2018 NORTHERN REGIONAL BEHAVIORAL HEALTH REPORT

Carson City, Churchill, Douglas, Lyon, Mineral and Storey Counties

Prepared by:
Northern Nevada Behavioral Health Policy Board
November 1, 2018

Please send all correspondence to:
Jessica Flood
Northern Nevada Behavioral Health Coordinator

EXECUTIVE SUMMARY

In 2017, the Nevada Legislature created four Regional Behavioral Health Policy Boards through the passage of AB 366. NRS 433.4295 directs the Regional Behavioral Health Policy Boards to coordinate and exchange information with the other behavioral health policy boards in the state, review the collection and reporting standards of behavioral health data to determine standards for such data collection and reporting processes, and advise the Commission on Behavioral Health, the Department of Health and Human Services, and the Department of Public and Behavioral Health regarding:

- Behavioral health needs of adults and youth in the region
- Progress, problems and proposed plans regarding the provision of behavioral health services, and strategies to improve the provision of such services in the region
- Identified gaps in behavioral health services in the region, and recommendations to address those gaps
- Identified priorities for allocating money to support and further develop behavioral health services in the region

The Regional Behavioral Health Policy Board legislation also directs the Boards to coordinate with existing entities in the state to submit a report to the Commission specifying specific behavioral health needs in the region. This report for the Northern Behavioral Health Region addresses the topics above with the intention of providing a broad perspective of behavioral health, including population trends, regional gaps and needs, and priorities and recommendations for sustaining and enhancing the behavioral health system in the region.

The report begins with a regional data profile derived from the Division of Public and Behavioral Health's "Substance Abuse Prevention and Treatment Agency (SAPTA) 2017 Epidemiological Profile Northern Region". While this section is lengthy at seven pages, it allows the reader to obtain a more broad and in-depth understanding of the behavioral health needs and patterns of the population residing in the Northern Region. Several data trends are worth highlighting. Data shows our region's youth reporting higher suicidal ideation and suicidal behaviors than youth in the other regions and statewide. Our region's high school youth also have higher rates of alcohol, marijuana, and tobacco use than the rest of the state, and have a slightly higher rate of drug use (including heroin, methamphetamines, cocaine, inhalants, ecstasy, and synthetic marijuana) than state and national rates.

Our adult population has a significantly higher rate of reporting missing 10 or more days of usual activities due to poor mental or physical health than other regions in the state and statewide. Additionally, our region has seen significant increases in anxiety and depression ER encounters and hospitalizations that range from several hundred percent to over a thousand percent over a

nine-year period. Marijuana, alcohol, and methamphetamine continues this trend of increased ER encounters and hospital admissions.

These data trends reflect the experience reported by community stakeholders and providers that have participated in the Northern Behavioral Health Coalition and county behavioral health taskforces for several years now. In response to the over-utilization of hospital ER's and jails, the region has prioritized the development of programs focused on youth and adults at risk of inappropriate and/ or repeated contact with the emergency and criminal justice systems. The goal of such diversion is to stabilize these individuals through connection with lower levels of care in the community. With this in mind, four out of six counties in the region have signed on to the Stepping Up Initiative, a national initiative to divert individuals from the criminal justice system. This concern is also reflected in our region's prioritization of continued and expanded funding for Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Training (CIT), and Juvenile Assessment Service Triage Teams (JASTT). As the region has found success in these programs, additional gaps have been identified in the need for increased behavioral health crisis response, and community treatment programs such as Assertive Community Treatment to assist individuals in living productive and meaningful lives in the community.

The Northern Region's stakeholders are appreciative for the state funding that initiated and continues to sustain the MOST, FASTT, CIT, and JASTT programs. The region is equally gratified to recently see our treatment providers receive funding to develop three additional Certified Community Behavioral Health Centers (CCBHC's), funding to develop a regional First Episode Psychosis Team aligned with the national best practice, NAVIGATE, and proposed funding to develop an Assertive Community Treatment program. Our region would not have experienced this success in addressing gaps without active participation from our community leaders and strong support from the Division of Public and Behavioral Health. The Northern Regional Behavioral Health Policy Board hopes to continue making progress in developing a more responsive and diverse behavioral health system in the future.

TABLE OF CONTENTS

NORTHERN NEVADA BEHAVIORAL HEALTH PROFILE

The Northern Region consists of Carson City, Churchill, Douglas, Lyon, Mineral, and Storey Counties, stretching across 11,802 square miles in northwestern Nevada. The total population of the Northern Region, estimated to be 192,784 in 2017, has increased 2.2% over the past 10 years. The median household income is $50,892, with a per capita income of $28,063 for the past 12 months. Approximately 12.5% of the population is in poverty, and 15.2% of the population under 65 has a disability. Many of the counties in the region have a larger aging population with 35.6% of the population 55 years or older. 77.7% of the Northern Region's residents are White not of Hispanic origin, while 15.5% individuals are Hispanic. 3.3% of the population are Native American, 2.3%, Asian, and 1.2% of the population are Black.

