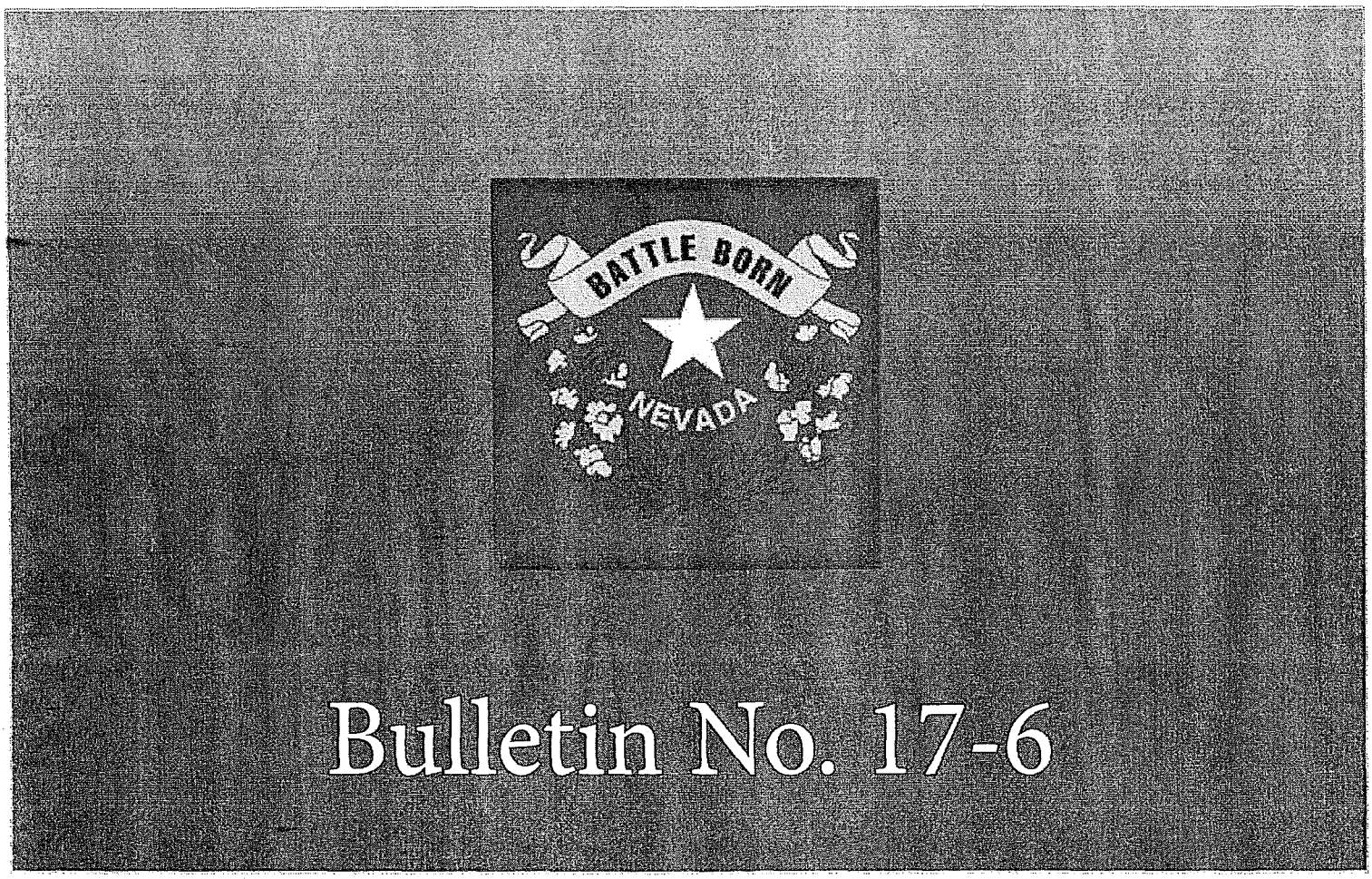
Legislative Counsel Bureau

Regionalizing the Mental Health System in Nevada: Considerations and Options



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REGIONALIZING THE MENTAL HEALTH SYSTEM IN NEVADA: CONSIDERATIONS AND POLICY OPTIONS

Legislative Charge

At its April 4, 2016, meeting, the Legislative Commission directed the Legislative Counsel Bureau (LCB) to study factors that may influence regionalizing the behavioral health system in Nevada. Commission members requested LCB staff to work with the Department of Health and Human Services (DHHS), local government entities, and community advocates to report on:

1. Issues the Legislature may wish to consider in proposing legislation to regionalize mental health in Nevada; and

2. Examples of states that have regionalized their mental health system, including successful and unsuccessful strategies and the advantages and disadvantages of transitioning to a regionalized behavioral health system.

