M., Poladko, T., & Vaughan Allen, M. (2011). Suicide Trends in Nevada, 1999-2009. *The Social Health of Nevada: Leading Indicators and Quality of Life in the Silver State*. Las Vegas, NV: UNLV Center for Democratic Culture.

NOT FINAL

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Southern Nevada has a provider which goes into schools to assist school age children with serious emotional disorders and mental health issues.

Assertive Community Treatment (ACT) programs have been developed and will be expanded within the state.

First Episode Psychosis (FEP) programs will be extended to cover the largest county in the state, Clark County in Southern Nevada.

Additionally, due to the rural nature of the state, the Bureau, in conjunction with the University of Nevada, Reno, developed Nevada Project EHCO (Expanding Community Healthcare Outcomes) program to bring state of the art mental health expertise through the developed platform.

Nevada Project EHCO is selected as the platform to provide technical assistance to clinical workforce for the implementation of a rural, First Episode Psychosis (FEP) treatment program, based on the NAVIGATE model. Utilizing highly accessible teleconnection technology, Project ECHO connects teams of practitioners in remote communities (the "spokes") via laptop computers to an interdisciplinary "hub" team of experts located at the University of Nevada, Reno School of Medicine. "Hub" teams are assembled based on expertise and knowledge of specific learning topics that are important to the end users (the spokes). Adult learning principles inform the ECHO model, as the model uses a case-based learning format that is practical and allows the participants to directly apply expert recommendations to the clinical problems that they experience daily. The interdisciplinary nature of the ECHO

Hub teams also ensures that the content includes well-rounded, nuanced and team-based learning that is essential in today's

complex healthcare environment. The ultimate result is a merging of the Spokes and Hub participants into a vital and supportive learning community that enhances the professional development and expertise of all.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

NOT FINAL

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf).⁶⁹

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
The state works with the SEOW, MHPAC and BHPAC to identify need in addition to a state needs assessment, strategic plan and program monitors.
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? Yes No
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No
3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.
The Council is responsible to meet on a regular basis and abide by Open Meeting Laws. The Council has representatives from the community, family members, individuals with MH/SU, state agencies and providers.
Please indicate areas of technical assistance needed related to this section.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁷⁰

⁷⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

BEHAVIORAL HEALTH PLANNING AND ADVISORY COUNCIL BYLAWS

ARTICLE I AUTHORIZATION AND PURPOSE

Section 1: Authorization

The Nevada State Behavioral Health Planning and Advisory Council (BHPAC) is authorized by Executive Order of the Governor. See Exhibit I.

Section 2: Purpose

1. Mission

The Nevada Behavioral Health Planning and Advisory Council will serve as an advocate for individuals with chronic mental illness, children and youth with severe emotional disturbance, other individuals with mental illnesses or emotional problems, and persons with substance abuse and co-occurring disorders.

2. Under federal statutes, the specific duties and responsibilities of the Council are:

- 1) The Council shall advise the Division of Public and Behavioral Health and the Division of Child and Family Services on the development of the state behavioral health plan.
- 2) Serve as an advocate for adults with serious mental illness, children with severe emotional disturbance, other individuals with mental illnesses or emotional problems and persons with substance abuse and co-occurring disorders.
- 3) The Council shall monitor, review, and evaluate, no less than once each year, the allocation and adequacy of behavioral health services within the state.

ARTICLE II MEMBERSHIP

Section 1: Appointments

The Governor shall appoint 23 members to the Nevada Behavioral Health Planning and Advisory Council.

Section 2: Composition

1. Council membership will be composed of residents of the state, including representatives from:

- 1) The principal state agencies with respect to:
Mental Health Services for Children and Adolescents
Mental Health Services for Adults

Substance Abuse Prevention and Treatment
Education
Housing
Vocational Rehabilitation
Criminal Justice
Social Services
Medicaid

- 2) Public and private entities concerned with the need, planning, operation, funding, and use of mental health, substance use and co-occurring services and related support services.
 - 3) Persons with mental illness and persons with substance abuse and co-occurring disorders, who are receiving (or have received) behavioral health services.
 - 4) The families of such individuals in (3) above.
2. At least 50 percent of the members of the Council will be individuals who are not state employees or providers of behavioral health, substance abuse or co-occurring services.