Mental Health

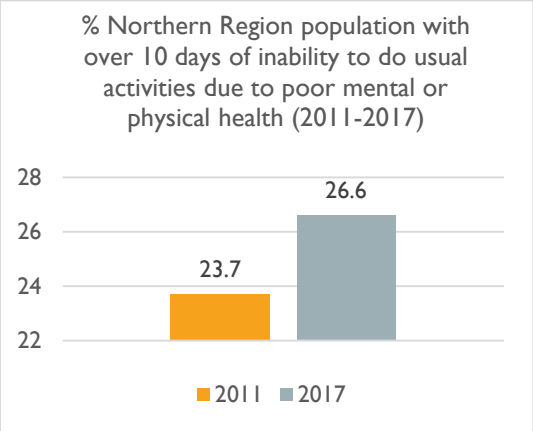
Youth Mental Health:

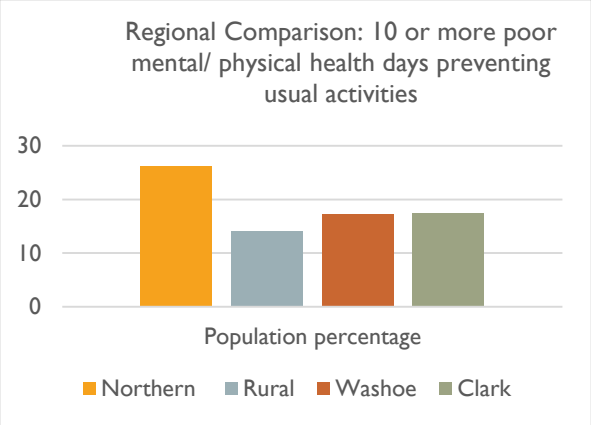
- Northern Nevada high school students have a greater suicide risk than high school students statewide.
  - 18.2 % considered suicide in comparison to 16.6% in Nevada
  - 16.6% planned suicide versus 14.4% in Nevada
  - 10.8% attempted suicide versus 8.5% for Nevada high school youth

- Northern Nevada middle school youth experience mental health risk behaviors at a higher rate than middle school youth statewide.
  - 32.4% of the youth felt sad or helpless in comparison to 29.3% of middle school youth in Nevada
  - 23.4% considered suicide in comparison to 21.3% statewide
  - 16.7% planned suicide versus 15.3% of middle school youth in Nevada
  - 9.7% attempted suicide in comparison to 8.2% in Nevada
  - 21.2% cut/ burned themselves in comparison to 18.4% of middle school youth in Nevada.

The Northern Region's high school youth have highest rates of suicidal ideation and behaviors in the state

Adult Mental Health:
Adults who experienced 10 or more days of poor mental or physical health that prevented them from doing usual activities increased from 23.7% of the Northern Region's population in 2011 to 26.6% in 2017. This percentage of the population is significantly higher than in the Rural/ Frontier Region (14%), Washoe (17.7%), and in the Southern Region (17.4%).

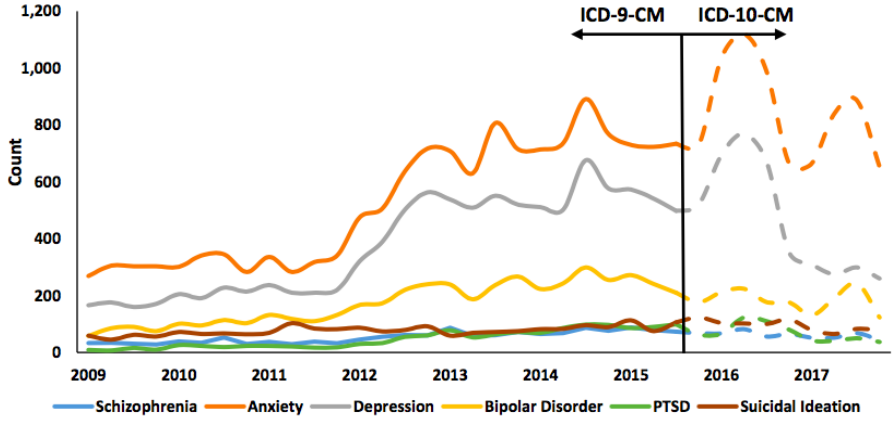




Mental Health Related Emergency Department encounters:

- Anxiety has been the most prevalent mental health related diagnosis in hospital emergency rooms (ER) since 2012.
- Adjusted for population growth, ER visits for anxiety almost tripled between 2009 and 2017. In the 2017 Epidemiological Profile for the Northern Region, DPBH reports that there were 1,962 anxiety related visits in the ER (1,026.3 per 100,000) which increased to 5,565 visits in 2017 (2,886.7 per 100,000).
- ER visits for depression increased by 1251% between 2009 and 2017, from 84 in 2009 (43.9 per population of 100,000) to 1,144 in 2017 (593.4 per population of 100,000 of Northern Nevada residents). ED encounters for anxiety increased from 1,026.3 per 100,000 population in 2009 to 2,886.7 per 100,000 population in 2017.

Figure 10. Mental Health-Related Emergency Department Encounters in Northern Nevada, by Quarter and Year, 2009-2017.