Commission members clarified that the resulting LCB report should build on, rather than duplicate, the work of the Governor's Behavioral Health and Wellness Council, which studied mental health governance systems, among other issues. In addition, upon signing Executive Order 2016-07 in March 2016, which concluded the Council's work, Governor Brian Sandoval directed the DHHS to work with the Interim Legislative Committee on Health Care and the LCB to "evaluate implementing 'a local/regional governance model of administration'" in preparation for the 2017 Legislative Session.[1]

Disclaimer

The LCB is a nonpartisan agency; as such, LCB staff neither advocate for nor against any issue, position, or ideology. The purpose of this report is to present information in an unbiased manner to better assist legislators in making informed decisions regarding the subjects addressed herein.

[1] State of Nevada, Executive Order 2016-07, 10 March 2016, gov.nv.gov/News-and-Media/Executive-Orders/2016/EO -2016-07-Concluding-the-Governor s-Behavior-Health-and-Wellness-Council/.

Executive Summary

Across the nation, the mode of governance for behavioral health systems varies significantly. In many ways, each state's behavioral health governance structure is unique. As policymakers consider transitioning the behavioral health system in Nevada from a governance and service delivery structure centralized at the State level to a more regionalized system, it is important to define the objectives for doing so. It is also important to consider how such a change might build on the strengths and reduce the weaknesses of the existing system, and what it might cost to transition to and maintain a more regionalized system.

Although some steps have been taken to improve behavioral health care in Nevada, many challenges remain. As the State population grew steadily in recent years, the behavioral health system lagged; funding fluctuated and decreased during the recession. Recent improvements to the system have been fueled primarily by behavioral health crises. Mental health advocates and professionals acknowledge that comprehensive improvements and reforms are still necessary to strengthen mental health care in Nevada. Currently, Nevada's mental health system ranks 51st overall, 48th in youth mental health care, and 51st in terms of adult mental health care and access to mental health care, according to a review of state mental health systems by Mental Health America. The report, *The State of Mental Health in America 2017,* evaluated states on a variety of factors that are essential for developing and maintaining a mental health system that adequately meets the needs of the population. While the analysis does not consider each state's governance structure, it does provide a baseline understanding of the status and quality of the existing system compared to others. According to the report, major factors influencing Nevada's low ranking include the availability of behavioral health care providers; access to, quality, and cost of health insurance; access to behavioral health treatment; and high rates of substance abuse.[2]

The objectives for considering regionalization of behavioral health governance in Nevada may include involving local stakeholders in the identification of key behavioral health issues and development of priorities; developing community-based resources and services; and improving access to care. This study outlines numerous issues and key factors to consider as policymakers weigh whether to regionalize the behavioral health system and the type or style of regional governance that might be most effective in Nevada. It is organized into three broad sections:

1. Key issues to consider, including:

    a. Access to behavioral health care, including data regarding the behavioral health workforce, health insurance coverage, and barriers to accessing services and treatment;

    b. Policy and program changes as a result of the Patient Protection and Affordable Care Act (ACA) of 2010 and the impact of the ACA on the State budget;

[2] Nguyen, Theresa, and Kelly Davis, *The State of Mental Health in America 2017*, Mental Health America, 2016, http://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Full.pdf.

c. The relationship between the mental health care system and other systems; and

d. The recent expansions of State funding to address behavioral health in Nevada;

2. An analysis of patterns demonstrating how Nevadans currently access behavioral health care and a discussion of existing behavioral health collaborations and coordination arrangements that may be refined to provide regional boundaries; and

3. A brief summary of select states that have regionalized behavioral health governance, a model of regional governance proposed by participants at the Southern Nevada Forum, and policy options recommended by stakeholders throughout the course of this study.

In addition, it is important to consider the costs associated with transitioning to a more regionalized system of behavioral health care. These costs—and the ongoing cost of operating a regional system—will depend on how policymakers approach regionalization in Nevada. However, without a clear description of what a regionalized behavioral health system might look like in Nevada, the associated costs cannot be quantified. Therefore, while policymakers may wish to keep cost considerations in mind while deliberating this issue, this report does not provide cost estimates.

Introduction

Nearly one in five adults in Nevada (18.5 percent) had a mental illness in 2014, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services.[3] Of those individuals, more than 4 percent had a serious mental illness—which includes certain mental disorders that result in substantial impairment in carrying out major life activities.[4] In addition, approximately 26,000 Nevada adolescents between the ages of 12 and 17, or 11.6 percent of all adolescents per year, reported at least one major depressive episode in 2013 and 2014.[5] Nearly 70 percent did not receive treatment for depression, while approximately 30 percent did.[6] Suicide is also a considerable issue in Nevada, and especially so for youth. In 2014, nearly 18 percent of Nevada youth seriously considered suicide; nearly 16 percent made a plan, and approximately

[3] "Mental illness" is defined by SAMHSA as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. See SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014, Table 68, www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeNevada2014.pdf.