Section 3: Term of Appointment

The term of an appointed member is four (4) years. An appointed member may be reappointed for an unlimited number of 4 year terms. The 4 year term of appointment does not apply to an appointed member who was/is appointed to serve "at the pleasure of the Governor."

Section 4: Reappointment

Reappointments of Council members will be processed in the following manner:

1. The Administrative Assistant to the Council will maintain a list of members and their appointment terms and request that an Application for Boards and Commissions be completed by each member six months prior to the end of their term and submitted to the Office of the Governor of the State of Nevada.
2. Reappointment is official when the Governor of the State of Nevada or his or her designee approves a candidate and issues a Certificate of Appointment.
3. The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.
4. New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years thereafter, if made available.

Section 5: Oath of Office

In accordance with Nevada Revised Statutes (NRS) 282.020, members of the Council shall, before they enter upon the duties of members of the Council, take and subscribe to the following oath:

I,, do solemnly swear (or affirm) that I will support, protect and defend the Constitution and Government of the United States, and the Constitution and government of the State of Nevada, against all enemies, whether domestic or foreign, and that I will bear true faith, allegiance and loyalty to the same, any ordinance, resolution or law of any state notwithstanding, and that I will well and faithfully perform all the duties of the office of Behavioral Health Planning and Advisory Council member, on which I am about to enter,
(if an oath) so help me God;
(if an affirmation) under the pains and penalties of perjury.

ARTICLE III VACANCIES

Section 1: Absences

Three absences from regularly scheduled meetings (which include regular BHPAC meetings and/or Executive Committee meetings) within any twelve month period without sufficient or overriding reason will be considered unexcused absences and may constitute grounds for the Council recommending the member's removal from the Council to the Governor. At each regularly scheduled meeting, absent members will be noted as either excused or "currently unexcused". The Chair, Vice Chair, or acting Chair will determine at the next scheduled meeting if the member's absence was excused or unexcused. An excused absence includes, but is not limited to, an unexpected occurrence or emergency with health, family, or employment that would prevent the member from attending the meeting. An unexcused absence includes, but is not limited to, lack of communication (no contact) with the BHPAC Chair, Vice Chair, or Administrative Assistant. Unless an absence is the result of an emergency or unexpected occurrence, members who cannot attend a regularly scheduled meeting must give written prior notice (letter, memo, or e-mail) to the BHPAC Chair, Vice Chair, or Administrative Assistant no less than two business days prior to the meeting. Failure to do so will result in an unexcused absence.

Section 2: Removal from Membership

When a member has a third unexcused absence within any twelve month period, the Chair will send a notification letter to the member that the Council intends to take action at the next scheduled meeting. At that meeting, the member will have an opportunity to refute the action or the Council will proceed with the removal

process. The removal process shall be a simple majority vote to recommend the removal to the Governor for action.

Section 3: Filling Vacancies of Other than State Representatives

Council vacancies for members other than State representatives are filled by the following process:

1. The Administrative Assistant to the Council shall maintain an active and secure file of interested applicants from which to draw in the event of Council vacancies.
2. Applications on file and newly received applications shall be reviewed based on Council composition requirements to establish candidates for open positions.
3. A Nominating Committee established by the Council shall nominate candidates from the pool of applicants.
4. A majority vote by the Council shall determine recommended candidates for appointment by the Governor.
5. Appointment is official when the Governor of the State of Nevada or his or her designee approves recommended candidates, issues Certificates of Appointment and a copy of the Certificates are received from the candidates by the Administrative Assistant to the Council.
6. The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.
7. New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years thereafter if made available. Failure to attend a Council member orientation within six months of appointment or within any two-year period may constitute grounds for the Council recommending to the Governor the member's removal from the Council.

Section 4: Filling Vacancies of State Representatives

Council vacancies for State Representatives are filled by the following process:

1. Upon receipt of a resignation notification, a letter to the Administrator (or his or her designee) of the Agency in which the vacancy occurs will be sent requesting that the name of a new prospective representative be provided to through the Council to the Governor's Office in the manner prescribed by the Governor's Office.
2. Appointment is official when the Governor of the State of Nevada or his or her designee approves recommended candidates, issues Certificates of Appointment and a copy of the Certificates are received from the candidates by the Administrative Assistant to the Council.
3. New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years

thereafter. Failure to attend a Council member orientation within six months of appointment or within any two-year period may constitute grounds for the Council recommending to the Governor's Office the member's removal from the Council.