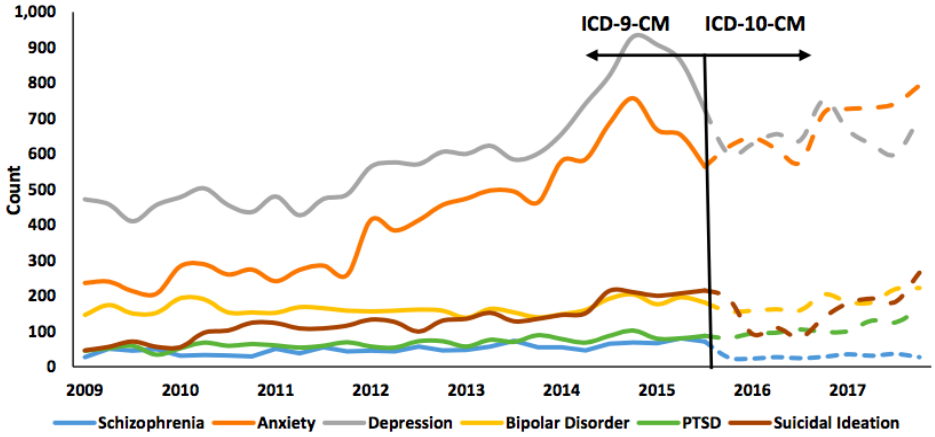


Source: Hospital Emergency Department Billing.
ICD-10 codes replaced ICD-9 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
Northern Nevada: Carson City, Churchill, Douglas, Lyon, Mineral and Storey Counties.

Retrieved from 2017 SAPTA Epidemiological Report Northern Region

- Anxiety and depression are leading diagnoses for mental health related inpatient admissions as well. Anxiety related hospital admissions have increased 187% and depression related admissions have increased 356 % in 8 years.

Figure 11. Mental Health-Related Inpatient Admissions in Northern Nevada, by Quarter and Year, 2009-2017.



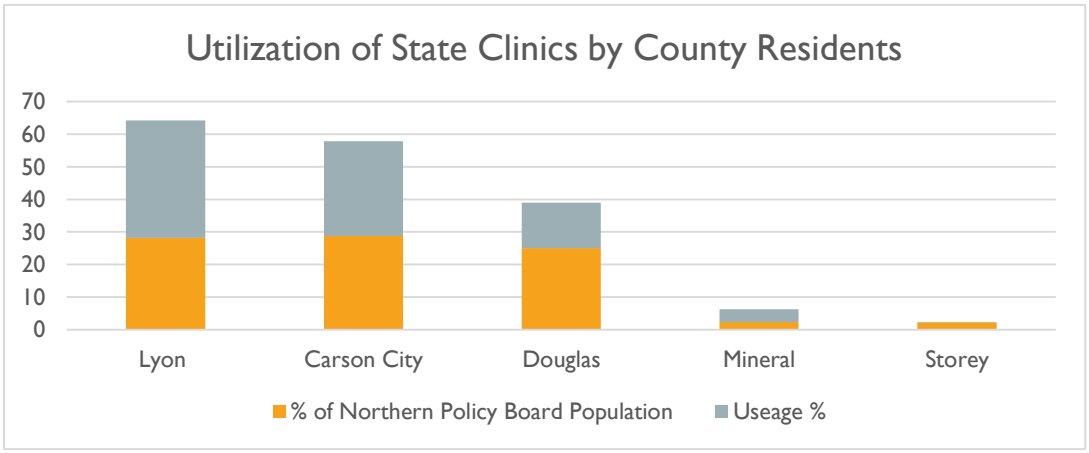
Retrieved from 2017 SAPTA Epidemiological Report Northern Region

Population accessing state funded Division of Public and Behavioral Health mental health services:

Utilization of clinics by county

Of Northern Nevada residents accessing DPBH state funded mental health services:

- 36% lived in Lyon County- Lyon has 28.2% of the population in the region
- 29% lived in Carson City- Carson City has 28.8% of the population in the region
- 14% lived in Douglas County- Douglas has 25% of the population in the region
- 4% in Mineral County- Mineral County has 2.3% of the population in the region
- .04% in Storey County- Storey County has 2.2% of the population in the region



- Since 2011, the region's number of residents accessing state mental health has increased by 100, however after peaking in 2014, this number has shown a downward trend continuing in 2017.

  Over the past several years, DPBH Rural Clinics has worked to fully utilize community providers by referring appropriate clients to them. This allows the Rural Clinics to serve as a safety net provider for individuals with no insurance or those who are beyond the capacity of the community to serve. Lyon and Mineral Counties show greater use of DPBH services relative to their population. This may reflect the significant healthcare provider shortage that both counties face.

  <u>Population characteristics for individuals utilizing State funded clinics:</u>
  - Females consistently utilize DPBH services more than males.
  - The most common age group is 55-64, accounting for 17% of the patients.
  - Patient utilization has declined across all races, due to the Affordable Care Act.
  - Black non-Hispanic population had the highest crude rate for accessing DPBH mental health services over the past 7 years (1113.1 per population).

Suicide:

- 3.0% of adults reported seriously considering suicide in 2017.
- The most common method for attempted suicide was substance use or drug overdose attempt, consisting of 56% of suicide attempts.
- Since 2015, there has been an increase in inpatient admissions where a patient did not expire due to suicide attempt. 82% of these admissions were related to substance and drug overdose.
- Over the past 12 years, 445 residents completed suicide, with an average of 49 suicides each year.
- Suicides are most common for the population aged 45-54 in 2017.
- Over the past 12 years, suicides were most common among high school graduates with 28 suicides in 2017.

The most common method for attempted suicide was substance use or drug over dose, which accounted for 56% of the attempts.

Rates of suicide for the White Non- Hispanic population in Northern Nevada were significantly higher than rates statewide

- Age adjusted rates for suicide for the White non-Hispanic population were significantly higher than the statewide rate from 2009-2017. In 2017, there were 27.1 suicides per population of 100,000 in the region.
- Rates of suicide for the Hispanic population were significantly lower than Nevada for all years.