[4] SAMHSA, *Behavioral Health Barometer: Nevada, 2015*, HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: SAMHSA, 2015, www.samhsa.gov/data/sites/default/files/2015_Nevada_BHBarometer.pdf.

[5] "Major depressive episode" is defined as a period of at least two weeks in which a person experiences a majority of symptoms of depression.

[6] SAMHSA, *Behavioral Health Barometer: Nevada, 2015*, HHS Publication No. SMA-16-Baro-2015-NV. Rockville, MD: SAMHSA, 2015, www.samhsa.gov/data/sites/default/files/2015_Nevada_BHBarometer.pdf.

10 percent attempted suicide. Suicide is the second leading cause of death for Nevadans between the ages of 15 and 34 and the 8th leading cause of death statewide.[7]

Currently, the behavioral health system in Nevada is centralized at the State level. Policy development, oversight, service administration and provision, and funding are provided by the State. The Commission on Behavioral Health, established in 1975 by *Nevada Revised Statutes* (NRS) 433.314, guides policy and provides system oversight. This ten-member body also is responsible for reviewing programs and finances and reporting improvements in the quality of behavioral health care to the Governor and Legislature. According to its bylaws, the Commission takes the lead in strategic planning for the DHHS and promotes and assures the protection of the rights of all clients in the behavioral health system.[8] However, advocates note that the Commission's structure, available resources, and authority to review only public facilities, limits its ability to function as envisioned in statute, as well as its ability to improve the behavioral health care system. See Appendix C for the Commission's establishing statute, bylaws, and most recent annual report summarizing successes, opportunities for improvement, and recommendations regarding the behavioral health and intellectual and developmental health systems.

The DHHS directly provides behavioral health care services in three administrative regions: (1) Clark County; (2) Washoe County; and (3) rural and frontier Nevada. The Division of Public and Behavioral Health (DPBH), DHHS, administers adult behavioral health services in all three regions. Children's behavioral health care is administered by the Division of Child and Family Services (DCFS), DHHS, in Clark and Washoe Counties and by the DPBH in rural and frontier Nevada. In addition, the DPBH provides forensic mental health services statewide through two maximum-security facilities: Lakes Crossing in northern Nevada and Stein Hospital in southern Nevada. While much of the capacity for forensic behavioral health is in the north, the majority of the need for such services remains in southern Nevada. Behavioral health care funding is provided through a mix of Medicaid funds, State General Fund appropriations, and federal grants.

In recent years, a couple of regionally organized behavioral health entities have been established to address mental health issues in Nevada. The exact functions of the Children's Mental Health Consortia and regional behavioral health coordinators differ, but both groups aim to improve mental health by developing regional priorities, improving communication, promoting collaboration, and addressing behavioral health care needs in their geographic areas. In addition, Chapter 433C ("Community Mental Health Programs") of NRS provides the statutory authority and structure for individual counties or groups of counties to establish a locally controlled "community mental health program," but this option has never been used.

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[7] Nevada's Office of Suicide Prevention, DPBH, DHHS, *Youth Suicide Prevention in Nevada*, 18 May 2016, www.leg.state.nv.us/App/InterimCommittee/REL/Document/6623.

[8] Nevada's Commission on Behavioral Health, DPBH, DHHS, *Bylaws*, September 2013, http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Boards/xxx/Bylaws-9-13.pdf.

According to *Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers* by the Kenny C. Guinn Center for Policy Priorities, Nevada, Idaho, North Dakota, and South Carolina all rely on a similarly centralized behavioral health system in which the state directly operates community-based programs. A majority of states (31) have state-centered models in which the state contracts with community-based programs to provide services. In contrast, 15 states have a more "regional" approach, in which the state provides funding to local authorities to operate directly or contract with other entities to provide behavioral health services.[9]

In evaluating the behavioral health system in Nevada, it is important to consider the State's unique qualities. Of particular concern is the geographic distribution of the population, which significantly affects access to behavioral health care. Specifically, while the State spans approximately 110,000 square miles, 90.5 percent of its 2.9 million residents live in only three counties (Carson City, Clark County, and Washoe County). These urban counties comprise a mere 13 percent of the State's land mass. In contrast, the remaining 9.5 percent of Nevadans reside in rural and frontier Nevada, which covers an area of more than 95,000 square miles. For the purposes of this analysis, counties with a population of less than seven people per square mile are considered frontier regions. Counties with a population density greater than seven people per square mile, but not defined as a metropolitan statistical area, are considered rural regions. As can be seen from the table and map below, the majority of the geographic land mass of the State of Nevada is considered frontier.

[9] Kenny C. Guinn Center for Policy Priorities, *Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers*, 1 December 2014, guinncenter.org/wp-content/uploads/2014/12/Guinn-Center-Mental-Health-Governance-Report-Dec 2014.pdf.