Section 5: Resignations

When a member resigns from the Council, a resignation notification shall be submitted to the Chair of the Council, copied to Council staff, via standard mail or electronic mail. Resignations should not be submitted directly to the Governor's Office. Vacancies created by resignations will be filled as outlined in Section 3 or 4 above.

ARTICLE IV REIMBURSEMENT

Section 1: Travel and Per Diem

Reimbursement for travel and per diem costs at State rates shall be processed by the Administrative Assistant to the Council and taken from the Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant allocated to the State of Nevada.

Section 2: Stipends

Members who are not employed by the government and do not receive compensation for their participation in meetings as part of their regular employment shall be given a stipend in the amount of \$80 per day for each regularly scheduled meeting of the Council. Stipends will also be provided to members of the Council who meet as part of a committee of the Council, attend conferences and other behavioral health related activities, or represent the Council at the direction of the Chair. Stipends for these activities shall be paid in the amount of \$80 per day for full-day activities and \$40 per day for half-day activities. Additionally, the BHPAC will also offer its members, who are not employed by the government and who do not receive compensation for their participation in meetings, reimbursement for respite and/or child care, to enable them to attend and participate in BHPAC meetings. The reimbursements for stipends shall be processed by the Administrative Assistant to the Council and taken from the Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant allocated to the State of Nevada.

ARTICLE V MEETINGS

Section 1: Frequency of Meetings

The Nevada Behavioral Health Planning & Advisory Council shall meet at least four times per year. Special meetings of the Council may be called at any time by the Chair, Executive Committee, or by a quorum of Council members.

Section 2: Open Meetings

All meetings of the Council shall comply with the requirements of the State of Nevada Open Meeting Law. A Public Comment item shall be included on each agenda to allow members of the public to address the Council.

Section 3: Agenda Items

Council members may request Agenda items for BHPAC meetings. Agenda item requests should be submitted via e-mail to the Administrative Assistant at least thirty (30) days prior to the next scheduled PHPAC meeting. The BHPAC Executive Committee will review and approve the final Agenda.

Section 4: Requesting Tapes or Transcripts of Meetings

All requests for tapes or transcripts of BHPAC meetings will adhere to established policy and procedures. Requests should be directed to the Division of Public and Behavioral Health (DPBH).

ARTICLE VI OFFICERS OF THE COUNCIL

Section 1: Officers

The members of the Council shall elect a Chair and a Vice Chair. The immediate past Chair shall be considered an officer of the Council and a member of the Executive Committee.

Section 2: Terms of Office

The Chair and Vice-Chair serve a term of office comprised of a two (2) year period. One additional term of office (two year period) is permitted with approval the Council. The maximum consecutive term of office that may be served in each office is four (4) years, unless an extension is approved by a 70% or greater vote of the Council. This does not preclude someone from serving in another office upon reaching the term limit for the currently held office.

Following a minimum of two years out of either office, the past Chair or Vice Chair would become eligible again to serve in the same office. Each officer shall serve until the installation of a successor.

Section 3: Officer Nominations and Elections

Elections for Council offices shall be held at the first regularly scheduled meeting falling on or after October 1 at the end of the current officers' two year term. A Nominating Committee established by the Council shall nominate candidates for open office positions, or Council members may make nominations from the floor. Each office shall be voted upon separately. If more than two nominees are selected for a single office, the lowest vote recipient shall be eliminated during each round of voting necessary until only two nominees remain. Nominees for offices who receive a majority vote for the office available shall be declared elected to that office, effective the next regularly scheduled meeting of the Council.

Section 4: Executive Committee

The Council shall have an Executive Committee comprised of the current Chair, current Vice Chair, immediate past Chair, the representative to the Council from the principal state agencies with respect to Mental Health Services for Children and Adolescents and Behavioral Health Services for Adults . The Executive Committee shall be authorized by the Council to make decisions concerning the affairs of the Council in the interim between regularly called meetings. Actions taken by the Executive Committee must be reported to all members of the Council at the next regularly called meeting.

Section 5: Vacancies in Office

Any vacancies in office during an unexpired term shall be filled by an election of the Council and the elected person shall hold office for the remainder of the unexpired term of office. If the immediate past Chair is no longer able to serve on the Executive Committee, the current Chair shall appoint a successor until the next officer election which allows for a new immediate past Chair to serve on the Committee.