Substance use:

Youth:

- Drug use rates for Northern Nevada high school students (including heroin, methamphetamines, cocaine, inhalants, ecstasy, and synthetic marijuana) are slightly higher than state and national rates.
- Northern Nevada high school and middle school students have higher rates of alcohol and tobacco use than the overall rate in Nevada as well.

Tobacco:

- The Northern Region's high school students show significantly higher use of tobacco and electronic vapor products than high school students in Nevada.
- 21.3% of high school students in the Northern Region compared to 12% of youth in Nevada use tobacco.
- 9.7% of high school students use smokeless tobacco in comparison to 4.0% of youth in Nevada.
- 12.3% of high school students in the Northern Region reported smoking cigarettes, versus 6.4% of youth in Nevada.
- The Northern Region's middle school students show high rates of use of tobacco and electronic vapor products than middle school students in Nevada as well.

Northern Nevada youth have significantly higher rates of alcohol, marijuana, and tobacco use than youth statewide

Alcohol:

- 35.8% high school students report currently drinking alcohol in comparison to 26.5% of high school students across Nevada.
- Northern Region's high school students report recent binge drinking (19.7%) in comparison to overall rate in Nevada (11.1%).
- Over 1 in 10 middle school students report drinking before the age of 11 (13.8%).
- 32.3% of middle school students reported drinking alcohol at some point in their lives.

Marijuana:

- In Northern Nevada, 44.7% of youth reported ever trying marijuana in comparison to 37% of high school students in Nevada. Youths in the Northern Region report using marijuana more (25.4%) in comparison to high school students in Nevada (19.5%).

Prescription drug use:

- 18% of high school students in the Northern Region reported using prescription drugs that were not prescribed to them in their life time.

Adult substance use:

- Between 2011 and 2017, there was a significant increase in the population who reported using marijuana/ hashish to get high in the past 30 days. The percentage of adults reporting use was 3.2% in 2011 and increased to 15.1% in 2017.
- Between 2011 and 2017, an average of .07% of the population used pain killers to get high.
- 8.6% of men and 9.8% of women in the Northern Region were considered heavy drinkers in 2017.
- 17.8% of men and 14.8% of women in the Northern Region were considered "binge drinkers" in 2017.

Substance use hospital Emergency Department ED) encounters and hospital admissions:

- In 2017, of the 1,262 total alcohol and drug related ED visits, 837 were alcohol related.
- Since 2013, Marijuana/hashish has been the most common drug associated with emergency department visits, followed by methamphetamines, and opioids. In 2017, there were 719 visits related to marijuana, and 442 visits related to methamphetamine.
- Since 2009, alcohol related admissions were the most common, until 2016 when drug related admission passed alcohol. In 2017 there were 4,281 drug and/ or alcohol related admissions.
- Inpatient admissions related to drugs and alcohol significantly increased from 2009-2017. Marijuana/ cannabis, opioids, and methamphetamines were the top three substances, respectively, listed on diagnoses. Notably, hospital admissions for methamphetamine almost quadrupled from 153 in 2009 to 581 in 2017.

Hospital admissions for methamphetamine almost quadrupled from 153 in 2009 to 581 in 2017.

Alcohol and substance use related deaths:

- Age-adjusted rates for alcohol and/or drug related deaths increased significantly in 2016 and remained at that higher rate in 2017.
- In 2017, alcohol related deaths, which make up 31% of alcohol and drug related deaths, increased 55% in per 100,000 age specific population between 2009 and 2017.
- Drug related deaths increased 13% in per 100,000 age specific population from 2009 to 2017.

Special Populations:

Newborns

- Between 2010 and 2018, alcohol and marijuana were the most reported substances for Northern Nevada mothers who self-reported using substances while pregnant.
- Since 2015, marijuana surpassed alcohol in substances used during pregnant, and self-reported poly substance use has been increasing since 2010.

Drug related deaths increased 13% in per 100,000 age specific population from 2009 to 2017.

- Self-reported tobacco use has decreased from 124.1 per 1,000 births in 2010 to 102.1 per 1,000 births in 2017.

Lesbian, Gay, Bisexual (LGB)

- Of students in the Northern Region who participated in the Youth Risk Behavior Survey in 2017, 3.1% reported that they were gay or lesbian, 9.6% were bisexual, and 3.9% were not sure about their sexual orientation for a sum of 16.6% of students who do not identify as heterosexual. 83.4% of Northern Nevada students reported that they were heterosexual.
- The Lesbian/ Gay/ Bisexual population has significantly higher rates of health risk behaviors than the rest of the Northern Nevada adults in 2017, including binge drinking (31.9% versus 15.5% respectively), difficulty doing errands because of physical, mental, or emotional problems (12.2% versus 7.5% respectively), and reporting ever being told they had depressive disorder (58.7% versus 20% respectively). Rates of binge drinking and those told they have depressive disorder significantly increased between 2016 and 2017.

Methods and Approach

The Northern Behavioral Health Policy Board has worked to obtain information about regional behavioral health needs, gaps, and priorities through multiple data sources and strategies. Since 2013, the Northern Region's leaders have placed a high priority on community planning and engagement focused on regional behavioral health gaps, needs, and priorities. These prior strategic planning efforts contributed to the Northern Behavioral Health Policy Board's direction and focus with the conscious intention of sustainability and continuity of behavioral health development in the region. Additionally, the Board heard presentations for a variety of topics related to behavioral health, state data reports, and reviewed important reports.