Section 6: Duties of the Chair

1. To preside at all meetings of the Council.
2. In consultation with the Executive Committee and Administrative Assistant to the Council, determine the agenda for Council meetings.

Section 7: Duties of the Vice Chair

The Vice Chair shall preside at Council meetings in the absence of the Chair.

Section 8: Duties of the Past Chair

The Past Chair shall preside at Council meetings in the absence of the Chair and the Vice Chair.

Section 9: Secretary

The Administrative Assistant to the Council shall act as secretary to the Council.

ARTICLE VII
COMMITTEES

Section 1: Appointments of all Permanent and Ad Hoc Committees

Except for the Nominating Committee and the Executive Committee, the Chair, in consultation with the Council, shall appoint all chairs and members of all committees established by the Council. Each Council member will serve on at least one committee. Only members of the Council are eligible for appointment to committees. The Nominating Committee shall be appointed by the Council. The Executive Committee is established as outlined under Article VI, Section 4.

Section 2: Powers

Committees appointed by the Chair or Council shall have power and authority to make decisions only as specifically assigned by a majority of a quorum of the Council at a regularly called meeting of the Council. Committee chairs shall be responsible for keeping minutes of committee meetings and reporting on committee activities to the Council.

Section 3: Removal

The Chair or any member of a committee may be removed by a majority of a quorum of the Council at any regularly called meeting of the Council.

ARTICLE VIII
QUORUM

Section 1: Quorum

A quorum will consist of a majority of the members of the Council (more than one-half of the total membership).

ARTICLE IX
VOTING

Section 1: Quorum Present

Voting shall occur only when a quorum is present. A vote of a majority of those present is required to carry a motion.

Section 2: Conflict of Interest

Members shall abstain from voting on issues that relate to a possible conflict of interest, e.g., funding to a program in which they are a salaried employee or a member of the governing or advisory board. A record of abstentions shall be part of the minutes. Agencies or programs with which Council members are directly employed or affiliated may not apply for or seek funding from the Council. Members shall not use their position on the Council to influence other members or the Council as a whole to award funding or give privileges, preferences, exemptions, or advantages to specific agencies or programs with which they are directly employed or affiliated. Members must disclose their employment or affiliation with specific agencies or programs when business related to such agencies or programs is set before the Council for deliberation.

ARTICLE X GRIEVANCES

Section 1: Grievance Rights

Grievances are limited to deviations from or violations of the bylaws established by the Behavioral Health Planning and Advisory Council.

Section 2: Grievance Procedure

1. The grievance process will be fair, impartial, and responsive to all parties.
2. A grievant shall not be discriminated against, nor suffer any retaliation, as a result of filing or participating in the grievance process.
3. A complaint or grievance must be submitted to the Executive Committee, which will serve as the Grievance Committee, within 30 days of the date of the alleged episode causing the grievance became known.
4. The Executive Committee shall address grievances for the Council, including making a formal recommendation regarding the grievance. In the event the grievant does not agree with the Executive Committee's final decision, the grievant may appeal to the Council as a whole within 30 days of the constructive receipt of the Executive Committee's decision. In such cases, the Executive Committee will bring the formal recommendation before the Council at the next regularly scheduled Council meeting, which will be presented as an agenda item. The Council will then, by majority vote, agree or disagree with the Executive Committee's formal recommendation in determining the final action regarding the grievance. The grievant may attend in person, or if not in person, elect to submit a letter on his or her behalf.

5. In lieu of the Executive Committee, the Council shall appoint an ad hoc Grievance Committee only if and when a grievance is filed against:

- a. The Executive Committee as a whole, or
- b. An individual member of the Executive Committee.

This ad hoc Grievance Committee will serve in the place of and handle all above-mentioned grievance-related duties otherwise to have been performed by the Executive Committee if the BHPAC determines that the Executive Committee cannot serve as a fair and impartial committee and if item a. or b. is met.

ARTICLE XI AMENDMENTS

Section 1: Amendment or Repeal

The Bylaws may be amended or repealed at any regular meeting of the Council by a majority vote of the quorum, provided that a written notice of proposed change(s) has been submitted to each member at least seven (7) days before said meeting and public notice has been provided at least three (3) days before said meeting.

Proposed amendments shall be received by the Administrative Assistant to the Council and circulated to the members of the Council.

ARTICLE XII FUNCTIONS NOT SPECIFICALLY COVERED BY THESE BYLAWS

Section 1: Rules of Order

Any necessary functions not specifically covered by these bylaws will be covered by Robert's Rules of Order, Revised.

THESE BYLAWS WERE LAST AMENDED September 9, 2016 AND REMAIN IN EFFECT UNTIL AMENDED OR REPEALED AS PROVIDED IN ARTICLE XI.

Footnotes:

NOT FINAL

BEHAVIORAL HEALTH PLANNING AND ADVISORY COUNCIL BYLAWS

ARTICLE I AUTHORIZATION AND PURPOSE

Section 1: Authorization

The Nevada State Behavioral Health Planning and Advisory Council (BHPAC) is authorized by Executive Order of the Governor. See Exhibit I.

Section 2: Purpose

1. Mission

The Nevada Behavioral Health Planning and Advisory Council will serve as an advocate for individuals with chronic mental illness, children and youth with severe emotional disturbance, other individuals with mental illnesses or emotional problems, and persons with substance abuse and co-occurring disorders.

2. Under federal statutes, the specific duties and responsibilities of the Council are:

- 1) The Council shall advise the Division of Public and Behavioral Health and the Division of Child and Family Services on the development of the state behavioral health plan.
- 2) Serve as an advocate for adults with serious mental illness, children with severe emotional disturbance, other individuals with mental illnesses or emotional problems and persons with substance abuse and co-occurring disorders.
- 3) The Council shall monitor, review, and evaluate, no less than once each year, the allocation and adequacy of behavioral health services within the state.

ARTICLE II MEMBERSHIP

Section 1: Appointments

The Governor shall appoint 23 members to the Nevada Behavioral Health Planning and Advisory Council.

Section 2: Composition

1. Council membership will be composed of residents of the state, including representatives from:

- 1) The principal state agencies with respect to:
Mental Health Services for Children and Adolescents
Mental Health Services for Adults

Substance Abuse Prevention and Treatment
Education
Housing
Vocational Rehabilitation
Criminal Justice
Social Services
Medicaid

- 2) Public and private entities concerned with the need, planning, operation, funding, and use of mental health, substance use and co-occurring services and related support services.
 - 3) Persons with mental illness and persons with substance abuse and co-occurring disorders, who are receiving (or have received) behavioral health services.
 - 4) The families of such individuals in (3) above.
2. At least 50 percent of the members of the Council will be individuals who are not state employees or providers of behavioral health, substance abuse or co-occurring services.

Section 3: Term of Appointment

The term of an appointed member is four (4) years. An appointed member may be reappointed for an unlimited number of 4 year terms. The 4 year term of appointment does not apply to an appointed member who was/is appointed to serve “at the pleasure of the Governor.”

Section 4: Reappointment

Reappointments of Council members will be processed in the following manner:

1. The Administrative Assistant to the Council will maintain a list of members and their appointment terms and request that an Application for Boards and Commissions be completed by each member six months prior to the end of their term and submitted to the Office of the Governor of the State of Nevada.
2. Reappointment is official when the Governor of the State of Nevada or his or her designee approves a candidate and issues a Certificate of Appointment.
3. The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.
4. New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years thereafter, if made available.

Section 5: Oath of Office

In accordance with Nevada Revised Statutes (NRS) 282.020, members of the Council shall, before they enter upon the duties of members of the Council, take and subscribe to the following oath:

I,, do solemnly swear (or affirm) that I will support, protect and defend the Constitution and Government of the United States, and the Constitution and government of the State of Nevada, against all enemies, whether domestic or foreign, and that I will bear true faith, allegiance and loyalty to the same, any ordinance, resolution or law of any state notwithstanding, and that I will well and faithfully perform all the duties of the office of Behavioral Health Planning and Advisory Council member, on which I am about to enter,
(if an oath) so help me God;
(if an affirmation) under the pains and penalties of perjury.

ARTICLE III VACANCIES

Section 1: Absences

Three absences from regularly scheduled meetings (which include regular BHPAC meetings and/or Executive Committee meetings) within any twelve month period without sufficient or overriding reason will be considered unexcused absences and may constitute grounds for the Council recommending the member's removal from the Council to the Governor. At each regularly scheduled meeting, absent members will be noted as either excused or "currently unexcused". The Chair, Vice Chair, or acting Chair will determine at the next scheduled meeting if the member's absence was excused or unexcused. An excused absence includes, but is not limited to, an unexpected occurrence or emergency with health, family, or employment that would prevent the member from attending the meeting. An unexcused absence includes, but is not limited to, lack of communication (no contact) with the BHPAC Chair, Vice Chair, or Administrative Assistant. Unless an absence is the result of an emergency or unexpected occurrence, members who cannot attend a regularly scheduled meeting must give written prior notice (letter, memo, or e-mail) to the BHPAC Chair, Vice Chair, or Administrative Assistant no less than two business days prior to the meeting. Failure to do so will result in an unexcused absence.