Northern Regional Behavioral Health Policy Board Presentations

All presentations, materials, and minutes provided to the Northern Regional Behavioral Health Policy Board are on the Board's website, here. The table below provides an overview of presentations provided to the Board since its initial meeting on January 31, 2018.

Date	Topic	Presenter(s)
1/31/2018	Northern Regional Behavioral Health Data Report	Jennifer Thompson, Department of Health and Human Services

3/12/2018	Presentation on Rural Nevada Suicide Data	Misty Allen, Statewide Office of Suicide Prevention Coordinator
	Review of Regional Behavioral Health Priorities	Jessica Flood, Northern Regional Behavioral Health Coordinator
	Presentation on Nevada's Behavioral Health Community Integration Strategic Plan	Kelly Marschall, Social Entrepreneurs Incorporated
	Presentation of Nevada's legal hold process (NRS 433A)	Jennifer Raines, Washoe County Public Defender's Officer
	Presentation on community collaboration opportunities with Elder Protective Services	Aging and Disability Services Division
	Presentation on existing community diversion/ stabilization programs including Forensic Assessment Services Triage Team (FASTT), Mobile Outreach Safety Team (MOST), Crisis Intervention Training (CIT), Mallory Crisis Center, Vitality Unlimited, and Life Change Center, and youth diversion program Juvenile Assessment Services Triage Team (JASTT)	Jessica Flood, Regional Coordinator and Carson City Juvenile Probation
4/6/2018	Housing is Healthcare	Chuck Duarte, CEO of Community Health Alliance
	Rural Health Workforce Planning and Development in Nevada	John Packham, Associate Dean for the Officer of Statewide Initiatives
5/10/2018	Overview of Funding Streams for Behavioral Health Services in Nevada	Division of Public and Behavioral Health, Behavioral Health Wellness and Prevention
	Presentation of Northern Regional Behavioral Health Strategic Plan	August Kvam, Northern Regional Behavioral Health Policy Board Intern

	Presentation of Northern Region's Coalitions regarding funding sources and recipients, budgets, priorities, and activities.	Linda Lang, Director of Nevada Statewide Coalitions
	Update on Workforce Development Efforts of Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors	Jake Wiskerschen, Board President
6/13/2018	Nevada Legislative Process and Bill Draft Requests	Legislative Council Bureau Staff
	Overview of Rural Children's Mental Health Consortium	Pamela Johnson, Chair of Rural Children's Mental Health Consortium
	Guardian Transportation on behavioral health transportation in Utah	Guardian Transportation
7/11/2018	Presentation and update on Nevada 2-1-1	Financial Guidance Center and staff from Division of Public and Behavioral Health
8/7/2018	Presentation on Youth Mobile Crisis Team	Michelle Sandoval, Division of Public and Behavioral Health, Rural Clinics
	National Alliance on Mental Illness (NAMI) Western Nevada Chapter, Family and Peer Support	Laura O'Neil, President of NAMI Western Nevada
9/13/2018	Update on statewide priorities and plans related to behavioral health and substance abuse	Dr. Stephanie Woodard, Division of Health and Human Services
	Presentation on statewide efforts to address opioid crisis	Dr. Stephanie Woodard, Division of Health and Human Services
	Presentation of Mobile Opioid Recovery and Engagement (MORE) Team, harm reduction and the role of peer support in community opioid response efforts	Lisa Lee, Life Change Center
10/10/2018	Presentation of DHHS Northern Regional Epidemiological Report	Jenn Thompson, Division of Health and Human Services

Overview of Prior Regional Behavioral Health Planning Efforts

The Regional Behavioral Health Coalition was developed in 2013 through partnership between Division of Public and Behavioral Health and community stakeholders from Carson, Douglas, and Lyon Counties, and eventually expanded to include Churchill County in 2016. Mineral and Storey Counties joined in 2017. During that time, the Coalition has served as a community forum for discussion, collaboration, and alignment regarding shared behavioral health issues throughout the region. Stakeholders from diverse disciplines and groups including county leadership, law enforcement, Fire/ EMS, behavioral health service providers, social service agencies, community coalitions, and peer and family advocacy groups actively engage in the coalition. Through these partnerships, the Regional Behavioral Health Coalition has generated momentum through common concerns for behavioral health issues, while reducing silos between agencies and disciplines. In October 2017, the coalition conducted a strategic planning session that identified the shared priorities of its members.

2018 Regional Behavioral Health Coalition Strategic Plan

In September 2018, the Northern Regional Behavioral Health Coalition Strategic Plan was developed to document the current and prior regional and county level behavioral health strategic planning efforts in the Northern Region. This document can be found in the materials presented to the Northern Regional Behavioral Health Policy Board on September 2018 here.