Section 2: Removal from Membership

When a member has a third unexcused absence within any twelve month period, the Chair will send a notification letter to the member that the Council intends to take action at the next scheduled meeting. At that meeting, the member will have an opportunity to refute the action or the Council will proceed with the removal

process. The removal process shall be a simple majority vote to recommend the removal to the Governor for action.

Section 3: Filling Vacancies of Other than State Representatives

Council vacancies for members other than State representatives are filled by the following process:

1. The Administrative Assistant to the Council shall maintain an active and secure file of interested applicants from which to draw in the event of Council vacancies.
2. Applications on file and newly received applications shall be reviewed based on Council composition requirements to establish candidates for open positions.
3. A Nominating Committee established by the Council shall nominate candidates from the pool of applicants.
4. A majority vote by the Council shall determine recommended candidates for appointment by the Governor.
5. Appointment is official when the Governor of the State of Nevada or his or her designee approves recommended candidates, issues Certificates of Appointment and a copy of the Certificates are received from the candidates by the Administrative Assistant to the Council.
6. The Council shall not discriminate in any regard with respect to age, race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child, physical disability, or mental disability.
7. New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years thereafter if made available. Failure to attend a Council member orientation within six months of appointment or within any two-year period may constitute grounds for the Council recommending to the Governor the member's removal from the Council.

Section 4: Filling Vacancies of State Representatives

Council vacancies for State Representatives are filled by the following process:

1. Upon receipt of a resignation notification, a letter to the Administrator (or his or her designee) of the Agency in which the vacancy occurs will be sent requesting that the name of a new prospective representative be provided to through the Council to the Governor's Office in the manner prescribed by the Governor's Office.
2. Appointment is official when the Governor of the State of Nevada or his or her designee approves recommended candidates, issues Certificates of Appointment and a copy of the Certificates are received from the candidates by the Administrative Assistant to the Council.
3. New BHPAC members must attend Council member orientation within six months of appointment, and refresher training at least every two years

thereafter. Failure to attend a Council member orientation within six months of appointment or within any two-year period may constitute grounds for the Council recommending to the Governor's Office the member's removal from the Council.

Section 5: Resignations

When a member resigns from the Council, a resignation notification shall be submitted to the Chair of the Council, copied to Council staff, via standard mail or electronic mail. Resignations should not be submitted directly to the Governor's Office. Vacancies created by resignations will be filled as outlined in Section 3 or 4 above.

ARTICLE IV REIMBURSEMENT

Section 1: Travel and Per Diem

Reimbursement for travel and per diem costs at State rates shall be processed by the Administrative Assistant to the Council and taken from the Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant allocated to the State of Nevada.

Section 2: Stipends

Members who are not employed by the government and do not receive compensation for their participation in meetings as part of their regular employment shall be given a stipend in the amount of \$80 per day for each regularly scheduled meeting of the Council. Stipends will also be provided to members of the Council who meet as part of a committee of the Council, attend conferences and other behavioral health related activities, or represent the Council at the direction of the Chair. Stipends for these activities shall be paid in the amount of \$80 per day for full-day activities and \$40 per day for half-day activities. Additionally, the BHPAC will also offer its members, who are not employed by the government and who do not receive compensation for their participation in meetings, reimbursement for respite and/or child care, to enable them to attend and participate in BHPAC meetings. The reimbursements for stipends shall be processed by the Administrative Assistant to the Council and taken from the Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant allocated to the State of Nevada.

ARTICLE V MEETINGS

Section 1: Frequency of Meetings

The Nevada Behavioral Health Planning & Advisory Council shall meet at least four times per year. Special meetings of the Council may be called at any time by the Chair, Executive Committee, or by a quorum of Council members.

Section 2: Open Meetings

All meetings of the Council shall comply with the requirements of the State of Nevada Open Meeting Law. A Public Comment item shall be included on each agenda to allow members of the public to address the Council.