County Behavioral Health Task Force Strategic Plans

Each county in the region has developed behavioral health task forces and community meetings to respond to the health and behavioral health needs in their communities. For some counties, this strategic planning process has taken place over multiple workshops and meetings which have focused on general strategic planning for behavioral health and on specific issues such as the Stepping Up Initiative. Priorities identified in planning efforts have been incorporated into "living" strategic planning documents that are updated as new issues arise or when progress is made. These behavioral health task forces and strategic planning sessions receive input from diverse community stakeholder groups, including EMS/ Fire, law enforcement, county officials, social services, behavioral health treatment providers, hospitals, and peer and family advocates. These county-based strategic planning efforts provided a basis for the regional behavioral health strategic plan

Stepping Up Workshops

The Stepping up Initiative Workshops were conducted in Carson City, Lyon, Douglas, and Churchill Counties from late 2016 to early 2017, and were facilitated by Steve Lewis from UNR Cooperative Extension. The primary focus of the workshops was on efforts to divert individuals with behavioral health issues from the criminal justice system, unnecessary EMS

contact and hospital E.R. admissions, as well as other inappropriate institutionalizations. The workshops utilized the Sequential Intercept Model to assist stakeholders, community leaders, and service providers to identify community strengths and areas of existing gaps in their behavioral health systems, and focused on the following objectives:

1. Examine treatment and service capacity in the county
2. Identify state and local policy that could be changed to enhance efforts toward stabilization and diversion of individuals in chronic crisis
3. Identify funding barriers to minimize involvement with the criminal justice system

Participants in the workshops included law enforcement, judges, District Attorneys, Parole and Probation, county officials, hospitals, behavioral health providers, community coalitions, social services, and peer and family advocates. These events provided information on best practices regarding community prevention, stabilization, and diversion efforts, and allowed for stakeholders from diverse disciplines to develop shared perspectives and priorities for moving forward. Reports were developed from these workshops, which highlight each participating county's current initiatives/ programs as well as identified priorities and needs.

Community Provider Survey

In January 2018, the Regional Behavioral Health Coalition developed and distributed a 4-questions survey to community providers asking them to prioritize the following issues identified by the regional coalition. 65 responses were collected, and the top 3 legislative priorities in sequence of identified importance were:

1. Develop services to support continuity of care (continuation of medication and service connections)
2. Identify strategies for funding to sustain/ increase jail diversion and crisis stabilization programs such as FASTT and MOST
3. Develop legal information sharing process for multi-disciplinary teams for vulnerable adults ages 18-59

Review of existing behavioral health reports:

In order to gain perspective on past behavioral health analyses, efforts, and initiatives in Nevada, the Board reviewed the following key behavioral health reports:

- 2013 Nevada DHHS/DCFS via Social Entrepreneurs, Inc.: "Comprehensive Gaps Analysis of Behavioral Health Services Recommendations"
- February 24, 2015 Dr. Dvoskin, Governor's Advisory Council on Behavioral Health and Wellness: "December 2014 Report to the Governor Sandoval"
- 2018 Rural Children's Mental Health Consortium "Annual Progress Report for 10-year Strategic Plan Status Update"
- Division of Public and Behavioral Health "2017 SAPTA Northern Regional Epidemiolocal Report"
- Nevada Legislative Council Bureau 2017 Bulletin, "Regionalizing the Mental Health System in Nevada: Considerations and Options

REGIONAL GAPS

Priority/ Need	Specific Descriptions
Youth	1. 24/7 youth behavioral health crisis response
	2. Sustainable funding and expansion of youth mental health diversion programs such as Juvenile Assessment Services Triage Team (JASTT) in Carson City
	3. Identification and funding for evidence-based youth treatment and interventions for juvenile justice diversion
	4. Behavioral health professionals capable of treating youth
Behavioral health system with variety of levels of care	1. Currently our region's primary levels of care are inpatient and outpatient behavioral health services. The region needs development of all levels of care described by the LOCUS (Levels of Care Utilization System)
	2. Sustainable funding for Assertive Community Treatment (ACT)
	3. Sustainable funding for support and expansion of Certified Community Behavioral Health Clinics (CCBHC's)
	4. Peer support services
	5. Group homes with varying levels of care
	6. Affordable and supportive housing
	7. Clarification of NRS 433A legal hold process to increase provider understanding and standardization of care
	8. Options for non-emergency behavioral health transport for mental health crisis holds
	9. Development of legal information sharing process of multidisciplinary teams for vulnerable adults 18-59
	10. Develop services to support continuity of care (i.e. continuation of medication/ service connection)

	11. Funding options for inmate healthcare
Crisis Stabilization and Diversion	1. Need for 24/7 behavioral health crisis response
	2. Need for sustainable funding mechanism for crisis triage centers such as Mallory Crisis Center
	3. Need for crisis triage centers in strategic locations in the rural counties to allow individuals to stay in their communities, reduce unnecessary long-distance travel, and reduce pressure on urban counties.
	4. Sustainable funding for existing Mobile Outreach Safety Teams (MOST)
	5. Case management follow up for MOST
	6. Sustainable funding for existing Forensic Assessment Services Triage Teams (FASTT)
	7. Sustainable funding to support Crisis Intervention Training programs
	8. Funding to expand crisis stabilization programs such as Crisis Intervention Training, Mobile Outreach Safety Teams, and Forensic Assessment Services Teams to other counties
Workforce Development	1. Behavioral health professionals with capability to treat youth
	2. Behavioral health professionals that are capable of treating co-occurring disorders
	3. Lack of psychiatrists, behavioral health clinicians, substance use treatment professionals
	4. Lack of clinical internship sites
	5. Funding opportunities to entice healthcare providers into rural areas
Data Needs	1. Accurate behavioral health data that is aligned with national indicators

	2. Legal hold tracking data
	3. Technical assistance for program evaluation
	4. Mechanism for central data
	5. Data Infrastructure: better communication between state and county (e.g., case management systems, referral tracking, case processing, outcomes
	6. Streamline use of research screening/assessment tools

REGIONAL PRIORITIES AND STRATEGIES

Our Board is focused on community diversion and crisis stabilization with the goal of allowing individuals to live satisfying and meaningful lives in our communities in the least restrictive setting. Representing rural communities that lack formalized behavioral health services and are limited in law enforcement, fire/EMS and healthcare facilities, we have focused our efforts this first year at improving the way we can deescalate difficult situations and connect individuals with appropriate services and treatment. Our law enforcement officers and firefighter/paramedics find themselves as the resource of last option for many patients after hours and on the weekends when the limited infrastructure within our rural areas are closed, creating a further dilemma for our patient and our communities. This focus provides requests to implement many of the programs we have used in trial format, are limited in their availability to only some communities or are evidence-based practices we have researched which show they would be useful in our given situations.

The Northern Regional Policy Board's number one priority is to revise NRS 433A to update stigmatizing and inaccurate language, develop standardized procedure statewide, improve patient rights, and enhance continuity of care. Our requested changes for this statute will allow emergency responders, treatment providers, and family and patients all to have a clear shared understanding of the "legal hold" process, allowing for greater system transparency and efficacy.

Our next priority is to appropriately fund the resources we feel are needed within our region. The funding that was cut during the recession greatly affected the behavioral health services in our region, but we are hopeful that providing sufficient, sustainable funding for the following efforts in each of our communities will allow for the significant progress we have achieved in our communities to be sustained:

- County level Mobile Outreach Safety Teams (MOST) that includes a firefighter/paramedic to rule out medical conditions, a licensed clinical social worker (LCSW) or case manager in communities where a LCSW cannot be found to provide care to the client, a law enforcement officer to place law enforcement in a good light with these clients, along with follow up from a case manager from social services to provide services to stop the patient's cycle;
- Regional Crisis Intervention Team (CIT) training for law enforcement, fire/emergency medical services, 9-1-1 dispatchers and other associated professionals. A program must be developed to allow some of the class to be delivered remotely to encourage rural and frontier agencies to participate in the training. The region has done a great job holding these classes, but responders have difficulty in attending the 40-hour class while still providing necessary coverage in the community. Future thoughts should be for a licensure mandate that requires CIT training for emergency responders;
- Forensic Assessment Services Treatment Team (FASTT) in each of our county jails consisting of case managers from social services and behavioral health treatment agencies working to break the cycle of recidivism through assessing client risk and needs, and supporting inmates in connecting to community services upon release;
- Juvenile Assessment Services Treatment Team (JASTT) in our counties in partnership with Juvenile Probation. JASTT provides the same services as FASTT but works with juvenile offenders and their families to break the cycle; and,
- Assertive Community Treatment (ACT) programs to address and support individuals in chronic behavioral health crisis in all of our counties using a regionalized approach. Lack of ACT services has been identified as one of the greatest gaps our region faces.

We also want to encourage additional community involvement by gaining the ability for county social service departments to hold multi-disciplinary team meetings (MDT) for those between the ages of 18 and 59. Child and Elder Protective Services are able to hold these meetings for those outside this age range. Enabling county social services to conduct MDT's will allow a targeted approach to assist super-utilizers.

Our region is very lucky to have a crisis stabilization unit that will accept patients from both law enforcement and fire/EMS at the Mallory Center in Carson City. We need to continue this model and ensure a sustainable funding source that will allow patients to be taken to the correct location for stabilization rather than an emergency department or county jail. We strongly advocate for this service and a sustainable funding stream for it. We must also better educate fire/EMS providers and their medical directors on such programs to encourage their use over the emergency department for patients presenting with a behavioral health crisis.

Our last priority is to maintain the regional behavioral health coordinator position. Our region has, in our opinion, the longest serving and best coordinator, allowing us to make giant steps towards inclusive decision making to address our issues. The coordinator position is taxed with

the workload as the regional coordinator and as the only staff member to the Board. This position, funded by the state but not a state or local government employee, allows everyone to share their hopes, dreams and failures to find a better tomorrow without worry to whom the position reports.

RECOMMENDATIONS

All of our priorities and strategies will require infrastructure within our rural communities. For that reason, we have one major recommendation that is difficult to measure. Our recommendation is to develop the infrastructure in our rural communities, so we can maintain our patients within our communities. This infrastructure involves work force development, sustainable reimbursable funding for treatment, a regional Medicaid coordinator similar to the regional behavioral health coordinator position, enhanced tele-health abilities and official coordination of efforts/oversight. Efforts today are made at the state level to provide services in rural communities without feedback from locals on perceived needs. Most rural communities must transport patients to urban areas for treatment causing disagreements between communities due to the perception of "patient dumping."

Official coordination and oversight are necessary, as this is a local issue that is addressed by federal funding, state government, local government, non-profits and for-profit companies. Our region has made great efforts to create county level task forces that feed information into our Regional Board. These efforts are to be commended but not all players are at the table to plan local efforts. This level of collaboration is underway but a more formal approach must be undertaken to apply the available resources to the problem while allowing decision making at the level closest to the people. This may be through the regional boards as proposed by the Southern Nevada Board. For a new program, we feel the regional board has worked very well for us, in coordination with county level behavioral health task forces. We had been meeting as a region on the issues for a few years prior, so that might have given the Northern Region a head start that other regions will see as time progress.