Section 3: Agenda Items

Council members may request Agenda items for BHPAC meetings. Agenda item requests should be submitted via e-mail to the Administrative Assistant at least thirty (30) days prior to the next scheduled PHPAC meeting. The BHPAC Executive Committee will review and approve the final Agenda.

Section 4: Requesting Tapes or Transcripts of Meetings

All requests for tapes or transcripts of BHPAC meetings will adhere to established policy and procedures. Requests should be directed to the Division of Public and Behavioral Health (DPBH).

ARTICLE VI OFFICERS OF THE COUNCIL

Section 1: Officers

The members of the Council shall elect a Chair and a Vice Chair. The immediate past Chair shall be considered an officer of the Council and a member of the Executive Committee.

Section 2: Terms of Office

The Chair and Vice-Chair serve a term of office comprised of a two (2) year period. One additional term of office (two year period) is permitted with approval the Council. The maximum consecutive term of office that may be served in each office is four (4) years, unless an extension is approved by a 70% or greater vote of the Council. This does not preclude someone from serving in another office upon reaching the term limit for the currently held office.

Following a minimum of two years out of either office, the past Chair or Vice Chair would become eligible again to serve in the same office. Each officer shall serve until the installation of a successor.

Section 3: Officer Nominations and Elections

Elections for Council offices shall be held at the first regularly scheduled meeting falling on or after October 1 at the end of the current officers' two year term. A Nominating Committee established by the Council shall nominate candidates for open office positions, or Council members may make nominations from the floor. Each office shall be voted upon separately. If more than two nominees are selected for a single office, the lowest vote recipient shall be eliminated during each round of voting necessary until only two nominees remain. Nominees for offices who receive a majority vote for the office available shall be declared elected to that office, effective the next regularly scheduled meeting of the Council.

Section 4: Executive Committee

The Council shall have an Executive Committee comprised of the current Chair, current Vice Chair, immediate past Chair, the representative to the Council from the principal state agencies with respect to Mental Health Services for Children and Adolescents and Behavioral Health Services for Adults . The Executive Committee shall be authorized by the Council to make decisions concerning the affairs of the Council in the interim between regularly called meetings. Actions taken by the Executive Committee must be reported to all members of the Council at the next regularly called meeting.

Section 5: Vacancies in Office

Any vacancies in office during an unexpired term shall be filled by an election of the Council and the elected person shall hold office for the remainder of the unexpired term of office. If the immediate past Chair is no longer able to serve on the Executive Committee, the current Chair shall appoint a successor until the next officer election which allows for a new immediate past Chair to serve on the Committee.

Section 6: Duties of the Chair

1. To preside at all meetings of the Council.
2. In consultation with the Executive Committee and Administrative Assistant to the Council, determine the agenda for Council meetings.

Section 7: Duties of the Vice Chair

The Vice Chair shall preside at Council meetings in the absence of the Chair.

Section 8: Duties of the Past Chair

The Past Chair shall preside at Council meetings in the absence of the Chair and the Vice Chair.

Section 9: Secretary

The Administrative Assistant to the Council shall act as secretary to the Council.

ARTICLE VII
COMMITTEES

Section 1: Appointments of all Permanent and Ad Hoc Committees

Except for the Nominating Committee and the Executive Committee, the Chair, in consultation with the Council, shall appoint all chairs and members of all committees established by the Council. Each Council member will serve on at least one committee. Only members of the Council are eligible for appointment to committees. The Nominating Committee shall be appointed by the Council. The Executive Committee is established as outlined under Article VI, Section 4.

Section 2: Powers

Committees appointed by the Chair or Council shall have power and authority to make decisions only as specifically assigned by a majority of a quorum of the Council at a regularly called meeting of the Council. Committee chairs shall be responsible for keeping minutes of committee meetings and reporting on committee activities to the Council.

Section 3: Removal

The Chair or any member of a committee may be removed by a majority of a quorum of the Council at any regularly called meeting of the Council.

ARTICLE VIII
QUORUM

Section 1: Quorum

A quorum will consist of a majority of the members of the Council (more than one-half of the total membership).

ARTICLE IX
VOTING

Section 1: Quorum Present

Voting shall occur only when a quorum is present. A vote of a majority of those present is required to carry a motion.