We would also like to recommend a comprehensive 24-hour crisis call line that works for the diversity of rural Nevada, expanding the Community Behavioral Health Clinics, and developing specific transportation for behavioral health patients to the correct location via the right transport services, not local law enforcement, local 911 ambulances, and not the local taxi cab company.

LEGISLATIVE REQUEST

The Northern Regional Behavioral Health Policy Board's proposed legislative bill draft request (BDR) is focused on clarifying Nevada's legal hold process in NRS 433A. In the effort to obtain support and input from other regions and stakeholders affected by NRS 433A, the Northern Regional Behavioral Health Coordinator initiated a Statewide Legal Hold Workgroup. This work

group has met twice a month since September 10th, 2018, to develop common understanding and consensus on needed changes for NRS 433A. The workgroup consists of representatives from DPBH, the Nevada Psychiatric Association, Nevada Hospital Association, Nevada Rural Hospital Partners, Northern Nevada Emergency Physicians, Nevada State Legislature, and stakeholders from the Washoe, Clark, and rural criminal justice systems, including their counties' respective District Attorneys, judicial staff, public defenders, and law enforcement, and members of. The Northern Board's Bill Draft Request is focused on the following goals which include the proposed changes below:

Goals:

1. Remove and update stigmatizing and inaccurate language regarding mental health crisis
2. Clarify the mental health crisis emergency admission process in 433A to enhance patient rights and standardize practice and processes statewide
3. Develop opportunities for regulation and strengthen continuity of care by adding option for behavioral health mental health crisis transport, clarifying provider and clarifying discharge planning criteria
4. Clarify and update court processes and enhance court information sharing abilities for increased efficiency.

LIMITATIONS AND AREAS OF FUTURE INQUIRY

The Northern Regional Behavioral Health Policy Board has worked at great length to identify regional behavioral health gaps, needs, and priorities with diverse provider and patient/ family advocacy input. However, the board is interested in obtaining broader community stakeholder participation including community members, the business community, peers affected by substance use and mental health issues, veterans, the Lesbian, Gay, Bisexual, and Transgender community, and other through an in-depth community survey and additional focus groups.

APPENDIX A: NORTHERN BEHAVIORAL HEALTH POLICY BOARD 2017 MEMBER APPOINTMENTS

Name	**Title and Agency**
Dr. Robin Titus	Assemblywoman, Nevada Assembly
Dr. Ali Banister	Chief, Carson City Juvenile Probation
Karen Beckerbauer, MA	Manager, Douglas County Social Services
Edrie LaVoie	Director, Lyon County Human Services
Nicki Aaker, RN	Director, Carson City Health and Human Services
Taylor Radtke	Executive Director, Douglas County Partnership
Adrienne Sutherland, CPC	Clinical Director, Community Chest
Sandie Draper	Board Member, NAMI Western Nevada
Dave Fogerson, MPA	Deputy Chief, East Fork Fire
Sheriff Furlong	Sheriff, Carson City
Wanda Nixon, RN	Public Health Officer, Mineral County
Dr. Joseph McEllistrem	Director of Forensic Health Service, Carson City and Douglas County Jails
Kevin Morss	Insurer, Health Plan of Nevada

APPENDIX B: NORTHERN LEGISLATIVE BILL DRAFT REQUEST OVERVIEW

Proposed changes:

1) **Stigmatizing language**
   - Change "person with mental illness" to "person in mental health crisis".

2) **433A language clarification and clean up**
   - Adjust language in NRS 433a for a process that is comprehensive, easy to read, and easy to understand. Definitions were added for terms such as "substantial likelihood of serious harm", "serious bodily injury", and "gravely disabled".

3) **Continuity of Care**
   - Clarify language that allows providers to exchange information aligned with HIPPA and confidentiality law during crisis, and courts to provide information for continuity of care to providers.

4) **Behavioral health transport**
   - Add behavioral health transport language to allow for future development of certified service.

5) **Start 72-hour clock at initiation of petition for emergency admission**
   - NRS 433a currently allows for the 72-hour hold to start after the patient is medically cleared. This creates confusion for the patient, an undefined time period in which the patient is detained and has caused differing practices across organizations and counties. Research so far has shown that no other state in the nation allows for a time period after detainment prior to when the 72-hour time period starts.

6) **Mandated reporting for legal holds**
   - Currently, there is no data for emergency admissions throughout the state. All stakeholders agreed on the necessity of collecting this data.

7) **Allow the Division to define medical clearance through regulation**
   - There is differing interpretation on the function of medical clearance (medical stability versus differential diagnosis) leading to confusion and lack of continuity of care in practice.

8) **Allow the Division to develop a court ordered involuntary medication protocol**
   - Involuntary medication is a current practice in hospitals statewide, however there is no protocol exists to provide hospitals with guidance for appropriate.

9) **Extending time from 5 to 6 days for scheduling court hearing for petitions for involuntary court ordered admission**
   - Allows for court to be held one day per week while staying within regulations.

10) **Establishing timeframe for discharge after petition is denied**
   - Provides hospitals with guidance and enhances patient rights.

11) **Stipulated continuances for treatment**
   - No process exists for circumstances in which patients need to remain in hospitals but receive a court order for involuntary admission to a psychiatric facility.