Section 2: Conflict of Interest

Members shall abstain from voting on issues that relate to a possible conflict of interest, e.g., funding to a program in which they are a salaried employee or a member of the governing or advisory board. A record of abstentions shall be part of the minutes. Agencies or programs with which Council members are directly employed or affiliated may not apply for or seek funding from the Council. Members shall not use their position on the Council to influence other members or the Council as a whole to award funding or give privileges, preferences, exemptions, or advantages to specific agencies or programs with which they are directly employed or affiliated. Members must disclose their employment or affiliation with specific agencies or programs when business related to such agencies or programs is set before the Council for deliberation.

ARTICLE X GRIEVANCES

Section 1: Grievance Rights

Grievances are limited to deviations from or violations of the bylaws established by the Behavioral Health Planning and Advisory Council.

Section 2: Grievance Procedure

1. The grievance process will be fair, impartial, and responsive to all parties.
2. A grievant shall not be discriminated against, nor suffer any retaliation, as a result of filing or participating in the grievance process.
3. A complaint or grievance must be submitted to the Executive Committee, which will serve as the Grievance Committee, within 30 days of the date of the alleged episode causing the grievance became known.
4. The Executive Committee shall address grievances for the Council, including making a formal recommendation regarding the grievance. In the event the grievant does not agree with the Executive Committee's final decision, the grievant may appeal to the Council as a whole within 30 days of the constructive receipt of the Executive Committee's decision. In such cases, the Executive Committee will bring the formal recommendation before the Council at the next regularly scheduled Council meeting, which will be presented as an agenda item. The Council will then, by majority vote, agree or disagree with the Executive Committee's formal recommendation in determining the final action regarding the grievance. The grievant may attend in person, or if not in person, elect to submit a letter on his or her behalf.

5. In lieu of the Executive Committee, the Council shall appoint an ad hoc Grievance Committee only if and when a grievance is filed against:
 - a. The Executive Committee as a whole, or
 - b. An individual member of the Executive Committee.

This ad hoc Grievance Committee will serve in the place of and handle all above-mentioned grievance-related duties otherwise to have been performed by the Executive Committee if the BHPAC determines that the Executive Committee cannot serve as a fair and impartial committee and if item a. or b. is met.

ARTICLE XI AMENDMENTS

Section 1: Amendment or Repeal

The Bylaws may be amended or repealed at any regular meeting of the Council by a majority vote of the quorum, provided that a written notice of proposed change(s) has been submitted to each member at least seven (7) days before said meeting and public notice has been provided at least three (3) days before said meeting.

Proposed amendments shall be received by the Administrative Assistant to the Council and circulated to the members of the Council.

ARTICLE XII FUNCTIONS NOT SPECIFICALLY COVERED BY THESE BYLAWS

Section 1: Rules of Order

Any necessary functions not specifically covered by these bylaws will be covered by Robert's Rules of Order, Revised.

THESE BYLAWS WERE LAST AMENDED September 9, 2016 AND REMAIN IN EFFECT UNTIL AMENDED OR REPEALED AS PROVIDED IN ARTICLE XI.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address, Phone, and Fax	Email(if available)
Charlene Frost	Others (Advocates who are not State employees or providers)			frost.charlene@gmail.com
Stacy Kollias	Family Members of Individuals in Recovery (to include family members of adults with SMI)			stacykollias@gmail.com
Susan Maunder	Family Members of Individuals in Recovery (to include family members of adults with SMI)			greyhoundwon@yahoo.com
Amber Neff	State Employees			amber.neff@housing.nv.gov
Rene Norris	Family Members of Individuals in Recovery (to include family members of adults with SMI)			renenorris@ymail.com
Jennifer Sexton	State Employees			jennifersexton@doc.nv.gov
Gillian Rae Stover	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			gillians@cox.net
Alyce Thomas	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			alycetconsulting@gmail.com
Karen Tory Greene	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			KTG@vipmhc.com
Dawn Walker	Providers			sinsay.us@gmail.com

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Current State Vacancies:
 Vocational Rehab
 Social Services
 Mental Health

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	10	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	1	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	7	70.00%
State Employees	2	
Providers	1	
Vacancies	0	
Total State Employees & Providers	3	30.00%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
 - a) Public meetings or hearings? Yes No
 - b) Posting of the plan on the web for public comment? Yes No
If yes, provide URL:
Nevada State DHHS/DPBH-SAPTA
URL: -----
 - c) Other (e.g. public service announcements, print media) Yes No

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Footnotes:

NOT FINAL